The American Society of Pediatric Nephrology (ASPN) Foundation is embarking on the “History of Pediatric Nephrology Project” to gather oral histories and archival material from the pioneers and mentors (and their family members) who created and shaped our field. This project will permit us to learn more about the motivations and accomplishments of the visionaries whose innovation and diligence helped develop the clinical and research programs that served as the templates for programs that exist today. With this effort, we hope to create lasting memories for all of us to treasure and to provide a pathway to take us into the future.

In early February 2017, I had the honor and privilege to visit and converse with one of the renowned pioneers of pediatric nephrology, Dr. Adrian Spitzer, as part of the History of Pediatric Nephrology Project. We talked for about two hours as I listened to Dr. Spitzer reminisce and share with me stories about his mentors and colleagues that laid the foundation for all of us to pursue careers in pediatric nephrology. These visionaries of pediatric nephrology developed the clinical and research programs that served as the templates for programs that exist today.

Like many of you have for your mentors, I have gained a tremendous appreciation for Dr. Spitzer since I finished my fellowship at the Albert Einstein College of Medicine/Montefiore Medical Center. My gratitude for Dr. Spitzer and many of our pioneers was long overdue. That fondness only increased during that conversation. I learned about the early years of his training, a period during which he and others became innovators in the development of pediatric nephrology at the Albert Einstein College of Medicine in the 1960s and for pediatric nephrology worldwide. Indeed, there he worked alongside other great future leaders in pediatric nephrology such as Drs. Henry Barnett and Chester Edelman. These were three of the distinguished “fathers” of pediatric nephrology. The more he spoke so eloquently, and in such wonderful detail, about the beginnings of his and others’ careers, the more I wanted to hear. For this was not simply history, but a window into what motivated these dedicated trailblazers and how they together navigated the uncharted waters of a pediatric subspecialty. What I did not know was that pediatric nephrology was among the first pediatric subspecialties to come into existence. Among the other fascinating facts I learned about was the generosity and collegiality shown by our colleagues in adult nephrology programs to help launch programs in pediatric nephrology.

Continued on Page 2
The two hours we conversed elapsed in what seemed like five minutes. And, those two hours did not even scrape the surface of what was a brilliant career in pediatric nephrology. Dr. Spitzer guided me through the early years of his career through the period during his stewardship of the program at Albert Einstein. He has kept a list of trainees that he and the faculty at Albert Einstein developed, which is a who's who in pediatric nephrology. Actually, a testimony to his incredible memory is that he did not need to refer to any list, as he remembered the names as if he was referring to children and grandchildren. In talking with Dr. Spitzer, it was obvious that he has great pride in those that preceded and followed him.

As much as I would like to reflect more about my conversation with Dr. Spitzer, the History of Pediatric Nephrology Project is about the many visionaries of our specialty. This effort is designed to create lasting memories for all of us to treasure and provide a pathway to take us into the future. For the path forward is guided by that behind us.

For those of you who have not heard about this effort, several of your colleagues at the ASPN have initiated the program to remind all of us about who worked diligently, creatively, and selflessly to help all of us pursue our careers. This project is essential so that we can better appreciate our history. While it is natural for younger persons to focus on the future, older folks like myself love to explore history since we can learn valuable lessons and better appreciate how we arrived where we are. As the project continues to gather interviews, archival material, and other sources of information, we hope that our community can contribute to this effort.

AAP and the SONp are poised to support the History of Pediatric Nephrology Project through various means, including providing access to the AAP Oral History Project. Funding has been made available to initiate the project, but more funding is required to permit the project to achieve its goals. If you are interested in providing funding, or performing an interview with a colleague or mentor, please contact Lisa Thompson (lthompson@aspneph.com), Rick Kaskel (frederick.kaskel@einstein.yu.edu), Vicky Norwood (vfn6t@virginia.edu), or myself (dsilverstein2011@yahoo.com).

