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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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