

Decision tree

Figure 1a shows our decision tree comparing a do-nothing scenario with a screening scenario. After the decision node, participants under the do-nothing scenario follow the Markov model shown in Fig. 1b. For those under the screening scenario, three types of screening test are considered: (a) dipstick test to check proteinuria only, (b) serum Cr assay only and (c) dipstick test and serum Cr assay. Other tests such as microalbuminuria and cystatin C [14] are not considered, because they are not available options in the context of this study.

Screened participants are portioned between CKD patients who undergo treatment and those who are left untreated through three chance nodes. The first chance node divides the participants between those who require further examination and those left untreated. Participants with (a) dipstick test only,  $\geq 1+$ ; with (b) serum Cr assay only,  $\geq$ stage 3; and with (c) dipstick test and serum Cr assay, either  $\geq 1+$  or  $\geq$ stage 3, are screened as requiring further examination. Those screened as requiring no further examination follow the Markov model. These are implemented by initial renal function stratum.

The second chance node divides participants screened as requiring further examination into those who seek detailed examination at health care providers and those who avoid any further examination. Its probability is assumed at 40.0% based on the literature [15, 16] and of the opinion of an expert committee set up for the purpose of this study, whose members are acknowledged in the “Acknowledgements” section. Those who avoid further examination follow the Markov model.

The third chance node divides participants who underwent further examination into those who undergo treatment

of CKD and those left untreated. We derived these probabilities by initial renal function stratum with a Delphi survey of the expert committee. Regarding the strata of stage 3 CKD, a cut-off value of eGFR ( $50 \text{ ml/min/1.73 m}^2$ ) and comorbidity such as hypertension, diabetes and/or hyperlipidaemia are considered in order to depict the difference in clinical practice when recommending start of treatment [17]. We label early stage 3 CKD and advanced stage 3 CKD according to this criterion. Among stage 3 CKD patients, the probability of falling into advanced stage 3 CKD by either eGFR  $< 50 \text{ ml/min/1.73 m}^2$  or having comorbidity is 83.5%, calculated from the Japan Tokutei-Kenshin CKD Cohort 2008. Each value is shown in Table 1. All participants follow the Markov model after their completion of detailed examination.

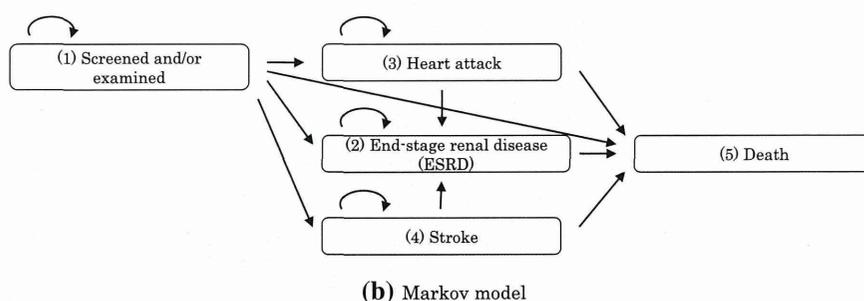
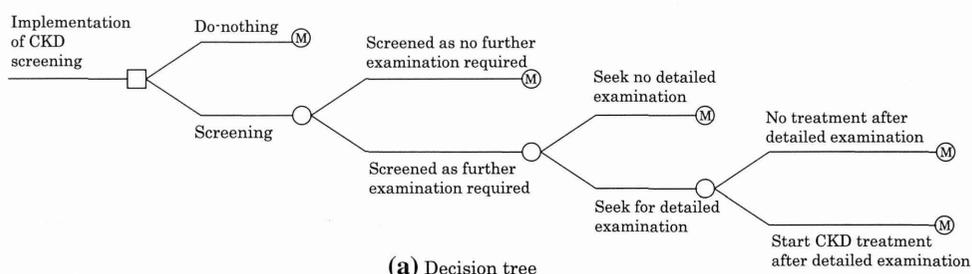
Markov model

The Markov model consists of five health states: (1) screened and/or examined, (2) ESRD, (3) heart attack, (4) stroke and (5) death. Transitions between these states are indicated by arrows. Although individuals follow various courses other than these five health states and indicated transitions, we model in this way based on available data and literature.

