Heterogeneity of atypical haemolytic uraemic syndromes

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Abstract
Atypical, non-diarrhoea associated haemolytic uraemic syndrome (D−HUS) is a heterogeneous disorder with a generally poor outcome, although this view has now been questioned. The clinical and laboratory features of 23 children with D−HUS, representing a third of all patients with HUS seen during the last 26 years, were examined. The median age was 4.9 years (range 3 days–13.8 years). Twenty one children (91%) survived the initial phase. All patients except six infants aged <18 months required dialysis (74%). Hypertension (43%), cardiomyopathy (43%), and cerebral convulsions (48%) were common. Nineteen (83%) children were followed up for a median period of 5.5 years (range 0.5–23.4). Only five (26%) patients, among them four infants, recovered completely. Six (32%) patients had one to 10 recurrences, including two siblings with neonatal onset, and eight (42%) developed end stage renal failure. Five children underwent cadaveric renal transplantation, with recurrence and subsequent graft failure in two. Four children died, resulting in an overall mortality of 26%. Atypical HUS is heterogeneous with regard to epidemiology, pathophysiology, and outcome. Children with a recurrent, familial, or neonatal course have worse outcomes; in contrast, infants not requiring dialysis in the acute phase have a better prognosis.

Keywords: haemolytic uraemic syndromes

Gasser et al first used the term ‘haemolytic uraemic syndromes’ (HUSs) in 1955. They reported five children from our institute with microangiopathic haemolytic anaemia, thrombocytopenia, and renal failure. Two of their patients had prodromal diarrhoea and two had pleuropneumonia; one patient had no prodrome. The plural form of HUS (‘Syndrome’ in German) was deliberately used in anticipation of the epidemiological, clinical, and pathophysiological heterogeneity of the disease. The current concept divides the HUSs into two major types: one is associated with a prodromal diarrhoea (D+HUS) and the other without diarrhoea (D−HUS). Most paediatric cases were D−HUS, affecting mostly younger children and generally having a good prognosis. D−HUS or atypical HUS is less common and is itself heterogeneous: some are familial, some are recurring, some have a neonatal onset, and some are related to neureaminidase producing microbes. D−HUS is generally associated with a greater morbidity and mortality than D+HUS. So far, only two studies have been confined to D−HUS: one from London confirmed the worse outcome in D−HUS, whereas the other from Utah, USA, reported that children with D−HUS had a milder nephropathy and did not have poorer outcomes.

Between 1970 and 1995 inclusive, 66 children with HUS were referred to our institute; 43 (65%) had prodromal diarrhoea and 23 (35%) did not. This paper reports the large clinical heterogeneity of patients with D−HUS, ranging from mild acute nephropathy with subsequent complete recovery to a familial, recurring course with neonatal onset and fatal outcome.

Patients and methods
The HUS was defined as the simultaneous and acute occurrence of microangiopathic haemolytic anaemia, thrombocytopenia, and renal failure. In children with D+HUS, verocytoxin producing Escherichia coli (VTEC) have been examined in stool specimens since 1990; eight of 20 samples were positive. Peritoneal dialysis or haemodialysis was performed in oliguric children unresponsive to diuretics or in the presence of severe electrolyte or acid-base disturbances. Plasma exchange, using the filtration technique, has been administered to all patients with D−HUS since 1992. The volume exchanged was 40 ml/kg body weight; a purified protein fraction was used and an infusion of fresh frozen plasma was given at the end of the treatment if plasma fibrinogen was <1 g/l. Cardiomyopathy was defined as heart failure requiring the use of inotropes. A short course of immunosuppressive or cytotoxic drugs was given to two patients (azathioprine/ prednisone and vincristine, respectively). Histological examination of renal tissue was available during the acute phase in eight children.

Nineteen children with D−HUS were regularly followed up either by us or by the local paediatrician. Re-evaluation included any signs of clinical and laboratory evidence of recurrence, renal function (as assessed by plasma creatinine), blood pressure, and urine analysis (haematuria, normal <10 erythrocytes/µl; and proteinuria, normal <1+ on albustix and/or protein/creatinine ratio <20 g/mol). Normal plasma creatinine (µmol/l) was defined according to age: <40 (<4 years), <50 (<4–6 years), <60 (<6–10 years), <70 (>10–12 years), and <90 (>12 years). Complete recovery was...
Atypical haemolytic uraemic syndrome

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ACUTE PHASE (<3 MONTHS)
Results
The median age of the 23 children with
D–HUS (12 girls) was 4.9 years (range 3
days–13.8 years). All presented at admission
with renal failure (median plasma creatinine
566 µmol/l) and anaemia (packed cell volume
0.18); 22 were thrombocytopenic (46 × 10^9/l).
The urine samples showed haematuria and
proteinuria in 20 patients; three were anuric at
admission. Twenty one of 23 children (91%)
survived the acute phase. Seventeen patients
(74%) were dialysed: 10 (including the two
children who died) had temporary dialysis for
5–122 days (median 28 days) and seven (30%)
subsequently required long term dialysis. Six
children, all infants aged <18 months, required
no dialysis (table 1). Seven patients, all requiring
dialysis, underwent plasma exchange: only
one recovered completely; two had moderate
sequelae and four developed end stage renal failure.

