

18TH BALTIC NEPHROLOGY SOCIETIES MEETING

in collaboration with ERA
Education meeting

KAUNAS, LITHUANIA
SEPTEMBER 24-26, 2026

PROGRAM



Day 1 ERA EDUCATION MEETING

September 24,
2026

Day 2 ERA EDUCATION MEETING & 18TH BALTIC NEPHROLOGY SOCIETIES MEETING

September 25,
2026

14:15–14:45

18th Baltic Nephrology Societies Meeting Opening

Inga Arune Bumblyte (President of the Lithuanian Nephrology, Dialysis and Transplantation Association)

Andrius Macas (Dean of the Faculty of Medicine, Lithuanian University of Health Sciences)

Roser Torra (President of the European Renal Association)

Inese Folkmane (President of the Latvian Association of Nephrologists)

Kulli Kolvald (President of the Estonian Society of Nephrology)

Marius Miglinas (President of the Lithuanian Kidney Foundation)

14:45–17:15

Session 1: Rare diseases

Chairs: Inga Arune

Bumblyte, Marius Miglinas

Oral mini lectures:

14:45–15:15

Alport syndrome: rethinking classification and risk

Roser Tora, Spain

15:15–15:35

Beyond the microscope: evolving perspectives on rare glomerulopathies

Marius Miglinas, Lithuania

15:35–15:55

Challenges of antifibrotic therapy in chronic kidney disease

Mai Rosenberg, Estonia

15:55–16:25

Coffee break

Oral scientific presentations and clinical case reports:

Chairs: Karlis Racenis,

Mai Rosenberg, Neda

Kusleikaite-Pere

16:25–16:35

Intracranial aneurysms in autosomal dominant polycystic kidney disease

Karlis Eglitis, Latvia

16:35–16:45

Renal manifestations and clinical profile of tuberous sclerosis in Latvian patients

Lelde Zilmane, Latvia

16:45–16:55

Placenta derived stem cells therapy for renal fibrosis: biomarkers of acute and chronic kidney injury

Agne Gryguc, Lithuania

16:55–17:05

IgG4-related disease: a diagnostic challenge

Liisi Leis, Estonia

17:05–17:15

Familial Mediterranean fever with a heterozygous MEFV mutation presenting as systemic AA amyloidosis: a case report

Natasha Eftimovska
Otovikj, Elizabeta Poposka,
North Macedonia

17:15–18:00

STADA Scientific Symposium.

Changing the Course of IgA Nephropathy: Earlier Recognition, Individualized Treatment and Long-Term Kidney Protection

Co-Chairs:

Marius Miglinas,

Inga Skarupskiene

- **Finding IgA Nephropathy Earlier: Lessons from the Latvian Screening Program**

Ieva Ziedina, Latvia

- **Beyond Proteinuria: How Should We Assess Treatment Response and Long-Term Kidney Protection?**

Ivan Rychlik, Czech Republic

- **Recurrent IgA Nephropathy After Kidney Transplantation: What Do the Evidence and Latvian Experience Tell Us?**

