LETTER TO THE EDITOR

INTRAVENOUS CYCLOPHOSPHAMIDE THERAPY IN ADULTS WITH HENOCH-SCHÖNLEIN PURPURA

doi: 10.1590/S1807-59322008000400025

Jae Il Shin, Jae Seung Lee – Comment on: Henoch-Schönlein Purpura in adults. Clinics. 2008;63(2):273-6.

We read with interest the article "Henoch-Schönlein Purpura in adults" by López Meiller et al.[1] They reported 3 adult patients with Henoch-Schönlein nephritis (HSN) (one with hematuria and two with heavy proteinuria) who were treated with IV cyclophosphamide (1g/m²/month for six months).[1]

Although the treatments of severe Henoch-Schönlein nephritis still remains controversial, oral cyclophosphamide has been used in children with severe Henoch-Schönlein nephritis with conflicting results.[2-4] Tanaka et al. reported that prompt initiation of oral prednisolone (1.5 mg/kg/day) combined with an 8-week course of oral cyclophosphamide (2 mg/kg/day) therapy could be effective not only in regressing the renal histologic findings but also in decreasing proteinuria in children with severe Henoch-Schönlein nephritis.[2] Kawasaki et al. also showed that methylprednisolone and urokinase pulse therapy combined with oral cyclophosphamide was more useful for children with severe Henoch-Schönlein nephritis than methylprednisolone and urokinase pulse therapy alone.[3] However, when Tarshish et al. performed a randomized controlled study (supportive therapy with or without oral cyclophosphamide 90 mg/m²/day for 42 days), there were no differences in outcome between the two groups.[4]

Nevertheless, there has been no study on the therapeutic effect of intravenous cyclophosphamide therapy on children or adults with severe Henoch-Schönlein nephritis. On this point, López Meiller et al.'s study[1] is novel and has important clinical implications for the treatment of severe Henoch-Schönlein nephritis. However, the indications and duration of intravenous cyclophosphamide therapy should also be considered, because this protocol (intravenous cyclophosphamide, 1g/m²/month for six months) which has been previously used in severe diffuse proliferative lupus nephritis can cause various side effects.[5] Therefore, at least heavy proteinuria or severe histologic findings should be the indications for intravenous cyclophosphamide therapy in severe Henoch-Schönlein nephritis. However it should be noted that one patient in the López Meiller et al.'s study[1] who showed hematuria without proteinuria was treated with intravenous cyclophosphamide. Also, one or two pulses of IV cyclophosphamide might be enough to control renal inflammations in Henoch-Schönlein nephritis, because two Henoch-Schönlein purpura patients with heavy proteinuria treated with 6 pulses of IV cyclophosphamide had shown a favorable clinical response after only one pulse.[1]

Therefore, further studies should be performed to evaluate the therapeutic effect of IV or oral cyclophosphamide in a large number of adults with severe Henoch-Schönlein nephritis, and the dose and duration of therapy should also be elucidated in the future.

The Institute of Kidney Disease, Department of Pediatrics, Yonsei University College of Medicine, Severance Children's Hospital, Seoul, Korea.
Email: jsyonse@yuhs.ac

REFERENCES

1. López Meiller MJ, Cavallasca JA, Maliandi Mdel R, Nasswetter GG. Henoch-Schönlein Purpura in adults. Clinics. 2008;63:273-76.

2. Tanaka H, Suzuki K, Nakahata T, Ito E, Waga S. Early treatment with oral immunosuppressants in severe proteinuric purpura nephritis. Pediatr Nephrol. 2003;18:347-50.

3. Kawasaki Y, Suzuki J, Suzuki H. Efficacy of methylprednisolone and urokinase pulse therapy combined with or without cyclophosphamide in severe Henoch-Schoenlein nephritis: a clinical and histopathological study. Nephrol Dial Transplant. 2004;19:858-64.

4. Tarshish P, Bernstein J, Edelmann CM Jr. Henoch-Schönlein purpura nephritis: course of disease and efficacy of cyclophosphamide. Pediatr Nephrol. 2004;19:51-6.

5. Omdal R, Husby G, Koldingsnes W. Intravenous and oral cyclophosphamide pulse therapy in rheumatic diseases: side effects and complications. Clin Exp Rheumatol. 1993;11:283-88.