Lady of light, I would admit a dream
To you, if you would take it in your hand.
Will you not let it in a gentle stream
Of living blood? How else may I remand
Your light if not as pulse upon your ear?

Alan Tate

“The Buried Lake”
End-stage renal disease (ESRD) patient complexity has posed many challenges for providers, public health officials, and policy makers. Over the past decade, necessary improvements in ESRD care have been identified by a number of organizations, including the Centers for Medicare and Medicaid Services—through their Clinical Performance Measures (CPM) project, the National Kidney Foundation—through its Kidney Dialysis Outcomes Quality Initiative (K/DOQI) guidelines, and professional organizations such as the Renal Physicians Association and the American Society of Nephrology.

Most notable among these efforts is the assessment of provider performance under CMS’s Clinical Performance Measures project, which assesses the implementation of NKF’s K/DOQI guidelines. Targets for areas such as dialysis therapy, vascular access, and anemia treatment have been developed, and are shown in Figure 5.1.

It appears, for instance, that the target for hemodialysis therapy—a Kt/V greater than or equal to 1.2 (single-pool kinetics), or a urea reduction ratio of 65 percent or greater—has been reached in 91 percent of patients. In the CAPD population, 76 percent have reached a delivered weekly Kt/V of 2.0 or greater.

Vascular access guidelines, which recommend increased use of arteriovenous fistulas, have been based on the considerable morbidity and mortality associated with dialysis catheters, and on the marked differences in the use of simple fistulas in the U.S. compared to Europe and other parts of the world. Growth in the number of new patients using a fistula as their first access, however, has slowed, and only 29 percent receive this type of access—far from the target of at least 50 percent. Prevalent use of fistulas, in contrast, continues to rise, and at 35 percent is nearing the 40 percent target.

Target hemoglobin levels of 11 g/dl and above are achieved in 86 percent of patients, but there has been little progress in the number of prevalent patients with a serum albumin above the test’s lower limit, currently at only 64 percent.

This year we have added data on preventive care in diabetic patients, and on influenza vaccinations. Although targets have not yet been developed for diabetes care, the American Diabetes Association practice guidelines suggest at least two lipid tests and at least four glycosylated hemoglobin A1C tests per year, and the HP2010 program sets a 90 percent target for influenza vaccinations by 2010. While considerable progress has been made in these areas, rates remain far from recommended levels.

In the rest of the chapter we explore these measures of clinical care and preventive health in greater detail. In terms of vascular access, for example, the use of dialysis catheters continues to be a major issue for hemodialysis patients because of associated infectious morbidity and central vein stenoses (which limit future accesses). CPM data show a slow but steady rise in the use of catheters as the first access, con-
Catheters are associated with repeated catheter use, and with 1.3 infectious episodes and 1.6 episodes of sepsis per patient year—rates far higher than those seen with fistulas. It is encouraging to note, however, that the likelihood of receiving a fistula is growing.

To help identify areas for improvement in efforts to reduce high cardiac morbidity and mortality in diabetics, we present updated data on diabetic care—including glycosylated hemoglobin testing, lipid monitoring, and the use of diabetic test strips. And new this year, we examine differences in this care in urban and rural settings. Lipid monitoring, for instance, is more frequent in urban settings, while glycosylated hemoglobin testing, the use of diabetic test strips, and the provision of comprehensive care are each more common in rural areas.

We next address prescription drug use in diabetic patients, illustrating differences between Medicare and EGHP cohorts.

As a common complication of advancing chronic kidney disease and of ESRD, anemia management continues to be a central concern. This year we present data on trends in EPO dosing patterns based on hemoglobin levels in the first month of billed ESRD services. We also look at blood transfusions in the ESRD population, which were dramatically reduced after the introduction of EPO in 1989. Not surprisingly, patients with the lowest hemoglobin levels have a greater cumulative use of transfusions, reaching almost 25 percent at six months. We complete our examination of anemia management with data on patterns of care relative to iron dosing and iron indices.

