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From Custom Gene Therapies to Multi-Disease Solutions: Initiatives Aim to Accelerate Rare Disease Therapies

By Bridget M. Kuehn

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The discovery of a shared therapeutic target for autosomal dominant tubulointerstitial kidney disease (ADTKD) and the eye disease retinitis pigmentosa is the latest in what could be a new era for rare disease therapy development.

The diseases, which are caused by distinct genetic mutations that lead to a toxic accumulation of misshapen proteins, converge on a single molecular pathway—a protein called TMED7, reported Anna Greka, MD, PhD, a core member of the Broad Institute in Cambridge, MA, and colleagues, according to a preprint study (1). TMED7 normally helps collect and redirect the occasional misfolded proteins for refolding. But in patients continuously producing mutant proteins, TMED7 can act as a dam, leading to a toxic build-up of proteins that overwhelm the cell. Greka and her colleagues have shown that using a small molecule to disable TMED7 releases the backlog and allows the malformed proteins to be broken down.

The idea is moving into clinical trials that may ultimately provide a therapy for ADTKD, retinitis pigmentosa, and potentially other diseases involving the accumulation of faulty proteins. The discovery has spawned a new approach to rare diseases called nodal biology, which, instead of targeting diseases or disease-causing mutations one by one, aims to identify and target shared pathways that contribute to numerous rare diseases.

"The idea is that many seemingly disparate genetic diseases, like kidney disease, in this case, or an eye disease or a form of Alzheimer disease, might actually share a common molecular node," Greka explained. "If you can develop a drug for that common mechanism, you can simultaneously address all the above diseases."

Greka's work runs in parallel with other ongoing efforts to develop custom gene-editing therapies for rare and ultra-rare diseases that correct genetic errors. Greka said that both approaches that lump rare diseases together to find common therapies and those that work almost like individualized surgical procedures to correct a very rare error in a patient's gene will be needed. "Patients are waiting," she said, explaining the urgency driving these multipronged efforts.

Lumping to leaping

To help advance the nodal biology approach and accelerate the development of therapies for many rare diseases, Greka and her colleagues at the Broad Institute have launched the

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Kidney Week Scientific Sessions

THURSDAY

Origins and Evolution of CD19 CAR-T Cells
State-of-the-Art Lecture: Michel Sadelain, MD, PhD
Featured High-Impact Clinical Trials: Jonathan Barratt, MBChB, PhD (ORIGIN 3); Jicheng Lv, MD (TELIGAN); and Dana V. Rizk, MD (VISIONARY)

Predictors of Cardiovascular Disease and Mortality in CKD
Jack W. Coburn, MD, Endowed Lectureship: Joachim H. Ix, MD, MAS, FASN

How Has the Clinical Trial Landscape in Glomerular Diseases Changed in the Past 5 Years?
Michelle P. Winn, MD, Endowed Lectureship: Brad Rovin, MD, FASN

Formulating a Dialysis Access Curriculum: Bridging the Gap in Education and Training
Burton D. Rose, MD, Endowed Lectureship: Matthew A. Sparks, MD, FASN

Targeting Metabolic Vulnerabilities in DKD and Therapeutic Strategies
Barry M. Brenner, MD, Endowed Lectureship: Anna Greka, MD, PhD

FRIDAY

New Frontiers in Air Pollution and Public Health
State-of-the-Art Lecture: Barbara J. Finlayson-Pitts, PhD

The Future of Blood Pressure Management: Precision Care in a Data-Rich World
ASN-AHA Donald W. Seldin Young Investigator Award: Jordana B. Cohen, MD, MS, FASN

Patient Voices: Living Through DGF
Celeste Castillo Lee Endowed Lectureship: Thelma Barber

Can We Do Better With Volume Management for Patients Treated With Dialysis?
Garabed Eknoyan, MD, Endowed Lectureship: Jennifer E. Flythe, MD, MPH, FASN

Improving Long-Term Kidney Transplant Survival: Opportunities and Challenges
Barbara T. Murphy, MB BAO BCh, Endowed Lectureship: Sundaram Hariharan, MD

SATURDAY

RNAi: A Molecular Spark in an Information Inferno
State-of-the-Art Lecture: Craig C. Mello, PhD

Transplant System Reform: A Congressional Perspective
Christopher R. Blagg, MD, Endowed Lectureship in Kidney Diseases and Public Policy: Priti R. Patel, MD, MPH

Oral Contraceptives and Hormone Replacement Therapy: Considerations in Patients With Kidney Diseases
Sharon R. Silbiger, MD, Endowed Lectureship: Sofia B. Ahmed, MD, MMSc

Kidney Applications of Spatial Metabolomics
Robert W. Schrier, MD, Endowed Lectureship: Ton J. Rabelink, MD, PhD

SUNDAY

Bridging Breakthrough Science Into Real-World Care: Challenges and Opportunities for the Nephrologist
State-of-the-Art Panel: Stanley D. Crittenden, MD, FASN; Jessica L. Mega, MD, MPH; Rachael L. Morton, MSc, PhD; and Ravi I. Thadhani, MD, MPH (moderator)

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Celebrating key achievements, programs, and progress shaping kidney health today and tomorrow

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The nephrologist's imperative in owning the delivery gap

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ASN and HHS-ONC partner to improve kidney care data interoperability and sharing.

Beyond the pitch
What happens to the kidney under athletic stress?

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From Custom Gene Therapies to Multi-Disease Solutions

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Ladders to Cures (L2C) Scientific Accelerator. They aim to bring together multidisciplinary teams of scientists from around the world to systematically map the shared biological nodes that connect disparate rare diseases. The goal is to accelerate the development of new therapies that could treat the disease-causing effects of hundreds or even thousands of mutations by targeting a shared node.

"If we're going to make a positive impact for patients with all rare diseases, including kidney diseases, we must use all the tools in the armamentarium," said Greka, who is the founder and chair of L2C. "That means small molecules, antibodies, nucleic acids like small interfering RNAs, or antisense oligonucleotide therapies and of course other genetic therapies like base editing and prime editing."

The L2C project will work with individual labs to identify and support promising projects and help them overcome the so-called "valley of death" in therapeutic development, in which many promising discoveries fail to advance long enough to become therapies. L2C will provide financial support and expertise in navigating drug development, including from biopharmaceutical leaders.

L2C will simultaneously deploy machine learning or artificial intelligence (AI) technologies to map shared nodes and develop models that the project's team hopes will one day match patients' genetic mutations to potential node-targeted therapies. The team also hopes that the AI tools will help predict which potential targets are most promising and safest.

"The plan is that if we develop these tools and capabilities using AI, we might be able to vastly accelerate the path of patients from diagnosis to therapy down the road," Greka explained. That may be particularly important for rare diseases like ADTKD, which can be caused by more than 100 different mutations in a single gene. "There are always new patients coming in with potentially new mutations," Greka said. "This approach may be able to quickly direct them to a clinical trial for a potential nodal therapy."

Already, the work being done by Greka and a disease registry run by Andrew Bleyer, MD, MS, a professor of nephrology at Wake Forest University School of Medicine in Winston-Salem, NC, has helped transform ADTKD, which is caused by mutations in *UMOD*, *MUC1*, or a few other genes. What was once an unnamed and often unrecognized hereditary form of kidney diseases is now known to affect at least 100,000 people in the United States alone, and two clinical trials are expected to launch in the coming years.

"We are really close," said Sharon McGroder, PhD, executive director of the Rare Kidney Disease Foundation and an individual with stage 4 kidney disease caused by a *MUC1* mutation. "Hopefully, there will be a treatment available for my kids' generation or anyone with ADTKD who is not yet on dialysis or in need of a transplant."

More people with ADTKD are being identified through genetic testing, and the condition may not be as rare as previously thought. McGroder said that it often takes a nephrologist being suspicious about a long family history without other common risk factors like hypertension and diabetes to propose testing. Until recently, testing was only available through the Broad Institute or through Bleyer at Wake Forest University. But McGroder said that the foundation is in talks with a commercial genetic testing laboratory (Natera), which could make testing more broadly available. "You can have this disease and be perfectly healthy until your numbers start to decline," McGroder said. "We want patients to feel comfortable talking with their nephrologist when something is going on."

Greka credited the advocacy of individuals with ADTKD and the Rare Kidney Disease Foundation with helping to launch a new approach to rare diseases. "It all kind of started with a humble genetic kidney disease, and now it's allowing us to have insights that hopefully can help more patients," she said.

Custom gene therapy

Stephanie Cherqui, MS, PhD, a professor of pediatrics at the University of California San Diego School of Medicine, recently completed a phase 1/2 trial of gene therapy for cystinosis. Cystinosis is a rare genetic disease caused by mutations in the *CTNS* gene that lead to a toxic buildup of the amino acid cystine in the body. It leads to multiorgan damage and ultimately kidney failure and death. Treatment with the drug cysteamine allows the built-up cystine to exit the cells

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For patients with IgA nephropathy (IgAN) at risk of progression

AT DIAGNOSIS,
START TARPEYO* TO TARGET A KEY SOURCE† OF IgAN[1,2]



The 2025 KDIGO guideline supports that TARPEYO‡ is the only FDA-approved treatment to date shown to reduce the levels of pathogenic forms of IgA and IgA immune complexes[3]

INDICATION

TARPEYO is indicated to reduce the loss of kidney function in adults with primary immunoglobulin A nephropathy (IgAN) who are at risk for disease progression.

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

TARPEYO is contraindicated in patients with hypersensitivity to budesonide or any of the ingredients of TARPEYO. Serious hypersensitivity reactions, including anaphylaxis, have occurred with other budesonide formulations.

WARNINGS AND PRECAUTIONS

Hypercorticism and adrenal axis suppression: When corticosteroids are used chronically, systemic effects such as hypercorticism and adrenal suppression may occur. Corticosteroids can reduce the response of the hypothalamus-pituitary-adrenal (HPA) axis to stress. In situations where patients are subject to surgery or other stress situations, supplementation with a systemic corticosteroid is recommended. When discontinuing therapy or switching between corticosteroids, monitor for signs of adrenal axis suppression.

Patients with moderate to severe hepatic impairment (Child-Pugh Class B and C, respectively) could be at an increased risk of hypercorticism and adrenal axis suppression due to an increased systemic exposure to oral budesonide. Avoid use in patients with severe hepatic impairment (Child-Pugh Class C). Monitor for increased signs and/or symptoms of hypercorticism in patients with moderate hepatic impairment (Child-Pugh Class B).

Immunosuppression and increased risk of infection: Corticosteroids, including TARPEYO, suppress the immune system and increase the risk of infection with any pathogen, including viral, bacterial, fungal, protozoan, or helminthic pathogens. Corticosteroids can: reduce resistance to new infections, exacerbate existing infections, increase the risk of disseminated infections, increase the risk of reactivation or exacerbation of latent infections, and mask some signs of infection. Corticosteroid-associated infections can sometimes be serious. Monitor for infection and consider TARPEYO withdrawal as needed.

Avoid corticosteroid therapy, including TARPEYO, in patients with active or quiescent tuberculosis or hepatitis B infection; untreated fungal, bacterial, systemic viral, or parasitic infections; ocular herpes simplex; or Kaposi's sarcoma. Avoid exposure to active, easily transmitted infections (e.g., chickenpox, measles). Corticosteroid therapy may decrease the immune response to some vaccines.

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and has helped prolong patients' lives into adulthood. However, patients still experience complications that require kidney transplantation and die prematurely due to organ failure, Cherqui explained.

To help fill the desperate need for improved therapies, Cherqui developed a gene-therapy approach using blood stem cells from patients, which delivers a normal copy of the *CTNS* gene to them via a harmless viral vector. The patients undergo chemotherapy to eliminate their remaining blood stem cells, which are then replaced with gene-modified blood stem cells. These cells then multiply in the bone marrow, giving rise to blood and immune cells with healthy copies of the *CTNS* gene. Some of these immune cells become engrafted in organs throughout the body, including the kidneys, and provide a source of the functional version of the protein.

"The kidney is a very challenging tissue for gene therapy because it is composed of multiple different cell types that are difficult to target effectively with a viral vector directly," Cherqui explained. But targeting the blood stem cells provided a way to reach the kidney. "We've seen that the hematopoietic stem cells can differentiate into macrophages in the kidney, and they can distribute the protein to most of the kidney cell types by generating what we call the tunneling nanotubes, which are like a cellular bridge that can transfer proteins to other cells."

The preliminary clinical trial has now followed adult patients, who received the stem cell transplants, for up to 7 years and has found the treatment to be safe and durable (2). "We've learned that our approach leads to long-term reconstitution of bone marrow with gene-modified stem cells. It has shown safety, and there is some positive clinical impact in different tissues," Cherqui said.

The adult patients already had advanced kidney disease or had undergone a kidney transplant, so the preliminary study could not assess the potential impact on the kidneys. But Novartis has licensed the therapy and launched a clinical trial in patients with cystinosis between the ages of 2 and 5 years to determine whether earlier intervention protects the kidneys. If the trial is successful, and the drug is approved by the US Food and Drug Administration (FDA), it would provide an additional treatment option that might be used with or without cysteamine, Cherqui said.

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TARPEYO is the first FDA-approved, potentially disease-modifying agent demonstrated to reduce kidney function loss[1,2]

The NefIgArd study—a Phase 3, randomized, double-blind, multicenter trial—was designed to evaluate the efficacy and safety of a 9-month course of TARPEYO (16 mg/day) compared with placebo in patients with primary IgAN. Conducted with optimized RAS blockade as background therapy, the primary endpoint was the time-weighted average change in eGFR over 24 months[1]

eGFR STABILIZATION

WHILE ON TREATMENT* & UPCR REDUCTION[1,2,4]

PRIMARY ENDPOINT: time-weighted average of eGFR change demonstrated a difference of 5.05 mL/min/1.73 m^2 over 2 years[2§]

Durable UPCR reduction was achieved **through 2 years[1¶]**

ESTABLISHED SAFETY PROFILE

The most common adverse reactions occurring in ≥10% of patients treated with TARPEYO + RASi and at a higher incidence than RASi alone were: peripheral edema, hypertension, muscle spasms, acne, and headache[1]

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EXPLORE THE DATA

*The effect of TARPEYO on proteinuria and kidney function was assessed in adults with biopsy-proven IgAN who were on a stable dose of maximally tolerated RAS inhibitor therapy.[1]
†Mucosal B cells present in the ileum, including the Peyer's patches, express glucocorticoid receptors, and are responsible for the production of galactose-deficient IgA1 antibodies (Gd-IgA1) causing IgAN. Through their anti-inflammatory and immunosuppressive effects at the glucocorticoid receptor, corticosteroids can modulate B cell numbers and activity. It has not been established to what extent the efficacy of TARPEYO is mediated via local effects in the ileum vs systemic effects.[1,5]
‡TARPEYO was studied under the name Nefecon, which was used in the 2025 KDIGO guideline.
§The effect of TARPEYO on the long-term rate of decline in kidney function has not been established.[1]
¶The mean reduction in UPCR from baseline was 35% at the end of treatment (month 9), with continued reductions off treatment, and a 34% reduction at month 24 (15 months off treatment), demonstrating durability of treatment effect.[1]

CI=confidence interval; eGFR=estimated glomerular filtration rate; IgA=immunoglobulin A; KDIGO=Kidney Disease: Improving Global Outcomes; RASi=renin-angiotensin system inhibitor; UPCR=urine protein-to-creatinine ratio.

Other corticosteroid effects: TARPEYO is a systemically available corticosteroid and is expected to cause related adverse reactions. Monitor patients with hypertension, prediabetes, diabetes mellitus, osteoporosis, peptic ulcer, glaucoma or cataracts, or with a family history of diabetes or glaucoma, or with any other condition where corticosteroids may have unwanted effects.

ADVERSE REACTIONS

In clinical studies, the most common adverse reactions with TARPEYO (occurring in ≥5% of TARPEYO-treated patients, and ≥2% higher than placebo) were peripheral edema (17%), hypertension (12%), muscle spasms (12%), acne (11%), headache (10%), upper respiratory tract infection (8%), face edema (8%), weight increased (7%), dyspepsia (7%), dermatitis (6%), arthralgia (6%), and white blood cell count increased (6%).

DRUG INTERACTIONS

Budesonide is a substrate for CYP3A4. Avoid use with potent CYP3A4 inhibitors, such as ketoconazole, itraconazole, ritonavir, indinavir, saquinavir, erythromycin, and cyclosporine. Avoid ingestion of grapefruit juice with TARPEYO. Intake of grapefruit juice, which inhibits CYP3A4 activity, can increase the systemic exposure to budesonide.

USE IN SPECIFIC POPULATIONS

Pregnancy: The available data from published case series, epidemiological studies, and reviews with oral budesonide use in pregnant women have not identified a drug-associated risk of major birth defects, miscarriage, or other adverse maternal or fetal outcomes. There are risks to the mother and fetus associated with IgAN. Infants exposed to in-utero corticosteroids, including budesonide, are at risk for hypoadrenalism.

References: 1. TARPEYO. Prescribing Information. Calliditas Therapeutics AB; June 2024. **2.** Data on file. Calliditas Therapeutics AB. **3.** Kidney Disease: Improving Global Outcomes (KDIGO). KDIGO 2025 clinical practice guideline for the management of immunoglobulin A nephropathy (IgAN) and immunoglobulin A vasculitis (IgAV). *Kidney Int*. 2025;108:S1-S71. **4.** Barratt J, Lafayette RA, Rovin BH, Fellström B. Budesonide delayed release capsules to reduce proteinuria in adults with primary immunoglobulin A nephropathy. *Expert Rev Clin Immunol*. 2023;19(7):699-710. **5.** Lafayette R, Kristensen J, Stone A, et al. Efficacy and safety of a targeted-release formulation of budesonide in patients with primary IgA nephropathy (NefIgArd): 2-year results from a randomized phase 3 trial. *Lancet*. 2023. http://doi.org/10.1016/S0140-6736(23)01554-4

Please see the accompanying Brief Summary on the adjacent pages.

calliditas THERAPEUTICS

From Custom Gene Therapies to Multi-Disease Solutions

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Overcoming barriers

Gene-editing–based therapies are being tested in preclinical studies for polycystic kidney disease and Alport syndrome (3, 4). Custom gene therapies have been used to treat a small number of patients with ultra-rare diseases, including a newborn with a genetic liver condition called severe carbamoyl-phosphate synthetase-1 deficiency, under a compassionate use exemption from FDA (5). But several hurdles remain to wider-scale deployment, especially for very rare genetic forms of kidney diseases.

Matthew H. Wilson, MD, PhD, the Ruth King Scoville Chair in Medicine at Vanderbilt University, Nashville, TN, noted that most in vivo cell-targeted gene therapies have relied on costly adeno-associated viruses to deliver the therapy. Still, some more recent efforts focus on nanoparticles or other delivery methods that may be less expensive and possibly more effective at selectively targeting cell types. "There are over 40 cell types in the kidney, and a genetic kidney disease may affect only one cell type," Wilson explained. "Delivering gene therapy to specific cells is going to continue to be a problem that, hopefully, we can overcome."

Additionally, pharmaceutical companies may be reluctant to develop therapies for conditions that affect fewer than 50,000 patients globally because they may not be commercially viable, Wilson noted. Greka added that the minimum number of patients that pharmaceutical companies require varies and may be as low as 5000. The lumping approach, she suggested, may be one way to overcome small patient numbers by grouping numerous conditions with shared targetable nodes, creating a larger potential market for a therapy.

Building reusable gene-editing therapy platforms that can target different mutations may be another approach. For example, the Advanced Research Projects Agency for Health (ARPA-H) launched the 5-year, up to $160 million Treating Hereditary Rare Diseases With In Vivo Precision Genetic Medicines (THRIVE) program to develop

TARPEYO® (budesonide) delayed release capsules
Brief Summary of Prescribing Information

4 CONTRAINDICATIONS

TARPEYO is contraindicated in patients with hypersensitivity to budesonide or any of the ingredients of TARPEYO. Serious hypersensitivity reactions, including anaphylaxis have occurred with other budesonide formulations.

5 WARNINGS AND PRECAUTIONS

5.1 Hypercorticism and Adrenal Axis Suppression

When corticosteroids are used chronically, systemic effects such as hypercorticism and adrenal suppression may occur. Corticosteroids can reduce the response of the hypothalamus-pituitary-adrenal (HPA) axis to stress. In situations where patients are subject to surgery or other stress situations, supplementation with a systemic corticosteroid is recommended. When discontinuing therapy *[see Dosing and Administration (2)]* or switching between corticosteroids, monitor for signs of adrenal axis suppression.

Patients with moderate to severe hepatic impairment (Child-Pugh Class B and C respectively) could be at an increased risk of hypercorticism and adrenal axis suppression due to an increased systemic exposure of oral budesonide. Avoid use in patients with severe hepatic impairment (Child-Pugh Class C). Monitor for increased signs and/or symptoms of hypercorticism in patients with moderate hepatic impairment (Child-Pugh Class B) *[see Use in Specific Populations (8.6), Clinical Pharmacology (12.3)]*.

5.2 Risks of Immunosuppression

Patients who are on drugs that suppress the immune system are more susceptible to infection than healthy individuals. Chickenpox and measles, for example, can have a more serious or even fatal course in susceptible patients or patients on immunosuppressant doses of corticosteroids. Avoid corticosteroid therapy in patients with active or quiescent tuberculosis infection, untreated fungal, bacterial, systemic viral or parasitic infections, or ocular herpes simplex. Avoid exposure to active, easily-transmitted infections (e.g., chicken pox, measles). Corticosteroid therapy may decrease the immune response to some vaccines.

How the dose, route, and duration of corticosteroid administration affect the risk of developing a disseminated infection is not known. The contribution of the underlying disease and/or prior corticosteroid treatment to the risk is also not known. If exposed to chickenpox, consider therapy with varicella zoster immune globulin (VZIG) or pooled intravenous immunoglobulin (IVIG). If exposed to measles, consider prophylaxis with pooled intramuscular immunoglobulin (IG). If chickenpox develops, consider treatment with antiviral agents.

5.3 Other Corticosteroid Effects

TARPEYO is a systemically available corticosteroid and is expected to cause related adverse reactions. Monitor patients with hypertension, prediabetes, diabetes mellitus, osteoporosis, peptic ulcer, glaucoma or cataracts, or with a family history of diabetes or glaucoma, or with any other condition where corticosteroids may have unwanted effects.

6 ADVERSE REACTIONS

The following clinically significant adverse reactions are described elsewhere in the labeling:

- Hypercorticism and adrenal suppression *[see Warnings and Precautions (5.1)]*
- Risks of immunosuppression *[see Warnings and Precautions (5.2)]*
- Other corticosteroid effects *[see Warnings and Precautions (5.3)]*

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

The safety of TARPEYO was evaluated in 389 patients in the randomized, double-blind, placebo-controlled study, NefIgArd (NCT: 03643965, Phase 3 clinical study in adults with primary IgAN). The data below reflect TARPEYO exposure in 195 patients with a median duration of 41 weeks, compared with comparable exposure to placebo in 194 patients.

The most common adverse reactions, reported in greater than or equal to 5% of TARPEYO-treated patients and greater than or equal to 2% higher than placebo, in the 9-month treatment period are listed in *Table 1*.

Most adverse reactions that occurred at a greater incidence for TARPEYO compared to placebo were consistent with hypercortisolism and reversible, resolving within 3 months after discontinuation.

Table 1: Reported adverse reactions occurring in greater than or equal to 5% of TARPEYO treated patients, and greater than or equal to 2% higher than Placebo

Adverse Reaction	TARPEYO 16 mg (N=195)	Placebo (N=194)
	n (%)	n (%)
Peripheral edema	33 (17)	10 (5)
Hypertension	23 (12)	6 (3)
Muscle spasms	23 (12)	8 (4)
Acne	22 (11)	2 (1)
Headache	19 (10)	14 (7)
Upper respiratory tract infection	16 (8)	12 (6)
Face edema	15 (8)	1 (0.5)
Weight increased	13 (7)	6 (3)
Dyspepsia	13 (7)	4 (2)
Dermatitis	12 (6)	2 (1)
Arthralgia	12 (6)	4 (2)
White blood cell count increased	11 (6)	1 (0.5)

7 DRUG INTERACTIONS

7.1 Interaction with CYP3A4 Inhibitors

Budesonide is a substrate for CYP3A4. Avoid use with potent CYP3A4 inhibitors; e.g. ketoconazole, itraconazole, ritonavir, indinavir, saquinavir, erythromycin, and cyclosporine *[see Clinical Pharmacology (12.3)]*.

Avoid ingestion of grapefruit juice with TARPEYO. Intake of grapefruit juice, which inhibits CYP3A4 activity, can increase the systemic exposure to budesonide *[see Clinical Pharmacology (12.3)]*.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Risk Summary The available data from published case series, epidemiological studies and reviews with oral budesonide use in pregnant women have not identified a drug-associated risk of major birth defects, miscarriage or other adverse maternal or fetal outcomes. There are risks to the mother and fetus associated with IgA Nephropathy Infants exposed to in-utero corticosteroids, including budesonide, are at risk for hypoadrenalism *(see Clinical Considerations)*. In animal reproduction studies with pregnant rats and rabbits, administration of subcutaneous budesonide during organogenesis at doses approximately 0.3 times or 0.03 times, respectively, the maximum recommended human dose (MRHD), resulted in increased fetal loss, decreased pup weights, and skeletal abnormalities. Maternal toxicity was observed in both rats and rabbits at these dose levels *(see Data)*.

gene-therapy platforms to accelerate the development of affordable, accessible therapies for rare genetic diseases. Instead of developing and testing a therapy for one disease at a time, which is slow and often not feasible, THRIVE hopes to create a modular block-like approach, in which, once a platform is developed, individual components can be swapped out to treat other diseases, said THRIVE's Program Manager Daria Fedyukina, PhD. The program will fund seven projects focusing on various diseases, none of them kidney diseases. But Fedyukina is optimistic that innovations developed through THRIVE will also benefit other conditions.

"We think that blazing that trail will spill over to all genetic diseases," she said. "With the same financial resources, people will be able to do way more to address many more mutations, many more rare diseases."

Greka's colleagues at the Broad Institute are also launching the nonprofit Center for Therapeutic Genetics (CTG), in collaboration with Boston Children's Hospital and The Jackson Laboratory, which will similarly develop platform-based approaches to create patient-tailored therapies for numerous rare and ultra-rare diseases. The program will work closely with US government agencies. The center is developing a gene-editing therapy for rare genetic epilepsies, supported by the ARPA-H THRIVE program. The goal is to turn gene therapies into standardized clinical procedures and share insights across institutions to speed up access to precision genetic medicines, said the center's founding director, Winston Yan, MD, PhD, in a statement.

"We receive messages every week from parents asking for help: Can we do for their child what has been done for other children who have received treatments?" said David Liu, PhD, the Richard Merkin Professor at the Broad Institute, who helped develop the platform used to treat the child with severe carbamoyl-phosphate synthetase-1 deficiency. "The honest answer today is usually 'not yet,' often not because the science doesn't exist but because we don't yet have the infrastructure to bring these treatments to many patients. CTG is our commitment to closing that gap so that eventually every family who needs this kind of treatment has a path forward."

Wilson noted that establishing the safety of gene therapies and ensuring proper regulatory oversight will be important to avoid harmful off-target effects on other genes. "Gene therapy is still a work in progress," said Cherqui. "It's a new technology. We are modifying patients' genomes, and that comes with risk. We must be very humble about that."

Work is ongoing at FDA to provide safety oversight, engage patient communities throughout the process, and ensure that these promising new therapies are safe. The ARPA-H project also intends to collaborate with FDA to establish streamlined regulatory pathways for platform-based genetic therapies.

Investment in kidney-focused gene therapies is also needed, Wilson said, to spur breakthroughs and approaches. "The kidney community needs investment in this area from pharma, from biotech, and from the NIH [National Institutes of Health]," Wilson explained. "Sometimes things may not be seen as novel if a technology has been used in another organ or another area, and we're trying to apply it to the kidney, and people may not fund that, but there's a whole wide-open space in the kidney field for applying these technologies." ■

The estimated background risk of major birth defects and miscarriage of the indicated population is unknown. All pregnancies have a background risk of birth defect, loss, or other adverse outcomes. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% to 4% and 15% to 20%, respectively.

Clinical Considerations *Disease-Associated Maternal and/or Embryo/Fetal Risk* IgA nephropathy in pregnancy is associated with adverse maternal outcomes, including increased rates of cesarean section, pregnancy-induced hypertension, pre-eclampsia and preterm delivery, and adverse fetal/neonatal outcomes, including stillbirth and low birth weight.

Fetal/Neonatal Adverse Reactions Hypoadrenalism may occur in infants born to mothers receiving corticosteroids during pregnancy. Infants should be carefully observed for signs of hypoadrenalism, such as poor feeding, irritability, weakness, and vomiting, and managed accordingly *[see Warnings and Precautions (5.1)]*.

Data

Animal Data Budesonide was teratogenic and embryo-lethal in rabbits and rats.

In an embryo-fetal development study in pregnant rats dosed subcutaneously with budesonide during the period of organogenesis on gestation days 6 to 15 there were effects on fetal development and survival at subcutaneous doses up to approximately 500 mcg/kg in rats (approximately 0.3 times the maximum recommended human dose (MRHD) on a body surface area basis).

In an embryo-fetal development study in pregnant rabbits dosed during the period of organogenesis on gestation days 6 to 18, there was an increase in maternal abortion, and effects on fetal development and reduction in litter weights at subcutaneous doses from approximately 25 mcg/kg (approximately 0.03 times the MRHD on a body surface area basis).

Maternal toxicity, including reduction in body weight gain, was observed at subcutaneous doses of 5 mcg/kg in rabbits (approximately 0.006 times the maximum recommended human dose on a body surface area basis) and 500 mcg/kg in rats (approximately 0.3 times the maximum recommended human dose on a body surface area basis).

In a peri- and post-natal development study, subcutaneous treatment of pregnant rats with budesonide during the period from Day 15 post coitum to Day 21 post partum, budesonide had no effects on delivery, but did have an effect on growth and development of offspring. In addition, offspring survival was reduced and surviving offspring had decreased mean body weights at birth and during lactation at exposures ≥ 0.012 times the MRHD (on a mg/m^2 basis at maternal subcutaneous doses of 20 mcg/kg/day and higher). These findings occurred in the presence of maternal toxicity.

8.2 Lactation

Risk Summary Breastfeeding is not expected to result in significant exposure of the infant to TARPEYO. Lactation studies have not been conducted with oral budesonide, including TARPEYO, and no information is available on the effects of the drug on the breastfed infant or the effects on the drug on milk production. One published study reports that budesonide is present in human milk following maternal inhalation of budesonide *(see Data)*. Routine monitoring of linear growth in infants is recommended with chronic use of budesonide in the nursing mother. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for TARPEYO and any potential adverse effects on the breastfed infant from TARPEYO, or from the underlying maternal condition.

Data One published study reports that budesonide is present in human milk following maternal inhalation of budesonide, which resulted in infant doses approximately 0.3% to 1% of the maternal weight-adjusted dosage and a milk to plasma ratio was approximately 0.5. Budesonide was not detected in plasma, and no adverse events were noted in the breastfed infants following maternal use of inhaled budesonide.

Assuming a daily average milk intake of about 150 mL/kg/day and a milk to plasma ratio of 0.5, the estimated oral dose of budesonide for a 5 kg infant is expected to be less than 2 mcg/day for a maternal dose of 16 mg TARPEYO. Assuming 100% bio-availability in the infant this is about 0.1% of the maternal dose and about 3% of the highest inhaled dose used clinically for asthma in infants.

8.4 Pediatric Use

The safety and efficacy of TARPEYO in pediatric patients have not been established.

8.5 Geriatric Use

Clinical studies of TARPEYO did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects. Other reported clinical experience has not identified differences in responses between the elderly and younger patients. In general, dose selection for an elderly patient should be cautious, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy.

8.6 Hepatic Impairment

Patients with moderate to severe hepatic impairment (Child-Pugh Class B and C, respectively) could be at an increased risk of hypercorticism and adrenal axis suppression due to an increased systemic exposure to budesonide *[see Warnings and Precautions (5.1) and Clinical Pharmacology (12.3)]*. Avoid use in patients with severe hepatic impairments (Child-Pugh Class C). Monitor for increased signs and/or symptoms of hypercorticism in patients with moderate hepatic impairment (Child-Pugh Class B).

10 OVERDOSAGE

Reports of acute toxicity and/or death following overdosage of corticoids are rare.

In the event of acute overdosage, no specific antidote is available. Treatment consists of supportive and symptomatic therapy.

Please see Full Prescribing Information for TARPEYO at TARPEYOhcp.com

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US-TAR-2300219

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KIDNEY WEEK 2026 HIGHLIGHTS

https://doi.org/10.62716/kn.005012026

Exciting, dynamic plenaries daily

ASN offers exciting, dynamic plenaries daily, which showcase this extraordinary time in nephrology. The opening plenary on Thursday, October 22, features the ASN President's Medal presentation to William E. Flanary, MD ("Dr. Glaucomflecken"); the ASN President's Address; the State-of-the-Art Lecture by Michel Sadelain, MD, PhD; and featured high-impact clinical trials.

On Friday, October 23, the plenary features award presentations and the State-of-the-Art Lecture, "New Frontiers in Air Pollution and Public Health," by Barbara J. Finlayson-Pitts, PhD.

On Saturday, October 24, the plenary features award presentations and the State-of-the-Art Lecture, "RNAi: A Molecular Spark in an Information Inferno," by Craig C. Mello, PhD.

The full plenary on Sunday, October 25, is focused on "Bridging Breakthrough Science Into Real-World Care: Challenges and Opportunities for the Nephrologist" with an expert panel: Ravi I. Thadhani, MD, MPH (moderator); Stanley D. Crittenden, MD, FASN; Jessica L. Mega, MD, MPH; and Rachael L. Morton, MSc, PhD.

Late-breaking clinical trials

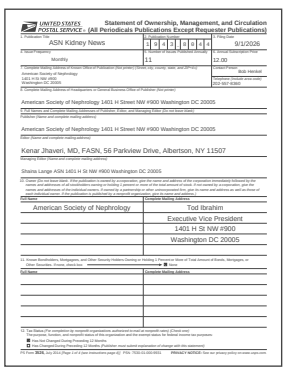
Kidney Week features late-breaking clinical trials that will have significant impact on clinical practice on all topics affecting kidney health. High-impact clinical trials will be featured in the opening plenary, with more presentation time for high-impact clinical studies and multiple late-breaking abstract oral sessions.

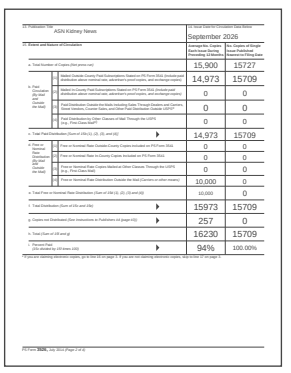
Engagement opportunities

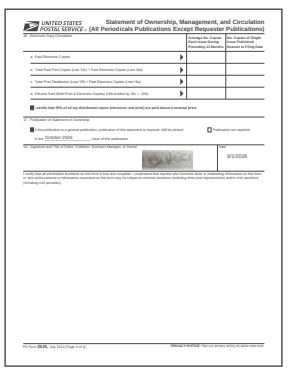
In addition to the hundreds of hours of educational content available at the meeting, there are numerous engagement opportunities:

- **ASN Kidney Week Around the World (Grand Concourse).** Pin from where you have traveled, and showcase the global community advancing kidney health.
- **NEW! Choose What Resonates (Grand Concourse).** Cast your vote! What brought you to Kidney Week? Share your answer with the kidney community.
- **NEW! Leave a Message (Grand Concourse).** Share your "why." Inspire a generation. Leave a 30-second message to encourage the kidney community. Why do you do this work? What drives your ambition every day?
- **NEW! Selfie Competition (various locations).** Think you can find them all? Track down all five Kidney Week spots, snap a photo at each, and post your adventure using #KidneyWk. ■









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ASN Executive Vice President's Update

ASN Creates Value, Meaning, and Hope

By Tod Ibrahim

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Kidney health has undoubtedly advanced during the past year. From groundbreaking therapeutic options for kidney diseases to crucial policy shifts that expand access for people living with kidney diseases, 2026 proved what is possible. Turning these breakthroughs into sustained, equitable outcomes across the entire kidney community requires deliberate strategy, organized leadership, and steadfast determination.

To accomplish its mission of "transforming kidney care and improving lives through science, education, advocacy, and collective action," ASN advances kidney care, fosters science and innovation, enhances nephrology education, asserts the value of nephrology, and leads kidney policy and advocacy (1). Describing one example from each of these five pillars highlights ASN's value to its members and to the broader kidney community, underscores how ASN produces meaningful results, and demonstrates how ASN sparks hope today and tomorrow.

Advancing kidney care

Through a coordinated portfolio of initiatives, ASN increases patient access to, strengthens the workforce's expertise in, and establishes national standards for high-quality care in home dialysis. In collaboration with Home Dialysis University (HDU), ASN offers scholarships that annually support up to 70 nephrology fellows to attend HDU in person and then participate virtually in a longitudinal education program. In 2027, ASN is launching a complementary program providing advanced home dialysis training to up to 15 early-career nephrologists annually.

Based on recommendations from ASN, both the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Internal Medicine (ABIM) recently increased their emphasis on "home dialysis therapies (peritoneal dialysis and home hemodialysis)" to "align with the national priority to address the underuse of home dialysis therapies" (2, 3). To help the community meet ACGME standards (for fellowship training) and ABIM standards (for initial and maintenance of certification), ASN offers training opportunities and enhanced continuing medical education in peritoneal dialysis and home hemodialysis. Additionally, ASN updated the Dialysis Core Curriculum in July, enhancing a key resource for nephrologists training in home dialysis.

ASN will also launch a Centers of Excellence in Home Dialysis program in 2027. Designed to recognize, support, and empower home dialysis facilities that deliver safe, effective, and patient-centered care, this program aims to expand access to high-quality home dialysis care across North America. The ASN Centers of Excellence in Home Dialysis program is built around education and training, infrastructure and care delivery, and quality improvement and assurance.

ASN thanks Vantive for funding the collaborations with HDU and the Centers of Excellence.

Fostering science and innovation

Established in 2012 by ASN, KidneyCure is the largest private funder of kidney research in the United States. The foundation's portfolio spans the entire spectrum of career development, from the Pre-Doctoral Fellowship Award and the Ben J. Lipps Research Fellowship for rising stars to the Transition to Independence Grants to help scientists become independent researchers. The foundation also supports the William and Sandra Bennett Clinical Scholars Program and ASN-Harold Amos Medical Faculty Development Program Award.

Beyond funding, KidneyCure supports its grant recipients through other mechanisms critical to ensuring their success. In addition to offering career development programming, KidneyCure provides a platform to highlight grant recipients' science to future employers and a network of peers to support them at every stage of their careers. The entire kidney community benefits from the impact of the foundation's hundreds of alumni. Grant recipients include academic leaders like medical school deans, department chairs, and nephrology division chiefs, as well as ASN leaders like ASN President Samir M. Parikh, MD, FASN (who received a Transition to Independence Grant in 2008).

KidneyCure awarded nearly $4.5 million in grants in 2026. This investment supports 56 recipients across the programs. As these recipients successfully transition into independent researchers, they will accelerate the momentum of bringing new therapies to people living with kidney diseases and of inspiring interest in research careers among the next generation.

Enhancing nephrology education

Earlier this year, ASN and the GlomCon Foundation launched a task force to define competence in glomerular diseases. With representation from the International Society of Glomerular Disease, the task force uses a three-tiered rubric (essential, individual, and advanced training) to standardize the curriculum for categorizing expectations for all nephrologists (4). For the quickly changing field of glomerular diseases, this approach provides a foundation for nephrologists in clinical practice while also offering a road map for those seeking more specialization and guiding every nephrologist in between.

To define core competencies in glomerular diseases for all graduating nephrology fellows, essential training encompasses ASN's expectations for what every nephrologist must know, such as recognizing clinical presentations of glomerular diseases, interpreting basic renal pathology, and managing relatively uncommon conditions like immunoglobulin A nephropathy and lupus nephritis. Individual training is practice-specific, identifying areas of training that can be personalized based on a fellow's intended practice setting, such as how clinicians in high-volume centers might require deeper expertise in immunology.

