

Nutritional Status of Patients with Chronic Kidney Disease in Iran: A Narrative Review

Shima Abdollahi; MSc^{1,2}, Elham Razmpoosh; MSc^{1,2}, Omid Toupchian; PhD³ & Amin Salehi-Abargouei; PhD^{1,2*}

¹ Nutrition and Food Security Research Center, Shahid Sadoughi University of Medical Sciences, Yazd, Iran.

² Department of Nutrition, School of Public Health, Shahid Sadoughi University of Medical Sciences, Yazd, Iran.

³ Cellular and Molecular Nutrition Department, School of Nutritional Science and Dietetics, Tehran University of Medical Sciences, Tehran, Iran.

ARTICLE INFO

REVIEW ARTICLE

Article history:

Received: 13 May 2017

Revised: 6 Jul 2017

Accepted: 13 Sep 2017

*Corresponding author:

abargouei@ssu.ac.ir

Department of Nutrition,
 School of Public Health,
 Shahid Sadoughi University of Medical Sciences, Yazd, Iran.

Postal code: 8915173160

Tel: +98 35 31492229

ABSTRACT

Background: Chronic kidney disease (CKD) is a progressive condition that affects many aspects of patient's life with adverse outcomes of kidney failure, cardiovascular disease (CVD), and premature death. Malnutrition is a relatively common problem in these patients that may be the result of inadequate intake, increased catabolism, or loss of nutrients in the dialysis. The aim of this study was to review the nutritional status and requirements of CKD patients in Iran using previous studies. **Methods:** Search engines including PubMed, Scopus, Embase, Science Direct, Google scholar, Magiran, and scientific information database (SID) were applied with keywords such as chronic kidney disease, malnutrition, renal disease, end stage renal disease, nutritional deficiency, malnutrition, quality of life, vitamin deficiency, wasting, and Iran to find related articles published up to 2016. **Results:** The persistence of malnutrition increases susceptibility to infectious and cardiovascular diseases, delays wound healing, and finally increases morbidity and mortality. **Conclusion:** Considering the importance of nutritional status in patients with chronic kidney disease, it is necessary to design and development of more effective strategies to optimize nutritional status of these patients.

Key words: Chronic kidney diseases; Renal disease; Chronic renal insufficiency; Malnutrition; Nutritional deficiency.

Introduction

Chronic kidney disease (CKD) as a progressive disease is defined as the decreased kidney function—glomerular filtration rate (GFR) < 60 ml/min/1.73 m² for 3 months or more (Levey *et al.*, 2005). It is a public health problem that is rapidly increasing, particularly in developing countries (Khajehdehi *et al.*, 2014, Levey *et al.*, 2007). Hypertension and diabetes are main reasons for

developing kidney disease in adults (Chobanian *et al.*, 2003, Stevens *et al.*, 2008). Prevalence, mortality rate, and cost of care for patients on dialysis, kidney transplant, and end stage renal disease (ESRD) have increased during the last two decades (Hamer and El Nahas, 2006, USRDS, 1999). The prevalence of CKD varies in different nations based on the age of study population and

among men and women (Zhang and Rothenbacher, 2008). A study in the United States of America (USA) reported that CKD prevalence was 1.5% in adult population (mean age 43.9 years) in 2005 (Kramer *et al.*, 2005). In another study the prevalence was reported 43.3% among people aged over 45 years (McClellan *et al.*, 2006). In a systematic review of 26 studies, the median prevalence of CKD in persons over 30 years of age was 7.2% (Zhang and Rothenbacher, 2008). A number of studies have investigated the prevalence of CKD in Iran. A study reported the prevalence of 18.9% among people aged over 20 years (Hosseinpah *et al.*, 2009). Another study reported 19.5% for the prevalence for CKD among Iranian adults (Najafi *et al.*, 2012). In a study conducted by Safarnejad *et al.* the prevalence of chronic renal insufficiency (defined as GFR of 15-59 ml/min per 1.73 m²) was 8.1% among Iranian adult population (Safarnejad, 2009). The prevalence of this disease in our country is higher than countries such as USA, Australia, and Norway based on the previous studies (Hamer and El Nahas, 2006, Kopple, 2001b). The possible reason can be that the risk factors of CKD including diabetes and dyslipidemia in Iranian population are more than other countries (Najafi *et al.*, 2012, Safarnejad, 2009). Furthermore, the elderly population in Iran is growing and it might be contributed to the increasing prevalence of patients with CKD (Cibulka and Racek, 2007).

