Renopath

Center for Renal and Urological Pathology Pvt Ltd

NABL ACCREDITED LABORATORY
CERTIFICATE No. MC-2331

PATIENT INFORMATION		PHYSICIAN INFORMATION
PATIENT NO	: 0100030917	St. John`s Medical College Hospital
NAME	: MADHUMITHA	Dr.Anil Vasudevan
AGE/GENDER	: 13 Y / Female	
SAMPLE No	: 01005555 / 2019	
COLLECT DATE	: 17/12/2019 13:11:00	Page : 1/3
REPORT DATE	: 18/12/2019 15:57:55	

HISTOPATHOLOGY REPORT

RENAL BIOPSY LM+IF(NATIVE)

SPECIMEN: Renal Biopsy

CLINICAL HISTORY

Recurrent episodes of gross hematuria, with nephrotic range proteinuria.

Normal BP and normal complements

S. creatinine 0.96 mg/dl

Protein creatinine ratio : 3.53

GROSS DESCRIPTION

Received from St. John's Medical College Hospital ,2 specimen bottles, one of formalin and the other Michel's fixative along with the clinical details of the patient labeled Ms. MADHUMITHA (13 Y / F)

In formalin is one piece of tissue measuring 0.2 cm Submitted in its entirety for light microscopy .

In Michel's fixative is one piece of tissue measuring 0.6 cm Submitted in its entirety for immunofluorescence microscopy.

IMMUNOFLUORESCENCE

3 glomeruli are present for evaluation. The section are stained for IgG, IgM,IgA,C3,C1q,Kappa& Lambda light chains. IgA (+3) and C3 (+1) are positive over the mesangium. No light chain restriction seen. Rest of the antisera are negative.

Door No.27 & 28, VMT Nagar, Kolathur, Chennai - 600 099, (Near DRJ Hospital)
Cell : 89396 47185, Email : renopath@yahoo.com
CIN : U93000TN2013PTC090362

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LIGHT MICROSCOPY

Sections and special stains (PAS,silver and trichrome) include only a small portion of renal cortex.

Six glomeruli are identified, two are globally sclerotic.

There is diffuse increase in mesangial cellularity.

Segmental endocapillary hypercellularity is noted in one glomerulus.

Glomerular basement membranes shows no spikes or double contour.

No segmental sclerosis, cellular crescent or necrotizing lesion identified.

RBC casts are seen in occasional tubules.

Scattered lymphocytic infiltration is present in the interstitium.

There is no interstitial fibrosis and tubular atrophy in the sampled cortex.

Arteries are unremarkable.

DIAGNOSIS

1. IgA NEPHROPATHY (see comment)

2. GLOBAL GLOMERULOSCLEROSIS - 2/6 GLOMERULI

Comment : There are insufficient number of viable glomeruli to assign the MEST-C score

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ST.JOHNS MEDICAL COLLEGE HOSPITAL

Sarjapur Road, Bangalore 560034
Information Desk : 080 - 22065008 / 22065250 Appointments : 080 - 22065003 / 22065004

CASE SUMMARY & DISCHARGE RECORD

Department of Paediatric Nephrology

DIATRIC NEPHROLOGY OPD DAYS (9am - 1pm)

Anil Vasudevan	Prof & Head	Tue / Sat
Arpana Iyengar	Professor	Thur / Sat (Tue - Evening special OPD)
Priya Pais	Assoc Prof	Tue / Thur
Dr. Nivedita	Asst Prof	Wed / Sat

nday: CKD and Transplant Clinics at 11am - 4pm (Unit of Hope Building)
dnesdays: NUC: 2pm - 4pm
OPD days are Tuesday/Thursday & Saturday (New/Silver Jubilee OPD) between 9am - 12.30pm

