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second, a large proportion of patients with MA can revert to normoalbuminuria (4-6); and third, many patients at the onset of MA have begun to experience early renal function decline (ERFD) (7, 8). These findings have called into question the previous paradigm of DN in T1D, in which the finding of MA conveyed a high risk of progressive renal dysfunction and support a new model in which a subset of those with MA develop progressive ERFD. This change in our understanding of diabetic renal disease also is indicative of our incomplete understanding of the mechanisms of ERFD, a process that takes place while measured renal function is still in the normal or even elevated range. These findings emphasize the need for the development of biomarkers to diagnose kidney disease such as ERFD in those with MA.

Accordingly, there is an unmet need for new biomarkers and methods of using same for diagnosing kidney disease.

15 SUMMARY

This Summary lists several embodiments of the presently disclosed subject matter, and in many cases lists variations and permutations of these embodiments. This Summary is merely exemplary of the numerous and varied embodiments. Mention of one or more representative features of a given embodiment is likewise exemplary. Such an embodiment can typically exist with or without the feature(s) mentioned; likewise, those features can be applied to other embodiments of the presently disclosed subject matter, whether listed in this Summary or not. To avoid excessive repetition, this Summary does not list or suggest all possible combinations of such features.

25 In some embodiments of the presently-disclosed subject matter, a method for diagnosing a kidney disease, or the risk thereof, in a subject is provided. In some embodiments, the method comprises determining an amount of at least one peptide of Table 1, Table 2, or both in a biological sample from the subject. The method then comprises comparing the amount of the at least one peptide in the sample with a control level, wherein if the

amount determined is different than the control level, the subject is diagnosed as having, or at an increased risk of developing, the kidney disease.

In other embodiments of the presently-disclosed subject matter, a method for determining treatment efficacy and/or progression of a kidney disease in a subject is provided. In some embodiments, the method comprises
5 determining an amount of at least one peptide of Table 1, Table 2, or both in a first biological sample collected from the subject at a first time point; determining an amount of the at least one peptide of Table 1, Table 2, or both in a second biological sample from the subject at a second time point; and
10 comparing the amounts of the at least one peptide in the first and second samples, wherein a change in the amounts of the at least one peptide from the first and second samples is correlated with determining treatment efficacy and/or progression of the kidney disease in the subject. In some embodiments, the first time point is prior to initiation of a treatment for the kidney disease and
15 the second time point is after initiation of the treatment. In other embodiments, the first time point is prior to onset of the kidney disease and the second time point is after onset of the kidney disease.

In some embodiments of the methods disclosed herein, determining the amount of the at least one peptide comprises determining the amount of the at
20 least one peptide in the sample using mass spectrometry (MS) analysis, immunoassay analysis, or both. The MS analysis can comprise in some embodiments matrix-assisted laser desorption/ionization (MALDI) time-of-flight (TOF) MS analysis or electrospray ionization (ESI) MS. The MALDI-TOF MS analysis can be direct-spot MALDI-TOF or liquid chromatography MALDI-TOF
25 mass spectrometry analysis. In some embodiments, the immunoassay analysis comprises an enzyme-linked immunosorbent assay (ELISA).

In some embodiments, the at least one peptide is a plurality of peptides. Further, in some embodiments, the biological sample is a urine sample and the at least one peptide is at least one peptide selected from Table 1. In other
30 embodiments, the biological sample is a blood sample or a plasma sample and the at least one peptide is at least one peptide selected from Table 2.

In some embodiments, the subject is human. In some embodiments, the subject is a diabetic subject. In some particular embodiments, the kidney disease is diabetic nephropathy.

In further embodiments of the presently-disclosed subject matter, an antibody or fragment thereof is provided that specifically recognizes a peptide of Table 1 or Table 2, a peptide associated with a peptide of Table 1 or Table 2, or both. In some embodiments, the antibody is a monoclonal antibody.

In still other embodiments of the presently-disclosed subject matter, a kit for detecting a kidney disease, or a risk thereof, in a subject is provided. The kit comprises one or more antibodies disclosed herein that specifically recognizes a peptide of Table 1 or Table 2, a peptide associated with a peptide of Table 1 or Table 2, or both. The kit can comprise instructions for using the kit. In some embodiments, the antibody is bound to a substrate. In some embodiments, the kit comprises a plurality of different antibodies.

Accordingly, it is an object of the presently disclosed subject matter to provide peptide biomarkers predictive of kidney disease and methods for using same. This object is achieved in whole or in part by the presently disclosed subject matter.

An object of the presently disclosed subject matter having been stated hereinabove, and which is achieved in whole or in part by the presently disclosed subject matter, other objects and advantages will become evident to those of ordinary skill in the art after a study of the following description of the presently disclosed subject matter, figures, and non-limiting examples.

BRIEF DESCRIPTION OF THE FIGURES

Figure 1 is a graph showing serial estimates of representative examples of patients with early renal function decline (hatched line) and with stable renal function (solid line). The solid line represents the annual linear change in cC-GFR for a representative control individual in which the loss of renal function did not exceed the fixed threshold for case definition of ~3.3%/year. The hatched line represents the annual linear change for a case with early renal

function decline. The mean slope for the control subject was ~1.4%/year while the mean slope for the case was ~12.0%/year. Beginning with a cC-GFR value of 152 ml/min, within 10 years this latter individual reached end-stage renal disease (*). Arrows indicate examinations from which urine samples were used
5 for peptide component analysis. cC-GFR, glomerular filtration rate estimated by 100/serum cystatin C (in mg/ml).

Figure 2 is a graph showing Immunoblots for IPP2K showed increased urinary expression in cases over control urine samples. Shown are pooled data of immunoblots analyzed by densitometry (Cases, n=8, Controls, n=8).

10 Figures 3A-3F are photomicrographs showing IPP2K renal expression is increased in the urine of microalbuminuric type-diabetics with early progressive renal function decline and in the renal parenchyma of type-1 diabetics with minimal nephropathy. Quantitative IPP2K IB analysis demonstrated increased urinary expression in MA T1D cases over MA T1D control urine samples (3A).
15 Immunohistochemical localization of IPP2K in a control kidney biopsy specimen (3B), T1D biopsy specimen (3C) and secondary antibody negative control (3D) demonstrates increased renal tubular cytoplasmic, nuclear, and perinuclear IPP2K staining within the diabetic phenotype. Further single antibody labeling experiments for IPP2K (3E) and TIAR (3F) were conducted in
20 T1D biopsy specimens. Black arrows identify regions of nuclear staining. Grey arrows identify regions of punctate cytoplasmic staining. Unless otherwise noted the presented image is at a 40X magnification.

Figures 4A and 4B are photomicrographs showing cytoplasmic ZO-3 expression and cell junction staining is increased in renal biopsies of diabetics
25 with minimal nephropathy. Control (4A) and diabetic (4B) renal biopsy sections stained for ZO-3 demonstrated enhanced staining for ZO-3 in the cytoplasm of diabetic biopsy sections and prominent, dense staining in the apical membrane of renal proximal tubular cells and in sites cell to cell interaction within renal tubules and were taken to be diagnostic of tubular adherens junctions.

30 Figure 5 is a graph showing analysis of low molecular weight (41kDa to 45kDa) fragment expression in the plasma of case and control phenotypic

extreme samples (n=6). Statistically significant differences at $p < 0.05$ between case and control samples. Insert- representative kininogen IB for case (n=3) and control (n=3) samples.

Figure 6 is a graph showing analysis of HMWK (58kDa) fragment
5 expression in the plasma of case and control phenotypic extreme samples (n=6). Significant differences at $p < 0.05$ between case and control samples. Insert- representative kininogen IB for case (n=3) and control (n=3) samples.

DETAILED DESCRIPTION

10 The details of one or more embodiments of the presently disclosed subject matter are set forth in the accompanying description below. Other features, objects, and advantages of the presently disclosed subject matter will be apparent from the detailed description, Appendix, and claims. All publications, patent applications, patents, and other references mentioned
15 herein are incorporated by reference in their entirety. Some of the polynucleotide and polypeptide sequences disclosed herein are cross-referenced to GENBANK[®] accession numbers. The sequences cross-referenced in the GENBANK[®] database are expressly incorporated by reference as are equivalent and related sequences present in GENBANK[®] or
20 other public databases. Also expressly incorporated herein by reference are all annotations present in the GENBANK[®] database associated with the sequences disclosed herein. In case of conflict, the present specification, including definitions, will control.

Unless defined otherwise, all technical and scientific terms used herein
25 have the same meaning as commonly understood to one of ordinary skill in the art to which the presently disclosed subject matter belongs. Although any methods, devices, and materials similar or equivalent to those described herein can be used in the practice or testing of the presently disclosed subject matter, representative methods, devices, and materials are now described.

30 Following long-standing patent law convention, the terms "a", "an", and "the" refer to "one or more" when used in this application, including the claims.

Thus, for example, reference to "a cell" or "a virus" includes a plurality of such cells or viruses, respectively, and so forth.

Unless otherwise indicated, all numbers expressing quantities of ingredients, reaction conditions, and so forth used in the specification and
5 claims are to be understood as being modified in all instances by the term "about". Accordingly, unless indicated to the contrary, the numerical parameters set forth in this specification and attached exemplary claims are approximations that can vary depending upon the desired properties sought to be obtained by the presently disclosed subject matter.

10 As used herein, the term "about," when referring to a value or to an amount of mass, weight, time, volume, concentration or percentage is meant to encompass variations of in some embodiments $\pm 20\%$, in some embodiments $\pm 10\%$, in some embodiments $\pm 5\%$, in some embodiments $\pm 1\%$, in some embodiments $\pm 0.5\%$, and in some embodiments $\pm 0.1\%$ from the specified
15 amount, as such variations are appropriate to perform the disclosed method.

Earlier identification and treatment of kidney disease can result in reducing or even preventing kidney disease progression and improving disease treatment prognosis. Presently, diagnosis of kidney disease usually occurs after significant damage has already resulted. Higher degrees of
20 previous kidney damage at diagnosis limit the efficacy of kidney function preservation therapies and result in higher disease progression rates. Thus, a biomarker of kidney damage that is able to indicate the presence of both early damage and identify patients at an increased risk of progressive disease would favorably impact kidney disease diagnosis and treatment. Desirably, the
25 biomarker would indicate renal damage prior to the current indicators of kidney dysfunction, be available non-invasively, and be easily interpretable.

Current markers of kidney disease and kidney disease progression include serum creatinine and urinary protein concentration, including microalbuminuria (MA). The slope of the decrease in glomerular filtration rate
30 (GFR) has been demonstrated to predict the timing of end-stage renal disease (ESRD), and the level of proteinuria has been shown to correlate with kidney

disease progression rates. These biomarkers of kidney disease provide some utility; however, their ability to recognize early kidney disease is limited. Recent studies have demonstrated that MA does not correlate well with the development of kidney disease in more than 30% of patients with Type I
5 diabetes (T1DM). Further, studies also demonstrate that 20-30% of patients with Type 2 diabetes (T2DM) progress to chronic kidney disease in the absence of MA. In addition, serum creatinine concentration is recognized as an unreliable measure of kidney function because it is dependent on age, gender, race, muscle mass, weight, and various medications. Correct
10 interpretation of kidney function based on serum creatinine requires complex formulas that are not routinely employed by practicing healthcare providers.

Thus, there is presently an unmet need for diagnostic and prognostic biomarkers of early and/or progressive kidney disease that become "positive" prior to or at the earliest point that kidney damage begins to occur. This
15 "subclinical" kidney damage recognition would occur prior to or in the absence of a rise in serum creatinine, the development of urinary creatinine, or MA. A benefit that identification of subclinical kidney damage would confer is the ability to initiate early interventions to promote kidney function preservation. The presently disclosed subject matter is based, in part, on the discovery that
20 proteomic profiling can be used to identify biomarkers in biological samples, such as for example urine, blood or plasma, that are associated with development of kidney disease, in some instances before any clinically identifiable alteration in renal function (e.g., glomerular filtration rate), serum creatinine concentration, or urine albumin excretion (e.g., MA) occurs.

25 In some embodiments of the presently disclosed subject matter, a method for diagnosing a kidney disease, or the risk for development thereof, in a subject is provided. In some embodiments, the method comprises obtaining a biological sample from the subject and determining an amount (including a qualitative determination of the presence or absence) of at least one peptide
30 biomarker associated with kidney disease, such as for example one or more peptides set forth in Table 1 or Table 2 (e.g., SEQ ID NOs: 1-59). The method

can further comprise comparing the amount of the at least one peptide in the sample with a control level. If the amount determined from the sample differs from (e.g., is greater than or less than) the control level, the subject can be diagnosed as having, or being at an increased risk of developing, the kidney disease.

TABLE 1
Urinary Peptide Biomarkers of Kidney Disease

SEQ ID NO.	Observed Mass* (m/z, z=+1)	Urinary Abundance Change with progressive RFD	Candidate Parent Protein**	Swiss Prot Accession No.
1	731.286	Decreased		
	736.238	Increased	B-cell lymphoma 9 protein P.GNPGNM(ox)M.F	O00512
		Peptide Sequence		
2	740.273	Decreased		
	764.288	Increased		
	766.437	Increased		
3	775.291	Decreased		
	805.408	Increased	B-cell lymphoma 9 protein S.STPLPPDG.T	O00512
		Peptide Sequence		
4	811.388	Increased		
	983.534	Increased	zona occludens 3 G.VSSQNLSLN.D	Q2VPE5
		Peptide Sequence		
5	1036.135	Increased		
	1067.423	Decreased		
	1126.515	Increased	Ubiquilin-2 I.GPIGPIGPTGPAA.P	Q9UHD9.2
6		Peptide Sequence		
	1165.525	Decreased	elF4 γ (eukaryotic translation initiation factor 4 gamma) I.IADRPGLPGPE.H	Q04637
		Peptide Sequence		
7	1190.638	Increased	FAT tumor suppressor 2 S.PEFQQHLYE.A	Q9NYQ8
		Peptide Sequence		
	1202.535	Increased	alpha-1 (IV) collagen L.PGPKGSPGVSGLK.G	P02462
8		Peptide Sequence		
	1202.553	Decreased	alpha-5 (IV) collagen P.GLPGP(OH)PGPMDP(OH)N.L	P29400
		Peptide Sequence		
9	1216.571	Decreased		
	1399.876	Decreased		
	1512.675	Increased	alpha-1 (III) collagen G.SP(OH)GSNGAP(OH)GQRGEP(OH)GP.Q	P02461
	Peptide Sequence			

	1650.846	Increased	Ubiquitin protein ligase URE-B1	Q7Z6Z7
10		Peptide Sequence	T.KLKKTPTEAPADCRA.L	
	1717.821	Increased		
	1819.831	Increased	alpha-1 (III) collagen	P02461
11		Peptide Sequence	Q.GLP(OH)GTGGP(OH)P(OH)GE NGKPGEPGP(OH).K	
	1838.831	Increased	Inositol-1,3,4,5,6- pentakisphosphate 2-kinase	Q9H8X2
12		Peptide Sequence	E.WGYHGEGNK(GlyGly)SLVVAH A.Q	
	1841.846	Decreased		
	2097.888	Decreased	alpha-1 (I) collagen	P02452
13		Peptide Sequence	N.GAP(OH)GNDGAKGDAGAP(OH))GAP(OH)GSQGAP(OH)G.L	
	2196.082	Decreased	alpha-1 (IV) collagen	P02462
14		Peptide Sequence	S.PGP(OH)WGAP(OH)GLP(OH)G EKGDHGFPGSS.G	
	2280.788	Decreased	alpha-1 (III) collagen	P02461
15		Peptide Sequence	G.KNGEYGP(OH)QGPPGPTGPG GDK(OH)GDT.G	
	2293.157	Decreased		
	2315.085	Decreased	alpha-1 (V) collagen	P20908
16		Peptide Sequence	G.PKGRGGPNGDPGPLGPP(OH) GEK GK(OH)LG.V	
	2339.108	Decreased	IT1 heavy chain H4	Q14624
17		Peptide Sequence	L.LSDPEQGVEVTGQYEREKAGF. S	
	2378.177	Decreased	alpha-1 (I) collagen	P02452
18		Peptide Sequence	P.GKNGDDGEAGKP(OH)GRP(OH))GER GPP(OH)GPQ.G	
	2413.091	Decreased	Fc alpha receptor isoform e	P24071
19		Peptide Sequence	Q.CQAI REAYLTQLMIK(OH)N(OH) STY.R	
	3266.384	Decreased	alpha-1 (III) collagen	P02461
20		Peptide Sequence	P.AGPPGP(OH)P(OH)GPPGTSG HP(OH)GSP(OH)GSP(OH)GYQGP (OH)P(OH)GEPGQAGP.S	

*Mass Accuracy ± 150 ppm

**First and last amino acids in the presented sequence are separated from the candidate peptide sequence by periods. The amino acid sequence contained within these bracketing amino acids is the proposed amino acid sequence for the peptide biomarker. () denotes a posttranslational modification of the preceding amino acid. (OH) denotes hydroxylation. (GlyGly) denotes a glycine-glycine modification to the lysine side chain epsilon amino group.

