



Chronic renal insufficiency: knowledge and perception by general practitioners

Charifa El alaoui Handira^{*}, Mohamed Naciri, Wafaa Fadili, Inass Laouad.
Service de néphrologie-hémodialyse et transplantation rénale; CHU Mohamed VI. Marrakech. Maroc.

ABSTRACT

Chronic kidney disease (CKD) is a major health problem Publicly available. We conducted a survey of general practitioners (GPs) to better understand their vision of IRC. A validated questionnaire was sent to a representative sample of 150 (40%) MG of Marrakech Haouz. Cent (66%) responded. The age of GPs is less than 40 years: 13%, 40-50: 47%, more than 50: 40%. The exercise zone is urban in 60% of the cases, rural: 40%. Seventy-five percent of GPs have a nephrology correspondent with whom they have "good relationships" in 80% of the cases. Twenty-one percent of GPs are sensitized to IRC intake. Seventy-five percent feel that the diagnosis of IRC is difficult. Twenty percent know there are benchmarks. Systematic screening is performed in the event of hypertension: 95%, diabetes: 99%, older than 65 years: 60%, urinary infection: 30%, haematuria / proteinuria: 79%, anemia: 45%, nephrotoxic treatment: 70%, in all these cases: 20%. A nephrological opinion is required for an average value of creatinine clearance according to Cockcroft of 40 ± 12 ml / min. For MG, an age greater than 80 years is a relative or absolute contraindication to supplementation in 35% of cases, dementia: 70%, progressive neoplasia: 65%. CME (continuing medical education) is associated with knowledge of benchmarks, use of clearance rather than serum creatinine.

Keywords: General practitioner-chronic renal failure-continuing medical education.

INTRODUCTION

Chronic kidney disease (CKD) is a major public health problem. The description of chronic kidney disease and the classification of chronic kidney disease (CKD) have improved, and precise figures are beginning to be available. The terminal IRC treated by dialysis in Morocco 191pmh. The organization of the health system places the general practitioner at the heart of preventive medicine and screening. A better knowledge of the call signs and the diagnostic means of the IRC is essential to Improve its management. The objective of our study is to better understand their vision and perception of IRC.

MATERIALS AND METHODS

This is a cross-sectional declarative descriptive study of perception developed through a survey of general practitioners in the Marrakech Haouz Region. A questionnaire of 17 items (Appendix 1) was written, validated by GPs, nephrologists. Feasibility was tested by ten independent MGs. Then

it was addressed to a representative sample of 150 (40%) MG of Marrakech Haouz, selected randomly through the register of the Medical Association.

RESULT AND DISCUSSION

-150 (40%) MG of Marrakech Haouz.Cent (66%) replied.

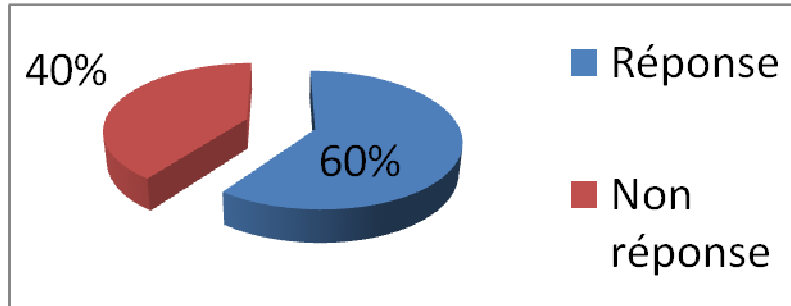
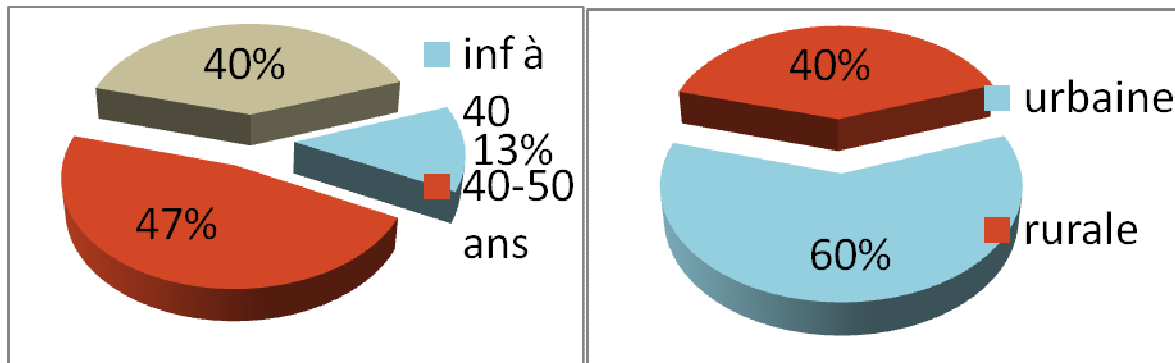


