WJ1

Clinical experience of Avacopan (Tavneos®) use in management of antineutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis (AAV) patients

Ewa Kislowska[1], Natasha Moore
[1]Guy's and St Thomas's Hospital

WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

Avacopan is a complement 5a receptor (C5aR1) antagonist that blocks C5a-driven neutrophil activation, thereby limiting the inflammatory effects of the C5a protein on blood vessels. It was authorised in the UK in May 2022 by the Medicines and Healthcare products Regulatory Agency (MHRA), received a positive recommendation from NICE in September 2022, and became available, including in England, in December 2022 for the treatment of severe ANCA-associated vasculitis (AAV).
At present, real-world data on avacopan use in AAV are limited. Post marketing evidence takes time to develop, as clinical practice adoption is often gradual—particularly for newer, high-cost treatments. Clinicians may initially restrict prescribing to carefully selected patients, and large-scale use has not yet been achieved. As with many novel therapies, uncommon side effects or long-term safety concerns typically become apparent only after thousands of patients have received the drug in routine practice, which has not yet occurred for avacopan.

We conducted a retrospective study at a single-centre involving 25 patients with newly diagnosed or relapsing AAV who were treated with avacopan. The primary outcomes assessed were clinical remission at 26 and 52 weeks. Descriptive statistics were used to summarize the data, and univariate logistic regression was applied to identify predictors of remission. Additionally, we gathered information on safety monitoring and adverse effects.

Among the 25 patients included in the study, 96% (n = 24) had a baseline estimated glomerular filtration rate (eGFR) of less than 15 ml/min/1.73 m², and 4% (n = 1) were receiving kidney replacement therapy at baseline. The mean eGFR at enrolment was 43 ml/min/1.73 m². All patients (100%) received rituximab in combination with avacopan, and 4% also underwent plasma exchange (PLEX). The median time from induction therapy to initiation of avacopan was 1.2 weeks. Following the commencement of avacopan, the median time to complete discontinuation of prednisolone was 4.6 weeks.
Clinical remission was achieved in 96% of patients at 26 weeks and in 80% at 52 weeks.
Avacopan therapy was discontinued in 20% of patients due to adverse events, the most frequent being elevated serum aminotransferases (4.3%). One patient independently chose to discontinue avacopan along with other medications.
Severe transaminitis occurred in 16% of patients (n = 4), all within the first three months of therapy. Two of these patients also experienced pruritus, suggesting a potential hepatic origin.
Gastrointestinal symptoms were reported in 20% of patients but resolved within two months of initiating treatment.

Exacerbation of hypertension was observed in three patients during therapy. In one case, avacopan was discontinued at the patient's request due to concerns that it may have contributed to recurrent infections of pre-existing venous ulcers.

The analysis showed that avacopan achieved a high remission rate and demonstrated an acceptable safety profile in the treatment of AAV. It is crucial that the clinical team is aware of which patients belong to high-risk groups. In the future, growing real-world evidence—including registry studies, post-marketing surveillance, and advances in pharmacogenomics—will provide further insights into its safety and effectiveness beyond clinical trial settings.

WJ2

Maribavir use in managing cytomegalovirus infection among UK kidney transplant recipients

Mr Gareth Bryant[1], Denise Cunningham[2], Rachel Fraser[3], Dane Howard[4], Danielle Jones[5], Sarah Knight[6], Sara Perkins[7], Linda Ross[8]
[1]Cardiff and Vale University Health Board, [2]Royal Free London NHS Foundation Trust, [3]The Newcastle Upon Tyne Hospitals NHS Foundation Trust, [4]Leeds Teaching Hospitals NHS Trust, [5]Liverpool University Hospitals NHS Foundation Trust, [6]Portsmouth Hospitals NHS Trust, [7]North Bristol NHS Trust, [8]Guy's and St Thomas' NHS Foundation Trust

WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

Background:
Refractory CMV is defined as an infection that does not respond well enough to usual treatments, suspecting resistance (an increase in 1 log10 or "persistence" of <1 log10 change in CMV viral load after 2 weeks of therapy). Refractory CMV encompasses CMV infection which is resistant (either suspected or confirmed) to first line treatments, with UL97 gene mutations being resistant to valganciclovir and ganciclovir. Previous options to treat these strains of CMV are limited to intravenous therapies, which often require an inpatient stay and can be nephrotoxic, requiring close monitoring with careful dose adjustments. UL54 gene mutations confer multidrug resistance, limiting therapeutic options further.
Maribavir is an oral antiviral for treatment for refractory CMV infection following solid organ or haematopoeitic stem cell transplantation, approved by NICE in January 2023.

