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editor's note

We hope you enjoy our third issue of AANPA News. We have included several clinical updates for your review. In addition, we have the minutes from the last AANPA meeting and information about the CME AANPA cruise scheduled for summer 2008. This is the first ever AANPA CME cruise and we hope to have these often. The cruise looks like it will be a lot of fun for all PAs and with the added bonus of CME hours, a great educational opportunity. Remember, families and nurse practitioners in nephrology are also invited. Make plans for the coming summer early before the cruise fills up!

Again, we ask for your contributions to AANPA News. Please e-mail any information, clinical reviews, or suggestions to aanpanews@sbcglobal.net.

The next newsletter is scheduled for the end of December.

Respectfully yours,

Peter Juergensen, PA-C

Marilyn Olsen, PA-C, MHS

Laura Troidle, PA-C

Christa Hodges, PA-C

Anemia Management with ESA – FDA Advisory Board Recommendation

The Food and Drug Administration advisory group met on September 11, 2007 to decide on the issue involving the use of erythropoietin stimulating agents (ESAs). This review was prompted by the data from the CREATE and CHOIR studies, the concern of overuse of ESAs in for-profit dialysis units, and the passage in the House of a bill to deter the excessive use of ESAs by changing the provider reimbursement rates.

In March, the FDA changed the labels stating that ESAs should be used as sparingly as possible and not to exceed hemoglobin (Hb) of 12.0 g/dL. The advisory group, in two 14 to 5 votes, rejected the FDA proposal to set the upper Hb limit at 11.0 g/dL in chronic kidney disease (CKD) and end-stage renal disease (ESRD) patients. The panels recommended an upper Hb limit of 12.0 g/dL in both CKD and ESRD.

The FDA is also planning to remove label claims that ESAs improve patient quality of life since they feel data for such are inadequate. The chairman of the advisory board, Dr. Richard Platt, bemoaned the fact that there are insufficient data after 18 years of ESA use and suggested that more clinical trials should be conducted to help us understand how to use ESAs effectively in the future.

It will be interesting to see what the final decision will be from the FDA in the next few weeks. *AANPA News* will keep you posted.

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Hypertension: The Use of Ambulatory and Home BP Monitoring

Blood pressure (BP) readings in the office or clinic can have limitations due to “white coat” hypertension (HTN). Ambulatory blood pressure readings can identify patients with white coat HTN when BP readings are normal at home but elevated in the office. Studies have documented that white coat HTN patients tend to have less target organ injury compared to patients with documented HTN. The converse is also true; patients with normal BP readings in the office may have elevated BP in the ambulatory setting, and they have similar outcomes to patients with documented sustained HTN.

Dolan et al in *Hypertension* (July 2005) noted two very important findings in the Dublin Outcome study: ambulatory BP readings are superior to measurements

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Just a Few Questions: Erythropoietin Stimulating Agent Survey

Recent studies have suggested that use of the erythropoietin stimulating agents (ESAs), erythropoietin and darbepoetin, used to treat anemia in both CKD and ESRD patients may require alternative dosing strategies (Singh et al, *N Engl J Med.* 2006;355:2085-2098; Druke et al, *N Engl J Med.* 2006;355:2071-2084). We wonder if your practice patterns have changed as a result. We ask that you complete the following questionnaire *anonymously*. Copy and paste the survey as a word document, print and complete it. Please mail your completed survey to: Laura Troidle, PA, Metabolism Associates, 136 Sherman Ave, New Haven, CT 06511.

1. What was your goal hemoglobin prior to the publication of the recent studies?
2. What is your current goal hemoglobin?
3. Have you made changes to the ESA protocol in your CKD population?
4. Have you made changes to the ESA protocol in your ESRD population?
5. Have you changed the type of ESA used (ie, from darbepoetin to erythropoietin, a change in brand, etc)?
6. Describe the specific changes your clinic has made to the ESA protocol you currently use. Specify if it is a CKD or ESRD population.
7. Has your use of iron increased, decreased, or remained stable as a result of a modified ESA protocol?
8. Have patients asked you specific questions regarding the use of ESA for anemia?
9. Has your practice been the subject of a lawsuit regarding the use of an ESA? (Optional question, you do not have to answer; your response is anonymous, however.)
10. Feel free to provide any additional comments regarding the use of ESAs in your practice.

