

THE SECTION ON

NEPHROLOGY



American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



Spring 2025 Newsletter

Chair Update

Amy Wilson, MD, FAAP



Having just run the gauntlet of the end of the school year with my own kids, it seems appropriate that this newsletter focuses on transitions in nephrology—in both patient care and professional life.

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In section news, I would like to recognize Dr. Teri Mauch for her many years of service to the Section of Nephrology, first as a member, and then with 6 years of service on the Executive Committee of the Section on Nephrology, followed by 3 years as Editor of this newsletter, which has benefitted immensely from her time and care. The entire Executive Committee extends to Dr. Mauch our best wishes for a long and happy retirement! I also extend our congratulations to Dr. Gabrielle McGlathery on her selection as the inaugural recipient of the Section’s scholarship to support attendance at the 2025 AAP Advocacy Conference.

The Executive Committee recently met for our annual spring meeting at the AAP headquarters in Itasca. Updates from that meeting include that the hard work of section members to bring you an updated Clinical Report on Perinatal Urinary Tract Dilatation will soon come to fruition (recently approved by the board for publication and expected release in early summer). Work also continues on an updated Clinical Practice Guideline on the management of UTIs in infants and young children. The EC continues efforts to bring attention to the need for an updated Clinical Practice Guideline on Hypertension. The AAP Advocacy team shared with us their multiple ongoing efforts to be a strong voice in support of prioritizing children’s health, science, and research in Congress. I would specifically highlight their efforts to protect Medicaid and CHIP (more info here: [Protecting Medicaid and the Children’s Health Insurance Program](#)), and encourage all of you to be voices of support for these programs with your own Representatives and Senators.



As always, I am grateful to all of you for your membership in the Section of Nephrology and for making the well-being of all kids your priority.



A Word from the Editor

Teri Jo Mauch, MD, PhD, FAAP



I'm excited to present the Spring 2025 edition of the Section on Nephrology (SONp) newsletter. The theme of this issue is Transitions, a particularly relevant topic for me personally, as I face retirement after over 30 years in practice. I've been an AAP fellow since 1988, served on the Executive Committee for six years, and for the last three years I've had the privilege of editing the Section

newsletter. This has been a joyful journey for me, and I will remember it fondly as I anticipate the next stage of my journey. In addition to retirement, my personal transitions will include moving to a different state and taking on new roles in the Fiber Arts community (I am a weaver and probably “that woman sitting in the back knitting” at many professional meetings), while maintaining connections and still contributing to nephrology. In the past year I have stepped down as director of my division and chair of my University's Promotions and Tenure committee, and it's time to pass the editorial baton as well. **Please click [this link](#) if you are at all interested in becoming the next editor of the SONp newsletter**, and please know that I would love to provide any help I can in smoothing this transition.

On the transition theme, this issue contains a wonderful slate of contributions for your reading pleasure and edification. Mark Hanudel and our own Training Fellow Liaison, Zenab Tamer, contributed our focus feature article on transition to adult providers and programs, and they did so under pressure at the last minute after a previously identified author was unable to contribute due to a family emergency. Jesse Hackell provides insight into retirement and succession planning in an article particularly relevant to my own career stage, while Zenab Tamer shares the Growing Pains at the other end of the career spectrum – the transition from residency through fellowship to practice. Encompassing all stages of the career ladder, Marissa Defreitas and Chryso Pefkaros submitted an information-packed summary of the inaugural Joint Pediatric Nephrology Meeting, the Pediatric Nephrology Research Consortium (PNRC) Spring Meeting, and the 51st Miami Pediatric Nephrology Seminar. Reminiscing on the early days of Pediatric Nephrology, Rick Kaskel took lead authorship on the Milestones section, with another report from the ASPN History Project. His report includes reflections on and a still timely message from the Founder of Pediatric Nephrology, Dr. Henry Barnett, regarding the importance of advocacy.

Advocacy has always been an AAP priority (please see also the Fall SONp Newsletter, which can be accessed through the [AAP SONp Collaboration Site](#) for articles on health care disparities and advocacy, and also see Advocacy Tools and Opportunities from the AAP towards the end of this issue). Given national cuts to research, education and health care services, our advocacy is more important than ever. Dr. Barnett's comments were made during the Reagan era but are no less relevant today. Now, more than ever, we need to support and care not only for all children everywhere, but for Pediatric Nephrologists, regardless of their place of birth. I am pleased to report that this year's Barnett Award recipient exemplifies many of the qualities stressed by Dr. Barnett, including advocacy.

Many things are changing, but some remain. Perennial favorites featured here include the Clinical Case Presentation with questions and answers. In this issue, Dr. Sudha Mannemuddhu and medical student Lindsay Walden provided an excellent review of hyponatremia, complete with algorithms and updated recommendations.



Original Painting by SONp member Sai Sudha Mannemuddhu, MD, FAAP - Transitions

Sudha also graced us with another painting, a four-seasons depiction of a kidney. Nowhere but in nature are transitions more apparent! Our featured new member is both new to the section and an experienced Pediatric Nephrologist. Welcome, Dr. Ijaz! Finally, I want to warmly welcome and express my gratitude to Heather Fitzpatrick, who has admirably filled the big shoes of her predecessors as our section manager. Heather takes the initiative, and this issue is not only better for her efforts but might still be “in process” without her! She is a wonderful addition to our team.

Focus Feature

More Than a Referral, The Importance of Thoughtful Transitions of Care

Mark Hanudel, MD; Zenab Tamer, MD, FAAP

For patients with chronic kidney disease, transitions of care can be challenging, stressful times. Some transitions of care and changes of providers are inevitable, such as when pediatric patients with chronic kidney disease transition to adult nephrology care. Other transitions of care are more unexpected, such as when patients with chronic kidney disease may have to change providers secondary to relocation or changes in insurance. For both anticipated and unanticipated transitions, there are things that patients and providers can keep in mind to help facilitate smooth transfers of care.

Pediatric patients with chronic kidney disease transition to adult nephrology care around 18 to 21 years of age. However, it is recommended that the preparation for transfer of care begin earlier, around 11 to 14 years of age. Longer, more thorough preparation for transfer to adult care can ensure a more seamless transition and help prepare young people for full autonomy with medical visits. Therefore, both adolescent patients and their pediatric providers should be mindful of the eventual transition to adult care and start the education and planning process early.

To help facilitate this process, there are tools available for use. As described in the 2024 KDIGO (Kidney Disease Improving Global Outcomes) chronic kidney disease guidelines, several resources are available to help guide the transition from pediatric to adult care, and to help assess readiness to do so, including TRxANSITION, Youth Quiz from the On Trac program, Transition Readiness Assessment Questionnaire (TRAQ), Readiness for Transition Questionnaire (RTQ), and Got Transition tools <http://www.gottransition.org>.

For pediatric nephrologists, seeing adolescent patients alone, without caregivers, for at least part of the clinic visit can help young people practice interacting with healthcare providers independently. Doing so also provides privacy for the discussion of sensitive topics. Additionally, allowing older adolescent patients to visit the adult clinic prior to transfer of care can be helpful.

For adult nephrologists caring for young adult patients, it is important to recognize that patients under 25 years of age with chronic kidney disease are a unique population at high risk of adverse outcomes. This is at least in part due to physiologic incomplete brain maturation, as the prefrontal cortex, responsible for planning and organization, is not fully developed until approximately 25 years of age. Healthcare transitions per se are associated with adverse outcomes, including loss to follow-up, but may be even higher risk in the young adult population. Therefore, it is recommended that young adults be seen in clinic more frequently than older adults with the same stage of chronic kidney disease. Increased awareness among adult nephrologists of the unique needs of the young adult subset of their patients can help to improve the transition from pediatric care.

For all healthcare providers, it is important to understand that adolescent and young adult patients are navigating not only a transition of care and change of healthcare providers, but also the larger transition from childhood to adulthood, with all its inherent challenges and complexities. Keeping this in mind, and framing clinical interactions accordingly, can help to optimize this critically important time of transition.

