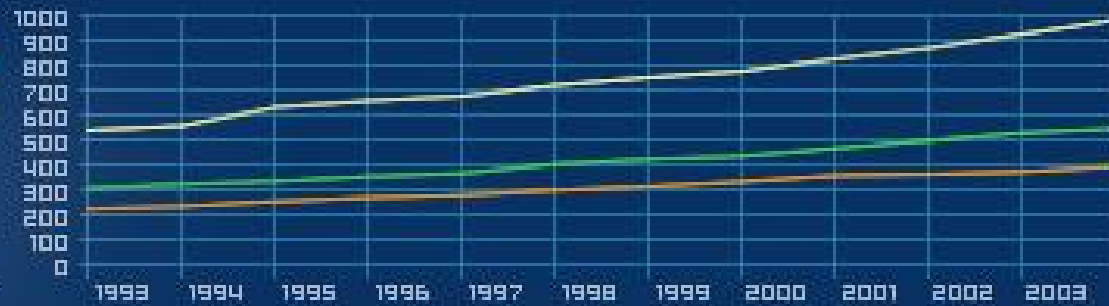




DIALYSE ■
TRANSPLANTATIE ■
TOTAAL ■



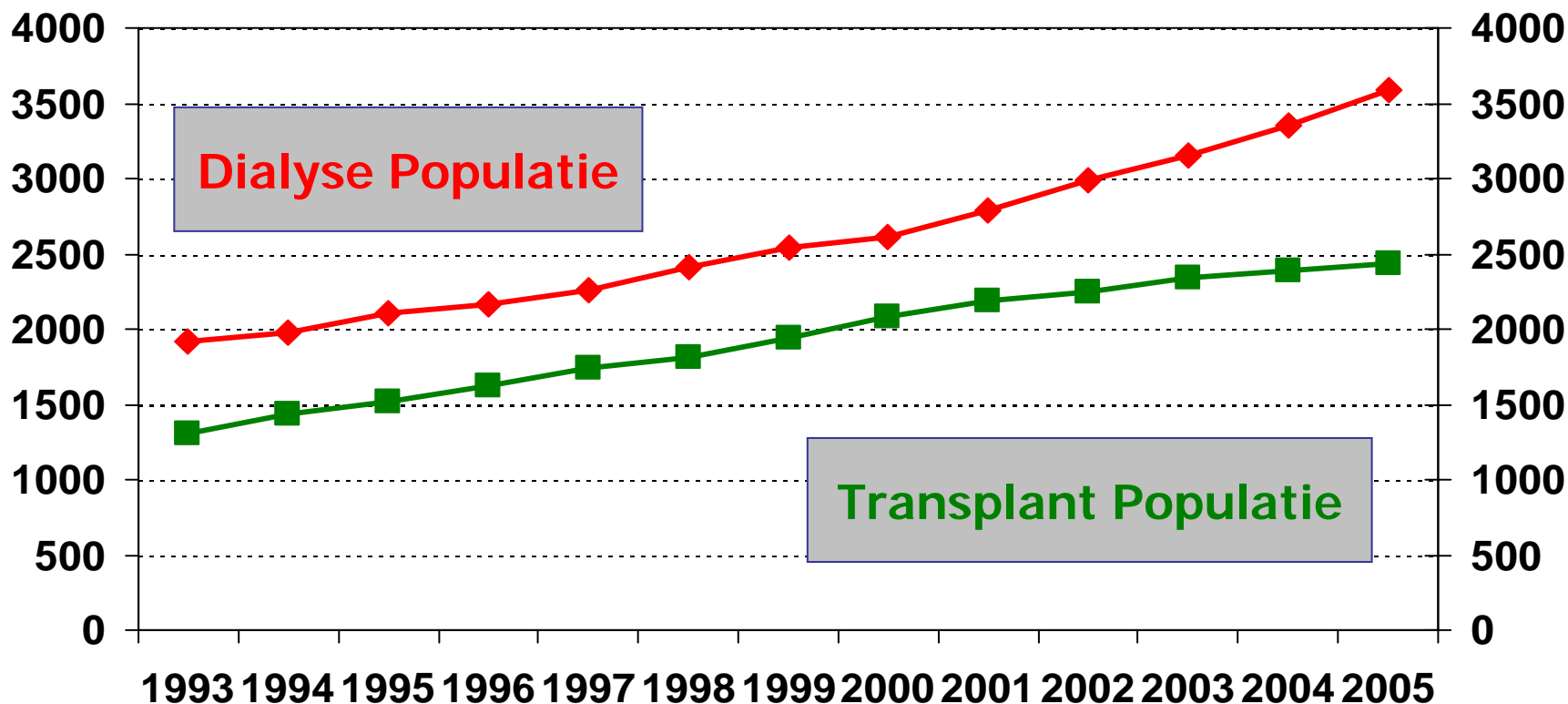
Nederlandstalige Belgische Vereniging voor Nefrologie



Dialyse patiënten & Transplant patiënten prevalentie

december 31, 1993 - 2005

PRE_PREVIEW



◆ dialyse ■ transplantatie

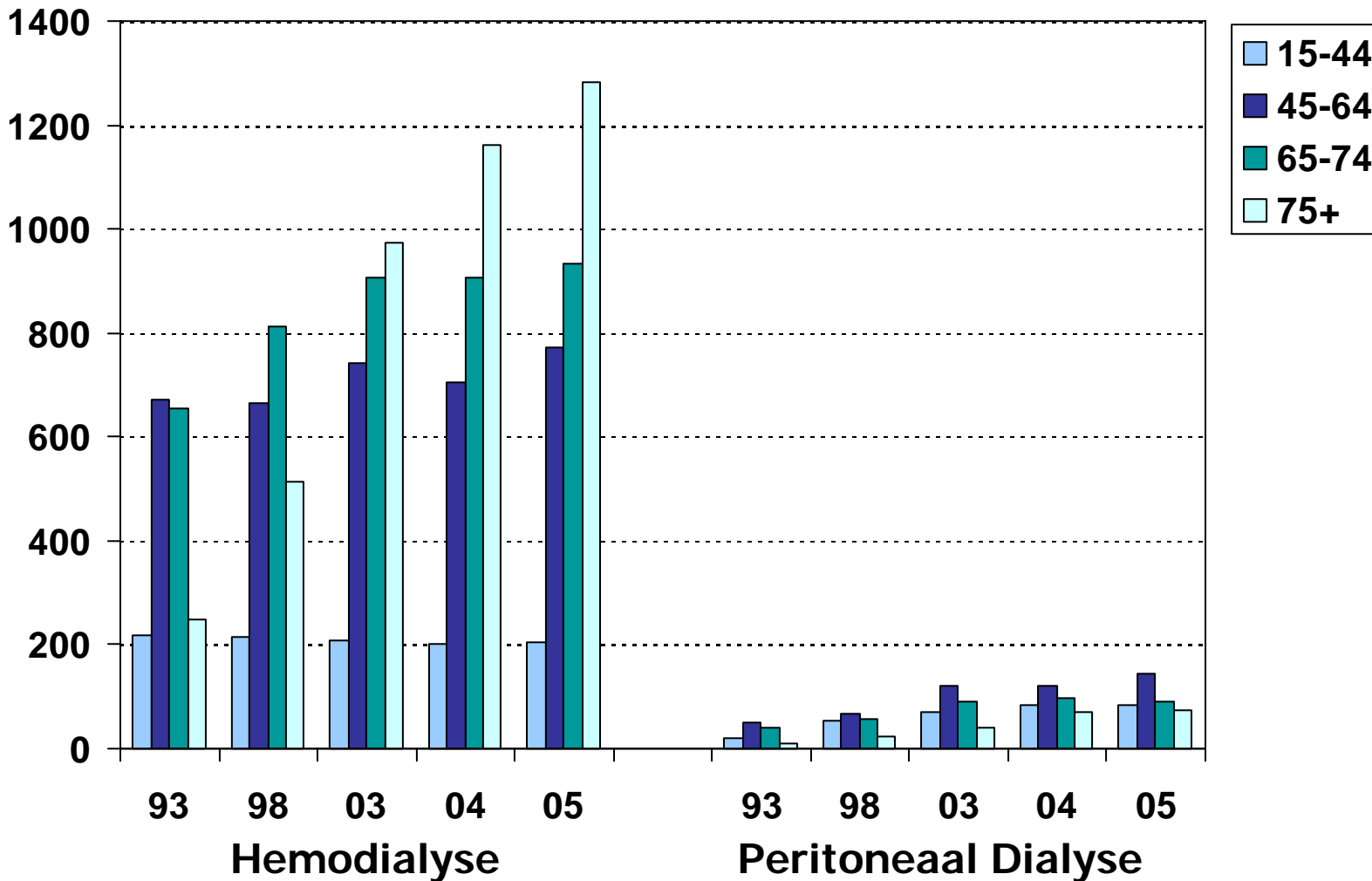


Dialyse patiënten – Prevalentie : Leeftijd

PRE_VIEW

december 31, 1993 - 2005

N= 1793 2208 2798 2950 3191 130 202 327 375 392





Prevalentie : Leeftijd

(3583) dialyse & bevolking (5.000.000)

PRE_VIEW

85 en ouder

75-84 jaar

65-74 jaar

55-64 jaar

45-54 jaar

35-44 jaar

25-34 jaar

15-24 jaar

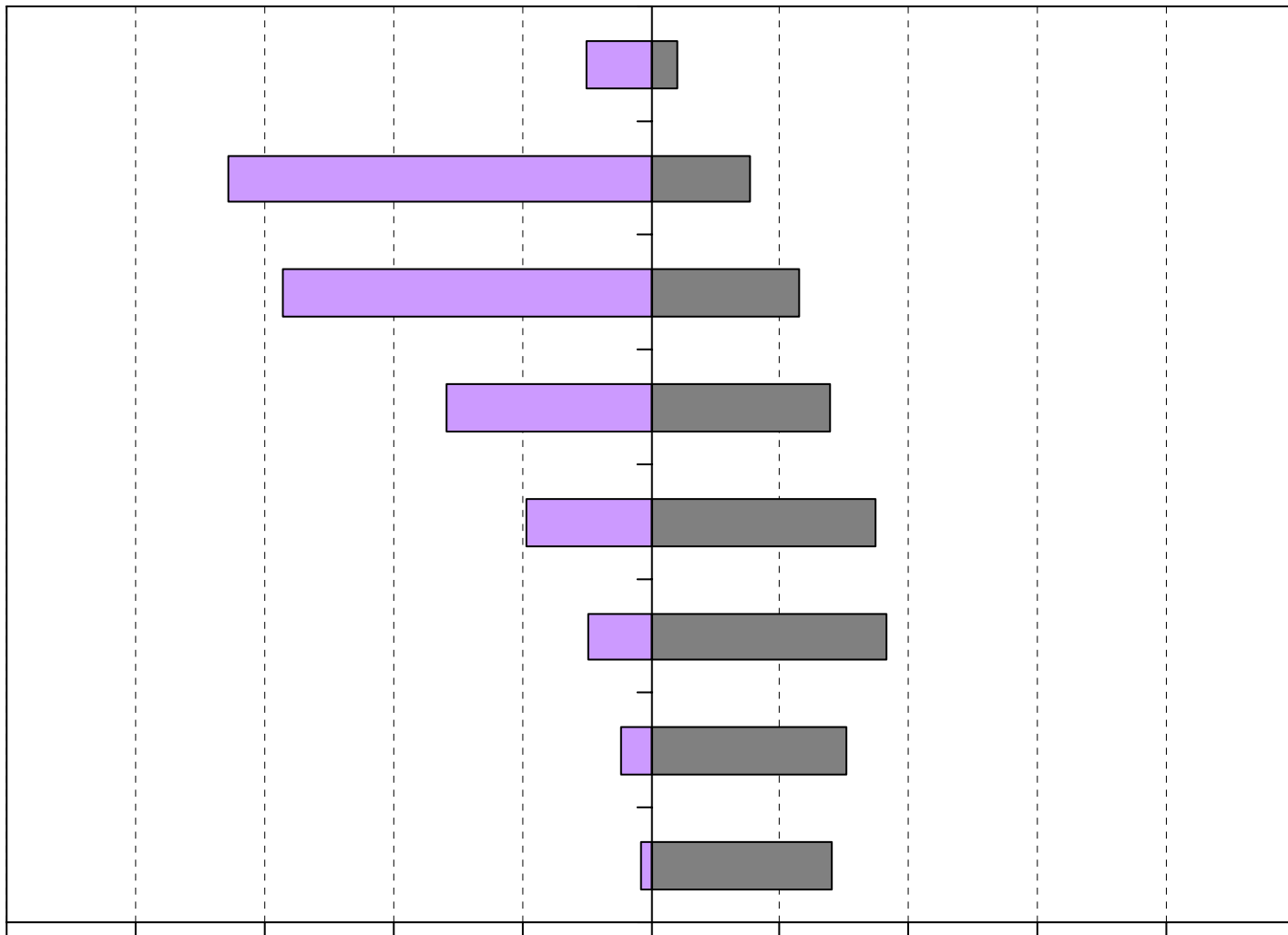
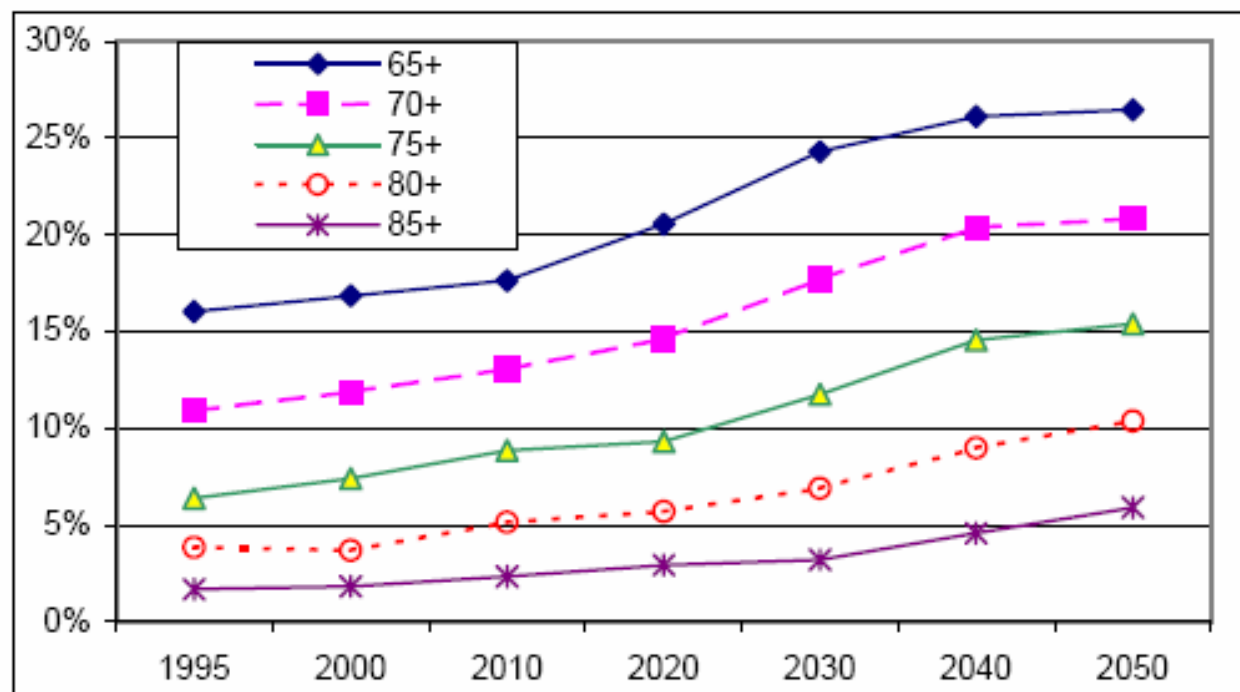
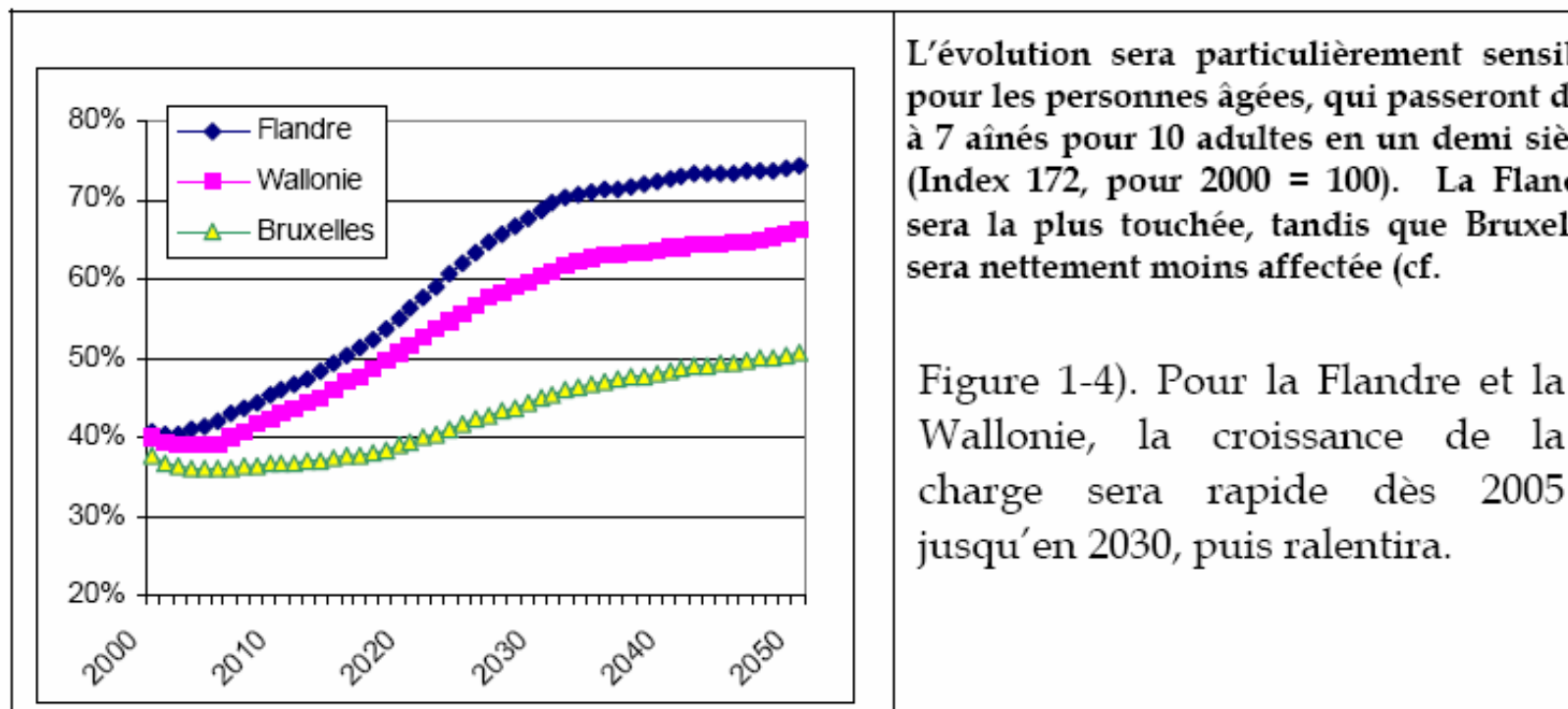


