



Inotropic Support in Severe Intra-dialytic Hypotension: A Comparison of Predialysis and Intradialytic Dopamine. A Single Center Retrospective Study

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Authors' contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

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ABSTRACT

Objectives: Despite advances made in dialysis delivery, management strategies for intradialytic hypotension (IDH) has largely remained suboptimal hence the need for more interventions to improve on it.

Methods: We compared in this retrospective study, predialysis dopamine (PDD) with intra-dialytic dopamine (IDD) in the treatment of severe IDH.

Results: Of the 2968 sessions, 518 (17.45%) had symptomatic IDH, of this, 9.65% had PDD while 12.16% had IDD. The mean age of all participants, participants with PDD, and those with IDD were 50.73 ± 6.51 years, 64.48 ± 8.22 years and 64.64 ± 10.31 years respectively, $P=0.001$. The intra-dialytic pulse rate increases, with BP reductions, were more with IDD treatments than PDD. Dialysis BFR, ultrafiltration volume, duration and dose were higher with PDD than with IDD treatment, $P=0.002$, $P=0.03$, $P=0.04$ and $P<0.001$ respectively. Hospitalization, dialysis termination and intra-dialytic death were more common with IDD than with PDD treatment, $P=0.08$, $P=0.001$ and $P=0.002$. PDD was commoner in females, advancing age and diabetes, $P=0.08$, $P=0.93$ and

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P=0.06. Independent associates of IDD were lower predialysis systolic, and diastolic BP, shorter dialysis duration, dialysis termination and intra-dialytic death.

Conclusion: The prevalence of overall IDH, of severe IDH using a nadir systolic BP less than 90 mmHg, and of severe IDH using a minimum 20 mmHg intra-dialytic fall in systolic BP were 17.45%, 1.68% and 2.12% respectively. Low dose PDD treatment of severe IDH allows for a relative optimization of the prescribed dialysis, gives higher dialysis dose and reduces the frequencies of dialysis termination and intradialytic death.

Keywords: Maintenance hemodialysis; Pre-dialysis dopamine; intra-dialytic dopamine; tachycardia; dialysis dose; dialysis termination; intra-dialytic death.

1. INTRODUCTION

Despite advances made over the years in managing intra-dialytic hypotension (IDH), its prevalence has remained high and likewise its complications [1]. This has largely be due to the complex interactive forces associated with its occurrence (patient, disease or dialysis related factors), from suboptimal preventive and treatment strategies, or from conditions that limit effective response to management strategies [2]. The occurrence of IDH is strongly tied to dialysis ultrafiltration, on a background of ineffective compensatory response to fluid removal [1-3]. Ultrafiltration can be minimized to reduce the frequency of IDH, however, this has to be weighed against the consequences of fluid overload which limits patients' quality of life (QOL), precipitate heart failure and other conditions associated with increased mortality [2,4].

The relationship between the inter-dialytic weight gain (IDWG) and the ultrafiltration rate (UFR) for any session is dependent on the interplay of forces such as the blood pressure (BP), blood flow rate (BFR) and the cardiovascular status particularly the cardiac reserve [5,6]. Various comorbidities like hypertension, diabetes, dyslipidemia and peripheral vascular disease (PVD) are known to be associated with CKD, more so with end stage renal disease (ESRD) and these worsen the clinical outcome of the disease [7]. CKD is particularly known to be associated with worsening cardiovascular profile, with more cardiac events and death [8,9]. Commonly, these comorbidities increase the risk of intra-dialysis complications and poor treatment outcome resulting in lower dialysis doses, higher frequencies of hospital admission, poor QOL and mortality [10,11]. An adequate dialysis dose usually entails higher BFR and UFR but these are expectedly, associated with BP reduction which might be severe enough to precipitate IDH and tissues ischemia that could lead to

myocardial ischemia, stunning and infarction, and brain damage [12]. The institution of measures to prevent wide BP reductions while maintaining relatively higher UFR would therefore be needed to deliver adequate dialysis doses, prevent IDH and its complications thereby decreasing morbidity and mortality [13].

