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Henoch-Schönlein Purpura and Retroperitoneal Fibrosis

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To the Editor,

A relationship between Henoch-Schönlein purpura and retroperitoneal fibrosis has not yet been published.

Case History

A 17-year-old boy from Istanbul was hospitalized in February 1980 with the chief complaints of purpuric rash, abdominal pain associated with nausea, and swelling of the knees and ankles for 15 days. He had a history of an upper respiratory tract infection 2 weeks before onset. He had used analgesics only. On physical examination, no pathologic findings were present in the all systems except for purpuric rashes on the lower legs and periarticular swelling of the knees and the ankles. On admission, his sedimentation rate, his biochemical tests and his hematological findings including hemostatic tests were within the normal limits. The antistreptolysin O titre was 833 Todd Units. Latex test, LE cell and cryoglobulin were negative. Staphylococcus aureus was isolated from the throat. Urinalysis revealed trace proteinuria, 1–2 white blood cells, 25–30 red blood cells and a few casts per high power field. Urine culture failed to yield growth of bacterial organisms. Glomerular filtration rate was 120 ml/min. 50 mg of parenteral prednisone was given to the patient daily for 6 weeks and 2 g of parenteral D-aminobenzylpenicillin was used daily for 2 weeks. Abdominal and articular manifestations persisted until April, 1980. Microscopic hematuria and trace proteinuria were still present in the urine examination after regression of these manifestations. An intravenous pyelogram obtained in April 1980 revealed right ureteropelvic stenosis and hydronephrosis, and in July 1980 repeated intravenous pyelogram demonstrated bilateral ureteropelvic stenosis.

In July 1980 the patient was operated on the left side. Fibrous tissue was observed around the ureter above the iliac bifurcation. Left ureterolysis and left ureteroplastic dilatation were done and the ureter was transplanted within the peritoneal cavity and ureterostomy was performed. In August 1980, he was operated on the right side. On

exploration, the right kidney was observed to be normal. The pelvis of the kidney was considerably dilated and about 5 cm below the ureteropelvic junction, a 5-cm piece of ureter was surrounded by a fibrous sheath. Ureterolysis and partial ureterectomy were performed. During the second operation a renal biopsy was also done. Light microscopic investigation of renal tissue showed focal segmental glomerulonephritis and chronic interstitial nephritis. Direct immunofluorescent studies using antisera to IgG and C3 detected IgG and C3 deposits in an irregular pattern which shows 3+ fluorescence in the center and peripheral zones of the glomeruli. The fluorescence also included the mesangium.

Prednisone was not given to the patient postoperatively. He has been seen many times after operation and has not had any complaints, his physical examination was normal and the laboratory findings did not show any abnormalities.

Discussion

This patient had Henoch-Schönlein purpura and retroperitoneal fibrosis. The common features of these disorders are a possible autoimmune etiology [1,2]. In this patient, the Henoch-Schönlein purpura and retroperitoneal fibrosis may have been initiated by the same stimulus or by different stimuli. An upper respiratory tract infection may be a common initial factor, but another common and unknown initial factor may also be responsible, or the occurrence of retroperitoneal fibrosis may have been provoked by the D-aminobenzylpenicillin used during the disease. Local segmental glomerulonephritis which occurred in this case, may be due to Henoch-Schönlein purpura or may be due to immune complex glomerulonephritis in the course of retroperitoneal fibrosis [3].

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