



KIDNEY KOLUMNs

Freely filtered from the ISN



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Kidney Kolumns is the official newsletter of the Indian Society of Nephrology (ISN). Launched in 2023, it is published quarterly and serves as a vibrant platform for the nephrology community to exchange knowledge, share updates, and foster professional growth.

The newsletter currently accepts contributions by invitation only. All content is reviewed by the editorial board prior to publication. However, student contributors are encouraged to submit their work without an invitation and should contact the student editors for further guidance.



As always, we welcome your **feedback & contributions** at education@isn-india.org

Hello.

Welcome to a new edition of the filtrate – albeit this one took a longer time brewing in the tubules... summertime blues!

Firstmost, this is to inform our readers that our founding EICs (aka Drs Mayuri and Sanjeev) decided that they will have guest editors each edition – all done to keep the fare wholesome and appealing – and also to make sure that KK discusses themes that its readership wants to explore. Our first guest editor is an avid KK reader too – Dr Kavita Vishwakarma, consultant nephrologist from Mumbai.

to the discerning
Kidney
Kolumn
Community!

This edition is dedicated to conservative kidney management – a theme selected by our guest editor, who evocatively makes her point for CKM and why it should be discussed in this edition. Once done reading the brilliant critiques on papers themed on CKM, do not forget to savour the Nephro nuggets and the fascinating case reports tucked in the Residents' corner. Additionally, we have the critical appraisal of the

much-talked about, and slightly contrarian findings from the CKDu-AGRI study, and KK got this, straight from the source.

All in all, if the GLP1RA and cardio-kidney-metabolic (CKM) axis-reading is getting on your nephron-nerves, this other CKM reading might restore your reading balance. So, without further ado, happy reading, and hope we get some feedback on this initiative and your other suggestions as well.

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THE CASE OF MR DANNY

Diminishing Returns of an Intervention

I am Dr Kavita Vishwakarma, and I am your guest editor for this edition of Kidney Kolumnns. I have loved reading KK myself, and I know, I can subliminally connect with others who partake of this filtrate. That's why, I'd like to share as to why I wanted this edition of KK to carry a conversation on conservative kidney management.

The Editorial.

For the last three and a half years, I have been managing an 86-year old gentleman, let's call him Mr Danny. He is kind, polite, and unfailingly compliant. I have been caring for him since he was initiated on dialysis for End Stage Kidney Disease. For a considerably long time, he remained relatively stable. But over the last year, things have changed. He has had recurrent hospitalizations - one for an episode of hematuria (ended up with TURP), second for an upper GI bleed attributed to medication-induced ulcers and a third admission for anorexia, generalized weakness and drowsiness. It was this last time that we initiated a conversation about possibly withdrawing dialysis. The family initially agreed but later withdrew consent. He was discharged with marginal improvement, only to be readmitted with markedly depressed sensorium in a few days. Again, we treated him and had the conversation about not continuing dialysis further.



Dr Kavita Vishwakarma, Consultant Nephrologist, Bhaktivedanta Hospital & Research Institute, Thane

His wife understands. She recognizes that at 86, he has lived a full life. I also sense that she is elderly herself, at the brink of burnout after caring for him for so long. But his son is not ready. For him, withdrawing dialysis feels morally wrong, a sin that he cannot commit with his father.

Over the years, I have seen many such patients, elderly individuals with strokes, cognitive decline, and other debilitating states being brought to dialysis units with immense difficulty. Dialysis sessions that often become inadequate, burdensome, and exhausting. Why do we consider dialysis the default? There exists a subset of patients who do not meaningfully benefit



*The Case of Mr Danny: Diminishing
Returns of an Intervention*



from dialysis, no matter how well we optimize care. And yet, we continue. Not because it always helps but because stopping feels harder. We all are seeing a greater number of elderly patients in our practice. While some benefit immensely from dialysis, nutrition, physiotherapy, and family support, others do not seem to. Caring for patients like Mr. Danny has compelled me to reflect deeply on my practice. I have realised that CKM is not about “doing nothing.” It is about choosing comfort, dignity, and quality of life when dialysis no longer serves the patient. Dialysis is a powerful tool but it may not be universally beneficial. Recognizing when not to use it is as crucial as knowing when to initiate it. Conservative Kidney Management offers us an opportunity to restore balance, place dignity, comfort, and patient-centered care at the heart of our decisions.

When the KK editorial team reached out to

me, I knew this was a conversation worth having. It gave me the opportunity to revisit the literature and critically examine a question that comes up repeatedly in my clinical care. What became evident was how often patients do not experience this as a real choice because for many, it is framed as ‘dialysis or die.’ Also that conservative kidney management is not the absence of care and may actually reduce hospitalization burden without clear survival disadvantage in older adults. That advance care planning in many such carefully selected patients may improve preparedness and reduce decisional conflict. And while the flavour of this edition is all “conservative” - the LIBERATE-D trial is also covered, which informs us as how, less dialysis may be more liberating in acute kidney injury too.

Happy reading everyone! Hoping that CKM manages to find a complementary role in our headspaces with this edition.

Kidney Kolumns

SECRETARY'S DESK

Dear Members

Greetings from the ISN Secretariat!

I would like to congratulate our young team for bringing out the new edition of Kidney Kolumns, the theme of which is **Conservative Management of Kidney Disease**. I am sure this would be liked and appreciated by our members. I would like to update about some of the activities in ISN through this newsletter

1) ISNCON 2026 Kochi

The 55th Annual Conference of the Indian Society of Nephrology, ISNCON 2026, is going to take place between **17th and 20th December 2026** at Kochi Convention Centre, Hotel Grand Hyatt, Kochi Balgotty, Kerala. Kochi, often referred to as the “Queen of the

Arabian Sea”, is a vibrant coastal city known for its natural beauty, rich cultural heritage, and warm hospitality. You can explore the venue by clicking at www.isnconkochi.com. I want to highlight some of the key attractions of ISNCON 2026.

ISN Workshops (17th December) - like preceding years, the Indian SN would be doing multiple workshops for the benefit of our students and delegates. We have brought some new webinars this year featuring renowned National and International faculty. You can register for one of the workshops.

- **Intervention Nephrology** - Dr Tushar Vacharajani and national faculty
- **Critical Care Nephrology and POCUS** - Dr Kianoush Kasani and national faculty
- **Finance and AI** - (4 hours each) - We will have Dr Girish Nadkarni from the US, a well-known faculty member in healthcare AI.
- **Histopathology and Immunogenetics**

Registration for Workshops is Complimentary; however, the seats are limited and one person can register in only one of the Workshops.



Dr Shyam B Bansal
Honorary Secretary,
Indian SN

Some of the **INTERNATIONAL FACULTY** who have confirmed their participation in ISNCON 2026

1. Dr Girish Nadkarni - AI
 2. Dr Tushar Vacharajani - Intervention Nephrology
 3. Dr Kianoush Kasani - Critical care and AI
 4. Dr Tobias Hubor - Glomerular diseases
 5. Dr Anant Karumanchi - Pregnancy and AKI
 6. Dr Priya Verghese - Transplantation
- Some more names are awaiting confirmation.

Registration for ISNCON 2026 is starting from 15th April. You can register by visiting the ISN website and going to the registration page: www.ISN-India.org

2) Webinar with ISGD on 29th May Friday

The Indian SN of Nephrology would be organising a webinar on Advances in Podocytopathy in collaboration with ISGD. The date of the webinar is 29th May, from 6.30 PM onwards IST. You can register for the webinar by clicking the [Registration Link](#). Registration is complimentary.



3) **Lastly, those of you who have not got their ERA Membership** can click on the link and get their ERA membership number. I would request to deposit Rs 500 those who have not deposited the money yet.

