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Organ donation from prison

156 Elizabeth Magee, Michael H Levy

Registering wishes about organ donation may decrease the number of donors

156 Mitchell Lawlor, Frank A Billson

Potential for organ donation in Victoria: an audit of hospital deaths

157 Deepak Bhonagiri, Patricia Wills

Suicide mortality data need revision

157 Diego De Leo

An unusual cause of severe metabolic acidosis

158 Mark A Boyd, Stephen Hedger

158 John V Peter, Natasha Rogers, Sandra L Peake

Performance indicators of a primary care skin cancer clinic network

159 Deborah A Askew, David Wilkinson, Gordon L Patrick

The psychosocial impact of prostate cancer on patients and their partners

159 James A Smith, Shaun M Filaault, Murray J Drummond, Robert J Knapman

160 Jeremy W Couper

Organ donation from prison

Elizabeth Magee and Michael H Levy

TO THE EDITOR: The National Health and Medical Research Council's *National statement on ethical conduct in research involving humans*¹ recognises that prisoners can participate in research, but categorises them as "persons in dependent or unequal relationships". They have limited capacity to provide informed consent.

Responding to the high levels of transmission of bloodborne viruses in Australian prisons,² the Australian Red Cross Blood Service excludes prisoners from donating blood and ex-prisoners are excluded for 12 months after they have been released from prison.³

The New South Wales *Human Tissue Act 1983* is silent on whether prisoners can donate organs.

We report here the case of a prisoner organ donor, highlighting the administrative, legal and operational hurdles that needed to be overcome.

A 53-year-old male prisoner was a suitable living kidney donor for his first cousin. He provided consent willingly and without coercion.

At initial assessment, the prisoner's classification required that he be escorted to hospital and that constant surveillance by prison officers be maintained — at a cost of \$1000 per day, for at least 7 days. These costs would have been borne by the family. Furthermore, as Australian prisoners are ineligible for Medicare under the Australian Constitution, the donor, as an uninsured patient, and his family would have been required to pay for all pre-, peri- and post-operative care.

The donation was deferred for 14 months while these two administrative hurdles were overcome to permit the donation to proceed:

1. The Commissioner for the Department of Corrective Services gave approval for the prisoner to be reclassified to the lowest security classification, thus removing the need for surveillance while in hospital; and

2. A rarely used provision within the *NSW Crimes (Administration of Sentences) Act 1999* was applied. Section 26(1) of the Act allows the Commissioner to issue a permit

allowing an inmate to be absent from a correctional centre: (a) on such conditions and for such period as may be specified in the permit, and (b) for such

purpose as the Commissioner considers appropriate.

This allowed the prisoner to be temporarily reinstated to receive Medicare entitlements.

The nephrectomy and transplantation were successfully performed. The donor returned to prison on the seventh postoperative day. The donor organ is functioning 4 months after the operation.

Prisoners have a right to participate in organ donor programs; however, their precarious position to provide informed consent needs to be protected.

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Registering wishes about organ donation may decrease the number of donors

Mitchell Lawlor and Frank A Billson

TO THE EDITOR: An important factor in the well documented shortfall of organs and eyes for transplantation is the apparent reluctance of people to agree to donate.¹ One nearly universal strategy in attempting to raise donation rates has been to encourage individuals to register their wishes about donation. Although evidence that this strategy increases donation rates is lacking, there is some evidence that more individuals make and communicate a decision with appropriate education.²

Most families consent to donation when the deceased had indicated this was their wish, and virtually none override a stated wish not to donate.³ When wishes are unknown, half of families consent and half refuse.³ Encouraging declaration of intention aims to increase the rate of consent for families who would otherwise not know the deceased individual's wishes. For this to be successful, most individuals newly recording their wishes must indicate a desire to

donate. This assumption has underpinned Australian education campaigns, including "Talk about it", "Share your life, share your decision", and most recently the national "Sign on to save a life" campaign.⁴

