transplants at four months subsequently had little evidence of rejection. Eight (32%) had no clinical or biochemical evidence of rejection at any time. Three had rejection crises between four and 12 months after operation which were successfully treated. In most of these patients the transplant function has slowly improved. The average blood urea level was 60 mg./100 ml., with a range of 27–150 mg./100 ml., serum creatinine 1.8 mg./100 ml., with a range of 0.9–3 mg./100 ml., and creatinine clearance 58 ml./min., with a range of 20–120 ml./100 ml. Twenty-four patients have been restored to normal activity: the majority have returned to their previous jobs; the most active patient operates a bulldozer. One patient lives a restricted life due to steroid arthropathy and probable chronic rejection of the transplant.

As soon as the transplants function adequately the patients develop a sense of well-being which is in excess of the euphoria due to steroids. They develop voracious appetites and often say that they feel “cleaner” than when they were on dialysis.

The complications developing in our patients were numerous and bizarre. They will be the subject of another communication. The correlation of clinical results with tissue typing will also be reported separately. The most obvious difficulty has been the management of rejection. The independent value of actinomycin C, extracorporeal irradiation, and antilymphocyte globulin were impossible to assess, since all rejection crises were also treated with massive doses of steroids. During the course of this series of cases policy has changed. Instead of pursuing immunosuppression to life-threatening toxicity, a kidney with inexorable rejection is now removed and immunosuppression stopped.

Discussion

Though the maximum follow-up period is only two and a half years, the satisfactory quality of life of the majority of our patients has convinced us that cadaveric renal transplantation is valuable therapy. Our patients do not require convincing; most had suffered severe symptoms of uraemia often complicated by hypertension, heart failure, peripheral neuritis, and pericarditis. To be restored from such a moribund condition to a normal life is worth while even if the ultimate prognosis is uncertain. The pressure on dialysis beds and the shortage of cadaver donors caused us to embark on a limited programme of live donor transplants from close blood relatives who insisted on giving a kidney. We feel that it is unjustifiable to refuse to perform a transplant under these circumstances when the alternative is death. There have been 20 deaths on the waiting-list in the past two years due to inadequate facilities for dialysis in the referring hospitals. This figure, however, means little in the context of the 2,000–3,000 deaths per annum from uraemia in the United Kingdom in patients between the ages of 5 and 55. Unfortunately, at present the dialysis and transplant centres in the United Kingdom can treat only a small fraction of these cases.

Summary

Fifty-four consecutive renal transplants in 49 patients are reported. There were 51 cadaver and 3 live donors. At the time of writing 33 (60%) of transplants were functioning and 34 patients (70%) were alive. All transplant failures had occurred within four months of operation. Seventeen of the 29 (59%) transplants were functioning at one year and six of the seven transplants performed more than 22 months ago continued to function. The longest period of survival is two and a half years since operation.

We wish to acknowledge the help we have had from our medical and nursing colleagues and in particular the nursing staff of the renal unit. We are grateful to the John Bennett Clinical Laboratories for the numerous biochemical, haematological, and bacteriological studies they have performed on our patients. We thank the referring physicians for their collaboration both preoperatively and in the postoperative follow-up period.

References


Preliminary Communications

Body Height and Imipramine Side-effects


Genetically determined variations in metabolism are of importance in determining the steady-state blood concentrations of some drugs. Variability in the population depends on polymorphisms of enzymes involved in the metabolism of a drug and may influence both clinical effectiveness and toxicity (Price Evans and White, 1964), and probably phenelzine (Price Evans et al., 1965).

The steady-state plasma levels of depressed patients on a standard dosage of tricyclic antidepressants have been shown to have markedly bimodal frequency distributions (Hammer and Sjögqvist, 1967); this suggests the existence of a genetic polymorphism for the metabolism of these drugs. Patients complaining of side-effects while on this group of antidepressants are those with high steady-state plasma levels (Hammer et al., 1967).

It seems possible that genes controlling drug plasma levels may also have an influence on physique. In this study a retrospective investigation has been made of the physique of patients who complained of side-effects while on imipramine therapy.

