



ISN
INTERNATIONAL SOCIETY
OF NEPHROLOGY



KRACON

CONFERENCE



23rd – 26th
September 2026



**PRIDE INN CONVENTION CENTRE,
SHANZU, MOMBASA**

Theme:

Kidney Health: Beyond Nephrology

PROGRAM



INTRODUCING

HEMOCARE HD & HDF HEMODIALYSIS MACHINES



SMC002 HD MACHINE



SMC008 HDF MACHINE

FEATURES

- Double Pump
- Large 15.6' Touch Screen
- Online BPM
- Intelligent Alarm Systems
- One Key Priming Function
- Timer Function
- Back Up Battery
- Bicart Function
- One key drainage feature
- Standby Function
- Dialysate Filter
- Blood Level Sensor
- Power Protection Circuit Breaker
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CONSUMABLES



**MANUAL & ELECTRIC
DIALYSIS CHAIRS**



DIGITAL CHAIR SCALE



**HEMODIALYSIS DIALYZERS
H1.4, 1.7, 1.8, 1.9, 2.0, 2.1**



**HEMODIALYSIS
BLOODLINE**



**HEMODIALYSIS BICARBONATE
650GM, 720GM, 750GM, 760GM**



**ACUTE SHORT TERM
HEMODIALYSIS CATHETERS**



**LONG TERM HEMODIALYSIS
CATHETERS**



BIBAG



**A.V. FISTULA NEEDLE
G15, 16, 17**



**TRANSPARENT WATERPROOF/
NON WOVEN DRESSING**



PATIENT MONITORS



**R.O WATER PLANT +
ACCESSORIES**



POWDER A & B



**DIALYSIS ON AND
OFF KIT**



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LIQUID BICARBONATE
CITRIC ACID 21%/50%**



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Delegates sponsor



Conference Materials sponsor



Exhibitors



KRACON 2026 Annual Scientific Conference



Venue & Location

The KRACON Annual Scientific Conference will be held at Pride Inn Conventional Centre, Mombasa, located a few minutes' drive from Mombasa City Centre. Mombasa is a vibrant city in Coastal Kenya, known for its hospitality and growing medical community. The commonly spoken languages are English and Kiswahili.

The conference and training sessions will be conducted in English only.

The country telephone code is +254 for mobile numbers and 041 for Mombasa landlines.



Currency:

The local currency is the Kenya Shilling (KES). Major hotels and establishments accept card payments, and ATMs are readily available in Mombasa.



Climate:

During early October, Mombasa experiences average daytime temperatures of 27°C, with occasional light showers and cooler evenings around 16°C. Delegates are advised to carry Portable fans



Accommodation:

Pride Inn Conventional Center,
Shanzu Mombasa
(Conference venue)
+254 723 634 669

Continental Hotel
+254 726 830 732

All hotels offer comfortable lodging and easy access to the conference venue. Kindly contact the hotels directly to make your reservation. For additional assistance, feel free to reach out to the conference organisers.



CPD Points:

CPD points will be awarded daily via email. Delegates are encouraged to register on the link to ensure correct caption on email address.



Personal Insurance and Safety:

Delegates are responsible for arranging their own medical and travel insurance. Mombasa is generally safe during the day, especially around the city centre, hotels, and conference venue. For visits beyond the hotel area, especially on foot, please seek advice from the hotel or event organisers for guidance.



Transport and Airport Transfers:

For local transportation and airport transfers in Mombasa, delegates may consider the following options:

Ride-hailing services such as Uber or LittleCab, available via app stores.

Hotel-arranged transfers – check with your respective hotel.

Direct taxi and airport pick-up/-drop-off via
+254 705 816 870

*For further support, contact the KRACON conference organisers:
Medics Management Services Kenya
Email: info@mmskenya.co.ke
Call: +254 726 830 732*



Parking:

Complimentary parking is available for all registered delegates at the venue. For any assistance, please consult the organisers at the registration desk.



WiFi:

Complimentary WiFi will be available at the conference venue. Access credentials will be provided at the registration desk.



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FOREWORD FROM THE PRESIDENT



Dear Esteemed Delegates,

It is our privilege once again to welcome all our delegates to KRACON 2026.

This annual conference as always provides an exciting blend of academic program and productive networking. Our theme this year is relevant to every professional working with or around kidneys.

The challenges facing nephrology in particular and the practice of medicine in general are myriad. Never before has so much strain been placed on the healthcare system. On the high demand side are the twin attacks of an explosion of chronic kidney diseases together with higher risks for acute kidney injury. On the poor supply side, we see a deficit of almost all the pillars necessary to deliver effective modern health care, ranging from insufficient and irregular healthcare financing to shortages in the healthcare workforce to governance issues.

This conference therefore tries to refocus your eyes Beyond Nephrology. While we push for and applaud excellence in individual patient management, we cannot isolate ourselves from what is happening in the health ecosystem around us. How do we connect the kidneys with other organs? How do we capture individuals at risk in the community? How do we work with the government, pharma and international community to enable kidney health for all?

So as you network and relax and bond, let this conference provoke these important discussions.

We as Kenya Renal Association are so proud to have you in the house in this KRACON 2026 looking at our kidneys and Beyond Nephrology.

Welcome one and all!

Dr. Jonathan Wala

President, Kenya Renal Association



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KRACON 2026 CONFERENCE CHAIR MESSAGE



Dear distinguished delegates,

It is my pleasure and privilege and on behalf of the Kenya Renal Association, to warmly welcome you all to our Annual Scientific Conference – KRACON 2026. This conference has gained appeal from the East African and the greater African region. We are indeed privileged yet again to have accreditation from the African Association of Nephrology (AFRAN) and the International Society of Nephrology (ISN).

The theme for this year's conference is Kidney Health Beyond Nephrology – the emphasis therein being, that provision of quality kidney health care goes beyond what is solely offered by the kidney specialist. Kidney disorders cause disturbances in other body systems and organs even as other organ and body system malfunction has capacity to affect kidney well-being. Thus, kidney-care at a primary level requires a multi-discipline team response to achieve favourable outcomes. Similarly, delivery of quality kidney health care, to individuals and communities at large, requires availability, accessibility and acceptability of i) the multi-discipline health care providers, ii) investigation facilities and other therapeutic systems as well as iv) well equipped health care facilities.

Through keynote plenary presentations, panel discussions, training workshops, scientific paper presentations, situation analysis updates and poster presentations, we aim to invigorate kidney health care providers and our partners in this service delivery who are here, to think broader and beyond our rather restricted domain of nephrology.

We welcome with deep appreciation, faculty for the conference, a blend of seasoned well known speakers and upcoming presenters both international and local experts in their fields of operation. We have talks from various cadres of health care providers as well as talks from allied partners who support kidney healthcare provision and accessibility.

This year we are proudly delighted to launch Nephrology practice guidelines relevant for use in our level 3, 4 & 5 hospitals. We are grateful to all who have taken their precious time and expertise to formulate and write up these guidelines, especially the young nephrologists who have been the backbone of this manuscript. Special thanks and recognition to Astra Zeneca who sponsored this project.

It is our expectation that you will fully engage in the deliberation during these stimulating presentations. We hope that by the end of our interactions we shall be better equipped to think beyond nephrology as a slogan in our future kidney care delivery programs.



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KRACON 2026 CONFERENCE CHAIR MESSAGE

Outside the conference halls there are exhibition sites with plenty to see from our partners in pharma and industry. Ample time will be provided to give delegates opportunity to engage those who provide support systems, equipment and medication that we use in the provision of kidney care services. Please commit yourself and visit these eye opening exhibitions, connect with colleagues and seize networking and collaboration opportunities available during our time together.

Enjoy the cozy facilities offered by the hotel and the beach front as well as the well-known warm, welcoming culture of Mombasa as a tourist attraction site. There will be opportunities too, for team building games, keep-fit sessions and a conference dinner as a KRACON 2026 highlight, to crown all the fun we intend to have together.

On the behalf of the KRACON 2026 organizing committee, I wish to express our heartfelt gratitude to our supporters, partners and sponsors from pharma, industries, partnering hospitals, laboratory and allied investigation centres, the Ministry of Health, and County Governments. Your immense support and contributions have brought this Conference this far.

I wish you all a memorable, and life changing experience during KRACON 2026.

Prof. Joshua K. Kayima

Conference Chair KRACON 2026



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KRACON 2026 SCIENTIFIC CHAIR ADDRESS



Distinguished colleagues, esteemed guests, partners in kidney care, ladies and gentlemen,

On behalf of the Scientific Committee, it is my profound honour to welcome you to KRACON 2026. Every year, this conference offers us a rare gift: the chance to pause from the daily rigour of clinics, wards, and dialysis units, and to think together as a community about where kidney care in Kenya, and indeed the world, is headed.

Our past achievements including the impactful annual KRA conferences, which has brought together over 500 delegates from across the globe and has featured pioneering workshops on Haemodialysis, Peritoneal Dialysis, POCUS, Vascular Access, and Transplantation laid a strong foundation for multidisciplinary collaboration. These efforts were further amplified by initiatives such as the ISN Educational Ambassador Program, which enhanced surgical training and strengthened local capacity-building at KRACON 2023.

This year, we ask ourselves to think even more expansively. Our theme, "Kidney Health: Beyond Nephrology," is a deliberate provocation. It challenges us to step outside the walls of the nephrology clinic and to recognise that nephrologists alone will not secure the future of kidney health. Our five sub-themes were chosen to carry this vision forward:

We begin by asking a question that demands honesty: Vision 2030 in Kidney Disease Are We There Yet? As we approach this milestone year, we owe ourselves a candid accounting of progress against the targets we have set, both as a nation and as part of the global kidney health community. Where have we succeeded? Where have we fallen short? And what must change in the years remaining?

We turn next to a challenge that defines equity in our field: Improving Access to Kidney Health Services. Too many Kenyans still travel too far, wait too long, or pay too much to access screening, dialysis, or transplantation.

No progress is possible without evidence, which is why we dedicate a theme to Obtaining and Utilizing Data for Kidney Health.

We then move into the clinic itself, with Precision Nephrology: Every Individual Matters.

And finally, we widen our lens with The Interconnected Kidney: The Kidney in a Community of Organs. The kidney does not fail in isolation, nor does it heal in isolation. Its story is deeply entangled with the heart, the metabolic system, and systemic disease at large.



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KRACON 2026 SCIENTIFIC CHAIR ADDRESS

Before our main scientific sessions begin, we are proud to offer a robust suite of pre-conference workshops, designed to translate knowledge into hands-on skill. Participants will have the opportunity to engage deeply with Critical Care in Nephrology, with particular attention to electrolyte management; POCUS in Nephrology, covering vascular access and ultrasound-guided technique; Peritoneal Dialysis, from catheter insertion to prescription writing and fluid preparation; Haemodialysis, Hemodiafiltration, CRRT, SLED, and Body Composition Analysis; and Renal Pathology, including microscopy and the diagnostic approach to glomerulonephritis. These workshops reflect our conviction that scientific dialogue must be matched by practical competence at the bedside.

To our speakers, moderators, and abstract presenters thank you for the intellectual generosity of sharing your work. To our reviewers and the Scientific Committee thank you for the many unseen hours spent shaping a rigorous, relevant programme. And to every delegate joining us thank you for bringing your curiosity, your questions, and your commitment to this shared cause.

Kidney disease does not respect the boundaries of a single specialty, and neither should our response to it. Let KRACON 2026 be the place where those boundaries begin, meaningfully, to dissolve.

Welcome, and welcome to a conference that dares to look beyond.

Dr Peris Mutuku Koge

Consultant Physician and Nephrologist

KRA Secretary General

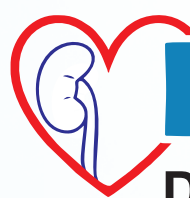
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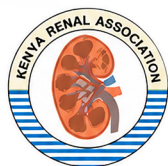
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KRA CONFERENCE PROGRAM 2026

DAY ONE Wednesday 23rd September 2026		
Time	Presentation	Speaker
8:00 -9:00am	Registration	MMS
Session 1 : Workshop		
9:00 -10:00am	Workshop 1:Critical care Nephrology/ electrolyte -ALL	Peter koech/Koge
10:00 -11:00am	Workshop 2:Renal Pathology- ALL	Kalebi/ Mutwiri
11.00-11:30am	Tea Break / Exhibition	
Session 2 : Workshop-Pararel session		
11.30-12:30pm	Workshop 3:Dialysis(Peritoneal and Haemodialysis/CRRT)	Mehreen
	Workshop3A Peritoneal dialysis	Koge/Grace Ngaruiya/ koech
	Workshop 3B Haemodiafiltration	ALI/Wala
	Workshop 3C: Continous Renal Replacement Therapy(CRRT)	Thomas /Essaji
	Workshop 3D :Body Composition Analysis	Peter /Mary
11.30-12:30pm	Workshop 4:Pocus in Nephrology /Vascular access Pararel session	
	Workshop 4A:Pocus Vascular Access	Sokwala/Nguringa
	Workshop 4B:Clinical Vascular access	Everlyn Omurunga
12:30-2:00pm	Lunch	
Session 3 : Case Presentations/Panel discussions/Debate		
Chair : Jonathan Wala/Peris Koge		
2.00- 2:20pm	Home Dialysis	Ali Benmansour
2.20- 2:40pm	Mobile dialysis	James Kahura
2:40- 3:00pm	An elusive GIT bleed in a kidney transplant recipient	Mohammed Maalim
3:00- 3:20pm	Gym Related Rhabdomyolysis	Grace Mwangi
3:20- 3:30pm	PD/HDF/CRRT/ SLED -Discussion	ALI/Thomas /Kahura
3:30- 3:40pm	Q&A	ALL



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KRA CONFERENCE PROGRAM 2026

DAY ONE Wednesday 23rd September 2026

OPENING CEREMONY

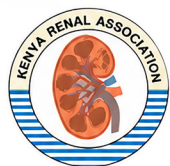
Time	Presentation	Speaker
3:40- 4:00pm	OPENING REMARKS:Renal Registry and Guidelines:using data to reach more	KRA President
4:00- 4:10pm	Kenya CKD screening Updates and outcomes(MOH/ ASTRAZENECA)	Stephen Mutiso
4:10- 4:40pm	Kidney Health for all	Guest of honor
4:40- 5:20pm	KRA 1ST EVER Guideline Launch	KRA & MOH
5:20- 5:30pm	Appreciation Remarks(MOH/KRA/ASTRAZENECA)	KRA Founder
5.30-6:00pm	Tea Break / Exhibition	

DAY TWO Thursday 24th September 2026

Session 1: Vision 2030 in kidney disease,are we there yet?

