

OPTN/UNOS Kidney Transplantation Committee Meeting
Report to the Board of Directors
June 21-22, 2010
Richmond, VA

Summary

I. Action Items for Board Consideration

- Incorporation of Kidney Donor Profile Index [KDPI] into DonorNet®
The Board is asked to consider a request to incorporate kidney donor profile index [KDPI] into DonorNet® for the purposes of allowing clinicians to gain familiarity with this value prior to inclusion in an allocation system or as organ offer acceptance criteria. (Item 1, Page 3)

- Policy Language Update 3.5.11.2 (Quality of Antigen Mismatch)
The Board is asked to consider a request to update Policy 3.5.11.2 (Quality of Antigen Mismatch) to accurately reflect the current location of the antigen equivalency tables. (Item 2, Page 4)

II. Other Significant Items

- Progress towards developing a revised national kidney allocation system
The Committee continues its work to develop a revised national kidney allocation system. It has decided to advance the concepts of age matching and survival matching for public consideration as the platform for a new system. (Item 3, Page 5)

- Feedback on Draft Proposed Revisions to Pancreas Allocation System
The Committee provided feedback to the Pancreas Transplantation Committee on its plans for a revised pancreas allocation system. (Item 4, Page 8)

- Review of OMB Forms Proposal
The Committee provided review and feedback on the elements proposed for the Tiedi® forms. (Item 5, Page 9)

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OPTN/UNOS Kidney Transplantation Committee Meeting
Report to the Board of Directors
June 21-22, 2010
Richmond, Virginia

Kenneth Andreoni, MD, Chair
John Friedewald, MD, Vice Chair

This report details the deliberations of the Kidney Transplantation Committee during its conference calls on December 21, 2009, and April 15, 2010, and during its in person meeting on February 1, 2010. Major topics of discussion included the Committee's continued efforts to:

- develop a revised system for allocation of kidneys from deceased donors, and
- launch a national kidney paired donation pilot program.

I. Action Items for Board Consideration

1. Incorporation of Kidney Donor Profile Index [KDPI] into DonorNet®

Throughout the policy development process to revise the deceased donor kidney allocation system, the kidney donor profile index [KDPI] has been a well-supported component. During its February 2010 meeting, the Committee discussed strategies for releasing KDPI prior to an allocation system revision. The Committee decided to table this matter until the cost estimates and a plan for release were ready. These estimates and plans were described in May 2010 in an e-mail to the Committee.

The intent for releasing KDPI to clinicians in advance of any new kidney allocation system is to permit clinicians to gain experience with the calculation. The plan is two-fold. In Phase 1, a rather basic calculator (in the form of an excel spreadsheet) would be posted on the OPTN and UNOS websites. Educational material on KDPI would accompany this posting.

In Phase 2, the KDPI calculation would be incorporated into DonorNet® so that it is available at the time of organ offer and based on the real-time information submitted by the OPO. This is estimated to be a larger project that is similar in scale to the implementation of the CPRA calculation. While it is not yet known when KDPI may be incorporated into DonorNet®, the Committee learned that it is a project that can occur simultaneously with the re-write of the Waitlist (sometimes referred to as the Chrysallis project). Additionally, it appears that a central question about this project is not whether it should occur, but when. Incorporating KDPI into DonorNet® will have to be done at some point if the Committee plans to use KDPI as acceptance criteria and/or as part of an allocation system in the future. These costs are likely unavoidable, so the Committee was asked to consider whether incorporation of KDPI at this time provides benefits (e.g., education of transplant professionals and patients) that may facilitate the implementation of a new allocation system in the future.

The Committee discussed that even if KDPI is not incorporated into an allocation system in the future, it is being strongly considered by the Effective Screening (formerly Tiered Acceptance) Working Group, as a future acceptance criterion in Waitlist. Therefore, calculating and displaying KDPI in DonorNet® can provide value independent of whether/when a new allocation system is implemented, by better equipping transplant programs to make sound offer accept/decline decisions and potentially to screen unwanted offers from being made in the first place.