Methods:
Members of the UK Renal Pharmacy Group compiled real-world data for patients who have received maribavir in the UK prior to January 2025.

Results:
Eight UK centres reported maribavir use in 18 patients, succeeding inadequate response to first line therapies. 12 patients (67%) successfully cleared CMV but reactivated following treatment cessation. Six patients required maribavir re-initiation with one of these patients requiring 3 courses. In total 25 courses of maribavir were completed. Table 1 outlines an overview of the maribavir treatment courses.

Conclusions:
Maribavir is an effective and well tolerated oral option to treat refractory CMV in an outpatient setting, avoiding the associated costs of hospital facilities and reducing the need for nephrotoxic or myelotoxic alternatives.
The average treatment duration reflects reports from the SOLSTICE trial, however real-world data highlights high reactivation rates post treatment, and strengthens the importance of close PCR monitoring following treatment cessation.
Reported adverse effects were similar to the trials, but demonstrates the need for pre-emptive tacrolimus dose alterations to avoid toxicity and its associated nephrotoxicity.

WJ3

Semaglutide is a safe and effective treatment for End Stage Renal Patients living with obesity

Miss Denise Cunningham[1]
[1]Royal Free Hospital

WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

Obesity is one of the greatest public health challenges of the 21st century. In patients living with chronic kidney disease (CKD) obesity poses additional challenges. People living with obesity and established CKD develop faster decline in glomerular filtration, progression to end-stage renal disease (ESRD) and death.
Glucagon-like peptide-1 receptor agonists (GLP-1 RAs),are medications used to treat type 2 diabetes and/or, they are effective and safe treatments for controlling blood sugar levels and reducing weight, and evidence from large clinical trials also suggests that GLP-1 RAs may be kidney protective. However, despite the benefits of GLP-1 RAs, they are not commonly prescribed in people living with CKD as the existing studies have not included large numbers of people with CKD, kidney failure or post kidney transplantation.
Kidney Fitness in Transplantation (KFiT) is a novel weight loss service for ESRD patients living with obesity to increase access to transplantation which combines psychology, physiotherapy, dietician input and pharmacology using the GLP1 Semaglutide.
KFiT has shown that Semaglutide is a safe and effective tool for weight loss in ESRD patients.

Method:
Over a 12 month period 31 patients ware assessed as part of the KFiT service, 24 of these were deemed suitable for pharmacological intervention with Semaglutide
Patients were dosed and uptitrated monthly as per the standard licencing for Semaglutide.
Patients were followed up monthly and assessed for efficacy and side effects.

Results:
24 patients were started on Semaglutide and uptitrated monthly as tolerated.
45% of patients experienced some form of side effects, mainly diarrhoea, constipation and nausea.
Side effect occurrence and severity matched those documented in large trials in the general population. 2 patients experienced severe nausea and needed to stop treatment.
Average weight loss was 10%.
12 patients met their target weight for transplant activation and 2 were transplanted.

Conclusion:
K-Fit demonstrates that a structured, MDT led programme combining psychological support, dietary interventions, physiotherapy, and pharmacology can significantly enhance access to kidney transplantation for ESRD patients living with obesity.
KFiT has also shown that GLP-1 agonists are a promising and safe weight loss tool for ESRD patients.

WJ4

Effectiveness of once-weekly erythropoietin-stimulating agent in maintenance haemodialysis: a single-centre prospective cohort analysis

Mr Isaac Tseng[1,2], Dr Ayushi Gupta[1], Mrs Mala Murugesan[1,3], Dr Sion Williams[1,3], Dr Ram Shenbagaraman[1,3,4], Mrs Raji Srinivasan[5], Dr Tanaji Dasgupta[1,5,6]
[1]Oxford Kidney Unit, Churchill Hospital, [2]Bristol Medical School, University of Bristol, [3]Whitehouse Dialysis Unit, Milton Keynes University Hospital, [4]Milton Keynes University Hospital, [5]Swindon Dialysis Unit, Great Western Hospital, [6]Great Western Hospital

WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

Background
Erythropoiesis-stimulating agents (ESAs) are central to anaemia management in individuals with end-stage kidney disease undergoing maintenance haemodialysis. In the UK, short-acting ESAs are typically administered thrice weekly, which requires substantial nursing input, and carries environmental and economic costs. With increasing emphasis on sustainable healthcare, including Green Nephrology, evidence on the effectiveness of once weekly short-acting ESA is limited. This study hypothesised that reducing ESA administration to once weekly may be safe, effective, and resource-efficient. The primary aim was to assess epoetin zeta (Retacrit) effectiveness following a dosing frequency change from thrice to once weekly in a prevalent haemodialysis cohort. The secondary aim was to explore its environmental impact.

Methods
A prospective cohort analysis was conducted using data from the Cerner electronic patient record at two haemodialysis units within the Oxford Kidney Unit. All adults (n=101) receiving maintenance haemodialysis were reviewed in multidisciplinary reviews for suitability of ESA frequency change. Data on demographics, dialysis modality, baseline haemoglobin (Hb), ferritin level, and ESA dosing were included. Descriptive statistics summarised baseline characteristics. The primary outcome was Hb response after ESA frequency change, analysed using a linear mixed-effect model (LMM). Estimated mean Hb at one-month (August) and two-month (September) follow-up were compared with baseline (June). A non-inferiority margin of -5 g/L was applied to assess Hb control. The secondary outcome examined changes in ESA weekly requirement using Wilcoxon signed-rank test. Statistical significance was set at a two-sided $p<0.05$. Analyses were performed using Stata version 18.

Results
Thirty-night individuals were included (mean age 63 years, 65.8% male, 63.2% White) (Figure 1). Most underwent thrice-weekly dialysis (86.8%). Median baseline Hb was 111g/L (interquartile ranges [IQR] 106-120) and weekly ESA dose of 13,500 units (12,000-20,000) (Table 1). The LMM showed estimated mean Hb 111g/L (107-115) at the intervention month, 110g/L (107-114) at one-month follow-up, and 109g/L (105-112) at two-month follow-up, compared with 110g/L (95% CI 107-114) at baseline. Compared to baseline, mean differences were -0.4g/L (95% CI -3.9-3.1) at one-month and -2g/L (-5.5-1.5) at two-month follow-up. Neither result was statistically significant. Hb control met the non-inferiority

threshold at one-month, but not at two-month follow-up. Figure 2 illustrates Hb distribution across the study period. Weekly ESA requirements remained stable; no significant differences were observed between baseline and one-month (p=0.98) or two-month follow-up (p=0.48). Implementation of once weekly ESA reduced syringe use by 32 per month in the study cohort.

Discussion

This analysis suggests reducing ESA administration from thrice to once weekly in haemodialysis is safe and maintains stable Hb, without significant difference compared to the conventional regimen. This represents the first real-world study exploring short-acting ESA (Retacrit) administration frequency in maintenance haemodialysis. Results require cautious interpretation due to small sample size, residual confounding, and risk of survival and selection bias from high drop-out rates. Nonetheless, implications of these findings extend beyond clinical effectiveness to include reduced nursing workload and pharmaceutical waste, and support for more sustainable “Green Nephrology” practices. Larger studies with longer follow-up are required to validate the cost-effectiveness and environmental impact.

WJ5

Audit to investigate haemoglobin levels following switch of ESA brand for haemodialysis patients.

Clare Morlidge[1], Mayomikun Elekolusi[1]
[1]East and North Herts NHS Teaching Trust

WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

Introduction

Anaemia is a common complication in Chronic Kidney Disease (CKD). Erythropoietin stimulating agents (ESAs) such as Eprex (epoetin alfa) are used to manage haemoglobin (Hb) anaemia of CKD.

As part of a cost-savings initiative in June 2023 we switched all haemodialysis patients on Eprex to Retacrit (epoetin zeta). Retacrit is a biosimilar of Eprex and evidence suggests pharmacologically as efficacious . This switch had taken place successfully in an American renal site with no safety signals and anecdotal data from a UK site. This audit aims to evaluate the clinical impact of the ESA switch investigating into the haemoglobin stability, dosing patterns and the requirement for dose adjustments.