CKD has a major impact on health; it not only leads to kidney failure but also is associated with increased levels of inflammatory markers and plasma homocysteine (Shlipak *et al.*, 2003), anemia (Hsu, 2002), increased vascular calcification (Raggi *et al.*, 2002), abnormal levels of apo lipoproteins (Shlipak *et al.*, 2003), endothelial dysfunction and arterial stiffness (London *et al.*, 2003), as well as premature mortality. In 2003, American heart association (AHA) declared that patients with CKD are considered as people at high risk for cardiovascular diseases (Sarnak *et al.*, 2003).

Metabolic conditions and several other factors affect nutritional status of patients with CKD.

Factors such as poor appetite, inadequate nutrient intake, insulin resistance, infection, and oxidative stress are associated with nutritional depletion (Chung *et al.*, 2012). Furthermore, protein-energy wasting (PEW) usually observed in these patients, especially in the end stages of the disease (Ikizler *et al.*, 2013). Because malnutrition is associated with increased morbidity and mortality and also according to the increasing incidence of this disease in Iran, it is important to recognize nutrition status to manage and improve the quality of life in these patients. Hence, in this narrative review we aimed to assess nutritional status in Iranian CKD patients for the first time.

Materials and Methods

This narrative review manuscript was extracted by searching the creditable databases, including PubMed, Scopus, Embase, Science Direct, Google scholar, Magiran, and scientific information database (SID) using keywords such as chronic kidney disease, malnutrition, renal disease, end stage renal disease, nutritional deficiency, malnutrition, quality of life, vitamin deficiency, wasting, and Iran from the published literature (English and Persian language). In this regard, a variety of studies including prospective cohort, retrospective, case-control, clinical guidelines, and review articles were studied up to 2016.

Results

Protein-energy wasting (PEW) in patients with CKD: In spite of the advancements in medical science, mortality rates are still high in CKD patients (Kalantar-Zadeh *et al.*, 2006). These patients especially the ESRD ones suffer from catabolic conditions. Weight loss, reduced fat and muscle mass (Su *et al.*, 2013), increased inflammatory markers (den Hoedt *et al.*, 2014), decreased levels of serum albumin (that is affected by both inflammatory and nutritional conditions) (Kim *et al.*, 2013), metabolic acidosis (Kalantar-Zadeh *et al.*, 2004), altered intracellular insulin like growth factor 1 (IGF-1) and insulin signaling (Bonanni *et al.*, 2011), as well as endocrine disorders (Ros and Carrero, 2013) are common in these patients. On the other hand, Anorexia

resulting from uremia (Carrero *et al.*, 2007), restrictive diet that limits potassium, phosphorus, or sodium intake, loss of nutrients in the dialysis, and other factors affect food intake and thus disrupt the energy balance (Ikizler *et al.*, 1994). One of the main mechanisms that lead to muscle atrophy in patients with CKD is associated with increased catabolism of Ubiquitin-proteasome system (UPS) mediated protein (that reduces muscle proteins) and activation musculoskeletal myostatin (which inhibits cellular proliferation and muscle synthesis) in uremic situation (Mitch and Goldberg, 1996). In addition, the extensive tissue damage will increase the level of circulating actin that consumes gelsolin (the protein that assembles and disassembles actin) (Zhang *et al.*, 2011). Increased level of actin and reduced level of gelsolin are associated with increased risk of mortality (Gracia-Iguacel *et al.*, 2014). Another mechanism is related to insulin resistance. Insulin-like growth factor 1 can lead to an upregulation of myostatin and a declined proliferation of satellite muscle cell by activating the phosphoinositide 3-kinase pathway (Zhang *et al.*, 2010). This situation leads to loss of protein and energy in patients with CKD. In fact, PEW is a pathological condition associated with sustained reduction in protein and energy reserves due to inadequate intake and increased catabolism as a result of reasons already mentioned (Fouque *et al.*, 2008, Mak *et al.*). The prevalence of PEW in CKD patients have been reported 18-75% in various studies (Leinig *et al.*, 2011). This variety is due to different assessment methods and cut-off points (Gracia-Iguacel *et al.*, 2014). However, according to our review, only one study has been conducted on prevalence of PEW in Iran by Tabibi *et al.* They reported that the prevalence rates of mild-to-moderate and severe PEW were 60.5% and 1% in hemodialysis patients, respectively (Tabibi *et al.*, 2012). It seems that this prevalence is high in Iran. Protein-energy wasting in kidney disease patients can lead to events that affect different systems and organs (Kovesdy and Kalantar-Zadeh, 2009). In these patients, muscle catabolism increased due to inflammation, reduction of nutrients, metabolic

