

Acute Kidney Injury: Global Health Alert

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Abstract

Acute kidney injury (AKI) is increasingly prevalent in developing and developed countries and is associated with severe morbidity and mortality. Most etiologies of AKI can be prevented by interventions at the individual, community, regional and in-hospital levels. Effective measures must include community-wide efforts to increase an awareness of the devastating effects of AKI and provide guidance on preventive strategies, as well as early recognition and management. Efforts should be focused on minimizing causes of AKI, increasing awareness of the importance of serial measurements of serum creatinine in high risk patients, and documenting urine volume in acutely ill people to achieve early diagnosis; there is as yet no definitive role for alternative biomarkers. Protocols need to be developed to systematically manage prerenal conditions and specific infections. More accurate data about the true incidence and clinical impact of AKI will help to raise the importance of the disease in the community, increase awareness of AKI by governments, the public, general and family physicians and other health care professionals to help prevent the disease. Prevention is the key to avoid the heavy burden of mortality and morbidity associated with AKI.

For the World Kidney Day Steering Committee 2013

World Kidney Day (WKD) is a joint initiative of the International Society of Nephrology and the International Federations of Kidney Foundations

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INTRODUCTION TO WORLD KIDNEY DAY 2013

On March 14, 2013, the 8th World Kidney Day (WKD) will be celebrated. WKD is an annual event jointly organized by the International Society of Nephrology and the International Federation of Kidney Foundations. This year, we aim to alert the public to the global increase in acute kidney injury (AKI) in both developing and developed countries. AKI is a syndrome of abrupt loss of kidney function, often with oliguria, which is strongly associated with increased early and long term patient morbidity and mortality, as well as the subsequent development of chronic kidney disease (CKD). There is an urgent need for a global health strategy to reduce the enormous growing burden of AKI and its consequences. We advocate that efforts focused on preventing AKI be coupled with early detection and treatment, and adequate follow up to reduce mortality and the long term burden of AKI-induced CKD.

GENERAL INFORMATION

Epidemiology of AKI worldwide

The KDIGO (Kidney Disease Improving Global Outcome) Clinical Practice Guideline for AKI, defines AKI as any of the following: increase in serum creatinine by ≥ 0.3 mg/dl (≥ 26.5 $\mu\text{mol/l}$) within 48 hours; or increase in serum creatinine to ≥ 1.5 times baseline, which is known or presumed to have occurred within the prior 7 days; or urine volume < 0.5 ml/kg/h for 6 hours [1]. Reports of the incidence of AKI in the community ranged from 2,147 to 4,085 per million population per year (pmp) in developed world [2,3].

Recent hospital studies in the developed world report AKI in 3.2-9.6% of admissions, with overall in-hospital mortality around 20%, and up to 50% in ICU patients [4,5]. AKI requiring renal replacement therapy occurs in 5-6% of ICU patients, with an extremely high in-hospital mortality rate of 60% [6]. It is estimated that about 2 million people die of AKI every year [6,7]. Those who survive AKI have a higher

risk for later development of CKD [8].

AKI in the developing world

Eighty-six per cent of the world's population lives in low and middle income countries, where AKI has a peculiar bimodal presentation. In urban areas, the main causes for AKI are renal ischemia, principally due to sepsis, and often associated with nephrotoxic drugs [9]. In rural areas, AKI is usually a community-acquired disease, affecting younger and previously healthy individuals. Specific causes of AKI include diarrheal diseases with dehydration, infectious diseases (malaria, dengue, yellow-fever, leptospirosis, tetanus and human immunodeficiency virus), animal venoms (snakes, bees, spiders, caterpillars), septic abortion, dyes and natural medicines [10-12]. Most of these factors triggering AKI are associated with poverty, poor sanitation and water hygiene (diarrheal diseases), a lack of education and access to an adequate urban infrastructure and healthcare system (septic abortions, snakebite, natural medicines, tetanus) and breaking of an ecological balance from uncontrolled and unplanned urbanization (leptospirosis, yellow-fever, bees and caterpillar accidents) [10-13].

