THB1

Managing Chronic Kidney Disease Better: Where Do We Stand?

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Background:

Chronic Kidney Disease (CKD) is a major global health burden associated with cardiovascular morbidity, progression to kidney failure, and reduced quality of life. Evidence-based management slows CKD progression and improves outcomes. The KIDGO guidelines recommend use of ACE inhibitors/ARBs, SGLT2 inhibitors, statins, and , more recently, Finerenone in appropriate patients. This audit assessed current practice in CKD management against KDIGO recommendations.

Methods:

A retrospective audit of 358 CKD patients (September - October 2023) was undertaken. Demographics, comorbidities, stage of CKD, and treatment with ACEI/ARB, SGLT2 inhibitors, statins, and Finerenone were collected. Blood pressure and proteinuria control, as well as antiplatelet use in patients with established cardiovascular disease, were reviewed. Outcomes were compared against KDIGO guideline standards.

Results:

A total of 358 CKD patients were included, of whom 56% were male and the majority (65%) were aged over 60 years. Diabetic kidney disease was present in 44% of the cohort, and one-third had proteinuria. Most patients were in advanced stages of CKD, with stages 3B and 4 together accounting for over half of cases.

Among proteinuric patients, 47% were prescribed SGLT2 inhibitors, and of these, 70% demonstrated a reduction in proteinuria of greater than 15% from baseline. ACE inhibitors or ARBs were prescribed in 76% of proteinuric patients, though in half of the cases where these agents were not used, no reason was documented. Statins were prescribed in 62% of the overall cohort, with higher use in patients with diabetic kidney disease (81%).

Finerenone use was very limited, with only 2.5% of diabetic kidney disease patients receiving this therapy. Blood pressure control was suboptimal, with less than half of proteinuric patients achieving the NICE recommended target of <130/80 mmHg, while 39% remained above target and 12% had no documented readings. Antiplatelet prescribing was appropriate in all patients with established cardiovascular disease.

Conclusion:

Our audit demonstrated reasonable adherence to KDIGO guidelines in ACEI/ARB and statin use but identified significant gaps in SGLT2 inhibitor and Finerenone prescribing, as well as suboptimal blood pressure control and documentation. Improved awareness, guideline implementation, and robust documentation are needed. A re-audit will assess the impact of interventions.

THB2

Transform AKC Project: A QI approach to document our health literacy journey with our advanced kidney care (AKC) population.

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Introduction:
Low health literacy affects 25% of people with CKD particularly minority ethnic groups and lower socioeconomic groups (1). In two of the five boroughs we serve, 50% of the population have low health literacy, rising to 69% when you include numeracy (2). Recognising the link between low health literacy and inability to navigate health care systems and outcomes. The nurse-led advanced kidney care team wanted to learn more. Our aim is to measure health literacy levels in 60% of the AKC population by 31/12/25 on our renal data base and plan how we use this information to shape AKC care.

Methods:
We identified a tool, Single item literacy screener (SILS) designed to identify patients with limited reading ability who need help reading health –related material. A question built into a consultation. A score more than 2 identifies a reduced reading ability. A free text box was added to allow for comments such as poor eyesight, or who helps them manging their medications etc to act as a resource for all renal staff regardless of modality. Baseline AKC staff survey to be repeated at intervals to monitor progress.
Education on health literacy toolkit for staff - chunk and check, teach back, Hemmingway app (HA), SILS record.
We recorded patient language, if interpreter required, kidney kitchen and kidney care support QR code scans.
Plan, do, study, act (PDSA) cycles facilitating modifications. Patient involvement in project and kidney patients' association at patient education sessions (PES). PES include data on those invited, attendees, evaluation of session with SILS and understanding why people do not attend with SILS and how we can adapt. Evaluation survey language adjusted using Hemingway app. Recruited AHP's to capture SILS during their consultations. Document on renal data base those that attended PES, did it help them decide treatment and whether SILS score impact on decision making, transplant activation. Monitor DNA's. Eliminate abbreviations in patient letters employing simple language with HA.

Results-
Challenges encountered, delay getting SILS on renal data base, SILS record started July 2025 with monthly target 10% being achieved to date.
Established patient education session could be better attended, SILS identified those with good reading ability more likely to attend PES.
Kidney kitchen QR code scanned 60 times from posters (38), letter (11) and patient letter (11). Kidney care support poster no QR scanned with flyers scanned 10 times.
Poor WiFi at one kidney care centre (KCC) affecting QR code scanning and PES evaluations had to switch to paper.
60% of staff felt neutral or not confident when assessing the health literacy level of patient in pre staff experience survey.

