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Authors' Reply

We thank Chilcot and Farrington[1] for their interest in our paper[2] and thoughtful comments surrounding the treatment of depression in hemodialysis patients. We agree with the letter writers that our observational study was not designed to evaluate the effect of antidepressant pharmacotherapy (versus no treatment) on mortality among individuals with hemodialysis-dependent ESRD. Under our active comparator new-user design, we could only conclude that the initiation of a higher (citalopram and escitalopram) versus lower (fluoxetine, fluvoxamine, paroxetine, and sertraline) QT-prolonging potential selective serotonin reuptake inhibitor (SSRI) was associated with a higher risk of sudden cardiac death.[2] Our study was designed to reflect a clinician's decision to prescribe an SSRI with higher versus lower QT-prolonging potential to a hemodialysis patient (*i.e.*, a treatment choice encountered in real-world practice).[2–4] The study provides population-specific safety information that clinicians can consider when prescribing SSRI therapy to hemodialysis patients.

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