Figure 1-9 - Part des aînés dans la population selon divers groupes d'âges (1995-2050)



Source : Calculs UCL, sur base de INS, Bureau du Plan, Perspectives de population, 2000-2050

Figure 1-4 Rapport de classes d'âges *versus* la population d'âge actif (20-59)

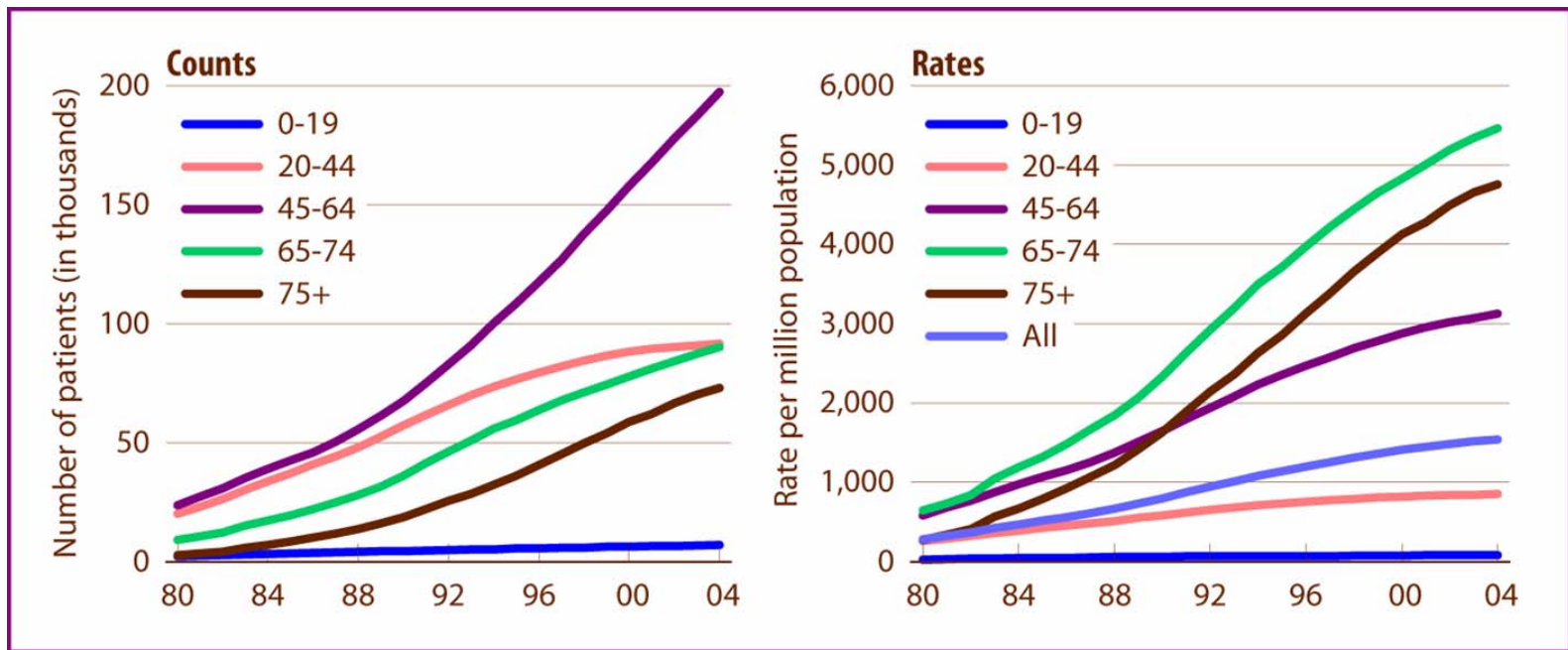


L'évolution sera particulièrement sensible pour les personnes âgées, qui passeront de 10 adultes pour 7 âgés en 2000 à 7 âgés pour 10 adultes en un demi siècle (Index 172, pour 2000 = 100). La Flandre sera la plus touchée, tandis que Bruxelles sera nettement moins affectée (cf.

Figure 1-4). Pour la Flandre et la Wallonie, la croissance de la charge sera rapide dès 2005 jusqu'en 2030, puis ralentira.

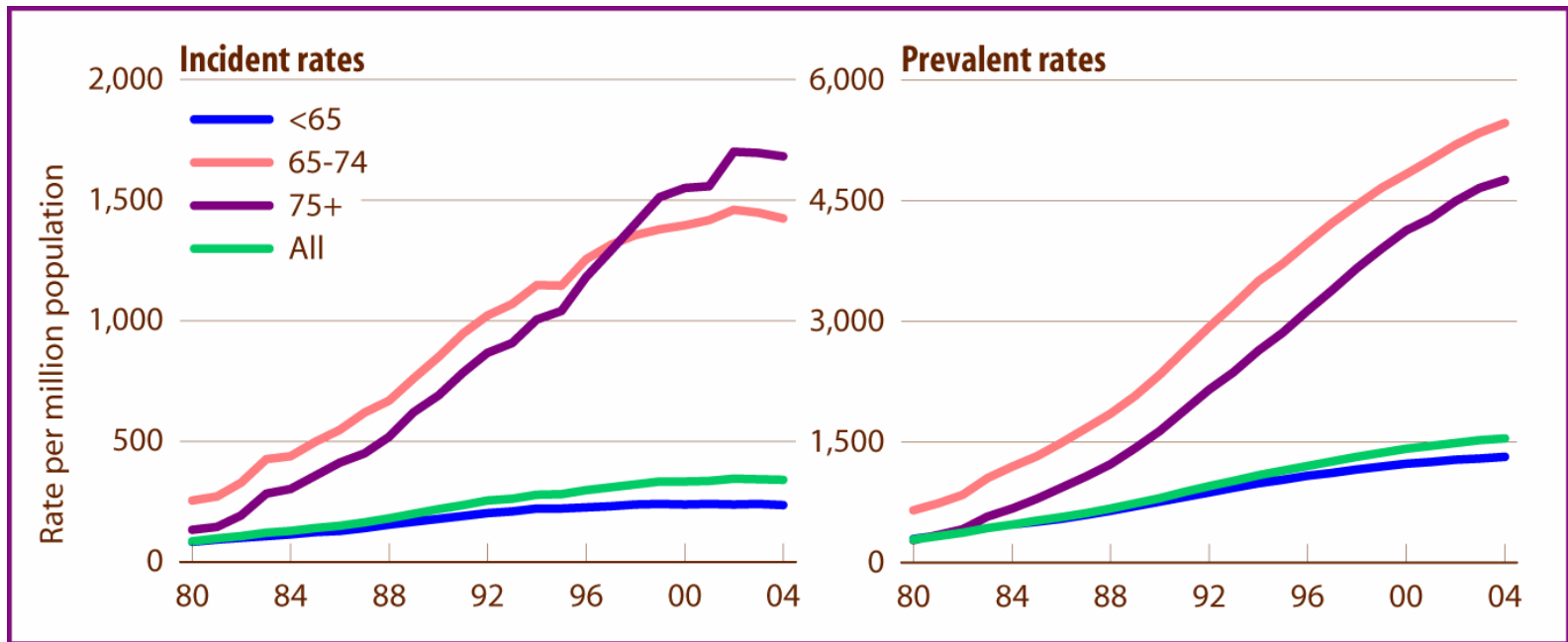
Source : Calculs UCL, sur base des données INS, Bureau du Plan, *Perspectives de population 2000-2050*

Prevalent counts & adjusted rates, by age



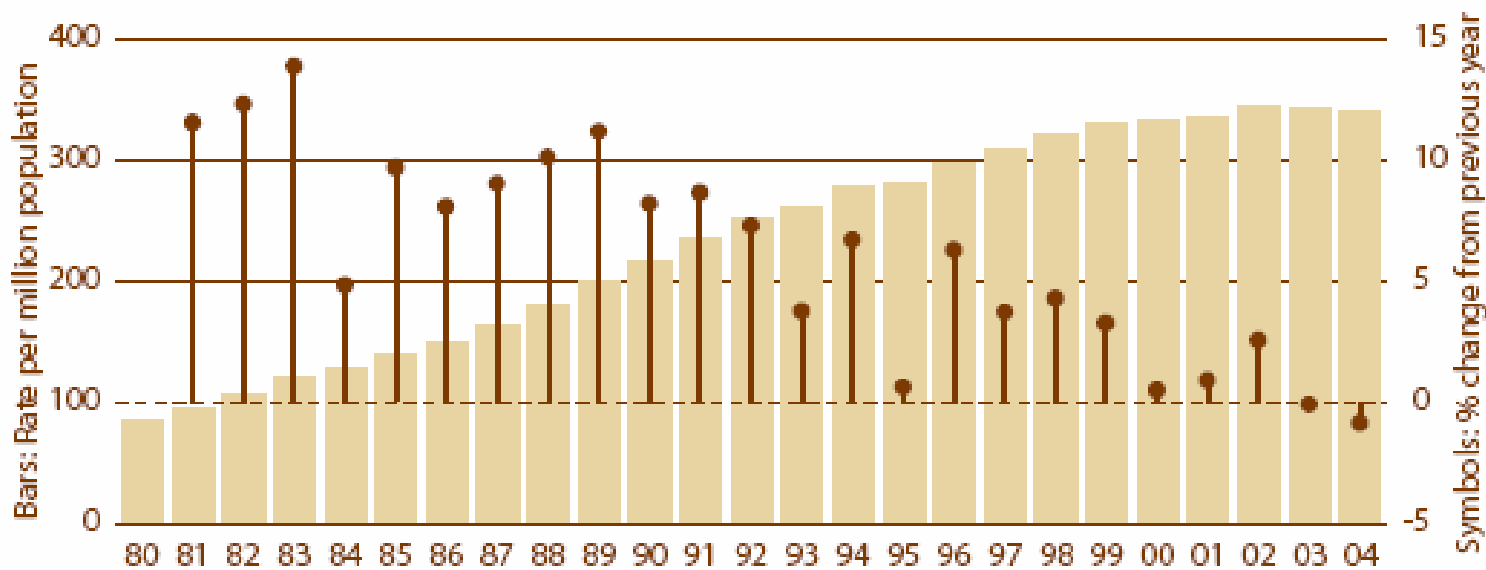
December 31 point prevalent ESRD patients. Rates adjusted for gender & race.

Incident & prevalent ESRD rates, by age

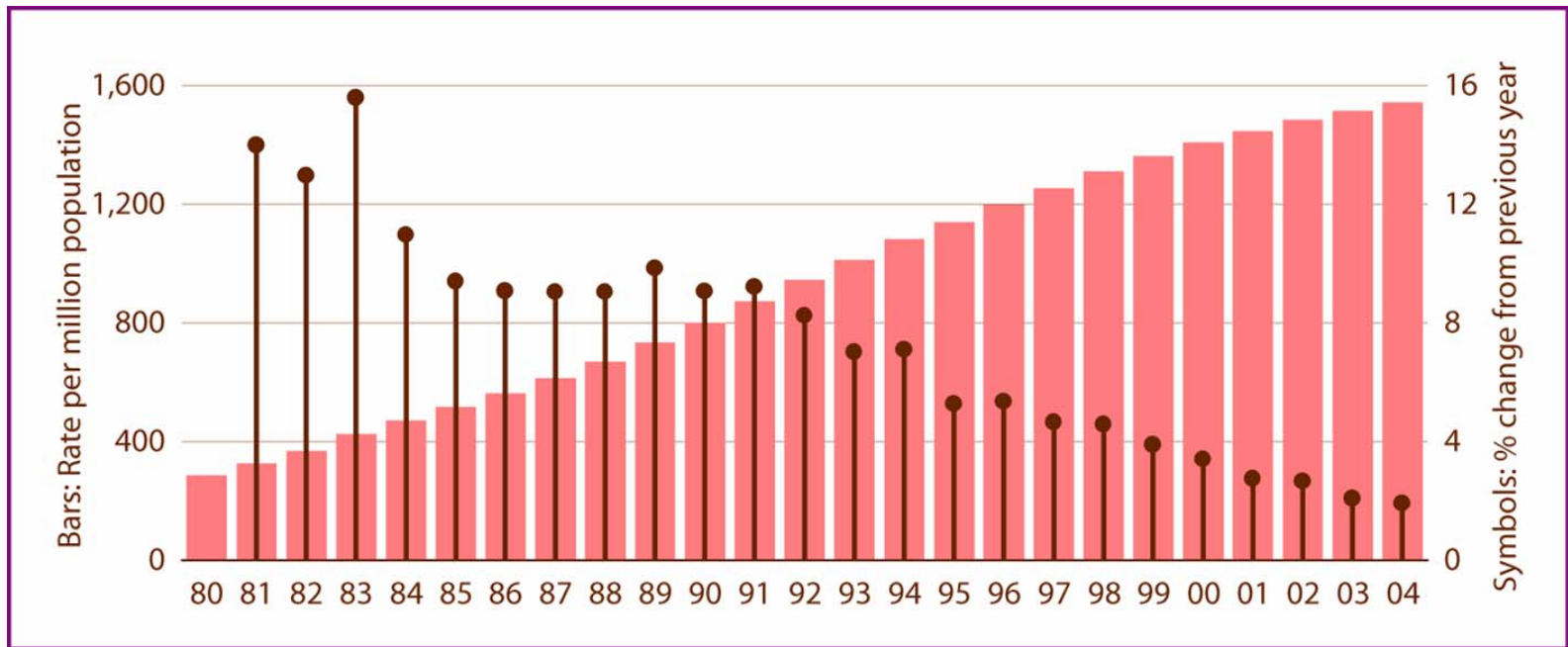


Incident ESRD patients age 75 & older at initiation, & December 31 point prevalent ESRD patients, age 75 & older. Rates adjusted for gender & race.