For each pediatric patient with kidney disease transitioning care to an adult nephrologist, an individualized transition plan

should be formulated well in advance, with input from the patient's caregivers, pediatric nephrologist, social worker, other providers (e.g., pediatric urologist), and support staff. Such plans should be tailored to the specific needs of the family and patient, taking into consideration the patient's developmental stage, medical complexity, and psychosocial circumstances. For pediatric nephrology practices with sufficient resources to do so, establishment of a dedicated transition clinic can help to facilitate the pediatric-to-adult nephrology transition; educate patients and caregivers regarding considerations involved in transitioning to adult care; and provide a structured environment in which patients, families, and providers can collectively develop an individualized, patient-specific transition plan.

An outstanding, comprehensive review discussing the transition from pediatric to adult nephrology care was recently published in *Kidney360* by Drs. Shi, Jang, Copp, and Ku (Shi et al, Pediatric to Adult Nephrology Transition in CKD, *Kidney360*, 2025 Apr 1;6(4):663-670. PMID: 40053397 PMCID: PMC12045502). This definitive review highlights considerations for both pediatric and adult providers; identifies provider- and patient-centered challenges; and suggests potential metrics that can be used to evaluate the success of the transition from pediatric to adult nephrology care.

In addition to the pediatric-to-adult transfer of care, other healthcare transitions can occur. Sometimes, patients with chronic kidney disease may have to change nephrologists, in the setting of a relocation or change in insurance. When meeting with the new nephrologist (pediatric or adult), it is important that patients are able to communicate key aspects of their medical history (e.g., etiology of chronic kidney disease, duration of chronic kidney disease, other medical conditions, etc.). Additionally, knowing prescribed medications, their dosages, and why they were prescribed helps to maintain optimal care while transitioning to a new nephrologist. Especially useful to the new healthcare team is an updated, printed list of medications, medication dosages, medication indications, drug allergies, and medical conditions. For patients, having an up-to-date list can help to avoid sub-optimal care during a healthcare transition, as communication between the transferring and receiving care teams may not always be comprehensive or thorough. Therefore, continually educating patients and their families, at a level appropriate to their understanding, regarding all aspects of the patient's clinical care can help to promote health literacy and self-sufficiency.

Additionally, when patients and caregivers meet with a new nephrologist, it is important that they discuss practical considerations, such as logistics, routes of communication, and clinical expectations. Some useful questions that patients should discuss with new providers include the following: How often should in-person clinic visits occur? Are telehealth video visits an option? Who should be contacted for scheduling, re-scheduling, or cancelling appointments? How are medication refills handled? What is the best way to contact a member of the healthcare team? Is there an app used by the clinical team that can help facilitate patient-provider communication? In what time frame should a response to a phone message or app-based text message be expected?

Transitioning care from a pediatric to adult nephrologist, or even from one practice to another, can be challenging for patients, families, and providers alike. Such transitions can increase the risk of sub-optimal care, possibly contributed to by factors such as inadequate provider-to-provider communication, unclear or insufficiently detailed transition plans, and mismatched or inconsistent expectations of care among all parties involved. Therefore, good communication, understanding, involvement, and preparation among healthcare providers, patients, and caregivers is paramount to facilitating seamless transitions of care for those with chronic kidney disease.

Business of Nephrology

Transitions in Pediatrics: The Pediatrician

Jesse M. Hackell, MD, FAAP

Jesse M. Hackell MD FAAP is the Chair of the AAP Committee on Pediatric Workforce (COPW), the immediate past chair of the Committee on Practice and Ambulatory Medicine (COPAM), and a member of the Section on Administration and Practice Management (SOAPM). He practiced independent primary care pediatrics in New York for 41 years prior to retiring from clinical practice in 2022.

Transitions are a regular occurrence in medicine, and indeed, in life. We transition from undergraduates in college to medical students, and then to residents and eventually to practicing pediatricians. As we are focused and organized (in most cases), we usually see these transitions coming, and plan for them in advance. However, having recently retired from clinical practice, I have come to realize that there is one transition for which many of us have not done any advance planning—the transition from practice to retirement in the later stages of our careers.

It is important to realize that planning for succession in the practice and our own retirement is not something that should be left until the decision is made that “the time has arrived.” In fact, succession and retirement planning is something that should begin at the beginning of a career, at least in general terms, and that should be refined as our status and available resources change. Recognizing that today’s physicians are far more likely to change employment more often than physicians of my generation may make this even more important, in order to ensure that any benefits earned through longevity are either carried with you or matched in any new positions.

To be more specific, thoughts of retirement should ideally be considered when planning for the area in which you want to practice. After all, if you are going to become a part of a community and develop roots, that area should ideally be one in which you would be happy to continue living, even if you are no longer practicing medicine. At the same time, you should be thinking about succession plans when you take your first job. Will you be joining a practice, with the eventual hope of ownership and management, or will you become an employee of a large healthcare system or academic institution, where ownership and control is not usually a consideration? These choices will reflect your goals and aspirations and should be an integral part of the initial contract with your first job, and every contract after that.

As you advance through your career, ownership and management decisions will continue to come up, as will leadership positions at institutions even in the absence of actual equity share. You may work to build your practice or develop a resume that will qualify you for academic or other advancements, but, again, your individual goals and desires should be a guide and should inform your choices.

As we get further into our careers, and as we age, we will face choices which will guide us through whatever transitions we pick. Some of us may choose to continue practicing, which is also a deliberate choice, while others of us may want to slow down, or focus on narrower areas of interest. It is crucial that any contracts allow you the flexibility to follow different paths, and that these options be specified well in advance of when you think that you may need them. For me, retirement was preceded by three years of part-time work—a reduction in hours and responsibilities with a commensurate, agreed-upon reduction in compensation. That time gave me a chance to explore more options for the future and gave my practice a chance to cultivate someone to take over the management work that I had done for decades. When I finally retired completely, it was with the comfort that I had left the practice and my patients in the best hands possible.

One other item about succession planning that is often overlooked is what I call “unplanned succession,” which would include illness or death of one of the members of the practice. While we have (hopefully) maintained disability insurance to protect us in the case of our own disability, it is equally important that the contract provides for the transition of responsibility should a sudden change occur. In smaller practices, partnership/stockholder agreements should specify the steps to occur when one member suddenly can no longer fulfill their obligations, as well as providing financial resources for both the individuals and the practice. In the case of employed physicians, the contract should also specify what happens when an employee undergoes a sudden change of circumstances, and it should also provide for an adequate time to recover from a disability (and insurance coverage for the interval) so that you do not suddenly find yourself out of a position without resources to replace your earnings. Failure to consider these questions can just add insult to injury should an injury occur.

We all spend a lot of time planning for our career—choosing where to train, what field to train in, and where to start our post-training practice. We also need to consider the other end of that career and make choices early on which will set us up for the later stage of that career, no matter what those stages eventually involve.

Section News

2025 Henry L. Barnett Award Recipient: Ann P. Guillot, MD, FAAP



Photo Courtesy of Larner College of Medicine

The AAP Section on Nephrology (SONp) recognizes one individual yearly for lifetime achievement in the field of pediatric nephrology. The SONp Executive Committee and the SONp Barnett Award Committee are pleased to present the 2025 [Henry L. Barnett Award](#) to Ann P. Guillot, MD, FAAP.

Dr. Guillot was nominated for the Henry L Barnett award for unending dedication to the health and wellbeing of children with kidney disease, as well as her leadership in the field of resident education. With a strong focus on medical student and resident education, Dr Guillot developed the pediatric residency program at the University of Vermont (UVM), where she was the program director from 1990-2014 and a Professor of Pediatrics since 2000. In these roles she has taught, mentored and inspired countless medical students, residents and faculty.