Most often, routine measure at treating IDH (removing/treating precipitants, fluid resuscitation, amongst others) are not enough, particularly in low income nations (LINs) due to the non-availability/application of modern strategies used to manage IDH [14]. Various strategies involving the relaxation of the left ventricle in left ventricular hypertrophy (LVH) and reducing tachycardia, have been employed in managing IDH with minimal success [15,16]. Inotropes such as midodrine, dobutamine, sertraline and droxidopa, and others including antidiuretic hormone analogs and adenosine A1 receptor antagonist have been used in the past to prevent and treat severe or persistent IDH with varying success rates [17-22]. Wen-Yuan et al reported intra-dialytic use of dopamine with improvement in the dialysis dose, reductions in the frequencies of IDH, dialysis termination and hospital admissions, without worsening patients' QOL [23].

The occurrence of IDH prior to inotropic support could lead to further worsening of kidney function [3, 13]. Dopamine and other inotropes have been used to maintain effective blood pressure and tissue perfusion prior to, during and after major maneuvers on medical and surgical wards and, intensive care units (ICUs) [24]. Considering the benefits associated with the avoidance of IDH, measures to avoid its occurrence are worth undertaking. The use of inotropes in managing IDH is not well reported worldwide, more so, it has not been reported from a LIN. We hypothesize that pre-dialysis dopamine (PDD) is more effective in preventing and treating IDH

compared to intra-dialytic dopamine (IDD). We compare the pre-dialysis and intra-dialytic use of dopamine in preventing and treating severe IDH in a low income setting.

2. MATERIALS AND METHODS

This was a retrospective cohort study of 2968 maintenance hemodialysis (MHD) sessions received by 557 participants, and of which dopamine was used in managing 36 participants who had severe IDH in 113 sessions. Participants were aged between 16 and 81 years and had CKD using the KDOQI 2012 diagnostic criteria [25]. The studied sessions were given from August 2018 to July 2021 at the dialysis suite of Babcock University Teaching Hospital, Ilishan-Remo, Nigeria. The sessions were grouped into 2 cohorts, with PDD, and with IDD.

Variables retrieved from participants' case notes and dialysis chats included: age, gender, etiology, and type of kidney disease, hospitalizations, comorbidities, oxygen saturation (SPO₂), pulse rate (PR) and blood pressure (BP), time, and dose of dopamine administered. The results of serum electrolytes, urea and creatinine, and the monthly calculated urea reduction ratio (URR) and Kt/V were recorded.

Indications for predialysis dopamine: 3 or more consecutive episodes of severe IDH (intradialytic systolic BP less than 90mmHg with symptoms (nausea, yawning, cramps, dizzy spells, syncope, body pains and/or chest discomfort in which nursing intervention was unsuccessful, leading to dialysis termination, after ruling out and/or correcting modifiable factors such as fever, drug effect or food intake).

Indications for intradialytic dopamine: 3 or more consecutive episodes of severe IDH (at least 20 mmHg drop in systolic BP to less than 100 mmHg, with symptoms and, in which nursing interventions were unsuccessful, leading to dialysis termination, after ruling out and/or correcting modifiable factors causing IDH).

3. Predialysis dopamine was commenced 30 minutes before dialysis at 2-5ug/kg/min at 10-15 drops/minute (depending on the extent of BP drop) in 200ml of 0.9% saline.

4. Intradialytic dopamine was commenced 2-5ug/kg/min at 10-15 drops/minute (depending on the extent of BP drop) in 200 ml of 0.9% saline.

2.1 Exclusion Criteria

Sessions in which other inotropes were used were excluded.

Anticoagulation was with unfractionated heparin (5000 IU). All sessions were given with a dialysate flow rate (DFR) of 500ml/min. The dialysate sodium, potassium, calcium and bicarbonate were 140.0 mmol/L, 2.0 mmol/L, 2.0 mmol/L and 34.0 mmol/L respectively. Whenever sodium profiling was carried out prior to dopamine infusion (no sodium profiling was done after commencement of dopamine), the mean dialysate sodium concentration was documented.

2.2 Definitions

Tachycardia, classified as mild (PR-101-119/min), moderate (PR-120-139/min), severe (PR-140-149/min) and life threatening (PR \geq 150/min) [26].

Hypoxemia, defined as SPO₂ < 95% [27].

Dopamine doses, classified as low (< 5ug/kg/min), medium (5.01-9.99ug/kg/min), high (\geq 10ug/kg/min) [24].

