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The Authors Reply: We thank Daugirdas for his comments in ‘Proposed controlled trials of phosphate reduction in CKD: which whey should we go?’¹ We agree that reducing dietary phosphorus intake is an important strategy to control phosphorus balance in renal failure that is worthy of testing in randomized trials. Daugirdas’s interesting approach would effectively dissociate phosphorus restriction from undesirable protein restriction through the use of whey supplements and through avoidance of foods with high phosphorus-to-protein ratios, such as processed foods. In support of this proposal, the feasibility of dietary counseling to reduce serum phosphate levels in dialysis patients has been established by a recent randomized trial.² It is likely, however, that several factors could limit the effectiveness and sustainability of dietary phosphorus restriction alone. First, the lack of accurate labeling of phosphorus content in food additives and its inconsistency across specific manufacturers³ complicates dietary counseling. Second, while the cost of whey may be low, effective ongoing dietary counseling requires dedicated and relatively costly nutritionists. Perhaps most importantly, kidney disease is largely a disease of poverty, which, under the strain of the recession, is deepening in the United States. Impoverished dialysis patients, even those most successfully counseled, will likely forgo healthy food choices in favor of cheap prepared foods that are phosphorus-laden and widely available. To benefit the majority of patients, we would therefore suggest a multipronged approach to reduce phosphate levels in dialysis patients, involving both pharmaceutical and dietary interventions as suggested by Daugirdas.

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Non-infected hemodialysis catheters are associated with increased inflammation compared with arteriovenous fistulas

To the Editor: We read with great interest the article by Goldstein *et al.*,¹ reporting that catheters may cause inflammation independent of infection as compared with arteriovenous (AV) fistula use. The authors showed greater levels of serum C-reactive protein (CRP) in patients dialyzed with central catheters in contrast to AV fistulas.

We wish to highlight a few important points. First, the authors did not give any information about comorbidity status, underlying primary renal disease, level of uremia, glycemic control of diabetic patients, echocardiographic data, anthropometric measures, or prealbumin and cholesterol concentrations showing nutritional status and residual renal function (RRF) at the start of hemodialysis. It is known that CRP is affected not only by infection but also by many variables, such as RRF, coronary heart disease, peripheral arterial disease, malnutrition, and metabolic syndrome.^{2,3} Thus, it is very difficult to attribute high CRP levels solely to the presence of a catheter unless these variables are appropriately controlled for.

Second, the authors measured only serum CRP concentrations, did not include other inflammation markers, and took measurements just twice in a 6-month period. CRP levels, especially in the hemodialysis population, may fluctuate; thus, obtaining single CRP measurements may be misleading.⁴

Third, the catheter group involved desperate patients in whom fistula attempt had failed. Thus, there was no option other than catheter use, of course after trying the fistula at a more proximal site and vascular grafts. The advantages of the ‘fistula first’ slogan have long been established for naive patients. Hence, a call for fistula first for patients with failed fistulas seems inappropriate.

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