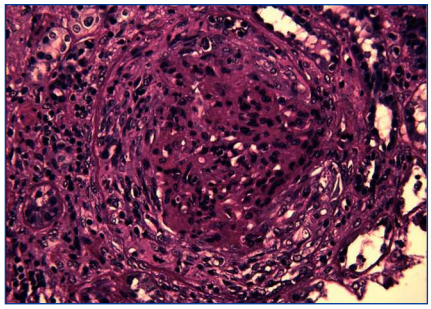

Figure 2. PAS stain shows a fibrocellular crescent in the urinary space that compresses the residual glomerulus and its tuft (PAS, x 400).

mary membranous glomerulonephritis. Vasculitic or crescentic glomerulonephritis is rarely seen in membranous nephropathy, except in those cases associated with systemic lupus. The immunopathogenesis of this unusual transformation is unclear. It is well recognized that patients with a crescentic glomerulonephritis have severe and often rapidly deteriorating failure. Unlike membranous nephropathy, which often has an insidious course progressing to renal failure over a period of years, patients with superimposed crescentic glomerulonephritis appear to have a more aggressive clinical course. The importance of recognizing this group of patients with membranous nephropathy and crescentic glomerulonephritis is that immunosuppressive therapy may ameliorate the progression of renal damage and in some cases early treatment was associated with useful recovery of renal function.[4] In our case, the discontinuation of prednisone and azathioprine therapy may have facilitated the rapid progression of kidney disease.

Conflict of interest

The authors declare that there is no conflict of interest associated with this manuscript.

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Respuesta

Response to "Comment on 'Membranous glomerulonephritis associated with mieloperoxidase antineutrophil cytoplasmic antibody associated glomerulonephritis'"

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Dear Editor,

We were very interested by the comment submitted by Dr. Gioacchino Li Cavoli and his collaborators, regarding their similar experience of a membranous glomerulonephritis with crescentic overlap. First of all, we would like to thank them for their input.

They reported a case of membranous glomerulonephritis (MGN) with crescentic transformation in a ANCA-negative vasculitis which revealed no evidence of systemic lupus erythematosus (SLE), anti-glomerular basement membrane (GBM) glomerulonephritis, infection, malignancy and showed no improvement after immunosuppressive treatments. The case they presented was similar to the patient that Kwan JT et al. described previously.[1] Although several authors have demonstrated the concomitance of MGN and ANCA-associated glomerulonephritis,[2-6] MGN accompanied by ANCA-negative crescentic glomerulonephritis has been rarely encountered.

The light microscopic visualization of renal tissue in their case showed the formation of 11 crescents (3 cellular crescents, 1 fibrocellular crescent and 7 fibrotic crescents) and 11 out of 17 glomeruli were globally sclerotic. These histopathological changes indicate the patient has reached to an advanced stage of crescentic glomerulonephritis and the renal disease has progressed to the sclerotic phase at the time of renal biopsy. Nasr SH et al. reported that the percentage of globally sclerotic glomeruli correlated with nonresponse to immunosuppressive agents.[5] This is why the patient showed no improvement after treated with steroid plus cyclophosphamide and started chronic haemodialysis treatment eventually. By contrast, our case showed 2 sclerosed glomeruli out of 19 glomeruli, the formation of 9 crescents including 4 cellular crescents and 5 fibrocellular crescents, as well as the fibrinoid necrosis lesions upon light microscopy. This indicates our patient might be at the relatively early stage of crescentic glomerulonephritis and the renal biopsy findings may interpret the better response to immunosuppressive treatments in our case.

Concerning the prognosis of this group of patients, Nasr SH et al. reported that 50% of patients had reached endpoints of end-stage renal stage (ESRD) or

death whether or not treated with immunosuppressive agents and the only independent predictor of progression to ESRD was serum creatinine at biopsy.[5] However, the different outcomes of the two cases we and Dr. Gioacchino Li Cavoli exhibited reveal that the histological finding is more reliable to predict the prognosis. As Dr. Gioacchino Li Cavoli mentioned in the comment, the importance of recognizing the patients with membranous nephropathy and crescentic glomerulonephritis at early stage of the disease is that early immunosuppressive treatment may ameliorate the progression of renal damage and may contribute to the useful recovery of renal function.

Watanabe S et al. demonstrated that the patient had MPO-ANCA-associated glomerulonephritis superimposed on idiopathic membranous nephropathy in the coexistence of MGN and ANCA-associated glomerulonephritis.[6] It is well recognized that ANCA-positive patient may develop ANCA-related crescentic glomerulonephritis; however, the immunopathogenesis of crescentic transformation in ANCA-negative patients with primary membranous nephropathy seemed to be more difficult to elucidate. Whether there are some other undetected autoantibodies involved in the pathogenesis of MGN accompanied by ANCA-negative crescentic glomerulonephritis remains unclear. Therefore, further research is required to clarify the pathogenesis of this rare concomitance and investigate the optimum treatment regimes for it.

Conflict of interest

The authors declare that there is no conflict of interest associated with this manuscript.

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B) COMUNICACIONES BREVES DE INVESTIGACIÓN O EXPERIENCIAS CLÍNICAS

Laparoscopia como técnica eficaz para la colocación del catéter peritoneal

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Sr. Director:

La diálisis peritoneal (DP) es uno de los tratamientos de los que disponemos para sustituir la función renal en los casos de insuficiencia renal crónica.

El éxito de la técnica de DP va a depender de la correcta colocación del catéter en la cavidad peritoneal. Existen diversos métodos para ello: laparoscopia, vía percutánea mediante técnica de Seldinger o con trocar y quirúrgica[1]. No existe evidencia sobre qué técnica ofrece mejores resultados, aunque, evidentemente, cada una tiene sus ventajas e inconvenientes. Las puramente quirúrgicas requerirán la disponibilidad de cirujanos, quirófanos y anestesia. Las técnicas percutáneas pueden ser realizadas por los nefrólogos y/o radiólogos en una sala adecuadamente preparada para ello, por lo que no suelen originar listas de espera[2]. Existen datos recientes sobre la seguridad de la laparoscopia frente a la cirugía abierta y sobre los métodos percutáneos asistidos por los radiólogos[3,4]. A pesar de ello, las técnicas quirúrgicas siguen siendo las más utilizadas.

En nuestro centro, la colaboración con el Servicio de Cirugía General es estrecha, por lo que la técnica de elección es la laparoscopia. Presentamos nuestra experiencia en la colocación de catéteres peritoneales.

MATERIAL Y MÉTODOS

Revisamos 80 pacientes a los que se les colocó un catéter de DP entre enero de 2007 y enero de 2012. Los datos demográficos y clínicos se recogieron prospectivamente.