

The First Twenty-five Years

EDTA to ERA

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The Start

The idea that became EDTA was born at a symposium on acute renal failure at the Royal Free Hospital in September 1963 (Fig. 1). Many of the participants were on their way home from the Second Congress of the International Society of Nephrology in Prague. It had been a memorable meeting. Our Czech hosts had triumphed over adversity to entertain us royally and had laid on a splendid scientific programme. They had even sent their Minister of Health to join John Merrill in conducting the community singing. All this was achieved without the help of professional conference organisers, who had only just begun to evolve as a species. It was the start of a life-long love affair with ISN.

But Prague had also revealed the adverse side of massive international congresses (Table 1). I had been particularly exasperated by the multiple parallel sessions for free communications. After three days of rushing from hall to hall, arriving just as the speaker I sought was stepping off the podium, I gave up. If you have to miss 13 parallel sessions you might as well miss 14, so I went sightseeing in Prague instead. There I met most of the other delegates who were not presenting papers or listening to their research fellows on the last afternoon.

To this the Royal Free Hospital Symposium was a complete contrast (Table 2). It was devoted to a single topic in which all the delegates had a strong interest. The discussion was lively and spontaneous in a way it can never be in a hall seating 2000. At tea break I said to Stanley Shaldon 'Great meeting. Let's start a society to hold symposia like this'. 'Funny you should say that', said Stanley, 'Willem Drukker has just made the same suggestion. Meet us in the Apothecaries' Hall after supper and we'll talk it over'.

We met and laid our plans. We designed a short questionnaire, which I sent out to nephrologists in

Britain and Ireland, the Low Countries, France, Germany and Scandinavia to see if they were interested. The response was encouraging so a planning meeting was held in Amsterdam in September 1964 to found the Society.

WEDA to EDTA

The 'gang of three' started with small ideas (Table 3). We planned a small society to complement ISN, not to compete with it. It would meet only in the years between ISN meetings. It would be small and focused enough to retain the flavour of the Royal Free meeting. So our questionnaire had specified a single topic—dialysis for renal failure. The gang of three all happened to share this interest. To keep the society small and its meetings cheap we had restricted our enquiries to the countries readily accessible from Amsterdam, London and Newcastle upon Tyne! We proposed a programme which every delegate could attend throughout and which would give pride of place to original communications, held in plenary session.

At the planning meeting our ideas were rapidly broadened. Gabriel Richet and others made an impassioned plea for a pan-European society. We were soon converted and embraced not only the geographer's Europe but all the nations bordering the Mediterranean Sea as well. At a stroke of the pen Syria, Lebanon, Israel, Egypt, Libya, Tunisia, Algeria and Morocco were incorporated in greater Europe. There were cries of 'What about Iraq?', 'What about Jordan?' and so on, but our skilful chairman, Professor de Graaf, intervened and insisted that a Mediterranean coastline was the touchstone. Without his intervention we could have finished up by annexing China to boot!

Then transplantation was added to our subject matter, but not in time for our first congress, which began that

