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Factors Affecting the Referral Time to Nephrologists in Patients With Chronic Kidney Disease

A Prospective Cohort Study in Korea

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Abstract: Timely referral to nephrologists is important for improving clinical outcomes and reducing costs during transition periods. We evaluated the impact of patients' demographic, clinical, and social health characteristics on referral time.

A total of 1744 CKD patients who started maintaining dialysis were enrolled in a Korean prospective cohort. The early referral (ER) and late referral group (LR) were defined as patients who were referred to a nephrologist more than or less than 1 year prior to dialysis initiation, respectively.

A total of 1088 patients (62.3%) were in the ER, and 656 patients (37.6%) were in the LR. Among the patients in the LR, 398 patients (60.7%) were referred within the 3 months prior to the start of dialysis (ultralate referral group [ULR]). The ER was younger at the time of referral than the LR; however, the ER was older at the start of dialysis. Patients with diabetes or hypertension as the cause of kidney disease were more common in the LR, whereas patients with glomerulone-phritis, females, and nonsmokers were more common in the ER. The ER had more well-controlled blood pressure, lower phosphorus levels, and

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higher hemoglobin levels at the start of dialysis. Congestive heart failure (CHF) was more common in the LR. In the multivariate analysis, male sex (odds ratio [OR] 1.465, 95% confidence interval [CI] 1.034–2.076), underlying kidney disease (diabetes mellitus [OR 1.507, 95% CI 1.057–2.148] and hypertension [OR 1.995, 95% CI 1.305–3.051]), occupation (mechanician [OR 2.975, 95% CI 1.445–6.125], laborer [OR 3.209, 95% CI 1.405–7.327], and farmer [OR 5.147, 95% CI 2.217–11.953]), CHF (OR 2.152, 95% CI 1.543–3.000), and ambulatory status (assisted-walks, OR 2.072, 95% CI 1.381–3.111) were proved as the independent risk factor for late referral.

Patients with hypertensive or diabetic kidney disease are referred later than those with glomerulonephritis. Male patients with physically active occupations exhibiting CHF and restricted ambulation were associated with a late referral. Considering the various factors associated with late referral, efforts to increase early referrals should be emphasized, particularly in patients with hypertension, diabetes, or congestive heart failure.

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Abbreviations: CKD = chronic kidney disease, ER = early referral group, LR = late referral group, OR = odds ratio, ULR = ultralate referral group.

INTRODUCTION

n patients with chronic kidney disease (CKD), timely referral to nephrologists and adequate care are important for improving the patients' clinical outcomes. The benefits of early referral to nephrologists have been well investigated in previous studies. Patients who were referred early showed a reduced use of temporary dialysis catheters, a decreased need for urgent dialysis, a time delay until the initiation of renal replacement therapy, and a higher incidence of peritoneal dialysis or kidney transplantation as an initial modality.¹ Patients referred early are relatively well managed, even with cardiovascular disease and other comorbidities.² Early referral can improve patients' survival, nutritional status, and quality of life.^{3,4} In addition, early referral can reduce hospitalization, length of hospital stay, and medical costs. We also investigated that patients who were referred early before the start of dialysis had benefits on overall and cardiovascular survival, medical expenses, and quality of life.^{5–7}

Although many clinicians have come to understand the importance of timely referral in patients with CKD, a large proportion of patients with CKD are still referred late relative to the start of dialysis. The referral time and proportion of late referral patients vary widely according to the country and definition of late referral. Previous studies have reported that

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only 20% to 35% patients are referred late.⁸ In the United States, despite a decreasing pattern of late referrals, 34.7% patients were still referred late in 2006.⁹ In Mexico, over 50% of patients were referred late at 1 month before dialysis initiation.¹⁰ In a Danish cohort study, 38% of patients were referred less than 16 weeks before the start of renal replacement therapy.¹¹

To increase the proportion of patients with early referral, an investigation of the clinical and socio-economic factors affecting referral time is required. Scarce data are available on the factors associated with referral time, especially in Asian countries. In this study, we evaluated the impact of patients' demographic, clinical, and social health characteristics on referral time.

METHODS

Cohort Description

This study was investigated as part of a cohort study (Clinical Research Center for End Stage Renal Disease, CRC ESRD) of patients with ESRD in South Korea. The CRC ESRD is a nationwide multicenter web-based prospective cohort of CKD patients receiving dialysis, and its aim is to analyze the effects of treatment effects on survival, quality of life, and cost effectiveness (clinicaltrial.gov NCT00931970). All of the enrolled patients are adults over 20 years old who started dialysis for ESRD without a kidney transplant scheduled within 3 months. Patient registration began in July 2008, and 31 hospitals are currently participating in the CRC ESRD cohort study in South Korea. The study was approved by the institutional review board at each center. All of the patients provided written consent to participate voluntarily in this study. All clinical investigators observed the Ethics for Medical Research and carried out this study in accordance with the guidelines of the 2008 Declaration of Helsinki.

Study Participants

From the new patient registry in the CRC ESRD cohort, we enrolled 1744 adult patients who started maintenance dialysis for newly diagnosed ESRD between August, 2008 and January, 2015. Patients with missing data on the dates of initial visits to a nephrologist and start dates of dialysis were excluded in this study. The early referral group (ER) was defined as patients who were referred to a nephrologist more than 1 year prior to dialysis initiation, the late referral group (LR) was defined as patients whose referral time was less than a year prior to dialysis initiation, and the ultralate referral group (ULR) was defined as patients whose referral time was less than 3 months prior to dialysis initiation.

Clinical Data Acquisition

The information used to analyze the participants was primarily collected from the data server of the CRC ESRD. The clinical, demographic, and socio-economic data had been stored in the online accessible web database. The contents of questionnaire were filled in by trained coordinators through medical chart reviews and direct interviews using a standard format. The questionnaires consisted of data on demographics, occupation, insurance status, marriage status, degree of familial and social support, education status, smoking history, previous medical history, laboratory results, dialysis modality and prescription, comorbidities, and medications. The estimated glomerular filtration rate was calculated by CKD-EPI equations.¹² time of dialysis for each patient. The questionnaire items were collected from all patients when they visited dialysis facilities or were admitted to hospitals for the first maintenance dialysis.

Statistical Analysis

In the descriptive analysis of the demographic and clinical characteristics and laboratory results, continuous variables were expressed as the mean and standard deviation, and categorical variables were described numerically with a percentage. All continuous variables were tested for normality distribution by Kolmogorov-Smirnov methods. Comparisons between the groups based on referral time were performed using a t test or ANOVA for continuous variables and Chi-square tests for categorical variables when appropriate. Continuous variables that were not in normality distribution were compared with Mann-Whitney U test or Kruskal-Wallis test method. Clinical, demographic, and socio-economic factors that are associated with late and ultralate referral were analyzed by logistic regression method. Statistically significant variables that showed P value below 0.2 in the univariate analysis were included in a multivariate analysis based on forward selection methods. IBM SPSS ver. 21.0 was used to compare the demographic and clinical parameters. A P value < 0.05 was considered statistically significant.

RESULTS

Distribution of Referral Time

The patients' referral times are presented in Figure 1. Among the 1744 study participants, 656 patients (37.6%) were referred late (<1 year before dialysis start) and 1088 patients (62.3%) were referred early (\geq 1 year before dialysis start) (Figure 1A). The number of patients who were referred late (short referral time) increased gradually throughout the referral time period. Among the 656 patients who were referred late to the nephrologists (<1 year before dialysis start), 398 patients (60.7%) were referred within 3 months prior to starting dialysis (ULR) and 304 patients (46.3%) were referred within 1 month prior to starting dialysis (Figure 1B).

