Author’s response to reviews

Title: Low documentation of chronic kidney disease among high-risk patients in a managed care population: a retrospective cohort study

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Author’s response to reviews:

Dear Dr. Burgess,

We thank the reviewers for their comments, and have addressed each with a detailed response below. We have attached the revised manuscript which incorporates our edits.

Responses to Reviewer’s Comments of MS#1911835595287531

Reviewer #2:

Minor essential revisions:

I think it would be helpful to record the timeframe that the study was undertaken in as awareness of CKD is changing rapidly.

The following sentences were added to the discussion section: “Because our analyses applied to CKD members identified between January 1, 1999 through January 1, 2006, it is possible that current (2009) documentation of CKD is higher as awareness of CKD in the general population and/or among medical professionals may have increased thanks to advertising and published reports”.

I think it would be helpful for the authors to avoid classifying people between the eGFR of 60 and 90 mls / min as having CKD. Without other markers of kidney disease it is not possible to use the GFR to identify CKD at this level and the estimation formula are least good with well preserved kidney function.

We agree with the reviewer’s comment and did not include people between the eGFR of 60 and 90 in our definition of CKD. (see Methods and Results sections: “To minimize misclassification on CKD status, the current analysis was restricted
to members with an eGFR 10-59 ml/min/1.73m²” and “(…) were excluded because they had an eGFR ≥ 60 (N=39,955).

The authors suggest that early identification delays progression to reverse RD and decreases mortality. Given the fact there have not been randomized controlled trials I think it would be appropriate to say that early identification MAY delay progression and decrease mortality.

We thank Reviewer#2 for this comment and have revised our language to state: “Early identification and appropriate care of CKD patients may delays progression to ESRD and decreases mortality, morbidities, and cost.”.

Reference 12 is not cited.

Reference 12 is now included in the revised manuscript.

Discretionary revisions:

The authors may want to discuss the fact that the MDRD formula used is the 186 formula rather than the IDMS formula. It is not clear if the assay has been calibrated against the Cleveland clinic original MDRD assay and if not there may be significant differences.

We thank Reviewer#2 for this comment. Because our goal was to assess the level of CKD documentation using KPG HMO as the study setting, we report the formula (i.e., MDRD 186) which was used in KPG HMO to derive eGFRs. The revised IDMS MDRD formula was published in 2005 – (Levey AS, Coresh J, Greene T et al). –and would not have reflected the clinical practice during our study period (1999-2007). It is worth noting that the level of CKD awareness in the general population as reported in NHANES (by Coresh et al. NHANES) used the same MDRD 186 formula as we used.

Reviewer #2:

Results are confirmatory of others, however it is important to raise the awareness of CKD in their region. It is unbelievable that the information of race is not available in the records. This reviewer does not understand why they studied eGFR 10-59 ml/min/1.73m² (stage 3 and 5, not stage 3 and 4 in the first session of the Discussion). According to the KDIGO, CKD stage 5 is less than 15 ml/min/1.73m².

Estimated GFR was categorized by 10-point sub-categories (including 10-20 ml/min/1.73m²) solely for the ease of interpretation. The exclusion of patients with an eGFR between 10 and 15 ml/min/1.73m² does not affect our results (the proportion of patients with an eGFR between 10 and 15 ml/min/1.73m² is less than 1% in our study population). However, we do agree that the mention “(stage 3 and 4)” in the first section of the discussion can be misleading and we have
removed it from the revised manuscript.

Quality of written English: Not suitable for publication unless extensively edited

The manuscript has been co-written and revised by four primary English-speaking authors. However, we would appreciate any comments from the editorial staff of BMC Nephrology regarding the quality of the English, should they have any suggested modifications.