

WOMEN IN NEPHROLOGY INDIA

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WINGS

WOMEN IN NEPHROLOGY GUP SHUP

Official newsletter of Women in Nephrology India



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CONTENTS

Editorial 04

Messages

Lisa M. Curtis 06

Dr. Nandita Choudhury 07

A tale of thorns and triumph -
The first 'Lady Doctors' in India 08

Case Study: Academic Corner 13

Resident's Column

Answers to the Quiz in 1st edition Aug 2021 17

Journal Scan 18

WIN INDIA Registry -

A sure path to literature from India 23

Upcoming events 24

Events organized 25

Publication corner 29

Achievements 30

EDITORIAL

We spread our ‘Wings’, pledging to soar higher each time, pervading through clouds and beyond the horizons.”

We are delighted to share that WIN INDIA had a great commencement and is now taking little steps towards accomplishing our vision and mission. We are grateful to the International Society of Nephrology; Dr. Lisa Curtis for encouraging WIN India Chapter and helping it evolve from just an ideation conceived by us to a society growing in full bloom.

WIN India has started several activities. We had two International meetings with ISN and initiated web series on various topics; Research methodology, Quiz, Case discussion, Transplant web series, which have benefited the trainees and the practitioners. We have also started mentor and mentee activity and would request the senior women nephrologists in India and the women nephrologists of Indian origin practising abroad to register themselves as mentors under this program to guide the budding women nephrologists. We have the registry coming up soon, which would help us have our India data in kidney diseases.

WIN India is also coming up with an e-Journal with contributions from women Nephrologists not only from India but also across the globe. The e-Journal would contain case reports, review articles, brief communication, images etc.

All the updates and events of WIN activities are posted in our vibrant WIN website www.winindia.org. We have a very energetic SoMe group, keeping us active in social media twitter @womeninNeph_India.

To enjoy the benefits of the WIN India initiatives and the activities, I request every one to become a WIN India member. Please visit our site www.winindia.org and join hands to help each other and ourselves.

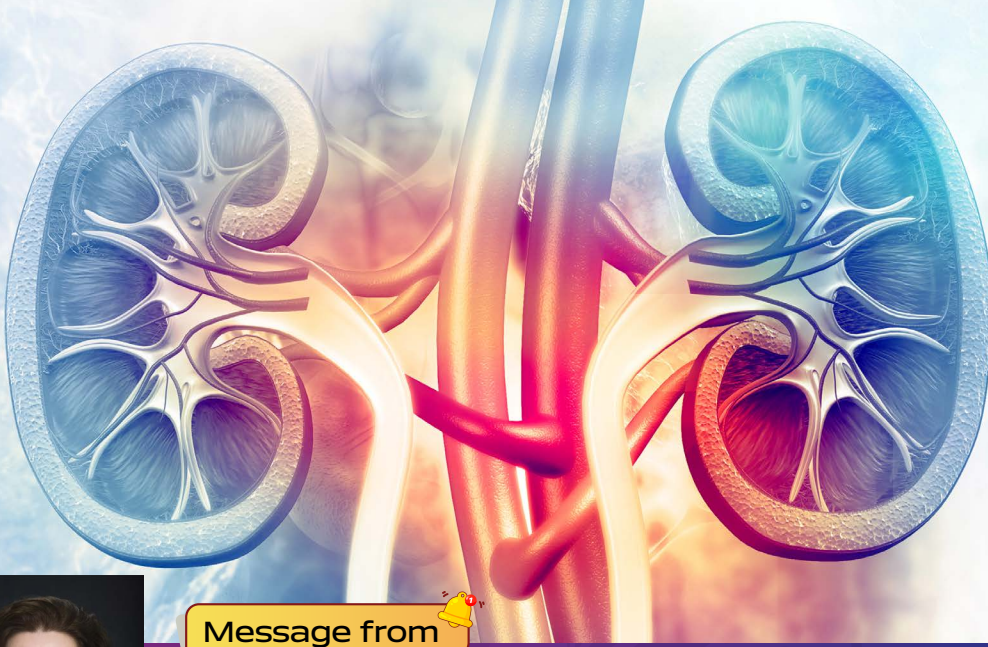
WISH YOU A HAPPY NEW YEAR

Dr. Swarnalatha Guditi

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Message from

Lisa M. Curtis PhD, WIN President
University of Alabama
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I am so pleased to be given the opportunity to send a message to the WIN_India newsletter! As President of Women in Nephrology (WIN), I am excited for WIN_India! What an amazing group of women! The issues faced by women in nephrology worldwide differ, but some commonalities remain. Equity and respect are what everyone should expect for their contributions. WIN is excited for our collaborations and we stand ready to assist WIN_India in any way. As we all work toward a more inclusive environment, I know that WIN_India will stand at the forefront of creating that ideal world. The legacy of the women in India who blazed a trail is in good hands!

With best wishes.

Lisa M. Curtis, PhD.



Message from 

Dr. Nandita Choudhury, MD, DM–Nephrology
(1980, PGI, Chandigarh), 1st DM Nephrologist from
East Zone of Nephrology | Past President of
Indian Society of Nephrology (2002–2003)


At the very outset, I would like to pay my homage to Madam Vidya Acharya who first conceived the idea of constituting a forum of women Nephrologists in India. First meeting of 'WIN' was held on 16th and 17th of July 2011 at Bangalore sponsored by Emcure. Pioneer women Nephrologists from India namely Dr. Vidya Acharya, Dr. Kumud Mehta from Mumbai, Dr. Muthu Jayaraman from Chennai, Dr. Nandita Choudhury from Guwahati, Dr. Anuradha from Hyderabad have participated with a host of young and energetic women Nephrologists from all over India whom I cannot name individually have attended the meeting. It was a grand success.

