Business Shifts Likely to Shape Future of Nephrology

By Bridget M. Kuehn

The merger between pharmacy giant CVS and health insurer Aetna is among the latest shake-ups in the healthcare industry that are likely to have ripple effects on nephrologists and patients with kidney diseases. The merger was finalized on November 28, 2018.

For nephrologist Bruce Culleton, MD, vice president of CVS Health, the CVS-Aetna merger offers the prospect of a new care delivery model that better meets patients’ needs.

“We believe this type of consolidation encourages the development of business models that are more patient-centric and more holistic than the current paradigm, which is focused on in-center dialysis care,” Culleton said. “Future models will support chronic kidney disease identification and care, dialysis options education with an emphasis on access to transplantation and home dialysis, and innovation to deliver improved outcomes at lower overall healthcare costs.”

Other experts in nephrology are cautiously optimistic that the merger could lead to new models of care and possibly better care for chronic diseases like hypertension that lead to kidney disease. But they also acknowledge that it is difficult to predict how this unusual merger might affect competition, costs, and quality.

Most research to date on consolidation in healthcare has focused on mergers between care providers like hospitals or dialysis providers, which have mixed effects on care quality, access, and cost.

Seismic shifts

The Aetna-CVS merger will bring together a large national insurance company with a powerhouse in the pharmacy and retail clinic space. The goal, according to a statement from CVS Health President and Chief Executive Officer Larry J. Mello, is to create a better experience for healthcare consumers by merging Aetna’s data and analytics with CVS frontline care.

It’s also a move to protect CVS’s mail order and pharmacy business lines, noted Janis Orlowski, MD, chief health care officer of the Association of American Medical Colleges. She explained that pharmaceutical manufac-

Debate Rages on About Role of Obesity in Transplant Outcomes

By Bridget M. Kuehn

Obesity should not disqualify patients from kidney transplants, suggested one study presented at Kidney Week 2018, while two other studies provided conflicting information on whether pretransplant weight loss may be beneficial.

The prevalence of obesity in both adult and child prospective kidney transplant recipients has increased, mirroring a trend in the general population.

Observational studies have found that higher body mass index (BMI) is associated with an increased risk of delayed graft function, noted Krista Lentine, MD, professor of internal medicine at Saint Louis University School of Medicine, and colleagues, “but [higher BMI] is often not associated with inferior long-term allograft or patient survival in these studies.” There are, however, increased risks of performing transplantation on patients who are obese compared to normal weight patients, including more surgical site complications, and there is some evidence of increased cardiovascular complications, noted Lentine, who has published a review on the topic.

“The debate regarding the impact of obesity on out-

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comes before and after kidney transplantation, and impli-
cations for transplant candidacy, have been weighing for
decades," Lentine said. "Part of the uncertainty and difficulty
deciding the debate relates to limitations of a BMI, which is
a measure of overall body size, and not specific for adiposity,
as well as the limitations of available data."

The studies presented at Kidney Week are likely to add
fuel to the debate, though they are unlikely to resolve it.
"Registry analyses can be very useful for hypothesis gen-
eration, but are also potentially limited by selection bias and
uncontrolled confounding due to the nature of the available
data," Lentine said.

Cutoff conundrum

It’s common for transplant centers to consider BMI in assess-
ing transplant candidates and opting against transplant for patients with BMIs above a set threshold.

"The impact of recipient obesity on long-term outcomes
for kidney transplantation is not clear," said Bhavna Chopra,
MD, a nephrologist in the renal transplant program at
Allegheny General Hospital in Pittsburgh.

In further assessing the effects of BMI on transplant
outcomes, Bhavna and her colleagues used United Network of
Organ Sharing data to identify all cases between 2006 and
2016 where each of a deceased donor’s kidneys were trans-
planted into a different recipient. They looked at 39,354
paired kidney recipients who shared a donor to assess the
effects of BMI on outcomes. Recipients with BMIs between
18 and 25 had significantly lower risks of death-censored
graft failure and graft failure compared with patients whose
BMIs were above 35, but risk of death was similar between
the groups. Recipients with BMIs between 25 and 30 had
a lower risk of death-censored graft failure than individuals
with BMIs 35 and up, but the two groups had similar rates
of graft failure and death.

Bhavna suggested that the non–inferior outcomes among
patients with BMIs above 35 may reflect careful pretrans-
plant selection in this subgroup for those most likely to have
a successful outcome. Or it could reflect a survival advantage
similar to that seen in patients who are obese and on dialysis,
she noted. Lentine agreed that patient selection could have
an impact on the outcome of an observational study.

"[Patients with obesity] who are selected for listing and ubi-
mate transplantation are inherently healthier than the full pop-
ulation of [patients with obesity] with kidney failure," she said.

Based on the data, Bhavna suggested kidney transplan-
tation BMI cutoffs between 35 and 40 are "arbitrary and
unfounded."

"Potential kidney transplant recipients should not be ex-
cluded from UNOS transplantation solely on the basis of
obesity; however, transplant patients [with obesity] should
careful optimization prior to surgery to minimize perio-
derative morbidity and reduce the likelihood of additional
graft injury," Lentine said. However, Lentine argued for considering both transplant
center and patient-level factors in decision-making.

"I believe that obesity is prognostically important and
potentially modifiable, but that it is also difficult to prescribe
a one-size-fits-all threshold for candidacy across transplant
programs," she said. She explained that not all centers have
the expertise to manage patients with obesity during and af-
after transplantation or may have lower tolerance for surgical risks
or for the potential elevated costs.

She argued for considering the potential risks and ben-
efits of transplant for patients with obesity and engaging pa-
tients in shared decision-making.

"At a minimum, we advocate for lifestyle alterations such
as healthy diet and appropriate exercise," she said. However,
she noted transplant programs may have limited interactions
with waiting list patients; so primary nephrologists may need
to take a larger role. However, she noted the few data to
guide such interventions, and patients and physicians may
have limited resources to pursue them.

Lentine cautioned that "observational registry studies
have not identified beneficial outcomes among ESRD pa-
cients who lost weight before transplantation; however, it is
critical to recognize that association studies cannot distin-
guish intentional from unintentional weight loss as a result of
ill in our volume overloaded patients, excess inflammation in
the frailty phenotype, and even malnutrition for patients
who take on aggressive weight loss strategies in the setting of
end stage kidney disease."

To better understand how such circumstances may af-
fect transplant outcomes, Harhay and her colleagues used
United Network of Organ Sharing’s national registry of
adult deceased donor kidney transplants between 2005 and
2014. They found a steep increase in the risk of death among
recipients who lost 10% or more of their body weight prior
to transplant. When they adjusted for potential confounders
like waiting time and dialysis vintage, they found those who
lost 10% or more of their weight pretransplant had a 14%
greater risk of dying posttransplant.

"Obese and morbidly obese recipients who lost 10% or
more of their body weight between listing and transplantation
showed the same association of higher mortality risk, ad-
justed for all those factors, as did the underweight, normal
weight that came onto the list and lost weight," she said.

Lentine emphasized the limitations of the available data
to resolve these questions. "I strongly advocate for ongoing research, including investi-
gation of more accurate measures of body composition beyond
BMI, and prospective studies, including prospective evalu-
ations of intentional weight loss in patients who are obese," Lentine said. "For now, pending more evidence, I believe that
pursuing and maintaining healthy body composition based on
guidelines for nutrition in renal failure are important priorities for kidney transplant candidates and recipients."