Chronic Kidney Disease

Consultation on draft scope
Stakeholder comments table

10/12/18 – 11/01/2019

Stakeholder	Page no.	Line no.	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Association of Nephrology Nurses	General	General	There are no comments from us at this stage.	Thank you.
Bayer PLC	5	8	As per the scope, the risk of progression and adverse outcomes in a person with, or at risk of, CKD is currently determined through monitoring creatinine-based estimates of GFR (eGFRcreatinine) and urine albumin:creatinine ratio (UACR). CG182 states that raised ACR is a powerful independent marker of the risk of adverse outcomes in CKD, and the use of ACR and GFR in combination will allow better risk stratification. We have noted that the uptake of UACR testing and ongoing monitoring is lower than that of GFR and wonder if this is due to the current lack of specific recommendations around frequency of this test in individuals at risk of, or with, a diagnosis of CKD. • The National Chronic Kidney Disease Audit - National Report (Part 1) January 2017, reported that: ○ whilst over 80% of those with CKD had had an eGFR test in the previous year, only 31% had a repeat ACR test • The National Diabetes Audit 2016-17. Report 1: Care Processes and Treatment Targets. England and Wales reports on the uptake of NICE recommended care processes and found that in 2016/17, for those with diabetes, 82.7% and 95% of patients with type 1 and type 2 diabetes respectively, had a check of their serum creatinine level. For urine albumin, the	Thank you for your comment. The updated guideline will consider the evidence for the following review questions: What is the best combination of measures of kidney function and markers of kidney damage to identify increased risk of progression in adults, children and young people with CKD? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline.

			respective uptake was 50.1% and 65.2% and declining over recent years. o We note that testing for CKD using eGFRcreatinine and ACR in patients with diabetes came under the key priorities for implementation in CG182. As the guideline scope addresses (1) determining the risk of adverse outcomes in CKD, (2) frequency of monitoring and (3) defining progression of CKD with respect to monitoring, a review of UACR testing would appear to be in scope.	
Bayer PLC	9		Oral antiplatelets and anticoagulants - people with chronic kidney disease (CKD) and concomitant coronary artery disease (CAD). The existing NICE clinical guideline - Chronic kidney disease in adults: assessment and management [CG182] which will be updated and combined with CG157 and NG8 as part of this guideline update, currently recommends offering antiplatelet drugs to people with CKD for the secondary prevention of cardiovascular disease. Please be aware that there is an ongoing NICE technology appraisal for rivaroxaban for preventing atherothrombotic events in people with coronary or peripheral artery disease (ID1397), including in a subgroup of people with CAD who also have poor renal function (publication expected in August 2019). The result of this technology appraisal should be incorporated into this NICE clinical guideline in line with the methods outlined in the NICE guidelines manual.	Thank you for your comment, the scope has been amended to include all relevant NICE technology appraisals in development. The updated guideline will have the opportunity to cross-refer to relevant NICE technology appraisals, as appropriate.
Bayer PLC	9		We understand that there are no plans to update the section of guideline CG182 regarding oral antiplatelets and anticoagulants. However, should this section eventually be	Thank you for your comment, the scope has been amended to include NICE technology appraisals including TA275, Apixaban for preventing stroke and systemic embolism in people with nonvalvular atrial fibrillation and other relevant technology

			included in the update we suggest the following should be taken into consideration: We consider that the singular recommendation for only one NOAC, apixaban, in preference to warfarin in patients with NVAF and a confirmed eGFR of 30–50 ml/min - albeit within the intended meaning of 'consider' as defined by NICE - is inappropriate, fails to take into account other very important clinical and practical considerations, and is contrary to the respective positive technology appraisals which recommend each NOAC as an option for the prevention of stroke and systemic embolism within their licensed indication, i.e. including patients with moderate renal impairment. In the absence of prospective, comparative, randomised clinical trials between NOACs, NICE appear to have considered the respective phase III studies comparing each NOAC to warfarin and then made their recommendation on the basis of which NOAC appears to have the most favourable data in patients with renal impairment. However, important differences exist between the phase III studies, notably stroke & bleeding risks of the study populations and whether a specific reduced dose was evaluated for renal impairment. In ARISTOTLE,[1,2] the stroke and, importantly, bleeding risk of the patient population was notably lower than in ROCKET AF,[3,4] and yet paradoxically the major bleeding rate in patients with renal impairment treated with warfarin in ARISTOTLE[5] was higher than in ROCKET AF[6] - thereby potentially exaggerating the observed difference to apixaban. A very important practical consideration is the complexity of the criteria for correct dose selection for each NOAC, as described in the respective summaries of product characteristics. Renal function (creatinine clearance [CrCl]*), or an indicator of such	appraisals in the related NICE guidance section. The updated guideline will have the opportunity to cross-refer to relevant NICE technology appraisals, as appropriate.

			(serum creatinine), is included in the dosing criteria for all 4 NOACs licensed for use in NVAF. However, for only one NOAC, rivaroxaban, renal function is the sole criterion for correct dose selection, whereas for all other NOACs several additional criteria (e.g. age, body weight, or specific drug interactions), either alone or in combination - and all of which will/ may change over time, determine whether a standard or reduced dose should definitely be prescribed or considered (based on an assessment of the thrombotic and bleeding risk of an individual patient). Importantly there is increasing evidence from observational studies in routine clinical practice, particularly in the UK[7,8] - but also in other countries,[7] that the proportion of reduced versus standard doses being prescribed differs from that in the respective phase III clinical trials (the evidence base for the licensed therapeutic indication). In the case of apixaban, the EMA Pharmacovigilance Risk Assessment Committee (PRAC) has requested the marketing authorisation holder to perform a qualitative research study designed to understand prescribers' rationale behind dosing strategies in those situations where a lower dose of apixaban is prescribed without meeting SmPC dose reduction advice, and that the provision of the results should expedited if the results warrant an update of the product information.[9] The potential for inappropriate dose selection cannot be ignored because of the serious consequences of failing to achieve adequate anticoagulation. A retrospective, observational study in the USA examined the use of standard NOAC doses in patients with a renal indication for dose reduction and a reduced dose in patients without a renal indication for dose reduction.[10] In apixaban-treated patients	

			with no renal indication for dose reduction, potential under-dosing was associated with a higher risk of stroke (HR 4.87, 95% CI 1.30 - 18.26), but no difference in major bleeding; however there was no relationship between dose reduction and risk of stroke or bleeding in the dabigatran- or rivaroxaban-treated patients. The effectiveness and safety of reduced dose NOAC regimens compared with warfarin was also examined in an observational, propensity weighted, study in a large "real world" cohort of patients in Denmark.[11] Apixaban 2.5 mg BD was associated with a trend towards higher rates of ischaemic stroke/systemic embolism compared with warfarin, while rivaroxaban 15 mg OD and dabigatran 110 mg BD showed a trend towards lower thromboembolic rates. For patients with renal impairment, selecting the correct dose of NOAC in accordance with SPC recommendations is obviously important. Any evidence of decline in renal function on anticoagulation should also be considered. When assessed by absolute change in CrCl over time, this was lower for rivaroxaban than warfarin in the ROCKET AF study,[12] but the same was not observed for apixaban versus warfarin in the ARISTOTLE study.[13] A retrospective cohort analysis comparing oral anticoagulant agents (apixaban, dabigatran, rivaroxaban, and warfarin) for their effects on renal outcomes, found that dabigatran and rivaroxaban may be associated with lower risks of adverse renal outcomes than warfarin, whereas apixaban was not associated with any differences compared to warfarin.[14] Taking into account the above clinical and practical considerations, no conclusions can be drawn regarding which NOAC should be preferred over warfarin.	

			Therefore, and in line with the NICE guidelines manual which states*: "A guideline committee cannot usually publish its own recommendations on health technologies covered by published or in development health technologies guidance"*, we propose that the recommendations for the NOACs from their respective technology appraisals should be incorporated verbatim in this guideline (or a cross-reference provided) as all are NICE recommended options for the prevention of stroke and systemic embolism within their licensed indication, i.e. including in patients with moderate renal impairment. 1. Apixaban versus Warfarin in Patients with Atrial Fibrillation; Granger CB, Alexander JH et al; N Engl J Med 2011;365:981-992 2. Efficacy and safety of apixaban compared with warfarin according to patient risk of stroke and of bleeding in atrial fibrillation: a secondary analysis of a randomised controlled trial; Lopes RD, Al-Khatib Sana M et al; The Lancet 2012;380 (9855):1749-1758 3. Rivaroxaban versus Warfarin in Nonvalvular Atrial Fibrillation; Patel MR, Mahaffey KW et al; N Engl J Med 2011;365:883-891 4. Gastrointestinal Bleeding in Patients With Atrial Fibrillation Treated With Rivaroxaban or Warfarin: ROCKET AF Trial; Sherwood MW, Nessel CC; JACC 2015;66 (21):2271-2281 5. Efficacy of apixaban when compared with warfarin in relation to renal function in patients with atrial fibrillation: insights from the ARISTOTLE trial;	

			Hohnloser SH, Hijazi Z et al; European Heart Journal 2012;33:2821–2830 6. Prevention of stroke and systemic embolism with rivaroxaban compared with warfarin in patients with non-valvular atrial fibrillation and moderate renal impairment; Fox KAA, Piccini JP; European Heart Journal 2011;32:2387–2394 7. Oral anticoagulant prescribing patterns for stroke prevention in atrial fibrillation among general practitioners and cardiologists in three European countries; Fay MR, Martins JL et al; ESC 2016, abstract & poster P2597 8. Use of Standard and Reduced Dose of Non-vitamin K Antagonist Oral Anticoagulants in Non-Valvular Atrial Fibrillation Patients by the Labelling Criterion in the United Kingdom; Rodríguez LAG, Pérez MM et al; EuroThrombosis 2018 poster 9. European Medicines Agency 11th January 2018; Pharmacovigilance Risk Assessment Committee (PRAC), Minutes of the meeting on 27-30 November 2017 10. Non–Vitamin K Antagonist Oral Anticoagulant Dosing in Patients With Atrial Fibrillation and Renal Dysfunction; Yao X, Shah ND et al; J Am Coll Cardiol 2017;69:2779–90 11. Effectiveness and safety of reduced dose non-vitamin K antagonist oral anticoagulants and warfarin in patients with atrial fibrillation: propensity weighted nationwide cohort study; Nielsen PB, Skjøth F et al; BMJ 2017;356:j510	

			12. On-Treatment Outcomes in Patients With Worsening Renal Function With Rivaroxaban Compared With Warfarin; Fordyce CB, Hellkamp AS et al; Circulation 2016;134:37-47 13. Efficacy and Safety of Apixaban Compared With Warfarin in Patients With Atrial Fibrillation in Relation to Renal Function Over Time; Hijazi Z, Hohnloser SH et al; JAMA Cardiol 2016;1(4):451-460 Renal Outcomes in Anticoagulated Patients With Atrial Fibrillation; Yao X, Tangri N; J Am Coll Cardiol 2017;70:2621–32	
British Dietetic Association – Renal Nutrition Group	12	27	The draft scope currently excludes “Treating malnutrition”. It also does not mention screening and assessing malnutrition in CKD. These three important issues are not addressed or covered by any other NICE Guidelines. We strongly feel screening; assessing and treating malnutrition in people with CKD should be included. The NICE guidelines for oral nutrition support are not applicable in patients with CKD where weight is often masked by changes in fluid balance. Up to 40 % of patients with CKD on dialysis are malnourished in the UK and up to 20% of patients with CKD before they start dialysis are underweight or at risk of malnutrition. Malnutrition in CKD is an independent risk factor which increases mortality in this patient group. Specific tool to assess malnutrition have been developed for patients with CKD (for example subjective global assessment, SGA) and there is a robust amount of evidence based practice which support the importance of maintaining a good nutritional status. Our population is getting older, frailer, and often present with CKD with multiple co morbidities which further impact on	Thank you for your comment. Treating malnutrition is outside the remit of this guideline. We will highlight this area to the surveillance team for consideration at the next surveillance review for other NICE guidelines.

			nutritional status hence indicating a growing need to identify and treat deteriorations in nutritional status. Providing a guideline to primary and secondary care and supporting GP's to identify and treat malnutrition early in in CKD is vital to reduce hospital admissions, reduce length of stay and optimise the treatment provided (for example there is evidence that improving nutritional status can reduce the amount to erythropoietin needed, suggesting that treating malnutrition may provide cost benefits for medication usage). In addition, the draft scope has included hyperphosphatemia but did not mention hypophosphatemia. This is often linked to malnutrition in patients on dialysis and the two are considered at the same time when assessing patients overall nutritional status. We strongly feel that highlighting the importance of Screening, assessing and treating malnutrition will be very helpful to health care professionals managing patients with CKD/ and could potentially lead to cost saving in the NHS as outlined in the examples provided. If you do decide to exclude the Screening, assessing and treating malnutrition from this guideline we would encourage you to explain why you have come to this decision and to be more explicit about the range of topics you are excluding rather than just 'malnutrition'. Finally, if your final decision is still to exclude malnutrition, would you consider a commitment to review this important area in the future?	

British Dietetic Association – Renal Nutrition Group	14	19	The draft scope document states: "We will take economic aspects into account when making recommendations" Given the potential economic aspects that treating malnutrition could potentially have we find it difficult to understand why it has been excluded and strongly feel that it is a vital inclusion to these guidelines. For example nutritional supplements are significant economic aspect. Specialist guidance on indication and prescription of nutritional supplements is required for these patients due to difficulty detecting malnutrition, fluid and multiple dietary restrictions often precluding default dietary fortification/supplementation strategies.	Thank you for your comment. Treating malnutrition is outside the remit of this guideline. We will highlight this area to the surveillance team for consideration at the next surveillance review for other NICE guidelines.
British Dietetic Association – Renal Nutrition Group	3	10	The guidelines scope states: "Calcium-based binders are current first-line treatment" New evidence published since NICE 2003 and NICE 2015 suggest limiting calcium containing binder. Please refer to most recent evidence KDIGO 2017 which states: In adult patients with CKD G3a–G5D receiving phosphate-lowering treatment, "…*we suggest restricting the dose of* *calcium-based phosphate binders (2B).>>"* https://kdigo.org/wp-content/uploads/2017/02/2017-KDIGO-CKD-MBD-GL-Update.pdf	Thank you for your comment. The updated guideline will consider the evidence for the following review questions: For people with stage 4 or 5 CKD who are not on dialysis, which phosphate binder, calcium and non-calcium based, is most effective in managing serum phosphate and its associated outcomes? For people with stage 5 CKD who are on dialysis, which phosphate binder, calcium and non-calcium containing, is most effective in managing serum phosphate and its associated outcomes? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed

				for the guideline. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update. NICE is aware of the KDIGO guidance and recognises the value of consistent national guidance, where this fits with NICE standard methods.
British Dietetic Association – Renal Nutrition Group	3	8 - 9	The guideline scope states: …"This can be achieved by the use of phosphate-binding agents in addition to dietary management" We feel that this should be written and presented as "This can be achieved by the use of phosphate-binding agents in addition to dietary management led by **a specialist renal dietitian"** (As recommended in NICE 2013, CG157)	Thank you for your comment. Section 1 of the scope is a summary of current practice and does not include the guideline recommendations, therefore we have not amended this section of the scope.
British Dietetic Association – Renal Nutrition Group	General	General	Although the scope highlights dietary management as a way of maintaining acceptable levels of serum phosphate, we feel this needs to be expanded and would recommend that the guidelines goes into more detail mentioning sources of organic, inorganic phosphate and phosphate additives. We would also recommend that the guideline highlights the use of low-sodium diets (such as the Mediterranean diet and DASH) in the management of CKD and hypertension. We would also like to see information in the guideline relating to low potassium diets and foods to limit when these are required.	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on dietary management to reduce phosphate levels. Therefore, this area will not be included in the update. The current guideline, CG157, recommends: 1.1.1 A specialist renal dietitian, supported by healthcare professionals with the necessary skills and competencies, should carry out a dietary assessment and give individualised information and advice on dietary phosphate management. 1.1.2 Advice on dietary phosphate management should be tailored to individual learning needs and preferences, rather than being provided through a generalised or complex multicomponent programme of delivery. 1.1.3 Give information about controlling intake of phosphate-rich foods (in particular, foods with a high phosphate content

