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PUBLISHER CORRECTION

Correction to: When the progresses in neonatology lead to severe congenital nephron deficit: is there a pilot in the NICU?

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Due to an unfortunate error during the processing of the article, Table 1 and Table 2 were missing in the first published version of this article. The publisher apologizes for this mistake. The missing Tables are displayed below. The original article was corrected, where the tables are now to be found.

Table 1 Neonatal KDIGO AKI definition

Stage	Serum creatinine (mg/dl)	Urine Output (ml/kg/h)
1	≥ 0.3 rise within 48 h or ≥ 1.5–1.9 × rise from baseline* within 7 days	≤ 1 for 24 h
2	≥ 2–2.9 × rise from baseline	≤ 0.5 for 24 h
3	≥ 3 × rise from baseline or ≥ 2.5 or KRT initiation	≤ 0.3 for 24 h

*(previous lowest value)

AKI acute kidney injury, *KRT* kidney replacement therapy

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Table 2 Recommendations for the kidney follow up of at-risk very premature infants (< 32 weeks of gestation), VLBWI and/or experienced AKI

	When ? / How often
Exclusive breastfeeding promotion	First 6 months of life
Prudent introduction of solid food	
Target regular and balanced growth, avoid rapid catch-up growth	After regaining birth weight
Family lifestyle education, avoidance of nephrotoxins	At discharge / During follow-up visits
Blood pressure measurement *	Before 1 year of age / Annual
Urinary analysis*	Before 1 year of age / Annual
Proteinuria*	If additional risk factors */ Every 2 years
Prudent dietary pattern, physical activity, avoidance of smoking	From childhood onwards
Blood pressure, BMI, and urinalysis	From 18 years onwards / Biannualy

*A baseline kidney ultrasound should be performed to detect small kidneys, asymmetry or structural abnormalities. Any abnormalities in kidney function or ultrasound should be followed-up by a pediatrician or pediatric nephrologist

VLBWI very low birth weight infants, *AKI* acute kidney injury, *CKD* chronic kidney disease, *BMI* body mass index