We set the span of staying in each state of the Markov model at 1 year. Annual transition probabilities from (1) screened and/or examined to (2) ESRD with no treatment by the initial renal function stratum are calculated from our database of screened cohort in Okinawa Prefecture [18] for this study, since there is no operational predictive model for progression of CKD to ESRD such as Tangri et al. [19] in Japan. Each value is shown in Table 1. Reductions of these transition probabilities brought about by treatment of CKD

Fig. 1 Economic model.

(M): Markov model



are set at 42.1% based on Omae et al. [20], who investigated the effectiveness of angiotensin-converting enzyme inhibitor in improving renal prognosis. This is a unique Japanese evidence of treatment effectiveness evaluating progression to ESRD which can be compared with our Okinawa cohort [18]. The subsequent transition probabilities to (5) death are calculated from the life expectancy of dialysis starters according to a complete count report of Japanese patients on dialysis [21] by sex and age. Each value is shown in Table 1.

Transition probabilities from (1) screened and/or examined to (3) heart attack with no treatment are adopted from an epidemiological study in Okinawa by Kimura et al. [22] by initial dipstick test result, age and sex. Each value is shown in Table 1. Reductions of these transition probabilities brought about by treatment of CKD are set at 71.0% based on the Hisayama study by Arima et al. [23]. The subsequent transition probabilities to (5) death are adopted from Kimura et al. [22] by age and sex for the first year, and from Fukiyama et al. [24] for the second year and thereafter. Each value is shown in Table 1.

Transition probabilities from (1) screened and/or examined to (4) stroke with no treatment are adopted from Kimura et al. [22] by initial dipstick test result, age and sex. Each value is shown in Table 1. Reductions of these transition probabilities brought about by treatment of CKD are set at 69.3% based on Arima et al. [23]. The subsequent transition probabilities to (5) death are adopted from Kimura et al. [22] by age and sex for the first year, and calculated from the Stroke Register in Akita of Suzuki [25, 26] for the second year and thereafter. Each value is shown in Table 1.

A transition probability from (3) heart attack and (4) stroke to (2) ESRD is adopted from an epidemiological study in Okinawa by Iseki et al. [27].

Transition probabilities from (1) screened and/or examined to (5) death are adopted from Vital Statistics of Japan 2008 [28] by age and sex. Each value is shown in Table 1.

We take a life-long time horizon so that the Markov cycle is repeated until each age stratum reaches 100 years old.

#### Quality of life adjustment

In order to estimate outcomes, use of quality-adjusted life years (QALYs) is recommended for economic evaluation of health care [29, 30]. QALYs are calculated as the sum of adjusted life-years experienced by a patient, where the adjustment is made by multiplying time by weights linked to the changing health state of the patient. The quality-adjustment weight is a value between 1 (perfect health) and 0 (death), which is one of the health-related quality of life measurements. Regarding (1) screened and/or examined, weights are assigned according to CKD stage based on initial renal function, using values adopted from Tajima et al. [31]. Weights for (2) ESRD, (3) heart attack and (4)

stroke are cited from a past economic evaluation of anti-hypertensive treatment in Japanese context by Saito et al. [32].

#### Costing

From the societal perspective, costing should cover the opportunity cost borne by various economic entities in society. In the context of this study, costs borne by social insurers and patients are considered, since the cost of SHC is borne by social insurers and the cost of treatment is shared by social insurers and patients in Japan's health system. The amount of direct payments to health care providers by these entities is estimated as costs, while costs of sector other than health and productivity losses are left uncounted in this study. Cost items are identified along the decision tree and Markov model: screening, detailed examination, treatment of CKD, treatment of ESRD, treatment of heart attack and treatment of stroke. Each value is shown in Table 1.

Costs of screening were surveyed in five prefectures by inquiring health checkup service providers' price of adding CKD screening test to a test package that does not include renal function tests. Average price of those for (a) dipstick test to check proteinuria only, (b) serum Cr assay only and (c) dipstick test and serum Cr assay was ¥267 (US \$3.0, with US \$1 = ¥90), ¥138 (US \$1.5) and ¥342 (US \$3.8) per person, respectively. Cost of detailed examination is set at ¥25,000 (US \$278) per person according to the national medical care fee schedule and a treatment model developed by the expert committee. Annual costs of CKD treatment per person are set at ¥120,000 (US \$1,333) for stage 1 CKD, ¥147,000 (US \$1,633) for stage 2 CKD, ¥337,000 (US \$3,744) for stage 3 CKD, ¥793,000 (US \$8,811) for stage 4 CKD and ¥988,000 (US \$10,978) for stage 5 CKD, also from the national medical care fee schedule and a treatment model developed by the expert committee. Annual cost of ESRD treatment per person, ¥6,000,000 (US \$66,667), is cited from a review of renal disease care in Japan by Fukuhara et al. [33]. Annual cost of heart attack treatment per person, ¥2,780,000 (US \$30,889) for the first year and ¥179,000 (US \$1,989) for subsequent years, are cited from a past economic evaluation of cardiovascular disease prevention in Japanese context by Tsutani et al. [34]. Similarly, annual costs of stroke treatment per person, ¥1,000,000 (US \$11,111) for the first year and ¥179,000 (US \$1,989) for subsequent years, are cited from Tsutani et al. [34] as well.

