The kidneys are paired organs but only one kidney is necessary for life. Chronic Kidney Disease (CKD) is the most common cause of kidney disease and is caused by diabetes, hypertension and obesity. The earliest sign of chronic kidney disease is proteinuria (the finding of protein in your urine). A simple urine test can identify if you have protein in your urine. This requires only 15-30cc’s of your urine. Proteinuria may be present long before severe damage is detected in your kidneys.

Blood tests such as Blood Urea Nitrogen (BUN) and serum creatinine (sCr) levels are obtained routinely to monitor the level at which your kidneys are functioning.

March is National Kidney Month: Are You At Risk for Kidney Disease?

By Clive O. Callender, MD

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There are 5 Stages of CHRONIC KIDNEY DISEASE:

<table>
<thead>
<tr>
<th>STAGE</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>is associated with a Glomerular Filtration Rate (GFR) of greater than 90cc/minute; this is not associated with detectable kidney damage. BUN or sCr Levels are normal.</td>
</tr>
<tr>
<td>2</td>
<td>is associated with a GFR of 60-89 cc/min which may be associated with very small increases in your BUN and sCr levels.</td>
</tr>
<tr>
<td>3</td>
<td>is associated with a GFR of 30-59cc/minute This is associated with a significant elevation of your BUN and sCr levels. These 3 Stages of CKD when detected early, can be reversed by administering medications which lower the blood pressure and the blood sugar.</td>
</tr>
<tr>
<td>4</td>
<td>is associated with a GFR between 15-29 cc/minute; is not reversible but can be managed until a kidney donor is found or until dialysis is necessary</td>
</tr>
<tr>
<td>5</td>
<td>CKD in which the GFR is less than 15cc/minute and necessitates urgent treatment with kidney replacement therapy: dialysis or transplantation</td>
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Chicago/Northwest Indiana MOTTEP celebrated 25 years of service in November 2022. “We cannot imagine where the time went” states Shelia George, program coordinator. “The best way to showcase the activities and accomplishments of the program is to share its historical highlights.”

The MOTTEP Chicago/Northwest Indiana program was established in November 1995 with Rev. Dr. Franklin D. Burns serving as the coordinator. Rev. Burns was the founder and pastor of Peace Baptist Church in Gary, IN and a transplant recipient. Shelia George became the coordinator of MOTTEP Chi/NWI after Pastor Burns passed the torch in 1999.

MOTTEP is managed under Multicultural Wellness Network (MWN) a 501c3 organization founded by Shelia George in 2000. She currently serves as the Executive Director of the non-profit organization. Multicultural Wellness Network/MOTTEP became synonymous in the early years to maintain recognition in the community. MWN/MOTTEP grew and served in eight offices over the years with the first being in East Chicago, IN. Currently, MWN maintains two offices one in Gary and the other in East Chicago.

MWN/MOTTEP worked diligently to get the message out to our communities about organ and tissue donation and the illness leading to the need for transplants.

One of most noteworthy successes is the MOTTEP Youth Summit: their motto Healthy Kids=A Healthy Future. Through this conference styled event, we provide children with a parent-free environment to discuss topics that affect their lives.

Collaborations with local agencies has been beneficial to spreading our messages. Local health departments, universities/colleges, Greek organizations, Insurance agencies, Federally Qualified Health Clinics (FQHCs), Indiana NAACP health committee, NWI Tobacco Prevention Program, American Heart Association, and American Diabetes Association.

MOTTEP Bio Continued from page 1

of the Faith-Based Alliance for Kidney Health Equity and The B.O.L.D. Health Equity Initiative. She has received several national and international research honors and has published findings from her work in leading medical journals, including JAMA, Health Affairs, American Journal of Kidney Diseases, Journal of the American Society of Nephrology, and American Journal of Transplantation. She is the recipient of multiple Teaching Excellence Awards from Johns Hopkins University.