5

TABLE 2
Plasma Peptide Biomarkers of Kidney Disease

Protein	SEQ ID NO.	Observed Mass* (m/z, z=+1)	Parent Protein	Peptide Sequence**	GenInfo. Accession (gi) No.	Expression with RFD [§]	Peptide Selection Method #
1			Fibrinogen		11761629		
	21	1536.701		T.ADSGEGDFLAEGGGV.R		I	T, F (>)
	22	1558.679		T.ADSGEGDFLAEGGGV.R (DE Sodiation)		I	F (>)
	23	2861.295		K.MADEAGSEADHEGTHSTKRGHAKSR PV.R		D	T
	24	2877.326		K.M(ox)ADEAGSEADHEGTHSTKRGHAKSR PV.R		D	T
2			HMW Kininogen		225724		
	25	757.409		K.RPPGFSP.F		I	T, C%, F (>)
	26	904.476		K.RPPGFSPF.R		I	T, F (>)
	27	920.479		K.RPP(OH)GFSPF.R		I	T
	28	920.479		K.RPPGFSP(OH)F.R		I	T
	29	1060.584		K.RPPGFSPF.R		I (m)	T
	30	1092.551		K.RPP(OH)GFSP(OH)F.R		I	T, C%
	31	1055.498		H.DWGHEKOR.K		D	F (<)
	32	1943.887		H.NLGHGKHHERDQGHQ.R		I	F (>)

3			Inter-alpha trypsin inhibitor heavy chain related protein			40966840			
	33	976.522					MNFRPGVLSSR	I	F (>)
	34	1786.844					LGLPDPDPDHAAYHPF.R	I	T
	35	1675.795					P.GPPDVPDHAAYHPFR.R	I (m)	T
	36	842.420					D.HAAYHPF.R	D	F (<)
4			Complement Component C4A			179674			
	37	1052.496					Q.DEGAEPLKQ.R (Gamma-carboxyl; E); (Sodiation, DE)	D	T, F (<)
	38	1342.679					R.NGFKSHALQLNN.R	D	T, F (<)
5			EGF-like-domain, multiple 8			23272552			
	39	958.453					P.E(CO ₂)PPTSASILS	I	F (>)
6			Alpha-protein kinase-3			74716863			
	40	1052.496					L.ICHTGEOAG.R	D	T, F (<)
	41	1208.556					L.ICHTGEOAGRE	I (m)	T
7			Ubiquitin hydrolase			1666075			
	42	1068.448					D.DDMSGDEKQ.D (2 Sociated, DE)		T
8			Membrane-type matrix metalloproteinase			793763			
	43	1040.454					Y.IRE(CO ₂)GHEKQ.A	I	T
	44						Y.IREGHE(CO ₂)KQ.A		

9			DNA polymerase epsilon catalytic subunit isoform c			5532284		
	45	958.453		T.MAEASEDSP.R Sodiated (DE)	D			F (>)
	46	1308.637		L.RSPSSLLHDPAL.H Hydroxylation (P)	I			T
10			Parvin, beta			20127528		
	47	1635.891		S.PTPRRPRRMKKDES.F Hydroxylation (P); Sodiated (DE)	D			F (<)
11			Complement protease C1r			34810714		
	48	972.489		R.VSVHPDYR.Q	D			CA ^b
12			Hypothetical protein			30268186		
	49	1231.640		Y.TDSE(CO ₂ ⁻)SSASLP(OH)R.S (Sodiated, DE)	D			F (>)
13			EPF autoantibody reactive epitope			345836		
	50	1738.918		D.RRTQEGGRGDPPPAGR.S (2 Hydroxylation, P)	D			F (>)
14			C20orf42 protein			23273527		
	51	1040.454		V.DHPNEEQQ.K (2 Sodiated, DE)	I			T
	52	1040.454		V.DHPNEEQQ.K (Gamma-carboxyl, E)	I			T
15			Hypothetical protein			51492643		
	53	934.447		P.GLESGDIP(OH)S.P (2 Sodiated, DE)	I			T

16	54	790.401	Unnamed protein	L.PHDSGQQ.H (Sodiated, DE)	34531092	I	F (>)
17	55	919.476	MAST1	S.RE(CO ₂ ⁻)TSP(OH)NR.I	38017107	I	T
18	56	1431.694	NAG-5	R.HRSHPPGWASGAR.P (Hydroxylation, P)	6996651	D	F (<)
19	57	1017.56	V-raf murine sarcoma 3611 viral oncogene homolog	A.NGAE(CO ₂ ⁻)P(OH)SRAVG.T	4502193	I	T
20	58	1842.945	DEAD-box protein abstract	A.RTDEVLP(OH)EEAAP(OH)RRK.M (Gamma-carboxyl, E)	6118555	I	F (>)
21	59	1762.741	PRKG1	H.YENGEYIIRQGARGD.T (Sodiated, DE)	38571600	D	F (<)

*Mass Accuracy ±150ppm

**First and last amino acids in the presented sequence are separated from the candidate peptide sequence by periods. The amino acid sequence contained within these bracketing amino acids is the proposed amino acid sequence for the candidate peptide biomarker. () denotes a posttranslational modification of the preceding amino acid. () at the end of a sequence indicates a modification within one or more of the amino acids listed within the parenthesis. (OH) denotes hydroxylation. (GlyGly) denotes a glycine-glycine modification to the lysine side chain epsilon amino group. (CO₂⁻) denotes gamma carboxylation of glutamic acid side chain. # The estimated statistical significance of a peptides differential expression was determined using three quantitative measures including t-test (T) at p<0.05, fractional abundance (F) at fold expression increase or decrease by 1-fold, and correlation analysis (C) at greater than 0.6 correlation with a p-value less than 0.005. C[§] equals increase in peptide abundance with increased renal function decline. C[§] equals increase in peptide abundance with stable renal function.

10 \$ With respect to a severe progressive increase in renal function decline, a correlative increase in plasma peptide abundance is denoted by an "f" and a correlative decrease in plasma peptide abundance is denoted by a "D". A (m) indicates a significant but marginal increased expression.

"Kidney disease", as used herein refers to an acute or chronic injury to at least one kidney of a subject, and in particular renal tubular cell injury. Kidney injury can be confirmed by any of a number of measurable criteria known in the art, including but not limited to measurement of the level of MA and renal function decline (e.g., by measuring glomerular filtration rate (GFR)) in a subject.

As used herein the expression "renal tubular cell injury" refers to a renal or kidney failure or dysfunction, either sudden (acute) or slowly declining over time (chronic). Kidney disease resulting in renal tubular cell injury can be triggered by a number of disease or disorder processes, including (but not limited to): (1) for acute renal tubular cell injury--ischemic renal injury (IRI) including acute ischemic injury and chronic ischemic injury; acute renal failure; acute nephrotoxic renal injury (NRI) toxicity including sepsis (infection), shock, trauma, kidney stones, kidney infection, drug toxicity, poisons or toxins, or after injection with an iodinated contrast dye (adverse effect); and (2) for chronic renal tubular cell injury, diabetes (T1DM or T2DM), chronic infections, chronic inflammation, glomerulonephritides, vascular diseases, interstitial nephritis, drugs, toxins, trauma, renal stones, long standing hypertension, congestive heart failure, nephropathy from sickle cell anemia and other blood dyscrasias, nephropathy related to hepatitis, HIV, parvovirus and BK virus, cystic kidney diseases, congenital malformations, obstruction, malignancy, kidney disease of indeterminate causes, lupus nephritis, membranous glomerulonephritis, membranoproliferative glomerulonephritis, focal glomerular sclerosis, minimal change disease, cryoglobulinemia, ANCA-positive vasculitis, ANCA-negative vasculitis, amyloidosis, multiple myeloma, light chain deposition disease, complications of kidney transplant, chronic rejection of a kidney transplant, chronic allograft nephropathy, and the chronic effects of immunosuppressive drugs.

Kidney disease is a common problem in many patients suffering from diabetes. In particular, diabetic nephropathy (DN) is a kidney disease that develops as a result of diabetes mellitus (DM). DM affects approximately 5% of the

U.S. population, and Type 2 Diabetes Mellitus (T2DM) is the most common cause of end stage renal disease (ESRD) in the U.S. Diabetic nephropathy is believed responsible for at least 25% of all renal dialysis patients. Approximately 25% to 40% of patients with DM ultimately develop DN, which progresses through about
5 five predictable stages, culminating in end-stage renal disease (ESRD) wherein renal replacement therapy (e.g., hemodialysis, peritoneal dialysis, or kidney transplantation) is required.

Diabetes can often result in DN and is thought to be caused by the progressive glycosylation of biomarkers, leading to a progressive loss of renal
10 function. Diabetic nephropathy generally results in a chronic and progressive degradation of kidney function, to the point where the patient must undergo dialysis or receive a transplant to survive. Excretion of low, but abnormal, levels of albumin in the urine is considered a clinical marker of the incipient phase of nephropathy. As the glomeruli become increasingly filled with mesangial matrix
15 products, albuminuria increases and eventually gross proteinuria appears. Microalbuminuria (MA) is defined as excretion of 30 to 300 mg of albumin per day, or an albumin-creatinine ratio between 30 and 300 in a random urine specimen. Clinical proteinuria is defined as excretion of more than 0.5 g of total biomarker a day. However, as previously discussed, MA is not a good predictor of ESRD in
20 subjects with diabetes, because not all people who develop MA develop ESRD, and not all subjects who develop ESRD also have evidence of MA. As such, in some embodiments of the presently disclosed subject matter, the diagnostic methods disclosed herein can be used to diagnosis a diabetic subject with DN, or at risk to develop DN, even prior to presentation of clinical symptoms of DN.

25 The terms "polypeptide", "protein", and "peptide", which are used interchangeably herein, refer to a polymer of the 20 protein amino acids, including modified amino acids (e.g., phosphorylated, glycosylated, etc.) and amino acid analogs, regardless of its size or function. Although "protein" is often used in

reference to relatively large polypeptides, and "peptide" is often used in reference to small polypeptides, usage of these terms in the art overlaps and varies. The term "peptide" as used herein refers to peptides, polypeptides, proteins and fragments of proteins, unless otherwise noted. The terms "protein", "polypeptide" and "peptide" are used interchangeably herein when referring to a gene product and fragments thereof. Thus, exemplary polypeptides include gene products, naturally occurring proteins, homologs, orthologs, paralogs, fragments and other equivalents, variants, fragments, and analogs of the foregoing.

The terms "polypeptide fragment" or "fragment", when used in reference to a polypeptide, refers to a polypeptide in which amino acid residues are absent as compared to the full-length polypeptide itself, but where the remaining amino acid sequence is usually identical to the corresponding positions in the reference polypeptide. Such deletions can occur at the amino-terminus or carboxy-terminus of the reference polypeptide, or alternatively both. Fragments typically are at least 5, 6, 8 or 10 amino acids long, at least 14 amino acids long, at least 20, 30, 40 or 50 amino acids long, at least 75 amino acids long, or at least 100, 150, 200, 300, 500 or more amino acids long.

A fragment can retain one or more of the biological activities of the reference polypeptide. In some embodiments, a fragment can comprise a domain or feature, and optionally additional amino acids on one or both sides of the domain or feature, which additional amino acids can number from 5, 10, 15, 20, 30, 40, 50, or up to 100 or more residues. Further, fragments can include a sub-fragment of a specific region, which sub-fragment retains a function of the region from which it is derived. When the term "peptide" is used herein, it is intended to include the full-length peptide as well as fragments of the peptide and measurable characteristics of the peptide. Thus, an identified fragment of a peptide claimed (e.g., see Tables 1 and 2 and SEQ ID NOs: 1-59) is intended to encompass the fragment, including measurable characteristics of the fragment, such as mass

spectrometry observed mass, as well as the full-length peptide. In some embodiments, the kidney disease biomarker peptide can be referenced (as in Tables 1 and 2) only by a measurable characteristic (e.g., MS observed mass); however, it is intended that the full range of identifying characteristics, including peptide sequence, are intended to be encompassed by the presently-disclosed subject matter. As one example, when reference is made herein to antibodies specific for the peptides of Tables 1 or 2, it is intended that the antibodies can have specificity for the peptide fragment disclosed in the table and/or the full-length peptide.

10 The term "biological sample" as used herein refers to any body fluid or tissue potentially comprising one or more biomarkers associated with a kidney disease. In some embodiments, for example, the biological sample can be a saliva sample, a blood sample, a serum sample, a plasma sample, a urine sample, or sub-fractions thereof. In particular embodiments of the presently disclosed subject matter, the biological sample is a urine sample and the amounts of the one or more biomarkers determined for diagnosing a kidney disease are selected from Table 1. In other embodiments of the presently disclosed subject matter, the biological sample is a blood or plasma sample and the amounts of the one or more biomarkers determined for diagnosing a kidney disease are selected from Table 2.

20 The terms "diagnosing" and "diagnosis" as used herein refer to methods by which the skilled artisan can estimate and even determine whether or not a subject is suffering from a given disease or condition. The skilled artisan often makes a diagnosis on the basis of one or more diagnostic indicators, such as for example a biomarker, the amount (including presence or absence) of which is indicative of the presence, severity, or absence of the condition.

