OPTN/UNOS *Ad Hoc* Disease Transmission Advisory Committee
Report to the Board of Directors
June 25-26, 2012
Richmond, Virginia

Summary

I. Action Items For Board Consideration

- The Board is asked to approve guidance for recognizing meningoencephalitis in potential deceased organ donors (Item 1, Page 5).

II. Other Significant Items

- The Committee considered a data summary of potential Toxoplasma transmission events (Item 2, Page 5).

- The Committee reviewed a list of recent testing policy questions received by the Department of Evaluation and Quality (Item 3, Page 6).

- The Committee discussed further defining donor-derived versus donor-transmitted tumors (Item 4, Page 7).

- The Committee discussed the potentially unnecessary discard of the contra-lateral kidneys when renal cell carcinoma is identified in its mate (Item 5, Page 7).

- The Committee reviewed potential donor-derived disease transmission events reported from July through December 2011 (Item 11, Page 13).

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Emily A. Blumberg, MD, Chair
Michael Green, MD, MPH, Vice Chair

This report reflects the work of the Ad Hoc Disease Transmission Advisory Committee (DTAC) during its March 28, 2012, meeting in Chicago, Illinois, as well as all monthly case review conference calls held from December 2011 through April 2012.

1. Guidance for Recognizing Meningoencephalitis in Potential Deceased Organ Donors: What to Consider During Donor Evaluation and Organ Offers. The Committee was tasked by the Board in 2011 with developing a guidance document to assist OPOs with the evaluation and recognition of donors with potential central nervous system (CNS) infection, and recipient centers that are offered organs from this category of donors. Review of potential donor-derived meningoencephalitis (ME) cases reported to the OPTN indicated that this diagnosis has been underrecognized in donors, and has been associated with high rates of transmission to recipients with subsequent morbidity and mortality. The Committee received an update from the Encephalitis Subcommittee regarding its February 6 conference call (**Exhibit A**) and its ongoing work on drafting this document.

   An abstract outlining these findings was presented at the 2011 American Transplant Congress in Philadelphia, Pennsylvania (**Exhibit B**). The Subcommittee considered these data, and additional cases reported through the end of 2011. Recognizing that CNS infection may be mistaken for stroke in adults in some cases, the Subcommittee reviewed potential transmission events classified by the Committee as probable or proven donor-derived infection and also those reports where there was medical intervention (prophylaxis or treatment) without documented transmission. They considered the following elements for each of the donors reported:

   - Gender and age
   - Body mass index (BMI)
   - Cause of death
   - Mechanism and circumstance of death
   - "High risk" donor using current US Public Health Service Guidelines
   - History of diabetes
   - History of hypertension
   - Fever (defined as >37.5–38.3 °C (99.5–100.9 °F))
   - Results of any head CT or MRI completed and documented by OPO

   Subcommittee members agreed that differentiating between stroke and meningoencephalitis is critical. Unexpected cases with no history of hypertension, no previous trauma, presenting with CNS concerns and fever may be a demographic that does not fit with suspected stroke. The clinical presentation and course in the donor with ME is not always clearly defined. A careful review of the donor-derived disease ME transmissions reported did not identify a set of inclusive risk factors. In most circumstances, organs from donors with diagnosed treatable forms of ME (e.g. pneumococcal meningitis) were safely used if antimicrobial treatment is administered to both the donor and the recipient(s). In other cases, however, ME was mistaken for a stroke, and infection is not recognized or anticipated either through testing or medical-social history provided by friends or family of a potential donor. This scenario led to significant recipient morbidity and mortality if unrecognized. While there is no way to capture a denominator based strictly on information reported to the Improving Patient Safety portal, subcommittee members agreed

that donors who appear to be at risk for meningoencephalitis should probably not be utilized. The Committee suggested that all donors with fever (without another obvious cause) at or soon after presentation of illness and/or otherwise unexplained altered mental status should be considered for further evaluation to rule out ME.

If evidence suggests unsuspected or untreated CNS infection, the Committee believed that caution should be considered in proceeding with allocation and acceptance of the organs for transplantation. Additionally, if ME is suspected and the suspected pathogen is one for which there are no treatment options (viral pathogens), extreme caution is urged before using any organs for transplantation. Committee members agreed that risk must be balanced with risk of poor recipient outcome if this donor is not used, and suggested that appropriate information should accompany the informed consent process.

The Committee did not wish to cause fear or reduce the number of donors unnecessarily, but wanted to raise awareness regarding the potential morbidity and mortality surrounding this diagnosis in donors - especially when it is not recognized pre-transplant. A Committee member questioned how many potential donors may already be recognized as having a CNS infection and eliminated after evaluation. It was noted that a registry to capture information on discarded organs and donors that are not utilized would be beneficial not only from a disease transmission perspective, but also from a larger donor utilization interest. This would allow the transplant community to learn from these discarded donors and determine whether there needs to be additional education or policy modifications related to tissue. A Committee member noted that this may be an opportunity for partnership with the American Society of Transplantation's (AST) Infectious Disease Community of Practice (ID CoP) and also with the Association of Organ Procurement Organizations (AOPO).

