

# AKI AND ESRD IN A WOMAN WITH A HISTORY OF PREECLAMPSIA

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## BACKGROUND

Pregnancy can be a "detector" of a woman's renal health. In this context, hypertensive disorders of pregnancy can be a marker of a kidney disease or an underlying predisposition, or they can act as a hit, in the context of kidney disorder whose pathogenesis involves multiple hits.

We describe a case of a woman with a history of preeclampsia and abuse of NSAIDs who comes to our observation for acute renal failure.

## CASE REPORT

Woman, 33 years old. No family history of kidney disease. Recent abuse of NSAIDs for low back pain.

She goes to the emergency room for oligoanuria. Alteration in renal function were recorded in blood chemistry (BUN 355 mg/dl, creatinine 17.8 mg/dl, sodium 140 mmol/l, potassium 2.9 mmol/l, calcium 7.58 mg/dl, phosphorus 10.5 mg/dl). White blood cells and reactive C protein appear in the norm. Obstructive pathology is excluded. Ultrasonographic signs of chronic disease (reduced kidney volume and reduced cortico-medullary differencing) are detected.

Dialysis treatment is started.

Due to the lack of resolution of the clinical picture, chronic dialysis treatment and the procedure for the insertion on the transplant list are started. The family members are evaluated for the preemptive transplantation. The patient is currently on a pre-emptive transplant list from a living donor father.

## CONCLUSION

Despite increasing evidence of long-term renal risk after an episode of preeclampsia, no indication is present in international gynecological guidelines for subsequent renal function monitoring. Conversely, the Italian Society of Nephrology has suggested best practices for nephrological follow-up after a hypertensive disorder of pregnancy in order to identify unresolved hypertension, impaired renal function or proteinuria and morphological alterations.

Our patient had echographic signs of chronic disease and developed the episode of AKI (in a context of abuse of NSAIDs), revealing chronic kidney disease, 3 years after the episode of preeclampsia; the latter suggests probably the presence of an unidentified pre-existing illness.

Our case emphasizes the need for nephrological screening for patients with PE which should include blood pressure control, evaluation of proteinuria, renal function and autoimmunity, as well as morphological assessment of the kidneys. The presence of alterations in renal function or morphology should induce an additional diagnostic process to determine the cause and ensure an early start of treatment in order to preserve renal function.