2.2 Adjusted incident rates & annual percent change incident ESRD patients



Adjusted prevalent rates & annual percent change



December 31 point prevalent ESRD patients. Rates adjusted for age, gender, & race.

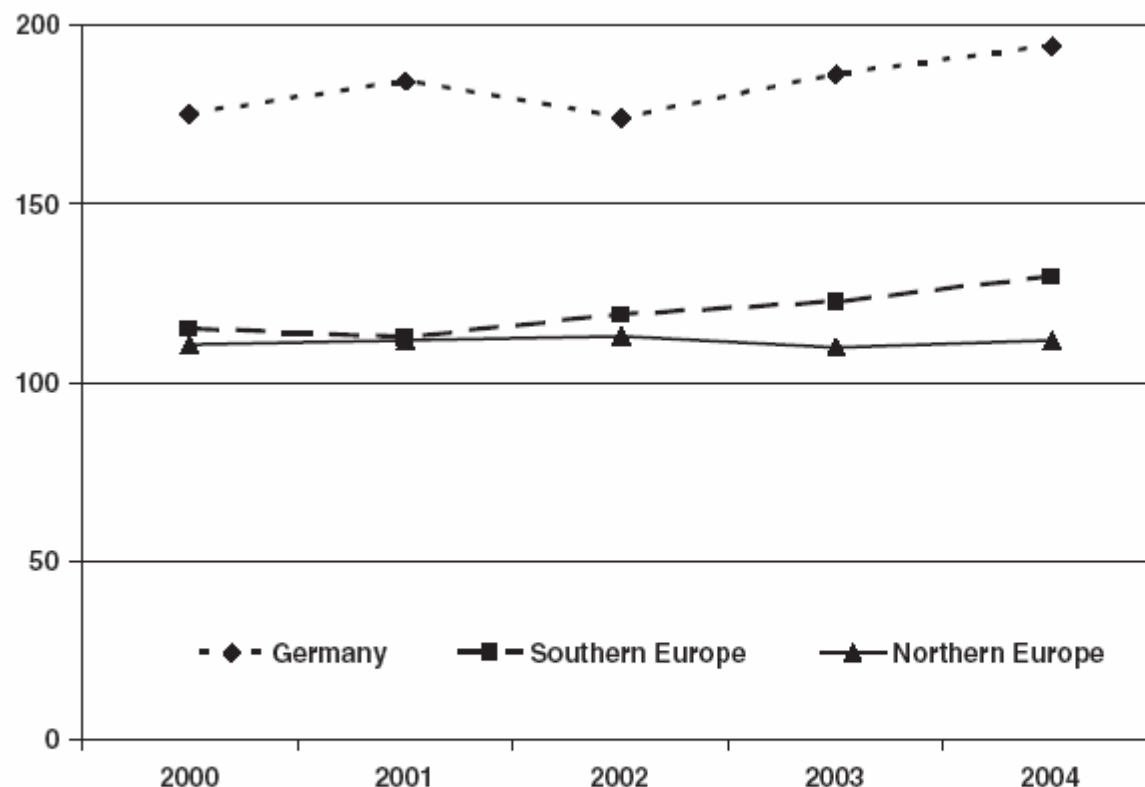
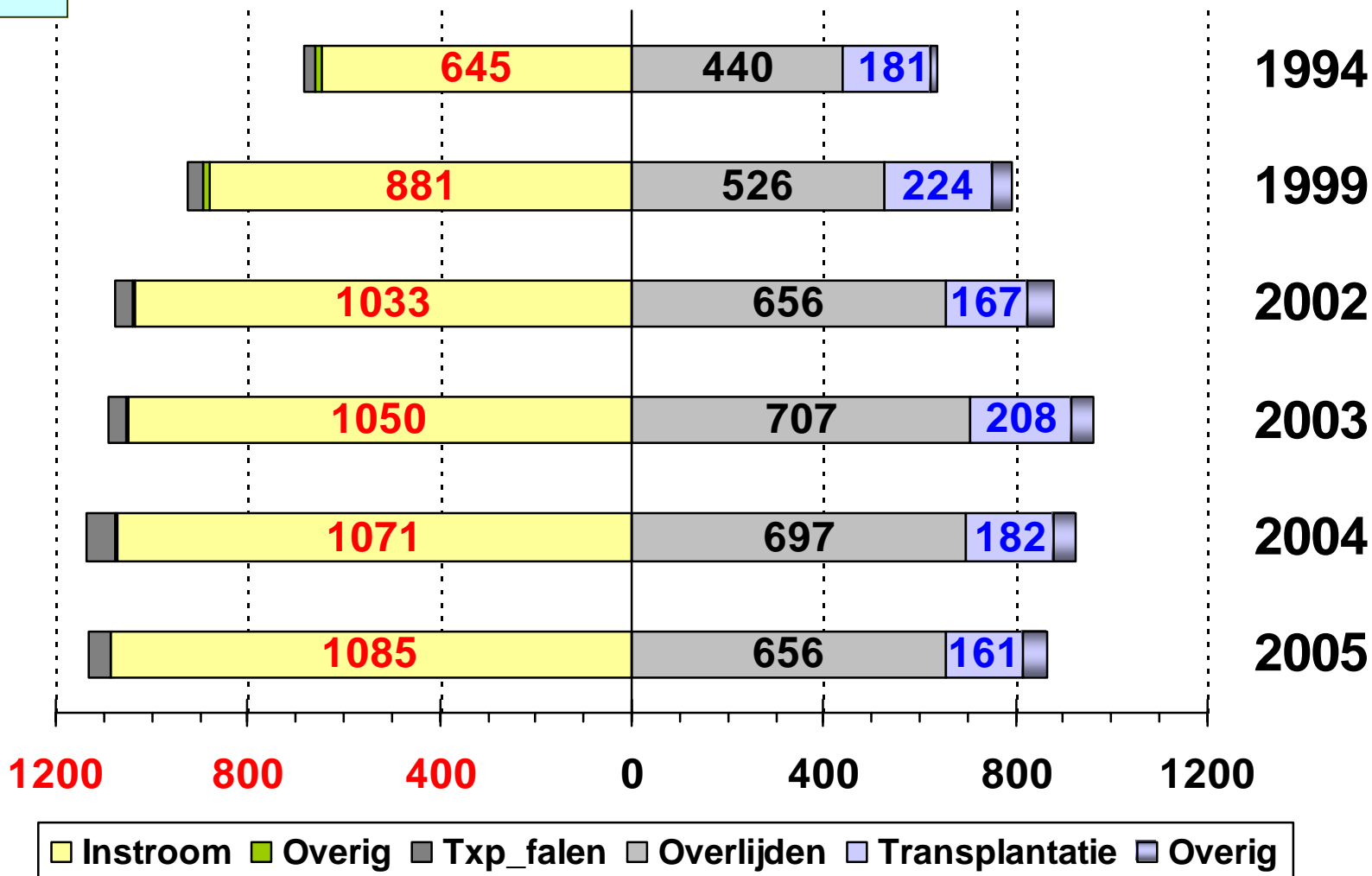


Fig. 1. Incidence rates of RRT in different parts of Europe over the period 2000–2004.

Note: Northern Europe includes the registries of Dutch-speaking and French-speaking Belgium, Denmark, Finland, Iceland, Norway, Sweden, The Netherlands and the registries of England, Wales and Scotland in the United Kingdom. Southern Europe includes the registries of Austria and Greece, the regional registries of Abruzzi, Basilicata, Liguria, Lombardy, Marche, Piedmont, Sardinia, Trentino-Alto Adige, Tuscany, Valle d'Aosta and Veneto (Italy) and the regional registries of Basque country, Catalonia and the Valencian community (Spain). For Northern and Southern Europe the data represent for age and sex adjusted incidence rates; for Germany the data represent crude incidence rates.

Dialyse Patiënten Instroom & Uitstroom

PRE_VIEW



Studies bij niet-diabetisch nierlijden.

Studie	R/	N	FU	PEP	ARR	RRR	NNT	Cr	UProt	BD
AIPRI (7)	benazepril placebo	583	3	31 (10%) 57 (20%)	10%	49%	10,2	2,1	1,8	143/88
REIN str2 (*) (8)	ramipril placebo	166	2,2	18 (23%) 40 (45%)	22%	49%	4,5	2,4	5,3	149/92
REIN str1 (9)	ramipril placebo	186	2,6	9 (9%) 18 (21%)	12%	56%	8,6	2,0	1,7	143/89
AASK (*) (10)	ramipril amlodipine	653	3,8	87 (20%) 56 (26%)	6%	23%	17,1	2,2	0,5	150/96
COOPERATE (11)	losartan+ trandolapril trandolapril	170	2,9	10 (12%) 20 (24%)	12%	50%	8,5	3,0	2,5	130/75
Hou et al. (12)	benazepril placebo	215	3,4	44 (41%) 65 (61%)	20%	33%	5,0	4,0	1,6	152/86

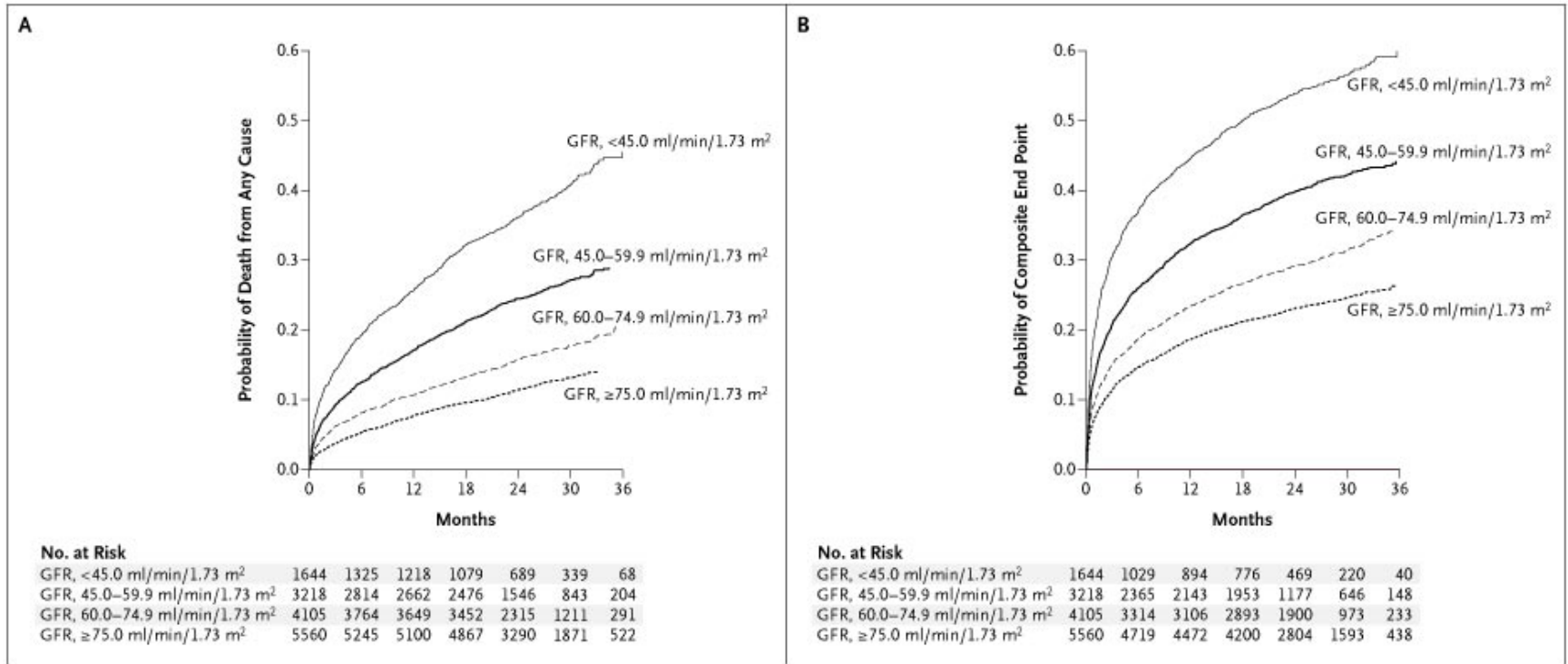
R/ = interventie; N = aantal geïncludeerde patiënten; FU = follow-up in jaren; ARR = absolute risicoreductie; RRR = relatieve risicoreductie; NNT = aantal te behandelen patiënten om één eindpunt te voorkomen; Cr = serumcreatinine; UProt = 2-uurs eiwitexcretie; BD = bloeddruk.

REIN str1 en str2 = stratum 1 en stratum 2 van de REIN-studie met proteïnurie < 3 g, respectievelijk > 3 g/dag.

De REIN- en AASK-studies hadden ook de verandering van GFR per jaar als eindpunt.

