

kidney news

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Introduction

I thought I would make this *kidney news* a pot-pourri of practice points, and (hopefully) useful hints.

There has been a good response to me opening up a South Auckland clinic at Takanini, and it has allowed me to be available to see patients twice per week. Some have been quite happy to travel some distance to be seen that week rather than waiting until an appointment time is available at their closer clinic.

I hope you and your patients are continuing to appreciate my help. If you have any ideas how I could be more helpful, or topics you would like me to cover in the *kidney news*, please let me know.

HYPERTENSION

When should I think of secondary hypertension?

Young people, especially below the age of 30 years.

When previously well-controlled blood pressure, now requires the addition of more agents to achieve control, or we adequate control is not achieved.

Are ACE inhibitors OK in renal artery stenosis?

If there is a need for ACE inhibition for cardiac failure, and renal function significantly deteriorates, as a result of the ACE inhibitor, then we need to cease the ACE inhibitor, and look for reversible renal artery stenosis.

Once the renal artery stenosis has been corrected (if possible), then it is OK to use an ACE inhibitor. If the stenosis can not be corrected, and the cardiac status demands an ACE, then the patient, of course, needs to be aware of the risk of progressive renal failure from the ischaemia caused by ACE/renal artery stenosis combination.

How significant is a significant rise in serum creatinine?

The serum creatinine can vary by 10-14% from day-to-day, so a rise below this may not be significant.

I recommend a pre-ACE serum creatinine. Then following the commencement of an ACE, a creatinine level **within** 7 days. And one serum creatinine analysis per week for up to a month after the ACE inhibitor is started. Sometimes the creatinine rises slowly, and may take several weeks before the creatinine rises significantly.

A rise in serum creatinine from (say) 0.11mmol/l to 0.125mmol/l is 14% - a rise of 0.015mmol/l. So any rise in the serum creatinine (in this case) above this requires further investigation/referral to a renal physician. A pre-ACE serum creatinine level of 0.2mmol/l, however, needs to rise to 0.228 – a rise of 0.028mmol/l – before the change is likely to be significant. It is important to note that although the absolute rise is higher in this instance the loss of renal function is the same. Hopefully that is not confusing. Any queries just give me a call.

What test for renal artery stenosis?

There continues to be disagreement about this. Basically, if there is serious suspicion there is renal artery stenosis, then the best test is renal angiography. Angiography requires day-stay, and if the serum creatinine is above 0.13mmol/l in-patient admission for fluid loading.

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This fluid loading minimises the risk of acute renal failure from the radio-contrast. The other option is an MR scan which uses gadolinium, which is much less reno-toxic, and can be safely used where the serum creatinine is at any level.

Should I do 24-hour catecholamines?

If there is suspicion of secondary hypertension – then these must be done. It is important, especially in patients who have the symptoms of hot-flushes, anxiety attacks, sweating, headaches, palpitations and/or weight loss.

HAEMATURIA

Where do I refer haematuria alone?

Isolated (no proteinuria), painless (and therefore probably not stones) microscopic haematuria requires cytology, ultrasound and IVU, and referral to a urologist – for ?cystoscopy. If under the age of 40 years we are unlikely to find any malignancy, or urological pathology, but going through the tests is necessary.

When do I send haematuria to the renal physician?

- When the urological investigations have been fruitless.
- If there is a family history of haematuria, or renal disease.
- If there is associated proteinuria (refer these patients to a renal physician **before** the urologist).
- If there is impaired renal function and/or there is no evidence of obstruction on the ultrasound (e.g. Stones, or tumour, and the urologist is needed first).

What do I do if all the investigations are normal?

No one knows the answer here. I recommend 3 monthly MSU monitoring for a year, then 6 monthly for 1-2 years. If the haematuria persists, then after a maximum of 5 years, the entire investigation package of radiology, cytology, cystoscopy, and possibly renal biopsy has to be performed again.

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CHRISTMAS ISSUE**

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Investigation of renovascular disease and hypertension

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Investigation of urinary calculi

Investigation of proteinuria and haematuria

Investigation and management of impaired renal function.

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