Hemodynamic Behavior During Hemodialysis: Effects of Dialysate Concentrations of Bicarbonate and Potassium

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Abstract
Background/Aims: Ultrafiltration that occurs during hemodialysis (HD) promotes profound alterations in a relatively short period of time. The dialysate content of bicarbonate (DBic) and potassium (DK) may have impact over intradialytic hemodynamics, which goes beyond ultrafiltration, and its impact was evaluated in a prospective cohort. Methods: 30 patients under HD were submitted to hemodynamic assessment (HA) at the beginning and at the end of HD sessions, through a non-invasive method. Serum minus dialysate potassium concentration was expressed as K-Gap. Cardiac index (CI) and peripheral arterial resistance (PAR) variation (post-HD minus pre-HD) were expressed as ΔCI and ΔPAR. Dialysate content of sodium and calcium were expressed as DNa and DCa, respectively. Results: Mean DNa, DK and DBic were, respectively, 136.4 ± 1.1, 2.1 ± 0.6 and 38.2 ± 2.1 mEq/L. In 15 patients, DCa was >1.5 mmol/L and in the other 15 patients ≤ 1.5 mmol/L. The K-Gap ranged from 1.4 to 5.1 mEq/L (median 3.0 mEq/L). There was a reduction in post-HD CI and systolic blood pressure (ΔCI = -0.72l/min/m² and -11.3±15.1mmHg, respectively, p<0.001 for both). Conversely, PAR increased (ΔPAR = 272dyn.s/cm⁵, p<0.001). Lower post-HD CI was was associated to higher DBic (p=0.0013) and lower K-Gap (p=0.026). In multivariate analysis, ΔCI was dependent on DBic and K-Gap, whereas ΔPAR was dependent on dialysate calcium during HD. Conclusion: We confirmed that Na and Ca dialysate content exerts and important role on hemodynamic during HD. In addition, our findings pointed out that higher dialysate concentrations of bicarbonate and potassium promote lower cardiac performance at the end of hemodialysis session.
Introduction

Not only traditional cardiovascular (CV) risk factors, but also bone mineral disorders and chronic volume overload play major role in the high mortality observed in chronic kidney disease (CKD) population [1-3]. Individualized hemodialysis (HD) is prescribed by nephrologists in order to keep CKD patients close to optimal physiologic conditions, through reaching dry weight and keeping serum electrolytes, hemoglobin and bicarbonate concentrations within a normal range. Notably, volume overload leads heart and vascular bed to a stressful hemodynamic condition, in which both are submitted to an overfilling state during the interdialytic interval, while ultrafiltration (UF) during HD treatment promotes rapid volume removal. This process may be accompanied by significant intradialytic hypotension and possibly, transient myocardial ischemia, which may impair left ventricular (LV) function even after restoration of myocardial blood flow, a phenomena known as myocardial stunning (MS), which is a cause of chronic LV dysfunction [4].

In maintenance HD treatment, dialysate prescription could exert significant impact over hemodynamic stability during the UF process [5-7]. It is already known that higher dialysate concentrations of sodium and calcium promote better UF tolerability, with lower hypotensive episodes during HD [8]. Nevertheless the role of other electrolytes on intradialytic hemodynamics remains subject of debate.

Individualizing dialysate content of bicarbonate and potassium may bring serum concentrations of these electrolytes close to normal range. Nevertheless, the impact of such prescription on intradialytic hemodynamics remains unknown. Therefore, the aim of the present study was to investigate, through a non-invasive methodology, the impact of dialysate content of bicarbonate and potassium on hemodynamic changes during HD treatment.

Patients and Methods

Study population

Adult patients receiving HD for at least 6 months were prospectively enrolled in this observational study. Patients with diabetes mellitus, non-sinusual cardiac rhythm, recent parathyroidectomy (less than 6 months), and prior history of congestive heart failure were excluded.

Study protocol

The study was performed according to the guidelines of the Helsinki Declaration and was approved by the Research Ethics Boards of the Universidade de São Paulo (CAPPesq #235.350). All subjects provided written informed consent before participation.

During the study, there was no change in dialysate content of sodium (DNa), potassium (DK), calcium (DCa), glucose and bicarbonate (DBic).

All HD sessions were performed using Fresenius 4008S machines and high flux polysulfone membranes (Fresenius Medical Care™, Bad Homburg, Germany). Blood flow was set to 350 ml/minute and dialysate flow to 800 ml/min in all patients.

