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Latest ASN Kidney Health Guidance Focuses on Conservative Management

By Bridget M. Kuehn

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For Zalikah Lewis' grandmother, Evelyn A. Lewis, conservative management was the care option that allowed her to make the most of her time with her family and maintain her independence and dignity without the fatigue and pain she knew would come with dialysis.

"She had been on this kidney disease journey for a long time," Zalikah explained. "She was well aware of what the trajectory would look like for her, and she felt that conservative management would allow her to prolong her experiences with her family even though it wasn't going to prolong her life."

Conservative management is a holistic, patient-centered option for kidney failure care that prioritizes patients' quality of life and symptom management while avoiding the burdens associated with dialysis. Yet this care option is underused in the United States, despite the potential benefits for patients who are older, with frailty, or who have comorbid conditions—individuals who may not experience extended life or a good quality of life on dialysis. A new ASN Kidney Health Guidance (KHG) provides tools and a framework to help nephrologists implement conservative management as a care option for their patients (1). The guidance emphasizes conservative management best practices such as shared decision-making with patients and care partners, customized chronic kidney disease (CKD) care, and support for patients and care partners navigating care transitions.

"Conservative management is a legitimate treatment path that, for certain patients, actually improves the outcomes that they're hoping for," said Jane Schell, MD, MHS, co-first author of KHG and co-chair of the ASN Kidney Health Guidance Workgroup on Conservative Kidney Management that developed it.

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Key ASN Priorities Advance in Federal Appropriations Package: NIDDK and KidneyX Funding Steady, HOLD Act Passed

By Bridget M. Kuehn

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The federal appropriations package approved by Congress in January and signed into law (1) bolsters federal funding for kidney research and several key transplant programs and included passage of the Honoring Our Living Donors (HOLD) Act, reflecting enactment of top ASN advocacy priorities.

Congress chose to maintain steady funding for the US Department of Health and Human Services and to preserve the current structure of the National Institutes of Health (NIH), including the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). The legislation, which was signed into law by President Donald J. Trump, alleviates concerns about ideas advanced via a "skinny budget," which was released by the Trump administration last spring, proposing massive federal research funding cuts and reorganization of NIH, including folding NIDDK into a new National Institute on Body Systems (2). Instead of cuts or elimination, NIDDK and several other kidney disease or transplant-focused programs were spared or received budget increases in the appropriation package.

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Dialysis by default

The guidance affirms that conservative management is a valid "4th option," alongside hemodialysis, peritoneal dialysis, and transplant. It recognizes that dialysis may involve trade-offs for patients, particularly older individuals and those with multiple comorbid conditions, including time spent in dialysis sessions, fatigue, hospitalizations, and other side effects that can negatively affect their quality of life.

"For all these reasons, dialysis should no longer be regarded as an automatic or default treatment for kidney failure, and conservative management can be considered as a viable treatment option depending on patients' clinical context, preferences, and goals," the guidance notes.

Schell, who is section chief of palliative care and a nephrologist at the University of Pittsburgh, PA, noted that many nephrologists have not received formal training in conservative management. Yet conservative management leverages the same skills used to manage CKD—such as managing electrolytes, blood pressure, and anemia—but instead of focusing on kidney failure prevention, it focuses on managing patients' symptoms and helping them achieve their quality-of-life goals. The guidance and accompanying executive summary provide education and tools to help nephrologists engage in shared decision-making about conservative management as a care option and to build care pathways to support it (1, 2).

"We hope that readers of this Kidney Health Guidance appreciate that you don't need to be trained in palliative care to do this work," Schell said. "You don't need to have a full interdisciplinary team and set up to do this."

Schell also debunked the notion that all patients will die shortly after choosing conservative management. She noted that many patients may live for months, if not a couple of years, depending on when they choose this option and their condition. "Many patients are expected to enjoy a relatively good quality of life and likely have their symptoms managed until they transition to hospice services when their time is shorter, or their needs become greater," Schell said.

Zalikah shared that this was true for her grandmother, who lived for 2½ years after choosing conservative management. During that time, Evelyn was able to prioritize making meaningful memories with her family, work with social workers to process her feelings, and communicate her wishes while planning how she wanted her end of life to be managed. "It was the best option for us," Zalikah said.

Conservative management is also an option that patients, care partners, and families want to learn more about. Sarah Sampsel, MPH, ASN's KHG lead, wishes her father, who passed away in early 2026 after living with heart failure and kidney failure for the last few years of his life, had been offered the option of conservative management. Instead, she felt that he was pushed toward dialysis without a full understanding that it was not curative and may impair his quality of life. While on dialysis, he suffered several complications that required hospitalization and, eventually, was admitted to a skilled nursing facility.

"Nobody ever presented the idea that there were other ways to maintain his quality of life," Sampsel said. "It would have given him the option of choosing his life: 'Do you want to be home where you can still go out with your friends and be involved in the community or other things important to you and your family?'"

Individualized care

Jessie Weiss, MD, MCR, lead author of the executive summary of KHG (2) and associate professor of medicine at Oregon Health & Science University, Portland, acknowledged that clinicians may have some anxiety about implementing conservative management. However, she emphasized that it is built on shared decision-making, grounded in the patient's values, symptom management, care planning, and transition management. The guidance helps break down the process into steps and provides templates for patient assessment and care planning.

"Customization of care is another way to think about it," Weiss said. "It is making sure the care we are offering and providing patients aligns with their personal goals. It means we are going to support you and help you feel as good as possible throughout the journey and help you navigate care transitions as the disease changes over time.

"Any patient, for whom the kind of challenges that go with dialysis [do] not align with their idea of an acceptable quality of life, is a candidate for conservative management," Weiss said. But she noted that this care is most often associated with patients who are 80 years or older, with frailty, or with multiple complex comorbidities. Data show that for these individuals, dialysis may not extend their life and can lead to a decline in functional status and reduced quality of life, Weiss added.

Shared decision-making is essential to conservative management, starting with explaining the patient's prognosis, listening to and understanding the patient's goals and values, and then helping them to make treatment choices that align with their goals and values. KHG notes that decision aids can help with this process and provides a list of tools including videos and worksheets that patients can use as they consider their options. Additionally, the guidance emphasizes engaging care partners in the process. Providing an open and honest recommendation based on the information gathered in the process can help patients, Weiss explained.

She suggested a clear statement, such as, "We've talked about these choices, and let me say that having met you and hearing what's important to you and understanding what dialysis can and cannot do for you, my recommendation would be that you consider conservative management."

Sampsel said she is not sure if her father would have chosen conservative management earlier in his disease trajectory, but she thinks he and his care partner would have benefited from a better understanding of their options and what to expect from them and with help in developing plans for the next stages of his illness. Instead, in his last 18 months of life, he had repeated hospitalizations, surgeries, admissions to skilled nursing facilities, and minimal time at home; yet, he and his family were led to believe he would improve.

"My hope is that even if nephrologists are not ready to implement all aspects of conservative management, they at least start the conversations with patients and their care partners that explore care plans that align with individual goals and values," Sampsel said.

> **"[D]ialysis should no longer be regarded as an automatic or default treatment for kidney failure, and conservative management can be considered as a viable treatment option depending on patients' clinical context, preferences, and goals."**

Navigating transitions

Assessing and managing a patient's symptoms and planning for the full spectrum of their care are also essential, according to KHG. Helping patients, care partners, and their families navigate care transitions is also key.

Weiss said it can be helpful for nephrologists to have a care template for conservative care visits and that partnering with other clinicians and allied health professionals can also help. For example, she said a patient's primary care team may help with pain relief, with support from physical and occupational therapists to help maintain functional status.

Evelyn Lewis' physician Samantha Gelfand, MD, a nephrologist and palliative medicine specialist at Brigham and Women's Hospital and the Dana-Farber Cancer Institute in Boston, MA, who was also part of the KHG workgroup, worked closely with Evelyn's cardiologist during her care. The entire care team participated in a virtual meeting with 14 of Evelyn's family members to discuss her decision to choose conservative management and share what it is and the care she would receive. Gelfand said those kinds of meetings are more common in crisis settings, but she noted that they can help family members cope with and understand the decision not to select a therapy like dialysis. The meetings also reduce the likelihood of a family member pushing for care that the patient does not want during an emergency. "It's just important nuts and bolts of good communication and coordination," Gelfand said.

As patients' kidney disease progresses from stable or slowly declining to deteriorating to a rapid decline, KHG emphasizes the need for nephrologists to adjust care, support and guide patients and caregivers, and assist with planning for the next stage. That should include patients developing advance directives and referral to hospice care.

Gelfand, along with a social worker and a nurse practitioner, saw Evelyn once every month or 2 months during her care. As it became more difficult to attend in-person visits during the last 6 months of her life, they relied

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ASN Kidney Health Guidance on Conservative Management in People with Kidney Failure

JASN Journal of the American Society of Nephrology

AIM To provide evidence-based clinical guidance for best practices in conservative management care delivery

What is Conservative Management? "4th pathway" - alongside hemodialysis, peritoneal dialysis, and kidney transplantation - and a legitimate and proactive therapeutic option for patients

Customized CKD care	Symptom management	Smooth navigation of care transitions
CKD care directed at preserving kidney function and managing its medical complications (hypertension, hypervolemia, electrolyte derangements, anemia, and bone mineral disease) is customized to support a patient's values, goals, and care preferences	Physical and psychological symptoms carefully and routinely assessed and addressed through diet and lifestyle modification, pharmacotherapy, and coordination with additional interdisciplinary services	Open conversations about prognosis and what to expect with kidney failure Ongoing discussion about who or what is important when making medical decisions, what their priorities are when they become sick, and wishes for future care Creating proactive action plans to avoid or minimize the impact of future health crises, including planning for end-of-life and hospice services

Conservative management focuses on personalization and whole-person attention across the CKD continuum of illness that is flexible to the needs and priorities of the patient.

ASN Kidney Health Guidance on Conservative Management in People with Kidney Failure. JASN DOI: 10.1681/ASN.0000001068. **Visual Graphic by Edgar Lerma, MD, FASN**

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more on email, telephone check-ins, and telehealth visits. They also met with Evelyn when the time grew near to consider hospice.

