Letters

MPGN and HCV infection in Istanbul, Turkey

Sir,

In a recent editorial in this journal D'Amico [1] discussed the possible link between HCV infection and non-cryoglobulinaemic membranoproliferative GN. In support of this argument Professor D'Amico cites the experience of Johnson et al. [2] in the USA and Yamabe et al. [3] in Japan, who found this to be a common association amongst their patients. He then goes on to point out that this association is infrequent in Southern Europe, notably France [4], Spain [5], and Italy [1].

With 2nd-generation ELISA testing, of 36 patients (24 males, 12 females; mean age 32±12 years) with biopsy-proven membranoproliferative GN presenting at our outpatient clinic in the last 2 years and followed for a mean of 11±6 months, no patient has been demonstrated to have HCV infection. HCV infection is, however, a problem on our haemodialysis unit, where at present 25% of patients are infected. Additionally, approximately 1.5% of blood donors screened at our hospital blood bank are HCV-antibody positive. Although we do not yet know the incidence of cryoglobulinaemia amongst our patient group, our experience appears to reflect that of Southern Europe rather than that of the USA or Japan.

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Iatrogenic acute oxalate nephropathy

Sir,

Further to C. G. Winearls' recent Editorial Comment on iatrogenic acute oxalate nephropathy [1], it is of interest to recall that the use of pharmaceutical agents which contain piridoxilate may induce oxalate nephropathy.

Dequieud et al. [2] reported in 1985 a case of acute oxalate nephropathy in an individual who had taken 6 g of piridoxilate in an attempted suicide, and two cases of chronic oxalate nephropathy in patients receiving long-term treatment with piridoxilate have been reported, also by French authors, a few years ago [3,4]. Like those patients with nafidrofuryl-induced oxalate nephropathy, these patients had a rise of serum and urinary oxalate concentrations and crystalluria. Renal biopsy showed tubulo-interstitial nephropathy with calcium oxalate deposition.

Piridoxilate is an association of glyoxyllic acid and pyridoxine. Glyoxyllic acid is mainly metabolized in vivo to oxalic acid, pyridoxine being supposed to facilitate its transformation to glycine rather than to oxalic acid. However, piridoxilate administration causes a rise of serum and urinary oxalate concentrations. These observations are important: indeed, if the two French pharmaceutical agents that contained piridoxilate have been withdrawn, some similar preparations may still be on the market in other countries.

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When dialysis becomes worse than death

Sir,

The review of Sessa [1] focuses on a problem in which nephrologists are increasingly involved. The increasing number of patients with advanced age or severe and multiple comorbid conditions can strongly reduce the quality of life and favour the consideration of the opportunity of withdrawing dialysis treatment. The article outlines the different rate of withdrawal from dialysis between US and Europe and points out the cultural, ethical, and legal factors that can influence the decision of stopping dialysis, problems which are largely debated in US or in Canada [2].

As European nephrologists we wonder if we should really hope that cultural changes will favour an increase in the choice of stopping dialysis. In particular we believe that implementation of ‘living wills’ or advance directives is ethically questionable. They are based on the principle of autonomy whose value is well recognized for the competent patient, but the value of these acts cannot be considered permanent and the possibility that the opinion of the patient may have changed over time cannot be excluded. Some people may be induced to subscribe such directives for depressive conditions or moved by the fear that the disease may involve an excessive burden for their family. In addition many problems remain unsolved: when and who has the right to say at what moment the patient had decided to die.

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Some dialysis patients have a slow deterioration of general conditions so that it is difficult to find objective criteria to say when life is worse than death.

Undoubtedly there are some conditions in which treatment may be considered futile, and it would be reasonable to forecast an imminent death. But in such conditions do we need a 'living will' perhaps subscribed many years before? Do we need laws that give legal value to these self-determination acts? There is also a real risk of abuse or interested interpretations. It has been reported that 50% of patients on dialysis, asked whether they wanted to discontinue the treatment if they developed dementia, said no [3], so there is some doubt on the opportunity that all patients are requested to subscribe their advance directive at the beginning of dialysis treatment. Even the opinion of an ethical committee cannot replace the legal and ethical responsibility of the nephrologist and we agree with Dr Sessa that the decision of stopping dialysis is a highly personal act of the nephrologist.

Finally we would make a comment on the role of religion.

Dr Sessa says that Christian religion tends to favour prolongation of life because of the redemptive value of suffering not only for the individual (the martyr) but also for her/his community. This concept resembles a form of sadomasochism or confers to the patient the role of hero who offers his suffering for himself or for his community. For a Christian suffering is no less painful and death is no less dramatic. We as Christians believe that in suffering we are not abandoned to solitude and that death is not the total destruction of the person. Christ has shown us the face of God who desired to share in our condition of pain. Human suffering is given value only by its sharing in the suffering of Christ. God has become a presence among us and accompanies on our journey of life towards a good outcome. Jesus overcame death through his resurrection and established a good destiny for all of us. The Christian, therefore, is motivated to help all people who suffer with every method they can to alleviate their pain and to accompany them in their suffering, encouraged by the love of Christ.

Emphasizing the need of laws or established rules which can legitimize stopping dialysis ultimately shows an incapacity to face pain and death with meaning and shows up weakness of many who cannot conceive the care of the sick when they cannot heal them.

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2. Oreopoulos DG. Is there a right time to say no to life? Perit Dial Int 1994; 14: 205–208

Table 1. Haemoglobin (Hb), reticulocytes (RC) and serum ferritin (SF) during the study period

<table>
<thead>
<tr>
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<th>Basal</th>
<th>3rd week</th>
<th>5th week</th>
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<tbody>
<tr>
<td>Hb (g/dl)</td>
<td>8.78 ± 1.01</td>
<td>9.46 ± 1.21*</td>
<td>9.48 ± 0.7**</td>
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<td></td>
<td>(7.2–9.6)</td>
<td>(7.7–10.4)</td>
<td>(8.2–10.4)</td>
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<tr>
<td>RC (%)</td>
<td>1.57 ± 0.53</td>
<td>2.28 ± 1*</td>
<td>2.16 ± 0.63**</td>
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<td></td>
<td>(0.8–2.3)</td>
<td>(1–4.3)</td>
<td>(1.2–3.1)</td>
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<tr>
<td>SF (μg/l)</td>
<td>21.12 ± 17.27</td>
<td>21.98 ± 8.39</td>
<td>25.77 ± 26.87</td>
</tr>
<tr>
<td></td>
<td>(5.8–59.8)</td>
<td>(8.8–31.5)</td>
<td>(10.8–91.1)</td>
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</tbody>
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*P<0.05, **P<0.01; Student t test for paired data.