Karlis Racenis, Latvia

- **Expert Panel: From Emerging Evidence to Clinical Decisions**

19:30

Gala Dinner

Archdiocese of Kaunas (Kauno arkivyskupija), Papilio St. 5, Kaunas

Day 3 18TH BALTIC NEPHROLOGY SOCIETIES MEETING

September 26,
2026

08:15 – 10:35	Session 2: Epidemiology and quality assessment in chronic and acute kidney disease	Chairs: Viktorija Kuzema, Kristina Petrulienė
	Oral mini lectures:	
08:15–08:45	The use of outcome information to support a national quality system and patient care	Willem-Jan Bos, The Netherlands
08:45–09:05	The Czech experience with the national-wide data of quality assessment treatment of dialysis patients	Ivan Rychlik, Czech Republic
09:05–09:25	Trends in kidney replacement therapy in Lithuania, 2013–2024	Edita Ziginskiene, Lithuania
09:25–09:45	A national framework for quality assessment in kidney care: Latvia's first clinical quality registry	Karlis Racenis, Latvia
09:45–10:05	From advanced CKD to transplantation: measuring what matters in kidney care – first data results from the new Latvian Kidney registry	Viktorija Kuzema, Latvia
	Oral scientific presentations:	
10:05–10:15	The occurrence of acute kidney disease has increased over time but mortality has decreased	Mai Rosenberg, Anne-Grethe Tuisk, Estonia
10:15–10:25	Etiology shapes outcome in severe acute kidney injury requiring continuous renal replacement therapy: a single-centre Latvian cohort	Svetlana Polnova, Latvia
10:25–10:35	Hidden kidney risks: ibuprofen and paracetamol use in dehydrated children	Dovile Ruzgiene, Lithuania
10:35 – 11:00	Coffee break	
11:00–11:45	Industry Symposium. Accumulated experience with regional citrate anticoagulation in CRRT	Dr. Robert Pohlmeier, Fresenius Medical Care and Unihealth UAB
11:45 – 13:05	Session 3: Kidney transplantation	Chairs: Egle Dalinkeviciene, Ieva Ziedina
	Oral mini lectures:	
11:45–12:05	Living kidney donors	Ieva Ziedina, Latvia
12:05–12:25	Obesity and its implications in kidney transplantation	Ruta Vaiciuniene, Lithuania
	Oral scientific presentations and clinical case reports:	
12:25–12:35	Trends in immunosuppressive therapy for kidney transplant recipients in Latvia	Anna Stasulane, Latvia
12:35–12:45	Prognostic value of structural MRI mapping in predicting long-term function of deceased donor kidney allografts	Emile Cironyte, Andrejus Bura, Lithuania
12:45–12:55	A 10-year retrospective analysis of kidney transplant biopsies – prevalence and patterns of allograft rejection	Maira Kasa, Estonia
12:55–13:05	A case of recurrent citomegalovirus infection after kidney transplantation: a challenge in diagnosis and management	Zygimantas Mickus, Egle Dalinkeviciene, Lithuania
13:05 – 13:15	Awards of scientific oral and poster presentations	
13:15 – 14:00	Lunch	

14:00 – 16:00	Session 4: Chronic kidney disease and kidney replacement therapy	Chairs: Diana Sukackiene, Aivars Petersons
Oral mini lectures:		
14:00–14:20	The impact of physical activity on cognitive function in patients with chronic kidney disease	Justina Mikelaite, Inga Arune Bumblyte, Lithuania
14:20–14:40	Monitoring the removal of classical uremic toxins during hemodialysis with an on-line optical sensor	Ivo Fridolin, Estonia
14:40–15:00	Strategies for infection prevention in dialysis catheters	Laurynas Rimsevicius, Lithuania
Oral scientific presentations and clinical case reports:		
15:00–15:10	Nonlinear and conventional microscopy in human AVF tissue assessment	Vilte Gabriele Samsone, Lithuania
15:10–15:20	Glim criteria for the diagnosis of malnutrition in dialysis patients: a single-center analysis	Irmante Bagdziuniene, Lithuania
15:20–15:30	Intradialytic parenteral nutrition in a malnourished chronic hemodialysis patients: a one-center experience	Elina Valdmene, Latvia
15:30–15:40	Strengthening CKD and hemodialysis self-management through mHealth: implementation of the NephroGo App in Europe	Giedre Zulpaite, Lithuania
15:40–15:50	Nutritional status in peritoneal dialysis patients	Ilze Puide, Latvia
15:50–16:00	Standardized conditions improve accuracy of peritoneal dialysate turbidity assessment	Anna Jana Saulite, Latvia
16:00–16:10	Closing remarks	

Faculty

18th Baltic Nephrology Societies Meeting (Alphabetical order by last name)

Irmante Bagdziuniene, Lithuania	Elizabeta Poposka, North Macedonia
Willem-Jan Bos, The Netherlands	Ilze Puide, Latvia
Inga Arune Bumblyte, Lithuania	Karlis Racenis, Latvia
Andrejus Bura, Lithuania	Laurynas Rimsevicius, Lithuania
Emile Cironyte, Lithuania	Mai Rosenberg, Estonia
Egle Dalinkeviciene, Lithuania	Dovile Ruzgiene, Lithuania
Natasha Eftimovska Otovikj, North Macedonia	Ivan Rychlik, Czech Republic
Karlis Eglitis, Latvia	Vilte Gabriele Samsone, Lithuania
Ivo Fridolin, Estonia	Anna Jana Saulite, Latvia
Agne Gryguc, Lithuania	Inga Skarupskiene, Lithuania
Maira Kasa, Latvia	Anna Stasulane, Latvia
Neda Kusleikaite-Pere, Lithuania	Diana Sukackiene, Lithuania
Viktorija Kuzema, Latvia	Roser Tora, Spain
Liisi Leis, Estonia	Anne-Grethe Tuisk, Estonia
Zygimantas Mickus, Lithuania	Ruta Vaiciuniene, Lithuania
Marius Miglinas, Lithuania	Elina Valdmene, Latvia
Justina Mikelaite, Lithuania	Ieva Ziedina, Latvia
Aivars Petersons, Latvia	Edita Ziginskiene, Lithuania
Kristina Petruliene, Lithuania	Lelde Zilmane, Latvia
Svetlana Polnova, Latvia	Giedre Žulpaite, Lithuania

