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Summary

Polycystic kidney disease (PKD) is a chronic, progressive hereditary condition characterized by abnormal development and growth of cysts in the kidneys and other organs. There is increasing interest in exploring whether dietary modifications may prevent or slow the disease course in people with PKD. Although vasopressin-receptor agonists have emerged as a novel drug treatment in advancing care for people with PKD, several recent landmark trials and clinical discoveries also have provided new insights into potential dietary-related therapeutic strategies. In this review, we summarize the current evidence pertaining to nutrients, foods, dietary patterns, cyst growth, and progression of PKD. We also describe existing evidence-based dietary care for people with PKD and outline the potential implications for advancing evidence-based dietary interventions.

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Polycystic kidney disease (PKD) is the most common inherited cause of kidney failure globally.¹ The condition is caused by mutations in the *PKD1* and *PKD2* gene, which result in abnormal prolific irreversible growth of fluid-filled cysts in the kidney.² Autosomal-dominant PKD accounts for up to 10% of patients undergoing kidney replacement therapy.³ The ongoing growth of cysts causes pain as well as damage to the architecture of the kidney parenchyma, leading to kidney failure.⁴

Several physiological mechanisms are disrupted in PKD.⁵ One of these is in the ability to concentrate urine.⁶ With infiltration of the cysts in the kidney parenchyma, the osmotic gradient in the kidney cortex and medulla is disrupted and polyuria develops. In addition, there is increased vasopressin secretion in response to dehydration, with high levels of vasopressin shown to promote cyst growth.⁷ An increase in water consumption has

been a long-standing recommendation to suppress vasopressin secretion.⁸ However, further clinical trials are required to confirm its efficacy in slowing down clinical progression of PKD. More recently, experimental models have observed altered glucose metabolism, with a preference for aerobic glycolysis in cyst cells.^{9,10} Other distinct metabolic alterations identified in PKD include impaired fatty acid metabolism and mitochondrial β oxidation.^{11,12} These metabolic derangements may form potential targets for dietary intervention in PKD.

The vasopressin receptor agonist (V2RA) tolvaptan, is an approved drug treatment for PKD and has been shown to inhibit cyst growth in experimental data and shown to be effective in slowing the decline of kidney function in PKD.¹³ However, its use is associated with significant aquaretic and other side effects,¹⁴ leading to a high discontinuation rate.¹⁵ Further interventions to slow PKD progression are needed.

Lifestyle modification including the manipulation of diet and fluid intake is therefore of great interest to people with PKD,^{16–18} health professionals,¹⁹ and the research community.^{20,21} Several reviews have been published in recent years but these have focused on specific elements such as water,²² specific diets such as energy restriction,²³ or were published^{21,24,25} before the release of results from landmark trials such as the PREVENT–Autosomal-Dominant Polycystic Kidney Disease (ADPKD) trial.²⁶ Given the close link between nutrients, foods, and dietary patterns, this review provides an overview of the current evidence on nutrients, foods, dietary patterns, and PKD, and describes the implications for clinical practice as well as areas for future research.

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NUTRIENTS

Sodium

Excessive intake of sodium has been associated with accelerated cyst growth and hypertension in individuals with PKD. In a post hoc analysis of the HALT progression of polycystic kidney disease study, Torres et al.²⁷ reported that each 18 mmol of urinary sodium excretion was associated with a faster decline in estimated glomerular filtration rate (eGFR) (-0.09 mL/min per 1.73 m² per year) and more rapid kidney growth (0.43%/year total kidney volume growth), showing the benefit of sodium restriction. However, despite regular support for up to 8 years with the goal of reduced sodium intake (~100 mmol salt/d), the mean urinary salt excretion (reflecting dietary intake) was not achieved (mean, 178 mmol/d).²⁷ This underscores the challenge of dietary interventions to reduce sodium intake.

The exact mechanism by which sodium accelerates cyst growth in PKD was explored by Kramers et al.²⁸ Analysis of an observational cohort of 589 individuals with ADPKD used mediation analyses to determine that the effect on disease progression was owing primarily to a salt-induced increase in circulating vasopressin, measured by plasma copeptin as a surrogate marker. The investigators eloquently translated this into practical terms and suggested that a reduction in salt intake to 5 g (2,000 mg/90 mmol sodium) per day could postpone dialysis commencement by 4 years, but this would require further evaluation in a randomized trial fashion. In a second observational cohort,²⁹ a single session of dietary counseling on sodium restriction was associated with an improvement in tolerance to V2RA medications by reducing polyuria, one of the most bothersome side effects of the medication. This led to the suggestion to consider dietary counseling of a reduced sodium diet in patients treated with V2RAs. A summary of the findings and implications from the small number of human studies exploring dietary sodium intake in PKD are shown in [Table 1](#).^{27–35}

Protein

Excessive protein intake in the chronic kidney disease (CKD) population is associated with increased glomerular hyperfiltration and worse proteinuria.³⁴ Higher levels of dietary protein also stimulate renin release, which increases angiotensinogen and increases blood pressure.²⁵ However, there is limited human evidence as to how or if protein may influence cyst growth. A 2-year follow-up evaluation of the modification of diet in renal disease study in 200 participants with PKD and a GFR of 25 to 55 mL/min per 1.73 m² found that a low protein (0.58 g/kg per day) diet had no benefit in slowing the rate of decline in GFR compared with a normal protein diet (1.3 g/kg per day).³⁵ Instead, blood pressure and

proteinuria predicted faster decline in kidney function. Similarly, a retrospective analysis of 109 patients with ADPKD also found no effect of lower protein intake (mean intake, 0.87 g/kg per day) on progression to kidney failure,³⁶ and a 4-year follow-up evaluation of patients with ADPKD showed no association between protein intake and annual change in eGFR.²⁸

