SLSON

NephCON 2026

KIDNEY HEALTH FOR ALL: EARLY ACTION, LASTING IMPACT

IN COLLABORATION WITH

ISN INTERNATIONAL SOCIETY OF NEPHROLOGY

Indian Society of Nephrology 1970

APSN

7th Annual Academic Sessions

Sri Lanka Society of Nephrology

ABSTRACT BOOK

24th – 26th November 2026

Lotus Ballroom, Shangri-La Colombo

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MESSAGE FROM THE PRESIDENT OF SLSON



Dr. Nalaka Herath
President
Sri Lanka Society of Nephrology

It is my great pleasure to welcome you to NEPHCON 2026, the 7th Annual Academic Sessions of the Sri Lanka Society of Nephrology (SLSON). This year's theme, **"Kidney Health for All: Early Action, Lasting Impact,"** reflects our shared commitment to strengthening kidney health through early detection, timely intervention, equitable access to care and sustainable improvements in nephrology services.

We are particularly honoured to welcome a distinguished international faculty from across the globe. Our collaborations with the International Society of Nephrology (ISN), the Asian Pacific Society of Nephrology (APSN) and the Indian Society of Nephrology highlight the value of international partnerships in advancing clinical practice, research and professional development.

The scientific programme has been carefully designed to provide a comprehensive academic experience, featuring **four plenary sessions and ten symposia** covering contemporary topics in adult and paediatric nephrology. The sessions will provide opportunities to discuss recent advances, share clinical experiences and translate scientific evidence into improved patient care.

In addition to the main programme, two pre-congress workshops have been organised to strengthen professional knowledge and practical skills. The first was *Haemodialysis Master Class* for dialysis doctors and nurses, conducted by local experts. The second, *State of the Art in Hemodialysis*, will feature an international faculty from the UK, Australia and India. These workshops reflect our commitment to continuous professional development and improving the quality of renal replacement therapy services.

We are pleased with the response to our call for abstracts, receiving **56 submissions, comprising 46 local and 10 international abstracts**. We are also delighted to offer four travel grants to support international abstract presenters and encourage wider academic participation. This response reflects the growing interest in nephrology research and scientific exchange.

Beyond the academic sessions, NEPHCON 2026 provides a valuable platform for networking, sharing experiences, building professional relationships and fostering future research collaborations. We hope these interactions will contribute to advancing kidney health in Sri Lanka and the wider region.

I extend my sincere gratitude to our international and local speakers, symposium organisers, moderators, abstract reviewers, sponsors and members of the organising committee for their invaluable contributions. I also warmly acknowledge all delegates and abstract presenters for being part of this important academic gathering.

I warmly welcome you all to NEPHCON 2026 and wish you an enriching and memorable academic experience.

Together, let us advance kidney health through collaboration, innovation and early action, ensuring a lasting impact on the lives of those affected by kidney disease.

MESSAGE FROM THE PRESIDENT OF ISN



Marcello Tonelli
President,
International Society of Nephrology

Dear friends and colleagues from the Sri Lanka Society of Nephrology.

On behalf of the International Society of Nephrology, I bring our warmest greetings and our very best wishes for a successful and inspiring meeting.

Although I wish I could join you in person, I am delighted to send this message of congratulations and appreciation. The Sri Lanka Society of Nephrology has long been a respected partner of the ISN, and your steady progress in kidney care and research is recognized throughout the region.

Our two societies have worked closely together for many years. Sri Lanka has been deeply engaged in ISN programs—from the Sister Renal Center collaborations that have strengthened training and service delivery, to the Continuing Medical Education initiatives that have supported your annual sessions and regional symposia. These efforts have helped nurture a vibrant and successful nephrology community.

The program for this year's NephCON meeting is outstanding. It exemplifies our shared goals of ensuring equitable access to high quality kidney care for everyone, worldwide…and speaking up for those whose voices might otherwise not be heard.

The ISN is proud of its partnership with the Sri Lanka Society of Nephrology. I look forward to continuing to work with you on our shared mission, and on working to achieve the commitments of the World Health Assembly resolution on Kidney Health, as well as the Political Declaration from the third High Level Meeting on prevention and control of noncommunicable disease. I am confident that Sri Lanka will continue to play an important role in these global efforts.

Please accept my warmest congratulations on this important occasion, and my best wishes for a productive and memorable conference.

MESSAGE FROM THE PRESIDENT OF APSN



Hyeong Cheon Park, MD, PhD
President, Asian Pacific Society of Nephrology (APSN)

Dear Distinguished Guests and Members of the Sri Lanka Society of Nephrology,

On behalf of the Asian Pacific Society of Nephrology (APSN), it is my distinct honor to extend my warmest congratulations to the NephCON 2026.

This year's theme, "Kidney Health for All: Early Action, Lasting Impact," resonates with APSN's core mission across the Asia-Pacific region. SLSON's dedicated focus on early detection, timely intervention, and sustained management of chronic kidney disease—particularly among high-risk individuals with diabetes mellitus and hypertension—sets a remarkable benchmark for preventive nephrology. Your commitment to strengthening screening programs, ensuring continuity of care, and empowering frontline medical officers through regional workshops and educational initiatives directly addresses the root causes of disease progression. Furthermore, your strong advocacy for expanding public-sector access to essential, evidence-based therapies such as SGLT2 inhibitors represents a vital step toward altering the trajectory of CKD and improving long-term patient outcomes.

As a testament to our enduring partnership and commitment to advancing regional education, APSN is delighted to support two distinguished speakers at NephCON 2026: Dr. Christy Au from Hong Kong, who will share valuable insights on Monoclonal Gammopathy of Renal Significance, and Dr. Nadim Beruni from Australia, who will present on Frailty in CKD and ESRD. By bringing together local practitioners and international experts, this congress fosters the collaborative spirit essential to overcoming healthcare disparities and advancing kidney care across our region.

I wish the organizing committee, faculty, and all participants a highly productive, inspiring, and successful congress.

Warmest regards!

MESSAGE FROM THE PRESIDENT OF INDIAN SOCIETY OF NEPHROLOGY & GUEST OF HONOUR



Prof. Ashwani Gupta
President, Indian Society of Nephrology
Co-Chair, Institute of Renal Sciences
Sir Ganga Ram Hospital
New Delhi, India

Dear Colleagues,

On behalf of the Indian Society of Nephrology, it is my privilege and honour to extend our warm greetings and heartfelt congratulations to the Sri Lanka Society of Nephrology on their 7th Annual Conference, being held in the capital city of Colombo. The theme of the conference is "Kidney Health for All: Early Action, Lasting Impact."

State-of-the-art kidney care and organ transplantation are progressing rapidly in Sri Lanka, as is evident from previous conferences and the scientific programme of this conference, which features four plenary sessions and ten symposia, along with two pre-conference hemodialysis workshops for doctors, nurses, and technicians. Invited faculty from various countries will be deliberating on topics within their areas of special expertise, and 46 abstracts from nephrology colleagues in Sri Lanka and 10 from abroad are being presented.

Webinars, zonal activities, and national conferences are a testament to our shared commitment to improving kidney health through clinical excellence, the exchange of advanced knowledge, and research. The burden of kidney disease is increasing all over the world, and there is a shortage of organs for transplantation. A partial answer to this challenge lies in early detection, prevention, and preservation of kidney function through the judicious use of medications.

The Indian Society of Nephrology values our Sri Lankan colleagues. We look forward to joint collaborations for clinical excellence through webinars for case discussions, trainee exchange, multicentric research, and fellowships in various subspecialties such as transplantation, CAPD, and interventional nephrology.

You are most welcome to become members of the Indian Society of Nephrology and avail yourselves of the benefits, including discounted membership of ERA and ISN.

I wish the Organising Committee of NephCON 2026, its Organising Chairman, Dr Nalaka Herath, and Honorary Secretary, Dr Buddhika Illeperuma, a highly successful conference.

Warm regards!

MESSAGE FROM THE GUEST OF HONOUR



Dr. Anil Jasinghe
Secretary, Ministry of Health and Mass Media, Sri Lanka

It is indeed a great pleasure and privilege to join you at NEPHCON 2026, the Annual Academic Sessions of the Sri Lanka Society of Nephrology, held under the important and timely theme, **"Kidney Health for All: Early Action and Lasting Impact."**

Chronic kidney disease remains a major public health concern in Sri Lanka, with far-reaching implications for individuals, families and the national healthcare system. Addressing this challenge requires a strong, coordinated and sustained national commitment, extending from prevention and early detection to the provision of comprehensive kidney care. The Government recognises the urgent need to strengthen screening and early diagnosis, particularly among high-risk populations, while ensuring that essential investigations and evidence-based cardio-renal protective medications are accessible at all levels of healthcare.

We need to expand and strengthen dialysis services, improve the equitable distribution of resources and advance a well-coordinated and sustainable deceased-donor kidney transplantation programme. These priorities must be supported by effective national policies, reliable surveillance systems and appropriate investment in renal healthcare infrastructure. Our objective must be not merely to respond to kidney disease, but to prevent its progression, reduce its burden and ensure timely, quality treatment for all who need it.

This Ministry is committed to working in close partnership with SLSON, healthcare professionals and all relevant stakeholders to translate these priorities into meaningful action. Our collective responsibility is to strengthen prevention, improve early diagnosis and ensure that quality renal care is accessible to every citizen, regardless of geographical or socioeconomic circumstances.

I commend SLSON for its valuable contribution to kidney health through professional education, research, advocacy and service development. I wish the Society every success in its future endeavors. I am confident that its continued partnership with this Ministry will contribute significantly towards building a stronger, more equitable and sustainable kidney care system for Sri Lanka.

MESSAGE FROM THE CHIEF GUEST



Hon (Dr.) Nalinda Jayatissa M.P.
Minister of Health and Mass Media
Democratic Socialist Republic of Sri Lanka

It gives me great pleasure to contribute this message to the abstract book of NephCON 2026, the 7th Annual Academic Sessions of the Sri Lanka Society of Nephrology (SLSON). I extend my warmest congratulations to the President, the Council, and the Organizing Committee for their dedication and tireless efforts in bringing together this prestigious scientific forum.

Chronic kidney disease continues to pose a significant public health challenge in Sri Lanka, making the work of our nephrology community vital to the well-being of our nation. Forums like NephCON 2026 play a crucial role in uniting clinicians, researchers, nurses, and trainees to exchange knowledge, showcase local research, and strengthen clinical standards. I am particularly encouraged by the Society's ongoing commitment to preventive nephrology, early detection, and expanding access to quality renal care across the country.

As the Ministry of Health and Mass Media works to strengthen Sri Lanka's healthcare system, partnerships with dedicated professional bodies like SLSON remain indispensable. By fostering local expertise and engaging in international collaborations, you are directly contributing to better patient outcomes and a healthier future for our citizens.

I commend all authors and researchers whose abstracts are featured in this publication for their valuable contributions to medical science. I wish the organizers, speakers, and all participants every success in this year's academic sessions and in your continued service to kidney health in Sri Lanka.

MESSAGE FROM THE EDITORIAL TEAM

It is our great pleasure to welcome you all to the 7th Annual Academic Sessions of the Sri Lanka Society of Nephrology – NEPHCON 2026, and to this year's Abstract Book. We are proud to share that this year, NEPHCON 2026 showcases the highest number of abstracts in the history of our annual sessions, reflecting the vibrant growth of nephrology research across the country and our regional collaborations.

To uphold the highest standards of scientific rigor, every submission underwent a thorough evaluation, with independent review by **two or more peer reviewers** before selection. We extend our heartfelt gratitude to all our reviewers for their dedication, meticulous evaluation, and hard work in maintaining the quality of this scientific compilation.

We also sincerely thank the esteemed judges who will be evaluating the oral and poster presentations during the conference for their valuable time and expertise. In keeping with our commitment to Green Nephrology, which we have maintained over the last two years, this year's abstract book is presented entirely in electronic form.

Curating and compiling this volume has been a demanding yet deeply rewarding journey—a labour of love carried out with immense pride and joy in service of our nephrology community.

We warmly invite you to explore these pages, engage fully in the sessions, and enjoy an inspiring and enriching scientific programme.



Dr Dilukshi Pilapitiya
The Editor
Sri Lanka Society of Nephrology

Associate Editors



Dr Brammah Thangarajah



Dr Nayomi Wadduwage

VIDYA JYOTHI PROFESSOR REZVI SHERIFF ORATION



Prof. Sradha Kotwal
BhB MBChB FRACP PhD
Program Head, Research Program
Associate Professor (Conjoint) , Faculty of Medicine, UNSW Sydney

FROM MONOTHERAPY TO MULTI-TARGETED PROTECTION: A NEW ERA OF COMBINED THERAPY IN CHRONIC KIDNEY DISEASE CARE

It is a distinct honour to deliver the **Vidya Jyothi Professor Rezvi Sheriff Oration** at the Annual Academic Sessions 2026 of the Sri Lanka Society of Nephrology.

Following Professor Rezvi Sheriff's passing earlier this year, this lecture carries deep significance. While I never had the opportunity to work with him directly, his towering legacy as the Father of Nephrology in Sri Lanka—having pioneered the nation's first kidney transplant in 1985 and as Founder President of this Society—continues to inspire the broader nephrology community.

Aligned with this year's theme, *"Kidney Health for All: Early Action, Lasting Impact,"* my oration, **"From Monotherapy to Multi-Targeted Protection: A New Era of Combined Therapy in Chronic Kidney Disease Care,"** examines how nephrology care has shifted clinical practice—enabling earlier intervention and reducing the need for dialysis for patients with kidney disease.

My sincere thanks to the SLSON President, Council, and Organising Committee for this privilege. I wish the Annual Academic Sessions 2026 every success.

SRI LANKA SOCIETY OF NEPHROLOGY
SLSON

NephCON 2026

KIDNEY HEALTH FOR ALL: EARLY ACTION, LASTING IMPACT

SCIENTIFIC PROGRAMME



PRE-CONGRESS Workshop 1

Mastering Haemodialysis

From Prescription to the Dialysis Chair

Interactive Lectures | Practical Sessions | Real-World Problem Solving

DATE	VENUE	TARGET AUDIENCE
13th November 2026 Friday	Hotel Ramada Colombo	Doctors and Nurses across Sri Lanka

MORNING PROGRAMME

Time	Session	Speaker, designation & workplace
09:00 – 09:05 AM	Welcome Address	**Dr. Nalaka Herath** President – SLSON Consultant Nephrologist Colombo North Teaching Hospital
09:05 – 09:30 AM	One Prescription Doesn't Fit All – How Do We Personalise HD?	**Dr. G.J. Ramesh** Consultant Nephrologist National Nephrology Specialized Hospital, Polonnaruwa
09:30 – 09:55 AM	Too Much Fluid – How Do We Find the Right Dry Weight?	**Dr. Anupama De Silva** Consultant Nephrologist National Institute of Nephrology, Dialysis & Transplantation (NINDT)
09:55 – 10:20 AM	When BP Falls – And When BP Doesn't: What Should We Do?	**Dr. Buddhika Wijayawickrama** Consultant Nephrologist National Nephrology Specialized Hospital, Polonnaruwa
Tea break – 15 minutes		
10:35 – 11:00 AM	Protect the Lifeline – Keep the Access Working	**Dr. Malaka Amarasinghe** Consultant Vascular and Transplant Surgeon, National Institute of Nephrology, Dialysis & Transplantation (NINDT).
11:00 – 11:25 AM	Protect the Line – Stop Bloodstream Infection Before It Starts	**Dr. S.B.A.M. Mujahith** Consultant Nephrologist Teaching Hospital Batticaloa
11:25 – 11:50 AM	Don't Just Press Mute! – Solve the Dialysis Machine Alarm	**Dr. Udana Rathnapala** Consultant Nephrologist District General Hospital, Gampaha
11:50 – 12:15 PM	When a Child Needs Haemodialysis – What Should We Do Differently?	**Dr. Venuja Bandara** Consultant Paediatric Nephrologist National Nephrology Specialized Hospital, Polonnaruwa
12:15 – 12:25 PM	Vote of Thanks	**Dr. T. M. Naseef** Consultant Nephrologist District General Hospital, Chilaw
Lunch break		
1:00 PM onwards | Afternoon practical sessions		

