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767 - Submission No. 941

LUPUS NEPHRITIS

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Case Description: A 40-year-old woman presented with a 3-week history of nausea, vomiting and hematuria, which started 1-week after a cholecystectomy. She reported no analgesic or anti-inflammatory drug abuse. She had history of repeated urinary tract infections, so a urinary tract infection was assumed and treated with Fosfomycin. She reported no improvement 1 month later and searched for medical attention. Her blood pressure was high. Blood tests revealed anemia and acute kidney injury. Urinalysis had leukocytes, erythrocytes, and proteins. Computed tomography reported no obstruction to urine output and normal kidneys. She was discharged with amoxicillin and clavulanic acid, as well as lisinopril. The symptoms retained and she was admitted to the hospital two weeks later.

Clinical Hypothesis: Glomerulonephritis was suspected.

Diagnostic Pathways: Dysmorphic erythrocytes and proteinuria in the nephrotic range were present. Blood tests were positive for ANA, anti-ds-DNA and low complement. Renal biopsy showed diffuse lupus nephritis (class IV). A diagnosis of Systemic Lupus Erythematous (SLE) with lupus nephritis was made. Treatment was started with prednisolone, mycophenolate mofetil and hydroxychloroquine. 1-week later, the patient reported no symptoms and was discharged from hospital with maintenance treatment.

Discussion and Learning Points: Hematuria can be a sign of glomerulonephritis and should not be overlooked. Lupus nephritis is one of the most severe organ manifestations of SLE and usually develops 5 years after the diagnosis. However, it can be the presenting manifestation leading to diagnosis of SLE. It represents an important cause of morbidity and mortality. Early diagnosis and prompt initiation of therapy are crucial to improve outcomes.

768 - Submission No. 1550

48H AMBULATORY BLOOD PRESSURE MEASUREMENT AND MEDIUM-TERM ULTRAFILTRATION IN PATIENTS ON HEMODIALYSIS

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Background and Aims: Arterial hypertension (AH) is a common comorbidity of patients treated with hemodialysis (HD). One of mechanisms responsible for this is positive water balance, which clinicians tackle during HD sessions with ultrafiltration (UF). The aim of our study was to assess the impact of medium-term UF on 48h ambulatory blood pressure measurement (ABPM).

Methods: We included 29 chronic HD patients, mean age 61.1±14.6 years. All patients received regular HD treatments thrice weekly. We performed 48h ABPM (Schiller MT-300 Holter-BPR, Baar, Switzerland) and recorded past medical history and average UFs during HD treatments for one month prior to 48h ABPM. The patients were divided into a low (<1 L) and high ultrafiltration (>1 L) group.

Results: Included patients (37.9% female) with a mean BMI of 25.9±4.8 had diabetes mellitus (17.9%), hypertensive retinopathy (25.0%), heart failure (7.1%), and previous stroke or TIA (6.9%). One-month UF average was 2.01±0.91 L, with 17.2% of patients having a low UF. The average 48h BP was 142±22/79±12 mmHg. Pearson's correlation showed a moderate negative correlation between 48h systolic BP and UF (r=-0.368, p=0.05), while no correlation was found between 48h diastolic BP and UF. The 48h systolic BP of the low UF group was 154±7 mmHg vs. 140±23 mmHg of the high UF group, which was significantly different (p=0.015).

Conclusions: We observed a negative correlation between 48h systolic BP and UF, probably due to intravascular volume depletion. Interestingly, our patients with low UFs had higher systolic BPs. Clinicians should consider reassessing dry weight using different modalities in these cases.

769 - Submission No. 2135

MODERN ASPECTS OF THE STUDY OF BIOMARKERS IN PATIENTS WITH DIABETIC KIDNEY DISEASE AND TYPE 2 DIABETES

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Background and Aims: Diabetic kidney disease (DKD) is a severe complication of diabetes and one of the leading causes of end-stage chronic renal failure. Detection in urine of the tubular biomarker N-acetyl-β-D-glucosaminidase (NAG), which indicates kidney damage, timely reflect the risks of progression of kidney damage and the risks of adverse cardiovascular and renal events. The aim of this study was to evaluate urinary NAG as reliable biomarker in detection of diabetic nephropathy.

Methods: In this study, we investigated the relationship between urinary NAG biomarker levels and the state of glycemic control and indicators of kidney status (blood creatinine, creatinine clearance (GFR), urine albumin to creatinine ratio (ACR)) in the group of patients with DKD and type 2 diabetes.

Results: The study included 82 patients, 46 men and 40 women. The mean age of patients was 63.37±8.59 years. BMI was 31.65 (28.45-33.68) kg/m^2. Fasting glucose was 10.49±3.15 mmol/l.

