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A joint Diabetic Renal Clinic: does it work?

Diabetic kidney disease affects 20-40% of people with diabetes and is a leading cause of ESRF; furthermore, it increases the risk of cardiovascular disease 3-5 fold and premature death 6 fold such that a significant number of patients do not survive long enough to receive renal replacement therapy.

In 2004 primary and secondary care multi-disciplinary group developed guidelines for early identification, treatment and timely referral to a joint diabetic renal clinic. The service was later redesigned to incorporate Diabetes and Renal NSFs. It was soon recognised that early disease (CKD 1-2) should be managed in primary care and progressive diabetic CKD 3, CKD 4-5 managed in the diabetic renal clinic in order to maximise renal protection and safety of the use of drugs for control of the RAS and more importantly to treat CV risk factors and prepare patients for renal replacement therapy or conservative (non dialytic) management.

This has led to a timely flow of patients and a significant reduction of diabetic “crash landers” (late referrals) to dialysis. The North Wales Network has allocated resources to meet the ever increasing demand of the service. The multi-disciplinary nature of the clinic was key to the success and an audit of 130 patients will illustrate this point. Currently the team consists of 2 Nephrologists, 1 Diabetologist, 1 Diabetes Specialist Nurse, 1 CKD/Anaemia Nurse, 1 Dietician, 1 Renal Pharmacist and is supported by a Consultant led Palliative Care Team, a Renal Social Worker and Consultant Psychologist are due to be appointed by the middle of this year.