that his moral genome has reached such high evolutionary levels. Dr. Praga says that "research is carried out for the love of truth... for our profession and for our patients". Beyond getting into an irresolvable discussion about the existence or not of authentic altruism, there is little real motivation for our species beyond glory, power, sex and money. Although I am willing to get excited about the possibility that Dr. Praga forms an exception, it would be a good thing if the scientific policy managers would take into account these ideas and, above all, the proposals of the editorial, to slowly transform the reality of research in the majority of Spanish hospitals.

1. Praga M. ¿Se está apoyando lainvestigación clínica independiente en España?. Nefrologia 2009;28 (6):575-82.
2. Lamas S. Los nefrólogos que elegimos ellaboratorio. Nefrología 2002;22:106-7.
3. Niranjan T, Bielesz B, Gruenwald A, PondaMP, Kopp JB, Thomas DB, et al. The Notchpathway in podocytes plays a role in the development of glomerular disease. Nat Med 2008;14:290-8.

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A paper on independent clinical research in Spain

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Dear Editor,

I have read Dr. Manual Praga[1] Terente's article about independent clinical research in Spain with great respect and admiration. I share many of his ideas, especially when he claims that quality research in hospitals will not be possible until there is real material recognition rather than mere moral support of the activity carried out. Unfortunately, the politically influenced persons who make the decisions regarding the management of personnel in the hospital environment systematically forget this premise, making the development of any type of quality research in this area very difficult.

Nonetheless, in spite of my respect and admiration for Dr. Praga, I would like to put a different point of view, not necessarily to the contrary of his about some of the topics that he covers. In particular, I would like to make a few brief references about the evaluation process, the role of Official Agencies concerning Clinical Research and the systematically evoked dichotomy between clinical and basic research.

The evaluation of a research project is a complex process. In general, it is based on a combined analysis of the scientific quality of the applicant group and of the project. At the same time, the research groups are usually evaluated with mixed criteria, depending on their capacity to obtain competitive funding and on their level of scientific productivity. It is true, as Dr. Praga notes, that certain programmes, or certain assessors, attribute excessive relative importance to some of these areas, creating a biased evaluation. The examples given make reference to highly productive groups without competitive funding and to groups with great amounts of competitive funding and low productivity that can be evaluated as "bad" and "good" respectively in some of these evaluation processes. Although it is true that this happens at times, the managers of the evaluation process as well as the very assessors themselves are absolutely convinced that a quality research group is defined by a reasonable balance between planning capacity, including obtaining resources, and scientific productivity. This is what normally happens bearing in mind that there are always exceptions. Although in reality, in the last few years, groups with abundant funding and little scientific production are evaluated, almost automatically, in a negative manner, while those with high scientific productivity, although they have no funding, are usually evaluated in a positive manner.

I would like to note here that as pointed out in the last cited hypothetical figure: it is the groups with high scientific productivity without funding in the hospital setting. It is true that these groups exist, as Dr. Praga clearly is aware but it is also completely true that they are an exception. Some of these groups have even been systematically funded by private companies with commercial interests leading to a scientific productivity that is not always based on their own ideas.

While even considering this possibility, there are still certain totally independent research groups of high quality, without funding, in the hospital setting. These groups, with an effort and dedication, could have obtained economic support from the Public Research Agencies which would have helped their research efforts.

The Public Agencies that evaluate and fund research have made huge efforts in the last few years to give proper attention to clinical research in the hospital setting. Three examples are enough. The ANEP, the Spanish *Agencia Nacional de Evaluación y Prospectiva* has remodelled its evaluation areas, creating a specific area of Clinical Medicine where not only the Coordinator but also the workers are hospital doctors. The Carlos III Health Institute, in its general project funding programme, includes a specific area of Epidemiology and an area of the Evaluation of Health-related Technologies in order to foster specific hospital research of a strong clinical character.

These areas, which group together a large number of projects are as successful as others in obtaining funding, are funded with success rates that are similar to others.

Finally, many research projects allow for the inclusion of atypical funding concepts which are very different from the classic

"laboratory reagents" in order to meet the needs of groups that carry out clinical research. There are many more examples of this concern for clinical research in the hospital setting but presenting an exhaustive list does not seem necessary.

A brief final reference to the dichotomy of clinical and basic investigation: we have to forget about it. We must stop systematically talking about this antagonism. Those researchers who identify themselves as basic researchers should start interiorizing a profound and convinced feeling of respect for clinical research. Clinical researchers should understand that some of their future activities are going to be conditioned by the work of basic researchers.