Targeted post dialysis weight (TPDW) defined as predialysis weight plus volume of administered fluid minus UFV [5].

IDH defined as intra-dialytic fall in SBP \geq 20 mmHg [3].

Severe IDH, defined as 3 or more consecutive episodes of intradialytic systolic BP < 90mmHg with symptoms, in which nursing intervention was unsuccessful, leading to dialysis termination, after ruling out and/or correcting modifiable factors [28] or

3 or more consecutive episodes of intradialytic SBP reduction \geq 20mmHg to less than 100 mmHg, with symptom, in which nursing interventions were unsuccessful leading to dialysis termination (after ruling out and/or correcting modifiable factors [29].

Anemia, defined as hematocrit < 33% [30].

Hypoalbuminemia, defined as serum albumin < 35mg/dL [31].

Dialysis dose (kt/V), classified as normal (\geq 1.2), low (0.9-1.1) and, very low (< 0.9) [10].

Hypertension associated CKD, defined as long standing hypertension complicated by kidney disease, common in elderly and late middle age [27].

Chronic glomerulonephritis, defined as kidney disease complicated by hypertension, common in the young and in early middle age, with or without antecedent history of pharyngitis or skin sepsis [27]

2.3 Statistical Analysis

Data was analyzed using SPSS version 22.0 (IBM, CA, USA). Continuous variables were presented as means and compared using t-test while categorical variables were presented as proportions and compared using Chi square test or fisher's exact test, for variables less than five. A P-value < 0.05 was considered statistically significant. Variables with P-value < 0.025 were entered into a multiple regression model to determine independent associates of intradialytic dopamine use in IDH using backward elimination to adjust for confounders [32].

3. RESULTS

A total of 2968 MHD treatments for 557 participants [378 (67.86%) males, and 179 (32.14%) females] participants were studied. Hypertension was the commonest cause of CKD (P=0.05). Sixteen (2.87%) of the participants had PDD in 50 (1.68%) of the sessions while 20 (3.59%) participants had IDD in 63 (2.12%) of the sessions. Six hundred and forty three (21.66%) sessions for 125 (22.44%) participants had intradialytic hypertension (IDHT). Five hundred and eighteen sessions (17.45%) for 108 (19.39%) participants had symptomatic IDH while 1807 (60.88%) sessions for 324 (58.17%) participants had no significant intradialytic BP changes (Table 1).

All participants had at least one comorbidity. Predialysis, hypertension was found in 2710 (91.31%) of all sessions, 421 (81.27%) of all sessions with IDH, 4 (8.0%) of sessions with PDD and 3 (4.76%) of the sessions with IDD, P=0.001. Around 8.42% of all sessions, 23.94% of all sessions with IDH, 40.0% of sessions with PDD and 36.51% of sessions with IDD were for diabetics, P<0.001. Around 9.66% of all sessions, 28.94% of all sessions with IDH, 38.74% of sessions with PDD and 36.22% of sessions with IDD were for participants with heart failure, P=0.004. The 557 participants had a total of 1644 hospitalizations within the three years of

dialysis treatment (mean 0.98 ± 0.13 /participant/yr). The 72 participants with IDH without dopamine had 212 hospitalization (0.98 ± 0.15 /participant/yr), the 16 with PDD had 46 hospitalization (0.95 ± 0.11 /participant/yr) while the 20 participants with IDD had 58 hospitalizations (0.96 ± 0.13 /participant/yr), P=0.08

Fifty (9.65%) of the symptomatic IDH sessions had predialysis dopamine while 63 (12.16%) had intradialytic dopamine. The mean age of all participants, participants with IDHT, those without significant BP change, those with PDD, and those with IDD were 50.73 ± 6.51 years, 49.63 ± 7.5 years, 53.8 ± 8.43 years, 64.48 ± 8.22 years and 64.64 ± 10.31 years respectively, P=0.001.

The mean predialysis SPO₂, pulse rate, systolic, and diastolic BP were higher in sessions with PDD treatment compared to IDD treatment, P=0.06, P=0.001, P<0.001 and P=0.001 respectively (Table 2). The mean post-dialysis SPO₂, pulse rate, systolic, and diastolic BP were higher in sessions with pre-dialysis dopamine treatment compared to IDD treatment, P=0.07, P=0.05, P=0.04 and P=0.05 respectively.