In the final spread we assess preventive care, looking at glycosylated hemoglobin and lipid testing, at diabetic medications, and at vaccinations for influenza, pneumonia, and hepatitis B.

Clinical indicators of care and preventive health care show important advances over the last five to seven years. Diabetes care, as measured by monitoring of risk factors, has not yet achieved recommended levels, but does continue to improve. These areas of improved care may in part explain the continued reductions in mortality rates, illustrated in Chapter Six.
Figures 5.2–4 examine first access placements in prevalent dialysis patients. Since 1998, catheter placements are up 15 percent in patients age 20–44, and 16 percent in those age 75 and older (Figure 5.2). By gender, a higher percentage of women receive catheters as their initial access, and, among racial/ethnic groups, placement is slightly higher in whites and blacks. A patient’s locality does not appear to influence placement—25 percent of patients received catheters as their first access in both rural and urban locales in 2002.

Guidelines issued by the National Kidney Foundation’s Dialysis Outcomes Quality Initiative (K/DOQI) stipulate increased use of arteriovenous (AV) fistulas as the primary dialysis access. Since 1998, however, there has been little progress in the percent of patients using a fistula as their first access. Patients age 20–44 are the most likely to receive an AV fistula; depending on age, the percent receiving this access in 2002 ranged from 17.9 to 29.6 (Figure 5.2). Over twice as many men receive AV fistulas compared to women. By race/ethnicity, AV fistula creation is highest in Native Americans, at 38.5 percent, closely followed by Asians and Hispanics at 31 percent. There is little difference in the percent of patients with AV fistulas by locale.

The use of arteriovenous grafts as a first access seems to be falling into disfavor with dialysis practitioners. Since 1998 there has been a noticeable decline in the percent of patients with this access across all age categories and both genders (Figure 5.4). By race, the largest decrease has occurred in Asians, at 25.9 percent (Figure 5.4). By locale, use has lowered 15.6 and 20.3 percent in urban and rural settings, respectively.

Figures 5.5–8 present data on access events and complications in the incident dialysis population. Among hemodialysis patients, complications are most frequent in those whose first access is a catheter, with rates of 1.3 infections and 1.6 sepsis events per year. After a graft failure, these patients are most likely to have the catheter replaced with an internal access, while patients starting with a fistula or graft are most likely to receive a catheter. The lowest rates of both events and complications occur in those whose first access is an AV fistula. In the peritoneal dialysis population, events occur at rates of 0.3 per year (catheter removal) to one per year (replacement with an internal hemodialysis access); the most frequent complication in these patients is an episode of peritonitis.

The odds ratio of using a fistula was 57 percent higher in 2002 than in 1998 (Table 5.1). Pediatric patients are 23 percent more likely, and elderly patients 53 percent less likely, to use a fistula than those age 20–44. Women are 62 percent less likely than men to have this type of access, perhaps because of differences in vasculature. Compared to whites, blacks are 39 percent less likely, and Native Americans 80 percent more likely, to have a fistula; Asian race and Hispanic ethnicity have little effect on the odds ratio. And patients in urban areas are 13 percent more likely to have this type of access than those in rural settings.

Geographic variations in the percent of patients who receive a fistula as their first access are markedly different between races, with use more widespread across the country for whites than for blacks (Figure 5.9).