After assessing the pros and cons of developing a subspecialty within nephrology focused on glomerular diseases, the task force will recommend whether the kidney community should pursue advanced training. Requiring education beyond what is available during the first 2 years of a nephrology fellowship, advanced training could include greater knowledge in immunology, management of rare diseases (such as C3 glomerulopathy), and the ability to lead clinical trials for emerging molecular-targeted therapies.

Asserting the value of nephrology

Transplant nephrologists are indispensable to the care of people with kidney failure, yet a portion of their work fails to generate billable revenue and goes unrecognized by conventional productivity metrics. This year, ASN unveiled a kidney transplant compensation tool kit to address these challenges. The tool kit helps division chiefs clearly and consistently articulate the value that transplant nephrologists bring to department chairs and other health system leaders.

To help transplant nephrologists advocate for their value, the tool kit synthesizes existing evidence, quantifies nonbillable effort, and provides scalable solutions for institutions and clinicians (5). By providing insights into several models for organizing transplantation at different institutions, the tool kit also considers the flow of funds for the billable portion of transplant nephrology's effort.

ASN will hold a session, "Unlocking Value: A Compensation and Advocacy Toolkit for Transplant Nephrologists," at Kidney Week 2026. A panel of experienced transplant nephrologists are slated to summarize the tool kit, describe how different practice models work, and answer questions to help participants adapt the tool kit locally to negotiate and advocate more effectively.

ASN thanks members of the Society of Transplant Nephrology for serving on the ASN Transplant Nephrology Compensation Task Force, which produced the tool kit.

Leading kidney policy and advocacy

Earlier this year, the American Society of Association Executives recognized the ASN "STAND for Kidney Health" Campaign with the Power of Associations Gold Award for "galvanizing the kidney community for policy change" (6). Other winners in this advocacy category include The American Institute of Architects, Rotary International, and the Smart Electric Power Alliance.

STAND for Kidney Health focuses ASN's federal legislative and regulatory priorities on:

- **S**tarting earlier: Shift kidney care away from reactive "end-stage" treatment toward proactive screening for high-risk populations. By integrating kidney health into broader chronic management models, the goal is to slow disease progression and reduce the human and financial costs of kidney failure.
- **T**ransforming transplant: Champion structural infrastructure modernization, advocate for stronger financial protections and reimbursements for living donors, and actively establish future policy pathways for emerging solutions like xenotransplantation.
- **A**ccelerating innovation: Secure significant federal funding ($1.8 billion annually) to scale novel therapies, support the Kidney Innovation Accelerator (KidneyX), and build clearer regulatory pathways for advanced technologies, including artificial intelligence integration.
- **N**urturing the workforce: Address challenges faced by nephrologists and other kidney health professionals, such as policy changes for international medical graduates (IMGs) to train or practice in the United States. ASN is partnering with the American Nephrology Nurses Association, the National Kidney Foundation, and the Renal Physicians Association on a task force to strengthen the US dialysis care team.

- **D**elivering value: Facilitate high-value clinical care pathways, expand coverage for cutting-edge therapies, and transition federal payment models away from historical volume-driven structures toward outcome-oriented systems.

Related to efforts to "nurture the workforce," last year, ASN asked the Migration Policy Institute (MPI) to analyze trends affecting the supply and demand for nephrology services (7). Before the end of this year, MPI will issue its report. MPI's publication will raise public awareness of—and federal interest in—the devastating impact of policy changes to the IMG pipeline on health care in the United States. The report will also provide a strategy for how ASN can better support the 53% of nephrologists who are IMGs.

Sparking hope today and tomorrow

As you consider renewing your ASN membership for another year or joining the society for the first time, you should ask yourself if any other organization is:

- commencing several initiatives to promote home dialysis,
- championing nearly 60 kidney researchers annually,
- classifying competence in glomerular diseases,
- creating a transplant compensation tool kit,
- conducting an award-winning advocacy campaign, and
- commissioning a report on policy changes to the IMG pipeline.

This year, ASN and the Department of Health and Human Services are "exploring opportunities to improve health data interoperability across the [people living with kidney diseases] journey" (8). Through the Early Career Training Grant Pilot Program, KidneyCure is currently soliciting grant submissions from "senior post-docs, clinical fellows participating in research-oriented fellowships, and new clinical faculty interested in kidney research" (9). In 2027, the third cohort of early-career nephrology professionals will complete the FIND [Fostering Innovative Leaders in Nephrology and Dialysis] program "to develop essential skills, gain strategies for overcoming professional challenges, and create a clear [road map] for career advancement" (4, 10). With several other initiatives planned for 2027, ASN will continue to create value, meaning, and hope for its valued members and the kidney community. ■

Tod Ibrahim, MLA, is chief executive officer and executive vice president, American Society of Nephrology, Washington, DC. You can reach him at tibrahim@asn-online.org.

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Basic Science and Clinical Research Advance Patient Care

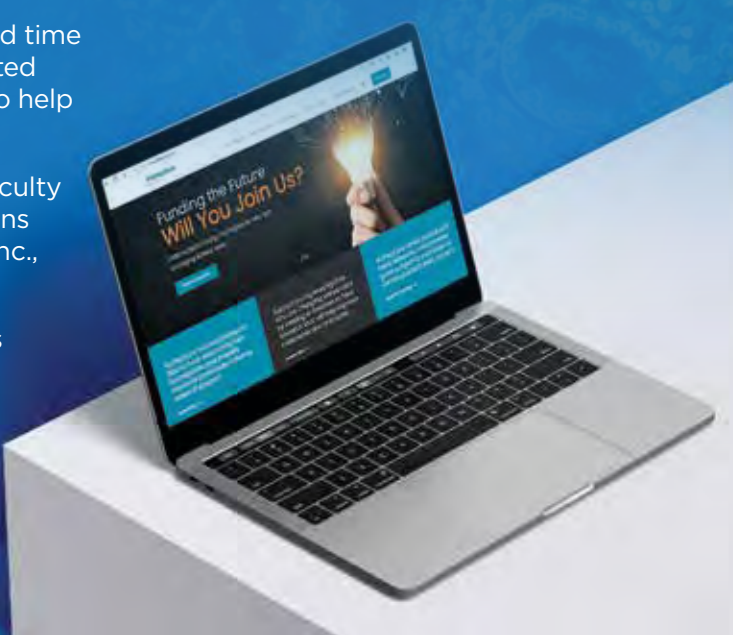
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Deadline to submit is Thursday, November 19, 2026 at 2:00 p.m. EST.

- **KidneyCure Pre-Doctoral Fellowship Program** provides support for PhD students to conduct kidney-related research with guidance from a mentor.
- **Ben J. Lipps Research Fellowship Program** provides funding to nephrology fellows for original and meritorious research conducted under the guidance of a sponsor and is fully endowed by contributions provided by Fresenius Medical Care, ASN, the American Renal Patient Care Foundation, Inc., Amgen, Vantive, and the PKD Foundation.
- **NEW Early Career Training Grant Pilot Program** provides protected time for senior post-docs, clinical fellows participating in research-oriented fellowships, and early career faculty interested in kidney research to help strengthen their application for a career development grant.
- **Transition to Independence Grants Program** helps early career faculty become independent researchers and is supported by contributions provided by ASN, Satellite Healthcare, Inc., Akebia Therapeutics, Inc., Otsuka and Visterra, and individual donors.
- **William and Sandra Bennett Clinical Scholars Program** provides support for a clinician-educator to conduct a project to advance all facets of nephrology education and teaching.

For details and online applications, visit the KidneyCure website, www.kidneycure.org/grants/funding.aspx or scan the QR code.



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Beyond the Pitch: Understanding the Kidney Under Athletic Stress

By Komal Safdar

https://doi.org/10.62716/kn.004802026



Soccer is played by hundreds of millions of people worldwide, but the kidney rarely enters the conversation. In "Kick, Sweat, Protect," Jhaveri and colleagues use soccer as a lens to examine a broader question: What happens to the kidney during repeated high-intensity exercise, and when does physiologic stress become disease (1)?

The first challenge is defining "normal." Transient increases in serum creatinine, albuminuria, hematuria, and tubular injury biomarkers may follow strenuous exercise and resolve with recovery. Albuminuria specifically is increasingly recognized as a continuous marker of cardiovascular, kidney, and metabolic risk, with growing evidence challenging the traditional less than 30 mg/g urine albumin-to-creatinine (UACR) threshold (2–5). A postexercise UACR could therefore lead to overdiagnosis, whereas dismissing persistent albuminuria as exercise-related could miss an early marker of disease. This is particularly consequential in younger athletes, for whom early recognition creates opportunities for prevention and longitudinal monitoring.

Another intriguing question is why substantial physiologic stress does not always translate into kidney injury. Athletes can develop striking creatine kinase (CK) elevations without acute kidney injury (AKI), and CK magnitude alone poorly predicts kidney injury in exertional rhabdomyolysis, highlighting coexposures such as volume depletion, heat, and nonsteroidal anti-inflammatory drug use (6–9). Could repeated exercise induce adaptations that confer renal resilience to subsequent stress? Jhaveri et al. highlight acute and chronic adaptations to training, including transient elevations in kidney injury biomarkers (1). Whether these episodes represent benign adaptation, renal "preconditioning," or cumulative subclinical injury remains unknown. Recurrent AKI in other settings is an established risk factor for chronic kidney disease (CKD), but longitudinal data examining repeated kidney stress in athletes are lacking. Understanding kidney resilience versus vulnerability may have implications well beyond sport.

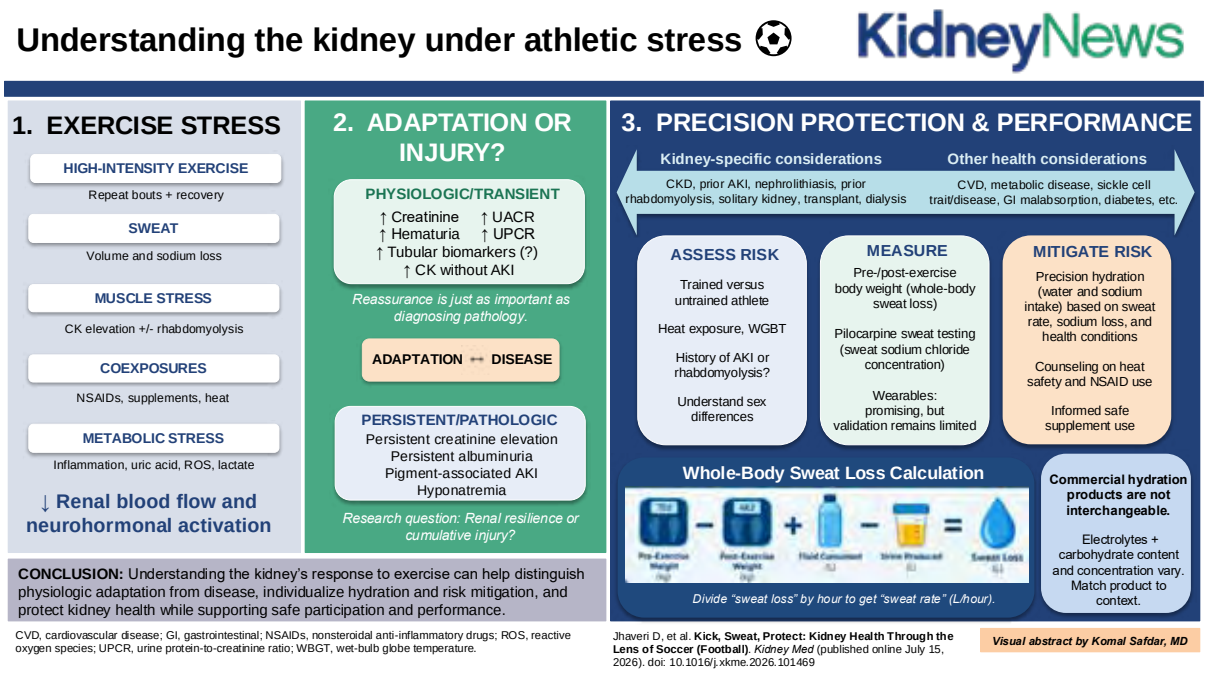
Precision is equally important for hydration. Sweat rate and sodium losses vary substantially among athletes; pilocarpine-induced regional testing in athletes demonstrated sweat sodium concentrations of approximately 17 to 92 mmol/L (391–2115 mg/L) (10). Hydration strategies should therefore consider the individual, environment, exercise intensity, and underlying health and kidney risk—particularly cardiovascular disease, hypertension, CKD, nephrolithiasis, recurrent AKI, rhabdomyolysis, or prior exercise-associated hyponatremia. Individualization also requires recognizing underrepresented populations, including female athletes, given physiologic differences that may influence kidney biomarkers and hydration needs (1).

Tools to guide this precision are rapidly expanding. Wearable technologies increasingly estimate sweat sodium and other physiologic signals, although validation across devices, exercise conditions, and populations remains under study (11, 12). Simple pre- and postexercise body weights, corrected for fluid intake and urine output (analogous to pre- and postdialysis weights), remain useful for estimating whole-body sweat losses (13, 14). Meanwhile, commercial hydration products vary widely in electrolyte concentration, carbohydrate content, and overall composition (1). These differences are not inherently better or worse; their value depends on matching the product to the athlete, exercise demands, environment, and clinical context. Understanding the utility and limitations of these increasingly accessible tools will become progressively relevant to nephrology practice.

The same literacy applies to sports supplements. Creatine monohydrate has evidence of performance benefits and appears generally safe in healthy athletes (15). However, very rare cases of acute interstitial nephritis and cast nephropathy after high-dose use have been reported (16–18). Creatine supplementation and greater muscle mass can increase serum creatinine without a corresponding reduction in the glomerular filtration rate, further complicating kidney function assessment in athletes (19, 20). Safe supplement practices, including independently third-party–tested products, remain important.

Ultimately, "Kick, Sweat, Protect" demonstrates that lessons from the soccer field extend beyond athletes. Heat, exertion, volume depletion, and repeated physiologic stress are shared by military personnel and outdoor workers, providing potential parallels to populations at risk for kidney injury. Although controversial, the 2026 FIFA [International Federation of Association Football] World Cup incorporated mandatory hydration breaks into every match. Similar principles—recognizing environmental risk and implementing structured opportunities for hydration and recovery—may inform strategies in heat-exposed populations, including those at risk for CKD of uncertain etiology.

What happens to the kidney during repeated high-intensity exercise, and when does physiologic stress become disease?



CVD, cardiovascular disease; GI, gastrointestinal; NSAIDs, nonsteroidal anti-inflammatory drugs; ROS, reactive oxygen species; UPCR, urine protein-to-creatinine ratio; WBGT, wet-bulb globe temperature.

Jhaveri D, et al. **Kick, Sweat, Protect: Kidney Health Through the Lens of Soccer (Football)**. *Kidney Med* (published online July 15, 2026). doi: 10.1016/j.xkme.2026.101469

Visual abstract by Komal Safdar, MD

Exercise and sport improve health, but they do not erase genetic or acquired risk or provide immunity to diseases. Kidney protection, however, should not come at the expense of participation. "Kick, Sweat, Protect" highlights an opportunity to distinguish adaptation from disease, identify modifiable risks, and individualize care. Ultimately, understanding the kidney under athletic stress may help optimize both kidney health and performance—on and beyond the playing field. ■

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The Nephrologist's Imperative: Owning the Delivery Gap in CKM Syndrome

By Christopher El Mouhayyar and Menaka Sarav

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In 2023, the American Heart Association (AHA) formally established what nephrologists had long witnessed at the bedside on rounds and in clinic: Hypertension, diabetes, chronic kidney disease (CKD), and cardiovascular disease (CVD) are not parallel comorbidities but manifestations of a single pathophysiologic continuum, which was defined as cardiovascular-kidney-metabolic (CKM) syndrome (1). Two and a half years later, the "2026 AHA/ACC/ADA/ASN Guideline for the Prevention, Detection, Evaluation, and Management of Cardiovascular-Kidney-Metabolic Syndrome," a report of AHA, the American College of Cardiology (ACC), the American Diabetes Association (ADA), and ASN, presents the field's most comprehensive clinical road map to date (2).

The 2026 guideline refines the five-stage CKM model, spanning stage 0 (ideal metabolic health) through stage 4 (established CVD, with or without kidney failure) (Figure). Central to this process is the use of Predicting Risk of Cardiovascular Disease Events (PREVENT) equations to quantify 10- and 30-year cardiovascular risk, which informs staging decisions and guides the prioritization of pharmacologic treatments. Critically, the guideline recommends the use of both estimated glomerular filtration rate (eGFR) and urine albumin-to-creatinine ratio (UACR) for CKD characterization and therapeutic decision-making across stages—a position for which nephrology has long advocated. To support early detection, routine screening for metabolic risk factors, kidney function, early heart failure, metabolic dysfunction-associated steatotic liver disease, and obstructive sleep apnea is recommended, alongside consistent systematic evaluation of social determinants of health. Given the inherent complexity and clinical overlap of CKM conditions, the guideline emphasizes interdisciplinary team-based care with a designated coordinator as essential to ensuring consistent application of evidence-based, guideline-directed treatment across all stages.

Pharmacologic management across CKM stages is anchored by four evidence-based pillars: 1) renin-angiotensin system (RAS) inhibitors, 2) sodium-glucose cotransporter-2 (SGLT2) inhibitors, 3) nonsteroidal mineralocorticoid receptor antagonists (nsMRAs), and 4) glucagon-like peptide-1 (GLP-1) receptor agonists, applied across the spectrum of obesity, type 2 diabetes, CKD, established atherosclerotic CVD, and heart failure, with lifestyle modification as the foundation at every stage. Agent selection and sequencing are guided by specific eGFR and UACR thresholds, with SGLT2 inhibitors serving as a cornerstone across multiple CKM conditions given their demonstrated cardiorenal benefits, and nsMRAs or GLP-1 receptor agonists added based on residual risk, ejection fraction, and metabolic burden.

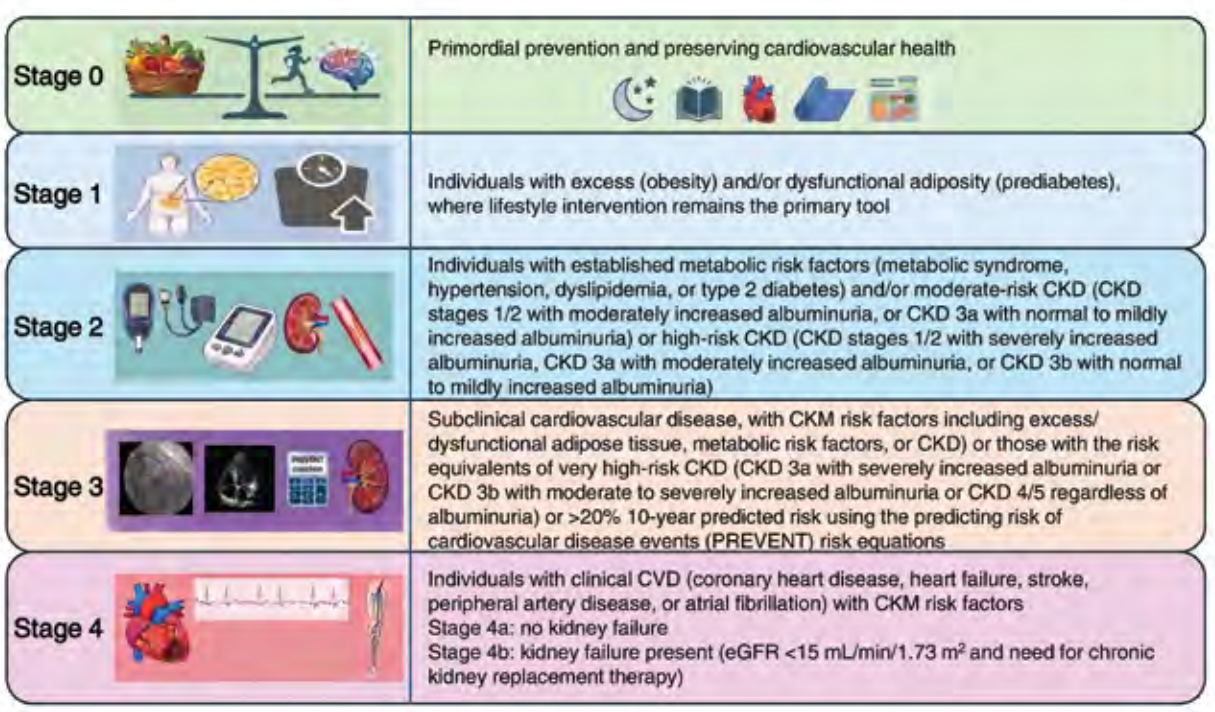
Yet, evidence alone does not translate to outcomes. Across 20 US health systems, only 4.6% of patients with CKD and albuminuria received an SGLT2 inhibitor, and only 3.6% received both an SGLT2 inhibitor and a RAS inhibitor, whereas 21.0% received neither therapy (3). Only 24.9% of eligible patients received both creatinine and UACR testing, and just 26.0% underwent UACR testing within 15 months, the very biomarker that the 2026 guideline recommends to guide treatment decisions, alongside eGFR (3).

The 2026 guideline's interdisciplinary care model, explicitly calling for nephrology referral per Kidney Disease: Improving Global Outcomes (KDIGO) criteria in patients with the highest risks, places our specialty at the center of implementation, not at the sidelines. Yet, the most pressing challenge is no longer lack of evidence but rather implementation and delivery. Translating the four-pillar guideline-directed medical therapy (GDMT) into consistent, real-world practice will require a thoughtful infrastructure. AHA has recognized this, actively partnering with various health systems to develop site-specific implementation frameworks.

Nephrologists must be present in these conversations. The recently released ASN Kidney Health Guidance on the Cardiovascular-Kidney-Metabolic Syndrome (4) aims to "unite the nephrology community" in these efforts, providing CKD-specific considerations and helping nephrologists navigate CKM care for people with kidney diseases. Engagement through initiatives such as the International Society of Nephrology Expert Forum on CKM syndrome, which brings together leaders from nephrology, cardiology, endocrinology, and health policy to generate consensus documents, offers a direct pathway to influence future guideline development. Participation in CKM Centers of Excellence provides a structural entry point for nephrologists to embed their expertise into integrated care frameworks. At a broader level, advocacy for cross-specialty collaboration is essential to ensure that kidney-focused endpoints and nephrology perspectives are represented from the earliest stages of guideline writing.

Our patients carry the highest pharmacologic stakes in terms of eGFR trajectories, albuminuria progression, and drug sequencing decisions. The question of who bears responsibility for ensuring GDMT in these patients—nephrologist or cardiologist—is best answered not by claiming sole ownership but by building the shared, coordinated model that the guideline envisions via a care coordinator. Nephrologists must help design and advocate for a model and ensure that our clinical expertise informs how this model is translated at every institution. The 2026 guideline does not diminish our role. It defines it. ■

Figure. CKM syndrome stages based on the 2026 AHA/ACC/ADA/ASN Guideline



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As Evidence of Benefits Grows, Kidney Community Works to Expand Use of Race-Free Kidney Function Algorithms

By Bridget M. Kuehn

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Amaka Eneanya, MD, MPH, FASN, chief transformation officer and professor of medicine at Emory Healthcare in Atlanta, GA, was an early advocate of removing race from kidney function assessments. She worked tirelessly with colleagues to publish studies revealing how race-based corrections impact Black patients' care and to assist hospitals in phasing out the use of race in kidney function assessments. She was also honored to be appointed to the NKF [National Kidney Foundation]-ASN Task Force on Reassessing the Inclusion of Race in Diagnosing Kidney Diseases. The work was challenging and met a lot of resistance, said Eneanya, who was the keynote speaker at the Encoding Health Equity Summit hosted by the Council of Medical Specialty Societies (CMSS) in June.

"I wanted to quit, but if I'd quit, I'd be in a very different place right now," said Eneanya. She stuck with it, and ultimately the NKF-ASN task force recommended a race-free kidney function assessment equation using cystatin C and creatinine in 2021 (1).

Eneanya's perseverance—with her father's dogged support—paid off in unexpected ways. In January, her father became one of the 23,000 Black patients who has had their kidney transplant wait times adjusted using the race-free equation as of 2026, something she had not anticipated during her advocacy work. Ongoing research continues to document the benefits of the shift, with a study published in March 2026 by Eneanya and colleagues in *JAMA Internal Medicine* showing that removing race from the kidney equation reduced waitlist time for receiving a deceased donor kidney among Black patients an average of 1.7 years without significantly affecting wait times or transplant rates for patients of other races (2). "Health equity doesn't take away from anything," Eneanya said. "Everybody gets better care with health equity."



In her keynote, Eneanya shared insights into how collaborative efforts across organizations and generations helped make the implementation of a race-free kidney function equation successful. ASN's leadership and ongoing work to promote broader implementation of the race-free equation, including in primary care settings, were also highlighted at the meeting in a presentation by Lauren Ahearn, ASN's senior policy and government affairs coordinator. Cynthia Delgado, MD, FASN, professor of medicine at the University of California, San Francisco, and cochair of the NKF-ASN task force, also served as a moderator of a panel at the event, highlighting how other medical societies are reassessing and revising their guidelines to eliminate inappropriate uses of race.

Over the course of the meeting, which was funded by the Doris Duke Foundation, organizations spanning numerous specialties—including the American Academy of Neurology, the American Gastroenterological Society, the College of American Pathologists, the American Academy of Pediatrics, the American Thoracic Society, the American College of Surgeons, the American Academy of Ophthalmology, the American Society of Anesthesiologists, and the American Society of Addiction Medicine—highlighted their work in this area. "I'm honored to have been a part of it from day one and to now see the progression of change," Eneanya said. "I've also been excited to hear all of the progress that's been made across the societies."

Advocating for change

Eneanya noted that there are 37 million people living with kidney diseases in the United States, including 831,000 with kidney failure. She noted that many kinds of distinctions—including racial and ethnic disparities—exist across the spectrum of kidney disease stages. Black patients have a fourfold higher prevalence of kidney failure compared with White patients, and Asian and Hispanic individuals also have a higher prevalence of kidney failure than White patients. Furthermore, there are disparities in who receives transplants, she noted.

"It's really structural racism, the impact of structural racism, the inequitable distribution of power and resources that impact economic, clinical, multiple aspects of outcomes that closely track along racial and ethnic lines," she said. "That is not biology."

The observation that Black individuals had higher serum creatinine levels than White individuals led to the creation of a 16% Black race correction in the 2009 CKD-EPI [Chronic Kidney Disease Epidemiology Collaboration] equation and a 21% race correction in the 1999 Modification of Diet in Renal Disease equations, Eneanya explained. At the time, the higher creatinine levels were assumed to be linked to greater muscle mass in Black individuals, she said. The hope was to create a more accurate equation, she said. However, the difference was more likely caused by altered kidney function caused by structural racism and racial discrimination, contributing to reduced access to quality housing, more food insecurity, greater exposure to pollutants, and levels of daily stress. "It is really a function of the environment and the stress that [individuals who have been historically minoritized] live with every single day in this country," she said.

Inappropriately attributing the difference to biology rather than social determinants of health and using a race adjustment inadvertently contributed to delayed referrals to nephrology care for Black patients, Eneanya said. As a result, Black patients received inflated kidney function scores and experienced delayed education about transplant and dialysis options, exposure to higher medication doses, and delayed waitlisting for transplant.

The race adjustment also did not include accommodations for the growing population of multiracial or multiethnic individuals. For example, Eneanya had a multiracial patient who was able to become waitlisted for a kidney earlier because she asked her physician to use the version of the equation without the race adjustment. In addition to creating situations in which physicians may be arbitrarily assigning race to patients, Eneanya said the lack of transparency around the use of race correction in clinical algorithms is a violation of shared decision-making for patients and the families of deceased donors.

However, correcting these harms was not easy. It took publications in high-profile journals, including *JAMA* (3) and *The New England Journal of Medicine* (4), to highlight the harms. It required a coalition including leaders at institutions, societies, and journals. It also required old-fashioned organizing tactics, such as petitions from medical students, to promote change, she said.

It also took unlikely alliances. Eneanya partnered with investigators, who developed the race-adjusted equation and fundamentally disagreed with the claim that it was harmful, to study its impact on patient care. "We had to come together to move forward," she said.

Engagement with news outlets and an episode of television's "Grey's Anatomy" highlighting the impact of the race correction on a fictional patient's care also helped raise awareness, Eneanya said. Increased awareness led some institutions to stop using the race modifier. Those "quick wins" helped build vital momentum, she added. Outreach to lawmakers led to the 2021 report from the US House Committee on Ways and Means and to the committee's letters to medical societies asking them to review the use of race in medical algorithms (5). The NKF-ASN task force then published the new race-neutral algorithm in December 2021 (1).

"There was significant resistance, and there continues to be resistance, by the way," Eneanya noted. But she said the effort demonstrates how applying classic advocacy and business transformation tactics can help enact medical reform.

Ongoing efforts

Changing the policy was just the first step; efforts to help implement the changes across institutions are ongoing. With support from CMSS and the Doris Duke Foundation, ASN launched the eGFR [estimated glomerular filtration rate] Toolkit 1.0 in 2024. The tool kit was intended to help both clinicians and patients understand the recommendation

to adopt a race-neutral algorithm. "We've noticed that low awareness and misconceptions still exist and persist," Ahearn said. "Many primary care physicians were not aware of the tool kit."

To address the gaps, ASN's Health Care Justice Committee partnered with primary care clinicians to draft the eGFR Toolkit 2.0 (6), also supported by CMSS and the Doris Duke Foundation. The new version includes streamlined information for clinicians, including specifically primary care clinicians. To help disseminate it, ASN has launched social media campaigns on LinkedIn, TikTok, and other platforms.

The updated version includes conversation guides to help clinicians explain the new algorithm to patients and navigate sometimes challenging conversations. Ahearn noted that there is also ongoing work to disseminate the tool kit and raise awareness among ASN members. "Health equity policy is at the forefront of our portfolio, and the eGFR Toolkit 2.0 is a great example of that," she said. "Our goal is to keep the conversation going."

Redressing harm

In June 2022, the Organ Procurement and Transplantation Network (OPTN) prohibited transplant centers from using race-based algorithms on waitlisted patients, and in 2023, OPTN required transplant centers to retroactively correct wait times for patients (7).

"It was the first time any national organization had released a policy that was designed specifically to target the patients affected by use of race in a clinical algorithm," said coauthor of the *JAMA Internal Medicine* study Rohan Khazanchi, MD, MPH, an adult and pediatric hospitalist and health services researcher at Boston Medical Center, MA (2). "[It was the first policy to] not just change the algorithm for the future but repair the harm for those who have been affected in the past."

The study found that the waitlist adjustment had its intended effect, with a median waitlist adjustment for Black patients affected by the race correction of about 1.7 years. Some patients had their waitlist time adjusted by 5, 10, or 15 years, Eneanya noted. Approximately 9800 Black patients received a transplant because of the adjustment, increasing the rate of transplant by 5.3 per 1000 listing among Black patients without a significant impact on transplants among patients of other races (2). Most of the increase in transplants was in deceased donor transplants conducted both preemptively and after initiation of dialysis, Khazanchi noted.

"It did not just help those folks [who] are sick and have been on dialysis for a while, and it did not have an adverse effect on living donor kidney transplantation," he said. "The policy worked in the way it was intended and had a significant effect on the kidney transplant landscape, as evidenced by shifts in overall disparities in transplantation across the country."

But only about one in three Black waitlisted patients received a waitlist modification. "There [are] a large number of waitlist candidates who did not receive a wait-time modification," Khazanchi noted. He said it is important to determine whether every potentially eligible individual received an adjustment or whether some patients "slipped through the cracks." Khazanchi noted that another study found center-level variations in the number of candidates who received adjustments (8). He suggested that some centers may need additional support to locate old medical records and ensure that every eligible patient receives a modification. He said it is also important to find patients who are not eligible for an adjustment because they had no prior eGFRs or may have crashed into dialysis. Khazanchi said he and his colleagues would also like to study the impact of the waitlist adjustment policy on transplant outcomes, including post-transplant mortality and graft failure, as well as its effect on organ allocation.

Khazanchi described how the results show that it is important for medical societies working to replace algorithms, which inappropriately use race, to also consider how to provide redress to those harmed by past use of race-based algorithms. For example, he noted that race-based pulmonary function equations may have led to Black workers receiving reduced workers' compensation payments, despite having similar lung impairment. He said that studying who was harmed and how they were harmed can help physicians and policymakers determine how to repair the harm.

"Fixing the equation—as the kidney community knows—is not the entire puzzle," he said. "I hope other organizations can learn from the kidney community how to remedy those harms." ■

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VERTEX

KidneyX EMPOWER Prize Winners: Empowering a New Era of Living Donation

By Eve Doolittle

https://doi.org/10.62716/kn.005002026

For most Americans living with kidney failure, living organ donation is the gold-standard treatment. But, as many readers will know well, substantial barriers too often stand between people living with kidney diseases and a living kidney transplant. Guided by a commitment to eliminating these barriers, empowering living donors, and paving the way for living kidney transplants to become more accessible, ASN and the US Department of Health and Human Services (HHS) launched the 2026 KidneyX EMPOWER: Living Link Prize Challenge to encourage innovations that better support living kidney donors.

The Kidney Innovation Accelerator (KidneyX) is a public-private partnership, created by HHS and ASN in 2018, to accelerate innovation in the prevention, diagnosis, and treatment of kidney diseases. The $4 million 2026 KidneyX EMPOWER: Living Link Prize Challenge sought to address critical gaps in living kidney donation by inviting impactful and scalable solutions in support of living donors and the people whose lives depend on them.

"Living kidney donation saves lives, yet too many willing donors face barriers that should not exist. We are removing those barriers and backing innovators with practical solutions that support donors, strengthen transplant care, and give more Americans a chance to live," said HHS Secretary Robert F. Kennedy, Jr., in a press release from HHS (1).

The competition drew 85 unique submissions, which were evaluated in a multidisciplinary review that included living donors, patients, transplant professionals, and an HHS judging panel, on four criteria: 1) alignment to the challenge focus areas, 2) clinical feasibility, 3) donor experience, and 4) technical sustainability (2).

Nine teams were recognized for their bold, practical solutions. Eight awardees receive $375,000 each, and one grand prize winner receives $1 million for their exceptional contributions to living kidney donation and the kidney community at large (1):

- **Grand Prize Winner: Richard Horsley.** *LivingLink*: A full-stack, open-source platform built on HL7 FHIR [Fast Healthcare Interoperability Resources] R4, which integrates natively into commonly used electronic health records (EHR) systems
- **Columbia University Irving Medical Center/NewYork-Presbyterian.** *DonorForward*: Turning unused donor readiness into nondirected kidney transplants; a structured identification and decision aid system to expand the living donor pool
- **Dartmouth Transplant.** *A Rural Living Donor Tele-Navigation Hub*: A telehealth-enabled care model shifting testing and care coordination closer to home to reduce travel barriers for rural donors
- **Kidney Connective.** *Best-Fit Routing for Donors and Their Pairs*: A donor and pair-facing best-fit routing experience that helps a donor and their recipient find the transplant center where they are both eligible
- **MedStar Georgetown Transplant Institute.** *Expanding Living Kidney Donation in Adults 65 and Older*: Replaces fixed criteria with an individualized, age-adjusted, and risk-stratified evaluation framework
- **National Kidney Donation Organization (NKDO).** *The NKDO Living Link Network*: A national model connecting prospective donors and patients with trained living donor mentors and moderated peer discussions
- **New York University Langone Health Transplant Institute.** *CADENCE*: A virtual program using trained lay navigators to deliver the "Live Donor Champion" program, equipping families to act as advocates
- **Regenstrief Institute.** *LIVINGkidney*: A stand-alone mobile app and website providing structured guidance and artificial intelligence knowledge assistance
- **Virginia Commonwealth University.** *The KHCP [Kidney Health Care Program] Living Link Pathway*: An EHR-enabled care model that uses rule-based chronic kidney disease identification and predictive risk equations to activate donors early

"A kidney transplant from a living donor is the optimal form of treatment for most people with kidney failure, yet a variety of barriers have prevented many Americans from becoming living donors," said ASN President Samir M. Parikh, MD, FASN. "Today, I am inspired by the nine KidneyX Living Link EMPOWER Prize Challenge winners, whose winning solutions will help many people overcome these barriers and save the lives of their fellow Americans through living donation" (1).

KidneyX prize competitions are complementary to traditional National Institutes of Health grant funding; although there are no strings attached to the awards, the aspiration is that awardees use the funds to scale and disseminate their winning solutions. Perhaps equally important is the national recognition that winning solutions receive from HHS and ASN, which past winners have reported has been instrumental in helping them increase their visibility and secure additional investment needed to grow.

Since its inception in 2018, KidneyX has awarded 80 innovators prizes in more than 20 states and 40 congressional districts across 7 prize competitions. For more information on the KidneyX EMPOWER: Living Link Prize Challenge and the winners, visit https://kidneyxempowerchallenge.org. ■

Eve Doolittle is with the policy team at ASN.

References

1. US Department of Health and Human Services. HHS announces winners of the 2026 KidneyX EMPOWER: Living Link Prize Challenge to advance living kidney donation and patient-centered innovation. August 27, 2026. https://www.hhs.gov/press-room/hhs-announced-winners-of-2026-kidneyx-empower-living-link-prize-challenge.html
2. KidneyX Innovation Accelerator. $4 Million to accelerate living donation. Start preparing your solution. KidneyX EMPOWER Challenge. https://kidneyxempowerchallenge.org

Wolters Kluwer

ASN American Society of Nephrology

Your Basic Research Deserves the Spotlight

Did you know that ***JASN***® and ***Kidney360***® are eager to publish your basic research?

The journals are not just committed to groundbreaking clinical studies—we enthusiastically welcome and publish high-quality basic research articles too. We're actively seeking laboratory research that dives deeply into the mechanisms of kidney diseases. Whether you're exploring new therapeutic approaches or uncovering systemic effects, we want to publish your research.





Learn More

Scientific Exposition

October 22–24



Exhibits and Posters

Colorado Convention Center, Exhibit Hall A
9:30 a.m.–2:30 p.m. daily

Highlights Include:

- Over 170+ Exhibiting Companies
- Over 3,000 Posters with Top Trainee Poster Sessions—Futures Theater
- ASN Communities Lounge
- Career Fair
- Exhibitor Spotlights
- Fellows-in-Training (FIT) Bowl—Futures Theater
- Innovation Avenue **NEW!**
- Headshot Lounge
- Participant Lounges
- Refreshment Breaks
- Welcome Reception
- Wellness Lounge

ASN Communities Lounge—Booth 737

Meet kidney leaders, learn about ASN Communities, and network with your peers.

Fellows-in-Training (FIT) Bowl—Futures Theater

Watch nephrology training teams test their knowledge against their peers.
Which team will reign supreme?

Thursday, October 22	**10:30 a.m.–12:30 p.m.**	**Elimination Rounds**
Friday, October 23	**10:30 a.m.–11:30 a.m.**	**Semi-Finals**
	11:30 a.m.–12:30 p.m.	**Championship**

Support provided by AsahiKASEI THERAPEUTICS

Headshot Lounge—Booth 1178; Aisles 1000–1100

Stop by for a complimentary professional headshot.

Support provided by GSK

NEW! Innovation Avenue—Aisles 1100–1200

See what's next in nephrology. Explore groundbreaking products and emerging technologies.
Drop by the Innovation Stage where industry experts share insights shaping the future of kidney care.

Welcome Reception—Thursday, October 22, 6:00–7:00 p.m.

Join ASN in welcoming you to Denver.

Support provided by AsahiKASEI THERAPEUTICS

Wellness Lounge—Booth 265; Aisles 200–400

Help train a service dog, pet a bunny, or enjoy a moment of relaxation at a massage station.

Support provided by TRAVERE® THERAPEUTICS

KIDNEY WEEK 2026

Exhibitor Spotlight Schedule

Join your colleagues for the latest advances in nephrology practices, products, services, and technologies presented in three theaters on the exhibit hall floor (no continuing education credit). Seating is limited and available on a first-come, first-served basis.

The 10:15 a.m. presentations include breakfast. All other presentations include lunch.

