Leading European Nephrology

NEWS

European Renal Association –
European Dialysis and Transplant Association

New Guideline on Management of Older Patients with Chronic Kidney Disease

November 2, 2016

In the industrialized world, the average age of dialysis patients is constantly rising. People have now a significantly higher life expectancy than 50 years ago, and chronic kidney disease (CKD) is a disease that often occurs in older age. The CKD and dialysis populations are aging, thus posing new challenges for nephrology. Older patients have more comorbidities, a different physiology and, of course, a shorter life expectancy. The latter aspect, especially, may impact therapeutic decisions, for example whether renal replacement therapy should be initiated or conservative treatment be maintained.

To face the challenges posed by this growing subgroup of CKD patients, the European Renal Best Practice Group has now published the "Clinical Practice Guideline on management of older patients with chronic kidney disease stage 3b or higher (eGFR<45ml/min/1.73m^2)".

"The Guideline intends to provide an evidence-based rationale and, thus, to facilitate informed decision-making on the management of older patients with CKD", explains Prof. Wim Van Biesen, the European Renal Best Practice chairman. "But old is not always old, meaning that chronological age and biological age may differ substantially. The Guideline therefore recommends that frailty scores and life expectancy be taken into account. The logic of the Guideline is to deliver a kind of risk stratification that helps to determine the best clinical management for each individual patient."

[See attachment for the full interview with Prof. Van Biesen]

Interested in reading the Guideline?
http://ndt.oxfordjournals.org/content/31/suppl_2

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About ERA-EDTA

With more than 7,500 members, the ERA-EDTA ("European Renal Association – European Dialysis and Transplant Association") is one of the biggest nephrology associations worldwide and one of the most important and prestigious European Medical Associations. It supports basic and clinical research in the fields of clinical nephrology, dialysis, renal transplantation and related subjects. The ERA-EDTA supports a number of studies as well as research groups and has founded a special "Fellowship Programme" for young investigators as well as grant programmes. In order to involve young nephrologists in all activities of the ERA-EDTA the Council decided to create a Young Nephrologists' Platform (YNP). Besides, it has established various research networks and different working groups to promote the collaboration of nephrologists with other medical disciplines (e.g. cardiology, immunology). Furthermore, a "European Renal Best Practice" (ERBP) advisory board has been established by the ERA-EDTA to draw up and publish guidelines and position statements. Another important goal of the ERA-EDTA is education: several series of CME-courses as well as the annual congress offer an attractive scientific programme to cover the need of continuous medical education for doctors working in the fields of nephrology, dialysis and transplantation. The association's journals, NDT (Nephrology, Dialysis, Transplantation) and ckj (Clinical Kidney Journal), are currently the leading nephrology journals in Europe. The ERA-EDTA Registry is a large epidemiologic database comparing countries by assessing nephrology practice throughout Europe. Finally, ERA-EDTA is member of the European Kidney Health Alliance (EKHA), a consortium of renal societies that actively interacts with the European Parliament. For more information please visit www.era-edta.org

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Interview with Prof. Wim Van Biesen, MD, PhD, Head of the Renal Division, Ghent University Hospital, ERBP Chairman

Why is a special guideline for the management of older CKD patients necessary?

Well, a special guideline is needed because older patients are a subgroup with very special characteristics. First of all, they have a shorter life expectancy - which may impact important therapeutic decisions. Second, these patients show significant differences in physiology that affect drug absorption. They may need different dosages of medication. Last but not least, older patients often have more comorbidities and require a special interdisciplinary approach. For these reasons, we found that a specific guideline was necessary.

What exactly does "old" mean? Which age group is covered by this Guideline?

To be honest, that is a difficult question to answer, and one that we discussed intensively in the guideline development group. For practical reasons, we defined the age of 65 or more as the threshold for this Guideline, although we know that chronological age alone is not sufficient

to define "older patients". What matters is a person's "biological" age, so we intended to base decisions on functional status rather than calendar age. Just to make it clear: We don't say that every patient over 65 is an old patient, but at this age we should start to consider screening and to find out about the functional status and eventual frailty of patients.

Many GPs measure only serum creatinine in order to diagnose CKD. Why is this not enough, especially with older people?

As creatinine is routinely measured, we need to rely on it as a kind of starting point. Of course, the eGFR is a better diagnostic tool. It is based on serum creatinine levels, but also takes age and gender into account. Creatinine alone may produce a false-negative result in sarcopenic persons – and many old people indeed have low muscle mass. This means that CKD might be underdiagnosed in these patients, if one looks at serum creatinine only. The eGFR is more reliable in that respect. On the other hand, a decreased eGFR can in older patients just indicate "physiologic" ageing, and not true kidney disease. Therefore, another important parameter that also indicates disease progression is albuminuria. Taken together, GFR and albuminuria provide a good indicator of the status quo and future evolution of kidney function. This is important for the orientation of treatment: If a patient's CKD progresses, we need to focus on renoprotective measures and on preparation for renal replacement therapy. If the GFR is stable and does not progress, we do not have to bother about these things, but should focus instead on maintaining the nutritional status and functional status in these patients. However, in very old or comorbid patients, especially, it is important to take life expectancy into account as well. The logic of the Guideline is to deliver a kind of risk stratification that helps to determine the best clinical management for each individual patient based on all these considerations in a holistic approach.

But isn't the evaluation of frailty very complex and time-consuming?

No, we recommend nutritional and functional status scores that are very basic and simple and which can be performed very quickly. The underlying idea was that these tests have to be done repetitively. Only then do you see whether the general health status of the patient has changed and if he or she is in need of special care (e.g. geriatrics). This is why we wanted to keep the tests very basic and very simple. In case the test signals that the patient is at risk, he or she should be referred to a geriatric program for more in-depth testing.

How can old CKD patients improve their functional status?

We know that the best outcomes are achieved with a multidisciplinary approach. The collaboration of nephrologists, geriatricians, physiotherapists and nutrition counsellors is very promising, whereas single-discipline interventions are much less successful. Although we do not usually see big changes, even with a multidisciplinary approach, we have to keep in mind that even small changes can have a big effect. A 10% rise in functional status, for example, can make the difference between being able to live at home or having to be transferred to a nursing home – and this makes the world of a difference to the patient and for his or her quality of life!

What if a very old and frail person is in need of renal replacement therapy? Can conservative treatment be an option, too?

The guideline group thinks it is important to present conservative treatment as a potential option in patients with a low life expectancy. This option is quite often neglected. When you have a high risk of dying within the next 3 or 6 months, conservative care might be preferable in terms of quality of life than renal replacement therapy. So this is something that you need to discuss with the patient – and what we aim for is shared decision-making: we want to provide the physicians and patients with the information they need to come to shared decision, so that the expectations and goals of the patient can be achieved as much as possible.