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MYOCARDIAL INFARCTION MANAGEMENT IN PATIENTS WITH CHRONIC KIDNEY DISEASE STAGE 3-5, END STAGE RENAL DISEASE, AND NORMAL KIDNEY FUNCTION: A RETROSPECTIVE COHORT STUDY.

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Patients with CKD are at higher risk for developing CAD; traditional and unique risk factors are prevalent and constitute challenges for the standard of care. However, little evidence is available to guide evidence-based treatment of CAD in patient with CKD.

We conducted a retrospective cohort study on patients admitted for the diagnosis of MI between January 2005 and December 2012. Patients were assigned to 1 of 3 groups according to their kidney function: 1) normal GFR, 2) CKDIII-V, and 3) ESRD (Dialysis). The treatment variables: 1) medical management including: statins, various anti-platelets, beta-blockers, and ace-inhibitors, and 2) medical interventions including: catheterization and coronary artery bypass grafting were studied in the 3 cohorts. Chi square analysis was used to compare the proportions between nominal variables. Binary logistic analysis was used in order to determine associations between treatment modalities and comorbidities, and to account for possible confounding factors.

334 patients (mean age 67.2±13.9) were included. In terms of management, medical treatment and CABG were not different among kidney function groups. However, cardiac catheterization was performed less in ESRD when compared to no CKD and CKDIII-V ($p=0.000$). In binary logistics regression CABG was not associated with degree of CKD ($p=0.078$). Cardiac catheterization on the other hand carried the strongest association among all studied variables ($p=0.000$). This association was maintained after adjusting for other comorbidities.

Kidney disease seems to affect the management of patients with acute MI. Cardiac catheterization is performed less in patients on HD. On the other hand, medical therapy was achieved at high rates in our study and was similar irrespective of kidney function.

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PREGNANCY OUTCOMES IN HEMODIALYSIS PATIENTS: A NATIONAL SURVEY

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Pregnancy among women on chronic dialysis has been reported in 1-7% of women. It has been more than a decade that the American experience of pregnancy in women on hemodialysis has been reported.

The purpose of this survey was to evaluate practice patterns and to trend maternal and fetal outcomes in the pregnant female on hemodialysis over the past five years.

An anonymous internet based survey consisting of 23 questions was electronically mailed to American nephrologists in May 2014. To date, 75 nephrologists have responded to the survey. Over the past five years, more than 59 pregnancies are being reported. During this time period, 43% of American nephrologist respondents have cared for pregnant females on hemodialysis. In 32% of the reported pregnancies, dialysis was initiated during the pregnancy while 58% occurred within the first five years of being on maintenance dialysis. Two pregnancies were reported as occurring between 5-10 years on hemodialysis and three pregnancies after being on dialysis for a duration of more than 10 years. Of the reported pregnancies 23% did not result in live births. 50% of the pregnancies were complicated by preeclampsia. There were no maternal deaths. 51% of American nephrologists/ or a member of their staff counsel their female dialysis patients about contraception. With respect to the dialysis prescription, most nephrologists prescribe 4 to 4.5 hours of hemodialysis. 64% of respondents provide dialysis for six days per week. Only 21 % aimed for a target predialysis BUN of less than 20mg/dL while 66% of nephrologists targeted a BUN less than 50mg/dl. 75% of respondents do not have access to fetal monitoring during dialysis for their pregnant patient. There are approximately 32% of American nephrologists who are somewhat to very uncomfortable caring for a pregnant woman on hemodialysis.

Providing intensive hemodialysis is a common treatment approach for the pregnant women on hemodialysis. There remain a significant number of poor maternal or fetal outcomes. Formal guidelines outlining the care of the pregnant woman on dialysis need to be established. These can hopefully improve outcomes.

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RENAL ULTRASOUND AND PROCEDURAL EXPERIENCE OF US ADULT NEPHROLOGY FELLOWS: A NATIONAL SURVEY:

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Procedures are a key component to nephrology fellowship training. Renal ultrasound (R-US) and other procedural experience of US adult nephrology fellows are not known. In addition, it is uncertain if nephrology fellows undergo formal training in R-US during fellowship. To gain a greater insight into nephrology fellows' experience regarding R-US and other nephrology procedures, we conducted this study.

An anonymous online survey was electronically mailed to US adult nephrology fellows through nephrology training program directors and coordinators in May 2014.

200 nephrology fellows responded to the survey (21% response rate). Half of the respondents were first-year fellows. 38% were graduating fellows. 9% of the respondents had formal R-US training during residency. 83% of the respondent's fellowship program did not offer formal clinical training in R-US during fellowship. Only 33% had formal didactic R-US experience during fellowship. 59% of the respondents described their ability to identify normal anatomy on R-US as either fair or poor. 72% of the respondents described their ability to identify pathological findings on R-US as either poor or fair. Majority (94%) of the respondents felt that fellowship programs should offer a formal training in R-US. Nearly one-fifth planned to undergo R-US training outside their fellowship programs. While 25% of the respondents had placed <5 temporary femoral hemodialysis (HD) catheters, another 27% had placed none. In addition, 30% fellows had not placed a temporary internal jugular HD catheter. R-US guided native or transplant kidney biopsies were more commonly performed than either CT guided or blind technique kidney biopsies. Three respondents had placed peritoneal dialysis catheters during fellowship

Most fellowship programs did not offer formal clinical training in R-US, although fellows believe this should be an important part of their curriculum. Measures to enhance R-US and other procedural experience of nephrology fellows should be considered by the training community.

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WEIGHT TRENDS IN U.S. LIVING KIDNEY DONORS: ANALYSIS OF THE UNOS DATABASE

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The obesity epidemic is increasing. This study was conducted to analyze the national trends associated with Body Mass Index (BMI) and living kidney donation.

47,705 adult living kidney donors as reported to the OPTN from 1999 to 2011 were analyzed using their pre-donation BMI. Predictor variables of interest included age, gender, ethnicity, relationship, education status, and transplant region.

16,971 of the living kidney donors were normal weight (35.6%); 19,337 were overweight (40.5%); 9007 were mildly obese (18.9%); 1992 were moderate to morbidly obese (4.2%). Overweight and mildly obese kidney donors have increased through time by 12% and 20% every 5 years, respectively ($p<0.05$). Donors 35-49 years of age, hispanic males or females and black females, those with high school diploma or GED, and biologically related or partner/spouses were more likely to be obese.

Over the past 13 years, the majority of living kidney donors have spanned the overweight to obese categories. Paralleling the national rise is an increase in overweight and mildly obese kidney donors. A fair number of moderate to morbidly obese living kidney donors are still allowed to donate.