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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.

Treatment of renal failure in a non-specialist unit

SIR,—We wish to compliment Dr N Wright and his colleagues (12 July, p 117) for their industry in establishing facilities for dialysis in a district general hospital and for their excellent results. We can substantiate their claims from our own experience, which started in 1962. Like Dr Wright's, our results compare favourably with those in patients treated in a specialist centre.

We treat our patients in a general intensive care unit, where most of the observations and treatments are made by specifically trained nurses.¹ We use both peritoneal dialysis and haemodialysis. For the latter we favour a rather old-fashioned but powerful and versatile machine, the Kolff Travenol.

The advantages of not moving the patients away from the admitting hospital are direct and indirect. The direct benefits to the patient are the continuity of care and the ease of visiting for relatives. Indirect benefits are also of great value.² Errors and omissions in patient management leading to renal failure can be recognised and prevented from recurring by a system of educational feedback. The incidence of preventable renal failure can thus be kept to a minimum.

It is important for anybody embarking upon

a programme of dialysis in a non-specialist unit to formulate criteria for commencing and discontinuing treatment; otherwise much effort may go unrewarded. Although any patient presenting as a uraemic emergency of unknown cause deserves a trial of therapy while a diagnosis is reached, treatment should be discontinued if an irreversible systemic disease is discovered. Similarly, patients developing renal failure during the course of a systemic illness should be dialysed only if the disease involved is potentially reversible. Particular attention is drawn to the incurable nature of renal failure in association with bacterial toxæmia, when there is shock and pulmonary involvement. In this instance intensive dialysis merely prolongs the inevitable.

In co-operation with the regional dialysis programme, we have also treated a small number of patients by maintenance haemodialysis, some of whom were later transplanted. The benefits of this arrangement were twofold. Firstly, regular dialysis enabled nurses to be trained in the necessary skills so that a trained pool of staff was always available to deal with emergency situations. Secondly, the nursing staff gained an insight into the

relative advantages and disadvantages of both maintenance dialysis and transplantation. A favourable atmosphere towards transplantation was thus created and led the way to a programme of cadaveric organ donation.³

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¹ Jones ES. *Essential intensive care*. Lancaster: MTP Press, 1978: 1-27.

² Jones ES. In: Walker WF, Taylor DEM, eds. *Intensive care*. London: Churchill Livingstone, 1975: 111-21.

³ Luksa AR. *Br Med J* 1979; *i*:1316.

Renal transplant rejection after gradual withdrawal of prednisolone

SIR,—Dr R B Naik and colleagues (7 June, p 1337) have shown that their renal transplant patients can maintain stable renal function with oral prednisolone (10 mg/day) as the sole immunosuppressive agent. Some patients suffered rejection episodes when the dose was less than 7 mg/day, but others maintained good graft function at lower doses (1 or 5 mg/day). They concluded that a standard

minimum threshold dose of prednisolone is unlikely to be generally applicable to transplant recipients. They demonstrated that there was large individual variation in plasma prednisolone concentrations after the same dose of prednisolone, but they did not demonstrate a definite relationship between plasma drug concentrations and rejection episodes. The intensity of the antigenic challenge to which the patients were exposed cannot be assessed since the HLA groups of the donors and recipients were not included in the paper.

Since there was no evidence in these studies that individual variation in the kinetics of drug handling could explain the differences in the threshold dose at which the risk of rejection episode becomes clinically relevant, it is worth considering the alternative possibility that the variation is at least partly due to differences between patients in immune function, or its susceptibility to glucocorticoid suppression. Potentially important factors include differential sensitivity of lymphocytes of various subpopulations to interference with circulation kinetics or blastogenic response,¹ intersubject variation in number of glucocorticoid receptors per cell,² and time of exposure to glucocorticoid relative to blastogenic challenge.³ We have recently shown in in-vitro studies of hydrocortisone effect on pre-S-phase cell cycle kinetics after phytohaemagglutinin stimulation that the log-dose response curve for lymphocytes from normal subjects can vary within tenfold limits⁴: it remains to be seen whether renal transplant recipients behave in the same manner and, if so, whether those subjects with a more sensitive dose-response curve are more susceptible to therapeutic immunosuppression with glucocorticoids.

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¹ Fauci AS. *J Immunopharmacol* 1978-9;1:1-25.

² Gleispach H, Schumik D, Zollner H, et al. *Cancer Treat Rep* 1979;63:1196.

³ Baxter JD, Harris AW. *Transplant Proc* 1975;7:55-65.

⁴ Robertson AJ, Gibbs JH, Potts RC, et al. *Internat J Immunopharmacol* (in press).

Kidney biopsy

SIR,—With reference to the article on kidney biopsy in the "Procedures in Practice" series (23 February, p 547), I would like to draw your attention to what I consider a dangerous practice and that is to carry out a biopsy aimed at the centre of the lower pole of the left kidney.