Another suggestion was made that autopsy should be required for all organ donors. A Committee member noted that, even when an autopsy is completed, it is often difficult for the Host OPO to acquire the results. An informal survey completed by a Committee member indicated that it often takes an average of 2-3 weeks after organ recovery to obtain results and up to 6-9 months from some larger metropolitan areas. Some OPOs noted that they do not follow up on autopsy results for organ donors because they are not required to, though this is a requirement for tissue donors. Private autopsies were also noted to present unique challenges as compared to those completed by a medical examiner, as it is much more difficult to get final copies of these reports. After further discussion by the Subcommittee, this information was compiled into a guidance document meant to aid the transplant community in recognizing donors with CNS infection.

The Subcommittee presented the guidance document to the full Committee, and then requested additional feedback from the organ specific, Organ Procurement Organization (OPO), and Pediatric Transplantation Committees. The OPO and Thoracic Transplantation Committees approved of the document in concept, but shared concerns that perhaps the language as originally drafted might be too prescriptive to be considered a guidance document. The Subcommittee welcomed this feedback, and worked to modify the language based upon these comments and also revise its list of questions to be considered during donor evaluation to clarify the meaning and intent.

After considering the data and extended discussion, the Committee created a list of questions it suggests should be considered when evaluating potential organ donors:

- *What is the potential donor's age and cause of brain death? Were there any co-morbidities that may support stroke/CVA diagnosis (i.e. diabetes, hypertension, prior CVA) versus possible ME noted*? Pediatric and young adult donors are less likely to have a stroke or CVA compared to older adults. Accordingly, caution should be used in evaluating younger potential donors given

this diagnosis. While older adults being evaluated are more likely to have stroke/CVA diagnosis, atypical presentations and/or the absence of co-morbidities should prompt consideration for ME.

- *Did the potential donor have a fever at presentation of illness/admission* (Fever defined as >37.5–38.3 °C (99.5–100.9 °F))? If yes, was there a clear explanation for this fever? If not, ME should be considered.

- *Were altered mental status and/or seizures part of the presentation that led to the donor's hospitalization*? If these were new and/or unexplained events, ME may be considered.

- *Was a CT or MRI of the head, or lumbar puncture consistent with an infectious process? For example, was there an unexplained CSF pleocytosis, low CSF glucose, or elevated CSF protein without a clearly defined bacterial pathogen? Is there unexplained hydrocephalus- another potential indicator of CNS infection?* Abnormal CSF due to a clearly defined case of bacterial meningitis currently under treatment would be an exception. CT or MRI may show a focal finding like infarct or hemorrhage; however, this may not necessarily exclude a diagnosis of ME.

- *Was the donor an immunosuppressed host?* This includes donors with a prior history of transplant on immunosuppressive medications (including steroids), a donor on immunosuppressive medications for other reasons, or with a history of an underlying condition associated with immunosuppression (i.e. cirrhosis, end stage renal disease, and other immune disorders).

- *Did the donor have any potential environmental exposures associated with organisms causing ME?* These exposures will vary depending on the region of the country and the time of year. For example, a donor with a recent bat exposure and mental status changes could have rabies. A donor who spent a lot of time outdoors in an area with heavy West Nile Virus activity would be at greater risk for WNV meningoencephalitis.

    - It should be noted that homeless donors or any donors in whom obtaining an adequate medical social history is problematic may pose a unique risk due to difficulty in collecting medical-social history and living conditions that may put them at increased risk for transmitting infection (e.g. tuberculosis or extended outdoor exposure that may increase risk for vector borne illness- like WNV, Lyme Disease, rabies, etc).

The Subcommittee's updated draft (**Exhibit C**) was reviewed by the full Committee. After careful review, the Committee voted unanimously to recommend the guidance document for consideration by the Board of Directors:

*****RESOLVED, that the guidance document "Guidance for Recognizing Central Nervous System Infections in Potential Deceased Organ Donors: What to Consider During Donor Evaluation and Organ Offers" developed by the Ad Hoc Disease Transmission Advisory Committee is hereby approved, effective June 26, 2012.**

Committee vote: 21 in favor, 0 opposed, 0 abstentions

2. Summary of Potential Toxoplasmosis Transmission Cases. During its September 2011 meeting, the Committee discussed several recent cases involving transmission of toxoplasmosis from donor to recipient. There is currently no requirement for screening potential deceased organ donors for

Toxoplasma. During its rewrite of Policy 2.0, the Committee proposed that this screening become a requirement. A number of concerns regarding cost and feasibility were raised during the Spring 2010 public comment, and this proposed requirement was removed from the proposal before consideration by the Board. In light of these recent transmission events, the Committee chose to revisit this issue.

