Of the patients admitted with a functioning renal graft 1/3 (33.3%) patients did not survive admission.

Of those with an AKI 111/200 (55.5%) had recovery (<1.25x baseline creatinine on discharge or death) whilst 89.5/200 (44.5%) did not. Of those with an AKI who died, 45/106 (9.4%) had recovery prior to death. The mean age for those recovering from AKI was 75.0 (+15.2) years compared to 78.2 (+15.2) years for those who did not recover.

In total 35 patients were admitted to intensive care. The mortality rate for these patients was 18/35 (51.4%). Of these patients 22 had an AKI with a mortality rate of 16/22 (72.7%). The mortality rate for patients with an AKI-1 requiring ITU admission was of 2/5 (40%), 5/6 (83.3%) for AKI 2 and ITU admission and 9/11 (81.8%) for AKI3 with ITU admission. 9 patients admitted to intensive care required acute hemofiltration, mortality rate was 7/9 (77.7%). A further 37 patients required Continuous Positive airway pressure, the mortality rate for these patients was 16/37 (43.2%).

Mortality rate and frequency of developing AKI varied by age with 0/50 (0%) mortality rate for those between 18-50 years old increasing to 2/3 (66.7%) in those over 100. See bar chart for full data set.

The overall mortality for inpatients admitted with COVID-19 was 164/481 (34.1%). In our patient set 277 (57.7%) were male and 204 (42.3%) were female. The mortality rate for females was 63/203 (31.0%) and for males was 101/278 (36.3%).

Conclusions: Patients with COVID-19 who developed an AKI had poorer outcomes than those who did not develop an AKI, especially if they required intensive care. Patient with advanced age also had a poor prognosis.

No conflict of interest

POS-197

AN UNUSUAL CAUSE OF RENAL ARTERY THROMBOSIS LEADING TO ACUTE RENAL INFARCTION

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Introduction: Renal artery thrombosis is a rare and often misdiagnosed condition that can lead to acute kidney injury and/or infarct.[1] Neuroradiologists and other physicians must consider this condition in cases of unexplained abdominal pain and acute kidney injury. We believe the distribution of mural thrombus in the following case led to a novel presentation of acute renal infarction.

Methods: A 59-year-old female presented to an outside hospital with twelve hours of sharp left upper and lower quadrant abdominal pain.

Conclusions: In most hospitalized patients with COVID-19, proteinuria and estimating glomerular filtration rate significantly improved after hospital discharge. Only patients who developed severe acute kidney injury and/or heavy proteinuria will require a specific follow-up by nephrologists.

No conflict of interest
Associated symptoms included nausea and vomiting. Her medical history included severe centrilobular emphysema complicated by cor pulmonale and biventricular heart failure. Physical exam was notable for mild abdominal pain to palpation, palpable 2+ femoral pulses, and biphasic dorsalis pedis and posterior tibial pulses bilaterally. Relevant laboratory studies:

**Results:** Computed tomography (CT) of the abdomen and pelvis (Figure 1) with contrast showed severe vascular disease with multiple foci of thrombus along the aorta extending into and filling the left renal artery. This was felt to be acute given the relative normal perfusion of the left kidney on CT scan of the abdomen and pelvis from six months prior. A nuclear medicine renal scan (Figure 2a) showed decreased renal perfusion without evidence of a significant left renal infarction. However, a duplex renal ultrasound shortly thereafter (Figure 2b) showed a hypoechoic rim at the lower pole of the left kidney and elevated velocity (500cm/s) in the left proximal renal artery, concerning for renal infarction and high-grade left renal artery stenosis respectively. An echocardiogram was negative for thrombus or valvular vegetation. Vascular surgery, interventional radiology, and nephrology were consulted for co-management. Renal artery thrombolysis was considered but ultimately deferred due to delay in transfer to our hospital and the patient’s significant cardiac comorbidities. The patient was managed with unfractionated heparin infusion and transitioned to coumadin on discharge with plan for lifelong anticoagulation. The patient’s creatinine gradually improved from 2.34 to 1.71 on discharge.

**Conclusions:** Renal artery thrombosis is a rare entity which can result in acute renal failure. This diagnosis requires complex interdisciplinary discussions to determine the best course of action regarding aggressive versus conservative approaches.[2] We suspect the renal artery thrombus was a novel and sentinel manifestation of antiphospholipid syndrome (APLS) that resulted in acute renal infarction. However, the diagnosis of APLS cannot be confirmed until APLS laboratory tests are rechecked after 12 weeks.

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**References:**


No conflict of interest

**POS-198**

**ACUTE KIDNEY INJURY IN PEOPLE LIVING WITH HIV/AIDS**

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**Introduction:** Despite great strides being made in the delivery of primary care to people living with HIV/AIDS, access to specialist care continues to remain a challenge. Hospitalisation for various medical and surgical complications is often associated with acute kidney injury (AKI) or an acute worsening of chronic kidney disease. This study attempted to define the aetiologies of AKI in the setting of hospitalised patients with HIV/AIDS.

**Methods:** This was a prospective observational study conducted at the Madras Medical College between March 2019 and October 2020. All hospitalised patients with HIV/AIDS who were referred to the department of Nephrology with AKI (as per the KDIGO 2012 definition) were included in this series. Historical, clinical and laboratory information were collected based on a pre-specified checklist. Follow-up telephone interviews were conducted in November 2020.

**Results:** Twenty-nine patients were included, of whom 16 were male. The median age was 47 years (IQR 44-51). The median time between HIV diagnosis and current presentation for AKI was 36 months (IQR 3.5-114), with six cases presenting within a month of diagnosis. Among those on ART, 18 patients were on tenofovird/lamivudine/efavirenz and 4 patients on zidovudine/lamivudine/nevirapine. The median last-known CD4 count was 160/mm3 (IQR 97-267). Comorbidities include diabetes mellitus (n=7), hypertension (n=5), malignancy (n=3), past or present tuberculosis (n=12), along with one case each of syphilis, rheumatic heart disease and hypothyroidism. The primary reason for hospitalisation was for renal failure in 12 patients, extra-renal organ involvement in 13, and both renal and extra-renal involvement in the remaining 4. Two patients developed renal failure de novo during hospitalisation, while the remainder had some degree of renal impairment since admission. Acute kidney injury stages 1, 2 and 3 were reached in 3, 8, and 18 patients respectively. Renal replacement therapy was initiated for 12 patients – 2 were given haemodialysis, 6 were given peritoneal dialysis, and 4 were given both modalities sequentially. The