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We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Cyclosporin A and the media

SIR,—Following our paper on the use of cyclosporin A (CyA) in patients receiving kidney, liver, and pancreas allografts from cadaver donors,¹ reports have appeared in the press and other media suggesting that CyA causes cancer, with the implication that the drug should not be used. This has caused great distress to our patients who are under treatment with the agent and we feel that the facts should be restated.

To date 43 recipients of organ allografts have been treated with CyA initially as the sole immunosuppressive agent. This followed more than three years' experimental work on the drug in a large number of species, the data testifying to the extreme efficacy, few side effects, and no record of tumour development. Initially we treated some of the patients with additional agents—namely, steroids and cytotoxic drugs. The incidence of infection in these patients was high and two patients died of sepsis and were found at necropsy to have B-cell lymphomas, but the lymphomas had not caused death. A third patient treated only with CyA developed a gastroduodenal lymphoma, which was resected and had not metastasised to adjacent lymph nodes. This patient is now well, though it is only a short time since the operation.

What has been studiously ignored by the reports in the media, despite careful explanation, has been the fact that a high incidence of lymphomas has been reported with the use of

all immunosuppressive agents. The risk was particularly high in heart graft recipients suffering from cardiomyopathy treated with high doses of azathioprine, steroids, and antithymocyte globulin² (including the cases mentioned in the addendum there was an 18% incidence of lymphoma). There are a number of publications on this subject, the most recent being in a recent *BMJ*.³

The developing risk of a lymphoma is an inevitable consequence of powerful immunosuppression. The aetiology is not yet established, but could be the proliferation of an oncogenic virus, since the lesions have some similarities to Burkitt's lymphoma. When more is known of the pharmacodynamics of CyA it might be possible to adjust the dose so that sufficient immunosuppression is achieved without there being a high incidence of lymphoma.

Patients receiving organ allografts are of necessity suffering from lethal diseases. Organ transplantation has provided excellent therapy for many patients. Nevertheless, with standard immunosuppressive treatment the incidence of rejection and infection is sufficiently high for there to be a pressing need for the development of better control of rejection (on the basis of the UK transplant figures, 48% of patients receiving cadaver grafts will be alive with functioning transplants at a year and 27% will have died from a variety of causes).

Patients on dialysis, apart from being

subjected to important restrictions in their life, not the least of which is physical and psychological dependence on a machine, also have an incidence of fatal complications. The one-year survival for dialysis patients who have never been transplanted is 91% according to the UK figures.

CyA is an entirely new immunosuppressive compound which can permit organ transplantation in some cases without the use of steroids. Its efficacy has enabled us to treat patients who would not otherwise have received treatment—namely, diabetics with microangiopathy and renal failure and young children with renal failure, who respond poorly to steroids.

It is our wish to emphasise these points so that an unbalanced reaction on the part of the media will not lead to pressure to discontinue this drug, which is currently undergoing a careful pilot study.

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¹ Calne RY, Rolles K, White DJG, Thiru S, Evans DB, McMaster P. *Lancet* 1979;2:1033-6.

² Anderson JL, Fowles RE, Bieber CP, Stinson EB. *Lancet* 1978;2:1174-7.

³ Kinlen LJ, Sheil AGR, Peto J, Doll R. *Br Med J* 1979;2:1461-6.