FIGURE 1: The MG response rate



FIGURES 2 and 3: Distribution by age and area of practice

• Description of the quality of contact between the GP and the nephrologist:

Correspondence with the nephrologist:

-60% of the GPs have among their usual correspondents a nephrologist doctor, with good relations in 80% of the cases.

Communication and coordination between GP and nephrologist:

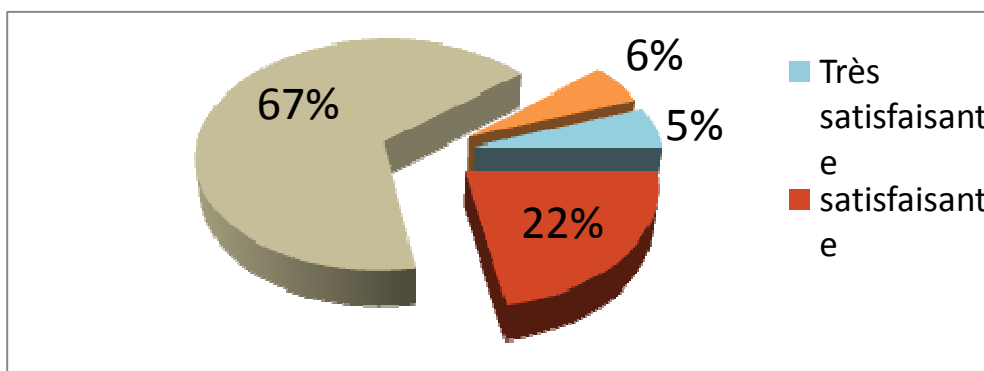


Figure 4: Quality of the coordination of care between the MG and the nephrologist.

• Description of the knowledge and perception of the IRC by the MG:

Only 21% of general practitioners say they are aware of the management of IRC.

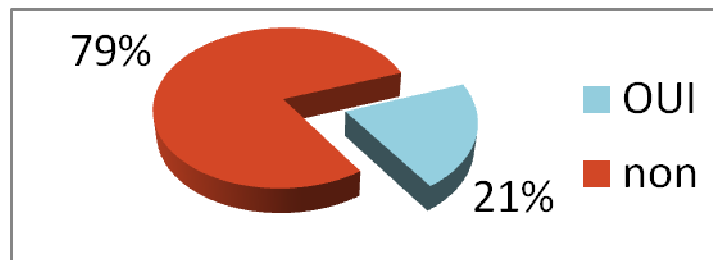


Figure 5: Distribution of GPs sensitized to the management of The IRC

-Evaluation of renal function:

For GPs who responded to the questionnaire, the marker most commonly used to assess renal function was serum urea-creatinine in 60% of cases.

