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Renal Dietitians

A Dietetic Practice Group of American Dietetic Association

Potassium Management in Peritoneal Dialysis Patients: Can an Increased Potassium Diet Maintain a Normal Serum Potassium without a Potassium Supplement?

By Karen F. Factor, MBA, RD, LDN. *Karen is a renal dietitian in Carrboro, North Carolina specializing in Peritoneal Dialysis. She can be contacted at Karenfactor@nc.rr.com*

Introduction

Potassium management of hemodialysis (HD) and peritoneal dialysis (PD) varies greatly. Because of the continuous nature of PD versus the intermittent schedule of HD, patients on PD tend to run normal to low serum potassium concentrations. Hyperkalemia rarely occurs in patients receiving PD, and it may indicate inadequate dialysis. Peritoneal dialysis removes more potassium (K+) than HD because of the increased time that patients undergo PD. Patients transitioning from HD to PD are at risk of hypokalemia because many patients were restricting dietary K+ prior to dialysis initiation or while receiving HD. The ranges for serum K+ levels can be found in Table 1 (1).

Table 1: Ranges of Serum Potassium Levels

3.5 – 5.5 mEq/L	(Normal range)
<3.5 mEq/L	(Hypokalemia)
>5.5 mEq/L	(Hyperkalemia)

Hypokalemia can be triggered by a variety of circumstances including: 1) inadequate dietary K+ intake, 2) malnutrition, 3) prolonged gastrointestinal losses such as diarrhea, vomiting, or gastric suction, 4) diuretic therapy, 5) diabetic acidosis, and 6) magnesium deficiency.

Patients with hypokalemia can have muscle weakness, abdominal distention, and irregular heart contractions. Hypokalemia can lead to central nervous system changes with confusion and affective disorders. When vomiting occurs without appropriate fluid replacement, a great loss of acid may result in metabolic alkalosis. Symptoms of metabolic alkalosis include labored breathing, headaches, drowsiness, irritability, nausea, and rapid heart rate (1).

Methods

Five patients, ages 18 – 60 years, with a history of hypokalemia were included in the study population. All patients were receiving continuous cyclical peritoneal dialysis (CCPD). No patient had a history of diarrhea or GI losses, and all patients reported normal appetites. The dialysate utilized by these patients contained no K+ and the electrolyte content remained constant throughout the study. None of the patients were taking a K+ supplement. Prior to the initiation of the study, these patients did not consume a significant amount of fruits and vegetables on a daily basis and their potassium intake was < 2 g/day.

Patients were counseled on a liberal K+ diet (2.4-3.5g per day) utilizing Tables 2 - 5. The meal plan was created from the Kansas Diet Manual, dividing the foods into categories based on potassium content. The food categories, which were developed prior to the National Renal Diet publication, were low K+ (5 – 150mg), medium K+ (150 – 250mg), high K+ (250 – 500mg) , and very high K+ (>500mg). Portion sizes were emphasized in order to liberalize the amount of potassium consumed. The meal plan

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In This Issue:

Renal Nutrition Forum is published quarterly (winter, spring, summer, fall) as a publication of the Renal Dietitians Dietetic Practice Group of the American Dietetic Association.

Articles about successful programs, research interventions, evaluations and treatment strategies, educational materials, meeting announcements and information about educational programs are welcome and should be sent to the editor by the next deadline.

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FROM THE EDITOR'S DESK

As my year as editor comes to an end, I wish to thank the Renal Practice Group Executive Committee for welcoming me onto the editorial board and giving me an amazing opportunity. In just one year, I've witnessed tremendous progress within RPG and have had the pleasure of getting to know and work with many talented individuals. I am looking forward to moving into the managing editor's position so that I can learn about copyrighting, reprint approvals, and to build upon the *Renal Nutrition Forum* foundation.

I would like to thank Sarah Carter, RD, CDE for all of the time and effort she has devoted to the *Renal Nutrition Forum* and to RPG over the past three years as a member of the editorial board. Sarah continues to be an important resource to the team as we move into our new roles.

In addition, I would like to thank Cathy Goeddeke-Merickel, MS, RD, LD for all of her work as assistant editor over the past two years and pass on the baton to her as she moves into the editor's position. Cathy will also be taking on the role of website manager/editor as the Renal Practice Group rolls out its newly created, updated website. Cathy, thank you for all of the hours you have devoted to developing the new website! Now it is an incredible resource for all of our members and to the renal community.

I would like to welcome our new assistant editor, Lesley Wujastyk, RD, LD, a renal dietitian from the Chicago area. Lesley brings a fresh perspective and helps us to understand the needs of the next generation of dietitians.

It is important to be aware of the benefits of being a member of RPG. Please take a look at page 20 to learn about the awards and scholarships that are available exclusively to RPG members.

As you will see, there is a research grant available to members. It is extremely important for dietitians to be involved in the research that is the foundation to the nutritional care that we provide our patients. Karen Factor, MBA, RD, LDN conducted research in her clinic regarding the potassium management of peritoneal patients. She originally presented this in abstract form at the Dialysis Conference in San Francisco and now you have an opportunity to review her original research paper in this issue.

At FNCE 2005, Judith Beto, PhD, RD, FADA spoke to RPG about the importance of evaluating your professional worth. In this issue of the *Forum* we bring this important information to all of you in Maximizing Your High Biological Value! Please take a look at this article and as you go about your daily routine, assess what your value is to yourself and those around you. After reading this article, I think you will see why this is such a significant activity that all renal dietitians should incorporate into our yearly reviews, if not more often.

As always, RPG would like to hear your opinions and ideas so please feel free to email us at rnfeditor@yahoo.com.

