Perfect Is the Enemy of Good: The Iranian System of Paid Donation

To the Editor:

We read the article and editorial titled “Comparison of health status and quality of life of related versus paid unrelated living kidney donors” and “Where there is smoke there is fire: The Iranian system of paid donation.” They tried to shed light on the darker side of living-unrelated donation (1,2). As there is no concrete solution for organ shortage, it is the responsibility of experts to discuss different aspects of every possible system to clarify its weaknesses and strengths. We fully agree with the authors that the lack of long-term donor follow-up and the direct method of payment by the recipient in the Iranian model are major weak points (3).

Apart from being for or against this model, there are some points in the articles that need to be elucidated, including the incorrect recipient payment of USD10,000 (2), which is actually not more than USD4000 (1). To the contrary of what the editorial states, living-unrelated kidney donors (LUKD) not only did not stop the progression of the brain dead donors (BDDs) program but paved the way for infrastructure development. We still need to transfer the identified BDD to an intensive care unit in an academic hospital for further management (4). What helped Iranian transplant teams to implement the BDDs program was their experience with a high number of LUKD in more than 25 centers. Although the absolute number of kidney transplantations increased from 1421 in 2000 to 2273 in 2011, the 2.2% share of BDD in 2000 increased to 34% in 2011 (3,5).

In our practice, unrelated donors usually prefer to be anonymous; therefore, they do not give their addresses in detail. But to our surprise the percentage of both groups who have not been accessed because of unavailable contact information was similar in Fallahzadeh et al’s study (paid donors: 334/681 [49%] vs. related donors: 280/513 [55%]) (1). Afterward, 131/233 (56%) of living-related kidney donors responded, which was surprisingly low, as we assumed they would be happy to publicize their altruistic intention (6). On the whole, 7.6% (52/681) of unrelated and 17.9% (92/513) of related donors participated in the study. The unwillingness of related donors to participate in the study may be due to some level of hidden dissatisfaction. It may raise the possibility of subtle family pressure on donors.

Another important issue in the article was gender as a confounding variable: the male ratio in related versus unrelated donors was 35% and 81%, respectively. We know that the 36-item short-form health survey is a patient-reported survey, and health status scores may differ significantly for males and females. The analysis should be adjusted based on observed baseline incomparability. Moreover, this ratio, based on the national report on gender of donors over a span of 22 years, was 54.1% (1441/2663) in related donations and 84.4% (11827/14009) in unrelated donations (7). Consequently, the results cannot be generalizable.

The last concern is regarding the number of urine measurements for microalbuminuria assessment. Because of day-to-day and biologic variability, any microalbuminuric patient needs two positive specimens out of three to rule out transient proteinuria, which was not included in the study (1,2). So, the clinical significance of the finding may be questionable.

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Disclosure
The authors of this manuscript have no conflicts of interest to disclose as described by the American Journal of Transplantation.

References


Correction made after online publication March 11, 2014: Reference 1 has been updated.