BMJ Open  Is decreased lung function associated with chronic kidney disease? A retrospective cohort study in Korea

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ABSTRACT

Objective There is some evidence that lung function and chronic kidney disease (CKD) may be related. We evaluated the impact of lung function on the development of CKD in a large-scale longitudinal study.

Method Retrospective longitudinal analyses were conducted among subjects who participated in comprehensive health check-ups at least four times during 7 years (between 2006 and 2012). We investigated the development of CKD during the follow-up period according to lung function status.

Results Ten thousand one hundred and twenty-eight individuals (mean age =51.2 years) without CKD at baseline were enrolled. During the mean follow-up of 5 years (58.5±14.4 months), 167 of the 10 128 subjects (1.6%) developed CKD. Multivariable Cox proportional hazards analyses adjusting for age, sex, body mass index, systolic blood pressure, fasting glucose, estimated glomerular filtration rate, uric acid, triglycerides, serum albumin, and the presence of diabetes and hypertension revealed that a decrease of 10% in the forced expiratory volume in 1s (FEV1)/forced vital capacity (FVC) ratio was associated with a 35% increase in the development of CKD during the follow-up. The incidence of CKD was higher in those with an FEV1/FVC ratio <0.8 compared with those with FEV1/FVC ratio ≥0.8 (HR=1.454; 95% CI 1.042 to 2.028, p=0.028).

Conclusions Limited airflow as measured by the FEV1/FVC ratio was associated with an increased risk of CKD.

INTRODUCTION

Chronic kidney disease (CKD) is an increasing public health problem in Korea and is associated with significant morbidity and mortality.1–4 CKD is linked to various other diseases, including hypertension, diabetes, atherosclerosis and metabolic syndrome (MetS).5 6 Chronic obstructive pulmonary disease (COPD) is a systemic inflammatory disease.7 It is known that cardiovascular disease, osteoporosis, diabetes and MetS are systemic effects caused by COPD and also its comorbidities.7 8 Proinflammatory cytokines, including tumour necrosis factor α and interleukin 6, induce insulin resistance by blocking signalling via the insulin receptor, thereby increasing the risk of type 2 diabetes and MetS in patients with COPD.3 However, only a few studies have examined the association between renal function and lung function, and found that kidney dysfunction is more common in patients with COPD.9–13 These studies suggest that CKD is associated with COPD. However, few studies have explored the relationship between lung function and the incidence of CKD. Thus, we examined cross-sectional and longitudinal associations between lung function, measured by calculating forced vital capacity (FVC), forced expiratory volume in 1s (FEV1), or the FEV1/FVC ratio, and the development of CKD after adjusting for other risk factors for CKD.

METHODS

Study population and data collection

This was a retrospective longitudinal cohort study. Many people undergo comprehensive health check-ups each year at the Samsung Medical Center. Initial data were obtained from 25 170 individuals who participated in comprehensive health check-ups at least four times over 7 years (between January 2006 and December 2012). The data from the first visits served as baseline data. In total, 15 042 subjects were excluded for the following reasons: (1)
missing pulmonary function test (n=3370), (2) age <20 years (n=7), (3) body mass index (BMI) <18.5 kg/m² (n=456), (4) CKD evident at baseline (n=965), (5) missing urine albumin/Cr ratio (n=6249) and (6) current smoker (n=3995). We excluded current smokers from this analysis because smoking itself has a significant effect on lung function. It would have been difficult to correctly evaluate the association between lung function and the development of CKD if we included current smokers in the study. A total of 10 128 individuals (mean age 51.2 years) without CKD at baseline were enrolled.

**Measurements**

All subjects fasted overnight, and blood was collected subsequently. All laboratory tests were performed in the central certified laboratory of Samsung Medical Center. Anthropometric and other biochemical variables were measured as described previously. Measured serum creatinine using the kinetic alkaline picrate method (Jaffe reaction; Roche Modular DP, Roche, Switzerland).