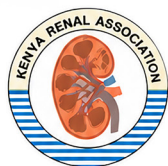
Session Chair: John Ngigi / Esther Getambu

Time	Presentation	Speaker
8:30- 9:00am	Decentralization & Equipment under UHC	Stephen Mutiso
9:00- 9:30am	The East African Kidney Institute (EAKI)Milestones and update	Mungai Ngugi
9:30- 10:00am	Patient Advocacy	John Gikonyo
10:00- 10:10am	Q&A	ALL
1010-11:00am	Tea Break / Exhibition	



KRA CONFERENCE PROGRAM 2026

DAY TWO Thursday 24th September 2026		
Time	Presentation	Speaker
Track 1: Obtaining Data Precision Nephrology		
Session 2	Session Chairs: Joshua Kayima /Seth Mcligeyo	
11:00– 11:25 am	Updates on FSGS , relevance for AFRICA	Lissane seifu
11:50 -12:15 pm	CRM Africa Programme Study outcomes	Samuel Kabinga
12:15-12:25pm	Role of home blood pressure monitoring in hypertension management in hemodialysis	Julius Okel
12:25-1:00pm	Epidemiology/Burden of CKD IN Africa	Antony Muriu
1300 - 1315	Q n A	
1.00-2.30pm	Lunch and Exhibition	
Track 2: Critical Care Nephrology		
Session 2	Session Chair : George Moturi/Zoya Adams	
11:00– 11:25 am	CRRT in critical care	Thomas rimmel-Crown Health
11:50 -12:15 pm	Acute Peritoneal dialysis in children	Cyriac Mbarubukeye
12:15-12:25pm	Plasma Exchange Modalities and Utilization	Tasneem Essaji
12:25-1:00pm	Erythropoietin Face-Off: Alpha vs Beta ,Is There Really a Winner?	Sokwala-ROCHE
1300 - 1315	Q n A	
1.00-2.30pm	Lunch and Exhibition	
Sub theme: Precision Nephrology; every individual matters		
Session 3	Session Chair. Evelyn Mbugua/Antony Wainaina	
2:30 -2:55pm	When the Kidney Signals Autoimmunity	Kalman Genga
2:55 - 3:20pm	Improving Kidney biopsy and Renal pathology outcomes	Anderson Mutwiri
3:20 -3:45pm	Better diet outcomes in CKD	Phillip lundu
3:45 - 4:15pm	Kidney Disease in the Elderly	Ben Ochola
4:15 - 4:30pm	Q n A	
4:30-5:00pm	Tea and Exhibition	
5:00- 6:30pm	AGM	



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DAY TWO Thursday 24th September 2026		
Time	Presentation	Speaker
Sub theme: Precision Nephrology;every individual matters		
Session 3	Session Chair: Florence Juma/Ben Lematayo	
2:30 -2:55pm	Understanding the Psychosocial impact of CKD	Tabitha Matekwa
2:55 - 3:20pm	The Renal benefits of GLP-1-Semaglutide(OZEMPIC)	Hussein Bagha-novonordisk
3:20 -3:45pm	Update in management Polycystic Kidney Disease	John Ngigi
3:45 - 4:15pm	The emerging paradigm in Podocytopathies	Ahmed Kalebi
DAY THREE Friday 25th September 2026		
Time	Presentation	Speaker
Sub Theme:Improving access to kidney health Services		
Session 1	Chair: mohammed Ibrahim/Peter koech/Benjamin Wambugu	
8:30 – 9:00am	When to refer to a Nephrologist	Esther Getambu
9:00 -9:30am	Fistula first initiative from a nephrologist perspective	Ahmed Sokwala
9:30-10:00 am	Peritoneal Dialysis are we there yet?PD 1st Policy	Peris Koge
10:00-10:10am	Q&A	
10:10-11:00am	Tea and Exhibition	
Track 1: Enviroment and kidney disease ;Green Nephrology		
Session 2	Chair: Juliet Akoth/ Samuel Kabinga	
11:00 – 11:25 am	Atmospheric pollution and climate change impact on Kidney health	Hussein Bagha
11:25 – 11:50am	Optimization of energy consumption&Water saving in Haemodialysis modalities	Everlyne Omurunga
11:50 -12:40pm	Case presentations	
	Navigating Poverty and Dialysis in Somalia	Amir Muse
	Acute Kidney Injury Following Multiple Bee Stings in a 91-Year-Old Patient	Nixon Omulimi
	Abstract oral Presentation	
	Acute Peritoneal Dialysis Adequacy among Children at a National Referral Hospital in Kenya	Doreen Nganga
	A Global Evaluation of Public Education Frameworks on Organ Donation	Nancy Wangombe



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DAY THREE Friday 25th September 2026

Time	Presentation	Speaker
	Abstract oral Presentation	
	Trajectories and Predictors of Chronic Kidney Disease Progression:SEARCH-CKD Study	Moses Odhiambo
12:50-1:00pm	Q&A	

Track 2: PEDIATRIC /Urology

Session 2	Session Chair. Philip Cheptinga/Doreen Nganga	
11:00 – 11:25 am	Management of CAKUT	Doris Kinuthia
11:25 – 11:50am	Approach to Posterial urethra Valves early in life(Virtual)	Tim Jumbi
11:50 -12:15pm	Posterior Valves and transplantation ,An African Experience	David Kimani(Thur)
12:15 -12:45pm	Obstructive Uropathy Adult	Patrick Mburugu
12:45-1:00pm	Q&A	

1.00-2.30pm Lunch and Exhibition

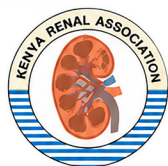
INTERCONNECTED KIDNEY

Session Chair. Maritim/Patrick Mbugua

2:30 -2:55pm	Cardiorenal syndrome ,a Cardiology Perspective	Yubrine Moraa
2:55-3:20pm	Cardiorenal syndrome ,a Nephrologist Perspective,	Hussein Bagha- Norvatis
3:20-3:45pm	The role of a Renal Nurse, a friend/ Confidant or a Foe	xx
3:45-4:30pm	Red Cell Exchange in Sickle cell disease	Abdillah Abubakar
4:30-4:45pm	Q&A	

4:45-5:30pm Tea and Exhibition

5:30 -6:30Pm	Physical Activity	All
7:00pm	Gala Dinner:Theme-Swahili	All



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DAY THREE Friday 25th September 2026		
Time	Presentation	Speaker
TRANSPLANT		
Session Chair: Nancy Wangombe/Tasneem Essaji/Khalida Soki		
2:30 -2:55pm	Preparation of a transplant patient-A coordinators perspective	Leah Ndirangu
2:55-3:20pm	Establishing new Transplant center:Challeges and gains at KUTRRH	Edward Njogu
3:20-3:45pm	Domino and Swap	Jatin Kothari
3:45-4:30pm	Toxic and Iatrogenic causes of AKI in transplant	Khalida Soki
4:45-5:30pm	Tea and Exhibition	
5:30 -6:30Pm	Physical Activity	All
7:00pm	Gala Dinner : Theme-Swahili	All

DAY Four: Saturday26th September 2026		
Time	Presentation	Speaker
Session 1 Sub theme: Controversies in Kidney care		
Session Chair: Patrick mburugu/Joel Kiyapi		
	Panel discussion/debate	
9:00-9:30am	ABO incompatible Transplant , Are we ready?	Bagha/Soki/Essaji
9:30-10:00am	Cardiac Disease and Transplant: Does all cardiac patients Qualify	Moraa/Victoria Simiyu/ Njogu
10:30-11:00am	Anaemia debate	Jatin Kothari
11:00-11:30am	Closing Ceremony	



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23rd-26th
September
2026



VENUE:
PRIDE INN CONVENTION CENTRE,
SHANZU, MOMBASA

Join us for a memorable

GALA DINNER

A NIGHT OF CELEBRATION, CONNECTION & CULTURE



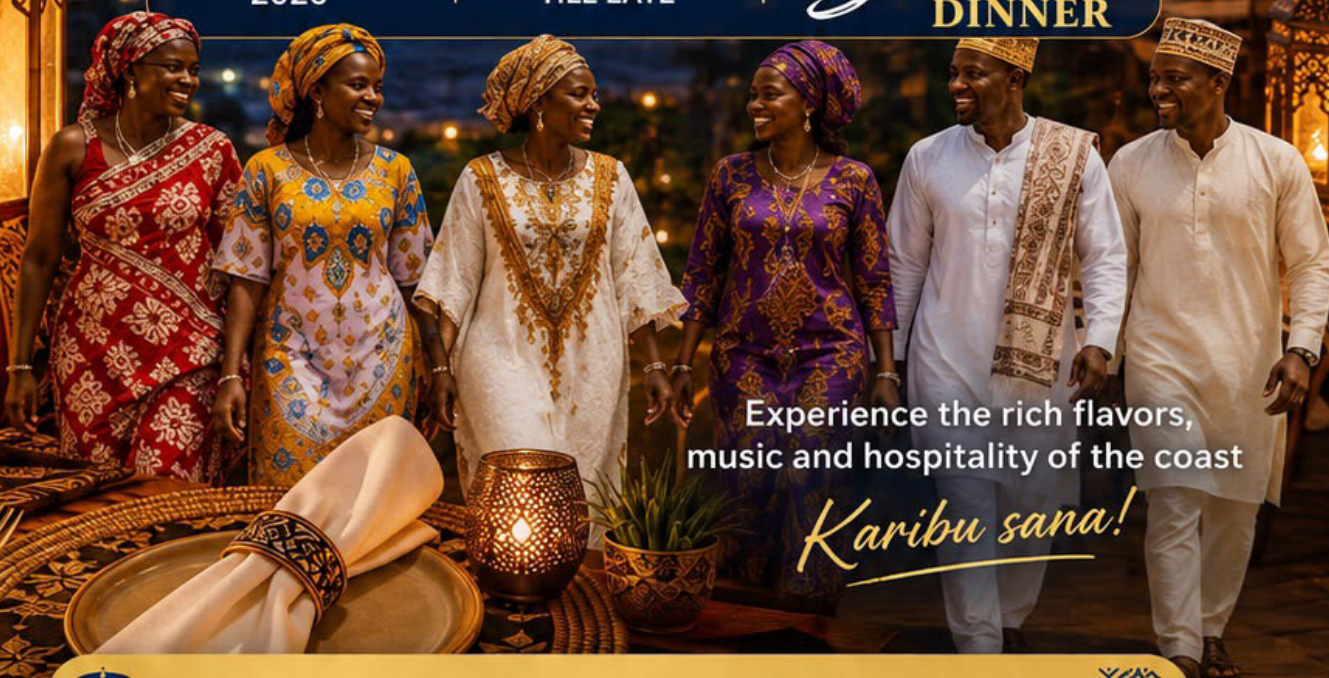
DATE:
25th September
2026



TIME:
7:00 PM
TILL LATE



THEME:
Swahili
DINNER



Experience the rich flavors,
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Karibu sana!



Let's celebrate our shared passion for kidney health
in true Swahili style!



