More paediatric renal donors should be used for adult recipients

EDITOR,—Appropriately, the shortage of organs for renal transplantation commands increasing space in journals.¹ One aspect, however, does not seem to have been adequately covered and offers the potential of increasing the number of donors for renal transplantation.

Paediatric donors are used for children unless they are very small, in which case they are often rejected, particularly in Britain. The United Kingdom Transplant Support Service Authority reports that up to April this year 480 donors were offered for kidney donation but only 306 were used; this indicates underuse in 174 cases (P Pocock, personal communication). This figure is probably below the true potential number of donors because the United Network for Organ Sharing in the United States reports that about 7% of the total cadaver donors recovered every year are children under 5.² Roughly one third of these are below the age of 1. In addition, potential paediatric donors are probably not offered in Britain because of their perceived lack of suitability.

The main reason for this underuse is the increase in technical complications resulting in vascular thrombosis and ureteric necrosis. In addition, it has generally been held that paediatric kidneys will be damaged by adult blood pressure.³ There is now increasing evidence that small kidneys from donors down to the age of 6 weeks can be successfully transplanted into adult recipients, provided they are grafted as a block with the aorta and vena cava.⁴ The kidneys subsequently grow normally and tolerate adult blood pressure. Most of this experience comes from the United States, Germany, and Spain, and only six recipients have received these grafts in Britain. This includes two patients from our centre, who now have creatinine concentrations of 120 and 85 $\mu\text{mol/l}$.

Use of these donors should be promoted to bring Britain into line with the United States. However, because of the specific problems, which seem to be most acute at the start of such programmes, such use should be restricted to a few centres. This would allow the most efficacious techniques and immunosuppressive regimens to be arrived at.

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Methods used in economic evaluations of prenatal screening are disputed

EDITOR,—Nicholas Wald and Hilary Watt's letter¹ about our paper on marginal analysis² contains some important misconceptions

regarding economic evaluation of prenatal screening services.

Firstly, we agree with the authors that they did not properly evaluate the economic consequences of changing from screening based on maternal age to biochemical screening in their earlier work³: this is precisely the point that we were making in our paper. If a new screening test might potentially replace an existing test then any extra costs and consequences of the new test should be measured to see if it is worth while, and this is the role of marginal analysis. If the authors set out with the intention of not evaluating the costs and benefits of changing from screening based on maternal age to biochemical screening what was the point of the evaluation?

Secondly, it is incorrect to claim that both tests should have the same detection rate for their cost effectiveness to be compared. In evaluations of screening for Down's syndrome different screening programmes have different detection and false positive rates, and there is no need to set an arbitrary detection rate for both programmes to make the comparison. Competing programmes can be compared over a wide range of false positive and detection rates. Indeed, this is precisely what the authors do in their figure (although they seem to use average rather than marginal costs). This applies to most forms of screening—for example, Cuckle *et al* recently compared two methods of screening for cystic fibrosis that had different detection rates and costs.⁴

Thirdly, the authors also argue that holding the detection rate at 60% for screening based on maternal age is unacceptable as this requires 30% of all pregnant women to have an amniocentesis. If this option is widely seen as unacceptable then it is an inappropriate comparison for an economic evaluation (analogous to evaluating the option of no treatment for bacterial meningitis). The appropriate comparison is outlined in our paper comparing screening based on maternal age for all women above a given age with biochemical screening.

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Rights and responsibilities in HIV prevention

Article was misleading

EDITOR,—Renée Danziger refers to an "uncanny consensus" regarding the need to protect individual human rights in responding to the AIDS epidemic.¹ She seems not to have considered that the consensus might not be uncanny but might merely be correct. In any case, although her article argues against freedom and in favour of coercion, she never specifies what form this coercion should take. If Brazilian men cannot be educated to have safe sex because of the "dominant, masculine sexual culture" what form of coercion might be applied? Is Danziger suggesting an Orwellian television camera in each bedroom?

The few allusions that Danziger makes to coercive measures are hardly reassuring. Russia has a long history of persecuting homosexuals, and its policy of compulsorily testing visitors for HIV infection has been widely criticised, as has the United States' policy of refusing entry to visitors known to be HIV positive. Cuba's policy of forcibly separating HIV positive people from their partners and locking them up is so inhumane that Danziger should be ashamed of her support for it, though she takes care to hedge her bets: the policy "seems justified" (is it or isn't it?) since "Cuba's epidemic seems to be relatively small scale." If she has any objective reliable evidence that this brutal Cuban policy has reduced the incidence of AIDS in the country then I should like to see it.

Finally, the comments of Michelangelo Signorile that she quotes are clearly intended to provide an argument in favour of individual responsibility rather than coercion. I believe that he would object to seeing his remarks in an article that, while encouraging "shifting the terms of the debate," in fact advocates restricting the basic rights of people with AIDS and those in high risk groups.

Danziger's article contains virtually no facts or concrete proposals; much of it is innuendo, which at times becomes misleading—such as the vague implication that AIDS can now be treated. As a gay physician who has lost his partner and several close friends to AIDS I find its publication in the *BMJ* deeply offensive.

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- 1 Danziger R. An epidemic like any other? Rights and responsibilities in HIV prevention. *BMJ* 1996;312:1083-4. (27 April.)

AIDS might have been tackled differently if it had presented as a disease of women

EDITOR,—To understand why AIDS has been treated differently from previous epidemics and venereal diseases in terms of legislation, it is worth considering that AIDS originally presented as a disease of men spread by men. It was soon recognised that HIV can also be spread by the intravenous route, including through needle sharing by drug misusers. Later, heterosexual transmission was reported. Nevertheless, today most cases in the Western world still occur in men.

