tests at home must do all this with only the aid of written information or, at best, a telephone hotline.

The Department of Health’s enthusiasm for self-care may be based on the premise that visits to health services, including primary care, will reduce as a result. There is some evidence to support this, for example self-monitoring of hypertension led to reduced consultations for blood pressure measurement. Over three-quarters of the public say, however, that they would be far more confident about taking care of their own health if they had guidance and support from an NHS professional. As this role is likely to fall to primary care, primary care professionals will need to be enabled to give guidance and support if potential benefits are to be realised.

Some may see patient-initiated self-care and self-testing as a threat to their professional role — some patients do not disclose their self-care to their doctors, and a possible extension of the current situation might be that primary care becomes redundant for those patients who can test, treat and refer themselves. It could also be viewed as an important opportunity to strengthen the patient–professional partnership and health outcomes by encouraging people to appropriately use and share their experiences of self-initiated self-care and self-testing. A recent study of GPs’ perspectives on their involvement in the facilitation of chronic disease self-management suggested that increasing patient involvement and control is valued, but that it is not necessarily prioritised because it conflicts with other issues, for example professional responsibility and accountability and contextual factors, such as consultation length.

We need to ensure that the public have enough information to make informed choices about when and how to care for themselves and when they should share information about self-care with their primary care team. Primary care doctors and nurses also need access to enough good quality information about available self-care activities to be able to ask questions and then advise patients appropriately, and any barriers to them doing so need to be addressed: they need to be able to adapt themselves to consultations with patients who are even more proactive and informed, but also, at the other end of the spectrum, with patients who are unable or unwilling to take a more active role. The clinical and academic communities will certainly have a role to play in listening to the public about why, how and when they self-care or self-test, and in generating and then providing the public and professionals with the information to make sensible self-care choices.

Angela Ryan
Clinical Research Fellow

Sheila Greenfield
Senior Lecturer

Richard McManus
Senior Lecturer

Sue Wilson
Professor of Epidemiology, Department of Primary Care & General Practice, University of Birmingham.

REFERENCES

ADDRESS FOR CORRESPONDENCE

Sue Wilson
Professor of Epidemiology, Department of Primary Care & General Practice, Primary Care Clinical Sciences Building, University of Birmingham, Birmingham, B15 2TT.
E-mail: s.wilson@bham.ac.uk

Chronic kidney disease: a new priority for primary care

Chronic kidney disease is a long-term condition that has been the focus of important recent initiatives. Although only a small minority of individuals with this condition will develop end-stage renal disease, the presence of even minor renal impairment is an independent risk factor for all cause mortality and cardiovascular disease. The number of patients treated for end-stage renal failure is increasing dramatically in the UK. Projections for hospital-based haemodialysis indicate an annual growth rate of 6–8%; a steady state is not predicted for at least 20 years. Currently one-third of people reach
Box 1. Causes of chronic kidney disease

- Diabetes mellitus
- Hypertension and vascular disease
- Acquired obstructive uropathy — especially prostate disease
- Glomerular disease — for example glomerulonephritis
- Adult polycystic kidney disease
- Reflux nephropathy

...
However, there are several points in the current guidelines that need careful clarification and further debate:

- The recommended formula to estimate glomerular filtration rate identifies a very high proportion of elderly, particularly elderly women as having chronic kidney disease. There are concerns in some quarters that this represents over-diagnosis. Age-related decline in kidney function is common and an expected loss of 10 ml/min/1.73 m² per decade beyond the age of 40 years is frequently quoted. However, this decline is probably a consequence of clinical or sub-clinical vascular disease rather than a ‘normal’ finding and should still be managed with cardiovascular risk factor intervention, until clarified by further research. Studies do suggest that strict treatment of blood pressure in older people is effective in slowing the rate of renal decline.

- Difference in blood pressure standards may be unhelpful for busy clinicians. Current UK guidelines suggest a target of 130/80 mmHg or 125/75 mmHg in the presence of greater than 1g/day proteinuria (total protein to creatinine ratio 100 mg/mmol). The QOF suggests 140/85 mmHg and American guidance suggests a target of 130/85 mmHg.

- Current guidance both in UK and US recommends all patients with stage three to five chronic kidney disease to have a parathyroid hormone blood test. The cost-effectiveness of this measure needs careful evaluation, with the high prevalence of this condition. Current guidance also recommends that people with a parathyroid hormone concentration over 70 ng/L also have serum 25-hydroxyvitamin D concentration checked, increasing costs further.

In summary, chronic kidney disease is a new priority for primary care. Its management presents a new challenge for primary care professionals in the identification and monitoring of the disease, but probably no greater than other clinical challenges to which general practice has risen in the last two decades.

Gabriela B Gomez
Research Assistant

Simon de Lusignan
Senior Lecturer in General Practice,
St George’s, University of London

Hugh Gallagher
Consultant Nephrologist, South West Thames Renal Unit St Helen Hospital, Carshalton

Conflict of interest
Simon de Lusignan has received (as the lead of a primary care informatics study team at St George’s — University of London) grants from Roche to process routinely collected general practice data as part of the NEOERICA study. Simon de Lusignan has received (as the lead of a primary care informatics study team at St George’s — University of London) grants from Roche to process routinely collected general practice data as part of the NEOERICA study. Simon de Lusignan has received (as the lead of a primary care informatics study team at St George’s — University of London) grants from Roche to process routinely collected general practice data as part of the NEOERICA study.

REFERENCES

ADDRESS FOR CORRESPONDENCE
Simon de Lusignan
Senior Lecturer in General Practice,
St George’s, University of London
Primary Care Informatics, Division of Community Health Sciences,
Cranmer Terrace, Tooting,
London SW17 0RE.
E-mail: slusigna@sgul.ac.uk