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Mean age was 57.1 ± 3.1 years, 90% (28) identified as black, 58% (28) were male, 66% (20) had less than a college education. The ability to express negative feelings with the healthcare team correlated with understanding of the importance of taking medication as scheduled (r=0.54, p=0.002), was inversely correlated with reported difficulty taking medication (r=-0.54, p=0.002), and number of times medication was mixed (r=0.61, p<0.001). Importance of taking medication as scheduled correlated with two KAS-R subsection scores, communication (r=0.06, p<0.001), and empowerment (r=0.38, p=0.033). Feeling that the provider did not allow free expression of opinion inversely correlated with overall feelings of being in control (r=-0.38, p=0.05), happiness with transportation and living space (r=-0.48, p=0.01 and r=-0.39, p=0.04), energy, safety and overall health (r=-0.58, p=0.001, r=-0.38, p=0.04, r=-0.45, p=0.01). None of these findings related to age, sex or education but pts with a higher income were more likely to report an active partnership with their healthcare team (r=0.49, p=0.03).

In our population: 1. Understanding of the importance of taking medicine and adherence to the medication regimen was associated with comfort discussing negative feelings with the healthcare team. 2. Pts who reported inability to express their opinion felt less in control overall, were more unhappy with other aspects of their lives including housing and transportation and reported poorer overall health. 3. Pts with a higher income were more likely to report an active partnership; negative social determinants may contribute to the provider-patient relationship, however, not communication and empowerment were both associated with understanding of adherence, both should be actively pursued in our patients regardless of economic background.

OUTCOMES OF PATIENTS WITH CKD III-V VS ESRD ADMITTED FOR HYPERTENSIVE EMERGENCY (FROM THE NATIONAL INPATIENT SAMPLE 2016-2017):
Niveda Shekar1, Emmanuel Akuny1, Mahaim Haque1, Yan Huang1, Abdullah Noor 1, Swetha Kanduri 1, Karthik Kovvuru 1. 1Ochsner Health System
Nearly half of the adult population in the United States has hypertension. An estimated 1-2% of these patients will be diagnosed with hypertensive crisis (includes hypertensive urgency and emergency) at some point in their lifetime. There is limited data on the outcomes of patients admitted with hypertensive emergency with underlying CKD III-V and ESRD.

We queried the National Inpatient Sample (NIS) database from 2016 and 2017 for adults aged 18 and above. ICD-10 codes were used to sort patients with hypertensive emergency as a principal diagnosis for hospitalization and CKD III-V or ESRD as a secondary diagnosis. The primary outcome was mortality, while secondary outcomes included length of stay (LOS) and hospitalization costs. STATA software was used for analysis. Multivariate logistic and linear regression analysis were used accordingly to adjust for confounders.

There were over 71 million discharges in the combined 2016 and 2017 NIS databases. Out of 55,510 hospitalizations for hypertensive emergency, 21.1% had coexisting CKD III-V, while 14.5% had coexisting ESRD. Patients hospitalized with hypertensive emergency with concomitant ESRD did have higher odds ratio for inpatient mortality compared to those with CKD III-V, however, this value was not statistically significant (AOR 3.19, 95% CI [0.92-12.4], P = 0.093). There was a statistically significant 0.54 day increase in LOS (95% CI [0.05-1.04], P = 0.032) and greater hospitalization costs of $10,874 (95% CI [6,135-15,613], P<0.001) in patients admitted for hypertensive emergency with ESRD compared to patients with hypertensive emergency with CKD III-V.

Previous studies have shown that decreased renal function during hypertensive emergency could be attributed to acute renal damage with or without preexisting renal dysfunction. Our study showed patients admitted for hypertensive emergency with coexisting CKD III-V or ESRD had no statistically significant difference in mortality, however, patients with ESRD had a greater LOS and higher hospitalization costs in comparison to patients with CKD III-V.

SYMPTOMATIC RENAL INFARCT SECONDARY TO COVID-19 INFECTION AND CONCOMITANTLY POSITIVE ANTIPHOSPHOLIPID ANTIBODY:
Abdullah Noor1, Swetha Kanduri 1, Karthik Kovvuru 1. Ochsner Health System
COVID-19 infection predisposes patients to a hypercoagulable state. The clinical significance of concomitantly positive antiphospholipid antibodies as a risk factor for thrombus formation is unknown. We report a case of renal infarct secondary to COVID-19 infection with mildly elevated antiphospholipid antibodies.

