A RENAL CASE THAT CATCHES THE EYE

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CASE INTRODUCTION

43-year-old female patient

PMH asthma, bipolar disorder, obstructive sleep apnea, type II diabetes, vitamin D deficiency

Presented with worsening eye pain and blurry vision of four days duration with associated clear discharge and moderate bilateral photophobia

Physical exam was remarkable for bilateral conjunctival injection, no discharge
Patient was diagnosed with anterior uveitis and prescribed prednisolone eye drops

Only remarkable lab work-up was elevated urine beta2-macroglobulin and CMP with elevated creatinine of 1.81, baseline 0.8; urinalysis showed 100 protein with trace ketones

Differential?
Lyme disease, tuberculosis, syphilis and sarcoidosis were ruled out with laboratory evaluation

Upon consultation with nephrology, further rheumatologic evaluation, including complement levels, anti-neutrophil cytoplasmic antibody and anti-nuclear antibody, as well as infectious evaluation, including hepatitis and HIV, were performed
Interstitial inflammation

Tubulitis
DISCUSSION

Diagnosis involves excluding multiple autoimmune processes, including sarcoidosis and systemic lupus erythematosus, as well as infectious processes, including HIV and hepatitis.

Among patients attending uveitis clinics, prevalence of TINU is < 0.1 to 2%.

Paucity of data regarding this disease process negatively impacts determination of genetic and environmental influences.
DISCUSSION (CONTINUED)

Underlying pathophysiology for this disease is not well understood.

Modified C-reactive protein may be implicated as this protein is found in both renal tubular cells and uvea.

In recent study, mCRP was found to be higher in patients with TINU syndrome and late-onset uveitis when compared to drug-induced interstitial nephritis.
TAKE-HOME POINTS

Close follow-up with ophthalmology and nephrology is essential in these patients as uveitis often recurs after corticosteroid withdrawal.

Chronic kidney damage can ensue if there is not sufficient monitoring.
THANK YOU! Questions?