That was the beginning; subsequent meetings were not possible to organize due to various reasons. I am happy that now, the younger and energetic women Nephrologists have come forward to bear the flag of WIN and take it forward. I wish 'WIN' goes a long way and establishes itself as an independent entity to study renal diseases particularly common in women but to remain as a wing of Indian Society of Nephrology and hold its meetings annually along with ISN-CON.

Best Wishes

Dr. Nandita Choudhury

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A tale of thorns & triumph - The First 'Lady Doctors' in India

*Lives of great men all remind us
We can make our lives sublime,
And, departing, leave behind us
Footprints on the sands of time;
Footprints, that perhaps another,
Sailing o'er life's solemn main,
A forlorn and shipwrecked brother,
Seeing, shall take heart again.*

Lady Doctors



The Untold
Stories of
India's First
Women in
Medicine

...a richly satisfying
read about a set of
extraordinary women
MANU S. PILLAI

Kavitha Rao

Reading the newly released book 'Lady Doctors' by Kavitha Rao brought back these famous lines from Longfellow to my mind. The book is a must read for all women doctors in India, and may be elsewhere too. Indeed women aspiring for greater accomplishment in any field and in any country can derive inspiration from this moving narrative about India's first Lady doctors.

The book describes in detail the life and times of six earliest lady doctors in India, starting from Anandibai Joshi to Mary Poonen Lukose and chronicles their difficult and painstaking journey in a orthodox and rigid patriarchal society in a lucid and extensive manner. At the outset there is a

glimpse of the societal views on women in medicine in the western world and the readers get an idea of the enormous difficulties faced by women in the United States as well as England, to obtain medical degrees. Elizabeth Blackwell became the first woman medical graduate in the US in 1849 and this was followed by a slow trickle of women graduates. The journey of these pioneers in the western countries too was beset with numerous challenges and it is fascinating to read the ways in which they overcame them to gain entry into 'all-men' medical colleges. The fascination turns into sheer awe as the author then focuses on the journey of the petite Indian women, who daringly forayed into the 'men's world' facing the ire of the orthodox society existing in those days, just about thirty years later than Blackwell.

The book begins with these lines spoken by a 18-yr old Anandibai Joshi, India's first woman doctor, 'You ask me, why I should do what is not done by any of my sex? To this I can only say that society has a right to our work as individuals. If anything seems best for all mankind, each one of us should try to bring it about.' It was in 1883 and she was a lone woman speaking these words before an entirely male audience in the town hall of Serampore, West Bengal, seeking to gain their approval for her plan to study medicine in the US. She spoke so well and convincingly that she got to sail to the US and gain entry to the Women's Medical College, Pennsylvania, eventually graduating with a medical degree. Her stay in the US was noteworthy for the difficulties she faced in sticking to the Hindu orthodox ways, especially to the vegetarian food and following the Hindu way of life with all

avoidance of conversion to Christianity despite many attempts by the missionaries. In doing so, it won her praise from the Indian media and the leaders and possibly softened their stand at least a little towards women's education, but it took a huge toll on her health. She took ill immediately after coming back to India and in 1887, succumbed to it at a mere 22 years of age, even before she could practise medicine.

Then there was Kadambini Ganguly (1862-1923), credited with being the first Indian woman to practise medicine. She studied in the Calcutta Medical College, a seat which she won with great hardship and was awarded the Graduate of Bengal Medical College (GBMC) qualification in 1886. She had some family support for her quest in Medicine as she had a supporting husband and father. She practised for nearly forty years, managing her responsibilities at practice as well as at home, having mothered eight children. She also entered the political arena and was the first woman to speak at the Indian National Congress session.

The author then narrates the life of Rukhmabai Raut (1864-1955) who became the first woman to practise medicine with a full medical degree, which she obtained at London School of Medicine for Women in 1895. Her story is noteworthy, as unlike her predecessors, she hailed from a lower caste, was married as a child, but fought against the shackles of marriage by fighting a lawsuit, almost single handedly, even facing the opposition of such stalwarts as Bal Gangadhar Tilak. After obtaining the medical degree, she worked in Surat, at the time of the plague pandemic and was active for the rest of her life in service.



Haimabati Sen (1866-1933) was a child widow and was abandoned by her family. She was even denied right to her family property, but somehow struggled to make ends meet and at the same time managed to get a degree from Campbell Medical college, Calcutta. Her work was mostly in the rural Bengal as the more sophisticated sisters with the MD degree practised in the cities and refused to go to the villages.

The author then chronicles the lives of two women doctors from the South, Muthulakshmi Reddy in Tamilnadu and Mary Poonen Lukose in Kerala. Muthulakshmi was born to a devadasi mother in 1886. She got support from her father in the early years. She joined the Madras Medical College and after graduating, made it her life mission to start a cancer hospital (standing to this day as the Adyar Cancer Institute, Chennai). She also joined active politics and was instrumental in legislation for the women's right to vote and also abolition of the Devadasi system and the abolition of child marriage. She was awarded the Padma Bhushan in 1956.

Mary (1886-1976) hailed from a Syrian Christian family in Travancore and obtained her medical degree from London. She later obtained training in Dublin and became an obstetrician and gynaecologist. She is credited with performing the first Caesarean section in Kerala, She was also nominated to the Legislative assembly and also became the Head of medical services at Travancore. She became the first female Surgeon general in 1938, a first for India and also the World; that it took another fifty years, for a woman to become the Surgeon general in the US, could give us a perspective of the achievement of Mary Poonen. She is credited with performing India's first caesarean section and was instrumental in establishing a very strong public health system in Kerala.

