Cast Nephropathy: Clinicopathologic Analysis of 4 Cases

Mary Mathew¹, Manjari Kishore²

¹Professor, Department of Pathology, Kasturba Medical College, Manipal, Karnataka, India
²Junior Resident, Department of Pathology, Kasturba Medical College, Manipal, Karnataka, India

Abstract: Multiple myeloma is a malignancy of plasma cells. Myeloma Cast Nephropathy (myeloma kidney), refers to intrinsic Acute Kidney Injury (AKI) that results as the filtered light chain component of M-protein (Bence-Jones protein) exerts toxic & obstructive injury to tubules. A total of 4 cases diagnosed with cast nephropathy between Jan’2010-Apr’2014 were analysed retrospectively as per histopathological and clinical criteria. All 4 cases were between age 44-62 yrs, 3 were males & 1 female. 1 case showed light chain cast nephropathy with early features of acute tubulopathy. Second case showed evidence of light chain deposition disease with inflammatory tubulointerstitial nephritis along with light chain cast nephropathy. Rest 2 of the cases showed presence of cast nephropathy with superadded hypertension induced changes. Conclusion: Cast nephropathy is seen in 30 to 50% patients of multiple myeloma. The likelihood of underlying cast nephropathy is increased in cases of more profound AKI. Cast nephropathy can be misinterpreted as interstitial nephritis, amyloidosis, light chain deposition diseases, etc., hence vital for nephrologists to review the histology with pathologists to avoid misdiagnosis.

Keywords: Myeloma Kidney, Acute Kidney Injury, Cast Nephropathy, Bence Jones proteins, Tamm Horsfall protein

1. Introduction

Multiple myeloma is a clonal B-cell disease of slow proliferating plasma cells accompanied by monoclonal protein production and lytic bone lesion. There is overproduction of monoclonal Immunoglobulin; so called M-protein. Myeloma Cast Nephropathy (myeloma kidney), refers to intrinsic Acute Kidney Injury (AKI) that results as the filtered light chain component of M-protein (Bence-Jones protein) exerts toxic & obstructive injury to tubules. Bence Jones protein cast nephropathy is characterised by prominent casts in tubules. Casts are usually large and “brittle,” have fracture lines or are broken into many fragments often with geometric shapes, surrounded by tubular epithelium, neutrophils. While they are more common in distal tubules, cast may be formed in any segment of nephron, including Bowman’s space.

2. Case Report

A total of 4 cases diagnosed with cast nephropathy between Jan’2010-Apr’2014 were analyzed retrospectively as per histopathological and clinical criteria. All 4 cases were between age 44-62 yrs, 3 were males & 1 female. 1 case showed light chain cast nephropathy with early features of acute tubulopathy. Second case showed evidence of light chain deposition disease with inflammatory tubulointerstitial nephritis along with light chain cast nephropathy. Rest 2 of the cases showed presence of cast nephropathy with superadded hypertension induced changes. Bone marrow aspiration & biopsy confirmed the diagnosis of myeloma in all patients. The clinical, biochemical and radiological features of all the four cases along with associated lesions are presented in a tabular form in Table no. 1 as follows.
The histopathological findings along with immunofluorescence and bone marrow aspiration & biopsy details of the cases are summarized in Table no. 2.

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Case 1</th>
<th>Case 2</th>
<th>Case 3</th>
<th>Case 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renal biopsy (light microscopy)</td>
<td>6/21 glomeruli show increase in mesangial matrix.</td>
<td>1/9 glomeruli is oblsolete, 1 shows focal mesangial hypercellularity.</td>
<td>4 /14 glomeruli shows glomerulomegaly with nodular hyalinosis, increased mesangial matrix &amp; cells, thickened basement membrane.</td>
<td>Glomeruli: normal</td>
</tr>
<tr>
<td>IF findings</td>
<td>Negative</td>
<td>Not performed as no glomeruli seen in th tissue sent for IF.</td>
<td>C3 deposits seen focally in Bowman’s capsule segmental mesangial (2+) along with Igg.</td>
<td>Not done due to absence of glomeruli (medulla)</td>
</tr>
<tr>
<td>BMA &amp; BMB</td>
<td>Not available</td>
<td>Consistent with myeloma</td>
<td>Consistent with multiple myeloma</td>
<td>Consistent with myeloma</td>
</tr>
</tbody>
</table>

Table no. 2: Histopathological features of 4 cases of cast nephropathy

Bence Jones protein cast nephropathy is characterised by prominent casts in tubules. Casts are usually large and “brittle,” have fracture lines or are broken into many fragments often with geometric shapes, surrounded by tubular epithelium, neutrophils.

