Clinical Pearls: Nephrology

Nephrology I

- The Aldosterone Renin Ratio screen for primary hyperaldosteronism requires both an elevated ratio and aldosterone.
    - The plasma renin activity may be very low (< 0.5) and this may drive a high ratio even if the aldosterone is not high < 10.
- Non-dipping or paradoxical nocturnal increase in sleep blood pressure on 24 hr ambulatory blood pressure monitoring may be sign of OSA.

Nephrology II

- Most patients with checkpoint inhibitor acute interstitial nephritis (AIN) are also on another medication that is associated with AIN, most commonly proton pump inhibitors (PPI's).
- Alport syndrome (Autosomal Dominant) is being found more often because of genetic testing.
    - Most have microscopic hematuria, some will have proteinuria and CKD.

Nephrology III

- Osmotic diuresis is a cause of polyuria and hypernatremia in hospitalized patients in a catabolic state.
    - Patients will have a urine osm > 300.
- Give 3% saline as 100 ml boluses as opposed to continuous infusion.
    - The rate of correction of 4-6 per 24 hours does not need to be spread out (i.e. 1 every 4-6 hours).
    - If it happens initially within the 1st 6 hours suspend further correction for the remainder of the 1st 24 hours by using DDAVP.
- Risk of overcorrection occurs in patients who gave transient stimulus for ADH (hypovolemia +/- thiazide) that is corrected with volume/sodium. These patients may develop a free water diuresis that is difficult to match with d5w and should get DDAVP.

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