and precautionary blood augmentation and conservation methods were employed in order to minimize the likelihood of any bleeding event having serious adverse outcomes. These measures included the use of a hand-assisted laparoscopic approach when appropriate, erythropoietin and iron supplementation, discontinuation of aspirin products, and acute normovolemic hemodilution. Intraoperative blood losses were lower in TR donors than in those who consented to receive transfusions (121 ml vs 298 ml; $P<0.03$). Intraoperative red blood cell scavenging was not required in any patient. Two of the consenting donors received intraoperative transfusions.

Donor survival was 100%, and no significant differences were observed between the two groups in any surgical or functional parameters. With appropriate consultation and precautionary measures, TR individuals might, therefore, be able to donate kidneys with acceptably low levels of risk to themselves, and with good functional outcomes.

Original article Mateo R *et al.* (2007) Living related donor nephrectomy in transfusion refusing donors. *Transpl Int* **20:** 490–496

A small proportion of living kidney donors experience donation-related insurance problems

To determine whether living organ donation (of kidneys, or lung or liver tissue) affects insurability, which might impact on the willingness of potential donors to proceed, Yang *et al.* systematically reviewed data from 23 studies performed in five countries during the period 1972–2006. Analysis of 229 survey responses from US and UK insurance companies found that almost all would provide life or health insurance to living kidney donors. Up to 33% would, however, charge a higher premium for donors or would not cover donation-related health problems. Of 1,188 living kidney donors, up to 11% reported difficulty obtaining or maintaining life, disability or health insurance, although insurance premiums did not increase for at least 96% of the donors.

In five studies encompassing almost 1,000 donors, 11–14% of individuals experienced significant stress or concern about their insurability. Living kidney donors were less likely to reaffirm their decision to donate if their insurance premiums increased ($P=0.0001$), and a survey of 524 donors found that 4% regretted their decision. A US telephone survey established, however, that respondents would be willing to donate a kidney to a sibling regardless of whether they themselves had health insurance.

Despite assurances from most insurance providers that they would not discriminate against living kidney donors, a notable proportion of donors were worried about issues of insurability. Addressing this potential barrier to donation could help to improve the poor organ donation rates that currently limit transplantation.

Original article Yang RC *et al.* (2007) Insurability of living organ donors: a systematic review. *Am J Transplant* **7:** 1542–1551

Postoperative heparin not routinely needed in low-risk renal transplant recipients

Routine heparinization might reduce the likelihood of renal allograft thrombosis, but some investigators claim that this approach increases morbidity without exerting beneficial effects. A recent randomized trial investigated prophylactic heparin use among 75 recipients of living donor kidneys at low risk of thrombotic complications.

Patients were randomized (1:1:1) to one of three regimens for 1 week after transplantation: no heparin (group 1); subcutaneous low-molecular-weight heparin (tinzaparin sodium 3,500 anti-Xa IU once daily; group 2); or subcutaneous conventional unfractionated heparin (5,000 IU twice daily; group 3). All patients received 'triple' immunosuppression, and intravenous ampicillin for 3 days after transplantation.

No patient developed graft vascular thrombosis, deep venous thrombosis or pulmonary embolism, and no grafts were lost during the early postoperative period. Spontaneous closure of arteriovenous fistulae occurred in four patients (one in group 1, one in group 2, and two in group 3). Rates of blood transfusion were also similar between groups. Among nontransfused patients, mean hemoglobin decreases were significantly greater in group 3 than in group 1 (1.6 ± 0.8 g/dl vs 0.7 ± 0.9 g/dl; $P=0.01$). Mean lymph drainage time was markedly shorter in group 1 than in groups 2 or 3 (4.7 ± 1.0 days vs 5.9 ± 2.6 days [$P=0.03$] and 6.3 ± 2.8 days [$P=0.01$]). Mean