Neonatal Renal Physiology and Pathophysiology
Fetal-Neonatal Transition

- Fetal kidneys - 3% CO
  - High renal vascular resistance
  - Low GFR
- Newborn about 15% (lambs)
  - At moment of birth immediate increase renal blood flow
    - 86% decrease renal vascular resistance (piglets)
  - Redistribution from the inner cortex to outer superficial cortex
- Weeks after birth
  - Rise in arterial blood pressure
    - Less important
  - Further decrease in vascular resistance
- Both anatomic and vasoactive effect
Fetal-Neonatal Transition

- Blood flow to all regions increases
  - Cortical, medullary, papillary
- Distribution differs – neonate vs adult
  - Greater % to the inner cortex and medullary
  - Greater perfusion of juxtaglomerular nephrons
  - As total renal blood flow reaches adult levels
    - Greater fraction - outer cortical nephrons
- Transition time to adult pattern varies with species
  - Man 3 months
Fetal-Neonatal Transition
Renal Hemodynamics

- Angiotensin II
- Renal Sympathetic Nervous System
  - Renal sympathetic nerves
  - Intrinsic adrenergic release
  - Circulating adrenergics
- PG
- NO
- Kallikrein-Kinin System
- ANF (atrial natriuretic factor)
- Endothelin
Fetal-Neonatal Transition
Renal Hemodynamics

- Angiotensin II
  - Growth factor
    - Required for normal nephrogenesis
  - Important in
    - Tubuloglomerular Feedback
    - Autoregulation
  - Decreased
    - Maternal dietary protein restriction
    - Decreased renal mass
    - In man - adult hypertension
Fetal-Neonatal Transition
Renal Hemodynamics

- Renal Sympathetic Nervous System
  - Circulating adrenergics
  - Sympathetic tone
  - Decrease renal blood flow
    - Neonates more sensitive than adults
  - Sympathetic control of renal blood flow
    - Part of baroreceptor reflex
    - Changes with baroreceptor reflex adaptation
Fetal-Neonatal Transition
Renal Hemodynamics

- **NO**
  - Important in vasodilation and other functions

- **Prostaglandins**
  - **COX 1** - renal vascular, glomeruli, collecting duct
  - **COX 2** - distribution species dependent
    - Activity increases after birth
    - Peaks 1-2 wk then declines
    - Important in nephrogenesis

- **Vasodilate**
  - Renal PG production increases perinatal period
  - Pathologic conditions - attenuate renal vasoconstriction
  - Important in renal blood flow in basal and stress conditions
Fetal-Neonatal Transition
Renal Hemodynamics

- **PG**
  - Intrinsic PGs are involved
  - NSAIDs in fetus, neonate
    - Decrease urine output
    - Significant decrease blood flow
    - Increase in renal vascular resistance
  - Fetus - oligohydramnios
- **Vasodilatory**
  - Counteract vasoconstricted state
Fetal-Neonatal Transition
Renal Hemodynamics

- Vasoconstrictors and vasodilators
  - Balance produces renal vascular resistance
  - Differ from adults
    - Different effects
    - Different intrarenal levels
    - Different sites of action
- Balance major determinate of GFR
Renal Hemodynamics
Summary

- Increased renal vascular resistance
  - Increased activity of Angiotensin II
  - Increased sensitivity to catecholamines
- Critical vasodilators counterbalance
  - NO
  - PG
- Increase in renal blood flow
  - Decrease vasoconstrictors
Fetal-Neonatal Transition

GFR

- Oppose/promote filtration
  - Changes in renal vascular resistance
  - Increasing nephron mass
  - Modification ultrafiltration
    - Glomerular membrane dynamics
    - Glomerular membrane area
  - Development of concentration gradients

- Lamb
  - GFR increases within hours of birth
  - Gradual increase GFR in the first week
    - Functional and not morphological change
    - Enhanced glomerular perfusion
    - Recruit more superficial cortical nephrons
Fetal-Neonatal Transition

GFR

- Rate of filtration
  - Starling factors
  - Rate of flow of plasma into glomerular capillaries
  - Permeability capillary wall
  - Total surface area of capillaries

