
Identification of renal damage and of risk markers for renal damage in a cohort of diabetic outpatients

Sir,

In the Western world, the proportion of diabetic subjects amongst patients on renal replacement therapy (RRT) is steadily increasing and the majority of diabetic patients have non-insulin dependent diabetes. It is common knowledge that these patients have a horrendous rate of cardiovascular complications. Although renal failure in itself is inexorably progressive, there is now agreement that metabolic control, treatment of hypertension, correction of lipid derangement and modifying smoking habits can affect both the cardiovascular risk and the evolution of renal damage towards end-stage renal failure [1–4]. This information has been available to clinicians through broadly disseminated guidelines. However, the increasing incidence rate of diabetic end-stage renal disease (ESRD) patients suggest that failure to identify and appropriately treat kidney disease among at-risk patients might contribute to this trend in the occurrence of diabetic patients with renal dysfunction and in the occurrence of multiple co-morbid conditions in diabetic subjects [5]. We believe that such problems belong not only to GPs but they could also apply to specialists working in outpatient clinics of general district hospitals.

In this work, we wanted to assess the degree of emphasis put into the diabetic outpatient clinic of our local Social-Sanitary Unit on some of the major factors usually associated with cardiovascular and renal diseases.

An author (VB) went through the clinical notes of 288 diabetic subjects consecutively referred to by the diabetic outpatient clinic of the local Social-Sanitary Unit (ULSS 17) in 1997 and checked where the following parameters have been evaluated or may be extrapolated from the information gathered: age, sex, height with weight (to calculate the body mass index (BMI)), duration and treatment for diabetes, smoking habits, blood pressure and hypertension treatment, serum creatinine, blood glucose, HbA1c, serum cholesterol, triglycerides, proteinuria, and microalbuminuria.

Age, sex and treatment for diabetes were reported on all notes: the mean age of the 288 diabetic patients was 61 ± 12 years (SD), 163 patients were males and 125 females, 20/288 patients (6.9%) were treated by insulin; diabetes duration on average was 1.5 ± 4 years and the mean age at diagnosis was 59 ± 12 years, (information available in 271/288 notes: 94%). Data concerning blood glucose and HbA1c were available in 285/288 (99%) and 227/288 (79%) clinical notes respectively. Data concerning BMI and smoking habits could be found in 201/288 (70%) and 208/288 (72%) clinical notes.

A blood pressure value was recorded in only 70/288 (24%) clinical notes and data concerning lipids, creatinine and microalbuminuria were missing in 164/288 (57%), 132/288 (46%) and 237/288 (82%) notes. Only in 4/288 patients, did we find any mention of proteinuria.

In order to reduce the number of diabetic patients with complications, it has been suggested that routine care in diabetic patients should be improved. To this extent, the St Vincent Declaration has suggested a prevention and treatment programme [6]. Since the first step in controlling these factors is measurement, our work was aimed at assessing whether in our diabetic outpatient clinics there was a similar degree of emphasis on metabolic control and markers for renal and cardiovascular risk factors. Our data suggest that at least in our diabetic outpatients, the emphasis is still placed mostly on metabolic control, whilst there is little emphasis on cardiovascular risk, on the risk of renal insufficiency and on the control of factors involved in progression of renal damage. The findings of our small survey are similar to those recently reported by other authors in hospitalized and non-hospitalized diabetic subjects [7,8] and suggest that preparation and dissemination of guidelines alone may have a limited effect on patients’ care. It is haphazard to generalize from our limited experience. However, we believe that more effective educational programmes should be looked into, not only with respect to GPs clinics but even to specialist clinics. We suggest that the excess of specialization coupled with the increased burden of older and complicated subjects, may push consultants to limit their intervention only to their specific area. On the other hand, elderly people bearing heavy handicaps caused by multiple and serious morbid conditions, might not be willing to spend most of their remaining days booking hospital visits and queuing in crowded waiting rooms.

In conclusion, our data suggest that quality of care may be poor even in specialist clinics. We wonder whether and how often in different countries, specialist clinics are reviewed with respect to quality of care. If regular reviews are not already routinely performed, a method of improving care might be to relate their founding to regular reviews. In order to make these reviews more effective, they might be performed by external referees.

1. U.O. di Nefrologia e Dialisi ULSS 17
2. Centro Antidiabetico Ospedale di Monselice
3. Monselice
4. Padova
5. Italy


© 1999 European Renal Association–European Dialysis and Transplant Association