The Committee decided to send the following resolution to the Board of Directors for consideration during its June 2010 meeting with a vote of 10 in favor, 0 opposed, and 0 abstaining:

****Resolved that including kidney donor profile index (KDPI) into DonorNet® be incorporated into the schedule of work for the purpose of providing time for transplant professionals to gain experience and develop clinical familiarity with this calculation in advance of any possible inclusion in an allocation system or use of this value as organ offer acceptance screening criteria.**

2. Policy 3.5.11.2 (Quality of Antigen Mismatch) Update

During its December 21, 2009 conference call, the Committee considered a minor policy update (**Exhibit A**). Currently, Policy 3.5.11.2 (Quality of Antigen Mismatch) directs readers to a document that is no longer produced and maintained by the OPTN Contractor. The antigen equivalency tables mentioned in this policy are now located in Policy Appendix 3A. The policy should be updated to point members to the correct location of the equivalency tables.

The Committee unanimously voted to forward the following resolution to the Board of Directors for consideration.

****Resolved that, OPTN/UNOS Policy 3.5.11.2 (Quality of Antigen Mismatch) be revised as set forth below to reflect the current location of the antigen equivalency tables, effective pending notice:**

3.5.11.2 Quality of Antigen Mismatch. Points will be assigned to a candidate based on the number of mismatches between the candidate's antigens and the donor's antigens at the DR locus. An antigen mismatch occurs when a donor antigen would be recognized by the recipient as being different from the recipient's own antigens. Quality of match points are assigned as follows:

- 2 points if there are no DR mismatches, as defined in the table below or;
- 1point if there is 1 DR mismatch as defined in the table below.

HLA Mismatch Definitions*

Mismatch Category	# HLA Locus		
	A	B	DR
0 ABDR MM	0	0	0
0 DR MM	0	1	0
	0	2	0
	1	0	0
	1	1	0
	1	2	0
	2	0	0
	2	1	0
	2	2	0
1 DR MM	0	0	1

	0	1	1
	0	2	1
	1	0	1
	1	1	1
	1	2	1
	2	0	1
	2	1	1
	2	2	1

- Antigens that are considered to be equivalent for matching purposes are currently shown in Appendix C of UNetSM User's Manual. Appendix A to Policy 3. [...]

II. Other Significant Items

3. Progress towards developing a revised national kidney allocation system

During its February 1, 2010 meeting, the Committee discussed the results from several new runs of the kidney pancreas simulation allocation model [KPSAM]. Among these runs were one run to allocate kidneys to candidates within fifteen years (older and younger) of the donor and another run to allocate kidneys with the longest estimated survival to candidates with the longest estimated post-transplant survival [EPTS]. A third run under consideration combined both of these approaches. After careful consideration, the Committee voted to circulate for public comment the allocation system that combined matching of post-transplant survival and age matching. The following is an account of the deliberations leading to this decision.

Simulation modeling results

The Committee was presented the findings of the latest round of KPSAM simulation modeling (Exhibit B). The simulation modeling results are presented in their entirety in Exhibit C.

During its August 2009 meeting, the Committee requested several runs to investigate the effects of using age matching and survival matching as premises for organ allocation.

Run #	Name	Description
Run 35	Current	Current kidney allocation rules (as of January 2009)
Run 36	Current + extras	Current kidney allocation rules (as of January 2009) with the following changes --incorporation of the A ₂ /A ₂ B kidneys for B candidates allocation system --kidney follows pancreas organ allocation for SPK candidates locally --dialysis time or waiting time (whichever is longer) for each candidate) --removal of kidney paybacks
Run 37	Top 20% KDPI to Top 20% EPTS	Top 20% of kidneys (as defined by KDPI) are allocated first to the top 20% of candidates (as defined by estimated post transplant survival). All other kidneys are allocated according to the rules in Run 36.
Run 39b	+/- 15 years	Kidneys are first allocated to candidates within 15 years (older and younger) of the donor.

Run 40	Top 20% KDPI to top 80% EPTS	Top 20% of kidneys (as defined by KDPI) are allocated first to the top 80% of candidates (as defined by post-transplant survival).
Run 41a	Combination approach	Combination of Run 37 and Run 39b. Top 20% of kidneys (as defined by KDPI) are allocated first to the top 20% of candidates (as defined by estimated post transplant survival). All other kidneys (those with a KDPI score >20%) are allocated to candidates within 15 years (older and younger) of the donor.