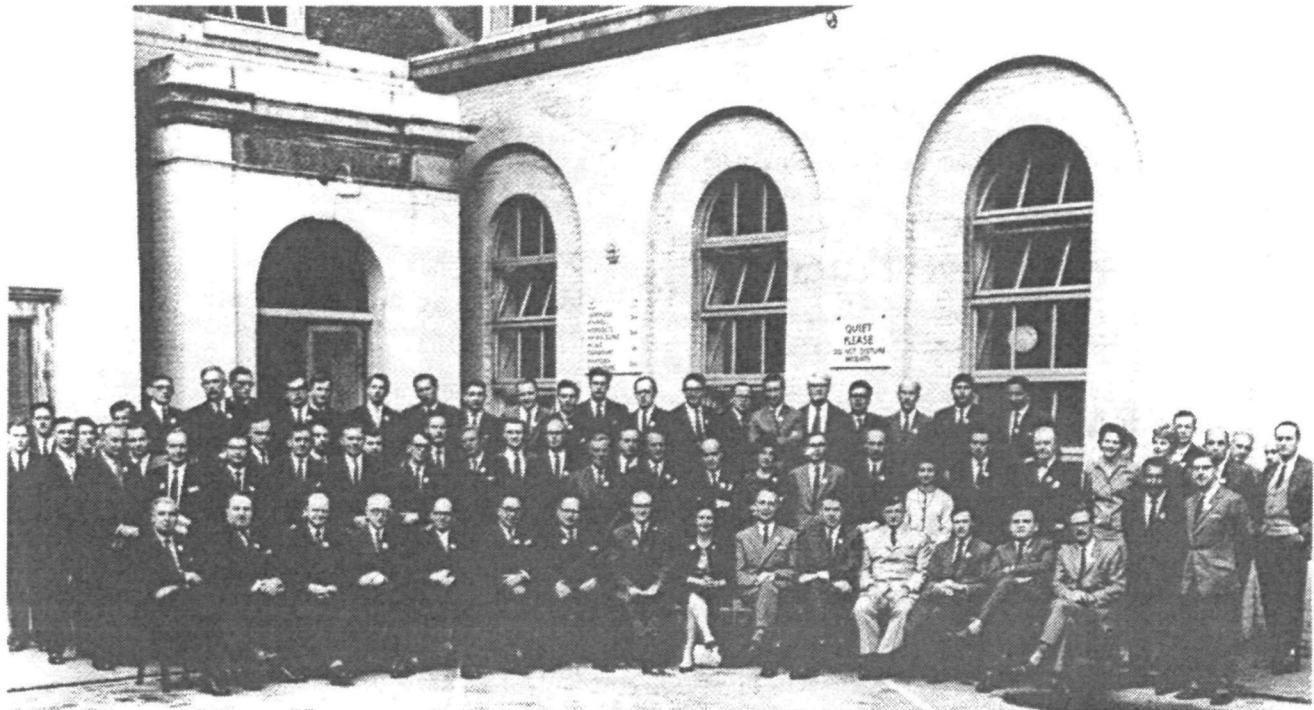


Fig. 1. Participants at the Symposium on Acute Renal Failure held at the Royal Free Hospital, London, on 2 September 1963.

Table 1. Drawbacks of large international congresses

| | |
|--------------------------------------|-------------------------|
| Expensive | |
| Move around the world—high air fares | |
| Held in capitals—high hotel costs | |
| Require large congress centres | } high registration fee |
| Need professional organisers | |
| Indigestible | |
| Parallel sessions of oral papers | |
| Gargantuan poster displays | |
| State of the Art | |
| Only the reviews in plenary session | |

Table 2. The Royal Free Hospital Acute Renal Failure Symposium, 1963 (Model for the original idea of EDTA)

| | |
|--|--|
| Cheap | |
| Small enough to hold at a University | |
| Easy to raise sufficient sponsorship | |
| Intimate and lively | |
| Modest number of delegates (Fig. 1) | |
| Small lecture hall—informal atmosphere | |
| Focused | |
| Single topic | |
| All delegates actively involved | |
| Up to date | |
| All original presentations, in plenary session | |

same afternoon. So volume 1 of our proceedings appeared with 'EDTA' on the cover but no 'T' in the Contents pages. I welcomed the enlargement of our fledgling society in geographic spread and subject matter, but recognised that the other original concepts that remained (Table 3) were doomed. The intimate meeting with a single plenary session had a longer run than I expected, but 9 years later I had the sad duty of presiding over its demise.

Halcyon Days—The Infancy of EDTA

One of our early decisions was to hold congresses annually. It was hotly debated. There were some who thought that we would use up the backlog of interesting work awaiting presentation in our first two meetings, which Willem Drukker has described. The crunch for the society would be its third meeting, when the bank balance was exhausted and we had to rely on new material produced each year. It would also be our first clash with ISN. The programme would be thin and enthusiasm would wane. The meeting at Lyon confounded the critics and for me it was the high spot of early EDTA. There was no shortage of interest in the scientific programme (Table 4) and the social programme was unforgettable. The 240 delegates could still be handled easily and well housed at modest expense.

We toured Lyon on foot and lost few of the delegates, despite the liberal lubrication. We were welcomed in the Hotel de Ville and dined under the arches of a medieval

Table 3. The small vision of the EDTA founders and the changes after Amsterdam, 1964

| | Founders' vision 1963 | Changes 1964 |
|-------------------|--|---|
| Meetings | Small—up to 200 Infrequent—miss ISN year | No fixed size Annual |
| Geographic spread | Narrow ('WEDA') | Pan-European |
| Topic | Restricted—dialysis | Wider—dialysis and transplantation |
| Presentations | All plenary sessions Oral original presentations Occasional guest lectures | All plenary sessions Oral plus poster presentations More guest lectures |

Table 4. The scientific programme at Lyon, 1966

| |
|---|
| Guest Lecture: J. Dausset—Leucocyte grouping and transplantation |
| Registry Reports: Dialysis and transplantation |
| National Programmes: First reports of programmes for regular dialysis in Sweden, UK and USA |
| Original oral presentations (47) including first EDTA reports on: |
| Home haemodialysis |
| Automated monitoring and proportioning |
| Haemodynamic response to haemodialysis |
| Trace element accumulation (arsenic) |
| Chelation for iron overload |
| Uraemic oxalosis |
| Transfusion and renal transplant |
| Renal preservation for transplantation |
| Poster presentations (29) including first EDTA reports on: |
| Charcoal regeneration of dialysate |
| Charcoal embolism from haemoperfusion |
| Theory of recirculation single-pass dialysis |
| The Hoeltzenbein coil |

