Adult Acute Kidney Injury Care Pathway for Primary Care

What is AKI?
- AKI is a sudden decline in kidney function over hours or days
- It is most often seen during episodes of acute illness
- It is diagnosed by a rise in serum creatinine as detailed in the table overleaf

Why is AKI important?
AKI occurs in 10-20% of emergency hospital admissions and >20% of these will die during hospital admission. AKI also causes:
- Increased length of hospital stay and costs
- The development or progression of CKD (may lead to needing dialysis)
- Increased cardiovascular risk

Up to two thirds of patients who sustain AKI have already developed it by the time they are admitted to hospital - prevention and management in primary care is essential

1. Risk Assessment
Consider who is at risk
- Age >65
- CKD at baseline
- History of previous AKI
- Falls with long lie

2. Prevention
In all at risk patients
- Avoid prescription of long term NSAIDs in patients with CKD
- Review the need for nephrotoxic medications and consider alternatives including during acute illness
- Educate patients/carers about the risk of dehydration during acute illness
- Check renal function early during acute illness
- Monitor for deterioration

Beware of sepsis and intervene early in at risk patients

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3. Management

Recognise

Please also refer immediately to local renal team for advice if:
- There is no clear cause of AKI
- New finding of 2+ blood and/or 2+ protein on urine dipstick (in absence of UTI, regardless of stage)
- Systemic symptoms e.g. vasculitic rash, epistaxis, haemoptysis
- Patient has a kidney transplant
- Inadequate response to initial treatment
- AKI on CKD stage 4 or 5

NB- Refer to urology if obstruction suspected.

For referral to local renal team call KCH switch on 02032999000 and ask for the renal referrals SpR on bleep 622 (24/7)

Review all AKI

- Review medications: Consider reducing/stopping:
  - ACEI/ARBs
  - Diuretics
  - NSAIDs
  - Metformin
  - PPI
- Complete volume assessment and advise on rehydration if appropriate
- Check blood pressure
- Complete a urine dipstick
  - if there is infection do not prescribe trimethoprim or nitrofurantoin
  - If blood +/- protein consider intrinsic renal problem
- Exclude palpable bladder
- Consider the cause!

Respond

Stage 1:
- Repeat U+Es in 5-7 days

Stage 2:
- Repeat U+Es in 48-72hours
- Organise outpatient USS

Stage 3:
- Refer immediately to local renal team for ongoing management advice

Stage 1
- Creat rise by ≥ 26µmol/L within 48 hours
- OR rise ≥ 1.5-1.9 x baseline

Stage 2
- Creat rise ≥ 2-2.9 x baseline

Stage 3
- Creat rise ≥ 3 baseline OR rise of ≥ 354µmol/L

London Acute Kidney Injury Network http://www.londonaki.net/
Acute Kidney Injury NICE clinical guideline 169: www.nice.org.uk/guidance/cg169
Think Kidneys: www.thinkkidneys.nhs.uk