We have recently reviewed eight cases of catheter adherence in our haemodialysis unit and similarly found that the duration of time these catheters were left in-situ was considerable, ranging from 1 to 10 years. Two of the catheters were removed under general anaesthetic by an experienced surgeon and the other catheters were ligated proximally and buried. With the increasing use of tunnelled haemodialysis catheters for long-term access in chronic haemodialysis, it is likely that this rare complication may become more prevalent. We are currently also considering prophylactic catheter exchange after 1 to 2 years, in order to try and prevent this complication.

Conflict of interest statement. None declared.

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Reply

Sir,

Although central venous access catheters are commonly inserted for temporary haemodialysis access, in some patients they become the definitive access, due to a combination of additional patient comorbidities, patient demands and differences in clinical practice. If a catheter is functioning well, then most centres do not routinely change them, unless a complication ensues. Catheter removal is typically left to junior medical staff, performed at the bedside, or in a treatment room. We reported our recent experience of being unable to simply remove such catheters, to highlight the problem of catheter adherence at the site of insertion into a central vein. Over enthusiastic pulling could lead to a tear in one of the major central veins with severe haemorrhage.

Liu and colleagues have also encountered this problem, and similarly have been unable to remove some catheters due to adherence, so cutting short the proximal portion of the catheter and burying the remnant in the subcutaneous tissues. In keeping with our experience, Liu and colleagues also found that the common factor was the time that the catheter had been in situ.

This raises the question as to whether central venous access catheters should be routinely replaced to prevent this serious complication, and as such, we have elected to replace catheters after 2 years.

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Assessment of vascular calcification with computed tomography and simple imaging tools

Sir,

I read with great interest the important paper by Muntner et al. [1]. Very recently, another leading nephrology journal published a similar study by the same authors [2]. Both studies apparently used the data of the same patients. Not only were the number, gender and race of the patients exactly the same, but their body mass index, prevalence of diabetes mellitus, systolic and diastolic blood pressure and the prevalence of aortic and mitral valve calcification were also similar. The differences between the two papers are mainly in statistical methodology. Curiously, the second paper [1] did not refer to the first paper [2]. Moreover, there are a number of inconsistencies between the two papers. First, the mean dialysis vintage of the patients was reported as 2.7 years in the first paper [2] and 4.01 years in the second paper [1]. Second, in their first paper [2] the pulse pressure of the study population was reported as 57 mmHg; however, according to data presented in Table 1 of this paper and their second manuscript [1], this value must be 68 mmHg. Finally, abdominal aorta plain roentgenography was read by different investigators (E.F. and A.B. vs A.B. and P.R.) in each paper. It would be valuable to compare the results of abdominal aorta x-ray scores read by different pairs of investigators, to have an idea of the reproducibility of this semi-quantitative technique. However, this data was presented as mean ± SD in their first paper [2] and median (range) in their second [1] paper, which did not mention their first paper.

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