ABSTRACT SUBMISSION INSTRUCTIONS

Authors are invited to submit abstracts summarizing current basic or clinical research related to kidney disease through the NKF website by **December 1, 2014**. Each abstract must be accompanied by a credit card payment of $40.

Format of Abstract

- The abstract should be typed single-spaced on **one page** to fit within the specified margins (see sample provided) using type no smaller than 10 point (12cpi).
- The title should be typed in CAPITAL LETTERS and should clearly describe the nature of the investigation. The title should be followed in upper and lowercase letters by the authors' first and last names, affiliation (if applicable), city, state, and country.
- Underline the primary author's name (one primary author per abstract).
- Omit degrees, titles, institutional appointments, street addresses, zip codes, and research grant support.
- Do not leave spaces between the title, author listings, and the body of the abstract or between paragraphs.
- Indent paragraphs three spaces. The abstract file should be saved as primary author's last name_first word in the title (e.g., Zucker_Effects).

Margins

Please ensure that your abstract is the correct length, no more than one page to fit within the following margins (using Microsoft Word):

Top 1", Bottom 4", Left 1", Right 3.5"

Abbreviations

Use of standard abbreviations is desirable, e.g., RBC. Use kg., gm., mg., ml., L, and %. Place a special or unusual abbreviation in parentheses after the full word or phrase the first time it appears. Use numerals to indicate numbers, except to begin sentences. Do not use subtitles, e.g., Methods, Results.

Graphics

Simple tables or graphs may be included; however, they must fit within the designated abstract space. Note: Average chart comes out postage stamp size in abstract publications.

Font

Please use a common font such as Helvetica, Times, or Courier.

Your abstract must conform to the above guidelines, as incorrect formatting will result in disqualification.

Body of Abstract:

Organize the body of the abstract as follows:

- Statement of the purpose of the study / program / project
- Statement of the methods used
- Summary of the results presented in sufficient detail to support the conclusion
- Statement of the conclusions reached

Review / Publication / Presentation

Original Publication

Abstracts previously published or presented at a national/international meeting prior to the NKF 2015 Spring Clinical Meetings will **not** be accepted.

*Please note that we've added "Case Reports" as its own separate topic. ***Case Reports submitted should be novel and should have a single, well-defined message with meaningful clinical, diagnostic or therapeutic implications adequately supported by the clinical evaluation and diagnostic tests.***

Notification

Authors will receive notification of receipt of their abstract via email. All abstracts are peer-reviewed by members of the SCM15 Program Committee. Primary authors will be notified in early January 2015 whether their abstract has been accepted for presentation at SCM15.

Journal Publication

Accepted physician abstracts will be published in the *American Journal of Kidney Diseases*.
Accepted dietitian abstracts will be published in the *Journal of Renal Nutrition*.
Accepted nurse and technician abstracts, nurse practitioner and physician assistant abstracts will be published in *Advances in Chronic Kidney Disease*. Accepted social worker abstracts will be considered for publication in the *Journal of Nephrology Social Work*.

Registration Fee

Please note: Acceptance of an abstract does not waive the NKF 2015 Spring Clinical Meetings registration fee. **You must register for the NKF 2015 Spring Clinical Meetings in order to present your poster.**

Abstract Submission Checklist

Before submitting your abstract, did you:

- ☐ Follow all requirements described under "Abstract Submission Instructions"?
- ☐ Carefully proof your abstract?
- ☐ Ensure your abstract fits within the specified margins?
- ☐ Print a record of your online submission confirmation?

Sample Abstract:

1" Margin

Exact title in ALL CAPS

Authors, Affiliations, city, state, and country. Underline the primary author's name (one primary author per abstract).

TOPIRAMATE RESULTS IN A RAPID AND PROGRESSIVE DECLINE IN URINARY CITRATE OVER 60 DAYS: A

Roy Jhagroo, Amanda Valliant, Stephen Nakada, Krista Penniston, University of Wisconsin Hospital and Clinics, Madison, WI, USA

Indent paragraphs three spaces

Topiramate is commonly prescribed for migraine headaches, and for weight loss. It exerts a well-known hypocitraturic effect. We characterized the time course to hypocitraturia, a risk factor for lithiasis.

Under IRB approval, headache clinic providers offered participation to adult patients starting topiramate; a titrated dosing regimen reaching 100-200 mg/d was prescribed. Patients withheld initiation until a baseline 24-hour urine collection could be done. After starting topiramate, subsequent collections were done at 30 and 60 d for comparison.

Twelve patients (M:F , 0.71; 38y) were recruited from 9/2011-4/2012 and contributed complete 24-hour urine collections confirmed by 24-hour urinary creatinine excretion. At baseline, 83% (n=10) were normocitraturic (urinary citrate 581+/-274 mg/d), 2 patients were mildly hypocitraturic (250+/-39 mg/d). At 30d, mean urinary citrate excretion decreased nearly 300 mg and averaged 279 +/-121 mg/d; it continued to decrease through 60 d (218+/-82 mg/d), at which time 83% (6 of 7 patients with 24 hour urinalysis) were hypocitraturic (196+/-64 mg/d for 6 with hypocitraturia). Paired t tests confirmed differences in urinary citrate between baseline and 30 d and between baseline and 60 d (p=0.001 and 0.002, respectively) but not between 30 and 60 d, though the 22% decline in mean citrate urinary excretion from 30 to 60 d is nonetheless clinically relevant. Urine pH increased from 6.1 at baseline to 6.6 and 6.5 at 30 and 60 d respectively (p=0.04 for each comparison), increasing brushite supersaturation of urine. In one patient started on potassium citrate therapy (30 meq/d), urinary citrate excretion increased by 102 mg/d within 2 weeks.

Hypocitraturia from topiramate is rapid and progressive. This should be taken into account when starting therapy, particularly in patients with a history of urolithiasis or with identifiable lithogenic risk factors. Potassium citrate should be considered as adjunctive therapy in some individuals.

1" Margin

3.5" Margin

4" Margin

Notes:

The abstract file should be saved as primary author's last name_first word in the title (e.g., Jhagroo_Topiramate).

Abbreviations

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