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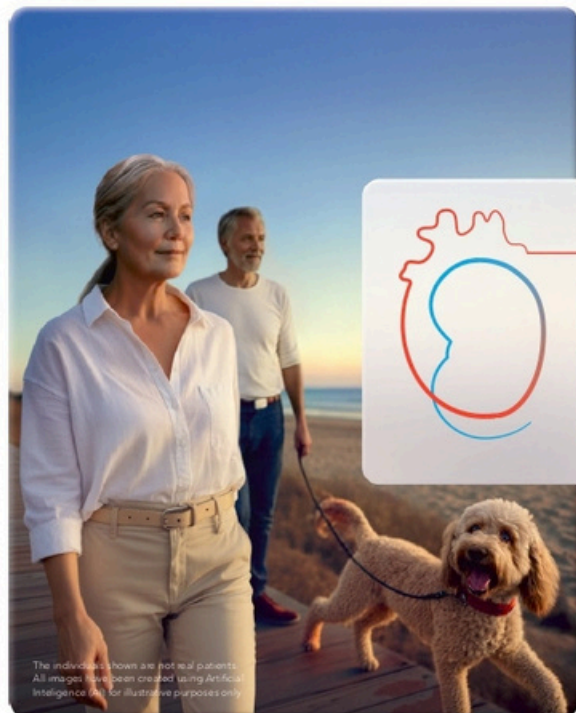
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In dedicated CKD and HF trials



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Forxiga is the only SGLT2i
to deliver a mortality benefit in dedicated CKD and HF trials:¹⁻³

- 1 All-cause mortality for patients with CKD¹
- 2 CV death for patients with HFrEF^{2,9}
- 3 CV death across the range of EF
in a pooled analysis³

Choose Forxiga first

Forxiga (dapagliflozin) 10 mg film-coated tablet. Medicinal product subject to medical prescription. Each tablet contains dapagliflozin propanediol monohydrate equivalent to 10 mg dapagliflozin. **Pharmacotherapeutic group:** Drugs used in diabetes, SGLT2 inhibitors. **Therapeutic indications.** Type 2 diabetes mellitus: indicated in adults and children aged 10 years and above for the treatment of insufficiently controlled type 2 diabetes mellitus as an adjunct to diet and exercise; as monotherapy when metformin is considered inappropriate due to intolerance; in addition to other medicinal products for the treatment of type 2 diabetes. Heart failure: indicated in adults for the treatment of symptomatic chronic heart failure. Chronic kidney disease: indicated in adults for the treatment of chronic kidney disease. **Posology and method of administration.** 10 mg once daily. Can be taken at any time of day with or without food. Tablets are to be swallowed whole. **Contraindications.** Hypersensitivity to the active substance or to any of the excipients. **Special warnings and precautions for use.** General. Dapagliflozin should not be used in patients with type 1 diabetes mellitus. Renal impairment. It is not recommended to initiate treatment with dapagliflozin in patients with GFR < 25 mL/min. The glucose lowering efficacy of dapagliflozin is dependent on renal function, and is reduced in patients with GFR < 45 mL/min and is likely absent in patients with severe renal impairment. Hepatic impairment. Dapagliflozin exposure is increased in patients with severe hepatic impairment. Use in patients at risk for volume depletion and/or hypotension. Caution should be exercised in patients for whom a dapagliflozin induced drop in blood pressure could pose a risk, such as patients on anti hypertensive therapy with a history of hypotension or elderly patients. Diabetic ketoacidosis. Rare cases of diabetic ketoacidosis (DKA), including life-threatening and fatal cases, have been reported in patients treated with SGLT2 inhibitors, including dapagliflozin. In patients where DKA is suspected or diagnosed, dapagliflozin treatment should be stopped immediately. Before initiating dapagliflozin, factors in the patient history that may predispose to ketoacidosis should be considered. Treatment should be interrupted in patients who are hospitalised for major surgical procedures or acute serious medical illnesses. Monitoring of ketones is recommended in these patients. Treatment with dapagliflozin may be restarted when the ketone values are normal and the patient's condition has stabilised. Necrotising fasciitis of the perineum (Fournier's gangrene). Postmarketing cases of necrotising fasciitis of the perineum (also known as Fournier's gangrene) have been reported in female and male patients taking SGLT2 inhibitors. **Interaction with other medicinal products and other forms of interaction.** Diuretics. Dapagliflozin may add to the diuretic effect of thiazide and loop diuretics and may increase the risk of dehydration and hypotension. Insulin and insulin secretagogues. Insulin and