It was explained that the KPSAM results for were one year of allocation only. Therefore, any benefits from reduction in the need for retransplant in the future (due to better matching of graft/patient survival) is not apparent in these results. The Committee was cautioned against reading too much into small changes as these are simulation models and a 1 percent change may or may not result in an actual change. KPSAM is based on current kidney acceptance patterns and that it determines a kidney to be discarded when it is not accepted within the first 200 offers. It may be unrealistic to assume that a kidney with a KDPI score in the top 20% would be discarded in actuality. Rather, that kidney would continue to be offered until it was placed.

The following table depicts the high-level results for each run presented.

Years	Run 35: current 2009 rules	Run 36: current 2009 rules + extras	Run 37: Top 20% to top 20%	Run 39b: Age match within 15 years	Run 40: Top 20% to top 80%	Run 41a: Top 20%, then within 15
Number of transplant recipients	10802	10974	10840	10788	10898	10930
Total lifespan after transplant	126155	125463	133542	139508	127542	140686
Total graft years of life	92808	92199	94036	95910	92708	97045
Total extra years*	54512	54197	56521	58965	55058	59309
Change in lifespan after transplant	691	(ref)	8,079	14,044	2,079	15,223
Change in graft years of life	610	(ref)	1,837	3,711	509	4,847
Change in extra years*	314	(ref)	2,323	4,767	861	5,112
Lifespan benefit per transplant	5.0	4.9	5.2	5.5	5.1	5.4

In summary, Run 36 (Current + extras) transferred 2-3% of all kidney-alone transplants from A2 to B recipients; reduced SPK transplants, increased allocation to African American recipients by 3% of all kidney-alone transplants and decreased allocation to Caucasian recipients by 4% of kidney-alone transplants, and may have reduced PRA 80+ access by roughly 2% of kidney-alone transplants.

When compared to Run 36, Run 39b (+/- 15 years) shifted 1,318 kidneys from recipients over 50; increased the extra lifespan of the candidate list from a year's worth of transplants by 4,767 years, or 3.6 years per shifted kidney, increased the graft lifespan by 3,711 years, or 2.8 years per shifted kidney, did

not substantially change the distributions of recipient race or blood type, may have reduced zero antigen mismatched transplants and 0 HLA-DR mismatched transplants by roughly 2% of kidney-alone transplants; and may have increased access among recipients with glomerular disease and decreased transplants among recipients with diabetes by roughly 3-4% of kidney-alone transplants.

When compared to Run 36, Run 37 (Top 20% KDPI to Top 20% EPTS) shifted 719 kidneys from recipients over 50; increased graft lifespan by 1,837, or 2.6 years per shifted kidney; increased the lifespan after transplant (by 18,500 and 7,100 years respectively) and the total extra years of life (6,300 years and 3,200 years) realized from the kidneys available in a year; and may have reduced the number of transplants to diabetic recipients by 2-3% of kidney-alone transplants.

When compared to Run 36, Run 40 (Top 20% KDPI to top 80% EPTS) increased graft lifespan by 509 years, or 2.3 years per shifted kidney; shifted 219 kidneys; increased extra lifespan by 2,323, or 3.2 years per shifted kidney; and increased extra lifespan by 861, or 3.9 years per shifted kidney.

When compared to run 36, Run 41a (combination approach) shifted 1,179 kidneys from recipients over 50 compared to run 36; increased extra lifespan by 5,112 over run 36, or 4.3 years per shifted kidney; increased graft lifespan by 4,847, or 4.1 years per shifted kidney; and resembled run 39b (+/- 15 years) in terms of years saved and distributions of recipients.

Discussion of the KPSAM results

Based on the results, the Committee focused its discussion on Run 41a (combination approach) and Run 39b (+/- 15 years). Of primary concern were the results by age category. While each system analyzed indicated a decrease in transplants for older candidates and an increase in transplants for younger candidates, some felt that these results were a worst case scenario. KPSAM models acceptance rates based on current acceptance practices and it is not used to predict the effects of changes in behavior under new allocation rules. The Committee expressed that acceptance of kidneys from older donors and from donors with higher KDPI scores is likely to increase under a system where organ offers are based on age. Many on the Committee remarked that a large proportion of kidneys currently discarded are actually transplantable and would be utilized under a different allocation system.