We look forward to hearing from you and promise to share the results with you in a later issue.

Hypertension: The Use of Ambulatory and Home BP Monitoring (cont'd)

obtained in a clinic to predict cardiovascular mortality, and nighttime blood pressure readings are the most powerful predictors of clinical outcome. The nighttime readings are important to determine which patients are the “dippers vs non-dippers” since non-dippers have a higher risk of stroke. The use of a 24-hour ambulatory BP cuff gives valuable information, but for some reason is not routinely used to document the presence or absence of sustained HTN or to diagnose nocturnal dipping.

A recent paper by ES Ommen et al in *Clinical Journal of the American Society of Nephrology* (September 2007) noted that ambulatory BP readings were very useful in identifying potential living kidney donors. Patients with sustained HTN are excluded from being donors; thus it is very important that the presence or absence of HTN be clearly documented. In their study of the 63 patients with HTN by clinic BP, 62% had white coat HTN by ambulatory BP. Of interest, of the 115 patients with normotensive clinic BP, 17% were hypertensive by ambulatory BP. Another fact to consider: patients who normally would have been excluded as potential kidney donors by clinic readings may actually be considered acceptable by 24-hour ambulatory readings.

These studies and other recent reports again stress the point that it is important to treat HTN to prevent organ damage, but the diagnosis has to be correct. Home BP monitoring with automatic BP cuffs with memory chips has also been successful in helping with BP management, especially for those patients with white coat HTN as well as to help monitor those patients started on medication. As nephrology PAs, it is important that we obtain home BP readings in our office patients to clearly document the presence or absence of HTN. In addition, monitoring blood pressure at home can be a powerful educational and compliance tool for patients.

References:

1. Dolan E, et al. Superiority of ambulatory over clinic blood pressure measurements in predicting mortality: the Dublin Outcome Study. *Hypertension.* 2005;46:156-161.
2. Ommen ES, et al. Routine use of ambulatory blood pressure monitoring in potential living kidney donors. *Clin J Am Soc Nephrol.* 2007;2:1030-1036.

Vitamin D: Its Importance for Overall Health

Recent in-depth reports have noted the importance of adequate vitamin D repletion to decrease mortality rates. A recent review by Dr. Michael Holick in the *New England Journal of Medicine* (July 2007) noted that vitamin D controls over 200 gene functions “responsible for the regulation of cellular proliferation, differentiation, apoptosis and angiogenesis.” He notes in his review that low levels of activated vitamin D (25-hydroxy-vitamin D of <20 ng/mL) may increase cancer risk for breast, colon, and prostate by 30%-50%. Osteoporosis and the risk of hip and nonvertebral fracture in elderly women have been reported to decrease by 32%-43% with calcium and vitamin D repletion (800 IU D₃/d). The use of vitamin D therapy decreases the risk of Type 1 diabetes, and the lack of adequate vitamin D levels was associated with reduced insulin secretion and insulin resistance. Low vitamin D levels are also associated with depression and schizophrenia, and repletion with vitamin D improved lung function in children. Vitamin D levels are estimated to be low in 1 billion people worldwide; 40%-100% of elderly Americans and 42% of young black girls and women in the USA were quite low with levels of <20 ng/mL. Dr. Holick recommends 800-1000 IU of D₃/day or 3000 IU of D₂/day in adults over the age of 50 years. The target is a serum 25OH-vitamin D level of at least 30 ng/mL.

A second review in the *Archives of Internal Medicine* (June 2007) reported on data from the Third National Health and Nutrition Examination Survey suggesting that lower levels of 25OH-vitamin D were associated with increased cardiovascular risk factors. A more recent meta-analysis of 18 studies reported in the *Archives of Internal Medicine* (September 2007) found that people who were supplemented with vitamin D were 7% less likely to die from any cause compared to people who took no vitamin D. A study by Wolf et al in *Kidney International* (August 2007) demonstrated that vitamin D deficiency is common and associated with increased mortality among incident hemodialysis patients.

