

# CJASN

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### On the Cover

*What's the diagnosis?* A thin young male with a history of Autosomal Dominant Polycystic Kidney Disease (ADPKD) and chronic kidney disease presented with severe recurrent anemia in the setting of a baseline creatinine of 4.0 mg/dl. There was no evidence to support ongoing hemolysis and serial imaging demonstrated large, bilateral polycystic kidneys with various stages of hemorrhage within the cysts on T1 weighted MRI image (upper panel). On the inside cover just below the text are hemorrhagic cysts (hyperintense or white) with varying degrees of hemorrhage as well as cyst with showing an air/blood level (arrow) on the T1 weighted MRI image (upper panel). Due to continuing cystic hemorrhage, the patient became transfusion dependent, and eventually underwent bilateral nephrectomies to resolve the source of ongoing blood loss. His kidneys were removed via open nephrectomy procedure and were noted to be 1900 and 1800 grams, respectively. Image of the nephrectomy specimen (lower panel) shows a 16 cm ruler adjacent to the kidneys. Patients with ADPKD and a large cyst burden suffer from various complications including flank/loin/abdominal pain, gross or microscopic hematuria, nephrolithiasis, gastrointestinal symptoms from a compressed bowel, or cyst rupture, cyst infection and hemorrhage into the cysts. In this case, severe, ongoing cyst hemorrhage led to the need for bilateral nephrectomy and initiation of dialysis. In most cases, all of these complications can be managed symptomatically, with only rare cases requiring nephrectomy. Bleeding is usually self-limited. Renal angiography may prove successful in some cases if a single bleed can be identified and successfully embolized. When all else fails, an operative intervention such as nephrectomy is required. Fortunately, this is rare. (Images and text provided by Ursula C. Brewster, MD, and Hristos Kaimakliotis, MD Yale University School of Medicine, New Haven, Connecticut)

