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CKD-aP Uncovered Prevalence & Pathophysiology

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Dr. Helou:
This is CE with GLC, and I'm Dr. Nancy Helou. Here with me today is Dr. Steven Fishbane.

We begin by talking about prevalence because chronic kidney disease-associated pruritus, or CKD-aP, is common, chronic, and often underdiagnosed in clinical practice. It should not be viewed simply as dry skin or an expected discomfort of chronic kidney disease. It is a clinically meaningful condition with important consequences for sleep, mood, and quality of life. It is a distressing itch that occurs in non-dialysis CKD, pre-dialysis, and in patients treated with peritoneal dialysis, hemodialysis, or even hemodiafiltration.

The reported prevalence varies across countries and dialysis population, ranging around 30% to 50%. It also depends on how actively and systematically we ask patients. In a recent Swiss study, despite high standards of dialysis and widespread use of hemodiafiltration, 1/4 of patients were still experiencing itching. This reinforces that CKD-aP cannot be explained by dialysis adequacy alone.

So clinically we should not wait for patient to report it. We need to ask, measure, and recognize its burden on sleep, mood, and daily functioning.

Dr. Fishbane:
One of the things that I think has been really interesting is in terms of continuity of therapy and trying to avoid interruptions, pruritus can be something that is chronic, can be something that can be very severe for patients.

And what I found since the initial studies of pharmacologic therapy in actual clinical practice is that patients are often hurt when we discontinue therapy too soon. It doesn't mean the therapy has to be lifelong, but we need to try to understand how the patient is responding to try to follow, in some fashion, whether it's using scales to try to understand the patient's itching or simply speaking to the patient and asking not just about itch but how the patient's quality of life that goes along with itch can be affected.

And in continuing, as part of the care team, to speak about itch, we continue therapy, we understand from the patient. Sometimes some of my patients will use symptom logs to try to keep track of how they're feeling and more objectively tell me. I don't care if the patient just subjectively wants to tell me, "I'm feeling better," "I'm feeling about the same," but we certainly continue to keep an eye.

And one thing, over the years in terms of pruritus, is that it flares, and we have to be ready for those kinds of changes. Is there a

worsening of itch? And in particular, is it affecting things like sleep or quality of life, or do I start to see more scratch marks that the patient may have?

Dr. Helou:
That is exactly the message. So the key takeaway is ask, measure severity, and reassess. CKD-aP is under recognized partly because patients normalize it. They may say, "I've had this. I have had it for years," or they may not mention it because they assume nothing can be done.

For clinicians, the first step is to make the itch visible. Ask about the worst episode, sleep, scratching, skin changes, and mood. Then document the score so the whole team can ensure follow-up over time. And because it is multifactorial, we should think beyond dialysis adequacy. We need skin care, symptom-directed therapy, and patient education.

So CKD-aP is common, chronic, and clinically significant. It deserves the same structured attention we give to other symptoms that affect quality of life.

That's our time. Thank you for listening.

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