The saga of these journeys are remarkable for the extra-ordinary grit and determination shown by these young women in their teens and early twenties to fight against the prevalent patriarchal system and to follow their heart's calling. The society then was in a pre-independence period and

only the men had the right for education of their choice. Girls were allowed only upto completion of schooling and college education was almost unheard of. The girls were asked to learn Sanskrit and needlework and had no access to science, mathematics and English. Child marriage was the norm and the girls were married off at a very young age and had to go to the husband's house after attainment of puberty. They were often married to older men in their thirties and forties and to widowers, with the result that child widows were common. They often were subjected to shaving of head and such tortures and were also deprived of properties and often had to resort to prostitution. Septic abortions were common and the women , even in elite households were often treated by midwives or dais; they could not be treated by doctors of modern medicine and usually were mistreated. It is indeed remarkable for these 'lodestars', then, to have demonstrated exemplary courage, grit and determination to fight the prevalent society to achieve what they achieved. The book graphically describes the obstacles in their paths. In the case of Rukhmabai , for instance, she took on the giants of nationalist forces such as Tilak. She fought for the right for Hindu women to divorce against all odds. There were

extensive articles decrying such women and some articles even described her as having ' loose character'. On her part, she wrote in the press , under a pseudonym and desperately argued for the right to education. The book also vividly describes the winds of change blowing across the country both on the social and political front. The effects of the Brahmo Samaj movement by RajaRam Mohan Roy and the education reforms propagated by Ishwar Chandra Vidyasagar helped bring about some support to these women. In the later years, Gandhi argued for participation of women in the freedom struggle and women like Sarojini Naidu and Annie Besant played a role in shaping the minds of young Muthulakshmi and Mary.

It is very interesting to note the conservative approach of the medical colleges of those days. Even in the US and in Britain, medical colleges were reluctant to admit women and often resorted to a different classroom to keep them away from male students. The boys protested that the women not be given admission. The same was true in India, with obstacles to earliest admissions to women students in Calcutta Medical college, Grant medical college, Bombay and Madras Medical college. Even here, the boys protested when the women candidates did exceedingly well. In fact



when Haimabati Sen secured the highest marks and was eligible for the gold medal, there were ugly scenes of protest, after which she had to forfeit the gold medal and settle for silver medal instead. There were cries that she should be killed even!

The sociopolitical happenings of those days also have been captured in detail, which is of course necessary, to give a perspective to the readers of the odds against the women. It is these social hurdles that gave an impetus for many of them to enter the political arena and be active in creating systems much more congenial to the future progress of women in India. In fact the author makes a flat statement that if women in India have a right to vote, they have to be thankful to Muthulakshmi Reddy for she fervently worked for the right to vote while she was a member of the Legislative council. Similarly it was Rukhmabai's dogged perseverance to fight for a legal separation, that later paved the way for woman's right to refuse to live with her husband and to raise the age of consent for marriage. Notably it was Mary Lukose's hard work that paved the way for universal immunization and public health reforms.

The author succeeds in capturing the essence of 'the fire in the belly and the steel in the characters' of these women. Clearly, these strong women paved the way for the succeeding generations of women doctors. It is with immense gratitude that I acknowledge their tireless crusade for better education and better life, which has helped us to easily access medical education and walk the path, already well laid out for us. Notwithstanding, it is somewhat disconcerting that some of those social ills pervade our society even today, although, in a veiled manner. Even today, it is a man's prerogative in the medical world with numerous instances of gender discrimination being reported the world over- be it an all- male panelists at conferences or greater representation of men holding high offices. Therein lies the relevance of this book in stirring the passion of at least a few women to set the things right. In the wake of the blossoming of the Women in Nephrology- India group, I think it is a right beginning to remember these trailblazers which could set the stage for amazing achievements from members of this group.

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CASE STUDY



Bile cast nephropathy in a patient with familial hypocalciuric hypercalcemia: A rare case report

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Abstract:

Familial hypocalciuric hypercalcemia (FHH) is a rare autosomal dominant inherited disease with variable penetrance. FHH is usually benign, however few case reports of recurrent pancreatitis have been published. The management strategy of FHH is unclear. Here we present a case of FHH presenting with bile cast nephropathy, obstructive jaundice due to recurrent pancreatitis. Patient recovered completely with

supportive treatment. He was started on cinacalcet following which his Serum calcium levels reached optimum levels. Since two years he has been on cinacalcet and has no further recurrence of acute pancreatitis. This case report highlights that a right approach to diagnosis and management is life saving and can mitigate unnecessary surgical interventions. It also highlights the use of cinacalcet in the treatment of FHH.

Introduction:

Familial hypocalciuric hypercalcemia (FHH) is a rare autosomal dominant inherited disease due to mutations in calcium sensing receptor genes (CaSR). The mutations in the CaSR can be present either in the long arm of chromosome 3 (FHH1), guanine nucleotide subunit protein alpha 11 (GNA11:FHH2) or adaptor protein complex 2 S1 subunit (AP2S1:FHH3). A loss of function or inactivating mutation in one of these three genes leads to reduced sensitivity of CaSR to extracellular calcium (FHH1) or reduced receptor signal transduction (FHH2, FHH3) causing hypercalcemia, reduced secretion of urinary calcium, increased reabsorption of renal tubular calcium and elevated circulating parathyroid hormone (PTH) levels. FHH1 is usually considered benign and FHH3 have a more severe phenotype.[1]

Here we present a rare case report of FHH presenting as obstructive jaundice.

