Editorials

697 Predicting Baseline Creatinine in Hospitalized Patients
Ron Wald
See related article on page 712–719.

700 What Is the Role of Vaptans in Routine Clinical Nephrology?
Daniel G. Bichet
See related article on page 742–747.

704 Monoclonal Antibodies for the Treatment of the C3 Glomerulopathies
Laurence H. Beck Jr.
See related article on page 748–756.

707 Frequent Hemodialysis: A Way to Improve Physical Function?
Kristen L. Jablonski and Michel Chonchol
See related article on page 782–794.

Original Articles

Acute Kidney Injury /Acute Renal Failure

712 Estimating Baseline Kidney Function in Hospitalized Patients with Impaired Kidney Function
Edward D. Siew, T. Alp Ikizler, Michael E. Matheny, Yaping Shi, Jonathan S. Schildcrout, Ioana Danciu, Jamie P. Dwyer, Manakan Srichai, Adriana M. Hung, James P. Smith, and Josh F. Peterson
See related editorial on page 697–699.

Chronic Kidney Disease

720 Pedometer-Assessed Physical Activity in Children and Young Adults with CKD
Aalia Akber, Anthony A. Portale, and Kirsten L. Johansen

727 FGF23, Albuminuria, and Disease Progression in Patients with Chronic IgA Nephropathy
Sigrid Lundberg, Abdul Rashid Qureshi, Sara Olivecrona, Iva Gunnarsson, Stefan H. Jacobson, and Tobias E. Larsson

Clinical Nephrology

735 Low Glomerular Density with Glomerulomegaly in Obesity-Related Glomerulopathy
Nobuo Tsuboi, Yasunori Utsunomiya, Go Kanzaki, Kentaro Koike, Masahiro Ikegami, Tetsuya Kawamura, and Tatsuo Hosoya

742 Efficacy and Tolerance of Urea Compared with Vaptans for Long-Term Treatment of Patients with SIADH
Alain Soupert, Michel Coffernils, Bruno Couturier, Fabrice Gankam-Kengne, and Guy Decaux
See related editorial on page 700–703.

748 Eculizumab for Dense Deposit Disease and C3 Glomerulonephritis
See related editorial on page 704–706.
### Epidemiology and Outcomes

<table>
<thead>
<tr>
<th>Page</th>
<th>Title</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>757</td>
<td>Evaluation of Clinical Outcomes and Renal Vascular Pathology among Patients with Lupus</td>
<td>Claire Barber, Andrew Herzenberg, Ellie Aghdassi, Jiandong Su, Wendy Lou, Gan Qian, Jonathan Yip, Samih H. Nasr, David Thomas, Joan Wither, Murray Urowitz, Daina Gladman, Heather Reich, and Paul R. Fortin</td>
</tr>
<tr>
<td>765</td>
<td>Modifiable Practices Associated with Sudden Death among Hemodialysis Patients in the Dialysis Outcomes and Practice Patterns Study</td>
<td>Michel Jadoul, Jyothi Thumma, Douglas S. Fuller, Francesca Tentori, Yun Li, Hal Morgenstern, David Mendelsohn, Tadashi Tomo, Jean Ethier, Friedrich Port, and Bruce M. Robinson</td>
</tr>
</tbody>
</table>

### ESRD and Chronic Dialysis

<table>
<thead>
<tr>
<th>Page</th>
<th>Title</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>782</td>
<td>Effects of Six versus Three Times per Week Hemodialysis on Physical Performance, Health, and Functioning: Frequent Hemodialysis Network (FHN) Randomized Trials</td>
<td>Yoshio N. Hall, Brett Larive, Patricia Painter, George A. Kayser, Robert M. Lindsay, Allen R. Nissenson, Mark L. Unruh, Michael V. Rocco, Glenn M. Chertow, and the Frequent Hemodialysis Network Trial Group</td>
</tr>
<tr>
<td>795</td>
<td>Fluoroscopic Manipulation of Peritoneal Dialysis Catheters: Outcomes and Factors Associated with Successful Manipulation</td>
<td>Matthew Miller, Brendan McCormick, Susan Lavoie, Mohan Biyani, and Deborah Zimmerman</td>
</tr>
</tbody>
</table>

### Genetics

<table>
<thead>
<tr>
<th>Page</th>
<th>Title</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>801</td>
<td>Familial Hypomagnesemia with Hypercalciuria and Nephrocalcinosis: Phenotype–Genotype Correlation and Outcome in 32 Patients with CLDN16 or CLDN19 Mutations</td>
<td>Astrid Godron, Jerôme Harambat, Valérie Boccio, Anne Mensire, Adrien May, Claire Rigothier, Lionel Couzi, Benoit Barrou, Michel Godin, Dominique Chauveau, Stanislas Faguer, Marion Vallet, Pierre Cochat, Philippe Eckart, Geneviève Guest, Vincent Guigonis, Pascal Houillier, Anne Blanchard, Xavier Jeunemaitre, and Rosa Vargas-Poussou</td>
</tr>
</tbody>
</table>