acidosis, and other factors. Reduction of muscle mass can affect the arteries and heart function, it also might cause ventricular hypertrophy together with other factors such as water and sodium retention (Gracia-Iguacel *et al.*, 2014). Moreover, in PEW patients nutritional deficiency is associated with chronic immunodeficiency state (Vanholder and Ringoir, 1993), increased oxidative stress, delay in wound healing (Vanholder *et al.*, 1993), and susceptibility to infections (Dong *et al.*, 2011, Gracia-Iguacel *et al.*, 2013). These reasons are leading to an increase in overall mortality (Gracia-Iguacel *et al.*, 2014).

As previously mentioned, the most important reason for PEW in patients with CKD is inadequate dietary protein and energy intake and also additional nutrient loss during dialysis (Combarous *et al.*, 2002, Kloppenburg *et al.*, 1999, Wang *et al.*, 2003). A study in Tehran showed that protein and energy intakes were less than the recommended rates in 86.1 and 94.1% of hemodialysis patients, respectively (Taghdir *et al.*, 2011). In another study conducted by Pashar *et al.*, lack of energy and protein intakes in hemodialysis patients were 66 and 30%, respectively (Pashar Khoshknab and Keshavarz, 1996). These prevalence rates were reported as 88 and 84.5%, respectively in a study conducted by Ashabi study *et al.* (Ashabi *et al.*, 2011). These results were consistent with findings of a study conducted by Pourghaderi *et al.* (Pourghaderi *et al.*, 2015). Average rates of energy and protein intake were reported as 17.5 kcal/kg and 0.8 g/kg of bodyweight per day in dialysis patients, that are lower than the recommended daily intakes (Mardani *et al.*, 2016). Several approaches can be used to avoid inadequate nutrition intake. Energy and protein intake in patients with stage 3-5 CKD who are clinically stable and not on dialysis, should be 30–35 kcal/kg and 0.6–0.8 g/kg of ideal body weight per day, respectively to prevent loss of muscle protein (Cano *et al.*, 2009, Kopple, 2001a). It is therefore worth noting that in patients who have hyper catabolic conditions such as infection, these values should be adjusted. In patients with end-stage renal disease who are on

dialysis, the minimum rate of protein and energy requirements should be 1.2 g/kg and 30–35 kcal/kg of ideal body weight per day, respectively according to the physical activity level (for both hemo- and peritoneal dialysis). Notably, at least 50% of protein should be of high biological value (Ikizler *et al.*, 2013).

Consumption of high-protein meals or supplements during dialysis is a strategy to meet the recommendation, especially in at-risk patients (Kalantar-Zadeh and Ikizler, 2013). The important issue in these patients is control of phosphorus intake. Studies have shown that increased protein intake and low serum phosphorous can get the best result in hemodialysis patients (Shinaberger *et al.*, 2008). So, when a protein is recommended, its phosphorus content should also be noted. Patients who received this recommendation are not able to prevent weight loss and muscle building, so, nutritional supplementation is the next step. Furthermore, in cases of patients who are unable to tolerate oral supplements (such as severe anorexia or dysphagia) tube feeding is used (Cano *et al.*, 2009).

