that are reversible like UA nephropathy, and helps avoid hemodialysis and improve outcomes. Including UA nephropathy in the differential for AKI post seizures is essential for accurate diagnosis.

258 WITHDRAWN

259 THE DILEMMA OF ATYPICAL FIBROMYXOID NEOPLASM OF A TRANSPLANT KIDNEY: A TUMOR WITH UNCERTAIN BIOLOGICAL POTENTIAL:
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The most common malignancies associated with renal transplants include: skin cancers, post-transplant lymphoproliferative disorders and Kaposi sarcoma. We present a case of an atypical fibromyxoid neoplasm in a transplanted kidney. This is the first case reported of atypical fibromyxoid neoplasm in the kidney allograft in the medical literature to the best of our knowledge.

Our case involves a 52-year-old male with a history of childhood nephrotic syndrome and 2 failed kidney transplants. In 1989, he underwent a transplant, from his father (living-related donor) which lasted for 13 yrs. In 2003 he received another transplant, this time from a deceased donor. The transplant lasted three years, it failed in 2006. In September 2016, as a part of a pre-transplant work up, a large amorphous globular mass was found in his right abdomen, it had features suspicious of malignancy. Upon further testing a malignancy of the allograft was discovered. In the operating room, the surgical team found that the tumor occupied most of the allograft. The mass was grossly resected.

The final pathology report revealed -Atypical fibromyxoid neoplasm of uncertain biological potential with positive margins in the ureter and hilar blood vessels. Per oncology, even though the natural history of this tumor is uncertain, if the tumor was to recur it would likely recur locally and have low metastatic potential. It was therefore decided that chemotherapy was not needed. Given the patient’s young age and otherwise good health, we decided to relist the patient for kidney transplant with close follow up for recurrence. The patient is doing well without cancer recurrence.

This is the first case reported of atypical fibromyxoid neoplasm of a kidney allograft, in the medical literature, to the best of our knowledge. Retransplant following atypical fibromyxoid neoplasm in the kidney allograft should be performed cautiously with close follow up after assessing the risk vs benefit ratio. Further studies are needed to elucidate the risk of cancer recurrence.

260 PATIENTS WITH CKD OR TRANSPLANT WHO HAVE DIABETES HAVE A MORE POSITIVE ATTITUDE TOWARDS CARE AND DIFFERENT DIETARY PATTERNS THAN THOSE WHO DO NOT:
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Diabetes mellitus is commonly found in patients with kidney disease and requires dietary accommodation, increased medication burden and increased interaction with the health care environment in addition to that required by kidney disease itself. We compared dietary adherence and attitudes in patients with kidney disease with and without diabetes in inner-city Brooklyn.

A face-to-face survey was conducted in a random convenience sample of pts from CKD (23) and transplant (33) clinics. Diet was studied by 24-hour recall using ASA24 software. Healthy Eating Index was calculated using the HEI-15 score. The Beliefs in Medicine Questionnaire (BMQ) was used to elicit attitudes toward the healthcare environment. Comparisons were by t-test.

15 (45%) transplant (TXP) and 13 (57%) CKD pts had diabetes (DIAB). DIAB were older than pts without diabetes (NODIAB) (62.1±1.98 vs 50.4±2.4 yrs, p<0.001) but age did not correlate with any of the following findings. Mean creatinine was 1.83±0.15 mg/dl and did not differ between CKD and TXP, or DIAB and NODIAB. Mean HbA1c was 8.0±0.28, mean time with diabetes was 97.7±20.3 months and did not differ between clinics. DIAB were more likely to agree that their health depends on their medications in the future (1.36±0.12 vs 2.0±0.26, p=0.024), less likely to believe that if doctors had more time, they would prescribe fewer medications (3.5±0.25 vs 2.79±0.28, p=0.034) and less likely to believe that medicines are poisons (4.5±0.14 vs 3.9±0.23, p=0.039). DIAB ate fewer carbohydrates (137.4±11.6 vs 211.8±13.4, p<0.001), less sugar (44.7±5.6 vs 89.4±9.5, p<0.001), less fiber (10.9±1.1 vs 16.1±1.4, p<0.005), less vitamin C (5.4±2.9 vs 11.0±2.3, p=0.031), less fruit (0.3±0.1 vs 1.96±0.6, p=0.015) and less refined grains (3.0±0.43 vs 4.6±0.59, p=0.035). There was no difference for HEI score, total caloric or protein intake.

In our population: 1. Approximately 50% of pts attending CKD or TXP clinics had diabetes. 2. Pts with diabetes had a more positive opinion of the healthcare environment. 2. Pts with diabetes ate fewer carbohydrates, sugars and refined grains but less fresh fruit, fiber and vitamin C. 3. Education of our pts with kidney disease and diabetes should reinforce their attitudes towards the healthcare environment while encouraging an overall healthy eating plan that includes fruits and vegetables, as patients appear to be focusing primarily on restricting sugar and carbohydrates.

261 FOCAL GLOMERULOPATHY WITH MESANGIAL FIBRILLARY DEPOSITS ASSOCIATED WITH STRONGYLOIDIASIS:
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Rare cases of glomerular disease associated with Strongyloidaisis have been published. Most reports described lesions of minimal change disease or membranoproliferative glomerulonephritis. Herein, we present a case of a patient with nephrotic syndrome caused by a glomerular lesion characterized by previously unreported mesangial amyloid-like fibrils that resolved promptly after anti-helminthic treatment.

A 63-year-old woman with essential hypertension and dyslipidemia was referred to a nephrology clinic for evaluation of a 6-week history