				per gram of protein, as well as food and drinks with high levels of phosphate additives) to control serum phosphate, while avoiding malnutrition by maintaining a protein intake at or above the minimum recommended level. For people on dialysis, take into account possible dialysate protein losses. 1.1.4 If a nutritional supplement is needed to maintain protein intake in children and young people with hyperphosphataemia, offer a supplement with a lower phosphate content, taking into account patient preference and other nutritional requirements.
British HIV Association (BHIVA)	General	General	BHIVA recommends that an HIV test should be carried out	Thank you for your comment. This guideline focuses on the assessment and management of chronic kidney disease. NICE has guidance on increasing uptake of HIV testing in people who may have undiagnosed HIV (NG60).
British Renal Society	12	13	We wish to question the reason for not including treating malnutrition in CKD in this guideline. The NICE guidelines for oral nutrition support are not applicable in patients with CKD where weight is often masked by fluid. Malnutrition in CKD is an independent risk factor which increases mortality in this patient group. Specific tool to assess malnutrition have been developed for patients with CKD (for example subjective global assessment, SGA) and there is a robust amount of evidence based practice which supports the importance of good nutritional status. We feel that screening for malnutrition should be included particularly as the population is getting older, frailer, and often present with CKD alongside multiple co-morbidities which affect nutritional status.	Thank you for your comment. Treating malnutrition is outside the remit of this guideline. We will highlight this area to the surveillance team for consideration at the next surveillance review for other NICE guidelines.
British Renal Society	15	15 - 17	An additional question should be asked: What is the best scoring system to predict the risk of progression of CKD. Identifying the best risk factors to monitor is relevant but to make this clinically useful, the best risk scoring system should also be identified.	Thank you for your comment. The updated guideline will consider the evidence for the following review question:

				What is the best combination of measures of kidney function and markers of kidney damage to identify increased risk of progression in adults, children and young people with CKD? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline.
British Renal Society	15	2 - 4	An additional question related to cystatin-C should be asked: What is the clinical utility of using cystatin C based equations to estimate GFR? There is published evidence that the approach recommended in the existing guideline would increase cost and potentially increase referrals to secondary care, the opposite of the intended outcome. (Shardlow A, et al. (2017) The clinical utility and cost impact of cystatin C measurement in the diagnosis and management of chronic kidney disease: A primary care cohort study. PLoS Med 14(10): e1002400. https://doi. org/10.1371/journal.pmed.1002400). Also there are concerns about variation in cystatin C assays from different manufacturers and the difficulty in standardising results to make them comparable between centres.	Thank you for your comment. The updated guideline will consider the evidence for the following review question: What is the accuracy of cystatin C-based equations to estimate GFR as a measurement of kidney function in adults, children and young people? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update.
British Renal Society	15	30 - 32	This question should specifically consider and discuss the results of the SPRINT trial as the largest randomised trial of different levels of BP control in older people with CKD.	Thank you for your comment. The updated guideline will consider the evidence for the following review question:

				In adults with proteinuric /nonproteinuric CKD, what are the optimal blood pressure ranges for slowing kidney disease progression, and for reducing cardiovascular disease risk and mortality? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update.
British Renal Society	8		Proteinuria(recs 1.1.17–1.1.22) - Acknowledgment of the Credance study for managing type 2 Diabetes with SGLT2 inhibitors should be considered in this section. Am J Nephrol 2017;46:462–472 The Canagliflozin and Renal Endpoints in Diabetes with Established Nephropathy ClinicalEvaluation (CREDENCE) Study Rationale, Design, and Baseline Characteristics; Published online: December 1, 2017 Perhaps this would be appropriate to include in the pharmacotherapy section regarding progression of CKD.	Thank you for your comment. The updated guideline will consider the evidence, for children and young people only, for the following review questions: In children and young people with CKD, what is the accuracy of reagent strips for detecting protein and blood in urine? What is the accuracy of albumin:creatinine ratio versus protein:creatinine ratio measurements to quantify proteinuria in children and young people with CKD? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you refer to meets the review

				protocol, this will be considered by the guideline committee during the update.
British Renal Society	General	General	What is the role of multi-professional teams in caring for people with CKD. There is recent published evidence that multiprofessional care is cost effective and improves outcomes. Lin E, Chertow GM, Yan B, Malcolm E, Goldhaber-Fiebert JD. Cost-effectiveness of multi-disciplinary care in mild to moderate chronic kidney disease in the United States: A modeling study. PLoS Med. 2018; 15(3): e1002532. https://doi.org/10.1371/journal.pmed.1002532	Thank you for your comment. A multidisciplinary team care approach has been recommended in several published NICE guidelines and is adopted in many secondary care settings throughout the UK. NICE is aware that the care of people with CKD requires a skilled multi-professional team. Thank you for providing the Lin et al (2018) reference. As no other evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on the role of multi-professional teams. Therefore this area will not be included in this update of the guideline. We will highlight this area to the surveillance team for consideration at the next surveillance review.
British Renal Society	General	General	Consider adding specific discussion of the difference in approach to managing and monitoring CKD in primary versus secondary care. Most people with CKD are managed in primary care but guidelines are often biased towards a secondary care perspective. In primary care, the dominant risk to people with CKD is cardiovascular risk, not CKD progression. Shardlow A et al.(2016) Chronic Kidney Disease in Primary Care: Outcomes after Five Years in a Prospective Cohort Study. PLoS Med 13(9): e1002128. doi:10.1371/journal.pmed.1002128	Thank you for your comment. The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. Please be reassured that there is primary care representation on the committee. The committee will use its judgement to decide what the evidence means in the context of the guideline referral and decide what recommendations can be made to practitioners, commissioners of services and others.
British Renal Society	General	General	Consider adding a review of the evidence for the use of home blood pressure monitoring in the management of CKD.	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on the use of home blood pressure monitoring in the management of CKD. Therefore this area will not be included in the update.

				The updated guideline will have the opportunity to cross-refer to the NICE guidance on Hypertension in adults: diagnosis and management as needed.
British Renal Society	General	General	Consider adding a review of evidence for the use of self-management in controlling hypertension associated with CKD.	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on the use of self-management in controlling hypertension associated with CKD. Therefore this area will not be included in the update. The updated guideline will have the opportunity to cross-refer to the NICE guidance on Hypertension in adults: diagnosis and management as needed.
Elcena Jeffers Foundation	5	7	The whole document need to be action more all round this subject	Thank you for your comment. People at high risk of developing progressive CKD will be specifically considered when making guideline recommendations on the assessment and management of CKD.
Fresenius Medical Centre	1	9	This guideline does not include management of hyperkalaemia, nor does it refer to any specific guidelines in the 'related NICE guidelines' section; this is a frequent complication in CKD, and a frequent cause of cessation of ACEi or ARB, which may have potentially beneficial effects in prevention of CKD progression. Use of patiromer is currently under review by NICE separately.	Thank you for your comment. The novel potassium binders, Sodium zirconium cyclosilicate and patiromer, both for treating hyperkalaemia, are the subject of NICE technology appraisals currently in development. The updated guideline on the assessment and management of chronic kidney disease will have the opportunity to cross-refer to these technology appraisals as appropriate. The scope has been amended to include the two in development technology appraisals. No further evidence that would impact on the current guideline was identified in the surveillance review or scoping searches for this area. Therefore this area will not be included in the update.

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Fresenius Medical Centre	10		Recs 1.3.9 – 1.3.10 - There is recent published evidence on novel biomarkers and medical device innovations for monitoring of Acute Kidney Injury.	Thank you for your comment. Acute kidney injury is outside of the remit of this guideline but it is covered by NICE clinical guideline 169, which published in 2013 and is currently being updated.
Fresenius Medical Centre	11		Recs 1.2.16 - We feel a review of evidence for patient education programmes should be included. Paper exist on the impact of patient activation and this also aligns with the NHS Long term Plan (excerpts 'evidence shows that better outcomes and experiences when services pay attention to health literacy and patient activation'.	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on patient education programmes. Therefore this area will not be included in the update. We will highlight this area to the surveillance team for consideration at the next surveillance review. The updated guideline will have the opportunity to cross-refer to the NICE guideline Patient experience in adult NHS services (CG138) as needed.
Fresenius Medical Centre	16	28	In the list of main outcomes, PROMs and PREMs has been removed compared to the original scope and we feel that this is an important and relevant outcome to include.	Thank you for your comment. The scope includes a list of the main outcomes that the guideline will consider. The guideline committee will define the outcomes that will be considered in the evidence reviews through development of the review protocols. The guideline committee will consider your comment when developing the evidence review protocols.
Fresenius Medical Centre	17	7 - 10	Will the NICE pathway on CKD be linked to the recently developed pathway on RRT & conservative management to ensure a continuous pathway that reflects the disease progression.	Thank you for your comment, the NICE pathway on CKD, include a link to the renal replacement therapy pathway. The pathway will be updated as appropriate following the publication of the updated guideline.
Fresenius Medical Centre	2	3 - 23	The key facts and figures are based on data from 2016 and cost data 2009-10. Query as to whether there is more up to date data available given the guidelines will be published in 2020.	Thank you for your comment. We were unable to source more recent data. During development of the guideline we will check for more recent data when producing the draft and final guideline.

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Fresenius Medical Centre	3	18 - 20	Anaemia management - eGFR threshold for treating anaemia as secondary to CKD - guidelines currently quote <60, but current practice <30. The latter may not necessarily reflect best practice, as there is variability among patients.	Thank you for your comment. The updated guideline will consider the evidence for the following review questions: For people with CKD, what eGFR threshold should trigger investigation of anaemia being due to CKD? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline.
Fresenius Medical Centre	6	4	There is a gap of how to care for CKD patients and transition management/patient education & choice from CKD to RRT besides anaemia management (does not fall in RRT guidelines NG107 and does not fall within CKD guidelines)	Thank you for your comment. The current guideline, CG182 makes a recommendation (1.4.2) that will be retained in the update, detailing the need for patient education and what it should cover: 'When developing information or education programmes, involve people with CKD in their development from the outset. The following topics are suggested. • What is CKD and how does it affect people? • What questions should people ask about their kidneys? • What treatments are available for CKD, what are their advantages and disadvantages and what complications or side effects may occur as a result of treatment/medication? • What can people do to manage and influence their own condition? • In what ways could CKD and its treatment affect people's daily life, social activities, work opportunities and financial situation, including benefits and allowances available?

				• How can people cope with and adjust to CKD and what sources of psychological support are available? • When appropriate, offer information about renal replacement therapy (such as the frequency and length of time of dialysis treatment sessions or exchanges and preemptive transplantation) and the preparation required (such as having a fistula or peritoneal catheter). • Conservative management and when it may be considered.'
Fresenius Medical Centre	9		Recs 1.4.1 – 1.4.5 - Refer to right patient, right time, right treatment and modality choices available to patients in pre-dialysis phase. Cross-refer to NG107 (RRT and conservative management) as needed.	Thank you for your comment. The updated guideline will have the opportunity to cross-refer to the NICE guideline on Renal replacement therapy and conservative management (NG107) as needed.
Fresenius Medical Centre	9		Recs 1.4.1 – 1.4.5 - Although diet is mentioned in 1.47, we feel that it should also be included in 1.4.2, as it is an important element of patient education.	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on information and education. Therefore this area will not be included in the update. In line with your comment, the current guideline, CG182, makes the following recommendation: 1.4.8 Where dietary intervention is agreed this should occur within the context of education, detailed dietary assessment and supervision to ensure malnutrition is prevented. [2008]
Fresenius Medical Centre	9		Recs 1.5.1-1.5.5 - We feel that this section needs review. For example, in the referral criteria of the existing guidelines: Referral by GFR category should be CKD3b (i.e. GFR below 45 ml/min/1.73 m2), as usually this is the point where progression is almost universal (first bullet of 1.5.2)	Thank you for your comment. Please be reassured that there is primary care representation on the committee. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on

			Heavy albuminuria (second bullet of 1.5.2) should be considered for referral, as diabetic patients may also have another pathology – 'known to be caused by diabetes' should be clarified. We feel that GFR decrease categories are complicated to follow by GPs (fourth bullet of 1.5.2)	referral criteria. Therefore this area will not be included in the update. We will highlight this area to the surveillance team for consideration at the next surveillance review.
Fresenius Medical Centre	Question	1	There are several examples of disease management programmes for CKD outside of the UK that show positive examples on cost savings and improved patient outcomes. All these programmes have several components in common: case management, patient education, telemonitoring and care coordination. Therefore, we would highly emphasise the importance of reviewing such new care programmes to be considered for inclusion in this guideline. Please find below a list with examples that we have identified: • Blakeman, T. et al. Effect of information and telephone-guided access to community support for people with chronic kidney disease: randomised controlled trial. PLoS One **9**, e109135, doi:10.1371/journal.pone.0109135 (2014). • Yu, Y. J. et al. Multidisciplinary predialysis education reduced the inpatient and total medical costs of the first 6 months of dialysis in incident hemodialysis patients. PLoS One **9**, e112820, doi:10.1371/journal.pone.0112820 (2014). • Hopkins, R. B. et al. Cost-effectiveness analysis of a randomized trial comparing care models for chronic	Thank you for your comment and for providing the listed references. In line with the findings of the surveillance review and scoping searches on the use of disease management programmes we feel there is no new evidence that would impact on the current guideline. Therefore, this area will not be included in the update. We will highlight this area to the surveillance team for consideration at the next surveillance review.

