### Table 3. CA 125 in haemodialysis patients in the literature

| HD | n   | Dosage | CA 125 mean ± SD U/mL | CA 125 range | CA 125, false positive rate |
|----|-----|--------|------------------------|--------------|------------------------------|
| Filella, *Int J Biol Markers*, 1990 [1] | 36  | Abbott, IRMA | 18.5 ± 11.9 median 15 | <6–55 | 8% |
| Arican, *Transplant Proc.*, 1999 [3] | 50  | Abbott, IRMA | 22.82 ± 24.5 |             |                              |
| Zeferos, *Nephron* 1991 [4] | 23  | IRMA | 16.4 ± 3.5 |             |                              |
| Walz, *Am J Nephrol*, 1988 [5] | 93  | Abbott, IRMA |             |             |                              |
| Odagiri, *Am J Nephrol*, 1991 [6] | 144 | Dinabot, RIA | 15.3 |             | 7.6% |
| Polenakovic, *Int J Artif Organs*, 1997 [7] | 62  | Cobas, EIA | 18.4 | 0.8–56.4 | 13.1% |
| Arik, *Intern Urol Nephrol*, 1996 [8] | 35  | Abbott, IRMA | 15 ± 1.9 |             |                              |
| Menzin, *Gynecol Oncol*, 1995 [10] | 25  | IRMA Centrocor | 14.2 ± 12 | 5.8–50.5 | 8% |

### Table 4. CA 19-9 in haemodialysis patients in the literature

| HD | n   | Dosage | Reference cut-off | CA 19-9 Mean ± SD U/mL | CA 19-9 range | CA19-9 False-positive rate |
|----|-----|--------|-------------------|------------------------|--------------|----------------------------|
| Filella, *Int J Biol Markers*, 1990 [1] | 36  | Sorin, IRMA | 37 U/mL | 18.4 ± 12.6 median 14 | 7–54 | 6% |
| Zeferos, *Nephron* 1991 [4] | 23  | IRMA | 14.9 | 14.9 |             |                              |
| Odagiri, *Am J Nephrol*, 1991 [6] | 144 | Centocor | 37 U/mL | 17.4 |             | 6.30% |
| Polenakovic, *Int J Artif Organs*, 1997 [7] | 62  | Cobas, EIA | 24 U/mL | 83 | 0–400 | 73% |
| Arik, *Intern Urol Nephrol*, 1996 [8] | 35  | Abbott, EIA | 78.4 ± 16.7 | 78.4 ± 16.7 |             |                              |

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**Kartagener’s syndrome and polycystic kidney disease**

Sir,

Kartagener’s syndrome (KS) is a clinical variant of primary ciliary dyskinesia (PCD) involving situs inversus associated with chronic airway infections [1]. Ciliopathy has now become recognized as a multisystem disease, of which PCD is an important subgroup. Other known ciliopathies include Bardet–Biedl syndrome, polycystic kidney and liver disease, nephronophthisis, Alstrom syndrome, Meckel–Gruber syndrome and some forms of retinal degeneration [2,3].

We report a patient with KS and polycystic kidney disease, presenting with severe renal failure.

A 25-year-old woman who presented with fever, weakness, nausea, cough, dyspnoea, poor general condition and respiratory distress was admitted to our hospital. The patient was diagnosed 15 years previously with KS.

On physical examination, blood pressure was 120/80 mmHg, heart rate was 117 beats/min and respiratory rate was 22 breaths/min. Heart sounds were distant and deep on
Her laboratory findings were as follows: serum sodium 112 mmol/l, chlorine 77 mmol/l, urea 442 mg/dl, creatinine 7.5 mg/dl, haemoglobin 6.5 g/dl, leucocytes 30 000, arterial blood gas pH 7.1, bicarbonate 8 mmol/l, pCO₂ 22 mmHg, C-reactive protein (CRP) 41 mg/l. Due to poor general condition of the patient, with acidosis, haemodialysis was started. Ultrasonographic examination of the abdomen revealed the situs inversus and polycystic kidney disease. The CT of the abdomen and thorax CT was performed (Figures 1 and 2).

To our knowledge, this is the first case of KS and polycystic kidney disease reported in the literature.

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A rare case of perinephric urinoma due to idiopathic retroperitoneal fibrosis

Sir,

Urinoma as a consequence of urine extravasation is a rare complication of severe urinary tract obstruction, where it is most frequently in the fetus and the newborn [1]. However, urinoma in adults is usually developed by the traumatic urinary tract injuries [2]. Retroperitoneal fibrosis is an uncommon disease that is characterized by chronic inflammatory process with progressive fibrosis of retroperitoneal tissue and entrapment of ureters and other structures located in the retroperitoneum [3,4]. We describe an uncommon case of perinephric urinoma secondary to idiopathic retroperitoneal fibrosis.

Case

A 33-year-old male was admitted to the hospital for severe back pain, general weakness and weight loss over the past 3-month duration. He had back pain continuously radiating to flanks, groins and thighs. His medical history was unremarkable. He had a family history of lymphoma. On examination, he presented with costo-vertebral angle tenderness and right upper abdominal tenderness. Laboratory findings revealed elevated erythrocyte sedimentation rate of 106 mm/h, C-reactive protein of 4.226 mg/dL and serum creatinine of 1.7 mg/dL. Urine analysis and its cytology were negative. Serologies and tumour markers were all negative. The chest X-ray and electrocardiogram were within normal. Computed tomography (CT) revealed bilateral hydronephrosis and right perinephric urinoma with retroperitoneal mass compressing both ureters and aorta (Figures 1 and 2). On the third hospital day, the patient’s serum creatinine level was increased up to 2.2 mg/dL and urine output was markedly decreased. Bilateral percutaneous nephrostomy was performed to relieve both hydronephrosis. A CT-guided needle-punctured biopsy of the retroperitoneal mass was performed to confirm the diagnosis. On the pathological examination, the tissue showed chronic inflammation with large numbers of mononuclear cells within fibroblasts and collagen bundles (3). Tissue Tb PCR examination to exclude tuberculosis revealed to be negative. There was no evidence of malignancy. The radiologic and pathological findings were consistent with idiopathic retroperitoneal fibrosis with perinephric urinoma, which were completely resolved by oral prednisolone treatment. There has been no sign of relapse during the follow-up of 2 years.

Discussion

Retroperitoneal fibrosis is a rare chronic inflammatory disease characterized by the progressive fibrosis of retroperitoneal tissue, which results in entrapment of ureters, and other retroperitoneal organs leading to an unusual back pain [3–5]. Approximately two-thirds of retroperitoneal fibrosis cases are considered to be idiopathic and to be related with