Commentary

Chronic kidney disease in the developing countries! Are we really so different?

The article "Chronic Kidney Disease in sub-Saharan Africa: Hypothesis for research demand" from Dr. Biruck published in this issue of the AAM put in the light many facts already very well known in the community of nephrologists all over the world.[1-4] The everyday problems regarding the nephrological practice in the developing countries such as lack of certified nephrologists ("brain drain"), lack of sufficient facilities for treatment of end-stage renal disease (ESRD) like dialysis and transplantation, lack of useful registries of ESRD patients as well as regular screeing of the population are practically the same not only in sub-Saharan Africa and Asia, but also in certain region of South-Eastern Europe and Latin America.[5,6] It is really very easy to follow the KDOQI guidelines in the developed world and discuss whether chronic kidney disease (CKD) stage 3 or 4 exists or not and where is a difference. But from the point of view of cruel reality, I could not find any sense when there are less than 20 prevalent ESRD patients who are on the regular dialysis treatment.[4] Especially when there is no precise information about CKD prevalence in different African countries as well the annual incidence of new ESRD patients. From that point of view, I fully agree with the demand of Dr. Biruck for research of the specificity of the CKD and ESRD in the Sub-Saharan region as long as some more basic information would be available. Therefore as a European nephrologist from South-Eastern Europe, I could suggest to my African colleagues the follows:

1. Establishing a useful registry for all sub-Saharan countries including ESRD prevalent and incident patients.
2. Performing the screening for CKD patients using the abbreviated MDRD equation for GFR and establishing a pan-African CKD registry to facilitate risk analysis and special groups of patients under the risk of developing CKD in the future. Adapting existing clinical practice guidelines for CKD detection and management to address specific problems in every region.[7]
3. Working closely with other international professional organizations to develop permanent education and multicentre scientific projects in different and specifics aspects of CKD.
4. Projecting the number of patients of ESRD using of any model for predicting the prevalence and incidence after 10 years.[8]
5. Working hardly to promote a renal replacement therapy everywhere is needed.
6. Introducing living expanded criteria renal transplantation using the worldwide experience and working on developing deceased donor donation as a long acting process to avoid organ trafficking.

Therefore, instead of any conclusion, it is time for hard work for any of us, gentlemen!

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