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The level of glycated hemoglobin was 7.92±1.54%. The GFR, was 51.19 (45.84-66.88), most patients (53.1%) had the degree of renal dysfunction to CKD G3a. The ACR was 38.47 (18.4-82.02) mg/g. In 59.4% of patients there was an increase in ACR level. NAG level in urine was 19.33 (8.34-38.08) ng/ml. The correlation analysis revealed a positive relationship between albuminuria and NAG (r_s = 0.61, p = 0.02); ACR with NAG (r_s = 0.61, p = 0.02).

Conclusions: NAG is a tubular biomarker that is considered as an early and sensitive marker than glomerular disorders, such as GFR, albuminuria, ACR. NAG is associated with reliable signs of kidney damage in diabetes.

770 - Submission No. 2364

AN UNUSUAL PRESENTATION OF GASTROINTESTINAL BLEEDING: MULTIPLE MYELOMA WITH LIGHT CHAIN AMYLOIDOSIS

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Case Description: A 44 years-old man with a history of hypertension and gout presented to the emergency department with the complaint of bloody stool. Physical examination revealed melena with no additional remarkable findings. Initial laboratory studies were found as: BUN 111 mg/dL, serum creatinine 1.55 mg/dL, total protein/albumin 6.6/4.4 g/dL, hemoglobin 8.3 g/dl. ANA (-), dsDNA (-), c3 1.39 g/L, C4 0.36 g/L, Ig A 0.476 g/L, IgG 6.74 g/L, IgM 0.29 g/L.24 hours urine protein 6980 mg/g. Hepatitis and HIV markers were negative. He underwent endoscopy that resulted with non-bleeding duodenal ulcer.

Clinical Hypothesis: Renal biopsy was required to explain the etiology in the patient who had mild renal impairment, proteinuria, and hematuria with a normal globulin/albumin ratio.

Diagnostic Pathways: In the kidney biopsy, accumulation consistent with amyloid was detected in the glomeruli, tubule membranes and vessel walls. Lambda staining was observed in the amyloid deposition areas. After the biopsy was reported as AL Amyloidosis, multiple myeloma was considered in the foreground. Tests for myeloma were sent but it was not found significant. Bone marrow biopsy showed 10% infiltration with lambda light chain-restricted and monotypic plasma cells staining positive for CD138 and MUM1.

Discussion and Learning Points: This is an unusual case of multiple myeloma with light chain amyloidosis that presented with gastrointestinal bleeding. In this case anemia in blood tests is an expected finding since the patient presented with gastrointestinal bleeding. However, no finding in favor of myeloma was found in the laboratory tests which prevented it from being considered as the primary diagnosis. Although amyloidosis is a rare finding in patients with multiple myeloma, especially in young individuals, it should be evaluated in the differential diagnosis of patients presenting with proteinuria.

771 - Submission No. 1525

A RARE CAUSE OF (PRESUMED) ACUTE INTERSTITIAL NEPHRITIS

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Case Description: A 29-year-old male patient with no known medical history was admitted to the hospital with a 4-day history of colicky abdominal pain, which worsened with fasting, and was associated with nausea, myalgias and a low-grade fever. Physical examination revealed a distended abdomen that was diffusely painful, but had no signs of peritoneal irritation or palpable masses.

Clinical Hypothesis: Initially, the most likely diagnosis was gastrointestinal viral infection.

Diagnostic Pathways: Blood workup showed a normocytic anemia (Hb 12.3 g/L, VGM 84 fl), mild thrombocytopenia (PLT 146,000 U/uL), high CRP (1.5 mg/dL) and acute kidney injury (urea 43 mg/dL and creatinine 2.25 mg/dL). Urine analysis revealed leukocyturia, hemoglobinuria with eumorphic red blood cells and no casts. Arterial blood gas analysis showed no acid-base or electrolyte disturbance. Abdominal ultrasound showed a bilateral kidney parenchyma hyper-echogenicity consistent with a medical nephropathy. The patient was treated with intravenous fluid therapy and during the hospital stay an increase in the liver enzymes was noticed (AST 184 U/L; ALT 288 U/L). Blood cultures and CMV serology were negative. EBV serology was compatible with acute infection - VCA IgM >160 U/mL. According to these findings the patient was diagnosed with a probable acute interstitial nephritis (AIT) secondary to EBV infection. The renal function recovered fully over the course of three weeks with supportive therapy.

Discussion and Learning Points: AIT is a renal disease with a wide range of etiologies. Infections – namely EBV infection - are an uncommon cause of AIT. In the appropriate clinical scenario – like the one we herein describe – EBV infection should be excluded.

772 - Submission No. 1643

KIDNEY CYSTS: A HEMORRHAGIC AND INFECTIOUS FOCUS

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Case Description: Male, 52 years old, independent in performing basic activities of daily living, with history of Autosomal Dominant Polycystic Kidney Disease (ADPKD) under program of hemodialysis. Multiple episodes of bleeding and infection of the cysts, requiring hospitalization. Already proposed for nephrectomy bilaterally. Hospitalized for prostration and fever (39°C). Blood analysis with elevation of inflammatory parameters.

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