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B/68253/DG Memo 190/AMRC/DGMS-5B

19 Jan 2018

HQ Southern Command (Med)
HQ Eastern Command (Med)
HQ Western Command (Med)
HQ Northern Command (Med)
HQ Central Command (Med)
HQ South Western Command (Med)

DGAFMS MEDICAL MEMORANDUM NO 190: CHRONIC KIDNEY DISEASE (REVISION OF OLD DG MEMO 166-CHRONIC RENAL FAILURE

3. Ref O/o DGAFMS note No 12256/DGAFMS/Web Site/DG-3B dt 12 Jan 2017.

4. Soft copy of the subject DG Med Memorandum has been uploaded on the DGMS (Army) website under "**Just in**" & "**DGMS-5B**" (under the head "DG Memorandum"). It is requested that the same may be downloaded at your end & disseminated to units under your AOR.

3. This is for your info and necessary action please.

(Vani Suryam)
Col
Dir MS (Health)

Encls: As above

Copy to:

DGAFMS/DG-3B - for info pl.

12256/DGAFMS/Web site/DG-3B

12 Jan 2018

OFFICE OF THE DGAFMS/DG-3B

DGAFMS MEDICAL MEMORANDUM NO 190 : CHRONIC KIDNEY DISEASE (REVISION OF OLD DG MEMO 166 - CHRONIC RENAL FAILURE)

1. DGAFMS has approved the DGAFMS Medical Memorandum No 190 (Revision of old Memo No 166) titled "**Chronic Kidney Disease**".

2. Soft copy (CD) of the above DG Med Memo is fwd herewith for uploading in non editable, read only format on respective service website.

3. It is requested to confirm the same.

(Sandeep Bhalla)
Col
Dir AFMS(MR)

Encls : 01 CD

DGAFMS/DG-1C

DGMS (Army)/DGMS-5B

DGMS (Navy)/JDMS(R&T)

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Copy to :

SO to Sr Conslt (Med) - for info wrt your SN No 27480/DGAFMS/GEN/SCM dt 11 Jan 2018.

DGAFMS MEMORANDUM NO 190
CHRONIC KIDNEY DISEASE

Introduction

1. This memorandum aims to lay down guidelines for Armed Forces Medical Services for the management of patients of Chronic Kidney Disease (CKD).

Definition

2. Definition, diagnosis and staging of CKD will be as per published international guidelines/ consensus statements. End Stage Renal Disease (ESRD) is defined as renal failure of a severity, which is incompatible with life without institution of renal replacement therapy. In absolute terms, when Glomerular Filtration Rate (GFR) declines to less than 10ml/min/1.73 sq. meter of body surface area, the patient is said to be in ESRD and in need of renal replacement therapy.

Renal Replacement Therapy

3. Renal Replacement Therapy comprises:-
(a) Dialysis:
    (i) Hemodialysis (HD)
(ii) Continuous Ambulatory Peritoneal Dialysis (CAPD)
    (iii) Automated Peritoneal Dialysis (APD)
(b) Renal Transplantation: Renal transplant will be governed by the Transplantation of Human Organs Act and Rules framed by the Govt Of India (GOI) from time to time.

Management of ESRD in Armed Forces

4. Serving personnel with Chronic Kidney Disease will be referred to a service nephrology center for opinion of a service nephrologist. These patients will be placed in low medical classification, and recommended for sheltered employment. Such patients will not be posted to high altitude, active field duties or in units involved in CI Ops. Such individuals will be recommended: -

(a) Posting back to their units (if units are located in peace station) and if they are to be reviewed once in 6 months. Normally such patients will be the ones in CKD Stage 1-3.

(b) Posting to a station within 4 hours travelling time from a service nephrology center if they are required to be reviewed more frequently than once in 6 months. Usually these will be patients in CKD Stage 4.

(c) Postings to a station where a service nephrology center is located if they are required to be reviewed atleast once a month. Commonly these are patients in CKD Stage 5.