Case report:

A 19-year-old male university student presented with symptoms of pain abdomen since 4 days, nausea and vomiting since 4 days and yellowish discoloration of the eyes since 2 days. He also complained of decreased urine output since 2 years. On probing, he gives history of recurrent episodes of pancreatitis since 5 years. He was a non-smoker and non-alcoholic. There was no significant family history. On examination, he was icteric and had signs of volume overload. Vitals were stable and systemic examination was unremarkable. Urine microscopic examination showed bile casts [Image1].

On lab evaluation, his creatinine was

10.78mg/dl, Urea was 192mg/dl, S. potassium was 5.4meq/L, Total bilirubin was 25mg/dl with predominantly direct hyperbilirubinemia. S.Amylase and S.Lipase were elevated more than 4 times the upper limit of normal. On reviewing his previous reports he was found to have elevated iPTH levels during the episodes of pancreatitis (even when the renal functions were within normal limits), however his S.calcium was marginally high during the episodes of pancreatitis

He was initiated on hemodialysis in view of persistent anuria for more than 12 hours and symptoms of volume overload. He also received supportive management with IV analgesia and maintenance fluids for pancreatitis and anti-hepatic encephalopathy measures

CT abdomen and pelvis was consistent with bulky pancreas. MRCP showed normal hepatic biliary radicles with main pancreatic duct edema. A diagnosis of obstructive jaundice secondary to pancreatitis (pancreatic edema) was made. Commonest causes of pancreatitis like drugs (mainly steroids), gallstones, hypertriglyceridemia were ruled out. S.Calcium was 11 mg/dl and S.iPTH was elevated (312pg/ml). In view of elevated S. calcium and iPTH during this and previous episodes, hyperparathyroidism was suspected as the cause of hypercalcemia. [Figure1]. T99m-Sestamibi Scan of the parathyroid glands showed no evidence of parathyroid adenoma. 24 hour Urinary calcium excretion was 55mg. Ca/Cr excretion ratio was 0.01. Serum calcium levels showed gradual increase once pancreatitis subsided. A clinical diagnosis of familial hypocalciuric hypercalcemia (FHH) was made in view of hypercalcemia, mild elevation of iPTH and reduced Ca/Cr excretion ratio. [Figure 1]

Patient was initiated on Cinacalcet 30mg once a day. As the pancreatitis subsided with supportive measures, his liver functions and renal functions normalized gradually over a period of one month. Renal dysfunction was attributed to bile cast nephropathy as there was spontaneous recovery with normalisation of liver functions and pancreatitis. At present he is not having any further episodes of pancreatitis and S.calcium levels are within normal limits since 2 years. Genetic analysis was not performed due to financial constraints.

Discussion:

FHH is usually a benign condition. Complications such as pancreatitis have been rarely reported[1,2]. Other complications are osteoporosis, gallstones and chondrocalcinosis[3]. It is well known that FHH is caused due to the inactivating mutations of calcium sensing receptor (CaSR) which reduces the sensitivity to extracellular calcium. However, the mechanism of pancreatitis caused by FHH is poorly understood. Recent studies have linked it with SPINK1 mutation in combination with CaSR mutations [4]. Also, calcium overload causes premature release of trypsinogen causing pancreatitis[5]. Theoretically, the improvement in the sensitivity of CaSR to the presence of extracellular calcium would maintain S.Ca levels within normal range.

Calcimimetics like cinacalcet activates the CaSR allosterically and lowers its activation threshold for extracellular calcium [6]. It is commonly used for the management of inoperable parathyroid adenoma, parathyroid carcinoma and secondary or tertiary hyperparathyroidism [6]. There are few case reports of successful management of FHH with cinacalcet[7]. Different mutations of FHH have different degrees of responsiveness to cinacalcet[8].

Hence, the dose required to maintain optimum S.Calcium levels are unpredictable and varies from patient to patient.

It is yet to be determined if cinacalcet can be used for long term therapy. Our patient was on cinacalcet for 3 years. One case series of FHH used cinacalcet treatment for 3 years and showed that it was safe, well tolerated and maintained optimum levels of S.Calcium and iPTH.

Recurrent pancreatitis is associated with high morbidity and mortality. This case report highlights that a right approach to diagnosis and management is life saving and can mitigate unnecessary surgical interventions. It also highlights the use of cinacalcet in the treatment of FHH.



Image 1: Urine microscopy showing bile cast

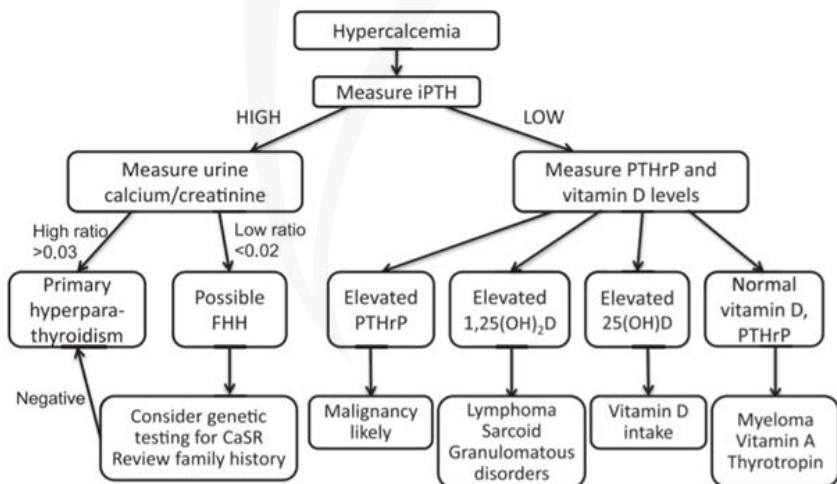
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Figure 1. Diagnostic algorithm for the workup of hypercalcemia