			kidney disease. Clin J Am Soc Nephrol **6**, 1248-1257, doi:10.2215/CJN.07180810 (2011). • Chen, S. H. et al. The impact of self-management support on the progression of chronic kidney disease--a prospective randomized controlled trial. Nephrol Dial Transplant **26**, 3560-3566, doi:10.1093/ndt/gfr047 (2011).Fishbane, S. et al. Augmented Nurse Care Management in CKD Stages 4 to 5: A Randomized Trial. Am J Kidney Dis, doi:10.1053/j.ajkd.2017.02.366 (2017).	
Kidney Care UK	3	7	In the serum phosphate management comments please can you add more emphasis to dietary management as simply adding medications alone will not reduce phosphate levels, without dietary advice and support for patients. 'Dietary management' should be defined and dieticians are the qualified advisors. Their role, especially in supporting children and young adults to promote growth cannot be under-emphasised and this is missing from the scope.	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on dietary management to reduce phosphate levels. Therefore, this area will not be included in the update. We will highlight this area to the surveillance team for consideration at the next surveillance review. The current guideline, CG157, recommends: 1.1.1 A specialist renal dietitian, supported by healthcare professionals with the necessary skills and competencies, should carry out a dietary assessment and give individualised information and advice on dietary phosphate management. 1.1.2 Advice on dietary phosphate management should be tailored to individual learning needs and preferences, rather than being provided through a generalised or complex multicomponent programme of delivery. 1.1.3 Give information about controlling intake of phosphate-rich foods (in particular, foods with a high phosphate content

				per gram of protein, as well as food and drinks with high levels of phosphate additives) to control serum phosphate, while avoiding malnutrition by maintaining a protein intake at or above the minimum recommended level. For people on dialysis, take into account possible dialysate protein losses. 1.1.4 If a nutritional supplement is needed to maintain protein intake in children and young people with hyperphosphataemia, offer a supplement with a lower phosphate content, taking into account patient preference and other nutritional requirements.
Kidney Care UK	4	15	Mineral bone disease is a frequent complication for people with transplants and their exclusion from this list is not logical.	Thank you for your comment. The management of mineral and bone disorder in chronic kidney disease will include those who have had a transplant.
Kidney Care UK	4	17	Please can you confirm that the MBD sub-group does mean people on conservative care, as does the sub-group for those on conservative care in the anaemia section below.	Thank you for your comment. The management of mineral and bone disorder in chronic kidney disease will include those on conservative care.
Kidney Care UK	4	21	Please clarify whether the anaemia subgroup will include people with a failing transplant, who might not yet have established kidney failure, and should not be inadvertently omitted; this group could miss out otherwise as they may be moving from one care team to another.	Thank you for your comment, the anaemia sub group will include all adults, children and young people with a clinical diagnosis of anaemia associated principally cause by CKD stages 1 to 5. This would include those with a failing transplant.
Kidney Care UK	4	3	Is it possible to add that specific attention will be given to the psychological impact of kidney disease, given the evidence that up to one third of kidney patients have depression. 1. Palmer S, Vecchio M, Craig JC, Tonelli M, Johnson DW, Nicolucci A, et al. Prevalence of depression in chronic kidney disease: systematic review and meta-analysis of observational studies. Kidney Int. 2013;84(1):179-91. 2. Zalai D, Szeifert L, Novak M. Psychological distress and depression in patients with chronic kidney disease. Semin Dial. 2012;25(4):428-38.	Thank you for your comment. The scope has been amended to include the following guideline in the related NICE guidance section: • Depression in adults with a chronic physical health problem: recognition and management. The updated guideline will have the opportunity to cross-refer to related NICE guidelines as needed. The current guideline, CG182, recommends:

			3. Hedayati SS, Yalamanchili V, Finkelstein FO. A practical approach to the treatment of depression in patients with chronic kidney disease and end-stage renal disease. Kidney Int. 2012;81(3):247-55.	1.4.5 Healthcare professionals working with people with CKD should take account of the psychological aspects of coping with the condition and offer access to appropriate support – for example, support groups, counselling or a specialist nurse.
Kidney Care UK	General	General	We welcome the addition of children and young people to the groups covered; we had fed back to the previous CKD guideline scope that they were missing.	Thank you.
Kidney Care UK	General	General	Overall we regret the lack of any mention of shared decision-making, shared care or similar in a scope covering a wide set of issues affecting kidney patients, who will need to be part of the treatment decisions integral to their quality of life. We have received this comment from a patient “We need a guideline that pushes forward clinical practice in all areas and is made more relevant to patients so that they can recognise that there is something they can do to help themselves”.	Thank you for your comment. The updated guideline will have the opportunity to cross-refer to related NICE guidelines as needed, including shared decision-making, which is due to publish in April 2021.The scope has been amended to include this in development guideline. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on shared decision-making. The current guideline, CG182, recommends: 1.4.1 Offer people with CKD education and information tailored to the severity and cause of CKD, the associated complications and the risk of progression. [2008] 1.4.2 When developing information or education programmes, involve people with CKD in their development from the outset. The following topics are suggested. What is CKD and how does it affect people? What questions should people ask about their kidneys? What treatments are available for CKD, what are their advantages and disadvantages and what complications or side effects may occur as a result of treatment/ medication?

				What can people do to manage and influence their own condition? In what ways could CKD and its treatment affect people's daily life, social activities, work opportunities and financial situation, including benefits and allowances available? How can people cope with and adjust to CKD and what sources of psychological support are available? When appropriate, offer information about renal replacement therapy (such as the frequency and length of time of dialysis treatment sessions or exchanges and pre-emptive transplantation) and the preparation required (such as having a fistula or peritoneal catheter). Conservative management and when it may be considered. [2008] 1.4.3 Offer people with CKD high-quality information or education programmes as appropriate to the severity of their condition to allow time for them to fully understand and make informed choices about their treatment. [2008]
Kidney Research UK	2 /3 / 6 / 9 / 15	General	We support and endorse the comments supplied by Dr Hugh Rayner, regarding the ASSIST-CKD project, which are reproduced with his permission below: **From:** ***** **Sent:** 06 January 2019 18:04:12 **To:** ***** **Subject:** NICE CKD guideline scope Dear *****	Thank you for your comment. The updated guideline will consider the evidence for the following review question: What is the best combination of measures of kidney function and markers of kidney damage to identify increased risk of progression in adults, children and young people with CKD? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed

			I would like to comment on the scope of the update to the NICE CKD guidelines. I am writing both in a personal capacity and on behalf of the ASSIST-CKD program, led by Kidney Research UK and supported by the Health Foundation (https://www.kidneyresearchuk.org/research/assist-ckd). This UK-wide project is studying the implementation of a simple way of Identifying and monitoring people at risk of progressing to ESKD. Pathology laboratory or renal staff review graphs of serial eGFR results in all patients with a reduced eGFR, in order to identify those with a declining trend. The requesting clinician is sent a report alerting them to this trend. The project currently involves 23 pathology laboratories and their surrounding GP practices, covering an estimated population of 11 million people across the UK. The protocol for the study has been published [1]. The project is also working with the Department of Health on a health economic analysis. Unfortunately formal publication of the results is not imminent but interim data, especially from qualitative studies in the implementation sites, have been gathered and these support the results published from the original site where the project was developed [2, 3]. The key issue that we would like the NICE guidance to incorporate is that an assessment of all patients with CKD must include a review of all the patient's previous eGFR results in the form of an eGFR graph.	for the guideline. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update.

			This issue is discussed in detail in Chapter 3 of Understanding Kidney Diseases [4], attached to this email. This book is endorsed by RA Past President Prof Donal O'Donoghue in a foreword. The value of graphs of serum creatinine results in clinical practice has been recognised for decades [5] but their use in scientific research has been hampered by the complexity of the mathematics required to analyse them. Hence simple equations that incorporate single eGFR and quantitated urine protein excretion values, notably by Tangri et al., have been more widely promoted. More recent studies by Tangri [6] and other groups [7] have demonstrated the additional information gained by studying multiple eGFR values in providing an estimated risk of progressing to ESKD. However, the percentage probability of reaching ESKD in the next two or five years, such as provided by the Tangri formula, has limited value to individual patients and their clinicians who want to know *when* dialysis is likely to be needed. This information is better provided by studying the patient's eGFR graph (discussed in Chapter 17, attached). We recognise that the evidence that routine surveillance of eGFR results by pathology laboratories is cost effective is not yet available. However, we suggest that there is sufficient evidence to support inclusion in the revised NICE CKD	

			guidance of a recommendation to clinicians to review the eGFR graph when assessing and monitoring patients with CKD. The graph should also be shared with the patient. For example, it is very helpful to include it in the letter written to the patient and copied to the patient's GP following an outpatient clinic consultation [8]. Thank you for considering this. Best wishes ***** Consultant Nephrologist University Hospitals Birmingham NHS Foundation Trust. References 1. Hugh Gallagher, Shona Methven, Anna Casula, Nicola Thomas, Charles R. V. Tomson, Fergus J. Caskey, Tracey Rose, Stephen J. Walters, David Kennedy, Anne Dawnay, Martin Cassidy, Richard Fluck, Hugh C. Rayner and Michael Nation. A programme to spread eGFR graph surveillance for the early identification, support and treatment of people with progressive chronic kidney disease (ASSIST-CKD): protocol for the stepped wedge implementation and evaluation of an intervention to reduce late presentation for renal replacement therapy. BMC Nephrology. 2017. doi.org/10.1186/s12882-017-0522-9 2. Rayner HC, Baharani J, Dasgupta I, Suresh V, Temple RM, Thomas ME, et al. Does community-wide chronic kidney	

			disease management improve patient outcomes? Nephrol Dial Transplant. 2014;29(3):644–9. 3. Kennedy DM, Chatha K, Rayner HC. Laboratory database population surveillance to improve detection of progressive chronic kidney disease. J Ren Care. 2013;39 Suppl 2:23–9. 4. Rayner H, Thomas M, Milford D. Understanding Kidney Diseases. Springer 2016. DOI 10.1007/978-3-319-23458-8 5. Mitch E, Walser M, Buffington GA, Lemann J. Simple Method of Estimating Progression of Chronic Renal Failure. Lancet 1976, December 18, 1326-8. 6. Navdeep Tangri, Lesley A. Inker, Brett Hiebert, Jenna Wong, David Naimark, David Kent, Andrew S. Levey. A Dynamic Predictive Model for Progression of CKD. Am J Kidney Dis. 69(4):514-520. 7. Kovesdy CP, Coresh J, Ballew SH, et al. Past decline versus current eGFR and subsequent ESRD risk. J Am Soc Nephrol. 2016;27: 2447–2455. 8. Academy of Medical Royal Colleges. Please, write to me. Writing outpatient clinic letters to patients. http://www.aomrc.org.uk/publications/please-write-to-me-writing-outpatient-clinic-letters-to-patients-guidance.	
Kidney Research UK	4 / 7 / 16	General	We strongly recommend the outcomes of the PIVOTAL clinical trial comparing proactive, high-dose and reactive low-dose intravenous iron regimens for haemodialysis patients are taken into account. The initial paper is published in the New England Journal here: https://www.nejm.org/doi/full/10.1056/NEJMoa1810742 An amended paper will be published in the New England Journal of Medicine imminently which contains highly significant updated results.	Thank you for your comment. The updated guideline will consider the evidence for the following review question: For people with stage 5 CKD who are on dialysis, what amount of IV iron is most clinically and cost effective in managing anaemia and its associated outcomes? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review

				questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you refer to evidence meets the review protocol, this will be considered by the guideline committee during the update.
Merck Sharpe & Dohme Ltd	General	General	MSD would like to thank for the opportunity of commenting on the proposed amendments on the Chronic kidney disease assessment and management. MSD does not have any comments to make.	Thank you.
NHS England – Renal Services Clinical Reference Group	General	General	Some standardisation around the administration of intravenous iron is desirable and we would support this	Thank you for your comment.
NHS England – Renal Services Clinical Reference Group	General	General	We note that CKD mineral and bone disease has been largely excluded despite the recent KDIGO guidance - it would be helpful to ensure alignment of the two guidelines	Thank you for your comment. The update will consider calcium and non-calcium based phosphate binders to manage mineral and bone disorder in CKD. No further new evidence was identified in the surveillance review or scoping searches on the recommendations in the current CKD mineral and bone disease. NICE is aware of the KDIGO guidance and recognises the value of consistent national guidance, where this fits with NICE standard methods.
NHS England – Renal Services Clinical	General	General	We have some concern over the frequency of monitoring for CKD in particular that is does not become over burdensome for primary care colleagues. In reality deterioration is often triggered by a random event and so it is more important to be vigilant and check blood tests during any significant generalised	Thank you for your comment. The update will consider the evidence for the following review questions:

Reference Group			illness rather than to institute overzealous interval screening. In the elderly there is evidence that deterioration in renal function is less likely and generally slower if it does occur	For adults, children and young people with CKD, what constitutes a clinically significant decline in eGFR in terms of risk of kidney disease progression? For adults, children and young people with CKD what is the optimal monitoring frequency based on different rates of decline in eGFR? Existing recommendations concerning the frequency of monitoring will be updated as needed. The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. Please be reassured that there is primary care representation on the committee. The committee will use its judgement to decide what the evidence means in the context of the guideline referral and decide what recommendations can be made to practitioners, commissioners of services and others.
NHS England – Renal Services Clinical Reference Group	General	General	We welcome the addition of children and young people to the groups covered; we received some feedback to the previous CKD guideline scope that they were missing	Thank you for your comment.

NHS England – Renal Services Clinical Reference Group	General	General	In the serum phosphate management section it was felt that there should be more emphasis on dietary management as simply adding medications alone will not reduce phosphate levels, without dietary advice and support for patients. 'Dietary management' should be defined and dieticians are the qualified advisors. Their role, especially in supporting children and young adults to promote growth cannot be under-emphasised and this is missing from the scope	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on dietary management to reduce phosphate levels. Therefore this area will not be included in the update. However, the guideline committee will consider the layout and headings in the guideline in relation to the amalgamation of the three guidelines and the updated recommendations. The current guideline, CG157, recommends: 1.1.1 A specialist renal dietitian, supported by healthcare professionals with the necessary skills and competencies, should carry out a dietary assessment and give individualised information and advice on dietary phosphate management. 1.1.2 Advice on dietary phosphate management should be tailored to individual learning needs and preferences, rather than being provided through a generalised or complex multicomponent programme of delivery. 1.1.3 Give information about controlling intake of phosphate-rich foods (in particular, foods with a high phosphate content per gram of protein, as well as food and drinks with high levels of phosphate additives) to control serum phosphate, while avoiding malnutrition by maintaining a protein intake at or above the minimum recommended level. For people on dialysis, take into account possible dialysate protein losses. 1.1.4 If a nutritional supplement is needed to maintain protein intake in children and young people with hyperphosphataemia, offer a supplement with a lower phosphate content, taking into account patient preference and other nutritional requirements.

Chronic kidney disease

Consultation on draft scope
Stakeholder comments table

10/12/2018 – 11/01/2019

NHS England – Renal Services Clinical Reference Group	General	General	We would like to see specific attention given to the psychological impact of kidney disease, given that we know up to one third of kidney patients have depression	Thank you for your comment. The scope has been amended to include the NICE guideline, 'Depression in adults with a chronic physical health problem: recognition and management' in the related NICE guidance section. The updated guideline will have the opportunity to cross-refer to related NICE guidance as needed. The current guideline, CG182, recommends: 1.4.5 Healthcare professionals working with people with CKD should take account of the psychological aspects of coping with the condition and offer access to appropriate support – for example, support groups, counselling or a specialist nurse.
NHS England – Renal Services Clinical Reference Group	General	General	Please clarify whether this will include people with a transplant with declining CKD; this group can miss out otherwise as they may be moving from one care team to another	Thank you for your comment. The management of mineral and bone disorder in chronic kidney disease will include those with a transplant with declining CKD.
NHS England – Renal Services Clinical Reference Group	General	General	Please can you confirm that the MBD sub-group does mean people on conservative care, as it does for those on conservative care in the anaemia section below	Thank you for your comment. The management of mineral and bone disorder in chronic kidney disease will include those on conservative care.
NHS England – Renal	General	General	We acknowledge the contribution of the Renal Pharmacy Group and would support their suggestions	Thank you for your comment.

