Dialysate as Food: Combined Amino Acid and Glucose Dialysate Improves Protein Anabolism in Renal Failure Patients on Automated Peritoneal Dialysis

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Protein-energy malnutrition as a result of anorexia frequently occurs in dialysis patients. In patients who are on peritoneal dialysis (PD), dialysate that contains amino acids (AA) improves protein anabolism when combined with a sufficient oral intake of calories. It was investigated whether protein anabolism can be obtained with a mixture of AA plus glucose (G) as a source of proteins and calories during nocturnal automated PD (APD). A random-order cross-over study was performed in eight APD patients to compare in two periods of 7 d each AA plus G dialysate obtained by cycler-assisted mixing of one bag of 2.5 L of AA (Nutrineal 1.1%, 27 g of AA) and four bags of 2.5 L of G (Physioneal 1.36 to 3.86%) versus G as control dialysate. Whole-body protein turnover was determined using a primed continuous infusion of t-[1-13C]leucine, and 24-h nitrogen balance studies were performed. During AA plus G dialysis, when compared with control, rates of protein synthesis were 1.20 ± 0.4 and 1.10 ± 0.2 μmol/kg per min leucine (mean ± SD), respectively (NS), and protein breakdown rates were 1.60 ± 0.5 and 1.72 ± 0.3 μmol/kg per min (NS). Net protein balance (protein synthesis minus protein breakdown) increased on AA plus G in all patients (mean 0.21 ± 0.12 μmol leucine/kg per min; P < 0.001). The 24-h nitrogen balance changed by 0.96 ± 1.21 g/d, from −0.60 ± 2.38 to 0.35 ± 3.25 g/d (P = 0.061, NS), improving in six patients. In conclusion, APD with AA plus G dialysate improves protein kinetics. This dialysis procedure may improve the nutritional status in malnourished PD patients.


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Protein turnover study (PTO) was carried out on day 3. Nitrogen balance took place during days 5 to 7 and 12 to 14. During 5 d (days 3 to 7 and 10 to 14), collection of materials for whole-body turnover study. Patients were randomized to start with AAG or G as the first dialysis scheme by drawing one of eight sealed envelopes.

The study design was a randomized, crossover study that consisted of two consecutive study periods of 7 d each. During these periods (days 1 to 7 and 8 to 14), dialysis with amino acids plus glucose (AAG) or with glucose (G) was performed. A controlled hospital-supplied diet was prescribed during 5 d (days 3 to 7 and 10 to 14). Collection of materials for nitrogen balance took place during days 5 to 7 and 12 to 14. Protein turnover study (PTO) was carried out on day 3.

Table 1. Characteristics of the patients

<table>
<thead>
<tr>
<th>Patient</th>
<th>Primary Diagnosis of Renal Disease</th>
<th>Time on PD (mo)</th>
<th>Gender</th>
<th>Age (yr)</th>
<th>Weight (kg)</th>
<th>Height (cm)</th>
<th>BMI (wt/ht²)</th>
<th>Kt/V</th>
<th>PET</th>
<th>nPNA (g/kg per d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Nephrosclerosis</td>
<td>14</td>
<td>M</td>
<td>57</td>
<td>69</td>
<td>170</td>
<td>23.9</td>
<td>1.95</td>
<td>HA</td>
<td>0.80</td>
</tr>
<tr>
<td>2</td>
<td>Reflux nephropathy</td>
<td>8</td>
<td>M</td>
<td>43</td>
<td>85</td>
<td>184</td>
<td>25.1</td>
<td>1.85</td>
<td>HA</td>
<td>0.90</td>
</tr>
<tr>
<td>3</td>
<td>Alport disease</td>
<td>63</td>
<td>M</td>
<td>35</td>
<td>84</td>
<td>180</td>
<td>25.9</td>
<td>1.82</td>
<td>High</td>
<td>0.72</td>
</tr>
<tr>
<td>4</td>
<td>Rapidly progressive glomerulonephritis</td>
<td>45</td>
<td>M</td>
<td>56</td>
<td>78</td>
<td>185</td>
<td>22.8</td>
<td>2.04</td>
<td>High</td>
<td>0.86</td>
</tr>
<tr>
<td>5</td>
<td>Periarteritis nodosa</td>
<td>5</td>
<td>M</td>
<td>47</td>
<td>67</td>
<td>174</td>
<td>22.1</td>
<td>1.76</td>
<td>HA</td>
<td>0.92</td>
</tr>
<tr>
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<td>Unknown kidney disease</td>
<td>9</td>
<td>M</td>
<td>66</td>
<td>94</td>
<td>176</td>
<td>30.4</td>
<td>2.49</td>
<td>High</td>
<td>0.91</td>
</tr>
<tr>
<td>7</td>
<td>Morbus Wegener</td>
<td>12</td>
<td>F</td>
<td>45</td>
<td>76</td>
<td>166</td>
<td>27.6</td>
<td>2.24</td>
<td>LA</td>
<td>0.69</td>
</tr>
<tr>
<td>8</td>
<td>Polycystic disease</td>
<td>36</td>
<td>F</td>
<td>45</td>
<td>80</td>
<td>163</td>
<td>30.1</td>
<td>1.98</td>
<td>HA</td>
<td>0.62</td>
</tr>
</tbody>
</table>