#### Discounting

Both outcomes and costs are discounted at a rate of 3% [30].

## Policy options for economic evaluation

To draw significant policy implications from this economic evaluation, policy options from status quo need to be defined. Under the current SHC, the dipstick test to check proteinuria is mandatory, while serum Cr assay is not. However, some health insurers voluntarily provide serum Cr assay to participants in addition to SHC. We surveyed health insurers in five prefectures and found that 65.4% of them implement use of serum Cr assay. Also, we analysed the Japan Tokutei-Kenshin CKD Cohort 2008 and found that 57.3% of participants underwent use of serum Cr assay. Therefore, we define the status quo regarding screening test for CKD as 40% of insurers implementing dipstick test only and 60% implementing dipstick test and serum Cr assay.

Then we evaluate two policy options in this study: 'Policy 1: Requiring serum Cr assay', and 'Policy 2: Requiring serum Cr assay and abandoning dipstick test'. Policy 1 means mandating use of serum Cr assay in addition to the currently used dipstick test, so that 100% of insurers implement both dipstick test and serum Cr assay if policy 1 is taken. Policy 2 is considered based on two recent health policy contexts. One is the discussion aroused during the development of SHC in which requiring serum Cr assay only and abandoning dipstick test used in the former occupational health checkup scheme attracted substantial support. It is expected that such a policy option will be proposed in the revision of SHC. Another relates to the change in diagnosis criterion of diabetes [35], in which a blood test to check the level of haemoglobin A1c instead of a dipstick test to check urinary sugar level has become pivotal. Implementing dipstick test for checking proteinuria only bears scrutiny from the viewpoint of economic evaluation. We assume that 100% of insurers would stop providing dipstick test if policy 2 is adopted.

We calculate incremental cost-effectiveness ratios (ICERs) for these two policy options using our economic model. ICER is a primary endpoint of cost-effectiveness analysis, which is defined as follows:

$$\text{ICER} = \frac{\text{Incremental cost}}{\text{Incremental effectiveness}} = \frac{\text{Cost}_{\text{New policy}} - \text{Cost}_{\text{Status quo}}}{\text{Effectiveness}_{\text{New policy}} - \text{Effectiveness}_{\text{Status quo}}}$$

This means the additional cost required to gain one more QALY under new policy.

## Sensitivity analysis

Economic modelling is fundamentally an accumulation of assumptions adopted from diverse sources. Therefore, it is imperative to appraise the stability of the model. We

perform one-way sensitivity analyses for our model assumptions. Assumed probabilities about the participant cohort, the decision tree and the Markov model are changed by  $\pm 50\%$ . Reductions of transition probabilities brought about by treatment are also changed by  $\pm 50\%$ . Utility weights for quality of life adjustments are changed by  $\pm 20\%$ . Costs are changed by  $\pm 50\%$ . Discount rate is changed from 0% to 5%. We also changed our assumption about status quo that 40% of insurers implement dipstick test only and 60% implement dipstick test and serum Cr assay by  $\pm 50\%$  as well.

## Results

### Model estimators

Table 2 presents the model estimators. Under the do-nothing scenario, no patient is screened, with average cost of renal disease care per person of ¥2,125,490 (US \$23,617) during average survival of 16.11639 QALY. When (a) dipstick test to check proteinuria only is applied, 832 patients out of 100,000 participants are screened, with additional cost of ¥7,288 (US \$81) per person compared with the do-nothing scenario, for additional survival of 0.00639 QALY (2.332 quality-adjusted life days). When (b) serum Cr assay only is applied, 3,448 patients are screened with additional cost of ¥390,002 (US \$4,333) per person compared with the do-nothing scenario, for additional survival of 0.04801 QALY (17.523 quality-adjusted life days). When (c) dipstick test and serum Cr assay are applied, 3,898 patients are screened with additional cost of ¥395,655 (US \$4,396) per person compared with the do-nothing scenario, for additional survival of 0.04804 QALY (17.535 quality-adjusted life days).

