OPTN Ad Hoc Multi-Organ Transplantation Committee
Meeting Summary
May 9, 2022
Conference Call

Alden Doyle, MD, MPH, Chair

Introduction

The Ad Hoc Multi-Organ Transplantation (MOT) Committee met via Citrix GoToMeeting teleconference on 05/09/2022 to discuss the following agenda items:

1. VOTE: Updated policy language for heart-kidney/lung-kidney proposal
2. Impact of kidney multi-organ transplantation on kidney-alone transplantation
3. Discussion/next steps

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

1. VOTE: Updated policy language for heart-kidney/lung-kidney proposal

Two minor, technical changes were made in the policy language. Members were asked 'Does the MOT Committee support sending this proposal to the OPTN Board of Directors at their June 2022 meeting?' Two members voiced opposition. No members abstained from voting. Eleven members voiced support for the proposal. The proposal received 11 votes in support, 0 abstentions, and 2 opposition votes.

Summary of discussion:

A member clarified that the purpose of the language revision is to reduce the potential for conflict in understanding. The Chair added that the policy language keeps with the spirit and intent of the policy and emphasized that the changes were technical.

2. Impact of kidney multi-organ transplantation on kidney-alone transplantation

In preparation for future work on prioritizing kidney multi-organ transplantation and kidney-alone transplantation, the Committee heard three presentations on the considerations between the two.

- Dr. Westphal's study considered the impact on the kidney-alone candidate who was next on the waiting list to receive the kidney if it had not gone to a kidney multi-organ patient.[1]
- Julia Foutz presented data was compiled for the OPTN Pediatrics Committee in December 2020 to understand if the prioritization of MOT candidates ahead of pediatric kidney-alone candidates adversely affects pediatric kidney-alone candidates.[2]
- Dr. Rachel Engen's research considered the impact that kidney-pancreas transplantation has on pediatric kidney candidates exclusively, but isolating the occurrences when the next sequential candidate on the match run was pediatric.[3]

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[1] Scott G. Westphal et al., "The impact of multi-organ transplant allocation priority on waitlisted kidney transplant candidates," *American Journal of Transplantation* 21, 6 (June 2021): 2161-2174. https://doi.org/10.1111/ajt.16390.
[2] Julia Foutz and Kelsi Lindblad, "Examining Kidney Priority for Multi-Organ Candidates Compared to Pediatric Kidney-Alone Candidates," OPTN Pediatric Committee, Descriptive Data Request Final Report, December 16, 2020.
[3] This research is currently unplubished.

3. Discussion and Next Steps

The Committee discussed the presentations and highlighted factors for consideration as they moved forward. The Committee could submit a concept paper for public comment to garner community feedback on how best to balance equity and utility for the kidney alone and kidney MOT patients.

Summary of discussion:

An attendee noted that the kidney-alone candidates most impacted were pediatrics, patients with long waiting time, and patients with high calculated panel reactive bodies (CPRA), and there may be strong equity and utility arguments for these candidates to receive those organs instead. A member commented that the Committee ought to keep the ethical framework for organ allocation at the forefront of their decisions and seeing the quantitative impact of on the sequential candidate helps that process.[4] A member added that the data Dr. Westphal shared represents a very large percentage of the pediatric kidney-alone waitlist, which tends to receive similar quality organs as MOT patients.

A member suggested that the Committee ought to consider the outcomes for the kidney-alone candidate that was next in line to understand if the added wait time lead to poorer outcomes. The member suggested looking at waitlist deaths for these patients, and all patients on the waitlist, to ensure that policy is improved from every perspective.

A member inquired if it is possible to distinguish the type of diabetes a kidney-pancreas recipient had by the data, suggesting that the group may be able to identify if there was a greater need amongst patients. Unfortunately, that data was not available during this analysis. A member inquired how they would parse out the extremely ill kidney-pancreas patients. The Chair suggested this could be distinguished by a variety of medical characteristics such as hypoglycemic unawareness, C-peptide, and separation of type 1 and type 2 diabetes. A member suggested greater stratification of kidneys by Kidney Donor Profile Index (KDPI) based on kidney-pancreas candidate characteristics.

A member noted that kidney-pancreas patients have historically had a high waitlist mortality rate compared to kidney alone patients which has resulted in the increased priority for these patients. However, it is imperative to parse out which kidney-pancreas patients are the most medically urgent in order to not inadvertently disadvantage pediatric patients. The member suggested this could be implemented in continuous distribution through a sliding scale that considers the growth impact for pediatric patients, noting that waitlist mortality is often not the most important consideration for this population. The presenter added that the cognitive growth needs to be considered in addition to physical growth. Members also expressed concern about patients who were listed after turning 18 years old, but were eligible as a pediatric patient but had decreased access due to socioeconomic factors.

A member inquired about the geographic variation that was depicted in Dr. Engen's research. The presenter and Chair both responded that there is a lot of variation in center practice, specifically identifying that not all kidney transplant programs perform kidney-pancreas transplants and some centers are more selective in their candidate acceptance criteria.

An attendee suggested developing a survival score that could be applied across these patient populations in order to develop a more equitable allocation system, suggesting that patients with 3-year versus 12-year survival should have different places on the match run. They expanded that not all MOT, kidney-pancreas, or safety net patients should take ultimate priority and highlighted the need to balance

[4] In June 2015, the OPTN Board of Directors approved an updated white paper by the OPTN Ethics Committee on *Ethical Principles in the Allocation of Human Organs.* https://optn.transplant.hrsa.gov/professionals/by-topic/ethical-considerations/ethical-principles-in-the-allocation-of-human-organs/.

different populations like pediatrics and high CPRA. A member commented that when extremely low quality organs are offered there is a negative impact on both equity and utility. A member added that due to the challenges associated with determining the quality of a pancreas, allocation ought to prioritize local pancreas donors for local pancreas recipients to reduce organ loss. A member added that it is important to have value judgements that are supported by relevant data.

Upcoming Meetings

- June 13, 2022

Attendance

- **Committee Members**
  - Alden Doyle
  - Chris Curran
  - Dolamu Olaitan
  - Evelyn Hsu
  - James Sharrock
  - Jennifer Prinz
  - Keren Ladin
  - Kurt Shutterly
  - Nicole Turgeon
  - Marie Budev
  - Molly McCarthy
  - Sandra Amaral
  - Shelley Hall
  - Stacy McKean
- **HRSA Representatives**
  - Jim Bowman
  - Marilyn Levi
  - Raelene Skerda
- **SRTR Staff**
  - Jon Snyder
  - Jonathan Miller
  - Katie Audette
- **UNOS Staff**
  - Ben Wolford
  - Eric Messick
  - Erin Schnellinger
  - James Jobes
  - Julia Foutz
  - Kaitlin Swanner
  - Kim Uccellini
  - Laura Schmitt
  - Lindsay Larkin
  - Matthew Cafarella
  - Rebecca Murdock
  - Robert Hunter
  - Ross Walton
  - Susan Tlusty
- **Other Attendees**
  - Lisa Stocks
  - Rachel Engen
  - Peter Reese
  - Scott Westphal