

Appendix E Renal services described for non-physicians

(reproduced from the Renal Association Standards document)

This appendix, taken from the Renal Association Standards document, provides background information on renal failure and discusses the services available for its treatment.

- Chronic renal failure**
1. In chronic irreversible renal failure, the kidneys are slowly destroyed over months or years. To begin with there is little to see or find, and this means that many patients present for medical help very late in their disease, or even in the terminal stages. Tiredness, anaemia, a feeling of being 'run down' are often the only symptoms. However, if high blood pressure develops, as often happens when the kidneys fail, or is the prime cause of the kidney disease, it may cause headache, breathlessness and perhaps angina. Ankle swelling may occur if there is a considerable loss of protein in the urine.
 - 2 Progressive loss of kidney function is often described as chronic renal insufficiency when in its early stages, chronic renal failure when it becomes obvious, and end stage renal failure when it reaches its terminal stage. At this point, if nothing is done, the patient will die. Two complementary forms of treatment, dialysis and renal transplantation are available and both are needed if end stage renal disease is to be treated.
 - 3 The incidence of end stage renal failure rises steeply with advancing age. Consequently an increasing proportion of patients treated for end stage renal failure in this country are elderly and the proportion is even higher in some other developed countries. Evidence from the United States suggests that the relative risk of end stage renal failure in the black population (predominantly of African origin) is two to four times higher than for whites [US Renal Data System 1993]. Data collected

during the review of renal specialist services in London suggest that there is in the Thames regions a similar greater risk of renal failure in certain ethnic populations (Asian and Afro-Caribbean) than in whites [Roderick et al 1994]; this is supported by national mortality statistics [Raleigh et al 1996]. people from the Indian subcontinent have a higher prevalence of non-insulin dependent diabetes, and those with diabetes are more likely than whites to develop renal failure. This partly explains the higher acceptance rate of Asians on to renal replacement programmes.

Causes of renal failure 4 Most renal diseases that cause renal failure fall into a few categories.:-

Auto-immune disease. 'Glomerulonephritis' or 'nephritis' describes a group of diseases in which the glomeruli (the filters that start the process of urine formation) are damaged by the body's immunological response to tissue changes or infections elsewhere. Together, all forms of nephritis account for about 30% of renal failure in Britain. The most severe forms are therefore treated with medications that suppress the immune response, but treatment makes only a small impact on the progress of this group of patients to end stage renal failure

Systemic disease. Although many generalised diseases such as systemic lupus, vasculitis, amyloidosis and myelomatosis can cause kidney failure, by far the most important cause is diabetes mellitus (about 20% of all renal disease in many countries). Progressive kidney damage may begin after some years of diabetes, particularly if the blood sugar and high blood pressure have been poorly controlled. Careful lifelong supervision of diabetes has a major impact in preventing kidney damage.

High blood pressure. Severe ('accelerated') hypertension damages the kidneys, but the damage can be halted — and to some extent reversed — by early detection and early treatment of high blood pressure. This is a common cause of renal failure in patients of African origin.

Obstruction. Anything that obstructs the free flow of urine can cause

back-pressure on the kidneys. Much the commonest cause is enlargement of the prostate in elderly men; although only a small proportion of them develop kidney failure, prostatism is so common that it becomes a major cause of renal failure over the age of 70 [Feest et al 1990, 1993].

Infection of urine. Cystitis is a very common condition, affecting about half of all women at some time in their lives, but it rarely has serious consequences. However, infection of the urine in young children or patients with obstruction, kidney stones or other abnormalities of the urinary tract may result in scarring of the kidney and eventual kidney failure.

Genetic disease. One common disease, polycystic kidneys, and many rare inherited diseases affecting the kidneys account for about 8% of all kidney failure in Britain. Although present at birth, polycystic kidney disease often causes no symptoms until middle age or later. Understanding of its genetic basis is rapidly advancing and may lead to the development of effective treatment.

Disease of renal blood vessels. This is being more and more frequently recognised as a cause of renal failure, both acute and chronic. It is especially common in patients aged more than 65 years.