Vitamins and minerals status in patients with CKD: Vitamin deficiency is common in CKD patients who do not take supplements (Piper, 1985). The reasons for this deficiency can be due to the low dietary intake caused by anorexia, loss through dialysis, kidney functional limitations, and limited foods because of their high potassium or phosphorus contents. Moreover, some drugs interfere with nutrients that can lead to deficiency (Piper, 1985, Steiber and Kopple, 2011). According to our review, a limited number of studies have been conducted on the micronutrient intake in Iranian CKD patients. In a study carried out by Ashourpour *et al.*, 96.8 and 97.9% of hemodialysis patients had low intakes of vitamin A and E, respectively. In addition, this study showed that in 50-100% of patients, thiamine, riboflavin, niacin, pyridoxine, cobalamin, folate, and vitamin C intakes were lower than the recommended levels. In addition, in 36-99% of patients calcium, iron, magnesium, and zinc intake rates were lower

than the recommendation (Ashourpour *et al.*, 2012). Mardani *et al.* carried out an investigation in Khorramabad and showed that the intake of calcium, magnesium, zinc, sodium, and potassium in more than 90% of the patients was lower than the recommended level. Furthermore, this study found that 5-50% of the patients were not taking the recommended amounts of riboflavin, pyridoxine, B12, folate, and vitamin C. However, 98% and 60% of these patients had deficient amounts of fat soluble vitamins E and A, respectively (Mardani *et al.*, 2016). The results of these studies in Iran are consistent with findings of most other studies (Cho *et al.*, 2008, Kalantar-Zadeh *et al.*, 2002, Raimundo *et al.*, 2006, Wang *et al.*, 2007).

Some studies expressed that vitamin C deficiency in dialysis patients is due to restrictions in the consumption of fruit and vegetables in order to reduce hyperkalemia. Dietary vegetables restriction might also lead to folic acid deficiency. In addition, cooking vegetables to reduce their potassium content causes inactivation of vitamin C (Chazot and Kopple, 1997, Wang *et al.*, 2001). While meat, beans, and dairy products are rich in vitamin B groups, they have a high phosphorus content; so, consumption of these foods are limited by patients (Sprenger *et al.*, 1983). In addition, consumption of protein-rich foods (meats and sea foods) is limited because of anorexia in these patients, which can lead to zinc and iron deficiency (Pollock *et al.*, 1997).

Lack of nutrients in patients with CKD has devastating effects on the endothelial dysfunction, antioxidant capacity, and increases vascular calcification and mortality (Wen *et al.*, 2008). Some studies suggested that patients need dietary supplements for water soluble vitamins and minerals (Mardani *et al.*, 2016). More studies are therefore needed for better illustration.

Quality of life in patients with CKD: One of the important aspects of patients with CKD, which is usually neglected, is the quality of life (QoL). Studies have indicated that kidney disease is associated with reduced QoL and increased mortality (Feroze *et al.*, 2011). In addition, poor

values in QoL are associated with worse situation in malnutrition markers (such as Low levels of albumin, creatinine, and decreased muscle mass) (Mazairac *et al.*, 2011). Moreover, poor QoL in mental aspect is common in dialysis patients (Allen *et al.*, 2002). These patients are facing with problems such as hospitalization, dietary restrictions, loss of appetite due to uremia, complications such as cardiovascular disease, depression, fear of failure, and memory loss and all these factors can affect daily activities of their life (Gracia-Iguacel *et al.*, 2014, Pakpour *et al.*, 2010). A study conducted by Pakpour and *et al.*, on Iranian patients showed that the QoL scores in all scales in patients undergoing hemodialysis were significantly lower than those of the general population (Pakpour *et al.*, 2010), which is consistent with most of other studies (Ahari *et al.*, 2007, Vos *et al.*, 2006). Further studies are required to determine and control factors affecting the quality of life in these patients.

