

Changes in Blood Pressure and Arterial Hemodynamics following Living Kidney Donation

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Changes in blood pressure and arterial hemodynamics following living kidney donation

Running title: The EARNEST study

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Abstract

Background and objectives

The Effect of a Reduction in Glomerular Filtration Rate after Nephrectomy on Arterial Stiffness and Central Hemodynamics (EARNEST) was a multi-center, prospective, controlled study designed to investigate the associations of an isolated reduction in kidney function on blood pressure and arterial hemodynamics.

Design, setting, participants and measurements

Prospective living kidney donors and healthy controls who fulfilled criteria for donation were recruited from centers with expertise in vascular research. Participants underwent office and ambulatory blood pressure measurement, assessment of arterial stiffness and biochemical tests at baseline and 12 months.

Results

A total of 469 participants were recruited and 306 (168 donors and 138 controls) were followed up at 12 months. In the donor group, mean eGFR was 27 mL/min/1.73m² lower than baseline at 12 months.

Compared to baseline, at 12 months the mean within group difference in ambulatory day systolic blood pressure in donors was 0.1mmHg (95% CI -1.7, 1.9) and 0.6mmHg (95% CI -0.7, 2.0) in controls. The between group difference was not significant, -0.5mmHg (95% CI -2.8, 1.7), p=0.62. The mean within group difference in pulse wave velocity in donors was 0.3m/s (95% CI 0.1, 0.4) and 0.2m/s (95% CI -0.0, 0.4) in controls. The between group difference was also not significant, 0.1m/s (95% CI -0.2, 0.3) p=0.49.

Conclusions

Changes in ambulatory peripheral blood pressure and pulse wave velocity in kidney donors at 12 months after nephrectomy were small and not different from controls.

Keywords (5-7): Blood pressure; Arterial stiffness; Hypertension; Living kidney donors; Chronic kidney disease; Pulse wave velocity.

Introduction

Chronic kidney disease (CKD) is a major risk factor for cardiovascular disease; there is a graded association, independent of multiple cardiovascular risk factors, between glomerular filtration rate (GFR) and cardiovascular risk.(1) In early stage CKD, mortality from cardiovascular events is more likely than the need for kidney replacement therapy.(2) Hypertension, increased arterial stiffness, chronic inflammation and uremic toxins are thought to be key mediators of the higher cardiovascular risk.(3) In patients with end stage kidney disease (ESKD) increased arterial stiffness as measured by pulse wave velocity is an independent predictor of mortality.(4) Increased arterial stiffness is also highly prevalent in earlier stages of CKD.(5) It is not clear whether increased blood pressure and arterial stiffness in CKD are direct consequences of the reduced GFR or result from multiple co-morbid conditions that tend to accompany CKD.

Living kidney donors provide an opportunity to prospectively examine the cardiovascular consequences of a reduction in kidney function without the confounding effects of co-morbid disease. In the long term, kidney donors lose approximately 30% of their baseline GFR and consequently over 65% have a GFR consistent with stages 2 and 3 CKD.(6) They also have similar biochemical abnormalities to patients with CKD.(7) While the risk of ESKD after nephrectomy is higher compared to controls, absolute risk over a 15 year period, remains low.(8, 9) To date, however, most studies of kidney donors have not shown a higher cardiovascular risk or mortality.(10, 11) Only one study has shown higher cardiovascular mortality compared to controls, which occurred later over a 10 year follow-up period.(8) The aim of this study was to determine the effect of the reduction in kidney function that occurs after kidney donation on arterial stiffness and blood pressure in a sample large enough to detect small differences.

Materials and Methods

Study design

The EARNEST (Effect of A Reduction in glomerular filtration rate after NEphrectomy on arterial STiffness and central hemodynamics) study was a prospective multicenter UK cohort study. We aimed to recruit 440 controls and 440 donors over a two year period from seven centers recognised for performing high numbers of living kidney transplants within the UK. Recruitment began in April 2012; the last follow up patient was studied in May 2016. Recruitment was terminated in May 2015 on pragmatic and financial grounds. This was principally due to unanticipated large numbers of recruited participants dropping out at follow up.

