**Findings**

*Does Bariatric Surgery Affect Kidney Transplant Risks?*

Available data suggest that patients with previous bariatric surgery are not at increased risk of complications or adverse outcomes after kidney transplantation, reports a meta-analysis in *Transplantation*.

A literature review identified 18 studies reporting on the outcomes of kidney transplantation in 315 patients with previous bariatric surgery. Approximately two-thirds of patients underwent sleeve gastrectomy, and most of the others underwent Roux-en-Y gastric bypass. Quality was rated good in all but one study. Data were pooled for meta-analysis of kidney transplant outcomes.

Reported percentage of excess weight loss was 46.3%–94.8%, with a mean of 62.8%. Delayed graft function and acute rejection each occurred in 10% of patients, based on reported data from 14 and 11 studies, respectively. Wound complications occurred in 5% of patients (from 12 studies), urinary complications in 19% (from 9 studies), and vascular complications in 2% (from 11 studies).

Eleven studies reported kidney transplant outcomes at follow-up times from 15 months to over 5 years. Based on data from 14 studies, the average rate of graft loss was 3%. In four studies reporting a comparison group of patients with obesity who underwent kidney transplantation without previous bariatric surgery, transplant outcomes and complications were similar between groups.

Obesity-related diseases are a major contributor to end stage kidney disease, and weight loss can improve access to kidney transplantation in patients with obesity. Although bariatric surgery has been suggested as a bridge to kidney transplant, its impact on transplant outcomes is unclear.


**Hemodialfiltration May Improve Survival Compared with Hemodialysis**

The pragmatic, randomized trial included 1360 patients with kidney failure and at least 3 months on high-flux hemodialysis, enrolled at 61 European centers. All were considered candidates for a convection volume of at least 25 L per session in post-dilution mode. Patients were assigned to open-label treatment with high-dose hemodialfiltration or continued conventional, high-flux hemodialysis. All-cause mortality was assessed at a median follow-up of 30 months, along with secondary outcomes.

In the hemodialfiltration group, the mean convection volume was 25.3 L per session. All-cause mortality was 17.3% in patients assigned to hemodialfiltration versus 21.9% in the hemodialysis group. The survival benefit of hemodialfiltration was greater for patients without a baseline history of cardiovascular disease or diabetes, hazard ratios, 0.58 and 0.65, respectively. Risks of death from cardiovascular causes and a