

**Abstract Submission No.: A-1378**

**A Rare Case of a 74 year-old Filipina with Sjogren's Syndrome presenting with Tubulointerstitial Nephritis on Kidney Biopsy**

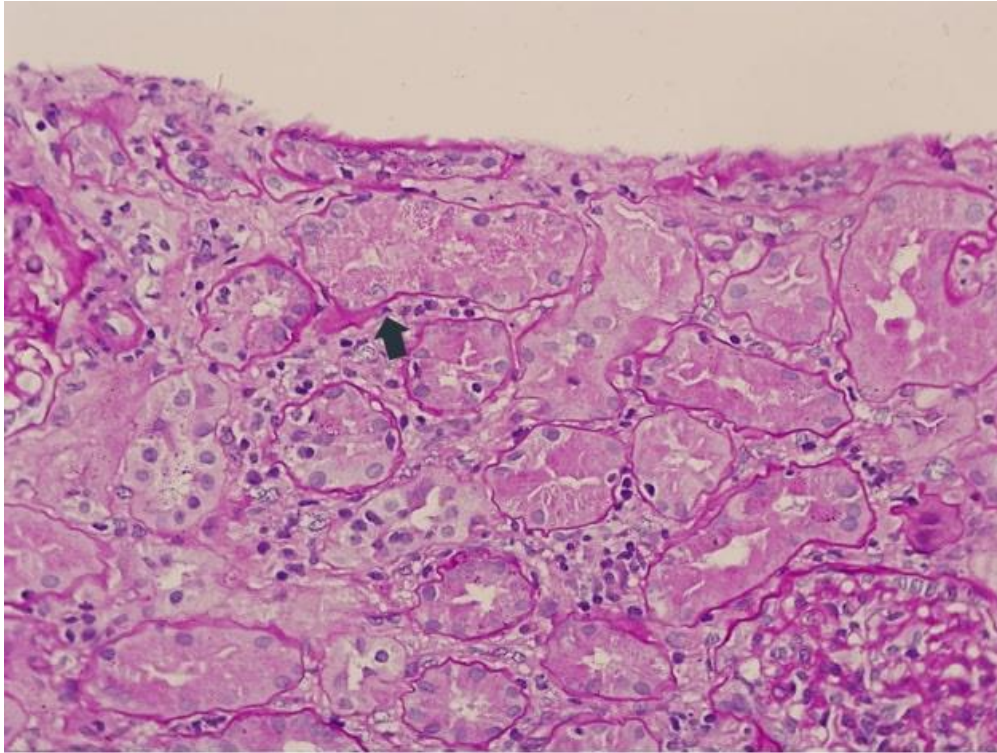
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**Case Study :** Background: Sjogren's Syndrome is a chronic, systemic, autoimmune disorder caused by lymphocytic infiltration of exocrine glands, mostly the lacrimal and salivary glands. It commonly presents with dry eyes and dry mouth and is seen primarily among women with onset at 40 to 50 years of age. Renal involvement in Sjogren's syndrome is rare and is present in about 5% of patients. The abnormalities can include tubular dysfunction, mainly tubulointerstitial nephritis, distal renal tubular acidosis, nephrogenic diabetes insipidus, and nephrolithiasis. Case Report: We present a case of a 74-year-old hypertensive Filipina who came in due to elevated Creatinine and non-nephrotic range proteinuria with hypokalemia as part of Distal Renal Tubular Acidosis. Patient had an ANA titer of 1:160 and she underwent renal biopsy to rule out Lupus Nephritis. Histopathologic findings showed acute and chronic tubulointerstitial nephritis, mild glomerular abnormality, negative staining on immunofluorescence with no electron dense deposits. She tested positive for AntiSSA and was treated as a case of Sjogren's Syndrome. Conclusions: The prevalence of Sjogren's Syndrome among Filipinos has not been established. At present, data is limited on few case reports of Sjogren's Syndrome in the Philippines. This was a rare case of Sjogren's Syndrome in a Filipina presenting with acute kidney injury, proteinuria, and renal tubular acidosis with tubulointerstitial nephritis on kidney biopsy. Patient was eventually referred to Rheumatology service and was started on oral immunosuppressant. Sjogren's Syndrome should be considered as a differential among patients presenting with elevated Creatinine, proteinuria, hypokalemia, and renal tubular acidosis.

Acute and Chronic Tubulointerstitial Nephritis.jpg



Acute and Chronic Tubulointerstitial Nephritis.jpg

Basic Metabolic Panel		Immunologic work up	
<b>Laboratory Test</b>	<b>Result</b>	<b>ANA</b>	<b>1:160</b>
<b>Creatinine</b>	1.76 mg/dL	<b>Anti dsDNA</b>	<b>2.7 U/mL (Negative)</b> (NV <20 U/mL)
<b>eGFR</b>	30 mL/min/1.7m <sup>2</sup>	<b>Anti Sm</b>	1.2 U/mL (Negative) (NV <15 U/mL)
<b>BUN</b>	20 mg/dL	<b>Anti RNP</b>	1.5 U/mL (Negative) (NV <25 U/mL)
<b>Na</b>	143 mEq/L	<b>Anti SSA</b>	<b>58.4 U/mL (Positive)</b> (NV <15 U/mL)
<b>K</b>	2.8 mEq/L	<b>Anti SSB</b>	3.9 U/mL (Negative) (NV <15 U/mL)
<b>Cl</b>	109 mEq/L	<b>C3</b>	102 mg/dL (NV 79-152 mg/dL)
<b>Bicarbonate</b>	23.3 mEq/L	<b>C4</b>	35.7 mg/dL (NV 16-38 mg/dL)
<b>Anion gap</b>	10.7	<b>Rheumatoid Factor</b>	<10 IU/mL (NV <10 IU/mL)
		NV-normal value	
Urinalysis		Imaging	
<b>Urine pH</b>	6.5	<b>Whole Abdominal Ultrasound</b>	
<b>Specific gravity</b>	1.006	Right kidney 10 x 4.2 cm CT 1.1 cm	
<b>Protein</b>	Trace	Left kidney 10.3 x 4 CT 1.1	
<b>Random urine protein</b>	50.2 mg/dL	Normal echogenicities and CM junctions.	
<b>Random urine Crea</b>	33.45 mg/dL	Cysts R 0.3 x 0.4 x 0.6 cm at M3	
<b>Random urine protein Crea ratio</b>	1.5 (gms)	1.3 x 1.4 x 1.5 cm L3	
		No hydronephrosis or calculi noted.	
		Normal study of the pancreas, liver, gallbladder, spleen, uterus, and urinary bladder; CT-cortical thickness	