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Advanced Chronic Kidney Disease and Secondary Hyperparathyroidism (HPT): Multidisciplinary Management

Narrator: You're listening to ReachMD. The following program Advanced Chronic Kidney Disease and Secondary Hyperparathyroidism (HPT): Multidisciplinary Management is sponsored by Amgen.

Dr. Russell: Welcome I'm your host, Dr. John Russell, and I'm going to be speaking with Drs. James Wetmore from Hennepin County Medical Center in Minneapolis, Michael Germain from Tufts University, registered nurse Barbara Weis Malone from the University of Colorado, and Mike Spigler from the American Kidney Fund. We are currently at the National Kidney Foundation Spring Clinical Meetings in Orlando, where we'll be discussing the multidisciplinary approach to treating a complication of chronic kidney disease called secondary hyperparathyroidism, or secondary HPT.

Dr. Wetmore, can you start by telling us a bit about secondary HPT?

Dr. Wetmore: Secondary hyperparathyroidism is a complex disease process which isn't fully understood but essentially, it's a condition that arises when the kidneys start to fail and the parathyroid gland secretes excessive amounts of parathyroid hormone. This results in many changes to calcium and phosphorus and other markers of mineral metabolism.¹

Dr. Russell: Who is at risk for developing secondary hyperparathyroidism?

Dr. Wetmore: Typically it occurs in very advanced chronic kidney disease and especially in patients whose kidneys have failed.¹

Dr. Russell: Is secondary hyperparathyroidism unique to patients with chronic kidney disease?

Dr. Wetmore: The vast majority of patients who have secondary hyperparathyroidism have chronic kidney disease.

Dr. Russell: Doctor, what are some of the symptoms?

Dr. Wetmore: In the absence of extremely advanced chronic kidney disease, the signs and symptoms often aren't recognized. It's usually only when the disease is extremely advanced that things like bone pain become manifest.² Therefore, the main way to diagnose secondary hyperparathyroidism is through laboratory testing.¹ It's often a silent disease in the early stages as it begins to develop.³

Dr. Russell: When you're saying diagnose it, what tests would you order in your office or clinic to figure this out in a patient?

Dr. Wetmore: The lab tests primarily are to check parathyroid hormone or PTH, calcium, and phosphorus.¹

Dr. Russell: So Dr. Germain, I know vitamin D is often prescribed for chronic kidney disease and secondary hyperparathyroidism,¹ but are there any other treatment options?

Dr. Germain: Well, there's newer medicines in the CKD population, that is in the vitamin D sphere, which is very exciting, that's available and on the market and then there's medicines that are used in the dialysis units.

Dr. Russell: When you're putting people on medicines and changing their regimen, you're monitoring PTH and vitamin D and some of these things along the way, correct?

Dr. Wetmore: That's absolutely correct, especially in patients on dialysis, these markers that we test for, calcium, phosphorus, and parathyroid hormone, and appropriate changes to medications have to be made on a very frequent basis,¹ and because the

management is very complex, the other components of the healthcare system who assist with the treatment, for example nurses, dieticians, also have to be informed about how medications often have to be changed and laboratory values have to be checked vigilantly.¹

Dr. Russell: And certainly, us being on a team is going to make the best outcome for our patients, correct?

Dr. Germain: Absolutely. I think the biggest problems I've seen is when there is a disconnect between the primary care doctor and the nephrologist because they are seeing these people in the context of their general population; they don't realize there are some very specific things going on in the dialysis unit and usually that's easily resolved by just having the conversation and them understanding, you know, what treatments we're doing, so we need to know what they're doing and they need to know what we're doing. We need to be on the same page, absolutely.

Dr. Russell: So doctor, you have patients that have long lists of medicines. How do you educate a patient that it's really important to take care of their secondary hyperparathyroidism?

Dr. Wetmore: Yes, it's certainly the case that when diseases don't have obvious signs and symptoms, they could be more challenging to treat in terms of educating the patient about the importance of the medical issues that confront them. Treatment requires that you educate the patient about the abnormalities, about the importance of downstream consequences, and about how both the patient and the provider have to be extremely vigilant about the evolution of the condition.¹

Dr. Russell: What role does the multidisciplinary team have in secondary hyperparathyroidism?

Dr. Wetmore: As the enterprise providing care for patients with end-stage renal disease has changed over the years, non-physician providers have been increasingly integrated into the patient care plan. We often have physician assistants and nurse practitioners rounding on dialysis patients. We have the nurses, who typically actually administer the medications in the dialysis unit, and so they have to be apprised of any potential changes, and then dieticians have played an increasingly important role in helping coordinate in the care of what we call mineral metabolic disorders, like secondary hyperparathyroidism, in the dialysis unit. The dieticians often manage many of the protocols which invoke the medications that we use to treat secondary hyperparathyroidism. So all these different players have to be fully apprised of the situation and participate in the patient's care.

Dr. Russell: So, Barbara, what are the biggest challenges?

Barbara Malone: I think the hardest part is, again, that silent diseases are the hardest to treat. 50% of the CKD population has diabetes, so that's major and the hypertension; so the silent diseases, they tend to stop those medications sooner.¹

I think it's because there are so many different aspects to it. Our patients, as we all do, don't like to stop anything dietary, and so that's a part of it, and then the integration with the medication and then the integration with exercise and everything else that they need to do to improve their bone health.¹

Dr. Russell: OK, so, Mike, you're helping set up kind of a multidisciplinary care coordination. I can't imagine that's a small job, right, for patients with chronic kidney disease?

