

taneous rupture of bladder and one rupture of both Achilles tendon. One patient developed acute adrenal insufficiency. Among two patients who underwent living unrelated kidney transplantation in India, one got severe polyoma BK infection and developed rapid loss of graft function. There have been 21 paid kidney transplantations from cadaveric donors performed in Moscow. Hyperacute rejection was noticed in two patients. Both of them underwent a re-transplantation one month after hyperacute rejection. One of them got thrombosis and arterial embolization of the graft. One developed an acute rejection three months after with unresolved urinary obstruction. In one patient abdominal aortic aneurysms was not resolved prior to transplantation, and the rupture occurred afterwards. One patient died after kidney transplantation in coma caused by Creutzfeldt-Jakob disease. Conclusion: Our data show that over 50% of patients in group of living unrelated transplantation have returned with complications, as well as over 50% in the group of patients with deceased donor transplantation. A possible cause of high incidence of complications was the inadequate preoperative evaluation. Many of the patients were sent without treatment of post-operative complications. This gave us motivation to work on the establishment of the transplant system.

PP44

CURRENT STATUS OF ORGAN PROCUREMENT FROM PRISONERS IN CHINA

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China is the only country in the world systematically using organs from prisoners for transplantation. For four decades, China's transplant medicine relied on organ procurement from executed prisoners. On December 3, 2014, the director of the China Organ Donation and Transplantation Committee and former vice-minister of health, Jiefu Huang, announced that China would completely cease the use of prisoner organs for transplantation after January 1, 2015. However, the announcement of December 2014 is neither a law nor a governmental regulation and has itself no force of law. Nor is it followed by any changes to China's organ donation laws/regulations. Chinese transplant officials have repeatedly, also after January 2015, stated that death-row prisoners have the same right as regular citizens for organ donation; they are allowed, or even encouraged to donate organs voluntarily. These prisoner organs are now simply classified as "voluntary donations from citizens". By re-defining prisoners as regular citizens for "voluntary" organ donation, China's national organ donation system whitewashes the use of organs from both death-row prisoners and prisoners of conscience. Since 2006, mounting evi-

dence suggests that prisoners of conscience are killed for their organs in China with the brutally persecuted Buddhist practice, Falun Gong, among others, being the primary target (see European Parliament resolution of December 12, 2013). To end the abuse, the use of organs from any kind of prisoners in China must be prohibited by law. China must make its organ donation system transparent and verifiable to independent professional organizations and open to international inspections to gain credibility.

PP45

TISSUE AND CELL'S TRAFFICKING: A BYPRODUCT OF TRANSPLANT ACTIVITY'S TRASH. THE FUTURE IS NOW. A PUBLIC HEALTH PROBLEM

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Transplantation is one of the most beautiful achievements for humanity in the last century and became the last hope to many patients. As other beautiful achievements, it has been used by criminals. The future of transplantation will be focused on tissue and cells transplantation. Trafficking of human beings to organ removal and trafficking of human organs are an early stage of trafficking on tissues and cells comparable with slaves trafficking in the 17th and 18th century. As 400 years ago, the motive for the crime is development, economy and profit. Transplant surgery is the modern "cotton gin" to this new commerce. Poverty exploitation, unprotected people, are always the victims. Even so, there are some differences since then. The paying buyers are the patients themselves and the "cotton" transplanted is not so harmless. Unsafe tissues and cells inappropriately collected and allocated can be so dangerous to the recipient and his family, that the dreamed transplant/implant becomes a nightmare. Beyond the trafficking crime, there is a most dangerous associated crime that is the crime of spreading dangerous infectious diseases. The infectious diseases transmitted by human body parts, if not correctly screened by medical history and screening tests, are a public health hazard because the live vehicles have free pass inside their communities. So, this crime is committed against a potentially countless people, being very difficult to track the spreading of virus as HIV, HCV and

HBV. This crime is not fiction. AIDS and Hepatitis were spread by this way by companies selling human parts (skin, bones, vessels, cornea, tympanic membrane, etc.) collected in morgues and sold as medical or dental products implanted in small clinics, offices dentists, otolaryngologists, ophthalmologists, etc. It has been spread HIV, HCV and HBV infection by this kind of trafficking and are not yet visible control measures to this reality. Polices around the world also seem not yet enough worried about this. The value of shares on the stock exchange of the companies working with regenerative medicine and stem cell treatments is one of the largest in recent years and so the crime in these areas is potentially more attractive, being public banks a preferential target of attack by these criminals. Universities and patient associations, as well as research international consortia can be searched as a cover for international networks that organize this type of trade. The collaboration between public health authorities and international police is urgent.

PP46

ILLEGAL TRANSPLANT AND MEDICAL RESPONSIBILITY UNDER THE LIGHT OF LAW AND ETHICS

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Human organ trade is based on one fact: Desperation. Both donor and recipient are desperate. The first for money, the second for health, yet both are desperate for survival. Black market «balances», with the right 'price', this desperation as well as the disproportion between high organ demand and poor supply. In that way, the patient avoids long transplant waiting lists and the donor directly receives money for his organ. Illegal transplants exist when the organ to be transplanted is illegally purchased and they are a worldwide phenomenon. Tracing the organ back to the donor is extremely difficult while there are surgeons that perform those transplants knowing that their colleagues won't report them. Donors will not talk, in fear of prosecution and in some cases the hospital staff itself knowingly becomes involved. All that in contradiction to the Oath of Hippocrates, dating back to 5th century BC and stating that the physician should always behave in an altruistic manner towards the patient. Medical responsibility, especially in cases of illegal transplants, is set under the European and international legislation as well as the rules of medical ethics and moral conduct. Its importance becomes even more crucial due to the rapid developments in the field of biomedicine and the continuous increase in global demand for human organs, cells and tissues, creating difficult moral dilemmas for health professionals that need to be addressed.

Psychosocial aspects

PP47

EVALUATION OF THE MEDICAL AND PSYCHOSOCIAL OUTCOMES OF A YOUNG ADULT CLINIC FOR KIDNEY TRANSPLANT RECIPIENTS: RESULTS FROM INTERVIEWS WITH YOUNG PATIENTS

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Transition from pediatric to adult care can be a challenging process. For many, it is associated with lowered adherence to medical regimen, episodes of rejection, graft failure or loss, and sometimes mortality. Self-Determination Theory (SDT) states that patients who perceive their healthcare environment as autonomy supportive will feel motivated and competent in managing their condition and show increased adherence. Guided by SDT, which has found empirical support in other clinical populations, our objective is to conduct an evaluation of the medical and psychosocial outcomes of the Young Adult Clinic (YAC) set up at Centre Hospitalier de l'Université de Montréal (CHUM) in 2008 in an effort to create a more patient-centered environment for young kidney recipients. A mixed method design, combining quantitative data obtained by means of self-reported, empirically validated questionnaires and review of medical records for all patients (N = 50-55) and qualitative interviews with a subset of them (N = 10-12, or until saturation) will be employed. Qualitative data presented here was analyzed using Interpretative Phenomenological Analysis. Quantitative data will be subjected to statistical analyses to test the explanatory value of SDT. Qualitative results thus far suggest that key factors have had a positive impact on patients experience: the smooth transition, the degree to which they feel supported in developing autonomy, the presence of pediatric nephrologists to help bridge transition, being with patients of the same age, the informal and personalized approach and the health care providers' flexibility & availability. To our knowledge, the CHUM's YAC is a unique example of a clinic tailored specifically to the needs of young renal transplant recipients and transfers. Our data will provide new knowledge and a point of reference that may help guide future efforts by other centers to develop comparable services.