

faculty members [4].

The primary job of a faculty member is teaching; therefore, research publications should not be made mandatory for promotions. If it has to be mandatory, the criteria for considering of publications should be based on a reasonable scoring system. This will result in original and honest research work by only those who are zealous and really interested in bringing new evidence to the fore, and prevent unethical publication practices and mushrooming of predatory journals.

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Outcome of Pediatric Living Donor Liver Transplantation in India

We read with interest a recent article by Mohan, *et al.* [1] who have summarized their experience of 200 pediatric living donor liver transplantations in one of the largest series from the country. We would like to highlight some issues with the study.

Authors have mentioned using Pediatric end stage liver disease (PELD) scores (>10 for age <12 years), and Model for end-stage liver disease (MELD) scores (>15 for age >12 years) for listing for liver transplantation in patients with chronic liver disease (CLD) as per Western guidelines [2]. This statement requires careful interpretation as these scores are not at all meant to be used for listing a patient or deciding the need of liver transplantation in an individual patient. The above statement infers that a patient with a PELD score of <10 or a MELD score of <15 would not be listed irrespective of his/her clinical status. Quoting the same guidelines, every CLD patient who develops worsening of hepatic functions (intractable ascites, progressive encephalopathy, uncorrectable coagulopathy and/or, recurrent infections; and not just uncontrolled portal hypertension), mandates evaluation for liver transplantation [2]. These severity scores are meant to be used only in countries having proper organ allocation mechanisms for diseased donor transplantation, and that too, only for deciding the priority and not for listing. In

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resource-constrained settings, where a vast majority of liver transplantations are living donor related, these scores have limited practical utility, except for prognostication. Thus, using fixed cut-offs for deciding need of liver transplantation in CLD is far from being an ideal strategy.

Despite having a long study period of 13 years, vital information on post transplant follow-up, including attrition/loss to follow-up, drug compliance rates, renal outcomes is missing from the reported study. Reasons for lower incidence of vascular complications, any trend (if seen) in the incidence of complications over the study period, and actual modifications in transplant protocols over the study period (to improve the outcomes) require further clarification [3]. Also, predictors of morbidity and mortality, if studied in the study cohort, would have added much needed information to the national database [4,5].

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AUTHOR'S REPLY

We appreciate the keen interest of authors of this correspondence in our recent article on outcome of living donor liver transplants. We wish to clarify that while PELD/MELD scores were originally devised to predict mortality over time in patients with chronic liver disease (CLD), they are currently the only objective tool to use as 'minimal listing criteria'. They are important, but are not the only consideration in deciding whether and when to transplant [1]. In our study, we used them as guidelines but not as fixed cut-offs for transplant. In CLD, irrespective of scores, we also factored-in evidence of deteriorating liver function such as poor weight gain, growth failure, recurrent variceal bleeding, intractable ascites, recurrent cholangitis or episodes of spontaneous bacterial peritonitis, pruritus, advancing encephalopathy, and, or uncorrectable coagulopathy, in the decision to transplant [2]. There are several limitations to use of PELD score and conditions in which the PELD score can be adjusted higher. Liver tumors, sick patients in ICU, in metabolic crisis as in Urea cycle defects or Organic acedemia or poor metabolic control necessitating early transplant [2,3]. As ours was a retrospective study, we realized that excluding the above mentioned exceptions, all our patients <12 years who underwent living donor related transplantation for CLD were having a PELD

score >10 and MELD score of >15.

Due to the need of brevity in the published paper, we did not include all long term follow-up issues. PTLD, chronic rejection, recurrence and retransplantation were adequately covered in this paper, and we might publish long-term outcome as a separate paper.

Vascular complications depend on the age of the patient, etiology (such as biliary atresia), post-surgical morbidity and expertise of the surgeon. Our surgical team has a vast experience of nearly 3000 liver transplants now. Modifications in vascular techniques included jump grafts in cases of narrow portal vein, close monitoring by frequent dopplers for portal vein and hepatic artery along with use of prophylactic anticoagulants in high-risk patients. Similar vascular complications rates have been earlier reported from a single, large volume center [4].

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