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Letter to the Editor

Is Proteinuria a Common Finding After Kidney Donation?

To the Editor:

I read with great interest the editorial article titled ''Where There Is Smoke There Is Fire: The Iranian System of Paid Donation'' by Gordon and Gill (1). This editorial paper focused its message on drawing attention to some ethical aspects of the Iranian model as a solution to the organ shortage.

Furthermore, Gordon and Gill (1) said that the Iranian program of kidney transplantation has been a contributing factor limiting the advancement of deceased donation and living-related donation in Iran. However, the annual number of deceased donor kidney transplants rose from less than 1% of all kidney transplants at the end of 2000 to 30% in 2012. Kidney transplantation using deceased donors was initiated in 2002 at Baqiyatallah Transplant Center, the largest kidney transplant unit in Iran with more than 4200 kidney transplants over 20 years, and deceased donor transplantation annual numbers have increased from 0.4% in 2002 to 31% and 50% in 2008 and 2013, respectively. The opposite of the current editorial's opinion (1), the Iran model for living unrelated kidney transplantation did not result in limiting the improvement of deceased donation.

I absolutely agree that the ''Iran model'' has some deficiencies and of course these problems need to be eliminated. However, the Society for Supporting Dialysis and Transplantation Patients (SSDTP), a charity founded by ESRD patients, has, by facilitating living-unrelated donation, eliminated the waiting list for unrelated kidney transplantation since 1999 (2). The SSDTP acts as a liaison agency between potential donors and recipients (2); however, the potential recipients, who would like to receive a kidney from an unrelated donor, still wait at least 6–12 months. If a potential recipient cannot find a deceased donor within this period, the recipient can be introduced to a potential donor who should be in complete health.

Although Gordon and Gill (1) claimed that the clinical evaluation of donors may be compromised when donor payments are allowed, this is not acceptable with the existing very strict donor evaluation program in whole-kidney transplant centers of Iran. The potential donors should be in complete health confirmed by a transplant nephrologist (2). Moreover, many relative contraindications for living donor selection such as mild hypertension, BMI >35, microalbuminuria >30 mg per day and history of nephrolithiasis are absolutely rejected by our centers.

It is of interest that Gordon and Gill (1) explained some causes of microalbuminuria in living donors after nephrectomy such as inadequate pretransplant evaluation and conditions related to the poverty of unrelated donors. However, most reported data suggest that proteinuria increased in the living kidney donor population, and the prevalence of microalbuminuria in living donors varied from 11.5% to 34% in different studies (3,4). In addition, a study showed that 56% of 152 donors developed mild proteinuria (>150 mg/day) (5). One meta-analysis demonstrated that the average proteinuria was 154 mg/day and concluded that kidney donation results in small increases in urinary protein (6). The suggested causes of proteinuria postnephrectomy were subclinical hyperfiltration damage of the glomeruli, hypertension and a lower glomerular filtration rate.

Finally, it is generally accepted that all kidney donors should be screened for microalbuminuria at 2- to 3-year intervals postkidney donation because albuminuria has been illustrated as an appropriate indicator of kidney damage in the context of nephrectomy.

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Disclosure

The author of this manuscript has no conflicts of interest to declare as described by the *American Journal of Transplantation*.

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