express their agreement with the conclusions we came to in the original review, to which we refer the reader,[1] and they demonstrate the interest in this subject that is aroused, which translates into a dynamism in the studies that are initiated and in the publications that arise in this regard.

Funding

This study received no specific funding from public, private or non-profit organisations.

Conflicts of interest

The authors have no conflicts of interest to declare.

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https://doi.org/10.1016/j.nefroe.2023.03.014

Comments on the consensus document on autosomal dominant polycystic kidney disease of the SENefro

Comentarios sobre el Documento de consenso de poliquistosis renal autosómica dominante de la SENefro

Dear Editor,

I have read the Consensus Document on Autosomal Dominant Polycystic Kidney[1] that the Spanish Society of Nephrology (Sociedad Española de Nefrología, SEN) drafted and published on its website and I would like to make some of comments on what has been exposed in that document.

They are based on the lack of definition of the term "rapid progressor" by the EMA[2] to establish some criteria that seem to me to be inaccurate. Anyone who starts renal replacement therapy before the mean global age for starting renal replacement therapy in Spain (65 years old) is considered a rapid

DOI of original article:
https://doi.org/10.1016/j.nefro.2021.04.017.

progressor. If a disease takes an average of X years to reach the terminal stage, the rapid progressors would be all those patients who reach that point before that X average, and slow progressors, who last longer than the average for that process. I believe that the overall average age at initiation of renal replacement therapy should not be used as a reference point since other diseases present at more advanced ages (diabetic nephropathy and nephroangiosclerosis) have an impact and therefore increase that average age. According to the logic used by the authors, it could also be said that any person who starts dialysis before the average life expectancy of the general population (80.6 years in men and 86 in women before the pandemic)[3] is a rapid progressor. Therefore most of our patients could be included in that definition. In type 1 polycystic kidney disease, the average onset of end-stage kidney failure is 54 years old,[4,5] and that should be, in my opinion, the point at which a person with polycystic disease is considered a rapid or slow progressor.

In addition, it is suggested to start treatment with tolvaptan in patients until 60 years old. I have only seen one study[6] (REPRISE) including patients >55 years. In that study, in the subgroup of patients >55 years old, the difference in progression was similar with respect to the placebo group (GFR drop: 2.54 vs 2.34 ml/min [p = 0.65]). The study included a limited number of patients, but no other study affirms otherwise; therefore, no treatment should be started at these ages outside of a controlled clinical trial.

I believe that the society allows us to manage public funds, that are limited, with a commitment to maximum efficiency. That means using them in those cases in which these treatments are truly useful. If we cannot manage these funds, we will totally lose the capacity of managing them.

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https://doi.org/10.1016/j.nefroe.2023.03.006

Reply to Comments on the SENefro Consensus Document on Autosomal Dominant Polycystic Kidney Disease

Respuesta a Comentarios sobre el Documento de Consenso de Poliquistosis Renal Autosómica Dominante de la SENefro

Dear Editor,

We appreciate the interest in the Ċonsensus Document on Autosomal Dominant Polycystic Kidney Disease (ADPKD).[1,2] The problem of the concept of rapid progression is raised, which has not been resolved. KDIGO defines rapid progression as a loss of glomerular filtration rate (GFR) >5 ml/min/1.73 m^2/year.[3] Based on the results of the REPRISE trial, it does not appear to be an adequate definition to identify those ADPKD patients who may benefit from tolvaptan[4]; the group of patients under 55 years of age treated with placebo lost GFR at a rate of −4.60 ml/min/1.73 m^2 in one year, and yet tolvaptan slowed the loss of GFR by 33%, a result offered by few or none of the chronic kidney disease (CKD) treatments. For instance, at 12 months neither dapagliflozin nor canagliflozin

DOI of original article:
https://doi.org/10.1016/j.nefro.2022.07.002.