- GFR dependent on
  - Renal blood flow
  - Glomerular capillary pressure

- Hydrostatic pressure favors filtration
- Transcapillary hydrostatic pressure
  - Efferent/afferent capillary resistance
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Fetal-Neonatal Transition
Tubular Function

- Sodium
  - Fetal FxNa 5-15%
    - Lack of efficient tubular reabsorption
    - More distal tubules than proximate tubules
      - Bulk Na absorbed proximal
      - Carrier density
      - Cellular polarization
  - Birth (sheep, man) – just before birth foal??
    - Sodium/hydrogen exchanger distal tubule
    - Sheep - increased activity 1st 24 hr after birth
    - Birth cortisol surge upregulates
  - Normal low FxNa in neonate
Fetal-Neonatal Transition
Tubular Function

- Na administration
  - Extracellular volume expansion
  - Edema
  - Hypernatremia
    - If large insensible losses
- Fractional Na absorption
  - Less in proximal tubule in neonate
  - More distal tubule
  - Overall lower FxNa
- Enhanced ability to reabsorb Na in the distal tubule
- Blunted Na excretion in the face of a Na load
- Increase transport
  - Maturation of the Na-K-ATPase
  - Increases density
Fetal-Neonatal Transition
Tubular Function

- **Glucose**
  - Higher renal threshold in fetus than adult

- **Phosphate**
  - Fetal level high
    - Placental transport against concentration gradient
    - Na-phosphorus cotransporter
      - Unique - growing animals
      - Not modulated by dietary phosphorus intake
      - High rate renal PO4 reabsorption in fetus/neonate
  - Fetal kidney responds to parathyroid hormone
    - Increased urinary excretion of Ca (opposite of adult)
    - Blunted effect on urinary PO4 excretion during fetal life
    - Hyperphosphatemia - relative parathyroid insufficiency
      - Compounded by an already low fetal renal clearance of phosphorus
Fetal-Neonatal Transition
Cortisol and Stress

- **Fetal stress**
  - Accelerate renal transition

- **Cortisol**
  - Increase GFR
  - Decrease PO$_4$ reabsorption by 50%
  - Na reabsorption
    - Decreases proximal
    - Increases distal
    - No change Fxna
  - Accelerate development tubular reabsorption capacity
    - Na
    - K
    - H$_2$O
    - Distal Na carrier mediated absorption
Autoregulation

- Range of autoregulation set to lower perfusion pressure
  - MAP 40-60
  - Renal pressure-flow relationship changes with renal maturation
- Mediated by PG dependent rennin release
  - Causing vasoconstriction at lower levels of perfusion pressure
  - NSAID therapy may disrupt
Tubuloglomerular Feedback

- Tubuloglomerular feedback
  - Macula densa cells
    - ↓ NaCl delivery distal tubules
    - Stimulate angiotensin II form juxtaglomerular cells
      - Constrict efferent arterioles
    - Stimulates PG
      - Vasodilates afferent arterioles
    - Increase GFR
  - Matures with growth
    - Maximally sensitive at normal tubular flow range
    - As GFR increases, maximum response and flow range also increases
    - Relative sensitivity unaltered during growth
Measuring Renal Function

- **Cr levels**
  - Rate of drop

- **Clcr**
  - Measure Cr in plasma and urine, urine volume
  - Inulin Clearance (PAH)
  - Plasma Disappearance Curve method
    - Multiple values over 4-5 hours
    - Confounders
      - Distribution phase
      - Edema
      - GI loss

- **FxNa**
  - Normal < 0.3%

- **U/A**
Measuring Renal Function
Urinalysis

- Urine specific gravity
  - Refractive index
- Urine pH
  - Systemic acid base
- Blood
  - Without protein
- Protein
  - After colostrum
- Glucose
  - Not spilling with high blood values
- Ketones
  - Ceftiofur
- Bili
- Sediment
Pathogenesis
Abnormal GFR