Objectives

- To determine whether ESA brand switching impacted Hb levels and compromised patient safety

Method

The Trust switched all haemodialysis patients from Eprex to Retacrit in June 2023. Patients were switched dose for dose if their Hb was in range and if Hb was out of range a dose adjustment was made at the time. Patients had their Hb measured at their scheduled routine blood testing post-switch and the consultant in charge of the patient would optimise the dose if required at that point.

We analysed data using the electronic renal system for the patients in a single dialysis unit. The patient's weekly Eprex dose pre switch and weekly Retacrit dose at the point of switch were recorded. Hb was recorded for two months pre and two months post switch.

Results

112 haemodialysis patients were included in this audit. Table 1 illustrates the level of adherence to set standards pre and post-switch.

Discussion

The findings from this audit demonstrate that brand switching didn't compromise Hb stability. The average Hb remained almost identical pre-switch (108.36 g/L) and post-switch (108.12 g/L) suggesting the pharmacological efficacy of Retacrit is comparable to Eprex and more importantly across sampled population caused no significant harm. Adherence to standard 3 was illustrated through the results of the Hb range becoming tighter post-switch compared to pre-switch. The narrower range could have been attributed to the dose adjustments made at the point of dose switch (42/112 (37.5%)) coinciding with the overall average weekly dosing of Retacrit (11,015 IU) compared to Eprex (10,970 IU) being higher. Further investigations would be needed to determine whether dose adjustments did tighten the range. There was non-adherence to standard 1 as the number of patients outside of NICE CKD guidance Hb level (100-120 g/L) range rose from 32.1% to 37.5%. This relatively

small increase post-switch isn’t truly indicative of introduction of Retacrit; there are several factors to consider that may have influenced Hb.
Overall, it is evident that the switch from Eprex to Retacrit was a success in the Trust as patient safety wasn't compromised. This audit should provide further evidence to wider Trusts to consider ESA alternatives as a cost-savings strategy and potentially improve clinical outcomes for haemodialysis on ESAs as demonstrated in this cohort.

WJ6

Hypophosphataemia with IV iron therapy in a paediatric renal population

Dr Rebecca Price[1], Ms Angela Lamb[1], Dr Ben Reynolds[1]
[1]Royal Hospital for Children

WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

Introduction

Hypophosphataemia is a well-recognised adverse effect in adult patients following the administration of intravenous ferric carboxymaltose (Ferinject). Reports in children are much rarer. Risks include symptomatic hypophosphataemia leading to osteomalacia and fractures. Monitoring serum phosphate levels in patients with additional risk factors, or those receiving multiple or high doses of Ferinject is advised. Administration of IV iron is a key element in managing anaemia of chronic kidney disease in our institution, but the incidence of hypophosphatemia was unknown and monitoring was not standardised. The aim was to audit the incidence of hypophosphataemia following Ferinject administration in our paediatric renal population.

Methods

Patients receiving Ferinject were identified from the electronic patient record. Data was collected retrospectively from 2017-2024, including the most recent serum phosphate level prior to Ferinject administration, first serum phosphate following Ferinject, and duration between administration and phosphate checking. Concomitant medications at the time of Ferinject, specifically phosphate binders, were documented. Each dose was treated as a separate episode i.e. patients could be included for multiple doses.

Results

38 patients were identified as having received Ferinject. Thirteen (34%) were female. A total of 123 doses of Ferinject were administered from 24/01/2017 – 10/12/2024.

A serum phosphate was checked prior to Ferinject administration for all doses. The mean interval between serum phosphate measurement and Ferinject administration was 3 days (range 0-57 days). The median serum phosphate prior to Ferinject was 1.16mmol/L (range 0.48-2.98) (Figure 1). Hypophosphataemia was evident pre-administration in 21 doses (17%), affecting 9 patients.

A serum phosphate was checked following Ferinject administration in 99% of doses, with a mean interval of 10 days (range 0-42). The median serum phosphate after Ferinject was 1.46mmol/L (range 0.52-3.46) (Figure 2). Only 5 doses (4%) had demonstrable hypophosphatemia after Ferinject, affecting 5 patients.

The mean change in phosphate level was +0.28mmol/L (range -1.05-2.38). (33% of levels decreased (Figure 3).

