Dear Sir,

The correction of anemia in hemodialysis patients with human recombinant erythropoietin increases appetite, anabolic effects, and improves physical, psychological activities and endocrine functions. As the sense of well-being improves, the patients increase food intake and frequently their compliance with dietary restriction may decrease. Plasma potassium must be monitored more frequently and, in some cases, the dialysis protocol is adjusted [1, 2]. Plasma lipid abnormalities are common among patients undergoing chronic hemodialysis, who are particularly prone to diffuse atherosclerosis [3]. During erythropoietin treatment, besides dietary changes, other factors related to hematocrit increase: tissue oxygenation, enzyme activity, physical and endocrine function improvement, all of which can influence lipid metabolism. There are a few and conflicting reports about the effects of erythropoietin on the lipid profile [1, 4, 5]. For these reasons it would be interesting to know whether long-term treatment with erythropoietin could induce changes in the lipid profile of hemodialysis patients.

The initial dose of erythropoietin was 100 U/kg per hemodialysis, and was then adjusted according to the Hb concentration. Thereafter, the patients affected by diseases or administered with drugs known to influence lipid metabolism were excluded from the final analysis. All lipid measurements were performed in a single laboratory with standard techniques. Dialysis efficacy (Kt/V) and patients’ dry weight did not change significantly throughout this period. The lipid patterns in 23 patients taking erythropoietin, dialyzed 63.65 ± 7.01 months, and in 25 patients without erythropoietin because of absence of health insurance and dialyzed 59.52 ± 9.38 months, were analyzed. In this study, patient groups’ predialysis blood total cholesterol, triglyceride levels, sex, age and time on hemodialysis were not significantly different (p > 0.05). In the patients taking erythropoietin, serum tri-glycerides, LDL cholesterol, apolipoprotein A1 and apolipoprotein B levels were higher than in the patients without erythropoietin (p < 0.001; table 1). Total cholesterol, lipop-
protein (a) and HDL cholesterol levels were not significantly different between the two groups (\(p > 0.05\)). The differences between the two groups were the lower mean concentration of apolipoprotein A1 and the higher prevalence of ‘atherogenic’ levels (i.e. < 90 mg/dl) of this lipoprotein in the patients not in the erythropoietin therapy group (table 2).

We conclude that long-term treatment with erythropoietin significantly changes some of the lipid patterns and improves serum apolipoprotein A1 levels in hemodialysis patients. Other studies and longer observation periods will be needed to confirm our results.

References


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