for example, extol such altruism as the very ideal of generosity. Again, the issue is complicated and demands thorough, individualized assessment.

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*To the Editor:* The review article by Trotter et al. is timely and thorough. However, there is one factual error. The first successful adult-to-adult transplantation of a right hepatic lobe from a living donor was reported by us,[1] not by Yamaoka et al.[2] The patient treated by Yamaoka et al. was a nine-year-old child. Contrary to the view of Trotter et al. that living-donor liver transplantation has a limited role in the treatment of patients with acute liver failure, we found that this procedure is most valuable in patients who have acute liver failure or cirrhosis with acute deterioration.[3]

Some centers have reported that the results of living-donor liver transplantation in patients whose United Network for Organ Sharing (UNOS) status is 1 or 2A have not been satisfactory. We believe the reason is that the surgeons chose to use right-lobe grafts without the middle hepatic vein — a type of graft that is suboptimal in function and that cannot meet the metabolic demands of critically ill patients. To improve the results, more attention should be paid to improving the venous drainage of the right-lobe graft rather than to increasing the graft volume.

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**1.** Lo CM, Fan ST, Liu CL, et al. Adult-to-adult living donor liver transplantation using extended right lobe grafts. Ann Surg 1997;226:261-9.
**2.** Yamaoka Y, Washida M, Honda K, et al. Liver transplantation using a right lobe graft from a living related donor. Transplantation 1994;57:1127-30.
**3.** Liu CL, Fan ST, Lo CM, Yong BH, Fung ASM, Wong J. Right-lobe live donor liver transplantation improves survival of patients with acute liver failure. Br J Surg 2002;89:317-22.

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*To the Editor:* Techniques for adult-to-adult living-donor liver transplantation have not been standardized, but we wish to point out our observations regarding the illustrations and the text concerning the operation in the article by Trotter et al. First, although the techniques used for all three of the major vascular reconstructions are critical, the establishment of unrestricted venous outflow is paramount. We perform right-hepatic-vein cavoplasty, anastomosis of all posterior hepatic veins larger than 5 mm, and reconstruction of the venous drainage of segment 8 if its major venous outflow crosses the plane of parenchymal transection into the middle hepatic vein, together with the extensive use of fine, interrupted sutures. Figure 5 in the article depicts a vessel identified as the middle hepatic vein. This vessel might more correctly be identified as a segmental tributary of the middle hepatic vein. In our program, the true middle hepatic vein, identified intraoperatively by ultrasonography, is never divided and always remains with the left lobe. Our plane of parenchymal transection is always to the right of it — which brings us to our second observation regarding Figure 5. The plane of parenchymal transection depicted in the illustration is midway between a true right lobectomy and a right trisegmentectomy and goes right through liver segment 4. Again, it is our practice to ensure that all of segment 4 remains with the donor. We suspect that the authors present these illustrations as general representations rather than exact depictions of operative details, and we hope that others interpret them as such.

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*To the Editor:* The article by Trotter et al. on living-donor liver transplantation and the Perspective by Surman on the ethics of this practice[1] raise important issues concerning the complications donors have suffered, including death in two cases. Their discussion raises a fundamental question: Is it morally acceptable to remove organs from living donors?

The fundamental goal of medicine is to help a sick person in need, from which stems the principle of nonmaleficence: "First, do no harm." Removing an organ or a portion of an organ from a healthy person harms that person by subjecting him or her to anesthetic, surgical, and postsurgical risks. The altruism of the donor does not change this. It is one thing for a soldier to jump on a grenade thrown by an enemy to save his or her fellow soldiers; it is quite another for a person to donate a healthy organ. In the former case, an enemy is harming the soldier; in the latter, a physician is harming the patient, even if the harm is at the patient's request, and even if the transplanted organ helps someone else. Public support for organ donation from living donors does not change this fact, nor does the popularity of a practice imply its moral rightness. Because the removal of organs from a living person does not benefit that person, but actually harms him or her, it violates the fundamental end of medicine to do no harm.

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