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Too Much Medicine: A commentary for nephrologists

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The screening of populations of "apparently" health adults or children for the purpose of early detection of serious, possibly life-limiting diseases (such as cancer, heart or kidney disease) occurring in a pre-symptomatic form has become a very controversial issue in recent years. A widely popular book published by Welch, Schwarz and Woloshin in 2011[1] helped draw attention to the possibility of such screening might have more harm than benefit. The Title of this book, "Overdiagnosis- making people sick in the pursuit of health", puts the issue in sharp focus and resonates with the comments of Dr. Moynihan in the this issue of the *Portuguese Journal of Nephrology and Hypertension*[2].

Our specialty, Nephrology, has been engaged in this controversy, by contributing a growing number of "overdiagnosed" patients as a direct consequence of a diagnosis and classification system that uses two biomarkers, estimated glomerular filtration rate (eGFR) and proteinuria (albuminuria) to identify chronic kidney disease (CKD)[3] and to determine its likely prognosis. Unfortunately, this schema, now globally adopted, is not calibrated for the expected changes in these biomarkers (especially the eGFR component) that accompany normal aging (renal senescence). Thus, many healthy older adults (>65-70 years of age) with reduced eGFR (usually 45-59ml/min/1.73m2, without albuminuria) consequent to the aging process *per se* are given a diagnosis of CKD, when this label may do more harm than good ("overdiagnosed"). While such older subjects may have hypertension, diabetes or cardiovascular disease (recognized or not), an eGFR or 45-59ml/min/1.73m2 in the absence of albuminuria (CKD stage 3B) seems to have little or no impact on subsequent life expectancy. It follows, that such labelling leads to unnecessary fear and anxiety, needless visits to the physician and unnecessary consultations and laboratory and/or imaging tests while offering little in the way of concrete benefits to the recipient of the diagnosis of CKD. Indeed, in 2013 I joined Drs. Moynihan and Doust to in authoring an article designed to bring attention to this form of "overdiagnosis"[4]. "Overdiagnosis" of CKD in older adults is very prevalent and contributes to a misperception concerning a possible "epidemic" of CKD on a global basis. The prevalence of CKD defined by current approaches will only increase as the general population ages and the elderly live longer. Suggestions have been made to modify the CKD diagnostic criteria in an age-sensitive manner, but so far they have been largely ignored[5]. Automated reporting of eGFR values and categorization of CKD by clinical laboratories will only aggravate the situation. Conferences and Journal articles, such as the "*Preventing Overdiagnosis*" meeting in Barcelona in 2016 and the BMJ *Too Much Medicine* series should help to enhance awareness of this situation and perhaps might construct and advocate practical solutions to the problem of "overdiagnosis" of CKD around the globe.

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