

Case 1

55 year old male
Type 2 diabetes for 15 years
Longstanding poor diabetic control
Moderate background retinopathy

Referred for investigation of proteinuria

Drugs:	Amlodipine 10mg od	Aspirin 75mg od
	Enalapril 5mg od	Ibuprofen 400mg bd
	Metformin 850mg bd	Omeprazole 20mg od
	Rosiglitazone 4mg bd	Simvastatin 40mg od

Smokes 10 cigarettes per day

BP 163/74mmHg

Urine dipstick 2+protein, no blood

Investigations:

	2005	Aug 06	Oct 06	Feb 07
Creatinine	75	86	93	98
eGFR		84	76	72
Urine ACR	10	20	40	60mg/mmol
HbA1c	10-11.5%	7.5%	8%	9.5%
Cholesterol				3.7
Haemoglobin				13g/dl

Questions

1. What is the most likely cause of the proteinuria?
2. Does he have CKD? If so, how would you classify his CKD?
3. Does he need referral to secondary care? If so where?
4. What are the key elements of his management now and long term?

Case 2

40 yr old male

Attends for a New Patient Check

Previously fit and well and on no medication

Urine dipstick - 3+ blood and 2+ protein

BP 160/94

Questions

1. What would you do next and what further investigations would be helpful?
2. Does he have CKD? If so, what stage?
3. What is your management plan for this patient now?

Case 3

70 year old lady

MI 2 years ago and long standing hypertension

Type 2 DM for 4 years, no microvascular complications

Attends surgery as feeling a little more tired

Medication: Metformin 500mg bd Gliclazide 40mg od
 Aspirin 75mg od Atenolol 50mg od

eGFR 32ml/min, creatinine 150

Haemoglobin 9.8, normochromic normocytic

Urine dipstick 1+ protein, no blood

Urine ACR 25mg/mmol

Cholesterol 5.8 HbA1c 6.8%

Blood pressure 165/95mmHg

Questions

1. What other piece of information do you need to decide if this lady has CKD?
2. How would you stage her CKD?
3. How would you manage her anaemia?
4. What are the other key elements of her management?