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Episode 2 Part B: Effectively Transferring Over the CKD Patient at the Right Time

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Weber:
Patients with chronic kidney disease who are considered high risk and do not receive appropriate specialized treatment may not be getting the best interventions given their level of risk. So today we're going to discuss when it's appropriate for a primary care provider to refer these patients to a specialist.

This is CME on ReachMD, and I'm Dr. Michael Weber, and delighted to be working with my distinguished colleague, Dr. Luiza Caramori. Luiza.

Dr. Caramori:
Thanks, Dr. Weber, it's a pleasure to be here. I'm Luiza Caramori.

Dr. Weber:
Very often, primary care providers are managing diabetes, chronic kidney disease, and other types of potential cardiovascular outcomes within their patient populations. So when is it appropriate for a primary care physician to refer a patient to a specialist for treatment, and what would we recommend?

Louisa, you obviously deal with the full spectrum of chronic kidney disease. When do you start to think about cardiovascular outcomes, and how would you go about that?

Dr. Caramori:
I think that that's a very great question, and I think that unfortunately we don't do a great job in screening our patients for cardiovascular disease. And we can talk about coronary artery disease and heart failure. And I think that we do even a poor job with heart failure. So there are ways now of screening patients, right, for heart failure. We do a blood work. If it comes back outer, for example, pro-BNP, you would order an echocardiogram. And if that echocardiogram is outer, then you can refer to the cardiologist. So this way we don't send everyone to the cardiologist, but you are also screening these high-risk patients. So I think that that's an important piece that we may be missing, both in primary care as well as in the endocrinology clinic. With the coronary artery disease, I think that's a bit tricker because screening on asymptomatic patients may not give a high yield, but in patients who have atypical symptoms, outer EKGs, or have other microvascular complications, for example, I think that the common sense would say that we should screen these people as well for coronary artery disease, and if the screening comes back outer, refer to one of our colleagues in cardiology and work in very close collaboration with them.

So I think that those things are quite important. But there is also the referral to a nephrologist that will depend on the severity of CKD. And that, we have quite clear guidelines, I would say, from the KDIGO with very clear recommendations. And those recommendations

include any degree of severely increased albuminuria. That's what we used to call proteinuria. It's the same thing just with a different name. Or macroalbuminuria, those are all the same. And those patients should be referred to a nephrologist because they tend to progress faster. And the same with patients who have a GFR lower than 45, those patients should be referred to a nephrologist for additional evaluation. But that does not preclude us from starting treatment, right? So it's not only referred. We need to treat these patients, start therapies, and then refer to our colleagues and to be in close communication.

Dr. Weber:
What would you suggest to me if I were a primary care physician? What should I do or provide for a patient so that when I send them to the nephrologist, the nephrologist is going to get what he or she needs to see?

Dr. Caramori:
So for patients with CKD screening, very clear recommendations, again, to screen with both estimated GFR; that usually comes from measurements of serum creatinine. And ideally, we should use the data from a lab that is IDMS [isotope dilution mass spectrometry] traceable, so you know that that's a reliable measurement and look at those values over time. By definition, the word chronic is there, right? It's chronic kidney disease. So you need to have at least 2 measurements to estimates of GFR that are lower than 60, at least 3 months apart to say that this is chronic CKD. And the reason for that, that patients can have also acute losses of kidney function that we call acute kidney injury, AKI. You get dehydrated, you have a severe diarrhea, you get a bad infection, you are in the hospital because you broke your femur, and your creatinine goes up, your GFR goes down, but then you recover. So that's not chronic kidney disease. So make sure that you have these measurements at least 3 months apart for the eGFR. And the same is true in regards to urinary albumin [UA]. We know that patients can have CKD with both high albuminuria and low GFR, but they can have one or the other. So that's why we need to certainly check both.

One thing that I tend to do, especially if the patients have high levels of albuminuria, is also get a simple UA just to make sure that there is not another kidney disease that's causing that albuminuria. Sometimes you get casts, you can have things that you usually don't see in diabetes, and that's quite important because that patient probably should be seen by nephrology even sooner and sometimes need a kidney biopsy to confirm diagnosis and may change therapy as well.

So screen, screen, screen, treat as much as you can, refer, and talk to your colleagues so that if patients need to be seen sooner, you can help facilitate that as well.

Dr. Weber:
Well, thank you, Louisa. That's a very, very helpful recommendation. Basically, it's no good sending a patient to the specialist unless we can send them along with data that allows the specialist to get to work.

Dr. Caramori:
Because then they can make it, we, again, we are fighting against inertia, right? So you have the data, they see the specialist, they can act on that appointment instead of ordering labs again and waiting 3 more months to do something.

Dr. Weber:
Yes. Okay. Thank you, Louisa.

Dr. Caramori:
My pleasure.

Announcer:
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