GENERAL DISCUSSION ON DIALYSIS AND TRANSPLANTATION STATISTICS

McGEOWN (Chairman): I would now like to have a general discussion on the statistical results. The presentation of Dr Parsons and his colleagues shows that the results of home dialysis in terms of patient survival are better than any form of transplantation, and better than hospital dialysis. This has considerable implications for us all because home dialysis, however good it may be, has to be financed. The cost of home dialysis is very great.

We were shown this computer-based model which showed that the number of patients being put on treatment per year would eventually reach a steady state. But this does not take into account the number of patients who could potentially need treatment. This relates to a single hospital or a single pool of dialysis patients, but we must base our planning on the number of patients who should be treated. The estimated figures for this lie somewhere between 30 and 50 new patients per million population per year. The question we must ask ourselves is, whether it is ever going to be possible to provide home dialysis for 50 new patients per year and, if not, how big a place can transplantation play in making the gap good. Are there any comments please?

V PARSONS (London): I don’t particularly want to take up any points that you mention, but I would like to come back to Dr Fisher’s presentation about the calculation of the cost of dialysis in the hospital and in the home, and whether he has built into his scheme the possibility of hepatitis occurring in his unit. It may affect the statistics, and I am wondering whether he has contributed to the discussion that we are having at the moment about the treatment of patients who develop hepatitis in the home and in hospital, and whether he is putting forward (as some have suggested) a second unit in each hospital for the treatment of patients with this trouble?

FISHER (London): The answer, very simply, is no, we have been unable to take into any account hepatitis occurring in units, because we don’t know enough about it. Ours is a statistical model. I think we must know far more, but I take your point that this is going to have far reaching implications.

D JOHNSON (London): If I could take up your comment, Madam Chairman, about the number of patients who could benefit from treatment. It is possible to use our model in the other sense and given the number of patients to be treated, calculate the resources we would need to treat them. It would be possible, given a fixed policy, for a country to estimate the requirements in terms of beds and other facilities.
McGEOWN: Would it also be possible to estimate the relative costs of a home dialysis programme and of a joint home dialysis and transplant programme?

JOHNSON: It would be possible to get different policies and estimate which was the best in terms of various criteria.

McGEOWN: So that given the right finance one could plan how far it would go towards treating the necessary population?

JOHNSON: That is correct.

McGEOWN: That would be very interesting.

K KOPP (Salt Lake City): Maybe I should mention that at present in the United States a trial is being made of a new approach to the problem of treating patients. This is the result of the incredibly high cost of dialysis, especially in hospital, but also in the home. The possibility that is under study is the use of a 'limited care facility' which consists of a centre which is not part of a hospital and which is usually located in a rented house. There are one or two nurses or technicians and most of the work is taken over by the patient and his family attendant. Professional help is only given in the event of an emergency.

McGEOWN: Thank you Dr Kopp. May I ask you if there is any hepatitis in your area?

KOPP: As far as Salt Lake City is concerned, we have had virtually no problem with hepatitis.

R BAILLOD (London): I want to comment on the fact that we have shown that home dialysis may be better than transplantation. I am often faced with the moral problem of trying to persuade a well-established home dialysis patient that the cadaver kidney that has been offered will be a suitable alternative. I think this is particularly so in someone who is well-established, like Dr Eady, with a life to lead which he can well define by his mode of dialysis. For example, he can plan to come to Berlin here today. Sometimes for many months after transplantation patients have the problem of waiting around for rejection. They can no longer define their lives. I don't think that home dialysis should take preference over transplantation; we have just got to put them all together, but we have this moral problem to face.

McGEOWN: Thank you Dr Baillod.
J MAY (Sydney): Although I could see Dr Parsons' graph very well from here, I couldn't quite see the figures. I wonder if he could just tell us very briefly how many patients are alive at the end of five years on home dialysis and how many are alive at the end of five years after a cadaver graft?

PARSONS: It was Hans Gurland who did the survival graphs for us and I can't rattle these figures off from memory, but if you wait for the Proceedings, all the calculations that you wish to undertake will be possible because all these figures will be there. You can adjust them as you like. We are dealing with 8,000 odd patients; I do apologise for my computer not being able to keep up with these figures but they will be published.

McGEOWN: Thank you. I appreciate Dr Baillod's moral dilemma of offering transplantation to a well-dialysed, well established patient, but nevertheless there is also the moral dilemma of patients who will not be treated by any form of treatment under the present situation. Transplantation would clearly increase the number of patients who could ultimately be treated.
PART II

REGULAR DIALYSIS TREATMENT

i) CLINICAL ASPECTS
Chairman: Professor L Migone

ii) CALCIUM AND BONE DISEASES
Chairman: Professor A C Kennedy

iii) METABOLISM
Chairman: Professor T Orłowski

iv) MISCELLANEOUS TOPICS
Chairman: Professor H Dutz