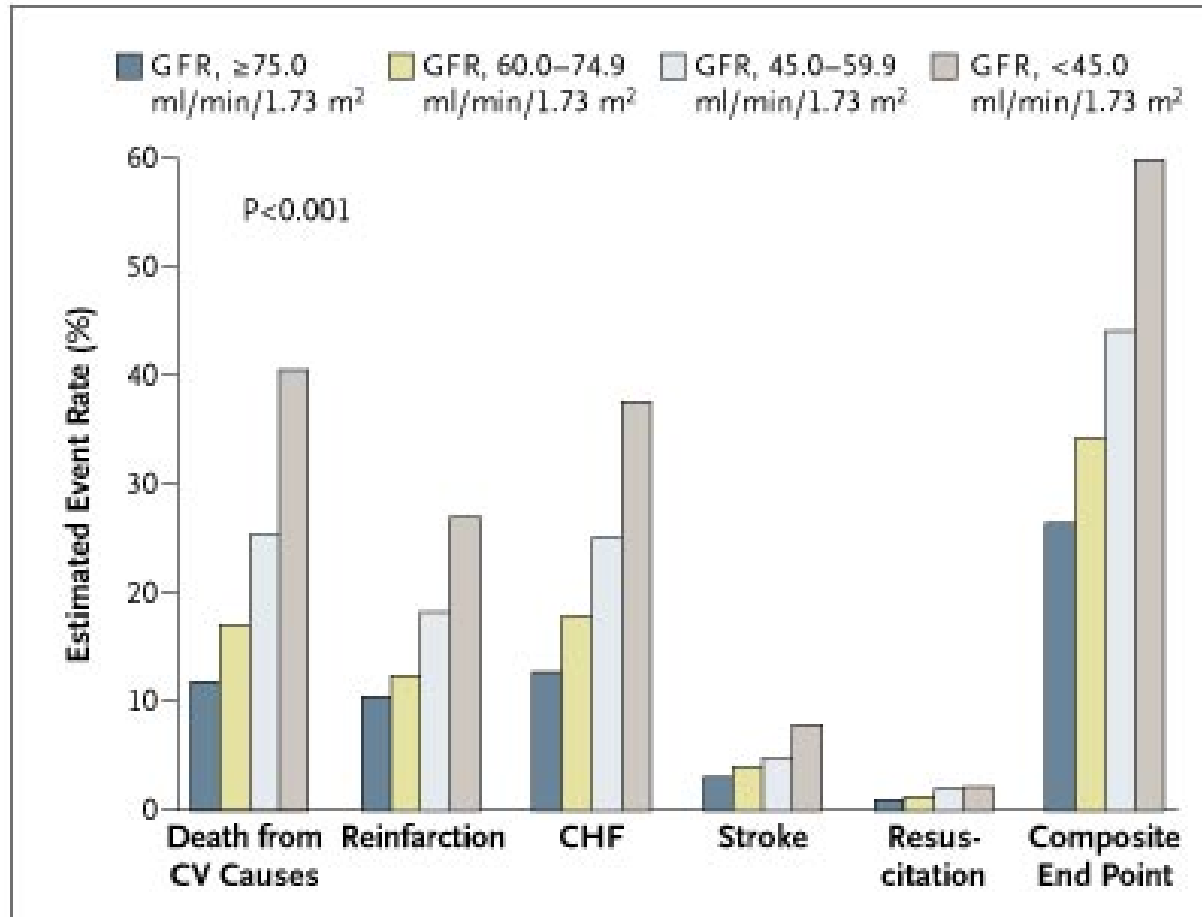
(*) vroegtijdige beëindiging van de studie.

Kaplan-Meier Estimates of the Rates of Death at Three Years from Any Cause (Panel A) and of the Cardiovascular Composite End Point (Panel B), According to the Estimated GFR at Baseline



Subanalysis VALIANT

Kaplan-Meier Estimates of the Rates of Death at Three Years from Cardiovascular (CV) Causes, Reinfarction, Congestive Heart Failure (CHF), Stroke, Resuscitation after Cardiac Arrest, and the Composite End Point, According to the Estimated GFR at Baseline



International Comparison of the Relationship of Chronic Kidney Disease Prevalence and ESRD Risk (HUNT II)

Stein I. Hallan,^{*†} Josef Coresh,^{‡§} Brad C. Astor,[‡] Arne Åsberg,^{||} Neil R. Powe,^{‡§} Solfrid Romundstad,^{¶**} Hans A. Hallan,[¶] Stian Lydersen,[†] and Jostein Holmen^{**}

Table 1. Prevalence of normal and decreased kidney function in the HUNT II study by demographics and clinical characteristics (Norway, 1995 to 1997)^a

	Overall		Prevalence of eGFR Category (ml/min per 1.73 m ²)			
	No. of Participants	% of Study Population	≥90	60 to 89	30 to 59	15 to 29
Total	65,181	100	56.7 (0.2)	38.6 (0.2)	4.5 (0.1)	0.16 (0.01)
Gender						
male	30,480	46.8	62.4 (0.3)	34.0 (0.3)	3.4 (0.1)	0.17 (0.02)
female	34,701	53.2	51.6 (0.3)	42.7 (0.3)	5.5 (0.1)	0.16 (0.02)
Age (yr)						
20 to 39	20,190	31.0	82.5 (0.3)	17.3 (0.3)	0.2 (0.03)	0.02 (0.01)
40 to 59	24,666	37.8	58.2 (0.3)	40.4 (0.3)	1.4 (0.1)	0.02 (0.01)
60 to 69	9040	13.9	36.7 (0.5)	56.9 (0.5)	6.1 (0.3)	0.22 (0.05)
>70	11,285	17.3	23.2 (0.4)	58.1 (0.5)	17.9 (0.4)	0.71 (0.07)
Diabetes ^b						
no	62,554	96.6	57.6 (0.2)	38.2 (0.2)	4.0 (0.1)	0.12 (0.01)
yes	2174	3.4	35.9 (1.0)	49.4 (1.1)	13.6 (0.8)	0.83 (0.2)
Hypertension ^c						
no	35,636	55.2	67.2 (0.3)	30.9 (0.3)	1.8 (0.1)	0.10 (0.01)
untreated	21,784	33.7	50.0 (0.3)	44.7 (0.4)	5.2 (0.2)	0.13 (0.02)
treated	7191	11.1	28.2 (0.5)	55.6 (0.6)	15.5 (0.4)	0.61 (0.1)

^aData are % (SE), except where indicated. HUNT II, Health Survey of Nord-Trøndelag County.

^bSelf-reported diabetes or venous plasma glucose ≥200 mg/dl (11.2 mmol/L).

^cSystolic BP ≥140 mmHg or diastolic BP ≥90 mmHg or taking antihypertensive medication.

CKD prevalence and ESRD incidence

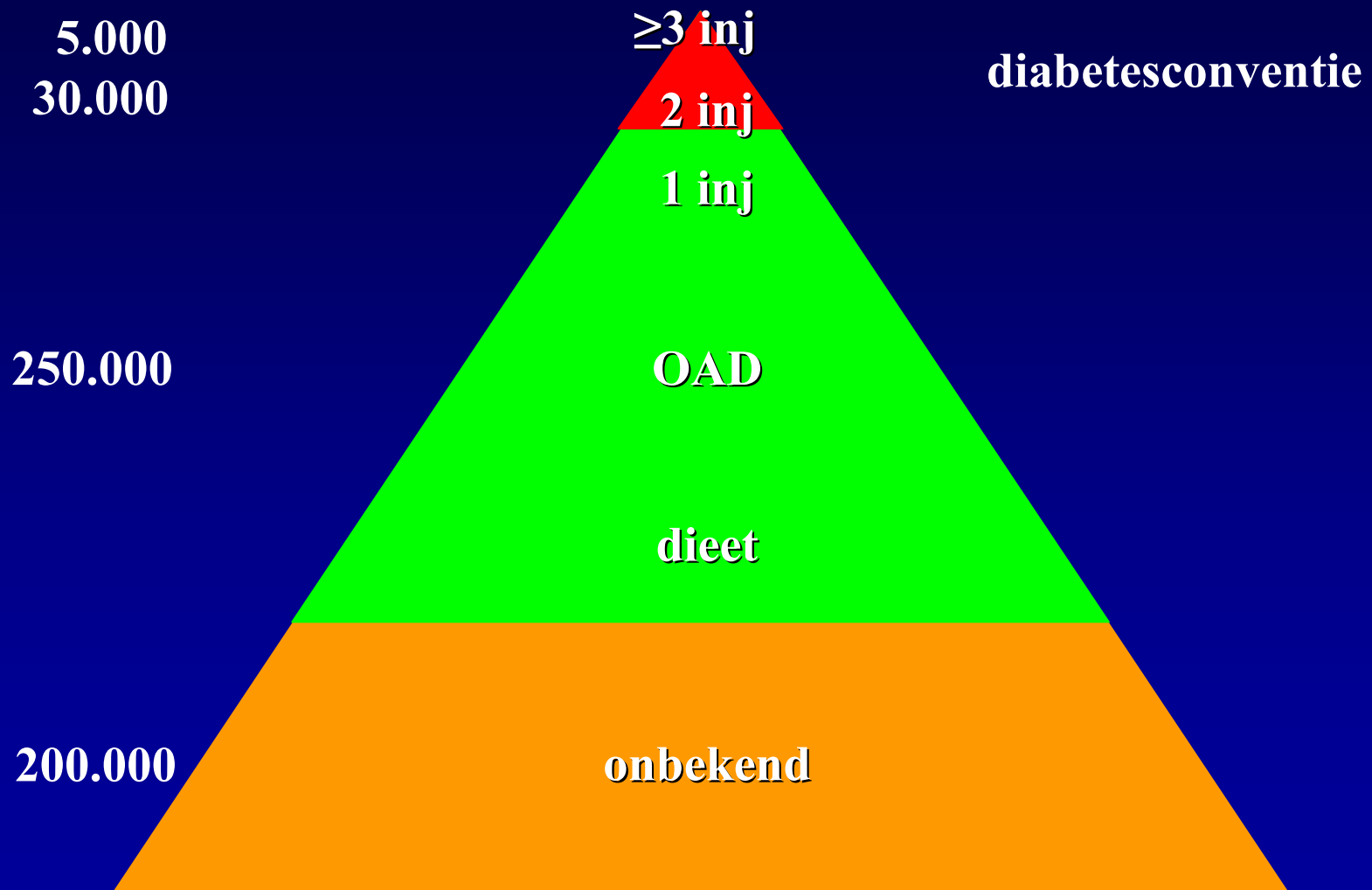
Prevalence of CKD stages 1 through 4 in Norway and the United States

	Norway	United States	United States	United States	United States
	1995 to 1997	1988 to 1994			1999 to 2000
	White(n = 65,181) ^b	White(n = 6635)	Black(n = 4163)	Overall (n =15,625)	Overall(n= 4104)
stage					
1	2.7 (0.3)	2.8 (0.3)	5.8 (0.3)	3.3 (0.3)	3.8 (0.5)
2	3.2 (0.4)	3.2 (0.3)	2.5 (0.3)	3.0 (0.3)	4.0 (0.5)
3	4.2 (0.1)	4.8 (0.3)	3.1 (0.2)	4.3 (0.3)	3.7 (0.4)
4	0.16 (0.01)	0.21 (0.03)	0.25 (0.08)	0.20 (0.03)	0.13 (0.06)
Total	10.2 (0.5)	11.0 (0.6)	11.6 (0.5)	11.0 (0.5)	11.7 (0.8)

	Norway	United States		
	Norway	White	Black	Total
ESRD incidence (per million inhabitants/y)	79	222	672	285
diabetes	9	92	231	111
hypertension	20	49	222	61
glomerulonephritis	20	35	73	34
cystic kidney diseases	7	9	11	8
Age (yr; mean) ^{b,c}	62	62	57	60
Unable to ambulate or transfer (%) ^{c,d}	9	7	7	7
GFR (ml/min per 1.73 m ²) ^{b,c}	7.6	7.8	7.4	7.7
Predialysis care by a nephrologist ^{d,e}				
duration (mo; median)	23	13	8	12
duration (%; <4 mo)	19	28	37	30
5 visits (%)	73	NA	NA	41
Transplantation as first treatment (%) ^{b,c}	11	3	1	2
Arteriovenous fistula as first access (%) ^c	32	17	14	17
Predialysis treatment with erythropoietin (43	26	20	24
Hemoglobin (g/dl) ^{c,d}	10.6	9.7	9.1	9.5
Albumin (g/L) ^{c,d}	36	32	31	32

Characteristics of incident patients at start of ESRD treatment in Norway and the United States regarding incidence rates, causes, treatment indications, and predialysis care (1995 to 1997)^a

type 2 diabetes in België : 2002



DM Prevalentie Nederland

type 1 diabetes mellitus

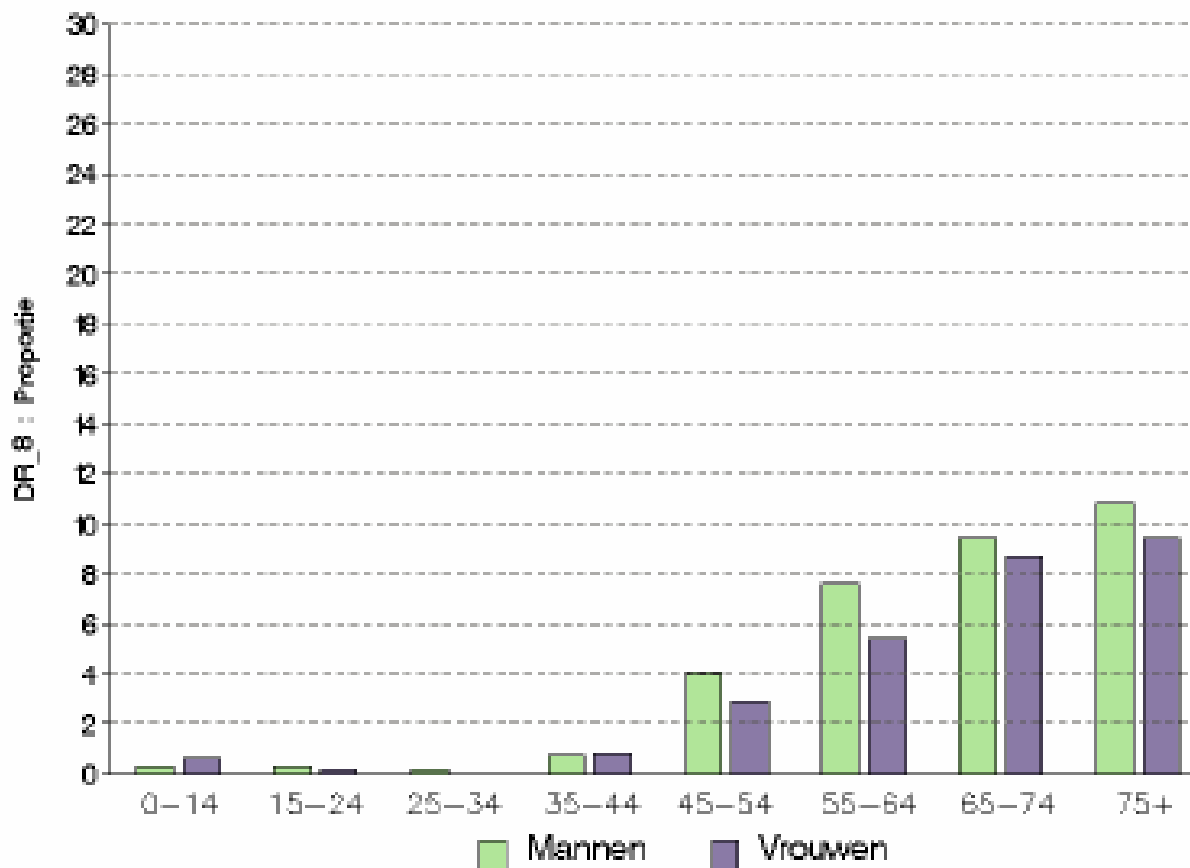
type 2 diabetes mellitus

	mannen	vrouwen	mannen	vrouwen
0-14	0,5	1,8	0	0
15-24	2,5	4,2	1,6	0
25-44	1,8	3,7	5,1	4,7
45-64	6,7	5,7	63,9	43,9
65-74	12,1	7,1	137,6	145,1
75+	7,8	16,7	143,6	156,1
totaal (per 1.000)	3,9	5,2	34,6	36,3
totaal (absoluut)	31.300	42.700	287.200	297.700