To support clinicians in providing conservative care and strengthening their skills, the guidance also recommends that medical training and continuing education include conservative management, communication about serious illness, and working in cross-disciplinary teams. It supports further research on the outcomes and implementation of conservative management. It also advises that policymakers develop reimbursement pathways that provide compensation for conservative management comparable with dialysis, reward care that supports improved patient quality of life, and cover allied health services to further bolster conservative management. The guidance also provides links to training resources for clinicians and patient educational material. Schell emphasized that the most important part of conservative care is being there for patients and their care partners as they navigate their condition and care transitions.

Gelfand recommended that clinicians take advantage of some of the self-guided resources available to learn more about conservative management. She noted that there are many medications and dosing strategies available to help manage symptoms in conservative management. She added that although conservative management may feel like uncharted territory, nephrologists bring a lot of valuable expertise, and it can lead to the most fulfilling types of patient relationships and care. "Don't underestimate the impact you can have for a patient and their family if you stick with them through that kind of care," Gelfand said.

Schell agreed with the huge value that nephrologists bring to patients through conservative management. "Patients value their nephrology clinicians so much," she said. "An important piece of [implementing] conservative management is to say, 'I'm still with you, and I'm on this journey.'" ■

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Key ASN Priorities Advance in Federal Appropriations Package

Continued from cover

ASN President Samir M. Parikh, MD, FASN, noted that the decision to hold NIH funding steady and increase funding for some programs provides a vital lifeline for researchers, the therapeutic development pipeline, and people living with kidney diseases. "When I walk into a clinic room, I want to be able to communicate and convey hope, and hope comes from research," he said. "To see the American government, which has fostered a position of global leadership around biomedical research for more than half a century, stepping up once again in this bipartisan, bicameral way, it is incredibly meaningful."

The HOLD Act, which lowers financial barriers for living donors, was also included in the appropriations bill after 2 years of advocacy by ASN. Roslyn Mannon, MD, FASN, chair of the ASN Transplant Policy Committee, said that financial considerations are often the biggest challenge for living donors, who often worry about being able to afford lost wages or other out-of-pocket costs not covered by insurance while they are recovering. "[Financial barriers] are a key disincentive, and we do not want living donors to have to think about that when they're trying to save somebody's life," Mannon said.

Congressional control

The newly passed law gives NIH a reprieve from the proposed 38% budget cut in the skinny budget, and instead, funding will remain steady at $48.7 billion for 2026 (1). As part of that funding, NIDDK received a $10 million funding boost over the 2025 fiscal year budget, bringing the organization's total budget to $2.3 billion for fiscal year 2026. The additional NIDDK funding is designated for research on type 1 diabetes. The law also maintains NIH indirect cost payments at the levels that were already in place, helping to assuage concerns about the potential negative impact on academic research centers of proposed indirect cost caps.

In addition to preserving the NIH budget and maintaining its current 27 institutes, Congress took several other steps to bolster NIH's independence and congressional authority over health agencies' funding and oversight. The law also included a provision requiring congressional notification prior to NIH grant cancellations. Sudden grant cancellations in 2025—with some later reinstated—created uncertainty in the kidney research community (3). But the new requirement would provide congressional oversight of future grant recisions.

"It's a real tribute to the ASN policy and advocacy team for building these longitudinal trust-based relationships on Capitol Hill with so many individuals and across the aisle," Parikh said. "It is wonderful that kidney diseases continue to have distinct representation at the NIH. There is so much we need to do with kidney innovation—everything from ways to identify kidney disease super early, all the way through the patient journey to the point of innovations in dialysis and transplantation."

The US Centers for Disease Control and Prevention Chronic Kidney Disease Initiative—which had been on the chopping block in the skinny budget—was also preserved in the appropriations law. The legislation also has accompanying language upholding Centers for Medicare & Medicaid Services guidelines, which support evidence-based care for chronic kidney disease and ensure access to early screening for chronic kidney disease.

"Identifying chronic kidney disease at its earliest stages is so incredibly important because we have medicines that can essentially stop kidney disease in its tracks, but we cannot do it if we don't know who has it," Parikh said. "The more we invest nationally to move upstream to test among individuals who are at increased risk, the better we can do for the whole community."

The law also includes a vital 2-year extension of telehealth flexibility, for which ASN, along with numerous other medical organizations, advocated. Suzanne Watnick, MD, FASN, ASN Health Policy Scholar, said ASN's ultimate goal is to make telehealth flexibility permanent because it can be vital for helping individuals with chronic illnesses or those on home dialysis more seamlessly access care. "If you are in a rural or urban environment, and you don't have access to easy transportation, having the ability to access telehealth as an adjunct to face-to-face care can be really helpful for maintaining patients' quality of life and lengthening a good life," Watnick said.

The Kidney Innovation Accelerator (KidneyX), a public-private partnership between the federal government and ASN to accelerate innovation in the prevention, diagnosis, and treatment of kidney diseases, will receive $5 million for 2026. KidneyX competitions award prize money to help promote innovation in kidney disease care, with previous competitions focused on dialysis innovations, artificial kidney development, reduction of COVID-19 transmission among people living with kidney diseases, and promotion of improvements in patient-centered care.

Transplant prioritized

The passage of the HOLD Act is vital to help lower barriers to living donation. Prior to the passage of the HOLD Act, a living donor's eligibility for federal financial assistance to offset costs associated with donating a kidney was assessed based on the income of the transplant recipient. Mannon explained that the policy was likely a throwback to an earlier era when most living donors were family members. However, the rule created an additional barrier for living donors who may have different financial circumstances from the transplant recipient. Mannon noted that although the donor's health insurance may cover the costs of the donation surgery, individuals may incur thousands of dollars in out-of-pocket expenses for lost wages, dependent care, or travel that are not covered by insurance. ASN helped craft the HOLD Act to address this barrier and played a major role in getting it introduced, said Watnick.

Several key transplant programs also received a funding boost in the appropriations bill. The Living Organ Donor Reimbursement Program received a $1 million increase to its budget. This program helps provide finance reimbursement to eligible living donors to offset lost wages, transportation, lodging, meals, and dependent care. The budget increase may help support growth in reimbursement-eligible donors following the passage of the HOLD Act.

The Health Resources and Services Administration (HRSA) also received a $5 million budget increase to help modernize its Organ Procurement and Transplantation Network (OPTN) activities. Additionally, the legislation clarifies that HRSA can collect OPTN patient waitlist fees and emphasizes transplant modernization efforts to improve organ matching and to upgrade OPTN electronic systems. These transplant-related changes were, together with the HOLD Act, a centerpiece of ASN's advocacy during its March 2025 Hill Day.

Mannon added that innovation in the field is important to help overcome stagnant rates of living organ donation and to increase access. "We are hoping to leverage startups or technology companies that might have novel tools to help patients going through transplant navigate the medical system or to support living donors," she said. ■

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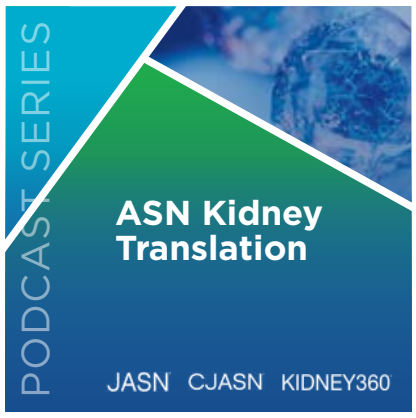

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ASN President's Update

Champions and Change

By Samir M. Parikh

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Shortly after joining The University of Texas (UT) Southwestern Medical Center in Dallas in the summer of 2021, I headed into my first one-on-one meeting with our university's president. Among his achievements, Daniel Podolsky, MD, had been a highly influential physician scientist before moving into administration. He had served as president of the American Gastroenterological Association and been inducted into the National Academy of Medicine so early in his career that it was then known as the Institute of Medicine.

After pleasantries, the conversation quickly pivoted to the Division of Nephrology that I had been recruited to lead. We talked about the division's history that began with the late Donald Seldin, MD, and the late Floyd Rector, Jr., MD, nephrologists who also helped launch ASN and now title our field's seminal textbooks. Then Dr. Podolsky shared the challenges and opportunities he saw for my division in the present. The detail in which my charge was understood by my boss's boss's boss greatly heightened my anxiety.

Before I could blurt out a half-formed thought about nephrology not being part of our health system's clinical strategic plans—unlike, for example, other medical subspecialties, including gastroenterology, cardiology, and hematology or oncology—Dr. Podolsky stated with conviction that the institution was driven by mission not margin, a pursuit of excellence, and internal champions. He was ready to hear the story of how nephrology could excel when I was ready to champion it.

Nearly 5 years later, I have been a fortunate traveler to meet so many kidney champions. The presidents from my first 2 years on the ASN Council—Deidra Crews, MD, ScM, FASN, and Prabir Roy-Chaudhury, MD, PhD, FASN—used their platforms to share their personal stories and spur progress. My fellow councilors and the staff at ASN imbue the entire organization with the ethos of mission, from the policy team tirelessly advocating on Capitol Hill to the publications team pursuing the highest editorial standards.

A little-known program that honors a former ASN staff member who succumbed to kidney disease, Cecilia Fogarty, hosts patient advocates at ASN Kidney Week every year. I encourage you to meet Cele's Champions in Denver, CO, this October. They are passionate, humble, and caring—as well as articulate spokespeople. They know their kidney disease better than anyone. If your fire is ebbing, they will stoke the flame. I guarantee it.

This year, ASN will continue to provide travel support for an estimated 75 nephrology fellows to attend the Nephrology Business Leadership University (NBLU). Each summer, NBLU brings second-year renal fellows from around the country to Dallas for a highly innovative 1-week program of networking, practice in negotiation, and preparation for life in clinical nephrology. From their questions throughout the week that include how to bring dialysis more effectively into our patients' homes, how to make state-of-the-art medicine available to all, and what the opportunities are in community-based practice, our fellows are ready to take the bull by the horns (forgive the cliché; longhorns are a thing in Texas). Last year, I left NBLU thinking that our fellowships around the country are achieving something both powerful and unique: imparting the tenets of physiology—and evidence-based kidney medicine—while simultaneously cultivating agents for change.

