

Patient Perspective on CKD in India

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The article entitled “Nonmedical factors and health-related quality of life in CKD in India” appearing in this issue of *CJASN* (1) analyzes the outcome of a survey from 2919 patients with CKD (both men and women) from different geographical parts of India about their quality of life. The 36 questions are drawn from an international tool, the Kidney Disease Quality of Life-36 (2). The patients are characterized by 22 parameters: socioeconomic factors, such as sex, region, education level, *etc.*, and medical factors, like body mass index, BP, and eGFR.

Interestingly, most of the surveyed patients had little to no educational background and come from poverty. The main weakness of the data comes from self-assessment of wellness as perceived by the patients. Also, I think that the six answer choices were rather subtle and difficult to select from, even for more educated individuals. It is impossible to eliminate the bias from social workers who assisted the illiterate patients. Additionally, the geographical locations involve at least six different languages, and it is difficult to judge the efficacy of translation without losing the essence of the questions. It is also important to note that “wellness” means different things to different persons.

Regarding socioeconomic correlations, women, rural residence, low education, and lower income, as expected, were associated with lower quality of life scores across all subscales, which is also the case with patients in hazardous occupations. It is surprising that alternative drug usage was associated with higher scores on the mental component scale, physical component scale, and burden scale. However, without understanding the nature of these alternative drugs, this observation is ambiguous. Do the authors mean chewing tobacco or something else? “Fluid restriction” for manual laborers is of serious concern because the Indian climate is very hot. There is very little scope for laborers to “travel.”

Lastly, the devastating air pollution in northern India is responsible for lung diseases, such as chronic obstructive pulmonary disease. Furthermore, these people cannot afford well balanced (vegetables and fruits) food other than jowar (sorghum). As a patient

with CKD myself, I wonder how factors, like drugs, alcohol, air pollution, and lack of access to healthy diets, factored into the survey outcome.

Similarly, lower body mass index and diabetes were associated with worse quality of life across all subscales, again as anticipated. Albuminuria, on the contrary, showed positive association on all subscale scores. This is not surprising if one understands that the staple food of low-income groups in India is inexpensive jowar (sorghum), a grain very rich in protein. Wealthier people eat rice, which is not as high in protein, along with more expensive lentils, beans, *etc.* that are protein rich. Hence, the albuminuria seems the same across all strata. Hypertension does not seem to affect any scores in any subscale, except in symptoms.

Despite the above-mentioned weaknesses, I believe that this study is an important addition to the preexisting literature, and I am grateful for the opportunity to provide a patient perspective on this study.

Disclosures

Dr. Uppaluri has nothing to disclose.

References

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See related editorial, “Socioeconomic Determinants of Quality of Life in Patients with Kidney Diseases,” and article, “Nonmedical Factors and Health-Related Quality of Life in CKD in India,” on pages 162–164 and 191–199, respectively.

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