Sharon Griff

Many Thanks

Thank you to the following peer reviewers for this issue:

Sarah Carter
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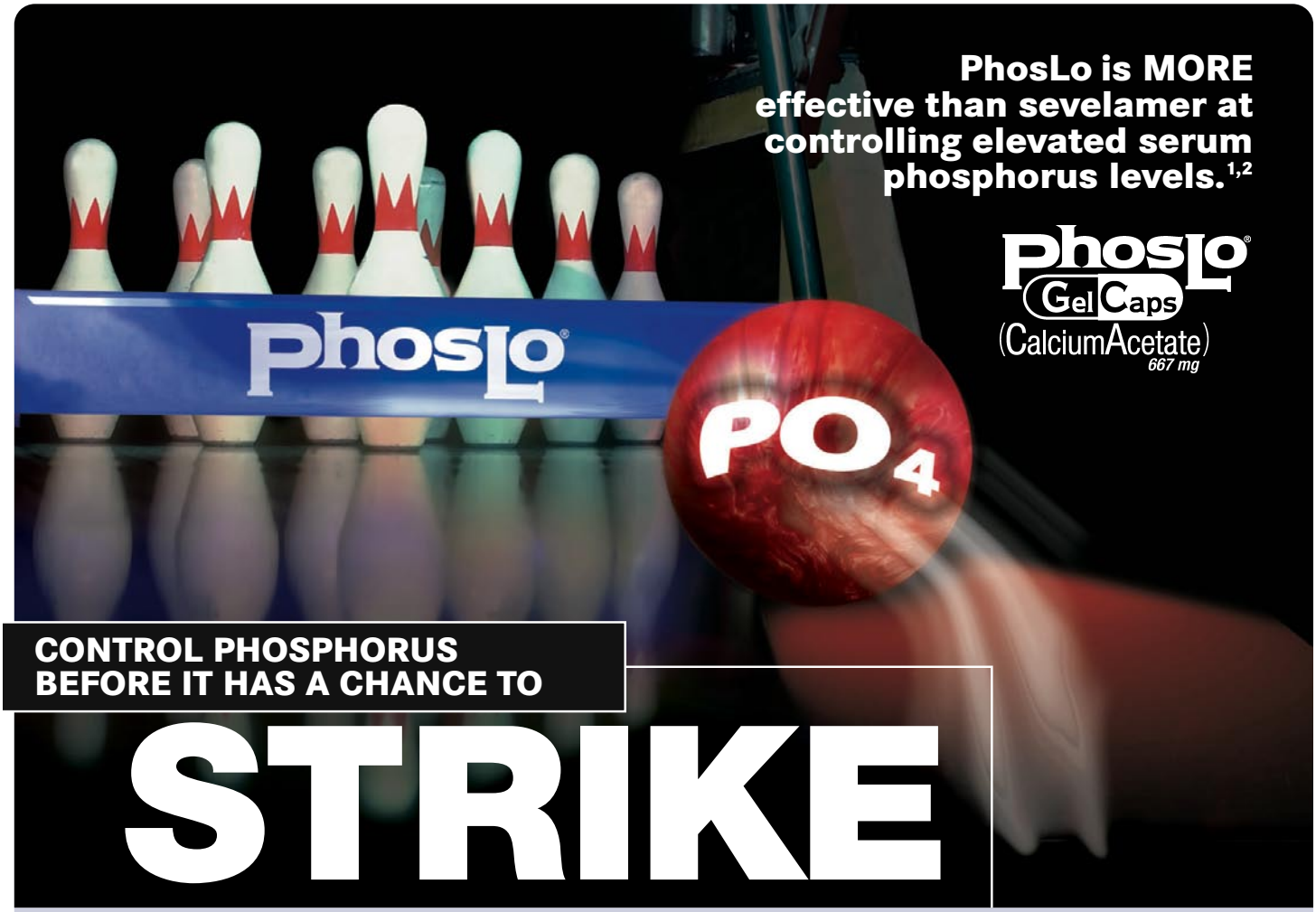


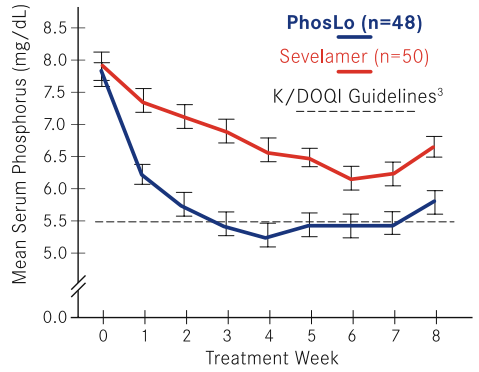
PhosLo is MORE effective than sevelamer at controlling elevated serum phosphorus levels.[1,2]

PhosLo® Gel Caps (CalciumAcetate) 667 mg

CONTROL PHOSPHORUS BEFORE IT HAS A CHANCE TO

STRIKE

Calcium Acetate Renagel Evaluation (CARE)[1]



Attainment of NKF K/DOQI Bone Guidelines Among Dialysis Patients Referred for Transplantation[2]*

	Sevelamer (n=40)	PhosLo (n=67)	p-value
Serum P (mg/dL)	6.2	5.0	<0.001
Ca x P (mg^2/dL^2)	52	43	0.002
% P ≤ 5.5	38%	75%	<0.001
% Ca x P ≤ 55	65%	85%	0.03

*Cross-sectional study to compare the efficacy of longer-term, calcium-based binder and sevelamer treatment in a series of 107 patients.

PhosLo® is indicated for control of hyperphosphatemia in end-stage renal failure. Patients with higher-than-normal serum calcium levels should be closely monitored and their dose adjusted or terminated to bring levels to normal. **PhosLo® is contraindicated in patients with hypercalcemia.** No other calcium supplements should be given concurrently with PhosLo.® Nausea, hypercalcemia and pruritus have been reported during PhosLo® therapy.