The BFR, ultrafiltration volume and dialysis duration were higher in sessions with predialysis dopamine treatment compared to intra-dialytic dopamine treatment, P=0.002, P=0.03 and P=0.04 respectively (Table 3).

Dialysis termination and intradialytic death were commoner in sessions with IDD compared to sessions with PDD, P=0.001 and P=0.002 (Table 4). The dialysis dose was higher in sessions with PDD treatment compared to sessions with IDD treatment, P<0.001.5.

Predialysis dopamine was commoner in females, advancing age and diabetes, P=0.08, P=0.93 and P=0.06 (Table 5). Participants with IDD treatment had more frequent dialysis sessions and erythropoietin treatment, P=0.003 and P=0.04, presented for dialysis with lower systolic and diastolic blood pressures, P<0.001 and P=0.03, and were less likely to receive dialysis treatment with an AVF, P=0.08.

From multiple regression analysis (Table 6), lower predialysis systolic, and diastolic BP, shorter dialysis duration, dialysis termination and intra-dialytic death were independently associated with intradialytic dopamine treatment of IDH.

Table 1. Sociodemographic characteristics of study population

| Variables | All sessions N=2968 (%) | All sessions with IDH N=518 (%) | IDH no dopamine N=405 (%) | IDH with PDD N=50 (%) | IDH with with IDD N=63 (%) | P- value |
|------------------------|----------------------------|---------------------------------------|---------------------------------|--------------------------|----------------------------------|----------|
| Sex | | | | | | |
| Males | 2033 (68.50) | 298 (57.53) | 238 (58.77) | 26 (52.00) | 34 (53.97) | 0.02 |
| Females | 935 (31.50) | 220 (42.47) | 167 (41.23) | 24 (48.00) | 29 (46.03) | |
| Ages, years | | | | | | |
| 16-39 | 673 (22.68) | 61 (11.78) | 52 (12.84) | 3 (6.00) | 6 (9.52) | 0.03 |
| 40-64 | 1771 (59.67) | 298 (57.53) | 241 (59.51) | 26 (52.00) | 31 (49.21) | |
| ≥65 | 524 (17.65) | 159 (30.69) | 112 (27.65) | 21 (42.00) | 26 (41.27) | |
| Etiology of CKD | | | | | | |
| Hypertension | 1315 (44.31) | 169 (32.63) | 136 (33.58) | 15 (30.00) | 18 (28.57) | 0.05 |
| CGN | 1057 (35.61) | 135 (26.06) | 119 (29.38) | 7 (14.00) | 9 (14.29) | |
| Diabetes | 250 (8.42) | 124 (23.94) | 81 (20.00) | 20 (40.00) | 23 (36.51) | |
| Others | 346 (11.66) | 90 (17.37) | 69 (17.04) | 8 (16.00) | 13 (20.63) | |
| Dialysis/week | | | | | | |
| 1 | 616 (20.76) | 135 (26.06) | 93 (22.96) | 18 (36.00) | 24 (38.10) | 0.03 |
| 2 | 1726 (58.15) | 323 (62.36) | 263 (64.94) | 28 (56.00) | 32 (50.79) | |
| 3 | 626 (21.09) | 60 (11.58) | 49 (12.10) | 4 (8.00) | 7 (11.11) | |
| Erythropoietin/week | | | | | | |
| 1 | 659 (22.20) | 172 (33.20) | 125 (30.87) | 21 (42.00) | 26 (41.27) | 0.06 |
| 2 | 1733 (58.39) | 295 (56.95) | 239 (59.01) | 25 (50.00) | 31 (49.21) | |
| 3 | 576 (19.41) | 51 (9.85) | 41 (10.12) | 4 (8.00) | 6 (9.52) | |
| Antihypertensive drugs | | | | | | |
| 1 | 574 (19.34) | 129 (24.90) | 54 (13.33) | 34 (68.00) | 41 (65.08) | 0.003 |
| 2 | 1201 (40.46) | 205 (39.58) | 172 (42.47) | 15 (30.00) | 18 (28.57) | |
| 3 | 1193 (40.20) | 184 (35.52) | 179 (44.20) | 1 (2.00) | 4 (6.35) | |