Ten children (43%) were hypertensive. Cerebral
convulsions occurred in 11 (48%); six were also hypertensive and their median plasma sodium concentration was 132 mmol/l (range 119–144), which was slightly lower than in those without convulsions (median 135 mmol/l), not statistically significant. At discharge, 19 of the 21 surviving children had a normal neurological assessment, but two children with severe convulsions had developed spastic tetraparesis. Cardiomyopathy was present in 10 (43%) children. One patient developed transient diabetes mellitus requiring insulin treatment for one week. Both children with an early fatal course had convulsions and cardiomyopathy.

Infections were present in 11 children
(48%). Neuraminidase producing Streptococcus pneumoniae was the causative organism in two (one with meningitis, one with pneumonia). A female neonate aged 12 days had HUS associated with (non-verocytotoxin producing) E
coli. Cultures of cerebrospinal fluid and blood
were positive, whereas urine and stool cultures
remained negative. Infections probably not
related to the HUS were present in eight
patients, upper respiratory tract infection in
seven, and florid chickenpox in one.

LONG TERM OUTCOME
Nineteen (91%) of the 21 surviving children
were regularly followed up for a median period
of 5.5 years (range 0.5–23.4). Only two infants
not requiring dialysis could not be located; at
discharge their plasma creatinine had almost
returned to normal. Five children (26%)
recovered completely, including three infants
and one neonate who had not received acute
dialysis. Of the eight children who had required
acute dialysis, only one showed complete
recovery, five had moderate sequelae (three
were also hypertensive), and two boys died, one
during the third episode of HUS and one of
end stage renal failure six months after a S
pneumoniae meningitis.

End stage renal failure
Eight children (42%) developed end stage
renal failure, five after the initial attack and two
siblings after a recurrent course. Of the seven
children undergoing long term renal replace-
ment treatment, two died, resulting in an over-
all mortality of 26% (six of 23; table 1). Five
children had cadaveric renal transplantation.

Recurrence
Six (32%) of the 19 children followed up had
recurrent HUS, two of them after plasma
exchange. Two brothers, born 1.9 years apart,
had a neonatal onset with the first episode on
the third and fourth day of life, respectively.
The elder sibling required acute dialysis at the
second to fourth attack and developed end
stage renal failure after the fifth episode at the
age of 6 months. During the next two years he
had five further haematological episodes with
anaemia and thrombocytopenia. He is cur-
tently 6 years old and is maintained on perito-
neal dialysis. His younger brother required
dialysis for end stage renal failure after the
fourth episode at the age of 5 months. He had
a further haematological episode within 8
months and died at 13 months of hyperkalaem-
ia. Complement deficiency^{26} and methyl-
alonic aciduria and homocystinuria
(CBLC phenotype){^27} were excluded.

Two further children had recurrences. One
boy (aged 9.7 years) had three episodes within
five months, requiring dialysis only during
the fatal third episode. The other boy had two
episodes within two months. During the initial

| Table 1 Clinical characteristics of 23 patients with D–HUS |
|-----------------|-----------------|-----------------|-----------------|-----------------|
| Age at presentation | No of patients | Acute dialysis | Long term follow up | Complete recovery |
| < 1 month (neonates) | 3 | 2 | 3 | 1 | 2 (0) |
| 1-18 months (infants) | 6 | 1 | 4 | 3 | 0 |
| > 18 months | 14 | 14 | 12 | 1 | 6 (5) |
| Overall | 23 | 17 | 19 | 1 | 8 |

*ESRF = end stage renal failure.
episode (aged 12 years) he had acute dialysis and plasma exchange for 10 days. During the second episode, requiring dialysis for two weeks, he began long term plasma exchange, with 53 exchanges during the next 15 months without any further recurrence.

Recurrence in the patients who had a transplantation occurred in two patients, resulting in immediate graft loss in a girl on day 1 and after four years in a boy. The girl is still maintained on haemodialysis, whereas the boy died three years later of heart failure. Neither of them had received cyclosporin.

