The development of large databases for end stage renal disease (ESRD) and organ transplantation in the late 1970s and 1980s revealed a number of disturbing trends: 1) blacks in the United States (African Americans) had a disproportionately higher rate of end stage renal disease; 2) access to the kidney transplant wait list and the waiting times for deceased donor kidney transplantation were worse for African Americans; 3) the rates of both living and deceased kidney donation for African Americans were much lower than those for whites; and 4) the results of kidney transplantation (short- and long-term allograft survival and acute rejection rates) were significantly inferior in African Americans compared with non-Hispanic white recipients (1–5).

Race-tailored treatments and practices

The kidney transplant literature is inundated with hundreds of articles on racial disparities in kidney transplantation, but progress has been slow and much remains to be done. "Racial" titles on manuscripts are eye-catching, and journal editors may pay homage to race issues by readily accepting manuscripts with such titles whether or not the content is germane or informative on the subject. Likewise, high-intensity immunosuppressive strategies have been widely adopted in African Americans on the basis of limited empirical and most often weak experimental evidence. Yet there has been an aversion to studying new immunosuppressive drugs in African American recipients so that "high risk" recipients would not dilute the putative findings of registration trials. Transplant professional thought leaders and funding agencies that set research agendas have shown a lack of commitment to study and address racial disparity issues.

Little of what is offered as explanation or basis of action to improve outcomes of kidney transplantation is based on rigorous evidence because seeking such evidence and finding answers takes finances and time—two scarce resources that no one is yet willing to spend. After all, there has not been a single large national scientific gathering with a comprehensive agenda that has been devoted to this problem.

A larger pool of African American transplant professionals is a desirable social objective, but it would not necessarily lead to improved living kidney donation or better care for African American recipients. We remain mired in the prevailing consensus that "high risk" recipients should be subject to a much lower rate of 8 to 15 percent in both African Americans and whites. The one-year graft survival rate is now similar in both African Americans and whites at 85 to 90 percent for deceased donor transplants and 95 to 97 percent for living donor kidney transplants, respectively. This is a marked and much welcome contrast to a much lower rate of 8 to 15 percent in both African Americans and whites. The one-year graft survival rate is now similar in both African Americans and whites at 85 to 90 percent for deceased donor transplants and 95 to 97 percent for living donor kidney transplants, respectively. This is a marked and much welcome contrast to the 1980s and 1990s when the rate of graft loss in the first year was 1.5 to two times as high in African Americans compared to whites.

These improvements in short-term graft survival are largely driven by increased intensity of immunosuppression and posttransplant surveillance. Patient survival has remained comparable between the racial groups over time. Long-term graft survival (five to 10 years) has improved by approximately 10 percent in whites, but African Americans continue to have a long-term graft survival rate that is relatively inferior by 15 to 20 percentage points.
Avoiding Steroids

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Most transplant centers in the United States are using induction therapy along with calcineurin inhibitors and MMF. In this setting, steroid withdrawal has already become an accepted practice in the transplant community. Data from the most recent report of the Scientific Registry for Transplant Recipients indicate that as of 2006, more than 30 percent of patients receiving kidney transplants in the United States are discharged from their initial hospitalization without maintenance steroid therapy.

The push for steroid elimination has been driven by patient preference and patient demand. In our center's experience, patients remain eager to avoid steroids, despite the increased risk of acute rejection. We routinely encounter patients who refuse to initiate oral steroids or who independently taper prednisone after transplantation. Use of corticosteroid therapy will likely diminish further over time as immunosuppressive therapies become more targeted and less toxic. Even with the current immunosuppressive arsenal, steroid avoidance is now a reasonable and successful strategy in kidney transplantation.

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Disparities

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at hand.

Neither the classic conservative ideology of “blaming the victim” by ascribing limited access to low donation rates (in African Americans) and poorer graft survival to recipient noncompliance, nor the paternalistic liberal position of ascribing all problems to systemic racism, cultural bias, and a “somewhat different” and recalcitrant immunobiology in African Americans offers a promising or produc- tive guide on how best to address these thorny issues.

