

1 **Chronic kidney disease as cardiovascular risk factor in routine clinical practice:**  
2 **a position statement by the Council of the European Renal Association**

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1 **Abstract**

2 The ESC 2021 guideline on Cardiovascular Disease (CVD) Prevention in Clinical Practice has major  
3 implications for both cardiovascular (CV) risk screening and kidney health of interest to primary care  
4 physicians, cardiologists, nephrologists and other professionals involved in CVD prevention. The  
5 proposed CVD prevention strategies require as first step the categorization of individuals into those with  
6 established atherosclerotic CVD, diabetes, familiar hypercholesterolemia or chronic kidney disease  
7 (CKD), i.e. conditions that are already associated with a moderate to very high CVD risk. This places CKD,  
8 defined as decreased kidney function or increased albuminuria as a starting step for CVD risk  
9 assessment. Thus, for adequate CVD risk assessment, patients with diabetes, familiar  
10 hypercholesterolemia or CKD should be identified by an initial laboratory assessment that requires not  
11 only serum to assess glucose, cholesterol and creatinine to estimate the glomerular filtration rate, but  
12 also urine to assess albuminuria. The addition of albuminuria as an entry-level step in CVD risk  
13 assessment should change clinical practice as it differs from the current healthcare situation in which  
14 albuminuria is only assessed in persons already considered to be at high risk of CVD. A diagnosis of  
15 moderate or severe CKD requires a specific set of interventions to prevent CVD. Further research should  
16 address the optimal method for CV risk assessment that includes CKD assessment in the general  
17 population, i.e. whether this should remain opportunistic screening or whether systematic screening .

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## 1 **Introduction**

2 The recent publication of the European Society of Cardiology (ESC) 2021 Guideline on Cardiovascular  
3 Disease (CVD) Prevention in Clinical Practice introduces chronic kidney disease (CKD) risk categories that  
4 are based on the integration of estimated glomerular filtration rate (eGFR) and urinary albumin-to-  
5 creatinine ratio (UACR) data. Furthermore, this guideline indicates that assessment of eGFR and UACR  
6 (i.e. a urine analysis) are needed for correct patient categorization according to CVD risk that will guide  
7 preventive measures. This has major implications for CVD risk screening as well as kidney health, which  
8 is of interest to primary care physicians, cardiologists, nephrologists and other professionals involved in  
9 CVD prevention. In this Position Paper we first provide an overview of the concept and disease burden  
10 of CKD and of the key messages on CKD embedded in the 2021 ESC guideline and then provide a call for  
11 action to implement this guideline in order to improve the outcomes of patients with CKD.

## 12 13 **The concept of chronic kidney disease**

14 In the 2012 KDIGO (abbreviation for Kidney Disease: Improving Global Outcomes), the global  
15 organization developing clinical practice guidelines for nephrology, defined CKD as abnormalities of  
16 kidney structure or function present for  $\geq 3$  months, with implications for health (1, 2). In clinical  
17 practice, the main diagnostic criteria for CKD are the presence of an eGFR below 60 mL/min/1.73 m<sup>2</sup>,  
18 and/or elevated albuminuria i.e. UACR over 30 mg/g. CKD is staged according to 6 eGFR and 3 UACR  
19 categories (Figure 1), with higher categories being associated with increased risk of adverse outcomes  
20 including CKD progression, kidney failure, and fatal and non-fatal CVD. Combinations of specific eGFR  
21 and UACR cells are used to define three global risk classes: CKD with mildly increased risk, CKD with  
22 moderately increased risk, and CKD with severely increased risk (Figure 1).

23 A key message from the 2012 KDIGO guideline was that a low eGFR is not a prerequisite for CKD  
24 diagnosis; for example, a person with normal eGFR can be diagnosed with CKD if albuminuria is

1 elevated. This enables CKD identification at an early stage, and thus allows timely start of effective  
2 prevention of CKD progression towards kidney failure.

3

#### 4 **Current and future burden of CKD**

5 Globally, around 10 to 12% of the general population has CKD, implying that this involves 850 million  
6 persons (3). Despite being largely preventable and treatable, the prevalence of CKD as well as mortality  
7 due to CKD are increasing (4). The Global Burden of Disease study projects that worldwide by 2040, CKD  
8 will become the fifth most common cause of death (5). The years of life lost due to CKD will double. This  
9 represents the fastest predicted increase among the major causes of death, after Alzheimer's disease  
10 (5). Notably, the increasing burden of CKD may be magnified in countries with changing demography  
11 due to an aging population, as is the case for several European countries. For example, it is projected  
12 that CKD will become the second leading cause of death in Spain before the end of the century (7).