[Perhaps, by improving adequate vitamin D substrate for the many genes that require vitamin D, we can improve the outcome of all of our patients.](#)

These recent papers suggest that low levels of 25OH-vitamin D (<30 ng/mL) are associated with an increased risk for a variety of medical problems (fracture, cardiovascular, immune, cancer) and increased risk of death in ESRD patients. The question as to whether replacement of vitamin D is of any benefit may have been answered in the meta-analysis

review reported in the September *Archives of Internal Medicine*. Perhaps, by improving adequate vitamin D substrate for the many genes that require vitamin D, we can improve the outcome of all of our patients. In our practice, we check 25OH-vitamin D levels in all our patients and replace with vitamin D₃ to attain target levels over 30 ng/mL.

References:

1. Holick FM. Vitamin D deficiency. *N Engl J Med.* 2007;357:266-281.
2. Martins D, et al. Prevalence of cardiovascular risk factors and the serum levels of 25-hydroxyvitamin D in the United States. Data from the Third National Health and Nutrition Examination Survey. *Arch Intern Med.* 2007;167:1159-1165.
3. Autier P, Gandini S. Vitamin D supplementation and total mortality: a meta-analysis of randomized controlled trials. *Arch Intern Med.* 2007;167:1730-1737.
4. Wolf M, et al. Vitamin D levels and early mortality among incident hemodialysis patients. *Kidney Int* online Aug 2007:1-10.



Sail Away on the Kidney Cruise

Reserve your space now for the 2008 Nephrology Kidney Cruise to the Bahamas, St. Thomas, and St. Maarten. The August 24-31, 2008 cruise has been approved for 24 hours of clinical Category I CME credit by the Physician Assistant Review Panel. The 8-day cruise includes three days of educational programs provided by the American Academy of Nephrology Physician Assistants while the ship is at sea.

For more information call Debbie Sons at 888-545-0044 or e-mail dsons@columbus.rr.com or CKD@swmail.sw.org.

Upcoming Meetings

2007

October 31-
November 5, 2007

Renal Week 2007
San Francisco, CA
www.asn-online.org

2008

January 15-17, 2008

10th International Conference on Dialysis:
Advances in CKD
Grand Coral Beach, Cancun, Mexico
<http://www.renalresearch.com/html/conferences.htm>

March 2-4, 2008

28th Annual Dialysis Conference
Rosen Shingle Creek Resort
Orlando, FL
www.muhealth.org/~dialysis

April 2-6, 2008

National Kidney Foundation
Dallas, TX
www.kidney.org

May 14-17, 2008

American Society of Hypertension
New Orleans, LA
www.ash-us.org

May 24-29, 2008

American Association of Physician Assistants
San Antonio, TX
www.aapa.org

May 30-June 4, 2008

American Transplant Congress
Toronto, Canada
www.a-s-t.org

Nephrology Jobs: Kidney Transplant Team

There are many different jobs for PAs within the field of nephrology and we thought it would be interesting to ask PAs who work in certain nephrology jobs to discuss their experiences. In this first segment of Nephrology Jobs, Rebecca Gordon, PA-C, reports her experiences working with a transplant team.

When I joined a kidney transplant team 6 months ago, I was unaware just how vital the physician assistant can be to the success of a transplant center. At California Pacific Medical Center (CPMC), approximately 250 kidney transplants are performed annually. The core of the CPMC kidney transplant team consists of three transplant surgeons, five transplant nephrologists, and three physician assistants. The role of a PA on this kidney transplant team is integral to the efficiency of the team and excellence of patient care.

The PA may assume a variety of roles in the transplant setting. Physician assistants on the CPMC kidney transplant team rotate shifts, working either in inpatient medicine or surgery; two PAs are present at all times during the week, one covering each side of the service. Depending on the needs of the team, the PAs work with each other, the hospital staff, and physicians to fill in wherever needed, adapting to the unique issues of

each day. For example, the medicine PA on occasion may break away from morning rounds to assist the surgeon and surgical PA with a living-donor transplant. The PA may be needed to assist on the back-table preparation of the organ while the laparoscopic nephrectomy is completed. Likewise, if no surgeries are scheduled on a given day, the surgical PA shares the workload of the inpatient service: pre-rounding, following up on studies, and dictating discharge summaries. The PA's skill set allows flexibility and maximal efficiency on any team, but is particularly well suited to a transplant team.

