

# CJASN

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## Editorials

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**2555 Acute Kidney Injury and Chronic Kidney Disease: A Work in Progress**

Jason R. Bydash and Areef Ishani  
See related article on page 2567.

**2558 Fluid Intake for Kidney Disease Prevention: An Urban Myth?**

Alex Chang and Holly Kramer  
See related article on page 2634.

**2561 A Preponderance of Evidence Is Sufficient**

Tom F. Parker, III  
See related article on page 2642.

**2564 Training the Next Generation of Nephrologists**

Donald E. Kohan  
See related article on page 2681.

## Original Articles

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**Acute Kidney Injury/Acute Renal Failure**

**2567 Acute Kidney Injury Episodes and Chronic Kidney Disease Risk in Diabetes Mellitus**

Charuhas V. Thakar, Annette Christianson, Jonathan Himmelfarb, and Anthony C. Leonard  
See related editorial on pages 2555.

**Clinical Immunology and Pathology**

**2573 Influenza A/H1N1 Vaccine in Patients Treated by Kidney Transplant or Dialysis: A Cohort Study**

Nilufer E. Broeders, Anneleen Hombrouck, Anne Lemy, Karl Martin Wissing, Judith Racapé, Karine Gastaldello, Annick Massart, Steven Van Gucht, Laura Weichselbaum, Aurelie De Mul, Bernard Brochier, Isabelle Thomas, and Daniel Abramowicz

**Clinical Pharmacology**

**2579 Dose-finding Study of Peginesatide for Anemia Correction in Chronic Kidney Disease Patients**

Iain C. Macdougall, Andrzej Wiecek, Beatriz Tucker, Magdi Yaqoob, Ashraf Mikhail, Michal Nowicki, Iain MacPhee, Michal Mysliwiec, Olgierd Smolenski, Władysław Sułowicz, Martha Mayo, Carol Francisco, Krishna R. Polu, Peter J. Schatz, and Anne-Marie Duliege

**Chronic Kidney Disease**

**2587 Pregnancy Outcomes in Women with Chronic Kidney Disease: A Systematic Review**

Immaculate F. Nevis, Angela Reitsma, Arunmozhi Dominic, Sarah McDonald, Lehana Thabane, Elie A. Akl, Michelle Hladunewich, Ayub Akbari, Geena Joseph, Winnie Sia, Arthur V. Iansavichus, and Amit X. Garg

**2599 Warfarin in Atrial Fibrillation Patients with Moderate Chronic Kidney Disease**

Robert G. Hart, Lesly A. Pearce, Richard W. Asinger, and Charles A. Herzog

**2605 Relationship between Blood Pressure and Incident Chronic Kidney Disease in Hypertensive Patients**

Rebecca Hanratty, Michel Chonchol, Edward P. Havranek, J. David Powers, L. Miriam Dickinson, P. Michael Ho, David J. Magid, and John F. Steiner

**2612 Correlates of Osteoprotegerin and Association with Aortic Pulse Wave Velocity in Patients with Chronic Kidney Disease**

*Julia J. Scialla, Mary B. Leonard, Raymond R. Townsend, Lawrence Appel, Myles Wolf, Matt J. Budoff, Jing Chen, Eva Lustigova, Crystal A. Gadegbeku, Melanie Glenn, Asaf Hanish, Dominic Raj, Sylvia E. Rosas, Stephen L. Seliger, Matthew R. Weir, and Rulan S. Parekh, on behalf of the CRIC Study Group*

**2620 Sympathetic Nerve Traffic and Asymmetric Dimethylarginine in Chronic Kidney Disease**

*Guido Grassi, Gino Seravalle, Lorenzo Ghiadoni, Giovanni Tripepi, Rosa Maria Bruno, Giuseppe Mancica, and Carmine Zoccali*

**2628 Chronic Kidney Disease and Albuminuria in Children with Sickle Cell Disease**

*Marianne McPherson Yee, Shameem F. Jabbar, Ifeyinwa Osunkwo, Lisa Clement, Peter A. Lane, James R. Eckman, and Antonio Guasch*

**Epidemiology & Outcomes**

**2634 Urine Volume and Change in Estimated GFR in a Community-Based Cohort Study**

*William F. Clark, Jessica M. Sontrop, Jennifer J. Macnab, Rita S. Suri, Louise Moist, Marina Salvadori, and Amit X. Garg*  
*See related editorial on pages 2558.*