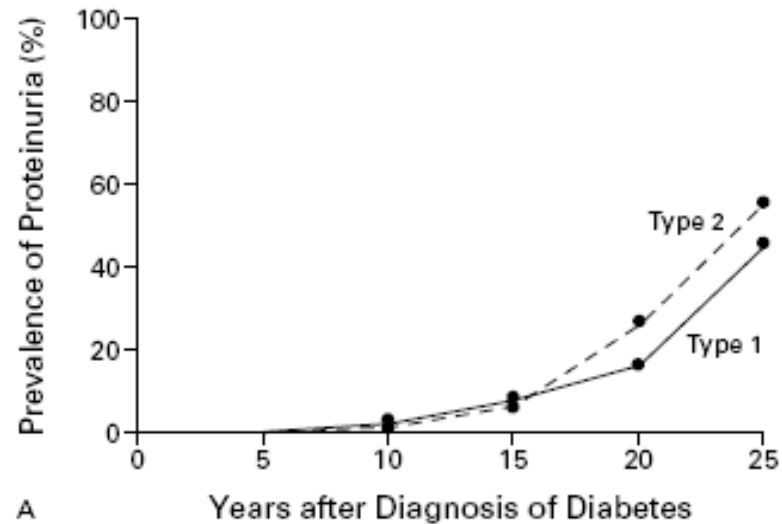
Gezondheidsenquête, België 2004

Gebruik van specifieke soorten geneesmiddelen in de afgelopen 24 uur, volgens geslacht en leeftijd

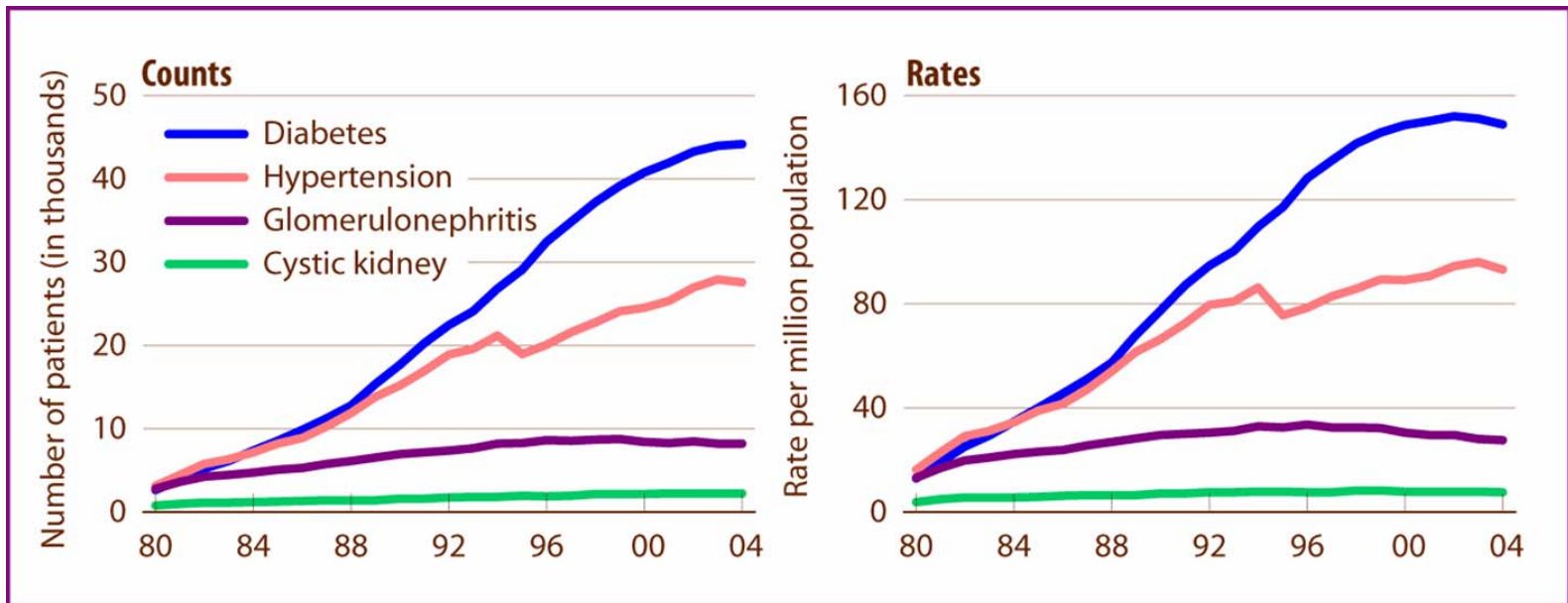
Geneesmiddelen voor diabetes (ATC: A10)



Nierziekte en duur van diabetes



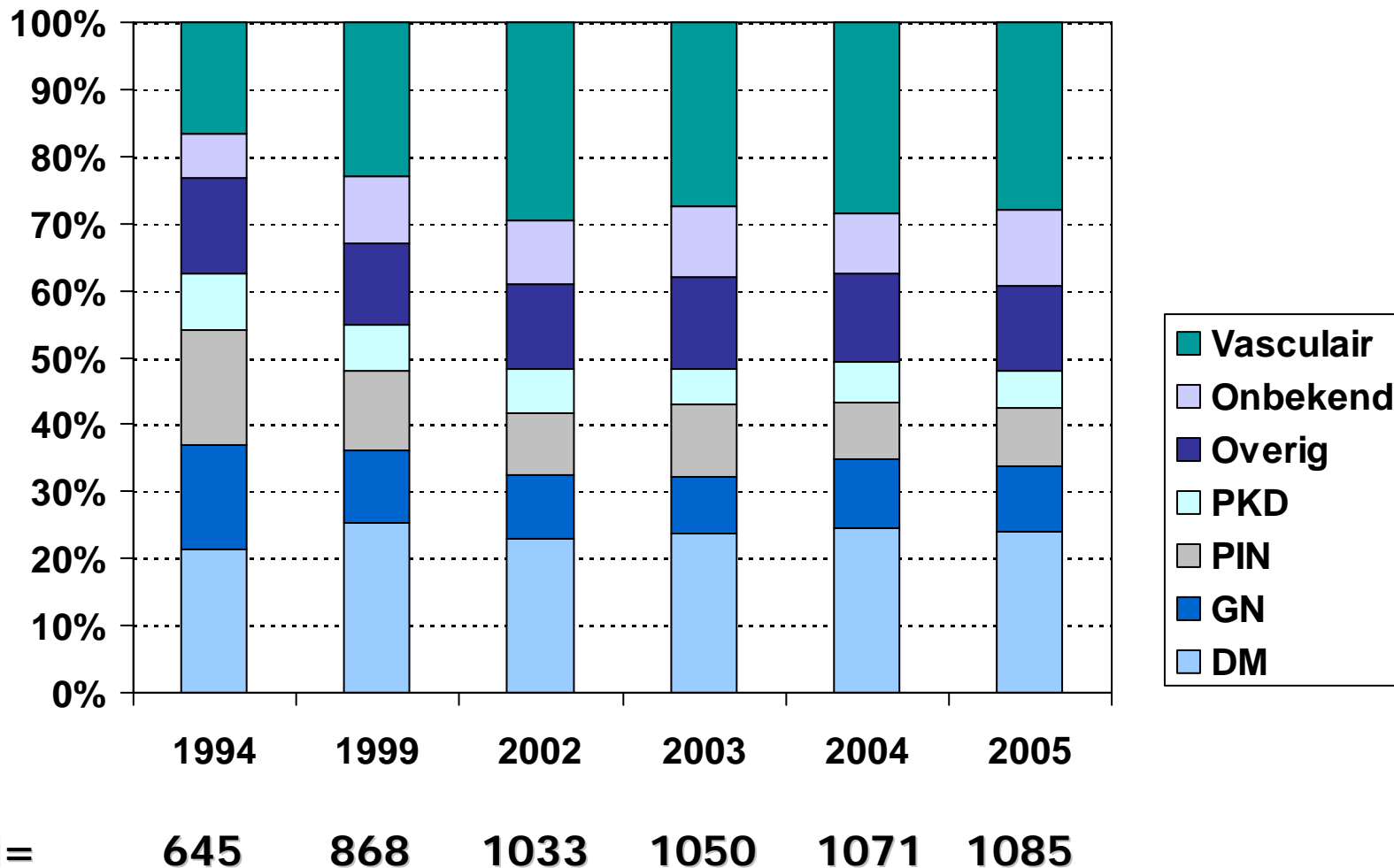
Incident counts & adjusted rates, by primary diagnosis



Incident ESRD patients. Rates adjusted for age, gender, & race.

Dialyse Patiënten – Instroom : **Nierziekte**

PRE_VIEW



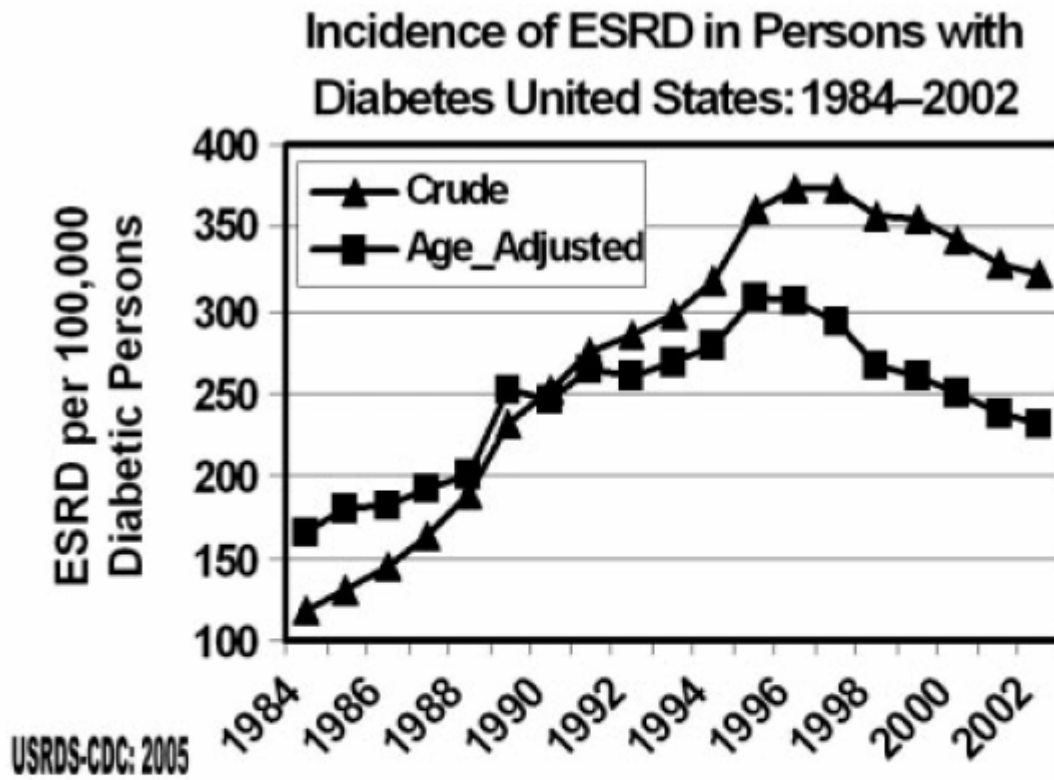
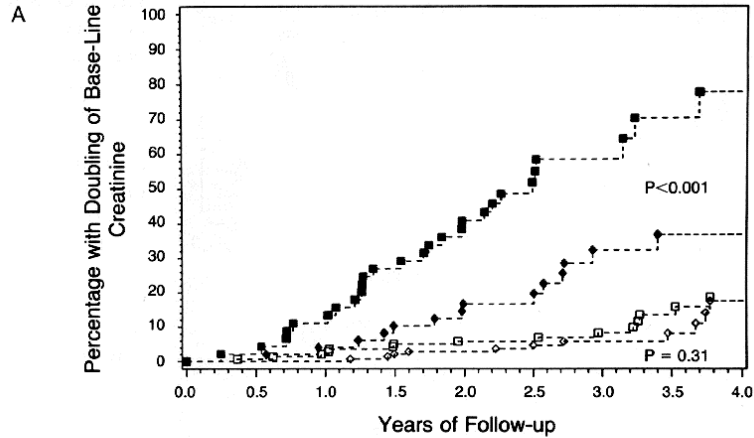
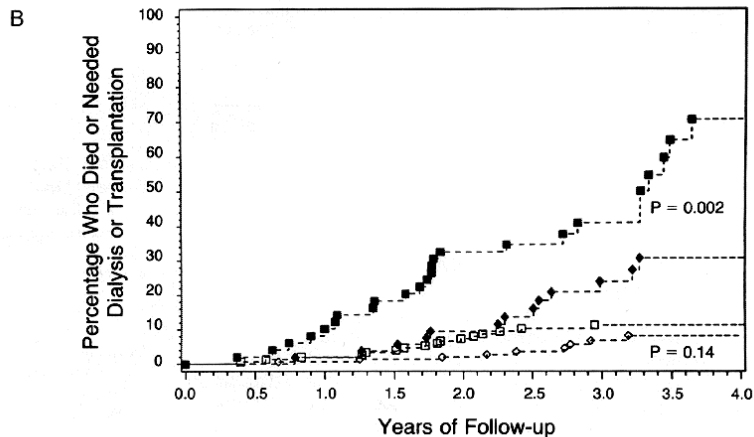


Fig. 3. A key inference indicating a favourable trend in the pandemic of diabetes is evident as both crude and age-adjusted incident rates of new onset ESRD per 100 000 persons with diabetes declining outcomes in incidence starting in 1995. This observation was first noted in the Centers for Disease Control and Prevention (CDC)'s Weekly Morbidity and Mortality Report in November 2005 [8]. From this finding, the subsidence of the pandemic of ESRD in persons with diabetes is inferred.

IDDM 1 en ACE-I



Creatinine \geq 1.5 mg/dl										
■	Placebo	49	44	39	32	25	15	8	4	1
◆	Captopril	53	50	46	42	37	28	17	13	3
Creatinine < 1.5 mg/dl										
□	Placebo	153	140	134	129	117	84	67	41	21
◇	Captopril	154	149	144	138	130	92	65	37	21



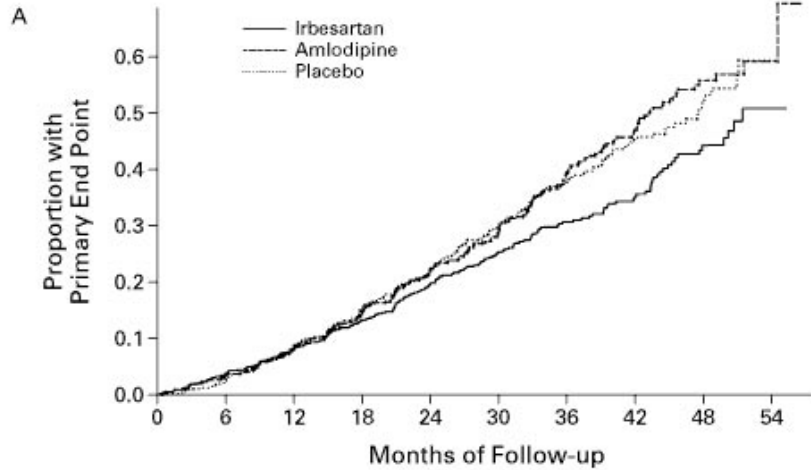
Creatinine \geq 1.5 mg/dl										
■	Placebo	49	48	44	40	33	23	16	7	1
◆	Captopril	53	53	52	51	48	36	25	17	8
Creatinine < 1.5 mg/dl										
□	Placebo	153	150	148	146	138	98	84	52	25
◇	Captopril	154	154	152	150	147	104	78	47	29

The Effect of Angiotensin-Converting-Enzyme Inhibition on Diabetic Nephropathy

Edmund J. Lewis, Lawrence G. Hunsicker, Raymond P. Bain, Richard D Rohde, for The Collaborative Study Group

