

# Erythropoietin Therapy and Left Ventricular Mass Index in CKD and ESRD Patients: A Meta-Analysis

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**Background and objectives:** The purpose was to evaluate changes in the left ventricular mass index (LVMI) among anemic chronic kidney disease (CKD) and end-stage renal disease (ESRD) patients treated with recombinant human erythropoietin (EPO).

**Design, setting, participants, & measurements:** A systematic review of the literature, reporting LVMI for patients before and after EPO therapy, was performed. The change in LVMI from baseline to the end of treatment was calculated and stratified by severity of anemia at baseline, target hemoglobin (Hb), and stage of kidney disease.

**Results:** Fifteen eligible studies involving 1731 patients were identified. Cohorts with severe anemia at baseline (<10 g/dl), when given EPO using a lower target level (Hb  $\leq$  12 g/dl or Hct  $\leq$  36%) experienced significant reductions in LVMI ( $-32.7$  g/m<sup>2</sup>; 95% CI:  $-49.4$  to  $-16.1$ ,  $P < 0.05$ ). However, these studies lacked control groups. Cohorts with moderate anemia at baseline showed insignificant changes in LVMI:  $5.3$  g/m<sup>2</sup> (95% CI:  $-0.8$  to  $11.3$ ) for patients assigned to a lower target, and  $-6.6$  g/m<sup>2</sup> (95% CI:  $-17.2$  to  $4.0$ ) for patients assigned to a higher target (Hb > 12 g/dl or Hct > 36%). The effect size was similar in direction for both CKD and ESRD cohorts.

**Conclusions:** Aggregated results from multiple studies suggest that in severe anemia conventional Hb targets for EPO therapy are associated with a reduction in LVMI, but that in moderate anemia target Hb above 12 g/dl does not have a significant beneficial impact on LVMI compared with conventional targets.

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Compared with the general population, the annual cardiovascular death rate in dialysis patients is higher for all age groups, particularly for the young, whose mortality is up to 100 times greater (1). Chronic kidney disease (CKD) is associated with a substantially increased incidence of congestive heart failure and of atherosclerotic vascular disease events in both diabetic and nondiabetic patients (2). In dialysis patients, cardiomyopathy predisposes to heart failure and to earlier death (3). A reduction in left ventricular mass index (LVMI) has been linked with an increase in both all-cause and cardiovascular survival (4), and progression of cardiomyopathy has been associated with the development of *de novo* heart failure (5). Anemia is an independent predictor for heart failure in dialysis patients (6), in renal transplant recipients (7), and in CKD patients (8). It is associated with the development of echocardiographic left ventricular hypertrophy (LVH) in predialysis CKD patients (9) and in dialysis patients (10), and with electrocardiographic LVH in transplant recipients (11).

Recombinant human erythropoietin (EPO) is indicated for the treatment of anemia in patients with CKD and end stage renal disease (ESRD). Numerous studies, including many ran-

domized controlled trials (RCTs), have demonstrated that treating anemia related to kidney disease with EPO increases hemoglobin/hematocrit (Hb/Hct) levels, reduces transfusion requirements, and improves the quality of life (QOL) (12–14). Other RCTs in which a normal hemoglobin target was compared with partial correction of anemia with EPO suggested that higher hemoglobin targets may be harmful. Clinical events related to higher hemoglobin targets in some trials have included higher vascular access thrombosis (15), higher BP or greater requirements for antihypertensives (16,17), cerebrovascular events (17), cardiovascular events (15,18), earlier need for renal replacement therapy (19), and higher mortality (15,18).

In recent years, RCTs have been undertaken to determine the optimal target hemoglobin level for EPO therapy using changes in cardiac structure as a primary or secondary outcome, on the assumption that this outcome is a surrogate for subsequent cardiac events (4,5). An attractive hypothesis is that treatment of anemia with EPO will decrease or prevent LVH, and subsequently prevent cardiac events associated with LVH. The purpose of this study was to evaluate the impact of EPO therapy on changes in the LVMI among anemic CKD and ESRD patients receiving recombinant human erythropoietin, and to evaluate whether target Hb is a determinant of the LVMI effect size.

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## Materials and Methods

### Search Strategy

Using the PubMed database, we performed a systematic review of the medical literature published between January 1990 and February

2007 to identify studies relating EPO treatment and cardiac outcomes. The initial search was performed using the following keywords: “EPO or rHuEPO or erythropoietin,” “cardiac or cardio or heart,” and “CKD or renal or dialysis.” An additional search for abstracts from relevant conference meetings, such as the American Society of Nephrology and the European Dialysis and Transplant Association, was also conducted. Results of the search were initially analyzed in title and abstract format. Reference sections from selected publications were then checked for additional articles or abstracts.