Table 5. Growth of the EDTA Proceedings

| Year | Pages | Papers | Publication time |
|------|-------|--------|------------------|
| 1964 | 320 | 52 | 10 months |
| 1969 | 379 | 55 | 6 months |
| 1984 | 1079 | 150 | 6 months |
| 1985 | 1284 | 187 | 6 months |

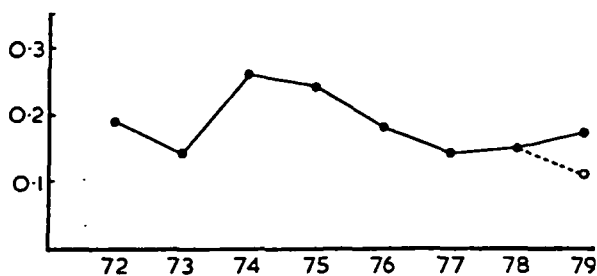


Fig. 2. Ratio of abstracts accepted to abstracts submitted 1972–1979. The rise from 1973–1974 followed extension to a 3-day meeting. Dotted line 1978–1979 shows the change that would have occurred without the introduction of parallel sessions.

palace, where Stanley Shaldon gave the speech of thanks in French. On the last afternoon we toured the vineyards of the Rhone valley and visited the home of Claude Bernard where our milieu interieure was lavishly replenished. On the way home we stopped for dinner at a chateau which housed the Hotel School of Lyon. It convinced us that the reputation of Lyon as the culinary capital of Europe was well founded. A handsome young French minstrel serenaded us from the gallery and set the tone for the community singing in the bus home. Nephrology was a new specialty. Its practitioners were young. We met our contemporaries from all over Europe and forged friendships which have lasted the quarter-century since.

The scientific programme contained many European, and some world, 'firsts' (Table 4). Paul Michielsen described the better tolerance of renal grafts by those who had been dialysed for several months than of those transplanted early. In discussion, John Merrill commented on the need to know whether blood transfusion, then an inevitable consequence of dialysis, sensitised patients against renal grafts, and said 'We have certainly seen evidence here that it does not. The data here suggest that dialysis might even help. I for one have given up being afraid of dialysing or transfusing patients who are potential recipients for this reason'. Although the two phenomena of sensitisation and a blood transfusion effect could not be disentangled in the infancy of HLA matching, the scene was set for the later work of Opelz, Terasaki and others.

One of its fascinations was the continuing role of the D-I-Y physician in dialysis. The poster session was the happy hunting ground of the Chitty-chitty-bang-bang inventors. Pride of place among them must go to Dr (now Professor) Hoeltzenbein. When stripping down the upholstery of his VW Beetle he came across a stiffening mesh, looked at its structure, visualised it in three dimensions, and recognised it as a promising dialyser membrane support. He traced it to its origin in a factory in Britain, built his coil in his own basement workshop, sold the idea to Travenol, and launched the design which dominated dialyser manufacture for nearly a decade.

The Rapid Growth Phase

The age of intimacy, innocence and innovation had to end. By the early 1970s the D-I-Y inventors had been overtaken by the growing investment of industry. The logarithmic rise in the number of patients and units, charted each year in our Registry Reports, fuelled a rapid growth in industrial investment and profit. Our congresses were well sponsored and industry was able to support many delegates who could not otherwise have attended. Attendance at congresses grew faster than membership of the society. The number of abstracts submitted grew to the point at which the chance of getting on the programme became unacceptably low (Fig. 2). The meeting was extended to three days in 1974, creating a temporary relief, but by 1979 the position had again become intolerable. As chairman of the selection committee that year I had to report that if we stuck to a three-day meeting and a single plenary session for oral presentations the chance of an abstract being accepted would fall to 14%. Council decided that a further extension of the length of the meeting was not a long-term solution and introduced parallel sessions.

The Arrival of EDTNA

Our daughter society held its first congress in parallel with EDTA in 1972 in Florence. The combined congress was an instant success, and welcomed by exhibitors at the trade congress. It added to the social life and offered a more didactic programme for those delegates to EDTA who found the fare there heavy going, while giving the more adventurous nurses the chance to sample our programme. However it also added to the headaches. The combined attendance at Florence in 1972 was 1200. When the two societies returned to Florence in 1984 it topped 3000. The combined societies had grown too big for all but the largest congress centres of the 1970s and we had to change to an end-on-end format with a combined Registry Report. This year EDTNA-ERCA has come of age and is meeting separately at Brighton; we hope the separation is only temporary and that we shall meet together again soon. However, despite their absence, this year attendance is back over the 3000 mark and EDTA congresses are larger than most ISN meetings.

