A) COMMENTS ON PUBLISHED ARTICLES

Comment on: IgA nephropathy and lupus antiacoagulant: an incidental association?

Nefrología 2009;29**(1)**:81.

Dear Editor,

We read with interest the article by Heras et al.[1] They reported the occurrence of IgA nephropathy (IgAN) in two sisters, one of whom had lupus anticoagulant (LA) and wondered whether this association was incidental or related to a common immune pathogenetic mechanism.[1]

Although not extensively studied in IgAN, there have been some reports on the associations of antiphospholipid antibodies with Henoch-Schönlein purpura (HSP),[2,3] which has a common pathogenesis of IgAN. Also, Kawakami et al.[4] recently reported a relatively high prevalence of antiphospholipid antibodies in adults with HSP. In their report,[4] 22 (73%) of the 30 HSP patients were positive for serum IgA anticardiolipin antibodies, 19 (63%) had IgA anti-phosphatidylserine-prothrombin complex (anti-PS/PT) antibodies and 20 (67%) IgM anti-PS/PT antibodies, suggesting that the prevalence of antiphospholipid antibodies have been underestimated in patients with HSP in the past, although thrombotic episodes were not evident in their patients.[4] They also showed that serum IgA anticardiolipin antibody levels were also significantly associated with proteinuria (a marker of nephritis severity).[4] Considering the similarity of renal histopathology between IgAN and HSP nephritis, antiphospholipid antibodies may have a pathogenic role in the development of IgA-mediated glomerulonephritis.

Furthermore, because some authors showed that antiphospholipid antibodies could cause thrombosis in patients with HSP,[2,3] and it was reported that anticardiolipin antibodies of IgG, IgM and IgA isotypes from patients with the antiphospholipid syndrome could play a role in thrombosis in vivo,[5] careful clinical monitoring for thrombosis would be necessary in patients with HSP or IgAN who show positive antiphospholipid antibodies.

Therefore, further studies should be performed to evaluate the prevalence and pathogenic role of antiphospholipid antibodies in patients with IgAN and the relationships among antiphospholipid antibodies, the severity of IgAN, and thrombosis should be further elucidated in the future.

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A discussion on quality

Nefrología 2009;29**(1)**:81-82.

Dear Editor,

There is a current trend towards the implementation of quality systems in haemodialysis, which is without doubt beneficial for all, both patients and health professionals. The interest of nephrologists is shown in the recent abundance of publications on this issue.[1,2] However, I would like to discuss[3] this new aspect of our study both verbally and physically. In order to demonstrate the virtues of the quality indicators, some of the articles[4,5] use very weak basal data and therefore the "improvement margin" is very wide. This should lead us to ask why we are neglecting these patients. In my opinion, there must be a sufficient "quality and quantity" of health professionals to provide proper treatment for chronically ill haemodialysis patients. I also believe that the Scientific Organisations involved should, as far as possible, place pressure on the corresponding administrations, so that all haemodialysis patients are treated by qualified nephrologists that the ratio of patients per nephrologists and nurses is acceptable and that paperwork is reduced to ensure greater contact between the nephrologist and patient.

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3. http://www.rae.es/

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B) BRIEF PAPER ON RESEARCH AND CLINICAL EXPERIENCES

Sleep quality in dialysis

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Dear Editor,
The prevalence of sleep disorders in the general public varies between 10 and 40%;[1] this figure increases to 50% in dialysis patients.[2,3] There are very few studies comparing sleep quality according to the type of renal replacement therapy, which differ dramatically in terms of lifestyle.

In our study, we compare sleep quality between patients undergoing Peritoneal Dialysis (PD) and those undergoing Haemodialysis (HD), with samples of 49 patients similar in age, comorbidity index and time in dialysis.

The *Pittsburg Sleep Quality Index* (PSQI) was used. This consists of 24 items grouped into seven components: subjective sleep quality, latency, duration, efficiency, disturbances and daytime dysfunction. The higher the score, the lower the sleep quality.[4,5]

PD was generally performed according to a daily routine (95% of patients underwent automatic PD.) In the group of patients undergoing HD, 49% underwent HD in the first shift (08.00-12.00) and 51% in the second (14.00-18.00.)

A total of 73% of HD patients presented with sleep quality problems compared to 55% of PD patients. The majority of the problems were slight to moderate. No relationship was found between sleep quality and the Charlson Comorbidity Index. However, in the overall sample, women presented with poorer sleep quality. Table 1 shows the affected sleep areas according to the type of therapy.

The only component with a higher score in PD was that of disturbances. This group of patients had a greater hourly routine than HD patients. In addition, HD patients who underwent treatment in the first shift presented a lower score.

Sleep quality is an important and determining factor in the quality of life during dialysis. The significant differences between both groups are consistent with the lifestyle associated with each technique.

The PSQI survey is a simple tool offering very complete information on sleep quality. The implementation of actions aimed at improving the hygiene of sleep may be an excellent way to improve the patients' quality of life in an efficient and effective manner.

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Table 1

PSQI Components	Peritoneal	Haemodialysis	Sig.
Subjective quality	0.74	1.06	0.054
Latency	1.46	1.56	0.680
Duration	0.68	1.15	0.030
Efficiency	1.32	1.77	0.054
Disturbances	1.38	1.25	0.301
Use of hypnotics	0.84	0.92	0.779
Daytime dysfunction	0.24	0.60	0.004
Sleep problems: total	6.70	8.35	0.057

PSQI: Pittsburg Sleep Quality Index.