Fifteen individual potential donor-derived transmission toxoplasmosis events were identified between 2006 and 2011 (**Exhibit D**). Of these cases:

- Four were reported in 2011
- No reports were made in 2010
- Region 5 accounted for 40% of the reported cases (6 of 15)
- No cases were reported in regions 1, 2, 6, 8 or 9
- Thirteen cases (87%) involved a heart or heart-lung recipient.

Ultimately, 12 of the 15 cases reported were excluded or cancelled. These included cases where the donor was known to be positive prior to transplant and the heart recipient received prophylaxis (this would not be a required report per policy), as well as cases not believed to be donor related. The three remaining cases were classified by the Committee as proven or probable transmissions.

None of the current OPTN data collection forms indicate the donor's Toxoplasma status as positive or negative. A Committee member did not understand why this information is not collected. It was opined that perhaps the community does not believe this information is necessary because most recipients receive prophylaxis. This is apparently not the case, as there has been more than one death involved in the 15 events reported to the OPTN as potential transmission events. The Committee was concerned that the proposed addition of Toxoplasma screening was so controversial. It was suggested that whether or not the OPO or a transplant center completes the test, the results should be recorded within the UNet^{SM} data. It was also noted that this test does not need to be completed on a STAT basis, as immediate prophylaxis is not critical for this particular parasitic protozoan.

Though the numbers are small, Committee members agreed that this is an easily preventable transmission. While it appears that many OPOs and transplant programs have plans in place to complete testing and this seems to work in most cases, the Committee agreed that pursuing policy modification to formalize this process is beneficial. The Committee voted in support (14 in favor, 0 opposed, 0 abstentions) of pursuing this effort if it is approved as a 2012-13 goal by the Board. It was acknowledged that beyond policy modification, the Committee may choose alternatives for education regarding this issue as an alternative.

3. <u>Overview of Testing Policy Questions from the OPO Community</u>. The Committee received an overview on a number of questions arising from the OPO community regarding screening versus diagnostic testing and changing test and platform availability:
    - Concerns regarding the use of the term "commercially available" within Policy 2.2.4 and the desire for a clear definition of what this term means.
    - Questions related to the new 4th generation antigen-antibody tests that are approved as diagnostic and not screening tests by the FDA.

A member noted that the reason for including language to require FDA licensed, approved or cleared serological screening tests was to prevent the use of donor tests that were not certified in some way as appropriate for use in the specific conditions present at brain death. It was suggested that perhaps clarifications of the language may help to clarify that screening test is a first choice, and use a diagnostic test only if a screening test is not available. The difficulty, again, is determining what "available" means, as there are options for contracting with larger independent labs if you are unable to obtain appropriate testing locally, especially for non-STAT tests.

- Questions related to VDRL (a positive versus negative test) and RPR (and up and down level test that can be monitored) testing versus STS results for checking donors for Syphilis. RPR and VDRL are diagnostic test kits. It was suggested that the exceptions language within Policy 2.2.4 should be modified to indicate that diagnostic testing is acceptable for Syphilis rather than using the language, "… for VDRL/RPR."

A meeting attendee noted that the FDA is not currently enforcing screening requirements for Syphilis at tissue banks because test kit availability is so inconsistent at this time.

- Additional concerns regarding Policy 2.2.5 and whether new serology results (e.g. Hepatitis B or C as an example) results require matches to be re-run and whether voice-to-voice contact be required for communicating this information. These issues were referenced earlier in the meeting, and will also need to be considered.

The Committee agreed that a subcommittee should be convened to consider these issues and begin to work on clarifications and/or modifications to related policy language.

4. Continuing to Refine the Process of Identify Donor Transmitted versus Donor-Derived Malignancies reported as PDDTE. The Committee continues to try to clearly define donor transmitted versus donor derived tumors in potential transmission reports. Currently, the Committee defines donor transmitted tumors as those present at the time of transplant and donor derived donors as those that arise from donor cells, but are not present at the time of transplant. A pathologist on the Committee noted that determining whether a tumor is known or "seen" at time of transplant is subjective, depending on the lower limit of detection by ultrasound and other means. He suggested that one more objective approach to this might be based on tumor size, with tumor doubling time based upon the time it takes for tumor volume or (in the case of this Committee) tumor diameter to double (**Exhibit E**). The growth rate of malignant tumors was noted as generally falling between 30 and 500 days, with a median of 100 days. Based upon the data shared with the Committee on tumor doubling, a new definition was suggested:

   - Donor Transmitted Tumor- one that can be detected at time of transplant (assuming a one centimeter tumor may be reasonably detected and has a (median) doubling time of 100 days, then it will ideally be a three centimeter tumor at 17 months post-transplant.
     - As a first estimate, a tumor that is show to be of donor origin as is three centimeters or larger at two years post-transplant is regarded as donor-transmitted rather than donor-derived as proven otherwise.

