



EDITORIAL COMMENT

‘The forgotten sex’: gender disparities in kidney disease

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Historically in anthropology, the female sex was considered the ‘fair sex’ or the ‘weak sex’, but medicine tells a different story. Cardiovascular (CV) disease represents one of the most common causes of morbidity and mortality in the Western world and the prevalence continues to increase. Women hold a more advantageous position in terms of CV risk than men because throughout all age strata, CV disease is more common in men than in women [1]. Despite this, CV disease remains a leading cause of death in women, perhaps in part because of the misperception that it is a man’s disease. As a result, cardiologists pay far more attention than other specialties to sex differences in the aetiology, pathogenesis and management of disease.

Sex is a biological construct and gender is based on socially defined features [2]. Why is it that there is a paucity of studies exploring sex and gender differences in the literature and why are women, based on either definition, often forgotten in medicine?

Women are the majority in the world population, yet they are all too often underrepresented in clinical trials [3]. This is particularly sobering in nephrology, where women have a higher prevalence than men of chronic kidney disease (CKD) across all stages and there is evidence that progression of CKD is affected by sex [4]. This in itself is controversial, because some believe that glomerular filtration rate (GFR) may be underestimated in

women depending upon the formula used to calculate it and lower urinary creatinine excretion in women may magnify urinary albumin:creatinine ratios [5, 6].

Pregnancy is an obvious CKD-related sex disparity. Historically, women with advanced kidney disease rarely became pregnant. Indeed, women were often actively discouraged from considering pregnancy by their healthcare team due to the associated risks: the high incidence of adverse maternal and foetal outcomes and flare and progression of existing kidney disease. It is now apparent that with proper planning and pre-pregnancy counselling, while the risk remains high, steps can be taken to lower the risk, making better outcomes possible [7].

Gender disparity and stereotypes can negatively impact upon all aspects of healthcare, with delays in diagnosis and treatment, poorer quality of care and resultant increased morbidity and mortality. Broadly speaking, this bias affects women more severely than men, but any bias contributes to health inequity and has a negative impact for everyone.

Thus the time is now to make gender inequality a priority in nephrology. This dedicated CKJ series explores gender bias, why it occurs, how it manifests, its impact and potential solutions in the setting of kidney disease.

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The topics covered include disparities and differences in diagnosis, access to healthcare, the aetiology of kidney disease, the pathogenesis of CKD complications (including bone disease, sexual dysfunction, psychological issues and malignancy), access to dialysis and discrepancies in dialysis modality (e.g. home-based therapies versus centre-based) and differences in kidney transplantation and living kidney donation.

CONFLICT OF INTEREST STATEMENT

M.C. is the ad interim editor-in-chief of *CKJ*. A.O. is one of the previous editors-in-chief of *CKJ*. The other authors are associate editors of *CKJ*.

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