25 Along with diagnosis, clinical disease prognosis is also an area of great concern and interest. It is important to know the stage and rapidity of advancement of the kidney disease in order to plan the most effective therapy. If

a more accurate prognosis can be made, appropriate therapy, and in some instances less severe therapy for the patient can be chosen. Measurement of biomarker levels disclosed herein (e.g., Tables 1 and 2) can be useful in order to categorize subjects according to advancement of kidney disease who will benefit
5 from particular therapies and differentiate from other subjects where alternative or additional therapies can be more appropriate.

As such, "making a diagnosis" or "diagnosing", as used herein, is further inclusive of determining a prognosis, which can provide for predicting a clinical outcome (with or without medical treatment), selecting an appropriate treatment
10 (or whether treatment would be effective), or monitoring a current treatment and potentially changing the treatment, based on the measure of diagnostic biomarker levels disclosed herein.

The phrase "determining a prognosis" as used herein refers to methods by which the skilled artisan can predict the course or outcome of a condition in a
15 subject. The term "prognosis" does not refer to the ability to predict the course or outcome of a condition with 100% accuracy, or even that a given course or outcome is predictably more or less likely to occur based on the presence, absence or levels of test biomarkers. Instead, the skilled artisan will understand that the term "prognosis" refers to an increased probability that a certain course or
20 outcome will occur; that is, that a course or outcome is more likely to occur in a subject exhibiting a given condition, when compared to those individuals not exhibiting the condition. For example, in individuals not exhibiting the condition (e.g., not expressing the biomarker or expressing it at a reduced level), the chance of a given outcome may be about 3%. In certain embodiments, a prognosis is
25 about a 5% chance of a given outcome, about a 7% chance, about a 10% chance, about a 12% chance, about a 15% chance, about a 20% chance, about a 25% chance, about a 30% chance, about a 40% chance, about a 50% chance, about a 60% chance, about a 75% chance, about a 90% chance, or about a 95% chance.

The skilled artisan will understand that associating a prognostic indicator with a predisposition to an adverse outcome is a statistical analysis. For example, a biomarker level (e.g., quantity of expression in a sample) of greater than a control level in some embodiments can signal that a subject is more likely to suffer from a kidney disease than subjects with a level less than or equal to the control level, as determined by a level of statistical significance. Additionally, a change in marker concentration from baseline levels can be reflective of subject prognosis, and the degree of change in marker level can be related to the severity of adverse events. Statistical significance is often determined by comparing two or more populations, and determining a confidence interval and/or a p value. See, e.g., Dowdy and Wearden, *Statistics for Research*, John Wiley & Sons, New York, 1983, incorporated herein by reference in its entirety. Preferred confidence intervals of the present subject matter are 90%, 95%, 97.5%, 98%, 99%, 99.5%, 99.9% and 99.99%, while preferred p values are 0.1, 0.05, 0.025, 0.02, 0.01, 0.005, 0.001, and 0.0001.

In other embodiments, a threshold degree of change in the level of a prognostic or diagnostic biomarker can be established, and the degree of change in the level of the indicator in a biological sample can simply be compared to the threshold degree of change in the level. A preferred threshold change in the level for markers of the presently disclosed subject matter is about 5%, about 10%, about 15%, about 20%, about 25%, about 30%, about 50%, about 75%, about 100%, and about 150%. In yet other embodiments, a "nomogram" can be established, by which a level of a prognostic or diagnostic indicator can be directly related to an associated disposition towards a given outcome. The skilled artisan is acquainted with the use of such nomograms to relate two numeric values with the understanding that the uncertainty in this measurement is the same as the uncertainty in the marker concentration because individual sample measurements are referenced, not population averages.

In some embodiments of the presently disclosed subject matter, multiple determination of one or more diagnostic or prognostic peptide biomarkers can be made, and a temporal change in the biomarker can be used to monitor the progression of disease and/or efficacy of appropriate therapies directed against the disease. In such an embodiment for example, one might expect to see a decrease or an increase in the biomarker(s) over time during the course of effective therapy. Thus, the presently disclosed subject matter provides in some embodiments a method for determining treatment efficacy and/or progression of a kidney disease in a subject. In some embodiments, the method comprises determining an amount of at least one peptide biomarker associated with kidney disease, such as for example at least one peptide of Table 1, Table 2, or both, in biological samples collected from the subject at a plurality of different time points and comparing the amounts of the at least one peptide in the samples collected at different time points. For example, a first time point can be selected prior to initiation of a treatment and a second time point can be selected at some time after initiation of the treatment. One or more biomarker levels can be measured in each of the samples taken from different time points and qualitative and/or quantitative differences noted. A change in the amounts of the biomarker levels from the first and second samples can be correlated with determining treatment efficacy and/or progression of the disease in the subject.

The terms "correlated" and "correlating," as used herein in reference to the use of diagnostic and prognostic biomarkers, refers to comparing the presence or quantity of the biomarker in a subject to its presence or quantity in subjects known to suffer from, or known to be at risk of, a given condition (e.g., a kidney disease); or in subjects known to be free of a given condition, i.e. "normal individuals". For example, a biomarker level in a biological sample can be compared to a level known to be associated with a specific type of kidney disease. The sample's biomarker level is said to have been correlated with a diagnosis; that is, the skilled

artisan can use the biomarker level to determine whether the subject suffers from a specific type of kidney disease, and respond accordingly. Alternatively, the sample's biomarker level can be compared to a control marker level known to be associated with a good outcome (e.g., the absence of kidney disease), such as an average level found in a population of normal subjects.

In certain embodiments, a diagnostic or prognostic biomarker is correlated to a condition or disease by merely its presence or absence. In other embodiments, a threshold level of a diagnostic or prognostic biomarker can be established, and the level of the indicator in a subject sample can simply be compared to the threshold level.

As noted, in some embodiments, multiple determination of one or more diagnostic or prognostic biomarkers can be made, and a temporal change in the marker can be used to determine a diagnosis or prognosis. For example, a diagnostic marker can be determined at an initial time, and again at a second time. In such embodiments, an increase in the marker from the initial time to the second time can be diagnostic of a particular type of kidney disease, or a given prognosis.

Likewise, a decrease in the marker from the initial time to the second time can be indicative of a particular type of kidney disease, or a given prognosis. Furthermore, the degree of change of one or more markers can be related to the severity of kidney disease and potential for future adverse events.

The skilled artisan will understand that, while in certain embodiments comparative measurements can be made of the same diagnostic marker at multiple time points, one can also measure a given marker at one time point, and a second marker at a second time point, and a comparison of these markers can provide diagnostic information.

Numerous methods and devices are well known to the skilled artisan for the detection and analysis of the biomarker peptides of the presently disclosed subject matter. With regard to polypeptides or proteins in subject test samples, mass

spectrometry and/or immunoassay devices and methods can be used, although other methods are well known to those skilled in the art (for example, the measurement of marker RNA levels). See, e.g., U.S. Pat. Nos. 6,143,576; 6,113,855; 6,019,944; 5,985,579; 5,947,124; 5,939,272; 5,922,615; 5,885,527; 5,851,776; 5,824,799; 5,679,526; 5,525,524; and 5,480,792, each of which is hereby incorporated by reference in its entirety. These devices and methods can utilize labeled molecules in various sandwich, competitive, or non-competitive assay formats, to generate a signal that is related to the presence or amount of an analyte of interest. Additionally, certain methods and devices, such as biosensors and optical immunoassays, can be employed to determine the presence or amount of analytes without the need for a labeled molecule. See, e.g., U.S. Pat. Nos. 5,631,171; and 5,955,377, each of which is hereby incorporated by reference in its entirety.

In certain embodiments of the presently disclosed subject matter, the biomarker peptides are analyzed using an immunoassay. The presence or amount of a peptide marker can be determined using antibodies or fragments thereof specific for each peptide marker and detecting specific binding. For example, in some embodiments, the antibody specifically binds a peptide of Table 1 or Table 2, which is inclusive of, but not limited to, antibodies that bind the full-length peptide as well. In some embodiments, the antibody is a monoclonal antibody.

Any suitable immunoassay can be utilized, for example, enzyme-linked immunoassays (ELISA), radioimmunoassays (RIAs), competitive binding assays, and the like. Specific immunological binding of the antibody to the marker can be detected directly or indirectly. Direct labels include fluorescent or luminescent tags, metals, dyes, radionuclides, and the like, attached to the antibody. Indirect labels include various enzymes well known in the art, such as alkaline phosphatase, horseradish peroxidase and the like.

The use of immobilized antibodies or fragments thereof specific for the markers is also contemplated by the present subject matter. The antibodies can be immobilized onto a variety of solid substrates, such as magnetic or chromatographic matrix particles, the surface of an assay plate (such as microtiter wells), pieces of a solid substrate material (such as plastic, nylon, paper), and the like. An assay strip can be prepared by coating the antibody or a plurality of antibodies in an array on solid support. This strip can then be dipped into the test biological sample and then processed quickly through washes and detection steps to generate a measurable signal, such as for example a colored spot.

10 In some embodiments, a kit for the analysis of biomarkers is provided that comprises antibodies having specificity for one or more biomarkers associated with kidney disease. The antibodies can be bound to a substrate, as disclosed herein. Such a kit can comprise devices and reagents for the analysis of at least one test sample. The kit can further comprise instructions for using the kit and
15 conducting the analysis. Optionally the kits can contain one or more reagents or devices for converting a marker level to a diagnosis or prognosis of the subject.

In some embodiments, mass spectrometry (MS) analysis can be used alone or in combination with other methods (e.g., immunoassays) to determine the presence and/or quantity of the one or more biomarkers of interest in a biological
20 sample. In some embodiments, the MS analysis comprises matrix-assisted laser desorption/ionization (MALDI) time-of-flight (TOF) MS analysis, such as for example direct-spot MALDI-TOF or liquid chromatography MALDI-TOF mass spectrometry analysis. In some embodiments, the MS analysis comprises electrospray ionization (ESI) MS, such as for example liquid chromatography (LC)
25 ESI-MS. Mass analysis can be accomplished using commercially-available spectrometers, such as for example triple quadrupole mass spectrometers. Methods for utilizing MS analysis, including MALDI-TOF MS and ESI-MS, to detect the presence and quantity of biomarker peptides in biological samples are

known in the art. See for example U.S. Patents 6,925,389; 6,989,100; and 6,890,763 for further guidance, each of which is incorporated by reference herein in its entirety. In some embodiments, the MS analysis can be utilized to identify specific polypeptide sequences and corresponding proteins and amounts compared to controls to diagnose a kidney disease. However, MS analysis can also be utilized with the methods of the presently-disclosed subject matter to determine a measurable characteristic of the peptide biomarkers, and in particular a MS observed mass. As such, "determining an amount" of one or more peptides of Tables 1 and 2 by MS analysis is inclusive of determining amounts of full-length polypeptides inferred from peptide fragment analysis by MS, specifically-identified peptide (e.g., polypeptide sequences set forth in SEQ ID NOs: 1-59) fragment amounts, as well as MS observed mass peak analysis.

The analysis of a plurality of markers can be carried out separately or simultaneously with one test sample. Several markers can be combined into one test for efficient processing of a multiple of samples. In addition, one skilled in the art would recognize the value of testing multiple samples (for example, at successive time points) from the same subject. Such testing of serial samples will allow the identification of changes in biomarker levels over time. Increases or decreases in marker levels, as well as the absence of change in marker levels, can provide useful information about the disease status that includes, but is not limited to identifying the approximate time from onset of the disease, the presence and amount of functioning tissue, the appropriateness of drug therapies, the effectiveness of various therapies, differentiation of the various types and stages of kidney diseases, identification of the severity of the disease, and identification of the subject's outcome (prognosis), including risk of future events.

A panel consisting of biomarkers associated with a kidney disease (e.g., the biomarker peptides of Tables 1 and/or 2) can be constructed to provide relevant information related to the diagnosis or prognosis of the kidney disease and

management of subjects with the kidney disease. Such a panel can be constructed, for example, using 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 15 or 20 individual biomarkers. The analysis of a single marker or subsets of markers comprising a larger panel of markers can be carried out by one skilled in the art to optimize clinical sensitivity or specificity in various clinical settings. These include, but are not limited to ambulatory, urgent care, critical care, intensive care, monitoring unit, in-patient, out-patient, physician office, medical clinic, and health screening settings. Furthermore, one skilled in the art can use a single marker or a subset of markers comprising a larger panel of markers in combination with an adjustment of the diagnostic threshold in each of the aforementioned settings to optimize clinical sensitivity and specificity. The clinical sensitivity of an assay is defined as the percentage of those with the disease that the assay correctly predicts, and the specificity of an assay is defined as the percentage of those without the disease that the assay correctly predicts (Tietz Textbook of Clinical Chemistry, 2.sup.nd edition, Carl Burtis and Edward Ashwood eds., W.B. Saunders and Company, p. 496).

The analysis of markers can be carried out in a variety of physical formats as well. For example, the use of microtiter plates or automation could be used to facilitate the processing of large numbers of test samples. Alternatively, single sample formats can be developed to facilitate immediate treatment and diagnosis in a timely fashion, for example, in ambulatory transport or emergency room settings.

Further with respect to the methods of the presently disclosed subject matter, a preferred subject is a vertebrate subject. A preferred vertebrate is warm-blooded; a preferred warm-blooded vertebrate is a mammal. A preferred mammal is most preferably a human. As used herein, the term "subject" includes both human and animal subjects. Thus, veterinary therapeutic uses are provided in accordance with the presently disclosed subject matter.

As such, the presently disclosed subject matter provides for the treatment and testing of mammals such as humans, as well as those mammals of importance due to being endangered, such as Siberian tigers; of economic importance, such as animals raised on farms for consumption by humans; and/or animals of social
5 importance to humans, such as animals kept as pets or in zoos. Examples of such animals include but are not limited to: carnivores such as cats and dogs; swine, including pigs, hogs, and wild boars; ruminants and/or ungulates such as cattle, oxen, sheep, giraffes, deer, goats, bison, and camels; and horses. Also provided is the treatment of birds, including the treatment of those kinds of birds that are
10 endangered and/or kept in zoos, as well as fowl, and more particularly domesticated fowl, *i.e.*, poultry, such as turkeys, chickens, ducks, geese, guinea fowl, and the like, as they are also of economic importance to humans. Thus, also provided is the testing and treatment of livestock, including, but not limited to, domesticated swine, ruminants, ungulates, horses (including race horses), poultry,
15 and the like.

In some embodiments, the subject tested is afflicted with or was previously afflicted with a disease other than kidney disease. In particular, the other disease can be a disease linked to or predisposing one to kidney disease. For example, in some embodiments, the subject is a diabetic subject, as diabetes can be a risk
20 factor for developing kidney disease. In some embodiments, the subject is a diabetic subject suffering from, or at risk of suffering from, diabetic nephropathy.

