assessment of splanchnic haemodynamic response) to detect responders to treatment. This should allow better selection of cirrhotic patients with varices for beta-blocker therapy in the future.

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Anisakis simplex, a co-factor of gastric cancer?

Sir,—Dr Davis and colleagues (Aug 25, p 474) note that mortality from stomach cancer is still falling in nearly all the countries studied “although the oldest groups in Italy and Japan show some continuing increases”. Japan has the highest national mortality rate in the world.1

A limited relation has been found between cancer mortality and consumption of salted fish that could be the origin of contamination by Anisakis simplex.2 Desowitz3 in work on anisakiasis, found a low molecular weight protein in the eggs of Anisakis simplex, a co-factor of gastric cancer—a hypothesis that can be tested by longitudinal studies, which take into account the long incubation period of cancers.

These epidemiological, experimental, and histopathological data suggest that A simplex may be a co-factor for certain forms of gastric cancer. It is therefore crucial that opposition to commercial transplantation be based not on the poor results (which have already shown improvement) but on total abhorrence of commercialism in organ donation, whatever the result.

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3. The Lipid Research Clinics Coronary Primary Prevention Trial (LRC-CPPT)2 adherence was not found to be related to event rate in the placebo group. Horwitz et al argue that this may be because the LRC-CPPT was a primary prevention trial, whereas BHAT and the Coronary Drug Project (CDP) were secondary prevention trials. LRC-CPPT differs from BHAT and CDP in other ways that seem more likely to explain the divergent findings. The patients in LRC-CPPT were younger and better

Living non-related kidney transplantation in Bombay

Sir,—In 1986 we reported our early experience in non-related living kidney donation done in Bombay and followed up by us.1 All the patients then (as now) went to Bombay for renal transplantation against our advice. The results reported then related to the first 20 such patients and showed, as found by Dr Salahudeen and colleagues (Sept 22, p 725), a high incidence of complications and graft failure. Later experience in a further 90 patients coming back from Bombay since that time revealed a worrying incidence of HIV infection2 so far there have been 6 cases, of whom 4 have died.

This complication was also reported by Salahudeen et al. However, unlike Salahudeen et al, we have noticed an improvement in one-year patient and graft survival (95% and 85%, respectively) compared with our early experience.3 This is perhaps not surprising; after many transplants had been done in Bombay the surgical technique had largely been mastered and postoperative and medical care is largely given by us because the patients return to Saudi Arabia 13 days postoperatively on average.

It is therefore crucial that opposition to commercial transplantation be based not on the poor results (which have already shown improvement) but on total abhorrence of commercialism in organ donation, whatever the result.

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Compliance and clinical trials in heart disease

Sir,—Professor Horwitz and colleagues (Sept 1, p 542) have re-examined the relation between compliance and mortality, using data from the Beta-Blocker Heart Attack Trial (BHAT).1 It would be interesting to know if an analysis over the whole duration of the study also shows a relation.

In the Lipid Research Clinics Coronary Primary Prevention Trial (LRC-CPPT)2 adherence was not found to be related to event rate in the placebo group. Horwitz et al argue that this may be because the LRC-CPPT was a primary prevention trial, whereas BHAT and the Coronary Drug Project (CDP) were secondary prevention trials. LRC-CPPT differs from BHAT and CDP in other ways that seem more likely to explain the divergent findings. The patients in LRC-CPPT were younger and better