Reply

Sir,

The objective of our study [1] was to examine the efficacy and tolerability of video-assisted thoracoscopic talc pleurodesis in the treatment of pleuroperitoneal communication in CAPD. Although spontaneous remissions have been reported in up to 38% of patients after ‘resting’ the peritoneal cavity with temporary haemodialysis [2], our unpublished experience shows that the result of such a conservative measure is often much more disappointing, at least among Chinese subjects. The socioeconomic and psychologic impact of a protracted course of temporary haemodialysis using a temporary vascular access can be substantial, particularly in places where access to haemodialysis facilities is scarce such as Hong Kong [3].

We are sceptical about the notion that ‘any degree of glucose concentration in pleural fluid higher than in the blood in CAPD patients could only result from a pleuroperitoneal leak’. Existing reports in the literature in this area are scarce and mostly based on small patient numbers only. There may well be exceptions, for example, in the poorly controlled diabetic subject in whom prolonged dwelling of dialysis solution may well have allowed sufficient time for absorption of glucose by the pleural mesothelium.

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Kidney transplantation in patients travelling from the UK to India or Pakistan

Sir,

I am interested in the letter by Higgins and co-workers [1]. I am of the opinion that patients should be discouraged from travelling abroad to purchase kidneys, not only to India and Pakistan (I & P), but for that matter anywhere in the world.

As to the difference in the number of complications occurring between patients transplanted in I & P and those transplanted in Coventry, I feel this is an unfair comparison. The dialysis patients travelling to I & P were a high-risk group (100% diabetic), whereas only 3% of the patients in the Coventry group were diabetic. Moreover, while I do accept that the risk of infection, which accounts for 50% of the major complications in the I & P group, is unacceptably high, this is to a great extent a public-health problem. These countries are probably on a ‘learning curve’ and need educating.

Conflict of interest statement. None declared.

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Reply

Sir,

I have discussed this response with Dr Higgins and we agree with Dr Ahmad that patients should not try to go around the world trying to buy a kidney. We are aware of a number of good units in the Indian Subcontinent, but they do not operate on a for profit basis.

The whole point of our original paper was to highlight the results of those units where kidneys can be bought, in a group of Coventry patients. Some of these patients had a number of medical problems and were advised by us that transplantation was high risk. What is so appalling is that these units agreed to operate with limited knowledge of the patients’ medical problems or any formal referral. It is therefore not surprising the results were so bad. A number of patients were long-waiters and these patients developed a number of complications that we would not have expected in the UK.

The issue of travelling abroad to receive a kidney has been taken up by the media in the UK. We have had no more patients from Coventry going abroad for a kidney recently. We are trying to address the issue of Asian long-waiters, encouraging living donation, discussing with UKT regarding tissue typing and trying to develop a regional urgent waiting list for patients who have been on the waiting list for over 10 years.

The publication of Dr Ahmad’s letter should stimulate more discussion about the problems for this group of patients and highlight that buying a kidney can cause more problems than it solves for the patients.

Conflict of interest statement. None declared.

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