A Committee member asked the representatives from the Health Resources and Services Administration (HRSA) to explain their current position on an allocation system that would shift kidneys from older candidates to younger candidates. It was noted that the results of the simulation modeling should not be compared to present day kidney allocation as the distribution of candidates has changed remarkably over the past 20 years. Rather, the historical context needed to be presented so that individuals would understand that candidates over the age of 65 have experienced a 400% increase in transplants over the past 20 years while younger candidates have experienced a nearly 30% decrease. HRSA explained that any shift of organs from older candidates to younger candidates is politically unpalatable and that the current distribution of recipients should be considered as the baseline. However, the KPSAM results may not provide the full picture of the number of kidneys that would be transplanted into older individuals under different organ allocation rules. HRSA intends to further investigate changes that may occur in organ acceptance under different organ allocation rules. It was explained that there needs to be a public clarification that it's the federal government's understanding that age is an appropriate component to meet

the policy objectives of the OPTN Final Rule. HRSA is working on a Federal Register notice to this effect.

The Committee discussed the benefits and limitations of both 39b (+/- 15 years) and 41a (combination approach). The concerns about 41a (combination approach) included the fact that it is more complicated. However, this approach does provide additional system flexibility for future policy development. If the OPTN's ability to predict patient and graft survival improves over time through improved data collection, it would be possible to expand the survival matching portion of the system. The parameters for both age and survival could be changed in response to changing waiting list dynamics, potentially averting the need for a major system overhaul for many years. Additionally, 41a (combination approach) results in better outcomes in terms of life years from transplant, graft survival, and patient survival. While 39b (+/- 15 years) is easier to understand, many on the Committee were concerned that it does not provide the same level of flexibility as 41a (combination approach). Without a major system redesign in the future, the OPTN would be limited to adjusting only candidate and donor age parameters as a way of modifying the allocation system.

The Committee discussed whether to release both 39b (+/- 15 years) and 41a (combination approach) as proposals but decided that this would not be a feasible approach because there is not a mechanism for assessing the feedback. The Committee envisioned a situation in which a letter-writing campaign resulted in a ballot stuffing competition. The Committee wants to receive thoughtful comments, not form letters. Given the amount of work that has gone into designing KDPI and its general acceptance by the transplant community, the Committee ultimately selected 41a (combination approach) to circulate for public comment.¹ The Committee determined that it could revert to 39b (+/- 15 years) if the feedback suggests that there is not enough support to advance 41a (combination approach).

4. Feedback on Draft Proposed Revisions to Pancreas Allocation System

Dixon Kaufman, MD, Chair of the OPTN/UNOS Pancreas Transplantation Committee presented an update on the draft proposal for a new pancreas allocation system (Exhibit D). Dr. Kaufman emphasized the importance of the involvement of the Kidney Transplantation Committee as well as other Committees in the development of this proposal.

One member asked how the disincentives were removed in this proposal for living donors before solitary pancreas transplant. It was explained that there are currently 28 DSAs where kidneys follow the pancreas but where the SPK candidates are prioritized ahead of pancreas alone candidates. So if the candidate is on the SPK list and gets a living donor kidney and become a pancreas alone candidate, he or she loses quite a bit of priority. It was also explained that they were not trying to incentivize living kidney donation, just remove a barrier to this practice. Some members were concerned that the policy proposal

¹ Following the Committee's February 1, 2010 meeting, the OPTN Executive Committee determined that the Committee should not use the formal public comment process as it is actually seeking feedback on the concepts of age matching and survival matching at this point. Public comment was determined to be necessary at the point when the Committee has a policy proposal. The Executive Committee recommended instead that the concepts be circulated for a period of time during which the Committee would receive feedback to incorporate into a formal policy proposal to be circulated for formal public comment at a later time. The Executive Committee stated that this approach would fulfill the OPTN's commitment to two rounds of public comment on this initiative.

would result in markedly shorter waiting times for SPK candidates and that it would be unlikely that any of them would pursue living donation.

Some concern was expressed regarding the criteria for Type 1 diabetes. It was noted that the Pancreas Transplantation Committee is trying to strike a reasonable balance with getting a reasonable volume of SPK candidates transplanted while realizing that pediatric and highly sensitized kidney-alone candidates are also high priority. Unfortunately, there are relatively few objective criteria for Type 1 diabetes that are not too restrictive. Some members expressed concern that the criteria are too loose and would encourage candidates with Type 2 diabetes to list for SPK.