Some work in nonorthologous animal models of PKD have shown that protein type may be important. For example, plant proteins (soy) as compared with animal protein (casein) may exert beneficial effects on PKD progression, as reviewed in work by Pickel et al.²³ Rats fed soy protein had reduced kidney weight,^{37–39} cyst volume,^{37,38,40} and kidney cyst growth.³⁷ These inhibitory effects were correlated to lower insulin growth factor-1 production,³⁷ as well as reduced inflammation as a result of improvements in long-chain polyunsaturated fatty acid intake.^{39,41} However, any evidence of benefit from plant protein failed to replicate in multiple orthologous rodent models.^{23,42} Moreover, the role of the protein source has not been tested in human dietary intervention studies.

Fat

Similar to protein source, there were suggestions from studies in nonorthologous rodent PKD models that the source of dietary fat may impact PKD progression, with dietary long-chain polyunsaturated fatty acid intake positively influencing all stages of cyst pathogenesis including epithelial cell proliferation, oxidation, inflammation, fibrosis, and cyst area^{25,43–46} ([Fig. 1](#)). This literature has been reviewed elsewhere.²³ Importantly, results were not replicated in orthologous rodent models.⁴² In the only human intervention study to date, 20 Japanese adults with PKD were randomized to supplementation with 2.4 g/d of eicosapentanoic acid (EPA) for 2 years or without supplementation.⁴⁷ Compared with patients not given supplementation, there was no impact on kidney volume or rate of kidney function decline with EPA supplementation over 2 years. However, the study population was small and did not report dietary intake, which may have seen a higher EPA intake than in Western countries given the high intake of fish and seafood in the Japanese diet. Given the paucity of PKD-specific dietary intervention studies, it seems prudent to recommend intake of foods rich in long-chain polyunsaturated fats, and the ratio of fat in the diet of PKD subjects according to that for the healthy population, that is, a suggested dietary intake of long chain polyunsaturated fats of 610 mg for men and 430 mg for women, and less than 30% calories from saturated fat.⁴⁸

Vitamin D

Observational data have suggested an inverse relationship between serum 25 hydroxyvitamin D levels

Table 1. Summary of Human Studies Examining Sodium Intake in People With PKD

Study	Outcome	Population	Results	Conclusions
Kramers et al, ²⁸ 2020 Observational cohort study, 4-year follow-up period	Association between dietary salt and protein intake and PKD progression	n = 589 patients with ADPKD Mean eGFR, 64 ± 24 mL/min per 1.73 m ² Mean age, 47 ± 11 y Gender, 59% female	High salt intake, but not protein intake, was associated significantly with decline in kidney function Mean salt intake, 9.1 g/d; protein intake, 84 g/d Results of protein intake was not normalized to g/kg per day	Salt intake induces an increase in plasma osmolality, triggering vasopressin secretion, which leads to cystogenesis Reduction of salt to 5 g/d (2,000 mg/90 mmol sodium) could delay kidney failure by 4 years in the model provided
Cote et al, ²⁹ 2020 Retrospective analysis	Effect of premedication dietary counseling on sodium and urea excretion rates in patients starting tolvaptan	n = 30 patients with ADPKD eGFR, 43-74 mL/min per 1.73 m ² Mean age, 47 ± 11 y Gender, 59% female	Dietary counseling was associated with a reduction in sodium excretion of 19 mmol sodium/d (~1 g dietary sodium) Reduction was greatest in patients with higher baseline dietary sodium Counseling in patients who also reduced protein intake (ie, reduced osmolar load overall), seemed to be more effective and persist over time	Reduction in sodium intake and excretion in those on tolvaptan helps to reduce polyuria, although adherence was temporary (4 mo) Multiple interventions to enhance adherence may be required to maintain reduced intake
Torres et al, ²⁷ 2017 Post hoc analysis of HALT PKD RCT studies A and B ³⁰	Effect of salt intake on progression of ADPKD All participants were instructed to follow a 6-g salt/d diet Study B also had potassium restriction (60-80 mmol/d) and phosphate and protein restrictions individualized	Study A, n = 558 aged 15-49 y Study B, n = 486 aged 18-64 y eGFR, 25-60 mL/min per 1.73 m ² Follow-up period varied from 60-94 mo Gender: study A, 49.3% female; study B, 51.6% female	Higher salt intake was associated with increased kidney cyst volume and faster decline in eGFR, although effects were small Intake declined during the trial only marginally (study A, 10 to 9.6 g/d; study B, 10 to 8.8 g/d) Each 1-g decrease in salt intake was associated with significantly less kidney growth (0.43%/y)	Sodium restriction is beneficial, but adherence is a challenge Poor adherence to sodium-restricted diets was evident in both groups According to the investigators, intensive counseling and monitoring of food diaries and feedback would have been beneficial
Torres et al, ³¹ 2011 Observational study with 6 years of follow-up evaluation	Identify markers for disease progression in ADPKD	N = 241 patients with ADPKD Mean eGFR, 89.1 ± 27.7 mL/min per 1.73 m ² Mean age, 32.4 ± 8.9 y at baseline Gender, 60.2% female	Baseline urinary sodium excretion was associated with greater increase in kidney volume and GFR decline Protein intake at baseline 71.9 ± 22.9 g/d Results not normalized to g/kg per day Baseline urine sodium 193.2 ± 86.1 mEq/24 h and urinary potassium 58.9 ± 23.3 mEq/24 h These did not change over 3 years. Protein intake was estimated using urinary nitrogen rather than dietary recall or estimation methods	Higher sodium intake and excretion was associated with more rapid cyst growth and loss of kidney function 24-hour urine results indicated excessive dietary sodium (~11 g salt/d) and inadequate potassium intake (indicative of low fruit and vegetable intake) Although protein intake increased over time, there was no relationship between protein intake at baseline and kidney volume or disease progression
Doulton et al, ³² 2006 Double-blind RCT	Effects of dietary sodium 50 mmol/d versus 350 mmol/d for 11 days on blood pressure and RAS	n = 11 patients with ADPKD and hypertension and n = 8 control subjects with essential hypertension Mean age, 38 ± 3 y Gender, 73% female eGFR not recorded Creatinine clearance, 92 ± 9 mL/min per 1.73 m ²	Responses of blood pressure and RAS to sodium intake were not different between patients with ADPKD and patients with essential hypertension A very low sodium diet using low-sodium breads and packaged products, as well as cooking methods, was sustained for 3 days A high-sodium diet was achieved by supplementing the low-salt diet with 300 mmol salt tablets	Activation of the RAS in response to dietary sodium is not unusually high in Caucasian individuals with ADPKD compared with hypertensive controls