IDH-intradialytic hypotension, PDD-predialysis dopamine, IDD-intradialytic dopamine, CKD-chronic kidney disease, CGN-chronic glomerulonephritis

Table 2. Peri-dialytic clinical findings in participants

| Variables | All sessions with IDH N=518 Mean ± SD | IDH, no dopamine N=405 Mean ± SD | IDH with PDD N=50 Mean ± SD | IDH with IDD N=50 Mean ± SD | P-value Mean ± SD |
|-----------------------------------|---|--|-----------------------------------|-----------------------------------|----------------------|
| Predialysis SPO ₂ , % | 96.61±13.26 | 96.89±12.61 | 95.81±9.46 | 95.62±17.28 | 0.06 |
| Postdialysis SPO ₂ , % | 96.94 ± 9.29 | 97.16 ± 16.41 | 96.48 ± 8.26 | 96.27 ± 11.24 | 0.07 |
| Predialysis pulse, b/min | 84.55 ± 7.92 | 82.99 ± 9.34 | 90.14 ± 8.26 | 88.63 ± 8.40 | 0.001 |
| Postdialysis pulse, b/min | 89.74 ± 6.47 | 89.68 ± 7.72 | 90.20 ± 7.31 | 91.97 ± 6.63 | 0.05 |
| Predialysis SBP, mmHg | 121.71 ± 9.22 | 126.37 ± 9.59 | 108.64±12.15 | 98.18 ± 10.31 | <0.001 |
| Postdialysis SBP, mmHg | 115.42 ± 9.01 | 114.78 ± 8.67 | 116.58 ± 5.79 | 118.64 ± 6.50 | 0.04 |
| Predialysis DBP, mmHg | 78.32 ± 8.62 | 78.75 ± 7.35 | 79.63 ± 7.42 | 74.49 ± 6.65 | 0.001 |
| Postdialysis DBP, mmHg | 70.11 ± 6.61 | 69.76 ± 6.37 | 70.54 ± 8.54 | 71.87 ± 5.43 | 0.05 |

PDD-predialysis dopamine, IDD-intradialytic dopamine, SPO₂-oxygen saturation, SBP-systolic blood pressure, DBP-diastolic blood pressure

Table 3. Prescribed dialysis for study population

| Variables | All sessions with IDH N=518 (%) | IDH, no dopamine N=405 (%) | IDH with PDD N=50 (%) | IDH with IDD N=63 (%) | P-value |
|---------------------------|------------------------------------|-------------------------------|--------------------------|--------------------------|---------|
| Blood flow rate, ml/min | | | | | |
| <300 | 128 (24.71) | 94 (23.21) | 13 (26.0) | 21 (33.33) | 0.002 |
| ≥300 | 390 (75.29) | 311 (76.79) | 37 (74.0) | 42 (66.67) | |
| Ultrafiltration volume, L | | | | | |
| <2 | 136 (26.25) | 87 (21.48) | 21 (42.0) | 28 (3.17) | 0.03 |
| ≥2 | 382 (73.75) | 318 (78.52) | 29 (58.0) | 35 (55.56) | |
| Dialysis duration, hrs | | | | | |
| <4 | 18 (3.47) | 15 (3.70) | 1 (2.0) | 2 (3.17) | 0.04 |
| 4 | 500 (96.53) | 390 (96.30) | 49 (98.0) | 61 (96.83) | |
| Vascular access | | | | | |
| Arteriovenous fistula | 63 (12.16) | 50 (12.34) | 6 (12.0) | 7 (11.11) | 0.004 |
| Tunneled IJVC | 229 (44.21) | 178 (43.95) | 24 (48.0) | 27 (42.86) | |
| Non-tunneled IJVC | 47 (9.07) | 39 (9.63) | 4 (8.0) | 4 (6.35) | |
| Femoral | 179 (34.56) | 138 (34.08) | 16 (32.0) | 25 (39.68) | |

IDH-interdialytic hypotension, PDD-predialysis dopamine, IDD-intradialytic dopamine, IJVC-internal jugular vein catheter.

