challenge of screening very large safety databases. It also illustrates the potential for simple forms of disproportionality analysis (PRR) to identify potentially meaningful DECs that fail to be identified by certain Bayesian methods such as MGPS, when commonly cited thresholds are used [5,6]. The cost of such enhanced sensitivity could be an overabundance of ‘signals’ including ‘false-positive’ signals not reflective of causality that would be likely to require additional triage criteria for practical implementation. The Bayesian methods were developed in the hope of improving the signal to noise ratio by down weighing signals associated with DECs for which there are small numbers of reports with corresponding statistical instability. However, they may also ‘filter out’ real ‘signals’ either absolutely or relatively in terms of timing, when compared with simple disproportionality analysis. However, since these methods currently are unvalidated and the choice of thresholds somewhat arbitrary and adjustable, performance differentials between DMAs using commonly cited thresholds are of uncertain clinical significance.

We and other drug safety specialists are continuing to study the proper positioning of these newer pharmacovigilance techniques within the universe of methods that have been used historically for routine signal detection. Our preliminary conclusion is that DMAs are promising tools but should only be considered as potential supplements to, not substitutes for, standard signalling strategies. Finally, we would like to re-emphasize the crucial role of clinicians as the first line of post-marketing safety surveillance by their publishing and/or reporting of unanticipated, possibly drug-related events to the manufacturer. We applaud the efforts of Dr Wierre and colleagues.

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DC cardioversion during continuous veno-venous haemofiltration

Sir,

Recently, we delayed starting continuous veno-venous haemofiltration (CVVH) treatment because we were reluctant to perform direct current (DC) cardioversion during CVVH. In the end, it proved to be no problem.

Case. A 15-year-old, previously healthy, girl was admitted with acute fulminant liver failure of unknown origin. She received an orthotopic liver transplantation without any subsequent problems. One day post-operatively, she was hypotensive in spite of noradrenaline, and became anuric with normal blood electrolytes, but rising BUN and creatinine. Furthermore, she developed an atrial flutter with a heart rate of 180 b.p.m. for which medical treatment was started.

It was decided to start renal replacement therapy. Because of her circulatory problems, we opted for CVVH treatment. However, as there was nearly no reaction to the d-sotalol given for the atrial flutter, there was a possible need for DC cardioversion.

We were all reluctant to try cardioversion during CVVH because it was not clear whether the system was adequately protected against electric cardioversion. In the literature, we could not find any publications in which it was stated if this would give any problems. Therefore, we delayed the start of the CVVH treatment.

After several hours, when the heart rhythm seemed to normalize, we started CVVH. Unfortunately, after another few hours, she deteriorated again and DC cardioversion was needed. We phoned Hospal®, the makers of the CVVH machine. They said there should be no problem although, according to them, it had never been tried before. It was stated in the machine description that there would be no interaction. Indeed there was no problem at all. Our patient was cardioverted (20 J, 50 J, 50 J) without any change in blood flow or on the CVVH machine, and 3 h later had to be cardioverted again (50 J, 70 J).

After each cardioversion, the atrial flutter reinitiated after a short period. Finally, normal sinus rhythm was obtained with amiodarone. The patient recovered completely.

Comment. DC cardioversion during CVVH treatment led to no interference in our setting. After all, we delayed the CVVH treatment unnecessarily.

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