Improving the prognosis of patients with severely decreased glomerular filtration rate (CKD G4+): conclusions from a Kidney Disease: Improving Global Outcomes (KDIGO) Controversies Conference

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Patients with severely decreased glomerular filtration rate (GFR) (i.e., chronic kidney disease [CKD] G4+) are at increased risk for kidney failure, cardiovascular disease (CVD) events (including heart failure), and death. However, little is known about the variability of outcomes and optimal therapeutic strategies, including initiation of kidney replacement therapy (KRT). Disease: Improving Global Outcomes (KDIGO) organized a Controversies Conference with an international expert group in December 2016 to address this gap in knowledge. In collaboration with the CKD Prognosis Consortium (CKD-PC) a global meta-analysis of cohort studies (n = 264,515 individuals with CKD G4+) was conducted to better understand the timing of clinical outcomes in patients with CKD G4+ and risk factors for different outcomes. The results confirmed the prognostic value of traditional CVD risk factors in individuals with severely decreased GFR, although the risk estimates vary for kidney and CVD outcomes. A 2- and 4-year model of the probability and timing of kidney failure requiring KRT was also developed. The implications of these findings for patient management were discussed in the context of published evidence under 4 key themes: management of CKD G4+, diagnostic and therapeutic challenges of heart failure, shared decision-making, and optimization of clinical trials in CKD G4+ patients. Participants concluded that variable prognosis of patients with advanced CKD mandates individualized, risk-based management, factoring in competing risks and patient preferences.

KEYWORDS: chronic kidney disease; kidney failure; prediction; prognosis; progression; supportive care

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See Appendix for list of other conference participants.

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Individuals with a GFR below 30 ml/min per 1.73 m² (i.e., CKD G4 or G5) are at particularly high risk across all albuminuria categories (Figure 1). In addition, CKD-specific complications increase markedly at low levels of GFR, with cardiovascular disease (CVD) being a leading cause of morbidity and mortality. Of particular relevance is heart failure (HF), one of the most common CVD conditions for patients with CKD G4 or higher.

Kidney replacement therapy (KRT; i.e., dialysis or transplantation) can mitigate the consequences of kidney failure and improve prognosis. However, there are large variations in incidence rates of KRT, and globally only approximately half of those with kidney failure receive KRT. Inequalities in access to KRT play an important role, but differences in practice patterns also exist. There is agreement that level of GFR alone should not be used as a trigger for KRT initiation, and that signs and symptoms associated with kidney failure should be considered. Nevertheless, defining the optimal time for KRT initiation remains a challenge. Importantly the first few months on dialysis have been identified as a very high-risk period, though it remains unknown to what extent adverse events are triggered by dialysis initiation. Referral to nephrology services shortly before dialysis initiation has been associated with an increased risk of adverse outcomes as compared with earlier referral.

Thus, low GFR (<30 ml/min per 1.73 m²) corresponding to CKD G4 or G5 (excluding patients on KRT and referred to subsequently as “CKD G4+”) reflects a critical state for patients. A better understanding of prognosis of patients with CKD G4+ may inform treatment strategies, including decision-making for initiation of KRT. Therefore, Kidney Disease: Improving Global Outcomes (KDIGO) collaborated with the CKD Prognosis Consortium (CKD-PC) to initiate a global meta-analysis of cohort studies (population-based cohorts, referred CKD cohorts, and research cohorts). The primary aim was to determine the prognosis of patients with advanced CKD with respect to initiation of KRT, CVD events, mortality, and relative timing of these events, with a second aim to determine variability of patient prognosis according to cohort, demographic, or health characteristics.

The results from the global meta-analysis were presented to an international expert group at a KDIGO Controversies Conference in December 2016, and implications for patient management were discussed. Breakout groups focused on: (i) management of CKD G4+, (ii) diagnostic and therapeutic challenges of HF in CKD G4+, (iii) shared decision-making for KRT initiation, and (iv) optimization of clinical trials in CKD G4+ patients. To curtail the scope of the conference, specific aspects of children and patients with a failing transplant were not addressed.

We present here a summary of the discussion and main conference conclusions with respect to management and future research in patients with CKD G4+. Detailed presentations of the meta-analysis are published in the companion papers.

**Figure 1 | Schematic presentation of chronic kidney disease (CKD) categories and conference focus.** Per definition, CKD G5 includes patients with kidney failure with and without kidney replacement therapy (KRT). The conference focus (dashed line) was on patients within glomerular filtration rate (GFR) categories G4 and G5, excluding individuals already on KRT, but including KRT as an important end point. D = patients on dialysis therapy, T = patients with a kidney transplant. Colors reflect different risk categories for adverse outcomes as compared with individuals without CKD: green = no increase in risk; yellow = slightly elevated risk; orange = moderately elevated risk; and red = severely elevated risk. Adapted with permission from Kidney Disease: Improving Global Outcomes (KDIGO) CKD Work Group. KDIGO 2012 Clinical Practice Guideline for the Evaluation and Management of Chronic Kidney Disease. Kidney Int Suppl. 2013;3:1–150.

**Prognosis of patients with CKD G4+: novel insights from a global meta-analysis of cohort studies**

In preparation for the conference, we conducted a global meta-analysis with the goal of examining absolute and relative risks of outcomes in a large, diverse population of patients with CKD stage G4+. The meta-analysis of risk factors for KRT, CVD events, and death included 28 cohorts (n = 185,024) using standard survival analysis and Cox regression. The risk prediction meta-analysis included 29 cohorts (n = 264,296).

The main findings included that established risk factors for CVD were highly relevant in CKD G4+ patients, but their relative importance differed by outcome (Figure 2). Age and history of CVD were negatively related to risk of KRT but positively related to CVD and death risk. Current smoking was most strongly associated with death. Blood pressure was positively associated with KRT risk but showed a U-shaped association with CVD and mortality. Diabetes and male sex were risk factors for all outcomes but strongest for CVD and KRT, respectively. Black race was only positively related to KRT. Lower estimated GFR (eGFR) and higher albumin-to-creatinine ratio (ACR) were more strongly associated with KRT than other outcomes. Finally, time-varying CVD events and initiation of KRT were strongly associated with subsequent occurrence of death. The second meta-analysis focused on the development of a new risk calculator for CVD events, KRT and death, as diagrammed in Supplementary Figure S1.
The CKD G4+ risk calculator uses a pie chart format to show the probability of all outcomes in a given follow-up period (2 or 4 years) (online calculator: http://www.kdigo.org/equation/). For example, as illustrated in Figure 3, at an eGFR of 25 ml/min per 1.73 m² and the covariates noted in the figure legend, the proportion of participants predicted to receive KRT within 4 years increases from 13% to 32% with increasing albuminuria, while the risk of death increases from 22% to 30%. In the overall population examined who had a median eGFR of 24 ml/min per 1.73 m² and ACR of 168 mg/g, over 50% of participants were predicted to be event free at 4 years.

The predicted risk of remaining event free for 2 years varies from less than 20% to greater than 80%, illustrating the predictive power of measured patient characteristics.9 This CKD-PC global meta-analysis9 extends the established kidney failure risk equation (KFRE) for prediction of KRT11,12 as well as confirms its value in CKD G4+. Together with the KFRE, the new CKD G4+ risk calculator provides easily accessible tools to physicians, patients, and policy makers that translate patient characteristics into powerful risk discrimination. It is still important to keep in mind that additional characteristics, often unmeasured, influence risk further, and hence part of individualization should include recognition of the limitations of quantitative risk estimates.

Management of patients with CKD G4+

Risk-based assessment and management. People with CKD G4+ are at risk for kidney failure, hospitalizations, CVD events, death, and often under-recognized outcomes such as disability, cognitive impairment, falls, and infection. The KFRE equation11 and the new CKD G4+ risk calculator provide useful tools in risk prediction, and their consistency is reassuring. Other similar models have also been published.13,14 Further refinement including prediction of additional patient-relevant outcomes remains an important task for future research. Nevertheless, the available models appear sufficient to advocate for their implementation.

