The Thirty First Report

Australia and New Zealand Dialysis and Transplant Registry

2008

Edited by

Stephen McDonald
Leonie Excell
Brian Livingston

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ANZDATA Registry offers its most grateful appreciation to everyone who helped make this 31st Annual Report possible, especially the professionals and the staff of all the Renal Units and Tissue Typing Laboratories, upon whose reporting of data this enterprise ultimately depends.

Suggested Citation

An example of suggested citation for this report is as follows:

.. [Author's name] ..
Peritoneal Dialysis .. [page numbers] ..
ANZDATA Registry Report 2008
Australia and New Zealand Dialysis and Transplant Registry
Adelaide, South Australia.

Editors: Stephen McDonald, Leonie Excell, Brian Livingston

Publications based upon ANZDATA Registry information reported here or supplied upon request, must include the citation as noted above and the following notice:

> The data reported here have been supplied by the Australia and New Zealand Dialysis and Transplant Registry.
> The interpretation and reporting of these data are the responsibility of the Editors and in no way should be seen as an official policy or interpretation of the Australia and New Zealand Dialysis and Transplant Registry.

Appendix I (On CD) (and website www.anzdata.org.au)

APPENDIX II - AUSTRALIA (Available on CD and from website www.anzdata.org.au)

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APPENDIX III - NEW ZEALAND (Available on CD and from website www.anzdata.org.au)

CONTENTS

It is with a great deal of pleasure that the ANZDATA Registry presents its 2008 Annual Report. This is the Thirty First Annual Report and it covers data collected until the end of the calendar year 2007. Once again, the report is a tribute to the commitment and involvement of Renal Units in Australia and New Zealand. This commitment has ensured 100% of units participate and we are confident that all of the patients who have received dialysis and transplantation services in Australia and New Zealand in this time period are included.

Lee Excell continues in her role as Manager of the Registry and has been in this position now for more than 30 years. This astounding performance has provided the rock upon which the Registry's success is based. Her interaction with staff of Renal Units and both countries is a tribute to her professionalism and persistence. Brian Livingston continues to provide information technology expertise and data analysis and Carol Young and Christina Leitch continue to provide administrative support. Hannah Dent is now in her second year as part time Biostatistician to the Registry.

Associate Professor Stephen McDonald has continued in his role as Executive Officer of the Registry. He once again has been the national and international face of the Registry and has provided considerable leadership in presentations and publications emanating from Registry data.

In 2008, Dr Andrew Brunskill was appointed as the Amgen Fellow in Epidemiology. He replaces Dr Sean Chang in the position. Dr Chang has been particularly productive in this role and we wish him well in his future endeavours. We have great hopes that Dr Brunskill will continue the excellent tradition of the Amgen Fellow in providing analysis and stimulating discussion, interaction with contributors and publications. We are greatly indebted to Amgen who have made a commitment to continue funding of this position.

Once again, the Registry has included in the Report publications which have appeared in peer reviewed journals based substantially on data from the Registry. These publications are listed on Page xix of the Report.

The major funding for the Registry continues to come from the Australian Commonwealth Department of Health and Ageing, Kidney Health Australia and the New Zealand Ministry of Health. We are also very grateful to support from Industry. Non tied grants have been received from Amgen for the employment of the Epidemiology Fellow as well as Novartis Pharmaceuticals, Janssen-Cilag, Roche Products Pty. Ltd and Wyeth Australia.

A number of individuals have provided their time and expertise as members of the ANZDATA Registry Committees and Working Groups. They are to be thanked for their contribution and their names are listed on Page vii.

Most of all though we are indebted for the time and effort put in by contributing units and their staff. We are proud that the ANZDATA Registry is at the forefront of End Stage Renal Failure Registries internationally. This could not be achieved without the overwhelming commitment of the contributors.

Graeme Russ

Chair ANZDATA Executive
December 2008

ANZDATA Registry Executive Committee

Professor Graeme Russ—Chair
A/Professor Stephen McDonald—Executive Officer
Mrs Leonie Excell—Registry Manager
Mr Brian Livingston—Information Technologist

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Dr Matthew Jose
Ms Gillian Gorham

PRIVACY

In December 2001 changes to the Commonwealth Privacy Act were introduced which have led to changes to the collection of personal information. Essentially these extend to the private sector a number of changes based around 10 "National Privacy Principles" (NPP's). A detailed exposition of these can be found at the Privacy Commissioner's website (www.privacy.gov.au). Briefly, however, health information is treated as "sensitive" information, which must usually be collected and handled with consent of the person, unless certain conditions are met. Patients are entitled to view the information the Registry holds about them, and request alterations if the data is thought to be inaccurate.

Each Australian State has also enacted similar provisions which cover practice and patients in public hospitals.

ANZDATA does not release data identifiable by patient name. Results are published/released in tabular or graphic format only. Requests for data are met using deindentified data only. On occasion, when data identifying particular hospitals is involved, consent from the Director of the relevent renal unit is sought prior to the release of information.

COLLECTION OF DATA

ANZDATA spent some time during 2002 formulating an appropriate response to these issues including seeking advice from a variety of sources. The approach taken has been that of a "opt-out" consent, whereby patients are distributed information outlining the nature and purpose of the information collected, offered an opportunity to view that data and ask questions, and the opportunity to request withdrawal of part or all of their data. This approach is explicitly suggested for Registries by the Privacy Commissioner in his "Guidelines for the Health Sector". To this end ANZDATA has circulated to all participating hospitals a patient information sheet (see opposite), for each hospital to use (or a locally modified version if appropriate) to inform patients.

At the time of data collection each unit is asked to certify that they have complied with measures under the relevant privacy measures.

Tissue Typing Data and Transplant Waiting List data are collected in each Tissue Typing Laboratory and entered into the National Organ Matching System database. These data are transmitted to ANZDATA for inclusion in the ANZDATA database and for this Report.

ANZDATA REGISTRY

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Important Privacy Information

As part of routine medical care of people receiving treatment with dialysis or kidney transplantation, your kidney specialist collects certain information about the patients they treat. All kidney specialists throughout Australia and
New Zealand report this information every twelve months to the Australia and New Zealand Dialysis and Transplant Registry (ANZDATA). ANZDATA collects the information for the purpose of monitoring treatments and performing analyses to improve quality of care for people with kidney failure.

1. What is ANZDATA ?

ANZDATA is an organization set up by Kidney Health Australia and the Australia and New Zealand Society of Nephrology to monitor dialysis and transplant treatments. ANZDATA is funded by the Australian and New Zealand Governments and Kidney Health Australia.

2. What information is collected about you ?

This information includes your name, age, gender, racial origin, hospital of treatment, some aspects of your medical condition (such as whether you have diabetes) and details about the type of kidney treatment you are receiving (dialysis or transplant).

We **DO NOT** collect details about your address, telephone number, medical insurance, or non-medical matters such as occupation, income, etc.

3. Is personal data ever released ?

The identity of people in the database **IS NOT released publicly nor in any reports**. Measures have been put into place to ensure the security of all collected information.

4. What is this information used for ?

The information is used primarily for quality assurance, investigating patterns of kidney disease, and planning appropriate health services. We release reports on a variety of topics, including an Annual Report examining the rates and treatment of kidney failure in Australia and New Zealand. We also have a major role in ensuring the quality of patient care by sending to each kidney unit each year a report outlining their activity. These reports also compare the outcome of the treatment they provide with that of other units throughout the two countries. Reports are also produced at a state and national level, and from time to time analyses are also produced for renal units, government health departments and industry concentrating on particular aspects of renal failure management eg peritoneal dialysis, transplantation, haemodialysis.

5. **Can you see what personal information ANZDATA collects and the reports that it produces ?**

Individuals are able to view their own information on request. You can request alterations if you believe it is inaccurate. You may also opt not to have your treatment included in this database, and you should let your kidney specialist know if this is the case. You can also choose not to have some information (eg racial origin) recorded. However, if your information is not included in the Registry, the ability to compare results in Australia and New Zealand or to analyse the results of different treatment methods and for different patient types (eg diabetics) will be compromised.

The national reports and much other material produced by ANZDATA are available free on the Internet at www.anzdata.org.au, or they can be sent to you on request to the address above. Your kidney specialist will also have copies of many of the reports.

If you wish to discuss any of the issues raised here, please let your doctor know or telephone the ANZDATA Registry direct on [08] 8222 6704. You may also write to us (ANZDATA Registry, C/- The Queen Elizabeth Hospital, 28 Woodville Road SA 5011) or send us an e-mail (anzdata@anzdata.org.au).

GUIDELINES FOR DATA RELEASE

The policy for release of data to investigators, renal units and others was revised during 2002 and is summarised on the Website. ANZDATA encourages the analysis, use and citation of its data, and receives many data requests annually which vary in size and complexity. At times these overwhelm the limited resources within the Registry, and must be prioritised. Generally, formal requests for data are preceded by a period of consultation with a member of the Registry staff. Requests are welcome from Renal Physicians, other staff members of Renal Units, Charitable Bodies, Academic Institutions, Government Departments and Industry. Requests dealing with identifiable Hospital data (ie data which identifies outcomes of an individual hospital) will only be fulfilled with the explicit consent of the Heads of the relevant Hospital Units. Individual patient identified data (names) is not released.

ATTRIBUTION OF PUBLICATIONS

The policy on attribution of publications which incorporate ANZDATA sourced data was revised during 2002, following a period of consultation with participating physicians.

Where a member of a participating unit has analysed data provided by ANZDATA and subsequently prepared a manuscript, then "ANZDATA Registry" should be acknowledged as a secondary institution in addition to the author's Hospital or University. This applies whether the primary data analysis is performed by the author or by ANZDATA staff. Where the author is an ANZDATA office holder or staff member then the primary attribution should be "ANZDATA Registry".

Where ANZDATA data is only a minor portion of the work, then it may be more appropriate to acknowledge the source explicitly in the "Acknowledgements" section.

In both cases the disclaimer on page ii of this report should be included.

In all cases the source and treatment of the data should be made clear in the "Methods" section. Preferably the abstract (and keywords if applicable) should also include "ANZDATA" which would allow for searching Registry publications.

