Appendix C
Guideline Comparison

Comparison of KDOQI, ADA, and JNC-VII Guidelines. Focus on CKD-Related Guidelines

KDOQI (NGC, from Am J Kidney Dis 2002 Feb)	ADA (in "Standards of Medical Care," Diabetes Care 30 (supp1) 2007 Jan)	JNC-VII
#1: Definition and Stages of CKD defined by GFR		
#2: Evaluation and Treatment. 1. CKD patients should be evaluated for diagnosis, comorbidities, severity, complications, risk for loss of kidney function, risk for CVD 2. Treatment of CKD should include dx-based therapy, E&M of comorbidities, slowing loss of kidney function, prevention and treatment for CVD, cx of dec. kidney function, preparation for replacement, and replacement/transplant 3. Develop clinical action plan. 4. Review medication 5. Incorp. S/M into tx plan 6. Referral to nephrologist for eGFR<30	V.A. The comprehensive diabetes examination includes, among other components, tests for microalbuminuria and serum creatinine (and calculation of eGFR)	Physical exam should include… examination of the abdomen for enlarged kidneys, masses, and abnormal aortic pulsation… Routine laboratory tests recommended before initiating therapy include …blood glucose and hematocrit; serum potassium, creatinine (or the corresponding estimated glomerular filtration rate [GFR]), and calcium; and a lipid profile… Optional tests include measurement of urinary albumin excretion or albumin/creatinine ratio..
#3: Patients at increased risk for CKD should be assessed		

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#4: eGFR should be used for assessment. Serum creatinine alone is insufficient Labs should report eGFR in addition to creatinine Timed GFR necessary only in exceptional circumstances		
#5: Assessment of proteinuria. Spot urine for most circumstances Dipsticks acceptable in most; if positive, confirm using quantitative w/in 3 mos. Adults: screen using albumin-specific of albumin to creatinine; monitor CKD patients using albumin-to-creatinine *More details that specifically relate to children*		Serum potassium and creatinine should be monitored at least 1–2 times/year.
#6: CKD markers other than proteinuria a. urine sediment or red/white blood dipstick for CKD or at risk for CKD b. kidney imaging for CKD or at risk for CKD c. other markers show promise; not ready yet		
#7: GFR and HTN a. monitor BP for all with CKD b. treat HTN using target BP, nonpharm therapy, and specific Rx agents (see GL 13 and GL 15)	VI.A.1 Measure BP at each visit Goal of 130/80 ACE/ARB	
#8: GFR and anemia Evaluate GFR<60 for anemia, incl. hemoglobin		
#9: GFR and nutrition GFR<60 assess protein and energy intake	V.D. Consultation with RD, weight loss, reduce fat/carb intake	
#10: Bone disease and Ca and Ph metabolism GFR<60 evaluate for bone disease		

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#11: Neuropathy Assess CKD patients for neurologic involvement	VI.D Annual screen	
#12: GFR and functioning GFR<60 assess for functioning and well-being		
#13: CKD progression a. assess GFR decline b. estimate rate of decline c. intervene with all CKD patients: glucose control for diabetics, BP control, ACE/ARB. (Protein restriction, lipid-lowering, and partial correction of anemia inconclusive) d. Prevent and correct acute decline due to common causes: volume depletion, IV radio contrast, some antimicrobial Rx, NSAIDs, use of ACE/ARBs, cyclosporine/ tacrolimus, urinary tract obst. e. Annually measure eGFR, more often for GFR<60, history of rapid decline (>4/year), risk factors for rapid progression, treatment for progression, risk of acute GFR decline	VI.A.1 Measure BP at each visit Goal of 130/80. ACE/ARB VI.B To slow CKD progression, optimize glucose and BP control. All diabetics: annual test for microalbuminuria; annual serum creatinine (to yield eGFR, the best method for evaluating kidney function)	CKD defined by eGFR<60 and/or albuminuria Target BP 130/80. ACE/ARB recommended; temporary creatinine increase of up to 35 percent OK unless hyperkalemia develops. For eGFR<30, loop diuretics recommended.
#14: CKD & diabetes a. CKD with diabetes: follow published guidelines for diabetics b. ACE/ARB particularly important c. CKD have "higher risk" of diabetic c/c	VI.B. For treating micro/macroalb., ACE/ARB unless pregnant. Reduce protein intake Monitor serum potassium if taking ACE/ARB Cont. surv. of microalb/proteinuria Refer to expert in diabetic/renal if eGFR<60. *Refer to nephrologist if eGFR<30 (in text, not a guideline)*	Thiazide diuretics, BBs, ACEs, ARBs, and CCBs
#15: CKD and CVD CKD are highest risk for CVD Measure CKD for "traditional" CVD risk	VI.A annual lipid panel. Statins recommended for most patients.	