Patients Characteristics by Referral Pattern

The patients' clinical and laboratory characteristics relative to the referral time are summarized in Table 1 and Supplementary Table 1, http://links.lww.com/MD/A954. The mean age at the time of referral was 52.8 ± 14.7 years old, and 60.8% of the patients were male. Of the 1744 patients enrolled in this study, 1088 patients were in the ER and 656 were in the LR. The time from referral to dialysis was significantly longer in the ER than in the LR (64.9 ± 58.2 months vs 3.1 ± 3.6 months, P < 0.001).

In the ER, the patients were younger at the time of referral to the nephrologists. At the referral time, the blood pressure, BUN, serum creatinine, and phosphorus levels were lower and the hemoglobin, albumin, calcium, total cholesterol level, and estimated glomerular filtration rate were higher in the ER than in the LR. In addition, more female patients were in the ER. According to the causes of primary renal disease, patients with glomerulonephritis were more common in the ER and patients with diabetes or hypertension were more common in the LR.

At the time of dialysis initiation, the patients' ages in the ER were significantly higher compared with that of the LR (56.6 ± 13.7 vs 54.5 ± 14.2 year, P = 0.001). Although certain variables, including the systolic blood pressure, body mass



FIGURE 1. Distribution of referral time from the initial visit to the nephrology clinic to dialysis initiation. (A) Among a total of 1744 study participants, 656 patients (37.6%) were referred late (<1 year before dialysis start) and 1088 patients (62.3%) were referred early (\geq 1 year before dialysis start). The number of patients who were referred late (short referral time) increased gradually throughout the entire referral time period. (B) Among patients (60.7%) were referred late to the nephrologist, 398 patients (60.7%) were referred 3 months before dialysis initiation (ultralate referral group) and 304 patients (46.3%) were referred just before dialysis (<1 month before dialysis start).

index, uric acid, intact PTH, glucose, HbA1c, and total cholesterol levels were similar in both groups, the diastolic blood pressure (77.3 ± 13.9 vs 79.6 ± 14.5 mm Hg, P = 0.005), phosphorus levels (5.4 ± 1.8 vs 5.6 ± 2.0 mg/dL, P = 0.038), and LDL cholesterol levels (87.4 ± 38.5 vs 93.0 ± 37.3 mg/dL, P = 0.003) were lower, and the hemoglobin levels (9.0 ± 1.6 vs 8.9 ± 1.6 g/dL, P = 0.016) and calcium levels (7.9 ± 1.0 vs. 7.7 ± 1.1 mg/dL, P = 0.012) were higher in the ER.

The patients' working status, medical insurance status, marriage status, familial numbers and support status, and social support status were not different between the ER and LR. However, in regard to occupation, professional specialist and office manager were more in the ER (P = 0.030). In addition, patients in the ER were more highly educated (university or graduate school) or uneducated (P = 0.050) and had a low proportion of current smokers (P = 0.001).

Regarding comorbidities, patients in the ER had a higher prevalence of connective tissue disease (P = 0.003), mild

liver disease (P = 0.001), and tumors, including cancers (P = 0.013), whereas patients in the LR had a higher prevalence of congestive heart failure (P < 0.001). The modified Charlson comorbidity indexes were higher in the ER (5.3 ± 2.3 vs 5.0 ± 2.3 , P = 0.014). Patients in the ER showed higher usage of vitamin D (P = 0.030) and calcium-based phosphate binder (P = 0.039).

Patients with diabetes mellitus as the cause of primary kidney disease presented similar characteristics as all of the ESRD patients between the ER and LR. Although the patients' ages were similar between the 2 groups at referral, the patients were older at the start of dialysis in the ER (59.5. \pm 12.0 vs 55.3 \pm 12.7 year, *P* < 0.001). Patients in the ER had a higher modified Charlson comorbidity index (6.3 \pm 2.1 vs 5.7 \pm 2.2, *P* < 0.001) and a greater prevalence of coronary heart disease (*P* = 0.042), mild liver disease (*P* = 0.008), and tumors, including cancer (*P* = 0.045). However, the diastolic blood pressure (75.6 \pm 13.4 vs 78.4 \pm 14.4 mm Hg, *P* = 0.014) and LDL cholesterol levels (85.7 \pm 40.7 vs 94.0 \pm 39.5 mg/dL, *P* = 0.001) were lower in the ER. Patients in the LR had a higher prevalence of congestive heart failure (*P*=0.001).

Characteristics of Patients With Ultralate Referral

The characteristics of patients in the ULR (referral time <3 months) were compared with those of patients in the LR (referral time, 3–12 months) (Table 2). The patients' age at the time of referral and time of dialysis initiation were not different between the groups. Patients in the ULR had a greater prevalence of hypertension as the cause of primary renal disease (P = 0.005). At the time of dialysis initiation, patients in the ULR presented lower modified Charlson comorbidity indexes (4.8 ± 2.2 vs 5.3 ± 2.3 , P = 0.003). The social factors, including occupation, working status, insurance status, marriage status, familial or social support status, and education status, were not different between the ULR and LR. The prevalence of diuretics usage was significantly lower in the ULR (49.2% vs 62.0%, P = 0.002).

Demographic, Clinical, and Social Factors Affecting Referral Times

The demographic, clinical, and social factors were analyzed according to referral time (Table 3). Female patients were referred earlier than male patients (46.0 ± 59.4 vs 38.8 ± 51.6 months, P = 0.010), and patients with glomerulonephritis $(63.3 \pm 71.5 \text{ months})$ were referred earlier than those with hypertension $(41.5 \pm 55.0 \text{ months})$ or diabetes mellitus $(31.3 \pm 40.3 \text{ months}, P < 0.001)$. Occupation (the sale and service, mechanic, laborer, and farmer or fisherman) was associated with short referral time (P = 0.028). A higher degree of familial support was associated with a long referral time (P = 0.001), and education status (highly educated, such as university or graduate school, or uneducated) was associated with a long referral time (P = 0.013). Current smoking was associated with a short referral time $(28.7 \pm 47.6 \text{ vs never})$ smoking 45.8 ± 58.0 , P < 0.001), and the use of vitamin D was associated with a long referral time $(53.9 \pm 64.3 \text{ vs})$ 39.1 ± 52.5 months, P < 0.001). Among comorbidities, congestive heart disease $(27.5 \pm 40.4 \text{ vs } 43.6 \pm 56.3, P < 0.001)$ was associated with a short referral time, whereas connective tissue disease (62.0 ± 73.4 vs 39.7 ± 52.4 months, P < 0.001), mild liver disease $(47.4 \pm 46.7 \text{ vs } 41.4 \pm 55.4 \text{ months}, P = 0.028)$, and neoplastic disease $(54.7 \pm 68.7 \text{ vs } 40.8 \pm 53.8 \text{ months})$ P = 0.012) were associated with a long referral time.

