|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Ref | Time | doi | PMID | Country | Relation | Variable |  | Gender | Calcification | Complications | CKD stages | sample |
| (1) | 2001 | 10.1159/000046119 |  |  | associates | Osteopontin | r=0.749 (age- and sex-matched) | x | Aortic calcification index (ACI) |  | 5D (HD) | 71 |
| (2) | 2013 | 10.1186/1471-2369-14-221 | 24119158 |  | causes | Male sex | All patients: OR 4.218 (1.403-14.207)  eGFR < 30: OR 4.167 (1.050-20.178) | v | Abdominal aortic calcification (AAC) (Kauppila Index) |  | 3-4 | 178 |
|  |  |  |  |  |  |  | Lack of a FEP-FGF23 correlation in patients with severe AAC (KI > 5) suggested a role for an impaired phosphaturic response to FGF23 but not to PTH in AAC. Logistic and zero-inflated analysis confirmed the independent association of age, CKD stage, male gender and CP with AAC, and also identified a threshold FEP/FGF23 ratio of 1/3.9, below which the chances for a patient of presenting severe AAC increased by 3-fold. |  |  |  |  |  |
| (3) | 2017 | 10.1186/s12882-017-0480-2 | 28253835 |  | complications | AAC score | OR 1.19 (1.07–1.30) | v | AAC | Coronary artery disease | 5D | 90 |
|  |  |  |  |  |  | Male gender | Univariate: 2.59 (1.00–6.68)  Multivariate: 2.73 (0.95–7.82) |  |  |  |  |  |
| (4) | 2012 | 10.1371/journal.pone.0039241 | 22723973 |  | complications | Male gender | β = -0.34 (-13.45– -4.48) | v | AAC | Left ventricular mass index | 3 | 120 |
|  |  |  |  |  |  | Mean femoral Z-score | β = -0.23 (-4.75– -0.85) |  |  |  |  |  |
|  |  |  |  |  | associates | Male gender | +24% compared to no calcification |  |  |  |  |  |
| (5) | 2009 | 10.1111/j.1525-1594.2009.00814.x | 19681840 |  | causes | Male gender | HR 0.87 (0.56–0.91, p=0.87) | v | Coronary artery calcification score (CACS) |  | 5D (HD) | 102 |
|  |  |  |  |  |  | HD vintage | HR 0.85 (0.58–0.95)  Independent of other influencing factors, HD vintage and serum PTH levels were significant determinants of low bone mass and T-scores in all anatomical sites whereas fetuin-A was an independent predictor in proximal radius, femoral neck, and trochanter |  | CACS |  |  |  |
|  |  |  |  |  |  | Serum PTH | Standard regression coefficient -0.21– -0.33 |  | Bone mineral densities (BMD) |  |  |  |
|  |  |  |  |  |  | Fetuin-A | Standard regression coefficient -0.29– -0.41 |  | BMD |  |  |  |
| (6) | 2021 | 10.1186/s12882-021-02251-y | 33541279 |  | complications | Male gender | B = 31.0 | v |  | Maximal ergometry workload (WMAX) | 4-5 | 174 |
|  |  |  |  |  |  | AAC score | B = -1.44 |  | AAC | WMAX% < 50% |  |  |
|  |  |  |  |  |  |  | AAC and TnT showed fair predictive power for WMAX% less than 50% of the expected value with AUCs of 0.70 and 0.75, respectively. |  |  |  |  |  |
| (7) | 2013 | 10.1186/1471-2369-14-122 | 23758931 |  | causes | Gender | β = -0.163 | v | Common carotid intima-media thickness (ccIMT) |  | 5D (HD) | 81 |
| (8) | 2014 | 10.1159/000360230 | 24847332 |  | complications | Male gender | HR 2.354 (1.371 – 4.042) | v | AAC | Cardiovascular mortality | 5D (HD) | 712 |
|  |  |  |  |  |  | AAC Grade 3 | HR 2.497 (1.237 – 5.043) |  |  | Cardiovascular mortality |  |  |
|  |  |  |  |  |  |  | HR 1.604 (1.058 – 2.431) |  |  | All-cause mortality |  |  |
| (9) | 2017 | 10.1159/000360230 | 27988970 |  | causes | Male gender | total iliac: 1.00 (0.25-1.75) vs. 0.50 (0.13-1.13) | v | Iliac vascular calcification grade |  | 5T | 205 |
|  |  |  |  |  |  | Male gender | external iliac: 1.00 (0.00-1.50) vs. 0.00 (0.00-0.50) |  |  |  |  |  |
|  |  |  |  |  |  | Male gender | left common iliac: 1.00 (0.50-2.00) vs. 1.00 (0.00-1.88) |  |  |  |  |  |
|  |  |  |  |  |  |  | \*Not adjusted for age |  |  |  |  |  |
|  |  |  |  |  |  | Older than 55 yrs | 1.25 (0.50-2.00) vs. 0.50 (0.00-1.16) |  | Total iliac calcification (without distal aortic segment) |  |  |  |
|  |  |  |  |  |  |  | Median total calcification score was 3 (2.2-3) in the patients declined for renal  transplantation, with similar results in the different regions of the iliac arteries. |  |  |  |  |  |
| (10) | 2020 | 10.1186/s12882-020-1710-6 | 32033584 |  | causes | Male gender | OR 4.4 (1.6–11.1) | v | Inferior epigastric artery & CACS |  | 5-5D | 149 |
|  |  |  |  |  |  |  | Male -x copeptin: β = −0.08 (0.31) |  |  |  |  |  |
|  |  |  |  |  |  | Copeptin (1-SD increase) | OR 1.6 (1.1–2.6) |  |  |  |  |  |
|  |  |  |  |  |  |  | Mechanisms of vascular calcification in CKD. In the setting of uraemic milieu, activation of renin-angiotensin and vasopressin systems,  upregulation of sodium-dependent phosphate transporter Pit-1 promotes osteochondrocytic transformation and apoptosis of vascular smooth muscle cell (VSMC) and, in consequence, accelerated vascular calcification |  |  |  |  |  |
|  |  |  |  |  |  | Higher Age (1-SD increase) | OR 2.5 (1.5–4.1) |  |  |  |  |  |
|  |  |  |  |  |  | Diabetes | OR 23.2 (2.5–210.5) |  |  |  |  |  |
| (11) | 2011 | 10.2215/CJN.03910411 | 21940840 |  | Associates | Female gender | Female -> Osteoprotegerin: 10.2% (0.2%– 21.3%) | v | OPG (percentage difference) |  | 1-5 | 226 |
|  |  |  |  |  | Causes | Osteoprotegerin (OPG) | Reference |  | Aortic pulse wave velocity |  |  |  |
|  |  |  |  |  |  |  | Tertile 2 (5.05 to 7.45 pmol/L): 1.06 (0.97– 1.15) |  |  |  |  |  |
|  |  |  |  |  |  |  | Tertile 3 (7.46 to 22.31 pmol/L): 1.10 (1.01– 1.20) |  |  |  |  |  |
