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Stroke and kidney disease: The dangerous connections

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Caribbean stroke patients are younger and their risk factors are different from those of European and North American patients, particularly in the young. The analysis of a prospective study of consecutive patients with a first hemispheric stroke admitted in Pointe-à-Pitre (Guadeloupe, French West Indies) between December 2010 and February 2011 revealed us that chronic kidney disease is very frequent, 23.6% of chronic renal failure. The study included 78 patients (33 women), 24.4% with haemorrhagic stroke. The mean age was 62.1 ± 17.7 years, 70.5% of patients had hypertension, 29.4% diabetes. A common origin of stroke and kidney disease by microangiopathy can be suggested by the high rate of hypertension and diabetes. Nevertheless, stroke aetiologies (TOAST classification), were cardio-embolism (19.3%), atherosclerosis (61.4%), lacunar stroke (1.8%), other known (3.5%) and unknown or indeterminate aetiologies (14%). Chronic renal failure has significant influence on functional state one year later ($p=0.03$) and probably influences the post stroke death ($p=0.07$ in our population). We discussed in this presentation, enclosing literature data and the results of our study, the kidney disease and neurovascular disease association.

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Kidney-foot syndrome: Outcomes after endovascular treatment of peripheral arterial disease in end stage renal disease diabetic patients

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Background: Diabetes is a strong risk factor for Peripheral Arterial Disease (PAD) and PAD has been reported at a rate of 50% in diabetic patients with foot lesion. End Stage Renal Disease (ESRD) under dialysis treatment is an independent risk factor for PAD and in diabetic patients increases the risk of ulceration, non healing ulcers and major amputation of lower limbs. Primary amputation rates of 22% to 44% have been reported for an ischaemic foot lesion in ESRD patients. Even if several studies suggest that angioplasty could be an attractive approach to treat Critical Limb Ischemia (CLI) in those patients, literature data are poor. The aim of this study was to assess the outcomes after Percutaneous Transluminal Angioplasty (PTA) in diabetic patients with PAD and ESRD.

Methods: From a cohort of 456 diabetic patients who performed PTA because of CLI complicated by foot lesion, we have identified two groups according to dialysis treatment (D+) (n=60) or not (D-) (n=396). We report the outcomes at twelve months as: Limb salvage, major amputation, death.

Results: ESRD+ were younger (67.4 ± 1.3 vs. 70.7 ± 0.5 $p < 0.02$), had more ischemic heart disease (54 vs. 39.9% $p < 0.039$) and more risk factors (4 risk factors 36 vs. 19% $p < 0.0036$) than ESRD- patients. ESRD+ required re-PTA in a major number of occasions (30 vs. 16% $p < 0.0426$) and had a technical failure after rePTA in a higher percentage (36.6 vs. 5.13% $p < 0.01$). Outcomes for ESRD+ and ESRD- patients were respectively: Limb salvage (60 vs. 77.6%), major amputation (18.33 vs. 11.48%), death (21.67 vs. 10.97%) ($\chi^2=0.0175$).

Conclusions: Our data suggest that endovascular treatment could be a useful option to treat PAD in ESRD diabetic patients. In comparison to published data on similar patients treated by open by-pass we found a similar percentage of limb salvage but a reduced mortality (22 vs. 38%); further our results were obtained in all the population and not only on the survivors, in addition our patients were consecutive and therefore unselected ESRD patients. In conclusion, we consider that angioplasty of lower limbs is not only an attractive option but should be considered as a first line treatment for CLI in diabetic patients with ESRD.

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