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**Reply**

Sir,
We thank Dr Sanchez-Cano et al. for this letter. However, we believe that the authors have misinterpreted the statement, ‘granulomatous disease seems more likely to be resistant to rituximab (RIT) than vasculitis’ in our article published in this journal [1]. The statement actually compared and referred to Wegener’s granulomatosis (WG) and microscopic polyangiitis (MPA) patients with active glomerulonephritis and alveolar haemorrhage (vasculitis), described by Keogh et al. [2] and Stasi et al. [3], as opposed to the more prominent granulomatous manifestations, in particular the retro-orbital granulomas, described in patients studied by Aries et al. [4] and Omdal et al. [5]. The former group of patients responded better and remained in remission as compared to the latter. Treatment of refractory granulomas of the upper respiratory tract and lungs with RIT has been well described by other authors [2–4,6–8]. We concluded in our article that in WG, patients with retro-orbital granulomas tend to be less responsive to RIT. This suggests that response to RIT may depend on the disease manifestation. The last statement by the authors also compliments our conclusion that RIT seems to be effective treatment in patients with refractory ANCA-associated vasculitis (AAV), both in WG and MPA. However, randomised controlled trials are needed to evaluate the efficacy of RIT in AAV before it can be considered a standard treatment.

Conflict of interest statement. None declared.

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1. Wong CF. Rituximab in refractory antineutrophil cytoplasmic antibody associated vasculitis: what is the current evidence? *Nephrol Dial Transplant* [Epub 7 November].


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**Prediction of glomerular filtration rate decline in diabetic subjects with impaired renal function**

Fontseré et al. [1] recently questioned the value of the Cockcroft–Gault (CG) formula and the MDRD equation for the long-term monitoring of glomerular filtration rate (GFR) in type 2 diabetic patients. As also reported by Rossing et al. [2], they found that these equations underestimate the GFR decline; however, they concluded that the MDRD prediction could be used in their most advanced patients (CKD stages 2 and 3; baseline isotopic GFR: 71.2 ± 13.9 ml/min/1.73 m²). We tested whether the prediction equations can also be used in diabetic patients with more advanced renal impairment.

We have prospectively followed-up for 2 years 50 diabetic subjects (31, type 2) with impaired renal function (K/DOQI stages 3–5). Their GFR was determined by 51Cr-EDTA clearance, and compared to the CG and MDRD-predicted values by paired *t*-tests. The subjects were defined as ‘progressors’ if their GFR decline was higher than the mean of the studied group.

The mean initial GFR was 37.9 ± 21.7 ml/min/1.73 m², similar to the MDRD (38.1 ± 15.9), whereas the CG overestimated GFR (42.4 ± 18.0; *P* < 0.05). Five subjects died during the follow-up. Their GFR (38.6 ± 21.8) did not differ from the others, but was overestimated by the CG (55.6 ± 12.0; *P* < 0.05) and the MDRD (44.1 ± 12.1; NS). Twelve subjects started haemodialysis. Their GFR (17.7 ± 8.9) was lower than the others (*P* < 0.0001), and was overestimated by the CG (26.4 ± 9.5; *P* < 0.0001) and the MDRD (22.3 ± 11.6; *P* < 0.05). Thirty-three subjects had a second GFR measurement 2 years later. Their GFR declined by −7.7 ± 18.0, ml/min/1.73 m² [−14 (±37)%], from 45.1 ± 20.6 to 37.3 ± 21.6 (*P* < 0.05). The assessment of GFR decline by the CG and the MDRD is shown in Table 1.

In accordance with Fontseré [1] and Rossing’s [2] findings, we found that the GFR decline was underestimated by...
the predictive equations. The prediction was, however, correlated to the measured loss of renal function, and the underestimation was moderate: most of the subjects were well-classified as progressors or non-progressors according to their predicted GFR, especially with the MDRD. Despite its limitations, we think that the MDRD prediction is an acceptable alternative when the direct measurement of GFR cannot be performed in renally insufficient diabetic patients [3].

**Conflict of interest statement.** None declared.

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<table>
<thead>
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Retained central venous haemodialysis access catheters

Sirs,

In their recent article, Hassan and colleagues [1] report six cases of retained central venous haemodialysis access catheters and advocate prophylactic catheter exchange in order to try and prevent this rare complication from occurring. In assessing the possible factors which may contribute to catheter adherence, it appears the time the catheter is in-situ was the most important. The duration of time prior to attempted removal of catheters ranged from 3 to 7 years in their series.