

of patients who are at lower risk of complication [8,9]. Generalizing the use of same-day biopsy to all patients is ill advised. Mackinnon *et al.* report their anecdotal experience with “day case” native percutaneous renal biopsy in 92 patients. Only two patients required overnight observation, and they report no significant complications. Unfortunately, it is not clear whether these patients represent all biopsies done since 2007 at their institutions or whether this is a select group of patients.

As a result of their anecdotal experience, Mackinnon *et al.* question the utility of our study which demonstrated that the absence of a perinephric haematoma on ultrasound at 1 h post-renal biopsy had a $\geq 95\%$ negative predictive value for a complication. Since all the patients undergoing percutaneous renal biopsy in our practise are observed for 24 h post-biopsy, we cannot know if the same results would have been observed if patients were discharged on the same day. Nonetheless, in programmes utilizing same-day discharge after percutaneous renal biopsy, the absence of a perinephric haematoma at 1 h post-biopsy should provide a nephrologist some assurance that the patient was likely to do well while the presence of a haematoma might lead one to observe the patient longer. To our knowledge, a similar study has not yet been performed in patients undergoing same-day discharge.

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Is there any survival advantage of obesity in Southern European haemodialysis patients?

Sir,

We read with much interest the article ‘Is there any survival advantage of obesity in Southern European hemodialysis patients?’ of Charles Chazot *et al.* published in your journal [1]. This study shows that, in a large prospective Southern European cohort, overweight and obese haemodialysis (HD) patients with high-risk comorbidities have a better survival than normal or underweight HD patients. From these interesting results, which confirm those of previous studies [2–5], arise an important question: ‘Must nephrologists in their daily clinical practice plan nutritional strategies aimed at increasing the weight of underweight or normal-weight HD patients and avoid adopting dietary restrictions in overweight and obese HD patients?’

We think that, today, it is difficult to answer this question and that further studies are needed. However, if the answer should be yes, it could be useful to consider some issues. First, it is unknown how much the body weight of underweight and normal-weight patients should increase and if these patients must be encouraged to become overweight or obese to benefit from the survival advantage of reverse epidemiology.

Second, it remains to be elucidated how the body weight of underweight and normal-weight patients should increase: increased dietary intake, artificial nutrition support or both?

Third, the increase of body mass index (BMI) or the maintenance of a high BMI may be associated with a higher frequency of comorbidities, especially cardiovascular diseases. Recently, studying a cohort of 112 prevalent chronic HD patients, we have shown in obese patients, with respect to overweight and normal-weight patients, a significantly higher prevalence of hypertension (88.8% vs 66.6% vs 31%; $P < 0.001$), diabetes (33.3% vs 9.1% vs 3.4%; $P = 0.001$), coronary disease (61.1% vs 36.3% vs 31%; $P = 0.001$) and cerebrovascular disease (50% vs 21.2% vs 22.4%; $P = 0.04$) [6]. Nevertheless, it is well known that a high burden of comorbidities is associated with higher frequency of hospitalization and costs.

Fourth, obesity may significantly impair the quality of life. In the same study cited above [6], we found that, at SF-36, there was a trend for the obese subjects to score lower than normal-weight patients on the bodily pain and role emotional scales. With regard to the physical functioning scale and the physical component summary score, the difference was statistically significant. However, obese HD patients did not score significantly lower on the scale related to mental health [6].

Fifth, the increase of BMI or the maintenance of a high BMI in HD patients may impact the access to kidney transplantation [7], affect both patient and graft survival [8] and increase the risk of congestive heart failure and atrial fibrillation [9].

With this in mind, it remains to be established if the game is not worth the candle.

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Reply

Sir,
We thank Bossola *et al.* for their thorough reading of our article. They raise several important issues coming from our finding in Europe, confirming previous US studies, which is the survival advantage observed in obese dialysis patients.

- (1) The aim at increasing the body weight (BW) in patients with low or normal body mass index (BMI) must

rely on the European best practice guidelines (EBPG) guidelines on nutrition [1]. If the patients present with protein-energy wasting (PEW) according to the guidelines criteria, the strategy to correct these criteria including correcting weight loss or increasing low BW must be implemented. For sure, the risk to become obese in this setting appears very low.

- (2) As stated in the EBPG [1], the way to treat malnutrition relies on dietary counselling, implementing the recommended energy and protein intakes, on oral supplementation and intradialytic parenteral nutrition if oral supplementation fails.
- (3) It is clear that obese patients have a higher rate of comorbidities, and this was confirmed in our study. It stresses the paradox of better survival in these patients. The important question is to understand why patients with low or normal weight have a high risk of death, outweighing the risk of the severe comorbidities of obese patients. One of the answers may be the relative more important uremic intoxication in lean patients because of proportional increase of the toxin-producing visceral mass [2,3].
- (4) Regarding the important issue of the impact of obesity on transplantation access and on quality of life, it is crucial that any weight loss programme is to be monitored with the EBPG criteria to avoid any additional malnutrition.

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