$n = 101$), stable weight ($n = 6{,}445$), or weight gain (>10 kg weight increase; $n = 348$). Individuals in the weight-loss group showed marked improvements in blood pressure, cholesterol and high-sensitivity C-reactive protein levels compared with those in the stable-weight group. The opposite was true of participants who gained weight. UAE increased significantly in individuals who gained weight (mean ± SD +0.4 ± 2.0 mg/24 h; $P < 0.05$) and decreased significantly in those who lost weight (mean ± SD –2.2 ± 1.1 mg/24 h; $P < 0.01$), in comparison with those who maintained a stable weight. Stepwise multivariate analysis revealed that the weight-change-induced alterations in UAE were largely independent of changes in blood pressure, cholesterol, glycemia status, sodium and protein intake, and creatinine clearance. Notably, however, when changes in high-sensitivity C-reactive protein level were included in the model, the relationship between weight change and change in UAE disappeared. The authors conclude that the weight-induced changes in albuminuria cannot be explained by changes in classic cardiovascular risk factors or renal function, but seem to be dependent on vascular inflammation

Original article Bello AK *et al.* (2007) Impact of weight change on albuminuria in the general population. *Nephrol Dial Transplant* **22:** 1619–1627

Heparin-induced thrombocytopenia in the UK hemodialysis population

The use of heparin to prevent coagulation in the extrarenal circuit during hemodialysis has potential complications. The frequency and treatment patterns of heparin-induced thrombocytopenia (HIT) type II in the UK hemodialysis population had not been assessed in a large-scale study. By distributing a questionnaire to all 81 UK renal units, Hutchison and Dasgupta have been able to carry out such an evaluation.

Responses to the questionnaire were received from 50 (61.7%) units, representing a total of 10,564 maintenance hemodialysis patients. The observed overall prevalence of HIT type II was 0.26 per 100 patients, and the overall incidence was 0.32 per 100 patient-years. Fourteen of the responding units reported cases of HIT type II, with prevalences ranging from 0.22 to 1.74 per 100 patients. Only 17% of affected patients suffered complications.

Of the 50 renal units, 36% reported a policy of using danaparoid for ongoing anticoagulation in hemodialysis patients with HIT type II, as recommended by British Committee for Standards in Haematology guidelines. Worryingly, 6% of units continued to use low-molecular-weight heparin for anticoagulation in patients with HIT type II, and 34% of units had no defined policy for management of this condition.

This study shows HIT type II to be less prevalent in maintenance hemodialysis populations than previously estimated, and highlights the need for more-widespread implementation of management guidelines.

Original article Hutchison CA and Dasgupta I (2007) National survey of heparin-induced thrombocytopenia in the haemodialysis population of the UK population. *Nephrol Dial Transplant* **22:** 1680–1684

Underuse of ACE inhibitors and ARBs in patients with heart failure and renal dysfunction

The use of angiotensin-converting-enzyme (ACE) inhibitors and angiotensin-receptor blockers (ARBs) in people with congestive heart failure (CHF) and renal dysfunction is poorly studied. Berger and co-workers have retrospectively analyzed data from more than 2,000 such patients in the population-based Minnesota Heart Survey, stratified by glomerular filtration rate, to investigate the relationship between use of these two medications and all-cause mortality.

In-hospital use of ACE inhibitors decreased with increasing severity of kidney dysfunction; use of ARBs, on the other hand, increased. Data were similar with regard to prescription of these medications on hospital discharge. Several factors were strongly associated with use of these agents during hospitalization, including presence of hypertension, diabetes or hypercholesterolemia.

There was a marked correlation between increasing severity of renal dysfunction and increased mortality at 30 days and at 1 year after hospital admission. Use of either an ACE inhibitor or an ARB during hospital stay significantly reduced 30-day mortality, independent of degree of renal dysfunction, while prescription of either of these drugs at discharge was associated with a considerable reduction in 1-year mortality. These benefits were not, however, seen in patients on hemodialysis.