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A number of definitions given below are used throughout this report unless otherwise stated.

1. Wording

Throughout this report 'treatment' refers to renal replacement therapy, including haemodialysis, peritoneal dialysis and transplantation

HD = haemodialysis
APD = automated peritoneal dialysis
CAPD = continuous ambulatory peritoneal dialysis
ESKD = end stage kidney disease

2. Data collection

ANZDATA collects information from all renal units in Australia and New Zealand. Data collection occurs at two time points. Key events (new patients, deaths, transplants) are notified as they occur, with units requested to send this at least monthly. This can occur either via a web-based interface or paper submission. An extensive cross-sectional survey is then performed twelve monthly (for data to 31st December). Currently this is by a paper-based system, with manual completion of the form and manual data entry. No formal audit mechanism is in place at this stage.

For transplants, HLA matching and panel reactive antibodies are obtained direct from the Tissue Typing laboratories in each State.

Monthly summaries are distributed to the contributing units. Results contained in this (and other reports) are based on a final database locked and prepared after the end of year survey returns are received.

3. Inclusion criteria

Included in the Registry are all patients receiving renal replacement therapy where the intention to treat is long-term, ie medical opinion is that renal function will not recover. Cases of acute renal failure are excluded. People who move overseas permanently are censored at date of last treatment (or departure in the case of transplant recipients).

4. Modality attribution

The initial mode of dialysis is determined at 90 days after first treatment, to allow for early changes and maturation of access. Other transfers (between modalities, or from satellite to hospital haemodialysis etc.) are not analysed if less than 30 days, except for transfers between dialysis centres to which a 60 day rule is applied to allow for holiday movements.

5. Underlying renal disease

This is recorded by the treating hospital according to a modified EDTA coding system (details on back of survey form).

6. Deaths

Death rate is predominantly reported as number of patients died/total number of years of treatment of all patients treated at any time during the year. It is expressed as deaths per 100 patient years (pt yrs) at risk.

7. Comorbid conditions

These are recorded by the treating hospital. No definitions are supplied; the treating clinician is asked to record whether the patient has coronary artery disease, chronic lung disease, cerebrovascular disease, peripheral vascular disease or diabetes according to their clinical opinion on a yes / suspected / no basis.

8. Transplant Waiting List

The active transplant waiting list definition has changed for this report. We now use data from the Tissue Typing Laboratories, cross-checked with ANZDATA. Waiting list analyses are for patients' status at 31st December 2006.

9. Derived measures

9.1 Haemoglobin

Haemoglobin is recorded as the last available measurement before the end of the survey period.

9.2 Erythropoietic agents

Erythropoietin agent use is recorded as "yes" if these agents were used at any time during the survey period.

9.3 Iron studies

Iron studies are requested within the last three months of the survey period.

9.4 Estimated creatinine clearance

Where creatinine clearance is estimated from serum creatinine at entry or post transplantation, the Cockroft-Gault equation is used [1].

$$Cl_{Cr}=(140\text{-age})*\text{weight} / (814*Cr_{serum})[*0.85 \text{ if female}]$$

The weight term used for this is lean body mass, calculated using the equation LBW=(0.9*[height-152])+(50 if male, 45.5 if female) [2].

9.5 Urea reduction ratio / Kt/V

Results are requested in one of these formats, using the stop flow method on a mid-week dialysis. Single pool Kt/V is collected, along with the method used.

For conversion of URR to Kt/V urea the formula used [3] is

$$Kt/V = 0.023*PRU - 0.284$$ (note that PRU = percent reduction in urea and not URR).

9.6 Body mass index

Body mass index (BMI) is calculated as $\frac{\text{weight (kg)}}{(\text{height (m)})^2}$

The standard NH&MRC categories are used: underweight <20 kg/m^2 normal 20-24.9 kg/m^2 overweight 25-29.9 kg/m^2 obese >=30 kg/m^2

9.7 Peritoneal dialysis measures

These are the standard measures, often calculated by computerised patient management programs.

9.7.1 Residual renal function

The measure used is the arithmetic mean of urea and creatinine clearance from a 24-hour urine collection and serum creatinine and urea.

9.7.2 Peritoneal equilibration test

The ratio of dialysate to plasma glucose is used, following a 4 hour dwell of a 2 litre 2.5% bag of dialysate, performed within 6 months after initiation of peritoneal dialysis.

10. Rates and Measures

10.1 Incidence rates

Except where otherwise stated, quoted incidence rates are per calendar year, and are expressed per million population.

10.2 Prevalence rates

Except where otherwise specified, prevalence rates are point prevalence rates at 31st December 2006.

10.3 Population denominator

The population estimates used are the estimated resident populations (ERP) for the year 2006, released by the Australian Bureau of Statistics and Statistics New Zealand. Figures used are those for the June quarter.

For both countries, the statistics bureaux record indigenous status on a self-identification basis. For Australia, there has been considerable change in the propensity to self-identify as indigenous, such that a number of estimates are released by the ABS [4]. For this report, the low range projections have been used.

10.4 Survival rates

For transplant recipients, survival rates exclude those who were transplanted overseas or were recipients of multiple organ grafts.

Graft survival (unless otherwise qualified) includes both cessation of graft function (ie return to dialysis) and patient death.

Patient survival for transplant recipients - rates for fixed periods are calculated according to the life-table method and include an adjustment to the risk-set of ½ of those censored without failure over the interval to create an "average" risk set.

10.5 Graft survival

For outcomes of kidney transplants, graft failure includes both loss of graft function (ie return to dialysis) and death of patients (with graft function). Calculations of patient survival for transplant recipients includes all subsequent modalities (ie deaths after graft failure are included). Patients transplanted overseas are excluded from calculations.

10.6 Dialysis Survival

Patient and technique survivals for haemodialysis and peritoneal dialysis are based on the dialysis modality at 90 days after first treatment for patients not grafted during that period. Patients are followed up until they are either grafted (at which point they are censored) or until they have a 'permanent' change of dialysis modality or until death or most recent follow up date. A 'permanent' change of dialysis is defined as any change in excess of 30 days.

Peritonitis survivals are calculated from first peritoneal dialysis (ignoring all earlier treatments) to date of first peritonitis episode. If there were no episodes of peritonitis then calculation is censored at change of treatment from peritoneal dialysis to haemodialysis or transplantation. Peritoneal dialysis includes automated peritoneal and continous ambulatory peritoneal dialysis. Excluded are patients who had peritonitis before commencing peritoneal dialysis.

10.7 Death and other event rates

Rates are expressed per 100 person years at risk (unless otherwise stated).
Some analyses include survival of all patients, others exclude the first 90 days of followup. This is stated in the individual analyses.

10.8 Age standardisation

All rates are crude, not age-standardised. The age distribution of the populations for Australia and New Zealand are given in Appendix I.

10.9 Peritonitis rates

Peritonitis rates are present using episodes of peritonitis reported during periods of peritoneal dialysis - episodes reported prior to commencement of peritoneal dialysis (for example between Tenckhoff catheter insertion and commencement of peritoneal dialysis) are not included in these calculations.

11. Database

Data is stored on a relational database using ORACLE version 9I.

12. Statistics

Statistical analyses were performed using SPSS release version 15 and Stata version 10.

13. References

1. Cockcroft DW, Gault MH: Prediction of creatinine clearance from serum creatinine. Nephron 1976: 16;31-41.
2. Zasadny KR, Wahl RL: Standardized uptake values of normal tissues at PET with 2-[fluorine-18]-fluoro-2-deoxy-D-glucose: variation with body weight and method for correction. Radiology 1993: 189;847-850.
3. Basile C, Casino F, Lopez T: Percent reduction in blood urea concentration during dialysis estimates Kt/V in a simple and accurate way. Am J Kidney Dis 1990: 15;40-45.
4. Australian Bureau of Statistics: Experimental Projections of the Aboriginal and Torres Strait Islander Population. Canberra, ABS Cat. No. 3101.0, 2002.

Parent hospitals are listed below. In some cases, these have combined as part of a regional network and this is also indicated. The definition of a 'parent hospital' is a pragmatic one, and refers to units which offer a full range of dialysis services (i.e. can commence patients on dialysis and have on-site nephrology presence).

In contrast, satellite units (see Page xvii) provide haemodialysis treatments to selected patients, usually with lower staff ratios and no on-site nephrologist.

QUEENSLAND

Allamanda Private Hospital (Fresenius)
Bundaberg Base Hospital
Cairns Base Hospital
Chermside Dialysis Unit (Fresenius)
Child and Adolescent Renal Service
Goldcoast Hospital
Henry Dalziel Dialysis Centre (Greenslopes) (Baxter)
Hervey Bay Hospital
John Flynn Hospital
Mackay Base Hospital
Princess Alexandra Hospital
  Queensland Renal Transplant Service
Rockhampton Base Hospital
Royal Brisbane Hospital
St Andrew's Dialysis Clinic (Diaverum)
Sunshine Coast Health District
  Caloundra Private Hospital
  Nambour General Hospital
  Nambour Selangor Private Hospital
The Townsville Hospital
Toowoomba Hospital
Wesley Private Hospital

NEW SOUTH WALES

Dubbo Base Hospital
East Coast Renal Service
  Prince of Wales Hospital
  St. George Hospital
  St. Vincent's Hospital
  Sydney Children's Hospital
  Wollongong Hospital
Gosford Hospital
John Hunter Hospital
Lismore Hospital
Macleay Dialysis Centre
Mater Misericordiae Hospital
Mayo Private Hospital - Taree
Port Macquarie Base Hospital
Port Macquarie Community Dialysis
Port Macquarie Private Hospital
Royal North Shore Hospital
South West Sydney Renal Services
  Liverpool Hospital
Statewide Renal Services
  Concord Hospital
  Royal Prince Alfred Hospital
Sydney Adventist Hospital
Tamworth Hospital
The Children's Hospital at Westmead
The Tweed Hospital
Western Renal Network
  Westmead Hospital
    Orange Base Hospital
    Penrith Community Dialysis Centre

AUSTRALIAN CAPITAL TERRITORY (ACT)

