Late referral for assessment of renal failure

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It has been recommended that adult patients with a serum creatinine above 150 μmol/l should be referred to a nephrologist for specialist assessment. This study ascertained all patients in Northern Ireland with creatinine above this concentration in 2001 (n = 19 286) to see if this triggered referral within the subsequent year. After exclusion of those who were already known to a nephrologist and those who had acute renal failure, it was found that younger patients and diabetic patients were more likely to be referred. There was no difference in referral rates between male and female patients. However, only 6.5% of all non-diabetic subjects and 19% of diabetic patients were referred within 12 months after a first increased serum creatinine test.

In the past 20 years, the number of patients receiving treatment for end stage renal disease (ESRD) has risen substantially in most developed countries. This trend is driven by the aging of the population, better recognition of the outcomes and value of renal replacement therapy, and increased resources for haemodialysis. Yet data from renal units point to a pronounced variation in referral of patients with ESRD.

The third edition of the Renal Association guidance suggests that patients should be referred to a specialist, early in the course of their disease when serum creatinine is between 150 and 200 μmol/l,2 while the NICE guidance on the management of type II diabetes recommends referral when the creatinine reaches 150 μmol/l.3 The impact of using such thresholds on existing services or on patient outcomes is unknown. To start such a study and determine the potential numbers of patients meeting these criteria, we have capitalised on the comprehensive coverage of the clinical biochemistry laboratories serving one region’s entire 1.7 million population (Northern Ireland).

METHODS

Our full methods (including details of record linkage protocols) and the prevalence of chronic kidney disease have been described elsewhere. Briefly, we retrieved data on all serum creatinine, albumin and urea tests, urinary protein excretion tests, and HbA1c tests performed in Northern Ireland laboratories between 1 January 2001 and 31 December 2002. We reduced the test level database to a relational person level database of patients who had had any of these tests performed during 2001 and 2002. This analysis focuses on subjects whose first raised serum creatinine (above 150 μmol/l) was in 2001.

We were able to define the source and specialty of the doctor requesting the test and thus could exclude (from the analysis of subsequent referral rates) those whose first abnormal test had been ordered by a nephrologist. We defined a referred case as someone who had had any subsequent serum creatinine test ordered by a nephrologist within 12 months of the first abnormal result in 2001. We excluded those with acute renal failure from the analysis. We ascertained all deaths through the Office of the Registrar General and censored subjects on their date of death. Subjects with acute renal failure were defined as those who had a creatinine >300 μmol/l in 2001 that returned to <120 μmol/l within six months of the first raised test.

We defined as diabetic those subjects who had had any HbA1c test undertaken during the two year period. Results are presented by age and sex for patients 20 years and over.

Figure 1 Distribution of creatinine results—maximum value for each subject tested in 2001.
Kaplan-Meier survival estimates (with 95% confidence limits) were obtained for the proportion referred by 12 months. Cox’s proportional hazards regression was used to test variation in the referred proportion according to age, sex, and whether diabetic or not.

The study was approved by the Queens University Medical Ethics Committee, 2002.

RESULTS

Twenty nine per cent of the resident population had at least one creatinine test in 2001 and 95% of all tests undertaken yielded a result below 150 μmol/l (fig 1).

Tables 1 and 2 show that across both sexes and among diabetic and non-diabetic subjects the proportion “referred” is significantly higher at younger ages. For example, compared with the oldest age category, 20–39 year olds had a more than fivefold chance of being referred to a nephrologist (table 2). Overall, less than 20% of diabetic patients and less than 7% of non-diabetic subjects had a subsequent investigation undertaken by a nephrologist within 12 months. Nevertheless the average number of renal/HbA1c tests performed on each “non-referred” case during that period was 20 for diabetic patients and 14 for non-diabetic subjects (including tests ordered in both primary and secondary care settings).

DISCUSSION

The feasibility and need for a study such as ours has previously been highlighted but our comparatively static population in Northern Ireland offers us advantages over other regions served by more fragmented or dispersed health services, serving more mobile populations. While our chronic kidney disease prevalence data are reported elsewhere, services, serving more mobile populations. While our chronic kidney disease prevalence data are reported elsewhere,4 whereas we have ana-

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<th>Table 2</th>
<th>Cox’s proportional hazards regression of effects of age, sex, and diabetes on proportion referred within 12 months</th>
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<td></td>
<td>Comparison Relative hazard</td>
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<tr>
<td>Sex</td>
<td>F v M</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Age group</td>
<td>20–39 v 80+</td>
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<td>60–69 v 80+</td>
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<td>70–79 v 80+</td>
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In Northern Ireland in 2001 there were about 1100 ESRD patients receiving renal replacement therapy and 9.5 whole time equivalent nephrologists saw about 1200 new outpatients with chronic kidney disease (Korner Statistics,
Many previous studies have assessed “late referral” as judged by the (“downstream”) interval between referral and the start of dialysis, for patients with chronic kidney disease. Given the existing Renal Association guidance (that all patient with creatinine >150 µmol/l should be referred to a specialist), the novelty of this study is that it has ascertained the population prevalence of chronic kidney disease and calculated how many such patients have been referred to a specialist within 12 months. As early intervention may slow a decline in renal function, chronic kidney disease abatement and prevention strategies need to be better informed by this “upstream” approach.

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REFERENCES

4. Reference withdrawn.
8. Reference withdrawn.