Incorporating patient preferences and values. There is growing recognition that patients want to be involved as equal partners in their care.15 Shared decision-making can lead to productive interactions between patients, family, carers, and health care providers, thus actively involving all partners in treatment decisions, providing sufficient education about treatment options and their attributes, utilizing strategies to elicit patients’ values, identifying patient preferences, and

<table>
<thead>
<tr>
<th>Variables</th>
<th>KRT</th>
<th>CVD</th>
<th>Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, 10 years</td>
<td>0.74</td>
<td>1.30</td>
<td>1.68</td>
</tr>
<tr>
<td>Male sex</td>
<td>1.44</td>
<td>1.14</td>
<td>1.14</td>
</tr>
<tr>
<td>Black</td>
<td>1.49</td>
<td>1.02</td>
<td>0.93</td>
</tr>
<tr>
<td>History of CVD</td>
<td>0.91</td>
<td>2.57</td>
<td>1.27</td>
</tr>
<tr>
<td>Smoker</td>
<td>1.02</td>
<td>1.07</td>
<td>1.37</td>
</tr>
<tr>
<td>SBP &lt; 140, 20 mm Hg</td>
<td>1.25</td>
<td>0.90</td>
<td>0.84</td>
</tr>
<tr>
<td>SBP ≥ 140, 20 mm Hg</td>
<td>1.17</td>
<td>1.09</td>
<td>1.02</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>1.30</td>
<td>1.41</td>
<td>1.12</td>
</tr>
<tr>
<td>eGFR, −5 ml/min per 1.73 m²</td>
<td>1.73</td>
<td>1.07</td>
<td>1.12</td>
</tr>
<tr>
<td>ACR, 2-fold increase</td>
<td>1.26</td>
<td>1.05</td>
<td>1.04</td>
</tr>
<tr>
<td>Time-varying CVD</td>
<td>2.28</td>
<td>−</td>
<td>2.87</td>
</tr>
<tr>
<td>Time-varying KRT</td>
<td>−</td>
<td>1.39</td>
<td>2.07</td>
</tr>
</tbody>
</table>

Figure 2 | Hazard ratios for KRT, CVD events, and death associated with different variables. Colors indicate the strength of association, from protective in green to strongly positive in red. Based on 19 cohorts with KRT, CVD, and death outcomes. Bold denotes statistically significant values. ACR, albumin-to-creatinine ratio; CI, confidence interval; CVD, cardiovascular disease; eGFR, estimated glomerular filtration rate; KRT, kidney replacement therapy; SBP, systolic blood pressure. Adapted with permission from Evans M, Grams ME, Sang, Y, et al. Risk factors for prognosis in patients with severely decreased GFR. Kidney Int Rep. https://doi.org/10.1016/j.ekir.2018.01.002.
achieving agreement about the course of treatment. Further work to develop and evaluate strategies and resources for shared decision-making within CKD care is required to achieve these goals.

**Models of care.** So far, data on the systematic implementation of models of care for people with CKD G4+ are relatively sparse, and the relationships between specific elements of CKD care and patient outcomes remain to be determined. Nevertheless, a number of overarching considerations appear valid (Table 1), and specific stakeholder issues should be considered (Supplementary Table S1). Moreover, key competencies can be outlined that appear critical for successful implementation of models of care (Supplementary Table S2).

The potential benefits of a multidisciplinary team approach have been described over 20 years ago. A recent systematic review (18 studies; 8853 patients) found that multidisciplinary care of patients with CKD was associated with lower risks of all-cause mortality, dialysis, and central venous catheter use for dialysis access. Although initially associations with improved outcomes have been limited to observational studies and had not been borne out in randomized trials, 2 recent trials have reported encouraging results. The ESCORT (Effectiveness of Integrated Care on Delaying Progression of Stage 3-4 Chronic Kidney Disease in Rural Communities of Thailand) study, a community-based, cluster randomized controlled trial, reported significant delay in progression of CKD associated with improvements in blood pressure and diabetes control and serum bicarbonate with the introduction of an integrated CKD care program. In addition to routine care, comprehensive medical care and education including advice on diet, exercise, and medication was provided as part of the intervention. In another cluster randomized controlled trial, Lalonde and colleagues introduced a training and communication network program for pharmacists as part of the multidisciplinary care of people with CKD in Quebec, Canada.

![Figure 3](https://example.com/figure3.png)
already benefiting from multidisciplinary care, the introduction of the program improved the quality of medication use and reduced the number of drug-related problems by 15%. It seems intuitive that access to multidisciplinary care providers may be attractive to many patients; however, the impact on patient experience and the optimal design and involvement of team members still remains unclear.23 We suggest that models of care should place patients at the center of a transparent and open structure that ensures optimal communication and use of available resources (Supplementary Figure S2).

Additional research is needed to explore models that address context-specific care in low- and middle-income countries, multi-morbidity and integration of multidisciplinary care providers and other specialists around the patient; new technologies that can enhance communication between stakeholders; and strategies to bridge transitions of care between hospital and community, as well as between phases of CKD, dialysis, and transplant care.

**Uncertainties about targets and therapies.** There are important uncertainties in CKD G4+ management (Table 2). In general these include interventions that are either targeting patient experience and the optimal design and involvement of team members still remains unclear. The inclusion of CKD G4 patients with CKD G4, including blood pressure and glycemic control, major surgery, and other medical procedures or exposures? Do these vary by degree of albuminuria? 2. Should treatment goals, including blood pressure, be modified dependent upon age and/or comorbidity? 3. Can we extrapolate recommended HbA1c targets to people with CKD G4+? 4. Should metformin treatment be discontinued in people with diabetes and CKD G4+? 5. Should we advise a restricted salt intake in people with CKD G4+, and if so what level of intake should we advise? 6. Should we advise modification of dietary protein intake in people with CKD G4+? For example, should we advise more plant-based protein intake? 7. Should we treat acidosis in people with CKD G4+, and if so, at what level of serum bicarbonate should treatment be initiated? 8. Should asymptomatic hyperuricemia be treated in people with CKD G4+, and if so, at what level of serum uric acid should treatment be initiated? 9. Should aspirin for prevention of cardiovascular disease be continued in people with CKD G4+, or does the risk of bleeding outweigh potential benefits? 10. Do other cardiovascular disease prevention strategies convey the same benefits in people with CKD G4+ as compared with people with less advanced CKD? 11. How can the risk of acute kidney injury in people with CKD G4+ be mitigated? Should we advise tablet holidays during intercurrent illness, and if so, what tablets should be temporarily discontinued and for how long? 12. Are there subclinical events such as tubulointerstitial injury, inflammation and fibrosis, and unrecognized episodes of acute kidney injury associated with CKD progression, and are these linked to short-lived prescription of medicines or to nonprescription medication exposures?

Research recommendations for management of patients with CKD G4+ are summarized in Table 3.

**Cardiovascular complications during CKD G4+: heart failure**

A focus of management during CKD G4+ is on preventing CVD, which remains one of the leading causes of morbidity and mortality. HF is of special relevance for CKD G4+ patients as it is one of the most common cardiovascular conditions, and yet there remain many diagnostic and therapeutic uncertainties in the management of HF during CKD G4+, particularly in patients approaching the transition to KRT.

