Black renal transplant recipients have poorer long-term graft survival than CYP3A5 expressers from other ethnic groups

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Abstract

Background. African American transplant recipients have poorer long-term outcomes than Caucasian Americans. This difference was not found in French patients, suggesting socialized medicine overcame this disparity. It has also been hypothesized that the difference relates to the higher prevalence of Black individuals who express the metabolic enzyme cytochrome P4503A5 (CYP3A5), with consequent altered handling of immunosuppressive drugs.

Methods. Records of 555 (50 Black; 505 non-Black) sequential renal transplant recipients from a single UK centre were analysed.

Results. Outcomes were significantly worse for Black patients: death-censored graft survival (5-year 66% versus 87%, P = 0.001); halving of year one estimated glomerular filtration rate (mean 8.8 versus 10.8 years, P = 0.008); first-year graft loss (12% versus 3.8%, P = 0.02); and death-censored graft survival in patients surviving the first year with functioning grafts (5-year 77% versus 94%, P = 0.02). Death-censored 5-year graft survival was poorer in Black CYP3A5 expressers than in non-Black CYP3A5 expressers (62% versus 93%, P = 0.002). Following multivariate analysis, the Black group demonstrated poorer graft survival as compared to the non-Black group (hazard ratio 0.46, 95% CI 0.25–0.85, P = 0.002). In a subgroup of genotyped transplant recipients, ethnicity (hazard ratio 0.31, 95% CI 0.15–0.64, P = 0.002), and not CYP3A5 expresser status, persists as an independent risk factor for graft survival following multivariate analysis.

Conclusion. In this cohort of patients with socialized medicine, Black recipients had poorer long-term outcomes than individuals from other ethnic groups. This was independent of CYP3A5 expresser status.

Keywords: CYP3A5; ethnicity; pharmacogenetics; renal transplantation; tacrolimus

Introduction

African American renal transplant recipients, both adult [1–8] and paediatric [9–11], have been reported to have poorer long-term outcomes than Caucasian Americans. The following factors are suggested to underlie this discrepancy include: human leucocyte antigen (HLA) matching [12,13], cold ischaemia time [12], donor and recipient age [12], grafts from deceased or living donors [6], time on transplant waiting list [14] and comorbidities such as hypertension [15] and diabetes mellitus [16]. The majority of these factors have generally been accounted for in these observational studies by multivariate analyses. Acute rejection is more common in African Americans and more likely to be steroid resistant [17].

Recently, Pallet et al. reported no difference in renal transplant outcomes comparing African Europeans with Caucasian Europeans in a French cohort of 1092 patients. It was proposed that universal access to socialized medicine overcame the discrepancies noted in the American studies [18]. A similar lack of difference in outcomes for Black patients in Canada, based on analysis of their national renal transplant registry, was published earlier this year [19]. Access to healthcare in the United States may be restricted in the African American population.

Currently, the evidence for socioeconomic factors influencing graft survival is conflicting [20–22]. An attempt to address the impact of access to healthcare was made by Chakker et al. who concluded that there was a similar increased risk ratio comparing African American and non-African American renal transplant graft survival in both those in the universal access to medical care environment of the Department of Veteran Affairs and those without universal access [23]. This suggested that the disparity in outcomes could not be fully overcome by universal healthcare. However, limitations already identified are that the population within the Department of Veteran Affairs may not reflect the general population and that the variation in care between Veteran Affairs hospitals is a potential confounding variable. Furthermore, there is an unexplained poorer...
outcome in the patients treated under the Department of Veteran Affairs, independent of ethnicity.

Outside the United States, a Brazilian cohort demonstrated poorer graft survival in the Afro-Brazilian group [24], but this study only accounted for the source of graft and not other confounding factors. A recent study from UK Transplant based on a national transplant registry identified poorer 3-year graft survival (76% versus 82%) in the British Black population, but this was statistically significant only after correcting for recipient and donor age and HLA matching [25].

