

**INTERIM REPORT
LIVER AND INTESTINAL ORGAN TRANSPLANTATION COMMITTEE
Conference Call, October 5, 2011**

1. Analyses of “Share 35.” The Committee reviewed analysis comparing the waitlist mortality for candidates with MELD/PELD of 35 or higher versus those listed in Status 1A and 1B, as requested of the SRTR during the July 2011 Committee meeting. The analyses included all candidates on the liver transplant waiting list between January 1, 2007 and December 31, 2009, who were listed in Status 1A, 1B, or MELD/PELD \geq 35 for the first time during that period. The cohort included 4,295 candidates listed with a MELD score of 35 or higher, 1,654 listed in Status 1A, and 232 in Status 1B. Two types of analyses were performed, an “intent-to-treat” analysis and an “as treated” analysis, as described below:

- *Intent-to-treat analysis:* patients were followed from the first date listed in Status 1A, 1B, or with a MELD/PELD score greater than or equal to 35, to the earliest date of death, transplant, or 1 year of follow-up.
- *As Treated Analysis:* patients were followed from the first date listed in Status 1A, 1B, or with a MELD/PELD score greater than or equal to 35 until the occurrence of death, transplant, MELD status change, removed from waiting list because of “improved” or “too sick to transplant”, or the 1 year of follow-up.

The Committee reviewed plots of risk of mortality in the first month, as well as stacked area plot of patient status in the first month (Status 1 and MELD35+). The SRTR noted that changes in Status occurs commonly in both the MELD35+ and Status 1 candidates (although the change in status is ignored in the “intent to treat” analysis).

The waiting list mortality is high for both the groups of candidates, and was highest for candidates in Status 1A early in the listing (during the first 5 days in the “intent-to-treat” analysis and first 12 days in the “as treated” analysis). Beyond those time frames (5 days for “intent to treat” and 12 days for “as treated”), those listed with a MELD score of 35 and higher have higher mortality than status 1A.

These analyses support the Committee’s proposal to offer livers regionally to candidates with MELD scores of 35 and higher, as is done currently for candidates in Status 1A and 1B.

2. Committee Responses to Comments. Each Committee must review all comments received on proposals it has circulated for public comment for incorporation into the briefing paper that is submitted to the Board. Several Committee members volunteered to assist in drafting the responses for comments received on the proposals circulated in during the Spring 2011 public comment cycle, which are being submitted to the Board for consideration in November 2011.
3. Subcommittee Updates. The Committee received brief reports on recent and upcoming subcommittee work. The MELD Enhancements and Exceptions Subcommittee had met by conference call on September 28, 2011, while the HCC and Liver Utilization Subcommittees have calls planned in October.

4. Proposals Circulated for Public Comment, Fall 2011. Committee members were assigned to review several proposals that have been circulated for public comment. The Committee will discuss these proposals and provide feedback to the sponsoring Committees during the December 14, 2012 conference call.
5. Review of Regional MELD/PELD Exception Agreements. The Committee was reminded that Policy 3.6.4.5 (Liver Candidates with Exceptional Cases) states that “Candidates meeting the criteria listed in 3.6.4.5.1–3.6.4.5.6 are eligible for additional MELD/PELD exception points, provided that the criteria are included in the clinical narrative. Unless the applicable RRB has a pre-existing agreement regarding for a higher point assignment for these diagnoses, an initial MELD score of 22/ PELD score of 28 shall be assigned. For candidates with Primary Hyperoxaluria meeting the criteria in 3.6.4.5.5, an initial MELD score of 28/ PELD score of 41 shall be assigned. These pre-existing agreements must be renewed on an annual basis.” The current Regional agreements will be reviewed to determine if any regions are currently assigning higher points for these exceptional case diagnoses, and, if so, the Region will be asked to renew these agreements. The Committee discussed reviewing all current agreements, so that the Committee is aware of what the regions are doing in this regard. There may be regional agreements that could be considered for national application.
6. Standardized Biopsy Form. Sandy Feng, MD, demonstrated the standardized biopsy form and accompanying resources that have been developed by the former Organ Availability Committee (OAC). The goal of this initiative is to improve the accuracy and completeness of the information provided to surgeons when considering a liver for their patients. These forms would not be mandatory, but would be provided by OPOs to their pathologists as a resource. The group has also developed an on-line resource, the Transplant Pathology Internet Services (TPIS) wiki page that includes the biopsy form, a “Pictorial Guide to Steatosis in Donor Livers,” and an overview of histopathologic grading of Hepatocellular Carcinoma (HCC), found here: http://tpis1.com/mwtpis/index.php?title=Main_Page.

The Committee discussed that different audiences (e.g., pathologists versus surgeons) may require different types of resources. For example, while the schematic diagrams of percent steatosis may be familiar to pathologists, it would also be helpful to have actual pictures of livers with different degrees of steatosis. Committee members felt that these resources would be very helpful. The OAC will be completing this task as it finishes up its work, and ask for a Committee volunteer to help finalize these resources.

Committee Participation, October 5, 2011

Kim Olthoff, MD	Chair	X
David C. Mulligan, MD	Vice Chair	
Shimul A. Shah, MD	Regional Rep. Region 1	X
Andrew Cameron, MD	Regional Rep. Region 2	X
Brendan McGuire, MD	Regional Rep. Region 3	
Mark R. Ghobrial, MD, PhD	Regional Rep. Region 4	X
Johnny C. Hong, MD	Regional Rep. Region 5	X
Jorge D. Reyes, MD	Regional Rep. Region 6	
David C. Cronin, II, MD, PhD	Regional Rep. Region 7	X
Michael D. Voigt, MB, ChB	Regional Rep. Region 8	
Lewis Teperman, MD	Regional Rep. Region 9	
John Fung, MD, PhD	Regional Rep. Region 10	
Michael Marvin, MD	Regional Rep. Region 11	X
Tom Mone	At Large	X
Kim Brown, MD	At Large	X
Kareem Abu-Elmagd, MD	At Large	X
Michael Charlton, MD	At Large	
James Trotter, MD	At Large	X
James Eason, MD	At Large	
Simon P. Horslen, MB, ChB	At Large	X
Goran B. Klintmalm, MD, PhD	At Large	X
Thomas Starr	At Large	
Fredric G. Regenstein, MD	At Large	
Srinath Chinnakotla, MD	At Large	X
Ryutaro Hirose, MD	At Large	X
Julie Heimbach MD	At Large	X
Ann Walia, MD	At Large	X
Ken Washburn, MD	At Large	X
Ken Murphy	Board Liaison	X
Sandy Feng, MD	Organ Availability Committee	X
James Bowman, MD	Ex Officio, HRSA	X
Monica Lin, PhD	Ex Officio, HRSA	X
Ba Lin, PhD	Ex Officio, HRSA	X
Peter Stock, MD	MMRF, SRTR Representative	X
Yi Peng, MS	MMRF, SRTR Representative	X
Jon Snyder, MD	MMRF, SRTR Representative	X
W. Ray Kim, MD	MMRF, SRTR Representative	X
Bertram Kasisky, MD	MMRF, SRTR Representative	X
Jory Parker	UNOS Business Analyst	X
Cheryl Hall	UNOS Business Analyst	X
Erick Edwards, PhD	UNOS, Assistant Director of Research	X
Ann Harper	UNOS, Policy Analyst	X