

RENAL DISEASE IN RACIAL AND ETHNIC MINORITY GROUPS

Introduction

In the fall of 2001, in the shadow of 'nine-eleven,' a group of nephrologists from around the world met in Santa Fe, New Mexico. Over two days they learned of the outcomes of epidemiological, clinical, and basic science studies and discussed the burgeoning problems relating to progressive renal disease that beset racial and ethnic minority groups worldwide. As the assembled group comprised basic scientists, clinicians, fellows in training, and physicians and health workers who operate on the front lines, not the least important feature of the meeting was the rare opportunity for people to bypass the traditional and somewhat daunting boundaries of health practice and to meet to share experiences.

This Supplement contains all but a few of the papers that were presented at the meeting, and while they could reasonably be described as an eclectic collection, they do represent the state of the art in this field. They are divided into three sections.

The first section groups together those presentations that discuss the etiology and pathogenesis of renal disease in racial and ethnic minorities. That the majority of the articles in this section describe work carried out in African American and American Indian populations reflects the deficiency of studies on this topic in most parts of the developing world. Of particular interest is the paper by Hoy and colleagues, which represents early work in the difficult task of questioning the relationship between a low nephron number and the subsequent development of renal failure. The second section includes articles that explore the prevention and treatment of renal disease, with a focus both on clinical trials, and the management of end-stage disease by the modalities of dialysis and renal transplantation. Of special interest are the articles by Rizvi et al, Ramirez et al, and by Mani. The first is inspiring in showing what can be achieved in a developing country by a dedicated team approach toward the problem of renal transplantation. While Singapore is by no means a poor country, the second paper, by Ramirez et al describes in depth how an active renal treatment program can be built and financed in a country that does not publicly support the full cost of treating renal failure. Mani describes, in a passionately written paper, a method for the investigation and treatment of renal disease in rural India, which is particularly important as it recognizes very clearly the need to match the

effort with the available resources. The third group includes articles on the current status of programs for the management of end-stage disease in nine different racial groups from around the world. As a result of increased surveillance over the last decade, few now doubt that renal disease is occurring in epidemic proportions throughout the developing world. As demonstrated in developed countries, renal disease tends to be clinically 'silent' and, therefore, goes largely unnoticed, as those who have contracted it are not likely to seek medical advice. A strong causal association with diabetes in many ethnic minorities and the lethal cardiovascular complications tend to lead to an underestimation of the primary importance of renal disease and, hence, under-reporting in official mortality statistics. This under-reporting is likely to reduce the priority afforded to research studies in this field. Furthermore, the poorer the country, in economic terms, the greater is the likely prevalence and incidence of renal disease, and the less likely that any resources will be available.

Governor Bowerkaty of the Zuni people, one of the indigenous tribes of the New Mexico, spoke eloquently of the problems that the Zuni face. They perceive that many prior researchers across a range of disciplines have not taken the people into their confidence, not shared their results, and not been prepared to recognize the value of intellectual property rights; more research degrees have been awarded than health advances achieved! This is a particularly important issue when studies are likely to be ongoing over a period of years, and when they involve assessment of the contribution of genetic endowment to disease. The Governor stated that in the future those who wish to conduct research are likely to have their proposals independently assessed, and the nature of research contracts subjected to legal review. He concluded that renal disease research remains a major research priority for the Zuni because of the great human and economic burden that kidney diseases impose.

How then is the problem to be tackled? Clearly with the majority of the world's nephrologists living and working far from those parts of the world where perhaps three quarters of the world's patients with renal disease live, there are not going to be sufficient resources available to manage the disease, particularly, end-stage renal disease. In many parts of the world such treatment is only available to the wealthy, and to those fortunate enough to be included in government insurance programs. Prevention thus must be the watchword! A broad

and cooperative public health approach would certainly espouse the need to embrace such basic requirements as clean water, good sanitation, vaccination programs, and good antenatal care to assist in combating the many afflictions contributing to the high rates of renal disease. It is at the same time essential to continue to gather evidence leading to accurate documentation of the prevalence and incidence of chronic renal disease, and where these are seen to be high, to study potential etiologic factors and pathogenetic mechanisms. The nature of medical practice and the lack of resources in many of these areas mean that there will have to be, of necessity, a transfer of resources and technology to achieve even the simplest of these goals. A focus on diabetes among many racial and ethnic minority groups is an imperative, and in sub-Saharan Africa it is clear that hypertension plays a powerful role, though its precise contribution to the development and progression of chronic renal disease remains imperfectly understood.

Many studies over the last decade attest to the value of angiotensin converting enzyme (ACE) inhibition therapy in at least slowing the progress of renal disease, and reducing proteinuria. There is now believed to be

sufficient evidence to promote treatment programs using these agents, though their use in developing countries is not going to be without its problems, particularly with regard to cost factors, and perhaps to concerns regarding the use of this class of agents in young fertile women. There is no reason why epidemiological studies and treatment programs should not run in a combined fashion, as Hoy and colleagues illustrate in this issue. It is clear, though, that progress will not accelerate until and unless the world in general—and the nephrological community in particular—amplify their commitment.

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DAVID J. PUGSLEY, LAWRENCE AGODOA,
and ROBERT G. NELSON
Guest Editors