

**OPTN/UNOS Pancreas Transplantation Committee
Report to the Board of Directors
June 23-24, 2014
Richmond, Virginia**

**Jonathan Fridell MD, Chair
Jon Odorico MD, Vice Chair**

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This report reflects the work of the OPTN/UNOS Pancreas Transplantation Committee during December 2013 through April 2014.

Action Items

None

Committee Projects

1. Require the Collection of Serum Lipase for all Pancreas Donors

Public Comment: March – June, 2014

Board Consideration: November 2014 (estimated)

The proposal to Require the Collection of Serum Lipase for all Pancreas Donors is currently out for spring 2014 public comment. It proposes to make serum lipase a required field in Policy 2.8.E (Required Information for Deceased Pancreas Donors), as well as required in DonorNet®, in order to make electronic pancreas offers. Currently, serum lipase is a listed field in DonorNet®, but is not required in order to make electronic pancreas offers. Serum lipase levels in deceased donors are reliable indicators of pancreas function and quality. As such, the serum lipase values assist in making an informed clinical decisions regarding electronic pancreas offers.

Further, it proposes to create a new field in DonorNet® where OPOs will report the upper limit of normal (i.e. maximum normal value or highest reference value) of the laboratory's normal serum lipase reference range. The reason for programming this new field is because laboratories' measurement ranges vary for serum lipase. As a result, a serum lipase value may have two different meanings at two different laboratories. This results in varying "normal" serum lipase values across the country. This new field will provide a reference point regarding the serum lipase value to the physician making the decision whether to accept the pancreas.

The Organ Procurement Organization (OPO) Committee is the only Committee that has opposed the proposal. The OPO Committee did not vote on the proposal, however it did comment that for remote regions it may be difficult for smaller OPOs to report serum lipase values at the time of the electronic pancreas offer. Notably, the data indicate that from 2010 through 2012 all OPOs in the US reported serum lipase on donors who have their pancreas recovered for transplant (99%) but not on donors who do not have their pancreas recovered for transplant (79%). In this period, in all DSAs where a pancreas donor was recovered, lipase values were reported for almost all of the pancreas donors. Further, the Pancreas Committee reached out to several smaller OPOs to inquire about their ability to collect serum lipase at the time of an electronic pancreas offer. The smaller OPOs that the Pancreas Committee contacted indicated that reporting serum lipase at the time of the electronic pancreas offer would be an extra task to complete, but is possible.

2. Definition for Pancreas Graft Failure

Public Comment: Fall 2014 (estimated)

Board Consideration: June 2015 (estimated)

Currently, there is no definition for pancreas allograft failure. In order for the Membership and Professional Standards Committee (MPSC) to monitor pancreas graft survival the MPSC needs a definition for pancreas allograft failure. As such, the Committee continues its work to establish a definition for pancreas allograft failure. The Committee's previously drafted definition for pancreas allograft failure is:

Pancreas graft failure has occurred if a Type 1 diabetic pancreas recipient has:

- a stimulated C-peptide less than 0.4 and is insulin dependent;
- undergone a pancreatectomy;
- been retransplanted; or
- died.

This definition includes a c-peptide threshold that indicates pancreas graft failure. The Committee performed a review of the literature in an effort to determine the appropriate c-peptide threshold for graft failure, however these reviews were inconclusive. In addition, c-peptide is not currently collected in the data system.

As such, the Committee has undertaken a retrospective data collection project in order to define the most appropriate c-peptide threshold within the pancreas graft failure definition. This project consists of collecting pancreas transplant recipients' c-peptide values at pre-transplant and graft failure for recipients who reported pancreas graft failure to the OPTN.

A preliminary review of the findings thus far show that c-peptide data is stored in varying formats. The formats include both continuously and categorically measured values, and the submitted data indicate that the values can be collected on different scales. The next step in the project will be to compile the submitted data from transplant centers. The data shows the c-peptide values pre-transplant and at graft failure for patients who reported pancreas graft failure, after transplant, to the OPTN. The Committee will then analyze the resulting multicenter data in order to determine the relationship between c-peptide values pre-transplant and at graft failure to establish the c-peptide threshold within the definition of pancreas allograft failure.

