Preface

This supplement comprises the manuscripts at the 2nd North American Pediatric Renal Transplant Cooperative Study (NAPRTCS) Workshop. The NAPRTCS is a research effort organized in 1987. The objective of the study group is to obtain the voluntary participation of all pediatric renal transplant centers in the United States and Canada. In 1987, the study group had 43 participating centers and enrolled 399 transplants (1). From small beginnings, the Study Group has mushroomed into 85 participating Centers with 2,202 transplants enrolled as of February 1992. The large pool of data on pediatric renal transplantation has enabled us to develop 3-yr patient and graft survival rates (2).

Graft survival of renal allografts in children lags behind the survival rates reported in adults (3). A major cause of graft attrition in children is noncompliance with immunosuppressive therapy. Whether the noncompliance is related to steroid-induced facial changes (4) or cyclosporine-induced dysmorphism (5) is speculative. The noncompliance may also just be a reflection of "adolescent mentality." The NAPRTCS plans to conduct a special study of the issue of noncompliance during the next calendar year.

Growth posttransplantation continues to worry most pediatric transplant physicians. Studies on the first 300 children with a functioning graft and 2 yr of linear growth show that catch-up growth, defined as an improvement of 0.5 SD in the Z score, is observed only in children in the age range of 0 to 5 yr. For the age ranges 6 to 12 and 13 to 17, no improvement in the Z score posttransplantation is noted (6). Much of the data presented in the growth session at the 2nd workshop, and published here, deals with the potential need for the use of growth hormone therapy in children posttransplantation.

At 30 months posttransplantation, 56% of all children continued to need antihypertensive therapy (2). Because 22% of transplanted children have all native kidney tissue removed before transplantation, it would appear that posttransplant hypertension is predominantly due to drug therapy (7). A special study is being considered to determine the genesis of hypertension in children posttransplantation, and the results will be reported at the 3rd NAPRTCS workshop, scheduled to be held in Vancouver in October 1992.

We are grateful to all of the principal investigators of the NAPRTCS clinical centers who participated in the symposium.

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REFERENCES