Dear Colleagues,

I would first like to thank those many members who participated in ASPN meetings at the Annual Meeting of the ASN in San Diego. Your contributions to our society are greatly valued and we appreciate your input.

I am delighted to announce the results of the recent election for new ASPN Councilors. The Nominating Committee (Sharon Andreoli, Chair; Allison Eddy and Steve Wassner) had solicited and received many nominations from the ASPN membership for three Council positions to be open in May 2010: one for an individual with interest and experience to become a Co-Chair of the Clinical Affairs Committee, another for the Co-Chair of the Research Committee, and a third for the Co-Chair of the Workforce Committee. A slate of outstanding nominees for each of the open positions, all with distinguished track records of service to the ASPN, was developed and distributed to the membership. Mary Leonard (CHOP) and Laurence Greenbaum (Emory) were elected for 4 year terms as Councilor and Co-Chair of the Research and Workforce Committees, respectively, commencing in May 2010. The election for the Clinical Affairs seat will be decided in a run-off election this month (watch for an email from the ASPN Central Office and please vote!). We thank the Nominating Committee for their efforts in this process and the membership for your participation!

The ASPN Committees and Task Forces have been hard at work on a number of fronts. Among their highlights and accomplishments are the following:

- The Public Policy Committee has been extremely busy working on ASPN’s comments on the CMS proposed ESRD bundled payment rule while Congress continues to try to pass health reform legislation.
- The Training and Certification Committee has added more information about ABP MOC onto our ASPN web site with useful links to the ABP site. You can read more about MOC in the Boardwalk.
- The Research Committee highlights the ongoing successes of the CKiD study and gives the web link to other ongoing clinical trials, awards, and grants of interest to the society.

In closing, I wish you all a wonderful holiday season!

Lisa M. Satlin, MD
President
**Note from the Treasurer**

With ASPN’s fiscal year at the halfway mark, it is appropriate to update the membership on our budgetary issues. While membership dues are just now coming in, we are considerably ahead of budget to date. Our revenues are almost exactly on target and expenses are at 40% of expected. Council is continuing to search for ways to maintain services at the least possible cost to our membership, and we appreciate your help. Remember to get those dues payments in on time to avoid the late fees!

Victoria F. Norwood, MD
Treasurer

**Announcements**

**ALEXION RECRUITING PATIENTS IN FOUR SOLIRIS CLINICAL STUDIES IN EUROPE, UNITED STATES AND CANADA**

Alexion Pharmaceuticals, Inc. announced that Soliris(R) (eculizumab), its first-in-class complement inhibitor, has been granted Orphan Medicinal Product Designation for the treatment of patients with atypical Hemolytic Uremic Syndrome (aHUS).

Atypical Hemolytic Uremic Syndrome is characterized by chronic inflammation, hemolysis (red blood cell destruction), thrombocytopenia (reduced circulating platelets), and microangiopathy (damage in small blood vessels), particularly in the kidney and brain, often progressing to end-stage kidney disease or failure. aHUS is caused by a deficiency in normally occurring complement inhibitor proteins. Typically, patients with aHUS have genetic mutations in one of several complement inhibitor proteins that lead to uncontrolled complement activation. Excessive complement activation may contribute to severe inflammation of the blood vessels and blood clotting through the activation of white blood cells, platelets, and the endothelial cell lining of blood vessels. (1)

The prognosis for patients with aHUS is generally poor. Approximately 70 percent of patients with the most common mutation experience chronic renal insufficiency, chronic dialysis, or death within one year of the first clinical episode. (2) Despite current best supportive care, following kidney transplantation, recurrent aHUS causes kidney transplant failure in up to approximately 60 to 90 percent of patients. (3)

Alexion is currently enrolling patients at the initial sites in four prospective, open-label clinical studies of eculizumab as a treatment for patients with aHUS in North America and multiple European countries: two studies of patients who are plasma therapy sensitive (one in adults and one in adolescents) and two studies of patients who are plasma therapy resistant (one in adults and one in adolescents). In addition to the ongoing trials, clinical studies are currently being planned to investigate the use of eculizumab as a treatment for children with aHUS. Physicians, patients and care givers who are interested in participating in these clinical trials can learn more by contacting Alexion bye-mail at clinicaltrials@alxn.com, or by visiting the Alexion website at www.alexionpharma.com and clicking on the clinical trials link. The ongoing trials are also posted to the www.clinicaltrials.gov website maintained by the U.S. National Institutes of Health.

**Important Safety Information**

Soliris is generally well tolerated. The most frequent adverse events observed in clinical studies were headache, nasopharyngitis (a runny nose), back pain and nausea. Treatment with Soliris should not alter anticoagulant management because the effect of withdrawal of anticoagulant therapy during Soliris treatment has not been established.

The U.S. product label for Soliris also includes a boxed warning: “Soliris increases the risk of meningococcal infections. Meningococcal infection may become rapidly life-threatening or fatal if not recognized and treated early. Vaccinate patients with a meningococcal vaccine at least two weeks prior to receiving the first dose of Soliris; revaccinate according to current medical guidelines for vaccine use. Monitor patients for early signs of meningococcal infections, evaluate immediately if infection is suspected, and treat with antibiotics if necessary.” During clinical studies, two out of 196 vaccinated PNH patients treated with Soliris experienced a serious meningococcal infection. Prior to beginning Soliris therapy, all patients and their prescribing physicians are encouraged to enroll in the PNH Registry, which is part of a special risk-management program that involves initial and continuing education and long-term monitoring for detection of new safety findings.


Announcements Cont’d...

NEWS RELEASE - IMPORTANT NEW POLICY FROM THE ABP

In June 2009, the American Board of Pediatrics (ABP) established a new policy that places a time limit on acceptance for a certifying examination in general pediatrics and its subspecialties. Candidates will no longer have an unlimited time to become certified. The ABP established the policy to ensure the public that individuals accepted for examination still possess the competencies verified at the completion of training.

TIME LIMITED ELIGIBILITY FOR INITIAL CERTIFICATION EXAMINATIONS

GENERAL PEDIATRICS:

Beginning in 2014, the American Board of Pediatrics will require that applicants have completed the training required for initial certification in general pediatrics within the previous 7 years (eg, 2007 or later for examinations administered in 2014). If the required training was not successfully completed within the previous 7 years, the applicant must complete an additional period of accredited training in order to apply for certification.

New applicants and re-registrants for the general pediatrics certifying examination who have completed residency training prior to the 7-year limit must satisfactorily complete a minimum of 1 year of additional residency training that offers a breadth of general pediatrics experience that assures the ability to practice unsupervised. This training must be completed in a program accredited by ACGME in the US, or by the RCPSC in Canada. The program director who supervises this training must provide the ABP with the specifics of the planned training, but has the latitude to start the trainee at a more junior level, thus requiring more than 1 year of residency. At the conclusion of training, the program director must verify satisfactory completion of the required training. Following the satisfactory completion of the required general pediatrics training, the candidate will have 7 years to become certified. When applying or re-applying for certification, the applicant must meet the requirements for acceptance in effect at that time.

PEDIATRIC SUBSPECIALTIES:

Beginning in 2014, the American Board of Pediatrics will require that applicants have completed the training required for initial certification in the pediatric subspecialties within the previous 7 years (eg, 2007 or later for examinations administered in 2014). If the required training was not successfully completed within the previous 7 years, the applicant must complete an additional period of accredited training in order to apply for certification.

New applicants and re-registrants for subspecialty certification who have completed fellowship (or were approved on the basis of practice) prior to the 7-year time limit must satisfactorily complete a minimum of 1 year of broad-based clinical subspecialty training in a program accredited by ACGME in the US or by the RCPSC in Canada. This training must be in the discipline in which certification is sought. The required clinical training must be as specified in the ACGME requirements for the subspecialty fellowship. The program director who supervises this training must verify satisfactory completion of the required clinical subspecialty training. Following the satisfactory completion of the required clinical subspecialty training, the candidate will have 7 years to become certified. When applying or re-applying for certification, the applicant must meet the requirements for acceptance in effect at that time.

KIDNEY AFGHANS FOR KIDS

I am Leah J, a recording artist who knits and crochets as a hobby. In March of 2008, my friend and fellow artist Alan Patterson, a kidney transplant survivor, founded Kidney Afgans For Kids in his hometown of Lima, Ohio. It began as a local church project. He invited friends and family to donate knitted or crocheted afghan squares to him that would be pieced together into afghans and given away to children on hemodialysis. In less than 2 years, it has reached contributors from California, New York, Florida, and all points in between. About 50 afghans have been completed, and there are still hundreds of squares donated that are waiting to be fashioned together.

I adopted this organization from the outset because I believe in and have experienced personally the comfort and security of a homemade afghan when I’m feeling unwell.

I am writing to make the Nephrology community aware that these gifts exist and that they are free and available to children with kidney failure. The afghan squares, the labor to piece and border them, and the shipping/handling is completely free to any child on hemodialysis. The churches, civic organizations, and individual contributors nationwide make this possible.

Please contact founder and coordinator Alan Patterson at 330-347-1447 or alan@pattersonmusicgroup.com to connect with KAFK and find out how our afghans can bless your patients.

Providing comfort, security, and warmth to children on hemodialysis,
Leah J


KAFK
1299 N. McClure Rd.
Lima OH 45801

Leah J. Hileman
2510 SE 16th PL #105
Cape Coral FL 33904
941-779-4722
www.leahjsongs.com
info@leahjsongs.com
**Washington Update**

**HEALTH REFORM CONSUMES WASHINGTON**

Congress returned after Labor Day with high hopes of completing health reform legislation, following President Obama’s speech to a Joint Session of Congress urging quick action on the matter. The Senate Finance Committee released a legislative framework on September 9, followed by a three-week mark-up process that culminated with the passage of America's Healthy Future Act by a vote of 14-9. Only Senator Olympia Snowe of Maine crossed party lines to join the Democrats in voting in favor of the bill. (Though she insisted that her vote was not assured when the bill is debated by the full Senate.)

Now Senate Majority Leader Harry Reid (D-NV) is working with Senators Dodd (D-CT) and Baucus (D-MT), along with a team of top White House officials, to reconcile the HELP Committee and Finance Committee’s two bills. Senator Harkin (D-IA) has taken over the chairmanship of the HELP Committee in the wake of Senator Edward Kennedy’s death, however, Harkin will leave it to Senator Dodd to manage this process since he shepherded the bill through the developmental stages.

Reid needs at least 60 votes in order to call up the combined bill for debate, so the legislation will have to be carefully crafted to garner enough support. The timetable for floor action has slipped over the past few weeks as hopes for passage prior to Thanksgiving wane. Although the immunosuppressive drug coverage language is not yet in either of the Senate committee bills, it could be offered as an amendment during floor debate. Another provision of interest to ASPN would be the preservation of the pediatric subspecialty loan repayment program that was included in the HELP bill.

Meanwhile, the House Energy and Commerce committee recently put the finishing touches on its version of health care reform and the House plans to take up HR 3962 the Affordable Health Care for America Act on November 6. There is likely to be some serious legislative maneuvering during this process over the shape of a public plan option and the bill’s cost among other items as House Democratic leaders work to secure enough votes to pass the bill.

**WHILE THE APPROPRIATIONS PROCESS PLAGUES ALONG**

As the weeks go by it seems more and more likely that Congress will have to pass an “omnibus” appropriations bill – that is, one large bill made up of several funding bills. Labor, Health and Human Services would be included in this measure. Government programs are currently operating on a continuing resolution due to expire on October 31. In all likelihood, that deadline will be extended to late December—a sign that Congress is in it for the long haul.

**MEDICARE DOC FIX STALLS IN SENATE**

On October 21, the Senate attempted to begin floor debate on S. 1776, the Medicare Physicians Fairness Act. This bill would eliminate the sustainable growth rate (SGR) and set the stage for an annual update in Medicare physician pay rates as well as ensure that the scheduled 20 percent cut to reimbursement rates slated for January 1, 2010 is avoided.

The physician pay fix provisions were originally part of health care reform legislation. Democratic leaders determined that the provisions’ cost would exceed President Obama’s $900 billion spending ceiling for reform, so they decided to pass the pay fix separately. But the legislative ploy failed when a procedural motion to begin debate in the Senate failed on a vote of 47-53, after 13 Democrats joined Republicans to defeat the measure. Senate Majority leader Reid subsequently announced that the Senate would defer further action on the bill until it completes broader legislation that would overhaul the health care system.

**ASPNS CONTINUES WORK ON CMS’ PROPOSED ESRD BUNDLED PAYMENT RULE**

On September 15, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule setting forth a new Medicare prospective payment system (PPS) for renal dialysis facilities. The proposed rule would apply to facilities that provide dialysis services to Medicare beneficiaries who have end-stage renal disease (ESRD), providing a single bundled payment that would cover the items and services related to dialysis, including dialysis treatment, prescription drugs, and clinical laboratory tests.

CMS indicated that it is accepting comments on the proposed rule through December 16th and is required to respond to all comments in a final rule that will be issued in 2010. The new payment system would apply to dialysis services furnished to Medicare beneficiaries on or after Jan. 1, 2011.

The ASPN is in the process of analyzing the proposed pediatric facility modifiers, but has found that there will be a negative impact on the pediatric population, and that the methodology used to determine the modifiers is flawed. A group from the ASPN recently met with CMS to outline some of the issues and will continue to draft its formal comment letter as well as ensure ongoing dialogue with CMS.

*Katie Schubert, Vice President*
*Cavarocchi Ruscio Dennis Associates, L.L.C*
NOTICE: ELECTION RUNOFF

Due to a tie for the Clinical Affairs Councilor seat there will be a runoff! Ballots will go out within the next few days so be on the lookout for yours!

SURVEY MONKEY WILL BE USED FOR VOTING SO IF YOU HAVE PREVIOUSLY OPTED OUT OF SURVEYS VIA SURVEY MONKEY PLEASE CLICK ON THE LINK BELOW TO OPT BACK IN.


Boardwalk

I am pretty sure that everyone has heard about Maintenance of Certification (MOC) by now. At the Training and Certification Committee meeting that took place at the PAS meeting in Baltimore, it was clear to me that there remains a lot of confusion regarding MOC and how it applies to you. So I thought I would begin a series of several columns in the ASPN newsletter to explain the process and relay information about MOC.

First, I think the overall concept is not difficult. However, like many things we do, the problems and confusion come in the details. So I will first give you an overview of the process, then we will get into some of the details. I also want to make it clear that enrollment in MOC is not automatic. You need to go to the ABP website and enroll and pay the fee (currently $990 every 5 years). Once you are enrolled, your certificate will reflect the fact that you are participating in MOC.

There are 4 components of MOC. Two of these components we are familiar with and should be very straightforward. The requirement for Part 1 is to have a valid, unrestricted medical license. I think most of us have that and can maintain a current license. Part 3 is the cognitive assessment. This means the written exam. The primary change in this part is that the examination for "recertification" is every ten years instead of every seven years. So I hope this will be viewed as an improvement.

I think the confusion sets in with Parts 2 and 4. Credit for these Parts is followed by a scoring system that runs in five year cycles (coinciding with the Fee payment schedule). This means that every 5 years you must accumulate a total of 100 points to maintain your certificate. 40 points must come from Part 2 activities and 40 points from Part 4 activities with the remaining 20 points coming from either area.

Part 2 is labeled Life-long Learning and Self-assessment. This section is in place to help ensure that we are current with the literature and have a life long commitment to scholarship. The ABP, with help from members of the Subboard of Nephrology and members of our society (ASPN), have put together a list of recent articles that are thought to be significant enough that the members of our society should have read them. On the ABP website, there are also questions related to these articles that the candidate can answer and accrue points. So this should not pose a problem for our membership.

I think most of the confusion and anxiety come from Part 4. This section is labeled "Performance in Practice" and is meant to help us track the quality of our clinical practice. The problem is how to go about doing this. The ABP has approved a number of projects that diplomats can participate in. Unfortunately there is not one that is specific for Nephrology. Members of the Subboard are currently developing projects that can be used for this section. Existing projects that have been approved include "Patient Safety Improvement Program" that is provided by the American Board of Medical Specialties. This project is available for every diplomate. Other projects, such as those involving Blood Stream Infections in the ICU, require that your hospital participate in a registry that can be very expensive. So, for now, you can look at approved projects that are on the ABP website and find one that is generic and can be used with no charge. We are in the process of developing a project that will be Nephrology specific and that will be low in cost.

I hope this answers at least some of your questions. For those members with Certificates expiring in 2009, you need to enroll in MOC now.

The ABP website (https://www.abp.org/ABPWebStatic/) has recently been revised and has a new look. There is a red button in the upper right corner for you to log into that will take you to your portfolio. This should let you know what your specific requirements are. In addition, there are a number of places on the website where you can get answers to most of your questions.

I plan to have a follow up column in the next issue of the ASPN Kidney notes. In January, I will no longer be serving on the Board, but will be happy to continue to provide updates on MOC as Co-chair of the Training and Certification committee of the ASPN.

Ray Quigley, MD, T&C Committee Co-Chair
RESEARCH COMMITTEE

The Chronic Kidney Disease in children (CKiD) Study is a multicenter observational cohort study in children that is being conducted at 43 pediatric nephrology centers in North America. Enrollment is now closed, but the study is still ongoing. Eligibility criteria for enrollment in the study included age 1 to 16 years, estimated Schwartz formula glomerular filtration rate (GFR) 30 to 90 mL/min/1.73 m², and signed written informed consent by parent/guardian. As of October 15, 2009 the CKiD study has had 586 baseline visits, 531 6-month follow up visits, and 490 1-year visits, 365 2-year follow up visits, and 175 3 year follow up visits. Recent publications resulting from the CKiD study have modified previous standards of care in the field of pediatric nephrology. The distribution of blood pressure, prevalence and risk factors for hypertension were characterized in children with chronic kidney disease (CKD). The study found that the rate of progression to CKD was significantly greater in hypertensive children, those with an estimated GFR<50mL/min/1.73m², and those who were older in age. Also, black children were found to have a significantly higher risk of hypertension at entry into the study even after adjustment for age, cause/duration of CKD, GFR, level of proteinuria, serum potassium level, obesity and antihypertensive use.

CKD in the pediatric population was also found to have a statistically significant effect on the level of hemoglobin for GFR below 43 ml/min/1.73 m². The hypothesis for the development of anemia during CKD is related to the decrease in erythropoietin production by the peritubular fibroblasts of the renal cortex in kidney disease. In a separate study, it was also found that the level of proteinuria is associated with decreasing GFR, regardless of cause of CKD. The CKiD study also resulted in the generation of a new estimated GFR equation, based on an enzymatic creatinine method:

$$\text{GFR(ml/min per 1.73 m(2))}=39.1[\text{height (m)}/\text{Scr (mg/dl)}](0.516) \times [1.8/\text{cystatin C (mg/L)}](0.294)[30/\text{BUN (mg/dl)}](0.169)[1.099](\text{male})[\text{height (m)}/1.4](0.188)$$

The CKiD study, the largest North American prospective cohort study of CKD in children, is still ongoing, and future analyses will need to be done on the above and other demographic and clinical information collected for analysis. ASPN members can get updates on other ongoing clinical trials as well as available awards and grants through the website http://www.aspneph.com/Research/researchmain.asp.

Submitted by Patty Weng

TRAINING & CERTIFICATION COMMITTEE AND TRAINING PROGRAM DIRECTORS SUB-COMMITTEE

The ASPN Training and Certification Committee and Training Program Directors Sub-Committee continue to be active in their inter-related areas.

- The ASPN Training and Certification Committee continues to explore methods to assure that our members are well informed about the issues regarding the new requirements for American Board of Pediatrics Maintenance of Certification (MOC). Additional information about the ABP MOC will be forthcoming in a column from Dr Ray Quigley, now Chair of the ABP Pediatrics Nephrology Sub-Board. A short primer on ABP MOC is now located on the ASPN Training & Certification area of the ASPN web site (http://www.asp neph.com/t&c/Main.asp) and a short guide on How to Access ABP MOC Information is located at the same site. Several members of the T&C Committee have tested these informational guides and found them to be quite useful. There will be further opportunities to explore the ABP MOC paradigm at our ASPN Business Meeting on Oct 2009 and there will be workshops devoted to this topic at the 2010 PAS Meeting. We continue to look for most effective information methods for our members regarding this important topic!

- Our Pediatric Nephrology community will enter into a second Pediatric Nephrology Match this winter/spring (for fellows to start training in July 2011). More information about Match dates and deadlines will be provided in future columns and on our ASPN website.

- The ASPN T&C Committee has completed a survey of pediatric residents regarding how they gained information and experiences relevant to a potential career in pediatric nephrology. The Committee is now analyzing these results with plans to utilize these insights to direct our efforts to reach our to pediatric residents about prospects for a career in pediatric nephrology

- The ASPN Training Program Sub-Committee conducted its 2nd Annual Training Program Directors (TPD) Workshop in Chicago (co-sponsored by the AAP) on Oct 2, 2009. A short presentation on the Pediatric Nephrology Match and Fellow Workforce Issues is now posted on the ASPN TPD area of the website (http://www.asp neph.com/t&c/Main.asp) and is available for your review. The numbers of new fellows continues to be very consistent with ACGME approved programs now at 39 and with 106 fellows (including 43 first year fellows in training as of Sept 2009). These numbers remain consistent over the last 5 years but a significant “attrition” rate, i.e., fellows leaving fellowship training before competing full training, at ~ 30-40% over 3 years of training, continues to bedevil us as TPDs and the Pediatric Nephrology community in general. We have some information about...
the issues that jeopardize our fellows continue engagement in training and our ASPN PFeNa group (pediatric nephrology fellows group with Parnell Mattison as Chair) will be involved in a more detailed investigation of these issues, both to help inform the ASPN on how we might provide support for fellows but also to help TPDs better understand these issues on a “macro” level.

- The ASPN 2nd Annual TPD Workshop was dedicated to an initial effort to define and develop a national Pediatric Nephrology Fellowship Training Program Curriculum. The 18 TPDs in attendance (representing 18 of the 39 ACGME approved Training Programs in the US) devoted several hours to defining core curricular content and useful instructional methods for fellowship training. The TPD group will utilize PDs who could not attend this session as a review group to further hone this product. Our goal is to have a second draft of the national curriculum ready for further input in January 2010 and eventual approval and publication by the TPD Sub-Committee by May 2010. This is of keen interest to TPDs and should help programs maintain high standards in their fellowship training efforts.

- Look for more information about this project, the Fellowship Match, and the AAP’s NephroPREP as well as other activities of the T&C and TPD groups in subsequent ASPN Kidney Notes.

John D Mahan, MD, Chair
ASPN Training and Certification Committee
ASPN Training Program Directors Sub-Committee

Welcome New Members!!

Olivera Couloures  
University of Oklahoma HSC  
Oklahoma City, OK

Irina Gershin-Stevens  
The Children’s Hospital of Southwest Florida  
Fort Myers, FL

Dwayne Henry  
University of Oklahoma HSC  
Oklahoma City OK

Charles Kwon  
Cleveland Clinic Children’s Hospital  
Cleveland, OH

Poyyapakkam Srivaths  
Baylor College of Medicine  
Houston, TX

Delbert Wigfall  
Duke University School of MedicineAnn Arbor, MI  
Durham, NC
Meeting Announcements

Pediatric Academic Societies Meeting
May 1-4, 2010 ~ Vancouver, Canada
More Information

International Conference on Early Disease Detection and Prevention (EDDP)
February 25-28, 2010
Munich, Germany
More Information

6th International Conference on Pediatric Continuous Renal Replacement Therapy (PCRRT)
Angelicum Congress Center
Rome, Italy
April 8 – 10, 2010
More Information

ASPN Annual Meeting
May 1-4, 2010 ~ Vancouver, Canada
More Information

21st Annual Symposium on Pediatric Dialysis
10th Annual Fundamentals of Dialysis in Children Course
March 6-10, 2010 ~ Seattle, Washington
More Information

The Miami Pediatric Nephrology Seminar
March 11-14, 2010
The Miami Pediatric Nephrology Seminar
More Information
More Information

THANK YOU
TO THE 2009 ANNUAL MEETING SPONSORS!!

International Pediatric Nephrology Association
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NephroPath

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