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HUMAN RIGHTS AND PRESUMED CONSENT FOR ORGAN DONATION IN THE UK

Editor,

Following the recent commentary on the importance of body donation for anatomical examination and teaching in Northern Ireland¹, the issue of organ donation has also received a fresh impetus. Organ donation is a fundamental concept in medical treatment. A recent survey on organ donation has indicated that approximately 90% of the UK population is in favour of organ donation. However, out of those, only 24% has signed the Organ Donation Register.

Over the past year, opinion in the UK among the public, politicians and the media, has shifted towards presumed consent whereby making donation the default position, from which everybody would retain the right to opt out during their lifetime. Recently, the Prime Minister Gordon Brown has pledged his support for such a system. A public opinion poll taken in October 2007 showed that 64% of respondents were in favour of a soft system of presumed consent, compared with 59% in 2004 (UK Transplant Records 2006-2007)².

The concept of presumed consent in organ donation is not new and has been the subject of a considerable debate among medical ethicists in the 1990s. There are basically three major schools of thoughts differing in their response to the idea of presumed consent

1. Is presumed consent the answer to organ shortages? Yes.

A leading view in this group is that of Veronica English (2007)³ a deputy head of medical ethics, British Medical Association, London. English argues that assuming people want to donate unless there is evidence to the contrary evidence will increase availability of donated organs. According to English, the new system would work when a person is identified as a potential donor, doctors must check the opt-out register. If the person has not opted out, the relatives are informed of this and, as an added safeguard, are asked if they are aware if the person has any unregistered objection. If the answer is no, the relatives are informed of the intention to proceed with donation.

2. Is presumed consent the answer to organ shortages? No.

A leading view in this group was initiated by the bioethicist Linda Wright (2007)⁴ at the University of Toronto. Wright's argument is based on the fact that presumed consent is hard to evaluate as it is implemented in different ways in different contexts, with different results. Wright compared two countries and found that the rate of donation in France in 2005 was 22.2 donors per million population while in Spain it was 35.1 per million. Both countries operate presumed consent and routinely ask families for their consent to donation, yet their organ donation rates vary greatly.

3. Is there any human rights influence on either of these arguments? Yes and No.

Under the ECHR, Article 8-the right to respect private and family life- would be violated where a person's organs

could be removed, after death, without consent having been obtained during their lifetime. On the human rights side of the argument (although, none of the Articles in either ECHR or Human Rights Act 1998 contain any provision to health care) organ donation with informed consent does satisfy Article 8. However, presumed consent *per se* could violate the right to respect the private life and diminish the support for organ donation.

The author has no conflict of interest.

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MILIARY TUBERCULOSIS CAUSING MULTIPLE INTESTINAL PERFORATIONS IN AN IMMIGRANT WORKER

Editor,

The incidence of tuberculosis (TB) in Northern Ireland is increasing¹. We present an uncommon case of perforated intestinal TB in an immigrant patient. The clinical presentation and endoscopic findings suggested inflammatory bowel disease (IBD). Subsequent multiple perforations necessitated emergency intestinal resection. With an increasing immigrant population, intestinal TB should be considered in such patients presenting with intestinal symptoms and signs.

Case Report: A 46-year old Polish immigrant presented with weight loss, abdominal pain and bloody diarrhoea. He appeared cachectic and had right iliac fossa tenderness. Colonoscopy revealed segmental ulceration with caecal involvement (Fig. 1). Given the distribution, Crohn's disease was suspected. However colonoscopic biopsies demonstrated caseating granulomatous inflammation and acid-fast bacilli.

Further examination revealed cervical lymphadenopathy and bilateral chest crepitations. Chest radiography showed bilateral infiltrates (Fig. 2). Identification of acid-fast bacilli in sputum and isolation of mycobacterium tuberculosis confirmed pulmonary TB.

After commencing anti-tuberculous treatment, the patient developed an acute abdomen. CT scanning demonstrated a pelvic collection, with free intra-peritoneal fluid.

Emergency laparotomy revealed generalised peritonitis due

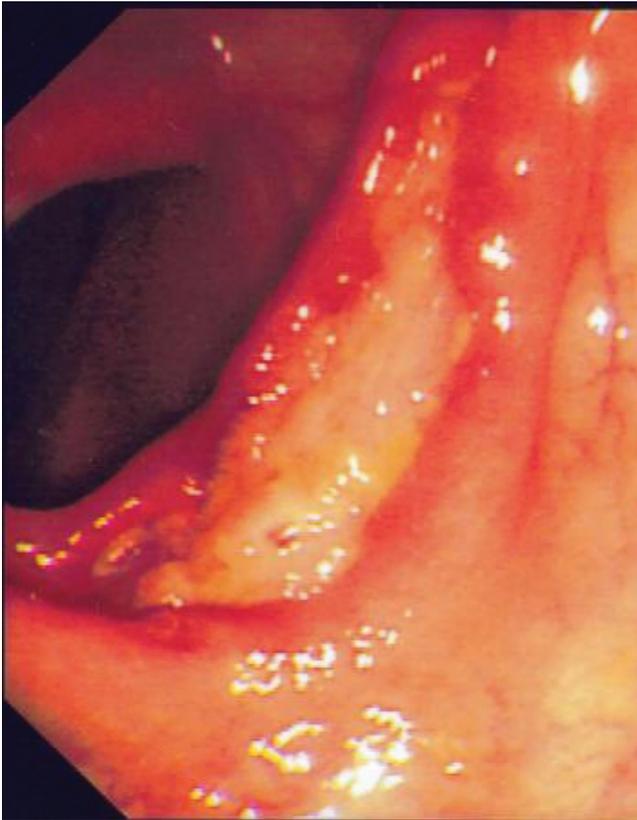


Fig 1. Caecal tuberculous ulcer.

to multiple ileal perforations. Apart from a short segment of proximal jejunum the entire small bowel and caecum were grossly diseased. An extensive enterectomy and caecal resection was performed, with a high jejunostomy and mucous fistula fashioned.