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Table 1 (Continued)

Study	Outcome	Population	Results	Conclusions
Schmid et al. ³³ 1990 Nonrandomized trial	Effect of very low sodium diet 20 mmol/d versus sodium intake of 200 mmol/d on blood pressure after 7 days	n = 9 patients with ADPKD with hypertension and n = 9 normo- tensive controls Mean age of ADPKD patients, 36 y (range, 28–53 y) Gender, 2 of 9 were female eGFR not stated Serum creatinine, 113.1 ± 15 umol/L	In the ADPKD group, higher salt intake increased blood pressure	A high-sodium diet in ADPKD may result in increased blood pressure sensitivity to salt, although the study was small No details on baseline diet were provided

Abbreviations: ADPKD, autosomal-dominant polycystic kidney disease; eGFR, estimated glomerular filtration rate; HALT PKD, HALT progression of polycystic kidney; RAS, renin-angiotensin system; RCT, randomized controlled trial.

and vitamin D–receptor expression with total kidney volume.⁴⁹ Furthermore, vitamin D deficiency in rat models of PKD had inhibitory effects on kidney enlargement and adverse effects on interstitial inflammation.⁵⁰ To explore this relationship, Vendramini et al.⁵¹ randomized 42 vitamin D–deficient patients with PKD to receive either monthly cholecalciferol or placebo for 3 months, but no difference was found in inflammation, vitamin D–receptor expression, or blood pressure. Further large-scale human studies are needed to evaluate the role if any of vitamin D supplementation in ADPKD.

Caffeine

Animal models of ADPKD showed that cyclic adenosine monophosphate (cAMP) promotes growth of human polycystic kidney epithelial cells.⁵² A murine model of ADPKD extended this observation and found that caffeine may stimulate the production of cAMP.⁵³ However, to date, there are no randomized trials testing the effects of reducing caffeine intake in human beings with ADPKD. A small case-control study in 102 adults with ADPKD did not find any association between caffeine intake and kidney volume.⁵⁴ Instead, kidney volume was associated with hypertension and the stage of CKD. Given the uncertainty, it would be reasonable to follow current guidance on caffeine intake for a healthy population¹⁹ in ADPKD (ie, 200 mg caffeine daily, equivalent to 2 cups coffee/4 cups of tea per day).

OXALATE

Nephrolithiasis is common in ADPKD, with a reported prevalence of up to 58% in some studies.^{55,56} The most common composition of stones are uric acid and/or calcium oxalate.⁵⁷ Animal studies have shown that oxalate stones are associated with cyst formation.⁵⁸ Several factors may contribute to the high prevalence of kidney stones in ADPKD including anatomic (such as cyst obstruction, or dilated lumens causing urine stasis) and metabolic derangements (low urine citrate,⁵⁹ low urine pH, and hyperuricemia). Urinary citrate is an inhibitor of calcium oxalate crystal formation.⁵⁸ Treatments to increase urinary citrate could be achieved via dietary means. Daily intake of lemon or lime juice would result in enhanced urinary citrate excretion, and also provide additional variety in fluid intake for people with PKD.⁶⁰ Approximately 60 mEq potassium citrate is provided in 85 mL lemon or lime juice.^{60,61} Advice to avoid high intake of vitamin C–rich foods (juices, smoothies) and supplements also is recommended because ascorbic acid is the precursor to oxalate.