Study population

The inclusion and exclusion criteria for donors and controls were in accordance with national guidelines disseminated by the Joint Working Party of the British Transplantation Society and the Renal Association for living kidney donors.⁽¹²⁾ Both donors and controls had to be deemed fit to donate a kidney.

Most healthy controls were individuals undergoing workup for donation but who were ultimately unable to donate due to factors such as immunological mismatch or recipient illness. Alternatively, donor-related family members or volunteers donating blood at local blood donation centers were recruited.

Study protocol

All participants were investigated at baseline (less than 6 weeks prior to nephrectomy for prospective living kidney donors) and at 12 months. A full illustrated and detailed protocol has previously been published with a summary presented below.(13)

- 1. Blood pressure measurement:** Office blood pressure was measured three times, from the non-dominant arm after 5 minutes of rest, using a validated automated device. Blood pressure was taken in both a sitting and supine position. Participants underwent 24hr ambulatory blood pressure monitoring using the Mobil-O-Graph NG; IEM (Stolberg, Germany).(14) Blood pressure recordings were taken every 30 minutes between the hours of 0800-2200, and every 60 minutes between 2201 and 0759.(15, 16)

- 2. Pulse wave velocity:** Pulse wave velocity was measured using SphygmoCor (Atcor Medical, Sydney, Australia) by trained personnel after asking the participant to lie supine for 15 minutes. Repeated uniform pressure waveforms were acquired from both the carotid and femoral artery using a high fidelity micromanometer (SPC-301; Millar Instruments, Houston, TX).(17) A 3 lead electrocardiogram was used to determine the time between the R wave and the foot of the pulse at each respective site as previously described.(18) Arterial path distance was inferred using the distance from the sternal notch to the femoral pulse subtracted by the distance between the sternal notch and the carotid pulse. (19)

- 3. Pulse wave analysis:** Using the SphygmoCor device; arterial pressure waveforms were obtained from which central waveforms can be calculated. Central blood pressure and augmentation index (AIx) were calculated using transfer functions as previously

described.(15, 20) Augmentation index is the augmentation pressure from the aortic waveform expressed as a percentage of pulse pressure, see **Figure 1**.

4. Assessment of glomerular filtration rate: Glomerular filtration rate was determined in all participants using standardised creatinine assays and the Chronic Kidney Disease Epidemiology Collaboration (CKD-EPI) creatinine 2009 equation.(21, 22) A subset of living kidney donors underwent isotopic GFR measurement using clearance of ⁵¹Cr-EDTA at both baseline and follow up.(23, 24)

5. Blood and urine: Biochemistry measurements included serum creatinine, calcium, albumin, phosphate and uric acid and urinary albumin: creatinine ratio.

Primary outcomes

1. Mean change in ambulatory systolic blood pressure.
2. Mean change in pulse wave velocity.

Statement of ethics

Ethical approval for the main study was obtained in February 2013 from the South Cambridge Regional Ethics Committee (Integrated Research Application System Reference: 118797, Research Ethics Committee approval number 13/EE/0015). The EARNEST sub study (CRIB-DONOR) commenced in 2011, ethical approval was obtained from the West Midlands Research Ethics Committee. All participants underwent informed consent in keeping with the principles set out by the Declaration of Helsinki.

Power calculations and sample size

Using data from previous studies, the standard deviation of the within-patient changes was assumed to be 10 mmHg for blood pressure and 1.0 m/s for pulse wave velocity.(17, 25) A sample size of 800 participants (400 subjects per group) was planned in order to provide 80% power to detect a difference of 2.2mmHg in systolic pressure or 0.22 m/s in pulse wave velocity using a 2-sided *t*-test at the 2.5% significance level. Values for a sample size of 400 participants (200 subjects per group) have 92% power to detect a difference of 4 mmHg for systolic blood pressure and 0.4 m/s for pulse wave velocity, allowing for 15% loss to follow-up at a significance level of 5%.

