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**AKI to CKD care- the light and the dark sides**

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Acute Kidney Injury (AKI) is a common clinical syndrome in hospitalized patients and is associated with increased morbidity, mortality, and cost of care. Patient survival from an episode of AKI has been improved by advances in critical care and renal replacement therapy (RRT) technology; therefore, an increasing number of hospitalized AKI patients who required RRT survive. Recent observational studies have linked the progression of ESRD, mortality, coronary events, stroke, and bone fracture to previous episodes of AKI among those who survived to hospital discharge. Only a minority of AKI requiring dialysis (AKI-D) patients visited a nephrologist after discharge. There is a significant gap between academic guideline (KDIGO and ADQI) recommendations regarding follow-up after AKI-D episode and what actually occurs. This severe AKI group should ideally receive follow up in a nephrology-focused, multi-disciplinary setting, such as a dedicated post-AKI/AKD nephrology clinic, where the nephrologist can work in close collaboration with allied health care practitioners (pharmacy, dietician, social work) and primary care. The benefits of nephrologists' follow-up for this specific group of patients could include better management of volume status and mitigated congestive heart failure; (CHF) severity, advice on metabolic medications (including more use of statin, anti-hypertension, anti-hyperglycemic agents, antiplatelet, and diuretics) during acute kidney disease (AKD) periods, implementation of evidence-based CKD management strategies (including use of angiotensin converting enzyme inhibitors or angiotensin receptor blockers in the case of proteinuria, diabetes, and heart failure; diuretics in heart failure; statin in dyslipidemia) to decrease subsequent MACE and close monitoring of various treatment options for other possible related issues, like sepsis and pneumonia. Improving care for AKD patients requires prioritization and implementation of healthcare providers, along with a change from the current management paradigm. Multi-disciplinary efforts should seek to leverage existing and future knowledge in the hopes of better care. Appropriate risk stratification, timely reliable pharmacologic treatments, and education of patients, their caregivers, and non-nephrologists could be strategies to optimize care.