RESIDENT'S COLUMN

Answers

Answers to the Quiz in 1st Edition Aug 2021

1. Urine Microscopy findings:

Urine microscopy shows envelop shaped colourless calcium oxalate crystals. However, calcium oxalate crystals do not develop in the urine for about 4-8 hours following ingestion and if significant renal insufficiency develops, they may not be present for 40 hours following the ingestion

2. Kidney biopsy findings:

Light microscopy shows intratubular oxalate crystals with positive birefringence under polarized light

3. Diagnosis: Ethylene glycol (EG)/ anti- freeze poisoning

4. Confirmation test:

For a definite diagnosis of EG poisoning, measurement of the EG concentration level is necessary, but practically difficult in most hospitals. Since rapid diagnosis and treatments are closely associated with the prognosis of the patients, clinical and laboratory findings are important for treating EG poisoning . EG poisoning is suspected when there is the presence of high anion gap metabolic acidosis, a high osmolar gap, hypocalcemia, and crystalluria. However, the osmolar gap may not be increased in accordance with the metabolism of EG. Therefore, the possibility of EG poisoning cannot be excluded, even if the osmolar gap is normal.

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1. Latency, Anti-Bacterial Resistance Pattern, and Bacterial Infection-Related Glomerulonephritis

Elenjickal Elias John, Athul Thomas, Jeethu Joseph Eapen, Sabina Yusuf, Sanjeet Roy, Anna T. Valson, Vinoi George David, Santosh Varughese and Suceena Alexander

CJASN August 2021, 16 (8) 1210-1220; DOI: <https://doi.org/10.2215/CJN.18631120>

Bacterial infection- related glomerulonephritis (IRGN) is a common clinical problem in Nephrology practice. It is known that IRGN manifestation in adults is often atypical, can occur concurrent to an ongoing infection or may occur after a variable latent period. The prognosis is often not benign and may resolve incompletely and progress to chronic kidney disease. In this paper, Dr Succena Alexander and team from CMC, Vellore have analysed the data of 501 consecutive adult patients with bacterial IRGN from the biopsy registry of 15,545 patients at their centre and studied their follow-up data until December 2019. They studied the latency, that is, the time between resolution of infection and onset of GN and classified it as parainfectious GN (concurrent with the infection, latency=0), peri-infectious (latency 1-7 days) and postinfectious GN (latency > 7 days). The difference in the type of bacterial infection, the antimicrobial resistance pattern, the clinical presentation, outcome and their implications for progression of kidney disease were the key areas of study. Parainfectious, peri-infectious and postinfectious GN were seen in 33%, 27% and 40% patients respectively. Urinary tract and lung infections were mostly associated with parainfectious GN whereas skin infections were mostly associated with postinfectious GN . Gram negative bacteria and drug resistant isolates(91%) were common with parainfectious GN . Of the 321 patients with >3 months followup, 15% developed kidney failure over a median period of 10 months and 4% died. The adverse kidney outcome was commoner in the parainfectious GN and with drug resistant bacterial infections.

Commentary: The article is noteworthy for the elaborate description of all aspects of IRGN - clinical, pathological and microbiological. It is a common clinical feeling that the latency of bacterial infection in IRGN is decreasing

in patients over the recent years. This paper documents this in no uncertain terms. The data is from a biopsy registry (with data from 2005 onwards) and has an impressive sample size. The study has important implications for clinical practice. It implores the clinicians to be watchful for parainfectious GN in cases of infection-associated acute kidney injury or glomerular disease and keep a low threshold for kidney biopsy in these settings. All efforts should be made to continue follow up of such patients for kidney damage, much after the acute event has passed. It also clearly demonstrates that the parainfectious GN group is the more sinister of the three groups and this helps in prognostication. Although the authors state that 36% patients had a short followup and is a limitation, it must be realised that the converse, that is, 64% having a long followup > 3 months is actually a major strength of this study. Coming as it is from the Indian subcontinent, makes it that much more special and relevant to our practice. The authors must be commended for publishing this data and adding significantly to the knowledge of IRGN in adults.

2. Urgent-start dialysis in patients referred early to a nephrologist—the CKD-REIN prospective cohort study

Victor Fages, Natalia Alencar de Pinho, Aghilès Hamroun, Céline Lange, Christian Combe, Denis Fouque et al

Nephrology Dialysis Transplantation, Volume 36, Issue 8, August 2021, Pages 1500–1510,

<https://doi.org/10.1093/ndt/gfab170>

It is well known that even with adequate followup in Nephrology clinics, patients with CKD stage 5 do, at times, initiate renal replacement therapy under emergency conditions. In this prospective observational study, the Chronic Kidney Disease Renal Epidemiology and Information Network collaborators present the data on determinants of urgent-start dialysis. They enrolled a cohort of 3033 adult patients with proven CKD with estimated glomerular filtration rate (eGFR) < 60 mL/min/1.73 m² from 40 nationally representative nephrology clinics over 2013-2016 and followed them over a median period of four years. Urgent-start dialysis was defined as that 'initiated imminently or < 48 hours after presentation to correct life threatening manifestations' according to the Kidney Disease: Improving Global Outcomes 2018 definition. Baseline data collection instruments included patient- and provider-level questionnaires. They noted that 541 patients initiated dialysis with a known start status and 86 (16%) were identified with urgent starts. Fluid overload, electrolytic disorders, acute kidney injury and post-surgery kidney function worsening were the reasons most frequently reported for urgent-start dialysis. Adjusted odds ratios for urgent start were significantly higher in patients living alone-2.14 [95% confidence interval (CI) 1.08– 4.25] or with low health literacy-2.22 (95% CI 1.28–3.84), heart failure-2.60 (95% CI 1.47–4.57) or hyperpolypharmacy (taking >10 drugs)-2.14 (95% CI 1.17–3.90), but not with age

or lower eGFR at initiation. They were lower in patients with planned dialysis modality [0.46 (95% CI 0.19–1.10)] and more nephrologist visits in the 12 months before dialysis [0.81 (95% CI 0.70–0.94)] for each visit.

