Chronic Ambulatory Peritoneal Dialysis in a Patient with End-Stage Renal Disease following Radiotherapy and Surgery for Transitional Cell Carcinoma

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start her on CAPD, which she tolerated well. She has now been on CAPD for 17 months with no evidence of tumour recurrence. We have considered a possibility of transplanting her, but at our centre we carry out only live related kidney transplants and this has brought in the questions of the kind of urinary drainages to use and the timing of such an operation, considering her original disease.

Dear Sir,

It was with interest that we read the report by Fernandez Lucas et al. [1] on 4 patients with transitional cell carcinoma (TCC) who underwent bilateral nephrectomy and thereafter were started on haemodialysis with commendable results. They point to the small proportion of patients reported with TCC who develop a progressive multi-focal disease that leads to bilateral nephrectomy and end-stage renal disease [2] and the uncertainty surrounding the management of such patients.

We report on a patient who had TCC of the bladder, had transurethral resections and radiotherapy followed by total cystectomy later, but developed end-stage renal disease and was included in the chronic ambulatory peritoneal dialysis (CAPD) programme. The patient, a 30-year-old female, chemical engineer, was diagnosed as having TCC of the bladder in April, 1992. She underwent transurethral resection followed by a full course of radiotherapy. However, 6 months later she developed features suggestive of recurrence of TCC and this was confirmed. At the end of 1992 a radical cystectomy with bilateral ureterosigmoidostomy was performed. There was no gross evidence of spread out of the bladder. She remained well until May 1994 when she presented with renal failure with a serum creatinine of 1,340 $\mu\text{mol/l}$ and a blood urea nitrogen of 51 mmol/l . She was in pulmonary oedema and was started on haemodialysis on an emergency basis. Renal ultrasound and computerised tomogram (fig. 1) revealed bilateral hydronephrosis and hydro-ureters, on the left more marked than

Fig. 1. CT scan showing left-sided pyonephrosis and right-sided hydronephrosis.

on the right. A nephrostomy tube was inserted in the left kidney and a lot of pus drained leading to a diagnosis of pyonephrosis. A radical left nephro-ureterectomy was performed in May 1994 and showed the lower ureter to be invaded by TCC. In mid June 1994 she had a left nephro-ureterectomy for persistent fevers and had similar findings (invasion of lower end

of ureters). Due to the fact that her residence was far from the haemodialysis centre, a decision was made to

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We thus report on what we believe to be the first case of TCC treated with CAPD following bilateral nephro-ureterectomy. Fernandez Lucas et al. [1] and Persad et al. [4] have reported on a series of similar patients whose quality of life was improved on haemodialysis. Despite the commendable outcomes of these modalities of treatments (haemodialysis and CAPD), transplantation in these patients is still likely to lead to some dilemmas, more so when considering live related kidney transplantation.

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496

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