Advancing Kidney Care Through Knowledge, Collaboration and Compassion

PRE-CONGRESS Workshop 2

State of the Art in Haemodialysis

24th November 2026 | Shangri La Colombo

WORKSHOP PROGRAMME

Time	Topic	Speaker
08:20 – 08:30 AM	Welcome and Introduction to the Workshop	**Dr Nalaka Herath** President Sri Lanka Society of Nephrology
08:30 – 09:00 AM	Dialysis prescription: optimizing dialysis dose	**Prof Andrew Davenport**
09:00 – 09:30 AM	Fluid management and avoiding intradialytic hypotension	**Prof Andrew Davenport**
09:30 – 10:00 AM	Vascular access – type, timing, selection, technique	**Dr Vineet Behera**
10:00 – 10:30 AM	Complications of Vascular Access – AV Fistula & Dialysis catheters	**Dr Vineet Behera**
10:30 – 10:45 AM · Tea		
10:45 – 11:15 AM	POCUS for fluid assessment, AV fistula & vascular access	**Dr Vineet Behera**
11:15 – 11:45 PM	Managing dialysis related complications	**Dr Nadim Beruni**
11:45 – 12:15 AM	Hemodialysis Machine Troubleshooting & Alarms	**Dr Vineet Behera**
12:15 – 12:45 PM	Incremental dialysis: is it a viable strategy in LMICs?	**Prof Andrew Davenport**
12:45 – 01:45 PM · Lunch		
01:45 – 02:15 PM	Conservative vs dialysis decision-making in frail patients	**Dr Nadim Beruni**
02:15 – 02.45 PM	Haemodialysis for the Small Child: Practical Challenges and Solutions	**Dr Perry Lau**
02:45 – 03:15 PM	Recent advances in haemodialysis	**Prof Andrew Davenport**
03:15 – 03:30 PM · Closing remarks and Tea		

INAUGURATION CEREMONY

7TH ANNUAL ACADEMIC SESSIONS

24th November 2026 | 6.00 pm onwards | Lotus Ballroom, Shangri-La Colombo

PROGRAMME

06.30 pm	Guests take their seats
06.45 pm	Ceremonial Procession
06.55 pm	National Anthem and Lighting of the Traditional Oil Lamp
07.05 pm	Welcome address by President SLSON **Dr Nalaka Herath**
07.25 pm	Video Address by the President of the International Society of Nephrology (ISN) **Prof. Marcello Tonelli**
07.30 pm	Address by Guest of Honour **Prof. Ashwani Gupta**, President Indian Society of Nephrology
07.35 pm	Address by Guest of Honour **Dr Anil Jasinghe**, Secretary, Ministry of Health and Mass Media
07.40 pm	Address by Chief Guest **Dr Nalinda Jayatissa**, Honourable Minister of Health & Mass Media
07.50 pm	Conferment of SLSON Fellowship
07.55 pm	Presentation of Medal to Immediate Past President of SLSON & Awarding of Research Grants
08.00 pm	Vidya Jyothi Professor Rezvi Sheriff Oration: ***From Monotherapy to Muli-Targeted Protection: A New Era of Combined Therapy in Chronic Kidney Disease Care*** **Prof. Sradha Kotwal**, Nephrologist and Clinical Dialysis Lead, Prince of Wales Hospital, Sydney, Australia; Program Head, Renal and Metabolic Division, The George Institute for Global Health, Australia
08.40 pm	Vote of Thanks by Secretary SLSON **Dr Buddhika Illeperuma**
08.45 pm	Cultural Performance
09.00 pm	Departure of the Ceremonial Procession
09.05 pm	Reception & Fellowship

NephCON 2026

KIDNEY HEALTH FOR ALL: EARLY ACTION, LASTING IMPACT

SCIENTIFIC PROGRAMME

7th Annual Academic Sessions of the Sri Lanka Society of Nephrology

24th – 26th NOVEMBER 2026 | Shangri-La Colombo, Lotus Ball Room

PRE-CONGRESS 1 – 13 NOVEMBER 2026

Hemodialysis Workshop for Dialysis Doctors and Nurses

Ramada by Wyndham, Colombo

By Local Experts

PRE-CONGRESS 2 – 24 NOVEMBER 2026

State of the Art in Hemodialysis: For Nephrology Specialists and Trainees

- Prof. Andrew Davenport, UK
- Dr. Nadim Beruni, Australia
- Dr. Vineet Behera, India

Shangri-La Colombo, Lotus Ball Room

SCAN QR TO REGISTER

DAY 1 – 25 NOVEMBER 2026

07.30 – 08.30	**Breakfast Capsule: SLSON joint session with University of Kelaniya and RemediumOne: Improving outcomes in kidney disease, the role of clinical trials** *Prof. Asita de Silva, Sri Lanka* *Prof. Sradha Kotwal, Australia* *Prof. Vivek Kumar, India*
08.45 – 09.15	**Plenary 1:** Acute kidney injury (AKI) – Overview Prof. Vivek Kumar, India
09.15 – 09.45	**Plenary 2:** Lupus nephritis – What's new in diagnosis and management Prof. Alan Salama, UK
09.45 – 10.00	**Tea Break**

ADULT NEPHROLOGY TRACK

10.00 – 11.15	**Symposium 1:** General Nephrology • Hepatorenal syndrome and AKI in liver disease – current concepts *Prof. Andrew Davenport, UK* • From protein to acidosis: The metabolic journey to CKD *Prof. Magdi Yaqoob, UK* • Monoclonal gammopathy of renal significance (MGRS) *Dr. Christy Au, Hong Kong*
11.15 – 12.30	**Symposium 2:** CKD Complications • Anaemia in CKD *Dr. Ranjith Nair, India* • CKD–MBD & Osteoporosis *Prof. Magdi Yaqoob, UK* • Frailty in CKD and ESRD *Dr. Nadim Beruni, Australia*

PEDIATRIC NEPHROLOGY TRACK

10.00 – 11.15	**Symposium 1:** Challenging Glomerular disorders in children • Complicated PIGN: When the course is not typical *Prof. Aditi Sinha* • IgA Nephropathy in children: Diagnosis, risk stratification and management *Prof. Nicholas Larkins* • Lupus Nephritis: Recognising the red flags and optimising treatment *Prof. Aditi Sinha*
11.15 – 12.30	**Symposium 2:** Paediatric kidney transplantation: challenges and solutions • The Failing Graft: Evaluation and preparing for a second transplant *Prof. Priya Verghese* • Rejection after kidney transplantation: Recognising and managing the challenging cases *Prof. Anne Durkan* • HLA in paediatric kidney transplantation: Matching, sensitisation and compatibility *Prof. Nicholas Larkins*

12.30 – 13.30	**Oral presentation**
13.30 – 14.30	**LUNCH**

ADULT NEPHROLOGY TRACK

14.30 – 15.45	**Symposium 3:** Tropical Nephrology • Tropical infections and the kidney *Dr. Nalaka Herath, Sri Lanka* • Toxins and the kidney *Prof. Vivek Kumar, India* • Renal complications of snakebite envenoming *Prof. Eranga Wijewickrama, Sri Lanka*

PEDIATRIC NEPHROLOGY TRACK

14.30 – 15.45	**Symposium 3:** Complex challenges in paediatric kidney care • Tubulopathies: Recognizing patterns in electrolyte disorders. *Dr. Perry Lau* • Imaging the paediatric kidney: Choosing the right investigation *Dr. Nilushi Hewawasam* • Transition to adult care *Prof. Priya Verghese*

15.45 – 16.45	**Shaping the Future of Deceased Donor Kidney Transplantation in Sri Lanka** **Moderator:** *Dr. Udana Ratnapala, Sri Lanka* *Prof. Magdi Yaqoob, UK* *Dr. Anura Hewageegana, Sri Lanka* *Dr. Sagari Kiriwandeniya, Sri Lanka* *Dr. Arjuna Thilakarathna, Sri Lanka* *Dr. Ayanthi Karunarathne, Sri Lanka* *Dr. Asha De Alwis, Sri Lanka* *Prof. Joel Arudchelvam, Sri Lanka* *Dr. Buddhima Jayawickrama, Sri Lanka*
16.45 – 17.00	**Evening Tea**

ORGANIZED BY

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KIDNEY HEALTH FOR ALL: EARLY ACTION, LASTING IMPACT

SCIENTIFIC PROGRAMME

7th Annual Academic Sessions of the Sri Lanka Society of Nephrology

24th – 26th NOVEMBER 2026 | Shangri-La Colombo, Lotus Ball Room

DAY 2 – 26 NOVEMBER 2026

08.30 – 09.00	**Plenary 3:** Cardio-Kidney-Metabolic disease: From evidence to clinical practice Prof. Sradha Kotwal, Australia
09.00 – 09.30	**Plenary 4:** Kidney disease in pregnancy Dr. Kate Wiles, UK
09.30 – 10.45	**Symposium 4:** Glomerular disease • Focal segmental glomerulosclerosis (FSGS) *Dr. John Booth, UK* • IgA Nephropathy *Dr. Thomas Oates, UK* • Complement mediated glomerulonephritis *Dr. John Booth, UK*
10.45 – 11.00	**Tea Break**
11.00 – 12.15	**Symposium 5:** Kidney Transplant • Evaluation and optimization of the kidney transplant recipient *Prof. Soumita Bagchi, India* • Management of acute and chronic antibody-mediated rejection *Prof. Alan Salama, UK* • Diagnosis and management of infections after kidney transplantation *Dr. Shyam Bansal, India*
12.15 – 13.30	**Symposium 6:** CAPD • Peritoneal dialysis prescription management *Prof. Andrew Davenport, UK* • PD Peritonitis – The Sword of Damocles *Dr. Sampath Kumar, India* • Lessons from a PD-First program *Dr. Christy Au, Hong Kong*
13.30 – 14.30	**Lunch**
14.30 – 15.45	**Symposium 7:** Genetic kidney diseases/Renal stone disease • Genetic kidney diseases *Dr. Thomas Oates, UK* • Biomarkers of disease progression in ADPKD *Prof. Dharmendra Bhadauria, India* • Metabolic evaluation and medical management of kidney stone disease *Dr. Anurag Gupta, India*
15.45 – 17.00	**Quiz followed by Award Ceremony**
17.00 onwards	**Evening Tea**

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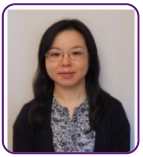
KIDNEY HEALTH FOR ALL: EARLY ACTION, LASTING IMPACT

FACULTY DETAILS



FACULTY DETAILS

MAIN CONGRESS AND PRE CONGRESS 2



Dr. Christy Au
Associate Consultant
Department of Medicine
Queen Mary Hospital, Hong Kong



Dr. Nadim Beruni
Medical Clinical Superintendent & Renal Physician
Westmead Hospital, Australia



Dr. Perry Lau
Senior Consultant
Division of Pediatric Nephrology, Dialysis and Renal Transplantation
National University Hospital, Singapore



Dr. Sampath Kumar
Senior Consultant Nephrologist
Meenakshi Mission Hospital and Research Centre
India



Dr. Shyam Bansal
Director & Head, Nephrology
Medanta Medicity, Gurgaon



Dr. Thomas Oates
Consultant Physician
Department of Nephrology and General Medicine
The Royal London Hospital, UK



Dr. Vineet Behera
Professor of Medicine & Nephrologist
Armed Forces Medical College
Pune



Prof. Alan Salama
Professor and Honorary Consultant Nephrologist
University College London, Royal Free Hospital, London



Prof. Anne Durkan
Clinical Associate Professor
University of Sydney



Prof. Magdi Yaqoob
Professor of Nephrology and Transplantation
The Royal London Hospital and Queen Mary University of London, UK



Prof. Priya Verghese
Professor of Pediatrics, Division Head of Kidney Diseases
Ann & Robert H. Lurie Children's Hospital of Chicago



Prof. Sradha Kotwal
Consultant Nephrologist
Prince of Wales Hospital, Sydney
Associate Professor (Conjoint), Faculty of Medicine, UNSW Sydney

FACULTY DETAILS



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Additional Professor
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Prof. Soumita Bagchi
Professor of Nephrology
All India Institute of Medical Sciences
New Delhi, India



Dr. Anura Hewageegana
Consultant Nephrologist
The National Hospital of Sri Lanka



Prof. Eranga Wijewickrama
Professor in Department of Clinical Medicine
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Honorary Consultant Nephrologist, National Hospital of Sri Lanka



Dr. Nalaka Herath
Consultant Nephrologist
Colombo North Teaching Hospital, Ragama, Sri Lanka



Prof. Joel Arudchelvam
Professor in Vascular and Transplant Surgery
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Prof. Asita de Silva
Senior Professor; Director,
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Dr. Sagari Kiriwandeniya
Deputy Director General
(Medical Services I)
Ministry of Health, Sri Lanka



Dr. Arjuna Thilakarathna
Deputy Director General,
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Dr. Buddhima Jayawickrama
Consultant Vascular Surgeon
National Hospital, Kandy,
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Dr. Asha de Alwis
Consultant Transfusion Physician
National Blood Centre
Narahenpita, Sri Lanka



Dr. Nilushi Hewawasam
Consultant Paediatric Radiologist
Lady Ridgeway Hospital

FACULTY DETAILS



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KIDNEY HEALTH FOR ALL: EARLY ACTION, LASTING IMPACT

ORAL & POSTER PRESENTATION

SESSION SCHEDULE



ORAL & POSTER PRESENTATION SESSION SCHEDULE

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ABSTRACTS

ORAL PRESENTATIONS



THE AUTOLOGOUS ESCALATION PATHWAY: A FOUR-TIERED STRATEGY FOR COMPLEX DIALYSIS ACCESS CREATION

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Background
In patients who lack suitable conventional radio-cephalic or brachiocephalic options, systematic arterial and venous mapping may identify alternative native access configurations and guide an autologous access strategy.

Methods
This prospective, single-centre observational study evaluated 78 autologous access procedures performed in 2022–2026: distal ulnar-cephalic transposition (UCF, n=20), single-stage brachio-basilic transposition (BBF, n=32), forearm basilic vein transposition (FBVT, n=25) and autologous saphenous vein conduit (ASVG, n=1). Preoperative ultrasound mapping was used to guide selection of autologous access.

Results
Ulnar artery dominance at the wrist was 24% of 475 distal arteries, supporting distal UCF when the radial artery remains unsuitable. Among 580 upper arms, the basilic vein patterns were classified as 4 types. Type A (60%) demonstrated axillary confluence with paired brachial veins and is suitable for BBF. In total, 168 patients had a forearm basilic vein diameter of ≥2.5 mm. A characteristic venous confluence was present just proximal to the medial epicondyle; 62% of patients demonstrated focal narrowing <2 mm just distal to this confluence, representing a potential site of stenosis. In the 78-procedure cohort, 12-month primary patency was 83% for UCF (95% CI 66.5–99.5), 100% for BBF (95% CI 89.3–100), 82% for radial FBVT (95% CI 65.6–98.4).

Conclusion
The pathway provided several native access options when conventional configurations were unsuitable. These findings are descriptive and should be interpreted in light of the single-centre design, selected vessel anatomy and limited follow-up.

TACROLIMUS-BASED MULTITARGET RESCUE THERAPY IN MMF-REFRACTORY C3 GLOMERULONEPHRITIS: A RETROSPECTIVE COHORT STUDY

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Background
Mycophenolate mofetil (MMF) plus glucocorticoids is used for moderate-to-severe C3 glomerulonephritis (C3GN), but persistent proteinuria or declining kidney function may occur. Evidence for rescue therapy after MMF failure is limited, and tacrolimus-based multitarget regimens remain unvalidated.

Methods
In this retrospective, single-centre, single-arm cohort study, adults with biopsy-proven C3GN and inadequate response after ≥6 months of MMF plus glucocorticoids were included. Monoclonal gammopathy was excluded by serum protein electrophoresis, immunofixation, and/or serum free light-chain assessment where clinically indicated. Patients had eGFR ≥45 mL/min/1.73 m^2, UPCR ≥1 g/g, and either <50% proteinuria reduction or ≥30% eGFR decline. Tacrolimus (0.08 mg/kg/day; target trough 5–7 ng/mL) was added to ongoing MMF (1 g/day) and glucocorticoids. Renal response was assessed at 12 months using prespecified criteria; adverse events and histopathological predictors were evaluated.

Results
Thirty-six patients were included. At 12 months, 16 (44.4%) achieved overall renal response: 11 (30.6%) complete and 5 (13.9%) partial. Mean 24-hour proteinuria decreased from 2.6±0.8 to 1.3±0.6 g/day; eGFR declined modestly by 1.4±0.3 mL/min/1.73 m^2. Median time to response was 13 weeks (95% CI 8–20). Greater chronic injury—>25% interstitial fibrosis/tubular atrophy (HR 2.05, 95% CI 1.19–5.10) and segmental sclerosis (HR 1.98, 95% CI 1.30–4.90)—was associated with lower likelihood of response; GBM double contours were not significant (HR 2.32, 95% CI 0.82–4.70). Adverse events occurred in 8 patients.

Conclusions
Tacrolimus-based rescue therapy was associated with renal response in nearly half of MMF-refractory C3GN patients, with acceptable short-term tolerability. Chronic histopathological injury may identify patients less likely to benefit, supporting risk-stratified strategies.

BK POLYOMAVIRUS DNAEMIA AND NEPHROPATHY AMONG GRAFT DYSFUNCTION EPISODES WITHIN TWO YEARS OF KIDNEY TRANSPLANTATION

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Introduction/Objectives
BK polyomavirus (BKPyV) is an important cause of kidney allograft dysfunction. We determined the proportion of BKPyV DNAemia and biopsy-proven nephropathy among graft-dysfunction episodes and explored associated factors, including recent corticosteroid exposure.