### Criteria for Inclusion of Studies

Further investigation of full-text versions of eligible publications revealed that LVMi was the most consistently reported cardiac outcome in the literature, leading to the choice of change in LVMi as the primary endpoint of interest for this study. On the basis of this information, we revised our search to include the additional keywords “epoetin” and “left ventricular hypertrophy” and included all studies that reported LVMi values before and after EPO treatment for anemia in CKD or ESRD patients. All of the selected articles were published in peer-reviewed journals. Only one eligible abstract was excluded from this analysis because the results presented therein had not subsequently been published in a peer-reviewed publication outlet.

### Data Extraction

Two reviewers (M.L. and D.L.V.) independently applied the inclusion criteria and assessed the quality of the data collected. Each reviewer evaluated the relevant data from the eligible studies and entered the information electronically into an Excel data collection form with prepared fields. If relevant data were reported only graphically, values were estimated by physically measuring the charts with a ruler. Quality control was done by comparing the two independent datasets. Any differences were reconciled by a third party, referring to the original sources.

Data on the study design, patient characteristics, and outcomes were collected for each selected study. These include, but are not limited to, the number of subjects; study duration; dose schedule and titration; target Hb/Hct; as well as baseline and final values for Hb/Hct, weight, BP, body surface area and LVMi.

### Definitions

Severe anemia was defined as mean baseline Hb <10 g/dl; moderate anemia, as mean baseline Hb  $\geq$ 10 g/dl <12 g/dl. The lower target Hb was Hb  $\leq$ 12 g/dl or Hct  $\leq$ 36%; higher target Hb was Hb >12 g/dl or Hct >36%.

Note that the definition of lower target Hb coincides with the current recommended guidelines for the treatment of anemia in CKD as established by the National Kidney Foundation. These guidelines suggest a target Hb in the range of 11 to 12 g/dl in most patients (20).

### Statistical Analyses

For each study cohort treated with EPO, the change in LVMi was calculated as the difference between the baseline and final LVMi values. When LVMi measurements were reported at several points in time, the last available data point was used to determine the effect size. Pooled effect sizes (or changes in LVMi) and 95% confidence intervals (CI), stratified by baseline Hb level and target Hb, were calculated and plotted for each cohort using traditional meta-analysis techniques. To further investigate the characteristics that could influence the impact of EPO on LVMi, we also pooled estimates generated for the set of all cohorts, stratified by baseline Hb, target Hb/Hct, and stage of kidney disease (CKD versus ESRD). The stratified pooled estimates were com-

puted using either a fixed-effects model—in the event that the between-study variance was small and a statistical test confirmed that the studies were sufficiently homogeneous—or a random-effects model, otherwise. To generate a fixed-effects estimate, the effect size of each study is weighted according to the inverse of its variance. For a random-effects estimate, it is assumed that there is variability between studies in addition to variability within studies. Therefore, each effect size is weighted according to the sum of between- and own-study variance. A two-sided alpha error of 0.05 was used to determine statistical significance.

## Results

### Selection of Studies

Figure 1 summarizes the search strategy that was used. The initial search yielded 635 research publications, of which 598 were excluded for the following reasons: anemia not treated with EPO, primary outcome not cardiac related, or non-CKD patients involved ( $n = 258$ ); studies presented a review of existing literature, meta-analysis, letter to the editor, editorial, or practice guidelines ( $n = 254$ ); studies were published before 1990 or evaluated nonhuman subjects ( $n = 68$ ); and other reasons including, but not limited to, same study population used in one of the selected articles, cross-over design used, and study not published in English ( $n = 18$ ). An additional 22 publications were excluded because they did not report baseline and final LVMi values.

### Study Characteristics

A total of 15 unique studies with nonoverlapping patient populations and involving 1731 CKD and ESRD patients treated with EPO were selected for inclusion in this analysis. Table 1 describes the study characteristics, including change in LVMi, for each of the 23 treated cohorts in these 15 studies (4,16–17,21–32). Five of the studies assigned cohorts using a randomized study design (16–17,28,30,33), and six compared the LVMi outcomes of patients assigned to a lower Hb/Hct target level to those of patients assigned to a higher Hb/Hct