Services Clinical Reference Group				
NHS England – Renal Services Clinical Reference Group	General	General	We note that the guidelines are being prepared for, “people with suspected or diagnosed chronic kidney disease and their families and carers”. Under these circumstances Under these circumstances we feel that there should be sufficient explanation in plain English	Thank you for your comment. The scope will be edited before being published, to ensure it meets NICE style.
NHSE	8	Table	**1.1 Investigations for CKD in adults, children and young people** • With reference to primary care – it would be outside the scope of expertise for GPs to manage children with Chronic kidney disease at any level – as such all recommendations for testing and investigation should be from a specialist – an abnormal renal function in a child would almost always trigger a request for advice and review from a specialist This is reflected in the current QOF which is restricted to patients over the age of 18 • In patients over the age of 18 the committee should include a review of the availability and cost of cystatin c based testing https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002400 indicated a significant cost implication could occur in those who are already diagnosed. Whilst there is good evidence for cystatin C	Thank you for your comment. The updated guideline will consider the evidence for the following review questions which relate to investigations for CKD in adults, children and young people: What is the accuracy of cystatin C-based equations to estimate GFR as a measurement of kidney function in adults, children and young people? In adults, children and young people from black, Asian and other minority ethnic groups with CKD, what is the biological and analytical variability in eGFR testing and what factors (including fasting) affect it? In children and young people with CKD, what is the accuracy of reagent strips for detecting protein and blood in urine?

			being a marker of GFR and risk in people with CKD, its use to define CKD in this manner has not been evaluated in primary care, the setting in which most people with GFR in this range are managed. The test is currently not used widely or uniformly across primary care in England and there will be commissioning and cost implications. • A clear definition of the appropriate first line and testing regime should be given to avoid unnecessary costs without benefit and to ensure patients have equality of access to the relevant tests for them The interpretation of results in patients from ethnic minorities deserves a much greater priority to facilitate discussion in some of our most vulnerable and deprived patient groups – especially those with risk factors such as diabetes and heart disease. However it may be extremely difficult in a primary care setting when reviewing large numbers of borderline test results to accurately establish ethnicity and calculate the implications of such changes	What is the accuracy of albumin:creatinine ratio versus protein:creatinine ratio measurements to quantify proteinuria in children and young people with CKD? Which children and young people should be tested for CKD? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update. Please be reassured that there is primary care representation on the committee. The committee will use its judgement to decide what the evidence means in the context of the guideline referral and decide what recommendations can be made to practitioners, commissioners of services and others.
NHSE	8	Table	**Proteinuria(recs 1.1.17–1.1.22)** **Haematuria (rec 1.1.23)** **Isolated invisible haematuria (recs 1.1.24–1.1.26)** **Who should be tested for CKD (recs 1.1.27–1.1.29)** • This review will solely be in relation to children and young people • In primary care it is extremely unusual for children with risk factors for renal disease to be solely managed in	Thank you for your comment. The updated guideline will consider the evidence for the following review questions which relate to investigation for CKD in children and young people: In children and young people with CKD, what is the accuracy of reagent strips for detecting protein and blood in urine?

			primary care; as a result many will be screened by specialists – e.g. diabetic clinics, cardiac clinics, paediatric clinics • It would be very helpful to have specific guidance about familial traits and when and how often if at all checking should be undertaken so that all families are able to access the same level of care and unnecessary testing is avoided. • The vast majority of children who have urine tests in primary care are suspected of having urine infections and it would be helpful to cross reference to that guideline	What is the accuracy of albumin:creatinine ratio versus protein:creatinine ratio measurements to quantify proteinuria in children and young people with CKD? Which children and young people should be tested for CKD? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. Please be reassured that there is primary care representation on the committee. The committee will use its judgement to decide what the evidence means in the context of the guideline referral and decide what recommendations can be made to practitioners, commissioners of services and others. The updated guideline on the assessment and management of chronic kidney disease will have the opportunity to cross-refer to related NICE guidelines including the urinary tract infection un under 16s guideline, as appropriate.
NHSE	8	Table	**Classification of CKD (recs 1.2.1–1.2.2)** This would be supported as a natural consequence of guidance relating to any change of testing, clarity however is needed for patients whose diagnosis would change as a result of any change in classification – in particular patient information guides, any changes in recommendations relating to referral to	Thank you for your comment.

			secondary care, changes in management of other co morbidities resulting from a change in disease classification	
NHSE	8	Table	**Investigating the cause of CKD and determining the risk of adverse outcomes (recs 1.2.3–1.2.4)** Appropriate to review evidence, should correlate to lifestyle guidance and include factors that may link to specific groups who are more likely to experience ckd and adverse outcomes, eg deprivation, co morbidities, smoking, alcohol	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on lifestyle guidance. Therefore this area will not be included in the update. We will highlight this area to the surveillance team for consideration at the next surveillance review.
NHSE	8	Table	**Frequency of monitoring (recs 1.3.1–1.3.2)** **Defining progression (Recs: 1.3.3–1.3.6)** Absolutely key in primary care in relation to adults, clearly also in secondary care and for children but that is outside scope for most GPs. Potential impact on referral pathways and need to ensure a system wide adoption would be imperative. Modelling to assess the changes in referral patterns would be needed to ensure services are commissioned appropriately Clarity needed in patient information to help patients be clear on why their risk of progression may alter and what the benefits /risks are, how do we assess patients who have now been told their risk of progression is greater or less than previously advised	Thank you for your comment. Please be reassured that there is primary care representation on the committee. The committee will use its judgement to decide what the evidence means in the context of the guideline referral and decide what recommendations can be made to practitioners, commissioners of services and others.
NHSE	8	Table	**Blood pressure control (recs 1.6.1–1.6.2)**	Thank you for your comment.

			Must be linked to hypertension guidance and diabetes guidance to ensure no confusion Children out side GP scope as will be under specialist care	The updated guideline on the assessment and management of chronic kidney disease will have the opportunity to cross-refer to related NICE guidelines as appropriate.
NHSE	8	Table	**Anaemia (rec 1.7.8)** I would expect most GPs to seek guidance from specialists if anaemia was thought to be due to CKD. If it is expected that this would be managed in primary care then specific guidance around exclusion of other causes is essential and it should be emphasised that changes could indicate other pathology and should be appropriately investigated	Thank you for your comment. This guideline will update the guideline on chronic kidney disease: managing anaemia (NG8). When making recommendations, the committee take into account the strengths and limitations of any intervention. Please refer to Developing NICE Guidelines: the manual, section 9 Developing and wording recommendations and writing the guideline, for more details on how recommendations are made. Please be reassured that there is primary care representation on the committee. The committee will use its judgement to decide what the evidence means in the context of the guideline referral and decide what recommendations can be made to practitioners, commissioners of services and others.
NHSE	8	Table	**Calcium and non-calcium containing phosphate binders: children and young people (recs 1.1.5–1.1.7)** **Calcium and non-calcium containing phosphate binders: adults (recs 1.1.8–1.1.12)** **Calcium and non-calcium containing phosphate binders: children, young people and adults (recs 1.1.13–1.1.15)** I would expect these drugs to only be commenced with specialist guidance and if monitored in primary care shared care guidance to be agreed	Thank you for your comment. The use of calcium and non-calcium based phosphate binders to manage mineral and bone disorder in CKD is included in the scope of the guideline update. When making recommendations, the committee take into account the strengths and limitations of any intervention. Please refer to Developing NICE Guidelines: the manual, section 9 Developing and wording recommendations and writing the guideline, for more details on how recommendations are made.

				Please be reassured that there is primary care representation on the committee. The committee will use its judgement to decide what the evidence means in the context of the guideline referral and decide what recommendations can be made to practitioners, commissioners of services and others.
NHSE	8	Table	I**V iron for the treatment of anaemia associated with CKD** A specialist only treatment, implications in primary care would be in terms of commissioning – changes in costs /beds for day case, commissioning for outcomes would be a possible option	Thank you for your comment. The use IV iron for the treatment of anaemia associated with CKD is included in the scope of the guideline update. Please be reassured that there is primary care representation on the committee. The committee will use its judgement to decide what the evidence means in the context of the guideline referral and decide what recommendations can be made to practitioners, commissioners of services and others.
Polycystic Kidney Disease Charity	General	General	We welcome the update to the Guidelines	Thank you.
Renal Association	6	17 - 22	The Renal Association would like to suggest that the revised NICE CKD guidance should include a recommendation to clinicians to review all the patient's previous eGFR results in the form of an eGFR graph when assessing and monitoring patients with CKD. The graph should also be shared with the patient. For example, it is very helpful to include it in the letter written to the patient and copied to the patient's GP following an outpatient clinic consultation. The ASSIST-CKD program, led by Kidney Research UK and supported by the Health Foundation (https://www.kidneyresearchuk.org/research/assist-ckd) is studying the implementation of a simple way of Identifying and	Thank you for your comment. The updated guideline will consider the evidence for the following review questions: What is the best combination of measures of kidney function and markers of kidney damage to identify increased risk of progression in adults, children and young people with CKD? For adults, children and young people with suspected CKD, what is the effect of proteinuria and/or albuminuria at any given eGFR on adverse outcomes?

			monitoring people at risk of progressing to ESKD. Pathology laboratory or renal staff review graphs of serial eGFR results in all patients with a reduced eGFR, in order to identify those with a declining trend. The requesting clinician is sent a report alerting them to this trend. The project currently involves 23 pathology laboratories and their surrounding GP practices, covering an estimated population of 11 million people across the UK. The protocol for the study has been published [https://bmcnephrol.biomedcentral.com/articles/10.1186/s12882-017-0522-9]. The project is also working with the Department of Health on a health economic analysis. Unfortunately formal publication of the results is not imminent but interim data, especially from qualitative studies in the implementation sites, have been gathered and these support the results published from the original site where the project was developed [https://www.ncbi.nlm.nih.gov/pubmed/24335381, https://www.ncbi.nlm.nih.gov/pubmed/23941701]. The value of graphs of serum creatinine results in clinical practice has been recognised for decades but their use in scientific research has been hampered by the complexity of the mathematics required to analyse them. Hence simple equations that incorporate single eGFR and quantitated urine protein excretion values, notably by Tangri et al., have been more widely promoted. More recent studies by Tangri [https://www.ncbi.nlm.nih.gov/pubmed/27693260] and other groups [https://www.ncbi.nlm.nih.gov/pubmed/26657867] have demonstrated the additional information gained by studying multiple eGFR values in providing an estimated risk of progressing to ESKD. However, the percentage probability of	For adults, children and young people with CKD, what constitutes a clinically significant decline in eGFR in terms of risk of kidney disease progression? For adults, children and young people with CKD what is the optimal monitoring frequency based on different rates of decline in eGFR? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update.

			reaching ESKD in the next two or five years, such as provided by the Tangri formula, has limited value to individual patients and their clinicians who want to know *when* dialysis is likely to be needed. This information is better provided by studying the patient's eGFR graph. We are aware that the evidence that routine surveillance of eGFR results by pathology laboratories is cost effective is not yet available and will not be during the period of this guideline review. However, we feel that there is ample evidence of the utility of this approach and that this information is of additive value when assessing patients with CKD compared to the more specific information provided by the Tangri formula, which will be considered for inclusion.	
Renal Association	General	General	The Renal Association has seen the submission by the Renal Services CRG representing service users comments and would like to support their submission and the issues they will raise separately	Thank you for your comment.
Renal Pharmacy Group	11		Box 1 - Etelcalcitide needs adding here	Thank you for your comment, the updated guideline will have the opportunity to cross-refer to relevant NICE technology appraisals, as appropriate, including TA448, Etelcalcetide for treating secondary hyperparathyroidism.
Renal Pharmacy Group	11		1.3 - We feel it would it be helpful to provide advice about biosimilar ESAs	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on assessment and optimisation of erythropoiesis. Therefore this area will not be included in the update.
Renal Pharmacy Group	2	7	KDIGO guidelines suggest avoiding hypercalcaemia and restricting the dose of calcium based binders https://kdigo.org/wp-content/uploads/2017/02/2017-KDIGO-CKD-MBD-GL-Update.pdf. Also the Renal Association	Thank you for your comment. The updated guideline will consider the evidence for the following review questions:

			guidelines state '*In patients with CKD stages G3a-5D, we suggest limiting the use of calcium-based phosphate binders. Whilst calcium-based phosphate binders still have a role in the management of hyperphosphataemia in adults with CKD, their place as first line agents in the majority can no longer be recommended, especially as generic, lower cost alternatives for non-calcium containing binders are becoming more widely available*.' Getting rid of discrepancies between guidelines would be helpful	For people with stage 4 or 5 CKD who are not on dialysis, which phosphate binder, calcium and non-calcium based, is most effective in managing serum phosphate and its associated outcomes? For people with stage 5 CKD who are on dialysis, which phosphate binder, calcium and non-calcium containing, is most effective in managing serum phosphate and its associated outcomes? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update. NICE is aware of the KDIGO guidance and recognises the value of consistent national guidance, where this fits with NICE standard methods.
Renal Pharmacy Group	2	7	Other non-calcium based binders are not referenced and although more expensive then generic sevelamer are useful for some patients	Thank you for your comment. The novel potassium binders, Sodium zirconium cyclosilicate and patiromer, both for treating hyperkalaemia, are the subject of NICE technology appraisals currently in development. The updated guideline on the assessment and management of chronic kidney disease will have the opportunity to cross-refer to these technology appraisals as appropriate.

				The scope has been amended to include the two in development technology appraisals.
Renal Pharmacy Group	2	7	Needs to mention patient preference. Any binder is expensive if the patient doesn't take it	Thank you for your comment. The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. When formulating recommendations, the committee will consider cost effectiveness in parallel with general effectiveness. The updated guideline will also have the opportunity to cross-refer to related NICE guidelines as needed, including shared decision-making, which is due to publish in April 2021.The scope has been amended to include this in development guideline.
Renal Pharmacy Group	6	24	KDIGO guidelines suggest avoiding hypercalcaemia and restricting the dose of calcium based binders https://kdigo.org/wp-content/uploads/2017/02/2017-KDIGO-CKD-MBD-GL-Update.pdf	Thank you for your comment. The updated guideline will consider the evidence for the following review questions: For people with stage 4 or 5 CKD who are not on dialysis, which phosphate binder, calcium and non-calcium based, is most effective in managing serum phosphate and its associated outcomes? For people with stage 5 CKD who are on dialysis, which phosphate binder, calcium and non-calcium containing, is most effective in managing serum phosphate and its associated outcomes? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review

				questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update. NICE is aware of the KDIGO guidance and recognises the value of consistent national guidance, where this fits with NICE standard methods.
Renal Pharmacy Group	7	2	We feel that the type of IV iron should be looked at, including high dose low frequency vs low dose high frequency dosing	Thank you for your comment. The updated guideline will consider the evidence for the following review question: For people with stage 5 CKD who are on dialysis, what amount of IV iron is most clinically and cost effective in managing anaemia and its associated outcomes? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline.
Renal Pharmacy Group	9		1.6 - We feel that in blood pressure management, often hyperkalaemia minimises the dose of ACEi/ARB that can be used. There are now licensed potassium binders that we feel should be included in the scope	Thank you for your comment. The novel potassium binders, Sodium zirconium cyclosilicate and patiromer, both for treating hyperkalaemia, are the subject of NICE technology appraisals currently in development. The updated guideline on the assessment and management of chronic kidney disease will have the opportunity to cross-refer to these technology appraisals as appropriate.