A simple review of New South Wales Roads and Traffic Authority organ donation data over the period of these campaigns suggests this assumption may not hold. From 1997 to 2004, a significant proportion of drivers licence holders newly indicated a preference about donation; the proportion indicating some decision rose from 59.4% to 78.6%. Over the same period, the proportion indicating *yes* to donation of all organs rose from 35.6% to 41.9% (a 17.7% increase); however, the proportion indicating *no* to any donation rose from 19.9% to 31.4% (a 57.8% increase).⁵

These results raise the possibility that encouraging individuals to make a decision about donation may increase the number of families who refuse donation. Individuals who had previously not made a decision about donation, when encouraged to do so, displayed an unwillingness to become organ donors at twice the rate of those who indicated willingness. Although it is imperative to recognise and respect the decision of individuals to refuse organ donation, this unwillingness may reflect either formalisation of a considered desire not to donate, or a decision made without personal discussion of fears and concerns about donation. Generalised education campaigns are limited in that they encourage action without addressing fears and concerns. Further policy should recognise a possible danger in simply exhorting the public to make a decision, and research should investigate why individuals are refusing to become organ and eye donors.

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1 Siminoff LA, Gordon N, Hewlett J, et al. Factors influencing families' consent for donation of solid organs for transplantation. *JAMA* 2001; 286: 71-77.

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Potential for organ donation in Victoria: an audit of hospital deaths

Deepak Bhonagiri and Patricia Wills

TO THE EDITOR: Opdam and Silvester concluded that the small pool of organ donors limits the potential for organ donation in Victoria.¹

According to the definition of death in the *Human Tissue Act 1983* (NSW):

a person has died when there has occurred: (a) irreversible cessation of all function of the person's brain, or (b) irreversible cessation of circulation of blood in the person's body.

Current cadaveric organ donation takes place predominantly after brain death, although it is also possible after cardiac death. This was previously described as "non-heart-beating organ donation", but the name was changed to "donation after cardiac death" (DCD) to emphasise that organ donation occurs only after death.

DCD can be classified by the Maastricht criteria (Box).² Category III is relevant in select patients undergoing planned withdrawal of therapy in intensive care units (ICUs). Planned withdrawal of therapy is said to occur in about 60% of all ICU deaths.³

Permission for organ donation is required before the planned withdrawal of life support, so the donor organ retrieval teams can be available and ready to retrieve organs soon after a 5-minute "cooling off" period after circulation ceases. These 5 minutes also allow families to spend time with the deceased after death. A period of less than 60 minutes between withdrawal of therapy and cessation of circulation is recommended to minimise warm ischaemia time in the retrieved organs. Withdrawal of life support may occur in the ICU or in the operating room complex, and local hospital guidelines should address the issue of where this occurs.

Between 1989 and 2004, 30 Australian organ donations involved non-heart-beating organ donors (data from the Australia New Zealand Organ Donor Registry). In 2005, eight New South Wales organ donations, accounting for 14% of all cadaveric renal transplantation, proceeded after cardiac death criteria were applied. In our unpublished retrospective audit, 7% of patients who had planned withdrawal of therapy in the ICU met the criteria for eligible organ donors after cardiac death. The organ donor

Maastricht donation after cardiac death protocol categories²

- I Dead on arrival (uncontrolled)
- II Failed resuscitation (uncontrolled)
- III Withdrawal of support (controlled)
- IV Arrest following brain death (uncontrolled) ◆

pool for organ donation after brain death was 1.7% in Opdam and Silvester's study.¹

The long-term function of transplanted kidneys is not significantly different for organs retrieved after cardiac death compared with organs retrieved after brain death.⁴ Liver and lung transplantation are also possible from organs retrieved from non-heart-beating organ donors.

Draft guidelines for DCD in NSW are soon to be released by NSW Health. Similar guidelines in other states and education of staff involved in organ donation would no doubt increase the organ donation pool and the potential for organ donation.