**Definition, risk factors, and diagnosis of heart failure in CKD G4+**

Patients with CKD have an elevated risk of HF27,28 that increases with severity of CKD.29 Among patients receiving KRT, 40% have HF,30 with higher prevalence rates among patients on hemodialysis compared with peritoneal dialysis and kidney transplant recipients.31 The cumulative incidence of HF is also high among patients with CKD and those receiving KRT (Supplementary Figure S3).32 HF is defined as a syndrome of inadequate filling and/or pumping to meet systemic demands. There are 2 types of HF, with preserved ejection fraction (HFpEF) and reduced ejection fraction (HFrEF), and defining HF subtypes has been an area of ongoing work by the ACCF/AHA33 and ESC.34

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**Table 1 | Ten points to consider within models of care for CKD G4+**

1. Patient-orientated care should be a key priority
2. Categorize CKD according to cause of kidney disease, level of GFR, and degree of albuminuria
3. Estimate risk and prognosis and tailor management accordingly
4. Prevent CKD progression and avoid acute kidney injury where possible
5. Evaluate and manage comorbid conditions, paying particular attention to ischemic heart disease, heart failure, and stroke prevention
6. Identify, prevent, and manage CKD-specific complications (e.g., malnutrition, anemia, bone disease, and acidosis)
7. Plan and prepare for treatment of kidney failure (e.g., choice of modality, access-placement and care, pre-emptive transplantation) and provide conservative care and palliative care options where required
8. Ensure that psychosocial support is provided
9. Maintain continuity across transitions of care
10. Ensure that all communication channels are open: CKD care system to patient and/or carer; between CKD team members; and between CKD team and other health professionals

**Table 2 | Therapeutic uncertainties in CKD G4+ management**

1. How should we weigh the risks-benefits of common medical and surgical interventions in people with CKD G4+, including blood pressure and glycemic control, major surgery, and other medical procedures or exposures? Do these vary by degree of albuminuria?
2. Should treatment goals, including blood pressure, be modified dependent upon age and/or comorbidity?
3. Can we extrapolate recommended HbA1c targets to people with CKD G4+?
4. Should metformin treatment be discontinued in people with diabetes and CKD G4+?
5. Should we advise a restricted salt intake in people with CKD G4+, and if so what level of intake should we advise?
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7. Should we treat acidosis in people with CKD G4+, and if so, at what level of serum bicarbonate should treatment be initiated?
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9. Should aspirin for prevention of cardiovascular disease be continued in people with CKD G4+, or does the risk of bleeding outweigh potential benefits?
10. Do other cardiovascular disease prevention strategies convey the same benefits in people with CKD G4+ as compared with people with less advanced CKD?
11. How can the risk of acute kidney injury in people with CKD G4+ be mitigated? Should we advise tablet holidays during intercurrent illness, and if so, what tablets should be temporarily discontinued and for how long?
12. Are there subclinical events such as tubulointerstitial injury, inflammation and fibrosis, and unrecognized episodes of acute kidney injury associated with CKD progression, and are these linked to short-lived prescription of medicines or to nonprescription medication exposures?

**CKD, chronic kidney disease; GFR, glomerular filtration rate.**

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Evaluation of novel, emerging, and existing pharmacotherapeutic approaches. Researchers should consider clinical impact analyses of tools that link prognostic information on kidney failure to specific guidance for common CKD management decisions and evaluate the impact on measures of appropriateness, timeliness, patient-centeredness, and efficiency of CKD care.

Derivation, validation, and impact analyses of prognostic models for other outcomes in addition to kidney failure. In addition to CVD events, kidney failure, and death, models should consider patient-centered outcomes including quality of life, functional status, cognitive impairment and hospitalization. Prognostic models that help patients and providers weigh the relative benefits and risk of common medical therapies, radiologic procedures (e.g., angiography), and surgery for patients with CKD should also be investigated.

2. Incorporating patient preferences and values
Development and evaluation of tools and resources to elicit patient values and preferences for management options throughout CKD stages. Such studies should evaluate the impact of tools to facilitate shared decision-making on patient-reported outcomes and experience measures, including measures of knowledge transfer and the quality of decision-making processes in CKD management.

3. Models of care
Evaluation of the impact of clinic structures and processes on patient experience, outcome measures, and costs of providing care. Specific structural interventions that require further evaluation include financial incentives to support longitudinal patient care rather than episodic health care contacts; novel strategies to address multi-morbidity; technology-based strategies to enhance communication; and transition of care interventions addressing gaps between hospital and community, as well as between phases of pre-dialysis, dialysis, and transplant care.

4. Uncertainties about targets and therapies
Evaluation of novel, emerging, and existing pharmacotherapeutic strategies in randomized controlled trials specifically in populations with CKD G4+. Promising therapies include bicarbonate therapy and treatment of asymptomatic hyperuricemia to slow progression in the later stages of CKD, as well as aspirin for primary prevention of cardiovascular events. Inclusion of patients with CKD G4+ should also be a priority for future trials of blood pressure control, glycomic targets, and comparative effectiveness studies of medication safety.

CKD, chronic kidney disease; CVD, cardiovascular disease.

Traditional as well as novel risk factors, including metabolic abnormalities, uremic toxins, and sympathetic overactivity, accelerate the development of HF in patients with CKD G4+ (Supplementary Table S5).

Outcomes associated with heart failure in CKD G4+. HF is associated with poor outcomes in patients with CKD, including greater risk of death, particularly in patients who are older, have HFrEF (Supplementary Table S6), or have severely decreased GFR (Figure 4). HF contributes significantly to morbidity among CKD patients, leading to frequent hospitalizations and re-hospitalizations. HF is also associated with episodes of acute kidney injury and progression of CKD. Among incident dialysis patients, volume overload compared with other dialysis indications is associated with the greatest risk of post-KRT mortality.

Progression of clinical and subclinical heart failure after initiation of dialysis. Only a few studies have evaluated longitudinal changes in subclinical HF, as assessed by echocardiograms, in patients with CKD G4+, and the results are not consistent. In the CRIC study, mean left ventricular mass index did not change after the initiation of KRT. However, there was a modest but statistically significant decline in left ventricular ejection fraction. The CASCADE study examined echocardiograms in patients with CKD G3+ and reported that left ventricular mass index and left atrial volume both increased within a year; however, the change in left ventricular ejection fraction was not statistically significant. In the IDEAL trial, serial echocardiograms performed 12 months apart showed no change in left ventricular mass index, left atrial diameter, diastolic dysfunction, or left ventricular ejection fraction after dialysis initiation. It should be noted, however, that in this study, over 40% initiated peritoneal dialysis (PD) versus hemodialysis (HD). In another study of 41 HF patients, left ventricular mass index decreased after initiation of HD.

Vascular access and heart failure. Vascular access preparation is a key component of management in CKD G4+ patients. There are numerous postulated changes in the cardiovascular system after creation of an arteriovenous fistula (Supplementary Table S7). Small studies or case reports have

(Supplementary Table S4). HFrEF is more common in patients with CKD.

Diagnosis of HF remains challenging in patients with CKD, particularly in CKD G4+, given the difficulty in distinguishing causes of volume overload. HF should be defined as the presence of HF symptoms and structural and/or functional abnormalities on cardiac imaging (Supplementary Table S4). In observational studies, imaging data are frequently not available. In fact, in the CKD-PC analysis, HF definitions were not sufficiently harmonized across cohorts to allow a valid analysis of incidence rates and risk prediction. Moreover, despite the recognized importance of HF, it remains unknown whether screening for HF, either with imaging or cardiac biomarkers, leads to improved outcomes in patients with CKD G4+.


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suggested that arteriovenous fistula may lead to development of high-output HF. \cite{34-38} Arteriovenous fistula creation has also been reported in small studies to worsen right ventricular hypertrophy and pulmonary hypertension \cite{34,39} and found to be associated with significant right ventricular dilatation and remodeling and an increased risk for development of incident heart failure. \cite{60} On the other hand, other studies found a stabilization of kidney function after access creation. \cite{61} Larger prospective studies are needed to understand optimal access management in patients with CKD G4+ and HF.

**Management of heart failure in CKD G4+.** Management of HF in patients with CKD, particularly CKD G4+, is complicated (Table 4). Almost all HF trials have excluded patients with advanced CKD, and few have been successful in improving outcomes in patients with HFrEF. Post hoc analyses have included some patients with moderate CKD, but suggest an attenuated effect of therapies such as β-blockers and implantable cardioverter defibrillators. \cite{62-64} In addition, the presumed risk of hyperkalemia limits the use of RAAS inhibitors and mineralocorticoid receptor antagonists in CKD G4+. \cite{44,65} Among patients receiving KRT with known HF, the proportion of patients with prescribed therapies such as RAAS inhibitors and β-blockers remains low. \cite{31} Further studies of HF therapies and cardiac devices specifically in CKD G4+ are needed, particularly for HFrEF, which remains the leading type of HF in patients with CKD G4+ (Supplementary Table S4 and Table 5). Although the rates of incident (i.e., de novo) and recurrent heart failure are reported to be lower in PD versus HD patients, \cite{66-68} in patients with established HF the mortality rate may be higher in PD versus HD patients. \cite{69} This likely reflects confounding by indication because frail HF patients are preferentially offered PD as it causes less acute hemodynamic stress. Prospective clinical trials comparing PD with HD are warranted.

