KSN 2017 Abstract

CPC Case 3
A 56-year old man who was developed sudden onset generalized edema and foamy urine

Hajeong Lee

Seoul National University, Korea

A 56-year old man visited our hospital for his right neck mass. One month before initial visit to our hospital, he found his neck mass incidentally, and checked CT scan in the outside clinic. The size of mass was 4.5 cm. During observation, the mass grew rapidly up to 7cm, and he was referred to our hospital for second opinion in Feb 2014. To diagnose the etiology of his neck mass, sono-guided needle biopsy was performed. Pathology finding revealed fibromuscular and adiopose tissue with lymphohistiocytic and eosinophilic infiltrations. In addition, vascular proliferation and perivascular inflammatory cell infiltration was seen. From the above, pathologic findings was suggested angiolymphoid hyperplasia with eosinophilia versus Kimura disease. Eosinophil count was within normal range. Therefore, his neck mass was considered as Kimura disease. He was prescribed antihistamines only. During follow up over 3-month, his neck mass was resolved slowly.

In July, 2014, he visited emergency room (ER) suffering from sudden abdominal pain and fever. He said foamy urine and scrotal edema had been developed since 3-4 weeks before ER visit. His body weight was increased about 7kg over 3-weeks. Also, he suffered from dyspnea on exertion and orthopnea. He denied any history of gross hematuria or lower urinary tract symptoms as well as chest discomfort or pain. He was chronic HBV carrier, heavy smoker with 30-PY of smoking history, and social alcoholics.

Initial blood pressure was 156/99 mmHg, heart rate was 76 per min, respiration rate was 22 per min, and body temperature was 36.0 ℃. His body weight was 62.3kg (usually 55.1kg) and height was 168.9 cm. He appeared acute ill state, but his mental status was alert and oriented. His lung sound was decreased, and dependent portion of body was edematous.

In the complete blood count test, white blood cell count 4.540/mm3, hemoglobin 9.5 g/dL and platelet 298,000/mm3. In the chemistry, blood urea nitrogen/creatinine 38/1.37 mg/dL and estimated MDRD-GFR was 53.9 ml/min/1.73m2. Serum albumin was lowered to 2.7 g/dl and serum cholesterol level was 209 mg/dL. Urinalysis with microscopic exam showed albuminuria with 4+, and microscopic hematuria with blood 3+ and RBC 50-99 per high power field. Proteinuria and albuminuria was quantified by 24 hour urine collection, and the result was nephrotic range proteinuria (8.0 g/day) and albuminuria (5.6 g/day). In the serologic test, FANA, ASO, Rheumatoid factor,

and cryoglobulin was all negative. Serum IgG, IgA, and IgM level was 1760, 148, and 82 mg/dL, respectively. Interestingly, there was siginificant hypocomplemetemia with 3 mg/dL of C3 level and 1 mg/dL of C4 level. Abdominal CT scan was checked due to his abdominal pain, and the result showed acute pancreatitis, multiple intraabdominal lymph node enlargement and peri-renal soft tissue thickening.
To explore the suddenly developed nephrotic syndrome, percutaneous kidney biopsy was performed.