Utility of renal allograft biopsy: An audit of 80 allograft biopsies

Sir,

Uppin *et al.*, deserve congratulations for sharing their experience on the utility of renal allograft biopsies in the management of renal transplant patients at their center.[1] Indeed, this is a timely contribution to the meager literature on this subject from the Indian Subcontinent. We have also previously published our experience on renal allograft biopsy findings in one of the largest studies in the world.[2] Although, our study also included live related renal transplants as that of Uppin *et al.,* our findings are quite different from those of the later study. I take this opportunity to highlight some of the discrepant points. I understand that this is just a correspondence and not a full original article, but some important points are lacking, which must have been incorporated in the paper. These include information on the donor relationship, human leukocyte antigen match, results of pre-sensitization, immunosuppressive regimens used and the donor age and sex. The authors will agree that the above information is crucial in understanding the pattern of histopathological lesions found on renal allograft biopsies. Just to cite a few examples of discrepant results, acute humoral rejection (AHR) was found more commonly in their biopsies than acute cellular rejection (ACR). Moreover, the rate of ACR is very low in the subject study. It seems that the mainstay for the diagnosis of AHR in the subject study comprised of morphological lesions, which are notorious for their non-specificity.[3-5] In fact, the definitive diagnosis of AHR requires fulfillment of all three criteria as envisaged in Banff 2001 revision of Banff 97 classification.[3,4] I hope, the authors will agree that it is not appropriate to label such cases as AHR on morphological criteria alone. Such a high rate of AHR is surprising for a live related renal transplant program if not carried across the immunological barriers, such as ABO bood group incompatibility. It is also surprising to note that the primary diseases causing end-stage renal disease (ESRD) were known in all cases. This is quite in contrast to the common finding in most of the studies from this region, which show that a significant number of cases of ESRD are of unknown origin.[6] Moreover, in the indications for biopsies, it is stated that one biopsy was carried out for proteinuria, but later on it is stated that two cases were biopsied for proteinuria, one of which turned out to be recurrent focal segmental glomerulosclerosis (FSGS). However, among the primary diseases causing ESRD, no case of FSGS is listed, which make recurrence of FSGS unlikely. The term of chronic allograft nephropathy was eliminated in Banff 2005 meeting report and not in Banff 2003 update as stated by the authors of the subject study.[4]

Another interesting observation, which we also commonly observe in our patients, is the frequency of culture negative acute pyelonephritis.[1,2] Two of their patients did not grow organisms on urine culture. More studies are needed to address this issue in greater detail.

In summary, the above study is a valuable addition to the meager literature on this subject from this area of

the world. Regional collaboration and interaction is needed to better define the prevalent causes of graft dysfunction in our setting, which is quite different from that of the west.

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