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1783  Still Asking “Which Rate Is Right?” Years Later
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1788  Does What Goes Around Always Come Around?
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1791  Acute Kidney Injury among Hospitalized Children in China
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1801  Home-Based Kidney Care, Patient Activation, and Risk Factors for CKD Progression in Zuni Indians: A Randomized, Controlled Clinical Trial
Robert G. Nelson, V. Shane Pankratz, Donica M. Ghahate, Jeanette Bobelu, Thomas Faber, and Vallabh O. Shah
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1810  Association of Monoclonal Gammopathy with Progression to ESKD among US Veterans
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On the Cover

What’s the diagnosis?
A 73-year-old woman with controlled hypertension and CKD (3B) insidiously developed abdominal and loin discomfort, weight loss, resistant hypertension and rapid decline of GFR. The physical examination was remarkable for hypertension and low-grade fever. A PET-CT scan unmasked a hypermetabolic lesion of the abdominal aorta at the level of D12-L3, further characterized on MRI (Figure 1) as an aortic wall irregularity causing luminal occlusion; the lesion extended to the renal ostia (mainly the left) and the kidneys were asymmetrical and poorly differentiated.

Differential diagnosis was vasculitis, atherosclerosis and rarer aortic neoplasm. The patient was considered unsuitable for endovascular procedure or surgery, given the extension of the disease. An empirical course of corticosteroids for vasculitis was tried. The patient deteriorated with hemodialysis dependent kidney failure, liver and intestinal ischemia and succumbed within days.

The autopsy study (Figure 2) revealed a vegetative and necrotic aortic neoplasm arising from the intima, with involvement by the contiguity of left renal artery; on hematoxylin and eosin stain (Figure 3), the luminal surface had loosely cohesive cells forming aggregates, with a high nuclei/cytoplasm ratio, scarce cytoplasm and marked pleomorphism. There was hepatic, intestinal and pulmonary microembolization.

Malignant renal artery stenosis is rare and has been described in patients with myeloproliferative neoplasms, retroperitoneal sarcoma and aortic intimal sarcoma. Clinical presentation is variable, often indistinguishable from infectious and noninfectious aortitis or atheroembolic disease. The radiomorphological pattern is nonspecific and diagnosis is commonly achieved only after resection. The prognosis is poor. When dealing with abdominal pain, uncontrolled hypertension and kidney failure, vascular disease should be suspected and ruled out.

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