

training in this field does not fully meet all the needs of children from birth to adolescence, and that we must be prepared to extend our knowledge and expertise so that the RSCN is more readily accepted in all fields of child care. We need the support of paediatricians and our colleagues. However, if paediatricians are willing to work with nurses who do not have the necessary qualifications, and if our nurse administrators are prepared to accept such nurses, then our position will not only be substantially weakened, but it will also have a detrimental effect on the services available for sick children.

References

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Survival of children with chronic renal failure

Sir,

Last year we reported 10 years' experience with regular haemodialysis and renal transplantation in the treatment of children with end stage renal disease (ESRD).¹ We should now like to update this report with the results from 1979 and 1980.

By 31 December 1980, 98 children, aged under 15 years, had been accepted for treatment of ESRD. Eighty-eight of these children have received 111 renal allografts (88 first grafts, 19 second grafts, and 4 third grafts); 50 live related donor grafts and 61 cadaver grafts) and 65 of them currently have a functioning graft, 10 are on dialysis, and 13 have died. Of the 10 children not transplanted, 4 were maintained on haemodialysis, 2 children (aged 10 months and 2½ years) were on hospital peritoneal dialysis awaiting cadaver grafts, 1 with the haemolytic uraemic syndrome had recovered renal function after 12 months on home haemodialysis, and 3 had died.

Actuarial patient survival in all 98 children accepted for treatment of ESRD was 81% at 5 years and 78% at 10 years, while the 5-year survival rate for the 66 children treated in the six years since 1 January 1975 was 90%; at 31 December 1978, the 5-year survival rate for all children treated was 76% and that for the 57 children treated during the preceding six years was 83%.

Actuarial graft survival for first grafts performed since 1 January 1975 is shown in the Figure. Live donor graft survival was 86% at 3 years and 76% at 5 years, compared with 71% at both 3 and 5 years for the six years ending in December 1978. First cadaver graft survival has also improved from 47% to 65% at both 3 and 5 years.

The trend towards improved results¹ has therefore continued, despite accepting younger children with more complex problems on to the programme. Recipients of

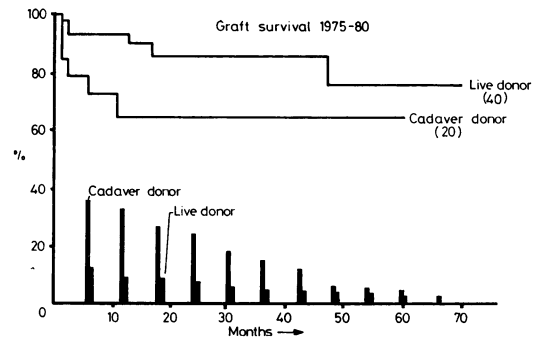


Figure Actuarial survival of first live donor and cadaver donor grafts in children 1975-80. Number of grafts at risk at each analysis point are shown.

cadaver grafts are now transfused on at least five occasions before transplantation and this may have contributed to the improved results.²

A grave problem that has become worse during the last 6 months is the poor supply of cadaver kidneys for transplantation and we especially need kidneys from children in order to treat infants and the younger children. We would ask our colleagues to consider contacting their local transplant unit if suitable kidneys become available.

References

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Bed occupancy not an index of efficiency

Sir,

Dr Forrester should be congratulated on his excellent Short Report¹ which clearly demonstrates what paediatricians have known for a long time. In our hospital group (and presumably in many others) bed occupancy is counted at midnight; this means that if a child is in with a febrile convulsion for 2 days and 1 night, according to the administrators his bed is occupied for only one day, making the statistics even more confusing.