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**2017 SONp Henry Barnett Award Recipient:**

**Isidro Salusky, MD**

Dr. Isidro B. Salusky has devoted his life to improving the care of children with chronic kidney disease worldwide through his research, teaching and advocacy. Dr. Salusky is a Distinguished Professor of Pediatrics at the David Geffen School of Medicine at UCLA and Chief of the Division of Pediatric Nephrology. He has been the Director of the Pediatric Dialysis Program at UCLA since 1984 and is committed to providing excellent care for children receiving renal replacement therapy. He has been involved not only in the teaching of pediatric nephrology fellows and residents in both basic and advanced concepts of pediatric nephrology, but also in the education of medical and graduate students as well and has over 50 trainees who have become renal researchers and clinicians throughout the world. His greatest contribution in teaching lies in his passion for clinical research. Dr. Salusky has been an active participant in the development and teaching of courses on “how to be an effective and successful clinical investigator”.

Dr. Salusky is a dedicated clinician scientist. His passion for clinical research and productivity is evident in more than 200 peer reviewed papers, non-peer reviewed articles, multiple editorials and book chapters. His clinical and basic research endeavors span over 30 years and has established the foundation for our understanding of bone and mineral metabolism in children with chronic kidney disease.

*Continued on Page 3*
Fellow Corner

Lyndsay Harshman, MD, SONp Training Fellow Liaison
University of Iowa, Division of Pediatric Nephrology, Dialysis and Transplantation
lyndsay-harshman@uiowa.edu

I have been very fortunate to serve as the SONp Training Fellow Liaison for the past two years. Through this role, I was able to experience a new window into how the AAP exists to serve our profession. My time and effort on the SONp has been focused on:

Research – My focus for the Winter 2016 Newsletter highlighted opportunity and options for residents to pursue training via the American Board of Pediatrics “Integrated Research Pathway” (https://www.abp.org/content/integrated-research-pathway-irp). The Integrated Research Pathway (IRP) was a way for me to experience extended, dedicated research time in residency that launched critical foundations for research success in fellowship. The IRP is designed for residents who have an MD with substantial research experience (e.g., formal year-out research fellowships, Master's degree programs) or an MD/PhD and are committed to an academic research career. Participants in the IRP receive 24 months of clinical training and up to 11 months of formal, mentored research training during their three years of residency. Mentorship is a central component to resident success in the IRP and the American Board of Pediatrics (and frequently the individual residency program itself) requires residents completing the IRP to establish a supervisory oversight committee in addition to a primary research mentor.

Education – During the past two years, I have worked with Drs. Frederick Kaskel (Pediatric Nephrology, Montefiore) and Brian Stotter (Fellow – Boston Children's) to develop a “Teaching on the Go (TOGO)” series. This series is in line with the mission of the AAP Section on Nephrology to develop and share information on issues pertaining to pediatric nephrology with physicians in practice, as well as young physicians in training. The TOGO series provides on-line access to case-based information on key inpatient and outpatient pediatric nephrology topics for medical students and residents in a short, power point format (15 – 20 slides) as a “teaching on the go” resource. We anticipate 3-6 TOGO lectures to be posted to the SONp website by early summer with a range of topics covering hematuria, hypertension and acute kidney injury. Additionally, I enjoyed the opportunity to participate in educational writing on a variety of topics during my term as the SONp Training Fellow. I authored an AAP News Focus on Subspecialties column regarding neonatal acute kidney injury and am currently working with Ann Guillot, MD (University of Vermont) to update the AAP Nutrition Handbook (“Yellow Book”) on the topic of Nutritional Management for Children with Chronic Kidney Disease.