A 71-year-old woman with a history of hypertension, supraventricular tachycardia, resected carcinoid tumor in remission, COVID-19 infection (20 days prior), presented to the hospital with acute onset of left lower quadrant pain radiating to the left flank for one day. She reported a fever of 101 F. Vital signs were normal in the emergency room. Physical exam showed left costovertebral angle tenderness, otherwise benign abdomen with no guarding or rigidity.

Laboratory findings showed normal liver function tests, mildly elevated creatinine at 1.1 mg/dl (baseline 0.8 mg/dl), and leukocytosis (14.2 K/ul). Urinalysis showed no evidence of proteinuria or microscopic hematuria. CT scan of the abdomen demonstrated a large area of patchy hypotumetion involving the upper pole and interpolar region of the left kidney with adjacent perinephric inflammation. There was no evidence of metastatic disease on PET scan. Patient was confirmed malignant sarcomatoid mesothelioma but without any mediastinal uptake nor distant disease on PET scan. Patient was started on nivolumab and ipilimumab, received 2 infusions of zolocromadot, 2 weeks followed by nivolumab and had presented to clinic for a second infusion of denosumab when he was sent to the ED due to increasing hypercalcemia.

On admission, serum calcium was elevated at 16.5mg/dL and downtrended to 11.8 at time of discharge. Repeat labs showed an undetectable level of PTHrP, low iPTH (9.7 pg/mL), severely elevated 1,25-dihydroxyvitamin D (140 pg/mL), 25-hydroxyvitamin D (40.1 ng/mL). After aggressive fluid resuscitation as well as calcium administration, serum calcium levels downtrended to 11.8 with improvement of symptoms at the time of discharge.

We present this rare case of hypercalcemia of malignancy due to tumor production of 1,25-dihydroxyvitamin D, refractory to bisphosphonates, denosumab and calcitonin. While both prednisone and hemodialysis are possible therapeutic options for resistant hypercalcemia of malignancy, our patient decided to forego treatment and instead opted for hospice after learning of progression of disease on repeat imaging.
monitors were negative for atrial fibrillation. An echocardiogram did not show any thrombus. Considering her negative tests, renal infarct was believed to be secondary to a hypercoagulable state from COVID-19 infection. Antiphospholipid antibodies repeated 3 months after this admission were mildly elevated. Renal infarct was treated with a heparin infusion and was subsequently transitioned to aspirin. Acute kidney injury resolved with intravenous fluid resuscitation. At a 3-month follow-up, her renal function remained stable with a resolution of symptoms.

Renal artery infarct is a possible thrombotic complication of COVID-19. Role of lupus anticoagulant antibodies in increasing this risk warrants further studies.

**317**

A RARE CASE OF ACUTE KIDNEY INJURY (AKI) INDUCED BY TOBRAMYCIN INHALATION SOLUTION (TIS) IN A LUNG TRANSPLANT RECIPIENT:

Mingye He1, Hema Balina1, Ilay Rahman1, Sheetal Kouli1, Iris Lee1, Serban Constantinescu1. Temple University Hospital Systemic aminoglycoside therapy is associated with nephrotoxicity. However, TIS is considered safe with minimal systemic toxicity. Therefore, routine monitoring of systemic tobramycin levels during inhalational therapy is not indicated.

We report a case of AKI induced by TIS in a lung transplant recipient.

A 73-year-old male with a history of CKD stage 3, COPD status post double lung transplant 5 years ago complicated by bronchiectasis due to atypical mycobacterial infection had a bronchiectasis exacerbation with Pseudomonas Aeruginosa in sputum culture which was resistant to Levofloxacin therapy. He required initiation of TIS 300 mg every 12 hours which was continued on a 2 week on 2 week off schedule.

After 6 weeks, he had AKI with a creatinine of 2.8 mg/dL from a baseline of 1.7 mg/dL. Urine sediment had no casts or cells, and no proteinuria. Tacrolimus level was 11 ng/ml and random tobramycin level was 3.0 mg/L (goal trough level: 1-2).

