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32482-ANSWERING REVIEWERS

Name of journal: World Journal of Nephrology

ESPS manuscript NO: 32482

Title: Fluid Overload as a Major Target in Management of Cardiorenal Syndrome; Implications for the Practice of Peritoneal Dialysis

COMMENTS: (Reviewer's code: 02511796)

This is a good article that raises some important points. While I agree that congestion is the key point the author could perhaps describe the pathophysiology a little better. The author has mentioned low forward flow or high backward pressure as examples. The mechanisms and treatment of this varies. While both respond to IV diuretics, the first could also be improved with inotropes. The latter could benefit from bed rest and leg raising. The net effects we are trying to achieve are improved transglomerular pressures. While we agree on diuretics, the dosing versus use of concomitant agents such as thiazides or spironolacatone are not exactly clear. So while the author builds an argument for PD it is important to broadly state these points. Background - ok Fluid Overload in CRS - see above. Needs more points on how the kidney clear fluid, R/L HF and transglomerular pressures. CKD and HF - ok ESRF and HF - OK Volume status and ESRD Hydration status and Residual renal function - ok Volume Status vs Solute Clearance - ok Decongestion: sodium vs water - ok Decongestion: CAPD vs APD - ok Enhancing sodium removal - ok

RESPONSE: Thanks. Based on your comment, I have expanded the section on the pathophysiologic mechanisms of cardiorenal syndrome and transglomerular pressure, with new references, and have also added information on the inconvenience of diuretic use as a reason for considering peritoneal dialysis in this setting. I appreciate your comments.

COMMENTS: (Reviewer's code: 00503321)

Excellent overview of a very important clinical area in urgent need of therapeutic improvement. I particularly liked the idea of making the achievement of normal hydration a target of PD adequacy with the clear implication for regular measurements of fluid status by bio-impedance and perhaps by blood tests (NT-proBNP, Albumin, Na, etc.) Only with these clear targets we could recommend PD over HD/HDF for the management of chronic fluid overload. I think your paper deserves the widest publication.

RESPONSE: I thank you for your kind comments.