		Total E	ŝRD			DM ES	RD	
	Total $(N = 1744)$	Early Referral $(N = 1088)$	Late Referral $(N = 656)$	P Value	Total $(N = 996)$	Early Referral $(N = 601)$	Late Referral $(N=395)$	P Value
Findings at the time of referral to nephrol Age at the time of referral, year	logist 52.8 ± 14.7	51.7 ± 14.9	54.5 ± 14.2	0.001	55.7 ± 12.6	55.9 ± 12.5	55.3 ± 12.8	0.306
Gender (male, %) Underlying bidney disease %	1061 (60.8)	642 (59.0)	419 (63.9)	0.044	634 (63.7)	376 (62.6)	258 (65.3)	0.377
Diabetes mellitus	996 (57.1)	601 (55.2)	395 (60.2)	100.0>				
Hypertension	262 (15.0)	147 (13.5)	115 (17.5)					
Glomerulonephritis	265 (15.2)	192 (17.6)	73 (11.1)					
Others	221 (12.7)	148 (13.7)	73 (11.1)					
Systolic BP, mm Hg	144.9 ± 25.9	141.9 ± 24.6	148.6 ± 27.1	< 0.001	144.0 ± 25.6	141.8 ± 24.5	146.8 ± 26.7	0.004
Diastolic BP, mm Hg	85.0 ± 10.2	82.7 ± 15.8	$84./\pm 10.8$	0.001	0.01 ± 1.18	0.5 ± 14.5	52.5 ± 5.28	0.164
	10.1 ± 2.2	11.0 ± 2.1	5.9 ± 1.8	<0.001	9.9 ± 2.0	10.0 ± 1.9	9.0 ± 1.7	<0.001
Albumin, mg/dL	5.6 ± 0.7	3.7 ± 0.7	3.4 ± 0.7	<0.001	3.4 ± 0.7	3.6 ± 0.7	3.3 ± 0.7	<0.001
Serum creatinine, mg/dL	4.00 ± 4.23	2.50 ± 2.0	1.13 ± 4.11	<0.001	3.5 ± 0.5	2.04 ± 2.09	0.39 ± 4.00	<0.001
eGFR, mL/min/1.73m ²	24.4 ± 22.4	33.6 ± 23.9	11.8 ± 11.4	< 0.001	24.8 ± 21.1	34.0 ± 22.2	12.8 ± 11.4	< 0.001
Time from referral to dialysis, month	41.7 ± 54.9	64.9 ± 58.2	3.1 ± 3.6	< 0.001	31.3 ± 40.3	49.5 ± 43.0	3.5 ± 3.7	<0.001
Findings at the time of dialysis			(.	100 0				100.01
Age at the time of dialysis, year	95.8 ± 13.9	50.0 ± 13.7	54.5 ± 14.2	0.001	$5/.9 \pm 12.5$	0.21 ± 0.60	55.5 ± 12.7	<0.001
Modified Charlson comorbidity index	5.2 ± 2.3	5.3 ± 2.3	5.0 ± 2.3	0.014	6.0 ± 2.2	6.3 ± 2.1	5.7 ± 2.2	< 0.001
Systolic BP, mmHg	141.5 ± 22.7	140.9 ± 22.6	142.6 ± 23.0	0.171	142.8 ± 23.3	142.7 ± 22.9	142.9 ± 23.9	0.915
Diastolic BP, mmHg	78.1 ± 14.2	77.3 ± 13.9	79.6 ± 14.5	0.005	76.7 ± 13.8	75.6 ± 13.4	78.4 ± 14.4	0.014
BMI, kg/m ²	23.0 ± 3.4	23.0 ± 3.4	23.0 ± 3.5	0.905	23.3 ± 3.4	23.4 ± 3.3	23.1 ± 3.5	0.180
Hemoglobin, g/dL	9.0 ± 1.6	9.0 ± 1.6	8.9 ± 1.6	0.016	9.0 ± 1.5	9.0 ± 1.5	8.9 ± 1.6	0.220
Calcium, mg/dL	7.8 ± 1.0	7.9 ± 1.0	7.7 ± 1.1	0.012	7.8 ± 1.0	7.9 ± 0.9	7.7 ± 1.1	0.007
Phosphate, mg/dL	5.5 ± 1.9	5.4 ± 1.8	5.6 ± 2.0	0.038	5.3 ± 1.8	5.2 ± 1.7	5.5 ± 1.9	0.063
LDL cholesterol, mg/dL	89.5 ± 38.1	87.4 ± 38.5	93.0 ± 37.3	0.003	89.1 ± 40.4	85.7 ± 40.7	94.0 ± 39.5	0.001
Occupation				0.030				0.044
Professional specialist	82 (4.7)	62 (5.7)	20(3.0)		44 (4.4)	33 (5.5)	11 (2.8)	
Office worker	64 (3.7)	40 (3.7)	24 (3.7)		29 (2.9)	16 (2.7)	13 (3.3)	
Manager	117 (6.7)	76 (7.0)	41 (6.3)		63(6.3)	38 (6.3)	25(6.3)	
Housewife and student	369 (21.2)	237 (21.8)	132(20.1)		198 (19.9)	126 (21.0)	72 (18.2)	
The unemployed	784 (45.0)	499 (45.9)	285 (43.4)		483 (48.5)	301 (50.1)	182(46.1)	
The sales and service	80(4.6)	47 (4.3)	33 (5.0)		33 (3.5)	21 (3.5)	14 (3.5)	
Mechanic and machine operator	87 (5.0)	44 (4.0)	43 (6.6)		58 (5.8)	28 (4.7)	30(7.6)	
Laborer	51 (2.9)	29 (2.7)	22 (3.4)		27 (2.7)	11 (1.8)	16(4.1)	
Farmer and fisherman	46 (2.6)	22 (2.0)	24 (3.7)		24 (2.4)	10(1.7)	14 (3.5)	
Others	64 (3.6)	32 (2.9)	32 (4.9)		35 (3.5)	17 (2.8)	18 (4.6)	
Education				0.050				0.090
Uneducated	62 (3.6)	47 (4.3)	15 (2.3)		35 (3.5)	28 (4.7)	7 (1.8)	
Elementary school	289 (16.6)	183 (16.8)	106 (16.2)		178 (17.9)	107 (17.8)	71 (18.0)	
Middle school	254(14.6)	148 (13.6)	106(16.2)		157 (15.8)	95 (15.8)	62 (15.7)	