With no improvement in renal function with IV fluids and a lower tacrolimus dose, TIS was discontinued. Following this, serum creatinine trended down to baseline over the course of the next 2 months.

This case presents a diagnostic challenge of AKI on CKD in a lung transplant recipient with long-term exposure to calcineurin inhibitor therapy.

TIS is commonly used to treat chronic lung infections caused by Pseudomonas Aeruginosa in cystic fibrosis. Serum levels in cystic fibrosis patients after inhalation are generally low. However, systemic absorption in lung transplant recipients has not been studied, and TIS may have a higher rate of systemic absorption. This may be because of less mucus production and a less acidic pH in the lungs. Underlying CKD, such as in our patient, may also contribute to high systemic levels.

This case illustrates the potential for TIS to cause AKI. It may be prudent to monitor tobramycin levels in patients with CKD or those taking other nephrotoxic medications, such as calcineurin inhibitors.

**318**

BELIEFS AND UNDERSTANDING OF PLANT-BASED EATING IN INNER-CITY PATIENTS WITH KIDNEY DISEASE:

Lulu Wei1, Edward Bae1, Brett Sherman1, Sasha Martinez-Machado1, Ariel Gidon1, Lekha Patel1, Mariana Markell1. SUNY Downstate Health Sciences University

Plant-based eating (PBE) may be protective against kidney disease progression and improve cardiovascular risk factors. Understanding interest in and beliefs regarding PBE is important in pts with kidney disease, especially those in underserved areas who may lack traditional resources.

A random sample of 33 dialysis and 22 kidney transplant pts in an inner-city environment were surveyed regarding beliefs about PBE and dietary intake by 24-hour recall using the ASA24 database. Results did not differ between populations so they were analyzed together. Not all pts completed all questions.

Mean age was 55 ± 2.1 yrs, 54% male (30); 80% (49) identified as Black, 36% US-born (20); 77% (30) reported annual income <$40K, 63% (35) did not finish college. 8/28 (29%) reported having tried PBE, and 22/39 (57%) were interested. 52% of patients (29) reported not having been recommended PBE before. Recommendations were more likely to have come from a friend or acquaintance and not a doctor or nutritionist (23 vs 4, p=0.048). Willingness to try PBE in the future was associated with belief that diet changes can improve kidney health (p=0.031), that PBE can improve kidney health (p=0.002), and that eating less meat and drinking less alcohol can improve hypertension (p=0.031) or diabetes (p=0.034). Pts who currently tried PBE were more likely to believe PBE can improve hypertension (p=0.045). Pts who believed PBE would worsen hypertension were more likely to be receiving SNAP benefits (p=0.044, p=0.032), and be eating more servings of starchy vegetables (p=0.011), poultry (p=0.041) and milk (p=0.011).

In our population: 1. Recommendations for PBE were more likely to come from non-healthcare professionals. 2. More than half of the pts surveyed wanted to try PBE. 3. Willingness to try PBE was associated with belief in the beneficial effect of plant diet on kidney health, hypertension, and diabetes. 3. Pts who believed PBE to be deleterious were more likely to be receiving food assistance, and ate more starchy vegetables, poultry and milk. 4. It is important that health professionals refer pts for nutrition counseling regarding PBE, especially those in underserved areas in order to improve health outcomes.

**319**

SYNDROME OF APPARENT MINERALOCORTICOID EXCESS INDUCED BY EXCESSIVE CONSUMPTION OF LICORICE-CONTAINING ALCOHOL:

Iaroslav Kondriuk1, Waleed Zafar1, Kartik Kaila1. Geisinger Medical Center

Syndrome of Apparent Mineralocorticoid Excess (SAME) has a constellation of findings including hypokalemia, hypertension, hypoaldosteronism and low renin levels. We present a case of recurrent hypokalemia in the setting of licorice containing alcohol consumption resulting in SAME.

