Opinion

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Renal Artery Partial Occlusion after Aortic Dissection

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Description

The most prevalent cardiac arrhythmia, atrial fibrillation is a significant risk factor for ischaemic stroke. Patients who have one or more additional risk factors for stroke can be treated with a non-vitamin K antagonist direct oral anticoagulant, which is recommended as an alternative to or preference over VKAs. This can reduce the risk of stroke. DOACs are cleared in varying degrees by the kidney; For instance, apixaban and rivaroxaban are less than 36% renally cleared, while dabigatran and edoxaban are less than 50% renally cleared. Patients with AF frequently suffer from renal impairment, which results in decreased drug clearance, prolonged half-life, and increased total drug exposure. It has been demonstrated that patients with renal impairment clear rivaroxaban more slowly than healthy patients, which has an effect on its pharmacodynamics. Patients with renal impairment and non-valvular AF have a higher risk of thromboembolic events, and those taking anticoagulants also have a higher risk of bleeding. In the phase III, randomised ROCKET AF study, the non-inferiority of rivaroxaban 20 mg once daily versus warfarin for the prevention of stroke or systemic embolism in patients with NVAF was demonstrated. In patients with NVAF and moderate renal impairment, a reduced rivaroxaban dose of 15 mg orally was found to be safe and effective in a subanalysis of this study.

Thromboembolic Events

However, there is insufficient evidence regarding the characteristics of the patients as well as the safety and efficacy of rivaroxaban in routine care for patients with NVAF and renal impairment. For patients with severe carotid stenosis, the first surgical option is carotid endarterectomy. In the meantime, international use of carotid artery stenting is on the rise as an efficient procedure. However, it appears that renal impairment is more prevalent following CAS than following CEA. There are few data on changes in renal function following CEA, despite the fact that numerous researchers have reported that CAS frequently results in chronic kidney disease and decreased renal function. As a result, as a measure of impairment in renal function, we examined the estimated glomerular filtration rate following CEA. We used our new method for creating useful images for CEA from cervical computed tomography and magnetic resonance angiography without contrast media and the CEA technique for treating undetected plaques in the distal portion of the internal carotid artery if we were unable to use contrast media because the patient had asthma, was allergic to contrast media, had a low eGFR, or did not consent to the use of contrast media. Patients with abdominal aortic aneurysm have been found to have renal artery stenosis, which can cause damage to the kidneys.

A thrombus at the artery's origin may reduce renal blood flow, resulting in renal colic and kidney impairment in otherwise normal renal arteries. We present a rare instance of a patient with dissecting aortic aneurysm symptoms and a thrombus at the level of the right renal artery's origin, which is otherwise normal. Regarding CYP2D6 intermediate and poor metabolizers, these studies did not provide any conclusive findings. Patients with hepatic or renal impairment now have access to the most recent recommendations and contraindications on the eliglustat label. For adults with Gaucher disease type 1 who exhibit extensive intermediate or poor CYP2D6 metabolizer phenotypes, Eliglustat is the first-line oral treatment. Due to a lack of data, it was initially not recommended for GD1 patients with hepatic or renal impairment. Following a single 84-mg dose of eliglustat, the effects of hepatic and renal impairment on pharmacokinetics and tolerability were examined in two Phase 1 studies.

Glucosylceramide Production

Geometric means for eligibility maximum concentration and area under the plasma concentration versus time curve extrapolated to infinity were not significantly different between EMs with mild hepatic impairment, moderate hepatic impairment, or severe renal impairment. A physiologically based pharmacokinetic model predicted higher steady-state exposures of eliglustat in EMs with mild or moderate hepatic impairment than in EMs with normal hepatic function following repeated doses of 84 mg of eliglustat. Eliglustat exposures were also predicted to be higher in EMs with mild hepatic impairment who received repeated doses of a CYP2D6 or CYP3A inhibitor in combination with the drug. The eliglustat drug label for patients with hepatic or renal impairment was updated in light of these findings. Deficient activity of the enzyme acid-glucosidase and subsequent accumulation of its substrates, glucosylceramide and glucosylsphingosine, are hallmarks of Gaucher disease type 1—an inherited lysosomal storage disorder. Debilitating visceral, hematologic, and skeletal manifestations result from the accumulation of these glycosphingolipids primarily in the

lysosomes of tissue macrophages. Eliglustat partially blocks the enzyme glucosylceramide synthase, reducing glucosylceramide production and allowing patients' residual acid-glucosidase activity to reduce glucosylceramide accumulation and alleviate symptoms.

Based on 1400 patient-years of data from four clinical studies, Eliglustat has been shown to be effective and generally well-tolerated, with a favorable efficacy and safety profile. Risk assessment prior to contrast media exposure, withdrawal of nephrotoxic medications, volume expansion with sodium chloride or sodium bicarbonate, hemofiltration or hemodialysis, and the optimal contrast media policy are some of the CIN prevention strategies that have been developed, despite the fact that no known pharmaceutical treatment can prevent or treat CIN. Guidelines recommend peri-procedural intravascular hydration as the single most significant comprehensive measure to prevent CIN. There are a few distinct methods of hydration, but the most effective method has not yet been determined. Furosemide-induced forced diuresis with matched hydration using the Renal Guard system has been shown to prevent CIN in patients with chronic kidney disease, according to a number of small randomized controlled trials and prospective studies.