   Committee members were supportive of this new method of defining tumors considered as part of case review, based on both pathology and measurements. A decision was made to utilize this distinction for the next year, and then review progress at one year.

   It was noted that the term donor-derived is used throughout the DTAC process on abstracts, guidance documents, and within policy. A suggestion was made to use the term donor cell derived to clarify that this new terminology is specific to malignancy case review to avoid confusion.

5. Potentially Unnecessary Discard of Kidneys with Small Sized Renal Cell Carcinoma. Renal Cell Carcinoma (RCC) is the most commonly reported potential donor-derived malignancy. After review of potential RCC transmissions reported for Committee review, it was noted almost half (26 of the 54) of the deceased organ donors with documented RCC ultimately ended up with both kidneys being discarded. In 18 reported cases where the unaffected kidney was utilized for transplant, no malignancy was transmitted; and as of last follow-up, there was no RCC reported in recipients of non-renal organs from these donors.

This information will be shared during an abstract presentation at the 2012 American Transplant Congress in Boston, Massachusetts (**Exhibit F**). Committee members agreed that there is concern that potentially useful kidneys may be discarded unnecessarily based upon these findings. They questioned what differentiated between the 18 contra-lateral kidneys that were transplanted as compared to the other 26 donors where both kidneys were discarded based upon findings in one. What are the characteristics of the 18 contra-lateral kidneys that were used as opposed to the 26 sets of kidneys that were discarded? If the kidney was recovered for the purpose of transplantation and then discarded, a discard reason must be provided from a drop down list within Secure Enterprise[SM]. Most RCC are not found until the kidneys are procured and fat is removed in preparation for transplant, and this usually takes place at the recipient center.

Data were requested regarding the discard reasons for discarded kidneys, donor age and the number of offers on placing these kidneys. Additionally, a suggestion was made to informally poll surgeons regarding their practices on considering the contra-lateral kidney when RCC has been found in its mate. A member noted that a survey may not reflect a clear picture, as responses may not match up with conservative practices at some centers. It was noted that there will be little objective data in this area.

A Committee member suggested the formation of a joint subcommittee with representatives of the Kidney Transplantation Committee to further discuss these concerns if the newly requested data indicate there is cause for concern and potential organ wastage of the contra-lateral kidney.

6. Update on 2011-12 Ongoing Goals and Projects. The Committee heard updates on various ongoing efforts, including committee goals and other educational efforts:

Newsletter Subcommittee. Committee members reviewed the November 2011 edition of the DTAC News (**Exhibit G**), which highlighted this group's abstracts presented at the 2011American Transplant Congress. The Committee plans a spring or early summer edition to cover this year's abstracts as well as some other educational items including information on using the contralateral kidney when renal cell carcinoma is found in its mate.

Joint DTAC-OPO Subcommittee on Sharing Updated Donor Information. Policy 2.2.4 currently requires the Host OPO to notify recipient centers when there is new or changed donor information learned after organ recovery and transplant. This notification must take place within 24 hours of the OPO receiving this new information. The Committee noted several instances of ineffective communication noted during review of potential donor-derived disease transmission reports. Some resulted in avoidable recipient morbidity and mortality. An abstract on communication gaps noted in these reports was presented at the May 2011 American Transplant Congress (**Exhibit H**).

While policy now requires prompt notification, it does not specifically state how this notification should be completed. During the November 2011, Board meeting, a recommendation was made to require voice-to-voice communication. For example, some Host OPOs may fax new information to recipient centers or call the importing OPO in the case of an exported organ. There is risk for information going unnoticed, getting lost, or not making it to the appropriate person at a recipient transplant center. A joint subcommittee with representation from the OPO Committee was convened on February 10, 2012, to discuss current communication practices and potentials for delays that may negatively impact organ recipients (**Exhibit I**).

OPO Committee participants shared their practices for communicating information. Staffing and resources varied widely among call participants, highlighting issues faced by OPOs nationwide. Voice-

to-voice communication over weekends and holidays could be potentially burdensome for smaller OPOs with only on-call staff available to work donor cases and manage these communications.

While the Joint Subcommittee did not agree that a change in policy was needed to require voice-to-voice contact, all agreed that education and guidance would be helpful. It was suggested that OPOs with effective methods of communication may be asked to share best practices with the community. Members agreed that evidence is critical to encourage the OPO community and raise awareness of poor outcomes related to delays in communication. The Committee feels strongly that policy language changes are critical to enhance patient safety in this area. A member noted that this needs to be framed as a patient safety issue and not a compliance issue to emphasize why voice-to-voice communication is so important. This effort was drafted as a potential 2012-13 goal for the Committee, and the issue will be addressed based upon feedback from the Policy Oversight and Executive Committees.

