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Global Perspectives in Acute Kidney Injury: Ireland

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**Introduction**

The impact of Acute Kidney Injury (AKI) on patient outcomes and healthcare systems has been demonstrated internationally (1). In the past 2 decades, Ireland has documented a rising incidence of AKI, particularly among hospitalised patients and the elderly (2). When compared to other OECD countries, Ireland has a high health expenditure, but a relatively low number of hospital beds per capita (3). AKI places further demands on a hospital system that is already pressurised. Northern Ireland, as part of the United Kingdom, is subject to a different governance and healthcare system. This article describes the experience with AKI for the island of Ireland in its entirety, including comments on clinical practice differences between the Republic of Ireland (RoI) and Northern Ireland (NI) where relevant.

**Epidemiology of AKI in Ireland**

Ireland does not have a national surveillance or audit system for AKI cases and hence epidemiological data is limited. One retrospective study using regional laboratory data reported an AKI incidence of 12.39% per 100 patient-years in 2014 (2). This data was predominantly gathered from the mid-west and northwest of Ireland. As the east of the country is the most populous region, this data may not be generalisable. However, this AKI incidence is comparable to the pooled incidence rate of 14.7% reported for Northern Europe in a meta-analysis of worldwide AKI rates (4). The majority of captured AKI cases in Ireland are diagnosed in a hospital-context (inpatient, emergency department attendance or outpatient clinic) with approximately 10% of cases diagnosed from samples requested from primary care practices (2). The authors are of the opinion that the impact of community-diagnosed AKI may be under-represented in published data.

Patients admitted to ICU in Ireland have a high illness severity on admission compared to international data, as evidenced by high APACHE2 scores and the relatively high proportion of patients receiving advanced respiratory support (ARS)(5–7). According to data published by the National Office of Clinical Audit (NOCA), 52% of patients admitted to ICU in RoI developed AKI (Stage 1-3) within 24 hours of admission to ICU (5,8). Comparable data from NI reported on an incidence of 35.5% (8). These rates are similar to those documented for other European countries but exceed incidence rates reported in the USA, Asia, Australia and New Zealand (9). Approximately 10% of AKI cases in the ICU receive RRT (both intermittent and continuous modalities).
Methodology of AKI Diagnosis

Trends in the diagnosis of AKI in Ireland have followed the evolution of standardised diagnostic criteria. The Kidney Diseases Improving Global Outcomes (KDIGO) Classification system is currently in widespread use (10). In recent years this has been increasingly utilised in clinical practice and in AKI research. NI developed and adopted a national algorithm for the management of AKI (11). It has been incorporated into the regional laboratory system, triggering an alert, prompting earlier recognition of AKI. A similar national algorithm has not been implemented in RoI, but local data would suggest that there is an appetite for implementing such a framework (12).

There is limited use of kidney injury biomarkers in a clinical context. However, some nephrologists have recently begun to use neutrophil gelatinase-associated lipocalin (NGAL) to improve diagnostic discrimination and aid management of AKI in routine clinical practice (13). Cote et al reported on the use of plasma and urinary NGAL in a heterogeneous cohort of AKI patients in their institution. In their experience, prospectively-measured urinary NGAL helped differentiate between transient (functional) AKI and persistent AKI. These results may prompt a shift in attitude and practice patterns in other centres in Ireland. The furosemide stress test (FST) can aid the prediction of AKI progression and renal recovery following RRT (14–16). The FST is gaining acceptance amongst many nephrologists in Ireland as an easily conducted and cost effective diagnostic tool in the management of AKI. It has been more widely incorporated into clinical nephrology practice than the use of plasma or urinary AKI biomarkers.

Prophylactic Prevention of AKI in High Risk Patients

Factors such as major surgery and exposure to nephrotoxic drugs confer an increased risk of AKI development, providing an opportunity for risk stratification and AKI prophylaxis. Data from Irish hospital admissions report an incidence of post-operative AKI in the range of 14-19% and 20-30% for non-cardiac surgery and cardiac surgery patients, respectively (17–21). Preoperative renal risk-prediction includes the measurement of serum creatinine and calculation of estimated GFR, and less frequently, detection and quantification of albuminuria. Risk stratification models are not routinely used in preoperative assessment but some nephrologists utilise the Cleveland Clinic (Dialysis Risk after Cardiac Surgery) Score (22). In our experience, those with underlying CKD are often prioritised for pre-procedure nephrology assessment to aid in medication reconciliation, haemodynamic optimisation and close post-operative monitoring. Such strategies are often omitted in those with a normal pre-procedure creatinine, despite the possibility of a low renal reserve. Kidney injury biomarkers are not routinely utilised to risk stratify patients undergoing cardiothoracic surgery, or
prior to any other anticipated renal threat (toxic or haemodynamic). In particular, Nephrocheck®,
which measures the urinary concentrations of [TIMP-2] x [IGFBP-7], has not been adopted in clinical
practice in Ireland.

