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CURSE OF ALTERNATE MEDICINE: ACUTE KIDNEY INJURY LEADING TO END STAGE RENAL DISEASE:
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Despite tremendous progress of modern medicine and increased longevity through adequate screening and diagnosis, alternate medicine continues to flourish worldwide. A 74-year-old Caucasian female fell victim to such therapy and ended up having acute kidney injury needing hemodialysis and subsequent end stage renal disease.

Our patient presented to the hospital with weakness, was found to have elevated creatinine of 8.2 mg/dl in labs. She was recently diagnosed with endometrium cancer 6 months ago and was getting monthly pacitaxel infusion as chemotherapy. She also consulted an alternate medicine doctor in Charlottesville, Virginia and was getting high dose vitamin C 100 gm intravenously weekly for last 6 weeks. This was part of their scheme to boost up her immunity from cancer. A month prior her serum creatinine was normal at 1.2 mg/dl. She didn’t take any medications at home. Her creatinine stayed elevated despite intravenous hydration. Serological workup for glomerulonephritis returned negative.

She underwent percutaneous kidney biopsy which revealed diffuse acute tubular injury, with refractile calcium oxalate crystal on polarized microscopy (fig. 1), mild interstitial fibrosis and no immune complex deposits. Serum oxalate levels were normal ruling our primary hyperoxaluria. Plasma vitamin C levels were extremely high. She was hyperkalemic and uremic, thus needing hemodialysis. Till date she is on hemodialysis for 4 months with no renal recovery.

Alternate medicine continues to be a healthcare hazard causing unwanted irreversible nephrotoxicity. Although low dose Vitamin C i.e., 500 mg-1000 mg is beneficial in medical conditions like scurvy, improving iron absorption in anemia; toxic doses carry high nephrotoxicity potential like our case. Awareness is required at multiple levels to prevent the debilitating health outcomes of alternate medicine.

IMPROVING RENAL FUNCTION IN ACUTE DECOMPENSATED HEART FAILURE PORTENDS INCREASED MORTALITY AND HAS NO RELATIONSHIP WITH MARKERS OF RENAL TUBULAR INJURY:
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Improving renal function (IRF) is a common goal when managing acute decompensated heart failure (ADHF). Yet, IRF in this setting is associated with adverse outcomes. The pathophysiology of IRF in ADHF remains largely undefined. This study investigates trends in renal tubular injury markers and their prognostic value in ADHF patients with IRF.

We performed a secondary analysis of 289 patients from the Renal Optimization Strategies Evaluation-Acute Heart Failure (ROSE-AHF) trial. This trial’s dataset included measurements of the renal tubular injury markers neutrophil gelatinase-associated lipocid (NGAL), N-acetyl-b-D-glucosaminidase (NAG), and kidney injury molecule 1 (KIM-1). IRF and worsening renal function (WRF) were defined as a ≥20% rise or ≥20% reduction in the estimated glomerular filtration fraction at any timepoint during treatment from baseline through 72h, respectively. Improving and worsening renal tubular injury markers were defined as ≥20% decrease or ≥220% increase in the average percent change of NGAL, NAG, and KIM-1 at 72h, respectively.

Patients with IRF had increased mortality at 6mo compared to patients who did not have IRF (30.8% vs 16.6%, p=0.008). No differences in survival were noted among cohorts of improving tubular injury markers, worsening markers, or stable variations (log-rank test for trend p=0.84). In patients with IRF, NGAL, NAG, and KIM-1 were each increased at 72h and 7d compared to baseline, but these increases did not reach statistical significance. In those without IRF, NAG levels were found to have a statistically significant increase compared to baseline at 72h (p=0.04) and 7d (p=0.02), while NGAL and KIM-1 had non-significant increases at 72h and 7d compared to baseline.

ADHF patients who demonstrate IRF during decongestive treatment with intravenous diuresis had worsened survival compared to their counterparts with either stable renal function or WRF. No one pattern of change in the renal tubular injury markers was associated with either enhanced or reduced survival. ADHF patients with IRF were found to have generally non-significant up-trends in renal tubular injury markers.

