LETTERS TO THE EDITOR

Inactivity of Hidradenitis Suppurativa After Renal Transplantation

Hidradenitis suppurativa (acne inversa) is a relatively common, chronic, recurrent disease most often involving apocrine-bearing skin with a predilection for intertriginous areas. It is considered to be a disorder of the follicular epithelium characterized by a sequence of follicular hyperkeratosis, occlusion, rupture, inflammation and, sometimes, secondary infection (1). This development is frequently followed by the formation of abscesses, sinus tracts and scars. The diagnosis is based on clinical findings but there is no consensus about medical treatment. Antibiotics are of limited use but estrogens, retinoids, finasteride, cyclosporine and infliximab have been helpful in some cases (2). Radical surgical treatment is needed in advanced disease.

We report a case that was submitted to our Division of Nephrology three years ago. The patient was a forty years old male who suffered from hypertension and renal failure. Renal biopsy revealed advanced nonspecific changes. A year later, hemodialysis treatment was started. In addition to the kidney disease, the quality of the patient’s life was compromised by a difficult skin disease of roughly 20 years’ duration, diagnosed as hidradenitis suppurativa stage II. Abscesses frequently developed leaving nodules and scars. In particular, the perineal, femoral, and axillary areas were involved but lesions were also regularly found on the upper arms and the trunk. Most of the time, there were one or more lesions in the active phase, causing pain and psychosocial difficulties. Antibiotics and surgical drainage often helped in the acute phase but antibiotics had no prophylactic effect. Other drugs had never been tried and major surgery had not been performed. When the patient learned about his irreversible renal failure he wished to receive a renal transplant. At first we were concerned due to the risk of infectious complications and the lack of reports in the literature. As a preliminary step the patient was prescribed cyclosporine in order to test the effect of immunosuppressive treatment on the skin disease, hoping for a curative response but monitoring for an infectious exacerbation. In spite of a cyclosporine trough concentration of about 100 μg/L for nine months, no change was noted. A year ago, the patient received a living donor kidney which has functioned adequately (serum creatinine concentration of 130–160 μmol/L) on an immunosuppressive regimen consisting of tacrolimus, mycophenolate mofetil and prednisolone. Already in the first postoperative weeks it was noticed that new skin lesions did not develop. Now, when the patient is receiving tacrolimus 6 mg b.i.d. (trough concentration 8–12 ng/L) and mycophenolate mofetil 750 mg b.i.d., there are still no signs of disease activity.

In this case, immunosuppressive treatment was accompanied by a total regression of the activity of hidradenitis suppurativa, leaving only old scars. Low-dose cyclosporine monotherapy had no effect whereas an immunosuppressive regimen including tacrolimus and mycophenolate mofetil totally abolished the disease activity during an observation period of one year. There are no reports of tacrolimus treatment in hidradenitis suppurativa but mycophenolate mofetil has been reported to be effective in pyoderma gangrenosum (3), a skin disease that shares some features with hidradenitis suppurativa. The present case supports the notion that it is of great importance to master the inflammatory component of hidradenitis suppurativa. Moreover, it serves as an encouragement for transplanting organs to these patients.

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REFERENCES

Occult Nephrolithiasis in Prospective Kidney Donors: A Source for Hematuria

In their report, Koushik et al. (1) identified causes for persistent, asymptomatic, microscopic hematuria in a series of 512 prospective kidney donors in Minnesota. Fourteen of these had hematuria, of whom two had a urinary tract infection, one had multiple renal arteries, one a renal cyst, two normal kidney biopsies (one with renal cysts), and eight had biopsies with varied findings. We wish to highlight another important cause for hematuria in this population: occult nephrolithiasis.