The practice of the presently disclosed subject matter can employ, unless otherwise indicated, conventional techniques of cell biology, cell culture, molecular biology, transgenic biology, microbiology, recombinant DNA, and
25 immunology, which are within the skill of the art. Such techniques are explained fully in the literature. See *e.g.*, *Molecular Cloning A Laboratory Manual* (1989), 2nd Ed., ed. by Sambrook, Fritsch and Maniatis, eds., Cold Spring Harbor Laboratory Press, Chapters 16 and 17; U.S. Pat. No. 4,683,195; *DNA Cloning*,

Volumes I and II, Glover, ed., 1985; Oligonucleotide Synthesis, M. J. Gait, ed., 1984; Nucleic Acid Hybridization, D. Hames & S. J. Higgins, eds., 1984; Transcription and Translation, B. D. Hames & S. J. Higgins, eds., 1984; Culture Of Animal Cells, R. I. Freshney, Alan R. Liss, Inc., 1987; Immobilized Cells And Enzymes, IRL Press, 1986; Perbal (1984), A Practical Guide To Molecular Cloning; See Methods In Enzymology (Academic Press, Inc., N.Y.); Gene Transfer Vectors For Mammalian Cells, J. H. Miller and M. P. Calos, eds., Cold Spring Harbor Laboratory, 1987; Methods In Enzymology, Vols. 154 and 155, Wu et al., eds., Academic Press Inc., N.Y.; Immunochemical Methods In Cell And Molecular Biology (Mayer and Walker, eds., Academic Press, London, 1987; Handbook Of Experimental Immunology, Volumes I-IV, D. M. Weir and C. C. Blackwell, eds., 1986.

15

EXAMPLES

The following Examples have been included to illustrate modes of the presently disclosed subject matter. In light of the present disclosure and the general level of skill in the art, those of skill will appreciate that the following Examples are intended to be exemplary only and that numerous changes, modifications, and alterations can be employed without departing from the scope of the presently disclosed subject matter.

20

EXAMPLE 1

We have identified several peptides from a number of unique gene products (see Table 1) that are present in the urine and are discriminatory markers of renal function decline (RFD) in Type 1 diabetes (TI DM) patients with microalbuminuria (MA). Three novel approaches were employed to identify the biomarkers: patient sample selection; peptide extraction; and analysis.

25

Sample Selection - The urine samples we studied to identify biomarkers of diabetic RFD were obtained from T1DM patients. The samples we studied were collected from a time (n=62) point preceding any loss of GFR. Samples used were developed from the 1st Joslin Cohort of the NIH funded project titled "Natural History Study of Microalbuminuria in Type 1 Diabetes (R01 DK41526). A cohort of 1394 T1DM individuals was followed for >8-10 years. Patient samples used to generate our preliminary data presented with confirmed MA (albumin excretion rate (AER) of 30-300 µg/min) during the two years preceding urine collection. Patients with non-diabetic kidney disease were excluded. The urine samples were matched between groups for age (54.5yr ± 5yr), gender and glycemic control (Hb Alc levels). Case samples (n=19) encompassed individuals with significant early progressive renal function decline. These individuals experienced an annual loss of more than 3.4mL/yr in their estimated glomerular filtration rate (eGFR) as measured by serum cystatin C. Control samples (n=42) encompassed individuals with renal function decline that was approximately equal to the loss experienced as a result of the normal aging process. These individuals experienced an annual loss of less than 3.4mL/yr in their estimated glomerular filtration rate (eGFR) as measured by serum cystatin C. The samples analyzed to generate the presently disclosed biomarkers were developed from banked patient urine samples collected before any of the patients experienced RFD. Thus, observed differences in the urine peptidome can reflect or correlate with the future development of RFD.

Peptide Extraction - The method used to extract urine peptides for biomarker studies is one developed and optimized by our group over the last three years. Briefly, peptides were isolated from urine in a two-step process. The urine peptides were first size selected from the proteins by ultrafiltration that produced a low molecular weight peptide panel having a mass less than 10,000 Daltons. We have determined from several hundred analyses that as little as 1mL urine provides >500µg urinary peptide (as µBCA peptide assay positive material). A

single capillary HPLC analysis requires 1-5 µg peptide and hence enough peptide material for the proposed project from a single mL of urine. The peptides were then concentrated, desalted, and mass quantified.

Data Acquisition and Analysis - Equivalent masses of peptides were
5 separated by 1D-RP-capillary HPLC and analyzed using high-sensitivity, high-throughput MALDI-TOF MS. A challenge in using MS analysis of clinical samples is the remarkable dimensionality of the spectra data sets. Our data analysis approach is to apply both supervised and unsupervised informatic methods. In our approach, statistical analysis of urinary peptide profiles using LC-MALDI peak
10 lists began with unsupervised sorting of the MS data using Principle Components Analysis (PCA) or Hierarchical Clustering (HC) followed by group annotation. This approach is more robust and has less intrinsic bias. In some cases, supervised sorting of the sample MS data was required. In those cases the investigator assigned the MS spectral data into groups. Principle data sets were developed
15 from MALDI-TOF spectral files. Here, the data were extracted from MALDI-TOF spectral files (.t2d files) using instrument manufacturer software (PEAK EXPLORER) and these peak lists were imported into analytical/statistical software for analysis. One software package (MARKERVIEW™) imports the peak list data as .txt files. Peak list data contains information for peptide retention time, m/z, and
20 signal response. These data were then imported with use of filters to remove masses associated with internal standards and matrix contaminants, adjustment of retention times and for mass accuracy. In either case of group membership assigned by unsupervised or supervised methods, MS spectral data were compared by univariate (student's t-test or Mann-Whitney t-test constrained by
25 false discovery rate analysis, FDR) or multivariate methods (PCA; RandomForest, RE, or receiver operator characteristic (ROC) curves). With these approaches we were able to simultaneously analyze thousands of features. To correct for simultaneous multiple hypothesis testing we estimated the q-value for every

feature in order to estimate the FDR. We assumed a false discovery rate of 0.10 was acceptable and hence any feature with a q-value less than 0.10 was considered significant. Peptide masses having sufficient specificity to sort MALDI-TOF MS spectra into groups were tabulated and selected for MALDI-TOF MS/MS

5 analysis

Prior to PCA analysis by MARKERVIEW™, data were imported, preprocessed using logarithmic data weighting and automatic data scaling filters. Patient urinary peptide samples were assigned to Groups and the imported/preprocessed data compared by two univariate statistical methods (unpaired, two-tailed students t-test and Mann-Whitney test) to discern peptides that were presented at levels significantly different between Groups. Only patient samples representing the extremes of eventual RFD or stability were initially selected for analysis (n=15). Unsupervised PCA demonstrates that dominate differences in the patients urinary peptide profiles sort the samples into two clear

10 groups.

15

In addition to PCA analysis, an expanded sample set (n=49) of individuals with low to moderate RFD (≤ 3.5 mL/yr) and moderate to high RFD (≥ 3.5 mL/yr) were used for unsupervised sorting analysis. Here the LC-MALDI TOF MS peak list data were classified with their urinary polypeptide profiles using HC classification algorithms with subsequent selection of classifying peptides by RF and ROC analyses. We calculated the most important features determined by the RF algorithm in terms of Gini index and mean square error. In order to minimize the effect of stochastic nature of the RF procedure we ran the algorithm a large number of times (>100) and determined the most important common features amongst all the runs. RF was utilized for selection of variables with two measures of variable importance utilized: 1) average decrease in classification accuracy and 2) Gini importance (average decrease of Gini index). RF parameters were estimated by minimizing generalization error estimate and maximizing stability of

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variable ranking, computed as the cardinality of intersection of the 20 top ranked features over 100 RF runs. After each run variables with corresponding importance measures smaller or equal to 0 were discarded. Following supervised and unsupervised comparison, we have identified upwards of 40 peptides that were associated with RFD in diabetics.

Additional Data Acquisition and Analysis:

Analysis of MALDI-TOF MS Data Sets - The statistical analysis of the data was broken down into three types of analysis: class discovery, class prediction, and class differentiation methods. With all methods the MS data sets were developed using aligned LC-MALDI-TOF MS peptide peak lists with the peptide data arrayed as mass (m/z ; +1) and retention time pairs. Peptide abundance was assigned based on the peptide MALDI-TOF MS ion cluster area.

Class discovery methods- The class discovery methods used primarily involved several types of cluster analysis. Initially Principal Components Analysis (PCA) and hierarchical cluster analysis using a variety of weight (correlation, Euclidian) and link functions (average, single, complete) was conducted. In addition the non-hierarchical cluster K-means clusters was used on the data. We used s/n 3 and s/n 10 data, with and without natural log. PCA is a graphical method to illustrate similarities of different samples within groups based on sample characteristics such as peptide abundance in the present study. A PCA plot illustrates the relationship of sample or sample data based on the two dominate sets of sample variance. Therefore a PCA plot is a qualitative tool to define sample groups in an unbiased fashion. Classical parametric and non-parametric tests can then be used to identify the specific differences between the groups.

Class differentiation methods- To determine differences in peak intensity between the cases and controls we used a t-test and adjusted the p-values using a Benjamini and Hochberg False Discover Rate procedure. We addressed the problem by holding RFD as a "continuum" of pathophysiology and analyzed the

entire MS data set. The slope of the decline in renal function and well as covariate data was regressed on the peak intensities (s/n3, s/n10, with and without natural log scaling) and significance was assessed using simple linear regression and correlations with Pearson's correlation. This has the effect of assigning no
5 specific rate of RFD to distinguish decliners from non-decliners. The data were then analyzed for correlation of peptide abundance with RFD (slope glm) using Spearman correlations calculations for the intensity of peptide mass-retention time pairs and slope glm. Peptide mass-rt pairs with Spearman correlation values >0.3 and <-0.3 then filtered by parametric t-tests. The Spearman correlation
10 coefficients values were filtered using minimum correlation cutoff values of less than or equal to -0.3 or greater than or equal to +0.3 and then by a second t-test filter. All peptides having a minimum Spearman correlation coefficient value and parametric t-tests with a p-value less than 0.01 were considered as significant. The FDR that was returned for these computations ranged from 0.35 to 0.89.
15 Peptides having parametric t-tests $p < 0.01$ were accepted as significant (Table 1). The MALDI-TOF MS spectra for these masses were then visually reviewed for further MS/MS analyses. In separate analyses, we computed the fractional peptide-presence/absence to remove the quantification error resulting from variability in observed MALDI-TOF MS signal intensity. The data were analyzed
20 by a clinical definition of RFD and by designation of phenotypic extremes (tertile extremes). First, the samples were designated as RFD (+) and RFD (-) based on the rate of RFD in a normal population (-3.3 slope glm). Observed peptide masses were assigned an intensity of "1" and unobserved masses assigned an intensity of "0". The fractional presence of each peptide was computed for case
25 (decliner) and control (non-decliner) samples. The fractional abundance (f) of each case and control peptide was used to compute a fractional abundance ratio ($f_{case}/f_{control}$). Fractional abundance ratio's greater than 2 or less than 0.5 in the tertile population were considered significantly differentially expressed within the

RFD populations. Next the ratio of fractional presentation of case (decliner)/control (non-decliner) was computed to determine the relative expressional abundance of a peptide within the sample population.

Class prediction (discriminate) analysis- Using the unselected s/n 3 and s/n
5 10 data separately, we conducted discriminate analysis using a grid of significance levels (0.01, 0.05, 0.2) on the decliner verses non-decliner patients. We evaluated a number of multivariate classification methods, including the Compound Covariate Predictor, Diagonal Linear Discriminant Analysis, Nearest Neighbor Predictor, Nearest Centroid Predictor, and Support Vector Machine
10 Predictor. We used leave-one-out cross validation to generate the final models as well as to determine the accuracy of the models. Sensitivity, specificity, Positive and Negative predictive values for each of the models was obtained.

EXAMPLES 2-9

15 We hypothesized that qualitative differences in urine proteins might provide insight into the etiology of progressive ERFD and serve as putative biomarkers of risk of progressive ERFD. To address this hypothesis, in these examples we have performed proteomic and peptidomic analyses of urine samples obtained during the Joslin Study of the Natural History of Microalbuminuria in Type 1 Diabetes. In
20 the present examples, the low molecular weight protein (<10 kDa), or peptidomic, fraction in urine was analyzed. We compared urine peptide expression in patients with MA who retained stable renal function to those with MA and EFRD. Our data demonstrate that the urinary expression of several protein fragments differs significantly between microalbuminuric diabetic patients who develop ERFD
25 compared to microalbuminuric diabetic patients who do not develop ERFD. Two such peptides, fragments of inositol pentakisphosphate 2-kinase (IPP2K) and zona occludens-3 (ZO-3) were further studied in human renal biopsies to determine if urine peptide fragments correlate with renal protein expression. In

biopsies from T1D patients with early signs of diabetic nephropathy, ZO-3 expression in renal tubular epithelial cells was increased compared to controls and ZO-3 translocated to the cytoplasm. IPP2K expression was increased and co-localized in renal tubules with granule-like cytoplasmic structures. T-cell
5 intracellular antigen-1 related protein (TIAR), a protein associated with stress granules, was also increased in diabetic kidney biopsies. These results confirm that urine peptide analysis can define pathogenic mechanisms of kidney disease including diabetic nephropathy and that the urine peptidome contains biomarkers that correlate with the future development of diabetic renal disease.

10

METHODS FOR EXAMPLE 2-9

Patient Selection and Case Definition for Early Renal Function Decline (ERFD). The protocol and consent procedures were approved by the Committee on Human Studies of the Joslin Diabetes Center and the University of Louisville.
15 Among the 943 patients with normoalbuminuria enrolled in the 1st Joslin Study of the Natural History of Microalbuminuria in Type 1 Diabetes, MA developed in 109 during the first four years of follow-up², it is this cohort of 109 patients with a documented onset of MA that is the population potentially eligible for this study.

Diagnoses of normoalbuminuria and microalbuminuria were based on
20 multiple measurements of the albumin excretion rate (in micrograms per minute), which was estimated from the albumin-to-creatinine ratio in random urine samples as previously described.(1, 2) Eighty six patients were followed until 2007, and 61 met the following additional criteria for inclusion in the analysis: 1) follow-up examinations spanning at least 8 years after the onset of MA for the estimation of
25 the slope of GFR over time; 2) at least one 6 ml aliquot of stored urine from an examination within five years of the onset of MA for analysis of peptide components. Among available urine samples, the earliest after MA onset was selected.

The 61 patients were divided into cases of ERFD and controls according to the regression slope fitted to their follow-up estimates of GFR based on serum cystatin C (cC-GFR). The protocol used for assessment of early progressive renal function decline has been described in detail previously. (8, 17) In brief, glomerular
5 filtration rate in ml/min was approximated numerically by the reciprocal of cystatin C (in mg/L) multiplied by 100. A regression slope fitted to serial measurements of cC-GFR over eight years accurately tracks the trend in renal function over that time. Patients had, on average, 4.8 cC-GFR estimates. As previously published, we used the longitudinal data available from the Baltimore Aging Study as the
10 reference distribution for evaluating whether a negative slope or trend in renal function qualified as an abnormal rate of decline (designated '*early renal function decline*' or 'ERFD').(7)

Sample Handling and Peptide Isolation. The order of case or control sample handling during peptide isolation was randomized to minimize technical or
15 methodological bias during data collection. Urinary peptides were isolated from the urine less than 10kDa ultrafiltrate by solid phase extraction (SPE) methods, filtered through regenerated cellulose syringe filter (0.2 μm National Scientific Co.), and transferred to autosampler vials in a final concentration of 0.1 $\mu\text{g}/\mu\text{L}$.