One clear benefit to having a PA run the transplant center, rather than a resident, is continuity of patient care. Physician assistants were introduced to the transplant service at CPMC over 15 years ago to satisfy this desire for improved continuity of care. Kidney transplant recipients who return for evaluation of elevated creatinine levels, infections, rejection, or other posttransplant complications are always familiar to at least one of the PAs on service. The patients are also comforted by seeing familiar faces during their admission or at the outpatient PA wound clinic.

Mrs. W., a kidney transplant recipient who recently was readmitted says, "I like seeing PAs when I have to come into the

hospital. They spend more time with the patients than the doctors, and they provide good continuity of care because the PAs follow me for several consecutive days when I am here."

Physician assistants have also been important to the success of research within the kidney transplant department. They help identify potential study participants, improve protocol adherence, and communicate with posttransplant coordinators to identify study participants, which has made it possible for many patients to play a part in the development of new drugs and drug regimens. In addition, PAs are encouraged to raise clinical questions of their own as well as participate in data collection for studies that others have initiated. Currently at CPMC, PAs will lead a study involving a retrospective analysis of the complications of the single "U"-stitch technique in ureter-bladder anastomoses after this technique was identified as a significant factor in urinary complications by Englesbe et al in the July 2007 *American Journal of Transplantation*.

I am proud to be a part of the kidney transplant team at CPMC. The PAs are integral to the efficiency of the team, improve the continuity of patient care, and are a key component to the success of the transplant center as a whole.

American Academy of Nephrology Physician Assistants (AANPA) 2007 Annual Meeting Minutes

I. Call to order

Peter Juergensen, president, called to order the annual meeting of the AANPA at 3:00 on Tuesday, May 29, 2007 in Room 413 at the Marriott Hotel, Philadelphia.

II. Roll call

The following AANPA Board members were present: Peter Juergensen, president; Molly Lenahan, treasurer; Marilyn Olsen, secretary; Kim Zuber, liaison and membership chair; Laurie Ellen Benton, CME chair; Garrett Smith, reimbursement chair. (Karen Burchell, vice president and Katey Wilson, student representative were not present.)

Various members of AANPA were also present.

Guests of AANPA included:

1. Charles J. Dushman of OMRON Healthcare, Inc. who made a brief presentation on OMRON products and gave some samples of blood pressure monitoring equipment.
2. Nikki Curtis and Todd Greco of Genzyme were thanked for sponsoring the meeting and an informal discussion ensued about new products on the horizon as well as resources available from Genzyme for patient education, grants for professional projects, and other resources for practitioners.
3. Representatives from the American Kidney Fund.

III. President's Report

Peter Juergensen gave a brief overview of the events of 2006/2007 including the following:

1. Thanks to Laurie Benton for the educational CD provided to new members.
2. Current member census is about 262, which likely includes both students and PAs who have changed specialties but continue to be on the AANPA rolls.
3. AANPA newsletter sponsored by Watson Pharma, Inc. and provided quarterly. The importance of this publication was stressed as a measurable device for recognition of the organization as well as dissemination of information important to the members.

4. Thanks to Kim Zuber for her continued efforts as liaison with respect to other organizations, such as RPA (Renal Physician's Association) and ASN (American Society of Nephrology).

IV. Update on Specialty Recognition and NCCPA

Marilyn Olsen presented information regarding the meeting in Atlanta with NCCPA attended by many PA specialty organizations to discuss the possibility of some sort of recognition for advanced experience and study in a specialty. It was stressed that NCCPA still maintains that generality is paramount to the ability of PAs to be employed in different areas of clinical practice, both throughout the career cycle as well as concurrently. The certification process will remain primary care focused, and NCCPA does not intend to provide testing or "certification" in specialties but recognition only. Pediatrics and OB-GYN were the only specialty groups opposed to any such recognition. NCCPA published a list of consensus points in their November newsletter and presented this to the AAPA HOD at this meeting (see attached). The February 28, 2007, *AAPA News* article on Dermatology PAs (page 3) was also discussed, as this group is now instituting a "diplomate" status for PAs in dermatology who have completed a course provided by the University of Texas Southwestern, worked for a board-certified dermatologist for at least a year, and are fellow members of the Society of Dermatology PAs.