The pediatric perspective was expressed, specifically that SPK candidates are competing for the same donor population that the pediatric candidates are. In this proposal, the pediatric candidates come secondary to SPK candidates. While the simulation results did not show a detriment to pediatric candidates, this could be problematic in DSA's where there is an aggressive pancreas transplant program.

Some members were concerned about the BMI threshold of 32 being too high, a recommendation was made to drop this value to a BMI of 30. One member recalled that candidates with Type 1 diabetes have extremely high LYFT scores because of their high mortality on the waiting list, but there are no data to suggest that candidates with Type 2 diabetes experience similar mortality rates. Dr. Kaufman explained that there are data to support a limited role for pancreas transplants for a small number of candidates with Type 2 diabetes. The Pancreas Transplantation Committee selected 32 because that is when insulin dependency increases and so in the absence of more compelling data, it is the best threshold available. While the Kidney Transplantation Committee agreed that these candidates should receive priority for pancreas transplant, it wrestled with whether these candidates should receive priority for kidney transplant. Perhaps they could receive priority for a pancreas but not as much priority for a kidney.

5. Review of OMB Forms Proposal

The Kidney Transplantation Committee convened by phone and Live Meeting on April 15, 2010, to review proposed changes to the data collected by the OPTN. UNOS Staff presented the proposal on behalf of the Policy Oversight Committee (Exhibit E).

By way of background, all OPTN forms must be reviewed and approved by the Office of Management and Budget (OMB) every three years. The OPTN initiated a review of the data elements in order to identify any necessary changes to the forms. This proposal details the recommended modifications to the data elements in Tiedi@. These recommendations follow a comprehensive review of all the data elements by OPTN/UNOS Committees, the Ad Hoc Data Management Group, an Expert Panel on Cardiovascular Risk Factors in Renal Candidates/Recipients, and the Policy Oversight Committee. The purpose of the changes is to add important variables that are not currently collected, clarify or modify questions on the forms, and eliminate variables that are redundant or no longer needed.

The Committee reviewed proposed changes to the Transplant Candidate Registration (TCR), Transplant Recipient Registration (TRR), and Transplant Recipient Follow-up (TRF) forms for kidney and kidney-pancreas candidates and recipients.

The Committee discussed whether the value of "unknown" should be allowed for method for ejection fraction. Members were concerned that allowing submission of "unknown" would lead to poor data

collection (i.e., data coordinators selecting unknown even when the method was known). The Committee felt that the methods allowed for ejection fraction (i.e., echo, cath, and nuclear scan) covered the majority of methods used for this particular diagnostic test, but that an additional option of “other” and “specify” should be allowed.

- Recommendation: Add options for “other” and “specify” to Method for Ejection Fraction on the TCR or TRR for kidney and kidney-pancreas candidates.
- Recommendation: In the data instructions for this field, make note that the ejection fraction test results should be the most recent available at time of listing.

The Committee then discussed the diagnosis of sleep apnea and method of treatment. Several committee members remarked that nearly all ESRD patients experience at least some symptoms associated with sleep apnea and that many carry a diagnosis of this condition. One member of the Committee noted that these fields were not recommended for collection by the Expert Panel. The Committee did not believe that the collection of this data would result in better outcome predictions.

- Recommendation: Do not add diagnosis of sleep apnea or sleep apnea treatment methodology to the TCR or TRR for kidney and kidney-pancreas candidates.

The Committee debated whether to retain the question about malignancies on the TRR. Ultimately, the Committee decided the average time between listing on the TCR and receiving a transplant (reported on the TRR) warranted continuing to collect this information on the TRR.

The Committee voted to remove medical condition at transplant from the kidney TRR just as it is being removed from the pancreas TRR and kidney-pancreas TRR because it is subjective.

- Recommendation: Remove medical condition at transplant from the kidney TRR.

The Committee found the question about atrial fibrillation on the kidney TRF and kidney-pancreas TRF to be confusing. It appears that the only options for response are “yes” and “no”. These options do not allow for mitigating circumstances such as medical management through medication, or to describe the timing of the atrial fibrillation. More information is necessary to collect meaningful information on atrial fibrillation to inform outcome measures.

- Recommendation: Clarify atrial fibrillation on the kidney TRF and kidney-pancreas TRF to account for timing of the event (e.g., currently, since last follow-up) and for other factors such as whether the condition is controlled with medication.