STRESS AND ADHERENCE DURING THE COVID-19 PANDEMIC IN AN INNER-CITY POPULATION OF DIALYSIS PATIENTS: RELATIONSHIP TO AGE:
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It has been reported that older pts adapt better to dialysis than younger pts. We investigated in response by age to various stressors encountered during the COVID-19 pandemic in a population of inner-city dialysis patients.

A survey was conducted in a random sample of 32 dialysis patients. Patients were asked about their fluid intake, general attitudes towards medical recommendations, and changes in their wellbeing due to COVID19. The FSS (Perceived Stress Scale) and KAS-R (Kim Alliance Scale Revised) were also used.

Mean age was 56.8 ± 18.2 years. 15 pts (46.9%) were <60 yrs (younger) and 17 (53.1%) were ≥60 yrs (older). Mean dialysis time was 88.0 ± 104.0 months. There were 20 (62.5%) male, 29 (90.6%) identified as black, 18 (56%) had a high school diploma or less, and 14 (44%) completed some college or more. 7% (1) of older and 46% (6) of younger pts reported “some of the time” or “never” rather than “most of the time” when asked how often they followed the fluid restriction recommendations (p=0.034). 29% (4) of younger pts reported fluid restrictions were difficult to follow, vs. none of the older pts (p=0.037). 33% (5) of younger pts reported “poor” or “average” when asked about wellbeing prior to the pandemic and 100% (15) of older patients reported “good” (p=0.05). When asked to rate their stress level over the last year, 64% (9) of younger pts reported being somewhat or very stressed and 78% (11) of older pts reported not at all or a little stressed (p=0.015). 29% (4) of younger pts stated they sometimes work well with their provider and 100% (15) of older patients stated...
always (p=0.026). There were no statistically significant differences between the groups for sex, race, or education.

In our population during the pandemic: 1. Younger pts were less adherent to fluid restriction and found them more difficult to follow. 2. Older pts were more likely to report feeling good prior to the pandemic and were less stressed following it. 3. Older pts were more likely to report a good relationship with their provider. 4. Younger pts may need more support through the pandemic as they appear to be coping less well, feel less connected, and are less able to follow important dietary restrictions.

201 ACUTE KIDNEY INJURY, NECROTIZING PANCREATITIS AND NEPHROCALCINOSIS: AN UNCOMMON SEQUELAE OF UNTREATED PRIMARY HYPERPARATHYROIDISM:
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Primary hyperparathyroidism is due to a solitary adenoma in 80-85% of cases[1]. Symptoms of hypercalcemia range from fatigue and constipation to renal insufficiency. Sequela such as pancreatitis and acute kidney injury (AKI) can cause electrolyte abnormalities and require close monitoring and management. Herein, we present the case of a patient with severe hypercalcemia causing necrotizing pancreatitis and AKI requiring CRRT (continuous renal replacement therapy) with resolution of symptoms after parathyroidectomy.

A 45 year old female with hypothyroidism and known parathyroid adenoma presented with abdominal pain. She was noted to have a calcium level of 16.2 mg/dL, AKI with serum creatinine of 2.7 mg/dL, PTH (parathyroid hormone) of 787 pg/mL and an elevated lipase > 2250 U/L. Computed tomography of abdomen was notable for bilateral nephrocalcinosis with features of pancreatitis. She was resuscitated with intravenous fluids and received calcium 4U/kg. She was transferred to the intensive care unit for necrotizing pancreatitis with anuric renal failure. Subsequently, hypocalcemia was noted and presumed to be due to saponification from severe pancreatitis. Patient was initiated on CRRT with 2.5 mEq/L calcium bath. After 72 hours, calcium levels peaked at 11.9mg/dL despite a zero calcium bath initiated on CRRT with 2.5 mEq/ L calcium bath. After 72 hours, symptoms after parathyroidectomy.

