

Diabetes and renal disease: who does what?

Editor – Jones *et al* (*Clin Med* October 2013 pp 460–4) provide a revealing analysis of the distribution of patients with diabetes and kidney disease across the health service. They show that applying traditional referral guidelines which use arbitrary estimated glomerular filtration rate (eGFR) criteria leads to patients who should be managed in primary care remaining under nephrologists and vice versa, with concerning evidence of ageism. They highlight that the rate of progression of eGFR should be intrinsic to the decision to refer the patient, but worry that this will overload the nephrology service.

We have operated an integrated diabetes kidney service for nearly 10 years based upon identifying those patients whose eGFR is declining.¹ It uses a database of diabetes patients to produce a weekly report listing those whose eGFR has been measured in the previous week. An eGFR graph is drawn for each patient and those with a declining trend are reviewed in the diabetes renal clinic by a nephrologist. Once assessed, diagnosed, educated and treated, patients with a stable eGFR are returned to primary or general diabetes care. Those likely to need dialysis or a transplant within the next 12 months are transferred to a multidisciplinary renal clinic.

As patients' eGFR results, wherever they originate, are monitored via the weekly report, they are never completely 'discharged' from specialist care. By having a safe exit route from the clinic, the number of patients attending the clinic in person is greatly reduced. Currently, an average of 85 patients per week are reviewed virtually by their eGFR graph. The clinic capacity that has been freed up is used to see more referrals at an earlier stage of CKD. The new to follow up ratio is now 1:1. Seeing patients at an earlier stage in disease progression helps prevent loss of renal function. The number of patients starting dialysis since the system was introduced has declined.¹

This system has now been incorporated into the clinical chemistry service to include all patients in the community.² This avoids the need for a separate diabetes database and should be possible in all NHS pathology laboratories.

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Editor – Jones *et al* criticise the current guidelines for referral of patients with diabetes (DM) and chronic kidney disease (CKD) to nephrology clinics (*Clin Med* October 2013 pp 460–4). They have provided their evidence on 26,759 patients aged between 68 and 81 years with declining renal function that was based on estimated glomerular filtration rate (eGFR). However, it must be understood that eGFR of <60ml/min is very commonly seen in healthy older people¹ and this is erroneously categorised as having CKD. It

is well recognised that about 25% of the population aged over 70 years do have an eGFR consistent with stage 3 CKD or worse.² In the geriatric age group, and without evidence of proteinuria/haematuria, an eGFR around 60ml/min should be considered as normal. In such patients a diagnosis of CKD should not be offered.

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Neurology: still in first gear

Editor – The Francis and Future Hospital Commission reports add to neurology's woes, eloquently summarised by Richard Langton-Hewer and met with diplomacy by the Association of British Neurologists (ABN) (*Clin Med* October 2013 pp 440–2 and *Clin Med* October 2013 pp 443). Part-time consultants, an aging population, the desire for specialist care in the community and the acknowledgement that stroke, dementia, fatigue, pain syndromes and adult learning disability are also neurological illnesses contribute further pressures. For availability of consultant-led neurological expertise in all admitting hospitals 24 hours per day, 7 days per week (which seems appropriate given the rapidity with which neurological knowledge and treatment is advancing) and if neurologists are to take a share in acute medicine, then expansion of neurology is inevitable. An additional 200 consultants would allow, with redistribution, one per 70,000 population (as suggested by the Royal College of Physicians [RCP]/ABN working party in 2011)¹ and an additional 800 consultants would bring the rest of the UK into line with the one per 40,000 population in London.²

Prof Langton-Hewer calls for evidence to guide service delivery. The specialty was battered by the National Audit Office (NAO), whose report commented that there was variation (by primary care trust [PCT]) in acute admission with neurological illness that could not be due to chance.³ The method used to justify this statement was to compare emergency admissions for three illnesses (multiple sclerosis, motor neurone disease and Parkinson's disease) with routine admissions for the same conditions. However, the admission figures used by the NAO show no correlation with the availability, by PCT, of new and follow-up appointments or follow-up to new ratio in neurology.⁴ Hence, either the availability of neurology appointments has no effect on acute admission or the figures used by the NAO were not representative of anything relevant. With knowledge of the many factors behind acute and chronic neurological admission, the latter seems more likely. Certainly no decision on neurology consultant staffing should be based on such evidence. In addition, illnesses and treatments change so rapidly, even in neurology, that by the time evidence appears it is out of date.

If we acknowledge that neurology consultant expansion must happen, how can we achieve this in austere times? There will be a