Method

Over a period of three years 93 patients with sustained depression in my general practice were considered for admission to a

lators of the drugs isoniazid, sulphadimidine, hydralazine (Price Evans and White, 1964), and probably phenelzine (Price Evans et al., 1965).

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Method

Over a period of three years 93 patients with sustained depression in my general practice were considered for admission to a
controlled trial of imipramine. At the same time demographic and physical data were collected as the basis for a study of the natural history of the disorder. It is thus possible to relate various indices of physique to the presence or absence of volunteered side-effects.

Of the 93 original patients (14 men and 79 women), 12 were excluded in accordance with the trial protocol, the escape clause was invoked for a further two, and 11 defaulted (four on placebo and seven on imipramine). Thirty-one of the remaining 68 patients had been allotted a placebo by the randomization procedure, leaving seven men and 30 women taking imipramine. Since there were so few men attention has been concentrated on the 30 women; of these, 10 volunteered side-effects (group 1) and the remaining 20 had no side-effects (group 2).

The following indices were recorded: age in years; nude weight in pounds, height in inches, ponderal index (height divided by cube root of weight), and subcutaneous fat in millimetres (measured with Harpenden's skinfold callipers over the left triceps).

Each patient was included in the trial for three weeks. The starting dose was one tablet (25 mg.) of imipramine thrice daily; if there was no response at the end of the first week the dose was increased to two tablets (50 mg.) thrice daily. Patients were not questioned about side-effects, but any volunteered symptoms were recorded. They were encouraged to avoid other drugs and sedatives; it is impossible in retrospect to be quite certain that no patient took a barbiturate, but is unlikely.

**RESULTS AND DISCUSSION**

Group 1 patients were similar in physique to those in group 2 except that they were significantly taller (see Table).

| Comparison of Various Indices of Physique for Women with Side-effects (Group 1) and Without Side-effects (Group 2) while Taking Imipramine |
| --- | --- | --- | --- | --- | --- |
| Index | Group | No. | Mean | S.D. | t | Significance |
| Age in years | 1.2 | 10 | 37.6 | 4.3 | 0.12 | N.S. |
| Height in inches | 1.2 | 10 | 65.4 | 2.0 | 2.7 | 0.01 < P < 0.02 |
| Weight in pounds | 1.2 | 137.7 | 29.5 | 0.37 | N.S. |
| Ponderal index | 1.2 | 10 | 2.7 | 0.2 | 0.74 | N.S. |
| Subcutaneous fat in mm. | 1.2 | 19 | 8.5 | 0.4 | 0.4 | N.S. |

The side-effects might have been a function of varying dosage alone, but there is no evidence for this; group 1 were taking an average of 3.3 tablets daily at the time they first volunteered side-effects, while group 2 were challenged by a peak average of four tablets.

As the weights of both groups are similar the factor of metabolically active mass is not likely to be of importance. It may be noted that the index of physique, which correlates significantly with the volunteering of side-effects, is the only one independent of age.

The main enzymic actions to which imipramine is subjected are demethylation and hydroxylation (Bickel and Baggioni, 1966; Moody et al., 1967). Other drugs, in particular barbiturates, are able to potentiate these biotransformations (Remmer and Merker, 1965) and lower the blood level of desmethyl-imipramine (Hammer et al., 1967); it is fortunate, therefore, that polypharmacy was avoided during the trial.

A result based on such a small series may be influenced by chance, and the ideal procedure would be to see if it could be corroborated by a larger prospective study.

Other explanations may also exist—tall women may, for example, be more expansive in declaring their symptoms than short ones. Alternatively, there might be an association between height, social class, and rhetoric, though the proportion of women of non-manual class in the two groups was not greatly different (5 out of 10 and 7 out of 20 respectively).

It remains possible that the same genes may influence both body height and imipramine metabolism.

**SUMMARY**

Women who volunteered side-effects while taking imipramine were found to be significantly taller than those who did not. This may indicate that both the rate of metabolism of imipramine and body height are influenced by the same genes.

This paper owes much to a lecture given by Dr. D. A. Price Evans in the "Scientific Basis of Medicine" series, and to his subsequent advice. I am also indebted to Professor W. W. Holland.

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