Introduction: Proliferative extracapillary (crescentic) glomerulonephritis is the leading cause of Crescentic GN followed by pauciimmune GN. Requirement of renal replacement therapy at presentation was highest in patients presenting with anti GBM disease followed by pauci-immune GN (93.3% vs 85.7%). Median number of glomeruli for evaluation were 11 (range 5–34). Morphology of crescents were cellular in 60 (64.51%) patients, fibro-cellular in 12 (12.93%), fibrous in 8 (8.6%), cellular to fibro-cellular in 13 (13.06%) patients. Viable glomeruli showed 100 percentage crescents of uniform morphology in 15 (93.7%) of patients with antiGBM disease. Glomerular tuft necrosis and vascular necrosis were noted in 18 (19.35%) and 14 (15.05%) patients respectively and were predominantly associated with antiGBM disease and pauciimmune glomerulonephritis. Four patients who underwent electron microscopic examination had features consistent with Immune complex glomerulonephritis.

Results: No conflict of interest

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CLINICAL AND HISTOMORPHOLOGICAL SPECTRUM OF CRESCENTIC GLOMERULONEPHRITIS FROM SOUTHERN INDIA-A SINGLE CENTER EXPERIENCE

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Introduction: Immune complex glomerulonephritis was the leading cause of Crescentic GN followed by pauciimmune GN in our cohort with female preponderance. Majority of the patients who presented as RPGN required renal replacement therapy.

No conflict of interest

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A CASE OF EGPA THAT DEVELOPED DURING REMISSION OF IGA NEPHROPATHY

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Introduction: Eosinophilic granulomatosis with polyangiitis (EGPA) is a systemic necrotizing vasculitis that affects small and medium sized vessels. EGPA is also characterized by allergic rhinitis, asthma, and prominent peripheral blood eosinophilia. EGPA is a rare disease, and its prevalence is about 11-13 cases per million. On the other hand, IgA nephropathy is the most common disease found to cause primary glomerulonephritis all over the world. There has been no case report of EGPA who had a history of IgA nephropathy.

Methods: We conducted a PubMed literature search using key words (eosinophilic granulomatosis with polyangiitis or EGPA or Churg-Strauss) and (IgA nephropathy), from 1986 to 2020. No case report was identified.

Results: A 54-year-old woman was diagnosed to have IgA nephropathy by a kidney biopsy when she was 25 years old and had 1.0 g/day of proteinuria. A remission was achieved using prednisolone, and the remission had been maintained under no immunosuppressant for 25 years. 7 years ago, she moved and follow up was started at our hospital. At the first visit, serum creatinine (sCr) was 0.53 mg/dl, eGFR was 95 ml/min/1.73m², MPO-ANCA was negative in the blood test. Urine glomerulonephritis of which group I had 50 (53.76%), group II had 16 (17.21%) and group III had 23 (24.78%) patients respectively (Figure 1). Four patients (4.30%) had a dual pathology antiGBM with IgA nephropathy. Mean age of the study population was 42.23±16.63 years however pauciimmune C3GN was more prevalent in relatively older patients (46±17.32) years. Women predominated the study cohort 48 (51.63%) and similar distribution was noted across the groups I, II, and III respectively (49.6%, 53.3%and 57.2%). Two thirds of the patients 63 (66.7%) presented as rapidly progressive glomerulonephritis (RPGN), 28 (30.13%) as acute nephritic syndrome and two patients presented with only nephrotic range proteinuria. Hypertension was seen in 46 (60.21%) patients and 14 (15.02%) patients had associated Diabetes. Mean creatinine on presentation was 5.67±3.4mg/dl in immune complex GN, 8.45±3.94mg/dl in anti GBM disease and 6.34±2.82mg/dl in pauciimmune GN.

Conclusion: Immune complex glomerulonephritis was the leading cause of Crescentic GN followed by pauciimmune GN in our cohort with female preponderance. Majority of the patients who presented as RPGN required renal replacement therapy.

No conflict of interest