Methods
This single-centre retrospective cohort included adults with graft dysfunction within 24 months of kidney-only transplantation who underwent plasma BKPyV PCR. A graft-dysfunction episode was a clinically significant rise in serum creatinine from established baseline prompting diagnostic evaluation; recurrent episodes required intervening resolution or stabilisation. Corticosteroid exposure was the total prednisolone-equivalent dose during the preceding 90 days, including prior pulse therapy but excluding steroids given to treat the index episode. Groups were compared using Mann–Whitney U and exact tests. Sensitivity analysis was restricted to the first eligible episode per allograft.

Results
Among 101 episodes from 77 recipients and 78 allografts, BKPyV DNAemia was detected in 17 (16.8%; 95% CI 10.8–25.3%); 7/17 (41.2%) had biopsy-proven BKPyV-associated nephropathy. Median viral load was higher with nephropathy than without (1.04×10^7 vs 1.85×10^4 IU/mL; p=0.002). DNAemia-positive episodes involved older recipients (45 vs 37 years; p=0.023) and exclusively living-donor allografts (100% vs 72.6%; p=0.011). Corticosteroid exposure did not differ significantly (600 vs 900 mg; p=0.127). In first-episode sensitivity analysis, DNAemia occurred in 12/78 allografts (15.4%).

Conclusions
BKPyV DNAemia occurred in approximately one-sixth of graft-dysfunction episodes, with biopsy-proven nephropathy in more than two-fifths of DNAemic episodes. Higher viral burden was associated with histological nephropathy, while recent corticosteroid exposure was not significantly different between groups.

AGREEMENT, BIAS, AND INTERCHANGEABILITY OF MEASURED AND ESTIMATED GLOMERULAR FILTRATION RATES IN SRI LANKAN CHILDREN WITH CKD

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Background
KDIGO 2024 emphasises regional validation of creatinine-based estimated glomerular filtration rate (eGFR) equations because of geographic differences in paediatric body composition and muscle mass. In resource-limited settings such as Sri Lanka, where exogenous filtration markers such as iohexol are unavailable, 24-hour urinary creatinine clearance (mClcr) remains a practical reference method.

Objective
To assess the interchangeability, systematic bias and P_{30} accuracy of the Modified Bedside Schwartz, CKiD U25, and Full Age Spectrum EKFC equations against 24-hour urinary mClcr in Sri Lankan children with CKD.

Methods
This secondary analysis included 56 children aged 4.1–18.2 years from a prospective paediatric CKD dataset with available serum creatinine and 24-hour urinary clearance measurements. Agreement was assessed using median bias, P_{30} accuracy, Passing–Bablok regression, Bland–Altman analysis, and staging concordance.

Results
All three equations overestimated the GFR with median bias ranging from 1 to 5 mL/min/1.73 m^2. The highest P_{30} accuracy (78.6%) was observed in CKiD U25, compared with EKFC (76.8%) and Schwartz (75.0%). No equation demonstrated significant constant bias. Significant proportional bias was observed with Bedside Schwartz and EKFC, indicating increasing underestimation at higher filtration rates, while CKiD U25 showed no significant proportional bias. All equations demonstrated wide 95% limits of agreement (−54.50 to +35.20 mL/min/1.73 m^2). The staging concordance rates were 55 to 57%.

Conclusion
CKiD U25 showed the best calibration and P_{30} accuracy; however, wide limits of agreement and low staging concordance indicate that none of the equations are interchangeable with 24-hour mClcr for individual clinical decision-making requiring diagnostic precision.

BONE-MINERAL DISORDERS AND VITAMIN D STATUS ACROSS NON-DIALYSIS CHRONIC KIDNEY DISEASE STAGES IN A TROPICAL SETTING: A SRI LANKAN CROSS-SECTIONAL STUDY

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Introduction and objectives
CKD-mineral bone disorder (CKD-MBD) and vitamin D deficiency are common in chronic kidney disease (CKD), yet poorly characterised in South Asia, where sunlight is presumed protective. We describe biochemical CKD-MBD and vitamin D status across non-dialysis CKD stages in Sri Lankan adults.

Methods
Consecutive adults with non-dialysis CKD stages 3–5 attending the Nephrology Clinic, Colombo North Teaching Hospital, Ragama, had calcium, phosphate, PTH and vitamin D extracted from records, interpreted using standard thresholds [hypocalcaemia <2.1 mmol/L, hyperphosphataemia >1.45 mmol/L, raised PTH >65 pg/mL, vitamin D deficient <20, insufficient 20–29, sufficient ≥30 ng/mL (inadequate <30)]. Chi-square, ANOVA, Spearman trend and multivariable logistic regression tests were used.

Results
Among 428 patients (mean age 62.9 years, SD 11.6; 59.6% male; stages 3A–5), biochemistry was available in 410 (calcium), 402 (phosphate), 275 (PTH) and 357 (vitamin D). Hyperphosphataemia occurred in 34.3%, hypocalcaemia in 10.7% and raised PTH in 72.0%; vitamin D was inadequate in 75.9% (deficient 36.1%, insufficient 39.8%). Raised PTH and hypocalcaemia rose progressively across CKD stages (28.1%→95.1% and 10.6%→25.7%, both $p<0.001$); vitamin D inadequacy remained uniformly high. Women had lower vitamin D than men (21.5 vs 26.1 ng/mL, $p<0.001$) and nearly twice the adjusted odds of inadequacy (OR 1.88, 95% CI 1.10–3.23).

Conclusions
CKD-MBD biochemistry and vitamin D inadequacy are highly prevalent in non-dialysis CKD despite a tropical setting and disproportionately affect women. These findings support vitamin D supplementation in CKD stages 3–5 alongside standard management of secondary hyperparathyroidism. Given resource constraints, testing of vitamin D and PTH in selected cases is pragmatic.

KNOWLEDGE, ATTITUDES AND PRACTICES REGARDING DIET AMONG PATIENTS WITH CHRONIC KIDNEY DISEASE: A CROSS-SECTIONAL STUDY

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Background
Dietary self-management is important for managing chronic kidney disease (CKD), yet patients hold misconceptions leading to unsafe or excessive restriction. Recent evidence favours individualised advice and plant-based foods over blanket restrictions.

Objective
To assess CKD patients' dietary knowledge, attitudes and practices, identify common misconceptions, determine factors associated with excessive dietary restriction, and examine its relationship with nutritional status.

Methods
A cross-sectional survey of 234 CKD patients (stages 1–5 non-dialysis) followed up at Colombo South Teaching Hospital assessed knowledge (13 items), attitudes, dietary practices, and information sources.

Results
Mean knowledge score was 6.2/13 (48%); education was the strongest predictor (primary-or-less 5.2 vs A/L-or-higher 7.1, p=0.001). Misconceptions were widespread: 68% believed all patients should drink over 2 L of water daily, 58% believed one strict low-protein diet suits every stage, and 87% endorsed at least one false belief. Excessive restriction (often/always avoiding protein foods, fruit, or vegetables) affected 39% of patients, rising with CKD stage (27% to 52%) and correlating most strongly with mealtime anxiety, fear of fruit/vegetables, and belief that stricter is safer (p<0.001–0.03); knowledge was not protective. Restriction was unrelated to BMI, but avoiding meat, fish, eggs and pulses was independently associated with weight loss (28% vs 8%, adjusted OR 4.2, 95% CI 1.5–11.9, p=0.006). Nearly all patients (99%) named doctors as their main source, though a third relied on non-professional sources.

Conclusion
CKD patients show substantial knowledge gaps and anxiety-driven over-restriction not explained by disease severity alone, which may compromise nutritional status. Targeted, individualised dietetic education addressing psychological drivers of restriction is needed.

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ABSTRACTS

POSTER PRESENTATIONS



HISTOLOGICAL SPECTRUM OF PAEDIATRIC RENAL TUMOURS IN SRI LANKA (2011–2022): PREDOMINANCE OF NEPHROBLASTOMA IN A MIDDLE-INCOME SETTING

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Background
Paediatric renal tumours are uncommon malignancies dominated globally by nephroblastoma (Wilms tumour), although regional histological variation exists. Data from South Asia remain limited, particularly regarding paediatric renal malignancies.

Methods
A retrospective descriptive study was conducted using aggregated paediatric cancer incidence data from the Sri Lanka National Cancer Registry from 2011–2022. Renal tumours occurring in children and adolescents aged 0–19 years were extracted according to ICCC-3 renal tumour classifications. Histological subtypes, sex distribution, and annual trends were analysed descriptively.

Results
A total of 334 paediatric renal tumours were identified during the 12-year study period, including 171 males and 163 females. Nephroblastoma represented the overwhelming majority of tumours (281 cases, 84.1%). Rare renal tumours included clear cell sarcoma of the kidney (15 cases, 4.5%), renal cell carcinoma (12 cases, 3.6%), malignant rhabdoid tumour (3 cases, 0.9%), papillary adenocarcinoma (1 case), transitional cell carcinoma (1 case), and spindle-cell malignant tumours (1 case). Annual renal tumour incidence ranged from 17 cases in 2012 to 38 cases in 2021. Histological diversity was greater during earlier years, whereas later years demonstrated increasing nephroblastoma predominance. Overall sex distribution was nearly equal despite marked annual fluctuations.

Conclusion
Paediatric renal tumours in Sri Lanka remain overwhelmingly dominated by nephroblastoma, supporting the persistent embryonal nature of childhood renal oncogenesis in middle-income settings. Epithelial renal malignancies were rare but consistently present throughout the study period. The recurrent identification of uncommon renal sarcomas and rhabdoid tumours highlights the importance of maintaining specialised paediatric oncopathology services and national cancer registry surveillance.

CLINICO-PATHOLOGICAL PROFILE AND TREATMENT OUTCOMES OF PATIENTS WITH IGA NEPHROPATHY USING THE INTERNATIONAL IGA NEPHROPATHY PREDICTION TOOL – A SINGLE CENTRE DESCRIPTIVE STUDY

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Background
Immunoglobulin A nephropathy (IgAN) in India is often severe, presenting with significant proteinuria and kidney impairment. The International IgAN Prediction Tool estimates 5-year progression risk using clinical data and Oxford MEST criteria, but its utility in directing short-term treatment in South Asian cohorts requires further evaluation.

Methods
This prospective, observational study at AIIMS Patna evaluated primary IgAN patients (eGFR >15 mL/min/1.73 m^2) from January to December 2025. Risk stratification was performed using the online prediction tool. All patients received supportive care; those at highest risk (proteinuria >1 g/day) received oral corticosteroids for 3 months. Clinical and biochemical responses were reassessed at 3 months.

Results
Out of 74 included patients (median age 26 years, 66% male), rapidly progressive glomerulonephritis was the most common presentation (39.2%), and 91.9% were hypertensive. The T-lesion (tubulointerstitial injury) was the primary determinant of baseline renal dysfunction. The prediction tool was applied to 35 patients: 0% lowest risk, 37.1% intermediate, 37.1% higher, and 25.8% highest risk. Serum creatinine increased systematically across risk strata. However, linear regression showed that risk category and immunosuppression did not significantly predict 3-month changes in creatinine or eGFR ($p > 0.60$) and ($p > 0.86$), respectively.

Conclusion
Indian IgAN patients display a late-presenting, chronicity-dominant phenotype where tubulointerstitial damage drives outcomes. While the International Tool is valuable for baseline risk stratification, Western-derived absolute thresholds may underestimate risk in South Asians, losing statistical discriminative power regarding treatment response over short timeframes.

EVALUATING TUBULO-GLOMERULAR OUTCOMES WITH LOW-DOSE CYCLOPHOSPHAMIDE (EURO-LUPUS REGIMEN) IN ACTIVE LUPUS NEPHRITIS

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Introduction / Objectives
In lupus nephritis (LN), glomerular dysfunction manifests as proteinuria, while urinary Neutrophil Gelatinase-Associated Lipocalin (NGAL) serves as a promising biomarker for tubular damage. This quasi-experimental study evaluated tubulo-glomerular outcomes after low-dose cyclophosphamide (Euro-Lupus regimen) induction by measuring proteinuria and urinary NGAL levels.

Methods
Nineteen patients meeting American College of Rheumatology (ACR) criteria for LN (ISN/RPS Class III and IV, with or without Class V) were evaluated. All participants received the Euro-Lupus induction regimen for 3 months. Clinical and laboratory parameters—including CBC, lupus serology (ANA, anti-dsDNA, C3, C4, anti-phospholipid), 24-hour urinary total protein (UTP), spot protein-creatinine ratio (PCR), spot urinary NGAL, NGAL/creatinine ratio, serum creatinine, serum albumin, and eGFR—were assessed monthly. Disease activity (SLEDAI), activity index (AI), and chronicity index (CI) were tracked accordingly.

Results
Patients had a mean age of 29.0 ± 10.0 years (95.5% female). After 3 months of therapy, overall renal function improved significantly ($p < 0.05$), marked by increases in haemoglobin, eGFR, and serum albumin alongside reductions in serum creatinine and SLEDAI scores. Quantitative monitoring demonstrated highly significant improvements in tubulo-glomerular biomarkers from baseline to 3 months (Table 1). Complete response was achieved in 26.3% of patients and partial response in 36.8%. Treatment response did not differ significantly among histological classes during this short-term period.

Conclusion
Low-dose cyclophosphamide induction significantly reduces proteinuria and urinary NGAL within three months. This regimen effectively reverses both glomerular and tubular damage in LN.

Table 1: Proteinuria and urinary NGAL values at baseline vs. 3 months after induction (N = 19)

Parameter	Baseline (Mean ± SD)	3 Months (Mean ± SD)	p-value*
24-h UTP (g/day)	3.03 ± 0.93	1.55 ± 0.62	0.001
Spot PCR	3.46 ± 1.28	1.64 ± 0.61	0.001
Urinary NGAL (ng/mL)	15.8 ± 6.3	11.4 ± 4.8	0.021
NGAL/Cr (ng/mg)	34.8 ± 10.36	28.3 ± 8.3	0.039

**p-value determined by paired t-test.*

HYPERKALAEMIC PARALYSIS MIMICKING GUILLAIN–BARRÉ SYNDROME IN ACUTE KIDNEY INJURY REQUIRING HAEMODIALYSIS: A CASE REPORT

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Introduction

Hyperkalaemia is a potentially life-threatening complication of acute kidney injury (AKI), usually recognised because of its cardiac effects. Acute flaccid paralysis is an uncommon presentation and may resemble Guillain–Barré syndrome (GBS).

Case Report

A 53-year-old woman with hypertension and type 2 diabetes mellitus developed rapidly progressive bilateral lower-limb weakness over six hours and became unable to stand or walk. Examination showed symmetrical flaccid paraparesis with Medical Research Council grade 1/5 power and absent knee and ankle reflexes. Upper-limb power and reflexes were normal and sensation was preserved. Serum potassium was 7.18 mmol/L and creatinine 231.8 µmol/L, compared with a documented premorbid creatinine of 88 µmol/L. Venous blood gas showed pH 7.41 and bicarbonate 28 mmol/L. Electrocardiography demonstrated peaked T waves. Her regular medication included enalapril and spironolactone; she had recently completed a 10-day course of diclofenac and reported consuming approximately six bananas daily. GBS was considered clinically, while nerve conduction studies later showed no evidence of neuropathy. Hyperkalaemia persisted despite intravenous calcium gluconate, insulin–dextrose and nebulised salbutamol. A single haemodialysis session reduced potassium to 4.7 mmol/L. Lower-limb power recovered rapidly and independent ambulation was restored within 24 hours. Follow-up creatinine was 105 µmol/L.

Conclusion

Severe hyperkalaemia should be considered in acute areflexic paralysis, particularly in patients with AKI or potassium-raising exposures. Hyperkalaemia may occur without metabolic acidosis, and refractory cases with electrocardiographic or neuromuscular manifestations may require urgent haemodialysis.

OPTIMISING LONG-TERM PATENCY IN TRANSPOSED ARTERIOVENOUS FISTULAS

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Background
The durability of transposed autologous arteriovenous fistulas (AVFs) may be compromised by swing point stenosis, kinking and twisting of the transposed vein.

Objective
To evaluate outcomes across two chronological surgical periods during the evolution from standard to technique-modified transposition, with particular attention to thrombosis, primary patency and secondary patency.

Methods
This retrospective, single-centre cohort included 98 transposed AVFs created between 2022 and 2025. Group 1 comprised 41 AVFs created from 2022–2023 using the standard approach; Group 2 comprised 57 AVFs created from 2023–2025, after adoption of a technique-refined approach. The later approach incorporated anastomotic alignment of 20–45°, feeding-tube-guided control of venous orientation during tunnelling, a wide swing-segment pocket, planned skip incisions and tributary management. Primary failure of AVF was defined as inability to cannulate within 3 months. Primary patency was defined as the interval from access creation to thrombosis or the first intervention to restore patency. Secondary patency was defined as continued access patency until abandonment, with salvage interventions.

Results
Primary failure due to thrombosis occurred in 9.8% of AVFs in Group 1 and none in Group 2. At two years, primary patency in Groups 1 and 2 was 82% and 98%, respectively.