The Canberra Hospital

VICTORIA

Alfred Hospital
Austin Health
Epworth Hospital
Forest Hill Dialysis Centre (Fresenius)
Geelong Hospital
Kew Private Dialysis Centre
Malvern Dialysis Centre (Fresenius)
Monash Medical Centre – Adult
Monash Medical Centre – Paediatric
North West Dialysis Service
Royal Melbourne Hospital
Royal Children's Hospital
St. Vincent's Hospital

TASMANIA

Launceston General Hospital
Royal Hobart Hospital

SOUTH AUSTRALIA

Flinders Medical Centre
The Queen Elizabeth Hospital
Royal Adelaide Hospital
Women's and Children's Hospital

NORTHERN TERRITORY

Alice Springs Hospital
Royal Darwin Hospital

WESTERN AUSTRALIA

Fremantle Hospital
Hollywood Private Hospital
Princess Margaret Hospital for Children
Royal Perth Hospital
Sir Charles Gairdner Hospital
St. John of God Private Hospital

NEW ZEALAND

Auckland City Hospital
Starship Children's Hospital
Christchurch Hospital
Dunedin Hospital
Hawkes Bay Hospital
Middlemore Hospital
Palmerston North Hospital
Taranaki Base Hospital
Waikato Hospital
Wellington Hospital
Whangarei Area Hospital

QUEENSLAND

Queensland Renal Transplantation Service
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WESTERN AUSTRALIA

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Royal Perth Hospital
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Christchurch Hospital
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Wellington Hospital
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Queensland

Atherton Private Hospital- Cairns Base Hospital
Cairns Private Hospital Satellite - Cairns Base Hospital
East Street Self Care Dialysis Unit —Rockhampton Hospital
Gympie Satellite—Sunshine Coast Health District
Home Hill Satellite - Townsville Hospital
Innisfail Hospital - Cairns Base Hospital
Ipswich Satellite - Princess Alexandra Hospital
Logan Satellite - GoldcoastHospital
Mt. Isa Satellite - Townsville Hospital
Noosa Satellite - Sunshine Coast Health District
North Ward Satellite - Townsville Hospital
Palm Island Satellite - Townsville Hospital
Redcliffe Satellite - Royal Brisbane Hospital
Redlands Satellite - Princess Alexandra Hospital
St Vincent's Robina Satellite - Goldcoast Hospital
Vincent Satellite - Townsville Hospital

New South Wales

Armidale Hospital -Tamworth Hospital
Ballina Hospital - Lismore Hospital
Bankstown Hospital - South West Sydney Renal Services
Bathurst Satellite Dialysis Centre - Orange Hospital
Bega Satellite - Statewide Renal Services
Blacktown Regional Dialysis - Westmead Hospital
Brewarrina Hospital
Broken Hill Hospital
Campbelltown Satellite - South West Sydney Renal Services
Cobar Hospital
Coffs Harbour Base Hospital
Coonamble Hospital
Dame Eadith Walker - Statewide Renal Services
Dubbo Base Hospital
Eora Satellite - Prince of Wales Hospital
Forbes Hospital - New South Wales
Gosford Satellite - Gosford Hospital
Goulburn Satellite (Fresenius) - Statewide Renal Services
Grafton Hospital - Lismore Hospital
Griffith Base Hospital - Statewide Renal Services
Invarell Satellite - Tamworth Hospital
Lakehaven Satellite - Gosford Hospital
Lanceley Cottage - Royal North Shore Hospital
Lindfield Dialysis Unit (Diaverum)
Liverpool Community Centre - South West Sydney Renal Services
Macleay Dialysis Centre - Kempsey
Maitland Hospital - Hunter New England Health
Moree Satellite - Tamworth Hospital
Moruya Satellite (Fresenius) - Statewide Renal Services
Muswellbrook - Hunter New England Health
Norfolk Island Hospital - Statewide Renal Services
Orange Base Hospital - Westmead Hospital
Shellharbour - Wollongong Hospital
Shoalhaven Satellite (Nowra) - Wollongong Hospital
Singleton Satellite - Hunter New England Health
Sydney Dialysis Centre - New South Wales
Taree Community Dialysis - Hunter New England Health
Wagga Wagga Base Hospital
Wansey Satellite - Hunter New England Health
Wellington Hospital - New South Wales
Wollongong Satellite - Wollongong Hospital - New South Wales

Australian Capital Territory (ACT)

Canberra Community Satellite
Northside Dialysis Clinic (Fresenius)

Victoria

Angliss Hospital
Ararat Hospital
Austin Training Satellite - Austin Health
Bacchus Marsh Hospital
Bairnsdale Regional Health
Ballarat Health Service
Bendigo Hospital
Broadmeadows Satellite
Brunswick Satellite
Casey Hospital - Berwick
Caulfield General Medical Centre
Coburg Satellite
Cohuna Hospital
Colac Hospital
Craigieburn Satellite
Cranbourne Satellite
Dandenong Satellite
Daylesford Hospital
Diamond Valley Dialysis Clinic (Diaverum)
Donald Hospital
Echuca Hospital
Edenhope Hospital
Epping Dialysis Unit
Frankston Satellite
Goulburn Valley Hospital
Hamilton Hospital
Hastings Hospital

Victoria (Continued)

Horsham Satellite
Kyneton Hospital
Latrobe Regional Satellite
Lorne Hospital
Mansfield District Hospital
Maryborough Hospital
Mildura Hospital
Moorabbin Satellite
Myrtleford Hospital
Newcomb Satellite
Nhill Hospital Satellite
North East Kidney Service - Austin Health
Northern Hospital Satellite
Omeo District Hospital
Orbost Hospital
Peter James Centre
Portland District Health
Rosebud Hospital
Royal Park Home Dialysis Service—Royal Melbourne Hospital
Sale Hospital
Sandringham Satellite
Seymour Hospital
South Geelong Satellite - Geelong Hospital
St. George's Hospital
Sunshine Satellite Centre
Swan Hill Hospital
Terang Satellite
Wangaratta Hospital
Warnnambool Hospital
Werribee Mercy Hospital
Western Gippsland Hospital
Williamstown Satellite
Wodonga Regional Health Service
Wonthaggi Hospital
Yarawonga District Hospital
Yarram Hospital

Tasmania

North West Renal Unit, Burnie - Launceston Hospital

South Australia

Berri Hospital
Ceduna Hospital
Clare Satellite
Hampstead Rehabilitation Satellite
Hartley Private Hospital (Fresenius)
Lyell McEwin Satellite
Millicent Hospital
Modbury Satellite (Fresenius)
Mount Gambier Satellite
Murray Bridge Hospital
Noarlunga Satellite
Payneham Satellite (Baxter)
Port Augusta Hospital
Port Lincoln Satellite Centre
Wayville Satellite Centre

Northern Territory

Community Health Centre - Alice Springs Hospital
Flynn Drive Satellite - Alice Springs Hospital
Katherine Dialysis Unit - Royal Darwin Hospital
Nightcliff Community Centre - Royal Darwin Hospital
Palmerston Satellite - Royal Darwin Hospital
Tennant Creek Hospital - Alice Springs Hospital
Tiwi Dialysis Centre - Royal Darwin Hospital

Western Australia

Albany - John Hortin Dialysis Unit
Armadale Satellite
Bunbury Satellite
Cannington Dialysis Clinic (Diaverum)
Geraldton Hospital
Joondalup Satellite Unit
Kalgoorlie Dialysis Unit
Kimberley Dialysis Centre - Royal Perth Hospital
Melville Satellite
Midland Private Dialysis Centre (Baxter)
Peel Health Campus - Mandurah
Pilbara Dialysis Unit [Port Hedland] - Royal Perth Hospital
Royal Perth Rehabilitation Hospital - Royal Perth Hospital
Stirling Dialysis Clinic (Diaverum)

New Zealand

Bay of Islands Hospital - Whangarei Hospital
Carrington Satellite - Auckland City Hospital
Greenlane Hospital - Auckland City Hospital
Manukau Satellite - Middlemore Hospital
Middlemore Satellite - Middlemore Hospital
Nelson Hospital
Porirua Community Dialysis - Wellington Hospital
Rotarua Hospital - Waikato Hospital
Tauranga Hospital - Waikato Hospital
Waitakere Satellite - Auckland City Hospital

Publications in peer-reviewed journals based substantially on data from ANZDATA and released during the period of data covered by this report (2007) and during 2008 are listed below.

2007

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2. Chang SH, Coates, PTH, McDonald, SP: Effects of Body Mass Index (BMI) at Transplant on Outcomes of Kidney Transplantation. Transplantation 84: 981-987, 2007.
3. Moist LM, Chang, SH, Polkinghorne, KR, McDonald SP: Trends in Hemodialysis Vascular Access from the Australia and New Zealand Dialysis and Transplant Registry (ANZDATA) 2000- 2005. Am J Kidney Dis 50: 612-621, 2007.
4. Villar E, Chang SH, McDonald SP: Incidences, treatments, outcomes, and gender effect on survival in end-stage renal disease patients by diabetic status in Australia and New Zealand (1991-2005). Diabetes Care 30: 3070-3076, 2007.
5. Lim WH, Chang SH, Coates PTH, McDonald SP: Parental Donors in Live-Donor Kidney Transplantation Affects Acute Rejection Rates and Glomerular Filtration Rates at 1 and 5 Years. Transplantation 84: 972-980, 2007.
6. Badve SV, Hawley CM, McDonald, SP, Mudge DW, Rosman JB, Brown FG and Johnson, DW: Automated and continuous ambulatory peritoneal dialysis have similar outcomes. Kidney Int. 73(4):480-8 2007.
7. McDonald SP, Russ GR, Campbell SB and Chadban SJ: Kidney Transplant Rejection in Australia and New Zealand: Relationships between rejection and graft outcome. Am J Trans, 7:1201-6, 2007.
8. Craven A.-M.S, Hawley C.M, McDonald SP, Rosman JB, Brown FG, and Johnson DW: Predictors of renal recovery in Australian and New Zealand end-stage renal failure patients treated with peritoneal dialysis. Perit Dial Int. 2007.27(2):p. 184-191.9.
9. Wiggins KJ, McDonald SP, Brown FG, Rosman JB and Johnson DW: High membrane transport status on peritoneal dialysis is not associated with reduced survival following transfer to haemodialysis. Nephrol Dial Transplant, 22:3005-12, 2007.
10. Webster AC, Craig JC, Simpson JM, Jones MP, Chapman JR. Identifying high risk groups and quantifying absolute risk of cancer after kidney transplantation: a cohort study of 15,183 recipients. Am J Transplant. 2007;7(9):2140-51.
11. Vajdic CM, McDonald SP, McCredie MRE, van Leeuwen MT, Stewart JH, Webster AC et al. Increased incidence of Squamous cell carcinoma of the eye after transplantation. J Natl Cancer Inst. 2007;99(17: 1340-2.

