Editorials

1823 **AKI and Medical Care after Coronary Angiography: Renalism Revisited**  
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1826 **Where What Is Not Stated or Required May Be the Most Illuminating**  
Julie Lin  
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1829 **Circulating Complement Levels and C3 Glomerulopathy**  
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1832 **Nephron Hypertrophy and Glomerulosclerosis in Normal Donor Kidneys**  
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1835 **The Hype Cycle for Soluble Urokinase Receptor in FSGS: Passing the Trough of Disillusionment?**  
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1837 **Intravenous Iron Exposure and Outcomes in Patients on Hemodialysis**  
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Original Articles

**Acute Kidney Injury**

1840 **Contrast-Associated AKI and Use of Cardiovascular Medications after Acute Coronary Syndrome**  
Kelvin C.W. Leung, Neesh Pannu, Zhi Tan, William A. Ghali, Merrill L. Knudtson, Brenda R. Hemmelgarn, Marcello Tonelli, and Matthew T. James for the APPROACH and AKDN Investigators  
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1849 **Plasma Catalytic Iron, AKI, and Death among Critically Ill Patients**  
David E. Leaf, Mohan Rajapurkar, Suhas S. Lele, Banibrata Mukhopadhyay, and Sushrut S. Waikar

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**  
Minesh Khatri, Yeseon P. Moon, Nikolaos Scarmeas, Yian Gu, Hannah Gardener, Ken Cheung, Clinton B. Wright, Ralph L. Sacco, Thomas L. Nickolas, and Mitchell S.V. Elkind  
See related editorial on page 1826.
1876 Defining the Complement Biomarker Profile of C3 Glomerulopathy
Yuzhou Zhang, Carla M. Nester, Bertha Martin, Mikkel-Ole Skjoedt, Nicole C. Meyer, Dingwu Shao, Nicolò Borsa, Yaseelan Palarasah, and Richard J.H. Smith
See related editorial on page 1829.

1883 M-type Phospholipase A2 Receptor Autoantibodies and Renal Function in Patients with Primary Membranous Nephropathy
Elion Hoxha, Sigrid Harendza, Hans Pinnschmidt, Ulf Panzer, and Rolf A.K. Stahl

1892 Nephron Hypertrophy and Glomerulosclerosis and Their Association with Kidney Function and Risk Factors among Living Kidney Donors
See related editorial on page 1832.

1903 Relationship between Serum Soluble Urokinase Plasminogen Activator Receptor Level and Steroid Responsiveness in FSGS
Furong Li, Chunxia Zheng, Yongzhong Zhong, Caihong Zeng, Feng Xu, Ru Yin, Qi Jiang, Minlin Zhou, and Zhihong Liu
See related editorial on page 1835.
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 preceede, 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 is 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.