Letters and Replies

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A systematic approach to managing pregnant dialysis patients—the importance of an intensified haemodiafiltration protocol

Sir,
We read with interest the paper by Haase et al. [1] reporting five successful consecutive pregnancies in patients on maintenance dialysis, as it closely parallels our experience.

We have indeed reported [2] seven consecutive pregnancies occurring between 1995 and 2001 in patients on dialysis for >1 year. The frequency and length of sessions, and haemoglobin targets, were systematically increased. One patient chose to terminate her pregnancy. The mean gestational age for the six other pregnancies was 31 weeks (24–34 weeks) with an average birth weight of 1495 g. One neonate born at 24 weeks died 2 days following delivery. Paediatric evaluation of the five other children showed a good outcome after up to 5.5 years.

We must, however, disagree with the statement that haemodiafiltration is the preferred treatment in pregnancy, as all our patients were on haemodialysis. Further studies are certainly necessary to identify the importance of factors such as dialysis technique and biological targets, but lack of availability of haemodiafiltration should not be a deterrent to taking charge of these pregnancies. In our opinion, as in that of Haase et al., it is indeed the quality of the collaboration between obstetricians, paediatricians and nephrologists that determines the outcome of pregnancy in patients on maintenance dialysis.

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Glomerular filtration rate prediction using lean mass is unsuccessful in diabetic subjects

Sir,
Taylor et al. [1] recently reported that glomerular filtration rate (GFR) could be accurately predicted from lean body mass (LM) assessed by DEXA and serum creatinine, using a simple formula. The first cause of renal insufficiency is diabetes, and we have reported that the usual predictive formulas, such as the MDRD equation and the Cockcroft–Gault formula, give an imperfect prediction of GFR in diabetic patients [2], so we tested to see whether Taylor’s equation gave better results.

In 54 diabetic subjects (age: 65±11 years, BMI: 26.5±4.5, 68.5% males, 24.1% with type 1 diabetes) with a wide range of renal function (serum creatinine: 1.05–4.20 mg/dl), we measured GFR (51Cr-EDTA clearance) and LM (by DEXA), and we compared GFR results to their predictions, by correlation studies and paired t-tests.

In nine subjects with serum creatinine (Scr) higher than 3.2 mg/dl, the proposed formula led to a negative result (−11±33 ml/min). This was expected because the formula is:

\[
\text{predicted GFR} = (2.4 \times \text{LM}) - (0.75 \times \text{LM} \times \text{Scr})
\]

The second part of the formula increases with Scr and the predicted GFR becomes null when Scr reaches 3.2 mg/dl.

For the 45 remaining subjects (mean GFR: 39±18 ml/min/1.73 m²), the predicted GFR, indexed on body surface area, are given in Table 1.

It seems logical to develop predictive formulas, better than for the Cockcroft formula that take account of the creatinine producing tissue mass and the correlation coefficient with

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