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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Evaluation of ultra-short dialysis

SIR,—The study undertaken by Dr J A P Trafford and others (24 February, p 518) confirms the feasibility of reducing the duration of haemodialysis treatment to less than the 16-30 hours weekly that has been accepted as the standard requirement by nephrologists for over a decade. Subsequent to Cambi's initial reports,[1 2] many workers have evaluated shortened dialysis schedules with respect to symptoms, biochemical control, and economics. The long-term effects of reducing dialysis times are, however, not yet clear and we may rediscover complications encountered in the early days of dialysis. The fact that we have not yet defined those "toxic" uraemic molecules makes this a distinct possibility.

Uraemic pericarditis still occurs in "well-dialysed" patients. This has been described as dialysis-associated pericarditis and its incidence is up to 16%,[3] although recent European Dialysis and Transplantation Association figures indicate a lower incidence.[4] The incidence of pericarditis in patients on short as opposed to long dialysis times is not known. Experience gained in this unit suggests pericarditis as a possible complication of short dialysis.

Regular short haemodialysis (9-11½ hours weekly) was commenced in May 1974 and the initial year's experience reported in the *BMJ*.[5] Since the introduction of this regimen, seven patients have developed "uraemic" pericarditis, after periods ranging from 3 to 54 months, representing an attack rate of 2-5·5% per year. These cases are reported elsewhere.[6] In the three years before the introduction of short dialysis there were 50% fewer patients on dialysis but no cases of pericarditis.

There seemed to be a seasonal link to the onset of pericarditis and a respiratory illness preceded the condition in some cases. As a result of this experience intensification of dialysis or prolongation of treatment times is now our current practice during any intercurrent illness.

The idea that a fixed regimen should suffice for all patients all the time is now discarded and we modify duration of dialysis and indeed surface area of dialyser according to blood pressure, weight, and the presence or absence of infection or intercurrent illness.

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[1] Cambi, V, *et al*, *Proceedings of the European Dialysis and Transplant Association*, vol 10, p 271. London, Pitman Medical, 1973.
[2] Cambi, V, *et al*, *Proceedings of the European Dialysis and Transplant Association*, vol 10, p 342. London, Pitman Medical, 1973.
[3] Ogburn, H M, *et al*, *Dialysis and Transplantation*, 1978, **7**, 1133.
[4] Wing, A J, *et al*, *Proceedings of the European Dialysis and Transplant Association*, vol 15, p 42. London, Pitman Medical, 1978.
[5] Martin, A M, *et al*, *British Medical Journal*, 1975, **3**, 758.
[6] Martin, A M, *et al*, *Dialysis and Transplantation*, in press.

Emotion and empiricism

SIR,—It is frequently held that the only circumstances in which a doctor may ethically start a randomised clinical trial is when he is in a state of complete impartiality about the relative merits of the treatments to be compared. Otherwise he would knowingly risk the allocation of patients to a treatment which he had anticipated would be suboptimal. Such an action would run contrary to his ethical obligation always to give his patients the treatment he thought was best. To fulfil these ethical responsibilities he also has a duty to find out which is the best treatment.

I do not believe, however, that any doctor would embark on a comparison of treatments he truly believed were indistinguishable, or design and carry out a time-consuming trial to show no difference. On the contrary, most doctors at the start of a trial have a modest expectation that the new treatment will offer some advantage. How then can he avoid giving anyone the treatment he suspects may *not* have the advantage? Choosing a historically controlled design offers a solution to this ethical dilemma, as you point out in your leading article (3 February, p 288), but brings other problems already extensively discussed by Dr A L Cochrane and others (17 February, p 486) and elsewhere.[1 2] The apparent ethical problems of randomised trials can be solved if we look at some of the realities of clinical decision taking.

Although the doctor may set out with some anticipation of benefit, knowledge of previous