Conclusion
The refined technique was associated with fewer primary failures and good primary patency. These observational findings do not establish causation; changes in follow-up and operator experience over time may have contributed to the observed difference.

PARENTAL KNOWLEDGE AND PRACTICES REGARDING URINARY TRACT INFECTION IN CHILDREN IN A SELECTED POPULATION IN SRI LANKA

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Introduction and Objectives
Urinary tract infections (UTI) are common in children. This study aims to describe the knowledge and practices regarding UTI among parents of children under 5 years in Gampaha district.

Method
A descriptive study was conducted in three MOH areas in Gampaha district, using stratified random sampling. Children <5 years attending well-baby clinics during April 2026 were recruited. Data were collected using an interviewer-administered questionnaire to mothers and analysed using SPSS.

Results
Four hundred children (male-48.5%, Sinhalese-94.3%, mean age-34.6±19.6 months) were recruited, of whom 28 had prior UTI. The mean maternal age was 32.2±5.3 years, and 70.5% were housewives. Only 35.5% of mothers could name >2 UTI symptoms, and 12.8% knew >1 UTI complication. 49.3% could not name >1 UTI risk factor. On direct questioning, most identified inadequate fluid intake (98.8%) and withholding behaviour (87.8%) as risk factors for UTI. Only 45.8% knew constipation is a risk factor. A significantly higher proportion of mothers educated beyond AL and from higher social class had better knowledge of symptoms ($p<0.05$), complications ($p<0.05$), and risk factors ($p<0.05$) of UTI. Mothers whose children had previous UTI had better knowledge of symptoms ($p<0.05$) and complications ($p<0.01$), but not of risk factors ($p=0.76$). 68.8% claimed lack of awareness as a reason for not practising UTI prevention measures.

Conclusion
Most mothers had poor knowledge of symptoms, complications, and risk factors of UTI. Having a child with previous UTIs increased knowledge regarding symptoms and complications of UTI, but not risk factors.

INTUSSUSCEPTION AS A RARE CAUSE OF ABDOMINAL PAIN IN A CHILD WITH IDIOPATHIC NEPHROTIC SYNDROME: A CASE REPORT AND REVIEW OF THE LITERATURE

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Introduction

Intussusception is a rare cause of abdominal pain in children with nephrotic syndrome, with fewer than ten reported cases to date. Management remains uncertain, with reports describing response to intravenous albumin and loop diuretics, while others required pneumatic, hydrostatic or surgical reduction. We describe a child with nephrotic relapse who developed simultaneous ileo-ileal and colo-colic intussusceptions requiring different management approaches.

Case report

A seven-year-old boy with idiopathic nephrotic syndrome presented with his first relapse and commenced prednisolone induction therapy. On day 5, he developed worsening, severe central abdominal pain with significant weight gain and worsening oedema. Despite a fever spike, he remained well perfused with good urine output and no peritonism. Inflammatory markers (CRP 3.5 mg/L) and serum amylase (52.7 U/L) were normal. Serum albumin was markedly low at 13 g/L (>30 g/L).

Intravenous 20% albumin (1 g/kg over 4 hours) with furosemide produced little symptomatic improvement. Abdominal ultrasonography demonstrated simultaneous ileo-ileal and colo-colic intussusceptions. Repeat ultrasonography five hours after albumin infusion demonstrated only the colo-colic intussusception, suggesting spontaneous reduction of the ileo-ileal intussusception following the albumin infusion. The persistent colo-colic intussusception was successfully reduced hydrostatically. Abdominal pain resolved, and he achieved nephrotic remission on day 15.

Conclusion

A broad differential diagnosis of abdominal pain in children with nephrotic syndrome is vital. If pain persists despite exclusion and treatment of common causes, an ultrasound is useful for identifying intussusception. Compared with colo-colic intussusception, ileo-ileal intussusception in nephrotic syndrome patients may be more amenable to treatment with intravenous albumin and loop diuretics.

CHOLESTEROL EMBOLISATION SYNDROME PRESENTING WITH ACUTE KIDNEY INJURY FOLLOWING PERCUTANEOUS CORONARY INTERVENTION: A CASE REPORT

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Introduction

Cholesterol embolisation syndrome (CES) is an uncommon and potentially fatal cause of acute kidney injury (AKI) following invasive vascular procedures. Diagnosis is challenging because renal dysfunction may initially be attributed to following percutaneous coronary intervention (PCI) contrast-associated AKI or other common causes. We report a case of severe AKI as part of multisystem CES following PCI.

Case Report

A 64-year-old man with hypertension, dyslipidaemia, heart failure, extensive coronary artery disease, and a 44-pack-year smoking history underwent emergency coronary angiography and rescue PCI following acute myocardial infarction. Nineteen days later, he presented with oliguria, severe abdominal pain, neurological manifestations, painful bilateral bluish discolouration and gangrene formation of the toes. Serum creatinine had risen from a baseline of 88 µmol/L to 1477 µmol/L, with hyperkalaemia, eosinophilia and elevated inflammatory markers. Brain non-contrast CT demonstrated a cerebellar infarction. Vascular imaging showed aortic atheromatous plaques and distal arterial obstruction, suggesting renal, hepatic, gastrointestinal and cutaneous ischaemia. CES was diagnosed clinically based on delayed onset of severe AKI following PCI, blue toe syndrome, eosinophilia, multisystem involvement and aortic atheroma. He underwent five sessions of haemodialysis and symptomatic management resulting in temporary clinical improvement. He was readmitted with intestinal bleeding and multisystem deterioration. Eventually, he succumbed despite continuous supportive management.

Conclusion

CES must be considered as an important differential diagnosis in patients presenting with AKI following PCI, especially when accompanied by blue toe syndrome, eosinophilia, systemic inflammation and multisystem involvement. Early recognition through clinical diagnosis is crucial, as CES carries a high mortality and requires immediate supportive management.

HAEMOLYTIC URAEMIC SYNDROME IN A YOUNG INFANT WITH STREPTOCOCCUS SALIVARIUS BACTERAEMIA: AN UNUSUAL ASSOCIATION

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Introduction

Haemolytic uraemic syndrome (HUS) is characterised by microangiopathic haemolytic anaemia, thrombocytopenia and acute kidney injury (AKI). Diarrhoea-associated HUS is classically associated with Shiga toxin-producing *Escherichia coli* and *Shigella dysenteriae*. We describe a young infant who developed HUS following a bloody diarrhoeal illness, complicated with severe haematological involvement, shock and stage 3 AKI. He had associated concurrent *Streptococcus salivarius* bacteraemia.

Case report

A two-month-old boy presented with fever, diarrhoea and vomiting. He was severely dehydrated and in shock, with severe metabolic acidosis, hypernatraemia and AKI. He was resuscitated and commenced on intravenous antibiotics.

During admission, he developed progressive thrombocytopenia and microangiopathic haemolytic anaemia with worsening kidney function and reduced urine output. Platelet count reached a nadir of 12,000/mm^3 and haemoglobin 5.9 g/dL. LDH was 530 U/L and blood film demonstrated fragmented red cells consistent with microangiopathic haemolysis. Peak serum creatinine was 103 µmol/L with oliguria, consistent with KDIGO stage 3 AKI. Coagulation remained normal. He developed haematemesis and bloody diarrhoea requiring blood-product support. Blood culture taken on the day of admission grew a pure growth of *S. salivarius*. He received organism-sensitive intravenous antibiotics for 10 days. Repeat blood and stool cultures were negative. He recovered completely, with normalisation of haematological parameters and serum creatinine returning to baseline without dialysis.

Conclusion

This case highlights HUS complicated with severe haematological involvement and stage 3 AKI in a young infant with diarrhoeal illness associated with concurrent *S. salivarius* bacteraemia. Although *S. salivarius* can rarely cause invasive infection, its role in HUS remains uncertain. HUS should be considered in young infants presenting with diarrhoea and AKI who develop thrombocytopenia and microangiopathic haemolysis.

IMMUNOSUPPRESSION AFTER KIDNEY ALLOGRAFT FAILURE: DOES DRUG CLASS INFLUENCE OUTCOMES AFTER RETURN TO DIALYSIS?

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Introduction
Dialysis after graft loss (DAGL) represents a substantial proportion of dialysis initiation. We examined post-graft failure immunosuppression patterns and their association with mortality.

Methods
This was a retrospective multicentre study of adults initiating dialysis over three years within Fresenius Medical Care North America. DAGL was identified by ICD-9/10 codes, with mortality assessed from day 30 using Kaplan–Meier and multivariable Cox regression.

Results
3,056 out of 3,183 incident DAGL patients were alive at the day-30 landmark. 2,302 (75.3%) were receiving at least one immunosuppressive medication. Immunosuppression remained prevalent among survivors at 90 (82.7%), 180 (84.9%) and 365 days (86.7%). Immunosuppression type was not mutually exclusive. Corticosteroids and CNIs were the most commonly used agents. Any immunosuppression use was associated with increased mortality in unadjusted analyses; however, this association was attenuated following multivariable adjustment. CNI use was associated with lower mortality at 90 days (adjusted HR 0.69, 95% CI 0.57–0.85) and 180 days (adjusted HR 0.78, 95% CI 0.62–0.99), with attenuation by 365 days. mTOR inhibitor use was associated with higher mortality at 90 days (adjusted HR 1.66, 95% CI 1.11–2.49), with no statistically significant associations at later time points.

Conclusion
Immunosuppression was frequently continued for ≥1 year after graft failure. Overall immunosuppression and corticosteroid use were not independently associated with mortality after multivariable adjustment. Early CNI use was associated with lower short-term mortality, whereas mTOR inhibitor use was associated with higher early mortality, suggesting class-specific effects. The CNI association may reflect modulation of inflammatory or graft intolerance–related immune pathways, although residual confounding and treatment selection remain possible.

DISCORDANT SERUM AND RENAL LIGHT-CHAIN FINDINGS IN PROLIFERATIVE GLOMERULONEPHRITIS: A DIAGNOSTIC CHALLENGE

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Introduction

Proliferative glomerulonephritis with monoclonal immunoglobulin deposits is considered a monoclonal gammopathy of renal significance (MGRS) lesion. However, light-chain restriction on routine immunofluorescence may represent monotypic rather than truly monoclonal deposition, creating diagnostic and therapeutic uncertainty.

Case Report

A 63-year-old South Asian man presented with generalised oedema and nephrotic syndrome. Serum creatinine was 1.06 mg/dL, albumin 2.3 g/dL, and urine protein-to-creatinine ratio 6.2 g/g, with microscopic haematuria. Complement levels were normal; ANA, ANCA, hepatitis B, hepatitis C, HIV, VDRL, and tuberculosis screening were negative. Serum immunofixation demonstrated an IgG lambda monoclonal gammopathy. Serum free light chains were elevated in absolute terms but the kappa-to-lambda ratio was normal (1.54); urine Bence-Jones protein was negative. Bone marrow examination showed 1% plasma cells without clonal proliferation, and PET-CT revealed no lymphoproliferative disorder. Renal biopsy demonstrated a membranoproliferative pattern with mesangial expansion, endocapillary hypercellularity, and double-contour formation. Immunofluorescence showed strong granular IgG (3+), C3 (2+), and kappa (3+) staining along capillary walls and mesangium, with mild lambda (1+) staining; IgA, IgM, and C1q were negative. IgG subclass staining and electron microscopy were unavailable. Despite discordance between circulating IgG lambda and kappa-predominant renal deposits, the patient was managed clinically as MGRS.

Conclusion

This case highlights the diagnostic complexity of proliferative glomerulonephritis with discordant serum and renal light-chain findings. Renal light-chain predominance does not invariably establish true monoclonality, and discordance does not necessarily exclude MGRS. Management therefore requires integration of renal histology, haematological findings, and the overall clinical context.

REDUCING PERITONEAL DIALYSIS-ASSOCIATED PERITONITIS THROUGH ITERATIVE QUALITY IMPROVEMENT: A TERTIARY-CENTRE EXPERIENCE FROM SRI LANKA

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Introduction
Peritoneal dialysis (PD)-associated peritonitis is a major cause of technique failure, hospitalisation and mortality, and remains an important quality indicator for PD programmes. A 2025 clinical audit in our tertiary PD programme identified a peritonitis rate substantially above International Society for Peritoneal Dialysis (ISPD) quality targets. We aimed to reduce PD-associated peritonitis through structured, iterative quality improvement and to establish sustainable infection-prevention practices within routine care.

Methods
We conducted a single-centre quality-improvement project using two sequential Plan–Do–Study–Act (PDSA) cycles between January and June 2026. Baseline audit findings were reviewed through root-cause analysis to identify patient-, staff- and process-related contributors. Interventions included PD nurse training, structured retraining of patients and caregivers, monthly hand-hygiene and exchange-technique competency assessments, optimisation of dialysate specimen collection and microbiological processing, and standardisation of peri-procedural antibiotic prophylaxis. The primary outcome was the number of peritonitis episodes per patient-year, assessed across baseline and successive PDSA cycles.

Results
At baseline, 12 patients contributed 7.24 patient-years and experienced 13 peritonitis episodes, corresponding to 1.80 episodes/patient-year. Following PDSA cycle 1, 17 patients contributed 3.16 patient-years and experienced five episodes, corresponding to 1.58 episodes/patient-year. After reinforcement and further process standardisation during cycle 2, 15 patients contributed 3.61 patient-years and experienced two episodes, corresponding to 0.55 episodes/patient-year. During cycle 2, no relapsing peritonitis, catheter removal, peritonitis-related technique failure or peritonitis-related mortality occurred.

Conclusions
Iterative multidisciplinary PDSA-based interventions were associated with progressive improvement in PD-associated peritonitis outcomes. Sustained quarterly audit is planned to assess durability.

BEYOND BASELINE eGFR: TUBULAR SECRETORY FUNCTION AND KIDNEY FUNCTION DECLINE IN THE KICSS STUDY

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Background
Estimated glomerular filtration rate (eGFR) is the principal measure of chronic kidney disease (CKD), but may not capture tubular injury or predict kidney function decline. The Kidney Tubular Clearance of Secretory Solutes (KICSS) study examined whether impaired tubular secretion of endogenous solutes was associated with subsequent eGFR decline.

Methods
In this prospective observational study, adults aged 21–65 years with CKD and baseline eGFR 20–60 mL/min/1.73 m^2 attending a nephrology outpatient department at a tertiary-care centre in Northern India were enrolled. Pregnancy, cirrhosis, severe heart failure, recent hospitalisation, and proteinuria >1 g/day were excluded. Plasma and urine concentrations of 10 endogenous proximal tubular secretory solutes—hippurate, p-cresol sulfate, indoxyl sulfate, kynurenic acid, pyridoxic acid, cinnamoylglycine, tiglylglycine, isovalerylglycine, xanthosine, and pseudouridine—were measured by liquid chromatography–tandem mass spectrometry. Tubular secretory function was summarised as a composite score based on urine-to-plasma ratios. The primary outcome was annual eGFR decline, assessed every 3 months for a median of 2.5 years; secondary outcomes were CKD progression and confirmed ≥50% eGFR decline.

Results
Of 620 participants, 500 completed follow-up. Mean age was 48 years, 68% were men, and baseline eGFR was 39.4 ± 18.1 mL/min/1.73 m^2. Lower baseline secretion scores independently predicted faster eGFR decline: each 1-SD decrease was associated with an additional 0.42 percentage-point/year reduction in eGFR (95% CI, −0.68 to −0.16; P=0.002). Fifty participants had CKD progression; 40 had confirmed ≥50% eGFR decline (HR 1.98, 95% CI 1.30–3.90).

Conclusion
Tubular secretory dysfunction provides prognostic information beyond baseline eGFR and may improve CKD risk stratification.

ANAEMIA AND QUALITY OF LIFE AMONG PRE-DIALYSIS CHRONIC KIDNEY DISEASE PATIENTS: A SINGLE-CENTRE STUDY

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Introduction
Anaemia is a common complication among chronic kidney disease (CKD) patients and negatively affects their health-related quality of life (HRQOL). This study aimed to assess the association between anaemia and HRQOL among pre-dialysis CKD patients.

Methods
This cross-sectional study included 171 adults with CKD stages 1–4 attending the Nephrology Clinic at Teaching Hospital Peradeniya, selected by purposive sampling. HRQOL was assessed using the validated Sinhala KDQOL-SF and summarised as Kidney Disease Specific Component (KDSC), Physical Component Summary (PCS), and Mental Component Summary (MCS) scores as per the guidelines. Haemoglobin and serum creatinine values were obtained from clinic records. Chi-square, Mann-Whitney U, Spearman's correlation (r_s) and multiple linear regression were used for analysis.