Laboratory Values

Blood tests were performed before and after each dialysis session. Biochemical concentrations of serum Ca, P, Na, K, creatinine, albumin and hemoglobin were measured. Serum intact parathyroid hormone (PTH) levels were measured using a chemiluminescence assay (RR = 15-65 pg/ml). HD adequacy was assessed by monthly Kt/V measurements using the Daugirdas’ equation [9]. Additionally, the difference between serum and dialysate concentration of bicarbonate, potassium and sodium were calculated and named as Bic-Gap, K-Gap and Na-Gap, respectively.

Hemodynamic measurements

Cardiac output index (CI), stroke volume (SV - integrated mean of the flow waveform between the current upstroke and the dichotic notch), peripheral arterial resistance (PAR - ratio of mean arterial pressure to stroke volume multiplied by heart rate) and blood pressure (BP) were accessed by finger beat-
to-beat monitor Finometer® (Finapress Medical Systems BV, Arnhem, The Netherlands) within 15 minutes after starting HD session (pre-dialysis) and again, 15 minutes before its end (post-dialysis). If frequent extra systoles were observed, monitoring was interrupted and the entire protocol was repeated afterwards. Ectopic beats were excluded from analysis. Differences between post- and pre-HD CI and PAR were expressed as ΔCI and ΔPAR, respectively.

**Statistical analyses**

Categorical variables were presented as proportion, and continuous variables were presented as mean ± SD unless indicated otherwise. Differences between continuous variables were calculated using Student t test or Mann-Whitney U test as appropriate. The χ² or Fisher’s exact test was used to compare categorical variables. Paired t test or Wilcoxon matched-pairs were used to compare variables pre- and post-hemodialysis, as appropriate. Relationships between single variables were examined by Spearman correlation coefficient. Multivariable relationships between ΔCI and independent variables, and between ΔPAR and independent variables were also examined by stepwise linear regression, with P < 0.05 to enter and P > 0.1 to remove. A two-tailed P value < 0.05 was considered significant. Analyses were performed with SPSS 21.0.1 (SPSS Inc., Chicago, USA) and GrapPad Prism 6 software (San Diego, USA).

**Results**

**Baseline characteristics**

As shown in Table 1, our population (N = 30) was relatively young, and with a high dialysis vintage. Sixty percent of them had arterial hypertension and also were taking hypotensive drugs. The dialysis dose (measured by standard Kt/V), serum albumin and hemoglobin levels were within recommended targets. The ultrafiltration rate was high.

**Dialysate prescription**

Mean DNa, DK and DBic were, respectively, 136.4 ± 1.1, 2.1 ± 0.6 and 38.2 ± 2.1 mEq/L. In 15 patients, DCa was >1.5 mmol/L and in the other 15 patients ≤ 1.5 mmol/L. The K-Gap ranged from 1.4 to 5.1 mEq/l (median 3.0 mEq/L) and the Bic-Gap ranged from -24 to -8.7 mE/L (median -17.8 mEq/L).

**Biochemical and hemodynamic variations secondary to HD treatment**

Extracellular fluid removal secondary to ultrafiltration caused an expected reduction in SV and CI and a compensatory PAR increase. All but three patients decreased post-HD CI. From pre- to post-HD, mean CI drop was -0.72 l/min/m² (range: -2.68 to 0.44 l/min/m²). Conversely, PAR increased in all but five patients (mean increase: 272 dyn.s/cm², range: -522 to 2,231 dyn.s/cm²). Systolic BP was significantly reduced (from 133.2 ± 23.8 to 121.9 ± 25.4 mmHg, p=0.0003), which was not observed for diastolic BP (from 74.5 ± 12.2 to 74.5 ± 13.6 mmHg, p=0.990). All these significant hemodynamic changes are shown in Figure 1. Diffusive process promoted an increase in serum bicarbonate (from 20.7 ± 3.4 to 29.6 ± 3.3 mEq/L, p<0.0001) and a decrease in serum potassium (from 5.2 ± 0.5 to 3.8 ± 0.5 mEq/l, p<0.0001).
Silva et al.: Hemodynamic Behavior in Hemodialysis: Dialysate Bicarbonate and Potassium Content

Higher DBic presented a higher post-HD CI drop (−0.92 ± 0.59 l/min/m² vs. −0.09 ± 0.47 l/min/m², p=0.002). There was no difference in ΔPAR and UF rate.

A multivariable analysis was done to elucidate factors related to ΔCI and ΔPAR as a consequence of HD treatment, in which all significant biochemical variables and dialysate content profile were modeled together, adjusted to UF rate. All models are seen in Table 3. ΔCI was independently related to DBic and K-Gap, which accounted for 51.2% of its variation during HD. Higher DBic (>38 mEq/L) and lower K-Gap were associated to lower post-HD CI. ΔPAR was independently related to DCa, which explained 31.9% of its variation during HD.

