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Beyond the Futility Argument: The Fair Process Approach and Time-Limited Trials for Managing Dialysis Conflict
Ann Rinehart
On the Cover
What’s the diagnosis? A young man with a renal carcinoma but no history of kidney stones or malabsorption underwent a nephrectomy and the non-neoplastic kidney parenchyma of the kidney was examined. The cortex was completely unremarkable. The image shows several large calcium phosphate deposits at the tip of papilla with associated medullary interstitial fibrosis. The calcium phosphate deposits are also present in the lumens of several tubules, suggesting a dystrophic type of calcifications that occur in the setting of cellular injury, as opposed to metastatic calcifications that are seen in the setting of hypercalcemic states and characterized by deposition along the tubular basement membranes. Interstitial calcium phosphate deposits, sometimes with associated interstitial fibrosis, have been identified in patients with kidney stones who have undergone biopsy during percutaneous stone removal. Some patients, typically those with an ileostomy or who have had a small bowel resection or gastric bypass surgery, may also have crystal deposits that plug the ducts of Bellini and inner medullary collecting ducts. The current hypothesis is that this interstitial calcium phosphate eventually erodes through the papillary epithelium to form a Randall’s plaque. Calcium oxalate and calcium phosphate then deposit on the plaque and grow into what is clinically recognized as a kidney stone. Thus, this interstitial process (which may also seen in individuals who have not formed a kidney stone), related to low urine volume and high urine calcium but for which the exact mechanism remains unknown, may be the initiating event for the common forms of calcium nephrolithiasis. (Images and text provided by Vanesa Bijol, MD, Brigham and Women’s Hospital)