Nephrology Times

Practical News, Trends, and Analysis

June 2026

VOLUME 18, NUMBER 5

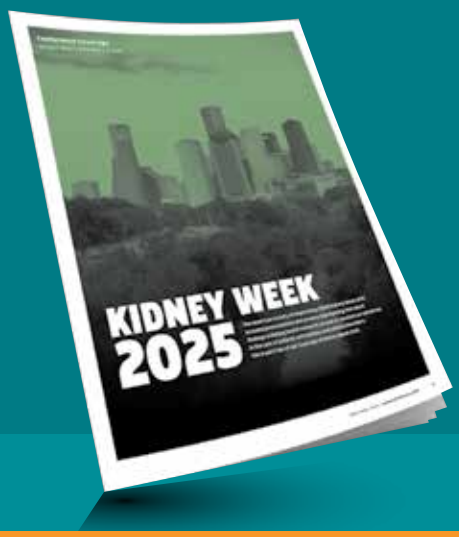
How climate change is affecting kidney health p10

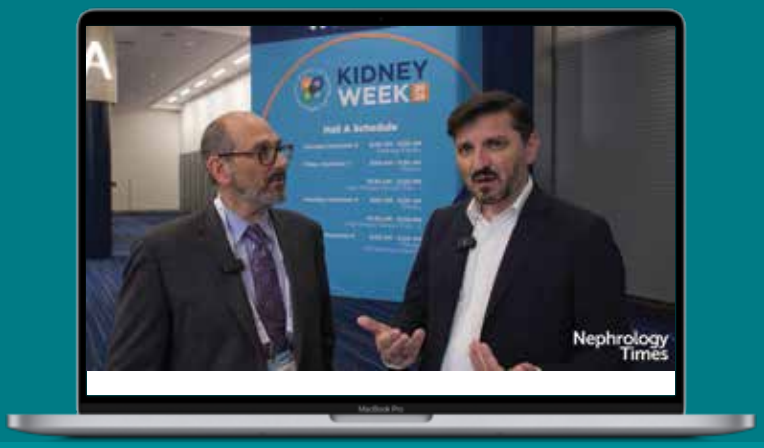
THE HEAT IS ON

PLUS...

CONFERENCE HIGHLIGHTS–

ON THE PAGE AND ON THE GROUND





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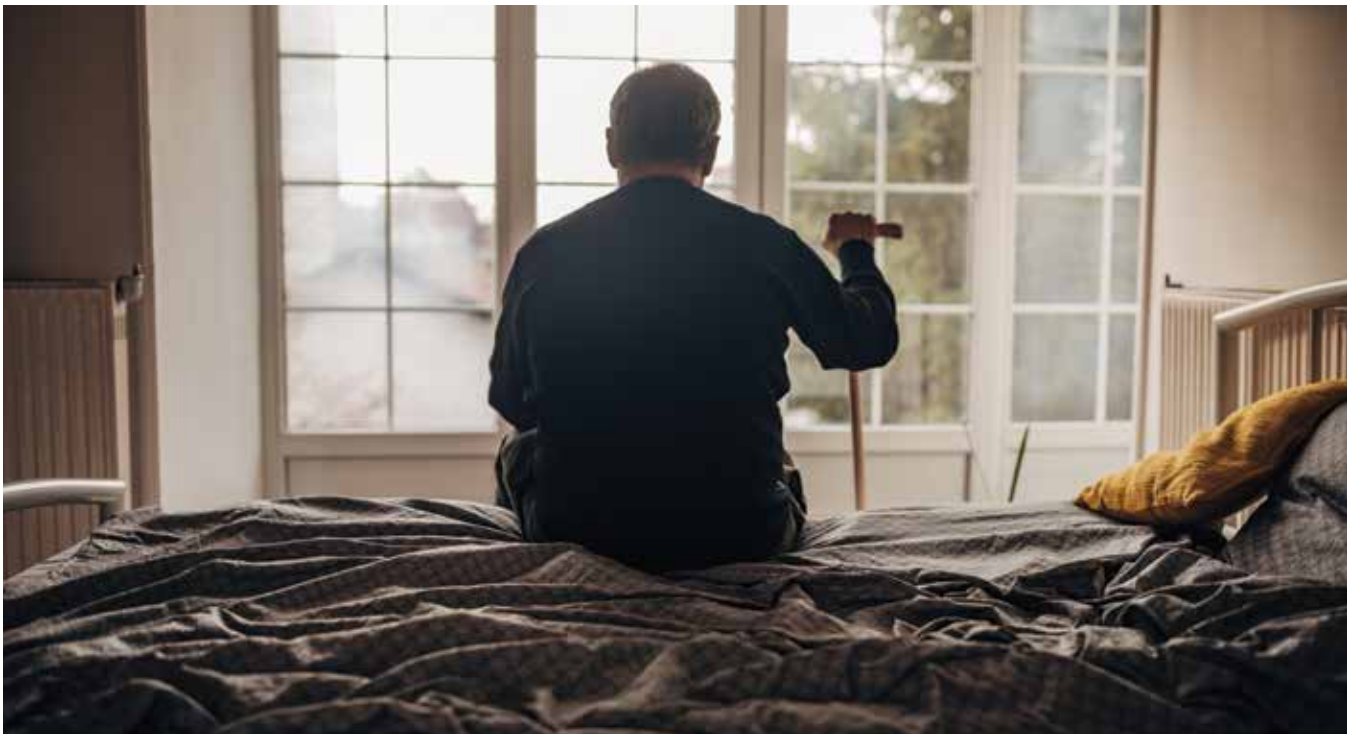
CONFERENCE COVERAGE

WORLD CONGRESS OF NEPHROLOGY 2026

The World Congress of Nephrology is the annual scientific, educational, and networking meeting that features regionally relevant symposia, presentations, training programs, and courses, offering the latest science and state-of-the-art education in nephrology.



Breaking the Silence on a Hidden Burden

Depression in CKD and the need for integrated care

Jami S. Brown,
DHEd, MSN, RN, CNN

*By **Jami S. Brown, DHEd, MSN, RN, CNN***

Chronic kidney disease is a significant and growing public health challenge, affecting millions of people worldwide and burdening patients, families, and healthcare systems.[1] Although clinical management has traditionally focused on slowing disease progression and managing physical complications, the role of mental health in patient outcomes is increasingly recognized. In particular, depression has emerged as a common yet often underrecognized condition that can profoundly influence the trajectory of chronic illness.[2]

Common Conditions With a Complex Link

CKD is defined as abnormalities in kidney structure or function that persist for more than 3 months and have adverse health implications. The CDC estimates that more than 1 in 10 adults, approximately 37 million individuals, in the United States have CKD. Notably, 9 out of 10 individuals with CKD are unaware of their condition, and 40% of those with severely reduced kidney function who are not on dialysis remain undiagnosed.[3]

Depression is one of the most common mental health conditions worldwide, affecting an estimated 332 million people. Approximately 5.7% of adults worldwide experience depression (4.6% of men and 6.9% of women).[4] Characterized by persistent sadness, hopelessness, and loss of interest in daily activities, depression may be long-lasting or recurrent and can significantly impair an individual's ability to manage their health, maintain relationships, and engage in treatment.[5]

Depression affects approximately 23.7% of individuals with CKD. The relationship between depression and CKD is complex and bidirectional. Depression may contribute to the development and progression of CKD by promoting adverse health behaviors, including smoking, physical inactivity, and obesity. These behaviors can worsen underlying conditions such as diabetes and hypertension, which are primary risk factors for CKD. Depressive symptoms are also more common among individuals with diabetes, further compounding risk.[6]

Patients with CKD face significant physical and treatment-related burdens that contribute to depression. Uremic symptoms, dialysis-related effects, and medication side effects, such as gastrointestinal

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discomfort from phosphate binders, are often linked to increased psychological distress. As CKD progresses, the prevalence of depression rises, with higher rates observed in patients receiving dialysis (34.5%).[7] The cumulative burden of chronic illness, complex treatment regimens, and lifestyle disruptions further increases vulnerability to depression.

Importantly, depression in CKD is associated with increased mortality and should not be viewed merely as a comorbidity. Rather, it is a critical factor that influences treatment adherence, quality of life, and overall clinical outcomes. Approximately 25% of patients with CKD report symptoms consistent with major depressive disorder, and many remain undertreated.[8] Patients with depressive symptoms are more likely to miss dialysis treatments, demonstrate poor medication adherence, and engage less effectively in self-management behaviors. Depression has also been linked to adverse outcomes, including increased hospitalizations, acute kidney injury, CKD progression, and cardiovascular events.[9,10]

The relationship between depression and CKD further complicates care. As physical health declines, psychological distress may intensify. Conversely, untreated depression can adversely affect physiologic outcomes and disease management. Recognizing and addressing depression is therefore essential to delivering holistic, patient-centered nephrology care. Routine screening, early identification, and timely intervention are key strategies for improving mental health and clinical outcomes, reinforcing the critical role of nephrology nurses in comprehensive patient management.[11]

Depression Screening and Management

Screening is critical for individuals with CKD because of the strong association between depression, poor clinical outcomes, and reduced quality of life. Screening should begin at the time of CKD diagnosis and continue periodically throughout the disease course. Although the CMS does not mandate a specific screening instrument, the tools used must be validated for depression to ensure accurate assessment.[12] Commonly used tools include the Patient Health Questionnaire-9 (PHQ-9), the Beck Depression Inventory (BDI), and the Hamilton Depression Rating Scale.[13]

Managing depression in patients with CKD requires a multifaceted approach. Cognitive-behavioral therapy and pharmacologic treatment may be appropriate, depending on symptom severity. In addition, nonpharmacologic interventions play a vital role in symptom management. Techniques such as deep breathing, meditation, yoga, progressive muscle relaxation, guided imagery, and mindfulness can reduce stress and anxiety. Support from family, friends, and support groups helps alleviate isolation, while regular physical activity improves mood and overall health.[12] Patient education that enhances understanding of CKD and self-management strategies further supports improved outcomes. Collectively, these interventions can reduce depressive symptoms, enhance coping, and improve adherence, quality of life, and clinical outcomes.[13, 14]

An Essential Part of CKD Care

Depression in CKD is common and consequential, yet it remains underrecognized and undertreated. Its impact extends beyond emotional well-being, affecting treatment adherence, quality of life, healthcare utilization, and overall clinical outcomes. Nephrology nurses are uniquely positioned to identify early signs, implement routine screening, and advocate for timely, evidence-based interventions.

