407

Moving towards a risk based model for timing of pre-dialysis planning: our unit's experience

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Introduction

Guidelines exist for the timing of pre-dialysis education but these use finite eGFR cut offs as a point at which pre-dialysis education should be commenced, traditionally at our low clearance service an GFR of ≤20mL/min has prompted the commencement of dialysis planning. The evidence base for this approach is poor; it is possible that complex education is being provided to patients who will never need to start dialysis while others who may progress quickly could be being educated late putting them at risk of unplanned starts.

The risk of progression to end stage kidney disease is influenced by factors other than starting eGFR, the most significant of which is proteinuria. With the introduction of the validated and widely available kidney failure risk equation (KFRE) it is possible to re-think the way that we risk stratify low clearance patients and as such at our organisation we introduced a service specification that all patients with either an eGFR ≤15mL/min or a 2 year risk of progression ≥20% should have CKD education.

Method

The prevalent low clearance clinic population at a large tertiary referral unit was audited, demographic data as well as eGFR (using the MDRD formula) and ACR were collected and the pre-dialysis education status or modality decision was also documented. The KFRE has been incorporated into our electronic patient record and this was also collected.

Results

At the time of the audit 255 patients were under active follow up in the low clearance clinic. The mean eGFR was 15mL/min, 29 patients had an eGFR ≤10mL/min, 100 had an eGFR 10-14mL/min, 87 had an eGFR 15-19mL/min and 39 had an eGFR >20mL/min. When assessing against previous criteria for modality planning (eGFR ≤20mL/min) 182 patients (84%) had a documented modality decision and 18% had received education but were undecided. 201 patients with an eGFR ≤20mL/min (95%) had a documented transplant decision. When assessed using the risk based model 169 patients had a KFRE 2 year risk ≥20%, of these 7 had an eGFR ≥20mL/min. 142 (84%) of these patients (KFRE 2 year risk ≥20%,) had a documented modality decision and 16% were undecided, 92% had a documented transplant decision. At the other end of the risk spectrum there were 40 patients with a 2 year risk of progression of ≤10%, 8 of them had an eGFR ≤15mL/min; of the remaining 32 patients 32% had made a modality decision.

Conclusion

These data show that there were very few patients within the low clearance clinic who were at significant risk but where that risk had not been appropriately recognised and acted upon, however there is some evidence that there are a small number of patients who are at low risk of progression but who have been provided with detailed education. This puts them at risk of unnecessary anxiety and or intervention. The next step at our organisation is ensuring that patients known to other renal clinics who are at enhanced risk of progression are being appropriately identified and managed.