Opponent’s comments

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Dr Lentine has effectively presented an argument for weight loss prior to transplant and has included a balanced view with important caveats. It should be noted that there are many points of agreement between our ‘polar views’. Most importantly, we agree that BMI is an imprecise measure of obesity and surgical risk and that a ‘one size fits all’ approach is not ideal. Our opinions diverge with respect to the relative importance applied to utility versus equity of organ distribution and whether weight loss is truly a modifiable risk factor.

EQUITY VERSUS UTILITY

Dr Lentine emphasizes the importance of effective utilization of the donor kidney as a scarce resource that, on balance, favors weight loss prior to transplant. It is notable, however, that outcomes in obese kidney transplant recipients are similar or better when compared with other comorbid conditions such as diabetes [1]. In addition, utility discussions should only concern those awaiting a deceased donor transplant, yet BMI cut-offs are often applied irrespective of donor source. This implies that organ utility is not a primary driver for most centers in defining weight loss policies and guidelines. If one emphasizes equity over utility, obesity should be treated the same as other co-morbid conditions. This principle should be upheld until it can be demonstrated that weight loss modifies risk after transplant.

WEIGHT LOSS AS A MODIFIABLE RISK FACTOR

In the ‘pro’ component of this discussion, a parallel was drawn between smoking and obesity as modifiable risk factors. Certainly, weight, like smoking, is potentially modifiable in some, but perhaps not all, obese individuals. The more important issue at hand, however, is whether weight change, like smoking cessation, modifies risk. As both sides of the debate report, there are limited data to show that intentional weight loss prior to transplant positively impacts risk after transplant. Yet there are abundant data that unqualified weight loss in hemodialysis patients is associated with higher mortality. Furthermore, weight loss takes time, and it is widely accepted that prolongation of time to transplant reduces graft and patient survival after transplant.

Finally, there is legitimate concern as to whether weight loss is actually attainable. Many studies of the general population have highlighted the often transient nature of weight loss resulting from diet- and exercise-based regimens in morbidly obese individuals [2]. There is every reason to believe that the dialysis population is similarly unlikely to achieve effective weight loss with these interventions. Dr Lentine has correctly pointed out that bariatric surgery in patients with CKD is more likely to result in sustainable weight loss. It is difficult, however, to recommend bariatric surgery as a bridge to transplant until the impact on pre- and post-transplant mortality and complications are more comprehensively defined.

In sum, equity of access to transplant demands that obese patients be treated similarly to patients with other comorbid conditions. Utility concerns do not outweigh equity in this case given a lack of evidence that weight loss positively modifies risk. More important than weight and BMI in risk assessment are measures of visceral obesity, nutritional state and muscle mass. An individualized approach that emphasizes fitness, nutrition and realistic goals for each candidate and center is preferred.

CONFLICT OF INTEREST STATEMENT

None declared.

REFERENCES


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