- All letters must be typed with double spacing and signed by all authors.
- No letter should be more than 400 words.
- For letters on scientific subjects we normally reserve our correspondence columns for those relating to issues discussed recently (within six weeks) in the *BMJ*.
- We do not routinely acknowledge letters. Please send a stamped addressed envelope if you would like an acknowledgment.
- Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.

Organ donation

SIR,—The recent articles by Mr N J Odom are to be applauded.¹ If they were standard reading the yield and quality of organs for transplantation would be improved. We must, however, comment on points made in the second article, "Logistical disincentives to organ donation."

Mr Odom states that in Northern Ireland the rate of heart and liver donation has been extremely low. He also suggests that "required request" might improve the number of organs for donation. We wish to consider these points in turn.

In 1988 Northern Ireland had the second best rate of donation for kidneys in the United Kingdom (23.1 per million population a year), just behind South East Thames region (24.7). This was a fairly typical year. In providing kidneys for donation we do somewhat better than most other regions in the United Kingdom.

With regard to the relative frequency of heart and liver donation we can speak only for our own unit, which normally provides roughly 70% of the kidneys harvested in Northern Ireland. Before 1987 there was no protocol for offering organs other than kidneys for donation. Since then this has been corrected. In the two years up to the spring of 1989, 33 of the 42 patients with a diagnosis of brain stem death became organ donors.² Medical contraindications (two), family's refusal to give consent (five), and failure to request donation (two) account for the nine other patients. This compares favourably with the performance of an intensive care unit in a specialist transplant centre.³ When organs were not requested (two cases) it had been judged that the relatives would not give consent for organ retrieval and that a request for donation would further alienate the family.

Twenty two of the patients donated only kidneys. The other 11 were suitable for multiple organ donation, and from them eight hearts and 11 livers as well as 22 kidneys were offered for donation. If repeated nationally this would be equivalent to 250 livers and 200 hearts available for transplantation each year. Only 10 of these 19 organs were actually harvested. The reasons for not harvesting them were lack of beds in the intensive care unit or staff at the transplant centre, lack of supplies of blood, lack of availability of a transplant surgeon or retrieval team, and lack of a suitable recipient. Many of these points were mentioned in a previous letter from our unit.⁴

Bodenham *et al* found that lack of permission by the coroner was a common cause of failure to retrieve organs.⁵ In our series the coroner did not withhold permission in any case.

We think that these data make two points. Firstly, Mr Odom's comments regarding liver and heart donation in Northern Ireland are no longer applicable. Secondly, although required request

may improve the yield of organs in units that deal with potential donors infrequently, it will have no benefit in units such as our own where every effort in this regard is already being made.

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- 1 Odom NJ. Organ donation. *Br Med J* 1990;300:1571-5. (16 June.)
- 2 Lavery GG, Coppel DL, Johnston JR, Lowry KG. An audit of organ retrieval—could we do better? *Journal of the Irish College of Physicians and Surgeons* (in press).
- 3 Bodenham A, Berridge JC, Park GR. Brain stem death and organ donation. *Br Med J* 1989;299:1009-10.
- 4 Lowry KG, Lavery GG. Brain stem death and organ donation. *Br Med J* 1989;299:1218.

Surgery for glue ear

SIR,—It is pleasing to see further British studies of methods of treatment for glue ear,¹ but I was concerned by the conclusions drawn from such doubtful material. Dr N A Black and colleagues state that children were admitted for surgery for bilateral glue ear, a necessary requirement when one is randomising treatments between two ears in the same patient—for example, unilateral myringotomy and grommet insertion against no treatment. But 44% of patients in this group had dry ears when myringotomy was performed. Does one presume that grommets were inserted into normal middle ear clefts in these cases and likewise through the four treatment groups, in which it seems that only between 56% and 76% were found to have glue or serous fluid in the middle ear. If so I would not concur with the authors' belief that this clinical management is fairly typical of otolaryngological practice in England and Wales in the 1980s.

Though it is accepted that this study does not address the many children aged less than 4 who have chronic glue ear, in whom audiometry is unreliable, and very young children, in whom it is impossible, the authors' choice of audiometry as a principal end point is unsatisfactory. Most studies would require impedance measurements and tympanometry together with otoscopic examination by a validated observer and a hearing assessment to provide more accurate end points for evaluating treatment. This being the case, and considering also that children with gross nasal obstruction requiring adenoid removal were excluded from the study, adenoidectomy may have been shown to have had a more important effect than Dr Black and colleagues found.

Of course the object of surgery for glue ear is to restore hearing. Nevertheless, if restoration by a

grommet is effective for only six to 12 months and if within two years 45% of the patients treated by only a grommet require revision surgery compared with 19% of cases treated by adenoidectomy follow up for more than two years may confirm that adenoidectomy is far from irrelevant. The need for readmission to hospital (even on a day basis) to reinsert a grommet under general anaesthesia in more than twice the number of cases within two years than for adenoidectomy may constitute a cost ineffective practice with appreciable overall morbidity. Our own studies in which truly bilateral cases of glue ear were analysed in a similar way show very similar readmission rates for both treatments.^{2,3} Further study of children selected for adenoidectomy on the basis of age and size of the postnasal airway rather than on a random basis showed that improvement in clearance of middle ear effusion one year postoperatively increased from 40% in the random group to 70% in the selected group.⁴

I share the concern of Dr Black and colleagues about the indications for surgery for glue ear and the number of these procedures carried out in this and in other countries, but I do not believe that the design of their study, in which a quarter to half of the ears treated did not have glue at the time of operation, allows them to make the somewhat sweeping statements in their discussion, particularly in relation to adenoidectomy for bilateral glue ear in children.

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- 1 Black NA, Sanderson CFB, Freeland AP, Vessey MP. A randomised controlled trial of surgery for glue ear. *Br Med J* 1990;300:1551-6. (16 June.)
- 2 Maw AR. Chronic otitis media with effusion (glue ear) and adenoidectomy: a prospective randomised controlled study. *Br Med J* 1983;287:1586-8.
- 3 Maw AR, Herod F. Otoscopic, impedance and audiometric findings in glue ear treated by adenoidectomy and tonsillectomy: a prospective randomised study. *Lancet* 1986;i:1399-402.
- 4 Maw AR. Adenoidectomy and adeno-tonsillectomy for otitis media with effusion (glue ear) in children: a prospective randomised controlled study. London: University of London, 1986:105. (MS thesis.)

SIR,—“There are lies, damned lies and statistics.” Whereas I agree with Dr N A Black and colleagues that the numbers in their trial are adequate for statistical analysis as defined in the paper,¹ it must be stated that the numbers in each group are too small to allow important conclusions to be reached.

Several points have not been adequately addressed. Firstly, the paper is entitled “Surgery for glue ear” but the study includes children with thick and thin fluid and even air in their middle ears. It seems to have been assumed that the fluid in both ears will have the same consistency, but this is often not the case. Indeed, a wide range of