Mentorship – While active in the SONp Training Fellow position, I have been engaged in raising awareness to mentorship opportunities within the AAP for pediatric nephrologists. Mentorship is one of the most important tools for professional development and has been linked to greater productivity, career advancement, and professional satisfaction. Through a very easy process, SONp members have the opportunity to connect with students and residents interested in pediatrics – and potentially stir an interest in pediatric nephrology early in a trainee's career trajectory! If interested, simply send an e-mail to mentorship@aap.org with a request to participate as a potential mentor, or login with your AAP login and

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Section Expertise & Volunteering Survey

The SONp Executive Committee would like to know the interests and expertise of our members. To that end, we invite you to respond to a short 2-question survey at: https://www.surveymonkey.com/r/5GBDJJS The SONp Executive Committee is relatively small group. Among other activities, each year the SONp Executive Committee is asked to review and comment upon many AAP Statements, textbook materials and other items produced in conjunction with various AAP Committees, Councils and Sections, as well as writing an annual article for AAP News. This survey will give SONp members an opportunity to identify those areas of pediatric nephrology where they may wish to volunteer their expertise such as reviewing certain textbook chapters, writing something for the SONp newsletter or AAP News, etc. For those members who want a more active role in the SONp, this survey will provide us the means to better identify your interests and to contact you, individually, as opportunities arise.

For Upcoming Newsletters . . .

We welcome your input and encourage you to submit ideas or information by email to Doug Silverstein, MD at dsilverstein2001@yahoo.com or Suzanne Kirkwood at skirkwood@aap.org for future issues of the newsletter.
Clinical Feature:
Vitamin D Supplementation and Risk for Intoxication

Stephanie Jernigan MD, FAAP, SONp Executive Committee Member
Medical Director of Dialysis, Division of Pediatric Nephrology, Emory University/Children's Healthcare of Atlanta

Lyndsay Harshman, MD, SONp Training Fellow Liaison
University of Iowa, Division of Pediatric Nephrology, Dialysis and Transplantation
lyndsay-harshman@uiowa.edu

Case presentation
A 3-year old girl presented to her general pediatrician with acute irritability, polyuria, and polydipsia. Clinical history was notable for approximately 1 kilogram weight loss in the preceding month. Electrolyte evaluation showed normal glucose (73 mg/dL), hypercalcemia (13.3 mg/dL) and creatinine elevated to 0.7 mg/dL. Upon discussion with the consultant pediatric nephrology team, bone-mineral labs were obtained showing a 25(OH)D of 480 ng/mL, 1,25(OH)-D of 82 pg/mL, PTH of 6.2 pg/mL, phosphorus of 2.3 mg/dL, and urine calcium/creatinine ratio >1 (normal ratio < 0.2 mg/mg in older children and < 0.4 mg/mg in infants). Renal ultrasound revealed medullary nephrocalcinosis. On review of history, the child had been receiving vitamin D supplementation as prescribed by a naturopathic medicine specialist with dosing instructions recommending one drop to provide 1000 IU daily. The child’s parents had inadvertently been administering one full dropper of vitamin D daily – estimated at 30,000 IU 25(OH)D per daily. She was admitted and received IV fluid and furosemide to assist with reduction of elevated serum calcium. She was discharged to home with a stable down-trend in serum calcium and on oral phosphorus supplementation.

Introduction
Vitamin D (in its inactive form, 25(OH)D) is widely used in both the general pediatric population and patients served within pediatric subspecialty clinics; however, the focus of use and monitoring of therapy may be very different across these settings. This review will focus on the potential for hypervitaminosis D (vitamin D intoxication) with supplementation in the non-chronic kidney disease population and complications thereof which may require pediatric nephrology and endocrinology intervention.

Vitamin D requirements in general pediatric populations
The benefits of vitamin D are widely promoted in popular health news segments. These proposed benefits extend beyond recognized use to augment bone and cardiovascular health. Consequently, there has been a dramatic increase in primary care testing for biochemical vitamin D deficiency and widespread use of over the counter vitamin D supplementation in the general pediatric population[1].