2008

1. Chang SH, Russ GR, Chadban SJ, Campbell SB, McDonald SP. Trends in adult post kidney transplant immunosuppressive use in Australia, 1991-2005. Nephrology (Carlton). 2008 Apr:13(2):171-6.
2. van Leeuwen MT, Grulich AE, McDonald SP, McCredie MRE, Amin J, Stewart JH, Webster AC, Chapman JR, Vajdic CM. Immunosuppression and other risk factors for lip cancer after kidney transplantation. Cancer Epidemiology, Biomarkers and Prevention *(in press)*.
3. Wong G, Howard K, Webster AC, Chapman JR, Craig JC. The health and economic impact of cervical cancer screening and HPV vaccination in kidney transplant recipients. Transplantation *(in press)*.
4. Wong G, Howard K, Chapman JR, Craig JC. Cost-effectiveness of breast cancer screening in women on dialysis. American Journal of Kidney Diseases *(in press)*.
5. Wong G, Howard K, Craig JC, Chapman JR. Cost-effectiveness of colorectal cancer screening in renal transplant recipients. Transplantation 2008 Feb 27;85(4): 532-541.
6. McDonald SP, Marshall MR, Johnson DW, Polkinghorne K. Relationship of dialysis modality with mortality. Journal of the American Society of Nephrology *(In Press; Acceptance date 7 July, 2008)*.
7. Johnson DW, Dent H, Hawley CM, McDonald SP, Rosman JB, Brown FG, Bannister KM, Wiggins KJ. Associations of dialysis modality and infectious mortality in incident dialysis patients in Australia and New Zealand. American Journal of Kidney Diseases *(In Press; Acceptance date 25 June, 2008)*.
8. Chang SH, Mathew TH, McDonald SP: Analgesic Nephropathy and Renal Replacement Therapy in Australia: Trends, Comorbidities and Outcomes. *Clin J Am Soc Nephrol,* 3: 768-776, 2008.
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10. Kerr, PG, Polkinghorne, KR and McDonald SP: Home Haemodialysis in Australia: Current perspective. *Haemodialysis Int,* 12: S6-S10, 2008.
11. Badve SV, Hawley CM, McDonald SP, Mudge DW, Rosman JB, Brown FG and Johnson DW: Automated and continuous ambulatory peritoneal dialysis have similar outcomes. *Kidney Int,* 73: 480-488, 2008.

XX

2007 # AUST. & N.Z. DIALYSIS AND TRANSPLANT SURVEY

THIS SECTION FOR ALL PATIENTS

REGISTRY NUMBER | **1 INITIAL HOSPITAL** (Hospital/State, Hosp. Unit No.) | **CURRENT PARENT HOSPITAL** (Hospital/State, Hosp. Unit No) | Physician (Optional)

2 Surname | Given Names | **3 DATE OF BIRTH** | **4 SEX**

5 RACIAL ORIGIN (Record from list) | OTHER | **6 PRIMARY RENAL DISEASE** (Record from list) | OTHER | **7 BIOPSY** Y/N | **8 SE. CREATININE** AT ENTRY

9 COUNTRY OF BIRTH (If Australia or NZ - Tick box) | AUST | NZ | OTHER COUNTRY (Please specify)

10 POSTCODE At Entry | **POSTCODE At End Survey**

11 CO-MORBID CONDITIONS AT ENTRY

LATE REFERRAL (<3 MTHS BEFORE FIRST TREATMENT) (Y/N) | HEIGHT (cms) | WEIGHT (kg) | CIGARETTE SMOKING (N=Never F=Former C=Current) | Kidney Health Australia

DISEASE AT ENTRY AND DURING CURRENT SURVEY

Y=Yes N=No S=Suspected

	CHRONIC LUNG Y/S/N	CORONARY ARTERY Y/S/N	PERIPHERAL VASCULAR Y/S/N	CEREBRO VASCULAR Y/S/N	DIABETES N=No O=Type 1 Insulin dependent P=Type 2 Non Insulin requiring Q=Type 2 Insulin requiring
AT ENTRY					
LAST					
CURRENT					

OTHER CO-MORBID CONDITIONS (Write In)

AT ENTRY	
PREVIOUS ENTRIES	
CURRENT	

12 CENTRE OF TREATMENT

Enter geographical location at Death or End of Survey

	HOSPITAL / CENTRE NAME (Write In or Tick if same)	CENTRE CODE	DATE TRANSFER
CURRENT			
LAST			

13 COURSE OF TREATMENT

COMPLETE ACCORDING TO CODE

A APD / IPD Hospital
C APD / IPD Satellite
E APD / IPD Home
L CAPD Hosp/Outpatient
M CAPD Home
B HD Hospital
D HD Satellite
F HD Home
G Transplant in AUST/NZ
H Date of last post graft dialysis
X Transplant Overseas
I Graft function Temporary/ Permanently ceased (Date return to dialysis)
J Own kidney function recovered. Dialysis ceased
K Date of last visit if lost to follow up
Z DATE OF DEATH

REASON FOR DIALYSIS MODALITY CHANGE from CAPD to APD / APD to CAPD / Any PD to HD / HD to any PD. Enter Reason for Change FROM Previous Modality TO Current Modality. Refer to codes on back of form

SEQ. No.	CODE	DAY	MTH	YR	REASON
1					
2					
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37					
38					

14 HEPATITIS C ANTIBODY

1=Positive 2=Negative 3=Not done | CURRENT | LAST

15 CANCER EVER? Y/N — If Yes, please complete Cancer Form

16 CAUSE OF DEATH (Record from list) | OTHER

17 WAS GRAFT SUSTAINING LIFE? — Without dialysis at time of death Y=Yes N=No

18 PARENTHOOD

HAS THIS PATIENT BECOME PREGNANT OR FATHERED A CHILD DURING THIS SURVEY — Y=Yes N=No

If Yes, please complete a Parenthood Outcome form

DATE OF LAST OUTCOME

THIS SECTION FOR ALL PATIENTS DIALYSED AT ANY TIME DURING THE SURVEY PERIOD

19 TYPE OF DIALYSIS (See list) | **20 DRY WEIGHT AT LAST DIALYSIS** kg (HD and PD Patients) | **21 UNCORRECTED CALCIUM** mmol/l | **22 PHOSPHATE** mmol/l (See instructions on the back of the form) | **23 HAEMOGLOBIN** g/l Last Available | **24 EPO AGENT** Y=Yes N=No | **25 FERRITIN** ug/l Within last 3 mths of Survey or record not done | **26 % SATURATION IRON** (Transferrin Saturation)

HAEMODIALYSIS

27 DIALYSER BRAND (Write In) CODE | BRAND NAME AND MODEL | **28 BLOOD FLOW RATE** Pump Speed (mls/min) | **29 SESSIONS PER WEEK** | **30 HOURS PER SESSION** | **31 UREA REDUCTION or Kt/V** Method (See List) Value

32 ACCESS IN USE (Functioning only) Enter for **ALL PATIENTS ON HAEMODIALYSIS** AT ANY TIME DURING THIS SURVEY PERIOD

AT FIRST HD | AT LAST HD — 1=Native 2=Synthetic 3=Tunnel CV Catheter 4=Non Tunnel CV Catheter

FOR FISTULAS AND GRAFTS ONLY: DECLOTTED during Survey (Y=Yes N=No D=Declotted and revised) | REVISED during Survey (N=No S=Surgical A=Angioplasty B=Both)

IN THE EVENT OF THE PATIENT HAVING BOTH HD AND PD, AND A TRANSPLANT DURING THE SURVEY COMPLETE SECTIONS 19-41 INCLUSIVE

ALL PERITONEAL DIALYSIS

33 PET TEST (Once Only) Within first 6 mths (Dx / Plasma Creatinine at 4 hours) | **34 CONNECTION SYSTEM** CODE (Write In) | **35 PERITONITIS** DATE OF FIRST EPISODE | **36 NUMBER OF EPISODES OF PERITONITIS** During this Survey | **37 TOTAL VOLUME OF WEEKLY CHANGES** (Litres/week)

38 CREATININE CLEARANCE Dialysate ONLY — Adjusted for Body Surface Area (Litres/week/1.73 m²) Range 10-200 Litres/Week

39 WEEKLY Kt/V Dialysate ONLY (Range 0.1 - 5.0)

40 RESIDUAL RENAL FUNCTION (Creatinine Clearance) — Adjusted for Body Surface Area (Litres/week/1.73 m²)

41 PD SOLUTIONS - Y=Yes N=No (Please fill in all boxes) — Glucose | Icodextrin | Low GDP Lactate | Low GDP Bicarbonate | OTHER

CURRENT GRAFT

(IN THE EVENT OF BOTH GRAFT FAILURE AND RETRANSPLANT IN THIS SURVEY - USE A NEW FORM)

42 GRAFT NUMBER | **43 DATE OF THIS TRANSPLANT** | **44 REFERRING HOSPITAL** | **45 DONOR HOSPITAL** | **46 TRANSPLANT HOSPITAL** | **47 RECIPIENT ANTIBODY STATUS AT GRAFT** CMV EBV (1=Positive 2=Negative 3=Not done) | **48 NUMBER REJECTION EPISODES THIS SURVEY** (Complete acute rejection form for each episode) (at any time)