<https://dbul-zgph.maillist-manage.in/click/>

Looking forward to seeing you in the beautiful City of
Kochi in December

Shyam Bansal

When Restraint Heals

THE CASE FOR CONSERVATIVE DIALYSIS

Dr Mohammed Fahad Khan, Consultant Nephrologist and Transplant Physician, Manipal Hospitals, Bangalore

The recently published LIBERATE-D trial addresses a question that nephrologists face frequently but for which evidence has been surprisingly sparse: once a patient with dialysis-requiring acute kidney injury (AKI-D) becomes hemodynamically stable, should we continue routine thrice-weekly hemodialysis, or should dialysis be withheld unless clear metabolic or clinical indications arise? In this multicenter, open-label randomized trial, 220 adults with AKI-D were assigned either to a conservative strategy, in which dialysis was given only for predefined triggers such as hyperkalemia, severe acidosis, pulmonary edema, marked azotemia, or clinician judgment, or to conventional thrice-weekly dialysis.¹ The headline result was provocative: kidney function recovery at hospital discharge occurred in 64.2% of the conservative group versus 50.5% of the conventional group. Patients managed conservatively also received fewer sessions, accrued more

dialysis-free days, and experienced fewer dialysis-associated hypotension events.

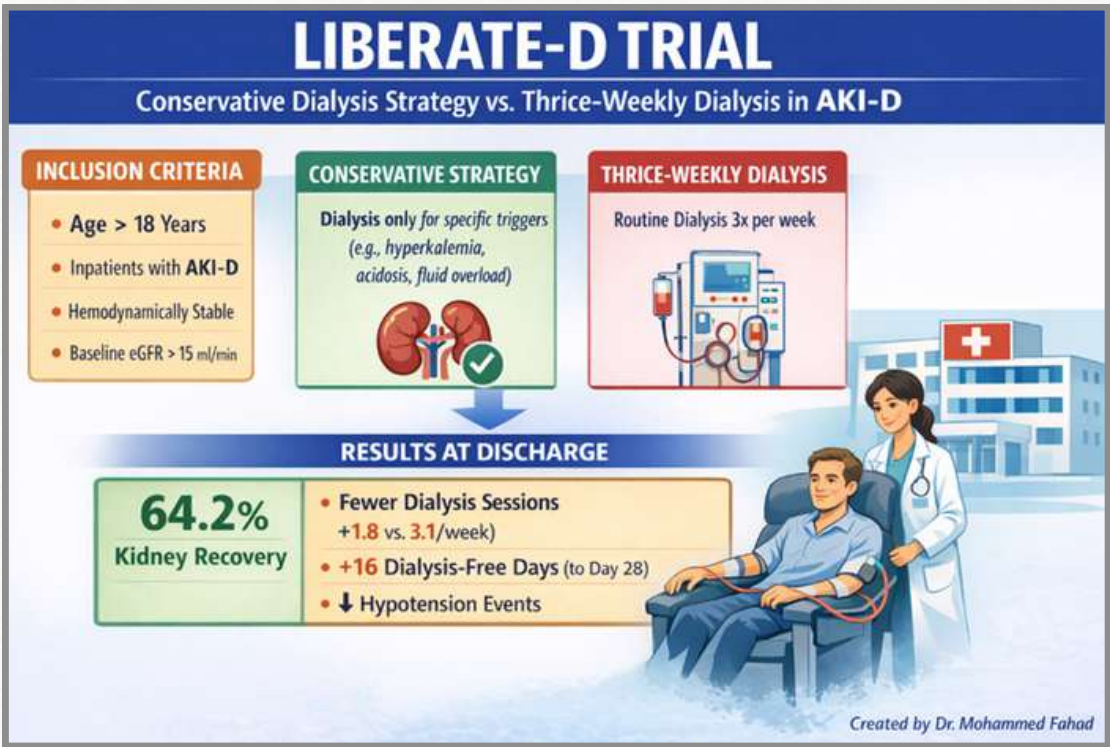
Why might this matter? The study challenges the reflex assumption that “more dialysis is safer” during recovery from AKI. Frequent dialysis may obscure spontaneous declines in creatinine, reduce urine output through repeated fluid removal exposes the kidney to recurrent intradialytic ischemia (Waikar et.al). LIBERATE-D therefore fits neatly into a broader body of evidence suggesting that, in AKI, the timing and intensity of kidney replacement therapy should be individualized rather than protocolized. Earlier trials such as AKIKI, IDEAL-ICU, and STARRT-AKI already showed that earlier or more intensive initiation of kidney replacement therapy does not reliably improve survival, and post hoc analyses from STARRT-AKI suggested that accelerated initiation may even increase subsequent dialysis dependence among survivors.

The strengths of LIBERATE-D are notable. It is randomized, pragmatic, and clinically intuitive. The separation between groups was substantial, with median dialysis exposure falling from 3.1 to 1.8 sessions per week. Just as important, the trial focused on a patient-centred endpoint: liberation from dialysis. That is highly relevant to patients, clinicians, and health systems alike. Fewer dialysis sessions also imply reduced catheter manipulation, lower resource use, and possibly less hemodynamic stress.

At the same time, caution is essential before over-generalizing these findings. The trial was relatively small, unblinded, and conducted in only 4 U.S. centres. The primary result was significant only in the unadjusted analysis; after prespecified adjustment, the odds ratio was attenuated and no longer statistically significant. The most common trigger for dialysis in the conservative arm was clinician judgment, which improves pragmatism but introduces subjectivity and potential crossover in practice style. Importantly, the enrolled patients were a selected population: they were off vasopre-

ssors, not invasively ventilated, and had planned intermittent hemodialysis. These data should not be extrapolated to unstable ICU patients, patients needing continuous kidney replacement therapy, or those with limited reserve and difficult-to-assess volume status.

LIBERATE-D is one of the most practice-shaping AKI-D trials in recent years, not because it closes the debate, but because it reframes it. The message is not “dialyze less at all costs”; it is “dialyze with purpose.” For a stable patient recovering from AKI-D, routine thrice-weekly dialysis should no longer be viewed as the unquestioned default. Instead, a physiology-guided weaning strategy deserves serious consideration, provided monitoring is meticulous and the team is comfortable acting on clear triggers. For now, LIBERATE-D is best seen as a strong signal rather than a final verdict. It supports a more conservative, kidney-recovery-oriented approach, while also underscoring the need for a larger confirmatory trial that extends into the outpatient transition period.



Comprehensive Conservative Kidney Management in Elderly

A LOGICAL ALTERNATIVE TO DIALYSIS RATHER THAN 'GIVING UP'

REVIEW of Comprehensive Conservative Kidney Management among Older Population - A Nationwide Administrative Claims Database Analysis

Dr Scientia Sanjeevani, Assistant Professor, Kalinga Institute of Medical Sciences, Bhubaneswar

Introduction:

In the recent years, we have seen a rise in chronic kidney disease (CKD) prevalence among the elderly. However, initiation of kidney replacement therapy (KRT) is complex in this group of individuals with risk of many complications including high mortality and decreased activities of daily living (ADL). Apart from medical risks, many of these patients regret starting dialysis at the end of life contributing to psychological burden.

Conservative kidney management (CKM)

involves care for people with kidney failure that focuses predominantly on providing kidney supportive care (KSC) as per individual's preferences, goals, and prognosis to promote quality of life and does not include KRT. Interventions are aimed at slowing the progression of kidney disease and managing the complications of disease including premature death. Choosing CKM does not mean imminent death and most people live for several months to years with kidney failure while receiving CKM.



Comprehensive Conservative Kidney Management in Elderly - A Logical Alternative to Dialysis rather than 'Giving Up'



Rationale for CKM in the Elderly:

The fastest-growing incident group receiving dialysis now comprises individuals aged 65 or older and the most difficult clinical decision faced by nephrologists today is whether their elderly patient with advanced CKD is likely to benefit from dialysis. Their symptom burden on dialysis is high, quality of life (QOL) is often poor, and the social effects of dialysis on elderly individuals are significant, particularly for those in nursing homes.

What Did this Study Show?