3. Pancreas as a Part of a Multivisceral

Public Comment: Spring 2015 (estimated)

Board Consideration: November 2015 (estimated)

The problem this project aims to solve is a discrepancy in whether a transplanted pancreas counts as a transplanted organ, during multi-organ transplant events. This inconsistency in reporting creates data discrepancies and inconsistent practices for post-transplant follow-up. It is important to note that the Committee will not be changing how organs are allocated, rather, it aims to change how the organs are reported in practice.

Previously, the Pancreas Transplantation Committee attempted to solve this discrepancy by setting a donor weight threshold for when a pancreas should be accounted for as transplanted (in combination with other organ(s)). Pancreata from donors above a certain

weight would be counted as transplants and pancreata from donors below a certain weight would not be counted as transplants. However, this was not seen as a viable solution by all interested parties.

As a first step to solve this discrepancy, the Committee voted on a definition for multivisceral transplants. The Committee voted in support of referring to a multivisceral transplant as “Liver-Intestine-Pancreas” and a modified multivisceral as “Intestine-Pancreas”. The Committee is exploring how to incorporate these definitions into the data collection system and any policy implications.

In addition several representatives from the Pancreas Committee will be participants on the Policy Oversight Committee’s (POC) multi-organ workgroup. There will be Pancreas Committee representatives on the POC’s workgroup to ensure that the two committee’s projects support each other and do not conflict.

4. Pancreas Underutilization

Public Comment: Spring 2015 (estimated)

Board Consideration: November 2015 (estimated)

The goal of the Pancreas Underutilization project is to determine why there is a decline in the number of pancreas transplantations and why a significant number of transplantable pancreata are not transplanted. This investigation may involve literature review, analyzing trends in OPTN data, and conferring with outside experts on the subject. The Committee is discussing everything from issues with the organ offer process through transplant. This project entails a broad look into allocation challenges, facilitated pancreas allocation updates, and issues from procurement to transplant (e.g. technical challenges, communication challenges, best practices).

Currently, the Committee is investigating the reasons behind increasing trends in pancreas discards, and depending on data and research results, the Committee may draft a “Best Practices” or “Guidance Document” in order to reduce the rising trend in discards. The Committee is also analyzing and updating the pancreas facilitated allocation section of Pancreas policy. This section of policy has not been updated recently and the Committee has identified several areas of improvement. Notably, the Committee identified that centers should have to meet certain requirements in order to participate in facilitated allocation. Further, there should be a monitoring mechanism to ensure that participating centers effectively and efficiently utilize the facilitated allocation option.

Pancreas Discards

The Committee had observed there are many pancreas allograft discards for reasons such as surgical error, surgical damage, and poor allograft description. Some of these discards may have to do with the experience level of the procuring surgeons, particularly if they are trainees. The Committee is investigating the reasons for the pancreas discards and is assessing whether there are any processes or policies that could help to reduce these discards.

Next steps for moving this project forward include identification of:

1. Reasons for increased pancreas discards
2. Solutions or mitigating factors for eliminating or reducing pancreas discards

- Best communication methods for sharing identified solutions or mitigating factors with the transplant community (i.e. draft a guidance document, draft transplant procedure best practices document, draft guidelines for the transplant procedure, Webinar, Podcast, etc.)

Data

The Committee reviewed and discussed Figures 1 and 2, based on Table 1 below. Figure 1 shows the number of pancreata recovered, discarded, and transplanted for deceased donors recovered in the U.S. from 2000-2013.