#KRACON2026



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Event Organizer: Medics Management Services (MMS)
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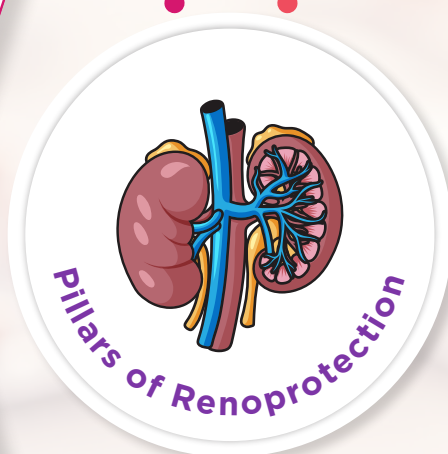
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KRACON SPEAKER BIOS



Ali Benmansour

From 05/16: BUSINESS DEVELOPEMENT at INFOMED – Geneva - SWITZERLAND: www.infomed.biz

- Developing the distribution on new destinations :Asia /USA/ EMEA
- Local involvement and support / KOL
- Defining the local business models and strategies / distributors portfolio
- Promotion of the CRRT and Plasmapheresis therapies trough conferences as speaker
- Following the publications and the litterature

05/10 to 05/16: SALES MANAGER at INFOMED – Geneva - SWITZERLAND: www.infomed.biz Management of a network of 25 distributors : Asia , Middle East , Eastern Europe

- Sales objectives / Field and exhibitions support / Tenders
- Clinical & application trainings : CRRT and Plasmapheresis

From 03/11: SALES MANAGER at INFOMED SAS – Confort (01) –FRANCE: www.infomed.biz/fr/ Direct distribution and installation of CRRT & Plasmapheresis devices to the end users in France

- Promotion and prospection / Selection of the end users / application trainings / support for in vivo treatments
- Disposables target definition / ROI - Participation to tenders and local exhibitions

03/08 to 05/10: EXPORT MANAGER at STID – Gréasque (13) – FRANCE www.stid.com Creation and structuration of the export department: Destinations/Products/ Partnerships

- Management of a network of 15 distributors: Europe, North Africa, Middle East
- Application trainings to the distributors

09/04 to 02/08: AREA EXPORT MANAGER at DMS-APELEM – Montpellier – FRANCE www.dms.com Management of a network of 12 distributors Middle East / Eastern Europe / Asia

- Field support / Clinical and applications trainings
- Involvement in the product design projects

EDUCATION

From 2010 until now: attending the major congresses on CRRT and Plasmapheresis

- EDTA/ French society of apheresis /WCN/ APCRRT / ISICEM/ ISFA/ ASFA/ CRRT.....
- Local Exhibitions in Asia , Eastern Europe and Middle East

2004/2008 – MBA – Marketing and Sales

- ECOLE SUPERIEURE DE COMMERCE ESARC-CEFIRE – Montpellier - FRANCE
- 2002 / 2004 – International Business Technics degree / BTS commerce International
- ETABLISSEMENT BRISTOL DE CANNES (06)
- 2001 / 2002 – Bachelor's degree of Economic Sciences
- FACULTE DE SCIENCES ECONOMIQUES DE RICHTER - MONTPELLIER (34)
- 1999 / 2001 – Pharmacy University
- FACULTÉ DE PHARMACIE DE MONTPELLIER (34)



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Dr. Khalida B. Soki

Senior Consultant Transplant Nephrologist

Dr. Khalida B. Soki is a distinguished Senior Consultant Transplant Nephrologist with extensive expertise in advanced kidney care and renal transplantation. She practices at The Nairobi Hospital under Kidney Care Consultants, where she provides comprehensive care across the full spectrum of kidney disease, with a particular focus on kidney transplantation and long-term renal outcomes.

Dr. Soki holds a Bachelor of Medicine and Bachelor of Surgery (MBChB) and a Master of Medicine in Internal Medicine and has undertaken advanced subspecialty training in transplant nephrology in Alberta, Canada. She is also a Fellow of the International Society of Nephrology (FISN), reflecting her global recognition and commitment to excellence in nephrology practice.

She serves as the Medical Director of Figo Care Plus Dialysis Centres, where she oversees the delivery of high-quality dialysis services and drives clinical standards in renal replacement therapy. In addition, she plays a key leadership role as Chair of the Transplant Committee at the Kenya Renal Association, contributing to the advancement of transplant policy, practice, and capacity in Kenya.

At the continental level, Dr. Soki serves as Deputy Secretary General of the African Association of Nephrology, where she is actively involved in shaping nephrology practice, education, and collaboration across Africa.

Dr. Soki is widely recognized for her leadership in transplant medicine, including patient selection, peri-transplant optimization, and post-transplant care. She is deeply committed to expanding access to kidney transplantation, improving patient outcomes, and strengthening multidisciplinary approaches to kidney care.

Her clinical approach combines evidence-based practice, innovation, and compassionate care, ensuring patients receive holistic and personalized treatment throughout their kidney care journey.



Dr. Anthony N. Muiru

Dr. Anthony N. Muiru is an Associate Professor in the Division of Nephrology, Department of Medicine at the University of California, San Francisco. He completed his undergraduate training at UC Berkeley, medical school at Harvard, residency at Massachusetts General Hospital, and an MPH at the Harvard Chan School of Public Health.

He is interested in improving our understanding of the determinants of kidney disease and thus informing the development of effective strategies to mitigate the risk of kidney disease and its long-term adverse outcomes, particularly among individuals of recent African ancestry—those living in sub-Saharan Africa and the United States.



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Dr. Ahmed Kalebi

Dr Ahmed Kalebi, OGW, is a Consultant General and Anatomical Pathologist with a special interest in renal pathology, renowned for his pioneering entrepreneurial work in advancing high-quality diagnostic services across Kenya and East Africa.

He is recognised as both a pioneering pathologist and a healthcare entrepreneur. In 2009, he founded Pathologists Lancet Kenya (now Cerba Lancet Kenya) in partnership with Lancet Laboratories South Africa, growing it into the largest independent laboratory network in East Africa.

Following a three-year sabbatical from 2021 to 2024, during which he focused on family and community initiatives, Dr. Kalebi established Dr. Kalebi Labs (DKL) Ltd. DKL is a groundbreaking diagnostic facility incorporating total laboratory automation (TLA), a fully digital pathology workflow, and advanced technologies from flow cytometry to genetic testing.

DKL was registered and licensed by KMLTTB as the first ever private Class G National & International Referral Clinical & Research Lab in September 2024, and was officially launched in October 2024. It achieved ISO15189 accreditation by KENAS in record time by December 2024 and recognised as the first accredited paperless lab in Africa.

Dr. Kalebi's leadership in laboratory medicine has earned him national and international recognition. In 2021, he received the Order of the Grand Warrior (OGW) from the President of Kenya for his role in the country's COVID-19 testing response, after leading the first independent lab to initiate testing and scaling it into the busiest private facility nationwide. He has also been named among Business Daily's Top 40 Under 40 Men and featured in The Pathologist magazine's Power List in 2019, 2020, 2021, and again in 2024 and 2025 following his return to active practice.

Dr. Kalebi has more than 15 years of experience reporting renal biopsies in Kenya. He undertook specialised training in renal pathology at the University of the Witwatersrand from 2006 to 2008 and at the University of Oxford in 2008.

He established and led the East African Division of the International Academy of Pathology (IAP), serving as General Secretary from 2009 to 2018 and subsequently as President from 2019 to 2024. He currently serves as Vice-Chair of the International Society of Nephrology (ISN) Renal Pathology Working Group for 2025–2026 and is the Incoming Chair for 2027–2028. He also teaches renal pathology to nephrology fellows at the University of Nairobi and remains actively engaged in research, publications, and international presentations in renal pathology. In addition, he is an active member of the Kenya Medical Association (KMA) and the Kenya Association of Clinical Pathologists (KACP).

Today, Dr. Kalebi continues to practise anatomical and clinical pathology through DKL in Nairobi, while mentoring colleagues and driving innovation in laboratory medicine across the region.



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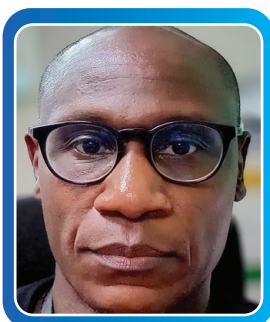


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Prof Thomas Rimmelé

Prof Thomas Rimmelé is an intensivist currently working in Nice, France. He gained his medical degree in 2004, specialising in anaesthesiology and intensive care, from the Claude Bernard University, Lyon, France, and subsequently completed a PhD on extracorporeal blood purification therapies in sepsis. Prof. Rimmelé is the author or co-author of approximately 300 peer-reviewed papers. In addition to blood purification for sepsis, Prof. Rimmelé's academic interests include Acute Kidney Injury, Renal Replacement Therapy in the intensive care unit, and simulation in healthcare as he was also the director of the simulation center at Lyon University. Since Fall 2025, Prof Rimmelé is the new chair of the AKI section of the European Society of Intensive Care Medicine (ESICM).



Dr. Anderson Mutuiri

Dr. Anderson Mutuiri is a Consultant Pathologist at the Aga Khan University Hospital, Nairobi, and a part-time faculty member at the Aga Khan University Medical College in East Africa. He completed a Clinical Fellowship in Renal Pathology at the University of Toronto. Dr. Mutuiri's areas of practice include autopsy pathology, histopathology, and cytopathology, with subspecialty expertise in the interpretation of medical kidney biopsies. His current research interests also include non-communicable diseases and oncopathology. He is passionate about increasing access to high-quality laboratory diagnostic services for the population of East Africa through continuing medical education and research. Dr. Mutuiri is a member of the Kenya Association of Clinical Pathologists and the East African Division of the International Academy of Pathology.



Dr. Ben Ochola

Nephrology Fellow with the ISN at the East African Kidney Institute (EAKI).



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Dr David K Kimani

Dr David K Kimani,
Consultant Surgeon and Urologist,



Dr Eugene Kalman Genga

Consultant Physician and Rheumatologist | Lecturer | Vice-President, ARSK

Dr Eugene Kalman Genga is a consultant physician, rheumatologist, medical educator and accomplished basketball coach whose career reflects a deep commitment to excellence, service and the development of others.

He is a Lecturer in the Department of Clinical Medicine and Therapeutics, Faculty of Health Sciences, University of Nairobi. He obtained his medical degree and completed his postgraduate training in Internal Medicine at the University of Nairobi. He subsequently gained specialist training and clinical experience in rheumatology at the University of Liverpool in the United Kingdom, where he worked under Professor Robert Moots and his team, and at Sancheti Institute for Orthopaedics and Rehabilitation in Pune, India, under Professor Arvind Chopra and Dr Amit Nalawade. He has also successfully completed the European Alliance of Associations for Rheumatology (EULAR) course and examination.

Dr Genga is the founder and lead rheumatologist at Liberty Arthritis Clinic and practises as a consultant physician and rheumatologist at several hospitals in Nairobi. He has authored publications in peer-reviewed journals and regularly addresses healthcare professionals, students, patients and the wider public. He currently serves as Vice-President of ARSK (Arthreuma Society of Kenya), contributing to the advancement of rheumatology education, advocacy and patient care in Kenya.

Beyond medicine, Dr Genga is a proud alumnus of Nairobi School, where he developed a lifelong appreciation for service, discipline, hard work and all-round excellence. A former basketball player for the University of Nairobi, Co-operative Bank of Kenya and the Kenya national team, he has won titles at national and regional levels. His sporting highlights include representing Kenya in international tournaments and competing in the 2009 Africa Club Championship in Rwanda.

He now channels this experience into coaching and developing student-athletes at Nairobi School and the University of Nairobi. He believes that academic and sporting excellence can reinforce each other, producing disciplined, resilient and socially responsible leaders.



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Dr Grace Mwangi

Dr Grace Mwangi an ECSACOP Internal Medicine resident at Kenyatta University Teaching, Referral and Research Hospital (KUTRRH), committed to improving patient outcomes through clinical practice and research. My interests include renal medicine, clinical research and the innovative use of technology to strengthen healthcare delivery. I will be presenting on exercise-induced acute kidney injury, with a focus on gym-related exertional rhabdomyolysis and its clinical management.



Dr James Kahura

Dr James Kahura MBChB, MMed Int. Medicine, Fellow Clinical Nephrologist EAKI [UON] Physician/Nephrologist
Muranga County Referral Hospital
Interests: Enthusiast on Rural Accessibility for Haemodialysis services and Preventive Nephrology.



Dr. Jatin Kothari

Principal Director and Chief Consultant Renal Transplant Medicine at Nanavati Max, with over three decades of experience in clinical nephrology, kidney transplantation, and healthcare system development. Trained at premier institutions in India, the United States, Canada, and Europe, with a distinguished record in clinical practice, research, medical education, and healthcare entrepreneurship. Co-founder of Apex Kidney Care —the largest nephrologists owned dialysis networks in the world, Co-founder of ASTRA (Apex Swap Transplant Registry), a technology-enabled paired kidney exchange registry. Committed to expanding access to high-quality, affordable kidney care across India.



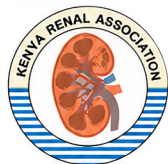
Dr Julius Okel

Dr Julius Okel is a Consultant Physician and Nephrologist, Founder and Director of Synergy Hospital, Kisumu.

He obtained his MMed in Internal Medicine from Aga Khan University Hospital, Nairobi, followed by a Fellowship in Nephrology in Alberta, Canada, and specialized training in Critical Care Nephrology.

His clinical and research interests include glomerulonephritis, haemodialysis, resistant hypertension, and critical care nephrology.

Dr Okel is passionate about advancing renal care in Kenya through clinical practice, research, education, and development of sustainable, high-quality dialysis and nephrology services, particularly improving access to specialist renal care in Western Kenya.



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Dr. Peris Mutuku Koge

Dr. Peris Mutuku Koge is a Consultant Physician and Nephrologist currently serving as the Lead Nephrologist /Head of Department at The Nairobi Hospital. She is a specialist in Peritoneal Dialysis and Critical Care Nephrology.