Mike Spigler: No, it's not, as I'm sure you know, these patients are really struggling with managing everything that's happening when you're first diagnosed as having kidney failure or chronic kidney disease, there are so many things involved. It is really hard to kind of reach across that whole spectrum of patients.

Dr. Russell: Mike, what are some of the challenges your team encounters?

Mike Spigler: I think it's a lot to do with patients who are just overwhelmed with what they're dealing with, right? You've got about a third of patients that kind of crash into dialysis that had no idea that they had kidney disease. They haven't had time to prepare for what modality they want. They are completely unprepared for the financial burden that they're about to encounter. Many patients can't work. You know, they are going to the dialysis center three or four times a week for many hours. The amount of medications that they're being hit with, the amount of doctor appointments they are dealing with.¹ You know, you've got endocrinologists, you've got cardiologists, nephrologists –

Dr. Russell: Who all might not talk to each other, correct?

Mike Spigler: Correct. I mean, we actually did a survey of our patients. We found one of the main reasons why patients are ending dialysis sessions early is because they had another doctor's appointment to go to, which just seems crazy. It's really hard to manage.

Dr. Russell: So, in the space of chronic kidney disease, now we're adding this other kind of large, important disease and

secondary hyperparathyroidism, so how is this played out for some of your patients?

Mike Spigler: That's a big challenge for a lot of our patients. Again, there are so many medications they are dealing with. There are so many other comorbidities they are dealing with, with high blood pressure and diabetes, sHPT isn't always top of mind for them, it is difficult to make them really keep that top of mind and manage that among all the other things they are dealing with. I mean, they likely already had diabetes or high blood pressure going into this there's a million other things that they're dealing with, so this is just one more piece, and it's not a very easy thing to communicate to patients, I mean this is a very complicated mechanism that's happening in your body.

Dr. Russell: Dr. Wetmore, what do you think are the biggest challenges for managing secondary HPT?

Dr. Wetmore: For providers, there are several challenges. First of all, patients with advanced chronic kidney disease and especially patients on dialysis have many different medical issues that need to be addressed,² and so it's important in secondary hyperparathyroidism not be lost in the sea of medical concerns that are ongoing at any given time and then being vigilant is always an issue. Checking labs on a frequent basis and understanding how it's often the case that multiple laboratory abnormalities occur simultaneously and so the treatment has to be tailored on an ongoing basis. Tailoring treatment means that medications often have to change.¹ That's difficult for patients, especially ones with high medication burdens like those with chronic kidney disease and end-stage renal disease, and then, as I say, the other members of the healthcare team such as nurses and dietitians, have to be in sync with the treating physician or the nurse practitioner when changes to medications are being considered.¹

Dr. Russell: Dr. Germain?

Dr. Germain: I think the biggest challenge is identifying it early² because it's a disease that takes a long, long time to do its damage I think a multidisciplinary team in the nephrology practice has a lot to offer these people and my own belief in the way we practice is that we can do a much better job for our patients by seeing them earlier. We can prepare them for options of dialysis, kidney transplant.²

Dr. Russell: So Barbara, you're seeing some patients who have had that diagnosis from a primary care physician who are sending patients on for specialty care early and then you have some patients who are caught later in the game and whose disease is not well managed. How do you reconcile this discrepancy?

Barbara Malone: I've been in primary care for 22 years and so I've been there with you, and I know that you're looking at labs and each laboratory test that you're doing you can't study each one. It's tough, and at that point, all of these complications are coming in. The bone is something that is often left behind in terms of –

Dr. Russell: We forget that.

Barbara Malone: Exactly, and it's not in any way in terms of your expertise; it's my expertise, and so that's what I do, and so when they come to me with PTHs of 250 and you never know for sure you're not going to know who's going to be high, who's going to be low, how to treat, how to balance that out, which medications for which – it's extremely difficult.

Dr. Russell: So, Mike, how would you advise your team to talk to patients about secondary hyperparathyroidism?

Mike Spigler: I think you should absolutely attempt to try to describe what it is, but even just saying secondary hyperparathyroidism is a challenge. I'm surprised I even got it out just now. So, to try to explain that to a patient and the mechanism can sometimes be difficult. I think it's something that you should try to do, but really it's talking about the clinical consequences of unmanaged sHPT.

Dr. Russell: So Barbara, what would be your advice to patients be about really being that advocate for themselves and dealing with a very serious disease at the same time?

Barbara Malone: Well, I advocate to my patients that we as nephrology providers, we have a lot of things going on as well, and so sometimes we don't always address everything at every visit like we should. I try to tell patients that bones are important. We think about them but, you know, there's specialists and there's this and that, and so they need to advocate and continue to ask, How am I doing? Should I be doing something else? How much exercise should I be doing? What other ways can I – what else can I do to prevent this?"

Dr. Russell: Thanks so much, Barbara, and thanks to our panel for joining us to talk about secondary hyperparathyroidism. It was wonderful to hear all of your insights and I think it is evident that the successful management of this disease requires a multidisciplinary, team approach. To all of our listeners, thanks for tuning in.

Narrator: You've been listening to ReachMD. This program was sponsored by Amgen. If you have missed any part of this discussion, visit ReachMD.com/secondaryHPT. Thank you.

References

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