A) COMMENTS ON PUBLISHED ARTICLES

Comment on assessment of the new CKD-EPI equation

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Dear Editor,

We read with great interest the prepublished article in your journal by Montañés et al.[1] for two reasons. The first, due to its current nature; it has only been a few months since formulas to estimate glomerular filtration rate (eGFR) were published, based on CKD-EPI study (Chronic Kidney Disease Epidemiology Collaboration).[2] The second reason is that our group is working, albeit more modestly, along the same lines.

In our project "Knowing Diabetes Numbers" we collected measurements of fasting plasma glucose and HbA_{1c} (FPG-HbA_{1c}) from September 2008 to February 2009 that were performed in the Department of Biochemistry of the Hospital of La Línea de la Concepción, where tests are carried out for the hospital and the six primary care centres (PC).

After excluding the 362 results that came from the outpatient nephrology clinic, 4,820 FPG-HbA_{1c} results were collected (from patients with a mean age of 64 ± 14 years), 55% were made in women and 74% came from PC. Of these, creatinine was also requested in 3,461 (72%), the albumin/creatinine ratio was requested in 1,397 (29%), and a specific request for eGFR was made in only 80 (less than 2%).

Subsequently, we calculated the eGFR in the 1,953 requests in which data were available for age, sex, and creatinine using the classical MDRD formula (coefficient 186),[3] since the laboratory uses the modified kinetic Jaffé method (Beckman) without traceability to isotope dilution mass spectrometry (IDMS).[4,5]

Table 1. CKD grade classification by MDRD

Men	KDOQI	KDOQI	KDOQI
n = 900	1-2	3	4-5
MDRD	767	119	14
	(85.2%)	(13.2%)	(2.2%)
CKD-EPI	744	136	20
	(82.7%)	(15.1%)	(2.2%)
Women	**KDOQI**	**KDOQI**	**KDOQI**
n = 1052	**1-2**	**3**	**4-5**
MDRD	807	210	35
	(76.7%)	(20%)	(3.3%)
CKD-EPI	794	210	48
	(75.5%)	(20%)	(4.5%)

Our results in men were of CKD grade 3 in 13.2% and grades 1-2 in 1.6%. In women, 20% with grade 3 and 3.3% with grades 1-2. These data match the most recently reported data on prevalence of kidney disease in patients with diabetes.[6] By applying CKD-EPI, 1.2% of women and 2.5% of men had worsened grading (Table 1).

If we apply the Bland-Altman graphic method, the results differ from those of Montañés et al.,[1] since there is an average discrepancy of 3.5ml/min (4.4%) favouring MDRD in men and 2.6ml/min (1.7%) favouring CKD-EPI in women (Figure 1). However, our concordance study (intraclass correlation coefficient and Lin coefficient) is greater than 98%.

These differences may be explained by the application of the classical formula (coefficient 186) rather than MDRD-IDMS (coefficient 175) and for the unequal population studied: PC versus the nephrology referral centre, 55% women vs. 30% and 81% with grades 4-5 vs. 63%.

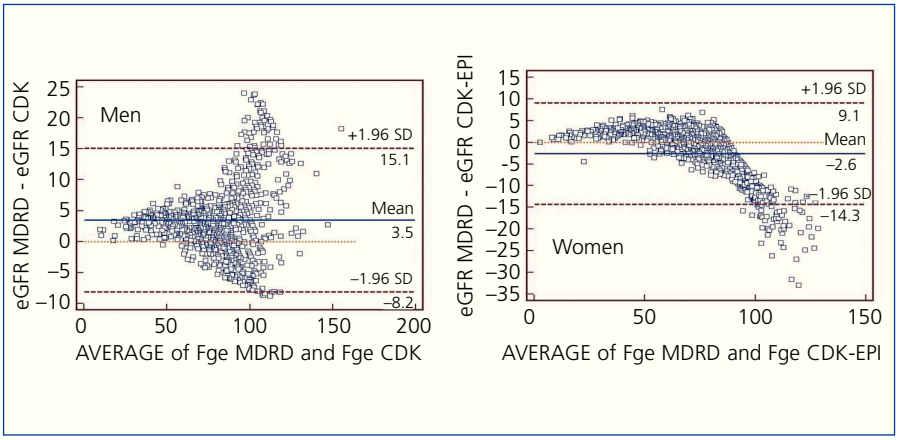

Figure 1. Bland Altman method for concordance between MDRD and CKD-EPI

However, on the other hand, the differences are so small that we can say that the new CKD-EPI formulas are tools that are as useful as MDRD and we hope that they will allow us to raise awareness and increase eGFR requests in primary care.

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Clinical recommendations: an opportunity to introduce research from research networks using scientific societies

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Dear Editor,

As coordinator of the Spanish network Renal Research (REDinREN) at the Carlos III Institute of Health (RETICS 0016/06) I am writing to you requesting that you disseminate this letter.

For three and a half years REDinREN has represented a large portion of the collaborative research being done on nephrology in Spain. That is one of its major objectives. As a result of this work, it has recently obtained approval of its project by the ISCIII for 2 additional years. However, within this evaluation we also had the opportunity to review our individual and joint failures. Among these we have detected the low and slow projection that we have given to much of our research. Since our network is very balanced by the appropriate ratio between basic and clinical research, we cannot afford this situation. With this letter I wish to publicly declare this deficiency and at the same time make an opportune statement that also affects our Scientific Society (SEN). Since it cannot be otherwise, clinical recommendations are the purview of scientific societies. With this public statement I wish to set all REDinREN researchers to this task, probably because our existence as a network depends on it or at least to help ensure that collaborative research continues to be a commitment of science policy (it is a requirement of the ISCIII that we move results worthy of our activity to the SNS).

As a methodology, I propose that any research outcome that takes place in a virgin field for other guidelines or clinical recommendations becomes a recommendation by a mechanism that should always be orchestrated by the SEN, with inclusion of the other research authors. A working group will be formed that will check on the status of the issue with systematic and critical review and will establish the scope and limits of the recommendation. It will reach a consensus on the degree and content of the recommendation. It will be something simple, but the information will remain available as a first for all readers of NEFROLOGIA, where it seems advisable to publish these issues, always at the discretion of the Editor.

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