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The authors respond.

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The authors respond

We thank Dr. Grant for his comments regarding our recent article on the role of hypertension and chronic kidney disease in the racial disparities in the incidence of renal cell carcinoma among members of Kaiser Permanente Northern California, a large integrated health care system in the greater San Francisco Bay area.[1] Dr. Grant presents intriguing evidence to suggest that racial differences in circulating 25-hydroxyvitamin D [25(OH)D] levels may contribute to the disparities in renal cell carcinoma, and this hypothesis warrants further examination. However, we note that the findings of studies evaluating the relationship between circulating 25(OH)D levels and renal cell carcinoma risk have been inconsistent. In contrast to the more recent report from the EPIC cohort,[2] no association was observed in a prospective investigation of renal cell carcinoma in the NCI Cohort Consortium that included a larger number of cases (560 and 775 cases, respectively).[3] Future studies evaluating the association between circulating 25(OH)D levels and risk of renal cell carcinoma among blacks and other non-white populations would be informative.

Beyond circulating 25(OH)D levels, several other factors might also explain how hypertension and chronic kidney disease contribute to racial disparities in the overall burden of renal cell carcinoma including differences by race in hypertension control and management of chronic kidney disease, the prevalence of modifiable risk factors related to renal cell carcinoma (e.g., obesity, smoking), and/or genetic susceptibility. Further investigation of each of these factors will likely yield important insights into the underlying mechanisms through which hypertension and chronic kidney disease influence renal cell carcinoma risk and will help us to better understand the racial disparities in this malignancy.

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