She is a Fellow of the International Society of Nephrology (ISN) through the East Africa Kidney Institute–University of Nairobi program, and a Fellow of the International Society of Peritoneal Dialysis (ISPD) via Stellenbosch University. Has done Critical Care Nephrology Fellowship with the World Kidney Academy and the American Association of Continuing Medical Education (WKA/AACME). She is also a Founding Fellow of the East, Central and Southern Africa College of Physicians (ESCACOP).

Dr. Mutuku holds a Master of Medicine in Internal Medicine from the University of Nairobi and a Bachelor of Medicine and Bachelor of Surgery from Makerere University. She is also certified in co-counseling and developmental counseling, and is a Trainer of Trainers in BLS, ACLS, and PHTLS.

She serves on several institutional and international committees, including the Nairobi Hospital Critical Care Unit (CCU) Users Committee and SHIF Optimization Committee. She is the Secretary General of the Kenya Renal Association (KRA). She is currently a member of the ISPD Early Career Committee and represents Africa on the ISPD Africa Chapter Interim Core Committee. African Association of Nephrology (AFRAN), International Society of Nephrology (ISN), International Society of Peritoneal Dialysis (ISPD), and the Kenya Association of Physicians (KAP).

Her key professional interests include Critical Care Nephrology, Peritoneal Dialysis, and Interventional Nephrology.



Dr Stephen Mutiso

Dr. Stephen Mutiso is the Lead of the Renal Program and Co-Chair of the Cardiovascular, Renal and Metabolic Health Technical Working Group within the Division of Cancer and Non-Communicable Diseases (NCDs) at the State Department for Medical Services, Ministry of Health, Kenya. He is a medical doctor and non-communicable diseases epidemiologist with over 15 years of experience across clinical practice, health policy, and implementation science research. He is committed to strengthening renal screening and prevention, diagnosis, and integrated linkage to care across Kenya's health system. His current focus is harnessing big data and digital health solutions to design and deliver sustainable, scalable kidney health programs in the region.



Nancy Wang'ombe

Head Renal Nursing- East Africa Centre of Excellence in Urology & Nephrology.

She holds a Master's Degree in International Course for Organ, Tissue & Cell Donation for Transplantation from the University of Barcelona, Spain. She has 11 years' experience in Renal Nursing & 15 years of experience in Transplant Coordination at the Kenyatta National Hospital. She is a Ph.D. Student in Nursing Sciences at the University of Nairobi, a founding member and Chair Emeritus Kenya Nephrology Nurses Association. Her main interest is in deceased organ donation.



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Dr Tim Jumbi

Dr Tim Jumbi is a Paediatric Surgeon at Kenyatta National Hospital in Kenya, specializing in Paediatric Urology and Uro oncology. He is a dedicated clinical instructor in paediatric surgery and a strong advocate for outcome based research. His published work primarily focuses on obstructive uropathy in paediatric populations. He is an active member of the Kenya Association of Urological Surgeons (KAUS), where he represents the Paediatric Urology Chapter, and he also serves as the current Treasurer of the Kenya Association of Paediatric Surgeons (KAPS).



Dr. Yubrine Moraa Gachemba

Dr. Yubrine Moraa Gachemba, MBChB, MMed, PGDip, MSc

Dr. Yubrine Moraa Gachemba is a Consultant Cardiologist and cardiovascular medicine specialist with expertise spanning preventive and cardiometabolic cardiology, multimodality cardiovascular imaging, structural heart disease, and women's cardiovascular health.

She serves on the Executive Committee of the Kenya Cardiac Society and is actively engaged in cardiovascular research, education, and collaborative initiatives across Africa and internationally. Her academic and clinical interests focus on cardiometabolic risk, obesity-related cardiovascular disease, precision prevention, and sex-specific cardiovascular phenotypes, with particular emphasis on translating contemporary evidence into clinical practice in African populations.

Dr. Gachemba trained in Kenya and the United Kingdom and holds an MSc in Preventive Cardiology from the University of South Wales, alongside advanced cardiology training in Scotland. She contributes to regional and international scientific programmes focused on advancing cardiovascular prevention, imaging, and equitable cardiovascular care.



Dr. Mohamed Maalim Mohamed

Dr. Mohamed Maalim Mohamed, Bachelor of Medicine and Bachelor of Surgery (MBChB), Master of Medicine in Internal Medicine (MMed), Postgraduate Diploma in Renal Medicine (University of South Wales, United Kingdom), Fellow of the College of Physicians of East, Central and Southern Africa (FCP [ECSA]), Fellow in Nephrology and Kidney Transplantation (Alexandria University, Egypt), and Fellow of the Glomerular Disease Study & Trial Consortium (GlomCon), is a Consultant Nephrologist and Internal Medicine Specialist dedicated to advancing kidney care in Kenya. He serves as the Head of the Department of Internal Medicine and Head of the Renal Unit at Msambweni County Referral Hospital and is also in private nephrology practice in Mombasa, providing comprehensive care for patients with kidney diseases, hypertension, dialysis, and kidney transplantation.

Dr. Mohamed has expertise in clinical nephrology, critical care nephrology, interventional nephrology, glomerular diseases, kidney transplantation, and nephrogenetics, with a particular interest in the diagnosis and management of genetic kidney diseases.



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Prof Ahmed Sokwala

Prof Ahmed Sokwala is an Associate Professor in the Department of Medicine and a Consultant Physician and Nephrologist at Aga Khan University. He serves as the Section Head of Nephrology and Kidney Transplant at Aga Khan University Hospital in Nairobi. Dr. Sokwala earned his MD from Marmara University in Istanbul, completed a Master's in Internal Medicine at Aga Khan University, and pursued a Fellowship in Nephrology at the University of Toronto, Canada. He is a Fellow of the American Society of Nephrology, Fellow of the international Society of Nephrology and also a fellow of the Royal College of Physicians Edinburgh. His professional interests include Interventional Nephrology and Critical Care Nephrology. He is a member of the International Society of Nephrology's Interventional Nephrology Working Group and the American Society of Diagnostic and Interventional Nephrology.



John Gikonyo

President, Renal Patients Society of Kenya (RPSKe)
Vice-Chair, NCD Alliance of Kenya

NCD Lived experience:	Living with Hypertension, Kidney Transplant
Education Background:	BA Degree Egerton University (1993)
Professional background:	Sales & Marketing; Business Management
Family:	Born in Kangema, Murang'a County, Kenya Father to Michelle & Leon

Experience:

- Lived with Hypertension since 2006
- Lived with Chronic kidney Disease since 2009. Transplanted 2015.
- Founded RPSKe in 2017
- Joined NCD Alliance of Kenya (NCDAK) in 2018
- Team leader, Caucus of Patients Led organizations and PLWNCDs under NCDAK
- Participated in & Coordinated successful NCD Global Week for Action activities 2019-2024
- Co-Chair, Ministry of Health Renal Technical Working Group (TWG)
- Member, Kenya Blood Transfusion and Transplant Service (KBTTs) Technical Working Group on Diseased Organ Donation
- Member. African NCDs Network Advisory Board
- Member, Africa Medicines Agency Treaty Alliance (AMATA) Steering Committee
- Member, Global Patients Alliance for Kidney Health (GloPAKH) Steering Committee
- Passionate about UHC and Meaningful Involvement of Persons Living with NCDs in all matters that affect them.



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Leah Ndirangu

Leah Ndirangu is a Nephrology Nurse working as a Transplant Coordinator at The Nairobi Hospital with over 15 years of experience in nephrology nursing, specializing in kidney transplantation and clinical preceptorship. She is also a part-time lecturer at The Nairobi Hospital College of Health Sciences.

She holds a Bachelor of Science in Nursing from the University of Nairobi and has completed specialized training in Organ Donation and Transplantation through the University of Barcelona. Her professional interests focus on advancing both living and deceased organ transplantation. Through her clinical practice, teaching, and advocacy, Leah is committed to improving kidney care and inspiring excellence among healthcare professionals and patients.



Lundu Philip

Member of Nutrition Academy of Kenya and Nutrition association of Kenya. Registered and licensed by Kenya nutrition and dietetics institute with 12+ years' experience in clinical set up.

He is passionate about Diabetes reversal, weight loss program, corporate wellness. Philip is a certified critical care nutritionist with Diploma in Community Nutrition from Kenya medical training college and a Bachelor Degree in Science (Foods, Nutrition and Dietetics), from Kenya Methodist university. Post Graduate Diploma in Paediatric Nutrition (Boston University). He is a founder and patron of Fanikisha; a Community-Based organization that deals with primary prevention of obesity and diabetes.

Author; Prediabetes and type 2 diabetes remission programme.

Author; The impact of patient flow and associated factors on nutrition assessments and intervention among People living with HIV.

He like trying new recipe and traveling.



Dr Lisaane Seif

Consultant Nephrologist
Ass. Professor
Addis Ababa university
Black Lion Hospital.
President, Ethiopian kidney Association
NCD Task.force Minster of Health
ISN CARE - NEPH Country Lead
AFRAN Transplant Committee , member

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Dapagliflozin



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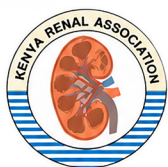
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3 Oral Presentations • 19 Poster Presentations • 22 Abstracts Total



A Global Evaluation of Public Education Frameworks on Organ Donation

Authors: Dr Wang'ombe N.N, Maina D.M & Omondi E.A

Department of Nursing Sciences, Faculty of Health Sciences, University of Nairobi

Background

Public Education Framework (PEF) on organ donation increases public awareness, addresses myths and misconceptions, and normalises donation conversation to meet transplantation needs. Mismatch between organ supply and demand is attributed to increase in End Stage Organ Failure (ESOF), a complication of Non-communicable diseases (NCD), Cardiovascular diseases (CVD), Cancers and Chronic Obstructive Diseases (COPD). Kenya lacks a PEF, and its development requires benchmarking with best-performing countries on the Global Observatory for Donation and Transplantation (GODT).

Research Objective

Analysing various public education frameworks on organ donation globally.

Methodology:

TDesk review adapting the Johnston-Webber et al. Conceptual Framework for Evaluating National Organ Donation and Transplantation Programs (Enabling elements). Twelve (12) countries were reviewed: ten with the highest number of deceased donors (DD) PMP of 90 countries in GODT 2024, plus an African and an Asian country.

Results:

Top ten (10) countries with highest donation rates: Spain (53.6), USA (49.6), Portugal (36.7), Czech (34.3), Belgium (32.6), Italy (30.6), Croatia (30.3), Finland (28.6), France (28.6) and Lithuania (24.8). Africa was represented by South Africa (1.4), the only country with an active DD program, and Asia by India (0.8), a lower-middle-income country like Kenya. Enabling elements identified included government and political support through funded National Donation & Transplant organisations, healthcare budgets averaging 10.1% of GDP, and donation legislation (58.3% presumed/opt-out, 41.7% informed/opt-in consent). Public education on organ donation is segmented by age: 5–11 years introduces a cartoon character ("Orgamites"); 9–14 years covers anatomy and brain-death concepts, solidarity and altruism; 15–18 years uses personal storytelling and myth-clearing; 18–25 years has a university donation education curriculum; and the 65+ general population receives family-discussion guidance, rumour-dispelling, and cultural/religious misconception education alongside end-of-life conversation.

Methodology:

The analysis of public education frameworks on organ donation identified long-term commitment, political support, funding, legislation and public support as the enabling elements for organ donation.



Acute Peritoneal Dialysis Adequacy among Children at a National Referral Hospital in Kenya: A Cross-Sectional Study in a Resource-Limited Setting

Authors: Doreen Nganga, Bashir Admani, Dalton Wamalwa, Cyriaque Mbarubukeye
Faculty of Health Sciences, University of Nairobi, Nairobi, Kenya

Background:

Acute peritoneal dialysis (PD) is an important renal replacement therapy for children with acute kidney injury (AKI), particularly in resource-limited settings. Inadequate PD may result in persistent uremia, prolonged hospitalization, increased mortality, and transition to hemodialysis. Dialysis adequacy is commonly assessed using urea and creatinine clearance, which are influenced by prescription parameters such as fill volume, dwell time, and dialysate dextrose concentration. However, there is limited data on target clearance values for children undergoing acute PD. This study aimed to assess PD adequacy and describe urea and creatinine clearance among children receiving acute PD at a national referral hospital in Kenya.

Methods:

A cross-sectional study was conducted at Kenyatta National Hospital, a teaching and referral hospital in Nairobi, Kenya. We enrolled children who were starting PD over a period of 5 months in the paediatric renal unit. Records of total drain volumes and serum and effluent concentrations of electrolytes, urea, and creatinine before and after 24 hours of dialysis were obtained via questionnaires. Daily urea and creatinine clearance were calculated for each child. A paired t-test was used to compare mean serum urea and creatinine concentrations before and 24 hours after dialysis, as measurements were obtained from the same participants

and were approximately normally distributed. Descriptive analysis was used to compare solute clearance between groups of dialysate dextrose concentrations.

Result:

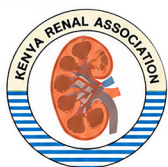
64 children were enrolled at a median age of 18 days, and 43% were female. The median daily creatinine clearance was 5.13 L/day/1.73m², and the median daily urea clearance was 1.03. There was a statistically significant reduction in mean serum urea and creatinine after the first day of dialysis. Sick neonates were at a higher risk of developing AKI than infants and older children.

Conclusion:

Peritoneal dialysis achieved measurable clearance of urea and creatinine among patients admitted to the paediatric renal unit at Kenyatta National Hospital.