In addition to her roles at UVM, she has provided leadership in pediatric nephrology at the national level. Within the AAP, Dr Guillot served on the Executive Committee of the AAP Section on Nephrology from 1992-2004 (as chairperson from 1997-2002), of which she has been a member since 1980. She participated on the PREP the course planning group from 2012-2017, serving as chair for several years. She has been a member of the American Society of Pediatric Nephrology since 1990 and a member of the Clinical Affairs Committee since 1992.

Dr. Guillot is first and foremost an excellent pediatrician and pediatric nephrologist. She served as the first and only pediatric nephrologist at the University of Vermont for over 25 years and developed the pediatric nephrology service at UVM, bringing much needed nephrology services to the children of Vermont and northeast New York. She has always been determined that the children in this region receive outstanding nephrology care close to home. She developed a pediatric dialysis service, transplant service, and apheresis service, and is always available to her patients. Her patients know that above all, she is their advocate.

Congratulations, Dr. Guillot, on this achievement!

Perspective

Making Waves: A Landmark Success at Miami's First Joint Pediatric Nephrology Meeting

Marissa DeFreitas, MD, MS¹; Chryso Katsoufis, MD¹; Myda Khalid, MD^{2,3}; Teri Crumb, MSN, RN, CCRC³; and John Mahan, MD^{3,4}, on behalf of the PNRC Board and Miami Seminar Executive Planning Committee.

A Historic Collaboration

From March 19–23, 2025, the 51st Miami Pediatric Nephrology Seminar convened at the Hyatt Regency in Miami, FL, in conjunction with the Pediatric Nephrology Research Consortium (PNRC) Spring Meeting—marking the first-ever joint event between these two organizations, both well known among the pediatric nephrology community. This landmark collaboration brought together more than 200 participants, including 60 trainees, from over 50 institutions across 22 countries in a dynamic hybrid format. This year's event expanded its impact by integrating the robust research and training mission of the PNRC, offering attendees a unique blend of scientific innovation, clinical insight, and cross-disciplinary discussion. In addition, trainee career development was a principal component of the multi-day program including the American Society of Pediatric Nephrology (ASPN)-PNRC First Year Fellows' Workshop and Young Investigators' Abstract Showcase. These important trainee focused programming opportunities contribute to addressing the critical need to build and sustain the pediatric nephrology

workforce.

PNRC: Expanding Collaborative Research

Originally founded in 2004 as the Midwest Pediatric Nephrology Consortium (MWPNC), the PNRC recently celebrated its 20-year anniversary and now spans 125 sites across North America and has published 87 peer-reviewed papers and conducted 54 multi-center studies. The group formally became a 501(c)(3) nonprofit in 2019, reflecting its nationwide reach. The mission of the PNRC is to improve the care of pediatric patients with kidney disease and hypertension and facilitate collaborative research in the field of pediatric nephrology. In addition, the PNRC strives to train the next generation of pediatric nephrology investigators by encouraging the development and research efforts of both fellows and junior faculty.

Over the years, PNRC has received 21 research grants, including 6 NIH-funded projects. It continues to thrive through biannual meetings and active Working Groups that incubate new research ideas. The Consortium's collaborative spirit was in full force during this joint Miami event for its 2025 Spring Meeting. PNRC President John Mahan, and the entire PNRC Board were instrumental in giving life to the Joint meeting and played an integral role in the Miami Seminar program as speakers and moderators.

Honoring a Legacy, Shaping the Future: The Miami Pediatric Nephrology Seminar

Founded by the late Dr. José Strauss (1930-2017) in 1974, the Miami Seminar continues its tradition of advancing pediatric nephrology education and nurturing international collaboration, now in its 51st year. The Seminar was led by the Executive Planning Committee and Co-Chairs Chryso Katsoufis and Marissa DeFreitas, who relayed their experiences from Seminar trainees to Co-chairs in an interview with Dr. Rick Kaskel as part of the ASPN History Project. Since its inception, the Miami Pediatric Nephrology Seminar has provided a unique gathering of multiple specialists and provides many opportunities to be involved in a dynamic exchange of information, experience, and insight with the goal of improving the care of patients with kidney disease. The Seminar provides opportunities for early and mid-career faculty to present in their areas of expertise, and for trainees and junior faculty to learn in a supportive environment. The focus on collaborative sessions, renal pathology and new approaches and therapies including the *Global Heroes* session with important insights into the unique challenges of providing pediatric nephrology care in middle- and low-income countries. Many faculty have participated in the Miami Seminar over many decades and speak to the importance of attending the meeting in their career development progress. The annual "Lunch with the Professors" provides an opportunity for trainees to network with senior faculty in a friendly environment. This year the program included 30 speakers and 16 moderators highlighting the following topic areas: 1) Emerging Therapeutic Targets & Pathophysiologic Principles 2) Advances in Clinical Practice from the Glomerulus to the Tubule 3) Growing Concerns: Pediatric Hypertension and Its impact on Cardiovascular Health 4) Exploring Developmental Nephrology and Its Impact on Kidney Health 5) Unraveling Pediatric Glomerular Diseases 6) New Horizons in Pediatric Kidney Transplantation and 7) Global Session: Uniting for a Brighter Future in Pediatric Nephrology with a Special Dedication to Patrick Brophy given by Dr. Melvin Bonilla-Félix. The style of talks included pro and con debates in addition to the traditional didactics with a focus on core educational topics interspersed with up-to-date clinical practice applications.

Supporting the Next Generation

In response to the declining number of pediatric residency applicants (NRMP 2024), the PNRC and the ASPN redoubled efforts to nurture early-career nephrologists. This joint meeting included the inaugural ASPN-PNRC Pediatric Nephrology First-Year Fellows Workshop. Held March 19–20, the workshop focused on career development, research mentorship, and collaborative training—offered at no cost to fellows. The PNRC Board created the PNRC Pediatric Nephrology Fellows Initiative in Spring 2024, led by Dr. John Mahan and Dr. Myda Khalid. ASPN enthusiastically endorsed this work as it aligns with the goals of ASPN and the ASPN's Workforce Committee. PNRC piloted a workshop in September 2024, supporting 15 fellows with partial funding to travel to the workshop that was aligned with the PNRC meeting in Philadelphia. The Joint Meeting in Miami allowed for the continuation of this effort and was open to all 40 first year Pediatric Nephrology Fellows in North America, of which 25 were in attendance.

Following the workshop, fellows actively participated in the PNRC's 2-day research meeting, joining in protocol development and scientific exchange with over 100 researchers. Their immersion continued into the Miami Seminar (March 21–23), fostering a unique, three-part educational arc alongside many senior level fellows and various trainees. In addition, many International Pediatric Nephrology Association (IPNA) fellows and Junior Empowerment and Mentorship Program (JEMs) joined virtually from across the globe.

Notably, the Young Investigators’ Showcase provided a vibrant platform for trainees and junior faculty to present groundbreaking work through oral and poster presentations. The abstracts were judged by the Executive Planning Committee and the top 5 selected for an oral abstract platform and award.

Securing Tomorrow’s Workforce: Fostering Careers and Wellness in Pediatric Nephrology

A record number of trainees participated in the Joint Meeting. We polled the trainees in a post-meeting survey with a response rate of 63%. Responses were included from a variety of training levels: medical students, masters students, doctoral and post-doctoral fellows, residents, and pediatric nephrology fellows in their first through third year. Almost all trainees surveyed agreed that the Joint meeting contributed to their personal wellness and career development, encouraged them to seek research opportunities, and provided core educational content for their training. The most highly cited well-liked feature of the meeting was the ample networking opportunities with several positive comments from trainees about the experience such as “I really enjoyed connecting in person with fellows and faculty from around the nation and across the ocean. I think the opportunities for personal and professional advancement were unparalleled.”

Looking Ahead

The success of this inaugural joint meeting demonstrates the power of partnership. The meeting was possible through the sponsorship of many organizations including the support of the ASPN, IPNA, and International Pediatric Transplant Association (IPTA) and the University of Miami Miller School of Medicine, Department of Pediatrics. Together, the Miami Seminar and PNRC are redefining how pediatric nephrology education, mentorship, and research converge—with an eye toward inspiring the next generation of clinician-scientists and improving outcomes for children with kidney disease. Importantly, we would like to acknowledge the PNRC Board and Executive Planning Committees for all the dedication and support that allowed for such a successful Joint Meeting.