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Suicide mortality data need revision

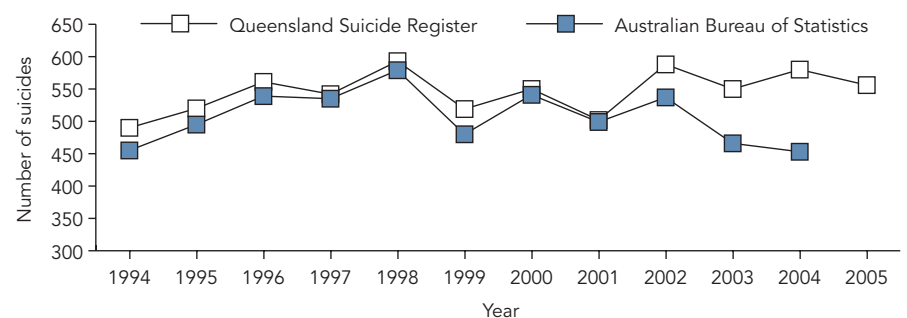
Diego De Leo

TO THE EDITOR: In 2004, there were 580 cases of suicide in Queensland, and not 453, as reported by the Australian Bureau of Statistics (ABS) on 14 March 2006.¹ These data alone reverse the declining trend for suicide mortality nationally in the most recent years. The Queensland Suicide Register, maintained by the Australian Institute for Suicide Research and Prevention (AISRAP), receives data directly from the Office of the State Coroner, and crosschecks them with other Queensland coroners, the John Tonge Centre (the Queensland Health Scientific Services mortuary), and the National Coroners Information System (NCIS). The ABS receives data from the state registries of births, deaths and marriages, and crosschecks them with the state coroners' offices. The agreement between the two agencies has been decreasing in recent years, with AISRAP detecting 550 suicide cases in 2003 and 588 in 2002, compared with 466 and 537, respectively, detected by the ABS (Box).

The ABS has acknowledged difficulties in getting reliable data for 2004 in a number of endnotes to its yearly report.¹ Most of the problems were related to a very large backlog of cases still under investigation by coroners, a phenomenon that is reported as increasing in recent years. A confirmation of problems in official data comes from the NCIS, whose most recent report has evidenced, from 2000 on, declining percentages of completeness in mortality data in Queensland and elsewhere in Australia, with the most incomplete figures in 2004.²

It is important to note that cases that are under investigation and those that end with

Number of suicides in Queensland according to the Australian Bureau of Statistics and the Queensland Suicide Register (QSR)



QSR data were provided by the Office of the State Coroner, the National Coroners Information System and the John Tonge Centre. "Possible" suicides are not included. Data for 2005 are an estimate. ◆

an open verdict would not enter official suicide mortality data, as these are never reconciled. Following the example of many European countries, it would be desirable to start a periodical publication (eg, every 3–5 years) to provide a more comprehensive picture of suicide mortality, including finalised investigations, reclassified (ex-accidental or ex-undetermined) causes of deaths, and deaths that occurred (especially in hospitals) with a delay from a self-injurious event. This would provide a more credible depiction of suicide mortality in the country, and permit better research.³

Meanwhile, efforts should be made to homogenise certification procedures (International classification of diseases, 10th revision terminology has yet to be extensively adopted) and streamline the bureaucratic procedures (we still suffer from a number of “lost in the system” data). In the registries of births, deaths and marriages, by law, the word “suicide” (or analogous term) does not appear. Frequently, the ABS, which collects data from the registries each month, has to reclassify the data obtained, and integrate the information received with further enquiries. Apart from being time-consuming, this routine does not provide foolproof results, and has potential for improvement.