Table 4. Intradialytic events and outcome in the study population

| Variables | All session with IDH 518 (%) | IDH, no dopamine N=405 (%) | IDH with PDD N=50 (%) | IDH with IDD N=63 (%) | P-values |
|----------------------|---------------------------------|-------------------------------|--------------------------|--------------------------|----------|
| Dialysis termination | 18 (3.47) | 15 (3.70) | 1 (2.00) | 2 (3.17) | 0.001 |
| Intradialytic death | 6 (1.16) | 5 (1.23) | 0 (0.00) | 1 (1.59) | 0.002 |
| Dialysis dose, Kt/V | | | | | |
| <0.9 | 106 (20.46) | 85 (20.99) | 7 (14.00) | 14 (22.22) | <0.001 |
| 0.9-1.19 | 386 (74.52) | 303 (74.81) | 39 (78.00) | 44 (69.84) | |
| >1.2 | 26 (5.02) | 17 (4.20) | 4 (8.00) | 5 (7.94) | |

IDH-intradialytic hypotension, PDD-predialysis dopamine, IDD-intradialytic dopamine

Table 5. Relationship between participants' variables and phase of dopamine treatment

| Variables | PDD N=50 (%) | IDD N=63 (%) | OR | 95% CI | P-value |
|------------------------------------|--------------|--------------|------|------------|---------|
| Sex | | | | | |
| Males | 26 (43.33) | 34 (56.67) | 1.01 | 0.87-1.11 | 0.08 |
| Females | 24 (45.28) | 29 (54.72) | | | |
| Age, yrs | | | | | |
| <65 | 29 (43.95) | 37 (56.06) | 0.96 | 0.88-0.97 | 0.93 |
| ≥65 | 21 (44.68) | 26 (55.32) | | | |
| Diabetes | | | | | |
| Yes | 20 (46.51) | 23 (53.49) | 1.43 | 1.36-2.68 | 0.06 |
| No | 30 (42.86) | 40 (57.14) | | | |
| Antihypertensives | | | | | |
| 1 | 34 (45.33) | 41 (54.67) | 1.19 | 0.78-1.69 | 0.06 |
| ≥2 | 16 (42.11) | 22 (57.89) | | | |
| Sessions/week | | | | | |
| <3 | 46 (45.10) | 56 (54.90) | 3.25 | 1.27-4.47 | 0.003 |
| 3 | 4 (36.36) | 7 (63.64) | | | |
| Erythropoietin/week | | | | | |
| <3 | 46 (44.66) | 57 (55.34) | 2.01 | 0.67-2.04 | 0.04 |
| 3 | 4 (40.0) | 6 (60.) | | | |
| Predialysis systolic hypertension | | | | | |
| Yes | 18 (54.55) | 15 (45.45) | 5.97 | 3.68-7.83 | <0.001 |
| No | 32 (40.0) | 48 (60.0) | | | |
| Predialysis diastolic hypertension | | | | | |
| Yes | 24 (48.98) | 25 (51.02) | 3.11 | 2.74-5.66 | 0.003 |
| No | 26 (40.63) | 38 (59.37) | | | |
| Blood flow rate | | | | | |
| <300 | 13 (38.24) | 21 (61.76) | 3.07 | 1.59-4.27 | 0.003 |
| ≥300 | 37 (46.84) | 42 (53.16) | | | |
| Ultrafiltration volume, L | | | | | |
| <2 | 21 (38.24) | 28 (57.14) | 1.13 | 1.09-3.01 | 0.07 |
| ≥2 | 29 (45.31) | 35 (54.69) | | | |
| Dialysis duration, hrs | | | | | |
| <4 | 1 (33.33) | 2 (66.67) | 4.42 | 2.22-6.04 | 0.001 |
| 4 | 49 (44.55) | 61 (55.45) | | | |
| Vascular access | | | | | |
| AVF | 6 (46.15) | 7 (53.85) | 1.06 | 1.04-1.51 | 0.08 |
| Non-AVF | 44 (44.0) | 56 (56.0) | | | |
| Vascular access | | | | | |
| Tunneled IJVC | 24 (47.06) | 27 (52.94) | 2.31 | 1.48-2.96 | 0.01 |
| Non-tunneled IJVC | 26 (41.96) | 36 (58.06) | | | |
| Dialysis termination | | | | | |
| Yes | 1 (33.33) | 2 (66.67) | 5.47 | 1.89-5.86 | <0.001 |
| No | 49 (44.55) | 61 (55.45) | | | |
| Intra-dialytic death | | | | | |
| Yes | 0 (0.0) | 1 (100.0) | 12.3 | 5.33-16.92 | <0.001 |
| No | 50 (44.64) | 62 (55.36) | | | |
| Dialysis dose, Kt _v /V | | | | | |
| <1.2 | 46 (44.23) | 58 (55.77) | 0.95 | 0.83-0.98 | 1.10 |
| ≥1.2 | 4 (44.45) | 5 (55.55) | | | |

