Guillain-Barré syndrome, myasthenia gravis) may require admission to intensive care for intubation or ventilation because of respiratory failure, loss of airway reflexes, or aspiration.

Renal support

Renal failure is a common complication of acute illness or trauma and the need for renal replacement therapy (haemofiltration, haemodialysis, or their variants) may be a factor when considering referral to intensive or high dependency care. The need for renal replacement therapy is determined by assessment of urine volume, fluid balance, renal concentrating power (for example, urine:plasma osmolality ratio and urinary sodium concentration), acid-base balance, and the rate of rise of plasma urea, creatinine, and potassium concentrations. In ill patients hourly recording of urine output on the ward may give an early indication of a developing renal problem; prompt treatment, including aggressive circulatory resuscitation, may prevent this from progressing to established renal failure.

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Measurement of urine output is important to detect renal problems promptly

Indications for considering renal replacement therapy

- Oliguria (<0.5ml/kg/h)
- Life threatening hyperkalaemia (>6 mmol/l) resistant to drug treatment
- Rising plasma concentrations of urea or creatinine, or both
- Severe metabolic acidosis
- Symptoms related to uraemia (for example, pericarditis, encephalopathy)

A memorable patient

What a rotten job you've got

He was a large man with gynaecomastia and he was covered in bruises. The day before his general practitioner had sent him up to hospital for a full blood count. The phlebotomist he saw had taken enough blood for a clotting screen and this had revealed disseminated intravascular coagulation. He had been admitted urgently to the ward on which I was house officer. There my efforts to obtain more blood were failing as each vein I tried ballooned and bled into his skin. I sweated, he contained his irritation, and finally there were a few more millilitres.

With some relief I stood near the door, talking in general terms about further tests. "What do you think's the cause of this blood not clotting then?" he asked. He had been diagnosed 17 years before with prostatic cancer and had taken stilboestrol long term, but I did not know what, if anything, he had been told about the implications of this new development. His directness caught me off guard. "I don't know. Sometimes it can be, er, an after effect of the, er, prostate." He frowned, looking as if he were trying to make sense of me. I made a polite escape.

The next day I apologised to my consultant for the small blood sample. "Don't worry," she said as we walked to the patient's room, "his bone marrow is stuffed with malignancy. There's nothing we can do. He could bleed suddenly or last several weeks. I'm going to tell him now." She sat down to tell him that he was dying and I busied myself on the ward.

Afterwards, a ward nurse, wincing in the direction of his room, asked me to write up some pain control for him. Hesitating, I went into his room to fetch his drug chart. "I'll not stay if you don't want me to," I said. "No stay," he said gratefully, "I'd like to talk. I've been waiting 17 years for this, and I sort of knew when you said last night. I knew what you wanted to do—to let me down gently—I sort of knew anyway. He turned away, and looking out of

the window he added, "God. What a rotten job you've got." I stared at him as he looked out into the watery sunlight of that winter day. I had no idea what I had been trying to do and I wondered at his equanimity. He turned back, "It's my wife I worry about. I just don't know how she's going to react. She could go to pieces and she's losing her job soon. I feel uneasy about going home too. Of course there are these new places—hospices—that might be a thing to consider." There he faltered.

Within those few minutes he had taken on board his diagnosis, his prognosis, and had begun thinking in practical terms. I realised then that I was out of my depth and that my training had not prepared me to know what to do. After he died I rather dutifully took some books out of the library on communication with the dying, but as a house officer I did not have time to read them. It was only later interviewing patients with cancer for research that my thoughts turned back to the clear sightedness of this man. He showed me that some patients can face more than we can as doctors and see the truth before us. They can also feel sympathy for us as we struggle behind.

Elizabeth Davies, *research fellow, London*

We welcome articles of up to 600 words on topics such as *A memorable patient*, *A paper that changed my practice*, *My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.