US Public Health Service Guidelines for Reducing Transmission of Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV) through Solid Organ Transplantation. A CDC representative provided the Committee with an update on the U.S. Public Health Service's ongoing efforts to update its 1994 Guidelines. CDC reviewed approximately one hundred public comments on the proposed recommendations. A Review Task Force will draft a revised document, taking into consideration feedback received. This draft will then be shared with the expert panel that was utilized for the first draft for review and discussion. Once consensus is reached within this group, additional feedback will be sought from the transplant professional societies and UNOS before the document is finalized and submitted for final clearance and release.

Members also briefly discussed the purpose and outline for the April 27, 2012, AHRQ-sponsored Increased Risk Consensus Conference, to be held in Chicago, Illinois. A number of Committee members attended this meeting, although this was not specifically a Committee effort. There are four working groups: donor evaluation, recipient evaluation, living donor evaluation and recipient consent. Each of these groups will report at the meeting. It was noted that this is an independent but related effort to the US PHS Guidelines. There is no obligation, however, for the CDC to utilize or draw from discussion at this meeting for this current revision effort.

Universal Donor Health Questionnaire. An update was provided regarding the ongoing efforts of a multi-disciplinary group to create a new medical-social history questionnaire to be used for potential blood, organ and tissue donors. The American Association of Tissue Banking took the lead on unifying these communities to formulate a common questionnaire. It was acknowledged that requirements vary for the different groups. This will be a minimum standard, but personalization for a specific region of the country or OPO is allowable to meet specific needs. The questionnaire was modified significantly after review of public comment, but is now ready for testing. A member noted the differences between first person consent (for blood donors) versus third person consent for tissue and organ donors. Validation will be difficult due to this issue, and it will be important to consider the validity of the data collected across the various donor types. Uniformity in how questions are posed was noted as an encouraging first step in this area.

7. Review of Suggested 2012-13 Committee Goals. The Committee briefly reviewed draft goals for 2012-13 (**Exhibit J**). These goals will first be reviewed by the Policy Oversight and Executive Committees before Board approval in June 2012. Proposed projects include:
    - Survey of OPO on Changes to Donor Screening Practices (a follow up to the October 2008 survey);
    - Updates to the Improving Patient Safety portal where potential donor-derived transmission events are reported by OPOs and transplant centers;

- Review of minimum screening requirements for deceased donor evaluation (due to changing test kit availability);
- Modifications to how new donor information received post-transplant is reported to recipient centers (possible voice-to-voice requirement in policy);
- Potential modifications to Policies 2.2.5, 2.2.6, and 3.2.4: Whether match runs should be re-run when serology results are updated;
    - A member noted that it will be important to note the frequency of discordant serology results for HIV, HBV, HCV and EBV. There will be a different component of weight depending on the disease.
    - Differences related to hemodilution, blood transfusion, etc also must be considered here.
    - Preliminary data is already requested to determine how many donors are being changed from pending to positive or negative to positive with or without change in match run.
- Modifications to require Toxoplasma screening during the evaluation of deceased donors.

8. Disease Transmission Reporting by Donor Service Area (DSA) and Region. Since its September 2010 meeting, the Committee has discussed variation in reporting within the various regions and donor service areas (DSAs). As a result bi-annual data was requested to better understand the potential for underreporting as the Committee works to review cases and assess the risk of donor-derived disease transmission (**Exhibit K**). There were 749 cases reported and reviewed by the Committee from 2006 through 2011. The dramatic year-to-year increases stabilized from 2009 to 2010, with another large increase in 2011. Regions 3 and 5 have reported the largest number of cases, while Region 1 has had the fewest reports during this period. It was noted that all OPOs have reported at least one case during this six year time period.

   When looking strictly at 2011 case reports, 13 of the 58 DSAs did not have any cases reported during this calendar year. The highest number of reported cases in a single DSA was 14.

   Members recognized that there is still concern regarding unnecessary reporting versus underreporting. A member opined that perhaps members with lower reporting rates may be more effective at knowing specifically what types of cases need to be reported. The group agreed that there is a need for clarifying policy language in 2.0 to better agree with 4.0 regarding reporting requirements. This effort, coupled with continued education, is expected to benefit the transplant community in better understanding these expectations.

   During the 2006-2011 time period, fifteen living donor cases were reported and discussed by the Committee. Nine of these were reported in 2011. Eight of these reports involved malignancy and the remaining seven involved infection. Five of the fifteen reports were classified by the Committee as proven or probable transmission events. The most common disease reported was renal cell carcinoma.