Peptides (5 μg) were separated using a reversed-phase capillary scale
20 column (Dionex 75 μm i.D. Nano Series Column, C18 PepMap 100, 3 μm , 100 \AA) with 45 min Solvent A (0.05% trifluoroacetic acid (TFA) to Solvent B (80% acetonitrile (ACN) / 0.05% TFA) gradient and 45 1-min fractions were collected with a robotic fraction collector (Accuspot, Shimadzu Corp., Kyoto, Japan). MALDI matrix (5 mg/mL α -CN (α -Cyano-4-hydroxycinnamic acid) and a 5.33 fmol/ μL
25 angiotensin I (AT I) standard dissolved in 50% ACN / 0.1% TFA) was overlaid onto dried LC fractions collected on archivable MALDI sample plates (ABI Opti-TOF plates) post run using the Accuspot to include an internal mass calibration standard at 4 fmol AT-I per spot.

Positive ion MALDI -TOF mass spectra were acquired using an Applied Biosystems (Foster City, CA) AB4700 Proteomics Analyzer operating in reflectron mode and with ion source pressure ~ 0.5 μ Torr. After a 400ns time-delayed ion extraction period, the ions were accelerated to 20kV for TOF mass spectrometric analysis. A total of 1000 laser shots (355nm Nd:YAG solid state laser operating at 200Hz) were acquired and signal averaged. MALDI-TOF spectra were exported as .t2d files as well as peak list files for chromatographic data alignment and for analysis by MarkerView (MDS Sciex).

Analysis of MALDI-TOF MS Data Sets. Aligned MS data sets were constructed (peptide mass (m/z; +1) and retention time pairs) with peptide abundance based on the MS ion cluster area. The prevalence of peptide abundance was determined. Cases of early renal function decline were defined by loss in GFR that exceeded $-3.3\%/yr$, a threshold that corresponds to the 2.5th percentile of the distribution of GFR slopes in an independent non-diabetic normotensive population. Observed peptide masses were assigned an intensity of "1" and unobserved masses assigned an intensity of "0". The fractional abundance (f) of each case and control peptide was used to compute a fractional abundance ratio ($f_{case}/f_{control}$). Fractional abundance ratios greater than 1.5 or less than 0.5 in case-to-control ratios were considered significantly differentially expressed within the two populations. The fractional abundance ratios for these peptides were reconsidered using only the patient samples found in the first and third tertile. Peptides having a ratio that became more extreme (greater than 1.5 or less than 0.5) were tabulated for further MS/MS analyses. To determine the correlation of peptide expression with ERF, the slope of the decline in renal function (slope glm) was regressed on the s/n 3 peak intensities with natural log scaling and significance was assessed using simple linear regression and correlations with Spearman rank order correlation analysis for the tertile extremes. The Spearman correlation coefficients values were filtered using minimum

correlation cutoff values of less than or equal to -0.4 or greater than or equal to +0.4. The goodness of the correlation fit was determined by a t-test filter. All peptides having a minimum Spearman correlation coefficient value and parametric t-tests with a p-value less than 0.01 were considered as significant. Peptides
5 having parametric t-tests $p < 0.01$ were accepted as significant (Table 1) were tabulated for further MS/MS analyses.

Peptide Sequence Tagging of Selected Peptide Ions using MALDI-TOF/TOF MS. Fragmentation data, post-source-decay (PSD) and collision-induced-dissociation (CID) data, were collected for each tabulated peptide using
10 the AB4700 MALDI TOF/TOF using 1KeV collision energy, atmospheric gases (medium pressure) and collection averaged data from 1500 laser shots.

Concatenated lists of averaged fragmentation spectra (PSD and CID) were submitted for computer assisted data analysis. Analyses were conducted in an iterative fashion with the concatenated lists starting with search parameters of a
15 mass accuracy of 0.15Da for peptides and 0.3Da for fragment masses. Sequence tagging analyses of MALDI TOF/TOF spectra were achieved using a combination of Global Protein Server (GPS) software (Applied Biosystems, Foster City, CA) and Matrix Science Mascot version 2.1 with manual review of all returned analyses. Peptide fragmentation peak lists were searched against the
20 unconstrained (non enzyme) NCBI nr 20060712 database (3783042 sequences, 1304471729 residues) with *Homo sapiens* taxonomy (111934 sequences) initially with no PTM's and proceeding sequentially with addition of possible PTM's sodiation and hydroxylation. Mascot search of the MALDI TOF-TOF data proceeded with assuming possible hydroxylation of lysine (K), asparagine (N),
25 proline (P), and possible sodiation of aspartic acid (D) or glutamic acid (E) side chains or carboxy termini. Returned Mascot probabilistic scores for peptides of ≥ 67 indicate identity or extensive homology ($p < 0.05$). As Mascot scoring is biased against single peptide identification, manual review of returned MASCOT

fragmentation data analyses was conducted and used to make sequence tagging assignments. Data were then re-searched using a NCBI nr Homo sapiens decoy database constructed using the online tool from Matrix Science MASCOT for randomization of database protein sequences. The top peptide assignments by
5 the *Homo sapiens* and the *Homo sapiens* -decoy databases were rank ordered and masses having a higher *Homo sapiens* -decoy rank order were discarded and not used for further analyses. Fragmentation spectra assigned a MASCOT scores of ≥ 20 for $m/z < 3,000$ and of ≥ 10 for $m/z > 3,000$ were manually reviewed using acceptance criterion including y-, b-, a-, ya- and yb- ion coverage, percentage of
10 fragmentation spectra assigned, root mean square (rms) mass accuracy errors for precursor (rms < 50 ppm) and precursor fragmentation products (rms < 500 ppm).

Immunohistochemistry (IHC). A modified version of a previously described IHC protocol was used. Formalin fixed, paraffin embedded kidney sections from human biopsy specimens were obtained and sections were dewaxed, treated with
15 antigen unmasking solution (H-3300 from Vector Laboratories Inc, Burlingame CA), and endogenous peroxidase activity was blocked. Kidney sections were selected from three different normal, disease control and disease biopsy specimens. Kidney sections were blocked, probed with primary antibody (1:1,000 dilution mouse polyclonal antibody to IPP2K; cat. no. H00064768-A01, Novus
20 Biologicals Inc, Littleton, CO), probed with secondary antibody and treated with ABC reagent. For negative controls, serial sections were stained as before with the exception of no primary antibody. Processed sections were scored by three blinded individuals using a scoring rubric for staining to nuclei, cytoplasm, basement membrane, and interstitium. Negative control and deletion control
25 experiments were conducted to optimize for antibody combination, antibody concentration, incubation times, and order of antibody visualization.

EXAMPLE 2

CHARACTERISTICS OF THE STUDY POPULATION

The study population was comprised of the patients whose onset of microalbuminuria (MA) was documented in the 1st Joslin Study of the Natural
5 History of Microalbuminuria in Type 1 Diabetes. Additional eligibility criteria included follow-up examinations spanning at least 8 years after MA onset for estimating the rate of GFR decline and availability of a 6 ml aliquot of stored urine for peptide analysis. The 61 patients who met all eligibility criteria were subdivided into 19 cases with early renal function decline, defined as a decline of 3.3% or
10 more per year (range: -3.3 to -16.1% per year), and 42 controls with lesser rates of renal function decline (range: +1.9 to -3.2% per year). For illustration, contrasting examples of longitudinal changes in renal function are shown in Figure 1. Both patients had T1D and MA. The control patient experienced age-appropriate renal function decline (approximately 1% per year), while the case
15 patient with ERFD progressed to end-stage renal disease.

Characteristics of the case and control groups are summarized in Table 3 at the onset of MA (Section A) and at the examination (approximately 3 years later) that provided the urine sample for peptide analysis (Section B). All patients were Caucasian and the groups had similar distributions of sex and duration of
20 diabetes at the onset of MA. ERFD cases were older and had higher average glycated hemoglobin A1c than controls, but had the same estimated GFR (cC-GFR) (Table 3, section A). At the time of urine sampling for peptide analysis (Table 3, Section B) the groups had similar MA duration, blood pressure, urinary albumin excretion and medications. Glycated hemoglobin continued to be higher
25 in cases than controls. The cC-GFR had declined slightly in both cases and controls from the time of MA onset, but still remained in the normal range. The cC-GFR was not below 60 ml/min in any patient during these baseline intervals. At the end of follow-up (Table 3, Section C), the mean duration of follow-up from the

onset of MA for both cases and controls was approximately 12 years (about 10 years after the time when urine samples were obtained for this study). By design, the rate of renal function loss (cC-GFR slope) was much greater in cases of ERFD (-6.5 % per year mean change) than in controls (-1.4% per year mean change). As
5 a result of this disparity in renal function deterioration, advanced chronic kidney disease or end-stage renal disease developed in half of the cases.

TABLE 3

Characteristics of Patients at Three Points in Time (Onset Microalbuminuria, Collection of Urine Sample, and End of Follow-up) According to Whether Early Renal Function Decline (ERFD) Developed During Follow-up

5	Characteristics:	ERFD – Yes Cases n=19	ERFD – No Controls n=42	
10	A. Onset of microalbuminuria			
	Duration of DM (y) 0.23	20 ± 8.5	18 ± 8.2	
15	Age (y) 0.02	36 ± 7.7	31 ± 7.5	
	HbA1c (%) 0.03	9.5 ± 1.4	8.7 ± 1.3	
	cC-GFR ml/min	148 ± 25	149 ± 24	0.89
	B. Collection of urine sample for peptide analysis			
20	Duration of microalbuminuria (y) 0.22	2.7 ± 1.5	3.2 ± 1.5	
	HbA1c (%) 0.004	9.7 ± 1.5	8.4 ± 1.5	
25	Systolic blood pressure 0.20	127 ± 21	121 ± 14	
	Urinary albumin excretion (µg/min) 0.33	39.8 (14.5, 53.1)	25.4 (10.2, 39.0)	
	Use of ACE inhibitors (%) 0.10	74	51	
30	cC-GFR ml/min	128 ± 27	138 ± 25	0.14
	C. End of follow-up			
	Duration of follow-up (y)* 0.37	11.6 ± 1.3	12.0 ± 2.1	
35	cC-GFR slope (%/y) <0.001	-6.5 ± 3.5	-1.4 ± 1.2	
	Urinary albumin excretion (µg/min)	1200 (300, 3000)	75 (5, 750)	
	Chronic Kidney Disease Stage ≥3 (%)	58†	0	

40 Data are mean ± SD except for urinary albumin excretion which is median (25th, 75th percentile) and categorical variables which are percents.

* Time interval between the onset of microalbuminuria and the last determination of cc-GFR.

† During follow-up, Stage 3 chronic kidney disease developed in 11 cases and end-stage renal disease developed in 3 of the 11.

45 DM, diabetes mellitus; HbA1c, hemoglobin A1c; ACE, angiotensin converting enzyme

EXAMPLE 3

URINE PEPTIDE ANALYSIS

Statistical analysis of the LC-MALDI-TOF MS data sets presented several challenges. First, only a few individual peptides were observed in every sample. For example, while 5,297 different peptides were observed, only 1,206 peptides were present in 50% of samples. The large numbers of undetected peptides introduced an equivalently large number of null values into the data sets; thus discouraging the application of classical t-test methods to select for differentially expressed peptides.

In order to focus effort on the most promising peptides, we imposed three stringent criteria for selecting peptides for further analysis. First, we eliminated the 3,364 peptides that were detected in less than 25% of the samples. Second, we required that there be a 50% difference in the detection frequency of a peptide between cases and controls. This reduced the number of peptides to 12. Third, we added a quantitative requirement to the evidence for association. Peptide quantity was calculated from its peak characteristics using integrated signal intensity. We then calculated the Spearman correlation coefficient between the peptide abundance and the rate of renal function loss, and selected four peptides with strong correlation (Table 4) for further analysis in these examples. All four had coefficients less than -0.40 and a p-value less than 0.01

TABLE 4

Urinary Peptides Determined To Be Differentially Present Between Case And Control Samples

Peptide Mass (m/z)	Proportion (%) of Urine Samples with Detectable Peptide				p-value	Proportion (%) of Urine Samples with Detectable Peptide		
	Cases N=19	All Controls N=42	Ratio	Correlation with GFR Slope		Cases N=19	Super Controls N=20	Ratio
842.347	79	43	1.8	-0.405	0.001	79	40	1.9

983.535	42	19	2.2	-0.437	0.006	42	5	8.4
1190.633	42	17	2.5	-0.416	0.001	42	10	4.2
1838.851	63	33	1.9	-0.421	0.008	63	20	3.2

EXAMPLE 4

5 DETERMINATION IF URINE PEPTIDES THAT IDENTIFY PATIENTS WITH RENAL FUNCTION DECLINE WERE PRESENT IN CONTEMPORANEOUS PLASMA SAMPLES

The discriminating peptides present in urine had a molecular weight (m/z) ranging approximately from 842 to 1838 Da and therefore might be present in the urine after being freely filtered from the plasma by the glomerulus. To investigate
10 the source of the selected peptides, we conducted additional LC-MALDI-TOF MS experiments of plasma samples obtained with the urine samples we had analyzed. We performed LC-MALDI TOF MS analysis of plasma peptides isolated from samples collected from the same individuals supplying the urine samples used in this study. The samples were available from 18 case and 18 control patients. The
15 isolated serum peptides were analyzed using identical LC-MALDI TOF MS methods employing chromatography retention time internal standards and on-plate per spot internal mass calibration standards.

One plasma peptide was detected in a majority of plasma samples at the correct chromatographic retention time and with the correct mass ($1190.638 \text{ m/z} \pm$
20 150ppm mass accuracy) to be assigned to one of the four urinary peptides which correlating with ERFD and which were further analyzed in the present examples. However there was no difference in this peptide's plasma abundance between Case and Control patients.

25

EXAMPLE 5

IDENTIFICATION OF RFD DISCRIMINATING URINE PEPTIDE AMINO ACID SEQUENCE BY MASS SPECTROMETRY

5 To better understand ERFD mechanisms we sought to identify the protein source for the discriminating urinary peptides selected for further analysis in these examples. We performed tandem mass spectrometry analysis to identify the amino acid sequence of the discriminating urine peptides.

10 As seen in Table 5, a total of three peptide sequence identifications were made including fragments of the cadherin-like protein FAT tumor suppressor 2, ZO-3 and a fragment of IPP2K. Further MS analysis demonstrated that the 1838.782 m/z ion had a peptide sequence having a missed trypsin cleavage site due to the presence of a glycyl-glycyl post-translational modification presumed resulting from ubiquitination of the parent protein IPP2K.

15

TABLE 5

Assignment Of Peptide Sequence To Differentially Expressed Urinary Peptides

Mass (m/z)	Parent Protein	Abundance Change In Cases	Peptide
1838.851	Inositol-1,3,4,5,6-pentakisphosphate 2-kinase	I	E.WGYHGEGNKSLVVAHA.Q + GlyGly (K)
1190.633	FAT tumor suppressor 2	I	S.PEFQQHLYE.A
983.535	Zona occludens 3	I	G.VSSQNLSLN.D

I = increased in RFD

20 Peptide sequence tags assignments for masses determined to be significant using presence-absence analyses or Spearman correlation analyses.

