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A clinical course of secondary IgA nephropathy presenting with crescentic glomerulonephritis accompanied with nephrotic syndrome in viral liver cirrhosis

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Case Study: Introduction: Glomerular IgA deposits, termed as secondary IgA nephropathy (IgAN), can be found in liver cirrhosis (LC). IgA deposits in LC are mild, however, if triggers such as bacterial infections are accompanied, large IgA deposits can be appeared. We report a clinical course of patient with secondary IgAN associated with LC, which simultaneously manifests crescentic glomerulonephritis and nephrotic syndrome without acute infection. **Case report:** A 60-year-old male was admitted due to abdominal distension. His vital signs were stable. He had no chronic diseases except of inactive CHB. His serological data showed followings: BUN, 81.8 mg/dL; creatinine, 8.49 mg/dL; platelet. 98k/uL; ALT, 32 IU/L; HCO_3^-, 14.8 mM/L; UACR, 5.28 g/g. Abdominal CT showed nodularity of liver with large ascites. SAAG was 2.4 g/dL. Although HBV DNA titer was minimally detected, we started entecavir due to decompensated LC. Symptoms began to improve after use of furosemide and anti-hypertensive agent, and creatinine was reduced to 3.85 mg/dl. The renal biopsy showed mesangial hypercellularity. Ultrastructural examination disclosed scattered lucencies with dense materials in mesnagium. Foot processes were effaced. On IF finding, predominant mesangial IgA staining was shown. Although he showed crescentic lesions and AKI accompanied by nephrotic proteinuria, immunosuppressants could not be initiated. Interestingly, he received only ARB and antiviral agent, but improved completely after 2 years. Recently, his serum creatinine and UACR decreased until 1.8 mg/dL and 1.0 g/g, respectively. **Discussion:** The clinical meaning of IgA deposition in secondary IgAN remains unclear and the IgA deposits are usually mild. However, large IgA deposits in patients with viral LC can lead to AKI, which can occur even in absence of active infection. Therefore, if secondary IgAN associated with viral LC manifests as AKI or nephrotic syndrome, immunosuppressants is better to be avoided until active infection or viral load can be excluded.

Figure 1. The findings of Light microscopy and electron microscopy of the kidney biopsy