

A) COMMENTARIES TO PUBLISHED ARTICLES

Comments to the proposal for the use of indicators for the group of quality management of the SEN

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To the editor: We fully respect the work accomplished by the Group of Quality Management of the SEN (1). However we would like to make some comments based on another interpretation of the available scientific information introduced in the article, as well as on our experience in the use of these quality indicators, which we measure at our Department since June of 2005.

1. Anemia indicators. In our experience it is not possible to achieve 90% of patients having an Hb value > 11 if one or both of the following conditions are not met: an important increase (> 15-20%) of the percent of patients having a blood Hb value of at least 13 g/dL, a limit that should not be exceeded according to the KDOQI guidelines (2007); or an Hb value > 12 g/dL in patients with underlying cardiovascular disease, as shown in the European guidelines for anemia management in patients with chronic renal disease (EBPG).³

Besides, the continuing efforts to achieve this objective increase the risk for a great variability in the hemoglobin.

We consider that this standard should be reevaluated and perhaps a lower percentage could be established (about 80%). The percentage of patients that should not have an Hb value higher than 13 g/dL should also be taken into account.

2. Cardiovascular risk indicators. The KDOQI guidelines on osteodys-trophy⁴ recommend monthly assess-

ment of calcium, phosphorus, and PTH measurement quarterly.

With the introduction of the new chelating agents and calcium-mimicking agents, it is possible to control calcium and phosphorus levels and the calcium-phosphorus product, as well as to improve the indicator percentages, according to the work of Arenas et al.⁵

That is not the case when an adequate control of PTH values (within the range 150-300 pg/mL) is tried.

We consider that indicator measurements of phosphorus and PTH should not be separately carried out, as both are related and are keystones when making important decisions about the therapies to be applied. We think that both parameters should be measured together quarterly.

3. Non-priority cardiovascular risk factors indicators. Both SEN⁶ and KDOQI (7) guidelines on cardiovascular risk recommend pre-dialysis blood pressure < 140/90 and post-dialysis blood pressure < 130/80.

Blood and pulse pressure values should be evaluated in patients in hemodialysis because they are predictors of cardiovascular morbimortality.^{6,7} We do believe it is indicated to include adequate blood pressure and/or pulse pressure control among priority cardiovascular risk indicators. That further reinforces the efforts that we make during the whole pre-dialysis period, which has been shown to be very beneficial.

Guidelines, indicators and standards are instruments that the scientific evidence offers the physician to improve the patient's care. Individualization and common sense assure its quality.

1. K.López Revuelta, G. Barril, C. Caramelo, R. Delgado, F. García López, J. García Valdecasas, E. Gruss, P. Jiménez Almonacid, A. Martínez Castela, J. Luis Miguel, A. Ortiz, M^a D. del Pino, J.M^a Portolés, C. Prados, P. Sanz, A. Tato, F. Álvarez Ude, M. Angoso, J. Aranaz, M.D. Arenas y S. Lorenzo. Desarrollo de un sistema de monitorización clínica para hemodiálisis: propuesta de indicadores del Grupo de Gestión de Calidad de la SEN. *Nefrología* 27 (5) 542-559, 2007.

2. KDOQI Clinical Practice Guideline and Clinical Practice Recommendations for Anaemia in Chronic Disease: 2007 Update of hemoglobin Target. *Am J Kidney Dis* 50 (3). 468-471, 2007.
 3. Revised European Best Practice Guidelines For The Management of Anaemia in Patients With Chronic Renal Failure. *Nephrol Dial Transplant* 19 Supplement 2. May 2004.
 4. DOQI Clinical Practice Guidelines for Bone Metabolism and Disease for Bone Metabolism and Disease in Chronic Kidney Disease. *Am J Kidney Dis* 42 (4) Supl. 3, 2003.
 5. Arenas MD, Álvarez Ude F, Gil MT, Mole-dous A, Malek T, Núñez C, Devesa R, Carrretón MA, Soriano A. Implementation of «KDOQI clinical practice guidelines for bone metabolism and disease in chronic kidney disease» after the introduction of cinacalcet in a population of patients on chronic haemodialysis. *Nephrol Dial Transplant* 22: 1639-44, 2007.
 6. Goicoechea MA. Guías de la SEN. Riñón y Enfermedad Cardiovascular. *Nefrología* 24 (6) 161-163, 2004.
 7. KDOQI Clinical Practice Guidelines for Cardiovascular Disease in Dialysis Patients. *Am J Kidney Dis* 45 (4), Supl. 3. 2005.

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Response to the letter about quality indicators

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To the editor: In response to the letter of Dr. del Pozo et al. the Group on Quality Management of the SEN wants to thank this kind of initiatives, since one of the fundamental characteristics of all quality systems, and in particular of defined indicators and standards, is to be open to continuous reviews and changes. For this reason a multicentric study is being currently carried out to validate the proposed quality indicators, with the aim to analyze their feasibility and to know the actual standards in our setting.

