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Streptococcus pneumoniae associated HUS with DIC

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Introduction: Streptococcus pneumoniae is an increasingly recognized cause of nondiarrheal HUS that may still be underrecognized due to overlapping feature with disseminated intravascular coagulation (DIC). Here we present a patient of pneumonia and DIC with acute kidney injury which may overlap with Streptococcus pneumoniae associated HUS.

Case: A 18 month-old baby with no past history was referred to our hospital for the evaluation of oliguria and generalized seizure accompanied by fever persisted for 3 days. She had suffered from upper respiratory tract infection 1 week before that gradually worsened. Generalized edema and a weight gain of 1.3 kg were noticed. Her initial laboratory findings were as follows: WBC 24,260/uL, Hb 7.3 g/dL, plt 96 k/uL, BUN 48 mg/dL, creatinine 1.94 mg/dL, LDH 5545 IU/L, C3 77 mg/dL, C4 32 mg/dL. Peripheral blood smear showed microcytic normochromic anemia with anisocytosis and several spherocyte but typical schistocytes could not be found. Several other tests demonstrated prolongation of PT and APTT, elevated D-dimer, decreased Antithrombin III activity, decreased fibrinogen and positive direct coombs test that slowly became weakened along clinical improvement. ADAMTS 13 activity was 15 percent. Her chest CT demonstrated multifocal consolidation in dependent portion of both upper lobes and both lower lobes but we could not find any evidences of streptococcal infection. Suspecting DIC due to sepsis or atypical HUS, we have treated by broad spectrum antibiotics, transfusion of washed RBC and replacement of Antithrombin III etc. CRRT started on the 3rd hospital day due to severe hyperkalemia and metabolic acidosis which could not responded to medical therapies. After 3 days of CRRT, her renal function recovered and she had improved slowly by supportive therapies. All her laboratory abnormalities totally improved in recent 4-month follow-up after discharge.

Key Words: 급성 신손상, 폐구균 용혈 요독 증후군, 파종성혈관내응고증
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