Management of Nephrotic Syndrome & Discharge Planning Checklist

Key Document code:	WAHT-TP-048	
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Approved by:	Paediatric Quality Improvement meeting	
Date of Approval:	26th March 2021	
Date of review: **This is the most current version and should be used until a revised document is in place**	26th March 2024	

Key Amendments

Date	Amendment	Approved by
26th March 2021	Approved with no amendments	Paediatric QIM

Management of Nephrotic Syndrome & Discharge Planning Checklist

Discharge planning and parent education should begin soon after admission and diagnosis. A checklist can be used and a printed copy can be provided to the patient and family at discharge.

1. Manage the oedematous state
    a. No added salt diet.
    b. Daily weights, daily urine dipstick.
    c. Strict fluid balance with close attention to volume status.
        - Discuss with nephrology if severe, difficult to control oedema
    d. Intravenous 20% albumin (with Frusemide).
        1. There are 2 indications (see above for details).
            a. Intravascular volume depletion.
            b. Severe or symptomatic oedema.
    2. It should only be given in consultation with the treating consultant, and ideally in daytime hours (risk of hypertension and pulmonary oedema), unless severe oedema or depletion – very rarely indicated.
    3. 20% albumin 5ml/kg (1g/kg) over 6 hrs IV.
        1. Give frusemide 1mg/kg (max 40mg) mid infusion.
        2. If giving for severe/symptomatic oedema, repeat frusemide 1mg/kg (max 40mg) at end of infusion, unless already has had brisk diuresis or signs of peripheral hypoperfusion.
        3. Larger doses of frusemide are sometimes given if poor response.

3. Prophylaxis against complications
    - Oral penicillin V (phenoxymethypenicillin) at a prophylactic dose 125mg/dose 12 hrly if under 5 years, or 250mg/dose 12 hrly if over 5 years.

    Phenoxymethypenicillin is to continue until oedema subsides.
    - i. If the child is profoundly ill or appears to have sepsis use IV Ceftriaxone 50 mg/kg/dose 24 hrly (max 2g)
    - Ranitidine 2-4 mg/kg/dose 12 hrly (max 150mg per dose) or a proton pump inhibitor as prophylaxis for prednisolone induced gastritis.

4. Family Education

a. The family should be taught to test urine protein each morning.

b. After remission, the urine protein should still be checked and documented daily (for at least 1-2 years), in order to identify a relapse (defined as 3+ or 4+ protein for 3 consecutive days), at which point the family should contact their treating clinician.

- This allows for re-institution of prednisolone **prior to the onset of oedema,** thus avoiding the associated consequences (admission, risk of sepsis, thrombosis).
- Weight should also be checked daily **while nephrotic** (as a sign of fluid accumulation).

c. It is important to convey that, though their child will likely respond to therapy, they will likely have relapses (80)% chance).

d. The most common relapse trigger is intercurrent infection. In patients on weaning or maintenance alternate day prednisolone, the risk of relapse can be reduced by temporarily increasing the dose from alternate to every day for 3-5 days.

Pre-discharge checklist

Nephrotic Syndrome Discharge Planning Checklist		**Date Complete**
Nephrotic syndrome info sheet/website links	☐	
• Prednisolone dose and reducing regimen • Penicillin prophylaxis regimen • Omeprazole/Ranitidine regimen	☐ ☐ ☐	
Urinalysis • Parent/carer education complete • Diary record • Dipstix ® provided	☐ ☐ ☐	
Dietetic referral • Diet information sheet • Fluid restriction during relapse discussed	☐ ☐	
Infection • Pneumococcal vaccination confirmed/arranged • Varicella status: Positive ☐ Negative ☐ Advice given for VZ seronegative	☐ ☐	
Information • InfoKid download and website details provided www.infokid.org.uk	☐	
Follow up • Outpatient appointment issued • Contact number/details issued	☐ ☐	