Determination of glomerular function in advanced renal failure

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SUMMARY In 15 children with advanced chronic renal failure, glomerular filtration rate was determined by different methods. Inulin clearance correlated well with the mean of creatinine and urea clearance, and also with 51-chromium edetic acid (EDTA) clearance measured over 24 hours. The absolute values of creatinine clearance and of 51Cr-EDTA clearance measured up to 8 hours were higher than inulin clearance. In advanced renal failure both the 51Cr-EDTA clearance measured over 24 hours, and the mean of creatinine and urea clearance, provide acceptable estimates of true glomerular filtration rate.

The measurement of residual renal function is important in planning dialysis and transplant programmes, and serial measurements of glomerular filtration rate (GFR) are the most suitable method of predicting when dialysis will be required. Different methods of measuring GFR in advanced chronic renal failure have been compared in adults (Lubowitz et al., 1967; Lavender et al., 1969; Skov, 1970; Favre, 1973; Milutinovic et al., 1975), but there are no comparable studies in children.

Patients and methods

Fifteen children, mean age 11 years (range 3–16), with advanced chronic renal failure were investigated; their diagnoses are shown in the Table. All children were in a stable condition at the time of the study. 4 were investigated twice. On the first day, GFR was determined by creatinine clearance (C_in) and urea clearance (C_urea) with a 24-hour urine collection and a single serum specimen. The arithmetical mean of both clearance values (Lubowitz et al., 1967) was also calculated. C_cr was also estimated from serum creatinine and body height (Counahan et al., 1976).

On the second day a standard inulin clearance (C_in) was performed with three collection periods (Stalder, 1960), each lasting for 20 minutes, and the single injection clearance of 51-chromium edetic acid (EDTA, Amersham) was determined. For the calculation of the EDTA clearances (C_EDTA) the radioactivity was measured in 10 serum specimens obtained 5, 10, 15, 30, 60, 90, 120, 180, 360, and 1440 minutes after injection of EDTA on the basis of the two-compartment model of Sapirstein (Donath, 1971). The resolution of the plasma-disappearance curve was performed graphically in two different ways. Firstly, by using all sera up to 8 hours after injection (C_24EDTA), and secondly, by considering the serum specimens from 5 to 60 minutes and at 24 hours only (C_1EDTA). The only difference between the two procedures to calculate C_EDTA was a different half-life time of the latter part of the plasma disappearance curve.

Standard techniques were used for the analytical procedures (Richerich, 1968; Brodehl, 1969; Helger et al., 1974) and for the evaluation of correlation coefficients (r). The calculation of the coefficient of variation of the three inulin clearance periods in each of the 15 patients was based on the logarithmic values (Zender et al., 1968).

Results

The results obtained by the different methods for the evaluation of GFR are compared in the Table. C_in ranged between 0.9 and 18.1 ml/min per 1.73 m². The mean coefficient of variation of the three C_in collection periods in each patient was 16%. Figs. 1, 2, and 3 compare the alternative methods of measuring GFR with C_in. The correlation between C_in and the reciprocal values of serum creatinine (S_cr) and serum urea (S_urea) was poor but improved when S_cr was corrected for height (Table) (Counahan et al., 1976). The correlations to C_cr and to S_urea were good, but mean C_cr overestimated C_in by 40%, whereas the mean C_urea was 22% less than C_in. A high correlation as well as an acceptable agreement...
Table  Determination of glomerular function in 15 children with advanced renal failure

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Height (cm)</th>
<th>CIN (ml/min per 1.73 m²)</th>
<th>SCR (mg/100 ml)</th>
<th>0.43 × height</th>
<th>CCR</th>
<th>CCR + C urea 2</th>
<th>CEDTA 8</th>
<th>CEDTA 24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oligomeganephronl hypoplasia</td>
<td>90*</td>
<td>5.4</td>
<td>3.3</td>
<td>12.2</td>
<td>7.6</td>
<td>4.6</td>
<td>6.1</td>
<td>9.1</td>
</tr>
<tr>
<td>Renal dysplasia</td>
<td>159</td>
<td>8.3</td>
<td>6.3</td>
<td>10.8</td>
<td>12.2</td>
<td>9.4</td>
<td>14.8</td>
<td>10.9</td>
</tr>
<tr>
<td>Nephronophthisis</td>
<td>121</td>
<td>11.7</td>
<td>3.1</td>
<td>17.6</td>
<td>17.3</td>
<td>10.5</td>
<td>13.9</td>
<td>15.6</td>
</tr>
<tr>
<td>Chronic pyelonephritis</td>
<td>140</td>
<td>12.9</td>
<td>2.3</td>
<td>22.5</td>
<td>17.6</td>
<td>16.3</td>
<td>17.4</td>
<td>12.9</td>
</tr>
<tr>
<td>Henoch-Schönlein nephritis</td>
<td>106</td>
<td>9.5</td>
<td>13.9</td>
<td>20.0</td>
<td>17.4</td>
<td>16.4</td>
<td>16.7†</td>
<td>16.7</td>
</tr>
<tr>
<td>Mean</td>
<td>8.5</td>
<td></td>
<td></td>
<td></td>
<td>1/0.69</td>
<td>0.80</td>
<td>0.83</td>
<td>0.89</td>
</tr>
</tbody>
</table>