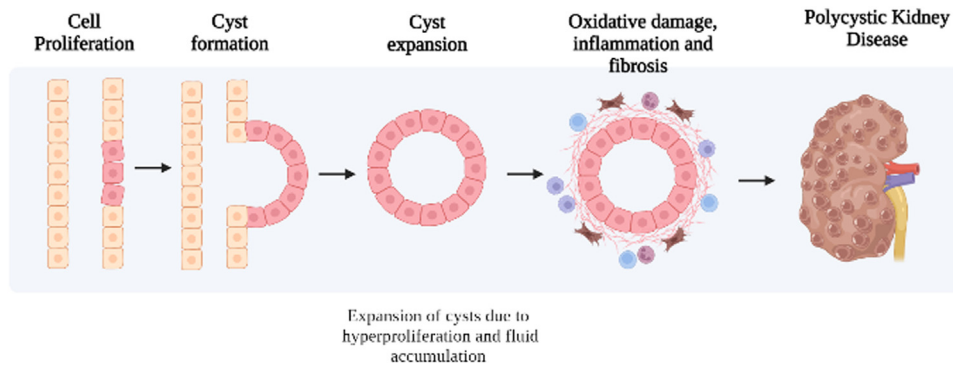


Figure 1. Conceptual diagram of cyst formation in human beings with polycystic kidney disease. Figure created in Bio-render.com. Adapted from Pickel et al.²³ and Maditz et al.²⁵

FOODS

Water

There is a clear relationship between cAMP and stimulation of epithelial cell proliferation and increased cyst fluid accumulation in PKD.⁶² Vasopressin stimulates cAMP production in the collecting ducts and the distal nephron, a common site for cyst formation.⁵² Maintaining fluid intake that is adequate to reduce vasopressin secretion recently was tested in the randomised controlled trial to determine the efficacy and safety of prescribed water intake to prevent kidney failure due to autosomal dominant polycystic kidney disease (PREVENT-ADPKD) trial.²⁶ This trial tested ad libitum intake versus individualized intake to reduce urine osmolality to 270 mOsm/kg or less for 3 years. Despite intensive, structured, evidence-based support, both groups had similar outcomes for total kidney volume and kidney growth, although only a proportion (52.3%) in the intervention group successfully maintained the target urine osmolality. The investigators concluded that detailed self-monitoring in enhanced fluid intake was challenging to persevere with over 3 years. A higher fluid intake still may be beneficial in ADPKD patients who can excrete the extra volume of fluid (usually GFR >60 mL/min)⁶² to reduce the formation of kidney stones and the incidence of urinary tract infections. Water is the preferred fluid because it is low in kilojoules and electrolyte-free.

Turmeric and Stevia

Turmeric is a rhizomatous plant from the ginger family, and has been used as a traditional medicine for many years.⁶³ The active ingredient is curcumin, and there is in vivo evidence that curcumin inhibits cyst production.⁶⁴ There are ongoing trials using curcumin to manage vascular health in chronic and polycystic kidney

disease (NCT03475017, NCT03223883, and NCT02494141) On the other hand, Stevia is a plant from the chrysanthemum family that contains steviol glycosides. Stevia may be used as an alternative to sugar but without calories because the body does not metabolize the glycosides.⁶⁵ Murine evidence has suggested that renal cyst growth is slowed with Stevia ingestion.^{66–68} However, neither have been tested in human beings with PKD, so their value beyond culinary purposes is unknown.

DIETARY PATTERNS

There are significant challenges translating nutritional science findings from the basic sciences to the bedside.⁶⁹ This is in part because people eat food and not isolated nutrients. The interconnected nature of nutrients within a food matrix is also highly complex, and may influence the bioavailability of nutrients and biological responses.⁷⁰ Given these complexities, it is important to examine the evidence about known dietary patterns in the PKD population.

Low-Acid Diets

Taylor et al⁷¹ conducted a small pilot study of a low-osmolar, low-acid diet in 20 adults with PKD with a mean eGFR of 84 mL/min per 1.73 m². The diet was designed to halve endogenous acid production and was low in urea (protein, 0.8-1.0 g/kg body weight per day), sodium (1-1.5 mEq/kg), and dietary acids, with a high water intake (urine osmolality, ≤285 mOsm/kg water per day). The premise of the intervention was based on evidence in animal studies showing that increased urine acid excretion accelerates cyst growth.⁷² Detailed instruction was provided by a dietitian and dietary points were awarded to specific foods, including a target of consuming 40 points per day from base-inducing fruits and vegetables (such as raisins, apricots, kiwifruit, spinach,

cauliflower, and zucchini). The relatively complex dietary intervention resulted in a tripling of fruit and vegetable intake, and significant improvements in protein, fiber, sodium, dietary acid load, and urine osmolality. However, because of the short-term nature of the intervention (4 weeks), it is unclear if this dietary pattern is sustainable and effective in the longer term and the impact on kidney cyst volume was not measured. In people with PKD, this approach of increasing fruit and vegetable intake, and reducing potential renal acid load, is consistent with evidence-based nutrition care for CKD and is unlikely to be harmful,⁷³ but whether it may ameliorate growth of cysts or PKD progression requires further evaluation. Caution may be necessary for patients with advanced CKD or undertaking dialysis when potassium control and increased protein intake may be required.

