

Letters

All letters are subject to editing and may be shortened. Letters should be sent to the BJGP office by e-mail in the first instance, addressed to journal@rcgp.org.uk (please include your postal address). Alternatively, they may be sent by post as an MS Word or plain text version on CD or DVD. We regret that we cannot notify authors regarding publication. Letters not published in the Journal may be posted online on our Discussion Forum. For instructions please visit: <http://www.rcgp.org.uk/bjgp-discuss>

Managing chronic kidney disease

The June editorial¹ makes it clear what the authors feel the responsibilities of primary care are in the management of CKD.

May I be allowed to list the responsibilities of secondary care and policy makers?

1. CKD came out of nowhere for most GPs. We still have inadequate information about it. Why is it called a disease when really it is more like a sign of end organ damage? GPs treat retinopathy related to diabetes and hypertension. Is this not a nephropathy?
2. Outcomes: I am not interested that the hazard ratio (HR) for death is 1.8 alone. The HR for bowel cancer if you eat pepper on your food is much the same. My understanding is that the causation link between CKD and heart disease has yet to be established and deaths in patients with CKD tend not to be from atheromatous disease. Is that right?

Can we be sure that screening for CKD and then treating patients as high risk of CHD will really make a difference? What I need to know are some real figures, such as the number needed to treat. At every meeting I have attended no nephrologist has been able to tell me how many patients I will need to treat for their CKD stage III to save a life. I know they are at greater risk of dying. It is whether we can do anything to change that. Not one nephrologist has had the answer. Perhaps you do?

I now have some experience of managing CKD and it seems to me that there are two main groups:

- The first is the patient who has borderline CKD III. One month it is 54 the next >60, and I look back through their 10 years of records and find their creatinine was even worse 5 years ago. These make the majority of my patients and are creating enormous levels of work (and worry). Have the opportunity costs of CKD screening been taken into account? Do you have figures for what they are? Does treating these aggressively make any difference? I need some good research to be convinced.
- The second is the patient with the declining estimated glomerular filtration rate. These patients are needles in the haystack. Of 10 000 patients in the practice I can expect very few. These need monitoring and having the burden of iatrogenic poisons lifted and properly treated and monitored. I think all GPs understand this will prevent many suddenly coming to dialysis (but not all, and I hope nephrologists will stop their 'tut-tutting' every time they see a patient that the GP has 'missed').

I was at the Kings Fund recently when the QOF targets for blood pressure management in CKD came up. A professor from Birmingham, I think, said how surprised she was that this target was not being hit. Yet the target is very tough, and most hypertension studies (ASCOT for example) show even in the environment of a study a minority of patients hit this level of target.

GPs' primary role is to be the patient advocate, and to ensure we do the best for them. Many of us are not yet convinced that good data supports NICE guidance that was based largely on consensus among nephrologists with little experience of primary care.

I am not suggesting that GPs don't

bother. I am suggesting that good medicine required thought, evidence, and discussion. We are partners as you say.

James AH Cave,
*The Downland Practice, East Lane,
Chieveley, Newbury, Berkshire, RG20 8UY.
E-mail: james.cave@nhs.net*

REFERENCE

1. Brady M, O'Donoghue D. The role of primary care in managing chronic kidney disease. *Br J Gen Pract* 2010; **60**(575): 396–397.

DOI: 10.3399/bjgp10X514828

If I were to invent a new disease, I would want to give it a name that would grab peoples' attention. I may use the example of the evangelical preacher, whose common strategy is to find words with strong emotional resonance and then juxtapose them. Chronic Kidney Disease. Brilliant.

Your editorial by Brady and O'Donoghue¹ is commendably full of talk of holism and encouraging patients to take ownership of their problem. Before, however, I empower one in 10 of my patients to take irreversible ownership of this terrifying label, I feel I ought to at least question both the appropriateness of eGFR as a screening test and the evidence for improved outcomes in earlier diagnosis. I keep typing both into Google™ and the results so far aren't good.

Perhaps the faith of the evangelist should be enough for me?

Roger Tisi,
*GP Principal, Audley Mills Surgery, Rayleigh,
Essex. E-mail: rbtisi@googlegmail.com*

REFERENCE

1. Brady M, O'Donoghue D. The role of primary care in managing chronic kidney disease. *Br J Gen Pract* 2010; **60**(575): 396–397.

DOI: 10.3399/bjgp10X514837