Last year, ASN started a first-of-its-kind forum across the country for chiefs of adult and pediatric nephrology. One goal was to communicate ASN's activities to local leaders. The recurring forum has added layers, like peer-to-peer discussion and communication back to ASN, about pressing issues ranging from compensation and trainee interest to evolving multidisciplinary care models and federal research funding. Our community has been strengthened by speaking openly and regularly, by sharing experience and knowledge about best practices, and by leaning on each other to identify emerging opportunities.

This forum has been so successful that ASN hosted an inaugural in-person chiefs' meeting in Scottsdale, AZ, 1 year after our very first videoconference. Timed with the annual Winter Meeting of the Association of Professors of Medicine, our chiefs engaged with department chairs, chiefs of other medical subspecialty divisions, deans, and health system leaders to identify novel strategies to assert our field's value. For example, growing emphasis on value-based kidney care and cardiovascular-kidney-metabolic syndrome presents unique opportunities to identify and treat kidney diseases sooner. Too many individuals still learn that they have kidney diseases late in the course of illness when options are limited and costs are high. What happens for our patients if (and hopefully when) health systems incentivize nephrologists to prevent, diagnose, and treat kidney diseases early?

I met Dr. Seldin once and only briefly when he was in his 90s, but I feel like I know him from the vivid stories his trainees relay to the present day and from the two copies (not one, because again, Texas) of his biography that I received in the mail before relocating. Possessed by an uncompromising inclination toward excellence, Dr. Seldin demanded the very best of himself, of the residents in internal medicine as its chair for 3½ decades, and of his mentees in research, who proceeded to garner biomedical science's highest accolades, including the Breakthrough Prize, the Lasker Award, and the Nobel Prize. On the way into my office, I pass a statue of Dr. Seldin that reminds me of his contributions to UT Southwestern, nephrology, ASN, and medicine.

Spurred by Dr. Podolsky's challenge to me at that very first meeting, our trainees and our faculty have been steadfast champions for the mission of kidney medicine. If anything, the surprise has been how many interested audiences are out there. Our C-suite wants to understand how we can leverage our resources to prevent hospitalizations for people living with kidney diseases. Other specialties want to collaborate around measuring and treating for better kidney health. Our community outreach is growing interest for more screening and educational events. The more we have told our stories, the more interest—and even investment—has come.

Far from perfect, our practice continues to strive higher for our most important audience—our patients. For example, 3 years ago, we opened a new peritoneal dialysis (PD) clinic at Parkland Memorial Hospital in Dallas. For many nephrologists, PD is the option of choice if we or a loved one were to need dialysis. Notably, Parkland cares for many patients who are uninsured, some of whom are unhoused, and many of whom face significant socioeconomic challenges. The hurdles to implementing PD in Parkland's patient population are substantial, and yet, the 2019 Executive Order for Advancing American Kidney Health encouraged all of us to think creatively about surmounting barriers to increase home dialysis (1). Today, the Parkland PD clinic is one of the larger such practices in the country, enabling more than 50 patients to perform treatments in their homes.

Nephrology is an incredibly cerebral specialty. For many of us, this was a major attraction to the field. We puzzle through the triple acid-base disorder first and then reconstruct the story of the patient: how the toxic ingestion led to breathing too fast—and then from fatigue, too slowly—followed by severe emesis. Another great teacher, the late Burton "Bud" Rose, MD, was fond of declaring that there were approximately only 50 facts to learn in nephrology and that the rest could be derived from understanding renal physiology.

I agree with Bud. Data are both great and essential. But the stories matter too. We are well-served by hearing each other's stories and by honing our own storytelling. Stories connect us through shared values. Stories illuminate and amplify the feelings that impel action. Stories are the swords (pens? TikToks?) of champions. The stories that I have heard in my journey through nephrology from many of you nourish my own sense of mission. Stories can spur change.

An origin story explains the initial events and defining moments that shape an identity or a purpose. Last year, ASN launched a new podcast series called "Convergence" to offer "a historical assessment of kidney diseases, nephrology, and health policy in the United States" and to illuminate how the evolution of kidney care and research influences the field of nephrology today. Thus far, one of my favorite episodes focused on how Bud created UpToDate out of sheer intellect, will, and passion (2).

Another great episode tells the story of Shep Glazer, who dialyzed before the House Ways and Means Committee on November 4, 1971 (3). Almost 1 year later to the day, Congress created the Medicare End-Stage Renal Disease Program as part of the Social Security Amendments of 1972 (4). As a result, every American has had access to dialysis starting on July 1, 1973, and this program has ensured lifesaving therapy to millions of people.

Stories matter—I asked my boss's boss's boss, and he agrees. ■

Samir M. Parikh, MD, FASN, is a professor of internal medicine and pharmacology and the Chief of Nephrology at The University of Texas Southwestern Medical School, Dallas, and ASN president.

To comment on Dr. Parikh's editorial, please contact email@asn-online.org.

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When Less Is More: Conservative Dialysis and Kidney Recovery

By Michael Cooper, Harrison Homer, and Hassan Mahmoud

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Acute kidney injury requiring dialysis (AKI-D) remains a major clinical challenge in nephrology, associated with high mortality, prolonged hospitalization, and frequent progression to dialysis dependence (1). The conventional practice for implementing dialysis in AKI-D typically follows a fixed thrice-weekly schedule, extrapolated from traditional maintenance hemodialysis. Prior studies evaluating dialysis intensity in people with AKI have shown that higher-dose dialysis does not confer additional benefit (2, 3). The Liberation From Acute Dialysis (LIBERATE-D) trial investigated a more conservative, indication-based approach to dialysis frequency in AKI-D (4), hypothesizing that routine fixed-schedule dialysis may expose recovering kidneys to unnecessary repetitive hemodynamic stress that may delay recovery (5).

The LIBERATE-D trial enrolled 220 adults with AKI-D, who were already receiving kidney replacement therapy, across four medical centers in the United States (4). The etiology of the AKI was required to be, at least in part, due to acute tubular necrosis. Participants were randomized into one of two strategies: a conservative, indication-based dialysis approach, in which dialysis was performed only when predefined metabolic or clinical thresholds were met, or a standard, three-times-weekly dialysis regimen. The indications for dialysis in the conservative group were any of the following: blood urea nitrogen >112 mg/dL, potassium >6 mmol/L, pH <7.15 (or serum bicarbonate <12 mmol/L), or hypoxia secondary to hypervolemia. The primary outcome of the study was kidney recovery at hospital discharge, defined as survival without the need for dialysis for 14 consecutive days. The secondary outcomes included the number of dialysis sessions per week and the number of dialysis-free days within the first 28 days.

The unadjusted results demonstrated that 64.2% of patients in the conservative strategy achieved the primary outcome, compared with 50.5% in the conventional strategy group (a difference of approximately 13.8%; p = 0.04). Furthermore, patients in the conservative group required fewer dialysis sessions per week (median, 1.8 versus 3.1), experienced earlier recovery to day 28 (21 versus 5 consecutive dialysis-free days), and had fewer episodes of dialysis-associated hypotension (69 versus 97 events). There was no increased risk of severe adverse events.

These findings suggest a potentially favorable "less is more" approach to dialysis in AKI-D, in which a conservative, individualized strategy may promote a better healing environment for injured kidneys and reduce the risk of dialysis dependence. Such an approach could be clinically meaningful and, if broadly implemented, may reduce the overall utilization of health care resources by substantially decreasing dialysis exposure.

However, several important questions remain. After prespecified adjustment, the odds ratio for achieving the primary outcome was 1.56 (95% confidence interval, 0.86–2.84; p = 0.15), which did not reach statistical significance and was likely limited by the sample size. A larger, adequately powered randomized clinical trial addressing this limitation would therefore be highly informative. While reducing the days on dialysis for people with AKI-D would certainly reduce resource utilization, the feasibility of frequent laboratory surveillance and close clinical monitoring required for a conservative, indication-based strategy—particularly in the outpatient setting—remains uncertain. Additionally, these findings are not generalizable to patients who are critically ill requiring vasopressors or mechanical ventilation, as such patients were excluded from the trial.

Nonetheless, despite these practical considerations, an indication-based approach to dialysis in AKI-D represents a meaningful shift toward patient-centered care and a deliberate effort to reduce the risk of long-term dialysis dependence in these individuals. ■

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The authors report no conflicts of interest.

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CREATIVE CORTEX

Fiery Filtration

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"Fiery Filtration" evokes the fiery turbulence of glomerulonephritis, an inflammation within the kidney's delicate filtration system. Swirling embers of red, orange, and black create a sense of internal chaos, resembling cellular distress and immune attack. The fluid, almost vascular patterns, reflects the microscopic entanglement of inflamed glomeruli, struggling against an overwhelming force. The interplay of heat and darkness suggests destruction and regeneration—an artistic interpretation of the body's relentless fight against inflammation. ■

Artwork by AnilzArt. Anil Saxena, MD, FASN, is a digital artist based in Dubai, United Arab Emirates. His abstract artwork blends trained medical expertise with vibrant color palettes, creating visually captivating landscapes of human identity and transformation. Saxena's work has been exhibited internationally and featured on the covers of medical journals.

Ambient AI Scribes: Evidence Arrives and What It Means for Kidney Care

By Wisit Cheungpasitporn, Jing Miao, and Charat Thongprayoon

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Documentation has long functioned as a structural tax on nephrology practice. Dialysis prescriptions, complex longitudinal care, high-risk medication reconciliation, and regulatory reporting create notes that are both time-consuming and high-stakes. For years, ambient artificial intelligence (AI) scribes—systems that listen to a clinical encounter and draft a note—have been promoted as a solution. Until recently, enthusiasm outpaced rigorous evidence. That evidence has now begun to arrive, with direct relevance to kidney care.

Randomized evidence now supports that ambient AI scribes can improve the clinician experience, although documentation time savings may vary by platform and workflow. A pragmatic three-group randomized trial compared Microsoft Dragon Ambient eXperience (DAX) Copilot, Nabla, and usual care across outpatient physicians. Nabla reduced time-in-note versus the control, whereas DAX showed no significant difference; both tools were associated with improved clinician-reported experience measures and reduced task load (1).