They should speak amongst themselves in order to understand each other and, despite the difficulty, speak less and less about this antagonism thus making it disappear.

1. Praga M. ¿Se está apoyando lainvestigación clínica independiente en España?. Nefrología 2009;28(6):575-82.

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Membranoproliferative Glomerulonephritis and Monoclonal Gammopathy of Uncertain Significance

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Dear Editor,

A series of patients with kidney problems secondary to monoclonal gammopathies without malignant criteria was recently published in Nephrology.[1] We present the case of a patient with membrane-proliferative glomerulonephritis of a non-filiated aetiology where a monoclonal gammopathy of undetermined significance was detected.

A 60 year old woman presented with a history of high blood pressure, heterozigous beta thalasaemia and plantar psoriasis treated topically. She sought a consultation for leg oedema of one week duration. Impairment of kidney function was detected in the blood tests. Cr 1.9mg/dl, urea 85mg/dl. The full blood count showed anaemia with the rest of the parameters and coagulation normal. There was nephrotic-range proteinuria with normal total serum protein and albumin levels. The urinary sediment contained 35 red blood cells/field. The immunological study showed hypocomplementaemia with a decrease in the C3, C4 and CH50 levels. Two cryoglobulin tests were carried out and both were negative. The electrophoretic blood study was normal while the electrophoretic urine study presented a Bence Jones Lambda band (200 mg/24 h). In the bone marrow biopsy, the percentage of plasma cells was 2%. The serology for HBV and HCV did not indicate active infections.

All of the glomeruli in the kidney biopsy presented a similar histological aspect with a diffuse proliferation of the matrix and the mesangial cellularity adopting a lobulated pattern. The interstitial area had a slight non-specific infiltration of lymphocytes without fibrosis. The vascular and tubular components showed no lesions. The immunoflourescence showed granular deposits of IgG and C3 (figures 1 and 2).

This patient presented with monoclonal gammapthy of unknown significance and membranoproliferative glomerulonephritis for which no underlying cause was found an aetiological factor.

The glomerular involvement in the monoclonal gammopathies generally occurs in the malignant forms and is usually associated with deposition of light chains.[2] The presence of renal involvement is less frequent in patients with benign monoclonal gammopathies. However, the benign character does not exclude the existence of secondary renal involvement.[3,4] Recently, a series of ten patients with glomerular involvement associated with benign monoclonal gammopathies has been published.

There is however a few reported cases in the literature.[1]

In 2004, Nasr *et al*. published a series of ten patients with idiopathic proliferative glomerulonephritis associated with a deposition of monoclonal immunoglobulins (IgG).[5] Half of the patients presented monoclonal bands on blood and urine electrophoresis, none of them meeting criteria for myeloma in bone marrow biopsies. Four of the patients presented hypocomplementaemia but the cryoglobulin determinations were negative for all of them. Samuh and coworkers suggested that the deposit of monoclonal immunoglobulins might cause a proliferative glomerulonephritis mimicking the immune complex-mediated glomerulonephritis. We report this new case of renal involvement in monoclonal gammopathies of undetermined significance that we believe could be similar to those published in the series of Nasr *et al*.[1,5]

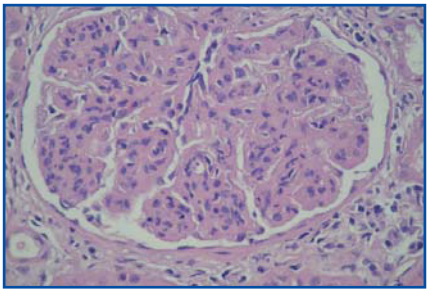

Figure 1. Kidney biopsy: hematoxylin-eosin: glomerulus of lobulated appearance with diffuse matrix expansion and increased megangial cellularity.

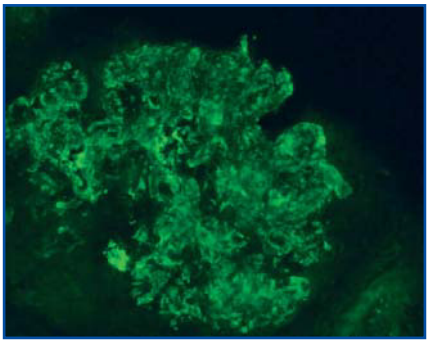

Figure 2. Kidney biopsy: immunofluorescence: deposits of IgG in the glomerular capillary wall.