AKI in the Developed World

The prevalence of AKI in the developed world has increased in the last decade [14,15]. AKI is now encountered in 45% of patients admitted to the ICU and 20% of hospitalized patients [16,17]. This increased prevalence likely reflects an aging population burdened by multiple co-morbidities, which is often managed with multiple drugs [18,19]. AKI is a multifactorial entity. Etiological factors include prerenal injury contributing to reduced renal perfusion, precipitated by iatrogenic events e.g. hypotension during anesthesia and surgery, or profound diarrhea secondary to *C. difficile* infection resulting from aggressive antibiotic therapy [20]. Drug induced kidney injury, hospital acquired infections, sepsis, complex surgery and diagnostic procedures requiring intravenous contrast are significant risk factors for development of AKI [21-23]. Patients in the ICU are dying of AKI and not just simply with AKI.

In the developed world, patients are increasingly cared for by multiple providers, often in different health care systems, with infrequent or minimal data sharing. This lack of knowledge often results in overdosing of nephrotoxic medications, like non-steroidal anti-inflammatory drugs (NSAIDs).

A recent national audit of the care provided to patients who died with a diagnosis of AKI in United Kingdom hospitals revealed several shortcomings: AKI was often diagnosed late, the initial severity underestimated, and diagnostic and

therapeutic interventions often incomplete or delayed [24]. This audit illustrates the urgent need for improving awareness of AKI and has prompted the medical community in the UK to implement specific measures to facilitate early recognition, timely diagnosis, and appropriate management and follow up of AKI patients [25].

AKI in children

The epidemiology of pediatric AKI has shifted in the last decades from intrinsic kidney diseases such as hemolytic uremic syndrome and glomerulonephritis to ischemia, nephrotoxins and sepsis in critically ill children [17]. The incidence of AKI is clearly increasing. Development of AKI is an independent risk factor for death in children, from neonates to adolescents. Recently, the concept of 'renal angina' was proposed and one of the strongest indicators of 'renal angina' and risk of further development of AKI in children is fluid overload [17,26]. As in adults, AKI carries a significant risk for late development of CKD in surviving children [17,27].

Other consequences of AKI

Patients with AKI utilize more resources and have longer hospital lengths of stay in part due to effect of AKI on other organ function: more difficulty being weaned off artificial ventilation, greater risk of fluid overload with a resultant increase in mortality, and impaired renal recovery and more prolonged recuperation. AKI contributes to CKD development and may result in dialysis dependency. Collectively these data demonstrate the high personal and community costs of an episode of AKI and stress the pressing need to address this problem in an effective way [28].

Is AKI preventable and treatable?

A central tenet of the WKD message since 2006 has been that "kidney disease is common, harmful and treatable". Like CKD, AKI is common, harmful and treatable, and is also largely preventable.

The heterogeneity of patients and the broad range of situations where AKI is encountered make it challenging to standardize an approach for evaluating and managing patients with this syndrome. The recent KDIGO guidelines for management of AKI provide an useful reference to assist clinicians for managing AKI, however the successful implementation of guidelines and their application to individual patients can be slow and requires concerted

efforts [1,29].

Prevention of AKI starts in the community with prompt assessment of those at risk, for example in taking prompt action following effective evaluation of the severity of fluid depletion in acute diarrhea. Regular drug therapy can compound that risk and the many older people taking NSAIDs or renin-angiotensin system blockers should be educated to discontinue them temporarily in the face of acute intercurrent illness, a so-called ‘medication holiday’.