Depression in CKD is common and consequential, yet it remains underrecognized and undertreated.

Integrating mental health assessment into standard CKD care is essential to comprehensive, patient-centered care. A proactive, interdisciplinary approach that integrates routine screening, patient education, and pharmacologic and nonpharmacologic interventions can significantly improve patient outcomes. By prioritizing mental health alongside physical health, clinicians can enhance coping, strengthen engagement in care, and reduce disease burden. Addressing depression is a critical step toward improving the lived experience and long-term outcomes for individuals with CKD. ●

Jami S. Brown is an associate professor and traditional BSN concentration coordinator at the University of Tennessee Health Science Center, College of Nursing, in Memphis, Tennessee.

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Pragmatic Trials and Nephrology

*By **Charlotte Robinson***

Laura M. Dember, MD

Laura M. Dember, MD, is a nephrologist and professor of medicine and epidemiology at the University of Pennsylvania Perelman School of Medicine in Philadelphia. As a clinical investigator, she focuses on chronic kidney disease and end-stage renal disease and has advocated for the potential of pragmatic trials in nephrology.

In a recent publication in the *Journal of the American Society of Nephrology,* she offered her thoughts on how approaches to pragmatic trials could evolve to increase their value, using examples from pragmatic trials in nephrology. In this conversation with *Nephrology Times,* Dr. Dember explains what pragmatic trials are, their relevance to nephrology, and their promise and limitations.

This transcript has been edited for length.

What are pragmatic trials?

Pragmatic trials are clinical trials that use rigorous methods such as randomization and have the goal of trying to understand whether a particular treatment or an intervention strategy works in the real-world setting. In contrast, more conventional clinical trials, often referred to as *explanatory trials*, evaluate interventions under carefully controlled conditions with substantial attention by the research team to maximize fidelity of the intervention and follow-up. In reality, most trials are neither fully pragmatic nor fully explanatory. A trial may have some features that are pragmatic and some that are not. And this is a good thing, since trials should be designed to be fit for purpose.

Why is there interest in pragmatic trials?

There are two major reasons for the recent interest in pragmatic trials. One is that the results of a highly pragmatic trial should reflect what will happen if the intervention is used in the real world outside of the trial setting. If the intervention shows benefit in the trial, it is reasonably likely to also show benefit when used outside the trial.

The second reason for interest is that because pragmatic trials leverage the clinical care infrastructure, rather than requiring a separate research infrastructure, the costs for conducting the trial should be substantially lower than those for a more conventional clinical trial. Given the always present limitations on resources for funding research, the relatively low cost of conducting pragmatic trials is highly appealing.

Why are pragmatic trials relevant to nephrology?

We have a lot of questions in nephrology about fundamental aspects of care and about practices that are employed day in and day out but are not based on great evidence to guide the care we deliver or the decisions we make. Pragmatic trials can help to answer these types of questions. Pragmatic trials are generally most appropriate for evaluating treatments that are already in widespread use by practicing clinicians rather than for evaluating new therapies that are not yet part of routine clinical care. A new drug, for example, usually requires a trial that is conducted under very carefully controlled and monitored conditions.

What are the downsides of pragmatic trials?

The objectives of pragmatic trials are very compelling, but trials that are highly pragmatic can be challenging to carry out because the investigators have less control than they do in a more conventional trial that relies on a research infrastructure for trial implementation. Because of the "messier" implementation of the intervention and also because of the broad eligibility criteria and resulting heterogeneity of the trial cohort, the magnitude of the effect size observed in pragmatic trials tends to be smaller than in explanatory trials. As a result, sample sizes for pragmatic trials usually need to be quite large.

Another challenge with pragmatic trials can be limitations of data collected as part of clinical care rather than through a standardized protocolized process. These challenges can often be addressed analytically but also require careful planning and thought. Working closely with the health system or care setting in which a pragmatic trial is embedded to ensure that the trial activities do not disrupt the workflow of the on-the-ground clinicians implementing the intervention is important when planning a pragmatic trial and requires ongoing efforts throughout the conduct of the trial because changes to care processes or competing initiatives implemented by health systems are common and may have important implications for delivery of the intervention.

When a pragmatic nephrology trial is neutral or negative, how should clinicians interpret that?

For all clinical trials, whether highly pragmatic or highly explanatory, if a result is null or negative, one needs to think about the underlying reasons. The reasons might (or might not) differ across these trial types. For a pragmatic trial with a null result, I would ask the question, "Was the result null because the intervention truly does not have benefit, or did the null finding result from challenges with implementing the intervention with sufficiently high fidelity?"

Null results are common in clinical trials regardless of whether they are pragmatic or explanatory, but the underlying reasons for the null result might be different. The challenge is in drawing appropriate interpretations of the observed null finding. ●

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Scan the code to read the full conversation with Dr. Dember.

The Case for "Good Enough" Kidneys in Older Adults

A recent study supports the clinical benefit and cost-effectiveness of transplants using less than perfect kidneys.

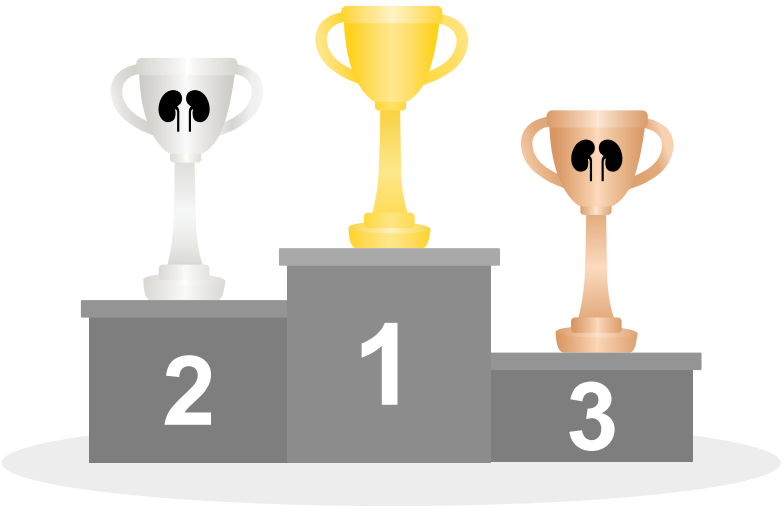
*By **Anna Gaddy, MD***

Call me Midwestern, but discussions about money always make me squirm. Never is that truer than when discussing the cost of healthcare. My discomfort notwithstanding, the economic impact of kidney transplants drives not only insurance coverage but the successful outcomes of transplant programs and patients. Nationally and internationally, more older adults (age >65 years) than ever are receiving kidney transplants,[1,2] and their health outcomes have been impressive on the whole.[3] The time was right for a study of how all this shakes out from a cost-benefit perspective.

Anna Gaddy, MD

The study *Cost-Effectiveness of Acceptable-Quality Deceased Donor Kidneys for Transplant in Older Candidates* by **Matthew Kaufmann, PhD,** and colleagues uses a microsimulation tool the authors developed previously,[4] which used Scientific Registry of Transplant Recipients (STTR) data to simulate life expectancy gains from allocating kidneys of lower quality (called *acceptable quality* in the current paper) across different age groups. When initially published, this tool was used to demonstrate a marked survival benefit to transplantation with acceptable quality organs in older adults compared with remaining on the waitlist.

The study published in *JAMA* uses this tool on a *synthetic cohort*—I like this phrase very much—of older adults who were on the transplant waiting list from 2010 to 2019 and data from the remainder of their lifetimes. The researchers simulated the effect of increasing the rate of transplantations in this cohort from 5% to 22% in small increments and derived health-related quality-of-life (HRQOL) weights. They concluded that not only does transplantation with acceptable quality kidneys improve quality of life for older adults, it does so at a cost of just over $8,000 per quality-adjusted life year at the highest rate of transplant increase. It's also critically important to note that, at higher rates of transplant, the risk for delayed graft function stayed status quo (after a small initial bump at 5%).



This study reinforces what we intuitively know to be true: older patients do well with organs of decreased quality. More importantly, it demonstrates that this resource-saving and life-improving change can be made without excess burden on the existing system of payment and organ allocation. I hope that transplant centers are heartened by this study and emboldened to implement these changes. ●

Anna Gaddy, MD, serves on the Nephrology Times *editorial board and is an associate professor of medicine at the Medical College of Wisconsin.*

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Azathioprine Linked to Increased Skin Cancer Risk in Organ Transplant Recipients

*By **Allison Casey** and **Charlotte Robinson***

Clinicians should be aware of the high skin cancer risk among organ transplant recipients treated with azathioprine, according to the authors of a meta-analysis published in *Cancer Reports.* **Amir Mohammad Salehi, MD, MPH,** and colleagues in Iran reported a heightened risk of both squamous cell carcinoma (SCC) and nonmelanoma skin cancer (NMSC) in this population.

The analysis evaluated data from 21,405 patients from 27 primary studies examining the skin cancer risk among transplant recipients treated with azathioprine. Studies were identified through searches of PubMed, Scopus, and Web of Science conducted through November 2025. Eligible studies evaluated the risk for developing skin cancer among patients treated with azathioprine, reported using odds ratios (ORs), relative risks (RRs), or hazard ratios (HRs), each with corresponding 95% CIs.

Azathioprine, a nonsteroidal immunosuppressive medication, is widely used to prevent rejection, particularly following kidney transplantation. Organ transplant recipients are already known to experience higher rates of skin cancer, especially SCC, than the general population. As a result, skin cancer represents a major contributor to mortality among transplant recipients.

When detected early, outcomes for SCC and basal cell carcinoma (BCC) are generally favorable. Earlier meta-analyses linked azathioprine specifically to increased SCC risk but did not show significant associations with BCC or NMSC overall.

