Dear Colleague,

Your patients may be identified as having possible Chronic Kidney Disease (CKD) during their hospital admissions to Royal Prince Alfred Hospital (RPAH), Concord Repatriation General Hospital (CRGH) or The Canterbury Hospital (TCH) this year by the CKD Stewardship team.

Optimal medical management can slow progression by up to 50%.

Recommendations

1. Please re-check the creatinine (eGFR) and urine albumin:creatinine ratio (ACR) three months apart to confirm the diagnosis.
2. Please code the CKD in your practice software

Yellow Clinical Action Plan*
eGFR >60ml/min/1.73m^2 with albuminuria >30mg/mmol OR
eGFR 45-59ml/min/1.73m^2 with NO albuminuria

1. Review every 12 months: blood pressure, weight, smoking, CV risk
2. Reassess Urine ACR, eGFR, lipids and HbA1c (if diabetic)

Orange Clinical Action Plan*
eGFR 30-59mL/min/1.73m^2 with albuminuria >30mg/mmol OR
eGFR 30-44ml/min with NO albuminuria

1. Review every 3-6 months: blood pressure, weight, smoking, CV risk
2. Reassess EUC, Urine ACR, eGFR, lipids, HbA1c (if diabetic),
3. Consider ACEi or ARB for hypertension first line therapy
4. Statin therapy indicated for CV risk
5. Consider SGLT2i if albuminuria >30mg/mmol (even in non-diabetics)

When to refer to nephrology*

1. Persistent Urine ACR >30mg/mmol regardless of eGFR
2. If confirmed Stage 4 (eGFR <30ml/min) or 5 (eGFR<15ml/min) of any cause
3. Sustained decrease in eGFR of 25% or more within 12 months
4. Sustained decrease in eGFR of 15ml/min/year
5. CKD with resistant hypertension despite at least three antihypertensives

*Action Plans and referral guideline adapted from Kidney Health Australia CKD management handbook for health professionals, 2020. https://kidney.org.au/health-professionals/ckd-management-handbook

We hope you find this information useful. CKD Stewardship Team, SLHD-CKD-Stewardship@health.nsw.gov.au

Nephrologists: Dr Lucy Wynter, Dr John Saunders, Dr Shaundeep Sen
Clinical Nurse Consultants: Carmen Moroney, Rowena Monteverde, Lisa Tienstra