| (12) | 2015 |  | 26629071 |  | associates | 5-hydroxyvitamin D | r = 0.193 | x | Kauppila score |  | 5D (HD) | 126 |
| (13) | 2019 | doi.org/10.1186/s12882-019-1235-z | 30777028 |  | causes | Total body bone mineral density (tBMD) in female | β = −0.27, se = 0.12, p = 0.03 | v | CACS |  | 5 | 174 |
|  |  |  |  |  |  | BMD at legs in female | β = −0.28, se = 0.12, p = 0.02 |  |  |  |  |  |
|  |  |  |  |  |  |  | Multivariate generalized linear model  (GLM) analysis adjusted for age, diabetes and hsCRP showed that in females per SD higher CAC score (1057 AUs) was  predicted by either per SD (0.13 g/cm2) lower tBMD or per SD (0.17 g/cm2) lower BMD at legs. **No such associations were found in male** **ESRD patients**. |  |  |  |  |  |
| (14) | 2017 | 10.1111/eci.12718 | 28036114 |  | Causes | Male gender | After adjustments for confounders by GLM (age, gender, BMI, diabetes, inflammation), only age, male gender, diabetes and statins remained significantly related to high CAC score. | v | CACS |  | 5D-5T | 240 |
|  |  |  |  |  |  |  | Model with hsCRP: estimate = −0.38, se = 0.11, p = 0.005 |  |  |  |  |  |
|  |  |  |  |  |  |  | Model with IL-6: estimate = 0.40, se = 0.13, p = 0.002 |  |  |  |  |  |
|  |  |  |  |  |  |  | Model with TNF but without statins: estimate = 0.35, se = 0.13, p = 0.008 |  |  |  |  |  |
|  |  |  |  |  |  | Statins | Model with hsCRP: estimate = 0.29, se = 0.11, p = 0.009 |  |  |  |  |  |
|  |  |  |  |  |  |  | Model with IL-6: estimate = 0.44, se = 0.14, p = 0.001 |  |  |  |  |  |
|  |  |  |  |  | Modifier | Statins | 0 (0-531) AUs to 273 (0-1256) AUs after 1.5 years of RRT |  | CACS |  |  |  |
|  |  |  |  |  | Complications | CACS | HR 1.52 (1.12-2.06) |  |  | Mortality |  |  |
| (15) | 2015 | 10.3109/0886022X.2015.1077316 | 26336882 |  | complications | Simple  vascular calcification score (SVCS) | https://www.tandfonline.com/na101/home/literatum/publisher/tandf/journals/content/irnf20/2015/irnf20.v037.i09/0886022x.2015.1077316/20151009/images/medium/irnf_a_1077316_f0002_c.jpg | v | SVCS | Vascular access flow (DU-Qa) | 5D (HD) | 50 |
|  |  |  |  |  |  | Male gender | P = 0.575 |  |  |  |  |  |
| (16) | 2008 |  | 19259046 |  | causes | Male gender | +27% compared to female (80/91 vs. 36/59) | v | Arterial intimal & media calcification (AIC & AMC) |  | 5D (HD) | 150 |
|  |  |  |  |  |  |  | The present results suggest a few emerging risk factors for the occurrence of arterial  calcifications, especially of AIC in our HD patients, such as age older than 55, male gender, diabetes, as well as higher CRP (> 4.5 mg/L), blood leucocytes (> 6.5 × 109L), corrected total serum Ca (> 2.35 mmol/L), serum triglycerides (> 1.8 mmol/L), PP (> 60 mmHg) and BMI (> 23 kg/m2). |  |  |  |  |  |
|  |  |  |  |  |  |  | Our findings of significantly higher percentages of ACA in patients who were younger (under  55 yrs at inclusion and 45 yrs at the start of HD), predominantly female, without diabetes and with higher percentages of K/DOQI guideline recommended levels for serum Ca, are supportive of the previous reports [11, 15, 17]. |  |  |  |  |  |
| (17) | 2010 | 10.2215/CJN.02560310 | 20576822 |  | associates | Male gender | R = -0.181, p = 0.016 | v | Gensini score |  |  |  |
|  |  |  |  |  |  |  | The Gensini score values significantly correlated in univariate analysis with gender (R = -0.181, P = 0.016), presence of hyperension (R = 0.203, P = 0.007), HDL cholesterol level (R = -0.158, P = 0.047), eGFR (R = -0.315, P 0.001), iPTH (R = 0.152; P = 0.044), FGF 23 (R = 0.868; P = 0.001), and fetuin A levels (R = 0.491; P = 0.001) but not with the vitamin D values. |  |  |  |  |  |
| (18) | 2008 | 10.1111/j.1365-2362.2008.02032.x | 19021697 |  | complications | Low fetuin-A | HR 2.3 (1.2–4.5) | x | Fetuin-A inhibits vascular calcification | Mortality | 5D (HD) | 222 |
|  |  |  |  |  |  |  | Patients with low fetuin-A levels (< median) had higher mortality (Hazard ratio ‘HR’ 2·2; CI 1·4–3·5, P< 0·001), but this association was lost after adjustment for age, gender, comorbidities score, dialysis vintage and inflammation (CRP > median). In inflamed patients with low fetuin a significantly independent association with mortality (HR 2·3; CI 1·2–4·5, P= 0·01) was observed compared to non-inflamed patients with high fetuin-A, after adjusting for the same variables. |  |  |  |  |  |
| (19) | 2016 | 10.15386/cjmed-515 | 27004031 | Romania | complications | male gender | HR 14.96 (2.09-106.98) | v | vascular or  other soft tissue calcifications (VC) by plain film | all-cause mortality | 5D (HD) | 92 |
|  |  |  |  |  |  | VC score | HR 1.30 (1.05-1.59) |  |  |  |  |  |
|  |  |  |  |  |  |  | HR 1.387 (1.095-1.757) |  | Cardiovascular mortality |  |  |  |
|  |  |  |  |  |  |  | Multivariable Cox analysis of CdV mortality used  as covariates age, gender, HD vintage, presence of DM,  VC score, presence of ROD, Ca in dialysis solution, oral  Ca salts, vitamin D treatment, serum Ca, P, iPTH, ALP,  creatinine, Hb, cholesterol, trygliceride, CRP, albumin,  ferritin levels, URR, spKt/V baseline renal disease, initial  CdV disease. The method was Forward LR stepwise.  VC score (HR=1.387; 95.0% CI 1.095-1.757; p=0.007)  and URR (HR=0.942; 95.0% CI 0.888-0.999; p=0.046)  remained in the ecuation. **Increased VC score and decreased**  **URR represent risk factors for CDV mortality.** |  |  |  |  |  |
| (20) | 2012 | 10.1093/ndt/gfs219 |  |  | causes | Male gender | T ratio = 2.15, p = 0.04 | v | Aortic calcification score (ACS) |  | 3-5 | 106 |
