Research Article

Safety and Efficacy Evaluation of Traditional Chinese Medicine (Qingre-Lishi-Yishen Formula) Based on Treatment of Regular Glucocorticoid Combined with Cyclophosphamide Pulse in Children Suffered from Moderately Severe Henoch–Schönlein Purpura Nephritis with Nephrotic Proteinuria

Lirong Fan, Huimin Yan, Xiaofang Zhen, Xiaoming Wu, Jing Hao, Linyi Hou, and Lei Han

Department of Traditional Chinese Medicine, Beijing Children’s Hospital, Capital Medical University, National Centre for Children’s Health, Beijing 100045, China

Correspondence should be addressed to Huimin Yan; huiminyan@sina.com

Received 4 June 2019; Accepted 30 December 2019; Published 27 January 2020

Objective. At present, the most appropriate management of Henoch–Schönlein purpura nephritis (HSPN) with nephrotic-range proteinuria still remains controversial; thus, the purpose of this study is to evaluate safety and efficacy of traditional Chinese medicine (TCM), Qingre-Lishi-Yishen Formula (QLYF), integrated with regular oral glucocorticoid and cyclophosphamide intravenous pulse therapeutic regimen in children suffered from moderately severe HSPN with nephrotic proteinuria. Methods. From 1 January 2012, to 1 January 2016, totally 150 hospitalized children suffered from HSPN with nephrotic proteinuria were included. All were treated with glucocorticoid and cyclophosphamide, and 100 of them were treated with integrative traditional Chinese decoction QLYF. Patients were followed up for 2 years. Rate of adverse event occurrence, short-term clinical effects, long-term clinical effects, and TCM therapeutic evaluation were all compared. Results. Total adverse event rate was lower in the QLYF group ($\chi^2 = 5.357$, $p = 0.022$); rates of respiratory infection, urinary infection, poor appetite, hepatotoxicity, cardiotoxicity, and neutropenia were all decreased in patients who received QLYF ($p < 0.05$), and no cases of hepatic and renal toxicities related to the herbal medicine were observed in the QLYF group. For short-term clinical efficacy evaluation, lower levels of 24 hour proteinuria ($p < 0.05$) and urine blood cell count ($p < 0.05$) were found in the QLYF group. For long-term efficacy evaluation, better clinical control rate effective rate, lower recurrence rate ($p < 0.05$), and fewer TCM syndrome score ($p < 0.05$) were found in the QLYF group. Conclusion. Compared with merely using regular oral glucocorticoid plus cyclophosphamide pulse therapeutic regimen, the therapeutic regimen that integrates QLYF with the abovementioned western medicine might be a safe means to decrease the occurrence rate of adverse events and improve short-term and long-term clinical effects in children who suffered from moderately severe HSPN with nephrotic proteinuria.

1. Introduction

Henoch–Schönlein purpura (HSP) is an immunoglobulin A- (IgA-) mediated disease characterized by a generalized vasculitis mainly involving the skin, joints, gastrointestinal tract, and kidneys [1, 2]. Skin purpura and other extrarenal symptoms usually resolve rapidly without severe complications. However, the long-term prognosis of HSP mainly depends on the severity of renal involvement, termed Henoch–Schönlein purpura nephritis (HSPN) [3, 4]. In one 20-year follow-up study, HSPN leads to the chronic kidney disease (CKD) in up to 20% affected children; furthermore, the ratio could be as high as 40% for children initially expressed as the moderately severe HSPN with nephrotic-range proteinuria [5]. Therefore, effective therapeutic interventions are considered necessary to prevent progressing to end-stage renal disease (ESRD).
According to the Kidney Disease: Improving Global Outcomes (KDIGO) guidelines, in HSPN patients with persisting proteinuria of >1 g/day/1.73 m² and glomerular filtration rate (GFR) >50 ml/min, a 6-month course of glucocorticoid therapy is recommended; in HSPN patients with nephrotic-range proteinuria, standard therapeutic regimen including regular oral glucocorticoid treatment and intravenous cyclophosphamide pulse is recommended [6]. However, it has been demonstrated that glucocorticoid usage could not prevent renal involvement in HSP [7]. Furthermore, the immunosuppressant usage may exert therapeutic effect but may also be blamed for severe adverse events both in the short-term and in the long-term. As to glucocorticoid, use of high-doses for a long time may lead to Cushing’s syndrome (moon face, weight gain, and centripetal redistribution of fat), secondary diabetes mellitus, hypertension, dyslipidemia, and ocular complication and prone to infections [8]. Cyclophosphamide is one of the most commonly used alkylating agents, which can exert immunosuppressive function by causing cytotoxic and anti-proliferative effects on various immune cells. The long-term use of cyclophosphamide may give rise to gastrointestinal effects (nausea and vomiting), liver toxicity, myocardial damage, bone marrow toxicity, bladder toxicity, and gonadal toxicity [9].

TCM has been used to treat pediatric nephropathy for several decades and has been proved to be effective in our previous clinical research [10]. QLYF is based on the clinical experience of professor Pei Xueyi (Traditional Chinese Medicine Department, Beijing Children’s Hospital affiliated to Capital Medical University). In Professor Pei’s academic view, the “spleen” is always too insufficient to govern movement and transformation in children, resulting in retention of heat and damp interior [11]. Table 1 displays the basic composition of QLYF, whose monarch herbs are Herba Pteridis Multifidae, Herba Achyranthis Asperae, Radix Sophorae Flavescentis, and Folium Pyrrosiae. There is a research telling us that oxymatrine, which is one of the effective constituents of Radix Sophorae Flavescentis, exerts cardioprotective effect by preventing ventricular remodeling, myocardial hypertrophy, and myocardial fibrosis [12]. Other studies have indicated that Herba Achyranthis Asperae not only exhibits promising anti-inflammatory activity but also shows significant gastroprotective activity [13, 14]. Therefore, we performed this clinical research to clarify the safety and efficacy of QLYF combined with western medicine glucocorticoid and cyclophosphamide for the treatment of HSPN children with nephrotic-range proteinuria.