Comorbidity 5. Renal failure is often accompanied by other disease processes. Some are due to the primary disease, eg diabetes may cause blindness and diseases of the nerves and blood vessels. Others, such as anaemia, bone disease and heart failure, are consequences of the renal failure. Coincidental diseases such as chronic bronchitis and arthritis are particularly common in older patients with renal failure. All these conditions, collectively called comorbidity, can influence the choice of treatment for renal failure and may reduce its benefits. Expert assessment of the patient before end stage renal failure can reduce comorbidity and increase the benefit and cost effectiveness of treatment. Thus early detection and referral of patients at risk of renal failure is important. Studies in France and in the United States showed

that the mortality rate among patients aged over 55 years at the start of regular dialysis increased dramatically if dialysis was started late in the illness [Jungers et al 1993; Byrne et al 1994]

Renal replacement therapy 6. The term renal replacement therapy is used to describe treatments for end stage renal failure in which, in the absence of kidney function, the removal of waste products from the body is achieved by dialysis and other kidney functions are supplemented by drugs. The term also covers the complete replacement of all kidney functions by transplantation.

Renal dialysis 7. Dialysis involves the removal of waste products from the blood by allowing these products to diffuse across a thin membrane into dialysis fluid which is then discarded along with the toxic waste products. The fluid is chemically composed to draw or 'attract' excess salts and water from the blood to cross the membrane, without the blood itself being in contact with the fluid.

Haemodialysis 8 The method first used to achieve dialysis was the artificial kidney, or haemodialysis. This involves the attachment of the patient's circulation to a machine through which fluid is passed, and exchange can take place. A disadvantage of this method is that some form of permanent access to the circulation must be produced to be used at every treatment. Each session lasts 4-5 hours and is needed three times a week.

Peritoneal dialysis 9 The alternative is peritoneal dialysis, often carried out in the form of continuous ambulatory peritoneal dialysis (CAPD). In this technique, fluid is introduced into the peritoneal cavity (which lies around the bowel) for approximately 6 hours before withdrawal. The washing fluid must be sterile in order to avoid peritonitis (infection and inflammation of the peritoneum), which is the main complication of the treatment. A silastic tube must be implanted into the peritoneum and this may give problems such as kinking and malposition. Each fluid exchange lasts 30-60 minutes and is repeated three or four times daily. Neither form of dialysis corrects the loss of the hormones

secreted by the normal kidney so replacement with synthetic erythropoietin and vitamin D is often necessary.

***Renal
transplantation***

10. Renal transplantation replaces all the kidney's functions, so erythropoietin and vitamin D supplementation are unnecessary. A single kidney is placed, usually in the pelvis close to the bladder, to which the ureter is connected. The kidney is attached to a nearby artery and vein. The immediate problem is the body's acute rejection of the foreign graft, which has largely been overcome during the first months using drugs such as steroids and cyclosporin. These drugs, and others that can be used for that purpose, have many undesirable side effects, including the acceleration of vascular disease, so myocardial infarcts and strokes are commoner in transplant patients than in age matched controls. During subsequent years there is a steady loss of transplanted kidneys owing to a process of chronic rejection; treatment of this is quite unsatisfactory at the moment, so many patients require a second or even a third graft over several decades, with further periods of dialysis in between.

11. The main problem with expanding transplantation is the shortage of suitable kidneys to transplant. Although the situation can be improved it is now clear that, whatever social and medical structures are present and whatever legislation is adopted, there will inevitably be a shortage of kidneys from humans. This remains the case even if kidneys from the newly dead (cadaver kidneys) are retrieved with maximum efficiency, and living donors (usually but not always from close blood relatives of the recipient) are used wherever appropriate. Hope for the future rests with solving the problems of xenotransplantation (that is using animal kidneys), probably from pigs, although baboons have also been suggested and are closer to humans. Many problems remain unsolved and it is thought highly unlikely that xenotransplantation will become a reliable treatment for end stage renal failure within the next 10 years.