An alternative hypothesis for this observed disparity in long-term outcomes is variations in drug metabolism. CYP3A5 expressers, more prevalent in Black renal transplant recipients than non-Blacks, on average require a 2-fold higher dose of tacrolimus to achieve target blood concentrations [26,27]. In the cohort of Black patients described in this study, 23 out of 26 (88%) transplant recipients who were genotyped were CYP3A5 expressers. This may result in sub-therapeutic dosing of immunosuppressants, especially in the initial stages or the potential for exposure to toxic metabolites. Studies have so far revealed mixed results for the impact of CYP3A5 expresser status on short-term outcomes of renal transplantation. CYP3A5 expressers had earlier onset of biopsy-proven acute rejection [26], but no difference in total incidence of acute rejection [26,28,29]. Biopsy-proven tacrolimus nephrotoxicity was found to be more common in CYP3A5 expressers, potentially related to an increased concentration of toxic metabolites [30].

We have addressed the issue of outcome in a cohort of Black patients with access to socialized healthcare in a single UK transplant centre, using tacrolimus as the primary immunosuppressive agent.

Subjects and methods

Patients and treatment

All 555 (50 Black; 505 non-Black) consecutive kidney-only renal transplants performed at St. George’s Hospital, London, UK, between September 1995 and April 2006 were included in this study, including those who had returned to dialysis. Individuals genetically of sub-Saharan African origin were classified as Black (predominantly African Caribbean or West African). The follow-up period extended to April 2007. The care of patients referred to this tertiary renal transplantation centre was returned to the initial nephrologists after 3 months. Data were available for 395 patients with functioning renal transplants at least 1 year post-transplantation (135 patients transferred to referring renal centres and 25 graft loss events during the first post-transplantation year). The demographic data are shown in Table 1.

The standard immunosuppressive regimen throughout the study period was based on tacrolimus (98% of patients) and prednisolone, and further information on concomitant immunosuppression is shown in Table 1. From October 2001, all patients were treated with basiliximab. Immunosuppressant protocols, both initiation and maintenance, including target blood concentrations for tacrolimus did not differ between the ethnic groups but did evolve with time according to the latest evidence base. The one difference between ethnic groups was a change in the initial dose of tacrolimus in Black patients from 0.2 mg/kg daily to 0.4 mg/kg daily in July 2002 and to 0.3 mg/kg daily in July 2005 in an attempt to avoid under-exposure in the early post-transplant period [31].

Genotyping

The study was approved by the Local Research Ethics Committee and subjects provided written informed consent. Genomic DNA was extracted from whole blood using a QIAamp DNA Mini Kit (Quiagen, Crawley, UK). Genotyping for CYP3A5 was performed using a

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Table 1. Demographics

<table>
<thead>
<tr>
<th></th>
<th>Black (n = 50)</th>
<th>Non-Black (n = 505)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender: male (% male)</td>
<td>30 (60%)</td>
<td>268 (65%)</td>
<td>N.S.</td>
</tr>
<tr>
<td>Age at transplant (years)</td>
<td>44.9 ± 2.0</td>
<td>46.6 ± 0.6</td>
<td>N.S.</td>
</tr>
<tr>
<td>Primary renal disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADPKD 2 (4%)</td>
<td>76 (15%)</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td>Structural0</td>
<td>58 (11.5%)</td>
<td>0.003</td>
<td></td>
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<tr>
<td>Glomerular disease 10 (20%)</td>
<td>103 (20.5%)</td>
<td>N.S.</td>
<td></td>
</tr>
<tr>
<td>Diabetic nephropathy 6 (12%)</td>
<td>48 (9.5%)</td>
<td>N.S.</td>
<td></td>
</tr>
<tr>
<td>Hypertension 14 (28%)</td>
<td>71 (14%)</td>
<td>0.02</td>
<td></td>
</tr>
<tr>
<td>Vasculitis 6 (12%)</td>
<td>20 (4%)</td>
<td>0.03</td>
<td></td>
</tr>
<tr>
<td>Other 10 (20%)</td>
<td>48 (9.5%)</td>
<td>N.S.</td>
<td></td>
</tr>
<tr>
<td>Unknown 2 (4%)</td>
<td>81 (16%)</td>
<td>N.S.</td>
<td></td>
</tr>
<tr>
<td>First transplant 47 (94%)</td>
<td>455 (90%)</td>
<td>N.S.</td>
<td></td>
</tr>
<tr>
<td>Cold ischaemia time (hours)</td>
<td>15.9 ± 1.0</td>
<td>16.8 ± 0.5 (n = 488)</td>
<td>N.S.</td>
</tr>
<tr>
<td>Donor age (years) 41.6 ± 2.1</td>
<td>45.3 ± 0.6 (n = 497)</td>
<td>&lt;0.001</td>
<td></td>
</tr>
<tr>
<td>Combined HLA-A, HLA-B and HLA-DR mismatches 3.9 ± 0.2</td>
<td>2.8 ± 0.1 (n = 499)</td>
<td>&lt;0.001</td>
<td></td>
</tr>
<tr>
<td>HLA-DR mismatch 1.2 ± 0.1</td>
<td>0.7 ± 0.03 (n = 499)</td>
<td>&lt;0.001</td>
<td></td>
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<tr>
<td>Initial immunosuppression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mycophenolate mofetil 8 (16%)</td>
<td>72 (14%)</td>
<td>N.S.</td>
<td></td>
</tr>
<tr>
<td>Azathioprine 6 (12%)</td>
<td>34 (7%)</td>
<td>N.S.</td>
<td></td>
</tr>
<tr>
<td>Cyclosporin 0</td>
<td>13 (2%)</td>
<td>N.S.</td>
<td></td>
</tr>
<tr>
<td>Daclizumab 5 (10%)</td>
<td>35 (7%)</td>
<td>N.S.</td>
<td></td>
</tr>
<tr>
<td>Anti-lymphocyte function-associated antigen 1 (2%)</td>
<td>8 (2%)</td>
<td>N.S.</td>
<td></td>
</tr>
<tr>
<td>Basiliximab induction 22 (44%)</td>
<td>268 (53%)</td>
<td>N.S.</td>
<td></td>
</tr>
<tr>
<td>Donor type</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Donation after cardiac death 18 (36%)</td>
<td>58 (12%)</td>
<td>&lt;0.001</td>
<td></td>
</tr>
<tr>
<td>Heart beating deceased 27 (54%)</td>
<td>354 (70%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living 5 (10%)</td>
<td>93 (18%)</td>
<td></td>
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</tr>
</tbody>
</table>

