CKD — Detection & the Treatment Pyramid

Kidney Health Check, KDIGO risk bands, ACEi/ARB first

CLINICAL PATHWAY

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Kidney Health Check = eGFR + uACR + BP, every 1–2 years in at-risk patients. Once CKD is confirmed: foundation therapy first (lifestyle + BP), then ACEi/ARB, then an SGLT2 inhibitor — escalate the pyramid whenever a target isn't met.

KIDNEY HEALTH CHECK

- **At-risk groups** (test every 1–2 years): diabetes, hypertension, CVD, age≥60, smoking, family history, Aboriginal or Torres Strait Islander background, obesity
- **Three core tests:** eGFR + uACR (first-morning sample) + BP — repeat in 3 months if abnormal
- **Confirm before labelling CKD:** 2 abnormal results ≥3 months apart
- **Stage by KDIGO:** eGFR category (G1–G5) × albuminuria category (A1 uACR<3, A2 3–30, A3>30mg/mmol)

KDIGO RISK BANDS

- **Low** (G1–G2 + A1): routine GP review
- **Moderate** (G1–G2+A2, or G3a+A1): annual eGFR + uACR
- **High** (G3a+A2, G3b+A1, or G1–G2+A3): start an SGLT2 inhibitor; consider a nephrology opinion
- **Very high** (G3b+A2/A3, or any G4–G5): SGLT2 inhibitor + nephrology referral; monitor 3-monthly

FULL KDIGO HEAT-MAP

This summarises the KDIGO eGFR × albuminuria heat-map by risk band. For the full colour-coded grid and exact monitoring intervals per cell, see the current KDIGO CKD guideline or the Kidney Health Australia CKD handbook at kidney.org.au.

THE CKD TREATMENT PYRAMID

Escalate when target not met, per KDIGO 2024 and the Kidney Health Australia handbook (5th ed, 2024).

1	**Foundation — lifestyle + BP:** low salt, no smoking; BP target <130/80mmHg (KHA/RACGP). Some very high-CVD-risk patients may benefit from a lower, standardised SBP<120mmHg target per KDIGO — weigh against falls/AKI risk
2	**ACEi or ARB:** up-titrate to the maximum tolerated dose; stabilise ≥4 weeks before adding an SGLT2 inhibitor
3	**Add an SGLT2 inhibitor:** dapagliflozin or empagliflozin — confirm the current PBS eGFR band at pbs.gov.au; once started, can usually continue below the initiation threshold until dialysis or transplant
4	**Add-on therapies:** finerenone, a GLP-1 receptor agonist (if type 2 diabetes), and a statin

FINERENONE NEEDS AN SGLT2i ON BOARD

Finerenone is PBS-listed for CKD with type 2 diabetes, used together with — not instead of — an SGLT2 inhibitor. Needs eGFR≥25, uACR≥22.6mg/mmol, and potassium≤5.0mmol/L to start; starting dose is lower at eGFR25–<60 than at eGFR≥60. Confirm current PBS criteria at pbs.gov.au.

■ SAFETY

- Don't start finerenone if potassium >5.0mmol/L; recheck potassium and eGFR 4 weeks after starting or up-titrating any RAS blocker, SGLT2 inhibitor or finerenone
- NSAIDs significantly worsen CKD — avoid at eGFR<60, absolutely avoid below eGFR30
- Discuss alternatives to IV contrast where possible if eGFR<30

■ RED FLAGS / REFER

- eGFR<30 (Stage 4–5) → nephrology referral, all patients
- Albuminuria uACR≥30mg/mmol (Stage A3) → nephrology referral
- Rapid decline — eGFR fall ≥15mL/min/1.73m²/year, or ≥25% within 12 months → nephrology referral

For health-professional use. Framework: KDIGO 2024 CKD Guideline; Kidney Health Australia CKD Management in Primary Care (5th ed, 2024).
Companion sheet: REN-01B CKD — Practical Care, Dosing & Referral.