According to the authors' knowledge, this is the first review article over nutritional status of CKD patients in Iran. Although the data presented in this review are not conclusive, it seems that nutritional status in these patients is not desirable. This

References

- Ahari S, et al.** 2007. Quality of Life in Hemodialysis Patients at Ardebil University of Medical Science (Arums) and Factors affecting it. *Research journal biological science*. **2 (5)**: 529-533.
- Allen KL, et al.** 2002. Association of nutritional markers with physical and mental health status in prevalent hemodialysis patients from the HEMO study. *Journal of renal nutrition*. **12 (3)**: 160-169.
- As habi A, Tabibi H, Hedayati M, Mahdavi-Mazdeh M & Nozari B** 2011. Association of energy-protein malnutrition with risk factors of cardiovascular diseases in hemodialysis patients. *Iranian journal of nutrition sciences & food technology*. **6 (2)**: 0-0.
- Ashourpour M, et al.** 2012. Assessment of Vitamin and Mineral Intake and Some Related Factors in Hemodialysis Patients Referred to

manuscript can encourage researchers to develop new strategies to improve these patients' life conditions. Finally, through this study, we hope to shed some light on this issue.

Conclusions

Paying attention to the nutritional status of CKD patients is very important. According to the previous studies most Iranian CKD patients suffer from lack of protein, energy, and some micronutrients. Nutrition education programs are suggested for patients, their families, and health professionals. Furthermore, using nutritional supplementation in these patients appears to be useful in order to decreased morbidity and mortality. In addition, more widespread research should be performed on the causes of malnutrition to find appropriate strategies for the patients.

Authors' contributions

Abdollahi SH wrote the manuscript. Razmpoosh E and Toupchian O provided critical revision of the manuscript. Salehi-Abargouei A edited the manuscript. All of the authors approved the content of the manuscript and agreed on all aspects of the work.

Imam Khomeini Hospital, Tehran. *Iranian journal of endocrinology and metabolism*. **13 (6)**: 607-613.

Bonanni A, et al. 2011. Protein-energy wasting and mortality in chronic kidney disease. *International journal of environmental research and public health*. **8 (5)**: 1631-1654.

Cano N, et al. 2009. ESPEN Guidelines on Parenteral Nutrition: adult renal failure. *Clinical nutrition*. **28 (4)**: 401-414.

Carrero JJ, et al. 2007. Comparison of nutritional and inflammatory markers in dialysis patients with reduced appetite. *The American journal of clinical nutrition*. **85 (3)**: 695-701.

Chazot C & Kopple JD 1997. Vitamin metabolism and requirements in renal disease and renal failure. In *Nutritional management of renal disease*, pp. 415-477. Williams & Wilkins Baltimore, MD.