Statistical analysis

Statistical analysis was performed using Stata statistical software (release 15. StataCorp LCC, College Station, TX). Continuous variables at baseline and 12 months were compared using independent *t*-tests. Categorical variables were compared using Chi squared tests. A paired samples *t* test was used to estimate the mean change and 95% confidence interval between baseline and follow-up in each group (within-group change). Change from baseline to 12 months was calculated for both donors and controls. An independent *t* test was used to estimate the mean change and 95% confidence interval between within-group change in donors and within-group change in controls (between-group change). Carotid-femoral pulse wave velocity was adjusted for average mean arterial pressure and average supine heart rate using unstandardized residuals calculated from a linear regression model. In supplementary analyses, we used multivariable linear regression to account for factors which may have confounded the relationship between kidney donation and change in pulse wave velocity (age, sex and smoking status). A p-value of <0.05 was considered significant, no adjustments were made for multiple comparisons. Data presented includes subjects who returned for follow up. We dealt with missing data by performing a complete case analysis. Further sub-analysis of those who remained in the study compared to those who were lost to follow up are detailed in supplement **Table S1, S2 and S3.**

Results

Follow up and events

A total of 469 participants were recruited; 20 were excluded as they lacked the minimal data set required for analysis and two were found to be ineligible after the initial visit (see **Figure 2**). Recruitment was terminated at 3 years despite the lower than planned sample size due to financial constraints. Of the remaining 447 participants, there were 201 controls and 246 donors. Of these, a total of 38 controls and 46 donors were patients that originally consented into the CRIB-DONOR sub study, who re-consented to allow their data to be included.(26) One hundred and forty-one participants were unable to attend follow up at 12 months leaving 168 donors and 138 controls with complete paired data, who were included in the final analysis. The commonest reasons for lack of study completion by participants were change of address or difficulty attending clinic visits due to travel distance, work and childcare commitments.

For comparison between patients who were lost to follow up and those who continued in the study, see **Table S1**. Minimal differences were observed in those who did not return for follow up at 12 months. Participants who continued in the study, had a marginally lower eGFR and were more likely to be taking anti-hypertensive medications.

In addition, a further 49 donors and 27 controls who returned for follow up had incomplete ambulatory blood pressure recordings.

Patient characteristics

The demographics of living kidney donors and healthy controls who attended for both baseline and 12 month follow up visits were comparable with the exception of tobacco use, see **Table 1**. Baseline hemodynamic and biochemical characteristics are shown in **Tables 2 and 3**. There were no significant differences between donors and controls in any of the

baseline hemodynamic values and no clinically significant differences in biochemical values. At follow up there were 6 living kidney donors whose eGFR fell into stage 3b CKD and one whose eGFR fell into stage 4 CKD according to the Kidney Disease Improving Global Outcome guidelines.

Patient demographics and hemodynamic and biochemical characteristics at baseline for all those recruited (n=447) are shown in supplementary **Tables S2 and S3**. Donors had a higher mean age than controls; (51 yrs. vs 47 yrs., p=0.003) and were more likely to have a history of previous smoking; (46% vs. 33%, p=0.007).

Comparison of hemodynamic variables in living kidney donors and controls

Arterial hemodynamic parameters at baseline and 12 months are given in **Table 2**. There were no significant differences between donors and controls in office or ambulatory blood pressures at 12 months. The changes in office systolic blood pressure from baseline to 12 months in donors and controls were small. The mean change seen in donors (+1.8mmHg) was however, different to that in controls, in whom there was a mean reduction of 1mmHg (difference of 2.8mmHg, 95% confidence interval (CI) 0.3-5.4, p=0.03). Using current American Heart Association ambulatory blood pressure criteria, 13 (9%) in the control group and 15 (9%) in the donor group developed hypertension over the 12 month period with no significant difference between the two groups, p=0.18.(27) The mean change in ambulatory heart rate was significantly greater in donors compared to controls at 12 months (difference of 2.8 bpm, 95% CI 0.1-5.5, p=0.04).