FIGURE 1. Number of Pancreata Recovered, Discarded, and Transplanted¹

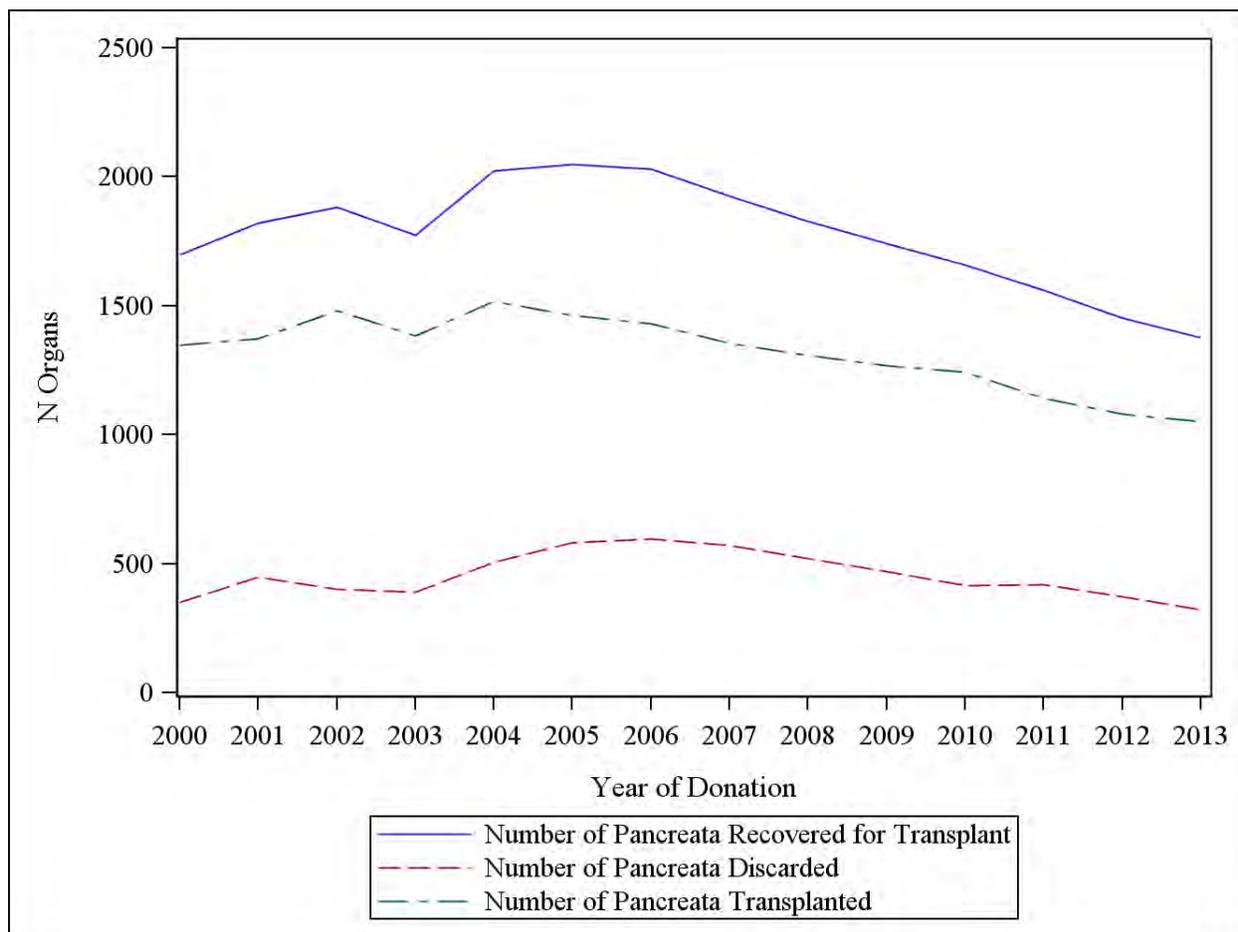


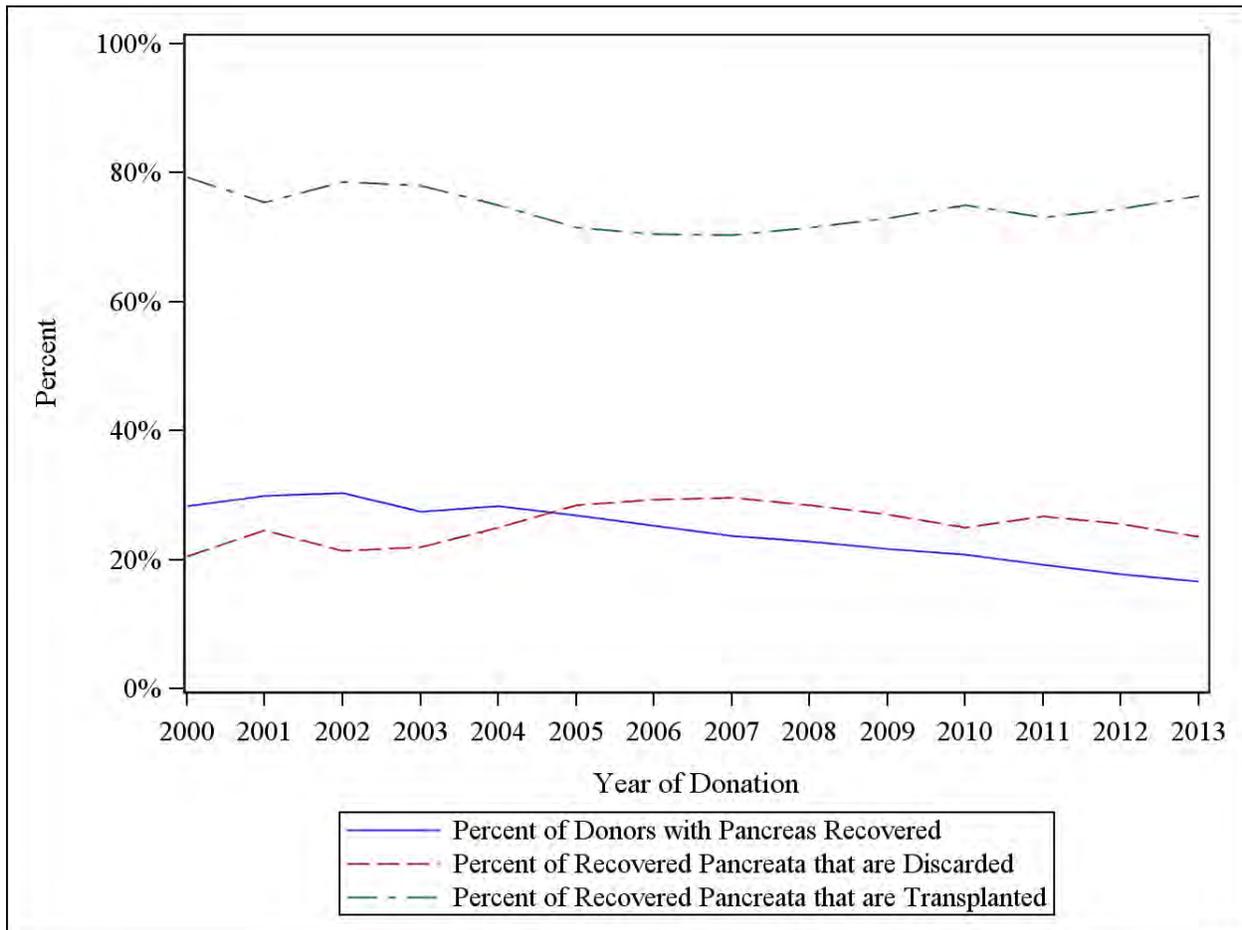
Figure 1 shows that the number of pancreata that are recovered for transplant overall and then either transplanted or discarded has been declining since 2003-2005 after an increase early in the 2000s. The percentage of the pancreata that are recovered for transplant and are transplanted has remained steady around 75%, and the percent of these organs that are recovered for transplant and then discarded has remained relatively stable at 25% (Figure 2). The reason these graphics indicate a trend in underutilization, perhaps, is that the

¹ Based on OPTN data as of April 4, 2014. Data subject to change based on future data submission or correction.

number of deceased donors has increased over time (Table 1) while the number of donors where the pancreas was recovered for transplant has decreased (along with the percentage). So, although the percentage of discarded pancreata has remained stable, and the number of discards has been level this is likely tied to the fact that fewer donors are having their pancreas recovered.

Figure 2 shows the percent of deceased donors with pancreata recovered for transplant, and percent of organs that were recovered for transplant and discarded or transplanted for deceased donors recovered in the U.S. from 2000-2013.

FIGURE 2. Percent of Deceased Donors with Pancreata Recovered for Transplant, and Percent of Organs that were Recovered for Transplant and Discarded or Transplanted²



² Based on OPTN data as of April 4, 2014. Data subject to change based on future data submission or correction.

Table 1 shows the Deceased Donors Recovered in the US from 2000 through 2013. It shows the number and percent of pancreata recovered, discarded, and transplanted.