A second pragmatic randomized trial using a stepped-wedge implementation evaluated ambient AI in ambulatory clinics and found a significant reduction in work exhaustion and interpersonal disengagement, along with decreased time spent on notes. Notably, billing diagnostic codes improved with ambient AI use, and documentation quality remained favorable, supporting the concept that the tool can reduce burden without compromising integrity when deployed in real-world workflows (2).

How ambient scribes work

Ambient AI scribes combine speech recognition with large language models to convert a conversation into a structured clinical note (Figure). The system typically produces a draft within minutes, and the clinician reviews, edits, and signs. This "draft-then-verify" workflow is essential in nephrology, in which small inaccuracies in recommendations, medication dosing, or follow-up plans can carry real risk. The technology should be viewed as documentation assistance, not clinical decision-making, and it still requires physician oversight.

Randomized evidence cautions against assuming universal time savings (1, 2). Efficiency gains depend on visit type, clinic pace, note style, and how much editing is required to reach an acceptable final note. Some clinicians may save time capturing histories and patient instructions but then spend similar time correcting subtle errors or restructuring the assessment and plan. Nephrology visits also require lab-trend interpretation and medication reconciliation, which may not be fully captured unless the clinician is explicit about the assessment, key numbers, and plan. Beyond time-in-note, ambient AI may also influence operational and financial outcomes; in a large ambulatory evaluation, ambient scribe use was associated with higher physician financial productivity, suggesting that the value proposition may extend beyond documentation minutes alone (3).

Across studies, the clearest and most consistent signal has been an improved clinician experience (1, 2). Even when documentation time changes modestly, clinicians often report lower mental workload and a smoother visit flow. This likely reflects cognitive offloading, allowing clinicians to focus on listening and decision-making rather than concurrent documentation. Importantly, both randomized trials (1, 2) reported benefits in well-being measures, including reduced task load and work exhaustion, reinforcing that the primary value proposition may be sustainability rather than speed alone.

Clinically significant inaccuracies appear uncommon, but they do occur. Errors may involve diagnoses, medication details, or follow-up instructions, which are exactly the elements that drive downstream decisions. In kidney care, risk concentrates around dose adjustments (e.g., diuretics, blood pressure medications, and immunosuppression), dialysis prescriptions, anemia therapies, and comorbidity management. Ambient AI notes should therefore be treated like any other scribe output: a draft that must be verified line-by-line. Safeguards that translate well to nephrology include confirming medication and dialysis parameters, keeping key values (estimated glomerular filtration rate; potassium, bicarbonate, and weight levels; and ultrafiltration goals) visible during review, and using structured templates for prescriptions.

What AI scribes mean for nephrology

Nephrology is a high-documentation specialty with a broad scope. Ambient AI scribes may be especially helpful for chronic kidney disease and dialysis follow-ups, in which recurring structure can accelerate note assembly; transplant clinics, in which long medication lists and complex histories challenge manual documentation; and multidisciplinary visits, in which consolidating discussions into a coherent plan supports continuity. Success should be judged not only by documentation minutes but also by note quality, safety events, team communication, and patient understanding (4, 5).

Ambient AI scribes should be deployed with practical governance—more seat belt than siren. Patients should be informed that an AI tool is assisting with documentation (i.e., securing a signature plus offering a brief verbal disclosure) and offered an easy opt-out for sensitive discussions. Health systems should ensure appropriate contractual protections, secure data handling, and provide clarity on whether audio is stored and for how long and who can access it. Billing integrity should be protected by keeping the note clinician-owned: The clinician remains responsible for content and coding, and organizations should monitor for documentation drift or inadvertent upcoding.

Ambient AI scribes are moving from promise to evidence. Randomized trials show consistent improvements in clinician experience and reduced cognitive load, whereas time savings vary by platform and workflow. From an implementation perspective, a realistic return on investment likely depends on local workflow design, clinician adoption, and careful monitoring of quality and compliance rather than expecting uniform time savings across settings (6). For kidney care, the opportunity is substantial but so is the responsibility to implement thoughtfully, verify rigorously, and measure outcomes that matter: safety, continuity, and clinician sustainability. ■

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The authors report no conflicts of interest.

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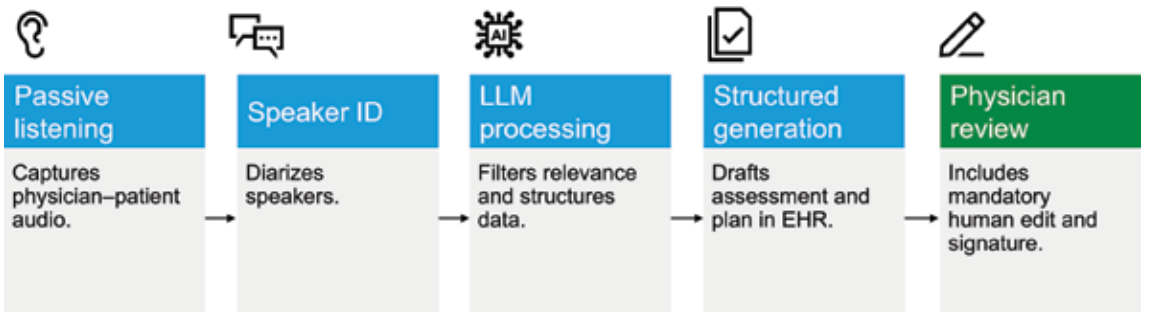
Figure. Ambient AI workflow



EHR, electronic health record; ID, identification; LLM, large language model.

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Pay Attention to Data Quality and Accessibility for Future Practice Success

By Katherine Kwon

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Longitudinal care of chronic diseases, including kidney diseases, is expanding beyond the episodic office visit. Payors are now reimbursing for programs such as chronic care management and remote patient monitoring, in addition to value-based care (VBC) payment models. There are also revenue-generating opportunities from participating in clinical research. Traditional fee-for-service margins continue to shrink, and new revenue models can help address the shortfall. A practice's ability to successfully participate in these opportunities will, in large part, hinge on the quality and accessibility of the data in its electronic medical record (EMR).

Understanding data quality is the first step in evaluating practice readiness. Patient data that are stored as discrete entries are easier to extract for population-based insights. Discrete data fields include categorized lab values and *International Classification of Diseases and Related Health Problems, Tenth Revision* (*ICD-10*) codes. Free-text data, such as scanned reports and narrative in the progress notes, are harder to automatically extract and search. Coding "stage 4 kidney disease" is searchable, whereas coding "kidney disease unspecified," and writing "stage 4 kidney disease" in the note make it harder to identify such patients at scale. Let us evaluate several scenarios for hypothetical practices and factors that relate to their data quality.

Practice A has hired a recent fellowship graduate and wants to evaluate the quality of the new physician's care. The practice participates in risk-based contracts, and adherence to guideline-directed medical therapy for diabetic nephropathy is a critical metric for its success. Many health systems still use clinician chart review of a small number of charts to evaluate physicians. A more comprehensive evaluation would automatically calculate, for example, the percentage of patients who had an albumin-creatinine ratio tested within the past 12 months or the fraction of patients with diabetic nephropathy receiving a sodium-glucose cotransporter-2 inhibitor. This requires discrete data fields for medications, lab values, and diagnoses. The ability to create custom queries allows the practice to drive quality improvement in the metrics that it deems most important.

A physician in Practice B would like to complete some online surveys for extra income. (These online surveys are a popular topic of discussion on the Physician Side Gigs website [1]). A survey may ask the physician how many patients with hypertension they have treated in the past 6 months and then seek to further categorize this group. Rough estimates may not provide adequate data quality, and physicians could miss out on invitations for future surveys. A search feature in the EMR will depend on the quality of diagnostic coding. If the physician is not coding for associated diagnoses such as hypertension, hyperkalemia, or other conditions, they will not be able to find information on the population of interest.

Practice C has started a clinical research program. It receives a feasibility request from an interested sponsor, asking how many patients with APOL1-mediated kidney disease (AMKD) it currently sees. The AMKD diagnosis code is still new, and most of these patients are still coded as nonspecific glomerulonephritis. Information about patient biopsies can only be found by looking for a pathology scan in each chart. It takes the practice much longer to respond to the feasibility request, and it misses the deadline to be considered for the study.

In addition to data quality, access to EMRs is a growing concern for practices. There are remote vendors and partners across an expanding range of possibilities, including care management, billing, and VBC participation. Furthermore, artificial intelligence (AI) tools have been developed to fix some of the data-quality problems just explored. Practices may not have control over which vendors they can partner with and which AI tools they can use, depending on their contract with their EMR vendor.

Practice D would like to partner with a third-party vendor to provide chronic care management services to its patients with advanced chronic kidney disease. It will split the monthly fee that is paid for each patient enrolled in the program. The remote care managers require access to the EMR to deliver their services. Practice D uses its health system's EMR. If it is not allowed to grant access, it will not be able to work with the vendor, and patients will not receive care management services.

EMR access is particularly challenging for the population living with kidney failure. Physicians caring for people on dialysis usually use the EMR of the dialysis unit and have little control over choice of vendor or access (2). The dialysis company will generate reports as needed for the required quality reports, but custom queries are not often available. Practice E is negotiating the use of an EMR with a new dialysis unit. It would like its VBC partner to have access to the charts for their mutual patients. It would also like to access the dialysis facility's notes after a patient transfers out of the unit or receives a transplant. If the dialysis company refuses to provide these EMR capabilities, the practice will have fewer tools at its disposal to provide longitudinal and comprehensive care.

There are some steps that practices should consider to improve their EMR utility. Self-assessment of accurate coding is critical, and each physician in the practice should understand the importance of specific and accurate coding. For chronic kidney disease, the correct stage should be selected and kept updated as the patient progresses. Albuminuria is covered by a separate *ICD-10* code, and including this as appropriate will make it easier to identify pools of patients with high risk. Glomerular diseases should also be coded to a specific diagnosis, rather than relying on the biopsy report to hold the clinical information. Patients with these rare and complex diseases are often of great interest to researchers and clinical trialists.

The practice leader or manager should also be very familiar with the EMR contracts, of which there may be several. These contracts should cover the access and rights of the practice. Evaluate if outside partners can access the EMR in the scope of their work with the practice. This could include billers, VBC companies, and remote care partners. Assess whether the EMR will interface with emerging AI vendors offering services such as data characterization. Vendors will often claim to work with a wide variety of EMR companies, but their success and the cost of integration can be quite variable.