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#### 14 **KDIGO 2012 guideline and the concept of CKD**

15 Awareness of the concept of CKD, and of the possible consequences, is key to promoting both  
16 cardiovascular and kidney health. However, in routine clinical practice, the implementation of  
17 diagnosing CKD is far from desirable. For instance, in several countries screening for eGFR and  
18 albuminuria in patients at high risk for CKD lags seriously behind what is advised in guidelines (6).  
19 Currently, the invisibility of CKD as a clinical diagnosis is a barrier to the implementation of  
20 cardiovascular risk mitigation strategies as CKD patients are not identified as such. In recent cohort  
21 studies, only 23% to 39% of patients with CKD actually had a CKD diagnosis registered in the electronic  
22 health records by their treating physician (8,9). This has consequences, as for instance patients lacking  
23 CKD diagnoses were more frequently prescribed nephrotoxic medications (8).

1 Notably, there is still confusion regarding the concept of CKD among some physicians. For  
2 instance, as recently as 2018, a seminal medical journal published a manuscript that referred to all  
3 patients with an eGFR above 60 mL/min/1.73 m<sup>2</sup> as having CKD G1/G2, although in most albuminuria or  
4 structural kidney abnormalities were not assessed (2).

### 6 **ESC 2021 guideline on CVD Prevention in Clinical Practice**

7 In 2021, the ESC issued an update of its seminal guideline on CVD Prevention in Clinical Practice (10).  
8 This update was made in consensus with 12 medical societies, including the European Renal Association  
9 (ERA) (10). As the prior 2016 edition, the 2021 guideline recognizes CKD, diagnosed as a low eGFR (<60  
10 mL/min/1.73 m<sup>2</sup>), as a cardiovascular risk factor (11). However, from the perspective of the ERA, this  
11 guideline incorporates four main novelties:

12 1. The concept of moderate and severe CKD is expanded by incorporating albuminuria into the  
13 definition. Thus, moderate CKD is no longer limited to persons with an eGFR 30-59 ml/min/1.73 m<sup>2</sup>  
14 and severe CKD is no longer limited to an eGFR <30 ml/min/1.73 m<sup>2</sup>, as they were in 2016. Rather,  
15 moderate, and severe CKD now follow the KDIGO global risk classes to encompass a combination of  
16 eGFR and UACR values that is associated with high or very high CVD risk (Figure 1). Thus, now CKD  
17 diagnosed by not only low eGFR, but also high UACR is acknowledged as a strong and independent  
18 risk factor for CVD. Although the 2016 guideline mentioned albuminuria, it did not integrate it into  
19 an integrated cardiovascular risk score.

20 2. Assessment of CKD, based on either elevated albuminuria (>30 mg/g) or low eGFR (<60  
21 mL/min/1.73 m<sup>2</sup>), should be part of routine CV risk assessment (see below).

22 3. When CKD is present, not only an ACE inhibitor or an ARB, but also an SGLT2 inhibitor should be  
23 considered if non-diabetic and is recommended if the patient has type 2 diabetes to prevent  
24 progression of CKD and CV events (Table 1). This advice was based on the results of the DAPA-CKD

1 trial, in which patients with CKD and with or without type 2 diabetes were included (12). Recently,  
2 the EMPA-KIDNEY Trial, that included a similar patient population, was stopped early because of  
3 positive efficacy that met the study's pre-specified threshold for early termination (13). This has  
4 strengthened the evidence supporting this advice.

- 5 4. Nomenclature for CKD classes is proposed, which is easier to understand than the original one by  
6 KDIGO. It is based on the associated overall risk of adverse health outcomes: mild CKD, moderate  
7 CKD (associated with high CV risk), and severe CKD (associated with very high CV risk) (Figure 1).  
8 This simplified nomenclature may facilitate uptake of the CKD concept, and its incorporation into  
9 clinical diagnostic codes and risk assessment tools.

#### 11 **Implications for screening**

12 The ESC 2021 guideline on CVD Prevention in Clinical Practice has major implications for both CV risk  
13 screening and kidney health, stating that not only blood pressure, cholesterol and glucose should be  
14 assessed to estimate CV risk in an individual, but also albuminuria and eGFR. This goes beyond the  
15 traditional view that eGFR and UACR should only be assessed in populations at high risk for CKD, i.e.  
16 those with proven hypertension, proven diabetes or a CVD history. In this regard, every healthcare  
17 system should promote that individuals should know their ABCDE profile regarding CV risk — i.e.  
18 albuminuria, blood pressure, cholesterol, diabetes status, and eGFR. This ABCDE profile should be  
19 considered along with other risk factors that are self-evident for the individual, such as obesity and  
20 smoking.

