



TOP TEN TIPS

**1. Indications for annual eGFR:**

- Previously diagnosed CKD
- Risk of obstructive uropathy (neurogenic bladder, urinary stone disease, urinary diversion, possible bladder outlet obstruction)
- High risk of silent CKD (HT, DM, IHD, arteriopathy)
- Nephrotoxic drugs (NSAID's, ACEI/A2RB, ASA's, lithium, calcineurin inhibitors)
- Multisystem disorder with potential for renal involvement,
- 1st degree relative with CKD stage 5.

**2. Safe use of ACEI/ARB:**

- In patients with eGFR <30ml/min consider diuretic withdrawal prior to starting ACEI/ARB.
- Check K+/Creatinine within 2/52 of starting/dose change/increasing diuretics.
- A fall in eGFR of <15% is acceptable, if ≥15% refer for opinion.
- If fall in eGFR of 10-15% recheck within 2-3/52 to ensure non-progressive.

**3. eGFR:**

- The level of GFR approximately equates to the percentage of kidney function compared to a healthy young adult
- Over 40yrs old eGFR normally declines at rate of 1ml/min/yr (1%/yr)
- Multiply by factor of 1.21 if black race

**4. CKD 1&2:**

- A person with a eGFR ≥60ml/min will have CKD only if other evidence of kidney damage; proteinuria, haematuria, abnormal renal structure or abnormal renal histology.
- Urinalysis only recommended if eGFR ≥60ml/min in presence of other risk factors (see tip 1 above)

**5. Repeat eGFR in CKD during an acute illness:**

- If eGFR declines by >25% in context of an acute illness without a readily identifiable reversible cause, the patient should be considered to have acute renal failure and should be referred urgently to a nephrologist for an opinion

**6. BP management:**

- Most patients will require 3 or 4 antihypertensive agents to achieve desired BP.
- ACE/ARB plus diuretic are first 2 agents for almost all CKD patients
- 'Lo-Salt' should be avoided because it contains potassium
- Patients with diabetes often retain sodium and often need loop diuretics to help BP control
- All patients with diabetes and microalbuminuria should be prescribed an ACEI/ARB regardless of BP

**7. QOF 2006/7**

- GP practices to produce a register of patients ≥18yrs old with CKD stage 3-5
- The % of patients on CKD register with BP measure in last 15 months
- The % of patients on CKD register with BP reading ≤140/85mmHg in last 15 months
- The % of patients on CKD register with hypertension treated with and ACEI or ARB (unless contra-indicated)

**8. Protein-Creatinine Ratio:**

- Proteinuria is best measured on a spot urine sample (ideally early am) for protein-creatinine ratio (PCR)
- Proteinuria ≥1+ on urine dipstick should be quantified with PCR
- Multiply PCR (mg/mmol) by factor of 10 to approximately convert to 24hr excretion rate (g/24hr)

**9. CKD is a potent cardiovascular risk factor:**

- Patients with all stages of CKD have a greatly increased risk of morbidity and mortality from cardiovascular disease
- Treat all cardiovascular risk factors aggressively

**10. If in doubt get in touch:**

- Contact xxxx