Thursday, October 22

10:15–11:00 a.m. **Theater 1**	Experiencing HighVolumeHDF: Perspectives from U.S. Prescribers and Patients	*Presented by* FRESENIUS MEDICAL CARE
11:00–11:45 a.m. **Theater 3**	Advancing Hypertension Care: The Role of Renal Denervation in Nephrology Practice	*Presented by* Medtronic
11:30 a.m.–12:15 p.m. **Theater 2**	Consensus and Clinical Implications: Interpreting the Proposed KDIGO Guidelines	*Presented by* Vantive
12:00–12:45 p.m. **Theater 1**	Moving Upstream in IgA Nephropathy: From Pathogenic Drivers to Patient Outcomes	*Presented by* VERTEX
12:30–1:15 p.m. **Theater 3**	Investigational Treatment Mechanisms in FSGS and Complement-Mediated Kidney Diseases	*Presented by* Akebia THERAPEUTICS
1:00–1:45 p.m. **Theater 2**	Advancing the Treatment Paradigm in IgAN	*Presented by* vera therapeutics

Friday, October 23

10:15–11:00 a.m. **Theater 1**	Why Aldosterone Matters for Kidney Outcomes in CKM Syndrome	*Presented by* Boehringer Ingelheim
11:00–11:45 a.m. **Theater 3**	Expanding Perspectives in Hyperphosphatemia Treatment; A Different Approach	*Presented by* ardelyx
11:30 a.m.–12:15 p.m. **Theater 2**	Evaluating the Heterogeneity of IgAN: Evolving Strategies for Treatment	*Presented by* NOVARTIS

Friday, October 23 (Continued)

12:00–12:45 p.m. **Theater 1**	Beyond B-cells: Pioneering Plasmablast and Plasma Cell Targeting in IgAN and PMN	*Presented by* Biogen
12:30–1:15 p.m. **Theater 3**	Expanded HD with ELISIO-HX: Transforming US Dialysis Treatment	*Presented by* NIPRO
1:00–1:45 p.m. **Theater 2**	A Treatment for Two Rare Glomerular Diseases: C3G and Primary IC-MPGN	*Presented by* Biogen

Saturday, October 24

10:15–11:00 a.m. **Theater 1**	Connecting the Dots in IgAN: Complement Nexus in Inflammation and Nephron Loss	*Presented by* ALEXION AstraZeneca Rare Disease
11:00–11:45 a.m. **Theater 3**	The Next Era in the Treatment of Hypertension	*Presented by* idorsia
11:30 a.m.–12:15 p.m. **Theater 2**	VOYXACT® (sibeprenlimab): Managing Adult Patients With Primary IgAN at Risk for Disease Progression	*Presented by* Otsuka
12:00–12:45 p.m. **Theater 1**	A Dual-Acting Approach in FSGS and IgAN	*Presented by* TRAVERE THERAPEUTICS
12:30–1:15 p.m. **Theater 3**	Expert-led Review: Identifying Treatment Opportunities for Patients with Lupus Nephritis	*Presented by* Genentech A Member of the Roche Group
1:00–1:45 p.m. **Theater 2**	A Novel Aldosterone-Targeted Treatment for Patients with Uncontrolled Hypertension	*Presented by* AstraZeneca

Educational Symposia Schedule

KIDNEY WEEK 2026
October 21–25 | Denver, CO

Hyatt Regency Denver
Thursday, October 22–Saturday, October 24
12:45–1:45 p.m. Daily (Doors open around 12:30 p.m.)

Lunch will be served at each symposium.
Seating is limited and available on a first-come, first-served basis to fully paid Annual Meeting participants.

Continuing Education Credit
These live activities are eligible for continuing education credit.
Please visit www.asn-online.org/KidneyWeek for more information.

Thursday, October 22

Advances in Treatment and Management of FSGS
*Support is provided by an educational grant from **Travere Therapeutics, Inc.***

B-Cell Therapy over a Patient's Lifetime: When and Where to Deploy It in Lupus Nephritis and Membranous Nephropathy
*Support is provided by an educational grant from **Genentech, a member of the Roche Group.***

In, Out, and In Between: Potassium Homeostasis in an Age of Treatment Options
*Support is provided by an educational grant from **AstraZeneca**.*

Is It Time to Target Complement in IgAN?
*Support is provided by educational grants from **Alexion, AstraZeneca Rare Disease and Novartis Pharmaceuticals Corporation**.*

Friday, October 23

Accelerating Development of Therapies for APOL1-Mediated Kidney Disease
*Support is provided by an educational grant from **Vertex Pharmaceuticals.***

Hemodiafiltration in 2026: Rationale, Evidence, and the Path to Implementation
*Support is provided by an educational grant from **Fresenius Medical Care.***

Idiopathic Nephrotic Syndrome: Getting Less Idiopathic?
*Support is provided by an educational grant from **Genentech, a member of the Roche Group.***

Redefining the IgAN Paradigm: Early Detection, Targeted Immunotherapy, and Clinical Reality
*Support is provided by an educational grant from **Vera Therapeutics, Inc.***

Saturday, October 24

Anti-CD38 Therapies for IgAN: Is Durable Remission Possible?
*Support is provided by an educational grant from **Takeda Pharmaceuticals U.S.A., Inc.***

Diagnosis and Treatment of Hypocalcemia, Hypercalciuria, Nephrocalcinosis, and Kidney Stones
*Support is provided by an educational grant from **BridgeBio Pharma, Inc.***

Expanded Hemodialysis with Super High-Flux Membranes: Rationale, Evidence, and Implementation Considerations
*Support is provided by an educational grant from **NIPRO Medical Corporation.***

All symposia will be recorded and available in the ASN Learning Center for up to three years starting in November; continuing education credits will not be awarded for the online content.

PLENARY SESSION

STATE-OF-THE-ART LECTURE

CAR-T Therapy Pioneer to Trace the Evolution of Cell Therapy

https://doi.org/10.62716/kn.004432026



Michel Sadelain, MD, PhD

A pioneer of chimeric antigen receptor T cell (CAR-T) therapy will deliver a state-of-the-art lecture during a plenary session on Thursday, October 22. Michel Sadelain, MD, PhD, will present "Origins and Evolution of CD19 CAR-T Cells."

Dr. Sadelain is the Herbert and Florence Irving Professor of Medicine in the Vagelos College of Physicians and Surgeons at Columbia University, New York, NY. He founded and directs the Columbia Institute for Cell Engineering and Therapy, a university-wide effort to advance cell and gene therapies. He also directs the Cancer Cell Therapy Initiative at the Herbert Irving Comprehensive Cancer Center at NewYork-Presbyterian/Columbia University Irving Medical Center.

He has transformed CAR-T therapy from an experimental concept into a clinically viable therapy. CAR-T therapy works by re-engineering a patient's own immune cells to recognize and destroy cells that would otherwise evade detection. These engineered cells identify and kill any cell displaying a specific target protein, bypassing the immune system's normal antigen-presentation pathway.

Dr. Sadelain's work has advanced every stage of CAR-T therapy development, establishing engineered cell therapy as a viable new category of medicine alongside drugs and biologics. He identified CD19—a protein found on the surface of both healthy and cancerous B cells—as an effective therapeutic target, provided critical early evidence that engineered T cells could eradicate CD19-positive leukemias and lymphomas in mice, and then helped establish the manufacturing infrastructure needed to bring those therapies to patients.

The framework that Dr. Sadelain helped build—target identification, receptor design, and manufacturing on a clinical scale—has become the template for CAR-T therapies aimed at other cancers, and researchers are now testing similar approaches to deplete disease-causing immune cells in autoimmune conditions such as lupus.

Dr. Sadelain has received numerous honors and awards lauding his seminal contributions to CAR-T therapy. These include the 2025 Richard N. Merkin Prize in Biomedical Technology, which recognizes breakthroughs in biomedicine; the 2025 King Faisal Prize in Medicine; the 2024 Canada Gairdner International Award; the 2024 Breakthrough Prize in Life Sciences; and the 2024 Warren Alpert Foundation Prize. He has also earned an Outstanding Achievement Award from the American Society of Gene & Cell Therapy, a Lifetime Achievement Award from the Stanford Drug Discovery Symposium, and many other accolades. He is an elected member of The American Society for Clinical Investigation, the American Academy of Arts and Sciences, and France's National Academy of Medicine.

He received his MD from the University of Paris in France and his PhD from the University of Alberta in Edmonton, Canada. He then trained as a research fellow at the Whitehead Institute for Biomedical Research at the Massachusetts Institute of Technology, Cambridge. Prior to joining Columbia University, he was founding director of the Center for Cell Engineering at the Memorial Sloan Kettering Cancer Center, NY, where he also held the Stephen and Barbara Friedman Chair.

Ophthalmologist, Comedian, and Health Care Advocate to Receive President's Medal

https://doi.org/10.62716/kn.004322026



William E. Flanary, MD

William E. Flanary, MD, an ophthalmologist whose medical satire has reached millions online, will receive the ASN President's Medal on Thursday, October 22, in recognition of his use of comedy to spotlight challenges in medicine and health care.

ASN presents this medal to individuals who have advanced the society's mission to fight against kidney diseases by educating health professionals, sharing new knowledge, advancing research, and advocating for patients.

Dr. Flanary is an ophthalmologist based in Portland, OR. He is best known to many as "Dr. Glaucomflecken," a comedian and social media personality with an audience of more than 5 million across social media platforms. His work combines comedy, satire, and advocacy to examine the culture of medicine, the US health care system, and the experiences of both patients and clinicians. He uses humor to examine everything from residency training and medical specialty stereotypes to insurance bureaucracy, academic publishing, and the everyday realities of practicing medicine. Together with his wife, Kristin Flanary (known as "Lady Glaucomflecken"), he also cohosts the medically themed podcast, "Knock Knock, Hi!"

Dr. Flanary's own experiences as a medical student, resident, physician, and patient have shaped his content and perspective. He is a two-time survivor of testicular cancer and survived cardiac arrest after receiving lifesaving cardiopulmonary resuscitation from his wife.

To honor his contributions as an advocate, educator, and influential voice in medicine, Dr. Flanary received an Award for Early Career Achievement from The University of Iowa Roy J. and Lucille A. Carver College of Medicine in 2026. In 2020, he was named one of Portland's Top Medical Providers by *Portland Monthly* magazine.

He received his medical degree from the Geisel School of Medicine at Dartmouth, Hanover, NH, and completed his residency in ophthalmology at the Roy J. and Lucille A. Carver College of Medicine at The University of Iowa in Iowa City. During his residency, he was editor-in-chief of EyeRounds, an ophthalmology education resource developed at The University of Iowa. Prior to earning his MD, he was inducted into the Alpha Omega Alpha Honor Medical Society.

Heart and Kidney Research Leader to Speak on Predictors of Heart Disease in CKD

https://doi.org/10.62716/kn.004372026



Joachim H. Ix, MD, MAS, FASN

A nephrologist, epidemiologist, and clinical trial leader whose research has advanced the understanding of biomarkers and heart disease risk in chronic kidney disease (CKD) will deliver the Jack W. Coburn, MD, Endowed Lectureship on Thursday, October 22. Joachim H. Ix, MD, MAS, FASN, will speak on "Predictors of Cardiovascular Disease and Mortality in CKD."

Dr. Ix is a professor of medicine, chief of the Division of Nephrology-Hypertension, and vice chair for Clinical Affairs in the Department of Medicine at the University of California (UC) San Diego School of Medicine in La Jolla. He is the inaugural holder of the Darrell and Dorthy Ann Fanestil Family Chancellor's Endowed Chair in Nephrology-Hypertension. He holds a secondary appointment at the Herbert Wertheim School of Public Health and Human Longevity Science and is a staff physician at the VA San Diego Healthcare System.

Dr. Ix is recognized for advancing the understanding of biomarkers and disease modifiers that influence cardiovascular outcomes and kidney disease progression. He has spent his career developing innovative approaches to assessing kidney health beyond traditional measures of kidney function. One major focus of Dr. Ix's research is CKD–mineral and bone disorder, examining how abnormalities in phosphate, calcium, and related hormones contribute to vascular calcification, cardiovascular disease, and mortality. Through large epidemiologic studies and multicenter clinical trials, his work has defined these relationships and evaluated novel therapies that reduce intestinal phosphate absorption in people with CKD.

Dr. Ix also leads research on the development of noninvasive biomarkers of kidney tubule health. Because tubule injury and fibrosis are key drivers of CKD progression but are poorly captured by traditional measures, his team has evaluated blood and urine biomarkers that more accurately assess kidney tubule health. This work aims to improve prediction of kidney disease progression and cardiovascular outcomes while advancing more precise approaches to evaluating kidney diseases.

Beyond his research, Dr. Ix has held leadership roles with ASN, the National Institutes of Health (NIH), and Kidney Disease: Improving Global Outcomes (KDIGO). Dr. Ix is an associate editor of *JASN* and serves on the ASN Publications Committee and the KDIGO Executive Committee. He previously served on the editorial board of *Circulation* and has participated in multiple NIH study sections.

Dr. Ix has coauthored more than 500 peer-reviewed publications in leading medical journals, including in *The New England Journal of Medicine*, *JAMA*, and *Circulation*. His contributions have been recognized with numerous honors, including the National Kidney Foundation's Shaul G. Massry Distinguished Lecture Award, the American Heart Association's Sandra A. Daugherty Award for Excellence in Cardiovascular Disease or Hypertension Epidemiology, and election to The American Society for Clinical Investigation.

Dr. Ix received his bachelor's degree from UC San Diego and his medical degree from The University of Chicago Pritzker School of Medicine, IL. He completed an internship and residency in internal medicine, a clinical fellowship in nephrology, and a Master of Advanced Study in biostatistics and epidemiology at UC San Francisco.

Glomerular Disease Expert to Examine Changes in the Clinical Trials Landscape

https://doi.org/10.62716/kn.004392026



Brad Rovin, MD, FASN

Brad Rovin, MD, FASN, will deliver the Michelle P. Winn, MD, Endowed Lectureship on Thursday, October 22. He will speak on "How Has the Clinical Trial Landscape in Glomerular Diseases Changed in the Past 5 Years?"

Dr. Rovin is the Lee A. Hebert Professor of Nephrology at The Ohio State University (OSU) Wexner Medical Center in Columbus. He is also a professor of internal medicine and pathology at OSU College of Medicine, where he previously directed the Division of Nephrology and served as vice chair of research in the Department of Internal Medicine. He currently serves as medical director for OSU's Center for Clinical Research Management and is a principal investigator for the Dorothy M. Davis Heart and Lung Research Institute.

His research spans the development of biomarkers for noninvasive assessment of kidney pathology, the molecular mechanisms of renal inflammation, and the immunopathogenesis of glomerular and autoimmune diseases. A major focus of his work has been the identification of biomarkers associated with disease activity, progression, and treatment response, as well as the development of novel therapeutic approaches for lupus nephritis and other glomerular diseases.

Dr. Rovin has been a driving force in clinical trial infrastructure for glomerular disease research. He has served as principal investigator on multiple trials of novel therapeutics for glomerular diseases, spanning investigator-initiated and industry-sponsored work, with a particular focus on lupus nephritis. He is also a founding member of NephroNet, a grassroots nephrology clinical trial organization, and of the Lupus Nephritis Trials Network—both aimed at building the trial pipeline for glomerular disease, a historically understudied disease area.

Dr. Rovin chairs the Medical-Scientific Advisory Council of the Lupus Foundation of America and is cochair for the development of glomerular disease practice guidelines for Kidney Disease: Improving Global Outcomes (KDIGO). He has held several ASN leadership and committee roles, including on the Kidney Week Education Committee, and is a fellow of both ASN and the American College of Physicians. He is deputy editor of *Kidney International*, the flagship journal of the International Society of Nephrology.

In 2024, Dr. Rovin received the Evelyn V. Hess, MD, MACP, MACR, Award from the Lupus Foundation of America for advancing understanding of lupus nephritis. In 2026, he received the Donald W. Seldin Distinguished Award from the National Kidney Foundation in recognition of his contributions to clinical nephrology research.

Dr. Rovin earned his medical degree from the University of Illinois College of Medicine Chicago. He then completed a residency in internal medicine at Barnes-Jewish Hospital (formerly Barnes Hospital), followed by a clinical nephrology fellowship at Washington University School of Medicine, both in St. Louis, MO.



Nephrology Educator to Make the Case for Dialysis Access Curriculum Changes

https://doi.org/10.62716/kn.004332026



Matthew A. Sparks, MD, FASN

A national leader in medical education will deliver the Burton D. Rose, MD, Endowed Lectureship on Thursday, October 22. Matthew A. Sparks, MD, FASN, will present a talk titled "Formulating a Dialysis Access Curriculum: Bridging the Gap in Education and Training."

Dr. Sparks is an associate professor of medicine and program director of the Nephrology Fellowship at the Duke University School of Medicine in Durham, NC. He also founded and leads the Department of Medicine's Society for Early Education Scholars, a mentored education program for fellows starting careers as education scholars or clinical educators.

Dr. Sparks is a member of the steering committee for the ASN Transforming Dialysis Access Together initiative. Through his work on the committee, Dr. Sparks has helped identify gaps in how fellows are trained in dialysis access placement and management—work that led directly to his effort to formulate a dedicated curriculum addressing those gaps.

A nationally recognized innovator in medical education, Dr. Sparks leverages social media and online platforms to enhance nephrology training. He is a founding faculty member and former program director of the Nephrology Education Collective internship, established in 2015 to develop future leaders in nephrology education through training in social media and free open access medical education, a movement known as FOAMed. He colaunched NephMadness, an educational initiative that adapts the format of the US National Collegiate Athletic Association basketball tournament to explore key topics in nephrology. Dr. Sparks also serves on the board of directors of NephJC, an online nephrology journal club and nonprofit organization dedicated to expanding free open access nephrology education. He is a faculty lead for the Renal Fellow Network and an advisory board member for NephSIM, a mobile-friendly nephrology teaching tool.

He has served on numerous national committees for ASN, the American Heart Association, and the National Kidney Foundation and is a fellow of all three organizations. In addition to positions on the editorial boards of the *American Journal of Kidney Diseases*, *Advances in Kidney Disease and Health*, *JASN*, *CJASN*, *Kidney Medicine*, *Kidney360*, and *ASN Kidney News*, he is the communications editor for the ASN journals portfolio.

In 2022, he received the ASN Distinguished Educator Award for midcareer professionals. At the Duke University School of Medicine, he has also received the Excellence in Education Award from the Department of Medicine and the Excellence in Mentorship Award from the Division of Nephrology.

Dr. Sparks received his MD from the University of Arkansas for Medical Sciences in Little Rock, where he also completed a residency in internal medicine and served as chief resident. He then completed a clinical fellowship in nephrology at Duke University Medical Center.

Physician-Scientist to Discuss Metabolic Vulnerabilities in Diabetic Kidney Disease

https://doi.org/10.62716/kn.004312026



Anna Greka, MD, PhD

A physician-scientist at the forefront of translational kidney research will deliver the Barry M. Brenner, MD, Endowed Lectureship on Thursday, October 22. Anna Greka, MD, PhD, will present a talk titled "Targeting Metabolic Vulnerabilities in DKD [Diabetic Kidney Disease] and Therapeutic Strategies."

Dr. Greka is a core member of the Broad Institute of the Massachusetts Institute of Technology (MIT) and Harvard, Cambridge, where she serves on the executive leadership team as director of the Kidney Disease Initiative. She is also a professor at Harvard Medical School, a physician at Mass General Brigham, and an associate physician specializing in renal disease at Brigham and Women's Faulkner Hospital and Brigham and Women's Hospital, where she founded and directs the Center for Kidney Disease and Novel Experimental Therapeutics.

A primary focus of her research is defining the cellular and molecular mechanisms underlying kidney diseases, with a longstanding focus on podocyte biology and membrane proteins. Her lab uncovered how calcium signaling through the transient receptor potential canonical (TRPC)5 ion channel drives podocyte injury and identified a TRPC5 channel blocker as the first ion channel-targeted therapy for kidney diseases. Her research has also revealed common biological pathways that drive dysfunction across diverse cell types and organs, including the kidney, eye, and brain.

At the Broad Institute, Dr. Greka founded and leads the Ladders to Cures Scientific Accelerator, which aims to advance the development of cures and treatments for rare genetic diseases. The initiative searches for shared biological pathways across diseases that may provide new opportunities for therapeutic intervention. She is also founder of two biotechnology companies and serves on the boards and scientific advisory boards of several others.

Dr. Greka has served on several ASN committees and was previously an elected member of ASN's former Glomerular Diseases Advisory Group. From 2024 to 2025, she served as president of The American Society for Clinical Investigation (ASCI). She is an advisory board member at *Cell Chemical Biology* and an associate editor at *Science Advances*.

Her work has earned her numerous awards, including the Donald W. Seldin Young Investigator Award from ASN and the Donald Seldin–Holly Smith Award for Pioneering Research from ASCI. She has also received the Presidential Early Career Award for Scientists and Engineers, which the US federal government bestows upon outstanding early-career investigators. In 2021, she was selected for the National Academy of Medicine's Emerging Leaders in Health and Medicine Program.

Dr. Greka received her MD from the Harvard Medical School–MIT Program in Health Sciences and Technology and her PhD in neurobiology from Harvard Medical School. She then completed a residency in internal medicine at Massachusetts General Hospital, followed by a clinical fellowship in medicine at Harvard Medical School and a clinical nephrology fellowship at Mass General Brigham.

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PLENARY SESSION

STATE-OF-THE-ART LECTURE

Atmospheric Chemist to Speak on New Frontiers in Air Pollution Research

https://doi.org/10.62716/kn.004442026



Barbara J. Finlayson-Pitts, PhD

A renowned atmospheric chemist will deliver a state-of-the-art lecture during a plenary session on Friday, October 23. Barbara J. Finlayson-Pitts, PhD, will present "New Frontiers in Air Pollution and Public Health."

Dr. Finlayson-Pitts is a distinguished professor emerita and professor of chemistry, recalled at the University of California Irvine (UCI). She also founded and codirects Atmospheric Integrated Research at UCI, or AirUCI, a multidisciplinary research team focused on air pollution and climate change, including their effects on human health.

Dr. Finlayson-Pitts studies the chemical processes that shape atmospheric composition and influence air quality, visibility, and climate. Her research has advanced understanding of how airborne particles form and grow, how pollutants are transformed through chemical reactions in the atmosphere, and the environmental fate of emerging contaminants. Much of her work has centered on chemical reactions that occur on the surfaces of atmospheric particles, providing new insights into the interactions between gases and particles that influence atmospheric composition and air quality. A current focus of her research is the atmospheric fate of neonicotinoid pesticides, a widely used class of agricultural insecticides, and their effects on food security and agricultural sustainability.

She has authored or coauthored more than 200 scientific publications, as well as two books on atmospheric chemistry. In 2016, she was cochair of the National Academies of Sciences, Engineering, and Medicine Committee on the Future of Atmospheric Chemistry Research, which produced a comprehensive report outlining priorities and challenges for the field, titled *The Future of Atmospheric Chemistry Research: Remembering Yesterday, Understanding Today, Anticipating Tomorrow*.

Throughout her career, Dr. Finlayson-Pitts has earned numerous awards in recognition of her excellence in research and teaching. She was honored by the L'Oréal-UNESCO [United Nations Educational, Scientific and Cultural Organization] For Women in Science International Awards in 2025 and was named California Assembly District 74's Woman of the Year in 2021. She has also received the Polanyi Medal and the Environment Prize from the Royal Society of Chemistry, as well as the American Chemical Society Award for Creative Advances in Environmental Science and Technology, the American Chemical Society Francis P. Garvan-John M. Olin Medal, the California Air Resources Board Haagen-Smit Clean Air Award, and the UCI Academic Senate Distinguished Faculty Award for Research, among other honors. She is an elected fellow of the American Association for the Advancement of Science, the American Geophysical Union, the Royal Society of Chemistry, the American Academy of Arts & Sciences, and the National Academy of Sciences.

Dr. Finlayson-Pitts completed her PhD in chemistry at UC Riverside. Before joining UCI, she spent 20 years on the faculty at California State University, Fullerton.

Clinician-Scientist and Patient Advocate Adeera Levin to Receive John P. Peters Award

https://doi.org/10.62716/kn.004572026



Adeera Levin, MD

ASN will bestow the John P. Peters Award on Adeera Levin, MD, on Friday, October 23, in recognition of her extensive research, leadership, and advocacy efforts. This award is given for outstanding contributions to improving the lives of patients and furthering the understanding of kidneys in health and disease.

Dr. Levin is a professor of medicine and head of the Division of Nephrology at the Faculty of Medicine of The University of British Columbia in Vancouver, Canada. She is also a consultant nephrologist at Providence Health Care and executive director of BC Renal, a provincial health program that coordinates care for patients with kidney diseases across British Columbia.

Her research has helped define the role of nontraditional cardiovascular risk factors in chronic kidney disease (CKD) and identified factors linked to disease progression. She has also conducted extensive health systems research to improve models of kidney care and patient outcomes. As a principal investigator of the Can-SOLVE CKD Network, Canada's largest kidney research initiative, she leads patient-oriented research to improve kidney care across the nation. She has authored more than 1000 peer-reviewed publications, as well as numerous book chapters.

During her career, she has held multiple leadership roles in scientific societies, including with the International Society of Nephrology (ISN), where she served as secretary general from 2009 to 2011, president from 2015 to 2017, and chair of the ISN-Advancing Clinical Trials initiative from 2024 to 2026. She has advocated for patient rights and equitable care access at local, regional, and global levels, including as a founding member and early cochair of the Declaration of Istanbul Custodian Group, an international organization that promotes ethical practices in organ donation and transplantation.

Her contributions to the field have been recognized with numerous teaching and research awards. These include the ISN Jean Hamburger Award, which honors excellence in clinical nephrology research; the Faculty of Medicine Distinguished Achievement Award for Overall Excellence from The University of British Columbia; and an award for outstanding service to Canadian nephrology from the Canadian Society of Nephrology. In 2014, she became an elected fellow of the Canadian Academy of Health Sciences.

Dr. Levin received her medical degree from the Michael G. DeGroote School of Medicine at McMaster University in Hamilton, Ontario, Canada, where she also completed a residency in internal medicine and served as chief medical resident at Juravinski Hospital (formerly Henderson Hospital), also in Hamilton. Through the University of Toronto's Temerty Faculty of Medicine, she then completed a clinical fellowship in nephrology at Toronto Western Hospital and St. Michael's Hospital, Toronto, Ontario, followed by a clinical research fellowship in nephrology at St. Michael's Hospital.

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Homer W. Smith Award to Honor Matthias Kretzler

https://doi.org/10.62716/kn.004562026



Matthias Kretzler, MD

Precision nephrology pioneer Matthias Kretzler, MD, will be presented the Homer W. Smith Award on Friday, October 23. This award recognizes outstanding contributions to the understanding of kidney function in normal and diseased states.

Dr. Kretzler is the Warner-Lambert/Parke-Davis Professor of Internal Medicine/Nephrology and Computational Medicine and Bioinformatics at Michigan Medicine's Michigan Kidney Translational Medicine Center (MiKTMC) in Ann Arbor, where he is also a professor of internal medicine and a research professor of computational medicine and bioinformatics.

His research has helped pioneer precision medicine approaches by advancing the molecular understanding of kidney diseases. By combining systems biology, bioinformatics, molecular biology, and clinical research, he works to define disease-specific pathways and link them to clinical phenotypes, biomarkers, and therapeutic targets. This work has resulted in new disease predictors and contributed to a successful phase 2 clinical trial of a novel therapeutic approach for diabetic kidney disease.

Dr. Kretzler leads or coleads several landmark collaborative research initiatives, including the central hub of the Kidney Precision Medicine Project, the Kidney Mapping Atlas Project, the Nephrotic Syndrome Study Network (NEPTUNE), the Renal Pre-Competitive Consortium (RPC^2), and the Proteinuria and GFR [glomerular filtration rate] as Clinical Trial Endpoints in Focal Segmental Glomerulosclerosis (PARASOL) Project. He is also a principal investigator of the Breakthrough T1D Cardiorenal Center of Excellence, a joint initiative of the University of Michigan and Oregon Health & Science University.

Through these and other collaborations, Dr. Kretzler has helped establish international research networks for precision nephrology, bringing together clinicians, biologists, bioinformaticians, and data scientists to accelerate the translation of molecular discoveries into clinical research and patient care. His work has resulted in more than 400 scientific publications.

Throughout his career, he has also demonstrated a strong commitment to teaching, mentorship, and professional service. He has chaired, cochaired, and served on numerous committees for ASN, the International Society of Nephrology, and other organizations and sits on the editorial boards of *JASN*, *Clinical and Experimental Nephrology*, and *Kidney International*.

His efforts have earned him multiple honors, including the Barry M. Brenner, MD, Endowed Lectureship from ASN; the Ulrich Hopfer Lectureship from Case Western Reserve University; and the Medical Professional of the Year Award from NephCure. He is an inducted member of the Association of American Physicians, a Distinguished Fellow of the European Renal Association, and an elected member of The American Society for Clinical Investigation.

Dr. Kretzler received his medical degree from Heidelberg University in Germany, followed by a research fellowship at the University of Michigan. He later completed a residency in internal medicine and a clinical nephrology fellowship at the University of Munich in Germany.

Young Investigator Recognized for Work on Hypertension in Kidney Diseases to Speak on the Future of Blood Pressure Management

https://doi.org/10.62716/kn.004582026



Jordana B. Cohen, MD, MS, FASN

Jordana B. Cohen, MD, MS, FASN, will receive the ASN-AHA [American Heart Association] Donald W. Seldin Young Investigator Award on Friday, October 23. She will speak on "The Future of Blood Pressure Management: Precision Care in a Data-Rich World."

Dr. Cohen is an associate professor in the Renal-Electrolyte and Hypertension Division of the Department of Medicine at the Perelman School of Medicine at the University of Pennsylvania, Philadelphia. She is also an associate professor and deputy director of epidemiology in the Department of Biostatistics, Epidemiology & Informatics and a senior scholar in the Center for Clinical Epidemiology and Biostatistics. In addition, she is an affiliated faculty member in the Center for Health Incentives and Behavioral Economics at the University of Pennsylvania and a clinical researcher at the Corporal Michael J. Crescenz Department of Veterans Affairs Medical Center.

Her research focuses on physiology-driven antihypertensive medication effects in individuals with chronic kidney disease and other complex, high-risk conditions. Through clinical trials, target trial emulations, and observational studies, she generates evidence to guide hypertension management and improve long-term cardiovascular and kidney outcomes.

Dr. Cohen is an ASN fellow and chairs the Kidney Health Guidance Oversight Committee. She also holds leadership roles within the American Medical Association and AHA and served on the guideline writing committee for the 2025 Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults, a report from the American College of Cardiology and AHA.

In 2026, she received the John H. Laragh Research Award (clinical science) from the *American Journal of Hypertension*. She has also earned numerous awards from the University of Pennsylvania, including the Marjorie A. Bowman New Investigator Research Award from the Perelman School of Medicine, the Sandy Norman Teaching Award from the Center for Clinical Epidemiology and Biostatistics, and the Chair's Distinguished Junior Faculty Spotlight Award from the Department of Biostatistics, Epidemiology & Informatics.

After receiving her medical degree from Rutgers New Jersey Medical School, Newark, she completed an internal medicine residency at Boston Medical Center, MA. She then completed a clinical fellowship in nephrology and a research fellowship in clinical epidemiology, both at the Perelman School of Medicine at the University of Pennsylvania, where she also earned a master's degree in clinical epidemiology.



Kidney Disease Advocate to Speak on the Power of Patient Voices in Kidney Care

https://doi.org/10.62716/kn.004362026



Thelma Barber

A passionate advocate for people living with kidney diseases will deliver the Celeste Castillo Lee Endowed Lectureship on Friday, October 23. Thelma Barber will present a talk titled "Patient Voices: Living Through DGF [Delayed Graft Function]," sharing how her personal journey has shaped her commitment to advancing patient-centered kidney care and advocacy.

Ms. Barber is a two-time kidney transplant recipient living with chronic kidney disease (CKD), type 2 diabetes, high blood pressure, and high cholesterol. She first experienced symptoms of kidney diseases at age 12, but it took nearly a decade before she received a diagnosis of immunoglobulin A nephropathy with nephrotic syndrome in 1993 and CKD in 1998. Having managed these conditions for more than 30 years, she has transformed her lived experience into a platform to educate and improve care for others.

Today, Ms. Barber advocates for all people living with kidney diseases, with a particular focus on racial and ethnic minority communities and individuals from limited-income backgrounds. Through the National Kidney Foundation's Voices for Kidney Health program, she works to advance policies that promote equitable access to quality health care, kidney transplantation, and patient education. She also emphasizes the importance of early detection, having a care partner, and managing cardiovascular-kidney-metabolic conditions in partnership with health care professionals.

Drawing on her own experiences navigating kidney disease, Ms. Barber encourages people living with chronic and rare diseases to take an active role in their care. She believes that meaningful partnerships between patients and physicians are essential to improving outcomes and empowering individuals to express their concerns, ask questions, and make informed decisions throughout their care journey.

In addition to her patient-facing efforts, Ms. Barber has helped develop educational modules on CKD and diabetic kidney disease. As vice chair of the Kidney Health Initiative Patient and Family Partnership Council, she works alongside patients, clinicians, researchers, and other stakeholders to advance innovation and strengthen patient-centered care.

Through her advocacy, educational initiatives, and leadership, Ms. Barber continues to ensure that the voices and experiences of people living with kidney diseases help inform clinical care, education, and advocacy efforts. Her work reflects a steadfast commitment to improving kidney health and expanding opportunities for all people affected by kidney diseases.

Dialysis Research Leader to Present Advances in Patient-Centered Volume Management

https://doi.org/10.62716/kn.004422026



Jennifer E. Flythe, MD, MPH, FASN

Jennifer E. Flythe, MD, MPH, FASN, will deliver the Garabed Eknoyan, MD, Endowed Lectureship on Friday, October 23. Her lecture, "Can We Do Better With Volume Management for Patients Treated With Dialysis?" will explore strategies to improve dialysis care through evidence-based approaches to fluid management.

Dr. Flythe is a professor of medicine and chief of the Division of Nephrology and Hypertension at The University of North Carolina (UNC) at Chapel Hill School of Medicine. She also serves as director of UNC Outpatient Dialysis Services and associate director of the UNC Kidney Center. In these roles, she combines clinical care with an active research program focused on improving care for people receiving dialysis.

Dr. Flythe is recognized internationally for advancing patient-centered clinical research that seeks to improve both the outcomes and experiences of people living with advanced kidney disease.

Her research focuses on identifying modifiable factors that influence survival, cardiovascular health, and quality of life among people receiving maintenance hemodialysis. Much of her work has examined dialysis hemodynamics, fluid management, blood pressure patterns, and other treatment-related factors that affect patient outcomes. She has also helped advance patient-centered research by integrating patient-reported outcomes into nephrology studies and clinical trials, ensuring that the experiences, symptoms, and priorities of people living with kidney diseases help shape research questions and treatment strategies.

A major contribution of Dr. Flythe's work has been advancing the development and implementation of electronic patient-reported outcome measures in nephrology. Her research has demonstrated how these tools can more effectively capture symptoms and quality of life, strengthen communication between patients and clinicians, and support shared decision-making. She has also emphasized the importance of engaging patients throughout the research process, from selecting study outcomes to interpreting findings and translating evidence into clinical practice.

Dr. Flythe continues to lead large multicenter clinical studies designed to improve care for people with advanced chronic kidney disease (CKD). In 2026, she became a coprincipal investigator of the Helping Optimize Pharmacologic Effectiveness in Advanced CKD Trial, a nationwide clinical trial evaluating therapies to slow advanced kidney disease progression while promoting equitable access to effective treatments.

Beyond her research, Dr. Flythe is an active leader in the nephrology community. She serves as an associate editor for the Patient-Centered Outcomes Research Institute's research reports and previously served as an associate editor for *Kidney360*. She also serves on numerous committees and advisory groups for ASN, the National Kidney Foundation (NKF), Kidney Disease: Improving Global Outcomes (KDIGO), the Kidney Health Initiative, and the National Institutes of Health. Her contributions have been recognized with NKF's Shaul G. Massry Distinguished Lecture Award and Editors' Choice Awards from both *JASN* and the *American Journal of Kidney Diseases*. She has authored more than 100 original research articles, along with editorials and review articles.

Dr. Flythe received her medical degree from the UNC School of Medicine. She completed a residency in internal medicine at Oregon Health & Science University, Portland, followed by a clinical nephrology fellowship at Mass General Brigham, Boston. She also earned a Master of Public Health from the Harvard T.H. Chan School of Public Health, Boston, MA.

Kidney Transplant Leader to Address Long-Term Survival Challenges and Opportunities

https://doi.org/10.62716/kn.004342026



Sundaram Hariharan, MD

A recognized leader in kidney transplantation will deliver the Barbara T. Murphy, MB BAO BCh, Endowed Lectureship on Friday, October 23. Sundaram Hariharan, MD, will speak on "Improving Long-Term Kidney Transplant Survival: Opportunities and Challenges."

Dr. Hariharan is an independent transplant consultant and an emeritus professor of medicine at the Thomas E. Starzl Transplantation Institute at the University of Pittsburgh School of Medicine, PA. Through his consulting work, he advises on the design and development of clinical kidney transplantation trials.

Over the past 4 decades, Dr. Hariharan's research has focused on the central challenges to long-term kidney transplant survival—rejection, infection, and recurrence—and on the strategies to overcome them. His expertise lies in immunosuppressive therapies, T cell-mediated rejection and antibody-mediated rejection, post-transplant viral infections, and recurrent glomerular diseases.

During his tenure at the University of Pittsburgh School of Medicine, he held appointments in the Renal-Electrolyte Division in the Department of Medicine and in the Division of Transplantation Surgery in the Department of Surgery. He also served as medical director of the Kidney and Pancreas Transplant Program at the University of Pittsburgh Medical Center. He later held the position of medical officer in the Division of Rheumatology and Transplant Medicine, Office of Immunology and Inflammation, within the Center for Drug Evaluation and Research at the US Food and Drug Administration.

He has published more than 200 peer-reviewed articles on clinical outcomes following kidney transplantation, including recurrent and de novo diseases, BK virus infection, subclinical T cell-mediated rejection, and surrogate markers of transplant outcomes. Dr. Hariharan has cared for patients receiving kidney transplants and trained numerous transplant nephrologists. He also edited a 2024 reference book on kidney transplantation, *Long-Term Care of Kidney Transplant Patients*, published by Oxford University Press.

He received his medical degree from the University of Mumbai (formerly University of Bombay) in India, followed by a residency in internal medicine at Lokmanya Tilak Municipal Medical College and Lokmanya Tilak Municipal General Hospital, also in India. He completed specialty training in nephrology at Jaslok Hospital & Research Centre and Christian Medical College Vellore, both in India. Dr. Hariharan then completed a clinical fellowship in nephrology at the University of Cincinnati Medical Center, OH.

STAND for Kidney Health advocacy campaign mobilizes nephrologists, kidney health professionals, researchers, patients, and advocates to drive progress on key priorities for advancing kidney health.

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Since its launch, STAND has mobilized nephrologists, kidney health professionals, researchers, patients, and advocates to drive progress on key kidney health priorities:

- **Start earlier** to prevent, diagnose, and treat kidney diseases
- **Transform transplant** to expand access to the optimal therapy
- **Accelerate innovation** to increase treatment options
- **Nurture a workforce** to meet patient needs
- **Drive efficiency** to deliver value

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PLENARY SESSION

STATE-OF-THE-ART LECTURE

RNA Biology Pioneer to Speak on the Discovery of Gene Silencing

https://doi.org/10.62716/kn.004302026



Craig C. Mello, PhD

Craig C. Mello, PhD, a Nobel laureate and pioneer in RNA biology, will deliver a state-of-the-art lecture at a plenary session on Saturday, October 24. His talk is titled "RNAi: A Molecular Spark in an Information Inferno."

Dr. Mello is a distinguished professor in the RNA Therapeutics Institute and the Program in Molecular Medicine at the University of Massachusetts Chan Medical School in Worcester, where he also holds the Blais University Chair in Molecular Medicine. From 2000 to 2024, he was a Howard Hughes Medical Institute Investigator.

He is best known for his pioneering work on RNA interference (RNAi), a biological process that cells use to selectively silence genes, which he discovered with biologist Andrew Fire, PhD. This work earned them the 2006 Nobel Prize in Physiology or Medicine, transformed the scientific understanding of gene regulation, and laid the groundwork for new approaches to studying and manipulating gene activity.

