

Renal Elective Report

My renal elective was at Wellington Hospital, New Zealand where I had a fantastic opportunity to experience the different aspects of a renal service. Wellington Hospital has a historic pedigree for renal medicine in New Zealand delivering the first hospital peritoneal dialysis in 1954 and haemodialysis in 1958. It has a 36-bed ward and a nine-bed haemodialysis unit as well as satellite dialysis centres in the community, the largest being at Kenepuru Hospital. New Zealand has a high cost of living and elective fees and I am very grateful for the money I received from The Renal Association which helped to fund this fantastic placement.

Wellington Hospital allowed me to immerse myself in a renal service. I was able to spend time on the ward, in renal clinics and on dialysis units (both central and satellite) as well as seeing the interaction between renal and transplant services in providing this life-changing treatment. Whilst working with the ward team I was involved in both consultant and registrar ward rounds allowing me to follow patients during their inpatient stay observing their progress as they went through diagnosis and treatment. There was an excellent range of conditions, from important renal presentations to very unusual and often puzzling symptom constellations.

One patient I assessed on behalf of the team was a very useful learning case. A middle-aged man presented with two months of increasing shortness of breath on exertion (now limiting his walking distance to 10m), increasing nocturia and polydipsia. He presented because of a haemoglobin of 67 measured in the community and deteriorating renal function. He was admitted under the medics and referred for a Renal review because of a left renal mass on his CT abdomen presumed to be a Renal Cell Carcinoma. On review the constellation of worsening renal failure, anaemia (plus mild pancytopenia) and a T7 bony lesion on CT led us to question a diagnosis of Multiple Myeloma (despite a normal calcium). The hypothesis was that the left renal mass was actually a plasmacytoma. We liaised with haematology and a bone marrow biopsy was organised. The results showed >30% plasma cells and the diagnosis was confirmed. He was started on treatment and despite requiring initial dialysis his renal function vastly improved and discharged home to continue haematological treatment as an outpatient.

The case was an excellent example of how a thorough history and assessment lead to a diagnosis and ensured the patient received rapid and effective treatment, potentially preventing long-term renal impairment. It also demonstrated one of the reasons why renal is such an interesting specialty: the kidneys not only have a vast array of isolated renal conditions but are also affected by many multi-system diseases. Renal physicians are therefore required to have both specialised renal knowledge and skills as well as the ability to manage general medical problems, something I find particularly rewarding about the area.

Another case I saw during my placement gave me some insight into end-of-life decisions in patients requiring dialysis. We were asked to advise on providing dialysis in an acutely unwell patient with acute alcoholic hepatitis. Before this episode he was a known drinker but otherwise well. He was admitted to ITU with hepato-renal syndrome and received Continuous Renal Replacement Therapy (CRRT) primarily to give the family time to adjust to the poor prognosis but also to give the patient some temporary support in case some hepatic recovery was possible. Once the patient was transferred to the ward it was clear that hepatic recovery was not possible in the setting of deteriorating liver function tests and a clinically worsening patient.

At this point the renal team were asked to provide an opinion on whether continued dialysis treatment was appropriate. A family meeting was organised to discuss the options and likely outcome with the family. It was hugely valuable for my learning to be allowed to observe this meeting to see how news about end-of-life decisions is broken to families. The consultant was incredibly clear with the information and allowing time for the family to process the likely outcome and ask any questions they had. This case again demonstrated how many aspects of medical care renal physicians can be involved in.

Overall this elective has been an excellent chance to experience renal medicine in a different country and culture. It has been very interesting to see some of the differences between the UK and New Zealand systems, primarily how the service is structured in New Zealand to provide for a smaller population over a larger area. This placement has allowed me to experience renal medicine in greater depth, seeing what is involved for all the different members of a renal team, from dialysis nurses to the clinical lead for the Wellington renal service. It has cemented my interest in the speciality and I am hugely grateful to have had this opportunity. I would like to thank The Renal Association for the grant which helped to facilitate such a fantastic placement.