Membranous Nephropathy in Hodgkin's Disease in Complete Remission

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Dear Sir,

Hotta et al. [1] have recently described in this journal the case of 61-year-old man with a corticoreistant nephrotic syndrome caused by a membranous nephropathy. Six months after the beginning of the disease, nodular sclerosing Hodgkin's disease (HD) was diagnosed. The nephrotic syndrome disappeared after successful chemotherapy for HD. For Hotta et al., this was the first reported case of membranous nephropathy associated with nodular sclerosing HD. We describe here the case of a 30-year-old man, admitted to hospital for two right cervical tumors (6×5 and 2×2 cm). The results of the hematological and biochemical analysis were as follows: hematocrit 44.8%, hemoglobin 15.7 g/dl, leukocytes 4,710/nl, normal serum glucose, urea, creatinine, uric acid, total cholesterol, bilirubin, ASAT, ALAT, alkaline phosphatase, transferrin, calcium, phosphate and iron. Thorax X-ray and abdominal echo-gram were normal. A ganglion biopsy was performed and histology showed mixed-cellularity HD. Total body scan did not reveal any intra-abdominal mass. Bilateral lymphography as normal. Ga scintigraphy showed a strong deposit in the right cervical region, but no other deposits. Bone marrow analysis did not show any Reed-Stemberg cells.

The patient was treated with an ABVD cycle, which induced a gradual decrease in ganglion size. One month later, a second cycle was administered, but the patient tolerated it badly and refused a third one. Supradiaphragmatic subtotal nodal irradiation with ⁶⁰Co (35 Gy) was then administered and repeated 4 weeks later (34 Gy). At the end of this treatment, the patient was in complete remission. Eighteen months after the initial manifestations, the patient was readmitted to hospital because of bilateral leg edema and weight gain. Urinalysis revealed proteinuria of 6.6 g/day and microhematuria. Total serum proteins were 5.2 g/dl, serum albumin 2.8 g/dl, total cholesterol 394 mg/dl; and serum glucose, urea, creatinine and uric acid were normal. A possible relapse of HD was ruled out. Simultaneously, prednisone treatment (1 mg/kg/day) was initiated, but proteinuria persisted 2 months later. Then percutaneous renal biopsy was performed. Light microscopy and immunofluorescence studies revealed a membranous nephropathy stage I. At that time, prednisone was interrupted, and the patient maintained under diuretic and antiaggregant therapy. Four months later, the leg edema had disappeared and

proteinuria decreased to 1.6 g/day with a serum albumin level of 3.2 g/dl and normal biochemical parameters. No signs of HD activity were detected.

Cervera et al. [2], in 1987, reported a similar case: a 16-year-old woman with a diagnosis of nodular sclerosing type HD, who developed a nephrotic syndrome and a biopsy-proven membranous nephropathy 5 years after successful treatment. The remaining examinations excluded a relapse of HD. The nephrotic syndrome disappeared after 6 months of treatment with prednisone and chlorambucil.

Although less frequent than minimal-change nephropathy, membranous nephropathy has been reported in approximately 10% of the cases [1-5], but histological data on tumor type are not always available. Usually, the nephrotic syndrome begins simultaneously with the initial manifestation of HD or during a relapse. To our knowledge, the case of Cervera et al. [2] and ours are the only reported cases of membranous nephropathy in HD patients in complete remission.

It is difficult to relate membranous nephropathy with HD treatment; were it related, there would be more frequent reports. The pathogenesis of minimal-change nephrotic syndrome in HD patients is easy to explain as a consequence of decreased T lymphocyte activity and increased lymphokine production, which are able to damage glomerular permeability. But in cases of membranous nephropathy, the pathogenesis is far from clarified; it could perhaps be related to cytokine release from tumor lymphocytes, as has been suggested [1].

In conclusion, the occurrence of a nephrotic syndrome in a patient with HD, also in complete remission, makes it mandatory to rule out a possible HD activity and justifies a renal biopsy.

References

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