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Opening a Pandora's box

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Case Study: A 40-year-old lady underwent deceased donor renal transplantation (DDRT, NKD-unknown, ATG induction). By post-operative day (POD) 7, patient developed graft dysfunction with nephrotic range proteinuria. Suspecting recurrent FSGS, patient was treated with iv methyl prednisolone and rituximab. Meanwhile, she developed severe anemia (Hb 3.4 gms%) with thrombocytopenia(18,000 cells/cumm), elevated serum LDH(1361 U/l) and schistocytes on the peripheral blood smear. Complement level and ANA were unremarkable. Lupus anticoagulant was positive. She underwent a graft biopsy on POD-10, which showed endothelial swelling of the glomerular tuft and dilated tubules with loss of brush border in the PCT, suspicious of **thrombotic microangiopathy** (TMA). Though drug induced TMA is predominantly local, we suspected tacrolimus could be a contributory factor in this setting. Therefore, tacrolimus was stopped, and patient was started on plasma infusions, IVIG and plasma exchange. Recurrent TMA was ruled out due to normal complement level. She was improving, but on POD 22 she developed flaccid paralysis of the lower limbs. NCS revealed **motor and axonal demyelinating neuropathy**, probably tacrolimus induced. Later, she developed **pulmonary hemorrhage**, which made us suspicious of catastrophic antiphospholipid syndrome. Meanwhile, the patient was started on everolimus. Within 5 days of starting everolimus, patient had **surgical site wound gaping** and recurrence of systemic TMA. Everolimus was stopped, and the TMA improved. Secondary wound suturing was done for the wound gaping. The patient was discharged on POD 60 on prednisolone and MMF, with lower limb power of 3/5. Six weeks later, she was admitted with severe neutropenia (ANC-660 cells/cumm). Prophylactic valganciclovir was stopped, but of no avail. The absolute CD19 level was 0 cells/mcl. Subcutaneous filgrastim was given for rituximab induced **late onset neutropenia** and the ANC improved. The final diagnosis was DDRT, post-transplant TMA, demyelinating polyneuropathy, late onset neutropenia. Unfortunately, patient developed COVID-19 infection in few months and succumbed.

figure 1-HPE IMAGE

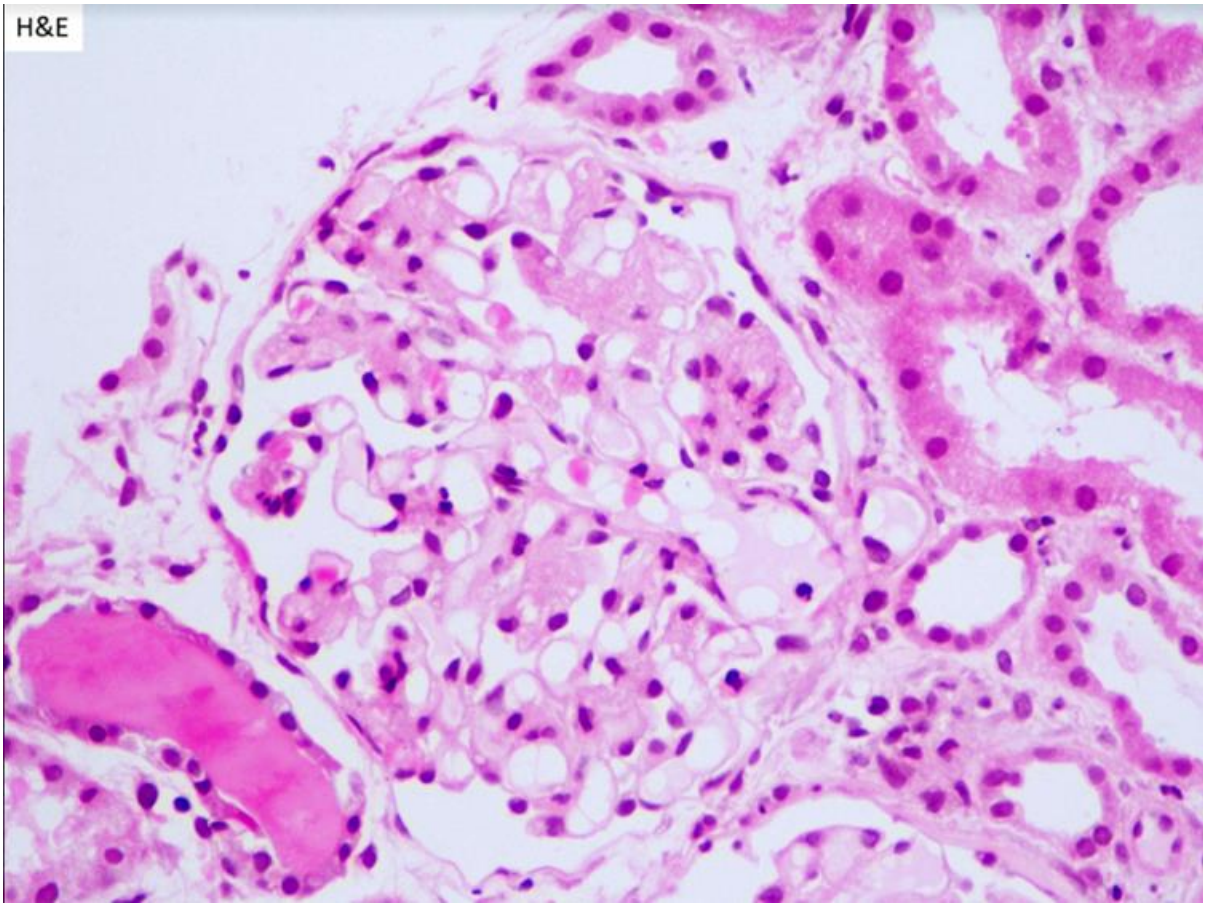

figure 2- peripheral smear