High Fruit and Vegetable/Mediterranean-Style Diets

The 2020 Kidney Disease Outcomes Quality Initiative guidelines for nutrition management in CKD recommended a dietary pattern high in fruit and vegetables in people with CKD,⁷³ including a Mediterranean diet for those with CKD stages 1 to 5 not on dialysis or post-transplant. This was based on epidemiologic evidence

that dietary patterns high in fruit and vegetables are associated with reduced mortality and morbidity in the CKD population.⁷⁴ To date, only a small cross-sectional study from Korea has examined the Dietary Approaches to Stop Hypertension and Mediterranean-style patterns in 68 ADPKD patients.⁷⁵ Those who followed a Dietary Approaches to Stop Hypertension style of eating (ie, a diet high in vegetables, legumes, fruit, nuts, whole grains, and low-fat dairy) had a reduced risk of low muscle strength and sarcopenia compared with those adopting a Mediterranean-style eating pattern (high in vegetables, legumes, fruit, nuts, whole grains, fish, and monounsaturated oils). However, cyst growth and kidney volume were not examined.

Caloric Restriction

Animal studies have found that a reduction in calorie intake may inhibit cyst growth and disease progression.^{76,77} Kipp et al⁷⁶ and Warner et al⁷⁷ found that reducing calories by up to 40% could be a potential treatment to slow disease progression in human beings with ADPKD. Numerous possible mechanisms for this effect have been proposed, notably inhibition of the mammalian target of rapamycin signaling pathway, and are reviewed in detail by Pickel et al.²³ Alterations in metabolic programming also have been observed in

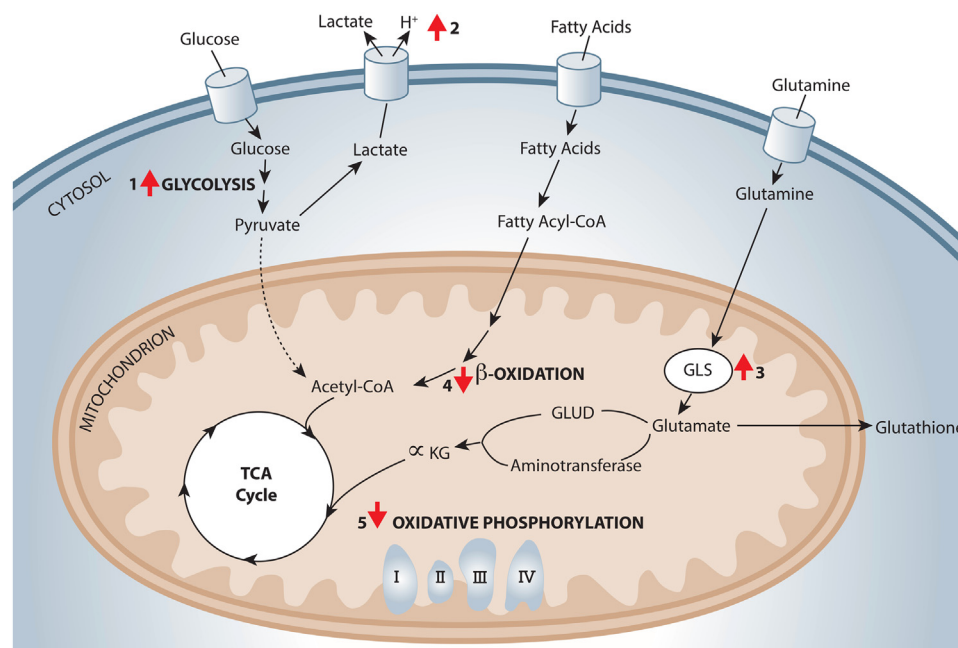


Figure 2. Altered cellular metabolism in PKD. Cyst lining cells show the altered cellular metabolism in ADPKD. Cyst-lining cells show the Warburg effect; aerobic glycolysis is increased (red arrow 1), resulting in extracellular accumulation of lactate (red arrow 2). In addition to glucose, highly proliferative cells have increased demands for glutamine, reflected by up-regulation of GLS (red arrow 3). At the same time, fatty acid oxidation (red arrow 4) and oxidative phosphorylation (red arrow 5) are impaired. Abbreviations: Acetyl-CoA, acetyl coenzyme A; ADPKD, autosomal-dominant polycystic kidney disease; GLS, glutaminase; GLUD, glutamate dehydrogenase; PKD, polycystic kidney disease; TCA cycle, tricarboxylic acid cycle; α KG, α -ketoglutarate. Figure and legend reprinted with permission from Pickel et al.²³

Table 2. Single-Center Phase 2 Human Clinical Trials Relating to PKD and Diet in Progress and Registered With clinicaltrials.gov

