Second Renal Transplants in Children

Renal failure in children is a distressing disease for both child and parents and apt to cause prolonged ill health. Recent reports have suggested that about one child per million population dies from chronic renal failure each year, and about a quarter of these children are receiving treatment by regular dialysis. As in adults three methods of treatment are available—hospital dialysis, home dialysis, and renal transplantation.

Until relatively recently few children were successfully dialysed for long periods. There were several reasons for this, including a dearth of suitable dialysis equipment and difficulty in gaining regular access to the patient's circulation. Now improvements in vascular surgery have made access to the circulation easier, and suitable equipment has become available. Thus long-term dialysis for children has become a reality, and many have been successfully dialysed for several years. The results are as good as those obtained with adults, but special problems in relation to children are becoming recognized.

Renal osteodystrophy, with stunting of growth, is common. Regular dialysis can arrest this complication but does not cure it. Growth does occur and ossification is normal but these children rarely grow to their expected normal height. Dietary fluids and sodium have to be restricted, and this can be difficult for children to accept for long periods. Despite the inevitable anaemia that accompanies haemodialysis, some children do manage to play games and mix with other children. Patients on hospital dialysis are dependent on the hospital and so are removed from their normal home and school environment. This difficulty can to a certain extent be solved by home dialysis, which offers the patient a chance of being more independent of the hospital and allows him to integrate more fully with his family and friends. Home dialysis has been found to be successful and acceptable to both parent and child.

It can be performed in the early part of the evening without interfering with the parents' sleep or the child's schooling. But in spite of the improvements in dialysis techniques the child has to lead a restricted life, with limitation of normal activity. In addition the parents, in particular the mother, have to bear a heavy physical and psychological burden. There is no escape from the routine. Neither the parents nor the child can look forward to a holiday or change of any duration away from the home. Moreover, the long-term well-being of these children remains to be assessed.

Against this background we should ask ourselves the question, What is the place of renal transplantation in children? The results from live donor transplants in adults have continued to improve and the two-year graft-survival figure is now 75%. The recipients of cadaver kidneys do not do so well, the average two-year graft-survival being 41%, though results from individual centres are better. Several centres have recently reported their results with transplants in children. Mortality has varied from 13 to 20%, and the two-year graft-survival for recipients of live donor kidneys is 73%, and for the recipients of cadaver kidneys 53%. In spite of these encouraging results few cadaver grafts have yet survived beyond five years, and though live donor organs tend to do better their length of survival remains to be settled. The complications that may follow transplantation are numerous, and some of them are especially relevant to children. In particular, steroids may produce stunting of growth in an already dwarfed child, but R. N. Fine has shown that normal growth can occur if the growth potential is high. Yet in spite of the problems there is no doubt that a successful transplant can transform a child's life and that of his parents.

But transplants undergo rejection and this can be a traumatic physical and psychological experience for the child and his family. When it happens, the physician has to ask, What should be done next? Second transplants in adults are known to do relatively worse than first transplants, and the possibility of exposing the child and his parents to the psychological distress of further failure must be considered. For this reason a recent publication by Fine and his colleagues is timely and answers some of these questions. Thirteen children were given second transplants, and 11 are functioning at three to 36 months after surgery. Two were lost because of rejection and the patients returned to dialysis. The authors state that loss of the graft was associated with depression and stress for both the child and his family, which improved after final loss of the graft. An unexpected finding was the extent to which parents and children adapted to a second transplant, possibly because they had already experienced the problems of the first.

These survival figures are much better than those previously reported for second transplants in children. None of the patients died and there is an overall graft survival rate of 85%. Though the numbers are small, and the follow-up time is yet short, the results are encouraging, particularly as children are likely to need more than one transplant in their lifetime. Provided the risks are not too high—and from this study they appear not to be—most children should be given the opportunity to receive a transplant, but a careful assessment of the family and the likely results of failure should be made in every case. If the child is doing well on home dialysis, it may be wiser to wait until he is older before attempting a transplant.
if he is not doing well physically or psychologically, one or if necessary more transplants should be attempted.

3 Scherer, K., Proceedings of the European Dialysis and Transplant Association, 1971, 8, 211.
16 Bell, P. R. F., et al., British Medical Journal, 1972, 4, 408.
19 Hulmes, B., et al., Archives of Disease in Childhood, 1972, 47, 486.