Biochemical vitamin D deficiency (serum vitamin D levels less than 20 ng/mL[2]) is considered to be widespread in pediatric patients across North America. Untreated hypovitaminosis D in infants and children can lead to clinical rickets as well as symptoms of severe hypocalcemia including tetany, seizures, cardiomyopathy and even death. Current American Academy of Pediatrics guidelines recommend a minimum daily vitamin D intake (see Table 1) of 400 IU per day for all infants, children, and adolescents.

Review of pediatric literature: Vitamin D excess and intoxication
There has been an increase in reported cases of acute vitamin D intoxication (serum 25(OH)D greater than 150 ng/mL) in both pediatric and adult patients in parallel with more widespread use of over-the-counter vitamin D. Retrospective data analysis from the National Poison Data System (NPDS) compared human over exposures to vitamin D, as a single substance, reported between the years 2000-2011[3]. Strikingly, there was a mean of 196 exposures reported during the years 2000-2005 and a 1600% increase in exposures reported from 2005-2011, lending to a new annual mean of 4535 exposures per year in the United States.

Unclear labeling of “concentrated” over-the-counter vitamin D supplementation, aimed towards infants and young children, has been reported as a risk for errant dosing. This was summarized in published cases, similar to the vignette presented with this review, where infants have received upwards of 30-fold the recommended daily allowance for vitamin D (doses ranging from 30,000-50,000 IU/day) after parents did not fully understand the concentration labeling of vitamin D provided in an over the counter supplement[4, 5]. Published reports document unintentional intoxication in infants

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and young children following manufacturing errors in the production of *over-the-counter* vitamin D that resulted in significantly higher vitamin D content than was labeled [6-8]. The active ingredient “content” of over the counter vitamin and mineral supplement products is not regulated by the Food and Drug Administration (FDA); thus, vitamin content has the potential to be variable across compounded pills, liquid preparations, and manufacturers. The FDA does provide valuable [consumer updates](#) about vitamin use with a mechanism to directly report adverse responses to vitamins or supplements.

In the past 15 years there have been an increasing number of case reports documenting vitamin D intoxication in pediatric patients after high dose vitamin D administration for “alternative indications” such as prevention of infection, treatment of fatigue, and even to treat “bow leggedness” in toddlers [9, 10]. One case report documents the use of stoss-dose (e.g., 600,000 IU x 3 doses) vitamin D administration for failure to thrive which subsequently resulted in symptomatic hypercalcemia requiring inpatient admission and therapy including hydration, furosemide, and pamidronate [11]. Another case series with seven children presenting with symptomatic hypercalcemia details use of vitamin D preparations ranging from 900,000-4,000,000 IU for the indications of “failure to thrive” and “developmental delay” [12].

Certainly, there are inherent metabolic and genetic risk factors that can increase susceptibility to hypercalcemia in the setting of vitamin D supplementation - one well-recognized cause being Williams syndrome. There is also evidence to suggest that genetic polymorphisms in vitamin D metabolism (regulation of synthesis and hydroxylation) and that of D-binding protein synthesis strongly impact serum 25(OH)D homeostasis [13, 14]. The potential for significant genetic variability in vitamin D metabolism further underscores the need to assess serum vitamin D and calcium levels prior to undertaking use of vitamin D supplementation above supplemental 400 IU/day dosing and to ensure long-term monitoring occurs with use.

**Table adapted from:** Holick MF [16], Wagner CL, Greer FR [17]
**Indications for pediatric nephrology intervention**

Signs and symptoms of acute clinical vitamin D intoxication parallel that of systemic hypercalcemia – irritability, polyuria and polydipsia, nausea, constipation, and nephrolithiasis/nephrocalcinosis. In the more chronic setting, hypervitaminosis D may lead to oversuppression of parathyroid hormone (PTH) with risk for adynamic bone disease, hypophosphatemia, and ectopic calcification.

