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Henoch-Schönlein nephritis triggered by *Salmonella enteritidis* infection

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Dear Editor,

Henoch-Schönlein purpura (HSP) is a common type of vasculitis in children. Renal involvement is frequent and not always benign. Prognostic factors have been recently reviewed by García et al. on your Journal, older age and relapses being related to a poorer renal prognosis.¹

We present a case of 5-years old boy who was admitted to our hospital with a history of fever-chills, vomiting, abdominal cramping and diarrhoea. He received IV and subsequent oral rehydration and his conditions improved in three days. A stool culture yielded *Salmonella enteritidis*. After an interval of one week by the onset of gastrointestinal symptoms he developed symmetrical purpuric papules and plaques at the lower extremities and arthralgia of the tibio-tarsal joints. Two days later appeared frank hematuria lasting one day

only and followed by microhematuria with mild proteinuria. Blood pressure was always normal. Among laboratory investigations creatinine was 77 µmol/l, platelet count, C3 and C4 levels were normal, antinuclear antibody and rheumatoid factor were absent, serum IgA levels were increased for his age (232 mg/dl). Characteristic skin manifestations, joint involvement and hematuria led us to the diagnosis of HSP nephritis (HSPN). Purpura and arthritis resolved in three weeks. Nephritis had a benign evolution. After six months the boy was normotensive without residual microhematuria nor proteinuria and his renal function was normal.

Pathogenesis of HSPN has very recently reviewed.² High levels of galactose-deficient IgA1 (Gd-IgA1) has been found in children with HSPN, but not in HSP affected patients without nephritis. Gd-IgA1 seems to have a pivotal role both in HSPN and IgA nephritis. Gd-IgA1 is recognised by anti-glycan antibodies and form large molecular immune complexes. Their deposit in renal mesangium is thought to initiate glomerular inflammation.

Many factors may activate IgA1 overproduction and subsequent disease: a list that includes various infective agents and medications has been published in a review by Rai et al., but it does not contain *Salmonella enteritidis*.³ Afterwards a case of HSP nephritis in a 50-year-old woman with *Salmonella typhi* septicaemia has been described.⁴ At our knowledge our case of HSP nephritis induced by *Salmonella enteritidis* is the first described in literature. This pathogen, very common in children, should be included in the number of infectious agent that can trigger HSPN.

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Acute rejection of pancreatic grafts

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Dear Editor,

Simultaneous renal and pancreatic transplantation is the best treatment option for young patients (< 45 years) who have type 1 diabetes mellitus (DM) and advanced stages of diabetic nephropathy, in the absence of other cardiovascular risk factors, as long as the transplantation waiting time is not unreasonably prolonged.¹

Due to the characteristics of this type of donors and recipients, patient and graft survival is similar to living donor transplant cases.² The pancreatic graft in this case has a survival rate of around 70% five years after transplantation.

We report a case of a 47-year-old man who underwent simultaneous pancreas and kidney transplantation and came in for follow-up; he was asymptomatic except for mild discomfort in the area