In the developed world, the growing adoption of electronic medical records (EMRs) assists continuity of outpatient and in-hospital care. Active surveillance for changes in creatinine can automate alerts to guide drug dosing and reduce the incidence of drug-induced kidney injury [30,31]. An “AKI sniffer system” embedded in the EMR to warn physicians of changing renal function has been shown to increase the number and timeliness of early therapeutic interventions [32]. Currently serum creatinine and urinary volume remain the clinical pointers to AKI diagnosis. Given advances in medical informatics, biomarker development and interpretation, and therapeutic interventions, physicians and care providers should be educated about AKI and also the tools to manage these patients timely and effectively.

In the hospital setting, AKI preventive measures include adequate hemodynamic control, hydration, hematocrit and oxygen profiling, avoidance of nephrotoxic drugs and preventive maneuvers for particular diseases or conditions causing AKI. In the developing world, awareness of the specific infectious or venomous organisms in certain areas will allow environmental protection, vaccines, pharmacologic prophylaxis, and early administration of anti-venom. Prompt diagnosis, early treatment, timely hemodialysis and adequate supportive therapy are associated with improved outcome in AKI, [10,33,34].

Prevention for AKI is clearly the key to avoid the heavy burden of mortality and morbidity associated with this syndrome (Table 1), and this will only come about through increasing awareness of the true incidence and clinical impact of AKI among governments, the public, general and family physicians and other health care professionals. Most etiologies of AKI can be prevented by interventions at the individual, community, regional and in-hospital levels. Effective measures must include community-wide efforts to increase an awareness of the devastating effects of this illness and provide guidance on preventive strategies and for early recognition and management. Efforts should be focused on minimizing AKI causes, increasing awareness of

the importance of serial measurements of serum creatinine in high risk patients and observing urinary volume to achieve early diagnosis. Protocols need to be developed to systematically manage prerenal conditions and specific infections.

Renal replacement therapy for AKI

When AKI patients require renal replacement therapy (RRT), the current KDIGO recommendations are to deliver an effluent volume of 20–25 ml/kg/h for continuous renal replacement therapy (CRRT) or to deliver a Kt/V of 3.9 per week when using intermittent or extended RRT [1].

Peritoneal dialysis (PD) should also be considered for AKI, particularly in developing countries, because it is a simple, effective, safe and relatively inexpensive form of RRT [1,35].

Table 1
Strategies for Preventing AKI

Government	Funding support for AKI research in hospital and community on AKI incidence, outcome and mortality
	Funding support for setting up AKI registries
	Recognition of natural hazards for AKI water sanitation, flooding, venomous animals
	Recognition of AKI in common infections : malaria, dengue, leptospirosis, HIV, post infectious hemolytic uremic syndrome
	Better obstetric care
Public	Collaboration with healthcare professionals on educating the public about AKI prevention
	Aware of the potential problems of AKI and avoid unsupervised, indiscriminate and long term use of nephrotoxic drugs and natural substances
	Awareness of patients at risk for AKI and situations contributing to AKI
	Aware of pre-renal causes of AKI and of the need for early and appropriate rehydration and hemodynamic optimization in hypovolemic patients
General practitioners and physicians	Aware of natural and man-made nephrotoxin, nephrotoxic drugs, herbs and indigenous medicine
	Judicious use of nephrotoxic drugs and aware of potential drug interactions
	Early recognition of AKI and early referral to nephrologists
	Establish and implement common AKI diagnostic criteria and definitions for prevention, treatment and research
Nephrologists	Find new diagnostic tools including inexpensive technology and biomarkers for AKI diagnosis and monitoring
	Adapt renal replacement therapy to regional needs, technique and resource availability

CONCLUSION

The worldwide celebration of World Kidney Day 2013 provides an opportunity to share the message that acute kidney injury is indeed common, harmful, preventable and treatable, and that protecting the kidneys from this lethal syndrome is an important health strategy for the patient and the community. The effective implementation of such strategies will only come when both the general public and the renal community work together to convince health

authorities of the pressing need to do this. Government and health authorities must allocate resources to manage this problem both in the developed and developing world.

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