Some underreporting in suicide statistics is virtually ubiquitous,^{3,4} and has to be tolerated (eg, misclassification as accident, road accident, or disease-related, particularly in the elderly; cover-up because of stigma, sociocultural norms, or insurance reasons; or remoteness of location). However, federal and state governments in Australia are committed to suicide prevention plans that require credible baselines for evaluating their effects. All relevant parties need to work jointly on improving data quality. This is of crucial importance for scientists and policymakers, and for those personally affected by a suicide death.

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An unusual cause of severe metabolic acidosis

Mark A Boyd and Stephen Hedger

TO THE EDITOR: We read with interest the “Diagnostic Dilemma” by Peter et al.¹ The case raises interesting management issues. The first is initiation of antibiotics. Despite 1 week of fever, rigors, haematuria and loin pain, we are informed that the patient was in no distress at initial assessment. In this situation there is, despite the anxieties of resident staff, no urgent need to administer antibiotics; hospitals are controlled, monitored environments in which observation, review and investigation can be undertaken, within reason, if a diagnosis is not immediately made. The second issue is antibiotic selection. The provisional diagnosis was a urinary tract infection, and ceftriaxone and gentamicin were administered. The justification for the use of two agents with a similar spectrum of antimicrobial activity is not given.² Likewise, no justification is given for the use of a potent nephrotoxin in the presence of moderately severe acute renal failure.

Flucloxacillin was added “to broaden the gram-positive antibiotic cover”. It is not apparent why staphylococcal cover was sought at this stage. All cultures (blood, urine and pleural fluid) remained negative. At Day 14, ceftriaxone and gentamicin were changed to ticarcillin/clavulanic acid and ciprofloxacin “because of persistent fever and rising [white cell count]”; this decision in the absence of positive cultures is not explained.

The patient’s renal function deteriorated further and he became profoundly acidotic. In fact, the patient’s renal function had performed heroically, given administration of gentamicin for 2 weeks in the presence of acute renal failure at admission. In the intensive care unit, flucloxacillin was replaced with vancomycin; the rationale is not explained.

This case illustrates important points regarding antibiotic use. Despite significant renal impairment at admission, the patient was administered a 2-week course of a nephrotoxic antibiotic, which contributed to renal collapse. This situation would have been terminal if not for supportive intensive care.

The treating team appears to have managed the patient as if sepsis were a given, and yet all cultures remained negative. This illustrates a basic but crucial teaching point — fevers, chills, rigors, raised inflammatory markers and neutrophilia do not necessarily equate with sepsis. If this experience reflects routine practice elsewhere (and it is our experience that it does), is it any wonder that we have reached an era in which we now encounter organisms so resistant that they are essentially untreatable?³

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1 Peter JV, Rogers N, Murty S, et al. An unusual cause of severe metabolic acidosis. *Med J Aust* 2006; 185: 223–225.

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John V Peter, Natasha Rogers and
Sandra L Peake

IN REPLY: Boyd and Hedger have raised concerns regarding the initiation and choice of antibiotics in our recent case report.¹ Several aspects of this correspondence need to be addressed. The primary focus of the article was to highlight an important and probably underrecognised cause of unexplained metabolic acidosis, and discussion regarding antibiotic choice was not within the scope of the article.

Further, the patient’s management before admission to the intensive care unit was by a different treating team. Subsequent case-note review did not reveal reasons for initiation or choice of antibiotics other than described in our article, although it was evident that gentamicin doses were adjusted based on drug levels. We agree that a less nephrotoxic agent could have been chosen and that the profligate use of antibiotics in the absence of strong evidence of infection could have been avoided.

The excessive use of antibiotics in the current medical milieu may stem from a physician’s lack of confidence, or even legal ramifications of “watching and waiting” in the setting of “fevers, chills, rigors, raised inflammatory markers and neutrophilia”, as encountered in our patient.