21 Screening strategies should begin at an age at which absolute risk for outcomes is high enough  
22 to warrant preventive strategies, and that allows sufficient lead time for preventive approaches to be  
23 successful. The ESC 2021 guideline on CVD Prevention in Clinical Practice supports considering  
24 opportunistic and even systematic CV risk assessment among the general population, in men >40 years

1 of age and in women who are postmenopausal or >50 years of age, even when these subjects have no  
2 known atherosclerotic CVD risk factors (class IIb, level C). As discussed above such screening should  
3 include eGFR and UACR, and could be repeated after 5 years, or sooner if risk was close to treatment  
4 thresholds (class IIb, level C).

5 The design of a health check-up directed at prevention of CVD includes CKD awareness and  
6 should be adapted according to local resources and characteristics of the population. It may range from  
7 opportunistic screening by general practitioners, as done nowadays in most countries, to an extensive  
8 health check-up performed at healthcare centres, including a medical history, physical exam and basic  
9 serum and urine biochemistry. From a CKD perspective, the future may even bring home-based urine  
10 screening for albuminuria. Such screening could be linked to currently existent colon cancer screening  
11 campaigns that in some countries are implemented around the assessment of occult faecal blood in a  
12 sample collected at home (14). Addition of a urine sample will take advantage of an ongoing screening  
13 effort and would only add the cost of albuminuria assessment. This would identify target organ injury  
14 (i.e. kidney injury) that could result from various known or unknown pre-existing conditions, and  
15 thereby identify patients who require a more in-depth assessment and optimized therapy. Such a  
16 strategy is likely cost-effective to delay or prevent dialysis and CVD (15).

17 Emphasizing that screening for CVD risk factors should include CKD markers is timely for several  
18 reasons. First, because we can now estimate risk better. Adding albuminuria and eGFR to the SCORE2  
19 and SCORE2-OP algorithms improves CVD risk prediction in subjects with CKD (16,17) (**Figure S1**). Precise  
20 information about prognosis may stimulate patients and physicians to start preventive treatments  
21 (Table 1). Second, because we can now treat patients better. In the last decade various agents have  
22 demonstrated cardio- and renoprotection on top of standard-of-care including RAS inhibitors, GLP1  
23 analogues, SGLT2 inhibitors, and the nonsteroidal MRA finerenone (18-22). Notwithstanding this  
24 progress in knowledge, it should also be noted that CKD patients have been excluded from several CVD

1 trials (23). For some interventions it is therefore still unresolved what their efficacy-safety ratio is in  
2 specifically subjects with CKD. Including subgroups of CKD patients in CVD trials yet to be started will  
3 therefore be important.

#### 4 5 **A call to action by the Council of the European Renal Association**

6 The ESC emphasizes in their guideline that subjects with CKD are at high risk for CVD, and has given CKD  
7 a prominent place in CVD prevention. The guideline now requires several stages of dissemination and  
8 implementation into clinical practice. If correctly planned this may also generate novel information  
9 regarding the optimal implementation strategies:

- 10 1. Wide dissemination of the concept that assessment of serum creatinine (eGFR) and albuminuria  
11 (UACR) should be part of any evaluation of CV risk. The message should reach all key stakeholders:  
12 healthcare system payers, healthcare personnel, patients, and the general population. To achieve  
13 this goal, nephrologists should liaise with primary care physicians, CVD physicians and cardiologists  
14 as key healthcare stakeholders. For instance, they could work out this concept in national  
15 guidelines for management of CKD and for cardiovascular disease prevention, develop educational  
16 tools, and organize post-graduate medical education for the various specialties involved. To reach  
17 other healthcare personnel, healthcare system payers and the general population the organization  
18 of CKD awareness campaigns are indicated. The ERA has templates for such campaigns, for instance  
19 to be organized around World Kidney Day (24).
- 20 2. Europe-wide evaluation of optimal screening strategies to identify CKD. Given the differences in  
21 baseline risk for CVD and CKD, and the different healthcare systems, it is unlikely that a single  
22 strategy fits all and that the type of screening will depend on local financial resources and logistic  
23 possibilities. On a national level initiatives should be started how to best screen for CKD, as for  
24 instance the THOMAS study in the Netherlands that investigates the cost-effectiveness of two



1 different ways of home-based albuminuria screening of the general population (25). A prospective  
2 pan-European evaluation of different screening strategies may allow definition of the optimal  
3 strategy for local conditions. This could be achieved via the organization of an invitational  
4 conference on this topic to be organized by the ERA, KDIGO and/or ESC.

