

study design entirely. This is because HIV prevalence represents infections that have accumulated over many years, whereas the survey measured concurrency only in the previous year.

### Mathematical modelling

Lurie and the proponents of concurrency all agree that the most powerful demonstrations of the influence of concurrency have come from simulation models. For example, Martina Morris and Mirjam Kretzschmar worked on Ugandan data and concluded that increasing the level of concurrency would have a more significant impact on epidemic spread than increasing the number of partnerships.

Lurie and Rosenthal say that even if these models show that concurrency can drive an epidemic, such theoretical work cannot demonstrate whether concurrency is actually doing so in Africa.

They also comment that other modelling studies, which found that the total number of partners or mixing between different social groups were more important than concurrency, tend not to be cited by the other authors.

In addition, in the articles published by Lurie and Helen Epstein, there is much claim and counter-claim as to the

definitions used and the validity of the assumptions that were fed into the various modelling studies.

### Conclusions

Mark Lurie and Samantha Rosenthal believe that the evidence base for the role of concurrency is weak and contradictory, and that better research with more refined definitions needs to take place before interventions to reduce concurrency can be delivered.

Morris counters that the studies Lurie and Rosenthal have looked at cannot prove or disprove the hypothesis. More sophisticated studies are being worked on and will give a more precise picture of concurrency's role, 'but no one argues that concurrency is irrelevant to transmission', she says.

As such, she says it would be a 'real tragedy' if methodological limitations were used to justify a do-nothing policy.

Mah and Halperin also argue that if HIV prevention interventions were never implemented until the most reliable evidence had been gathered, the only ones in use today would be male circumcision and interventions to prevent mother-to-child transmission. They believe that prevention messages which encourage

people to have only one partner at a time are needed as one component of a prevention response.

### Further reading

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BRIDGET FARHAM

# World Kidney Day

*Diabetic kidney disease:  
act now or pay later*

### World Kidney Day 11 March 2010: we must act on diabetic kidney disease

In 2003, the International Society of Nephrology and the International Diabetes Federation launched a booklet called *Diabetes and Kidney Disease: Time to Act*<sup>1</sup> to highlight the global pandemic of type 2 diabetes and diabetic kidney disease. It aimed to alert governments, health organisations, providers, doctors and patients to the increasing health and socio-economic problems due to diabetic kidney disease and its sequelae, end-stage kidney disease requiring dialysis and death from cardiovascular causes. Seven years later, the same message has become even more urgent. World Kidney Day 2010, under

the auspices of the International Society of Nephrology (ISN) and the International Federation of Kidney Foundations (IFKF), together with the International Diabetes Federation (IDF), provides yet another chance to underline the importance of diabetic kidney disease, stress its lack of awareness at both public and government levels and emphasise that its management involves prevention, recognition and treatment of its complications. Primary prevention of type 2 diabetes will require massive lifestyle changes in the developing and developed world supported by strong governmental commitment to promote lifestyle and societal change.

### The global threat of type 2 diabetes

The 21st century has the most diabetogenic environment in human history.<sup>2,3</sup> Over the past 25 years or so, the prevalence of

type 2 diabetes in the USA has almost doubled, with 3 - 5-fold increases in India, Indonesia, China, Korea and Thailand.<sup>4</sup> In

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2007 there were 246 million people with diabetes in the world, but by 2025, that number is estimated to reach 380 million.<sup>5</sup> People with impaired glucose tolerance, a 'prediabetic state', numbered 308 million in 2007 and will increase to 418 million by 2025.<sup>5</sup> The increase in prevalence of diabetes will be greater in the developing countries. In Mexico, for example, 18% of its adult population will have type 2 diabetes by 2025. According to the WHO, China and India will have about 130 million diabetics by 2025 who will consume about 40% of their country's health care budget in addition to reducing productivity and hindering economic growth.

It was against this background that on 21 December 2006 the United Nations General Assembly unanimously passed Resolution 61/225 declaring diabetes an international public health issue and identifying World Diabetes Day as a United Nations Day, only the second disease after HIV/AIDS to attain that status. For the first time, governments have acknowledged that a non-infectious disease poses as serious a threat to world health as infectious diseases like HIV/AIDS, tuberculosis and malaria. The problems of diabetes are now seen as a major global public health concern, especially in the developing world which can least afford it. The first step to act on diabetic kidney disease must encompass public health campaigns aimed at preventing the development of type 2 diabetes.

### Diabetic kidney disease

Diabetes is now the major cause of end-stage kidney failure throughout the world in both developed and emerging nations.<sup>6</sup> It is the primary diagnosis causing kidney disease in 20 - 40% of people starting treatment for end-stage renal disease worldwide.<sup>7</sup> In Australia, new type 2 diabetes patients starting dialysis increased 5-fold between 1993 and 2007.<sup>8</sup> Between 1983 and 2005 there was a 7-fold increase in new patients starting renal replacement therapy in Japan because of diabetes, accounting for 40% of all new incidence patients.<sup>9</sup> Thus, some 30% of the predicted 1.1 trillion dollar medical costs of dialysis worldwide during this decade will result from diabetic nephropathy.<sup>10</sup>

In the United Kingdom Prospective Diabetes Study (UKPDS), the rates of progression of newly diagnosed type 2 diabetics between the stages of normoalbuminuria, microalbuminuria, macroalbuminuria and renal failure were 2 - 3% per year.<sup>11</sup> Over a median of 15 years of follow-up of 4 000 participants, almost 40% developed microalbuminuria.<sup>12</sup> In the DEMAND study of 32 208 people from 33 countries with known type 2 diabetes

attending their family doctor, 39% had microalbuminuria and prevalence increased with age, duration of diabetes and presence of hypertension.<sup>13</sup> About 30% of the UKPDS cohort developed renal impairment, of which almost 50% did not have preceding albuminuria.<sup>12</sup> Reduced glomerular filtration rate and albuminuria caused by diabetic nephropathy are independent risk factors for cardiovascular events and death.<sup>14</sup> Therefore, a strategy to detect early diabetic kidney disease by screening for albuminuria as well as reduced glomerular filtration rate is the second step in taking action on diabetic kidney disease.