**Shared decision-making for kidney failure therapy**

**Predicting adverse outcomes after initiation of kidney replacement therapy.** Several registries \cite{70,71} and cohort studies, \cite{6} provide population-based risks of mortality in patients initiating KRT. An important observation is that mortality rates are highest within the first 4 months of starting dialysis and decline in subsequent months. \cite{6} In the DOPPS cohort, such high early mortality was observed across countries, and differences between early and later mortality were more pronounced among patients aged ≥65 years compared with younger patients. \cite{7} Although dialysis withdrawal accounts for some of the early mortality, it does not provide the only explanation. CVD events are also much higher in the first weeks after KRT initiation. \cite{5}

Studies have also demonstrated a high residual burden of symptoms and geriatric syndromes, such as dementia and disability, and utilization of health care among patients commencing dialysis, especially in those who are frail, have multiple chronic conditions, and start dialysis in the context of a prolonged hospitalization. \cite{72-76} These outcomes are important to patients and sometimes more so than mortality.

High early morbidity and mortality raises questions about the potential causes and risk mitigation strategies; in particular it raises concerns that for some patients, initiation of KRT may not be the optimal choice of therapy. Several prognostic tools have been developed to predict short-term mortality among patients who have initiated dialysis. \cite{77-80} Nevertheless, it is difficult to predict with sufficient certainty which patients will do poorly on dialysis. \cite{31} By providing quantitative estimates of the risk of KRT initiation, CVD events, and mortality based on individual patient characteristics, the novel CKD-G4+ risk calculator may facilitate decision-making (Figure 3). For patients not yet in kidney failure, it is also noteworthy to recognize that a substantial proportion of CKD G4+ patients survive without CVD events and KRT over 2- and 4-year observation periods.

**Optimal counseling for treatment modality decisions.** Counseling for KRT should be risk-based, iterative, and patient-centered. In addition, it should be tailored to the cultural setting, health literacy, and psychosocial and emotional needs while being mindful of the presence of cognitive impairment. Options available once kidney failure is expected include comprehensive conservative care

### Table 4 | Management of HF in CKD G4+

<table>
<thead>
<tr>
<th>Approach</th>
<th>Are there data in CKD G4+?</th>
</tr>
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<tbody>
<tr>
<td>β-Blockers</td>
<td>Yes: observational data and small trials</td>
</tr>
<tr>
<td>RAAS inhibitors</td>
<td>No</td>
</tr>
<tr>
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<td>Ongoing trials</td>
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<td>Frequent dialysis</td>
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<td>Ultrafiltration</td>
<td>Small observational studies and trials</td>
</tr>
<tr>
<td>Cardiac resynchronization therapy</td>
<td>Small observational studies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Limitations for use in CKD G4+?</th>
</tr>
</thead>
<tbody>
<tr>
<td>May have more adverse effects</td>
</tr>
<tr>
<td>May have higher risk of hyperkalemia</td>
</tr>
<tr>
<td>May be linked with worse outcomes</td>
</tr>
<tr>
<td>Many patients cannot do home therapies, and frequent in-center dialysis is not always available</td>
</tr>
<tr>
<td>May cause intradialytic hypotension and/or myocardial stunning</td>
</tr>
<tr>
<td>May have more adverse effects, such as infections</td>
</tr>
</tbody>
</table>

CKD, chronic kidney disease; eGFR, estimated glomerular filtration rate; HF, heart failure; MRA, mineralocorticoid receptor antagonist; RAAS, renin-angiotensin-aldosterone system.

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Table 5 | Research recommendations for HF diagnosis and management in CKD G4+

<table>
<thead>
<tr>
<th>Areas for future research</th>
<th>Research recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening for HF in CKD G4+</td>
<td>- Does screening lead to better outcomes?</td>
</tr>
<tr>
<td>- Is screening cost effective?</td>
<td></td>
</tr>
<tr>
<td>- What is the best way to screen for HF (e.g., imaging biomarkers)?</td>
<td></td>
</tr>
<tr>
<td>Definition and classification of HF in CKD G4+</td>
<td>- What is the incidence of HFrEF versus HFrEF?</td>
</tr>
<tr>
<td>- Conduct study of the burden and outcomes associated with right ventricular dysfunction</td>
<td></td>
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<tr>
<td>- What is the relationship between residual kidney function in HD and risk of progression of subclinical and clinical HF?</td>
<td></td>
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<tr>
<td>- Assess contribution of ischemic heart disease to development of HF</td>
<td></td>
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<tr>
<td>- Pay specific focus on progression of CKD and initiation of dialysis</td>
<td></td>
</tr>
<tr>
<td>Outcomes related to HF in CKD G4+</td>
<td>- Examine risk of other CVD subtypes and death related to HF specifically in CKD G4+</td>
</tr>
<tr>
<td>- Conduct quality of life and other patient-reported outcome studies after dialysis initiation</td>
<td></td>
</tr>
<tr>
<td>Management of HF in CKD G4+</td>
<td>- What is the strategy for use of RAAS inhibitors, beta-blockers, MRAs, and neprilysin?</td>
</tr>
<tr>
<td>- What are point-of-care tests for kidney function, electrolytes, and surrogate markers of heart failure (e.g., BNP)?</td>
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<tr>
<td>- What are test interventions for novel risk factors?</td>
<td></td>
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<tr>
<td>- Determine optimal targets for volume management</td>
<td></td>
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<tr>
<td>- What is the efficacy of invasive and noninvasive devices for volume assessment?</td>
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<tr>
<td>- What is the efficacy of mechanical circulatory support?</td>
<td></td>
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<tr>
<td>- What are the desirable outcomes for heart-kidney transplants?</td>
<td></td>
</tr>
<tr>
<td>- What is the optimal vascular access strategy?</td>
<td></td>
</tr>
<tr>
<td>- What is the role of urgent start PD for acute HF and CKD/AKI?</td>
<td></td>
</tr>
<tr>
<td>- What is the role of conservative care in this population?</td>
<td></td>
</tr>
</tbody>
</table>

AKI, acute kidney injury; BNP, B-type natriuretic peptide; CKD, chronic kidney disease; CVD, cardiovascular disease; HD, hemodialysis; HF, heart failure; HFrEF, heart failure with preserved ejection fraction; HFrEF, heart failure with reduced ejection fraction; MRA, mineralocorticoid receptor antagonist; PD, peritoneal dialysis; RAAS, renin-angiotensin-aldosterone system.

without dialysis, in-center or home HD, PD, and transplantation. Circumstances may exist in which a specific modality of KRT may be contraindicated, but when options exist, a shared decision-making approach to the choice of KRT optimizes patient engagement and may potentially improve outcomes. Discussions should be revisited at regular intervals to ensure that important health or social circumstances have not changed.

Two scenarios require special considerations: counseling for transplantation in older adults and counseling to forgo dialysis. It is accepted that, among patients placed on the waiting list, kidney transplantation improves life expectancy and quality of life compared with those remaining on dialysis across all age ranges. In and of itself, older age is not a contraindication to transplantation. Although only a proportion of patients will qualify for transplantation, transplantation should be considered in all patients who do not have obvious contraindications for KRT. Referral and evaluation for transplantation should be based on patient characteristics, preferences, and regional circumstances. Unwarranted regional variability in access to transplantation is well-documented, and transplant programs should establish transparent policies for accepting patients on the waiting list.

General counseling about KRT should also include information about the option to forgo dialysis and receive conservative care. The Renal Physicians Association has published guidelines regarding circumstances in which forgoing dialysis may be appropriate (Supplementary Table S8). Although the benefit of initiating KRT declines with increasing age, older age per se should not be considered as a contraindication for KRT; in fact, conference participants questioned the Renal Physicians Association recommendation to generally forgo dialysis in patients ≥75 years with poor prognosis and favored a more individualized approach, taking into account patient preferences and values along with prognosis.

