

Editorial

Reflections on two consensus documents about chronic kidney disease

Reflexiones a propósito de dos documentos de consenso sobre enfermedad renal crónica

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Introduction and Background

According to data from the EPIRCE¹ (epidemiology of chronic renal disease in Spain) research study, chronic kidney disease (CKD) affects up to 9.2% of the Spanish population, 6.8% of which have advanced-stage disease, including prior definition of chronic renal failure (CRF) or estimated glomerular filtration rate (GFR) of <60 ml/min/1.73 m².

The Spanish Society of Nephrology (SEN) has been concerned about this major epidemiological problem for years, which, in its most advanced stage (stage 5 CKD in renal replacement therapy [RRT]), accounts for 2.5% of the total Spanish health budget. The SEN has therefore created a spe-

cific working group, known as the Strategic Action Group, for the purpose of continuously monitoring this problem and establishing contacts with other scientific societies to adopt and improve the multidisciplinary approach to this serious public health challenge.

In 2006 the consensus document for appropriate calculation of GFR was therefore published jointly with the Spanish Society of Clinical Chemistry² (SEQC), and in 2007 the first consensus document for CKD management was prepared jointly with the Spanish Society for Family and Community Medicine³ (semFYC).

SEN also created a specific working group for the creation of "Strategies in Renal Health", which were then reported to the Ministry of Health. These strategies were also discussed

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and communicated to other scientific societies at a meeting in Madrid in 2008 and published on two occasions in the medical journal "Nefrología"^{4,5}.

As proteinuria is a marker of kidney injury and its increase a sign of progression towards advanced stages of CKD, the creation and publication of the document with recommendations for the detection and monitoring of proteinuria in CKD⁶ was promoted in 2011 by SEN and SEQC.

The presence of CKD in our general population has been increasing, and our approach needs to be updated based on current criteria. Therefore, SEN, in collaboration with another nine scientific societies, assembled a group of experts representing each of the societies involved (two per society). In December 2012, the first draft was ready of the "Consensus Document by ten societies for the detection and management of chronic kidney diseases". The document was initially published on the web site of each of the societies, where it was submitted for public review. The final document was sent to all the societies with the comments received and was again published on the respective web sites. It was finally published in "Nefrología" last March⁷.

Over the last three years, the *Kidney Disease Improving Global Outcomes* (KDIGO) initiative has simultaneously published guidelines on general management and blood pressure control in patients with CKD^{8,9}. Its most relevant contents were integrated and summarised in the "SEN document on the KDIGO guidelines for the evaluation and treatment of CKD", recently published in "Nefrología"¹⁰.

Judging by the number of website visits to the journal "Nefrología", both documents are the object of a high number of consultations. Since its online publication on 6th March 2014, the "Consensus Document by ten societies for the detection and management of chronic kidney diseases"⁷ has received 5,223 visits, and the "SEN document on the KDIGO guidelines for the evaluation and treatment of CKD"¹⁰ has had 5,282 visits. In both cases, these are the most visited articles in the past year and they triple or quadruple the average number of visits to the "Nefrología" journal articles, which may represent the multidisciplinary interest in documents that are being consulted by specialties other than nephrology.

Why were so many consensus documents on CKD promoted by SEN? (Table 1)

In view of the fact that both reference documents on CKD were promoted by SEN and published sequentially, our aim in this edition is to comment upon the specific or differentiating aspects of said documents.

Both are similar in length: the first consists of 20 pages, which contain 7 tables, 2 figures, and 77 bibliographical references; meanwhile, the second has 15 pages, 7 tables, 2 figures, and 45 bibliographical references.

If we analyse the contents of both documents, we note that they agree on all essential aspects and there are no discrepancies with regards to content or recommendations.

There are, however, different minor nuances, which we will comment upon.

The consensus document from the ten societies⁷ represents a multidisciplinary approach from societies that are in some way involved in CKD patient management: primary care, cardiology, diabetes, endocrinology, internal medicine, and SEN itself. Others are involved in the laboratory diagnosis of CKD, as is the case of SEQC. Beyond the current discussion about how we should diagnose CKD¹¹, it is the multidisciplinary nature and the publication of this document further afield than our journal which have led to the transversal transmission of current knowledge on the diagnosis and management of the most important aspects of our speciality. This facilitates its appropriate implementation in general clinical practise (and not merely in other specialties) while increasing awareness of its earliest stages. Thanks to these initiatives, other specialties as diverse as vascular surgery or anaesthesiology are incorporating nephrological awareness into their clinical practice in their leading journals^{12,13}. For the first time, this document successfully united the highest number of scientific societies in our field in Spain and obtained their consensus on the basic aspects of CKD diagnosis, prevention and treatment.