| (21) | 2013 | 10.1016/j.ejmhg.2013.07.003 |  |  | Causes | Male gender |  | ? | SVCS |  | 5-5T | 73 |
|  |  |  |  |  |  |  | VC was significantly associated with older age, male gender, longer HD duration, lower albumin, higher LDL-c, higher carotid plaques and lower BMD at the lumbar spine and the T-score value but had no significant association with the following parameters: duration of transplantation, blood pressure, total cholesterol, TG, Ca, PO4, Ca·PO4, iPTH, CRP, fetuin A, e-GFR and IMT. Also no significant association was seen between fetuin-A gene polymorphism and VC. Patients with VC had higher CRP than those without but did not reach a significant value. (Table 10). | P = 0.056 不應該相關，但是內文說相關 |  |  |  |  |
| (22) | 2015 | 10.1093/ndt/gfv200.30 |  |  | Causes | Gender? | HR 0.50 (0.28-0.87) | v | Adragao calcification scores | All-cause mortality | 5D (HD) | 220 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| (23) | 2009 | 10.1159/000221064 | 19468238 |  | Causes | Male gender | 2.75 (1.41–5.38) | v | Adragao calcification score |  |  |  |
|  |  |  |  |  |  |  | 2.32 (1.19–4.52) |  | Composite score |  |  |  |
| (24) | 2014 | 10.1007/s00223-013-9811-x | 24193439 |  | complications | Male gender | HR 0.225 (0.100-0.509) | ? |  | All-cause mortality | 5D | 120 |
|  |  |  |  |  |  |  | HR 0.043 (0.008-0.241) |  |  | cardiocerebrovascular  mortality |  |  |
| (25) | 2005 | 10.1093/ndt/gfi236 | 16263735 |  | causes | Male gender | Calcification tertile 1/2/3: 18 (46%) / 28 (71%) / 39 (81%), P<0.001 | v | Multi-slice spiral CT scanning of a 5 cm standardized  segment of superficial femoral artery |  | 4-5D | 134 |
| (26) | 1988 | 10.1159/000184864 | 3340252 |  | Associates | Male gender | Simple covariance coefficient = 1.97, p < 0.01 | V | Linear calcifications of the abdominal aorta and of the iliac and femoral arteries |  | 5D (HD) | 24 |
| (27) | 2008 | 10.1053/j.jrn.2008.04.003 | 18721733 |  | ? | Female gender | Vitamin D deficient vs. sufficient: 53% vs. 28%, p < 0.05 | ? | semiquantitative (0 to 6) score of vascular calcification by using x-rays, in accordance with London et al. |  | 5D (HD) | 253 |
|  |  |  |  |  |  |  | Vitamin D deficiency was reported to be  associated with cardiovascular calcification, 5 |  |  |  |  |  |
| (28) | 2002 | 10.1053/ajkd.2002.30955 | 11774125 |  | modifiers | Male gender | Indeed, this observation is reminiscent of our own observation regarding the **extension of calcification** assessed prospectively on 3 years in 24 hemodialysis patients who never received vitamin D derivatives. The calcifications were measured on lateral and frontal X rays of lumbar spine and pelvis at the level of aorta, iliac, and femoral arteries.' This extension was exponential, and simple covariance analysis showed that the main significant risk factors for extension were **male gender**, age (only in male patients) | v | Extension of calcification |  | 5D (HD) | 24 |
| (29) | 2014 | 10.1371/journal.pone.0114358 | 25479288 |  | causes | Male gender | OR 4.92 (2.07–11.70) | v | CACS |  | 2-5 | 117 |
|  |  |  |  |  |  | Pericardial fat | OR 1.85 (1.00-3.42) |  |  |  |  |  |
| (30) | 2013 | 10.1186/1471-2369-14-263 | 24289833 |  | complications | Aortic arch calcification score (AoAC) | Score 1 1.52 [0.99, 2.34] 0.06 | x | AoAC | Mortality | 5D (HD) | 824 |
|  |  |  |  |  |  |  | Score 2 1.22 [0.72, 2.05] 0.47 |  |  |  |  |  |
|  |  |  |  |  |  |  | Score 3 2.49 [1.28, 4.82] 0.01 |  |  |  |  |  |
| (31) | 2011 |  | 22259897 |  | Associates | Gender | No association between VC and gender | x | Hand X-rays |  | 5D (HD) | 43 |
| (32) | 2019 |  | 31122190 |  | Associates? | Female gender | OPG tertile 1/2/3: 62.5% / 55.0% / 32.%, p = 0.008\* | v | OPG |  | 5D (HD) | 120 |
|  |  |  |  |  |  |  | Bone loss -> OPG -> calcification |  |  |  |  |  |
| (33) | 2014 | 10.1186/1471-2369-15-190 | 25465028 | Brazil | Associates? | Gender (M/F) | Low vs High sclerostin: 24/22 vs. 31/14, p = 0.103 | x | Sclerostin |  | 5D (HD) | 91 |
|  |  |  |  |  | Complications? | Male sex (versus  female) | HR 0.82 (0.39-1.75), p = 0.620 | x |  | Mortality |  |  |
|  |  |  |  |  |  | Sclerostin | HR 2.18 (1.41-3.38) |  |  |  |  |  |
| (34) | 2011 |  | 22013298 |  | Associates? | Gender | No association with superficial temporal artery calcification |  |  |  |  |  |
| (35) | 2018 | 10.1186/s12882-018-0872-y | 29558928 |  | Causes | Male gender | OR 3.29 (1.27–8.53) | v | Abdominal aortic calcification index |  | 5D (HD) | 184 |
| (36) | 2018 | 10.1080/0886022X.2018.1455588 | 29619867 |  | Complications | Male gender | HR 2.89, p = 0.357 | x | aortic arch calcification | Cardiovascular event | 5T | 37 |
|  |  |  |  |  |  |  | Multivariate linear regression revealed that **donor age, donor gender, and recipient eGFRdischarge (R-squared 0.65, p = 0.002)** better predict eGFR1year than AoAC combined with recipient eGFRdischarge (R-squared 0.35, p = 0.006). During 1-year follow-up, four (10.81%) patients experienced **cardiovascular events**, which were predicted by **PWV ratio** (HR 7.549, p = 0.045), but **not related to AoAC score** (HR 1.044, p = 0.158). |  |  |  |  |  |
| (37) | 2014 | 10.1111/nep.12210 | 24447254 | Thailand | causes | Male gender | Kidney transplant, univariate: OR 2.36 (1.13–4.91), p = 0.02\* | v | Total vascular calcification score |  | 5-5T | 261 |
