

HA130 Related FAQ

1. What are the main clinical applications of HA130 hemoperfusion?

MHD patients have the following clinical manifestations, they recommended to the HP treatment^[1]:

- Severe uremic pruritus
- Severe uremic-related sleep disorders
- Protein energy consumption
- Microinflammatory status
- Severe secondary hyperparathyroidism
- Severe hyper β 2-MG
- Refractory hypertension
- Restless Leg Syndrome (RLS)
- Uremic peripheral neuropathy

2. What is the treatment scheme for Ha130?

The treatment scheme of HA130 could be as follow^[2,3]:

- Intensive program: 4 times/month
- Maintenance program: 1-2 times/month
- Treatment duration: 4 hours combined with HD or HDF
- The treatment scheme could be adjusted according to the patient's condition.

3. In some cases, why is the PTH still higher or did not reduce after the HA130 treatment?

HP treatment is expected to improve the symptoms and reduce the middle uremic toxins and protein-bound uremic toxins; try to analyze the factors which may affect the results:

- Patient's diet: A high phosphate diet and phosphate levels may increase PTH secretion^[4].
- Serum low vitamin D and calcium may increase the phosphate levels and increase PTH secretion^[4].

- Secondary hyperparathyroidism: Associated with high levels of PTH^[5].
- Note: Compare the HA130 group to the non-HA130 group to better outline the effect of HA130.

4. Is there any impact of HA130 on quality of life?

Combining HA130 and HD could improve body pain, general health, vitality, emotional role, mental health, and total QoL score^[2].

5. Is there an impact of HA130 on survival?

The Systematic Review and Meta-Analysis on the survival outcomes for the patients with End-Stage Renal Disease showed that the 1-year overall survival (OS) rate, the 2-year OS rate, and the 5-year OS rate of patients with ESRD treated with HP + HD were better than those treated with HD^[6].

6. Is there a cost-effectiveness study on hemoperfusion treatment?

The cost-effectiveness study with 1,407 patients recruited to the HD/HP trial from 30 clinical centers with two years' follow-up period demonstrated that^[7]:

- In the base case analysis, compared with HD alone, HD + HP results in 2.87 LYs saved, 1.32 QALY gains and an additional cost of RMB 33,340 per patient. The probabilistic ICER of HD + HP is USD 25,251 per QALY, which is lower than the USD 30,778 willingness-to-pay threshold. Therefore, HD + HP is considered to be cost-effective.
- HP+HD reduces the incidence of severe CVD events and subsequent CVD deaths.

[1] Gengru Jiang, "Shanghai Expert Consensus of Hemoperfusion Therapy Application in Maintenance Hemodialysis Patients", 39th Vicenza Course on AKI & CRRT, 26-29 October 2021.

[2] Chen, Shun-Jie, et al. "Combination of maintenance hemodialysis with hemoperfusion: a safe and effective model of artificial kidney." The International journal of artificial organs 34.4 (2011): 339-347.

[3] Huu, Dung Nguyen, et al. "A Combination of Hemodialysis with Hemoperfusion Helped to Reduce the Cardiovascular-Related Mortality Rate after a 3-Year Follow-Up: A Pilot Study in Vietnam." Blood purification 50.1 (2021): 65-72.

[4] Takeda, Eiji, et al. "Increasing dietary phosphorus intake from food additives: potential for negative impact on bone health." Advances in nutrition 5.1 (2014): 92-97.

[5] Yuen, Noah K., Shubha Ananthakrishnan, and Michael J. Campbell. "Hyperparathyroidism of renal disease." The Permanente Journal 20.3 (2016).

[6] Cheng, Wendi, et al. "Survival Outcomes of Hemoperfusion and Hemodialysis versus Hemodialysis in Patients with End-Stage Renal Disease: A Systematic Review and Meta-Analysis." Blood Purification (2021): 1-13.

[7] Wang, Haiyin, et al. "Cost-effectiveness analysis of hemodialysis plus hemoperfusion versus hemodialysis alone in adult patients with end-stage renal disease in China." Annals of Translational Medicine 9.14 (2021).

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