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Pharmacotherapy for chronic kidney disease (CKD) in primary care

Screening for CKD:

eGFR<60mls/min for >90 days

and/or

Urine albumin:creatinine ratio (ACR)>3mg/mmol

Type 2 diabetes†

In all people with CKD at any stage

Offer atorvastatin 20mg OD and titrate as necessary.

eGFR 25-75mls min and/or ACR>3mg/mmol

Offer ACE-I or ARB and titrate to highest tolerable dose. Maintain BP <140/90

When at highest tolerable dose of RAAS inhibitor, add dapagliflozin 10mg regardless of glycaemic control to improve cardiorenal outcomes

If glycaemic control remains suboptimal add other agents according to NICE guideline NG28

ACR>70mg/mmol

Refer for specialist advice if diagnosis of diabetic kidney disease is in doubt (e.g. non-visible haematuria, rapid decline in eGFR, rapid increase in proteinuria, systemic symptoms)

BP target now <130/80

eGFR<30mls/min

Refer for specialist advice

†Does not apply in Type 1 diabetes

No diabetes*

In all people with CKD at any stage

Offer atorvastatin 20mg OD and titrate as necessary

If hypertensive with CKD (criteria above)

ACR<30mg/mmol: follow NICE guideline NG136 on management of hypertension.

ACR >30mg/mmol: use ACE-I or ARB in preference to other agents. Titrate to highest tolerable dose. Maintain BP <140/90 (add other agents as necessary)

If taking highest tolerable dose of RAAS inhibitor, eGFR 25-75mls/min and ACR still 22.6mg/mmol

Offer dapagliflozin 10mg OD to improve cardiorenal outcomes

eGFR<30mls/min or ACR>70mg/mmol*

*BP target now 130/80. Refer for specialist advice

*** Does not apply to patients with renal transplants, or on immunosuppression for ANCA-associated vasculitis or other immunological disease**

A renal diagnosis is required in people who develop CKD with proteinuria. Refer if there is doubt.