In pooled analyses, azathioprine exposure was associated with increased NMSC risk across multiple statistical measures.

Summary estimates were 1.83 based on ORs, 2.09 based on RRs, and 1.12 based on HRs. When results were stratified by skin cancer subtype, statistically significant associations were observed between azathioprine use and SCC, including an OR of 2.67, an RR of 2.59, and an HR of 1.26. In contrast, the researchers identified no significant relationship between azathioprine and BCC across any estimate type.

Additional subgroup analyses examined the impact of different immunosuppressive regimens. Single-drug azathioprine therapy was significantly associated with NMSC based on OR and RR estimates. For triple-drug regimens, significant associations were observed using RR and HR estimates, whereas dual-drug regimens were not significantly associated with NMSC under any statistical measure. Leave-one-out sensitivity analyses confirmed that the overall findings remained consistent and were not disproportionately influenced by individual studies.

In conclusion, the authors wrote, "Our findings indicate that OTRs [organ transplant recipients] treated with AZA [azathioprine] are at an increased risk for SCC and NMSC. Therefore, it is recommended to prioritize monitoring for skin cancer in OTRs treated with AZA." ●

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How do you foster strong communication within a multidisciplinary care team?

"Communication strategies are best facilitated using a point person to serve as the liaison between several aspects of team care. This helps streamline communication and facilitates direct contact with patients, without the need for navigating a fragmented and complex healthcare system. Several health systems are now piloting simultaneous visits coordinated between several specialists on a given day to ensure quick and holistic decision-making in a patient-centered fashion. Finally, the expansion of telehealth-based resources provides opportunities to create touchpoints and communication between smaller/rural centers with larger tertiary care centers to deliver specialty care equitably in resource-challenged areas."

Janani Rangaswami, MD
George Washington University and Washington DC VA Medical Center
X: @RANGASWJ

"Superior patient care is only possible when every team member feels safe and comfortable speaking up—questioning decisions, sharing concerns, and advocating without fear. Each person brings a critical and important viewpoint; whether it's a nurse, pharmacist, fellow, dietitian, social worker, or technologist, their perspectives matter. Fostering strong communication within a multidisciplinary care team starts with leadership that intentionally builds a culture of trust by creating space for honest dialogue, listening well, and showing that every voice actually counts."

Jeffrey Perl, MD
St. Michael's Hospital, University of Toronto
X: @PD_PERLS

"Strong communication between team members may be fostered by initiating dialogue via messages sent via online patient portals, text messaging systems, or direct dialogue via telephone or in person. The more communication there is between the multidisciplinary team members, the more patients and providers will have a sense of satisfaction and agreement regarding treatment plans. Strong patient-centered communication practices that should be used by all members of the multidisciplinary team include structured shared decision-making about treatment options and modalities; real-time data sharing that allows interdisciplinary teams to review clinical values and patient-reported outcomes; and developing shared treatment plans among multiple specialty providers."

Kelly Liang, MD
University of Kansas Health System
HTTPS://WWW.DOXIMITY.COM/PUB/KELLY-LIANG-MD

"I foster strong communication by being accessible and responsive to members of the care team to help build trust and ensure our care plans are aligned and informed by each other. For particularly complex cases, such as a systemic lupus erythematosus patient involving obstetrics, rheumatology, cardiology, and nephrology, I find that multidisciplinary discussions or meetings are often the most effective way to align care. For asynchronous communication through the EHR, I always ensure that my documentation clearly outlines my clinical reasoning, plan, and any specific questions for the care team." ●

Fahmeedah Kamal, MD
Stanford University
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THE HEAT IS ON

How climate change is affecting kidney health

*By **Mary West***

Due to the increasing effects of climate change, hot weather poses a greater threat to public health than ever before. Exposure to rising temperatures speeds deterioration of kidney function that can culminate with CKD.

"As extreme heat events become more frequent and intense, the scale of heat-related kidney disease is likely to grow," **Katherine Barraclough, MD,** told *Nephrology Times.* Dr. Barraclough is a nephrologist at the Royal Melbourne Hospital in Australia and associate professor in the School of Medicine at the University of Melbourne.

"In terms of the magnitude of the problem, reliable global prevalence estimates are difficult to obtain because heat-related kidney injury often goes unrecognized and surveillance is limited in many of the regions most affected," she said. However, although estimates suggest that hundreds of thousands of people worldwide may be affected, the true number is likely much higher, Dr. Barraclough added.

Statistics suggest a strong association between acute kidney injury (AKI) and heat-related illnesses. A UK study shows that a 7-day heatwave in 2021 was linked to a 28.6% rise in AKI. Other research indicates that AKI is present in 91% of exertional heatstroke cases and suggests that less severe maladies, such as heat exhaustion, also may lead to AKI. Another investigation shows that the likelihood of having an AKI episode is higher at a temperature of 89.6 °F compared with 62.6 °F. [1]

Aside from being associated with AKI, heat is related to the formation of kidney stones, Dr. Barraclough said. She cited an analysis that predicts the US could see an additional 1.6 to 2.2 million lifetime cases of nephrolithiasis by 2050.[2]

Certain segments of the population are especially vulnerable to heat-related illnesses, including older adults, young children, those lacking access to air conditioning, and those with chronic illnesses. Even people who are healthy but engage in sustained or vigorous activity outdoors—such as construction workers, farmers, athletes, and members of the military—are at a higher risk.

"Repeated exposure to very hot temperatures can absolutely cause AKI in someone without any other risk factors or previous kidney problems," **Karen Papez, MD,** director of Pediatric Critical Care Nephrology at Phoenix Children's Hospital in Arizona, explained in an interview. "When episodes of AKI happen close together, before the kidneys have fully recovered at a cellular level, it can cause chronic inflammation. This can progress to chronic kidney disease and even permanent kidney failure."

As evidence mounts on the broad scope and serious nature of the effects of global warming on kidney health, nephrologists are examining the underlying mechanisms involved and proposing means of mitigation. Addressing the problem requires a multifaceted approach, including clinical practice interventions, hospital preparations for heatwaves, and advocacy.

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Underlying Mechanisms

The kidneys are uniquely susceptible to the effects of heat for several reasons. Dehydration causes the urine to become concentrated, an effect that decreases the glomerular filtration rate (GFR), with the most rapid declines correlating with the highest heat exposure. In fact, even among patients with modest CKD, hot weather can impair this function. One analysis shows that an additional annual GFR loss of 3.7 mL/min/1.73 m² occurs in hot temperatures.[1]

Moreover, when body temperatures rise, more blood flows away from internal organs to the skin to promote cooling, resulting in reduced perfusion to the kidneys and resulting in tissue hypoxia injury.[3] Also, hyperthermia and dehydration boost energy demands, increasing the body's efforts to conserve electrolytes and fluids. This puts additional strain on the kidneys and may lead to kidney damage.[3]

Interventions for Clinical Practice

"Extreme heat should be considered a modifiable risk factor for kidney injury," **Pranav Garimella, MBBS, MPH,** chief medical officer at the American Kidney Fund, told *Nephrology Times.* "As temperatures continue to rise, both clinicians and patients need to treat heat exposure with the same seriousness as other established stressors for the kidneys. The encouraging message I can provide is that many heat-related kidney injuries are preventable."

The following interventions can help protect patients and optimize outcomes.

Patient Counseling

Counseling about the effects of high temperatures on CKD progression should focus on the following areas[4]:

- ***Hydration:*** Replacing fluids lost through perspiration can help prevent some of the harmful effects of heat by reducing sodium reabsorption in the kidneys. It can also preserve kidney perfusion by helping to maintain plasma volume and lowering core temperature. "For individuals with established CKD, avoiding heat-related volume depletion may be as important as pharmacologic therapies in slowing disease progression," said Dr. Barraclough.

- ***Rest and Shade:*** Rest lowers metabolic heat production, and shade decreases exposure to the sun and fosters heat dissipation in the environment. Outdoor workers should be advised to avoid payment systems involving piece-rate compensation, which incentivizes overwork. Cooling approaches—such as ice slurry or cold-water ingestion, cooling vests, and wind/skin wetting techniques—may help prevent hyperthermia in athletes, but these approaches are not always feasible for outdoor workers.

- ***Heat Acclimation:*** To some extent, outdoor workers may adapt to a hot environment over time. Repeated heat exposure can lead to physiologic adaptations for improving temperature regulation, such as a lower core body temperature and a higher perspiration rate. However, these adaptations may not be sustainable over the long term because they can increase the risk for AKI.

- ***Nutritional Supplementation:*** Decreased blood flow to the kidneys due to physical exertion in heat can result in kidney hypoxia and ischemia, which generate reactive oxygen species that can harm tubal cells. Adding antioxidants to beverages may help prevent AKI worsening from this cause, but more research is necessary to verify the benefit.

- ***Recognize Signs of Heat Illness:*** If patients with AKI or CKD know the signs and symptoms of heat-related illness, they are more likely to engage in remediation measures when they become overheated and seek prompt medical attention.

Risk Stratification

Despite expanding evidence of the link between heat exposure and kidney health, the nephrology community has not fully incorporated environmental stressors into guidelines and risk models. Yet more endeavors in this area can help. Just as pulmonary physicians consider exposure to environmental allergens when making patient care plans, nephrologists can incorporate heat stress into risk stratification to optimize kidney disease treatment.

Factors that increase risk include older age, dehydration, and comorbidities that tax the kidneys, making them less able to tolerate high temperatures.[5] Estimating heat stress also involves consideration of indoor and outdoor temperatures and humidity in addition to direct sunlight exposure and contact with hot surfaces. Other relevant factors include fluid access, work intensity, and type of clothing worn because some garments can trap heat.

> "As temperatures continue to rise, both clinicians and patients need to treat heat exposure with the same seriousness as other established stressors for the kidneys."