References: **1.** Qunibi WY, Hootkins RE, McDowell LL et al. Treatment of hyperphosphatemia in hemodialysis patients: the Calcium Acetate Renagel Evaluation (CARE study). *Kidney Int.* 2004;65:1914-1926. **2.** Nolan C et al. Attainment of NKF K/DOQI Bone Guidelines Among Dialysis Patients Referred for Transplantation. Abstract. *Journal of American Society of Nephrology.* Volume 16, 2005. American Society of Nephrology Renal Week. Pennsylvania Convention Center, Philadelphia, PA. November 8-13, 2005. **3.** National Kidney Foundation K/DOQI clinical practice guidelines for bone metabolism and disease in chronic kidney disease. *Am J Kidney Dis.* 2003;42(suppl 3):562-578.

For more information on PhosLo®, please contact the Nabi Biopharmaceuticals Medical Affairs Department at 1-800-458-4244, email us at phoslo@nabi.com, or visit our website at www.nabi.com.

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PhosLo® Gelcaps
(Calcium Acetate)

DESCRIPTION: Each opaque gelcap with a blue cap and white body is spin printed in blue and white ink with "PhosLo®" printed on the cap and "667 mg" printed on the body. Each gelcap contains 667 mg calcium acetate, USP (anhydrous; Ca(CH3COO)2; MW=158.17 grams) equal to 169 mg (8.45 mEq) calcium, and 10 mg of the inert binder, polyethylene glycol 8000 NF. The gelatin cap and body have the following inactive ingredients: FD&C blue #1, D&C red #28, titanium dioxide, USP and gelatin, USP.

PhosLo® Gelcaps (calcium acetate) are administered orally for the control of hyperphosphatemia in end-stage renal failure.

CLINICAL PHARMACOLOGY: Patients with advanced renal insufficiency (creatinine clearance less than 30 ml/min) exhibit phosphate retention and some degree of hyperphosphatemia. The retention of phosphate plays a pivotal role in causing secondary hyperparathyroidism associated with osteodystrophy, and soft-tissue calcification. The mechanism by which phosphate retention leads to hyperparathyroidism is not clearly delineated. Therapeutic efforts directed toward the control of hyperphosphatemia include reduction in the dietary intake of phosphate, inhibition of absorption of phosphate in the intestine with phosphate binders, and removal of phosphate from the body by more efficient methods of dialysis. The rate of removal of phosphate by dietary manipulation or by dialysis is insufficient. Dialysis patients absorb 40% to 80% of dietary phosphorus. Therefore, the fraction of dietary phosphate absorbed from the diet needs to be reduced by using phosphate binders in most renal failure patients on maintenance dialysis. Calcium acetate (PhosLo®), when taken with meals, combines with dietary phosphate to form insoluble calcium phosphate which is excreted in the feces. Maintenance of serum phosphorus below 6.0 mg/dl is generally considered as a clinically acceptable outcome of treatment with phosphate binders. PhosLo® is highly soluble at neutral pH, making the calcium readily available for binding to phosphate in the proximal small intestine.

Orally administered calcium acetate from pharmaceutical dosage forms has been demonstrated to be systemically absorbed up to approximately 40% under fasting conditions and up to approximately 30% under non-fasting conditions. This range represents data from both healthy subjects and renal dialysis patients under various conditions.

INDICATIONS AND USAGE: PhosLo® is indicated for the control of hyperphosphatemia in end-stage renal failure and does not promote aluminum absorption.

CONTRAINDICATIONS: Patients with hypercalcemia.

WARNINGS: Patients with end-stage renal failure may develop hypercalcemia when given calcium with meals. No other calcium supplements should be given concurrently with PhosLo®.

Progressive hypercalcemia due to overdose of PhosLo® may be severe as to require emergency measures. Chronic hypercalcemia may lead to vascular calcification, and other soft-tissue calcification. The serum calcium level should be monitored twice weekly during the early dose adjustment period. **The serum calcium times phosphate (Ca x P) product should not be allowed to exceed 66.** Radiographic evaluation of suspect anatomical region may be helpful in early detection of soft-tissue calcification.

PRECAUTIONS: GENERAL: Excessive dosage of PhosLo® induces hypercalcemia; therefore, early in the treatment during dosage adjustment serum calcium should be determined twice weekly. Should hypercalcemia develop, the dosage should be reduced or the treatment discontinued immediately, depending on the severity of hypercalcemia. PhosLo® should not be given to patients on digitalis, because hypercalcemia may precipitate cardiac arrhythmias. PhosLo® therapy should always be started at low dose and should not be increased without careful monitoring of serum calcium. An estimate of daily calcium intake should be made initially and the intake adjusted as needed. Serum phosphorus should also be determined periodically.

Information for the Patient: The patient should be informed about compliance with dosage instructions, adherence to instructions about diet and avoidance of the use of non-prescription antacids. Patients should be informed about the symptoms of hypercalcemia (see ADVERSE REACTIONS section).

Drug Interactions: PhosLo® may decrease the bioavailability of tetracyclines.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic potential, mutagenicity, or effect on fertility of PhosLo®.

Pregnancy: Teratogenic Effects: Category C. Animal reproduction studies have not been conducted with PhosLo®. It is not known whether PhosLo® can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. PhosLo® should be given to a pregnant woman only if clearly needed.

Pediatric Use: Safety and effectiveness in pediatric patients have not been established.

Geriatric Use: Of the total number of subjects in clinical studies of PhosLo® (n=91), 25% were 65 and over, while 7% were 75 and over. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

ADVERSE REACTIONS: In clinical studies, patients have occasionally experienced nausea during PhosLo® therapy. Hypercalcemia may occur during treatment with PhosLo®. Mild hypercalcemia (Ca>10.5mg/dl) may be asymptomatic or manifest itself as constipation, anorexia, nausea and vomiting. More severe hypercalcemia (Ca>12mg/dl) is associated with confusion, delirium, stupor and coma. Mild hypercalcemia is easily controlled by reducing the PhosLo® dose or temporarily discontinuing therapy. Severe hypercalcemia can be treated by acute hemodialysis and discontinuing PhosLo® therapy. Decreasing dialysate calcium concentration could reduce the incidence and severity of PhosLo®-induced hypercalcemia. The long-term effect of PhosLo® on the progression of vascular or soft-tissue calcification has not been determined. Isolated cases of pruritus have been reported which may represent allergic reactions.