EXAMPLE 6

CHANGES IN URINE EXPRESSION OF INTACT IPP2K

We examined if intact IPP2K was present and also differentially expressed
5 in case and control urine protein samples. In preparing samples for peptidomic
analysis, we had isolated a fraction containing proteins with molecular size >
10,000 Da. These samples were then resolved by 10% SDS-PAGE and IPP2K
was identified by immunoblot.

As show in Figure 2, IPP2K was detectable in urine and was approximately
10 2.6 times greater in patients with ERFD who subsequently developed advanced
chronic kidney disease.

EXAMPLE 7

CHANGES IN IPP2K EXPRESSION IN THE INTACT KIDNEY

15 We examined whether urinary peptide levels might provide insight into
disease-induced changes in renal protein expression. We first analyzed IPP2K
expression in kidneys from normal and diabetic patients by immunohistochemistry.
In keeping with our focus on ERFD for these examples, we analyzed biopsies from
diabetic patients with minimal albuminuria and serum creatinine levels of 1.2 to 1.9
20 mg/dl.

Shown in Figure 3 are representative images from six pairs of experiments
that examined IPP2K expression in kidneys from normal patients (Figure 3A), a
patient with early DN (Figure 3B) and negative control for non-specific binding
(Figure 3D). Patients with DN had increased IPP2K expression in renal tubules
and glomeruli. While the majority of increased staining was observed in the
25 cytoplasm, intense areas of staining were noted in nuclei or perinuclear areas.

EXAMPLE 8

IPP2K IS PRESENT IN CYTOPLASMIC GRANULES IN DIABETIC
NEPHROPATHY

IPP2K has been shown recently to be a constituent of mRNA-containing
5 granules responsible for protein translation arrest in stressed cells (9). These
cytoplasmic inclusions, referred to as stress granules, are observed in cells
subjected to environmental stress including heat, irradiation, oxidative conditions
and hyperosmolarity (10). Based on our findings of increased renal and urinary
IPP2K in ERFD, we examined if DN was associated with the formation of stress
10 granules.

Shown in Figure 3D is a 100x magnification image of DN kidney stained for
IPP2K. Increased IPP2K staining is seen throughout and is strongly localized in
cytoplasmic granules. IPP2K was strongly expressed in nuclei or peri-nuclear
areas. We also used immunohistochemistry to determine expression of another
15 protein marker of stress granules, T-cell intracellular antigen-1 related protein
(TIAR). Shown in Figure 3 are sections stained for TIAR from normal kidney (3E)
or early diabetic nephropathy (3F). We observed increased TIAR staining in
diabetic nephropathy. TIAR was primarily localized to the cytoplasm and in a
granular pattern indicative of stress granules.

20

EXAMPLE 9

CHANGES IN ZO-3 EXPRESSION IN THE INTACT KIDNEY

To further examine if urine peptide changes may reflect alterations in intact
kidney proteins, we analyzed ZO-3 expression in kidneys from normal and diabetic
25 patients by immuno-histochemistry. We used the same biopsies, studied above,
from diabetic patients with minimal albuminuria and serum creatinine levels of 1.2
to 1.9 mg/dl. As shown in Figure 4, ZO-3 expression was increased in biopsies
from patients with DN (4B) when compared to controls (4A). We also observed

that ZO-3 staining was less linear, not confined to the cell periphery and increased in the cytoplasm when compared to normals.

DISCUSSION OF EXAMPLES 2-9

5 Our goal in these examples was to identify urinary peptides that are associated specifically with the risk of kidney diseases including ERFD, an early phenotype that indicates the initiation of renal function loss while GFR is still in the normal range and while MA is present. Urine samples available in this study were unique: They were taken from subjects early after the development of MA, and
10 could be classified into cases and controls according to their future changes in renal function. As such, the samples could be used to measure peptides that may discriminate those that retain stable renal function from those with ERFD. We reasoned if such discriminating peptides could be identified that they would be specific for ERFD and might provide new insights into the pathophysiology the
15 initiation of renal function loss – as opposed to the onset of MA - and could serve as candidate biomarkers in future studies. We focused on 4 identified peptides for these examples. Each was more abundant in the urine of cases as compared to the urine of well-matched controls. MS sequence tag analysis identified individual peptide fragments of derived from the tight junction protein-3/ ZO-3, FAT-2 and
20 IPP2K. The novel findings in these examples include that changes in renal protein expression in diabetes are reflected in the urinary peptidome and occur very early in DN. Secondly, based on the urine peptidomic analysis, we were able to determine that intact IPP2K protein is increased in diabetic kidney and is present in stress granules not observed in normal kidney.

25 Based on the differential expression of an IPP2K urinary fragment in case and control samples, we examined whether this protein was differentially regulated in normal kidneys and those from patients with T1D. We observed increased expression of IPP2K in renal tubules of patients with T1D compared to normal

kidney. Increased IPP2K expression was observed both in nuclei and in the cytoplasm. This finding suggests a hitherto unrecognized role for IPP2K in the damaged kidney or in kidneys responding to stress. IPP2K may have several possible roles in DN. Higher inositol phosphate production proceeds through the action of a IP5/6-kinase to produce Ins(1,3,4,6)P4 which in turn is acted on by a
5 IP5-kinase to produce Ins(1,3,4,5,6)P5, that is then modified by IPP2K to produce InsP6 (11, 12). The role in renal cell function of IPP2K is incompletely understood and the actions of InsP6, the primary product of IPP2K activity, are a focus of considerable interest. One major role for IPP2K has been in the regulation of
10 mature messenger RNA nuclear export and mRNA translation arrest during cellular stress (13). Most recently, cytoplasmic IPP2K has been associated with stress granule formation. Stress granules are phase-dense cytoplasmic particles that appear in eukaryotic cells exposed to environmental stress (e.g. oxidative conditions, hyperosmolarity, nutrient deprivation and UV irradiation). Stress
15 granule assembly is a consequence of abortive translational initiation. If the stress is relieved, the stress granules disassemble, and translation resumes. The persistence of stress granules is considered a reflection of ongoing insults that, if left unchecked, may lead to apoptotic cell death. We observed evidence of stress granules in kidneys with early diabetic nephropathy, as well as in other renal
20 diseases, suggesting that stress-induced changes in translation had occurred.

We also observed that increased amounts of urine peptides derived from the ZO-3 protein reflected changes in the diabetic kidney. Diabetic kidneys had increased tubule cell ZO-3 expression and apparent translocation of the protein from the cell membrane to cytoplasm. ZO-3 is a member of the zona occludens
25 protein family found in epithelial cell apical junction complexes (14). Zona occludens proteins play an important role in maintaining barrier integrity formed by epithelial cells and loss of ZO-3 in particular results in increased permeability of cell layers (15). Recently, Sharma *et al.* have shown glucose causes translocation

of ZO-1 from the cell membrane to the cytoplasm in cultured podocytes (16). Similarly, we observed increased cytoplasmic and decreased membrane ZO-3 staining in renal tubules in human diabetic kidneys. These data indicate that increased ZO-3 fragments in the urine may be a result of the diabetes-induced
5 change in ZO-3 cellular distribution.

In summary, we have identified peptides in the low molecular fraction of urine that correlate with early renal function decline in Type-1 diabetes mellitus. These peptides reflect changes in both tubular and glomerular protein expression that are associated with the formation of stress granules and may define a new
10 cellular mechanism by which diabetic nephropathy is initiated or progresses. Thus, urine peptide expression can provide insight into renal pathophysiologic mechanisms.

EXAMPLE 10

15 This Example provides comparison of peptide profiles of plasma samples collected from type-1 diabetic individuals prior to the onset of significant renal function decline. It was determined that discernable changes in the plasma peptidome accompany early progressive renal function decline in type-1 diabetics with microalbuminuria.

20 Longitudinal patient study allowed for stratification of patient renal function into two groups: significant renal function decline (case) and age-equivalent renal function decline (control). Peptide profiles generated using liquid chromatography (LC), robotic fraction collection, and matrix assisted laser desorption ionization-time of flight mass spectrometry (MALDI-TOF MS) were compared using class
25 discovery and class differentiation methods.

A total of 213 peptide masses out of >9,000 peptide masses were identified as being differentially present to some degree between case and control groups. Manual review of the data allowed for rank ordering of peptide importance based

on apparent abundance within samples. Peptides having significant abundance (e.g. a signal to noise (s/n) ratio ≥ 50) were selected for further studies dedicated to identifying the peptide's amino acid sequence.

Initial analysis provided sixty-three (63) peptides were significant by univariate t-test analysis at the $p < 0.01$ significance level. Thirty-two (32) peptides classified patient group samples with case sensitivity (0.5), specificity (0.882) and positive (0.8) and negative (0.652) predictive values. Forty-one (41) peptide sequence tags involving twenty two (22) proteins were identified. A complete listing of plasma peptide biomarkers associated with kidney disease is provided in Table 2. In conclusion, the plasma peptidome significantly differs between T1D with MA that do and do not succumb to ERFD. In addition, the difference between the plasma peptidome's of T1D with MA with ERFD and T1D with MA but without ERFD is exhibited months to years in advance of any significant renal function decline.

15

EXAMPLE 11

Summary: The experiments noted in Example 10 identified eight peptide sequences as derived from the biologically important peptide bradykinin including one apparently previously-unknown variant of bradykinin. Bradykinin, a proteolytic fragment of the protein kininogen, and differential expression of bradykinin receptors (B1KR and B2KR) are of known significant importance to renal function (Tan et al., (2007) Am J Physiol Renal Physiol. 293(4):F1026-35.).

Differential plasma expression of the bradykinin parent protein, kininogen, has been established in the data of the present example using immunoblot analysis of early progressive renal function decline phenotypic extremes.

A question addressed by the present example was "are the urinary peptides identified as differentially abundant in case versus control patients actually filtered from the plasma through the glomerulus into the urine". We were able to

demonstrate that none of the significant urinary peptides originated from the plasma. The analysis of LC-MS data from these 33 plasma samples (n=16 case; n=17 control) identified 63 peptides to be significantly difference between case and control groups by t-test ($p < 0.05$); eight of these peptides were fragments of high molecular weight kininogen. From these observations we developed the following hypothesis: The presence of increased amounts of specific peptide fragments of high molecular weigh kininogen (HK) in the case patient plasma as compared the control patient plasma would reflect changes in the amount of the corresponding intact protein in the plasma.

10 Background: Two splice variants of kininogen occur with the larger variant referred to as high molecular weight kininogen (HK) and the smaller variant referred to low molecular weight kininogen (LK). HK contains six protein domains including protease inhibitor domains, a cytokeratin binding domain, a gC1qR binding domain, a prekallikrein/Factor XI binding domain, and a domain containing the peptide hormone bradykinin (BK). BK is released from HK primarily by the proteolytic activity of plasma kallikrein. BK binds to the constitutively expressed bradykinin-1 receptor (B1R), a G-protein coupled receptor. BK can be degraded by a number of metalloproteinases including the protease, Kininase II also known as angiotensin (AT) converting enzyme (ACE). Interestingly ACE has a higher affinity for BK than for AT. ACE inhibitors are used to treat hypertension in hypertensive diabetics and have a beneficial side effect of reducing proteinuria. Some people ascribe the beneficial effects of ACE inhibitors to the resulting increase in BK half-life and resulting increase in effective tissue BK concentration.

15 The proteolysis of LK by tissue kallikrein releases decapeptide known as kalladin and corresponds to BK plus an additional N-terminal lysine (also known as Lys-bradykinin). BK and kalladin are both proteolytically degraded by enzymes in the kidney and yield the hepta-, hexa-, and penta-polypeptides which were observed in the low molecular proteomic studies conducted in our preliminary studies. The

20

25

release of BK from HK yields a heavy chain having a molecular weight range of approximately 68,000 to 65,000 Daltons and a light chain having a molecular weight of approximately 58,000 Daltons; subsequently the light chain is further degraded to fragments with a mass range of 49,000 to 42,000 Daltons. The two chains are held together by a single disulfide bond. The heavy chain contains multiple N-linked glycan structures and the light chain contains multiple O-linked glycan structures. Therefore, the differential abundance of BK peptides and BK degradation products should be reflected by the differential abundance of kininogen heavy chain and light chain proteins in the plasma of case versus control patients.

Methods: In order to examine if the increased plasma abundance of kininogen fragments was the result of increased kininogen protein expression, immunoblotting experiments using reduced and denatured plasma protein samples were conducted. The plasma samples were enriched for low abundant proteins including kininogen by depleting albumin using albumin-specific antibody methods (VivaScience, Sartorius, Germany). Samples were prepared using 10µg of depleted plasma proteins dissolved in Laemmli buffer, separated using 10% NuPAGE gels at 200V constant and electroblotted onto 0.45µm nitrocellulose. The blocked membrane was immunoblotted using rabbit anti-high molecular weight kininogen polyclonal antibodies in Odyssey infrared imaging blocking buffer (Licor, Lincoln, NE) supplemented with 0.1% Tween 20. Proteins were visualized by incubation of membranes with fluorescent-tagged anti-rabbit antibodies (Molecular Probes, Carlsbad, CA) and scanning on an Odyssey infrared imager (Licor).

Results: Immunoblot experiments were conducted using polyclonal antibodies to high molecular weight kininogen. The samples selected for these experiments were composed of the phenotypic extremes (the patients who through 12-20 years longitudinal follow-up demonstrated the most (case) and least

(control) severe loss of renal function). These immunoblot experiments identified multiple immunopositive bands migrating at molecular weight ranges between approximately 56,000 and 38,000 Daltons. Data are presented for the analysis of case (n=3) and control (n=3) samples for the bands migrating between 49,000 and 5 38,000 Daltons (Figure 5) and a single band migrating between 65,000 and 49,000 Daltons (Figure 6). From these data and an additional three samples a Pearson analysis for the correlation of band intensities with the estimated rates of renal function decline computed a correlation coefficient of 0.8. The strength of this correlation coefficient suggests that kininogen metabolism is dysregulated 10 between T1D MA individuals with and without early progressive renal function decline.

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20 It will be understood that various details of the presently disclosed subject matter can be changed without departing from the scope of the subject matter. Furthermore, the foregoing description is for the purpose of illustration only, and not for the purpose of limitation.

CLAIMS

What is claimed is:

1. A method for diagnosing a kidney disease, or the risk thereof, in a subject, comprising:
 - (a) determining an amount of at least one peptide of Table 1, Table 2, or both in a biological sample from the subject; and
 - (b) comparing the amount of the at least one peptide in the sample with a control level, wherein if the amount determined in (a) is different than the control level, the subject is diagnosed as having, or at an increased risk of developing, the kidney disease.
2. The method of claim 1, wherein determining the amount of the at least one peptide comprises determining the amount of the at least one peptide in the sample using mass spectrometry (MS) analysis, immunoassay analysis, or both.
3. The method of claim 2, wherein the MS analysis comprises matrix-assisted laser desorption/ionization (MALDI) time-of-flight (TOF) MS analysis or electrospray ionization (ESI) MS.
4. The method of claim 3, wherein the MALDI-TOF MS analysis is direct-spot MALDI-TOF or liquid chromatography MALDI-TOF mass spectrometry analysis.
5. The method of claim 2, wherein the immunoassay analysis comprises an enzyme-linked immunosorbent assay (ELISA).
6. The method of claim 1, wherein the at least one peptide is a plurality of peptides.
7. The method of claim 1, wherein the biological sample is a urine sample and the at least one peptide is at least one peptide selected from Table 1.
8. The method of claim 1, wherein the biological sample is a blood sample or a plasma sample and the at least one peptide is at least one peptide selected from Table 2.