2. Materials and Methods

2.1. Patients. From 1 January 2012, to 1 January 2016, 150 moderately severe HSPN children with nephrotic proteinuria were enrolled continuously. The diagnosis of HSPN with nephrotic proteinuria is based on the evidence-based guideline for diagnosis and treatment of HSPN revised by the Kidney Group of Chinese Pediatric Society, Chinese Medical Association [15]. The inclusion criteria were as follows: (1) age of 5–16 years; (2) 24 hour proteinuria ≥50 mg/kg; (3) urine erythrocyte ≥10/HPF; (4) the first-visit TCM pattern is “dampness-heat accumulation syndrome” [16]; (5) therapeutic regimen is glucocorticoid plus cyclophosphamide; (6) patients have no surgical operation history caused by HSP. The exclusion criteria were as follows: (1) during therapeutic period change for or add with another immunosuppressant (cyclosporin A, tacrolimus, mycophenolate mofetil, etc.); (2) diagnosed with hypercalciuria; (3) diagnosed with other systemic disease (systemic lupus erythematosus, ANCA vasculitis etc.) that may influence the renal function; (4) irreversible decrease of renal function within 3 months of disease onset; (5) those with other organs disfunction (liver, heart, brain, etc.). Finally, we enrolled the total 182 patients who received regular oral glucocorticoid and cyclophosphamide pulse therapy, of whom 119 also received QLYF (QLYF group) and 63 received merely the western medicine (control group).

2.2. Treatment Protocol

2.2.1. Western Medicine Treatment Protocol. All participants received regular oral glucocorticoid plus intravenous cyclophosphamide pulse regimen. Prednisone is commenced at a dose of 1.5–2 mg/kg/d daily (the maximum dose should not exceed 80 mg/d) for 4–8 weeks and followed by 1.5–2 mg/kg/d on alternative days for further 4–8 weeks. On the basis of regularly oral prednisone, cyclophosphamide is intravenous infused at 500–750 m²/kg once a month for 6 months and the total cumulated amount of cyclophosphamide ≤150 mg/kg. Finally, oral prednisone dose was gradually reduced to zero by regular outpatient visits. Participants of the QLYF group received the same glucocorticoid and cyclophosphamide regimen as the control group did.

2.2.2. Traditional Chinese Medicine Treatment Protocol. Traditional Chinese herbal decoction QLYF includes basic herbs and limited optional herbs. Basic herbs are specifically targeted for dampness-heat accumulation syndrome, while optional herbs are targeted for variable secondary TCM

| TCM materials        | Equivalent pharmaceutical name       | Amount (g) |
|----------------------|---------------------------------------|------------|
| Feng Wei Cao         | Herba Pteridis Multifidae             | 15         |
| Yi Yi Ren            | Semen Coicos                          | 30         |
| Ku Shen              | Radix Sophorae Flavescentis           | 10         |
| Shi Wei              | Folium Pyrrosiae                      | 12         |
| Dao Kou Cao          | Herba Achyranthis Asperae             | 15         |
| Bai Jiang Cao        | Herba Patriniae Scabiosaefoliae       | 10         |
| Qian Shi             | Radix Paeoniae Rubra                  | 10         |
| Shan Yao             | Rhizoma Dioscoreae Opposita           | 15         |
| Pu Huang             | Pollen Typhae                         | 10         |
| Lian Xu              | Stamen Nelumbinis                     | 10         |
| Dan Dou Chi          | Semen Sojae Preparatum                | 12         |
| Chi Xiao dou         | Semen Vigneae Anglicis                | 30         |
| Qian Shi             | Semen Euryales                        | 20         |
syndromes in recovery phase of HSPN. Although there were herb adjustments, the core pathogenesis was consistent and the adjusted herbs did not change the overall nature of the QLYF. Basic herbal composition, which could clear damp-heat, nourish kidney, and consolidate essence, is displayed in Table 1. For primary dampness-heat accumulation syndrome, we used TCM syndrome score scale [10] to evaluate the therapeutic effect at baseline, 12-month, and 24-month treatment. The more TCM syndrome score was obtained, the worse the TCM therapeutic effect the participants had. Bian-Zheng-Lun-Zhi (syndrome differentiation and treatment) would be performed according to the “Diagnostics of Traditional Chinese Medicine” and “Pediatrics of Traditional Chinese Medicine” by an experienced TCM doctor at the fixed visit time point. On the basis of the basic herbs, the doctor would adjust herbs according to the “Guidelines for the Diagnosis and Treatment of Pediatric Common Diseases in Traditional Chinese Medicine” recommended when one patient was mixed with other second TCM syndromes in the recovery phase. Rules are as follows: (1) for yang deficiency syndrome, *Radix Astragali* (Huang Qi), *Atractylodes macrocephala Koidz* (Bai Zhu), and *Cortex Cinnamomi* (Rou Gui) would be added; (2) for yin deficiency with effulgent fire syndrome, *Cortex Phellodendri* (Huang Bai) and *Rhizoma Anemarrhenae* (Zhi Mu) would be added; (3) for heat-toxin congestion syndrome, *Rhizoma Smilacis Glabrae* (Tu Fu Ling) and *Herba Hedysoris Diffusa* (Bai Hua She She Cao) would be added; (4) for blood stasis syndrome, *Semem Persicae* (Tao Ren), *Angelica sinensis* (Dang Gui), and *Rhizoma chuanxiong* (Chuan Qiong) would be added; (5) for phlegm-damp syndrome, *Pheretima* (Di Long), *Bombbyx Batryticatus* (Jiang Can), and *Peristericum Cicadae* (Chan Yi) would be added; (6) for spleen-deficiency and qi-stagnation syndrome, *Poria cocos* (Fu Ling), *Radix Aucklandiae* (Mu Xiang), and *Fructus Amomi* (Sha Ren) would be added. Raw herbs were all provided by Cachet Pharmaceutical Co., Ltd (Beijing, China). The herbs were initially soaked in water for 1 hour at room temperature, followed by 1 hour of decoction at 100°C, then filtering the solid components of the residue, and finally condensing the decoction to the specified volume. The herbal formula preparation was completed by the decoction room of traditional Chinese medicine in the Pharmacy Department of Beijing children’s hospital. The formula was taken orally twice a day, a combination of gastric volume and drug tolerance was considered, and drug volume is set as the 50 ml for patients weighing <20 kg and 100 ml for the patients weighing ≥20 kg. TCM treatment lasted for about 2 years.

