appropriate specialty review committee—in this case the Internal Medicine Review Committee, which is made up of leading educators in the specialty, as well as a public member and resident—to review as we do with all recommendations. [The committee] will review the information provided and discuss the recommendations per our process. The ACGME will respond directly to the organizations that sent us the letter.”

Some fellows lack procedural skills

Surveys have found that nationwide about 25% of graduating fellows have not achieved competence to perform dialysis catheter placement or kidney biopsies (or both) without supervision, despite being ACGME program requirements.

“Some programs provide no hands-on training in one or both of these procedures or little to no experience with taking care of patients utilizing home dialysis (either home hemodialysis or peritoneal dialysis),” the letter states.

A recent survey of nephrology program directors published in CJASN found that “51% indicated that fellows should not be required to demonstrate minimal procedural competence in biopsy, although 97% agreed that fellows should demonstrate competence in knowing/managing indications, contraindications, and complications.”

A similar survey published in the Journal of Vascular Access found that only 55% of program directors believe that competence in non-tunneled temporary hemodialysis catheter insertion should be a requirement.

Core competencies, says ASN

Despite these reservations by program directors, “the ASN Council just voted specifically to endorse the view that biopsies and lines are things that nephrology programs should provide training in because they are so essential to the practice of nephrology,” Ellison said.

He said he could envision a system in which fellows were offered different pathways, in which some fellows would receive hands-on training in performing biopsies and in another track the fellow would simply master the indications for and complications of biopsy, leading to two different certifications. But that idea would provide flexibility for the individual, not the program. “ACGME should make sure that programs are only accredited if they can train people in all the things that are required to be certified. The program should be able to demonstrate that they provide home dialysis training, biopsy training, and line training,” Ellison said.

Borns, chair of the ABIM nephrology board, said that when he interviews applicants for his fellowship program, they confirm that they have visited programs where they have been told they won’t get any experience doing kidney biopsies. Borns said this is a difficult situation for applicants, who can’t know enough about the field to realize that by choosing the wrong program they could be limiting their future employment options.

“They can decide after the conclusion of training whether or not they want to do them again, but it is hard to expect somebody who is coming into fellowship training to make an intelligent decision about whether or not they want to develop these skills,” Borns said. An applicant should be able to go to every single training program in the country when they are applying for fellowships and know that they are going to get training across the entire breadth and scope of the field. That is not the case right now.”

Distinction between lines and biopsies?

Rob Rope, MD, associate program director for the nephrology training program at Oregon Health and Science University, said he is “agnostic” about the need for training programs to cover all these procedures thoroughly. He sees a difference between the needs for competency in placing lines and performing biopsies.

When it comes to placing a temporary dialysis catheter, the primary decision a nephrologist makes is whether the patient needs dialysis. “If that decision is made, then a dialysis catheter has to be placed, and it doesn’t matter to me who does it. It is whoever is qualified,” he said. “Given the way that nephrology practice has gone, a lot of people in private practice will never place a nephrology catheter again. And therefore, in some ways we are spending time training people for something that doesn’t give them a lot of career benefit.”

“My feeling is there is more variation with who does biopsies, so based on practice patterns, it makes more sense to [be trained] in the use of dialysis catheter. Generally, kidney biopsies are done on patients who are going to be our long-term patients, and there is a risk/reward element,” he said. “It is helpful that the person doing the procedure knows how important the biopsy is [in terms of] how likely it is that the results will change the management of the patient.”

Clinicians may be more or less aggressive depending on how important it is to find what they may be looking for, perhaps making an extra pass when needed, Rope said.

Data needed

The CJASN and Journal of Vascular Access studies surveyed the graduates of a single nephrology training program, and found that in their current practices, 58% place non-tunneled temporary hemodialysis catheters and 35% perform biopsies. But those numbers are from the Walter Reed National Military Medical Center so may not be generalizable.

In the surveys of training program directors, the most common barriers cited to fellows achieving competency in biopsies were time (45%), logistics (45%), a belief that

Pre-Eclampsia Linked to Increased Risk of Chronic Kidney Disease

Women who develop pre-eclampsia during pregnancy are at increased risk of developing kidney disease later in life, reports a study in the British Medical Journal.

Using national registry data, the researchers identified all women in Denmark who had at least one pregnancy lasting at least 20 weeks between 1978 and 2015. Hazard ratios for later diagnosis of kidney disease were compared for women with and without a history of pre-eclampsia, stratified by gestational age at delivery. The analysis included more than 1 million women, average follow-up of 18.6 years.

Kidney disease was diagnosed in 14,816 women, 7.2% of whom had a history of pre-eclampsia. Pre-eclampsia was associated with an increased risk of chronic renal conditions, with hazard ratios (HRs) of 3.93 for early preterm pre-eclampsia (34 weeks), 5.35 for late preterm pre-eclampsia (34 to 36 weeks), and 2.27 for term pre-eclampsia (37 weeks or after). Associations were strongest for the diagnoses of chronic kidney disease, hypertensive kidney disease, and glomerular/proteinuric kidney disease. The associations were only somewhat weakened by adjustment for cardiovascular disease and hypertension.

The greatest pre-eclampsia-related increases in kidney disease risk were seen within 5 years of the last pregnancy: HR 6.13 for chronic kidney disease and 4.77 for glomerular/proteinuric disease. Though still significant, the associations were weaker at 5 years or longer after the last pregnancy: HR 2.06 and 1.50, respectively. History of pre-eclampsia was not strongly related to acute renal conditions.

Although pre-eclampsia has been linked to end-stage renal disease, there are conflicting data on its association with chronic kidney disease and kidney dysfunction. In this nationwide cohort study, history of pre-eclampsia is strongly associated with increased risks of chronic but not acute kidney diseases. The association is strongest for chronic kidney disease and glomerular/proteinuric disease, particularly within 5 years of the latest pregnancy [Kristensen JH, et al. Pre-eclampsia and risk of later kidney disease: nationwide cohort study BMJ 2019; 365: 1516].