Model estimators of ICERs were calculated as ¥1,139,399/QALY (US \$12,660/QALY) for (a) dipstick test only, ¥8,122,492/QALY (US \$90,250/QALY) for (b) serum Cr assay only and ¥8,235,431/QALY (US \$91,505/QALY) for (c) dipstick test and serum Cr assay.

### Cost-effectiveness

Table 3 presents the results of cost-effectiveness analysis. Regarding the status quo that 40% of insurers implement dipstick test only and 60% implement dipstick test and serum Cr assay, 2,837 patients out of 100,000 participants are screened, with average cost of screening and renal disease care per person of ¥2,365,798 (US \$212,922) during average survival of 16.14777 QALY. Taking policy 1 that 40% of insurers currently using dipstick test only start use of serum Cr assay screens more patients (3,898).

**Table 2** Model estimators

	No. of patients per 100,000 participants	Cost (¥)	Incremental cost (¥)	Effectiveness (QALY)	Incremental effectiveness (QALY)	Incremental cost-effectiveness ratio (¥/QALY)
Do-nothing	0	2,125,490		16.11639		
(a) Dipstick test only	832	2,132,778	7,288	16.12278	0.00639	1,139,399
(b) Serum Cr assay only	3,448	2,515,492	390,002	16.16440	0.04801	8,122,492
(c) Dipstick test and serum Cr assay	3,898	2,521,145	395,655	16.16443	0.04804	8,235,431

**Table 3** Results of cost-effectiveness analysis

	No. of patients per 100,000 participants	Cost (¥)	Incremental cost (¥)	Effectiveness (QALY)	Incremental effectiveness (QALY)	Incremental cost-effectiveness ratio (¥/QALY)
Status quo	2,837	2,365,798		16.14777		
Policy 1: requiring serum Cr assay	3,898	2,521,145	155,347	16.16443	0.01666	9,325,663
Policy 2: requiring serum Cr assay and abandoning dipstick test	3,448	2,515,492	149,694	16.16440	0.01663	9,001,414

It costs more, but it gains more. Its incremental cost is ¥155,347 (US \$1,726), and its incremental effectiveness is 0.01666 QALY (6.081 quality-adjusted life days), resulting in ICER of ¥9,325,663/QALY (US \$103,618/QALY). Taking policy 2 that 40% of insurers currently using dipstick test only start use of serum Cr assay and abandon dipstick test screens more patients (3,448) compared with the status quo as well. It also costs more, but it gains more. Its incremental cost is ¥149,694 (US \$1,663), and its incremental effectiveness is 0.01663 QALY (6.070 quality-adjusted life days), resulting in ICER of ¥9,001,414/QALY (US \$100,016/QALY).

#### Stability of cost-effectiveness

One-way sensitivity analyses produce similar results not only between policy 1 and policy 2 but also among three model estimators of ICER. Therefore, we present a tornado diagram of policy 1 as an example in Fig. 2. Ten variables with large change of ICER are depicted. A threshold to judge cost-effectiveness is also drawn, which is according to World Health Organization's (WHO) recommendation, being three times gross domestic product (GDP) per capita [36]. Its value is ¥11.5 million/QALY (US \$128 thousand/QALY) gain in 2009 in Japan.

The effectiveness of CKD treatment to delay progression to ESRD is found to be the most sensitive. Decreasing the effect by 50% increases ICER to ¥16,280,537/QALY (US \$180,895/QALY). The effectiveness of CKD treatment to prevent stroke is also found to be the 10th largest change of ICER, but its range is limited.

The cost of treatment for stage 5 CKD is found to be the second most sensitive. Increasing the cost by 50%

increases ICER to ¥14,404,335/QALY (US \$160,048/QALY). The cost of ESRD treatment is found to be the fifth largest change, and the change is in the opposite direction; decreasing this increases ICER. Another cost item depicted is the cost of treatment for stage 3 CKD, which is found to be the sixth largest change.

