

Donation by living donors is effective for recipient and safe for donor

EDITOR.—Celia Wight and Bernard Cohen use a recent report by the British Transplantation Society as the basis for a discussion about the shortage of organ donors for transplantation.¹ They are not alone in suggesting that this is the main obstacle facing transplantation today.² Their editorial focuses on cadaveric organs used for transplantation. Surprisingly, they do not mention the use of kidneys donated by living relatives. This form of renal donation has been popular in the United States for a number of years but is less common in Europe.²

In patients with diabetes mellitus, kidney grafts from a living related donor have a better graft survival rate than cadaveric grafts.³ Good evidence shows that there is little risk to the kidney donor, and a 20 year follow up of living kidney donors from Minneapolis concluded that perioperative mortality in North America was low, while no evidence of progressive renal deterioration or other serious disorders was found in the donors.⁴ More recently, high graft survival rates have been reported for kidneys transplanted from spouses and living unrelated donors.⁵

Taken together, these data strongly support the belief that transplantation of a kidney from a living donor is both an effective treatment for the recipient and safe for the donor. More frequent use of kidneys from living (related or unrelated) donors in Britain and throughout Europe might relieve some of the shortages of organs for transplantation.

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- 2 Soullilou JP. Kidney transplantation from spousal donors. *N Engl J Med* 1995;333:379-80.
- 3 Basadonna G, Matas AJ, Najarian JS. Kidney transplantation in diabetic patients: the University of Minnesota experience. *Kidney Int* 1992;42(suppl 38):S193-6.
- 4 Najarian JS, Chavers BM, McHugh LE, Matas AJ. 20 years or more of follow-up living kidney donors. *Lancet* 1992;340:807-10.
- 5 Terasaki TI, Cecka JM, Gjertson DW, Takemoto S. High survival rate of kidney transplants from spousal and living unrelated donors. *N Engl J Med* 1995;333:333-6.

Transplant coordinators need more money for education

EDITOR.—Celia Wight and Bernard Cohen point out that the fall in the numbers of organ donors due to declining death rates from intracranial haemorrhage and road traffic accidents should be welcomed.¹ We would suggest that herein lies the most important limitation on the current transplantation programme. However, organ donation, as well as providing the obvious benefit to potential transplant recipients, can offer a bereaved family considerable comfort. It is the family's bravery and generosity at a time of tragedy that allow this practice to continue. This factor should not be lost in the continuing debate surrounding the perceived shortage of donor organs.

Failure to provide adequate physiological support to potential organ donors accounts for the loss of at least a quarter of donor organs.² Further education in the management of donors could reduce this figure, so that better use could be made of this scarce resource. We recognise that there are geographical inadequacies in the service of transplant coordinators, but the report of the British Transplantation Society Working Party found that only a quarter of coordinators have a budget for educational purposes and many rely on money from pharmaceutical firms.³ We agree with the report's recommendation that the existing service should be expanded so that all coordinators have the resources with which to carry out this vital function, and we believe that this should be done

before investment is made in the commercial ventures suggested by Wight and Cohen.

While we understand our transplant colleagues' desire to find new ways to increase the pool of donors, we urge them to proceed with care in their bid to change the law regarding interventional ventilation. The report of the British Transplantation Society suggests that only 19% of 141 units where interventional ventilation was discussed would support this practice.³ Transplant coordinators have worked for many years to build and secure trust among medical and nursing staff in intensive care units. This trust is based on the knowledge that the life of one person is not more important than the life and process of death of another. Anything that might jeopardise this relationship would be detrimental to current donor referral rates.

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Half of physicians are unaware of surveillance system for Creutzfeldt-Jakob disease

EDITOR.—Surveillance of disease is crucial in the development of control strategies, and particularly so for infectious diseases. Will *et al* recently hypothesised that a newly described variant of Creutzfeldt-Jakob disease is causally linked to bovine spongiform encephalopathy.¹

The epidemiological value of a surveillance system is associated with its capacity to detect a high proportion of cases of the disease under surveillance. We carried out a survey of 50 physicians in Leeds to evaluate their awareness of the national surveillance system for Creutzfeldt-Jakob disease; 38 responded. Table 1 shows the results, which, not surprisingly, reflect clinical exposure to the disease in its more typical manifestations. Patients with the new variant of the disease described by Will *et al* may not initially present with obvious neurological symptoms; the first referral may be to a psychiatrist, a group apparently less aware of the surveillance system. Clearly, the new variant of Creutzfeldt-Jakob disease will need to be considered in a range of differential diagnoses.

To ensure the maximum epidemiological benefit from the national surveillance system we suggest that the existence of the Creutzfeldt-Jakob Disease Surveillance Unit in Edinburgh is made known more widely; also useful would be

working case definitions for provisional, possible, and confirmed cases.

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- 1 Will RG, Ironside JW, Zeidler M, Estibeiro K. A new variant of Creutzfeldt-Jakob disease in the UK. *Lancet* 1996;347:921-5.

Diagnosing testicular torsion

Isotope scanning is useful

EDITOR.—We agree with Mark Davenport that acute testicular torsion is difficult to diagnose clinically.¹ His article suggests that the diagnosis may be aided by Doppler ultrasonography, but this investigation can be unreliable² and may lead to a false sense of security. Often surgery is required to exclude torsion, with no therapeutic benefit. This is undesirable if the diagnosis can be made without surgery, as any operation has potential complications and cost implications.

We are surprised that Davenport does not mention nuclear medicine in his review. Testicular isotope scanning has been used since 1973³ and is effective in assessing the acute scrotum. Melloul *et al* reported a series of 87 patients in whom isotope scanning was used to aid diagnosis.⁴ Scanning with technetium-99m as pertechnetate produced a 100% specificity and 98% sensitivity for testicular torsion, which is comparable to previous published results. In a retrospective audit of 36 patients in North Staffordshire who underwent ^{99m}Tc scintigraphy we found a specificity of 90% and a sensitivity of 100%.

It has been suggested that isotope scanning introduces unjustifiable delay and expense.⁵ We have found, however, that, with appropriate arrangements, this investigation does not increase morbidity but can considerably reduce unnecessary surgery. The test is one of the cheapest and simplest of all nuclear medicine imaging procedures. It involves an acceptable dose of radiation (2 mSv), and the gamma camera is used for only a short time.

We therefore believe that isotope scanning should have a more central role in the assessment of the acute scrotum. Because successful testicular salvage relies on the time between the onset of symptoms and surgery,¹ however, this depends on departments of nuclear medicine providing an immediate access service both during and outside normal working hours.

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- 2 Haynes BE. Doppler ultrasound failure in testicular torsion. *Ann Emerg Med* 1984;13:1103.

Table 1—Results of survey among various physicians to evaluate awareness of national surveillance system for Creutzfeldt-Jakob disease

Specialty	Aware of system		Not aware of system	
	No of physicians	Cases seen in past 5 years*	No of physicians	Cases seen in past 5 years*
Neurology	4	2, 3, 2	0	—
Psychiatry	3	—	7	1
Geriatrics	5	1	2	—
Other medical specialists	8	—	9	—

*Numbers of cases seen by individual physicians who had seen any cases.