Pediatr Nephrol (1993) 7: 330

Pediatric Nephrology

Erratum

Comment

In: Pediatric Nephrology 7: 218 – 219

Due to an unfortunate printing error on page 219, two lines were missing:

The idea of correcting the metabolic defect in primary hyperoxaluria type 1 (PH1) by liver transplantation, *before* renal failure has occurred, is tempting. Indeed, if sufficient organs were available and liver transplantation was a safe procedure, no one would question this approach. Performing a total hepatectomy in a paediatric patient whose liver function is normal in every respect constitutes a major decision and requires strict criteria. These are not easy to define, since renal function in patients with PH1 does *not* decline at a predictable rate. Indeed, it may remain stable over several years or even temporarily improve, but may also deteriorate abruptly following an episode of dehydration or obstruction. The authors cannot easily overcome this fundamental problem. While they consider isolated liver transplantation to represent a first choice treatment for patients prior to having reached an advanced stage of ***chronic renal failure, they maintain it should be limited to those with a decrease of glomerular filtration rate (GFR) of*** about 20% per year. Our first patient illustrates this dilemma: isolated liver transplantation was seriously considered in view of his decreased GFR (34 ml/min per 1.73 m^2) and repeated passage of stones with colicky pains. However, conservative treatment led to clinical improvement and stable renal function over the next 3 years.

I would nevertheless agree that isolated liver transplantation is an option, but only exceptionally, and only after all conservative methods have strictly been applied. In my view, combined liver/kidney transplantation constitutes the best approach at present, and it is of course not performed unless renal function is severely impaired, but before generalized oxalate deposition has occurred. Early planning is therefore important. Isolated cadaveric kidney transplantation using a special protocol [1] may still have a place in older patients, but most nephrologists in Europe would probably refuse to use a kidney from a living donor in patients with PH1, a treatment modality applied with some success by Dr. Scheinman [1]. In conclusion, a patient-tailored approach is essential in a disease which has such a wide clinical spectrum, and more attention should be paid to early diagnosis and to optimal conservative management.

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References

1. Scheinman JI (1991) Primary hyperoxaluria: therapeutic strategies for the 90's. Kidney Int 40: 389 – 399