Renal histology
All eight biopsy samples, taken in the acute phase, showed a thrombotic microangiopathy. Glomerular and arteriolar lesions were present in six patients: three developed end stage renal failure, including two brothers; two had moderate sequelae; and one (a neonate) recovered completely.

COMPARISON WITH D+HUS
All 43 cases of D+HUS were sporadic and there was no outbreak. The median age of D+HUS (19 girls) was significantly lower at 1.1 year (range 0.3–7.4, p <0.005). The initial clinical and laboratory presentation was not significantly different, however. Forty children (93%) survived the acute phase and three died. Thirty one children (72%) required acute dialysis. All patients were in renal failure (median plasma creatinine 382 µmol/l) and were anaemic (packed cell volume 0.18); 39 were thrombocytopenic (49 × 10^9/l) and 11 (26%) were hypertensive. Sixteen (37%) experienced cerebral convulsions, three suffered (fatal) cardiomyopathy (7%, p <0.002) and five (12%) developed intussusception. Thirty four (85%) of the surviving patients were followed up for a median period of 3.5 years (range 0.3–13.9): 56% recovered completely, whereas 12 and 32%, respectively, had mild and moderate sequelae. End stage renal failure, recurrence, or a HUS related death were not observed (all p <0.05). Nine of 10 children without dialysis made a complete recovery, in contrast with only 10 of 24 of the children who underwent dialysis.

Discussion
The current concept divides childhood HUS into postdiarrhoeal D+HUS and non-diarrhoeal or atypical D−HUS. D+HUS accounts for >80% of paediatric cases, mostly infants and young children, and most cases of D+HUS are caused by VTEC. D+HUS is generally associated with a good prognosis. There remains, however, a considerable mortality of up to 10% during the acute phase and the risk of renal failure 15 years later after seemingly cured HUS is not negligible.

Typical HUSs, in contrast, comprise a heterogeneous group of various epidemiology, pathophysiology, and outcome. D−HUS is generally associated with a greater morbidity and mortality than D+HUS, except for an Italian study (34% D−HUS). The absence of D+HUS outbreaks and epidemics in our referral area partly accounts for the high percentage of patients with D−HUS.

A subgroup in our series, seven infants aged <18 months with non-familial HUS, showed a remarkably good outcome: only one required acute dialysis and three of four with long term follow up recovered completely. The age at presentation and benign outcome mimicked the pattern of D−HUS associated with VTEC. VTEC was not routinely searched for in patients with D−HUS and D+HUS, however. It is noteworthy that the patients from Utah had an unusually mild course during the acute phase, with only 21% requiring dialysis, which is far less than in the other series, ranging from 53 to 80%. A full third of our patients with HUS had D−HUS, which is higher than previously quoted, except for an Italian study (34% D−HUS). The absence of D+HUS outbreaks and epidemics in our referral area partly accounts for the high percentage of patients with D−HUS.

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due to intracellular vitamin B12 deficiency (CBCL phenotype), 13, 19, 20 and collagen type III glomerulopathy. 39 Recurrence has also been reported in 10 of 11 patients after an apparently successful plasma exchange treatment in the acute phase. 19 Plasma exchange was less successful in our small series of seven patients. Four developed end stage renal failure and two had recurrences.

The risk of recurrence after transplantation in patients with D−HUS (and the role, if any, of cyclosporin) is still a matter of debate. The European Dialysis and Transport Association registry, including D+HUS and D−HUS, quoted a recurrence rate of 10% in children 36 and only one study showed a higher recurrence rate. 37 No recurrence was reported in two publications on classical D+HUS. 8, 38 A few series of sporadic recurrence of D−HUS after transplantation have been reported, however, 13, 19, 20 and patients with a recurrent course before transplantation may run a higher risk. 13, 20

A further distinct subgroup of patients with D−HUS is associated with neumaminidase producing micro-organisms. 37 The poor prognosis may be improved with prompt recognition and appropriate treatment. 8

The renal biopsy sample findings in our small series were not conclusive with respect to their prognostic implications as arteriolar lesions were shown in children with both subsequent recovery and end stage renal failure. Extensive arteriolar involvement has been shown to be associated with D−HUS and an impaired outcome. 5

We conclude that atypical or D−HUSs represent a heterogeneous group of various epidemiology, pathophysiology, and outcome. Children with D−HUS who require dialysis in the acute phase, and in particular children with a recurrent, familial, or neonatal course, have poorer outcomes. A subgroup of (young) patients presenting with a mild nephropathy and not requiring dialysis has a good prognosis, however.
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