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NEWS AND NOTES

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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.

Audit in renal failure

SIR,—Renal physicians can justifiably claim that collectively, through the European Dialysis and Transplant Association and national transplant-sharing organisations, as well as individually they have done more than any other group to audit their practice and to provide information concerning the complications, outcome, and costs of dialysis and transplantation for end-stage renal failure. It is therefore disappointing that a professional research organisation such as the Study Group of the Royal College of Physicians should not consider the extensive literature[1-10] before reaching conclusions concerning the availability of resources to treat end-stage renal failure (25 July, p 282). It must be unusual for a paper with conclusions at variance with and in apparent ignorance of so much published data to be accepted by the *BMJ*. Unfortunately, the general public and their appointed representatives, who the authors claim are being misled, are more likely to be misled by the publication of such a paper, even with editorial criticism both in your journal (p 261) and in *The Times* of 24 July to balance the issue.

While the Study Group's remit was to consider only mortality under the age of 50 years, conclusions drawn from such an analysis must be put in the context of the overall problem. It is well known, as your leading article emphasises, that facilities for treating patients over 45 years of age are less adequate in the United Kingdom than in most developed non-socialist countries and that the incidence of chronic renal failure rises logarithmically with age. Under these circumstances, to foster a feeling of complacency when the main question of treatment for those over 45 years of age has not been addressed, and when the epidemiological techniques used are unsound, is unacceptable. This begs the question of whether or not the grounds for non-treatment in individual cases cited under the age of 50 years would be unchanged given better resources, though we accept that for some people with renal failure the severity of other problems must reasonably exclude dialysis or transplantation. The publication of details of the reasons for non-treatment of patients with renal failure is valuable, but it is wrong to broaden the conclusions drawn far beyond the limits imposed by the data given.

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[1] Leumann EP. Die chronische niereninsuffizienze in Kindersalter. *Schweiz Med Wscher* 1976;**106**; 244-9.
[2] Branch RA, Clark GW, Cochrane AL, *et al.* Incidence