### 2.4. Study Design

This is a prospective controlled open-label study performed in a single center. Figure 1 shows schematic diagram of the clinical research. The selection of therapeutic regimen was decided by patients and/or their parents. They considered their compliance and preference, because TCM tastes bitter and should be often adjusted by syndrome differentiation in different periods of HSPN. At the end of follow-up, there left 100 patients in the QLYF group and 50 patients in the control group. We set up a specialized team which was composed of experienced doctors to evaluate the primary and secondary observed indexes.

### 2.5. Primary and Secondary Observed Indexes

The primary observation index is the rate of adverse events, which includes rate of respiratory inflammation, urinary infection, poor appetite, hepatotoxicity, cardiotoxicity, infectious diarrhea, neutropenia, and others (including the rare adverse events such as fungal infection, secondary hypertension, secondary diabetes mellitus, secondary ocular hypertension, and dyslipidemia).

The secondary observation index is the short-term and the long-term clinical effect. Short-term clinical effect is reflected by serum creatine, urine, 24 hour proteinuria, and urine red blood counts (URBCs); the abovementioned data were recorded after 3 and 6 months of treatment. According to the book named “Chinese Traditional Medicine New Drug Clinical Research Guiding Principle,” long-term clinical effect is reflected as follows: (1) clinical control: 24 hour proteinuria returned to be normal (≤150 mg) for proteinuria and URBC returned to be normal (3/HPF) for hematuria; (2) clinical efficacy: 24 hour proteinuria reduction ≥50% for proteinuria and URBC reduction ≥50% for hematuria; (3) recurrence: by the routine urine test, urine protein turned positive from negative or URBC turned ≥10/ HPF from ≤3/HPF. The primary TCM syndrome score is evaluated after 12-month and 24-month treatment, and secondary TCM syndrome distribution was evaluated every 6 month.

### 2.6. Statistical Analysis

The SPSS version 22.0 software (SPSSInc., Chicago, IL, USA) was used to analyse data. Baseline comparisons between the two groups were performed using Student’s *t* test for continuous variables, chi-square test for categorical variables, and Mann–Whitney *U* test for nonnormal distribution. Quantitative data were expressed as the mean ± standard deviation (mean ± SD). Differences in measurement data were compared using the chi-square test. Discontinuous variables were expressed as...
median (Q1, Q3). Values of \( p < 0.05 \) were considered statistically significant.

3. Results

3.1. Basic Clinical Characteristics for all Patients. As shown in Table 2, the present study included a total of 150 patients, with 50 cases in the control group (mean age 9.32 ± 2.68, male proportion 52%) and 100 cases in the QLYF group (mean age 9.52 ± 2.96, male proportion 56%). No statistically significant differences in gender, age, additional symptom, systolic blood pressure (SBP), albumin, serum urea, serum creatine, estimated glomerular filtration rate (eGFR), tri-glyceride, cholesterol, urinered blood cell count (URBC), 24 hour proteinuria, serum IgA, serum C3, and serum C4 were observed between the two groups.

3.2. Comparison of Adverse Events of Two Groups. As shown in Table 3, compared with the control group, the total adverse events rate is significantly lower in the QLYF group (66% versus 84%, \( \chi^2 = 5.357, p = 0.022 \)). Compared with the control group, significantly fewer patients in the QLYF group suffered from respiratory infection (37% versus 58%, \( \chi^2 = 5.966, p = 0.023 \)), urinary infection (11% versus 26%, \( \chi^2 = 5.580, p = 0.031 \)), poor appetite (10% versus 26%, \( \chi^2 = 6.573, p = 0.015 \)), hepatotoxicity (18% versus 34%, \( \chi^2 = 4.770, p = 0.040 \)), cardiotoxicity (18% versus 36%, \( \chi^2 = 5.921, p = 0.035 \)), neutropenia (0% versus 6%, \( \chi^2 = 3.444, p = 0.036 \)), and others (refers to rare adverse events, 7% versus 20%, \( \chi^2 = 5.606, p = 0.027 \)).

3.3. Comparison of Short-Term Renal Indexes between Two Groups. To evaluate the short-term efficacy of QLYF-integrated treatment on HSPN with nephrotic proteinuria, we used renal indexes such as urea, serum creatine, URBC, and 24-hour proteinuria to compare the short-term efficacy of two groups of patients. As shown in Table 4, firstly, we made a comparison within the group. Results indicated that, in both two groups, values of 24-hour proteinuria and URBC significantly decreased after the treatment as compared with those before treatment (Table 2, \( p < 0.05 \)). Meanwhile, compared with baseline data, no significant differences were found in serum creatine and BUN after 3-month or 6-month treatment. And, we made a comparison between two groups in the same treatment time point. Compared with two groups after 3-month treatment and 6-month treatment, only 24-hour proteinuria and URBC were significantly lower in the QLYF group than those in the control group (\( p < 0.05 \)). These results indicated that, as for short-term clinical efficacy, QLYF integrated therapy could decrease 24-hour proteinuria and URBC better in children with nephrotic proteinuria.