Miami Seminar Executive Planning Committee

Co-Chairs

Marissa DeFreitas, MD, MS	Chryso Katsoufis, MD
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PNRC Executive Team:

Corinna Bowers, Executive Director; **Teri Crumb**, Program Manager; **Elisa Kaufman**, Administrative Assistant; **Matthew Neal**, PNRC Technical Director; **Rick Metzler**, AV/Website Creator/Website Host

Miami Team:

Ashley Vann, Practice Manager, Pediatric Nephrology; **Alexis Belmondo**, Audio Visual Technician

Relevant links:

[2025 Spring Fellows Agenda](#)

[2025 Spring PNRC Meeting](#)

[2025 Miami Seminar Program](#)

[ASPN History Project](#)

For more information about the PNRC click here <https://www.pnrconsortium.org/> or email admin@pnrconsortium.org

For more information about the Miami Seminar click here [Miami Pediatric Nephrology Seminar Miller School of Medicine](#) or email mdefreitas@med.miami.edu.

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³ Pediatric Nephrology Research Consortium

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Milestones

Reflections on a Visionary in Pediatrics and Pediatric Nephrology, Dr Henry L. Barnett

Frederick Kaskel, MD, PhD, FAAP; Meredith Atkinson, MD; Manju Chandra, MD, FAAP; Robert L. Chevalier, MD, FAAP; John Foreman, MD; Aaron L. Friedman, MD; Kevin Lemley, MD; Victoria Norwood, MD, FAAP; William Primack, MD; George Schwartz, MD; F. Bruder Stapleton, MD, FAAP; Teri Jo Mauch, MD, FAAP



Henry L. Barnett, MD, FAAP

During these unsettling times with widespread cuts in federal aid for medical care, research and safety nets for the poor, it is important to look at the history of our field and learn from those visionaries who tackled challenges and founded our subspecialty. The foremost among those was Dr Henry L. Barnett, who some consider the Founder of Pediatric Nephrology.

At the time, Dr. Barnett's vision for a better world for our children and families clearly was formed in part by his experience during World War II, as the base pediatrician for the Manhattan Project in Los Alamos, N.M. He also was one of the first U.S. physicians to observe first-hand, the devastation after the atomic bombs were dropped in Japan. His quest for global collaboration resulted in the formation of the seminal "International Study of Kidney Disease in Children (ISKDC)" and in the development of American Society of Pediatric Nephrology.

It is timely to recall Dr. Barnett's comments made at his Presidential Address to the American Pediatric Society at the annual meeting in Washington, DC in 1982 entitled "Challenges Facing the American Pediatric Society". (Pediatr. Res. 16: 807-808, 1982). At the time he was Professor Emeritus in the Department of Pediatrics of the Albert Einstein College of Medicine, and Medical Director, Children's Aid Society, New York City. Concurrently, President Ronald Reagan's administration had initiated a

wide range of cutbacks to medical care, research, and other social services.

“This has been an eventful year for academic medicine, for children and their families, for the country and for the world. Academic medicine has been challenged by reduced funding for biomedical research and education, by increased external political influences on it, and by reimposition of limitations on freedom of exchange with scientists from other countries. The welfare of children and their families, especially the poor, is being threatened by cruel cutbacks and even eliminations of social programs adversely affecting the health and dignity of children. As individuals we have a large stake in seeking solutions to these challenges and threats. As physicians, and especially as academic pediatricians, we have unique responsibilities for some of them in order to work for solutions.”

The theme of his presentation is uncannily relevant in view of the current uncertainties facing our responsibilities as child health investigators and providers. We should acknowledge Dr. Barnett’s wisdom and insight as we strive to remain focused on our mission to provide the best care for our children and advance the field of pediatric nephrology.

The mission of the American Academy of Pediatrics (AAP) is to attain optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults. The mission of the Section on Nephrology (SONp) is to improve the health and well-being of infants, children, and adolescents with disorders of the kidneys and urinary tract and hypertension by:

- Providing educational information and opportunities for the pediatric medical community, patients and families;
- Promoting pediatric nephrology as a career among medical students and pediatric residents;
- Providing expert recommendations for Academy programs, policy, and other public materials; and,
- Advocating for those who provide and require pediatric nephrology care.

The challenges currently facing medical scientists, child health investigators and providers are similar to what worried Dr Barnett in 1982. In these trying times, we have to follow the footprints of the founding visionaries of Pediatric Nephrology and make progress amidst the chaos. Pediatricians and pediatric specialists from all nations need to collectively rise to shoulder new responsibilities and devise meaningful ways to provide the best care for children everywhere, while continuing to advance the field of Pediatric Nephrology.

SONp Training Fellow Liaison Column

Growing Pains: Navigating the Transition from Residency to Fellowship

Zenab Tamer, MD, FAAP – SONp Training Fellow Liaison



Stressed about moving to a new city, navigating unfamiliar highways, remembering to bring my own grocery bags to the supermarket, and rebuilding a support system from scratch - Again!!! The amplified feeling of imposter syndrome!!! I assumed these would be the steepest climbs of fellowship transition. But those challenges quickly faded into the background just a few days in my fellowship, when my pager went off at 4 a.m., pulling me into a busy ICU to initiate CRRT. I stood there, uncertain how to place CRRT orders, barely familiar with the new EMR. I remember staring at the machine, wondering how I'd survive fellowship if this was merely the first week.

Transitions in medical training are far more than resume milestones. They are periods of identity shift, emotional discomfort, and accelerated personal growth. The move from residency to fellowship marks a profound professional shift. First-year fellows are expected to manage complex patients, teach residents, and conduct research—all while adjusting to new roles and expectations. Fellows move beyond the structured, gradual progression of residency training into a deeper, more complex subspecialty medicine. For most entering a new institution, the transition can feel even steeper, with the added challenge of unfamiliar systems, workflows, and team dynamics. Fellows who stay at their home institution may find the early transition

smoother, benefiting from existing relationships and prior exposure.

Fellowship is not a one-size-fits-all experience, and regardless of setting, one of the most essential skills in early fellowship is learning to advocate for your learning. That means speaking up when you're uncomfortable, asking for more supervision when needed, and requesting more independence when ready. It's also important to remember that many fellows, at some point, question whether they made the right choice. Nearly every subspecialist I've spoken with has admitted they considered leaving fellowship, especially when the alternative—general pediatrics—offers a more familiar, less stressful path with immediate financial stability. Coping effectively involves seeking support early. Connect with peer mentors who understand this stage and find attendings who can offer both guidance and reassurance.

Embracing discomfort and remaining curious, even when it's difficult, is key. As someone once told me, “The more you are out of your comfort zone, the bigger your comfort zone becomes”. Give yourself time to adjust and explore different clinical areas and projects. You may not know your niche right away—and that's okay. Sometimes you don't discover what you're passionate about until you try it. Outside of clinical duties, invest time in activities that recharge you—try new foods, explore communities, and engage in hobbies that help maintain your mental and physical wellbeing. This is essential to sustain resilience through the demanding fellowship years. Your knowledge will grow as you consistently read about your patients and revisit core concepts over time. And above all, never hesitate to ask questions or seek help—it's one of the most powerful tools for growth.

As fellowship comes to an end, your path often becomes clearer, guided by your clinical interests, personal priorities, and long-term goals. This is the time to ask yourself: What kind of attending do I want to be? How can I find—or create—my professional niche? How can I maintain wellness, life-work balance and find meaningful purpose while meeting clinical demands?

Many of the same lessons from earlier transitions apply: growth often emerges from discomfort, it's okay not to master everything, how you respond to uncertainty matters most. Mentorship remains crucial; stay connected with your peers and attendings. Meeting new colleagues at national conferences is a chance to build meaningful relationships and open new doors.