- **Nephrocalcinosis** is a likely consequence when the concentration of calcium in the glomerular filtrate exceeds the solubility limit, resulting in precipitation of calcium within the renal tubules and subsequent nephrocalcinosis. Available data suggest that approximately 25% of patients with vitamin D intoxication will demonstrate radiographic evidence of nephrocalcinosis[15].

- **Acute kidney injury** may result in the setting of polyuria (dehydration) and significant nephrocalcinosis. On initial laboratory evaluation, the patient may also present with evidence metabolic (renal tubular) acidosis.

**Therapeutic options for hypervitaminosis D**

Consider partnering with a pediatric endocrinologist in providing care for any patient with hypervitaminosis D. Acute intervention for hypervitaminosis D revolves around reduction of the serum calcium and restoration of fluid status. In any suspected case of vitamin D intoxication, all exogenous forms of vitamin D and calcium should be discontinued immediately.

- **Dehydration** is a key feature of the clinical presentation. Consider judicious use of normal saline hydration. Use diuretics sparingly as these can worsen the patient's underlying dehydration.

- **Dietary calcium restriction (< 1000 mg/day)** is required as heightened absorption of dietary calcium is a primary mechanism for the hypercalcemia observed in hypervitaminosis D.

- **Calcitonin** can be considered for patients with serum calcium > 14 mg/dL to provide a rapid reduction in serum calcium in combination with adequate hydration. Tachyphylaxis, resulting in limited effect, is often seen after 48 hours of use.

- **A bisphosphonate** can be used in combination with hydration and calcitonin to provide a longer effect (weeks) on calcium homeostasis. Calcium, phosphorus, and magnesium must be monitored carefully with use of these medications.

- **Glucocorticoids** are indicated only in cases of hypercalcemia thought originating from granulomatous disease; thus, there is no clear role in hypercalcemia secondary to hypervitaminosis D.

- **Renal replacement therapy** may be indicated in cases of severe, life-threatening hypercalcemia to provide immediate reduction in serum and ionized calcium with correction of associated acidosis that may accompany the clinical picture, as described above.

**Conclusions**

Awareness of the consequences of untreated vitamin D deficiency must remain ongoing; however, with increased prescription use of vitamin D and over the counter vitamin D supplementation, increased risk for unintentional toxicity and resultant renal effects may emerge. For the pediatric nephrologist, this may require both long and short-term management related to hypercalciuria, nephrocalcinosis, and acute kidney injury. With any prescription use of vitamin D at repletion dosages, there should be regular surveillance of vitamin D status in conjunction with routine calcium assessment.

**References:**


**Continued on Page 8**


CoPS Updates:

Dr. Amy Wilson serves as the AAP Section on Nephrology Liaison to the Council on Pediatric Subspecialties (CoPS). You can view the January, 2017 CoPS update and additional information about CoPS on their website.

Important Modification to the J-1 Visa Program – as of April 17, 2017

To promote resident well-being, in October 2014 the Council of Pediatric Subspecialties adopted a recommendation that pediatric fellowships should start no earlier than July 7, 2017 with orientation occurring no sooner than July 5. CoPS strongly encourages fellowship programs to implement this change and hopes that the information below is helpful.

ECFMG has advised the CoPS Fellowship Start Date Action Team that it has received formal approval from the Department of State to permit a brief (less than 30 day) gap between pediatrics residency and fellowship. As a condition, the J-1 physician must provide confirmation that health and accident insurance will be maintained. ECFMG is currently finalizing a form that will be available on their website within the next two weeks. This form will be posted in the Exchange Visitor Sponsorship Program (EVSP) section under “Forms and Memos” (http://www.ecfmg.org/evsp/forms-memos.html). It will provide, among other things, attestation from the applicant that he/she understands the insurance requirement.