OVERDOSAGE: Administration of PhosLo® in excess of the appropriate daily dosage can cause severe hypercalcemia (see ADVERSE REACTIONS section).

DOSAGE AND ADMINISTRATION: The recommended initial dose of PhosLo® for the adult dialysis patient is 2 gelcaps with each meal. The dosage may be increased gradually to bring the serum phosphate value below 6 mg/dl, as long as hypercalcemia does not develop. Most patients require 3-4 gelcaps with each meal.

HOW SUPPLIED:

Gelcap: A white and blue gelcap for oral administration containing 667 mg calcium acetate (anhydrous Ca(CH3COO)2; MW=158.17 grams) equal to 169 mg (8.45 mEq) calcium.

Gelcap
NDC 59730-6402-1 Bottles of 200

STORAGE: Store at 25°C (77°F); excursions permitted to 15-30°C (59-86°F). See USP "Controlled Room Temperature."

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 continued from page 1

encouraged two to three choices from each of the very-high, high-, and medium-K+ lists and one to two foods from the low-K+ list. The liberal K+ diet was reinforced on a monthly basis. Patients' verbal dietary recalls were recorded by the dietitian monthly over a 6 month period. Serum K+ levels were monitored monthly as well. Patients' K+ intakes were calculated from diet recalls using the Kansas Diet Manual, a reference of the Kansas Dietetic Association.

Table 2. Low Potassium Foods

Low K+ Foods: 5-150 mg per serving
Choose 1-2 of these foods daily:

Alfalfa sprouts	Apples	Blackberries
Cabbage	Eggplant	Fruit cocktail
Green beans	Plums	Sweet peppers
Raspberries	Radishes	Tangerines
Onions	Grapes	

Table 3. Medium Potassium Foods

Medium K+ Foods: 150 – 250 mgper serving
Choose 2-3 of these foods daily:

Broccoli	Apricots	Carrots
Grapefruit	Corn	Peaches
Okra	Pears	Zucchini
Strawberries	Turnips	Watermelon
Molasses	Pudding	Beets
Catsup	Chickpeas	
Juices: Apple and Grape		

Table 4. High Potassium Foods

High K+ Foods: 250-500 mg per serving
Choose 2-3 of these foods daily:

Artichoke	Apricots	Beet greens	Avocados	Parsnips
Banana	Oranges	Pumpkin	Cantaloupe	Tomatoes
Spinach		Kiwi	Lentils	Yogurt
Juices: Grapefruit and Orange				

Table 5. Very high Potassium Foods

Very High K+ Foods: >500 mg per serving
Choose 2-3 of these foods daily:

White potato	Peanut butter	Sweet potato	Nuts
Papaya	Tomato sauce		
Beans(except green and wax)			

Results

The mean pre-dietary K+ intake was 790 mg/day. The mean post-dietary K+ intake was 1635.6 mg/day. Overall, there was a mean increase in intake of potassium of 845.6 mg/day. The food sources that contributed to the increase in potassium intake which resulted in a net increase in serum potassium were bananas, orange juice, cantaloupe, tomato sauce, okra, potatoes, and tomatoes. No reasons were identified as to why some patients increased their K+ intake more than others except for patient preference.

According to their diet recalls, all patients increased dietary K+ intake by 10 – 50%. Results are shown in Table 6. The mean pre-serum K+ level was 3.2 mEq/L; the mean post-serum K+ level was 3.92 mEq/L resulting in an overall mean change in serum K+ levels of 0.72 mEq/L. This small, clinic-based study indicates that minor increases in dietary K+ without a K+ supplement can bring serum K+ levels into normal range even if K+ intake is under 2g per day.

Table 6. Pre and Post Potassium Intake and Serum Potassium Levels

Time Period (months)	# of Pts.	Pre Serum K+ Levels (mEq/L)	Pre K+ Intake (mg)	Post Serum K+ Levels (mEq/L)	Post K+ Intake (mg)	Average Increase in K+ Intake
1 – 6 months	5	3.0 – 3.4	150 – 1440	3.6 – 4.7	721 – 2457	41%

Discussion

All patients starting PD should be cautioned on risk of developing hypokalemia. Renal nutrition professionals should counsel patients starting PD on a 2.4 -3.5 gram K+ diet utilizing a list of low, medium, high, and very high K+ foods.

Some High K+ foods are also high in phosphorus such as ice cream, pudding, corn, lentils, yogurt, milk, beans (except wax and green), peanut butter, and nuts. When counseling patients with a low serum K+, renal nutrition professionals should caution patients about these foods (2).

If K+ levels do not increase or continue to decrease, this may be due to the following:

1) non-compliance with diet
2) extrarenal losses (e.g. gastrointestinal losses, acidosis, or excess sweating)
3) use of diuretic therapy

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Potassium Mgmt.

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Alternatives to dietary management in correcting hypokalemia are increasing K+ concentration in peritoneal dialysate and potassium supplementation using pharmaceuticals, such as potassium chloride, K-Dur, and K-Tab (3).

When patients achieve a normal serum K+ levels through diet alone, they should be encouraged to continue consuming liberalized K+ diets. Patients should understand that even though their K+ levels are currently within normal limits, they are still at risk for hypokalemia if their K+ intakes decline.

References

1. Levine, DZ. *Caring for the Renal Patient*. Philadelphia, PA: W.B. Saunders Company; 1997.

2. Section K in Amick, BL, Lopes, GL. *Diet Manual*, Topeka, KS: Kansas Dietetic Association; 1992: 280 – 297

3. Williams, SR. *Nutrition and Diet Therapy*.. 8th Ed. St. Louis, MO: Mosby-Year Book, Inc.; 1993: 218 – 219, 618.

Congratulations to

Maryanne Meade,
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on receiving the

Mary Abbott Hess Award
for Recognition of an
Innovative Culinary Effort

Maximizing Your High Biological Value!

