PSYCHOSOCIAL ASPECTS OF DIALYSIS AND RENAL TRANSPLANT

Pages with reference to book, From 96 To 96

Samina Matin (Department of Psychiatry, Dow Medical College and Civil Hospital, Karachi.)

Renal transplantation has become the preferred treatment of end stage renal failure (ESRF), more so in the developing countries[1]. Not only is transplantation cost effective, it also restores normal life to the recipient of a functioning graft. However, dialysis will continue to play a pivotal role in the treatment of ESRF because of shortage of donor organs as well as the fact that patients of failed transplants have to return to dialysis for renal support. There is also a paucity of transplant units at teaching hospitals thus emphasising the need for an integrated programme of dialysis and transplantation for successful rehabilitation of patients with end stage renal failure. Shortage of donor organs has brought into focus ethical and moral issues in transplantation[2]. The best results of renal transplantation are achieved with the use of living related donors. Unrelated donor transplantation is not only unethical but is likely to promote rampant commercialism as witnessed in a neighbouring country. For these reasons cadaveric donation should be encouraged on priority not only to pre-empt any unrelated transplantation but more importantly to enlarge the spectrum of transplantation to include other organs such as heart, liver, pancreas, etc. Psychosocial sequelae in post-transplant renal patients have been extensively studied in the west with special emphasis on quality of life in contrast to those patients who are on dialysis. The patient on dialysis is in a state of limbo between the world of sick and the world of well belonging to neitheryet part of both[3]. This is a predicament, which has been highlighted by Haq et al[4]. When dialysis transplant patients are compared, it is found that transplant recipients return to work in a high percentage whereas patients on haemodialysis remain elusive with increased prevalence of psychiatric morbidity. Psychiatric symptoms are also seen following renal transplant. These can be organic with a confusional state or seen as depression, anxiety, paranoid psychosis and hypochondriasis. Penn et al[5] state that nearly all patients show episodes of reactive depression at some stage. On the other hand Simmons[6] reports patientâ€™s perceived level of physical rehabilitation, general psychological, social adjustment and ability to perform occupational roles as dramatically improved post-transplant compared to the pre- transplant period. In this issue two articles[4,7] evaluate the psychosocial aspect of common and safe procedures like dialysis and transplant in end stage renal failure in Karachi. This is an important issue as cultural factors not only determine presentation of a disease process or disorder but play an important part in management and prognosis. With the advent of transplant surgery in Pakistan it is pertinent to study the psychosocial implications. One study was conducted at Civil Hospital Karachi[4] and the other at Jinnah Postgraduate Medical Centre[7]. Both studies have made encouraging observations in post transplant renal patients showing no significant evidence of psychiatric disorder. In fact they observed considerable improvement in the physical, social and psychological status and working capacity. This could be related to the use of live related donor kidneys, strong family support and social acceptance post-operatively. Intensive treatment and support by the medical and paramedical staff is another important factor in the process of rehabilitation. The number of patients in the studies reproduced are small but the efforts made is commendable, being a significant stepping stone in the dynamics of renal transplant surgery in Pakistan. These studies highlight the importance of strong family support present in our culture for producing better psychosocial adjustment. With the better quality of life offered by transplantation as compared to dialysis and the fact that transplantation is cost effective, there appears to be a case for widening the scope of transplantation.

REFERENCES

1. Daar, AS. Renal transplantation, in developing countries, in kidney transplantation. Edited by Peter J. Morris. 3rd ed. Philadelphia, Saunders, 1988,p.709.
2. Sells, R.A. Ethics and priorities of organ procurements and allocation in transplantation proceedings (Proceedings of the twelfth International Congreaa of the Transplantation Society), August 14-19 1988, Norwalk, Appleton & Lange, 1988. V.21, p.1391.
3. Landsman, M.K. The patients with chronic renal failure: A marginal man. Ann. Intern. Med., 1975; 82:262-70.
4. Haq,I., Zainuddin, F., Naqvi, A., Rizvi, S.A.H. and Ahrnad, S.H. Psychosocial aspects of dialysis and renal transplant. JPMA., 1991; 41: 99.
5. Penn, I., Bunch, D., Olenik, D. and Abouna, G.M. Seminars in psychiatry in Psychiatric aspects of organ transplantation. Edited by P. Castelnuovo-Tedesco, New York Grune and Stratton, 1971, v.3, p.133.
6. Simmons, RG., Kiein, S.D., Simmons, R.L Giftof life. Psychological and social rehabilitaÂ¬tion of the adult transplant patient. New York, Wiley 77.
7. Abmad, I., and Abmad., S.H. Psychological adjustment after Renal transplantation. JPMA, 1991; 41: 97.