Note: Structural included congenitally absent kidneys, reflux disease, spina bifida and nephro lithiasis. Where incomplete data were available, the numbers available are indicated.
LightCycler (Roche Diagnostics Ltd, Lewes, UK) with specific primer sequences (forward: 5′-ACTGCCCTTGACAGCTTAG-3′; reverse: 5′-CATACCCCTAGTTGACGCA-3′) for amplification [32]. Genotyping was performed for a subset of 224 (26 Black, 198 non-Black) transplant recipients. Individuals with at least one CYP3A5*1 allele, both heterozygotes and homozygotes, were classified as CYP3A5 expressers. Individuals homozygous for the CYP3A5*3 allele were classified as CYP3A5 non-expressers. The allelic distributions were in Hardy-Weinberg equilibrium.

Fig. 1. Summary flow diagram of genotyped patients, CYP3A5 expresser status and initial tacrolimus dosing regimen.

Patient outcomes

Patient outcomes were obtained retrospectively from both electronic and paper records. The median follow-up period was 2.46 years (IQR 0.32–6.56).

Primary outcomes were time to graft loss (defined by death, return to dialysis or re-transplantation), patient survival and death-censored graft survival.

Secondary outcomes were estimated glomerular filtration rate (eGFR) at 3 months (n = 433) and 1 year (n = 306) post-transplantation, rate of progression of graft dysfunction and the time to halving of the Year 1 eGFR (abbreviated Modification of Diet in Renal Disease formula [33]).

Outcomes

Five-year patient survival was 96% for the Black and 90% for the non-Black groups (P = N.S.). Uncensored graft survival was significantly poorer for the Black cohort (5 year survival: 63% versus 80%, P = 0.03) as was death-censored graft survival (5 year survival: 66% versus 87%, P = 0.001; Figure 2). Black recipients received more kidneys from donors after cardiac death (36%) than non-Black recipients (12%). The recipients of renal grafts donated after cardiac death had significantly more combined graft failure and mortality events than other donor sources (17% versus 6.7%, P = 0.003).

