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(13.6%), while *Enterobacter aeruginosa*, all of our literature in Indonesia has not been reported as causing bacteria PUS. Both patients were given meropenem according to the results of antibiotic sensitivity then experienced clinical improvement and changes in urine color to normal. **Conclusions:** The case report demonstrates two patients diagnosed with PUS with risk factors for ESKD underwent hemodialysis and complicated UTI. After administration of antibiotics according to the results of antibiotic sensitivity there was clinical improvement and changes in urine color to normal.

No conflict of interest

## POS-011

### ACUTE KIDNEY INJURY (AKI) DUE TO SEPSIS ON POST MITRAL VALVE REPLACEMENT SURGERY: A CASE REPORT

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**Introduction:** Cardiac valve replacement, including mitral valve replacement (MVR), is a high risk procedure with possible acute kidney injury (AKI) and sepsis complications. AKI occurs in 7.7% to 40% of patients after cardiac surgery with a poor prognosis; more than half of patients died. On the other hand, sepsis is a low prevalence situation after cardiac surgery. It only happens in less than 2.5% patients. However, the prognosis is also poor, with mortality is varying from 65 to 79%. Here we report a case of Acute Kidney Injury due to sepsis on post mitral valve replacement surgery.

**Methods:** A woman 46-years old on surgery for moderate-severe mitral valve regurgitation and mild mitral valve stenosis. On the fifth day of post-surgery, there was a sepsis complication with leucocyte count of 16.300/uL, SOFA score of 6 (bilirubin >12 mg/dL, creatinine 2,08 mg/dL, P<sub>a</sub>O<sub>2</sub>/FiO<sub>2</sub>279,9 mmHg), procalcitonin 3,42 ng/mL and an increasing creatinine from 0,78 mg/dL before surgery to 2,08 mg/dL suggesting AKI was also occurred.

**Results:** The patient was treated with antibiotic and supportive therapy including hydration and high dose of acetylsistein since day nine of post-surgery. The patient's condition was improved on eleventh day of post-surgery with creatinine 2,08 mg/dl to 0,71 mg/dL

**Conclusions:** A case of acute kidney injury due to sepsis has been reported in post-operative mitral valvular replacement patient who had improved. The prognosis for this patient is good if the sepsis condition could be treated.

No conflict of interest

## POS-012

### RISK FACTORS FOR AKI AND MORTALITY IN COVID-19 IN WESTERN MEXICO

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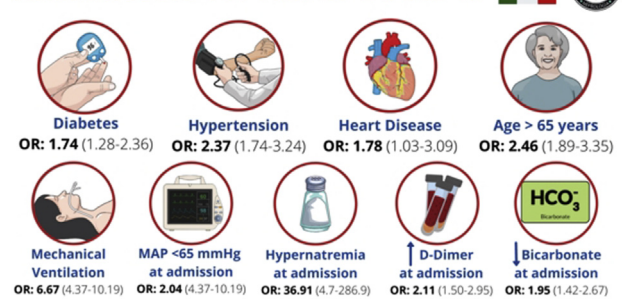
**Introduction:** Acute kidney injury (AKI) in COVID-19 is associated with disease severity. The aim of this study was to identify risk factors associated with the development of AKI and its clinical impact, such as need for RRT and mortality

**Methods:** Retrospective cohort study of hospitalized adult patients COVID-19, with normal kidney function, from April to December 2020 in Western Mexico.

**Results:** 882 patients (60.8% men) with a mean age of 58.9y were included. 342 (38.8%) had a prior diagnosis DM, 412 (46.7%) HTN, 161 (18.3%) obesity, 59 (6.7%) heart diseases, 25 (2.8%) neurological disease, 47 (5.3%) lung disease. 216 (24.5%) smoking history. 270 patients (30.6%) developed AKI, 95 (10.77%) KDIGO stage 1, 44 (4.98%) stage 2, and 84 (9.52%) stage 3. 59 patients required RRT (6.23%), and 111 patients (12.6%) mechanical ventilation. Overall mortality was 30.6% (270 patients). Risk factors for mortality were: DM, HTN, neurological disease, age > 65 y, need for mechanical ventilation, and MAP < 65

mmHg, hypernatremia, increased D-dimer or decreased HCO<sub>3</sub> at admission. Risk factors for AKI were: DM, HTN, heart disease, age > 65 y, need for mechanical ventilation, and MAP < 65 mmHg, hypernatremia, increased D-dimer or decreased HCO<sub>3</sub> at admission. Image shows risk factors, ORs with CI.

### Risk Factors for AKI in COVID19



**Conclusions:** A high incidence of AKI in the Mexican population compared to reports from other countries, with a significantly high risk for death.

No conflict of interest

## POS-013

### PROTEIN ENERGY WASTING IN ACUTE KIDNEY INJURY REQUIRING HEMODIALYSIS AND INTRADIALYTIC PARENTERAL NUTRITION

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**Introduction:** A 78-year-old female with a previous diagnosis of type 2 diabetes mellitus attended to the emergency room after presenting dyspnea of small efforts, chest pain and generalized edema of three days of evolution, as well as a history of decreased food intake from approximately 8 months related to depressive disorder.

**Methods:** Upon admission on 12/30/2020, laboratories report serum creatinine 6.70mg/dL (glomerular filtration= 7.2mL/min/1.73m<sup>2</sup> by CKD-EPI), urea106.30 mg/dL, potassium 8.01mmol/L, glucose 297 mg/dL; electrocardiographic findings of peaked T waves, widened QRS and supraventricular tachycardia. Admission weight= 44Kg, height= 1.52 m, BMI=19.04 Kg/m<sup>2</sup>. Nutritional risk was assessed through Malnutrition Universal Screening Tool (MUST) which scored 4 (high risk of malnutrition). The patient was admitted to the hospital with the following diagnoses: Uncontrolled type 2 diabetes mellitus, acute kidney injury KDIGO 3, severe hyperkalemia and protein energy wasting (PEW). Right jugular tunneled vascular access was placed and an urgent hemodialysis session was scheduled at the same day.

After three hemodialysis sessions control laboratories were carried out: serum creatinine 3.34mg/dL, urea 53 mg/dL, albumin3.7 mg/dL, potassium4.69 mmol/L. As the patient showed improvement in clinical and biochemical parameters, she was discharged from hospital, and she continued treatment with outpatient hemodialysis two sessions per week. Nutritional counsel was given.

During the follow-up, a tendency to decrease in weight prior to hemodialysis sessions was detected, the relatives reported that the patient persisted with low dietary intake (<10kcal/kg ideal weight/day) still related to depressive disorder, so that nutritional status was assessed again founding severe protein energy wasting thus, we decided to start with intradialytic parenteral nutrition (IDPN) on 01/29/2021 in order to increase caloric-protein intake and improve clinical prognosis. It was started with standard emulsion for infusion of 1100 Kcal/986 ml placed in a venous chamber with infusion pump, with good tolerance from the first occasion and continues to be administered during the following 8 sessions.

During this period there were no episodes of catheter-related bacteremia, infections or complications associated with treatment; the infusion of parenteral emulsion did not interrupt or complicate the proper functioning of any hemodialysis session. The patient reported a constant increase in her dietary intake evidenced by a