Chronic kidney disease

Recently the College distributed a new set of guidelines: 'Promoting good CKD management'.[1] Raising awareness of chronic kidney disease (CKD) is a good thing as CKD often goes unrecognised in primary care.[2] People with CKD are at higher risk of cardiovascular disease and all cause mortality is also increased.[3–5] Strict control of blood pressure improves outcome,[6] angiotensin-converting enzyme inhibitors (ACE-I) and angiotensin receptor blockers (ARB) are particularly effective.[7]

There are two points in the guidance which need careful consideration. Firstly it may be unhelpful to a glomerular filtration rate (GFR) of 100ml/min/1.73m^2 as normal. Secondly, it may not be cost-effective to require the 6% of the population, who with the advent of reporting estimated GFR have been newly been diagnosed as having CKD (eGFR<60ml/min/1.73m^2), to all have a parathyroid hormone (PTH) tests.

While the mean GFR in adult kidney donors up to age 40 years has been reported normally distributed with a mean of 100ml/min/1.73m^2 (SD = 15)[8] the population in general practice who have their creatinine measured, and therefore GFR estimated, may be unwell or being tested as part of a chronic disease management programme.

In a registered GP population of approximately 50 000 people 26% (28% women and 22% men) had their GFR estimated. The mean eGFR for was men 75.6ml/min/1.73m^2 (SD = 19.0) and for women 69.2 ml/min/1.73m^2 (SD = 20.2). Only males aged 20–24 years have a mean eGFR at the 'normal' level quoted; and a majority of women over 75 years and men over 80 years have eGFR <60ml/min/1.73m^2. However, loss of renal function with age is largely attributable to hypertension; CKD should be treated with aggressive risk factor reduction regardless of age.[9]

Only 13 women and three men in the sample have a record of having their PTH tested. PTH tests cost between £12 and £18; and it is recommended that if PTH is raised a vitamin D blood test, costing a further £10 to £19, is carried out. Before everyone with newly diagnosed CKD (eGFR <60 ml/min/1.73m^2) is sent for a PTH tests, careful appraisal is needed of the evidence-base for these tests. The potential benefit of early detection and treatment is that hyperparathyroidism is associated with low vitamin D levels,[10] which, in turn, predisposes to poor bone mineral density and fractures.[11] These changes may be amenable to reversal by the administration of calcium and vitamin D. However, there is limited evidence that early detection of renal osteodystrophy in people with stable moderate CKD improves outcome.[12]

In summary, GPs should expect that around 6% of their practice population (8.5% of women and 4% of men) to have CKD. While disturbance of bone and mineral metabolism offers an avenue for intervention in terms of improving biochemical markers, further research is needed to know whether outcomes are improved in this group. A pragmatic approach would be to measure PTH in all new diagnoses of stage 4 and 5 CKD (eGFR <30ml/min/1.73m^2) and in stage 3 (30–59ml/min/1.73m^2) where deteriorating renal function leads to referral. Meanwhile management of cardiovascular risk in CKD should remain paramount. GPs should concentrate on tight control of blood pressure, ideally using ACE-I or ARB and conduct medication reviews as suggested in this guidance.

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Ever been HAD?

Tony Kendrick[1] has produced some evidence that shows that the use of the Hospital Anxiety and Depression Scale can lead to more selective prescribing of antidepressants. This does not surprise me at all, and if he reads my column[2] again, he will find that nowhere do I suggest that the use of scales 'will encourage antidepressant prescribing'. My concerns are more profound than the simple issue of the level of prescribing, and I think they are worth re-iterating, especially since Tony was involved in developing the Quality and Outcomes Framework (QOF) mental health indicators and has not responded to the deeper thrust of my opinion piece.

Put briefly, I have two points to make, one specific to the management of depression, the other more general. Specifically, I fear that the routine use of depression scoring scales will detract from the human interaction between doctor and patient that is so vital to the consultation, especially when approaching emotional and psychological issues. To provide evidence for and against this proposition would require a far wider remit than the one used in Professor Kendrick's study, and might be almost impossible. Unless and until such evidence is available, I strongly believe that individual GPs should be allowed to follow their own approach to management, which may or may not include the (selective) use of quantitative screening instruments.