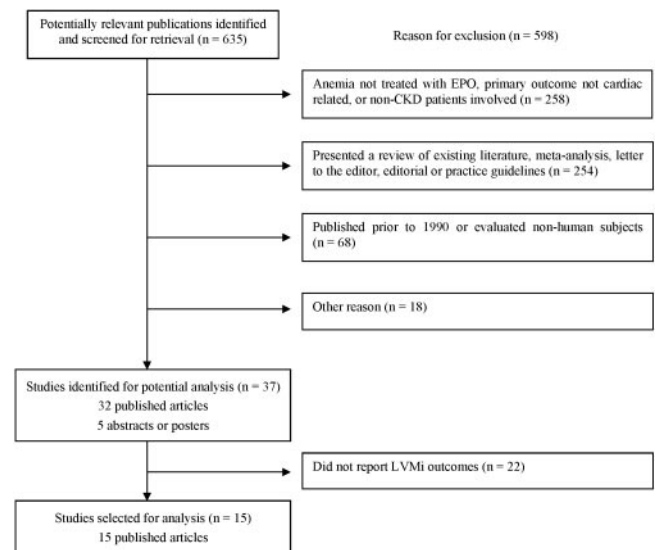


Figure 1. Flowchart showing how studies were selected.

Table 1. Characteristics of studies included in the analysis

Study (Year)	Publication	Cohort Description <sup>a</sup>	N	Treatment Period (weeks)	Dialysis	Target Hb/Hct	Hemoglobin, mean g/dl (SD)		SBP, mean mmHg (SD)		DBP, mean mmHg (SD)		LVMI, mean gm/m <sup>2</sup> (SD)		Δ LVMI
							Baseline	Final	Baseline	Final	Baseline	Final	Baseline	Final	
Cannella (1990)	<i>Clin Nephrol</i>	Treated	9	26	Y	10 g/dl	5.9 (1.30)	10.2 (1.30)	115 (17)	112 (19)	70 (5)	73 (14)	115 (17)	78 (14)	-37
Pascual (1991)	<i>Clin Nephrol</i>	(i) Hypertensive	8	52	Y	30-35%			159 (7)	145 (12)	96 (8)	87 (9)	235 (40)	168 (51)	-67.2
Portoles (1997)	<i>Kidney Int</i>	(ii) Normotensive Treated	7	52	Y	30-35%	6.4 (0.90)	10.5 (0.90)	133 (10)	122 (11)	82 (10)	75 (9)	183 (43)	107 (24)	-75.8
Massimetti (1998)	<i>Blood Purif</i>	Treated	11	26	N	35%	9 (1.0)	11.7 (1.30)	144 (32.5)	147.2 (31.2)	76.0 (20.90)	81.1 (15.3)	178 (68)	147 (68)	-30.9
Foley (2000)	<i>Kidney Int</i>	(i) CLVH / Lower Hb	36	65	Y	30-35%	8.4 (0.80)	10.9 (1.20)	155 (12)	154 (24)	87 (7)	85 (9)	186 (56)	189 (39)	3
		(ii) CLVH / Higher Hb	34	48	Y	9.5-10.5 g/dl	10.1 (0.60)	10.5 (1.20)	157 (11.8)	NA	81 (8.9)	NA	139 (25)	145.1 (NA)	6.1
		(iii) LVD / Lower Hb	37	48	Y	9.5-10.5 g/dl	10.0 (0.90)	12.8 (1.10)	162 (12.9)	NA	82 (7.2)	NA	147 (26)	148.1 (NA)	1.1
		(iv) LVDc / higher Hb	39	48	Y	13-14 g/dl	10.3 (0.60)	12.8 (2.20)	154 (18.5)	NA	84 (9.3)	NA	172 (36)	166 (NA)	-5.8
Hayashi (2000)	<i>Am J Kidney Dis</i>	Partial Hct correction <sup>b</sup>	9	16	N	30%	7.9 (0.5) <sup>c</sup>	10.7 (0.6) <sup>c</sup>	147.8 (23.1)	151.3 (22.8)	74.2 (14.70)	76.5 (7.8)	141 (36)	127 (30)	-13.7
London (2001)	<i>J Am Soc Nephrol</i>	Treated	153	54(37) <sup>d</sup>	Y	10-11 g/dl	8.7 (1.70)	10.5 (1.50)	169.4 (29.7)	146.7 (29)	90.2 (15.60)	78 (14)	174 (45)	162 (45)	-12
Sikole (2002)	<i>Artificial Organs</i>	Treated	14	52	Y	30-35%	7.9 (1.40)	10.0 (1.00)	NA <sup>e</sup>	NA <sup>e</sup>	NA <sup>g</sup>	NA <sup>g</sup>	172 (29)	129 (26)	-43.4
Frank (2004)	<i>Kidney Int</i>	Treated	23	28	Y	12.5 g/dl	10.5 (0.90)	13.4 (3.10)	132 (4)	128 (3)	76 (2)	73 (2)	134 (26)	97 (25)	-37
Roger (2004)	<i>J Am Soc Nephrol</i>	(i) Lower Hb	78	104	Mixed <sup>f</sup>	9-10 g/dl	11.2 (0.80)	10.8 (1.30)	137 (18)	133 (20)	81 (10)	77 (11)	101 (23)	105 (24)	4
Ayus (2005)	<i>Kidney Int</i>	(ii) Higher Hb Treated	74	104	Mixed <sup>f</sup>	12-13 g/dl	11.2 (0.90)	12.1 (1.40)	139 (19)	138 (23)	80 (11)	79 (12)	105 (23)	107 (25)	2
Hampf (2005)	<i>Kidney Int</i>	Treated	40	26	N	12 g/dl	9.1 (0.70)	11.3 (1.90)	148 (21)	146 (18)	82 (11)	81 (9)	157 (56)	142 (56)	-15
Levin (2005)	<i>Kidney Blood Press Res</i>	Treated	230	229	Y	13.5-14.5 g/dl	11.2 (2.20)	14.1 (1.40)	165 (8)	130 (10)	92 (8)	80 (5)	159 (50.4)	130.2 (42.7)	-28.8
	<i>Am J Kidney Dis</i>	(i) Lower Hb	74	104	Mixed <sup>f</sup>	9-10.5 g/dl	11.7 (0.80)	11.4 (NA)	140.5 (18.6)	133.4 (NA)	79.6 (10.50)	75.1 (NA)	98 (25)	104 (NA)	5.2
		(ii) Higher Hb	78	104	Mixed <sup>f</sup>	12-14 g/dl	11.8 (0.80)	12.7 (NA)	137.1 (17.5)	133.9 (NA)	75.8 (11.50)	75.6 (NA)	101 (22)	101 (NA)	0.4
Parfrey (2005)	<i>J Am Soc Nephrol</i>	(i) Lower Hb	300	96	Y	9.5-11.5 g/dl	11.0 (1.20)	10.9 (1.20)	140 (20)	139 (22)	80 (12)	79 (14)	112 (33)	128 (40)	16.3
		(ii) Higher Hb	296	96	Y	13.5-14.5 g/dl	11.0 (1.20)	13.3 (1.50)	144 (21.65)	141 (22.14)	81 (11.48)	80 (12.57)	117 (36)	128 (43)	11.8
Ritz (2007)	<i>Am J Kidney Dis</i>	(i) Lower Hb	82	60	Mixed <sup>f</sup>	10.5-11.5 g/dl	11.7	12.1 (NA)	133 (NA)	134 (NA)	80 (NA)	80 (NA)	116 (35)	117 (36)	0.5
		(ii) Higher Hb	88	60	Mixed <sup>f</sup>	13-15 g/dl	11.9	13.5 (NA)	134 (NA)	134 (NA)	78 (NA)	76 (NA)	114 (31)	112 (33)	-1.2

