Case Report

De Novo Postinfectious Glomerulonephritis Secondary to Nephritogenic Streptococci as the Cause of Transplant Acute Kidney Injury: A Case Report and Review of the Literature

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Acute kidney injury is common among kidney transplant recipients. Postinfectious glomerulonephritis (PIGN) secondary to nephritogenic streptococci is one of the oldest known etiologies of acute kidney injury in native kidneys but rarely reported among kidney transplant recipients. We present a biopsy-proven rare cause of AKI in a KTR as PIGN secondary to nephritogenic streptococci.

1. Introduction

Acute kidney injury (AKI) is common in kidney transplant recipients (KTR) [1] and it has been identified as a risk factor for graft failure [1, 2] and death with a functioning transplant [2]. Postinfectious glomerulonephritis (PIGN) secondary to nephritogenic streptococci is a well-recognized cause of native kidney AKI. In a seminal paper in 1812, Wells detailed the complications of scarlet fever and described this glomerulonephritis as the “dropsy that follows scarlet fever” [3]. He noted that it mainly occurred in children, approximately three weeks after a mild fever and it consisted of edema starting in the face, decreased urine output, red urine, nausea, and vomiting, which would “recede after no long stay” [3].

PIGN secondary to nephritogenic streptococci has a heterogeneous clinical presentation ranging from asymptomatic to nephrotic syndrome [4]. Diagnosis is based on clinical findings in addition to documentation of a recent GAS infection by positive throat or skin culture or serologic tests, such as anti-streptolysin O (ASO) antibodies [5].

Few reports of PIGN secondary to nephritogenic streptococci as the cause of AKI in KTR are currently available in the literature. We present a biopsy-proven rare cause of AKI in a KTR as PIGN secondary to nephritogenic streptococci.

2. Case Presentation

The patient was a 45-year-old Hispanic male who had end-stage renal disease of unknown etiology, hypertension, and hyperlipidemia. His HLA typing was A 2, -B 7, 35, Cw 4, 7, DR 4, - DQ 8, -. His donor was a 46-year-old Hispanic female with history of hyperlipidemia with a measured 24-hour urine creatinine clearance of 151 ml/min. Her HLA typing was A 2,31, B 35,44, Cw 4,5, DR 4,-, DQ 7,8. The patient had been on intermittent hemodialysis for two years prior to undergoing living related kidney transplant. Induction therapy consisted of basiliximab and solumedrol. Maintenance therapy was with tacrolimus, mycophenolate mofetil, and prednisone. His two-year course after transplant had been unremarkable, with a baseline serum creatinine of 1.5–1.7 mg/dL (134–150 𝜇mol/L), without proteinuria or hematuria.

Two years after transplant he presented to the renal transplant clinic with complaints of lower extremity edema that had appeared over the previous three days. He stated he had experienced a flu-like illness a week prior. In addition, he admitted to inadvertently taking tacrolimus 1 mg q12h, rather than his prescribed dose of 3 mg twice a day for almost one month. He had corrected the dose approximately 3 weeks prior to presentation. On examination, he was normotensive...
and afebrile. Cardiovascular and respiratory examinations were normal. He had periorbital edema and 6 mm pitting edema in lower extremities. He did not have graft tenderness or bruit.

Laboratory data was remarkable for creatinine of 2.2 mg/dL (194 μmol/L). Urinalysis showed moderate blood and 3+ protein (previously no proteinuria), urinary sediment of more than 50 red blood cells (RBCs), 11–20 white blood cells (WBCs) per high power field (HPF), and urine protein/creatinine ratio of 8.2 g (previously 100 mg). Tacrolimus trough was 4.9 ng/mL.

Due to acute kidney injury, proteinuria, and hematuria in the setting of suboptimal immunosuppression, there was a high concern for acute rejection versus rapidly progressive glomerulonephritis perhaps due to recurrence of the unknown primary disease. Renal ultrasound and a renal biopsy were ordered. Given the risk of acute rejection due to inadvertent medication noncompliance, prednisone was increased from 10 mg daily to 50 mg daily, tacrolimus was increased from 3 mg twice a day to 5 mg twice a day, and mycophenolate mofetil was increased to 1500 mg twice a day. Of note, BK virus and donor specific antibodies were negative a month prior.

The renal US was negative for hydronephrosis or calculi. Three days later, a biopsy was performed.

Preliminary biopsy report was consistent with postinfectious glomerulonephritis (Figure 1). Due to the recent infection, anti-streptolysin O (ASO) antibodies, C3, and C4 were ordered. Since initial biopsy did not have any glomeruli for immunofluorescence (IF), he was scheduled for repeat biopsy.

