**Referral pathway for Proteinuria**

**ACR to PCR**

**NOTE: An ACR of 70 is comparable to a PCR of 100 both of which equate to 1g proteinuria/24 hours**

**NOTE: The combined presence of both blood and protein in the urine may suggest a glomerulonephritis.**

**Such patients should have urgent bloods sent and be discussed with the renal on call if concurrent AKI found.**

**If renal function is normal or stable CKD urgent OP referral to nephrology**

**Proteinuria**

**Urine PCR >150**

1. **Nephrotic syndrome = Urine PCR >200 and Low blood albumin and Oedema**

**Urgent OP referral to nephrology**

1. **Non nephrotic but PCR >150**

**Referral nephrology for routine OP review**

**Urine PCR >100 but <150**

**1)Normal Renal function or stable CKD – Repeat in PCR and U&E 1 month**

**If stable monitor 6 monthly (follow PCR <100 guidance)**

**If rising creatinine, PCR or uncontrolled BP**

**Referral to nephrology for routine Op review.**

**Urine PCR <100**

1. **Normal renal function or stable CKD – monitor 6/12 U&E and PCR**
2. **Optimise BP control**
3. **ACEi/ARB if not contraindicated**
4. **Address cardiovascular risk factors**

**Referral to nephrology for routine Op if rising creatinine and/or PCR**

**If no change in the first 2 years monitor yearly.**

**1) Dip urine for concurrent haematuria (see NOTE)**

**2) Send urine for PCR**

**3) Request Renal USS**

**4) Check BP**

**5) Send bloods for U&E, LFT, Bone (inc blood albumin) and FBC**

**6) Is the patient diabetic? If yes refer to diabetes renal pathway**