*Interactive case report***A 35 year old woman with diabetic nephropathy who wants a baby: case outcome**

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This is the final part of a three part case report, which describes the outcome and summarises the comments made by readers during the case presentation

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	Left kidney	Right kidney
Functional contribution (%) (1.5 - 2.5 min)	53.3	46.7
Peak time (min)	5.9	5.6
Residual activity (% at 20 min)	58.2	49.1

Tommy's renal scintiscan

Four weeks ago, we presented the case of Maria Tomasa, who had requested in vitro fertilisation (18 September, p 674). As none of us had any direct experience of assisted conception in patients with overt diabetic nephropathy we searched the literature to determine the risk (25 September, p 729). The data were limited, and after extensively discussing the odds and risks with Tommy on three occasions, we decided to support her decision to have in vitro fertilisation and organised treatment.

Two embryos were placed and one implanted. Two weeks after the procedure, Tommy developed ovarian hyperstimulation syndrome with ascites. When proteinuria increased to 9 g/day in the third month of pregnancy, she was admitted to hospital and remained there for the rest of her pregnancy. At rest, her proteinuria decreased to 4-5 g/day and remained stable; her blood pressure was low to normal without treatment. Her coagulation measurements were normal, and she had no overt oedema.

At 31 weeks+2 days, she went into spontaneous labour and delivered a boy of normal weight for gestational age (1590 g) and in good condition (Apgar score 8 at 5 min). One and half years after delivery, Tommy is clinically well. She restarted angiotensin converting enzyme inhibitors and angiotensin II receptor inhibitors were restarted her serum creatinine concentration is 133 $\mu\text{mol/l}$, proteinuria 5.2 g/day; serum albumin 29 g/l, and total protein 60 g/l. She is starting evaluation for a pre-emptive pancreas-kidney graft (figure). The baby is developing normally, and the nephrologist was chosen as the baby's godmother.

Ethical conflict

This case is a good example of the conflict that can arise between the imperative on doctors to "first do no harm" and each patient's right to self determination. Initially, we avoided making a decision, hoping that nature would decide for all of us. That did not happen, and two years later we had to face an even harder decision; we found it particularly difficult because it regarded the risks of an optional medical intervention to allow a physiological condition, pregnancy.

There are no easy solutions. The evidence based medicine approach helped to support crucial decisions but could not give definitive answers, partly because so little is published on this problem. Even when the literature was able to give a general idea on risks and benefits, it couldn't help in defining whether these risks were acceptable or in identifying a risk threshold.

Since Tommy's case was submitted to the *BMJ*, the Italian laws on assisted fertilisation have changed, making a similar story unlikely in the future. This case left us with several unanswered questions, on the border between clinical and ethical issues: What should caregivers do when dealing with a clinical choice they do not agree with? How much risk becomes "too risky"? What difference did the need for assisted fertilisation matter make compared with a natural pregnancy? If the end of the story had been sad, would we be talking about it now?

Competing interests: None declared.

We welcome contributions of interactive case reports. Cases should raise interesting clinical, investigative, diagnostic, and management issues but not be so rare that they appeal to only a minority of readers.
Full details of criteria are available at:
bmj.com/cgi/content/full/326/7389/564/DC1

*Endpiece***Being good**

It is impossible to be a good surgeon if one is not familiar with the foundations and general rules of medicine [and] it is impossible for anyone to be a good physician who is absolutely ignorant of the art of surgery.

Henri de Mandeville (c1260-c1320)

John Zorab, retired consultant anaesthetist, Bristol