A Cox proportional hazards analysis confirmed that our Black cohort had a poorer outcome independent of other potential confounding variables (hazard ratio = 0.46, P = 0.01; Table 2). There were significantly more graft failure events (12% versus 3.8%, P = 0.02), and combined graft failure and mortality events (16% versus 6.7%, P = 0.04) in the Black cohort in the first year.
Black renal transplant recipients have poorer long-term graft survival

The poorer outcomes in the Black group persisted for recipients surviving the first year with functioning grafts, with continued poorer 5-year death-censored graft survival (77% versus 94% of patients surviving the first year with functioning grafts, $P = 0.02$). Biopsy-proven acute rejection episodes occurred in (22/50) 44% of Black and (152/505) 30% of non-Black patients ($P = N.S.$).

Renal function

There were no significant differences between the Black and non-Black groups with regard to 3-month eGFR (Black $37.4 \pm 3.3$ mL/min/1.73 m$^2$, $n = 38$; non-Black $39.5 \pm 0.9$ mL/min/1.73 m$^2$, $n = 395$; $P = N.S.$), 1-year eGFR (Black $37.8 \pm 4.0$ mL/min/1.73 m$^2$, $n = 41$; non-Black $40.8 \pm 1.2$ mL/min/1.73 m$^2$, $n = 265$; $P = N.S.$) and the rate of decline after the first year ($-2.5 \pm 1.6$ mL/min/1.73 m$^2$/year, $n = 32$; non-Black $-1.2 \pm 0.4$ mL/min/1.73 m$^2$/year, $n = 255$; $P = N.S.$), but time to halving of Year 1 eGFR was significantly shorter for Black patients (mean $8.8 \pm 0.8$ years versus $10.8 \pm 0.2$ years, $P = 0.008$). There were no significant differences between the number of points per regression slope comparing the Black and non-Black groups (data not shown).

The median Year 1 eGFR of the overall population was 42.9 mL/min/1.73 m$^2$. Graft survival was better in the greater than median eGFR group as compared to the less than median eGFR group (11.7 years ± 0.2 versus 9.8 years ± 0.3, $n = 139$ both groups; $P = 0.002$). The Black cohort maintained the poorer outcomes in both the greater than/equal to median and less than median eGFR groups (Table 3). The independent effect of ethnicity on graft survival after surviving the first post-transplantation year with functioning graft was again confirmed by a Cox proportional hazards analysis (hazard ratio = 0.28, 95% CI 0.12–0.64, $P = 0.002$), where the only other statistically significant covariate was Year 1 eGFR (hazard ratio = 0.27, 95% CI 0.11–0.62, $P = 0.002$).

CYP3A5 expresser status

In our subgroup of 224 genotyped transplant recipients, Black CYP3A5 expressers ($n = 23$) also had a poorer graft survival rate when compared with the non-Black CYP3A5 expresser ($n = 43$) group (5-year survival – 62% versus 93%, $P < 0.001$; Figure 3). There was no difference in death-censored graft survival between the 155 non-Black CYP3A5 non-expressers and the 43 non-Black CYP3A5 expressers.

Multivariate analysis demonstrated that ethnicity persisted as an independent risk factor (hazard ratio = 0.31, 95% CI 0.15–0.64, $P = 0.002$), as did donor age ≥47 (hazard ratio = 0.40, 95% CI 0.20–0.80, $P = 0.009$) and combined number of HLA-A, HLA-B and HLA-DR mismatches 3–6 (hazard ratio = 0.33, 95% CI 0.12–0.85, $P = 0.02$), while CYP3A5 expresser status was not an independent risk factor.

There were no significant differences in the outcomes of the genotyped group, compared to the non-genotyped group with regard to graft or patient survival and proportion of Black transplant recipients.

Outcomes within the non-Black group

There were no differences between the Caucasians ($n = 419$) and non-Caucasians ($n = 86$) in the non-Black subgroup in primary and secondary outcomes (data not shown).

Table 2. Cox proportional hazards analysis of the effect of ethnicity, graft type, donor age, gender, combined number of HLA-A, HLA-B and HLA-DR mismatches and primary renal disease on graft survival

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Hazard ratio for death-censored graft survival (95% CI)</th>
<th>$P$-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>0.46 (0.25–0.85)</td>
<td>0.01</td>
</tr>
<tr>
<td>Donation after cardiac death</td>
<td>0.43 (0.24–0.78)</td>
<td>0.005</td>
</tr>
<tr>
<td>Donor age (≥47)</td>
<td>0.50 (0.31–0.82)</td>
<td>0.006</td>
</tr>
<tr>
<td>Male</td>
<td>0.54 (0.31–0.94)</td>
<td>0.03</td>
</tr>
</tbody>
</table>

545 patients available for analysis due to incomplete data set for 10 patients.