9. The method of claim 1, wherein the subject is human.
10. The method of claim 1, wherein the subject is a diabetic subject.
11. The method of claim 10, wherein the kidney disease is diabetic nephropathy.
12. A method for determining treatment efficacy and/or progression of a kidney disease in a subject, comprising:
 - (a) determining an amount of at least one peptide of Table 1, Table 2, or both in a first biological sample collected from the subject at a first time point;
 - (b) determining an amount of the at least one peptide of Table 1, Table 2, or both in a second biological sample from the subject at a second time point; and
 - (c) comparing the amounts of the at least one peptide in the first and second samples, wherein a change in the amounts of the at least one peptide from the first and second samples is correlated with determining treatment efficacy and/or progression of the kidney disease in the subject.
13. The method of claim 12, wherein determining the amount of the at least one peptide in the first and second biological samples comprises quantitating the amount of the at least one peptide in the samples using mass spectrometry (MS) analysis, immunoassay analysis, or both.
14. The method of claim 13, wherein the MS analysis comprises matrix-assisted laser desorption/ionization (MALDI) time-of-flight (TOF) MS analysis or electrospray ionization (ESI) MS.
15. The method of claim 14, wherein the MALDI-TOF MS analysis is direct-spot MALDI-TOF or liquid chromatography MALDI-TOF mass spectrometry analysis.
16. The method of claim 13, wherein the immunoassay analysis comprises an enzyme-linked immunosorbent assay (ELISA).
17. The method of claim 12, wherein the at least one peptide is a plurality of peptides.

18. The method of claim 12, wherein the first and second biological samples are urine samples and the at least one peptides are at least one peptides selected from Table 1.
19. The method of claim 12, wherein the first and second biological samples are urine samples and the at least one peptides are at least one peptides selected from Table 2.
20. The method of claim 12, wherein the subject is human.
21. The method of claim 12, wherein the subject is a diabetic subject.
22. The method of claim 21, wherein the kidney disease is diabetic nephropathy.
23. The method of claim 12, wherein the first time point is prior to initiation of a treatment for the kidney disease and the second time point is after initiation of the treatment.
24. The method of claim 12, wherein the first time point is prior to onset of the kidney disease and the second time point is after onset of the kidney disease.
25. An antibody or fragment thereof that specifically recognizes a peptide of Table 1 or Table 2, a peptide associated with a peptide of Table 1 or Table 2, or both.
26. The antibody of claim 25, wherein said antibody is a monoclonal antibody.
27. A kit for detecting a kidney disease, or a risk thereof, in a subject, the kit comprising one or more antibodies of claim 25.
28. The kit of claim 27, wherein the antibody is bound to a substrate.
29. The kit of claim 27, comprising instructions for using the kit.
30. The kit of claim 27, wherein the subject is human.
31. The kit of claim 27, wherein the subject is a diabetic subject.
32. The kit of claim 27, wherein the kidney disease is diabetic nephropathy.
33. The kit of claim 27, wherein the one or more antibodies is a plurality of different antibodies.

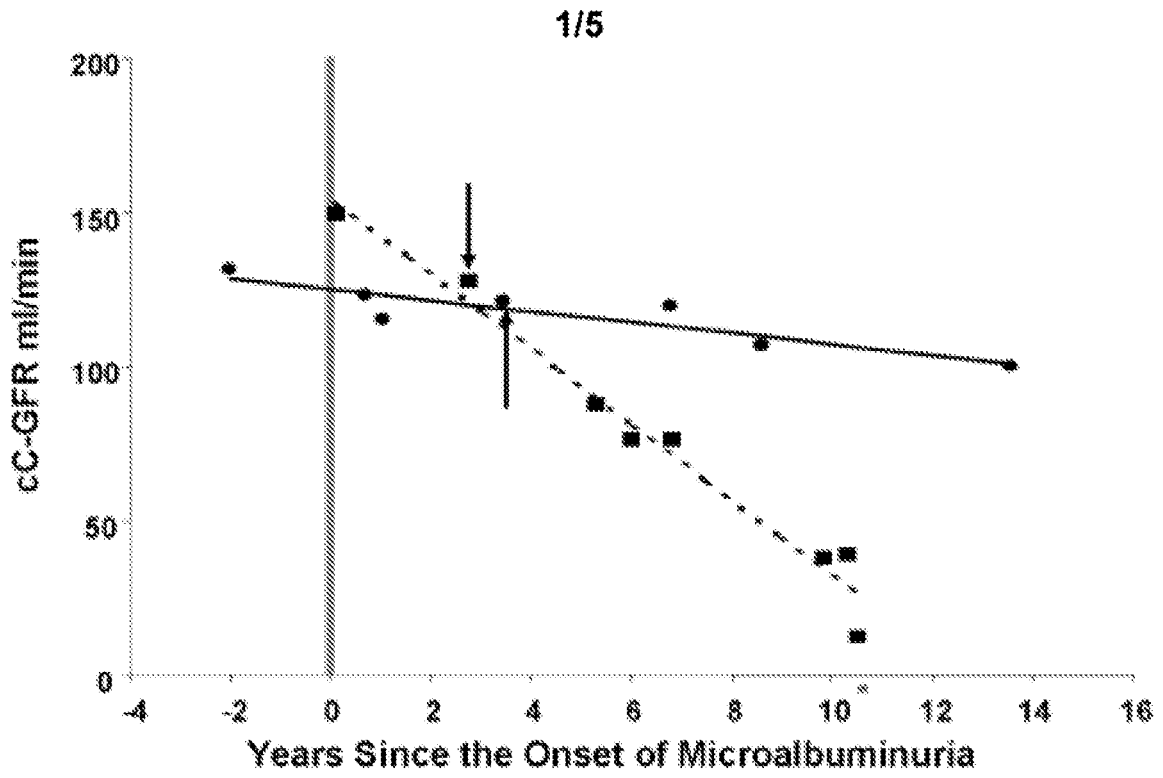


FIGURE 1

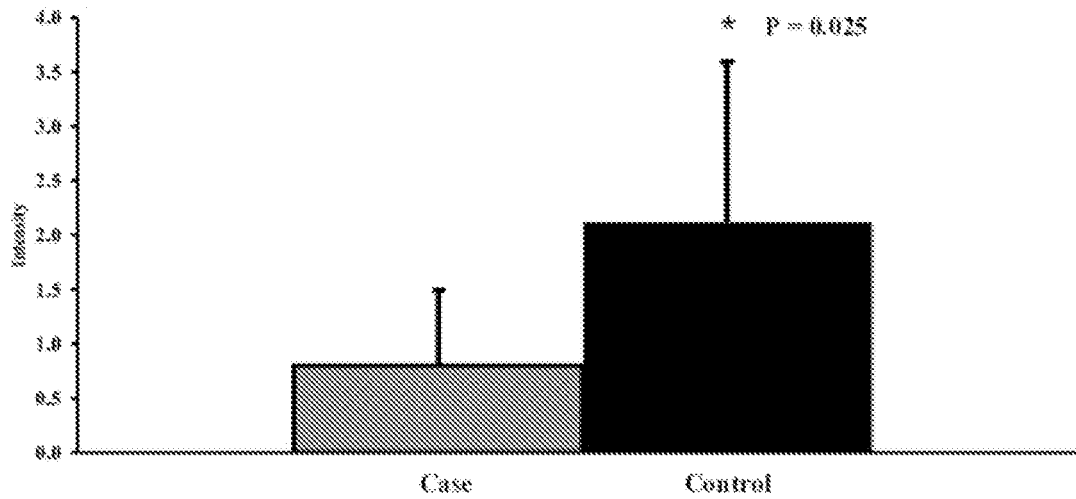


FIGURE 2

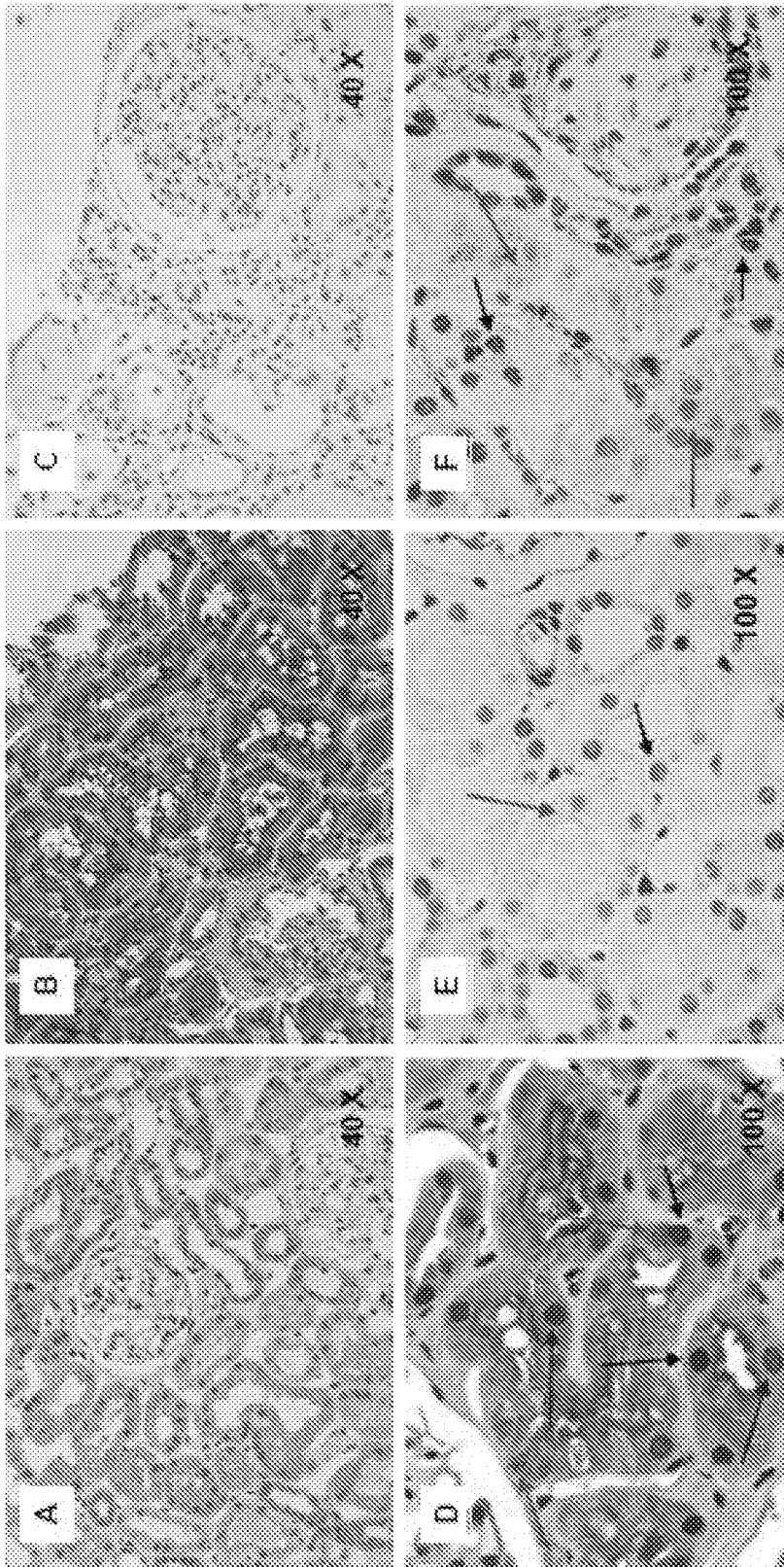


FIGURE 3

Figure 4A.

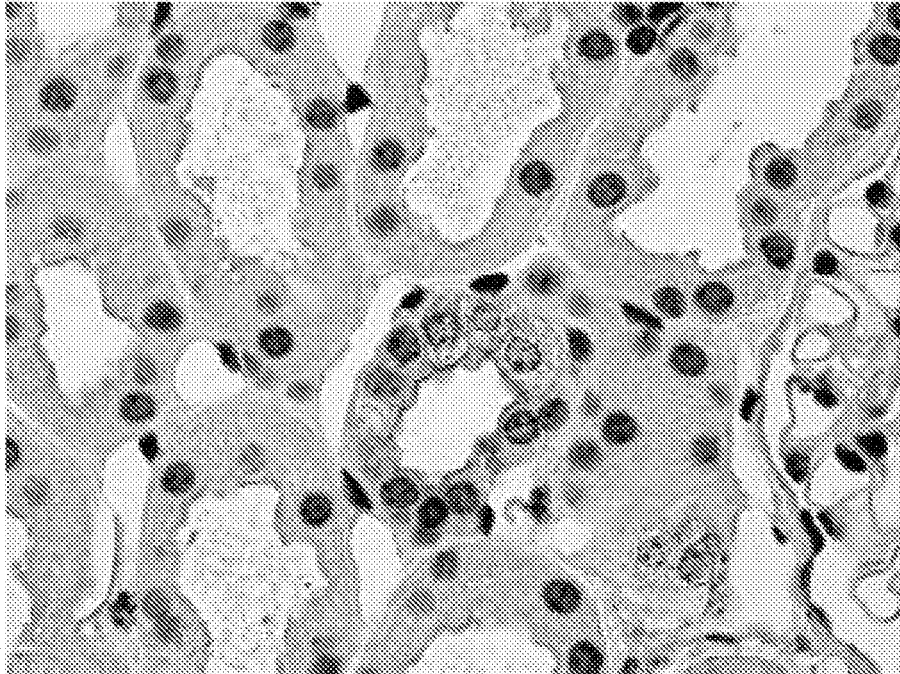


Figure 4B.