(Figures 5.2–4) incident hemodialysis patients, CPM data; includes only patients who are also in the USRDS database, whose day 90 begins prior to October of the incident year, & whose day 90 access is known. Year represents the prevalent year & the year the CPM data were collected; access represents the access used on day 90. (Figures 5.5–7) incident hemodialysis patients who are also in the CPM database, 1999–2002.
2002 combined includes patients whose first access is the access shown in the figure. First access determined from day 90 access, according to the CPM data. Events & complications identified from claims during the first year after the first service date; events identified from Part B CPT codes, & infections/sepsis from Parts A & B ICD-9-CM codes. [Figure 5.8] incident prevalent hemodialysis patients, 1999–2002 combined. First access determined from CPM data. Events & complications identified from claims during the first year after the first service date; events identified from Part B CPT codes, & infections/sepsis from Parts A & B ICD-9-CM codes. [Table 5.a & Figure 5.9] period prevalent hemodialysis patients also in the CPM database, on hemodialysis at least three months prior to October of the prevalent year, & with a known access type recorded in the CPM data as the most recent used at time of data collection, 1998–2002 combined. In Figure 5.9, race information from CPM data; state represents the state of the patient’s dialysis provider.
Since 1993 the percent of patients receiving four or more glycosylated hemoglobin tests has increased dramatically across the nation (Figure 5.10). As of 2003, however, only 42 percent of patients receive the four or more HbA1c tests per year recommended in the guidelines of the American Diabetic Association (Figure 5.11). In 1992-1993, only one in four diabetic ESRD patients received any testing; by 2002-2003 this had risen to 74 percent.

Across most age and racial/ethnic groups, the percent of patients receiving recommended testing is higher in rural areas (Figure 5.12). Fifty-four percent of Hispanic patients in rural areas, for example, receive four or more tests, compared to 45 percent of those living in larger cities. Still unclear are the reasons why the youngest diabetics are least likely to receive these tests.

Rates of lipid testing have also increased over the last decade, and 44 percent of diabetic ESRD patients now receive at least two tests per year, up considerably from the 18.6 percent seen in 1993 (Figures 5.13-14). Thirty-seven percent, however, receive no testing at all. Patterns by geographic location differ from those seen with HbA1c testing, with the percent of patients receiving two or more tests slightly higher in urban areas overall and for patients age 31 and older (Figure 5.15). By race, rates for blacks, Native Americans, and Asians are higher in urban areas.

In 1997, Medicare added glucose testing supplies to the benefits received by diabetic patients. It is unclear, however, whether diabetic testing strips may be purchased without Medicare reimbursement, and thus not captured in the database. The percent of patients prescribed two or more glucose test strips per day increased nationwide from 5.4 to 13.2 percent between 1994 and 2003 (Figure 5.16). More than 60 percent of diabetic ESRD patients, however, are not prescribed any diabetic test strips (Figure 5.17).
The percent with a prescription for at least two strips per day is only 12.3 in urban areas, and 15.9 in rural ones (Figure 5.18). Patients age 31–40 who live in rural areas are most likely to have this prescription. By race, prescription rates are greatest among white patients, and lowest in Native Americans—with fewer than 2 percent of rural patients prescribed two or more tests strips per day.

Clearly, then, diabetic monitoring in the ESRD population is far from recommended levels. Although it has improved across the country, complete monitoring—at least four HbA1c tests, at least two lipid tests, and at least two diabetic test strips per day—was provided to only 3.4 percent of diabetic patients in 2004, and less than one percent of Native Americans (Figures 5.19 and 5.21).

Fewer than one in four diabetic patients receives the minimum preventive care of at least one HbA1c test, at least one lipid test, and at least one diabetic testing strip (Figure 5.20).

(All figures) patients with Medicare Parts A & B primary payer coverage. [Figures 5.10–11, 5.13–14, 5.16–17, & 5.19–20] point prevalent patients initiating ESRD 90 days prior to January 1 of the first year, age 18–75 on December 31 of the second year, & alive through the end of the second year, with diabetes as the primary cause of ESRD or a comorbidity on the Medical Evidence form, or with diabetes diagnosed during the first year. Maps by HSA, unadjusted. Testing/test strips tracked in second year; for Figures 5.19 & 5.20, tests are at least 30 days apart. [Figures 5.12, 5.15, 5.18, & 5.21] point prevalent patients, 2002, with 90-day rule, age 18–75 on December 31, 2003, & alive through that day, with diabetes as the primary cause of ESRD or a comorbidity on the Medical Evidence form, or with diabetes diagnosed in 2002. Testing/test strips tracked in 2003. Complete diabetic monitoring includes at least four HbA1c tests, at least two lipid tests, & at least two diabetic test strips per day. “Limited monitoring” includes at least one HbA1c test, at least one lipid test, & at least one diabetic test strip.
his spread addresses prescription drug use in employed diabetic patients with and without ESRD, using the Medstat database. Insulin therapies continue to be the mainstay of glycemic control in ESRD patients with diabetes, used in 58–61 percent, compared to 25–37 percent of non-ESRD patients (Figure 5.22). The use of secretagogue agents (sulfonylureas, repaglinide, nateglinide) is less common in ESRD than non-ESRD patients—not surprising, given the lack of effectiveness with beta-cell burnout, which is more common in the long-standing diabetes seen in ESRD patients (Figure 5.23). Use of thiazolidinediones, insulin sensitizers, has increased, and is twice as high in non-ESRD patients age 45–63 as in those with ESRD (Figure 5.24). Just over 1 percent of prevalent ESRD patients were prescribed metformin in 2003 as compared to 41–52 percent of non-ESRD patients (Figure 5.25). This is expected, given that metformin is contraindicated in patients with abnormally high serum creatinine values.

