**Canadian Society of Nephrology Guidelines/
Recommendations on Peritoneal Dialysis
Adequacy 2011—Response to Comments
by Liakopoulos *et al.***

We thank Liakopoulos *et al.* for their comments on our opinion-based recommendation that, in patients established on peritoneal dialysis (PD), serial assessment of membrane transport characteristics using the peritoneal equilibration test (PET) is not necessary in the absence of clinical suspicion of a change in transport status or ultrafiltration failure, such as the presence of volume overload. Their concern is two-fold: first, that development of fast transport status may indicate encapsulating peritoneal sclerosis (EPS), and second, that the PET is crucial to implementation of an optimal PD regimen.

We agree that EPS is a concerning complication of PD that is often associated with fast transport status. Nonetheless, routine serial assessment of peritoneal membrane characteristics was not felt to be indicated for these reasons:

1. Most patients who develop fast transport or ultrafiltration failure will not subsequently develop EPS (1), and thus the PET alone lacks specificity for the diagnosis. In addition, patients who develop fast transport status or ultrafiltration failure usually display signs such as volume overload, which should then prompt a reassessment of membrane characteristics, as recommended in the guidelines.

2. Evidence supporting the cessation of PD in fast transporters to prevent progression to EPS is lacking. In fact, EPS often develops after the cessation of PD for kidney transplant or transfer to hemodialysis (for reasons other than EPS) (2–5).

For those reasons, the Work Group feels that the added effort and expense imposed by routine serial PET assessment are not justified. We feel that early diagnosis and prevention of EPS are important goals in PD care that require further study.

The second comment by the authors, that the PET is crucial to implementation of an optimal PD prescription, is highlighted as being of particular importance in fast transporters who may have better outcomes with automated PD and icodextrin (6). In recent years, automated PD has become increasingly common in Canada, independent of transport status, because of patient lifestyle choice. We agree that a PET at the time of PD initiation may be a useful guide to a suitable prescription, but in general, patients with significant residual renal function tend to do well with most continuous ambulatory and continuous cycling PD prescriptions.

We disagree that routine serial PET is crucial to PD prescription in all patients. For example, in those who are clinically well on their current regimen, the PET result is unlikely to alter management regardless of transport status. We advocate close follow-up of all PD patients for clinical (and laboratory) signs and symptoms of inadequate dialysis. Potentially inadequately dialyzed PD patients should be reassessed, with a PET if necessary, and suitable prescription changes made at that time.

DISCLOSURES

The authors have no pertinent financial conflicts of interest to disclose.

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