		Total ES	SRD			DM ESI	8D	
	Total (N = 1744)	Early Referral $(N = 1088)$	Late Referral $(N = 656)$	P Value	Total $(N = 996)$	Early Referral $(N = 601)$	Late Referral (N = 395)	P Value
High school	597 (34.2)	363 (33.4)	234 (35.7)		358 (35.9)	204 (33.9)	154 (39.0)	
University	425 (24.4)	274 (25.2)	151(23.0)		213 (21.4)	133 (22.1)	80 (20.3)	
Graduate school	44 (2.5)	33 (3.0)	11 (1.7)		20 (2.0)	15 (2.5)	5 (1.3)	
No relevant data	73 (4.2)	40 (3.7)	33 (5.0)		35 (3.5)	19 (3.2)	16(4.1)	
Smoking				0.001				0.020
Never	946 (54.2)	615 (56.5)	331 (50.5)		508 (51.0)	306(50.9)	202 (51.1)	
Current	177 (10.1)	89 (8.2)	88 (13.4)		117 (11.7)	59 (9.8)	58 (14.7)	
Former	600 (34.4)	369 (33.9)	231 (35.2)		360(36.1)	227 (37.8)	133 (33.7)	
Unknown	10(0.6)	9(0.8)	1 (0.2)		(0.0)	6(1.0)	0(0.0)	
No relevant data	11 (0.6)	(0.0)	5(0.8)		5(0.5)	3(0.5)	2(0.5)	
Comorbidities								
Coronary heart disease	232 (13.3)	149 (13.7)	83 (12.7)	0.558	164(16.5)	111 (18.5)	53 (13.4)	0.042
Peripheral vascular disease	136 (7.8)	88 (8.1)	48 (7.3)	0.575	110(11.0)	73 (12.1)	37 (9.4)	0.183
Congestive heart failure	199 (11.4)	96(8.8)	103 (15.7)	< 0.001	136 (13.7)	65(10.8)	71 (18.0)	0.001
Connective tissue disease	157 (9.0)	115 (10.6)	42 (6.4)	0.003	61 (6.1)	42 (7.0)	19(4.8)	0.167
Liver disease, mild	95 (5.4)	74 (6.8)	21 (3.2)	0.001	57 (5.7)	44 (7.3)	13 (3.3)	0.008
Cerebrovascular accident	48 (2.8)	35 (3.2)	13 (2.0)	0.130	27 (2.7)	20(3.3)	7 (1.8)	0.143
Tumors	113 (6.5)	83 (7.6)	30 (4.6)	0.013	65 (6.5)	47 (7.8)	18 (4.6)	0.045
Ambulation status				0.042				0.318
Normal	1516 (86.9)	964 (88.6)	552 (84.1)		834 (83.7)	514 (85.5)	320(81.0)	
Walks with assistance	136 (7.8)	71 (6.5)	65 (9.9)		90(9.0)	48 (8.0)	42 (10.6)	
Wheelchair	58 (3.3)	32 (2.9)	26(4.0)		47 (4.7)	25 (4.2)	22 (5.6)	
Bed ridden	29 (1.7)	18 (1.7)	11 (1.7)		21 (2.1)	12 (2.0)	9 (2.3)	
No relevant data	5(0.3)	3 (0.3)	2(0.3)		4 (0.4)	2 (0.3)	2(0.5)	
Medications								
ACE inhibitor	159 (9.1)	89 (8.2)	70 (10.7)	0.079	107 (10.7)	60(10.0)	47 (12.0)	0.328
Angiotensin receptor blocker	891 (51.1)	548 (50.4)	343 (52.3)	0.499	515 (51.7)	307 (51.3)	208 (52.8)	0.635
Diuretics	950 (54.5)	594 (54.6)	356 (54.3)	0.851	613 (61.5)	383 (63.7)	230 (58.5)	0.099
Beta blocker	907 (52.0)	566 (52.0)	341 (52.0)	0.976	555 (55.7)	335 (55.7)	220 (56.0)	0.941
Calcium channel blocker	1069 (61.3)	682 (62.7)	387 (59.0)	0.124	628 (63.1)	391 (65.1)	237 (60.5)	0.142
Vitamin D	304 (17.4)	206 (18.9)	98 (14.9)	0.030	135 (13.6)	86 (14.4)	49 (12.5)	0.399
Phosphate binder, calcium	1041 (59.7)	670 (61.6)	371 (56.6)	0.039	566 (56.8)	345 (57.6)	221 (56.5)	0.738
The early referral group was defined as r less than a year prior to dialysis initiation.	patients who were referr ACE = angiotensin-cor	ed to a nephrologist m werting-enzyme, BMI	ore than 1 year prior to [= body mass index, F	o dialysis initia 3P = blood pres	ion. The late referr sure, DM = diabet	al group was defined as es mellitus, eGFR = est	s patients whose refer imated glomerular fil	al time was tration rate,
ESRD = end-stage renal disease, LDL = h	ow-density lipoprotein.	,)	•	4		x)	

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		Total ES	RD			DM ESF	Ð	
	Late Referral $(N = 656)$	Late Referral Except ULR $(N = 258)$	Ultralate Referral (N=398)	P Value	Late Referral $(N = 395)$	Late Referral Except ULR $(N=177)$	Ultralate Referral $(N = 218)$	<i>P</i> Value
Findings at the time of referral to nephrol	logist							
Age at the time of referral, year	54.5 ± 14.2	55.2 ± 13.5	54.1 ± 14.6	0.486	55.3 ± 12.8	55.7 ± 12.4	55.0 ± 13.1	0.775
Gender (male, %)	419 (63.9)	160(62.0)	259 (65.1)	0.425	258 (65.3)	112 (63.3)		0.443
Underlying kidney disease, %				0.005				
Diabetes mellitus	395 (60.2)	177 (68.6)	218 (54.8)					
Hypertension	115 (17.5)	33 (12.8)	82 (20.6)					
Glomerulonephritis	73 (11.1)	24 (9.3)	49 (12.3)					
Others	73 (11.1)	24 (9.3)	49 (12.3)					
Findings at the time of dialysis								
Age at the time of dialysis, year	54.5 ± 14.2	55.2 ± 13.5	54.1 ± 14.6	0.484	55.3 ± 12.7	55.7 ± 12.4	55.0 ± 13.1	0.773
Modified Charlson comorbidity index	5.0 ± 2.3	5.3 ± 2.3	4.8 ± 2.2	0.003	5.7 ± 2.2	5.9 ± 2.1	5.5 ± 2.3	0.053
Diastolic BP, mm Hg	79.6 ± 14.5	78.0 ± 13.6	80.7 ± 15.1	0.048	78.4 ± 14.4	77.8 ± 14.0	78.8 ± 14.7	0.650
Hemoglobin, g/dL	8.9 ± 1.6	9.0 ± 1.5	8.8 ± 1.7	0.125	8.9 ± 1.6	9.0 ± 1.5	8.8 ± 1.6	0.606
Calcium, mg/dL	7.7 ± 1.1	7.7 ± 1.0	7.7 ± 1.1	0.488	7.7 ± 1.1	7.7 ± 1.0	7.6 ± 1.1	0.300
Phosphate. mg/dL	5.6 ± 2.0	5.5 ± 1.6	5.7 ± 2.3	0.095	5.5 ± 1.9	5.6 ± 1.7	5.4 ± 2.0	0.192
PTH, intact	266.2 ± 216.7	234.5 ± 168.5	287.1 ± 241.3	0.021	237.6 ± 214.5	210.2 ± 155.6	260.6 ± 251.8	0.149
B2-Microolohulin	21.0 + 9.5	19.8 + 8.4	21.8 + 10.1	0.039	19.7 + 8.7	18.6 ± 7.3	20.8 + 9.7	0.074
HbA1r %	61+15	63 + 16	60 + 14	0.010	64+16	65 ± 1.8	64 + 15	0.413
I DI chalesteral ma/dI	03.0 ± 37.3	88.5 ± 34.8	$0.0 \pm 1.1 \times 38.6$	0.054	04.0 ± 30.5	0.0 ± 3.7 7	070 ± 410	0.734
LUL VIDIESCIUI, IIIS/UL	$c.ic \pm 0.cc$	0.+C T C.00	0.07 ± 0.07	0.074	U.40 ± 0.46	1.10 ± 1.00	7.0 ± 41.0	0.230
				610.0	11 (0 0)		1 (1 0)	0.240
Protessional specialist	20(3.0)	(5.5) 6	11(2.8)		11 (2.8)	/ (4.0)	(1.8)	
Office worker	24 (3.7)	10(3.9)	14 (3.5)		13 (3.3)	6 (3.4)	7 (3.2)	
Manager	41 (6.3)	15 (5.8)	26 (6.5)		25 (6.3)	11 (6.2)	14 (6.4)	
Housewife and student	132 (20.1)	58 (22.5)	74 (18.6)		72 (18.2)	35 (19.8)	37 (17.0)	
The unemployed	285 (43.4)	116 (45.0)	169(42.5)		182 (46.1)	83 (46.9)	99 (45.4)	
The sales and service	33(5.0)	14 (5.4)	19(4.8)		14 (3.5)	9 (5.1)	5 (2.3)	
Mechanic and machine operator	43 (6.6)	16 (6.2)	27 (6.8)		30(7.6)	13 (7.3)	17 (7.8)	
Laborer	22 (3.4)	8 (3.1)	14 (3.5)		16 (4.1)	6 (3.4)	10(4.6)	
Farmer and fisherman	24 (3.7)	3 (1.2)	21(5.3)		14 (3.5)	2(1.1)	12 (5.5)	
Others	32 (4.9)	9 (3.5)	23 (5.8)		18 (4.6)	5 (2.8)	13 (5.9)	
Familial support	~	~	~	0.378	~	~	~	0.170
None	78 (11.9)	24 (9.3)	54 (13.6)		42 (10.6)	14 (7.9)	28 (12.8)	
<50%	339 (51.7)	137 (53.1)	202 (50.8)		207 (52.4)	94 (53.1)	113 (51.8)	
50% - 100%	142 (21.6)	56 (21.7)	86 (21.6)		83 (21.0)	35 (19.8)	48 (22.0)	
Full support, 100% dependent	93 (14.2)	40 (15.5)	53 (13.3)		62 (15.7)	34 (19.2)	28 (12.8)	
No relevant data	4 (0.6)	1(0.4)	3 (0.8)		1(0.3)	~	1(0.5)	
Comorbidities								
Peripheral vascular disease	48 (7.3)	26(10.1)	22 (5.5)	0.028	37 (9.5)	21 (11.9)	16 (7.3)	0.122
Congestive heart failure	103 (15.8)	42 (16.3)	61 (15.3)	0.769	71 (18.2)	29(16.4)	42 (19.3)	0.423