RNAi works by hijacking a natural cellular defense system to shut genes off before they can be translated into protein. An enzyme called Dicer chops double-stranded RNA into short fragments, which are then loaded into a protein complex containing Argonaute proteins. That complex uses the RNA fragment as a guide to find and destroy matching messenger RNA, silencing the corresponding gene. Because the process is sequence-specific, it can silence virtually any gene simply by supplying RNA that matches it.

Beyond its use as a fundamental research tool, RNAi has become the basis of a new class of approved drugs. Since 2018, the US Food and Drug Administration has approved several RNAi-based therapeutics with many more in clinical development.

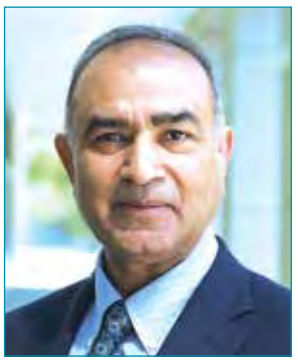
Building on this discovery, Dr. Mello now studies how small RNAs and Argonaute proteins regulate gene expression and maintain genome integrity in the nematode worm *Caenorhabditis elegans*. His team investigates how reproductive cells protect the genome from potentially harmful sequences by identifying and silencing foreign genetic material. He has also uncovered mechanisms that allow small RNA-mediated gene-silencing information to be passed from parents to offspring, influencing gene expression across generations without altering the underlying DNA sequence.

In addition to the Nobel Prize, Dr. Mello's contributions have been recognized with numerous honors and awards throughout his career. These include the National Academy of Sciences Award in Molecular Biology, The Wiley Prize in Biomedical Sciences, the Lewis S. Rosenstiel Award for Distinguished Work in Basic Medical Research, the American Academy of Achievement Golden Plate Award, and others. Dr. Mello received honorary doctorates from Brown University and Simmons University and was the inaugural recipient of Johnson & Johnson's Dr. Paul Janssen Award for Biomedical Research in 2006. He is an elected member of the National Academy of Sciences and the American Academy of Arts & Sciences.

Dr. Mello completed his PhD in biology from Harvard University, Cambridge, MA, and conducted postdoctoral research at Fred Hutch Cancer Center in Seattle, WA.

Robert G. Narins Award to Honor Ravindra L. Mehta

https://doi.org/10.62716/kn.004592026



Ravindra L. Mehta, MBBS, MD, DM, FASN

ASN will present the Robert G. Narins Award to Ravindra L. Mehta, MBBS, MD, DM, FASN, on Saturday, October 24, for his career-long contributions to the field of nephrology.

Dr. Mehta is a professor emeritus in the Division of Nephrology, Department of Medicine, and director of the Master's in Clinical Research program at the University of California San Diego School of Medicine, where he has served on the faculty since 1988.

Dr. Mehta is internationally recognized for his contributions to critical care nephrology and acute kidney injury (AKI) research. His work has advanced the understanding, classification, and management of AKI, particularly in the areas of continuous kidney replacement therapy, fluid management, and biomarker development. These discoveries have informed the development of the Kidney Disease: Improving Global Outcomes (KDIGO) Clinical Practice Guideline for Acute Kidney Injury and Acute Kidney Disease and helped establish many of the concepts that underpin modern AKI care. Throughout his career, he has authored more than 300 scientific publications and more than 50 book chapters.

He has provided longstanding leadership in the field of nephrology, spearheading several major international collaborations, including the Oby25 Initiative from the International Society of Nephrology (ISN), which seeks to eliminate preventable deaths from AKI worldwide. He is a founding member of the Acute Disease Quality Initiative and the Acute Kidney Injury Network, organizations that have helped shape AKI research and practice. He also chairs the annual International Conference on Advances in Critical Care Nephrology (AKI & CRRT [Continuous Renal Replacement Therapy]), which will hold its 32nd meeting in 2027.

His leadership also extends to professional service, including numerous advisory boards; task forces; and committees at local, national, and international levels. For ASN, he has served on the Dialysis Advisory Group and the Postgraduate Education Committee, among other committees. For ISN, he chaired the Acute Kidney Injury Committee from 2003 to 2014 and was a councilor from 2015 to 2019.

In honor of his impact in the field, Dr. Mehta has received a number of awards. These include the 2024 Zbylut J. Twardowski Lifetime Achievement Award in Hemodialysis from the Annual Dialysis Conference and the 2011 ISN Bywaters Award. In 2020, ISN established an AKI training fellowship in his name. He is a fellow of ASN, ISN, the American College of Physicians, and the Royal College of Physicians.

In India, he received his medical degree from Guru Nanak Dev University and then completed postgraduate training in internal medicine and nephrology at the Postgraduate Institute of Medical Education and Research.

Leading Biostatistician to Receive Belding H. Scribner Award

https://doi.org/10.62716/kn.004692026



Tom Greene, PhD

ASN will present the Belding H. Scribner Award on Saturday, October 24, to Tom Greene, PhD, to honor his extensive contributions to the field of nephrology.

Dr. Greene is a professor at the University of Utah Spencer Fox Eccles School of Medicine, Salt Lake City, in both the Division of Biostatistics, Department of Population Health Sciences, and the Division of Epidemiology, Department of Internal Medicine. He also codirects the Translational Research: Implementation, Analysis, & Design team at the Utah Clinical & Translational Science Institute and holds an H.A. and Edna Benning Presidential Endowed Chair.

After beginning his career as an assistant professor at the University of Kentucky and later at Case Western Reserve University, Dr. Greene held the role of biostatistician at the Cleveland Clinic from 1991 through 2006. During his tenure there, he served as the lead statistician on numerous multicenter clinical trials in nephrology, including the Modification of Diet in Renal Disease Study, the Hemodialysis (HEMO) Study, the African American Study of Kidney Disease and Hypertension, the Frequent Hemodialysis Network, and the Dialysis Access Consortium.

In 2006, he joined the University of Utah Eccles School of Medicine, where he founded the Study Design & Biostatistics Center and the Translational Research: Implementation, Analysis, & Design team. He has continued contributing to nephrology research, with a particular focus on glomerular filtration rate estimation, surrogate endpoint validation for clinical trials, and clinical trial design.

Beyond his research efforts, Dr. Greene has also served on data safety and monitoring boards and external advisory committees for several major clinical trials. These include the Correction of Hemoglobin and Outcomes in Renal Insufficiency (CHOIR) trial, the Therapeutic Evaluation of Steroids in IgA [Immunoglobulin A] Nephropathy Global (TESTING) study, and HALT [Hypertension and Lipid Trial] Progression of Polycystic Kidney Disease (HALT PKD), among others. His professional service has also included advisory committees for the National Institutes of Health and the Scientific Registry of Transplant Recipients.

He served on the editorial board of *JASN* from 2000 to 2005 and received the Shaul G. Massry Distinguished Award from the National Kidney Foundation in 2008.

Dr. Greene completed his PhD in statistics at Cornell University, Ithaca, NY, with minors in mathematics and operations research.

ASN to Bestow Barbara T. Murphy Award on Sharon M. Moe

https://doi.org/10.62716/kn.004682026



Sharon M. Moe, MD, FASN

The Barbara T. Murphy Award will be tendered on Saturday, October 24, to Sharon M. Moe, MD, FASN. This award is named for the nephrology leader and late ASN president-elect. It honors leaders who strengthen the foundation of nephrology while advancing the field through innovation, creativity, inspiration, and tenacity.

Dr. Moe is the associate dean for clinical and translational research and codirector of the Indiana Clinical Translational Sciences Institute at the Indiana University School of Medicine in Indianapolis. She also directs the Division of Nephrology and Hypertension and is the Stuart A. Kleit Professor of Medicine, as well as a professor of anatomy and cell biology. In 2019, she was named a Distinguished Professor by Indiana University, where she has been a faculty member for more than 30 years.

A central focus of her research is chronic kidney disease–mineral and bone disorder (CKD-MBD), particularly the mechanisms linking kidney diseases, vascular calcification, bone disease, and disorders of mineral metabolism. Her laboratory combines basic and clinical research to investigate the pathophysiology of CKD-MBD and inform new diagnostic and therapeutic approaches. Throughout her career, she has authored more than 200 scientific manuscripts and more than 25 textbook chapters.

Dr. Moe served on the ASN Council from 2008 to 2015 and as ASN president from 2013 to 2014. She has also been a councilor for the International Society of Nephrology and Women in Nephrology. Her expertise has shaped several clinical practice guidelines, including the National Kidney Foundation's Kidney Disease Outcomes Quality Initiative (KDOQI) Clinical Practice Guidelines for Bone Metabolism and Disease in Chronic Kidney Disease and the Kidney Disease: Improving Global Outcomes (KDIGO) Guideline for the Diagnosis, Evaluation, Prevention, and Treatment of CKD-MBD. She also serves on the editorial boards of *JASN* and the *Journal of Renal Nutrition*.

Her contributions have earned her numerous honors, including the 2009 Garabed Eknoyan Award from the National Kidney Foundation for exceptional contributions to the organization's key initiatives. She is a fellow of ASN, the American Heart Association, and the American College of Physicians, as well as an elected member of The American Society for Clinical Investigation.

Dr. Moe received her medical degree from the University of Illinois College of Medicine Chicago and completed her residency in internal medicine at Loyola University Medical Center. She then completed both clinical and research fellowships in nephrology at The University of Chicago Pritzker School of Medicine.

Aliza Thompson to Receive Inaugural Joint Award From ASN and the National Kidney Foundation

https://doi.org/10.62716/kn.004902026



Aliza Thompson, MD, MS

ASN and the National Kidney Foundation (NKF) will present an inaugural special recognition award to Aliza Thompson, MD, MS, during a plenary session on Saturday, October 24.

The joint award bridges ASN's focus on physician- and scientist-led research and education with NKF's emphasis on patient-centric advocacy and public health. It will honor individuals whose public service has advanced kidney health through exceptional leadership in shaping public policy, expanding research funding, or raising public awareness. The award will be presented biennially, either during ASN Kidney Week or the NKF Spring Clinical Meetings.

The first awardee, Dr. Thompson, directs the Division of Cardiology and Nephrology (DCN) within the Center for Drug Evaluation and Research at the US Food and Drug Administration (FDA). She has been with FDA since 2007. DCN is responsible for regulating and reviewing marketing and Investigational New Drug applications for the treatment of cardiovascular and kidney diseases, including chronic kidney disease, acute kidney injury, and glomerular diseases. DCN also oversees solutions used in peritoneal dialysis and continuous kidney replacement therapy, along with products used to treat hyperphosphatemia in people with chronic kidney disease and hyperkalemia.

Before leading DCN, Dr. Thompson served as a clinical team leader focused on the development of treatments for kidney diseases. Her work addressed a longstanding challenge in kidney drug development: Many kidney diseases progress slowly, making it difficult to determine within a conventional clinical trial whether a treatment will prevent kidney failure. She contributed to efforts to establish earlier measures of treatment benefit, including changes in proteinuria, albuminuria, and estimated glomerular filtration rate. These measures can help researchers assess whether investigational therapies are likely to preserve kidney function.

In 2021, she received the NKF Public Service Award in recognition of her contributions to advancing treatment for kidney diseases, including her efforts to center patient voices in the drug development process. She has also received the 2025 Medical Professional of the Year Award from NephCure for work toward improving treatment for rare kidney diseases. In 2026, the Glomerular Disease Study & Trial Consortium established the Aliza Thompson Endowed Lectureship in honor of her leadership in regulatory science and advancing new therapies for kidney diseases.

Dr. Thompson earned her medical degree from the Johns Hopkins School of Medicine in Baltimore, MD. She then completed a residency in internal medicine, followed by a research and a clinical fellowship in nephrology at NewYork-Presbyterian Hospital. She also holds a master's degree from Columbia University Mailman School of Public Health, both in New York, NY.

PLENARY SESSION

ASN Announces Midcareer Award Winners

ASN's Midcareer Awards recognize individuals who have made substantial and significant contributions in a variety of areas early in their professional lives.

Presented on Saturday, October 24, these awards recognize up to three winners in each of five categories: clinical service, education, leadership, mentorship, and research.

Distinguished Clinical Service Award

https://doi.org/10.62716/kn.004602026



Arwa Nada, MD, MS, MSc

Dr. Nada is an associate professor of pediatrics and head of the Division of Pediatric Nephrology at Loma Linda University School of Medicine, CA. She also serves as medical director of the Pediatric Dialysis, Acute Care Nephrology, and Neonatal Nephrology and Antenatal Counseling programs at Loma Linda University Children's Hospital. Her clinical leadership has focused on expanding specialized kidney care for children and neonates.

At Le Bonheur Children's Hospital in Memphis, TN, Dr. Nada introduced one of the first Aquadex neonatal dialysis programs in the United States and established one of the earliest dedicated neonatal nephrology follow-up clinics in the country. Her research focuses on neonatal and pediatric acute kidney injury (AKI), including developing systems to improve AKI early recognition and management using electronic medical record alerts, a neonatal AKI prediction model, and a follow-up calculator.

She is principal investigator of the Neonatal and Infant Kidney Support Therapy international registry and was among the first to identify hemoglobin and albumin as modifiable risk factors for neonatal AKI. She has developed artificial intelligence–based tools to support risk stratification for neonates vulnerable to chronic kidney disease.

Dr. Nada has held numerous leadership roles with the American Society of Pediatric Nephrology, including chair of its Quality Improvement and Artificial Intelligence Special Interest Group and its Workforce Committee. She also leads its Pediatric Nephrology National Fellow Lectures Series. Her contributions have been recognized with an AIMed [Artificial Intelligence in Medicine] Rising Star Award in 2024 and the Neonatal Kidney Collaborative Advocacy Committee Service Award in 2025.

Dr. Nada received her medical degree and master's degree from the Faculty of Medicine at Alexandria University in Egypt. She completed pediatric residency training at Alexandria University Children's Hospital, Egypt, as well as at Nassau University Medical Center, Long Island, NY, before completing a clinical fellowship in pediatric nephrology at Nationwide Children's Hospital, Columbus, OH.

Distinguished Educator Award

https://doi.org/10.62716/kn.004622026



Suzanne M. Boyle, MD, MS, FASN

Dr. Boyle is a professor of medicine and nephrology and director of the nephrology fellowship program at the Lewis Katz School of Medicine, Temple University. She is also a staff physician at Temple University Hospital, DaVita Buttonwood Dialysis, and Fresenius Kidney Care Episcopal Dialysis Center, all in Philadelphia, PA.

A leader in nephrology education, Dr. Boyle has published and presented extensively on issues affecting trainee education and the nephrology workforce, including educational debt, subspecialty workforce trends, and family planning policies in fellowship programs. She has also developed and validated a formative assessment tool for clinical reasoning in nephrology fellows and studied the intersection of clinical reasoning and artificial intelligence in medical education.

For ASN, she has served on the Workforce and Training Committee and chaired the Data Subcommittee. In the latter role, she guided and analyzed the annual ASN Nephrology Fellows Survey, which provides insights into nephrology training and employment trends among new nephrologists. In 2021, she received a William and Sandra Bennett Clinical Scholars Grant from KidneyCure, ASN's grant-making foundation. Dr. Boyle is the nephrology representative on the writing committee for the American College of Physicians Internal Medicine In-Training Examination and a fellow of the American College of Physicians.

Dr. Boyle received her medical degree from the Robert Wood Johnson Medical School at the University of Medicine and Dentistry of New Jersey. She then completed a residency in internal medicine at Temple University Hospital, as well as clinical and research fellowships in nephrology at the Hospital of the University of Pennsylvania. She also earned a master's degree in clinical epidemiology from the Perelman School of Medicine at the University of Pennsylvania.

Distinguished Educator Award

https://doi.org/10.62716/kn.004632026



Sana Waheed, MD, FASN

Dr. Waheed is an associate professor in the Division of Renal Medicine at the Emory University School of Medicine, Atlanta, GA, where she is also associate program director of the Nephrology Fellowship Program. In addition, she is associate section chief for renal medicine at Grady Memorial Hospital.

A major focus of her work is advancing nephrology education through curriculum development and learner assessment. Prior to joining Emory University, she was medical director of the renal course at the University of Wisconsin (UW) School of Medicine and Public Health in Madison, where she cultivated interest in nephrology among medical students.

At UW, she received the Dean's Teaching Award in 2019, the Department of Medicine Schilling-Harkness Teaching Award in 2017, and the Excellence in Teaching Award from the Division of Nephrology in 2015 and 2017.

For ASN, she has contributed to the In-Training Examination and Kidney Self-Assessment Program; chaired the Quality, Assessment, Improvement, and Education Steering Committee from 2022 to 2024; and served on the Workforce and Training Committee from 2015 to 2021. She currently chairs the Quality, Assessment, Improvement, and Education Steering Committee of the ASN Nephrologists Transforming Dialysis Safety initiative. She also serves on the Review Committee for the National Kidney Foundation Continuing Medical Education Program.

In addition to her work in nephrology education, Dr. Waheed has made important contributions to research on kidney diseases in patients with HIV and those undergoing peritoneal dialysis. As chair of the American Board of Internal Medicine's Nephrology Board, she has helped modernize nephrology procedural requirements to reflect current clinical practice.

Dr. Waheed earned her medical degree from the Aga Khan University in Pakistan and completed a residency in internal medicine at the University of Cincinnati Medical Center, OH. She then completed a nephrology fellowship at The Johns Hopkins Hospital, affiliated with the Johns Hopkins School of Medicine, Baltimore, MD.

Distinguished Leader Award

https://doi.org/10.62716/kn.004652026



Tara I. Chang, MD, MS, FASN

Dr. Chang is a professor of medicine and chief of the Division of Nephrology and holds an endowed chair at Stanford University School of Medicine, CA. She is also a member of the Stanford Cardiovascular Institute. A physician-scientist and hypertension specialist, she has demonstrated leadership across clinical care, research, education, and professional service.

Dr. Chang's research focuses on hypertension, chronic kidney disease, and cardiovascular outcomes. Her research has helped define effective treatments for people with kidney diseases and has informed clinical practice guidelines and scientific statements on blood pressure management and cardiovascular disease in chronic kidney disease.

Dr. Chang has made significant contributions to ASN through service on the Nominating Committee and Kidney Week Education Committee, as well as through her work as a Kidney Week abstract reviewer, category chair, and Kidney Students and Residents (STARS) program mentor. She has also held leadership roles with Kidney Disease: Improving Global Outcomes (KDIGO), the National Kidney Foundation, and the American Heart Association. Her commitment to building a more inclusive nephrology community is reflected in her role as a founding member of the Coalition of Asian Americans Transforming Opportunities in Nephrology (CATION+).

Dr. Chang is deputy editor of the *American Journal of Kidney Diseases* and serves on the editorial boards of *Kidney360*, the *Journal of Human Hypertension*, and the *American Heart Journal*. Her honors include The American Society for Clinical Investigation Young Physician-Scientist Award and a Stanford University McCormick Faculty Award, which supports the advancement of women in medicine and medical research.

Dr. Chang received her medical degree from the University of Michigan Medical School, Ann Arbor, and a master's degree in epidemiology from Stanford Medicine. She completed her internal medicine residency at the University of California San Francisco and her clinical and research fellowships in nephrology at Stanford Medicine. She subsequently completed a research fellowship at the Stanford-Kaiser Cardiovascular Outcomes Research Center.

Distinguished Leader Award

https://doi.org/10.62716/kn.004662026



Timmy C. Lee, MD, MPH, FASN

Dr. Lee is a professor of medicine and director of the Division of Nephrology at The University of Alabama at Birmingham (UAB) Marnix E. Heersink School of Medicine. He also holds the Marie S. Ingalls Endowed Chair in Nephrology Leadership, serves as the vice chair for research in the Department of Medicine, and holds a secondary appointment in the Department of Biomedical Engineering. In addition, he is a staff nephrologist at the Birmingham VA Medical Center.

Dr. Lee's research focuses on improving outcomes for patients requiring vascular access for hemodialysis. He leads a translational research program investigating the mechanisms of arteriovenous fistula maturation and failure, developing novel therapies to improve vascular access outcomes, and advancing a patient-centered approach to dialysis vascular access.

He has helped shape national guidelines on vascular access, including as part of the work group behind the 2019 update to the National Kidney Foundation's Kidney Disease Outcomes Quality Initiative (KDOQI) Clinical Practice Guideline for Vascular Access. From 2015 to 2018, he was a councilor of the American Society of Diagnostic and Interventional Nephrology. For ASN, he has served on the Kidney Week Education Committee and the Workforce and Training Committee and as a leadership mentor for the Fostering Innovative Leaders in Nephrology and Dialysis program. He is currently a deputy editor of *Kidney360*.

His work has been recognized with multiple awards, including the Gerald Beathard Award from the American Society of Diagnostic and Interventional Nephrology and the UAB Richard B. Marchase, PhD, Interdisciplinary Research Award, which honors a UAB investigator who promotes or leads interdisciplinary collaboration across campus.

Dr. Lee received his medical degree from Louisiana State University Health Shreveport. At UAB, he then completed an internal medicine residency and a nephrology fellowship, which included both clinical and research training, as well as a master's degree in public health.

Distinguished Leader Award

https://doi.org/10.62716/kn.004612026



Leonardo V. Riella, MD, PhD, FASN

Dr. Riella is the Harold and Ellen Danser Endowed Chair in Transplantation and an associate professor of medicine and surgery at Harvard Medical School. He is also medical director of kidney transplantation at Massachusetts General Hospital, Boston, MA.

Dr. Riella's work focuses on immune regulation, xenotransplantation, and transplant tolerance. In 2024, he led the first successful transplantation of a gene-edited pig kidney into a living human, paving the way for clinical trials. He now leads the first US Food and Drug Administration–approved clinical kidney xenotransplantation study and directs research focused on understanding the xeno-immune response and developing improved immunosuppressive strategies.

His leadership has helped advance transplantation science at institutional and global levels. He founded and leads the Post-Transplant Glomerular Diseases (TANGO) Consortium, a large, international collaboration studying the recurrence of glomerular diseases following kidney transplantation. He is also cofounder and director of the Legorreta Center for Clinical Transplant Tolerance, which aims to prevent lifelong immunosuppressive therapy for recipients after transplant, and a senior investigator at the Center for Transplantation Sciences.

Dr. Riella currently serves on the editorial board for the Kidney Self-Assessment Program and as an associate editor for the *American Journal of Transplantation*. He was the 2023 NephCure Medical Honoree and has received multiple awards, including the 2024 Basic Science Investigator Award from the American Society of Transplantation and the Star Friedman Challenge for Promising Scientific Research award from Harvard University.

Dr. Riella received his medical degree from the Federal University of Paraná in Brazil. He completed a residency in internal medicine, a clinical and research fellowship in nephrology, and a fellowship in renal transplantation at Mass General Brigham. Dr. Riella also earned his PhD in transplant immunology from the Federal University of São Paulo, Brazil.

Distinguished Mentor Award

https://doi.org/10.62716/kn.004642026



Sushrut S. Waikar, MD, MPH

Dr. Waikar is the Norman G. Levinsky Professor of Medicine at the Boston University Chobanian & Avedisian School of Medicine and chief of nephrology at Boston Medical Center, MA. He is also a physician at Brigham and Women's Hospital and Boston Health Care for the Homeless Program, as well as a lecturer at Harvard Medical School, where he was previously an associate professor of medicine.

Throughout his career, Dr. Waikar has demonstrated a commitment to mentoring and training future kidney researchers. He has mentored numerous nephrologists who have gone on to become leaders in patient-oriented kidney research in areas such as epidemiology, randomized clinical trials, novel imaging modalities, and implementation science. He received the Medicine Housestaff Mentor of the Year Award at the University of California San Francisco (UCSF) in 2001 and the Excellence in Tutorial Facilitation award from Harvard Medical School in 2007.

His own research program includes epidemiologic, translational, and interventional studies of diagnostic testing in acute and chronic kidney disease, biomarkers of kidney injury and fibrosis, and therapeutic targets for kidney diseases. He is a principal investigator of several National Institutes of Health–funded projects, including the Kidney Precision Medicine Project and the Chronic Kidney Disease of Uncertain Etiology in Agricultural Communities Research Consortium, and has authored or coauthored more than 350 peer-reviewed publications. In addition, he serves on the external expert panel for the Symptoms of Lower Urinary Tract Dysfunction Research Network, a consortium established by the National Institute of Diabetes and Digestive and Kidney Diseases.

Dr. Waikar received his medical degree from the Yale School of Medicine and completed a residency in internal medicine at UCSF, where he was chief resident. He then completed clinical and research fellowship training in nephrology at Mass General Brigham and earned a Master of Public Health degree from the Harvard T.H. Chan School of Public Health.

PLENARY SESSION

Distinguished Researcher Award

https://doi.org/10.62716/kn.004402026



Rahul Chanchlani, MBBS, MD, MS, FASN

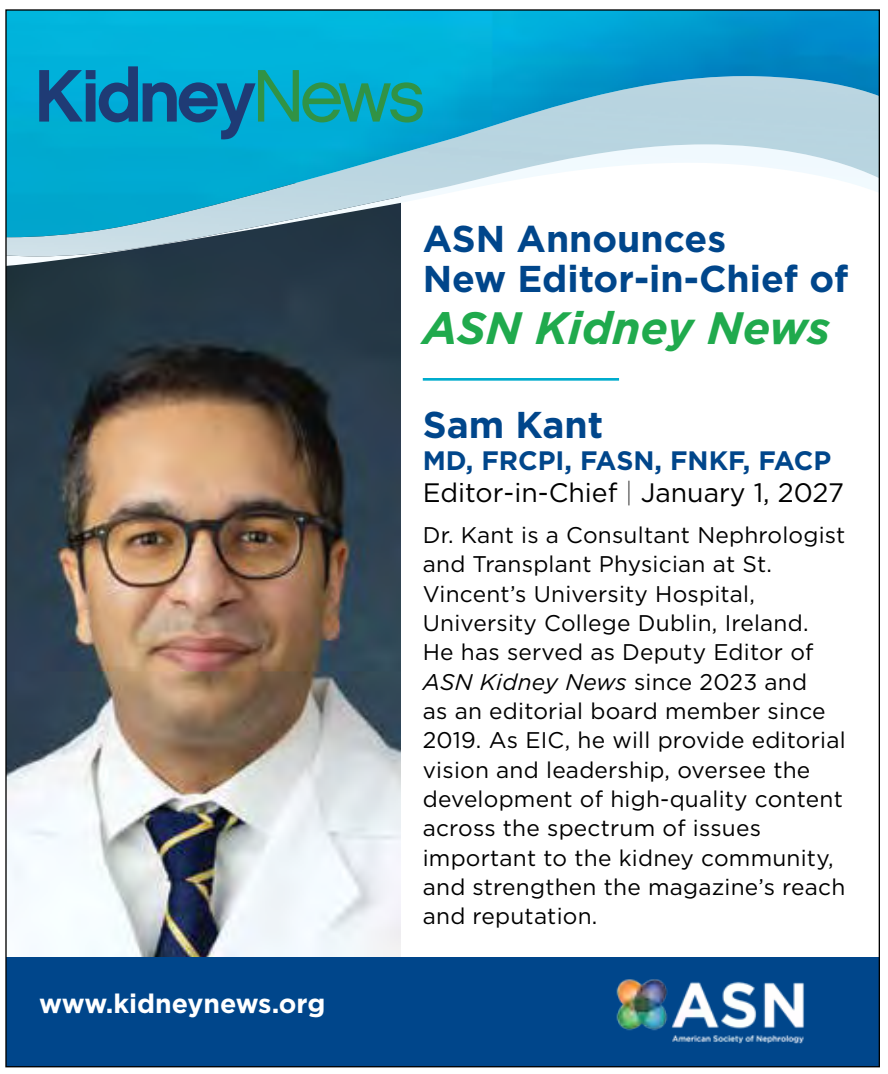
Dr. Chanchlani is an associate professor in the Division of Nephrology, Department of Pediatrics, at McMaster University and a staff pediatric nephrologist at McMaster Children's Hospital, both in Hamilton, Ontario, Canada. He is also an associate scientist at the Population Health Research Institute, a joint institute of McMaster University and Hamilton Health Sciences, and an adjunct scientist (full status) in the Kidney, Dialysis & Transplantation Research Program at the Institute for Clinical Evaluative Sciences (ICES) McMaster, a nonprofit research institute funded by the Ontario Ministry of Health.

Dr. Chanchlani's research focuses on improving the prevention, detection, and management of pediatric kidney diseases. Using population-based health data, implementation science, and community-engaged research, he develops and evaluates strategies to better care for children with hypertension, acute kidney injury, kidney transplant, and nephrotic syndrome.

He is a fellow of ASN and an associate editor of *Kidney360*. He is also coleader for Hypertension Canada's 2026 pediatric hypertension guidelines and will serve as president of the Canadian Association of Paediatric Nephrologists from 2027 to 2029.

In recognition of his excellence in research and mentorship, Dr. Chanchlani has received the 2025 Jacques de Champlain New Investigator Award from Hypertension Canada, the Renée Habib Young Investigator Award from the International Pediatric Nephrology Association, and a Faculty Mentor Award from McMaster University. He was also named to the International Society of Nephrology's Emerging Leaders Program.

Dr. Chanchlani completed his medical degree and pediatric training in India, including research and clinical fellowships in pediatric nephrology at the All India Institute of Medical Sciences, New Delhi. He then completed a clinical fellowship in pediatric nephrology at The Hospital for Sick Children (now SickKids) in Toronto, Ontario, as well as the Clinician Investigator Program at the University of Toronto Temerty Faculty of Medicine. He also earned a Master of Science degree from the University of Toronto Institute of Health Policy, Management and Evaluation.



Distinguished Researcher Award

https://doi.org/10.62716/kn.004412026



Madhav C. Menon, MBBS, MD

Dr. Menon is an associate professor of nephrology in the Department of Internal Medicine at the Yale School of Medicine, New Haven, CT, where he is also a steering committee member of the Human and Translational Immunology Program, which aims to accelerate progress in the field of immunology. He holds a secondary appointment with the Program in Translational Biomedicine. Previously, he was director of research in kidney transplantation at the Yale School of Medicine.

Dr. Menon is a physician-scientist whose research investigates the genetic and molecular mechanisms underlying kidney diseases and long-term kidney transplant outcomes, particularly allograft failure. His laboratory has uncovered mechanisms linking the *SHROOM3* gene and associated signaling pathways to proteinuria and renal fibrosis, laying the groundwork for new diagnostic and therapeutic approaches.

Dr. Menon's research has earned him a number of early-career honors. These include an Early Career Researcher Award from *Kidney International* and the International Society of Nephrology, a Basic Science Career Development Award from the American Society of Transplantation, and the Dr. Harold and Golden Lamport Research Award from the Icahn School of Medicine at Mount Sinai.

He is an associate editor for *Clinical Transplantation* and serves on the ASN Publications Portfolio Board. In 2024, he was elected to The American Society for Clinical Investigation.

Dr. Menon received his MBBS and MD in India from the University of Calicut and Postgraduate Institute of Medical Education and Research, respectively. He later completed a residency in internal medicine at the State University of New York (SUNY) Upstate Medical University in Syracuse, as well as clinical fellowships in nephrology at the Icahn School of Medicine at Mount Sinai and in kidney and pancreas transplantation at the Recanati/Miller Transplantation Institute at Mount Sinai, both in New York, NY.

Distinguished Researcher Award

https://doi.org/10.62716/kn.004672026



Meghan E. Sise, MD, MS

Dr. Sise is an associate professor of medicine at Harvard Medical School. She is also a nephrologist and director of onconephrology at Massachusetts General Hospital (MGH), both in Boston.

Dr. Sise's research spans three complementary areas: onconephrology, viral kidney disease, and clinical trials in immune-mediated kidney diseases. A primary focus of her work is developing biomarker-based approaches to aid in the diagnosis and management of immune checkpoint inhibitor-associated kidney injury. Her research also examines the effects of hepatitis C virus and HIV on kidney disease progression. She is principal investigator on multiple clinical trials evaluating novel therapies for immunoglobulin A nephropathy, lupus nephritis, monoclonal gammopathy of renal significance, and other immune-mediated kidney diseases and serves as coinvestigator on the Transplanting Hepatitis C Kidneys Into Negative Kidney Recipients (THINKER-NEXT) study, which is funded by the National Institute of Diabetes and Digestive and Kidney Diseases at the National Institutes of Health.

Beyond her research, she has helped shape clinical practice by serving on the work group for the Kidney Disease: Improving Global Outcomes (KDIGO) 2022 Clinical Practice Guideline for the Prevention, Diagnosis, Evaluation, and Treatment of Hepatitis C in Chronic Kidney Disease and has held multiple roles within ASN and the National Kidney Foundation. Her contributions have earned her several honors, including an Anne Klibanski Visiting Scholars Award from Mass General Brigham and a Claflin Distinguished Scholar Award from MGH.

Dr. Sise received her medical degree from the Columbia University Vagelos College of Physicians and Surgeons, New York, NY. She then completed a residency in internal medicine at MGH and a clinical fellowship in nephrology at Columbia University Irving Medical Center, followed by a nephrology research fellowship at MGH. She also earned a master's degree from Columbia University Mailman School of Public Health.

Visit the ASN Communities Lounge at ASN Kidney Week

Exhibit Hall A, Booth 737

Thursday, October 22

William Flanary, MD (aka Dr. Glaucomflecken): ASN President's Medal Recipient — **10:00 a.m. – 11:00 a.m.**
Meet-and-greet, questions-and-answers, and casual conversation.

The Art of Discussion: Tips and Strategies — **11:00 a.m. – 12:00 p.m.**
Best practices, seed questions, and quality content.

Glomerular Diseases Compendium Demonstration — **12:00 p.m. – 1:00 p.m.**
Learn about ASN's Glomerular Diseases (GD) Compendium, an essential hub of open access online resources that includes the most up-to-date content on GD, clinical guidance, drug-specific treatment, and patient education materials.

Immigration Journeys, Career Success Stories, and Networking — **1:00 p.m. – 2:00 p.m.**
Have questions about navigating the US immigration system while building a career in nephrology? Hear from those with lived experiences and network with colleagues. This session is intended primarily for fellows-in-training, but all are welcome.

Friday, October 23

ASN Compensation Tool Demonstration — **10:00 a.m. – 11:00 a.m.**
Learn about the ASN Compensation Tool, powered by Phairify, and how to leverage this exclusive ASN member benefit.

Becoming a Community Leader — **11:00 a.m. – 12:00 p.m.**
Engagement strategies, moderation, replies, and follow-through.

Connect with the Kidney Health Initiative (KHI) — **12:00 p.m. – 1:00 p.m.**
KHI is ASN's public-private partnership with the FDA and the broader kidney innovation community. Attend this informal gathering to network and learn how KHI advances patient-centered innovations in kidney health.

Open Community Dialogue with CMMI — **1:00 p.m. – 2:00 p.m.**
Gather with representatives from the Center for Medicare and Medicaid Innovation to share stories and ask questions about the Kidney Care Choices (KCC) Model and the Increasing Organ Transplant Access (IOTA) model.

Saturday, October 24

Communities Library — **10:00 a.m. – 11:00 a.m.**
Keyword searching, studies and reports, and credible research.

AI-Powered Kidney Care Network — **11:00 a.m. – 12:00 p.m.**
Engage with nephrology AI leaders, ask questions about the new ASN Community, and generate ideas for AI education and training.

Hot Topics — **12:00 p.m. – 1:00 p.m.**
Chronic kidney disease, home dialysis, kidney transplantation, and other subjects.

Open Discussion — **1:00 p.m. – 2:00 p.m.**
New ideas, future directions, and lingering questions.

ASN Communities

Health Policy Leader to Speak on Transplant System Reform

https://doi.org/10.62716/kn.004382026



Priti R. Patel, MD, MPH

A national leader at the intersection of public health and health policy will deliver the Christopher R. Blagg, MD, Endowed Lectureship in Kidney Diseases and Public Policy on Saturday, October 24. Priti R. Patel, MD, MPH, will give a talk titled "Transplant System Reform: A Congressional Perspective."

Dr. Patel is Senior Advisor for Health System Resilience in the Division of Healthcare Quality Promotion at the US Centers for Disease Control and Prevention (CDC), Atlanta, GA, which works to protect patients and health care workers through safe care delivery systems, infection prevention, and quality improvement initiatives in the United States and abroad. She is also an adjunct assistant professor in the Department of Family and Preventive Medicine at the Emory University School of Medicine and an instructor in the Department of Health Policy and Management at the Emory University Rollins School of Public Health. She is currently serving as a Health and Aging Policy Fellow in the congressional office of US Representative Diana DeGette (D-CO).

Her policy expertise runs through the regulatory machinery itself, not just around it. At CDC, leading the agency's dialysis efforts, she worked directly with the Centers for Medicare & Medicaid Services to strengthen infection prevention requirements within end-stage renal disease quality and safety programs and oversaw a national surveillance system, tracking outcomes across thousands of dialysis facilities. That regulatory fluency, paired with her current seat inside a congressional office, gives her important insights on transplant system reform: how it gets written into federal rule and how it is actually negotiated into law.

Dr. Patel has held several leadership roles during her tenure with CDC, which spans more than 2 decades. Her CDC career began in the Epidemic Intelligence Service, the agency's applied epidemiology training program, where she conducted outbreak investigations and epidemiologic studies. She worked in three infectious disease centers and contributed to national public health responses to COVID-19, Ebola, SARS, H1N1 influenza, and Hurricanes Katrina and Rita. She later completed the CDC Preventive Medicine Residency and Fellowship program at the Maryland Department of Health, gaining experience in state health policy during the Maryland legislative session.

From 2022 to 2023, she was a Leadership in Health Policy Scholar with the Society of General Internal Medicine. In addition, she serves on the ASN Health Care Justice Committee and is on the board of directors for the Kidney Health Initiative.

Dr. Patel earned a Master of Public Health from Columbia University Mailman School of Public Health, New York, NY, and then her medical degree from the Howard University College of Medicine, Washington, DC. She completed a residency in internal medicine at the Perelman School of Medicine at the University of Pennsylvania in Philadelphia.

Women's Kidney Health Expert to Discuss Hormone Therapy Considerations

https://doi.org/10.62716/kn.004292026



Sofia B. Ahmed, MD, MMSc

Sofia B. Ahmed, MD, MMSc, a women's kidney health expert, will deliver the Sharon R. Silbiger, MD, Endowed Lectureship on Saturday, October 24. Her talk is titled "Oral Contraceptives and Hormone Replacement Therapy: Considerations in Patients With Kidney Diseases."

Dr. Ahmed is a professor of medicine at the Faculty of Medicine and Dentistry at the University of Alberta in Edmonton, Alberta, Canada, where she also holds the University of Alberta Chair in Sex and Gender. In addition, she is an adjunct professor at the University of Calgary Cumming School of Medicine, Alberta, where she was previously a professor.

A central goal of her research is understanding how sex and gender differences influence kidney and cardiovascular physiology, clinical outcomes, and the delivery of care. Her research spans hormonal influences on kidney and cardiovascular health, sex and gender differences in kidney diseases and clinical outcomes, and the effects of gender-affirming hormone therapy on heart and kidney health.

Dr. Ahmed's early work established that oral contraceptive use alters how the kidney responds to angiotensin II, producing greater renal vasoconstriction in healthy women—a renin-angiotensin system effect she then linked to increased risk of diabetic nephropathy in a follow-up study. More recently, her research has shifted toward the clinical care gap around contraception in chronic kidney disease (CKD), including an international mixed-methods study examining how women with CKD access and use contraception and what is missing from the counseling they receive.

In addition to her own scholarly work, Dr. Ahmed has played a prominent role in integrating sex and gender considerations into health research. She is chair of the Advisory Board for the Institute of Gender and Health, part of the Canadian Institutes of Health Research, and chair of the *Canadian Medical Association Journal* Governance Council, which provides oversight for one of Canada's leading medical journals. She previously served as president of the Organization for the Study of Sex Differences, an interdisciplinary scientific society that promotes research on sex differences in health and disease.

Dr. Ahmed is also helping shape key guidelines on kidney and cardiovascular health. She serves as a primary panel member for the Canadian Cardiovascular Society Guideline on Prevention: Obesity and Cardiometabolic Care, a work group member for the Kidney Disease: Improving Global Outcomes (KDIGO) 2024 Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease, and a member of the writing group for an upcoming American Heart Association scientific statement on women's kidney health.

She is dedicated to mentoring the next generation of researchers, which earned her the ASN Distinguished Mentor Award in 2020 and the Canadian Medical Association May Cohen Award for Women Mentors in 2021. She has also received the Senior Investigator Award from Hypertension Canada, which recognizes significant contributions in hypertension research, among other accolades.