Nationally, Dr. Purnell is the Immediate Past Chair of the American Society for Transplant Surgeons (ASTS) Diversity, Equity, and Inclusion Committee and was the inaugural recipient of the ASTS Excellence in Diversity, Equity, and Inclusion Award. Dr. Purnell is also a member of the Board of Directors for the National Minority Organ Tissue Transplant Education Program (MOTTEP), a member of the Governing Board for the Living Legacy Foundation of Maryland, and a member of the National Kidney Foundation (NKF) Transplant Advisory Committee.
**MY BLOOD DONATION EXPERIENCE**

Growing up in Washington, DC, I never really thought about being an organ/tissue donor. I just knew that I did not like needles, especially when getting my blood drawn. Unable to even look at the needle when it pierced my skin, I winced in pain when it did.

During the summer of 1996, I was working a research fellowship with the IT branch of the NIDDK on campus at the NIH in Bethesda, Maryland. We were helping to upgrade the Institute’s computer network. One Friday I noticed that there was an open lecture at the Lipsett Auditorium in the main hospital building 10, featuring Dr. Clive O. Callender from Howard University.

I absorbed the featured topic “Organ Donation” and recalled that African Americans at that time were 65% of the recipients of organ donation, but only 15% of the organ donors. I thought that those figures were unfair and that I should do something to help. I had already checked off the “Organ Donor” box on my DC Driver’s License, but I felt there was much more I could do.

Dr. Callender introduced a beautiful young African-American lady who told her story of bone marrow donation. I was really hooked then! She remarked that the donation process was relatively painless, akin to being “punched in the hip”. I figured that if she could do it, then I could do too.

Ironically, one of the greatest departments of transfusion medicine in the entire world resided right down the hall from the lecture hall. I quickly signed up to be a blood donor. From that time on, I have been a regular donor every two months or so, donating a pint or more each time.

In March of 2022 I made my 100th donation and became a member of the NIH DTM Donor Hall of Fame! I have donated more than 12 gallons of “O Positive” blood over a period of 26 years.
Expanding the Journey of saving lives has been one of our long-term goals which calls for National MOTTEP to emphasize not only areas such as living donations but to prioritize additional expansions, into working with other programs such as the American Red Cross, the National Marrow Donor Program, and the Muslim community.

MOTTEP already works closely with other minority ethnic organizations such as AMAT, the four historically Black Medical Colleges and Universities (Howard University, Moorehouse, Charles Drew, and Meharry) and The Links Incorporated.

Traditionally, there has been no focus on expanding our journey into areas of donation such as the American Red Cross and its role in blood and plasma donations, as well as the National Bone Marrow Donation Program. Blood donation is one of the most common forms of donation. Working with these organizations makes sense, as they work also is about saving lives, a mission that aligns with that of MOTTEP.

There is also a need to embrace other religious and ethnic communities such as Muslim communities, and those of Caribbean and African descent. Within many regions in the United States, you can find pockets of immigrants that share a common ethnic bond. They all share a need: a need for more outreach and education around organ donation and transplantation.

The broader vision for MOTTEP is to embrace not only these communities, but reach further beyond into the Caribbean Islands and the Continent of Africa.

Chronic Kidney Disease is an often-reversible illness when caught early! Continued from page 1

Other causes of CKD are:
1. Cancer
2. Bacterial Infection
3. Autoimmune Diseases
4. Viral infections
5. Medications such as Ibuprofen, Naproxen, and other nonsteroidal inflammatory drugs
6. Obesity

Ethnicities such as African American, Native American and Latino -Hispanics have higher incidences of CKD. Older adults are also at a higher risk of developing chronic kidney disease due to age progression.

Ten percent of kidney diseases are caused by unknown causes. Often by the time the patient visits the nephrologist, the kidneys are too small to be biopsied and therefore we are unable to find the cause of the kidney disease.

Genetic profiles and more accurate blood genotyping in the future may help us make an earlier diagnosis if more of our patients get urine screenings at an earlier stage. The best time to make this diagnosis of kidney damage is when patients present with only proteinuria and the kidneys are normal in size.

The diagnosis of chronic kidney disease can be made by the following tests:
1. Screening for protein in the urine— the earliest sign of kidney disease
2. Routine blood testing – annual monitoring of BUN and sCr which can signal a change in kidney function
3. Radiologic Imaging such as an ultrasound or CT scan can often detect abnormalities of the kidneys. These are not done as routine screening in usual circumstances
4. A kidney biopsy can be diagnostic, if the kidney disease is not far advanced.
5. Blood genetic testing can identify kidney diseases caused by genetic abnormalities if there is a family history of such abnormalities.