Integrated Care Pathway for Antenatally Detected Renal Tract Abnormalities for East Midlands:

18+0 – 20+6 Fetal Anomaly Scan demonstrated renal tract abnormality confirmed with 2nd level scan.

Renal tract anomaly with other anomalies suspected. 2nd Level scan within 3 working days

Refer to fetal medicine unit if needed. Discuss/offer Chromosomal testing and Microarray. Consider referral to other specialist e.g. paediatric cardiologist as appropriate.

Isolated renal tract anomaly suspected/confirmed. If High Risk condition suspected then 2nd level scan within 3 working days.

Renal tract anomaly likely to be incompatible with postnatal life e.g. bilateral renal agenesis, bilateral MCDK. 2nd level scan within 3 working days

Refer to fetal medicine unit if needed. Discuss potential outcomes, in conjunction with nephrology team if needed. Offer choices of continuation with support or TOP as clinically relevant

Give parents written information and /or refer to www.infoKID.org.uk. Arrange follow-up scan at 28 weeks and 34-36 weeks. Refer after 28 week scan. Consider earlier referral in high risk cases. If syndromic/ genetic cause is suspected please seek advice from local clinical genetics service.

High Risk Conditions;

- Suspected bladder outlet obstruction (e.g. posterior urethral valve or obstructing ureterocoele)
- Bilateral renal parenchymal abnormality (echogenic kidneys, renal cystic disease, small kidneys, ARPKD)
- Any renal abnormality associated with oligohydramnios
- Suspected congenital nephrotic syndrome
- Unilateral hydronephrosis ≥10mm in a fetus with a single kidney or suspected non-functioning contralateral kidney (e.g. MCDK)
- Any other abnormality where the fetal medicine team recommend paediatric nephrology involvement at an early stage

Arrange counselling with consultant paediatrician with experience in postnatal management of the condition. This is likely to include a paediatric nephrology consultant or experienced local paediatrician with an interest in nephrology. If appropriate also consider discussion with paediatric urologist and / or neonatologist.

Moderate Risk Conditions;

- Severe unilateral hydronephrosis ≥20 mm with pelvicalyceal dilatation
- Bilateral hydronephrosis ≥10mm
- Complex duplex i.e. significant hydronephrosis or non-obstructing ureterocoele
- Hydronephrosis ≥7mm and < 10mm in a single functioning kidney

Arrange counselling with consultant paediatrician with experience in postnatal management of the condition. This is likely to be local paediatrician with an interest in nephrology. If appropriate also consider discussion with paediatric urologist.

Low Risk Conditions;

- Simple duplex
- Unilateral hydronephrosis <20mm with normal contralateral kidney
- Unilateral MCDK with normal contralateral kidney
- Unilateral renal agenesis with normal contralateral kidney
- Unilateral renal dysplasia / hypoplasia with normal contralateral kidney
- Other renal abnormality with no hydronephrosis, normal contralateral kidney and normal liquor volume e.g. horseshoe kidney

Counselling with fetal medicine team / obstetrician

Agree plan for timing, place, method of delivery and postnatal management plan.
Written communication of plan to parents, local neonatal and obstetric team, local paediatrician with an interest in nephrology, neonatal and obstetric team in hospital where delivery planned if not local hospital and other specialist e.g. paediatric urologists as needed.
Postnatal management guidelines can be found at http://www.emeesykidney.nhs.uk/professional-area/individual-guidelines or see local guidelines.

COMMUNICATION BETWEEN PARENTS AND ALL HEALTH PROFESSIONALS

FEEDBACK, AUDIT AND MONITORING SYSTEMS