Conflict of interest statement. None declared.

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Reply

Sir,

MacGregor et al. give an interesting example of the utility of Geographical Information Systems (GIS) in the planning of dialysis facility provisions. In effect, GIS permits decision-making for health programmes at local, state and governance assessment levels [United States National Public Health Performance Standards Program http://www.phppo.cdc.gov/nphpsp/EssentialPublicHealthServices.asp]. For local assessment, GIS demonstrates accessibility and quality of services delivered and the effectiveness of personal and population-based programmes provided. This level provides information necessary for allocating resources and reshaping programmes. For state assessment, GIS may contribute to the evaluation of patients’ health status and service utilization data, helping to assess programme effectiveness and to provide information necessary for allocating resources and reshaping dialysis and renal transplantation programmes to improve efficiency, effectiveness and quality. GIS permits the elaboration of scenarios supporting more effective planning for dialysis as well as for transplantation services.

For governance assessment, GIS may contribute to the assurance of ongoing evaluation and critical review of dialysis or transplantation programmes based on analysis of health status and service utilization data.

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Short-term rosiglitazone treatment in renal transplant recipients

Sir,

We read with great interest the article by Voytovich et al. [1], demonstrating the beneficial effect of a new insulin sensitizer, rosiglitazone, in renal transplant recipients. They concluded that short-term treatment with rosiglitazone improves glucose tolerance, insulin sensitivity and endothelial function in this group of patients.

The treatment modalities for diabetes mellitus and glucose intolerance include lifestyle modification, diet, exercise and pharmacologic intervention [2]. In this study, the authors did not give any information on dietary intervention, which is the mean predictor of the blood glucose level in diabetic and glucose-intolerant patients. Although this was not a crossover study, as the authors reported in the limitations section of the study, it might have been better to give a 4 week study period with a standard diet for all patients, in order to exclude the effect of nutritional factors. Also, seven patients were determined as post-transplant diabetes mellitus (PTDM) according to oral glucose tolerance test (two of them were previously known PTDM), but the authors did not give any information on the patients’ glycohaemoglobin or fructosamine levels, which could be more valuable parameters (not influenced by acute changes in blood glucose) before and after the rosiglitazone, even in a 4 week period. Fructosamine seems to be a more suitable measure in this study design, because it is a more sensitive marker for abnormal glucose tolerance and it reflects 3–4 weeks’ blood glucose control [3].

The main immunosuppressive agents responsible for PTDM are calcineurin inhibitors and steroids. Current evidence shows greater diabetogenicity of tacrolimus in multicentre studies [4]. Therefore, it would be interesting to see if there is any correlation in insulin resistance and the response to the rosiglitazone between the patients on cyclosporin or tacrolimus.
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Reply

Sir,
We thank Ergün and Keven for their response and constructive remarks. We agree that diet and lifestyle intervention should generally be recommended for patients with new-onset diabetes mellitus after transplantation. However, in this study, the patients were treated within a few weeks to 6 months after transplantation at a time when an alternative to OGTT to detect diabetes mellitus or gestational diabetes. Ann Clin Biochem 1987; 24: 447–452


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Revised European Best Practice Guidelines
for the management of anaemia in patients with chronic renal failure, part III.2: treatment of anaemia with iron

Sir,
Evidence-based Guidelines provide a valuable framework for developing and implementing treatment strategies for patients. As such they should be based on a comprehensive search and appraisal of prevailing evidence. We write to express concerns regarding the omission of evidence relative to the above mentioned section.

The Guidelines recommend the use of iron sucrose and iron gluconate over iron dextran. The bibliography indicates that newer studies documenting the differences in regard to safety between high and low M.W. iron dextran were not considered. Neither did the drafting of the Guidelines include recent documentation concerning the acute toxicological profiles of the available parenteral iron formulations or issues associated with long term safety.

In the Guidelines there is an assumption that iron dextran preparations can be considered as a single class of product and as such the recommendations are dismissive of all iron dextran formulations. Closer scrutiny of recent published literature would reveal that low molecular weight iron dextran offers a safety profile that is very different from the older high molecular weight iron dextran complexes [1–6]. Low M.W. iron dextran has a significantly lower risk of both serious and non-serious acute adverse drug events compared to high M.W. iron dextran [1–6].

In the same issue of Nephrology Dialysis Transplantation, in which the Guidelines were published, Chertow et al. evaluates all reported adverse drug events recorded by the FDA during three years (1998–2000), where a total of 21 million doses of 100 mg iron were administered. The study reports a superior safety profile for low molecular weight iron dextran (INFeD®/CosmoFer®) vs the high molecular weight iron dextran (Dexferrum®). The study also reveals that the rates for total ADEs are significantly lower among those patients receiving low molecular weight iron dextran than those receiving iron gluconate.

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