Dr. Ahmed completed her medical degree and a residency in internal medicine at the University of Toronto Temerty Faculty of Medicine in Ontario, Canada, followed by a clinical nephrology fellowship at Mass General Brigham in Boston, MA. She also earned a master's degree from Harvard Medical School, Boston.

Kidney Regeneration Researcher to Detail Applications of Spatial Metabolomics

https://doi.org/10.62716/kn.004352026



Ton J. Rabelink, MD, PhD

Ton J. Rabelink, MD, PhD, an internationally recognized expert in renal metabolism and regenerative medicine, will deliver the Robert W. Schrier, MD, Endowed Lectureship on Saturday, October 24. His talk is titled "Kidney Applications of Spatial Metabolomics."

Dr. Rabelink is a professor of internal medicine and a nephrologist at Leiden University Medical Center in the Netherlands, where he also leads the Department of Internal Medicine. He directs the Leiden Node of the Novo Nordisk Foundation Center for Stem Cell Medicine, an international consortium working to advance stem cell–based therapies, and is a figurehead of regenerative medicine for the national Dutch Research Agenda.

A major focus of his research is understanding how cellular metabolism influences kidney development and regeneration, using a research method called spatial metabolomics. He has pioneered new approaches to characterize metabolic activity within kidney tissues and kidney organoids derived from human-induced pluripotent stem cells. This work has established the metabolism as an active regulator of tissue organization, vascularization, and cell fate during kidney development and regeneration. His lab is now leveraging these insights to develop regenerative therapies and other novel treatment strategies for chronic kidney disease.

Dr. Rabelink's scientific contributions have earned him prestigious grants, including an Advanced Grant from the European Research Council to study kidney regeneration mechanisms. His publications have appeared in leading journals, including *The New England Journal of Medicine*, *The Lancet*, *Nature Genetics*, *Nature Metabolism*, and *Cell Stem Cell*, and have received more than 44,000 citations.

He has also launched several initiatives to help shape the future of regenerative medicine in Europe. He is a cofounder of Regenerative Medicine Crossing Borders (RegMed XB), a public-private research consortium that aims to accelerate translational research in regenerative medicine, and founder and chief scientific officer of NecstGen, the Netherlands Center for the Clinical Advancement of Stem Cell and Gene Therapies, a nonprofit contract development and manufacturing organization that helps advance new cell and gene therapies into clinical testing. As a physician-scientist, he remains actively involved in patient care and translational efforts, including caring for patients receiving kidney transplants and participating in clinical trials.

Dr. Rabelink received his medical degree from Utrecht University in the Netherlands, as well as a doctoral degree in renal physiology. He then completed residency and clinical fellowships in internal medicine and nephrology at Utrecht University, where he later became a professor and chair of the Department of Medicine before moving to Leiden University Medical Center in 2004.



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PLENARY SESSION

STATE-OF-THE-ART PANEL

State-of-the-Art Panel to Discuss Translating Breakthrough Science Into Real-World Care

https://doi.org/10.62716/kn.004702026

This is an exciting time for the kidney community. With breakthrough science and technology providing challenges and opportunities for real-world care, this state-of-the-art expert panel will focus on various aspects of implementation science, health policy, health economics, and the future of kidney care. "Bridging Breakthrough Science Into Real-World Care: Challenges and Opportunities for the Nephrologist" will take place on Sunday, October 25, and will be moderated by Ravi I. Thadhani, MD, MPH, with expert panelists: Stanley D. Crittenden, MD, FASN; Jessica L. Mega, MD, MPH; and Rachael L. Morton, MSc, PhD.

Moderator



Ravi I. Thadhani, MD, MPH

Dr. Thadhani is executive vice president, chief physician executive, and dean of the medical faculty at Cedars-Sinai, Los Angeles, CA. He oversees the organization's academic and clinical enterprises, unifying its missions in patient care, research, and education.

A leading expert in nephrology and preeclampsia, Dr. Thadhani researches new diagnostics and therapeutics. He led development of the first US Food and Drug Administration–approved test to predict preeclampsia. He is the author or coauthor of more than 300 publications, including in *The New England Journal of Medicine*, *The Lancet*, and *JAMA*.

Previously, Dr. Thadhani served as executive vice president of clinical affairs and chief medical officer for Cedars-Sinai Health System. He also previously oversaw 11 of Emory University's academic health sciences programs in Atlanta, GA. Earlier in his career, he served as executive director of the Woodruff Health Sciences Center at Emory University, as well as chief academic officer at Mass General Brigham and Faculty Dean for Academic Programs at Harvard Medical School, both in Boston, MA. His leadership roles with ASN have included codirector of postgraduate courses and cochair of the Late Breaking Clinical Trials Committee.

In 2020, he was awarded the ASN John P. Peters Award and in 2015, the Robert W. Schrier, MD, Endowed Lectureship. In 2021, he received the Gregory Pincus Medal for pioneering work in women's health. He was elected to the National Academy of Medicine in 2025 and named a Fellow of the American Association for the Advancement of Science in 2026.

Dr. Thadhani received his medical degree from the Perelman School of Medicine at the University of Pennsylvania, Philadelphia, and a Master of Public Health in epidemiology from Harvard T.H. Chan School of Public Health. He completed his residency in internal medicine and a clinical fellowship in nephrology at Mass General Brigham, as well as a research fellowship in medicine at Harvard Medical School.

Panelists



Stanley D. Crittenden, MD, FASN

Dr. Crittenden is senior vice president and chief medical officer of Cigna Healthcare, the health insurance and benefits division of The Cigna Group. In this role, he leads clinical strategy and oversees programs designed to improve health outcomes, expand access to care, and enhance experiences for patients and clinicians. His work focuses on using data, analytics, and value-based approaches to translate evidence into scalable, effective models of care.

Previously, Dr. Crittenden served as enterprise chief medical officer at Quantum Health and as chief medical officer at Evergreen Nephrology, where he was the founding clinical leader and helped design and scale integrated payor–practitioner models for kidney care. Earlier in his career, he held senior medical leadership positions at Elevance Health (formerly Anthem) and Humana, two of the largest managed care organizations in the United States, leading clinical transformation initiatives across Medicare Advantage, Medicaid, and commercial populations.

Dr. Crittenden is passionate about chronic disease management, health equity, value-based care, and health system improvement. He serves on national professional committees focused on innovation and advancing the responsible use of technology in kidney health. His contributions have been recognized with the Humana Excellence and Leadership Award and a 2025 Columbus Business First C-Suite Award.

He received his medical degree from Tulane University School of Medicine, New Orleans, LA; completed his residency in internal medicine at The University of Chicago Pritzker School of Medicine, IL; and completed a clinical fellowship in nephrology and hypertension at Weill Cornell Medicine and NewYork-Presbyterian, New York City, where he was the chief nephrology fellow.



Jessica L. Mega, MD, MPH

Dr. Mega is a cardiologist at Stanford Medicine, CA, and serves on the advisory board of the Stanford Center for Digital Health. A leader at the intersection of technology, life science, and health care, she is cofounder and former chief medical and scientific officer of Alphabet's Verily, where she worked to translate technological innovations and scientific insights into improved patient outcomes. She currently serves on the board of directors of Boston Scientific, as a senior advisor at SandboxAQ, and on the board of advisors for Research!America and the Duke-Margolis Institute for Health Policy.

Previously, Dr. Mega was a faculty member at Harvard Medical School and a cardiologist at Brigham and Women's Hospital. As a senior investigator with the TIMI [Thrombolysis in Myocardial Infarction] Study Group, she led large international clinical trials evaluating novel cardiovascular therapies and technologies. As director of the TIMI Genetics Program, she helped establish the role of *CYP2C19* genetic variants in response to antiplatelet medications. Her research has been published in *The New England Journal of Medicine*, *The Lancet*, *Circulation*, and *JAMA*.

Her contributions to cardiovascular research have been recognized by the American Heart Association, with the Samuel A. Levine Early Career Clinical Investigator Award and a Laennec Society Award, and by the American College of Cardiology, with the 2014 Douglas P. Zipes Distinguished Young Scientist Award.

Dr. Mega received her bachelor's degree from Stanford University, medical degree from Yale School of Medicine, and Master of Public Health from Harvard T.H. Chan School of Public Health. She completed a residency in internal medicine at Brigham and Women's Hospital and a clinical fellowship in cardiology at Massachusetts General Hospital. She is a Fellow of the American Heart Association and a Fellow of the American College of Cardiology.



Rachael L. Morton, MSc, PhD

Dr. Morton is a professor and director of health economics and health technology assessment at the Sydney Clinical Trials Centre (formerly National Health and Medical Research Council [NHMRC] Clinical Trials Centre) at the Faculty of Medicine and Health at The University of Sydney in Australia. She specializes in evaluating the cost-effectiveness of treatments, diagnostic tests, digital technologies, and models of care. She incorporates patient-reported and economic outcomes into clinical trials to support decision-making based on evidence, cost-effectiveness, and patient preferences.

Dr. Morton has studied coronary artery disease screening for kidney transplant candidates, the effects of social determinants on kidney disease outcomes, employment support for people receiving dialysis, and advance care planning for older adults receiving dialysis.

Dr. Morton has published in *The BMJ* [*British Medical Journal*], *The Lancet*, the *Journal of Clinical Oncology*, *Kidney International Reports*, *The Lancet Planetary Health*, and *Nature Reviews Nephrology*. She has coauthored health technology assessment monographs for the Australian government's Medical Services Advisory Committee. She also co-led a consortium of 36 countries for the European Centre for Disease Prevention and Control to evaluate infectious disease screening strategies among migrants to the European Union.

She has held leadership roles, including president of the Health Services Research Association of Australia and New Zealand and cochair of the Australian Health Research Alliance Health Services Research Working Group. Her honors include the 2019 Health Services Research Association of Australia and New Zealand Mid-Career Distinguished Investigator Award and the 2024 Australian Clinical Trials Alliance (ACTA) Health Economics Analysis and Trial (HEAT) Excellence in Trial-Based Health Economics Award.

She earned a master's degree in clinical epidemiology and a PhD in health economics at The University of Sydney. She then received the NHMRC Sidney Sax Overseas Fellowship to conduct research at the University of Oxford. She subsequently received an NHMRC Translating Research Into Practice (TRIP) Fellowship and The University of Sydney's Robinson Fellowship.



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KIDNEY WEEK 2026

ASN Calls for More Flexible, Patient-Centered Approaches to Kidney Care

By Lauren Ahearn

https://doi.org/10.62716/kn.005022026

Each summer, the Centers for Medicare & Medicaid Services (CMS) releases a series of proposed rules that help shape how Medicare will pay for and measure health care in the year ahead. For nephrologists, few are more consequential than the End-Stage Renal Disease (ESRD) Prospective Payment System and Quality Incentive Program (QIP) proposed rule.

This year's rule was particularly expansive (1). Beyond annual updates to dialysis payment and quality measurement, CMS sought input on broader questions about the future of kidney care—including how to expand access to home dialysis, better support palliative approaches to dialysis, incorporate patients' life goals into treatment planning, and potentially rethink how Medicare pays for different dialysis schedules.

Led by ASN's Quality Committee, with support from the Policy and Advocacy Committee and Transplant Policy Committee, ASN developed two comment letters (2, 3), including a comprehensive response to more than 100 Request for Information (RFI) questions posed by CMS, reflecting the expertise and perspectives of members across the kidney community. In both letters, ASN's message was consistent: Federal policy should give nephrologists and their patients greater flexibility to individualize kidney care, ensure that payment supports access to high-quality treatment, and focus quality measurement on practices that meaningfully improve patient care.

- **Protecting access to pediatric dialysis care.** ASN strongly opposed CMS's proposal to base payment for pediatric dialysis on facility treatment volume after the current pediatric payment adjustment expires at the end of 2026. ASN emphasized that the cost of pediatric dialysis is driven by the complexity of caring for pediatric patients—including specialized staffing, equipment, supplies, and clinical expertise—not by how many treatments a facility provides. ASN urged CMS to develop a permanent pediatric payment adjustment that reflects the actual resources required to care for pediatric patients on dialysis and provides facilities treating pediatric patients with a stable, predictable payment structure.
- **Ensuring dialysis payment supports high-quality care.** ASN weighed in on several potential changes to Medicare dialysis payment, emphasizing that payment policy should support patient access and clinical decision-making. Most notably, ASN strongly opposed a uniform daily payment rate for conventional in-center hemodialysis, cautioning that it could create unintended incentives around treatment frequency when dialysis prescriptions should be driven by patients' clinical needs. ASN also supported increasing the home and self-dialysis training add-on payment to better reflect the resources required to prepare patients and caregivers for home treatment. Finally, ASN urged CMS to provide greater stability as new dialysis drugs transition out of the Transitional Drug Add-on Payment Adjustment and into the ESRD payment system, including safeguards to prevent manufacturer pricing-reporting issues from disrupting patients' access to treatment.
- **Advancing home dialysis uptake by addressing real-world barriers.** Efforts to expand access to home dialysis have been a longstanding focus of federal kidney policy. In 2019, the Advancing American Kidney Health initiative brought renewed attention to that goal (4), setting forth a series of federal policy initiatives designed to increase home dialysis utilization. This focus remains a priority for CMS, as reflected in the breadth of questions in this year's RFI related to increasing uptake. In response, ASN emphasized that further progress will require addressing the practical barriers that affect whether patients can choose and successfully maintain a home modality. ASN urged CMS to expand access to kidney disease education, strengthen support for home dialysis training, increase access to staff-assisted home dialysis, and address additional costs that patients may face when dialyzing at home, including higher utility expenses. The goal is not simply greater utilization but ensuring that patients who choose home dialysis have the education, resources, and support necessary to succeed.
- **Expanding options for palliative dialysis and hospice care.** This year's RFI also signaled CMS' interest in advancing policies to better support palliative dialysis and hospice care for patients with kidney failure. In this year's comment letter, ASN defined palliative dialysis as an individualized approach to dialysis that prioritizes symptom relief, comfort, and quality of life, with treatment tailored to a patient's symptoms, prognosis, goals, and preferences (3). ASN urged CMS to provide greater flexibility for nephrologists and patients to individualize the frequency, duration, and intensity of dialysis as goals of care evolve. ASN also called for changes to the Medicare payment policy that would make it easier for patients with kidney failure to receive hospice services while continuing dialysis when clinically appropriate, rather than forcing patients and families to choose between the two.
- **Keeping quality measures meaningful.** ASN weighed in on several potential changes to ESRD QIP, urging CMS to prioritize measures that are evidence-based, meaningful to patients, and actionable for kidney care teams. ASN raised concerns with the proposed hyperphosphatemia measure, urging CMS to wait for stronger clinical trial evidence before holding facilities accountable to the proposed serum phosphorus target. ASN also opposed removing the Medication Reconciliation reporting measure from QIP, emphasizing the continued importance of medication reconciliation for patients who are often treated with numerous medications and receive care from multiple clinicians. Finally, ASN supported the goals behind the proposed Dialysis Facility Discussion of Patient Life Goals Patient-Reported Outcome performance measure but did not support adding it to QIP at this time, citing the need for further development and testing and cautioning against a measure that simply documents whether a conversation about life goals occurred rather than whether those goals meaningfully inform a patient's care.

Looking ahead

ASN is also weighing in on the proposed 2027 Medicare Physician Fee Schedule, which includes several policies with direct implications for nephrologists and their practices.

Among the issues on which ASN is focused are the continued sustainability of Medicare physician payment, a proposal to reduce payment by 50% when certain separately identifiable evaluation and management services are provided on the same day as a procedure, proposed changes to the Healthcare Common Procedure Coding System G2211 code and how Medicare recognizes the complexity of longitudinal care, and a new quality measure promoting appropriate use of sodium-glucose cotransporter-2 inhibitors for people with chronic kidney disease.

As CMS moves from proposed rules to final policies this fall, ASN will continue advocating for policies that reflect the realities of kidney care, appropriately recognize the work of nephrologists and kidney care teams, and preserve the ability of clinicians and patients to make care decisions based on individual needs and goals.

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

Lauren Ahearn is the senior policy and government affairs coordinator with ASN.

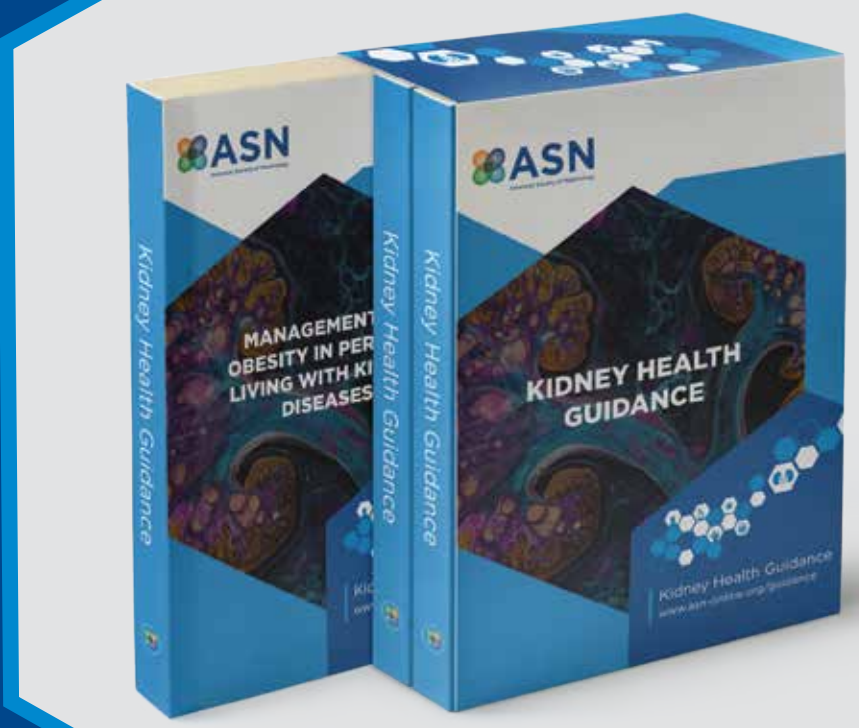
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Going Beyond Survival: Kidney Transplantation in the Older Population

By Rima Patel, Emily Joachim, Ty Dunn, and Beje Thomas

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The recent trial by Leeaphorn et al. (1), comparing deceased-donor kidney transplantation (DDKT) with continued dialysis in patients aged 75 years or older, invites a broader question than survival alone: What benefit does transplantation truly offer to older adults with kidney failure?

In their study, Leeaphorn et al. demonstrated that patients aged 75 years or older derive a survival benefit from DDKT (1). However, the study also highlights a substantial early risk in these patients, with a 2.3-fold higher risk of mortality during the first 90 days after transplant, and a modest long-term survival advantage of fewer than 4 additional months at 5 years after transplant. But are there other benefits to examine beyond survival, including health-related quality of life (HRQoL) improvements, reduction of dialysis-related burden, and preservation of autonomy?

Older kidney transplant recipients have superior HRQoL compared with patients on dialysis or age-matched waitlisted patients (2–4). Dialysis is a major daily disruption. The schedule of in-center hemodialysis, travel requirements, postdialysis fatigue, and treatment-related symptom burden can consume a substantial portion of remaining life. Transplantation may give greater independence and less treatment burden. This difference matters because older patients often prioritize QoL over length of life alone.

Older adults represent a heterogeneous population with respect to frailty, comorbidity burden, cognitive function, and physiologic reserve. The early postoperative period may carry substantial risks that may increase short-term mortality. The reported 5-year survival advantage of 111 days does not account for the time after transplantation spent hospitalized, readmitted, undergoing dialysis because of delayed graft function, or attending medical appointments. The analysis does not capture the number of "medical-free" days gained or lost following transplantation. Such measures may be particularly relevant to older adults.

The study included 2670 patients who were waitlisted, of whom 1012 underwent transplant; unfortunately, about 30% of those listed died during the study period without a transplant (1). At the time of waitlisting, 90% of patients were on dialysis, less than half had diabetes or peripheral vascular disease, and 80% had a Karnofsky score of 70% or higher. The mean dialysis vintage was 1.6 years, and the median time from waitlisting to DDKT was 1.9 years. Patients who are frailer have a higher burden of vascular disease, and longer dialysis vintage might not have the same survival and HRQoL advantage as those in the study (5, 6). It should be noted that although not a primary objective of this study, the significantly lower rates of female and non-White waitlisted patients demonstrate continued inequities in access to transplantation.

This study provides information to support discussions about transplantation and dialysis as viable options for people living with kidney failure. The goal is not universal transplantation but rather identifying which patients will benefit from transplantation and for whom the procedure aligns with their preferences. For patients, an improved HRQoL may be as important as longevity. Further data are needed to clarify the potential benefits with a living-donor allograft in older patients. Another important consideration is that earlier referral prior to a patient starting dialysis might decrease morbidity and maximize the benefit of transplantation. Ultimately, for carefully selected older adults, kidney transplantation may offer not only an opportunity to live longer but also to live better. This must be weighted alongside alternatives including dialysis (particularly home modalities) and palliative approaches. ■

Rima Patel, DO; Emily Joachim, MD; Ty Dunn, MD, MS; and Beje Thomas, MD, are with the Medical College of Wisconsin, Milwaukee.

The authors report no conflicts of interest.

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Deceased donor kidney transplantation versus continued dialysis in older patients

KidneyNews

Transplant-eligible adults aged ≥75 years who initiated dialysis and were listed in the Organ Procurement and Transplantation Network registry (2015–2023) for kidney-only transplantation
N = 2670

511 Auxiliary trials

505,438 Person-trial observations

76.8 Years (mean age)

70.7% Male

49.0% With diabetes

DDKT recipients

HR, 2.29 (95% CI, 1.50–3.49) Mortality risk (for days 0–90)

HR, 0.34 (95% CI, 0.26–0.45) Survival benefit after 3 years

At 3 years—the break-even point—survival was equivalent between groups (p = 0.9).

2.0 days RMST difference

By 5 years, DDKT conferred a 111-day survival advantage.

95% CI, 65.6–156.4 (p < 0.001)

Which patients experienced greater numerical benefit?

133.6 versus 81.2 days Without diabetes versus with diabetes (p interaction = 0.3)

156.1 versus 107.9 days ≥2 Years of dialysis versus <2 years (p interaction = 0.3)

CI, confidence interval; HR, hazard ratio; RMST, restricted mean survival time.

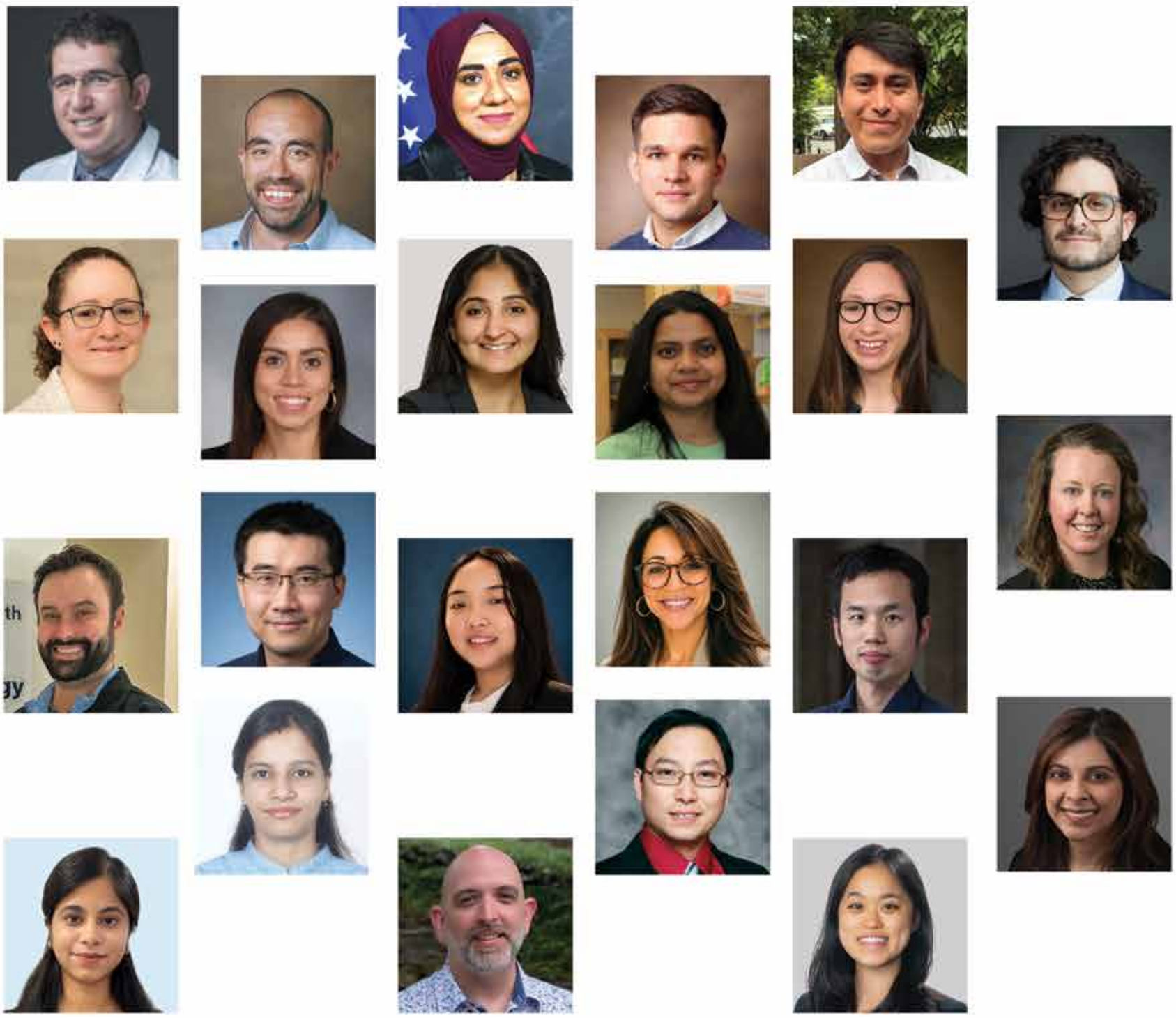
Conclusion: DDKT confers a survival benefit to wait-listed patients aged 75 years or older, although this benefit emerges only after 3 years, providing a critical benchmark for patient counseling. The modest 5-year advantage for DDKT should be weighed against earlier elevated risks of mortality.

Leeaphorn N, et al. **Deceased Donor Kidney Transplantation Versus Continued Dialysis Among Patients Aged 75 Years or Older: A Target Trial Emulation.** *Am J Kidney Dis* 2026; 88:356–365.e1. doi: 10.1053/j.ajkd.2026.02.647

Visual abstract by Edgar Lerma, MD, FASN

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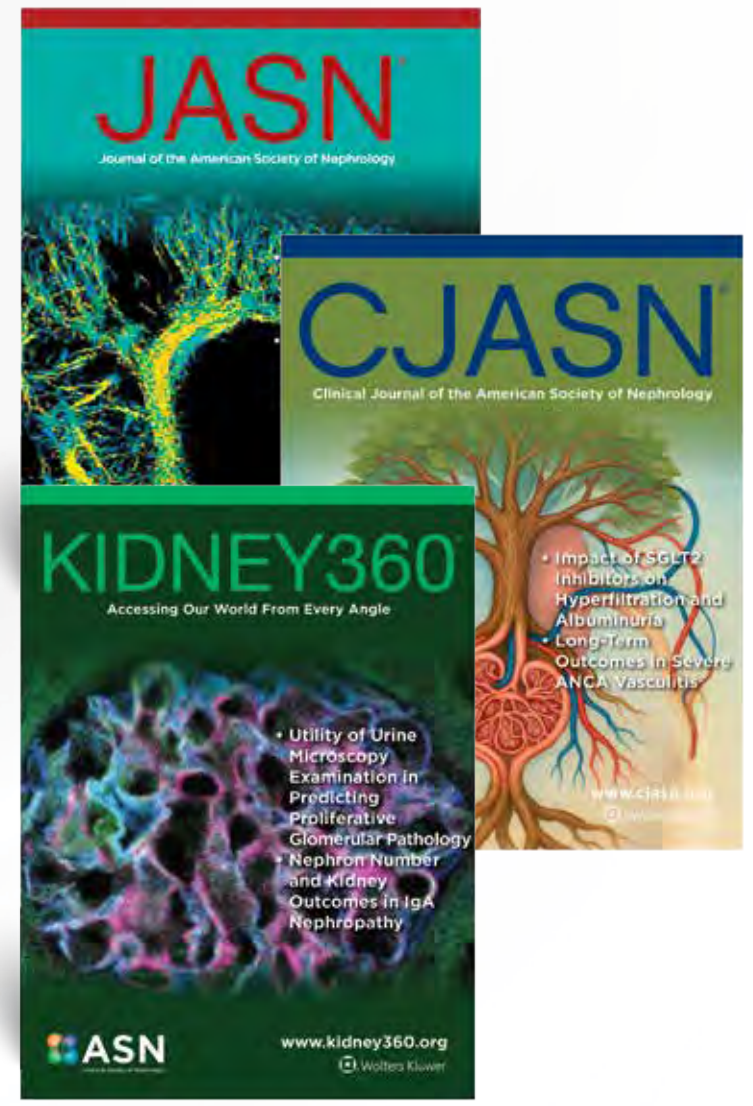
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Excellence in Patient Care Celebrates Its 10th Anniversary

By Alan S. Kliger

https://doi.org/10.62716/kn.004232026

Ten years ago, Susie Stark (now, vice president of Excellence in Patient Care) and Tod Ibrahim (ASN executive vice president and chief executive officer) asked me to help with a new ASN project regarding safety and dialysis. I was fascinated. As a nephrologist with an interest in quality measurement and improvement, I had worked with the Forum of ESRD Networks, the Renal Physicians Association, and the National Quality Forum to develop and critically review kidney quality metrics. I had long known that infection was second only to heart disease as the cause of death for people treated with dialysis. Although the Centers for Disease Control and Prevention (CDC) published evidence-based maneuvers during dialysis that reduce infection risk, patients on dialysis often did not receive these measures. Why were our patients dying of preventable iatrogenic infections? ASN and CDC discussed a new joint initiative to address this problem, and so was born Nephrologists Transforming Dialysis Safety.

What started as a professional society's work to effectuate CDC guidance expanded to include a vigorous response to protecting people living with kidney diseases during the COVID-19 pandemic, responses to other infectious threats, and work to anticipate future threats to our patients' safety. We recruited leading adult and pediatric nephrologists as well as infectious disease specialists to work together with CDC experts.

Our guiding principle was that success required three components: the best evidence-based care; patient empowerment and participation; and effective, inspirational leadership. We understood that our challenge was in translation: If the science was clear, and the performance gap was measurable, our task was to develop effective ways to bring the best science to every patient. By actively engaging patients in our activities, we championed their experiences, preferences, and values, and we advanced equitable access to care by promoting equity, pursuing inclusion, and addressing disparities. Recognizing the need to address financial, legislative, and regulatory challenges, we also needed to find ways to assist patients, nephrologists, and other health professionals to navigate our health systems.

As our work expanded, this approach succeeded at raising awareness and reducing infection risk. Our methodology effectively facilitated collaborative work among professionals and patients across ASN and the broader kidney community. New work groups included Current and Emerging Threats, Core Interventions for the Prevention of Peritoneal Dialysis-Related Infections, Emergency Preparedness and Response, the Kidney Community Vaccination Collaborative, and Transforming Dialysis Access Together. The American Medical Association even approached ASN to partner on Project Firstline, focusing on front-line dialysis professionals.

Such expansion led us to a wider vision. Infection prevention was not the only area in which translation efforts could close the gap in caring for people living with kidney diseases. Other gaps in care were glaring. For example, evidence that angiotensin converting enzyme inhibitors and angiotensin receptor blockers slow chronic kidney disease (CKD) progression in people with diabetes was published in 1991 through 1993 and in those with nondiabetic CKD, from 1997 through 2001. Yet, more than 20 years later, prescription rates for these medications for people with CKD are barely more than 50%.

In the past 5 years, additional medications have proven far more effective in preventing or reducing the rate of CKD progression, including sodium-glucose cotransporter-2 (SGLT2) inhibitors, glucagon-like peptide-1 agonists, and nonsteroidal mineralocorticoid antagonists. Yet, one study of 28 health systems reported that none had more than a 25% SGLT2 inhibitor prescription rate among people with diabetes and a class 1a recommendation for their use. Medication rates for those without diabetes and with a class 1a recommendation for use were even lower (1). Thus was born ASN's Diabetic Kidney Disease Collaborative to translate this science to every eligible person with kidney disease and diabetes. Now expanding to all people with kidney diseases and cardiometabolic syndrome, the Saving Kidneys, Hearts, and Lives initiative, in partnership with the American Heart Association and other stakeholders, is using our model of translation to prevent diseases and improve care.

Our wider vision is now better described under the umbrella of Excellence in Patient Care (EPC). In addition to the aforementioned projects, EPC includes: Diagnostic Excellence: eGFR [estimated glomerular filtration rate] Toolkit, Fostering Innovative Leaders in Nephrology and Dialysis, Glomerular Diseases Collaborative, Home Dialysis Project, Humanitarian Kidney Support Program, and Sustainability, a project to examine kidney and dialysis care in a world of climate change and limited resources. Each project has a leader and steering committee with content and leadership expertise and work groups with defined deliverables and timetables. Volunteer professionals working in these teams now number more than 150, and many of their accomplishments have been published (https://epc.asn-online.org/resources/). EPC has active partnerships with 25 professional, governmental, care delivery, and education organizations (Table).

EPC celebrates its 10th anniversary by reaffirming its commitment to bring the best evidence-based care to every person living with kidney diseases. More than 150 strong, we are committed to equitable access to care and to patient advocacy to assure that care is available and affordable to all who need it. I am so fortunate to be working with some of the best nephrologists, infectious disease specialists, and other health professionals in North America. None of our work is possible without the vision, collaboration, and hard work of the many ASN members, leaders, and staff who do the heavy lifting for these projects. Thanks to all, and congratulations on our 10th anniversary!

Alan S. Kliger, MD, chairs ASN's Excellence in Patient Care Advisory Committee. He is a nephrologist and clinical professor of medicine at Yale University School of Medicine, New Haven, CT.

The author reports no conflicts of interest.

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Table. EPC ecosystem: Strategic partners and collaborators

Focus area	Partners and collaborators
Kidney health collaborators	American Heart Association, American Kidney Fund, American Nephrology Nurses Association (ANNA), American Society of Diagnostic and Interventional Nephrology, American Society of Pediatric Nephrology, European Renal Association (ERA), Home Dialysis University (HDU), IgA [Immunoglobulin A] Nephropathy Foundation, International Society of Nephrology (ISN), Kidney Disease: Improving Global Outcomes, Lupus Foundation of America, NephCure, Vantive
Infection-prevention partners	ANNA, Community Pharmacy Enhanced Services Network, ERA, Innovative Renal Care, ISN, North American Chapter-International Society for Peritoneal Dialysis (ISPD), Virginia Tech
Humanitarian responders	Bridges of Life, Dialysis Company Chief Medical Officers Group, Direct Relief, ERA, ISN, Kidney Community Emergency Response, Renal Dynamics
Leadership development	Fostering Innovative Leaders in Nephrology and Dialysis, HDU, ISPD

Can't Keep Missing ("CKM") Opportunities: Saving Kidneys, Hearts, and Lives

By Brian S. Rifkin and Melissa West on behalf of the Saving Kidneys, Hearts, and Lives Steering Committee

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When the 2026 AHA/ACC/ADA/ASN guideline on cardiovascular-kidney-metabolic (CKM) syndrome was released (1), I [B.S.R.] was more than a little surprised by the pushback from the online nephrology community. Some called it a "fake" condition, whereas others questioned the weak messaging and confusing staging. Some felt like it was cardiologists telling other specialties what to do—more preventive cardiology, of course! Some were concerned about the development of a "CKM specialty" designation that is meaningless but would require additional credentials, Many were asking, "Don't nephrologists handle this care already?"

CKM care is not a shiny, new area of expertise. It is the gritty, meticulous guidance of chronic disease management that is necessary for the health and well-being of millions of people.

In this world of practice silos, preventive medicine fatigue due to patients' inability to access guideline-directed medical therapy (GDMT), and electronic health records with meaningless medication alerts, how does CKM care gain a higher priority with nephrologists? The answer is easily said but hard to accomplish: caring for the whole patient.

We know that 37 million people in the United States are living with kidney diseases. We also know that an overwhelming majority of them will die prior to kidney failure and that the most common cause of death is from cardiovascular disease. So, yes, at some level, all nephrologists are preventive cardiologists because heart and vascular diseases are often the most pressing issues when trying to improve the quality and quantity of our patients' lives.

It is understandable that by the time a patient encounters a nephrologist, they are often late in the course of a complex interaction of comorbidities. We know that initiation of GDMT earlier in the course of organ damage from CKM-related diseases is much more effective in improving outcomes. Referring people to nephrology later in disease management can lead to feelings of futility and frustration for both patients and physicians.

This frustration is further complicated by the increasing shortage of nephrologists and the limited capacity of nephrology access, particularly in rural areas. Many nephrology professionals are feeling the crunch and are doing the best that they can with the available resources.

This crisis gets to the heart (pun intended) of the problem. To address this, it is essential that we use population-based care and accessible resources to gain a foothold in patients who are high-risk at the beginning of their CKM syndrome history. Yes, it requires more recognition and action from primary care clinicians, but this does not absolve nephrologists from having a significant role to play in CKM management. In fact, many practicing nephrologists were attracted to the specialty because of its complex clinical care.

Finally, engaging the community as a whole (especially people who are not medically trained) is critical to this campaign. The first pillar of CKM care is education. An educated public is absolutely necessary to move the needle on preventing organ damage when it matters: decades before seeing a cardiologist, nephrologist, or endocrinologist.

People affected by CKM syndrome must become more aware and demanding of proven preventive therapeutics and support policies that increase access. Maybe preaching to the choir (i.e., specialists) is a little irksome, but nephrologists need to be leaders in education and be instrumental in refining and distributing the message.

CKM care is not a shiny, new area of expertise. It is the gritty, meticulous guidance of chronic disease management that is necessary for the health and well-being of millions of people. ASN initiated the Saving Kidneys, Hearts, and Lives program to improve care, bolster the nephrology workforce, strengthen kidney research, raise awareness of kidney health, and prioritize legislative and regulatory activities (Figure) (2).

CKM syndrome is a call for all health care professionals to reinvigorate their zeal for lifestyle modification, judicious prescribing, and patient-centered care for the whole person (3). Nephrologists have more tools than ever to help patients; let's not miss the opportunities.

To learn more about Saving Kidneys, Hearts, and Lives, visit the ASN Excellence in Patient Care website by scanning the QR code. ■

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The authors report no conflicts of interest.

Figure. Goals and activities of Saving Kidneys, Hearts, and Lives



The graphic was created with the assistance of Claude (Anthropic, 2026). All content is original.

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Bridging Knowledge, Empowering Community, and Advancing Care: Glomerular Diseases Collaborative

By Laura Mariani and Christina Silva on behalf of the Glomerular Diseases Collaborative Steering Committee

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Improving care for people living with glomerular diseases (GD) requires more than new therapies. It requires timely diagnosis; practical education; and access to trusted, evidence-based resources. ASN's Glomerular Diseases Collaborative (GD-C) was established in 2024 to promote high-quality care for people living with GD by addressing gaps in knowledge, training, continuing education, and awareness across the spectrum of GD.

The past year marked an important milestone in the evolution of GD-C, demonstrating the value of bringing together clinical experts, professional societies, and industry partners. Through GD-C, ASN also empowered the broader nephrology and medical communities to improve the quality of care for people living with GD.

In May 2025, the inaugural GD-C Industry Roundtable established a forum for collaborative discussion around shared challenges and opportunities to improve care for people living with GD. These conversations reinforced the importance of coordinated efforts to increase awareness, accelerate diagnosis, and improve access to treatment.

Last July, GD-C authored a perspective in *JASN* highlighting the persistent barriers to timely diagnosis and treatment and raising awareness of opportunities to improve care across the nephrology community (1). This editorial examines the administrative, financial, and health-system barriers that can prevent people with GD from accessing specialized treatments and calls for collaborative solutions to improve timely, equitable access to care.

Momentum continued last September when GD-C submitted immunoglobulin A nephropathy (IgAN) as a topic of interest to the ASN Kidney Health Guidance (KHG) Oversight Committee. IgAN will be a topic of focus for an upcoming KHG to be published in *JASN* in 2027.