The purpose of the various legislative measures concerning venereal disease that were introduced in many countries during the 19th century, such as the inspection of prostitutes for disease, was to protect the male customers. Men might use brothels or street walkers, but to pass a sexually transmitted disease to your wife was to give the game away—and was likely to make you a social outcast.

The Norwegian artist and writer Christian Krohg (1852-1925) illustrated the degrading practice of inspection in a painting, "Albertine to see the Police Surgeon" (1885-7). It caused a scandal but is now exhibited in the National Gallery in Oslo (fig 1). Krohg originally trained as a lawyer. He was a social critic—Norway's answer to H C Andersen but working in a different medium. Indeed, the painting illustrates a detail from his own biting critical novel *Albertine*, which had been confiscated and for which he had been fined a substantial sum.

Albertine was a young girl who had entered prostitution for "socioeconomic" reasons. The painting shows her shyly waiting her turn, surrounded by experienced (that is, hardened)

"Albertine to see the Police Surgeon," by Christian Krohg

prostitutes watched over by a police officer. Two magnificent "ladies of the night" dominate the painting.

Would AIDS have been tackled differently had it presented as a disease of women spread by women?

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HIV negative people should be responsible for protecting themselves

EDITOR,—Renée Danziger reports on moves to change the emphasis of policy on HIV prevention on the grounds, apparently, that AIDS has become "normalised," but the evidence that she presents to justify this assertion is unconvincing.¹ She points out that in the West the epidemic has not spread as rapidly as predicted; she is right, but how can this be said to show normalisation? If anything, it tends to prove the effectiveness of those elective preventive measures that she seeks to challenge.

Danziger argues that, because of the development of new treatments, the benefits of knowing whether one is HIV positive outweigh the possible harm. Unfortunately, the position is still not that clear cut. People with HIV infection have a longer life expectancy now than in the early years of the epidemic, but this is due as much to successful management of opportunistic infections as to treatment of the HIV infection. Combination treatment looks hopeful, but then so did early intervention with zidovudine once upon a time. The decision whether to have an HIV test still demands a careful weighing of pros and cons.

Danziger's version of normalisation may reflect the viewpoint of epidemiologists or clinicians, but what of the perception of people with HIV infection, of groups at risk, or of the general public? I am due to attend a funeral in a remote corner of England, where the family and friends of the person who has died will pretend

that death was not due to an HIV related condition. Has AIDS really been normalised?

Apparently the obvious needs to be restated: policies for prevention should take into account both the peculiarities of the medical condition in question and the social and cultural make up of the target population. What works with gay men in London may or may not work with working class women in Brazil.

There are, of course, some worrying examples of irresponsible behaviour,² but most people with HIV infection do not need lessons in behaviour from the rest of us. The lengths to which my HIV positive friends have gone to protect their sexual partners have always moved me. As a gay man who is HIV negative, however, I believe that the responsibility for protecting my body lies not with them or with Michelangelo Signorile¹ but with me.

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Maternal mortality in India

Maternal mortality is falling in India but at slower rate than in Britain

EDITOR,—James Owen Drife's patronising article on India's maternal mortality, despite its feeble justification, angered me.¹ Articles in this genre—clever Western doctor on holiday in India shows how bad the local doctors are—usually are ill researched, perpetuate ignorance, and expose the author's naivety and supercilious attitude.

Drife says that Indian doctors attending a conference in Delhi, where a session on in vitro fertilisation was the main attraction, were blasé about their country's maternal mortality. The Europeans attending the conference were upset

about it, though "these were not our patients but how could we ignore them?" The speaker who talked about his job training primary care workers—the right answer to the problem—was formerly a consultant in England. The only people who left the hall when this doctor spoke were female Indian doctors wearing expensive dresses.

Drife forgets that doctors who attend expensive conferences in Delhi often work in tertiary care. They usually pay to listen to topics of interest to them, and why not? A large number of doctors working in primary care are not former consultants from Britain. They are unlikely to attend conferences of this type. Perhaps Drife expects doctors to wear clothes that reflect their country's maternal mortality.

By referring to the death during childbirth of the queen in whose memory the Taj was built, Drife creates the impression that maternal health care has not changed in India since then. He adds that maternal mortalities in Britain and India were the same in 1935 but that the rate subsequently fell in Britain because people got angry about it. India's maternal mortality has also fallen since 1935 but more slowly. This difference in the rate of fall is unsurprising given Britain's relative prosperity. A rich country is likely to improve the health of its mothers faster than a poor country. Drife should realise that you need more than anger to solve socioeconomic problems such as illiteracy. This "more" usually means money; without it, anger is a frustrating emotion. Drife mentions a recent study of 140 moribund women, of whom 97 arrived at hospital by bus, 12 by ambulance, and some by bullock cart. Does he wonder what these figures might have been in 1935?

Drife is welcome to write about India's health and compare it with Britain's without forgetting India's comparatively minuscule resources. But, hopefully, he will stick to British tourists, the Taj, and Princess Di's bench.

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Preventable ill health occurs in Britain too

EDITOR,—James Owen Drife rightly bemoans the lack of action on preventable disease in India.¹ The images—of a lack of anger, of affluent doctors walking away, of greater interest in in vitro fertilisation—are compelling. "Any nation without the will to get angry is a pitiful place," he says. Just so.

There is an uncanny echo in the same issue when Graham Watt talks about preventable ill health on our doorstep in Britain.² The difference is only of dimension. How many who read Drife's article will read Watt's too and discern similar detachment, this time among affluent doctors in Britain. Why is this? With finite money, is there a fear that if more was spent on social issues or prevention then less would be available for technological techniques, such as in vitro fertilisation, that we too prefer? Is this another reason for looking at values in medicine itself—that others follow where we lead?

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