insulin secretagogues, such as sulphonylureas, cause hypoglycaemia. Therefore, a lower dose of insulin or an insulin secretagogue may be required to reduce the risk of hypoglycaemia when used in combination with dapagliflozin in patients with type 2 diabetes mellitus. **Fertility, pregnancy and lactation.** The use of dapagliflozin is not recommended during the second and third trimesters of pregnancy. When pregnancy is detected, treatment with dapagliflozin should be discontinued. Dapagliflozin should not be used while breastfeeding. The effect of dapagliflozin on fertility in humans has not been studied. **Effects on ability to drive and use machines.** Forxiga (dapagliflozin) has no or negligible influence on the ability to drive and use machines. Patients should be alerted to the risk of hypoglycaemia when dapagliflozin is used in combination with a sulphonylurea or insulin. **Undesirable effects.** Very common: hypoglycaemia (when used with SU or insulin). Common: vulvovaginitis, balanitis and related genital infections, urinary tract infection, dizziness, rash, back pain, dysuria, polyuria, haematocrit increased, creatinine renal clearance decreased during initial treatment, dyslipidaemia. **Marketing Authorisation Holder:** AstraZeneca AB. **Local representatives:** Lithuania: UAB AstraZeneca Lietuva Tel: +370 5 2660550. Latvia: SIA AstraZeneca Latvija, Tel: +371 67377100. Estonia: AstraZeneca Eesti, Tel: +372 6549 600. Last revised: 2026 03 12. This is abbreviated information. Full information can be found in the Summary of Product Characteristics: <http://www.ema.europa.eu>. Healthcare professionals are asked to report any suspected adverse reactions via the national reporting system: Lithuania – Valstybinė vaistų kontrolės tarnyba, Tel.: +370 8 007 3568, <https://vkt.lt/lt/>. Latvia – Zāļu valsts aģentūra, Jersikas iela 15, Rīga, LV 1003, www.zva.gov.lv. Estonia – Ravimiamet, www.ravimiamet.ee.

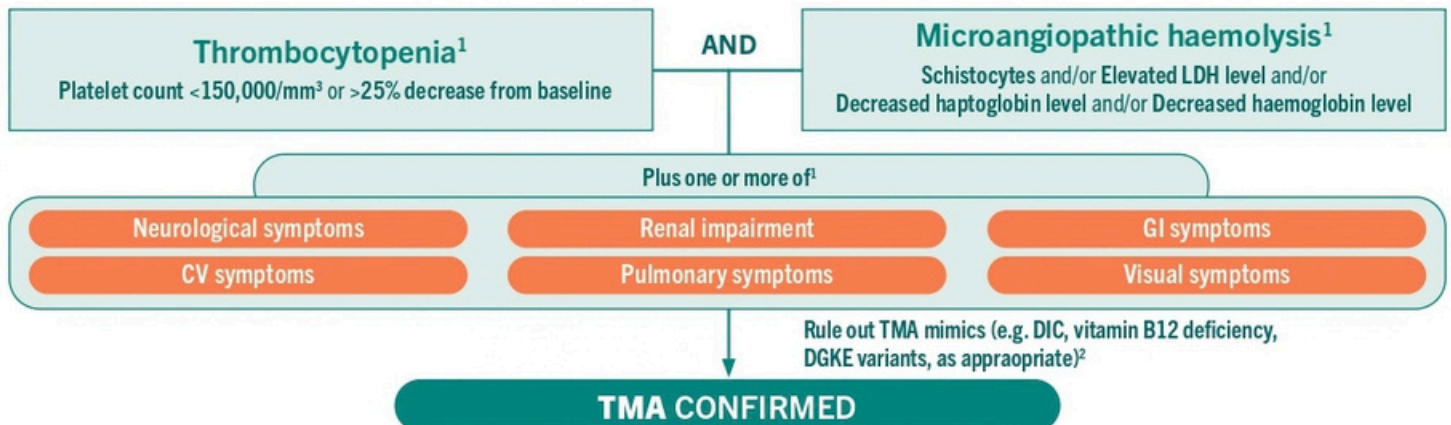
CKD, chronic kidney disease; CV, cardiovascular; EF, ejection fraction; HF, heart failure; HFrEF, heart failure with reduced ejection fraction; SGLT2i, sodium-glucose cotransporter 2 inhibitor.