|  |  |  |  |  |  |  | Kidney transplant, multivariate: OR 2.49 (0.87–7.14), p = 0.09 |  |  |  |  |  |
|  |  |  |  |  |  |  | CKD 5-5D, univariate: 1.44 (0.71–2.91), p = 0.32 |  |  |  |  |  |
|  |  |  |  |  |  |  | CKD 5-5D, multivariate: 2.02 (0.71–5.78), p = 0.19 |  |  |  |  |  |
| (38) | 2014 | 10.1111/nep.12212 | 24506475 |  | ? | Gender | Not significant | x | abdominal aorta  calciﬁcation score ≥ 1 | All-cause mortality | 5T (KT or simultaneous pancreas-kidney transplantation [SPKT]) | 531 |
|  |  |  |  |  |  |  | Patients with 25D <or= 16.7 ng/ml (median) had a significantly lower survival rate than patients with 25D >16.7 ng/ml (mean follow-up, 605 +/- 217 d; range, 10 to 889; P = 0.05). Multivariate adjustments (included age, gender, diabetes, arterial pressure, CKD stage, phosphate, albumin, hemoglobin, aortic calcification score and PWV) confirmed 25D level as an independent predictor of all-cause mortality. |  |  |  |  |  |
| (39) | 2019 | 10.1159/000501392 | 31291619 |  | associates | Male gender (%) | Stable PWV vs. increased PWV: 33% vs. 75% | v | Pulse wave velocity as surrogate |  | 5D (PD) | 24 |
| (40) | 2015 | 10.1210/jc.2015-3056 | 26505822 |  | causes | Male gender (F 1) | β = -0.64, t = 5.6, p = 0.0001 | v | Baseline CACS |  | 5T | 268 |
|  |  |  |  |  |  |  | β = -0.32, t = 2.3, p = 0.008 |  | Baseline aortic calcification |  |  |  |
|  |  |  |  |  | modifiers | Male gender | β = -0.45, t = 4.01, p = 0.0001 |  | Annualized CACS change |  |  |  |
|  |  |  |  |  |  |  | OR 2.1 (1.1–3.7) |  |  |  |  |  |
|  |  |  |  |  |  |  | β = -0.24 , t = 2.36, p = 0.02 |  | Annualized aortic calcification change |  |  |  |
|  |  |  |  |  | causes | Male gender | P = 0.002 |  | Sclerostin |  |  |  |
|  |  |  |  |  |  |  | In multivariate regression analysis, higher age (P =.0001), male gender (P =.002), lower eGFR (P =.002), lower PTH (P =.0001) and lower calcitriol levels (P =.05) were identified as independent determinants of higher levels of circulating sclerostin. |  |  |  |  |  |
|  |  |  |  |  |  | Sclerostin | Remarkably, **a lower circulating sclerostin** **level** was identified as independent determinant of a higher baseline AoC score in the final regression model, ie, **after adjustment** for traditional (older age, male gender, high BMI, presence of  diabetes, hypertension) and nontraditional (inflammation, high PTH, low calcidiol, long dialysis vintage) risk factors |  | baseline aortic calcification score |  |  |  |
| (41) | 2019 | 10.1159/000501687 | 31437840 | Sweden | causes | Male gender | β = 0.413, p = 0.030 | V | AAC volume |  | 3-4 | 84 |
| (42) | 2018 | 10.1159/000494441 | 30347400 | Japan | cuases | Male gender | β = 0.221, 95%CI 0.124–0.319, p <0.0001 | v | AoAC score |  | 5D (HD) | 216 |
| (43) | 2004 | 10.1053/j.jrn.2004.09.027 | 15648030 | Japan | Causes | Male gender | OR 3.380 (1.289-8.860) | V | Vascular calcification |  | 5D (HD) | 332 |
| (44) | 2010 | 10.1038/ki.2010.70 | 20237457 | USA | Causes | Male gender | Using multivariate linear regression analysis, increasing age  (P = 0.001), male gender (P = 0.01), and non-Latino whites (P = 0.003) were independently associated with a higher log-  transformed baseline CAC score. | 沒有列詳細數據 | CAC |  | 1-5 | 225 |
| (45) | 2017 | 10.1007/s11255-017-1515-0 | 28124305 | Serbia | causes | Female gender | OR 0.134 (0.04–0.45) |  | calcification in arteriovenous fistula (AVF)-blood vessels |  | 5D (HD) | 90 |
| (46) | 2014 | 10.1159/000368476 | 25571879 | Japan | Causes | Male gender (%) | Grade 0 vs. 1 vs. 2+3: 98/126 vs. 63/112 vs. 37/63, p = 0.0009 | v | AoAC |  | 5D (HD) | 301 |
|  |  |  |  |  | Complications | Male gender | Univariate: HR 1.502 (0.624-4.163), p = 0.3772 |  |  | Cardiovascular mortality |  |  |
|  |  |  |  |  |  |  | Univariate: HR 1.485 (0.746-3.215), p = 0.2690 |  |  | All-cause mortality |  |  |
|  |  |  |  |  |  | AoAC Grade 1 | Univariate: HR 2.838 (1.053-8.920), p = 0.0390 |  |  | Cardiovascular mortality |  |  |
|  |  |  |  |  |  |  | Multivariate: HR 1.731 (0.616-5.623), p = 0.3065 |  |  |  |  |  |
|  |  |  |  |  |  | AoAC Grade 2+3 | Univariate: HR 4.636 (2.794-9.149), p = 0.0011 |  |  |  |  |  |
|  |  |  |  |  |  |  | Multivariate: HR 2.629 (1.455-5.124), p = 0.016 |  |  |  |  |  |
|  |  |  |  |  |  | AoAC Grade 2+3 | Univariate: HR 3.409 (2.015-5.781), p = 0.0261 |  |  | All-cause mortality |  |  |
|  |  |  |  |  |  |  | Multivariate: HR 1.699 (1.052-2.680), p = 0.0222 |  |  |  |  |  |
| (47) | 2015 | 10.1159/000380823 | 25823466 | Serbia | causes | Male gender | β = –0.432, p < 0.001 | v | overall calcification  score |  | 5D (HD) | 90 |
| (48) |  |  |  |  |  |  | Compared with those with no RAC, those with RAC >0 were significantly older but not different by gender or race. | x |  |  |  |  |
| (49) |  |  |  |  |  |  | Compared with controls, **warfarin-treated male** patients had more vertebral fractures (77.8 vs. 57.7%, p<0.04), but not females (42.1% vs. 48.4%, p=0.6); total BGP was significantly reduced (82.35 vs. 202 µg/L, p<0.0001), with lower levels in treated men (69.5 vs. women 117.0 µg/L, p=0.03). In multivariate logistic regression analyses, the use of **warfarin** was associated with **increased odds of aortic (OR 2.58, p<0.001) and iliac calcifications (OR 2.86, p<0.001);** identified confounders were age, atrial fibrillation, angina, PPI use and total BGP. Seventy-seven patients died during a 2.7±0.5 year follow-up. In univariate Cox regression analysis, patients on warfarin had a higher risk of all-cause mortality (HR 2.42, 95% CI 1.42-4.16, p=0.001) when compared with those untreated and data adjustment for confounders attenuated but confirmed the significant warfarin-mortality link (HR: 1.97, 95% CI: 1.02-3.84, P=0.046). |  |  |  |  |  |
