Title	Monotherapy with angiotensin-converting enzyme inhibitors and combined antihypertensive therapy in patients with diabetic nephropathy: retrospective study
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Introduction:
Diabetes and hypertension are affect heart, kidneys, brain and blood vessels of the retina. End-stage renal disease with a combination of these pathologies is the commonest cause of disability and mortality.
The aim was to compare the efficacy of monotherapy with ACE inhibitors at high doses and combination therapy (ACE inhibitor and moxonidine or ACE inhibitor and indapamide) in patients with hypertension on the background of diabetic nephropathy.
Materials and methods:
We analyzed 68 cards inpatients and 34 blood pressure diaries. The first group of patients represented by 16 patients who received only ACE inhibitor (enalapril or lisinopril) at a dose of 20-60 mg/day, the second group - 27 patients treated with the combination of enalapril or lisinopril (10-20 mg/day) with moxonidine (3-4 mg / day), III group - 25 patients treated with the combination of ACE inhibitors (as in the second group) and inadapamid at a dose of 1.5 mg/day.
Results:
It was proved more pronounced effect in the second group (blood pressure after treatment was 130 ± 4 (systolic) and 85 ± 3 mm Hg (diastolic) vs. 136 ± 4 and 88 ± 2 in the first group and 133 ± 3 and 80 ± 2 in the second group ($P<0,05$), respectively, and found a positive effect in the second group on heart rate (70 ± 3 beats/min in the second group vs 80 ± 6 in the first group and 83 ± 4 beats/minute in the third group ($P<0,05$)), which positively changed quality of patients' life.
Conclusion:
Usage of combined therapy with ACE inhibitors and moxonidine in patients with diabetic nephropathy demonstrates higher clinical efficacy and a favorable safety profile.

Title	Rejection of the renal transplant: the histological diagnosis evaluated
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Introduction:
In 1991, the idea for a histologic classification system of renal allograft biopsies was introduced as there was a great need for standardization of diagnosis and treatment of acute rejection. The proposal for harmonization became the Banff-classification, a system that has been continuously adapted over the years based on scientific and clinical research. In this retrospective blinded study, we aim to investigate if the diagnosis based on the Banff '13 classification (considered as gold standard) is comparable to the previous diagnostic evaluation methods including descriptive biopsy analysis and previous versions of the Banff classification.
Method:
We selected 151 allograft biopsies that were sampled between 2001 and 2013 and stored at the Antwerp University Hospital. All biopsies were re-evaluated according to the Banff '13- classification and compared to the histologic diagnosis as recorded in the patient files by a previous Banff-classification or a descriptive method (PSS: meaning previous scoring system; descriptive method or previous version of Banff-classification).
Results:
Of the 151 biopsies, only 37 received the same diagnosis by Banff '13 compared to PSS while 116 biopsies were differently diagnosed, either more or less severe. Moreover, results by Banff '13 showed a more equal distribution between the different categories compared to PSS, where most of the biopsies were found to have a 'normal' histology (n=108) and little biopsies showed 'borderline' (n=9) or 'chronic' (n=10) changes. Of the same population PSS only diagnosed 24 with acute rejection, while this number increased to 35 using the Banff '13-classification. Meanwhile the 'normal' group was reduced to 29 biopsies after re-evaluation.
Conclusion:
The results showed significant discrepancies between the old and the new histologic diagnosis,
most likely leading to different therapy choices with a potentially different graft outcome and
different side effects by overtreatment or undertreatment.