*In combination with stable background guideline-directed medical therapy (maximum tolerated labelled dose of an ACEi or ARB) in DAPA-CKD.¹⁰⁽¹⁾ †In combination with stable background guideline-directed medical therapy, defined as treatment with an ACEi/ARB/ARNi, beta blocker and MRA in DAPA-HF and intermittent diuretic use in DELIVER.¹³

References: 1. Heerspink HJL, et al. *N Engl J Med.* 2020;383(15):1436-1446. 2. McMurray JJV, et al. *N Engl J Med.* 2019;381(21):1995-2008. 3. Jhund PS, et al. *Nat Med.* 2022;28(9):1956-1964. 4. Solomon SD, et al. *N Engl J Med.* 2022;387(12):1089-1098. 5. Madero M, et al. *Kidney Med.* 2024;6(8):100851. 6. Schechter M, et al. *Ann Intern Med.* 2023;176(7):59-66. 7. Kosiborod MN, et al. *Circulation.* 2020;141:90-99. 8. Kosiborod MN, et al. *JACC.* 2023;81(5):460-473. 9. Forxiga 10 mg film coated tablets. Summary of Product Characteristics. 10. Supplement to: Heerspink HJL, et al. *N Engl J Med.* 2020;383(15): 1436-1446. 11. Heerspink HJL, et al. *Nephrol Dial Transplant.* 2020;35(2): 274-282.

aHUS diagnostic algorithm

Confirm the diagnosis of TMA



Note: the 'classic triad' is helpful, but absence of one component may not exclude TMA³

In a study of 967 renal biopsy-proven TMA cases:^{3*}

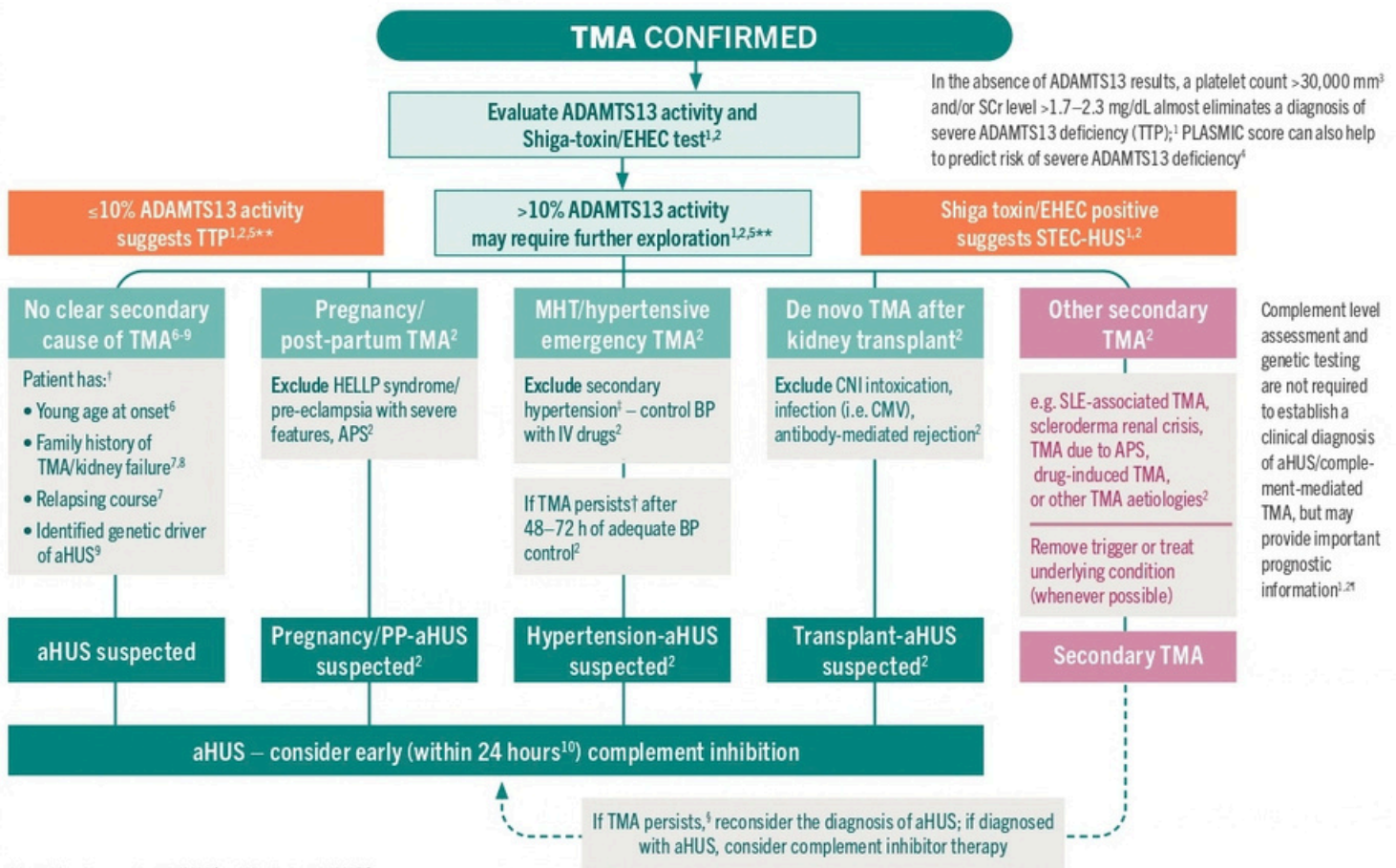
- 0–67.9% were not thrombocytopenic
- 0–86.4% did not have schistocytes >1%
- 16.7–70.4% did not have low haptoglobin
- 0–40.7% did not have elevated LDH