Mean 24 ± 21 SD

SD 9.8 ± 8.8 BMI 49.3 ± 8.1 Kt/V 26.0 ± 8.1 PET 2.0 ± 8.1 nPNA 0.8 ± 8.1

ABMI, body mass index; Kt/V, value per week; PET, peritoneal equilibrium test; nPNA, normalized protein equivalent of nitrogen appearance (PD adequacy 2.0, software Baxter); HA, high average; LA, low average.

Study Design

The study was a single-center, open-label, randomized, crossover study of 14 d duration (Figure 1). In two consecutive periods of 7 d each, a dialysis scheme using dialysate-containing AAG (Nutrineal 1.1% plus Physioneal 1.36 to 3.86%; Baxter BV, Utrecht, The Netherlands) was compared with a control scheme that contained G (Physioneal 1.36 to 3.86%). Before the study, all patients used G-based dialysis fluid (Dianeal or Physioneal; Baxter BV).

The study was performed on an outpatient basis, except for the overnight stay. The NB study was carried out on an outpatient basis. Primary end points of the study were whole-body protein turnover (WBPT) and 24-h nitrogen balance (NB). Secondary end points were changes in acid-base homeostasis and blood chemistry. Before the study and at the end of the first and second weeks (day 7 and day 14), venous blood samples were taken for chemistry and an acid-base profile. On the third day of each period, patients were admitted to the metabolic ward, where WBPT was determined during an overnight stay. The NB study was carried out on an outpatient basis.

Dialysis Procedures

Six nighttime exchanges were performed automatically using a cycler (HomeChoice; Baxter BV). In the daytime, there were one or two exchanges with G (Dianeal or Physioneal) and/or polyglucose-containing (Extraneal, Baxter BV) dialysate.

During the study, the APD schedule for each patient was similar to that used before the study to meet adequacy and ultrafiltration targets. The cycler regulated mixing of AA and G. The AAG dialysate was obtained after mixing one bag of 2.5 L of Nutrineal 1.1%, which contained 27 g of AA, and four bags of 2.5 L of Physioneal, 1.36 to 3.86% G, depending on ultrafiltration targets. In one patient (patient 8), only bags with 2.0 L were used. The AA and G solutions need to be mixed such that at each cycle, AA are given together with a sufficient amount of energy. To obtain an AAG mixture from the first cycle onward, we applied an “empty bag procedure,” while all bags were hung with the undersides on the same level. For the first cycle, a weighed amount of AA solution was mixed in the so-called heater bag (the bag where the solutions are mixed) with the G solutions to a final ratio of 1:4. For the NB studies, when the patients were dialyzed at home, mixing during the other cycles was regulated automatically by the cycler. This mixing procedure was tested in an in vitro experiment by labeling the AA solution with methylene blue. A proper mixing for each cycle was found (interbag coefficient of variation for methylene blue concentrations, 7%). During the WBPT studies, in each cycle, the heater bag first was filled by the research nurse with the AA solution in an exactly weighed amount, whereupon the cycler filled the bag with the required amount of G solution so that exactly the same amount of AA was supplied and the steady-state conditions could be met in each cycle. During the G period, five bags of 2.5 L of Physioneal 1.36 to 3.86% were infused, individualized per patient depending on ultrafiltration targets.

