Much has changed in the collective view of chronic kidney disease. The terms chronic renal insufficiency, chronic renal failure, and chronic renal disease have all been replaced by the now almost ubiquitously used umbrella term chronic kidney disease (CKD). CKD is increasingly recognized in the United States and Europe as a problem affecting as many as 5% to 10% of the population. Over the past few years, a new classification of CKD encompassing five stages of CKD from the earliest (stage 1) to the most severe (stage 5) has been adopted. Furthermore, there is now consensus that because the serum creatinine has major limitations as a measure of kidney function, actual or calculated glomerular filtration should be used. Through sterling work by the National Kidney Foundation, the Renal Physician’s Association, and the National Kidney Disease Education Program several CKD clinical guidelines are now available. These address bone disease, hypertension, nutrition, and cardiovascular disease; importantly, still more guidelines from the National Kidney Foundation are being developed. Most recently, two palpable shifts in perspective have occurred. First, there is a big push to make guidelines in CKD global in reach and perspective. Second, there is tremendous enthusiasm to raise the awareness of CKD as a public health problem, both in the developed world and in the developing world.

Despite all of this progress, much remains to be done. Although strategies to slow progression are available, such as angiotensin blockade and a more aggressive target for blood pressure reduction, many patients still progress to end-stage renal disease. Understanding the role of genetic factors in
disease progression and in disease treatment (pharmacogenomics) remains an embryonic field as it pertains to CKD care. The role of much investigated treatments, such as dietary protein restriction, remains unresolved. Although the toll that cardiovascular disease (CVD) has taken and continues to take in terms of morbidity and mortality in CKD patients is obvious and staggering, the precise role of factors that account for this heightened risk of CVD remains unclear. Preventing CVD in CKD patients continues to be an important challenge. The mechanistic aspects of the complications of CKD (eg, abnormalities in mineral metabolism and anemia) have not been completely resolved; nor for that matter have all aspects of treatment. For example, the optimal hemoglobin target in a CKD patient remains a conjecture. The management of bone and mineral metabolism continues to be challenging. To try and improve CKD management and implement guidelines in CKD patients, the concept of the CKD clinic has emerged. The CKD clinic is a multidisciplinary clinic led by a physician or a nurse that focuses on all aspects of CKD care, running the gamut from renal progression management to the treatment of complications. Although many centers are now setting up CKD clinics, the precise structure of these clinics, the target population, and the relationship between the CKD clinic and referring doctors has not been worked out.

With the advances in CKD and awareness of the vexing issues as a backdrop, what follows in this issue of the *Medical Clinics of North America* is a series of articles by true experts in the CKD field on various aspects of CKD care. They place in perspective the scope of the various problems in CKD care. It is hoped that the next decade will herald new data and better evidence so that CKD management improves dramatically. Moreover, it is hoped that the next several years will allow us to tackle CKD care as a global issue.

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