General discussion

Chairman: DR ROGER WILLIAMS

PROFESSOR H. E. DE WARDENER (London): Why do you call the renal failure of cirrhosis 'functional'? Renal failure means abnormal renal function so you are talking of 'functional abnormal renal function'!! What you have is a renal vasoconstriction and so a reduced glomerular filtration rate. If a reduced filtrate enters normal tubules all the sodium is resorbed. Find another word for it, e.g. 'renal failure with low sodium'. I think that what you mean by functional renal failure is reversible renal failure.

DR MARTINI (Marburg): In favour of Dr Vesin's concept of functional renal failure is the finding that kidneys from patients dying with this condition have been transplanted into human recipients and functioned normally. If there were any morphological abnormalities in these kidneys it is very surprising that they regained their function so quickly.

CHAIRMAN: Some 10 years ago it was apparent that there was no histological abnormality in these kidneys and so the term 'functional' was used.

PROFESSOR DE WARDENER: But we see a low GFR with low urine sodium in many situations, e.g. after haemorrhage. So, if it is seen in other diseases, why imply it is a different syndrome, and why give it a special name?

DR S. P. WILKINSON (London): Most hepatologists would agree that 'functional' is not an entirely satisfactory term. However, they all know what this means, namely, severe renal vasoconstriction, reduced GFR, and good tubular function. The important difference between the abnormality seen in cirrhosis when compared with a

similar renal abnormality seen as a result of haemorrhage or other cause of blood volume depletion is the response to therapy. In cirrhosis you can expand the plasma volume by several litres without improving renal function but, in the other instances mentioned, the renal failure is reversed by such methods.

DR H. RING-LARSEN (Copenhagen): A similar renal abnormality may occur in cardiogenic shock. But the unique feature about the renal failure of cirrhosis is its great severity. Even with a major degree of cardiac failure the degree of renal insufficiency is only relatively minor.

DR H. J. KRAMER (Bonn): In internal medicine, when we find a patient with a reduced GFR with low urinary sodium, the cause is usually haemorrhage or some other reason for plasma volume depletion and a reflex renal vasoconstriction. It is thus usually referred to as pre-renal uraemia. In cirrhosis there appears to be an active renal vasoconstriction, e.g. as a result of an endotoxin.

DR JAMES (Newcastle): Why is the vasoconstriction in this condition so difficult to reverse? Non-specific vasoconstrictors don't appear to be of any value. Can Professor de Wardener suggest what we try next?

PROFESSOR DE WARDENER: I don't know!

DR E. N. WARDLE (Newcastle): Could an elevated inferior vena caval pressure account for the functional renal failure syndrome seen with ascites?

DR RING-LARSEN: To reduce renal blood flow the caval pressure must be at least 25–30 mmHg, and these pressures are not seen in cirrhosis.