By Judith A. Beto PhD, RD, FADA. *Judith is a Research Associate with the Division of Nephrology and Hypertension at Loyola University Medical Center in Maywood IL. Judith is the recipient of the 2005 OSA from RPG. She can be contacted at jbeto@lumc.edu.*

High biological value (HBV) is a term we all know. We first learned about high biological value and protein metabolism in basic nutrition. We have applied the concept of high biological value with our renal patients in an effort to maximize the power of protein in their diets. But, in the process, have you maximized your own high biological value? The goal of this brief inspirational message is to foster critical thinking and encourage your own self-evaluation of your professional worth: your own high biological value.

The definition of high biological value is simple: the measure of the amount of essential amino acids compared to the amount of total protein or amino acids consumed. In our patients, we talk about using at least 70% or more high biological value to improve their ability to use the limited amount of protein they can consume. In short, we try to get the most value for our effort—or "the most bang for my buck" in the words of one of my patients. The food that is highest on the list is the egg. I use the acronym, EGG, to represent Energy Going Great. When we are using the highest level of biological value in our practice, our energy is going great! We can handle it all. We can accomplish our workload with ease. We are on the top of our game!

Measuring Your Worth

How do we measure our own biological value? You should be able to get a clearer picture and measure of your own worth using a self-reflection exercise. Table 1 poses a series of questions in a checklist format that you should ask yourself. The checklist is by no means inclusive, and in fact, you are encouraged to customize the checklist to your own individual work environment. Discuss the answers with a co-worker or a supervisor to get their objective perspective as well. The goal of this exercise is to evaluate where you are in the process of worth and discover pathways to greater worth. Most of us are responsible for many tasks in our current job situation but in reality, get credit for only a small percentage of what we actually do. Personally, I did research for several years early in my renal nutrition career without even a simple acknowledgement in the manuscripts that were subsequently published. I had to make the decision to ask for recognition of my worth or stop doing what I was doing (even though I loved it!) This is an essential part of the worth cycle: defining what we do and putting a "cost" or worth on each skill or talent we deliver.

Defining Your Worth

After you measure your worth, you need to create a visual measure and definition of your worth. One way to define your professional high biological value or worth is to create a curriculum vitae or CV. The CV differs from a resume. A resume format is used to look for employment and focuses on your job history. A CV takes the resume format and expands it to represent your entire career history. The CV is an evolving, growing file of your "worth". Table 2 lists the essential components of a CV. Ask for copies of CV's from your mentors, supervisors, peers, DPG officers. I would be happy to share a copy by email with you.

In addition, continue your professional worth history by:

- An ongoing list of all presentations you give by date, audience, location, and title.
- Maintain a portfolio of projects you have done. Years later, you will have examples of all your professional work.
- Assemble a file of recommendation letters from your current and past employers. They may be hard to track down in the future but you will have a complete file documenting your worth when you need it.
- Keep a reprint copy of all your publications.

Going Forward

Defining worth is an on-going process that involves personal goals as well. Each year write a personal goal statement. You don't have to share it with anyone but yourself. Research shows that people who do not have goals are more likely to be depressed because they cannot measure their progress over time. People who create unattainable goals are consumed with disappointment. Therefore, writing a goal statement requires the combination of careful

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thought, reality check, and a dose of inspiration. You must let your goals evolve with life experiences. Update your goals over time as you consider your changing priorities and resources.

Everyone should have a "pride" list. Experts suggest that it isn't what has happened in life but rather how you perceive life happened to you. There is no objective way to measure your worth in some areas of life, but if you feel good about what you have done or what you are doing, certainly this provides inspiration to get up each day. They may be simple acts of kindness or huge outlays of time—but they have produced a sense of satisfaction that needs to be recognized. Maintain a collection of writings or sayings that inspire you. There are numerous resources to help keeping chronic employment and education exciting.

Overcoming Barriers

A cornerstone of renal nutrition is the autonomy we enjoy compared to other specialties. Because of the complexity of our craft and the evolving science in our field, we may sometimes feel overwhelmed by perceived barriers to our worth. We have staffing equations and federal requirements for our employment in our units but our reimbursement is lost in the bundled reimbursement process. Medical nutrition therapy services for CKD stages 1-4 are reimbursable but we have to complete paperwork and be recognized in a complex billing system to be part of that process.

How do we increase our worth? We can take on responsibilities that are tied to outcome and link our worth.

- Agree to take on responsibility for increasing a defined albumin parameter (ownership). Create a protocol with a budget for money to cover responsibility (action). Set measures and timeline with reimbursement incentives tied to performance (outcome measure). Link increases in albumin to decreased hospitalization or mortality events. Each event a patient from your unit for treatment and deducts billable dialysis treatment from your unit's income (cost savings). Translate cost savings into higher reimbursement for your worth and continued ownership of this responsibility.

- Evaluate your current responsibilities in relationship to your time allotment and priorities. Delete "assumed ownership" of projects and responsibilities you are not receiving recognition or worth. Re-negotiate new ownership with the tools, time, and worth in place. Realize there may be a period of denial on the part of others regarding your ownership status and worth.

- Look within your own renal community or corporation for a common problem. Work within your support system to develop a solution that may improve the worth of a cohort of dietitians or team members, not just yourself. "Selling" the solution to a larger audience may provide synergy that is unavailable to you at present as a single entity.

- Increase your knowledge base. Become proficient in an area you can parlay into a greater worth such as the physiological compensation mechanism of the chronic kidney disease gut. Use your new understanding to develop new problem-solving solutions for phosphorus and potassium management.