5.These patients will also be educated regarding the eventual need for renal replacement therapy, options available and counselled to keep their families informed of the same. All patients will be tested for HbsAg, Anti-HCV antibodies and anti HIV antibodies in their blood and will be vaccinated against HBV if found to be HBsAg negative. The patients will also be administered pneumococcal vaccines as per existing guidelines of the Indian Society of Nephrology.

6. Serving personnel detected to have ESRD will be admitted to a service nephrology center to create a vascular access and initiation of HD/ CAPD/ APD. The modality of maintenance dialysis may be intermittent haemodialysis or CAPD/ APD, based on patient evaluation, technical feasibility and treating nephrologist's recommendations.

7. Neither hemodialysis nor peritoneal dialyses are definitive modalities of treatment and the patient continues to remain 100% disabled and unfit to perform military duties. Hence, Individuals with no transplant prospects either due to medical reasons or absence of suitable voluntary donors will be invalided from service in Med Classification P5 (Permanent) of SHAPE in terms of Army Rule 13 (3)(iii) or its equivalent in Navy & Air Force in case of JCO/ OR's and Army Rule 15 A or its equivalent in Navy & Air Force in case of officers, and referred to suitable ECHS empanelled facility for continuation of renal replacement therapy (HD or CAPD).

8. Although in CAPD and APD the patient carries out the dialysis procedure on his own, there is no change in his disability status. Therefore there is no difference in the guidelines for invalidment between hemodialysis and CAPD/ APD in the absence of renal transplant.

9. At present among the three modalities of treatment available, only successful renal transplant surgery is the definitive treatment. As a rule, such patients will be provided maintenance dialysis in a service hospital for a maximum period of six months from the date of initiation of dialysis to permit identification of a prospective voluntary kidney donor for undergoing renal transplantation.

10. Renal transplantation will be governed by the provisions of theTransplantation of Human Organs Acts and Rules promulgated by the Government of India (GOI) from time to time. Patients opting for transplant may be transferred to the nephrology center closest to their home station to facilitate identification of suitable donors and completion of legal formalities. The patients will also be asked to apply for medical certificate for posting to a station with service nephrology/ transplant center prior to transplant to enable pre operative evaluation, legal documentation and subsequent post operative care and follow up.

11. Cadaver renal transplant in India is still in a nascent stage and availability of cadaver kidney is unpredictable and subject to multiple variables such as blood group, sensitization status and medical fitness of the recipient. Hence, retention of such personnel indefinitely in service in the hope of a cadaver transplant is not feasible and

therefore invalidment proceedings will be carried out paripassu. Subsequent to invalidment from service the individual may seek cadaver transplant through the ECHS.

In case the patient chooses to undergo cadaveric transplant at a non service hospital (private or government),prior to invalidment from service, he may be permitted to register himself for the same and suitable referral will be provided to the individual to enable him to claim reimbursement of costs involved at prevailing CGHS rates.

Auth:

(i) GOI, Ministry of Defense, letter no 20028/ DGAFMS/ DG 3A/ 2327/ D (Med)/ 2001 dated 13 Aug 2001. Grant of medical advance to defense service personnel including their dependents for emergency/ elective specialized treatment from civil hospitals/ medical institutions approved by Ministry of Health and Family Welfare.

(ii) Para 294 & Para 305 of RMSAF 2010 and IHQ of MOD, AG Branch, DGMS (Army) letter no 76760/ DGMS- 5B/ Gen/ 2013 dt 14 Feb 2013. Reimbursement of medical claim expenses

12. In case the hospital, where the patient is registered for cadaver transplant, is located in a place where there is no service nephrology/ dialysis center, he may be permitted to undergo hemodialysis at a center of convenience and claim reimbursement at CGHS rates. Alternately, he/ she may be put on APD/ CAPD. However, serving personnel on any form of dialysis (HD/ CAPD/ HD) will remain admitted in the nearest service hospital till the individual undergoes cadaver renal transplant or is invalided from service, whichever is earlier.