6 | www.md-journal.com

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		Total ESI	RD			DM ESR	D	
	Late Referral $(N = 656)$	Late Referral Except ULR $(N = 258)$	Ultralate Referral (N=398)	P Value	Late Referral $(N=395)$	Late Referral Except ULR $(N = 177)$	Ultralate Referral (N = 218)	P Value
Connective tissue disease	42 (6.5)	18 (7.0)	24 (6.0)	0.643	19 (4.9)	10 (5.6)	9 (4.1)	0.494
Liver disease, mild	21 (3.2)	7 (2.7)	14 (3.5)	0.554	13 (3.3)	6 (3.4)	7 (3.2)	0.947
Ambulation status				0.779				0.499
Normal	552 (84.1)	217 (84.1)	355 (84.2)		320(81.0)	144 (81.4)	176 (80.7)	
Walks with assistance	65 (9.9)	25 (9.7)	40(10.1)		42 (10.6)	19(10.7)	23 (10.6)	
Wheelchair	26 (4.0)	10(3.9)	16(4.0)		22 (5.6)	8 (4.5)	14 (6.4)	
Bed ridden	11 (1.7)	6 (2.3)	5(1.3)		9 (2.3)	6 (3.4)	3 (1.4)	
No relevant data	2(0.3)		2(0.5)		2(0.5)		2(0.9)	
Medications								
ACE inhibitor	70 (10.7)	24 (9.3)	46 (11.6)	0.328	47 (12.0)	19 (10.7)	28 (12.8)	0.488
Diuretics	356 (54.3)	160(62.0)	196 (49.2)	0.002	230 (58.5)	116 (65.5)	114 (52.3)	0.011
Calcium channel blocker	387 (59.0)	165 (64.0)	222 (55.8)	0.049	237 (60.5)	115 (65.0)	122 (56.0)	0.097
The late referral group was defined as pa dialysis initiation. ACE = angiotensin-com PTH = parathyroid hormone, ULR = ultral	tients whose referral timeration $P = b^{2}$ are referral group.	he was less than a year lood pressure, DM = d	prior to dialysis init iabetes mellitus, ES	iation. The ULR SRD = end-stage	was defined as pati renal disease, HbA	ants whose referral time lc = hemoglobin Alc,	t was less than 3 mc LDL = low-density	nths prior to lipoprotein,

Demographic, Clinical, and Social Factors Associated With Late and Ultralate Referral

The association of various demographic, clinical, and socio-economic factors with late and ultralate referral was analyzed with univariable logistic regression methods (Table 4). Male sex, underlying kidney disease (diabetes mellitus and hypertension), occupation (generally considered to be associated with low income and physical activity, including the sale and service, mechanic, laborer, and farmer or fisherman), smoking, congestive heart failure, and restricted ambulation with assistance were associated with late referral. Vitamin D and phosphate binder usage were associated with early referral in univariable analysis. Male sex, hypertensive kidney disease, occupation (mechanic, laborer, and farmer or fisherman), poor familial support, congestive heart failure, and not using diuretics were associated with ultralate referral. To validate the independent effects of various factors on late and ultralate referral, we analyzed the association using the multiple logistic regression methods (Table 5). Various factors, including male sex, hypertensive kidney disease, occupation, congestive heart failure, and restricted ambulation with assistance, were independently associated with late and ultralate referral. Diabetic kidney disease was associated with late referral, and smoking was associated with ultralate referral.

DISCUSSION

We investigated the influence of various demographic, clinical, and social factors on the referral time from the initial visit to a nephrologist to the start of dialysis using a prospective cohort of patients with end-stage renal disease. We found that patients with hypertension or diabetes as a cause of kidney disease were referred later than those with glomerulonephritis. Hypertensive or diabetic kidney disease, occupation, congestive heart failure, and restricted ambulation with assistance were proved to be independently associated with late referral. In addition, patients who were female and presented connective tissue disease or neoplastic disease, a high degree of education or an uneducated status, and a high degree of familial support were associated with a long referral time, whereas patients who presented congestive heart failure and smoking habits were associated with a short referral time.

The causes of primary kidney disease are important factors that determine the referral time of CKD patients. Patients with glomerulonephritis are referred early throughout the world, 13-15 which is easily understood because glomerulonephritis is treated almost exclusively in the nephrology department. The reason for the high proportion of kidney biopsies might be related to the high probability of glomerulonephritis in the ER. CKD patients with diabetes mellitus are recommended for early referral to prevent the rapid progression of kidney disease and improve patient survival.^{16,17} Many other studies have reported that patients with diabetic kidney disease are referred early at more than 3 or 4 month before dialysis initiation.^{18–22} Kessler et al¹⁵ and Kinchen et al²³ reported that the most prevalent referral time for diabetic kidney disease patients is between 4 and 12 months. Contrary to expectations, the results of this study showed that patients with diabetes were referred late compared with patients with glomerulonephritis and polycystic kidney disease. When we compared the referral time according to the causes of primary kidney disease, the referral time for diabetic kidney disease $(31.3 \pm 40.3 \text{ months})$ was shorter than that for glomerulonephritis $(63.3 \pm 71.5 \text{ months})$ or hypertension $(41.5 \pm 55.0 \text{ months})$. Among the 996 patients with diabetic kidney disease, 395

