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A Case of Portal vein thrombosis in Minimal change disease

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Thromboembolic events are considered critical complications of the nephrotic syndrome. Renal vein and deep veins of the lower limbs are most frequently involved, which often lead to acute kidney injury and pulmonary embolism, respectively. However, portal vein is a rare site where thrombus forms in patients with nephrotic syndrome. This report describes a case of histologically proven minimal change disease complicated by portal vein thrombosis. A 26-year-old male visited our hospital due to suddenly developed nausea, vomiting, and epigastric pain. Five months prior to the visit, he was diagnosed with minimal change disease by renal biopsy. Complete remission was achieved after treatment with oral corticosteroids at an initial dose of 1 mg/kg/day, followed by a slow taper over the next 4 months. Physical examination revealed pitting edema, ascites, and direct tenderness in epigastric abdominal area without rebound tenderness. Initial laboratory tests showed the following values: serum creatinine, 1.39 mg/dL (corresponding to eGFR 67 ml/min/1.73 m^2); BUN, 13.9 mg/dL; total protein, 4.4 g/dL; albumin, 1.7g/dL; urine 24-h protein, 25.2 g. Abdominal CT showed thrombosis involving main and right portal vein without cavernous transformation suggesting an acute phase of thrombosis. The patient immediately started anticoagulation therapy with intravenous heparin infusion, followed by oral warfarin. In addition, high dose oral prednisolone at a dose of 60 mg/day was administered for relapsing of nephrotic syndrome. However, two-week corticosteroid treatment failed to achieve remission and 24-h proteinuria was 19 g/day, cyclosporine at a dose of 5 mg/kg was added. A month later, 24-h proteinuria decreased to 0.52 g/day and his kidney function recovered (eGFR≥90 ml/min/1.73 m^2). Follow-up abdominal ultrasound showed a patent portal vein without thrombus. Complete remission was achieved after the use of cyclosporine for 6 weeks. In conclusion, portal vein thrombosis is rare and may not be easily diagnosed in patients with nephrotic syndrome who have abdominal pain. Early recognition of this rare complication and prompt anticoagulation therapy and immunosuppression should be emphasized to avoid fatal outcome.

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Both hydronephrosis

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A 76-year-old man was visited to our hospital because of palpable abdominal mass. The physical examination revealed palpable huge mass on peri-umbilical area. His blood pressure was 120/70 mmHg and his pulse was 72 beats/min. Laboratory investigations on admission indicated as the followings: hemoglobin 8.9 g/dL, blood urea nitrogen 65 mg/dL, and creatinine 3.03 mg/dL. The unenhanced computed tomography (CT) of abdomen and pelvis revealed both hydronephrosis with showing external compression of ureters by both common iliac aneurismal sacs with no evidence of stones or related peri-ureteric mass .Right common iliac artery involved 7×11 cm aneurysmal sac with heterogenous attenuation suggestive of hematoma. Fortunately, the decrease in urine output was not seen, and the creatinine level maintained unchanged. This patient was discharged awaiting review by the vascular surgical team without percutaneous nephrostomy.