The composition of the AA 1.1% dialysis solution (g/L) was 0.714 histidine, 0.850 isoleucine, 1.020 leucine, 0.955 lysine-HCl, 0.850 methionine, 0.570 phenylalanine, 0.646 threonine, 0.270 tryptophan, 1.393 valine, 1.071 arginine, 0.951 alanine, 0.595 proline, 0.510 glycine, 0.510 aspartic acid, 0.570 phenylalanine, 0.646 threonine, 0.270 tryptophan, 1.393 valine, 1.071 arginine, 0.951 alanine, 0.595 proline, 0.510 glycine, 0.510 aspartic acid, 0.570 phenylalanine, 0.646 threonine, 0.270 tryptophan, 1.393 valine, 1.071 arginine, 0.951 alanine, 0.595 proline, 0.510 glycine, 0.510 aspartic acid.

Figure 1. The study design was a randomized, crossover study that consisted of two consecutive study periods of 7 d each. During these periods (days 1 to 7 and 8 to 14), dialysis with amino acids plus glucose (AAG) or with glucose (G) was performed. A controlled hospital-supplied diet was prescribed during 5 d (days 3 to 7 and 10 to 14). Collection of materials for nitrogen balance took place during days 5 to 7 and 12 to 14. Protein turnover study (PTO) was carried out on day 3.
WBPT Studies
In the two study periods, rates of WBPT during nocturnal dialysis were determined with a primed continuous intravenous infusion of 13C-leucine (25). WBPT was studied on day 3, at the end of the dialysis between 2.30 and 5.00 a.m. (Figure 2). To create baseline conditions, patients were instructed to drain all dialysate 12 h before starting the APD, leaving the abdomen empty. Thus, only during day 3, when WBPT was performed, the patients had a dry day. At 5:00 p.m., two catheters were inserted into superficial veins on both arms, one for continuous infusion of the tracer solution and the other for repeated blood sampling. Dialysis started at 8.30 p.m. (T0). Baseline blood samples and expiratory breath samples were collected in duplicate at 2.30 a.m. (6 h from the start of the dialysis, T360), and priming doses of L-[1-13C]leucine (3.8 μmol/kg) and of NaH13CO3 (1.7 μmol/kg) were given to label the leucine and CO2 pools. Then, a continuous infusion of L-[1-13C]leucine (infusion rate 0.063 μmol/kg per min) was started and continued for 150 min until the end of the nocturnal dialysis at T510. For measuring plateau plasma keto-isocaproic acid (KIC) and CO2 13C enrichment, blood and expired air samples were collected simultaneously in duplicate at T480, T495, and T510 min, i.e., at 120, 135, and 150 min, after priming and starting the tracer infusion. Indirect calorimetry (Deltatrac metabolic monitor; Datex, Helsinki, Finland) was performed to measure CO2 production. Patients were not allowed to eat during the isotope studies, but noncaloric beverages were permitted.

Diet
A renal dietitian instructed the patients on how to complete a 4-d food diary. On these food records and a subsequent dietary interview, the patient’s habitual dietary intake was determined. A balanced diet was designed, isonitrogenous and isocaloric to the prestudy habitual diet. Meals were prepared and deep-frozen in the Erasmus MC according to the prescription of the dietitian. The patients took nothing but this food during days 3 through 7 of each period. The patients recorded all food intake in the diaries.

NB Studies
On day 3 of each week, patients started the individually tailored diets and continued them until the end of day 7. During days 5, 6, and 7, all dialysate and all urine produced per 24-h period were collected. On the daily patient visits, the research nurse delivered the hospital-prepared food, supervised the study procedures, checked for changes in body weight, and returned to the hospital all collected materials (urine, spent dialysate) and the remaining food of the previous day. The dietitian weighed the remaining food to calculate its protein and energy content. An aliquot of every collection was stored at −20°C until later analysis.