Medication Review

The widespread use of medications including nonsteroidal anti-inflammatory drugs, metformin, antibiotics, diuretics, and sodium-glucose cotransporter 2 inhibitors can contribute to drug-induced nephropathy. The repeated use of medications with harmful effects on the kidneys accounts for 20% of all causes of kidney toxicity.[5] Their use can cause direct tubular injury, resulting in cellular damage, acute tubular necrosis, and obstruction due to crystalline precipitation. In addition, chemotherapeutic agents, quinine, antiangiogenic agents, and gemcitabine can compromise renal perfusion, impair glomerular filtration, and induce thrombotic microangiopathy, leading to kidney injury.

Such adverse effects highlight the need to review a patient's medication regimen more frequently during hot conditions to determine the need for dosage adjustments or changes to alternative drugs that do not impair thermoregulation.

Comorbidity Management

Management of comorbidities that affect kidney health—including diabetes, hypertension, and obesity—is vital. Diabetes interferes with the body's ability to maintain an optimal temperature because it compromises the main mechanisms of heat loss and affects the nerves that facilitate involuntary function, including thermoregulation. Hypertension constricts blood vessels throughout the body, including the kidneys, reducing blood flow. Obesity lowers the body's capacity to dissipate heat, an effect that raises the risk for heat-related illnesses and their consequences, such as kidney disease.

Close Oversight

Patients with AKI face dangers from hot weather that necessitate closer clinical oversight during heatwaves. This involves updating care plans, using telehealth check-ins, and having tighter monitoring windows.

Hospital Preparation Strategies

The Texas Hospital Association provides the following recommendations for hospitals to take when preparing for heatwaves[6]:

- Devise plans to address heat-related illness during power outages and conduct regular drills to promote efficient response in a crisis.
- Establish infrastructure in facilities to ensure staff and patient comfort, including power generators, alternate cooling systems, and temperature-monitoring tools.
- Educate staff on the dangers of extreme heat and train them to recognize symptoms of heat-related illness.
- Use innovative technology to monitor the vital signs and temperatures of patients to foster prompt intervention when needed.
- For high-risk patients, designate cool zones within the hospital, equipped with water dispensers, air conditioning, and fans.
- Launch public awareness campaigns to spread information on heat safety.

Advocacy

Dr. Barraclough believes the kidney community has an important role to play in advocacy for occupational safety and climate safeguards.

Occupational Safety Advocacy

Advocacy for occupational safety includes promoting improved access to cooling, water, and shaded rest for outdoor workers. An example reported by the International Labor Organization offers some evidence that such measures can make a significant difference.

A program founded in Central America in 2017 provides safer conditions for sugarcane workers who face very high temperatures and their consequences. It involves mandated access to water and restrooms and the provision of work breaks in mobile tents for shaded rest throughout the day. In its first 3 years, the program resulted in a 94% drop in AKI due to exposure to excessive heat, along with a 10% to 20% increase in productivity.[7]

> "Kidney health and planetary health are closely interconnected, and progress in one will increasingly depend on advances in the other."

Advocacy for Climate Safeguards

Advocacy must extend to the root cause of the problem, global warming. Worldwide temperatures are rising at a rate of approximately 0.27 °C per 10 years, which greatly surpasses warming rates in the past.[8] While this is concerning, the rate is expected to increase even more in the coming years.

Dr. Barraclough recommends that clinicians support policies that reduce greenhouse gas emissions, strengthen urban design, and reduce the environmental footprint of healthcare, including dialysis and transplant services.

However, as Dr. Barraclough explained in a recent editorial, addressing environmental stressors that affect kidney disease requires more than advocacy from nephrologists. Instead, a fundamental change in how the natural world and society intersect is needed.[9] She suggested that the kidney health community work with oversight agencies, such as the WHO, to engage with structural and economic drivers of environmental degradation to advocate for interventions, such as decarbonization.

A key takeaway of Dr. Barraclough's editorial is to adopt environmental stewardship as a key part of kidney care, while continuing to ensure safety and quality of treatment. "Kidney health and planetary health are closely interconnected, and progress in one will increasingly depend on advances in the other," she wrote. ●

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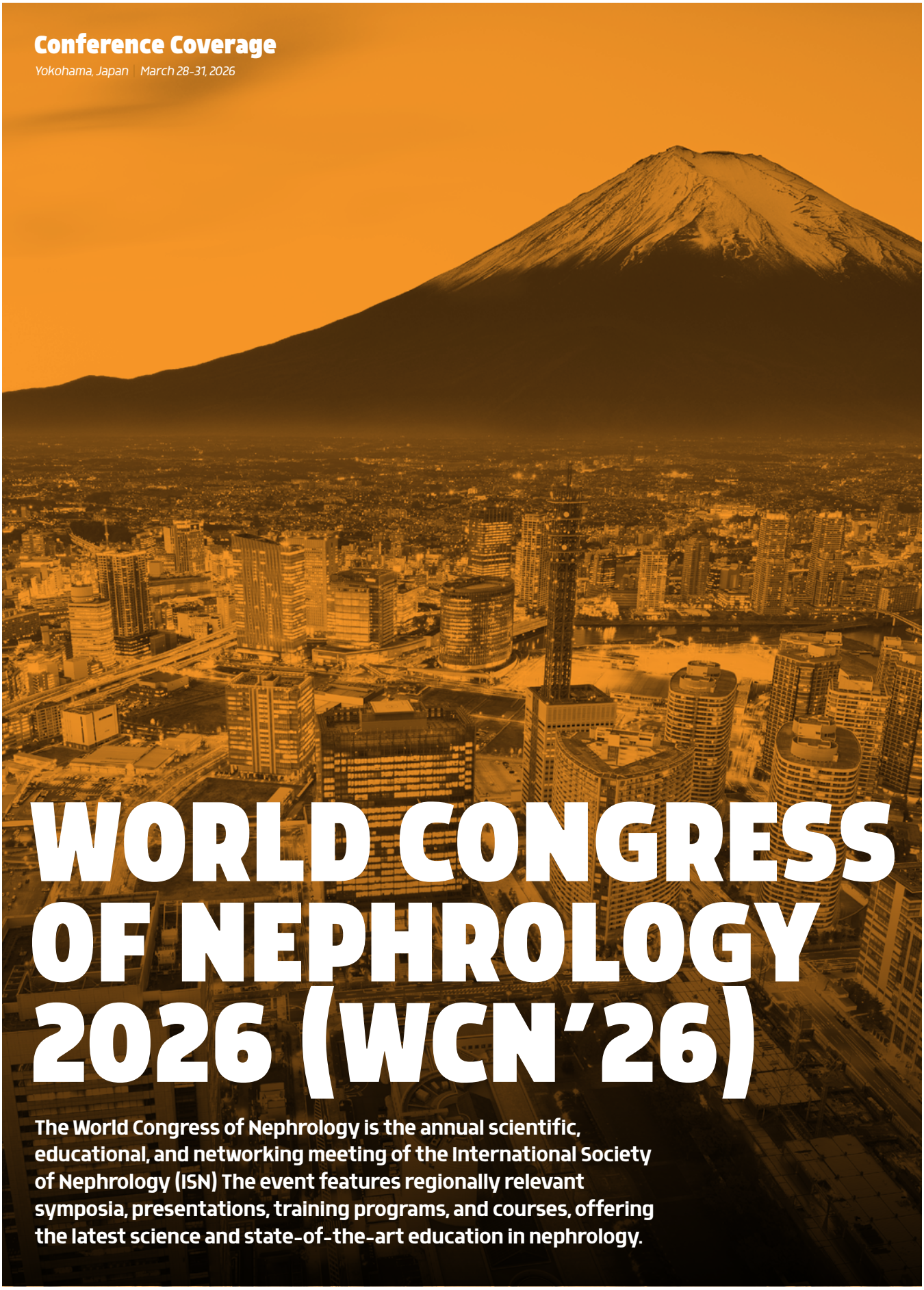

WORLD CONGRESS OF NEPHROLOGY 2026 (WCN'26)

The World Congress of Nephrology is the annual scientific, educational, and networking meeting of the International Society of Nephrology (ISN) The event features regionally relevant symposia, presentations, training programs, and courses, offering the latest science and state-of-the-art education in nephrology.

PHOTO CREDIT: ISTOCK.COM/SEANPAVONEPHOTO

Conference Coverage

Yokohama, Japan | March 28-31, 2026

Do Sodium-Glucose Cotransporter 2 Inhibitors Influence the Effects of Semaglutide in Type 2 Diabetes?

Sodium-glucose cotransporter 2 (SGLT2) inhibitors and the glucagon-like peptide-1 receptor agonist semaglutide both have nephroprotective effects. Research suggests that the mechanisms behind their effects are independent of one another and potentially additive.

A post hoc analysis of the REMODEL trial, presented by **David Cherney, MD, PhD,** and colleagues at WCN'26, assessed the kidney-protective effects of semaglutide 1.0 mg among adults with type 2 diabetes (n=71), stratified by SGLT2 inhibitor use. All participants had an estimated glomerular filtration rate (eGFR) of 30 to 75 mL/min/1.73 m² and urine albumin-creatinine ratio (UACR) of 20 to 4,999 mg/g.

Participants were randomly assigned 2:1 to weekly semaglutide subcutaneous 1.0 mg (n=71) or placebo (n=35) for 52 weeks. The researchers assessed kidney oxygenation (R2*) using blood oxygenation level-dependent MRI, and they assessed mean global kidney perfusion (GKP), renal artery resistive index (RARI), and cortical and medullary estimates of fibrosis (diffusion-weighted imaging for the apparent diffusion coefficient [ADC]) with phase-contrast MRI-measured arterial flow.

At baseline, eGFR-creatinine did not vary based on SGLT2 inhibitor use, although SGLT2 inhibitor use was linked with higher UACR. Similarly, SGLT2 inhibitors were not linked with changes in RARI, which semaglutide reduced in both SGLT2 inhibitor users and nonusers (*P*-interaction=0.29). SGLT2 inhibitors did not show any impact on the increases in cortical or delta ADC observed with semaglutide compared with placebo, reflecting stabilized fibrosis or lack of progression in both groups (*P*-interaction=0.73 and *P*-interaction=0.53, respectively). Changes in the ratio of cortical R2* and medullary R2* also did not vary significantly between SGLT2 inhibitor users and nonusers in both semaglutide and placebo groups (*P*-interaction=0.88 and *P*-interaction=0.84, respectively). Global kidney perfusion also did not vary significantly between SGLT2 inhibitor users and nonusers, although higher GKP was observed in the semaglutide group compared with placebo (*P*-interaction=0.42).

