Prevalence of co-morbidities among subjects with renal dysfunction:
- Diabetes: 12 (1.1%)
- HTN: 178 (33%)
- Anemia: 778 (70.2%)
- Sickle cell anemia: 41 (3.5%)
- Low BMI: 216 (47.3%)

Conclusions: Prevalence of renal dysfunction among PVTG’s is 7.9%, with maximum prevalence among subjects with 6-10 years of age. CKD-U being the most common cause of renal dysfunction followed by Hypertensive nephrosclerosis and Sickle cell anemia, while the prevalence of diabetic nephropathy being low.

No conflict of interest

**POS-308**

CHARACTERIZATION OF PRE-CLINICAL CHRONIC KIDNEY DISEASE (SCKD) IN THE POPULATION OF CHILE

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Introduction: sCKD detected by screening in at-risk population, is poorly studied in Chile. Its characterization would contribute to treat it early, mitigating its late consequences. The objective was to characterize clinically sCKD in our country.

Methods: A descriptive study was conducted in a population of 1,032 subjects. Subject were recruited in asymptomatic patients from primary care cardiovascular programs, and direct relatives of dialysis patients. A structured survey was applied to patients. A physical examination (3 blood pressure, weight and height measurements) and laboratory tests (serum creatinine and albumin/creatinine ratio in spot urine). The survey was applied by 16 trained nursing professionals, with previous informed consent. CKD was defined by KDOQI 2012 criteria. Glomerular filtration rate (eGFR) was estimated by MDRD. Albumin/creatinine ratio in first boid expressed in mg/g. An eGFR < 60 ml/min and/or Albuminuria ≥ 30 mg/g, one or both defined sCKD in asymptomatic patients. Group prevalence and statistical significance were determined (2-0.05). Ratio of proportion of individuals with sCKD per each variable, was calculate by means of proportion tests and mean tests.

Results: 205 subjects (20%) met the sCKD criteria. Their characteristics were compared with individuals without sCKD (table). Subjects over 65 y.o. had sCKD significantly different from younger individual. In those who achieved basic studies, sCKD is more frequent than those who had higher educational levels. People working as maid and retired had greater involvement. Relatives on dialysis also had higher frequency of sCKD. Smoking was not correlate with the presence of sCKD. Physical activity in the 65-year-old group showed lower prevalence of sCKD than sedentary subjects. Diabetics using Insulin had the highest prevalence of sCKD (70.6%), and those with diet or oral hypoglycemic treatment demonstrated prevalence similar to the non-diabetic group. No significant differences were found between BMI groups. The relationship between ABP, pulse pressure (PP) and sCKD demonstrated strong statistical relationship; the higher ABP and PP intensity, the higher frequency of ERGs. In the sCKD group de Systolic, MAP and PP was 132.9 ± 75.9 - 97.3 ± 53.4 respectively, compared with values 124.6 - 75.9 - 92.1 - 48.7 in the group without sCKD (p<0.05)
### POS-300

**PREDICTION OF NON-RESPONSIVENESS TO PRE-DIALYSIS CARE PROGRAM IN PATIENTS WITH CHRONIC KIDNEY DISEASE: A RETROSPECTIVE COHORT ANALYSIS**

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**Introduction:** The responsiveness of patients with chronic kidney disease (CKD) to nephrologists’ care is unpredictable. The definition and prognostic values of responsiveness are also undetermined.

**Methods:** We defined the longitudinal stages (LSs) 1–5 of estimated glomerular filtration rate (eGFR) by group-based trajectory modeling for repeated eGFR measurements of 7135 patients with CKD aged 20–90 years from a 13-year pre-end-stage renal disease (ESRD) care registry. Patients were considered nonresponsive to the pre-dialysis care if they had a more advanced eGFR LS compared with the baseline. Conversely, those with improved or stable eGFR LS were considered responsive. We evaluated the association between responsiveness and progression to ESRD and all-cause mortality. We further developed Renal Care Responsiveness Prediction (RCRP) model to predict the responsiveness.

**Results:** The proportion of patients with CKD stage progression increased with the increase in the baseline CKD stage (stages 1-2: 29.2%; stage 4: 45.8%) (Figure 1). The adjusted times to ESRD and all-cause mortality in patients with eGFR LS-5 were 92% (95% confidence interval [CI]: 86%-96%) and 57% (95% CI: 48%-65%) shorter, respectively, than in patients with eGFR LS-3A. Among patients with baseline CKD stages 3 and 4, the adjusted times to ESRD and all-cause death in the nonresponsive patients were 39% (95% CI: 33%-44%) and 20% (95% CI: 14%-26%) shorter, respectively, than in the responsive patients. Our proposed RCRP model performed significantly better than the conventional Kidney Failure Risk Equation in discrimination, calibration, and net benefit according to decision curve analysis.

**Conclusions:** Non responsiveness to nephrologists’ care is associated with rapid progression to ESRD and all-cause mortality. The RCRP model improves early identification of responsiveness based on variables collected during enrollment in a pre-ESRD program.

No conflict of interest

### POS-310

**DYSLIPIDEMIA IN CHRONIC KIDNEY DISEASE**

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**Introduction:** Chronic kidney disease (CKD) is associated with a dyslipidemia comprised of elevated triglycerides and low HDL-cholesterol. Levels of LDL-cholesterol (and thus, total cholesterol) are generally not elevated; however, proteinuria correlates with cholesterol and triglyceride levels. CKD leads to a down regulation of lipoprotein lipase and the LDL-receptor, and increased triglycerides in CKD are due to delayed catabolism of triglyceride rich lipoproteins, with no differences in production rate. The prevalence of dyslipidemia increased from 45.5% in CKD stage 1 to 67.8% in CKD stage 4; similarly, the use of lipid lowering agents increased from 18.1% in CKD stage 1 to 44.7% in CKD stage 4. Our aim was to determine the lipid abnormalities of kidney disease patients who were admitted to our Nephrology ward in the past five years.

**Methods:** We studied 450 patients with chronic kidney disease and hypertension (180 women, 40% and 270 men 60%, mean age 65±25 years). Mean eGFR was 40±12 ml/min/1.73m². The parameters determined and analyzed were: total-cholesterol (<180mg/dl), LDL-cholesterol (<100mg/dl) and triglycerides (<150mg/dl). All patients were receiving treatment for regulating dyslipidemia.

**Results:** The percentage of patients with total cholesterol, LDL-cholesterol and triglycerides within the recommended targets were 30%, 15% and 36% respectively. Total cholesterol above the recommended targets had the 315 of patients (189 men, 60% and 126 women, 30%), 15% and 36% respectively. Total cholesterol above the recommended targets had the 315 of patients (189 men, 60% and 126 women, 30%), 15% and 36% respectively. Total cholesterol above the recommended targets had the 315 of patients (189 men, 60% and 126 women, 30%) had LDL-cholesterol over the targets (48 men, 65% and 134 women, 53%). High levels of triglycerides has been found at 23.2% in stage 1, 25.6% in stage 2, 33.3% in stage 3, 35.7% in stage 4.

**Conclusions:** Our results are in accordance with current bibliographic data. There is a low percentage of our patients that non achieved the recommended targets, despite the fact that they receiving treatment and remain disregulated. Certainly in patients with chronic kidney disease and dyslipidemia the periodical monitoring of the lipid profile is required for a proper regulation.

No conflict of interest