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Treatment of steroid resistant nephrotic syndrome in children.

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Source

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Abstract

Achieving remission in **children** with **steroid-resistant nephrotic syndrome** (SRNS) could be difficult. Many immunosuppressive drugs are used with variable success rates. We have studied the response of **children** with SRNS who presented to our pediatric's renal unit between 2002 and 2007 to various modalities of **therapy**. We included patients with no response to prednisolone (60 mg/M2/day) after four weeks of **therapy**; all the patients had renal biopsy and followup duration for at least one year. We excluded patients with congenital **nephrotic syndrome**, lupus, or sickle cell disease. There were 31 (23 girls and 8 boys with F:M = 2.9:1; the mean age at presentation was 4.2 +/- 3.2) **children** who fulfilled the inclusion criteria. The mean duration of follow up was 3.1 +/- 1.6 years. Twenty **children** (65%) achieved partial (6 **children**) or complete (14 **children**) remission. There were 16 **children** treated with cyclophosphamide either oral or intravenous, and only 4 of them (25%) achieved remission. Seven **children** received oral chlorambucil, and only2 of them (28.5%) achieved remission; none of the **children** experienced side effects. Fifteen **children** received cyclosporine, and only eight of them (53%) achieved remission. Six **children** developed gum hypertrophy and one had renal impairment, which was reversible after discontinuing the drug. Mycophonelate mofetil (MMF) was used as the last option in 5 **children**, and 2 of them achieved complete remission. One **child** developed a systemic cytomegalovirus (CMV) infection which indicated discontinuing the drug. Fourteen (45%) **children** needed more than one immunosuppressive **therapy**. Three **children** progressed to end stage renal failure and required dialysis. We conclude that SRNS in **children** is a difficult disease with significant morbidity. However, remission is achievable with cyclosporine and other immunosuppressive agents. **Treatment** should be individualized according to the underlying histopathology, and clinical and social conditions of the **children**