Keywords:

peritoneal dialysis, urea clearance, creatinine clearance, acute kidney injury



Navigating Poverty and Dialysis: Delayed Hemodialysis Initiation in a Patient with End-Stage Kidney Disease in Somalia

Authors: Dr. Amir Muse Mohamud

Background:

Access to kidney health services remains a major challenge in low-resource settings, where patients with end-stage kidney disease (ESKD) frequently encounter barriers related to affordability, limited dialysis infrastructure, and delayed referral systems. In Somalia, dialysis is largely financed through out-of-pocket payments, making life-saving treatment inaccessible for many patients. This case highlights the clinical and socioeconomic challenges affecting equitable access to dialysis services.

Case Presentation:

A 40-year-old man with hypertension presented to a private hospital in Mogadishu with vomiting, fatigue, poor appetite, and progressive edema. Laboratory investigations revealed severe kidney failure with creatinine 38.5 mg/dL, urea 240 mg/dL, and hemoglobin 3.8 g/dL. Although urgent hemodialysis and blood transfusion were advised, the patient declined treatment because of financial hardship and initially prepared for end-of-life care. Through advocacy and financial assistance from coworkers and medical peers, he eventually underwent intermittent hemodialysis and transfusions. However, repeated interruptions in care occurred because of inability to sustain treatment costs and limited dialysis capacity.

Discussion:

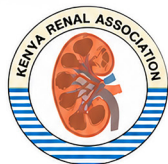
This case illustrates how poverty, inadequate health financing, and limited dialysis availability contribute to delayed initiation and discontinuation of renal replacement therapy in sub-Saharan Africa. Informal social support networks temporarily bridged critical gaps in care, but reliance on such mechanisms is unsustainable. The case also demonstrates the need for stronger referral pathways, affordable dialysis programs, psychosocial support, and public awareness initiatives to improve engagement with kidney care services.

Conclusion:

Improving access to kidney health services in low-income settings requires government-supported dialysis financing, expansion of dialysis infrastructure, and integration of kidney disease into national non-communicable disease strategies. Public-private partnerships and community-based advocacy may help reduce preventable deaths related to untreated ESKD.

Keywords:

End-stage kidney disease, dialysis access, health equity, Somalia, hemodialysis, kidney health services



Lobito Hemodialysis Clinic: The 8-Year Experience (2017–2025) of Success in Southern Angola

Authors: Gilsemar Edilásio Chango de Boavida (Nephrologist, Clinical Director, Lobito Hemodialysis Clinic – Angolan Kidney Institute), Laurinda Paulo (Head Nurse, Lobito Hemodialysis Clinic – Angolan Kidney Institute), José Diogo Barata (Nephrologist, Pluribus II International - Angolan Kidney Institute (IAR), Lobito, Angola)

Background:

Chronic Kidney Disease (CKD) places great pressure on public health and has been increasing worldwide, currently affecting millions of people. In Angola, the progressive increase in CKD prevalence, associated with the structural challenges of the health system, drove the creation of the Angolan Kidney Institute (IAR) in 2012, with the aim of expanding access to specialized nephrological care and dialysis therapies. In this context, the Lobito Hemodialysis Clinic (CHL) emerged, becoming a regional reference for the care of renal patients in southern Angola. The objective of this work is to describe the main care, clinical and quality indicators of the Lobito Hemodialysis Clinic from 2017 to 2025, evidencing its contribution to nephrological care and the training of specialized human resources.

Methods:

This is a retrospective descriptive study based on analysis of the computer records of the Lobito Hemodialysis Clinic between January 2017 and December 2025. Evaluated parameters included the number of patients treated, hemodialysis sessions performed, age profile, type of vascular access, main causes of CKD, mean hemoglobin, dialysis adequacy (Kt/V), recovery of renal function in patients admitted with Acute Kidney Injury (AKI), mortality, and complementary services provided by the institution.

Results:

During the period analyzed, 1,953 patients were treated, corresponding to a monthly average of 217 patients. 141,233 hemodialysis sessions

were performed, with an annual average of 15,692 sessions. A predominance of the 18–44 year age group was observed, with a progressive reduction in the average age of patients over the years, from 52.9 to 40.5 years. More than 70% of patients used arteriovenous fistula, the access of choice for chronic hemodialysis. Hypertensive nephropathy was the main cause of CKD. Average hemoglobin was 10.6 g/dl, reflecting adequate anemia control. Dialysis adequacy showed an average Kt/V of 1.29, compatible with internationally recommended standards. Among patients admitted with AKI, recovery of renal function increased progressively over the years, reaching 45% of cases. Annual mortality in CKD was consistently below 10%, appropriate for international results in equivalent age groups. CHL also offers integrated multidisciplinary assistance, including nephrology consultations, psychology, nutrition, social assistance, clinical analysis, permanent medical follow-up and drug support.

Conclusion:

In eight years of activity (2017–2025), the Lobito Hemodialysis Clinic has consolidated itself as a reference center in nephrology and hemodialysis in southern Angola, demonstrating high productivity and consistent quality indicators, a positive impact on the management of CKD in the region, and a relevant contribution to specialized training in hemodialysis.

Keywords:

hemodialysis, CKD, Angola, quality indicators



Improving Access to Kidney Health Services among Patients on Maintenance Haemodialysis: Key Contributors of Missed Haemodialysis from a Renal Unit in Kenya

Authors: Njaramba Caroline (Registered Renal Nurse, KUTRRH), Edward Njogu (Consultant Nephrologist, KUTRRH), Joseph Waithanji (Clinical Nurse Specialist, KUTRRH)
Renal Unit, Kenyatta University Teaching, Referral and Research Hospital (KUTRRH), Kenya

Background:

Patients on maintenance haemodialysis due to End Stage Kidney Disease (ESRD) require regular planned dialysis treatment. Missed haemodialysis treatment is associated with poor health and outcomes. This study shares findings from a single-centre review at Kenyatta University Teaching, Referral and Research Hospital (KUTRRH), a 650-bed national referral facility in Nairobi that launched its dialysis programme in November 2019.

Objective:

To determine the rate of, and factors contributing to, missed maintenance HD sessions at KUTRRH.

Methodology:

A retrospective review was conducted over a six-month period, January to June 2026, involving outpatients on maintenance haemodialysis at the KUTRRH renal unit, drawing de-identified data from patient files. Inpatients receiving dialysis during this period were excluded.

Results:

Of 75 patients on a twice-weekly dialysis schedule, 64 (16.6%) missed sessions were recorded overall across the months, with monthly rates of: January 14 (21.8%), February 9 (14.0%), March 7 (10.9%), April 6 (9.3%), May 15 (23%) and June 13 (20.3%). The leading causes of missed dialysis were high transportation costs (31.25%), adverse weather during the rainy season (23.43%), political instability in May and June (15.6%), job commitments (18.7%), health insurance noncompliance (4.6%), transfers to other facilities (4.6%), and religious holidays (1.5%). Eleven patients were hospitalized during the review period, largely related to missed dialysis and worsening illness.

Conclusion:

Compliance with haemodialysis is required to enhance dialysis adequacy and improve outcomes. Health education is key to reducing missed dialysis and avoiding its complications. Nurses should act as patient advocates in the management of missed dialysis, and government intervention — particularly during protests — is needed to ensure that restrictions on movement do not affect patients on dialysis.

Keywords:

haemodialysis, missed dialysis sessions, end-stage kidney disease, kidney health access



Kidney Replacement Therapy in Profound Hyponatremia: A Case Report and Review of Practical Strategies in a Resource-Limited Setting

Authors: Ibsen Ongidi, Emmanuel Kiplagat, Nelson Sang, Cyrus Mwanzia, Mercy Kosgei, Alonzo Mongare, Brenda Chelangat, Nathan Anjichi, Bethlehem Admassu

Background:

Severe hyponatremia in patients requiring kidney replacement therapy presents a therapeutic challenge. Rapid correction during hemodialysis may cause osmotic demyelination, while delaying dialysis in patients with refractory volume overload, acidosis, hyperkalemia or uremic complications may not be feasible. This challenge is particularly relevant in resource-limited settings where continuous kidney replacement therapy, customized dialysate and frequent biochemical monitoring may be unavailable..

Case:

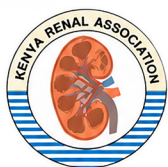
We report the case of a 35-year-old woman with advanced kidney disease, severe hypertension and suspected SLE who presented with generalized edema, oliguria, severe renal dysfunction, hyperkalemia, metabolic acidosis and profound symptomatic hyponatremia (serum sodium 103 mmol/L). Her clinical picture was consistent with hypervolemic hyponatremia in advanced kidney failure, with persistent fluid retention despite high-dose intravenous loop diuretics and metolazone. Sodium remained critically low, reaching approximately 106 mmol/L despite fluid restriction and repeated hypertonic saline administration. Dialysis was initially deferred because of concern for overly rapid sodium correction. As anuria, metabolic derangements and fluid overload progressed, she subsequently developed pulmonary edema and severe hypoxemic respiratory failure requiring emergency hemodialysis, intubation and mechanical ventilation. The dialysis session was complicated by hemodynamic instability requiring resuscitation.

Literature Review:

Current guidance emphasizes limiting correction of chronic profound hyponatremia to approximately 8–10 mmol/L in 24 hours. However, urgent indications for kidney replacement therapy may not necessarily be deferred due to severe chronic hyponatremia. Reported hemodialysis strategies include low-efficiency hemodialysis, reduced blood-flow rates, low-sodium dialysate, isolated ultrafiltration, SLED and CKRT using customized replacement or dialysate solutions. CKRT offers particularly precise control of sodium and fluid removal but may be unavailable in resource-constrained environments.

Conclusion:

Severe hyponatremia is a dialysis-prescription challenge in kidney failure patients. Early multidisciplinary planning, strict sodium correction monitoring and locally feasible modified dialysis protocols may reduce the risk of osmotic demyelination in this category of patients, enabling dialysis in those with urgent indications.



Persistent Left Superior Vena Cava: Implications for Central Venous Catheterization

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Introduction:

Persistent left superior vena cava (PLSVC) is the most common congenital thoracic venous anomaly, occurring in 0.3–0.6% of the population. It is usually discovered incidentally but may complicate central venous catheterization, particularly when reliable vascular access is required.

Case Summary:

A 69-year-old woman with ESRD on haemodialysis, COPD, HFpEF (EF 60%) and pulmonary hypertension (RVSP 50 mmHg) was admitted with prolonged critical illness requiring mechanical ventilation and tracheostomy. Imaging incidentally demonstrated a PLSVC. A temporary haemodialysis catheter was inserted via the left-sided neck venous system, followed the expected course of the PLSVC, and was successfully used without complications or evidence of catheter dysfunction. Following clinical stabilisation, the temporary catheter was exchanged for a tunneled right-sided permanent haemodialysis catheter.

Key Anatomy:

PLSVC runs along the left mediastinum, anterior to the aortic arch, and usually drains into the coronary sinus (CS) in 80–90% of cases (seen as a dilated CS on imaging). It often co-exists with a normal right SVC (80–90%), and less commonly drains directly into the left atrium.

Recognition:

A central venous catheter placed from the left side that crosses the midline and descends vertically, with the catheter tip projecting along the left heart border, produces the “double SVC sign” on an AP chest X-ray. Diagnosis is confirmed with echocardiography, CT or a contrast study.

Potential Complications:

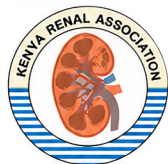
Arrhythmias, coronary sinus dissection or perforation, inability to advance the catheter or leads, catheter malposition, misinterpretation of imaging or line position, thromboembolism, and dilated coronary sinus.

Conclusion:

PLSVC is an important anatomical variant that should be recognized in patients requiring central venous access. An unusual left-sided catheter course should prompt consideration of PLSVC rather than presumed malposition. In this case, recognition of the anomaly allowed successful temporary haemodialysis access without complications, followed by definitive right-sided access.

Key Message:

Recognising PLSVC and confirming catheter position can prevent unnecessary catheter removal and facilitate safe, effective vascular access in patients with kidney disease.



Health Related Quality of Life in Kidney Transplant Recipients: Using WHOQOL-BREF and KDQOL-36 Questionnaires – A Single Centre Study

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Background:

Kidney transplantation is associated with improved quality of life (QoL). Health related QoL (HRQoL) is the impact that one's health has on QoL. Several factors in the post-transplant period may influence it. KDQOL-36 assesses HRQoL in kidney disease while WHOQOL-BREF assesses one's QoL.

Aim:

The primary aim was to determine the HRQoL of recipients and factors that impact it. The secondary aim was to determine the agreeability of the KDQOL-36 and WHOQOL-BREF questionnaires.

Methods:

A descriptive cross-sectional study was carried out at Kenyatta National Hospital from May–September 2022. Recruitment was done at the regular outpatient transplant clinic. All recipients with a functioning graft transplanted more than 3 months prior to recruitment were included. Medical records were retrieved for clinical and laboratory characteristics. Acute graft dysfunction was defined as a rise in baseline creatinine of >25%. Glomerular filtration rate (GFR) was calculated using the CKD-EPI formula. An average blood pressure reading of three consecutive visits was recorded.