202 ASSOCIATIONS BETWEEN MINDSET AND CLINICAL OUTCOMES IN PERITONEAL DIALYSIS (PD) PATIENTS:
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Background: PD patients learn to perform dialysis procedures themselves. Mindsets are beliefs or assumptions that affect individual perceptions and actions. Mindset theory describes two general categories: fixed and growth. A fixed mindset is the belief that ability and intelligence cannot develop or improve. A growth mindset reflects belief that knowledge and ability can change and grow over time. Variation in a patient’s mindset specific to performing PD procedures, especially in the setting of setbacks such as peritonitis events, may be related to clinical outcomes such as PD modality persistence and survival to transplant. This study describes associations between mindset and future clinical outcomes at one year of follow-up in a sample of patients on PD.

Methods: Adult PD patients were enrolled, and demographics were obtained. The Health Mindset Scale (HMS), a 3-item survey scored from 3 to 18, with higher numbers indicating greater growth mindset, was administered. Patient status of on PD, changed to HD, transplanted, or died, was determined at 1 year. Competing risks models were constructed, and adjusted for age, race, diabetes, hypertension, and albumin.

Results: 101 patients were followed for a mean of 297 days (SD 113 days). Average age was 52 years, with 57% male, 32% black, and 42% diabetic. Average HMS was 12.79 [median 14, SD 4.2]. At follow-up, 66% remained on PD, 12% were on HD, 10% were transplanted, and 12% died. Higher HMS score was significantly associated with receiving a transplant: HR 1.33 (95% CI 1.01, 1.76), and lower mortality: HR 0.87 (95% CI 0.76, 0.99).

Patients with a growth mindset may be more likely to navigate tasks needed to survive on PD, be listed, and then receive a transplant. Patients with a more fixed mindset may not believe that their actions can change their clinical course, and so may be less likely to carry out health behaviours. Mindset may be an important psychosocial predictor of outcomes in PD patients.

203 ALK INHIBITOR RELATED TUBULAR DYSFUNCTION AND ELECTROLYTE ABNORMALITIES WITH PRESERVED KIDNEY FUNCTION:
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The anaplastic lymphoma kinase (ALK) inhibitor, Alectinib, is an example of a tyrosine kinase inhibitor (TKI) that is known to cause elevated serum creatinine (SCr) and renal insufficiency in patients [1]. Electrolyte derangements such as hypo/hyperkalemia, hypocalcemia and hypophosphatemia have also been associated with this TKI [1]. Herein, we present a case of a patient initiated on Alectinib who developed multiple electrolyte derangements, including hypomagnesemia, which has not been commonly reported with Alectinib use.

This is a 49 year old female with CKD G2 and metastatic Hurthle cell thyroid cancer post-thyroidectomy in 2018 who was being followed in clinic. She was initiated on Alectinib with subsequent hypocalcemia, hypomagnesemia and hypophosphatemia. This was held with subsequent improvement in electrolytes. Hypophosphatemia noted was attributed to parathyroidectomy with parathyroid hormone level of 109g/ml. Alectinib was restarted however stopped due to derangements in electrolytes. Lenvatinib was attempted, however electrolytes worsened again and was stopped. She was admitted for repletion of electrolytes in a closely monitored setting. She denied any diarrhea or proton pump inhibitor use. Despite supplementation, she continued to be hypomagnesemic during her stay. Urine studies revealed a fractional excretion of sodium at 0.4%, of potassium at 14.3%, of calcium at 3.1% and of magnesium at 20.5%. She was also hypouricemic at 1.7 mg/dL. Throughout her admission, her SCr remained relatively stable. New onset proteinuria of 938mg/g was noted.

| Ca (mg/dL) | SCr (mg/dL) |
|-----------|-------------|
| Day 1     | 16.2        |
| Day 3     | 8.4         |
| Day 5     | 6.7         |
| Day 7     | 9.6         |
| Day 9     | 10.8        |
| Day 11    | 10.8        |
| Day 13    | 11.9        |
| Day 15    | 7.9         |
| Day 17    | 8.0         |
| Day 19    | 8.8         |
| Day 21    | 9.1         |

This case highlights the uncommon sequelae of untreated primary hyperparathyroidism which is rare since the introduction of automated chemistry analyzers [2]. Pancreatitis is reported in < 3% of patients with hyperparathyroidism and is seldom seen in current practice. Nephrocalcinosis and pancreatitis are rare complications of untreated hyperparathyroidism and could have been averted with the definitive treatment of parathyroidectomy.