Commentary: While it is well known that patients get delayed referral to nephrology clinics and may start dialysis on an emergency basis with consequent morbidity and mortality implications, studies have not quantified the percentage of urgent start dialysis even after adequate follow up at nephrology clinics. The study is unique because it gives an estimate of the incidence of urgent-start dialysis in patients with CKD, who are on followup at nephrology clinics. About 19% patients with mostly Stage 3-4 CKD needed dialysis and of them, about one-fifth needed to begin dialysis urgently over a four- year period. It also highlights that of the patient-related factors influencing urgent start, low health literacy and living alone were predictors of urgent start. Number of nephrology visits before dialysis and planning dialysis modality were favourable for the patients with more planned dialysis initiations. This objective assessment of determinants for urgent start dialysis helps clinicians to focus on the high risk groups and thereby reduce morbidity and mortality associated with urgent start dialysis. Hyperpolypharmacy, commonly seen in our patients, must be avoided and attempts must be made periodically to lower the pill burden by assessing ongoing need for those drugs. The study identified several areas of potential improvement in clinical practices, including arranging patient

information clinics, increasing intensity of nephrology care and attendance at education programmes in advanced CKD. In the Indian context, the financial status of the patient/family and the presence or absence of government subsidy for dialysis is also an important consideration, and this highlights the need for region-specific and country -specific studies for such socio-medical issues.

3. Roxadustat for the treatment of anaemia in chronic kidney disease patients not on dialysis: a Phase 3, randomized, open-label, active-controlled study (DOLOMITES)

Jonathan Barratt, Branislav Andric, Avtandil Tataradze, Michael Schömgig, Michael Reusch, Udaya Valluri, Christophe Mariat

Nephrology Dialysis Transplantation, Volume 36, Issue 9, September 2021, Pages 1616–1628, <https://doi.org/10.1093/ndt/gfab191>

Roxadustat, an orally administered hypoxia-inducible factor prolyl hydroxylase inhibitor, is a new agent being evaluated for treatment of anaemia of chronic kidney disease (CKD). In this randomized, open-label, active-controlled Phase 3 study, authors compared roxadustat versus darbepoetin alfa (DA) in non-dialysis-dependent (NDD) CKD patients with anaemia for ≤ 104 weeks. Doses were titrated to correct and maintain haemoglobin (Hb) within 10.0–12.0 g/dL. The primary endpoint was Hb response in the full analysis set, defined as Hb ≥ 11.0 g/dL and Hb change from baseline (BL; CFB) ≥ 1.0 g/dL in patients

with BL Hb >8.0g/dL or CFB ≥2.0g/dL in patients with BL Hb ≤8.0g/dL during the first 24 weeks of treatment without rescue therapy (non-inferiority margin, -15%). Key secondary endpoints included change in low-density lipoprotein (LDL), time to first intravenous (IV) iron use, change in mean arterial pressure (MAP) and time to hypertension occurrence. Adverse events were assessed. In all, 616 patients were randomized to Roxadustat or DA. Hb response with roxadustat was non-inferior to DA (roxadustat: 256/286, 89.5% versus DA: 213/273, 78.0%, difference 11.51%, 95% confidence interval 5.66–17.36%). Roxadustat maintained Hb for up to 2 years. It was non-inferior to DA for change in MAP and time to occurrence of hypertension and superior for change in LDL and time to first IV iron use. Safety profiles were comparable between groups. There was no difference between groups regarding the composite endpoints major adverse cardiovascular events (MACEs) and MACE+ [MACE: 0.81 (0.52–1.25), P=0.339; MACE+: 0.90 (0.61–1.32), P=0.583]. The authors conclude that Roxadustat is a viable option to treat anaemia in NDDCKD patients maintaining Hb levels for up to 104 weeks.

Commentary : It is well known that anaemia is a key factor for adverse clinical outcome in patients with CKD, even among the earlier stages, not requiring dialysis. For years, we have used erythropoietin or darbepoetin with the aim of correction of anaemia. However there are some patient subsets, these agents may not be well tolerated. Since these are to be administered parenterally, there are additional challenges with adequate

dosing and compliance. Roxadustat is a promising drug in this respect, as it is an oral drug. This study demonstrates the safety and efficacy of Roxadustat in management of anaemia in patients with nondialysis dependent CKD. The effect is sustained over 2 years and the requirement for iron seems to be lower in patients on Roxadustat compared with those on Darbepoetin. The ferritin levels are lower in those on Roxadustat indicating effective iron utilisation, which again may translate into better cardioprotection. Lowering of LDL cholesterol and thereby beneficial cardiac effects are an added advantage. However the study is an open label study which may be a source of bias. Further the generalizability of this study to Asians or Indians is not clear from this study indicating the need for more such work across races.

4. Adverse clinical outcomes associated with RAAS inhibitor discontinuation: analysis of over 400 000 patients from the UK Clinical Practice Research Datalink (CPRD)

Toby J L Humphrey, Glen James, Eric T Wittbrodt, Donna Zarzuela, Thomas F Hiemstra

Clinical Kidney Journal, Volume 14, Issue 10, October 2021, Pages 2203–2212, <https://doi.org/10.1093/ckj/sfab029>

This article examines the risk of adverse clinical outcomes in patients with CKD who had to discontinue Renin-angiotensin-aldosterone system inhibitors (RAAS), for various reasons.