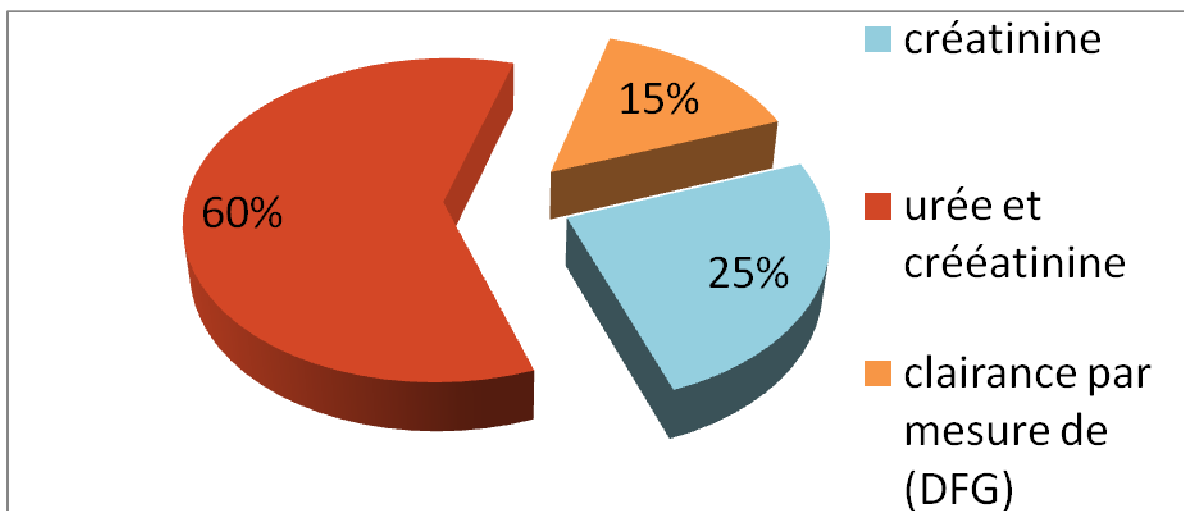


Figure 6: Different biological markers of renal function used by our physicians

-Displacement of chronic kidney disease:

From the point of view of GPs diabetes and hypertension seem more clearly associated with a renal risk.

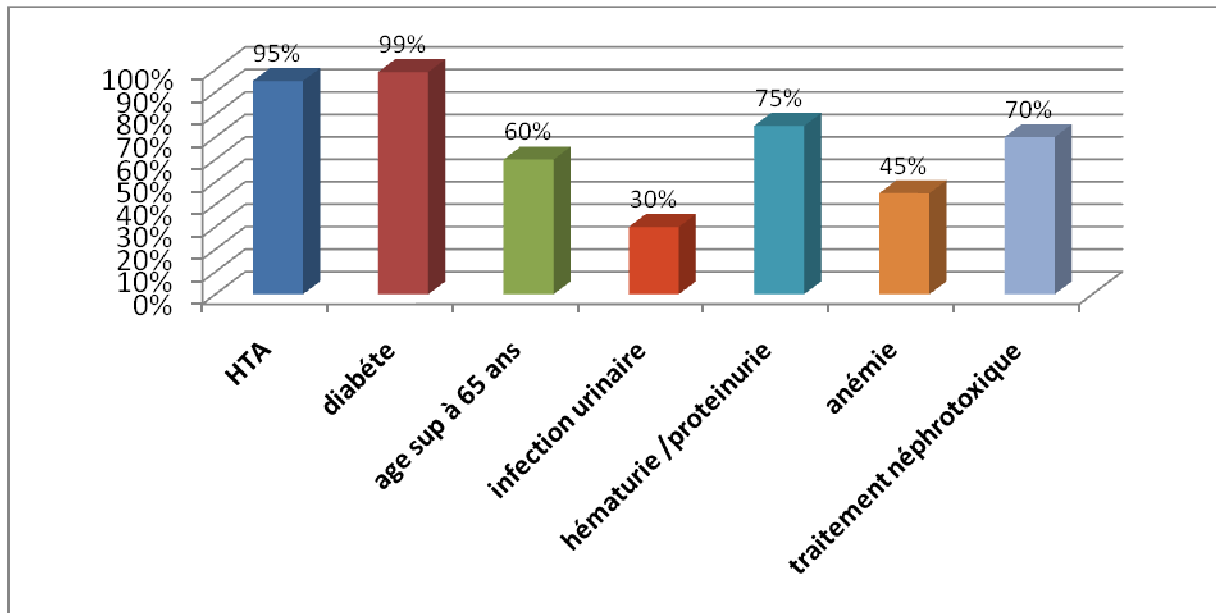


Figure 7: Circumstance justifying IRC screening from the point of view of GPs.