In the interim, C3 and C4 were reported. C3 was low at 59 mg/dL with a normal C4 at 35 mg/dL (Table 1). Tacrolimus trough was 8.6 ng/mL.

Second kidney biopsy one week later revealed minimal residual subendothelial electron dense deposits, but no evidence of large subepithelial electron dense deposits (Figure 2). IF showed nonspecific patchy staining with C3 in glomeruli and some tubules. All other reagents were negative, including C4d in peritubular capillaries, BK, and SV40 in tubular cells. There is no evidence of cell-mediated or antibody mediated glomerulonephritis. Overall, biopsy was consistent with resolving postinfectious glomerulonephritis. Anti-streptolysin O (ASO) was elevated at 603 IU/mL (Table 1), highly indicative of *Streptococcus* being the causative agent.

Given that his AKI did not appear to be due to rejection, tacrolimus was decreased back to his basal dose of 3 mg twice a day and prednisone was tapered to 10 mg daily. Fluid management was achieved with furosemide. He was not prescribed any antibiotics. A month later, creatinine had decreased to 1.9 mg/dL (168 μmol/L), and in a 3-month period, it had returned to baseline and proteinuria and hematuria had completely resolved (Figure 3 and Table 1).

### 3. Discussion

AKI is common in renal allograft recipients [1] due to multiple risk factors including single kidney, use of calcineurin...
Table 1: Laboratory parameters during clinical course.

<table>
<thead>
<tr>
<th>Day</th>
<th>0</th>
<th>1</th>
<th>5</th>
<th>10</th>
<th>15</th>
<th>55</th>
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<td>Creatinine (mg/dL)</td>
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<td>2.1</td>
<td>2.3</td>
<td>1.9</td>
<td>1.8</td>
<td>1.7</td>
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<tr>
<td>Protein/creat ratio</td>
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<td>8.3</td>
<td>4.4</td>
<td>2</td>
<td>1.6</td>
<td>0.4</td>
<td>0.2</td>
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<td>Urine RBCs</td>
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<td>0–2</td>
<td>&gt;50</td>
<td>21–50</td>
<td>11–20</td>
<td>11–20</td>
<td>0–2</td>
</tr>
<tr>
<td>Urine WBCs</td>
<td>0–2</td>
<td>0–2</td>
<td>11–20</td>
<td>11–20</td>
<td>11–20</td>
<td>3–5</td>
<td>0–2</td>
</tr>
<tr>
<td>C3 (mg/dL)</td>
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<td>93</td>
<td>146</td>
<td></td>
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<tr>
<td>C4 (mg/dL)</td>
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<td>36</td>
<td>42</td>
<td></td>
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<td></td>
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<tr>
<td>ASO Ab</td>
<td>603</td>
<td>359</td>
<td></td>
<td></td>
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</tbody>
</table>

*C3 normal range: 90–180; **C4 normal range: 10–40 mg/dL; ***ASO Ab = anti-streptolysin O antibodies.

Figure 2: (a) Light microscopy. Hematoxylin and Eosin stain with decreased endocapillary proliferation of neutrophils with some karyorrhectic debris and moderate crescents. (b) Jones stain with an early fibroepithelial crescent. (c) Trichrome stain with crescent and focal mild interstitial fibrosis and tubular atrophy. (d) Electron microscopy. Minimal residual subendothelial electron dense deposits but no evidence of large subepithelial electron dense deposits “humps”.

Figure 3: Creatinine and spot urine protein/creatinine ratio during clinical course.

inhibitors, and increasing use of marginal donor kidneys, among others. AKI in this population has been identified as a risk factor for graft failure [1, 2] and death with a functioning transplant [2]. Infections are the second most common cause of death in kidney transplants recipients due to multiple factors including immunosuppressed status, donor-derived infection, and underlying comorbidities [6]. CMV disease, Epstein-Barr virus infection, and BK polyomavirus infection are among the most common infections in kidney transplant recipients [7]. Glomerular disease because of infection has been described in KTR in the case of cryoglobulinemic and noncryoglobulinemic membranoproliferative GN secondary to hepatitis C; however, there are only seven reported cases of postinfectious glomerulonephritis [8], with only one reported case to our knowledge of poststreptococcal glomerulonephritis occurring in a pediatric transplant recipient [9]. Three cases were due to Staphylococcus aureus, none of which had recovery of their graft function and one died.

PIGN secondary to nephritogenic streptococci is caused by nephritogenic strains of group A beta-hemolytic Strep- tococcus, which cause skin and throat infections. Two of the primary antigens are the nephritis-associated plasmin
Acute glomerulonephritis is sometimes seen in transplant recipients,
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