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CORRESPONDENCE

Tumor Lysis Syndrome : Authors' Reply

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To the Editor: We thank Gupta et al. for their interest in our article [1] and bringing up practical queries in the management of tumor lysis syndrome (TLS).

Choice of fluid for hyper-hydration: Five percent dextrose in ¼ normal saline is the recommended fluid [2]. We have observed iatrogenically induced hyperglycemia as a result of hyper-hydration with fluids containing dextrose. Blood sugar should be monitored; we have managed hyperglycemia by alternating fluid containing dextrose with fluid lacking it.

Relevance of Lactate Dehydrogenase level (LDH): LDH level is a surrogate for tumor proliferation. The higher the level, the greater the risk of TLS [3].

Duration of alkalinization: Alkalinization should be discontinued when: 1) Uric acid normalizes, 2) Cytotoxic therapy begins, 3) Urine pH exceeds 7.5, or 4) Hyperphosphatemia develops [2–4].

Grading the severity of TLS: Several attempts have been made to classify and grade TLS; a popular one is the Cairo–Bishop grading classification [5]. As per this grading, laboratory TLS is defined as either a 25 % change or level above or below normal, for any two or more serum values of uric acid, potassium, phosphate, and calcium within 3 d before or 7 d after the initiation of chemotherapy. Clinical TLS is defined as the presence of laboratory TLS and any one or more of: 1) Creatinine: ≥ 1.5 upper limit of normal, 2) Cardiac arrhythmia/sudden death, or 3) Seizure.

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