The present study by Kobayashi et al. is a retrospective cohort study using data from a national health examination cohort from Japan. It mainly recruited individuals age 75 years or older with an eGFR of less than 8 ml/min/1.73 m² who did not receive KRT. It divided participants into two groups: the CKM and non-CKM groups. The CKM group was defined as those who had no procedures related to KRT induction during the observation period, whereas the non-CKM group was defined as those who had undergone some procedures related to KRT induction, such as vascular access surgery or peritoneal dialysis catheter insertion. The factors affecting CKM selection were age, sex, BMI category, frailty category, and renal function.

A total of 428 participants were included in this study, out of whom, 307 were classified into the CKM group, whereas 121 were divided into the non-CKM group. The observation time was longer, and non-frail individuals were more frequently observed in the CKM group with more active involvement in decision making for medical management. The impact on hospitalization as described as Incidence rate ratios (IRR) within 6 months and 1 year were significantly lower in the

CKM group; however, after 1 year, this difference was not statistically significant. Also, in the CKM group, both single and multiple hospitalizations were significantly less frequent. A total of 69 deaths were observed during the study period, of which 53 deaths (17.3%) were in the CKM group, and 16 deaths (13.2%) were in the non-CKM group with no significant difference in mortality between the two groups.

This study demonstrates that CKM serves as a viable, often preferred, alternative to dialysis for patients aged 75 and older, offering similar survival rates with a 60% reduction in hospitalizations. However, the study has important limitations. Due to the retrospective nature of the study, it is unclear how patients selected CKM such as the nature of patient counseling, decision aids, status of multidisciplinary collaboration, socio-economic status and access to care. Also, patients dialyzing for absolute indications for dialysis initiation like signs of heart failure or uremic symptoms were not evaluated in the study.

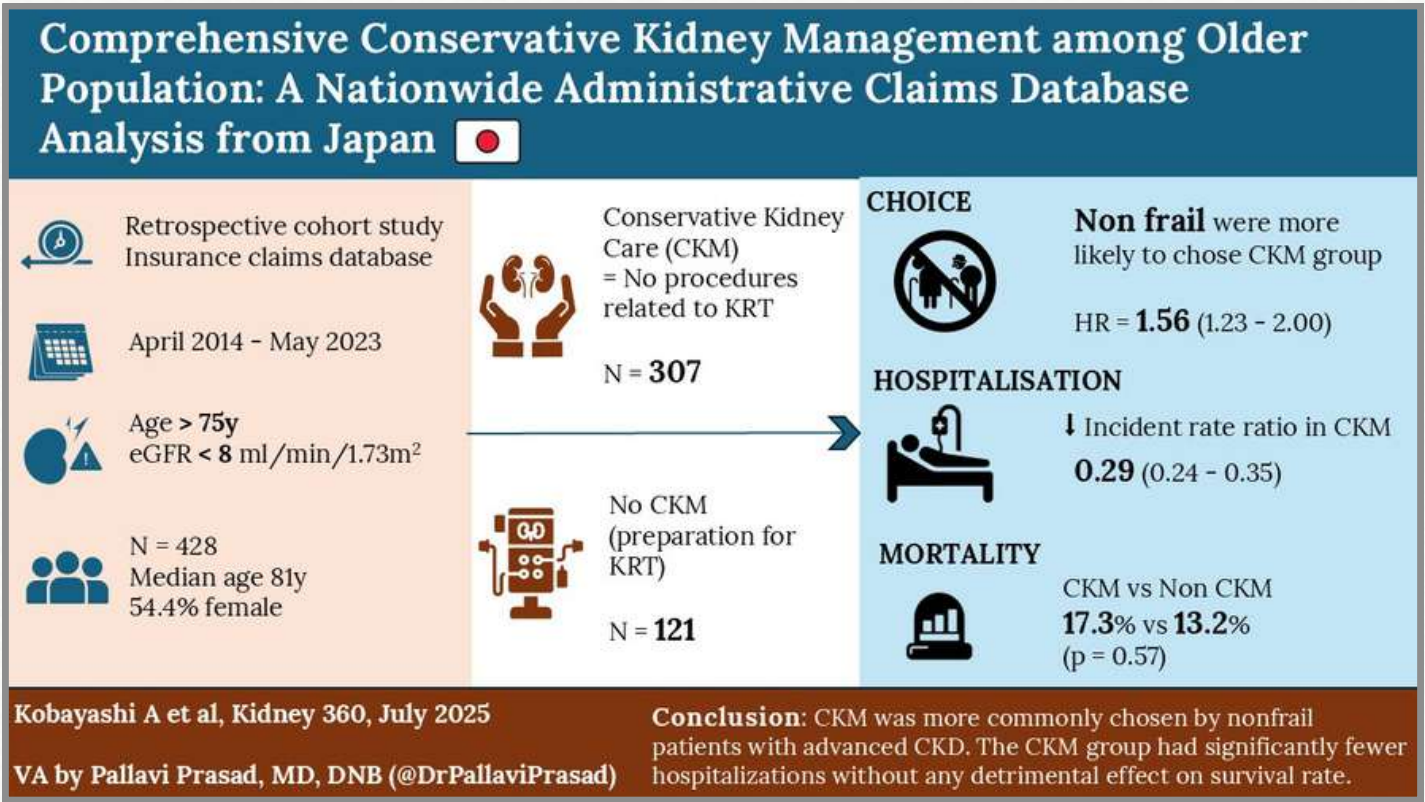
Scope of CKM in India:

Frailty prevalence among older adults is significantly higher in India as compared to Japan. Although this study paves an optimistic path around CKM, extrapolating these results to the Indian population should be done with caution. Despite advances in healthcare in India, lack of access to medical treatment, especially for dependent populations like the elderly, may still be a reason that forces them to opt for CKM over RRT, making it a choice-restricted care. Again, bridging over to KRT during emergencies, may be fraught with complications, especially among elderly people relocating to rural areas. This

“Comprehensive Conservative Kidney Management in Elderly - A Logical Alternative to Dialysis rather than ‘Giving Up’”

situation can be improved by a structured and comprehensive care plan which includes major red flag symptoms requiring

emergency care, provision of emergency drug kits and expedited transfer to higher centers.



Beyond 'Dialysis Or Death'

REFRAMING CHOICE IN ADVANCED KIDNEY DISEASE

REVIEW of *Hole B, et al. (2025): It's Basically 'Have that or Die' - A Qualitative Study of Older Patients' Choices between Dialysis and Conservative Kidney Management*

Dr Rama V, Assistant Professor, Sri Ramachandra Medical College, Chennai

Why this Study Matters?

In everyday nephrology practice, especially with elderly patients, we like to believe we are practicing shared decision-making. But are we really?

When an 82 year old gentleman with advanced CKD presents to our clinic with eGFR 10 ml/min, the conversation often appears straightforward: prepare for dialysis. But is this truly a 'choice' or is dialysis presented as an inevitable conclusion?

Decision-making in elderly patients with advanced CKD is one of the most ethically complex and clinically nuanced areas in nephrology. While nephrologists often assume that patients actively "choose" dialysis, this study challenges that assumption. The alternative option of Conservative Kidney Management (CKM) involves care focused on

managing the symptoms of kidney failure and maintaining quality of life in the absence of dialysis. This study explores a crucial but under-recognized issue: do patients truly perceive CKM as a real option?

A recent qualitative study by Hole et al. forces us to pause and reflect. Through conversations with elderly patients approaching kidney failure, the authors uncover a strikingly simple and troubling narrative: for many patients, the choice is not between dialysis and conservative kidney management (CKM), but between "dialysis or death."

Summary

This is a qualitative study conducted across three UK renal units, involving 15 elderly patients (median age 81 years, eGFR ~12 mL/min) who had not yet initiated kidney replacement therapy.