Y, yes; N, no; CLVH, concentric left ventricular hypertrophy; LVD, left ventricular dilation.

<sup>a</sup>Reporting only for cohorts treated with EPO. <sup>b</sup>Same study cohort evaluated at two targets. Only the results for partial-correction are reported here. <sup>c</sup>Hematocrit has been converted to hemoglobin by dividing by 3. <sup>d</sup>By patient, mean (SD). <sup>e</sup>Mean arterial pressure increased from 114.7 ± 13.9 at baseline to 119.3 ± 13.8 mmHg at end of treatment period (where mean arterial pressure = [systolic arterial pressure + diastolic arterial pressure] / 3). <sup>f</sup>These cohorts are classified as CKD for the purpose of this analysis. The following are numbers of patients who commenced dialysis during the study period: 15 out of 78, Roger 2004 (i); 24 out of 74, Roger 2004 (ii); 8 out of 74, Levin 2005 (i); 11 out of 78, Levin 2005 (ii); 3 out of 82, Ritz 2007 (i); and 2 out of 88, Ritz 2007 (ii).

target level. None of the studies compared the outcomes of treated patients to a randomly assigned, untreated control group. The treatment period for these studies ranged from 4 mo to 4.4 yr, with a mean duration of 16 mo.

Patient cohorts varied considerably with respect to several dimensions at baseline (Table 1). Sample sizes ranged from 7 to 300 patients. In eight of the 23 cohorts, patients were assigned to a higher Hb/Hct target, defined as Hb > 12 g/dl or Hct > 36%. The remaining 15 cohorts were assigned to a lower Hb/Hct target (Hb ≤ 12 g/dl or Hct ≤ 36%). A majority of the cohorts (14 out of 23) comprised only dialysis patients. In the remaining nine, six contained a mix of predialysis and dialysis patients, and the rest were composed entirely of predialysis patients. Of note, mean LVMi at baseline was within the normal range (< 125 g/m<sup>2</sup>) in just one of nine cohorts with severe anemia and in eight of 14 cohorts with moderate anemia (34). More than half of the total patients evaluated were being treated for hypertension.

