Patient Voice

439 Distance from a Transplant Center and Getting Listed for a Transplant
Lisa Garner
See related editorial and article on pages 453 and 539, respectively.

Editorials

441 Ambulatory BP Phenotypes and Their Association with Target Organ Damage and Clinical Outcomes in CKD
Panagiotis I. Georgianos and Rajiv Agarwal
See related articles on pages 455 and 501, respectively.

444 Liraglutide for the Treatment of Type 2 Diabetes and Safety in Diabetic Kidney Disease: Liraglutide and Diabetic Kidney Disease
David Z. Cherney and Katherine R. Tuttle
See related article on page 465

447 Kidney Failure with Urinary Tract Cancers
Ankur Shah and Susie L. Hu
See related article on page 484

450 The Value of Primary Care Provider Involvement in the Care of Kidney Failure Patients on Dialysis: Finding the Balance
Salman Ahmed and Mallika L. Mendu
See related article on page 521

453 The Long Road to Kidney Transplantation: Does Center Distance Impact Transplant Referral and Evaluation?
Tanjala S. Purnell and Mara McAdams-DeMarco
See related Patient Voice and article on pages 439 and 539, respectively.

Original Articles

Chronic Kidney Disease

455 Association of 24-Hour Ambulatory Blood Pressure Patterns with Cognitive Function and Physical Functioning in CKD
See related editorial and article on pages 441 and 501, respectively.

465 Safety of Liraglutide in Type 2 Diabetes and Chronic Kidney Disease
Johannes F.E. Mann, Vivian A. Fonseca, Neil R. Poulter, Itamar Raz, Thomas Idorn, Søren Rasmussen, Bernt Johan von Scholten, and Otri Mosenzon, on behalf of the LEADER Trial Investigators
See related editorial on page 444.

Clinical Nephrology

474 Nephrology Fellows’ and Program Directors’ Perceptions of Hospital Rounds in the United States
Clinical Nephrology (Continued)

484 **Trends and Outcomes with Kidney Failure from Antineoplastic Treatments and Urinary Tract Cancer in France**
Imène Mansouri, Natalia Alencar de Pinho, Renaud Snanoudj, Christian Jacquelinet, Mathilde Lassalle, Clémence Béchade, Cécile Vigneau, Florent de Vathaie, Nadia Haddy, and Bénédicte Stengel,
on behalf of the French REIN registry
See related editorial on page 447.

Hypertension

493 **Prognostic Value of Ambulatory Blood Pressure Load in Pediatric CKD**
Jason Lee, Charles E. McCulloch, Joseph T. Flynn, Joshua Samuels, Bradley A. Warady, Susan L. Furth, Divya Seth, Barbara A. Grimes, Mark M. Mitsnefes, and Elaine Ku

501 **Ambulatory Blood Pressure Phenotypes in Adults Taking Antihypertensive Medication with and without CKD**
Stanford E. Mwasongwe, Rikki M. Tanner, Bharat Poudel, Daniel N. Pugliese, Bessie A. Young, Marwha Abdalla, Solomon K. Musani, Orlando M. Gutiérrrez, Adolfo Correa, Daichi Shimbo, and Paul Muntner
See related editorial and article on pages 441 and 455, respectively.

Maintenance Dialysis

511 **A Systematic Review and Jurisdictional Scan of the Evidence Characterizing and Evaluating Assisted Peritoneal Dialysis Models**
Mark Hofmeister, Scott Klarenbach, Lesley Soril, Nairne Scott-Douglas, and Fiona Clement

521 **Association of Primary Care Involvement with Death or Hospitalizations for Patients Starting Dialysis**
See related editorial on page 450.

530 **Association of Tubular Solute Clearance with Symptom Burden in Incident Peritoneal Dialysis**
Ke Wang, Michelle Nguyen, Yan Chen, Andrew N. Hoofnagle, Jessica O. Becker, Leila R. Zelnick, John Kundzins, Anne Goodling, Jonathan Himmelfarb, and Bryan Kestenbaum

Transplantation

539 **Distance to Kidney Transplant Center and Access to Early Steps in the Kidney Transplantation Process in the Southeastern United States**
Laura J. McPherson, Vaughn Barry, Jane Yackley, Jennifer C. Gander, Stephen O. Pastan, Laura C. Plantinga, Sudeshna Paul, and Rachel E. Patzer, on behalf of the Southeastern Kidney Transplant Coalition
See related Patient Voice and editorial on pages 439 and 453, respectively.

Genomics of Kidney Disease

550 **Single Cell Sequencing and Kidney Organoids Generated from Pluripotent Stem Cells**
Haojia Wu and Benjamin D. Humphreys

Kidney Case Conference: How I Treat

557 **Intravascular Volume Assessment in the Critically Ill Patient**
Jean-Louis Vincent

Perspectives

560 **Consenting for Dialysis or Its Alternative: Systematic Process Is Needed**
Kelly Chenlei Li and Mark A. Brown

563 **Contraception and CKD**
Anna Burgner and Michelle A. Hladunewich

566 **Making Assisted Peritoneal Dialysis a Reality in the United States: A Canadian and American Viewpoint**
Matthew J. Oliver and Page Salenger
Poststreptococcal glomerulonephritis (PSGN) is an immunological-mediated glomerular lesion caused by prior infection, with specific nephritogenic stains of group A β-hemolytic streptococcus. Histologically, it is characterized by exudative glomerular injury, dominant C3 staining, and subepithelial humps. The clinical picture varies from asymptomatic to rapidly progressive glomerulonephritis. Although it is considered a self-limited condition, especially in children, it may occasionally follow a rather persistent course, leading to chronic kidney insufficiency. Patients with pre-existing pathology, where PSGN is superimposed, have been reported to have a poor outcome. Specifically, patients with comorbidities, such as diabetes mellitus, hypertension, smoking, and alcoholism, are more likely to end up on chronic dialysis.

For patients with PSGN who require or are progressing toward dialysis treatment, a kidney biopsy is mandatory in the acute phase to confirm the diagnosis and exclude other conditions that may present with acute glomerulonephritis and hypocomplementemia, such as C3 glomerulopathy, cryoglobulinemic glomerulonephritis, lupus nephritis, membranoproliferative glomerulonephritis, and IgA-dominant, staphylococcus-associated glomerulonephritis. The pattern of hypocomplementemia and its duration (the disease time-course), i.e., acute onset versus persistent-recurrent active glomerulonephritis over a prolonged period, in correlation with histopathology, depict the diagnosis. Clinically, a critical distinction pertains to the time of infection occurrence; prior to PSGN or co-incidently with the IgA-dominant, staphylococcus-associated glomerulonephritis.

Left image: A large glomerulus from the first biopsy with a significant number of inflammatory cells, mostly neutrophils, into distended capillary lumina. Thick basement membranes, diffuse mesangial matrix increase, and a well-formed mesangial nodule at the bottom right can be appreciated (H&E ×400).

Left center image: A large glomerulus from the second biopsy with extensive neutrophil infiltration in association with distension of glomerular lumena, superimposed on mesangial expansion caused by diabetes (H&E ×400).

Right center image: Diffuse, coarsely granular deposits along the glomerular capillary walls and focally in the mesangial regions, in a starry sky appearance (C3 ×400).

Right image: Electron microscopy revealed numerous and large subepithelial, electron-dense deposits (humps) situated on moderately thickened basement membranes. Plentiful neutrophils were seen in the glomerular lumena (uranyl acetate and lead citrate ×4400).

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