Adjusted pulse wave velocity was not significantly different at 12 months nor was there any difference in changes from baseline. Our supplementary analyses showed no association between kidney donation and change in pulse wave velocity when accounting for factors which may influence this relationship, see **Table S4**. Change in central diastolic blood pressure and

augmentation index adjusted for heart rate were not significantly different in donors compared to controls. When considering changes from baseline, only central systolic blood pressure changes were significantly greater in donors than controls (difference of 3.3mmHg, 95% CI 0.3, 6.3, $p=0.03$).

Comparison of biochemistry in living kidney donors and controls

Results are shown in **Table 3**. At 12 months, eGFR fell by a mean of 27mL/min/1.73m² in donors but was unchanged in controls. Although iGFR measurement was part of the protocol for donation, in practice few subjects consented to a 12 month iGFR due to concerns about the duration of the test and exposure to ionising radiation. The mean change from baseline for phosphate in donors was significantly lower compared to controls (difference -0.31 mg/dL, 95% CI -0.31, -0.1, $p<0.001$). In contrast a significant increase in uric acid was seen in donors compared to controls (difference 0.9 mg/dL, 95% CI 0.7, 1.0, $p<0.001$).

Discussion

This prospective study of ambulatory blood pressure monitoring and arterial hemodynamics in kidney donors provides important findings. There was no difference in office or ambulatory blood pressure in donors compared to controls at 12 months after nephrectomy. Pulse wave velocity also did not differ in these groups. Central systolic blood pressure increased slightly more in donors than controls and at 12 months was higher in the donor group. These results suggest that the risk of a significant rise in blood pressure at 12 months in kidney donors is small. This is in keeping with findings from the smaller sub-study CRIB-DONOR but is surprising in view of the high prevalence of hypertension in patients with CKD and similar levels of GFR.(26) Our data suggest that a simple loss of nephron numbers does not invariably result in an elevated blood pressure and that other aspects of CKD such as inflammation and nephron dysfunction may be required for this key pathophysiological mediator to occur.

Previous data have been contradictory. In a 2006 meta-analysis of 48 studies of office blood pressure in kidney donors, including a total of 5145 patients, there was an increase in systolic blood pressure of 6 (95% CI 2-11) mmHg and an increase in diastolic pressure of 4 (95% CI 1-7) mmHg in donors at 5 years.(28) More recently however, Kasiske et al. found no significant difference in over 300 participants between kidney donors and controls in office blood pressure at any time point up to 36 months.(29) There was also no difference in ambulatory blood pressure in 135 donors and 126 controls at 36 months.(29) Taken together, our data and the study of Kasiske et al. suggest that the risk of a clinically important change in blood pressure in the short term following kidney donation is low.(29) Longer term data are of course required.

Despite the absence of change in peripheral pressure, the mean change in central systolic pressure was greater in donors at 12 months compared to controls (+ 2.1 vs -1.2mmHg, p=0.03). While this small difference may be a chance result due to multiple comparisons it may be

