the cellular crescents from crescentic glomerulonephritis and the proliferative podocytes are derived from the same progenitor source: parietal epithelial cells.

No conflict of interest

**POS-169**

**LEVAMISOLE IS A PROMISING ALTERNATE IMMUNOSUPPRESSIVE THERAPY IN FREQUENT RELAPSING AND STEROID DEPENDENT CHILDHOOD NEPHROTIC SYNDROME**

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**Introduction:** Frequent Relapsing Nephrotic Syndrome (FRNS) and Steroid Dependent Nephrotic Syndrome (SDNS) are often difficult to manage in terms of need of prolonged steroid use, recurrent relapses, frequent infection and hospital admission. Similarly, alternate immunosuppressive therapies have themselves risk of bone marrow suppression and organ toxicities. Levamisole is an anthelmintic with less immunomodulatory action which can be effective in managing FRNS and SDNS

**Methods:** This is a retrospective chart review of data from Feb 2018 to Jan 2020 of children with nephrotic syndrome who received levamisole and whose initiation on levamisole was begun before August 2019. The response of levamisole on course of Nephrotic Syndrome and side effect profile among FRNS and SDNS was observed.

**Results:** 45 cases were put on levamisole during the study period, of which 9 cases were SDNS and remaining were FRNS. The mean age of FRNS was 6±2 yrs., among FRNS cases remission for at least 6 months was achieved among 61.1%, while 22.2% had In-frequent Relapsing course. On the other hand, switch over to other immunosuppressive therapy was required in just 16.6% of the cases. The mean age of SDNS was 4.5±2 yrs., 22.2% among SDNS had sustained remission for at least 6 months and 55.5% had in frequent relapsing course and 22.2% needed switch over to other immunosuppressive therapy. 1 case of FRNS was admitted with pneumonia while 2 cases of SDNS needed admission (1 with pneumonia and 1 with peritonitis). No cases had bone marrow suppression, 2 cases with SDNS had skin manifestation in the form of Tinea cruris and molluscum contagiosum.

**Conclusions:** Levamisole is one of the cheap and effective alternate immunosuppressive agents which can be used in FRNS and SDNS, with better advantage in FRNS and also has minimum side effect profile.

No conflict of interest

**POSTER SESSION: TROPICAL KIDNEY DISEASES (VIRAL NEPHROPATHIES, TB, SCHISTOSOMIASIS)**

**POS06**

15/04/2021
Poster Area
05:00 – 06:00

**POS-170**

**LEISHMANIASIS COMPLICATE SYSTEMIC LUPUS ERYTHEMATOSUS: ABOUT 7 CASES**

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**Introduction:** The association between leishmania (Lsc) and systemic lupus erythematosus (SLE) is rare. It is particularly serious in cases of visceral leishmania (VL). It is a parasitic infection whose hallmarks may mimic SLE symptoms especially when the two pathologies appear concomitantly. The prognosis of SLE depends on the one hand on the rapidity of diagnosis and on the other hand on the quality of treatment. The aim of this study was to analyze the characteristics of infection in leishmania in patients affected by SLE.

**Methods:** It was a retrospective study including 07 patients hospitalized for leishmania and systemic lupus erythematosus (SLE) in the Internal Medicine Department of the Charles Nicolle hospital during the period between January 1976 and November 2020. All patients fulfilled four or more criteria defined by the American College of Rheumatology 1982, revised in 1997. The diagnosis of cutaneous leishmaniasis (CL) was confirmed by a biopsy specimen. The diagnosis of VL was confirmed by the association of clinical and biology sings associated with positive bone marrow smear and/or positive serologic tests for Leishmania antibodies.

**Results:** Seven patients were enrolled in the study. Their mean age was 27, 85 years [14-41]. There were six women and one man. The diagnosis of SLE was concomitant in three patients, while in four cases the diagnosis of leishmania was after the diagnosis of LES. The time interval between the date of discovery of leishmania and the date of confirmation of the diagnosis of SLE was 36 months [2-24].

For the diagnosis of LES, malar rash, photosensitivity, nephritis, arthralgia and positive antinuclear antibody were observed in six cases.

Anti-double stranded DNA antibody was positive in two cases. For the diagnosis of CL, it was based on clinical manifestation in one case and was based in cutaneous biopsy in two cases. Five patients had nephrotic syndrome and one patient had proteinuria. Patients who had renal biopsy had active lupus nephritis class III in one case and lupus nephritis class IV in three cases. Two patients had not renal biopsy because one of them had severe hypertension and the other had severe sepsis. The diagnosis of CL was clinical in one case and histological in two cases.

Clinical manifestations of VL were dominated by fever, pale mucous membranes and splenomegaly. There was pancytopenia in all patients with VL.

The diagnosis of VL was confirmed by serology (n=3) and bone marrow smear (n=4).

Meglumine antimonite was prescribed in the three cases of CL. In the other cases pentagonal polysulfate was prescribed in a single patient while in the other two cases, they required the addition of liposomal amphotericin B. One patient was died by tamponade before treatment. Two patients were died by septic shock and only one was cured.

Patients with CL had scar in two cases. The last patient died of it.

**Conclusions:** The distinction between the diagnosis of SLE or its exacerbation and VL may be a clinical dilemma responsible for diagnostic delay. All the cases diagnosed so far have been by conventional techniques, which may underestimate the incidence of this association. The results of this study highlight a high mortality rate in cases of VL with SLE accordingly with several studies in literature.

No conflict of interest

**POS-171**

**TB OR NOT TO BE, THAT IS THE QUESTION**

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**Introduction:** Although the incidence of Tuberculosis (Tb) worldwide is decreasing, the risk of pulmonary and disseminated disease remains high in recipients of solid organ transplants. The presentation of Tb is not always overt and should be considered in all transplantation patients.

**Methods:** A case report of a patient presenting to a tertiary renal transplantation centre.

**Results:** We present a case report of a 71-year-old man who underwent a kidney transplant due to end stage renal failure secondary to diabetic nephropathy. The induction agent was Basiliximab on day zero and day four and he was immunosuppressed with MMF, Tacrolimus and Prednisolone. Seven months after transplantation he presented with vague symptoms of abdominal pain, fevers and leukopenia. On admission his LFTs were deranged and an MRCP showed a diffuse cholangiopathy of infective origin which was stented with ERCP. The patient did not respond to antibiotics and continued to spike temperature. At the fourth admission his LFTs were deranged and an MRCP showed a diffuse cholangiopathy of infective origin which was stented with ERCP. The patient did not respond to antibiotics and continued to spike temperature. Throughout admission the patient did not culture Tb in sputum or blood.

**Conclusions:** We present a case report of a patient presenting to a tertiary renal transplantation centre.

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