

kidney news

Volume 1, Issue 1

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Introduction

A new venture to keep you informed on renal matters...

With so much new information, and newer developments, it is difficult to keep up with the latest. That ever-increasing mountain of mail grows too. I do not want **kidney news** to add to that mountain. I want this – and subsequent – **kidney news** newsletters be something you look forward to receiving. I want you and your patients to gain from these newsletters.

I am not a hardened publisher. I would delight in your contributions, ideas, and thoughts on how subsequent **kidney news** newsletters can be improved, and become more useful. Please feel free to make suggestions. That way, the future editions will be more useful to you.

I intend to use a similar format each newsletter.

Regular articles:

how to contact me column.

the management of a specific renal problem.

case study.

Case Study

An 18-year-old previously well University Student presents with two weeks of shortness of breath, tiredness. Swollen legs have developed over four days, and reduced urine output over a similar period. No other symptoms.

Physical examination reveals a well looking female; blood pressure 108/66. Gross pitting oedema to the knees. No rashes. Remainder of examination normal.

1. What relevant tests are imperative?
2. Anything else indicated?
3. What indicated the need for referral to a renal physician now?

Problem is: Nephrotic Syndrome

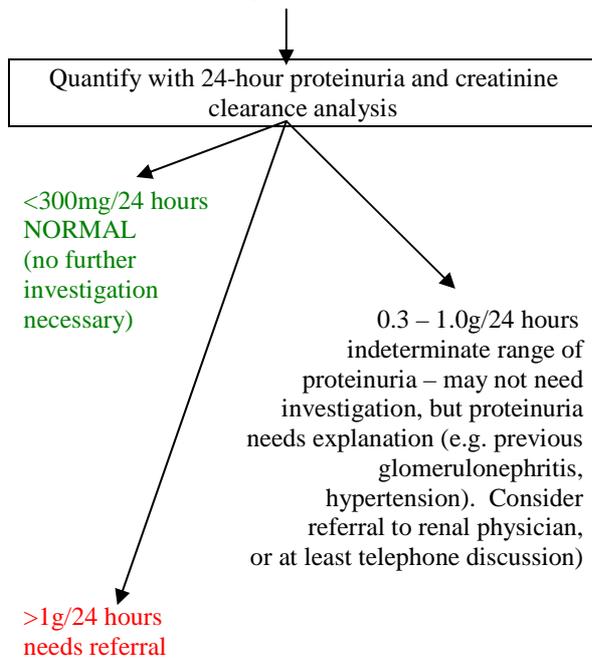
1. Full blood count (for ?anaemia); serum urea (compared to creatinine for pre-renal failure), creatinine (assess renal function), sodium and potassium; serum albumin (degree of hypoalbuminaemia); calcium and phosphate (cramps with hypocalcaemia secondary to hypoalbuminaemia, although she had no cramps). MSU (?blood, infection, and confirm proteinuria); 24 hour urine for proteinuria (if MSU shows proteinuria), and creatinine clearance (always do the creatinine clearance with a proteinuria analysis, to ensure the collection is for the full 24 hours – judged by the amount of creatinine). Serum cholesterol/lipids.
2. ASOT, complements, ANA and dsDNA may be subsequently indicated, especially if blood in the urine). Ultrasound scan of the kidneys, although this could be done immediately prior to the renal biopsy – which will be required if the initial results confirm nephrotic syndrome.
3. If serum creatinine abnormal. (Hypertension, if present). Otherwise, await imperative results and then either discuss by telephone, or refer. Almost always patients with proteinuria need a renal biopsy to diagnose, stage the disease, and indicate prognosis.

WHAT'S IN HERE THIS TIME?

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In approximately 4% of patients (especially women) orthostatic proteinuria (usually less than 1g/24 hours) is seen with late in the day (after ambulation) MSU. In orthostatic proteinuria, an early morning MSU is normal, and requires no further investigation.

Patient with isolated proteinuria (no haematuria) or only minor haematuria on screening MSU, *then* check MSU after one to two weeks – and if persists...



URGENT referral if creatinine abnormal, macroscopic haematuria (may suggest renal vein thrombosis), new hypertension, heavy proteinuria (>5g/24 hours) with marked oedema, not responding to diuretics. Or diuretics produce acute renal failure, with rising creatinine over a week or two.

Sometimes commencement of prednisone on spec is appropriate, especially in under 18 year olds, where the likelihood of minimal change nephropathy is high.

Main causes of nephrotic syndrome (>3g proteinuria/1.73m² body surface area/24 hours) in adults:

- Focal and segmental glomerulosclerosis (30-35%)
- Membranous nephropathy (20-25%)
- Minimal change nephropathy (15-20%)
 - Diabetes mellitus
 - Lupus nephritis
 - IgA nephropathy
- Hypertensive nephropathy (uncommon to have nephrotic range proteinuria)

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Interests

Investigation of renovascular disease and hypertension

Management of urinary tract infections

Investigation of urinary calculi

Investigation of proteinuria and haematuria

Investigation and management of impaired renal function.