# MANAGEMENT OF PREGNANT CKD PATIENT

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# Management of Pregnant CKD patient

- Management of pregnant CKD patient requires a multidisciplinary approach.
- This  involves experienced Obstetrician, Nephrologist and Neonatologist.
- Decision making must be team based requiring inputs from all the above mentioned specialists and the patient.

# HIGH RISK PREGNANT CKD PATIENT

- CKD patients in stages 3-5
- CKD  with poorly controlled hypertension and severe proteinuria irrespective of the GFR/CKD Stage
- CKD patients with history of preeclampsia
- CKD patient with poor social and family support
- CKD patient with financial constraints

# Pre-pregnancy Counseling

***This should be done for all CKD females in the child bearing age***

- Educate on associated maternal risk
- Educate on associated fetal risk
- Educate  on the appropriate methods of contraceptives for high risk patient
- Educate on discontinuation of potentially nephrotoxic antihypertensives such as ACEIs, ARBs
- Adherence to Antenatal clinic

# Principles of ANC in Pregnant CKD patient

- Regular assessment of fetal well being
- Aim at BP target of 110-140/80-90 mmHg
- Add  Sol ASA if serum Cr is> 1.5mg/dL or 130micromol/L
- Correct interpretation and management of changes in serum creatinine

# Principles of ANC in Pregnant CKD patient

- Early identification and treatment of UTIs
- Antihypertensive review
- Discontinue ACEIs, ARBs, warfarin and statins
- Heparin prophylaxis in Nephrotic syndrome
- Early identification and management of superimposed preeclampsia

# Assessment of fetal well-being

- Early USS for accurate fetal dating and EDD in the first trimester
- Mid trimester scan at 18-20 weeks for fetal morphology, structural anomaly, fetal well-being and placental position
- 2-4 weekly USS thereafter especially those in CKD stages 3-5 to assess fetal growth and amniotic fluid volume
- Doppler studies of umbilical arterial blood flow

# Challenges that may occur during the management of a pregnant CKD patient

- Worsening of BP/ difficulty in BP control
- Worsening Proteinuria
- Deterioration in GFR
- Pregnancy loss
- IUGR
- Prematurity
- Congenital anomaly
- Anaemia
- Malnutrition

# Management of Pregnant CKD patient

- Increase dialysis dose: 20 hours/week
- Gentle Ultrafiltration of not more than 2L per dialysis session
- Increase Erythropoietin and Iron
- Regulate dialysate calcium
- Achieve bicarbonate of 18-22mmol/L

# Management of Pregnant CKD patient

- Phosphate supplementation
- Increase heparin dose
- Increase Protein intake
- Folate supplementation
- Soluble aspirin: 75-100mg/day
- Achieve BP goal of 110-140mmmHg/80-90mmHg

# TAKE HOME MESSAGES

- Successful pregnancy and delivery is realistic in CKD females if well planned.

- The successful management of a pregnant CKD female in Nigeria depends largely on availability of medical expertise, facilities and funds.

# TAKE HOME MESSAGES

- Management  requires a multidisciplinary approach involving experienced Obstetrician, Nephrologist and Neonatologist.

- Decision making must be team based requiring inputs and commitments from all the above mentioned specialists and the patient

# THANKS FOR YOUR ATTENDANCE AND ATTENTION