9. Donor Related Malignancies Not Reported to the Improving Patient Safety Portal. Over the course of the last five face-to-face meetings, the Committee has reviewed data related to donor-related malignancies reported on the post-transplant malignancy (PTM) Form, but not to the Improving Patient Safety portal as a potential donor-derived disease transmission event. The Committee requested an update on this information with follow-up from the transplant centers to determine why cases were not reported (**Exhibit L**).

   Post-transplant malignancies reported as "donor related" on the PTM forms with a diagnosis date of January 2007 through December 2011 were compared with reports to the Improving Patient Safety portal. A total of 70 donor related malignancies were reported, and 30 (42.9%) were reported as potential donor-derived disease transmission events. It was noted that the eight cases reported with a diagnosis date in

2011 were also reported to the Improving Patient Safety portal. Five additional cases reported from 2010-2011 were reported as donor related, but calls to the transplant centers led to corrected forms. These misreported events included data entry errors and misunderstanding of the system.

Within this 2007-2011 sample, there were 201 total recipients from 70 donors. Death occurred in 83 of these recipients (41%) from 52 donors. Thirty-six of these deaths were listed with malignancy as the cause of death (18% of the 201 recipients). The other deaths included less specific causes, but may have been related to malignancy.

It was noted that there continue to be cases reported on the PTM forms as donor related but not reported as potential donor-derived disease transmission events. Improvement has been seen in the past year. Staff consistently points members to the article in the February 2010 DTAC Newsletter for guidance on this topic (http://communication.unos.org/2010/02/disease-transmission-advisory-committee-launches-newsletter/). Staff will also work to develop a standing process for review of cases reported on the PTM form, but not reported for this Committee's consideration, and for following up with the centers make reports to one site but not the other if donor-derived disease is suspected.

10. Review of Policies and Bylaws Issues for Public Comment. The Committee reviewed the ten policy proposals released for public comment on March 16, 2012, during its face-to-face meeting.

    1) Proposal to Clarify Priority for Prior Living Organ Donors who Later Require a Kidney Transplant (*Kidney Transplantation Committee*)

       Upon review, the Committee determined that it had no comment regarding this issue.

    2) Proposal to Establish Kidney Paired Donation (KPD) Policy (*Kidney Transplantation Committee*)

       Upon review, the Committee determined that it had no comment regarding this issue.

    3) Proposal to Include Bridge Donors in the OPTN Kidney Paired Donation (KPD) Program (*Kidney Transplantation Committee*)

       Upon review, the Committee determined that it had no comment regarding this issue.

    4) Proposal to Allow Transplant Centers to Place Liver Candidates with HCC Exceptions on 'HCC Hold' Without Loss of Accumulated Exception Score (*Liver and Intestinal Transplantation Committee*)

       Upon review, the Committee determined that it had no comment regarding this issue.

    5) Proposal to Revise the Lung Allocation Score (LAS) System (*Thoracic Organ Allocation Committee*)

       Upon review, the Committee determined that it had no comment regarding this issue.

    6) Proposal to Require Reporting of Unexpected Potential and Proven Disease Transmission Involving Living Organ Donors (*Living Donor Committee*)

       The Committee heard from a member who had attended the Region 1 discussion of this proposal. She noted that they believed that the two year time frame had no basis, and that linking it to the two year period for post-recovery living donor follow up made no sense. They specifically asked

that this Committee provide some information for the timeline for proven transmissions to justify the two year window. The region was very adamant that pinning the time limit to another policy was not appropriate.
Committee members noted that in discussing this proposal with the Living Donor Committee before its release, they believed that an open ended time frame may be more appropriate. It was noted that current Policy 4.5 does not specifically set a timeline for reporting for either deceased donor or recipient. The Living Donor Committee felt strongly that the two year limit should be present in the proposed policy language. Several examples were provided from recent case reviews completed by the Committee where a year or more had elapsed since reporting. One such event was the highly publicized living donor HIV transmission. A member noted that the donor-derived versus transmitted discussion held earlier in this meeting indicated that approximately 18 months might be appropriate for malignancy transmission based upon tumor doubling rates.

Committee members recognized that living donors can be difficult to follow or track after recovery and recuperation, and that protecting the living donor's privacy is a concern. Screening living donors may be difficult for a two year period. Is it the recovery center's responsibility to track down this information if they are lost to follow-up but later found to have died due to malignancy? As an example, where does their responsibility lie in reporting, treatment and other aspects of care? It was noted that CMS may also interpret policy differently and hold centers to a different level of accountability. Additionally, a member noted that within living donor informed consent, it is noted that your recipient may learn things about you and that you have the opportunity to opt out of donation at any time if you are not comfortable with this relationship. A certain amount of disclosure regarding information that is relevant to the recipient should be expected.

A member asked if it would be helpful to reach out to other countries with a national system to learn more about their experience with living donors. It was noted that most countries outside of the U.S. still do not have national tracking systems for recording this type of information.