- Cho J-H, Hwang J-Y, Lee S-E, Jang SP & Kim W-Y** 2008. Nutritional status and the role of diabetes mellitus in hemodialysis patients. *Nutrition research and practice*. **2** (4): 301-307.
- Chobanian AV, et al.** 2003. The seventh report of the joint national committee on prevention, detection, evaluation, and treatment of high blood pressure: the JNC 7 report. *Journal of the American medical association*. **289** (19): 2560-2571.
- Chung S, Koh ES, Shin SJ & Park CW** 2012. Malnutrition in patients with chronic kidney disease. *Open journal of internal medicine*. **2**: 89-99.
- Cibulka R & Racek J** 2007. Metabolic disorders in patients with chronic kidney failure. *Physiological research*. **56** (6): 697-705.
- Combarrous F, et al.** 2002. Albumin loss in on-line hemodiafiltration. *The international journal of artificial organs*. **25** (3): 203-209.
- den Hoedt CH, et al.** 2014. Clinical predictors of decline in nutritional parameters over time in ESRD. *Clinical journal of the American society of nephrology*. **9** (2): 318-325.
- Dong J, Li Y, Xu Y & Xu R** 2011. Daily protein intake and survival in patients on peritoneal dialysis. *Nephrology dialysis transplantation*. **26** (11): 3715-3721.
- Feroze U, et al.** 2011. Quality-of-life and mortality in hemodialysis patients: roles of race and nutritional status. *Clinical journal of the American society of nephrology*. **6** (5): 1100-1111.
- Fouque D, et al.** 2008. A proposed nomenclature and diagnostic criteria for protein-energy wasting in acute and chronic kidney disease. *Kidney international*. **73** (4): 391-398.
- Gracia-Iguacel C, et al.** 2014. Defining protein-energy wasting syndrome in chronic kidney disease: prevalence and clinical implications. *Nefrologia*. **34** (4): 507-519.
- Gracia-Iguacel C, et al.** 2013. Prevalence of protein-energy wasting syndrome and its association with mortality in haemodialysis patients in a centre in Spain. *Nefrologia*. **33** (4): 495-505.
- Hamer RA & El Nahas AM** 2006. The burden of chronic kidney disease. *British medical journal*. **332** (7541): 563-564.
- Hosseinpanah F, Kasraei F, Nassiri AA & Azizi F** 2009. High prevalence of chronic kidney disease in Iran: a large population-based study. *BMC public health*. **9** (1): 1-8.
- Hsu C-y** 2002. Epidemiology of anemia associated with chronic renal insufficiency. *Current opinion in nephrology and hypertension*. **11** (3): 337-341.
- Ikizler TA, et al.** 2013. Prevention and treatment of protein energy wasting in chronic kidney disease patients: a consensus statement by the International Society of Renal Nutrition and Metabolism. *Kidney international*. **84** (6): 1096-1107.
- Ikizler TA, Flakoll PJ, Parker RA & Hakim RM** 1994. Amino acid and albumin losses during hemodialysis. *Kidney international*. **46** (3): 830-837.
- Kalantar-Zadeh K, et al.** 2006. Epidemiology of dialysis patients and heart failure patients. In *Seminars in nephrology*, pp. 118-133. Elsevier.
- Kalantar-Zadeh K & Ikizler TA** 2013. Let them eat during dialysis: an overlooked opportunity to improve outcomes in maintenance hemodialysis patients. *Journal of renal nutrition*. **23** (3): 157-163.
- Kalantar-Zadeh K, Kopple JD, Deepak S, Block D & Block G** 2002. Food intake characteristics of hemodialysis patients as obtained by food frequency questionnaire. *Journal of renal nutrition*. **12** (1): 17-31.
- Kalantar-Zadeh K, Mehrotra R, Fouque D & Kopple JD** 2004. Poor Nutritional Status and Inflammation: Metabolic Acidosis and Malnutrition- Inflammation Complex Syndrome in Chronic Renal Failure. In *Seminars in dialysis*, pp. 455-465. Wiley Online Library.
- Khajehdehi P, Malekmakan L, Pakfetrat M, Roozbeh J & Sayadi M** 2014. Prevalence of chronic kidney disease and its contributing risk factors in southern Iran: A cross-sectional adult population-based study. *Iranian journal of*

