think it is rather unlikely that so few patients in their study were truly thionamide naïve.

Conflict of interest statement. None declared.

Consultant Renal Physician, Renal Unit, Lancashire Teaching Hospitals NHS Foundation Trust, Harish B. Shetty
Royal Preston Hospital, Shareo Green Lane, Preston PR2 9HT, UK

E-mail: Alex.Woywodt@lthtr.nhs.uk


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Dialysis or not? A comparative survival study of patients over 75 years of age with chronic kidney disease stage 5

Sir,
In their article [1], Murtagh et al. carry out a retrospective, intention-to-treat analysis, comparing survival among those who elect to receive dialysis versus conservative management. Their results support the contention that patients who elect dialysis have a better survival than those who elect conservative treatment but that ‘...the survival advantage is substantially reduced by comorbidity and ischaemic heart disease in particular’. We emphasize the word elect here because, unfortunately, it is not clear from the authors’ Abstract, nor from the Tables and Figure, that the results DO NOT refer to patients who actually receive dialysis but rather to patients who elect to receive dialysis. The authors are careful to point this out within the article itself but the more ‘casual’ reader should be warned that the survival curves and hazard ratios shown in the article do not reflect the actual treatment received during the course of follow-up. Indeed, an analysis reflecting the actual treatment received would require using a more sophisticated Cox- proportional hazards model with time-dependent treatment groups. Such an as-treated analysis may or may not alter the conclusions reached from the authors’ intent-to-treat analysis. For example, the total number of deaths attributed to the dialysis
group is mentioned as 12. However, as noted by the authors, 8 of 12 died prior to starting dialysis. Another 16 in the dialysis group never started dialysis prior to the study completion date. How were these 24 patients managed? We presume that they were given the same treatment that was offered to patients in the conservative arm before starting dialysis. In an as-treated type of analysis, the total number of patients who actually received dialysis would be 52 – 24 = 28, out of which 4 would have died following the initiation of dialysis. Likewise, at initiation, the conservative treatment arm would have started off with a total of 77 + 24 = 101 patients, of which 59 (= 51 + 8) would have died while on conservative treatment. Thus, an as-treated analysis may or may not yield results and/or conclusions different from those reached by the authors. It is not that we object to the intent-to-treat approach taken by the authors, it is just that results could vary according to the type of analysis one performs and we wish to make readers aware of such a possibility.

Conflict of interest statement. None declared.

1Division of Nephrology, Department of Internal Medicine, University of Missouri Columbia, MO, USA
2Department of Nephrology, Toronto Western Hospital, Toronto, Canada
3Vonesh Statistical Consulting, LLC
1928 Forest Creek Lane
Libertyville, IL 60048

E-mail: misram@health.missouri.edu

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Reply

Sir,

We agree that the result may vary according to the type of analysis that is performed. However, we chose the intention-to-treat type of analysis to best inform nephrologists and patients at the time when decisions on future treatment are being made. We feel that there is very little data available to help this process. Changing to an as-treated analysis would be less useful for this purpose. Performing the as-treated analysis would focus on the effect of dialytic treatment, which was not the primary purpose of the study. Using an as-treated analysis, where the start point of the study is at eGFR of 15 mL/min, could be flawed, as those patients needing dialysis would generally have survived longer.

Patients who choose dialysis do have a better survival. We are not claiming that this is necessarily due to dialysis treatment. Indeed, as Misra et al. point out, patients who chose dialysis may not have started treatment, either because of death or not requiring dialysis in the study period. We therefore speculate that many factors affect the decision to choose dialysis, including patient’s wishes and advice from physicians. These factors are not readily identified from the medical records. However, the result is that the two groups of patients identified at the time of the dialysis decision have different survival, some of this difference possibly being attributable to dialysis.

Conflict of interest statement. None declared.

1Department of Palliative Care and Policy, King’s College Hospital, London
2Department of Renal Medicine, Epsom and St Helier University Hospitals, Surrey
3Department of Renal Medicine, King’s College Hospital London
4Division of Renal Medicine, St George’s Hospital, London
5School of Clinical Medical Sciences, Newcastle University, Newcastle upon Tyne, UK

E-mail: Neil.Sheerin@newcastle.ac.uk
doi: 10.1093/ndt/gfm882

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Occurrence of peritonitis in APD versus CAPD: methodologic problems

Sir,

We read with interest the article by Rabindranath et al. ‘Automated vs continuous ambulatory peritoneal dialysis: a systematic review of randomized controlled trials’ [1], especially with reference to the occurrence of peritonitis on continuous ambulatory peritoneal dialysis (CAPD) versus automated peritoneal dialysis (APD). The authors report both the relative risk and the rate ratio for peritonitis based on three randomized controlled trials involving a total of 139 patients.

While the review found a significant reduction in peritonitis rates with APD relative to CAPD, no reduction in the relative risk was found. The authors relate this apparent discrepancy to the fact that some patients may have had more than one episode of peritonitis. It is important to note that comparing peritonitis rates is far more appropriate than determining relative risk, because a peritonitis rate in any given individual incorporates information on the number of episodes of peritonitis as well as the duration of follow-up on peritoneal dialysis (PD). In contrast, a relative risk simply determines if one group is at a higher risk of developing peritonitis than another group, irrespective of the number of episodes per patient or the follow-up time. For example, if one patient has three peritonitis episodes within...