A conference call with NCCPA will be scheduled in the near future attended by Peter, Marilyn, Kim, and Laurie to discuss AANPA's current and future plans for CME and what, if anything, NCCPA can do to facilitate this process. Molly Lenahan gave a brief overview of NCCPA presentation at the AAPA meeting and stressed again that testing is not planned, but the Commission is available for logging of procedures or hours of experience or other means of objective proof of advanced study or experience.

V. CME Update

Laurie Benton discussed the ongoing plans for an AANPA-sponsored online course for both basic and advanced nephrology training. The course currently contains 10 units and the plan is to keep both operating costs and costs to users as low as possible. The course will be overseen by an award-winning educational

center and will be available to all who wish to take it (including advanced practice nurses or MDs/nephrology fellows). Laurie was recently contacted by the ISN (International Society of Nephrology) which is interested in the program as a possible adjunct for training international nephrologists as well.

Peter Juergensen made the point that AANPA must be careful to keep control of our own product but that interfacing with international organizations is also desirable to improve recognition of PAs worldwide. RPA and NKF may be interested in co-sponsoring this program, but this may not be in our best interests due to state by state requirements.

Laurie then discussed the strides that have been made into the NKF with respect to how PAs are recognized and what sort of CME is provided to PAs. Prior to this session, PAs were lumped with nurses and did not have a “checkbox” on the registration forms. Laurie is now co-chair with Barbara Weiss, RN, NP on the Executive Council for NPs and PAs to design CME in the future for the Spring Clinical Meetings. Their plan is to provide a day-long separate track for PAs and NPs containing CME that is appropriate for our level of expertise and to be able to efficiently log these hours with our respective organizations. Kim Zuber stressed that NKF was unaware of PA attendance at these meetings because they did not provide a space for PAs to check on the registration forms. Now that PA attendance can be tracked, attendance doubled from 2006 to 2007.

Laurie Benton put out a call for topics and speakers to present both at the NKF meeting next year as well as the AAPA annual conference. NKF is interested in a PA-oriented procedure workshop for 2008. General topics are helpful for inclusion so that the session covers more than one specialty (ie, “flank pain” is more likely to be used by AAPA vs. “kidney stones” which is more nephrology-specific). Topics can be suggested via the AAPA website at the following address:

<http://www.formsite.com/aapa/form464408037/index.html>.

Laurie and Kim ask that any submissions be copied to them via e-mail for tracking purposes.

Next, the discussion moved to an upcoming AANPA-sponsored CME opportunity on a cruise ship. The cruise is scheduled for August 2008; it will be 5 days long and includes Ocho Rios and the Cayman Islands as ports of call. Ticket prices start at \$445 per person for an inside cabin and the CME add-on will be approxi-

mately \$100 and will be provided on the “at sea” days (ie, no stops at port). A total of between 10 and 16 hours of CME will be provided. There is no cost to AANPA to have conference rooms made available, and AV equipment is also provided for speakers free of charge. Each CME registration will provide approximately \$50 in revenue to AANPA. Programs will be available to all nephrology professionals including PAs, NPs, other nurses, techs, dietitians, social workers, etc, but will be at the level of PA education. There will be approximately 180 seats available for CME registration. There is no deposit required to reserve the ship for this purpose. Family members will be welcome on the cruise but not at the CME presentations.

Motion: made by Laurie Benton to move forward with the above cruise so that the ship and facilities are reserved for AANPA use in August 2008. The motion was seconded by Marilyn Olsen. There was no discussion and the motion was unanimously carried.

