Another case of HBV associated membranous glomerulonephritis resolving on lamivudine

Connor and colleagues (see page 446) report rapid resolution of a hepatitis B associated membranous glomerulopathy and nephrotic syndrome after two months of oral lamivudine. We would like to add our experience with a similar case.

A 5 year old female of Vietnamese origin presented with a two week history of periorbital swelling and weight gain. She had 3 plus protein, 10–20 dysmorphic red blood cells, and red blood cell casts in her urine. Serum albumin was low at 19 g/l, cholesterol was 9.8 mmol/l, and serum complement C3 and C4 were reduced (0.61 g/l and <0.1 g/l, respectively). She was hepatitis B surface antigen positive and hepatitis B surface antibody negative. The physician caring for her at that time placed her on prednisone 60 mg/m²/day in three divided doses, and referred her to our service six weeks later, as the nephrotic syndrome was unresponsive to steroids. Her viral load initially was 1090 pg/ml of hepatitis B DNA in peripheral blood, and rose to >2000 pg/ml after four weeks of steroids, when ALT peaked at 72 U/l. A renal biopsy revealed stage II membranous glomerulonephritis. A liver biopsy showed focal lobular and portal inflammation and changes consistent with a mild chronic hepatitis.

She was started on lamivudine at a dose of 50 mg once daily (2.5 mg/kg), with steroids being weaned off over four weeks. Two weeks later the hepatitis B DNA dropped to 1686 pg/ml, decreased to 7 pg/ml two months later, and was undetectable at three months. She continued to be hepatitis e antigen positive without detectable e antibodies. The patient's proteinuria was cleared after three months of treatment, and serum albumin remained normal thereafter. She continued to take lamivudine for 13 months without rebound proteinuria. Six months after discontinuing lamivudine she remained clinically well, her urinalysis showed 0.04 g of protein per 24 hours, and there was microscopic haematuria. Hepatitis B DNA rose to >2000 pg/ml, indicating continued active viral replication. A repeat renal biopsy showed multiple electron dense deposits which had been incorporated into the lamina densa with fragmentation of the latter, consistent with a membranous glomerulonephritis stage II/III. She has evidence of hyperfiltration with a glomerular filtration rate of 163 ml/min/1.73 m² as determined by "To the Editor "—submit a response"

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the previous infant(s) were killed by the parent, rather than dying of natural causes. Currently, there does not seem to be a mechanism for correcting the national childhood mortality statistics when later, correct diagnoses are made. For instance, in the 1990s, I am aware of at least 20 infants who were initially categorised as SIDS, but who in later years, after extensive child protection investigations, were deemed to have been killed, usually by smothering. Colleagues know of other cases: the true number will be higher. It is unfortunate that the official statistics do not seem to be altered retrospectively, and remain a misleading figure for any research worker. I should add that, since 2001, I have been involved in parental killing of which I am aware involves twins, the conclusions of Platt and Pharoah are more likely to have been strengthened rather than weakened by such false diagnosis. Hopefully, as the number of SIDS continues to fall, it will become ever more difficult for research workers to compare small subgroups of SIDS within national mortality statistics unless the statistics are revised retrospectively in response to later correct diagnosis.

It is appropriate to warn of an additional hazard for research workers in this field. In the same issue of Archives there was an interesting letter from epidemiologists in Paris pointing to a particular concern the possibility of vagal overactivity as a cause of sudden infant death. They referred to a “positive family history of SIDS”. A particular hazard there is that, unless details of that family history are verified in considerable detail, mistakes may be made. In recent years I have been involved with families in which parents who have repeatedly denied that, since birth, the children were killed by the mother responsible for smothering or killing infants, have written to me offering to provide the demographic population of the relevant grandparent has revealed that no such infant deaths occurred. Presumably, the mother responsible for smothering or killing the infant has invented the family history, either to gain more medical attention for herself, or as a cover to distract from her actions. A second reason for verifying the alleged previous infant deaths in more detail is that, even if a death has occurred, it is necessary to explore the extent of the contemporary investigation and pathological examination. In one of Professor Emery’s studies of infants initially categorised as SIDS, detailed re-assessment pointed to either a definite natural cause, or abuse, in two thirds of the cases. The recent publication by the CSM PostScript 461 1

References

Use of inhaled corticosteroids in children

I read with interest the article Survey of adrenal crisis associated with inhaled corticosteroids in children by de Jongh and the accompanying editorial in the December issue of Archives.

In the reported cases, the children had been administered substantially (up to 5 times) higher than the Glaxo SmithKline (GSK) Core Data Sheet recommended Fluticasone dose of 400 mcg/day and use of fluticasone (FP) at such doses is certainly not endorsed by GSK. Within the recommended doses, there is a wealth of data from controlled clinical trials that Fluticasone is a well tolerated and effective drug in adults and children. There are a number of recent studies in children which identified no cases of adrenal crisis and no effect on growth following 12 months treatment with FP at licensed doses.

There are also a number of methodological deficiencies in this survey, the most important being that the survey is not case-controlled and lacks information on true incidence if a death has occurred, it is necessary to

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References
1 Barnes NC, Hallent C, Harris TA. Clinical experience with fluticasone propionate in asthma: a meta-analysis of efficacy and systemic activity compared with budesonide and beclomethasone dipropionate at half the microgram dose or less. Respir Med 1998;92:95–104.
9 DIN-LINK Data, Computifile Ltd, (March 2002).