Keep an open mind:

- Repeat testing where suspicion remains³
- Consider biopsy/alternative markers if clinical signs and labs diverge³
- Reassess as the patient's condition evolves³

Adapted from Laurence J, et al. (2016)³ and Morelle J, et al. (2025)²

Determine TMA aetiology



Adapted from Laurence J, et al. (2016)³ and Morelle J, et al. (2025)²

This algorithm is intended as educational information for HCPs. It does not replace HCP's professional judgment or clinical diagnosis. **aHUS**, atypical haemolytic uraemic syndrome; **CV**, cardiovascular; **DIC**, disseminated intravascular coagulation; **DGKE**, diacylglycerol kinase epsilon; **GI**, gastrointestinal; **LDH**, lactate dehydrogenase; **TMA**, thrombotic microangiopathy. * Values are the range of percentages presented, which differ by aetiology of TMA. ³ Exact ADAMTS13 cut-off value is dependent upon the assay used. ¹¹ List not exhaustive. ¹² Renal artery stenosis, endocrine disorders, drugs, underlying CKD. ² Absence of normalisation of platelet count and absence of significant improvement in kidney dysfunction. ² Relapse risk after discontinuation of complement inhibition, stratification of recurrence risk following kidney transplantation and guiding decisions regarding the duration of terminal complement inhibition. ² 1. Laurence J, et al. Clin Adv Hematol Oncol. 2016;14 Suppl 11(11):2–15. 2. Morelle J, et al. Nephrol Dial Transplant. 2025;gfa091. 3. Halimi J-M, et al. Kidney Int Rep. 2025;10(6):1950–1959. 4. Bendapudi PK, et al. Lancet Haematol. 2017;4:e157–e164. 5. Azoulay E, et al. Chest. 2017 Aug;152(2):424–434. 6. Ardissino G, et al. J Nephrol. 2024;37(4):1017–1026. 7. Bu F, et al. Clin Dev Immunol. 2012;2012:370426. 8. Noris M, et al. Genetic atypical hemolytic-uremic syndrome. In: GeneReviews; last updated September 2021. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK1367/>; last accessed October 2025. 9. Goodship THJ, et al. Kidney Int. 2017;91:539–551. 10. Ávila A, et al. Front Med (Lausanne). 2023;10:1264310.

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Albuminuria is an SOS for hidden CV risk^{1–3}

CV-cardiovascular

References:

1. Barzilay J, et al. J Am Heart Assoc 2024;13(2):e030131.
2. Marx-Schütt, et al. Eur. Heart J. 2025 46;2148–2160.
3. Xia F, et al. Int J Clin Exp Med. 2015;8(1):1–9.
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