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Case Report: Anca-Associated Vasculitis In Post-Transplant Renal Graft

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Case Description

A 38-YEAR-OLD WOMAN case with background history of right nephrectomy due to a renal artery stenosis, in which glomerulosclerosis and secondary tubular atrophy in renal tissue was evidenced, at that moment with Antiphospholipid antibodies and Anti-neutrophil cytoplasmic antibody (ANCA) both negative. She remained in hemodialysis treatment for three years, and she had a renal transplant in 2015, with follow-up therapy with tacrolimus, everolimus, mycophenolate mofetil (MMF) and prednisone. Also, she had history of pulmonary hypertension, arterial hypertension, and cerebral and peripheral vascular thrombotic episodes.

Nowadays, patient shows history of acute kidney transplant rejection, 3.2 g/24 hrs. proteinuria, active sediment, renal function impairment (creatinine: 4.44 mg/dl, and Urea Nitrogen: 73mg/dl) and elevation of acute phase reactants. Physical examination showed easy shedding of hair and livedo reticularis. Laboratory data showed positive ANCA and myeloperoxidase antibody concentrations of 24.5 U/mL (reference value<5). Renal biopsy revealed active tubule interstitial rejection, global and diffuse glomerosclerosis, crescentic glomerulonephritis, extracapillary hypercellularity, mild and focal presence of mononuclear leukocytes in capillary loops, inflammatory infiltrate > 25% in tubule interstitial of the total cortical surface **(Figure 1, 2)**, with C3c Positive (++), trapped in vascular walls.

