

## LETTER TO THE EDITOR

# Comment on: Clinical, Histopathological and Immunofluorescent Findings of IgA Nephropathy

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### TO THE EDITOR

We read with interest the recently published article by Tipu et al. entitled “Clinical, histopathological and immunofluorescent findings of IgA nephropathy”, in the esteemed *Iranian Journal of Immunology* (1). The study described frequency of different clinical, histopathological and immunofluorescent characteristics of IgA nephropathy. The authors should be applauded for their findings; however, we would like to remind a few points about IgA nephropathy (IgAN). After popularization of Oxford classification of IgAN on July 2009 (2), it is necessary to describe the morphologic lesions in the cadre of this classification. Thus, it is indispensable to change the morphologic lesions of table 2 of the mentioned work, according to the MEST variables. In the materials and methods section, the authors stated that, specimen for immunofluorescence, stained for antibodies of IgA, IgG, IgM, C3, C4 and fibrinogen. However, the definition of IgAN requires the presence of IgA deposits which were graded  $\geq 2+$  and the absence of C<sub>1</sub>q deposition (2,3). Hence, the specimens for C<sub>1</sub>q antibody must be stained and its strict negative, brightness should be stated in the paper as an important part of definition of IgAN following  $\geq 2+$  brightness of IgA antibody deposits (1-5). Since IgAN has various morphologic features, it is indispensable to rule out the lupus nephritis. While in the later, there is a prominent deposit of C<sub>1</sub>q. As the authors also mentioned, IgA nephropathy (IgAN) is very common form of primary glomerulonephritis and occurs worldwide (4-9) and the disease may have distinct morphologic and clinical presentation in different regions (1). Therefore these kinds of studies are crucial in our region to further understand the presentations of immunoglobulin A nephropathy.

*Nasri H, et al. Iran J Immunol. 2012; 9(4):266-7*

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## RESPONSE TO THE LETTER

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With thanks to Dr. Nasri for guidance/rectification, I would like to mention the followings:

1. Dr. Nasri required Oxford classification of morphological lesions of IgA nephropathy as referenced (1). This is a recently adapted classification system, though widely accepted and praised, it is not without its own limitations (2,3). Our study was done from Jan 2009 to Dec 2009, while Oxford classification was published in 2009. During the study period and at the time of manuscript preparation, this classification was not introduced/widely used. Hence it could not be followed. Though we agree with Dr. Nasri that it should be followed in future endeavors.

2. Secondly, Dr. Nasri commented regarding C1q deposition. At the time of study anti-C1q antibodies were not available in Pakistan and not deemed very necessary as these are non-specific for IgA nephropathy, being present in few of IgA nephropathy cases and found in a variety of other lesions as well (4,5).

3. Thirdly, Dr Nasri emphasizes upon differentiation of this entity from lupus nephritis, aided by anti-C1q antibodies. Lupus patients were already excluded from our study by referring physicians on the basis of positive ANA test and thus there was little chance of having any lupus patient included in our study.

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