Superannuation

The introduction of the new N.H.S. Superannuation Scheme1 has prompted a shoal of inquiries to Tavistock Square in recent months. While most doctors have written about their individual problems some letters, including one or two to the B.M.J.,2 have raised the more general problem of practitioners who retired in the years immediately before 25 March 1972, the starting date of the new scheme. Despite the fact that such doctors have had their pensions improved by the Government's Pensions (Increase) Act,3—aimed to keep all public service pensions abreast of inflation—understandably there is dissatisfaction at the considerable gap between the benefits of those doctors retiring before and after the changeover.

Any reform has to have a starting date and it is politically and administratively difficult to backdate any complex restructuring. Though as much advance warning as possible was given to doctors about the forthcoming reforms so that those able to do so could postpone their retirement,4 some doctors could not wait, and inevitably many had retired before any warning could be given. So, as Mr. R. D. Rowlands and Dr. J. C. Cameron, chairman respectively of the Compensation and Superannuation and General Medical Services Committees recently pointed out in an exchange of letters with the Secretary of State,5 there is a strong case for the Government seeing what might be done to lessen the financial handicap for practitioners who retired between the beginning of 1969 and March 1972. It was the sharp acceleration in inflation from 1969 onwards that largely destroyed the effectiveness of the escalation formula negotiated in 1966 to protect pension values in the old scheme. The point has also been fairly made that this group of doctors had been among those who had "borne the brunt of the teething troubles of the N.H.S."6 Furthermore, they worked through several periods when doctors' N.H.S. incomes were less than satisfactory—a deficiency subsequently reflected in many pensions.

Predictably, the Government stonewalled the B.M.A.'s request maintaining that changes in occupational pension schemes should be restricted to people in post at the operative date and not extended to existing pensioners. The profession's representatives had, however, already persuaded the Government to backdate the improved pension for doctors to 25 March 1972, the operative date of the N.H.S. Superannuation Act; even though negotiations on the profession's particular problems were not completed until 1973. The Government will probably remind the B.M.A. that doctors form only a part of the 420,000-strong N.H.S. Scheme and that its representatives had agreed to the new proposals—dates and all. Nevertheless, the profession's negotiators have a strong card in the conviction that an injustice has been done to some doctors who have served the community well. It will not be easy to move the Government but a determined effort to do so is fully justified and deserves the profession's support.

The inclusion of doctors with the rest of the N.H.S. staff when their career pattern and earnings have a special place in the Service is another criticism that has been levelled at the scheme. Some doctors have called for a separately funded, commercially based scheme. These possibilities have been thoroughly explored—with expert help—and turned down by the B.M.A.'s Superannuation Committee. Mr. Rowlands in recent public speeches has forcibly countered some criticisms of the new scheme,7 saying that he knew of no private pension scheme or annuity which could compare with the Government's commitment to increase pensions in line with cost-of-living increases. While insurance companies ran schemes which gave built-in increases, it could, he claimed, be done only with very expensive premiums. His reception at various B.M.A. meetings recently suggests that doctors acknowledge that his committee has done a good job.

Doctors wedded to the idea of a commercially based fund should ask themselves whether when the profession has been part of the N.H.S. Superannuation Scheme since 1948 it is practical politics to withdraw now. It would need a very determined profession prepared to face up to a major political confrontation to take doctors out, and this at a time when most people accept the value of integration in the Health Service.

Superannuation is a complex subject and actuary, like doctors, may occasionally differ about the merits of a particular course of action. But it needs little actuarial skill to see that the revised scheme is an advance on the old one and doctors should be retiring on better pensions in real terms than in the past. Admittedly to an extent this may reflect the inadequacies of the previous benefits. But the list of improvements is nevertheless substantial.8 These include a halved qualifying period for a pension on retirement (with the qualifying period for death gratuity abolished altogether), the pension and lump sum retiring allowance for a salaried officer being based on the best year of the last consecutive three years of service, and better widows' and children's benefits. Furthermore, retirement benefits should stand comparison with those of other walks of life.

It had been provisionally agreed that to help pay for these improved benefits the contribution by employer and