OP No : 4397074 In-Patient No : 1464409
Patient Name : MS. MADHUMITHA S
Age : 14 Yrs 05 Mnths 05 Days Gender : Female
Address : GAREPALYA LAKSHMI LAYOUT 1ST CROSS BOMMANAHALLI B LORE
Date of Admission : 18/07/2020
Date of Discharge : 19/07/2020
Tel No :
Mob No : 9538954284
E-Mail :
Ward Name : 0CP - PAEDIATRIC WARD - PAED. NEPHRO
SRF ID :

ADMISSION DIAGNOSIS

IgA Nephropathy
(M1E1S0T0C0)
2nd dose cyclophosphamide given on 19/7/2020
Steorid toxicity - Hypertension/Secondary Diabetes Mellitus/Vitamin D deficiency/Proximal myopathy

PRESENTING COMPLAINTS

Admitted for 2nd dose cyclophosphamide

HISTORY

Madhumitha 14 years old child a k/c/o IgA nephropathy on tab. Wysolone 40mg daily for past 6 months (started on 13/12/19) biopsy - IgA Nephropathy (2/6 sclerosed), started on enalapril 5mg OD and tab MPA 360mg BD (714mg/m2) started on 30/1/2020 in view of peristent nephrotic range proteinuria & then increased to 360mg-0-540mg (850mg/m2). She was admitted last month with significant steroid toxicity and noted to have partial response with MPA. 1st dose of IV cyclophosphamide was given on 12/6/2020 and dose of steroid tapered to 30mg OD from 10/6/2020. She was due for 2nd dose of IV cyclophosphamide last week, but dose deferred in view of mumps infections. Presently no complaints of fever, cough, breathing difficulty, headache or vomiting
No h/o passing red colour urine or reduced urine output
On Metformin for secondary diabetes mellitus, enalapril, amlodipine, oral steroids, calcium and vitamin D supplements

FAMILY HISTORY

Renal stone for father & elder brother +

DEVELOPMENT HISTORY / DIET HISTORY / IMMUNIZATION

Appropriate for age
Immunised as per National Immunisation Schedule. Not received Pneumococcal or varicella vaccine

ON EXAMINATION

Wt: 63.5kgs (+0.8z); Ht: 157cms (-0.9z);
BMI - 25.3kg/m2 (+2z)
BSA - 1.4m2
Discharge Wt: 63.50kg;
PR: 90/min; RR: 24/min; BP: 104/70mmHg (50th-90th centile);
Obser: cushingoid facies +, buffalo hump +
Proximal myopathy +, UL + LI: straie all over body +
Bony tenderness of spine +
CVS: S1 S2 +, no murmur
RS: B/L AE +, NVBS +
PA: Soft, straie +, no HSM
CNS: Normal

LABORATORY INVESTIGATIONS

18/07/2020 pH- 5.50, Protein 2 +, RBC 11 WBC 3 Epithelial Cells 4 Bacteria 107.0

DISCUSSION

14yr adolescent girl with IgA nephropathy was admitted for the following issues

1) IgA nephropathy

She was diagnosed with IgA nephropathy in December 2019 when she presented with painless gross hematuria not associated with oliguria, hypertension, edema or systemic symptoms. S.creat - 0.96 (eGFR - 69ml/min/1.73m2). Normal complement levels noted. Secondary work up - ANA, viral markers negative. Ophthal evaluation for Alport syndrome was normal. Urine showed 3+ albumin and PC ratio of 3.53. 24hrs quantification 2349mg. Serum albumin and cholesterol normal. Renal biopsy was done on 16/12/19 which showed IgA nephropathy (M1E1S0T0C0). She was discharged on steroids 40mg/day. In view of persisting gross hematuria even after 6 weeks of steroids advised for alternate immunosuppression. MPA was started on 29/2/2020.

Previous admission (June 2020) - Urine albumin 3+, R40 and severe steroid toxicity noted

In view of poor response to MPA, IV pulse cyclophosphamide 750mg was given on 12/6/2020. She was discharged on steroids 30mg OD from 10/6/2020.