There have been cases of probable or proven transmission after two years of transplant. This, in conjunction with the understanding of tumor doubling that indicates transmission can be recognized 18 months or greater after transplant from a donor without suspected malignancy, supports the two year minimum period of follow-up. That being said, the Committee does not support requirements on centers to actively follow living donors, but believe that this should be passive. If you find out about a potentially transmissible condition that may have been present in the living donor at time of donation (e.g. final culture results received after recovery and transplant, updated or discordant test results, diagnosis of malignancy, etc.), there is an ethical/moral obligation to share this information with other parties that are involved.

After discussion, the Committee voted in support of the proposal with feedback. The Committee believes that follow-up up to two years post-recovery and transplant is justified based on the biologic behavior of certain tumors and infections, and that this Committee has noted case reports of new detection of transmissions at least at two years. (Specific case data cannot be shared due to confidential medical peer review protections.) Based on this information, the Committee believes it is reasonable to set two years as a time point; however, they acknowledge that to actively solicit this information is not feasible from all donors. Consequently, we think that if donor information is presented to the transplant centers during this time, it should be reported to the Improving Patient Safety system. We do not believe that the timeline should define the active mandatory reporting process (13 in favor, 0 opposed, 0 abstentions).

A member questioned how confidential reporting of diseases such as HIV would be handled post-transplant. It was noted that state health departments have varying requirements regarding how mandatory reporting is handled and contact tracing is managed.

7) Proposal to Require Extra Vessel(s) Disposition to be Reported to the OPTN within Five Days of Transplant or Disposal (*Operations and Safety Committee*)

   After discussion, the Committee voted to support the proposal as written (14 in favor, 0 opposed, 0 abstentions).

8) Proposal to Document All Locally Assigned Unique Identifiers in the Donor Record (*Organ Procurement Organization (OPO) Committee*)

   Upon review, the Committee determined that it had no comment regarding this issue.

9) Proposal to Update and Clarify Language in the DCD Model Elements (*Organ Procurement Organization (OPO) Committee*)

   Upon review, the Committee determined that it had no comment regarding this issue.

10) Proposal to Update Data Release Policies (*Organ Procurement Organization (OPO) Committee*)

    Upon review, the Committee determined that it had no comment regarding this issue.

11. Review of Reported Potential Donor-Derived Disease Transmission Events. The Committee completed its semi-annual review of potential disease transmission events reported to the Patient Safety System. Overall, 181 cases were reviewed and classified based upon the probability of donor-derived transmission for 2011. Of these cases, 29 were classified as proven or probable transmissions to date.

    The CDC ex officio member invited subject matter experts on Tuberculosis and Hepatitis B to dial in to discuss several specific case reviews led by the CDC in order to share their extensive knowledge on these cases and these diseases in general, specifically related to testing and treatment for immunocompromised organ transplant recipients.

    The Chair thanked Committee members responsible for refining case classification definitions and flow chart now used down to the individual recipient level for all 2012 reports (**Exhibit M**). Additionally, all were thanked for their efforts in reviewing and presenting cases at the monthly case review calls. Committee members were encouraged to carefully review as many cases as they could in order to promote thorough case discussion. Additionally, the Committee noted its appreciation to the CDC ex officio member for improved discussions and the introduction of subject matter experts into the discussions as needed to address both specific and general questions.

    The Committee was very supportive of the new flow chart, and encouraged the author to publish his work on developing the documentation related to classifying potential transmission events.

12. Reported Potential Donor-Derived Disease Transmission Events Not Posted for Full Committee Review. As case volume workload continues to increase, staff and Committee leadership worked together to develop a triage system for case management (**Exhibit N**). In addition to the 181 cases reviewed by the full Committee, patient safety staff also processed and additional 61 reports or queries:
    - 31 reports through the Improving Patient Safety Portal
    - 6 calls/emails requesting advice on whether to report

- 18 duplicate reports (OPO & TXC(s) report)
- 6 updates or patient safety situations mistakenly reported as new PDTE

Preparing a reported event for Committee review generally takes 2-3 hours of staff time. Had these additional cases been processed by staff, the case total would have reached 242. After discussing the effort involved in posting a case on SharePoint for Committee review, it was determined by Committee and organizational leadership that some reports do not warrant this level of effort because there is little for the Committee to discuss that relates to its charge. Examples of these types of reports include:

- Duplicate reports (OPO and one or more transplant center report the same event)
- OPO notifies recipient of new information (usually a final culture result covered by standard peri- or post-operative antibiotics. All recipients are doing well and receiving appropriate coverage for the new finding.)
- False positive test results (i.e. HTLV 1/2 screening was positive, but confirmatory testing was negative)
- Reported disease or malignancy developed 5+ years post-transplant
- Event is misreported (should have been reported as a patient safety situation or living donor adverse event)
- Non-transmissible or benign tumor is reported
- A suspected contaminant in a culture is reported, all recipients are well
- A potential donor with a positive test result is not pursued or all organs are discarded
- A reported transmission involving a blood product (not an organ donor)

In order to maintain case work load for both staff and Committee members, Committee leadership supported the creation of a triage system to eliminate such cases from full committee review. When such a case is reported (or any other questionable situation), staff notifies the Chair, Vice Chair and any other subject matter expert on the committee (frequently members with malignancy background) to determine if full committee case review if all recipient centers have been notified and all recipients are well. In any event where a full case review is not completed, centers are encouraged to contact staff with questions or concerns or even re-report if concerns related to the original report arise.

