pre-existing coronary lesion, yet act on newly formed lesions—we simply don't know.

As the power of the study was not sufficient to render the coronary end point statistically significant, it is wise to state that the currently available data do not allow to draw definite conclusions regarding the efficacy of statins on coronary death in hemodialyzed patients. Absence of evidence is not necessarily evidence of absence. We have to wait for the outcome of the SHARP study to know the definite answer.[7]

The conclusion that statins are ineffective in dialyzed patients is certainly not strictly proven and cannot be answered conclusively today. Admittedly, it is possible that coronary heart disease in terminal renal disease differs from coronary heart disease in nonrenal patients and is resistant to statin treatment as suggested by some previous observations[8,9]—but a Socratic attitude demands to admit that currently we simply don't know the answer.

We believe that at the current state of our ignorance it is wise to continue with statins in patients who had been on statins before dialysis, and, in view of their encouraging side-effect profile, to administer statins (admittedly without the definite evidence) at least in dialysis patients with clinically proven coronary heart disease.

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The Authors Reply: Ritz and Wanner[1] provide insightful remarks about the need to understand the limitations of evidence from trials before applying the results in practice. In our study, statin use in dialysis patients continued to rise despite the results of the 4D study.[2,3] We wish to emphasize that the purpose of our study was not to applaud or criticize physicians in their continued use of statins. We agree that although the evidence from the 4D and AURORA studies seem to suggest a lack of benefit, the limitations of those trials make the results less conclusive than they could be.[4] Given the resources needed to conduct randomized trials, it is vital that they contribute to scientific knowledge without ambiguity. The availability of funds is a major challenge to conducting trials of common cardiovascular medications. Industries may be less interested in financing these trials, as dialysis patients represent a small proportion of the overall market sales. Yet, our need for such evidence remains high, as renal patients were frequently excluded from trials that influenced the use of these medications in the general population.[5] The main purpose of our study was to explore the translation of knowledge in renal practice. Our discussion offers several explanations as to why physicians continued to prescribe statins after the 4D study, which includes uncertainty about the overall result. As Ritz and Wanner point out, the SHARP trial will provide more information about the effectiveness of statins in renal patients.[6] We await these results to guide the care of our patients.

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Very low blood pH is life threatening

To the Editor: In the review 'assessing acid–base disorders', Adrogué *et al.*[1] have discussed the usefulness of three approaches to assess acid–base disorders with the final aim 'to undertake appropriate intervention' (p 1239). However, they have omitted to discuss the importance of blood pH *per se* (i.e., the concentration of hydrogen ions (H^+) in the blood).