1. Chuang ML, Manning WJ. Pitfalls in comparison of left ventricular mass measurements by echocardiography and cardiovascular magnetic resonance imaging. Nephrol Dial Transplant 2006


3. Belloinger NG, Burges MI, Ray SG et al. Comparison of left ventricular ejection fraction and volumes in heart failure by echocardiography, radionuclide ventriculography and cardiovascular magnetic resonance; are they interchangeable? Eur Heart J 2000; 21: 1387–1396

doi:10.1093/ndt/gfl319

Letters

Advance Access publication 7 July 2006

Pregnancy in a patient with retroperitoneal fibrosis who underwent in vitro fertilization

Sir,

Retroperitoneal fibrosis (RPF) is characterized by the replacement of the retroperitoneal normal tissue with fibrotic tissue and it can entrap retroperitoneal organs such as the ureter, causing hydronephrosis, hydroureter and renal failure [1,2]. Recently, a number of reports have suggested that the anti-estrogen drug ‘tamoxifen’ was an effective therapy for RPF [2]. Therefore, high oestrogen condition may induce some changes of pathema of RPF. We performed in vitro fertilization for an infertile female RPF patient and embryo transfer (IVF-ET) procedures and report about the pathema of this patient. A 34-year-old female with RPF introduced to our department complaining of primary infertility. She received two abdominal operations for right hydronephrosis following occlusion of the right ureter and she suffered from an ileus. The patient had been taking prednisolone (PSL) dosage to 12.5/15.0 mg/d. Then, her ultrasonography (USG) and computed tomography (CT) images revealed no clear manifestations of RPF. The C-reactive protein (CRP) was moderately elevated at 1.0–3.9 mg/l level. In generic examination for infertility patients, she and her husband did not exhibit any abnormal findings. The right fallopian tube, however, demonstrated hydrosalpinx and the left tube exhibited mild pooling of contrast medium by hysterosalpingography. Therefore, we attempted laparoscopic observation and it revealed dense adhesions around the bilateral adnexae. After this examination, we suggested an IVF-ET attempt and the couple wanted to receive it. Ovarian stimulation was performed under short protocol. The HMG was started at 300 IU from day four and gradually decreased until day 11. Her oestradiol plasma concentration was 2069 mIU/ml on day 10. On day 13, 10 000 IU of human chronic gonadotropin (hCG) was given. Oocyte retrieval was performed on day 14; we removed nine oocytes and oocytes were inseminated. Three embryos were transferred into the uterus on day 16. On day 31, plasma hCG was measured at 519 mIU/ml and oestradiol concentrations was 1591 pg/ml. On day 38, a gestational sac was first recognized by USG. There were no specific events in her pregnancy period, however, during the 33rd week of gestation, she suffered from a threatened premature delivery and was forced to get admitted to the hospital. Caesarean section was performed in the 34th week of gestation, because the uterine cervix was gradually open and position of the foetus was in a breech presentation. The baby girl was healthy. In this surgery, no findings of RPF deprivation were observed. The mechanisms of tamoxifen effects for RPF might be of no concern with oestrogen–oestrogen receptor [3,4]. However, a report presented aggravation of RPF during pregnancy. However, she rejected treatments for RPF that led to eventual maternal death [5]. We think plasma concentrations of oestradiol might not have induced deprivation for her RPF pathema. To our knowledge, this is the first report demonstrating successful artificial reproductive technique for a female RPF patient.

Conflict of interest statement. None declared.

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doi:10.1093/ndt/gfl075

Cardiac tamponade . . . a wire too far?

Sir,

On many occasions dialysis is initiated with a temporary jugular venous catheter which is later exchanged for a permanent tunnelled venous catheter, pending creation of an arteriovenous fistula. The exchange of catheter over a guide wire is usually a low-risk procedure and in uncomplicated cases, a chest radiograph is not warranted [1,2]. Cardiac tamponade is a rare complication following initial insertion of a central vein catheter via the Seldinger technique. We report a case of cardiac tamponade, following routine exchange of a temporary jugular catheter to a permanent tunnelled catheter.

A 56-year-old man with advanced renal failure secondary to diabetic nephropathy presented with pulmonary oedema. On the 10th day of admission, his temporary right internal jugular catheter was changed for a permanent tunnelled catheter. The procedure was performed by an experienced practitioner. The procedure was uneventful, although a straight guide wire was used after initial difficulty passing