- 5 3. CKD patients should be included in CVD trials yet to be started. Integration of cohorts into registries  
6 may generate pragmatic trials that test novel CV protective strategies identified through clinical  
7 trials from which CKD patients were excluded. Conversely, clinical trials focused on CKD populations  
8 should also have CV end points as CVD constitutes a major proportion of morbidity and mortality in  
9 this patient population.

10  
11 In conclusion, the ESC 2021 guideline on CVD Prevention in Clinical Practice identifies albuminuria and  
12 eGFR as cardiovascular risk factors that need assessment. Ample dissemination of this guideline among  
13 primary care physicians and specialists offers the opportunity for an earlier diagnosis and treatment of  
14 CKD and is expected to improve both cardiovascular and kidney outcomes in affected subjects.

15  
16 **Conflict of interest:** authors are members of the Council of the European Renal Association (ERA).  
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ACCEPTED MANUSCRIPT

1 **Table 1: Interventions suggested or recommended for primary prevention in persons with CKD**  
2 **according to the ESC 2021 guideline on CVD Prevention in Clinical Practice.**

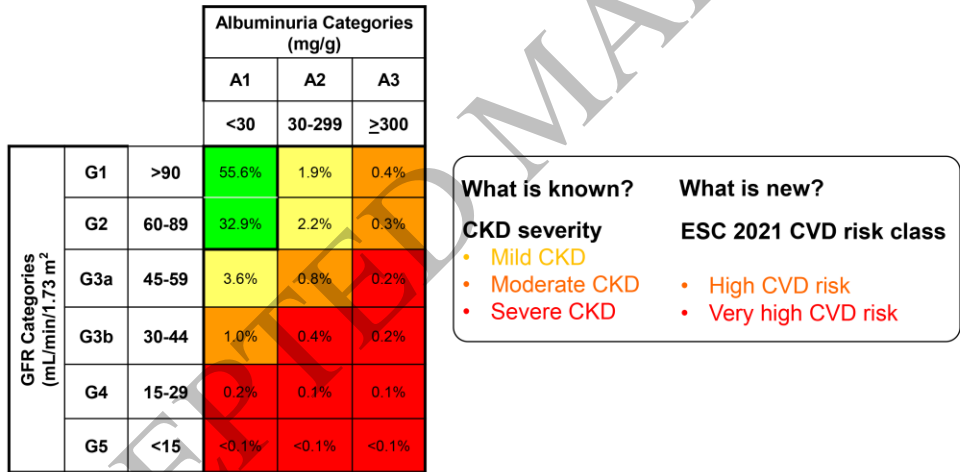
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4 In persons with moderate or severe CKD, there is no need to estimate 10-year fatal and nonfatal CVD  
5 risk with either SCORE2 or SCORE2-OP. The CVD risk is already high (moderate CKD) or very high (severe  
6 CKD), respectively warranting preventive interventions according to the level of risk, such as:

- 7 • *For all patients with CKD:*
  - 8 - Lifestyle advice including diet and appropriate weight
  - 9 - Blood pressure control, preferably by RAS inhibitors
- 10 • *For CKD patients with specific conditions:*
  - 11 - LDL-cholesterol reduction to target (LDL-C <1.8 mmol/L (70 mg/dL) in high-risk patients and  
12 <1.4 mmol/L (55 mg/dL) in very-high risk patients)
  - 13 - RAS inhibition in case of severely elevated albuminuria, independent of blood pressure
  - 14 - SGLT2 inhibition for those with type 2 diabetes, or with diabetic as well as non-diabetic  
15 kidney disease and an eGFR higher than 25 ml/min/1.73m<sup>2</sup>, or with heart failure
- 16 • *In addition, for consideration to prevent CVD in specific patients (not part of the ESC guideline):*  
17 *(nonsteroidal) mineralocorticoid receptor antagonists and/or PCSK9 inhibitors.*

18

1 **Figure 1: Translation of chronic kidney disease (CKD) risk classes (as defined by KDIGO in 2012) into**  
 2 **cardiovascular disease (CVD) risk classes as defined by the European Society of Cardiology in the 2021**  
 3 **guideline on CVD Prevention in Clinical Practice.** Numbers within cells represent prevalence in the  
 4 general population.

**Figure 1.** Translation of chronic kidney disease (CKD) risk classes (as defined by KDIGO in 2012) into cardiovascular (CVD) risk classes as defined by the European Society of Cardiology in the 2021 guideline on CVD prevention. Numbers within cells represent prevalence in the general population.



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