- Increase your earning worth by expansion of your billable skills. Take a statistics course and learn a software program to support research analysis. Become proficient in new skills such as physician's assistant, certificates in motivational interviewing, or management skills.

Facing the Future

We can't always have EGG (energy going great)! Chronic education can make us chronically numb. We can let our high biological value drop – we can burnout – we can replace the EGG with BACON (bad attitude creating overwhelming numbness)! What can we do? I have been called the eternal optimist, but I believe most of my efforts, when pursued with integrity and passion, result in increased worth. I would encourage you to measure your worth, whatever that would currently be, as a beginning of an on-going conversation and effort to keep improving our worth. We need to define our worth so it is apparent to others, not only to ourselves. Maximize your high biological value! You are worth it!

Suggested references:

1) Niven D. *The 100 Simple Secrets of Happy People: What Scientists Have Learned and How You Can Use It.* New York: Harper Collins, 2000.
2) http://jobsearch.about.com/cs/curriculmvitae. Accessed May 1, 2006

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Table 1: Your Biological Value Checklist

Category: Team Biological Value

Question	Your Answer
Are you missed when you are not there?	
Are you an indispensable member of the team?	
Do you perform functions that no other team member is primarily responsible for?	
Do you generate essential reports?	
Do you require physical coverage of another person when you are away?	
Are you functioning at a level where your activities and work is central to the operation of your unit? And more importantly, does anyone know this besides you?	
Is your name connected to these activities on each report heading, in your job description, in your monthly activity log of work?	
Do you have the same level of worth with all personnel, all shifts?	

Category: Patient Biological Value

Question	Your Answer
Do patients ask for you by name (not just "the dietitian")?	
Do patients make appointments to see you (and keep them)?	
Do you know all of your patients by name (and call them by name)?	
Is you day tightly or randomly scheduled?	
Are you a central part of your patients' education and treatment plans?	
Do patients look forward to seeing you because you provide a valued service or do they pretend to be in a deep sleep when you pass by?	
Do patients consider you an expert in your field (and maybe other fields as well, like bone management) or are they addressing their questions to others?	
Do you have the same level of worth on all shifts of patients?	

Table 2: Essential Components of Your Curriculum Vitae

- Name, degrees, contact information
- Education (degrees, certificates, licenses)
- Present Professional Endeavors (Title, employment, dates)
- Present Volunteer Endeavors
- Past Professional Endeavors
- Current Professional Memberships (include leadership roles)
- Publications (abstracts, book chapters, articles)
- Grants Received (include funded or unfunded research in progress)
- Date and paginate

In secondary HPT,

NOT ALL RECEPTORS ARE CREATED EQUAL

Data show that the vitamin D receptor and the calcium-sensing receptor play independent roles in the pathogenesis of secondary HPT

Secondary hyperparathyroidism (HPT) begins at early stages of chronic kidney disease and becomes increasingly severe over time.[1,2] Disease progression is characterized by parathyroid gland hyperplasia—defined as cell proliferation—and gland enlargement.[3,4] It is crucial, therefore, to understand the factors that mediate parathyroid gland hyperplasia and its role in disease progression.[3-7]

Calcium, acting through the calcium-sensing receptor (CaR), and vitamin D, acting through the vitamin D receptor (VDR), have diverse effects in a variety of tissues[8] and independently impact parathyroid gland function.[4-6,9] Vitamin D directly diminishes parathyroid hormone (PTH) gene expression and hormone synthesis and indirectly reduces PTH synthesis and secretion by raising blood calcium levels.[7,10] In contrast, calcium signaling through the CaR directly inhibits PTH secretion and reduces PTH gene expression.[3,6-8]

Moreover, recent evidence suggests that signaling through the CaR is a key determinant of parathyroid gland enlargement and cell proliferation.[3,6] Findings from preclinical studies by Li et al suggested that calcium-dependent signaling through the CaR was sufficient to prevent parathyroid gland hyperplasia even in mice lacking a functional VDR whose tissues cannot respond to vitamin D.[6,11]

Research suggests that there are 2 independent pathways involved in the pathogenesis of secondary HPT.[5,12] Signaling through the VDR inhibits PTH gene expression and hormone synthesis[12] while signaling via the CaR affects PTH secretion, PTH synthesis, and parathyroid cell proliferation[3,6,12]—the last impacting parathyroid gland hyperplasia.[3,6,8]

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RENAL DIETITIANS CHAIR MESSAGE

Patricia Weber, MS RD CSR CDE

Quam Plurimis Prodesse…"To benefit as many as possible." This is the commendable motto which is fixed on the seal of the American Dietetic Association (ADA). The seal also displays symbols of life, growth, accuracy and evaluation. It even includes a cooking vessel….yes, a cooking vessel. Renal Dietitians have a worthy task: to translate the latest scientific information into practical applications so our patients have the knowledge to make the best food selections.

At the NKF Spring Clinical Meetings in Chicago this year, the Council on Renal Nutrition (CRN) session on the proposed K/DOQI Guidelines on Diabetes and Chronic Kidney Disease generated passionate comments on the balancing act of providing information that might preserve kidney function vs. preserving nutritional status. The guidelines will emphasize the importance of dietitians trained in renal nutrition, so that those goals are not mutually exclusive. The RPG is pleased to continue collaboration with the CRN in development of Standards of Practice and Standards of Professional Performance. When completed, these standards of competence will help us evaluate and then improve our practice. The mix of RPG and CRN members who are self-motivated and determined will get great results! It is my distinct pleasure to follow the very accomplished outgoing RPG Chair, Cathi Martin, RD, LDN, and join in partnership with CRN.

At ADA's Food and Nutrition Conference in Honolulu this September, the Renal Dietitians Practice Group's (RPG) Priority Session will feature Duane Sunwold, a chef who has reversed the progression of CKD. He has developed interesting menus that utilize soy and omega-3 fatty acids. He will be joined by Joni Pagenkemper, MS, RD, who will add the elements of research and science about CKD nutrition. They will blend the science of nutrition with the art of cooking.