In Figures 5.26–30 we look at medication use in diabetic patients with cardiovascular disease (CVD). Use of angiotensin-converting enzyme inhibitors (ACE-Is) and angiotensin receptor blockers (ARBs) is common, at 50 and 54 percent in those age 20–44 and 45–63.

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**Figure 5.22** Cumulative percent of diabetic patients receiving insulin, by age & ESRD status

**Figure 5.23** Cumulative percent of diabetic patients receiving secretagogues, by age & ESRD status

**Figure 5.24** Cumulative percent of diabetic patients receiving thiazolidinediones, by age & ESRD status

**Figure 5.25** Cumulative percent of diabetic patients receiving metformin, by age & ESRD status

**Figure 5.26** Cumulative percent of diabetic patients with CVD receiving ACE-Is/ARBs, by age & ESRD status

**Figure 5.27** Cumulative percent of diabetic patients with CVD receiving beta blockers, by age & ESRD status
63, respectively. This compares with 62 percent of new dialysis patients age 20–63 years with and without CVD (see Chapter Three). Lower ACE-I/ARB use in prevalent ESRD patients with CVD may reflect issues with hyperkalemia as kidney function declines.

As in CKD and incident dialysis patients with diabetes (Chapters One and Three), beta blocker use has increased in older prevalent patients with diabetes and CVD (Figure 5.27). It has fallen in younger dialysis patients, but this might reflect a small sample size and not represent the trends in the population as a whole. Use also increased between 2000 and 2003 in non-ESRD patients with diabetes and CVD; overall use, however, was less in 2003 compared to ESRD patients. This makes sense, as CHF is more common in ESRD patients, and ESRD patients often require multiple antihypertensive medications to control hypertension.

The percent of diabetic prevalent ESRD patients with CVD receiving dihydropyridine calcium channel blockers (CCBs: amiodipine, felodipine, isradipine, nicardipine, nifedipine, nimodipine, and nisoldipine) rose from 38–39 percent to 44 percent in 2003. These are similar to the percentages seen in incident diabetic ESRD patients (Figure 5.28). The use of these agents is substantially less in non-ESRD patients, which may reflect lesser amounts and degrees of hypertension in that population.

The use of nondihydropyridine CCBs (diltiazem and verapamil) has decreased to 6–10 percent in the prevalent ESRD population with diabetes and CVD (Figure 5.28) and is even less than the use in new ESRD patients with diabetes (see Chapter Three). The use of these agents in non-ESRD patients is similar to that of ESRD patients.