Results
The mean (±SD) age of participants was 58±16 years, and 57% were male. Anaemia (haemoglobin <13 g/dL in males, <12 g/dL in females) was present in 63.2% (n=108), with 38.6% having mild, 24% moderate, and 0.6% severe anaemia. Anaemia was significantly associated with older age and advanced CKD (p<0.050), with 72.8% of those ≥61 years and 78.8% of stage IV patients having anaemia. Median (IQR) HRQOL scores were 75.7 (15.2) for KDSC, 64.1 (35.7) for MCS, and 46.3 (34.2) for PCS. KDSC [74.7 (14.6) vs. 77.3 (14.9), p=0.030] and PCS [42.5 (26.2) vs. 59.1 (40.6), p=0.001] scores were lower in anaemic patients compared to non-anaemic patients, while MCS scores were not different [63.2 (34.0) vs. 69.0 (37.1), p=0.327]. After accounting for age, sex, and CKD stage, anaemia was independently associated with a lower PCS score (B=−9.2, 95% CI −16.6 to −1.81, p=0.015) but not KDSC score (p=0.168).

Conclusions
Anaemia was common among pre-dialysis CKD patients and was associated with poorer physical aspects of HRQOL.

BEYOND POST-INFECTIOUS GLOMERULONEPHRITIS: C3-DOMINANT GLOMERULOPATHY IN A SEVEN-YEAR-OLD BOY WITH PERSISTENT HYPOCOMPLEMENTAEMIA

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Introduction

Post-infectious glomerulonephritis (PIGN) commonly presents with haematuria, oedema and hypocomplementaemia, with serum complement component 3 (C3) typically normalising within 8–12 weeks. Significant proteinuria, recurrent haematuria and persisting hypocomplementaemia should prompt consideration of alternative diagnoses, including complicated PIGN and C3 glomerulopathy (C3G). We describe a child with an infection-associated presentation who subsequently developed recurrent haematuria, proteinuria and persistent C3 consumption.

Case presentation

A previously healthy seven-year-old boy presented with fever and cough for three days followed by haematuria and periorbital oedema. Blood pressure and renal function were normal. Urinalysis showed numerous red and white cells with 3+ protein, while C-reactive protein was 172 mg/L. Initial C3 was 38 mg/dL (90–207), with normal C4 of 34 mg/dL (17–52).

Over the next two months, he developed recurrent haematuria, oedema and fluctuating sub-nephrotic to nephrotic-range proteinuria. At two months, C3 remained low at 49 mg/dL and urine protein creatinine ratio was 770 mg/mmol (<20 mg/mmol). Renal biopsy at two months demonstrated diffuse proliferative and exudative glomerulonephritis. Immunofluorescence showed C3-dominant coarse granular staining (2+) along capillary walls and mesangium, without significant IgG, IgA, IgM or C1q, supporting C3 glomerulopathy. Electron microscopy was not done due to resource limitations. High-dose oral corticosteroids were commenced and the patient achieved complete remission in one month.

Conclusion

Persistent C3 hypocomplementaemia, recurrent haematuria and significant proteinuria following an infection-associated presentation should prompt evaluation for C3G. C3-dominant glomerular deposition with persistent C3 consumption and preserved C4 supports alternative complement pathway dysregulation and warrants treatment, along with long-term renal surveillance.

PATIENT AND GRAFT OUTCOMES AFTER KIDNEY TRANSPLANTATION AT A TERTIARY CARE CENTRE IN NORTHERN SRI LANKA: A RETROSPECTIVE SINGLE-CENTRE ANALYSIS

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Background
Renal transplantation remains the optimal renal replacement therapy for end-stage renal disease (ESRD), yet data on outcomes from live and cadaveric donor programmes in Northern Sri Lanka are limited.

Methods
Retrospective registry analysis of 31 recipients (16 live-donor, 15 deceased donor) transplanted from November 2021 to August 2026 (census 31 October 2026). Delayed graft function (DGF) was defined as dialysis within the first week. Patient, overall graft, and death-censored graft survival (DCGS) were estimated using the Kaplan–Meier method with 95% confidence intervals (CI). Three recipients lost to follow-up were censored at one month.

Results
Mean age 33.2 ± 11.6 years; 80.6% male. Causes of ESRD: diabetic nephropathy 38.7%, chronic pyelonephritis 12.9%, hypertensive nephrosclerosis, membranous nephropathy and lupus nephritis 6.5% each, other 12.9%, unknown 16.1%. Median follow-up 14.8 months (IQR 5.1–32.9). Pre-transplant dialysis duration was comparable between live and cadaveric groups (17.3 vs. 17.6 months). DGF occurred in 12.5% of live-donor vs. 33.3% of deceased-donor recipients. Three deceased-donor recipients died within one month (COVID-19, fungal infection, surgical bleeding); one live-donor recipient died after graft failure. One- and three-year patient survival was 100% and 87.5% (CI 38.7–98.1; 3 at risk) for live-donor and 80.0% (CI 50.0–93.1; 5 and 4 at risk) for deceased-donor recipients (log-rank p=0.21); one-year DCGS was 100% vs. 86.7% (CI 56.4–96.5). Mean creatinine (µmol/L) at years 1–3: 111.6 ± 43.9 (n=13), 89.6 ± 17.6 (n=7), 82.3 ± 17.5 (n=3) (live donor) and 87.8 ± 9.5 (n=5), 91.0 ± 6.8 (n=4), 94.5 ± 18.0 (n=4) (deceased donor).

Conclusion
Renal transplantation at Teaching Hospital Jaffna, drawing almost equally on live and cadaveric donors, achieved favourable medium-term survival. Outcomes were encouraging but imprecise given small numbers and short follow-up. All deceased-donor deaths were early and infective or surgical, supporting closer peri- and post-transplant surveillance.

CLINICAL CHARACTERISTICS AND OUTCOMES OF PATIENTS RECEIVING CONTINUOUS AMBULATORY PERITONEAL DIALYSIS AT A TERTIARY CARE CENTRE IN NORTHERN SRI LANKA: A SINGLE CENTRE EXPERIENCE

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Background
Continuous ambulatory peritoneal dialysis (CAPD) is an important renal replacement therapy for end-stage renal failure, but infections and catheter-related complications can affect continuity of treatment and outcomes. This study describes the sociodemographic characteristics, complications and outcomes of patients receiving CAPD at a tertiary care centre in Northern Sri Lanka.

Methods
A retrospective descriptive analysis was conducted using a registry of patients who underwent CAPD catheter insertion between December 2021 and August 2026. Data on sociodemographic characteristics, primary renal disease, CAPD duration, peritonitis episodes, catheter-related complications and outcomes were extracted.

Results
Sixty-eight (68) CAPD catheter insertions were performed (52 males, 76.5%; 16 females, 23.5%). Detailed clinical follow-up data were available for 25 patients (80.0% male), mean age 54.8 ± 8.7 years. Most were from Jaffna (64.0%) and Kilinochchi (24.0%). Diabetic nephropathy was the leading cause of renal disease (36.0%), followed by lupus nephritis and chronic pyelonephritis (12.0% each). Of the 68 patients, 14 (20.6%) died while receiving CAPD and 15 (22.1%) converted to HD; no transplant conversions occurred. 19/68 (27.9%) experienced at least one episode of peritonitis and 6/68 (8.8%) developed peritonitis within one month; catheter repositioning was required in 12/68 (17.6%). Among 25 patients with follow-up data, the mean CAPD duration was 12.44 months (range 1–54); catheter-related complications were observed after 2 months, mainly due to obstruction, exit-site infection, and malposition.

Conclusion
Infectious and catheter-related complications were challenges in this CAPD cohort. Conversion to HD and mortality were substantial, while no patients underwent transplantation, underscoring the need for stronger infection prevention and catheter-care practices.

BEYOND DIABETIC NEPHROPATHY: RENAL INFILTRATION BY B-CELL NON-HODGKIN LYMPHOMA PRESENTING WITH RAPIDLY PROGRESSIVE KIDNEY DYSFUNCTION – A CASE REPORT

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Introduction

B-cell non-Hodgkin lymphomas encompass a spectrum of clinical manifestations ranging from indolent to aggressive diseases. Renal infiltration by B-cell lymphomas is uncommon and poses a diagnostic and therapeutic challenge.

Case report

A 75-year-old man with type 2 diabetes and stage-4 chronic kidney disease presented with a deterioration in kidney function disproportionate to progression of diabetic kidney disease (DKD). His serum creatinine had increased from 3.5 mg/dl to 6.8 mg/dl (eGFR 17 to 8 ml/min/1.73 m^2) within 1 year, with proteinuria of only 500 mg/day. He had an absolute lymphocytosis (16.44 × 10^9/l) with small mature lymphocytes on blood picture. There was no lymphadenopathy or hepatosplenomegaly. Flow cytometry identified a mature B-cell lymphoproliferative disorder expressing CD20, CD19, and CD79, negative for CD5 and CD10, with kappa restriction. Serum protein electrophoresis revealed a monoclonal band in the gamma region with 0.9 g/dl monoclonal globulin level. Immunofixation confirmed IgM and kappa chains in the gamma region. The bone marrow and the renal interstitium were infiltrated by a similar population of small mature atypical lymphocytes, positive for CD20 on immunohistochemistry. A low-grade B-cell non-Hodgkin lymphoma was diagnosed on the background of diabetic nephropathy. He did not meet standard criteria for initiating lymphoma treatment. A rituximab-based chemotherapy regimen was started based on renally significant lymphomatous disease; following the first dose, modest creatinine improvement was noted (6.8 mg/dl to 5.9 mg/dl; eGFR 8 to 9.4 ml/min/1.73 m^2), and treatment is ongoing.

Conclusion

In patients with DKD, a rapid decline in kidney function should raise suspicion for an alternative pathology. Identification of a lymphoma-associated renal pathology is rare and may influence treatment decisions; evidence regarding renal outcomes remains limited.

BEYOND CHILDHOOD: EXPLORING THE DISEASE COURSE OF NEPHROTIC SYNDROME IN YOUNG ADULTS

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Introduction
A proportion of childhood nephrotic syndrome (NS) patients carry on the disease into adulthood. Hence, understanding its clinical behaviour during young adulthood is important for long-term disease management. We aimed to identify the post-childhood disease course of NS in young adults, with particular focus on disease patterns, remission rates, and use of immunosuppressive therapies.

Methods
We conducted a retrospective longitudinal study of young adults with childhood-onset NS over two years, followed up at the adolescent-adult transition clinic at Teaching Hospital Peradeniya. We performed a subgroup analysis of patients who completed two years of follow-up. Demographic and clinical data were collected from medical records, including their primary disease, biopsy findings, clinical and biochemical parameters, and treatments used.

Results
Seventy (n=70) patients were studied. Most were male (58.6%), with a median age of 19 years at enrolment (IQR 18–20), and were of Sinhalese ethnicity (77.1%). The majority were steroid-dependent NS (n=53, 75.7%), with 4 (5.7%) steroid-resistant and 13 (18.6%) steroid-sensitive NS. Renal biopsy was performed in 29 (41.4%) patients at some point in the disease course, of whom 11 had FSGS and 11 had minimal change patterns of injury. All patients had corticosteroid exposure at some point, with 31.4% showing steroid side effects. Of the 55 patients who completed two years of follow-up, nine (n=9, 16.7%) had steroid-free remission during the follow-up period, while five (n=5, 9.2%) continued to have recurrent relapses.

Conclusions
Childhood NS demonstrates heterogeneous clinical behaviour during young adulthood, with substantial variation in relapse, remission and treatment exposure. A significant proportion of patients are left with longstanding steroid side effects that carry into adulthood.

ISOLATED RENAL ALLOGRAFT TUBERCULOSIS: A CLOSE MIMIC OF ACUTE REJECTION

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Introduction

Tuberculosis (TB) is a major opportunistic infection in kidney transplant recipients in Sri Lanka, where it is endemic. While pulmonary and disseminated forms predominate, isolated graft involvement is less commonly recognised. We report a case of isolated renal allograft TB diagnosed on histological evaluation of a smear-negative granulomatous lesion, identified on a biopsy performed for rising serum creatinine.

Case Report

A 48-year-old female, 3.5 years post renal transplant, presented with evening pyrexia, malaise, anorexia, graft pain, and acute allograft dysfunction (creatinine 6.4 mg/dL), with elevated inflammatory markers and sterile pyuria. Screening for pulmonary TB was negative.

Biopsy showed extensive granulomatous tubulointerstitial inflammation with severe interstitial infiltrate and tubulitis (Banff i3/t3), without microvascular injury. Granulomas were discrete and well-formed but non-caseating. C4d and SV40 were negative, donor-specific antibodies undetected, and no acid-fast bacilli or fungi seen on special stains.

Xpert MTB/RIF Ultra on biopsy tissue identified Mycobacterium tuberculosis complex at a very low bacillary load, with no rifampicin resistance, confirming renal allograft tuberculosis.

She was commenced on rifampicin-based quadruple anti-TB therapy. As rifabutin was unavailable locally, tacrolimus was raised roughly threefold under close monitoring. Symptoms settled within two weeks, and creatinine fell to 1.6 mg/dL by five months, with a 12-month course planned.

Conclusion

Isolated renal allograft tuberculosis is a close mimic of granulomatous acute cellular rejection with nonspecific clinical and histological features often confounded by negative smears and absent extrarenal disease. This case highlights the diagnostic value of molecular testing on biopsy tissue when clinical suspicion persists, even in the absence of caseation, as potent immunosuppression may fail to mount the necrotising response, and the therapeutic challenge of managing rifampicin–tacrolimus interactions in the absence of rifabutin.

EXPRESSION PATTERNS OF ANXA3 GENE IN TYPE 2 DIABETES MELLITUS AND DIABETIC NEPHROPATHY: A COMPARATIVE STUDY

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Introduction
Diabetic nephropathy (DN) is a major complication of type 2 diabetes mellitus (T2DM) and a leading cause of chronic kidney disease worldwide. Annexin A3 (ANXA3) is a calcium-dependent phospholipid-binding protein involved in inflammatory pathways. Upregulation of *ANXA3* in DN has been studied. However, gene dysregulation in DN compared with T2DM remains unclear. This study investigated *ANXA3* gene expression in T2DM with and without nephropathy and its association with selected clinical and demographic factors.

Methods
Whole blood samples were collected from patients with DN (n = 37), T2DM without nephropathy (T2DM, n = 32), and healthy controls (HC, n = 9). RNA was extracted, reverse-transcribed into cDNA, and analysed using quantitative real-time PCR, with *GAPDH* as the reference gene. Relative *ANXA3* expression was compared among study groups, and associations with factors were assessed using log2-normalised fold-change values.

Results
ANXA3 expression was significantly higher in T2DM (*ANXA3*: FC 72.26 ± 14.29, $p < 0.001$) and DN (*ANXA3*: FC 474 ± 287.96, $p < 0.001$) compared to HC, with significantly higher expression in DN than T2DM ($p = 0.022$). Early-stage DN exhibited higher expression than late-stage DN ($p = 0.035$). Most assessed clinical and demographic factors were not significantly associated with *ANXA3* expression in either group. However, in the DN group, significant associations were observed with insulin use ($p = 0.031$) and gliclazide use ($p = 0.030$).

Conclusion
ANXA3 expression increased from T2DM to DN, with limited factor associations, suggesting a potential role in nephropathy progression and warranting further evaluation as a biomarker.

DISEASE PATTERN OF CHILDREN ATTENDING THE NEWLY ESTABLISHED PAEDIATRIC NEPHROLOGY CLINIC AT TEACHING HOSPITAL BATTICALOA, EASTERN PROVINCE, SRI LANKA: A ONE-YEAR REGISTRY-BASED CLINICAL SURVEY ANALYSIS

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Introduction/Objectives
In Sri Lanka, national data on the burden of kidney disease remain limited, leaving paediatric disease patterns in the Eastern Province largely undocumented. The aim of the survey is to evaluate and understand the disease pattern, which is crucial for effective healthcare management and resource allocation.

Methods
A descriptive, registry-based cross-sectional analysis was conducted using prospectively recorded clinic data for all children enrolled between January 2025 and January 2026 in the paediatric nephrology clinic at Teaching Hospital Batticaloa.

Results
A total of 184 children were enrolled, of whom 135 (73%) had a classifiable diagnosis across 25 distinct diagnostic groups. The overall cohort was 112 male and 72 female (male:female ≈ 1.6:1), with an overall mean age of 5.7 years (median 5.0 years). CAKUT subtypes collectively formed the largest disease burden (50, 37%), led by pelvi-ureteric junction obstruction (18, 13.3%) and vesicoureteric reflux (17, 12.6). Idiopathic nephrotic syndrome accounted for 30 children (22.2%), dominated by steroid-dependent nephrotic syndrome (16, 11.9%). Chronic kidney disease of any stage was recorded in 13 children (9.6%), and renal calculi in 11 (8.1%). By age band, 38% of all children were under 4 years and 15% were aged 12 to under 16, reflecting the early-life predominance of congenital anomalies.

Conclusion
In this first-year registry from a newly established paediatric nephrology service in a resource-limited setting in Eastern Sri Lanka, results mirror the global and South Asian literature. These findings highlight the value of establishing structured paediatric renal registries in under-resourced regions of Sri Lanka.

PLEXIFORM NEUROFIBROMA CAUSING ACUTE ON CHRONIC KIDNEY INJURY SECONDARY TO SEVERE, PROLONGED OBSTRUCTIVE UROPATHY: A RARE CASE PRESENTATION

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Introduction

Plexiform neurofibroma (PN) is a characteristic but potentially debilitating manifestation of neurofibromatosis type 1 (NF1). Genitourinary involvement is rare, and extensive bladder involvement causing urinary tract obstruction and progressive renal impairment is particularly unusual.