important as central blood pressure is better related to left ventricular mass, carotid intimal thickness and cardiovascular events than peripheral pressure.(30, 31) The small increase in AIX was not accompanied by any rise in pulse wave velocity. Discrepancies between changes in AIX and pulse wave velocity have been found by other observers in a number of situations and remain incompletely explained.(32) Any increase in AIX suggests an increase in wave reflection which might explain the increase in central blood pressure. As pulse wave velocity was unchanged it is possible that this increased reflection occurred due to changes in peripheral, rather than central arterial stiffness. We speculate that this occurred as a consequence of ligation of one of the renal arteries causing amplification of the reflection site without a corresponding change in pulse wave velocity, although to date this has no supportive animal or human evidence. Previous studies examining arterial stiffness in kidney donors have been small and uncontrolled. De-Seigneux et al. studied 21 patients before and one year after nephrectomy and found no change in AIX or pulse wave velocity.(33) Similarly Fesler et al. found no change in pulse wave velocity at 12 months post nephrectomy in 45 donors.(34) A cross sectional study of 101 living kidney donors, however, found that pulse wave velocity was 10% higher than control patients.(35) We cannot exclude a small effect on pulse wave velocity, as the study was not powered to detect a difference of less than 0.4m/s.

Most of the biochemical changes after donation are in accord with previous studies (26, 29) Our finding of lower phosphate levels in donors is perhaps surprising in view of the renal excretion of phosphate but is consistent with a large prospective study of bone metabolism in kidney donors.(36) We speculate that this is a result of an increase in fibroblast growth factor 23 which has a pivotal role in phosphate homeostasis and has been associated with left ventricular hypertrophy.(37, 38)

Conclusions

In summary, this is the largest controlled longitudinal prospective study of hemodynamics in living kidney donors. This study indicates there is no change in ambulatory blood pressure or arterial stiffness at 12 months post nephrectomy despite changes in biochemistry. This has important implications for the future of living kidney donors but also provides valuable insight into the pathophysiology of hypertension and myocardial disease in CKD suggesting that an increase in blood pressure is not an inevitable consequence of a reduced GFR.

Limitations

We did not reach the planned sample size and a substantial proportion of participants did not return for follow up at one year, which limited the study power and introduces the potential for selection bias. Barriers to studies of living kidney donors have been reported by others.(39) They are often geographically remote from the transplant center (in contrast to the recipient) and after donation are usually in full time work. Barriers to ambulatory blood pressure monitoring in this study were in keeping with those previously observed, where one in five patients describe 24-hr monitoring as uncomfortable and nearly 70% are woken from sleep.(40, 41)

These limitations however, do not affect the internal validity of our results. There were only minor differences between participants who did and did not return for follow-up so our results should be generalizable to the wider pool of potential kidney donors. Although not statistically different, the healthy controls were on average 2 years younger, more likely to be male and more likely to have a history of hypertension. There was a greater rate of smoking amongst donors which could be due to in part to social deprivation based on geographical area or reflect health promoting behaviour in healthy controls. In addition, the large number of parameters

measured beyond the pre-specified primary end-points mean that there are issues of multiple testing necessitating caution in interpreting results as some differences may have arisen by chance.

Lack of ethnic diversity has been a notable problem in living kidney donor research.(7) Over 90% of our cohort were Caucasian and this does reflect the vast racial disparity currently facing transplantation.(42) We recognise that while our data at 12 months are reassuring, longer term and more diverse studies are required particularly in light of literature showing higher cardiovascular risk in the long term.(8)

Disclosures

No conflict of interests to declare.

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Supplemental material-Table of Contents

Table S1: Baseline characteristics of patients who were lost to follow up compared to those who continued the study.

Table S2: Baseline patient demographics of the whole cohort recruited.

Table S3: Baseline biochemical and hemodynamic characteristics of the whole cohort recruited.

Table S4: Linear regression model: Association between 12 month change in adjusted pulse wave velocity and kidney donation, age, sex and smoking status.

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Figure 1: A typical aortic pulse wave form generated from applanation tonometry of the radial artery using the SphygmaCor, taken from Stoner et al (43). The maximum pressure is systolic and the minimum pressure is diastolic. The first peak, the forward wave, indicates ejected blood from the heart. The second peak, the reflected wave, is that returned from peripheral vasculature. The difference between the two is augmentation pressure. Augmentation index is augmentation pressure expressed as a percentage of pulse pressure. As augmentation index is influenced by timing of the reflected wave, augmentation index is corrected for a heart rate of 75 beats per minute.

