

Table 1. Comparison between HHV-8-seronegative and HHV-8-seropositive groups

	HHV-8 seronegative	HHV-8 seropositive	P-value
Age (<i>n</i> = 805)	56.6 ± 16.5	59.3 ± 17.8	0.075
Gender (<i>n</i> = 805)			0.574
Male	408 (61.8%)	86 (59.3%)	
Colour/race (<i>n</i> = 805)			0.798
White	407 (61.7%)	88 (60.7%)	
Pardum	129 (19.1%)	30 (20.7%)	
Black	106 (16.1%)	21 (14.5%)	
Yellow	18 (2.7%)	6 (4.1%)	
Type of dialysis (<i>n</i> = 349)			0.748
Haemodialysis	239 (36.2%)	56 (38.6%)	
Peritoneal dialysis	46 (7.0%)	8 (5.5%)	
Immunosuppressive therapy (<i>n</i> = 803)			0.952
Yes	31 (4.7%)	7 (4.8%)	
Blood transfusion (<i>n</i> = 793)			0.385
None	374 (57.5%)	80 (55.9%)	
One	126 (19.4%)	23 (16.1%)	
Many	150 (23.1%)	40 (28.0%)	
Transplantation (<i>n</i> = 805)			>0.0001
None	629 (95.3%)	124 (85.5%)	
Kidney	27 (4.1%)	20 (13.8%)	
Others	4 (0.6%)	1 (0.7%)	
Sexuality (<i>n</i> = 717)			0.086
Heterosexual	588 (99.5%)	123 (97.6%)	
Homosexual	3 (0.5%)	2 (1.6%)	
Bisexual	0 (0.0%)	1 (0.8%)	
Personal antecedents (<i>n</i> = 723)			0.484
Yes	565 (95.0%)	124 (96.9%)	
HIV (<i>n</i> = 723)			0.096
Yes	6 (1.0%)	4 (3.1%)	
STDs (<i>n</i> = 710)			0.003
Yes	10 (1.7%)	8 (6.4%)	

Personal antecedents: use of intravenous drugs, use of condom, cytomegalovirus and hepatitis; STDs: sexually transmitted diseases; *n*: number.

Conflict of interest statement. None declared.

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Extended haemodialysis hours may improve the clinical outcome of patients on maintenance haemodialysis without increasing the cost

Sir,

The incidence of severe chronic kidney disease is rising worldwide, and the poor nations suffer more. Haemodialysis is the predominant form of renal replacement therapy in our environment and is still very expensive and hardly available to the majority of those who need it. At present the few patients who commence dialysis in Nigeria do not achieve adequate dialysis because of paucity of funds to sustain the treatment. The result is progressive deterioration in their clinical situation [1]. Recent reports suggest that a more frequent haemodialysis strategy might be expected to increase life expectancy by between 2 and 24 months depending on the frequency (four, five or six times per week). However, more frequent haemodialysis is much more expensive [2]. In Europe and America, more

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frequent but shorter durations of sessions are being advocated [2]. The same cannot be advocated for the poor countries since it is certainly more expensive.

When we reviewed the first 1-year experience of haemodialysis in Zaria, Kaduna State, Nigeria, it was observed that only 40% of those recommended for dialysis got started on the procedure and 80% of those who started could not continue maintenance haemodialysis beyond 3 months [1]. The situation was similar in other dialysis centres across the country. The major reasons were lack of financial resources to either commence or continue the treatment.

Some of our patients who had initially done well on the standard 4-h sessions three times a week for the oliguric and 4 h two times a week for those who made up to 500 ml of urine a day had reduced the frequency of dialysis because of poor funding. This resulted in progressive deterioration in their clinical condition. A tailor-made programme [3] was designed for this group of patients with the hope of maximizing the benefits they get from the money available to them. The programme extended the duration of dialysis to 6 h a session and also maximized the blood flow rate without increasing complications or the quantity of consumables. The cost of consumables used is what is paid for directly by the patients in the setting of our practice.

The urea reduction ratio (URR) was calculated as the ratio of the fall in blood urea divided by the predialysis blood urea. Equilibrated Kt/V was calculated directly from predialysis blood samples and postdialysis samples taken 30–60 min postdialysis with volume of distribution estimated as 0.5 times body weight [4]. The functional state of the patients was based on their subjective responses to the question ‘how do you cope at home and at work?’ and also on physical examination by the doctor.

Our patients on the extended duration programme showed significant improvement in their overall clinical condition compared to when they were on four hourly sessions with the same frequency of attendance. This was shown in all six patients who had better URR, higher Kt/V and were more active both at home and at work while on the extended hours programme than before it.

Our study, though limited to only six patients, has shown that prolonging the duration of dialysis for patients with inadequate treatment could improve the overall patient outcome without additional costs to the patient. Quality of life that concerns the well-being of the patient from his/her own perspective clearly improved.

Conflict of interest statement. I confirm that none of the authors has any interest that could influence them to have bias in this work.

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