- **Vasomotor nephropathy**
  - Decrease renal blood flow
  - Hypovolemia
    - Release vasoconstrictors
      - Angiotensin II, vasopressin, catecholamines
  - Sepsis
    - Inflammatory mediators
    - Hypovolemia
    - Release of vasoactive mediators
  - Hypoxia/asphyxia
    - Overactivation of the rennin-angiotensin system, intrarenal adenosine, vasopressin, catecholamines

- **Prerenal**
  - Hypotension, hypovolemia, hypoxemia, asphyxia
  - Extrarenal and intrarenal – difficult to separate
Pathogenesis
Abnormal GFR

- Other causes - NSAIDs
  - High PG levels
    - Needed to maintain perfusion neonatal kidney
  - Hypotension/hypovolemia
    - High PG levels
- NSAIDs
  - Reduce GFR
  - Reduce renal blood flow
  - Effect transient
  - Nonselective and COX-2 selective inhibitors
    - Same effect
  - Also may affect
    - Autoregulation
    - Tubuloglomerular feedback
Clinical Acute Renal Failure

- Azotemia - acute decrease in GFR
- Classic classification
  - Prerenal – disorder of systemic circulation
  - Intrinsic Renal Failure
    - ATN – clinical syndrome
    - Vascular
    - Glomerular
    - Interstitial
  - Postrenal
Clinical Acute Renal Failure

- Decrease GFR
  - Loss of number of filtering nephrons units
    - Trauma
    - Renal vessel thrombosis
  - Decrease in rate of filtration in individual nephrons
- Ischemia and nephrotoxic injury
  - Deeper nephrons are at more risk
  - Outer medulla nephron segments
Clinical Acute Renal Failure

- Loss of GFR– reduced SNGFR
  - Rate of glomerular plasma flow
    - Prerenal or intrinsic renal blood flow
  - Glomerular transcapillary hydraulic pressure
  - Plasma colloid osmotic pressure
  - Permeability properties glomerular capillary
Acute Renal Failure
Autoregulation

- Control afferent and efferent vascular tone
  - Consistent GFR
  - Decrease renal perfusion
    - Afferent dilation
    - Efferent constriction – angiotensin II
- Autoregulation impaired in Acute Renal Failure
  - Decreasing renal blood flow
  - Decrease GFR
  - Cause additional renal ischemia
- Neonates
  - Autoregulate with low BP
  - Low set point
  - But with volume depletion
    - Higher renal vascular resistance
    - Lower GFR
    - Potentially more injury
Acute Renal Failure

- Tubular epithelial cell function
  - Defined apical and basolateral membranes
  - Integrins - tubular epithelial cell adhesion
  - ATP depletion
    - Integrins relocate to apical membrane
    - Change actin cytoskeleton
    - Cellular rounding and detachment from basement membrane
Acute Renal Failure

- Tubular epithelial cell function
  - Loss cell tubular lumen
    - Obstruction - cell adhere in clumps
    - Back pressure decrease GFR
  - Cells in lumen may be viable

- Reorientation of Na-K ATPase
  - From basolateral position
  - Reverses Na absorption
    - Na wasting
    - Na in distal tubule stimulate vasoactive decrease renal blood flow
      - Tubuloglomerular feedback mechanism
ARF

- Tubular injury
  - Interrupts structural integrity
  - Loss of tight junctions
    - Desmosomes
    - Gap junctions
  - Backleak of Cr
- High plasma CR
  - How much is decrease GFR
  - How much is back leak
Causes Acute Renal Failure

- Prerenal
- Renal artery or vein thrombosis
- Intrinsic vasogenic renal failure
  - Neonatal Vasomotor Nephropathy
- Acute Tubular Necrosis
- Interstitial nephritis
- Pyelonephritis
- Nephrotoxicity
  - Aminoglycoside
  - NSAIDs
    - Vasogenic
    - Interstitial
Renal/Prerenal Concept

- Prerenal completely benign?
- Renal always mean damage?
- Is separating the 2 useful?
- Oliguria
  - Appropriate with hypovolemia
  - More profound – tubular function intact
    - Low flow help concentration mechanisms
  - Tubules injured
    - Concentration impaired
    - More normal amt of urine
- High UsG and low UNa
  - Normal tubular function
  - Not necessary normal renal function
ATN Concept