3.4. Comparison of Therapeutic Evaluation for Two Groups at the End of 2-Year Follow-Up. As shown in Table 5, clinical control rate and effective rate of both hematuria and proteinuria in the QLYF group were better than those in the control group. While both of the clinical control rate (89% versus 74%, \( \chi^2 = 5.580, p = 0.031 \)) and effective rate (94% versus 80%, \( \chi^2 = 6.856, p = 0.012 \)) on haematuria in the QLYF group have significant difference than those in the control group, there were no significant differences on both
of them in proteinuria between the two groups. The recurrence rates both on haematuria (15% versus 36%, \( \chi^2 = 8.566, p = 0.006 \)) and proteinuria (7% versus 20%, \( \chi^2 = 5.606, p = 0.027 \)) of the QLYF group were significantly better than that of the control group.

3.5. Traditional Chinese Medicine Syndrome Therapeutic Effect. As indicated in Table 6, in both two groups, compared with the baseline data, for dampness-heat accumulation syndrome, the TCM syndrome score was lower after 12-month treatment (\( p < 0.05 \)) as well as after 24-month treatment (\( p < 0.05 \)). Compared with the control group at the same follow-up time point, the primary TCM syndrome score was significantly decreased in QLYF group after 12-month treatment (\( p = 0.005 \)) as well as after 24-month treatment (\( p = 0.001 \)).

As Figure 2 shows, in the control group, we could find that the proportion of dampness-heat accumulation syndrome mixed with yin deficiency with effulgent fire syndrome was also increased as

### Table 2: Basic clinical characteristics for all patients.

|                      | Control group \((n = 50)\) | QLYF group \((n = 100)\) | \(p\) |
|----------------------|----------------------------|--------------------------|------|
| Gender (male)        | 26 (52%)                   | 56 (56%)                 | 0.643|
| Age (year)           | 9.32 ± 2.68                | 9.52 ± 2.96              | 0.692|
| Additional symptom   |                            |                          |      |
| GI involvement       | 23 (46%)                   | 41 (41%)                 | 0.599|
| Joint involvement    | 17 (34%)                   | 21 (21%)                 | 0.127|
| SBP (mmHg)           | 108.2 ± 12.6               | 109.5 ± 11.3             | 0.543|
| Albumin (g/L)        | 38.45 ± 5.21               | 33.11 ± 6.45             | 0.204|
| Urea (mmol/L)        | 4.45 ± 1.41                | 4.46 ± 1.52              | 0.970|
| Creatine (\(\mu\)mol/L) | 46.57 ± 7.24             | 45.13 ± 7.93             | 0.283|
| eGFR(ml/min·1.73 m\(^2\)) | 97.5 ± 16.0              | 99.6 ± 10.2              | 0.314|
| Triglyceride (mmol/L)| 1.62 ± 0.90                | 1.44 ± 0.94              | 0.275|
| Cholesterol (mmol/L) | 4.87 ± 1.11                | 4.63 ± 1.19              | 0.235|
| URBC (/HP)           | 26.88 ± 11.16              | 25.92 ± 11.06            | 0.618|
| 24 h proteinuria (g) | 2.76 ± 0.88                | 2.70 ± 0.73              | 0.659|
| Serum IgA (g/L)      | 1.97 ± 0.68                | 1.84 ± 0.66              | 0.278|
| Serum C3 (g/L)       | 0.993 ± 0.271              | 0.991 ± 0.251            | 0.976|
| Serum C4 (g/L)       | 0.732 ± 0.615              | 0.578 ± 0.459            | 0.170|

GI: gastrointestinal; SBP: systolic blood pressure; URBC: urine red blood cell count; eGFR: estimated glomerular filtration rate; 24h: 24 hour.

### Table 3: Comparison of adverse events of two groups.

| Adverse events         | Control group, \(n = 50\) | QLYF group, \(n = 100\) | \(\chi^2\) | \(p\) |
|------------------------|----------------------------|--------------------------|-----------|------|
| Total adverse events rate | 42 (84%)                   | 66 (66%)                 | 5.357     | 0.022|
| Respiratory infection  | 29 (58%)                   | 37 (37%)                 | 5.966     | 0.023|
| Urinary infection      | 13 (26%)                   | 11 (11%)                 | 5.580     | 0.031|
| Infectious diarrhea    | 3 (6%)                     | 3 (3%)                   | 0.195     | 0.401|
| Poor appetite          | 13 (26%)                   | 10 (10%)                 | 5.573     | 0.015|
| Hepatotoxicity         | 17 (34%)                   | 18 (18%)                 | 4.770     | 0.040|
| Cardiotoxicity         | 18 (36%)                   | 18 (18%)                 | 5.921     | 0.035|
| Neutropenia            | 3 (6%)                     | 0 (0%)                   | 3.444     | 0.036|
| Others*                | 10 (20%)                   | 7 (7%)                   | 5.606     | 0.027|

*Rare adverse events, such as fungal infection, secondary hypertension, secondary diabetes mellitus, secondary ocular hypertension, and dyslipidemia.

### Table 4: Comparison of short-term renal indexes between two groups.

| Time point     | Group                      | Creatine (\(\mu\)mol/L) | Urea (mmol/L) | 24 h proteinuria (g) | URBC (/HP) |
|----------------|----------------------------|--------------------------|--------------|----------------------|-----------|
| Prior treatment | Control group              | 46.57 ± 7.24             | 4.45 ± 1.41  | 2.76 ± 0.88          | 26.88 ± 11.16 |
|                | QLYF group                 | 45.13 ± 7.93             | 4.46 ± 1.52  | 2.70 ± 0.73          | 25.92 ± 11.06 |
| 3-month treatment | Control group             | 43.13 ± 5.85             | 4.12 ± 1.22  | 1.37 ± 0.45\(^*\)   | 12.64 ± 5.78\(^*\) |
|                | QLYF group                 | 41.52 ± 6.01             | 4.09 ± 1.32  | 1.20 ± 0.42\(^*\)   | 9.80 ± 4.22\(^*\) |
| 6-month treatment | Control group             | 40.41 ± 5.19             | 3.75 ± 1.24  | 0.42 ± 0.24\(^*\)   | 5.16 ± 7.52\(^*\) |
|                | QLYF group                 | 39.14 ± 5.61             | 3.74 ± 1.28  | 0.31 ± 0.18\(^*\)   | 2.46 ± 1.35\(^*\) |

