LETTERS TO THE EDITOR

Lung donors for cystic fibrosis patients

As a centre involved in the care of patients with cystic fibrosis both before and after transplantation, we read with considerable interest the experience of Ryan and Stableforth of the transplant options for their patients (March 1996;51:302–5). Their observation that one third of their patients die while awaiting transplantation in the UK is well made. It is predicted that transplant programmes will only provide a limited service for the expanding adult cystic fibrosis population in view of the limited number of lung donations within the UK over the next decade.

In 1994 there were 7.1 cadaveric thoracic organ donations per million population made in the North West of England, compared with 9.8 per million for the Northern/Yorkshire region. In contrast, there were 26.4 cadaveric renal transplant donations per million population in the North West of England and 31.9 per million in the Northern/Yorkshire region.1 The fact that donor rates vary suggests that local factors may result in unequal emphasis on the promotion and management of multiorgan donations in different regions of the country. A study of the factors that influence local lung donation rates is required to clarify these issues. We believe that a comprehensive initiative from the British Thoracic Society and the cystic fibrosis community is needed to maximise donor availability in the face of the expanding need for lung transplantation.

With such a demand for organs the question remains whether colonisation with 

*Pseudomonas cepacia* represents a contraindication to transplantation. Although the patients colonised with *B cepacia* in the Birmingham study have not done well following transplantation, we believe that there is currently insufficient evidence to preclude these patients from transplantation and that continued follow up experience in the UK and in some North American centres is needed to clarify these issues. We believe that a comprehensive initiative from the British Thoracic Society and the cystic fibrosis community is needed to maximise donor availability in the face of the expanding need for lung transplantation.

Hepatotoxicity of antituberculosis drugs

I have some concerns about the editorial by Ormerod and associates (February 1996;51:111–3) on the hepatic toxicity of antituberculosis agents. The figures they present for reported hepatic reactions, fatal and otherwise, include a large number due to rifampicin and a few due to ethambutol. Since ethambutol has not previously been recognised as hepatotoxic and rifampicin is thought to cause only mild hepatitis as part of a generalised hypersensitivity,1 I would like to know on what basis reactions were attributed to these drugs.

Despite reports of fatalities and severe reactions requiring transplantation,2 they continue to advocate monitoring of liver function only in the presence of symptoms. Unfortunately by this time we may be dealing with a severe and, indeed, reversible situation.

Finally, they unaccountably advise challenging the patient with the various drugs once the reaction has subsided, and even mention desensitisation although the reactions to isoniazid and rifampicin are not due to hypersensitivity. Unless there are no alternatives, this recommendation would seem unwise since rechallenge may result in a severe and possibly fatal reaction.3

The Joint Tuberculosis Committee may be interested in my approach based on many years of "hands on” experience caring for patients with cystic fibrosis. In patients aged 20 years or over who are receiving potentially hepatotoxic drugs I measure serum levels of alanine transaminase (ALT) every two weeks for the first three months. If values above 100 units are persistently obtained, or increasing values approaching 100 units, I discontinue isoniazid and pyrazinamide if the patient is receiving it. With active disease, treatment may be safely continued with rifampicin and one of ethambutol, ciprofloxacin, or streptomycin. If a patient is being treated with prophylactic isoniazid it may be prudent simply to stop treatment. Patients with pre-existing liver disease are generally treated with alternative regimens. I have never had a fatality or a patient who required transplantation.

J J Egan

K Webb

A A Woodcock

North West Lung Research Centre, Wythenshawe Hospital, Southmorton Road, Wythenshawe, Manchester M23 9LT, UK


2 United Kingdom Transplant Support Services Author, Fourth annual report of the special health authority 1994–5.


L M KAHANA

McMaster University, Hamilton, Ontario L8N 1Y2, Canada


3 Mydronas and associates (August 1996)."