- Clinical syndrome
  - Usually not tubular necrosis – rare

- True tubular necrosis - experimental
  - Ischemia > 1 hr then reperfusion
  - Necrosis of outer medulla/proximal convoluted tubules
  - Distal nephron usually OK
ATN Concept

- Clinical ATN
  - Not morphologic change – most cases
  - Clinical situation – hypoperfusion/hypoxia/ischemia
    - Adequate renal perfusion to maintain tubular integrity
    - Not sustain GFR
    - Minimal parenchymal compromise
    - Severe organ dysfunction
    - Loss cellular polarity
    - Loss of cells to lumen
ATN Concept

- Clinical ATN
  - Clinical ATN – not hypoperfusion/hypoxia/ischemia
    - Sepsis/SIRS
      - Endothelial dysfunction
    - Coagulation abnormalities
    - Toxicity
      - Aminoglycoside
      - NSAIDs
RIFLE

- Clinical definition – like SIRS
  - Consensus definition
  - Distinguish between the severity/degree dysfunction

- RIFLE
  - R - risk
  - I - injury
  - F - failure
  - L - loss of renal function
  - E - end stage kidney disease

- Acute Renal Injury
  - Spectrum - risk to injury to failure
  - Not ATN or ARF - dysfunction not failure
    - Evidence of dysfunction including both and more
  - Leads to fluid, electrolyte and acid-base problems
**Risk**
- Increased creatinine ×1.5 (or increase creatine of ≥0.3 mg/dl)

**Injury**
- Increased creatinine ×2

**Failure**
- Increase creatinine ×3 or creatinine ≥4 mg/dl (acute rise of ≥0.5 mg/dl)

**Urine output criteria**
- UO < 0.5 ml/kg/h ×6 h
- UO < 0.5 ml/kg/h ×12 h
- UO < 0.3 ml/kg/h ×24 h or Anuria ×12 h

**Loss**
- Persistent AKI = Complete loss of renal function >4 weeks

**ESKD**
- End-stage kidney disease
Neonatal Vasomotor Nephropathy
Neonatal Vasomotor Nephropathy

- GFR and RBF
  - Balance afferent/efferent tone
  - Vasoconstrictors
    - Angiotensin II
    - Adrenergics
      - Circulating – epi/norepi
      - Renal derived
      - Renal sympathetic tone
  - Vasodilators
    - PG
    - NO
Neonatal Vasomotor Nephropathy

- **Risk**
  - Hypovolemia/hypoperfusion
  - Stress
  - Hypertension
  - Autonomic dysfunction
  - Pressor therapy
  - NSAID therapy
  - Failure birth transition

- **Signs**
  - Oliguria
  - Concentrated urine
  - Normal/high/low Fxna
  - Slow Cr decrease or increase
Neonatal Vasomotor Nephropathy

- **Therapy**
  - Volume trial
  - Inotrope/pressor trial
    - Dopamine?
  - Furosemide trial
    - Increase PG – vasodilate
    - 1-4 mg/kg trial doses
  - Time

- **Consequences**
  - Usually no parenchymal damage
    - Can occur rare cases
    - Increase/failure to decrease Cr
    - Sodium waisting
  - Fluid/water overload
  - Na overload
  - Impaired acid/base correction?
Renal Tubular Acidosis

- Group of renal tubular disorders
  - Hyperchloremic acidosis
    - Non-anion gap acidosis
  - No decrease in GFR
- Genetic and acquired defects
  - H⁺ and HCO₃⁻ transporters
  - Cl⁻ and Na transporters
Types of RTA

