Change in definition could change results

Sir,
Tisler et al. [1] published their findings about patients’ survival suffering from intradialytic hypotension (IDH). To our knowledge this is the first study to have defined IDH with these criteria. Although up to now there has not been a consensus on IDH definition, some past issues use different definitions. Begin et al. [2] selected their patients when they represented IDH in 30% of haemodialysis sessions. Hoeben et al. [3] defined IDH as at least three episodes of a decrease in systolic blood pressure (by at least 20 mm Hg to <100 mm Hg) accompanied by symptoms (dizziness, blurred vision, nausea, vomiting, cramps, or fatigue) in 50% of HD treatments over 1 month. Like another article published by these authors [4], Barnas et al. [5] defined IDH as a dialysis-induced fall in mean arterial pressure to <65 mmHg in >25% of the dialysis sessions in the previous 2 months. However, Tisler et al. characterized their frequent IDH patients with the occurrence of 10 or more hypotension episodes during the run-in time.

This could have an effect on the number of patients who have divided in three groups and increase number of patients in frequent IDH group. So some patients have been noted as frequent IDH who are not really suffering from this problem as previously defined. We think regarding this issue that if authors modify their definition, the number of patients who are categorized as frequent IDH would decrease and it would affect the final results.

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Reply

Sir,
Atabak is right to note the inconsistency in the literature regarding definitions of IDH, and the criteria for frequent IDH, in particular. In our study, patients with frequent IDH where those with more than 12 IDH episodes over the 10-month run-in period (with a medium number of 12 episodes), which is clearly less than in those studies cited by Atabak. Our criteria for frequent IDH, albeit arbitrary, were decided prior to the follow-up phase; therefore, change in the definition would have rendered our study a post hoc analysis.

We agree with Atabak that using a more stringent definition would have decreased the number of patients in the group with frequent IDH, however our main conclusion—i.e. frequent IDH is associated with an increased risk of dying, for whatever reason—would not have been altered. Using the definition of more than 12 hypotensive episodes over 10 months (i.e. one in 10 haemodialysis sessions) 38 patients would have been regarded as frequent IDH, and the relative hazard of death would have been 1.6 (0.94–2.73) compared with those with no IDH episodes. Using the definition of more than 20 IDH episodes over 10 months (i.e. one in 10 haemodialysis sessions) 38 patients would have been included in the group of frequent IDH, and the relative hazard of death would have been 2.35 (1.23–4.47) compared with those with no IDH episodes. These, however, are the post hoc analyses.

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