

OPTN Lung Transplantation Committee

Meeting Summary

February 17, 2021

Conference Call

Erika Lease, MD, Chair

Marie Budev, DO, Vice Chair

Introduction

The Lung Transplantation Committee (the Committee) met via Citrix GoTo teleconference on 02/17/2021 to discuss the following agenda items:

1. Public Comment Proposal: Change Calculated Panel Reactive Antibody (CPRA) Calculation
2. Public Comment Proposal: Establish Eligibility Criteria and Safety Net for Heart-Kidney and Lung-Kidney Allocation

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

1. Public Comment Proposal: Change Calculated Panel Reactive Antibody (CPRA) Calculation

The OPTN Histocompatibility (Histo) Committee Vice Chair presented their public comment proposal and asked for the Committee's feedback. The purpose of the proposal is to revise the current CPRA calculator to include additional human leukocyte antigen (HLA) loci and use higher resolution typing data from a significantly larger data set. This revised CPRA will better reflect actual sensitization and improve access to transplant for the highly sensitized and minority candidates.

Summary of discussion:

A member noted that while they are not an expert in HLA, they understood the rationale for and supported updating the data with a richer database and accounting for diversity. The member also stated that the lung community is likely underestimating unacceptable antigens, but there will be more information in continuous distribution since CPRA will contribute to a candidate's composite allocation score (CAS). A member questioned whether or not the information should be based on what is entered as unacceptable because there are times where antibodies are not listed since the program may accept the risk of one or two unacceptable antigens. The member asked if their listing practices would need to change due to how they would be expected to list unacceptable antigens. The presenter stated that transplant programs would need to work with their HLA lab to come up with a process that matches the process of the program. They continued to explain that unacceptable antigens can be adjusted for candidates.

Another member mentioned that they almost never list unacceptable antigens because they want to entertain any offer and stated that unacceptable antigen needs to be clearly defined. The member asked for clarification on if the process of a program is to not enter unacceptable antigens would the candidate be disadvantaged in their CAS, and members clarified that it would be a tradeoff. A member asked for clarification on which organ programs would be accountable for providing data on CPRA sensitization over 99% and the presenter clarified that it would only be a requirement for kidney and if it were to be applied to all programs the HLA laboratory director and transplant program medical director

would have to attest that the sensitization data is correct. UNOS staff added that the reasoning behind the requirement for kidney is that is the point that the offer is required to be a national share.

A member felt that adding the additional loci would have some benefit from a patient safety standpoint but it is hard to be sure since it is not really monitored in terms of outcomes. They added that time will determine the true tradeoff of the CPRA CAS benefit versus not including unacceptable antigens and considering all offers. The presenter explained that post-implementation monitoring would review that information. A member stated that if there are antigens that a program would not cross for a patient, and those patients should be awarded the CAS points and if there is the chance that those “unacceptables” are accepted, they should not get the points in their CAS.

2. Public Comment Proposal: Establish Eligibility Criteria and Safety Net for Heart-Kidney and Lung-Kidney Allocation

The Vice Chair presented the Ad Hoc Multi-Organ Transplantation (MOT) Committee’s proposal to establish policies for heart-kidney and lung-kidney allocation. The proposal would establish criteria to make heart-kidney and lung-kidney patients eligible for a multi-organ transplant and that eligibility is based on the patient’s kidney function. The proposal also will create criteria for prioritizing patients who previously received either a heart or lung transplant, and now need a kidney transplant. The prioritization is referred to as a “safety net” for these patients. The proposed eligibility criteria and safety net prioritization are intended to improve equity in access to transplant for both multi-organ and single-organ patients.

Summary of discussion:

A member stated that when thinking through this proposal, they felt that the safety net is important because several programs have looked at patients while trying to adhere to organ stewardship and if a candidate has a higher than 30 estimated glomerular filtration rate (eGFR) the program wrestles with if that is a good candidate for transplant or not. A member pointed out that multiple studies have shown that patients have poor outcomes (over 50% mortality) when they go into Stage 5 renal failure and need dialysis within the first year of their lung transplant. They also noted that some programs try to establish a living donor in anticipation that the recipient may need a kidney transplant, but acknowledged that there are instances where it is not anticipated so it is important to have these safety nets in place. Another member voiced support for the proposal and felt it would improve access to lung transplant and provide a fairer assessment of a patient’s candidacy for transplant.

The Vice Chair mentioned that the comments that came from the Region 10 meeting were supportive since they felt some kidneys are going to not medically suited candidates and another member stated that their Regional Meeting was unsure how sick the lung candidates were that would be pulling kidneys. The Vice Chair explained that there has been some concern over CAS cutoff, but that it is an opportunity for education since the CAS is different than the lung allocation score (LAS). A member noted that this may change the listing practices at some programs since they know there is that safety net in place for lung candidates with moderate kidney disease and asked if there would be monitoring of program metrics as this is implemented. The Vice Chair acknowledged that program behavior may change and will be something that is monitored post-implementation.

A member mentioned that they thought it was interesting that Sequence A kidneys would not be available to safety net candidates and the Vice Chair clarified that it was proposed that way to assure the community that the highest quality organs would not be going to safety net candidates. A member added that even the lowest quality kidneys that would be allocated would have a projected five year

graft survival of over 60 percent. A member asked if there has been modeling done on how long safety net candidates end up waiting for a kidney and the Vice Chair clarified that lung should expect the same time frames as liver which is about 109 days.

Upcoming Meetings

- March 17, 2022
- April 21, 2022

Attendance

- **Committee Members**
 - Erika Lease, Chair
 - Marie Budev, Vice Chair
 - John Reynolds
 - Julia Klesney-Tait
 - Whitney Brown
 - Errol Bush
 - Cynthia Gries
 - Denny Lyu
 - Nirmal Sharma
 - Marc Schecter
 - Dan McCarthy
 - Jasleen Kukreja
 - Scott Scheinin
 - Soma Jyothula
 - Kelly Willenberg
 - Pablo Sanchez
 - Karen Lord
- **HRSA Representatives**
 - Jim Bowman
 - Marilyn Levi
- **SRTR Staff**
 - Katie Audette
 - David Schladt
 - Maryam Valapour
- **UNOS Staff**
 - Elizabeth Miller
 - Susan Tlusty
 - Krissy Laurie
 - Leah Slife
 - Sara Rose Wells
 - Holly Sobczak
 - Courtney Jett
 - Eric Messick
 - Kaitlin Swanner
- **Other Attendees**
 - John Lunz
 - Laurel Avery
 - Matt Hartwig