	Time From Referral to Dialysis, Month	<i>P</i> Value
Gender		0.010
Female	46.0 ± 59.4	
Male	38.8 ± 51.6	
Underlying kidney disease		< 0.001
Diabetes mellitus	31.3 ± 40.3	
Hypertension	41.5 ± 55.0	
Glomerulonephritis	63.3 ± 71.5	
Others	64.3 ± 74.7	
Occupation		0.028
Professional specialist	48.2 ± 54.6	
Office worker	52.9 ± 67.5	
Manager	44.6 ± 54.6	
Housewife and student	45.8 ± 59.1	
The unemployed	41.0 ± 53.7	
Ine sales and service	34.9 ± 51.1	
Mechanic and machine operator	33.2 ± 52.3	
Laborer	$38.1 \pm 4/.3$	
Farmer and fisherman	33.8 ± 01.8	0 724
Hoalth care (I)	377 ± 47.6	0.734
Health care (II)	37.7 ± 47.0	
Health insurance, working poor	40.2 ± 34.4 36.1 ± 47.7	
Health insurance, rare/incurable disease	30.1 ± 47.7 40.5 ± 61.2	
Health insurance, general	40.3 ± 01.2 42.4 ± 55.6	
Unknown	42.4 ± 35.0 35.0 ± 30.3	
Marriage	55.7 ± 57.5	0.259
Single, never been married	43.3 ± 55.5	0.209
Married, live together	42.8 ± 57.1	
Widowed	43.6 ± 51.6	
Divorced	30.8 ± 38.9	
Married, live separately	35.9 ± 39.3	
Familial support		0.001
None	29.5 ± 35.3	
<50%	39.0 ± 48.5	
50%-100%	44.8 ± 65.8	
Full support, 100% dependent	52.7 ± 63.0	
Education		0.013
Uneducated	44.9 ± 49.8	
Elementary school	38.7 ± 47.5	
Middle school	35.0 ± 48.3	
High school	42.1 ± 57.9	
University	46.0 ± 60.5	
Graduate school	61.6 ± 62.1	-0.001
Smoking	45.0 + 50.0	< 0.001
Never	45.8 ± 58.0	
Current	28.7 ± 47.0	
Former	38.9 ± 31.3	
Coronary heart disease		0.874
Vas	35.0 ± 42.2	0.0/0
No	33.7 ± 43.3 42.7 ± 56.5	
Perinheral vascular disease	±2.1 ± 30.3	0 114
Ves	38.4 ± 42.1	0.440
No	42.0 ± 56.0	
Cerebrovascular disease	-12.0 ± 30.0	0 430
Yes	33.2 + 36.4	0.150
	55.2 ± 50.7	

	Time From Referral to Dialysis, Month	<i>P</i> Value
No	42.6 ± 56.3	
Congestive heart failure		< 0.001
Yes	27.5 ± 40.4	
No	43.6 ± 56.3	
Connective tissue disease		< 0.001
Yes	62.0 ± 73.4	
No	39.7 ± 52.4	
Liver disease, mild		0.028
Yes	47.4 ± 46.7	
No	41.4 ± 55.4	
Cerebrovascular accident		0.271
Yes	46.2 ± 56.0	
No	41.7 ± 55.0	
Tumors		0.012
Yes	54.7 ± 68.7	
NO A substation states	40.8 ± 53.8	0.0(2
Ambulation status	427 557	0.063
Normai Wellie with essistence	42.7 ± 33.7	
Wheelebair	36.4 ± 37.0	
Red ridden	20.0 ± 29.8 31.0 \pm 33.7	
Medications	51.0 ± 55.7	
ACE inhibitor		0.062
Yes	333 + 413	0.002
No	42.6 ± 56.2	
Angiotensin receptor blocker		0.311
Yes	40.0 ± 53.9	
No	43.4 ± 56.1	
Diuretics		0.140
Yes	38.5 ± 52.7	
No	45.4 ± 57.4	
Beta blocker		0.128
Yes	39.0 ± 52.7	
No	44.7 ± 57.8	
Calcium channel blocker	10 5 1 55 1	0.092
Yes	42.5 ± 55.1	
NO Vitamin D	40.3 ± 54.7	<0.001
Vitamin D	52.0 ± 64.2	< 0.001
No	33.9 ± 04.3 30.1 \pm 52.5	
Phosphate binder, calcium	37.1 ± 32.3	0 099
Yes	42.9 ± 56.0	0.077
No	40.0 ± 53.4	
Iron	1010 ± 0011	0.478
Oral	41.2 ± 53.3	
IV	38.6 ± 54.9	
IV + Oral	57.4 ± 72.8	
Not used	42.1 ± 57.0	
ESA		0.187
Epoetin alpha	43.3 ± 56.0	
Epoetin beta	35.7 ± 46.3	
Darbepoietin alpha	37.9 ± 50.6	
CERA	51.7 ± 65.5	
Not used	43.3 ± 58.0	

 $\label{eq:action} ACE = angiotensin-converting-enzyme, \ CERA = continuous \ ery-thropoietin receptor activator, ESA = erythropoietin-stimulating agent.$