1. The document focuses on the diverse methods of GRF measurement, recommending CKD diagnosis through GRF estimations based on the CKD-EPI formula (just like the KDIGO document on general patient management with CKD) and the determination of the albumin/creatinine ratio (ACR) in an isolated sample of early morning urine. It uses the same categorisation as CKD, taking into account the kidney function stage according to GFR measurement and ACR in urine, following the KDIGO classification of A1, A2 or A3, depending on the intensity of albuminuria. It recommends referring to "elevated urinary albumin excretion" instead of the term "microalbuminuria", and also the term "proteinuria" for urinary elimination of 300 mg/day or higher.

Table 1 – Key documents on chronic kidney disease

Document	Authors (reference)	Year
EPIRCE	Otero et al. ¹	2005
SEN-SEQC Consensus document	Gracia et al. ²	2006
Strategies for Renal Health	Alcázar, de Francisco ⁴	2006
SEN-semFYC Consensus document	Alcázar et al. ³	2008
Strategies for Renal Health Proteinuria Recommendations	Martínez Castela ⁵	2009
KDIGO-CKD	Montañés et al. ⁶	2011
KDIGO-CKD	KDIGO-CKD Working Group ⁸	2013
KDIGO-BPKDIGO BP	KDIGO BP Working Group ⁹	2012
10 societies consensus document	Martínez Castela et al. ⁷	2014
SEN document on KDIGO guidelines	Gorostido et al. ¹⁰	2014

EPIRCE: *Epidemiology of chronic renal disease in Spain*; CKD: *chronic kidney disease*; SEN: *Spanish Society of Nephrology*; SEQC: *Spanish Society of Clinical Chemistry*; semFYC: *Spanish Society for Family and Community Medicine*; KDIGO: *Kidney Disease Improving Global Outcomes*; BP: *Blood Pressure*; CKD: *Chronic Kidney Disease*.

2. It reinforces the relevance of radiological or histological criteria for the diagnosis of CKD.
3. It strongly underlines CKD progression factors with a specifically designed chart.
4. It considers the progression of CKD with the same criteria as the KDIGO document and stresses the passing from one category to another depending on the disease stage itself and the ACR.
5. When this section refers to the criteria for referral to a nephrology specialist, the document introduces several precise criteria, expressed as a referral "algorithm", in accordance with GFR measurement, ACR and patient age. Specific considerations are added in the case of elderly or diabetic patients and a CT scan in certain cases.
6. The recommended practice for monitoring and following-up CKD patients is to carry out specific biochemical and haematological determinations given the possible presence of anaemia and iron deficiency or alterations in bone and mineral metabolism.
7. A chapter of special recommendations is focused on the prevention of nephrotoxicity, how to prevent hyperkalaemia, volume depletion, the unnecessary use of non-steroid anti-inflammatory drugs (NSAID), distal diuretics, nephrotoxic antibiotics or radiological examinations with radio-contrast agents..
8. The document also particularly underlines aspects relating to life habits, physical exercise and diet.
9. Regarding pharmacological treatment goals, this document coincides with the KDIGO document on target figures for patient blood pressure with or without proteinuria. A specific section is added, however, for the management of anti-diabetic drugs in diabetic patients with CKD, including oral anti-diabetic drugs or insulin, with specific consideration given to these particular cases.
10. The document focuses on cardio-vascular risk stratification in the same way as the KDIGO document, but it also includes several specific considerations for the management of statins and treatments combined with Ezetimibe. In addition, there are several comments with respect to obesity, tobacco, alcohol and hyperuricaemia.
11. Differentially, consideration is given to anaemia, haemoglobin targets, the use of erythropoiesis-stimulating agents and iron metabolism management. Also included are aspects relating to mineral and bone metabolism alterations, the diagnosis of hyperparathyroidism secondary to CKD, metabolic acidosis management, management of CKD patients not on dialysis, and the preparation of patients for RRT.
12. Recommendations are specifically added for joint management with Primary Care doctors regarding patients with RRT who are either on haemodialysis/peritoneal dialysis or are kidney transplant recipients. Recommendations are also given for the vaccination of these patients.
13. Finally, a particular section is added for the consideration of palliative care in patients with advanced CKD not resulting from RRT.

A distinctive aspect of the consensus document promoted by SEN compared with the KDIGO¹⁰ guidelines is that said

guidelines make recommendations for the management and treatment of CKD following a systematic evaluation procedure of the existing evidence, using the level of recommendation according to the GRADE system (*Grading of Recommendations Assessment, Development and Evaluation*). Very little grade 1 evidence exists, and the different aspects that create uncertainty are discussed. The data in the consensus document of the ten societies was not presented in this manner.

In short, the ten societies' document⁷ adapts the recommendations of the KDIGO¹⁰ document to the reality of our setting, with several specific recommendations.

It is SEN's intention to periodically include scientific evidence as it is generated, updating clinical practice recommendations and existing consensus documents, while evaluating international documents resulting from the multi-factorial and multidisciplinary approach to the management of patients with chronic kidney disease.

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Conflict of interest

The authors have no conflict of interest to declare.

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