Overall, the findings indicate that SGLT2 inhibitor therapy did not significantly alter the effects of semaglutide on reducing RARI and mitigating fibrosis. The authors note that semaglutide could be combined with SGLT2 inhibitor therapy to provide additional nephroprotective benefits.

Reference

2026 World Congress of Nephrology. Abstract No. WCN26-3792.

Mechanisms Underlying Effects of Finerenone and Empagliflozin in CKD and Type 2 Diabetes

The CONFIDENCE trial found that simultaneous initiation of finerenone and empagliflozin further reduced albuminuria in patients with diabetic CKD when compared with monotherapy. In a study presented by **Mario Berger, MS, MSc, PhD,** and colleagues at WCN'26,, researchers assessed the drug-related changes in the urine proteome of patients taking finerenone and empagliflozin to determine what mechanisms underpinned the drugs' clinical benefits.

Seven hundred nineteen patients from the CONFIDENCE trial, who all had both CKD and type 2 diabetes (T2D), were randomly assigned to receive finerenone, empagliflozin, or a combination of finerenone and empagliflozin. First morning void urine samples were collected at baseline, 1 month, and 6 months. At baseline, the mean estimated glomerular filtration rate was 54.5 mL/min/1.73 m² (standard deviation, 17.2), and the median urinary albumin-to-creatinine ratio was 572 mg/g (interquartile range, 284-1,065).

In patients receiving finerenone monotherapy, 236 of the 239 significantly (false discovery rate [FDR] $q<0.05$) altered urinary proteins were decreased by month 6 compared with baseline, with only three increasing. The researchers noted that highly downregulated markers seemed to be involved in extracellular matrix remodeling, transport processes, and complement/coagulation pathways.

In patients receiving empagliflozin, 177 of 264 treatment-responsive proteins decreased, and 87 increased (FDR $q<0.05$). Empagliflozin appeared to modulate members of central metabolic pathways (carbohydrate and amino acid metabolism, eg, GOT1 [glutamic-oxaloacetic transaminase 1]), acid-base handling (carbonic anhydrase 14), markers of the lysosome, and tubular epithelial transmembrane proteins.

In patients receiving combination therapy, effects were similar to those observed in patients receiving either monotherapy, with 697 proteins decreasing and 57 increasing. Effects on coagulation and complement-related markers appeared to be amplified in this treatment arm.

These findings provide key insights into the renoprotective effects of both finerenone and empagliflozin for patients with T2D and CKD receiving different therapies. In particular, the findings indicate that these two drugs have synergistic effects on distinct pathways, with finerenone altering remodeling and complement-driven inflammation cues and empagliflozin optimizing the metabolic workload to slow CKD progression.

Reference

2026 World Congress of Nephrology. Abstract No. WCN26-4303.

PHOTO CREDIT: ISTOCK.COM/WNJAY_WOOTTHISAK

Obinutuzumab Results Superior to Mycophenolate Mofetil in Phase 3 Nephrotic Syndrome Trial

The most common pediatric glomerular disease worldwide is idiopathic nephrotic syndrome (INS). The efficacy of B-cell-depleting monoclonal antibodies for steroid minimization in frequently relapsing nephrotic syndrome (FRNS) or steroid-dependent nephrotic syndrome (SDNS) supports a pathogenetic role for B cells in that patient population.

During a late-breaking session at WCN'26, **Julien Hogan, MD, PhD,** and colleagues reported results of the phase 3 randomized, open-label INShore trial (NCT05627557). Conducted across 12 sites in nine countries, the trial was designed to compare the humanized type II anti-CD20 antibody obinutuzumab (OBI) with mycophenolate mofetil (MMF) in patients with INS.

Eligible patients aged 2 to 25 years with FRNS/SDNS who were in complete remission (CR) were randomly assigned 1:1 to either OBI (1,000 mg or 20 mg/kg if patients weighed <45 kg) on days 1, 15, and 168 (week 24) and 182 (week 26) (n=44) or MMF (1,200 mg/m^2/day; maximum, 2 g/day) for 52 weeks, followed by a 3-month taper period (n=41). Patients receiving glucocorticoids at the time of randomization had doses tapered.

The primary end point of interest was sustained CR at 1 year, measured by first morning void urine protein-to-creatinine ratio (UPCR) of 0.2 g/g or lower at week 52 without relapse or intercurrent event. Ranked key secondary end points included relapse-free survival (RFS), cumulative glucocorticoid dose, number of relapses, and sustained complete remission at week 76.

Of the overall cohort (n=85), 64.7% were male, 63.5% were younger than 12 years, median disease duration was 46 months, 75.3% had received prior nonsteroid immunosuppressive therapy, and 84.7% were receiving glucocorticoids at baseline. One participant in the OBI group and nine in the MMF group discontinued the study before week 52.

The primary end point and the first three secondary end points were statistically significant and clinically meaningful in favor of OBI: 95.5% of patients in the OBI group achieved CR compared with 73.2% in the MMF group at week 52 (adjusted difference, 23.36%; P=0.003). Researchers observed a 75% reduction in risk of relapse or death, lower cumulative glucocorticoid dose, fewer relapses from baseline to week 52, and a numerically higher proportion of patients who achieved sustained CR at week 52 in the OBI group.

More adverse events (AEs) occurred in the OBI group than in the MMF group, and one patient in each group discontinued treatment due to an AE. The researchers observed no new safety signals for OBI or MMF.

"OBI was superior to MMF in achieving sustained CR at 1 year in childhood-onset INS," the researchers wrote. "OBI showed statically significant and clinically meaningful key secondary end points, including overall RFS and reduced glucocorticoid use, with no new safety signals. These encouraging results from the INShore trial suggest OBI as a potential B-cell-targeted intervention in INS."

Reference

2026 World Congress of Nephrology. Abstract No. WCN26-7699.

Reduction in eGFR With Finerenone and Empagliflozin Correlates With UACR and BP Changes

Results of the CONFIDENCE trial demonstrated an association between simultaneous initiation of finerenone and empagliflozin and a marked reduction in UACR, as well as an acute reduction in eGFR. The frequency, determinants, and associations with changes in clinical parameters of acute eGFR reduction are unclear.

CONFIDENCE trial participants (n=818) were randomly assigned to receive empagliflozin 10 mg, finerenone 10 or 20 mg, or their combination. During a late-breaking session at WCN'26, **Hiddo J. L. Heerspink, PhD,** and colleagues presented results of a prespecified analysis of the efficacy and safety of the agents in patients with initial decline in eGFR.

Acute reduction in eGFR was defined as change in eGFR from baseline to day 14. The researchers compared the proportion of participants who experienced eGFR reductions of more than 10% or up to 10% or those who had an increase in eGFR among treatment groups. They also examined the association between acute eGFR reduction by quartile with UACR, systolic BP, biomarkers of kidney injury, and safety outcomes.

Baseline and day 14 eGFR data were available for 761 patients. At baseline, mean eGFR was 54.2 mL/min/1.73 m^2 and median UACR was 579. On day 14, the least-squares eGFR reductions from baseline were -6.1, -1.3, and -4.0 mL/min/1.73 m^2 in the combination, finerenone, and empagliflozin groups, respectively. In the overall population and prespecified subgroups (by eGFR, UACR, and diuretic use), following a 4-week washout, the reductions in eGFR were mostly reversible.

Compared with the finerenone and empagliflozin groups, an acute reduction in eGFR of greater than 10% was more common in the combination group. Higher baseline eGFR, higher systolic BP, and combination treatment were independently associated with an acute reduction in eGFR. At day 14, there were associations between changes from baseline in UACR and baseline BP with changes in eGFR in all treatment groups.

Regardless of acute changes in eGFR, the rates of adverse events in the combination group were comparable with those in the finerenone and empagliflozin groups. There was no significant increase from baseline to day 30 in urinary kidney injury biomarkers in any of the three treatment groups. The biomarkers were not differentially regulated by either drug in patients with a greater than 10% change in eGFR versus those without.

In summary, the researchers wrote, "Acute reduction in eGFR was common and reversible with simultaneous initiation of finerenone and empagliflozin, was not associated with more frequent adverse events or an unfavorable kidney injury biomarker profile, and correlated with changes in UACR and systolic BP. Acute change in eGFR with finerenone and empagliflozin appears to reflect a favorable hemodynamic treatment response."

Reference

2026 World Congress of Nephrology. Abstract No. WCN26-5829.

PHOTO CREDIT: iSTOCK.COM/7MARU

Novel Targeted-Release Budesonide Formulation Shows Potential for Treating IgAN

IgA nephropathy (IgAN) is a leading cause of kidney failure worldwide. Because evidence suggests that the gut-associated mucosal immune system may be involved in IgAN's pathogenesis, HR19042, a formulation of budesonide that delivers the drug to the distal ileum where gut-associated lymphoid tissue is most abundant, shows promise for treating the disease.

A phase 2/3 trial, presented by **Xiaobing Yang, MD,** and colleagues at WCN'26, assessed HR19042's efficacy and safety in adults with biopsy-confirmed primary IgAN (n=316).

Patients were randomly assigned (1:1:1) to receive either 12-mg or 16-mg HR19042 capsules or a placebo for 9 months. This was followed by a 2-week tapering period, a 2.5-month safety follow-up, and an optional 12-month long-term extension, with optimized supportive therapy provided throughout. Co-primary end points included the ratio of change in UPCR from baseline to month 9 and change in eGFR from baseline to month 12.

At baseline, the geometric mean UPCR was 1.06 g/g, while the mean (standard deviation) eGFR was 78.94 (25.81) mL/min/1.73 m^2. A total of 70.9% of patients had an eGFR greater than 60 mL/min/1.73 m^2. At month 9, the least-squares geometric mean percentage change in UPCR from baseline versus placebo was -40.9% (95% CI, -51.3% to -28.1%) for HR19042 12 mg and -47.7% (95% CI, -56.9% to -36.4%) for HR19042 16 mg, both of which are statistically significant reductions.