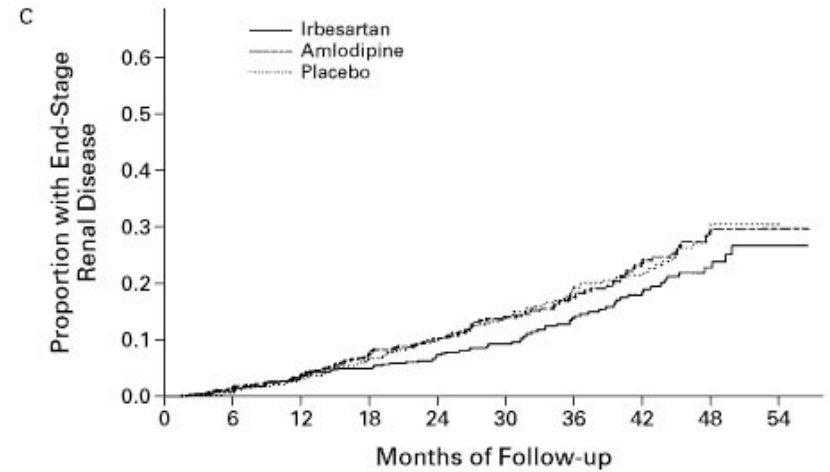
NEJM 1993

DM2 en ARA



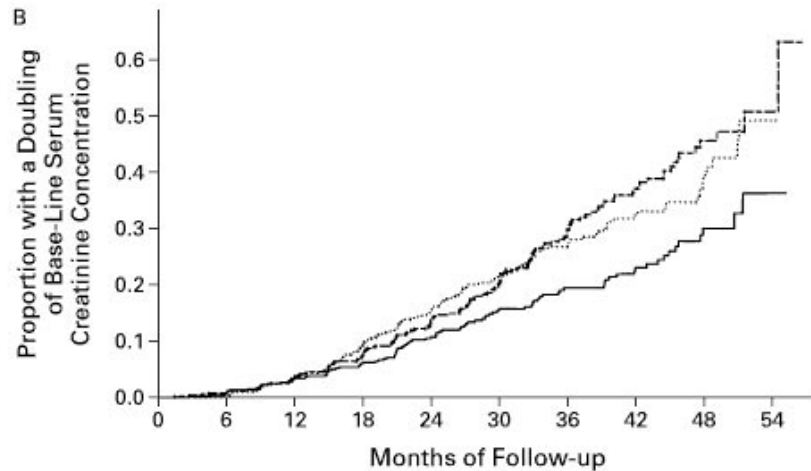
No. AT RISK

	0	6	12	18	24	30	36	42	48	54
Irbesartan	579	555	528	496	400	304	216	146	65	
Amlodipine	565	542	508	474	385	287	187	128	46	
Placebo	568	551	512	471	401	280	190	122	53	



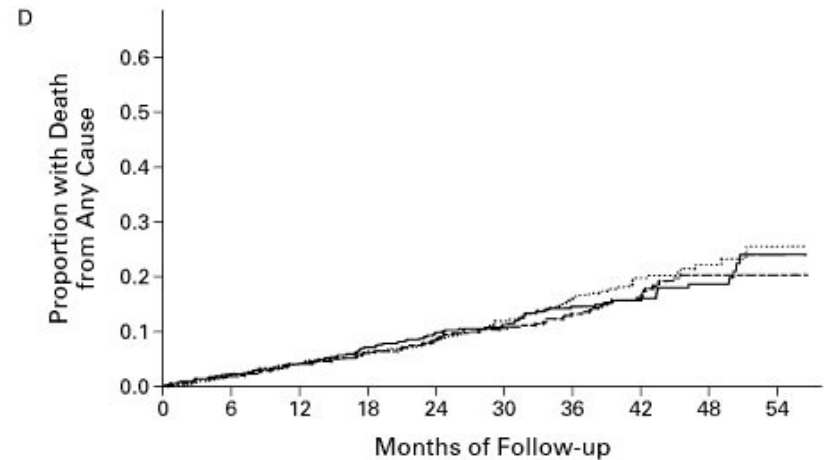
No. AT RISK

	0	6	12	18	24	30	36	42	48	54
Irbesartan	579	549	523	501	418	327	234	162	78	7
Amlodipine	565	538	510	482	408	310	221	152	58	7
Placebo	568	542	517	487	418	302	205	141	63	2



No. AT RISK

	0	6	12	18	24	30	36	42	48	54
Irbesartan	579	534	495	457	363	273	191	131	57	5
Amlodipine	567	516	476	439	347	254	166	108	40	5
Placebo	569	527	482	436	360	252	173	107	47	2



No. AT RISK

	0	6	12	18	24	30	36	42	48	54
Irbesartan	579	563	550	530	452	355	264	196	99	10
Amlodipine	567	552	536	524	457	358	266	201	83	9
Placebo	569	553	539	522	465	354	255	185	94	7

Studies bij diabetes type 1 en type 2.

Studie	R/	N	FU	PEP	ARR	RRR	NNT	Cr	UA1b	BD
Lewis et al. (†) (2)	captopril placebo	402	3	25 (13%) 43 (21%)	9%	41%	11,4	1,3	2,5	138/85
IDNT (3)	irbesartan amlodipine	1146	2,6	189 (33%) 233 (41%)	8%	21%	11,8	1,7	1,9	159/87
IDNT (3)	irbesartan placebo	1148		189 (33%) 222 (39%)	6%	16%	15,7			
RENAAL (4)	losartan placebo	1513	3,4	327 (44%) 359 (47%)	4%	8%	28,0	1,9	1,2	152/82
IRMA (**) (5)	irbesartan placebo	345	2	10 (6%) 30 (18%)	12%	67%	8,5	1,0	< 0,3	153/90
BENEDICT (6)	trandolapril verapamil	604	3,6	18 (6%) 36 (12%)	6%	50%	16,9	0,9	< 0,03	150/87
BENEDICT (6)	trandolapril placebo	1204		35 (6%) 66 (11%)	5%	47%	19,5			

R/ = interventie; N = aantal geïncludeerde patiënten; FU = follow-up in jaren; ARR = absolute risicoreductie; RRR = relatieve risicoreductie; NNT = aantal te behandelen patiënten om één eindpunt te voorkomen; Cr = serumcreatinine; UA1b = 24-uurs urinaire albumine-excretie; BD = bloeddruk.

(†) studie bij diabetes type 1, alle andere studies werden uitgevoerd bij diabetes type 2.

(**) irbesartan 300 mg-arm

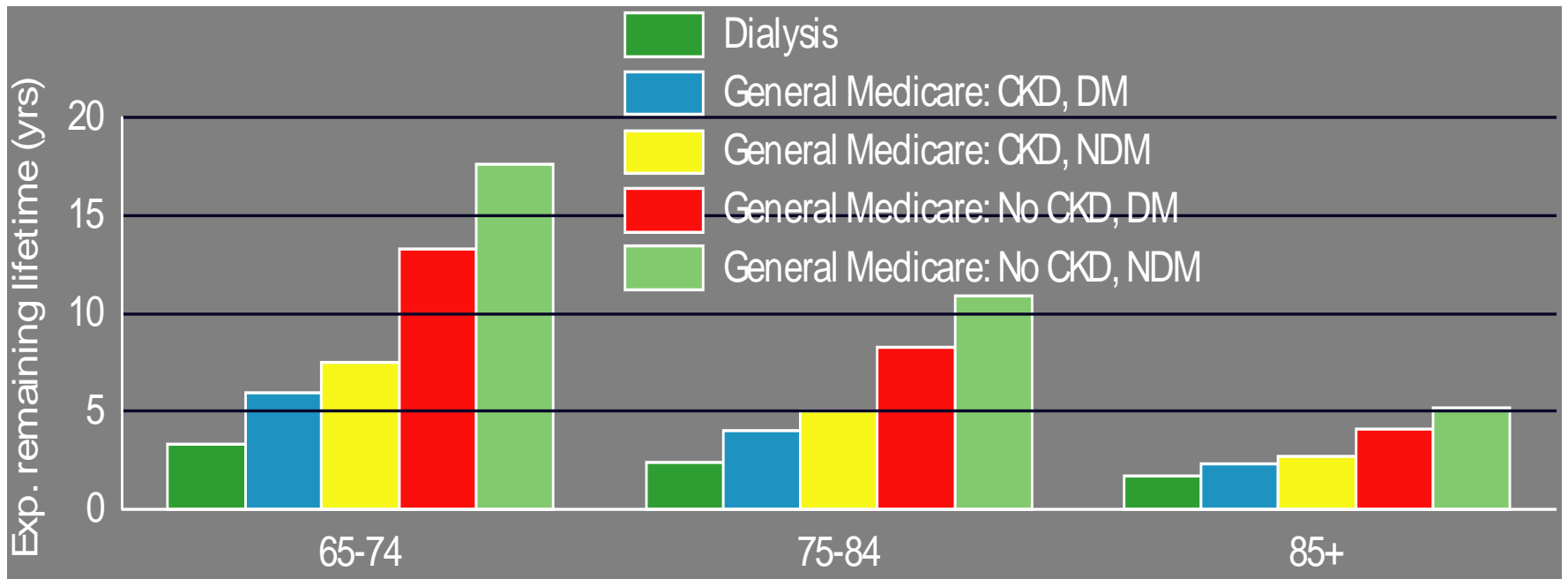
Mortaliteit met diabetes

Nederlandse LASA-studie

Na acht jaar ruim 40% van de oudere patiënten overleden

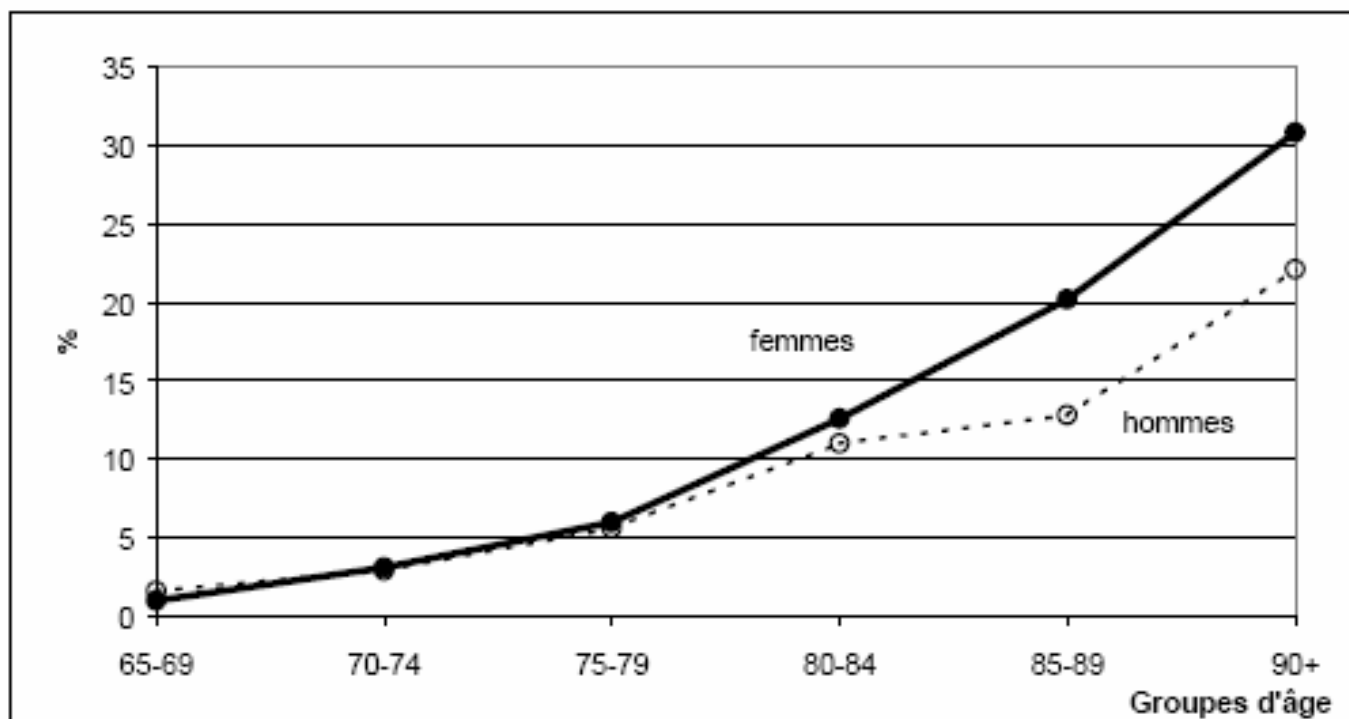
jaren na beginmeting	Mannen		Vrouwen	
	met diabetes	zonder diabetes	met diabetes	zonder diabetes
0	100	100	100	100
1	90,8	97,3	94	98,3
5	61,7	84,3	66,6	90
8	54,1	77	60,3	84,4

Levensverwachting en nierziekte




Prevalentie van dementie in Europa

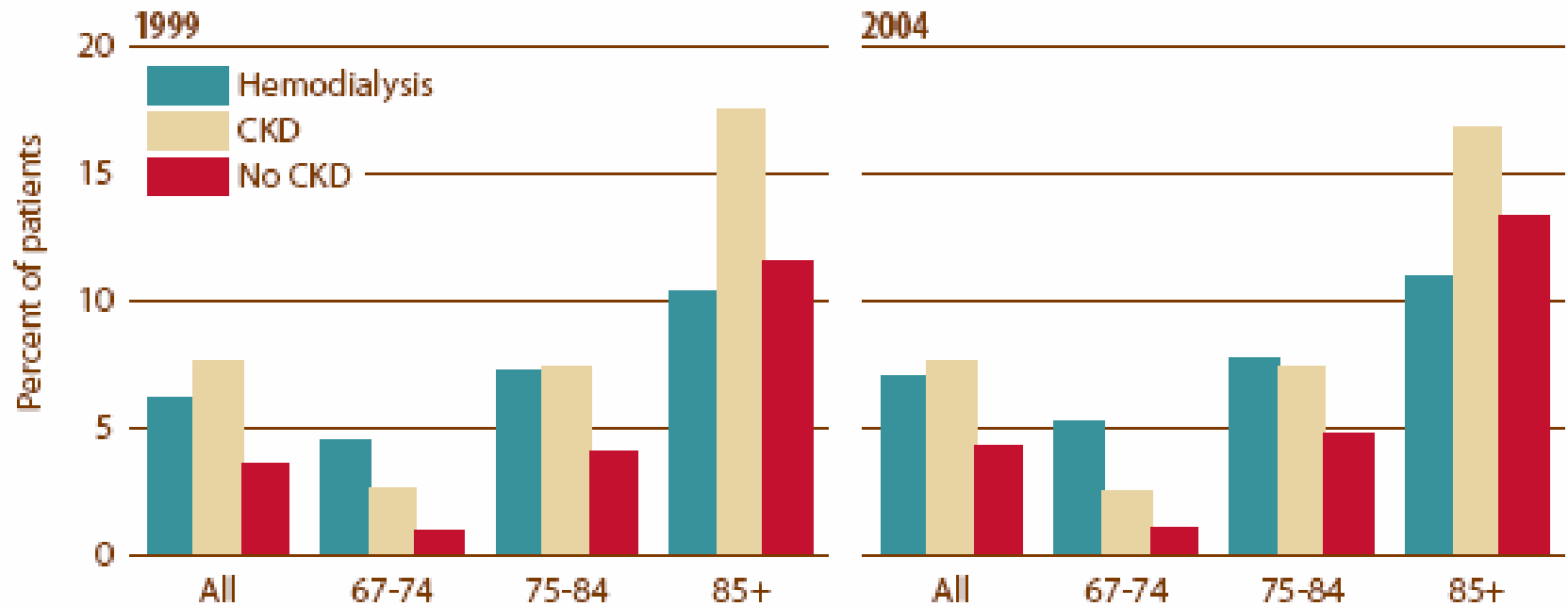
Figure 2.25 Prévalence des démences toutes causes par groupe d'âges et genre.