Despite its challenges, fellowship is deeply rewarding. The privilege of caring for medically complex children, the opportunity to guide families through uncertainty, and the intellectual stimulation of a dynamic field of nephrology are all affirmations of why this training is worth it. Finishing fellowship is not just a Milestone, it's a transformation. And as the early years of attending life begin, they mark yet another stage of becoming. Finally, I would say: *Embrace it!!! because you've already come farther than you think.*

Case Q & A:

For the Love of Water, What's the Cause of this Hyponatremia?

Lindsay Walden, BS - Medical Student
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Case Presentation:

An 18-year-old female with Systemic Lupus erythematosus (SLE) diagnosed at the age of 17, class IV lupus nephritis (CKD stage 3 with GFR 30 mL/min/1.73 m²), and multiorgan involvement came to follow up with her primary care physician 10 days after discharge from hospitalization for SLE-associated hypertensive emergency. Her blood pressure (BP) was well controlled at the time of discharge.

The patient reported having less energy and sometimes feeling dizzy. She does not report joint aches or swelling, nor hypertensive or hypotensive symptoms. She is on mycophenolate mofetil, hydroxychloroquine, lisinopril, labetalol, amlodipine, clonidine, and sodium bicarbonate tablets. During her hospitalization, she received cyclophosphamide, rituximab, and methylprednisolone.

On examination, her vital signs were normal, temperature: 98°F, heart rate 94 beats/min, respiratory rate: 16/minute, BP: 110/66 mm Hg. Her weight was 45.6 kg (baseline 50 kg). Physical examination was unremarkable, except for mild pedal edema, which had improved compared to the time of discharge as noted in the photographs shown by the family. Given her significant weight loss (4.4 kg in 10 days), laboratory testing was done and was significant for moderate hyponatremia and hyposthenuria.

	At Discharge	Today
Sodium (mEq/L)	140	125
Potassium (mEq/L)	3.9	4.5
Bicarbonate (mmol/L)	25	22
BUN (mg/dL)	31	26
S. Creatinine (mg/dL)	1.21	1.19
S. Albumin (g/dL)	4.0	4.5
Hemoglobin (g/dL)	6.5	9.5
Platelets (x10³/uL)	54	138
Urinalysis	pH 7.5, SG 1.009, 2+ protein, trace blood	pH 7, SG 1.004, otherwise normal
Weight (kg)	50	45.6
Blood Pressure (mm Hg)	126/92	110/66

She had normal blood glucose, serum electrolytes, serum albumin, lipid profile, C-reactive protein, TSH and free T₄; uric acid was slightly elevated at 6.9 mg/dL (baseline 6); brain natriuretic peptide was 67. Review of recent imaging showed normal

doppler renal ultrasound, and a subacute to chronic vasculitis pattern on brain MRI. Echocardiogram showed a normal left aortic arch without coarctation, mild LV hypertrophy, low normal systolic function, possible diastolic dysfunction, mild mitral and trivial aortic regurgitation, mild pulmonary hypertension, thickened pericardium with no significant pericardial effusion, and possible left pleural effusion.

Questions:

1. How urgent is this?
2. What is the differential diagnosis for the etiology of hyponatremia in this patient?
3. What additional information can the patient provide?
4. What is the management of hyponatremia in this patient?

How urgent is this?

Hyponatremia is one of the most common electrolyte abnormalities in pediatric patients in both inpatient and outpatient settings. Hyponatremia in children is defined as a serum sodium concentration less than 135 mEq/L, but it can be further classified based on severity, onset, and neurological symptoms, and volume status.

Classification based on serum sodium level:

Mild: Serum sodium of 130-134 mEq/L

Moderate: Serum sodium of 125-129 mEq/L (OUR PATIENT)

Severe: Serum sodium <125 mEq/L

Classification based on onset:

Acute: Develops in <48 hours

Chronic: Persists >48 hours

It was unknown whether it is acute or chronic in this patient. When unknown, it is safer to treat as a chronic condition.

Classification based on neurological symptoms:

	S. Sodium	Neurological Symptoms	Typical duration of hyponatremia
Mild	< 135 mmol/L	Headache; Irritability; difficulty in concentrating; altered mood; depression	Chronic (days-weeks)
Moderate	< 130 mmol/L	Nausea; confusion; disorientation; altered mental status; unstable gaits/ falls	Intermediate/ chronic (>24-48h)
Severe	<125 mmol/L	Vomiting; Seizures; obtundation, resp. distress, coma	Acute (<24-48 h)

Fortunately, apart from dizziness this patient did not have any symptoms.

The clinical manifestations are the result of cerebral swelling. This cellular swelling is due to water moving into cells in response to the osmotic gradient across the cell membrane. While there are regulatory mechanisms to try to minimize abrupt volume shifts, these can take several days to complete. If there is not enough time for these adaptations to take place, it can result in cerebral edema and cause neurologic dysfunction. The severity of neurological symptoms depends on the degree of brain volume regulation rather than serum sodium level.

How do you approach a patient with hyponatremia?

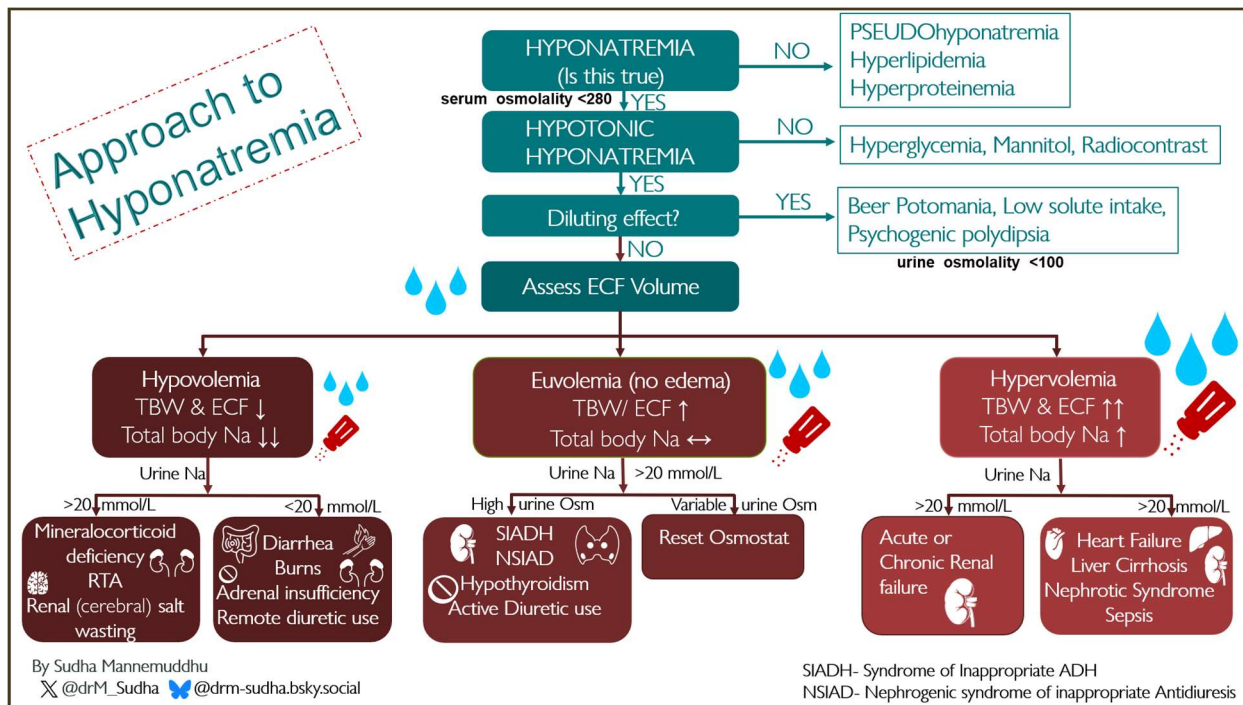


Figure 1: Approach to Hyponatremia

In order to determine the possible cause of hyponatremia in pediatric patients, serum osmolality and the patient's volume status must be established. As depicted in Figure 1, the first step is determining serum osmolality. If the serum osmolality is normal (280-295 mOsm/kg) then the patient has isotonic hyponatremia. This state is also referred to as pseudohyponatremia because the sodium level is not decreased in relation to the water phase of plasma; instead, the overall water content of the volume is reduced. Pseudohyponatremia often presents in children with hyperproteinemia or hyperlipidemia, so patients should be evaluated for their lipid and protein levels. High serum osmolality (>295 mOsm/kg) indicates hypertonic hyponatremia. Common causes are hyperglycemia, recent use of mannitol or sorbitol, and radiocontrast.

