

EDITORIAL

RENAL TRANSPLANT IN SINGAPORE

The first renal transplant has been done in Singapore, and so far the progress of the case has been satisfactory. This is the natural conclusion of a campaign which began in 1960 with haemodialysis, for it soon became evident that chronic dialysis would be too costly and not entirely satisfactory. Compared with others, we have begun about ten years after them, and hence we are better placed in that we can use the experience of the pioneers, so that we can avoid many teething troubles. There still remain the problem of donors, the question of advertisement and publicity, and the labour of long term care of the transplanted case, and these will have to be solved as they arise.

With the cultural setting, donor will remain serious problems unless laws and public opinions change radically, and laws and public opinions cannot change without wholesale public education. This can only be undertaken if the medical ethics regarding advertisement and publicity be modified considerably, as they have in other countries. The people must be persuaded to accept that dead bodies are not sacred or important, and for the sake of knowledge, examination of the dead should be encouraged. What is more, when a person dies, some of his tissue remains alive for some time and can be salvaged to prolong the lives of others, and this would require an altered attitude regarding life and death, so that the criteria of the moment of death can be set anew.

Over the past few years, cornea transplant has made tardy progress in Singapore, and it is certain that renal transplant, a new activity, is going to have the same difficulty. Should many living remain blind, and scores of people die of renal illness each year in order that the dead body may be interred intact to go back to ashes? This is a value judgement which society alone can decide, and the doctors must try to create an informed society so that a sound judgement can be made.

Renal transplant will not, however, save all the two or three hundred renal deaths annually, for a good number cannot be salvaged, and at least a quarter to a half of transplants fail ultimately. Prophylaxis on a large scale will no doubt be more valuable in the long run to eliminate acute glomerulonephritis, and reduce

the ravages of hypertensive kidney diseases. This, however, should not lead us to think that effort would be wasted to acquire expertise in transplant work, for the advance of medicine depends on posing new problem for conquest, and in making new conquest, new knowledge is gained so that in turn, a greater expertise is achieved in prophylaxis. What is important is that a proper balance between prophylaxis, treatment and research should be achieved so that as the science advances, the health of the community improves, and the service to the sick remains satisfactory. Those who feel that esoteric research should be undertaken until the general care is entirely satisfactory, err as much as their counterpart who maintains that excellence should be attained without regard of the need of the community at large. Renal transplant in Singapore is not a breakthrough in knowledge, but it is a milestone in Singapore medicine, and it emphasises the need for the local medical profession to reorientate its attitudes.

The long term care of a transplanted case requires the presence of a medical team closely linked with transplant surgical group, for after the acute stage, there is need for prolonged treatment and observation to detect and treat late rejection of donor kidney, and when treatment fails, to resort if need be to a fresh transplant. This means good follow-up requiring doctors as constant members of the team, and patients as active cooperating partners in treatment. At the beginning, the number of cases are few, and part time workers only are involved, but sooner or later, as transplant gains tempo, full-time team is necessary. Renal transplant then is a long term undertaking, and not a transitory activity such as an appendectomy where one needs a surgeon and facilities for only a short moment, and after that no further problem arises. If we assume that in Singapore population, 10 to 20 transplants would be needed a year, and with pre- and -post operative dialysis, rejection detection and treatment, and re-transplant, then within 5 to 10 years, such teams should be there to meet the demand. It takes 7 years to train a doctor and another 7 years to train a specialist, and if

we need the teams in 10 years, then the training to build up manpower required has to be done now. Too easily, the human mind is obsessed

by events of the moment, and if we do not make active provisions now, we shall be creating a problem within the next decade.

Gwee Ah Leng