| (50) | 2002 | 10.1007/s00125-002-0920-8 | 12378387 | Japan | causes | Male gender | OR 3.380 (1.289-8.860) | 重複 | Vascular calcification |  | 5D (HD) | 421 |
| (51) | 2011 | 10.1093/ndt/gfr089 | 21414968 | The Netherlands | Complications | Female gender | B = 3.14, β = 0.23, 95% CI -0.05–6.32, p = 0.05 | v |  | Capillary recruitment | 5D | 35 |
|  |  |  |  |  |  |  | Male -> rarefaction |  |  |  |  |  |
| (52) | 2016 | 10.1007/s11255-016-1231-1 | 26865177 | Turkey | causes | Male gender | RR 4.14 (2.01–8.51) | v | CACS |  | 5D (HD) | 224 |
|  |  |  |  |  |  | FGF-23 (per 50 pg/ml) | RR 1.17 (1.05–1.30) |  |  |  |  |  |
| (53) | 2013 | 10.1159/000334597 | 22143191 | Belgium | causes | Male gender (%) | PWV ≤ 7.35 m/s vs. > 7.35 m/s: 74 vs. 56, p = 0.05 | v | PWV |  | 5T | 115 |
|  |  |  |  |  | complications | Gender | Parameter estimate = 1.07001, p = 0.0182, HR 2.915 (1.2–7.08) |  |  | Cardiovascular events |  |  |
|  |  |  |  |  |  | AC present | Parameter estimate = 3.07957, p = 0.0024, HR 21.749 (2.97–159.4) |  | Aortic calcification |  |  |  |
|  |  |  |  |  |  | AC score | Parameter estimate = 0.16250, p <0.0001, HR 1.176 (1.11–1.244) |  |  |  |  |  |
| (54) | 2011 | 10.1016/j.bone.2011.01.016 | 21281749 | UK | Causes | Male gender | β = 0.29, t =2.04, p =0.049 |  | Arterial Stiffness (SIDVP) |  | 1-4 | 145 |
| (55) | 2012 | 10.1159/000334597 | 22143191 | Belgium | complications | Female gender | Univariate: Parameter estimate = –7.9, p = 0.05, R2 = 0.014 | v |  | Prolonged corrected QT interval | 5T | 193 |
|  |  |  |  |  |  | Aortic calcification score | Univariate: Parameter estimate = 1.12, p= 0.0017, R2 = 0.045 |  | Aortic calcification score |  |  |  |
|  |  |  |  |  |  |  | In multivariate linear regression analysis, female gender, a higher aortic calcification score, hematocrit and PTH levels and lower calcium and potassium levels were found to be independently  associated with QTc. These variables explain 21% of the variability of QTc. Similar associations were found for JTc. |  |  |  |  |  |
| (56) | 2015 | 10.1038/ki.2015.194 | 26331407 | Sweden | causes | Male gender | RR 1.82 (1.03–1.16) | v | Vascular calcification |  | 5T | 89 |
|  |  |  |  |  |  | Sclerostin | middle+high sclerostin tertiles vs. low sclerostin tertile: RR 3.67 (1.23–11.02) |  |  |  |  |  |
| (57) | 2008 | 10.1093/ndt/gfn571 | 18852190 | France | associates | Male gender | Score 3 vs. score 0: 77% vs. 45% | v | diffuse VCs with aortic, iliac, femoral, popliteal and arm artery VCs |  | 5D (HD) | 161 |
| (58) | 2016 | 10.1159/000443845 | 26890570 | France | Causes | Female gender | OR 0.16 (0.075−0.362) | v | Serum sclerostin level |  | 5D (HD) | 227 |
| (59) | 2018 | 10.1007/s11255-017-1758-9 | 29236239 | Thailand | Complications | Male gender | CKD 2-5: HR 2.35 (0.93–5.91) |  |  | Mortality | 2-5T | 419 |
|  |  |  |  |  |  |  | CKD 5D: 1.14 (0.49–2.65) |  |  |  |  |  |
|  |  |  |  |  |  |  | KT: 1.36 (0.41–4.52) |  |  |  |  |  |
|  |  |  |  |  |  | AAC > 6 | CKD 2-5: HR 2.35 (1.05–5.25)\* |  | AAC |  |  |  |
|  |  |  |  |  |  |  | CKD 5D: HR 1.84 (0.77–4.39) |  |  |  |  |  |
|  |  |  |  |  |  |  | KT: HR 2.93 (0.9–9.22) |  |  |  |  |  |
|  |  |  |  |  |  | pelvic arterial calcification (PAC) > 1 | CKD 2-5: HR 3.04 (1.33–6.96)\*\* |  | PAC |  |  |  |
|  |  |  |  |  |  |  | CKD 5D: HR 2.64 (1.14–6.08)\* |  |  |  |  |  |
|  |  |  |  |  |  |  | KT: HR 13.9 (3.74–51.3)\*\* |  |  |  |  |  |
|  |  |  |  |  | Associates | Male gender (%) | AAC > 6 vs. ≤ 6: 44.4 vs. 62.6 (in CKD 2-5) |  | AAC |  |  |  |
| (60) | 2010 | 10.5414/cnp73360 | 20420796 | Japan | causes | Male gender | Male gender was identified as an independent determinant for CAP. |  | Coronary artery plaque (CAP) |  |  |  |
| (61) | 2006 | 10.1159/000095362 | 16940716 | Italy | Complications | Male gender | RR 0.85 (0.81–0.76), coefficient = –2.01, p = 0.001 | v |  | QT dispersion (QTd) | 4-5D (HD) | 46 |
|  |  |  |  |  |  | TC score ??? | RR 11.2 (8.22–16.7), coefficient = 1.571, p = 0.0001 |  |  |  |  |  |
|  |  |  |  |  |  |  | TC score到底是甚麼? |  |  |  |  |  |
| (62) | 2002 | 10.1016/s0735-1097(01)01781-8 | 11849871 | Multicenter (USA & Europe) | causes | Female gender | Parameter estimate = -0.587547, p = 0.0167 | v | Coronary artery calcification |  | 5D (HD) | 205 |
| (63) | 2014 | 10.1007/s11255-013-0620-y | 24318369 | Japan | Complications | CS | OR 9.9759x1030 (12.528–7.9429x1060) |  | Calcification score |  | 5D (HD) | 49 |
|  |  |  |  |  |  | Male gender | OR 23.194 (1.452–370.372) |  |  |  |  |  |
| (64) | 2007 | 10.2215/CJN.02190507 | 17928470 | UK | modifiers | Male gender | OR 8.82 (1.82 to 42.65) | v | Vascular calcification progression during 24 months |  | 4-5D | 134 |
| (65) | 2009 | 10.1159/000157629 | 18802328 | Japan | Causes | Male gender | HR 3.034 (1.028–8.948) | v | OPG level |  | 5D (HD) | 99 |
| (66) | 2013 | 10.1093/ndt/gft039 | 23605174 | Belgium | complications | Male gender | HR 0.55 (0.25–1.19), p = 0.13 |  |  | All-cause mortality | 5D (HD) | 100 |
|  |  |  |  |  |  | Sclerostin | HR 0.33 (0.15–0.73) |  |  |  |  |  |

