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US Preventive Services Task Force Will Consider CKD Screening Recommendation

USPSTF Responds Positively to Request from Coalition for Kidney Health

By Eric Seaborg



The US Preventive Services Task Force (USPSTF) will consider adding screening for chronic kidney disease (CKD) as a potential recommendation in response to a nomination from the Coalition for Kidney Health. The coalition submitted its request in December 2021 and received a response in February 2022, stating that USPSTF has added “Screening for CKD” to its “list of preventive services topics under active consideration.”

The positive response kicks off a thorough, multi-year review, according to Miriam Godwin, health policy director at the National Kidney Foundation (NKF), whom the coalition designated as its contact person in its request to USPSTF. Godwin said that the coalition is asking that USPSTF bring its screening recommendations into concordance with established evidence-based guidelines from the NKF and the American Diabetes Association, which recommend that high-risk individuals be screened for CKD.

The letter from USPSTF notes that the task force has a large portfolio of suggested topics “to work on as part of its deliberative process, and it may take some time” to turn its

attention to CKD. The letter only commits the task force to “begin the process of determining when to begin work on a new recommendation,” and it will decide later whether it will “prioritize” CKD to consider this year.

Turned down in 2012

USPSTF last reviewed kidney screening in 2012 and concluded that “the evidence on routine screening for CKD in asymptomatic adults is lacking and that the balance of benefits and harms cannot be determined.” But the coalition notes that this nomination is different because “rather than general population or mass screening,” it wants the task force to consider current evidence that supports testing of individuals at risk for CKD, including those with diabetes, hypertension, cardiovascular disease, family history of kidney diseases, or a history of acute kidney injury.

In the 2012 review, the task force found little evidence of a benefit from early intervention and even “convincing evidence...that medications used to treat early CKD may have adverse effects.” But the drug-treatment realm has changed

Continued on page 8 ➤

ASN Commits to Reconsidering Future of Nephrology

By Eric Seaborg

ASN plans to lead the kidney community in reconsidering “every aspect of the future of nephrology” over the next 8 months, ASN President Susan E. Quaggin, MD, said in a March letter to the American Board of Internal Medicine (ABIM) Nephrology Board and the Accreditation Council for Graduate Medical Education (ACGME).

Quaggin was responding to separate messages from the two organizations asking for ASN’s input on major revisions of their certification and training program requirements.

In a letter to Quaggin in January, the ABIM Nephrology Board wrote, “For some time the nephrology community has grappled with whether or not certain procedures (temporary dialysis catheters and kidney biopsies) should remain a required procedure for nephrology fellows to learn to perform competently and whether other requirements should be strengthened like training for peritoneal and home hemodialysis.” The letter asked for ASN to share its views on these and other procedures by February 25.

Continued on page 7 ➤

Inside

Basic Science Research

Our special section looks at how recent developments will lead to improved therapies for people with kidney diseases.



Hypertension in pregnancy

New scientific statement from the American Heart Association



Policy Update

ASN advances key legislative priorities during Kidney Health Advocacy Day.



New educational tools contest

Contest aims to promote educational tools spanning heart disease and kidney diseases.

CKD Screening

Continued from cover

radically in the intervening decade with the advent of efficacious new medications, several experts told *Kidney News*.

“We have many more effective tools than we did in 2012,” said Frank “Chip” Brosius, MD, a professor in the Division of Nephrology at the University of Arizona in Tucson. “Back in 2012, essentially all we had was blood pressure control, good blood sugar control in those that have diabetes, and then either an ACE [angiotensin-converting enzyme] inhibitor or angiotensin-receptor blocker in at least some of the CKD patients. Now we have these newer classes of medications that were brought out 15 years ago as diabetes drugs.”

Sodium glucose co-transporter 2 (SGLT2) inhibitors and glucagon-like peptide 1 (GLP-1) receptor agonists were once considered niche drugs, but they gained widespread acceptance when “the cardiovascular outcome studies that included kidney endpoints started coming out about 6 years ago. It became clear that at least these two classes of medications had pretty profound cardiovascular protection for chronic kidney disease patients and also had positive effects on preserving kidney function,” Brosius said.

