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LETTER TO THE EDITOR

Response to Webb *et al.* (2008)

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It is certainly an overdue and under-discussed issue that Webb *et al.* [1] present in their consideration of illicit drug use and liver transplantation. With a sincere lack of international evidence on illicit drug use pre- and postliver transplantation, Webb *et al.* attempt to capture the available evidence, consider some clinical concerns and report on UK nationally agreed criteria for listing preliver transplant candidates with a history of drug misuse. In concordance with Dew *et al.* [2], Webb *et al.* consider a return to harmful use of illicit drug use postliver transplantation without description or evidence of what these harms may be but approach the subject from an abstinence-based ideology that underlies the medical approach of treating people with alcohol-related liver disease undergoing liver transplantation. As the authors report, this approach conflicts with the harm minimization approach pursued by UK substance misuse services. Why is abstinence ideology the preferred approach in liver transplantation? Transplant clinicians may argue improved graft outcomes, compliance and public support. Substance misuse clinicians may argue what is the evidence for graft harm, poor compliance or altered public opinion. What illicit substances truly harm the graft? What harms do they cause and can these harms be minimized? Public opinion has shown low preference for transplantation of injecting drug users but this does not necessarily correlate with professionals' opinions who are allocating organs [3]. Professional opinion should be based upon considered evidence and thereby to reassure public opinion. Furthermore, transplant and substance misuse professionals need to consider these factors and base transplant listing and treatment criteria upon this evidence rather than upon an abstinence ideology.

Credibly, Webb *et al.* acknowledge the drug-using career, the relapsing nature of chronic drug misuse and the conflicting ideals presented by transplant and substance misuse communities. Is it possible to incorporate harm minimization into transplantation services? Conceptually, it is plausible to consider harm minimization in transplantation. A transplantation programme should attempt to optimize a candidate's chance of success by monitoring and engaging that individual into substance misuse treatment to facilitate that individual into and through transplantation rather than excluding on predetermined arbitrary measures. However, practically it is at present inconceivable owing to patient ill health, geographic dispersal of patients, altered patient motivation for behaviour change [4] and transplant professional perception. Substance misuse professionals in liver transplantation need to consider effective interventions in this small but significant population to optimize their outcomes.

What is the argument for declining current illicit substance users when the majority of illicit drugs do not impact upon liver function? Appreciatively, it remains the transplant clinicians' nightmare of judging right versus wrong when allocating liver grafts, Webb *et al.* have introduced the topic to provide some foundations for equity of access to individuals being considered for listing for liver transplantation in its first guise. Transplant clinicians need to continue the momentum, to implement and evaluate the guidelines and question their own values and perception when considering transplant candidates with a history of substance misuse.

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