VI. Treasurer’s Report

Submitted by Molly Lenahan and approved by the AANPA Board of Directors:

a) Beginning balance	\$11,479.56
b) Dues receipts	\$520.00
c) Grant from Watson Pharma	\$14,500.00
d) Check #1011 to Amy White, AANPA Webmaster	\$300.00
e) Check #1012 to Kim Zuber to cover mailing expenses	\$937.12
f) Check #1013 to Marilyn Olsen for certificate expenses	\$141.88
g) Check #1014 to USPS for postage	\$82.05
h) Check #1015 to Sciris for newsletter	\$14,500.00
i) Check #1016 to Kim Zuber for misc. expenses	\$51.38
j) Fee for new checks	\$5.00
k) Ending balance	<u>\$10,508.46</u>
l) Goal continues to be to keep a \$10,000 - \$15,000 balance. Greater than \$15,000 will change the tax status of the organization.	

Motion: made by Marilyn Olsen to create a fiscal year of June 1 to May 31. The motion was seconded by Garrett Smith.

AANPA 2007 Annual Meeting Minutes (cont'd)

There was no discussion and the motion was unanimously carried. Molly then pointed out that in the reaccreditation process undertaken last year that a mission statement is required by our by-laws and does not yet exist. The board of directors will put this on the agenda as an action item for the 2007-2008 year.

VII. Open issues

- a) **Election of new AANPA Board of Directors.** Peter Juergensen was reelected for another 2-year term as president. Vice President: Karen Burchell was reelected for another term. Treasurer: Molly Lenahan was reelected for another term. Secretary: Marilyn Olsen was reelected for another term. Student Representative: Adriana Sikyta. Membership Chair: Christa Hodges. CME Chair: Laurie Benton was reappointed for another term. Reimbursement Chair: Garrett Smith was reappointed for another term. Liaison: Kim Zuber has again agreed to another 2-year term as the AANPA liaison.
- b) There was discussion about including a new board position in the form of "President Elect" to provide for mentoring of the new candidate for one year before taking over as President. This was tabled until the next annual meeting in favor of creating a mission statement and further focusing of the intent of the organization.
- c) Discussion to resubmit online membership survey through the AAPA.
- d) Discussion to change annual certificate printing to only sending certificates to new members. The cost is high.
- e) Molly Lenahan made mention of an available grant of \$2,500 (not given out this year due to no applicants) for constituent organization use. The discussion centered on application for our online CME program. The contact name is Sue Curtis.
- f) Ed Sorace of AAPA requests a copy of the minutes of this meeting for publication in his quarterly newsletter for all constituent organizations.
- g) Representatives from the American Kidney Fund (AKF) spoke about current and upcoming CME opportunities regarding CKD and handed out information packets to attending members who were unable to attend the presentation at this conference. PAs are now invited to two regional conferences; more information including dates and agendas

can be found at the following web address: http://www.kidneyfund.org/fpr_regional_con.asp. The first conference will be held on August 9, 2007 in Atlanta, GA. Deadline for early registration is July 30, 2007. Request was made for members to be placed on the AKF mailing list for a newsletter distributed to more than 18,000 nephrology professionals, including dialysis units, social workers, dietitians and others. They offered to promote the upcoming cruise in the newsletter. The AKF is also planning to place their CKD CME offerings as Category I via their website (see above). It was clear that AKF is interested in partnering with PAs in all aspects of patient care and professional issues. Kim Zuber commended the AKF for their continued support of the "kidney quilts" project.

VIII. Action Items

- a) Create a mission statement for the organization to complete requirements for reaccreditation.
- b) Follow up with NCCPA regarding specialty recognition and the online CME program being devised by AANPA.
- c) Update membership survey and resubmit for use by December, 2007.
- d) Apply to Sue Curtis for constituent organization grant of \$2,500 to further work on our online CME program.
- e) Provide copy to the AKF regarding the planned cruise in August, 2008.

IX. Adjournment

Peter Juergensen, AANPA President, adjourned the meeting at 6:30 pm.

Minutes submitted by: Marilyn Olsen, PA-C, MHS, AANPA Secretary.

X. Addendum

The AANPA Board of Directors adopted the following Mission Statement via online vote:

The mission of the American Academy of Nephrology Physician Assistants is to provide excellence in patient care among kidney patients and to promote the use of PAs in nephrology by education, professional development, and advocacy within the medical community.