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1826 Where What Is Not Stated or Required May Be the Most Illuminating
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1835 The Hype Cycle for Soluble Urokinase Receptor in FSGS: Passing the Trough of Disillusionment?
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1840 Contrast-Associated AKI and Use of Cardiovascular Medications after Acute Coronary Syndrome
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1849 Plasma Catalytic Iron, AKI, and Death among Critically Ill Patients
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1857 Urinary Biomarkers and Progression of AKI in Patients with Cirrhosis
Justin M. Belcher, Guadalupe Garcia-Tsao, Arun J. Sanyal, Heather Thiessen-Philbrook, Aldo J. Peixoto, Mark A. Perazella, Naheed Ansari, Joseph Lim, Steven G. Coca, and Chirag R. Parikh for the TRIBE-AKI Consortium

Chronic Kidney Disease

1868 The Association between a Mediterranean-Style Diet and Kidney Function in the Northern Manhattan Study Cohort
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1876 Defining the Complement Biomarker Profile of C3 Glomerulopathy
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1883 M-type Phospholipase A2 Receptor Autoantibodies and Renal Function in Patients with Primary Membranous Nephropathy
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1892 Nephron Hypertrophy and Glomerulosclerosis and Their Association with Kidney Function and Risk Factors among Living Kidney Donors
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1903 Relationship between Serum Soluble Urokinase Plasminogen Activator Receptor Level and Steroid Responsiveness in FSGS
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1912 Associations of Anemia and Renal Dysfunction with Outcomes among Patients Hospitalized for Acute Decompensated Heart Failure with Preserved or Reduced Ejection Fraction
Katsuya Kajimoto, Naoki Sato, Takehiko Keida, Yasushi Sakata, and Teruo Takano on behalf of the Acute Decompensated Heart Failure Syndromes (ATTEND) Investigators

1922 Cumulative Systolic BP and Changes in Urine Albumin-to-Creatinine Ratios in Nondiabetic Participants of the Multi-Ethnic Study of Atherosclerosis
Paul Zemaitis, Kiang Liu, David R. Jacobs, Jr., Mary Cushman, Ramon Durazo-Arvizu, David Shoham, Walter Palmas, Richard Cooper, and Holly Kramer

1930 Intravenous Iron Exposure and Mortality in Patients on Hemodialysis
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1940 Health-Related and Psychosocial Concerns about Transplantation among Patients Initiating Dialysis
Megan L. Salter, Natasha Gupta, Elizabeth King, Karen Bandeen-Roche, Andrew H. Law, Mara A. McAdams-DeMarco, Lucy A. Meoni, Bernard G. Jaar, Stephen M. Sozio, Wen Hong Linda Kao, Rulan S. Parekh, and Dorry L. Segev

1949 Comparison of Mortality of ESRD Patients with Lupus by Initial Dialysis Modality
Gabriel Contreras, Javier Pagan, Ruchir Chokshi, Sharad Virmani, Jorge M. Diego, Patricia Byers, Tamara Isakova, Jair Munoz Mendoza, Ali Nayer, Jose Roberto Contreras, Gabriel Panama, Oliver Lenz, Maria Carpeniero, Timothy Muchayi, and David Roth

1958 X-Linked Alport Syndrome Caused by Splicing Mutations in COL4A5

1965 Decreased Conversion of 25-hydroxyvitamin D₃ to 24,25-dihydroxyvitamin D₃ Following Cholecalciferol Therapy in Patients with CKD
Jason R. Stubbs, Shiqin Zhang, Peter A. Friedman, and Thomas D. Nolin
What’s the diagnosis? A 19 year-old healthy male presented with 3 weeks of worsening bilateral red eyes, blurry vision and pain with eye movement. Ophthalmologic exam was consistent with anterior uveitis as seen on the upper panel. Oral prednisone 60 mg daily with rapid taper, and topical prednisolone and cyclopentolate eye drops were administered. Symptoms improved; however, review of lab-work obtained on initial evaluation noted serum creatinine of 3.2 mg/dl. He was admitted for further workup. Vital signs were within normal limits while physical examination revealed minimal scleral injection, but no skin rash, or joint tenderness or edema. Repeat serum creatinine measured 2 weeks later was 1.8 mg/dl and urinalysis revealed pH 7.5, +1 glucose (serum glucose 105 mg/dl), negative blood and protein with bland manual urine microscopy. Spot urine protein/creatinine ratio was 0.1 mg/mg Cr and urinary beta-2 microglobulin 8749 mcg/L (normal range 0-300). Workup was negative for the following: ANA, ENA, rheumatoid factor, ANCA, SPEP, HIV, HLA-B27, gonorrhea/ chlamydia cultures, complement levels, and ACE levels. A clinical diagnosis of tubulointerstitial nephritis and uveitis (TINU) was made. However, 2 weeks later, serum creatinine remained elevated (1.7 mg/dl) on oral prednisone 30 mg daily. Repeat urine microscopy revealed 1-2 WBC casts/LPF. Kidney biopsy revealed a lymphocyte predominant tubulointerstitial nephritis (lower panel). TINU syndrome was confirmed and oral steroids were escalated to 60 mg daily with a plan for a slower taper.

TINU is a relatively rare syndrome with only approximately 250 published cases. It can occur at any age, but is more common in adolescents. Ocular symptoms may precede, coincide, or occur up to 14 months after tubulointerstitial nephritis is noted. Fever, weight loss, fatigue, abdominal/flank pain, arthralgias, and polyuria may be seen. Uveitis is typically bilateral and manifests as painful red eyes, which may also be associated with photophobia and decreased visual acuity. Uveitis is most often anterior, but can be posterior with intraretinal hemorrhage, cotton wool spots, and retinal edema. TINU should be considered in any patient presenting with unexplained interstitial nephritis. An ocular workup was warranted if symptoms develop. Supportive laboratory data include eosinophilia, anemia, mildly abnormal LFTs, and elevated CRP. Normoglycemic glycosuria, leukocyturia, and increased urinary beta-2 microglobulin may also be seen. Typical kidney biopsy findings include interstitial edema with an inflammatory cell infiltrate composed of lymphocytes, plasma cells, histiocytes, and eosinophils. Noncaseating granulomas may also be seen. Treatment includes prednisone 1 mg/kg/day for 3-6 months (depending on renal response) with a slow taper. Images and text provided by Barry Gorlitsky, MD; John Huang, MD; Gilbert Moeckel, MD and Mark A. Perazella, MD, Yale University School of Medicine, New Haven, Connecticut.