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P068 -The longer-term prognosis in Acute Kidney Injury (AKI) and the role of neoplasia.

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Background
The contemporary, longer-term prognosis of AKI, and the impact of cancer on that prognosis, are not well understood. We present here the longer-term results of AKI patients in our three AKI studies (a total of 2633 patients) commenced between 2008 and 2015, with follow-up of patient survival to late 2018. The impact of neoplasia on prognosis is not well understood: different solid neoplasia present challenges to Renal teams, as a variety of staging systems are used for individual neoplasia.

Methods
We staged the main solid neoplasm in the patient histories, at the time of AKI, rather than at the time of cancer diagnosis. We staged this neoplasm with the Surveillance, Epidemiology and End Results (SEER) staging system of the US National Cancer Institute. It is applicable to all solid tumours, and divides them into five main categories: In situ, Localised, Regional, Distant (Metastatic), and Unknown/unstageable status. The few cases of in situ cancer / dysplasia were included in the "localised" cancer group. We also recorded all other solid neoplasia, up to three in total. This included: i) all active solid neoplasia with treatment within 5 years; ii) inactive solid neoplasia where all treatment had finished more than 5 years before the AKI; and separately iii) haematological neoplasia; and iv) the total number of active neoplasia (both solid and haematological).

Results
The patients in all three studies had a broadly similar profile (table 1). Although survival seems to be improved in our 2015 study, this may be explained by the trial exclusions. In our earliest study, by ten years from the AKI event less than a quarter of patients were alive. Active neoplasia were present in at least a fifth of all AKI patients in our studies. The impact of neoplasia in our largest study (the AKORDD trial) largely had the expected pattern. For each additional active neoplasm survival worsened progressively. However, to our surprise, patients with localised solid tumours / dysplasia had better survival than those without cancer. Otherwise, compared to patients without cancer, survival was progressively worse in this order: those with solid neoplasia last treated more than 5 years ago; regional cancer and haematological neoplasia (these two had similar survival); metastatic cancer and those unable to be staged (these two had similarly very poor survival). Further analyses will be presented.

Discussion
Our data show the poor long-term prognosis of AKI, and the varying impact of different numbers and stages of neoplasia. Patients with active but localised neoplasia should be offered the full range of therapies for any AKI.