

Historical Reflections: Dialysis and Transplant in the 1970s.

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Abstract

In Sydney Hospital in the seventies peritoneal dialysis was undertaken in unisex Nightingale wards using both tenckhoff and hard metal stick catheters. Peritoneal dialysis was delivered in glass bottles. A cramped eight bed haemodialysis unit was situated in an enclosed balcony. External arterio-venous shunts, formaldehyde major blood spills were common. Kidney transplants were successful with patients being cared for in laminar flow beds.

“The Sydney Hospital Transplant Unit had its own cook who soaked the salads in Milton solution prior to serving.”

Excluding the advances in technology, surprisingly little about the basics of renal nursing and dialysis has changed in the last forty years. However, trying to recall my memories of Sydney Hospital Renal Unit 1976-1979, is to return to a different world.

In those days, the Nurses Registration Board was located in Macquarie Street and, newly arrived for a “working holiday” in Australia, I drifted across the road to be offered a job in Ward 17, that otherwise difficult to staff combination of renal and haematology. Like most of the other new recruits from, I had no dialysis experience. Since graduation, I had been working in midwifery and child health, in United Kingdom (UK) and Africa, and I had barely heard of dialysis, which had only recently become widely available. The major UK teaching hospital where I trained in the mid sixties, had no dialysis facilities, and the renal patients were maintained on a diet consisting mainly of white bread and butter, until they progressed to severe acidosis, pulmonary oedema and death. Therefore, I was excited to have landed, by chance, at the cutting

edge of nursing. I had joined a great team of renal physicians and a core of experienced renal nurses, who maintained high standards and high morale. Another plus was that the nursing staff were all young, including the Charge Nurse, Penny Horner (m.Paton), and this also led to plenty of fun and social activities!

During this time, I did the renal course, working four shifts a week in the unit and attending a fifth day of lectures in the Lucy Osborne School of Nursing. I have a poor memory for names, but the very supportive tutors were Valda and Yvonne. Of course, there were no computers or internet, all the essays were hand written, and we had only one text book: *The Kidney*, by H.E. De Wardner, which I still have and sometimes consult! However, due to the excellent lectures given by nephrologists John Mahony, John Stewart, Robyn Caterson, Lloyd Ibels and Elliot Savdie, the course was very thorough and laid a great foundation for many who, like me, have remained in renal nursing to this day.

Sydney Hospital is the oldest hospital in Australia, and Ward 17 was a traditional

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“Nightingale ward”, shaped like a wide corridor, with painted iron beds lined up along the walls, facing inwards. The original division of male and female wards had been changed to accommodate renal and haematology patients separately, so the whole ward was “unisex”. If this lack of privacy disturbed the patients, they did not complain—this was the seventies after all. Despite obvious drawbacks, I preferred the Nightingale wards because of the high visibility and the co-operative working practices that this encouraged. The Nightingale wards provided plenty of exercise, with no need for gym membership, as we ran twenty kilometres a day, pushing trolleys with bedpans, washing bowls, medications, dressings and peritoneal dialysis equipment. The ward was busy, but sufficiently staffed to prevent the stress experienced by many nurses today. During the evening shifts, there was plenty of time to talk to patients and build good relationships.

At that time in Australia, the most common cause of renal failure was analgesic nephropathy. This was phenacetin toxicity resulting from an ingredient of the over-the-counter combination analgesics such as Bex, Vincents and APC (aspirin, phenacetin and codeine). Bex powders, which were used by housewives to help them get through the day, were an Australian icon, immortalized by the 1960’s play

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“A cup of tea, a Bex, and a good lie down”. However, a newly arrived South African doctor, Priscilla Kincaid-Smith, made the connection with renal failure, and phenacetin was removed from the powders during the 1970s. The analgesic nephropathy patients were feisty, prematurely aged ladies, who had lived through the Great Depression, two world wars and had struggled to raise large families in the poor inner city areas. They were usually also smokers, had very poor veins and had to be either haemodialysed via an external shunt or receive peritoneal dialysis.

Patients were admitted twice weekly for 24 hours of peritoneal dialysis. The soft Tenckhoff catheter was already in use, but emergency dialysis was carried out via a hard metal catheter which was stabbed into the peritoneal cavity at the bedside (the procedure was as barbaric as it sounds!). The dialysate was delivered in one litre glass bottles, warmed in a water bath, and requiring a metal airway to induce flow (the latter providing a useful weapon against attack, when, at the end of the late shift at 11pm, we set off across the menacing Domain!). I think we used hourly cycles, so there was constant activity in changing the bottles. Peritonitis must have been ubiquitous, but I do not remember a specific incidence. In reality, peritoneal dialysis treatment was not a long term proposition until the widespread adoption of CAPD in the early eighties.

Although there must have been armchairs, I really can't recall any patients sitting or ambulant. In my memory, all the patients were lying in bed, even during haemodialysis.

The main reason for this was that, prior to the introduction of Erythropoietin in the late eighties, renal patients, apart from those with polycystic kidneys, tended to be sick and weak, with a haemoglobin of 7 g/dl considered good! In the seventies, patients had grey, itchy skin, anorexia, neuropathy and an uraemic odor that is rarely encountered today. However, just like today, the home dialysis population enjoyed a better quality of life.

Haemodialysis was carried out on an enclosed balcony, adjacent to the ward. The unit of about eight beds was cramped, and often reeked of spilt formalin, resulting in constant headaches and I dread to think what other damage! The unit had already given up re-using lines (I worked in another unit that was still re-using lines in 1981), but the dialysers were re-used up to three times and formalin was also used to disinfect the machines. Only the young, fit men had an AV fistula, most women had vein grafts or arterio-venous external shunts, which required great care to prevent blood loss. At the end of dialysis, the venous and arterial ends of the external shunt were joined with a straight connector, and separation accidents were common. I can still recall the, sickly sweet smell of sprayed, spilt or leaked blood, which was an accepted part of the job. There was an underlying fear of Hepatitis B, which had wiped out renal unit staff in Edinburgh in 1970. We tested our own blood regularly, but there was no vaccine available. During 1979, there was an outbreak on Ward 17 and the unit was “closed” (no new patients or staff allowed in).

The machines were mainly Drake Willocks, which I liked because they were easy to understand by opening up the back of the machine and recognizing each part with the aid of a diagram. Nursing staff were responsible for taking the machines apart and cleaning them every week, so there was no mystery to the process of dialysis. The alarms had to be set manually and the ultrafiltration worked out with a formula and a calculator. The patient “going flat” was an accepted part of the treatment. Some home dialysis patients used REDY machines, which contained an internal dialysate bath and were therefore portable!

Due to the bad roads and the lack of drink driving laws, the waiting list for a cadaveric transplant was shorter than today (living related transplants were less common) and most young people received a transplant, some carrying pagers to make sure that they did not miss the call. The transplant patients were nursed in complete isolation, with laminar flow, theatre garb and all articles passed through UV light. The Sydney Hospital Transplant Unit also had its own cook, who soaked the salads in Milton solution prior to serving!

I have many good memories, but I have no wish to return to the “good old days”, where many patients suffered poor quality of life; and the nursing staff were pickled in formalin, and exposed to Hepatitis B! Let us all learn from the past but look forward to continuous improvement in the future.