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1 Peter JV, Rogers N, Murty S, et al. An unusual cause of severe metabolic acidosis. *Med J Aust* 2006; 185: 223-225. □

Performance indicators of a primary care skin cancer clinic network

Deborah A Askew, David Wilkinson and Gordon L Patrick

TO THE EDITOR: Primary care skin cancer clinics continue to receive negative publicity. We have previously reported on the workload profile of one network of clinics.¹ We report here the profile of clinical activity of the four MoleScan skin cancer clinics situated on the Sunshine Coast, Queensland. Between them, these clinics have been open for a total of 22 years, ranging from 2 years to nearly 9 years of operation.

MoleScan is a service company with clinics across Australia. Doctors are employed as sub-contractors and are provided with digital dermoscopes. The clinics do not have dedicated day surgery facilities, and surgical procedures are conducted in the consulting rooms (<http://www.molescan.com.au>).

Using Medicare Benefits Schedule item number billing data (as previously reported¹), we calculated the number of consultations, biopsies, excised lesions (benign, non-melanoma skin cancers [NMSCs] and melanoma), surgical repairs, non-surgical

treatment of skin cancers, and non-surgical treatment of other skin lesions. We also estimated the number needed to treat (NNT), defined as the number of benign lesions removed per melanoma.

There were 98 276 consultations at the four clinics during the 22 years of operation (Box). In all, 14 982 skin cancers were treated: 395 melanomas and 7468 NMSCs by surgical excision, and 7119 NMSCs by non-surgical methods. The estimated NNT was 22.5.

Of the 16 962 lesions excised, 11% (1812) were repaired by a skin flap, 68% (1226) of which were simple flaps. Our previous report, on a different network of clinics,¹ showed a different pattern of surgical repairs: 33% (2651) of the 8055 lesions excised were repaired by a skin flap, 45% (1187) of which were simple flaps. Clearly, the clinical practices of these two clinic networks vary.

Another area of apparent difference between the two clinic groups is the NNT — 22.5 reported here, compared with 28.6 from the other network.¹ The lower NNT in these MoleScan clinics may result from the use of digital dermoscopy, but this requires further study.

These early findings from our analyses of MoleScan data highlight the dangers of generalising about the activities of primary care skin cancer clinics from one dataset. Workload profiles of different clinical services may vary markedly, and the widely expressed concern about large numbers of inappropriate surgical repairs may not be warranted.

Competing interests: Gordon Patrick is the founder and a director of MoleScan. He is also a practising clinician working in a MoleScan clinic. MoleScan made the data available for our study

with no restriction on the analysis undertaken. The company viewed this letter for accuracy prior to submission, but had no influence on the data presented or their interpretation.

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1 Wilkinson D, Askew DA, Dixon A. Skin cancer clinics in Australia: workload profile and performance indicators from an analysis of billing data. *Med J Aust* 2006; 184: 162-164. □