Trial	Study Design	Study Aim	Study Outcomes	Dietetic Prescription
NCT04680780 Keto-ADPKD Ketogenic Dietary Interventions in ADPKD (Active, not recruiting)	Three-arm randomized controlled trial Recruited: 63 patients (21 patients per arm) Site: University Hospital, Cologne, Germany Duration: 4 mo (120 d)	Determine the feasibility of two ketogenic diets in adults with ADPKD versus ad libitum diet control in adults age 18-60 y with CKD stages 1 to 3	Primary outcomes: adherence was measured using blood ketone and patient-reported outcomes (feasibility questionnaire) Secondary outcomes: change in total kidney volume, body mass index, insulin sensitivity, inflammation, QOL, BP, and adverse events	Active dietary intervention arm: classic ketogenic diet—no further details specified OR 3 days of water fasting (ie, consume only water on 3 consecutive days in the first 14-day period of the month for 3 mo) Comparator diet: eat ad libitum, with low salt intake (5-7 g/d) and >3 L water/d
NCT04534985 Time-Restricted Feeding in ADPKD (Recruiting)	Randomized controlled trial Recruitment target: 30 Site: University of Colorado Duration: 12 mo Co-sponsor: PKD Foundation	Determine the feasibility of time-restricted feeding without energy restriction compared with standard healthy eating advice in adults 18-65 with a BMI 25-45 kg/m ² and eGFR ≥30 mL/min	Primary outcome: adherence, recruitment rate, retention rate Secondary outcomes: safety, tolerability, change in body weight, abdominal obesity, body composition, insulin sensitivity, AMPK expression, kidney volume, mood, pain, energy expenditure, energy intake, physical activity	Active dietary intervention arm: prescription of 2.3-3 g sodium, 0.8-1 g/kg protein, <800 mg phosphate, 'moderate calorie intake' and 'appropriate hydration' with consumption of daily food intake in 8-hour window from within 3 hours of waking. Comparator diet: 2.3-3 g sodium, 0.8-1 g/kg protein, <800 mg phosphate, 'moderate calorie intake' and 'appropriate hydration'. Low-sodium, low-protein diet—no further details specified
NCT03858439 DIAT Dietary Intervention in ADPKD on Tolvaptan (Recruiting)	Single-arm pre-post study Recruitment target: 30 patients (15 patients per arm) Site: Hamilton Nephrology Clinic, Ontario, Canada Duration: not specified	Determine the effect of a low-solute (low-sodium, low-protein) diet on urine output in adult patients stable on tolvaptan	Primary outcome: change in 24-hour urine volume Secondary outcome: QOL, urine total solute load	
NCT05228574 TRAMPOLINE Treatment of Vascular Stiffness in ADPKD (Recruiting)	Randomized, double-blind, placebo-controlled, clinical trial Recruitment target: 54 Site: Erasmus University Medical Centre, The Netherlands Duration: 6 wk	Determine if arterial stiffness is exacerbated by a high-salt diet in adults with PKD age ≥18 years and an eGFR ≥60 mL/min	Primary outcome: arterial stiffness measured using pulse-wave velocity Secondary outcomes: 24-hour ambulatory BP, salt tasting thresholds, skin sodium levels, vascular inflammation, and endothelial dysfunction	Active dietary intervention arm: low-salt diet (3.5 g salt/d) for 6 weeks followed by 4 weeks of 6 g salt capsule daily + amiloride Comparator diet: low-salt diet (3.5 g/d) for 6 weeks followed by 4 weeks of placebo salt capsules + amiloride
NCT03102632 A clinical trial of water therapy for ADPKD (Active, not recruiting)	Nonrandomized clinical trial Recruited: 10 patients (target not specified) Site: Cornell University, NY Duration: 18 mo	Examine if increased consumption of water can slow cyst growth or kidney function decline in adults age 18-65 years with an eGFR >40 mL/min	Primary outcome: total kidney volume Secondary outcomes: kidney function (creatinine) change, urine and blood sodium level	Active dietary intervention arm: 6 months of high water intake based on 24-hour urine results No further details specified Control period: 6 months of usual fluid intake (no further details specified)
NCT04310319 WATER Wishing to Decrease Aquaresis in ADPKD Patients Treated With V2Ra: the Effect of Regulating Protein and Salt (Recruiting)	Randomized crossover clinical trial Recruitment target: 12 patients Site: University Medical Centre, Groningen, The Netherlands Duration: 8 wk	Determine if reduced salt and increased water will reduce polyuria in adults age ≥18 years with an eGFR >30 mL/min	Primary outcome: 24-hour urine volume Secondary outcomes: serum copeptin, eGFR, BP, QOL	Active dietary intervention arms: 6 g NaCl tablets per day or placebo; or 6 g NaCl and 40 g protein drink per day or placebo; or 40 g protein drink and salt placebo; or placebo salt and placebo protein drink No further details were specified

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Table 2 (Continued)

Trial	Study Design	Study Aim	Study Outcomes	Dietetic Prescription
NCT03342742 Daily Caloric Restriction and Intermittent Fasting in Overweight and Obese Adults With ADPKD (Completed)	Randomized clinical trial Recruited: 29 participants Site: University of Colorado, CO Duration: 1 year Co-sponsor: National Institute of Diabetes and Digestive and Kidney Diseases	Determine the feasibility of delivering two behavioral interventions for weight loss in adults with ADPKD	Primary outcome: feasibility, retention, percentage change of body weight from baseline Secondary outcomes: QOL, safety, tolerability, mood energy intake, IGF-1, change in kidney volume, change in AMPK expression	The intervention/treatment target for group 1 was to reduce energy intake by 34% with caloric restriction and group 2 reduced energy intake by 34% using 3 d/wk intermittent fasting
NCT04907799 Daily Caloric Restriction in Overweight and Obese Adults With ADPKD (Recruiting)	Randomized, double-blind, controlled clinical trial Recruitment target: 126 Site: University of Colorado, CO Duration: 2 years Co-sponsor: National Institute of Diabetes and Digestive and Kidney Diseases	Compare the efficacy of a daily caloric restriction weight loss intervention in adults age 18-65 years with a BMI 25-45 kg/m ² and an eGFR \geq 30 mL/min	Primary outcome: total kidney volume Secondary outcomes: abdominal adiposity, insulin sensitivity, adiponectin level, leptin, inflammation, gene expression (pAMPK/AMPK, pS6K/S6K), safety, tolerability, adherence, physical activity, adverse events	Group-based weight loss intervention with a prescription of 30% reduction in caloric intake and increased physical activity No other details specified