Last February, as incoming Chair, I was able to attend the ADA's Leadership Conference in San Diego, along with our Treasurer, Pamela Kent. Once again, the ADA had a commendable goal: to further our growth as leaders, not only to benefit the Association, but also to benefit us personally. Pam and I both were impressed with the topics and speakers. Although Jim Collins, the author of the book *Good to Great* was not a speaker, the book has been a source of inspiration to the ADA staff, so it was often referenced. Mr. Collins says that great organizations have a "big hairy audacious goal (BHAG)", something about which they are fervent, are the best at doing, and can make profitable for their customers. This BHAG is adopted only after the right people are selected. To adapt a "bus analogy" from Jim Collins' book, *Good to Great*, we get the right people on the bus first, and then we will decide where to drive it. When dietitians get on this bus because they are fervent about renal nutrition, because they are the best in the field, and because they plan to make the project profitable for patients, they won't get off at detours. You have joined the RPG, which makes me think you are the "right people". Bring us fresh ideas about which you are passionate. Help us refine our existing projects to make them the most profitable for renal dietitians, and thus profitable for patients. Don't just sit there reading! Get on the bus. We have a place for you, and believe me, it is fun. Here's to a great year!

Member Issues:

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Renal Practice Group: Educational Materials

Title/Description	*Price*
Eating Simply with Renal Disease: (25 per pkg) Simple overview of the renal nutrition plan for patients with CKD Stage 5	$15.50 per pkg
Eating Simply with Renal Disease: (25 per pkg) Spanish version of the renal nutrition plan overview for patients with CKD Stage 5	$15.50 per pkg
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Please Note:
Shipping and Handling Fees: 1 – 3 items: $5.00 4 – 13 items: $10.00 (pkg of 25 = 1 item)

To order materials:
Please download order form from RPG website at www.renalnutrition.org under Member Resources.
Make checks payable to: ADA/DPG#21

Mail form and check to:
Pam Kent – RPG Treasurer
114 Infantry Road, Vermillion, OH 44089

For additional information:
Please contact Pat Williams at gpatwill@comcast.net

CRN CHAIRPERSON MESSAGE

Revisiting the Nutrition Guidelines

Deborah Brommage

In June 2000, the NKF KDOQI Clinical Practice Guidelines for Nutrition in Chronic Renal Failure were published. This important body of work redefined how dietitians in nephrology care evaluate nutritional status and calculate nutrition needs of patients on maintenance dialysis. Measures for monitoring nutritional status and frequency of measurements were established. Emphasis was also placed on non-biochemical nutrition markers such as subjective global assessment (SGA) to emphasize that no single measure provides a comprehensive means of assessing protein-energy malnutrition.(1)

Subsequent discussions regarding the nutrition guidelines focus on the fact that although the guidelines have not been updated for six years, the science has not changed significantly to warrant the reconvening of a workgroup. Financial support for a revision is also a major consideration. But there are several areas that CRN members have expressed concern over and deserve our attention. These areas include calculation of adjusted body weight, determination of standard body weight or healthiest weight, and predictive equations versus indirect calorimetry (IC) equipment for estimating energy needs in CKD. These are critical issues since we have an obligation to make recommendations for goals and safety levels of nutrients for our patients.

One controversial issue is that the K/DOQI formula for adjusted edema-free body (aBWef), which is used to calculate protein and energy needs, is the reverse of the traditional method registered dietitians have used in the past. The K/DOQI equation, which is to be used for both overweight and underweight patients, adjusts weight by a smaller amount so that the overweight person can gradually adjust to a lower caloric intake and the under weight person can gradually adjust to a higher caloric intake. This requires that dietitians continually revise the nutrient levels as the patient gains or loses weight and necessitates the use of clinical judgment especially in morbidly obese patients. Since neither method for calculating aBWef has been validated, the rationale for their use raises speculation. The guidelines research recommendations state that the use of the equation for calculation of aBWef needs to be validated experimentally. There is also the question as to whether adjusted body weight should be used at all, and that validation of predictive energy equations and use of handheld indirect calorimetry equipment to determine energy requirements for the CKD population needs to be studied.(2)

The K/DOQI method using NHANES for determining standard body weight for patients with CKD has also raised concerns. NHANES data represents body weights of the normal US population but these weights have risen over the past 30 years and are not actually linked to morbidity and mortality (3). NHANES also uses frame size based on elbow breadth determined by sliding bicondylar caliper measurement. Since many clinicians do not have access to this measuring tool, other methods to determine frame size, such as wrist circumference using a tape measurement, are being applied to the NHANES data.

The use of body mass index (BMI) to determine healthy weight for dialysis patients has been suggested since BMI correlates to morbidity and mortality, and data is available for chronically ill patients. Calculating BMI (weight / height2) does not require the use of frame size measurements or tables and is representative of all ethnic, economic and age groups (3). The K/DOQI Nutrition Workgroup recommended BMI in the upper 50th percentile for the dialysis population, which is 23.6 for men and 24 for women (1). Research to determine the best BMI for patients with CKD is needed.

These issues imply that the following nutrition research areas for the CKD population are a high priority:

- Validation of the equation for calculation of adjusted body weight
- Validation of predictive energy equations and hand held IC equipment
- Determination of a BMI range predictive of healthiest weight

CRN offers members the opportunity to apply for research

Continued on page 15

 continued from page 14

grant funding for viable projects related to renal nutrition issues (see the CRN website for details).

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3. Harvey, KS: Evaluation of body weight. NKF 2005 Spring Clinical Meetings, Washington DC. May 4 – May 8, 2005.