Figure 2: A flow chart demonstrating those recruited and those lost to follow up.

*Following eligibility assessment there were 22 patients who consented to take part but were ultimately excluded from the study. After baseline blood tests two 'healthy controls' did not meet criteria due to incidental findings; one was diagnosed with diabetes and one had an insufficient kidney function. Consequently, neither met living kidney donation criteria. A further 20 patients consented to take part and withdrew prior to completing baseline assessment. This was usually because of competing appointments during living kidney donor work up.

Table 1: Baseline characteristics of participants in the EARNEST study (Effect of A Reduction in glomerular filtration rate after NEphrectomy on arterial STiffness and central hemodynamics) who completed both baseline and 12-month evaluations.

	Controls n=138	Donors n=168
Sex (male) *	57 (41)	78 (46)
Age (years) *	49 ± 14	51 ± 12
Race	Caucasian=127 (92) Non-white=8 (6) Unknown=3 (2)	Caucasian=158 (94) Non-white= 9 (5) Unknown= 1 (1)
History of hypertension	9 (7)	17 (10)
Anti-hypertensive usage*	9 (7)	18 (11)
ACE/ARB usage	4 (3)	5 (3)
Calcium channel blocker usage	4 (3)	6 (4)
Current or ex-smoker *	38 (28)	74 (44)
eGFR, categories (mL/min/1.73m²)	<80= 25 (18) 80 to <90= 23 (17) >90 =88 (65)	<80= 38 (23) 80 to <90= 39 (23) >90= 91 (54)
Normalised isotopic GFR (ml/min/1.73m²)*	89 ± 13	89 ± 12

ACE; Angiotensin Converting Enzyme. ARB; Angiotensin receptor blocker. CKD; Chronic Kidney Disease. eGFR; estimated Glomerular Filtration Rate. GFR; Glomerular Filtration Rate.

*For the following categories: sex, age, anti-hypertensive usage and current or ex-smoker there were n=168 donors and n=137 controls due to an incomplete data set for one healthy control. For isotopic GFR, results from controls were part of the CRIB-DONOR sub study and included n=90 donors and n=22 controls.

Categorical variables are presented as n (%) and continuous data are represented as mean \pm standard deviation.

Table 2: Changes in hemodynamic and arterial parameters over 12 months.

Variables	Patient group n=sample size	Single Time point		Within-group*	Change	
		Baseline	12 months		Between-group†	p-Value ‡
Weight (kg)	Donors=168	75.4 ± 13.5	77.1 ± 14.7	1.7 (0.4, 3.0)	1.5 (-0.12, 3.0)	0.07
	Controls=136	74.7 ± 13.9	74.9 ± 13.8	0.2 (-0.4, 0.8)		
BMI (kg/m²)	Donors=168	26.2 ± 3.3	26.8 ± 4.6	0.6 (0.1, 1.2)	0.5 (-0.1, 1.1)	0.09
	Controls=136	26.0 ± 4.0	26.2 ± 4.0	0.1 (-0.1, 0.3)		
Seated office systolic BP (mmHg)	Donors=168	125 ± 14	127 ± 12	1.8 (-0.0, 3.6)	2.8 (0.3, 5.4)	0.03
	Controls=135	125 ± 17	124 ± 17	-1.0 (-2.8, 0.7)		
Seated office diastolic BP (mmHg)	Donors=168	78 ± 9	80 ± 8	1.7 (0.4, 2.9)	1.0 (-0.74, 2.9)	0.25
	Controls=135	77 ± 10	78 ± 9	0.7 (-0.8, 1.9)		
Ambulatory day systolic BP (mmHg)	Donors=119	124 ± 10	124 ± 10	0.1 (-1.7, 1.9)	-0.5 (-2.8, 1.7)	0.62
	Controls=111	122 ± 10	123 ± 12	0.6 (-0.7, 2.0)		
Ambulatory day diastolic BP (mmHg)	Donors=119	79 ± 8	79 ± 8	0.2 (-0.9, 1.4)	-0.6 (-2.1, 0.9)	0.40
	Controls=111	77 ± 8	78 ± 9	0.9 (0.0, 1.7)		
Ambulatory day HR (bpm)	Donors=65	73 ± 9	74 ± 10	1.5 (-0.9, 3.9)	2.8 (0.1, 5.5)	0.04
	Controls=82	72 ± 9	71 ± 10	-1.3 (-2.8, 0.2)		
Ambulatory night systolic BP (mmHg)	Donors=111	111 ± 11	112 ± 11	0.9 (-1.1, 3.0)	1.5 (-1.2, 4.3)	0.27
	Controls=105	110 ± 10	110 ± 12	-0.6 (-2.5, 1.3)		
Ambulatory night diastolic BP (mmHg)	Donors=111	67 ± 9	69 ± 9	1.4 (-0.2, 3.0)	1.1 (-0.9, 3.3)	0.27
	Controls=105	66 ± 8	66 ± 9	0.3 (-1.15, 1.7)		

