Hemodialysis Prescription and Life Expectancy

To the Editor:

Hornberger [1] in his otherwise thoughtful analysis of dialysis adequacy promotes a prevalent myth, that the survival of dialysis patients in the United States has been decreasing over the past decade. None of the four references cited by Hornberger validate the statement that “Aggregate survival for patients receiving hemodialysis in the United States has declined during the past decade.”

As reported in 1993 by the United States Renal Data System (USRDS) [2], Table E.30, between 1980 and 1990, crude (unadjusted) 1-yr survival of American dialysis patients actually improved. For example, respective survival of those aged 20 to 24 rose from 85.64% in 1980 to 93.21% in 1990. Diabetic patients who had a 1-yr survival of 65.80% in 1980 reached 73.93% in 1990. Total crude survival, which was 75.83% in 1980, increased to 76.91% in 1990, despite increases in the number of diabetic and geriatric patients. My purpose in writing is not to preclude needed efforts or strategies designed to improve the survival of dialysis patients in the United States, but rather to insist on starting with facts as they are. We are in the midst of a wave of “America bashing,” in which the annual survival of U.S. dialysis patients is presented as starkly inferior to that attained in Europe or Japan. Whether or not this assertion is true, and there are rational arguments to the contrary, it should not be necessary to begin the debate with the frequently repeated, although wrong, allegation that mortality is increasing in the United States.

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REFERENCES


Response

A primary motivation for the development of clinical guidelines is to provide health professionals with an up-to-date summary of the medical evidence for best clinical practices, thereby limiting “unnecessary” and potentially harmful and costly variations in the provision of care. Data collected by the USRDS, however, have led to heightened concern about the effects of changes in dialysis care (e.g., shortened dialysis, high-flux dialysis, reuse) on patient outcomes, particularly survival [1]. Dr. Friedman is correct that the 1993 USRDS data suggest an improvement in 1-yr survival at the end of the 1980s. An improvement in long-term survival is not yet established. Aggregate 2-yr survival for patients starting dialysis in 1980 decreased steadily from 60.6 to 58.6% for patients starting dialysis in 1986 and increased slightly to 59.8% for patients starting dialysis in 1989 [2]. Five-year survival decreased from 33.7 to 27.7% for patients starting dialysis in 1980 compared with patients starting dialysis in 1986. The two leading hypotheses for increased aggregate mortality were changes in the reporting of data and changes in the age and severity of illness of the patient population. The alternative hypothesis that quality of care may be an important consideration is based on correlations of reduced dialysis-treatment duration and increased mortality and the evidence that a substantial fraction of patients were not treated with a minimally acceptable level of Kt/V, based on findings of the National Cooperative Dialysis Study. The studies of the efficacy and cost effectiveness of dialysis treatment options were intended to be applicable to dialysis patients, regardless of their national origins; comparisons of the quality of care and outcomes of patients in the United States with patients in other countries were not intended.

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REFERENCES