In patients with a low serum osmolality (<280 mOsm/kg), the possibility of diluting effect should be considered, which is typically seen with water intoxication or low dietary solute intake (through dilute formula and malnutrition), and beer potomania, where urine osmolality is typically less than 100 mOsm/kg. Incorrect administration of hypotonic IV fluids, water enemas, and primary polydipsia are all known causes of water intoxication. Primary polydipsia is most often reported in patients with previously existing psychiatric or neurodevelopmental disorders. Once this is excluded, hypotonic hyponatremia must be further classified based on the volume status by evaluating vital signs, skin turgor, mucous membranes, blood urea nitrogen, and uric acid levels.

Hypovolemic hyponatremia occurs in volume depleted patients. In addition to decreased total body water, sodium is lost through the urine or extrarenal loss. Urinary sodium levels can be measured to determine whether sodium is lost through renal or extrarenal causes. Urinary sodium greater than 20 mEq/L suggests renal loss, typically through diuretics, salt-losing nephritis, mineralocorticoid deficiency, or renal tubular acidosis. Urinary sodium that is less than 20 mEq/L suggests hyponatremia is due to extrarenal loss of sodium. Common causes of extrarenal loss in pediatric patients are vomiting, diarrhea, burns, or adrenal insufficiency.

Normovolemic hyponatremia is characterized by normal total body sodium levels in the presence of an increase in total body water level. Children who present with normovolemic hyponatremia most often have excess anti-diuresis due to the syndrome of inappropriate anti-diuretic hormone secretion (SIADH) or nephrogenic syndrome of inappropriate anti-diuresis (NSIAD). Patients with SIADH will have unsuppressed ADH excretion in the absence of its normal triggers. NSIAD is due to the

activating mutation of Vasopressin (V2) receptor in the collecting duct. Common causes of SIADH in children are central nervous system diseases, lung diseases, acquired immunodeficiency syndrome, endocrine disorders, and adverse reactions to medications. Certain chemotherapy and anticonvulsant medications can cause SIADH, increase the vasopressin receptor sensitivity, or act by mimicking the effect of ADH at the renal receptor. Patients with SIADH and NSIAD will have higher urine osmolality (typically greater than 100 mOsm/kg), which can be used to differentiate them from other causes. A reset osmostat is a less common cause of normovolemic hyponatremia, which can be associated with variable urine osmolality. These patients have a plasma osmolality ADH release threshold that is lower than normal. Resetting of the osmostat can occur in children with genetic defects and traumatic brain injuries.

Hypervolemic hyponatremia is associated with fluid overload that manifests as edema in patients, and it is one of the less common causes of hyponatremia in pediatric patients. In hypervolemic hyponatremia, total body sodium and water are both increased, but there will be a larger increase in total body water. Possible causes of hypervolemic hyponatremia can be differentiated by using urinary sodium, just as it is used in hypovolemic hyponatremia. Urinary sodium levels of more than 20 mEq/L indicate renal failure in the patient. Fluid retention in renal failure is due to the inability of the kidneys to excrete the free water load, as the glomerular filtration rate decreases. Urinary sodium levels of less than 20 mEq/L indicate that the fluid retention is most likely due to congestive heart failure, capillary leakage from sepsis, hypoalbuminemia due to nephrotic syndrome or protein-losing enteropathy, or cirrhosis.

Differential diagnosis of hyponatremia in this patient:

- Cyclophosphamide, cerebral vasculitis, Rituximab usage (SIADH)
- Acute dehydration
- Low solute intake/ malnourishment
- Hypoalbuminemia (nutritional vs. renal losses)
- Calcium channel blockers, beta blockers, Lisinopril (ACEi) rare causes

What additional information can the patient provide?

Upon inquiry, the patient reported that she had been drinking raw vegetable smoothies and eating raw fruits and vegetables without any added salt. She had been drinking 80-100 oz. of fluids per day. She reported consuming a few spoonfuls of rice. No other protein intake was reported. In addition, she reported that she found a curing diet for lupus online, and she reported that drinking raw vegetable smoothies and eating raw fruits and vegetables can reverse and cure lupus. This is a typical “tea and toast syndrome” due to consuming large amounts of water, without electrolytes (and low solute intake).

Management of Hyponatremia:

Principles for the management of hyponatremia:

- Assess for shock & treat. Treatment of shock takes priority.
- Obtain laboratories (urine and serum electrolytes, urine and serum osmolality, Thyroid function tests, copeptin, serum cortisol, etc).
- Assess the risk of hyponatremic encephalopathy.
- Follow the optimal method to raise plasma sodium (water restriction, saline solutions like normal saline and hypertonic saline, Tolvaptan, Urea, Furosemide).
- Correct hyponatremia slowly to minimize the risk of ODS.
- Patients whose sodium rises too quickly can be managed with an arginine vasopressin (DDAVP) clamp.

Once the probable cause of hyponatremia in a pediatric patient has been identified, the first step should be to treat the underlying cause, if possible, while also correcting the sodium levels. The patient’s sodium levels must be corrected slowly to prevent further damage and osmotic demyelination syndrome (ODS) or central pontine myelinolysis. ODS occurs when subacute or chronic hyponatremia is corrected too fast, resulting in axonal demyelination and irreversible brain damage. The brain damage from ODS is caused by the brain cells rapidly shrinking in response to the extracellular sodium levels returning to normal, and water following it out of the cell. Risk factors for ODS are severity of hyponatremia (< 120 mM), acuity of

presentation, presence of symptoms, hypoxemia (often undetected), delay or too aggressive correction of [Na], over-correction, age, gender, chronic illness, and malnutrition. Common neurological manifestations of ODS are agitation, confusion, dysphagia, dysarthria, quadriparesis, and death in the most severe cases. These changes can be irreversible. ODS is more common in the adult population than in the pediatric population.

The acuity of the onset of hyponatremia can be used to help determine the appropriate rate of correction. Because patients with symptomatic acute hyponatremia have such a significant risk of developing severe neurologic symptoms and even death, rapid correction with hypertonic fluids is indicated. The goal should be an emergent correction to a level at which the patient is asymptomatic. Once the patient is asymptomatic, a more gradual approach can be taken to complete the correction. It is important to note that there is still risk for ODS in this scenario, however, it is outweighed by the overwhelming risk of the neurologic symptoms caused by cerebral edema. For patients with sub-acute and chronic hyponatremia, correcting the intravascular volume depletion should be the first step in management. Once intravascular volume has been repleted, sodium can start being replenished. Sodium levels should not be increased by more than 12 mEq/L over 24 hours.

Rate of increase of Sodium:

Symptomatic patients:

- 4 to 8 mmol/L/d for those at low risk of ODS
- 4 to 6 mmol/L/d if the risk of ODS is high

Asymptomatic patients (not to exceed):

- 8 mmol/L in any 24-hour period (high risk)
- 10 to 12 mmol/L (24-hour period) (normal risk)
- 18 mmol/L in a 48-hour period

Methods to Raise serum Sodium:

1. *Restrict water*

- Hyper/euvolemic hyponatremia (increased TBW)
 - SIADH
 - Edematous disorders
 - Primary polydipsia
 - Renal failure
- Corrects [Na] very slowly
- Daily volume in \leq measured plus insensible loss out
- Furosemide is often helpful once the patient is fluid restricted

2. *Sodium supplementation*

[Na] can be raised enterally with sodium chloride or sodium bicarbonate tablets or liquid and parenterally via Na solutions (normal saline (NS) = 155 mEq/L; 3% saline = 513 mEq/L)

3. *DDAVP clamp*

4. *Vasopressin 2 receptor (V2R) antagonists/ Vaptans*

5. *Urea*

Calculating Sodium Deficit and Volume Needed to Correct Sodium

Question 1: Calculating sodium deficit in an 18-year-old patient with serum [Na] 125 and weight 50 kg.

