Importance of urine albumin-creatinine ratio in the diagnosis and prognosis of chronic kidney disease

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Abstract

Introduction

New Kidney Disease Improving Global Outcomes guidelines represent a significant change from the National Kidney Foundation’s Kidney Disease Outcomes Quality Initiative, which indicate that the urinary albumin/creatinine ratio is now integral to the classification of chronic kidney disease. The urinary albumin/creatinine ratio has been found to be fundamentally important for both the diagnosis and the prognosis of chronic kidney disease. It is now recommended that all patients with diabetes or hypertension be screened annually with this test. The presence of albuminuria helps decide the medications for the treatment of hypertension. This review discusses the importance of urine albumin–creatinine ratio in chronic kidney disease.

Conclusion

More research is needed to determine definitively whether or not the treatment of albuminuria delays the progression of chronic kidney disease and reduces mortality.

Introduction

The 2012 Kidney Disease Improving Global Outcomes (KDIGO) clinical practice guidelines1 represent a significant update from the 2002 National Kidney Foundations Kidney Disease Outcomes Quality Initiative (KDOQI)2, which indicates that the urinary albumin–creatinine ratio (UACR) is now integral to the classification of chronic kidney disease (CKD). The UACR is found to be fundamentally important for both the diagnosis and the prognosis of CKD. It is now recommended that all patients with diabetes and/or hypertension be screened annually with this test. The presence of albuminuria helps decide the medications for the treatment of hypertension. This review discusses the importance of urine albumin–creatinine ratio in chronic kidney disease.

Conclusion

More research is needed to determine definitively whether or not the treatment of albuminuria delays the progression of chronic kidney disease and reduces mortality.

Discussion

The authors have referenced some of their own studies in this review. These referenced studies have been conducted in accordance with the Declaration of Helsinki (1964) and the protocols of these studies have been approved by the relevant ethics committees related to the institution in which they were performed. All human subjects, in these referenced studies, gave informed consent to participate in these studies.

Diagnosis and staging of CKD

The most significant change in the new KDIGO guidelines3 (versus the original KDOQI guidelines)2 is the new classification that makes the UACR as important as estimated glomerular filtration rate (eGFR) in evaluating the severity of the disease3. The recommendations call for characterising CKD based on underlying cause, GFR category and albuminuria category, as all these influence clinical management, outcomes and mortality3. (Figure 1) demonstrates (reprint of KDIGO, Figure 4) rapid increase in mortality once the eGFR drops below 60 ml/min/1.72 m² and/or once the UACR rises above 3.0 mg albumin/mmol creatinine10. Effects of both eGFR and UACR are additive in causing mortality in patients with both CKD and acute kidney injury (AKI) (Figure 2)10. Opportunities to delay progression of the disease and prevent cardiovascular events are lost if the clinician relies only on changes in eGFR and serum creatinine to diagnose and follow the progression of disease.

CKD is diagnosed based on low eGFR, which is <60 ml/min/1.73 m², and/or UACR >30 mg albumin/g creatinine. The UACR is also known as the microalbumin test. There must be two consecutive abnormal values for eGFR and/or UACR of at least 90 days apart to confirm the diagnosis of CKD11. The
Review

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Settings to include everything from dipstick assessment of total protein to the intended quantitative measure of UACR. Too low levels of “microalbuminuria”, which is referred to as urine albumin, are to be detected by a routine urine dipstick test. KDIGO recommends discontinuing the use of micro- and macroalbuminuria levels in favour of the terms “moderate” and “severe” albuminuria.

For each GFR stage, the degree of albuminuria is an independent risk modifier (Figure 3). Recent studies have suggested that urinary albumin may play a causative role in renal damage. Renin–angiotensin–aldosterone system (RAAS) blockade has been demonstrated to reduce albuminuria and reduce the rate of eGFR decline. For simplicity and clinical relevance, current recommendations suggest recognition of three categories of albuminuria (Figure 4).

Stage A1: UACR < 3 mg albumin/mmol creatinine level is currently considered to be physiologic level.

Stage A2: UACR 3–29.9 mg albumin/mmol creatinine, formerly microalbuminuria, now referred to as moderate albuminuria.

Stage 3: UACR =>3 mg albumin/mmol creatinine, formerly macroalbuminuria, now referred to as moderate-to-severe albuminuria.

Risk related to the level of albuminuria is continuous, that is, it is graded across the spectrum, and current categories may be revised, based on the results of ongoing studies. Levels of 15–30 mg/ml (15–30 mg albumin/mmol creatinine) may prove to be clinically significant, as it has been demonstrated recently that as little as 1.5 mg albumin/mmol creatinine is associated with an increased risk of adverse events.

Some researchers have referred to those with <3 mg albumin/mmol creatinine as normoalbuminuric (or similar terms) to distinguish these patients from those with undetectable urine albumin. Prevention of Renal and End Stage vascular Disease (PREVEND) a
other recent population-based studies have suggested that albuminuria of <3.0 mg/mmol is associated with increased risk factors for CVD and mortality, and is a potential early indicator of glomerular hyperperfusion and elevated GFR in the early stages of diabetic glomerulonephropathy. Levels above 30 mg albumin/mmol creatinine are already recognised by specialty centres, such as levels in excess of 220 mg albumin/mmol creatinine in nephrotic syndrome.

Screening and monitoring with UACR

Although a recently published article indicated a 60% lifetime risk of Stage 3 CKD or worse in US population, which may foretell trends in other developed nations, routine screening of all adults is not recommended by the US Preventive Services Task Force and is unlikely to be cost-effective, according to the Belgian PREVEND study. KDOQI and KDIGO guidelines recommend obtaining urine protein or albumin-creatinine ratio annually during the routine physical examination for adults with risk factors for CKD, including hypertension, diabetes, family history of CKD, and age >60 years.

The prevalence of CKD increases with age, prompting the US National Kidney Foundation to recommend screening of all adults aged 60 years and older, in response to a recent finding that 6 of 10 US adults will develop CKD. Owing to the widespread availability of non-prescription nonsteroidal anti-inflammatory drugs (NSAIDs) in many countries, coupled with general public unawareness of the potential renal risk, routine screening of older adults can help identify and monitor individuals at a higher risk.

Additional risk groups may benefit from routine checking of UACR, though the evidence supporting its efficacy is lacking. Those with impaired glucose tolerance/metabolic syndrome, a history of AKI, certain autoimmune disorders and smokers are also at a higher risk, and recent evidence indicates that obesity is an independent risk factor for CKD, even in the absence of other known predictors. African-Americans tend to develop kidney disease 10–15 years earlier than the general population; therefore, earlier screening may be warranted for this group.

Management of albuminuria

Measurement of albuminuria is an indication for the treatment of hypertension with an angiotensin-converting enzyme inhibitor or angiotensin II receptor blocker. Dual RAAS blockade with spironolactone has also been found to be helpful. However, safety signals of AKI and hyperkalaemia in the Ongoing Telmisartan Alone and in Combination with Ramipril Global Endpoint Trial (ONTARGET) and NEPHRON D trials suggest that dual RAAS blockade with an ACE inhibitor and ARB should be avoided. Intensifying monotherapy with ACE inhibitor or ARB may be a better strategy.

Conclusion

Diagnosis and classification of CKD require assessment of both eGFR and UACR. Urine albumin-creatinine screening should be incorporated.

References