Eating Simply with Renal Disease: Simple overview of the renal nutrition plan for patients with CKD Stage 5

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Please see page 13 for ordering information

Annual RPG Leadership Meeting

The annual RPG leadership meeting took place in Jackson Hole, WY in early June. This picture shows the entire board following an educational presentation: (left to right) top - Cathy Goeddeke-Merickel, Pam Kent, Cathi Martin, our waiter, Lesley Wujastyk, Pat Weber, Jane Louis, bottom - Connie Cranford, Lois Hill, Sharon Griff, Marrianne Hutton.

During the annual RPG leadership meeting, a team building event was held. Team members had to navigate around Jackson Hole using a GPS syste, and clues in order to reach the final destination: (clockwise): Lois Hill, Marianne Hutton, Jane Louis, Pam Kent, Lesley Wujastyk, Cathy Goeddeke-Merickel, Sharon Griff, Pat Weber, Connie Cranford, Cathi Martin.

RPG Member Advantages

As a member of the Renal Practice Group, you have numerous member-only benefits available to you. Below is a description of awards and scholarships that you may apply for online. As with many opportunities, it is up to the individual to start the process for a scholarship, research grant, or stipend award.

Scholarships:

RPG offers a one-time scholarship, for tuition only, of up to $2000 for anyone pursuing a post -baccalaureate degree in a field applicable to renal nutrition. Qualifications include being an RD and/or DTR, an ADA-RPG member for the past year, worked in the field of dietetics for the past year or are currently working in the field and demonstrate active enrollment in a program at an accredited university and commitment to complete the program with financial assistance.

Research Grant:

RPG offers a onetime payment of up to $500 for a RPG member pursuing an original research project in an area related to or benefiting those with renal disease.

Stipend Awards:

RPG supports continuing education in the area of renal nutrition for its members. RPG will award up to $500 for a member to attend a program of interest. The program must deal with issues concerning the patient with CKD or treatment of CKD. The applicant is required to summarize the meeting or an aspect of the meeting to be printed in the RPG Renal Nutrition Forum.

Outstanding Service Award (OSA):

RPG offers an Outstanding Service Award to one of its members. This award recognizes an RPG member who has demonstrated leadership of and service to the practice group; shown initiative and dedication while working to promote good nutrition in patients with renal disease and worked for promotion of dietitians involved in the care of renal patients.

RPG members can find out more information, including policies and application forms, by visiting the ADA-RPG website at www.renalnutrition.org and click on the member resources tab.

Congratulations to all of the 2005 – 2006 recipients

Scholarship - 2005:
Joyce Vergili, MS, RD

Stipend Awards – 2005-2006:
Jean Olson and Susan Salmi attended NKF Spring Clinical Meeting in Chicago.

Roxanne Poole attended FNCE'2005 in St. Louis.

Allison Hull attended the Northwest Renal Dietitians Spring meeting in Anchorage, Alaska.

OSA recipient - 2005:
Judith Beto,PhD, RD, LD, FADA

2005 - 2006 RPG Membership Survey Results

Thank you to the RPG members who took the time to complete the 2006 Membership Survey. Your feedback is extremely valuable to the organization as decisions are made regarding future allocation of resources for member benefits.

Overall, 88% of the respondents believe that the greatest member benefit of RPG is the education opportunities provided. Unfortunately, only 5% of you felt that meeting stipends and scholarships were of value. Please review the information on page 20 that explains these benefits in detail so that you may take advantage of these opportunities in the future.

Many of the comments received focused on continuing education. It is clear that the membership would like to see additional CEU offerings in the Forum. Please look for CEU opportunities in upcoming issues. One of the goals of the editorial board is to increase the frequency of CEU approved issues to meet your needs.

Just as the world of renal evolves, so does our membership. It is always important for RPG to continually assess the needs of our members to ensure that you are a valued resource in nephrology nutrition. Please feel free to contact Connie Cranford, Membership Chair, at connie.cranford@davita.com with any questions regarding your membership or benefits.

The results of the ***Compensation & Benefits Survey of the Dietetics Profession 2005*** are in and the news is good: dietetics salaries are on the rise. The survey, conducted May 11 to July 5, 2005 by Readex Research on behalf of the American Dietetic Association (ADA) and the Commission on Dietetic Registration (CDR), collected demographic, employment, and compensation data from over 12,000 dietetics professionals. Both registered dietitians (RDs) and dietetic technicians, registered (DTRs) reported wage gains equal to or greater than inflation, an 8.2% increase over the median income levels reported in the previous compensation survey, conducted in 2002. It was also found that dietetics professionals receive benefits packages considered among the best in any profession.

In order to understand the factors that contribute to the level of compensation dietetics professionals receive, the survey collected specific information about education levels, work experience, job responsibilities, ADA membership, and practice area. First, it was found that higher education isnít just its own reward, as advanced degree earned brought with it a substantial increase in median income, with a jump of $5,000 per year a Masterís degree, and a median increase of over $20,000 a year for a Doctoral degree. Dietetics professionals also earn more than the national average for each degree they earn. When it comes to work experience and responsibility, the more you have, the more you earn. Not surprisingly, income continues to rise as experience is gained. Compensation also increases with greater responsibility, as management of both employees and budgets brings significant gains in pay. Earnings varied according to practice area, and the survey identified those areas experiencing the most growth as well as those with the highest salaries, with private practice being the most lucrative. Last but not least, the survey found that ADA members had a median income more than $3,000 higher than non-ADA members.

The complete, 190-page *Compensation & Benefits Survey of the Dietetics Profession 2005* contains much more detailed, in-depth analysis of salaries, including compensation analysis for 48 different positions in dietetics and salary calculation worksheets to help dietetics professionals determine their own fair level of compensation. To order your own copy of the survey, call ADA at 800-877-1600, ext. 5000 or visit the online catalog at www.eatright.org/catalog.

2005-2006 RPG Executive Committee

Mission: Renal dietitians dietetic practice group is leading the future of dietetics by promoting and supporting ADA members working in nephrology practice.
Vision: RPG members are a valued source of expertise in nephrology nutrition.

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