argued that complex molecular changes might be easier to access in tumour samples than in CTCs [4]. Ross and co-workers are to be congratulated for broadening our knowledge base for further development of patient-centred bladder cancer trials.

Conflicts of interest: The author has nothing to disclose.

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http://dx.doi.org/10.1016/j.eururo.2016.03.067

Re: Kidney-Failure Risk Projection for the Living Kidney-Donor Candidate

Grams ME, Sang Y, Levey AS, et al

N Engl J Med 2016;374:411–21

Experts' summary:

Grams et al report results obtained during follow-up of seven population cohorts for 4–16 yr to estimate the lifetime risk of end-stage renal disease (ESRD) for individuals who do not donate a kidney. The study utilized data from more than 31 million person-years of follow-up, and 15-yr projections were then compared to the risk observed in US kidney donors.

The risk projections varied according to race and sex, and the 15-yr risk observed in kidney donors was 3.5 to 5.3 times as high as the risk projected for the general population.

The authors developed an online tool that includes ten health characteristics that can help to estimate a person's ESRD risk to allow careful selection of living kidney donors.

Experts' comments:

Transplantation execution and efficacy are constantly increasing worldwide thanks to better national and international networks and to technological progress. In 2013, 78 952 renal transplants were recorded by the Global Observatory on Donation and Transplantation, of which 41.6% were derived from a living donor. In most countries, especially in Africa, Asia, and the Middle East, the number of transplantations from living donors greatly exceeds the number from dead donors (up to 80%) [1].

Considering the exponential growth of living donor transplantation, the guiding principles of the World Health Organization (WHO) state that "Live donors should be informed of the probable risks, benefits and consequences of donation in a complete and understandable fashion" [2]. Therefore, an accessible tool for estimating ESRD risk is essential to fulfill the WHO principles concerning information for subjects who might donate a kidney.

Furthermore, thresholds for acceptable risks in donors vary among transplant centers and clinicians, and there has already been a call for a universally accepted donor-centered tool [3].

A donor-centered model of risk assessment would integrate the donor's will with an objective projection of risks to reach a truly shared decision about donation eligibility.

It is our hope that an accessible, internationally recognized tool, such as the one presented by Grams et al, could be established. We believe that their findings are extremely important, as the tool could (1) help to minimize the number of living kidney donors in whom ESRD might ultimately develop and (2) support donation among people whose long-term risk was previously misunderstood (eg, donors older than 65 yr, even with a low estimated glomerular filtration rate or mild hypertension, who might never develop ESRD after donating a kidney). This could save more lives not only among those who need a transplant but also among donors who might develop ESRD. By possibly enhancing the number of donors, the tool could help in fulfilling the most admirable aim, to improve the lives of others.

Conflicts of interest: The authors have nothing to disclose.

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http://dx.doi.org/10.1016/j.eururo.2016.03.068