13. Where a prospective suitable donor has been identified but renal transplantation can not be done immediately due to technical / medical reasons, the patient may be provided maintenance dialysis for an additional year (Total 18 months from initiation of dialysis) before invalidating out of service on medical grounds. The reason for delay in transplant should be such that, it can be overcome with therapy and there is reasonable chance of carrying out a successful renal transplant.

14. Discharge from hospital : As mentioned in Para 7, patients with renal failure, whether on HD or CAPD/ APD continue to have 100% disability and are thus unfit for military duties. Hence discharge from hospital and dialysis on OPD basis is not permitted. Such patients will remain admitted in the service hospital while on dialysis till they are transplanted or invalided from service.

15. Sick Leave: Sick leave is granted for convalescence when an improvement in the disease status is expected. In patients of ESRD, renal replacement therapy is initiated only once finality of disease status is reached and thus no further improvement is expected. Hence, sick leave is not permitted routinely in such cases. (Para 425-427,

RMSAF 2010). However, in genuine cases sick leave may be granted on a case-to-case basis as per applicable rules and subject to medical fitness.

Disposal of patients following a successful transplantation

16. Following successful renal transplantation, patients will be recommended a period of convalescence leave of four to eight weeks(Para 425-427, RMSAF 2010). As these patients need to be reviewed one to two times per week in the first three months after transplantation, they will have to spend their leave in station and report for regular reviews. Preferably such patients should have already got an attachment/ posting to the station and alloted a service accommodation before the transplant surgery. These formalities should be completed during the pre transplantwork up period.

17. On review following sick leave, the patient will be placed in Med Cat P 3 (T-24). Subsequently the patient will be placed in Cat P 3 (Perm) for a period of 2 years. In the next review if the patient is found to have normal graft function and no other complications he may be upgraded to Cat P 2 (Perm) as per the considered decision of the treating nephrologist. If the graft function is suboptimal, or the patient develops any other medical issues or complications he should be continued in Cat P 3 (Perm).

18. Posting to a station with service nephrology center will be recommended for the first two years following transplant. Subsequently these patients may be posted to a station with service med specialist and within 4 hours travel time from a service nephrology center, provided they have stable graft function and no ongoing medical issue requiring active management by a nephrologist.

Disposal of Patients following an unsuccessful transplantation

19. If, for any reasons, the renal transplantation is unsuccessful, the patient will be returned to maintenance hemodialysis/ CAPD/ APD. He/she will be offered a second transplantation provided a suitable voluntary kidney donor is available. If a donor is not forthcoming even six months after return to dialysis, he/she will be invalided out of service.

20. If however, a suitable donor is available but transplantation is not possible for technical/medical reason, the patient may be kept on MHD at the service nephrology center for another one year (Total 18 months from return to dialysis), before the patient is invalided out of service on medical grounds, provided there is a reasonable chance that the transplant can be carried out.

Disposal of patients following late failure of allografts

21. These patients will be offered a second transplantation provided a suitable voluntary kidney donor is available. Other instructions will be same as para 14 above.

Entitlement of patients for renal replacement therapy

22. All Armed Forces personnel & their entitled dependants will be entitled renal replacement therapy in Armed Forces Hospitalssubject to provisions mentioned in Para 7-13 and 23.Due to constaints of age/ distance/ finance /health, dependants are often unable to travel two to three times a week to a service nephrology center for dialysis. Such patients should be provided with an essentiality certificate to enable them to receive dialysis at a center of convenience close to their residence and claim reimbursement of charges.