### Meta-Analyses

Figure 2, which provides a graphical representation of the data points and 95% CIs used to generate the pooled estimates, reveals that several study cohorts experienced reductions in LVMi that were considerably larger than the overall pooled value of  $-9.2$  g/m<sup>2</sup> (all studies; Table 2), whereas several others experienced much smaller, even positive, changes in LVMi. In this Figure, the 23 study cohorts were stratified according to severity of anemia at baseline (mean Hb < 10 g/dl versus mean Hb ≥ 10 g/dl) and target Hb for EPO therapy (lower versus higher).

Table 2 presents the pooled LVMi effect size for various subsets of the 23 treated cohorts that were identified in the 15 selected studies. The stratified analysis reveals that the estimated effect size for the pooled cohorts with severe anemia at baseline, all of whom were assigned to a lower target, was  $-32.7$  g/m<sup>2</sup> (95% CI:  $-49.4$  to  $-16.1$ ,  $P < 0.05$ ; Figure 2a). Likewise, among the cohorts with moderate anemia at baseline, the estimated effect size ranged from 5.3 (95% CI:  $-0.8$  to 11.3; Figure 2b) for lower target cohorts to  $-6.6$  (95% CI:  $-17.2$  to 4.0; Figure 2c) for higher target cohorts. The estimated change in LVMi was not significantly different from zero for either group of pooled cohorts with moderate anemia at baseline. The two studies showing a significant reduction in LVMi with increase in Hb levels did not have a control group (Figure 2c) (31,32), and one of them included co-intervention with optimized heart failure therapy (32).

Among cohorts with severe anemia at baseline, LVMi outcomes may have been influenced by a decrease in systolic BP during the studies, as final systolic BP was significantly lower than baseline ( $-9.6$  mmHg; 95% CI:  $-17.6$  to  $-1.66$ ,  $P < 0.05$ ; Table 3). The estimated BP effect size among cohorts with moderate anemia at baseline was not significantly different from zero, irrespective of target Hb.

Once cohorts were further stratified by stage of kidney disease, the number of observed data points that contribute to each pooled estimate was small. Four of the six resulting cohort subsets rely on three or fewer cohorts each to generate a pooled

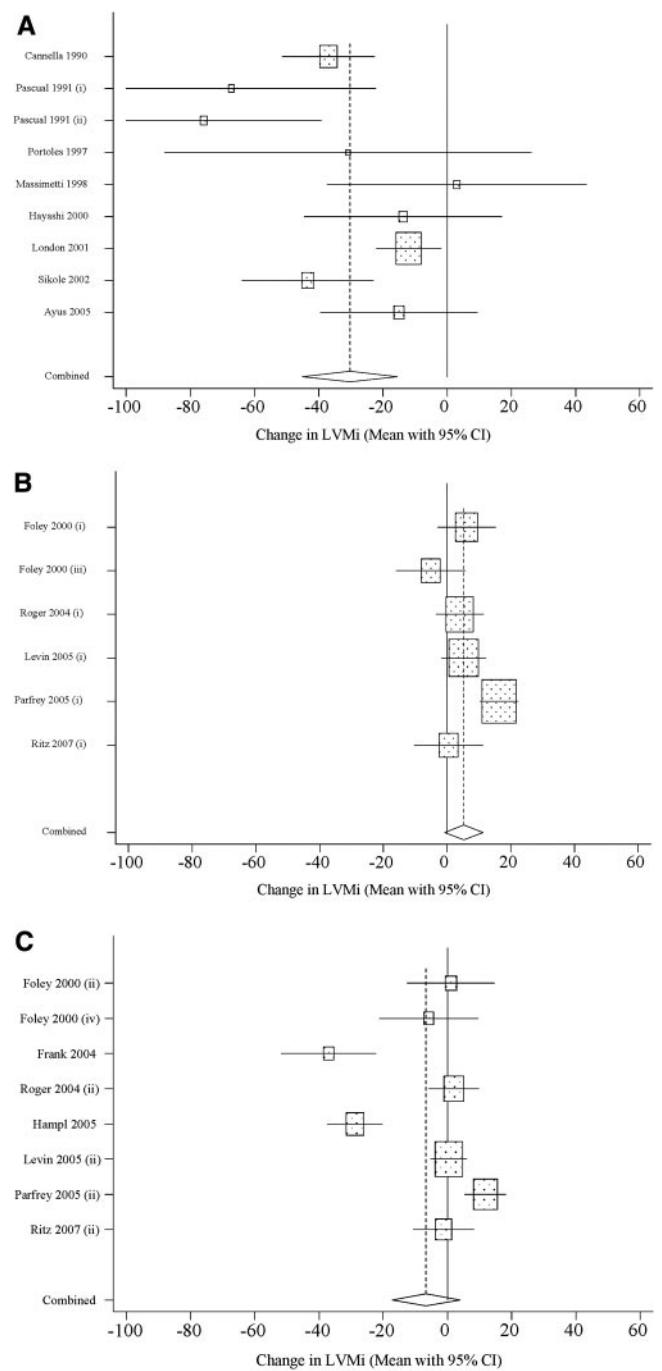


Figure 2. (a) Study cohorts with severe anemia at baseline and lower target Hb. (b) Study cohorts with moderate anemia at baseline and lower target Hb. (c) Study cohorts with moderate anemia at baseline and higher target Hb.