- Distal RTA
  - Failure to secrete acid
  - Type 1
  - Classic

- Proximal RTA
  - Failure to reabsorb $\text{HCO}_3^-$
  - Type 2

- Heterogeneous RTA
  - Type 3
  - Not real

- Hyperkalemic distal RTA
  - Type 4
  - Aldosterone problem??
Proximal RTA

- Impaired recovery of bicarbonate
- Fanconi’s syndrome - defective reabsorption
  - Glucose
  - Amino acids
  - Electrolytes – PO₄, K
  - Organic acids
- Urine pH < 5.5
  - Systemic acidosis – HCO₃ < 15
  - Little HCO₃ filtered – most absorbed
- Bicarbonaturia
  - Fe > 15%
    - On bicarbonate replacement - plasma HCO₃ > 22
- Acidosis
  - Failure to absorb HCO₃
  - Failure to secrete Cl
Distal RTA

- Inability to acidify the urine distal tubules
  - $\text{NH}_4^+$ not excreted < acid production
- Urine pH > 5.5
  - Despite metabolic acidosis
- Low urine PCO2
  - After bicarbonate loading
  - Lack distal H$^+$secretion
- In man
  - Hypercalciuria.
    - Nephrocalcinosis
    - Nephrolithiasis
Type 3 and 4 RTA

- Type 3 renal tubular acidosis
  - Carbonic anhydrase dysfunction?
  - Mixed RTA
    - Impaired proximal HCO₃⁻ reabsorption
    - Impaired distal acidification
  - Most authors – not really distinct type

- Hyperkalaemic RTA (type 4)
  - Heterogeneous group
  - Failure to excrete acid
  - Hyperkalaemia
  - Associated with
    - Aldosterone deficiency
    - Defective aldosterone signaling
RTA

- **Primary**
  - Persistent
    - Genetic defects in transporters
  - Transient

- **Secondary**
  - Number of other diseases
  - Drugs or toxins
  - Genetic defects of carrier systems
    - Fanconi’s syndrome
  - Structural disruptions of renal tubules
    - Trauma
    - Other primary renal diseases
RTA

- Drugs
  - Amphotericin B
    - Distal RTA
  - Trimethoprim potentiated sulfa drugs
    - Type 4
  - Tetracyclines
    - Proximal RTA
    - Outdated or degraded tetracycline products
  - Aminoglycosides
  - Carbonic anhydrase inhibitors
  - NSAIDs
RTA - TMS

- Developed RTA within 6 days of treatment
  - Variability onset and recovery
- Reversibility in most instances
  - Recovering within 3–4 days of discontinuation
Tetracycline - RTA

- Outdated or degraded tetracycline
  - Exposure to high temperatures/humidity
- Both tetracyclines and degradation products
  - Accumulate within mitochondria
  - Inhibit oxidative phosphorylation
- Proximal tubular dysfunction (type 2)
  - Alone
  - More commonly Fanconi ‘s syndrome
- Reversible after withdrawal
RTA
Clinical Signs

- Lethargy
- Failure to thrive
- Growth retardation
- Generalized weakness
  - Ataxia
- GI
  - Anorexia
  - Colic
  - Constipation
- Tachycardia, tachypnea
- Polyuria and polydipsia
- Signs may be quite vague
RTA Diagnosis

Hyperchloremic acidosis
- Decreased strong ion difference
- Normal anion gap

Possibilities
- GI - diarrhea
- Treatment with large volumes of saline
- RTA

Blood creatinine usually normal

Urine strong ion difference
- Urine Na + Urine K – Urine Cl
- Normal about 80
- With acidosis – expect negative value
- With RTA it will stay positive
RTA Diagnosis

- If RTA present
- Urine pH
  - Fresh urine
  - pH meter
    - Dipstick not reliable
- If not treated
  - Plasma HCO₃⁻ <15 mEq/L)
  - pH < 5.5 = Proximal RTA
  - pH > 6.0 = distal RTA
- Fx HCO₃⁻
  - Rx
    - plasma HCO₃⁻ >22 mEq/L
    - Fe HCO₃⁻ > 15% = proximal RTA
RTA - Rx

- **Symptomatic treatment**
  - Correcting the acidosis

- **Distal RTA**
  - Usually easily accomplished
  - 2-4 mEq/kg/day bicarbonate

- **Proximal RTA**
  - More refractory
  - Up to 20 mEq/kg/day of bicarbonate