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biopsy showed IgAN. The Oxford MEST-C score was M1E0S1T0Co. She was started on Lisinopril. Upr was 976mg/24h. Subsequently, 2 days after the booster vaccine she developed GH, Upr increased to 2063mg/24h and was started on Dapagliflozin.

This is the first reported case of de novo IgAN following each dose of COVID-19 vaccine and booster presenting with recurrent GH and SNRP. This case illustrates the need for pharmacovigilance and whether we should use non-mRNA or a different vaccine schedule in this vulnerable population.

The new-onset and recurrence of GH shortly after the COVID-19 vaccines suggests a potential association with the development of IgAN and relapses. Further studies are needed to understand the pathophysiology of the vaccine-associated glomerular diseases, optimize vaccine strategies and guide optimal therapeutic management.

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KNOWLEDGE GAPS REGARDING CHRONIC KIDNEY DISEASE AND DIABETES IN A POPULATION OF INNER-CITY DIALYSIS PATIENTS:

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Prevention of progression of kidney disease relies in part on early intervention. We interviewed pts with ESKD secondary to diabetic kidney disease regarding their knowledge of their disease and how it is related to chronic kidney disease (CKD). 15 randomly selected dialysis pts with diabetes (DM) were surveyed regarding knowledge about DM and kidney disease, including questions about the state of their knowledge at the time of DM diagnosis. Demographic information was also collected. Mean age was 64.3±2.9yrs, 8 men (53%), 7 (47%) had less than a college education, 8/9 (89%) made ≤$40K/yr, mean time with diabetes 29.0±6.9yrs, 8/13 (54%) pts saw an endocrinologist, 4 (27%) reported most recent HbA1c >10%. 12/13 (92%) reported no knowledge of what CKD was and 10/13 (77%) did not know that diabetes could cause kidney disease at the time of their DM diagnosis. There was no correlation between knowledge and age, education, length of time with diabetes, income or sex. Pts who were older were less likely to see an endocrinologist (r=-0.64, p=0.019), checked their blood glucose less frequently (r=-0.71, p=0.006), and did not check after eating (r=-0.62, p=0.023). 13/14 (93%) pts stated that they knew what HbA1c was. 11/14 (79%) pts knew that insulin decreases blood glucose levels. 12/14 (86%) pts knew that a person with type 2 diabetes has increased blood glucose. 10/14 (71%) patients knew HbA1c should be checked every 3 months. 6/13 (40%) said they did not know what a nephrologist is. 9/13 (69%) did not know how kidney function is measured.

In our population of inner-city dialysis pts with DM: 1. The majority were knowledgeable about diabetes although older pts were less likely to see an endocrinologist and check their blood sugar frequently or after eating. 2. The majority of pts had no knowledge of kidney disease and did not know that diabetes could cause kidney disease at the time of their diagnosis. 3. Almost half of pts currently did not know what a nephrologist was and did not know how kidney function is measured. 4. An early education program for our underserved population regarding the relationship between kidney disease and diabetes should be designed in the hopes of delaying progression to ESKD.

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ACUTE KIDNEY INJURY ASSOCIATED WITH ANAPLASMOSIS:

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The clinical features of human granulocytic anaplasmosis (HGA) can be variable, ranging from asymptomatic infection to multi-organ dysfunction. We present an interesting case of AKI associated with HGA.

A 64-year-old male with prior history of ischemic cardiomyopathy status-post cardiac transplantation, hypertension and CKD related to chronic CNI use, presented with 5 days of fevers, myalgias and generalized weakness. The patient resided in Midwestern USA and was a deer hunter. Physical exam was unremarkable; no rash was noted. Labs were notable for AKI, transaminitis and pancytopenia (Table). Urinalysis was bland, however, spot urine protein to creatinine ratio revealed 3 g of proteinuria. Ferritin and LDH were elevated but haptoglobin was normal. Peripheral blood smear, although negative for schistocytes, did reveal morulae. Serologies for EBV, CMV, HIV, anaplasma, babesia, lyme disease were all negative. PCR ultimately returned positive for Anaplasma phagocytophilum. Treatment was initiated with doxycycline and the patient’s fevers quickly defervesced. Lab abnormalities subsequently improved with continued antibiotic therapy.

Tick-borne illnesses have been associated with interstitial nephritis. A case of MPGN has also been reported with HGA requiring treatment with steroids. Our patient’s urinalysis did not...