

DISCUSSION

SHALDON (London): Dr. Drukker, last year I asked you whether we would have any data on frequency of dialysis, as I find the complication rates still as high as ever, which is rather disturbing. I think that there is some doubt in many people's minds as to what is the optimal frequency of dialysis and I was disappointed not to see on your questionnaire this year a specific question asking what frequency patients were dialysed with. I think this is important and I think it might help to determine ultimately what is the optimum treatment on intermittent dialysis, which is clearly in dispute at the moment. Do you have any data on this?

DRUKKER (Amsterdam): We asked for frequency of dialysis in the previous questionnaire and we were disappointed with the answers. We did not get accurate answers on the frequency and, as important, the total number of hours of dialysis per week. As we did not get reliable figures last time, we left it out this year.

MCGEOWN (Belfast): The mortality figures may be misleading as to home dialysis, because you have clearly shown that the mortality occurs early—in the first and second week—in the patients dialysed in the centres. If a given patient is selected for home dialysis, they and their mortality ought to go to home dialysis, not centre dialysis.

Another way of looking at it is, if you take only the mortality after three months for home dialysis, then that ought to be compared with a similar incidence of mortality in the centres.

KERR (Newcastle): Dr. Drukker, you mentioned that, as far as you know, no woman had ever borne a child on regular dialysis. On the other hand there are a fairly large number of males who have now procreated. I appreciate that they are all tied to the machine twice or three times a week and the more cynical have asked for their blood groups, but we have at least one man who, we are fairly certain, is the father of his child.

CLARK (Chester): Recently at the American Society for Artificial Internal Organs Meeting in Philadelphia it was reported by the Seattle group that one of their female patients, whom they had put on chronic maintenance dialysis, with a frequency of five daily dialyses per week, had indeed borne a child and her creatinine ranged between 8 and 10 at the conclusion of her pregnancy and, following the pregnancy, they took her off maintenance dialysis.

DRUKKER (Amsterdam): I think that this case was a little different. This was a woman who was not on dialysis before she became pregnant.

CLARK (Chester): That is correct. She had not been on maintenance dialysis prior to her pregnancy. However, during her pregnancy, her uraemia progressed and her creatinine went up and the decision was made because it was not anticipated that she would bear a live child. She was dialysed five days a week for about the last four months of her pregnancy.

SHALDON (London): I think, in fairness, this last case is not relevant, because there is no proof that this woman would not have borne a viable child without dialysis. This was a prophylactic measure in a patient who did not require maintenance dialysis by normal criteria of living. I think that it is no more relevant than the fact that patients with acute renal failure have borne viable children after dialysis.

The CHAIRMAN (Walsh, Dublin): Well, at least I think we can all agree that the figure of 1 is not yet statistically significant.

DISCUSSION

MAHER (Washington): I happen to have in my hand a copy of the transactions of the A.S.A.I.O. meeting, which was held about two months ago, as you know!! I think, in response to Dr. Shaldon, that the patient had certainly not been on chronic dialysis for any extended period of time, but at least the dialysis procedure itself did not interrupt the pregnancy. This is one thing we can clearly learn from Dr. Scribner's experience. There was nothing like heparinisation that did damage to the pregnancy. I agree with him that it is very difficult to evaluate whether this patient had to be dialysed in order to maintain the pregnancy, but nevertheless it was a first.

The CHAIRMAN: Would anyone like to comment on the transplant figures? It seems to me that, compared with the figures of previous years, they are extremely encouraging. Quite obviously, room can only be made for patients on maintenance dialysis by transplanting many of the patients on a maintenance dialysis programme. There is great encouragement in the present figures to continue with this policy. I think it particularly interesting to see the very great improvement in the results of cadaver transplantation.

You will notice that this year we have not included in the dialysis report an analysis of the type of machine used. This is because we feel that, although there is a difference between centres using one type of machine and centres using another type, this may in no way reflect the merits of the machine. I think that this is probably an important point to stress: that we do not, yet, have the data to let us know whether the difference is in the people using the machines or in the machines themselves. For this reason, one of the points which is going to be considered by the subcommittee set up by the Council to decide on how the dialysis reports should be done in future is the possibility of analysing this factor and of giving any sort of answer to it.

SEINFELD (Munich): As you have mentioned a technical point, I would like to ask a similar question regarding transplants: it would be very interesting to find out what sort of immuno-depressant maintenance was employed.

PARSONS (Leeds): This was kept out of the European statistics, but I think it is included in the world collection from Boston. It is very, very difficult, of course, to interpret the answers to any question that you like to frame on immuno-suppressive therapy.

The CHAIRMAN: Well, Ladies and Gentlemen, I think that the very best thanks of the Association are due to Dr. Drukker and to Dr. Parsons for the great amount of work they have put into producing these reports, which we shall all have to digest at our leisure.