OPTN Pancreas Transplantation Committee
Meeting Summary
March 13, 2023
Conference Call

Rachel Forbes, MD, Chair
Dolamu Olaitan, MD, Vice Chair

Introduction

The OPTN Pancreas Transplantation Committee (the Committee) met via Citrix GoToMeeting teleconference on 3/13/2023 to discuss the following agenda items:

1. Public Comment Presentation: Create National Liver Review Board (NLRB) guidance for Multi-Visceral Transplant (MVT) candidates
2. Public Comment Presentation: Identify Priority Shares in Kidney Multi-Organ Allocation
3. Public Comment Presentation: Mandatory Usage of Offer Filters

The following is a summary of the Committee's discussions.

1. Public Comment Presentation: Create National Liver Review Board (NLRB) guidance for Multi-Visceral Transplant (MVT) candidates

The Committee received a presentation on the OPTN Liver and Intestinal Transplantation Committee's *Create National Liver Review Board (NLRB) guidance for Multi-Visceral Transplant (MVT) candidates* proposal.

Summary of discussion:

The Committee voiced support for the proposal. The Committee Vice Chair voiced concern for program behavior and that an increase in points every 90 days may result in a patient waiting for their score to become higher. The presenter mentioned that if the median meld at transplant (MMAT) plus 6 was done every 90 days at a three point increase, the recipient would get to a MELD of 40 in roughly 180 days. The presenter also mentioneds that since MVT candidates require such a small and specific pool of donors, it is not believed that transplant centers would not want to pass up on donors just to get a higher MELD score. Staff clarified that this is a question that the Liver and Intestine Committee did consider in the development of this proposal. Staff continued by noting that the initial push was to place these candidates at the top of the liver list; the three point increase was to slow this progression of those scores.

The Committee Vice Chair then asked if there were regions where there were differences between the model for end-stage liver disease (MELD) and median MELD at transplant (MMAT) for transplant that could present a disadvantage for liver patients? The presenter replied by stating that there would not be a significant impact on liver alone candidates since MVT candidates are such a small population. The Committee Vice Chair agreed with this and stated that the number for pancreas is so small that it is not believed that it should be a huge impact, however, it should be reviewed periodically in the case that the number increases in the future and needs to be addressed.

The Committee Vice Chair then asked to avoid taking the pancreas unless it is necessary, does the pancreas always need to be recovered at the frequency it is currently or are there situations where just

bowel and liver is needed and the pancreas is left if the patient is not a diabetic. The presenter confirmed that this would be dependent on the diagnosis of the patient and what their need is. The Committee Vice Chair continued by summarizing that something that could be considered is not to take the pancreas unless it is actually necessary and not just because it is available. The presenter agreed with this.

An SRTR representative inquired how often the liver is taken. The impression is that almost all of these procurements include the pancreas regardless whether there is a candidate available for the pancreas because it is believed that these organs are almost always procured unblocked.

A member voiced support for this proposal and commented that overall this change does not impact liver alone patints based on number of patients involved. It is also doubtful that this would impact pancreas allocation.

An SRTR representative added that this was looked into a few years ago and it was discovered that at least a porth of the pancreas is procured for technical reasons. There was a separate classification for those where there was a large majority of diverse roles where pancreata were transplanted for technical reasons only. When the pancreas is procured and classified this way, the transplant program does not have to do reporting outcomes for the pancreas and it does not count this way. The SRTR representative continued by summarizing that it is true that the overwhelming majority is done with a pancreas for technical reasons only and it is almost impossible to do a liver intestinal MVT candidate transplant without using a portion of the pancreas. However, this is a small number and tranditionally, this is something that the Committee has not had objections to.

Staff clarified that in the two year period after the implementation of acuity circles, there were 135 liver intestines – pancreas transplants, 13 liver intestine-kidney-pancreas and then five that were just liver intestine. Staff continued by stating that when discussing the multi-visceral population and most of the transplants that have historically occurred, do include the pancreas.

Next steps:

The Committee's feedback will be synthesized into a formal statement that will be submitted for public comment.

2. Public Comment Presentation: Identify Priority Shares in Kidney Multi-Organ Allocation

The Committee received a presentation on the OPTN Ad Hoc Multi-Organ Transplantation (MOT) Committee's *Identify Priority Shares in Kidney Multi-Organ Allocation* concept paper.

