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Acute Nephritis Complicating Coxsackie B Infection

The pathogenetic linkage between viral infections, including Coxsackie viruses, and renal diseases is difficult to establish(1). We present patient with acute mixed infection with B2 and B4 Coxsackie viruses complicated by glomerulonephritis.

A 4-year-old Caucasian girl was admitted with a 4-day history of fever, diarrhea and vomiting, and 12-hs of oliguria. Her past medical history was negative for any renal disease. On admission, she had a temperature of 39.5°C and blood pressure of 93/48 mm Hg. Physical examination was normal. Investigations showed leukocytosis with 88% neutrophils and anemia (hemoglobin level of 8.7 g/dL), elevated serum creatinine (3.84 mg/dL) and urea nitrogen (BUN) (164 mg/dL), estimated glomerular filtration rate (GFR) of 15.7 mL/min/1.73m² and metabolic acidosis. Erythrocyte sedimentation rate was 61 mm at the end 1-hr and C-reactive protein was 22.5 mg/dL. Urinalysis showed 3+ proteinuria, hematuria with dysmorphic erythrocytes and red cells casts. Blood levels of electrolytes were normal. Urine, blood, stool and throat

swab cultures were negative for pathogenic bacteria or fungi. Serum C3 and C4 complement levels, antistreptolysin O titer and auto-antibodies were normal.

Renal ultrasound examination showed enlarged kidneys with increased echogenicity. Due to normal values of C3 and C4 levels and presence of acute renal failure, a renal biopsy was done, which showed glomerular and mesangial hypercellularity and infiltration with polymorphonuclear cells. Immunofluorescence examination was negative for IgA deposits. A diagnosis of postinfectious glomerulonephritis was made on biopsy.

The oliguria lasted for three days. On day 3 blood level of creatinine was 5.4mg/dL, calcium 6.7 mg/dL and potassium 6mEq/L. On day 4, urine output normalized. At discharge, one week after admission, blood levels of creatinine, BUN and GFR were normal. One month later urinalysis was normal with no abnormal hematuria or proteinuria.

Serologic tests, using an indirect immunofluorescence method (Biognost, Gräfelfing, Germany), on acute and convalescent serum showed rising titres (1:40 each) of specific IgG, suggestive of a mixed infection by Coxsackie viruses B2 and B4.

A review of the literature yielded no previous reports of Coxsackie B virus infection in children complicated by acute glomerulonephritis. The role of enteroviruses and especially Coxsackie B viruses in nephritis was suspected previously(2). Several experimental and early clinical studies have suggested nephritogenicity of Coxsackie B viruses and in particular B4(2,3). In a murine model, Coxsackie B4 virus found to induce IgA nephropathy(4). Conaldi, *et al.* studying frozen biopsy samples from patients with IgA nephropathy or other glomerulonephritides observed a significant association between Coxsackie B virus and IgA nephropathy(5).

The present report highlights, for the first time an association of Coxsackie B2 and B4 virus infection with acute glomerulonephritis. Further studies including ultrastructural examination for viral inclusions *in situ* hybridization for Coxsackie B virus on renal histology might be necessary to establish a "causal" effect.

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Fatal Rabies Despite Appropriate Post-exposure Prophylaxis

The Indian subcontinent accounts for almost half of the deaths worldwide due to rabies encephalitis. The magnitude of problem is compounded by inappropriate post-exposure rabies prophylaxis(1). We describe a case of fatal rabies despite use of purified chick-embryo vaccine (PCEV) and human rabies immunoglobulin (HRIG).

A 5-year-old girl presented to us with a 7

cm laceration with a flap hanging in front of the left eye following a stray dog bite 6 h back. Wound cleansing with povidone iodine and tetanus toxoid administration had been done at a nearby dispensary immediately after the bite. PCEV (Rabipur, Chiron Behring Vaccines Pvt. Ltd.) was given over deltoid region and 20 IU/kg of HRIG (RABGLOB, Bharat Serums & Vaccines Ltd.) was administered (~ 50% infiltrated locally and rest intramuscularly). Laceration was sutured after 24 h because of the high likelihood of a bad scar in the girl child. She was discharged after the 3rd dose of