The Committee had several concerns with the recommendations to the living donor registration (LDR) and living donor follow-up (LDF) forms. Among these, the Committee did not believe that history of birth control use was specific enough to lead to meaningful collection of this information.

- Recommendation: Remove history of birth control use from LDR.

Additionally, the Committee did not believe that the question regarding ER or urgent care visits captured all of the hospital-related events that a living donor may experience or the reasons for these events. Further, the reasons for these visits should be documented so that it can be determined whether each visit was donation-related.

- Recommendation: Modify ER or urgent care visits on LDF to include hospital admissions. Also include a field for explanation about the visit or admission.

Finally, the Committee did not agree with the addition of chronic incisional pain to the LDF. Members of the committee explained that chronic incisional pain is an actual diagnosis, but that question as worded would capture donors who may have had discomfort at the incision site but do not actually have true chronic incisional pain as a condition. The Committee is concerned with living donor outcomes and is committed to improving data collection to inform donation decisions, but does not agree that inclusion of this data element is appropriate in its current form. A more useful method may be to include a severity scale as a follow-up question to chronic incisional pain, or to ask whether the donor has been evaluated by a pain management specialist.

- Recommendation: Remove or modify chronic incisional pain on the kidney LDF.
- Recommendation: Adjust recommended additions to the LDR and LDF to optimize the questions and answers so that good useable data will result for evaluating donor risk or improving donor outcomes.

An overall recommendation by the Committee is that substantial training on data entry be made available to everyone who enters data into UNetsm. The Committee believes that this training would result in substantially improved data quality for the OPTN.

6. Kidney Paired Donation

John Friedewald, MD, Chair of the Kidney Paired Donation Working Group described recent progress on efforts to launch a national kidney paired donation pilot program (KPDPP). Dr. Friedewald described the most recent history of KPD. HRSA had asked that the program be put on hold in August of 2009. In December, there were meetings among the leadership of the transplant community, including HRSA, UNOS, ASTS, AOPO, NATCO, ASHI, and SRTR representatives who discussed ways in which the OPTN should move forward in the areas of living donor transplantation and kidney paired donation oversight. A path forward was developed and HRSA allowed for the project to move forward. HRSA requested that UNOS add additional living donors and representatives of existing KPD programs to the KPD Work Group.

UNOS staff is contacting the selected KPD coordinating centers to determine if they are still interested in participating. Additional contracts may be necessary for all participating programs. These contracts will state that the programs will abide by the Operational Guidelines. Currently, if the MPSC determines that there has been a violation, the only penalty is that the program could no longer enter pairs in the KPDPP. Further details and a timeline will be available at the end of the planning phase (estimated date for release of timeline: March 2010).

Policy Development for KPD

HRSA directed the OPTN to develop interim policies to govern the KPDPP. Once adopted, members that violate these policies will be subject to policy compliance actions under the OPTN bylaws, up to and including member not in good standing. At the end of the KPDPP, the OPTN will make recommendations for permanent policies to govern the ongoing KPD program administered by the

OPTN. These policies will go out for public comment. These permanent policies *may* apply to all participants in *all* KPD exchanges. Work in this area is still in the planning phase as well.

The Committee will receive an update when more information is available and will be included in any KPD policy development. A member asked for the names of the four participating centers. These names will be released once all four centers sign the revised contracts.

7. Transplantation of Sensitized Candidates

Michael Cecka, PhD, Chair of the Histocompatibility Committee discussed some of the policy projects in development by the Histocompatibility Committee. The first is a proposal to require that deceased kidney donor HLA typing be performed by DNA methods and identify splits of HLA-A,-B,-Cw,-DR and -DQ antigens for kidney offers. It was explained that in 2008/2009, 20% of class I and 16% of class II donor HLA types were determined by serological tests alone. About 28% of discrepant HLA types involved donors who were HLA typed by serological methods. Additionally, labs cannot type HLA-Cw or -DQ antigens by serology. The Histocompatibility Committee has assessed availability of molecular technology and found that 98 of the 103 UNOS member laboratories that reported deceased donor types during 2008-2010 used molecular typing. There are only a few labs that do not have the technology to accomplish this testing. A member had a question about the sensitivity of the testing and whether there were going to be guidelines developed for unacceptable antigens. It was explained that even without requiring standardization, most labs do have fairly standard criteria for assigning these antigens. Another member remarked that this proposal is timely because both cost and access to the technology have been found not to be prohibitive.