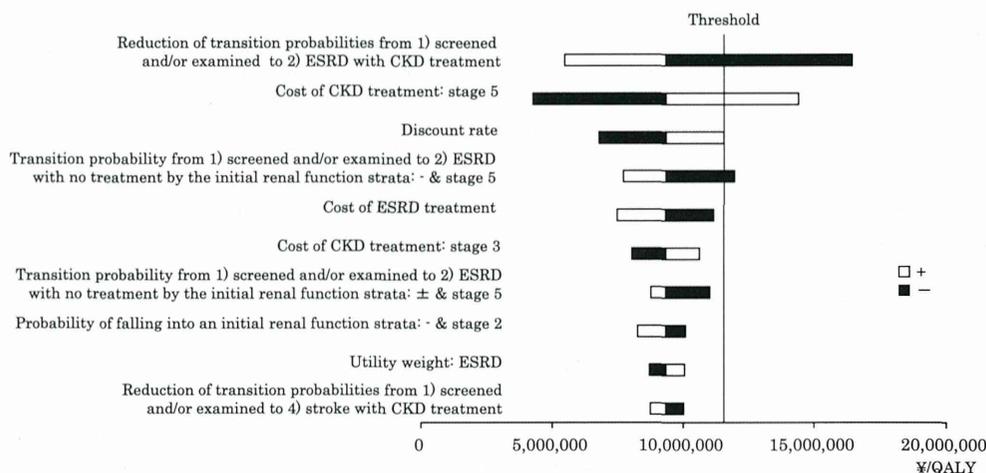
The discount rate is found to be the third most sensitive. Discounting at a rate of 5% makes ICER ¥11,373,185/QALY (US \$126,369/QALY). Since policy 1 can screen CKD patients without proteinuria by use of serum Cr assay, the prognosis of non-proteinuric stage 5 CKD without treatment is found sensitive as the fourth and the seventh largest change. The eighth largest change depicted relates to the prevalence of CKD in participating population, i.e. stage 2 CKD without proteinuria. The ninth largest change is utility weight for ESRD.

Taking the threshold to judge cost-effectiveness, one-way sensitivity analyses alter the interpretation of the results for only three variables: reductions of transition probabilities from (1) screened and/or examined to (2) ESRD with the treatment of CKD; cost of treatment for stage 5 CKD; and transition probability from (1) screened and/or examined to (2) ESRD with no treatment by initial renal function for stage 5 CKD without proteinuria.

#### Discussion

We conduct a cost-effectiveness analysis of CKD screening test in SHC. Facing the scheduled revision of mandatory test items, we appraise two possible policy options compared with the status quo that 40% of insurers implement dipstick test to check proteinuria only and 60% implement

**Fig. 2** Tornado diagram of policy 1. This tornado diagram shows ten variables which are found to be sensitive to the change in assumptions. Ten variables are presented, ordered according to the size of the change of ICER from top to bottom. The change of ICERs is represented by *white bars* when increasing the variable or by *black bars* when decreasing the variable from base-case value. The threshold to judge cost-effectiveness is  $3 \times$  GDP per capita (¥11.5 million/QALY gain)



dipstick test and serum Cr assay. Policy 1 is to mandate serum Cr assay in addition to the current dipstick test, so that 100% of insurers implement both dipstick test and serum Cr assay. Policy 2 is to mandate serum Cr assay and abandon dipstick test, so that 100% of insurers would stop providing dipstick test and switch to serum Cr assay. Our base-case analysis suggests that both policy options cost more and gain more. Estimated ICERs are ¥9,325,663/QALY (US \$103,618/QALY) for policy 1 and ¥9,001,414/QALY (US \$100,016/QALY) for policy 2.

To interpret these ICERs, there is no established value of social willingness to pay for one QALY gain in public health programmes such as mass screening in Japan, although some suggest ¥5 million/QALY (US \$56 thousand/QALY) for an innovative medical intervention [37]. We follow WHO recommendation in this study, which is three times GDP per capita [36]. Its value is ¥11.5 million/QALY (US \$128 thousand/QALY) gain in 2009 in Japan. Given this threshold, both policy 1 and policy 2 are judged as cost-effective. Therefore, mandating serum Cr assay in SHC can be justifiable as an efficient allocation of finite resources for health. Between policy 1 and policy 2, the ICER of policy 2 is slightly more favourable than that of policy 1, while 450 more patients out of 100,000 participants are screened by adopting policy 1. If secondary prevention of CKD is emphasised as a policy objective in addition to efficiency, policy 1 is an acceptable option as well as policy 2.

Our model estimators have a policy implication, although estimated ICERs do not directly depict any marginal change in society. The ICER of (a) dipstick test only compared with the do-nothing scenario, ¥1,139,399/QALY (US \$12,660/QALY), is remarkably favourable. This implies that mass screening with dipstick test only is cost-effective compared with abolishment of mass screening for kidney diseases altogether. Therefore, continuing the current policy, i.e. mandatory dipstick test, could be justifiable as an efficient resource allocation.