Analytical Determination
Dialysate and urine nitrogen content were determined by a continuous flow elemental analyzer (Carlo Erba NC-1500; Interscience BV, Breda, The Netherlands). In brief, triplicate samples are weighed in tin containers, freeze-dried, and combusted at 1020°C; the resulting nitrogen gas is measured. This is an automation of the Dumas combustion method (26).

Leucine carbon flux was calculated from the 13C enrichment of KIC (27). In brief, the sample was deproteinized with sulfosalicylic acid and the supernatant was put on a cation exchange column to isolate the AA. The effluent that contained the KIC was reacted with phenylene-diamine to form quinoxalinols. These derivatives were extracted with a mixture of dichloromethane/hexane, dried, and silylated with N-methyl-N-(tert-butyldimethylsilyl)-trifluoroacetamide. The 13C enrichment was determined by gas chromatography–mass spectrometry by measuring the fragments 259 and 260 of natural and 13C KIC, respectively. Gas chromatography–mass spectrometry analyses were carried out on a Carlo Erba GC8000 gas chromatograph coupled to a Fisons MD8000 mass spectrometer (Interscience BV) by injecting 1 μl of test material with a split ratio of 50:1 on a 25-m × 0.22-mm fused silica capillary column, coated with 0.11 μm of HT5 (SGE, Victoria, Australia). Oxidation of L-[1-13C]leucine was determined by measuring breath CO2 13C enrichment (Automatic Breath Carbon Analyser; Europa Scientific, Crewe, Great Britain).

Blood Chemistries
Fasting blood samples were taken before the morning exchange, before the study, at the end of each study period, and at the start of WBPT studies. Serum urea, creatinine, phosphate, albumin, G, bicarbonate (standardized at 40 mmHg), insulin, glucagon, and 24-h dialysate contents of urea and protein were measured by routine laboratory procedures. Insulin was measured by a chemiluminescent immunometric assay (Immulite 2000 Insulin; DPC, Los Angeles, CA). Glucagon was measured by means of a radioimmunochemical method (Eurodiagnostics, Apeldoorn, The Netherlands).

Calculations of NB
The classical NB was calculated, with the equation Nbal = Nin – Nout. Then, the mean of the 3 study days was calculated. The supply of nitrogen (Nsup) consisted of the sum of the calculated daily dietary nitrogen intake and the dialysate nitrogen content (i.e., nitrogen in the infused dialysate). The loss of nitrogen (Nout) included the measured nitrogen content of all peritoneal drainage fluid and the urinary nitrogen losses. For fecal and integumental nitrogen losses, fixed values of 1.5 and 0.5 g/d, respectively, were assumed. The differences between the study periods were evaluated by subtracting the NB on G from that on AAG. No correction was made of the NB for potential changes in the body urea-N pool. To convert the results of the NB (g of N/24 h) to its protein equivalent (g protein/24 h), it was assumed that 1 g of N corresponds to 6.25 g of protein.

Calculations of Whole-Body Turnover
Leucine carbon flux was calculated as described previously (25). Leucine carbon flux (Q) is equal to the sum of endogenous leucine appearance from protein breakdown (B) plus exogenous leucine appearance via oral intake and via dialysate (I). At metabolic equilibrium (steady state), Q is also equal to the sum of leucine disappearance into body proteins (S) plus leucine oxidation (O). Therefore, Q = S + O = B + I. Leucine flux in μmol/kg per hr is calculated as Q = Inf (E/IPlasma KIC − 1), where Inf is the leucine infusion rate (μmol/kg per hr), E is the 13C enrichment of the L-[1-13C]leucine infused, and EKIC is the 13C enrichment of plasma KIC as measured at isotopic equilibrium. Isotopic steady state (plateau plasma 13KIC enrichment) was assumed between T480 and T510 min. Leucine oxidation (O, in μmol/kg per hr) is
calculated as \( F = \frac{E_{13C}}{E_{\text{CO}_2} - 1} \times 100 \), where \( E_{13C} \) (in \( \mu \)mol \(^{13}\text{C} \)/kg per hr) is the rate of expired \(^{13}\text{C} \) calculated from \( \text{CO}_2 \) \(^{13}\text{C} \) enrichment in expired air and from \( \text{CO}_2 \) production. Leucine absorption from dialysate was calculated by subtracting the amount of leucine in spent dialysate from that in fresh dialysate.

