Letter to the Editor

Documentation and analysis of aetiology of end-stage renal failure

Sir,
The article by Neild [1] in a recent issue of Nephrology Dialysis and Transplantation is enlightening since it provides an insight into the causes of primary renal disease leading to end-stage renal failure (ESRF) in the UK. In his analysis of the USRDS data, he has included three categories of patients under ‘ESRF of unknown aetiology’ namely Aetiology uncertain (USRDS Code 69), Hypertension (USRDS Code 35) and Glomerulonephritis—histologically not examined (USRDS Code 4). I entirely agree with him that ‘Hypertension (excluding malignant or accelerated hypertension) is not a cause of renal failure in non-black patients age 0–39’. It is very likely that this group of patients actually has some other cause of renal failure and should be included under the category of ‘ESRF of unknown aetiology’. However, I have some reservations regarding the third category of patients. It will be helpful if the author clarifies the data pertaining to ‘Glomerulonephritis—histologically not examined’ in the USRDS data (USRDS Code 4). I feel this group should not be included under ‘ESRF of unknown aetiology’.

Nephrologists can make a reasonably correct diagnosis of glomerulonephritis based on clinical features and a careful examination of the patient’s past medical records (of hypertension, significant proteinuria and or glomerular haematuria). Biopsying all patients with chronic kidney disease is neither practically feasible nor required in all cases. In fact, we regularly teach our students the classical clinical presentations of the three main causes of chronic kidney disease, namely glomerular, chronic tubulo-interstitial and renovascular diseases. Clinicians must make all reasonable efforts to establish the primary cause of renal disease. I accept that a clinical diagnosis may be incorrect in a small percentage of cases. In my humble opinion, making a reasonable clinical diagnosis of the aetiology of ESRF is important both for pre- and post-transplant management of ESRF patients, and adequate efforts should be made so that the percentage of ‘ESRF of unknown aetiology’ is as low as possible. Of course, I do appreciate the author’s strictly scientific point of view of analysing the aetiology of primary renal disease.

Conflict of interest statement. I have had no involvements that might raise the question of bias in the work reported or in the conclusions, implications or opinions stated. The matter presented in this paper has not been published previously in whole or part.

Editorial Note: Prof. Neild had no further comments on this letter.

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