34 Ferinject doses were administered to patients on a phosphate binder (28% total doses) with a reduction in serum phosphate when checked post-administration in 9 cases (26%), however not resulting in hypophosphataemia.

Discussion

The incidence of hypophosphataemia following Ferinject was low in our population of children with anaemia of chronic kidney disease. No child had an adverse impact of low phosphate. The tendency towards higher serum phosphate in CKD may explain this. There was high variability in post-dose monitoring. Local guidelines were updated to include a standard monitoring frequency recommendation and disseminated.

WJ7

Establishing a Tacrolimus Monitoring Recommendations for Glucagon-like Peptide-1 Receptor Agonists (GLP-1 RA) in Renal Transplant Recipients: Experience from a Large UK Transplant Unit

Sadaf Fatima, Mr Dane Howard
[1]St James's University Hospital

WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

Background:
Obesity, diabetes, and metabolic syndrome are highly prevalent among renal transplant recipients and contribute significantly to post-transplant morbidity, graft loss, and cardiovascular mortality.
GLP-1 RAs (tirzepatide and semaglutide), have demonstrated substantial efficacy in improving glycaemic control and achieving weight loss in patients with type 2 diabetes and obesity in the general population . However, evidence for their safety, efficacy, and tolerability in solid organ transplant recipients is currently limited. Key concerns include their impact on immunosuppressant absorption and metabolism, potential gastrointestinal side effects influencing drug levels, and the absence of established monitoring protocols tailored to the transplant setting.
At a large UK transplant unit, the increasing use of GLP-1 RAs supplied via private providers for weight-loss among renal transplant recipients highlights the urgent need to establish a clear monitoring guideline. This would ensure safe and effective integration of the drug into post-transplant care, balancing metabolic benefits against the risks of graft dysfunction, drug interactions, and adverse effects.
Methods:
Patients recorded as taking tirzepatide or semaglutide for any indication (diabetes or weight loss) were identified from the trusts renal database (Vital data).
GP and the Trust patients' records were then used to ascertain GLP-1 RAs dosing schedules, Tacrolimus levels and the number of days between dose initiation/dose change and Tacrolimus monitoring.
Results:
N=16 patients were identified as taking GLP-1 RA for diabetes (n=15 tirzepatide, n=1 semaglutide). A further n=3 patients were identified as taking tirzepatide prescribed privately for weight loss but were unable to have full analysis due to lack of information regarding date of initiation and dose changes.
Out of a total of n=31 dose initiation or dose changes, only n=20 had complete pre and post tacrolimus levels taken.
The mean change in tacrolimus levels was an increase of 0.58 ug/L (SD 1.7 ug/L) however only one of the post-GLP1 RA dose initiation or dose change levels resulted in a tacrolimus dose modification.
The mean number of days after GLP-1 RA dose initiation or change was 42 days (SD 35.2 days).
No patients experienced graft dysfunction or episodes of rejection during follow up after dose initiation.
Discussion:

In this small cohort of renal transplant recipients, it is encouraging to see no episodes of rejection or graft dysfunction during follow-up.
Although the average effect of dose initiation or change was minimal, with only a small increase in mean tacrolimus levels, the large standard deviation indicated substantial variability.
Regarding tacrolimus levels after GLP-1 RA dose changes, the data shows considerable variability in monitoring timings, likely due to the lack of standardised guidance for renal transplant patients on GLP-1 RAs.
These findings suggest that GLP-1 RAs can be used safely in this population; however, given the theoretical risk of altered drug absorption from delayed gastric emptying and the limited clinical evidence, additional monitoring of tacrolimus levels is recommended after initiation or dose escalation of GLP-1 RAs until larger-scale studies confirm long-term safety.

WJ8

Evaluating calcimimetic use: An audit of two UK renal centres

Dr Nicki Ruddock[1], Dr Sharon Huish[2,3]
[1]University Hospitals of Leicester NHS Trust, [2]Royal Devon University Healthcare NHS Foundation Trust, [3]University of Plymouth

WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

Introduction

Secondary hyperparathyroidism (SHPT) in chronic kidney disease (CKD) heightens risks of bone deformities, vascular calcification, cardiovascular events, and mortality, yet remains poorly controlled. In clinical practice, prescribing of calcimimetics can appear variable. This audit aimed to evaluate calcimimetic prescribing patterns and treatment effectiveness in haemodialysis patients across two renal centres in different UK regions.