\(^*p < 0.05\) compared with the same group prior treatment; \(^\#p < 0.05\) compared with the same group in 3-month treatment; \(^\dagger p < 0.05\) compared with the control group in the same treatment period.
Table 5: Comparison of therapeutic evaluation for two groups at the end of 2-year follow-up.

| Group     | Proteinuria |                |                | Haematuria |                |                |
|-----------|-------------|----------------|----------------|------------|----------------|----------------|
|           | Clinical control rate | Effective rate | Recurrence rate | Clinical control rate | Effective rate | Recurrence rate |
| Control group | 41 (82%)  | 42 (84%) | 10 (20%) | 37 (74%) | 40 (80%) | 18 (36%) |
| QLYF group  | 85 (85%)  | 91 (91%) | 7 (7%)  | 89 (94%) | 94 (94%) | 15 (15%) |
| \chi^2     | 0.223      | 1.625       | 5.606       | 5.580      | 6.856       | 8.566       |
| p          | 0.643      | 0.274       | 0.027       | 0.031      | 0.012       | 0.006       |

Table 6: Primary TCM syndrome score was compared between two groups at the different time points.

| Time       | QLYF group | Control group | Z    | p     |
|------------|------------|---------------|------|-------|
| Baseline   | 38 (28, 50)| 38 (30, 49)   | −0.579| 0.563 |
| 12-month   | 20 (16, 27.5)* | 25 (18, 30.5)* | −2.780| 0.005 |
| 24-month   | 8 (6, 12)*  | 12 (8, 16)*   | −3.437| 0.001 |

*Compared with the 0-week baseline data, after 4-week, and 12-week routinely treatment; the TCM syndrome score was statistically significantly (p < 0.05).

Figure 2: Continued.
At the 6-month treatment, dampness-heat accumulation syndrome mixed with yin deficiency with effulgent fires syndrome account for the main part of all, whereas at the 24-month treatment, dampness-heat accumulation syndrome mixed with spleen-deficiency and qi-stagnation syndrome account for the largest of all. However, in the QLYF group, the pie chart shows that the largest proportional always falls on dampness-heat accumulation syndrome, and there are no obvious differences in proportion of dampness-heat accumulation syndrome mixed with any other TCM syndromes as time went on.

4. Discussion

As a most common vasculitis in children, HSP is generally a self-limiting condition, usually resolving within 6–8 weeks [17]. However, once HSPN is diagnosed, the HSPN prognosis is always dependent on the severity and long-term outcome of HSPN [18]. The HSPN clinical manifestations could be classified as follows: (1) isolated hematuria; (2) isolated proteinuria; (3) hematuria and proteinuria; (4) nephritic syndrome; (5) nephrotic syndrome; (6) rapidly progressive glomerulonephritis; (7) chronic nephritis [19]. One study has indicated that long duration time of nephrotic-state is an independent risk factor of long-term poor prognosis outcomes in children suffered from moderately severe HSPN with nephrotic proteinuria [20]. Hence, it is necessary to perform early aggressive treatment when the HSPN is at early progress stage. A recent meta-analysis has showed that HSPN patients who received immunosuppressive agents plus regular glucocorticoid treatment have better complete remission rate and total remission rate than those who received merely regular glucocorticoid treatment. Furthermore, children seem to benefit more from immunosuppressive agents plus glucocorticoid treatment than adults [21]. HSP recurs in about 1/3 of affected children, and the rate appears to be more common in older children and in children with renal involvement [22]. However, there seems that glucocorticoid might have no direct relevance with preventing the renal involvement [23], and there exists some inevitable adverse events using glucocorticoid and other immunosuppressive agents.

To evaluate the efficacy and advantage for integrated QLYF with the western medicine treatment, we performed this prospective controlled study. It could be inferred from the results that QLYF integrated with western medicine treatment has advantages over merely western medicine treatment in improving short-term efficacy, reducing HSPN recurrence (both proteinuria and hematuria) and preventing adverse events (both common and rare). Furthermore, in academic perspective of TCM, on the one hand, QLFY could decrease more dampness-heat accumulation syndrome score than the control group. On the other hand, long-term use of immunosuppressive agents may cause many secondary TCM syndromes, especially yin deficiency with effulgent fire syndrome and spleen-deficiency and qi-stagnation syndrome, while QLYF-integrated treatment could effectively prevent the occurrence of secondary TCM syndrome in recovery phase of HSPN.

As a recent study found that the presence of hematuria was closely associated with a faster decrease in renal function in advanced massive proteinuric patients, especially in younger patients with high levels of proteinuria [24]. Therefore, it is necessary to alleviate hematuria especially when one patient is in a massive proteinuria state. However, although massive proteinuria could be treated by steroids and immunosuppressant, there is lack of disease-targeted and excellent western medicine choice for coinstantaneous haematuria. Previous clinical studies have demonstrated that TCM could exert better clinical effect on haematuria than merely using western medicine [10, 25].

At present, more attention has been focused on TCM with its well-defined and established therapeutic system. TCM posits that disease of the body arises from an imbalance within the body and between the body and the nature, leading to an alteration in the entire body system [26]. In the practice of TCM, it is generally considered that multiple herbal medications are more effective than a single herbal agent, and in this way, the TCM formula could increase or promote therapeutic effectiveness and minimize toxicity and side effects [27].