**2642 Early Outcomes among Those Initiating Chronic Dialysis in the United States**

*Kevin E. Chan, Frank W. Maddux, Nina Tolkoff-Rubin, S. Ananth Karumanchi, Ravi Thadhani, and Raymond M. Hakim*  
*See related editorial on pages 2561.*

**2650 Interaction of Time-Varying Albumin and Phosphorus on Mortality in Incident Dialysis Patients**

*Emanuel Zitt, Claudia Lamina, Gisela Sturm, Florian Knoll, Friederike Lins, Otto Freistätter, Florian Kronenberg, Karl Lhotta, and Ulrich Neyer*

**ESRD & Chronic Dialysis**

**2657 Effect of Dialysis Modality on Survival of Hepatitis C-Infected ESRF Patients**

*Bhadran Bose, Stephen P. McDonald, Carmel M. Hawley, Fiona G. Brown, Sunil V. Badve, Kathryn J. Wiggins, Kym M. Bannister, Neil Boudville, Philip Clayton, and David W. Johnson*

**2662 Effectiveness and Safety of Warfarin Initiation in Older Hemodialysis Patients with Incident Atrial Fibrillation**

*Wolfgang C. Winkelmayr, Jun Liu, Soko Setoguchi, and Niteesh K. Choudhry*

**2669 Access Survival amongst Hemodialysis Patients Referred for Preventive Angiography and Percutaneous Transluminal Angioplasty**

*Kevin E. Chan, Timothy A. Pflederer, David J. R. Steele, Michael P. Lilly, T. Alp Ikizler, Frank W. Maddux, and Raymond M. Hakim*

**Health Services Research**

**2681 Alignment of Nephrology Training with Workforce, Patient, and Educational Needs: An Evidence Based Proposal**

*Cathie Lane and Mark Brown*  
*See related editorial on pages 2564.*

**Mineral Metabolism/Bone Disease**

**2688 Fibroblast Growth Factor 23 in Patients Undergoing Peritoneal Dialysis**

*Tamara Isakova, Huiliang Xie, Allison Barchi-Chung, Gabriela Vargas, Nicole Sowden, Jessica Houston, Patricia Wahl, Andrew Lundquist, Michael Epstein, Kelsey Smith, Gabriel Contreras, Luis Ortega, Oliver Lenz, Patricia Briones, Phyllis Egbert, T. Alp Ikizler, Harald Jueppner, and Myles Wolf*

**Renal Transplantation**

**2696 Belatacept-versus Cyclosporine-Based Immunosuppression in Renal Transplant Recipients with Pre-existing Diabetes**

*Lionel Rostaing, Hans H. Neumayer, Rafael Reyes-Acevedo, Barbara Bresnahan, Sander Florman, Stefan Vitko, Michael Heifets, Jun Xing, Dolca Thomas, and Flavio Vincenti*

## Original Articles (Continued)

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### **2705** Late Graft Loss among Pediatric Recipients of DCD Kidneys

*Kyle J. Van Arendonk, Nathan T. James, Jayme E. Locke, Robert A. Montgomery, Paul M. Colombani, and Dorry L. Segev*

### **2712** Association of Pretransplant Serum Phosphorus with Posttransplant Outcomes

*Marcelo S. Sampaio, Miklos Z. Molnar, Csaba P. Kovesdy, Rajnish Mehrotra, Istvan Mucsi, John J. Sim, Mahesh Krishnan, Allen R. Nissenson, and Kamyar Kalantar-Zadeh*

## Special Feature

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### **2722** ASN Clinicopathologic Conference

*Ajay K. Singh and Lorraine C. Racusen*

### **On the Cover**

*What's the diagnosis?* This image depicts a single red blood cell cast contained in a urinary sediment examined at 40X under phase contrast microscopy. Individual red blood cells are clearly seen within the cast, which is held together by Tamm Horsfall Protein (THP). Copious amounts of THP are produced in the thick ascending limb, with 40–80 mg/day appearing in the final urine of normal individuals. This highly glycosylated protein tends to form a gel in concentrated urine, and in the process trap any elements that are present within the tubule at that time into the resulting cast. Presence of a red blood cell cast in the urinary sediment suggests a renal as opposed to lower urinary tract source of hematuria, and therefore that glomerular damage has occurred. Causes include glomerulonephritis, vasculitis with renal involvement, and renal infarction. Since red blood cell casts can disintegrate over time, examining a fresh urine sediment can increase the odds of spotting one. (Image and text supplied by Rachel Miller and John Lieske MD, Mayo Clinic Renal Testing Laboratory, Rochester, MN).