**Definition of development of CKD**

The estimated glomerular filtration rate (eGFR) was calculated using the Chronic Kidney Disease Epidemiology Collaboration (CKD-EPI) formula. CKD was defined as an eGFR <60 mL/min/1.73 m² in patients over 40 years old and eGFR <75 mL/min/1.73 m² in patients younger than 40 years old.

**Statistical analysis**

Data expressed as mean±SEM. Metabolic risk factors, the prevalence of diabetes and other clinical characteristics were compared between subjects who did and did not develop CKD. A Student’s t-test was used to compare continuous variables, and the exact $\chi^2$ test was used to detect differences between groups. Pearson’s correlation analyses were used to generate correlation coefficients between eGFR and other factors. We used multivariable Cox proportional hazards analyses to estimate HRs with 95% CIs for the development of CKD during follow-up. We compared the development of CKD between two groups (FEV₁/FVC ratio >0.8 vs FEV₁/FVC ratio <0.8) during follow-up using the HRs for incidences of CKD estimated by Cox proportional hazards analysis. All statistical analyses were performed using Predictive Analytics Software (PASW) (V.17.0; SPSS, Chicago, Illinois, USA). A p value <0.05 was considered statistically significant.

**Patient and public involvement statement**

This study was a retrospective study. Patients were not involved in this study.

**RESULTS**

During the mean follow-up of 5 years (58.5± 14.4 months), 167 of the 10 128 subjects (1.6%) developed CKD. The baseline characteristics of those with and without de novo CKD are shown in table 1. Those who developed CKD during the follow-up were significantly older and had a higher baseline BMI, higher triglyceride (Tg) levels and higher blood pressure (table 1). These subjects also had a lower baseline eGFR and FEV₁/FVC ratio (table 1). In addition, the incidence of hypertension at baseline was higher in subjects who developed CKD (table 1). The baseline eGFR correlated negatively with age, BMI, systolic blood pressure (SBP), total cholesterol, Hemoglobin A1c (HbA1c), uric acid, and high-sensitivity C reactive protein (hs-CRP). Conversely, eGFR correlated positively with High-density lipoprotein cholesterol (HDL).
We found that lower FEV1/FVC ratio was associated with an increased risk of CKD during the mean follow-up of 5 years. The FEV1/FVC ratio (Tiffeneau Index) is an index of airflow limitation. To the best of our knowledge, only a few studies have explored associations between lung function and CKD. Some studies found that kidney dysfunction was more common in patients with COPD. In a study by van Gestel et al., they found that the prevalence of CKD is increased in patients with COPD, and CKD is a common comorbidity of COPD. Van Gestel et al. also found that COPD was associated with CKD in patients undergoing vascular surgery. However, most of these studies were conducted in patients with COPD and had a cross-sectional design. Even less is known about the relationship between lung function and CKD incidence. Chen et al. explored the association between COPD and CKD incidence using hospital records and found that the overall incidence of CKD was higher in patients with COPD than patients without COPD. Our study also showed that subjects with a lower FEV1/FVC ratio were at increased risk of developing CKD. This remained true after adjusting for other known risk factors for CKD. Chen et al. used insurance research data, which did not include information on the GFR, pulmonary function or laboratory test results. Unlike Chen et al., we used the eGFR and pulmonary function test data to define CKD and pulmonary function.

Although our study results may be due to a causal relationship, there are some plausible explanations for this relationship. The lung dysfunction has risk factors in common with CKD including old age, smoking, diabetes, hypertension and obesity. Patients with reduced lung function may have coexisting diabetes, MetS and/or hypertension, which are known risk factors for CKD.

