

PATIENT INFORMATION · GENERAL HEALTH

Chronic kidney disease

a label that alarms people far more than it should

Chronic kidney disease means reduced kidney function or protein leaking into the urine for more than three months. It is common, particularly with age, and **most people with it never progress to needing dialysis**. What it mainly signals is cardiovascular risk — and that is very treatable.

Seek urgent assessment if you have

- **passing little or no urine**, or sudden severe swelling
- **breathlessness at rest**, or unable to lie flat
- **confusion, drowsiness or seizures**
- **vomiting and unable to keep fluids down**, particularly while on kidney medicines
- **visible blood in the urine**
- a **rapid fall in kidney function** on a recent blood test

Acute kidney injury — a sudden decline — is different from chronic disease and is often reversible if caught early. It is commonly triggered by dehydration, infection, and certain medicines taken while unwell. In an emergency call 999, or go to the Royal London Hospital Emergency Department, Whitechapel Road, London E1 1FR.

What the numbers mean

- **eGFR** estimates how well the kidneys filter. Above 90 is normal; 60–89 is mildly reduced and often just reflects age; below 60 for over three months defines CKD.
- **ACR (albumin-to-creatinine ratio)** measures protein leaking into the urine, from a single urine sample. **This matters at least as much as eGFR** and is frequently not checked — a raised ACR is a stronger predictor of progression and of cardiovascular risk than a mildly reduced eGFR.
- The two together give a stage, from G1 to G5 and A1 to A3.
- **A single abnormal result is not CKD**. It must be persistent over three months, and dehydration, infection and recent illness all temporarily reduce eGFR.

Most people do not get worse

Being told you have kidney disease sounds ominous, and the great majority of people with stage 3 CKD have stable function for the rest of their lives and die of something entirely unrelated. Progression to dialysis is uncommon, and it is largely predictable from ACR, blood pressure and the rate of change over time. The label is best understood as a prompt to control blood pressure and cardiovascular risk, not as a countdown.

What causes it

- **Diabetes and high blood pressure** — between them, most cases
- ageing, which reduces filtration naturally
- recurrent urine infections, kidney stones, and obstruction from an enlarged prostate
- **Long-term anti-inflammatory use**
- glomerulonephritis, polycystic kidney disease, and some autoimmune conditions
- Higher risk in people of South Asian and African-Caribbean heritage

Protecting your kidneys

Do

- Control blood pressure — the single most important thing, target usually under 130/80
- Control diabetes, and ask about SGLT2 inhibitors, which now protect kidneys directly
- Reduce salt to under 6g a day
- Stop smoking, and keep alcohol moderate
- Stay well hydrated, but do not force large volumes of fluid

Avoid

- Regular ibuprofen, naproxen and diclofenac
- High-dose or long-term proton pump inhibitors without review
- Herbal remedies and bodybuilding supplements, several of which are nephrotoxic
- High-protein and high-creatine regimens without advice
- Ignoring urine infections

Sick day rules

If you become unwell with **vomiting, diarrhoea, fever or sweats severe enough to cause dehydration**, certain medicines should be paused temporarily because they can cause acute kidney injury in that setting. These typically include **ACE inhibitors and ARBs (drugs ending in -pril or -sartan), diuretics, metformin, SGLT2 inhibitors and anti-inflammatories**. Restart them when you have been eating and drinking normally for 24 to 48 hours. Ask us for a written sick day card — this single measure prevents a great many hospital admissions.

Monitoring

Depending on stage: eGFR and ACR at least annually, more often at higher stages; blood pressure regularly; and blood tests for anaemia, calcium, phosphate and parathyroid hormone at more advanced stages. Referral to a kidney specialist is indicated for rapid decline, heavy proteinuria, stage 4 or worse, uncontrolled blood pressure, or a suspected specific cause.

Why come to us. The most common failing in kidney care is that **ACR is never checked** — people are followed on eGFR alone, missing the measure that best predicts risk. We test **eGFR, ACR, HbA1c, lipids, calcium and full blood count in-house**, explain the actual numbers and what they mean, review every medicine for kidney safety, provide a written sick day card, and refer to nephrology when it is genuinely indicated. Seven days a week.

The urine test most people are never given

eGFR and ACR in-house, medicines reviewed, sick day card provided.

Book an appointment

or call 020 7916 0029

Where to get help

Tower Bridge Hospital London

97–99 Whitechapel Road, London E1 1DT

020 7916 0029

WhatsApp **07903 284 189**

info@mhwclinic.co.uk

Open 7 days, 9am–7pm

In an emergency

Call 999, or go to the Royal London Hospital Emergency Department, Whitechapel Road, London E1 1FR.

When we are closed and it is not an emergency

Call NHS 111 or visit 111.nhs.uk.

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This leaflet is based on current NHS and NICE NG203 guidance on chronic kidney disease assessment and management. It is general information and does not replace advice from a clinician who has assessed you. If your symptoms change or you are worried, contact us on 020 7916 0029, call NHS 111, or call 999 in an emergency.

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