LETTER TO THE EDITOR

Current practices of donor pancreas allocation in the UK: future implications for pancreas and islet transplantation

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We read with the interest the article by Ridgway *et al.* [1] describing the current allocation practices for donor pancreata in the UK. The data they presented were based on a retrospective analysis of UK data from 2000 to 2001. We are delighted to be able to report that the actual current practice of pancreas allocation and transplantation in UK is very different from the practice that was described in their paper.

In 2001 UK Transplant established an on-going Task Force to address the issues surrounding the practice of pancreas transplantation in the UK. Representatives from the seven UK centres practicing pancreas transplantation at that time sit on the Task Force, together with a representative of the islet transplant centres. Since its inception the Task Force has transformed pancreas transplantation. A zonal retrieval system has been put in place similar to that operated by the Liver Transplant units in the UK, with each centre responsible for organ retrieval within its zone. A national sharing scheme was developed to allocate pancreata outside a retrieval zone where the retrieving centre was unable to use the pancreas. In 2000 the Scottish Office approved funding for a pancreas transplant programme in Scotland, currently based at Edinburgh. In 2003 the Department of Health approved funding for pancreas transplantation in England based on seven centres in Newcastle, Manchester, Liverpool, Oxford and Cambridge, together with St Mary's and Guys hospitals in London. In 2004 the Welsh Office agreed to fund pancreas transplantation in Cardiff. To accompany these developments a national audit has also been implemented. The result of the changes has been an increase in pancreas transplant activity from 33 transplants in 2000 to 79 in 2004, with the national waiting list increasing from 39 to 112 respectively. The results of pancreas transplantation in the UK were recently presented at the International Pancreas and Islet Transplant Association meeting in Geneva, 2005, and were comparable with International Pancreas Transplant Registry data.

Centres involved in islet transplantation in the UK, which include several of the centres with active whole pancreas transplant programmes, have also devised a national allocation scheme for pancreata for islet transplantation. Establishment of a national pancreas transplant service has indirectly helped the islet centres as multiorgan donors are now being considered as pancreas donors and more pancreata are being retrieved. Pancreata not suitable for whole organ transplantation are offered for allocation for islet transplantation. The main limitation to whole organ and islet transplantation in the UK at present is lack of consent for retrieval of the pancreas.

In summary the current practice of pancreas transplantation in the UK is very different from the picture painted by Ridgway *et al.* from analysis of 2000–2001 data and discussed in the editorial by Berney *et al.* [2]. We fully support their concern regarding the availability of pancreata for transplantation. While the long-term success of whole organ transplantation exceeds that of islet transplantation preferential allocation will be given to whole organ transplantation.

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