Abbreviations: ADPKD, autosomal-dominant polycystic kidney disease; AMPK, cytoplasmic AMP-activated protein kinase; BMI, body mass index; BP, blood pressure; CKD, chronic kidney disease; eGFR, estimated glomerular filtration rate; IGF-1, insulin-like growth factor 1; pAMPK, phosphorylated cytoplasmic AMP-activated protein kinase; pS6K, phosphorylated ribosomal protein S6 kinase β -1; QOL, quality of life; S6K, ribosomal protein S6 kinase β -1.

animal models of PKD, including defective glucose metabolism, dysregulated lipid and amino acid metabolism, impaired autophagy, and mitochondrial dysfunction.⁹ For an excellent overview of evidence on metabolic reprogramming and dietary interventions in PKD, readers are referred to Pickel et al.²³ This also is outlined in Figure 2. Human studies exploring daily caloric restriction in PKD (NCT04907799) currently are underway or have been completed but not yet published (NCT03342742). These include strategies to test time-restricted feeding to studies examining reduction in energy intake by more than 30%. These are shown in more detail in Table 2. Advice to patients to adopt this dietary pattern is premature, and not appropriate for those who have a healthy weight.

Intermittent Fasting and Time-Restricted Diets

Although caloric restriction shows promise to reduce cyst volume, fibrosis, and inflammation in animal studies,^{76,77} examination of other dietary approaches to reduce cell proliferation pathways and that may be more tolerable and safer than pharmacologic strategies is underway. These include intermittent fasting (NCT03342742) (Table 2) and time-restricted feeding (NCT04534985) (Table 2). Both dietary strategies theoretically may reduce caloric intake, although their mechanism of action may not rely on caloric restriction.²³ For example, time-restricted diets limit eating to a specific time such as an 8-hour window, and intermittent fasting involves fasting for specific meals or alternate days. Interestingly, observations of patients with ADPKD who follow time-restricted diets during Ramadan showed a reduction in proteinuria and no negative impact on kidney function.⁷⁸ Preclinical evidence showed that time-restricted feeding compared with ad libitum feeding reduced kidney weight, cyst size, and epithelial proliferation⁷⁹ in animal models.

Ketogenic Diets

Based on the beneficial effects on cyst growth observed from caloric restriction, Torres et al⁷⁹ identified that a key mechanism driving these improvements was ketosis. Cyst cells show defective glucose metabolism and are reliant on aerobic glycolysis and glucose for proliferation.¹⁰ Traditional ketogenic diets are high in fat and low in carbohydrates. The composition of the diet therefore deprives the body of glucose and theoretically could result in lower cell proliferation and higher cell death. Beyond glucose deprivation, multiple interacting mechanisms may contribute to the effect of the ketogenic diet on ADPKD progression, many of which overlap with caloric restriction or intermittent fasting.²³ A clinical trial of ketogenic diets in ADPKD is underway (NCT04680780) (Table 2), and commercial plant-based

ketogenic diet programs have been developed in the United States.⁸⁰ No human data exist yet on the impact of ketogenic diets on cyst growth or disease progression.

To date, three case series have been published^{80–82} describing the feasibility of ketogenic diets in ADPKD. The first provided survey feedback on the experiences of 131 patients who had self-initiated ketogenic diets.⁸¹ The second case series reported feedback from the beta version of the Ren.Nu commercial program in 24 participants.⁸⁰ This remote, dietitian-supervised, 16-week program advocates a plant-based, low-carbohydrate, high-fat diet that is high in fluid, and low in oxalate, phosphate, sodium, and purines. In addition, participants take one sachet of KetoCitra supplement (Santa Barbara Nutrients) per day to provide exogenous β -hydroxy butyrate and citrate. The supplemental β -hydroxy butyrate provides an energy substrate as well as anti-inflammatory effects.⁷⁹ Adverse effects reported include fatigue, hunger, constipation, and ‘keto flu’. Adherence in the two case series was reported to be 50%⁸¹ and 92%,⁸⁰ respectively, with issues such as ketone level tracking, cost, eating out, and time taken to prepare meals as barriers to sustainability. The third case series tested the feasibility of a 3-day water fast ($n = 5$) or a 14-day ketogenic diet ($n = 5$). All but one participant successfully reached measurable ketosis and rated the

intervention as feasible.⁸² Although promising, there still is limited human evidence of efficacy to recommend widespread adoption of these dietary patterns in PKD.⁸³ Further randomized controlled trials are needed to evaluate the efficacy of ketogenic diets in slowing the progression of ADPKD. Potential side effects of the ketogenic diet include increased kidney stone formation and cardiovascular risk resulting from increased hypercholesterolemia.

