Response to ‘Ultrasound surveillance and graft patency’


To the Editor: We read with great interest the recent paper by Suissa et al.1 The authors found that the use of angiotensin-converting enzyme inhibitors (ACEI) by patients with diabetes was not associated with long-term decreased risk of renal failure. Their findings suggested instead a higher risk of renal failure in those who took ACEI, even after having adjusted for other risk factors.

In our previous publication,2 where we reported that ACEI/angiotensin II receptor antagonist (ATRA) therapy decreases proteinuria by improving glomerular permselectivity in IgA nephritis, we found ATRA to be superior. Our data showed that majority of the non-responders were on ACEI compared to the responders who were on ATRA ($\chi^2 = 6.3, P < 0.02$; Table 1a), suggesting that ATRA is more effective in decreasing proteinuria. In this respect, we are not surprised by the data of Suissa et al.,1 who showed that ACEI

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ACE inhibitor use and the long-term risk of renal failure in diabetes


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There are several differences in the study design that could theoretically explain contradictory results.

Robbin et al.1 included subjects later after surgery – the mean graft age was 9 months at inclusion, while we performed inclusion and first ultrasound examination within 4 weeks after access creation. We could hypothesize that high-risk grafts, which thrombose within first year after access creation, were therefore not included into Robbin’s study. Such patients probably profit from ultrasound surveillance most.

Another difference is that although Robbin et al.1 performed a single-center study, our patients were hemodialyzed in 25 centers. Although all dialysis centers in our study made every effort to follow K/Dialysis Outcome Quality Initiative guidelines, their experience could vary. Access flow was monitored in less than 50% of patients in our study. These factors could increase the profit of ultrasound surveillance in our study. We think that multi-center study reflects better routine care, which is probably less perfect than in highly specialized hemodialysis units of university hospitals. On the contrary, in the light of Dossabhoy’s study, higher use of access flow monitoring would probably not change dramatically our results.


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