In Prof. Pei’s academic view, the essence of HSP is intertwined damp-heat and consumptive moving “blood”, the disease position is mainly in the “lung,” “spleen,” and

Figure 2: Participants’ traditional Chinese medicine syndromes distribution in two groups at the different time points. DHS: dampness-heat accumulation syndrome. YDS: Yang deficiency syndrome. YEFS: Yin deficiency with effulgent fire syndrome. HCS: heat-toxin congestion syndrome. BSS: blood stasis syndrome. PDS: phlegm-damp syndrome. SDQSS: spleen-deficiency and qi-stagnation syndrome.
“kidney,” the cause could be ascribed to “wind,” “heat,” “dampness,” “stasis,” and “deficiency.” HSP always occurs in later period of epidemic febrile disease, when dampness-heat toxin still exists and accumulating in blood tier, thus injuring the channels and collaterals, with blood-heat bleeding; above all, HSP belongs to “dampness-syndrome” and “blood-syndrome.” Haematuria appearance is considered to be due to dampness-heat accumulation, thus damaging the liver and kidney. In detail, the mechanism is that dampness-heat has accumulated inside for a long time and then flows into the lower Jiao, damaging the liver and kidney, injuring yin collaterals, finally blood being failed to circulate in the vessels. In our herbal formula, some constitutes such as Liu Qiao, Chi Xiao Dou, and Dan Dou Chi could clear the dampness-heat in lower Jiao, thus cooling the blood for hemostasis. For patients with intractable and protracted haematuria, constitutes such as Pu Huang could warm and smooth channels and collaterals, thus consolidating the lower Jiao aiming at hemostasis [28]. QLYF prescription is based on the above principles.

Different from single-target therapy of western medicine, traditional Chinese herbal formula is usually a combination of prescriptions and multiple targets for disease. QLYF basic components totally contain fifteen kinds of herbs, and they play different roles in the therapy process. In the QLYF basic components, monarch herbs are Radix Sophorae Flavescentis, Folium Forsythiae, Herba Achyranthis Asperae, and Herba Pteridis Multifidae. Radix Sophorae Flavescentis, which is bitter and cold in nature, takes its unique effect by heat-clearing and damp-drying. Folium Forsythiae keeps water unobstructed up to bladder. Achyranthis Asperae and Herba Pteridis Multifidae play mutual roles in dispersing the dampness-heat and cooling blood to stop bleeding. Minister drugs are Semen Coicus, Herba Patriniae Scabiosaefoliae, Fructus Forsythiae Suspensae, Semen Vignae Angularis, Stamen Nelumbinis, and Semen Sojae Preperatum. Semen Coicus which could invigorate spleen to eliminate dampness and induce diuresis to reduce edema, combined with Herba Patriniae Scabiosaefoliae, takes the synergistic effect in clearing away heat and toxicant. Fructus Forsythiae Suspensae dissipates blood stasis and qi; Semen Vignae Angularis moves body fluid to diuretics; Stamen Nelumbinis strengthens the kidney to stop emission; Semen Sojae Preperatum promotes the circulation of qi and blood. Ministerial herbs supplement with each other in removing dampness and promoting diuresis, detoxifying and arresting seminal emission, and dispersing renal qi. QLYF has been used in children suffered from HSPN for a long time. It is proved to be effective not only in previous randomized clinical trial [10] but also in a recent published animal experiment study [29].

According to TCM theory, glucocorticoids are masculine material. Initially, long-term or high-dose glucocorticoids use would generate heat and reinforce yang, making exhaustion of yin fluid and finally resulting in syndrome of hyperactivity of fire due to yin deficiency, Liu Qiao, Shan Yao, and Zhi mu could nourish yin to lessen fire; in glucocorticoid administration gradually decreased process, patients would fall into syndrome of deficiency of both yin and yang, Fu Ling, Ze Xie, Chan Yi, Liu Qiao could nourish yin and warm the kidney [30, 31]. The TCM syndrome distribution variation tendency results in our clinical trial is consistent with the abovementioned theory. Numerous clinical trials have also confirmed that TCM could lessen the glucocorticoid side effect. Li and Dong compared clinical symptoms with or without TCM in nephrotic syndrome, and finally they found that the incidences of flushed face, tachycardia, insomnia, acne, and thrombosis were significantly lower in TCM-integrated group [32]. Xie conducted a clinical trial to compare the adverse events occurrence with or without TCM, and they found that Cushing’s syndrome, infection, upper gastrointestinal haemorrhage, and femoral head necrosis were significantly less in the TCM integrated group, and finally they concluded that the TCM-integrated group (10%) has significantly fewer side effects than the control group (50.31%) [33]. Xiang organized a clinical randomized controlled trial to explore the TCM effect in treating primary nephrotic syndrome; this research revealed that TCM-integrated treatment could significantly improve the clinical effect and prevent adverse events (hepatic function damage, hyperglycemia, acne, mental excitation, and central obesity) during glucocorticoid long-time use [34].

In addition to glucocorticoid, the cyclophosphamide also leads to a lot of adverse events, and there are numerous basic experiments demonstrating that some constitutes of our herbal formula could alleviate the adverse events. It has been proved by Zhang et al. that the fruit of Forsythia suspense can effectively inhibit liver fibrosis by abrogating hepatic stellate cells activation, reversing the liver epithelial-mesenchymal transition and reducing liver extracellular matrix deposition in the mouse model [35]. Another in vivo study has indicated that the extract of Forsythia suspense has a potential to develop anti-hyperglycemic and anti-hyperlipidemic agent via regulation of oxidative stress, hepatic glucose metabolism, and pancreatic insulin secretion [36]. Bo et al. have shown that paoniflorin, which is the main component of Radix Paeoniae Alba, could notably reduce blood pressure variability, stabilize blood pressure, and mitigate target organ damage in spontaneous hypertensive mice [37]. Furthermore, it is proved by Chen et al. that the anti-hypertensive active of Radix Paeoniae Alba extract may be related to its effect on regulating serum nitric oxide and endothelin levels [38]. Oxytmartine, one of the principle components of Radix Sophorae Flavescentis, was demonstrated in vitro and in vivo by Zhang et al. that may be a promising cardioprotective agent in part through inhibition of cardiac apoptosis and oxidative stress [39].