Method

Inclusion criteria were haemodialysis patients with a calcimimetic prescribed on the electronic care record on the 01/05/2025. Up to 12 months data was collected retrospectively from the point of calcimimetic initiation (baseline). Data included serum intact parathyroid hormone (iPTH) and adjusted calcium throughout, surveillance practices (initial calcium monitoring and adherence to checking PTH monthly), hypocalcaemia episodes, and PTH reduction against guideline targets. Data are reported as percentages and mean±SD.

Results

Centre 1 - 69 patients (17% of HD population) were identified; 48/69 (70%) were prescribed Cinacalcet and 21/69 (30%) Etelcalcetide. Full data were collected for all 69 patients. 26/69 had baseline PTH >200pmol/l, the remaining 43/69 had a mean PTH 154.5±35.6pmol/l, 68/69 (99%) had PTH >9 times the upper normal assay limit. 63/69 (91%) had serum calcium checked within 1-4 weeks of starting calcimimetic.12/69 (17%) had PTH recorded every month. 678 calcium results were recorded across the audit period: 174/678 were low (26% hypocalcaemia). 46/69 (67%) experienced hypocalcaemia. At the last data point, 48/67 (72%) had achieved >30% PTH reduction (2 on calcimimetics <3/12) but only 31/67 (46%) had a PTH within KDIGO target.

Centre 2 – 75 patients (14% of HD population) were identified; 49/75 (65%) were prescribed Cinacalcet and 26/75 (35%) Etelcalcetide. Full data was collected for 35 patients. Baseline PTH was 96.2±32.1pmol/L (n=35), 30/35 (89%) had PTH >9 times the upper normal assay limit. 35/35 (100%) had serum calcium checked within 1-4 weeks of starting calcimimetic. 8/35 (23%) had PTH recorded every month. 398 calcium results were recorded across the audit period; 89/398 were low (21% hypocalcaemia).18/35 (51%) experienced hypocalcaemia. At the last data point, 25/35 (71%) had achieved >30% PTH reduction but only 13/35 (37%) had a PTH within KDIGO target.

Discussion

Calcimimetic prescribing rates were similar across both centres, though baseline PTH levels were higher at Centre 1. Most patients achieved >30% PTH reduction (a NICE target); however, fewer than half met the KDIGO PTH target. Inconsistent PTH monitoring and hypocalcaemia likely effected optimal titration of calcimimetics, limiting their efficacy and impacting safety. Hypocalcaemia frequency may represent suboptimal prescribing of active vitamin D analogues and questions safety of prescribing practices. Limitations include i) patient small sample size and number of renal centres ii) Inclusion criteria (people prescribed calcimimetic on 01/05/2025) excluded those that previously discontinued calcimimetic treatment.

Conclusion

Good PTH response was seen in most patients receiving calcimimetics but this audit highlights areas where guideline recommendations are not consistently being implemented. Given the burden of symptoms, the costs, and the tablet burden associated with SHPT, ensuring effective prescribing is key. Findings highlight a need for prescribing protocols to guide management and improve the clinical safety and effectiveness of calcimimetics.

WJ9

Optimising Immunosuppressive Therapy in Glomerulonephritis: The Impact of a Pharmacist-Led Clinic on Safety and Financial Sustainability

Miss Katerina Adamou[1], Miss Chiara Vaccarone
[1]Royal Free Hospital

WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

Background
Patients reviewed at the Trust's glomerulonephritis clinics, including those with Systemic Lupus Erythematosus (SLE), Vasculitis, IgA Nephropathy, and Glomerulonephritis, require complex treatment regimens involving high-cost immunosuppressive therapy. Whilst clinically effective, these therapies pose significant risk of toxicity, adherence challenges, and funding implications. Review of current practice highlighted that some patients had received high-cost medicines without appropriate funding approvals, causing financial strain on the renal division. Nationally there is considerable variation in Blueteq form completion, with many services relying on consultants doing them. Embedding a specialist renal pharmacist within this clinic ensures consistent and streamlined reimbursement processes for high-cost medications, whilst also delivering improvements in patient safety and adherence.

