

Recognition of Acute Kidney Injury [Editorial]

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EDITORIAL

Acute kidney injury (AKI) is a common clinical syndrome characterised by a rapid (over hours to days) decline in glomerular filtration rate, perturbation of extracellular fluid volume, electrolyte and acid-base homeostasis, and accumulation of nitrogenous waste products from protein catabolism (blood urea nitrogen and creatinine).¹⁻² This is a common clinical syndrome which complicates up to 5% of hospital admissions¹ and has considerable morbidity and mortality¹⁻³. Indeed, mortality for community-acquired AKI ranges between 10-30%, depending upon patient comorbidities¹, and patients requiring renal replacement therapy for AKI have a mortality rate in excess of 50%³. Therefore, this is condition that junior clinicians and students will see regularly and will be required to manage promptly and effectively. However, there is commonly voiced uncertainty about the clinical care of these patients on the general surgical and medical ward. In this edition of the Scottish Universities Medical Journal, Dr Fiona Duthie and Professor Jeremy Hughes provide a framework for the junior clinician or non-specialist to approach patients with AKI in the Acute Receiving Unit, with consideration of the potential underlying cause and initial investigations and management³.

Within this issue we have two research papers in the speciality of nephrology looking at clinical issues within transplant medicine⁵ and for patients who have received a unilateral nephrectomy⁶. Firstly, Dr Mohammed Waduud and colleagues outline some of the complications of newly recommended immunosuppressant regimens to reduce the incidence of cytomegalovirus in the post-renal transplant patient population. The work found that patients treated with mycophenolate mofetil (MMF) and valganciclovir (VGC) are at a significantly higher risk of leucopenia when compared to patients not treated with MMF and VGC in the first 3 months post-renal-transplant. The paper discusses the implications of these findings and how best to manage the risks and benefits of different immunosuppressant regimens. Secondly, Stephen Hamilton and colleagues look at renal function for patients who underwent unilateral nephrectomy. The authors found that there were smaller reductions of GFR after partial versus total unilateral nephrectomy. The authors discuss the importance of these findings in relation to both surgical and medical decisions and make recommendations about follow-up care of this patient group. As always we welcome comments and suggestions about our publication and welcome submissions for future main issues, online platform and supplements. Finally, as several members of the committee graduate this year, we will be handing over to a new committee who I hope will continue to develop the journal in the coming academic year.

References

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