Meanwhile, at month 12, the least-squares mean difference in change in eGFR from baseline versus placebo was 3.30 mL/min/1.73 m^2 (95% CI, 0.50-6.10; one-sided P=0.0105) for HR19042 12 mg and 5.22 mL/min/1.73 m^2 for HR19042 16 mg (95% CI, 2.44 to 7.99; one-sided P=0.0001). This indicates a significantly smaller decline in eGFR compared with placebo for both.

Overall, these results indicate that clinically meaningful reductions in proteinuria and slowed eGFR decline occurred within 9 months of treatment with HR19042 compared with placebo, suggesting that HR19042 has a potential disease-modifying effect for patients with IgAN.

Reference

2026 World Congress of Nephrology. Abstract No. WCN26-5099.

Aerobic Exercise During Hemodialysis and Cardiovascular Outcomes

Compared with the general population, individuals with kidney failure receiving maintenance hemodialysis have significantly higher cardiovascular morbidity, as well as increased symptom burden and cognitive impairment. Hemodialysis-induced ischemia in these patients decreases organ perfusion, worsens symptom burden and cardiovascular outcomes, and contributes to myocardial stunning.

Paul N. Bennett, PhD, MHSM, RN, and colleagues conducted a randomized controlled trial at six hemodialysis centers in Canada and Australia to examine the ability of intradialytic cycling to mitigate cardiac stunning (NCT04877041). Results of the one-to-one parallel design, allocation-concealed, and assessor-blinded trial were reported during a late-breaking session at WCN'26.

The study intervention was supervised intradialytic cycling three times per week for 12 weeks. The primary outcome of interest was the effects of the intervention on myocardial stunning of adults receiving maintenance hemodialysis compared with standard of care (no intradialytic cycling). The primary outcome was defined as change in mean number of cardiac regional wall motion abnormalities at peak hemodialysis stress (last 30 minutes of hemodialysis) from baseline to 12 weeks, measured by echocardiography using speckle tracking analysis. Secondary outcomes included hemodialysis recovery time, cognitive function, symptom burden, and physical function.

Individuals were approached for study participation from February 2024 to October 2025. Of 355 patients approached, 125 consented to participate (Adelaide, n=10; Winnipeg, n=47; Calgary, n=10; Edmonton, n=21; London, n=26; Vancouver, n=11). A total of 111 participants progressed to baseline assessment and randomization. Of those, 101 completed the study (intervention group, n=49; control group, n=52).

"We anticipate that this trial will contribute critical evidence regarding the effect of aerobic exercise during HD [hemodialysis], potentially informing clinical practice and guidelines for hemodialysis care," the researchers wrote.

Reference

2026 World Congress of Nephrology. Abstract No. WCN26-6966.

PHOTO CREDIT: iSTOCK.COM/LEFT: TORSAKARIN; TOP: GRADYREESE

Status of Phase 4 Platform Trial of South Asian Patients With Primary IgAN

Previous studies have demonstrated an association between South Asian ethnicity and markedly more severe phenotype and rapid progression of IgAN. Few pragmatic clinical trials have evaluated commonly available approved generic drugs as a long-term strategy to improve clinical outcomes in the South Asian region.

A pragmatic platform trial by **Suceena Alexander, MD, PhD,** and colleagues that is in progress is testing the hypothesis that 2 years of treatment with commonly available drugs (oral steroids, gut-directed budesonide hydroxychloroquine, mycophenolate mofetil, or nonsteroidal mineralocorticoid receptor antagonists) in combination with standard of care (SOC) (maximally tolerated renin-angiotensin-aldosterone system inhibitors and sodium-glucose cotransporter 2 inhibitors) would result in significant improvement in adults with biopsy-proven IgAN at high risk for disease progression. The study design was described during a late-breaking session at the International Society of Nephrology 2026 World Congress of Nephrology in Yokohama, Japan.

The randomized, embedded, adaptive, multi-arm, multistage (MAMS) phase 4 trial includes a concurrent comparator arm and four interventional arms. Eligible participants are aged 18 to 65 years with an eGFR of 20 mL/min/1.73 m^2 or greater, UPCR of 0.75 g/g or greater or 24-hour urine protein of 1 g/day or greater, renal biopsy-proven primary IgAN, and SOC for a minimum of 3 months with a BP goal below 140/90 mm Hg.

The projected sample size is 585 patients (allocation 1:1 in the control arm and approximately 117 in each of the treatment arms). To date, approval has been obtained in 11 sites, and the trial is registered on Clinical Trials Registry-India (CTRI/2024/11/076794) and ClinicalTrials.gov (NCT06676384). The master protocol version 1.62 has been approved in all sites. The first patient was randomly assigned on January 2, 2025, and all 11 sites randomly assigned their first patient by January 2026. More than 50% of the participant recruitment was expected to be completed by March 2026.

As of the abstract presentation, the Independent Data Monitoring Committee (IDMC) completed the initial safety review. When 50% of the participants have completed 9 months of follow-up, the interim analysis for the percentage reduction in proteinuria will be conducted. The Trial Steering Committee will use prespecified futility analysis to decide whether to stop interventions and introduce new interventional arms as recommended by the IDMC.

At 2 years of follow-up, the researchers will evaluate the primary efficacy end point of interest, change in eGFR slope, and secondary end points of adverse events, patient-reported outcomes measures, and glucocorticoid toxicity. They will conduct sample biobanking at baseline and at each 6-month in-center visit.

"We will be able to generate primary evidence of clinical efficacy and toxicity of anti-proteinuric and immunomodulatory therapies in primary glomerular diseases in the South Asian population," the researchers said. "The Platform MAMS trial design is being used for the first time in IgAN therapeutics, and it will help establish the GRACE-Clinical Trial Network for similar studies in glomerular diseases."

Reference

2026 World Congress of Nephrology. Abstract No. WCN26-5982.

PHOTO CREDIT: ISTOCK.COM/HELOVI

ISN RECOGNIZES AWARD WINNERS AT WCN'26

The ISN honored several 2026 award recipients at WCN'26 in Yokohama, Japan.

Vivekanand Jha, MBBS, MD

ISN AWARD WINNERS

Vivekanand Jha, MBBS, MD, received the Jean Hamburger Award for outstanding research in nephrology with a clinical emphasis. Dr. Jha is executive director of the George Institute for Global Health, India, chair of global kidney health at Imperial College London, UK, and a former ISN president.

John A. Kellum, MD

John A. Kellum, MD, was this year's recipient of the Bywaters Award for exceptional contributions to understanding acute kidney injury. Dr. Kellum is Distinguished Professor of Critical Care Medicine, Medicine, Bioengineering and Clinical and Translational Science and holds an endowed chair in critical care research from the University of Pittsburgh in Pennsylvania. He is on leave while serving as chief medical officer for Spectral Medical, a medical device company.

Drs. Jha and Kellum received their awards during plenary sessions on March 28 and 29, respectively.

Ron T. Gansevoort, MD, PhD

KAPLAN PRIZE

Ron T. Gansevoort, MD, PhD, was the 2026 recipient of the Lillian Jean Kaplan International Prize for excellence and leadership in clinical or basic research in polycystic kidney disease. Dr. Gansevoort is a professor of medicine and nephrologist at the University Medical Center Groningen in the Netherlands and is a former board member of the European Renal Association.

Dr. Gansevoort received his award on March 30, at which time he presented a lecture on disease-modifying drugs for autosomal dominant polycystic kidney disease.

OTHER HONOREES

Also taking place on March 30 was an ISN Program Awards presentation, during which recent participants in the ISN Fellowship and Mentorship Programs presented their winning abstracts. The awardees included **Henry H. L. Wu, MBChB, PhD; Sukanya Govindan, MBBS, MD; Priya Pais, MD;** and **Phu Tran Nguyen Trong, MD, PhD**.

In addition, a March 30 session featuring the best of ISN journals *Kidney International* and *Kidney International Reports* included the presentation of Early Career Researcher Awards and Best Reviewer Awards.

FDA Sets Decision Date for Desensitization Drug Imlifidase

The FDA has set a Prescription Drug User Fee Act action date of December 19, 2026, for imlifidase, a potential desensitization therapy for highly sensitized patients awaiting kidney transplantation.

Representing about 10% to 15% of patients on transplant waiting lists, highly sensitized patients have high levels of preformed donor-specific antibodies (DSAs) with wide reactivity against human leukocyte antigens. These DSAs can trigger an immune response against a transplanted organ, resulting in tissue damage and graft rejection. Finding compatible donors for this population can be difficult.

Imlifidase can be used for desensitization treatment of such patients with a positive crossmatch against an available deceased donor. The drug is approved in Australia and Switzerland and has received conditional approval in the European Union, Norway, Lichtenstein, Iceland, and the UK.

SOURCE: HANSA BIOPHARMA

Sparsentan Becomes First FDA-Approved Treatment for FSGS

The FDA approved sparsentan for the reduction of proteinuria in adults and pediatric patients aged 8 years and older with focal segmental glomerulosclerosis (FSGS) without nephrotic syndrome. The approval makes sparsentan, which was previously approved to treat IgA nephropathy, the first FDA-approved therapy for the treatment of FSGS.

The approval was supported by results from the phase 3 DUPLEX study, the largest head-to-head interventional clinical trial conducted to date in FSGS. In the overall study population, patients treated with sparsentan experienced a statistically significant 46% reduction in proteinuria from baseline to week 108, compared with a 30% reduction in patients treated with the maximum labeled dose of irbesartan.

Among patients without nephrotic syndrome, proteinuria was reduced by 48% with sparsentan and by 27% with irbesartan. This subgroup also showed a treatment difference in estimated glomerular filtration rate of 1.1 mL/min/1.73 m^2 based on mean change from baseline to week 108.

