The primary care physician's role in treating chronic kidney disease

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Twenty million Americans have chronic kidney disease (CKD); another 20 million are considered at risk. CKD is defined as either kidney damage or GFR<60mL/min/1.73m2 for 3 months; kidney damage is defined as pathologic abnormalities or markers of damage, including abnormalities in blood or urine tests or imaging results. One in 9 Americans has CKD, and this population is growing as the prevalence of the causes of kidney disease—primarily diabetes and hypertension—continues to escalate. With such a high prevalence, it is imperative that CKD be diagnosed early when it can be treated and managed, and progression to end stage renal disease can be avoided or delayed.

In view of the above statistics, it is most important that primary care physicians routinely assess patients with risk factors for CKD and provide ongoing management of those patients diagnosed with CKD. A predicted shortage of nephrologists places primary care physicians in the tients in growing numbers. This makes it necessary for primary care physicians and nephrologists to take a team approach to care of CKD patients.

Patients with diabetes or hypertension; a family history of kidney disease, hypertension or diabetes; who use tobacco; are male; or are a minority are at risk for kidney disease. Patients assessed to be at increased risk for CKD should have the following screening tests: blood pressure, glucose, urinalysis, microalbuminaria/proteinuria, and serum creatinine to determine the estimated glomerular filtration rate.

Once patients are diagnosed with CKD, the stage of their disease can be determined and a clinical action plan developed in conjunction with a nephrologist. Figure 1 offers an algorithm developed by the Upper Midwest Fistula First Coalition, of which MetaStar is a member. Patients in Stages 1 (GFR >90 ml/min) and 2 (60-89 ml/min) are monitored and treated by the primary care physician with possible consults from nephrology as needed. In Stage 3 (GFR 30-59mL/min/1.73m2) the primary care physician and nephrologist should co-manage the patient. In Stages 4 and 5, when the GFR drops below 30, the patient should be referred to the nephrologist for continuing care and possible vas-

Early intervention in the management of CKD by the primary care physician, consulting as needed with the nephrologist, can result in delayed progression of CKD, and provide the patient with the opportunity to receive vital education regarding the course of CKD and vascular access placement. Primary care physicians play a significant role in helping patients understand their condition and the comorbid conditions contributing to the disease, along with providing treatment options and preventive measures that help the patient remain stable.

Educational and reference materials regarding the management of CKD can be obtained from www.kidneyorg/professional/KDOQI/guidelines.cfm or from www.esrdnet11.org. A small wall chart (see Figure 1) with the 5 stages of CKD assessment and treatment outlined on 1 side and a CKD Assessment Algorithm on the other is available from MetaStar. A laminated pocket card with the stages of chronic kidney disease and clinical interventions is also available. Both can be obtained by calling MetaStar at 800.362.2320 or by sending a request to jreyes@metastar.com. These resources are also available for download at www.metastar.com.

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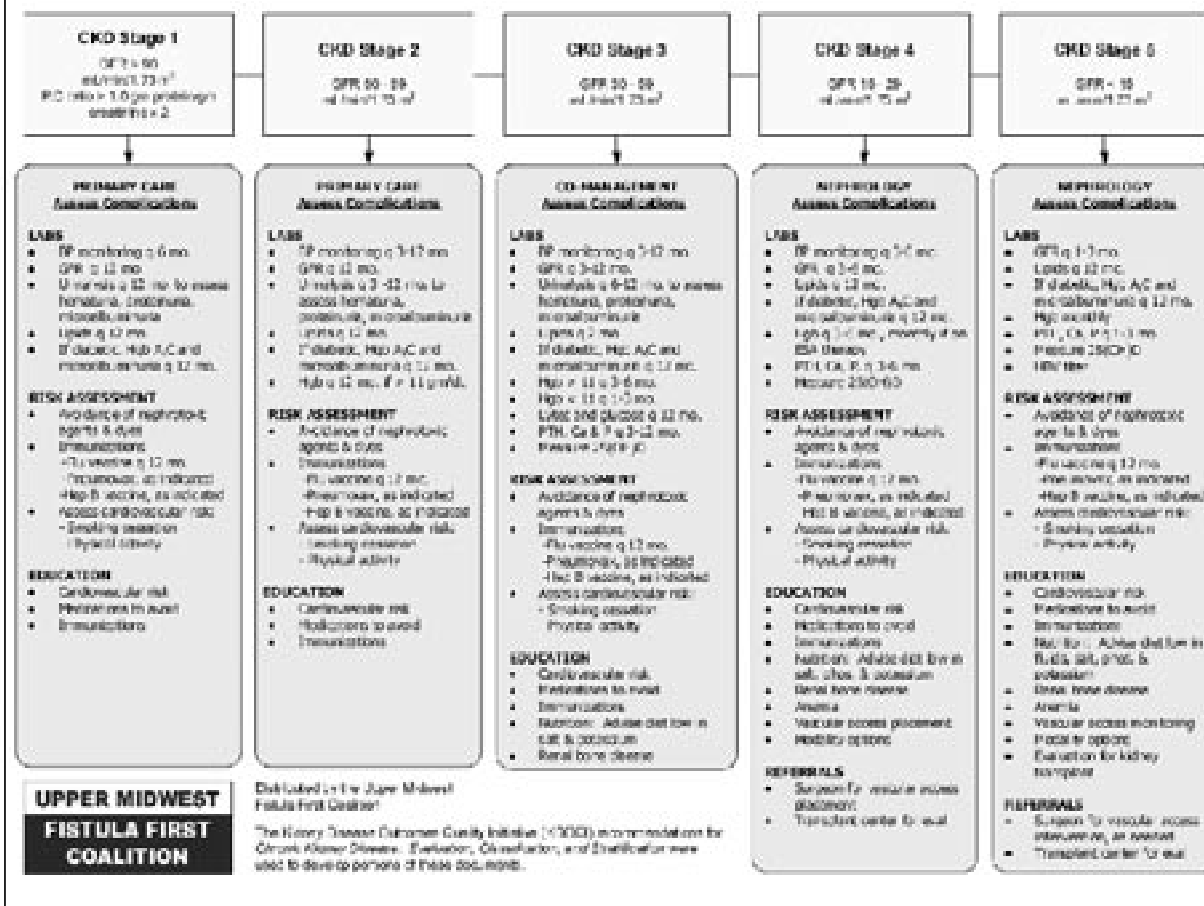

Figure 1 Side 2 of a wall chart with a CKD Assessment Algorithm. The 5 stages of CKD assessment and treatment are outlined on side 1.

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