Role of research and future directions

No adequately powered multicenter prospective study of medical adherence behavior has been conducted in kidney transplantation. Let alone convincingly documented that African Americans are less compliant with immunosuppressive regimens, yet this explanation is convincingly offered as an important cause of diminished allograft survival in African Americans. It is also a fact that no evidence shows that overt racism or cultural bias play any role in allocation of donor organs to the detriment of African American transplant candidates. Some organized professional continue to massage the medical system at great effort to accomplish marginal interstitial redistribution of deceased donor organs as a way of redressing racial imbalance.

Given the significance of this issue, it is lamentable that we have yet to conduct an adequately powered multicenter clinical trial to address the question of optimal immunosuppression in African Americans. Not one such study has been sponsored either by the National Institutes of Health (NIH) or the pharmaceutical industry. Instead, posthoc analysis of completed clinical trials and single center retrospective studies have been the main sources of data on how African American kidney transplant recipients should be managed.

The key problem may be that very few individuals and, worse yet, no governmental entity or representative of the pharmaceutical industry is seriously committed to tackling the problems presented by racial disparities in organ transplantation, at least not as can be judged by demonstrable interest in sponsoring or organizing research projects to address the problems. This lack of commitment is not evident from public pronouncements, advertisements, or the medical literature. Symbolic gestures and politically correct attentiveness to racial disparity issues abound ad nauseam. Given the inadequacy of current approaches, the way forward requires that a number of questions should be tackled with the utmost urgency. What is the most promising package to stimulate an increase in live kidney donation from which African Americans stand to benefit? Should there be a systematic testing of recommendations of radical ideas such as significant financial compensation for both deceased and live kidney donation? Which of the immunosuppressive drugs under development confer benefits in African Americans, rather than just giving larger doses to African Americans in phase four clinical trials? Why is the optimal posttransplant management scheme that will improve long-term outcomes in African Americans? Should amply reimbursed capitated posttransplant management schemes be tested through private-public partnerships to assess the potential impact of intensive and well-coordinated posttransplant follow-up? It is time to establish a consortium of committed professionals to conduct research studies and develop guidelines on racial issues in kidney transplantation just as there are consortia for interventional cardiology, AIDS, type 1 diabetes mellitus, breast cancer, and other diseases. The understandable risk aversion of pharmaceutical companies to offer new drugs in development to African American recipients can be addressed by establishing an active collaboration between relevant agencies within NIH, FDA, and the pharmaceutical industry.

One way to start the ball moving toward tangible goals today is for professional societies to assemble the many individuals who have championed these issues to develop a roadmap to advance the agenda of improving access to and outcomes of kidney transplantation in African Americans and other minorities. Unless a new course is charted and vigorously traveled, the next generation will lament the same apalling statistics and revisit an even greater magnitude of unmet needs for human suffering, ill health, and
Steroid avoidance and acute rejection

What about those patients on steroid avoidance in whom an AR occurs? Are these patients at risk for worse outcomes if they stay steroid-free? There are no rigorous data at present. However, Humar et al. provided some indication of possible steroid avoidance: patients with high PRA levels and those with expanded epitopes may not be candidates for steroid avoidance. Patients with high PRA levels or a prior transplant comprise an ever-increasing proportion of the transplant population. Furthermore, published studies did not enroll African Americans to a significant extent, yet this group is known to be at higher immunologic risk. DGF occurs in a significant percentage of transplant recipients. A significant minority of such recipients will have a greater propensity to immunologic events requiring steroid use pretransplant. Potential side benefits of steroid avoidance or minimization have been much more modest in the recently reported randomized controlled trials than in prior series. Whether steroid minimization is better than avoidance when DGF is present is unknown. Furthermore, late steroid withdrawal may not be as bad as previously thought, with the switch from CsA-Aza to tacrolimus-mycophenolate mofetil-based maintenance immunosuppression.

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premature deaths of untold number of those with end stage kidney disease.

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