

UK Kidney Association (UKKA) position statement on the care of patients with kidney disease and at increased risk from COVID-19

People with kidney disease have been amongst those with the highest risk of mortality and hospitalisation during the COVID-19 pandemic.

Recent observational data show that this risk continues¹. Whilst the overall absolute risk of dying from COVID-19 has gone down due to the effectiveness of vaccination coupled with naturally acquired immunity and better treatments, the relative risk of death for those with kidney disease, particularly patients with kidney transplants, *increased* in the third wave of the pandemic. These data may be an under-estimate of relative risk as many of the most vulnerable patients continued to shield², with impacts on their mental health and that of their family.

Although the current autumn round of COVID-19 booster vaccines is welcomed, we are already entering a widely anticipated rise in COVID-19 infections. Whilst the majority of patients with kidney disease do respond to vaccination against COVID-19³, a group of at least 13,000 kidney patients are likely to remain unprotected as they have no detectable antibodies against COVID-19 even after four doses of vaccine⁴. The patients most likely to suffer from lower efficacy of vaccination include an estimated 8,000 patients with kidney transplants (from a total of ~40,000 prevalent kidney transplant patients) and up to 5,000 patients who are treated with immunosuppression for immunological diseases that affect the kidneys and other organs. Data suggest that in the Omicron wave (i) people with kidney transplants had around a 3 times higher rate of COVID-19 mortality than over 80-year-olds in the general population and (ii) people with stage 5 CKD had around 8 times higher age-adjusted risk of COVID-19 mortality compared to the general population⁵.

Key recommendations:

1. **Antibody testing:** UKKA recommends that the highest risk patients with kidney disease should be offered 6 monthly antibody testing
2. **Prophylactic antibodies:** UKKA considers that evidence supports the use of Evusheld as prophylaxis for patients who are antibody negative. This is based on real world data and advice from clinical experts. UKKA requests that any further NICE evaluation of Evusheld considered necessary should be completed and published within the next 6 weeks
3. **COVID-19 testing:** UKKA recommends continued use in high-risk settings including for patients who are immunosuppressed
4. UKKA strongly supports the **continued availability of sotrovimab** for patients with kidney disease in the most vulnerable groups

5. The UKKA recommends that **renal units should be resourced to allow them to continue to support kidney patients to receive vaccination and access to COVID 19 therapies**

Background to recommendations

Antibody testing: UKKA recommends that the highest risk patients with kidney disease should be offered 6 monthly antibody testing.

This would necessitate testing in approximately 40,000 patients with kidney transplants and an estimated 10,000 patients with autoimmune kidney disease. Patients whose transplants have failed and have returned to dialysis but continue to receive immunosuppressant therapies should also be included in this group. Currently, not all renal units have ready access to antibody testing for their patients.

Around 20% (equating to approximately 8,000 patients) of those with kidney transplants are antibody negative after a four-vaccination course. A further estimated 5,000 patients have recently received B-cell depleting or equivalently immunosuppressant therapies for autoimmune diseases. These patients are at higher risk of hospitalisation and death. Knowledge of antibody status will support these patients in making a risk assessment around social behaviour and management strategies, as it reflects immune status and may encourage those with previous antibody responses to continue booster vaccination rounds.

Prophylactic antibodies: UKKA considers that the evidence supports the use of Evusheld as prophylaxis for antibody negative patients. This is based on real world data and advice from clinical experts.

Evusheld has been used in 32 countries including North America and most European countries with clear efficacy. The Department for Health and Social Care have decided so far not to proceed with Evusheld prophylaxis for autumn/winter 2022. This is out of alignment with North America and multiple other European countries who have assessed the same evidence. NICE are evaluating Evusheld and a stakeholder consultation on this has been completed. However, NICE are not going to publish this evaluation for some months. It is widely anticipated that there will be a further surge in cases this autumn and winter and we are therefore requesting that this timescale is significantly accelerated, and the evaluation is completed and published in the next 6 weeks to inform the targeted use of Evusheld for prophylaxis to protect vulnerable patients and the NHS over the winter months.

COVID-19 Testing: UKKA recommends continued use in high-risk settings, including for immunocompromised patients who are admitted to hospital for any reason, including as a day case.

For all patients who are receiving in centre haemodialysis we have recently published recommendations that can be accessed [here](#).

Sotrovimab: UKKA considers that sotrovimab therapy should remain available as first line therapy for vulnerable patient with kidney disease.

Paxlovid is not a therapeutic option for many kidney patients due to drug interactions or lack of safety data in patients with advanced kidney disease whilst data demonstrate that molnupiravir is not as effective as sotrovimab in many patients with kidney disease. Extensive laboratory data have demonstrated continued efficacy of sotrovimab against newer COVID 19 variants while observational data also suggest better efficacy compared to molnupiravir, including in the BA2 era^{6,7}.

Renal services should work to ensure that all eligible patients are able to access appropriate treatments promptly. Data currently suggest that access is inconsistent. Patients with moderate to advanced kidney impairment (chronic kidney disease stage 3-5) are known to be at increased risk of poor outcomes from COVID-19. Despite this, UKKA are aware of major differences in care for patients with kidney disease in relation to the COVID-19 pandemic and are recommending a standard of care that some organisations are currently not able to implement. This represents a major inequality in care for people with kidney disease and demands rapid correction. At-risk kidney patients need to be aware of the availability of pre-hospital treatment and how to access it. Ideally, patients should be able to self-refer to CMDUs in all parts of the UK; however, given that they currently cannot, it is vital that renal units are prepared to facilitate such referrals happening in a timely and effective manner. Such access needs to be supported both pre-hospital and in hospital, given the high relative risk of worse outcomes and the difficulties of using some of the drugs in kidney patients (due to low eGFR and/or drug interactions).

It is imperative that access to neutralising monoclonal antibodies for high-risk kidney patients remains regardless of cost benefit analysis for the more general population.

Vaccination: The autumn booster vaccine programme is now underway. Renal services should be resourced to allow them to focus on supporting patients to be able to access vaccination through close working with vaccination centres, including providing advocacy for patients with kidney disease.

Both single centre analyses and that within the linked UKRR population suggests that there is substantial variation with people of non-White ethnicity, socially deprived backgrounds, and those with severe mental illness less likely to have received a full course of vaccination⁸. Data have also highlighted that where renal units themselves have been able to lead vaccination programmes, increased rates of vaccination have been achieved in comparison to the local population^{9,10}.

There is also a need for the continued systematic collection of data (e.g., through renal networks) to ensure that early changes in disease burden are identified.

We encourage clinicians to work in their organisations to support implementation for their patients.

These recommendations are also being sent to system leaders asking for support including to ensure transparency of decision making and equality of access to care.

References

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