With respect to the DCOR study, its duration was limited to 3 years. Note that in the follow-up study of the RIND population [3], no survival difference was apparent at this time point, but that it rather took >5 years to show a benefit of avoiding calcium-containing phosphate binders in this admittedly small study. Furthermore, a 49% dropout in DCOR by the end of the study renders any interpretation of that trial difficult.

Finally, my central argument was—and still is—that in CARE-2, as opposed to TTG, the prevalence of diabetic nephropathy and of smokers, both established and very potent risk factors for cardiovascular calcifications, were considerably higher. They may have driven the faster progress of calcifications in CARE-2 and both are unlikely to be affected by the choice of phosphate binders. I absolutely agree with Drs Qunibi et al., that there is not, and likely never will be, any formal evidence to support this notion. It just seems pretty likely to me.

Conflict of interest statement. None declared.

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**Letters**

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**Chronic kidney disease, hypertension and silent brain infarction**

Sir,

We read with great interest the recent article by Kobayashi et al. [1] in the August Advance Access of *Nephrology Dialysis Transplantation*. In this cross-sectional study in 335 with chronic kidney disease (CKD) and 40 with essential hypertension patients, the authors found an independent association between glomerular filtration rate (GFR) and silent brain infarction (SBI).

We agree with them that CKD patients because of greater prevalence of SBI should receive active detection of SBI and more intensive treatment for hypertension. But considering the design of the study, the association between GFR and SBI is not proved to be independent. Blood pressure levels are good but not sufficient adjustment for hypertension. Patients with identical hypertensive current measurements may be at different risk of stroke, depending on how long they have been hypertensive [2]. The duration and severity of hypertension increase progressively with the stage of renal disease even when hypertension is not a primary cause for renal damage [3]. This necessitates additional adjustment for hypertension duration and its control status.

The estimation of hypertension duration is relatively easy, even if not always precise, being based mainly on information from self-reports and medical records. We suppose that CKD patients with an estimated longer duration of elevated high blood pressure will to the same extent be more likely to have SBI. Ophthalmoscopy, although there may be some controversies, can be used in the detection of severity of hypertension [4]. This is also appropriate because of the close correlation between retinal and cerebral arteriolar findings shown in Goto and colleagues’ autopsy study of patients with stroke [5].

Conflict of interest statement. None declared.


doi: 10.1093/ndt/gfn535

**Calcimimetics, calcium set point and calcium balance**

Sir,

We read with interest the article by De Francisco et al., demonstrating that cinacalcet treatment led to a decrease in the set point for Ca$^{2+}$ and to a leftward shift of the Ca$^{2+}$–PTH curve in haemodialyzed patients with secondary hyperparathyroidism [1]. The authors have studied their patients 12–18 h after drug administration.
But, as pointed out by the authors, we know that the administration of cinacalcet results in an intermittent reduction of iPTH that is highest 3–4 h after administration and stabilizes after 16–18 h on values of <30% less than their starting values [2]. Furthermore, pharmacokinetics and pharmacodynamics of cinacalcet showed a pronounced interindividual variability.

So it can be assumed that in the first hour of drug administration the shift of the 
\[\text{Ca}^{2+}\text{–PTH} \text{ curve may be more leftward than that highlighted by the authors in the next hours during dialysis.} \]

Instead, the ionized calcium usually follows a more stable trend, probably for a role of calcitonin.

It would therefore be interesting to know the kinetics of changes in ionized calcium and PTH in relation to the kinetics of the drug, to identify exactly for each patient the best time to calculate the set point.

In addition, the iPTH during the dialysis session is also regulated by the calcium balance that is closely related to hourly ultrafiltration obtained during the dialysis. Calcium balance alone can make important changes in the iPTH blood values [3].

The authors have rightly unspecified this aspect according to their previous experience; however, it is important to know if the ultrafiltration profile remained constant during the dialysis session and has been similar in the two sessions (before and after treatment of cinacalcet) for each single patient.

We conclude that the experience of the authors has been extremely rich in information; however, due to the intermittent variation of iPTH obtained by calcimimetics agents, more data are needed.

**Editorial Note:** Dr De Francisco et al. declined the opportunity to reply to this letter.

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

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**Haemoglobin (g/L) at start**

<table>
<thead>
<tr>
<th>Conversion factor (mean of each patient conversion factor)</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epoetin beta U/week</td>
<td>10.7</td>
<td>10.7</td>
</tr>
<tr>
<td>Darbepoetin Ug/week</td>
<td>12.9</td>
<td>12.9</td>
</tr>
<tr>
<td>Darbepoetin dose (mean)</td>
<td>7058</td>
<td>7058</td>
</tr>
<tr>
<td>Darbepoetin</td>
<td>10.3</td>
<td>10.3</td>
</tr>
<tr>
<td>Epogen</td>
<td>119</td>
<td>119</td>
</tr>
<tr>
<td>Epogen beta</td>
<td>730</td>
<td>730</td>
</tr>
<tr>
<td>Epogen beta</td>
<td>48.1</td>
<td>48.1</td>
</tr>
<tr>
<td>Epogen beta</td>
<td>257</td>
<td>257</td>
</tr>
</tbody>
</table>

**Mean dose was chosen as it better demonstrates the total use of ESA.** As can be found in the table, the mean conversion factor between epoetin beta and darbepoetin in this group of patients was 257. There was a positive correlation between the conversion factor and the initial epoetin beta dose indicating that a smaller relative dose of darbepoetin is needed when changing from a high epoetin beta dose.

**Editorial Note:** Dr Bock et al. had no further comments on this letter.

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