Discussion:
Improve patients WiFi at our busiest KCC located in deprived area as QR codes cannot be scanned. To improve accessibility for PES addressing kidney health inequalities. Add level of education to renal data base. Audit sample patients- is there a correlation between SILS score, PES attendance, treatment decision, treatment option and attendance. Create visual tools. Staff learning and simplify language in letters to patients.

THB3

The role of colchicine in ameliorating inflammation and fibrosis in chronic kidney disease

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Chronic kidney disease (CKD) represents a significant global health burden, affecting nearly 10% of the adult population and contributing to considerable morbidity, mortality and healthcare expenditure. A hallmark of CKD progression is the development of tubulointerstitial fibrosis, a pathological process that irreversibly damages renal architecture and function, regardless of the initial insult. Increasing evidence points to a critical interplay between chronic inflammation and fibrosis in the kidney, with inflammatory pathways driving fibrogenesis through sustained activation of immune cells, cytokine release and profibrotic signalling cascades.

Given this strong association, we hypothesised that mitigating renal inflammation could attenuate fibrosis and thereby slow the progression of CKD. To explore this, we investigated the therapeutic potential of colchicine, a long-standing anti-inflammatory agent with a well-characterised safety profile and clinical utility in diseases such as gout and pericarditis. Its ability to inhibit microtubule polymerisation and modulate the NLRP3 inflammasome makes it a promising candidate for targeting the inflammatory milieu in CKD.

Our study employed both in vitro and in vivo models to assess the effects of colchicine on key fibrotic pathways and renal function. In vitro, we examined colchicine's impact on cytokine release under pro-inflammatory conditions. In vivo, we utilised established murine models of renal fibrosis- including unilateral ureteral obstruction (UUO) and adenine-induced CKD- to determine whether colchicine reduces histological fibrosis, inflammatory infiltration and preserves renal function.

Our results demonstrate that in experimental models of CKD, colchicine treatment resulted in reduced fibrotic burden and improved functional outcomes, thereby providing preclinical evidence for its repurposing as a potential therapeutic in CKD. Together, we believe this research paves the way for novel anti-inflammatory strategies aimed at decelerating fibrosis and preserving renal function in patients with CKD.

THB4

“The main focus was something else” - exploration of health care professionals’ perspectives of chronic kidney disease and kidney failure risk in multimorbidity and frailty: a qualitative study

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Background and Aims: Chronic kidney disease (CKD) is predicted to increase in prevalence and commonly co-exists with multiple long-term conditions (multimorbidity) and/or frailty, creating growing challenges for healthcare systems. These overlapping conditions add complexity and burden for both patients and healthcare professionals, where priorities and decision-making are often complex and may lack an evidence-base. Clinical guidelines recommend the use of the Kidney Failure Risk Equation (KFRE) to guide referral to secondary care kidney services. However, its role in supporting patients with multimorbidity or frailty is under-researched. This qualitative study aimed to explore healthcare professionals’ perspectives on CKD, kidney failure risk and the use of KFRE in the context of multimorbidity and/or frailty.

Method: Focus groups and semi-structured interviews were conducted with healthcare professionals caring for individuals with CKD and multimorbidity and/or frailty from primary and secondary care settings in a single NHS health board between March 2024-July 2025. Purposeful sampling was used to ensure variation in job role and to capture differences in practice across settings. Topic guides were informed by the Ottawa Decision Support Framework and Ottawa Personal Decision Guide. Data were collected until saturation and analysed using a theory informed abductive approach underpinned by Normalisation Process Theory.

Results: Seven healthcare professionals from primary care and twelve from secondary care settings participated, the majority had over ten years’ experience in their job role. Participants included renal consultants, specialty registrars, specialist nurses, general practitioners and practice nurses involved in CKD care. Five key themes were identified that influenced healthcare professionals perception and communication of CKD and kidney failure risk: 1) Variation in individual patient knowledge and health literacy, with terminology around CKD often confusing or concerning for patients; 2) The additional “work” created for both patients and healthcare professionals as a consequence of multimorbidity and frailty; 3) Relationships and interactions between individuals, healthcare professionals, the healthcare system and support networks, where trust and continuity facilitated shared decision-making; 4) Context and priorities, including the relative prioritisation of CKD; and 5) Uncertainty, relating to prognosis, trajectories, how and when to discuss kidney failure risk and the role of KFRE, which was viewed as valuable for

standardising decision making but limited by integration challenges and lacking of nuance in the complexity often encountered in individuals with CKD and multimorbidity or frailty.