Building an accurate database with well-characterized, discrete elements takes significant cognitive work from the clinicians working in the EMR. Until now, the return on investment has primarily been in cleaner claims with fewer denials and faster payment. In the era of machine learning and incentives toward better population health management, practices should recognize that their data have significant value. Nephrologists in particular have patients who are chronically ill with a high cost of care. Practices should critically assess their EMR use and capabilities now to perform well in newer payment models that emphasize improved outcomes at scale. ■

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The author reports no conflicts of interest.

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Detective Nephron

The Case of the Disappearing Protein

By Kenar D. Jhaveri

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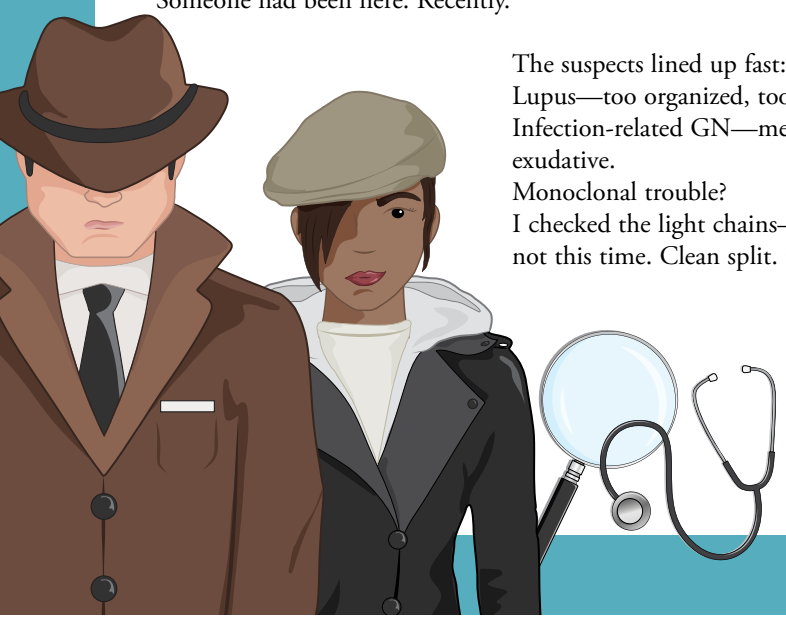
It was another long night in the cortex.
The lights were dim, the urine was foamy, and something didn't add up.

Our pathology friend lit up the scope—
LM first.
The glomerulus stared back, innocent enough,
but I've learned not to trust appearances.

IF was next.
Bam! Granular deposits—
IgA, bold as a calling card, but so were IgG and IgM
spread through the mesangium like a bad alibi.
Alternative pathway footprints all over the scene.
Complement never lies—it just doesn't apologize.
I was convinced the house was full.

EM sealed it.
Electron-dense deposits, tucked in tight,
hiding where only magnification could find them.
Foot processes—flattened.
Someone had been here. Recently.



The suspects lined up fast:
Lupus—too organized, too many players.
Infection-related GN—messy, loud,
exudative.
Monoclonal trouble?
I checked the light chains—
not this time. Clean split. Case closed.

But then came the curveball.
Went back to see the LM, and bingo—crescents.
Fast ones. Mean ones.
The kind that tell you the clock is already ticking.

Labs don't lie either. Lupus it is. What do we do?

I called in backup:
Steroids hit hard.
Obi kept quiet but effective. Or should we pull the big ones, the "C"?
Complement blockers—new kids in town—
Maybe not here, promising they could stop the damage at the source.
But we have others for this disease, many others—the BAFFs, the tacros, the cyclos, and the mycophenos.
I've heard that before, but sometimes…
they deliver.

The proteinuria and hematuria backed off.
Creatinine blinked, steadied.
Not a full confession—but enough.

Another night, another nephron saved.
In this city of capillary loops and silent leaks,
the glomerulus always leaves clues.
You just need to know where to look.
Case status: Managed. Detective Nephron—still on call. ■

BAFFs, B cell activating factors; cyclos, cyclosporine; EM, electron microscopy; GN, glomerulonephritis; IF, immunofluorescence; Ig, immunoglobulin; LM, light microscopy; mycophenos, mycophenolate mofetil; Obi, obinutuzumab; tacros, tacrolimus.

Detective Nephron was developed by Kenar D. Jhaveri, MD, FASN, professor of medicine at the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell, Hempstead, NY. Send correspondence regarding this column to kjhaveri@kidneynews.org.

Are you a fellow with a tip or idea you'd like to share with your fellow peers and the broader kidney community?

Send your idea to the *ASN Kidney News* Fellows First column at kidneynews@asn-online.org

Collaboration Drives Opportunity for New Therapeutics for People With *APOL1* Kidney Diseases

By Howard Trachtman and Melissa West

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Chronic kidney disease and kidney failure disproportionately affect Black individuals (1). In the past, epidemiologic studies attributed this observation primarily to social determinants of health and to disparities in access and provision of medical care (2). The discovery of the chromosomal 22 locus and subsequent identification of the apolipoprotein 1 (*APOL1*) gene and the strong association of the two variants, G1 and G2, with a marked increased risk of progressive kidney disease indicated that there was some biological basis for the high prevalence of kidney disease in Black individuals of West African ancestry (3). Moreover, it raised the possibility that interventions that target the *APOL1* disease pathway could reduce the burden of kidney disease in this vulnerable population (2). In the last 5 years, several promising therapeutic strategies and agents have emerged that counteract the consequences of high-risk *APOL1* variants (4). Clinical trials were initiated to assess the impact of these innovative treatments on the course of *APOL1* kidney disease. "We know high-risk *APOL1* variants drive a 15% to 30% risk of chronic kidney disease and an 80% risk of progression to [kidney failure]. With a precision medicine approach, we may finally have a chance to rewrite the future of so many patients faced with this devastating disease," said Keisha Gibson, MD, MPH, FASN, University of North Carolina Kidney Center, Chapel Hill, and cochair of the PARASOL-APOL1 initiative described in this article.

The Kidney Health Initiative (KHI) recognized the need for greater awareness, education, and therapeutic development for *APOL1* kidney diseases in 2022. "Roadmap for Advancing Awareness, Genetic Testing, and Clinical Studies of *APOL1* Kidney Disease" was developed by a multisector group of stakeholders to support the kidney health community in a coordinated effort in tackling *APOL1* kidney diseases (5). The roadmap focuses on increasing awareness of *APOL1* kidney diseases, increasing access to and awareness of genetic testing and associated counseling, and empowering patients with *APOL1* kidney diseases to make informed decisions about participating in clinical studies.

Central to the design, implementation, and successful completion of randomized control trials is the definition of endpoints that are clinically meaningful and feasible for patients, investigators, and pharmaceutical sponsors. Proteinuria and Other Biomarkers as Endpoints for Clinical Trials in Kidney Disease (PARASOL) is an international collaboration, led by the International Society of Glomerular Disease in partnership with KHI, NephCure, and the National Kidney Foundation, that focuses on evaluating endpoints at the earlier stages of *APOL1* kidney disease (6). PARASOL was launched in December 2023 to address the critical issue of defining proteinuria as a validated surrogate endpoint that could be utilized in randomized control trials for focal segmental glomerulosclerosis (FSGS) (7). "PARASOL has demonstrated that through global collaboration and data sharing, the nephrology community can provide the evidence needed to understand how best to assess novel therapeutics for uncommon kidney diseases," reflected PARASOL Cochair Laura Mariani, MD, MS, FASN, University of Michigan, Ann Arbor.

With the guidance of regulatory authorities, it is now recognized that the effort to define trial endpoints needs to be disease specific, and efforts focused on surrogate endpoints need to include an understanding of the biological plausibility or causal relationship to the outcome of interest. In its second project, PARASOL kicked off a focus on *APOL1* kidney disease during an initial meeting on October 9–10, 2025, in Minneapolis, MN. Clinical investigators, biostatisticians, patients, and industry representatives then convened for a 2-day meeting, dedicated to reviewing interim results, on February 5–6, 2026, in Raleigh-Durham, NC.

PARASOL's *APOL1* Kidney Disease Interim Meeting opened with two state-of-the-art presentations about the basic biology of *APOL1* gene expression and the various mechanisms of injury within the kidney (by Katalin Susztak, MD, PhD, University of Pennsylvania, Philadelphia; and Opeyemi Olabisi, MD, PhD, Duke University, Durham, NC) and the broad clinical phenotype associated with the presence of two high-risk alleles (by Barry Freedman, MD, Wake Forest University, Winston-Salem, NC). Preliminary findings from an analysis of data from patients with two high-risk *APOL1* alleles, who are enrolled in the Nephrotic Syndrome Study Network (NEPTUNE: NCT01209000) and Cure Glomerulonephropathy (CureGN) observational cohort studies, were reviewed to serve as a basis for the more comprehensive analysis that will be performed on the larger amalgamated cohort (by Abigail Smith, PhD, Northwestern University, Chicago, IL; and Margaret Helmuth, MA, University of Michigan). The attendees were divided into workgroups that addressed specific issues including: 1) criteria for eligibility for inclusion of cohorts into a PARASOL-APOL1 analysis and the minimum required data elements, 2) the scope of genetic variants and clinical phenotypes to be included, and 3) potential clinical trial designs and the impact on the endpoints to be developed by the PARASOL-APOL1 project. The closing presentation (by Hailey Desmond, MS, University of Michigan) addressed the logistics of data collection and curation to enable sharing and transfer to the data coordinating center at the University of Michigan. The meeting concluded with next steps to be taken and a proposed timeline to conduct this work.

PARASOL-APOL1 reflects a broad and deep collaboration among all of the engaged participants around the world. The final analysis will benefit from additional datasets that can be used for validating the endpoint model. Similar to PARASOL-FSGS, engagement of over 20 groups across the globe provided critical data to support the development of clinical trial endpoints. Collaboration across nephrology programs with patient-level data and genetic testing of *APOL1* is an important step. We encourage those who have potential datasets or patient registries to reach out to us for collaboration. Furthermore, collaborative efforts among clinical experts, clinical trialists, patients, and industry will ensure that effective and patient-centered therapies are developed for people with *APOL1* kidney disease and promote wider understanding within the nephrology community of the regulatory pathways and evidence that supports the proposed clinical trial endpoints. Trial endpoints, specifically, are an important discussion to have as a community to appreciate why specific surrogate endpoints are used as intermediate outcomes versus longer-term clinically relevant outcomes such as mortality and kidney failure for accelerated versus traditional approval.