One of GD-C's most significant achievements in 2025 was the October launch of the Glomerular Diseases Compendium. Designed for busy community nephrologists and primary care professionals, the compendium serves as a central online hub that brings together trusted resources from leading GD experts. It provides streamlined access to clinical guidelines, current evidence and disease-specific information, drug-specific treatment resources, and links to patient education.

Developed by working groups of GD experts and patient advocates from across the country, the compendium is a living resource that is updated as new evidence and therapies emerge. Current chapters include "Recognition to Referral," "Navigating Access to Treatment," "ANCA [Antineutrophil Cytoplasmic Antibody]-Associated Vasculitis," "IgA Nephropathy," and "Lupus Nephritis," with additional topics planned.

The treatment landscape for GD continues to evolve rapidly, making it increasingly important for health care professionals to have access to educational resources that evolve just as quickly. The compendium was intentionally designed as a living resource that is updated to reflect emerging evidence, new therapies, and evolving clinical guidance. While continuing to maintain and update its published chapters, the compendium is broadening its disease portfolio to address additional areas of unmet educational needs to include "C3 Glomerulopathy," "Membranous Nephropathy," "Focal Segmental Glomerulosclerosis and Nephrotic Syndrome," and "APOL1 [Apolipoprotein 1]-Mediated Kidney Disease," with additional disease chapters planned.



To expand awareness of the compendium and broaden its reach across the kidney community, GD-C is building an integrated educational ecosystem. Through short educational videos, podcasts, journal clubs, and other educational offerings, GD-C will deliver timely education on emerging therapies, practical implementation strategies, and disease-specific topics that help health care professionals translate evidence into practice.

Recognizing that earlier identification and timely referral are essential to improving patient outcomes, GD-C is also expanding educational outreach to primary care physicians and health professionals. Through the "Recognition to Referral" chapter of the compendium and discussions during the GD-C Industry Roundtable, ASN is helping strengthen the connections between primary care and nephrology, promoting earlier recognition of GD and more timely referral to specialty care.

Collaboration remains central to GD-C's mission. Through partnerships with GD experts, industry, nonprofit organizations, and patient advocacy groups, GD-C continues to align educational efforts, reduce duplication, and accelerate progress across the field.

The second annual GD-C Industry Roundtable further strengthened these efforts by bringing together members of the GD-C Steering Committee, industry partners, private practice nephrologists, and primary care physicians and health professionals to exchange perspectives, share knowledge, and identify opportunities to amplify existing educational resources and initiatives. The discussions reinforced the value of collaboration across the kidney community and strengthened a shared commitment to advancing care for people at risk for or living with GD.

As the field of GD continues to evolve, GD-C remains committed to delivering trusted educational resources that empower the kidney community and improve the quality of care. Health care professionals are encouraged to explore the compendium and follow its continued expansion as new chapters, educational resources, and implementation tools become available.

To access the compendium and learn more about how GD-C is advancing GD care, please visit the website by scanning the QR code. ■

Laura Mariani, MD, MS, FASN, is chair of the Glomerular Diseases Collaborative (GD-C) Steering Committee and a nephrologist at the University of Michigan, Ann Arbor. Christina Silva, BSN, RN, is the clinical project specialist within the Excellence in Patient Care at ASN and staff lead for GD-C.

Support for GD-C is provided by Calliditas Therapeutics; Novartis Pharmaceuticals Corporation; Otsuka; Travere Therapeutics, Inc.; Vera Therapeutics; and Vertex Pharmaceuticals.

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Building the Future Home Dialysis Workforce: ASN HDU Home Dialysis Scholarship Program

By Jeffrey Perl, Edward Gould, Kerry Leigh, and Joseph Kessler
on behalf of the ASN Home Dialysis Steering Committee

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As the kidney community continues working to expand access to home dialysis, preparing the next generation of nephrologists to confidently deliver high-quality home dialysis care has never been more important.

In 2023, the ASN Home Dialysis Steering Committee examined the state of home dialysis education in nephrology fellowship programs across the United States. Its findings highlighted significant variation in fellows' clinical exposure to home therapies. Only 72% of nephrology fellowship training program directors reported that all graduating fellows could independently provide peritoneal dialysis (PD) care, and just 30% reported the same level of competency for home hemodialysis (HHD) (1). These findings highlighted a critical need for additional educational opportunities to better prepare fellows for independent practice.

To help address this need, ASN partnered with Home Dialysis University (HDU) to launch the ASN HDU Home Dialysis Scholarship Program in 2023. Designed for second- and third-year nephrology fellows, the program bridges the gap between fellowship training and real-world clinical practice.

Attending the in-person HDU and longitudinal virtual courses significantly augmented my understanding of PD and HHD and gave me the skills to provide more nuanced clinical recommendations during my home dialysis rotations as a fellow. By practicing cases and focusing on a specific topic each session, I gained a deeper understanding of these modalities and created a broad set of resources that I can continue to use throughout my career.

–Alessandra Tomasi, MD, Duke University Hospital, Durham, NC

The scholarship combines an intensive 2½-day, in-person HDU course with a year-long virtual learning series. Following the in-person course, fellows participate in 11 interactive, case-based sessions, in which they discuss real patient cases, learn from nationally recognized faculty, and collaborate with peers from across the country.

The curriculum spans the full spectrum of home dialysis care, including shared decision-making around home dialysis, PD, and HHD access; dialysis prescriptions; management of infectious and noninfectious complications; volume management; strategies to improve time on therapy; and development of successful home dialysis programs.

Since its launch, the program has received more than 450 applications and trained 150 fellows from across the United States. ASN awarded scholarships to 70 additional fellows for the 2026/2027 cohort—the program's largest class to date—reflecting both the increasing demand for home dialysis education and the enthusiasm among trainees to pursue expertise in home therapies.

The growing need for training opportunities in home dialysis was further underscored when the Accreditation Council for Graduate Medical Education (ACGME) revised the program requirements for ACGME-accredited nephrology fellowship training programs. ACGME now requires fellows to demonstrate competence in providing patient-centered education on all kidney replacement therapy options—including PD and HHD—as well as competence in the delivery and management of home dialysis therapies. As fellowship training programs work to meet these evolving training expectations, the ASN HDU Home Dialysis Scholarship Program provides a valuable opportunity to supplement clinical training with immersive, longitudinal education focused on developing competency and confidence in home dialysis care.

The program's impact is perhaps best reflected in participant feedback. Fellows consistently report that the curriculum fills an important gap in their training, increases their confidence in caring for patients receiving home dialysis, and better prepares them for independent practice. Many fellows also cite the value of the longitudinal learning format, noting that monthly case discussions allow them to immediately apply new knowledge in clinical practice while receiving guidance from nationally recognized experts.

Equally important, the program fosters lasting professional relationships among faculty leaders and fellows, creating a growing national network of future leaders committed to advancing home dialysis care.

Building on this success, ASN plans to expand the scholarship program beyond fellowship training. Beginning in 2027, the ASN HDU Home Dialysis Scholarship Program will introduce an Early Career Nephrologist Track for physicians within their first 5 years of independent practice.

Although fellowship training provides the clinical foundation for home dialysis care, many early-career nephrologists encounter new challenges as they begin leading home dialysis programs; implementing quality improvement initiatives; and navigating the operational, financial, and leadership responsibilities necessary to sustain successful programs.

The Early Career Nephrologist Track will combine a 2-day advanced HDU course with a 6-session virtual education series focused on advanced clinical management, program development, quality and patient safety, leadership, organizational engagement, and sustainable program growth. Intended for nephrologists who are up to 5 years out of fellowship, the program will select 15 early-career nephrologists to participate in the inaugural cohort, further strengthening the pipeline of physicians prepared to expand access to high-quality home dialysis care.

The ASN HDU Home Dialysis Scholarship Program represents more than an educational initiative; it is an investment in the future of kidney care. By combining immersive learning, longitudinal mentorship, and a growing national community of educators and learners, ASN is helping prepare the next generation of nephrologists to lead innovative, patient-centered home dialysis programs. As graduates enter independent practice and develop home dialysis programs across the country, the impact of this investment will extend well beyond fellowship training, ultimately improving access to high-quality home dialysis care for people living with kidney diseases.

To learn more about the program, visit the ASN HDU webpage by scanning the QR code. ■

ASN HDU in-person course participants, August 2026



Jeffrey Perl, MD, a staff nephrologist at St. Michael's Hospital and associate professor of medicine at the University of Toronto, Ontario, Canada, and Edward Gould, MD, FASN, chief of medicine at the Nashville VA Medical Center and an assistant professor of medicine at Vanderbilt University School of Medicine, Nashville, TN, are cochairs of the ASN Home Dialysis Steering Committee. Kerry Leigh, BSN, RN, and Joseph Kessler, MSN, RN, CPDN, are senior clinical nurse program managers at ASN and staff liaisons to ASN Home Dialysis University.

Support for the ASN HDU Home Dialysis Scholarship Program is provided by Vantive.

The authors report no conflicts of interest.

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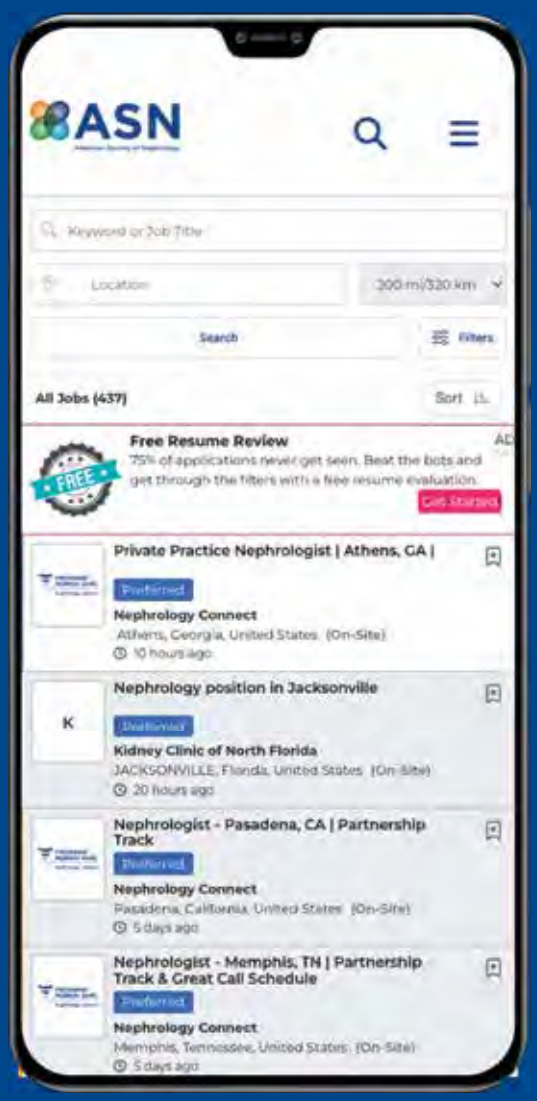
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Fostering Innovative Leaders in Nephrology and Dialysis: Growing Future Generations of Leaders

By Cynthia Delgado, Joseph Kessler, Elizabeth McNamara, and Christina Silva on behalf of the Fostering Innovative Leaders in Nephrology and Dialysis Steering Committee

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ASN launched the Fostering Innovative Leaders in Nephrology and Dialysis (FIND) leadership program in 2025 to cultivate the next generation of leaders who will drive innovation, advance kidney care, and shape the future of nephrology. For the inaugural cohort, ASN selected 11 early-career nephrology professionals from across the United States to participate in a 12-month leadership development experience. Building on its early success, FIND's 2026 cohort expanded to 17 mentees, and the curriculum was enhanced based on feedback from mentees, mentors, and the FIND Steering Committee.

FIND supports ASN's commitment to improving patient-centered kidney care and advancing innovation by developing leadership skills that extend beyond clinical expertise. Drawing on ASN's multidisciplinary membership of more than 20,000 professionals across clinical practice, research, education, policy, and administration, FIND connects emerging leaders with experienced mentors and provides practical leadership training. FIND mentees develop the skills to lead interdisciplinary teams, influence health care delivery, navigate complex challenges, and advance meaningful improvements in kidney care for people living with kidney diseases.

In nephrology, a skills gap exists in leadership training. Leadership skills are increasingly recognized as crucial for health professionals to navigate the complexities of medical care and improve patient outcomes. Yet, to date, traditional medical training does not address leadership, leaving professionals without the needed skills, knowledge, and experience to address real-world challenges (1).

As the complexity of kidney care continues to grow, nephrology professionals need leadership skills that extend beyond clinical expertise. FIND was designed to provide structured leadership development through a comprehensive curriculum that combines personalized mentorship, interactive roundtable discussions with established leaders, self-paced educational modules, and a capstone project, which is used as the vehicle for leadership development. Through these experiences, mentees strengthen their ability to lead interdisciplinary teams, navigate complex health care environments, and drive meaningful change. Capstone projects provide an opportunity to apply these leadership skills while advancing initiatives in quality improvement, innovation, workforce development, and health policy that strengthen kidney health.

A recent FIND graduate highlighted the capstone project as a key contributor to their professional growth, adding that it "provided good exposure to policy navigation around health care."

2025 FIND leadership program participants



FIND moves away from the "on-the-job training" model for leadership, in which only one method of leadership is taught (2). The program intentionally exposes mentees to a variety of leadership styles and perspectives through engagement with accomplished leaders across the nephrology community. In addition to personalized mentorship, FIND fosters meaningful professional connections through interactive roundtable discussions, collaborative learning experiences, and in-person events. Leadership development extends beyond the 12-month program, as FIND alumni remain connected through an expanding network of peers, mentors, future cohorts, and ASN leaders, creating ongoing opportunities for collaboration, mentorship, and professional growth that strengthens the nephrology community.

When asked to reflect on their experience with the program, a FIND graduate stated: "First, the program connected me to a wonderful mentor and provided the structure for us to collaborate on a project. Second, it has been fantastic to get to know so many people in dialysis, both people at a similar career stage and leaders in the field. I particularly think the in-person meeting was critical to solidifying these connections, with our project presentations serving as vehicles for discussion." Another graduate stated, "Honestly, the program is very well structured and executed. The timeline and duration are both adequate, and the frequency of meetings is optimal. In addition, meeting in person was a great opportunity to network."

This year, highlights from the FIND curriculum include:

- Program Introduction and Capstone Project Development Overview
- Strength and Leadership Assessments Reflection
- Leadership Pathways in Action: A Roundtable With Emerging Leaders
- Artificial Intelligence in Nephrology and Research
- Capstone Project Outline Presentations and Leadership Feedback
- Lessons Learned in Leadership: A Roundtable Discussion
- Policy, Quality, and Finance: How Change Happens
- Translating Leadership Principles into Practice (Essential Leadership Qualities, Emotional Intelligence, and Coaching in the Moment)
- Navigating Conflict and Microaggressions
- Networking With Nephrology Leaders and Peers at the Excellence in Patient Care (EPC) Reception During Kidney Week in Denver, CO (optional)
- Capstone Project Presentation and Graduation (Chicago, IL)
- ASN Initiatives and Future Opportunities

Building on lessons learned, mentor and mentee feedback, ongoing curriculum evaluation, and refinements to the mentee selection process, ASN continues to strengthen the program for future FIND cohorts.

One key insight was the value of bringing mentees, mentors, and ASN leaders together early in the program to foster relationships, build professional networks, and establish a foundation for collaboration. As a result, beginning in 2027, the FIND leadership program will hold a kickoff meeting, allowing mentees to connect with mentors and peers in person, beginning their year-long leadership development journey together.

To learn more about the FIND leadership program, please visit the website by scanning the QR code. ■

Cynthia Delgado, MD, FASN, is chair of Fostering Innovative Leaders in Nephrology and Dialysis (FIND) and a nephrologist at the University of California San Francisco. Joseph Kessler, MSN, RN, CPDN, is a senior clinical nurse program manager; Elizabeth McNamara, MN, RN, is a clinical nurse advisor; and Christina Silva, BSN, RN, is the clinical project specialist, all within the Excellence in Patient Care at ASN and are staff coleads for FIND.

Support for FIND is provided by a grant from the National Institute of Diabetes and Digestive and Kidney Diseases in the National Institutes of Health.

The authors report no conflicts of interest.

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Supporting the ASN Humanitarian Kidney Support Program

By Jeffrey Silberzweig, Elizabeth McNamara, Joseph Kessler, and Bonnie Freshly on behalf of the Humanitarian Kidney Support Program Steering Committee

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ASN's Humanitarian Kidney Support Program (HKSP) is dedicated to supporting people living with kidney diseases and kidney health professionals in:

- natural and man-made disaster preparedness and response
- identification of current and emerging threats
- support of and education on sustainable kidney care

HKSP directs ASN's efforts to provide humanitarian support for kidney communities in North America and the Caribbean that have been affected by disasters, biologic threats, and climate and heat-related injury through collaboration, education, and advocacy. To accomplish these goals, the program has three components: 1) Emergency Preparedness and Response (EPR), 2) Current and Emerging Threats (CET), and 3) Sustainability.

EPR

After Hurricanes Irma and Maria in September 2017, ASN provided logistical support to kidney health professionals and people living with kidney diseases in the Caribbean and North America, collaborating with the kidney community and relief organizations. ASN helped provide information (1) about the extent of each emergency (2) and identified open dialysis centers.

Recognizing the certainty of future disasters, ASN formed the Emergency Partnership Initiative, which evolved into the EPR Committee. Additionally, ASN partnered with the European Renal Association (ERA) and the International Society of Nephrology (ISN) to establish the ASN-ERA-ISN Global Humanitarian Kidney Support Initiative. Coordinated by ERA, this effort allows ASN to focus on North America and the Caribbean, ERA to lead efforts in Europe and surrounding countries, and ISN to concentrate on Asia and Middle Eastern countries including Australia and New Zealand.

In 2024, Hurricane Helene caused extensive damage to a Baxter plant in North Carolina that provides most of the peritoneal dialysis fluid used in the United States. ASN produced guidance for the preservation of peritoneal dialysis fluids while avoiding a negative impact on patient care and outcomes.

In 2025, Hurricane Melissa caused extensive damage in Jamaica. ASN connected nephrologists in Jamaica with support via ASN's partnership with Direct Relief, a humanitarian aid organization active in all 50 states and more than 90 countries.

Recent efforts have focused on helping the kidney community prepare for emergencies. ASN has launched a series of podcasts covering topics such as water quality at dialysis facilities during emergencies, a conversation with two nephrologists who were practicing in Jamaica during Hurricane Melissa, and the firsthand account of a medical director who also experienced personal loss during the Tubbs Wildfire in California in 2017. The next podcast will address the role of dialysis facility social workers in helping people with kidney diseases plan for and manage their care during disasters. Through these podcasts, kidney health professionals can learn and better plan for untoward events.

ASN has also developed an online module entitled, "Emergency Preparedness for Dialysis Providers and People Living with Kidney Diseases." This resource includes sections on general preparedness, such as risk assessment, and group-specific guidance for members of the kidney care team, as well as informational cards to be completed and carried by people living with kidney diseases.

CET

ASN CET enhances the quality of life for people living with kidney diseases by engaging nephrologists as team leaders in transformational change that continuously improves patient safety, specifically in the areas of current and emerging bacterial, viral, and fungal threats.

Recent CET efforts include the Multi-Drug Resistant Organisms (MDROs) Compendium, which is designed to help health care professionals better understand risks, testing, infection prevention and control (IPC) precautions, and treatments for MDROs. The first sections include an introduction, general IPC recommendations, and *Candida auris*. Additional chapters will include extended-spectrum beta-lactamase and carbapenem-resistant organisms.

Additionally, CET released frequently asked questions and informational bulletins on Ebola, measles, and resources for people with kidney diseases at risk of or in detention.

Providing quality care to individuals with kidney diseases requires adapting to changing circumstances.

Sustainability

Dialysis care has a large environmental impact that includes water consumption (>450 billion liters annually), energy consumption, greenhouse gas emissions, and massive generation of waste, including plastics like dialyzers and bloodlines (3–9).

The Sustainability Program Committee defines ASN's focus on sustainable nephrology practice and builds on national and international partnerships. For example, ASN has representatives to the ISN Global Environmental Evolution in Nephrology and Kidney Care (Green-K) Steering Committee, whose mission is sustainable kidney care for a healthy planet and healthy kidneys (10).

The Sustainability Program Committee launched its first podcast in September 2026, focusing on why sustainability is important to the nephrology community. In November 2026, the Sustainability program will host a live journal club featuring a discussion of the article, "Sources of Variation in the Carbon Footprint of Hemodialysis Treatment" (7).

Through its EPR Committee, CET Committee, and Sustainability Committee, ASN HKSP is well-positioned to help the kidney community respond to evolving world conditions, now and into the future.

For further details about the HKSP program, please visit the website by scanning the QR code. ■

Jeffrey Silberzweig, MD, FASN, is chair of the Humanitarian Kidney Support Program (HKSP), chief medical officer and vice president for dialysis services at the Rogosin Institute, professor of clinical medicine and associate program director for Internal Medicine Residency and Nephrology Fellowship programs at Weill Cornell, and medical director of hemodialysis at NewYork-Presbyterian Hospital/Weill Cornell and Lower Manhattan Hospitals, New York, NY. Elizabeth McNamara, MN, RN, is a clinical nurse advisor; Joseph Kessler, MSN, RN, CPDN, is a senior clinical nurse program manager; and Bonnie Freshly, MEd, CMP, is a senior project specialist, all within the Excellence in Patient Care at ASN and staff liaisons for HKSP.

The authors report no conflicts of interest.

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Strengthening Community: ASN Home Dialysis Centers of Excellence

By Edward Gould, Kerry Leigh, and Joseph Kessler on behalf of the ASN Centers of Excellence in Home Dialysis Steering Committee

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What does it mean to be "excellent"? ASN's Centers of Excellence (CoE) in Home Dialysis program, launched last year, was established to answer that question, establishing a pathway for recognition of high-quality home dialysis programs while providing a network of like-minded clinicians to help spark innovation.

The overarching goals are simple: Ensure every person is presented with the opportunity for home therapy while enhancing the quality and consistency of home dialysis care through propagation of ideas that improve outcomes and quality of life for people living with kidney failure.

In 2025, the ASN CoE in Home Dialysis Steering Committee introduced a conceptual framework, grounded in a "culture of excellence," with three core pillars that support excellence in home dialysis care:

- Education and Training
- Infrastructure and Care Delivery
- Quality Improvement and Assurance

Centers may possess varying strengths in these individual domains, but these pillars serve as the foundation for development of CoE criteria and reflect the multidisciplinary nature of successful home dialysis programs.

During the past year, the steering committee made significant progress toward launching the ASN Home Dialysis CoE program. Most notably, the committee set out this year to gather opinions on this work from the broader kidney community and—most importantly—the people it serves: individuals receiving dialysis at home.

To better understand the characteristics of high-performing home dialysis programs, ASN conducted nine virtual focus group sessions, including people receiving home dialysis, care partners, nephrologists, nurses, social workers, and administrators. These discussions explored participant experiences with home dialysis, barriers to delivering high-quality care, and opportunities to refine program pillars and, by extension, CoE criteria.

People receiving home dialysis and their care partners offered firsthand perspectives on training and ongoing support. Multidisciplinary care team members highlighted real-world challenges and successful approaches to delivering home dialysis care. The insights gained through these discussions have directly informed development of the program, including highlighting the role of home dialysis programs in advertising the modalities both within and outside of the organization that the program calls home.

To inform development of the application, ASN gathered input from potential applicant programs through an "expression of interest" survey. The survey provided an opportunity for prospective applicants to offer feedback on the scope and purpose of the CoE program, as well as encouraged self-identification of home dialysis programs interested in testing the CoE application process.

Survey responses reflected strong enthusiasm for a structured, collaborative program supporting home dialysis care, interest in sharing ideas and energy across boundaries among large organizations, and investment in the process of building a successful program. Feedback from these home dialysis programs also helped to shape the application materials and the overall implementation process.

ASN looks forward to continuing the conversation with the kidney community during a Town Hall session at Kidney Week 2026. The session will describe the development process, outline the conceptual framework, and seek input from the community that will help inform what the program looks like as it matures.

As development continues, the ASN Home Dialysis CoE program represents an important opportunity to recognize and promote best practices while supporting programs in their pursuit of continuous improvement. Through broad collaboration with the multidisciplinary care team, ASN is working to develop a program that is evidence-informed and stakeholder-driven, advancing high-quality, patient-centered home dialysis care and supporting greater access to home therapies for people living with kidney diseases.

For more information on participating in the Kidney Week 2026 CoE in Home Dialysis Town Hall, scan the QR code. ■

Edward Gould, MD, FASN, chairs the ASN Centers of Excellence in Home Dialysis Steering Committee and is Chief of Medicine at the Nashville VA Hospital and an assistant professor of medicine at Vanderbilt University School of Medicine, Nashville, TN. Kerry Leigh, BSN, RN, and Joseph Kessler, MSN, RN, CPDN, are senior clinical nurse program managers at ASN and staff liaisons to the ASN Centers of Excellence in Home Dialysis Steering Committee.

Support for the ASN Centers of Excellence in Home Dialysis initiative is provided by Vantive.

The authors report no conflicts of interest.

ASN Centers of Excellence in Home Dialysis Steering Committee, 2025



Advancing Vascular Access Education and Training: Transforming Dialysis Access Together

By Vandana Dua Niyyar, Joseph Kessler, and Kerry Leigh on behalf of the Transforming Dialysis Access Together Steering Committee

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Dialysis access is a lifeline for people receiving kidney replacement therapy. Too often, dialysis access turns out to be their greatest vulnerability. While multiple factors contribute to the increased morbidity and mortality associated with dialysis access, variability in training and clinical practice across the kidney community remains a critical—and modifiable—risk factor. ASN launched Transforming Dialysis Access Together (TDAT) to address these gaps through a coordinated, multidisciplinary effort focused on training, education, and collaborative practice improvements.

TDAT aims to enhance the quality of life for people living with kidney failure by putting the patient perspective front and center as well as engaging nephrologists, surgeons, interventionalists, nurses, and technicians as partners to drive meaningful change in dialysis access care. By aligning consensus recommendations, launching educational initiatives, and standardizing training and clinical practice efforts, TDAT brings together stakeholders across the dialysis access community to advance a shared standard of care.

TDAT prioritizes developing a structured framework for dialysis access education to standardize the widely varying approaches found in current nephrology training programs. To address this gap, TDAT developed competency-based recommendations for nephrology fellows that define essential knowledge and skills across multiple domains of practice. These recommendations include understanding access types and indications, performing comprehensive physical examinations, recognizing and managing complications, and interpreting interventional procedures.

The recommendations are designed to be practical and adaptable, with tiered competencies that reflect varying levels of training and institutional resources. This approach provides a consistent educational foundation while allowing flexibility for programs to tailor implementation to local needs. To complement formal training recommendations, TDAT has developed an open-access video education series available through ASN's Excellence in Patient Care platform. These 18 educational modules are designed to support learners across the continuum, from trainees to practicing clinicians, by reinforcing core concepts and practical skills in dialysis access care and aim to provide ongoing support for clinicians seeking to build expertise in dialysis access management.

Recognizing that sustainable change depends on local leadership and expertise, TDAT is advancing a "train-the-trainer" model to support dissemination of dialysis access education across nephrology training programs. For example, TDAT will host regional workshops designed for training program directors and faculty. These sessions will focus on equipping participants with the knowledge, tools, and instructional strategies needed to implement vascular access curricula and lead hands-on training initiatives within their institutions.

This combined approach, which integrates digital learning with in-person faculty development, aims to foster durable adoption of best practices and reduce variability in training experiences across programs. Together, these efforts provide a structured curriculum spanning the full dialysis access life cycle—from access planning and creation to ongoing use, monitoring, complication management, and revision.

Collaboration is central to TDAT. By engaging a broad range of stakeholders—including nephrologists, surgeons, interventionalists, nurses, and patients—the initiative promotes a multidisciplinary model of care that reflects the complexity of dialysis access management.

Through this collaborative framework, TDAT seeks to improve communication, enhance care coordination, and promote shared accountability for patient outcomes. These efforts align with ASN's broader goals to advance patient-centered care and strengthen the nephrology workforce.

TDAT represents a significant step toward advancing dialysis access education and improving care delivery for individuals with kidney failure. By establishing a standardized training framework, expanding access to high-quality educational resources, and supporting faculty development through train-the-trainer initiatives, the program lays the groundwork for sustained improvement across the field.

As the kidney community evolves, TDAT serves as a model for how coordinated, multidisciplinary initiatives can advance training, education, and practice to improve patient outcomes

To view the video education series and learn more about TDAT, please visit the website by scanning the QR code. ■

Vandana Dua Niyyar, MD, FASN, is chair of Transforming Dialysis Access Together (TDAT) and a professor of medicine in the Division of Nephrology at Emory University, Atlanta, GA. Joseph Kessler, MSN, RN, CPDN, and Kerry Leigh, BSN, RN, are senior clinical nurse program managers at ASN and staff liaisons to TDAT.

Support for TDAT is provided by CorMedix Therapeutics.

The authors report no conflicts of interest.

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Through focused discussion and audience engagement, this Exhibitor Spotlight aims to **equip nephrologists, dialysis nurses,** and **allied health professionals** with the knowledge and confidence to translate KDIGO guidance into **meaningful improvements in patient care,** while fostering critical dialogue about future directions in kidney disease management.

OUR ESTEEMED FACULTY WILL COVER THE FOLLOWING TOPICS:



Diagnosis of AKI

Professor Marlies Ostermann
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Medical Management of the AKI Patient

Jay Koyner, MD
University of Chicago Medicine

Director of ICU Nephrology and researcher focused on innovative dialysis therapies



Renal Replacement Therapy Practice Considerations

Pedro Teixeira, MD
University of New Mexico Health Sciences

Clinician, educator, and investigator working to improve critically ill patient outcomes

DATE

Thursday, October 22

TIME

11:30 am-12:15 pm

LOCATION

Theater #2, Exhibit Hall A
Colorado Convention Center
Denver, CO

There is no advance registration or assigned seating. Please come early for the best seats.

Please note: the Exhibitor Spotlight is not a Continuing Education (CE) activity.

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Kidney News Editorial Fellow Shares Experience Contributing a Voice to the Magazine

By Karen Blum

https://doi.org/10.62716/kn.004782026



Annie Liu, DO, MS, MPH

A nephrology fellow with a background in health policy and management, ASN member Annie Liu, DO, MS, MPH, was intrigued by the opportunity to become an editorial fellow for *Kidney News*. As her 2-year fellowship with the newsmagazine wrapped up in June, Liu says the experience working with editorial leaders and planning content was invaluable. Now poised to join *Kidney News'* editorial board in January 2027, Liu—an instructor of medicine at Harvard Medical School and associate physician in nephrology at Mass General Brigham in Boston, MA—talked to us about her time as an editorial fellow.

How did you find out about the editorial fellowship program, and what interested you in applying?

Liu: I was on the mailing list for an ASN newsletter for fellows and had seen the fellowship advertised. A few things caught my attention. I think life is all about timing—my husband and I always say that. I was, at that point, just starting out in my clinical research. I thought that a fellowship with *Kidney News* would give me the opportunity to focus not just on original research articles but also on the policy side. I thought it would also give me the opportunity to really learn and communicate emerging science in a way that was accessible and relevant to the nephrology community.

How was your experience overall?

Liu: It was great! As a nephrology fellow early in my career, I would not have had the opportunity otherwise to regularly encounter so many leaders in nephrology. The other fellows and I had the opportunity to meet with editorial leadership often: Editor-in-Chief Kenar Jhaveri, MD, FASN, and Deputy Editors Sam Kant, MD, FASN, and Prakash Gudsoorkar, MD, FASN. We also interacted with leaders of the other ASN journals and learned about scholarly publishing through monthly didactic sessions. These interactions helped me understand the editorial process and what editors look for when reviewing submissions for publication. That editorial insight has also helped me as a physician-scientist to further my work.

What types of duties did you have during the fellowship?

Liu: Typical responsibilities included monthly meetings with editorial leadership and inviting and reviewing content for the Fellows First column. Our meetings discussed information about upcoming topics, story ideas, and logistical issues. The editorial fellows also ran the Fellows First column. It was a wonderful opportunity because we were in charge of that column, and we had to fill it with articles and authors for upcoming issues. We also reviewed the Fellows First submissions and provided authors with feedback on how to make it more scientific or appropriate for *Kidney News*. This was all under the mentorship of the editorial leadership team.

Besides finding the authors, did you help select the topics they wrote about?

Liu: Yes, we tried to tie each Fellows First topic to the special section theme, if there was one, for that particular issue. Most of the time, the authors came from other nephrology fellowships, so it was great to connect with other programs.

How was the work balance on top of your fellowship responsibilities?

Liu: All of our monthly meetings were virtual, with a time commitment of 30 minutes a month, so it was reasonable, on top of reviewing the articles. We did meet in person during Kidney Week, and it was nice to celebrate the past year.

What was your favorite part?

Liu: It was the autonomy. The editorial fellows of *Kidney News* have the ability to run a column. I didn't do that in college, and so it was great to pick the stories that I found were relevant to the nephrology fellows. Also, we edited the articles for scope, comprehension, and fit, and the authors listened to our feedback and incorporated it. It was great to have a say and a voice at the table.

Was there anything surprising to you or that you did not expect?

Liu: What surprised me was how much work occurs behind the scenes. Before the fellowship, I thought the hardest part was writing the article, because I only saw it from an author perspective. But there is also the editing process, formatting, and then the design and production aspects of it too so that the readership is engaged with our content. All of these steps have to occur after acceptance to get an article to what we see in the print and online versions. It was naive of me to think, "Oh, we just have to write the paper." Seeing the back-end work was an eye-opening experience.

What is your advice to others who are considering the editorial fellowship?

Liu: *Kidney News* has the ability to explore not only scientific innovation but also policy and topics that impact the nephrology community. For anyone considering the editorial fellowship, I would encourage them to apply even if they don't have a traditional editorial background. I didn't come into the fellowship with a strong editorial background, but it gave me a perspective that I wouldn't have gained through my clinical and research training alone. You get to see how topics are identified, how articles are shaped for a broad nephrology audience, and how an editorial team thinks about what is timely and important to the field.

If you enjoy writing, exchanging ideas, and thinking about nephrology beyond one area, I think there is a lot to gain from the experience. As a nephrology fellow, my advice would be as you're encountering the world of nephrology, if there are topics that you want to explore, the *Kidney News* editorial fellowship is the opportunity to do so. You can submit an article for consideration to *Kidney News'* Fellows First to engage with your peers and spread the importance of nephrology to the community.

What is next for you?

Liu: I just finished my first year as a nephrology attending. My research focus is in supportive and palliative care for older adults with kidney failure on chronic dialysis. I hope to continue furthering my research toward becoming an independent physician-scientist and to continue with the editorial process throughout my career. ■

This interview was edited for style.

Want to learn even more about how changes in health care policy, the kidney workforce, and new research will affect you?

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Beyond the Bedside: The Business of Nephrology

By Priscilla Koirala

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NBLU 2026 participants. Photo courtesy of NBLU; used with permission.

As trainees, the emphasis is often placed on patient care, research, and climbing the academic ladder. When I first heard about the Nephrology Business Leadership University (NBLU), I was immediately intrigued. Here was a program designed to give aspiring nephrologists the opportunity to learn about private practice and the business of medicine, an entire side of our profession that is often absent from academic training.

I recently had the opportunity to participate in NBLU, held in Plano, TX, in August. We learned about topics rarely discussed during traditional medical training, including how to start and grow a private practice, practice management, joint ventures, coding and billing, physician compensation, and health policy and advocacy. We also heard directly from practicing nephrologists and practice leaders about career opportunities, practice ownership, and realities of building a career outside of academic medicine.

Throughout the program, patient care remained at the center of every discussion. At the same time, NBLU acknowledged an important reality: Physicians should understand the value of the care they provide and how that care is compensated. I realized that while becoming an excellent clinician is essential, understanding the business of medicine is also important to building a sustainable career. These were lessons I was never formally taught in medical school, residency, or even fellowship, but NBLU created a space to have these conversations openly and practically.

The course culminated in a "Shark Tank"–style presentation, in which we were tasked with building a private nephrology practice from the ground up. In teams, we developed a practice model addressing our patient population, marketing strategy, reimbursement and physician compensation, practice operations, and long-term growth. The exercise challenged us to think beyond our roles as clinicians and begin thinking as future practice leaders.

Equally valuable were the mentorship and networking opportunities that developed throughout the program. Speaking candidly with nephrologists who had built and led successful practices offered invaluable insight into their experiences, lessons learned, and approaches to navigating a career in nephrology. We also had the opportunity to learn from an expert panel of prominent leaders in nephrology, including ASN President-Elect Crystal A. Gadegbeku, MD, FASN; National Kidney Foundation President Kirk Campbell, MD; and Renal Physicians Association President Gary Singer, MD, FASN. These conversations allowed us to ask practical questions about our careers and learn alongside fellows from across the country who were navigating many of the same decisions.

NBLU filled a gap in my training that I did not fully appreciate until I attended. Fellowship prepares us extensively to care for people living with kidney diseases, but preparing for the next generation of nephrologists should extend beyond the clinical knowledge alone. Understanding how practices operate, how our work is valued, and how to navigate the business of medicine can make us more informed physicians and future leaders. These concepts deserve a greater role in nephrology fellowship education. ■

Priscilla Koirala, MD, is a nephrology fellow at Columbia University Irving Medical Center, New York, NY, and an editorial fellow with ASN Kidney News.

The author reports no conflicts of interest.

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Protect the Line with DefenCath® (taurolidine and heparin) catheter lock solution



- First and only FDA-approved catheter lock solution (CLS) proven to significantly reduce the incidence of catheter-related bloodstream infections (CRBSIs) by 71%[1,2] (95% CI [38%, 86%], log-rank p=0.0006) in adult patients with kidney failure receiving chronic hemodialysis (HD) through a central venous catheters (CVC)[1]
- When instilled into the catheter, DefenCath protects the entire length of the lumen, with broad spectrum activity and no known antimicrobial resistance[1,2,3]*

* The following *in vitro* data are available, but their clinical significance is unknown. Taurolidine has been shown to be active against most isolates of the following microorganisms[1]: gram-positive bacteria (*Staphylococcus aureus* [including methicillin-sensitive *Staphylococcus aureus* (MSSA) and methicillin-resistant *Staphylococcus aureus* (MRSA)], *Staphylococcus epidermidis*, and *Enterococcus faecalis*); gram-negative bacteria (*Escherichia coli, Klebsiella pneumoniae, Pseudomonas aeruginosa,* and *Serratia marcescens*); and fungi (*Candida albicans, Candida glabrata,* and *Candida auris* [*Candida auris in vitro* data were not submitted and reviewed by the FDA]). No known antimicrobial resistance.

INDICATIONS AND USAGE[1]
LIMITED POPULATION: DefenCath is indicated to reduce the incidence of catheter-related bloodstream infections (CRBSI) in adult patients with kidney failure receiving chronic hemodialysis (HD) through a central venous catheter (CVC). This drug is indicated for use in a limited and specific population of patients.

Limitations of Use
The safety and effectiveness of DefenCath have not been established for use in populations other than adult patients with kidney failure receiving chronic HD through a CVC.

DEFENCATH®
Taurolidine and Heparin Catheter Lock Solution
Limited Population

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

DefenCath is contraindicated in patients with:

- Known-induced thrombocytopenia (HIT).
- Known hy heparinpersensitivity to taurolidine, heparin, or the citrate excipient (components of DefenCath), or pork products.

WARNINGS AND PRECAUTIONS

- **Heparin-Induced Thrombocytopenia (HIT):** HIT was reported in patients using heparin, a component of DefenCath, as a catheter lock solution. If HIT occurs, discontinue DefenCath and institute appropriate supportive measures.
- **Drug Hypersensitivity:** Drug hypersensitivity reactions have been reported. If a hypersensitivity reaction occurs, discontinue DefenCath and institute appropriate supportive measures.

ADVERSE REACTIONS

The most frequently reported adverse reactions occurring in ≥2% of patients using DefenCath as a CLS were hemodialysis catheter malfunction, hemorrhage/bleeding, nausea, vomiting, dizziness, musculoskeletal chest pain, and thrombocytopenia.

