Reply: acute kidney injury after orthotopic liver transplantation

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Editor—We thank Dr Xue and colleagues for their letter concerning our paper.1 As the goal of our study was to examine the renal outcomes for patients after liver transplant, we excluded patients receiving dialysis (either for chronic renal failure or AKI) before transplant. This group invariably includes some patients who have lost all renal function before liver transplant (LT) and therefore are not ‘at risk’ for AKI. In patients with preoperative AKI/CKD but not on renal replacement therapy (34 patients), the incidence of AKI was not different from patients with normal renal function and/or with mild preoperative AKI. This result is consistent with our finding that the serum creatinine (SCr) and MELD score did not impact the incidence of post-LT AKI. For the forward stepwise logistic regression model, the variables that were used showed significant differences in univariable analysis (entering and removing probabilities are 0.05 and 0.10 respectively), and as pre-transplant renal function (as measured by pre-transplant SCr and MELD score) did not reach that level of statistical significant, we did not include in the logistic regression model. As the definition of post-LT AKI and when AKI is studied during the post-LT period are different from one study to another, it is not surprising that the results may vary from one study to the next. The development of PRS did not impact the incidence of post-LT AKI in our cohort. There is always the possibility that differences in management and/or definitions of PRS or differences in patient populations may affect these relationships.

Declaration of interest
None declared.

Reference

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The size of the problem

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Editor—I was interested to read the study of difficult intubation in obese patients in theatre compared with the intensive care unit (ICU).1 The NAP 4 study2 demonstrated an increased risk of airway complications in the ICU compared to theatres, and in obese patients. However, while obesity provides clinical challenges, including potential difficult airways, the authors of this study state that the association of BMI with difficult intubation per se remains controversial.

I was wondering, therefore, if they had calculated the incidence of difficult intubations in the non-obese population during the study period. Only with this baseline information can the increased rate of difficult intubations be related to being obese in the ICU as opposed to simply being in the ICU. In essence, how much of the risk from intubation in the ICU relative to intubation in theatres was actually related to obesity.

Overall, this study provides more compelling evidence that airway intervention in the ICU has its own inherent dangers that need to be addressed in order to improve patient safety. Is the risk related to the personnel, the equipment, or the training, and how much is related to anatomical or physiological changes in the critically ill patient? There are clear differences in airway management techniques between departments and hospitals and we need evidence to see which ones are safest as a whole and in higher-risk populations.

Declaration of interest
None declared.

References

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