Author's response to reviews

Title: Monitoring of hemodialysis quality-of-care indicators. Why is it important?

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Author's response to reviews: see over
Dear Editor,

Thank you very much for reviewing our manuscript « Monitoring of hemodialysis quality-of-care indicators: Why is it important? ».
We are pleased to submit a revision of our case article, which takes into account the constructive remarks of external reviewers.
Special care has been taken in modifying this manuscript according to your concerns and we sincerely do hope that this revised version will satisfactorily address requirements for publication in your journal.

Sincerely,

Steven Grange

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**POINT-BY-POINT RESPONSE**

~~~~~~ REVIEWER COMMENTS ~~~~~~~

**Reviewer #1:**

“Seems that the method and discussion sections is too long. These sections should be changed to concise”

This study underlines the importance of monitoring quality-of-care indicators. We think that attainment of clinical and biochemical targets strongly depends on the technical specificities of dialysis. That's why we found important for the good interpretation of the article to give every detail concerning dialysis support and drugs prescriptions in the method section. Nevertheless, we took special care in reducing the Methods and Discussion sections as far as possible.

**Reviewer #2:**

**Major Compulsory Revisions:**

“Dialysis dose: Authors used OCM for calculation of dialysis adequacy, it is known that OCM underestimates the delivered dose and they should mention this”

Thank you for your remark. We agree that the delivered dose (Kt/V) is underestimated when using some online conductivity-based devices (Petitclerc et al, Nephrol Dialysis Transplant 1995). Contrary to ionic dialysance (Hospal), we did not find any specific data in the literature showing that the Kt is underestimated with the Online Clearance Monitoring (OCM) of Fresenius.
In addition to potential bias related to Kt estimation, the urea distribution volume (V) is overestimated with the anthropometric Watson formula, which is used with the OCM of Fresenius 5008 (default settings). Thus the Kt/V is underestimated in most cases.
Importantly, we did not estimate the urea distribution volume with the Watson formula, but with the Body Composition Monitor (BCM). Therefore, with the OCM device-based Kt and the BCM-based V, we believe that the Kt/V reported in our study is as precise as could be in such conditions.

“Intradialytic parenteral nutrition was prescribed in the patients who experienced dietary support and/or oral supplements failure. Please explain in more details.”

We used Smofkabiven (Fresenius Kabi, France) at the initial dose of 1100 kcal per dialysis session. The dose was increased at 1600 kcal per dialysis session in case of good tolerance. These information are now included in the revised manuscript.

“I prefer if authors could point to the results of EVOLVE trial recently announced which is in contrast to this finding”.

Thank you for your appropriate and up-to-date remark concerning the results of the EVOLVE trial. They are in contrast with the results of Block et al. Thus we obviously added the conclusions of the EVOLVE trial in the revised discussion of our study, according to the reviewer’s remark. The latter results show once again the complexity of interpreting the results of observational studies.

Minor Essential Revisions:

“The language of the paper needs more careful revision, there are many linguistic and grammar mistakes, I advise authors to seek help of a native English speaking person”

Our manuscript was corrected by a native English speaking person. Consequently, we do hope that all the mistakes will have been rectified.

“Abstract : is very vague, specially the methodology section, even the number of the patients is not mentioned, I advise to be written again in a simple and clear way”

We simplified the abstract and mentioned the number of patients included in the study.

“Results; Text section is very concise, tables and figures need more description in the text section.

Table 2: the variables should be well defined. Patients number table 2, 124, table 3 Jan 2009, 65. Till the end of the study I do not recognize how many patients were included. Table 3 need thorough revision. No need to mention daily HD if not used. Please add reference units between brackets.”

We had deliberately chosen to present the results in the tables and figures because we thought it was clearer and because of the length of our article which seems already important to us, as was underlined by reviewer 1.

Altogether, 124 patients were included in the study. 33 patients were evaluated during the entire follow-up period. 65 patients were present in our dialysis center in January 2009. 69 patients were present in our dialysis center in April 2010, but after having excluded the 33 permanent patients, the other patients were not the same in January 2009 and April 2010.

We took in account all your remarks concerning the tables, figures and units and applied the adapted corrections in the revised manuscript.
Reviewer #3:

We thank the reviewer for his positive feedback and constructive remarks. We fully agree with the importance of focusing on indicators based on strong evidence, although such indicators are lacking in this clinical setting. We have enhanced the discussion stressing on the importance, in our view, of using indicators for dialysis adequacy, anemia, serum albumin, and the use of a vascular access other than an arteriovenous fistula.

In addition, the importance of reverse epidemiology in the observational studies performed in this population is now discussed. Whether using quality-of-care indicators makes a significant difference in clinical practice certainly remains to be established, and we believe such observational studies are a first step in an attempt to design specific prospective studies addressing this point.