49 DONOR DETAILS SOURCE AGE SEX (See list) | **50 TOTAL ISCHAEMIA** (Hours) | **51 IMMEDIATE FUNCTION** (See list) | **52 DISEASE IN GRAFT** If Yes (See list) | **53 DATE FIRST PROVEN** (eg. Graft biopsy) | **54 CAUSE OF GRAFT FAILURE** OTHER (Record from list)

55 MONOCLONAL / POLYCLONAL THERAPY (Record from list)

COURSE	DATE	AGENT	OTHER	NUMBER OF DOSES GIVEN	REASON	OTHER
1st						
2nd						
3rd						

56 TOTAL DAILY DRUG DOSE (mg)

	TOTAL INITIAL ORAL DOSE	1 MTH	2 MTH	3 MTH	6 MTH	1 YR	2 YR	3 YR	5 YR	7 YR	10 YR	15 YR	20 YR	25 YR	30 YR	35 YR
CYA																
AZA																
PRED																
TACROL																
MMF																
SIROL																
OTHER																

57 CYA SPARING DRUG 0=NOT GIVEN 1=GIVEN (eg DILTIAZEM - KETOCONAZOLE - VERAPAMIL)

58 BODY WEIGHT (kg)

59 SERUM CREATININE µmol/L

FOR OFFICE USE ONLY

60 HLA TYPING

	BLOOD GROUP	A		B		DR		DQ	
RECIPIENT									
DONOR									

62 PRA AND CROSSMATCH

MAXIMUM	CURRENT

DATA COLLECTION FORM

ANZDATA Registry 2008 Report

INSTRUCTIONS FOR DIALYSIS AND TRANSPLANTATION SURVEY COMPILATION
PLEASE READ THE EXPLANATORY NOTES BEFORE COMMENCING TO FILL IN THE FORMS
Please complete the form using neat capitals

5 – RACIAL ORIGIN
1 Caucasoid
2 Australian Aborigine
3 Chinese
4 Maori
5 Arab
61 Cook Islander
63 Samoan
64 Tongan
65 Torres Strait Islander
69 Pacific People – other (**specify**)
7 Indian
8 Indonesian
9 Malay
10 Filipino
11 Vietnamese
20 Other (**specify**)
00 Patient objects to answering question

Mixed race coded by patient's assessment

6 - PRIMARY RENAL DISEASE
Results of ANCA (Anti Neutrophil Cytoplasmic Antibody) test in association with glomerulonephritis should be entered in box marked OTHER

100 Presumed GN, type undefined histologically (no biopsy)
110 Focal sclerosing GN (including hyalinosis)
111 Primary focal sclerosing GN or focal glomerular sclerosis
112 Secondary focal sclerosing GN
121 Mesangiocapillary GN with subendothelial deposits (double contour)
122 Mesangiocapillary GN with intramembranous deposits (dense deposit disease)
130 Membranous GN
140 Extra and intra capillary GN (extensive crescents - clinically rapidly progressive)
151 Mesangial proliferative (IgA+ positive)
152 Mesangial proliferative (IgA- negative)
153 Mesangial proliferative (no I.F. studies)
160 Focal and segmental proliferative GN (including focal necrotising)
170 Advanced GN (unclassified = end stage)
180 GN with systemic disease (**specify**)
181 Goodpasture's syndrome with linear IgG and lung haemorrhage
182 Proliferative GN with linear IgG -no lung haemorrhage
183 SLE
184 Henoch-Schonlein purpura
185 Wegener's Granulomatosis
186 Microscopic Polyarteritis
187 Scleroderma
190 GN other (**specify**)
191 Familial GN (**specify Alport's - yes** or **no**)
200 Analgesic nephropathy
300 Renal vascular disease due to malignant hypertension (NO primary renal disease)
301 Renal vascular disease – type unspecified
302 Renal vascular disease – due to hypertension (nephrosclerosis) (NO primary renal disease)
303 Atheroembolic disease (cholesterol emboli)
304 Bilateral renal artery stenosis
400 Polycystic kidney disease
401 Medullary cystic disease
402 Infantile/juvenile polycystic kidney disease
500 Reflux nephropathy
600 Pyelonephritis
700 Calculi
701 Gout
801 Diabetes – Type 1 (insulin dependent) **[Juvenile onset]**
802 Diabetes – Type 2 (non-insulin requiring)
803 Diabetes – Type 2 (insulin requiring) **[Mature onset]**
000 Other (**specify**)
001 Uncertain diagnosis
002 Lead nephropathy
003 Cadmium toxicity
004 Renal tuberculosis
005 Amyloid disease
006 Haemolytic uraemic syndrome
007 Cortical necrosis
008 Interstitial nephritis
009 Congenital renal hypoplasia and dysplasia
010 Loss of single kidney **(specify - e.g. trauma, surgery)**
011 Megaureter
012 Oxalosis
013 Cystinosis
014 Balkan nephropathy
015 Renal cell carcinoma (GRAWITZ)
016 Transitional cell carcinoma of urinary tract
017 Paraproteinaemia (including multiple myeloma)

PRIMARY RENAL DISEASE cont.
018 Light chain nephropathy (benign)
019 Lithium toxicity
020 Post partum nephropathy
021 Sarcoidosis
031 Posterior urethral valves
032 Pelvi-ureteric junction obstruction
033 Obstructed megaureter
034 Neuropathic bladder
035 Non-obstructed dilated bladder and ureters (megacystitis – megaureter)
036 Spina bifida or myelomeningocoele
037 Bladder neck obstruction (incl. prostatomegaly)
039 Other lower urinary tract abnormalities (with secondary reflux) (**specify**)
040 Ureteric obstructive nephropathy
041 Obstructive nephropathy

13 – REASON FOR MODALITY CHANGE
From CAPD to APD
From APD to CAPD
From any form of PD to HD
From HD to any form of PD

10 Recurrent / persistent peritonitis
11 Acute peritonitis
15 Tunnel / exit site infection
16 Diverticulitis
20 Inadequate solute clearance
21 Inadequate fluid ultrafiltration
22 Excessive fluid ultrafiltration
27 Abdominal abscess
30 Dialysate leak
31 Catheter block
32 Haemoperitoneum
33 Catheter fell out
35 Hernia
36 Abdominal pain
40 Abdominal surgery
41 Sclerosing peritonitis
42 Peritoneal infection
43 Multiple adhesions
44 Pregnancy
45 Haematuria
46 Pleural effusion
47 Cardiovascular instability
48 Geography – poor access to dialysis services
49 Vascular access problems
50 Patient preference
51 Unable to manage self-care
60 Recovery of renal function
70 Transplantation
80 Death
81 Transfer outside Australia or New Zealand
82 Other surgery
83 Hydrothorax
85 Poor nutrition
86 Scrotal oedema
90 Planned transfer after acute PD start
91 Planned transfer after acute HD start
99 Other (**specify**)

16 - CAUSE OF DEATH
CARDIAC
10 Myocardial ischaemia (presumed)
11 Myocardial ischaemia and infarction
12 Pulmonary oedema
13 Hyperkalaemia
14 Haemorrhagic pericarditis
15 Hypertensive cardiac failure
16 Cardiac arrest – cause uncertain
17 Other causes of cardiac failure (**specify**)

VASCULAR
21 Pulmonary embolus
22 Cerebrovascular accident
23 Gastrointestinal haemorrhage
24 Haemorrhage from dialysis access site
25 Haemorrhage from transplant artery
26 Aortic aneurysm – rupture
27 Haemorrhage from elsewhere (**specify**)
28 Bowel infarction

INFECTION
Please enter code for nature of infective organism, after the code for site of infection. Please **specify type of organism**
eg Staph, CMV, Candida, etc

eg 321 Lung infection – bacterial (staph)
322 Lung infection – viral (CMV)

31	CNS	1	Bacterial
32	Lung	2	Viral
33	Urinary tract	3	Fungal
34	Wound	4	Protozoa
35	Shunt	5	Other
36	Peritoneum		

CAUSE OF DEATH cont.
37 Septicaemia – site unknown (**specify organism**)
38 Liver (incl. viral hepatitis) (**specify** A, B, CMV, herpes, etc)
39 Other site (**specify**)

SOCIAL
40 Withdrawal for psycho-social reasons
41 Patient refused further treatment (**specify reason**)
42 Suicide
43 Therapy ceased for any other reason (**specify reason**)
44 Accidental death (**specify**)
45 Withdrawal for cardiovascular comorbid conditions
46 Withdrawal for cerebrovascular comorbid conditions
47 Withdrawal for peripheral vascular comorbid conditions
48 Withdrawal related to malignancy
49 Withdrawal related to dialysis access difficulties (AVF, Tenckhoff, etc)

MISCELLANEOUS
50 Hepatic failure (**specify**)
51 Uraemia caused by graft failure
52 Pancreatitis
53 Bone marrow depression
54 Cachexia
55 Unknown
56 Malignant disease
57 Perforation of abdominal viscus – peptic ulcer, diverticulum, appendix
58 Dialysis dementia (aluminium)
59 Other (**specify**)
60 Immunodeficiency due to viral infection (**specify organisms involved**)
61 Chronic respiratory failure
62 Sclerosing peritonitis

19 – TYPE OF DIALYSIS
11 Haemodialysis – plate dialysers
12 Haemodialysis – hollow fibre dialysers
15 Haemofiltration
16 Haemodiafiltration
19 C.V.V.HD (Intensive Care Unit)
20 Peritoneal – bags no cycler
21 Peritoneal – continuous ambulatory (CAPD)
22 Peritoneal – automated (APD)
23 Peritoneal – intermittent cycler (IPD)
25 Peritoneal – other (**specify**)

20 – DRY WEIGHT
At end of survey, transplantation or death.

21 – UNCORRECTED CALCIUM
Not corrected for albumin
Midweek, predialysis and closest to end of survey, transplantation or death.

22 – PHOSPHATE
Midweek, predialysis and closest to end of survey, transplantation or death.

23 – HAEMOGLOBIN
Midweek, predialysis and closest to end of survey, transplantation or death.

