CONCLUSIONS:

We observed a weaker association of serum IS level with CV events in patients.

We maintain low levels of IS and other uraemic toxins may induce better survival in HD patients.

RESULTS:

The median serum IS level at baseline was 31.6 ug/mL (interquartile range, 22.6, 42.0). Serum IS level was positively associated with dialysis vintage, nPCR, and spKt/V. We assessed possible effect modification (interaction) of the association with all-cause mortality, with increased toxicity suggested in patients with RKF (HR, 1.44; 95% CI, 1.20-1.73; interaction p<0.01).

We included 1,170 HD patients from the J-DOPPS phase 5 (2012-2015) in the Japan Dialysis Outcomes and Practice Patterns Study (J-DOPPS).

Few studies have examined the relationship in a large cohort of HD patients. In this collection and continued until the clinical outcome occurred, the study phase ended, or infection with active replication that results in the chronic inflammatory state.

We evaluated the associations of serum IS levels with all-cause mortality and cardiovascular (CV) death or hospitalization using Cox regressions with adjustments for potential kidney disease (CKD)-related comorbidities. Indoxyl sulfate (IS), a representative protein-derived uraemic toxin, is suggested to be a new potential cardiovascular risk factor in the current chronic inflammatory state.

IS with clinical outcomes in CKD and dialysis patients have been reported; however, few studies have examined the relationship in a large cohort of HD patients. In this study, we showed that treating patients has improved their inflammatory state i.e. reversal of these markers after treatment course including isoniazid 5 mg/kg/day with maximum daily dose 300 mg/day for 3 months. The beneficial effect of giving anti-tuberculous drugs to occult tuberculous patients diagnosed as latent tuberculosis was offered the chance to receive three months of the medical school of Alazhar university. Participants were evaluated, and active TB was considered to have occult tuberculosis.

Control that routine screening and treatment of latent TB infection should be done for ease, if infected, maybe 1-2%. The recommendations by the U.S. Centers for Disease Control and Prevention (CDC) and National Tuberculosis Controllers (NTC) are not widely accepted.

This is a prospective study performed at Kafr Elshiekh Insurance Hospital, Kafr Elshiekh, Egypt. Enter various physicians. Then patients will be tested with tuberculin. TST was carried out by the intradermal (Mantoux) method. Then Quantiferon-TB Gold in-tube bacteriological studies. Entering the study, all patients had a chest X-ray, evaluated by two independent physicians. Then patients will be tested with tuberculin. TST was carried out by the intradermal (Mantoux) method. Then Quantiferon-TB Gold in-tube.

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number of patients are still starting hemodialysis in emergency setting, even in developed countries, because of late referral to nephrologists and improper vascular access caused by this delay in referral. The aim of the present study was to identify the impact of late patients’ referral on the modality of hemodialysis (HD) initiation (as an emergency versus elective procedure) and upon survival.

METHODS: We performed a prospective study between August 2013-October 2015. We analyzed residual diuresis, type of HD initiation, biological parameters, CKD complications (heart failure, digestive intolerance, acid-base, electrolytes, neurological and pulmonary complications), short (at 1 month) and long-term (at 3 months) survival. Independent risk factors for emergency HD and death were identified by logistic regression, with backward elimination to select an appropriate model (a p-value >0.10 was used for removal) using IBM SPSS ver. 20.0.

RESULTS: We included 260 patients (137F, 123M), mean age 59.9±13.5 years (18-88). 125 (48.1%) patients started emergency HD, 135 started elective HD. Vascular access was a temporary central venous catheter (CVC) for 96% of emergency HD cases, while elective HD was initiated on long-life CVC in 56.3%, arterio-venous fistula in 37%, and temporary CVC in 6.7% of patients. Late referral (less than 3 months before HD initiation) was associated with a 3.7 risk of emergency HD (95%CI 1.7-7.7, p<0.001). Emergency HD was associated with lower eGFR (7.5±2.2 vs 9.4±4.5 ml/min/1.73m², p=0.001) and longer hospitalization (16.8±2.1 vs 13.3±1.7 days, p=0.02). The most frequent uremic complication was digestive intolerance (44.7% of patients) and this was a risk factor for malnutrition (OR 2.2, 95%CI 1.3-3.7, p=0.001). Heart failure (HF) was associated with a 2.2 risk of emergency HD (95% CI 1.3-4.1, p=0.002) and independent risk factors for HF were malnutrition and serum creatinine >5 mg/dl. Patients with more than 2 uremic complications had a 3.9 higher risk of emergency HD (95% CI 2.0-7.6, p=0.001). Independent risk factors for emergency HD were late referral (adjusted OR 4.6, p<0.001), electrolytes disorders (hyperkalemia/hyponatremia- adjusted OR 1.8, p=0.03), serum creatinine >5 mg/dl (adjusted OR 3.4, p=0.001), and the number of uremic complications. All deaths at 1 month were observed in patients with emergency HD initiation. Emergency HD was an independent risk factor for death in less than 1 month after HD initiation, together with hypoalbuminemia, hyponatremia and pericarditis. After adjustment for confounders, the only independent risk factor for death at 3 months after HD initiation was emergency HD (OR 3.4, 95%CI 1.2-5.3, p=0.01).

CONCLUSIONS: Late referral for ESRD patients is associated with increased incidence of uremic complications and a higher risk of emergency HD using a temporary CVC as vascular access, with prolonged hospitalization and reduced short-term survival. A proper management of these patients in pre-dialysis by nephrologists is the key for choosing the best timing of elective HD in order to improve survival and quality of life.