Beyond 'Dialysis or Death': Reframing Choice in Advanced Kidney Disease



Using semi-structured interviews and inductive thematic analysis, the authors explored how patients understand and decide between dialysis and CKM. The unique feature of the study is that the focus here is decision-making psychology, not outcomes.

Key Findings - Beyond the Obvious:

1. 'DIALYSIS OR DIE' - THE FALSE BINARY

Patients overwhelmingly perceived dialysis as synonymous with survival, and non-dialysis as equivalent to death. In extreme cases, declining dialysis was equated to suicide or passive euthanasia. In fact, a systematic review showed survival among older people with kidney failure (of median age 77 years) was 73% at 1 year in those treated with dialysis, and 71% in those receiving CKM.

This reflects a fundamental gap in communication, where the natural trajectory of kidney disease and the realistic benefits of dialysis are not clearly conveyed and there is often overestimation of the survival benefit of dialysis.

2. DIALYSIS AS THE DEFAULT ('THE NEED')

Dialysis was viewed not as a choice, but as an inevitable necessity. CKM, in contrast, was often misunderstood as "doing nothing." This underscores the need to reframe CKM as an active, legitimate treatment pathway, not a default inaction. This requires structural investment in kidney supportive care services and consistent interactions across multidisciplinary teams.

3. QUALITY VS QUANTITY - PATIENTS DO THINK RATIONALLY

Contrary to assumptions, patients demonstrated nuanced reasoning. They weighed independence, symptom burden, and lifestyle disruption. Dialysis was

perceived as intrusive and exhausting, while CKM was acceptable if it preserved dignity and autonomy.

What the Study Does Well (and Where it Falls Short):

Methodologically, this is a well-conducted qualitative study. The use of purposive sampling, semi-structured interviews, and thematic analysis with constant comparison ensures depth and rigor.

Inclusion of patients before dialysis initiation is a major strength, capturing real decision-making rather than retrospective justification. However, certain limitations must be acknowledged. The sample size is small (n=15), though acceptable for qualitative research. More importantly, all participants were white British from three UK centres, which limits generalizability and external validity - particularly to culturally diverse settings like India, where family dynamics, financial considerations, and beliefs significantly influence decisions. There is also potential for interviewer bias, given that interviews were conducted by a clinician, and recall bias, as patients describe prior counselling experiences. Despite these limitations, the consistency of findings strengthens its validity.

The Indian Perspective - Where the Gap Widens:

In our setting, decision-making is rarely individual - it is family-driven, often influenced by financial constraints, accessibility of dialysis centres, and sociocultural beliefs about illness and end-of-life care. The "dialysis or death" narrative may, in fact, be even stronger here, but for different reasons.



Beyond 'Dialysis or Death': Reframing Choice in Advanced Kidney Disease



For many patients, dialysis is not just a medical decision but an economic one. The cost of long-term dialysis, travel burden, and loss of livelihood often push families into difficult compromises. Yet, paradoxically, CKM is not presented as a structured, active alternative. Instead, it is frequently equated with “giving up” or “no treatment”. Awareness of CKM remains limited – not just among patients, but sometimes even within healthcare systems where dedicated kidney supportive care services are lacking. As a result, patients may undergo dialysis not because it aligns with their goals, but because it appears to be the only morally and medically acceptable option. Cultural factors further complicate this. In many Indian families, opting out of dialysis may be perceived as abandonment or loss of hope, making open discussions about prognosis and quality of life even more challenging.

In India, CKM is often presented only if dialysis is declined or dialysis is no longer possible due to logistic or vascular access issues. It is uncomfortable but true that CKM is rarely presented as an option upfront. Instead, it tends to enter the conversation only when patients and caregivers have reached a point of fatigue or when the patient's clinical condition has already deteriorated, rather than being considered early in those unlikely to derive meaningful benefit from dialysis.

What this means for us as nephrologists: This study does not argue against dialysis, nor does it advocate for CKM. Instead, it exposes a deeper issue – the illusion of choice.

If CKM is perceived as “no treatment,” it will never be chosen. If dialysis is framed as “life-saving,” it will rarely be questioned.

As nephrologists, we are not just offering treatments – we are shaping how patients understand their illness and their options.

Indian Data on CKM:

Although formal data on conservative kidney management (CKM) from India remain limited, available literature highlights significant gaps in structured kidney supportive care.

Indian reviews suggest that CKM is often practiced informally rather than as an organized care pathway, and discussions regarding non-dialytic care are infrequent in routine nephrology practice [\(Wei Ji et al\)](#).

Studies also note that many patients initiate dialysis late in the disease course, often influenced by financial and logistical constraints. [Palliative care literature](#) from India further demonstrates that patients with advanced CKD experience a high symptom burden, yet referral to supportive care services remains uncommon. Together, these findings highlight the urgent need to integrate structured CKM and kidney supportive care into comprehensive kidney care in India.

The Shift We Need

The 82-year-old patient asked us, ‘Doctor, if I don’t take dialysis, I’ll die immediately, right?’. Despite evidence that patients can live for meaningful periods on conservative kidney management (CKM), the fact that this remains a common belief reflects not their ignorance, but the way we frame the conversation.

Perhaps the most important takeaway from the study is this: we need to move from

“
Beyond ‘Dialysis or Death’: Reframing
Choice in Advanced Kidney Disease
”

default decisions to deliberate decisions. Because in the end, the question is not: “Dialysis or death?” but rather: “What kind of

life does this patient value - and how can we help them live it?”



Advance Care Planning in Dialysis

FROM FORMS TO MEANINGFUL CONVERSATIONS

Dr Sudharshan Karthikeyan, Associate Consultant, Department of Nephrology & Renal Transplant, Kauvery Hospital, Chennai

Patients receiving maintenance dialysis face a substantial burden of morbidity and mortality, yet discussions regarding end-of-life (EOL) preferences are often delayed or overlooked. Studies consistently demonstrate that many dialysis patients receive aggressive medical interventions during the final months of life without prior conversations regarding their goals and values. Although advance care planning (ACP) is widely recommended in nephrology practice, it frequently remains limited to completing advance directive forms rather than fostering meaningful dialogue. A recent randomized clinical trial by Song and colleagues published in JAMA Network Open (2024) highlights how structured communication interventions may improve preparedness for EOL decision-making among dialysis patients and their families.

In this pragmatic cluster randomized trial conducted across 42 dialysis clinics

in the United States, 426 patient-surrogate dyads were enrolled. Clinics were randomized to either the SPIRIT intervention (Sharing Patients' Illness Representations to Increase Trust) or usual care. The intervention consisted of structured, facilitator-guided discussions led by trained healthcare professionals such as nurses, nurse practitioners, and social workers. These sessions lasted approximately 45–60 minutes and focused on exploring patients' understanding of their illness, clarifying treatment goals, and preparing both patients and surrogate decision-makers for complex decisions regarding life-sustaining treatments. Usual care primarily involved routine counselling regarding advance directives.

The primary outcomes assessed at two weeks focused on preparedness for EOL decision-making and included patient-surrogate congruence regarding goals of care, patient decisional conflict, surrogate decision-making confidence,



and a composite measure combining dyad congruence with surrogate confidence. Secondary outcomes evaluated bereavement-related psychological distress among surrogates three months after the patient's death, including anxiety, depression, and post-traumatic stress. The SPIRIT intervention significantly improved agreement between patients and surrogates regarding EOL goals of care and reduced patient decisional conflict compared with usual care. The composite preparedness outcome also favoured the intervention group, although surrogate decision-making confidence did not differ significantly. Among bereaved surrogates, the intervention was associated with lower anxiety, while depression and post-traumatic distress were similar between groups.

These findings are consistent with earlier studies evaluating structured ACP interventions in advanced illness. Initial randomized trials of the SPIRIT intervention among dialysis patients demonstrated improved patient-surrogate communication and greater preparedness among surrogate decision-makers. Surrogates reported better understanding of patient values and less decisional burden following the patient's death. The present pragmatic trial extends these observations by demonstrating that such discussions can be successfully implemented across multiple dialysis units using routine staff rather than specialised research personnel. Similar observations have been reported in broader palliative care research, including the landmark randomized trial by Karen M. Detering and colleagues, which demonstrated that structured ACP improved concordance between patients' wishes and delivered care while reducing anxiety and stress among bereaved family members.