APPD LEAD Leadership Development Course

APPD LEAD (Association of Pediatric Program Directors Leadership in Educational Academic Development) is a nationally recognized 9-month longitudinal faculty development program to develop leadership and educational scholarship skills for pediatric educators. It was designed for program directors and associate program directors of pediatric residencies and fellowships across the country.

The scholarly and leadership track record of LEAD graduates shows what a tremendous opportunity the LEAD program represents as an investment in your career development. APPD LEAD graduates have become the newest wave of national leaders in medical education. By way of example, 40% of workshops presented at APPD's recent spring meeting were led by LEAD graduates. One-third of the at-large members from the APPD Board of Directors, APPD's Fellowship Directors’ Executive Committee, and APPD's Associate Program Directors’ Executive Committee, are comprised of LEAD graduates. Under the leadership of LEAD graduates, the APPD Fellowship Directors’ Executive Committee now directs the Core Curriculum for Fellows at PAS (Pediatric Academic Societies), including a full pre-PAS conference day for fellows.

Please take a minute to consider if you, or other members of your education faculty, might benefit from participating in APPD LEAD and encourage them to apply. Requirements for participation include a minimum three years of educational leadership experience as Program Director, Associate Program Director, Fellowship Director, Associate Fellowship Director or Clerkship Director. In addition, participants need the commitment of their Department Chair for program fees, travel expenses, and time to attend meetings and complete assignments. Applications are due April 21, 2017.

For any questions on this exciting program, please contact Su-Ting Li, MD, MPH; APPD LEAD Council Chair, via email at sutli@ucdavis.edu or by phone at 916-734-2428. Also, please visit the LEAD website: https://www.appd.org/ed_res/LEAD.cfm.

AAP Quality Connections Newsletter

The current issue of AAP Quality Connections can be accessed here.

Content in this issue of AAP Quality Connections:
- COQIPS Committee Updates
- National Quality and Patient Safety Update
- Featured Article: Practice Partners with EHR Company to Improve Evidence-Based Diagnosis of Pediatric Hypertension
- Announcements, Opportunities, Resources from AAP
Welcome to our New SONp Members

If you know of others who might be interested in joining the Academy and the Section, please have them call 1-800-433-9016 ext. 5885 or go to www.aap.org and click on the link “Become a Member” in the upper right-hand corner of the page. Current Academy members may join the Section by accessing the online application (member ID and login required) at: http://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Pages/Council-Section-Membership.aspx.

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<tr>
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<td>Karyn Yonekawa, MD, FAAP</td>
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<tr>
<td>Turki Al Shareef, MD</td>
<td>Riyadh, Saudi Arabia</td>
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<td>Wendy Glaberson, MD</td>
<td>Miami Beach, FL</td>
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<tr>
<td>Stephanie Davis, MD</td>
<td>Cincinnati, OH</td>
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<tr>
<td>Maria Novo Villalobos, MD</td>
<td>Bronx, NY</td>
</tr>
<tr>
<td>Paloma De Albuquerque, MD</td>
<td>Sao Paulo, Brazil</td>
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<tr>
<td>Raghdha Bchech</td>
<td>St. Johns, St. John, Antigua</td>
</tr>
<tr>
<td>Franco Chevalier</td>
<td>Oak Park, IL</td>
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<tr>
<td>Andrea Carolo Anglero</td>
<td>Mayaguez, PR</td>
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Upcoming Meetings

2017 Pediatric Academy Societies
May 6 - 9, 2017
San Francisco, CA

European Renal Association-European Dialysis and Transplant Association – 54th Congress
June 3 – 6, 2017
Madrid, Spain

50th Annual Scientific Meeting of the European Society of Pediatric Nephrology
September 7 -9, 2017
Glasgow, Scotland

AAP National Conference & Exhibition
September 16 – 19, 2017
Chicago, IL

Kidney Week 2017
October 31 – November 5, 2017
New Orleans, LA
The Section on Nephrology
Executive Committee

Chairperson:
Douglas Silverstein, MD, FAAP

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