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https://reachmd.com/programs/cme/establishing-a-best-practice-between-primary-care-and-specialists/26452/

Released: 07/31/2024
Valid until: 07/31/2025
Time needed to complete: 58m

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Establishing a Best Practice Between Primary Care and Specialists

Announcer:
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Dr. Weber:
We know that high-risk patients with chronic kidney disease associated with type 2 diabetes may need to be referred by their primary care providers to specialists given the nature of the long-term cardiovascular outcomes associated with these diseases. So let's discuss the best practice for this transition.

This is CME on ReachMD, and I'm Dr. Michael Weber at the Downstate University of the Health Sciences in New York.

Dr. Rossing
And I'm Dr. Peter Rossing from the Steno Diabetes Center, Copenhagen, happy to be here.

Dr. Caramori:
And I'm Luiza Caramori, and it's a pleasure to be here today.

Dr. Weber:
Well, thank you, Louisa. So how could primary care physicians best refer their patients? They often hesitate. They know it's difficult to get appointments for their patients. So what should they be thinking about? How should they and their patients get ready to finally go and see a specialist?

Dr. Caramori:
I think that that's a very important question. And of course, as we know, there's a shortage of specialists and a very high frequency of patients with diabetes that we see in clinic. So I think that's very important, to only refer patients that really need the specialists. So there's a lot that can be done with the primary care physicians, and we do understand that the primary care physicians are also very busy, and they are treating these patients for many issues, not only for their diabetes, but I think that there is a lot that can be done in the primary care setting starting from screening for complications. So I think that's very important to screen for renal disease, for heart failure, for renal disease, of course, these patients who would need to be screened with estimations of GFR, usually from serum creatinine and, screened for urinary albumin levels.

And on the cardiovascular perspective, if the patients have symptoms of course, or any signs they have carotid bruit, they have changes on EKG. Those patients need additional screening and probably need a referral. Once there are abnormalities, then it's very important to start treatment and start as early as we can, following the guidelines. There are multiple guidelines that are very coherent. Now we have the KDIGO guidelines that have been coordinated with the American Diabetes Association guideline for treatment of CKD in diabetes, for example. And that's a very helpful instrument. So we can diagnose, you can start treatment, and if things are not progressing as we would like to see, the patient starts to deteriorate, GFR starts falling and reaches, usually the KDIGO guideline and

the American Diabetes Association, we use 45 as an indication to refer to nephrologist, or if there is presence of albuminuria, usually these patients should be referred to a nephrologist.

Regarding the cardiologist, then I think that many times it takes quite a while for these patients to actually be referred to a cardiologist. They are usually seeing a cardiologist after they have an event. And I don't think that that's what we want to do. I think that we really want to prevent these events from happening. So the screening becomes here quite important and something that we need to really be aware and fight to implement in our settings. I think that we are doing a better job with CKD screening because we get creatinine in everything that we order. Still not great with the urinary albumin. And we need to keep in mind that urinary albumin not only reflects renal risk, but can also reflect cardiovascular risk in these patients. And I think that we need to learn and start screening them for heart failure, at least creatinine, proBNP on patients who are high risk, patients who are above age of 50 or having diabetes for greater than 10 years, any other complications. So these patients should certainly be screened, and if their results are abnormal, we can do another layer of screening. You can order an echocardiogram, for example, before you refer them to the cardiologist. So you can really try to identify these people at high risk so that you really refer people who really need the cardiologist. So I think that's a matter of working with our systems to make sure that patients that diagnosed early, treated early, and referred as they need to.

Dr. Weber:
Well, thank you, Louisa, the points you made are really so important.

Peter, let's get back to you. What do you think about the best practices for referral, bearing in mind your experience in Europe?

Dr. Rossing:
I think referral is a critical collaboration, maybe even more critical when we learn that the majority of these people with kidney disease, diabetes, cardiovascular events are in primary care, but there are also a need for specialists, as we just heard from Dr. Caramori, and many things are similar in our setting. When kidney function declines, reaches approximately 30, or with very fast decline in kidney function, you **refer** to a nephrologist. But before that, you can refer to specialists in endocrinology in special cases where you have challenges with glycemic control or blood pressure control, or you can refer to cardiologist, of course, if you have suspicion of heart failure or ischemia. And as we have heard, this threshold for suspicion for referral for cardiologists should be very low, appreciating that symptoms are often very vague and small.

So in that sense, I think very many things, even though our systems are different, are similar in the sense that we need to collaborate around this type of patients.

Dr. Weber:
And I couldn't agree more that if you are seeing a patient with chronic kidney disease and you're worried that sooner or later cardiovascular disease is going to become calling and be a problem and you'd like to prevent it, as you so eloquently said, we are in the business of prevention. So doing the echocardiogram, measuring the pro-BNP, and something that we often forget to do, just talking to the patient.

But the fact is if you just sit and talk to the patient, they'll tell you they have trouble climbing the stairs. They can't walk as far as they used to, and their legs are hurting when they walk more than a certain distance. And you have to think, oh, my gosh, do they have peripheral artery disease? Which may be the first manifestation sometimes of cardiovascular outcomes, and you've covered that all so beautifully. We really have to, as nephrologists, have to think like cardiologists and vice versa. So I think your approach has been absolutely perfect. Thank you.

Dr. Caramori:
No, thank you, and thanks for bringing this up because I think that really talking to the patients is where we learn, right, what's bothering you, and sometimes they tell you, oh, I don't exercise. You need to go the next step and ask why is it that you don't exercise. And sometimes you learn what you just said. They have pain, they have difficulty, they get short of breath. And without these additional questions, we are not going to be able to diagnose and treat the conditions that could be treated and actually have a global improvement on the patient's health.

Dr. Weber:
Yes, yes. So many issues we deal with, including the problem of patient adherence to their medications. We know what to prescribe. Patients don't always understand that. And this whole concept now of shared decision making, really explaining to patients what their conditions are, what the best treatments might be, and why taking those pills that we're recommending and prescribing really have been shown to prolong life and to protect people from getting to end-stage kidney disease.

Dr. Caramori:

Yeah, I think that those, again, are important points, and essential, right? Because if you don't have the buying in from the patient, there is no treatment, right?

Dr. Weber:
Thank you, Louisa. That's a beautiful summary of our discussion. And we really all have to learn, no matter where we are in the medical spectrum, that very few people have just one thing going on. And we have to assume if they have kidney disease, they have cardiovascular disease, if they have high blood pressure, there's a good chance they're going to have diabetes. It all seems to come together, particularly with our aging population, and your thoughts and recommendations are really very, very valuable. And of course, what make it makes it even more exciting is now the availability of newer drugs, nonsteroidal mineralocorticoid receptor antagonists, for instance, and other new drug classes that have been shown to have such important and impressive protective effects against kidney deterioration and also cardiovascular events.

So all exciting times and, again, my real thanks to you for joining us and sharing your experience.

Dr. Caramori:
The pleasure was all mine and thanks for having me.

Dr. Rossing:
Thank you.

Dr. Weber:
Thank you. And I'd like to thank all of you who've been following, our discussion today. I hope you appreciated this subject, the importance of dealing with our patients in a very comprehensive fashion. Thank you.

Announcer:
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