SOURCE: TRAVERE THERAPEUTICS

Biogen to Acquire Apellis, Adding C3G Treatment to Its Portfolio

Biogen announced that it will acquire Apellis Pharmaceuticals for approximately $5.6 billion, a move that will bring pegcetacoplan to Biogen's portfolio. Pegcetacoplan is a complement inhibitor approved by the FDA to treat complement 3 glomerulopathy (C3G) and primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN) in patients aged 12 years and older. It is also approved to treat adults with paroxysmal nocturnal hemoglobinuria.

Apellis brings an established US commercial infrastructure, including nephrology-focused field capabilities. Biogen stated in a press release that it expects the acquisition to strengthen its position as it advances felzartamab, which is currently in phase 3 studies for three kidney diseases. The first readout for felzartamab is expected in the first half of 2027.

SOURCE: AMGEN, BIOGEN

ASN Issues Guidance on Conservative Management of Kidney Failure

The American Society of Nephrology (ASN) issued its latest Kidney Health Guidance (KHG): Conservative Management in People with Kidney Failure, offering evidence-based support for a conservative management care pathway. The KHG and an executive summary—the first to be included in a KHG series—were published in the *Journal of the American Society of Nephrology.*

The new guidance emphasizes shared decision-making and cross-disciplinary collaboration. The KHG Workgroup on Conservative Kidney Management, composed of experts representing nephrology, geriatrics, palliative care, bioethics, social work, and advanced practice professionals, authored the new guidance.

SOURCE: AMERICAN SOCIETY OF NEPHROLOGY

PHOTO CREDIT: ISTOCK.COM/MARIA STAVREVA

CHRONIC KIDNEY DISEASE

Study Describes Bidirectional Association Between Depression and CKD

Front Nephrol. 2026;5:1743594. doi:10.3389/fneph.2025.1743594

Previous studies have established the link between depression and worse clinical outcomes among patients with CKD. However, according to **Ki Jin Jeun, MS,** and colleagues, few data are available on the influence of depression on progression of kidney disease in earlier stages of CKD. Using real-world data from the TriNex electronic medical records database (2007-2022), the researchers conducted a retrospective cohort analysis to examine the role of depression in progression of CKD by stages, as well as the bidirectional relationship between depression and disease progression.

The cohort included patients older than 18 years with diagnosed CKD. The primary outcome of interest was progression to kidney disease; the secondary outcome was diagnosis of depression or anxiety. The researchers evaluated the relationship between the dependent and independent variables using Kaplan-Meier analysis and Cox proportional hazards model with adjustments for sex, race, ethnicity, and age.

A significant association between depression and higher risk for kidney disease progression was shown (hazard ratio [HR], 1.94; 95% CI, 1.77-2.11; $P<0.001$). Among the subgroup of patients with CKD, the risk for a new diagnosis of depression was significantly higher among those with CKD stages 4 and 5 (HR, 1.26; 95% CI, 1.17-1.35 and 1.38; 95% CI, 1.23-1.54; $P<0.001$, respectively) compared with those in stages 1 to 3. After matching and adjusting for age, sex, race, and comorbidities, the associations remained statistically significant.

In conclusion, the researchers wrote, "Depression significantly accelerates CKD progression and patients with stage 5 CKD had the highest risk of developing depression. Our study advocates for integrating frequent mental health screenings for patients with CKD. This could improve patient outcomes and minimize negative consequences associated with depression."

DIABETES

Dementia and Alzheimer's Disease Risk Lowered With GLP-1 RA Use

Nephrol Dial Transplant. 2026. doi:10.1093/ndt/gfag032

Among patients with CKD and type 2 diabetes, vascular dysfunction, insulin resistance, and chronic inflammation are associated with an increased risk for dementia and Alzheimer's disease. Previous studies have demonstrated neuroprotective properties associated with the use of glucagon-like peptide-1 receptor agonists (GLP-1 RAs). However, according to **Wen-Teng Lee, MD,** and colleagues, little is known about the impact of those agents among patients with diabetes and CKD.

The researchers conducted a retrospective cohort study to examine the association between use of GLP-1 RAs and the risk for dementia in patients with CKD stage 3 or later, compared with use of dipeptidyl peptidase-4 (DPP-4) inhibitors. The study used data from the TriNex global research network, including electronic medical records from 67 healthcare organizations in the US Collaborative Network. Eligible patients were newly prescribed GLP-1 RAs or DPP-4 inhibitors between January 1, 2015, and December 31, 2020.

The primary outcome of interest was the incidence of dementia, Alzheimer's disease, vascular dementia, frontotemporal dementia, Parkinson's disease, extrapyramidal and movement disorders, and dementia with Lewy bodies. Follow-up ranged from 90 days to 5 years. The researchers used Kaplan-Meier survival curves and Cox proportional hazards models in statistical analyses.

They observed an association between the use of GLP-1 RAs and a significantly lower risk for dementia and Alzheimer's disease (HR, 0.80; 95% CI, 0.71-0.91; $P=0.001$ and HR, 0.76; 95% CI, 0.59-0.98; $P=0.033$, respectively), compared with use of DPP-4 inhibitors. No significant differences were observed regarding the remaining outcomes of interest.

"GLP-1 RAs [sic] therapy may reduce the risk of dementia and Alzheimer's disease in patients with CKD stage 3 or later, offering potential neuroprotective benefits beyond glycemic control," the researchers wrote. "Research is needed to confirm these findings and optimize treatment strategies for this vulnerable population."

END-STAGE KIDNEY DISEASE

AI Models Can Reduce Odds of Hospitalization in ESKD

NEJM Catal Innov Care Deliv. 2026;7(3). doi:10.1056/CAT.25.0212

Models driven by artificial intelligence (AI) may predict the risk for hospitalization among patients with end-stage kidney disease (ESKD), a patient population with a high rate of hospitalization associated with fluid overload and infections.

To test that hypothesis, **Sheetal Chaudhuri, PhD,** and colleagues conducted a retrospective, observational matched cohort study. Study participants were adult patients with ESKD receiving value-based hemodialysis at integrated kidney care centers across the United States in 2023. Risk scores (range, 0-1) were calculated using two AI-powered

machine learning models. The models identified patients with a risk score of 64.0 or above who were at risk for hospitalization for infections or abnormalities in fluid status within 7 days.

The models generated scores for all patients; those with high-risk scores triggered case review and possible intervention to prevent avoidable hospitalizations. Electronic medical records and Medicare claims data were linked, and the researchers performed multivariate logistic regression analyses to assess the impact of interventions driven by AI on the odds of all-cause hospitalizations among patients with ESKD.

The study included 10,294 patients representing 83,928 risk scores. Analysis showed an association between AI-driven intervention and an 8% reduction in the odds of hospitalization within 7 days (odds ratio, 0.92; *P*=0.025). The interventions were most effective among patients with scores between 0.64 and 0.85. For patients with scores above 0.85, the effects of the interventions were not statistically significant. Higher risk score (>0.75), chronic high-risk scores, older age, and a greater number of hospital admissions in the year prior were independently associated with higher rates of hospitalization.

"AI-driven interventions were associated with a reduction in the odds of hospitalization among patients with ESKD receiving managed kidney care," the researchers wrote. "These findings underscore AI's potential to assist health care providers with targeted risk interventions for patients with ESKD."

FSGS

Sparsentan Safe and Effective Among Patients With Genetic FSGS

Clin J Am Soc Nephrol. 2025. doi:10.2215/CJN.0000000948

Diagnosis of focal segmental glomerulosclerosis (FSGS) is based on characteristic histopathologic lesions. Patients with forms of FSGS with underlying genetic variants commonly experience resistance to current treatments.

Jennifer Yee, MD, and colleagues conducted a post hoc exploratory analysis of data from the DUPLEX clinical trial. DUPLEX was designed to examine the efficacy and safety of the dual endothelin-angiotensin receptor antagonist sparsentan in patients with biopsy-proven or genetic FSGS (gFSGS). The study findings suggested that, compared with the active control irbesartan, sparsentan had a greater antiproteinuric effect over 108 weeks.

The post hoc analysis was designed to examine the efficacy and safety of sparsentan in a subset of patients in the DUPLEX trial with pathogenic variants in genes coding for podocyte proteins, *COL4A3-5* variants, and *APOL1* high-risk genotypes (all referred to as gFSGS).

Using next-generation sequencing, the researchers identified 31 patients with podocyte gene variants; 25 had *COL4A3-5* variants, and 14 had *APOL1* high-risk genotypes. Variations between genetic subgroups occurred at baseline. Patients in the podocyte group were, on average, slightly younger, and there were more Black patients in the *APOL1* high-risk genotype group.

Consistent with the results of the full DUPLEX trial cohort, compared with irbesartan, results of the exploratory analysis suggested that sparsentan was associated with substantial and sustained reductions in proteinuria and more frequent complete remission of proteinuria. In addition, a smaller proportion of patents in the sparsentan arm reached composite kidney end points compared with those in the irbesartan arm.

"These findings support sparsentan's antiproteinuric benefit in patients with gFSGS, a subgroup that is often resistant to other therapeutic interventions," the authors wrote.

LUPUS NEPHRITIS

Anifrolumab Treatment Reduced Urinary Biomarkers in Patients With Lupus Nephritis

Arthritis Rheumatol. 2026. doi:10.1002/art.70089

One of the most severe manifestations of systemic lupus erythematosus (SLE) is lupus nephritis (LN). The phase 2 TULIP-LN trial (NCT02547922) examined the impact of anifrolumab, an approved treatment for patients with SLE, in a cohort of patients with LN who were receiving standard therapy. **Andrea Fava, MD,** and colleagues conducted a proteomic analysis of samples from TULIP-LN to assess the impact of anifrolumab treatment on urinary biomarkers in patients with LN.

The study population was divided into three subcohorts: (1) patients treated with the anifrolumab basic regimen (n=35); (2) those receiving an intensified regimen (n=42); and (3) those receiving placebo (n=35). All three groups also received standard therapy. Urine samples were collected at weeks 0, 12, and 48 and analyzed for the presence of 197 proteins.