Uncertainties about initiation of kidney replacement therapies and research priorities. A recent meta-analysis of cohort studies and trials has demonstrated that those who commence dialysis with a higher eGFR have a higher mortality. It is likely that this is due to reverse causality, with frailty and accumulated comorbidities, in particular HF, pushing the patient and clinician to initiate dialysis. Global differences exist in how planned KRT is initiated. These include a “PD first” approach, commencement with a functioning arteriovenous fistula and differences in site of fistula placement and “incremental” start to dialysis with either reduced blood flow rates, reduced hours, or limited PD exchanges. To which extent these factors influence outcomes is largely unclear. The indication for initiation of dialysis should be recorded routinely in registry data in addition to reporting elective versus unplanned start to dialysis. In the IDEAL study the majority of patients allocated to late start who started early had the indication for start dialysis documented.

Needs, opportunities, and challenges for clinical trials in patients with CKD G4+

Barriers for clinical trials in patients with CKD G4+ and strategies to overcome them. There is an urgent need to
Table 6 | Research recommendations for shared decision-making for KRT

- Assess optimal ways to deliver information to people and families with CKD.
- Does provision of prognostic data alter decision-making?
- What are the reasons for variation in acceptance onto dialysis or transplantation programs?
- Why is morbidity and mortality high in the first 3 months of commencing hemodialysis, and can it be modified?
- Is there an optimal approach to the commencement of dialysis to reduce morbidity and mortality?
- Can comorbidity be factored into the reporting of kidney outcomes?
- Place greater emphasis on collection of patient-centered KRT outcomes, including quality of life, symptom burden, physical and cognitive function, and financial and caregiver burdens.
- Can the reasons for commencing dialysis be uniformly collected to improve the understanding of variability in the timing of initiation of dialysis?

CKD, chronic kidney disease; KRT, kidney replacement therapy.

increase the number and quality of completed clinical trials in patients with CKD, including people with CKD G4+ (Supplementary Table S9). A summary of selected barriers and proposed solutions is shown in Table 7 and Supplementary Table S10. For industry, the potential economic benefits of a successful clinical trial must be offset against the potential financial and nonfinancial risks. Slow recruitment, higher-than-average adverse event rates, a relatively small total patient population (i.e., prospective users), and several recent null clinical trials in CKD populations may all increase perceived risk. However, trials in populations with CKD G4+ also have key advantages, including the large potential economic benefits of preventing kidney failure and CVD events, a relatively captive and highly motivated patient population, and high event rates (reducing the required sample size or duration of follow-up).

Investigator-initiated trials have different challenges: the nephrology community understands the clinical need and opportunities in the CKD G4+ population but often struggles to complete adequately powered studies. Environmental scans of ongoing trials suggest that certain topics (e.g., sodium bicarbonate treatment in CKD G4+) are being independently studied by multiple groups in different countries. One potential solution could be to link multiple existing national trial networks to increase statistical power, either by use of common protocols or by pooling results from similar but not identical protocols using meta-analysis.

Choosing patient-relevant interventions and outcomes. As for most medical disciplines, available trial evidence in CKD G4+ populations reflects the interests and priorities of clinicians and researchers rather than patients and families. Correcting this misalignment is critical for improving the utility of trial findings and potentially for facilitating trial conduct by increasing participant recruitment and retention. Existing processes for identifying patient-centered research priorities and patient-relevant outcomes (e.g., those identified using the James Lind Alliance methodology) will be helpful for achieving this aim. A list of such priorities for CKD G3a to G5 patients is already available and could be used as the basis for people with CKD G4+ specifically. Initiation of KRT is clinically meaningful and, therefore, the obvious choice as an outcome in trials of therapies aimed at slowing the loss of kidney function. However, KRT initiation is determined by many factors such as local habits and guidelines, physicians’ and patients’ preferences, and patients’ well-being and comorbidities. Functional and symptomatic outcomes that are patient-oriented, both before and after the initiation of KRT, are important to address for safety as well as efficacy, and are relevant for the patient. A toolbox that includes validated symptomatic assessment will support trials with functional outcomes.

Increasing and sustaining patient engagement in trials and other clinical research is critical, but no consensus was reached on how this goal should be achieved or approached. A key starting point could be to describe lessons learned from leading patient-centered initiatives (e.g., SONG-HD and NICE) and establish an organization responsible for patient engagement in CKD G4+ research specifically.

Increasing the success of clinical trials in CKD G4+ by optimizing other aspects of trial design. Besides outcomes, other aspects of clinical trial design could be optimized. Thus, the KFRE and the newly developed predictive instrument specific for CKD G4+ could be used in potential trial participants to inform power calculations or enrich recruitment of participants at higher-than-average risk. Alternative methods (e.g., pragmatic trials, stepped-wedge designs, or registry-based studies) could also be used to facilitate trial conduct.

Pragmatic trials are well suited for patients with CKD G4+ because such trials can enroll socially disadvantaged populations (usually excluded from traditional randomized controlled trials), are directly applicable to patient care, allow assessment of a range of interventions, include patient-centered outcomes, and are cheaper than traditional randomized controlled trials. There are also some challenges,
such as lack of experience, collection and ascertainment of outcomes, and informed consent procedure, which may pose challenges given the increasing use of electronic health records.

Conclusions and perspectives

Patients with CKD G4+ represent a high-risk population that requires specialized care and expertise that should ideally be coordinated by nephrologists. Despite their severely reduced level of GFR, the prognosis of patients with CKD G4+ is variable, with a substantial proportion of up to more than 50% surviving CVD event- and KRT-free for at least several years. The newly developed risk prediction tool specific for CKD G4+ may help to establish a comprehensive quantitative analysis of possible adverse outcomes, including CVD events, kidney failure and mortality, and thereby guide therapy. Such prognostic information can be factored into decisions for surveillance, CVD risk reduction, and eventual preparation for KRT. Another important finding of the meta-analysis is that traditional CVD risk factors appear to be relevant in CKD G4+, like in earlier stages of CKD and in the absence of CKD. Although such associations do not prove the efficacy of risk factor targeting, it appears rational to apply such strategies as long as no opposing evidence is available. Finally, there was general agreement that the complex comorbidities of people with CKD G4+, particularly those with functional impairment, older age, and limited life expectancy, mandate a patient-centric approach with joint decision-making both in routine practice as well as during the design of trials to optimize management and outcomes.

DISCLOSURE

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CAH declared having received consultancy fees from AbbVie, FibroGen, Relypsa, Sanifit, and ZS Pharma; and research support from Amgen and Zoll. MTJ declared having received research support from Amgen Canada. HJ LH declared having received consultancy fees from AbbVie, AstraZeneca, Boehringer Ingelheim, Fresenius, Janssen, and Merck; speaker honoraria from AstraZeneca and Boehringer Ingelheim; and research support from AstraZeneca and Boehringer Ingelheim. PES declared having received speaker honorarium from Janssen-Cilag. MKT declared having received research support from National Institutes of Health, Veterans Administration, and Gordon and Betty Moore Foundation. DCW declared having received consultancy fees from Akebia, Amgen, AstraZeneca, Boehringer Ingelheim, GlaxoSmithKline, Janssen, and Vifor Fresenius Medical Care Renal Pharma; speaker honoraria from Amgen and Vifor Fresenius Medical Care Renal Pharma; and research support from AstraZeneca. WCW declared having received consultancy fees from Akebia, AMAG Pharmaceuticals, Amgen, AstraZeneca, Bayer, Daiichi Sankyo, Relypsa, and ZS Pharma; speaker honoraria from FibroGen; and research support from National Institutes of Health. All the other authors declared no competing interests.

SUPPLEMENTARY MATERIAL

Table S1. Various ways that individualized risk-based information may be used by different stakeholders involved in CKD care.