Statin use in non-ESRD patients is higher than in ESRD patients with diabetes and CVD; both populations showed increases in use from 2000 to 2003 (Figure 5.29). A large prospective study (the 4D study), evaluating the use of 20 mg a day of atorvastatin in prevalent ESRD patients receiving hemodialysis for less than two years, demonstrated negative results. Atorvastatin had no significant effect (after a median followup period of four years) on the primary endpoint, a composite of death from cardiovascular causes, nonfatal myocardial infarction, and stroke. The study results may lessen enthusiasm for starting a statin in prevalent dialysis patients. Non-statin use in ESRD patients is substantially less than use of statins, and use of non-statins in prevalent ESRD patients is similar to that seen in incident patients (see Chapter Three).
EPO doses per week overall differ little for hemodialysis patients living in urban versus rural settings (Figure 5.31). Among patients who begin ESRD therapy with hemoglobins less than 11 g/dl, however, doses for rural patients are slightly lower at month two after day 90 of ESRD and at months five and six.

Figures 5.32–33 compare EPO doses at months 2–5 to those given during the first month following day 90 of therapy. Doses per week vary, not unexpectedly, with hemoglobin level. Patients with the lowest hemoglobins—between 9 and 10 g/dl—have the greatest increases in EPO use in the first six months of treatment.

For patients who begin ESRD treatment with a hemoglobin of 12 g/dl or higher, differences are slight between urban and rural patients. For patients who begin with hemoglobins less than 11 g/dl, however, they are more dramatic, particularly among patients whose initial hemoglobin is 10–10.5 g/dl. In this population, patients living in a rural setting—where dialysis units tend to be hospital-based, and not affiliated with a chain—have their EPO doses cut back more aggressively, and doses at months five and six are 5–6 percent lower than in month one.

Geographic comparisons of weekly EPO dose by hemoglobin level show that dosing patterns across the nation are quite similar (Figure 5.34). While all providers appear to use patterns commensurate with hemoglobin level, states in the Gulf Coast region and on the East Coast tend to give the highest overall doses.

In the first month after day 90 of ESRD therapy, transfusions are received by 11.3 percent of patients who begin treatment with a hemoglobin less than 11 g/dl, compared to 3.3 and 1.5 percent of those starting with hemoglobins of 11–<12 g/dl and 12 g/dl or higher, respectively (Figure 5.35). By six months after day 90, nearly 23 percent of those who start with a low hemoglobin have been transfused. Most transfusions are given in an inpatient setting.

For prevalent dialysis patients included in the CPM survey (October–December of each year), with iron saturation levels of less than 20 percent, the cumulative percent of patients receiving IV iron in the first six months of the next year is the same for all hemoglobin levels (Figure 5.36). Interestingly, however, is that those with low ferritin levels (less than 100 µg/ml) have the highest iron use rates when their hemoglobins are in the target range of 11–12 g/dl. For those with iron saturation levels greater than 50, it still appears that almost 60 percent, at any hemoglobin level, receive IV iron. The combination of a low iron saturation and low ferritin, an indication of iron deficiency, leads to the greatest percentage of patients receiving IV iron when the hemoglobin is 11–12 g/dl at almost 100 percent.

Changes in EPO dose based on iron dosing patterns are presented in Figure 5.37. Patients with both low iron saturation and low ferritin levels who do not receive IV iron throughout the six-month study period ultimately increase their weekly EPO doses.
Those with a low iron saturation but a high ferritin (evidence of inflammation in functional iron deficiency) show the greatest reductions in EPO doses when iron is not given.

(Figures 5.31–35) incident patients, 2003, whose initiation began at least 90 days prior to June 30, 2003, who were alive, on hemodialysis, & with Medicare as primary payor for six months after day 90, who had at least one valid EPO claim during each of those months, & who had a valid ZIP code. “Starting hemoglobin” represents the mean hemoglobin from all EPO claims during the first month after day 90 for each patient. Dose per week is adjusted for inpatient days. In Figures 5.32–33, percentages represent the difference of the months mean dose per week from the mean dose per week during the first month after day 90. (Figures 5.36–37) prevalent patients, 2003, who are also in the 2003 CPM report, who have valid, non-missing values for at least one iron saturation & ferritin in the CPM data, & who are alive, with Medicare as primary payor, on hemodialysis through June 30, 2003, with at least one valid EPO claim during each of the first six months of 2003. Hemoglobin represents the patient’s mean hemoglobin, from EPO claims, from January, 2003. For Figure 5.33, EPO dose is adjusted for inpatient days.