The importance of this study lies in its emphasis on communication rather than

documentation alone. Traditional ACP initiatives have largely focused on increasing completion of advance directives; however, documentation alone does not reliably translate into care aligned with patient preferences. Structured conversations involving both patients and their surrogate decision-makers appear to play a more meaningful role in guiding treatment decisions.

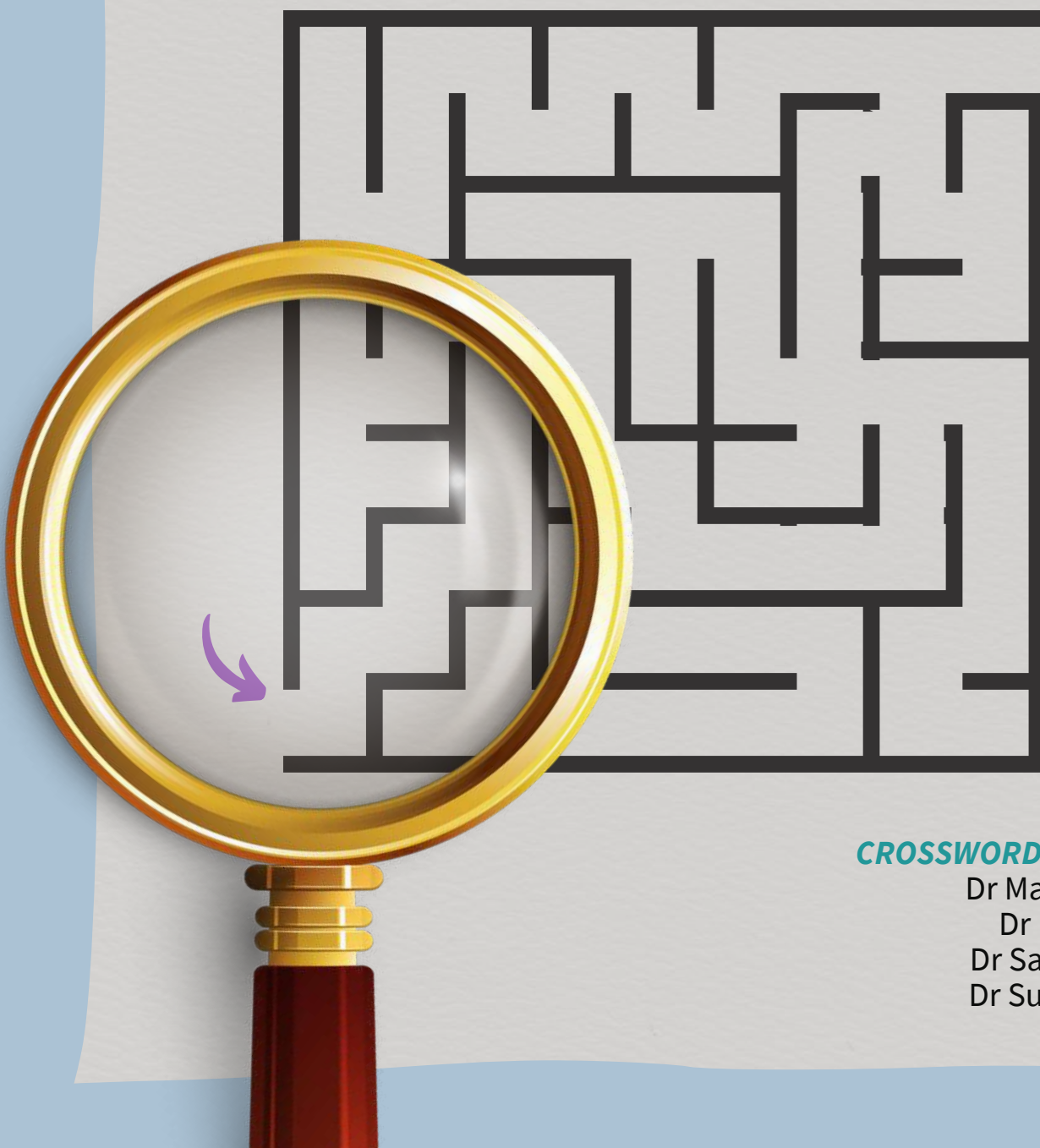
This perspective is particularly relevant in nephrology, where decisions regarding dialysis continuation or withdrawal often occur during episodes of clinical deterioration. Dialysis withdrawal accounts for a significant proportion of deaths among patients with end-stage kidney disease, particularly among elderly and frail individuals, and families are frequently required to make complex decisions under emotional stress.

The implications of these findings are especially relevant in the Indian context. In many dialysis units in India, formal advance directives are uncommon and discussions regarding treatment limitation are often initiated only during episodes of acute deterioration. Decisions are frequently made collectively by families, sometimes under considerable emotional and financial strain. Structured communication models such as SPIRIT may therefore help prepare patients and families for difficult decisions and ensure that treatment choices align more closely with patient values.

In conclusion, for nephrologists, advance care planning should extend beyond documentation of advance directives. Early, structured conversations that explore patient values and prepare families for future decisions are essential to ensuring that end-of-life care truly reflects what matters most to patients.

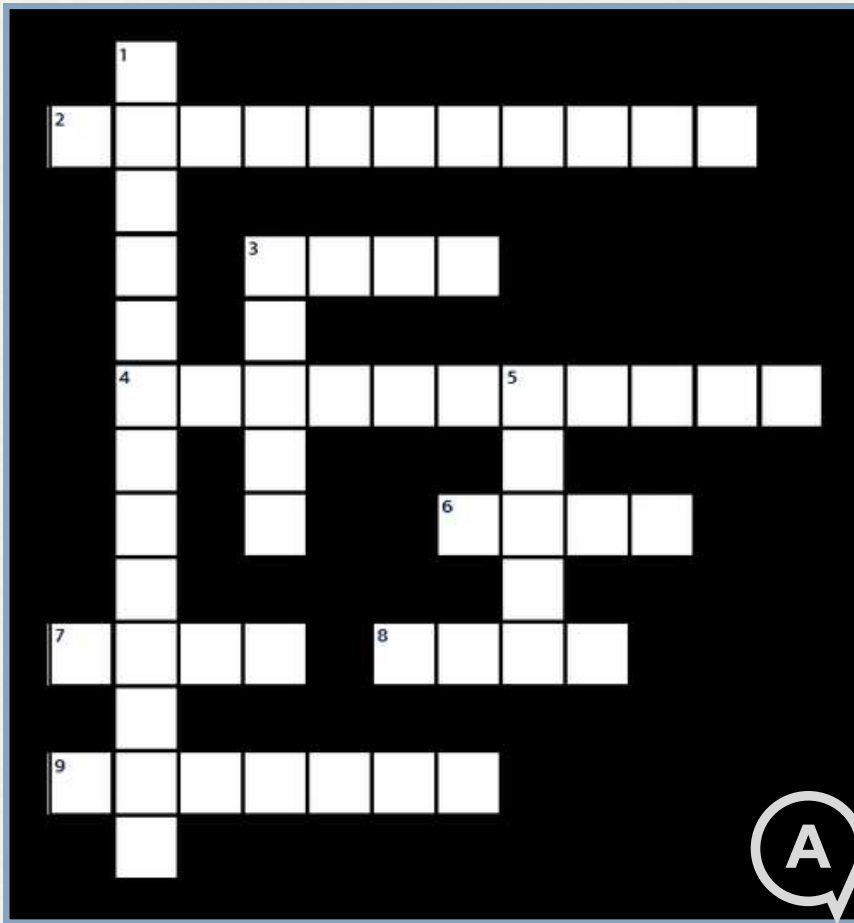
KIK Crossword

NEPHRO NUGGETS



**THE
CROSSWORD QUAD**

Dr Manusha
Dr Pallavi
Dr Sandhya
Dr Subashri



[Solve the
crossword
ONLINE](#)