PDD-predialysis dopamine, IDD-intradialytic dopamine, AVF-arteriovenous fistula, IJVC-internal jugular vein catheter

4. DISCUSSION

We found the incidence of intra-dialytic hypotension, severe IDH with intra-dialytic systolic BP less than 90mmHg (for which PDD was used), and severe IDH with intra-dialytic

systolic BP reduction of at least 20mmHg (for which IDD was used) to be 17.45%, 1.68% and 2.12% respectively. Women and the aged were more likely to received dialysis treatments with predialysis dopamine (PDD) and, sessions with PDD had higher predialysis blood pressures,

Table 6. Multivariate analysis showing independent associates of intra-dialytic dopamine

| Variables | aOR | 95% CI | P-value |
|------------------------------------|-------|------------|---------|
| Dialysis frequency | 1.36 | 1.06-2.11 | 0.05 |
| Predialysis systolic hypertension | 6.38 | 2.49-9.48 | <0.001 |
| Predialysis diastolic hypertension | 2.97 | 2.42-4.95 | 0.04 |
| Blood flow rate | 2.88 | 1.49-3.81 | 0.05 |
| Dialysis duration | 3.91 | 0.85-4.37 | 0.004 |
| Tunneled IJVC | 2.02 | 1.45-2.35 | 0.07 |
| Dialysis termination | 6.06 | 3.59-10.73 | <0.001 |
| Intra-dialytic death | 14.26 | 3.82-17.62 | <0.001 |

aOR-adjusted odds ratio, CI-confidence interval, IJVC-internal jugular vein catheter

blood flow rate, ultrafiltration volume, dialysis duration, dialysis dose and fewer episodes of intra-dialytic complications such as dialysis termination, hospitalization and intra-dialytic death.

The 17.45% incidence rate of symptomatic IDH in this study mirrors findings by Sands et al and falls within the wide range reported in previous studies, and also falls within the narrower ranges reported in studies that used, similar to this study, the European Best Practices Guidelines (EBPG) criteria. Kuipers et al using the EBPG criteria, found a prevalence of 21.4% [4] In this study, the higher frequency of severe IDH using the systolic BP reduction of at least 20 mmHg compared with that of severe IDH using the nadir systolic BP less than 90 mmHg, is similar to findings by Kuipers et al in 2016 and Flythe et al, who in separate studies, found frequencies of 21.4% and 9.2% respectively [4, 28]. Kuipers et al, in another study, 3 years later, found a higher prevalence of IDH using a nadir systolic BP less than 90 mmHg (11.6%) compared to the 10.1% using the systolic BP reduction of at least 20 mmHg by the EBPGs [29]. Due to the very high likelihood of attaining the intradialytic systolic BP reduction of 20 mmHg whenever the intradialytic systolic BP is less than 90 mmHg (and not viz visa), it can reliably be inferred that the nadir BP less than 90mmHg is a more severe form of IDH. This is in agreement with findings that associated higher mortalities in patients who meet the systolic BP less than 90 mmHg compared to the systolic BP reduction of at least 20mmHg [28].

The fact that dialysis sessions with the PDD had more severe IDH was further confirmed by the frequencies of PDD in females and the elderly, a pair that is well reported to be risk factors for the occurrence and severity of IDH [33]. Since the elderly are expected to have higher frequencies and severity of IDH occasioned by poor cardiac reserve (with or without left ventricular

hypertrophy), the higher predialysis BP in participants with PDD reflects the predialytic inotropic support that was mostly sustained all through dialysis [34].

The marginal reductions in the hospitalization of participants with PDD compared to those with IDD, further buttresses the relative advantage of PDD therapy over the IDD. This is more so considering the fact that participants with PDD were more likely to have poorer hemodynamic stability associated with worse systolic, with or without diastolic dysfunction as shown by their worse mortality profile [28, 35]. The higher dialysis dose in cohorts with PDD despite having worse background hemodynamic and cardiovascular profile only reflects the importance of a sustained low dose inotropic support in dialysis that led to higher BP which allowed for a relative optimization of the prescribed dialysis dose [36].