Criteria for referring the IRC patient to the nephrologist:

The MG estimates that nephrologist intervention is essential in 75% of cases.

-Dialysis indication:

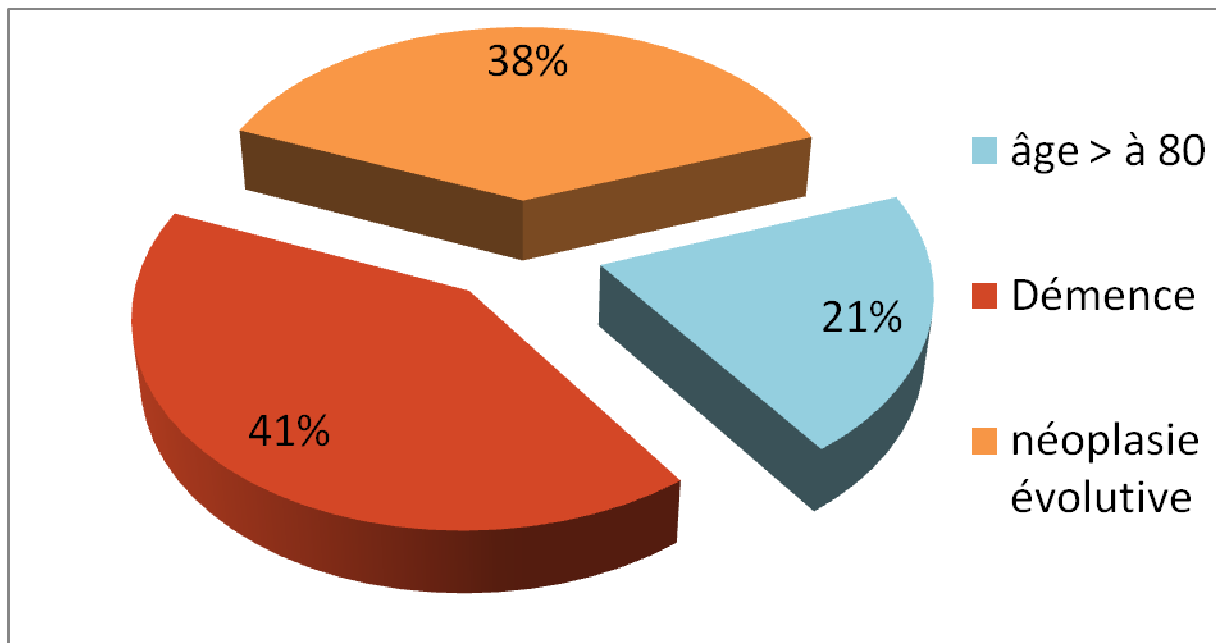


Figure 9: contraindications to dialysis reported by our doctors

• Impact of continuing medical education (CME):

59% of GPs followed a CME for the IRC. In 49% was under 5 years.

CONCLUSION

GPs have an important role in early detection of IRC to limit progression and ensure optimal patient management (1,2).

Early detection and management of CRF would reduce the risk of progression of renal insufficiency by 50% and cardiovascular risk factors (3).

Late management is associated with increased morbidity and mortality (4).

GPs would not be sufficiently sensitized and therefore some gaps appear to exist to address this problem (5,6).

According to our study, almost all GPs are concerned with the kidney in the case of diabetes and hypertension, as these pathologies are the most frequent causes of IRC (7,8).

Our doctors' knowledge of the recommendations of the HAS (High Health Authority) are largely insufficient compared to MGs from other countries.

A study conducted in the United Kingdom of 160,000 patients shows that screening for IRC and control of risk factors for worsening IRC are poorly controlled (9). Although studies show that knowledge of GPs does not are not always optimal. (10) Others show that sensitizing them with recommendations considerably improves the quality of care of their patients (11) and this is even more so if, in collaboration with a nephrologist (12).

Improved co-operation between GPs and nephrologists through the development of a regional health network is now emerging as the most effective way to improve the management of patients with CKD (13).