**References**

1. Nitta K, Ishizuka T, Horita S, Hayashi T, Ajiro A, Uchida K, et al. Soluble osteopontin and vascular calcification in hemodialysis patients. Nephron. 2001;89(4):455–8.

2. Craver L, Dusso A, Martinez-Alonso M, Sarro F, Valdivielso JM, Fernandez E. A low fractional excretion of Phosphate/Fgf23 ratio is associated with severe abdominal Aortic calcification in stage 3 and 4 kidney disease patients. BMC Nephrol. 2013;14.

3. de Bie MK, Buiten MS, Rotmans JI, Hogenbirk M, Schalij MJ, Rabelink TJ, et al. Abdominal aortic calcification on a plain X-ray and the relation with significant coronary artery disease in asymptomatic chronic dialysis patients. BMC Nephrol. 2017;18(1):82.

4. Chue CD, Wall NA, Crabtree NJ, Zehnder D, Moody WE, Edwards NC, et al. Aortic calcification and femoral bone density are independently associated with left ventricular mass in patients with chronic kidney disease. PLoS One. 2012;7(6).

5. Kirkpantur A, Altun B, Hazirolan T, Akata D, Arici M, Kirazli S, et al. Association Among Serum Fetuin-A Level, Coronary Artery Calcification, and Bone Mineral Densitometry in Maintenance Hemodialysis Patients. Artif Organs. 2009;33(10):844–54.

6. Lankinen R, Hakamäki M, Metsärinne K, Koivuviita N, Pärkkä JP, Saarenhovi M, et al. Association of maximal stress ergometry performance with troponin T and abdominal aortic calcification score in advanced chronic kidney disease. BMC Nephrol. 2021 Feb 4;22(1):50.

7. Pateinakis P, Papagianni A, Douma S, Efstratiadis G, Memmos D. Associations of fetuin-A and osteoprotegerin with arterial stiffness and early atherosclerosis in chronic hemodialysis patients. BMC Nephrol. 2013;14.

8. Lee C Te, Huang CC, Hsu CY, Chiou TTY, Ng HY, Wu CH, et al. Calcification of the aortic arch predicts cardiovascular and all-cause mortality in chronic hemodialysis patients. CardioRenal Med. 2014;4(1):34–42.

9. Kahn J, Ram LM, Eberhard K, Groselj-Strele A, Obermayer-Pietsch B, Mueller H. Calcification score evaluation in patients listed for renal transplantation. Clin Transplant. 2017;31(3).

10. Golembiewska E, Qureshi AR, Dai L, Lindholm B, Heimbürger O, Söderberg M, et al. Copeptin is independently associated with vascular calcification in chronic kidney disease stage 5. BMC Nephrol. 2020 Feb 7;21(1):43.

11. Scialla JJ, Leonard MB, Townsend RR, Appel L, Wolf M, Budoff MJ, et al. Correlates of osteoprotegerin and association with aortic pulse wave velocity in patients with chronic kidney disease. Clin J Am Soc Nephrol. 2011;6(11):2612–9.

12. Wang F, Wu S, Ruan Y, Wang L. Correlation of serum 25-hydroxyvitamin D level with vascular calcification in hemodialysis patients. Int J Clin Exp Med. 2015;8(9):15745–51.

13. Chen Z, Qureshi AR, Brismar TB, Ripsweden J, Haarhaus M, Barany P, et al. Differences in association of lower bone mineral density with higher coronary calcification in female and male end-stage renal disease patients. BMC Nephrol. 2019;20.

14. Chen Z, Qureshi AR, Parini P, Hurt-Camejo E, Ripsweden J, Brismar TB, et al. Does statins promote vascular calcification in chronic kidney disease? Eur J Clin Invest. 2017;47(2):137–48.

15. Guedes Marques M, Botelho C, Maia P, Ibeas J, Ponce P. Doppler ultrasound and calcification score: Improving vascular access surveillance. Ren Fail. 2015;37(9):1425–9.

16. Gelev S, Spasovski G, Trajkovski Z, Damjanovski G, Amitov V, Selim G, et al. Factors associated with various arterial calcifications in haemodialysis patients. Prilozi. 2008;29(2):185–99.

17. Kanbay M, Nicoleta M, Selcoki Y, Ikizek M, Aydin M, Eryonucu B, et al. Fibroblast growth factor 23 and fetuin A are independent predictors for the coronary artery disease extent in mild chronic kidney disease. Clin J Am Soc Nephrol. 2010;5(10):1780–6.

