



Figure 2: Lactophenol cotton Blue Mount of the colonies grown on Sabouraud's Dextrose agar showing septate, brown hyphae, brown conidiophores, and conidia. Conidiophores showed sympodial geniculate arrangement. The conidia were pyriform, brown, and multiple

in preventing secondary fungal infection in patients who were treated for bacterial peritonitis in CAPD.^[5] However, we encountered fungal peritonitis due to *curvularia* despite fluconazole prophylaxis during treatment of bacterial peritonitis in our patient.

Patient was shifted to maintenance hemodialysis after catheter removal, and was treated with Tab. Voriconazole 400 mg B.D loading dose and 200 mg B.D maintenance dose for 3 weeks. At present patient is asymptomatic on regular follow-up.

The points of interest in our presentation are: development of a rare entity *C. lunata*-related peritonitis probably secondary to earlier antibiotic usage and its response to voriconazole.

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How does KDQoL-36 questionnaire predict quality of life in Indian hemodialysis patients?

Sir,

We read with interest an article published by Veerappan *et al.*^[1] in the Indian journal of nephrology titled “predictors of quality of life of hemodialysis patients in India”. They focused on the factors that affect quality of life in hemodialysis patients based on the KDQoL-36 questionnaire. In addition, the authors have compared some results with Dialysis Outcomes and Practice Patterns Study (DOPPS).

From the 1980s until now, there has been a growing interest in the evaluation of Health Related Quality of Life (HRQoL) among end-stage renal disease (ESRD) patients. HRQoL is a multidimensional concept that includes physical, mental, psycosocial, and spiritual aspects of health.^[2,3] In addition, nonbiological factors such as patient culture, religious behaviors, and ethics, may play an important role in HRQoL because they can influence patients' perceptions and expectations. This concept has been examined by several investigators.^[4-6] For example, Antonio *et al.* 2003 and Donna *et al.* 2004 showed that mortality risk was lower for African Americans and Asians than for non-Hispanic whites treated by dialysis, though black and Asians people were more susceptible to diabetes and lower levels of socioeconomic status.^[5,6] Furthermore, Donna *et al.* suggested that survival differences among dialysis patients from different ethnic groups must be assessed in terms of variation in HRQoL.^[6] Anne *et al.*

studied large established Asian communities from the Indian subcontinent that existed in UK.^[7] They believed that there was a high incidence of renal disease in this ethnicity. A total of 42 Indians were compared with 51 white Europeans to evaluate the effect of ethnicity on QoL among hemodialysis patients. They found similar QoL in the two groups (MCS scores 45 ± 23 vs. 65 ± 20 and PCS score 34 ± 17 vs. 45 ± 18). Asian patients with other chronic conditions, such as diabetes and asthma has shown that they have a poor awareness of their illness compared with white patients.^[7]

Since our people have no strict program for CKD screening and follow-up, they are not aware about their disease and majority of them presented with advanced renal failure for the first time. A great deal of them experience an urgent acute dialysis requirement and few of the CKD patients are scheduled for elective dialysis; it means that ESRD patients in our countries suffer from uremic symptoms for a long time. Hence, after starting dialysis treatment, they rarely achieve well-being. Moreover, after dialysis initiation, as Veerappan *et al.*^[1] mentioned, the dialysis prescription is empiric in the majority of our dialysis centers.

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Unusual association of a positive pANCA pauci-immune extracapillary glomerulonephritis in a lupus patient

Sir,

We report a case of pauci-immune proliferative and crescentic glomerulonephritis in a 22-year-old female with systemic lupus erythematosus (SLE) who was admitted because of a rapidly progressive glomerulonephritis syndrome. On admission, the patient had generalized edema, a blood pressure of 130/80 mmHg and anuria. There were no extra-renal signs.

Investigations showed a serum creatinine of 15.2 mg/ dl, hemoglobin of 6.9 g/dl, a lymphopenia (900/cumm), low serum complement C₃ concentration of 20 (50- 120 mg/ dl), positive antinuclear antibodies at 1/640 with homogenous fluorescence, and positive anti-DNA antibodies >300 UI/ml.

Renal histology included 23 glomeruli, there was extracapillary proliferation with circumferential crescents in 13 glomeruli and one obsolescent glomerulus [Figure 1].

Immunofluorescence (IF) examination of the kidney biopsy did not reveal any significant deposit of immunoglobulins and complement. Anti-myeloperoxidase (MPO) antibodies were positive at 212 UI/ml by enzyme-linked immunosorbent assay (ELISA).

Immunosuppressive treatment included corticosteroids and intravenous cyclophosphamid. The renal evolution was characterized by a persistent anuria for 45 days. A progressive amelioration of renal function led to a

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