An added difficulty to overcome is the remarkable lack of awareness among patients about their condition. In population-based surveys, for every known diabetic patient, there is at least one more that is unknown;<sup>15</sup> only 8.7% of the general population were able to identify diabetes as a risk factor for kidney disease.<sup>16</sup> For patients with diabetic kidney disease, very few are aware of their condition, with some community surveys putting patient awareness of their disease as low as 9.4%, particularly in those with milder impairment.<sup>17</sup> Thus, public education is the third step required for acting on diabetic kidney disease in the community. The IFKF has a long-term goal for all kidney patients world-wide to not only be aware of their disease, but to actively know, for example, their blood pressure and the treatment objectives.

### Management of diabetic kidney disease

There is little use in screening populations or 'at risk' groups unless follow-up is undertaken and effective treatment is begun and assessed.<sup>18</sup> Fortunately there is evidence that early therapeutic intervention in patients with chronic kidney disease or diabetes can delay onset of complications and improve outcomes. For example, the UKPDS,<sup>19,20</sup> STENO-2<sup>21</sup> and ADVANCE studies<sup>22-24</sup> all demonstrated that tight control of blood glucose level and blood pressure (and lipids in STENO-2) significantly reduced incidence and progression of diabetic kidney disease. In people with type 2 diabetes, inhibition of the renin-angiotensin-aldosterone system using an ACE inhibitor or an angiotensin II receptor blocker (ARB) decreased the progression from normoalbuminuria to microalbuminuria,<sup>25</sup> reduced the progression from microalbuminuria to macroalbuminuria,<sup>26</sup> and slowed the development of end-stage renal disease (ESRD).<sup>27</sup> Thus the use of an ACE inhibitor or ARB is now standard therapy for patients with diabetic nephropathy as

well as glucose, lipid and blood pressure control. Effective management using evidence-based therapies is the fourth step in tackling diabetic kidney disease.

The fifth step is development of new therapies. Many new agents are now in clinical trials to reduce renal damage and fibrosis, including blockade of formation of advanced glycation endproducts and other signalling pathways. Other novel agents may potentially prove to be effective in large randomised double-blind clinical trials.<sup>28</sup>

### How can we act now?

The steps to be taken are clear. Campaigns should be aimed at:

- prevention of type 2 diabetes
- screening for early diabetic kidney disease
- increasing patient awareness of kidney disease
- using medications of proven strategy.
- researching and trialling of new therapies.

The ultimate challenge is to get action from primary health care to all higher levels; from the individual patient, to those at risk, in various health jurisdictions, in all countries despite varying economic circumstances and priorities. The problem is a global one and yet requires action at a local level; prevention screening and treatment strategies; education, including increasing awareness both in diabetic patients and those at risk of developing diabetes; and health priorities and governments. Basic research and clinical trials searching for a new understanding and therapies must be supported.

The United Nations, as noted earlier, recognised the importance of diabetes in 2006 by establishing a World Diabetes Day. Both the ISN and the International Diabetes Federation are working closely with the WHO to provide increasing understanding of the challenge that diabetic kidney disease poses to world health and health care budgets. However, World Kidney Day also provides a focus for other international agencies, government ministries of health, non-government organisations, foundations and academic institutions to come together with national kidney foundations to be involved in the effort to prevent and manage diabetic kidney disease.

The ISN, through its COMGAN Research and Prevention Committee, has developed a web-based programme, the KHDC for detection and management of chronic kidney disease, hypertension, diabetes and cardiovascular disease in developing countries (<http://www.nature>.

com/isn/education/guidelines/isn/pdf/ed\_051027\_2x1.pdf) as a global template involving a detection management and data assessment programme which has so far screened some 42 000 people in 25 developing countries, and the data are being stored and analysed at the Kidney Disease Data Centre at the committee headquarters at the Mario Negri Institute in Bergamo, Italy. This programme can be tailored to any individual country's needs and resources. The IFKF also has a programme initiated by the National Kidney Foundation in the USA called the Kidney Early Evaluation Programme (KEEP), which is a screening programme for people at high risk of kidney disease. KEEP has now been implemented in many countries and will again screen and manage patients with diabetic kidney disease.

The focus on diabetic kidney disease for World Kidney Day 2010 brings awareness of the magnitude of the problem and ramifications for global health for people with diabetes and kidney disease. It is therefore time to act and act urgently. It is time for strategies that prevent diabetes and its sequelae. It is time for programmes for health care workers to diagnose and treat people with diabetic kidney disease. It is time for governments to pass legislation to enable the diabetes pandemic to be controlled. After all, diabetic kidney disease, like the epidemics of infectious diseases that have long dominated public health agendas, is potentially preventable. Indeed, 11 March 2010 is time to act on diabetic kidney disease and to sustain that action long after World Kidney Day.

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