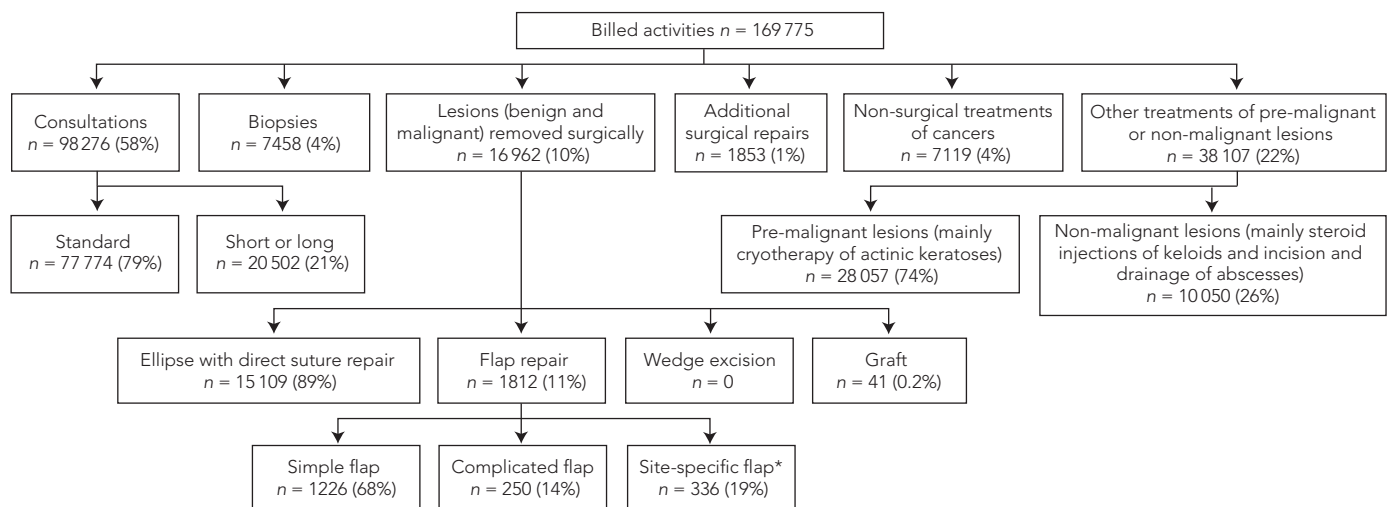
The psychosocial impact of prostate cancer on patients and their partners

James A Smith, Shaun M Filiault, Murray J Drummond and Robert J Knapman

TO THE EDITOR: We read with interest the article by Couper et al on the psychosocial impact of prostate cancer (PCA) on patients and their female partners.¹ We agree that involvement of partners in the research process is pivotal to understanding the relational dimension of how PCA is both understood and approached by men and their partners.²

However, this could be extended to consider the unique experiences of gay men diagnosed with PCA and their partners. Heteronormative viewpoints are commonplace in PCA research. This bias is unfortunate, as there is a 28% possibility that one of the men

Activities billed at four MoleScan skin cancer clinics on the Sunshine Coast, Queensland, over a total of 22 years of operation



* Eyelid, nose, ear, lip, neck, hand, digit or genitals. ◆

in a gay relationship will develop PCA over the course of his lifetime.³

While it is probable that gay men and their partners have some of the same concerns regarding PCA as heterosexual couples, there are also unique concerns that are specific to gay men and their partners. Such considerations may include (but are not limited to):

- the prostate gland as a site of sexual pleasure and the associated implications of being able to engage in penetrative anal sex after prostate surgery;⁴
- homophobia and/or disregard for sexuality within the health care system⁵ when being diagnosed with and treated for PCA; and
- the impact of polygamous (open) relationships and the ambiguous position of gay partners having to care for their mates.⁴

At this stage, the above concerns are purely speculative, as there is a paucity of literature on gay men and PCA.^{4,6} We believe future research on the psychosocial impacts of PCA should consider the experiences and special concerns of gay men with PCA, as well as those of their partners.

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Jeremy W Couper

IN REPLY: We thank Smith et al for their acknowledgement of the importance of the relational dimension to understanding how

prostate cancer (PCA) is understood and approached by men and their partners. The psychosocial implications of prostate cancer for same-sex couples are important and need specific investigation.

However, there are methodological difficulties in attempting to quantify the impact of PCA on same-sex couples and in comparing their experience with other couples. In our review of the literature,¹ we discovered that where previous researchers had included same-sex partners in their studies, insufficient numbers were recruited for meaningful quantitative statistical comparisons. For example, Perez and colleagues,² Neese and colleagues³ and Davison and colleagues⁴ each recruited only one same-sex couple into their studies of 134, 164 and 74 couples, respectively.

We believe that a qualitative approach is needed, specifically seeking out and examining the experiences of a group of same-sex couples and comparing and contrasting their experiences with those of a group of male-female couples. This is an approach we are considering in future studies to help us develop and refine an effective but broadly applicable couple-focused psychosocial intervention for PCA.

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