estimate (Table 2). Under these conditions, traditional meta-analysis techniques do not contribute a lot beyond what can be plainly observed by looking at individual data points. Nevertheless, one can observe that among the cohorts with moderate anemia at baseline, dialysis patients (as represented by eight cohorts) were no more likely to experience an increase in LVMi than predialysis patients (as represented by six cohorts).

Table 2. Weighted average LVMI effect size for various cohort stratifications

Stratification	No. of Cohorts	Sample Min	Sample Max	Estimated Effect Size (gm/m <sup>2</sup> )		
				Estimate	95% CI	Type <sup>a</sup>
All studies	23	7	300	-9.20	-16.05 to -2.34	R
By severity of anemia and target Hb/Hct						
severe anemia / lower target	8 <sup>b</sup>	7	153	-32.73	-49.37 to -16.10	R
moderate anemia / lower target	6	36	300	5.26	-0.80 to 11.33	R
moderate anemia / higher target	8	23	296	-6.63	-17.21 to 3.95	R
Severe anemia/lower target by stage of kidney disease						
CKD	8 <sup>b</sup>	9	11	-17.57	-44.66 to 9.51	F
ESRD	6	7	153	-36.12	-55.97 to -16.27	R
Moderate anemia/lower target by stage of kidney disease						
CKD	3	74	82	3.89	-0.67 to 8.46	F
ESRD	3	36	300	6.42	-5.84 to 18.67	R
Moderate anemia/higher target by stage of kidney disease						
CKD	3	74	88	0.54	-3.52 to 4.61	F
ESRD	5	23	296	-11.55	-32.13 to 9.04	R

Severe anemia: Hb < 10 g/dl; moderate anemia: Hb ≥ 10 g/dl; lower target: Hb ≤ 12 g/dl; higher target: Hb > 12 g/dl.

<sup>a</sup>F, fixed effects estimate; R, random effects estimate.

<sup>b</sup>Excludes one study (Ayus et al. 2005) that did not achieve the target Hb/Hct.

Table 3. Weighted average SBP and DBP effect sizes for various cohort stratifications

	Type <sup>a</sup>	Estimated Effect Size (mmHg)	
		Estimate	95% CI
Systolic Blood Pressure			
severe anemia/lower target ( <i>n</i> = 7)	R	-9.63	-17.60 to -1.66
moderate anemia/lower target ( <i>n</i> = 2)	F	-1.72	-4.65 to 1.21
moderate anemia/higher target ( <i>n</i> = 4)	R	-10.83	-30.70 to 9.04
Diastolic Blood Pressure			
severe anemia/lower target ( <i>n</i> = 7)	R	-4.04	-9.66 to 1.58
moderate anemia/lower target ( <i>n</i> = 2)	F	-1.86	-3.62 to -0.09
moderate anemia/higher target ( <i>n</i> = 4)	R	-4.34	-10.14 to 1.47

<sup>a</sup>F, fixed effects estimate; R, random effects estimate.

## Discussion

This study reviewed existing literature to evaluate the impact of EPO therapy in anemic CKD and ESRD patients on LVMI and investigate the determinants of the effect size across study cohorts. The results suggest that patients with severe anemia had a substantial improvement in LVMI when assigned to a target Hb ≤ 12 g/dl, whereas those with moderate anemia had no improvement in LVMI, irrespective of target Hb.

Reductions in LVMI are considered to be a surrogate marker of improvement in the cardiovascular health of ESRD patients (4,5). The large difference in observed outcomes between groups with severe *versus* moderate anemia may be attributable to the corresponding state of cardiovascular health at baseline. On the basis of reported LVMI values at baseline, 89% (8/9) of

the cohorts with severe anemia at baseline reported having a corresponding LVMI ≥ 125 g/m<sup>2</sup>, in contrast to just 43% (6/14) of the cohorts with moderate anemia at baseline. The potential for change in the group with severe anemia at baseline is considerably greater relative to patients in the group with moderate anemia at baseline, many of whom had LVMI values in the normal range and would therefore be unlikely to experience any significant reduction in LVMI as a result of EPO therapy.