18. Metry G, Stenvinkel P, Qureshi AR, Carrero JJ, Yilmaz MI, Bárány P, et al. Low serum fetuin-A concentration predicts poor outcome only in the presence of inflammation in prevalent haemodialysis patients. Eur J Clin Invest. 2008;38(11):804–11.

19. Moldovan D, Rusu C, Kacso IM, Potra A, Patiu IM, Gherman-Caprioara M. Mineral and bone disorders, morbidity and mortality in end-stage renal failure patients on chronic dialysis. Clujul Med. 2016;89(1):94–103.

20. Capusa C, Stancu S, Barsan L, Ilyes A, Dorobantu N, Petrescu L, et al. Are mineral metabolism abnormalities predictors of vascular calcifications in non-dialysis chronic kidney disease? Nephrol Dial Transplant. 2012;27:ii152.

21. Maharem DA, Gomaa SH, El Ghandor MK, Mohamed EI, Matrawy KA, Zaytoun SS, et al. Association of serum fetuin-A and fetuin-A gene polymorphism in relation to mineral and bone disorders in patients with chronic kidney disease. Egypt J Med Hum Genet. 2013;14(4):337–52.

22. Schlieper G, Frisch B, Djuric Z, Dimkovic N, Floege J. Sp711Comprehensive Comparison of Cardiovascular Imaging Tools and Biomarkers for Risk Prediction in Hd Patients: Imt Beets Them All. Nephrol Dial Transplant. 2015;30(suppl\_3):iii613–4.

23. Schlieper G, Brandenburg V, Djuric Z, Damjanovic T, Markovic N, Schurgers L, et al. Risk factors for cardiovascular calcifications in non-diabetic Caucasian haemodialysis patients. Kidney Blood Press Res. 2009;32(3):161–8.

24. Zhang DL, Wang LY, Sun F, Zhou YL, Duan XF, Liu S, et al. Is the dialysate calcium concentration of 1.75 mmol/L suitable for Chinese patients on maintenance hemodialysis? Calcif Tissue Int. 2014;94(3):301–10.

25. Sigrist M, Bungay P, Taal MW, McIntyre CW. Vascular calcification and cardiovascular function in chronic kidney disease. Nephrol Dial Transplant. 2006;21(3):707–14.

26. Renaud H, Atik A, Herve M, Moriniere P, Hocine C, Belbrik S, et al. Evaluation of vascular calcinosis risk factors in patients on chronic hemodialysis: lack of influence of calcium carbonate. Nephron. 1988;48(1):28–32.

27. Jean G, Charra B, Chazot C. Vitamin D Deficiency and Associated Factors in Hemodialysis Patients. J Ren Nutr. 2008;18(5):395–9.

28. Oprisiu R, Bunea D, Tarek S, Hedi B, Fournier A. Progression of vascular calcification and dyslipidemia in patients on chronic hemodialysis. Vol. 39, American Journal of Kidney Diseases. 2002. p. 209.

29. Harada PHN, Canziani ME, Lima LM, Kamimura M, Rochitte CE, Lemos MM, et al. Pericardial fat is associated with coronary artery calcification in non-dialysis dependent chronic kidney disease patients. PLoS One. 2014;9(12):e114358–e114358.

30. Bohn E, Tangri N, Gali B, Henderson B, Sood MM, Komenda P, et al. Predicting risk of mortality in dialysis patients: a retrospective cohort study evaluating the prognostic value of a simple chest X-ray. BMC Nephrol. 2013;14(1):263.

31. Al-Rifai R, Arabi A, Masrouji R, Daouk M. Prevalence of peripheral vascular calcifications in patients on chronic hemodialysis at a tertiary care center in Beirut: A pilot study. J Med Liban. 2011;59(3):117–21.

32. Hou J-S, Lin Y-L, Wang C-H, Lai Y-H, Kuo C-H, Subeq Y-M, et al. Serum osteoprotegerin is an independent marker of central arterial stiffness as assessed using carotid-femoral pulse wave velocity in hemodialysis patients: a cross sectional study. BMC Nephrol. 2019;20(1):N.PAG-N.PAG.

33. F.L.C. G, R.M. E, L.M. DR, F.G. G, F.G. Z, R.B. O, et al. Serum sclerostin is an independent predictor of mortality in hemodialysis patients. BMC Nephrol. 2014;15(1):190.

34. Anwar Z, Zan E, Carone M, Ozturk A, Sozio SM, Yousem DM. Superficial temporal artery calcification in patients with end-stage renal disease: Association with vascular risk factors and ischemic cerebrovascular disease. Indian J Radiol Imaging. 2011;21(3):215–20.

35. Okamoto T, Hatakeyama S, Kodama H, Horiguchi H, Kubota Y, Kido K, et al. The relationship between poor nutritional status and progression of aortic calcification in patients on maintenance hemodialysis. BMC Nephrol. 2018;19.

36. Laucyte-Cibulskiene A, Boreikaite E, Aucina G, Gudynaite M, Rudminiene I, Anisko S, et al. Usefulness of pretransplant aortic arch calcification evaluation for kidney transplant outcome prediction in one year follow-up. Ren Fail. 2018;40(1):201–8.

37. Vipattawat K, Kitiyakara C, Phakdeekitcharoen B, Kantachuvesiri S, Sumethkul V, Jirasiritham S, et al. Vascular calcification in long-term kidney transplantation. Nephrology. 2014;19(4):251–6.

38. Chau K, Martinez G, Elder GJ. Vascular calcification in patients undergoing kidney and simultaneous pancreas-kidney transplantation. Nephrology. 2014;19(5):275–81.

39. K. T, A. D, Tangvoraphonkchai K, Davenport A. Reduction in Aortic Pulse Wave Velocity Is Associated with a Short-Term Reduction in Dual-Energy X-Ray Absorptiometry Lumbar Spine Bone Mineral Density T Score. Blood Purif. 2019;1–5.

40. Evenepoel P, Goffin E, Meijers B, Kanaan N, Bammens B, Coche E, et al. Sclerostin serum levels and vascular calcification progression in prevalent renal transplant recipients. J Clin Endocrinol Metab. 2015;100(12):4669–76.

41. Jansson H, Saeed A, Svensson MK, Finnved K, Hellström M, Guron G. Impact of Abdominal Aortic Calcification on Central Haemodynamics and Decline of Glomerular Filtration Rate in Patients with Chronic Kidney Disease Stages 3 and 4. Kidney Blood Press Res. 2019;44(5):950–60.

42. Nitta K, Hanafusa N, Okazaki M, Komatsu M, Kawaguchi H, Tsuchiya K. Association between risk factors including bone-derived biomarkers and aortic arch calcification in maintenance hemodialysis patients. Kidney Blood Press Res. 2018;43(5):1554–62.