Aim
A pilot specialist renal pharmacist led glomerulonephritis clinic was developed to optimise care for patients with autoimmune kidney diseases. We aimed to evaluate the impact on patient safety, prescribing governance and cost-savings for the renal division. Patient and clinician satisfaction was also assessed.

Methods
The pharmacy team liaised with the divisional clinical director and lead clinic nurse to ensure clinical space availability. A meeting was held with key stakeholders to discuss the clinic structure and to outline pharmacist roles and responsibilities. Pharmacists conducted dedicated clinics where they prescribed and clinically screened all medications for this patient cohort. They delivered counselling on high-risk medicines, provided tailored patient information leaflets, attended multidisciplinary team meetings, and completed funding applications for high-cost drugs both inside and outside of the clinic. Pharmacy leadership on funding applications ensured standardised processes and highlighted cases where the renal division had paid for NHSE commissioned drugs. Patient and medical team satisfaction surveys were conducted to evaluate service acceptability and perceived impact. Consultant nephrologists were invited to provide formal feedback on the pilot.

Results
To date the specialist pharmacy clinic has demonstrated measurable benefits in safe prescribing practices, an increase in compliance following patient education sessions and an increase in NHSE / ICB reimbursement for high-cost drugs. Early findings highlighted that several patients had received multiple courses of high-cost medicines without appropriate

local and national funding approval processes. By leading on Blueteq applications, pharmacists ensured consistent processes and maximised NHSE reimbursement for expensive immunosuppressive drugs. Preliminary patient and multidisciplinary team surveys reported high levels of satisfaction, with respondents rating the service positively. Consultant feedback has also been excellent, providing strong support for permanently embedding pharmacy within the service.

Conclusion

Renal pharmacists are experts in renal medications and the preliminary results show that pharmacists provide significant value within the glomerulonephritis clinic, providing benefits for patients, clinicians and the wider health service.

This pilot pharmacist led glomerulonephritis clinic has delivered demonstrable improvements in patient safety, adherence, and prescribing governance, while generating cost savings for the renal division through consistent processes for funding of high-cost medicines. Both patients and clinicians have expressed strong support for this service, providing a compelling case for permanent integration of specialist pharmacists. This pharmacist-led clinic addresses the dual challenges of managing complex immunosuppressive therapy and rising financial pressures within the NHS.

WJ10

Understanding Polypharmacy and Bridging Best Practices

Shahid Muhammad[1]
[1]Coventry University

WEDNESDAY - Moderated Poster Session, HALL Q, March 11, 2026, 13:45 - 14:45

Introduction: The National Health Service (NHS) is driven by quality and patient outcomes. The increase in provision of point of care testing healthcare services can assist in supporting the best practices, as highlighted in the NHS Outcomes Framework. Aims: During 2023 and 2024, a collaborative effort took place across organizations to better understand challenges surrounding polypharmacy. The collaborative effort looked to present several international workshops to unite communities, with a focus on young people. Methodology: The collaboration prompted the co-development of several workshops between 1) August 2023 - November 2023, 2) April 2024, 3) May 2024 - June 2024, and 4) September 2024 - October 2024. The focus was on a) polypharmacy and understanding nephrotoxicity, b) healthcare service users having ability to make healthcare decisions, envisaging brighter perspectives and c) attaining wellbeing through expression. Results: The workshops' attendance ranged from approx. 30 YP to 150 people across the different workshops. Over the workshops there was a conversion rate of approx. 15 (regular attendees). In a single week there was an average of 11-12 who attended each session and a low of 10. Results: Overall, the collaborative project was a huge success united communities to collectively prompt co-developing opportunities to expand efforts in communities. Each workshop featured core May Gardens Project (MGP) facilitators. Discussion: Polypharmacy has become an increased societal norm across populations; not all polypharmacy and/ or nephrotoxicity can be entirely precluded. It is to be noted that populations should have an awareness concerning polypharmacy (especially if it leads to nephrotoxicity), however, awareness that specifically targets illicit substance use is lacking and should be addressed in future research. Conclusion: All inappropriate polypharmacy can induce nephrotoxicity; it is difficult to distinguish and is still a focus in the remit of toxicology of drug compounds. Having access to Allied Health Professionals (AHPs) should also encourage healthcare service users to feel more included, thus increasing practical understanding surrounding best practices.
Keywords: Polypharmacy, Nephrotoxicity, Laboratory Medicine