Na deficit = TBW (Δ Na)

TBW or total body water for an adult female is 50% or 0.5 of body weight in kg.

= (0.5) (50) (135-125) = 250 mEq

This can be achieved over a period of days.

Let's raise Na by 5 mEq.

Question 2: How much intravenous fluids are needed to raise serum Na from 125 to 130 mEq/L?

The modified Adrogue–Madias equation can be helpful in this scenario-

V_i (Volume to infuse) = sodium deficit (TBW(Δ Na)) / (Na infused - Na_f), where
Na_f = final sodium

For example: the V_i for Normal Saline (154 mEq/L)
= (0.5) (50) (5) / (154 - 130) = 5.2 L

The V_i for 3% Saline (513 mEq/L)
= (0.5) (50) (5) / (513 - 130) = 0.32 L (326 mL)

By a rough estimate, 1 mL/kg of 3% NaCl is estimated to raise the serum Na by 1 mEq/L.

DDAVP clamp: When correcting for hyponatremia, if too much fluid is given before the target sodium is achieved, ADH volume receptors turn off and the patient voids the excess water too quickly, so the sodium level quickly and unavoidably overshoots the 24 hr target. This is particularly worrisome in severe and symptomatic hyponatremia (usually for serum [Na] <115). The DDAVP clamp (ADH administration) with IV hypertonic saline will remove the kidney from the equation. The typical recommended dose of ADH is 1-2 mcg IV q12.

Vasopressin 2 receptor (V2R) antagonists/Vaptans: Vaptans can be used when water restriction alone is not enough in conditions like SIADH or edematous disorders like congestive heart failure or cirrhosis.

Urea appears to be an effective treatment for hyponatremia with a very low risk of overcorrection and infrequently reported adverse effects. Urea increases the renal excretion of electrolyte-free water. The important limiting factors are patient tolerance (dysgeusia), and affordability.

How was this patient managed?

The patient was advised to stop smoothies and was sent to the emergency room (ER). Laboratories in the ER showed serum sodium: 124 mEq/L (K 5.2 mEq/L), normal BUN and serum creatinine. Serum osmolality was 260 mOsm/kg, urine osmolality was 112 mOsm/kg. Urine [Na] was <20, urine [K] was 23, urine [Cl] was 20.9, and urine Creatinine was 12.3 mg/dL. Thyroid function was normal.

This patient received 1 L of normal saline bolus. She was admitted overnight for observation with a fluid restriction of 1500 mL/day. Serum [Na] increased to 130 mEq/L in the morning. She was discharged home and was advised to continue a fluid restriction of 1500 mL per day. She was recommended to consume 50g protein per day (~1 g/kg/day). In 2 days, her Sodium was 136 mEq/L and her fluid restriction was liberalized to 2000 mL/day. In the following months, she maintained [Na] 136-140 mEq/L.

Take Home Message:

- Hyponatremia can cause serious health issues if not identified and treated appropriately.
- Tea and Toast syndrome comes in various flavors.
- It is important to assess the volume status.

- Differentiate: acute vs chronic, symptomatic vs asymptomatic.
- Use water restriction, increasing solute, sodium supplementation (enteral vs. parenteral), Tolvaptan, Urea, Furosemide.
- DDAVP clamp can be used to slow correction.

We acknowledge Lawrence Shoemaker, MD, for making hyponatremia interesting.

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Advocacy

Advocacy Tools and Opportunities from the AAP

Op-ed Guide: Advocating for Medicaid and CHIP

[This op-ed guide](#) (AAP login required) provides specific tips and messaging on advocating for Medicaid and CHIP. For more information on writing and pitching op-eds in general, please see the op-ed guidance in the [AAP Advocacy Guide](#) (AAP login required).

Share Your Stories

If you are experiencing direct impacts on the ground from the recent public health funding cuts, please email patientstories@aap.org and share what you're experiencing.

The more specific you can be about the source of the cuts and resulting outcomes in your community, the better. AAP advocacy staff will use these to inform strategy and to share with congressional offices and with the media to help paint a picture of how these cuts impact children and pediatricians.

SONp Partner Opportunity: NKC



Trainee Opportunities for Involvement with the Neonatal Kidney Collaborative (NKC)!

We are now accepting applications for trainees to get involved in the NKC. This includes the THIRD class of The Six-2 Crew as well as the FIRST class of the Ureteric Buds. Each opportunity is a structured 2 year internship for trainees with an interest in neonatal nephrology. The Six-2 Crew and Ureteric Buds will provide longitudinal mentorship and exposure to the research, advocacy and educational work of the NKC. Learn more at <https://babykidney.org/> and complete the application <https://www.babykidney.org/six-2-crew-application-2025>. Any questions, please contact Marissa DeFreitas, Education committee co-chair mdefreitas@med.miami.edu.

SONp Partner Opportunity: AAP Section on Pediatric Trainees

Medical Schools and Residency Programs: Identify a Delegate!

News from the AAP Section on Pediatric Trainees

The AAP Section on Pediatric Trainees (SOPT) is reaching out to institutions to gather contact information for their delegates for the 25/26 academic year. Delegates serve as ambassadors to residents at their local institutions, helping to increase support, facilitate connections, and streamline communication. Each institution is asked to conduct an internal election to select a primary delegate, with the option to identify an alternate delegate as well. All delegates must be AAP members. For more information about this role, view the position descriptions within this [delegate nomination form](#). Questions? Contact AAP staff at soptdelegates@aap.org. **Submit the delegate nomination form by July 15, 2025.**

SOPT Chair: Megan Rescigno, MD

SOPT Chair-Elect: Zachary Kravetz, MS

Immediate Past Chair: Sarah Soffer, MD, MPH, FAAP

AAP Staff: Britt Nagy, MPH

SOPT is on Instagram! Follow the SOPT at @AAPSOPT to stay up to date on all SOPT opportunities and initiatives!

Spotlight on New SONp Members



I am Dr Iftikhar Ijaz. I have more than 30 years of experience as a pediatrician and 24 years of experience in the field of pediatric Nephrology. I recently retired from [King Edward Medical University](#) (KEMU) in Pakistan where I have served for 8 years as professor of pediatrics and pediatric nephrology. I am an IPNA fellow and have worked with various international projects including the [DRAGoN study](#). I am a pioneer of the Children Kidney Centre at KEMU and developed all interventional services in the field of pediatric Nephrology. So far, I have trained many pediatric nephrologists in my country. I have also started ambulatory peritoneal dialysis programs.

The biggest challenges we face, other than the limited number of trained human resources and very few centres, which are well equipped to fulfill the need of patients with kidney diseases, are a lack of awareness among the community, very late diagnosis, and delays in referral.

Glomerulopathies and obstructive uropathies account for the major kidney disease burden but a high prevalence of stone disease, especially hyperoxaluria, cannot be denied. The luxury of genetic testing of patients was a dream until a decade ago but now it is available with extra efforts. Obviously, cost is a barrier and genetic testing is not possible for all deserving patients.

I am looking forward to your support for finding new avenues where we can provide better care to our patients by developing collaboration and involvement in research.

Looking forward to meeting the SONp community.

Section Member Benefits

Section on Nephrology Collaboration Site!

