HDD cannot be advocated for all patients

Sir,
Saner and colleagues have made a good case for home haemodialysis (HHD) as an effective renal replacement therapy in Switzerland [1]. Yet, in the last paragraph of their case-cohort study of 58 patients, they admit that patient selection may have influenced their results. We agree. Our analysis of a much larger cohort, that of the United States Renal Data System, used the standardized mortality ratio (SMR) to compare HHD patients with in-centre haemodialysis patients. The SMR takes age, race, gender and diabetes into account. Contrary to older reports, we found that HHD had a higher SMR compared with in-centre dialysis (see Table 1) [2].

In addition, the cost of HHD was not cheap, while somewhat less than in-centre dialysis, which was $54,917 per year over the same time of study.

Our data run counter to accepted wisdom about HHD. Increasing patient co-morbidity, decreasing family support and waning of doctor and nurse expertise may explain the inferior HHD outcomes in the USA. It is also likely that in-centre dialysis has improved its dialysis delivery to a greater extent than has HHD in recent years.

HHD cannot be advocated for all patients. Even the still-infrequent newer daily HHD therapies will require scrutiny and proper outcome analysis.

Table 1.

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of HHD</th>
<th>% of all dialysis</th>
<th>Cost/year (US$) for HHD</th>
<th>SMR</th>
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<tbody>
<tr>
<td>1998</td>
<td>1676</td>
<td>0.7</td>
<td>44,160</td>
<td>1.19</td>
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<tr>
<td>1999</td>
<td>1327</td>
<td>0.5</td>
<td>43,304</td>
<td>1.09</td>
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<tr>
<td>2000</td>
<td>1444</td>
<td>0.5</td>
<td>42,326</td>
<td>1.38</td>
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<tr>
<td>2001</td>
<td>1338</td>
<td>0.5</td>
<td>47,554</td>
<td>1.37</td>
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</tbody>
</table>

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