

AUTHORS' REPLY

Singapore Med J 2014; 55(9): 506 doi: 10.11622/smedj.2014123

Dear Sir,

We would like to thank Dr Sakallioglu for his insightful comments on our report⁽¹⁾ and the opportunity to clarify a number of points.

Firstly, the patient presented with a seven-, and not nine-, day history of fever and neck swelling. It was also highlighted that the fever was of a high grade, and associated with vomiting and diarrhoea for two days before, and not after, admission.

Secondly, although a renal biopsy may have been diagnostically helpful, it was deferred due to the patient's improving renal functions, and clinically, the patient was not deteriorating. After three weeks of hospitalisation, his urine output was consistent at > 1 mL/kg/hr, and at four weeks, his renal function normalised. Furthermore, renal biopsy is not generally performed in cases of post-streptococcal acute glomerulonephritis or acute glomerulonephritis following pneumococcal bacteraemia because of rapid clinical improvement. Other case reports reviewed in our paper⁽¹⁾ did not state the histological type of acute glomerulonephritis; only three cases had renal biopsies performed – two complicated cases in adults with rapidly increasing creatinine levels beyond four weeks⁽²⁾ and who required dialysis,⁽³⁾ and one paediatric case for the purpose of academic exercise.⁽⁴⁾ As with other case series of children with pneumococcal glomerulonephritis previously summarised in our report,⁽¹⁾ our patient had a good prognosis for both renal and lung involvements – the recovery of renal functions was observed to be achieved within 11 days to 8 weeks following disease onset.

Finally, *Streptococcus pneumoniae* (*S. pneumoniae*) is known to present with a wide range of symptoms, including diarrhoea⁽⁵⁾ and cervical lymphadenopathy. Our case highlighted these unusual presentations of *S. pneumoniae*.⁽¹⁾ After two weeks of hospitalisation, the unresolved fever complicated with bronchopneumonia and pleural effusion was attributed to the pathogenesis of pneumococcal glomerulonephritis. The possibility of nosocomial infections was ruled out by subsequent cultures, which were negative. We also performed a workup for autoimmune and immunodeficiencies causes, which were all negative. The patient was found to respond to the antibiotic treatment the following week.⁽¹⁾

Yours sincerely,

Intan Hakimah Ismail¹, Zurina Zainudin¹, Norlijah Othman¹

¹Department of Paediatrics, Faculty of Medicine and Health Sciences, Universiti Putra Malaysia, Selangor, Malaysia. ihakimah@yahoo.com

REFERENCES

1. Ismail IH, Zainudin Z, Othman N. Pneumococcal glomerulonephritis in a healthy child: a case report and literature review. Singapore Med J 2014; 55:e69-72.
2. Kaechny WD, Ozawa T, Schwarz ML, et al. Acute nephritis and pulmonary alveolitis following pneumococcal pneumonia. Arch Intern Med 1978; 138:806-8.
3. Usmani SZ, Shahid Z, Wheeler D, Nasser K. A rare case of post-infectious glomerulonephritis caused by pneumococcus in an adult patient. J Nephrol 2007; 20:99-102.
4. Hyman LR, Jenis EH, Hill GS, Zimmerman SW, Burkholder PM. Alternative C3 pathway activation in pneumococcal glomerulonephritis. Am J Med 1975; 58:810-4.
5. Cleveland KO, Gelfand MS, Goswami R. Diarrhea as a symptom in bacteremic pneumococcal pneumonia. Infect Dis Clin Pract 2007; 15:35-7.