The results for both the severe and moderate anemia groups can be interpreted as beneficial to the heart. On the one hand, EPO therapy is linked with a significant reduction in LVMI among those with severe anemia at baseline, especially among patients with ESRD. However, this result must be tempered by

the fact that no control group without EPO therapy was studied, and the potential for regression to the mean of the echocardiographic measurements was not assessed. On the other hand, EPO therapy is linked with maintaining LVMI among those with moderate anemia, which was likely to have kept a majority of patients within the normal range for LVMI. One exception applies to four cohorts with moderate anemia who started the study with LVMI above the normal range and who were also assigned to a higher target Hb. When pooled, the estimated change in LVMI for those four cohorts is negative and significant ( $-17.9$ ; 95% CI:  $-35.0$  to  $-0.8$ ,  $P < 0.05$ ). Although reduction in LVMI was not otherwise observed across the moderate anemia group, in the absence of any real potential for reducing LVMI, prevention of LVH could be considered the best possible outcome. This interpretation must be tempered by the fact that again no control group with moderate anemia was left untreated.

Observed outcomes varied considerably across studies in which cohorts with moderate anemia were assigned to a higher target Hb. Although these differences may be explained by certain study or population characteristics, further investigation may be needed to better understand the relationship between EPO and LVMI. In the largest study reviewed, an RCT of incident hemodialysis patients without symptomatic cardiac disease, whose baseline LVMI levels were normal, patients suffering from moderate anemia were randomly allocated to either lower or higher Hb targets and followed for 2 yr (17). Both cohorts demonstrated an increase in LVMI (Figures 2b and 2c) that was not prevented by EPO therapy. These results are consistent with the belief that hemodialysis is a state of hemodynamic and metabolic perturbation which predisposes to LVH (17,33).

In a second large RCT, two cohorts of hemodialysis patients who demonstrated concentric LVH at baseline were assigned to lower and higher Hb target groups, both of which experienced an increase in LVMI (16). By contrast, a cohort of 230 patients in yet a third study were assigned to a higher target Hb and experienced a significant decline in LVMI (32). However patients in this study may have benefited from a treatment method that combined the correction of anemia with optimized heart failure therapy. Regression to the mean may also have occurred, as no control group was studied.

This study is subject to several limitations, inherent in the studies reviewed. First, there is potential for the impact of EPO therapy to be confounded by the development of EPO-induced hypertension and prescription of concomitant antihypertensives (16,17). However, it is of interest that in the cohorts with severe anemia at baseline, systolic BP fell during follow-up, which may have contributed to the regression of LV hypertrophy. Second, there is a lack of optimal control groups (*i.e.*, no untreated anemic cohorts). Third, there is variation across studies in terms of study design (cohort *versus* RCT), patient populations (CKD *versus* ESRD), and achievement of target Hb levels (27,29). The absence of comparable control groups ensures that cohort studies are weak designs for the evaluation of treatment efficacy. Fourth, the outcome variable of interest in each study was determined on the basis of a formula that has

been refined over time. It is possible that more recent studies would evaluate LVMI size more accurately. Fifth, the potential for bias resulting from regression to the mean could result in larger changes in LVMI among patients with low Hb values at baseline (who, in general, have relatively high LVMI values at baseline) simply because patients tend to return to their long-term average LVMI level (35,36). Sixth, the assumption that LV hypertrophy is a surrogate marker for adverse clinical events in CKD has not been confirmed by an RCT in which clinical cardiovascular outcomes after an intervention were mirrored by LV mass outcomes.

Finally, we recognize that publication bias has the potential to distort the results of meta-analyses and systematic reviews of literature. Although there exist techniques for identifying the presence of publication bias (*e.g.*, plotting effect size against variance or sample size and checking for symmetry), the most vulnerable studies (*i.e.*, those with small sample sizes and those funded by entities with a financial interest in the results) share traits that could potentially confound the results of such a test. Larger and more negative LVMI effect sizes were observed among cohorts with severe anemia at baseline (Figure 2a). It would be difficult to determine whether the resulting asymmetry between these cohorts and the moderate anemia cohorts is due entirely to differences in baseline Hb or, instead, reflects a degree of publication bias.

