Although fluorescence using M-20 or MAB 307 does not unequivocally localize EpoR, it can be used in association with WB to demonstrate whether the tissue expresses the EpoR, even in small quantities.

Our data, therefore, appear to be in agreement with those of Elliott et al. [1] and should prompt greater caution in the interpretation of results obtained in immunohistochemistry using currently available antibodies. Far from being a simple speculative exercise, the careful definition of the receptor for Epo, whose functional activities go well beyond erythropoiesis [4] is of fundamental importance, especially in the field of neoplastic diseases [5–8].

Conflict of interest statement. None declared.

Sir,
Nodular pulmonary amyloidosis associated with Sjögren’s syndrome is a very rare condition [1]. In our practice, such a case occurred in a patient with chronic renal failure.

Case
A 53-year-old woman was admitted to the hospital with a 3-month history of malaise, general weakness, high blood pressure and progressive renal failure. Laboratory tests at admission showed elevated erythrocyte sedimentation rate 112 mm/h. Serum creatinine level was 5.7 mg/dl. Electrophoresis of serum proteins revealed hypergammaglobulinaemia. The 24-h urine protein output was 2.7 g. On renal ultrasound, the kidneys measured 9.2 and 10.0 cm on the right and left respectively, with increased echogenicity of renal cortex. Due to end-stage renal disease at the time of diagnosis, renal biopsy was not performed. A month later she
was readmitted to the hospital because of dyspnoea and worsening kidney function with serum creatinine level of 7.0 mg/dl. Renal replacement therapy with intermittent haemodialysis was started. She complained of eye itching and sore swallowing. Physical examination revealed dryness of the eyes, as well as reddening and dryness of buccal cavity. The Schirmer’s test was positive. The rheumatologist recognized Sjögren’s syndrome. Her lungs were clear at auscultation. The chest radiograph showed solitary nodular shadows in both the lungs (Figure 1A). Computer tomography scan showed 5–6 hemispherical nodules, from 5–40 mm in diameter, in each lung. Serological tests for autoimmune diseases revealed rheumatoid factor 1:80 (normal range <1:80), perinuclear and cytoplasmatic anti-neutrophil cytoplasmatic antibodies negative, antinuclear antibodies 1:160 (normal range <1:20), and antinuclear antibodies profile with increased anti-SS-A and anti-SS-B, 5.02 and 6.03, respectively (result >1.0 positive). Bence-Jones protein was not detected. Bronchofiberoscopy revealed no endobronchial lesions. The bronchial washings were negative for malignant cells. Bacterial culture of the washings, including tuberculosis, did not reveal bacterial growth. Bronchial biopsy revealed features of chronic bronchitis.

After 2 years of treatment with intermittent haemodialysis, a thoracotomy with enucleation of the nodules from the right lung was done. Histological examination showed massive deposits of amyloid (Figure 1B). Based on the histological examination, radiological pictures and pulmonological consultation, we recognized diffuse nodular pulmonary amyloidosis. At present, the patient is typically haemodialysed for 4 hours per session, three times a week and is on a waiting list for renal transplantation.

Discussion

Several studies indicate that the majority of patients with primary Sjögren’s syndrome have pulmonary problems [2]. Our report presents the case of nodular pulmonary amyloidosis associated with Sjögren’s syndrome. The current case illustrates the fact that renal insufficiency makes the diagnosis of Sjögren’s syndrome and nodular pulmonary amyloidosis more difficult [3]. The thoracotomy with a subsequent histological examination was the final diagnostic procedure.

In summary, the co-existence of pulmonary nodules and Sjögren’s syndrome should incline us towards a diagnosis of localized amyloidosis. Thoracotomy is a good diagnostic procedure to specify the character of tumour changes in lungs.

Conflict of interest statement. None declared.


doi:10.1093/ndt/gfl823

Fig. 1. (A) Chest radiograph showing nodule shadows in both lungs. (Original magnification 200×). (B) With the Congo red stain, the presence of the amyloid deposits.