Two common tests

The request letter from the coalition also notes that CKD screening is practical because it can be implemented by a pri-

mary care clinician using two readily available tests: estimated glomerular filtration rate based on serum creatinine and urine albumin-creatinine ratio. NKF’s Godwin said a USPSTF recommendation would be significant because many primary care physicians look to it for guidance.

Brosius agreed that if the USPSTF includes CKD screening in its recommendations, then primary care physicians will be more cognizant of its importance and pay more attention to the potential consequences. Serum creatinine is part of the standard testing panel that patients undergo for many primary care visits—including annual physicals—but too often, abnormal results are ignored. “The doctor doesn’t recognize it or doesn’t recognize its importance and doesn’t tell the patient,” Brosius said. Similarly, obtaining “an albumin-creatinine ratio in the urine just doesn’t happen at anywhere near the level that it should,” he said.

A screening recommendation would raise the awareness among primary care physicians to pay more attention to these tests, Brosius said, with the potential benefit of beginning early intervention while the condition is more manageable. “Despite being preventable and treatable, CKD is too often not intensively managed until a patient has progressed to kidney failure,” the coalition letter notes. “An estimated 37 million Americans have CKD, and the vast majority are unaware.”

In the 10 years since the 2012 decision, rates of kidney diseases have continued to grow in tandem with the greatly rising rates of diabetes. CKD has grown to become the ninth leading cause of death in the United States.

Countering racial inequities

Another aspect of medicine that has changed drastically since 2012 is the recognition of systemic racial inequity and the resolve to take action to combat it, particularly in the kidney community, according to David L. White, regulatory and quality officer at the American Society of Nephrology. Increased screening would help to address inequity, because Americans of Black race are significantly more likely than those who are White to have diabetes—the leading cause of CKD—as well as more likely to experience its downstream consequences, including kidney failure and death.

The agreement by USPSTF to consider screening for CKD is the first step in a well-defined and exhaustive process. “[It is] a highly evidence-based body and really process oriented,” Godwin said. “There are public review periods with opportunities for public comment.” The Coalition for Kidney Health and other organizations will ensure that nephrologists are well represented in the review process, Godwin said.

“The absence of a current CKD screening recommendation exacerbates the lack of attention paid to the growing kidney disease public health crisis and contributes to the low rates of CKD diagnosis in the primary care setting,” the coalition letter notes. It continues, “We believe that the opportunity to improve outcomes for CKD patients warrants a CKD screening recommendation for patients at high risk of CKD.” ■

ASN President’s Update Close the Gap— Time for a Kidney Health Check

By Susan E. Quaggin



“Doc, I was told I have stage 5 kidney disease. What happened to stages 1 through 4?”

Almost every nephrologist, including myself, has had this heartbreaking and far too common question asked of them by patients receiving their diagnosis of kidney disease for the first time. Even worse: A patient first learns about kidney function coincident with placement of a catheter to initiate urgent dialysis.

Not surprisingly, these diagnoses trigger a mixture of emotions: fear, anxiety, disbelief . . . anger. It is time we do better.

The first diagnosis of kidney disease as kidney failure is truly a failure—of the system. It should come as no surprise that underserved communities with lack of access to health care services and timely intervention are vastly over-represented in this category.

One decade ago, the US Preventive Services Task Force (USPSTF) reviewed the literature and current knowledge available (at that time) to support population-based screening for chronic kidney disease (CKD). In its summary statement, the task force concluded that no data existed to support a recommendation that intervening early in CKD is beneficial (1).

In 2013, the American College of Physicians (ACP) published its guidelines on screening for kidney diseases in the *Annals of Internal Medicine*, advising against testing for proteinuria in adults with or without diabetes who are currently taking an angiotensin-converting enzyme inhibitor (ACEi) or

an angiotensin II receptor blocker (ARB) (2). Bruce A. Molitoris, MD, FASN, ASN president at the time, responded with an article highlighting the potential dangers, weaknesses, and risks inherent in the recommendations by ACP (3).