5.34 Patient-level mean weekly EPO dose (1,000s of units), by pt-level mean hgb & state

5.35 Blood transfusions in the first six months of therapy, by location & starting hemoglobin

5.36 Cumulative percent of patients receiving iron in the first six months of 2003, by iron saturation, ferritin, & hemoglobin levels

5.37 Mean EPO dose, by iron dosing & iron saturation & ferritin levels
Diabetic hemodialysis patients are more likely than their counterparts on peritoneal dialysis to receive four or more glycosylated hemoglobin tests; they are less likely, however, to receive two or more lipid tests (Figures 5.38 and 5.40). The HP2020 program sets a goal of a 90 percent influenza vaccination rate. Less than one-third of pediatric dialysis patients, however, and only 67 percent of those age 75 and older, are vaccinated (Figure 5.43). Rates of pneumococcal pneumonia vaccinations, at their highest, barely top 15 percent in hemodialysis patients age 65 and older and in whites (Figure 5.45). Hepatitis B vaccination rates are somewhat higher, yet only one in ten pediatric patients is vaccinated (Figure 5.47).

More patients received general preventive care nationwide in 2003 than in 1996 (Figures 5.44, 5.46, and 5.48). The percent of patients receiving influenza, pneumococcal pneumonia, and hepatitis B vaccinations, respectively, grew from 42 to 57, from 10.2 to 13.7, and from 14 to 20.9. These increases, while encouraging, indicate that preventive care initiatives should be expanded.
Figure 5.2 Since 1998, catheter placements are up 15 percent in patients age 20–44, and 16 percent in those age 75 and older. Figure 5.3 Since 1998 there has been little progress in the percent of patients using a fistula as their first access. Patients age 20–44 are the most likely to receive an AV fistula; depending on age, the percent receiving this access in 2002 ranged from 17.9 to 29.6.

Figure 5.4 The use of arteriovenous grafts as a first access seems to be falling into disfavor with dialysis practitioners. Since 1998 there has been a noticeable decline in the percent of patients with this access across all age categories and both genders. Figure 5.5 Among hemodialysis patients, complications are most frequent in those whose first access is a catheter, with rates of 1.3 infections and 1.6 sepsis events per year.

Figure 5.11 As of 2003, only 42 percent of patients receive the four or more HbA1c tests per year recommended in the guidelines of the American Diabetic Association. Figure 5.14 Rates of lipid testing have increased over the last decade, and 44 percent of diabetic ESRD patients now receive at least two tests per year, up considerably from the 18.6 percent seen in 1993.

Figure 5.22 Insulin therapies continue to be the mainstay of glycemic control in ESRD patients, with 58–61 percent of diabetic patients using these medications. Insulin use in the non-ESRD population is only 37 percent in the youngest patients and 25 percent in those age 45–63. Figure 5.24 Use of insulin sensitizers, particularly TZDs, has increased in both the ESRD and the non-ESRD populations, with the latter utilization almost twice that of the ESRD population.

Figure 5.31 EPO doses per week overall differ little for hemodialysis patients living in urban versus rural settings. Figure 5.36 For patients with iron saturation levels less than 20 percent, the cumulative percent of patients receiving IV iron therapy is the same for all hemoglobin levels. Figure 5.37 Patients with both low iron saturation and low ferritin levels who do not receive IV iron throughout the six-month study period ultimately increase their weekly EPO doses.

Figure 5.38 Diabetic patients on hemodialysis are more likely than their counterparts on peritoneal dialysis to receive four or more glycosylated hemoglobin tests; they are less likely, however, to receive two or more lipid tests. Figures 5.44, 5.46, & 5.48. Between 1996 and 2003, the percent of patients receiving influenza, pneumococcal pneumonia, and hepatitis B vaccinations, respectively, grew from 42 to 57, from 10.2 to 13.7, and from 14 to 20.9.

**MAPS: NATIONAL MEANS & PATIENT POPULATIONS**

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