This contrasts with the reported cost-ineffectiveness of annual mass screening for adults using dipstick test to check proteinuria in the USA [12], although direct comparison cannot be made between the results of economic evaluations under different health systems. The difference could be attributable to the difference in the prevalence of proteinuria among screened population, with 5.450% being used in our model based on the Japan Tokutei-Kenshin CKD Cohort 2008, while 0.19% is assumed in the US study. Such epidemiological differences are known in terms of not only quantity but also in quality [7]. The prevalence of glomerulonephritis, especially IgA nephropathy, is higher in Asian countries including Japan compared with Western countries [10]. Also, the prevalence of renovascular disease such as ischaemic nephropathy, with which patients are often non-proteinuric until advanced stages of CKD, is lower in Asian countries [38]. The inclusion of heart attack and stroke into our model, which are excluded in the US model [12], may have also made the ICER more favourable.

There is a report of cost-ineffectiveness of population-based screening for CKD with serum Cr assay from Canada [39]. This Canadian model can be compared with our model estimators of (b) serum Cr only compared with the do-nothing scenario. Their health outcomes gain or incremental effectiveness is 0.0044 QALY, which is smaller than ours, 0.04801 QALY, while their incremental cost is C \$463 (US \$441, using US \$1 = C \$1.05), which is also smaller than ours, ¥390,002 (US \$4,333). These differences probably reflect the difference in the prevalence of CKD between Canada and Japan. Regarding the efficiency of screening programme, our model estimator of ICER, ¥8,122,492/QALY (US \$90,250/QALY), is slightly more favourable than that of Canada, C \$104,900/QALY (US \$99,905/QALY). However, the contradictory conclusion regarding cost-effectiveness is not due to this difference but rather the threshold taken. The Canadian study adopts lower value such

as C \$20,000 to C \$50,000/QALY (US \$19,048 to US \$47,619/QALY) following local practice [40].

Our sensitivity analysis suggests instability of the results in only three variables, so our findings are robust to a certain extent. The most sensitive variable is the effectiveness of CKD treatment delaying progression to ESRD: 42.1% reduction is adopted in our economic model according to the unique clinical evidence from Japan, whose agent is angiotensin-converting enzyme inhibitor. It is marginally larger than comparative values reported from Western countries. Reductions in the rate of GFR decline are 35.9% by Agodoa et al. [41], 39.8% by The GISEN Group [42] and 22.5% by Ruggenenti et al. [43]. However, we think our assumption of base-case value is reasonable in two accounts: in light of the indication of angiotensin receptor blockers [17], whose use is more tolerated than angiotensin-converting enzyme inhibitors [44], and the higher prevalence of glomerulonephritis including IgA nephropathy, being a primary renal disease for ESRD, in Japan [10], for which the effect of early treatment such as renin–angiotensin system (RAS) inhibition, an immunosuppression, reduces risk of ESRD by 60% [45].

In regards to the other sensitive variables, we think the prognosis of non-proteinuric stage 5 CKD without treatment does not greatly undermine our findings of base-case analysis, since the value is calculated from extended follow-up of an established database [18]. Uncertainty of the base-case value should be much less than the analysed  $\pm 50\%$ . On the other hand, the cost of treatment for stage 5 CKD relates to one of the weaknesses of this study, as discussed in the following.

There are weaknesses in this study. The most significant one is that our economic model depicts the prognosis of CKD by initial renal function stratum. This approach is taken because of the limitation of epidemiological data, and it has little difficulty in estimating outcomes in terms of survival. However, it becomes problematic when it comes to costing. For example, a patient initially screened as stage 1 CKD stays at (1) screened and/or examined before transiting to the following health states such as (2) ESRD. This means that a patient skips over stage 2 CKD to 5 CKD before progressing to ESRD. To estimate the cost for this health state, the diversity of patients in terms of progression of the CKD stages should be taken into account. Our expert committee has developed treatment models to understand this problem. This type of uncertainty is larger in stage 1 CKD and smaller in stage 5 CKD, but the cost of stages 1–4 CKD are not found to be so sensitive in our sensitivity analysis. Also, we think that uncertainty of the cost of stage 5 CKD, the second most sensitive variable, is less than the analysed  $\pm 50\%$ , and our findings based on the base-case analysis are plausible. The problem

**Table 4** Recommendation of the Japanese Society of Nephrology Task Force for the validation of urine examination as a universal screening

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Mandate use of serum Cr assay in addition to the current dipstick test in the next revision of SHC

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also affects quality of life adjustment, which tends to produce larger QALY outcomes.