The analysis assessed the impact of anifrolumab relative to placebo on prespecified biomarkers linked to histologic activity. In addition, the researchers compared proteins detected in 75 or more of samples obtained from responders versus nonresponders.

Across all regimens and including patients classified as proteinuric nonresponders, there was significant reduction in urinary CD163 and MCP-1 expression at week 12 with anifrolumab treatment compared with placebo. At week 48, biomarker levels declined in all three subcohorts, suggesting that standard therapy alone can suppress intrarenal inflammation in time, albeit with slower kinetics. Results of proteomic analyses demonstrated that, regardless of responder status, anifrolumab was superior to placebo in reducing the proteomic inflammatory signature.

In summary, the authors wrote, "Compared with placebo, anifrolumab treatment significantly reduced urinary biomarkers of renal histological activity in patients with LN, which may accelerate the resolution of intrarenal inflammation, potentially preventing damage accrual."

PEDIATRIC NEPHROLOGY

Comparison of Novel Iron Therapies in Children With CKD and Iron Deficiency Anemia

Pediatr Nephrol. 2026. doi:10.1007/s00467-025-07138-w

Few data are available related to the use of novel iron therapies for pediatric patients with CKD. **Happy Sawires, MD,** and colleagues reported results of a crossover study comparing iron polymaltose complex (IPC) and liposomal iron in children with CKD and iron deficiency anemia (IDA).

The study cohort included 33 children with CKD and IDA. Study participants were randomized into two groups, group A (n=17) and group B (n=16), to receive either liposomal iron or IPC for 3 months. After an 8-week washout period, the groups were switched to the other therapy. At baseline and after each 3-month period, measurements of red blood cell and iron indices and bone minerals and 25-hydroxyvitamin D3 were taken. To identify any possible adverse events, patients underwent a follow-up visit during the treatment period.

Increases in hemoglobin levels of at least 1 g/dL were observed in 48% of participants after liposomal iron therapy and in 51.5% after IPC therapy. There were no statistically significant differences between the groups regarding change in hemoglobin, iron, transferrin receptor (TR), or transferrin saturation (TSAT).

Results of mixed-model analysis demonstrated that, compared with liposomal iron, IPC showed higher responses in hemoglobin and TSAT and a lower response in TR. IPC treatment led to a significant reduction in serum phosphorus in both groups; liposomal iron did not.

Thirty-six percent of IPC recipients experienced adverse effects, compared with 3% of liposomal iron recipients.

"Both IPC and liposomal iron effectively improved iron status in children with CKD and IDA," the researchers wrote. "However, IPC indicated a superior response, whereas liposomal iron was associated with a more favorable tolerability profile."

TRANSPLANTATION

Assessment Reveals Gaps and Variations in Dialysis Staff Knowledge of Transplantation Processes

Kidney Int Rep. 2025;11(3):103720. doi:10.1016/j.ekir.2025.103720

Staff at dialysis centers play an important role in educating patients and helping them make informed decisions about their treatment. **Catherine E. Kelty, PhD,** and colleagues conducted a study to examine staff knowledge of the transplant process and identified staff and facility factors associated with knowledge.

To assess staff knowledge of the process surrounding kidney transplantation, the researchers used a 17-item adaptation of the Knowledge Assessment of Renal Transplantation (KART) instrument. Between August 2021 and August 2022, surveys were emailed to 2,000 dialysis centers across four US regions. Analysis of variance and ordinal regression for score quartiles were used to identify associations between staff and facility characteristics and correct response scores.

The survey response rate was 33.5%. Of the 630 respondents, 91.4% were female, 81.1% were social workers, and 86.2% were employed at chain-owned facilities. The average correct response score was 11.8 (69%). For individual items, correct responses ranged from 9.4% to 95.9%.

Results of the adjusted regressions demonstrated a substantial reduction in the odds of scoring highly among non–social workers versus social workers (adjusted odds ratio [aOR], 0.39; 95% CI, 0.25-0.63). Other factors associated with lower odds of scoring highly were time working in role (<1 year: aOR, 0.11; 95% CI, 0.04-0.25; 1-3 years: aOR, 0.21; 95% CI, 0.10-0.43; 4-7 years: aOR, 0.38; 95% CI, 0.19-0.78; >10 years: aOR, 0.42; 95% CI, 0.21-0.85, vs 8-10 years) and region (New York: aOR, 0.52; 95% CI, 0.29-0.94, vs Southeast).

"The adapted-KART assessment revealed significant gaps and variation in dialysis staff knowledge of transplantation processes," the authors wrote. "Interventions to improve staff training and reduce gaps in staff knowledge are needed to ensure appropriate patient education regarding kidney transplantation for patients receiving dialysis."

Fracture Risk After Kidney Transplant Remains High Over Time

Clin Kidney J. 2026. doi:10.1093/ckj/sfag029

Among other adverse events, recipients of kidney transplants face a high risk for fractures. The rates of fractures in this patient population vary and may have changed over time. Noting that data are limited on the consequences of a fracture, including subsequent fractures, **Ina Karstoft Ystrøm, MD,** and colleagues conducted a retrospective cohort study to identify the current risk for and prognosis of fractures after kidney transplantation.

The study cohort included all adults who underwent a first single-organ kidney transplant in Denmark between 2000 and 2022. Researchers identified eligible participants and demographic data, diagnostic and procedural codes, and prescription data via nationwide health registries. With death as a competing risk, the researchers computed the cumulative incidence (risk) of first fracture and subsequent fracture and estimated crude and sex- and age-standardized incidence rates for different periods.

Of the 3,877 first–kidney transplant recipients in the study cohort, 788 sustained any fracture after transplant, resulting in a 10-year risk of fracture of 21% (95% CI, 20%-23%); fractures were primarily located at the peripheral skeleton. Over time, the crude incidence rates of any fracture remained unchanged, but there was a slight decline in standardized estimates. Of patients with a fracture, 28% sustained a subsequent fracture; the highest incidence of subsequent fracture occurred 6 to 12 months after the initial fracture.

In conclusion, the researchers wrote, "Kidney transplant recipients remain at high fracture risk, with unchanged fracture rates over the past 20 years. The imminent fracture risk following a first fracture is high and largely unaddressed. Although formal guidelines have yet to be established, this knowledge should urge clinicians to perform risk assessment and consider intervention following a post-transplant fracture." ●

Sarah Tolson

Back to Basics

Common questions and a few misconceptions about the MCP

*By **Sarah Tolson***

Over the past several years, I've noticed something interesting: even experienced nephrologists and seasoned billers have questions about the Monthly Capitation Payment (MCP). While many of us learned the fundamentals years ago, operational changes, staffing models, and evolving care patterns have created confusion—especially around partial months and patients with acute kidney injury (AKI).

Let's revisit the basics and address some of the most common questions I hear from the field.

What Exactly Is the MCP–And What Are You Really Being Paid For?

At its core, the MCP is a monthly payment for managing end-stage renal disease (ESRD) care in the outpatient setting of a patient receiving dialysis. It is not just a payment for face-to-face visits; it represents the full scope of physician oversight throughout the month.

This includes but is not limited to:

- Dialysis prescription and adequacy
- Anemia and bone/mineral management
- Access monitoring
- Care coordination with staff and other providers
- Ongoing review of labs and treatment plans

While visit frequency affects reimbursement for in-center patients, the MCP addresses the ongoing management plus a required complete monthly assessment of a patient with ESRD.

Who Should Bill the MCP?

This question comes up frequently in practices utilizing nurse practitioners (NPs) and physician assistants (PAs).

The rule is straightforward: the healthcare professional who performs the complete assessment, establishes the plan of care, and manages the patient should bill the MCP. That professional may be a physician, NP, or PA.

Other professionals can perform visits during the month, but they must be either part of the same group or employed/contracted by the MCP provider. If an NP or PA performs the complete assessment and drives the plan of care, the MCP should be billed under their NPI—not automatically under the physician.

What Counts As a "Month"?

This seems simple, but it matters operationally. A "month" is always a calendar month. The first month of dialysis begins on the start date of dialysis and runs through the end of that month. Every month after that resets on the first.

This becomes especially important when dealing with new dialysis starts, hospitalizations, patient transfers, and patients changing from in-center to home dialysis.

When Can You Bill the MCP for a Partial Month?

This is a topic I receive the most questions about. The key question is, "Was a complete monthly assessment performed?"

If YES: You can bill the MCP even if the patient was hospitalized part of the month.

If NO: You must bill per diem (daily) ESRD codes for the days you were responsible for the patient's care.

Common scenarios where per diem billing applies include:

- Hospitalization before a complete assessment is performed
- Patient expires before assessment
- Patient receives a transplant
- Patient switches nephrologist mid-month
- Transient (traveling) patients

A frequent mistake is attempting to bill the MCP simply because visits occurred. Without a complete assessment, the MCP is not appropriate.

What Services Are Not Included in the MCP?

Another area of confusion is what can and should be billed separately.

The MCP includes most outpatient ESRD-related management, but it does not include:

- Procedures (eg, catheter placement, thrombectomy)
- Interpretation of tests with a professional component (eg, echocardiograms)
- Complete transplant evaluations
- Hospital inpatient services
- Non-renal care (if clearly unrelated and separately documented)

Understanding these exclusions is critical to avoiding both compliance issues and missed revenue opportunities.

How Should Patients With AKI in the Dialysis Facility Be Billed?

This is where I see some of the most significant misconceptions.

Patients with AKI receiving dialysis in a facility are not ESRD patients and are therefore not eligible for the MCP. Instead, nephrologists should bill a per-visit dialysis code. The key distinction is that ESRD patients have a chronic condition that is managed under a monthly MCP structure, whereas an AKI patient is managed and billed per encounter because the condition is expected to resolve or the patient will be reclassified as ESRD.

Even though the physician may be overseeing the patient's care throughout the month—similar to ESRD management—there is no monthly capitation structure for AKI. The correct approach is to bill each dialysis-related encounter individually, reflecting the actual services performed.

As practices continue to evolve—with increasing patient complexity and operational pressure—getting these fundamentals right is essential for both compliance and financial performance. As always, I welcome your questions from the field. ●

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