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Nephrology
Dialysis
Transplantation

Letters

[The views expressed in Letters do not necessarily present the views of the Editor.]

Abuse of live related kidney transplantation

Sir,
At the recent EDTA meeting in Amsterdam I welcomed the opportunity to attend the symposium on the ethics of live related kidney transplantation. Unfortunately I left disquieted by my understanding that at least some of the speakers felt that this was acceptable practice simply because their results were good. Although the success of their programmes in pure medical terms is undeniable, many of the more far-reaching consequences of acceptance of this practice could not be adequately discussed because of constraints of time.

More disturbingly when both myself and another participant from Iran pointed out that there is unfortunately widespread abuse of live related renal transplantation in countries outside of Europe and that this abuse stems in part from the original aceptance that live related transplantation is ethically acceptable, the consensus opinion of the panel appeared to be that as Europeans they were in no part responsible for this, any responsibility for less ethical approaches to the procedure lying solely where they are practiced.

The abuse to which we were referring was related to the sale of kidneys for transplantation. The Iranian delegate described situations where organ recipients were threatened with physical violence by the donor years after the transplantation unless they paid more money. I described the situation in Turkey some of which has been reported previously in this journal [1]. Essentially, patients from Turkey have received live related tranplant kidneys in India and probably Russia in return for payment. These patients have returned home after surgery following inadequate hospitalization, or with absent documentation (including no details of donor tissue type), and with many unacceptable complications, including several cases of malaria.

There was not time at the meeting to discuss other problems such as the touting for business carried on by Russian doctors in Istanbul; just how voluntary donation can be between members of highly nuclear families in cultures where the family is the hub around which life evolves; or the part that being a woman may play in cultures where to be a woman is to be a second-class citizen.

Although these problems are not seen in the West, surely it is not enough for us to behave as if they do not exist or to claim that we are not responsible for the lack of clear ethical codes of practice in those countries where by Western standards malpractice occurs. Any discussion of the pros and cons of live related renal transplantation has to take account of possible abuse wherever it may occur. To take just one example, given the fact that donation for cash is, at least in poorer parts of the world, an invariable consequence of the practice of live related kidney transplantation, surely this has to be put into the equation when we seek to evaluate the practice of live related transplantation. In the world we live in (not just Europe) you cannot have live related transplantation without some sale of organs occurring, and no amount of decrying the sale of organs will change this truth.

It may be that despite these problems the consensus opinion will be that live related transplantation still in overall terms does more good than harm and is therefore morally acceptable. It may even be that some ethicists may conclude that transplantation as carried out in other countries is not ethically incorrect when seen in the context of those societies. When, however, we evaluate the results of live related transplantation and discuss its morality surely we are obliged to look at its impact not just in Europe but farther afield. The EDTA is a highy influential voice in nephrology and a selective isolationism in our approach to codes of practice in transplantation in my opinion at least does us little credit and throws away an invaluable opportunity to help influence others to act in a manner more in keeping with the universal image of the physician, which all of us (at least in theory) subscribe to.

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1. Sever MS, Ecder T, Aydýn AE *et al.* Living unrelated (paid) kidney transplantations in Third-world countries: high risk of complications beside the ethical problems. *Nephrol Dial Transplant* 1994; 9: 348–349

Renal transplantation from paid, unrelated donors in India—it is not only unethical, it is also medically unsafe

Sir,
Over a 4-year period, we followed up 14 patients who had received renal transplants from living, unrelated donors. The information concerning the transplantation procedure was obtained directly from the transplant recipients, because the medical documents regarding the recipients and donors on file at the Indian transplant centres were inadequate. There was no data regarding HLA type, MLC, and cross-matching. Upon arrival in our transplant unit, comprehensive records were maintained and the patients received immunosuppressive therapy consisting of cyclosporin A, methylprednisolone, and azathioprine. Patients with surgical or medical complications were hospitalized and rejection episodes were treated with methylprednisolone pulse therapy and/or antithymocyte globulin.

The average age of the 14 patients (12 males, 2 females) was 33.6 years (range 10–58 years). Data was available for four donors who were male and were between the ages of 22 and 29 years. Post-transplant hospitalization in India was an average of 10 days (range 6–16 days). The mean follow-up period in our unit was 22.8 months (range 1–39 months). The graft survival rage was 78.6% at the end of the first year and 64.3% after the second. The following complications were observed: ureteral leakage with infection, massive perirenal haematoma, perirenal abscess (2 cases), graft infection with Pseudomonas (3 cases), and pulmonary infection with sepsis leading to a fatal outcome (2 cases). Four patients had repeated acute rejection episodes during the first year