NKDEP
National Kidney Disease Education Program

KICC News

A quarterly newsletter by the National Kidney Disease Education Program | Issue #2 | Spring 2007

This Issue: New NIDDK Director | Monitoring Kidney Care | CKD Data Released | Standardizing Urine Albumin Testing

Griffin P. Rodgers, M.D., Named Director of NIDDK

On April 1, 2007, Dr. Elias A. Zerhouni, Director of the National Institutes of Health, appointed Griffin P. Rodgers, M.D. as Director of the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). Dr. Rodgers has served as the Deputy Director of NIDDK since 2001 and as chief of NIDDK's Clinical and Molecular Hematology Branch since 1998.

Dr. Rodgers will be attending the Kidney Interagency Coordinating Committee meeting on Thursday, June 14, 2007 at the NIH's Natcher Conference Center.

IHS Monitors Kidney Care with Renal Preservation Report

Racial and ethnic minorities bear a disproportionate burden of chronic kidney disease (CKD). Indian Health Service provides care to about 1.5 million American Indians and Alaska Natives (AI/AN) including communities with some of the highest rates of treated end-stage renal disease (dialysis or transplantation) in the world. Most of the CKD among AI/AN is due to diabetes. IHS monitors the care provided to people with diabetes through an annual diabetes chart audit. Since 1997, IHS has produced the Renal Preservation Report, which measures care intended to reduce the risk for diabetic kidney disease.

During 2006 over 48,000 charts were audited from the roughly 123,000 patients on the combined diabetes registry for all IHS Areas. Fourteen percent* of the diabetics had Stage 3 CKD, 2% had stage 4. Stage 5 patients were excluded. Eighty-six percent were hypertensive. Of these, 76% were receiving an ACE inhibitor or angiotensin receptor blocker (ARB). Blood pressure was controlled (<130/<80) in 37% of hypertensives. Twenty-seven percent of patients had blood pressure >140/>90. Seventy-seven percent of the patients identified with abnormal protein excretion (microalbuminuria or greater) were treated with an ACEI or ARB.

These quality of care measures compare favorably to published data from a variety of U.S. healthcare settings and suggest that a systematic primary care based approach to CKD risk reduction can be implemented successfully in disadvantaged populations with a disparate burden of disease. *For more information, contact the IHS Division of Diabetes Treatment and Prevention (diabetesprogram@ihs.gov).*

*All percentages provided here from the Renal Preservation Report are unadjusted for sample size.

Continued on next page

A quarterly newsletter by the National Kidney Disease Education Program | Issue #2 | Spring 2007

CDC Releases CKD Prevalence Data

In recognition of National Kidney Month, throughout the month of March, CDC released five CKD-related reports in the MMWR. One of the reports, entitled "Prevalence of Chronic Kidney Disease and Associated Risk Factors --- United States, 1999–2004" (March 2, 2007 / Vol. 56 / No. 8), examines the most recent data from the National Health and Nutrition Examination Survey (NHANES), a continuous survey of the health and nutritional status of adults and children living in the United States.

The analysis of the 1999-2004 NHANES data demonstrated that 16.8 percent of the U.S. population 20 years of age or older had CKD based on a single spot urine test to determine albuminuria. This percentage—compared to 14.5 percent from the 1988-1994 NHANES—reflects an increase of 15.9 percent based on crude estimates of prevalence. These data correlate with the most recent CKD prevalence data on non-Hispanic blacks and Mexican Americans, as well as patients with diabetes and cardiovascular disease. The article concludes that the incidence and prevalence of end-stage renal disease have increased during the past 30 years and are expected to continue increasing through 2010.

With CKD prevalence on the rise, enhancing the Federal response and developing comprehensive public health strategies are important and timely objectives. These data provide further support for targeting populations disproportionately affected by CKD. They also underscore the need for a comprehensive public health strategy for CKD under development by CDC that includes a national CKD surveillance system, as well as the need to support CKD measures in national surveys, such as NHANES and others. *For more information, contact Desmond Williams at desmond.williams@cdc.hhs.gov.*

Please send your story ideas for future issues of *KICC News* to Elisa Gladstone at GladstoneE@extra.niddk.nih.gov.

NIDDK Convenes Urine Albumin Experts

Those who oversee programs with implications for the detection and treatment of diabetes, hypertension, and cardiovascular disease are aware that urinary albumin is a key measure for detecting chronic kidney disease (CKD). Indeed, most diagnoses of CKD are based on identification of urine albumin, not a reduced GFR. Many health professionals are not aware, however, that various issues prohibit health professionals from obtaining reproducible urine albumin results — a problem with public health, clinical care, and research implications. For example, if one patient's urine sample were split into three and sent to as many labs, it is possible that a clinician would receive three different results. One reason for this variation: each laboratory can use a different testing method.

Variation in test results is caused, in part, by lack of availability of a "standard" method for measuring urine albumin, as well as materials that can be used to ensure that every laboratory gets the same result for a urine sample with a known amount of albumin. Also lacking is agreed upon ranges and cutpoints for healthy levels of urine albumin for patients of various ages, races, and genders.

The above are just two of the many of the measurement- and reporting-related issues discussed during a March 27 and 28, 2007, meeting of urine albumin experts convened in Washington, DC, by NKDEP and the International Federation of Clinical Chemistry and Laboratory Medicine. Attendees included almost 20 representatives from the NIH, CDC, National Institutes of Standards and Technology, research hospitals and institutions, the in vitro diagnostic industry, and other sectors of the clinical chemistry community—each with an established track record of resolving difficult problems faced by the clinical chemistry community. The group outlined all related problems and posed strategies that will eventually help redefine who is screened for CKD and how patients are treated. *For more information, contact Andrew Narva at narvaA@niddk.nih.gov.*