Case Presentation

This case describes an 8-year-old boy clinically diagnosed with NF1. He first presented with left buttock swelling at the age of 4 years. MRI evaluation demonstrated a large PN involving the sacral neural plexus, with extensive local extension into the surrounding pelvic tissues. Since this large plexus was not amenable to surgical intervention, he was managed conservatively. There was probable evidence of the PN extending to the bladder wall and corpora cavernosa, resulting in genital disfigurement. After a period of being lost to follow-up, four years later he presented with respiratory symptoms, which were managed as pneumonia complicated by acute kidney injury. The unresolving renal impairment necessitated further evaluation, detecting evidence of stage 5 CKD with a creatinine of 400 µmol/L due to progressive pelvic involvement of the PN causing infiltration of the urinary bladder, resulting in urinary tract obstruction. While bladder function is being evaluated, urinary obstruction is currently being managed with catheterisation, which reduced creatinine to 150 µmol/L with CKD-3b. Complications are being managed conservatively with oral medications, and the possibility of surgical decompression is being evaluated through the multidisciplinary team.

Conclusion

This case describes a rare complication of NF1-associated plexiform neurofibroma resulting in CKD due to severe genitourinary extension and highlights the need for regular follow-up and management to prevent progression of CKD.

SHORT- AND LONG-TERM OUTCOME OF CHILDREN WITH RAPIDLY PROGRESSIVE GLOMERULONEPHRITIS

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Introduction
Rapidly progressive glomerulonephritis (RPGN), characterised by a more than 50% drop in glomerular filtration rate over a short period of time, is a rare paediatric nephrological emergency in children with glomerulonephritis, requiring early recognition and treatment. We evaluated the short- and long-term outcomes and factors associated with disease progression in children with RPGN.

Methods
A retrospective cohort study included children diagnosed with RPGN and managed at the Paediatric Nephrology Unit, National Hospital, Galle, Sri Lanka, from 2014–2026.

Results
Seventy-nine children were included (mean age 8.7±3.2 years; 63% male), presenting after 6±5 days of illness. Macroscopic haematuria (73%) and oedema (74.7%) were the commonest clinical features. Aetiologies included post-infectious glomerulonephritis (39.2%), systemic lupus erythematosus (27.8%), C3 glomerulopathy (16.5%), IgA disease (11.4%), and ANCA-associated vasculitis (5.1%); none had anti-GBM disease. Mean nadir eGFR was 38.4±15.4 mL/min/1.73 m^2, with 38% having stage 3 acute kidney injury (AKI). Mean UPCR was 5.3±3.7, and 64.6% had nephrotic-range proteinuria. Biopsy showed crescents in 22.4%, predominantly cellular. The presence of crescents was associated with higher proteinuria (6.7±3.7 vs. 4.7±3.3; p=0.03) and moderately associated with nephrotic-range proteinuria (Cramer's V=0.28), but not with eGFR, stage 3 AKI, or treatment regimen. All received intravenous methylprednisolone; 69.6% received cyclophosphamide. None required dialysis. At discharge, 83% had normal renal function. After 3.2±2.3 years, 96.1% had normal renal function and 6.5% had persistent subnephrotic proteinuria.

Conclusion
Post-infectious glomerulonephritis and lupus nephritis predominated in this cohort. Despite association with greater proteinuria, presence of crescents did not predict poor renal recovery. Renal function normalised in most children during follow-up.

CARDIAC SURGERY ASSOCIATED ACUTE KIDNEY INJURY: EXPERIENCE AT A TERTIARY CARE HOSPITAL IN BANGLADESH

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Introduction
Cardiac surgery-associated acute kidney injury (CSA-AKI) occurs from a rapid deterioration in renal function following cardiac surgery, expressed as a significant decrease in glomerular filtration rate (GFR). The reported prevalence of CSA-AKI is up to 30%, and the majority of patients experience long-term morbidity and mortality.

Methods
This hospital-based observational study was conducted at the post-surgical intensive care unit of Ibrahim Cardiac Hospital and Research Institute (ICHRI), Dhaka, Bangladesh, from January 2024 to July 2025. A total of 62 patients who underwent cardiac surgery were included in this study. AKI was defined according to KDIGO 2012 guidelines. Data were analysed using SPSS version 24.

Results
The mean age was 56.32 ± 10.23 years, and the cohort was male-predominant (males 43, 69.4%). Types of cardiac surgery were coronary artery bypass graft (CABG) and mitral valve replacement (MVR) operations (CABG 87.1%, MVR 9.7%, and both 3.2%). Hypertension (51, 82.3%) and diabetes mellitus (38, 61.3%) were the major comorbidities. Among 62 patients, 21 (33.9%) developed CSA-AKI. Hypotension (30, 48.4%), sepsis (22, 35.5%), and arrhythmia (17, 27.4%) were the major factors associated with the development of CSA-AKI. Most of the patients who developed AKI improved after conservative treatment, and four required renal replacement therapy. Among AKI patients, four patients died due to prolonged hypotension and sepsis.

Conclusion
One-third of patients developed CSA-AKI, and hypotension, sepsis, and arrhythmias were the major factors associated with developing CSA-AKI. Therefore, preventive measures, early detection, and proper management help to reverse the adverse outcome.

A COMPARISON OF EARLY- AND LONG-TERM GRAFT SURVIVAL BETWEEN CYCLOSPORINE- AND TACROLIMUS-BASED IMMUNOSUPPRESSIVE THERAPIES IN KIDNEY TRANSPLANTATION: EXPERIENCE IN A TERTIARY CARE HOSPITAL OF BANGLADESH

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Introduction
Kidney transplantation is the optimum treatment for most patients with end-stage renal disease. Calcineurin inhibitors (CNIs), cyclosporine or tacrolimus, are one of the three major components of immunosuppressive therapy for kidney transplantation. Our aim was to evaluate and compare early- and long-term graft survival in kidney transplant recipients receiving either of these two CNIs.

Methods
This retrospective observational study included all live-related kidney transplant recipients who underwent surgery at BIRDEM General Hospital, Dhaka, Bangladesh, from November 2004 to December 2022. A questionnaire was developed, and data were collected from the hospital records. A total of 148 live-related kidney transplant recipients were included, and patients were divided into group 1 (52 patients on cyclosporine) and group 2 (96 patients on tacrolimus).

Results
Patients receiving tacrolimus showed renal function similar to that of patients receiving cyclosporine in the early post-operative period; serum creatinine was 1.40 ± 1.04 versus 1.50 ± 1.21 mg/dL (p = 0.598) but they required less time for serum creatinine to become normal (4.02 ± 2.95 versus 5.86 ± 9.83 days, respectively; p=0.092) and less duration of post-transplant hospital stay (12.22 ± 2.16 versus 17.77 ± 18.01 days, respectively; p = 0.003). Acute rejection was higher in group 1 than group 2 (15.1% versus 8.5%, p = 0.014). One- and five-year graft survival was 92.0% and 83.3% in the cyclosporine group and 96.2% and 89.2% in the tacrolimus group, respectively (p-values were 0.276 and 0.306, respectively).

Conclusions
Tacrolimus is associated with significantly lower acute allograft rejection rates and shorter immediate post-transplant hospital stays while yielding comparable early and long-term survival rates.

POST-KIDNEY TRANSPLANTATION DIABETES MELLITUS IN KIDNEY-TRANSPLANTED INDIVIDUALS ATTENDING NATIONAL HOSPITAL GALLE

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Introduction/Objectives
Post-kidney transplant diabetes mellitus (PKTDM) is a common complication after kidney transplantation. Although PKTDM has been extensively studied internationally, local evidence from Sri Lanka remains limited. Therefore, this study aimed to evaluate PKTDM among kidney transplant recipients attending National Hospital, Galle.

Methods
A descriptive cross-sectional study was conducted among kidney transplant recipients with a transplantation history of more than 45 days. Patients with pre-transplant diabetes mellitus were excluded. Data were collected using an expert-validated interviewer-administered questionnaire and medical records. According to the WHO (2011) criteria and previous literature, PKTDM was classified based on HbA1c levels as follows: PKTDM (≥6.5%), pre-diabetes/high risk of diabetes (6.0–6.4%), and non-diabetes/low risk (<6%). Data were analysed using SPSS version 25. The chi-square test was used to determine associations and differences between categorical variables, and Spearman correlation was used for the continuous variables.

Results
Among 52 participants, the majority were males (39, 75%). The majority of participants had a normal BMI (26, 50%), followed by overweight participants (24, 46.2%). Thirty participants (57.7%) had PKTDM, seven (13.5%) were at high risk of diabetes, and 15 (28.8%) were non-diabetic/low risk. More than two-thirds had hypertension, while half of the participants had a family history of diabetes mellitus, suggesting a potential risk factor for the development of PKTDM. Mean serum potassium (p=0.021) and cholesterol (p=0.007) levels were significantly higher among participants with PKTDM.

Conclusions
PKTDM was highly prevalent among kidney transplant recipients, with significantly higher serum potassium and cholesterol, highlighting the importance of regular metabolic monitoring and early identification of factors associated with PKTDM.

PREVALENCE AND SEVERITY OF ANAEMIA IN DIFFERENT STAGES AMONG NON-DIALYSIS CHRONIC KIDNEY DISEASE PATIENTS AT A SRI LANKAN TERTIARY CARE NEPHROLOGY CLINIC

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Introduction and Objectives
Anaemia complicates non-dialysis chronic kidney disease (CKD), but Sri Lankan data are largely limited to prevalence alone. We aimed to determine the prevalence and severity of anaemia, its clinical correlates, and accompanying iron-status patterns in this population.

Methods
We conducted a cross-sectional study of 428 consecutive, consenting adults with non-dialysis CKD stages 3–5 at the Nephrology Clinic, Colombo North Teaching Hospital, Ragama. Haemoglobin, MCV and ferritin were extracted from clinic records; anaemia was defined by WHO criteria and graded mild, moderate or severe. Chi-square, ANOVA and multivariable logistic regression (age, sex, CKD stage) were used for analysis.

Results
Mean age was 62.9 years (59.6% male); 424 of 428 patients had Hb data. Anaemia was present in 83%, graded mild in 33%, moderate in 47% and severe in 3%. Mean Hb declined from 11.7 g/dL (stage 3A) to 10.2 g/dL (stage 5; ANOVA $p<0.001$). Anaemia was more frequent in women on crude comparison (88.8% vs 79.9%, $p=0.022$), but after adjustment only CKD stage independently predicted anaemia (OR 1.46/stage, 95% CI 1.13–1.89); female sex was no longer significant (OR 1.69, 0.94–3.02). Ferritin was <100 ng/mL in 65.1% of 232 tested, despite predominantly normocytic indices (96.8%).

Discussion and Conclusions
As expected, anaemia worsened as CKD progressed. Iron deficiency is suggested by low ferritin levels despite normocytic indices. Overall, though anaemia seemed to be more prevalent among females, when corrected for CKD stage, female sex was not an independent predictor.

DECLINING USE OF PROTECTIVE MEDICINES AS CKD ADVANCES IN NON-DIALYSIS CHRONIC KIDNEY DISEASE PATIENTS AT A TERTIARY REFERRAL CENTRE

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Introduction and objectives

RAAS blockers and SGLT2 inhibitors protect the kidneys and heart, and guidelines support their use in advanced chronic kidney disease (CKD). We examined their use across CKD stages and whether lower use was explained by hyperkalaemia or blood pressure.

Methods

This cross-sectional study included adults with non-dialysis CKD stages 3–5 attending the Nephrology Clinic, Colombo North Teaching Hospital, Ragama. Hyperkalaemia was defined as serum potassium ≥5.5 mmol/L. In hypertensive patients, multivariable logistic regression (CKD stage, hyperkalaemia, systolic blood pressure, age, sex, diabetes) identified factors associated with RAAS blocker use. In diabetic patients, SGLT2 inhibitor use was assessed separately in stages 3–4 and stage 5.

Results

Of 430 patients, 358 had hypertension and 282 diabetes. RAAS blocker use fell from 84.6% in Stage 3A to 35.8% in Stage 5. Hyperkalaemia increased from 10.0% to 27.8% across stages and was less frequent in RAAS blocker users (16.3% vs 27.1%; p=0.024). After adjustment, Stage 4 (OR 0.25; 95% CI 0.10–0.63) and Stage 5 (OR 0.12; 0.05–0.30) remained associated with lower RAAS blocker use, whereas hyperkalaemia (p=0.20) and systolic blood pressure (p=0.68) were not. Systolic pressure below 100 mmHg was rare (1.6%). SGLT2 inhibitor use was 22.2% in diabetic patients with Stage 3–4 CKD and 10.0% in Stage 5.

Conclusions

RAAS blocker use declines with advancing CKD independently of potassium and blood pressure, and SGLT2 inhibitor use is low even in Stage 3–4 CKD, where it is recommended. Acute kidney injury, urinary tract infection and cost were not recorded and require prospective evaluation.

INCOME AND DISEASE BURDEN IN NON-DIALYSIS CHRONIC KIDNEY DISEASE IN A TERTIARY REFERRAL CENTRE

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Introduction and objectives

Lower income is associated with poorer health, but whether this applies across chronic kidney disease (CKD) care in a country with free healthcare is unclear. We assessed the association of household income with disease burden, depression, quality of life (QoL) and use of kidney-protective medicines in non-dialysis CKD.

Methods

This cross-sectional study included 430 adults with CKD stages 3–5 not on dialysis attending the Nephrology Clinic, Colombo North Teaching Hospital, Ragama. Total monthly household income was grouped as <Rs. 50,000, Rs. 50,000–70,000 and >Rs. 70,000. We recorded comorbidities, anaemia (haemoglobin <13 g/dL in men, <12 g/dL in women), bone symptoms, physical activity (IPAQ), depression (DASS-21) and QoL (KDQOL-36). Use of protective medicines was defined as current treatment with a renin–angiotensin–aldosterone system (RAAS) blocker or SGLT2 inhibitor recorded at interview. Groups were compared using chi-square and Kruskal–Wallis tests.

Results

Income data were available for 412 patients; 82.3% had household income below Rs. 70,000 and 68.7% had education up to O-Level or below. Mean comorbidity count fell with rising income (2.41, 2.26 and 1.88; p=0.003), as did anaemia prevalence (87.4%, 82.0% and 73.6%; p=0.023). Bone symptoms (p=0.72) and low physical activity (p=0.06) did not differ. Depression (p=0.007), QoL category (p=0.002) and CKD stage (p=0.011) differed across groups without a consistent gradient. Use of RAAS blockers (p=0.21) and SGLT2 inhibitors (p=0.20) did not differ.

Conclusions

Lower household income was associated with more comorbidities and anaemia, but not with use of kidney-protective medicines. Depression, QoL and CKD stage varied across income groups without a consistent income gradient.

ASSOCIATION OF PLASMA PCSK9 LEVELS WITH MAJOR ADVERSE CARDIOVASCULAR EVENTS IN PATIENTS ON MAINTENANCE HAEMODIALYSIS

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Background
Cardiovascular disease is a significant cause of mortality in patients undergoing maintenance haemodialysis. Proprotein convertase subtilisin/kexin type 9 (PCSK9) plays a key role in regulating lipid metabolism and has been identified as a potential cardiovascular biomarker. However, its connection to major adverse cardiovascular events (MACE) in haemodialysis patients remains insufficiently explored.

Methods
We conducted a cross-sectional study at the Department of Nephrology, National Institute of Kidney Diseases and Urology, Dhaka, Bangladesh, from August 2022 to January 2024, including 77 adults on maintenance haemodialysis and 77 age-matched healthy controls. Plasma PCSK9 levels were assessed by enzyme-linked immunosorbent assay. Continuous variables were reported as median (interquartile range) and compared using the Mann–Whitney U test. Spearman correlation was applied for continuous associations. Receiver operating characteristic (ROC) analysis evaluated discrimination.

Results
The haemodialysis group had higher median systolic blood pressure [150 vs. 120 mmHg; p<0.001] and diastolic blood pressure [90 vs. 70 mmHg; p<0.001] than controls. Total cholesterol and LDL cholesterol were lower in the haemodialysis group, while triglyceride and HDL cholesterol levels did not differ significantly. Plasma PCSK9 levels were significantly higher in haemodialysis participants compared to controls [144.34 (96.12–186.24) vs 75.42 (50.24–104.76) ng/mL; P<0.001]. Among haemodialysis participants, 34 out of 77 (44.2%) experienced at least one MACE. PCSK9 levels were notably elevated in those with MACE compared to those without [187.00 (167.69–220.00) vs 104.60 (78.23–128.92) ng/mL; P<0.001]. A positive correlation was found between PCSK9 and total cholesterol (rho=0.449; P<0.001), while a negative correlation existed with HDL cholesterol (rho=−0.377; P<0.001). The AUROC for MACE discrimination was calculated at 0.993 (bootstrap 95% CI 0.978–1.000).

