UK Prevalence of Chronic Kidney Disease for the Adult Population Is 6.76% Based on Two Creatinine Readings

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We would like to correct an error in our paper about the UK prevalence of chronic kidney disease (CKD) [1]. We incorrectly made comparisons of the prevalence of CKD with other studies based on the denominator being the whole population rather than just adults.

Although our central thesis that 'relying on a single eGFR reading with no allowance for fluctuation has a greater influence on prevalence than using CKD-EPI instead of MDRD' still applies, we incorrectly compared population prevalence with the prevalence in adults. When we just include adults as the denominator in our estimations of prevalence we inevitably get a higher prevalence, which is much more similar to other studies, notably NEOERICA [2].

The prevalence of CKD in the Quality Improvement in Chronic Kidney Disease (QICKD) trial [3] using two estimates of glomerular filtration rate (eGFR) in the adult population is 6.76% compared with the 5.4% for the whole population we quoted in our paper. However, if we just use the single latest eGFR reading, the

Table 1. The prevalence of CKD for the adult population in the QICKD trial baseline data

MDRD	Female	Male	Population
Stage 3–5 CKD	34,106	16,213	50,319
Population >18	374,567	369,649	744,216
<i>Prevalence taking into account chronicity</i>	9.11	4.39	6.76
Latest eGFR stage 3–5 CKD	39,808	19,839	59,647
Population >18	374,567	369,649	744,216
<i>Prevalence based on latest eGFR</i>	10.63	5.37	8.01
NEOERICA prevalence	10.60%	5.80%	8.50%

MDRD = Modified Diet in Renal Disease.

prevalence rises to 8.0% (table 1) compared with the quoted 6.7% in the population as a whole. The adult QICKD trial prevalence when using a single creatinine reading, at 8.0%, is very close to the prevalence reported in the NEOERICA study and not different as we suggest in the discussion section of our paper. The preva-

lence for females is very similar, and the difference in male prevalence is 0.43%. This reinforces the importance of allowing for chronicity when estimating the prevalence of CKD but displays a similarity rather than a difference between prevalence estimates made on routinely collected UK primary care data.

References

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