**KK CROSSWORD
ANSWERS**
@ pg 29

ACROSS

- 2** This agent showed better renal outcomes in SURPASS-4 trial, on comparison with titrated insulin glargine
- 3** Acronym for a novel ecofriendly HD prescription studied in a pilot study in Madras Medical College to save water consumption in dialysis
- 4** PREVAIL is a phase 3 RCT evaluating this anti-CD38 monoclonal antibody in IgA nephropathy
- 6** GLP-1 receptor agonist should not be given in those with history of this syndrome
- 7** The FINE-ONE trial studied the effect of Finerenone on this end point in type 1 diabetes with CKD

- 8** This recent trial studied the role of hydration in prevention of urinary stones
- 9** This phase 3 study is evaluating the role of finerenone in non diabetic CKD

DOWN

- 1** Antibiotic to be started as oral prophylaxis when starting eculizumab in unvaccinated patients
- 3** This device has received FDA breakthrough device designation for implantable artificial kidney
- 5** Shimon Sakaguchi was awarded the 2025 Nobel Prize in Physiology or Medicine for the discovery of these cells in maintaining immune tolerance

Fungus Among the Filters

A RARE CASE OF RENAL HISTOPLASMA

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Histoplasmosis is a systemic fungal infection caused by the dimorphic fungus, *Histoplasma capsulatum*. It is often asymptomatic in immunocompetent individuals but presents with varied clinical presentations in solid organ transplant recipients. In transplant recipients, histoplasmosis is a rare but serious opportunistic infection, with most reported cases presenting as disseminated disease. Renal involvement is uncommon, and isolated histoplasmosis of the renal allograft is exceptionally rare. We present a rare case of solitary renal histoplasmosis.

A thirty-one year old gentleman underwent deceased donor ABO-compatible renal transplantation with kidney donor profile index (KDPI) of 84%. He underwent induction with methylprednisolone 1g and rabbit antithymocyte globulin (rATG) 1.5mg/kg and was initiated with tacrolimus, mycophenolate and prednisolone. In the peri-transplant period, the patient had delayed graft function, one episode of hypocalcemic seizure and lower respiratory infection, all of which settled by day 18, when he was discharged

with a serum creatinine of 2.0 mg/dl.

The patient was doing well until two months later, when he presented with asymptomatic rise in creatinine. On evaluation, he was found to have mild hydronephrosis of the graft kidney with normal renal artery doppler and acceptable tacrolimus trough level. The patient underwent perurethral catheterization, but subsequent days only showed further worsening of renal functions. Evaluation for cytomegalovirus, BK virus, Epstein-Barr virus, blood and urine cultures were all negative. The patient was administered pulse steroids for suspected T-cell mediated rejection, but had no improvement in graft function.

Following this, the patient had acute onset bilateral submandibular swellings along with fever and pancytopenia which was empirically treated with antibiotics (meropenem and clindamycin) suspecting Ludwig's angina. The patient improved clinically and pancytopenia also resolved, with this treatment. For the persistent graft dysfunction, he underwent renal biopsy which was suggestive of graft histoplasmosis with less than 5% interstitial fibrosis and tubular atrophy. Urine cytology showed fungal hyphae and urine histoplasma antigen was positive. He was started on intravenous amphotericin B at 3mg/kg for next 21 days.

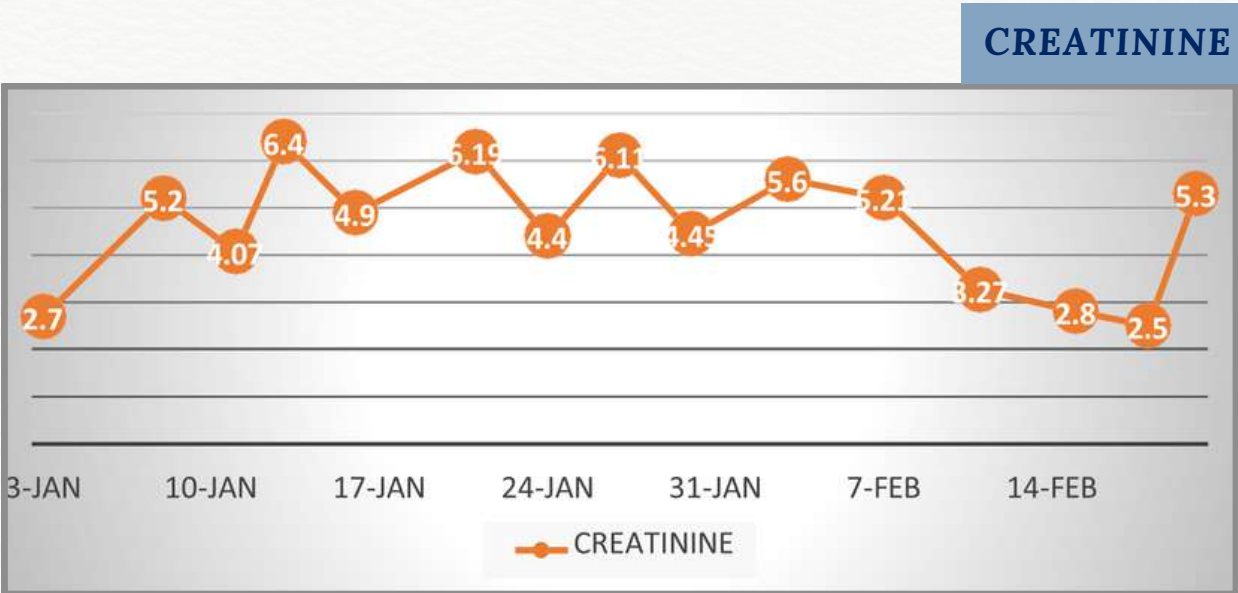
“ Fungus Among the Filters - A Rare Case of Renal Histoplasma ”

During subsequent hospitalization, the patient developed bilateral pneumonia and worsening graft dysfunction. The patient required intubation and mechanical ventilation, cotrimoxazole, vancomycin were added, and renal replacement therapy started. Recovery of pneumonia occurred over 3-4 days and repeat urine histoplasma

antigen turned negative. Despite other organ-system recovery, the patient still required hemodialysis twice weekly. Since then, the patient is on MHD 2/7 and itraconazole for histoplasmosis and doing well and his immunosuppression tapered to only low dose steroids now.

