Editorials

1911 Continued Search for Therapies to Favorably Modify Phosphate and FGF23 Levels in CKD
Rupal Mehta and Tamara Isakova
See related article on page 1930.

1914 A Perspective on Inherited Kidney Disease: Lessons for Practicing Nephrologists
Mathieu Lemaire and Rulan S. Parekh

1917 Burden of Proof—When Is Kidney Disease Attributable to Diabetes?
Pierre-Jean Saulnier and Robert G. Nelson
See related article on page 1984.

1919 Effective Treatment of PD Peritonitis
Beth Piraino
See related article on page 2016.

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Chronic Kidney Disease

1922 Urinary Fibrinogen as a Predictor of Progression of CKD
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2024 Association of Kidney Transplantation with Survival in Patients with Long Dialysis Exposure
Caren Rose, Jagbir Gill, and John S. Gill

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2032 Diabetic Kidney Disease: Challenges, Progress, and Possibilities
Radica Z. Alicic, Michele T. Rooney, and Katherine R. Tuttle

Kidney Case Conference: How I Treat

2046 Drug-Induced Acute Interstitial Nephritis
Dennis G. Moledina and Mark A. Perazella

Perspectives

2050 The Journey to Full Health Care Responsibility for One ESCO Provider
Franklin W. Maddux and Terry L. Ketchersid

2053 Challenges in Developing New Therapies for Vascular Access Dysfunction
Karl A. Nath and Michael Allon

2056 Perspectives on the Strengths and Weaknesses of the National Kidney Allocation System
Richard N. Formica Jr.

2057 Early Experience with New Kidney Allocation System: A Perspective from the Organ Procurement Agency
Kevin J. O’Connor and Kevin Cmunt
On the Cover

What’s the diagnosis?

A 72 year-old woman with a history of end-stage kidney disease secondary to hypertensive nephrosclerosis status post living donor kidney transplant six months prior presented for evaluation of skin lesions. She reported the appearance of tender, erythematous skin lesions on her bilateral upper and lower extremities and face one week prior to presentation, with new lesions appearing daily. She denied other symptoms. She underwent a skin biopsy which demonstrated lobular panniculitis with mixed inflammatory infiltrate; stains for fungi and mycobacteria were negative. Fungal culture of the biopsied tissue grew mold, identified by DNA sequencing as *Blastomyces dermatitidis*.

She was admitted for evaluation and treatment. A magnetic resonance image (MRI) of the brain revealed multiple new intraparenchymal, leptomeningeal, and facial subcutaneous enhancing foci suspicious for blastomycosis. A computer tomography image of the chest showed a centrally necrotic hilar lymph node and a few scattered pulmonary nodules. She was initiated on treatment with intravenous liposomal amphotericin and had improvement in her skin lesions within three days. Follow-up brain MRI two weeks later showed decreased size and associated edema of the enhancing brain lesions. She was transitioned to oral voriconazole but was unable to achieve therapeutic levels and is now on oral posaconazole for a planned 12 month course, and is clinically stable.

**Learning objectives:**

Blastomycosis is caused by an endemic fungus found in decomposing wood and leaves primarily in the Ohio and Mississippi River Valleys and the Great Lakes region. Infection usually follows inhalations of spores and is typically localized to the lungs but approximately 30% of those infected will develop extra-pulmonary manifestations (1). Disseminated infection is more common in immunosuppressed populations, such as solid organ transplant recipients and HIV-infected individuals. Early recognition and treatment is essential to achieve best outcomes.

Lipid formulations of amphotericin B are the recommended treatment for blastomycosis in immunosuppressed patients. A 1-2 week course, or until clinical improvement is noted, is recommended, with step down to itraconazole therapy for 12 months thereafter (2). When central nervous system disease is present, a longer 4-6 week course of amphotericin B lipid formulation is recommended, followed by an oral azole for at least 12 months (2). The optimal azole for treatment remains debatable; voriconazole and posaconazole have excellent CNS penetration and have been used with success.

**Image descriptions:**

1. Erythematous papules and plaques, some with overlying erosion and crust, located on the cheek
2. Magnetic resonance image of brain showing multiple intraparenchymal, left frontal leptomeningeal and facial subcutaneous soft tissue enhancing foci suspicious for infectious blastomycosis
3. Fungal culture demonstrating mold with septate hyphae with round conidia at the apex of short and long conidiophores in a “lollipop-like” appearance, consistent with *Blastomyces dermatitidis*

**References:**


(Images and text provided by Alden Michael Doyle, MD and Jessica Lewis, MD, University of Virginia, Charlottesville, Virginia)