We also found that those who developed CKD were more likely to have hypertension and/or dyslipidaemia at baseline and more likely to be older. Baseline age, BMI, HbA1c level and SBP negatively correlated with eGFR. However, reduced lung function (FEV1/FVC ratio) at baseline and more likely to be older. Baseline age, BMI, HbA1c level and SBP negatively correlated with eGFR. However, reduced lung function (FEV1/FVC ratio) at baseline and more likely to be older. Baseline age, BMI, HbA1c level and SBP negatively correlated with eGFR. However, reduced lung function (FEV1/FVC ratio) at baseline and more likely to be older. Baseline age, BMI, HbA1c level and SBP negatively correlated with eGFR. However, reduced lung function (FEV1/FVC ratio) at
baseline was associated with CKD development after adjusting for these risk factors although the HR decreases after adjusting other risk factors, and baseline FEV₁/FVC also positively correlated with eGFR. This implies that lung function affects CKD development. Hypoxaemia or increased oxidative stress caused by decreased lung function could contribute to the development of CKD. Accumulating evidence suggests that renal hypoxia is a key player in the progression of CKD. Chronic renal hypoxia is closely linked to capillary rarefaction, which affects tubular epithelial cells, fibroblasts and inflammatory cells, resulting in tubulointerstitial fibrosis. Increased oxidative stress could also contribute to the onset of CKD. Oxidative stress increases the generation of advanced glycation end products (AGEs), which in turn interact with receptors for AGEs (RAGE). AGEs were increased in patients with COPD, and one recent study showed that pulmonary and renal endothelial cell injury was linked to increased endothelial AGEs and RAGE. These studies were done in patients with COPD or COPD animal models, and lung function in our study group was near normal. The attenuated association between FEV₁/FVC and the development of CKD after adjustment for other factors might be explained by the difference in lung function status of subjects in our study and those of other studies.

Systemic inflammation may also be a link between lung dysfunction and CKD. COPD is a systemic inflammatory disease. Low-grade systemic inflammation was noted in subjects with airflow obstructions. High serum CRP concentrations have been reported in patients with COPD. Thus, COPD is a systemic inflammatory disease involving the lungs. Inflammation also plays a role in the development of CKD and is associated with increased levels of inflammatory and procoagulant biomarkers, including CRP and fibrinogen. Inflammation may trigger the development of CKD in those with lung dysfunction. To understand why lung function was associated with the development of CKD, we explored the association between hs-CRP levels and lung function. The hs-CRP level was negatively associated with the FEV₁/FVC ratio. This indicates that inflammation may play a role in the relationship between lung dysfunction and CKD.

Figure 1 Cumulative survival curve for incident chronic renal failure from values of FEV₁/FVC ratio. The data are adjusted for age, sex, smoking status, body mass index, estimated glomerular filtration rate, systolic blood pressure, levels of haemoglobin, albumin, uric acid, triglyceride and fasting glucose, and the presence of diabetes and/or hypertension at baseline. Cox’s proportional hazards regression model was employed to draw the curves. FEV₁, forced expiratory volume in 1s; FVC, forced vital capacity.
Our study has certain limitations. First, all subjects were volunteers, self-scheduling comprehensive health examinations (sometimes annually) for at least 5 years, implying that they were more concerned about their health and therefore not representative of the general population. Second, we used the CKD-EPI equation to estimate GFR, because the Modification of Diet in renal disease (MDRD) equation was developed in subjects with CKD and underestimated GFR. So the incidence of CKD was low, and we did not assess proteinuria. Thus, we did not analyse the relationship between lung function and proteinuria. Third, the work was retrospective in nature and the symptoms of any airway disease were not noted. Prospective studies are needed to further define these relationships.

We confirmed that the incidence of CKD is increased in patients with airflow limitation, as measured by the FEV1/FVC ratio. CKD is associated with mortality and morbidity. Therefore, it is important to recognize the relationship between reduced lung function and CKD development in clinical practice.

CONCLUSION

Limited airflow as measured by the FEV1/FVC ratio was associated with an increased risk of CKD. This implies that common pathogenic mechanisms exist between a decline in lung function and the development of CKD. The baseline FEV1/FVC ratio could be helpful for identifying individuals at risk for CKD.

Contributors SKK, JHK, JCB: Substantial contributions to the conception or design of the work, or the acquisition, analysis or interpretation of data. J-HB, KWH, M-ML: Drafting the work or revising it critically for important intellectual content. JHK: Final approval of the version published and agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Funding This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent Not required.

Ethics approval Ethical Committee of Samsung Medical Center at Sungkyunkwan University, Seoul, Korea.

Provenance and peer review Not commissioned; externally peer reviewed.

Data sharing statement No additional data are available.

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