

Top 10

Top 10 Takeaways on Management for Primary Care Physicians from the KDIGO 2024 Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease



Promote participation in high-quality research in CKD across the lifespan

1

Comprehensive treatment strategy

CKD is a long-term condition. Treat people with CKD with a comprehensive treatment strategy to reduce risks for complications (e.g., cardiovascular disease) and for progression to more advanced stages of CKD; ideal strategies encompass education, lifestyle, exercise, smoking cessation, diet, and medications, where indicated (Figure 1).

2

Healthy and diverse diet

Adopting a healthy and diverse diet with a higher consumption of plant-based foods compared to animal-based foods and a lower consumption of ultra-processed foods has the potential to benefit complications related to progressive CKD such as acidosis, hyperkalemia, and hyperphosphatemia with less risk of protein energy-wasting.

3

Individualize BP control

Ideal BP target in CKD is <120/80 mm Hg; however, BP-lowering therapy should be individualized in people with frailty, high risk of falls and fractures, very limited life expectancy, or symptomatic postural hypotension (Figure 1).

4

RASi and SGLT2i

Evidence-based treatments that delay progression of CKD include renin-angiotensin inhibitors (RASi) and SGLT2i in people with and without diabetes. In people with CKD and without diabetes, the presence of even mild albuminuria indicates benefits from RASi, and severe albuminuria indicates substantial benefits from SGLT2i.

5

CKD, cardiovascular disease, and heart failure

Estimate 10-year cardiovascular risk using a validated risk tool that incorporates CKD to guide treatment for prevention of cardiovascular disease. Use statins for most people with CKD to prevent cardiovascular disease (Figure 1). In people with CKD and heart failure, SGLT2i confers benefits irrespective of albuminuria.

6

Hemodynamically active therapies

Changes in eGFR are expected following initiation of hemodynamically active therapies, but GFR reductions of $\geq 30\%$ on subsequent testing exceed the expected variability and warrant evaluation (Figure 2).

7

Perform thorough medication review

Perform thorough medication review periodically and at transitions of care to assess adherence, continued indication, and potential drug interactions. People with CKD have increased risk for adverse events due to over-the-counter medicines, dietary, or herbal remedies, so encourage your patients to limit their use.

8

Equations for drug-dosing

For most people and clinical settings, validated eGFR equations using SCr are appropriate for drug-dosing, but the combined eGFR_{cr-cys} is more accurate and should be used when a more accurate kidney function estimation is important.

9

Discontinued medications

If medications are discontinued during an acute illness, communicate a clear plan of when to restart the discontinued medications and ensure documentation in the medical record. Unfortunately, medications are frequently not restarted, which leads to undertreatment and unintentional harm.

10

Referral to specialist kidney care services

Common reasons for referral to specialist kidney care services include the evaluation of cause of CKD, GFR <30 ml/min/1.73 m², significant decline in GFR, >3%–5% risk of requiring KRT in 5 years, significant albuminuria, microscopic hematuria, changes in symptoms, or management of CKD complications.

Figure 1

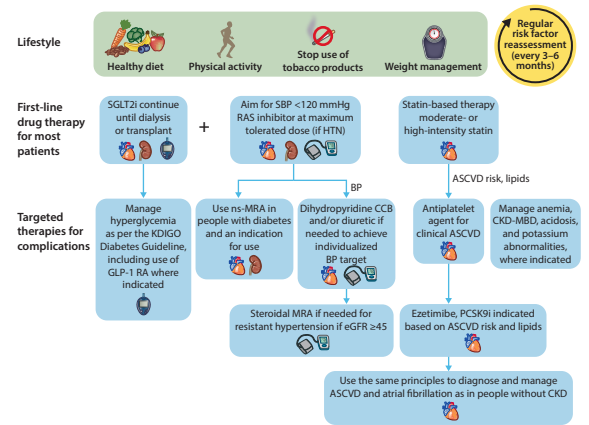
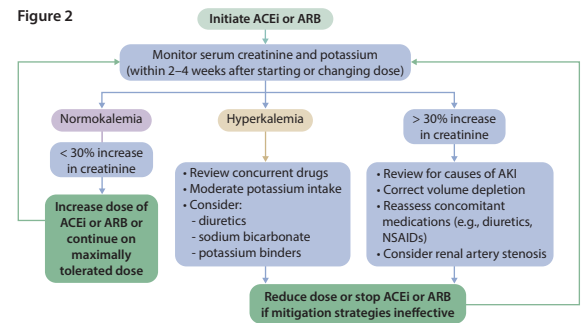


Figure 2



ACR, albumin-creatinine ratio; CKD, chronic kidney disease; cr, creatinine; cys, cystatin C; (e)GFR, (estimated) glomerular filtration rate; KRT, kidney replacement therapy; RASi, renin-angiotensin inhibitors; SGLT2i, sodium-glucose cotransporter-2 inhibitor