

**INTERIM REPORT OF THE  
OPTN/UNOS AD HOC DISEASE TRANSMISSION ADVISORY COMMITTEE**

**May 12, 2011**

The OPTN/UNOS Ad Hoc Disease Transmission Advisory Committee met via teleconference on Thursday, May 12, 2011, and considered the following items:

1. The Committee received a brief update regarding CDC participation on DTAC calls. CDC is not participating in calls currently, but does receive case related emails. Staff reported that Dr. Eileen Farnon would no longer be working with the CDC BOOTS group that is involved in donor-derived transmissions. She is to be replaced by Dr. Susan Hocevar in July. In the interim, Dr. Matt Kuehnert and Debbie Seem will be handling nationally notifiable infectious condition reports.
2. Dr. Michael Ison, Chair of the Advisory Committee of Blood Safety and Availability (ACBSA) provided an overview of the June 7-8 meeting of this group. Both DTAC and the Operations and Safety Committee will be asked to provide overviews of their charge and role in patient safety and biovigilance. This is expected to be a standing relationship, with regular reporting. The SCBSA is being retooled and renamed to be more inclusive of the organ and tissue donation communities while still involving blood safety.
3. The Chair provided a brief update regarding the timeline for public comment on the soon-to-be released proposed changes to the US PHS “high risk” donor guidelines. The proposal is currently at HRSA now, and the upcoming public comment period is expected to run for 30 days. A release date has not been announced. A subcommittee has been formed and is at the ready for public comment release, but the Chair asked for additional OPO representation.
4. Members discussed how to best handle cases reported to the Improving Patient Safety Portal that are reviewed by UNOS Staff and the DTAC Chair and Vice-Chair and deemed not to require review by the full committee. Staff is currently tracking the number of such cases and will report out at an upcoming meeting. Such cases may involve duplicate reports, reports of positive tests or cultures known pre-transplant (expected transmissions), and final culture results reported to recipient centers where no recipients are showing signs or symptoms of disease, and/or suspected contaminants (ex one of four tubes show blood culture positive for Staph aureus). In all cases, the Host OPO still receives the PDTR form and notes notification of all recipient centers. A request is made for re-report or OPTN notification if related infection or disease develops. The Committee will continue to evaluate this process.
5. The Chair provided an introduction regarding the need for potential input from this committee related to the issue of transplant tourism. The Ad Hoc International Relations Committee has been looking at this issue for some time.
6. The Chair provided a recap of DTAC abstracts and shared the positive feedback and subsequent media coverage regarding the Miller et al abstract on communication delays in reporting potential donor-derived disease transmission events.
7. The Committee reviewed twelve potential disease transmissions with 45 day follow-up and assigned tentative classifications to each.

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