The Histocompatibility Committee's efforts to develop a sliding scale for sensitization points based on CPRA were discussed. This is something that should be incorporated into the new kidney allocation system. Currently patients with 80+% CPRA receive 4 points. The Histocompatibility Committee proposes a linearly increasing point award ranging from 0-4 allocation points for patients with 20-95% CPRA. The Histocompatibility Committee also believes that patients with >95% CPRA should be given priority for any compatible donor because you are not likely to receive another offer within a reasonable amount of time.

Finally, the Committee discussed patients who are disadvantaged by CPRA because they are undergoing desensitization. In order to receive offers, these candidates undergo desensitization and have their unacceptable antigens removed. Under CPRA, the patient loses their 4 point priority when these antigens are removed. The Histocompatibility Committee wants to develop a variance under which you could freeze a candidate's CPRA while they are undergoing desensitization. This is a problem because almost all OPOs currently have a variance. One member recommended giving medical urgency points to these candidates, but this requires OPO involvement and unanimous agreement amongst all of the transplant centers. Someone remarked that the CPRA should be held static while unacceptable antigens are removed. A UNOS staff member explained that the CPRA is calculated based on the unacceptable antigens and that it cannot be held static. A member asked whether the four points would be necessary if these patients were in the top 10% for waiting time. Dr. Cecka remarked that when patients with longer waiting times are selected, many of them are receiving offers, but there are some patients who need the four points to continue to receive offers. A member asked the Committee to consider to support the concept of restoring the priority for these candidates. It was suggested that UNOS add a fake antigen for

patients undergoing sensitization that would automatically set the CPRA level to 85%. The Committee offered its support in the form of a joint subcommittee with the Histocompatibility Committee on this matter as it pursues solving this issue.

**Attendance during the
OPTN/UNOS Kidney Transplantation Committee
December 21, 2009
Conference Call**

John Friedewald, MD	Vice Chair
Richard Formica, MD	Region 1 Representative
Shamkant Mulgaonkar, MD	Region 2 Representative
Bernard Fischbach, MD	Region 4 Representative
William Bry, MD	Region 5 Representative
Paolo Salvalaggio, MD	Region 6 Representative
Alexander Wiseman, MD	Region 8 Representative
Mark Aeder, MD	Region 10 Representative
Erica Hartmann, MD	Region 11 Representative
Eileen Brewer, MD	At Large Member
Harold (Jack) Fassnacht, JD	At Large Member
Oscar Grandas, MD	At Large Member
Patricia Niles, RN, BS, CPTC	At Large Member
Steven Rayhill, MD	At Large Member
Sharon Swofford, MA, RN, CNN, CCTC	At Large Member
Sean Van Slyck BA, CPTC	At Large Member
Peter Stock, MD, PhD	Ex Officio
Monica Lin, PhD	HRSA
Robert Wolfe, PhD	SRTR
Keith McCullough	SRTR
Maureen McBride, PhD	UNOS Staff
Wida Cherikh, PhD	UNOS Staff
Ciara Samana, MSPH	UNOS Staff
Darren Stewart	UNOS Staff
Kerrie Cobb	UNOS Staff
John Hodges, MA	Visiting Board Member
Jill Marla McMaster, MA, CAPT-USNR (Ret)	Visiting Board Member

OPTN/UNOS Kidney Transplantation Committee

April 15, 2010

Conference Call and Live Meeting

Attendees

Ken Andreoni, MD	Chair
John Friedewald, MD	Vice Chair
Richard Formica, MD	Regional 1 Representative
Shamkant Mulgaonkar, MD	Regional 2 Representative
Ari Cohen, MD	Regional 3 Representative
William Bry, MD	Regional 5 Representative
Mikel Prieto, MD	Regional 7 Representative
Mark Aeder, MD	Regional 10 Representative
Erica Hartmann, MD	Regional 11 Representative
Eileen Brewer, MD	At Large Member
J. Michael Cecka, PhD	At Large Member
Harold (Jack) Fassnacht, JD	At Large Member
Dixon Kaufman, MD, PhD	At Large Member
James Bowman III, MD	Ex Officio
Monica Lin, PhD	Ex Officio
Ba Lin, MD	Ex Officio
Keith McCullough	SRTR
Wida Cherikh, PhD	UNOS Staff
Ciara Samana	UNOS Staff