Results:

Seventy-three participants were recruited; 75% were male with a mean age of 46.6 (SD 14.4); 65% resided in an urban setup and 42% had tertiary-level education. Highest scores were

in the psychological (75.4±8.9), environmental (76.9±13.9) and social (87.5±13.8) domains. Males had higher physical health scores than females (65.9±7.1 vs 58.9±10.3, $p=0.002$), while urban residents had higher environmental scores (79.5±14.2 vs 71.8±12.0, $p=0.025$). Blood pressure <130/80 mmHg was associated with higher social and environmental scores. Hemoglobin >12 g/dl was associated with higher physical and psychological scores. GFR>45 ml/min was associated with higher physical, psychological, and environmental scores. Acute graft dysfunction was associated with lower physical, psychological, and environmental domain scores. Length of time post-transplantation was not associated with higher scores; however, participants with a shorter hemodialysis period (<2 years) prior to transplantation had higher physical health scores. KDQOL-36 and WHOQOL-BREF correlated poorly in the physical and social domains, with a moderate correlation in the psychological domain; there was no domain in KDQOL-36 comparable to the environmental domain.

Conclusion:

Transplant recipients have high QoL and HRQoL. Factors that positively impact it include male gender, urban residency, well-controlled blood pressure, and higher GFR and hemoglobin levels. Presence of acute graft dysfunction has a negative effect. The KDQOL-36 and WHOQOL-BREF questionnaires correlate poorly and should be used separately.



Bridging the Gap: Rethinking Education and Mentorship Frameworks for the Next Generation of Kidney Health Professionals

Authors: Kennedy Gacaga Mbui (Clinical Officer – Nephrology)

Background:

The growing burden of chronic kidney disease (CKD) demands a workforce that extends far beyond traditional nephrology. Yet training pipelines remain siloed, mentorship is informal and inequitably distributed, and interdisciplinary competencies — spanning primary care, dietetics, pharmacy, social work, and patient advocacy — are rarely embedded in structured curricula. This abstract presents a framework for transforming kidney health education into a multidisciplinary, mentorship-driven, and equity-centred enterprise.

Objectives:

To (1) identify gaps in current kidney health educational pathways across disciplines, (2) propose evidence-informed mentorship models that support early-career professionals from underrepresented backgrounds, and (3) outline actionable curriculum innovations that align with the multidisciplinary demands of modern CKD care.

Methods:

A mixed-methods approach was employed, combining a scoping review of published kidney health education programmes (2015–2025) with structured interviews of 42 trainees and early-career clinicians across nephrology, primary care, nursing, and allied health. Thematic analysis identified recurring barriers and enablers to mentorship access and interdisciplinary training. Programme evaluations from three pilot interprofessional kidney health curricula were also analysed.

Results:

Fewer than 30% of surveyed trainees reported access to a formal mentor in kidney health, with women and trainees from minority ethnic groups disproportionately underserved. Scoping review findings revealed that only 18% of identified curricula included dedicated modules on CKD prevention or patient-centred communication. Pilot programmes integrating case-based interprofessional learning and peer mentorship networks demonstrated significant improvements in trainee confidence ($p < 0.01$), interdisciplinary knowledge, and intention to pursue kidney health careers. Key enablers included protected time for mentorship, structured onboarding to mentorship relationships, and exposure to lived-experience educators — patients and caregivers — as co-teachers.

Conclusion:

Transforming kidney health education requires dismantling disciplinary silos and institutionalising mentorship as a core professional responsibility rather than a privilege. Embedding interprofessional training, structured mentorship pathways, and patient-led teaching into kidney health curricula can build a resilient, equitable workforce equipped to address CKD beyond the clinic. Recommendations for conference-endorsed education standards and a national mentorship registry are proposed for discussion.

Keywords:

chronic kidney disease, medical education, mentorship, interprofessional training, workforce development, health equity, curriculum innovation, allied health



A Fatal Case of Renal Amyloidosis with Cardiorenal Syndrome Masquerading as Lupus Nephritis

Authors: Dr. Penina Machoka (Senior Registrar, ECSACOP, KUTRRH); Supervisor: Dr. Caroline Gituku (Consultant Nephrologist, KUTRRH) Kenyatta University Teaching, Referral and Research Hospital (KUTRRH)

Background:

A 46-year-old female was referred from a rheumatology clinic with a provisional diagnosis of newly diagnosed SLE / lupus nephritis / peripheral neuropathy. She presented with a 1-month history of generalised body swelling (including facial swelling), body aches, periorbital darkening, and exertional dyspnoea, on a background of a 3-year history of bilateral lower-limb swelling treated at multiple facilities without improvement. There was no gross haematuria, fever, oral ulcers, photosensitivity, or Raynaud's phenomenon. On examination she was hypotensive (BP 90/61 mmHg) and tachycardic (HR 108 bpm), with bilateral pitting oedema to mid-thigh and periorbital darkening; cardiorespiratory and abdominal examination were otherwise unremarkable, and rheumatology review found no rash, alopecia, oral ulcers or active synovitis.

Case Course:

Initial serology showed a high ANA (45.32) and high anti-dsDNA (286), and the patient was started on empiric prednisolone 20 mg and hydroxychloroquine 200 mg for presumed SLE nephritis. However, on rheumatology review she did not meet clinical SLE criteria, and repeat ANA, anti-dsDNA, ENA, C3 and C4 normalised, excluding SLE. Urine albumin-creatinine ratio was markedly elevated (113.1) with a normal renal ultrasound. Echocardiography demonstrated concentric biventricular hypertrophy with apical sparing, raising suspicion for amyloidosis; this prompted an image-guided renal biopsy. Congo red staining of the biopsy was positive, with apple-green birefringence under polarised light confirming amyloid deposition (sclerosis 2.7%, mild IFTA); immunofluorescence showed a non-restricted pattern (IgM, kappa and lambda all

positive; IgG, IgA, C3 and C1q negative). Cardiac evaluation was discordant: echocardiography (repeated) remained suggestive of infiltrative disease (moderate concentric biventricular hypertrophy, preserved LVEF 60%, small pericardial effusion, mild apical sparing, borderline biatrial dilatation, small bilateral pleural effusions, mild pulmonary hypertension), but cardiac MRI and DPD/PYP bone scintigraphy were both negative for amyloid infiltration. Serum protein electrophoresis and serum free light chains were unremarkable, arguing against AL amyloidosis, but definitive typing by mass spectrometry was never performed, so the amyloid subtype remained unclassified — AL was considered unlikely given normal SPEP/SFLC, while AA and hereditary forms were never excluded.

Management and Outcome:

Initial empiric management (pre-biopsy) included prednisolone, hydroxychloroquine, enalapril, furosemide, enoxaparin thromboprophylaxis, and pregabalin for neuropathic symptoms. Post-diagnosis, haematology work-up was unremarkable with no clone-directed therapy indicated, and management shifted to diuretic escalation (furosemide, eplerenone, empagliflozin, metolazone) under nephrology follow-up. Despite this, the patient had persistent oedema, back pain and dyspnoea on minimal exertion, progressing to refractory generalised swelling, facial puffiness and abdominal distension requiring admission for IV diuresis, with haemodialysis/haemofiltration considered. She subsequently deteriorated with acute decompensated heart failure, fluid overload, oliguria and haemodynamic compromise, and succumbed before any disease-specific therapy for amyloidosis could be initiated.



A Fatal Case of Renal Amyloidosis with Cardiorenal Syndrome Masquerading as Lupus Nephritis

Authors: Dr. Penina Machoka (Senior Registrar, ECSACOP, KUTRRH); Supervisor: Dr. Caroline Gituku (Consultant Nephrologist, KUTRRH) Kenyatta University Teaching, Referral and Research Hospital (KUTRRH)

Conclusion / Learning Points:

This case illustrates several diagnostic pitfalls in renal amyloidosis masquerading as lupus nephritis: positive autoantibodies do not equal lupus nephritis, and biopsy remains essential when clinical SLE criteria are not met; a normal renal ultrasound does not exclude amyloidosis; echocardiographic and cardiac MRI findings for suspected cardiac amyloid can be discordant, and no single imaging modality is definitive; amyloid typing was incomplete, as mass-spectrometry typing on biopsy tissue was never performed; and the therapeutic window in amyloidosis is narrow — fatal cardiorenal decompensation occurred before disease-specific therapy could start, underscoring the time-critical importance of early typing and treatment, alongside systems-level factors such as inpatient bed availability.



Lupus in the Lungs: A Challenging Case of Pulmonary-Renal Syndrome

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Department of Internal Medicine, Moi University, Eldoret

Introduction:

Pulmonary-renal syndrome (PRS) is a medical emergency requiring prompt recognition and multidisciplinary management. Distinguishing autoimmune etiology from severe multisystem infection remains particularly difficult in resource-limited settings, often delaying definitive therapy.

Aim:

To highlight the diagnostic and therapeutic challenges encountered when PRS presents with overlapping infectious and autoimmune symptomatology.

Case Summary:

A 27-year-old previously well female presented with a three-week history of productive cough, recurrent hemoptysis, progressive dyspnea, oliguria, lower limb edema, fevers and chills. On initial assessment she was profoundly hypoxemic (SpO₂ <60% on room air) with diffuse bilateral crepitations but oriented. Investigations revealed microscopic hematuria, severe hyperkalemia (7.49 mmol/L), metabolic acidosis, and acute kidney injury (creatinine 1247 µmol/L), prompting rescue hemodialysis and emergency hyperkalemia management. CT pulmonary angiography excluded pulmonary embolism but demonstrated bilateral ground-glass opacities and consolidation, raising suspicion for atypical pneumonia and diffuse alveolar hemorrhage. Post-dialysis, she remained on oxygen therapy, empiric antibiotics, and pulse methylprednisolone for suspected autoimmune PRS. During a 53-day admission, her course was complicated by steroid-induced hyperglycemia and psychosis, severe anemia

requiring transfusion, and a catheter-related right atrial thrombus requiring anticoagulation, which delayed renal biopsy. Extensive infectious investigations were negative. Autoimmune testing revealed strongly positive ANA (1:640) and extractable nuclear antibodies, with negative ANCA, supporting immune complex-mediated rapidly progressive glomerulonephritis. A diagnosis of lupus was eventually made using the 2012 SLICC criteria, though ANCA-negative vasculitis remained a differential. She was discharged on hydroxychloroquine, low-dose prednisolone, warfarin, maintenance dialysis, and planned outpatient cyclophosphamide, with renal biopsy deferred.

Discussion and Conclusion:

This case illustrates the diagnostic complexity of PRS, where autoimmune disease closely mimicked severe infection and diagnostic certainty was deferred by biopsy deferrals. It underscores the importance of early multidisciplinary care, balancing immunosuppression against diagnostic uncertainty, anticipating treatment-related complications, and individualizing decisions regarding biopsy timing, fertility preservation, and renal recovery.

Keywords:

Pulmonary-renal syndrome, Rapidly progressing glomerulonephritis



Beyond Dialysis Provision: Strengthening Infection Prevention and Control Systems to Improve Quality and Sustainability of Kidney Health Services at KUTRRH

Authors: Lucy Walegwa
Kenyatta University Teaching, Referral and Research Hospital (KUTRRH)

Introduction:

Hemodialysis units are high-risk healthcare environments for healthcare-associated infections (HAIs) due to repeated vascular access procedures, frequent patient turnover, close patient–healthcare worker interactions, and the generation of hazardous healthcare waste. Inadequate waste segregation, improper disposal practices, and suboptimal environmental hygiene may increase the risk of cross-contamination, occupational exposure, and infection transmission among patients and healthcare workers. Strengthening infection prevention and control (IPC) systems is therefore essential to ensure safe, sustainable, and high-quality kidney health services.

Aim:

This quality improvement project aimed to evaluate the role of effective waste management and environmental hygiene practices as core components of IPC in the KUTRRH Dialysis Unit between January 2025 and March 2026.

Methods:

A quality improvement project utilizing the Plan–Do–Study–Act (PDSA) cycle methodology was conducted in the KUTRRH Dialysis Unit. Interventions included strengthening waste segregation at the point of generation through colour-coded waste bins, improving safe disposal of sharps and contaminated dialysis materials, and implementing standardized environmental cleaning and disinfection protocols. Additional strategies included staff training, supportive

supervision, routine IPC audits, and monthly audit-feedback meetings. Data were collected using standardized IPC audit checklists and analyzed descriptively, comparing frequencies and percentages between baseline and post-intervention assessments.

Results:

Following implementation of the interventions, compliance with appropriate waste segregation practices improved from 62% at baseline to 91%. Correct disposal of sharps and contaminated dialysis waste increased from 70% to 95%, while environmental cleaning compliance improved from 65% to 93%. Occupational exposure incidents decreased from six reported cases at baseline to one post-intervention incident. Continuous training and supervisory support contributed to improved staff adherence to IPC standards.

Conclusion:

Strengthening waste management and environmental hygiene practices significantly improved IPC compliance within the KUTRRH Dialysis Unit and reduced occupational exposure risks. The interventions were practical, cost-effective, and sustainable, demonstrating potential for replication in other high-risk healthcare environments. Integrating robust IPC systems into dialysis services is essential for improving patient safety, protecting healthcare workers, and sustaining quality kidney health services.