The study is ongoing, but the participation is still open for all interested centers. In fact, one of the middle-term objectives is to have a registry available, representative of current quality standards in Spain. At this moment we possess modules of indicators measurement, developed by the main computer programs employed in hemodialysis like Nefrosoft® (Visualimes) and Renalsoft® (Baxter), and others that are being developed like Nefrolink®. With them it is easy to share the results.

We agree with all the suggestions made by the group of Alcoy. Our intention is to progressively change both the indicators and the standards, as well as the monitoring periods, in such a way that at the end they fit to our every-day practice. Some defined standards are probably too ambitious but we hope that the multicentric study will help to adjust them to the daily routine. For example, in the multicentric study the mean of the percentage of patients with Hb values > 11 g/dL was 81.24 ± 9.97 (similar to what Dr. del Pozo et al. propose) and the mean of the superior quartile was 93.2%. The mean percentage of patients with Hb > 13 g/dL was 20% of

the total sample (3142 patients) with a big inter-center variability. The aim is to maximize the percentage of patients with Hb values in a range between 11 and 12 g/dL. Considering the last recommendations we agree that it is necessary to include among the indicators the percentage of patients with Hb values > 13 g/dL.

We also agree that phosphorus levels should be frequently measured, and it seems logical that this measurement should be as frequent as, or even more frequent than, PTH determination. In fact, in the indicators module and in our study the periodicity for phosphorus determination was established on monthly base. The preliminary data from the multicentric study for these indicators were: 1) compliance with PTH standard (between 150 y 300 pg/mL) $32\% \pm 10.9\%$, with some centers reaching 46%; 2) compliance with phosphorus standard (< 5.5 mg/dL) 70.8%, with a maximum of 84.4%.

With respect to the last issue about the inclusion of the blood pressure measurement as a priority indicator, we would like to explain, that it was not initially included because the standard of this indicator is not yet enough clear.

In a recent study (1) the achievement of the blood pressure objective (BP < 140/90) in patients in hemodialysis was associated with a higher mortality risk, while achievement of other indicators yielded favorable results. We conclude that the objective for the BP is extrapolated from those in the general population, and that randomized controlled studies are needed to identify the optimal blood pressure value in patients on hemodialysis.

In summary, this matter is open to discussion, and in permanent change. Every proposed indicator can only be used as an orientation. With the results of the multicentric study and also with the different inputs, the quality indicators monitoring system will be progressively defined.

1. Tentori F, Hunt WC, Rohrscheib M y cols. Which Targets in Clinical Practice Guidelines Are Associated with Improved Survival in a Large Dialysis Organization? *J Am Soc Nephrol* 18: 2377-2384, 2007.

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B) CLINICAL EXPERIENCES AND BRIEF CLINICAL REPORTS

AA Amyloidosis due to renal cell carcinoma in a horseshoe kidney

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To the editor: The development of tumors on horseshoe kidneys is very rare. The most frequent tumor in this setting is the renal cell carcinoma, a genitourinary neoplasm that is commonly accompanied by a paraneoplastic syndrome. Amyloidosis is one of the manifestations of this syndrome.

We present a 69 year-old woman with a history of hypothyroidism and horseshoe kidney, in which a hypernephroma developed (fig. 1). The disease

was diagnosed in another department and the patient was scheduled for surgery. She came to the Emergency Room because of edemas and malaise and she was admitted to the hospital. The laboratory parameters were: hemoglobin 11,1.4 g/dL; normal MCV; prolonged coagulation times, creatinine 4.9 mg/dL; urea 142 mg/dL, total proteins 4.7 g/dL; calcium 8 mg/dL, mild metabolic acidosis; proteinuria > 4 g/24 hours, important hematuria and leukocyturia.

Renal failure and nephrotic syndrome persisted for several weeks. The intervention was postponed for one month because of paroxysmal atrial fibrillation. A right nephrectomy was performed, as the kidney was irrigated by three arteries. A wedge of the he-

althy kidney was taken for microscopic study. The pathological study confirmed the hypernephroma and disclosed the presence of AA amyloidosis AA in the contralateral kidney. The postoperative course was without complications, but the renal function kept on worsening. A few days later the patient had seizures and the cranial CT scan revealed a hyperdense image in the right occipital lobule compatible with hemorrhage, without mass effect, which suggested the presence of an amyloid angiopathy.

The clinical picture evolved with increasing malaise, asthenia, anorexia, continuing vomiting and anemia. The patient presented an episode of melena and an urgent endoscopy was performed, which disclosed esophageal lacer-