### Mineral Metabolism/Bone Disease

<table>
<thead>
<tr>
<th>Page</th>
<th>Title</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>810</td>
<td>Combined Use of Vitamin D Status and FGF23 for Risk Stratification of Renal Outcome</td>
<td>Chikako Nakano, Takayuki Hamano, Naohiko Fujii, Issa Matsui, Kodo Tomida, Satoshi Mikami, Kazunori Inoue, Yoshitsugu Obi, Noriyuki Okada, Yoshiharu Tsubakihara, Yoshitaka Isaka, and Hiromi Rakugi</td>
</tr>
<tr>
<td>820</td>
<td>Daily Variability in Mineral Metabolites in CKD and Effects of Dietary Calcium and Calcitriol</td>
<td>Tamara Isakova, Huijiang Xie, Allison Barchi-Chung, Kelsey Smith, Nicole Sowden, Michael Epstein, Gina Collerone, Leigh Keating, Harald Jüppner, and Myles Wolf</td>
</tr>
</tbody>
</table>

### Nephrolithiasis

<table>
<thead>
<tr>
<th>Page</th>
<th>Title</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>829</td>
<td>Effect of Vitamin D Repletion on Urinary Calcium Excretion among Kidney Stone Formers</td>
<td>David E. Leaf, Ruslan Korets, Eric N. Taylor, Jie Tang, John R. Asplin, David S. Goldfarb, Mantu Gupta, and Gary C. Curhan</td>
</tr>
</tbody>
</table>

### Renal Transplantation

<table>
<thead>
<tr>
<th>Page</th>
<th>Title</th>
<th>Authors</th>
</tr>
</thead>
</table>
Special Features

842 Designing Clinical Trials in Acute Kidney Injury
Bruce A. Molitoris, Mark D. Okusa, Paul M. Palevsky, Paul L. Kimmel, and Robert A. Star

844 Design of Clinical Trials in Acute Kidney Injury: Report from an NIDDK Workshop on Trial Methodology

851 Design of Clinical Trials in Acute Kidney Injury: A Report from an NIDDK Workshop—Prevention Trials

856 Design of Clinical Trials in AKI: A Report from an NIDDK Workshop. Trials of Patients with Sepsis and in Selected Hospital Settings

861 Ongoing Clinical Trials in AKI
Sarah Faubel, Lakhmir S. Chawla, Glenn M. Chertow, Stuart L. Goldstein, Bertrand L. Jaber, and Kathleen D. Liu, for the Acute Kidney Injury Advisory Group of the American Society of Nephrology

Erratum

874 Correction

On the Cover

What’s the diagnosis? Positron emission tomography (PET) coronal scan (upper right) and the fused PET/CT coronal scan (upper left) demonstrate significant uptake in multiple lymph nodes and in the kidneys. The patient in this case developed a systemic illness characterized by fever, skin rash, diffuse lymphadenopathy, profound peripheral eosinophilia, mild transaminitis, altered mental status, and acute kidney injury following re-exposure to intravenous vancomycin. As seen here, renal biopsy revealed a granulomatous acute interstitial nephritis (AIN) (lower left) with a cellular infiltrate consisting of numerous eosinophils, lymphocytes, neutrophils, plasma cells, and macrophages (lower right). Lymph node biopsy was consistent with a reactive lymphadenitis. Vancomycin was discontinued, and the patient received intravenous methylprednisolone for 3 days followed by oral prednisone tapered over 4 weeks, with complete resolution of the systemic illness and recovery of kidney function back to baseline. This presentation is consistent with DRESS (Drug rash with Eosinophilia and Systemic Symptoms) syndrome, which is characterized by the presence of at least three of the following findings: fever, skin rash, peripheral eosinophilia, atypical circulating lymphocytes, lymphadenopathy, and hepatitis. DRESS syndrome often defies diagnosis initially as it has clinical features that mimic those found with other systemic disorders. This idiosyncratic reaction occurs most commonly after exposure to drugs such as allopurinol, sulfonamides, and aromatic anticonvulsants such as phenytoin, phenobarbital, and carbamazepine. Diagnosis essentially consists of recognizing the clinical syndrome and identifying the causative agent. Fused PET/CT scan in this case demonstrated a diffuse inflammatory process, including widespread lymph node enlargement and an exuberant granulomatous AIN. Treatment for DRESS syndrome includes discontinuing the suspected medication, and in some patients, treating with systemic steroids for several weeks. Surveillance for a relapse after cessation of symptoms and completion of steroids is required. (Image and text provided by Deepak Kadiyala, Gilbert Moeckel, and Mark A. Perazella, Yale University School of Medicine)