Table S2. Key competencies required for delivery of CKD G4+ care.
Table S3. Selected therapies for future research in CKD.
Table S4. Definition of HF according to ACF/C/AHA and ESC.
Table S5. Risk factors for HF in patients with CKD G4+.
Table S7. Consequences of arteriovenous fistula on the cardiovascular system.
Table S8. Recommendations from the Renal Physicians Association regarding forgoing dialysis.
Table S9. Key goals and activities identified by the Clinical Trials Group at the Vancouver Kidney Health Summit.
Table S10. Challenges, potential solutions, and suggested actions related to increasing the number and quality of clinical trials in CKD G4+ populations.

Figure S1. Markov model: modified graph illustrating the different possible pathways.
Figure S2. CKD chronic care model.
Figure S3. Cumulative probability of heart failure in incident patients.

Supplementary References.

Supplementary material is linked to the online version of the paper at www.kidney-international.org.

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APPENDIX

Other Conference Participants
Ali K. Abu-Alfa, Lebanon; Shuchil Anand, USA; Mustafa Arici, Turkey; Shoshana H. Ballew, USA; Geoffrey A. Block, USA; Rafael Burgos-Calderon, Puerto Rico; David M. Charytan, USA; Zofia Das-Gupta, UK; Jamie P. Dwyer, USA; Danilo Fiser, Germany; Marc Froissart, Switzerland; John S. Gill, Canada; Kathryn E. Griffith, UK; David C. Harris, Australia; Kate Huffman, Canada; Lesley A. Inker, USA; Kitty J. Jager, Netherlands; Min Jun, Australia; Kamyar Kalantar-Zadeh, USA; Bertrand L. Kasiske, USA; Csaba P. Kovesdy, USA; Navaneethan SD, et al. Pragmatic clinical trials in CKD: opportunities and challenges. J Am Soc Nephrol. 2016;27:2948–2954.

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SUPPLEMENTAL TABLES AND FIGURES

Eckardt KU et al. Improving the prognosis of patients with severely decreased glomerular filtration rate (CKD G4+): Conclusions from a KDIGO Controversies Conference
Table S1. Various ways that individualized risk-based information may be used by different stakeholders involved in CKD care

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>Potential value, need, or use of risk information</th>
</tr>
</thead>
</table>
| Patients, family, and caregivers | Knowledge of risks for the outcomes deemed important  
Information explained in language that is understandable  
Care providers offer the insights with patient preferences and values considered in the development of the management plan  
Education, social class, literacy and beliefs all contribute to self-management |
| Primary care providers           | Knowledge of risk provides confidence in referral, management, and communication with patients – especially patients at low risk, not requiring referral to specialist care  
Consistent, agreed upon messages from different specialists involved in a patient’s care are desired  
Recognize that patients often underestimate risks, and specialist healthcare providers may overestimate benefits and underestimate harms of interventions¹ |
| Specialists, CKD care providers  | Risk prediction tools combined with clinical judgment help identify patients requiring transition to different modalities of care and help guide necessary interventions (including educational initiatives)  
Differing risk guides intensity of follow-up and appropriate timing of: education and discussion of conservative treatment versus KRT; type of KRT modality; planning for dialysis access; end-of-life decision making  
Differing risks may also guide decisions concerning investigations and therapies |
| Health system payers, policy makers | Appropriateness, efficiency and affordability of care  
Risk prediction tools for the key outcomes of advanced CKD, including mortality and cardiovascular complications (heart failure, myocardial ischemia and stroke) combined with good epidemiological data enables prioritization and planning of use of healthcare resource  
Getting services to remote areas and reaching high risk vulnerable populations, national priorities versus local |

CKD, chronic kidney disease; KRT, kidney replacement therapy
## Table S2. Key competencies required for delivery of CKD G4+ care

1. **Diagnosis and categorizing CKD**  
   Assessment of prognosis; identification of kidney-related and non-kidney related complications; initiation of required interventions and determination of a care plan; identification of people with care needs despite prediction of low risk of progression of CKD

2. **Education**  
   Education of patient/family/carer concerning CKD; explanation of competing risks of CKD progression and mortality; kidney failure treatment options; coordination of care between patient/family/carer(s) and other members of CKD multidisciplinary team and primary care physician

3. **Planning for kidney failure**  
   Evaluation for kidney transplant including living transplantation options and transplant education; assessment of dialysis options (hemodialysis and peritoneal dialysis); creation of dialysis access; provision of end-of-life care, symptom control and palliation; setting goals of care with aligned treatment plans

4. **Nutrition**  
   Dietary advice as required, including salt and fluid management

5. **Medications**  
   Medicines reconciliation and education of potential harm of over-the-counter medicines; advice with respect to “tablet holidays” during severe intercurrent illness and strategies to avoid/ameliorate acute kidney injury; review of immunizations and implementation of vaccination programs

6. **Psychosocial support**  
   Access to counselling; access to housing and transport support; insurance advice

CKD, chronic kidney disease.
<table>
<thead>
<tr>
<th>Therapy</th>
<th>Evidence</th>
<th>Current Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aspirin for prevention of cardiovascular disease</strong></td>
<td>In secondary prevention low-dose aspirin therapy reduces the incidence of adverse cardiovascular events and all-cause mortality. In primary prevention the evidence does not support the universal use or avoidance of aspirin. A systematic review (3 studies, n=4468) found no clear benefit of aspirin for the primary prevention of cardiovascular events in CKD and no statistically significant reduction in mortality. Major bleeding events were significantly increased with aspirin.</td>
<td>Both KDIGO⁴ and NICE⁵ recommend that aspirin is indicated for secondary but not primary prevention. NICE have recommended future research to address this question for those at highest risk of cardiovascular disease (What is the clinical effectiveness of low-dose aspirin compared with placebo for primary prevention of cardiovascular disease?)</td>
</tr>
<tr>
<td><strong>Bicarbonate therapy in CKD G4+</strong></td>
<td>A meta-analysis of 6 studies (n=312) concluded that bicarbonate therapy was associated with improvement in kidney function and possibly a reduction in progression of CKD. However, differences in study protocols and small sample sizes precluded definitive conclusions.</td>
<td>KDIGO suggest treatment with oral bicarbonate supplementation in people with CKD and serum bicarbonate concentrations &lt; 22 mmol/l; NICE suggest considering oral sodium bicarbonate supplementation in people with CKD G4+ and a serum bicarbonate concentration of &lt; 20 mmol/l.</td>
</tr>
<tr>
<td><strong>Treatment of asymptomatic hyperuricemia</strong></td>
<td>A systematic review (24 studies n=25,453) found that elevated serum uric acid levels were significantly associated with risk of mortality in patients with CKD. Another systematic review (13 studies, n=190,718) found a significant positive association with new-onset CKD at follow-up. However there is little evidence to justify uric acid-lowering in CKD G4+. Recent systematic review and RCT evidence on allopurinol use are inconsistent in terms of the potential benefits of lowering uric acid.⁹¹³</td>
<td>KDIGO suggested there is insufficient evidence to support or refute the use of agents to lower serum uric acid concentrations in people with CKD and either symptomatic or asymptomatic hyperuricemia in order to delay progression of CKD. NICE make no recommendation but suggested that in people with CKD who are at high risk of progression, the clinical and cost effectiveness of uric acid-lowering agents on the progression of CKD and on mortality should be the subject of further research.</td>
</tr>
<tr>
<td>Metformin therapy in people with diabetes and CKD G4+</td>
<td>Metformin is widely prescribed given evidence suggesting it reduces the risk of myocardial infarction, stroke, atrial fibrillation and all-cause mortality. However its use in CKD has been limited because of the perceived increased risk of lactic acidosis. A Cochrane analysis of 347 controlled studies covering 70,490 patient-years of metformin use revealed no cases of lactic acidosis and no significant change in plasma lactate. A Swedish Diabetes Registry study suggested that metformin was well tolerated in people with CKD G3, and its use was associated with 13% lower all-cause mortality in this population. Blood levels of metformin are influenced by kidney function and the main problem for metformin treatment in CKD G4+ is the prevention of intoxication. Recently published dosage guidelines suggest a maximum of 1 g daily in CKD G4+.</td>
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<tr>
<td>Recent diabetes management guidelines from the American Association of Clinical Endocrinologists/American College of Endocrinology recommended discontinuing metformin at eGFR &lt; 45 mL/min/1.73 m². KDIGO recommended that metformin be discontinued in people with eGFR &lt; 30 ml/min/1.73 m².</td>
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</table>