Having had considerable experience in renal biopsy procedures I am very aware of the fact that respiration is associated with considerable movement of the kidney. If a bigger breath is taken the lower pole will descend below the biopsy needle, which may then be poised over the central calyces and large vessels. I hold very strongly that the correct position for a biopsy is the outer edge of either kidney, for at this site an alteration in the size of the breath cannot bring larger vessels beneath the biopsy needle. I have no doubt that the complication rate from renal biopsy

carried out at the site recommended by Drs McGonigle and Sharpstone will be very much higher than at a site aimed a few millimetres inside the lateral edge. This can be accurately determined by placing a mark on the skin over the approximate site and taking an x-ray photograph centred carefully on the marker, so avoiding parallax error. The marker can be moved to an exact position by taking further films if required.

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SIR,—The introduction of percutaneous renal biopsy has contributed to a better knowledge of renal diseases. The technique does not present serious difficulties, and the complications are minimal if it is practised by a well-trained physician (23 February, p 547). Nevertheless, the technique of percutaneous renal biopsy still presents certain difficulties connected with the handling of the needle when obtaining the renal specimen, which can be easily obviated by adapting a positioning carrier to the biopsy needle.

The carrier devised to be adapted to needles of the disposable type, specifically to the Tru-Cut model, consists of two adjustable slotted runners, joined together by means of a hand-screw assembly. Each runner ends in a flanged foot (facing the other). The foot which will rest on the patient's skin is perforated for the biopsy needle to run through it; the other has a slotted opening to house the shaft of the biopsy needle and to act at the same time as a stop for the travel of the shaft. The length of the biopsy needle introduced into the patient is determined by the distance between the two feet of the two runners, in such a way that the one provided with an orifice rests on the patient's skin; with this support as a bearing point the pertinent movements are carried out to obtain the piece. Finally the needle and carrier assembly with the obtained biopsy are withdrawn.

The use of the positioning carrier offers no problems at all, but rather a series of advantages: (1) It maintains a constant depth as desired to carry out the biopsy. (2) It avoids excessive penetration when carrying out the puncture, thus preventing eventual trauma to the renal parenchyma. (3) It avoids the false movements which are frequently the cause of the loss of the specimen and which increase renal damage. (4) It reduces considerably the apnoea time, as the movements necessary for the collection of the specimen can be carried out in a quick and reliable manner. (5) It enables users to carry out the biopsies safely with a shorter training period.

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Skin biopsy

SIR,—In their recent articles on the techniques of skin biopsy (24 May, p 1259 and 31 May, p 1312) Drs A S Highet and R H Champion offer useful guidance on many points. However, several points should perhaps be questioned. They ban the use of vasoconstrictors in local anaesthetic solutions used on the ears, but cite no work to support this. It is routine practice in this centre to use 0.5% lignocaine/1:80 000 adrenaline solutions for

operations on the ear pinna, and neither skin nor cartilage necrosis has been seen. To deliver this solution the dental cartridge syringe is far more convenient than the disposable one illustrated.

On p 1259 they refer to the standard method of skin biopsy as elliptical excision biopsy, although it appears from the subsequent article (p 1312) that they in fact advocate *incisional* ellipse biopsy of the edge of various lesions. While it may be reasonable to perform incisional biopsies of obscure or inflammatory lesions, it is difficult to find any justification for the routine practice of incisional biopsy of skin tumours. The vast majority of basal cell carcinomas, squamous cell carcinomas, and malignant melanomas can be diagnosed clinically, and even if the diagnosis is in doubt an adequate *excision biopsy of the whole lesion*, with appropriate closure, provides the best material for a complete histological diagnosis to be made. The best cosmetic result furthermore is likely to follow such treatment.

They also advocate curettage as a therapeutic measure for basal cell carcinomas. This practice, apart from preventing any histological assessment of the adequacy of "excision," cannot be regarded as an appropriate treatment for a tumour notorious for its tendency to local invasive recurrence.

With regard to the keratoacanthoma, the appearance of this at either clinical or histological examination may be equivocal, and a rapidly growing squamous cell carcinoma may mimic it. The only safe treatment is excision of the whole lesion, unless perhaps one clinician is prepared to see that patient weekly, personally to witness the tumour's continuing growth or regression, and even this for no longer than three months.

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Care of the unconscious

SIR,—In Dr Jean M Horton's excellent article on the care of the unconscious (5 July, p 38) I was surprised to read that she does not recommend the use of the fine-bore nasogastric tubes and continuous feeding through these because of the danger of regurgitation of feeds and aspiration pneumonia. This method of enteral nutrition has been used routinely in the intensive care unit of this hospital for the last two years. Regurgitation has been a problem only when the strength and volume of the feed have been increased too quickly or where there has been some mechanical cause of delayed gastric emptying.

Even if regurgitation should occur, however, aspiration of gastric contents ought not to follow. If the upper respiratory tract reflexes are active in the unconscious patient he will protect his own lower respiratory tract. If these reflexes are obtunded then, as Dr Horton rightly points out, a cuffed endotracheal tube should be in place.

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