Central systolic BP (mmHg)	Donors=105	113 ± 14	115 ± 14	2.1 (-0.2, 4.4)	3.3 (0.3, 6.3)	0.03
	Controls=108	111 ± 17	109 ± 17	-1.2 (-3.1, 0.7)		
Central diastolic BP (mmHg)	Donors=105	77 ± 9	78 ± 10	1.3 (-0.7, 3.2)	1.5 (-0.9, 4.0)	0.22
	Controls=108	75 ± 10	75 ± 10	-0.3 (-1.9, 1.1)		
Augmentation index, corrected for HR (%)	Donors=104	22.1 ± 12.0	25.6 ± 12.2	3.4 (1.5, 5.3)	1.6 (-1.0, 4.2)	0.23
	Controls=108	20.4 ± 12.5	22.3 ± 12.0	1.8 (-0.0, 3.6)		
Adjusted carotid-femoral pulse wave velocity (m/s)	Donors=168	7.0 ± 1.3	7.3 ± 1.4	0.3 (0.1, 0.4)	0.1 (-0.2, 0.3)	0.49
	Controls=138	7.0 ± 1.4	7.2 ± 1.4	0.2 (-0.0, 0.4)		

BPM; Beats per minute. BMI; Body mass index. BP; Blood Pressure, CI; Confidence interval, HR: Heart rate, SD: Standard deviation.

Data is displayed as mean ± SD or mean (95% lower CI, 95% upper CI).

* Within-group change refers to change in values between baseline and follow up in each group i.e. mean weight in donors for baseline was 75.4 kg and at follow up was 77.1 kg giving a within-group change of 1.7kg. The 95% confidence interval was estimated using paired sample *t*-tests.

† Between-group change refers to the difference between donors and controls within-group change i.e. for weight, within group change for donors is 1.7kg and 0.2kg for controls giving a between group-change of 1.5kg. The 95% confidence interval was estimated using independent *t*-tests.

‡ Comparison between controls and donors was made for within-group change [i.e. mean change in weight in donors (1.7kg) vs mean change in weight in controls (0.2kg)] using an independent samples *t*-tests.

Table 3: Changes in biochemical parameters over 12 months.

