SUMMARY

Cardiovascular disease is very common in patients with chronic kidney disease and contributes significantly to the morbidity and mortality in this group of patients. In fact, patients with CKD are more likely to die of cardiovascular diseases than progress to end stage renal disease. Focus had been on the management of end stage renal disease by haemodialysis and transplantation. The cost of this is usually not within the reach of patients in the developing world like ours.

Studies have identified the established cardiovascular risks in patients with CKD and they are divided into traditional and non traditional risks. The established traditional risks are hypertension, smoking, diabetes, proteinuria, and LVH while the non-traditional risks are anaemia, altered calcium and phosphorus metabolism and inflammatory markers.

Incidentally, many of these cardiovascular risk factors are also risk factors for progression to end stage renal failure in patients with CKD and they are most times preventable.

If these factors are identified and controlled, the impact on morbidity and mortality of CKD patients can be ameliorated and the progression to end stage renal disease retarded. There is paucity of data on prevalence of these risks in this environment making it difficult to focus on implementing preventive strategies against them. Identifying these risk factors in this environment will be a rational basis for CKD management as preventive strategies can be mounted against them. I therefore set out to determine the prevalence and pattern of the established risk factors and events in our CKD population. 52 subjects with CKD were recruited as well as 50 age and sex-
matched controls. They were taken through a questionnaire, had clinical examination and laboratory investigations.

I found out that the prevalence of anaemia, hypertension, proteinuria, and LVH were high in this study with a prevalence of 88.46%, 80.7%, 98.07%, and 88.6% respectively. Inflammatory markers were also statistically higher. Dyslipidaemia, obesity, smoking, and CaP0$_4$ seem not be major problems in our CKD population. Prevalence of CCF and PVD were also high in this study 61.5% and 30.8% respectively. But the prevalence of CVA was not statistically different from the controls. CHD was not found in any of the study population and control.

I therefore concluded that in the management of our patients with CKD in this environment effort should be directed at preventing these highly prevalent risk factors while we look out for the other established risks.