*Parenthesis indicates same patient investigated twice.
†This is the only patient with important proteinuria and overt oedema. These values are not included in calculation of the mean and r.

Conversion: Traditional units to SI—Serum creatinine: 1 mg/100 ml = 88.4 μmol/l.

Fig. 1  Inulin clearance (C IN) related to creatinine clearance and urea clearance.

with the mean value of C IN (+9%), were obtained with (CCR + C urea)/2 (Fig. 2).

CEDTA 8 did not significantly correlate with C IN (P < 0.01), and overestimated it by 36%. On the other hand, CEDTA 24 correlated well with C IN (r = 0.92) and underestimated it by only 6%.

Fig. 2  Inulin clearance related to the mean of creatinine and urea clearance.

Discussion

It is generally accepted that while C IN is the most accurate method of measuring GFR, even in advanced uraemia (Hierholzer et al., 1972), it is not applicable to routine clinical practice (Barratt and Chantler, 1975). In adults the variation coefficient of C IN in the same patient with normal or slightly impaired GFR varies between 8 and 12% (Zender et al., 1968; Kramer et al., 1974). In the present
series of children with advanced chronic renal failure the variation coefficient was slightly higher.

$C_{\text{Cr}}$ overestimates GFR especially in chronic renal failure. This has been attributed to tubular secretion of creatinine, to fluctuations in the daily creatinine formation and excretion, and to interference of creatinine chromogenic material with the Jaffé reaction (Lubowitz et al., 1967; Kim et al., 1969; Hierholzer et al., 1972). It has been known for a long time, that $C_{\text{Urea}}$ underestimates GFR and is highly dependent on dietary protein intake. On the other hand, Lubowitz et al. (1967) showed in adults with advanced chronic renal failure that the mean of $C_{\text{UB}}$ and $C_{\text{Urea}}$ gives a good estimate of the true GFR. Our results show that the same applies to children with advanced chronic renal failure.

Recently isotopic single injection clearance techniques have become increasingly popular for the estimation of true GFR because of their simplicity, accuracy, and noninvasive nature. $C_{\text{EDTA}}$ has been tested in large groups of children with normal or slightly impaired renal function (Vögel et al., 1971; Chantler and Barratt, 1972). Few data, however, have been published on the determination of GFR by $C_{\text{EDTA}}$ in children with advanced chronic renal failure (Vögel et al., 1971). In adults with advanced chronic renal failure the single injection technique ($C_{\text{EDTA}}$) overestimates GFR (Favre, 1973). This has been attributed to an expansion of the extracellular volume, present even in the absence of overt oedema.

In newborns a similar mechanism seems to be responsible for the overestimation of GFR after feeding (Broberger, 1973).

The mathematical model used to analyse the falling plasma concentration curve is in any case an approximation and involves an overestimate of the plasma clearance of the chelate (Chantler et al., 1969). This overestimate is small but becomes relatively more important when GFR is low and can be corrected for by extending plasma sampling (Maisey et al., 1969).

Our study with $C_{\text{EDTA}}$ suggests that in patients with advanced chronic renal failure one blood sample should be taken at 24 hours after injection to obtain an acceptable correlation with true GFR.

References


The following articles will appear in future issues of this journal:


Aural temperature of the newborn infant. D. Stratton.

Diabetes insipidus, diabetes mellitus, optic atrophy, and deafness: 3 cases of ‘DIDMOAD’ syndrome. Joyce E. Richardson and W. Hamilton.

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