				The scope has been amended to include the two in development technology appraisals.
Renal Pharmacy Group	9		1.7 - We feel that with the addition of etelcalcitide, this should be included within the scope of this review	Thank you for your comment, the updated guideline will have the opportunity to cross-refer to relevant NICE technology appraisals, as appropriate, including TA448, Etelcalcetide for treating secondary hyperparathyroidism.
RenalytixAI Plc	6	19	The classification of CKD in adults should consider the use of Biomarker and / or Multi-factorial risk scores (incorporating biomarkers) reported in the literature and under development to assess prognosis of patients diagnosed with CKD, particularly in the context of Diabetes. Type 2 diabetes mellitus (DM) is the leading cause of ESRD globally. Standard clinical measurements of kidney disease status (eGFR and ACR) do not perform well in predicting which patients with type 2 diabetes or will experience rapid decline in kidney function over time. [1,2] Tumor necrosis factor (TNF) is a pleotropic cytokine that is produced predominantly by immune cells. TNF can function in its membrane bound form or can be released as a soluble circulating 17kDa polypeptide upon cleavage by a metalloproteinase.[3-5] TNF can bind to two transmembrane receptors designated TNFR1 (p55 or CD120a) or TNFR2 (p75 or CD120b).[6,7] In the kidneys, TNFR1 is expressed primarily in glomeruli and endothelial cells while TNFR2 is expressed in tubular epithelial, mesangial and interstitial cells in various kidney diseases [8,9] Kidney Injury Molecule (KIM)-1 is expressed in the apical membrane of proximal tubular cells in response to injury and	Thank you for your comment. The updated guideline will consider the evidence for the following review questions: What is the best combination of measures of kidney function and markers of kidney damage to identify increased risk of progression in adults, children and young people with CKD? For adults, children and young people with suspected CKD, what is the effect of proteinuria and/or albuminuria at any given eGFR on adverse outcomes? For adults, children and young people with suspected CKD, what is the effect of interventions to lower proteinuria on favourable outcomes? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update.

			promotes kidney fibrosis. KIM-1 may enter the circulation because of increased transepithelial permeability or loss of epithelial cell polarity with basolateral membrane expression in early injury.[10] Moreover, KIM-1 is homologous to TIM-1 (T-cell immunoglobin and mucin-domain containing protein-1) that is an activating receptor of T-helper 2, Th1, and Th17 cells, as well as B cells, dendritic cells and natural killer T cells.[11] Thus, assays for KIM-1 in the plasma may reflect a combination of kidney injury as well as immune activation. It has been demonstrated that the plasma soluble tumor necrosis factor receptors 1 and 2 (TNFR1 and TNFR2), along with plasma kidney injury molecule-1,[10,12-16] are strong prognostic markers for incident and progressive chronic kidney disease (CKD) in persons with type 1 and type 2 diabetes. Examples of supporting literature are provided below. 1. Dunkler D, Gao P, Lee SF, et al. Risk Prediction for Early CKD in Type 2 Diabetes. Clin J Am Soc Nephrol. 2015;10(8):1371-1379. 2. Jardine MJ, Hata J, Woodward M, et al. Prediction of kidney-related outcomes in patients with type 2 diabetes. Am J Kidney Dis. 2012;60(5):770-778. 3. Vassalli P. The pathophysiology of tumor necrosis factors. Annual review of immunology. 1992;10:411-452. 4. Dong X, Swaminathan S, Bachman LA, Croatt AJ, Nath KA, Griffin MD. Resident dendritic cells are the predominant TNF-secreting cell in early renal ischemia-reperfusion injury. Kidney Int. 2007;71(7):619-628.	

			5. Black RA, Rauch CT, Kozlosky CJ, et al. A metalloproteinase disintegrin that releases tumour-necrosis factor-alpha from cells. Nature. 1997;385(6618):729-733. 6. Dembic Z, Loetscher H, Gubler U, et al. Two human TNF receptors have similar extracellular, but distinct intracellular, domain sequences. Cytokine. 1990;2(4):231-237. 7. Brockhaus M, Schoenfeld HJ, Schlaeger EJ, Hunziker W, Lesslauer W, Loetscher H. Identification of two types of tumor necrosis factor receptors on human cell lines by monoclonal antibodies. Proc Natl Acad Sci U S A. 1990;87(8):3127-3131. 8. Al-Lamki RS, Mayadas TN. TNF receptors: signaling pathways and contribution to renal dysfunction. Kidney Int. 2015;87(2):281-296. 9. Al-Lamki RS, Wang J, Vandenabeele P, et al. TNFR1- and TNFR2-mediated signaling pathways in human kidney are cell type-specific and differentially contribute to renal injury. FASEB journal : official publication of the Federation of American Societies for Experimental Biology. 2005;19(12):1637-1645 10. Sabbisetti VS, Waikar SS, Antoine DJ, et al. Blood kidney injury molecule-1 is a biomarker of acute and chronic kidney injury and predicts progression to ESRD in type I diabetes. J Am Soc Nephrol. 2014;25(10):2177-2186. 11. Ichimura T, Brooks CR, Bonventre JV. Kim-1/Tim-1 and immune cells: shifting sands. Kidney Int. 2012;81(9):809-811. 12. Nowak N, Skupien J, Niewczas MA, et al. Increased plasma kidney injury molecule-1 suggests early progressive renal decline in non-proteinuric patients with type 1 diabetes. Kidney Int. 2016;89(2):459-467. 13. Coca SG, Nadkarni GN, Huang Y, et al. Plasma Biomarkers and Kidney Function Decline in Early and Established Diabetic Kidney Disease. J Am Soc Nephrol. 2017;28(9):2786-2793.	

			14. Niewczas MA, Gohda T, Skupien J, et al. Circulating TNF receptors 1 and 2 predict ESRD in type 2 diabetes. J Am Soc Nephrol. 2012;23(3):507-515. 15. Pavkov ME, Nelson RG, Knowler WC, Cheng Y, Krolewski AS, Niewczas MA. Elevation of circulating TNF receptors 1 and 2 increases the risk of end-stage renal disease in American Indians with type 2 diabetes. Kidney Int. 2015;87(4):812-819 16. Gohda T, Niewczas MA, Ficociello LH, et al. Circulating TNF receptors 1 and 2 predict stage 3 CKD in type 1 diabetes. J Am Soc Nephrol. 2012;23(3):516-524.	
RenalytixAI Plc	6	22	The literature supports that accelerated progression can be defined as eGFR decline of >5mls/min/year or 30% / 40% decline over 2-5 years. For example: Kidney Disease: Improving Global Outcomes (KDIGO) guidelines' define rapid progression as a rate of eGFR decline exceeding 5 ml/min/yr.[1] Declines in estimated GFR smaller than those included in current CG182, section 1.3.3 were strongly and consistently associated with the risk of ESRD and mortality, supporting consideration of lesser declines in estimated GFR (such as a 30% reduction over 2 years) as an alternative definition of CKD progression.[2,3] 1. KDIGO: Definition, identification, and prediction of CDK progression. Kidney Int. 2013;(suppl 3):63–72. 2. Coresh J, Levey AS et al. Decline in Estimated Glomerular Filtration Rate and Subsequent Risk of End-Stage Renal Disease and Mortality. JAMA. 2014 Jun 25;311(24):2518-2531	Thank you for your comment. The updated guideline will consider the evidence for the following review questions: For adults, children and young people with CKD, what constitutes a clinically significant decline in eGFR in terms of risk of kidney disease progression? For adults, children and young people with CKD what is the optimal monitoring frequency based on different rates of decline in eGFR? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update.

			3. Levey AS, Coresh J et al. GFR Decline as an End Point for Clinical Trials in CKD: A Scientific Workshop Sponsored by the National Kidney Foundation and the US Food and Drug Administration. American Journal of Kidney Disease (AJKD), December 2014 Volume 64, Issue 6, Pages 821–835	NICE is aware of the KDIGO guidance and recognises the value of consistent national guidance, where this fits with NICE standard methods.
Royal College of Nursing	General	General	This is just to inform you that the feedback I have received from nurses working in this area of health suggests that there are no comments to submit on behalf of the Royal College of Nursing to inform on the consultation of the draft scope of Chronic kidney disease: assessment and management. Thank you for the opportunity to participate. We look forward to participating at the next stage.	Thank you.
Royal College of Paediatrics and Child Health	General	General	The commenters were happy with the documents.	Thank you.
Royal College of Physicians of Edinburgh	10 - 11		College Fellows suggest that the anaemia guidelines require updating – the recent renal association guidelines would serve as a starting point and the recent PIVOTAL study will need to be considered in a revised recommendation. In addition there have been several additional studies using IV iron which may allow refinement of the guidelines.	Thank you for your comment. The updated guideline will consider the evidence for the following review question: For people with stage 5 CKD who are on dialysis, what amount of IV iron is most clinically and cost effective in managing anaemia and its associated outcomes? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you refer to meets the review

				protocol, this will be considered by the guideline committee during the update.
Royal College of Physicians of Edinburgh	10 - 11		Diagnostic test to determine iron status and predict response to iron therapy (recs 1.1.3 and 1.1.4) may require revision. The College would appreciate clarity on why both ferritin and TS% are needed to make an assessment. Those with a low ferritin confirms iron deficiency and no further test is needed. %HRC remain difficult to collect optimally and is unreliable.	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on diagnostic tests to determine iron status and predict response to iron therapy. Therefore this area will not be included in the update. The existing full guideline, NG8, notes: Transferrin saturation TSAT is a cheap and readily available test. TSAT measures storage and transport, but not the potential utilisation of what is stored. Based on limited sensitivity and specificity observed from the diagnostic meta-analysis, the GDG recommended against the use of TSAT in isolation for the diagnosis of iron deficiency. Serum ferritin is a cheap and readily available test. SF is currently used for diagnosis of iron deficiency and iron overload. The GDG were concerned about the widespread use of SF alone for diagnosis of iron deficiency given that it demonstrated very low sensitivity (39%, pooled meta-analysis data). The GDG agreed that, while it was still useful to test for iron overload (when SF levels are greater than 800 micrograms/litre), SF was not very useful to test for iron deficiency and recommended against its use. The GDG recommended its use for diagnosis of iron deficiency only in combination with TSAT and when other sensitive tests (%HRC, CHr) were not available.

Chronic kidney disease

Consultation on draft scope
Stakeholder comments table

10/12/2018 – 11/01/2019

Royal College of Physicians of Edinburgh	16		For people with stage 4 or 5 CKD non Dialysis it is important to develop a useful algorithm to allow a sensible approach to use of phosphate binders and the place of non-calcium based binders based on the clinical trials. The evidence remains limited but there are several studies which can refine the current recommendations to be more evidence based.	Thank you for your comment. The updated guideline will consider the evidence for the following review questions: For people with stage 4 or 5 CKD who are not on dialysis, which phosphate binder, calcium and non-calcium based, is most effective in managing serum phosphate and its associated outcomes? For people with stage 5 CKD who are on dialysis, which phosphate binder, calcium and non-calcium containing, is most effective in managing serum phosphate and its associated outcomes? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update.
Royal College of Physicians of Edinburgh	5	18 - 19	The exclusion listed on p5, lines 18/19: there is evidence for developing renal osteodystrophy from rising PTH levels in stage 3 CKD. It would be of value to seek research evidence for the use of phosphate binders in stage 3 CKD when phosphate may be in the normal range to determine an effect on PTH and calcitriol levels.	Thank you for your comment. The use of phosphate binders in stage 3 CKD is outside of the remit of this guideline.
Royal College of	8		It is critical with the huge number of publications to give a clear indication of the value of cystatin C-based estimate of GFR for	Thank you for your comment.

Physicians of Edinburgh			diagnosis of CKD in children, young people and adults. This important question will need to direct the availability of the test.	The updated guideline will consider the evidence for the following review question: What is the accuracy of cystatin C-based equations to estimate GFR as a measurement of kidney function in adults, children and young people? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline.
Royal College of Physicians of Edinburgh	8		Investigating the cause of CKD and determining the risk of adverse outcomes (recs 1.2.3–1.2.4): the College would appreciate clarity if this indicates the increased use of genetic diagnosis and hence the relationship with personalised medicine which may affect outcomes?	Thank you for your comment. The updated guideline will consider the evidence for the following review questions: What is the accuracy of cystatin C-based equations to estimate GFR as a measurement of kidney function in adults, children and young people? In adults, children and young people from black, Asian and other minority ethnic groups with CKD, what is the biological and analytical variability in eGFR testing and what factors (including fasting) affect it? In children and young people with CKD, what is the accuracy of reagent strips for detecting protein and blood in urine?

				What is the accuracy of albumin:creatinine ratio versus protein:creatinine ratio measurements to quantify proteinuria in children and young people with CKD? Which children and young people should be tested for CKD? What is the best combination of measures of kidney function and markers of kidney damage to identify increased risk of progression in adults, children and young people with CKD? For adults, children and young people with suspected CKD, what is the effect of proteinuria and/or albuminuria at any given eGFR on adverse outcomes? For adults, children and young people with suspected CKD, what is the effect of interventions to lower proteinuria on favourable outcomes? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. The committee will consider the evidence review for each review question, any economic analyses and any additional evidence (for example, expert testimony, views of service users from a reference group, information from focus groups or other exceptional consultation activity). It will then discuss how these answer the review questions and summarises each area of evidence.

Royal College of Physicians of Edinburgh	9		Blood pressure control (recs 1.6.1–1.6.2). There have been a number of landmark studies which will undoubted change practice such as the SPRINT study from Cheung et al. The use of SGLT-2 inhibitors may also need detailed assessment as a potential in the armoury of practice.	Thank you for your comment. The updated guideline will consider the evidence for the following review question: In adults with proteinuric/ nonproteinuric CKD, what are the optimal blood pressure ranges for slowing kidney disease progression, and for reducing cardiovascular disease risk and mortality? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update.
Royal College of Physicians of Edinburgh	General	General	The College agrees that the updated guidance is generally useful, however our Fellows have also noted a number of suggestions and queries in the comments below. The key questions/issues are important, especially the new GFR threshold for anaemia investigation; the Tangri score for risk of progression which will guide referral and monitoring frequency, and information on renal measurement in minority ethnic populations and children. The reviewers feel that there is new evidence that should be brought into the guideline which will be useful for the renal community. Kidney Disease Improving Global Outcomes (KDIGO)	Thank you for your comment. The updated guideline will consider the evidence for the following review questions: In adults, children and young people from black, Asian and other minority ethnic groups with CKD, what is the biological and analytical variability in eGFR testing and what factors (including fasting) affect it? What is the best combination of measures of kidney function and markers of kidney damage to identify increased risk of progression in adults, children and young people with CKD?

			https://kdigo.org/ is a huge resource with a wealth of information which College Fellows encourage NICE to utilise during the revision of the current guidelines.	The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update.
Royal College of Physicians of Edinburgh	General	General	There is no reference to the management of hyperkalaemia: the introduction of 2 novel potassium binders requires assessment by NICE and the revision of current guidelines.	Thank you for your comment. The novel potassium binders, Sodium zirconium cyclosilicate and patiromer, both for treating hyperkalaemia, are the subject of NICE technology appraisals currently in development. The scope has been amended to include the two in development technology appraisals in the related NICE guidance section. The updated guideline will have the opportunity to cross-refer to related NICE guidance as needed.
Stanningley Pharma	1	20	Reference is made to the "surveillance review decision" which in turn makes the comment that the focus will be upon "*Cost effectiveness of phosphate binders for children, young people and adults with chronic kidney disease (CKD) stages 4–5, both on dialysis and not on dialysis".* It is important to highlight that all licenced PO4 binders gained their approvals upon the basis of non-inferiority with previous products. On this basis all binders are effective. A more significant question might be to ask why it is that the outcomes seen in the UK Renal Registry show such variance. This could have many reasons including such factors as the level of specialist dietetic and pharmacist support available. Another major factor is that though effective binders will only work if patients are concordant with what is	Thank you for this information. The updated guideline will consider the evidence for the following review questions, which we believe will address the issue you have highlighted: For people with stage 4 or 5 CKD who are not on dialysis, which phosphate binder, calcium and non-calcium based, is most effective in managing serum phosphate and its associated outcomes? For people with stage 5 CKD who are on dialysis, which phosphate binder, calcium and non-calcium containing, is most effective in managing serum phosphate and its associated outcomes?