A Dialysis Toolkit for Ebola Virus Disease-Associated Acute Kidney Injury

Authors: Dr. Mohamed Maalim

Abstract:

Ebola virus disease (EVD), a high-fatality hemorrhagic fever endemic to Central and West Africa, frequently presents with multiorgan dysfunction, including acute kidney injury (AKI). The management of AKI in EVD presents unique challenges owing to the infection's highly contagious nature, the need for critical care in low-resource environments, and the logistics of providing kidney replacement therapy (KRT) in high-biohazard settings. This manuscript outlines a "dialysis toolkit" to guide clinicians managing AKI in EVD, covering infection control protocols, preferred KRT modalities, anticoagulation strategies, effluent disposal, and machine handling. Based on existing literature and biosafety guidance, this toolkit is intended for nephrologists, intensivists, ICU nurses, dialysis nurses, infection-prevention teams, and biomedical staff, aiming to balance optimal nephrological care with maximal protection for healthcare workers across both resource-rich and austere outbreak settings.

Core Components and Clinical Considerations:

The core concept of dialysis in EVD is strict adherence to biosafety protocols: dialysis personnel should observe universal precautions and wear full PPE (impermeable gowns, double gloves, face shields, N95/PAPRs, protective footwear), with isolated dialysis facilities or negative-pressure isolation tents preferred to prevent aerosol spread. CKRT is the modality of choice for hemodynamically unstable patients, offering enclosed systems that reduce the risk of circuit breaches, with closed-loop devices favourable in full-PPE environments; it should be initiated early in oligo-anuric patients with volume overload, electrolyte abnormalities

or uremic symptoms, prescribed to achieve a delivered effluent dose of 20–25 mL/kg/hour per KDIGO recommendations. Where CKRT is unavailable, prolonged intermittent kidney replacement therapy (PIKRT) offers an alternative with improved hemodynamic tolerance and reduced circuit manipulation compared with conventional IHD. Vascular access carries the highest exposure risk and should be established under real-time ultrasound guidance by an experienced, IPC-trained provider, preferably via the right internal jugular or femoral vein, with closed needle-free connector caps used to reduce blood exposure. All dialysis effluent must be treated as Category A infectious waste, contained in puncture-proof sealed biowaste bags, and never flushed into public drainage; dialysis machines should be physically isolated and disinfected with agents effective against enveloped viruses. Regional citrate anticoagulation is preferred where available for circuit patency without systemic bleeding risk, given the variable coagulopathy of EVD; anticoagulation-free protocols may be used cautiously in resource-limited settings. Team dynamics, pre-assigned roles, wireless communication, checklists and periodic audit of patient outcomes and healthcare worker exposures are essential to safe, sustained delivery.



A Dialysis Toolkit for Ebola Virus Disease-Associated Acute Kidney Injury

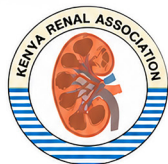
Authors: Dr. Mohamed Maalim

Conclusion:

Dialysis for patients with EVD requires strict compliance with clinical protocols, logistical readiness, and infection prevention measures. This toolkit compiles current research into a standardized and flexible method for managing EVD-related AKI. By focusing on CKRT, rigorous biosafety protocols, and safe anticoagulation and effluent management, patient outcomes can be enhanced while safeguarding dialysis staff from occupational risk. As healthcare systems globally face regular outbreaks of high-threat pathogens, incorporating specialized toolkits into epidemic preparedness strategies will be crucial for developing strong and adaptable kidney care policies.

Keywords:

Acute kidney injury, Ebola virus disease, Dialysis, Hemodialysis, Kidney replacement therapy, Peritoneal dialysis



Trajectories and Predictors of Chronic Kidney Disease Progression: A 5-Year Retrospective Cohort Study at a Tertiary Mission Hospital in Kenya (SEARCH-CKD Study)

Authors: Moses Osoo, Peter Nthumba, Mary Adam, Elijah Mbandi Mwasaru, George Otieno, George Muhua, Evelyn Mbugua - Department of Research, Kijabe Hospital; Strathmore Institute of Mathematical Sciences, Strathmore University; Department of Surgery, Kijabe Hospital; Department of Mathematics, University of Nairobi; Department of Renal, Kijabe Hospital

Background:

Chronic kidney disease in Kenya is often diagnosed late, with many patients presenting at advanced stages. There is limited longitudinal data on CKD progression, nephrotoxic drug exposure, and time to dialysis in Kenyan settings, yet this knowledge is crucial for Vision 2030 kidney disease targets and the Kenya Renal Association's focus on advancing kidney care.

Methods:

This retrospective cohort study (2020–2025) evaluated 604 adult CKD patients, following a progression-eligible cohort of 248 individuals who were not in ESRD at baseline. Longitudinal clinical data and eGFR (CKD-EPI 2021) were used to track stage transitions (G1–G5) and determine time-to-dialysis initiation. LASSO-Cox regression and Random Survival Forest (RSF) models were used to identify key predictors of progression, and Hidden Semi-Markov Modeling (HSMM) further characterized disease trajectories and estimated stage-specific sojourn times.

Results:

Among 604 CKD patients, the mean age was 60 ± 16 years and 61% were male. Hypertension and diabetes were present in 87% and 54% of patients, respectively, and 63.3% had both. In the progression cohort excluding baseline ESRD ($n=248$), 56.7% progressed by at least one CKD stage. Blood pressure was uncontrolled in 73.8%, and among diabetes cases with HbA1c readings, 53.6% had HbA1c >6.9 . Only 13.1% had

normal hemoglobin. Median time-to-dialysis was 5.9 years. LASSO-Cox identified obstructive uropathy and HIV nephropathy as predictors, while RSF highlighted age, sex, diabetes, hypertension, smoking, and alcohol use. HSMM showed rapid transition from G1 (11.7 days), with longer dwell times in G3a (136.8 days) and G5 (161.1 days).

Conclusion:

CKD progression in this cohort was rapid and shaped by multimorbidity, especially hypertension and diabetes. The short sojourn in G1 and longer dwell in G3a point to a critical window in intermediate stages for intervention to delay ESRD. Earlier screening and tighter control of blood pressure and glycemia are essential to improve outcomes.



Burden of Chronic Kidney Disease Risk Factors Identified Through a Nationwide World Kidney Day 2026 Screening Initiative in Kenya

Authors: Joseph Kabinga, Jonathan Wala, Elvis Odhiambo, Irene Mwonga

Background:

Chronic kidney disease (CKD) is a growing global public health concern associated with significant morbidity, mortality, and high healthcare costs. In sub-Saharan Africa, the increasing prevalence of hypertension, diabetes mellitus, obesity, and other cardiovascular risk factors is contributing to the rising burden of kidney disease. Early detection of CKD and its risk factors through community-based screening programs remains a key strategy for preventing disease progression and improving outcomes. In commemoration of World Kidney Day 2026, a nationwide screening campaign was conducted by the Kenya Renal Association to assess the prevalence of CKD risk factors and urinary abnormalities among the population in Kenya.

Methods:

A cross-sectional community-based screening exercise was conducted across participating healthcare facilities during World Kidney Day 2026. Individuals voluntarily presenting and consenting for screening were enrolled and underwent standardized assessment, including demographic characteristics, smoking history, family history of hypertension/diabetes/CKD, blood pressure, random blood sugar, known diabetes status, BMI, and urine dipstick analysis (proteinuria, hematuria, leukocyturia, glycosuria). Descriptive statistics summarized participant characteristics and screening abnormalities, and chi-square tests assessed associations between CKD risk factors, with statistical significance set at $p < 0.05$.

Results:

A total of 2,447 individuals were screened, of whom 60.9% were female. The mean age was 46.0 (± 16.1) years. Family history of hypertension, diabetes mellitus, and CKD was reported by 39.8%, 28.6%, and 9.3% of participants, respectively. Hypertension was identified in 24.4% of participants and diabetes in 11.3%; smoking history was reported by 5.1%. Nutritional assessment revealed 36% overweight and 24% obese. Urinalysis demonstrated proteinuria in 5.3%, hematuria in 5.5%, leukocyturia in 7.6%, and glycosuria in 5.0% of screened individuals. Abnormal screening findings were more prevalent among older participants and those with a personal or family history of hypertension, diabetes, or CKD, underscoring the clustering of risk factors within high-risk populations.

Conclusion:

The World Kidney Day 2026 screening initiative identified a substantial burden of modifiable and non-modifiable CKD risk factors among screened individuals. High rates of hypertension, diabetes, obesity, family history of chronic diseases, and urinary abnormalities suggest a significant proportion of the population may be at increased risk of developing CKD. These findings reinforce the need for sustained community-based screening programs, targeted risk stratification, public awareness campaigns, and integrated management of cardiovascular and kidney disease risk factors.

Keywords: *Chronic Kidney Disease, World Kidney Day, Screening, Hypertension, Diabetes Mellitus, Family History, Proteinuria, Obesity, Public Health, Kenya, Early Detection*



Yield, Severity Distribution, and Short-Term Estimated Glomerular Filtration Rate (eGFR) Persistence in Targeted Primary Care Screening for Chronic Kidney Disease in Kenya: 2025–2026

Authors: Stephen M. Mutiso, Gathecha G., Onyango E., Atandi D., Nzai J., Ruuri A., Kihoro P., Mutegi J., Otieno N., Kigwe M., Pohja-Hutchison P., Adam M. - Ministry of Health, Kenya; Kenya Conference of Catholic Bishops (KCCB); AstraZeneca-Kenya; Kenya Renal Association

Background:

Evidence on CKD case-finding yield and the reproducibility of eGFR in primary care settings in sub-Saharan Africa remains limited. This study evaluated screening yield, stage distribution, and eGFR persistence among high-risk adults across 35 primary and secondary care clinics in Kenya.

Methods:

From May 2025 to April 2026, a cross-sectional study within the Healthy Heart Africa Program enrolled adults with hypertension and/or type 2 diabetes who underwent dipstick urinalysis and serum creatinine testing to calculate eGFR using CKD-EPI 2021. Patients with an index eGFR <60 mL/min/1.73m² were offered repeat testing to assess short-term persistence, with KDIGO protocol adaptations including opportunistic follow-up intervals and semi-quantitative proteinuria.

Results:

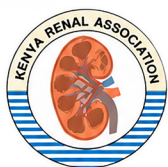
Among 11,023 patients with valid index eGFRs, 3,572 (32.4%) had an index eGFR <60 mL/min/1.73m², including 850 (7.7%) with eGFR <30 and 335 (3.0%) with eGFR <15 ; none had prior documented kidney disease. Positivity increased with age (14.5% in those <30 years vs. 46.4% in those ≥ 71 years). Repeat testing was completed in 539 patients (15.1%; median interval 92 days); eGFR reduction persisted in 347 (64.4%). Persistence correlated directly with severity: 47.8% for eGFR 45–59, 68.8% for 30–44, 81.6% for 15–29, and 97.9% for <15 mL/min/1.73m².

Conclusion:

Targeted point-of-care eGFR screening uncovers a high burden of unrecognized advanced CKD. Values <45 mL/min/1.73m² are highly reproducible, supporting immediate clinical action, whereas moderate decrements require confirmatory testing. High follow-up attrition (84.9%) indicates that scaling requires structured retention and referral pathways.

Keywords:

Chronic Kidney Disease, Hypertension, Type 2 Diabetes Mellitus, eGFR, Screening, Kenya



Ambulatory Blood Pressure Phenotypes among HIV-Positive and Negative Adults with CKD in Rural Uganda and Kenya: The SEARCH-CKD Study

Authors: Gordon Orori, Erick M. Wafula, Edwin D. Charlebois, Jane Kabami, Mucunguzi Atukunda, Debbie Adam, Matthew D. Hickey, Maya Petersen, Moses R. Kamya, Diane Havlir, Michelle M. Estrella, Chi-yuan Hsu, James Ayieko, Anthony N. Muir - Kenya Medical Research Institute, Nairobi; University of California, San Francisco; Infectious Diseases Research Collaboration, Kampala; University of California, Berkeley; Makerere University, Kampala

Background:

Ambulatory blood pressure monitoring (ABPM) can detect abnormal blood pressure (BP) phenotypes that are not captured by single-time-point BP measurements. These phenotypes are particularly important in populations with high burdens of HIV and CKD, where consequences of BP misclassification may lead to adverse outcomes.

Methods:

We conducted an ABPM sub-study among participants in a CKD screening study in rural Western Kenya (SEARCH-CKD). Participants underwent a single-point standardized BP measurement, followed by a 24-hour ABPM using the Oscar 2 ABPM system, which measured BP every 30 minutes. BP phenotypes were defined using 2025 ACC/AHA thresholds: white-coat hypertension, masked hypertension, and sustained hypertension. We compared ABPM phenotypes by HIV status using chi-square tests and used multivariable linear regression to assess associations of HIV infection with ambulatory systolic blood pressure.

Results:

Among 81 Kenyan participants with CKD at baseline in 2016–2017, 51 (63.0%) were living with HIV. In 2023–2024, 52 (64.2%) participants were traced and consented for ABPM studies, of whom 41 (78.8%) had valid ABPM studies. Mean 24-hour blood pressure (SD) was 128.2 (22.9)/73.6 (11.4) mmHg. The prevalence of white-coat, masked, and sustained hypertension was 12.2%, 24.4%, and 29.3% respectively, and did not differ significantly by HIV status ($p=0.68$). In multivariable analysis adjusted for age, sex, wealth, smoking, alcohol use, NSAID use, and traditional medicine use, HIV infection was associated with a -19.3 mmHg difference in mean 24-hour systolic blood pressure compared with HIV-negative status (95% CI -33.2 to -5.3 ; $p=0.01$).