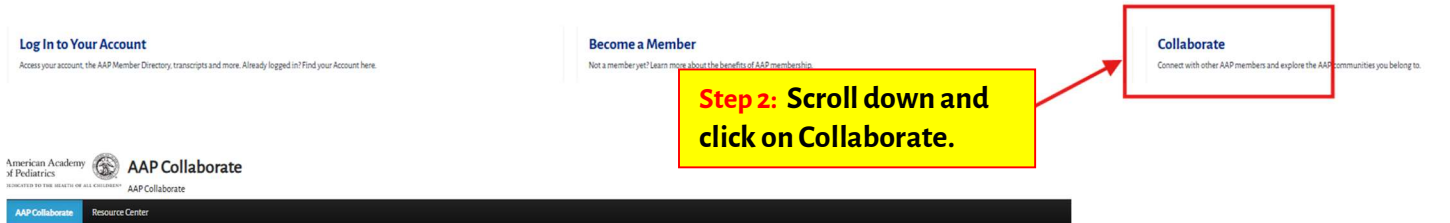
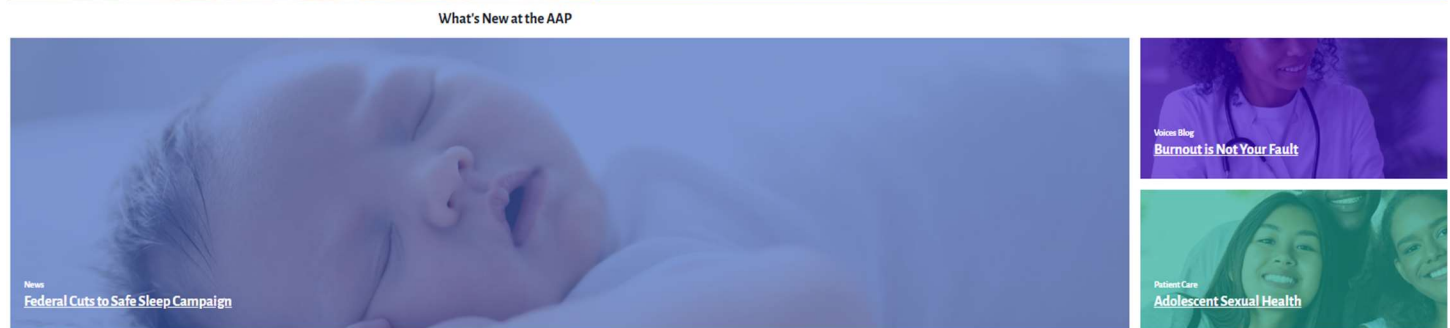
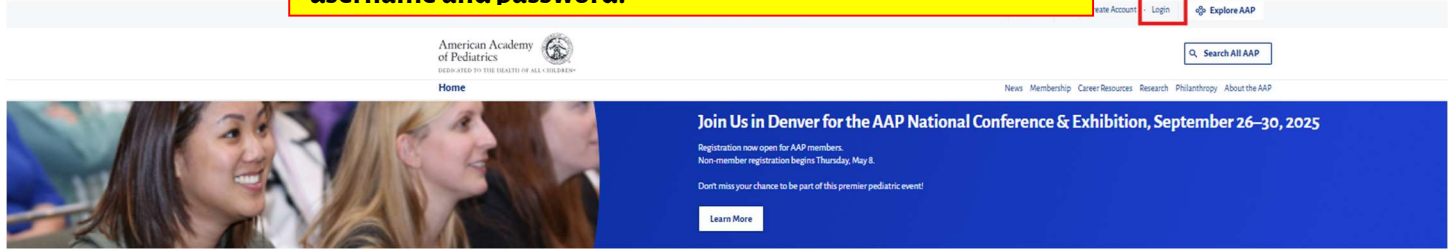
As a member of the AAP SONp you have access to the [SONp collaboration site](#). This SONp member-only benefit grants each current section member access to the following:

- Opportunities to get involved in the [SONp leadership committees](#).
- Information on how to recognize a colleague through nomination for the [Henry L. Barnett Award](#).
- Information for trainees regarding a [career in pediatric nephrology](#).
- [SONp publications](#) including the newsletter, AAP News articles, pediatric nephrology Choosing Wisely list, and parent articles on pediatric nephrology topics.
- Quick links to professional resources for SONp members.
- Quick access to new and/or existing AAP policies of interest to SONp members.

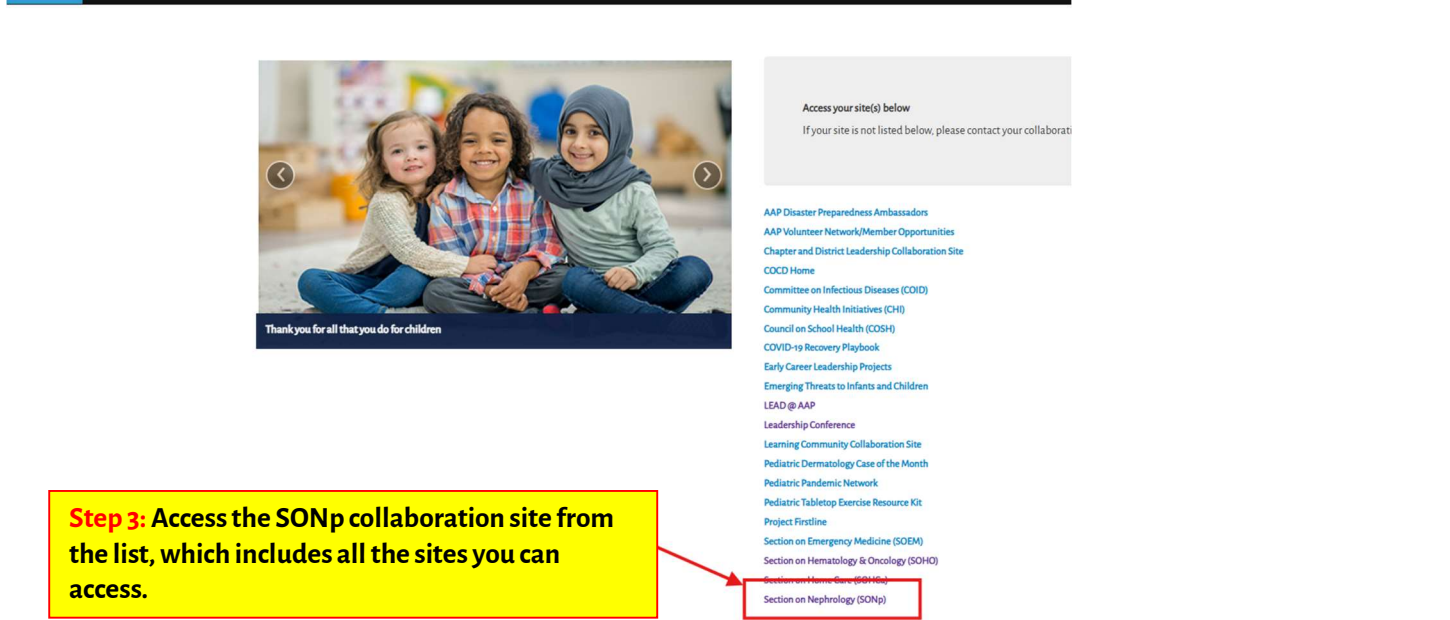
And much more!

Screenshots and instructions to assist members with access to the SONp collaboration site are below. Question? Contact SONp Staff, [Heather Fitzpatrick](#), or the SONp Chair, [Dr Amy Wilson](#).

Step 1: Visit <https://www.aap.org> and log in with your AAP username and password.



Step 2: Scroll down and click on Collaborate.



Step 3: Access the SONp collaboration site from the list, which includes all the sites you can access.

Step 4: Begin navigating the site – and *bookmark the page for quicker access in the future!*

The Section on Nephrology Leadership

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For Upcoming Newsletters...

We welcome your input and encourage you to submit ideas or information by e-mail to our SONp staff person Heather Fitzpatrick, MPH (hfitzpatrick@aap.org) for future issues of the newsletter.