			prescribed. It is well known that binders are not the most agreeable medicines to take and as a result determining "cost effectiveness" may be problematic. Possibly offering guidance regarding the suitability of different products to different patients at different time in their disease progression would be helpful?	The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you refer to meets the review protocol, this will be considered by the guideline committee during the update.
Stanningley Pharma	10		1.1.1-1.14 - Would it be possible to make a comment regarding the importance of specialist renal dietetic and pharmacist support? Managing PO4 is not easy and oversimplification can confuse. Whilst achieving appropriate PO4 control is important so is adequate protein intake. Just as high PO4 levels are associated with poor outcomes so is low protein intake. Foods high in protein are often high in PO4 again supporting the need for specialist renal dietetic support. Measuring PO4 is easily done by a laboratory test, nutritional assessment is much more involved, and no simple test is available. The *Equality Assessment* comments upon reduced protein intake in CKD and increased loss. Patients with CKD have dietary needs that differ greatly from other patient groups and would benefit from specific guidance. This could look at protein intake, vitamin supplementation both water soluble and vitamin D, management of K+ in the diet. This later point is important as high K+ levels are associated with poor outcomes and make it difficult to escalate doses of the likes of ARB's to optimal levels.	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on the role of dietetic and pharmacist support. Therefore this area will not be included in the update. We will highlight this area to the surveillance team for consideration at the next surveillance review. CG157 makes the following recommendations, which will be retained in the update, regarding dietary management: 1.1.1 A specialist renal dietitian, supported by healthcare professionals with the necessary skills and competencies, should carry out a dietary assessment and give individualised information and advice on dietary phosphate management. 1.1.2 Advice on dietary phosphate management should be tailored to individual learning needs and preferences, rather than being provided through a generalised or complex multicomponent programme of delivery. 1.1.3 Give information about controlling intake of phosphate-rich foods (in particular, foods with a high phosphate content per gram of protein, as well as food and drinks with high levels of phosphate additives) to control serum phosphate, while

				avoiding malnutrition by maintaining a protein intake at or above the minimum recommended level. For people on dialysis, take into account possible dialysate protein losses. 1.1.4 If a nutritional supplement is needed to maintain protein intake in children and young people with hyperphosphataemia, offer a supplement with a lower phosphate content, taking into account patient preference and other nutritional requirements.
Stanningley Pharma	10		1.1.5-1.1.15 - It is important to remember that all binders are effective but only in the patient is concordant with therapy. Offering choice to patients and prescribers is likely to improve achievement of targets. Questions of cost effectiveness though interesting are of limited relevance. Different binder may be more appropriate at differing stages in progression, the question arises when a patient is non-concordant with the preferred agent. Is it better for a patient to take no PO4 binder than to take a product that is deemed less appropriate?	Thank you for your comment. The updated guideline will consider the evidence for the following review questions: For people with stage 4 or 5 CKD who are not on dialysis, which phosphate binder, calcium and non-calcium based, is most effective in managing serum phosphate and its associated outcomes? For people with stage 5 CKD who are on dialysis, which phosphate binder, calcium and non-calcium containing, is most effective in managing serum phosphate and its associated outcomes? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. We will keep in mind the issue you have raised when developing the guideline.
Stanningley Pharma	12	27	Excluding “Treating Malnutrition” will miss a major opportunity. The nutritional needs of patients with CKD are very different	Thank you for your comment. Treating malnutrition is outside the remit of this guideline. We will highlight this area to the

			from other patient groups and should be regarded as a priority. Patients with CKD are not covered by the nutritional aspects of other Nice guidance. Assessing nutritional status is no easy and is compounded in CKD by several factors. These include the following, weight assessment being of limited value due to potential fluid issues, the conflicting need for great protein intake vs. the need to control PO4 intake, requirement to reduce K+ intake, the potential for reduced intake of water-soluble vitamins due to food preparation to reduce K+ intake, the increased removal of water-soluble vitamins during dialysis.	surveillance team for consideration at the next surveillance review for other NICE guidelines.
Stanningley Pharma	2	1	IV iron is a treatment for iron deficiency which may be a component of the anaemia associated with CKD. It is recognised that iron deficiency in the absence of anaemia should be detected and corrected. No mention is made of the potential merits of using oral iron therapy which may be a simpler and cheaper option for some patients	Thank you for this information. The updated guideline will consider the evidence for the following review questions: For people with stage 5 CKD who are on dialysis, what amount of IV iron is most clinically and cost effective in managing anaemia and its associated outcomes? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. With regards to oral iron therapy, the current guideline, NG8, recommends: 1.3.23 Offer oral iron therapy to adults and young people who are receiving ESA therapy only if: intravenous iron therapy is contraindicated or

				the person chooses not to have intravenous iron therapy after discussing the relative efficacy and side effects of oral and intravenous iron therapy. [new 2015] No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches for recommendation 1.3.23. Therefore this area will not be included in the update. We will highlight this area to the surveillance team for consideration at the next surveillance review.
Stanningley Pharma	2	9	Possibly add a comment that the other patients have a functioning transplant?	Thank you for your comment. Section 1 of the scope is a summary of current practice: therefore, we are unable to include a comprehensive outline of why the guideline is needed.
Stanningley Pharma	2	9	Regarding the achievement of recommended PO4 control could comment be made regarding contributory factors? Comment 1 above raises this as well.	Thank you for your comment. Section 1 of the scope is a summary of current practice; while we are therefore unable to include a comprehensive outline of why the guideline is needed we have made an amendment, noting that standard management of CKD involves the use of both pharmacological and nonpharmacological interventions, as well as the provision of education and support.
Stanningley Pharma	3	10 - 15	The availability of generic version of products may potentially reduce costs but only if the patient will take the product. The availability of different binders enables patients and prescribers to have choice. Restricting the availability of any binder would reduce choice and be likely to reduce quality of PO4 management and outcomes.	Thank you for your comment. The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. When formulating recommendations, the committee will consider cost effectiveness in parallel with general effectiveness as well as where appropriate if there is a patient preference decision this will be considered in the guideline.
Stanningley Pharma	3	26	The guidance could also be of use to non-NHS dialysis providers plus those companies involved in the development and supply of equipment and pharmaceuticals.	Thank you for your comment. The guideline will cover all settings where NHS-funded care is provided.

Stanningley Pharma	3	8	“maintaining acceptable levels” is possibly a little optimistic based upon the current Renal Registry reported data.	Thank you for your comment. This section describes current practice and the aim of standard management, therefore we have not amended the scope.
Stanningley Pharma	3	9	Dietary management should be regarded as the first line intervention with the use of binders as secondary. A potential issue in some units may be the level of specialist dietetic and pharmacy support available.	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on dietary management to reduce phosphate levels. Therefore, this area will not be included in the update. We will highlight this area to the surveillance team for consideration at the next surveillance review. The current guideline, CG157, recommends: 1.1.1 A specialist renal dietitian, supported by healthcare professionals with the necessary skills and competencies, should carry out a dietary assessment and give individualised information and advice on dietary phosphate management. 1.1.2 Advice on dietary phosphate management should be tailored to individual learning needs and preferences, rather than being provided through a generalised or complex multicomponent programme of delivery. 1.1.3 Give information about controlling intake of phosphate-rich foods (in particular, foods with a high phosphate content per gram of protein, as well as food and drinks with high levels of phosphate additives) to control serum phosphate, while avoiding malnutrition by maintaining a protein intake at or above the minimum recommended level. For people on dialysis, take into account possible dialysate protein losses. 1.1.4 If a nutritional supplement is needed to maintain protein intake in children and young people with hyperphosphataemia,

				offer a supplement with a lower phosphate content, taking into account patient preference and other nutritional requirements.
Stanningley Pharma	4	24 - 27	The use of binders should be regarded as secondary to specialist renal dietary and pharmacy support. Without appropriate resource this support may not be available and contribute to the variance seen in the Renal Registry report.	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on dietary management to reduce phosphate levels. Therefore, this area will not be included in the update. We will highlight this area to the surveillance team for consideration at the next surveillance review. The current guideline, CG157, states the use of phosphate binders to control serum phosphate should be in addition to dietary management, which should be carried out by a renal dietitian and supported by healthcare professionals with the necessary skills and competencies: 1.1.1 A specialist renal dietitian, supported by healthcare professionals with the necessary skills and competencies, should carry out a dietary assessment and give individualised information and advice on dietary phosphate management. 1.1.2 Advice on dietary phosphate management should be tailored to individual learning needs and preferences, rather than being provided through a generalised or complex multicomponent programme of delivery. 1.1.3 Give information about controlling intake of phosphate-rich foods (in particular, foods with a high phosphate content per gram of protein, as well as food and drinks with high levels of phosphate additives) to control serum phosphate, while avoiding malnutrition by maintaining a protein intake at or above the minimum recommended level. For people on dialysis, take into account possible dialysate protein losses.

				1.1.4 If a nutritional supplement is needed to maintain protein intake in children and young people with hyperphosphataemia, offer a supplement with a lower phosphate content, taking into account patient preference and other nutritional requirements.
Stanningley Pharma	7	2	IV iron may not in itself treat anaemia. Iron correct iron deficiency. No mention is made of the potential value of oral iron therapy in certain patients.	Thank you for this information. The updated guideline will consider the evidence for the following review questions: For people with stage 5 CKD who are on dialysis, what amount of IV iron is most clinically and cost effective in managing anaemia and its associated outcomes? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. With regards to oral iron therapy, the current guideline, NG8, recommends: 1.3.23 Offer oral iron therapy to adults and young people who are receiving ESA therapy only if: intravenous iron therapy is contraindicated or the person chooses not to have intravenous iron therapy after discussing the relative efficacy and side effects of oral and intravenous iron therapy. [new 2015]
The British Association of Prosthetists	General	General	The British Association of Prosthetists and Orthotists support the concerns raised by the College of Podiatry that the draft scope excludes any mention of foot screening for people with CKD. People with chronic kidney disease (CKD) have a high incidence of foot ulceration and both minor and major	Thank you for your comment. Renal foot disease is outside the remit of this guideline. The updated guideline will have the opportunity to cross-refer to related NICE guidelines as needed.

and Orthotists			amputations. This cohort should be receiving proactive and preventative foot care; many require intensive management and interventions. The consequences of poor management of the renal foot are considerable: prolonged ulceration and ill health, gangrene and amputation, depression and death. The health complications are increased with the added complication of co-morbidities, such as diabetes. The consequences of poor management of the renal foot are considerable: prolonged ulceration and ill health, gangrene and amputation, depression and death. The health complications are increased with the added complication of co-morbidities, such as diabetes and peripheral arterial disease (PAD). A study found that dialysis treatment was independently associated with foot ulceration.[i] Diabetes is documented as being the most common single cause of established renal failure.[ii] Up to 40% of patients with diabetes develop CKD[iii], with a temporal relationship demonstrated between foot ulceration and the onset of dialysis for those with end stage renal failure [iv] and a higher rate of amputation (up to 30%) [V]. Peripheral arterial disease is an independent predictor of mortality in dialysis patients [vi]. The mechanisms of PAD are: alteration in function of the renin-angiotensin system; fluid retention; hypertension; dyslipidaemia; possible contribution from an underlying state of chronic inflammation. There needs to	The scope has been amended to include the following guidelines in the related NICE guidance section: • Diabetic foot problems: prevention and management (NG19) • Peripheral arterial disease: diagnosis and management (CG147) We will highlight this area and references provided to the surveillance team for consideration at the next surveillance review for other NICE guidelines.

			be close multi-disciplinary working with all members of the team (including Vascular, Renal, Microbiology, Radiology, Podiatry, and Diabetic Departments). It is important to realise that a patient on dialysis attends hospital 3 times a week for 4-5 hours (156 hospital visits per year), during which time they will be resting their feet against a vinyl couch and be relatively immobile, putting them at increased risk of pressure sores. Patients diagnosed with stage 4/5 renal failure should automatically be considered as being at high risk of developing foot ulceration in the absence of any active foot problems, with a referral for specialist expert advice and treatment if an active problem is discovered during the examination – placing this in line with the recommendations set by NICE in NG19 (Diabetic Foot Problems: Prevention and Management). A recent study which looked in to the validation of the diabetes foot screening recommendations in detecting lower-limb-threatening risk factors in patients with end stage renal failure found the test to be reliable and reproducible in detecting evidence of peripheral neuropathy and peripheral arterial disease in this homogenous sample of ESRD patients on haemodialysis therapy without a concomitant diagnosis of diabetes [vii]. When screening a patient, once neuropathy or ischaemia has been documented, the need to continue to screen for this would not be necessary continuously as this is not likely to improve, however inspection of both feet is crucial at all visits.	

			Literature suggests that patients with renal complications are more prone to Charcot osteoarthropathy. Therefore, patients should always be screened for swelling, temperature difference and any deformity about the foot/ankle complexes. With dialysis treatment being independently associated with foot ulceration and the risk factors contributing to foot ulceration within the diabetic population being well established, The British Association of Prosthetists and Orthotists supports and reinforces the opinion of The College of Podiatry in recommending that Renal and dialysis services should have a named health care professional responsible for ensuring access to regular foot checks and improving quality of foot health for renal patients. Responsibilities should include working with the local foot protection service, podiatry, orthotic, diabetes and vascular teams and the multidisciplinary foot service (MDFS) in order to support training of health care professionals and improve patient education and awareness. References [i] Ndip et al, 2010. Dialysis treatment is an independent risk factor for foot ulceration in patients with diabetes and stage 4 or 5 chronic kidney disease. Diabetes Care, 33 (8), 1811 – 1816. ii Eggers PW, Gohdes D, Pugh J. Nontraumatic lower extremity amputations in the Medicare end-stage renal disease population. Kidney Int 1999; 56:1524–33	

			iii De Boer IH, et al. Temporal Trends in the Prevalence of Diabetic Kidney Disease in the United States. JAMA 2011; 305: 2532–2539 [iv] Jeffcoate WJ, Vileikyte L, Boyko EJ et al (2018) Current challenges and Opportunities in the Prevention and Management of the Diabetic Foot. *Diabetes Care* 41(4): 645–52 [v] **Morbach S**, **Quante C**, **Ochs HR**, **Gaschler F**, **Pallast JM**, **Knevels U**. Increased risk of lower-extremity amputation among Caucasian diabetic patients on dialysis. **Diabetes Care.** 2001 Sep;24(9):1689-90. [vi] Chen J, et al. Risk factors for peripheral arterial disease among patients with chronic kidney disease. Am J Cardiol. 2012;110:136–141. doi: 10.1016/j.amjcard.2012.02.061. [vii] *Jones NJ, Mathieson I, Morris K and Riley S.* Validation of the diabetic foot screening tool in detecting lower-limb-threatening risk factors in end-stage renal disease patients. The Diabetic Foot Journal 21 (2) 2018: 76-82	
The College of Podiatry	General	General	The College of Podiatry are concerned that the draft scope excludes any mention of foot screening for people with chronic kidney disease (CKD). People with CKD have a high incidence of foot ulceration and both minor and major amputations. This cohort should be receiving proactive and preventative foot health treatment; many require intensive management and tailored interventions. The consequences of poor management of the renal foot are considerable: prolonged ulceration and ill health, gangrene and	Thank you for your comment. Renal foot disease is outside the remit of this guideline. The updated guideline will have the opportunity to cross-refer to related NICE guidelines as needed. The scope has been amended to include the following guidelines in the related NICE guidance section: • Diabetic foot problems: prevention and management (NG19) • Peripheral arterial disease: diagnosis and management (CG147)

			amputation, depression and death. The health complications are increased with the added complication of co-morbidities, such as diabetes and peripheral arterial disease (PAD). A study found that dialysis treatment was independently associated with foot ulceration.[iv] Diabetes is documented as being the most common single cause of established renal failure.[v] Up to 40% of patients with diabetes develop CKD.[1] PAD is an independent predictor of mortality in dialysis patients.[vi] The mechanisms of PAD are: alteration in function of the renin-angiotensin system; fluid retention; hypertension; dyslipidaemia; possible contribution from an underlying state of chronic inflammation. There needs to be close multi-disciplinary working with all members of the team (including Vascular, Renal, Microbiology, Radiology, Podiatry, and Diabetic Departments). Good management requires close coordination between different health care professions – such coordination is not yet widespread. Reorganisation needs to be implemented to improve health outcomes and reduce costs. It is important to realise that a patient on dialysis attends hospital 3 times a week for 4-5 hours (156 hospital visits per year), during which time they will be resting their feet against a vinyl couch and	We will highlight this area and references provided to the surveillance team for consideration at the next surveillance review for other NICE guidelines.

