Conclusion

In conclusion it would be regrettable if readers would conclude from reports such as Salem’s [6] that lowering elevated blood pressure is unnecessary and harmful. Fortunately, the authors do not draw that conclusion. But decisions like that of the HCFA are a sign on the wall. Let all of us beware, the secret of real improvement is: more care [10].

References

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Haemodialysis for French diabetic patients

Eli A. Friedman

Department of Medicine, State University of New York, Brooklyn, New York, USA

For 20 years, disparity between dialysis survival in Europe and the US has been a vexing concern. Especially difficult to understand is the nearly miraculous longevity reported in Tassin, France by Laurent, Calemard and Charra [1]. In a stirring 1983 retrospective analysis of 373 haemodialysis patients, survival was 75% at 10 years and 65% at 15 years [1]. Setting aside a potentially key criticism, the authors classified their patients as ‘an unselected population.’ However, only 15 (4%) of the Tassin subjects had diabetes while another 15 (4%) had systemic disease. What happened to uraemic diabetic people in Tassin who were not accepted for dialytic therapy? They died, uncounted in any survival statistics.

Previously, I rebutted the assertion that the Tassin dialysis subset was representative of the renal-failure population at large on the grounds that the low prevalence of co-morbidity, especially diabetes, must be the result of strict selection. It follows, I deduced, that the purportedly distinctly superior survival was a misperception: the product of comparing nonequivalent cohorts in France and the US [2].

Apologists for the American style of uraemia therapy take as a ‘given’ that the country that invented maintenance haemodialysis, continuous ambulatory peritoneal dialysis and kidney transplantation is incapable of delivering treatment at a standard uniformly practiced in less-rich nations. The reality that European treatment rates are half that in the US, meaning that sicker and older patients, those most likely to die, are grossly excluded, was ignored. Instead, the ‘American Tragedy’ was explained by defective dialysis, due to dialyser reuse or inordinately short dialysis treatment times. Worry over application of American ‘short dialysis’ spread to Europe [3]. Troubled by substandard quality in dialysis care, the National Kidney Foundation, supported by an ‘unrestricted educational grant’ from AMGEN Inc., Thousand Oak, CA, USA, conducted a broad extensive review termed the Dialysis Outcomes Quality Initiative (DOQI) [4]. Virtually every aspect of the dialysis process from the establishment of a vascular access to management of anaemia and metabolic bone disease is spelled out in DOQI advisories. Not covered, however, is the patient referral process that may exclude elderly, diabetic and minority group members.

Elsewhere in this issue, Chantrel et al. 1 lament the high mortality in type II diabetic haemodialysis patients treated in Strasbourg. Chantrel et al. report that 27 of 84 (32%) of type II diabetic patients begun on dialysis died in a mean follow-up of 211 days. Strict comparison of this outcome with the 1-year survival of 78% for diabetic dialysis patients in the US is flawed.
by exclusion of the first 90 days by the US Renal Data System [5]. Nevertheless, it is evident that Chantrel et al. had to cope with extensive undertreatment of hypertension as well as absent planning for the provision of a vascular access and elective initiation of uremia therapy. Had this cohort of diabetic patients been intermixed with the Tassin selectees, the slope of survival curves would have been bent downward. In other words, the best method for ensuring superior survival is to treat patients less likely to die.

Other components in the Chantrel et al. report reflect universal problems in dealing with diabetic azotaemic patients: (i) Distinguishing acute from chronic kidney failure may be difficult. (ii) Pulmonary oedema induced by hypoproteinaemia is readily confused with congestive heart failure. (iii) The misconception that keto-acidosis is restricted to type I diabetes when it is actually more prevalent in type II diabetes [6,7]. (iv) Ophthalmoscopy is inadequate screening for the detection of diabetic retinopathy missing 25% of cases detected by retinal photography [8].

There is another important message communicated by Chantrel et al., that bias against accepting diabetic patients for uremia therapy continues in France today. How else can the authors’ statement that although diabetes accounts for 40% of their patients entering dialysis, other dialysis facilities in France admit only 15.7% with diabetes [9]. Either renal failure induced by diabetes has an extraordinary epidemiology in France, varying widely from city to city, or criteria for acceptance for dialysis are applied unequally. From introspective studies in other countries, particularly the UK [10,11], it is clear that the treatment acceptance rate for diabetic renal-failure patients is a correlate of governmental policies and economic pressures [12].

Returning to the issue raised at the outset, admiration is justified for the wonderful life extension effected by the Tassin team. High-quality haemodialysis does facilitate rehabilitation minimizing the need for erythropoietin and antihypertensive drugs. Emulating carefully performed dialytic therapy is a desirable objective for all clinical nephrologists striving for excellence in patient care. Improving the outcome of dialysis in diabetic patients is a complex and elusive goal worthy of all of us. Chantrel et al. are to be congratulated for their candor in recounting the complexity, stress and disappointment that is usual when trying to deliver uremia therapy to diabetic patients afflicted with life-threatening extrarenal co-morbidity.

References

Myco phenolate-update after it has come of age

Josep M. Grinyó
Servei de Nefrologia, Hospital de Bellvitge, Ciutat Sanitària i Universitària de Bellvitge, Universitat de Barcelona, Spain

Myco phenolate mofetil (MMF) is the morpholino-ethylester of myco phenolic acid that is a potent, non-competitive and reversible inhibitor of inosine monophosphate dehydrogenase, that depletes the cell of guanosin nucleotides. Myco phenolic acid selectively inhibits the proliferation of T and B lymphocytes, the production of antibodies, and the generation of cyto toxic T lymphocytes. Furthermore, depletion of guanosine nucleotides results in the inhibition of glycosilation of adhesion molecules, which might interfere

Correspondence and offprint requests to: Josep M. Grinyó, Servei de Nefrologia, Hospital de Bellvitge, E-08907 L’Hospitalet, Barcelona, Spain.