Consistently, our clinical observation indicated that QLYF integrated with western medicine could significantly reduce common adverse events like respiratory infection, urinary infection, poor appetite, hepatotoxicity, cardiotoxicity, and leukocytopenia, as well as rare adverse events like fungal infection, secondary hypertension, secondary diabetes mellitus, secondary ocular hypertension, and dyslipidemia.
5. Conclusions

In conclusion, this clinical study indicated that, compared with merely western medicine regimen, QLYF integrated with regular oral glucocorticoid and intravenous cyclophosphamide pulse treatment might decrease the adverse events, decrease the TCM syndrome score, prevent the occurrence of secondary TCM syndrome, and improve the short-term (both in hematuria and proteinuria) and the long-term (in clinical control rate, effective rate, and recurrence rate) clinical efficacy in children suffered from HSPN with nephrotic proteinuria.

Data Availability

The figures and data used to support the findings of this study are included and available within the article.

Ethical Approval

All procedures performed in this study were in accordance with the ethical standards of the Institutional and National Research Committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. This study was approved by the Ethics Committee of our hospital (2018–78).

Consent

All patients gave informed consent.

Conflicts of Interest

The authors declare that there are no conflicts of interest regarding the publication of this paper.

Authors’ Contributions

All the authors have read through the paper and approved for publication.

Acknowledgments

This study was supported by the National Famous Chinese Medicine Experts Inheritance Studio of Professor Yan Huimin and Beijing Health System Special Funds for Health Technical Personnel of China (2015-3-077).

References

[1] G. D’Amico, "Natural history of idiopathic IgA nephropathy and factors predictive of disease outcome," *Seminar in Nephrology*, vol. 24, no. 3, pp. 179–196, 2004.
[2] X. Huang, L. Ma, P. Ren et al., "Updated Oxford classification and the international study of kidney disease in children classification: application in predicting outcome of Henoch-Schönlein purpura nephritis," *Diagnostic Pathology*, vol. 14, no. 1, 2019.
[3] O. Jauhola, J. Ronkainen, O. Koskimies et al., "Outcome of Henoch-Schönlein purpura 8 years after treatment with a placebo or prednisone at disease onset," *Pediatric Nephrology*, vol. 27, no. 6, pp. 933–939, 2012.
[4] J. Ronkainen, M. Nuutinen, and O. Koskimies, "The adult kidney 24 years after childhood Henoch-Schönlein purpura: a retrospective cohort study," *The Lancet*, vol. 360, no. 9334, pp. 666–670, 2002.
[5] A. R. Goldstein, R. H. White, R. Akuse, and C. Chantler, "Long-term follow-up of childhood Henoch-Schönlein nephritis," *Lancet*, vol. 339, no. 4, pp. 280–282, 1992.
[6] KDIGO, "Chapter 11: Henoch-Schönlein purpura nephritis," *Kidney International Supplements*, vol. 2, no. 2, pp. 218–220, 2012.
[7] J. Craig, E. Hodson, N. Willis et al., "Interventions for preventing and treating kidney disease in Henoch-Schönlein Purpura (HSP)," *Evidence-Based Child Health A Cochrane Review Journal*, vol. 5, no. 2, pp. 637–700, 2010.
[8] G. Ferrara, M. Petrillo, T. Giani et al., "Clinical use and molecular action of corticosteroids in the pediatric age," *International Journal of Molecular Sciences*, vol. 20, no. 2, pp. 444, 2019.
[9] C. Ponticelli and R. J. Glassock, "Prevention of complications from use of conventional immunosuppressants: a critical review," *Journal of Nephrology*, vol. 32, no. 6, pp. 851–870, 2019.
[10] D. Ding, H. Yan, and X. Zhen, "Effects of Chinese herbs in children with Henoch-Schönlein purpura nephritis: a randomized controlled trial," *Journal of Traditional Chinese Medicine*, vol. 34, no. 1, pp. 15–22, 2014.
[11] Y. Hu, Y. Yao, J. Liu et al., "Experience of Pei Xue-yi in treating children’s nephropathy," *China Journal of Traditional Chinese Medicine and Pharmacy*, vol. 24, no. 9, pp. 1169–1171, 2009.
[12] X. Y. Huang and C. X. Chen, "Effect of oxymatrine, the active component from Radix Sophorae flavescentis (Kushen), on ventricular remodeling in spontaneously hypertensive rats," *Phytomedicine*, vol. 20, no. 3–4, pp. 202–212, 2013.
[13] U. A. Bhosale, Y. Radha, P. Prachi et al., "Effect of aqueous extracts of Achyranthes aspera Linn. on experimental animal model for inflammation," *Ancient Science of Life*, vol. 31, no. 4, pp. 202–206, 2013.
[14] A. K. Das, P. Bigoniya, N. K. Verma, and A. Rana, "Gastroprotective effect of Achyranthes aspera Linn. leaf on rats," *Asian Pacific Journal of Tropical Medicine*, vol. 5, no. 3, pp. 197–201, 2012.
[15] Kidney Group of Chinese Pediatric Society, Chinese medical association, "Evidence-based guideline on diagnosis and treatment of henoch-schonlein purpura nephritis," *Chinese Journal Pediatric*, vol. 47, no. 12, pp. 911–912, 2009.
[16] W. Y. Dang, H. M. Yan, X. M. Wu et al., "Correlation between traditional Chinese medicine symptom patterns and the renal function, immunologic function index, and blood coagulation index in patients with Henoch-Schönlein Purpura nephritis," *Evidence-Based Complementary and Alternative Medicine*, vol. 2018, Article ID 1972527, 7 pages, 2018.
[17] T. V. Ting, "Diagnosis and management of cutaneous vasculitis in children," *Pediatric Clinics of North America*, vol. 61, no. 2, pp. 321–346, 2014.
[18] J.-Y. Chen and J.-H. Mao, "Henoch-Schönlein purpura nephritis in children: incidence, pathogenesis and management," *World Journal of Pediatrics*, vol. 11, no. 1, pp. 29–34, 2015.
[19] Kidney Group of Chinese Pediatric Society, Chinese Medical Association, "Evidence-based guideline on diagnosis and treatment of henoch-schonlein purpura nephritis," *Chinese Journal Pediatric*, vol. 55, no. 9, pp. 647–651, 2017.
[20] H. Wakaki, K. Ishikura, H. Hataya et al., “Henoch-Schönlein purpura nephritis with nephrotic state in children: predictors of poor outcomes,” Pediatric Nephrology, vol. 26, no. 6, pp. 921–925, 2011.