IMPLICATIONS FOR PRACTICE

Although dietary modification is of great interest to people with PKD,¹⁶ very limited randomized controlled studies have investigated the efficacy and practicalities of various aspects of dietary intervention specifically in patients with PKD. Social listening analysis¹⁶ identified a strong desire by people with PKD for practical and specific dietary information and a desire for assistance to navigate conflicting information about diet.

The Patient Perspective

Evaluation of the Re.Nu program (a plant-focused ketogenic diet) reported that, when provided with weekly

Table 3. Dietary Recommendations for PKD (Including Those Undergoing Dialysis)

	People With PKD CKD Stages 1 to 3	People With PKD CKD Stages 4 and 5	People Undergoing Dialysis
General advice	Enjoy a wide variety of foods, especially fruits and vegetables, and minimal amounts of processed foods		
Fluid intake	Choose water to drink and drink to satisfy thirst Seek advice from doctor on the exact volume, but aim for >2 L urine volume per day	Choose water to drink Seek advice from doctor on the exact volume	Choose water to drink Seek advice from doctor on the exact volume if receiving dialysis
Fruit	Eat 2 cups per day	Eat 2 cups per day Avoid fruit juice	Eat 2 cups per day Avoid fruit juice if on hemodialysis
Vegetables	Eat 2.5 cups per day	Eat 2.5 cups per day Seek individual advice if on low-potassium diet	Eat 2.5 cups per day Seek individual advice if on low-potassium diet
Breads, cereals, rice, pasta	Choose whole grain or wholemeal varieties		
Dairy foods (milk, cheese, yogurt, milk alternatives)	Eat 3-4 cups per day	Limit quantity to control serum phosphate levels Seek advice from dietitian on exact amount	
Protein-rich foods (meat, chicken, fish, eggs, legumes, nuts)	Do not exceed recommended portion of meat/chicken and fish (approximately palm size or 150 g/d) Include at least one meal per week of oily fish Enjoy plant-based proteins (nuts, legumes) often	Do not exceed recommended portion of meat/chicken and fish (approximately palm size or 150 g/d) Include at least one meal per week of oily fish Include plant-based proteins (nuts, legumes), seek advice from dietitian on exact amount	Ensure adequate protein to replace dialysis losses—aim for protein-rich food at each main meal Include at least one meal per week of oily fish Include plant-based proteins (nuts, legumes) Seek advice from dietitian on exact amount
Limit salt	Read food labels on packaged foods to reduce salt intake to ideally <5 g (2,000 mg/90 mmol sodium/d) Do not add salt to foods or cooking, minimize processed and convenience foods		
Caffeine	Enjoy up to 200 mg per day or 2 cups coffee/4 cups of tea per day Avoid cola drinks or other drinks containing caffeine	Enjoy small volumes if on a fluid allowance Avoid cola drinks or other drinks containing caffeine	

Abbreviations: CKD, chronic kidney disease; PKD, polycystic kidney disease.

support for 12 weeks, participants expressed a high degree of satisfaction with the new eating pattern and enjoyment of food.⁸⁰ However, data on the sustainability of the program as well as clinical outcomes are lacking. In another qualitative study, 12 participants who followed a low-osmolar, low-acid dietary intervention⁸⁴ found that tracking nutrients was challenging and tedious. Eating out was always problematic, with a complex dietary prescription acting as a barrier to social interactions.

It may be disappointing for people with PKD when they are unable to tolerate or are not suitable to take V2RA therapy. In these instances, people with PKD may choose to modify their diet. However, dietary modification must be sustainable for patients for many years if the aim is to at least slow, if not prevent, further kidney function decline. People with PKD require dietary advice to be readily accessible, available, and evidence-based. Healthy dietary habits are essential for all people with kidney disease. We believe that the earlier children and young people with PKD are introduced to good PKD dietary practices the better their PKD course will be. We also know from our experience that people with PKD want specific advice about foods they can enjoy and whether there are foods they should avoid. Whether there are specific dietary components that could impact cyst growth and progression in PKD needs further evaluation and trials. In the interim, guidance around the suitability of popular diets is recommended, along with plain language explanations of the pathophysiology of their disease.

The answer to the question ‘what is evidence-based dietary advice for people with PKD?’ is summarized in Table 3. Currently, the recommended diet consists of eating a variety of fruits and vegetables combined with an intake of protein that is appropriate for the stage of CKD; with an emphasis on including some plant-based proteins for good health. The long-term diet should contain adequate water intake and be as low in salt as possible. It is important to advise patients to drink an appropriate amount of fluid for the stage of kidney disease. Further studies examining urine osmolarity and cyst growth are needed to confirm these inferences.

SUMMARY AND CONCLUSIONS

Understanding how diet and lifestyle changes may affect or alter the course of PKD is a research, clinical, and patient priority. Currently, several dietary approaches including time-restricted feeding, ketogenic regimens, and fasting regimens are under investigation in randomized controlled trials. However, the benefits of each are yet to be proven and caution is required before widespread use is recommended. Before more quality evidence is available, people

with PKD should be advised to follow the dietary recommendations and receive dietary counseling as for patients with CKD, encourage a diet with adequate variety of fruits and vegetables, with protein intake according to the stage of CKD, and with salt restriction. Fluid recommendations are individualized according to the stage of CKD, but water is the preferred choice of fluid at all stages. Other nutrients, foods, and dietary patterns are not supported by sufficient evidence at this stage, although investigations are underway. Further dietary interventions appropriate for the PKD community require evaluation.

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