FW: Confidential Letter from Professor Maurice Savage

Edel Hagan

Sent: Monday, August 01, 2011 10:55 AM
To: Maurice Savage
Importance: High

FYI

From: Kate Verrier Jones [redacted]
Sent: 29 July 2011 18:23
To: Edel Hagan
Subject: RE: Confidential Letter from Professor Maurice Savage

Dear Maurice,

Good to talk the other day.

I do not have a copy of the raw data to which you have referred and can barely remember the study. I think the most likely source of the data is UK Transplant. I remember setting up an audit meeting for BAPN members and UKT near Bristol many years ago, when audit first became fashionable. I think the causes of death may have been presented at that meeting or may have been done following that meeting. It is always much harder to remember a study when others have done the work. I think it is likely that I would have been keen to promote looking at causes of death post transplant as I always felt that their valuable data was underused and that there were some avoidable death happening in children treated in adult centres and to a less extent under paediatric nephrologists. I had noticed our own unit that all the patients in the ESRF programme died within 1-2 years mainly of hypertensive encephalopathy or pulmonary oedema before I was appointed. My first task was to analyse the causes of death and the second task was to set up practices to avoid these situations. However, I tended to see the problem in terms of fluid overload rather than focussing on the low sodium, although I suspect that some of them were significantly hyponatraemic when they died.

You might find something in the archives as the abstracts of the BPA were published there. UK Transplant also kept records of the various analyses they did. Fluid overload is a basic medical problem taught to every medical student, but for the average paediatrician they do not see it very often. The early signs are very subtle but can be detected if you actively seek them out. By the time the symptoms and signs are obvious the patients' condition is often critical.

I recall that some of our esteemed colleagues did not believe that children under their care ever died of overload! Consequently there was not a lot of enthusiasm for publishing this or doing anything further about it. I was paranoid about this problem and we had some simple rules to minimise the risks of pulmonary oedema and hypertension and its consequences. These included the need to notify the consultant if any renal patient needed oxygen, and should be considered to have pulmonary oedema until proved otherwise and every renal patient had a line drawn on their BP chart so that any BP above the line should be repeated and if necessary a change of management, eg less IV saline/slow blood transfusion or a dose of nifedipine.

Let me know if you require anything more formal. I hope you enjoy your retirement and don't forget that we are open for visitors here. We don't go away all that much but very much enjoy seeing old friends and showing them the local sights and culture.

Best wishes Kate