SPECIALTY

Nephrology

Arista|MD

CHIEF COMPLAINT

Chronic Kidney Disease

COMMENTS TO SPECIALIST

This is a 76 y/o AA female with active medical conditions: DM2, HTN, CKD4, dementia, GERD and OSA. s/p 12-day hospitalization from 5/28 through 6/9 for toxic encephalopathy and tremors. Work-ups while hospitalized included UA, CT head, VBG, TSH, ammonia, and B12, all of which were unremarkable. MRI brain negative for acute stroke. EEG negative. Her Zyprexa and Tramadol were discontinued, and weaning of Baclofen began with noted improvement. She was provided IV hydration for AKI with improvement back to baseline of CKD 4.

MAIN QUESTION

She was sent to SNF. Veltassa 8.4 mg once a day. The series of BMP showed potassium ranging from 3.7-3.9. She continued to have watery stools on colostomy output. Today, her creatinine is up to 3.43 BUN of 40 from 1.87/22 last 06/19/23. I plan to give her a slow IV x2 L. I am giving her D5.45 at 80 ml/h for 1 L daily x2 doses. Pharmacy supplies do not have 0.45 NS. I have the renal panel and magnesium orders for Monday, 07/03/ 23. I am seeking further recommendations.

Specialist Response

SUMMARY

Treatment options are available at the primary care level.

DETAILS

Thank you for the consultation. The patient seems quite complicated. It seems like she was recently hospitalized for encephalopathy and unresponsiveness. It is suspected that the cause for her decreased mentation was due to her centrally acting and sedating medications, which likely caused some toxicity in the setting of her AKI. When the renal function declines, medications can build up, and the metabolites can stay in her system longer, causing confusion.

I agree with stopping some of her centrally-acting and sedating medications (Zyprexa, Tramadol, and weaning of her baclofen). Her current AKI may be due to increased colostomy output. We seen this type of prerenal clinical course when the colostomy output is high, and this leads to a relative dehydration and volume depletion. I'm curious as to why she has a colostomy.

If her colostomy output is high, then I definitely agree with IV fluids. She may even need more than 2 liters a day if the colostomy output is high. If D5 1/2 NS is not available, then NS is fine. I would try and match her ostomy output with her IV fluids or even consider targeting a net positive balance of 1 liter a day for the next few days. If her renal function improves with IV fluids, then this tells us that her recent AKI is all prerenal and volume-mediated.

I would like a urinalysis, urine sodium, urine creatinine, and urine microalbumin as well. I want to make sure I'm not missing anything else. If you could also get a phosphorus level, vitamin D-25 OH level, uric acid, iron panel, and ferritin, that can also give us some information about her underlying CKD severity as well. Regarding high colostomy output, I recommend stopping any enemas and suppositories for now. Please avoid Fleets enema in CKD as well. We can even consider a bulking agent (fiber, Metamucil), as well as loperamide (Imodium). This may increase the consistency of her colostomy output slow it down and help minimize the GI losses. Also, if her colostomy output has been high, her blood pressure may even be a little on the lower side. I would place hold parameters on her amlodipine and clonidine for now so that they are not given if her blood pressure is less than 120 mm Hg; otherwise, we run the risk of causing hypotension in a state of volume depletion. This can further worsen her AKI. You can continue her Veltassa for now; however, her potassium doesn't seem to be a major issue at this time. If her K continues to be stable, we can consider stopping the Veltassa in the near future once her repeat labs come back on Monday. Keep me posted and let me know if you have any other questions.