To report SUSPECTED ADVERSE REACTIONS, contact CorMedix Inc at 1-844-424-6345 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

INDICATIONS AND USAGE

LIMITED POPULATION: DefenCath® is indicated to reduce the incidence of catheter-related bloodstream infections (CRBSI) in adult patients with kidney failure receiving chronic hemodialysis (HD) through a central venous catheter (CVC). This drug is indicated for use in a limited and specific population of patients.

Limitations of Use
The safety and effectiveness of DefenCath have not been established for use in populations other than adult patients with kidney failure receiving chronic HD through a CVC.

Please see the Brief Summary of Prescribing Information on following page.

Reference 1. DefenCath® (taurolidine and heparin) catheter lock solution Prescribing Information, CorMedix, Berkeley Heights, New Jersey. **2.** Agarwal AK, Roy-Chaudhury P, Mounts P, Hurlburt E, Pfaffle A, Poggio EC. Taurolidine/heparin lock solution and catheter-related bloodstream infection in hemodialysis: a randomized, double-blind, active-control, phase 3 study. *Clin J Am Soc Nephrol.* 2023;18(11):1446-1455. **3.** Reidenberg BE, Jenkins SG, Crandon JL, *et al.* In vitro activity of taurolidine against clinical Candida auris isolates: relevance to catheter-related bloodstream infections. *Antimicrob Agents Chemother.* 2024;68(7):e0038124.

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BRIEF SUMMARY OF PRESCRIBING INFORMATION
This Brief Summary does not include all the information needed to use DEFENCATH safely and effectively. See full prescribing information for DEFENCATH.

DEFENCATH (taurolidine and heparin) catheter lock solution

1 INDICATIONS AND USAGE

LIMITED POPULATION: DEFENCATH® is indicated to reduce the incidence of catheter-related bloodstream infections (CRBSI) in adult patients with kidney failure receiving chronic hemodialysis (HD) through a central venous catheter (CVC). This drug is indicated for use in a limited and specific population of patients [*see Clinical Studies (14)*].

Limitations of Use
The safety and effectiveness of DEFENCATH have not been established for use in populations other than adult patients with kidney failure receiving chronic HD through a CVC.

4 CONTRAINDICATIONS

DEFENCATH is contraindicated in patients with:
• Known heparin-induced thrombocytopenia (HIT) [*see Warnings and Precautions (5.1*)].
• Known hypersensitivity to taurolidine, heparin or the citrate excipient (components of DEFENCATH) or pork products [*see Warnings and Precautions (5.2*)].

5 WARNINGS AND PRECAUTIONS

5.1 Heparin-Induced Thrombocytopenia
Heparin-induced thrombocytopenia (HIT) was reported at an incidence rate of 0.3% in Trial 1 in patients using heparin, a component of DEFENCATH, as a CLS. If HIT occurs, discontinue DEFENCATH and institute appropriate supportive measures [*see Contraindications (4*)].

5.2 Drug Hypersensitivity
Drug hypersensitivity reactions were reported at an incidence rate of 0.5% in Trial 1 in patients using heparin, a component of DEFENCATH, as a CLS. If a hypersensitivity reaction occurs, discontinue DEFENCATH and institute appropriate supportive measures [*see Contraindications (4*)].

6. ADVERSE REACTIONS
The following clinically significant adverse reactions are described elsewhere in the labeling:
• Heparin-Induced Thrombocytopenia [see Warnings and Precautions (5.1)]
• Drug Hypersensitivity [*see Warnings and Precautions (5.2*)]

6.1 Clinical Trials Experience
Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

Overview of the Safety Evaluation of DEFENCATH
The safety of DEFENCATH was evaluated in a single, active-controlled, double-blind, randomized Phase 3 trial, LOCK-IT-100 (referred to as Trial 1), in adult patients with kidney failure receiving chronic HD through a CVC. In Trial 1, the safety population was comprised of 797 patients with 398 patients using DEFENCATH as a CLS and 399 using heparin as a CLS. Patients used DEFENCATH as a CLS for a mean duration of 173 days, and a range of 4 to 863 days.

The mean age of the patients in Trial 1 was 61 years, 58% of patients identified as male (42% patients identified as female), 63% of patients identified as White and 30% identified as Black or African American. Patients with diabetes at baseline accounted for 70% of patients and the mean body mass index (BMI) of patients in the study was 30. The majority of patients (68%) had been receiving HD for 12 months or less. The location of the CVC was the jugular vein in 92% of patients.

Serious Adverse Reactions and Adverse Reactions Leading to Discontinuation
In Trial 1, serious adverse reactions occurred in 40% (159/398) of patients receiving DEFENCATH as a CLS and 42% (167/399) of patients receiving heparin as a CLS. Adverse reactions leading to death occurred in 5% (18/398) of patients in the DEFENCATH arm and 5% (21/399) of patients in the heparin arm.
Adverse reactions leading to discontinuation of study drug occurred in 17% (69/398) of patients in the DEFENCATH arm and 18% (72/399) of patients in the heparin arm.

Common Adverse Reactions
In Trial 1, adverse reactions were reported in 79% (314/398) of patients using DEFENCATH as a CLS and 79% (315/399) of patients using heparin.

Table 1 lists selected adverse reactions occurring in ≥2% of patients using DEFENCATH or heparin in Trial 1.

Table 1: Selected Adverse Reactions Occurring in Greater Than or Equal to 2% of Patients Receiving DEFENCATH in Trial

Adverse Reactions	**DEFENCATH** (N=398) N (%)	**Heparin** (N=399) N (%)
Product Issues		
Hemodialysis catheter malfunction[a]	68 (17)	47 (12)
Blood and lymphatic system disorders		
Hemorrhage/bleeding[b]	27 (7)	34 (9)
Thrombocytopenia	7 (2)	4 (1)
Gastrointestinal disorders		
Nausea[c]	28 (7)	44 (11)
Vomiting[d]	24 (6)	32 (8)
Nervous system disorders		
Dizziness	22 (6)	16 (4)
Musculoskeletal and Connective Tissue Disorders		
Musculoskeletal chest pain[e]	11 (3)	7 (2)

[a] Grouped term includes device malfunction
[b] Grouped term includes: hematoma/hemorrhage, intracranial hemorrhage, arteriovenous graft or fistula site hemorrhage, catheter site hematoma/hemorrhage, cerebral/cerebellar hemorrhage, eye/conjunctival hemorrhage, gastrointestinal hemorrhage, hematuria, hemobilia, hemoptysis, renal hematoma, vaginal/uterine hemorrhage
[c] Grouped term includes nausea and procedural nausea
[d] Grouped term includes vomiting and procedural vomiting
[e] Grouped term Includes non-cardiac chest pain, musculoskeletal chest pain, chest discomfort

Table 2 lists the proportion of patients in Trial 1 that developed loss of catheter patency defined as requiring use of a thrombolytic agent to resolve catheter thrombosis or removal of the catheter due to malfunction/dysfunction.

Table 2: Loss of Catheter Patency in Trial 1

	DEFENCATH (N=398) N (%)	**Heparin** (N=399) N (%)
Loss of Catheter Patency	63 (16)	48 (12)
Use of a Thrombolytic Agent[a]	46 (12)	33 (8)
Catheter Removal[b]	28 (7)	26 (7)
Catheter Removal without Thrombolytic Agent Use	17 (4)	15 (4)

[a] 11 subjects in each arm had catheter removal following thrombolytic agent use and are included under both categories of use of a thrombolytic agent and catheter removal.
[b] Catheter removal refers to catheters removed due to loss of catheter patency. Overall, a total of 236 patients in the DEFENCATH arm and 225 patients in the heparin arm had a catheter removal for any reason, including loss of catheter patency.

Other Adverse Reactions
Clinically significant adverse reactions that occurred in fewer than 1% of patients receiving DEFENCATH in Trial 1 are listed below:

Metabolism and Nutrition Disorders: Hypocalcemia
Nervous System Disorders: Dysgeusia

6.2 Postmarketing Experience
The following adverse reaction has been identified during the use of a taurolidine and heparin containing CLS outside of the United States. Because this reaction is reported from a population of uncertain size, it is not always possible to reliably estimate its frequency or establish a causal relationship to drug exposure.

Nervous System Disorders: Paresthesia

8. USE IN SPECIFIC POPULATIONS

8.1 Pregnancy
Risk Summary
DEFENCATH is not intended for systemic administration. It is intended for use as a CLS in patients with kidney failure requiring chronic HD; therefore, maternal use is not expected to result in fetal exposure to the drug [*see Dosage and Administration (2*)]. No animal reproduction study was conducted with DEFENCATH.

8.2 Lactation
Risk Summary
DEFENCATH is not intended for systemic administration. It is intended for use as a CLS in patients with kidney failure requiring chronic HD; therefore, breastfeeding is not expected to result in exposure of the infant to DEFENCATH [*see Dosage and Administration (2*)].

8.4 Pediatric Use
The safety and effectiveness of DEFENCATH have not been established in pediatric patients. There are no available data on DEFENCATH use in pediatric patients.

8.5 Geriatric Use
There were 327 patients 65 years of age and older in Trial 1 [see Clinical Studies (14)]. Of the total number of patients using DEFENCATH in this study, 162 (41%) were 65 years of age and older, while 64 (16%) were 75 years of age and older. No overall differences in safety or effectiveness were observed between patients 65 years of age and older and younger adult patients.

Manufactured for:
CorMedix Inc.
300 Connell Drive, Suite 4200
Berkeley Heights, NJ 07922

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A Better Blood Gas but Not a Better Outcome: Rethinking Bicarbonate in the ICU

By Luis Sette

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It is 2 a.m., and the intensive care unit (ICU) pages you about an intubated patient in septic shock requiring two vasopressors. The arterial blood gas test reveals that the pH is 7.22, the serum bicarbonate is 15 mmol/L, and the partial pressure of carbon dioxide ($PaCO_2$) is 31 mm Hg. The patient is producing urine with no urgent indication for kidney replacement therapy (KRT), but the ICU staff's question is simple: "Should we start intravenous sodium bicarbonate?"

The physiologic rationale is appealing. Acidemia can impair myocardial contractility and catecholamine responsiveness, so correcting the pH might improve hemodynamics and prevent kidney injury. The recent Sodium Bicarbonate for Metabolic Acidosis in the ICU (SODa-BIC) study (NCT05697770) evaluated whether the physiologic rationale translates into better clinical outcomes (1).

This pragmatic, adaptive, double-blind randomized trial enrolled 500 adults receiving vasopressors across 55 ICUs in 7 countries. Metabolic acidosis was defined as a pH less than 7.30, a base excess of –4 mmol/L or less, and a $PaCO_2$ of 45 mm Hg or less in patients who were not intubated or 50 mm Hg or less in patients who were intubated. People with chronic kidney disease stages G4–G5, current or planned KRT, diabetic ketoacidosis, major bicarbonate losses, or another clear indication for bicarbonate were excluded.

Participants received either sodium bicarbonate diluted in 5% dextrose to a final concentration of 600 mmol/L or 5% dextrose alone (placebo). Infusion began at 100 mL/hour and was adjusted based on blood gas results at 1 and 3 hours, targeting a pH of 7.30 or more and a base excess of 0 mmol/L or more. The intervention ended after 5 hours; subsequent open-label bicarbonate was left to the treating team.

The primary outcome was 30-day major adverse kidney events (MAKE30): death, KRT, or persistent kidney dysfunction within 30 days. Among 498 patients in the modified intention-to-treat analysis, MAKE30 occurred in 40.2% of the bicarbonate group and 39.4% of the placebo group (adjusted difference, 1.2 percentage points [95% confidence interval, –7.1 to 9.4]; p = 0.78). In the bicarbonate group versus the placebo group, KRT occurred in 16.8% versus 20.9%, and 30-day in-hospital mortality occurred in 25.4% versus 24.0%; neither difference was significant. No clinically meaningful differences in adverse events were observed between groups.

These results add important context to the BICAR-ICU (NCT02476253) (2) and BICARICU-2 (NCT04010630) (3) studies (Table). BICAR-ICU found no overall benefit but suggested lower mortality and less KRT among people with stages 2–3 acute kidney injury (AKI) (2). Comparing the bicarbonate group with the control group, BICARICU-2 found no reduction in 90-day mortality—62.1% versus 61.7%—but KRT use fell from 50% (control group) to 35% (bicarbonate group) (3). Both trials were open-label, and pH was part of the decision to initiate KRT, raising the possibility that knowledge of treatment assignment influenced this outcome. The SODa-BIC trial's blinded, placebo-controlled design reduces that bias. Although it enrolled a less acidemic population (median pH, 7.26 versus approximately 7.15 in BICARICU-2), this was an intentional design choice (1, 3). The investigators sought to study patients at the stage when clinicians are most likely to consider bicarbonate therapy in routine ICU practice, making the findings particularly relevant to everyday decision-making. An important limitation, however, is that KRT initiation was not protocolized, and the criteria used by treating teams were not reported, making the KRT component of MAKE30 more difficult to interpret.

These findings do not suggest that bicarbonate should never be used. In people with a pH of 7.20 or less and Kidney Disease: Improving Global Outcomes (KDIGO) AKI stages 2–3, prior trials suggest that bicarbonate may reduce or delay KRT, although a survival benefit remains unproven. In contrast, SODa-BIC found no benefit from routine bicarbonate use in less-severe acidemia, reinforcing that the threshold and clinical context should drive the decision (1).

So, when the ICU calls again to ask, "Should we administer bicarbonate?" the answer should integrate the severity of acidemia, AKI stage, the cause of acidosis, and the patient's trajectory. In practice, the blood gas matters—but correcting it does not necessarily improve the outcome. ■

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Table. Differences in major bicarbonate trials

Trial	Population and design	Intervention	Primary outcome	Key finding
BICAR-ICU (2)	389 Patients in the ICU; pH ≤7.20; open-label RCT; 47% with AKIN stages 2–3	4.2% Bicarbonate targeting pH ≥7.30 versus no bicarbonate	Death by day 28 or organ failure at day 7	In the overall population: no difference in the composite outcome of 28-day mortality (66% versus 71%); in AKIN stages 2–3: 28-day mortality: 46% versus 63%; KRT use: 51% versus 73%
BICARICU-2 (3)	627 Analyzed patients; pH ≤7.20 plus KDIGO AKI stages 2–3; open-label RCT	4.2% Bicarbonate targeting pH ≥7.30 versus no bicarbonate	90-Day mortality	No difference in 90-day mortality (62.1% versus 61.7%); KRT use: 35% versus 50%; absolute difference: –15.5 percentage points
SODa-BIC (1)	498 Analyzed patients receiving vasopressors; pH <7.30; double-blind placebo-controlled RCT	Bicarbonate 600 mmol/L in D5W for up to 5 hours versus D5W	MAKE30	No difference in MAKE30 (40.2% versus 39.4%); no difference in KRT use (16.8% versus 20.9%)

AKIN, Acute Kidney Injury Network; D5W, dextrose 5% in water; RCT, randomized controlled trial.

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Intravenous Bicarbonate for Metabolic Acidosis in the ICU: Improving Outcomes or Just Fixing Numbers?

By J. Pedro Teixeira, Lenar Yessayan, and Ashita Tolwani

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To give or not to give intravenous bicarbonate for patients who are critically ill with metabolic acidosis? That question has challenged nephrologists and intensivists for decades and has resulted in wide practice variation (1–3). Metabolic acidosis is associated with higher mortality and several adverse physiologic effects. These include impaired catecholamine responsiveness, myocardial depression, increased respiratory workload and pulmonary vascular resistance, renal hypoperfusion, and neurologic dysfunction (4–6). However, an association between acidemia and adverse outcomes does not establish that correcting the pH with exogenous bicarbonate will improve organ function or survival. Furthermore, bicarbonate administration is not without potential adverse effects. It increases carbon dioxide generation, which may lead to hypercapnia in patients unable to adequately increase alveolar ventilation, and may also cause sodium and volume loading, hypernatremia, hypokalemia, and reduced ionized calcium, as well as more theoretical concerns such as impaired oxygen unloading from hemoglobin and transient intracellular acidosis, the clinical significance of which remains uncertain (5, 7). Thus, traditionally, clinicians needed to balance plausible physiologic benefits against equally plausible adverse effects while relying on surprisingly limited randomized evidence.

The modern evidence base began with the BICAR-ICU trial (NCT02476253), which found no improvement in its primary composite outcome among patients with severe metabolic acidemia. Nevertheless, the trial generated considerable enthusiasm because bicarbonate therapy reduced the use of kidney replacement therapy (KRT) and appeared to improve survival in the prespecified subgroup of people with stages 2–3 acute kidney injury (AKI) (4). BICARICU-2 (NCT04010630) subsequently enrolled only people with severe metabolic acidemia and stages 2–3 AKI. Although 90-day mortality was unchanged, bicarbonate therapy again reduced KRT initiation, strengthening the evidence that its principal benefit may lie in reducing or delaying dialysis rather than improving survival (6). On the basis of this evidence, the 2026 Surviving Sepsis Campaign suggests use of bicarbonate therapy in people with septic shock, severe acidemia (pH <7.2), and stages 2–3 AKI, albeit as a conditional recommendation supported by very low-certainty evidence (8).

The more recent completed trial, SODa-BIC (NCT05697770), adds an important new perspective (9). Unlike its predecessors, it used a pragmatic, adaptive, double-blind placebo-controlled design, thereby minimizing the bias inherent to open-label trials. Adults receiving vasopressors with metabolic acidosis (pH <7.30 and base excess ≤−4 mmol/L) were randomized to protocolized infusions of 5% sodium bicarbonate or 5% dextrose for up to 5 hours. The infusion was adjusted to achieve a pH of 7.30 or more and a base excess of 0 mmol/L or more. Despite its more rigorous design, 5% sodium bicarbonate did not improve the primary endpoint of 30-day major adverse kidney events (MAKE30), a composite of death, KRT use, and persistent doubling of serum creatinine. Although none of the individual components differed significantly, the strongest signal of benefit was a lower rate of KRT use within 30 days (16.8% versus 20.9%). In a subgroup analysis of the 99 people with stages 2–3 AKI at baseline, bicarbonate therapy was also associated with lower 30-day in-hospital mortality, but this finding should be interpreted cautiously given the exploratory nature and limited sample size.

Where do the results of SODa-BIC leave us? The neutral primary outcome accompanied by a possible reduction in KRT initiation is unlikely to resolve the debate. Nevertheless, several conclusions can be drawn. The three trials provide little evidence that routine bicarbonate

Table. Multicenter randomized controlled trials of intravenous sodium bicarbonate use for metabolic acidosis in intensive care

Trial component	BICAR-ICU (4)	BICARICU-2 (6)	SODa-BIC (9)	MOSAICC	ESCALATE
N	389[a]	627[a]	498[a]	1672 (target)[b]	660 (target)[c]
Trial status	Published, 2018	Published, 2025	Published, 2026	Recruiting; completion expected 2027	Not yet recruiting
Registration	NCT02476253	NCT04010630	NCT05697770	ISRCTN14027629	NCT07464431
Setting	26 ICUs in France, 2015–2017	43 ICUs in France, 2019–2023	55 ICUs in 7 countries, 2023–2025	UK multicenter trial; recruitment began 2022	Multicenter trial in Germany
Acid-base criteria	pH ≤7.20, $PaCO_2$ ≤45 mm Hg, and serum bicarbonate ≤20 mmol/L	pH ≤7.20, $PaCO_2$ ≤45 mm Hg, and serum bicarbonate ≤20 mmol/L	pH <7.30, BE ≤−4 mEq/L, and $PaCO_2$ ≤45 mm Hg if not intubated or ≤50 mm Hg if intubated	pH <7.30 and $PaCO_2$ <49 mm Hg	pH ≤7.25, $PaCO_2$ <49 mm Hg, BE <−2 mEq/L, and serum bicarbonate ≤20 mmol/L
Other inclusion criteria	SOFA score ≥4 or serum lactate ≥2.0 mmol/L	BICAR-ICU severity criteria + stages 2–3 AKI	Continuous vasopressor infusion for <48 h	Stages 2–3 AKI at any time during ICU stay	Stages 2–3 AKI
Blinding	Open-label	Open-label	Double-blinded	Open-label	Double-blinded
Formulation, dose, and duration of $NaHCO_3$	4.2% (500 mEq/L) $NaHCO_3$ 125–250 mL at a time over 30 min, up to 1 L/d, until ICU discharge or day 28	4.2% (500 mEq/L) $NaHCO_3$ 125–250 mL at a time over 30 min, up to 1 L/d, until ICU discharge or day 28	5% (600 mEq/L) $NaHCO_3$ (or 5% dextrose) via single protocol-adjusted infusion for up to 5 h	8.4% (1000 mEq/L) $NaHCO_3$ 50 mL at a time over 30–60 min, up to 0.5 L/d, until ICU discharge, KRT initiation, or day 90	8.4% (1000 mEq/L) $NaHCO_3$ (or balanced crystalloid solution) via protocol-adjusted infusion for ≥5 h
Treatment target	pH ≥7.30	pH ≥7.30	pH >7.35 and BE >0 mmol/L	pH ≥7.30	pH 7.30–7.35 and BE >0 mmol/L
KRT initiation criteria	Protocolized	Protocolized	Clinician-determined; not protocolized	Clinician-determined	Clinician-determined; not protocolized
Primary endpoint: $NaHCO_3$ versus control arm	Composite of 28-day all-cause mortality or ≥1 organ failure at day 7: 66% versus 71% (NS)	90-Day all-cause mortality: 62.1% versus 61.7% (NS)	MAKE30: 40.2% versus 39.4%; adjusted difference, 1.2 percentage points (95% CI, −7.1 to 9.4)	90-Day all-cause mortality: results pending	MAKE90: results pending
Key secondary or exploratory findings	In the overall population: KRT use in ICU: 35% versus 52% (p = 0.0009); in AKIN stages 2–3: 28-day mortality: 46% versus 63% (p = 0.028)	KRT use by day 28: 35% versus 50% (difference, −15.5 percentage points; 95% CI, −23.1 to −7.8)	KRT use within 30 days: 16.8% versus 20.9% (adjusted difference, −3.9 percentage points; 95% CI, −10.6 to 2.7); exploratory stages 2–3 AKI subgroup mortality: 15.1% versus 37.0%	Results pending	Results pending

Excludes trials of sodium bicarbonate use in cardiac arrest.
BE, base excess; BICAR-ICU, Sodium Bicarbonate to Treat Severe Acidosis in the Critically Ill; BICARICU-2, Sodium Bicarbonate for the Treatment of Severe Metabolic Acidosis With Moderate or Severe Acute Kidney Injury in ICU; CI, confidence interval; ESCALATE, Evaluating the Clinical Effectiveness of Sodium Bicarbonate for Critically Ill Patients With Metabolic Acidosis and Acute Kidney Injury; MAKE90, major adverse kidney events at day 90; MOSAICC, Multicentre Evaluation of Sodium Bicarbonate in Acute Kidney Injury in Critical Care; $NaHCO_3$, sodium bicarbonate; NS, not significant; $PaCO_2$, partial pressure of carbon dioxide in arterial blood; SODa-BIC, Sodium Bicarbonate for Metabolic Acidosis in the ICU; SOFA, Sequential Organ Failure Assessment.
[a]Participants included in the primary analysis.
[b]Original target enrollment of 2250 was revised to 1672 in protocol, version 6.0 (ISRCTN14027629).
[c]Estimated study start was May 2026 (NCT07464431).

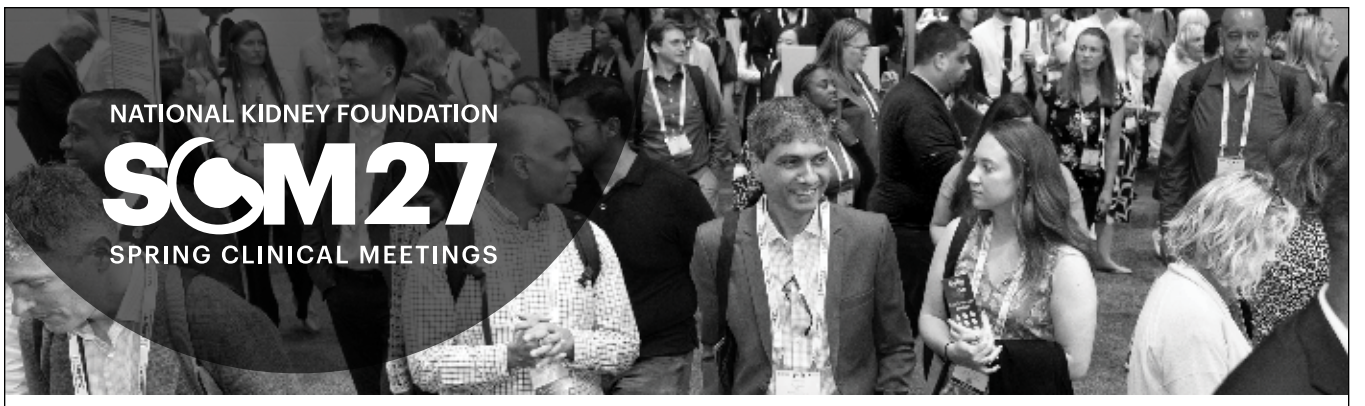
administration improves survival in the intensive care unit (ICU) populations studied. However, they also provide little useful evidence for patients with extreme acidemia, such as a pH of 7.10 or less, in whom bicarbonate may still be used as a temporizing intervention while the underlying cause is treated. Although not without risk, the low rates of adverse effects across these trials suggest that intravenous bicarbonate, particularly when administered as a protocolized continuous infusion (10), is generally well tolerated. However, SODa-BIC excluded several patients at heightened risk of sodium, volume, or electrolyte complications, including those with advanced chronic kidney disease, severe dysnatremia, hypokalemia, hypocalcemia, severe pulmonary edema, or risk of cerebral edema. Therefore, its safety findings should not be extrapolated indiscriminately to these higher-risk populations. Perhaps the most consistent signal across the available trials has been a reduction, or at least a trend toward reduction, in KRT initiation, an outcome highly relevant to patients and health care systems. Ongoing trials should help determine whether bicarbonate meaningfully reduces the need for KRT and whether any benefit is concentrated among patients with severe AKI or more profound acidemia (Table). Until then, bicarbonate can reliably correct metabolic acidosis, but whether correcting acidemia improves outcomes remains uncertain. ■

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Dr. Teixeira reports receiving consulting fees from Mallinckrodt, Outset Medical, Talphera, and Vantive and having ownership of publicly available stock and/or stock options in Eli Lilly, Novo Nordisk A/S, and Pfizer. Dr. Yessayan reports receiving consulting fees from Vantive and serving on the Medical Advisory Board for Fresenius Medical Care. Dr. Tolwani reports serving on a Speakers Bureau for and receiving consulting fees from Baxter/Vantive, having a patent on a 0.5% trisodium citrate solution for continuous KRT anticoagulation (the license has been bought by Baxter), and serving on the Scientific Advisory Board for SeaStar Medical.

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Goodbye, Fax? ASN and HHS-ONC Collaborate to Improve Kidney Care Data Interoperability and Sharing

By Bridget M. Kuehn

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Morgan Reid's experience as a patient advocate and government affairs specialist, who is focused on kidney transplantation, has helped her understand the challenges that poor communication and data transfer create for patients. Reid, MS, was diagnosed with immunoglobulin A nephropathy at aged 18 years, spent 2 years undergoing peritoneal dialysis, and has lived with a kidney allograft donated by her college best friend for 19 years.

"There is a lot of onus that falls on the patient to make sure they have their health information and to communicate that to each stakeholder in the process," said Reid, who shared her experience during the ASN and US Department of Health and Human Services Office of the National Coordinator for Health Information Technology's (HHS-ONC's) Kidney Data Discovery Series in September. "It's a burden," she added.

The series is part of a joint effort by ASN and HHS-ONC to improve information sharing in kidney care by strengthening data standards and interoperability. Speakers at two webcasts and an in-person workshop shared the day-to-day frustrations that patients, social workers, nephrologists, and transplant surgeons face in trying to share vital health information about patients as they move throughout the kidney care ecosystem from chronic kidney disease (CKD) to dialysis and transplant. Despite the large amount of data collected and stored in electronic records systems, clinicians noted that they often rely on telephone calls, facsimiles (or faxes), and manually re-entering data shared via Portable Document Formats (or PDFs).

"The goal is not interoperability for interoperability's sake; it's better care, better decisions, less burden, and a system that works more effectively for the people who depend upon it," explained Stephen Konya, chief of innovation and strategic partnerships at HHS-ONC, during the transplant-focused webcast. Konya noted that the lack of standardized longitudinal information also hinders innovation, research, and evidence-based policy-making about how to increase access to transplant and improve the system.

Transplant journeys

Konya noted that data sharing in the transplant ecosystem is particularly complex. He explained that data must follow the recipients' journey from referral and evaluation through waitlisting, organ offer, transplantation, and long-term post-transplant care. It must also follow a living donor's journey from initial interest and evaluation to donation and follow-up or the journey of an organ from a deceased donor—from identification of a potential donor, evaluation and donor management, organ recovery, allocation, transportation, and eventually transplantation. "Some of those information exchanges have to happen not simply accurately but very quickly," Konya said.

For example, David Axelrod, MD, a transplant surgeon and vice chair of the Department of Surgery at University Hospitals in Cleveland, OH, explained that 2 a.m. organ offers may provide limited organ data, requiring him to dig through PDFs or imaging on DonorNet in the middle of the night for more information. Then, he must look for a suitable candidate recipient using his health system's electronic medical records system and may find, at the last minute, that an individual who he thought might be a good candidate had a heart attack 2 days before and is not currently eligible.

"We've delayed allocation for 30 to 60 minutes, and then we might have to call two or three people on the waiting list," Axelrod explained. He noted that with better data systems, it might be possible to send a detailed message to the prospective allograft recipient's cell phone with all of the information they need to assess the offer quickly.

Improving the system could benefit all stakeholders, Konya said. It could relieve patients of the burden of being the data go-between and give them greater transparency into the referral and transplant evaluation process. It could give clinicians a more complete and timely picture of their patients' health when making care decisions. For dialysis organizations and transplant programs, it could increase access to information throughout the referral, evaluation, and waitlisting processes. It would also reduce the huge administrative burden for transplant centers and organ procurement organizations associated with manually sharing and reconciling donor and organ information.

Benjamin Hippen, MD, FASN, senior vice president and global head of transplant medicine at Fresenius Medical Care, noted that manually assembling data for transplant referrals creates a huge bottleneck at dialysis centers that can hinder referrals. He explained that social workers at dialysis centers may need 2½ hours to assemble documentation for a referral. He and his colleagues used large language model tools to help automate this process and increased referrals from 28,867 to 42,414 in 2025. However, he noted that research by the Southeastern Kidney Transplant Coalition has found that half of referrals do not result in transplant evaluation, and only 30% of referred patients make it on the waitlist (1). "There are many points of failure along the way where patients get lost in the process," Hippen said, and there is no good way to track patients' progress to help prevent that.

Reid noted that patients also often lack easy access to the information they need to be active participants in their care. She said that these data access and sharing challenges can lead to poor patient outcomes and reduced quality of life. "How do we give patients their lives back?" she asked.

Adam Wilk, PhD, associate professor in the Department of Surgery at Indiana University School of Medicine and investigator at the William M. Tierney Center for Health Services Research at Regenstrief Institute, both in Indianapolis, also noted that the lack of data standardization and sharing is a missed opportunity for research and quality improvement efforts. "Data at each step could be harnessed to improve care," Wilk said.

Across the care continuum

Similar challenges exist across the kidney care continuum. Konya noted during the workshop focused on nephrology and dialysis care that information must follow the patient from primary care or hospitalization; through laboratory testing; into nephrology specialist care, kidney replacement therapy, and potentially to the transplant system.

ASN Councilor Daniel E. Weiner, MD, MS, FASN, a nephrologist and professor at Tufts University School of Medicine in Boston, MA, explained that despite the emergence of electronic medical records and the proliferation of patient data over the course of his career, too often, nephrologists are still resorting to telephone calls and faxes because data are not accessible when they are needed by the clinicians providing care. By the time the individual reaches the dialysis center, the data have ballooned to a 192-page fax from which the social worker must extract vital information, he noted.

"Across all these scenarios, better interoperability creates an opportunity to reduce the amount of health care work that is essentially human beings moving information between systems that cannot effectively communicate with one another," Konya said.

Deidre C. Crews, MD, MS, FASN, ASN past president and professor of medicine in the Division of Nephrology at Johns Hopkins University School of Medicine, Baltimore, MD, noted that nephrologists seeing people living with CKD or on dialysis often cannot access basic urinalysis data. Those delays can cost patients in worsening kidney function, she said. "We see so many delays in terms of our ability to be able to identify that individuals have kidney disease in the first place," Crews shared. The challenges can be particularly acute as patients transfer between health systems or specialists or from pediatric to adult care. She added that the lack of data standardization also hampers research using clinical datasets.

Rajendra Baliga, MD, FASN, president of Florida Kidney Physicians and a general and transplant nephrologist at Tampa General Hospital, noted that it is often not worth waiting for results, and nephrologists end up ordering a repeat test. "We may get results, but if it is 4 days from now, are we better off repeating the test now? It does put patient care in jeopardy," he said.

Those repeated tests can be costly for patients, especially if their insurance refuses to pay for the duplicate testing, said Precious McCowan, PhD, MS, a research assistant at the University of North Carolina Kidney Center. McCowan—a former patient of an in-center dialysis facility, a three-time kidney transplant recipient, and a pancreas transplant recipient—also found herself having to fill information gaps for her clinicians, including while in the emergency department. "When information is fragmented, patients become the bridge between disconnected systems, and that creates risk," she noted. "A patient may not remember the name of a medication; why it was changed; what specialist recommended it; or even what your most recent laboratory results showed, particularly when they are frightened, exhausted, and when they are critically ill."

Building a better data ecosystem could reduce the burden on patients and clinicians, reduce the need for repeated tests, reduce medication errors, lead to safer emergency care, and enable smoother transitions between specialists, McCowan noted. "We need to design interoperability around the simple principle that the right information should be available to the right clinicians at the right time without requiring the patient to carry it from one health care setting to another," McCowan said. "Patients should absolutely have access and be

empowered to participate in their care, but empowerment should not be confused with making it the patient's responsibility to fix a fragmented information system."

Improving data exchange

The ultimate goal of ASN and the HHS-ONC Kidney Data Discovery Series is to develop a road map to facilitate better data sharing across the kidney care continuum. "We are not starting from scratch," said Rachel Meyer, ASN Strategic Policy Advisory to the CEO. "No one wants to reinvent the wheel," she added.

Wilk noted that much of the needed data are available but need to be in a standardized format that can be shared and understood across settings. Konya noted that programs to help standardize data and improve data sharing are already underway, including through the Health Resources and Services Administration's (HRSA) Organ Procurement and Transplantation Network modernization, the Centers for Medicare & Medicaid Services (CMS) interoperability initiatives, and the Agency for Healthcare Research and Quality and the National Institute of Diabetes and Digestive and Kidney Diseases eCare Plan for Multiple Chronic Conditions. Konya noted that those existing programs can provide a foundation for ASN's and HHS-ONC's data collaboration.

The in-person workshop in Washington, DC, on September 10, brought together patients; their family members and caregivers; dialysis professionals; transplant care clinicians; representatives from CMS, HRSA, and the National Institutes of Health; leaders from the Congressional Kidney Caucus and the Congressional Transplant Caucus; advocates; technology developers; and bioinformaticists, Wilk noted in an interview with *Kidney News* after the meeting. Wilk is a member of ASN's Quality Committee and helped organize the data series. "There are a lot of people who care a lot about the quality of data that can be transmitted to support the needs of [people] with kidney diseases, and they were all present and motivated to identify the best paths forward to strengthen kidney data sharing across the spectrum," he said.

Breakout groups were held to identify data-sharing and standards priorities for CKD, dialysis, transplant, and organ procurement organizations and donor hospitals, Wilk said. "Those brainstorming discussions were very productive and identified reasonable choices for what to prioritize as next steps to improve kidney care," he said.

For example, Wilk noted that the transplant breakout group identified the need for specific codes for different types of transplant complications and standardized codes for the various causes of allograft failure to help facilitate data sharing about patients and research. "If we want to learn about how to prevent graft failure through multisite studies, we need systems that can communicate accurately with each other what happens to these patients, and right now, we don't have that," Wilk said.

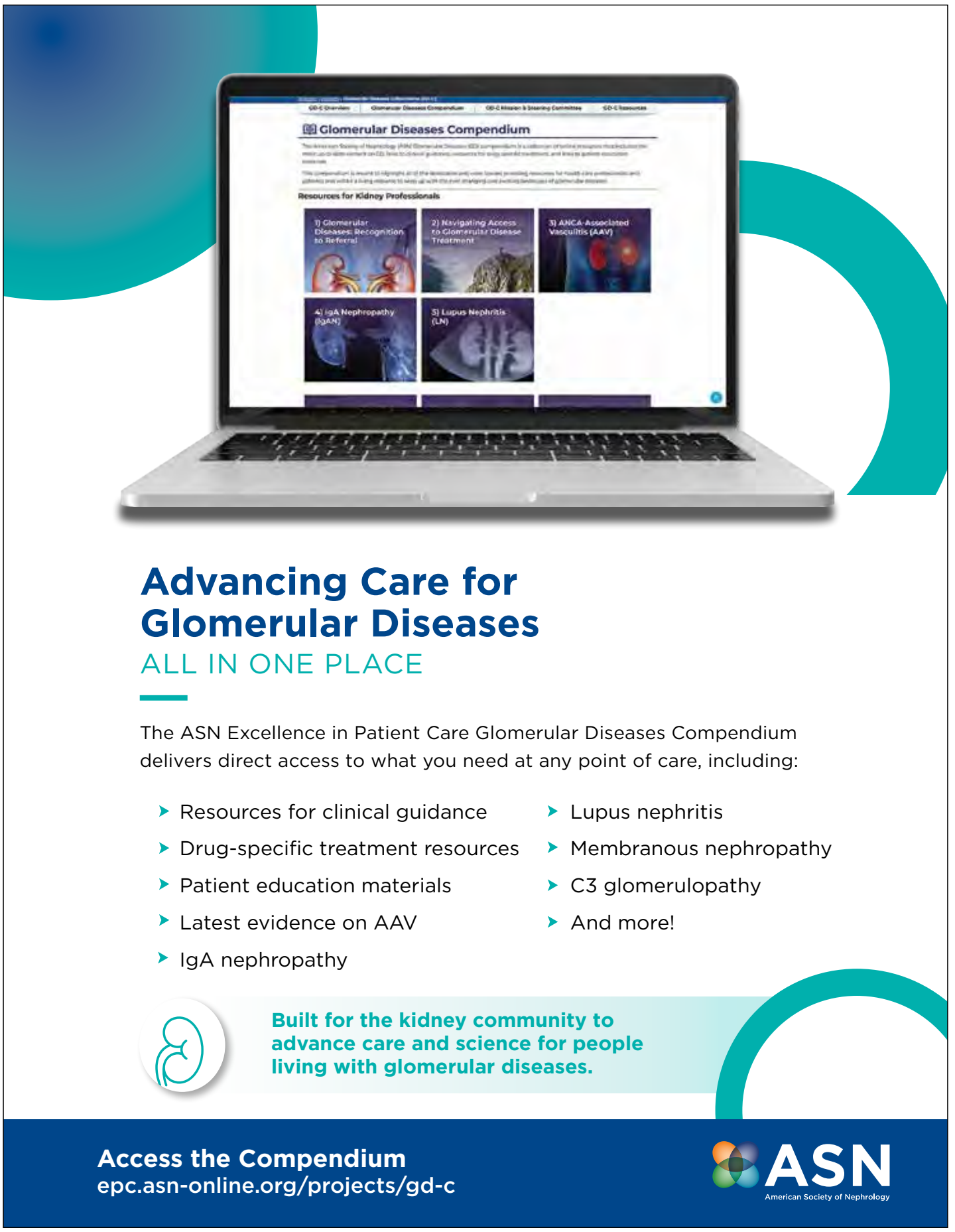
Additionally, the group identified a need for a minimum viable product standard for the data necessary for a patient referral to a transplant center. Wilk noted that a more consistent standard for referral data across transplant centers could not only make it easier for dialysis centers to make referrals, but it might also enable the development of a more patient-centered system to help connect patients with a transplant center that will accept them, he said.

Wilk also emphasized the potential benefits for patients of data improvements that could help prevent CKD or progression to kidney failure by ensuring that patients have early access to multidisciplinary care teams to manage their health conditions.

