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There are 2 more aspects worth discussing. The National Kidney Foundation of South Africa (NKFSA), a not-for-profit organization found in 1967, has tried its best for many to comply with the World Health Organization and the ISN/IFKF “World Kidney Day” endeavors. This has, however, had little success. Despite this, it is important to recommend that other “poor” countries create their own kidney foundations. This is best done in geographical areas. The potential of such organizations could be of great value.

The second proposition is to the “International Kidney Fraternity” to become involved. It is well known that many prominent nephrologists from South Africa, the United States, and the United Kingdom and elsewhere in Europe have had various outreach projects to other countries in Africa in the past. These have been on educational-level (e.g., “sister” units) and on technical-level (e.g., “Water for all”) projects. In conclusion, to the members of the ISN/IFKF, the Kidney Societies, and all major countries with “Kidney Health for All” skills, help to the poorer countries is essential for them to progress. The South African Kidney Health team could certainly help in this respect as we could send our own teams into sub-Saharan Africa to help improve their situation but would have to be funded in doing so. All these endeavors would include the whole spectrum of nephrology (i.e., nephrology, dialysis, transplantation, kidney nursing, and other “kidney health care” work).

1. Langham RG, Kalantar-Zadeh K, Bonner A, et al. for the World Kidney Day Joint Steering Committee. Kidney health for all: bridging the gap in kidney health education and literacy. *Kidney Int.* 2022;101:432–440.

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The authors reply: We appreciate Meyers for sharing a real-world perspective of caring for patients with kidney diseases in developing countries. The author also provided guidance for dealing with kidney diseases of these populations as a lower priority among other public health problems, including economic crisis.¹



Low health literacy has long been recognized as one of the crucial social determinants of health.² While health literacy has impacted low-income countries, it remains a barrier to improving health even in the developed countries.³

Nonetheless, we agree with the author that the implementation of health literacy programs, regardless of the topic, needs to be tailored to the needs of the local community.

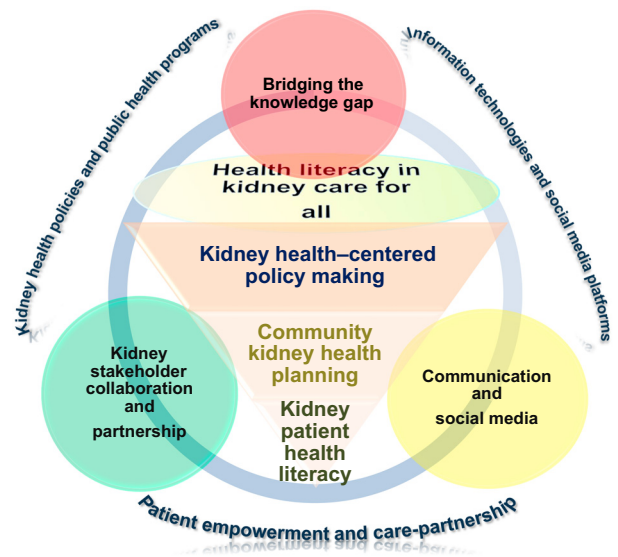


Figure 1 | Proposed implementation framework to achieve kidney health promotion.

Success has been demonstrated in programs that are consumer-codesigned, and culturally appropriate, even in places without the ability to access social media.

A health economics analysis of the cost, evaluation, and health impact of health literacy programs is critical in the engagement of policy makers.⁴ For kidney health, we agree that this should be a shared responsibility of all stakeholders: that government, advocacy, public health, and health care professionals all need long-term plans that should be concurrently implemented.

Kidney health-centered policy should not only emphasize the importance of adequate resourcing, regardless of economic status, but also truly understand the community to generate appropriate community kidney health planning. Ultimately, bridging the gap of public health economics and community by promoting patients’ kidney health literacy should be implemented to enable kidney health with creativity, collaboration, and communication in a sustainable way (Figure 1).

DISCLOSURE

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KDIGO recommendations on blood pressure management in chronic kidney disease



To the editor: The “KDIGO 2021 Clinical Practice Guideline for the Management of Blood Pressure in Chronic Kidney Disease” recommends a systolic blood pressure (BP) target <120 mm Hg, solely based on the Systolic Blood Pressure Intervention Trial (SPRINT), a multicenter randomized control trial that also formed the basis of the 2017 American Heart Association (AHA)/American College of Cardiology (ACC) guideline.^{1,2} The study population was essentially a low-risk cohort from a kidney point of view as diabetic patients were excluded and patients with chronic kidney disease (CKD) who constituted 28% of this cohort had a predominantly mild degree of kidney dysfunction (mean serum creatinine = 1.43 ± 0.39 mg/dl).² Hence they were not representative of all CKD stages, and extrapolating these results to the entire CKD population especially without a lower cutoff for target BP may not be pragmatic. In fact, in the subgroup with estimated glomerular filtration rate <45 ml/min, the cardiovascular benefit was not statistically significant (hazard ratio: 0.92, 95% confidence interval: 0.62–1.38).³ The posttrial follow-up data from SPRINT, apart from failing to show a difference in the renal composite outcome in CKD patients with intensive BP control, showed a significantly higher incidence of 30% reduction in estimated glomerular filtration rate to <60 ml/min per 1.73 m² in non-CKD participants (hazard ratio: 3.67; 95% confidence interval: 2.62–5.26) and a significantly increased incidence of hypotension, acute kidney injury, and electrolyte abnormalities.⁴ Also, the BP goals were difficult to achieve and the mean BP during follow-up was 6.9 mm Hg higher in the intensive arm.

Further studies in patients with different stages of CKD and in diabetes using conventional BP measurement are desirable to define the appropriate BP targets in this population.

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The authors reply: We thank Subbiah and Bhowmik¹ for their comments. They point out that the Kidney Disease: Improving Global Outcomes recommendation² focuses on the chronic kidney disease (CKD) subgroup of Systolic Blood Pressure Intervention Trial (SPRINT). That is because it is the best available evidence for target blood pressure (BP) in CKD. Only 3 other outcome trials examined target BP in CKD, all generating a low number of cardiovascular and death outcomes. Two of those trials (African American Study in Kidney Disease and Hypertension [AASK] and Modification of Diet in Renal Disease [MDRD]) examined mean arterial pressure, non-systolic or diastolic BP as a target, whereas the third study, Ramipril Efficacy In Nephropathy (REIN-2), with 338 participants, was underpowered.



SPRINT-CKD enrolled high-risk participants (cardiovascular event rate of 2.68% vs. 3.19% per year in the intensive and standard groups, respectively). The trial was stopped prematurely on recommendation of the data monitoring committee based on the overwhelming benefit of intensive BP lowering.

There was no hint of effect modification of this benefit by CKD status. Loss of estimated glomerular filtration rate was slightly and significantly greater in SPRINT with intensive BP lowering, but albuminuria was lower. We do not know how those 2 parameters influence the outcome kidney failure. In addition, rates of adverse events with intensive BP lowering should be considered in light of the substantial reduction in mortality.

We need further trials along the design of SPRINT-CKD to explore benefits of intensive BP lowering in CKD subgroups alluded to by the authors; as it stands now, we have no firm evidence of effect modification based on primary kidney