Variables	Patient group n=sample size	Single time point			Change	
		Baseline	12 months	Within-group*	Between-group†	p-Value ‡
Sodium (meq/L)	Donors=167	140 ± 2	140 ± 2	-0.3 (-0.7, 0.0)	-0.1 (-0.6, 0.4)	0.59
	Controls=137	141 ± 2	140 ± 2	-0.2 (-0.5, 0.2)		
Potassium (meq/L)	Donors=167	4.3 ± 0.3	4.4 ± 0.4	0.1 (0.0, 0.2)	0.1 (0.0, 0.2)	0.02
	Controls=134	4.2 ± 0.3	4.2 ± 0.3	-0.0 (-0.1, 0.1)		
Urea (mg/dL)	Donors=167	31 ± 8	38 ± 10	8.4 (7.2, 9.6)	7.2 (5.4, 9.0)	<0.001
	Controls=136	30 ± 8	31 ± 8	1.0 (0.03, 2.4)		
Creatinine (mg/dL)	Donors=168	0.8 ± 0.2	1.2 ± 0.2	0.3 (0.3, 0.4)	0.3 (0.3, 0.4)	<0.001
	Controls=136	0.8 ± 0.2	0.8 ± 0.2	-0.02 (-0.03, 0.009)		
eGFR (mL/min/1.73 m²)	Donors=168	91 ± 15	64 ± 14	-27 (-29, -26)	-29 (-32, -26)	<0.001
	Controls=136	94 ± 16	96 ± 17	2 (-0.4, 3.8)		
Albumin (g/dL)	Donors=145	4.27 ± 0.39	4.22 ± 0.43	-0.04 (-0.10, 0.01)	-0.07 (-0.15, -0.0)	0.04
	Controls=135	4.16 ± 0.44	4.19 ± 0.48	0.03 (-0.01, 0.08)		
Corrected calcium (mg/dL)	Donors=148	9.2 ± 0.4	9.2 ± 0.4	0.0 (-0.0, 0.0)	-0.0 (-0.0 – 0.0)	0.28
	Controls=136	9.2 ± 0.4	9.2 ± 0.4	0.0 (-0.0, 0.0)		
Phosphate, (mg/dL)	Donors=130	3.4 ± 0.6	3.1 ± 0.6	-0.3 (-0.3, -0.3)	-0.31 (-0.31, -0.1)	<0.001
	Controls=121	3.4 ± 0.6	3.4 ± 0.6	0.0 (-0.0, 0.3)		
Magnesium,	Donors=77	2.2 ± 1.7	2.2 ± 0.2	0.0 (-0.0, 0.0)		

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(mg/dL)	Controls=85	2.2 ± 1.7	2.2 ± 0.2	0.0 (-0.0, 0.0)	-0.0 (-0.0- 0.0)	0.94
Uric acid (mg/dL)	Donors=93	5.0 ± 1.2	5.9 ± 1.3	0.9 (0.69, 1.0)	0.9 (0.7, 1.0)	<0.001
	Controls=95	4.8 ± 1.1	4.8 ± 1.1	-0.0 (-0.6, 0.1)		
Urine albumin: creatinine ratio (mg/mmol)	Donors=66	24.6 ± 41.2	23.1 ± 39.8	-1.5 (-9.7, 7.1)		
	Controls=69	20.1 ± 32.7	17.1 ± 32.0	-3.0 (-11.5, 5.3)	-1.5 (-9.7, 12.4)	0.80

CI; Confidence interval, eGFR; estimated glomerular filtration rate, SD: Standard deviation.

Data is displayed as mean ± SD or mean (95% lower CI-95% upper CI).

* Within-group change refers to change in values between baseline and follow up in each group i.e. mean potassium in donors for baseline was 4.3 meq/L and at follow up was 4.4 meq/L giving a within-group change of 0.1 meq/L. The 95% confidence interval was estimated using paired sample *t*-tests.

† Between-group change refers to the difference between donors and controls within-group change i.e. for potassium, within group change for donors is 0.1 meq/L and 0.0 meq/L for controls giving a between group-change of 0.1 meq/L. The 95% confidence interval was estimated using independent *t*-tests.

‡ Comparison between controls and donors was made for within-group change [i.e. mean change in potassium in donors (0.1 meq/L) vs mean change in weight in controls (0.0 meq/L)] using an independent samples *t*-tests.

The EARNEST study

The EARNEST study