31 – URR or Kt/V **Please enter method used**
A Urea Reduction Ratio % (URR%)
B Kt/V (by BIOSTAT)
C Kt/V (by UKM)
D Kt/V (by DAUGIRDAS – single pool)
E Kt/V (other method – **specify**)

Kt/V (for HD patients) Range 0.5 – 2.2

UREA REDUCTION RATIO %
(Pre dialysis urea – post dialysis urea) x 100 = **URR%**
Pre dialysis urea

Pre dialysis urea:
Blood should be drawn from the 'arterial' needle immediately prior to dialysis, at a mid-week dialysis session

Post dialysis urea:
Blood is again drawn from the 'arterial' needle and this should occur **within 20 seconds** after cessation of the blood pump (alternatively the pump can be turned down to 50 ml/min) – this is to avoid problems with recirculation

32 – ACCESS IN USE
Type at First HD - leave blank if initial renal replacement treatment was not haemodialysis.

Type at Last HD - enter for all patients on haemodialysis at any time during the survey. Enter the procedure closest to the end of survey, change to PD, transplantation, or death.

33 – PET TEST (Required **Once Only** per patient)
Standard Peritoneal Dialysis Equilibration Test
performed 1-6 months after initiation of PD
(2.5% 2 litre exchanges)

Provide dialysis/plasma creatinine at 4 hours
Range 0.1 – 1.2

38 to 40 – PD CLEARANCE STUDIES
Generated from a 24 hour collection of PD effluent and urine

NOTE: Dialysate Creatinine Clearance and Kt/V both refer to dialysis clearances ONLY (NOT the total of dialysis and renal clearances).

38 **CREATININE CLEARANCE (Dialysate only)**
Range 10 - 200 litres/week
Litres/week/1.73m² Body Surface Area

39 **WEEKLY Kt/V (Dialysate only) - Range** 0.1 – 5.0

40 **RESIDUAL RENAL FUNCTION (Creatinine Clearance)**
Litres/week/1.73m² Body Surface Area

49 – SOURCE OF DONOR KIDNEY
1 Deceased Donor
2 Sister (if twin, record 6 or 7)
3 Brother (if twin, record 6 or 7)
4 Mother
5 Father
6 Monozygotic (identical) twin
7 Dizygotic (non-identical) twin
8 Other related living donor (**specify**)
9 Son
10 Daughter
11 Husband
12 Wife
13 Cousin
14 Unrelated living donor (**specify**)

50 – TOTAL ISCHAEMIA (HOURS)
From time of donor renal artery interruption or aortic clamp, until time of release of renal artery in the recipient (clamp off)

51 – IMMEDIATE FUNCTION
1 Spontaneous fall in se.creatinine by 10% within 24 hours
2 Spontaneous fall in se.creatinine by 10%, first recorded between 25-72 hours
3 Poor immediate function. No spontaneous fall in se.creatinine within 72 hours; but no dialysis needed
4 No immediate function. No spontaneous fall (> 10%) in se.creatinine; dialysis required within 72 hours

52 – DISEASE IN GRAFT **Histologically proven**
Complete this section for **FUNCTIONING or FAILED GRAFTS**

Please enter **Date first proven (e.g. Graft Biopsy)**

B = BK virus nephropathy in graft
Y = Disease recurrence
– primary renal disease and disease in graft the same
D = De novo glomerulonephritis
– primary renal disease known and not the same
G = Glomerulonephritis in graft
– primary renal disease unknown or not biopsied

In cases of glomerulonephritis, where histological confirmation of recurrence may be uncertain, enter as G

54 – CAUSE OF GRAFT FAILURE
REJECTION
10 Hyperacute rejection (within 48 hours of transplantation)
20 Acute rejection at anytime, causing graft failure
40 Chronic allograft nephropathy (slow progressive loss of renal function, not due to recurrent original disease or acute rejection)

VASCULAR
50 Renal artery stenosis
51 Renal artery thrombosis
52 Renal vein thrombosis
53 Renal vessel haemorrhage (primary)
54 Renal vessel haemorrhage (secondary)
55 Embolus – thrombo
56 Embolus – cholesterol
57 Haemolytic uraemic syndrome

TECHNICAL
60 Non-viable kidney (due to pre-transplant cortical necrosis)
61 Cortical necrosis post transplant (not due to rejection)
70 Ureteric and bladder problems

GLOMERULONEPHRITIS
82 Mesangiocapillary GN with subendothelial deposits
83 Mesangiocapillary GN with intramembranous deposits (dense deposit disease)
84 Focal sclerosing GN (including hyalinosis)
85 Membranous GN
86 Mesangial proliferative GN (IgA positive)
87 Goodpasture's syndrome
88 Intra and extra capillary GN with extensive crescents (clinically rapidly progressive)
89 Other (**specify**)

DRUG THERAPY
90 Complications of drug therapy requiring reduction or withdrawal of steroid and/or immunosuppressants
91 Non-compliance with therapy – causing graft failure
92 Rejection following I/S reduction due to malignancy
93 Rejection following I/S reduction due to infection

MISCELLANEOUS
00 Other (**specify**)
01 Donor malignancy
02 Malignancy invading graft
05 BK virus nephropathy

55 – MONOCLONAL / POLYCLONAL THERAPY
Record in order of administration, each separate course of such drugs; a second course of the same drug should be separately recorded
Complete the requested details regarding, date, identity of drug, number of doses given, and reason for administration, according to the following codes

TYPE OF AGENT
2 Daclizumab (Zenepax)
4 OKT3
5 Intravenous Immunoglobulin
6 Basilixmab (Simulect)
7 Rituximab
8 Polyclonal anti T cell
9 Other monoclonal (**specify**)

NUMBER OF DOSES
Record actual number of doses given

REASON FOR USE
1 Prophylaxis
7 Treatment for acute rejection
8 Other (**specify**)

56 – TOTAL DAILY DRUG DOSE
Enter the total daily dose for each drug where applicable; if an unlisted drug is used, enter the name in the space provided marked **OTHER**

Only those drugs taken at the listed intervals should be entered; where necessary provide the dose recorded on the closest day preceding the requested time interval

The initial drug dose (at zero months) is **the first oral maintenance dose**; do **NOT** enter the intravenous loading doses administered at or shortly after transplantation

(2007)

SUMMARY

KEY SUMMARY POINTS

AUSTRALIA

- There were 16,751 people (797 per million) receiving renal replacement therapy (RRT) at 31st December 2007. Of these, 7,109 (338 per million) had a functioning kidney transplant and 9,642 (459 per million) received dialysis treatment.
- 2,311 people commenced RRT in Australia in 2007 (110 per million per year). The incident rate varied from 326 per million population per year in the Northern Territory to 101 per million per year in the Australian Capital Territory.
- The mean age at commencement was 60.2 years, the median 62.6 years and the age range 0.4 - 95.8 years.
- 31% of new patients had diabetic nephropathy attributed as their cause of end stage renal failure, 25% had glomerulonephritis and 16% hypertension.
- Of patients < 65 years of age and receiving dialysis treatment, 23% were on the active kidney transplantation waiting list at 31st December 2007. This proportion varied between 1% in the Northern Territory and 34% in the Australian Capital Territory. Only 4% of Aboriginal/Torres Strait Islander patients < 65 years were on the transplant waiting list.
- The death rate per 100 patient years was 15.4 for dialysis dependent patients (haemodialysis 15.7, peritoneal dialysis 14.3) and 2.2 for those with a functioning kidney transplant (deceased donor 2.7, live donor 1.1).
- Of the 1,452 deaths among dialysis dependent patients in 2007, 36% were due to cardiovascular causes, 35% to withdrawal from treatment, 10% to infection and 5% from malignancy.
- Of the 151 deaths among patients with kidney transplants, 33% were due cardiovascular causes, 25% to malignancy and 17% to infection.
- There has been a 4% increase in the total number of prevalent dialysis patients from 9,251 in December 2006 to 9,642 in December 2007.
- There were 615 kidney transplant operations performed in 2007, a transplant rate of 29 per million population.
- Of these, 44% (271 grafts) were from live donors compared to 43% (274 grafts) in 2006.
  26% of primary live donor operations were performed without the recipient receiving prior dialysis therapy.
- For primary deceased donor grafts performed in 2005-2006, the 12 month patient and graft survival rates were 96% and 91% respectively.
- The five year primary deceased donor recipient and graft survival for operations performed in 2001-2002 were 90% and 82% respectively.
- There were 7,109 functioning kidney transplants in Australia at 31st December 2007, a prevalence of 338 patients per million represents a 4% increase over 2006.

