병리 (CPC)

Case 1

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A 52−year−old man was administrated because of our hospital because of fatigue, generalized edema and myalgia. Ten days before this admission, he had received calf injection due to dull pain on his legs. Thereafter bilateral lower leg purpura was developed and he had administrated NSAIDS on a local clinic. At that time, 2+ proteinuria and 4+ hematuria (>60/HPF) were detected and referred to our hospital. On physical examination, he appeared acute ill looking and had anemic conjunctiva. The purpura was restricted on his legs with bilateral pitting edema. There was no palpable lymphadenopathy in cervical/axillar/inguinal regions. His blood pressure and body temperature were normal. He was married, not homosexual, and he is working in the construction business with no special medical history. Laboratory data revealed severe anemia (hemoglobin 4.4 g/dL, hematocrit 20%) but normal platelet (177,000/μL) and white blood cell (4,750/mm^3) count. He had normal liver function (aspartate transaminase 20 IU/L, alanine transaminase 14 IU/L, alkaline phosphatase 91 IU/L, gamma−glutamyl transferase 14 IU/L, total protein 5.2 g/dL, albumin 1.5 g/dL) and coagulation. However, his renal function was decreased (blood urea nitrogen; 51 mg/dL, creatinine; 2.49 mg/dL) and urine analysis showed nephrotic range proteinuria (4,422.6 mg/day) and hematuria. In urine protein electrophoresis, non−selective type glomerular proteinuria was observed. The serum C3 concentration was slightly decreased, and the C4 concentration was normal and the results for antinuclear antibody, anti−neutrophil cytoplasmic antibody, rheumatoid factor, anti−glomerular basement membrane (GBM) antibody and cryoglobulin were all negative. The serum concentrations of IgG and IgM were normal, but the IgA concentration was increased (612.6 mg/dL). Hepatitis B surface antigen, antibody and hepatitis C virus antibody were negative, but human immunodeficiency virus (HIV) antibody and antigen test were positive, in addition, quantitative plasma HIV RNA (viral load) testing was 74,500 copies/ml. Absolute CD4+ cell count (135/μL) and the CD4/8 ratio (0.08) were decreased. Chest CT showed inactive pulmonary tuberculosis and on abdomen computed tomography, multifocal ascites was noted in abdominopelvic cavity; however, there were no other pathological findings around the kidney. Therefore, we performed renal biopsy to confirm the diagnosis.