Quality of life assessment in a recent haemoglobin trial in CKD (CHOIR)

Sir,

We read with interest the editorial comment by Levin [1] on methods and lessons learned from recent haemoglobin trials in chronic kidney disease (CKD). Levin identifies a number of issues on the design, reporting and conclusions of one of these trials, the Correction of Haemoglobin and Outcomes in Renal Insufficiency (CHOIR) study, published in the New England Journal of Medicine [2]. Improvement in quality of life (QOL) is an anticipated benefit of correcting anaemia, but in the CHOIR study there were no differences in QOL in the high Hgb group, in contrast to any other study to date [1]. Levin notes that it is not clear when QOL was measured in the CHOIR study [1], and we noted additional issues.

One measure used in the CHOIR study to assess QOL was a disease-specific instrument, the Kidney Disease Questionaire (KDQ). Unfortunately, the correct reference for the KDQ, developed by Laupacis et al. [3], was not provided. The purpose of the KDQ is to assess five distinct QOL domains found to be salient for CKD patients: physical symptoms, fatigue, depression, relationships with others and frustration. Instead of reporting results for each of the five KDQ domains, however, a ‘KDQ total score’ was reported for CHOIR participants (Table 2) [2]. In the absence of a well-validated composite score, summing across discrete domains of a QOL measure is meaningless. Moreover, important information on QOL differences among patients participating in the CHOIR study may have been obscured. Change may occur in some domains but not in others, as Foley et al. [4] showed when they used the KDQ in their study of the normalization of Hgb in haemodialysis patients. Continued study of Hgb targets, epoetin alfa use and associated clinical outcomes among CKD patients is important [1], and QOL perceptions, appropriately measured and analysed, can furnish valuable information.

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Neisseria-cinerea-induced pulmonary cavitation in a renal transplant patient

Sir,

Neisseria cinerea is a commensal microbe that colonizes the nasal and oropharynx cavities [1], generally considered to be a non-pathogenic organism. Nevertheless, it has been described as an aetiological agent responsible for various diseases. Herein, we report the first case of N. cinerea related pulmonary cavitation to occur in a male renal transplant patient. A routine chest radiography, performed 16 months after transplantation in a 58-year-old renal transplant patient, revealed the presence of de novo cavitation located in the upper lobe of the right lung. A computed tomography (CT) scan showed a single mass in the right upper lobe with a large cavitation and a thick margin (Figure 1A), without lymphadenopathy. At that time, the patient had been complaining of an intermittent non-productive cough and fatigue for a few days, and a low-degree fever (38°C). C-reactive protein was 80 mg/l (N < 15 mg/l), and serum creatinine was unchanged (225 μmol/l). His immunosuppressive therapy was based on the combination of sirolimus (trough level 9 ng/ml) and steroids (5 mg/day). Blood and urine cultures, as well as fluid obtained from gastric aspirations, induced-sputum and bronchoalveolar lavage (BAL) were negative for bacteria, mycobacteria including anti-fast bacilli and fungi (culture and polymerase chain reaction). No anaerobic agent grew on specific culture media. Aspergillus antigenaemia was negative. A transthoracic CT-guided biopsy of the peripheral component of the cavity and an aspiration of fluid were performed (Figure 1B). The fluid aspirated from the cavity was inflammatory. Pathological analysis of the biopsy showed a fibrino-inflammatory pulmonary tissue without any granuloma or malignant cells. The culture of the biopsy grew a Gram-negative, oxidase-positive diplococcus, which was further identified as N. cinerea (ApiSystem, BioMérieux, France). The patient was treated with amoxicillin at 2 g three times per day for 3 weeks. The fever disappeared, and C-reactive protein returned to normal range 9 days later. Another CT scan, performed 15 days after starting amoxycillin therapy, showed that the margins were thinner and the cavitation represented the majority of the lesion (Figure 1C, D). Finally, an antero-posterior chest radiography and a CT scan, performed 3 months after completion of amoxycillin therapy, showed a residual cystic lesion with a thin margin (Figure 1E, F). Close monitoring of Aspergillus antigenaemia at 2-monthly intervals was initiated. After 1 year of follow-up, the patient had not presented with a relapse or any symptomatic pulmonary manifestations, though the cavitation was still evident on the CT scan.

The main infectious causes of lung cavitation in transplant recipients are aspergillosis, tuberculosis and nocardiosis [2]. In transplant patients in whom a cavitory lung lesion is demonstrated, if a complete investigation procedure including BAL does not yield a pathogen, one should consider