CKD, chronic kidney disease; KDIGO, Kidney Disease: Improving Global Outcomes; NICE, National Institute for Health and Nutrition Examination
Table S4. Definition of heart failure (HF) according to ACCF/AHA and ESC

<table>
<thead>
<tr>
<th>Heart failure (HF) Classification</th>
<th>Left ventricular ejection fraction (LVEF)</th>
<th>Description from ACCF/AHA</th>
<th>Description from ESC</th>
</tr>
</thead>
<tbody>
<tr>
<td>HF with reduced ejection fraction (HFrEF)</td>
<td>LVEF ≤ 40%†</td>
<td>Also referred to as systolic HF. Randomized controlled trials have mainly enrolled patients with HFrEF, and it is only in these patients that efficacious therapies have been demonstrated to date.</td>
<td>Symptoms ± signs(^a)</td>
</tr>
<tr>
<td>HF with preserved ejection fraction (HFpEF)</td>
<td>LVEF ≥ 50%</td>
<td>Also referred to as diastolic HF. Several different criteria have been used to further define HFpEF. The diagnosis of HFpEF is challenging because it is largely one of excluding other potential non-cardiac causes of symptoms suggestive of HF. To date, efficacious therapies have not been identified.</td>
<td>Symptoms ± signs(^a) Elevated levels of natriuretic peptides(^b); At least one additional criterion: a. relevant structural heart disease (LVH and/or LAE), b. diastolic dysfunction</td>
</tr>
<tr>
<td>HFpEF, borderline‡</td>
<td>LVEF 41-49%</td>
<td>These patients fall into a borderline or intermediate group. Their characteristics, treatment patterns, and outcomes appear similar to those of patients with HFpEF.</td>
<td>Symptoms ± signs(^a) Elevated levels of natriuretic peptides(^b); At least one additional criterion: a. relevant structural heart disease (LVH and/or LAE), b. diastolic dysfunction</td>
</tr>
<tr>
<td>HFpEF, improved</td>
<td>LVEF &gt; 40%</td>
<td>It has been recognized that a subset of patients with HFpEF previously had HFrEF. These patients with improvement or recovery in EF may be clinically distinct from those with persistently preserved or reduced EF. Further research is needed to better characterize these patients.</td>
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</table>

\(^a\)Signs may not be present in the early stages of HF (especially in HFpEF) and in patients treated with diuretics.
\(^b\)BNP >35 pg/ml and/or NT-proBNP >125 pg/ml.
†ESC defines HFrEF as LVEF < 40%
‡Also known as heart failure mid-range ejection fraction (HFmrEF) as coined by ESC whose LVEF is defined as 40-49%
ACCF, American College of Cardiology Foundation; AHA, American Heart Association; BNP, B-type natriuretic peptide; ESC, European Society of Cardiology; LAE, left atrial enlargement; LVH, left ventricular hypertrophy; NT-proBNP, N-terminal pro-B type natriuretic peptide. Adapted from ACCF/AHA\(^19\) and ESC\(^20\)
Table S5. Risk factors for HF in patients with CKD G4+

<table>
<thead>
<tr>
<th>Traditional risk factors</th>
<th>Non-traditional risk factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Volume overload</td>
</tr>
<tr>
<td>Male sex</td>
<td>Anemia</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Mineral metabolism abnormalities</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>Cause of CKD</td>
</tr>
<tr>
<td>Smoking</td>
<td>Aldosterone</td>
</tr>
<tr>
<td>Obesity</td>
<td>Inflammation</td>
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<tr>
<td>Coronary artery disease</td>
<td>Residual renal function</td>
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<tr>
<td>Left ventricular hypertrophy</td>
<td>Sympathetic overactivity</td>
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<td></td>
<td>Endogenous cardiac glycosides</td>
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<td></td>
<td>Uremic toxins</td>
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<td>Hyperkalemia</td>
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<td>Oxidative stress</td>
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<td></td>
<td>Malnutrition</td>
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<td></td>
<td>Myocardial stunning</td>
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</tbody>
</table>
Table S6. Adjusted hazard ratios of all-cause death in patients with heart failure, by CKD status, 2010-2011

<table>
<thead>
<tr>
<th>No CKD</th>
<th>Hazard ratio</th>
<th>CI</th>
<th>p-value</th>
<th>CKD</th>
<th>Hazard ratio</th>
<th>CI</th>
<th>p-value</th>
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</thead>
<tbody>
<tr>
<td>Age: 66–69</td>
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<tr>
<td>70–74</td>
<td>1.36</td>
<td>1.33-1.40</td>
<td>&lt;.0001</td>
<td></td>
<td>1.13</td>
<td>1.06-1.20</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>75–84</td>
<td>2.62</td>
<td>2.55-2.68</td>
<td>&lt;.0001</td>
<td></td>
<td>1.61</td>
<td>1.53-1.70</td>
<td>&lt;.0001</td>
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<td>85+</td>
<td>7.10</td>
<td>6.93-7.27</td>
<td>&lt;.0001</td>
<td></td>
<td>3.14</td>
<td>2.98-3.31</td>
<td>&lt;.0001</td>
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<tr>
<td>Male</td>
<td>reference</td>
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<td></td>
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</tr>
<tr>
<td>Female</td>
<td>0.83</td>
<td>0.82-0.84</td>
<td>&lt;.0001</td>
<td></td>
<td>0.89</td>
<td>0.87-0.92</td>
<td>&lt;.0001</td>
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<td>White</td>
<td>reference</td>
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<td></td>
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</tr>
<tr>
<td>Black/Af Am</td>
<td>1.02</td>
<td>1.00-1.05</td>
<td>0.106</td>
<td></td>
<td>0.95</td>
<td>0.91-0.99</td>
<td>0.0152</td>
</tr>
<tr>
<td>Other</td>
<td>0.80</td>
<td>0.78-0.83</td>
<td>&lt;.0001</td>
<td></td>
<td>0.85</td>
<td>0.80-0.90</td>
<td>&lt;.0001</td>
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<tr>
<td>Diabetes</td>
<td>1.14</td>
<td>1.13-1.16</td>
<td>&lt;.0001</td>
<td></td>
<td>1.09</td>
<td>1.06-1.12</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Hypertension</td>
<td>0.85</td>
<td>0.84-0.86</td>
<td>&lt;.0001</td>
<td></td>
<td>0.73</td>
<td>0.70-0.77</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Other cause</td>
<td>reference</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Heart failure: none</td>
<td>reference</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Systolic</td>
<td>2.10</td>
<td>2.02-2.18</td>
<td>&lt;.0001</td>
<td></td>
<td>2.34</td>
<td>2.24-2.44</td>
<td>&lt;.0001</td>
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<tr>
<td>Diastolic</td>
<td>1.79</td>
<td>1.71-1.86</td>
<td>&lt;.0001</td>
<td></td>
<td>1.93</td>
<td>1.83-2.02</td>
<td>&lt;.0001</td>
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<tr>
<td>Both</td>
<td>2.02</td>
<td>1.88-2.17</td>
<td>&lt;.0001</td>
<td></td>
<td>2.21</td>
<td>2.05-2.39</td>
<td>&lt;.0001</td>
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<td>Unspecified</td>
<td>1.90</td>
<td>1.87-1.94</td>
<td>&lt;.0001</td>
<td></td>
<td>1.80</td>
<td>1.73-1.86</td>
<td>&lt;.0001</td>
</tr>
</tbody>
</table>

Reproduced from the USRDS ADR 2013, volume 1\textsuperscript{21}
Table S7. Consequences of arteriovenous fistula on the cardiovascular system