[21] J. X. Tian, Y. Tang, Z. X. Zhong et al., “The efficacy and safety immunosuppressive agents plus steroids compared with steroids alone in the treatment of Henoch–Schönlein purpura nephritis: a meta-analysis,” International Urology and Nephrology, vol. 51, no. 6, pp. 975–985, 2019.

[22] O. Jauhola, J. Ronkainen, O. Koskimies et al., “Clinical course of extrarenal symptoms in Henoch-Schönlein purpura: a 6-month prospective study,” Archives of Disease in Childhood, vol. 95, no. 11, pp. 871–876, 2010.

[23] J. Ronkainen, O. Koskimies, M. Ala-Houhala et al., “Early prednisone therapy in Henoch-Schönlein purpura: a randomized, double-blind, placebo-controlled trial,” Journal of Pediatric, vol. 149, no. 2, pp. 241–247, 2006.

[24] C. Yuste, A. Rubio-Navarro, D. Barraca et al., “Haematuria increases progression of advanced proteinuric kidney disease,” PLoS One, vol. 10, no. 5, pp. 1–12, 2015.

[25] N. Zhou, X. Shi, and Y. Shen, “Short-term therapeutic effects of TCM for IgA nephropathy in children,” Journal of Traditional Chinese Medicine, vol. 31, no. 2, pp. 115–119, 2011.

[26] Y. Zhong, Y. Deng, Y. Chen, P. Y. Chuang, and H. J. Cijiang, “Therapeutic use of traditional Chinese herbal medications for chronic kidney diseases,” Kidney International, vol. 84, no. 6, pp. 1108–1118, 2013.

[27] Y.-L. Shen, S.-J. Wang, K. Rahman, L.-J. Zhang, and H. Zhang, “Chinese herbal formulas and renal fibrosis: an overview,” Current Pharmaceutical Design, vol. 24, no. 24, pp. 2774–2781, 2018.

[28] Y. Hu, Y. Yao, J. Liu et al., “Experience of Pei Xue-yi in treating children’s Henoch-Schönlein purpura,” Journal of Emergency in Traditional Chinese Medicine, vol. 18, no. 4, pp. 577–578, 2009.

[29] W. Y. Dang, L. Y. Hou, H. M. Yan et al., “Effectiveness of Qingre Lishi Yishen decoction on the glomerular fibrosis of immunoglobulin A nephropathy in a rat’s model,” Journal of Traditional Chinese Medicine, vol. 39, no. 4, pp. 516–523, 2019.

[30] T. Liu, L. F. Nie, and H. Y. Sun, “Experience of Nie Lifang in treating primary nephrotic syndrome from traditional Chinese medicine differentiation view,” Chinese Journal of Integrated Traditional and Western Nephrology, vol. 16, no. 4, pp. 286–288, 2015.

[31] Y. Zhang and H. Xiang, “Understanding and treatment progress in pediatric nephrotic syndrome in traditional Chinese medicine view,” Asia-Pacific Traditional Medicine, vol. 13, no. 3, pp. 62–64, 2017.

[32] Y. X. Li and W. Dong, “Curative effect of traditional Chinese medicine on steroids side effects in 78 primary nephrotic syndrome,” Shanxi Medicine Journal, vol. 36, no. 5, pp. 466–467, 2007.

[33] M. Y. Xie, “Clinical observation of Shenbing formula prevent the steroids side effects in nephrotic syndrome,” Journal of Sichuan of Traditional Chinese Medicine, vol. 20, no. 5, p. 39, 2002.

[34] L. Xiang, “Traditional Chinese medicine exert effect-enhancing and toxicity-reducing influence on primary nephrotic syndrome glucocorticoid treatment process,” Journal of Clinical Research, vol. 34, no. 7, pp. 1436–1438, 2017.

[35] Y. Zhang, H. Miao, H. Yan, Y. Sheng, and L. Ji, “Hepatoprotective effect of Forsythiae Fructus water extract against carbon tetrachloride-induced liver fibrosis in mice,” Journal of Ethnopharmacology, vol. 218, no. 23, pp. 27–34, 2018.

[36] Y. Zhang, F. Feng, T. Chen, Z. Li, and Q. W. Shen, “Antidiabetic and antihyperlipidemic activities of Forsythia suspensa (Thunb.) Vahl (fruit) in streptozotocin-induced diabetes mice,” Journal of Ethnopharmacology, vol. 192, no. 4, pp. 256–263, 2016.

[37] L. Bo, B. Y. Zheng, S. L. Shan et al., “Beneficial effects of paoniflorin enriched extract on blood pressure variability and target organ damage in spontaneously hypertensive rats,” Evidence-Based Complementary and Alternative Medicine, vol. 2017, Article ID 5816960, 16 pages, 2017.

[38] S. H. Chen, Q. Chen, B. Li et al., “Antihypertensive effect of Radix Paeoniae Alba in spontaneously hypertensive rats and excessive alcohol intake and high fat diet induced hypertensive rats,” Evidence-Based Complementary and Alternative Medicine, vol. 2015, Article ID 731237, 8 pages, 2015.

[39] Y.-Y. Zhang, M. Yi, and Y.-P. Huang, “Oxymatrine ameliorates doxorubicin-induced cardiotoxicity in rats,” Cellular Physiology and Biochemistry, vol. 43, no. 2, pp. 626–635, 2017.