

Acute Dialysis Quality Initiative

Introducing ADQI

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Introduction

An increasing number of patients develop acute renal failure each year, and mortality is still higher than 50% despite new treatment strategies. In recent years, there have been considerable advances in our understanding and technical capabilities, but consensus over the optimal way to deliver care does not exist. Consequently, we decided to initiate a process which will include a series of conferences and interactions with a large number of reviewers and experts entitled Acute Dialysis Quality Initiative (ADQI). ADQI aims at establishing an evidence-based appraisal and set of consensus recommendations to standardize care and direct further research.

CRRT is being used at ever increasing rates worldwide. Today, approximately one quarter of all patients with acute renal failure are treated with CRRT. Despite the increasing use, there are presently no published standards for the application of this therapy and practice patterns vary widely between individual centers. Results from recent clinical trials on selection of dialysis membranes, and dialysis dose provide strong, yet conflicting evidence to guide therapy. Other areas of uncertainty have not been sufficiently addressed by clinical studies and directives for future research are needed. Finally, the success of multi-centered clinical trials in supportive care in the ICU (transfusion thresholds and ventilator management) have intensified and renewed interest in the study of supportive care methods as a major target for future research. These developments have set the stage for the first ADQI conference held in New York on August 28-30, 2000. The conference focused on the application of continuous renal replacement therapy (CRRT) in the critically ill patient with acute renal failure.

While the primary aims of this conference were to establish the methodology for the consensus process, to describe current clinical practice and to identify important clinical and research questions, the final objectives of ADQI are the development of evidence-based practice guidelines and directions for future research.

Since among the several controversial points concerning CRRT there is the question of who should be in charge of patient's care and what should be the specific contribution of intensive care and renal physicians, the founding group of ADQI in New York was constituted by a balanced group of scientists of both branches.

The First ADQI Conference

Chaired by John Kellum, Claudio Ronco and Ravindra Mehta as directors of the ADQI conference, the group featured 7 intensivists (Drs Murray, S. Mehta, Gibney, Bellomo, Wensley, Schetz and Angus) and 7 nephrologists (Drs Paganini, Leblanc, Bunchman, Levin, Depner, Palevsky and Davenport) (figure 2). In the group a few members from the industry (Drs Tetta, Lazarus and Clark) and two representatives from the American National Institutes of Health (Drs Star and Kimmel) were also included. Since the meeting took place in the US, the American Society of Nephrology and the Society of Critical Care Medicine endorsed the scientific event. Nevertheless, for the future we are very much looking forward to receiving further sponsorships and endorsement from other scientific societies in Europe and Asia and possibly to organize focused conferences of ADQI on different specific issues in various countries. The ADQI writing committee included the conference directors and 2 other members of the group. This committee was entrusted to compile the findings of the conference. This document will be completed as soon as all the necessary revisions will be made from the original drafts and will be posted on the internet (www.ADQI.net) for comment by the remainder of the participants. The period for comment will be limited in time and revisions will be made accordingly. The final product will be submitted as a manuscript for publication immediately following this process.

Conclusions

In conclusion, ADQI is a moving process that will produce evidence-based statements on different issues concerning acute dialysis. The first step was to try to reach consensus on Continuous Renal replacement Therapies, an area where major controversies are still present. The next step will be the development of consensus statements that should provide the basis for recommendations to be used in clinical practice. Our effort aims at obtaining a common ground where acute dialysis should be discussed and optimized. At the present time there is very little agreement on how much, when and how dialysis should be provided. We hope to move much further with the cooperation of all who may be interested in helping and becoming temporary or permanent members of the commission for the development of the ADQI tasks.

References

1. www.KDOQI.org

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