The more general point relates to the insidious and apparently unstoppable trend towards centrally dictated micromanagement of primary care by government, aided and abetted by expert advisory groups and mediated through the QOF. The Back Pages carry pieces lamenting this trend in every issue (see Mark Vorster's letter and Mike Fitzpatrick's column in the October issue for examples), as does every other current UK medical journal and newspaper. Practice common rooms echo the same tune, and I don't know of a single GP colleague who does not regret at least a part of this takeover of our professional independence.

What can we do about it? I suggest that at the very least we can fight back — at some cost to our own pockets — by declining to comply with those parts of the QOF that offend us the most.

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Malignancy and deep vein thrombosis

Oudega *et al's* neat study of malignancy and deep vein thrombosis (DVT) in the September issue found that 4.4% of patients with a DVT went on to have a malignancy diagnosed in the next 2 years. We have performed a similar — albeit retrospective — study of 813 patients diagnosed with either a primary colorectal (*n* = 349), prostate (*n* = 217) or lung (*n* = 247) cancer during 1998–2002.[1–4] Each case was matched with five controls without the cancer of interest for age, sex and doctor's surgery. We coded the records for 2 years before the diagnosis for both cases and controls. Only 10 of the 813 cases had had a DVT confirmed (nine in the last year), and a further nine of 4059 controls had a DVT (four in the last year). In addition, three cases (one in the last year) and five controls (two in the last year) had had a pulmonary embolism. Combining the two conditions gives a likelihood ratio for thrombo-embolic disease in the year before a new cancer of 8.5 (95% confidence interval = 3.1 to 22%). These thrombo-embolic conditions occurred in the age group at risk from cancer. The UK population over 40 years of age is approximately 30 million, and these people have approximately 250 000 new cancers, giving an annual risk of developing a new cancer of approximately 0.83%. Using Bayes' theorem, the risk of a new cancer being identified following thrombo-embolism can be estimated to be 6.6%, which is not dissimilar to Oudega's figure.

The key clinical decision is whether to investigate an apparently spontaneous thrombo-embolism for an underlying cancer. On the face of it, a risk of 4.4% (Oudega) or 6.6% (this study) appears to warrant investigation, at least by simple measures.

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Warfarin for atrial fibrillation

In their paper on the safety of antithrombotic therapy for atrial fibrillation, Burton and colleagues point out that patients with atrial fibrillation in the community are older and have more comorbidity than those included in trials.[1] This is very topical as UK GPs go through their registers of patients with atrial fibrillation with a view to maximising their Quality and Outcomes Framework points and related income in 2007.

In August 2006 we examined the medical records of all 43 patients known to have persistent atrial fibrillation in our practice. As in Burton's study, the mean age of the patients was 77 years (range = 56–94 years), but five (12%) were of African origin reflecting our inner city population. Eighteen patients (42%) were on warfarin, 16 on aspirin, two on clopidogrel and seven did not seem to be taking any antithrombotic treatment of whom four were in a nursing home. A questionnaire survey found that only 13 (59%) of 22 responders knew that warfarin or aspirin helps to prevent strokes or blood clots.

As in Burton's study we noted a 'healthy user effect' in warfarin prescribing. Of patients aged <75 years, 71% (12/17) were prescribed warfarin compared with 23% (6/26) of those aged 75 years ($P<0.01$). However, despite the tendency for GPs to prescribe warfarin for their fitter, younger patients, Burton and colleagues found that the risk of severe bleeding on warfarin, defined as death, intracranial bleeding or hospital admission, was 2.6% per patient year, twice the rate found in clinical trials. Over a fifth of patients on warfarin consulted their GP with at least one bleeding event during up to 5 years follow up. Combining these risks with the additional effort involved in anticoagulant monitoring, it is not surprising if compared to hospital doctors, many GPs have a more conservative approach to starting patients with atrial fibrillation on warfarin.

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