The extension of PARASOL to study *APOL1* kidney disease addresses a pressing clinical problem in a high-risk population. "ASN continues to advocate for transformational change in health care for our patients. And in conjunction with KHI, ASN continues to raise awareness, advocate for patient engagement and interdisciplinary collaboration, and [promote] more research," shared Cochair Rulan Parekh, MD, MS, FASN, University of Toronto, Ontario, Canada. The work of PARASOL-APOL1 builds on the momentum generated by the PARASOL-FSGS initiative. It leverages the lessons learned from that groundbreaking effort and offers hope that feasible trial endpoints will be defined in the very near future and will spur the performance of randomized clinical trials in this area of huge unmet clinical need. ■

To learn more about PARASOL-APOL1, please contact Laura Mariani, MD, MS, FASN, at lmariani@med.umich.edu.

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The authors report no conflicts of interest.

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One Child in Every Classroom Has Hypertension, and Few Are Diagnosed or Treated

By Catherine Quinlan

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High blood pressure in children is under-recognized, underdiagnosed, and undertreated, argue Chanchlani and colleagues in a recent review in *The Lancet Child and Adolescent Health* (1). As a result, pediatric hypertension remains largely invisible in routine clinical care despite compelling evidence that it is common, persistent, and harmful. Conservative estimates suggest that at least 4% of children worldwide have elevated blood pressure or hypertension, equating to one child in every classroom (2). Yet, hypertension continues to be viewed primarily as an adult disease, minimizing its detection and management in childhood.

The authors clearly show that although there are differences in the frequency of blood pressure monitoring recommended around the world (e.g., annually in the United States and every other year in Europe), all guidelines recommend that blood pressure measurement is part of the routine assessment of well children. Despite this, multiple large studies demonstrate that hypertension and prehypertension are infrequently diagnosed in pediatric practice. In a retrospective cohort of more than 1.2 million children in the United States, fewer than one in four children meeting criteria for hypertension received a documented diagnosis, with 5.6% of those with persistent hypertension prescribed antihypertensive medication within 1 year (3). Qualitative and survey-based studies provide insight into this gap. Primary care clinicians consistently report discomfort with pediatric blood pressure interpretation, uncertainty regarding pharmacologic treatment, competing priorities during visits, and concern about parental acceptance of medication (4). The result is a pattern of deferral, referral, or inaction.

This reluctance persists despite clear evidence that elevated blood pressure in childhood is not benign. Longitudinal data from the International Childhood Cardiovascular Cohort Consortium demonstrate that higher systolic blood pressure was independently associated with an increased risk of cardiovascular events in adulthood after a mean follow-up of 35 years. Furthermore, the combination of childhood risk factors, including blood pressure, was more strongly associated with adult cardiovascular events than any single factor alone. These findings demonstrate that blood pressure levels in childhood are clinically meaningful predictors of premature cardiovascular disease in midlife and support the importance of early identification and risk modification (5).

Current pediatric hypertension guidelines recommend nonpharmacologic interventions as first-line management for uncomplicated primary hypertension, commonly over an initial period of 6 months. Evidence summarized in a recent systematic review from Tiplady et al. indicates that lifestyle interventions can produce meaningful reductions in blood pressure in children, particularly when interventions are multicomponent and implemented in school or community settings (6). Interventions incorporating physical activity, Dietary Approaches to Stop Hypertension (DASH)-style dietary patterns, weight loss, regular physical activity, dietary sodium restriction, and health education were more likely to be associated with blood pressure reduction than single-component approaches, with physical activity emerging as a key contributor. Reported reductions in blood pressure ranged from small population-level shifts to larger reductions in higher-intensity programs, especially among children with elevated baseline blood pressure. Importantly, lifestyle-first does not mean lifestyle-only. Failure to achieve control after a structured trial should prompt escalation rather than prolonged observation.

Pharmacologic treatment of pediatric hypertension is well established and supported by clinical guidelines. Whereas long-term comparative effectiveness data in children remain limited, the absence of perfect evidence does not justify therapeutic paralysis. Current recommendations favor initiation with a single agent from a small number of familiar classes, most commonly angiotensin-converting enzyme inhibitors, angiotensin receptor blockers, long-acting calcium channel blockers, or thiazide diuretics, with gradual dose titration and escalation to combination therapy if needed (7). In children with chronic kidney disease, proteinuria, or diabetes, renin-angiotensin system blockade is preferred because of kidney-protective effects. Evidence from randomized trials and meta-analyses confirms that these agents are effective and generally well tolerated in children, although direct comparative data between drug classes and long-term outcome studies remain limited. Importantly, pharmacologic therapy is intended to complement, not replace, ongoing lifestyle interventions, and failure to initiate treatment when indicated risks prolonged exposure to elevated blood pressure during a critical period of cardiovascular development (8, 9).

Nephrologists and cardiologists cannot be expected to manage 4% of the pediatric population. The solution must therefore lie in earlier recognition, routine blood pressure measurement, and greater confidence within primary care. Implementation of existing guidelines, supported by training, appropriate equipment, decision support tools, and public awareness, may yield greater benefit than any new threshold or treatment algorithm.

Normalizing blood pressure measurement in childhood should be as routine as vision screening or dental checks. Without this shift, childhood hypertension will remain a missed opportunity for cardiovascular disease prevention. ■

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The author reports no conflicts of interest.

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Chronic Kidney Disease Following Preeclampsia: A Call to Action

By Mairéad Hamill

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Pregnancy is increasingly recognized as a physiologic "stress test," unmasking an individual's susceptibility to future cardiometabolic disease. Preeclampsia is a well-established risk factor for chronic hypertension, cardiovascular disease, stroke, and kidney failure (1). However, its association with earlier, potentially modifiable stages of chronic kidney disease (CKD) is less well characterized (2, 3).

In a population-based cohort study from Stockholm, Sweden, Yo et al. (4) examined whether preeclampsia is associated with subsequent laboratory evidence of CKD. The study included more than 170,000 nulliparous women with pregnancies between 2006 and 2020, of whom 10,538 (6%) developed preeclampsia. Women with preexisting hypertension, diabetes, or CKD were excluded. Inverse probability of treatment weighting was used to address confounding. Outcomes were defined by laboratory markers: severe albuminuria (urine albumin-to-creatinine ratio >300 mg/g), reduced kidney function (estimated glomerular filtration rate [eGFR] <60 mL/min/1.73 m^2), or a composite of both.

Over a median follow-up of 7 years, severe albuminuria occurred in 0.5% of women, reduced kidney function in 0.1%, and the composite outcome in 0.6%. Incidence rates per 1000 person-years were higher among women with preeclampsia than in those without for severe albuminuria (1.53 versus 0.57), eGFR (0.52 versus 0.18), and the composite outcome (2.00 versus 0.73). Women with a history of preeclampsia developed evidence of kidney disease more than a decade earlier than those without.

The investigators should be commended for providing robust population-level evidence of an association between preeclampsia and laboratory markers of CKD. The therapeutic armamentarium for slowing CKD progression—including renin-angiotensin-system blockade, sodium-glucose cotransporter-2 inhibitors (5), and now glucagon-like peptide-1 receptor agonists (6)—has never been stronger. However, the unresolved questions are not about whether preeclampsia confers risk but rather about who should be followed, how intensively, and by whom.

The study offers limited insight into which subgroups are at highest risk. The low absolute event rate (two composite events per 1000 person-years) suggests that universal postpreeclampsia screening among otherwise healthy nulliparous women in Sweden is unlikely to be cost-effective. The absence of race and ethnicity reporting of this presumably predominantly White European cohort limits generalizability to more diverse populations with higher preeclampsia incidence (7). Individuals with early-onset (8) and/or recurrent preeclampsia (9), who are known to have markedly elevated long-term cardiovascular risk, may represent a more informative target for surveillance.

As this study demonstrates, framing preeclampsia as an obstetric complication alone risks underestimating its long-term consequences. In this cohort, only 1 in 5 women underwent serum creatinine testing, and just 1 in 10 had urinary albumin assessed during the first year postpartum. A constructive approach may be to recognize preeclampsia as a systemic condition with lifelong implications, warranting structured chronic disease management within primary care for those at greatest risk. However, primary care physicians must be adequately trained, funded, and supported with consensus guidelines from the obstetric nephrology field on effective optimization with clear referral pathways. Developing cost-effective, risk-stratified models of postpreeclampsia care represents an important next step in translating epidemiologic insight into CKD prevention strategies to improve outcomes for women who are high risk. ■

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The author reports no conflicts of interest.

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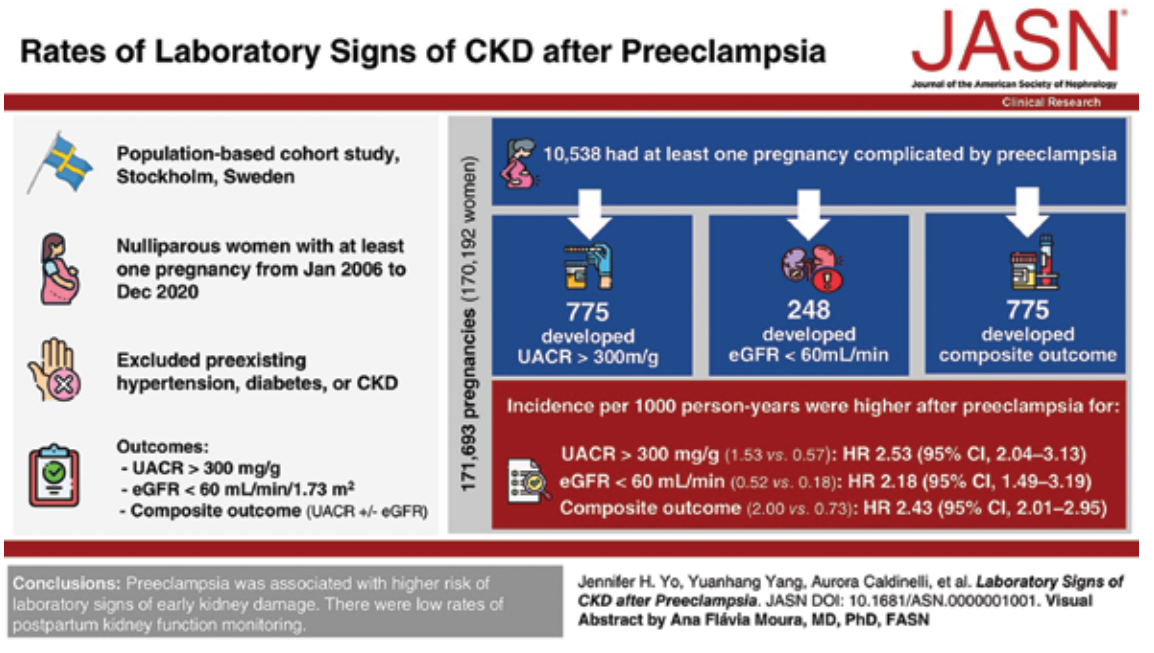

Reprinted from Yo et al. (4). CI, confidence interval; HR, hazard ratio; UACR, urine albumin-to-creatinine ratio.