KEY SUMMARY POINTS

NEW ZEALAND

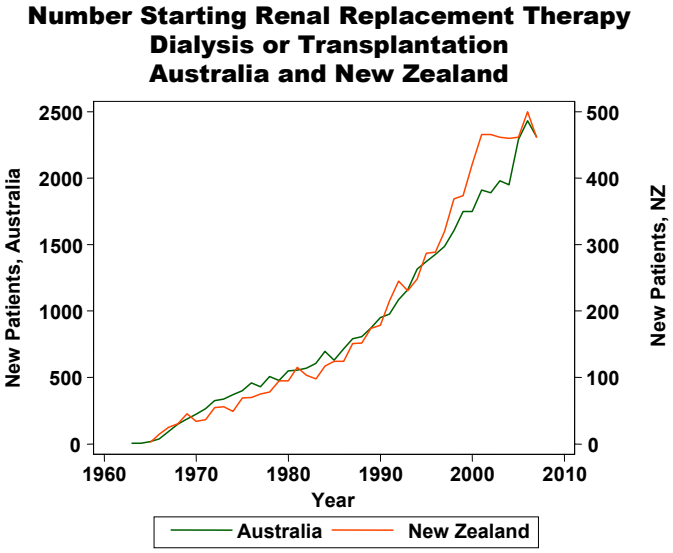
- There were 3,353 people (793 per million) receiving renal replacement therapy (RRT) at 31st December 2007. Of these, 1,289 (305 per million) had a functioning kidney transplant, and 2,064 (488 per million) received dialysis treatment.
- 461 people (109 per million per year) commenced RRT in 2007.
- The mean age at commencement was 55.9 years, the median age 57.8 years and the age range 0.4 - 89.6 years.
- Diabetic nephropathy accounted for 41% of new patients, glomerulonephritis 25% and hypertension 11%.
- Of patients < 65 years of age, 18% were on the active kidney transplantation waiting list at 31st December 2007. 19% of Maoris, 14% of Pacific People and 10% of Asians < 65 years of age were on the transplant waiting list.
- The death rate per 100 patient years was 14.5 for dialysis dependent patients (haemodialysis 13.7, peritoneal dialysis 16.0) and 3.5 for those with a functioning kidney transplant (deceased donor 4.5, live donor 1.7).
- Of the 295 deaths among dialysis dependent patients in 2007, 41% were due to cardiovascular causes, 23% to withdrawal from treatment, 16% to infection and 6% from malignancy.
- Of the 44 deaths among patients with a kidney transplant, 36% were due to malignancy, 32% to cardiovascular causes and 20% due to infection.
- The number of patients who were dialysis dependent at 31st December 2007 (2,064) was an increase of 3% over the previous year. 51% of all dialysis dependent patients were receiving home dialysis. 70% of these were on peritoneal dialysis.
- There were 123 kidney transplant operations performed in 2007, a rate of 29 per million population.
- The percentage of live donors in 2007 was 47% (58 grafts), compared to 54% (49 grafts) in 2006.
- For primary deceased donor grafts performed in 2005-2006, the 12 month patient and graft survival rates were 96% and 90% respectively.
- The five year primary deceased donor recipient and graft survival for operations performed in 2001-2002 were 84% and 77% respectively.
- The 1,289 functioning kidney transplants at 31st December 2007, a prevalence of 305 per million represents a 3% increase from 2006.

TRENDS IN KIDNEY DISEASE AND TREATMENT

In this "précis", we highlight the major trends in rates of renal disease, as well as selected issues from elsewhere in the report. In this report, we examine the distribution of dialysis modalities.

For both Australia and New Zealand, incidence rates for renal replacement therapy (RRT=dialysis and transplantation) have increased steadily until around the year 2000. Since that time rates in New Zealand have been stable. Rates in Australia have fallen somewhat since the peak of 2007, but whether this is a change in the overall pattern of increase over the past 20 years is unclear (Figure 0.1).

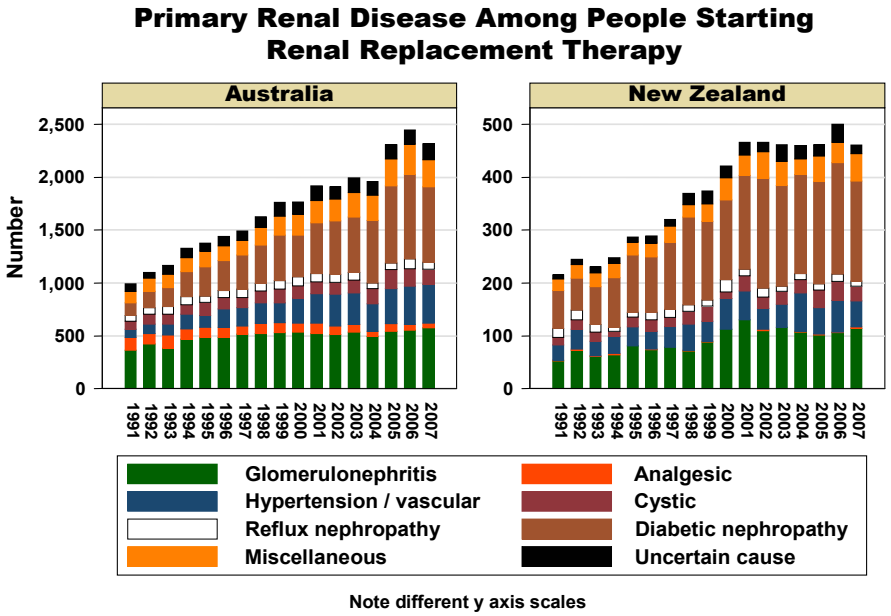
Figure 0.1



These numbers reflect both changes in the population and the incidence rates per million population of renal disease. These changes have not been constant across all age groups. In particularly, the steady increases in incidence rates in the older age groups appear to have slowed in the most recent year in most States. More details about these trends are contained in Chapters 1 and 2.

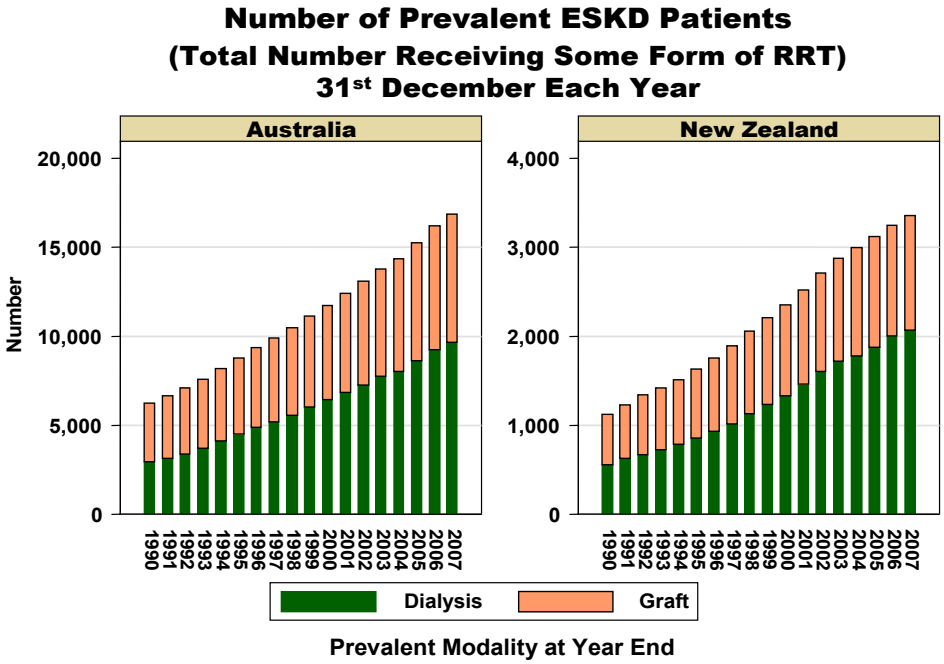
The types of kidney disease to which the end-stage kidney failure is attributed have continued to evolve, with a progressively greater proportion of people with diabetic nephropathy and kidney disease related to hypertension and renovascular disease (Figure 0.2).

Figure 0.2



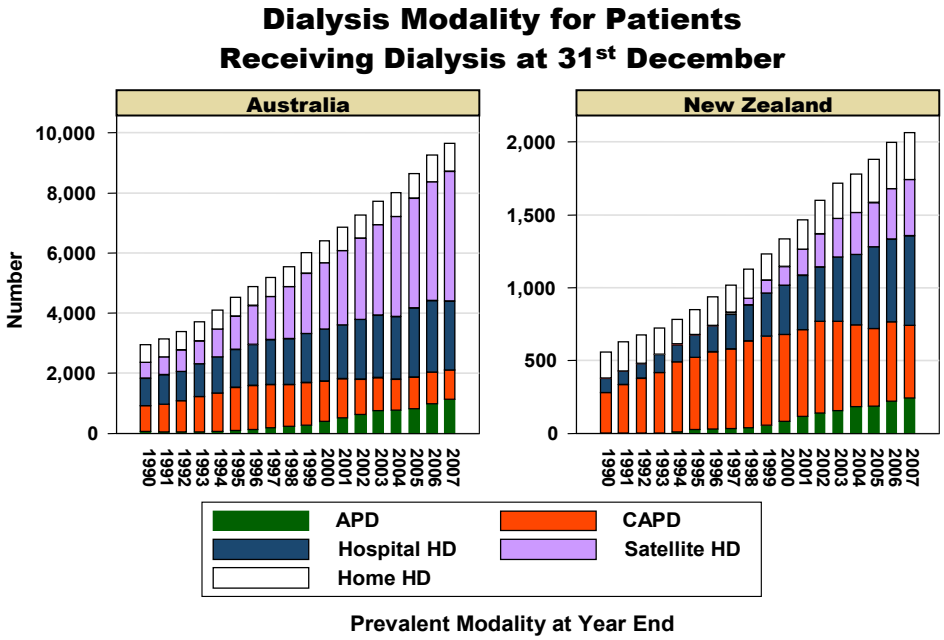
An outcome of the increasing rates of new patients starting RRT each year is an increase in the total number of patients receiving some form of RRT at any one time (Figure 0.3). This was examined in more detail in the corresponding section of the 2007 report. There is a steady increase year on year, with the greatest increase in patients receiving dialysis treatment rather than transplantation - that is, over time, the proportion of all people receiving RRT who had a functioning kidney transplant has steadily fallen in both countries.

Figure 0.3



Patterns of dialysis treatment have also changed over time. In both Australia and New Zealand, the larger increase in numbers has been in haemodialysis rather than peritoneal dialysis. In particular, the number of people receiving haemodialysis in satellite units has increased dramatically in recent years.

