Disaster-related education for dialysis patients
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To the Editor: I read with great interest the recent paper by Kutner et al.1 on the effect of Hurricane Katrina and the mortality of dialysis patients. To be sure, as noted by Kutner et al., ‘each disaster may present a different set of circumstances and challenges that will require unanticipated response efforts’.1 I, hereby, would like to make an additional comment on disaster-related education for patients. What should we teach patients? The education program for the primary management of dialysis2 at home or nearby clinics might be a possible useful topic for countries where machines are easily available and the general populations are well educated. However, for the poor countries, is this really useful?


Response to ‘Disaster-related education for dialysis patients’

Dr Wiwanitkit is concerned that, in the event of a disaster, dialysis patients in poor countries may lack opportunities to go to another location for dialysis, as well as resources to manage dialysis in the home setting.1 These difficulties highlight the more general point that poor patients are likely to be especially vulnerable in a disaster, as Abdel-Kader and Unruh2 have emphasized. For all patients, possible disaster scenarios should be discussed, and there should be a detailed disaster plan that is repeatedly reviewed and practiced. Each patient should have a ‘survival kit’ that contains a list of the patient’s medications and information about the specific treatment prescription, information needed by medical relief workers. It is especially important that patients receive information about following strict fluid restriction and emergency diet policy when the availability of dialysis treatments is limited for a period of time.3 Sever et al.3 have also recommended that patients store potassium exchange resins as a way to prevent hyperkalemia when dialysis treatment cannot be obtained in the initial days after a disaster.


Targeting hyperphosphatemia: truth or dare

To the Editor: We are pleased that Isakova et al.1 have generated the momentum for long-awaited randomized trials on phosphorus management in patients with chronic kidney disease. We fully agree that these are long overdue. Treatment of millions of patients worldwide, following the Kidney Disease Outcome Quality Initiative guidelines,2 is based on experimental and observational data, rather than on prospective trials. Predictably, but somewhat disappointingly, Isakova et al. rebut the concept of a placebo-controlled randomized controlled trial of phosphorus binders in hemodialysis patients. They argue this would be considered unethical, given the wide acceptance of current practice guidelines for maintaining serum phosphate levels between 3.5 and 5.5 mg/dl.1 Would it not make more sense, when designing these pivotal trials, to challenge these targets?

First, phosphate level targets refer to predialysis concentrations and do not take into account the sawtooth pattern of phosphorus concentrations. The time-averaged phosphorus exposure in hemodialysis patients is about 30% lower than that suggested by predialysis phosphorus concentrations. Second, although observational data unequivocally demonstrate associations between high phosphorus and adverse outcomes, numerous interventional studies in, for example, diabetes or with erythropoietin therapy have shown that ‘normalization’ does not equal the optimal therapeutic target.3,4 Third, availability of calcimimetics obviates the need for phosphate binder therapy to control secondary hyperparathyroidism. Finally, treat-to-target trials likely require a combination of several phosphorus binders, thereby introducing heterogeneity in treatment effects, and thus jeopardizing the safety evaluation of individual phosphate binders.5

When looking for the truth about phosphate control, we might need to dare and ‘violate’ phosphate targets in randomized trials.


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