Summary of discussion:

The Committee voiced concern to qualifications for a safety net kidney. A member asked if there was any data for heart and lung at the one-year timeframe, specifically what is the number of patients who have a glomerular filtration rate (GFR) that would qualify them for a safety net kidney. The member continued by stating that those patients currently do not have timely access to transplant, but in the near future, those high quality kidneys will go instantly to those candidates. The Committee Vice Chair answered by stating there is currently a safety net for liver kidney but there is none for lung kidney and heart kidney. The thought is that as this has reduced the number of liver kidney for the liver patients, it should make more kidneys available for the kidney patients and others that need kidneys with the organ. Currently the heart-kidney and lung-kidney can take any kidney but to discourage that, the safety net is in place. The member replied by commenting that this would be surprising for lungs as the total number of lung-kidneys is fairly small. The incidence of end stage renal disease and chronic renal failure is at one-year for lungs. It has also been observed that the number of heart-lungs did increase

substantially over the years and may be due to the change in allocation for heart. The Committee Vice Chair agreed with this and stated that the data that the MOT Committee looked at, after the creation of safety net for liver-kidney, the increase in the number of liver-kidney decreased because of the availability of the safety net for those candidates to receive a kidney later if the patient has kidney failure. The Committee Vice Chair continued by agreeing that the number of lung-kidney is small in volume so it may not have a significant effect but is something for the MOT Committee to look into further. The motivation for wanting to do MOT reduces because if a heart transplant recipient should need a kidney within the next year, they would receive that priority; the average wait time is about 286 days after a patient qualifies for the safety net.

The member suggested consideration in getting an estimate; for all of the patients who received a lung and heart transplants, there should be an estimate of their their 12-month GFR and to know, as an estimate, the total number of patients that could potentially qualify for a kidney at 12 months. This data would be informative in thinking about how these kidneys may be allocated in the future.

Another member voices support for the concept in preserving a kidney for the vulnerable population, however as a representative of a pediatric transplant center, it seems unfair for a low KPDI kidney to be used by multi-organ, especially for liver-kidney and heart-kidney. In terms of weight for different MOT, it was suggested that there should be policy to govern this. The Committee Vice Chair agreed with these points and stated that from the public comment received so far, there is a general consensus among the community that this is an important policy to work on and provide guidance on how to allocate these different organs. There have also been suggestions that the MOT Committee is considering in terms of waiting time, waitlist mortality, and post-transplant survival.

A member stressed that it is important to remember that first and foremost, patients who are in need of a kidney-pancreas transplant are kidney patients. This is very different from the MOTs. The member suggested consideration in how to prioritize kidney pancreas patients or it can severely impact access to kidney transplantion for insulin dependent diabetics that would otherwise be candidates.

The Committee Vice Chair summarized the Committee's discussions in the general support for the concept paper with some concerns related to which multi organ should be prioritized as mentioned.

Next steps:

The Committee's feedback will be synthesized into a formal statement that will be submitted for public comment.

3. Public Comment Presentation: Optimizing Usage of Offer Filters

The Committee received a presentation on the OPTN Operations and Safety Committee's *Optimizing Usage of Offer Filters* proposal.

Summary of discussion:

A member asked if the default filters are specific to individual transplant programs or if they would be applied across all programs. The presenter clarified that the default filters would be applied across all programs and would be specific to the transplant program behaviors; the model-identified flters would be generated based on the acceptance practices of each program.

The Committee Vice Chair stated that medically urgent and highly sensitized candidates should be excluded and agreed with the automatic exclusions that were listed.

There were no further comments or questions. The meeting was adjourned.

Next steps:

The Committee's feedback will be synthesized into a formal statement that will be submitted for public comment.

Upcoming Meeting

- April 3, 2023 (Teleconference)

Attendance

- **Committee Members**
  - Dolamu Olaitan
  - Antionio Di Carlo
  - Colleen Jay
  - Dean Kim
  - Jessica Yokubeak
  - Mallory Boomsma
  - Maria Helena Friday
  - Nikole Neidlinger
  - Parul Patel
  - Randeep Kashyap
  - Ty Dunn
  - Todd Pesavento
- **HRSA Representatives**
  - Jim Bowman
  - Marilyn Levi
- **SRTR Staff**
  - Bryn Thompson
  - Raja Kandaswamy
  - Peter Stock
  - Jonathan Miller
- **UNOS Staff**
  - Joann White
  - Austin Chapple
  - Carol Covington
  - James Alcorn
  - Krissy Laurie
  - Lauren Mauk
  - Lauren Motley
  - Matt Cafarella
  - Sarah Booker
- **Other Attendees**
  - Vanessa Pucciarelli