Abstract

25 year old female university student presented with a history of recurrent painless hematuria for six months duration. She did not have evidence to suggest a urinary tract infection, renal or urothelial malignancy or calcular disease in the history or in the investigations done prior to admission to hospital, including repeatedly negative urine cultures and negative ultrasound and CT imaging. Patient denied any hemoptysis or other bleeding manifestations. This hematuria was not proceeded by any upper respiratory tract infection or diarrhea. Patient was having severe loss of appetite and loss of weight and was feeling week and unwell since about two months. She was started on Homeopathic treatment due to those symptoms, one month back. She had a normal urine output initially, until she developed gradually declining urine output over 2 weeks duration with features of fluid overload. On examination, she was pale, had generalized edema and pulmonary edema and was hypertensive. Rest of the examination was unremarkable.

Upon investigation she had hematuria with positive dysmorphic red cells and nephrotic range proteinuria, rapidly rising serum creatinine levels and ultrasound evidence of acute renal parenchymal changes. Her renal biopsy showed crescentic glomerulonephritis and immunofluorescence was positive for linear IgG. Serum

anti glomerular basement membrane (anti-GBM) antibodies became positive with a high titer.

Patient was given intravenous pulses of Methyl Prednisolone and continued with high dose oral Prednisolone. She received 14 cycles of plasma exchange after which, her anti GBM antibodies became negative. She was also commenced on two weekly intravenous pulses of cyclophosphamide and continued for a total of 6 cycles. Her serum creatinine remained persistently elevated and she remained dialysis dependent at 3 months after her initial presentation, and was thought to be having end stage renal failure and work up initiated for renal transplantation.