Conclusions
Higher plasma PCSK9 concentrations were strongly associated with prevalent MACE among patients receiving maintenance haemodialysis. The findings support further prospective investigation of PCSK9 as a cardiovascular risk biomarker in dialysis populations.

CONTINUOUS AMBULATORY PERITONEAL DIALYSIS (CAPD) DISCONTINUATION IN ADULT PATIENTS TREATED AT A TERTIARY HOSPITAL IN SRI LANKA: A RETROSPECTIVE AUDIT

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Introduction
CAPD is an important renal replacement therapy modality, particularly in resource-limited settings, as it is more accessible and expandable. However, CAPD discontinuation remains a challenge. This study assessed the rate and causes of CAPD discontinuation at a tertiary care centre.

Methods
A retrospective audit was conducted among patients who underwent percutaneous CAPD catheter insertion at the Nephrology and Dialysis Unit, CNTH, Ragama, from June 2024 to June 2026. Data were collected from the ward clinical database, which was closed for analysis in June 2026. CAPD discontinuation was defined as death while receiving CAPD or transfer to haemodialysis for 30 days or more.

Results
Of 113 patients, 70 (61.9%) were male, with a mean age of 56.7 years. Overall CAPD discontinuation was 35.4% (40/113), 51.3% (20/39) in 2024–2025 (discontinuation rate at 2 years), and 27.0% (20/74) in 2025–2026 (discontinuation at one year). Death on CAPD was the leading cause (16.8%, 19/113), with the majority being sudden deaths at home or in hospital. Recurrent peritonitis (10.6%, 12/113) was the leading cause among surviving patients. Poor drainage accounted for 5.3% (6/113); four occurred within the first month, consistent with catheter-related failure. Other causes were exit-site infection (0.9%, 1/113), psychosocial issues (0.9%, 1/113), and fluid overload (0.9%, 1/113).

Discussion/Conclusion
Approximately one-third experienced CAPD discontinuation. Death was the leading cause, while recurrent peritonitis was the main potentially modifiable cause among surviving patients.

SUBNEPHROTIC RANGE PROTEINURIA IN A PATIENT WITH AUTOIMMUNE THYROID DISEASE – A DIAGNOSTIC AND THERAPEUTIC CONUNDRUM

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Introduction

Nephrotic syndrome can cause hypothyroidism through urinary loss of thyroid-binding proteins. Conversely, renal involvement in autoimmune thyroid disease (AITD) is uncommon and diagnostically challenging.

Case report

A 56-year-old woman presented with confusion, overt hypothyroidism and periorbital oedema. Examination revealed patchy vitiligo and periorbital skin changes. Investigations showed markedly elevated thyroid-stimulating hormone (TSH), low free thyroxine, elevated thyroid peroxidase (TPO) titres and sub-nephrotic proteinuria (urine protein-to-creatinine ratio [UPCR], 2.8). Myxoedema coma was diagnosed and treated with thyroxine and corticosteroids. Despite initial treatment, periorbital and lower-limb oedema persisted, as did sub-nephrotic proteinuria, while renal function remained preserved. Renal biopsy was not performed because she had a solitary kidney and declined the procedure. Evaluation for secondary causes of proteinuria was negative.

Proteinuria resolved within eight weeks of levothyroxine therapy, alongside TSH normalisation and without additional immunosuppression.

Conclusion

Hypothyroidism and renal dysfunction are bidirectionally related. AITD may cause immune-mediated glomerulopathies, while hypothyroidism can contribute to proteinuria through renal vasoconstriction and glomerular/tubular basement-membrane thickening. Without biopsy, distinguishing these mechanisms was challenging because immune-mediated glomerulopathies may require immunosuppression. Given the bland urinary sediment and preserved renal function, she received levothyroxine alone. Complete proteinuria resolution supports hypothyroidism-related glomerular dysfunction as the predominant mechanism, although immune-mediated injury cannot be excluded. Distinguishing these mechanisms is important because immune-mediated renal disease may require antiproteinuric therapy and immunosuppression in addition to levothyroxine. Biopsy should be considered for persistent unexplained proteinuria, especially if heavy or accompanied by declining renal function or active urinary sediment, to guide treatment.

ASSESSMENT OF COMPLICATIONS AND ITS ASSOCIATED FACTORS IN PAEDIATRIC RENAL BIOPSIES PERFORMED AT A TERTIARY CARE HOSPITAL IN THE UNITED KINGDOM

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Introduction
Renal biopsy is an important diagnostic procedure in paediatric nephrology but may be associated with bleeding and other procedure-related complications. This study evaluates complication frequency and associated factors of paediatric renal biopsies performed at a tertiary paediatric nephrology centre in Birmingham, United Kingdom.

Methods
A retrospective cross-sectional study was conducted using records of children aged 0–17 years who underwent renal biopsy at Birmingham Children's Hospital between 2021 and 2025. Demographic, clinical, procedural, histopathological and post-procedural outcome data were extracted from relevant medical records. Factors associated with complications were assessed using multivariable logistic regression, with statistical significance set at $p<0.05$.

Results
A total of 220 renal biopsies were included. The mean age was 11.7 ± 3.9 years and 58.2% were male. Ultrasound guidance was documented in all procedures, while interventional radiologists performed 51.4% of biopsies. A 16G needle was used in 84.1% of procedures. More than one biopsy attempt was required in 62.7% of procedures, while adequate/acceptable tissue was obtained in 88.6%. Overall, 43 (19.5%) procedures had at least one documented complication. Complications were significantly associated with day-case procedures (22.9% vs. 8.0%; p=0.019) and more than one biopsy attempt (23.9% vs. 12.2%; p=0.034). Patients with complications had lower mean age (10.00 ± 4.04; p=0.012) and weight (41.12 ± 17.28; p=0.048).

Conclusions
Paediatric renal biopsy was associated with relatively infrequent clinically important bleeding complications. Multiple biopsy attempts and day-case procedures were independently associated with documented complications. Optimising first-pass tissue acquisition and appropriate post-biopsy monitoring may improve procedural safety.

RENAL INVOLVEMENT IN CHILDHOOD LEPTOSPIROSIS

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Introduction

Renal involvement occurs in 40–60% of adults with leptospirosis and accounts for approximately 22% of deaths. It is a significant risk factor for pulmonary haemorrhages. The data for children are limited due to sparsity of cases.

Objective

To assess the patterns of renal involvement and clinical associations in children with leptospirosis.

Methods

This retrospective observational study included children with serologically confirmed leptospirosis and renal involvement admitted to the Paediatric Nephrology Unit at National Hospital, Galle, between 2021 and 2026.

Results

Fifteen patients presented at 4.2±1.2 days of illness with renal involvement. The mean age was 11.4±1.7 years with male predominance (80%).

At presentation, 40% were in KDIGO AKI 3 (<35 ml/min/1.73 m^2), with mean eGFR of 43.4±27.6. The nadir eGFR 25.7±16.6 occurred at 1.8±1 days after admission, with 73% reaching nadir within the first 48 h. Overall, 11 (73%) progressed to AKI stage 3 and 40% had eGFR <15. The nadir eGFR showed a significant association with the onset bicarbonate level (β=0.75, $p<0.05$).

Most needed initial fluid resuscitation and frusemide to maintain urine output. One underwent CRRT to assist ECMO. The timing of nadir eGFR strongly correlated with nadir platelet count (R=0.8, $p<0.01$) and heralded the onset of the polyuric phase. Renal function normalised within 8.5±3.7 days.

One (6.7%) died on day 29 of septicaemia. Plasmapheresis was carried out in two (13%) with pulmonary haemorrhages. Other organ involvement except haematology was mild.

Conclusion

Despite severe renal involvement, appropriate fluid resuscitation with judicious use of frusemide to maintain urine output >1 ml/kg/h until a veer in creatinine or platelets (first 48-36 hours) may result in favourable renal recovery in children.

BEYOND THE BLOOD: GASTROINTESTINAL CMV DETECTED IN GASTRIC TISSUE DESPITE NEGATIVE BLOOD PCR IN A KIDNEY TRANSPLANT RECIPIENT

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Introduction

Tissue-invasive CMV disease can occur after kidney transplantation despite negative blood CMV PCR. This diagnostic paradox may delay recognition, particularly when symptoms are nonspecific.

Case Report

A 21-year-old man, seven months post kidney transplantation, presented with two days of acute epigastric pain and anorexia, followed by fever. He had no vomiting, diarrhoea or gastrointestinal bleeding. He had preserved renal function and was maintained on triple immunosuppressive therapy (T_0 9 ng/mL). As a CMV D+/R− recipient, he had completed six months of valganciclovir prophylaxis.

Initial blood CMV PCR was negative. In view of persistent symptoms, endoscopy was performed, which revealed multiple gastric and duodenal ulcers. Histology showed chronic inflammation without definite CMV inclusions; immunohistochemistry was unavailable. However, gastric biopsy PCR detected CMV DNA (3.54×10^4 IU/mL), confirming tissue-invasive disease.

He received intravenous ganciclovir (5 mg/kg twice daily) for 14 days, followed by oral valganciclovir (900 mg twice daily) for another 14 days, alongside immunosuppression adjustment, with marked symptomatic improvement and fever resolution.

Initial investigations revealed severe hyponatraemia (Na 116 mmol/L, serum osmolality 270 mOsm/kg, urine Na 42 mmol/L), which improved markedly following intravenous ganciclovir, suggesting a possible link to CMV infection.

Conclusion

Negative blood CMV PCR does not exclude tissue-invasive disease. Persistent symptoms in high-risk transplant recipients warrant tissue-based investigation and timely antiviral treatment.

HEPATITIS C–ASSOCIATED IMMUNE COMPLEX GLOMERULONEPHRITIS MIMICKING RELAPSING ANCA-ASSOCIATED VASCULITIS

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Introduction

Hepatitis C virus (HCV) infection can cause a range of immune-mediated kidney diseases, including immune complex glomerulonephritis. The presence of anti-neutrophil cytoplasmic antibodies (ANCA) can make diagnosis challenging, especially in patients previously treated for ANCA-associated vasculitis (AAV). We describe a case of HCV-associated immune complex glomerulonephritis that initially presented as AAV and later mimicked a vasculitic relapse.

Case Report

A 52-year-old man with hypertension presented in 2017 with fever, inflammatory polyarthritis, generalised oedema, macroscopic haematuria, significant proteinuria and acute kidney injury, with a serum creatinine of 3.09 mg/dL. He was p-ANCA (MPO) positive, and renal biopsy showed crescentic glomerulonephritis. He was treated with intravenous methylprednisolone and cyclophosphamide, with good clinical and renal recovery. He was subsequently lost to follow-up and returned in 2025 with recurrent oedema, proteinuria (UPCR 2.13 g/g) and a creatinine of 1.5 mg/dL. Although MPO-ANCA remained positive, repeat renal biopsy showed mesangial and endocapillary hypercellularity with IgA, IgM and C3 deposition. C3 was low, while C4 and cryoglobulins were negative. HCV antibody and viral RNA were positive. The findings favoured HCV-associated immune complex glomerulonephritis rather than recurrent AAV. He was treated with sofosbuvir/velpatasvir, following which proteinuria gradually decreased and renal function improved.

Conclusion

This case highlights the diagnostic challenge of persistent MPO-ANCA positivity in patients with HCV infection. Repeat renal biopsy was crucial in distinguishing immune complex glomerulonephritis from recurrent AAV and helped avoid further unnecessary immunosuppression. Treatment of the underlying HCV infection resulted in good renal recovery.

ONE DIAGNOSIS MAY NOT EXPLAIN EVERYTHING: WHEN THE CLINICAL COURSE IS INCOMPLETE OR UNEXPECTED, CONSIDER A SECOND INFECTIOUS PROCESS

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Introduction

Opportunistic infections remain an important cause of morbidity in kidney transplant recipients, even years after transplantation. We report an uncommon dual infection of cryptococcal meningitis and CMV viraemia five years post-transplantation.

Case Report

A 37-year-old man, five years post-kidney transplantation, presented with fever, severe headache and photophobia, suggestive of meningitis. He was receiving triple immunosuppression with mycophenolate mofetil, tacrolimus and prednisolone, with a tacrolimus trough level of 6 ng/mL. CSF analysis showed elevated protein, with positive cryptococcal microscopy and PCR, confirming cryptococcal meningitis. Non-contrast CT of the brain was normal, and inflammatory markers were negative.

He was commenced on liposomal amphotericin B, with dramatic improvement in his headache and photophobia. However, fever persisted despite appropriate antifungal therapy. Given his ongoing immunosuppression, a concurrent opportunistic infection was considered. CMV PCR was subsequently strongly positive, with a viral load of 2.8×10^4. Intravenous ganciclovir was added to ongoing antifungal therapy. Following dual antimicrobial therapy, his fever resolved and his overall clinical condition improved significantly.

Conclusion

Recognition of dual infection requires careful interpretation of clinical findings and targeted microbiological investigations, while treatment must balance infection control with preservation of graft function.

SOCIODEMOGRAPHIC AND CLINICAL PREDICTORS OF HEALTH-RELATED QUALITY OF LIFE AMONG PATIENTS WITH CHRONIC KIDNEY DISEASE: A HOSPITAL-BASED CROSS-SECTIONAL STUDY

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Introduction

Chronic kidney disease (CKD) is increasing worldwide and adversely affects health-related quality of life (HRQoL). This study aimed to assess the associations between sociodemographic characteristics, clinical factors, and HRQoL among patients with CKD at National Hospital (Teaching), Kandy.

Methods

A descriptive cross-sectional study was conducted among 210 randomly selected CKD patients attending the Nephrology Clinic and wards of the National Hospital (Teaching), Kandy. Data were collected using the Kidney Disease Quality of Life Short Form (KDQOL-SF™) and a pre-tested general questionnaire. Data were analysed using descriptive statistics, one-way ANOVA, and Spearman's correlation. A p-value <0.05 was considered statistically significant.

Results

Among 210 participants, 61% were male and 39% female with a mean age of 38.9 ±1.0 years. CKD stages 3 (31.9%) and 4 (27.6%) were most prevalent, while 52.9% had a disease duration of 2–6 years. PCS (45.7±20.7) was lower than MCS (60.2±19.9) and KDSC (71.7±11.9). Gender was significantly associated with all three QoL domains (p = 0.002, 0.002, and 0.004, respectively). Age and income were also significantly associated with all three domains (p<0.05). Ethnicity was associated with PCS (p = 0.040) and MCS (p = 0.017), while educational status was associated with KDSC (p = 0.002) and PCS (p = 0.034). CKD stage was associated with PCS (p = 0.001), whereas CKD duration showed no significant association with any QoL domain.

Conclusion

Sociodemographic and clinical factors were associated with HRQoL among CKD patients. Gender, age, and income showed associations across domains, highlighting the importance of these factors in planning patient-centred interventions.

REFRACTORY ASCITES IN A PATIENT WITH END-STAGE RENAL DISEASE – AN INSIGHT INTO NEPHROGENIC ASCITES

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Introduction

Refractory ascites in end-stage kidney disease (ESKD) warrants systematic evaluation to identify the underlying cause.

Case presentation

A 57-year-old man with ESKD (haemodialysis vintage of 1.5 years) presented with refractory ascites despite thrice-weekly haemodialysis (HD). Urea reduction ratio (URR) exceeded 65% in documented sessions. Repeated therapeutic paracenteses provided no significant relief.

Ascitic fluid analysis showed a serum ascites albumin gradient (SAAG) of 1.1 g/dL, protein 2.6 g/dL, 80 lymphocytes/µL and 8 polymorphonuclear cells/µL, with few undifferentiated cells; screening for peritoneal tuberculosis was negative. Contrast-enhanced abdominal CT and portal vein Doppler showed no radiological evidence of decompensated advanced chronic liver disease, established portal hypertension, peritoneal carcinomatosis, significant omental thickening or visceral malignancy. Laparoscopy was deferred owing to perioperative risk and patient refusal. Echocardiography revealed only mild diastolic dysfunction.

Discussion and Conclusions

Nephrogenic ascites was considered after no convincing infective, hepatic, cardiac or malignant cause was identified. Persistence despite regular HD supported this working diagnosis. SAAG has limited diagnostic utility in ESKD and requires cautious interpretation. Proposed mechanisms include increased peritoneal membrane permeability, impaired lymphatic drainage and altered hepatic and portal haemodynamics. The relative contribution of these mechanisms remains uncertain. Management comprised nutritional optimisation, salt and fluid restriction, optimised ultrafiltration during HD and intermittent therapeutic paracentesis for symptomatic relief.

This case highlights the need for systematic evaluation of ascites in ESKD and recognition of potentially treatable causes. Nephrogenic ascites remains a diagnosis of exclusion. Early recognition may facilitate timely intervention, improve symptom control and reduce morbidity.