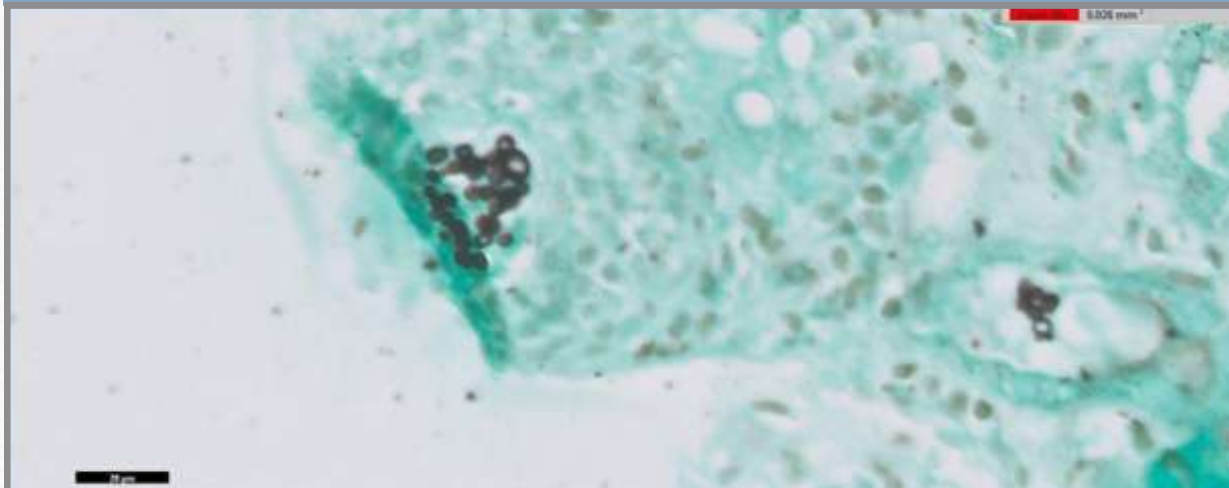


WBC

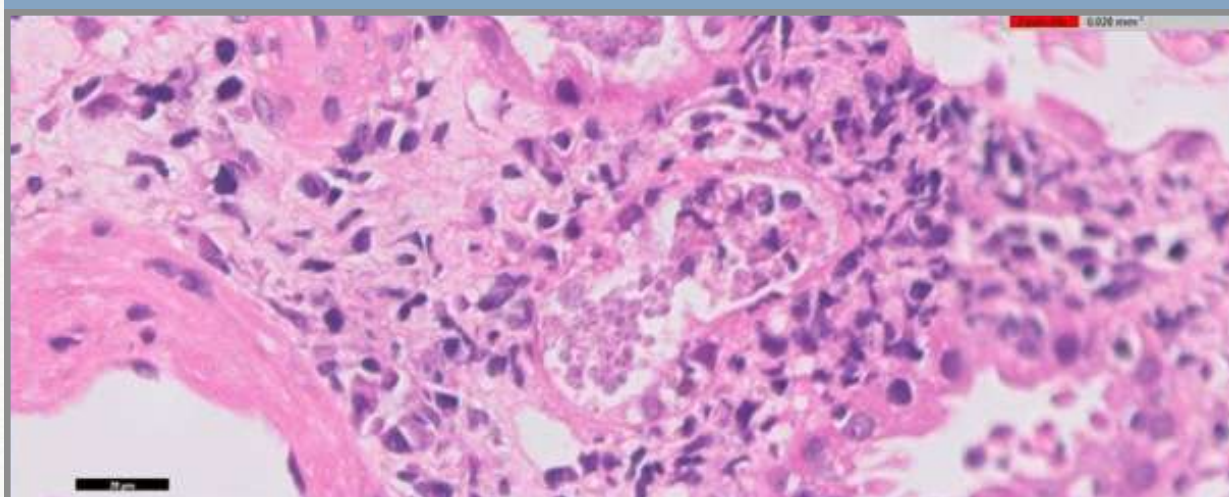


CREATININE

GROCCOTT'S STAIN SHOWING BUDDING YEAST IN HIGH POWER MAGNIFICATION



H&E STAIN SHOWING YEAST IN TUBULES



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Nephrotic Syndrome Unmasks Schimke's Immune-Osseous Dysplasia

REVEALING A HIDDEN DISEASE

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A 5 yr old female born of second degree consanguineous marriage, initially consulted a pediatrician with features of nephrotic syndrome and was started on prednisolone at a dose of 2mg/kg/day.

After four weeks of therapy, she presented with status epilepticus associated with severe hypertension and persistent proteinuria. She was managed with anti-epileptic medications and required four anti-hypertensive agents for blood pressure control. steroids were discontinued. MRI brain revealed reduced brain volume. In view of associated behavioural disturbances, psychiatric evaluation was sought and started on anti-psychotic agents.

The child failed to attain remission of nephro

-tic syndrome and was subsequently referred to the present for further management. On examination short stature was noted. In view of steroid resistant nephrotic syndrome (SRNS), a renal biopsy was performed which demonstrated collapsing variant of focal segmental glomerulosclerosis (FSGS) with 20% IFTA. Subsequently, she was initiated on tacrolimus and on maximum tolerated dose of ARBs and achieved partial remission.

Genetic analysis revealed a homozygous mutation in the SMARCA1 gene – classified as likely pathogenic, consistent with autosomal recessive inheritance and a phenotype suggestive of Schimke's immune-osseous dysplasia (SIOD). However, kyphosis, scoliosis, degenerative hip disease and corneal opacities were not detected.

One year later, her twin sister also presented with nephrotic syndrome, was diagnosed as steroid resistant, and was unresponsive to tacrolimus too. Renal biopsy in the sibling revealed FSGS-not otherwise specified type. Genetic testing similarly demonstrated a

Nephrotic Syndrome Unmasks
Schimke's Immune-osseous Dysplasia:
Revealing a Hidden Disease

homozygous SMARCAL1 mutation with an SIOD phenotype. She is currently being managed with maximum tolerated dose of ARBs.

Schimke immunoosseous dysplasia is an extremely rare hereditary disorder with an estimated prevalence of 1 in 1-3 million individuals. It is caused by biallelic pathogenic variants in the SMARCAL1 gene and follows an

autosomal recessive pattern of inheritance.

Phenotypically it is characterized by spondyloepiphyseal dysplasia (SED) resulting in short stature, nephropathy, and T cell deficiency. Radiographic manifestations of SED include ovoid and mildly flattened vertebral bodies, small ilia with shallow dysplastic acetabular fossae, and small deformed capital femoral epiphyses.

	TWIN 1	TWIN 2
Nephrotic Syndrome - SRNS	✓	✓
FSGS	✓	✓
Short Stature	✓	✓
Short Neck, Short Trunk, Depressed Nasal Bridge	×	×
Spondylo Epiphyseal Dysplasia (Avoid Vertebral Bodies, Degenerative Hip ds)	Avoid Vertebral Bodies	Avoid Vertebral Bodies
Scoliosis, Kyphosis	×	×
Developmental Issues	✓	×
T-cell Immunodeficiency	×	×
Neutropenia, Lymphopenia	×	×
Hypothyroidism	×	×
Transient Ischemic Attacks	×	×
Progressive Renal Failure	eGFR- 42ml/1.73min/m2 - CKD G3b	eGFR- 85ml/min/1.73m2 - CKD G2
Atherosclerosis	×	×

*Nephrotic Syndrome Unmasks
Schimke's Immune-osseous Dysplasia:
Revealing a Hidden Disease*

	TWIN 1	TWIN 2
Cerebral Infarction	×	×
Dental Manifestations	Tulip shaped molars	Tulip shaped molars
Corneal Opacities Lenticular Opacities Fundus	×	×
	×	×
	×	×
Migraine like Headaches	×	×
Lymphadenopathy	×	×
Hyper Pigmented Macules Over Skin	×	×
Recurrent Infections	×	×

Nearly all affected individuals have progressive steroid-resistant nephropathy, usually developing within five years of the diagnosis of growth failure and terminating with end-stage renal disease.

SIOD involves a spectrum that ranges from an infantile or severe early-onset form with a greater risk of death during childhood to a juvenile or milder later-onset form with likely survival into adulthood if renal disease is appropriately treated.

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Most tested individuals have T cell deficiency and an associated risk for opportunistic infection, a common cause of death.

While genetic evaluation is standard in SRNS, this case highlights how a common renal presentation can unmask a rare multisystem disorder like Schimke immuno-osseous dysplasia, with other extrarenal manifestations evolving over time.

2. Babaei AH, Inaloo S, Basiratnia M. Schimke immuno-osseous dysplasia: A Case report. Indian J Nephrol 2019;29:291-4

The CKDu AGRI Study

A CRITICAL APPRAISAL

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CKDu in India

Chronic Kidney Disease of unknown etiology (CKDu) is emerging as a significant cause of CKD in India, particularly among rural and agricultural communities. It accounts for 21% of patients in the Indian CKD Study and is the third most common cause of CKD nationwide. CKDu was first identified in the Uddanam region of Andhra Pradesh and later found in Tamil Nadu, Karnataka, Orissa, Chhattisgarh, and Maharashtra. Those most affected are from lower socio-economic backgrounds and are often exposed to heat stress, agrochemicals, and contaminated drinking water containing heavy metals – factors presumed to increase risk.

