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## Overcoming Obstacles in the Management & Treatment of Diabetic Kidney Disease

Announcer:

You're listening to *Diabetes Discourse* on ReachMD. This episode is sponsored by Renalytix. Here's your host, Dr. Jennifer Caudle.

Dr. Caudle:

Welcome to *Diabetes Discourse* on ReachMD. I'm your host, Dr. Jennifer Caudle, and joining me today to explore challenges and gaps in diabetic kidney disease management is Dr. Jennifer Green, Professor of Medicine at the Duke University School of Medicine. Dr. Green, thanks so much for being here today.

Dr. Green:

Thank you, it's my pleasure to be here.

Dr. Caudle:

Now Dr. Green, before we dive into some of these clinical challenges and gaps in care, let's do some level setting. Can you tell us about the prevalence of diabetic kidney disease and its diagnostic rates?

Dr. Green:

So, there are approximately 34 million people with Type 2 diabetes in the U.S., and it's estimated that about 37 percent of those individuals also have some evidence of diabetic kidney disease, so there are many, many people affected in this country. And just before we dive in, I think it's helpful to review the diagnostic criteria for diabetic kidney disease or chronic kidney disease of any type, for that matter, and that would include an eGFR of less than 60, or a urine albumin to creatinine ratio that is elevated above 30. So that can capture quite a large number of individuals. I think it's important to note that we're not doing a terrific job at identifying the individuals in this country who have diabetic kidney disease, despite the fact that we have very, very good tools to do that. I note, for example, some very recent studies, both of VA and Medicare data that looked at rates of screening for diabetic kidney disease or chronic kidney disease, with eGFR testing, and then they looked in the electronic health record to see if patients with an abnormal eGFR actually were described or labeled or diagnosed as having chronic kidney disease in the medical record. And rates were extremely low. Unfortunately, in the group of individuals who had an eGFR of less than 60, only very, very small percentages carried a diagnosis of chronic kidney disease. And generally, it wasn't until the kidney disease was very, very advanced that patients did have that diagnosis listed in their medical record. People seem to be pretty good about screening for chronic kidney disease, or at least performing eGFR testing, so that bloodwork does get done, for the most part, annually in people with Type 2 diabetes, but we're not very good at doing the other component of testing.

That's the urine albumin to creatinine ratio assessment, so the rates of simply the testing for urine albumin to creatinine ratio in people with diabetes, for whom it's clearly indicated – those rates are extremely low in the United States and elsewhere. So it's really a missed opportunity to identify diabetic kidney disease early.

Dr. Caudle:

Okay. And you've touched on this a little bit already, but with that being said, what are some of the primary clinical challenges that can keep us from detecting diabetic kidney disease early on?

Dr. Green:

Yeah, I mean, I think that there are a number of challenges. First is simply awareness of the need to screen people with Type 2 diabetes on an annual basis, and many people at the time that they're diagnosed with Type 2 diabetes have some evidence of kidney damage or

kidney dysfunction at that time, so that needs to start early. It's probably not terribly difficult to get an eGFR done, because most patients with diabetes are having their chemistries checked on an annual basis, so we seem to be doing pretty well with the eGFR testing. The problem, though, as I'd already alluded to, is that even when that eGFR is low, let's say it's less than 60 on two consecutive occasions, there's not as much recognition that that's abnormal and indicative of the patient's associated risk of progressive kidney disease and cardiovascular disease as there should be.

Dr. Caudle:

Okay. And if we zero in on available clinical markers, how are they impacting our ability to identify and monitor diabetic kidney disease? You know, are better predictive markers and tools needed?

Dr. Green:

You know, that's a really good question, and I'm sure we can always benefit from better biomarkers, etc. But for the most part, the tools that we have are really good; so the eGFR value, the UACR, these are incredibly powerful tools, if we use them, and if we actually think about the results and decide which of our patients have chronic kidney disease and understand the risks associated with that. In particular, people with very low eGFRs, which is kind of when the chronic kidney disease is often clinically noted, or those with significant amounts of albuminuria – so what we use to describe as macroalbuminuria, now called severe albuminuria – so when that UACR is 300 milligrams per gram or greater.