This exploratory, retrospective analysis utilized data from the UK's Clinical

Practice Research Datalink, linked to Hospital Episodes Statistics and the Office for National Statistics databases. Adults (≥ 18 years) with first RAAS inhibitor use between 1 January 2009 and 31 December 2014 were included. Time to the first occurrence of adverse clinical outcomes [all-cause mortality, all-cause hospitalization, cardiac arrhythmia, heart failure hospitalization, cardiac arrest, advancement in chronic kidney disease (CKD) stage and acute kidney injury] was compared between RAAS inhibitor users with and without interruptions or cessations to treatment during follow-up. Among 434 027 RAAS inhibitor users, the risk of the first occurrence of all clinical outcomes, except advancement in CKD stage, was 8–75% lower in patients without interruptions or cessations versus patients with interruptions/cessations. Increasing age, smoking, CKD, diabetes and heart failure are some factors which were seen to enhance the risk for adverse clinical outcomes.

Commentary: It is well known that the RAAS inhibitors are very often discontinued due to a variety of reasons - hypotension, hyperkalemia and so on. Even after those factors are rectified, it is usual to avoid reinstating them. This study shows that there is a need for effective management of factors associated with RAAS inhibitor interruptions or cessations in CKD patients. The sample size is large and is one of the strengths of the study. The authors argue that RAAS inhibitors must be reinstated whenever possible and as soon as possible after the adverse effect attributable to their use has been effectively tackled. In a similar article,

also published in October 2021 (Nephrol Dial Transplant, 2021; 36(10): 1893–99), Walther et al studied a cohort of more than 140,000 patients over a mean duration of 4.87 years. Discontinuation of ACEI/ARB was associated with a higher risk of death as well as End stage kidney disease (ESKD) in these patients, the risk progressively worsening with the duration of discontinuation of treatment. Both the studies support the notion that all efforts must be made to continue CKD patients on RAAS inhibitors with modification of diet, other medications etc., and the dose must be titrated to reach the maximally tolerated dose. Even when they are discontinued for some adverse clinical event, the patients should be reinitiated on these drugs with adequate doses. Both the studies give the message that we can easily adopt in our clinical practice.

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WIN INDIA Registry - A Sure path to literature from India

I wish to introduce everyone to the WIN registry concept. We are all aware that we have a lot of patient load and huge clinical experience in our country. However, we do not have many multi-centric publications from our country. We rely on Western data and follow Western guidelines. If we have our own registry we can use the data for meaningful research and analysis and translate that to publications under the WIN banner.

Many of us are worried about the time needed for data filling.

1. I am busy with my clinical work and this would be time consuming.

The registry data entry would be so designed that you will need to fill the data once which you can do in your hospital or clinic. You need not use paper and pen to write patient's prescription. Once you fill the data, you can generate a printout of prescription in a minute and give it to the patient and at the same time your data entry is complete. I am doing this since last couple of years and the patients are also very happy with the printed prescriptions and I am saving a lot of time as well.

2. Who owns the data?

Data would be with the primary nephrologist filling the data. Each one of us willing to enter the data would get a unique user-name and password. The link for registry would soon be

added on the WIN website. You will have access to your own data. Anonymized data would be under WIN registry. Publications would be according to the publication policy of WIN which would be transparent and as per guidelines.

There is very little data on kidney diseases in women and we Indian women in Nephrology can take the initiative. This would be a major step forward and a huge contribution from WIN to Indian Nephrology. Not only this, we would become a major player in the International WIN network and contribute to the world literature. Remember publication is one aspect of WIN which would be there to stay for a long time to come.

Let us move forward as a TEAM.

Together Everyone Achieves More

Dr. Manisha Sahay

Convenor, WIN Registry

E: drmanishasahay@gmail.com

Upcoming Events

4th Dec 2021

1st WIN Transplant Web Series

Immune stratification of Transplant recipients case discussion - Dr. Shruti Tapiawala & Dr. Swarnalatha

25th Jan 2022

Basics of an RCT- an interactive session

by Primyamavada, Nivedita and Arpana



Events Organized

30th Oct 2021

Clinical Research Methodology Workshop - Session -1” (Formulating a research question and selecting the right study design)

Dr. Arpana Iyengar, Dr. Priyamvada, Dr. Niveditha

The collage consists of six screenshots from a Zoom meeting. The top-left screenshot shows a presentation slide titled "CONSTRUCTING RESEARCH QUESTIONS" with a crane hook icon and the text "GOING INTERESTING RESEARCH" and "MATS ADELSSON & JACQUEL SANDERSSON". The top-right screenshot shows a slide titled "Sample size and precision" with a normal distribution curve and a diagram of a population being sampled. The middle-left screenshot shows a grid of video feeds of participants. The middle-right screenshot shows a slide about "conclusion from statistical analysis" with a 2x2 matrix for Type I and Type II errors and a normal distribution curve. The bottom-left screenshot shows a slide titled "STEP 3: PICOT" with a list of Population, Intervention, Comparator, Outcome, and Time. The bottom-right screenshot shows a circular diagram with 10 steps for "Building a core of independent research to answer questions".

Link: <https://youtu.be/PuAelyndPml>

Events Organized

3rd October 2021

**Touching Basics of Nutritional Intervention -
Cardiovascular Complications in CKD
Dr. Anitha Saxena**

10th Sept 2021

**Quiz conducted Dr Sonal Dalal and
Dr. Shruti Tapiawala**

CONGRATULATIONS TO ALL WINNERS !!!!!

