

Talk Transplant at 20 or Run the Risk?

Dr Sherry Masoud¹, Dr Elvin Subramanian¹, Dr Qiaoling Zhou¹, Dr Jim Moriarty¹

¹Gloucestershire Royal Hospital, Gloucester, United Kingdom

Talk Transplant at 20 or Run the Risk?

Introduction

Renal transplantation represents the best treatment for end-stage renal disease (ESRD) for those patients suitable. There remains variance in access to transplantation, and this is not entirely explained by patient characteristics. Several regions, including ours, have adopted improving access to transplantation as a regional Kidney Quality Improvement Partnership (KQuIP) priority¹.

With an overall aim of “More transplants, faster, with better experience” we have adopted a change idea of a documented transplant decision for patients with $eGFR \leq 20$ ml/min. Here, we measure our local baseline state of transplant decision making in a single unit, and consider whether tools other than eGFR such as a 4 variable kidney failure risk equation (KFRE) can help stratify risk of needing renal transplantation and be used to prioritise pre-transplant workup.

Methods 1

Data on patients ≤ 80 years old, receiving nephrology care in a Low Clearance clinic, with $eGFR \leq 20$ ml/min measured in the last 180 days, was extracted from the renal medical record. Patients with acute kidney injury were excluded, as were patients who had not completed initial clinic workup. Fields for transplant status, clinical problem list and the last five clinic letters were examined for evidence of a decision regarding transplantation.

Methods 2

A KFRE was applied to the patients identified above with $eGFR 16-20$ ml/min. A threshold of $\geq 40\%$ risk of needing dialysis or transplant over the next 2 years was used to identify the highest risk patients².

Results 1

For patients with $eGFR \leq 15$ ml/min, 36/39 had a clear transplant decision documented in the electronic medical record. Of those with a clear decision, 30/36 had this recorded in the “Transplant Status” screen, the others elsewhere in the record.

Decision making was less clearly documented in the $eGFR 16-20$ ml/min group, where only 32/72 patients had a clear transplant decision noted.

Results 2

In patients we identified with $eGFR 16-20$ ml/min, there is variability in the predicted two-year risk of progression to end stage renal disease. 10/72 patients had a $< 10\%$ 2-year risk of progression to ESRD, and only 13/72 had a $> 40\%$ 2-year risk of progression to ESRD.

Conclusion

Local recording of transplant decisions is robust for patients with CKD5 but less so for patients with only marginally better renal function, eGFR 16-20ml/min.

An eGFR trigger of 20ml/min to prompt discussion of transplant options and commence transplant workup will capture many high-risk patients, but also a substantial number at lower risk of progressing to ESRD.

A risk-based approach may be a more selective than an eGFR-based trigger in identifying and prioritising patients with renal disease who might benefit from renal transplantation.