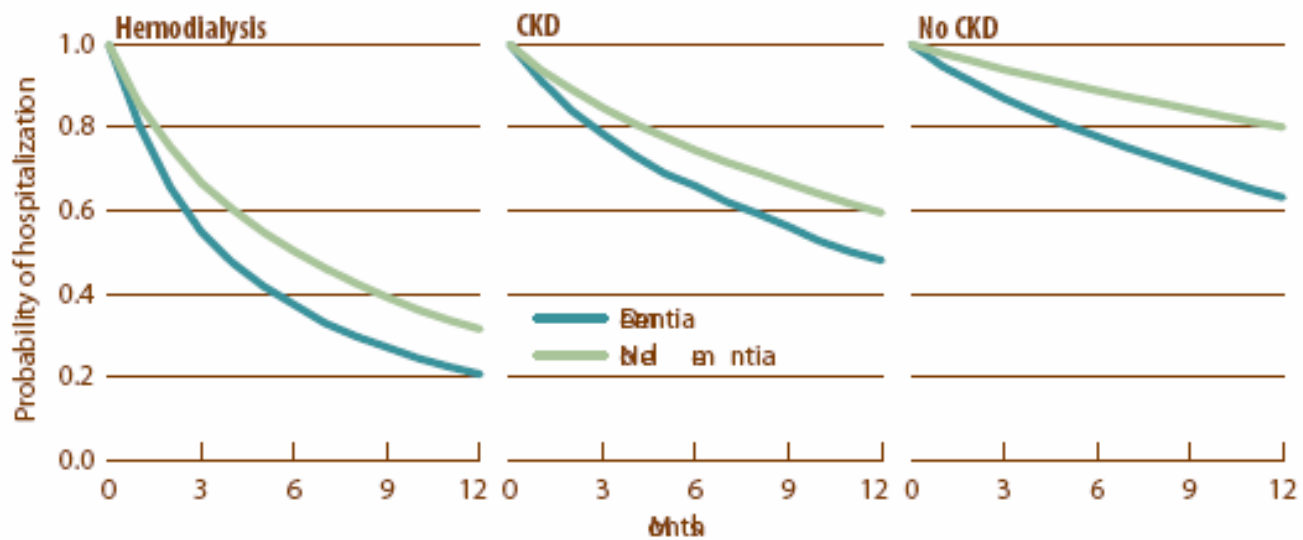
Source : Lobo, 2000 (« Pooled analyse », Europe).

PREVALENT DEMENTIA IN PREVALENT PATIENTS

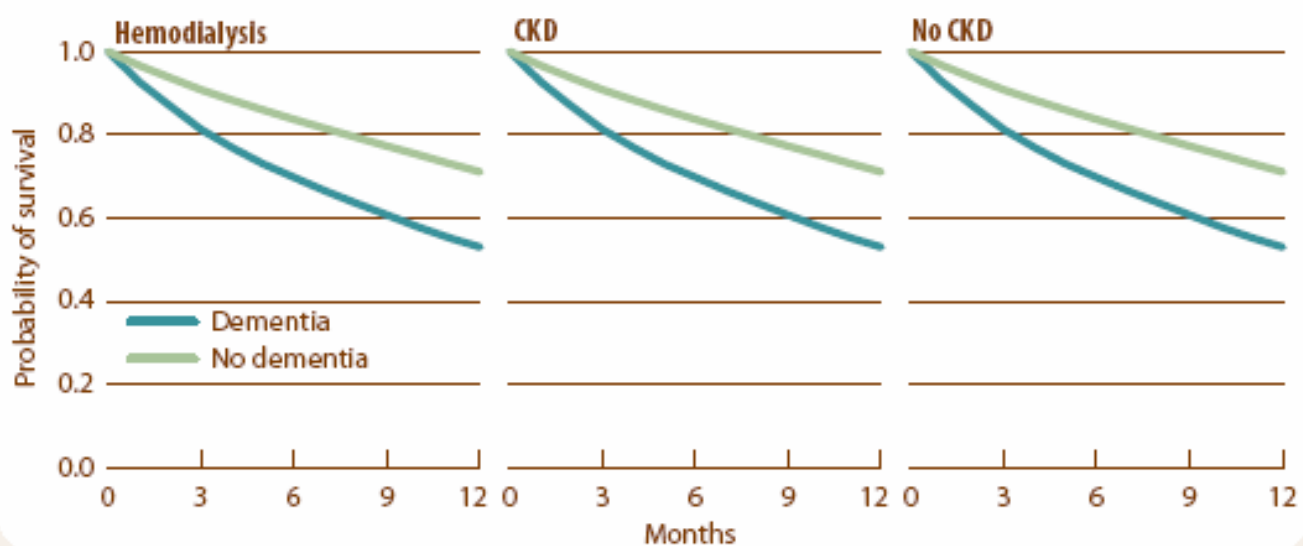
6.43 Occurrence of dementia, by age & time period  point prevalent patients



6.45 Event-free probability of hospitalization in patients with or without dementia point prevalent patients, 2004

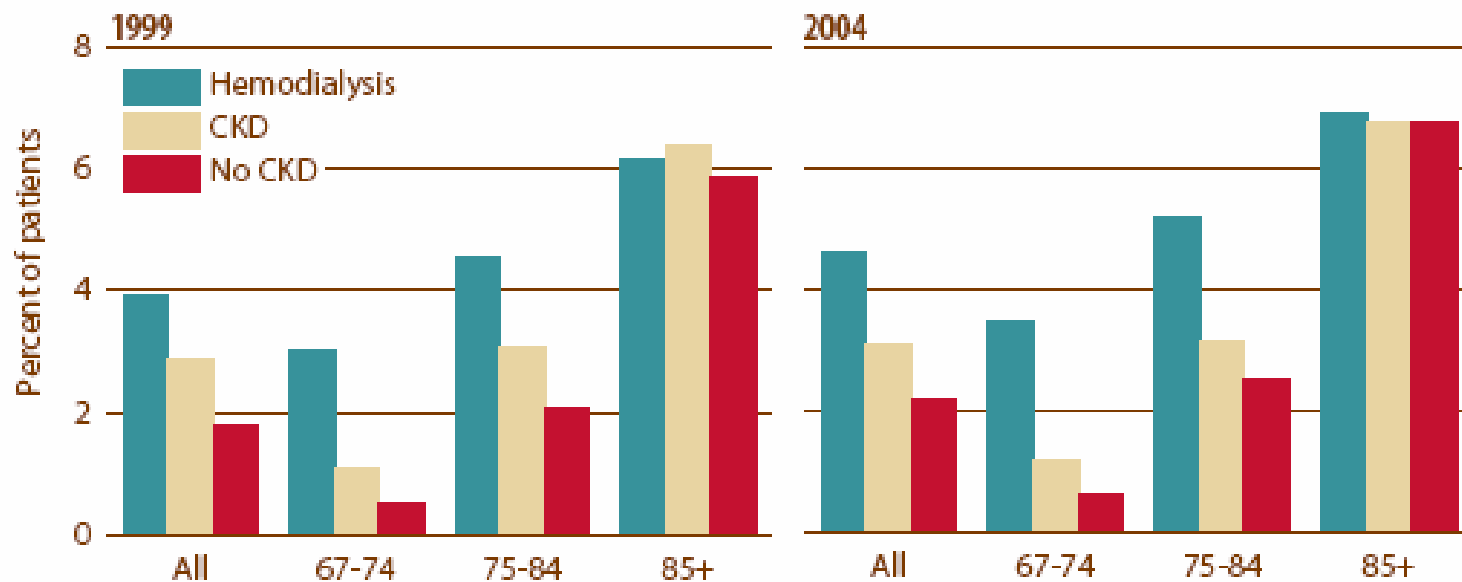


6.46 Survival probability in patients with or without dementia point prevalent patients, 2004



INCIDENT (NEW) DEMENTIA IN PREVALENT PATIENTS

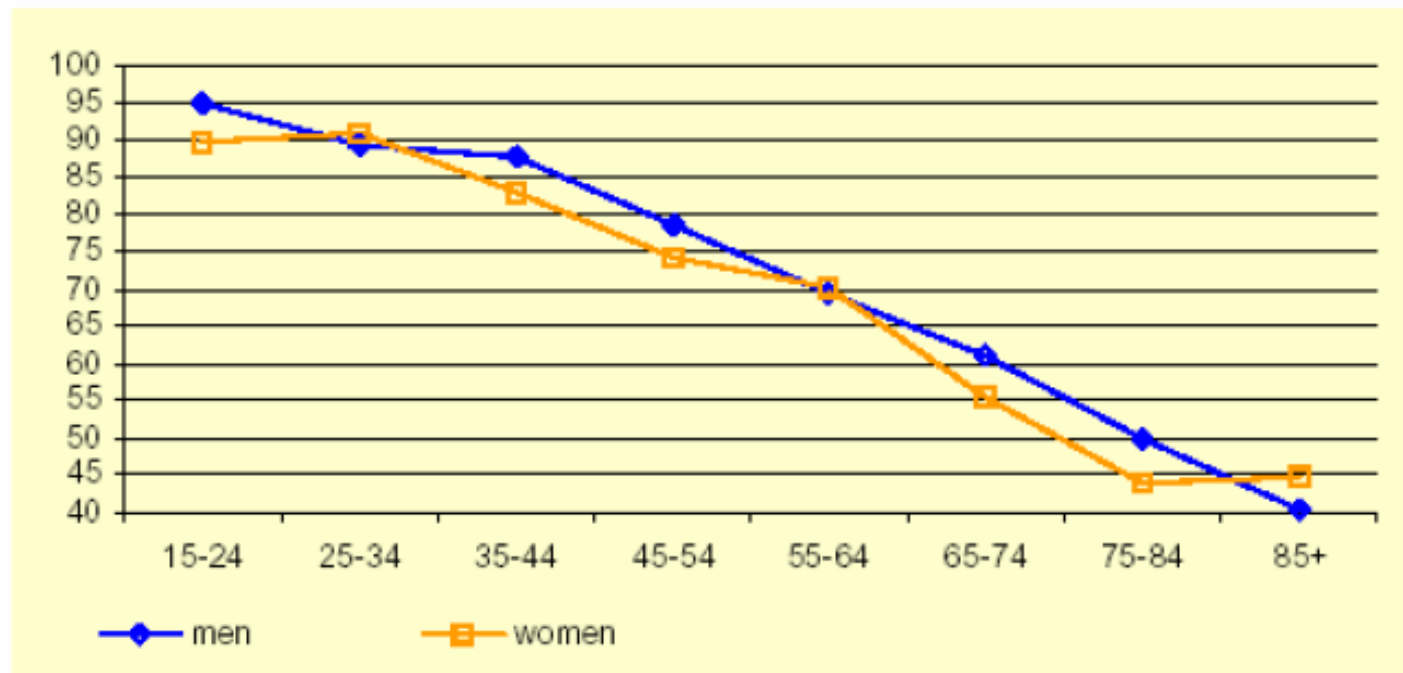
6.47 First diagnosis of dementia, by age & time period  point prevalent patients



MMSE

MMSE (/30)	Totaal	HC	LC	<60j	60-69j	70-79j	≥80j *
Gemiddelde	25,2	24,4	26,6	27,3	26,3	25,1	21,1
mediaan	26,5	26	27	28	27	26	23,5
0-17 n (%)	6 (8%)	6 (12%)	0 (0%)	1 (6%)	1 (5%)	1 (3%)	3 (25%)
18- 23	11 (14%)	8 (17%)	3 (11%)	1 (6%)	0 (0%)	7 (24%)	3 (25%)
24-30	59 (78%)	34 (71%)	25 (89%)	14 (88%)	18 (95%)	21 (72%)	6 (50%)

Figure 2.9 Population en bonne santé par groupe d'âges et genre, 2001 (%)

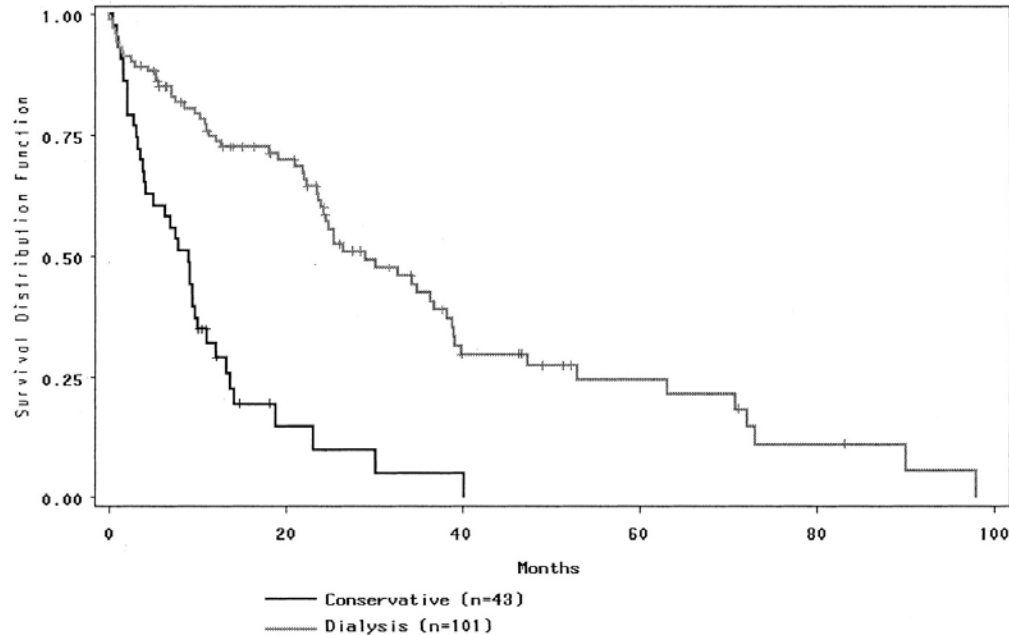


Source : Health Interview Survey, 2001, in Mestdagh et al, Agir Project, 2003.

80 + ESRD decision making and clinical outcomes

- 146 consecutive patients (75 men, 71 women) > 80 yr with creatinine clearance below 10 ml/min per 1.73 m² (Cockcroft-Gault formula), and not yet on dialysis seen in a single renal unit were included in a computer-based cohort.
- The decision whether or not to propose dialysis was formally taken in a weekly dialysis decision meeting, involving the nephrology team, a social worker, a dietitian, and a psychologist; whenever possible, the opinions of the patient, relatives, and the family doctor were taken into consideration.
- individual assessment of predictable benefits was used during the meeting by the nephrology consultant in charge of the patient for decision regarding dialysis recommendation. Patients excluded from or refusing dialysis were maintained on conservative treatment and continued to benefit from a regular follow-up in close cooperation with the family doctor.

Not starting dialysis in > 80 years old patients



Month	0	12	24	36	48	60	72	84	96
Conservative treatment									
N patients at risk	43	10	3	1	0				
N cumulated event	0	30	34	36	37				
Dialysis treatment									
N patients at risk	101	63	42	29	12	8	6	4	1
N cumulated event	0	25	35	43	54	55	57	58	60

Selection

Causes of death

	Dialysis	Conservative
Number of deaths (%)	61 (60.4)	38 (88.4)
Identified acute vascular event	20 (32.8)	8 (21)
Cancer	12 (19.7)	2 (5.3)
Withdrawal from dialysis or *uremia	10 (16.4)	*13 (34.2)
Cardiac failure/pulmonary edema	6 (9.8)	9 (23.7)
Sudden death	7 (11.5)	3 (7.9)
Infection	2 (3.3)	2 (5.3)
Other (suicide, bleeding, iatrogenic event)	4 (6.6)	1 (2.6)

Is there a cost reduction of no
treatment?

