Round Table: Management of Advanced Kidney Disease

Chair: ***Adedamola Soyibo***

The History of Transplantation in the Caribbean: Past, Present and Future

Ludlow Lawson Douglas

Kidney transplantation started in the region at the Kingston Public Hospital (KPH) in September 1970. The donor kidney was from a cadaver. This success resulted in transplants being performed on a regular basis at the rate of two to five per year at that institution until the late 1980s when, with improved immunosuppression, they performed the first live donor transplant. The KPH remains the only centre in the British Caribbean to have performed cadaver kidney transplantation. Just over 100 kidney transplants have been done at the KPH; the great majority since 1993 being from live donors. There have been transplants at the University Hospital of the West Indies (UHWI) with the joint KPH/UHWI transplant team. The cost of modern immunosuppression for live donor kidneys has resulted in a cessation in transplantation over the past five years. Since 2014, the Dialysis Unit at Cornwall Regional Hospital in Montego Bay, Jamaica, has done about four transplants along with an imported team from the United Kingdom, and subsidized cost of immunosuppression.

Barbados started live donor transplantation in 1987 and still has a functioning programme. Trinidad has a very active live donor kidney transplant unit started in the early 1990s and, like Montego Bay, has an imported British team coming in at intervals to assist.

In the future, it is hoped that the cost of improved immunosuppression will be subsidized or become affordable and that all three major islands will develop both cadaver and live transplant programmes to alleviate the urgent need for kidneys. This will of course necessitate developing transplant teams independent of outside help.

The Diabetic Child and Kidney Disease

Maolyne Miller

With the obesity epidemic in children, Type 2 diabetes is rivalling Type 1 in the paediatric population. Microalbuminuria and/or renal failure usually do not become apparent until five years after diagnosis and is rarely seen in children, as young age at diagnosis appears protective. Puberty is a risk factor for diabetic nephropathy (DN). Good control of hypertension, hyperglycaemia and hyperlipidaemia helps reduce the risk of DN and slows its progression. Microalbuminuria is the gold standard for early detection of DN and management includes angiotensin-converting enzyme inhibitors and angiotensin receptor blockers. In overt renal failure, some hypoglycaemic agents may need dose adjustments or avoidance.

Chronically poor or no diabetes control in childhood may manifest as Mauriac syndrome and the early manifestation of diabetic bladder disease, which may result in obstructive uropathy, hypertension, urinary tract infection and secondary renal pathology. Patients on high-dose steroids for glomerulonephritis and immune-mediated disease may develop steroid-induced diabetes which, if not properly managed, may ultimately worsen the renal prognosis.

As established DN is incurable, attention must be paid to preventing childhood obesity and early detection of incipient nephropathy at a stage when disease is reversible.

The Critical Importance of Psychological Care before, during and after End-stage Renal Disease Diagnosis

Coretta Brown-Johnson

Having been involved primarily with children who have had to cope with the effects of diabetes as a medical challenge over the past few years, and in partnership with the Diabetes Association of Jamaica, it has been made clear that the psychological challenges after diagnosis, if not managed effectively, can seriously impede adequate and efficient management, as well as impact the client/patient behaviourally and socially in a way that renders them dysfunctional.

The psychological application process can involve: i) medical specialist, ii) diagnosis, iii) counselling with planning, iv) treatment – counselling/treatment management/case management, v) psychological support, vi) end-phase transition and vii) discharge – post consult/follow-up. The psychological input and process would run concurrently as needed and required.

According to Cohen (2007), "Patients with ESRD treated with haemodialysis deal with the multiple stressors of their illness and attempt to make their way through life in the context of their intimate relationships, families,

social networks, treatment programmes and cultures. They must cope with the demands of their occupations, the changes in their life roles, and the challenges and opportunities that life exposes them to while balancing the restrictions that life on haemodialysis entails."

All factors linked to psychological impact have to indeed be managed effectively for better outcomes to manifest and allow for amiable transitions and acceptance.