for vibrant public health leadership and debate,⁴ which are necessary if consumers are to have confidence in official communiqués. When these are absent the media will gladly fill the vacuum.

CHRISTOPHER SIMPSON
Consultant psychiatrist

Friarage Hospital,
Northallerton DL6 1JG

STEPHEN DEALLER
Consultant microbiologist

Burnley General Hospital,
Burnley BB10 2PQ

WILL PATTERSON
Consultant in communicable disease control

North Yorkshire Health Authority,
York YO3 4XF

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En bloc paediatric renal transplantation is not always appropriate

EDITOR,—D Talbot and colleagues suggest that using the en bloc technique to transplant kidneys from young donors would allow the transplantation of organs that are currently not used.¹ If all paediatric kidneys were transplanted en bloc the number of kidney transplant operations would be halved. Possibly more transplant operations would be successful if single paediatric kidneys were used because, despite the worse graft survival, twice as many operations could be performed. Comparable graft survival for single and en bloc paediatric kidney transplants from donors aged 5 years and under have been reported,² but not from donors aged 2 years and younger. Talbot and colleagues state that the kidneys from 36% of potential renal donors in the United Kingdom were not transplanted.¹ Few of these potential donors would have been aged 5 years and under, and therefore the potential of en bloc transplantation to increase the number of recipients of renal transplants is small.

En bloc renal transplantation has been performed in Australia. The Australia and New Zealand Dialysis and Transplantation Registry reports a donation rate of 10 per million population. Altogether 1984 kidneys were offered for transplantation between 1990 and 1994, of which 1895 were transplanted. Sixty six kidneys were from donors aged 5 years and under, and 22 of these were transplanted en bloc as described by Talbot and colleagues.¹ Only four kidneys from a donor aged 5 years and under were retrieved and not transplanted. The registry reports that, for kidneys transplanted from donors aged 5 years and under into adult recipients, the one year graft survival is over 85% for en bloc kidneys compared with 60% for single kidneys.

Clinically, the en bloc technique was first used to transplant the kidneys of an anencephalic baby into a child in 1969.³ En bloc transplantation of paediatric kidneys into adult recipients was first described by Meakins *et al* in 1972.⁴ The advantages of the en bloc technique, originally described by Carrel,⁵ are that the donor aorta and vena cava used in the vascular anastomoses are larger than the corresponding renal vessels, the anastomosis is technically easier, and the incidence of vascular thrombosis is reduced. The transplanted renal mass is doubled and capable of meeting the biochemical demands of an adult recipient. However, two ureters require reimplantation, and the incidence of ureteric complications might therefore be

expected to be higher. The age below which the kidneys from paediatric donors should always be transplanted with the en bloc technique remains controversial, but 2 years remains a conservative estimate.

I thank the Australia and New Zealand Dialysis and Transplantation Registry for the data on en bloc kidney transplants and for its permission to publish them.

PETER HORTON
NH&MRC research fellow

National Pancreas Transplant Unit,
University of Sydney,
Westmead Hospital,
Westmead, NSW 2145,
Australia

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Giving vitamin K at birth

Approach to giving vitamin K should be reconsidered

EDITOR,—Alvin Zipursky concludes that intramuscular administration of vitamin K at birth is not associated with an increased risk of childhood cancer.¹ The recommendation by the British Paediatric Association in 1992 that vitamin K should be given orally rather than intramuscularly was never successfully implemented,² with the result that most maternity units continued to offer an intramuscular injection. The unease about the possible risk that this conferred was resolved by decisions to request informed parental consent. The way in which consent is requested, however, is often unsatisfactory. Parents have to make a difficult choice between two unlikely but disastrous outcomes, and if consent is requested in the labour ward (sometimes between delivery of the baby and the placenta) uptake is often poor.

Now that injections of vitamin K are believed to be safe it seems important to review this policy. Two courses of action seem reasonable. If we are to ask parents to choose between oral and intramuscular vitamin K then the place to do this is in the antenatal clinic. The alternative is to discontinue the practice of parental consultation and reintroduce the routine use of intramuscular vitamin K.

NICK LESSOF
Lecturer in child health

Charing Cross and Westminster Medical School,
London W6 8RP

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Paediatricians should return to policies of parenteral prophylaxis

EDITOR,—Rüdiger von Kries and colleagues¹ and Pat Ansell and colleagues² provide further evidence against a relation between the administration of parenteral vitamin K in the neonatal period and cancer in later childhood, this relation having been reported by Golding *et al* in 1992.³ As the efficacy of oral prophylaxis has not

been definitely shown, intramuscular vitamin K seems to be the best treatment for preventing haemorrhagic disease of the newborn.

According to Barton *et al*, in 1993 almost three fifths of babies born in the United Kingdom received oral vitamin K without there being any consensus about dose or frequency of administration⁴; thus infants were exposed to an increased risk of haemorrhage.⁵ This shift towards a policy of oral prophylaxis can be observed worldwide.

Late onset bleeding is potentially life threatening but preventable and rare, and doubts concerning the safety and efficacy of oral vitamin K remain. Now that a risk of cancer associated with parenteral vitamin K has been ruled out, all paediatricians should return to policies of parenteral prophylaxis until this question has been definitely solved. Next time, before we change our practice we should be confident that the new treatment works as well as the old one.

JAVIER MIRANDA
Resident
IGNACIO GUEMES
Resident

Department of Paediatrics,
Division of Neonatology,
La Fe Children's Hospital,
46009 Valencia,
Spain

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Alternative theories about AIDS should not be dismissed out of hand

EDITOR,—Stuart W G Derbyshire's review of Peter Duesberg's book *Infectious AIDS: Have We Been Misled?* is tendentious.¹ He says that all Duesberg's supporters contend that Duesberg's ideas "were wilfully suppressed by AIDS investigators for reasons associated with ideology and personal gain." Branding all supporters in this manner misses the point that many thoughtful scientists agree with Duesberg on many points while disagreeing on others. I wrote the preface to this book because I support openness in science and because I agree that "integrity" or rigour in AIDS science is wanting, beginning with the tautological definition of AIDS given by the United States Centers for Disease Control (no HIV = no AIDS). I, and many other supporters of Duesberg, should be identified with specific issues instead of being swept into a general category. For examples of specific support one can consult the jacket of this book, where Nobel prize winner Kary Mullis is quoted as saying, "We have not been able to discover any good reasons for why most people ... believe that AIDS is a disease caused by a virus."

Neither is a conscious conspiracy among scientists necessary for this lack of integrity and shutting out of minority opinion to take place. The pressures brought on basic scientists to follow consensus thinking, especially in times of scarce research funds, are much discussed, and it is clear that integrity and openness in science are doomed when consensus take over.

Derbyshire insists that "overwhelming evidence" exists for HIV as the cause of AIDS and cites