

LETTER TO THE EDITOR

INTRAVENOUS CYCLOPHOSPHAMIDE THERAPY IN
ADULTS WITH HENOCCH-SCHÖNLEIN PURPURA

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Jae Il Shin, Jae Seung Lee – Comment on: Henoch-Schönlein Purpura in adults. Clinics. 2008;63(2):273-6.

We read with interest the article “Henoch-Schönlein Purpura in adults” by López Meiller et al.¹ They reported 3 adult patients with Henoch-Schönlein nephritis (HSN) (one with hematuria and two with heavy proteinuria) who were treated with IV cyclophosphamide (1g/m²/month for six months).¹

Although the treatments of severe Henoch-Schönlein nephritis still remains controversial, oral cyclophosphamide has been used in children with severe Henoch-Schönlein nephritis with conflicting results.²⁻⁴ Tanaka et al. reported that prompt initiation of oral prednisolone (1.5 mg/kg/day) combined with an 8-week course of oral cyclophosphamide (2 mg/kg/day) therapy could be effective not only in regressing the renal histologic findings but also in decreasing proteinuria in children with severe Henoch-Schönlein nephritis.² Kawasaki et al. also showed that methylprednisolone and urokinase pulse therapy combined with oral cyclophosphamide was more useful for children with severe Henoch-Schönlein nephritis than methylprednisolone and urokinase pulse therapy alone.³ However, when Tarshish et al. performed a randomized controlled study (supportive therapy with or without oral cyclophosphamide 90 mg/m²/day for 42 days), there were no differences in outcome between the two groups.⁴

Nevertheless, there has been no study on the therapeutic effect of intravenous cyclophosphamide therapy on children

or adults with severe Henoch-Schönlein nephritis. On this point, López Meiller et al.’s study¹ is novel and has important clinical implications for the treatment of severe Henoch-Schönlein nephritis. However, the indications and duration of intravenous cyclophosphamide therapy should also be considered, because this protocol (intravenous cyclophosphamide, 1g/m²/month for six months) which has been previously used in severe diffuse proliferative lupus nephritis can cause various side effects.⁵ Therefore, at least heavy proteinuria or severe histologic findings should be the indications for intravenous cyclophosphamide therapy in severe Henoch-Schönlein nephritis. However it should be noted that one patient in the López Meiller et al.’s study¹ who showed hematuria without proteinuria was treated with intravenous cyclophosphamide. Also, one or two pulses of IV cyclophosphamide might be enough to control renal inflammations in Henoch-Schönlein nephritis, because two Henoch-Schönlein purpura patients with heavy proteinuria treated with 6 pulses of IV cyclophosphamide had shown a favorable clinical response after only one pulse.¹

Therefore, further studies should be performed to evaluate the therapeutic effect of IV or oral cyclophosphamide in a large number of adults with severe Henoch-Schönlein nephritis, and the dose and duration of therapy should also be elucidated in the future.

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