

# kidney news

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## **Who should be referred?**

All patients with chronic renal failure should be referred (telephone conversation or formal clinic letter of referral) to a renal physician for diagnosis, management and optimisation of therapies in progressive renal failure; assessment for dialysis and renal transplantation, no matter what their age or complications and medical conditions. Most of the care can be shared with the GP handling the day-to-day care, with guidance from the renal physician from both clinic letter and telephone communications. Often the issue(s) can be addressed on the telephone without a clinic visit. Review can be required.

## **How often should I, as the GP, monitor the patient's tests?**

This depends upon both the cause of renal failure, and the expected rate of progression of renal failure.

Generally a patient will lose between 5 and 10 ml/min per annum GFR. Diabetic patients often lose their function faster (from creatinine of about 0.15 mM to end-stage in 2 to 4 years). Polycystic patients may lose their renal function much slower, and progress from 0.15mM to end-stage over ten to twenty years.

Monitoring every three to six months is adequate until GFR is below 0.5 ml/sec (30ml/min). Then every one to three months is necessary.

Monitoring is with serum urea, creatinine, sodium, potassium and calcium and phosphate, albumin; and full blood count and an MSU (sometimes 24-hour urine for protein quantification).

## **What can be done about...?**

**..Diet.** Fluid restriction will reduce the need for diuretics. Well worth trying (if not already) when the diuretic dose is as high as 200 to 300mg/day. Sodium restriction to less than 100mmol/day, preferably below 70 (dietician's referral). Protein intake restriction is worthwhile, but must only be undertaken under the watchful eye of a renal dietician, otherwise malnutrition will develop, and substantially increase the mortality. I have access to a renal dietician, who is often needed here. Between 28 and 46% of patients commencing dialysis are malnourished! Inadequate protein and calories intake are a common problem.

**..Exercise.** Anything the patient can do should be encouraged for general health. Patients on high dose steroids should avoid high-impact activities (e.g. running) so as not to damage the bones and joints.

**..Acidosis.** Malnourishment, lethargy and tiredness are worse with the acidosis of renal failure. Unfortunately no longer are alkali tablets available. Serious acidosis may be an indication to start dialysis.

## ***Introduction***

I will be away for a prolonged period of late November 2002 to January 2003. I will be in Auckland, and will be available most of the time by telephone (021 664664) as usual. I will still hold clinics, although either myself or Dr Ratanjee (as he did for me 2 years ago when I was in Samoa) will be seeing patients. I am sorry for this little change. Appointments, and contact details, and clinic times will remain the same though.

Finally my website is under construction. It has been more difficult than I thought, and far more time consuming. Although now active, there is nothing to see, but a set-up page.

I am enjoying seeing your patients you are all sending. I have had some very interesting challenges recently, and they are bringing me much enjoyment. I hope you and your patients are finding reviews with me beneficial.

Thank you for referring your patients and your continued support.

The criteria for renal replacement therapy (renal transplantation and dialysis) have been relaxed over the years, so this newsletter is to help you with day-to-day management, and what to do with those patients with chronic renal failure; how to maximise their care; and when to refer. Some patients will not want to have dialysis after seeing what it involves, and I can offer ways to assist you manage their symptoms in the latter stages of renal failure. This *Kidney News* is briefly addressing some of those challenges in CRF.

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**What can be done about (continued)....?**

**..Parathyroid hormone/calcium/phosphate.** Early initiation with oral vitamin D therapy, even before significant detectable changes in calcium and phosphate, minimises long-term bone problems. Start once GFR below 1ml/sec (60ml/min). Oral  $\alpha$ -calcidol 0.25 $\mu$ g three times per week to daily. Watch for hypercalcaemia (monthly to three monthly is adequate blood test monitoring).

**..SOB/fluid overload.** Almost always cough and SOB in chronic renal failure (CRF) patients is due to pulmonary oedema, and restriction of salt, water intake and increase in diuretics resolves the issue. If not, CXR, and/or antibiotics may be necessary.

**..Anaemia.** Iron deficiency is uncommon in renal failure, unless there is blood loss (usually GI). 50% of CRF patients get GI tract ulcers, and a high urea with a generalised tendency to bleeding leads to greater blood loss. Usually the anaemia is of chronic disease. Ferritin is high in CRF, and oral Fe is not indicated. Soon erythropoietin will be available to ALL CRF patients. Referral and prescribing by a renal physician is required for patients to get erythropoietin (epoietin). In such patients on epoietin, oral Fe may not be adequate to provide adequate substrate, and IV Fe is necessary.

**..Lipid management.** Cholesterol and lipid control helps reduce the vascular contribution to progressive CRF. Maximisation of control of lipids (criteria as for cardiac disease) seems appropriate for renal – unfortunately no evidence for this advice. Statins are the safe medication to use.

**..Reducing hypertension.** Control of hypertension to values below 130/80 mmHg has been shown to reduce progression of CRF. Not always is this target achievable, however. ACE inhibitors and ARBs both reduce intra-renal pressures resulting in less proteinuria and longevity of glomerular survival – probably in all CRF patients, not only diabetes mellitus.

**..Reducing proteinuria.** ACE inhibitors and ARBs reduce proteinuria – by about 50% as a rule of thumb. Proteinuria *per se* is toxic to the kidney, and over years will lead to progression of CRF. Again early use of ACEIs and ARBs is encouraged. Limited dietary intake of proteinuria in nephrotic syndrome reduces proteinuria, and again needs specialist renal dietician input before being implemented.

**..Avoiding nephrotoxins.** Especially NSAIDs in patients with gout. Use prednisone and/or colchicines more.

**Who should get dialysis and transplant?** The national guidelines recommend several medical and psychiatric and social parameters in the assessing of a patient for acceptance on to dialysis. If a patient – regardless of age - is not likely to survive for at least 1 to 2 years on dialysis, they will probably not be offered dialysis. I consider social and ability to cope with day-to-day activities very important, and the GPs and families input here is very important – a quality of life assessment.

Generally patients over the age of 70 years are unlikely to be offered a renal transplant. Assessment is rigorous and detailed, and many fail the (mostly cardiac) tests.

I am happy to see any patient for an opinion if not sure. Often the referral clarifies the situation for all.

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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.

Renal nutrition.

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