43. Nishizawa Y, Jono S, Ishimura E, Shioi A. Hyperphosphatemia and vascular calcification in end-stage renal disease. J Ren Nutr. 2005;15(1):178–82.

44. Chiu Y-W, Adler SG, Budoff MJ, Takasu J, Ashai J, Mehrotra R, et al. Coronary artery calcification and mortality in diabetic patients with proteinuria. Kidney Int. 2010;77(12):1107–14.

45. Jankovic A, Damjanovic T, Djuric Z, Marinkovic J, Schlieper G, Djuric P, et al. Calcification in arteriovenous fistula blood vessels may predict arteriovenous fistula failure: a 5-year follow-up study. Int Urol Nephrol. 2017;49(5):881–7.

46. Komatsu M, Okazaki M, Tsuchiya K, Kawaguchi H, Nitta K. Aortic Arch Calcification Predicts Cardiovascular and All-Cause Mortality in Maintenance Hemodialysis Patients. Kidney Blood Press Res. 2014;39(6):658–67.

47. Jankovic A, Damjanovic T, Djuric Z, Marinkovic J, Schlieper G, Tosic-Dragovic J, et al. Impact of Vascular Calcifications on Arteriovenous Fistula Survival in Hemodialysis Patients: A Five-Year Follow-Up. Nephron. 2015;129(4):247–52.

48. Vashishtha D, McClelland RL, Ix JH, Rifkin DE, Jenny N, Allison M. Relation Between Calcified Atherosclerosis in the Renal Arteries and Kidney Function (from the Multi-Ethnic Study of Atherosclerosis). Am J Cardiol. 2017;120(8):1434–9.

49. Fusaro M, Tripepi G, Noale M, Plebani M, Zaninotto M, Piccoli A, et al. Prevalence of Vertebral Fractures, Vascular Calcifications, and Mortality in Warfarin Treated Hemodialysis Patients. Curr Vasc Pharmacol. 2015;13(2):248–58.

50. Ishimura E, Okuno S, Kitatani K, Kim M, Shoji T, Nakatani T, et al. Different risk factors for peripheral vascular calcification between diabetic and non-diabetic haemodialysis patientsn - Importance of glycaemic control. Diabetologia. 2002;45(10):1446–8.

51. Thang OHD, Serne EH, Grooteman MPC, Smulders YM, ter Wee PM, Tangelder G-J, et al. Capillary rarefaction in advanced chronic kidney disease is associated with high phosphorus and bicarbonate levels. Nephrol Dial Transplant. 2011;26(11):3529–36.

52. Turan MN, Kircelli F, Yaprak M, Sisman AR, Gungor O, Bayraktaroglu S, et al. FGF-23 levels are associated with vascular calcification, but not with atherosclerosis, in hemodialysis patients. Int Urol Nephrol. 2016;48(4):609–17.

53. Claes KJ, Heye S, Bammens B, Kuypers DR, Meijers B, Naesens M, et al. Aortic calcifications and arterial stiffness as predictors of cardiovascular events in incident renal transplant recipients. Transpl Int. 2013;26(10):973–81.

54. Manghat P, Souleimanova I, Cheung J, Wierzbicki AS, Harrington DJ, Shearer MJ, et al. Association of bone turnover markers and arterial stiffness in pre-dialysis chronic kidney disease (CKD). Bone. 2011 May 1;48(5):1127–32.

55. Claes KJ, Heye S, Nuyens D, Bammens B, Kuypers DR, Vanrenterghem Y, et al. Impact of vascular calcification on corrected QT interval at the time of renal transplantation. Am J Nephrol. 2012;35(1):24–30.

56. Qureshi AR, Olauson H, Witasp A, Haarhaus M, Brandenburg V, Wernerson A, et al. Increased circulating sclerostin levels in end-stage renal disease predict biopsy-verified vascular medial calcification and coronary artery calcification. KIDNEY Int. 2015;88(6):1356–64.

57. Jean G, Bresson E, Terrat J-C, Vanel T, Hurot J-M, Lorriaux C, et al. Peripheral vascular calcification in long-haemodialysis patients: associated factors and survival consequences. Nephrol Dial Transplant. 2009;24(3):948–55.

58. Jean G, Chazot C, Bresson E, Zaoui E, Cavalier E. High Serum Sclerostin Levels Are Associated with a Better Outcome in Haemodialysis Patients. Nephron. 2016;132(3):181–90.

59. Disthabanchong S, Vipattawat K, Phakdeekitcharoen B, Kitiyakara C, Sumethkul V. Abdominal aorta and pelvic artery calcifications on plain radiographs may predict mortality in chronic kidney disease, hemodialysis and renal transplantation. Int Urol Nephrol. 2018;50(2):355–64.

60. Sumida Y, Nakayama M, Nagata M, Nakashita S, Suehiro T, Kaizu Y, et al. Carotid artery calcification and atherosclerosis at the initiation of hemodialysis in patients with end-stage renal disease. Clin Nephrol. 2010;73(5):360–9.

61. Di Iorio BR, Bortone S, Piscopo C, Grimaldi P, Cucciniello E, D’Avanzo E, et al. Cardiac vascular calcification and QT interval in ESRD patients: Is there a link? Blood Purif. 2006;24(5–6):451–9.

62. Raggi P, Boulay A, Chasan-Taber S, Amin N, Dillon M, Burke SK, et al. Cardiac calcification in adult hemodialysis patients: A link between end-stage renal disease and cardiovascular disease? J Am Coll Cardiol. 2002;39(4):695–701.

63. Kamiura N, Yamamoto K, Okada S, Sakai M, Fujimori A, N. K, et al. Calcification of the thoracic aorta determined by three-dimensional computed tomography predicts cardiovascular complications in patients undergoing hemodialysis. Int Urol Nephrol. 2014;46(5):993–8.

64. Sigrist MK, Taal MW, Bungay P, McIntyre CW. Progressive vascular calcification over 2 years is associated with arterial stiffening and increased mortality in patients with stages 4 and 5 chronic kidney disease. Clin J Am Soc Nephrol. 2007;2(6):1241–8.

65. Nishiura R, Fujimoto S, Sato Y, Yamada K, Hisanaga S, Hara S, et al. Elevated Osteoprotegerin Levels Predict Cardiovascular Events in New Hemodialysis Patients. Am J Nephrol. 2009;29(3):257–63.

66. Viaene L, Behets GJ, Claes K, Meijers B, Blocki F, Brandenburg V, et al. Sclerostin: another bone-related protein related to all-cause mortality in haemodialysis? Nephrol Dial Transplant. 2013;28(12):3024–30.