While they are more common in distal tubules, cast may be formed in any segment of nephron, including Bowman’s space. In the present cases, typical fractured appearance, jig-saw puzzle appearance and angulated casts were noted which are highly specific for myeloma cast nephropathy (Fig 1-4). Hyaline arteriosclerosis was also noted in few of the vessels.
The final diagnoses based on clinical, biochemical and histopathological findings were made and summarized as:

**Case 1:** Light Chain (Myeloma) Cast Nephropathy With Early Features Of Acute Tubulopathy (Myeloma Related)

**Case 2:** Cast Nephropathy

**Case 3:** Light Chain Deposition Disease With Inflammatory Tubulointerstitial Nephritis & Light Chain Cast Nephropathy

**Case 4:** Cast Nephropathy With Superadded Hypertension Induced Changes.

### 3. Discussion

The diagnosis of Myeloma Cast nephropathy (MCN) is based on demonstration of tubular casts in distal nephron that are composed of immunoglobulin light chains, and light chains in cast is same as that in serum and urine. There can be numerous precipitating factors like hypercalcemia, dehydration, infection, contrast media, nephrotoxic drugs (NSAIDs, furosemide, aminoglycosides), acidic urine etc.

The mechanism behind cast formation is excessive light chain endocytosis in tubular cells. This occurs because of oxidative stress leading to activation of NF-kB and MAP kinases. There is production of inflammatory cytokines and causing morphological changes. Myeloma casts leads to obstruction. Casts are associated with tubular rupture & when they rupture, they cause interstitial nephritis.

Extent of cast formation does not parallel the degree of interstitial fibrosis & tubular atrophy & despite role of casts in pathogenesis of tubulointerstitial lesion. Renal function correlates with interstitial fibrosis and tubular atrophy not with cast formation.

The cast have reasonably typical tinctorial properties; PAS negative, eosinophilic, fuchsinophilic with Masson’s trichrome; infrequently, Congo red positive. The staining is not uniform within the same cast or among all casts in the same kidney, but the above colors are more typical. The cast may be lamellated, contain crystals of a variety of shapes, and rarely at periphery have spicular appearance.

Patients with cast nephropathy are more likely to have hypercalcemia, severe anemia, advanced myeloma (Durie-Salmon stage 3) & light-chain myeloma compared with patients who have myeloma without renal failure.

The differential diagnosis which can be considered in these type of cases are:

- Amyloidosis,
- Multiple myeloma,
- Light chains deposition disease,
Waldenström's macroglobulinemia, Monoclonal gammopathy of undetermined significance,

Fibrillary and immunotactoid glomerulopathy

Cryoglobulinemias

Diabetic Nephropathy.

Interstitial nephritis

Patients with cast nephropathy present with renal insufficiency that can be severe (i.e., serum creatinine 7 mg/dl). In up to 50% of patients, renal failure is acute in nature & often is attributed to a precipitating factor such as dehydration, infection, hypercalcemia or use of contrast medium or NSAID.

4. Conclusion

Cast nephropathy is seen in 30 to 50% patients of myeloma. The likelihood of underlying cast nephropathy is increased in cases of more profound AKI. The propensity of a particular myeloma light chain to produce cast depends on amount of Bence-Jones protein & its tendency to aggregate together with Tamm-Horsfall protein. Cast nephropathy can be misinterpreted as interstitial nephritis, amyloidosis, light chain deposition diseases, etc. Hence, vital for nephrologists to review the histology with pathologists to avoid misdiagnosis.

5. Acknowledgement

I express my sincere thanks to Dr. Ranjini Kudva, Dr. Manna Valiathan, Dr. Anuradha C.K. Rao and Dr. Vidya Monappa for providing their support in writing this article.

References


Author Profile

Dr. Manjari Kishore, is a final year Resident (M.D.) in Dept. Of Pathology, Kasturba Medical College, Manipal, (576104) Karnataka, India.