Discussion

In this study, we found that ΔCI is strongly dependent on dialysate concentrations of bicarbonate and potassium. Lower post-HD CI (higher drop) was associated to higher DBic and lower K-Gap.
Hemodynamic changes during hemodialysis

Ultrafiltration, a process that removes intravascular volume, promotes a controlled hypovolemic state during HD sessions. In this study, fluid removal led to stroke volume reduction, with consequent CI decrease, while PAR increased, with little changes in BP. These same hemodynamic findings were obtained by Riddez et al [10], in a study that performed a venosection of 900 ml in healthy individuals under invasive hemodynamic monitoring. However, HD is a much more complex procedure, in which serum electrolytes and osmolarity change throughout its duration, according to a myriad of factors, such as patients’ clinical characteristics, HD efficiency and dialysate prescription, which also influence hemodynamic response to the induced hypovolemia.

Bicarbonate dialysate content

Metabolic acidosis is common in patients under maintenance HD and may have adverse consequences not only for bone metabolism [11, 12] but also on nitrogen balance, which might decrease skeletal muscle mass [13]. For such reasons, nephrologists struggle to reach KDIGO’s goal of pre-HD serum bicarbonate concentration of 22 mEq/l [14] which can be obtained by increasing dialysate bicarbonate concentration [15]. Nevertheless, a recent prospective cohort study from DOPPS linked prolonged exposure to high dialysate bicarbonate levels to increased mortality [16]. Possible mechanisms are more frequent cardiac arrhythmias [17] and a greater propensity for intradialytic hypotensive episodes [7, 18], which could be related to higher intracellular shift of both calcium and potassium. In the present study, higher DBic was associated to a more pronounced decrease in post-HD CI, regardless of pre-HD serum Bic concentration. Although we did not directly accessed intradialytic myocardial contraction/perfusion, one could hypothesize that higher DBic content might lead to MS and, therefore, to a worse cardiovascular outcome in this population.
Potassium dialysate content

Reducing DK content is an efficient measure for removing more potassium in a single dialysis session [19]. However, potassium’s role on intradialytic hemodynamics remains elusive. In vitro studies have demonstrated increased myocardial contractility after acute exposure to potassium-deficient solutions [20, 21]. Conversely, chronic hypokalemia has an opposite effect, leading to inotropic response impairment after epinephrine or volume infusion [22]. Hypokalemia also affects vascular tonus, by inducing systemic vasoconstriction through a complex mechanism, which involves Na⁺-K⁺-ATPase inhibition, decreased uptake of norepinephrine into sympathetic nerve endings and increased calcium influx into vascular smooth muscle cell [23].

In this study, higher K-Gap (and, therefore, lower DK concentration) was associated to better post-HD CI. None of our patients were hypokalemic before HD. Our findings are consistent with increased myocardial contractility after acute reduction in serum potassium concentration, which are the same conclusions obtained by Brace et al. in a study performed with dogs treated with HD [24]. Such effect may be attributed to an ouabain-like effect of hypokalemia on sodium-potassium adenosine triphosphate of the myocytes [24]. Possibly, higher K-Gap promoted a more pronounced potassium removal, leading to a better myocardial performance at the end of HD session. Despite this favorable hemodynamic effect, it must be highlighted the risks associated to acute reductions in serum potassium on the development of arrhythmias and cardiac arrest during HD [25].

This study has some limitations: it was an observational study and the sample size was relatively small. We also did not directly measure effluent electrolyte concentrations in order to determine electrolyte balance during HD, which could explain some of our findings.

This study has several strengths: first of all, it describes how CI and PAR behave in response to ultrafiltration through a non-invasive assessment. Such behavior, although predictable, had never been described before through this methodology. Another strength was the demonstration that DBic and DK have independent impact over intradialytic hemodynamics. Previous studies only addressed the individual impact of DBic on hemodynamics. Additionally, as far as we are concerned, this is the first study to actually show the impact of acute hypokalemia on cardiac performance in humans under HD.

Conclusion

HD promotes a controlled hypovolemic state, with stroke volume and CI reduction, along with PAR increase in order to sustain BP. Dialysate content directly alters this hemodynamic balance: higher DBic and lower K-Gap lead to more profound post-HD CI reduction.

Disclosure Statement

The authors of this manuscript state that they do not have any conflict of interests and nothing to disclose.

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Silva et al.: Hemodynamic Behavior in Hemodialysis: Dialysate Bicarbonate and Potassium Content