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Advocacy Momentum Builds as ASN Hosts Spring Hill Day, and CMS Delays Data Policy Change

By Ryan Murray

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Advocacy efforts by ASN gained momentum this spring as kidney leaders traveled to Washington, DC, for ASN's annual Hill Day, while federal officials simultaneously announced a key policy shift affecting kidney research. Together, the developments reflect growing federal attention to kidney health following several major legislative and appropriations victories earlier this year.

ASN leaders bring kidney priorities to Capitol Hill

On March 10th, members of the ASN Policy and Advocacy Committee and ASN Transplant Policy Committee met at congressional offices to advance key ASN policy priorities. In meetings with their congressional delegations, the advocates urged Congress to increase federal investment in kidney research and support for living kidney donors.

ASN encouraged lawmakers to provide an initial $1 billion investment dedicated to prioritizing kidney health research at the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) in the Fiscal Year (FY) 2027 Labor–Health and Human Services (L-HHS) appropriations package. This initial investment is the first step toward the kidney community's goal of securing the $1.8 billion in annual federal kidney research funding called for by the "Transforming Kidney Health Research" (TKHR) report (1). Kidney research funding at NIDDK and the recommendations of the TKHR report were also included in a congressional sign-on letter being led by Representatives Marilyn Strickland (D-WA) and Joe Wilson (R-SC), together with a recommendation for the Centers for Disease Control and Prevention's (CDC's) Chronic Kidney Disease Initiative to expand programs aimed at increasing kidney disease awareness, early detection, and access to care—a top National Kidney Foundation (NKF) priority. "ASN and NKF are collaborating closely on advocating for increased support for kidney funding priorities, which allows our organizations' voices to be greater than the sum of their parts," said Suzanne Watnick, MD, FASN, chair of the ASN Policy and Advocacy Committee and ASN Health Policy Scholar. ASN is greatly appreciative of the TKHR inclusion in the sign-on letter, which is an indication of strong bipartisan support for the report in its inaugural introduction to congressional offices.

> *"Nephrologists and researchers are on the cusp of breakthroughs that could alter the course of kidney diseases, but we need robust and sustained federal commitment to critical kidney health research to maintain progress," said Watnick.*

ASN also worked with congressional champions Representatives Suzan DelBene (D-WA), Carol Miller (R-WV), and Kim Schrier (D-WA) to have the Expanding Support for Living Donors Act introduced the day before ASN members ascended the Hill to urge support for it. This legislation is designed to make living donation more financially feasible by expanding eligibility for donor reimbursement, increasing reimbursement caps, and improving transparency in the federal program that supports living donors.

> *"As a transplant nephrologist, I've seen firsthand how living donors transform the lives of their recipients," said Roslyn B. Mannon, MD, FASN, chair of the ASN Transplant Policy Committee. "The Expanding Support for Living Donors Act honors that selfless act by reducing or eliminating out-of-pocket costs for living donors, making living donation a possibility for more Americans interested in saving the life of others."*

March is appropriations season, when many national organizations bring their advocates to Washington, DC, to meet with members of Congress. ASN's policy requests are being reinforced both by separate Hill Days of other kidney community organizations and through a community sign-on letter led by ASN and NKF with more than 35 patient and health care professional associations, nonprofit organizations, and industry partners endorsing them (2). The letter urged congressional leaders in FY 2027 to support:

- $5.5 Million for the CDC's Chronic Kidney Disease Initiative
- $51.3 Billion for the National Institutes of Health (NIH) and robust funding for kidney disease research, specifically with $1 billion designated for kidney research at NIDDK
- Developing the kidney workforce by supporting opportunities to train, attract, and support young cross-disciplinary researchers and junior faculty members
- Innovation in kidney transplantation, including xenotransplantation
- $77 Million for the Health Resources and Services Administration (HRSA) Organ Procurement and Transplantation Network Modernization
- Living organ donation reimbursement at HRSA
- $25 Million for the Kidney Innovation Accelerator (KidneyX) to continue to catalyze innovation in kidney care

These requests and ASN's Hill Day come on the heels of Congress passing the FY 2026 L-HHS appropriations package, which featured several ASN priorities, including the enactment of the Honor Our Living Donors Act. The package also included funding for KidneyX ($5 million), HRSA organ transplant activities ($5 million), a $1 million increase above prior funding levels for the Living Organ Donor Reimbursement Program (bringing it to $9 million), NIH ($48.7 billion), and NIDDK ($2.3 billion).

CMS indefinitely delays research data policy after advocacy

Also earlier this year, kidney researchers received welcome news from the Centers for Medicare & Medicaid Services (CMS). The agency announced on February 11th that it will indefinitely delay plans to require all studies using Research Identifiable Files to transition to the Chronic Conditions Warehouse Virtual Research Data Center (VRDC). CMS cited growing concerns about data security and breaches across the health care data ecosystem as the primary rationale for the change. However, the proposal also introduced substantially higher upfront and ongoing fees, along with new logistic and operational requirements. These changes raised concerns among researchers who rely on Medicare data to conduct complex health services and policy analytes, including studies focused on kidney diseases. As of 2023, the most recent year for which data are available, approximately 77% of individuals living with kidney failure are covered by Medicare, making Medicare claims data one of the most comprehensive national data sets available for studying the population with kidney failure.

CMS's announcement to delay the transition follows nearly 2 years of sustained advocacy by ASN and the broader research community. In numerous letters to CMS, ASN stressed that the VRDC transition could limit transparency about migration of kidney-related datasets; undermine timely access to data that are critical for evidence-based policy and quality improvement; significantly increase costs for researchers, especially at smaller programs; and reduce research capacity by deterring new investigators. The agency's decision to delay the requirement is a welcomed announcement that provides time for further evaluation of the operational and scientific implications of such a shift.

Sustaining momentum for kidney policy

Together, the Hill Day advocacy and CMS policy announcement illustrate the growing influence of the kidney community in shaping federal policy. With Congress increasingly focused on research investment and transplantation access and federal agencies responding to concerns raised by researchers, sustained engagement from ASN members will be essential to translating recent policy momentum into long-term improvements for people living with kidney diseases. As lawmakers begin considering FY 2027 funding and additional policy reforms, ASN plans to continue working with Congress and federal agencies to ensure that kidney research, innovation, and patient access remain national priorities. ■

To keep track of ASN's policy efforts throughout the year, follow coverage in *Kidney News* and the ASN podcast feed, and visit ASN's Kidney Health Advocacy and Public Policy webpage (www.asn-online.org/policy/kidney-health.aspx). For real-time updates from ASN Policy, follow @ASNAdvocacy on X.

Ryan Murray is the senior manager of Policy and Government Affairs at ASN.

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Findings

Semaglutide Reduces Infection Serious Adverse Events in Diabetic Kidney Disease

https://doi.org/10.62716/kn.003292026

In people with chronic kidney disease (CKD) and type 2 diabetes, treatment with the glucagon-like peptide-1 receptor agonist semaglutide reduces the risk of serious adverse events (SAEs) related to COVID-19 and other infections, according to a study in *Nephrology Dialysis Transplantation*.

The researchers analyzed data on 3533 people with type 2 diabetes and CKD from the international, multicenter FLOW [A Research Study to See How Semaglutide Works Compared to Placebo in People With Type 2 Diabetes and Chronic Kidney Disease] trial. In that placebo-controlled study, patients assigned to semaglutide had significant reductions in adverse kidney events and cardiovascular (CV) mortality.

In a prespecified secondary analysis, the researchers evaluated the impact of semaglutide on the risk of serious infections including COVID-19. A three-component composite of infection SAEs, hospitalization due to infection, or all-cause mortality was compared between the semaglutide and placebo groups, along with adverse outcomes related to COVID-19.

Patients assigned to semaglutide had a significant reduction in the primary composite outcome (hazard ratio [HR], 0.79) compared with the placebo group. The benefit was greater among subgroups with baseline glycemic hemoglobin A_{1c} greater than 8% (HR, 0.63) and with a urine albumin-creatinine ratio of 2000 mg/g or greater (HR, 0.53).

Semaglutide was associated with a reduced risk of infection SAEs (17.9% versus 21.3%) and hospitalization due to infection (17.5% versus 20.4%). There were also significant reductions in COVID-19 overall adverse events (20.3% versus 22.9%) and COVID-19 SAEs (6.7% versus 8.8%). In the initial FLOW report, the semaglutide group had greater reductions in body weight, hemoglobin A_{1c}, and systolic blood pressure.

People with type 2 diabetes and CKD are at increased risk of COVID-19 and other serious infections and subsequent risks of kidney disease progression, CV events, and death. The new analysis of FLOW data shows a reduced rate of infection SAEs, including COVID-19, in patients assigned to treatment with semaglutide versus placebo.