56-year-old male with an alcohol use disorder and hypertension presented to the clinic for outpatient follow-up for persistent hypokalemia. Patient’s potassium had ranged from 3.3-3.5 mmol/L despite oral supplementation (100 mEq oral potassium daily). Current medications included losartan 100 mg, amlopidine 10 mg and spironolactone 50 mg. Review of systems was negative. Examination revealed elevated blood pressure (156/90 mmHg) and 1+ pitting edema. Labs showed sodium 138 mmol/L, potassium 3.2 mmol/L, bicarbonate 29 mmol/L, creatinine 1.0 mg/dL, and magnesium 1.8 mg/dL. Urine labs showed potassium 25 mmol/L and potassium to creatinine ratio >25 mEq/L. Plasma renin activity was 0.124 ng/ml/hr and aldosterone was 2.4 ng/dL.

On further history, patient reported that he was consuming Jagermeister (about 500 ml daily). He was advised alcohol abstinence. Follow-up labs revealed improvement in potassium to 4.8 mmol/L. His oral potassium supplementation had decreased to 20 mEq daily and his blood pressures were better controlled.

Contents of Jagermeister were reviewed which included 56 herbs, licorice, poppy seeds, ginseng etc. The Glycyrrhizic acid (GZA) compound in European licorice inhibits 11-beta-hydroxysteroid dehydrogenase (11 beta-HSD), thereby allowing endogenous cortisol levels to constantly signal via the mineralocorticoid receptor. 11 beta-HSD modifies cortisol and converts to cortisone thereby rendering cortisol ineffective in interacting with the receptor. 11 beta-HSD inhibition via GZA results in hypokalemia, metabolic alkalosis and enhanced sodium reabsorption via epithelial sodium (ENAC) channels. These effects are reversible upon withdrawal of licorice. This condition is called pseudo- hyperaldosteronism or SAME.

Jagermeister contains licorice. The amount that can successfully inhibit 11 beta hydroxy steroid dehydrogenase enzyme is variable. This case illustrates the importance of obtaining a complete dietary history including alcohol use and its contents when working up hypokalemia.

**320**

A RARE CASE OF LUPUS LIKE GLOMERULONEPHRITIS MEDIATED BY HEPATITIS C FOLLOWING SUSTAINED VIROLOGIC RESPONSE WITH DIRECT ACTING ANTIVIRAL AGENTS (DAA):

Mingye He1, Iris Lee2, Sheetal Kouli1. Temple University Hospital

We present a case of resistant hypercalcemia of malignancy due to PTHrP, osteolytic metastases with local release of cytokines, and PTH-independent hypercalcemia is humoral hypercalcemia due to the production of 1, 25-dihydroxyvitamin D, which is rare in cancer. PTHrP stimulates bone resorption and decreases renal 1, 25-dihydroxyvitamin D production.

On admission, serum calcium was elevated at 16.5 mg/dL and albumin at 3.2 g/dl. Serum iPTH was 4.1 pg/ml and 25(OH)D was 20 ng/ml. Urine calcium was 66 mg/dl and 24 hour creatinine clearance was 110 ml/min.

Our patient is a 75-year-old Caucasian man with sarcomatoid renal cell carcinoma. He was diagnosed with metastatic disease to the liver, lungs, and pleura in 2018. Despite chemotherapy, his disease progressed and he was referred to our center on 2/1/2020 for hypercalcemia.

Our patient had a history of hypertension, hypothyroidism, and osteoporosis. He had previously undergone a right radical nephrectomy in 2018 and a left radical nephrectomy in 2019.

On admission, his physical exam was significant for left costovertebral angle tenderness, otherwise benign abdomen and normal cardiac exam.

Initial labs revealed a hypercalcemia of 14.7 mg/dl, hematocrit of 44%, WBC 14,000 with 70% neutrophils, BUN 15 mg/dl, Creatinine 1.7 mg/dl. Urine sediment had no casts or cells, and no pyuria. Uric acid was 5.4 mg/dl and urate 11.3 mg/dl. Urine sodium was 30 mg/dl and chloride 107 mg/dl. Urine calcium was 66 mg/dl and creatinine clearance 110 ml/min.

Bone densitometry was performed with a lumbar spine T-score of -2.5, left hip T-score of -2.4, and right hip T-score of -2.6. Renal artery infarct is a possible thrombotic complication of COVID-19. Role of lupus anticoagulant antibodies in increasing this risk warrants further studies.