Prophylactic strategies are evidence-based and reserved for selective patient populations.
Prophylactic strategies in routine clinic use in Ireland include pre- and post-insult volume expansion
for those receiving cisplatin-based chemotherapy, early fluid resuscitation in cases of
rhabdomyolysis, intravenous hydration and hypouricaemic agents in tumour lysis syndrome, and
therapeutic drug monitoring for potentially nephrotoxic antimicrobial agents. In terms of the
prevention of contrast-associated AKI, the clinical practice has followed international trends. In RoI,
pre- and post-contrast volume expansion strategies are generally reserved for patients with an eGFR
< 30ml/min/1.73m² for computed tomography (CT), with a higher eGFR threshold generally used for
those undergoing angiography (<45ml/min/1.73m² or <60 ml/min/1.73m²). The Northern Ireland
Guidelines for AKI recommend adequate volume expansion for those receiving radiological contrast
media with an eGFR < 30ml/min/1.73m² (or <60ml/min/1.73m² and additional AKI risk factors) (11).
The choice of fluid preparation, volume, rate and route of administration vary depending on
physician and department preference. N-Acetylcysteine is no longer in routine use as part of these
regimens.

Organisational Structure and RRT Management
The availability of renal replacement therapy (RRT) varies according to the hospital level. Renal units
are primarily located in larger tertiary referral centres (see Figure 1), with some smaller regional
hospitals also providing intermittent haemodialysis (IHD) (23). In larger centres, both intermittent
and continuous modalities are available. ICUs are a mix of open and closed units and working
relationships between nephrologists and intensivists are harmonious. Most nephrology consultants
in Ireland are also general medical physicians and manage their own cohort of acute and chronic
renal inpatients and general medical inpatients, in addition to providing advice and support to other
specialties.

RRT prescribing is conducted by both specialties: Nephrologists almost exclusively prescribe and
monitor the use of intermittent modalities, whereas continuous modalities are prescribed and
overseen by both critical care and nephrology physicians. As Ireland has a relatively low ICU bed
capacity, available ICU beds are in high demand (3). Most patients with sustained AKI are treated
with a combination of continuous and intermittent modalities, as their illness acuity changes. We do
not have a documented national breakdown of the proportional use of each RRT modality, but the authors estimate an approximate 50-50 balance between continuous and intermittent modalities in the acute setting. The preferred intermittent modality is intermittent haemodiafiltration. Prolonged IHD is used infrequently. CRRT (predominantly continuous venovenous haemodiafiltration) is available solely in intensive care units (ICUs), and the decision to opt for this modality is dictated by the individual clinical circumstances and to a lesser degree, by resource availability. RRT (both continuous and intermittent) is funded by the health service and no patient in need of dialysis is denied it for financial reasons.

**AKI Outcomes**

Outcome data for AKI survivors is not nationally audited in Ireland. The data captured stems predominantly from ICU audit data, which is recorded by NOCA in RoI, and by the Intensive Care National Audit and Research Centre (ICNARC) in NI. Data gathered from over 22,000 ICU admissions in NI from 1999 to 2007 reported ICU and hospital mortality rates for those with early AKI of 29.8% and 40.6%, respectively (8). Data from the Dublin Acute Biomarker Group Evaluation (DAMAGE) Study, a prospective cohort study of critically ill patients, reported that 98 of 186 patients with early AKI progressed to death or RRT within 30 days of admission (24). Unpublished data from the DAMAGE study found that amongst critically ill patients with AKI who survived to hospital discharge, the 12-month mortality was 12.7%. This compared to a mortality rate of 6.9% for those who did not develop AKI. Stack et highlighted the importance of AKI as a risk factor for CKD (25). In their study of patients in RoI, the prevalence of CKD was almost 50% among patients with a past history of AKI. Unfortunately, long-term survival data and outcomes such as the progression or development of CKD and cardiovascular events are not audited or recorded nationally.

**AKI Follow Up**

In Ireland, AKI clinical follow-up practices (criteria for nephrology outpatient follow-up, timing and duration of follow-up) vary between departments but there is a consensus amongst nephrologists that most AKI survivors require clinical follow up. This takes place in Nephrology outpatient clinics for those with prolonged or severe AKI (Stage 2 and above), incomplete renal recovery or proteinuria. Those with functional or pre-renal AKI which resolves promptly are often followed up in primary care, with guidance from Nephrology departments. The NI Guidelines for AKI recommend that those patients who are still recovering from AKI at the time of hospital discharge require follow up renal function tests to guide decisions regarding nephrology referral and to document recovery of baseline renal function.
Challenges & Conclusion
The impact of AKI on patient outcomes and hospital resources in Ireland mirrors that reported internationally. However, infrastructural limitations on the healthcare system pose additional challenges in the management of AKI. As previously mentioned, Ireland has a relatively low number of hospital beds and a shortage of ICU beds. Bed shortages often delay inter-hospital and ICU transfers, sometimes impacting the timing of RRT initiation. Consultant nephrology staffing levels are also low by international standards. In 2014 the RoI had 4.6 whole-time equivalent (WTE) nephrologists per million population (26). This figure is now closer to 8 WTE per million population. The authors estimate that NI has 13.8 WTE nephrologists per million population (27). This compares to a value of 7.4 for the United Kingdom and a value of 20.1 per million population for Europe (28). Hence, in reality, the timely and ongoing clinical follow-up of AKI survivors may be influenced by staffing and resource availability. An island-wide audit of AKI epidemiology and outcomes is warranted. There is a clear need for coordinated collation of AKI outcome data for Ireland, which could guide nephrology service planning and development nationally. Ultimately, this would improve the management and outcomes of this resource-intensive syndrome.

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References


**Figure Legend**

The major renal units in Ireland are marked on this map. The majority of these units are tertiary referral centres with a smaller number of regional hospitals. These units have dialysis centres and access to specialist nephrology services.