Histopathology revealed marked small bowel and caecal ulceration. Extensive caseating granulomatous inflammation (Fig. 3) and acid-fast bacilli confirmed intestinal TB.

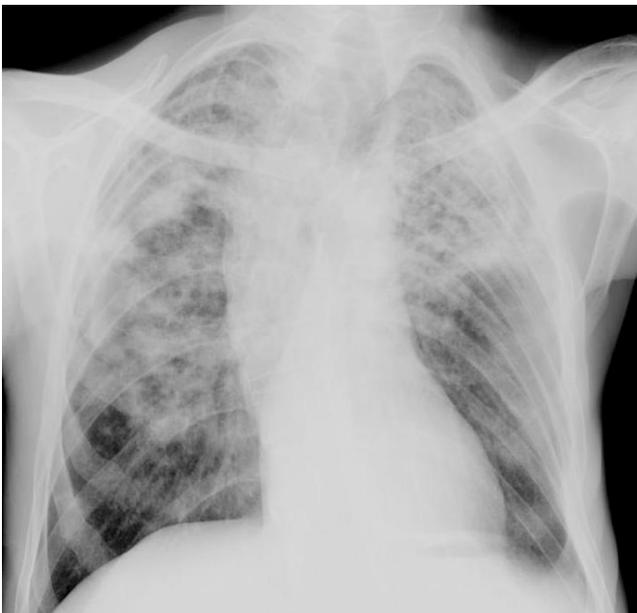


Fig 2. Bilateral upper and mid-zone infiltrates consistent with active pulmonary tuberculosis.

Discussion: In recent years the incidence of intestinal TB in developed countries has increased. In the UK higher rates have been identified in non-UK born individuals. This reflects increasing levels of disease in areas from which migrants are coming to the UK and increasing numbers arriving from high incidence areas¹.

In Northern Ireland the incidence of TB is rising, with a notification rate of 4.7/100,000 in 2004 (compared with 24.6/100,000 in Poland). Furthermore, the proportion of non-UK born cases of TB in Northern Ireland rose to 37% of those reported in 2006².

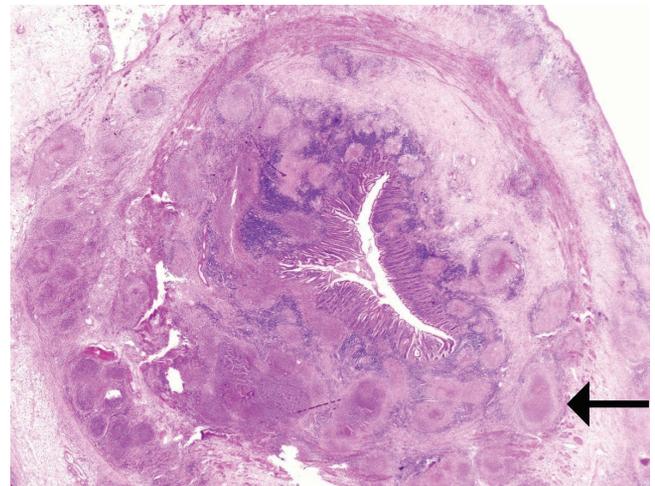


Fig 3. Photomicrograph of appendix demonstrating multiple trans-mural caseating (arrow) and non-caseating granulomata. (Haematoxylin and eosin, low power x1).

Intestinal TB presents a diagnostic challenge. Patients can present with abdominal pain, diarrhoea and weight loss, mimicking IBD³. The ileo-caecal region is the most frequent site of intestinal TB (similar to classical Crohn's). Colonic mucosal ulceration is often segmental and may be indistinguishable from Crohn's disease endoscopically. Colonoscopy is valuable in aiding the histopathological diagnosis of ileo-caecal disease⁴. The presence of caseating granulomata differentiates intestinal TB⁵. Identification of acid-fast bacilli together with isolation of mycobacteria confirms the diagnosis.

Intestinal TB is primarily managed with anti-tuberculous agents. Surgical intervention is reserved for complications including perforation which is an uncommon but serious complication with high mortality rates. Perforations may be solitary or multiple and surgical resection is required.

With an increasing incidence of TB and a rising immigrant population this case demonstrates the importance of considering intestinal TB in patients, particularly non-UK born, who present with symptoms suggestive of IBD. The role of endoscopic biopsy in differentiating intestinal TB from Crohn's disease is highlighted. This case also underlines the importance of recognition of perforated intestinal TB and the role of timely surgery.

The authors have no conflict of interest.

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