Discussion

Chairman: PROFESSOR SHEILA SHERLOCK

CHAIRMAN: Ought we to investigate renal function in every patient with ascites in the way you describe?

DR V. ARROYO (Barcelona): By determining the free water clearance and glomerular filtration rate, we have been able to predict whether or not the patient will survive in most cases. The simpler tests, maximal urinary flow rate and plasma urea, are almost as useful in that nearly all patients die who have a maximal urinary flow rate of less than 4 ml/min with a plasma urea greater than 30 mg/100 ml.

DR D. VESIN (Paris): We have performed some longitudinal studies on patients who have lost ascites on bed rest and low sodium diet, i.e. like the patients in your first group. Initially plasma volume was high, urinary aldosterone normal or low—although I suppose it must have been high before. The GFR was not very high, being similar to the patients in your second group. After a few days we repeated the measurements and found that neither aldosterone nor plasma volume had changed. But the GFR had increased substantially, with values similar to those you found in patients after 7 days of bed rest. The increase in renal perfusion may have been of considerable importance. Not all of these patients lost all

their ascites spontaneously. One case illustrates the importance of hyperaldosteronism. This patient was initially losing ascites spontaneously but then began to retain sodium. The sodium retention was associated with an increase in urinary aldosterone.

DR R. WILLIAMS (London): How many of your cases, Dr Arroyo, remain in the same category as initially, when readmitted with a relapse of their ascites?

DR ARROYO: This is very variable. Some patients come for the first time as salt intolerant patients. They receive diuretics, lose their ascites and are discharged. Two months later they may come back with further ascites but are now salt tolerant. In some patients it is the other way around.

DR C. RECORD (London): What did your patients in group III die from, since their GFR of 40 ml/min was not really too bad?

DR ARROYO: The study I described was carried out at the end of the first week of their hospital admission and subsequently renal function deteriorated progressively and they all had severe renal failure at the time of death, as well as hepatic failure.