Acute renal infarction: a presentation of essential thrombocytosis

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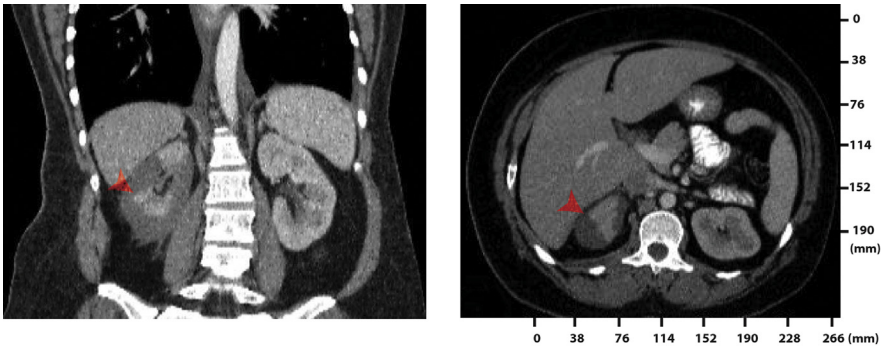

Figure 1 | Coronal (right) and axial (left) computed tomography images after i.v. contrast enhancement shows a clear demarcation zone of an extensive perfusion defect in the right kidney (arrows). To optimize viewing of this image, please see the online version of this article at www.kidney-international.org.

A 37-year-old woman was presented to the emergency department with sudden-onset, persistent, severe right flank pain for 2 hours, after 2 weeks of an eventless caesarean section. Her past medical history was significant for myocardial infarction and 2 second trimester (4th and 5th months) miscarriages. She appeared in severe pain on physical examination; her temperature was 37.8°C, blood pressure was 150/90 mm Hg, heart rate was 94 bpm and regular, and her right flank was tender on percussion. Laboratory tests were as follows: leukocytes 18 × 10^3/μl, hemoglobin 11 g/dl, platelets 450 x 10^3/μl, serum creatinine 1.4 mg/dl, and lactate dehydrogenase 630 IU/l, and urinalysis revealed 50 erythrocytes/high-powered field. Computed tomography of the abdomen showed a near total infarction of the right kidney (Figure 1). Low-molecular-weight heparin and warfarin were started. Antinuclear antibody, anti-double stranded DNA, antinuclear cytoplasmic antibody, anticardiolipin, and beta-2 glycoprotein 1 antibodies were negative; homocysteine levels and CD55 and CD59 expression were normal. BCR-ABL-1 and JAK2 V617F mutations were negative. Bone marrow biopsy showed an increased number and proliferation of megakaryocytic cells and slightly increased reticulin deposition. Detailed investigation for thrombophilia led to the diagnosis of essential thrombocytosis based on the revised World Health Organization criteria for essential thrombocytosis.[1] The patient was discharged with a drug regimen of aspirin (300 mg), warfarin (5 mg), and hydroxyurea (500 mg). Hydroxyurea was started with relatively lower doses compared with the standard regimen because of the patient's low glomerular filtration rate (< 60 ml/min). At the third month of follow-up, the patient was doing well, with platelet counts at 300 x 10^3/μl and serum creatinine levels at 1.4 mg/dl.

DISCLOSURE

All the authors declared no competing interests.

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In the above-stated article, Tuncay Sahutoglu was omitted as an author. His affiliation is the Department of Nephrology, University of Health Sciences, Sanliurfa Mehmet Akif Inan Health Research and Application Center, Sanliurfa, Turkey. The revised author list is as follows:

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