### Statistical Analyses

Data were analyzed using the statistical program SPSS, version 10.0, for Windows (SPSS Inc., Chicago, IL). Data are expressed as mean ± SD. The paired \( t \) test was used to compare differences between the two treatment regimens (AAG versus G dialysis) after verifying that there were no significant carryover or period effects. All tests of significance were two sided, and differences were considered statistically significant at \( P < 0.05 \).

### Results

Table 1 shows the baseline characteristics of the eight patients, three of whom were anuric. Apart from the use of medications that are taken regularly by PD patients, patients 4, 5, and 7 used prednisone in a dose of 5, 7.5, and 2.5 mg/d, respectively. The treatment protocol was performed easily and well tolerated by all patients. There were no complaints of loss of appetite or nausea, and there were no other adverse reactions reported during the use of AA-containing dialysate fluid. None of the patients dropped out of the study.

**WBPT**

During dialysis with AAG, protein synthesis increased \((1.20 \pm 0.4 \text{ versus } 1.10 \pm 0.2 \mu \text{mol leucine/kg per min})\); mean difference \(0.10 \pm 0.31 \mu \text{mol leucine/kg per min; NS}\) and protein breakdown decreased \((1.60 \pm 0.5 \text{ versus } 1.72 \pm 0.3 \mu \text{mol leucine/kg per min; mean difference } 0.11 \pm 0.30 \mu \text{mol leucine/kg per min; NS})\) compared with the use of G. Net protein balance \((S - B)\) was negative in all patients (fasting state conditions). With the use of the AAG mixture, net protein balance was invariably less negative by a mean of \(0.21 \pm 0.12 \mu \text{mol leucine/kg per min} (P = 0.001)\) compared with G dialysis in all patients. The oxidation of leucine remained unchanged also during the supply of AA (Table 2). Net peritoneal absorption of AA was approximately 47% of infused AA. The amount of \(^{13}\text{C} \) leucine lost into the dialysate was not significantly different between AAG and G \((<1\%\) of the dose).

As shown in Figure 3, isotopic steady state was reached in the time frame in which sampling was done \((T_{480} - T_{510})\). The gain through change in net protein balance \((0.21 \mu \text{mol leucine/kg per min})\) during the 8.5 h of dialysis can be expressed as grams of protein by taking a molecular weight of 131 for leucine and assuming a leucine content of muscle protein of 7.8%. There was no significant treatment period interaction for the WBPT studies \((P = 0.71)\).

### Energy and Protein Intake

The prestudy \((i.e., \text{ habitual})\) dietary protein intake was \(0.9 \pm 0.2 \text{ g/kg per d}\); only one of the eight patients had an intake of \(1.2 \text{ g protein/kg per d}\). Also, dietary energy intake was low \((21.1 \pm 6.2 \text{ kcal/kg per d})\). The prestudy calorie supply via peritoneal dialysate was estimated to be approximately \(5.6 \pm 3.0 \text{ kcal/kg per d}\). The prescribed diet contained on average \(0.9 \pm 0.2 \text{ g protein/kg per d and } 22.1 \pm 5.5 \text{ kcal/kg per d}\). During the NB energy intake, including G absorbed from dialysate was \(25.4 \pm 7.0 \text{ kcal/kg per d with the AAG dialysate versus } 27.0 \pm 6.7 \text{ kcal/kg per d with the G dialysate} (P = 0.10, NS)\). Protein intake calculated as the sum of protein from diet and AA absorbed from dialysate (on average 47%) was \(1.0 \pm 0.2 \text{ g/kg per d on AAG and } 0.85 \pm 0.2 \text{ g/kg per d on G dialysis} (P = 0.002)\).

