Continuous Arteriovenous Hemofiltration (CAVH)

International Conference on Continuous Arteriovenous Hemofiltration (CAVH), Aachen (FRG), November 2-3, 1984

Continuous Arteriovenous Hemofiltration (CAVH)

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are in accord with current recommendations and practice at the time of publication. However, in view of ongoing
research, changes in government regulations, and the constant flow of information relating to drug
therapy and drug
reactions, the reader is urged to check the package insert for each drug for any change in
indications and dosage and
for added warnings and precautions. This is particularly important when the recommended agent
is a new and/or
infrequently employed drug.
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Certainly the most physiological form of assuring the proper equilibrium of water, electrolyte, and acid-base balances is continuous renal function. Starting from this basis, it would seem that continuous substitution, using an artificial kidney in whatever form, represents the best replacement. This enables us to avoid rapid fluctuations of the state of hydration, and also sudden changes in the retention parameters and in the electrolytes. From this point of view, continuous arteriovenous hemofiltration (CAVH) represents a better form of therapy than any of the intermittent methods of detoxification. Because of its simplicity, the method has rapidly become widely used, including in centers which previously did not treat acute renal failure cases.

The most important question to be faced by this conference is whether CAVH really does have the advantages I outlined just now, or whether it does not also involve substantial disadvantages. The use of this method by inexperienced therapeutic teams or even individuals has, through inadequate balancing, resulted in cases of very serious hyperhydration or of extreme exsiccosis. And standard problems of acute renal failure, such as the involvement of other organs and the need to consider the altered pharmacokinetics, have been left unconsidered.

But even when carried out properly, to the rules of the art, CAVH involves a number of problems. It is absolutely essential to take them into account when using the method. I mention here only the vascular access problems, the continuous heparinization, and the often inadequate efficacy in hypercatabolism.
On many occasions I was able to discuss these and other problems of
CAVH with Peter Kramer, we finally decided to hold a joint symposium to
discuss the results achieved to date and the problems remaining to be
solved. I most deeply regret that we must face this task today without his
stimulating help.

Aachen, November 1984 Heinz-Günter Sieberth

Obituary

Prof. Dr. med. Peter Kramer1 studied at Innsbruck, at Freiburg, and
at Göttingen, where his doctoral dissertation under Prof. M. Schwab was
on separate-side renal function studies in the initial stage of essential
hypertension. His period as a research assistant included eighteen months
at the Middlesex General Hospital, New Brunswick, N. J., USA, under a
rotating internship arrangement, and subsequent theoretical training in
the physiology department (Prof. Ochwadt) of the Max Planck Institute of
Experimental Medicine in Göttingen. After training as a specialist, which
he started in 1971 as a research assistant at the Medical Clinic and Policlinic
he received in 1974 the Venia Legendi for internal medicine from
the medical faculty of the Georg-August University of Göttingen. He
became senior clinical physician in 1977, extra-numerary professor in

Peter Kramer was a physician by conviction and calling, and a passionate
nephrologist. His wide-ranging interests were directed equally to
clinical practice and to theory, and he was as fascinated by the problems of
the pharmacokinetics of renal insufficiency as by dialysis technique. He

1 Born 8th April 1938 in Mödling, near Vienna; died 7th October 1984 in Göttingen

made a decisive contribution to the question of the pathological mechanism
of hyponatremia in the genesis of hypertension, and the results of his
extensive studies on the pharmacokinetics of the cardiac glucosides form
an essential part of present-day clinical practice. The development of
hemofiltration, which originated in Göttingen and is long recognized as a
method of equal value to hemodialysis for treating patients with chronic
renal insufficiency, owes a great deal to Peter Kramer. We must thank his
gift for observation for the discovery of a simplified method of filtration, the technique of continuous arteriovenous hemofiltration (CAVH). Its use has rapidly spread in intensive wards. This scientific commitment did not go unrecognized: one of Peter Kramer’s research projects was adopted by the Artificial Kidney Program of the NIH, Bethesda, USA; he received numerous invitations to give papers and was chosen as the leading member of the E.D.T.A. registration committee.

An eagerness or even passion for hard work, a capacity for rigorous action, a profusion of ideas, and infectious optimism were Peter Kramer’s conspicuous qualities. A brilliant speaker, he was an enthusiastic teacher, able to generate a like enthusiasm in his students. His sudden death has set an all too early end to a scientific career of great promise and to a life wholly dedicated to his profession as a physician. Peter Kramer will not be forgotten by any of those who knew him.

F. Scheler, Göttingen