

**INTERIM REPORTS OF THE  
OPTN/UNOS AD HOC DISEASE TRANSMISSION ADVISORY COMMITTEE  
March 28, 2012  
Chicago, Illinois**

The OPTN/UNOS Ad Hoc Disease Transmission Advisory Committee (DTAC) met in Chicago, Illinois on March 28, 2012, and considered the following items.

1. The Committee reviewed progress made on goals assigned by the Board of Directors for 2011-12. These efforts included the bi-annual newsletter and a guidance document under development by the Encephalitis Subcommittee.
2. Committee members started preliminary discussions on the topic of communicating new donor information. A new joint subcommittee was formed with members of the Organ Procurement Organization (OPO) Committee to discuss whether policy changes to require voice-to-voice communication of new donor information learned after organ recovery may enhance patient safety. The Committee received an overview of discussion from the Joint Subcommittee's first conference call.
3. A CDC representative provided the Committee with an update of efforts related to the U.S. Public Health Service's ongoing efforts to update its *Guideline for Reducing Transmission of Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and Hepatitis C Virus (HCV) Through Solid Organ Transplantation*. Members also briefly discussed the purpose and outline for the April 27, 2012 AHRQ-sponsored Increased Risk Consensus Conference. A number of committee members plan to attend this meeting.
4. The Chair provided a brief update on the Universal Donor Health Questionnaire, which will be tested for use across organ, tissue and blood donation soon.
5. The Committee heard a brief review of proposed goals for 2012-13 that will be considered by the Policy Oversight Committee, and later the Executive Committee. Many of these goals involve educating the transplant community regarding what has been learned during the review of reported potential donor-derived disease transmission events.
6. Data regarding the number of potential Toxoplasmosis transmissions reported to the OPTN was reviewed, as the Committee determines whether it would like to pursue educational efforts or policy modifications to reduce the number of such transmission events. Toxoplasma is not currently a screening requirement for potential deceased organ donors.
7. The Committee began to discuss a number of policy-related questions from the OPO community as testing quality and availability changes. Questions included: (1) screening versus diagnostic testing requirements, (2) 4<sup>th</sup> generation antigen/antibody test kits, and (3) clearly defining the term "commercially available" in policy. A subcommittee will be formed to discuss these questions in greater detail and determine whether policy modifications and/or education are warranted in these areas.
8. An update on potential disease transmission event reporting by region and donor service area was presented to the Committee for consideration. This is a standing update that Committee members receive at each face-to-face meeting on aggregate case numbers and types.
9. The Committee completed its semi-annual case review, finalizing classifications for cases reported from July through December 2011. At this time, subject matter experts from both the

Tuberculosis and Hepatitis B teams at the CDC joined the call to provide additional expertise related to testing and the interpretation of testing results.

Committee members received an update on cases reported to the OPTN but not shared with the full committee for consideration. Due to the volume of cases being reported, staff and Committee leadership worked to develop a triage system to rule out cases that do not warrant full committee review in an effort to streamline staff workload and reduce member email fatigue.

Committee members discussed the new classification system that has been employed for reviewing cases in 2012. From this point forward, all cases will receive an overall classification as well as a specific classification for each recipient of a reported donor. The Committee thanked Dr. Michael Nalesnik for developing the decision tree that helps drive this new classification process.

10. The Committee discussed ongoing concerns on how to best classify malignancy cases, discerning between what is a donor-derived versus a donor-transmitted tumor. Definitions of each term were considered and approved by the group for use.
11. Updated data regarding donor related malignancies not reported to the Improving Patient Safety system as a potential donor-derived disease transmission were reviewed by the Committee. Staff continues to follow up on events reported on a post-transplant malignancy (PTM) form as donor-related but not reported as a potential transmission event. It appears that educational efforts related to this issue are benefitting the transplant community, as there have been fewer incorrectly reported events as the committee has followed this data.
12. Committee members considered reported data regarding potentially unnecessary discard of kidneys with small sized renal cell carcinomas (RCC) found prior to transplant. A member questioned whether being conservative in this scenario is potentially being wasteful. Members agreed that there is perhaps not enough data at this point to take a strong stand against such discards, but hope to continue educating members regarding the possibility of excising small RCC found in hopes of still successfully using these kidneys. The group will continue to consider this data as it becomes available.
13. The Committee reviewed proposals released for public comment on March 16, 2012.
14. The Committee recognized outgoing members for their service and dedication, including the Chair, Dr. Emily Blumberg.

Dr. Emily A. Blumberg, Chair  
University of Pennsylvania Medical Center  
Philadelphia, PA

Dr. Michael Green, Vice-Chair  
Children's Hospital of Pittsburgh  
Pittsburgh, PA

Shandie Covington  
UNOS Staff/DTAC Liaison & Sr. Patient Safety Specialist  
Richmond, VA