Other weaknesses include our assumption of 100% adherence to treatment and so on. However, the most significant strength of this study is that our economic model depends totally on evidence from Japan only, which could justify our simplification in modelling on data availability basis. There is an opportunity for further refinement of our economic model, because a large-scale field trial evaluating the effect of multifactorial treatment including lifestyle modification for early-stage CKD [46] is ongoing in Japan, which will enable us to model progression of CKD with more rigorous clinical evidence [47].

In conclusion, we, the Japanese Society of Nephrology Task Force for the Validation of Urine Examination as a Universal Screening, recommend to mandate use of serum Cr assay in addition to the current dipstick test in the next revision of SHC, from the viewpoint of value for money and the importance of secondary prevention (Table 4). We think that continuation of current policy, in which dipstick test only is mandatory, is still a sensible policy option. Development of adequate Specific Counselling Guidance for screened participants is also recommended.

Whereas the primary objective of this study is to appraise policy options in Japanese context, it also demonstrates that good value for money can be expected from mass screening with dipstick test to check proteinuria in population with high prevalence; that is, a population strategy could be adopted for control of CKD. However, caution is needed when extrapolating this conclusion, since the scope of costing of our economic model does not cover the initial cost of launching mass screening. The model here is based on currently running SHC. The practice of annual mass screening for adults in Japan is quite exceptional, while such universal programmes are rarely found in other countries [48].

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**Conflict of interest** The authors have declared that no conflicts of interest exist.

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## Weight gain after 20 years of age is associated with prevalence of chronic kidney disease

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### Abstract

**Background** Weight gain after maturity is a risk factor for diabetes, coronary heart disease, and stroke, even in individuals with a normal body mass index; however, there is little information about the influence of weight gain after maturity on chronic kidney disease (CKD). Therefore, we examined the association between weight gain after 20 years of age and the prevalence of CKD.

**Methods** A cross-sectional study was performed on 28,151 women and 21,110 men aged between 40 and 59 years who participated in the specific health check and guidance system of Japan in 2008. We compared prevalence of CKD between participants with and without weight gain of at least 10 kg after 20 years of age. Multivariate logistic regression models and stratified analyses were used to adjust for possible confounding factors.

**Results** The prevalence of CKD among participants with weight gain was significantly higher than among those without weight gain both in women (11.8 vs 8.3%,  $p < 0.0001$ ) and in men (12.2 vs 9.2%,  $p < 0.0001$ ). After adjustment for age, smoking, regular exercise, alcohol intake, history of kidney disease, hypertension, diabetes, and hypercholesterolemia, the odds ratio (95% confidence interval) for CKD was 1.24 (1.14–1.36) in women and 1.15 (1.05–1.26) in men with weight gain of at least 10 kg after the age of 20 years. Even in participants without metabolic syndrome, weight gain was independently associated with CKD in both genders.

**Conclusions** Weight gain after 20 years of age is associated with CKD among Japanese, even those without metabolic syndrome.

**Keywords** Weight gain · Chronic kidney disease · Obesity · General population · Cross-sectional study

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### Introduction

The prevalence of obesity in Japan has increased over the past several decades [1], and is a worldwide public health problem of growing importance. Obesity is an established risk factor for several chronic diseases, including hypertension and diabetes mellitus. Even in individuals with a normal body mass index (BMI), weight gain after maturity is an important risk factor for diabetes [2, 3], coronary heart disease [4, 5], and stroke [6].

Obesity has also been recognized as a risk factor for chronic kidney disease (CKD). Weight gain has been reported to be associated with the incidence of CKD among Korean men, even when BMI remained within the normal range [7]. However, information is lacking about the influence of weight gain after maturity on CKD among

women, because previous studies of the association between obesity and CKD defined obesity by the BMI or waist circumference [8, 9]. An increase of weight after maturity largely reflects increased fat mass, so such an increase may be more closely associated with the risk of CKD, especially among participants with a normal BMI or waist circumference. The average BMI of Asian populations is lower than that of non-Asian populations, although the tendency for abdominal obesity might be greater than in non-Asian populations [10]. Weight gain after maturity might be a basis for recommendations on lifestyle modification, and it may be especially attractive to use this measure for Asian populations. Measures such as weight and weight gain are also attractive from a public education perspective, because they are much easier for the general population to understand than BMI and can be measured more accurately than waist circumference.