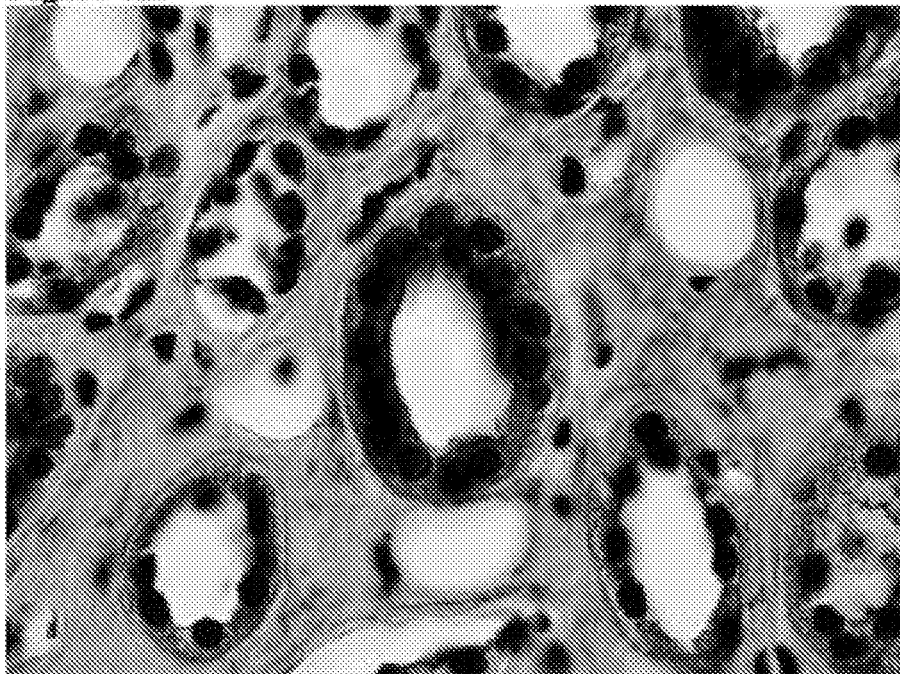


FIGURE 4

4/5

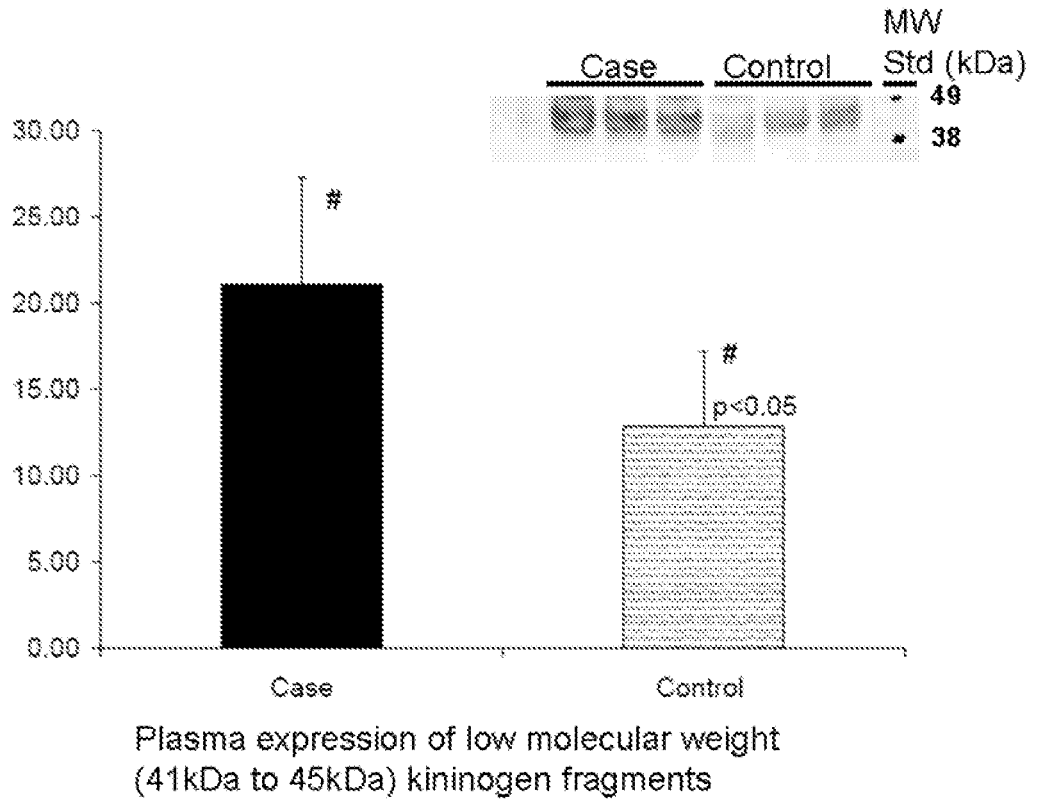


FIGURE 5

5/5

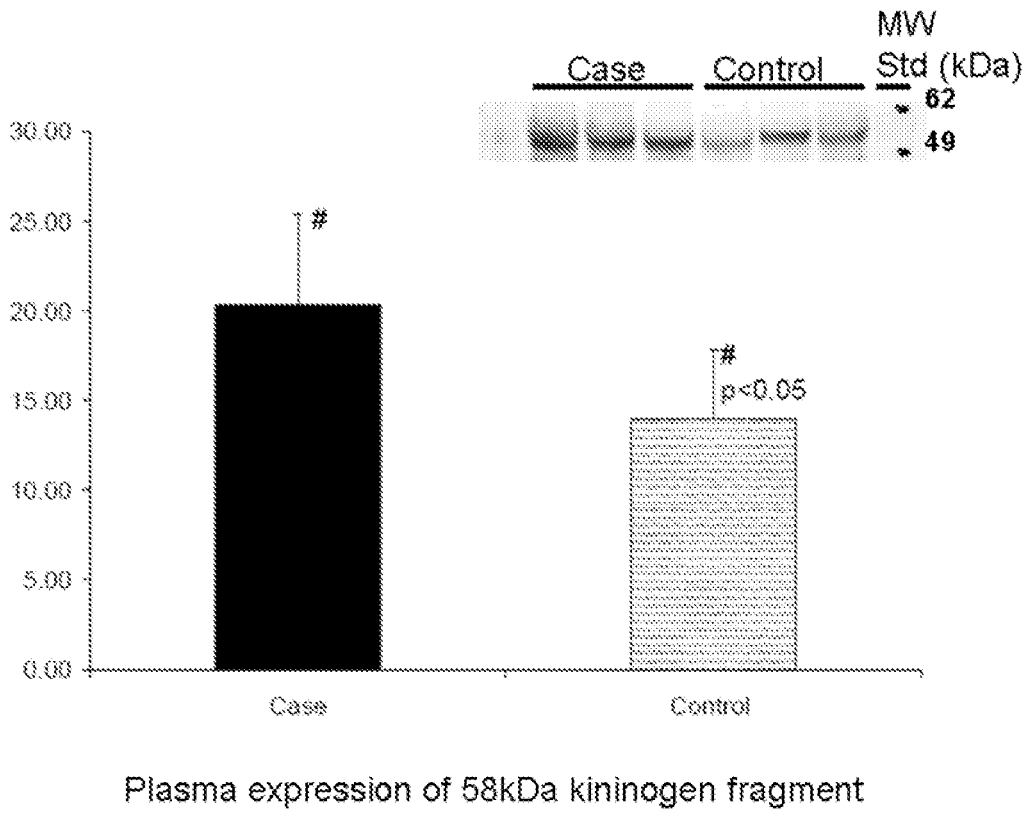


FIGURE 6

INTERNATIONAL SEARCH REPORT

International application No.

PCT/US 08/77091

A. CLASSIFICATION OF SUBJECT MATTER

IPC(8) - G01N 33/53; G01N 24/00 (2009.01)

USPC - 435/7.1; 436/173

According to International Patent Classification (IPC) or to both national classification and IPC

B. FIELDS SEARCHED

Minimum documentation searched (classification system followed by classification symbols)

IPC(8) - G01N 33/53; G01N 24/00 (2009.01)

USPC - 435/7.1; 436/173; 435/7.21; 436/174

Documentation searched other than minimum documentation to the extent that such documents are included in the fields searched

IPC(8) - G01N 33/53; G01N 24/00 (2009.01) - see keyword below

USPC - 435/7.1; 436/173; 435/7.21; 436/174 - see keyword below

Electronic data base consulted during the international search (name of data base and, where practicable, search terms used)

PubWEST(USPT,PGPB,EPAB,JPAB); Medline, Google

Search terms: B-cell lymphoma 9 protein, BCL9, Bcl-9, kidney, disease, control, sample, cancer, mass spectrometry, MS, MALDI, TOF, ESI, spot, liquid chromatography, ELISA, plurality, peptide, urine, human, diabetic, nephropathy, progression, efficacy, treatment, time

C. DOCUMENTS CONSIDERED TO BE RELEVANT

Category*	Citation of document, with indication, where appropriate, of the relevant passages	Relevant to claim No.
X --- Y	US 2007/0105133 A1 (CLARKE et al.) 10 May 2007 (10.05.2007), Abstract, para [0010], [0020], [0021], [0038], [0039], [0040], [0044], [0072], [0078], [0082], [0107], [0114], [0215], [0227], [0235], [0236], [0246], [0256], [0296], [0314], [0487], and [0533]	1-2, 5-7, 9, 12-13, 16-18, 20, 23-24 ----- 3-4, 10-11, 14-15, 21-22
Y	US 2004/0101874 A1 (GHOSH et al.) 27 May 2004 (27.05.2004), para [0109], [0121], and [0152]	3-4, 14-15
Y	US 2007/0050146 A1 (BENTWICH et al.) 01 March 2007 (01.03.2007), Abstract, para [0123], [0169], and [0170]	10-11, 21-22

Further documents are listed in the continuation of Box C.

* Special categories of cited documents:

"A" document defining the general state of the art which is not considered to be of particular relevance

"E" earlier application or patent but published on or after the international filing date

"L" document which may throw doubts on priority claim(s) or which is cited to establish the publication date of another citation or other special reason (as specified)

"O" document referring to an oral disclosure, use, exhibition or other means

"P" document published prior to the international filing date but later than the priority date claimed

"T" later document published after the international filing date or priority date and not in conflict with the application but cited to understand the principle or theory underlying the invention

"X" document of particular relevance; the claimed invention cannot be considered novel or cannot be considered to involve an inventive step when the document is taken alone

"Y" document of particular relevance; the claimed invention cannot be considered to involve an inventive step when the document is combined with one or more other such documents, such combination being obvious to a person skilled in the art

"&" document member of the same patent family

Date of the actual completion of the international search

08 February 2009 (08.02.2009)

Date of mailing of the international search report

13 FEB 2009

Name and mailing address of the ISA/US

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PCT Helpdesk: 571-272-4300
PCT OSP: 571-272-7774

INTERNATIONAL SEARCH REPORT

International application No.

PCT/US 08/77091

Box No. II Observations where certain claims were found unsearchable (Continuation of item 2 of first sheet)

This international search report has not been established in respect of certain claims under Article 17(2)(a) for the following reasons:

- 1. [] Claims Nos.: because they relate to subject matter not required to be searched by this Authority, namely:
2. [] Claims Nos.: because they relate to parts of the international application that do not comply with the prescribed requirements to such an extent that no meaningful international search can be carried out, specifically:
3. [] Claims Nos.: because they are dependent claims and are not drafted in accordance with the second and third sentences of Rule 6.4(a).

Box No. III Observations where unity of invention is lacking (Continuation of item 3 of first sheet)

This International Searching Authority found multiple inventions in this international application, as follows:
This application contains the following inventions or groups of inventions which are not so linked as to from a single general inventive concept under PCT Rule 13.1. In order for all inventions to be examined, the appropriate additional examination fees must be paid.
Group I: Claims 1-7, 9-18, and 20-24, directed to a method for diagnosing a kidney disease or a method for determining treatment efficacy and/or progression of a kidney disease, limited to a peptide biomarker of Table 1 (plasma markers of kidney disease), where the first biomarker listed in Table 1 will be searched without an additional search fee. Applicant may have additional biomarker(s) searched for additional search fee(s).
Group II: Claims 1-6, 8-10, 11-17, and 19-24, directed to a method for diagnosing a kidney disease or a method for determining treatment efficacy and/or progression of a kidney disease, limited to a peptide biomarker of Table 2 (plasma markers of kidney disease), where the first biomarker listed in Table 2 will be searched. Applicant may have additional biomarker(s) searched for additional search fee(s)

*****Continued in extra sheet*****

- 1. [] As all required additional search fees were timely paid by the applicant, this international search report covers all searchable claims.
2. [] As all searchable claims could be searched without effort justifying additional fees, this Authority did not invite payment of additional fees.
3. [] As only some of the required additional search fees were timely paid by the applicant, this international search report covers only those claims for which fees were paid, specifically claims Nos.:
4. [X] No required additional search fees were timely paid by the applicant. Consequently, this international search report is restricted to the invention first mentioned in the claims; it is covered by claims Nos.: 1-7, 9-18, and 20-24

Remark on Protest [] The additional search fees were accompanied by the applicant's protest and, where applicable, the payment of a protest fee.
[] The additional search fees were accompanied by the applicant's protest but the applicable protest fee was not paid within the time limit specified in the invitation.
[] No protest accompanied the payment of additional search fees.

INTERNATIONAL SEARCH REPORT

International application No.

PCT/US 08/77091

Continuation of:

Box No III (unity of invention is lacking)

Group III: Claims 25-33, directed to an antibody or a kit for detecting kidney disease, limited to a biomarker peptide of Table 1 (urinary markers of kidney disease), where the first biomarker listed in Table 1 will be searched. Applicant may have additional biomarker(s) searched for additional search fee(s).

Group IV: Claims 25-33, directed to an antibody or a kit for detecting kidney disease, limited to a peptide biomarker of Table 2 (plasma markers of kidney disease), where the first biomarker listed in Table 2 will be searched. Applicant may have additional biomarker(s) searched for additional search fee(s).

The inventions the listed groups do not relate to a single general inventive concept under PCT Rule 13.1 because, under PCT Rule 13.2, they lack the same or corresponding special technical features for the following reasons:

The special technical features that link Groups I-IV are a method for diagnosing kidney disease comprising detecting a peptide biomarker of kidney disease, and an antibody that specifically recognizes a peptide biomarker of kidney disease. However, this is not an improvement over the prior art US 20060240437 A1 (Krolewski et al.) teaches diagnosing kidney disease by measuring a peptide biomarker (fibrinogen; para [0006]) and teaches an antibody that specifically recognizes the peptide biomarker (para [0017]).

Accordingly, unity of invention is lacking under PCT Rule 13.2 because the groups do not share a same or corresponding special technical feature providing a contribution over the prior art.

专利名称(译)	肽生物标志物预测肾功能下降和肾脏疾病		
公开(公告)号	EP2203743A1	公开(公告)日	2010-07-07
申请号	EP2008832096	申请日	2008-09-19
[标]申请(专利权)人(译)	路易斯维尔大学研究基金会公司		
申请(专利权)人(译)	路易斯维尔研究基金会, Inc.的.大学.		
当前申请(专利权)人(译)	路易斯维尔研究基金会, Inc.的.大学.		
[标]发明人	KLEIN JON MERCHANT MICHAEL L BORATYN GRZEGORZ		
发明人	KLEIN, JON MERCHANT, MICHAEL L. BORATYN, GRZEGORZ		
IPC分类号	G01N33/53 G01N24/00		
CPC分类号	G01N33/6893 G01N2800/042 G01N2800/347 G01N2800/50 G01N2800/52 G01N2800/56		
代理机构(译)	JONES, ANDREW NICHOLAS		
优先权	60/974002 2007-09-20 US 61/050521 2008-05-05 US		
其他公开文献	EP2203743A4		
外部链接	Espacenet		

摘要(译)

本发明公开的主题提供了用于诊断受试者中的肾病或其风险的方法。该方法包括确定来自受试者的生物样品中本文公开的至少一种肽生物标志物的量,并将样品中至少一种肽的量与对照水平进行比较,其中如果测定的量不同于对照水平。 ,该受试者被诊断为患有肾病或具有增加的肾病风险。