The higher dialysis dose in cohorts with PDD is expected to lead to better QOL, lesser hospitalization and better fluid and BP control. The higher BP in the PDD cohorts allowed for higher BFR and ultrafiltration rates, both surrogate markers of higher dialysis doses as widely reported in previous studies [5, 23, 37]. Similarly, the longer dialysis duration in sessions with PDD reflects the lower incidence of dialysis termination in these cohorts [38]. Although we didn't seek to study the outcome of dopamine treatment in this study, lesser dialysis termination (a pointer to reductions in the frequencies of IDH, and therefore, myocardial ischemia and stunning) in the PDD cohorts would further add to the advantages of PDD over IDD [39].

The greater increases in the pulse rate with a concurrent fall in BP following dialysis in cohorts who had IDD treatment compared to cohorts with PDD is also a pointer to the relative advantages of PDD treatment [40]. Narrow and wide

intradialytic variations in BP, even without symptoms, have both been reported to induce ischemic changes in the organs/systems that may lead to myocardial stunning and infarction, and further diminution of kidney function [4, 41]. The maintenance of a narrow intradialytic pulse, and blood pressure gradient, as was found in the PDD treated cohorts in this study, goes a long way in minimizing the ischemic tissue injury associated with the dialysis procedure [42]. Apart from preventing IDH and dialysis termination, optimal intradialytic BP control ensures the distribution of an effective blood volume, leading to improved cardiac output and improved renal perfusion which is needed to optimize the contribution of the residual kidney function in achieving higher dialysis dose, as was found in cohorts with PDD in this study [43]. Considering the fact that many of the adverse effects of dopamine use is predicated on tachycardia which cause increased myocardial oxygen demand and ischemia, it becomes imperative to, not only prevent/minimize tachycardia, but also to maintain a narrow intradialytic pulse gradient even within normal values [44, 45]. The greater risk of intradialytic death in the IDD treated cohorts could also be explained on the basis of the wider intradialytic pulse gradient. The poor diastolic filling associated with tachycardia only worsens the cardiac ischemia which if severe and/or prolonged, could induce arrhythmogenic discharges some of which could be malignant and fatal as was seen in one of the IDD cohorts [46]. This is particularly so with background cardiac systolic and diastolic dysfunction [8].

5. CONCLUSION

The prevalence of IDH was 17.45%, of severe IDH using a nadir systolic BP less than 90 mmHg was 1.68%, and of severe IDH using a minimum 20 mmHg fall in systolic BP was 2.12%. Severe IDH that was managed with PDD was common in women while severe IDH managed with IDD was common in males. The intradialytic increases in pulse rate along with reductions in BP were more in IDD treated cohorts. Dialysis termination and intradialytic death were common in IDD treated cohorts. Predialysis low dose dopamine treatment of severe IDH allows for a relative optimization of the prescribed dialysis resulting in higher dialysis dose and reductions in the frequencies of complications such as dialysis termination, hospitalization and intradialytic death compared with IDD treatment. Further studies with larger sample size, and with follow up, would

be needed to determine the long term effect of dopamine treatment in dialysis.

6. LIMITATIONS

Limitations encountered in this study that needed to be addressed in future studies include its single center and retrospective design. Some measures targeted at reducing the frequency of IDH like sodium profiling and increasing dialysate calcium concentration among others were not routinely carried out, particularly sodium profiling which has a tendency of worsening the poor BP and fluid control that is associated with under-dialysis that is prevalent in LINDs [5, 37]. We didn't seek to estimate the residual kidney function and its contribution to the dialysis dose. Symptom reportage being subjective, its reliability in diagnosing IDH could be compromised. Cardiac enzymes were not assayed and the blood PH, despite being a better assessment tool for acid base balance was not determined.

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ETHICAL APPROVAL

The study was approved by the Babcock University Human Research Ethics (BUHREC/723/19, NHREC/24/01/2018).

CONSENT

It is not applicable.

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COMPETING INTERESTS

Authors have declared that no competing interests exist.

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