In this study, we examined the effect of weight gain after maturity on the prevalence of CKD among Japanese. We hypothesized that the prevalence of CKD might be associated with weight gain after maturity, even for individuals within the normal range of BMI or waist circumference.

## Methods

### Study population

We used data from 68 areas of 7 prefectures obtained by the Japanese specific health check and guidance system (SHC) in 2008; the SHC has been described elsewhere [11]. In brief, participants answered a self-administered questionnaire that covered their medical history, smoking habits, alcohol intake, and exercise pattern. Trained staff then measured the height, weight, blood pressure, and waist circumference of each participant, after which serum and spot urine samples were collected. We only included participants aged between 40 and 59 years in this study, because previous reports have indicated that metabolic syndrome was a risk factor for CKD only for younger participants ( $\leq 60$  years) among men [12, 13] and because body weight might decrease due to comorbidities  $>60$  years. Participants with missing information were also excluded. All of the participants remained anonymous and the study was conducted according to Japanese privacy protection laws and the ethical guidelines for epidemiological studies published by the Ministry of Education, Science and Culture and the Ministry of Health, Labor and Welfare in 2005.

### Proteinuria and CKD

Proteinuria was defined by a dipstick urinalysis score of  $\geq 1+$  proteinuria (equivalent to  $\geq 30$  mg/dl) because of poor

discrimination between negative and trace positive dipstick readings [14]. The primary endpoint was the prevalence of CKD, which was defined as  $\geq 1+$  proteinuria on urinalysis, a glomerular filtration rate (GFR)  $<60$  ml/min/1.73 m<sup>2</sup> as calculated by using the estimated GFR (eGFR) formula shown below for Japanese [15], or both [16].

$$\text{eGFR} = 194 \times (\text{serum creatinine}^{-1.094}) \times (\text{age}^{-0.287}) \times (0.739 \text{ for females}).$$

### Weight gain, obesity, and metabolic syndrome

Information about weight gain was collected from the self-administered questionnaire, which included the following item: “Have you gained more than 10 kg since 20 years of age?” Participants answered yes or no. Using BMI values (calculated as weight in kilograms/(height in meters)<sup>2</sup>), the subjects were categorized as non-obese ( $<25$  kg/m<sup>2</sup>) or obese ( $\geq 25$  kg/m<sup>2</sup>). Using waist circumference measured at the umbilicus, they were categorized as having abdominal obesity ( $\geq 90$  cm for women and  $\geq 85$  cm for men) or not ( $<90$  cm for women and  $\leq 85$  cm for men) according to the definition of the metabolic syndrome in the SHC [11]. The SHC definition of the metabolic syndrome is not the same as that used by the World Health Organization or the Japanese Society of Internal Medicine [17, 18]. Instead, metabolic syndrome is defined as abdominal obesity (waist circumference  $\geq 90$  cm in women and  $\geq 85$  cm in men) and/or obese (BMI  $\geq 25$  kg/m<sup>2</sup>) plus any two of the following three categories: (1) fasting blood glucose  $\geq 100$  mg/dl, hemoglobin A<sub>1c</sub>  $\geq 5.2\%$ , use of insulin, and/or oral antidiabetic medication; (2) triglycerides  $\geq 150$  mg/dl, high-density lipoprotein cholesterol  $<40$  mg/dl, and/or the use of cholesterol-lowering medication; or (3) blood pressure  $\geq 130/85$  mmHg and/or use of antihypertensive medication.

### Covariates

Information about current smoking, alcohol, and exercise habits, a history of stroke, heart disease, CKD, or dialysis, and use of medication for diabetes mellitus, hypertension, or hypercholesterolemia was collected from the questionnaire. Diabetes mellitus was defined as the use of insulin or oral antidiabetic medication, a fasting serum glucose  $\geq 126$  mg/dl, or both. Hypertension was defined as the use of antihypertensive medication, a systolic blood pressure  $\geq 140$  mmHg and/or a diastolic blood pressure  $\geq 90$  mmHg, or both. Hypercholesterolemia was defined as the use of cholesterol-lowering medication, a low-density lipoprotein cholesterol level  $\geq 140$  mg/dl, or both.

### Statistical analysis

We analyzed the data separately by gender, because previous reports have indicated that the influence of BMI or