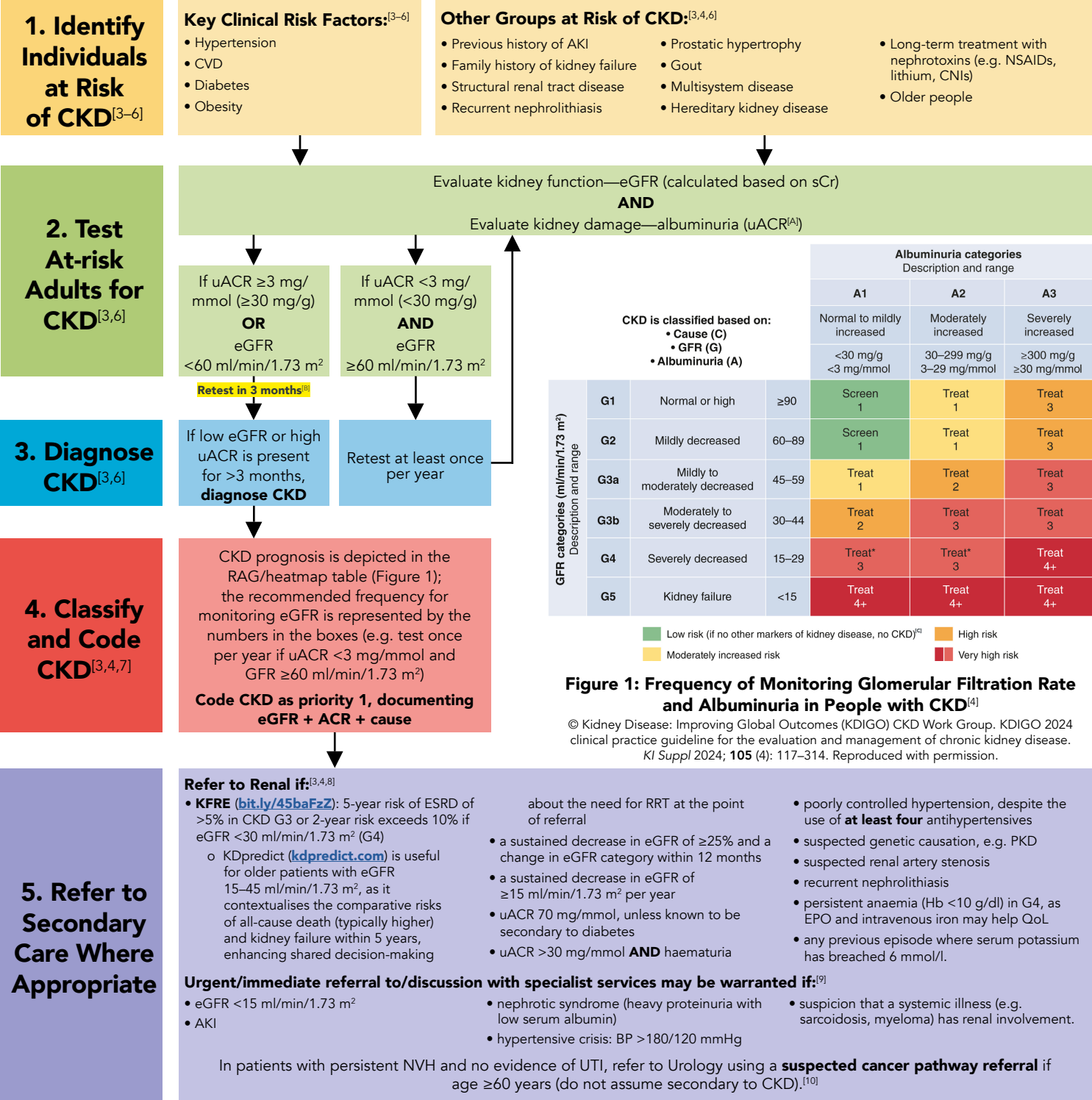


Identification of Chronic Kidney Disease in Primary Care

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Prevention of ESRD matters, as it has lower survival rates than colorectal, prostate, and breast cancer.^[1] Microalbuminuria and eGFR <60 ml/min/1.73 m² are independent and amplifying predictors of mortality risk.^[2]



Footnotes

[A] A spot uACR is acceptable.^[3,5]

[B] NICE suggests repeating the eGFR within 2 weeks if eGFR <60 ml/min/1.73 m²^[3]—this is at the discretion of the ordering clinician, based on the acuity of the presenting cause. If there is persistent invisible haematuria, also consider referring for investigation for urinary tract malignancy.^[3]

[C] Key markers of kidney disease include urine sediment abnormalities, tubular disorders, histology-proven abnormalities, imaging-proven structural abnormalities, and kidney transplantation.^[4]

ACR=albumin to creatinine ratio; AKI=acute kidney injury; BP=blood pressure; CKD=chronic kidney disease; CNI=calcineurin inhibitor; CVD=cardiovascular disease; CVE=cardiovascular event; eGFR=estimated glomerular filtration rate; EPO=erythropoietin; ESRD=end-stage renal disease; GFR=glomerular filtration rate; KFRE=Kidney Failure Risk Equation; NSAID=nonsteroidal anti-inflammatory drug; NVH=non-visible haematuria; PKD=polycystic kidney disease; QoL=quality of life; RAG=red, amber, green; RRT=renal replacement therapy; sCr=serum creatinine; uACR=urine albumin to creatinine ratio; UTI=urinary tract infection