Conclusion: Healthcare professionals recognised the challenges of supporting individuals with CKD in the context of multimorbidity and frailty, where priorities are often competing and shared decision-making is complex. Variation in patient knowledge, understanding and awareness of CKD and the prioritisation of CKD by patients, healthcare professionals and government/policy makers is an important area for future work. Awareness of KFRE was limited in primary care, but it was regarded as a potentially useful tool for standardising communication and referral. However, concerns remain about its integration into practice and its utilization in the complexities of multimorbidity and frailty. These findings will inform care planning, healthcare systems and shared decision-making discussions about CKD and kidney failure in individuals with multimorbidity or frailty.

THB5

Finerenone in diabetic kidney disease: a retrospective review of kidney function, potassium and proteinuria in a chronic kidney disease medicines optimisation clinic in secondary care

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Introduction

Finerenone is a novel non-steroidal mineralocorticoid antagonist recommended by NICE in 2023 for treating stage 3 and 4 chronic kidney disease (CKD) with proteinuria (urinary albumin-creatinine ratio (uACR) equal to or greater than 3 mg/mmol) associated with type 2 diabetes (T2D) in addition to standard of care treatment with renin-aldosterone angiotensin system inhibitors (RAASi) and sodium-glucose co-transporter 2 inhibitors (SGLT2i).

The FIDELIO-DKD study demonstrated that finerenone in combination with RAASi/SGLT2i reduced risk of kidney failure, death from renal causes and a sustained decrease of at least 40% in the eGFR from baseline by 18% compared to patients with diabetic kidney disease and proteinuria treated with only RAASi/SGLT2i. Finerenone also reduced the risk of myocardial infarction, nonfatal stroke, death form cardiovascular causes and hospitalisation for heart failure by 17% compared to placebo in patients with diabetic kidney disease and proteinuria (FIGARO -DKD).

The use of finerenone is inequivalent across South East London with a lack of local data regarding hyperkalaemia, tolerability and efficacy limiting its use. This review aims to evaluate these factors in a retrospective approach to encourage prescribing more widely.

Methods

Data was collated and reviewed retrospectively for patients with proteinuric diabetic kidney disease (eGFR greater than or equal to 20 ml/min and uACR greater than or equal to 3 mg/mmol) optimised on RAASi/SGLT2i (as per tolerability), attending a specialist nurse/pharmacist led CKD medicines optimisation clinic at 3 hospital sites across one trust between July 2024 to August 2025. Demographic characteristics of patients (age and gender) and primary clinical results were collected at baseline, as well as changes in the eGFR (using CKD-EPI 2009 formula), serum potassium levels and uACR during follow up at 1, 3 and 6 months.

Results

In total, 100 patients with proteinuric (uACR greater than 3 mg/mmol) diabetic kidney disease (eGFR greater than 20ml/min with T2D) were initiated on Finerenone at three

London hospitals in a CKD medicines optimisation clinic by a specialist renal nurse/pharmacist between July 2024 to August 2025. 71% (71/100) of the population were male and the median age was 68 years. At the point of review, 81% (81/100) of the population had follow up data at 1 month, out of which 49% (40/81) had data at 3 months and 22% (18/81) at 6 months. The average changes from baseline of eGFR, serum potassium levels and uACR for each cohort during follow up is shown in Table 1. At 6 months there was an overall improvement in kidney function (average eGFR increase of 5 ml/min) and proteinuria (average reduction in uACR of 52.8 mg/mmol) with no change in serum potassium levels.

9% (9/100) of patients had discontinued treatment with 44% (4/9) related to hyperkalaemia (notably all of these patients had a history of hyperkalaemia) and the rest had treatment discontinued as a result of other adverse effects.

Discussion

Real world practice indicates that treatment with finerenone and standard of care medications (RAASi/SGLT2i) is safe, effective and well tolerated in patients with proteinuric diabetic kidney disease.