Covariates ‘Combined number of HLA-A, HLA-B and HLA-DR mismatches (3–6)’ and ‘Primary diagnoses more common in the non-Black group (ADPKD and structural)’ were removed from the forward conditional analysis, as they did not reach significance.

‘Primary diagnoses more common in the Black group (Hypertension and Vasculitis)’; ‘Primary diagnosis of diabetic renal disease’; ‘Recipient age at transplant (<47 versus ≥47 years)’, ‘Not first transplant’ and ‘Era of immunosuppression’ had $P$-values of >0.10 on univariate analysis and were not included in multivariate analysis.
Table 3. Mean survival (years ± SE) stratified by ethnicity and year 1 eGFR in transplant recipients surviving the first year with functioning grafts

<table>
<thead>
<tr>
<th>Year 1 eGFR &lt; 42.9 mL/min/1.73 m²</th>
<th>Year 1 eGFR ≥ 42.9 mL/min/1.73 m²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>Non-Black</td>
</tr>
<tr>
<td>7.1 ± 1.2 (n = 14)</td>
<td>10.1 ± 0.3 (n = 125)</td>
</tr>
<tr>
<td>9.9 ± 0.9 (n = 17)</td>
<td>11.9 ± 0.2 (n = 122)</td>
</tr>
</tbody>
</table>

Mean survival (years ± SE) comparing non-Black and Black groups for patients surviving first year post-transplantation with functioning graft within stratified Year 1 eGFR split at the median value.

**Fig. 3.** Kaplan–Meier analysis of death-censored graft survival comparing non-Black CYP3A5 non-expressers (n = 155), non-Black CYP3A5 expressers (n = 43) and Black CYP3A5 expressers (n = 23) renal transplant recipients. Log-rank P < 0.001.

**Discussion**

In a single Renal Transplant centre in the United Kingdom with universal access to healthcare, long-term graft survival in the Black population was poorer than that of non-Blacks. The impact of the greater degree of HLA-mismatch and higher proportion of grafts donated after cardiac death in the Black population did not fully account for this discrepancy as the independent effect of ethnicity persisted following multivariate analysis. The poorer graft survival associated with a more rapid rate of deterioration in renal function when assessed by the time for eGFR to fall to 50% of the value at 1 year after transplantation.

The greater rate of first-year graft failure in the Black cohort may reflect the increased proportion of grafts donated after cardiac death and higher immunological risk. In order to minimize the influence of early events, an analysis was performed excluding patients who died or lost their grafts during the first year. This demonstrated poorer graft survival in Black patients. This difference in outcome was independent of Year 1 eGFR, which in itself is a strong predictor of long-term outcome [4]. There appeared to be an increase in the incidence of both early and late events in Black patients. However, early events may have increased the risk of chronic allograft damage. Of note, grafts donated after cardiac death and higher immunological risk are no longer a risk factor in the analysis of patients surviving the first year with a functioning graft, suggesting that they reflect risk for graft loss mainly in the first year.

One hypothesis for the discrepancy in outcomes between Black and non-Black individuals is the difference in pharmacokinetics of the immunosuppressive drugs due to the high prevalence of CYP3A5 expression in the Black patients. In a subgroup analysis of known CYP3A5 expressers, the poorer outcome in the Black population is still maintained with excellent outcome for non-Black CYP3A5 expressers. This finding persisted following multivariate analysis. With therapeutic drug monitoring, the genotyped subgroup has previously been reported to have trough blood tacrolimus concentrations within target therapeutic range, where the non-Black (previously split into White, Middle Eastern and South Asian) non-CYP3A5 expressers had significantly lower tacrolimus dose requirements and higher dose-normalized tacrolimus concentrations as compared to the non-Black CYP3A5 expressers [34]. Our genotyped subgroup did not appear to be a self-selected group, with no statistical differences in demographics and outcomes of the genotyped and non-genotyped subgroups (data not shown). Thus, CYP3A5 expresser status is unlikely to be a factor in the poorer graft survival, despite the well-characterized influence on tacrolimus dose requirement.