TABLE 4. Univariable Analysis for Late and Ultralate Referral

	Late Referral		Ultralate Referra	l
Factors	OR (95% CI)	P Value	OR (95% CI)	P Value
Age at the time of dialysis, years	0.989 (0.982-0.996)	0.002	0.989 (0.981-0.997)	0.005
Sex (male)	1.228 (1.006-1.500)	0.044	1.264 (1.001-1.596)	0.049
Underlying kidney disease		< 0.001		0.003
Diabetes mellitus	1.432 (1.044-1.964)	0.026	1.046 (0.729-1.502)	0.807
Hypertension	1.705 (1.168-2.489)	0.006	1.701 (1.117-2.589)	0.013
Glomerulonephritis Others	0.829 (0.558–1.230) 1	0.351	0.847 (0.539–1.331) 1	0.471
Modified Charlson comorbidity index	0.949 (0.910-0.991)	0.017	0.910 (0.865-0.958)	< 0.001
Systolic BP, mm Hg	1.003 (0.999-1.008)	0.136	1.005 (1.000 - 1.010)	0.069
Diastolic BP, mm Hg	1.012 (1.005-1.019)	0.001	1.016 (1.008-1.024)	< 0.001
BMI	$1.005 \ (0.977 - 1.034)$	0.718	1.001 (0.968-1.034)	0.965
Occupation		0.035		0.007
Professional specialist	1		1	
Office worker	1.860 (0.911-3.799)	0.089	1.807 (0.758 - 4.308)	0.182
Manager	1.672 (0.890-3.143)	0.110	1.844 (0.854-3.984)	0.119
Housewife and student	1.727 (0.999-2.984)	0.050	1.619 (0.817-3.210)	0.168
The unemployed	1.711 (1.048-2.992)	0.033	1.774 (0.919-3.423)	0.088
The sales and service	2.177 (1.111-4.264)	0.023	2.010 (0.888-4.554)	0.094
Mechanic and machine operator	3.030 (1.572-5.840)	0.001	2.905 (1.330-6.341)	0.007
Laborer	2.352 (1.112-4.974)	0.025	2.442 (1.009-5.912)	0.048
Farmer and fisherman	3.382 (1.570-7.284)	0.002	5.422 (2.294-12.815)	< 0.001
Others	2.583 (0.971-6.876)	0.057	1.898 (0.582-6.192)	0.288
Insurance		0.307		0.661
Health insurance, general	1		1	
Health care (I)	1.081 (0.764-1.530)	0.660	0.934 (0.619-1.408)	0.743
Health care (II)	0.210 (0.048-0.916)	0.038	0.199 (0.026-1.502)	0.117
Health insurance, working poor	1.558 (0.727-3.339)	0.255	1.185 (0.496-2.827)	0.703
Health insurance, rare/incurable disease	1.067 (0.734-1.552)	0.732	1.152 (0.757-1.754)	0.509
Marriage		0.675		0.216
Married, live together	1		1	
Single, never been married	1.201 (0.891-1.620)	0.230	1.495 (1.076-2.077)	0.017
Widowed	1.024 (0.696-1.506)	0.904	0.957 (0.604-1.516)	0.851
Divorced	1.335 (0.831-2.145)	0.232	1.193 (0.690-2.064)	0.528
Married, live separately	1.434 (0.590-3.486)	0.427	1.237 (0.446-3.436)	0.683
Unknown	1.126 (0.484-2.623)	0.783	1.624 (0.661-3.989)	0.290
Family numbers	1.024 (0.945-1.108)	0.568	0.998 (0.910-1.095)	0.969
Familial support		0.104		0.030
None	1.626 (1.104-2.395)	0.014	1.921 (1.240-2.976)	0.003
<50%	1.272 (0.920-1.761)	0.146	1.314 (0.895-1.929)	0.163
50%-100%	1.224 (0.923-1.623)	0.161	1.247 (0.890-1.747)	0.199
Full support, 100% dependent Social support	1	0.437	1	0.487
None	1.165(0.797 - 1.702)	0.430	1.331 (0.854-2.075)	0.206
<50%	1.036 (0.726-1.478)	0.845	1.059 (0.694-1.618)	0.789
50%-100%	0.933 (0.663-1.314)	0.692	1.128 (0.752-1.693)	0.560
Full support, 100% dependent Education	1	0.055	1	0.398
Uneducated	1		1	
Elementary school	1.815 (0.968-3.403)	0.063	1.777 (0.833-3.791)	0.137
Middle school	2.244 (1.192-4.224)	0.012	1.861 (0.868-3.992)	0.111
High school	2.202 (1.104-3.695)	0.023	1.804 (0.868-3.749)	0.114
University	1.727 (0.934-3.191)	0.081	1.604 (0.763-3.375)	0.213
Graduate school	1.044 (0.426-2.560)	0.924	0.930 (0.305-2.832)	0.898
Smoking		0.001		0.063
Never	1		1	
Current	1.837 (1.329-2.539)	< 0.001	1.572 (1.097-2.251)	0.014
Former	1.163 (0.941-1.438)	0.162	1.171 (0.917-1.496)	0.206

	Late Referral		Ultralate Referra	ıl
Factors	OR (95% CI)	P Value	OR (95% CI)	P Value
Comorbidities				
Coronary heart disease	0.918 (0.688-1.224)	0.558	0.848 (0.602-1.194)	0.345
Peripheral vascular disease	0.901 (0.625-1.299)	0.575	0.633 (0.395-1.013)	0.057
Cerebrovascular disease	0.996 (0.704-1.407)	0.980	0.919 (0.611-1.381)	0.684
Congestive heart failure	1.938 (1.440-2.609)	< 0.001	1.600 (1.156-2.213)	0.005
Arrhythmia	0.715 (0.370-1.382)	0.319	0.654 (0.289-1.482)	0.310
Connective tissue disease	0.581 (0.402-0.839)	0.004	0.589 (0.376-0.924)	0.021
Peptic ulcer disease	0.845 (0.564-1.266)	0.414	0.871 (0.543-1.398)	0.568
Liver disease, mild	0.456 (0.278-0.747)	0.002	0.575 (0.322-1.025)	0.061
Liver disease, moderate to severe	0.787 (0.452-1.370)	0.397	1.065 (0.578-1.961)	0.841
Cerebrovascular accident	0.611 (0.321-1.164)	0.134	0.675 (0.313-1.455)	0.316
Tumors	0.583 (0.379-0.896)	0.014	0.719 (0.437-1.182)	0.193
Ambulation status	× , , , , , , , , , , , , , , , , , , ,	0.043	× ,	0.170
Normal	1		1	
Walks with assistance	1.599 (1.124-2.274)	0.009	1.469 (0.996-2.166)	0.052
Wheelchair	1.419 (0.837-2.406)	0.194	1.343 (0.746-2.419)	0.326
Bed ridden	1.067 (0.500-2.276)	0.866	0.734 (0.278-1.940)	0.533
Medications				
ACE inhibitor	1.343 (0.966-1.866)	0.080	1.440 (1.002-2.070)	0.049
Angiotensin receptor blocker	1.069 (0.880-1.299)	0.499	0.977 (0.781-1.223)	0.841
Diuretics	0.981 (0.808-1.193)	0.851	0.762 (0.608-0.953)	0.018
Beta blocker	0.997 (0.821-1.211)	0.976	0.929 (0.742-1.162)	0.517
Calcium channel blocker	0.855 (0.701-1.044)	0.124	0.748 (0.596-0.940)	0.013
Vitamin D	0.747 (0.575-0.972)	0.030	0.862 (0.637-1.168)	0.338
Phosphate binder, calcium	0.812 (0.666-0.989)	0.039	0.878 (0.699-1.103)	0.265
Iron		0.724		0.316
P.O.	0.928 (0.748-1.151)	0.497	0.951 (0.742-1.218)	0.689
I.V.	1.011 (0.668-1.529)	0.960	1.042 (0.650-1.670)	0.864
P.O + I.V.	0.684 (0.319-1.466)	0.329	0.324 (0.097-1.079)	0.066
No use or unknown	1		1	
ESA		0.283		0.095
Epoetin alpha	0.872 (0.679-1.120)	0.285	0.893 (0.670-1.189)	0.437
Epoetin beta	0.891 (0.575-1.382)	0.607	1.341 (0.840-2.142)	0.219
Darbepoietin alpha	0.992 (0.763-1.290)	0.953	0.863 (0.637-1.170)	0.344
CERA	0.554 (0.308-0.996)	0.048	0.443 (0.205-0.959)	0.039
No use or unknown	1		1	

ACE = angiotensin-converting-enzyme, BMI = body mass index, BP = blood pressure, CERA = continuous erythropoietin receptor activator, 95% CI = 95% confidence interval, ESA = erythropoietin stimulating agents, OR = odds ratio.

(39.7%) patients were treated by their primary physician or endocrinologists and referred less than 12 months before dialysis initiation. These discrepancies result from the definition of an early or late referral. In this study, we defined an early referral as more than 12 months prior to the start of dialysis. The continuing problem of late referral for diabetic patients might result from the lack of knowledge on the benefits of early referral and optimum referral times among physicians.²⁴ A referral time of 1 year is insufficient to adequately care for diabetic kidney disease patients or to prevent or delay the renal complications of diabetes mellitus. We showed that the clinical outcomes of patients with diabetic CKD can be associated with better clinical prognosis through early referral; lowering blood pressure, phosphorus levels, and LDL cholesterol levels; and start of dialysis at later time. Patients with diabetic kidney disease should be referred earlier at the stage of microalbuminuria or decreased kidney function (before CKD stage 3).