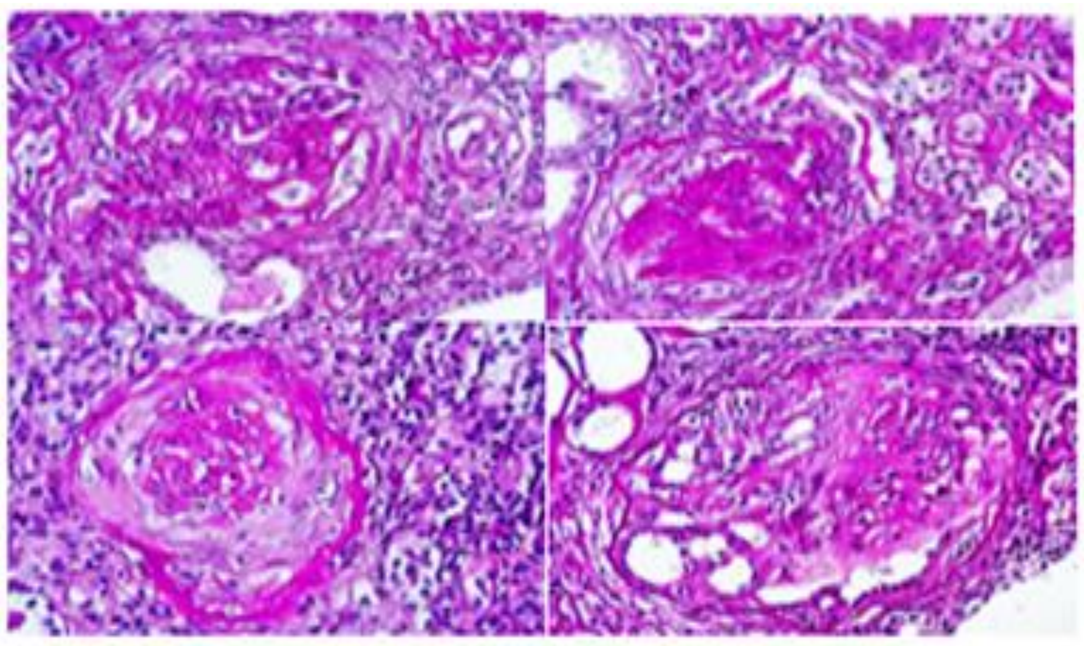

Figure 1

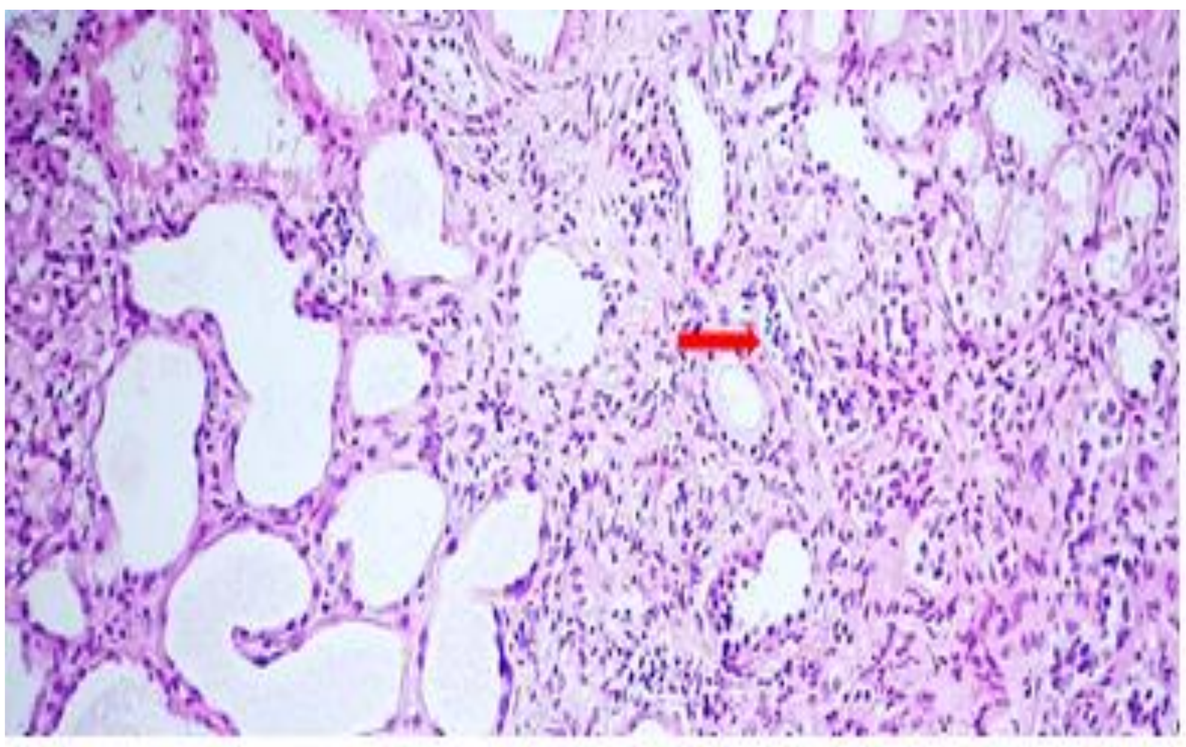

Figure 2

Discussion

A diagnosis of ANCA-Associated Vasculitis (AAV) was made, based on the Chapel Hill classification. The diagnosis of AAV is rare. From patients diagnosed with AAV and kidney transplant, 5.4% relapsed after 5 years of follow-up, with a mean of graft conservation of 13 years. The AAV like a new diagnosis in a post transplanted patient, has been reported in only 4 cases to our knowledge. Treatment has been based on stopping acute transplant rejection, graft preservation, and the choice of the best immunosuppressant to short and long term for vasculitic disease, a complete response after treatment has not been seen.

Conclusion

Systemic glucocorticoids and Rituximab treatment was initiated, plasmapheresis, immunoglobulins were administered and continued with MMF 1.5 g/day and tacrolimus 3 mg/day as renal graft preservation. After 2 weeks of follow-up, the patient was sent to hemodialysis, and 6 months later she continued in renal replacement therapy, with no partial or complete response.