<table>
<thead>
<tr>
<th></th>
<th>Immediate</th>
<th>Days-weeks</th>
<th>Weeks-months</th>
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</thead>
<tbody>
<tr>
<td>Decrease in blood pressure</td>
<td>Increase in blood volume</td>
<td>Further increase in cardiac output</td>
<td></td>
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<tr>
<td>Reduced arterial stiffness</td>
<td>Increase in LV end diastolic volume</td>
<td>Increase in LV mass and LV size</td>
<td></td>
</tr>
<tr>
<td>Decrease in total peripheral resistance</td>
<td></td>
<td>Increase in atrial chamber size</td>
<td></td>
</tr>
<tr>
<td>Increase in heart rate and stroke volume</td>
<td></td>
<td>Diastolic and systolic dysfunction</td>
<td></td>
</tr>
<tr>
<td>Increase in cardiac output</td>
<td></td>
<td>Increase in pulmonary flows and later pulmonary hypertension</td>
<td></td>
</tr>
</tbody>
</table>

LV, left ventricular. Reproduced from Rao et al. 22
Table S8. Recommendations from the Renal Physicians Association regarding forgoing dialysis

If appropriate, forgo dialysis for patients with CKD or ESRD in certain, well-defined situations:

• Patients with decision-making capacity, who being fully informed and making voluntary choices, refuse dialysis
• Patients who no longer possess decision-making capacity who have previously indicated refusal of dialysis in an oral or written advance directive
• Patients who no longer possess decision-making capacity and whose properly appointed legal surrogates refuse dialysis
• Patients with irreversible, profound neurological impairment such that they lack signs of thought, sensation, purposeful behavior, and awareness of self and environment.

Consider forgoing dialysis for CKD or ESRD patients who have a very poor prognosis or for whom dialysis cannot be provided safely. Included in these categories of patients are the following:

• Those whose medical condition precludes the technical process of dialysis because the patient is unable to cooperate (e.g., advanced dementia patient who pulls out dialysis needles or profound hypotension)
• Those who have a terminal illness from non-renal causes (acknowledging that some in this condition may perceive benefit from and choose to undergo dialysis)
• Those with CKD G5 older than age 75 years who met two or more of the following statistically significant very poor prognosis criteria: 1) clinician response of “No” to the ‘surprise’ question, 2) high comorbidity score, 3) significantly impaired functional status (e.g., Karnofsky score less than 40), 4) severe chronic malnutrition (e.g., serum albumin < 2.5 g/dl).

Forgo dialysis if initiating or continuing dialysis is deemed to be harmful, of no benefit, or merely prolongs a child’s dying process. The decision to forgo dialysis must be made in consultation with the child’s parents. Give children and adolescents the opportunity to participate in the decision to forgo dialysis to the extent that their developmental abilities and health status allow.

Consider forgoing dialysis in a patient with a terminal illness whose long term prognosis is poor if the patient and the family are in agreement with the physician that dialysis would not be of benefit or the burdens would outweigh the benefit.

Develop a palliative care plan for all pediatric patients with ESRD from the time of diagnosis and for children with AKI who forgo dialysis. The development of a palliative care plan is a continuation of the process of advance care planning and should be family-centered.

AKI, acute kidney injury; CKD, chronic kidney disease; ESRD, end-stage renal disease.
Table S9. Key goals and activities identified by the Clinical Trials Group at the Vancouver Kidney Health Summit

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encourage and promote the conduct of clinical trials in people with CKD</td>
<td>Develop value proposition for trials in kidney disease&lt;br&gt;Promote trials in areas of unmet need and orphan diseases&lt;br&gt;Engage activated patient groups, payers and other stakeholders, aiming to substantially increase the number of clinical trials in CKD&lt;br&gt;Promote models for early conditional approval of new therapies to encourage investment&lt;br&gt;Work to increase the number of people with CKD who are included in CV, diabetes, and oncology trials, aiming to reflect the prevalence of CKD in such patient populations&lt;br&gt;Develop a regular stand-alone meeting to review ongoing and planned clinical trials with CKD patients</td>
</tr>
<tr>
<td>Optimize the design of clinical trials in people with CKD</td>
<td>Develop and refine appropriate endpoints for CKD trials and promote their uptake and dissemination&lt;br&gt;Assess factors that lead to &quot;success&quot; or &quot;failure&quot; of clinical trials in CKD trials&lt;br&gt;Facilitate strategies to pre-select patients for clinical trials according to their risk for progression or likelihood to respond to an intervention&lt;br&gt;Develop innovative trial designs to enhance feasibility and success of CKD trials&lt;br&gt;Implement priority setting exercises for interventions to be tested in clinical trials globally and by region&lt;br&gt;Establish recommendations for clinical trials in people with CKD for use by ethical and regulatory boards, including opportunities for sample collection for future analyses</td>
</tr>
<tr>
<td>Grow capacity in conducting clinical trials in people with CKD</td>
<td>Develop networks of kidney clinical trialists including community physicians, and other specialties, etc.&lt;br&gt;Catalogue sites/centers capable of participating in kidney trials&lt;br&gt;Develop and implement professional training in trial design and conduct, involving nephrology and related specialties</td>
</tr>
</tbody>
</table>

CKD, chronic kidney disease; CV, cardiovascular Reproduced with permission from Levin A et al. (2017)"
Table S10. Challenges, potential solutions and suggested actions related to increasing the number and quality of clinical trials in CKD G4+ populations

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Potential solution</th>
<th>Suggested action</th>
<th>Actor</th>
</tr>
</thead>
<tbody>
<tr>
<td>The clinical needs of CKD G4+ patients are apparent, but other elements of a business case for conducting trials in this population have not been well described</td>
<td>Build the “business case” for industry and other payers to support trials in this population</td>
<td>Work with large health care providers that have used such business cases to justify their own CKD G4+ programs (e.g., Mayo, Kaiser Permanente). Use this information to create a briefing document for payers</td>
<td>KDIGO, ISN, ASN Kidney Health Initiative, French CKD trial network and others</td>
</tr>
<tr>
<td>Recruitment and retention to trials is an ongoing challenge in CKD G4+ populations</td>
<td>Engage patients to lead and support clinical trials in this population</td>
<td>Commission and support a group to conduct scoping review and propose structures/processes to enable sustained patient engagement</td>
<td>KDIGO, ISN, ASN Kidney Health Initiative, French CKD clinical trials network</td>
</tr>
<tr>
<td>Available trials often do not address the needs of CKD G4+ patients and families</td>
<td>Ensure that the findings of trials in CKD G4+ are maximally relevant for patients and families</td>
<td>Review existing lists of patient-centered research priorities and commission a new list for CKD G4+ if required</td>
<td>KDIGO</td>
</tr>
<tr>
<td>Available trials are often small or underpowered, and recruitment is challenging</td>
<td>Leverage collaborations between existing national CKD trial networks to facilitate multinational trials</td>
<td>Partner with ISN-ACT to conduct a multinational investigator-initiated clinical trial on common interventions such as bicarbonate, uric acid reduction, ACEi/ARB or phosphate binder therapies</td>
<td>ISN-Advancing Clinical Trials (ISN- ACT), ASN Kidney Health Initiative, French CKD clinical trials network and others</td>
</tr>
<tr>
<td>Little is known about how to manage symptoms of CKD G4+, which is a key treatment objective for patients</td>
<td>Do more studies of symptom management</td>
<td>Create a toolbox of validated instruments for common CKD G4+ symptoms that can be used in trials or in supporting studies</td>
<td>KDIGO*</td>
</tr>
</tbody>
</table>

* Although KDIGO could act as a catalyst to establish these initiatives, they will likely require the creation of a dedicated organization or structure to ensure sustainability. ACEi, angiotensin-converting enzyme inhibitor; ARB, angiotensin-receptor blocker; CKD, chronic kidney disease; KDIGO, Kidney Disease: Improving Global Outcomes; ISN, International Society of Nephrology, ASN, American Society of Nephrology.
Figure S1. Markov Model – modified graph illustrating the different possible pathways
Reproduced from Grams et al.\textsuperscript{25}
Figure S2. CKD Chronic Care Model
Figure S3. Cumulative probability of heart failure in incident patients
Reproduced from the USRDS ADR 2007^{26}

ESRD: Incident ESRD patients, age 20 & older
Patients with CHF at baseline excluded. Probabilities unadjusted.
REFERENCES