THB6

Auto-Reporting of KFRE with Primary Care uACR Requests – A Single PCN Experience

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Title

Auto-Reporting of KFRE with Primary Care uACR Requests – A Single PCN Experience

Introduction:

The Kidney Failure Risk Equation (KFRE), recommended in NICE NG203, predicts 5-year risk of kidney replacement therapy to guide referral, patient counselling, and timely intervention. This pilot embedded automated KFRE reporting in primary care to identify high-risk patients, optimise referrals, and support shared decision-making.

Methods:

Led by Central and West Warrington PCN and supported by Warrington & Halton Teaching Hospital's biochemistry team and the North West Kidney Network, the pilot introduced automated KFRE reporting with each primary-care uACR result when:

- A valid eGFR <59 ml/min/1.73 m² was recorded in the past 12 months,
- No KFRE had been issued in the previous 6 months, and
- No AKI was linked to the latest eGFR.

Before automation, the PCN and Kidney Network ran clinician teaching sessions, including a drop-in session available to Primary care staff across the PCN and a Protected Learning Time (PLT) event on CKD guidelines and KFRE use. These were supported by circulated clear guidance on KFRE and updated CKD pathways, ensuring staff readiness for the laboratory integration.

Data collected included ICE laboratory reports, referral coding data, and clinician feedback. Measured outcomes were:

- Proportion of uACR tests with valid KFRE
- Nephrology referrals prompted by KFRE ≥5%
- Advice-and-guidance requests
- Primary Care Clinicians perceptions of KFRE usefulness.

Results:

The pilot went live on 5th May 2025. By August 2025, 2,551 CKD stage 3a–5 patients were identified across the PCN. uACR uptake rose steadily from May, peaking in July and testing increased 4.2% in the first four months (Figure 1 & 2), nephrology referrals fluctuated without a significant overall rise (Figure 3), but advice-and-guidance requests to secondary care increased after the pilot began (Figure 4). Primary care feedback was strongly positive: 76% said KFRE improved CKD management, 88% found it useful for decision-making, and 75% were satisfied with its role in referral support.

Discussion & Conclusion:
Criteria led automated KFRE reporting supported by primary care education and pathway redesign improved CKD risk stratification and strengthened clinician confidence without increasing secondary care referrals. uACR testing rose against the backdrop of national downward trend post removal from GP QOF and advice and guidance requests increased, so secondary care must plan for this demand. The model is feasible, acceptable and transferable to other PCNs ensuring earlier identification, referral, and optimisation of risk factors in high-risk patients. The next steps are to assess long term effects on patient outcomes and service sustainability.

THB7

Optimisation of medications to delay the progression of chronic kidney disease and improve cardiometabolic risk factors in a holistic, person-centred multimorbidity pharmacist-led clinic

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Introduction

Early intervention to modify blood pressure (BP), lipid management and glycaemic control can slow chronic kidney disease (CKD) progression and avoid the requirement for renal replacement therapy (RRT). The combination of renin-aldosterone angiotensin system inhibitors (RAASi) and sodium-glucose co-transporter 2 inhibitors (SGLT2i) can delay progression to end-stage kidney disease by up to 15 years. NICE recommends the use of RAASi, SGLT2i and statins for people living with CKD, with the addition of finerenone for people living with proteinuric diabetic kidney disease.

At the current rate of dialysis growth, London will exceed its capacity for RRT by 2036. South East London (SEL) data shows that only 50% of people with CKD are on optimised medications to delay disease progression. 33% of people with proteinuric CKD are not on RAASi; 33% of people with CKD have uncontrolled BP and 25% are not on lipid lowering therapy.

Multimorbidity pharmacists are integral to enhancing care for these patients by providing holistic management in a shared decision-making approach focusing on medicines optimisation using evidence-based medicine, structured diet/lifestyle advice and addressing polypharmacy to improve outcomes that align with the NHS 10-year plan to transition from sickness to prevention.

Methods

A multimorbidity pharmacist-led CKD medicines optimisation clinic concordant with local and national guidance was implemented in a London hospital in January 2025. Patients seen in consultant-led nephrology clinics were referred as clinically appropriate; referrals for patients with an estimated glomerular filtration rate less than 20ml/min, pregnant or breastfeeding were rejected. Comprehensive consultations were carried out to review co-morbidities, observations, blood test results, medications, diet and lifestyle, with a treatment plan agreed jointly with the individual. Data was collected for each patient, including number of contacts with the pharmacist, medication interventions (categorically grouped in initiation, optimisation and deprescribing), education or counselling intervention (including diet and lifestyle) and referrals to specialist teams.

