SUPPLEMENTARY FILE 1

METHODS

Study design and setting

The study was a prospective, observational, cohort study conducted at the Postgraduate Institute of Medical Education and Research (PGIMER), Chandigarh, India. The study was approved by the Institute Ethics Committee at PGIMER, Chandigarh.

Study population

Patients who received hemodialysis in the Department of Nephrology at PGIMER, Chandigarh were screened. Age ≥ 18 years and diagnosis of AKI were inclusion criteria. Patients with prior diagnosis or suspicion of underlying chronic kidney disease (CKD) or previously documented creatinine based chronic kidney disease epidemiology collaboration (CKD-EPI) estimated glomerular filtration rate (eGFR) <60 ml/min/1.73m^2, history or presence of hepatitis B and/or C virus and/or Human Immunodeficiency Virus infection, or organ transplant recipient or with clinical diagnosis of glomerulonephritis or who were admitted in ICUs were excluded. Admission to and discharge from hospital were at the discretion of the treating physician. Patients were enrolled after informed consent.

Study measurements and end points

Baseline demographics and biochemical data were recorded at enrolment. The cause of AKI was recorded as the one based on clinical judgement of treating physician during admission. Outcomes after hospitalization were recorded. In those who were discharged, recovery of kidney function was assessed at 3 months after hospital discharge. Complete recovery at 3 months was defined as CKD-EPI$_{Cr}$ eGFR ≥ 60 ml/min/1.73m^2. Incomplete recovery at 3 months was defined as CKD-EPI$_{Cr}$ eGFR <60 ml/min/1.73m^2 and no need of dialysis. Those who remained dialysis dependent at 3 months were categorized as having kidney failure with no recovery.

Statistical analyses

Descriptive statistics were used to describe baseline characteristics of enrolled participants. Categorical data were reported as frequencies or proportions. Quantitative data were expressed as mean ± standard deviation or median and interquartile range (IQR) as appropriate. Data were analyzed using the Statistical Package for the Social Sciences (SPSS) software for Macintosh, version 26.0.0.0 (IBM Corp., Armonk, NY, USA).

SUPPLEMENTARY FILE 2

SUPPLEMENTARY TABLE

Table S1: Etiology of AKI in the study population

Cause of AKI	Total (n=162)
Sepsis	89 (54.9)
Decompensated liver disease	11 (6.8)
Decompensated heart failure	10 (6.2)
Pregnancy related AKI	9 (5.6)
Drug induced nephrotoxicity	8 (4.9)
Acute pancreatitis	6 (3.7)
Others	29 (17.9)

Data expressed as number (percentage)

SUPPLEMENTARY FILE 3

REFERENCES

S1. Annigeri RA, Ostermann M, Tolwani A, Vazquez-Rangel, A, Ponce D, Bagga A, Chakravarthi R, Mehta RL. Renal Support For Acute Kidney Injury In The Developing World. Kidney Int Rep 2017;2:559-578.

S2. Ponce D, Zamoner W, Addad V, Batistoco MM, Balbi A. Acute Renal Replacement Therapy in Intensive Care Units versus Outside Intensive Care Units: Are They Different? Int J Nephrol Renovasc Dis 2020;13:203-209.

S3. Hoste EA, Bagshaw SM, Bellomo R, Cely CM, Colman R, Cruz DN, Edipidis K, Forni LG, Gomersall CD, Govil D, Patrick M, Honoré PM, Joannes-Boyau O, Joannidis M, Korhonen AM, Lavrentieva A, Mehta RL, Palevsky P, Roessler E, Ronco C, Uchino S, Vazquez JA, Andrade EV, Webb S, Kellum JA. Epidemiology of acute kidney injury in critically ill patients: the multinational AKI-EPI study. Intensive Care Med 2015;41:1411-1423.