It has been hypothesized that the differences between the previous American [1–4,6–8,10,11,23] and French/Canadian [18,19] cohorts reflected socialized medicine levelling the outcomes between the two groups, excluding the influence of poverty as a confounding factor [20]. However, in our cohort, the difference in outcomes mirrors the American findings but in a socialized medical system similar to that in France [18]. Our findings confirm the results for the UK cohort reported by Rudge et al. [25], but with a longer follow-up time. Thus, access to treatment is unlikely to be the sole factor underlying the differences in long-term graft survival. However, universal access to treatment may not necessarily exclude poverty per se as a socioeconomic risk factor for allograft survival, as it may still impact on environmental factors affecting healthcare.

Non-compliance, which has been associated with increased renal graft failure, has also been proposed to contribute to the poorer outcomes in the African American population [35]. However, the influence of ethnic group on compliance is not universally supported by the published literature [36] and is unlikely to be a major factor in the discrepancy in outcomes. A potential underlying factor for the difference between our findings and those of Pallet [18] is the relatively low usage of anti-proliferative agents in our population. However, this could not account for the differences noted in the United States, where the majority of
patients in the published series were given antiproliferative agents.

Other explanations for this observed difference are the differences in comorbidities, genetic or socioeconomic factors. Although this study accounted for hypertension and diabetes as the primary renal diseases, we were unable to assess the contribution of these conditions as comorbidities if not documented as the primary cause of renal disease due to the retrospective nature of the study. This could be important as diabetes and hypertension as comorbidities have been demonstrated to have an impact on long-term renal transplant outcomes [15,16,37]. In particular, NODAT (new-onset diabetes after transplantation) is more prevalent in the Black population [16,38]. Furthermore, Black patients in the UK awaiting kidney-only transplants are known to have a longer time on the waiting list [24], a known risk factor for poorer graft survival [14] and a higher level of panel reactive antibodies—a risk factor [39].

A range of potential genetic polymorphisms have been proposed as potential contributors to the observed poorer outcomes [40–42], predominantly related to increased immune responsiveness in the Black population. One other previously hypothesized genetic contributor is the single nucleotide polymorphisms of the ABCB1 gene, encoding P-glycoprotein. In this cohort, 208 (183 non-Black, 25 Black) renal transplant recipients with ABCB1 genotype data, there was no influence of the g.1236C > T, g.2677G > [T,A] and g.3435C > T single-nucleotide polymorphisms individually or in combination on primary or secondary outcomes (data not shown).

In this retrospective study, it was not possible to determine the potential contributions of social or environmental factors. Our study did not differentiate between more specific ethnic groups that are represented by our broad definition of the Black population, and may potentially explain the differences in the observations compared to the French cohort with differences in traditional migration patterns [18]. As causes of graft failure or decline in renal function were not identified, they could not be directly attributed to immune-mediated graft loss and cannot be regarded as direct evidence to support ethnicity as a factor in selection of the immunosuppressive regimen. In the long-term, ethnicity is unlikely to be easily defined due to an increasing degree of ethnic admixture, but ethnic group remains a surrogate marker for environmental and genetic risk factors.

Our data suggest the need to investigate the potential biological causes underlying poor transplant outcomes in Black patients.

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References

Use of isoniazid chemoprophylaxis in renal transplant recipients

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Abstract

Background. The use of isoniazid (INH) as chemoprophylaxis for tuberculosis (TB) in renal transplant recipients has not been widely studied or reported from a country where TB is endemic. We are reporting here the results of the largest ever-reported randomized, prospective study of the use of INH in renal transplant recipients.

Methods. Four hundred consecutive live related renal transplant recipients between April 2001 and September 2004, from this single center, were randomized to receive or not receive INH for 1 year after transplantation.

Results. There were 12 dropouts. Of the remaining 388, 181 recipients received INH for 1 year post-transplant and 207 did not. The primary disease, comorbidities, HLA (human leucocyte antigen) match, immunosuppression, episodes of rejection, the use of anti-rejection agents, a past history of TB in the donor, the recipients and in family members living in same house and a history of TB in the family were factors compared in the two groups. The only significant difference between the two groups was that there was an increased family history of TB in recipients who received INH \( (P = 0.01) \). One recipient from the INH group and 16 recipients from the non-INH group developed TB \( (P = 0.0003) \). Discontinuation of INH for hepatotoxicity was not required in any patient.

Conclusion. These results provide evidence that the use of INH following renal transplantation should be considered mandatory in geographical areas where the prevalence