

LETTER TO EDITOR

Reply letter to: Mixed messages and the disparity between various levels of care in chronic kidney disease management

Seng Wee Cheo, Qin Jian Low, Tzyy Huei Lim, Woh Wei Mak, Chow Alexander Kok Yip, Koh Wei Wong

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Authors:

Seng Wee Cheo

(Corresponding author)

MRCP (UK)

Department of Internal Medicine,
Hospital Lahad Datu, Peti Bersurat
60065, Lahad Datu, Sabah,
Malaysia.

Email: cheosengwee@gmail.com

Qin Jian Low

MRCP (UK)

Department of Internal Medicine,
Hospital Sultanah Nora Ismail, Jalan
Korma, Taman Soga, Batu Pahat,
Johor, Malaysia.

Tzyy Huei Lim

MRCP (UK)

Department of Internal Medicine,
Hospital Sultanah Nora Ismail, Jalan
Korma, Taman Soga, Batu Pahat,
Johor, Malaysia.

Woh Wei Mak

MRCP (UK)

Department of Internal Medicine,
Hospital Bentong, Jalan Tras, Darul
Makmur, Bentong, Pahang, Malaysia.

Chow Alexander Kok Yip

MRCP (UK)

Department of Internal Medicine,
Hospital Raja Permaisuri Bainun,
Jalan Raja Ashman Shah, Ipoh,
Perak, Malaysia.

Dear Editor,

We read Jamaluddin et al.'s letter to the editor with great interest.¹ Most chronic kidney disease (CKD) patients are managed in primary care. The authors have highlighted the discrepancies between our approach and the Malaysian clinical practice guidelines (CPGs) on the management of CKD in adults.² As the author has correctly pointed out, medicine is evolving rapidly; therefore, there will be certain differences or discrepancies between different guidelines and reviews. Our review of the article is meant to provide some insight into the management of CKD in primary care.

First, regarding the first comment on the recommendation that all patients with CKD should undergo an ultrasound, the CPGs do not restrict ultrasounds to be performed only in patients with rapid deterioration of renal function, presence of haematuria, symptoms or history of urinary tract obstruction, family history of polycystic kidney disease and age over 20 years, or when a renal biopsy is indicated; rather, these are general indications of kidney ultrasound.² Ultrasound serves as a useful, non-invasive test to detect urinary tract obstruction or structural abnormalities.³ Furthermore, patients with urinary tract obstruction or congenital renal tract abnormalities may not present with typical symptoms, and deranged creatinine may be the first presentation.⁴ The KDIGO guideline also recommends that most CKD patients should undergo an ultrasound evaluation.⁵ In addition to structural abnormalities, renal ultrasound may detect renal masses, renal calculi, and abnormalities in the renal cortex. By diagnosing the structural abnormalities early, the patients can be referred for early urological intervention, which may potentially limit the damage to the kidneys and prevent further deterioration of kidney function. Overall, renal ultrasound is a helpful tool that CKD patients should utilise as it may potentially alter the management and disease course.

Regarding blood pressure targets, the target that is mentioned in our article is the same as the target recommended by the Malaysian CPGs, as in Jamaluddin's letter. There were typography mistakes made by the publisher, and an erratum has been published separately to rectify the errors.⁶ In terms of lipid-lowering therapy, we recommended that all CKD patients should undergo lipid evaluation, as dyslipidaemia is an important cardiovascular risk factor.⁷ In all CKD patients above 50 years old not on renal-replacement therapy (RRT), lipid-lowering therapy should be initiated. In contrast, in adults aged 18–49 years with CKD not on RRT, lipid-lowering therapy is recommended if the patient has one of the following indications: known coronary artery disease, diabetes mellitus, prior ischaemic stroke, or 10-year risk of cardiovascular event >10%.⁸ The rationale is that the risk of a coronary event is age-dependent in patients with CKD, just as it is in the general population. Although the absolute rate of cardiovascular events is generally lower in the population <50 years old, CKD patients with the aforementioned risk factors are generally considered to have a higher risk of developing a cardiovascular event and statin therapy is thus indicated.⁸ However, polypharmacy and potential drug toxicities need to be taken into consideration prior to initiation of statins.

Regarding parathyroid hormone (PTH) measurement, it should be performed if there is sufficient laboratory support. According to the KDIGO guidelines, PTH measurement should be performed at baseline and every 6–12 months in CKD stage 4 and more frequently in

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Koh Wei Wong

MRCP (UK)

Nephrology Unit, Department of
Internal Medicine, Hospital Queen
Elizabeth, 13a, Jalan Penampang,
Kota Kinabalu, Sabah, Malaysia.

CKD 5.⁹ However, we understand the challenges faced by primary care practitioners, as PTH measurement is not widely available, and the same applies to bicarbonate. Serum bicarbonate testing is not widely available in primary care settings; however, it should be performed if testing is available.

Finally, this article aims to serve as a review of literature on the available resources; it does not replace the current guidelines. All treatment or management plans will have to be modified according to available resources in local settings.

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