**NB**

Mean values of NB were \(0.35 \pm 3.25\) and \(-0.60 \pm 2.38\) g of N/24 h \((\text{mean } \pm \text{ SD})\) for AAG and G, respectively (Table 3). The strongly negative values in both series in one patient (patient 6) are primarily responsible for the large SD. In six patients, NB improved with the AAG compared with G solu-

### Table 2. Whole-body protein turnover

<table>
<thead>
<tr>
<th>Patient</th>
<th>AGG</th>
<th>G</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flux</td>
<td>Oxidation</td>
<td>Intake</td>
</tr>
<tr>
<td>1</td>
<td>2.19</td>
<td>0.95</td>
</tr>
<tr>
<td>2</td>
<td>1.91</td>
<td>0.62</td>
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<tr>
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<tr>
<td>Mean</td>
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</tr>
<tr>
<td>SD</td>
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<td>0.18</td>
</tr>
</tbody>
</table>

aData are expressed in \( \mu \)mol leucine/kg per min as mean ± SD; AAG, combined amino acids plus glucose dialysis; G, glucose dialysis.

bNet protein balance is synthesis minus breakdown. \(P = 0.001\) for net protein synthesis on AAG versus G dialysis.
There was no significant treatment period interaction for NB were no appreciable changes in body weight in any patient. 0.061, NS), corresponding to 6.0

tion of AA and G improves protein anabolism in APD patients.

Discussion

Losses of protein via dialysate were not different. AAG dialysate, serum bicarbonate concentrations showed a

cantly different at the end of both study periods. The total

Biochemical Parameters

As shown in Table 4, mean serum concentrations of creatinine and urea did not show a statistically significant difference at the end of either study period. Phosphate levels were significantly lower after treatment with AAG compared with G dialysate. Mean serum venous bicarbonate concentrations before the study were in the (low) normal range. After treatment with AAG dialysate, serum bicarbonate concentrations showed a slight and statistically significant decrease compared with G dialysate. Mean serum levels of albumin and G remained unchanged. Mean fasting insulin and glucagon were not significantly different at the end of both study periods. The total excretion of urea in dialysate and urine during AAG dialysis did not show a significant difference compared with G dialysate. Losses of protein via dialysate were not different.

Discussion

Our results show that combined intraperitoneal administration of AA and G improves protein anabolism in APD patients. Recently, the importance of supplying calories simultaneously with intraperitoneal AA to stimulate protein metabolism was demonstrated in CAPD patients (22). In that daytime study, calories were taken orally. However, poor appetite may restrain patients from ingesting enough food including calories. Giving AAG as dialysate during regular APD would be a practical approach.

We found that protein synthesis increased and breakdown decreased during AAG dialysis. Although neither component attained statistical significance, net protein balance (i.e., synthesis minus breakdown) during AAG dialysis improved in all APD patients.

This is the first study to measure WBPT during AAG dialysis. A previous daytime study that involved CAPD patients and used an automated cycler showed an increase in muscle protein turnover (24), whereas a similar study performed during one night in children showed an increase in AA levels without concomitant rise in blood urea nitrogen levels (23).

Anorexia is an important factor in the development of malnutrition (28). In our patients, we noticed a low habitual dietary energy intake and a mean daily protein intake below the Kidney Disease Outcomes Quality Initiative–advised 1.2 g of N/kg per d. In only one patient were Kidney Disease Outcomes Quality Initiative standards actually met. We did not notice any interference of the AA dialysis with appetite or daily food intake. The clinical relevance of the increase in net protein balance (0.21 μmol/kg per min) can be appreciated when one calculates that during 8.5 h of dialysis with AAG mixture, a 70-kg person would gain an average of 13 g of body protein. We supplied 27 g of AA during the night, approximately 47% of which was absorbed. This suggests that virtually all of the absorbed AA were utilized for protein synthesis. This gain in protein exceeds the usual 24-h protein and AA losses via dialysate (10). A stimulatory effect of intraperitoneal AA on protein synthesis was also found previously (22). The slow rate of AA supply in our study (27 g during 8.5 h) might explain the small increase in protein synthesis rate. In Delarue’s study, the additional supply of oral calories simultaneously with AA dialysate induced a decrease in protein breakdown, probably mediated through insulin secretion (16,22,23,29).

