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Pregnancy and Renal Disease: A Clinical Practice Guideline

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Introduction

In high-income nations, Chronic Kidney Disease (CKD) is estimated to afflict 3% of pregnant women, equating to 15,000-20,000 pregnancies each year in England. Because of rising maternal age and obesity, the prevalence of CKD in pregnancy is expected to rise in the future. Although CKD does not prevent most women from reproducing, it can raise the risk of complications during pregnancy, such as preeclampsia, foetal growth restriction, premature delivery, and hastened loss of maternal renal function. Communication, decision-making, and surveillance and care of women before, during, and after pregnancy are all impacted by CKD [1].

The UK Consensus Group on Pregnancy in Renal Disease and expert review are two sources of existing guidelines on the management of CKD in pregnancy. Neither the Kidney Disease Outcomes Quality Initiative (KDOQI) nor the National Institute of Health and Care Excellence (NICE) have issued specific guidelines on the management of renal disease during pregnancy. There is published guidance that contains information pertinent to the care of pregnant women with CKD [2].

Discussion

Rationale

Any drug used during pregnancy should be weighed against the risks of uncontrolled disease to the mother and any real or perceived harm to the foetus. Inappropriate discontinuance or failure to commence therapy when plainly recommended can be more damaging to a mother's health than judicious use [3].

If the benefit to the woman (and thus the foetus) surpasses the prospective or speculative harm to the foetus, medication should be provided during pregnancy. The woman should be included in conversations concerning medication throughout pregnancy, which should ideally occur prior to the pregnancy as part of pre–pregnancy counselling.

Clinical practice guideline

Only a few medications have been approved for use during pregnancy. As a result, monitoring the outcomes of pregnancies in women who have been exposed to medicines is used to determine pregnancy safety. The underlying medical disorders for which therapy is required may skew the results [4], therefore clinical interpretation of data must be fair and pragmatic. In women with CKD, there are no randomised controlled studies of medication during pregnancy. Data from unselected or control obstetric cohorts are generalised when randomised controlled trial data is available. Only a few medications have been approved for use during pregnancy [5]. As a result, monitoring the outcomes of pregnancies in women who have been exposed to medicines is used to determine pregnancy safety. The underlying medical disorders for which therapy is required may skew the results; therefore clinical interpretation of data must be fair and pragmatic. In women with CKD, there are no randomised controlled studies of medication during pregnancy [6]. Data from unselected or control obstetric cohorts are generalised when randomised controlled trial data is available.

In a poll of 212 women with lupus, 46 percent said they were at risk of unwanted pregnancy, and 23 percent said they had unprotected sex 'most of the time.' According to a state-wide survey in the United Kingdom, one third of pregnancies in renal transplant recipients are unplanned, based on the usage of folic acid supplements at the time of conception. Despite rising pregnancy rates in contemporary dialysis cohorts and a link between intense dialysis and an increased rate of conception, contraceptive counselling of women on dialysis is frequently ignored in published literature.

Conclusion

Unintended pregnancy is associated with an increased risk of obstetric complications, even in the absence of co-morbidity, according to a systematic review of observational studies, with important additional considerations in women with CKD including optimising disease management prior to pregnancy, avoiding teratogenic medication, and providing awareness of an increased risk of adverse pregnancy outcomes.

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Conflict of Interest

There are no conflicts of interest by author.

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