When we compared the comorbidities, the proportion of patients with congestive heart failure was high in the LR. Reduced kidney function and advanced CKD are high risk factors for heart failure.²⁵ Volume overload, high blood pressure, increased renin-angiotensin-aldosterone system activity, and abnormal lipid metabolism, which are complicated in CKD, can contribute to the development of heart failure.²⁶ Heart failure can aggravate the progression of CKD and increase the risk of end-stage renal disease and death in patients with CKD.27,28 Therefore, dietary salt restrictions and adequate blood pressure control, which are emphasized in the management of advanced CKD patients, are important for preventing volume overload and the development or aggravation of heart failure. Patients in the ER in this study could present a low prevalence of congestive heart failure because of adequate drug prescriptions and education regarding CKD and diet in the nephrology clinics. In fact, patients in the ER had low diastolic blood pressure and low cholesterol levels. Patients in the LR had a higher prevalence of congestive heart failure and a higher usage of diuretics, especially among patients who were referred between 3 and 12 months prior to starting dialysis. Patients in the ER are relatively well controlled with salt restriction, and patients in the LR might be treated less adequately for volume

	Late Referra	1	Ultralate Refer	ral
Factors	OR (95% CI)	P Value	OR (95% CI)	P Value
Age at the time of dialysis, years	0.978 (0.969-0.987)	< 0.001	0.980 (0.971-0.989)	< 0.001
Sex (male)	1.465 (1.034-2.076)	0.032		
Underlying kidney disease		< 0.001		0.001
Diabetes mellitus	1.507 (1.057-2.148)	0.023	1.362 (0.964-1.922)	0.080
Hypertension	1.995 (1.305-3.051)	0.001	1.776 (1.175-2.685)	0.006
Glomerulonephritis	0.904(0.582 - 1.404)	0.654	0.808 (0.524-1.244)	0.332
Others	1		1	
Diastolic BP, mm Hg	1.011 (1.003-1.019)	0.007	1.010 (1.002-1.018)	0.011
Occupation		0.010		0.016
Professional specialist	1		1	
Office worker	2.292 (1.033-5.086)	0.041	2.227 (1.008-4.920)	0.048
Manager	1.896 (0.945-3.803)	0.072	1.848 (0.924-3.694)	0.082
Housewife and student	3.225 (1.684-6.175)	< 0.001	2.473 (1.333-4.591)	0.004
The unemployed	2.385 (1.318-4.315)	0.004	2.337 (1.297-4.212)	0.005
The sales and service	2.837 (1.363-5.908)	0.005	2.609 (1.256-5.420)	0.010
Mechanic and machine operator	2.975 (1.445-6.125)	0.003	3.029 (1.479-6.205)	0.002
Laborer	3.209 (1.405-7.327)	0.006	3.197 (1.408-7.259)	0.005
Farmer and fisherman	5.147 (2.217-11.953)	< 0.001	5.221 (2.268-12.021)	< 0.001
Others	2.559 (0.816-8.022)	0.107	3.848 (1.354-10.939)	0.011
Smoking		0.094	× , , , , , , , , , , , , , , , , , , ,	0.003
Never	1		1	
Current	1.564 (1.042-2.348)	0.031	1.832 (1.260-2.665)	0.002
Former	1.137 (0.843-1.533)	0.399	1.311 (1.013-1.696)	0.040
Comorbidities			· · · · ·	
Congestive heart failure	2.152 (1.543-3.000)	< 0.001	1.979 (1.430-2.741)	< 0.001
Connective tissue disease	0.554 (0.371-0.828)	0.004	0.552 (0.371-0.822)	0.003
Liver disease, mild	0.358 (0.205-0.625)	< 0.001	0.373 (0.214-0.649)	< 0.001
Cerebrovascular accident	0.411 (0.196-0.860)	0.018		
Ambulation status		0.002		0.008
Normal	1		1	
Walks with assistance	2.072 (1.381-3.111)	< 0.001	1.937 (1.299-2.887)	< 0.001
Wheelchair	1.699 (0.942-3.061)	0.078	1.529 (0.870-2.689)	0.140
Bed ridden	1.470 (0.620-3.485)	0.381	1.155 (0.496-2.693)	0.738

TABLE 5. Multivariable Analysis for Late and Ultralate Referral

overload and high blood pressure. Therefore, the clinical need for diuretics would be increased in the LR.

Studies have suggested that demographic and socioeconomic status affect the referral time to nephrologists and showed that discrepancies occur according to race, nations, and social or medical systems. In general, patients without insurance or employment and with low education and restricted ambu-latory status are referred late.^{20,23} In this study, the status of medical insurance was consistent between the ER and LR. In South Korea, all patients have obligatory public medical insurance, and accessibility to medical facilities is relatively good. The status of medical insurance might affect referral time when the insurance system is diverse, nonobligatory, or not generalized to all populations. However, occupation, education, smoking, degree of familial support, and status of ambulation are important factors associated with referral time. Occupation (generally considered to be associated with low income and physical activity, including the sale and service, mechanician, laborer, and farmer or fisher) was associated with short referral time. Low level of education (elementary or middle school) was

associated with short referral time, and highly educated patients who graduated from a university or finished graduate school and uneducated patients were strongly associated with long referral time. The association of uneducated patients with early referral might be related to hereditary or advanced kidney disease causing disturbances to normal education in childhood. Patients with reduced familial support and restricted ambulation are involuntarily susceptible to late referral. CKD patients with these socio-economic and lifestyle-related factors might experience difficulties or obstacles in visiting nephrology clinics. These results suggest the possibility of improving the status of nephrology referrals by a widespread social campaign or patient education to convey the importance of CKD and the reasons why patients should visit nephrologists at earlier stages.

The benefits of early referral to nephrologists are well known, and early referral improves patient survival and quality of life and reduces hospitalization, length of hospital stay, and medical costs.^{1,29–32} Using the CRC ESRD cohort in South Korea, we also demonstrated that early referral could provide benefits with regard to cardiovascular survival, medical

expenses, and quality of life after dialysis initiation.^{5–7} In addition, this study showed that early referral can be associated with the delay of renal replacement therapy. Jones et al³³ showed that reductions in the glomerular filtration rate slowed significantly after nephrology referral. These clinical benefits of early referral might arise from appropriate advanced CKD care during visits to nephrology clinics. Patients in the ER had visited nephrology clinics a greater number of times and had been educated regarding CKD and diet control to a greater degree compared with patients in the LR. The appropriate control of CKD in the ER resulted in improved patient health status at the start of dialysis, including a low diastolic blood pressure, high hemoglobin levels, low phosphorus levels, and low LDL cholesterol levels.

Herein, the association of various demographic, clinical, and social factors with referral time was analyzed using a largescale prospective cohort study. However, because of the nature of cross-sectional studies, we cannot directly prove the causal relationship between various factors and referral time. The results of this study, that revealed the factors associated with early or late referral to nephrologists, can be used in clinical practice to improve the care of patients with CKD and increase the proportion of patients who are referred early to nephrologists. In future studies, it will be helpful to investigate the optimal time of referral that is sufficient to delay the progression of kidney disease and prevent the episodes of heart failure aggravation, among CKD patients with diabetes mellitus or heart failure.

In conclusion, despite the various benefits of early referral, a large proportion of CKD patients with hypertension or diabetes are referred later than those with glomerulonephritis. Male sex, diabetic or hypertensive kidney disease, occupation, congestive heart failure, and restricted ambulation with assistance are independent risk factors for late referral. A low level of education, low familial support status, and smoking habits are factors associated with short referral time. Education regarding CKD and the benefits of early referral might be helpful to increase the number of patients who are referred early. Clinicians should be aware of the factors associated with late referral and attempt to refer these patients at an earlier CKD stage to improve clinical outcomes.

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