Results

Data was collected for 18 clinics (January to July 2025), 54 patients were seen in clinic with a total of 100 patient contacts. A total of 190 interventions were made with 51% (97/190) related to medications. 92% (89/97) of the medication interventions were related to CKD, cardiovascular disease and diabetes management. 26% (23/89) of these interventions were for the initiation/management of finerenone, 24% (21/89) for RAASi initiation/optimisation, 21% (19/89) for lipid management (initiation/optimisation of statins and ezetimibe), 20% (18/89) for BP management (out of which 50% (9/18) were deprescribing anti-hypertensives), 6% (5/89) for SGLT2i initiation and 6% (5/89) for diabetes management. 8% (8/97) of medication interventions were classed as other (not related to CKD, cardiovascular disease or diabetes management).

The remaining interventions comprised 11% (10/93) for referrals to specialist teams, 44% (41/93) for medication counselling, 43% (40/93) for diet/lifestyle advice and 2% (2/93) for other non-pharmacological interventions.

Discussion

Multimorbidity pharmacists are transformational in supporting the sustainability of the NHS by optimising medications for patients with CKD and cardiometabolic risk factors to delay disease progression, promote medicines safety and efficiently deliver holistic, person-centred care encompassing pharmacological and non-pharmacological approaches.

THB8

Effect of prebiotic, probiotic and synbiotic supplementation on protein-energy wasting in people with chronic kidney disease: a systematic review.

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Introduction: Protein-energy wasting (PEW) is a prevalent feature in people with chronic kidney disease (CKD) that is associated with poor long-term outcomes. Gut dysbiosis may be a contributing factor to PEW due to the increased production of uraemic toxins and pro-inflammatory biomarkers known to cause sarcopenia and decreased dietary intake. Prebiotics, probiotics and synbiotics are potential strategies for addressing PEW and gut dysbiosis simultaneously. Most of the systematic reviews conducted in CKD and dialysis populations have assessed the impact of pre-, pro- and synbiotics on the reduction of uraemic toxins and systemic inflammation, and improvement in kidney function. Therefore, this systematic review assessed the effects of supplementation with “biotics” on markers of PEW in people with CKD.

Methods: A comprehensive systematic search was conducted from inception to 31 May 2025 in seven electronic databases and 2 trial registries. Included studies were randomised controlled trials in adults with CKD investigating the effects of prebiotic, probiotic, and/or synbiotic supplementation on markers of PEW including the Subjective Global Assessment (SGA, primary outcome), other nutritional scoring and/or assessment tools, serum albumin, prealbumin and creatinine, dietary energy and protein intake, body mass index, body fat mass/percentage, markers of muscle mass, handgrip strength and bioimpedance phase angle.

Results: Title and abstract screening included 2,468 studies of which 160 full-text articles were assessed for eligibility. A total of 55 studies met the inclusion criteria. Thirty-three studies were conducted in dialysis populations, 21 in pre-dialysis CKD and 1 in kidney transplant recipients. A narrative review of these studies will be presented. Only 5 studies in people receiving dialysis (3 in haemodialysis and 2 in peritoneal dialysis) comparing synbiotic supplementation vs placebo had available results on SGA, and were therefore included in meta-analyses. Two studies used the original version of the SGA and 1 study the 7-point scale SGA (dichotomous variable meta-analysis: well-nourished and malnourished), and 2 studies used a modified version of the SGA (continuous variable meta-analysis: lower SGA score is better; <10 points = well-nourished). Synbiotic supplementation was associated with a significantly lower likelihood of malnutrition/PEW occurring (3 studies, 109 participants: Risk ratio 0.43, 95% Confidence Interval [CI] 0.20 to 0.92, P=0.03; Figure 1). Synbiotics may have also slightly decreased SGA score and therefore improved nutritional

status (2 studies, 104 participants: Mean difference -1.51, 95%CI -2.72 to -0.31, P=0.01; Figure 2); however, heterogeneity was moderate (I2=33%).

Discussion: These preliminary findings suggest that synbiotic supplementation may have beneficial effects on the nutritional status of people receiving dialysis. However, we still need to conduct the quality and certainty of the evidence assessments to establish the level of confidence that the observed effect size was representative of the true effect. Analysis of secondary outcomes is currently underway and full analysis of results will be presented at the conference if the abstract is accepted.