Ten years later, in February 2022, USPSTF added “Screening for CKD” to the list of preventive services topics under “active consideration” following nomination and wide support from ASN, the National Kidney Foundation (NKF), other members of the kidney community, and members of Congress (4). Although the task force’s decision to re-evaluate its decade-old finding is a hopeful advance for patients and the community, there is no guarantee that CKD screening will be prioritized this year. In its response letter, the task force acknowledged that kidney diseases are a serious public health issue and emphasized that kidney diseases disproportionately affect communities of color but did not indicate a timeline for reconsidering its position.

It is important to recognize that several members of the kidney community have argued against screening of asymptomatic patients, citing studies that identifying CKD does not alter management of patients as long as blood pressure and glucose are controlled (5). Of course, these studies report on those lucky enough—no, *those privileged enough*—to have access to health care when they received their diagnoses of hypertension or diabetes and who were lucky and privileged enough to receive appropriate treatments. As outlined in the KDIGO (Kidney Disease: Improving Global Outcomes) report, which makes the case for CKD screening in at-risk individuals, the authors point out that the burden of CKD falls on the socially disadvantaged and vulnerable (6).

Furthermore, the studies that do not support screening predate the overwhelming and numerous positive clinical trials demonstrating the power of “flosins” (sodium glucose co-transporter 2 inhibitors [SGLT2i]) to prevent mortality, kidney function decline, and cardiovascular disease in people with kidney diseases, regardless of whether the patient has diabetes (see EMPA-REG and CREDENCE trials) (7). In fact, data from the DAPA-CKD trial were so spectacular that the US Food and Drug Administration (FDA) granted breakthrough status for the use of this SGLT2i in patients with CKD, with or without diabetes—the first time ever for a kidney-targeted therapy. Recently, the flosins have been joined by additional classes of medications, including the nonsteroidal mineralocorticoid receptor antagonists and glucagon-like peptide 1 (GLP1) agonists, which have been added to the ever-growing menu of beneficial kidney treatments (see FIDELIO trial) (Figure 1).

Indeed, the ACP guidelines that recommended against screening for proteinuria in patients with diabetes and CKD (i.e., diabetic kidney disease [DKD]) contradict more current guidelines from the American Diabetes Association and KDIGO, which recommend SGLT2i and/or finerenone for patients with proteinuria on therapeutic renin-angiotensin system (RAS) blockade. (Please note that ACP’s guidelines expired after 10 years and are no longer in effect.) The outdated belief that “early identification of CKD is pointless because we have no therapies” no longer applies.

That is not to say screening of the general population—particularly low-risk individuals—is automatically warranted or that the importance of having USPSTF revisit the issue should be discounted. However, it is hard to imagine that screening the one in three Americans at risk of kidney diseases—so-called “case finding”—is not warranted. The use of creatinine in combination with urine albumin (uACR) measurement in patients at risk formed the basis of the request to USPSTF by ASN, NKF, other members of the kidney community, and members of Congress.

In the United States, a majority of “crash starts” for dialysis in hospitals occur in patients from underserved communities, where social and political determinants of health determine who has access to care and to treatments that can protect the kidneys and save lives. The failure to detect kidney diseases in these populations is yet one more example of pervasive racism in the health care system. How can we do better?

In Canada, the Can-SOLVE CKD Network launched a program to promote kidney health in First Nations communities (8). Kidney Check provides point-of-care testing for kidney function (creatinine and urine protein), hypertension, and diabetes. Built on the central symbol of *Meyayawin* (getting better), the project is guided by an Elder, with truth and reconciliation recommendations, a diverse and inclusive team, and shared concepts, such as Two-Eyed Seeing, which recognizes that Indigenous and Western knowledge can exist in parallel (9). A single finger-prick blood sample and urine protein analysis on-site provide real-time results and a kidney health plan, tailored to the patient’s needs (10).

Similar to at-risk communities in the United States, the First Nations communities are at higher risk of kidney diseases and kidney failure than the general population. In both Canada and the United States, one in every 10 people is estimated to have kidney diseases, whereas in Canadian First Nations communities, that number increases to one in three. In the United States, individuals of Black race or African Americans are almost four times more likely to develop kid-