			be relatively immobile, putting them at increased risk of pressure sores. Patients diagnosed with stage 4/5 renal failure should automatically be considered as being at high risk of developing foot ulceration in the absence of any active foot problems, with a referral for specialist expert advice and treatment if an active problem is discovered during the examination – placing this in line with the recommendations set by NICE in NG19 (Diabetic Foot Problems: Prevention and Management). When screening a patient, once neuropathy or PAD has been detected, the need to continue to formally screen the patient is unnecessary, however inspection of both feet is crucial at all visits. Literature suggests that patients with renal complications are more prone to Charcot osteoarthropathy. Therefore, patients should always be screened for swelling, temperature difference and any deformity about the foot/ankle complexes. The College of Podiatry recommend that Renal and dialysis services should have a named health care professional responsible for ensuring access to regular foot checks and improving quality of foot health for renal patients, and rapid access to Podiatry Foot Protection Services. Responsibilities should include working with the local foot protection service, podiatry, orthotic, diabetes and vascular teams and multidisciplinary foot service in order to support training of	

			healthcare professionals and improve patient education and awareness. References Ndip et al, 2010. Dialysis treatment is an independent risk factor for foot ulceration in patients with diabetes and stage 4 or 5 chronic kidney disease. Diabetes Care, 33 (8), 1811 – 1816. Eggers PW, Gohdes D, Pugh J. Nontraumatic lower extremity amputations in the Medicare end-stage renal disease population. Kidney Int 1999; 56:1524–33 De Boer IH, et al. Temporal Trends in the Prevalence of Diabetic Kidney Disease in the United States. JAMA 2011; 305: 2532–2539 Chen J, et al. Risk factors for peripheral arterial disease among patients with chronic kidney disease. Am J Cardiol. 2012;110:136–141. doi: 10.1016/j.amjcard.2012.02.061.	
Vifor Pharma UK Ltd	1	21 - 22	A further bullet point needs to be added to this area: monitoring potassium in patients with CKD and comorbidities.	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches for this area. Therefore this area will not be included in the update.
Vifor Pharma UK Ltd	10		Chronic Kidney disease – managing anaemia. - In the introduction of NG8, change from iron deficiency in anaemia to 'iron deficiency and iron deficiency anaemia' to ensure clinicians realise that both have an adverse impact on patients. This section is best placed above that describing "ESA resistant" so that the correct context can be gleaned.	Thank you for your comments on chronic kidney disease: managing anaemia (NG8). This guideline will update and combine the NICE guidelines on chronic kidney disease in adults: assessment and management (CG182), chronic kidney disease (stage 4 or 5): management of hyperphosphataemia (CG157) and chronic kidney disease: managing anaemia (NG8). The guideline will be developed using the methods and processes outlined in developing NICE guidelines: the manual.

			Rather than mentioning an intercurrent illness, better generalise to an acute inflammatory condition that is often due to an intercurrent condition. This is mentioned in the preceding paragraph, but might not be realised by those not familiar with the disease area.	The NICE guideline considers specifically iron deficiency in anaemia rather than other types of iron deficiency therefore we have not amended this inn the scope.
Vifor Pharma UK Ltd	10		Diagnostic evaluation and assessment of anaemia (page 9 of NG8) - Rather than 'Do not request transferrin saturation or serum ferritin measurement alone to assess iron deficiency status in people with anaemia of chronic kidney disease (CKD)', State: Transferrin and Serum ferritin levels require measurement of CRP to assess iron deficiency in people with anaemia of chronic kidney disease due to the chronic inflammation. CRP is required to help ascertain whether the patient is likely to have functional iron deficiency due to inflammation	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on diagnostic tests to determine iron status and predict response to iron therapy. Therefore this area will not be included in the update. We will highlight this area to the surveillance team for consideration at the next surveillance review.
Vifor Pharma UK Ltd	10		Assessment and optimisation of erythropoiesis (p. 9 of NG8) - The section on Iron therapy for people who are iron deficient and not on ESA therapy should be moved above ESA therapy since iron levels will need to be optimised prior to ESA therapy.	Thank you for your comment. The scope does not describe the order of the recommendations. The guideline committee will consider the layout of the guideline in relation to the amalgamation of the three guidelines and the updated recommendations.
Vifor Pharma UK Ltd	10		ESAs: monitoring iron status during treatment (p. 10 of NG8) - TSAT 20% and Ferritin of over 100 are relatively low levels for optimal results for use with ESA therapy. The ERBP group suggests levels of >30% and >300	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on ESAs: monitoring iron status during treatment. Therefore, this area will not be included in the update. We will highlight this area to the surveillance team for consideration at the next surveillance review.

				NICE recognises the value of consistent national guidance, where this fits with NICE standard methods.
Vifor Pharma UK Ltd	10		Iron therapy for people who are iron deficient and not on ESA therapy (p. 10 of NG8) - Change: 'Hb levels are not reached within 3 months' to: '1-3 months', this is in line with the KDIGO guidelines	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on iron therapy for people who are iron deficient and not on ESA therapy. Therefore, this area will not be included in the update. We will highlight this area to the surveillance team for consideration at the next surveillance review. NICE is aware of the KDIGO guidance and recognises the value of consistent national guidance, where this fits with NICE standard methods.
Vifor Pharma UK Ltd	10		1.1 - Change title to "Diagnostic evaluation and assessment of anaemia and Iron Deficiency"	Thank you for your comment. NICE acknowledges that iron deficiency is a key treatable form of anaemia, but the guideline considers all forms of anaemia and this is reflected in the wording of the scope.
Vifor Pharma UK Ltd	10		1.1.1 - Change to "they develop symptoms attributable to anaemia or iron deficiency"	Thank you for your comment. NICE acknowledges that iron deficiency is a key treatable form of anaemia, but the guideline considers all forms of anaemia and this is reflected in the wording of the scope.
Vifor Pharma UK Ltd	10		1.1.1-1.1.4 - We would welcome any updated recommendations to reflect the most recent "KDIGO 2017 Clinical Practice Guideline Update for the Diagnosis, Evaluation, Prevention, and Treatment of Chronic Kidney Disease–Mineral and Bone Disorder (Chronic Kidney Disease - MBD)"	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on dietary management. Therefore this area will not be included in the update. We will highlight this area to the surveillance team for consideration at the next surveillance review. NICE is aware of the KDIGO guidance and recognises the value of consistent national guidance, where this fits with NICE standard methods.

Vifor Pharma UK Ltd	10		1.1.8 of CG157 - Based on a recent commentary from the renal association, this recommendation needs to be amended. *"Whilst calcium-based phosphate binders still have a role in the management of hyperphosphataemia in adults with CKD, their place as first line agents in the majority can no longer be recommended"*	Thank you for your comment. The updated guideline will consider the evidence for the following review questions: For people with stage 4 or 5 CKD who are not on dialysis, which phosphate binder, calcium and non-calcium based, is most effective in managing serum phosphate and its associated outcomes? For people with stage 5 CKD who are on dialysis, which phosphate binder, calcium and non-calcium containing, is most effective in managing serum phosphate and its associated outcomes? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline.
Vifor Pharma UK Ltd	10		1.1.12 of CG157 - Change to: "consider either combining with, or switching to, sevelamer hydrochloride **sucroferric oxyhydroxide** or lanthanum carbonate,.." or to "consider either combining with, or switching to **a non-calcium-based binder**,.."	Thank you for your comment. The updated guideline will consider the evidence for the following review questions: For people with stage 4 or 5 CKD who are not on dialysis, which phosphate binder, calcium and non-calcium based, is most effective in managing serum phosphate and its associated outcomes?

				For people with stage 5 CKD who are on dialysis, which phosphate binder, calcium and non-calcium containing, is most effective in managing serum phosphate and its associated outcomes? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline.
Vifor Pharma UK Ltd	10		1.2.2 - Add: 'at least 1 week after' to the end of the sentence 'when serum ferritin levels reach 500 mcg/L'. – to be in line with 1.4.1	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on maximum iron levels in patients with anaemia of CKD. Therefore, this area will not be included in the update. We will, however, highlight this area to the editorial team to ensure, following amalgamation and update, both existing and new recommendations, are sense-checked.
Vifor Pharma UK Ltd	10		1.2.4 - Change 'is likely to negate the benefits of correcting the anaemia' to 'is likely to negate the benefits of treatment.' Just because the anaemia might not warrant the treatment with ESA it may warrant treatment with other methods.	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on the clinical utility of ESA therapy in iron-replete patients. Therefore this area will not be included in the update.
Vifor Pharma UK Ltd	10		1.1.3-4 - Specifically mention functional iron deficiency. This patient population is highly inflamed and functional iron deficiency occurs in a significant % of patients	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on diagnostic test to determine iron status and predict response to iron therapy. Therefore this area will not be included in the update.

Vifor Pharma UK Ltd	11		1.3.17 - Change to 'unless serum ferritin is greater than 800, tested 1 month or at least a week after treatment in the case of IV treatment'	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on assessment and optimisation of erythropoiesis. Therefore this area will not be included in the update.
Vifor Pharma UK Ltd	11		1.3.17 - Most patients will need 500-1000mg of iron per course of therapy, which may require repeating	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on assessment and optimisation of erythropoiesis. Therefore this area will not be included in the update.
Vifor Pharma UK Ltd	11		1.3.18 - Change sentence to: Ferritin level is greater than 100 microgram/litre if the CRP is not raised	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on assessment and optimisation of erythropoiesis. Therefore this area will not be included in the update.
Vifor Pharma UK Ltd	11		1.3.22 - Add in evidence from the recently published PIVOTAL clinical trial with intravenous iron	Thank you for your comment. The updated guideline will consider the evidence for the following review question: For people with stage 5 CKD who are on dialysis, what amount of IV iron is most clinically and cost effective in managing anaemia and its associated outcomes? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. If the evidence you refer to meets the review

				protocol, this will be considered by the guideline committee during the update.
Vifor Pharma UK Ltd	11		1.3.20 - Move section above ESA therapy.	Thank you for your comment. The scope does not describe the order of the recommendations. The guideline committee will consider the layout of the guideline in relation to the amalgamation of the three guidelines and the updated recommendations.
Vifor Pharma UK Ltd	11		1.3.20 - Second bullet change 3 months to 1 - 3 months.	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on assessment and optimisation of erythropoiesis. Therefore this area will not be included in the update.
Vifor Pharma UK Ltd	12		1.4.4 - This section does not address iron deficiency or functional iron deficiency as a cause.	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on monitoring treatment of anaemia of CKD. Therefore this area will not be included in the update.
Vifor Pharma UK Ltd	12		1.4.7 - The most common causes of resistance to ESA are iron deficiency (absolute or functional) and inflammation Besides iron deficiency, there are only a few other reversible / easily correctable factors that contribute to ESA hyporesponsiveness Untreated iron deficiency is an important cause of hyporesponsiveness to ESA treatment	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on monitoring treatment of anaemia of CKD. Therefore this area will not be included in the update.
Vifor Pharma UK Ltd	12	10 - 11	We feel that not covering these areas will be a missed opportunity for the health care provider to identify the disease early, in stage 3 of chronic kidney disease, allowing appropriate treatment interventions. This is in line with the “KDIGO 2017 Clinical Practice Guideline Update for the Diagnosis, Evaluation, Prevention, and Treatment of Chronic Kidney Disease–Mineral and Bone Disorder (Chronic Kidney Disease -	Thank you for your comment. While outside the remit of this guideline, we will highlight this area to the surveillance team for consideration at the next surveillance review for the following related NICE guideline: • Osteoporosis: assessing the risk of fragility fracture (2015)

			MBD)", recommending the monitoring of calcium, phosphate, parathyroid hormone, and alkaline phosphatase activity beginning in chronic kidney disease stage 3a. Furthermore, this guideline also suggest that vitamin D levels might be measured as of stage 3a. This would enable the health care provider to identify trends of rising parathyroid hormone levels early on, so that therapeutic interventions can ameliorate the progressive nature of secondary hyperparathyroidism and related effects of mineral and bone disorder.	The updated CKD guideline will have the opportunity to cross-refer to related NICE guidelines as needed. The current guideline includes the following recommendation: 1.7.1 Do not routinely measure calcium, phosphate, parathyroid hormone (PTH) and vitamin D levels in people with a GFR of 30 ml/min/1.73 m 2 or more (GFR category G1, G2 or G3). [2008] NICE is aware of the KDIGO guidance and recognises the value of consistent national guidance, where this fits with NICE standard methods.
Vifor Pharma UK Ltd	16	16	Add a bullet to this section to include: measuring Potassium control.	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on measuring potassium control. Therefore, this area will not be included in the update.
Vifor Pharma UK Ltd	16	28	Given CKD is an inflammatory condition, include CRP and explain this is required to interpret Ferritin levels. Add in TSAT.	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on diagnostic tests to determine iron status and predict response to iron therapy. Therefore, this area will not be included in the update. We will highlight this area to the surveillance team for consideration at the next surveillance review. The existing full guideline, NG8, notes: C Reactive protein: • There is good understanding that haemoglobin (Hb) concentrations alone (in g/litre) do not give adequate information about the aetiology of anaemia or potential for

				treatments available to ameliorate the anaemia. Given the vital importance of iron for Hb synthesis, tests must provide some understanding of iron homeostasis within the patient. Traditional tests of iron fall short, since low levels of SF are unusual in CKD, yet we know that there is iron-restricted erythropoiesis, because patients respond to intravenous iron with normal or even raised ferritin levels. If there are indications that the patient has an inflammatory process, such as a raised C Reactive Protein or plasma viscosity, there is a much higher likelihood that both ferritin and hepcidin levels will be increased. The aetiology of raised SF in this setting is just a function of increased storage cell 'leakage'. Transferrin saturation • TSAT is a cheap and readily available test. TSAT measures storage and transport, but not the potential utilisation of what is stored. Based on limited sensitivity and specificity observed from the diagnostic meta-analysis, the GDG recommended against the use of TSAT in isolation for the diagnosis of iron deficiency. Serum ferritin • is a cheap and readily available test. SF is currently used for diagnosis of iron deficiency and iron overload. The GDG were concerned about the widespread use of SF alone for diagnosis of iron deficiency given that it demonstrated very low sensitivity (39%, pooled meta-analysis data). The GDG agreed that, while it was still useful to test for iron overload (when SF levels are greater than 800 micrograms/litre), SF was not very useful to test for iron deficiency and

