

Screening for CKD: A Pro and Con Debate

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Should doctors screen asymptomatic patients for CKD? Screening for a disease is useful if it leads to improved outcomes for those so identified. Screening also carries risks: false-positive tests may cause anxiety and unnecessary procedures. Overdiagnosis is a risk (*i.e.*, identifying individuals with a positive screen who have no inherent risk of progression or debility from that condition). False-negative tests can give false reassurance when disease progression occurs nonetheless.

Debates rage over screening women for breast cancer with mammography or screening men for prostate cancer with prostate-specific antigen testing. Do the potential harms outweigh the benefits? One article is titled “Mammography screening in Norway caused substantial overdiagnosis and did not reduce late-stage breast cancer” (1). The American Urological Association guideline on prostate cancer detection recommends against routine prostate-specific antigen screening for men younger than 55 years old at average risk. A subsequent study showed that men no longer recommended for screening had equivalent if not worse outcomes from prostate cancer than those with screening (2).

Does population screening with serum creatinine and urine protein testing lead to improved outcomes without undue harm?

In 2012, the US Preventive Services Task Force concluded that the evidence is insufficient to assess the balance of benefits and harms of routine screening for CKD in asymptomatic adults (3). In 2013, the American College of Physicians recommended against screening for CKD in asymptomatic adults without risk factors for CKD (4). In sharp contrast, the American Society of Nephrology strongly recommends regular screening for kidney disease, regardless of an individual’s risk factors (5). The National Kidney Foundation and the Renal Physicians Association recommend that health care professionals test patients in specific high-risk groups for CKD—particularly those with diabetes or high BP (6). Do possible harms of screening outweigh potential benefits?

The debate follows. Qaseem *et al.* (7) argue that screening for CKD does not improve important clinical

outcomes. Therefore, Qaseem *et al.* (7) argue against screening asymptomatic adults as well as adults with diabetes if they are already taking an angiotensin-converting enzyme inhibitor or an angiotensin II receptor blocker. On the other side of the debate, Berns (8) argues for a thoughtful and selective approach to CKD screening, including screening those with diabetes, hypertension, other CKD risk factors, or family history of hypertension, diabetes, or CKD.

Do you screen your patients for CKD? Do you think routine screening should be done for asymptomatic adults with or without diabetes or hypertension? See what you think after reading this debate.

Disclosures

None.

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