These are really, really good predictors of progression to end-stage kidney disease, and even at earlier stages of chronic kidney disease, we know that the risk of cardiovascular complications, the development of cardiovascular comorbidities, such as heart failure, it's really significantly increased. So, I think our tools are great. We just need to use them.

Dr. Caudle:

For those of you who are just tuning in, you're listening to *Diabetes Discourse* on ReachMD. I'm your host, Dr. Jennifer Caudle, and today I'm speaking with Dr. Jennifer Green, about challenges and care for patients with diabetic kidney disease. So Dr. Green, now that we've taken a look at some of these obstacles, let's turn our attention to the patient. What are some primary gaps in care that we need to know about?

Dr. Green:

It's testing, it's the importance of understanding the need to detect diabetic kidney disease early, so that effective therapies can be implemented at that time. And then, of course, there are gaps, in patients' ability to access some of the treatments medications or otherwise that can help to limit additional kidney damage and preserve their kidney function and reduce their associated cardiovascular risk. So there are lots of gaps absolutely.

Dr. Caudle:

And for patients in underserved communities, what are some of their unmet needs?

Dr. Green:

In underserved communities, all of those issues apply. But they're worsened by a lack of consistent access to care, and that's a community where access to what we know are beneficial therapies; so medications in particular can be extremely challenging. Another really important thing to think about in the underserved population is that their care for most medical conditions, or all of their medical conditions, can be significantly compromised. So these are people who, for example, might not be being seen on a regular basis for management of their diabetes, for management of their blood pressure, and so they're a population at greater risk for the development of chronic kidney disease and other complications, for that matter, and so that really compounds their risk compared to the general patient population.

Dr. Caudle:

With all of this in mind, how can we overcome obstacles in disease management and address gaps in care for patients with diabetic kidney disease?

Dr. Green:

Well, that's a really important question, and there will be no one-size-fits-all answer, but I'd really like to move away from expecting the individual provider to remember to do all the appropriate screening and implement appropriate interventions. Just let's take that out of their individual hands and utilize the power of the electronic health record. So for example, to prompt us to perform testing when indicated to maybe map our patients on the KDIGO heat map, which visually displays their risk of progressive kidney disease, and risk for cardiovascular complications. And for the EHR to perhaps suggest some indicated therapies for patients who have indications for medications to improve their cardiovascular and kidney outcomes. So, I think that that will be helpful. The other aspect of this is patients' access to indicated medications, and some hospitals have addressed this, or clinics have addressed this by assembling care teams,

often including the pharmacist to help navigate those waters. I'm also happy to mention that at my institution, we're beta testing a feature in the electronic health record that tells us immediately what the patient is covered for in the way of medications that can be used. So I think that clearly needs to be streamlined so that we can implement these effective therapies in the affected patient population.

Dr. Caudle:

And before we close, Dr. Green, do you have any final takeaway thoughts you'd like to share with our audience today?

Dr. Green:

Sure. In almost every presentation that I've given recently, I've liked to remind everyone that we are all responsible for our patients' kidney health, cardiovascular health, overall health, and we can't bounce the need to understand and treat kidney disease around between us like a hot potato. It really doesn't belong to any one specialist, and so we all need to look for opportunities to diagnose and treat disease, so that we can improve our patients' long-term trajectory of health.

Dr. Caudle:

Well, with those closing thoughts in mind, I'd like to thank Dr. Jennifer Green, for joining me to share her insights on obstacles and gaps in diabetic kidney disease care, and how we can overcome them. Dr. Green, it was great speaking with you today.

Dr. Green:

Thank you, I enjoyed it very much.

Announcer:

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