Despite these limitations, the results of this study support the treatment of severe anemia with EPO. Not only will this therapy prevent blood transfusion and improve quality of life, it is likely to have a beneficial effect on cardiac structure. The results from RCTs do not support higher target Hb levels for EPO therapy as there is no evidence for beneficial effects on cardiac structure. A possible exception is cases in which baseline LVMI levels are already elevated above normal, but the evidence to support this conclusion has arisen from two studies without a control group, one of which included cointervention with both EPO and optimized heart failure therapy. One must remember that RCTs have produced a signal that high target Hb may have negative health outcomes (15–19,37). These adverse outcomes have not been observed uniformly across these studies, and several outcomes have had marginal statistical significance and wide confidence intervals for effect estimates. Current National Kidney Foundation guidelines recommend a target Hb of 11 to 12 g/dl (20), and a large RCT ( $N = 4000$ ), TREAT, is examining the efficacy of a high-target hemoglobin compared with placebo in type 2 diabetes with CKD (38).

### Conclusion

This systematic review and meta-analysis revealed that in cohort studies of patients with severe anemia, a significant decrease in LVMI was observed. However, the lack of control groups was a major problem. In RCTs of CKD and ESRD patients with moderate anemia, no difference in cardiac structure was observed in comparisons of patients randomly allocated to lower or higher Hb targets.

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## **ANEMIA TREATMENT IMPROVES HEART STRUCTURE AND QUALITY OF LIFE IN KIDNEY DISEASE PATIENTS**

*However, Different Levels of Erythropoietin Therapy Are Needed to Achieve These Effects*

**Washington, DC (Friday, March 27, 2009)** — In chronic kidney disease patients, different levels of anemia treatment have a beneficial effect on the heart and improve quality of life, according to a pair of studies appearing in the April 2009 issue of *the Clinical Journal of the American Society Nephrology* (CJASN). The findings indicate that different levels of treatment may be warranted for different patients.

Patients with chronic kidney disease often have low levels of erythropoietin (a hormone that stimulates the formation of red blood cells) and develop anemia. Anemia can cause enlargement of the heart, predisposing individuals to heart failure and death. Synthetic erythropoietin partially corrects anemia, and doctors prescribe it to try to increase patients' hemoglobin levels to 10-12 g/dl (hemoglobin is the predominant protein in red blood cells). Prescribing higher levels of erythropoietin may result in normal hemoglobin levels (greater than 13 g/dl), but recent clinical trials suggest that this may cause serious adverse effects, including death.

Two recent studies by Patrick Parfrey, MD (Memorial University of Newfoundland), and colleagues examined the effects of different levels of anemia treatment on heart structure and quality of life in chronic kidney disease patients.

The first study was a systematic review of published data on the effects of anemia on the heart. By analyzing 15 available studies involving 1,731 patients with kidney disease, the investigators found that partial correction of severe anemia with erythropoietin improved heart structure, but fully correcting anemia provided no additional benefit.

The second study assessed whether normalization of hemoglobin improves quality of life in kidney disease patients. The study was conducted because anemia-induced fatigue is a prominent symptom in patients with kidney disease. In a randomized trial performed in Canada and Europe, Dr. Parfrey and his team enrolled 596 relatively healthy patients starting dialysis. The researchers found that patients

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experienced less fatigue when they were treated with erythropoietin to reach a normal hemoglobin level compared with patients who were treated to achieve only partial correction of anemia.

Erythropoietin therapy can provide some benefits (such as reduced fatigue), but investigators concluded that the recommended hemoglobin target range is 10-12 g/dl. Treating patients to reach a normal hemoglobin level (>13 g/dl) does not improve heart structure and can cause significant harm to patients.

“It is possible that patients at low risk of an adverse side effect from erythropoietin therapy would value the improvement in quality of life provided by the higher hemoglobin level,” said Dr. Parfrey. “However the cost of this improvement in quality of life will be high, because erythropoietin is expensive,” he added.

The authors noted that a large clinical trial (TREAT) of 4,000 diabetic patients with chronic kidney disease will end this year and should provide additional information on the benefits and harms of prescribing erythropoietin to achieve a normal hemoglobin level.

The authors reported no financial disclosures.

The articles, entitled “Erythropoietin Therapy and Left Ventricular Mass Index in CKD and ESRD Patients: A Meta-Analysis” (doi 10.2215/CJN.02730608) and “Erythropoietin Therapy, Hemoglobin Targets, and Quality of Life in Healthy Hemodialysis Patients: A Randomized Trial,” (doi 10.2215/CJN.04950908) will appear online at <http://cjasn.asnjournals.org/> on April 1, 2009.

More than 11,000 physicians and scientists committed to preventing kidney disease and making life better for patients work together as members of the American Society of Nephrology (ASN). Whether providing expert care to patients, performing cutting-edge medical research, or training the next generation of kidney experts, these nephrologists change lives. Through advocacy, ASN informs policymakers about issues of importance to kidney doctors and their patients. ASN also funds research, convenes world-renowned meetings, and generates educational tools that enable nephrologists to be most effective. Building on a 40-year history, ASN brings rigor, integrity, and ingenuity to all its work.

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