The reductions in infection-related adverse events appear greater in people with lower glycemic control or more severe CKD. The researchers conclude, "[M]itigation of infectious complications with semaglutide may provide a clinically important benefit in addition to improving kidney, CV, and metabolic outcomes" [Rayner B, et al. Effect of semaglutide on COVID-19 and other infections: An analysis from the FLOW randomized clinical trial. *Nephrol Dial Transplant*, published online February 23, 2026. doi: 10.1093/ndt/gfag036]. ■

Renal Denervation May Reduce Hepatic Steatosis

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For individuals with uncontrolled hypertension and metabolic syndrome, renal denervation (RDN) may bring improvement in noninvasive measures of hepatic steatosis, according to a clinical trial report in *Hypertension*.

The retrospective analysis included 42 people with uncontrolled hypertension and associated cardiometabolic comorbidities. As participants in previous randomized trials, 32 patients underwent RDN, while 10 had a sham procedure. The median age was 62 years; 76% of patients had a body mass index over 30 kg/m^2, and 31% had type 2 diabetes. Noninvasive measures of hepatic steatosis—including the hepatic steatosis index (HSI) and fatty liver index (FLI)—were compared between groups up to 1 year after their assigned treatment.

Active RDN was followed by a significant reduction in HSI. From a baseline value of 43.3, HSI decreased by 1.3 at 3 months, 2.6 at 6 months, and 2.1 at 12 months compared with no changes in the sham group. The RDN group also had significant reductions in FLI: by 3.8 at 3 months, 5.7 at 6 months, and 6.2 at 12 months. Neither measure of hepatic steatosis was affected in the sham group.

At 12 months, office systolic blood pressure decreased by 19.3 mm Hg in the RDN group and by 10.8 mm Hg in the sham group. The RDN-associated improvements in HSI and FLI were unrelated to the effect on blood pressure. On analysis of data from an external cohort (the UK Biobank), both noninvasive measures were correlated with a proton density fat fraction on liver magnetic resonance imaging scans.

Sympathetic overactivity contributes not only to the development of metabolic syndrome but also to fat accumulation in the liver. RDN is an effective treatment for uncontrolled hypertension via modulation of the autonomic sympathetic nervous system. The current study evaluated the potential effects of RDN on measures of hepatic steatosis.

The results suggest that RDN may reduce HSI and FLI in people with uncontrolled hypertension and cardiometabolic comorbidities. The metabolic benefit of RDN may be greater in people with type 2 diabetics. While emphasizing the need for further prospective studies, the researchers conclude: "These findings emphasize the potential metabolic effects of RDN and its potential for the treatment of metabolic dysfunction-associated steatotic liver disease" [Tokcan M, et al. Renal denervation improves hepatic steatosis in hypertensive patients with metabolic syndrome. *Hypertension* 2026; 83:e26601. doi: 10.1161/HYPERTENSIONAHA.125.26601]. ■

Social Risk Factors, Dialysis, and Kidney Transplantation

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Individuals on maintenance dialysis with a high burden of social risk factors (SRFs) are less likely to receive or be waitlisted for a kidney transplant, reports a study in *Kidney Medicine*.

The cross-sectional study included data on 12,994 people receiving maintenance dialysis at 240 centers operated by a nationwide dialysis company. Between 2023 and 2025, the individuals completed the Accountable Health Communities Health-Related Social Needs Screening Tool, which assesses "potentially intervenable" SRFs such as housing, food security, utilities, transportation, and personal safety.

A total SRF burden score was calculated for each patient, based on the number of positive screening results. The association between SRF burden and transplant status was assessed, with adjustment for a range of demographic and clinical characteristics.

Overall, 10.5% of patients had an SRF burden score of 1, whereas 3.4% had a score of 2 or higher. Food insecurity was the most frequently reported SRF (7.7%), followed by housing instability (4.5%) and transportation insecurity (3.6%).

On adjusted analysis, patients with one or more positive SRFs had significantly higher odds of not undergoing kidney transplant (odds ratio [OR], 1.19) and not being waitlisted (OR, 1.65). Other factors associated with the primary outcome included financial discomfort (OR, 1.54) and attending a rural dialysis clinic (OR, 1.26). On exploratory analysis, transportation insecurity was the SRF most strongly associated with the study outcome (OR, 2.59).

SRFs are associated with an increased risk of chronic kidney disease, but there are few data on SRF burden among people on dialysis. The new study finds a substantial burden of SRFs in a nationally representative sample of individuals on dialysis and shows that individuals with SRFs are less likely to undergo or be waitlisted for kidney transplantation. The researchers highlight the need to assess and "meaningfully address" transportation insecurity and other unmet social needs among those receiving dialysis [Hamdan H, et al. Social risk factors and kidney transplant waitlisting among patients receiving dialysis: A national cohort study. *Kidney Med* 2026; 8:101294. doi: 10.1016/j.xkme.2026.101294; https://www.kidneymedicinejournal.org/article/S2590-0595(26)00055-5/fulltext]. ■

High-Dose ESAs and Increased Cancer Risk

https://doi.org/10.62716/kn.003302026

People on dialysis receiving high doses of erythropoiesis-stimulating agents (ESAs) for treatment of anemia are at increased subsequent risk of incident cancers, suggests a study in *JAMA Network Open*.

From a Korean national insurance database, the researchers identified 9776 individuals with kidney failure who initiated long-term dialysis and received ESAs between 2006 and 2017. Of these, 2320 patients with new cancers diagnosed 6 months after the start of dialysis were identified at a median follow-up of 5 years. Digestive system cancers were the most common type, followed by respiratory and kidney cancers.

Each patient was matched to four control patients based on birth year, sex, length of follow-up, year of dialysis initiation, and dialysis type. Associations between incident cancer and mean weekly ESA dose—categorized as high or low dose—were analyzed. Multivariable models included adjustment for demographic characteristics and comorbid conditions.

The analyses showed an increased likelihood of new cancers among patients receiving high-dose ESAs (adjusted odds ratio [AOR], 1.23) compared with low-dose ESAs. Cancer risk was significantly higher among patients aged 60 years or older (AOR, 1.47) compared with an AOR of 0.90 for younger patients. AORs associated with high-dose ESAs were 1.37 for digestive system cancers, 1.48 for respiratory system cancers, and 1.64 for cancers at ill-defined or unspecified sites.

This population-based study adds new evidence that high-dose ESA use may increase the risk of new cancers, particularly in older patients. The study "provides important insights into the potential cancer risk associated with high-dose ESA use in this understudied population," the researchers conclude [Kim JY, et al. Erythropoiesis-stimulating agents and development of cancer among patients receiving dialysis. *JAMA Netw Open* 2026; 9:e260140. doi: 10.1001/jamanetworkopen.2026.0140]. ■

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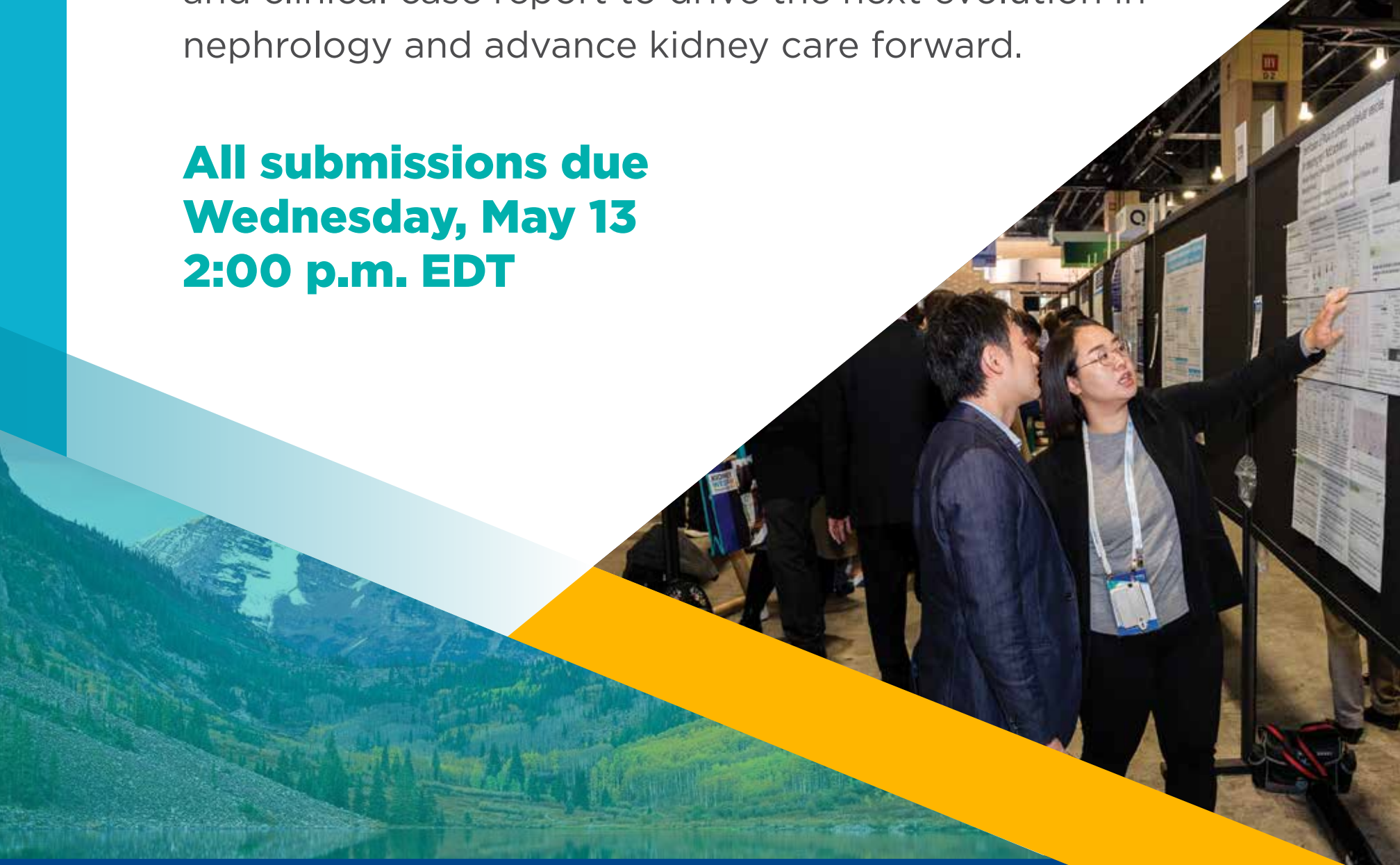

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