# A) COMMENTS ON PUBLISHED ARTICLES

## Comment on "Kaposi´s sarcoma in the early post-transplant period in a kidney transplant recipient"

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**To the Editor,,**

We have read the article by Ercam et al. in the Clinical Case Section of Nefrologia about a case of Kaposi's sarcoma in a transplant recipient.[1] Renal transplantation and immunosuppressive medication used for it leads to a high rate of tumors and among them Kaposi's sarcoma is common. There is extensive literature on the development of malignancies after renal transplantation, so the description of another case does not seem to justify its publication. However, what seems novel and so the authors justify its interest is the prematurity of the Kaposi´s sarcoma development (only 4 months after renal transplantation), together with the authors statement that this would be the first reported case with this precocity.[1]

In 1990 we published a case of Kaposi's sarcoma associated with renal transplant developed 4 years after kidney transplant[2] and in which the skin lesions stabilized after withdrawing immunosuppressive medication. In the discussion of the case we pointed out references describing cases in 1979 and the time of appearance of the tumor could be even after three months of transplantation.[3] Interestingly before the time of our communication there have been published some references describing cases where tumor appear between first and 4 months after renal transplantation.[4,5]

It is true that most of the cases described in the literature the time elapsed from transplant to tumor development are longer than that of Ercam et al. and the well documented case by this authors is unusual on this matter, however it is also true that we get used to refer recent references in our publications, without taking into account some previous periods. **To be fair we should not forget that it is not easy to find past issues, either completely or it abstract.** Finally note that these circumstances should encourage us to avoid statements like "the first or only case or reference" given the lack of access to all available information.

### Conflict of interest

The authors declare that they have no conflicts of interest related to the contents of this article.

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## Increase of ischaemic colitis incidence in haemodialysis

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**To the Editor,**

Ischaemic colitis (IC) is a disease with an increasing incidence in haemodialysis (HD) patients, due to their changing profile (significantly older, with more cardiovascular disease and with increased survival in relation to the past)[1]. Despite the fact that IC can be secondary to vascular thrombosis or mesenteric vasospasm, the most frequent aetiology in HD patients is low output, which occurs during the session usually as a consequence of a lowering of blood pressure.

The case published by Gutiérrez-Sánchez et al.[2], despite concerning a patient who had only been on HD for two months, presented many of the classic characteristics of patients with non-occlusive ischaemic colitis: high vascular risk patient with hypotensive episode who developed rectorrhagia and abdominal pain[2]. In the study recently published by our group involving the most cases of non-occlusive IC in HD, the factors associated with suffering this disease were older age, diabetes mellitus (DM), cardiovascular history (such as peripheral vascular disease), time on dialysis and resistance to erythropoietin. This last parameter is shown to be an independent predictor in multivariate analysis (together with DM and time on HD), demonstrating the association of this symptom with inflammation and, consequently, with atherosclerosis[3]. In a published study that included incident patients on dialysis (HD and peritoneal dialysis), the risk factors associated with suffering from non-occlusive IC were similar, apart from time on dialysis. However, on studying the various

techniques, the authors found that the patients on peritoneal dialysis had a 1.5 times increased risk of suffering from this condition, despite being younger and having less comorbidity, which they associated with exposure to solutions with a high dextrose content[4].

In this case series, the authors found 80 % mortality; this contrasts to our study in which mortality in the acute episode was 59 %. However, we performed a case-control study with patients who survived the acute episode over an average of 56 months (± 69). We found that the patients with non-occlusive IC had significantly lower survival, attributable to the condition being the result of these patients' high cardiovascular risk. In fact, the causes of death were divided into infectious and cardiovascular. To date, the only study that compared survivors of non-occlusive IC with patients on HD was that by Bassilios et al., which showed identical survival in both groups, probably because it only included in the analysis those patients who survived more than three months[5].

As regards treatment, as was the case in the abovementioned study, it is usual to administer wide-spectrum antibiotic therapy and have a wait-and-see approach; surgery is opted for in the minority of cases (only 33 % in our study), which is likely due to the patients' profile (elderly, with cardiovascular risk, etc.). In fact, our results only revealed significant differences in age (younger) when we compared candidates for surgery with those in which a conservative approach was maintained. Previous studies have shown that the delay in carrying out surgery following diagnosis is associated with an increase in mortality[6].

As a result, it seems reasonable to establish a more conservative ultrafiltration profile in patients at high risk of suffering from non-occlusive IC, due to its harmful consequences in HD patients

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