Minutes of the Phosphate Management Scoping Workshop

27th July 2011, Derwent | MidCity Place | 71 High Holborn | London WC1V 6NA

Questions on the draft scope

A. Is the population correct and are there any other sub groups

B. Are the healthcare settings correct?

C. Are the key clinical issues covered correctly?

D. Are these the main outcomes?

E. Is the health economic question correct?

Feedback from group 1

1. Population

Group suggested removing 'at risk of hyperphosphatemia' as all patients in this group would have this.

Group highlighted equality issues and noted that vitamin D deficiency occurs differently in certain ethnicities.

2. Clinical Management

Include calcium acetate to list of phosphate binders in section 4.3.1 a

Group noted issues around adherence to phosphate binder medication and the increased risk of depression in these patients.

Group discussed inadequate access to dialysis being a factor in not properly managing phosphate levels. Although the stakeholders at the workshop acknowledge this it was felt to be outside the remit.

Group felt that 4.3.1 b was not essential to the remit of the guideline and it would be ok to remove.

The group noted that when using phosphate binders clinicians need to manage vitamin D and calcium intake so these need to be considered even if we do not cover if full.

3. Outcomes
4.4 c needs to change to ‘effect of calcium levels’

4. **Health Economic Question**

The group agreed with the proposed economic questions

5. **GDG Constituency**

The group noted the following in addition to the GDG constituency:

- 2 dieticians
- Psychologist
- Pharmacist
- GP

**Feedback from group 2**

6. **Guideline title**

This was felt to lack clarity. Suggested ‘management of hypo and hyperphosphataemia in dialysis’ or ‘phosphate management for CKD’

7. **Current practice**

Standard management is done in the following sequence: Diet alone, diet + phosphate binders, diet + higher doses of phosphate binders + calcimimetics

8. **Population**
CVD is biggest killer of CKD patients, and phosphate is the biggest risk. Therefore the management of phosphate starts pre-dialysis and treatment decisions are made before the scope of this guideline begins.

Remove ‘age’ from the sentence ‘consideration will be given to age appropriate subgroups’.

Should consider dosing ages, and outcomes based on dose.

Should consider prior therapy subgroups (e.g. those not on phosphate binders prior to dialysis). This will be useful for addressing treatment sequencing.

If the guideline is addressing hyperphosphataemia it is illogical to exclude tertiary hyperparathyroidism. If the title changes then this exclusion would be justified.

9. Clinical management

Calcium as a single item is missing from the list of phosphate binders

Magnesium/calcium carbonate combinations have patient related issues as they cannot be taken with other medications.

To exclude calcimimetics (cinacalcet) from the guideline would not be appropriate. There is a clinical movement towards using more calcimimetics and less phosphate binders.

If guideline development is put on hold until the TA117 update, then why not have a phosphate management guideline for all of CKD. This reflects the patient and clinical reality, as only a small proportion of patients would require the use of calcimimetics.

If the guideline addresses both hypo and hyperphosphateaimia, then the term ‘dietary restriction’ should be replaced with ‘dietary management’.

10. GDG composition
In addition to the proposed line up the following were recommended:

paediatric dietician in addition to an adult dietician

Biochemist

Don't need a paediatric specialist nurse