Pattern of steroid-resistant nephrotic syndrome in children and the role of histopathology: A single-centre study

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Steroid-resistant nephrotic syndrome (SRNS) remains a challenge for paediatric nephrologists. The underlying histopathology usually affects the course of the disease and the response to treatment.1,2 There is still controversy over the role of renal biopsy in the management of children with SRNS.2,3 Studies by the International Study of Kidney Disease in Children (ISKDC) showed focal and segmental glomerulosclerosis (FSGS), mesangial proliferative glomerulonephritis (MPGN) and minimal-change disease (MCD) to be the morphological lesions in 70%, 44% and 7%, respectively, of these children.2,3 The glomerular morphological pattern of SRNS in Indian children has seldom been described, and in eastern India data on childhood nephrotic syndrome are almost non-existent because facilities where biopsies can be carried out and specialised centres for renal care are very scarce. It has therefore become necessary to determine the true pattern of the glomerulopathies underlying SRNS in a large cohort of children in this part of the world, where a major proportion of renal pathology is due to malaria. This study was designed to determine the spectrum of histopathological lesions in children with SRNS at our institution.

Methods

This descriptive and prospective study was conducted from January 2009 to March 2013 at the Sardar Vallabh Bhai Patel Postgraduate Institute of Pediatrics and Sriram Chandra Bhanja Medical College, Cuttack, Odisha, India. A total of 40 patients with SRNS aged between 1 and 14 years were included on the basis of lack of remission despite treatment with prednisolone 2 mg/kg/day for 4 weeks as per the Indian Society of Pediatric Nephrology (ISPN) consensus guideline. Complete remission was defined as a spot urine protein/creatinine ratio (UPCR) <0.2 or dipstick proteinuria <30 mg/dl for 3 consecutive days. Children with congenital nephrotic syndrome, lupus nephritis and other secondary causes of nephrotic syndrome were excluded from the study. The demographic profile, clinical and biochemical parameters, histological subtypes and outcomes at 6 months were analysed. Demographic, clinical and laboratory data at the time of presentation and at last follow-up were retrieved from case files and the histopathological data, including light microscopy (LM) and immunofluorescence (IF) findings, were recorded from the original renal biopsy forms. Standard definitions of the disease and treatment responses were based on the ISPN guideline. The LM categorisation of glomerular lesions is shown in Figs 1 and 3. Parents or legal guardians were counselled regarding the need for renal biopsy, and informed consent was obtained before obtaining ultrasound-guided percutaneous renal biopsy specimens by means of an automated biopsy gun.

Results

Of the 40 patients, 23 were boys. The mean age of presentation (± standard deviation) was 4.47 (±2.98) years (range 1 - 14 years). The histopathological lesions seen on renal biopsy specimens comprised minimal-change disease (MCD) (n=18), focal segmental glomerulosclerosis (FSGS) (n=12), immunoglobulin A nephropathy (IgAN) (n=5), immunoglobulin M nephropathy (n=2), membranous nephropathy (n=2) and idiopathic mesangial proliferative glomerulonephritis (n=1). MCD is the predominant lesion in children with SRNS at our institution, followed by FSGS and IgAN.

Discussion

SRNS is a common problem in paediatric nephrology practice, and the treatment of these children is often challenging.4,5 Approximately 10 - 20% of children with nephrotic syndrome are classified as having SRNS and are at risk of progressive renal disease as well as complications due to side-effects of prolonged treatment with immunosuppressive medication.6 Earlier
reports have suggested that the outcome of the disease can be predicted from the clinical response to steroids, and that biopsy is unnecessary for the vast majority of children with idiopathic nephrotic syndrome. There is no consensus regarding routine renal biopsy and therapeutic protocol in children with SRNS. Various agents have been used with different outcomes. Although the response to treatment is the best prognostic indicator in children with nephrotic syndrome, renal biopsy has a definite role and is of significant prognostic value in SRNS.

Our study delineates the spectrum of histopathological findings in SRNS in eastern India. In conclusion, and in contrast to other studies, our results indicate MCD to be the commonest histopathological lesion in children with SRNS, followed by FSGS and IgAN. Children with SRNS secondary to MCD are more likely than those with non-MCD to respond to therapy and achieve remission, and have a better long-term prognosis. Renal biopsy therefore has diagnostic and prognostic value in children with SRNS.

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References