Figure 0.4

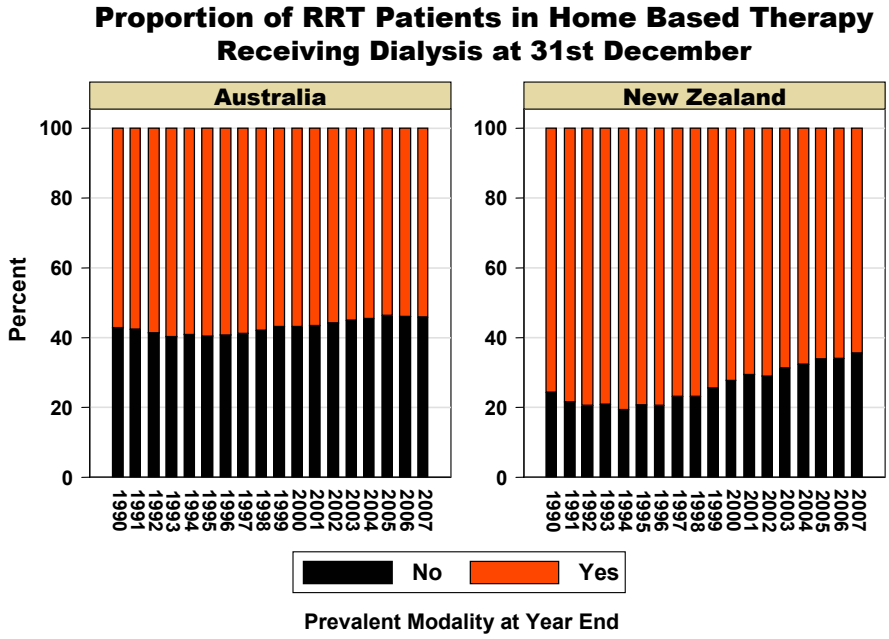


Provision of RRT at home is usually considered a desirable outcome for both patient and healthcare system; this allows more independence for patients at potentially lower cost.

Kidney transplantation is the ultimate form of home-based RRT. Among dialysis modalities, peritoneal dialysis is performed in the home in the vast majority of cases, while haemodialysis is performed both at home, in hospitals and in separate facilities ("satellite units").

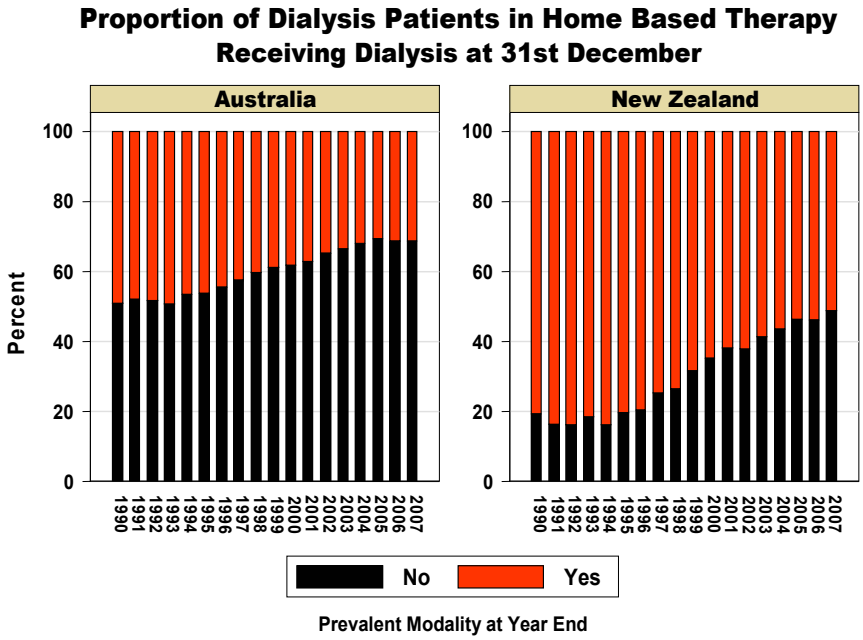
Overall, the proportion of patients receiving home-based therapy has remained stable in Australia over the past two decades; in New Zealand the proportion has been falling for the past ten years (Figure 0.5).

Figure 0.5



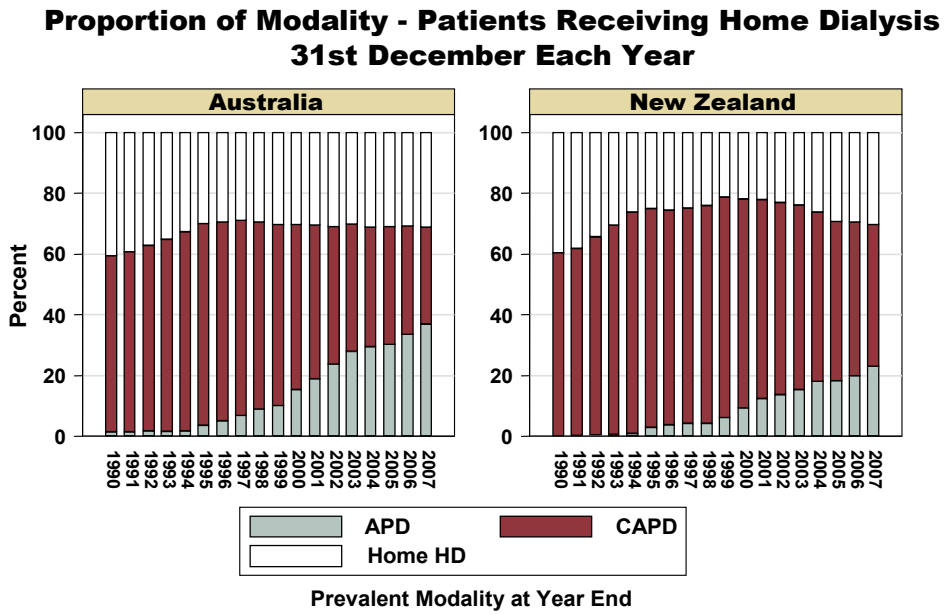
However, the majority of the home-based group is comprised of those with functioning kidney transplants. When this group is excluded (i.e. the analysis is restricted to patients receiving dialysis therapies only), the proportion receiving home-based treatment has been declining steadily in both countries (Figure 0.6).

Figure 0.6



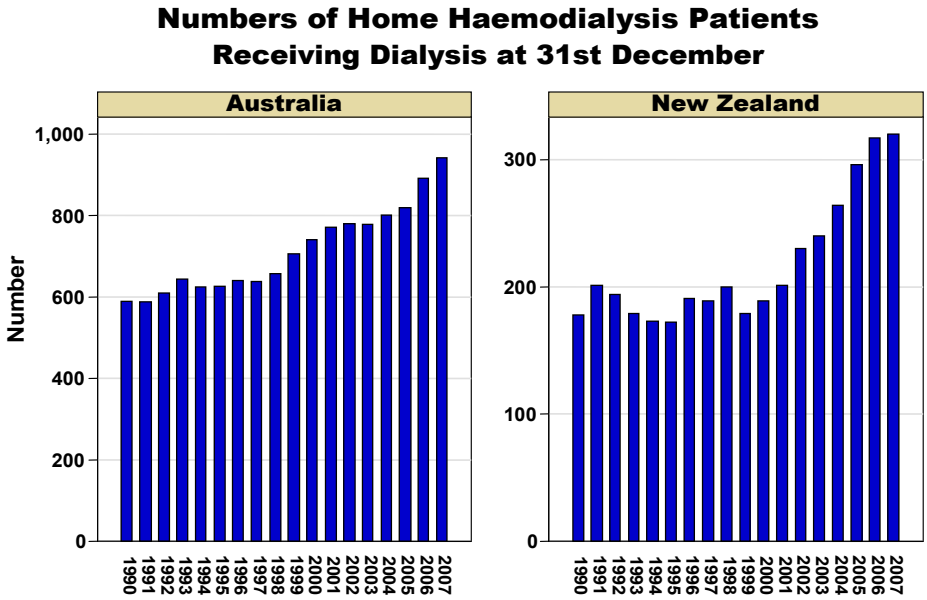
Of those receiving home based dialysis treatment, the majority are receiving a form of peritoneal dialysis. In recent years the proportion receiving automated peritoneal dialysis has increased substantially, especially in Australia (Figure 0.7).

Figure 0.7



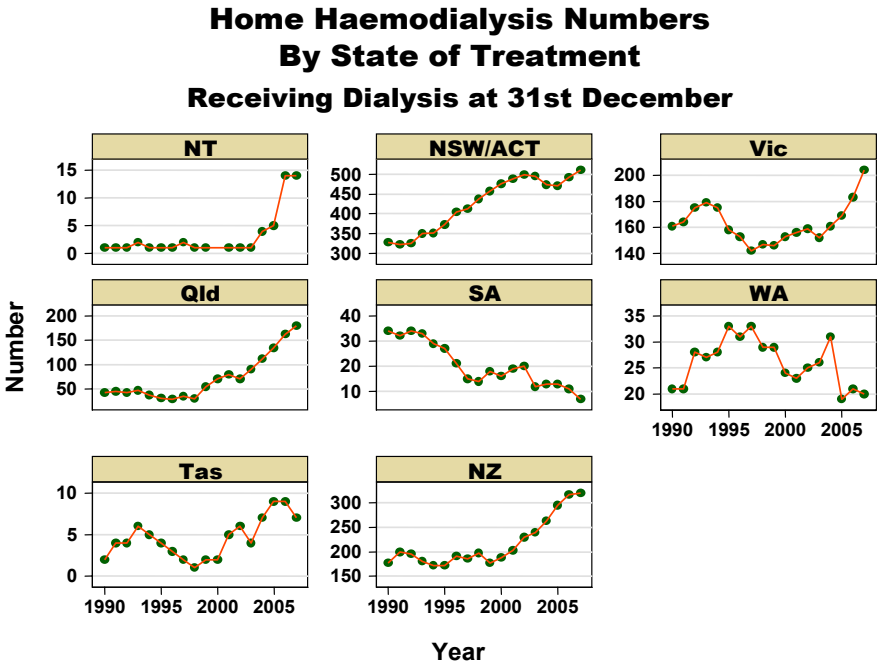
It is difficult to appreciate in Figure 0.7, however, the number of home haemodialysis patients has been increasing (Figure 0.8), in New Zealand and more recently Australia.

Figure 0.8



While the overall numbers have changed, the effect is very uneven across different States in Australia (Figure 0.9). There are a number of factors underlying this variation. Important ones included different transplant rates and service distribution.

Figure 0.9



The flexibility offered by home haemodialysis extends to changing the frequency and duration of dialysis such as nocturnal and daily haemodialysis; these are described in the haemodialysis chapter.

It is likely we will continue to see more innovative approaches to treatment in the area in coming years.

References:

1. Cass, A, Chadban, S, Craig, J, Howard, K, McDonald, S, Salkeld, G and White, S:
The economic impact of end-stage kidney disease in Australia. Sydney, The George Institute, 2006.