The Rise and Fall of the EDTA Proceedings

The Proceedings grew in parallel with our meetings (Table 5). From time to time we tried to check this exuberant growth by trimming our discussions, omitting the posters and limiting the length of papers, but by 1985 the volume had grown to an unwieldy size and it was replaced

by our new journal *Nephrology Dialysis Transplantation*. Publication time for the first volume of the Proceedings was 10 months, but by the time I laid down the editor's pen in 1969 we had formed our long association with Betty Dickens, now of Transmedica, and the Proceedings appeared within 6 months. It is a great credit to all my successors that the publication time was kept at that figure until the end, while the work of editing the Proceedings during the summer holidays quadrupled. Although I launched the Proceedings, I shed no tears for it. It has served its function and was right to take its bow before it ceased to please the crowd. In today's competitive research environment the only publications that matter are those in peer review journals. The society has shown its maturity by moving with the times.

The Gradual Change to ERA

In the heyday of the Hoeltzenbeins, EDTA had some of the flavour of ASAIO. For a few years the society remained a meeting ground for doctors and engineers, but in the late 1960s it was obvious that nephrology was reverting from a machine-orientation to mainstream medicine. When Arthur Kennedy became the first President of EDTA he announced his intention of adding an 'N' to the 'D&T'. The following year there was a Nephrology section in the Congress for the first time. To begin with it struggled to survive, as Transplantation had done in the earlier years. In 1977 it was still necessary to boost the nephrology content of the congress by accepting papers with a lower score than in the other sections. The cut-off point (above which papers were automatically accepted) was 2.5 for Nephrology against 3.2 for Dialysis that year. However, Nephrology soon picked up. By 1979 the scores had levelled at 3.1.

The steady growth in the society's interest in nephrology since then can be judged by the distribution of papers in the Proceedings and in *Nephrology Dialysis Transplantation* (Table 6). General nephrology is now the leading topic.

Table 6. The addition of 'N' to 'D & T'

| Original articles published in <i>Nephrology Dialysis Transplantation</i> Volume 2 | |
|--|----|
| Nephrology | 31 |
| Mixed | 4 |
| Dialysis | 26 |
| Transplantation | 13 |

After compiling the above table I was tempted to stop and say 'The "N" is now incorporated with the "D&T"; "EDTA" has changed into "ERA".' But I do not believe the transformation is yet complete. A further analysis of the contents of *Nephrology Dialysis Transplantation* shows why (Table 7). As patients pass from conservative

Table 7. Clinical studies and renal failure still predominateAll articles published in *Nephrology Dialysis Transplantation* Volumes 1 and 2

| | |
|--------------------------|-----|
| Renal failure | 38 |
| Clinical nephrology | 28 |
| Haemodialysis | 18 |
| CAPD | 18 |
| Clinical transplantation | 17 |
| Clinical | 119 |
| Experimental | 9 |

treatment to haemodialysis, to transplant, to CAPD, to retransplant etc., they no longer fit tidily into pigeon-holes. Clinical studies increasingly encompass several treatment groups. Table 7 shows that our largest single interest is still renal failure and that the combination renal failure–dialysis–transplantation still makes up the bulk of our subject matter. Experimental work and the basic sciences that underpin nephrology—which form the bulk of the contents of *Kidney International*—are under-represented in *Nephrology Dialysis Transplantation*. There are members of EDTA–ERA, whose opinions I respect, who would like to keep it this way. They are glad that one of the ideas of the founder members survives, albeit in attenuated form—the focused subject matter.

I do not now share that view. Sensible parents want their children to develop as individuals and are proudest

when they succeed in enterprises which their parents did not plan for them. I take great pride in EDTA–ERA because it has shown itself to be a living organism capable of growing, adapting and (if EDTNA–ERCA will pardon the term) reproducing. It should be firmly committed to continuing change. The nephrologists of tomorrow will have to come to terms with an explosion of biological knowledge which affects every aspect of their specialty. I hope that this society will seize the high ground of nephrology in Europe and will help its members to use the riches that basic scientists are providing. If we do not, someone else will.

Envoi

I have traced the development of EDTA as it has taken each of the ideas of its founder members, discarded them, and replaced them with better ones. I hope, and am confident, that it will continue to do so. There is only one legacy we left you that I hope you will preserve intact. A *friendly society* in the proper sense of the words: one in which care for our patients and comradeship with our colleagues from all over Europe dominate personal ambition and unite us in the search for truth that becomes more exciting as the days pass.