Persistent flank pain without active urinary sediments

A 45-year-old man presented to the emergency department because of persistent steady flank pain for 18 h. He denied having any systemic illness or trauma. On arrival, his vital signs were normal. Physical examination showed knocking tenderness over his left flank. His laboratory results disclosed leucocytosis (white cells 10 700/l), mildly raised serum creatinine (1.1 mg/dl) and aspartate aminotransferase (78 U/l). The urinary analysis showed absence of pyuria or haematuria. Ultrasonography of the kidneys showed no hydronephrosis, but a hypoechoic area over the lower portion of the left kidney. Contrast-enhanced computed tomography confirmed the diagnosis of acute renal infarction (fig 1A, arrow). Angiography of the left renal artery showed several segmental thrombi (arrows) in the left main renal artery (fig 1B). Intra-artery thrombolytic treatment with urokinase was carried out. Follow-up angiography showed patency of the affected artery. On follow-up at 2 months his serum creatinine was normal, but a renal scan showed 52% loss of estimated renal perfusion flow in the affected kidney. The diagnosis of renal infarction is often delayed. Nevertheless, neither clinical characteristics nor laboratory tests are

sufficient to make the diagnosis. Early-stage renal infarction may present as a hypoechoic area in ultrasonography.¹ In patients with persistent flank pain but lack of evidence of calculus, a contrast-enhanced computed tomography is warranted to elucidate the possibility of renal infarction.

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REFERENCES

- 1 Hazanov N, Somin M, Attali M, et al. Acute renal embolism: forty-four cases of renal infarction in patients with atrial fibrillation. *Medicine* 2004;**83**:292–9.

Figure 1 (A) Contrast-enhanced computed tomography of abdomen confirmed the diagnosis of acute renal infarction (arrow). (B) Angiography of the left renal artery showed several segmental thrombi (arrows) in the left main renal artery.

Lamotrigine rash—a potentially life-threatening complication

A 10-year-old boy with epilepsy presented with a maculopapular rash over the face (fig 1). He had been started on lamotrigine 4 weeks earlier. The rash spread and he developed itching. Lamotrigine was stopped and treatment started with antihistamines and steroids. Of all the adverse events associated with lamotrigine, rash has caused the greatest concern and been the most frequent reason for stopping lamotrigine.¹ The incidence is higher in children (1%) than in adults, and can range from simple rash to the more serious Steven Johnson and hypersensitivity syndromes. Rash usually occurs within 12 weeks of initiation of treatment. The risk factors include the concomitant use of valproate and exceeding the recommended starting dose or rate of dose escalation. It is difficult to predict the progression of the rash and to establish the cause. If there is no alternate explanation, it must be presumed to be due to lamotrigine; the drug should be stopped immediately and

the neurologist involved in the care should be contacted to discuss how to handle the potential worsening of seizures.

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REFERENCES

- 1 Mackay FJ, Wilton LV, Pearce GL, et al. Safety of long-term lamotrigine in epilepsy. *Epilepsia* 1997;**38**:881–6.

Figure 1 Face of a 10-year-old boy with maculopapular rash. Parental/guardian informed consent was obtained for publication of this figure.