- kidney diseases. **8 (2)**: 109-115.
- Kim Y, et al.** 2013. Relative contributions of inflammation and inadequate protein intake to hypoalbuminemia in patients on maintenance hemodialysis. *International urology and nephrology*. **45 (1)**: 215-227.
- Kloppenburger WD, de Jong PE & Huisman RM** 1999. Low calorie intake in dialysis patients: an alternative explanation. *American journal of kidney diseases*. **33 (6)**: 1202-1203.
- Kopple JD** 2001a. The National Kidney Foundation K/DOQI clinical practice guidelines for dietary protein intake for chronic dialysis patients. *American journal of kidney diseases*. **38 (4)**: S68-S73.
- Kopple JD** 2001b. National kidney foundation K/DOQI clinical practice guidelines for nutrition in chronic renal failure. *American journal of kidney diseases*. **37 (1)**: S66-S70.
- Kovesdy CP & Kalantar-Zadeh K** 2009. Why is protein-energy wasting associated with mortality in chronic kidney disease? In *Seminars in nephrology*, pp. 3-14. Elsevier.
- Kramer H, Toto R, Peshock R, Cooper R & Victor R** 2005. Association between chronic kidney disease and coronary artery calcification: the Dallas Heart Study. *Journal of the American society of nephrology*. **16 (2)**: 507-513.
- Leinig CE, et al.** 2011. Predictive value of malnutrition markers for mortality in peritoneal dialysis patients. *Journal of renal nutrition*. **21 (2)**: 176-183.
- Levey A, et al.** 2007. Chronic kidney disease as a global public health problem: approaches and initiatives—a position statement from Kidney Disease Improving Global Outcomes. *Kidney international*. **72 (3)**: 247-259.
- Levey AS, et al.** 2005. Definition and classification of chronic kidney disease: a position statement from Kidney Disease: Improving Global Outcomes (KDIGO). *Kidney international*. **67 (6)**: 2089-2100.
- London GM, et al.** 2003. Arterial media calcification in end-stage renal disease: impact on all-cause and cardiovascular mortality. *Nephrology dialysis transplantation*. **18 (9)**: 1731-1740.
- Mak R, et al.** Wasting in chronic kidney disease. *J Cachexia Sarcopenia Muscle* 2011; **2**: 9-25. *Journal of cachexia sarcopenia muscle*. **2 (1)**: 9-25.
- Mardani M, Rezapour P, Baba H, Balavar S & Naghdi N** 2016. The nutritional status of hemodialysis patients admitted to Khoramabad's Shohadie Ashaier hospital, Korramabad, Iran. *Journal of preventive epidemiology*. **1 (1)**: 1-5.
- Mazairac AH, et al.** 2011. Protein-energy nutritional status and kidney disease-specific quality of life in hemodialysis patients. *Journal of renal nutrition*. **21 (5)**: 376-386. e371.
- McClellan W, et al.** 2006. Racial differences in the prevalence of chronic kidney disease among participants in the Reasons for Geographic and Racial Differences in Stroke (REGARDS) Cohort Study. *Journal of the American society of nephrology*. **17 (6)**: 1710-1715.
- Mitch WE & Goldberg AL** 1996. Mechanisms of muscle wasting—the role of the ubiquitin-proteasome pathway. *New England journal of medicine*. **335 (25)**: 1897-1905.
- Najafi I, et al.** 2012. Prevalence of chronic kidney disease and its associated risk factors: the first report from Iran using both microalbuminuria and urine sediment. *Archives of Iranian medicine*. **15 (2)**: 7075.
- Pakpour AH, et al.** 2010. Health-related quality of life in a sample of Iranian patients on hemodialysis. *Iranian journal of kidney diseases*. **4 (1)**: 50-55.
- Pasdar Khoshknab Y & Keshavarz S** 1996. Nutritional status of hemodialysis patients. *Improvement journal*. **1**: 20-26.
- Piper CM** 1985. Very-low-protein diets in chronic renal failure: nutrient content and guidelines for supplementation. *Journal of the American dietetic association*. **85 (10)**: 1344-1346.
- Pollock CA, et al.** 1997. Protein intake in renal disease. *Journal of the American society of nephrology*. **8 (5)**: 777-783.
- Pourghaderi M, et al.** 2015. Nutritional