Rationale for the Study:

In 2021, our hospital registry data highlighted CKDu as a major contributor to CKD in districts of Tamil Nadu bordering Puducherry, with CKDu making up half of CKD cases at our center and over 40% of referrals from Villupuram, Cuddalore, Ariyalur, and Tiruvannamalai. However, hospital-based

studies can overstate the actual burden due to selection bias. Therefore, a population-based study using rigorous epidemiological methods was necessary to accurately assess CKDu prevalence and its associated factors in the region.

CKDu AGRI Study

To fill this gap, Prof. N Gopalakrishnan and colleagues at Madras Medical College conducted a comprehensive population-based study in Tamil Nadu, spanning five agroclimatic zones. In Phase 1, 3,350 participants involved in farming were recruited using stratified multi-stage cluster sampling. Researchers gathered demographic data, family histories, comorbidities, and environmental exposures, and tested blood and urine samples to estimate kidney function using the CKD-EPI 2021 equation. In Phase 2, three months later, 642 individuals (including 584 with low eGFR in Phase 1) were retested. Ultimately, 178 participants met criteria for CKD, while 406 who initially had low eGFR returned to normal levels, categorized as 'sub-clinical AKI.' CKD prevalence was calculated at 5.31%, with nearly half attributed to CKDu. The highest rates were in the northeast zone, which had a higher Universal Thermal Climate Index (UTCI). Older age, male sex, lack of education, anemia, and extended outdoor work were linked to CKDu.

Key Study Findings and Questions

1. The CKD prevalence found in this study (5.31%) is lower than most prior Indian and global reports. Worldwide, CKD prevalence is estimated at 9–13%, with higher prevalence in the South Asian region. A recent systematic review suggests rates in India are around 13.24%, with rural areas higher (15.34%) than urban (10.65%). Previous studies in Tamil Nadu and Andhra Pradesh reported CKDu prevalence up to 14%, and CKD rates as high as 19% in certain villages. Prevalence of CKD and CKDu reported from TN in earlier studies were all higher than reported in the CKDu AGRI study. O'Callaghan-Gordo et al reported the prevalence of eGFR<60ml/min to be 1.6% overall and 4.8% in Rural Southern India (TN and AP) after excluding people with DM, HT and heavy proteinuria, suggesting the prevalence of CKDu itself was 4.8%. The ICMR-INDIAB kidney sub-study reported low eGFR at 4.3% at TN, slightly higher than the national average of 3.2%, indicating the CKD prevalence in TN is higher than the national average. Given all these observations, the numbers reported in the CKDu AGRI study are surprising, and these findings require further validation and should not be considered definitive.
2. The study also identified 'transient subclinical AKI' in 12.1% of participants, where kidney function normalized on repeat testing. Earlier studies on AKI due to occupational heat exposure measured kidney function before and after shifts, whereas this study sampled participants

12–24 hours after potential exposure. The exact nature of farm work was not specified, and there was no data on urine concentration or dehydration symptoms. Furthermore, the frequency of transient AKI did not consistently match regional heat index data. For example, the frequency of AKI was highest in the Southern (22.7%) and Western (19.5%) zones. The UTCI was lower in the Western zone compared to the Southern and North-Eastern zones. Southern and North-Eastern zones have comparable UTCI. However, the frequency of AKI was similar between southern and western zones and much lower in the north-eastern zone, where the prevalence of CKDu was the highest. All these suggest that the explanation is still speculative and warrants further investigation.

Strengths of the Study

Despite the challenges in interpreting the findings, the study stands out for its ambitious scope and effective use of Tamil Nadu's public health infrastructure, enabling large-scale data collection on a limited budget. The study's design and execution were strong, and some ambiguities in results reflect the complex nature of CKDu rather than flaws in methodology.

The Way Forward

Current knowledge of CKD and CKDu epidemiology in India remains limited. Studying CKDu as a distinct entity is challenging without a universal definition. Systematic, nationwide studies on CKD, its risk factors, patient outcomes, and determinants are needed to better understand and address the CKD burden in India.

ACROSS

2 TIRZEPATIDE: In a post hoc analysis of the SURPASS-4 trial, which compared the effects of tirzepatide versus titrated insulin glargine, tirzepatide slowed the rate of eGFR decline (-1.4 versus -3.6 mL/min/1.73 m² per year) and reduced a composite kidney end point (time to first occurrence of eGFR decline of $\geq 40\%$ from baseline, ESKD, death from kidney failure, or new-onset macroalbuminuria) compared with insulin glargine (HR: 0.58, 95% CI: 0.43–0.83), respectively, during a mean treatment duration of 85 weeks. The reduction in eGFR decline with tirzepatide was more pronounced in trial participants with baseline eGFR < 60 mL/min/1.73 m²

3 HTLF: The primary outcome of adequate dialysis (spKt/V ≥ 1.2) was not significantly different between NTNF (normal temperature normal flow dialysate) prescription vs HTLF (High temperature low flow dialysate) prescription (70.14% vs 68.75% respectively, OR 1.07, $P=0.45$) indicating that reducing dialysate flow rate could be used as a water conservation strategy without compromising adequacy and safety in young hemodynamically stable patients

4 FELZARTAMAB: It targets CD38-positive plasma cells and is being studied in the PREVAIL trial for its potential to reduce proteinuria and preserve eGFR in IgA nephropathy, following promising results from the phase 2 IGNAZ study

1 CIPROFLOXACIN: As per guidance for developing countries, patients who are unvaccinated or incompletely vaccinated for meningococcus at initiation of eculizumab should receive 2 weeks of iv prophylaxis with ceftriaxone or oral prophylaxis with ciprofloxacin before being shifted to long term prophylaxis with azithromycin or penicillin V or erythromycin

3 HOLLY: The FDA has granted breakthrough device designation to this continuous renal replacement device currently being tested in animals. This will pave the way forward for first in human clinical trials for safety /efficacy in the

6 MEN2: GLP-1 receptor agonists can cause proliferation of C cells in medullary carcinoma of thyroid and are hence contra-indicated in those with history of MEN2a or MEN2b

7 UACR: In this phase 3 trial in patients with type 1 diabetes, CKD (eGFR 25 to < 90 mL/min/1.73m²) and albuminuria (UACR 200 to < 5000 mg/g) on ACEI/ARB, Finerenone was associated with 25% greater UACR reduction (geometric mean ratio from baseline Finerenone vs placebo 0.75, 95% CI 0.65 to 0.87, $P<0.01$)

8 PUSH: This trial studied the role of multicomponent behavioural intervention to improve fluid therapy vs standard of care in patients with urinary stone disease and low urinary volume. There was no difference in recurrence of urinary stones at 2 years follow up between intervention and control arms

9 FINDCKD: This double blind placebo controlled RCT is studying the role of finerenone in adult patients with CKD with a urinary albumin:creatinine ratio (UACR) ≥ 200 – ≤ 3500 mg/g and an estimated glomerular filtration rate (eGFR) ≥ 25 – < 90 mL/min/1.73 m². Although results have not yet been published, the sponsor announced in a recent press release that Finerenone has met its primary endpoint in the trial demonstrating a statistically significant improvement vs. placebo in the estimated glomerular filtration rate (eGFR) slope from baseline to Month 32

future. It is an investigational device NOT meant for commercial use at this time.

5 TREGS: SHIMON SAKAGUCHI was awarded the 2025 Nobel Prize in Physiology or Medicine for his pioneering identification of regulatory T cells, which function as “security guards” of the immune system by suppressing excessive immune responses and preventing autoimmunity. He shared the prize with Mary Brunkow and Fred Ramsdell for their complementary work on peripheral immune tolerance and Treg biology.

DOWN