Our study suggests that combining AA with the G solution inhibits protein breakdown and stimulates protein synthesis. Human feeding experiments have shown that AA augment the insulin-mediated inhibition of protein degradation in addition to stimulating protein synthesis. Such an inhibitory effect of AA levels on endogenous AA appearance minimizes oxidation and maximizes protein utilization (30,31). Our study does not take into account retention of peritoneally absorbed leucine in the splanchic bed during AA dialysis. Ignoring splanchic retention may have resulted in overestimation of the entry rate of absorbed leucine in the plasma pool (i.e., exogenous leucine appearance) and thereby in underestimation of protein breakdown (i.e., endogenous leucine appearance) as the latter is calculated as flux (Q) minus exogenous appearance. A reliable assessment of splanchic sequestration of AA (leucine) is difficult, and values of 10 to 40% have been reported (22,30). However, even if a value as high as 40% for splanchic retention had been present with AA dialysis, the net protein balance observed in our study still would have improved in all patients.
who were treated with an AA-based dialysis fluid (11). NB was reported previously in malnourished CAPD patients evidence of a gain in body protein over 24 h. Improvement in urea pool. Nevertheless, our results do not provide conclusive start tends to suggest that there was no increase in the body weight did not change appreciably and plasma urea at the end in urea N pool are not taken into account. However, that body gen content. Whether a positive balance indicates a gain in such as urea, cannot be judged from this method, as any change in body protein or an increase in another nitrogenous compound, which were chosen to meet ultrafiltration targets. The best energy-to-protein ratio for optimal protein accretion is un-
known and remains to be determined. Various studies have reported increased urea levels with AA dialysis in CAPD patients (11–14). In contrast, our study showed similar plasma urea levels and urea excretion into dialysate in both study periods. This is in line with an effective utilization of the intraperitoneally administered AA. We also found a decrease in serum phosphate levels, suggesting a shift of phosphate toward the intracellular space, which is another indication that AAG dialysis induced an anabolic response (11,17). With the use of the AAG, serum bicarbonate levels were

The improvements in protein anabolism during nocturnal APD are acute effects in the fasting state. The results of the 24-h NB studies suggest an improvement in nitrogen retention with the AAG mixture; however, this change was not statistically significant (P = 0.061). We performed the classical NB (Nbal = Nin − Nout), which describes changes over time in body nitrogen content. Whether a positive balance indicates a gain in body protein or an increase in another nitrogenous compound, such as urea, cannot be judged from this method, as any change in urea N pool are not taken into account. However, that body weight did not change appreciably and plasma urea at the end of each study week was not different from the values at the start tends to suggest that there was no increase in the body urea pool. Nevertheless, our results do not provide conclusive evidence of a gain in body protein over 24 h. Improvement in NB was reported previously in malnourished CAPD patients who were treated with an AA-based dialysis fluid (11).

In our study, the proportion of energy and protein given via dialysate varied between 160 and 340 kcal/g N overnight. This suggests that some patients received a considerable surplus of energy in proportion to protein than is present in the normal West-European diet (approximately 150 to 200 kcal/g N). AA were given in a fixed amount of 27 g. The variation in calorie supply resulted from the G concentrations in the dialysate, which were chosen to meet ultrafiltration targets. The best energy-to-protein ratio for optimal protein accretion is unknown and remains to be determined.

