PROTOCOLLO DI PROFILASSI DELLA NEFROPATIA DA MEZZO DI CONTRASTO NEL PAZIENTE CON INSUFFICIENZA RENALE CRONICA OSPEDALIZZATO

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❖ IDENTIFICAZIONE DEL PAZIENTE CON IRC E PROFILO DI RISCHIO PER LO SVILUPPO DI NMC

Nella pratica clinica la creatininemia viene usata come indice della funzione renale; la creatininemia varia in maniera inversamente proporzionale al GFR ma tale relazione dipende in gran parte dalla massa muscolare e dalla produzione della creatinina: l'età, il sesso, ed il peso corporeo. Nei pazienti che hanno ridotto tessuto muscolare (anziani e donne) un minimo aumento della creatininemia può corrispondere ad una significativa riduzione della funzione renale.
La misurazione della clearance della creatinina richiede la raccolta delle urine delle 24 ore che non è sempre di semplice realizzazione. La formula di Cockroft-Gault stima con sufficiente attendibilità la clearance, tiene conto del peso corporeo, del sesso e dell'età e correla con il GFR.
Clearance della creatinina ml/min
(Maschi) (140-età) x peso corporeo/(creatinina serica x 72)
(Femmine) (140-età) x peso corporeo/(creatinina serica x 72) X 0.85

Pazienti ad alto rischio.

1. Clearance della creatinina stabile < 25ml/min
2. Clearance della creatinina 25-50ml/ min + uno dei seguenti fattori di rischio

- Diabete mellito
- Scompenso cardiaco congestizio
- Recente somministrazione di mdc
- Necessità di alte dosi di mdc

Pazienti a rischio moderato

1. Clearance della creatinina stabile 25-50 ml/min
2. Clearance della creatinina stabile 50-75 ml/min + un fattore di rischio:

- Diabete mellito
- Scompenso cardiaco congestizio
- Recente somministrazione di mdc
- Necessità di alte dosi di mdc

❖ MISURE DI PROFILASSI DA ATTUARE

Per tutti i pazienti con funzione renale ridotta:

- Segnalare nella richiesta dell'esame contrastografico la riduzione della funzione renale
- Sospendere i diuretici (se non controindicato clinicamente), i FANS, il dipiridamolo, gli aminoglicossidi, gli ACE-inibitori e sartanici e la metformina.
- Prescrivere acetilcisteina (600mg x 2) a partire dal giorno prima dell'esame avendo cura di somministrare una dose un' ora prima dell'esame.
- Teofillina in infusione di 30 min prima dell'esame se non ci sono controindicazioni.
- Usare mezzi di contrasto a bassa osmolalità preferibilmente l'iodixanolo.
- Idratazione
- Ottenere un buon controllo glicemico (glicemia 200-250mg/dl)

1. **Per i pazienti a rischio moderato:**
   Idratazione orale con almeno 1 Lit di acqua nelle 10 ore precedenti l'esame.

Idratazione parenterale a partire da 4 ore prima dell'esame e per 8-12 ore dopo alla velocità di infusione di 1-1.5 ml/Kg/min.

2. **Per i pazienti ad alto rischio:**
   Idratazione parenterale a partire da 12 ore prima e per 12-24 ore dopo alla velocità di 1-1.5ml/Kg/min.

La scelta della soluzione salina (ipotonica vs normale) può variare in base alla sodiemia e soprattutto alla tollerabilità del carico di sodio. E' comunque preferibile usare l'ipotonica almeno nell'immediato periodo periprocedurale.

- **CONTROLLO DELLA FUNZIONE RENALE: A 24 ORE PER IMPOSTARE ULTERIORE IDRATAZIONE SE NECESSARIO.**

- **CONTROLLO DELLA FUNZIONE RENALE A 72 ORE.**

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