delivery of dead bodies by the relatives has contributed to underutilization of cadavers; furthermore, some cadavers were reclaimed by their relatives due to religious beliefs (2). In addition, detection of HIV seropositivity on the retesting of some donated cadavers is another problem that prevents their use further for organ donation (3). The fact that HIV-seropositive cadavers can still be detected, although the donors were previously screened and confirmed to be HIV seronegative, is another fact that needs to be considered in the organ donation system. It is possible that some donors became infected with HIV after stating their intention to donate and passing the first HIV screening test, whereas the other cases are due to false-negative results due to the window period in the first HIV screening test (3).

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Transcranial Sonography as a Bridge to Brain Death Diagnosis

We read with great interest the article by Orban et al. (1) published in Transplantation showing that transcranial color-coded sonography shortened the time between clinical brain death and angiographic confirmation, despite that this technique is not accepted in France as a confirmatory test. Based on our experience, we endorse their opinion. However, we would like to call attention on some points of their study.

The authors reported that, in up to 50% of the cases, the middle cerebral arteries were not insonated, and also in 82% of the basilar arteries. This implies that most of the patients were considered to present a cerebral circulatory arrest based on an absence of flow pattern, which can only be accepted as a confirmatory pattern when a previous study, preferably performed by the same (and experienced) operator, has previously shown appropriate insonation of those vessels. This is a condition necessary to rule out ultrasonic problems as a cause of this pattern (2, 3). As the authors point out, time between clinical brain death and computed tomography angiography confirmation was 2 hr in the group of transcranial color-coded sonography, and of 22 patients, only 1 underwent repeated examinations. It results striking that, in this short period, after the clinical diagnosis, those vessels could not be insonated because of an advanced sonographic pattern. Although the authors only used this technique as a guide to perform computed tomography angiography, we would like to highlight that, according to the Spanish guidelines on the use of transcranial sonography as a confirmatory test, most of their patients cannot be considered as having a cerebral circulatory arrest (2).

In addition, we would like to support the use of ultrasound contrast agents to increase the number of conclusive studies, namely those with a pattern of oscillating flow or systolic spikes in both middle cerebral and basilar arteries when no study has been previously performed. Using a bolus of ultrasound contrast agents, we obtained a conclusive pattern in up to 98% of the cases (4), a fact that motivizes the need of a previous study in the sonographic diagnosis of cerebral circulatory arrest.

In summary, and although we basically agree with the author’s conclusions, we believe that the interpretation of their data should be considered with caution.

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