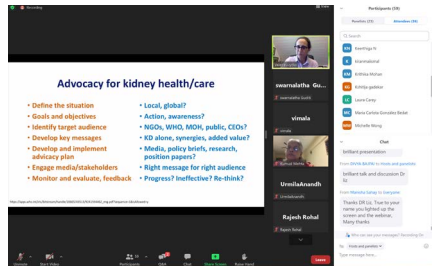
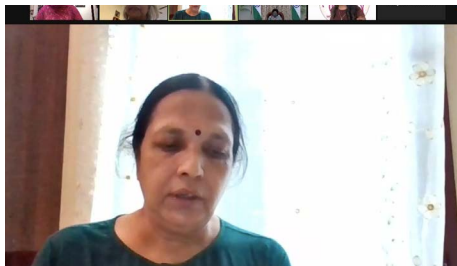
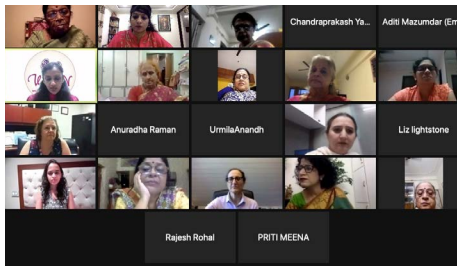
- I. Dr.Indradipmaitya -AIIMS, NewDelhi
- II. Dr.Arpit Gupta -AIIMS, NewDelhi
- III. Dr.Anita Ramavajula -OMC, Hyderabad

Events Organized

21st August 2021

Women in Nephrology - India 1st International meet
Conference

Dr. Lisa M Curtis, Prof. Liz Lightstone
Prof. Valerie Luyckx



Publication corner – Recent publication by WIN Members

1. Y J Anupama, Ravi G N Patel, Mahesha Vankalakunti. Nephrotic Syndrome Following ChAdOx1 nCoV-19 Vaccine Against SARS-CoV-2.
[https://www.kireports.org/article/S2468-0249\(21\)01283-3/fulltext](https://www.kireports.org/article/S2468-0249(21)01283-3/fulltext)
2. Sahay M, Jasuja S, Tang SCW, Alexander S, Jha V, et al. Aetiology, practice patterns and burden of end-stage kidney disease in South Asia and South-East Asia: A questionnaire-based survey. *Nephrology (Carlton)*. 2021 Feb;26(2):142-152.
<https://doi.org/10.1111/nep.13825>
3. Suceena Alexander, Santosh Varughese, Rajanbabu Franklin, Sanjeet Roy, Grace Rebekah, Vinoi George David, et al. Epidemiology, baseline characteristics and risk of progression in the first South-Asian prospective longitudinal observational IgA nephropathy cohort. *Kidney Int Rep*. 2021 Feb; 6(2): 414–428 doi: 10.1016/j.ekir.2020.11.026.
4. Yadla M. Transplantation of Human Organs Act: Act of transplantation – Time to act on the Act! - Narrative review. *Indian J Transplant* 2021;15:260-5 DOI: 10.4103/ijot.ijot_19_19.
5. Soumyadeep Bhaumik, Maya Gopalakrishnan, Priti Meena. Mitigating the chronic burden of snakebite: Turning the tide for survivors. *The Lancet*. 2021 Oct; 398(10309):1389-1390.
6. Rao SN, Chandra A, Tiwari P, Mishra P. Development and Validation of a Novel Food-frequency Questionnaire for Hemodialysis Patients in Lucknow, India. *Indian J Nephrol*. 2021 May-Jun;31(3):276-282. doi: 10.4103/ijn.IJN_134_19. Epub 2021 Apr 10. PMID: 34376943; PMCID: PMC8330646.

Achievements



WIN Congratulates

**Dr. Dhanalakshmi,
Dr. Deepti & Dr. Anitha**

for their the 1st successful
Kidney transplant in ESI
Hospital Hyderabad

Achievements

1. **Women in Nephrology** - India for Neph JC Social justice award
2. **Dr. Mythri Shanker** for Neph JC CJASN Visual Abstract of the year award
3. **Dr. Nivedita Girmaji** and **Dr. Arpana Iyengar** for 1st Mentee and Mentor under WIN India activity
4. **Dr. Divya Bajpai** for EC Member in ISOT and Digital Nephrology initiation and appreciation
5. **Dr. Manish Sahay** for President Hyderabad Nephrology Forum and Deputy chair CME Committee, ISN
6. **Dr. Majusha** for Vice president, Hyderabad Nephrology Forum
7. **Dr. Swarnalatha** for General Secretary, Hyderabad Nephrology Forum, FRCP
8. **Dr. Kiranmai Ismal** for executive member, Hyderabad Nephrology Forum
9. **Dr. Namrata Parikh** for Ottawa Renal Transplant fellow
10. **Dr. Anita Ramavajula** for GLOMCON fellowship








Tributes to Dr. Srilatha Vadlamusi MD. DM. (Nephrology)

She started her journey in Nephrology from Andhra Medical College, Vizag. She was brilliant in her studies and was hard working. She won gold medal for DM Nephrology in NTR University. She presented paper on SLE in an international conference during residency days. She also received fellowship in Nephrology from an Italian University soon after completing DM Nephrology. Due to her interest in academics, she joined as faculty at NRI Medical College and rose to become the professor. She was very dynamic and had clear vision with great concern for the kidney patients. She was instrumental in starting renal transplantation program at NRI Hospital and performed over 250 renal transplants in a short span. Unfortunately we lost her on 15th Aug 2021 at a very young age. It's a great loss to the entire Nephrology Community and Women in Nephrology.

She will always live in our hearts and memories.



www.winindia.org

   @WomenNeph_india