Conclusion:

Abnormal BP phenotypes are highly prevalent in western Kenya among those with CKD, affecting 65.2% of such individuals. ABPM was feasible in this rural setting and identified clinically important blood pressure misclassification, including substantial white-coat and masked hypertension. Continued reliance on single-time-point BP measurements in this population would miss 1 in 4 individuals with masked hypertension and may lead to overtreatment in those with white-coat hypertension.



Mortality among Individuals with Chronic Kidney Disease (CKD) in Rural Kenya: The SEARCH-CKD Study

Authors: Erick M. Wafula, Anthony N. Muiro, Gordon Orori, Mucunguzi Atukunda, Jane Kabami, Edwin D. Charlebois, Debbie Adam, Matthew D. Hickey, Maya Petersen, Moses R. Kamya, Diane Havlir, Michelle M. Estrella, Chi-yuan Hsu, James Ayieko - University of California, San Francisco; Kenya Medical Research Institute, Nairobi; Infectious Diseases Research Collaboration, Kampala; Makerere University, Kampala; San Francisco VA Health Care System

Background:

Chronic kidney disease (CKD) is an increasingly important contributor to morbidity and premature mortality globally, yet longitudinal data examining the relationship between kidney function and mortality in rural African populations remain limited.

Methods:

We conducted a longitudinal cohort study nested within a cluster-randomized HIV test-and-treat trial (SEARCH, NCT01864603). Individuals from nine rural communities in Western Kenya were randomly sampled for CKD assessment in 2016–2017 and revisited in 2023–2025, when vital status was ascertained. Causes of death were determined using verbal autopsy interviews and classified per Global Burden of Disease Level 1 categories (communicable/maternal/neonatal/nutritional (CMNN), non-communicable diseases (NCDs), and injuries). Associations between baseline eGFR and all-cause mortality were evaluated using Gompertz interval-censored proportional hazards models adjusted for sociodemographic factors, community region, education, occupation, smoking, HIV status, diabetes, hypertension, and dipstick proteinuria.

Results:

Vital status was ascertained for 1,442 (97%) of 1,482 eligible participants, confirming 119 deaths. At baseline, 1,068 (72.1%) participants had eGFR ≥ 90 mL/min/1.73m², 355 (24.0%) had eGFR 60–89, and 59 (4.0%) had eGFR < 60 ; only 28 (1.9%) had dipstick proteinuria $\geq 1+$. Overall, 48.6% of participants were living with HIV, 1.9% had diabetes, and 14.1% had hypertension. Of the 119 deaths, 55 (46.2%) were attributed to NCDs, 31 (26.1%) to CMNN causes, 4 (3.4%) to injuries, and 29 (24.4%) had an unknown/undetermined cause. Compared with participants with eGFR ≥ 90 , having an eGFR < 60 mL/min/1.73m² was associated with more than a twofold increased risk of death (adjusted hazard ratio 2.22; 95% CI 1.07–4.60; $p=0.03$) — an effect size exceeding all other significant predictors of mortality in the study. Living in the Kisegi community was associated with a lower risk of death (aHR 0.24; 95% CI 0.07–0.81; $p=0.02$).

Conclusion:

NCDs were the leading cause of death in this rural Kenyan cohort. Baseline eGFR < 60 mL/min/1.73m² was independently associated with a more than twofold higher risk of subsequent mortality. These findings demonstrate the prognostic importance of reduced kidney function in rural Kenya and support integrating kidney function assessment into routine care to identify individuals at elevated risk of death.



Comparative Analysis of Acute Coronary Syndrome Outcomes in Patients With and Without Chronic Kidney Disease in a Kenyan Tertiary Hospital: A Retrospective Cohort Study

Authors: Dr Charlene Fernandes, Dr Mzee Ngunga, Dr Ahmed Sokwala, Dr Jasmit Shah
Department of Internal Medicine, Aga Khan University Hospital, Nairobi, Kenya

Background:

The prevalence of both Acute Coronary Syndrome (ACS) and Chronic Kidney Disease (CKD) is soaring in sub-Saharan Africa (SSA), with ACS in-hospital mortality rates as high as 17% in patients with elevated creatinine levels in Kenya. Various studies have independently associated elevated creatinine with mortality, and regional cardiology societies in SSA have recognised the need for more data on ACS to build a clearer understanding of disease presentation, management, and outcomes in the region.

Methods:

This retrospective study was carried out on eligible adult patients admitted with a diagnosis of ACS at The Aga Khan University, Nairobi (AKUHN) between January 2022 and September 2025. Patients were stratified based on the presence or absence of CKD. Primary outcomes were a comparison of in-hospital mortality and in-hospital adverse outcomes between those with and without CKD. Multivariate logistic regression was used to identify predictors of in-hospital mortality.

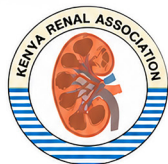
Results:

Among 367 patients with ACS, 18% had CKD. CKD patients were significantly older (median 68.6 vs 58 years, $p<0.001$) with a higher prevalence of hypertension (79% vs 55%, $p<0.001$) and diabetes mellitus (60.6% vs 30.7%, $p<0.001$). Typical chest pain was

significantly less reported in the CKD group (33.3% vs 85.7%, $p<0.001$), with more atypical presentations including dyspnea, epigastric pain and syncope. Time from symptom onset to hospital presentation was longer in the CKD group, and multi-vessel disease was more pronounced. In-hospital mortality was significantly higher in CKD patients (19.7% vs 3.0%, $p<0.001$), with the highest rate in stage 3 CKD, along with increased rates of arrhythmias, cardiogenic shock, mechanical ventilation, and new dialysis initiation. On multivariable analysis, CKD remained an independent predictor of in-hospital mortality (adjusted OR 6.35, 95% CI 2.24–18.05, $p=0.001$).

Conclusion:

CKD was associated with older age, atypical ACS presentation, delayed hospital presentation, higher coronary disease burden, and substantially increased mortality and in-hospital adverse outcomes. Heightened clinical vigilance, early recognition of atypical symptoms in CKD patients, and targeted management strategies in CKD patients presenting with ACS are therefore fundamental to improving outcomes.



Optimal Timing for Initiation of Angiotensin Converting Enzyme Inhibitors or Angiotensin Receptor Blockers after Acute Kidney Injury: A Systematic Review and Meta-Analysis

Authors: Abdul Rehman Arshad, Ayesha Munaf, Muhammad Umar Rafique, Isbah Nabeel Qaiser, Haniya Bano, Malaika Ashraf - Combined Military Hospital, Lahore, Pakistan

Background:

Angiotensin-converting enzyme inhibitors and angiotensin receptor blockers are often discontinued in acute kidney injury. The optimal timing for resuming them after recovery from acute kidney injury remains uncertain.

Objective:

This meta-analysis was conducted to compare early versus delayed resumption of these drugs in acute kidney injury survivors.

Methods:

The study protocol was registered with PROSPERO (registration number CRD420261303396). PubMed, Cochrane Library, LILACS, and LIVIVO were searched until 22 February 2026. Randomized controlled trials and observational studies comparing early and delayed resumption of ACE inhibitors or ARBs following acute kidney injury were included. Random-effects meta-analysis was performed using Review Manager 5.4.

Results:

Two retrospective cohort studies with 51,645 patients were included. Early resumption showed no significant association with all-cause mortality (pooled hazard ratio 1.01, 95% CI 0.79–1.29, $I^2=94\%$) or progression to end-stage renal disease (hazard ratio 0.97, 95% CI 0.66–1.41, $I^2=91\%$). Major adverse cardiovascular and cerebrovascular events were reported in only one study (hazard ratio 0.88; 95% CI 0.82–0.94). Recurrent acute kidney injury and severe hyperkalemia were also reported by one study, with no significant association observed.

Conclusion:

Due to marked heterogeneity in the results of the two retrospective cohorts, no definite conclusions can be established about the effect of early resumption of these drugs after acute kidney injury.

Keywords:

acute kidney injury, angiotensin-converting enzyme inhibitors, angiotensin II type 2 receptor blockers, angiotensin receptor antagonists



Improving Access to Kidney Health Services among Patients with Hypertension and Diabetes in Taita Taveta County, Kenya

Authors: Peninah Kisenga (Nephrology Nurse)

Renal Unit, MOPC and Laboratory Department, Moi County Referral Hospital, Voi, Taita Taveta County, Kenya

Background:

Chronic kidney disease (CKD) is a major complication of hypertension (HTN) and diabetes mellitus (DM), yet awareness and early detection remain low in many rural counties. In Taita Taveta County, reports indicate frequent late presentation to dialysis and limited kidney-focused care in NCD clinics. This study assessed patient knowledge, healthcare worker (HCW) practices, and system barriers to kidney health service access at Moi County Referral Hospital, Voi.

Specific Objectives:

1. To assess patient knowledge and awareness of CKD risk among HTN/DM patients.
2. To evaluate HCW counseling practices and UECs laboratory capacity at MOPC.
3. To identify system and patient-level barriers to kidney health service access.
4. To document clinical outcomes of late referral using a case study.

Methods:

A mixed-methods cross-sectional study was conducted at the MOPC of Moi County Referral Hospital, Voi, from November 2025 to May 2026. Written informed consent was obtained from all participants. A purposive sample of 18 patients with HTN and/or DM was interviewed on CKD knowledge, risk awareness, and clinic attendance. Four HCWs from the MOPC were interviewed on counseling practices and laboratory capacity. Facility records on Urea, Creatinine and Electrolytes (UECs) testing were reviewed, and a case narrative of late referral from Bura to the Moi Dialysis Unit was

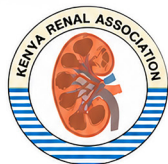
included. Quantitative data were summarized as frequencies and percentages; qualitative data were analyzed thematically.

Results:

Only 5 of 18 patients had adequate CKD knowledge; 72% of HTN/DM patients were unaware that their kidneys were at risk from their condition, with most citing stroke, foot ulcers, and eye disease as complications while kidney risk was rarely mentioned. HCWs reported rarely counseling on kidney risk during routine NCD visits. UECs testing was available at MCRH-Voi but was not routinely ordered for all at-risk NCD patients. Of 157 patients booked for MOPC, only 30–45 attended (19%–29%) due to ignorance, reluctance, distance, and transport costs, limiting monitoring, UECs ordering, and early intervention. A case narrative from Bura illustrated the effects of delayed care: a patient presented in uremic encephalopathy after symptoms were attributed to witchcraft by relatives; this was identified at the Moi Renal Unit, and after three consecutive dialysis sessions the patient showed marked clinical improvement and was well oriented.

Conclusion:

Gaps in patient knowledge, counseling, routine UECs use, and clinic attendance limit early CKD detection in Taita Taveta County. Recommended actions include routine kidney-risk counseling for all NCD patients, routine UECs ordering for at-risk clients, community health volunteer tracing with community education, clear early referral pathways to Voi Dialysis, and dedicated NCD kidney service budgeting. Addressing these gaps can prevent late ESKD and reduce pressure on tertiary care.



Acute Kidney Injury Following Multiple Bee Stings in a 91-Year-Old Patient: A Case Report

Authors: Dr. Nixon Omulimi

Background:

Multiple bee stings can cause systemic envenomation, leading to rhabdomyolysis, hemolysis, shock, and acute kidney injury (AKI). Severe AKI requiring kidney replacement therapy is an uncommon but potentially life-threatening complication.

Case Presentation:

A 91-year-old male patient developed severe systemic illness after multiple bee stings and was admitted to the intensive care unit. He developed hypotension, oliguria, and severe AKI, with an initial serum creatinine of 855 $\mu\text{mol/L}$ that rose to a peak of 899 $\mu\text{mol/L}$. Biochemical evaluation revealed hyperkalemia (6.02 mmol/L) and severe metabolic acidosis (bicarbonate 9.9 mmol/L). Creatine kinase was markedly elevated at 17,811 U/L, and hematuria was present, consistent with significant muscle injury and pigment-associated kidney injury. His clinical condition deteriorated, requiring mechanical ventilation and kidney replacement therapy. Haemodialysis was initiated, with a total of nine sessions performed. With supportive and critical care management, his kidney function progressively improved. He achieved dialysis independence after 29 days and was discharged home with stable kidney function. Two weeks post-discharge, his kidney function had returned to normal.

Discussion:

Bee venom-associated AKI may result from multiple mechanisms, including rhabdomyolysis, pigment nephropathy, hemolysis, direct nephrotoxicity, and hemodynamic compromise. Cytotoxic venom components (such as melittin) and enzymes (including phospholipase A2) damage skeletal muscle and red blood cells, releasing myoglobin and free haemoglobin that are directly toxic to kidney tubular cells and can obstruct the tubules, while venom-induced hypotension further reduces kidney perfusion. This case demonstrates severe AKI requiring prolonged kidney replacement therapy after bee envenomation in a very elderly patient, with eventual complete kidney recovery.

Conclusion:

Multiple bee stings can cause severe, potentially reversible AKI that requires kidney replacement therapy. Early recognition of rhabdomyolysis, metabolic derangements, oliguria, and haemodynamic instability, coupled with timely kidney replacement therapy and comprehensive supportive care, may result in complete kidney recovery even in very elderly patients.

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