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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.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

Treatment of renal failure in a non-specialist unit

SIR,—We wish to compliment Dr N Wright and his colleagues (12 July, p 117) for their industry in establishing facilities for dialysis in a district general hospital and for their excellent results. We can substantiate their claims from our own experience, which started in 1962. Like Dr Wright's, our results compare favourably with those in patients treated in a specialist centre.

We treat our patients in a general intensive care unit, where most of the observations and treatments are made by specifically trained nurses.[1] We use both peritoneal dialysis and haemodialysis. For the latter we favour a rather old-fashioned but powerful and versatile machine, the Kolff Travenol.

The advantages of not moving the patients away from the admitting hospital are direct and indirect. The direct benefits to the patient are the continuity of care and the ease of visiting for relatives. Indirect benefits are also of great value.[2] Errors and omissions in patient management leading to renal failure can be recognised and prevented from recurring by a system of educational feedback. The incidence of preventable renal failure can thus be kept to a minimum.

It is important for anybody embarking upon a programme of dialysis in a non-specialist unit to formulate criteria for commencing and discontinuing treatment; otherwise much effort may go unrewarded. Although any patient presenting as a uraemic emergency of unknown cause deserves a trial of therapy while a diagnosis is reached, treatment should be discontinued if an irreversible systemic disease is discovered. Similarly, patients developing renal failure during the course of a systemic illness should be dialysed only if the disease involved is potentially reversible. Particular attention is drawn to the incurable nature of renal failure in association with bacterial toxaemia, when there is shock and pulmonary involvement. In this instance intensive dialysis merely prolongs the inevitable.

In co-operation with the regional dialysis programme, we have also treated a small number of patients by maintenance haemodialysis, some of whom were later transplanted. The benefits of this arrangement were twofold. Firstly, regular dialysis enabled nurses to be trained in the necessary skills so that a trained pool of staff was always available to deal with emergency situations. Secondly, the nursing staff gained an insight into the relative advantages and disadvantages of both maintenance dialysis and transplantation. A favourable atmosphere towards transplantation was thus created and led the way to a programme of cadaveric organ donation.[3]

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[1] Jones ES. *Essential intensive care.* Lancaster: MTP Press, 1978: 1-27.
[2] Jones ES. In: Walker WF, Taylor DEM, eds. *Intensive care.* London: Churchill Livingstone, 1975: 111-21.
[3] Luksza AR. *Br Med J* 1979;i:1316.

Renal transplant rejection after gradual withdrawal of prednisolone

SIR,—Dr R B Naik and colleagues (7 June, p 1337) have shown that their renal transplant patients can maintain stable renal function with oral prednisolone (10 mg/day) as the sole immunosuppressive agent. Some patients suffered rejection episodes when the dose was less than 7 mg/day, but others maintained good graft function at lower doses (1 or 5 mg/day). They concluded that a standard