As a result of the new triage plan, 61 reports did not require full DTAC review. The majority of these events were duplicate reports and OPO reports of positive cultures such as Staphylococcus aureus in sputum when lungs were not used and post-transplant Toxoplasma positive results where recipients received prophylaxis and had no related problems.

Staff will continue to provide summary data of cases not reported at each of the Committee's face-to-face meetings, and a preview for cases not posted for full Committee review are still available to Committee members on the SharePoint site along with the Chair and/or Vice Chair's decision for not requiring full Committee consideration. Plans for developing specific criteria to screen out cases that do not require full committee reporting are ongoing, and staff believes this documentation will be very help to them as they continue to work to streamline the case management process.

Committee members encouraged educational efforts through the OPTN and professional societies to really emphasize this area of reporting and policy, as well as promoting the guidance document it developed in 2011 to assist the community in better understanding what and when to report a potential transmission event.

13. Recognizing Outgoing Committee Members. The Chair recognized the Committee members who are completing terms on June 30, 2012 for their time and dedication to the case review process. The Chair was also recognized for her service and leadership as she prepares for a one year ex officio term.

	MONTH	DECEMBER	JANUARY	FEBRUARY	FEBRUARY	MARCH	MARCH	APRIL
	DAY	8	10	9	23	8	28	12
	FORMAT (select)	Phone	Phone	Live Meeting	Live Meeting	Live Meeting	In Person	Live Meeting
NAME	COMMITTEE POSITION							
Emily Blumberg MD	Chair	X	X	X	X	X	X	X
Michael Green MD, MPH	Vice Chair	X	X	X	X	X	X	
Carrie Comellas BS, RN, CPTC	At Large		X	X	X		X	X
Edward Dominguez MD , FACP, FIDSA	At Large	X	X	X	X		X	
Afshin Ehsan M.D.	At Large		X	X		X		
Barry Friedman RN, BSN, MBA, CPTC	At Large	X					X	X
Thomas Gross MD, PhD	At Large	X			X	X		X
Daniel Kaul MD	At Large		X	X		X	X	X
Shimon Kusne MD	At Large	X		X			X	
George Lyon III, MD, MMSc	At Large		X	X	X	X	X	X
Rachel Miller MD	At Large	X	X	X	X	X	X	X
Samantha Mitchell RN, CCRN, CTBS	At Large							
Michael Nalesnik MD	At Large	X		X		X	X	X
Volker Nickeleit MD	At Large							
Martha Pavlakis MD	At Large	X	X	X		X	X	X
Timothy Pruett MD	At Large	X		X		X	X	
Phillip Ruiz Jr , MD	At Large				X		X	
Michael Souter	At Large			X			X	X
J. Elizabeth Tuttle-Newhall M.D.	At Large							
Linda Weiss	At Large		X		X			X
Russell Wiesner MD	At Large				X		X (phone)	
James Bowman III, MD	Ex Officio - HRSA	X	X	X	X	X	X	X
Bernard Kozlovsky MD, MS	Ex Officio - HRSA	X		X			X (phone)	
Raelene Skerda, RPh, Bpharm	Ex Officio - HRSA			X				
Susan Hocevar, MD	Ex Officio - CDC		X	X	X	X	X	X
Matt Kuehnert, MD	CDC		X			X	X (phone)	X
Shandie Covington BS	Committee Liaison	X	X	X	X	X	X	X
Kimberly Parker	Support Staff	X	X	X	X	X	X (phone)	X
Sarah Taranto	Support Staff		X	X	X	X	X	
Kimberly Taylor RN	Support Staff	X	X	X	X	X	X (phone)	
Cheryl Hall	Support Staff		X					
Anthony Daguison	Support Staff	X						
Cassandra Meekins	Support Staff	X	X	X	X	X		X
Kate Breitbeil	Support Staff					X		X
Franki Chabalewski, RN MS	UNOS Staff				X		X	X

James Alcorn	UNOS Staff						X	
Melissa Greenwald, MD	FDA- guest			X			X	
Tom Chiller	CDC- guest SME							X
Rachel Smith	CDC- guest SME							X