According to the results of our studies, GPs consider that the role of the nephrologist is essential in 58% of cases, but the transfer criteria remain ill-defined according to 79% between them. A study has shown that in the United Kingdom, Canada and In the United States, mean creatinemia for a nephrological opinion was 29.50, 33.75, 38.36mg / l (14), respectively.

Finally, for the CME, many authors recommend in their study that didactic CME be abandoned. (15) Thus, intervention studies have shown that the most effective method is a head-to-head between a specially trained health professional and The practitioner. On the other hand, the creation of websites and the use of telemedicine equipment within healthcare networks will improve the exchange of information between the nephrologist and the general practitioner and have a feedback Patients referred to the nephrologist.

REFERENCES

- [1] SynderS, Pendergraph B. Detection and evaluation of chronic kidney disease. *American Academy of family physicians*.**2005**;72(9):pp. 1723-32.
- [2] Curtis B, BarrettBJ, Levin A. Identifying and sloqing progressice chronic renal failure. *Canadian Family Physicians*, **2001**;47:pp 2512-8.
- [3] Iseki K1 Role of chronic kidney disease in cardiovascular disease are we different :are we different from others ?*ClinExpNephrol* **2011**;15(4):pp 450-5.
- [4] Kumar S1, JeganathanJ, Amruthesh. Timing of nephrology referral :influence on mortality and morbidity in chronic kidney disease .*Nephrourol Mon*, **2012**;4(3):pp 578-81.

- [5] Fox CH, BrooksA, ZayasLE, McCellanW, Murrau B. Primary care physicians knowledge and practice patterns in the treatment of chronic kidney disease :an Upstate New York Practice –based Research Network (UNYNET)study.*J Am Board Fam Med*, **2006**;19(1):pp 54-61.
- [6] Ravera M .et coll.CKD awareness and blood pressure control in primary care hypertensive population .*Am J Kidney Dis*, **2011**;57(1):pp 71-7
- [7] Lassalle M1, Ayav C, FrimatL, JacquellinetC, CouchoudC ;et al. The essential of 2012 results from the french renal epidemiology and information Network(rein) ESDregistry. *Nephrol Ther* **2015**;11(2):pp 78-87.
- [8] Di LorioBR, DiMiccoL, DeBlasioA, RubinoR, Guastaferro P. A short report :blood pressure variability and outcomes in chronic kidney disease long survivors patients.*GItal Nefrol*, **2015**;32(3).
- [9] New JP, MiddeltonRJ, KlebeB, FarmerCK, delusignanS, Stevens PE et al . Assessing the prevalence ,monitoring and management of chronic kidney disease in patients with diabetes compared with those without diabetes in general practice. *Diabetic medicine*, **2007**;24(4):pp 364-9.
- [10] FrimatL, Siewe G, Loos-AyavC, BriançonS, KessierM, Aubrège A.Chronic kidney disease: do generalists and nephrologists differ in their care? *Nephrologie et Therapeutique*, **2006**;2(3):pp 127-35
- [11] PatwardhanMB, MatcharDB, SamsaGP, Haley WE.Opportunities for improving management of advanced chronic kidney disease .*American Journal of Medical quality*, **2008**;23(3):pp 184-92.
- [12] BonaniM, Fehr T.Chronic kidney disease in the general practitioner’s office .*Praxis (Bern 1994)*, **2009**;98(15):pp 823-32.
- [13] JungersP, JolyD, Nguyen-KhoaT, MothuN, BassiliosN, Grunfeld JP.Continued late referral of patients with chronic kidney disease .causes, consequences and approaches to improvement. *Pressemedicale*, **2006**;35(1):pp 17-22.
- [14] Wilson R, GodwinM, SeguinR, BurrowsP, CaulfieldP, ToffelminreE, et al. End-stage renal disease :factors affecting referral decisions by family physicians in Canada.the United States, and Britain.*Am J Kidney Dis*, **2001**;38:pp 42-8.
- [15] Durieux P, RavaudP, Chaix C, Durand –Zaleski I.La formation médicale continue améliore-t-elle le comportement des médecins ?*Presse Med*, **1999**;28:pp 468-72.