Leaders of the ASN and HHS-ONC project will compile and share the meeting results and begin planning next steps for the project, Wilk said. He added that the commitment shown to solving these data challenges by policymakers, government agencies, and the entire kidney community makes him hopeful that the project will lead to data improvements that help patients and reduce the information-sharing burden on them. "I'm quite optimistic that we'll see some of those wins in CKD or the transplant space in the next handful of years," Wilk said. ■

Reference

1. Patzer RE, et al. Dialysis facility referral and start of evaluation for kidney transplantation among patients treated with dialysis in the Southeastern United States. *Am J Transplant* 2020; 20:2113–2125. doi: 10.1111/ajt.15791



Advancing Care for Glomerular Diseases

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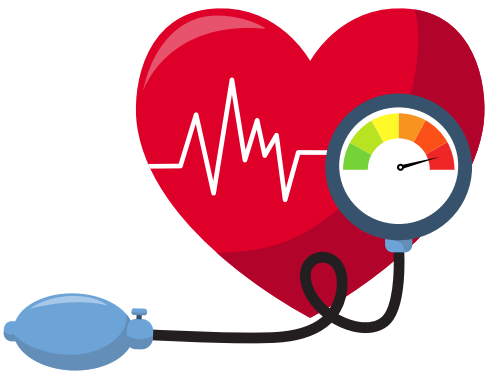
The ASN Excellence in Patient Care Glomerular Diseases Compendium delivers direct access to what you need at any point of care, including:

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ASN American Society of Nephrology



High Rate of Delayed Hypertension Diagnosis in Young Men

https://doi.org/10.62716/kn.004922026

Delayed diagnosis of hypertension is common in young adults, especially men, according to a report in the *Journal of the American Heart Association*.

The researchers analyzed electronic health records from a large California health system to identify young adults (aged 18–39 years) with a new diagnosis of hypertension. Eligible patients had a systolic blood pressure (BP) of 140 mm Hg or greater or a diastolic BP of 90 mm Hg or greater, with no previous history of hypertension. Time to diagnosis of hypertension and associated risk factors were assessed.

The analysis included 2443 young adults (mean age, 31 years) diagnosed with hypertension between 2009 and 2016. Men accounted for 57% of patients and were more likely to be in the youngest age group (aged 18–24 years) compared with women. Men with hypertension were less likely than women to have a body mass index (BMI) of 30 kg/m^2 or higher. Men were more likely to be current smokers and to have high cholesterol.

Delayed diagnosis of hypertension occurred in both men and women, with a median delay of 1.8 years. However, time to diagnosis was 2.3 years in men versus 1.4 years in women. About 80% of patients started antihypertensive therapy within 1 year after diagnosis; the median time to treatment was 2.5 years for men versus 1.7 years for women.

Men also had fewer outpatient visits after their initial high BP measurement. On Cox proportional hazards analysis, factors associated with time to diagnosis were lower index BP values, lower BMI, and absence of dyslipidemia or prediabetes or diabetes.

Although a "substantial prevalence" of high BP has been reported in young adults, they have lower rates of hypertension awareness, treatment, and BP control. The new analysis finds significant rates of delayed hypertension diagnosis in adults under aged 40 years, with longer delays in men compared with women. The findings "highlight the need for health care system–level interventions to improve the recognition, diagnosis, and treatment of hypertension in this population," the researchers conclude [An J, et al. Sex differences in hypertension diagnosis among young adults in a US integrated health care system. *J Am Heart Assoc* 2026; 15:e042879. doi: 10.1161/JAHA.125.042879].

Conservative Protocol May Allow Earlier Dialysis Discontinuation in AKI

https://doi.org/10.62716/kn.004992026

Many people with acute kidney injury requiring dialysis (AKI-D) can successfully undergo dialysis discontinuation at relatively low levels of residual kidney function, according to a pre-proof clinical trial report in *JASN*.

In an ancillary study of the Liberation From Acute Dialysis (LIBERATE-D) trial, the researchers evaluated a protocolized approach to dialysis discontinuation in people with AKI-D. The analysis included 85 people with AKI-D who were hemodynamically stable receiving intermittent hemodialysis. All had been assigned to the intervention arm of LIBERATE-D, which compared a conservative dialysis strategy with thrice-weekly dialysis. In the main analysis, the conservative strategy increased the rate of recovery of kidney function at hospital discharge.

In the ancillary study, timed urine collections were obtained for blinded analysis of metrics including creatinine



INDICATION and IMPORTANT SAFETY INFORMATION for VOYXACT® (sibeprenlimab-szsi)

INDICATION

VOYXACT is indicated to reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk for disease progression.

This indication is approved under accelerated approval based on reduction of proteinuria. It has not been established whether VOYXACT slows kidney function decline over the long-term in patients with IgAN. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory clinical trial.

IMPORTANT SAFETY INFORMATION

CONTRAINDICATION

VOYXACT is contraindicated in patients with serious hypersensitivity to sibeprenlimab-szsi or any of the excipients of VOYXACT.

WARNINGS AND PRECAUTIONS

Immunosuppression and Increased Risk of Infections: VOYXACT suppresses the immune system by reducing antibody production, which may increase the risk of infections. Patients with chronic or recurring infections may have an increased risk of serious infection. In clinical trials, infections occurred in 49% of patients treated with VOYXACT compared with 45% of patients treated with placebo.

Before initiating VOYXACT, assess patients for active infections. During treatment, monitor patients for signs and symptoms of infection. If a serious infection develops, consider interrupting VOYXACT until the infection is controlled.

clearance, urea clearance, urine output, and estimated glomerular filtration rate (eGFR) calculated from serum creatinine. Creatinine clearance and 24-hour urine output were evaluated for their association with the need for dialysis, based on protocolized indications, over the subsequent 7 days. Study participants underwent dialysis for a median of 14 days before their first timed urine collection.

In a total of 147 collections, the median creatinine clearance was 7 mL/min, with urine output of 930 mL/d. Creatinine clearance was the metric most strongly associated with freedom from further dialysis: For each 1 mL/min increase in clearance, the odds of dialysis requirement decreased by 18%.

Dialysis was not required over the subsequent week after 96% of collections showing creatinine clearance greater than 20 mL/min and 81% of those with clearance of 10 mL/min to 20 mL/min. This figure dropped to 44% for collections with creatinine clearance of 5 mL/min to less than 10 mL/min. The area under the curve for freedom from dialysis was highest for creatinine clearance and lowest for eGFR.

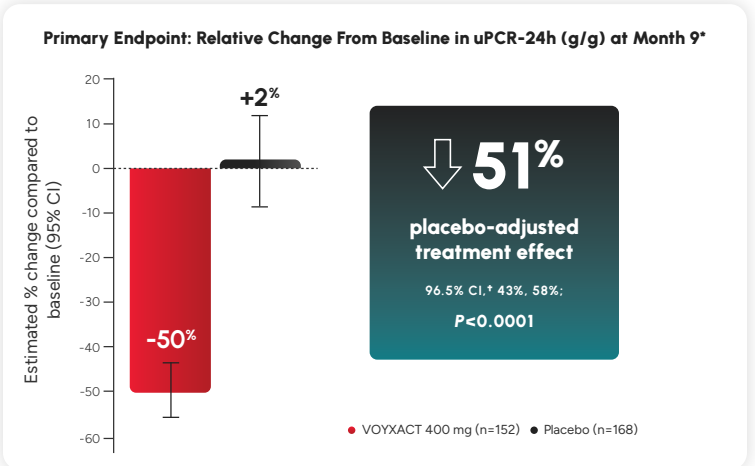
Decisions about when to discontinue dialysis for people with AKI-D can be clinically challenging. Although previous studies have evaluated metrics from timed urine collections to inform these decisions, LIBERATE-D is the first trial, to our knowledge, to focus on creatinine clearance, especially after resolution of critical illness.

The findings suggest that protocolized indications for dialysis may enable earlier discontinuation in people with AKI-D who are hemodynamically stable. Creatinine clearance outperformed urine output; more than 40% of people with clearance of less than 10 mL/min did not require dialysis in the subsequent week. "[W]e believe these results represent the best available data to prognosticate dialysis requirement in patients with AKI-D who have survived the most acute part of their illness," the researchers write [McCoy I, et al. Dialysis discontinuation rates at low levels of kidney function in patients with acute kidney injury on intermittent hemodialysis. *J Am Soc Nephrol*, published online August 25, 2026. doi: 10.1681/ASN.0000001245].

For adults with primary IgA nephropathy at risk for disease progression, VOYXACT® (sibeprenlimab-szsi) delivers significant proteinuria reduction with a demonstrated safety profile

Voyxact® (sibeprenlimab-szsi) Injection 400 mg/2 mL

Patients treated with VOYXACT achieved significant proteinuria reduction at 9 months



*Estimated geometric mean percentage change at 9 months compared with baseline. Data were included in the analysis regardless of early treatment discontinuation and initiation of confounding therapy (treatment policy strategy). Missing data were imputed using multiple imputation.

†96.5% CI corresponds to the two-sided significance level of 0.035 for the interim analysis.

ACE=angiotensin-converting enzyme; ARB=angiotensin receptor blocker; CI=confidence interval; eGFR=estimated glomerular filtration rate; SGLT2=sodium-glucose cotransporter 2; uPCR=urine protein-creatinine ratio.

STUDY DESIGN

- VISIONARY is a randomized, double-blind, placebo-controlled study of 510 adults with biopsy-confirmed IgA nephropathy, an eGFR ≥30 mL/min/1.73 m², and proteinuria (defined as either uPCR based on 24-hour urine collections ≥0.75 g/g or urine protein ≥1.0 g/day)
- Patients were randomized 1:1 to receive VOYXACT (n=259) or placebo (n=251) subcutaneously every 4 weeks and remained on a stable and maximally tolerated dose of ACE inhibitors and/or ARBs with or without an SGLT2 inhibitor throughout the study
- An interim analysis for efficacy was conducted on the first 320 randomized patients who reached the Month 9 visit (VOYXACT, n=152; placebo, n=168)

Safety evaluated in VISIONARY study

- The most common adverse reactions in patients treated with VOYXACT (n=259) and placebo (n=251), respectively, were infections (49% versus 45%) and injection site reactions (24% versus 23%)
- Most adverse reactions were reported as mild or moderate in severity and resolved without treatment interruption or discontinuation

Learn more about VOYXACT now

Reference: 1. Cheung CK, Barratt J, Liew A, Zhang H, Tesar V, Lafayette R. *Front Nephrol.* 2024;3:1346769. doi: 10.3389/fneph.2023.1346769. eCollection 2023.

IMPORTANT SAFETY INFORMATION (cont'd)

WARNINGS AND PRECAUTIONS (cont'd)

Immunosuppression and Immunization Risks: Because of its mechanism of action, VOYXACT may interfere with immune responses to vaccines and increase the risk of infection from live vaccines. Live vaccines are not recommended within 30 days prior to initiation of VOYXACT or during treatment with VOYXACT as safety has not been established. No data are available on the secondary transmission of infection from persons receiving live vaccines to patients receiving VOYXACT or on the efficacy of immunizations administered while receiving VOYXACT.

Common Adverse Reactions: The most common adverse reactions (reported in ≥10% of patients treated with VOYXACT and at a higher incidence than placebo) in patients treated with VOYXACT and placebo, respectively, were infections (49% versus 45%) and injection site reactions (24% versus 23%). The most common infection was upper respiratory infection (15% versus 14%), and the most common injection site reaction was injection site erythema (13% versus 12%). Most adverse reactions were reported as mild or moderate in severity and resolved without treatment interruption or discontinuation.

Pregnancy: There are no available data on VOYXACT use in pregnant women to evaluate for a drug-associated risk of major birth defects, miscarriage or other adverse maternal or fetal outcomes. Monoclonal antibodies, such as sibeprenlimab-szsi, can be actively transported across the placenta as pregnancy progresses; therefore, potential effects on a fetus are likely to be greater during the second and third trimester of pregnancy.

Please see additional Important Safety Information on the following page and accompanying Brief Summary of FULL PRESCRIBING INFORMATION.

Tirzepatide May Lower Cardiovascular Risks in People With Diabetes and Atherosclerosis

https://doi.org/10.62716/kn.004942026

Added to standard treatment, the dual glucose-dependent insulinotropic polypeptide and glucagon-like peptide-1 (GLP-1) receptor agonist tirzepatide may reduce the risk of cardiovascular events in patients with type 2 diabetes and established atherosclerosis, reports a study in *The BMJ* (previously the *British Medical Journal*).

The population-based cohort study included 52,971 patients, aged 40 years or older, with type 2 diabetes and diagnosed atherosclerotic diseases, identified from US insurance claims databases. Of these, 35,353 patients initiated treatment with tirzepatide. The remaining 17,618 patients started treatment with sitagliptin, a "cardiovascular outcome neutral comparator" analyzed as a placebo proxy. The two groups were well balanced after propensity score overlap weighting.

A composite outcome of major adverse cardiovascular events (MACE)—myocardial infarction, stroke, or death from any cause—was compared between groups. Data analysis followed an approach previously benchmarked against randomized trials.

One year after treatment initiation, weighted MACE risk was significantly lower in patients receiving tirzepatide: 2.9% compared with 4.4% in the group with sitagliptin. The hazard ratio (HR) was 0.68 in the tirzepatide group, with a number needed to treat of 70. The reduction in MACE was significant for myocardial infarction (HR, 0.67) but not for ischemic stroke. Tirzepatide was also

INDICATION and IMPORTANT SAFETY INFORMATION for VOYXACT® (sibeprenlimab-szsi)

INDICATION

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IMPORTANT SAFETY INFORMATION

CONTRAINDICATION

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WARNINGS AND PRECAUTIONS

Immunosuppression and Increased Risk of Infections: VOYXACT suppresses the immune system by reducing antibody production, which may increase the risk of infections. Patients with chronic or recurring infections may have an increased risk of serious infection. In clinical trials, infections occurred in 49% of patients treated with VOYXACT compared with 45% of patients treated with placebo.

Before initiating VOYXACT, assess patients for active infections. During treatment, monitor patients for signs and symptoms of infection. If a serious infection develops, consider interrupting VOYXACT until the infection is controlled.

Immunosuppression and Immunization Risks: Because of its mechanism of action, VOYXACT may interfere with immune responses to vaccines and increase the risk of infection from live vaccines. Live vaccines are not recommended within 30 days prior to initiation of VOYXACT or during treatment with VOYXACT as safety has not been established. No data are available on the secondary transmission of infection from persons receiving live vaccines to patients receiving VOYXACT or on the efficacy of immunizations administered while receiving VOYXACT.

Common Adverse Reactions: The most common adverse reactions (reported in ≥10% of patients treated with VOYXACT and at a higher incidence than placebo) in patients treated with VOYXACT and placebo, respectively, were infections (49% versus 45%) and injection site reactions (24% versus 23%). The most common infection was upper respiratory infection (15% versus 14%), and the most common injection site reaction was injection site erythema (13% versus 12%). Most adverse reactions were reported as mild or moderate in severity and resolved without treatment interruption or discontinuation.

Pregnancy: There are no available data on VOYXACT use in pregnant women to evaluate for a drug-associated risk of major birth defects, miscarriage or other adverse maternal or fetal outcomes. Monoclonal antibodies, such as sibeprenlimab-szsi, can be actively transported across the placenta as pregnancy progresses; therefore, potential effects on a fetus are likely to be greater during the second and third trimester of pregnancy.

Lactation: There are no data on the presence of sibeprenlimab-szsi in human milk, the effects of sibeprenlimab-szsi on the breastfed infant, or the effects of sibeprenlimab-szsi on milk production.

Pediatric Use: Safety and effectiveness of VOYXACT in pediatric patients have not been established.

Geriatric Use: Clinical studies of VOYXACT did not include sufficient numbers of patients aged 65 and over to determine whether they respond differently from younger adult patients.

Pregnant women exposed to VOYXACT, or their healthcare providers, should report VOYXACT exposure by calling 1-833-869-9228 or visiting www.VOYXACT.com

To report SUSPECTED ADVERSE REACTIONS, contact Otsuka America Pharmaceutical, Inc. at 1-800-438-9927 or FDA at 1-800-FDA-1088 (www.fda.gov/medwatch).

Please see Brief Summary of FULL PRESCRIBING INFORMATION on the following page.

Voyxact® (sibeprenlimab-szsi) Injection 400 mg/2 mL



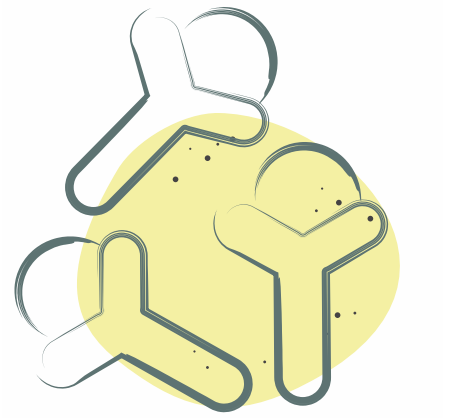
associated with reduced risks of infection requiring hospitalization (HR, 0.64), infection-related death (HR, 0.40), and all-cause mortality (HR, 0.55).

A previous head-to-head trial found tirzepatide noninferior to dulaglutide in terms of MACE for type 2 diabetes with established cardiovascular disease. The new analysis suggests a significant reduction in MACE—including myocardial infarction and all-cause mortality—with tirzepatide added to standard treatment compared with a cardiovascular outcome-neutral comparator. The authors note that the early reduction in cardiovascular events with GLP-1 treatment, before meaningful weight loss, "may reflect improvements in systemic and vascular inflammation that act independently of metabolic benefits" [Krüger N, et al. Tirzepatide and the risk of atherosclerotic cardiovascular events: Population based cohort study. *BMJ* 2026; 394:e100011. doi: 10.1136/bmj-2026-100011].

Anti-DQα Donor-Specific Antibodies May Increase Rejection Risk

https://doi.org/10.62716/kn.004952026

For kidney transplant recipients, the presence of preformed donor-specific antibodies (DSAs) against DQα is an independent risk factor for antibody-mediated rejection (AMR), reports a study in *Transplantation*.



The researchers performed human leukocyte antigen typing to assess the frequency, characteristics, and pathogenicity of preformed anti-DQα DSAs in 2041 patients receiving kidney transplants at three French centers between 2010 and 2015. The results showed preformed anti-DQα and anti-DQβ antibodies in 122 patients. Microvascular inflammation was assessed in 3-month biopsy specimens from these patients compared with matched controls without DSAs.

Antibodies against DQα accounted for 35.2% of anti-DQ DSAs. These anti-DQα antibodies predominantly targeted the DQA1*05 antigen and consistently targeted the donor α/β heterodimer. At 2 years, recipients with anti-DQα DSAs were at higher risk of AMR, independent of DSAs targeting other loci (hazard ratio, 2.61). The presence of anti-DQα antibodies was associated with higher microvascular inflammation scores in 3-month biopsies.

Previous studies have linked anti-DQ DSAs to an increased risk of AMR in kidney transplant recipients. Most of these studies have focused on the β-chain, not addressing the polymorphic α-chain.

The new research finds an independent association between anti-DQα DSAs and the risk of AMR after kidney transplantation. The investigators conclude: "[O]ur study highlights the importance of screening for anti-DQα DSAs in patients waiting for transplantation and systematically performing DQA1 typing of recipients and donors to ascertain the status of these DSAs" [Ursule-Dufait C, et al. Preformed anti-DQ alpha donor-specific antibodies and the risk of antibody-mediated rejection after kidney transplantation. *Transplantation* 2026; 110:e1946–e1956. doi: 10.1097/TP.0000000000005797].

VOYXACT® (sibeprenlimab-szsi) injection, for subcutaneous use

BRIEF SUMMARY OF PRESCRIBING INFORMATION

(For complete details, please see *Full Prescribing Information and Patient Information*.)

INDICATIONS AND USAGE: VOYXACT is indicated to reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk for disease progression.

This indication is approved under accelerated approval based on reduction of proteinuria. It has not been established whether VOYXACT slows kidney function decline over the long-term in patients with IgAN. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.

CONTRAINDICATIONS: VOYXACT is contraindicated in patients with serious hypersensitivity to sibeprenlimab-szsi or any of the excipients of VOYXACT.

WARNINGS AND PRECAUTIONS

Immunosuppression and Increased Risk of Infections: VOYXACT suppresses the immune system by reducing antibody production, which may increase the risk of infections. Patients with chronic recurring infections may have increased risk of serious infection. In clinical trials, infections occurred in 49% of patients treated with VOYXACT compared with 45% in patients treated with placebo.

Before initiating VOYXACT, assess patients for active infections. During treatment, monitor patients for signs and symptoms of infection. If a serious infection develops, consider interrupting VOYXACT until the infection is controlled.

There are limited clinical study data with concomitant use of VOYXACT and systemic immuno-suppressants. Consider the potential for increased immunosuppression when coadministering VOYXACT and immuno-suppresants or when initiating VOYXACT either before or after immuno-suppressive therapy.

Immunosuppression and Immunization Risks: Because of its mechanism of action, VOYXACT may interfere with immune responses to vaccines and increase the risk of infection from live vaccines. Live vaccines are not recommended within 30 days prior to initiation of VOYXACT or during treatment with VOYXACT as safety has not been established. No data are available on the secondary transmission of infection from persons receiving live vaccines to patients receiving VOYXACT or on the efficacy of immunizations administered while receiving VOYXACT.

ADVERSE REACTIONS

Clinical Trials Experience: Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

The safety of VOYXACT was evaluated in a randomized, double-blind, placebo-controlled, clinical study in patients with IgAN (VISIONARY). The median duration of exposure was 44 weeks in the 259 patients treated with VOYXACT and 48 weeks in the 251 patients administered placebo. The most common adverse reactions (reported in ≥10% of patients treated with VOYXACT and at a higher incidence than placebo) in patients treated with VOYXACT and placebo, respectively, were infection (49% versus 45%) and injection site reactions (24% versus 23%). The most common infection was upper respiratory infection (15% versus 14%), and the most common injection site reaction was injection site erythema (13% versus 12%). Most adverse reactions were reported as mild or moderate in severity and resolved without treatment interruption or discontinuation.

USE IN SPECIFIC POPULATIONS

Pregnancy: Risk Summary There are no available data on VOYXACT use in pregnant women to evaluate for a drug-associated risk of major birth defects, miscarriage or other adverse maternal or fetal outcomes. Monoclonal antibodies, such as sibeprenlimab-szsi, can be actively transported across the placenta as pregnancy progresses; therefore, potential effects on a fetus are likely to be greater during the second and third trimester of pregnancy. In an enhanced prenatal and postnatal development (ePPND) toxicity study, administration of sibeprenlimab-szsi subcutaneously to pregnant monkeys did not result in any adverse effects on embryofetal or postnatal development at exposures approximately 10-times the clinical exposure at the maximum recommended human dose (MRHD) based on area under the curve (AUC).

Clinical Considerations *Disease-Associated Maternal and/or Embryo/Fetal Risk* IgA nephropathy is associated with adverse maternal outcomes, including increased rates of cesarean section, pregnancy-induced hypertension, pre-eclampsia and preterm delivery, and adverse fetal/neonatal outcomes, including stillbirth and low birth weight. *Fetal/Neonatal Adverse Reactions* Transport of endogenous IgG antibodies across the placenta increases as pregnancy progresses, and peaks during the third trimester. Therefore, VOYXACT may be present in infants exposed *in utero.* Consider the potential clinical impact of VOYXACT exposure in infants who are exposed to VOYXACT *in utero.*

Lactation: Risk Summary There are no data on the presence of sibeprenlimab-szsi in human milk, the effects of sibeprenlimab-szsi on the breastfed infant, or the effects of sibeprenlimab-szsi on milk production. Endogenous maternal IgG and monoclonal antibodies are transferred into human milk. The effects of local gastrointestinal exposure on sibeprenlimab-szsi in the breastfed infant are unknown. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for VOYXACT and any potential adverse effects on the breastfed child from VOYXACT or from the underlying maternal condition.

Pediatric Use: Safety and effectiveness of VOYXACT in pediatric patients have not been established.

Geriatric Use: Clinical studies of VOYXACT did not include sufficient numbers of patients aged 65 and over to determine whether they respond differently from younger adult patients.

No clinically meaningful differences in the pharmacokinetics of VOYXACT were observed in patients aged 65 and over compared to younger adult patients.

PATIENT COUNSELING INFORMATION

Advise the patient and/or caregiver to read the FDA-approved patient labeling (Patient Information and Instructions for Use).

Pregnant women exposed to VOYXACT, or their healthcare providers, should report VOYXACT exposure by calling 1-833-869-9228 or visiting www.VOYXACT.com

To report SUSPECTED ADVERSE REACTIONS, contact Otsuka America Pharmaceutical, Inc. at 1-800-438-9927 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

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Semaglutide Exposure and Adverse Pregnancy Outcomes

https://doi.org/10.62716/kn.004982026

People who are treated with semaglutide before or during pregnancy may be at increased risk of excess gestational weight gain and other adverse pregnancy outcomes, according to a study in *Obstetrics and Gynecology*.

Using a national-level database linking electronic medical records to pharmacy dispensing data, the researchers identified women with overweight or obesity before pregnancy who delivered between 2022 and 2026. Semaglutide exposure was analyzed for its association with a range of adverse pregnancy outcomes. The study included propensity score-matching for maternal age; race and ethnicity; and prepregnancy body mass index (BMI), diabetes, and hypertension.

The analysis included 429 people exposed to semaglutide before or during pregnancy. The mean age at delivery was 32.7 years, the mean prepregnancy BMI was 36.9 kg/m^2, and the median total exposure time was 44 days. For about one-third of people with prepregnancy exposure, semaglutide use continued into pregnancy. Adverse pregnancy outcomes were compared with those of 2203 people who were not exposed to semaglutide.

Semaglutide exposure was associated with increases in several adverse outcomes. Adjusted odds ratios were 2.88 for excessive gestational weight gain, 1.59 for gestational diabetes, 1.78 for excessive fetal growth, and 3.35 for cesarean delivery. Similar increases were noted for former semaglutide users: adjusted odds ratio, 1.98 for excessive gestational weight gain, 1.43 for gestational diabetes, 1.54 for excessive fetal growth, and 3.92 for cesarean delivery.

Current obstetric guidelines recommend that women with obesity lose weight before conception. Those being treated with semaglutide are advised to discontinue treatment for at least 2 months before attempting to conceive. The new study adds to limited evidence on possible consequences of semaglutide before and during pregnancy.

The results suggest increased rates of several adverse outcomes in women who are exposed to semaglutide before pregnancy. The effects appear similar regardless of whether exposure continues into pregnancy, "support[ing] the hypothesis that weight and metabolic changes following semaglutide discontinuation, rather than in utero exposure itself, may contribute to the observed pregnancy risks," the researchers write [Yu Y, et al. Gestational weight gain and pregnancy outcomes after semaglutide exposure. *Obstet Gynecol,* 2026; 148:229–237. doi: 10.1097/AOG.0000000000006325]. ■

With or Without Diabetes, No Change in Post-Transplant Mortality

https://doi.org/10.62716/kn.004962026

Among kidney transplant recipients, diabetes is known to be associated with increased mortality. Recent studies have reported a decline in death from cardiovascular causes among patients with diabetes in the general population. A study in *Nephrology Dialysis Transplantation* assessed trends in all-cause and cause-specific mortality after kidney transplantation in patients with and without diabetes.

From the European Renal Association Registry, the researchers identified 134,231 adults in 12 countries who underwent primary kidney transplantation between 2005 and 2022. Of these, 15.5% had diabetes as the reported cause of kidney failure. Age- and sex-specific trends in all-cause and cause-specific mortality were compared for patients with versus without diabetes as the cause of kidney failure.

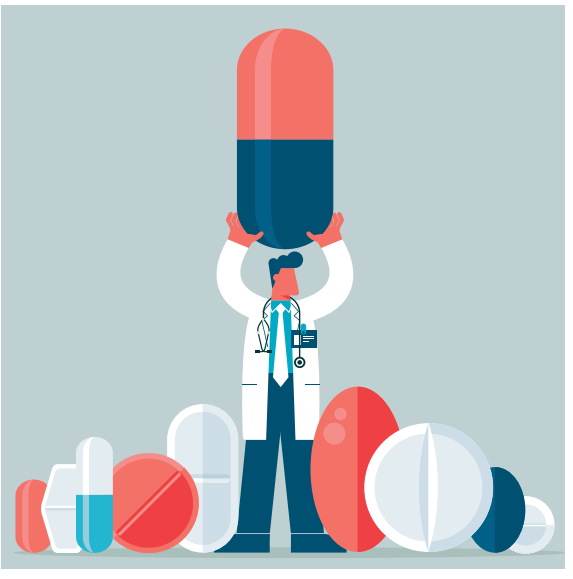
Of 12,675 kidney transplant recipients who died during a maximum follow-up of 5 years, 25.5% had diabetes as the cause of kidney failure. Mortality was nearly twice as high for patients with diabetes compared with those without diabetes: 45.5 versus 24.9 deaths per 1000 person-years. Cardiovascular disease and infections were the main contributors to excess mortality in the group with diabetes. Cancer mortality was similar between groups.

Before the COVID-19 pandemic, trends in all-cause and cause-specific mortality were similar for patients with and without diabetes. In both groups, mortality increased during the pandemic years, mainly related to infections.

In contrast to the general population, the gap in cardiovascular mortality among kidney transplant recipients with and without diabetes has not narrowed over time. Amid ongoing increases in diabetes as the cause of kidney failure, "Further research is needed to better understand the factors contributing to the lack of improvement in cardiovascular mortality among kidney transplant recipients with and without diabetes," the researchers conclude [Oliveras L, et al. Trends in mortality in adult first kidney transplant recipients with and without diabetes as cause of kidney failure: An ERA Registry study. *Nephrol Dial Transpl*, published online August 19, 2026. doi: 10.1093/ndt/gfag188]. ■

Finerenone Reduces Adverse Outcomes in Hypertensive Nephropathy

https://doi.org/10.62716/kn.004972026



The nonsteroidal mineralocorticoid receptor antagonist finerenone slows decline in kidney function and reduces the risk of adverse kidney and cardiovascular outcomes in patients with hypertensive nephropathy, according to a pre-proof study in the *European Heart Journal*.

The researchers present a subgroup analysis of patients with hypertensive nephropathy enrolled in the multicenter, phase 3 FIND-CKD trial (NCT05047263). In that study, nondiabetic adults with chronic kidney disease were randomly assigned to finerenone or placebo. The current analysis focused on 459 patients with investigator-reported hypertensive nephropathy, representing 29% of randomized participants. Outcomes of interest included the total slope of the estimated glomerular filtration rate (eGFR) from baseline to 32 months and a composite kidney-cardiovascular disease outcome comprising a sustained eGFR decline of 57% or greater, kidney failure, heart failure hospitalization, or cardiovascular death.

Among participants with hypertensive nephropathy, the mean blood pressure was 134/80 mm Hg, the mean eGFR was 44 mL/min/1.73 m^2, and the median urine albumin-to-creatinine ratio was 797 mg/g. At 32 months, finerenone was associated with a lower total decline in eGFR: –3.17 mL/min/1.73 m^2 compared with –3.82 mL/min/1.73 m^2 with placebo. Patients assigned to finerenone also had a lower rate of kidney or cardiovascular disease outcomes (hazard ratio, 0.61).

In subgroup analyses, the benefits of finerenone were independent of baseline systolic blood pressure. Hyperkalemia was more common with finerenone (17.1% versus 9.8%) but rarely led to treatment discontinuation.

Despite current guideline-recommended treatments, patients with hypertensive nephropathy continue to have a residual risk of kidney failure. Finerenone targets inflammatory and fibrotic pathways mediated by overactivation of mineralocorticoid receptors in the heart and kidneys.

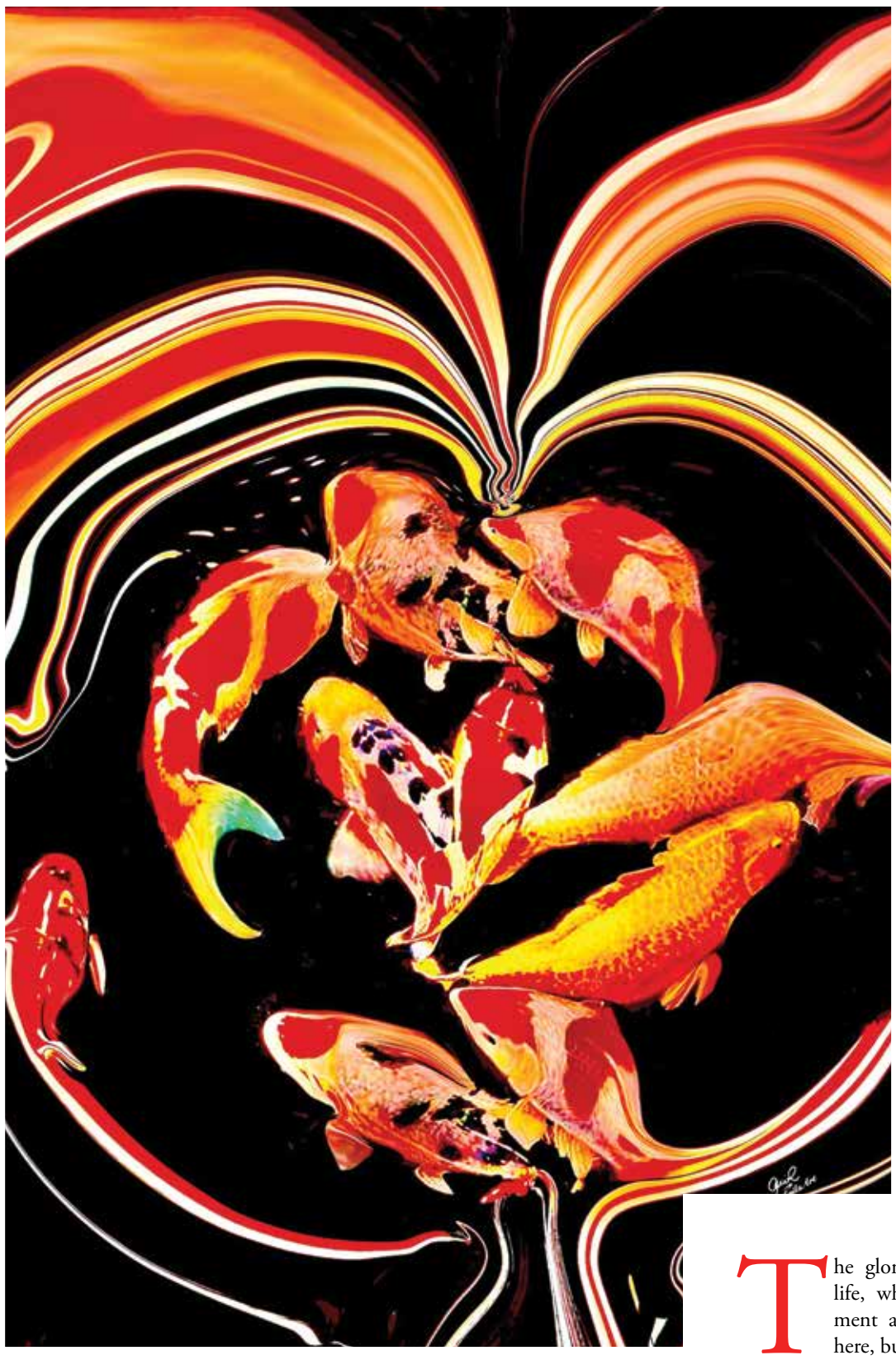
The prespecified subgroup analysis of FIND-CKD data suggests that finerenone slows kidney function decline and reduces adverse kidney and cardiovascular outcomes in hypertensive nephropathy. The findings "support blockade of mineralocorticoid receptor overactivation as a therapeutically relevant treatment pathway and suggest that finerenone may help address residual kidney/cardiovascular risk in this population," the investigators conclude [Heerspink HJL, et al.; FIND-CKD Investigators. Finerenone in hypertensive non-diabetic chronic kidney disease: A FIND-CKD subgroup analysis. *Eur Heart J*, published online August 30, 2026. doi: 10.1093/eurheartj/ehag729]. ■

CREATIVE CORTEX

Hydration Is Key

By Anil Saxena

https://doi.org/10.62716/kn.003182026



Artwork by AnilzArt. Anil Saxena, MD, 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.

The glomerulus becomes a fishbowl of life, where every drop sustains movement and breath. Water is not excess here, but mercy—keeping currents clear, nephrons alive. When the bowl runs low, silence follows. Hydration is remembrance: that kidneys, like living creatures, survive by flow and fail by neglect.

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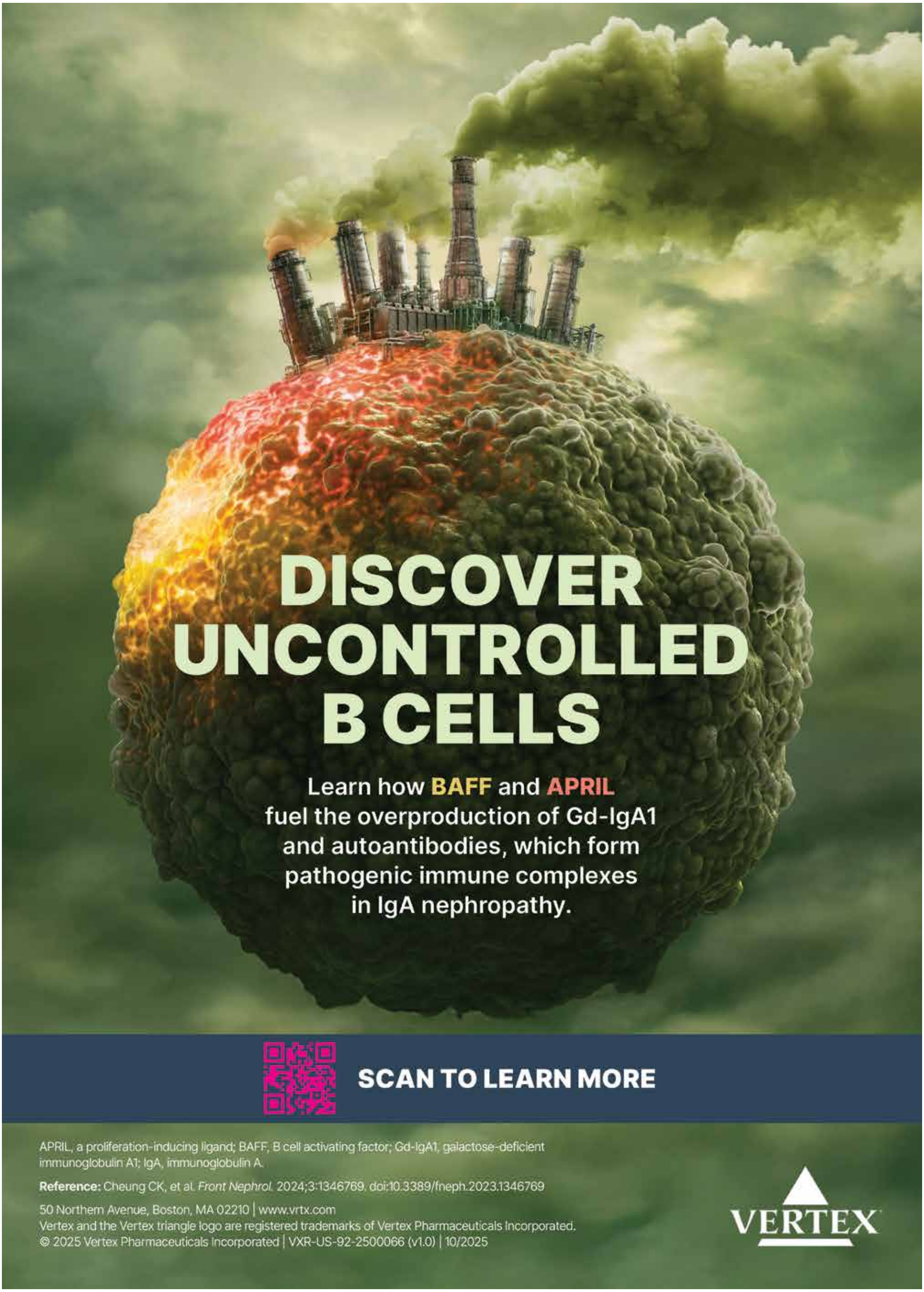
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