Repeat urine routine showed improvement - urine albumin 2+, R11

2nd dose of IV cyclophosphamide 1gram was given on 19/7/2020 with adequate pre and post hydration and Mesna. Plan for 3 monthly pulses and to assess response. Steroids tapered to 25mg daily.

2) Steroid toxicity

She was started on steroids 40mg/day from 13/12/2019 for IgA nephropathy. She was detected to have significant steroid toxicity during previous admission. Presently on 25mg daily steroids.

a) Severe cushingoid features, central obesity with buffalo hump and striae

b) Hypertension

She did not have hypertension at onset of disease. Detected to have stage 2 asymptomatic hypertension in June 2020 with no evidence of end organ damage. Blood pressures are well controlled on amlodipine and metaprolol.

c) Secondary Diabetes Mellitus

Her fasting and postptandial sugars were high (174/230), HbA1c - 5.8. 24hr sugar monitoring showed deranged profile and endocrinology opinion was taken. She was started on oral metformin in June 2020. Endocrinology advised to taper metformin if adequate glucose control once steroids tapered below 20mg daily. Advised for home glucose monitoring.

d) Ophthalmology screening showed no evidence of cataract, glaucoma or hypertensive retinopathy.

e) Vitamin D deficiency

She had low back ache with bony tenderness on examination. Xray spine showed no evidence of fracture. Osteoporosis was noted. Hypocalcemia (8.6) and vitamin D deficiency (16.6) seen. She is on calcium and vitamin D weekly supplements.

f) She has significant proximal myopathy of lower limbs

PLAN

Taper steroids after 2 weeks to t.wysolone 20mg O.D
Taper metformin after endocrinology follow up next month
3rd dose of cyclophosphamide after 4 weeks on 18/08/2020
To assess response after 3rd dose of cyclophosphamide
Daily home glucose monitoring (to inform in premeal >200mg/dl)
Increase dose of enalapril at follow up
Pneumococcal vaccine at follow up
to do CBC, s.albumin, urine PCR , s.creatine,urine routine and microscopy IN Next visit

In case of any emergency, please report 24/7 to our Emergency or to the nearest doctor or hospital in your vicinity

This is especially if you develop any of the following severe, persistent, new onset and unusual complaints listed below

"Severe unbearable pains anywhere, bleeding anywhere, convulsions, unresponsiveness, loss of vision, inability to drink liquids, vomiting, diarrhea, breathlessness, palpitations, jaundice, absence of urine, fever, rash, joint swellings, behavioural changes including violence/self-harm/agitation, and weakness/fatigue"

In addition, any of these listed specific complaints for your condition such as fever, increasing edema, persistent cough, breathlessness, cold extremities, persistent vomiting, severe pain abdomen, persistent headache, seizures, change in sensorium

In case of any emergency dial: 080-22065458

ADVICE ON DISCHARGE

T Prednisolone 25mg (after food) OD(from 18/07/2020 - 1/08/2020)
and then taper to T.Prednisolone 20 mg O.D(2/08/2020 t0 18/08/2020)
T. Enalapril 5mg BD
T. Amlodipine 5mg BD
T. Shelcal 500mg 2-1-1 (2hrs before food)
Calcirol sachets 60,000 IU once/ 2weekS
T. Metformin 250mg-500mg-500mg

Follow up on 18/8/2020 (Tuesday) for 3rd dose of cyclophosphamide - CBC, S.creatinine, S.electrolytes,s.albumin, Urine routine and microscopy, urine PCR

Prepared By

Name: Dr. Vidhya MBBS, MD
TNMC No. 106004
Senior Resident - Pediatrics Nephrology
Staff ID : F020, SJMCH

KMC NO:

Date & Time:

Checked By

Name: Dr. Vidhya MBBS, MD
TNMC No. 106004
Senior Resident - Pediatrics Nephrology
Staff ID : F020, SJMCH

KMC NO:

Date & Time:

Summary Recieved by:

Signature: S.R3

Receiver's Contact / Mobile No.: 9538954284

Reciever's Name: