Autosomal Dominant Polycystic Kidney Disease in Older Adults

Dear Editor,

While the epidemiology and clinical characteristics of autosomal dominant polycystic kidney disease (ADPKD) in children and younger adults are clearly defined, it is much less so for older adults.[1] This may be explained by the fact that older adults living with ADPKD are difficult to screen, as many have milder forms of disease with subtle clinical presentations. ADPKD patients who have more severe forms of the disease may not survive to old age, with complications such as cardiovascular events and septic infections resulting in early mortality. Observational studies detailing the clinical characteristics of the older ADPKD population are lacking, but the two published studies by Milutinovic *et al*.[2] in the USA and Helal *et al*.[3] in Tunisia have both concurred that ADPKD diagnoses in older adults are often made late, when patients are already diagnosed with kidney failure. Indeed, these trends are backed up by ascertainment of the prevalent genetic profile in older ADPKD cohorts, in which disease harboring *PKD2* gene mutations were common.[4] *PKD2* mutation produces a milder form of disease, with the mean age of kidney failure occurring approximately 20 years later than ADPKD with *PKD1* mutation.[4] Disease modification trials typically excluded patients aged >55, hence the impact of treatment in older adults with ADPKD is still relatively uncertain.[5] It will likely require several years for therapies to show any efficacy toward renal endpoints of these patients, which makes investigation challenging. Moreover, potential therapies often have important side effects, and benefits of treatment, if any, will unlikely outweigh risks in this patient population. Going forward, further comprehensive data in diverse populations is anticipated to determine potential solutions for earlier ADPKD identification and establish strategies to reduce progression of disease in older patient cohorts.

Conflicts of interest

There are no conflicts of interest.

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The Ups and Downs of Live Posting in Nephrology Conferences

Dear Editor,

Recently, with the surge of social media, live coverage of conference on social media has become the modern note-taking art that demands the social media personnel to be at a fast pace and equally attentive in a conference to craft a tweet. Social media can foster an atmosphere of excitement at academic conferences and help in the dissemination of scientific content and provide a platform for discussion of ideas presented at a meeting. Academic conferences nowadays identify a team of interested delegates (social media education team) to disseminate the conference content on social media by posting conference sessions, visual abstracts (prepared and live created), online quizzes, and faculty interviews. This is not only limited to the social media team, any interested conference delegate can live post and thus help in the dissemination of scientific content. Most meetings now make an official hashtag well in advance, and this makes

the content easily searchable and drives traffic directly to the content, thus boosting views, likes, and reposts. The best hashtags are often short, unique, and easily memorable. Hashtags can also be tracked to generate conference metrics like popularity, reach, engagement, and user count by using some native apps like Sprout. A common way of live posting is to photograph the slides from an ongoing talk and post the picture along with a tagline/heading. Alternatively, X can be used as a note-making system to craft a tweet by summarizing all the important takeaway points/snippets from the talk. Live posting helps in the broader dissemination of conference scientific content and benefits the speaker by improving the visibility and recognition of work.[1] Social media–based conference coverage limits the time, travel, and expenditure incurred with physical attendance and enables a wider global audience, including those who may not be in a position to attend such a conference.[2] It also generates organic discussions and debates, where the audience can also post live questions, which can then be directed to the speakers. In addition to benefiting the speaker, the content creator gets indirect rewards of more organic participation, increased social media reach, and improved networking, getting response from stalwarts in your field crossing beyond geographic boundaries.[3,4] Creating meaningful original X content opens many gates of further opportunities like invited commentaries on a specific topic discussed during the conference. Live posting is now recognized as a research contribution and leads to enhancing your connections with like-minded folks around the world that could throw up various opportunities including research publications and collaborations in multicentric trials.

However, live posting on social media carries certain concerns. Firstly, wider dissemination of a speaker's unpublished work can sometimes be undesirable with concerns of confidentiality and copyrights breach. The posts on social media lack an official peer review, and some content can be controversial, which might spark arguments. Practitioners may act inappropriately if they utilize scientific content on social media without a complete understanding of the shared information in an inappropriate manner to treat their patients. Sometimes, unpublished naïve data is presented, and the presenter might not be interested in broadcasting those ideas to the general public via live posting. There are some basic rules of live tweeting that one needs to keep in mind. Most Nephrology societies have their own set of social media guidelines published on the conference website. Slides from scientific presentation that contain unpublished data should not be live posted. If the speaker has declared before/during the presentation that they do not wish pictures/posts regarding the presentation to be shared on social media, than the tweeter is not allowed to post that content. The conference organizers reserve the right

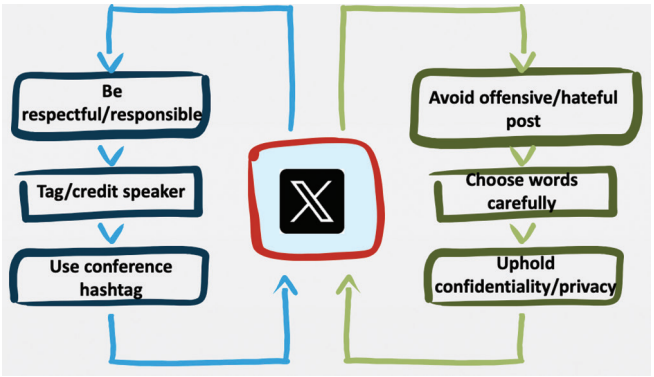

Figure 1: Do's of live posting on social media.

at their sole discretion to remove any posts/comments they deem inappropriate. The tweeter should always give due attrition to the speaker and include the conference hashtag. Copying the slide or work presented and circulating it without acknowledging the speaker should be discouraged by the conference organizers. Even if the tweeter does not agree at some point with the speaker, one should not be sarcastic and comments should be posted with constructive criticism. One should take care to protect patient confidentiality and privacy and avoid posting sensitive content (images of procedures/reports) that could identify an individual. It is strictly forbidden to post offensive, disrespectful, hateful, and inappropriate comments. Lastly, the tweeter should not miss comprehend the talk while he/she is so deeply engaged in crafting a perfect tweet.

To conclude, X is an excellent tool for wider dissemination and outreach of a scientific conference but it comes with its pitfalls. One should be considerate and respectful while live posting even when one disagrees with the speaker/faculty over some scientific content. Live posting is a boon for enthusiastic people interested in communicating and networking on social media, provided the tweeter follows the basic rules of live posting. Social media is forever and here to stay, and one should read twice and think thrice before hitting "post" while live posting [Figure 1].[3,4]

Conflicts of interest

There are no conflicts of interest.

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Urinary Biomarkers for Non-Invasive Diagnosis of Acute Interstitial Nephritis

Dear Editor,

Acute interstitial nephritis has been found in 5–15% of hospitalized patients with acute kidney injury (AKI).[1] Kidney biopsy which is the gold standard for diagnosis[2] may not be attempted in all patients, and hence, it may be useful to employ urinary biomarkers. Urinary monocyte chemoattractant protein-1 (MCP-1) and tumor necrosis factor-alpha (TNF-α) have been investigated in this regard.[1] There is paucity of information from India on urinary biomarkers.

We conducted a study to identify patients with acute interstitial nephritis (AIN) among AKI patients admitted in the Department of Medicine. Here, we are reporting the biomarker results in patients who underwent kidney biopsy. Twenty-seven patients had undergone kidney biopsy and AIN had been diagnosed in ten patients. Thirteen patients had glomerular disease and four patients had ATN. Twenty-five controls in whom urinary tract infection had been ruled out by urine routine examination and culture were also tested. Urinary MCP-1 levels and TNF-α were measured by enzyme-linked immunosorbent assay (R and D systems and Abbkine, respectively). Urine MCP-1 and TNF-α levels were standardized to urinary creatinine measured in the same spot urine.

The average urinary MCP-1 was 893.6 ng/mmoL Cr and average urinary TNF-α was 116.2 ng/mmoL Cr, both well above the levels seen in other diseases and controls [Figure 1]. This validates the results from previous studies[3,4] that

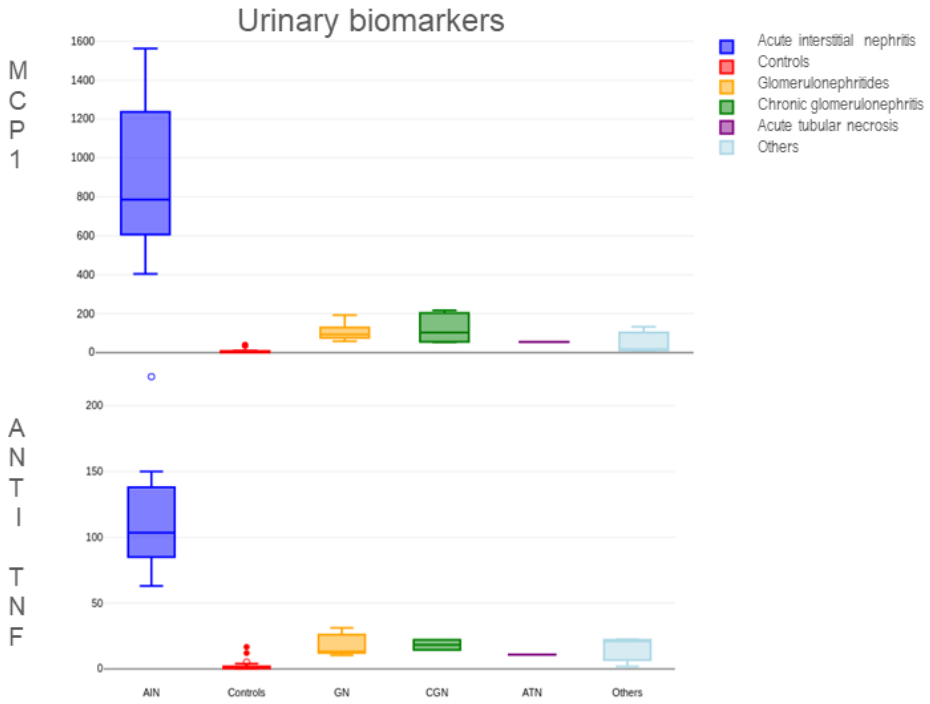

Figure 1: Box and plot diagram comparing urinary tumor necrosis factor alpha and monocyte chemoattractant protein-1 levels among various etiological subgroups and controls. AIN: Acute interstitial nephritis, GN: Glomerulonephritides, CGN: Chronic glomerulonephritis, ATN: Acute tubular necrosis , MCP: monocyte chemoattractant protein, TNF: tumor necrosis factor