23. The number of patients that can be dialysed at any service nephrology center is limited by the number of functional hemodialysis machines and availablity of dialysis technicians. Patients opting for renal transplant and having a related voluntary kidney donor will be provided hemodialysis in service nephrology centers till renal transplant is successfully carried out. If the patient has no donor or is found unfit for renal transplant he/ she will be given the option of shifting to CAPD/ APD. In case the patients refuse or are unfit for the same and the center faces a crisis of dialysis slots or shortage of manpower, they will be given an essentiality certificate to enable them to continue hemodialysis at a center of convenience and claim reimbursement of the charges.
Auth: (i). AO 32/81
(ii) Para 293 & 295 of RMSAF
(iii) SAO 21/D/76
(iv) IHQ of MOD letter no 76760/ DGMS 5B dt 03 Jul 15. Entitlement of Medical Treatment in Civil/ Private Hospitals and Procedure for Reimbursement of Medical Expenses.
(v) Para 5.7 of Schedule 5 of DFPDS 2016

24. ECHS members and their dependants will not be provided maintenance hemodialysis at any service nephrology center. They will be referred to an ECHS empanelled center of their choice for the same. They may however be offered CAPD/ APD/ renal transplant depending on availablity of spare capacity in the service nephrology center.

Management of renal donors in the Armed Forces

25. Identification of suitable donors and documentation for renal transplant will be in conformity with the provisions of Transplantation of Human Organs Acts and Rulespromulgated by the GOI from time to time.

26. The service hospitals do not have the wherewithal to verify the genuineness of certificates and documents provided as proof of residence/ identity/ relationship. For

example certificates of Gram panchayat/ MLA/ Police Station etc. All such certificates should be countersigned as verified by the Commanding Officer/ Equivalent in case of serving personnel& their dependants and by the Zila Sainik Boards in the case of ECHS patients & their dependants.

27. Donors will be followed up in OPD once 15 days after discharge from hospital and thereafter as deemed necessary, by transplant surgeons.

28. The liability of the service Transplantation Centers towards the donors after nephrectomy will be limited only to complications arising directly as a consequence of donor nephrectomy in the same admission in the case of donors who are otherwise not entitled treatment in service hospitals. Some examples are – Wound infection, incisional hernia, ipsilateral hydrocoele etc. The donors will not be entitled to renal replacement therapy at a service hospital in the rare event of failure of their remaining kidney leading to ESRD.
Auth: Min of Defence letter no PC/ 20028/ Renal Transplant/ DGAFMS/ DG-3A/ 2271/12/D (Medical) dt 21 Jan 2013. Amendment to RMSAF 2010: Medical Entitlement Rules for Organ Donors

Donation of kidneys by healthy serving personnel

29. Healthy serving personnel willing to donate a kidney to their dependents suffering from ESRD will be permitted to do so after applying for permission from their OC/CO units. On recommendation of treating nephrologist, the OC/CO unit will obtain a certificate from the service personnel stating acceptance of all consequences of a kidney donation including placement in low medical classification and its effect on future postings/promotions. Following kidney donation, the service personnel will be sent on convalescence leave of four to eight weeks and reviewed thereafter by the transplant surgeon. They will be observed in low medical classification P3 (Temp) for 24 weeks.Thereafter, if the remaining kidney continues to show normal renal functions, they will be upgraded to SHAPE-1 after obtaining the opinion of urologist and with the concurrence of Senior Advisor (Surgery/ Urology).

30. Similar to healthy individuals, service personnel can develop renal disease in the remaining kidney following renal donation. The attributability will be guided by the nature of renal disease. For instance, development of Diabetic nephropathy or Urolithiasis at a later date will not be attributable to service, being constitutional disorders. However, post infectious glomerulonephritis or pyelonephritis will be deemed attributable, being consequences of infections contracted while in service. Injuries sustained to the remaining kidney will be judged in the light of injury report and Court of Inquiry findings.

31. In the rare event of development of CKD/ESRD in service personnel following renal donations the same rules will apply so long as patients is in service. Upon retirement/ superannuation, he/she will be referred to an ECHS empanelled hospital for maintenance hemodialysis.