### Table 3. Nitrogen balance

<table>
<thead>
<tr>
<th>Patient</th>
<th>Energy Intake</th>
<th>Nitrogen Intake</th>
<th>Excretion (g N/d)</th>
<th>Balance (g N/d)</th>
<th>Difference (g N/d)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Diet (kcal/kg per d)</td>
<td>Dialysate (kcal/kg per d)</td>
<td>Dialysate (g/d)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>20</td>
<td>12.3</td>
<td>10.19</td>
<td>4.25</td>
<td>8.99</td>
</tr>
<tr>
<td>2</td>
<td>19</td>
<td>3.4</td>
<td>9.17</td>
<td>4.25</td>
<td>11.40</td>
</tr>
<tr>
<td>3</td>
<td>24</td>
<td>6.4</td>
<td>12.53</td>
<td>4.25</td>
<td>11.51</td>
</tr>
<tr>
<td>4</td>
<td>26</td>
<td>5.3</td>
<td>11.63</td>
<td>4.25</td>
<td>12.58</td>
</tr>
<tr>
<td>5</td>
<td>27</td>
<td>5.5</td>
<td>12.37</td>
<td>4.25</td>
<td>12.59</td>
</tr>
<tr>
<td>6</td>
<td>13</td>
<td>2.7</td>
<td>9.65</td>
<td>4.25</td>
<td>18.53</td>
</tr>
<tr>
<td>7</td>
<td>18</td>
<td>3.3</td>
<td>10.51</td>
<td>4.25</td>
<td>11.93</td>
</tr>
<tr>
<td>8</td>
<td>13</td>
<td>4.1</td>
<td>6.29</td>
<td>3.40</td>
<td>9.14</td>
</tr>
</tbody>
</table>

### Table 4. Serum biochemistry before study and at the end of each study period

<table>
<thead>
<tr>
<th></th>
<th>Prestudy</th>
<th>End AAG Dialysis Period</th>
<th>End G Dialysis Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bicarbonate (mmol/L)</td>
<td>22.8 ± 2.2b</td>
<td>24.5 ± 1.7c</td>
<td>26.3 ± 1.0</td>
</tr>
<tr>
<td>Urea (mmol/L)</td>
<td>22.7 ± 7.1</td>
<td>21.1 ± 4.1</td>
<td>21.1 ± 5.1</td>
</tr>
<tr>
<td>Creatinine (μmol/L)</td>
<td>915 ± 251</td>
<td>878 ± 242</td>
<td>770 ± 237</td>
</tr>
<tr>
<td>Phosphate (mmol/L)</td>
<td>2.0 ± 0.4</td>
<td>1.9 ± 0.6d</td>
<td>2.1 ± 0.4</td>
</tr>
<tr>
<td>Albumin (g/L)</td>
<td>38 ± 3.0</td>
<td>38 ± 3.0</td>
<td>39 ± 3.0</td>
</tr>
<tr>
<td>Glucose (mmol/L)</td>
<td>4.4 ± 0.6</td>
<td>4.2 ± 0.5</td>
<td>4.6 ± 1.0</td>
</tr>
<tr>
<td>Insulin (mU/L)</td>
<td>32.1 ± 9.9</td>
<td>37.0 ± 10.9</td>
<td>37.8 ± 10.9</td>
</tr>
<tr>
<td>Glucagon (ng/L)</td>
<td>67.9 ± 21.7</td>
<td>71.4 ± 46.5</td>
<td>72.3 ± 31.4</td>
</tr>
<tr>
<td>Dialysate urea (mmol/24 h)</td>
<td>ND</td>
<td>264 ± 85</td>
<td>247 ± 71</td>
</tr>
<tr>
<td>Dialysate protein (g/24 h)</td>
<td>ND</td>
<td>7.5 ± 3.2</td>
<td>6.8 ± 2.6</td>
</tr>
</tbody>
</table>

aData are mean ± SD. ND, not determined.
bP = 0.022 versus G.
cP = 0.005 versus G.
dP = 0.04 versus G.
slightly lower than on G dialysis but remained within the normal range. In six of eight patients, the levels of serum bicarbonate were even higher than the prestudy levels; this may be attributable to the use of dialysis fluids that contained lower buffer concentrations (35 instead of 40 mmol/L) in some patients in the prestudy period. Furthermore, in the prestudy period, some patients performed fewer than six cycles during nightly dialysis. This suggests that when AA are given in a dose of 27 g in which sufficient amounts of buffer are also present, acidosis can be prevented.

In summary, APD with dialysate composed of a mixture of AAG improves protein anabolism. This finding promises an improvement of nutritional status of PD patients with inadequate protein intake. Studies in larger groups, especially in those with malnourishment, inflammation, and anorexia, are needed to evaluate the long-term clinical relevance of this concept.

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References
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