IDENTIFICATION OF LATENT SLEEP PHENOTYPES AMONG MAINTENANCE HAEMODIALYSIS PATIENTS USING A FOUR-DOMAIN MECHANISTIC SLEEP FRAMEWORK: A LATENT CLASS ANALYSIS

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Introduction/Objectives
Sleep disturbance in maintenance haemodialysis is multifactorial and may reflect a range of interacting factors, including respiratory, sensory-motor, psychological and somatic symptoms. This study aimed to identify and characterise distinct latent sleep phenotypes among Sri Lankan haemodialysis patients using a four-domain framework.

Methods
This multicentre cross-sectional study included 213 adults receiving maintenance haemodialysis at three centres. Ten categorical indicators representing sleep-disordered breathing, restless legs syndrome (RLS), psychological distress and nocturnal somatic symptoms were analysed using Latent Class Analysis (LCA). Two- to five-class solutions were evaluated using model fit, classification quality and clinical interpretability. Overall sleep quality (1–10 scale) was used for external construct validation. Clinical and demographic characteristics were compared across classes.

Results
A three-class solution was retained (207 complete cases; AIC = 3256.943; BIC = 3472.066), identifying a multisymptom phenotype (14.6%), psychological-distress-predominant phenotype (20.7%) and low-symptom phenotype (64.8%). Mean posterior probabilities of assigned-class membership ranged from 0.879 to 0.942. Overall sleep-quality scores differed significantly across classes (5.35, 6.14 and 7.11, respectively; $F(2,210) = 9.393$, $p < 0.001$). The low-symptom phenotype had significantly better scores than both other classes. The multisymptom phenotype remained independently associated with poorer sleep quality following adjustment. Age and dialysis frequency were associated with class membership, which also differed across centres. No significant class differences were observed in haemoglobin, ferritin, dialysis duration or interdialytic weight gain.

Conclusions
Three distinct symptom-based sleep phenotypes were identified, demonstrating heterogeneity in sleep-related symptom patterns among Sri Lankan haemodialysis patients. Their association with independently measured sleep quality supports a multidimensional approach to sleep assessment and may inform more targeted clinical evaluation.

PREVALENCE OF IMPAIRED RENAL FUNCTION AT A SINGLE POINT AMONG PATIENTS WITH DIABETES MELLITUS ATTENDING SELECTED HOSPITALS IN GALLE DISTRICT, SRI LANKA

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Introduction/Objectives
Impaired renal function, which might lead to chronic kidney disease (CKD), is a common complication of diabetes mellitus (DM) and may remain asymptomatic until advanced stages. This study aimed to describe the prevalence of impaired renal function at a single point among patients with DM attending selected primary care hospitals in Galle District, Sri Lanka.

Methods
We conducted a descriptive cross-sectional study among adult patients with DM attending four selected primary care hospitals in Galle District. Data were collected using an interviewer-administered questionnaire and clinic records. Serum creatinine, estimated glomerular filtration rate (eGFR) and urinary albumin-to-creatinine ratio (UACR) were used for assessment. Impaired renal function was defined as eGFR <60 mL/min/1.73 m^2 or UACR >30 mg/g. Descriptive analyses were planned.

Results
Data from 325 patients with DM were available. Fifty-five patients (16.9%) had eGFR <60 mL/min/1.73 m^2, including three (0.9%) with eGFR <30 mL/min/1.73 m^2. UACR was in the A2 category in 39 patients (12.0%) and the A3 category in 13 (4.0%). Ten patients (3.1%) had both reduced eGFR and elevated UACR, and 97 patients had at least one abnormal kidney marker, giving a prevalence of impaired renal function of 29.8%.

Conclusions
Nearly one-third of patients with DM had impaired renal function at a single point. The findings highlight the importance of systematically assessing kidney function and albuminuria in patients with DM to facilitate early detection and appropriate management to prevent them from developing end-stage kidney disease.

TIME-TO-EVENT ANALYSIS OF ERYTHROPOIETIN RESPONSE DURATION IN NON-DIALYSIS CKD PATIENTS: A SEX-STRATIFIED KAPLAN–MEIER ANALYSIS

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Introduction & Objectives
Erythropoietin (EPO) therapy is widely used to manage anaemia in patients with chronic kidney disease (CKD). However, the duration of treatment response may vary between patients. This study assessed the duration of EPO response in non-dialysis CKD patients and compared outcomes between sexes.

Materials & Methods
A retrospective observational study included 205 non-dialysis patients receiving EPO therapy at the National Institute of Nephrology, Dialysis and Transplantation (NINDT), Colombo, between May and December 2025. Laboratory records were reviewed to assess the duration of EPO response. An event was defined as haemoglobin below target (<10 g/dL) or major EPO dose escalation. Patients without treatment failure during the observation period were censored. Kaplan–Meier analysis was done using IBM SPSS 25 to compare outcomes between males and females using the log-rank test.

Results
The overall cohort (N=205) showed a mean EPO response duration of 29.6 months (SE = 2.08; 95% CI: 25.38–33.54) and a median response duration of 18.0 months (SE = 1.41; 95% CI: 15.25–20.76). Female patients (n=77) demonstrated a mean response duration of 28.8 months (SE = 3.48; 95% CI: 21.96–35.60) and a median of 15.0 months (SE = 2.21; 95% CI: 10.67–19.33). Male patients (n=128) demonstrated a mean response duration of 29.5 months (SE = 2.46; 95% CI: 24.69–34.32) and a median of 24.0 months (SE = 3.81; 95% CI: 16.53–31.47). The difference in response duration between the two groups was statistically significant (log-rank p = 0.040).

Conclusion
Males showed a longer median EPO response duration than females.

ASSOCIATION AND PREDICTIVE VALUE OF THE CALCIUM–PHOSPHORUS PRODUCT FOR MYOCARDIAL INFARCTION IN NON-DIALYSIS PATIENTS WITH MODERATE TO END-STAGE CHRONIC KIDNEY DISEASE

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Introduction/Objectives

To assess the association and predictive value of serum calcium–phosphorus (Ca–P) product in relation to myocardial infarction (MI) among non-dialysis patients with moderate to end-stage chronic kidney disease (CKD).

Methods

A descriptive cross-sectional study included 330 non-dialysis CKD patients with eGFR <60 mL/min/1.73 m^2 attending the National Institute of Nephrology, Dialysis and Transplantation and University Hospital KDU from September to December 2025. Participants were categorised according to documented MI status: with MI (n=99) and without MI (n=231). Total serum calcium and phosphorus were measured, and Ca–P product was calculated. A threshold of ≤28 mg^2/dL^2 was selected based on published literature. Group comparisons, Spearman correlation and receiver operating characteristic (ROC) analysis were performed.

Results

Median age was 63 years (IQR 16), and 63.3% were male. Compared with patients without MI, those with MI had lower median calcium (6.6 vs. 8.50 mg/dL), phosphorus (2.92 vs. 3.96 mg/dL), and Ca–P product (16.53 vs. 33.8 mg^2/dL^2; all p<0.001). Ca–P product ≤28 mg^2/dL^2 was more frequent in the MI group (77.8% vs. 30.3%; p<0.001). Ca–P product negatively correlated with eGFR (r=−0.243; p<0.001). ROC analysis using documented MI status as the outcome showed an AUC of 0.745 (95% CI 0.686–0.804; p<0.001), with 70.6% sensitivity and 77.8% specificity at a cut-off of 27.33 mg^2/dL^2.

Conclusions

Lower Ca–P product was associated with the presence of MI, contrary to expectations. The observed inverse association warrants further investigation. The cross-sectional design does not establish causality or predict future MI.

ANAEMIA MANAGEMENT IN CHRONIC HAEMODIALYSIS PATIENTS IN A TERTIARY CARE CENTRE: A QUALITY IMPROVEMENT PROJECT

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Introduction
Anaemia in haemodialysis (HD) patients increases morbidity and mortality. Its prevalence, characteristics, and severity in our unit were unknown.

Methods
The aims were to describe the above and identify interventions to improve anaemia management. All patients on chronic haemodialysis in Dialysis Unit 2 of the National Hospital of Sri Lanka in the preceding 4 months were included. A Google-based data collection system for gathering information, including Hb, erythropoietin dosing, and iron status, was used. Data were extracted in June and August 2026 and audited for completeness. The prevalence of anaemia (defined as haemoglobin < 9 g/dL) and the iron status were described and compared between the time points.

Results
Eligible patients numbered 164 (June) and 168 (August). Data completeness for Hb, ferritin, and TSAT was 88.4% (n=145), 15.8% (n=26) and 0% in June, and 92.2% (n=155), 30.4% (n=51) and 16.7% (n=28) in August.

The prevalence of anaemia in June was 73.10% (n=106), and in August 74.19% (n=115). Interventions targeted Hb < 7 g/dL in June and Hb <9 g/dl in August. Erythropoietin-stimulating agent (ESA) dose and frequency increased in 17 and 18 patients and were initiated in 6 and 12 patients, while the dose was reduced or omitted in 1 and 8 patients with Hb >10.5 g/dl in June and August, respectively. IV iron sucrose was given in 14 (June) and 25 (August) patients with ferritin <500 µg/l (systemic iron deficiency). Two were identified as having functional iron deficiency and 4 patients as having ESA hyporesponsiveness in August.

Conclusion
Anaemia is common among our dialysis patients, but an audited manual-entry electronic data collection system shows promise in assisting anaemia management at cohort level.

CATHETER-RELATED BLOODSTREAM INFECTIONS (CRBSI) AMONG DIALYSIS-DEPENDENT END-STAGE KIDNEY DISEASE (ESKD) PATIENTS IN A TERTIARY CARE CENTRE

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Introduction
Catheter-related bloodstream infection (CRBSI) is a significant complication of vascular access in dialysis-dependent end-stage kidney disease (ESKD), contributing to morbidity, mortality and healthcare expenditure.

Methods
We described the incidence, characteristics, and outcomes of CRBSI among patients with ESKD undergoing haemodialysis at Dialysis Unit 2, National Hospital of Sri Lanka, between June and August 2026. CRBSI was defined as concurrently positive blood and central line cultures, where the line was the likely source.

Results
Of 168 eligible patients, vascular access comprised arteriovenous fistulas (n=78, 46.4%), temporary neck lines (n=40, 23.8%), temporary femoral lines (n=14, 8.3%), and tunnelled cuffed haemodialysis catheters (n=36, 21.4%). Nineteen CRBSI episodes occurred among 18 patients (21.11%).

Median time since line insertion at diagnosis was 19 days. Median time for temporary lines was 15 days. Affected patients had temporary neck lines (12/40), femoral lines (3/14) or tunnelled cuffed haemodialysis catheters (3/36). Isolates included MRSA (15), MSSA (1), *Corynebacterium diphtheriae (2),* and *Corynebacterium spp.* (1). Eleven patients received antibiotics for more than 14 days from the first negative culture. Complications included septic shock (n=4), endocarditis (n=1), endophthalmitis (n=1), and discitis (n=1). There were 4 deaths. Interventions included MRSA decolonisation, multidisciplinary meetings with microbiology, patient information leaflets, and referrals for arteriovenous fistula formation or peritoneal dialysis.

Conclusion
An unacceptably high prevalence of temporary lines is the biggest risk factor. Prevalence of MRSA infection was high at this time point. Further longitudinal surveillance of CRBSI is needed to fully characterise the problem. This healthcare-associated infection commonly affects dialysis-dependent patients; therefore, prevention and adequate treatment are of utmost importance.

SYSTEMIC LUPUS ERYTHEMATOSUS AND ANTINEUTROPHIL CYTOPLASMIC ANTIBODY (ANCA)-ASSOCIATED VASCULITIS OVERLAP CAUSING A RENO-PULMONARY SYNDROME: A CASE REPORT

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Introduction

Individual cases presenting with systemic lupus erythematosus (SLE) or ANCA-associated vasculitis causing reno-pulmonary syndrome are common. However, first presentation for medical attention with SLE along with ANCA-associated vasculitis affecting both lung and kidney is rare.

Case report

We report a case of a 27-year-old female who is a previously unevaluated university student presenting with nephrotic syndrome, which progressed to pulmonary haemorrhage. Her serum creatinine at presentation was 481 µmol/l with urinary sediment showing 3+ proteinuria and red cell casts. The renal biopsy under microscopy revealed necrotising glomerulonephritis with crescents (activity score 18/24), favouring an ANCA-associated vasculitis pattern. Immunofluorescence revealed a full-house staining pattern, which suggested lupus nephritis class IV. Pulmonary haemorrhage was evident in HRCT chest as bilateral peribronchovascular opacities. Her anti-nuclear antibody was negative, but double-stranded DNA antibody was positive. Considering the clinical picture, positive perinuclear (myeloperoxidase) ANCA favoured the diagnosis of SLE-ANCA vasculitis overlap over a false-positive result, because diffuse alveolar haemorrhage occurs in less than 5% of SLE presentations, while it is 30% with ANCA vasculitis. A CT pulmonary angiogram later revealed a segmental branch pulmonary embolism; however, her screening for antiphospholipid antibody syndrome was negative. She was initially managed with haemodialysis, and following the biopsy findings, was induced with intravenous methylprednisolone and intravenous cyclophosphamide. With the progression to pulmonary haemorrhage, we escalated her management aggressively, adding 5 cycles of plasma exchange, intravenous immunoglobulin, and intravenous rituximab, which was successful.

Conclusion

SLE and ANCA-associated vasculitis overlap is rare. Once diagnosed, it is better managed with multimodal immunomodulation, as the disease is aggressive in nature.

CONCURRENT PIGMENT NEPHROPATHY AND ACUTE INTERSTITIAL NEPHRITIS CAUSING SEVERE ACUTE KIDNEY INJURY FOLLOWING MONOPOLAR TRANSURETHRAL RESECTION OF THE PROSTATE

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INTRODUCTION

Acute kidney injury (AKI) following transurethral resection of the prostate (TURP) is rare but severe. Possible causes include acute tubular injury, drug-induced injury, TURP syndrome, and pigment-induced nephropathy.

CASE REPORT

A 65-year-old man with a baseline serum creatinine of 1.08 mg/dL underwent monopolar TURP using sterile water. Within 24 hours, he developed oliguria, and creatinine rose to 13.3 mg/dL on post-operative day 3, requiring haemodialysis. He received co-amoxiclav and non-steroidal anti-inflammatory drugs (NSAIDs) post-operatively.

Ultrasonography excluded obstruction. The urine was visibly red with a pink supernatant after centrifugation; microscopy showed minimal red blood cells and absent muddy brown casts, confirming pigmenturia. Normal creatine phosphokinase excluded rhabdomyolysis. Differential diagnoses included NSAID/beta-lactam-associated kidney injury and pigment-induced nephropathy.

Because anuria persisted for two weeks, a renal biopsy was done on post-operative day 17. It revealed intratubular pigment casts and acute interstitial nephritis (AIN) without eosinophilia, confirming concurrent NSAID/beta-lactam-induced AIN and haemolysis-related pigment nephropathy. Urine output improved from week 3, and he became dialysis-independent after post-operative day 17. Oral corticosteroids (prednisolone 30 mg daily) were started on post-operative day 20 and tapered over 4 weeks. His creatinine recovered to 1.3 mg/dL by post-operative week 9.

CONCLUSION

Severe AKI after TURP warrants careful urine evaluation for intravascular haemolysis-related pigment nephropathy, an event that is extremely rare but possible. Urine centrifugation and microscopy are simple, invaluable tools to identify pigmenturia once post-renal obstruction and other causes have been excluded.

IMPROVING MICROBIOLOGICAL YIELD IN PERITONEAL DIALYSIS-ASSOCIATED PERITONITIS: A RE-AUDIT FROM A TERTIARY CARE CENTRE IN SRI LANKA

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Introduction/Objectives
Peritonitis is the leading cause of peritoneal dialysis (PD) technique failure, and accurate microbiological diagnosis is essential for targeted antibiotic therapy. Our previous audit (November 2024–October 2025) showed 20.7% culture-negative peritonitis, above the International Society for Peritoneal Dialysis (ISPD) target of <15%, suggesting suboptimal culture yield. We evaluated whether increasing the effluent volume sent for culture reduced the culture-negative peritonitis rate.

Methods
After multidisciplinary discussion with the Microbiology Department in October 2025, the effluent volume sent for culture was increased from 5 mL to 20 mL. As ISPD-recommended centrifugation of 50 mL was not available, the 20 mL sample was allowed to sediment and the sediment was cultured. Peritonitis episodes from November 2025 to June 2026 were retrospectively re-audited and compared with the previous audit.

Results
During the re-audit period, 106 PD patients had 40 peritonitis episodes (0.57 episodes/patient-year, compared with 0.86 previously). Following the increase in effluent culture volume, culture-negative peritonitis fell from 20.7% (6/29) to 12.5% (5/40), within the ISPD target of <15%.

Conclusions
Increasing effluent culture volume from 5 mL to 20 mL, using a simple sedimentation technique developed with the Microbiology Department, was associated with a reduction in culture-negative peritonitis to within the ISPD target, despite the absence of centrifugation facilities. This low-cost approach is readily applicable to resource-limited PD units. Peritonitis rates remain above the ISPD target of 0.40 episodes/patient-year, warranting continued surveillance and prevention.

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