- Indicators and Some Related Factors in Hemodialysis Patients Referred to Hospitals Covered by Alborz University of Medical Science, Summer 91. *Alborz university medical journal*. **4** (1): 1-10.
- Raggi P, et al.** 2002. Cardiac calcification in adult hemodialysis patients: A link between end-stage renal disease and cardiovascular disease? *Journal of the American college of cardiology*. **39** (4): 695-701.
- Raimundo P, Ravasco P, Proença V & Camilo M** 2006. Does nutrition play a role in the quality of life of patients under chronic haemodialysis? *Nutrición hospitalaria*. **21** (2): 139.
- Ros S & Carrero JJ** 2013. Endocrine alterations and cardiovascular risk in CKD: is there a link. *Nefrologia*. **33** (2): 181-187.
- Safarnejad MR** 2009. The epidemiology of adult chronic kidney disease in a population-based study in Iran: prevalence and associated risk factors. *Journal of nephrology*. **22** (1): 99-108.
- Sarnak MJ, et al.** 2003. Kidney disease as a risk factor for development of cardiovascular disease a statement from the American Heart Association Councils on kidney in cardiovascular disease, high blood pressure research, clinical cardiology, and epidemiology and prevention. *Circulation*. **108** (17): 2154-2169.
- Shinaberger CS, et al.** 2008. Is controlling phosphorus by decreasing dietary protein intake beneficial or harmful in persons with chronic kidney disease? *The American journal of clinical nutrition*. **88** (6): 1511-1518.
- Shlipak MG, et al.** 2003. Elevations of inflammatory and procoagulant biomarkers in elderly persons with renal insufficiency. *Circulation*. **107** (1): 87-92.
- Sprenger K, et al.** 1983. Improvement of uremic neuropathy and hypogeusia by dialysate zinc supplementation: a double-blind study. *Kidney international. supplement*. **16**: S315-318.
- Steiber AL & Kopple JD** 2011. Vitamin status and needs for people with stages 3-5 chronic kidney disease. *Journal of renal nutrition*. **21** (5): 355-368.
- Stevens LA, Coresh J & Levey AS** 2008. CKD in the elderly—old questions and new challenges: World Kidney Day 2008. *American Journal of kidney diseases*. **51** (3): 353-357.
- Su C-T, et al.** 2013. Changes in anthropometry and mortality in maintenance hemodialysis patients in the HEMO Study. *American journal of kidney diseases*. **62** (6): 1141-1150.
- Tabibi H, As'habi A, Heshmati BN, Mahdavi-Mazdeh M & Hedayati M** 2012. Prevalence of protein-energy wasting and its various types in Iranian hemodialysis patients: a new classification. *Renal failure*. **34** (10): 1200-1205.
- Taghdir M, et al.** 2011. Assessment of Energy and Protein Intake and Some of the Related Factors in Hemodialysis Patients Referred to Imam Khomeini Hospital. *Iranian journal of endocrinology and metabolism*. **13** (6): 690-696.
- USRDS U** 1999. Renal data system 1999 annual data report. *The National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases: Bethesda, MD*.
- Vanholder R, et al.** 1993. Depressed phagocytosis in hemodialyzed patients: in vivo and in vitro mechanisms. *Nephron*. **63** (4): 409-415.
- Vanholder R & Ringoir S** 1993. Infectious morbidity and defects of phagocytic function in end-stage renal disease: a review. *Journal of the American society of nephrology*. **3** (9): 1541-1554.
- Vos PF, et al.** 2006. Effect of short daily home haemodialysis on quality of life, cognitive functioning and the electroencephalogram. *Nephrology dialysis transplantation*. **21** (9): 2529-2535.
- Wang AY-M, et al.** 2003. Important factors other than dialysis adequacy associated with inadequate dietary protein and energy intakes in patients receiving maintenance peritoneal dialysis. *The American journal of clinical nutrition*. **77** (4): 834-841.
- Wang AY-M, et al.** 2001. Independent effects of residual renal function and dialysis adequacy on

actual dietary protein, calorie, and other nutrient intake in patients on continuous ambulatory peritoneal dialysis. *Journal of the American society of nephrology*. **12 (11)**: 2450-2457.

Wang AY-M, et al. 2007. Nutrient intake during peritoneal dialysis at the Prince of Wales Hospital in Hong Kong. *American journal of kidney diseases*. **49 (5)**: 682-692.

Wen CP, et al. 2008. All-cause mortality attributable to chronic kidney disease: a prospective cohort study based on 462 293 adults in Taiwan. *The lancet*. **371 (9631)**: 2173-2182.

Zhang L, et al. 2011. Pharmacological inhibition of myostatin suppresses systemic inflammation and muscle atrophy in mice with chronic kidney disease. *The FASEB journal*. **25 (5)**: 1653-1663.

Zhang L, Wang XH, Wang H, Du J & Mitch WE 2010. Satellite cell dysfunction and impaired IGF-1 signaling cause CKD-induced muscle atrophy. *Journal of the American society of nephrology*. **21 (3)**: 419-427.

Zhang Q-L & Rothenbacher D 2008. Prevalence of chronic kidney disease in population-based studies: systematic review. *BMC public health*. **8 (1)**: 1-13.