A day in the life of a renal registrar

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Author: Alexandra Gallagher

Editor: Duncan Campbell | Elizabeth Campbell

In my biased opinion, nephrology offers the best there is in the practice of medicine. Nephrology is a broad-reaching specialty that spans across the management of hypertension and preeclampsia, acute kidney injury, chronic kidney disease, haemodialysis, peritoneal dialysis, kidney transplantation, renal supportive care, and electrolyte disturbances. My work day regularly encompasses all these areas and more. As doctors, we form part of a bigger team of nurses and allied health professionals that service a spectrum of patients in both inpatient and outpatient settings. We develop strong connections with our patients who we are privileged to care for over long periods of time allowing us to establish continuity of care and excellent rapport and a therapeutic relationship.

A typical day starts at 6am with the "renal spin club"- a regular spin cycle class at a local gym attended by my Head of Department, fellow renal trainees and dietitians. It's a nice chance to socialise and feel energised for the day ahead. After a quick shower and breakfast, I arrive at the renal clinic at 8am for my first patient in the acute renal transplant clinic. She is a 30 year old female who had a living donor renal transplant ten days ago for IgA nephropathy. Her graft function is excellent, and her wounds are healing well. We discuss her immune risk and immediate post-operative course. This involves an assessment of her complex drug regimen, blood pressure and how to help her manage looking after her 3 year old son who has a viral upper respiratory tract infection while she is at the peak of her immunosuppression. Next is a 56 year old man who received a deceased donor transplant and is due for discharge back to his usual nephrologist. He has had three months of close observation in our acute transplant service, that manages all the ups and downs of the first stages of kidney transplantation including surgical complications, infection, metabolic risk factor management and that tricky balance of immunosuppression to prevent rejection but not result in toxicity. He is in good spirits as his graft is working well, and we have confirmed there is no rejection on the protocol biopsy I performed on him the week prior. He is planning some time away with family now that he isn't dependent on haemodialysis three times a week. The final patient is a re-referral to our clinic for management of a cytomegalovirus infection five months after transplant that has required intensive titration of his immunosuppression to allow his immune system to suppress the virus. After arranging for some immunoglobulin therapy for another transplant patient for the next visit, I finish up the transplant clinic and prepare for my general nephrology clinic at 9am.

This general nephrology clinic is a mixed bag. I see new referrals for patients with uncontrolled hypertension, potential glomerulonephritis, long term transplant and dialysis patients, patients opting for supportive/conservative care for their end stage renal failure and those with recurrent urinary tract infections. There is a spectrum of

disease acuity and patient demographic. Although most of my patients are over 65 years old, their medical complexities only add to the enjoyment I get in applying evidence-based medicine to make individual variations and pragmatic decisions about competing risks and benefits. Most chronic kidney disease patients have at least four specialists involved in their care and ten or more regular medications that need to be factored into treatment decisions - the art of medicine in action!

It's now midday and I've seen my last patient in the clinic. My consultant and I catch up about the patients we each have seen in clinic and discuss the difficult cases. This is a great learning opportunity to gain from their experience. Next, I return a few calls that have come through from our satellite dialysis unit regarding dosing of iron and dialysis prescriptions before meeting up with my resident on the wards to start the inpatient round. We have been on-take today and have had three new consults and three referrals from the emergency department for admission this morning. We paper round about the current inpatients and then triage which patients to see first. We prioritise a 66 year old female haemodialysis patient who has been admitted with line sepsis. She has a previous history of colorectal cancer requiring multiple bowel resections resulting in short gut syndrome, which is managed with total parenteral nutrition. She has a high output stoma that has been worsening with the prescription of antibiotics for her infection. I spend a good hour coordinating her care between the vascular surgeons, interventional radiologists and infectious diseases physicians before scheduling in her dialysis and adjusting her fluid and electrolyte management. Next we see our new referrals in the emergency department - a transplant patient with an upper gastrointestinal bleed and two elderly patients with acute kidney injury for investigation. One appears to be due to dehydration, the other is more concerning for myeloma kidney.

It's now 2pm and my resident and I make a quick 15-minute pit stop for some lunch while we review some blood tests from the morning. Feeling refreshed, we recommence the round on the last remaining patients. Finally I am called away to our in-centre dialysis unit to help troubleshoot some issues with patients on dialysis and decide with the nursing team how we will schedule everyone's dialysis around their investigations while in hospital.

By now it's 5pm and time for some chocolate and a review of some outpatient investigations. I call a GP about a patient who is prone to dehydration from their eating disorder to arrange a review after seeing some worsening electrolytes, and fax a script to a transplant patient's pharmacy to treat a urinary tract infection. My consultant rounds three times a week and today is a non-rounding day which means we just catch up over the phone. I fill him in over the phone and we plan for the next day. It's finally time to head home around 6pm. I settle into my latest gory true crime podcast on the train. The ride home serves as time to wind down after a busy day.

Nephrology is a specialty that combines highly specialised areas of complex medicine along with "bread and butter" diseases and their management. The enjoyment is in the complex interplay of multiple comorbidities and competing biopsychosocial interests. Our patients are sick, and we have the opportunity to make a big difference in their lives. We rarely cure, but we alter disease progression and most importantly improve symptom control and quality of life for our patients.

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