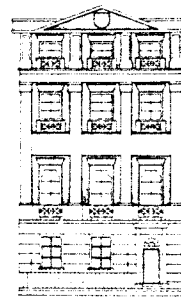


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DISTINGUISHING BETWEEN RENAL ALLOGRAFT REJECTION AND CYCLOSPORIN NEPHROTOXICITY

SIR,—Dr Taube et al (July 27, p 171) describe the distinct histological pictures of acute transplant rejection and cyclosporin-induced damage which are associated with similar impairments of renal allograft function. They conclude that making the distinction between these two conditions is important and difficult but that a kidney biopsy is often helpful in doing so. Although a biopsy is quite easy and safe, it is nonetheless invasive and expensive.

Staining the urinary sediment with methyl-green/pyronin and quantifying the number of pyronin positive ("turned on") mononuclear cells permits the early diagnosis of acute allograft rejection.¹ 14 of 16 episodes of biopsy-proven acute rejection were diagnosed by the use of this method. This prospective study was done before the availability of cyclosporin so that it is not known whether examination of the urinary sediment is useful for differentiating cyclosporin damage from acute rejection episodes. However, the histopathological pictures which Taube et al describe lead me to believe that different urinary sediment findings might be expected. The large amount of mononuclear cell infiltration that is seen in renal biopsy specimens obtained during acute rejection episodes is consistent with the lymphocyturia previously described. The absence of this process with cyclosporin-induced renal damage might be expected to be reflected by a much less active urinary sediment. I would suggest that the diagnostic value of this simple test be compared with renal biopsy.

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1. Hrushesky WJM, et al. Lymphocyturia in human renal allograft rejection. *Arch Surg* 1972; **105**: 424-26.