Department of Nephrology

Protocol

Work-up for Acute Renal Patients

1. This is applicable to all renal patients admitted to MAW not previously followed by a Grey’s Hospital Nephrologist, including acute and chronic renal patients and hospital consults.

2. Complete History: including uraemic symptoms such as nausea, weight loss, restless leg syndrome; change in urinary habits and volume; recent illnesses; medications (prescribed and over the counter) for at least the last six months; comorbidities including history of chronic pain; rashes; joint pain; oedema; contrast exposure; NSAID use; family history; past medical history; alcohol use; tobacco use; chemical and radiation exposure.

3. Full set of vitals including patient’s weight, orthostatic BP and pulse.

4. Full Physical exam: in particular signs of uraemia; volume status; mental status; neurological status; full skin exam for rashes, petechiae, turgor, excoriations and embolic phenomena; pulmonary auscultation and oxygen saturation, abdominal exam paying particular attention to bladder size.

5. Urine analysis: Dipstick and microscopy for casts and cells. (Do not order urine MC&S).

6. Serum: U&E, Ca2, PO4, Mg, Uric acid, alb, FBC, CK, PTH, hepatitis B and C, HIV, ESR, CRP

7. ECG, pay particular attention to T and P waves in hyperkalaemics

8. Chest X-Ray (PA and Lat)

9. Urgent Kidney Ultrasound for size, echotexture, hydronephrosis, etc.

10. Foley Catheter (note post void residual), strict intake and output, daily weight.

11. Evaluate for need of emergency HD. The following patients require emergent dialysis: Refractory hyperkalaemia (>6.0) with ECG changes, Hyperkalaemia > 7.0, uraemic encephalopathy, uraemic neuropathy, refractory pulmonary hypertension (DIALYSIS IS NOT A SUBSTITUTE FOR INTUBATION), severe metabolic acidosis with renal failure, ethylene glycol intoxication, lithium toxicity, tri-cyclic toxicity, cefepime toxicity, severe alcohol toxicity, etc. (your local poison control centre can help you identify other toxicities that may be amenable to dialysis).

12. Patients with encephalopathy should have an urgent CT scan of the brain before dialyzing (if unable to get CT scan, the patient must receive heparin free dialysis)

13. Pericardial friction rub is an indication for intense daily dialysis, not emergent dialysis. These patients should be monitored in a critical care setting and get an urgent echocardiogram prior to dialyzing as they are at high risk for tamponade and bleeding into the pericardium. Make sure other causes of pericarditis are properly explored as it is a relatively uncommon presentation of uraemia.

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