Letters to the Editor will be published, if suitable, and as space permits. They should not exceed 500 words in length, typed double space, and may be subject to editing or abridgment. If bibliographic references are necessary, they should not exceed five and should conform to the standards of the Journal. When a single table, graph, diagram or photograph will amplify or clarify the thoughts, it will be printed if space and expense permit. Letters should be addressed, To the Editor, and mailed to The American Journal of Medicine, 666 Fifth Avenue, New York, New York 10019.

GLOMERULITIS

To the Editor:

The results and conclusions of "Glomerular Lesions After Renal Transplantation" (Mathew, Mathews, Hobbs, Kincaid-Smith, *Am J Med* 59: 177, 1975) depend entirely upon the pathologic appearance of renal biopsy material. I believe this article contains several fundamental errors. Case 3 is reported as focal and segmental hyalinosis, a disease characterized by deposition of strongly periodic acid-Schiff–positive hyaline material and by increase in mesangial fibrillar material which in no way resembles the glomerular changes in Figure 1. This disease also shows immunofluorescent focal deposits of IgM, β_1C and sometimes IgG. However, in Case 3 the patient had linear deposits of IgG and β_1C. Although I cannot make a pathologic diagnosis from the material presented, it most certainly does not represent typical focal and segmental hyalinosis. Cases 4 and 5 are reported as focal and segmental proliferative glomerulonephritis with mesangial IgA. This disease is characterized by IgA deposits in the mesangium, and electron-dense deposits limited to the mesangium and paramesangial area. Yet in Case 5 the patient showed no immunofluorescence for IgA, and in Case 4 (Figure 3) the patient had electron-dense deposits in intramembranous locations along the basement membrane. To my knowledge, these findings have never been reported in this disease and therefore raise doubts about the correct diagnosis. Case 7 is reported as familial glomerulonephritis. According to Heptinstall [1], electron-dense deposits are not a feature of this disease, and immunoglobulins have not been shown with any consistency by immunofluorescence. Yet the electron micrograph of a biopsy specimen from the patient in Case 7 shows very impressive subendothelial electron-dense deposits and unusual fibrillar structures on the outside of the basement membrane which are not at all characteristic of this disease. Furthermore, with immunofluorescence, IgA was found which tends to rule out this diagnosis. In Table IV the authors assemble the results of immunofluorescent studies in six cases of mesangiocapillary glomerulonephritis. The immunofluorescent hallmark of this disease is the presence of C3 along the capillary wall with or without the presence of immunoglobulins, and one should hesitate to make this diagnosis in its absence. Yet the authors diagnose mesangiocapillary glomerulonephritis in four of six cases in the absence of stains positive for C3. In the legend of Figure 7 the authors state that a subepithelial hump is atypical of mesangiocapillary glomerulonephritis. Yet, in a symposium organized by them, Habib reported 12 cases with humps, and Burkholder observed that frequently electron-dense humps were seen in this disorder. Humps are mentioned in Heptinstall's text. Although not a constant finding, they are surely not "atypical." When the authors' article [2] about Goodpasture's syndrome appeared, two letters criticized their criteria for diagnosis [3,4]. These interpretative errors are potentially dangerous. Renal pathologists have worked hard to establish criteria for classification of glomerular disease. This report which either ignores or purposely contradicts these criteria may confuse clinicians, particularly those who cannot evaluate renal pathologic material and yet who must make clinical decisions based upon their reading. In the future, articles based so heavily upon renal pathologic findings should be critically reviewed by persons well versed in this field.

J. GARY ABUELO, M.D.
Division of Renal Diseases
Rhode Island Hospital
Providence, Rhode Island 02902

References

1. Heptinstall RH: Pathology of the Kidney, Boston, Little Brown, 1974.
2. Mathew TH, Hobbs JB, Kalowski S, et al.: Goodpasture's syndrome: normal renal diagnostic findings. Ann Intern Med 82: 215, 1975.
3. Poskitt TR: Goodpasture's syndrome. Ann Intern Med 83: 283, 1975.
4. Bolton WK: Goodpasture's syndrome. Ann Intern Med 83: 284, 1975.

The Reply:

I find it difficult to agree with Abuelo's comments. As a member of a WHO committee on nomenclature and classification of renal disease, I am in close touch with experts (including Habib and Heptinstall) who deal with exactly what Abuelo discussed. I am disturbed that he thought our report did not adhere closely to modern conventions. At our Geneva meeting in June 1975, I agreed fully with other committee members about criteria for renal pathologic diagnoses. Our Case 3, Figure 1, closely remembles that in Figure 20 of Habib's paper in which she proposed the terms focal and