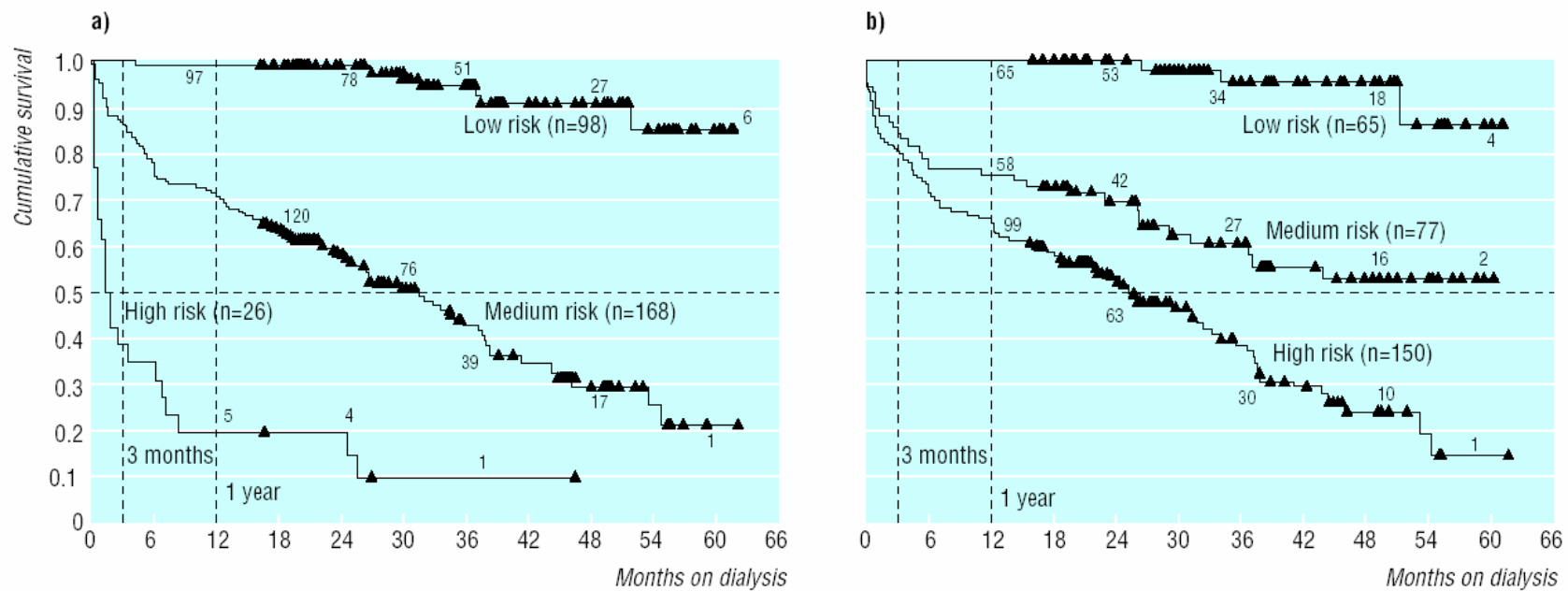


Fig 4 Risk stratification. Risk groups based on (a) logistic regression and (b) scheme by Wright, and Khan et al^{15 16}

Cost savings

Table 3 Cost reduction by exclusion of high risk patients

Cut off point*	Risk group	No of patients excluded (% of all patients)	No of 1 year survivors lost (% of excluded patients)	Cost saving in £ (% of total cost over 5 years)
0.36	High	26 (8.9)	5 (19.2)	407 495 (3.2)
0.5	Medium	52 (17.8)	18 (34.6)	1 227 831 (9.3)
0.7	Medium	100 (34.3)	49 (49.0)	3 012 482 (23.3)
0.85	Medium	146 (50.0)	84 (57.5)	5 182 950 (40.1)
0.94	Medium	194 (66.4)	125 (64.4)	7 428 667 (57.4)

*Cut off points obtained from logistic regression equation.

$$\text{Predictive probability} = \frac{e^z}{1+e^z}$$

where $z=6.3565$ [constant]–(age×0.0388)–(comorbidity severity score×0.2650)–([100–Karnofsky performance score]×0.0418).

Multi-disciplinary clinic vs standard nephrologist care

Standardized philosophy including educational programs

Regular, protocol-based clinic and laboratory follow-up.

The frequency of both visits and laboratory tests is predetermined based on the level of kidney function with reminder systems to facilitate follow-up.

Regularly scheduled bloodwork and clinical examinations and prespecified educational topics are reviewed with each patient.

In the Canadian centre, the multi-disciplinary clinic team consists of

- nurse educator,
- physician
- social worker
- nutritionist
- pharmacist,

though exposure to each individual is varied depending on level of glomerular filtration rate

(GFR).

In the Italian centre the team consists of

- program-dedicated nephrologists
- multi-disciplinary nurses responsible for implementation of recommended diagnostic and intervention strategies, information, education and support.
- The formal team accesses the nutritionist, psychologist, and social worker when necessary.

MDC

Average duration of exposure of the patient to the team =~ 1.5 h per visit (range 1–2.5 h).

Average number of visits per patient-year depends on the protocol, =~ level kidney function.

Five visits per year (including a specialized education visit for treatment modality

selection at 2 h), total exposure to the clinic team is approximately 8 h ($4 * 1.5 + 2$ h) per patient-year.

Standard care:

Duration of visits to the nephrology office is estimated to be 0.5 h. Number of visits to nephrologist offices is estimated to be the same number: 5 ($4 * 0.5 +$ the same 2 h specialized education session). Thus, patients attending nephrology offices had 'exposure' for ~ 4 h per patient-year.

Lab results at the start and after 3 and 6 months

Table 2. Laboratory data (mean \pm standard deviation) at dialysis start, 6 and 12 months post-dialysis

	Standard nephrologist office care	Nephrologist and multi-disciplinary clinic	<i>P</i>
Kidney function at dialysis start			
Creatinine ($\mu\text{mol/l}$)	707 \pm 188	650 \pm 225	0.03
GFR ^a (ml/min/m ²)	7.0 \pm 2.6	8.4 \pm 3.8	0.001
Haemoglobin (g/l)			
Dialysis start	90 \pm 14	102 \pm 18	<0.0001
6 months	108 \pm 15	116 \pm 16	<0.0001
12 months	110 \pm 17	120 \pm 16	<0.0001
Albumin (g/l)			
Dialysis start	34.8 \pm 5.3	37.0 \pm 5.4	0.002
6 months	36.5 \pm 4.5	37.0 \pm 4.7	0.4
12 months	36.9 \pm 4.6	37.0 \pm 4.2	0.9
Calcium (mmol/l)			
Dialysis start	2.16 \pm 0.27	2.29 \pm 0.21	<0.0001
6 months	2.33 \pm 0.24	2.32 \pm 0.22	0.9
12 months	2.28 \pm 0.21	2.29 \pm 0.17	0.6
Phosphate (mmol/l)			
Dialysis start	1.73 \pm 0.55	1.73 \pm 0.54	0.9
6 months	1.56 \pm 0.51	1.61 \pm 0.43	0.4
12 months	1.61 \pm 0.47	1.59 \pm 0.44	0.8

^aGFR estimated by abbreviated MDRD formula.

Multi-disciplinary clinics in nephrology impact survival

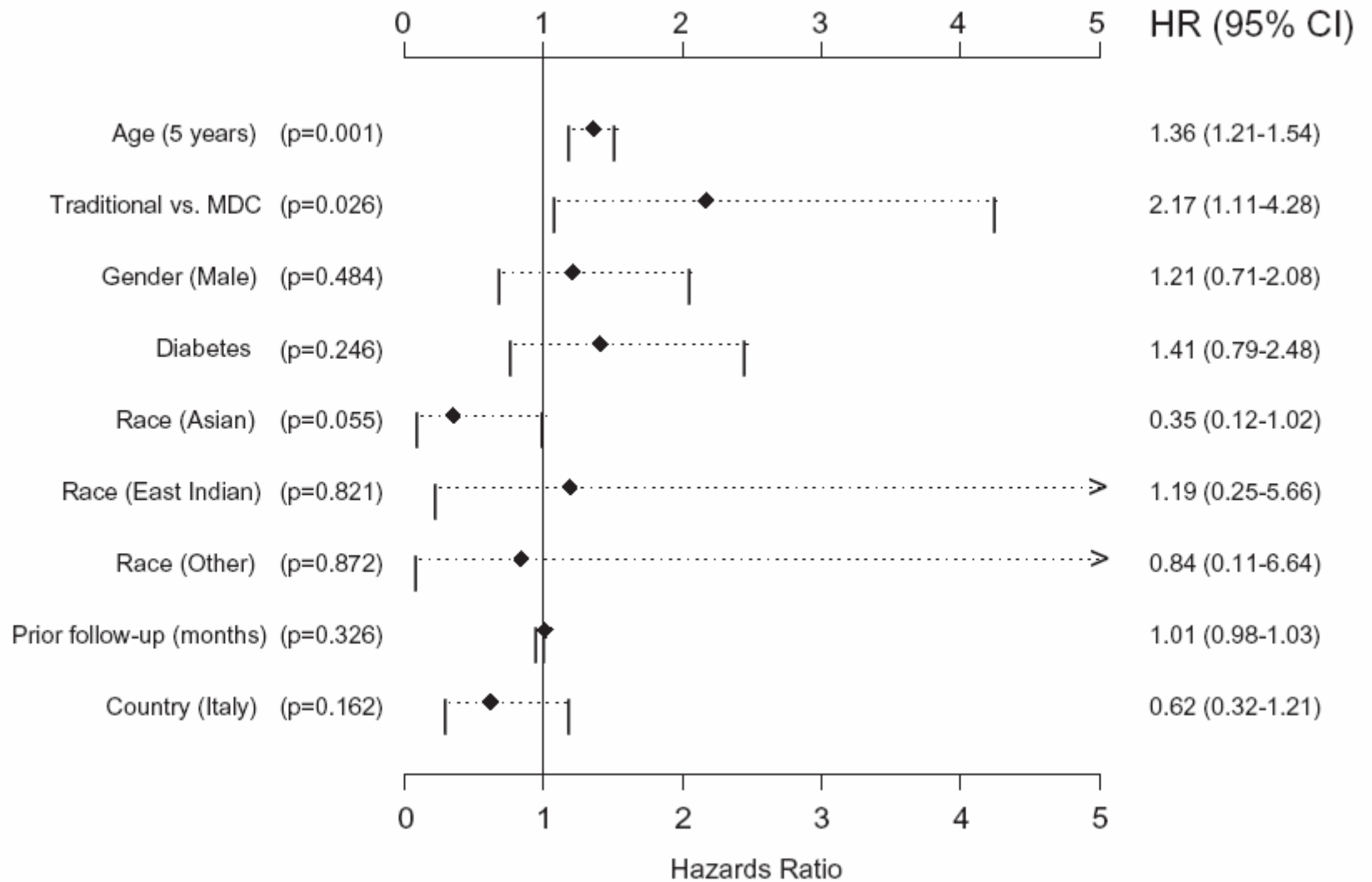


Fig. 2. Risk of death according to multivariate Cox proportional hazards modelling. Comparator for race is Caucasian.

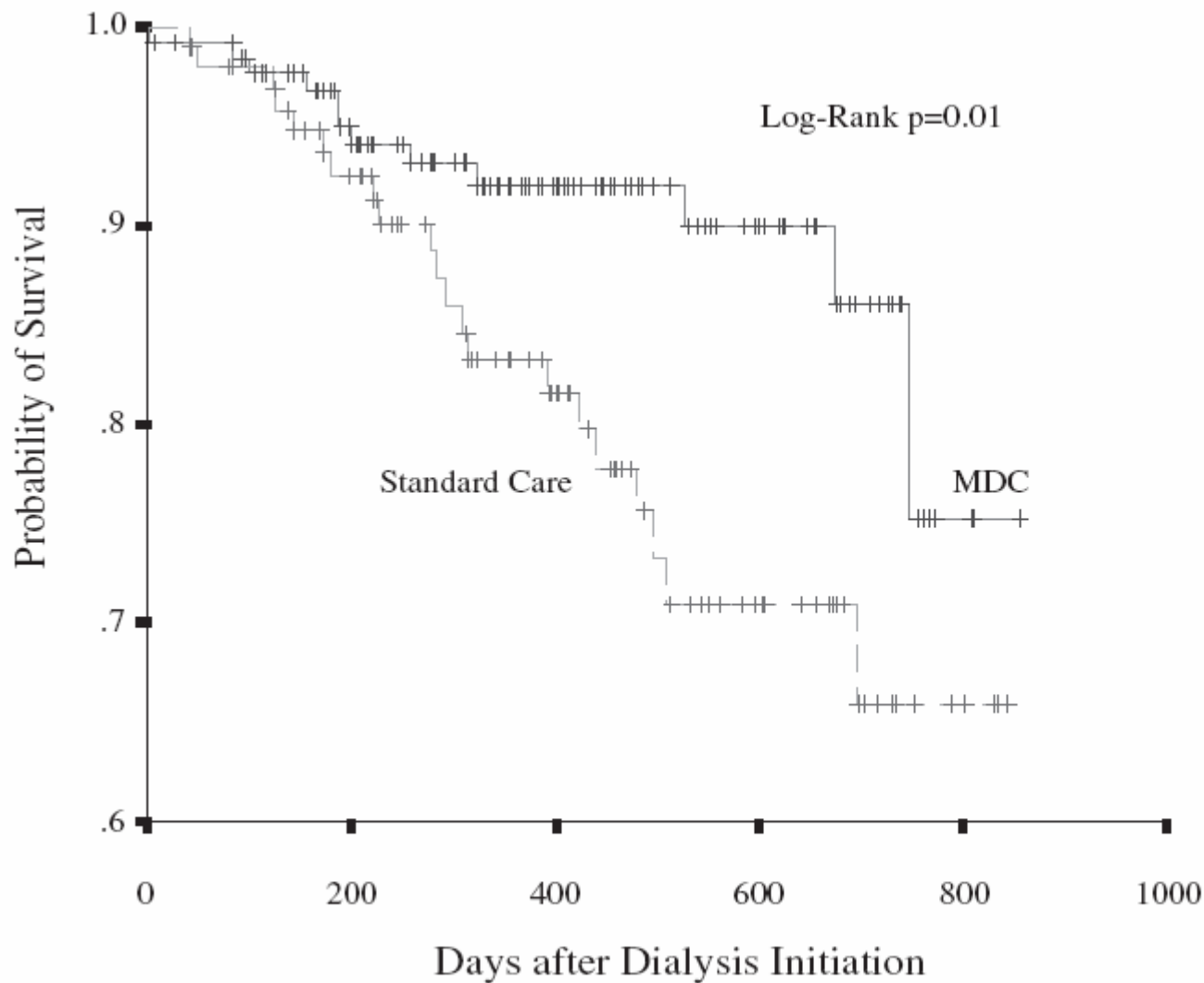


Fig. 1. Kaplan–Meier survival after starting chronic dialysis therapy. Comparison is made between patients seen prior to dialysis initiation in the multi-disciplinary clinic (MDC) vs standard nephrology care.

Besluit

- Voorspelling van incidentie ESRD uitgaande van actuele trend is gevaarlijk
- Arbitrair niet behandelen leidt tot onderbehandeling en is economisch zinloos
- Keuze tot niet behandelen is beslissing van patient
- Accent ligt op preventie en structurering van pre-ESRD opvang.

Between foreseeing and averting change
Lies all the mastery of elements
Which clocks and weatherglasses cannot alter.
Time in the hand is not control of time,
Nor shattered fragments of an instrument
A proof against the wind; the wind will rise,
We can only close the shutters.

Adrienne Rich

“Storm Warnings”