				recommended against its use. The GDG recommended its use for diagnosis of iron deficiency only in combination with TSAT and when other sensitive tests (%HRC, CHr) were not available.
Vifor Pharma UK Ltd	16	9 - 11	In most patients, the underlying cause of anaemia will be multifactorial and the therapeutic interventions remain constant. Patients should be screened annually when diagnosed with CKD and then appropriately treated to target.	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on annual screening. Therefore, this area will not be included in the update. We will highlight this area to the surveillance team for consideration at the next surveillance review. The updated guideline will have the opportunity to cross-refer to the NICE guidelines on multimorbidity: clinical assessment and management (NG56) and patient experience in adult NHS services (CG138) as needed.
Vifor Pharma UK Ltd	2	1	Add iron deficiency to anaemia.	Thank you for your comment. NICE acknowledges that iron deficiency is a key treatable form of anaemia, but the guideline considers all forms of anaemia and this is reflected in the wording of the scope.
Vifor Pharma UK Ltd	2	15 - 16	Add iron deficiency to anaemia	Thank you for your comment. NICE acknowledges that iron deficiency is a key treatable form of anaemia, but the guideline considers all forms of anaemia and this is reflected in the wording of the scope.
Vifor Pharma UK Ltd	2	15 - 18	Quantifying prevalence of iron deficiency and anaemia would be helpful to clinicians e.g. from 8% for CKD stage 1 rising to over 50% for stages 4 and 5	Thank you for this information.
Vifor Pharma UK Ltd	2	18 - 19	Anaemia of CKD contributes significantly to both the morbidity and mortality of CKD and other comorbidities instead of just 'burden' – this is more likely to ensure clinicians are more aware of the importance of adequate treatment Add "iron deficiency" after anaemia	Thank you for your comment. Section 1 of the scope is a summary of current practice; therefore, we are unable to include a comprehensive outline of why the guideline is needed. NICE acknowledges that iron deficiency is a key

				treatable form of anaemia, but the guideline considers all forms of anaemia and this is reflected in the wording of the scope.
Vifor Pharma UK Ltd	2	24	The section on current practice ignores all co-morbidities that have an effect on progression and adverse outcomes.	Thank you for your comment. Section 1 of the scope is a summary of current practice, therefore we are unable to include a comprehensive outline of why the guideline is needed.
Vifor Pharma UK Ltd	2	24	Current practice section: should also include the management of the patient's potassium levels since there are now effective treatments rather than reducing other therapeutic agents.	Thank you for your comment. Section 1 of the scope is a summary of current practice, therefore we are unable to include a comprehensive outline of why the guideline is needed.
Vifor Pharma UK Ltd	3	16 - 22	Although current practice might indicate diagnostic measures are not taken until eGFR decreases to 30, this will lead to an under-treating of a considerable cohort of patients. These guidelines should be designed to encourage best practice.	Thank you for your comment. The updated guideline will consider the evidence for the following review question: For adults, children and young people with CKD, what constitutes a clinically significant decline in eGFR in terms of risk of kidney disease progression? For adults, children and young people with CKD what is the optimal monitoring frequency based on different rates of decline in eGFR? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline.
Vifor Pharma UK Ltd	3	3	The frequency of eGFR review will vary on the underlying pathophysiology – annually for some conditions but more frequently in others such as with heart failure. Better use language of at least annually as used in CG182 1.1.28	Thank you for your comment, we have amended this section accordingly.
Vifor Pharma UK Ltd	4	17	Secondary hyperparathyroidism can manifest as early as in chronic kidney disease stage 3, is progressive if untreated and	Thank you for your comment.

			associated with adverse outcomes. The health care provider shall be encouraged to identify the disease early, in stage 3, allowing appropriate treatment interventions. This is in line with the "KDIGO 2017 Clinical Practice Guideline Update for the Diagnosis, Evaluation, Prevention, and Treatment of Chronic Kidney Disease–Mineral and Bone Disorder (Chronic Kidney Disease -MBD)", recommending the monitoring of calcium, phosphate, parathyroid hormone, and alkaline phosphatase activity beginning in Chronic Kidney Disease stage 3a. Furthermore, this guideline also suggest that vitamin D levels might be measured as of Chronic Kidney Disease stage 3a. This would enable the health care provider to identify trends of rising parathyroid hormone levels early on, so that therapeutic interventions can ameliorate the progressive nature of secondary hyperparathyroidism.	Diagnosing and managing secondary hyperparathyroidism is outside of the remit of this guideline. NICE is aware of the KDIGO guidance and recognises the value of consistent national guidance, where this fits with NICE standard methods.
Vifor Pharma UK Ltd	5	18 - 19	The draft excludes adults, children and young people with stage 3 kidney disease , Secondary hyperparathyroidism can manifest as early as in chronic kidney disease stage 3, is progressive if untreated and associated with adverse outcomes. The health care provider shall be encouraged to identify the disease early, in stage 3, allowing appropriate treatment interventions. This is in line with the "KDIGO 2017 Clinical Practice Guideline Update for the Diagnosis, Evaluation, Prevention, and Treatment of Chronic Kidney Disease–Mineral and Bone Disorder (Chronic Kidney Disease - MBD)", recommending the monitoring of calcium, phosphate, PARATHYROID HORMONE, and alkaline phosphatase activity beginning in Chronic Kidney Disease stage 3a. Furthermore, this guideline also suggest that vitamin D levels might be measured as of Chronic Kidney Disease stage 3a. This would enable the health care provider to identify trends of rising	Thank you for your comment. Diagnosing and managing secondary hyperparathyroidism in those with CKD stages 1-3 is outside of the remit of this guideline.

			parathyroid hormone levels early on, so that therapeutic interventions can ameliorate the progressive nature of secondary hyperparathyroidism and related effects of MBD.	
Vifor Pharma UK Ltd	5	23	CKD is a chronic inflammatory disease state and this wording could be misleading. This does have an important clinical role regarding interpreting ferritin measurements relating to anaemia. Suggested wording is acute and other chronic inflammatory disease states	Thank you for your comment. We have amended the scope to make this section clearer that we are excluding anaemia caused by acute and chronic inflammatory disease states other than CKD.
Vifor Pharma UK Ltd	6	30	The prevalence of anaemia increases with the progression of kidney disease. However, GFR has no diagnostic role; anaemia is diagnosed by measurement of Hb, regardless of GFR, and continue to monitor for anaemia for eGFR below 60.	Thank you for your comment. The guideline committee will consider the layout and headings in the guideline in relation to the amalgamation of the three guidelines and the updated recommendations. We will keep in mind your suggestion when considering the layout and the headings in the guideline
Vifor Pharma UK Ltd	8		1.1.23 - Add in advice regarding screening for testing for anaemia/iron deficiency. If the haematuria cannot be rectified advise on iron therapy as well as monitoring for anaemia/iron deficiency.	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on haematuria testing. The updated guideline will consider the evidence, for children and young people only, for the following review question: In children and young people with CKD, what is the accuracy of reagent strips for detecting protein and blood in urine? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline.
Vifor Pharma UK Ltd	8		1.1.28 - Add in unexplained anaemia (Hb<12g/dL). Given Anaemia has been associated with an increased risk for	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the

			progression to end-stage kidney disease in patients with CKD add anaemia to the list of risk factors.	surveillance review or scoping searches on who should be tested for CKD. The updated guideline will consider the evidence, for children and young people only, for the following review question: Which children and young people should be tested for CKD? The update of the guideline will follow the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline.
Vifor Pharma UK Ltd	8		1.2.3 - Mention anaemia and iron deficiency as another variable to consider when determining the risk of adverse outcomes.	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on variables to consider when determining the risk of adverse outcomes. Therefore this area will not be included in the update. We will highlight this area to the surveillance team for consideration at the next surveillance review.
Vifor Pharma UK Ltd	8		1.3 - In section 1.3.2, specifically mention in heart failure that frequency of monitoring is both for eGFR as well as potassium levels in reference to RAAS treatment and diuretics	Thank you for your comment. The updated guideline will consider the evidence for the following review questions: For adults, children and young people with CKD, what constitutes a clinically significant decline in eGFR in terms of risk of kidney disease progression?

				For adults, children and young people with CKD what is the optimal monitoring frequency based on different rates of decline in eGFR? This section of the guideline will be updated following the processes and methods described in Developing NICE guidelines: the manual. Evidence reviews will be conducted for each of the review questions described in the scope which will include all published evidence which meet the review protocols developed for the guideline. We will keep in mind the issue you have raised relating to heart failure when developing the guideline.
Vifor Pharma UK Ltd	9		1.3.7 - Add anaemia to list of risk factors. Add COPD since it can lead to cardio-renal syndrome. After cardiovascular disease state especially Chronic Heart Failure; add 'Intercurrent illness and other causes of inflammation'	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on risk factors associated with CKD progression. Therefore this area will not be included in the update.
Vifor Pharma UK Ltd	9		1.4.2 - Secondary hyperparathyroidism can manifest as early as in CKD stage 3, is progressive if untreated and associated with adverse outcomes. The health care provider shall be encouraged to identify the disease early, in CKD3, allowing appropriate treatment interventions. Guidelines also suggest that vitamin D levels might be measured as of CKD stage 3a. This would enable the health care provider to identify trends of rising PTH levels early on, so that therapeutic interventions can ameliorate the progressive nature of secondary hyperparathyroidism.	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on information and education. Therefore this area will not be included in the update. Diagnosing and managing secondary hyperparathyroidism is outside of the remit of this guideline.
Vifor Pharma UK Ltd	9		1.4.7 - Add 'and where appropriate, treatments that can reduce the potassium absorption.'	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on reducing potassium

				absorption. Therefore this area will not be included in the update. We will highlight this area to the surveillance team for consideration at the next surveillance review.
Vifor Pharma UK Ltd	9		1.6.8 – 1.6.10 - Change to 'do not routinely offer a RAAS with CKD if their potassium has yet to be optimised to below 5.0mmol/L'. Mention use of chronic potassium binders in those who require RAAS therapy, such as patients with Chronic Heart Failure	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on choice of anti-hypertensive agent. Therefore, this area will not be included in the update. We will highlight this area to the surveillance team for consideration at the next surveillance review.
Vifor Pharma UK Ltd	9		1.6.11 - Add 'if potassium increases to 6.0mmol/L, maximise use of potassium binders before stopping RAAS antagonists, especially in patients with Chronic Heart Failure'	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on this area. Therefore, this area will not be included in the update. We will highlight this area to the surveillance team for consideration at the next surveillance review.
Vifor Pharma UK Ltd	9		1.7 - Add Hyperkalaemia as a separate heading	Thank you for your comment. The novel potassium binders, Sodium zirconium cyclosilicate and patiromer, both for treating hyperkalaemia, are the subject of NICE technology appraisals currently in development. The updated guideline on the assessment and management of chronic kidney disease will have the opportunity to cross-refer to these technology appraisals as appropriate. The scope has been amended to include the two in development technology appraisals.
Vifor Pharma UK Ltd	9		1.7 - We feel that retaining the existing recommendations would be different to "KDIGO 2017 Clinical Practice Guideline Update	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the

			for the Diagnosis, Evaluation, Prevention, and Treatment of Chronic Kidney Disease–Mineral and Bone Disorder (Chronic Kidney Disease -MBD)", recommending the monitoring of calcium, phosphate, parathyroid hormone, and alkaline phosphatase activity beginning in Chronic Kidney Disease stage 3a. Furthermore, this guideline also suggest that vitamin D levels might be measured as of Chronic Kidney Disease stage 3a. This would enable the health care provider to identify trends of rising parathyroid hormone levels early on, so that therapeutic interventions can ameliorate the progressive nature of secondary hyperparathyroidism and related effects of MBD.	surveillance review or scoping searches on other complications. Therefore, this area will not be included in the update. We will highlight this area to the surveillance team for consideration at the next surveillance review. NICE is aware of the KDIGO guidance and recognises the value of consistent national guidance, where this fits with NICE standard methods.
Vifor Pharma UK Ltd	9		1.7 - It should be considered to adapt the existing recommendation 1.7.6 to restrict the use calcitriol and active vitamin D analogs in the non-dialysis setting to patients with severe and progressive hyperparathyroidism, which would be in line with the latest KDIGO guidelines. Recent evidence suggest against the routine use of active vitamin D (calcitriol) and its analogs (i.e., paricalcitol, doxercalciferol, and alfacalcidol) to lower parathyroid hormone in non-dialysis Chronic Kidney Disease patients, and this has been recently brought forward in the "KDIGO 2017 Clinical Practice Guideline Update for the Diagnosis, Evaluation, Prevention, and Treatment of Chronic Kidney Disease–Mineral and Bone Disorder (Chronic Kidney Disease -MBD)". Although benefits are associated with suppression of secondary hyperparathyroidism, adverse effects of hypercalcemia can be of concern by the use of calcitriol and active vitamin D analogs.	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on the use of active vitamin D. Therefore this area will not be included in the update. We will highlight this area to the surveillance team for consideration at the next surveillance review. NICE is aware of the KDIGO guidance and recognises the value of consistent national guidance, where this fits with NICE standard methods.
Vifor Pharma UK Ltd	9		1.7.8 - Change title to anaemia and iron deficiency	Thank you for your comment. This recommendation will be replaced by the update of the anaemia guideline (NG8).

				NICE acknowledges that iron deficiency is a key treatable form of anaemia, but the guideline considers all forms of anaemia and this is reflected in the wording of the scope.
Vifor Pharma UK Ltd	General	General	Add iron deficiency to anaemia	Thank you for your comment. NICE acknowledges that iron deficiency is a key treatable form of anaemia, but the guideline considers all forms of anaemia and this is reflected in the wording of the scope.
Vifor Pharma UK Ltd	General	General	Based on the 2012 KDIGO guideline of anaemia in CKD, anaemia is defined in males when Hb < 130 g/L and in females when Hb < 120 g/L Lower levels have been used, but this has been thresholds above which ESA therapy has been found to have a poor risk : benefit ratio	Thank you for your comment. No new evidence that would impact on the current guideline was identified in the surveillance review or scoping searches on haemoglobin threshold levels and ESA therapy. Therefore this area will not be included in the update.
Vifor Pharma UK Ltd	General	General	We welcome the patient centred approach of NICE to amalgamate and update existing overlapping guidance into one comprehensive document, which will provide clarity to all relevant stakeholders in the management of Chronic Kidney Disease-Mineral and Bone Disorder. There is a possibility that if the recommendations differ to those in the latest “KDIGO 2017 Clinical Practice Guideline Update for the Diagnosis, Evaluation, Prevention, and Treatment of Chronic Kidney Disease–Mineral and Bone Disorder (Chronic Kidney Disease - MBD)” will cause confusion to healthcare professionals, providers and commissioners and result in detriment to patients.	Thank you for your comment. NICE is aware of the KDIGO guidance and recognises the value of consistent national guidance, where this fits with NICE standard methods.

Chronic kidney disease

Consultation on draft scope
Stakeholder comments table

10/12/2018 – 11/01/2019

Organisation name – Stakeholder or respondent	Number of comments extracted	Comments
Bayer PLC	3	**Current Situation** Bayer does not have direct or indirect links with, or funding from, manufacturers, distributors or sellers of smoking products but Bayer provides pesticides for crops, which would therefore include tobacco crops. Bayer is a member of the Cooperation Centre for Scientific Research Relative to Tobacco (CORESTA) (http://www.coresta.org/) within the scope of recommendations of pesticides used for protection of tobacco plants. It is also a member of country and EU business federations such as the Confederation of British Industry (CBI) and 'Business Europe', which include tobacco companies. **Past Situation** In 2006, Bayer and its subsidiary Icon Genetics piloted a new process for producing biotech drugs in tobacco plants. Icon Genetics was acquired by Nomad Bioscience GmbH from Bayer in 2012