Table 1. Deceased Donors Recovered in the U.S. from 2000 through 2013 - Number of Pancreata Recovered, Discarded, and Transplanted³

Year of Donation	N Donors	Number of Pancreata Recovered for Transplant	Percent of Donors with Pancreas Recovered	Number of Pancreata Discarded	Percent of Recovered Pancreata that are Discarded	Number of Pancreata Transplanted	Percent of Recovered Pancreata that are Transplanted
2000	5985	1698	28.37%	350	20.61%	1348	79.39%
2001	6080	1821	29.95%	447	24.55%	1374	75.45%
2002	6190	1883	30.42%	403	21.40%	1480	78.60%
2003	6457	1775	27.49%	391	22.03%	1384	77.97%
2004	7150	2022	28.28%	506	25.02%	1516	74.98%
2005	7593	2048	26.97%	583	28.47%	1465	71.53%
2006	8017	2029	25.31%	597	29.42%	1432	70.58%
2007	8085	1924	23.80%	570	29.63%	1354	70.37%
2008	7989	1829	22.89%	520	28.43%	1309	71.57%
2009	8022	1740	21.69%	471	27.07%	1269	72.93%
2010	7943	1660	20.90%	416	25.06%	1244	74.94%
2011	8126	1562	19.22%	419	26.82%	1143	73.18%
2012	8143	1451	17.82%	372	25.64%	1079	74.36%
2013	8267	1376	16.64%	324	23.55%	1052	76.45%
Total	104047	24818	23.85%	6369	25.66%	18449	74.34%

Facilitated Pancreas Allocation

The facilitated pancreas language in Policy 11.7.A has not been updated since 2007 when DonorNet® was implemented. As such, the Committee's goal is to clearly define the purpose of the facilitated pancreas allocation and to align the policy language to meet this purpose in the DonorNet® era.

When a transplant hospital agrees to participate in facilitated pancreas allocation that transplant hospital agrees to accept offers for pancreas on a conditional basis. The conditional basis is pending tissue typing information and redistribution of the organs if there is a candidate on the waiting list for whom there is a zero antigen mismatch. In addition, the transplant hospital must have a written agreement with the Organ Center to participate in facilitated pancreas allocation.

The OPO can use facilitated pancreas allocation to allocate a pancreas if *at least one of the following* occurs:

³ Based on OPTN data as of April 4, 2014. Data subject to change based on future data submission or correction.

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- No candidate accepts a pancreas offer from the Organ Center within five hours of the first offer
- The Organ Center is notified that procurement of the pancreas will occur within one hour

Then, the Organ Center must offer the pancreas to pancreas candidates in the order of the match run who meet the following criteria:

- Have not previously received an offer for that pancreas.
- Isolated pancreas candidates with unacceptable HLA antigens reported to the OPTN Contractor sufficient to yield CPRA \geq 80%.
- Combined kidney-pancreas candidates if the kidney is voluntarily being offered.

Notably, the OPO elects to use the facilitated pancreas allocation process but the Organ Center makes the actual offers when performing the facilitated pancreas allocation process.

The Committee agreed that the facilitated pancreas allocation serves a purpose, which is for aggressive pancreas transplant centers to attempt to transplant imperfect pancreata. As such, the Committee believes the facilitated pancreas allocation process should remain in policy. Further, the Committee agreed that the facilitated pancreas allocation policy needs thorough revision. Revision of the policy will include consideration of the following topics:

- Notify centers about the facilitated pancreas policy
- Development of draft qualifying criteria
- Establish time periods for when the transplant center may decline an initially accepted pancreas
- Create a process to routinely review participating centers performance in this process
- Address the logistics of shipping a pancreas and sharing costs
- Suggest procurement techniques and procurement standards

5. Patient Brochure for Pancreas and Islet Allocation

Public Comment: n/a

Board Consideration: n/a

The Committee will release a patient brochure on pancreas, kidney-pancreas, and islet allocation in early summer 2014. This brochure will be released in conjunction with educational efforts for the implementation of the new pancreas allocation system. The brochure's format will coincide with existing organ-specific patient brochures and aims to answer frequently asked patient questions regarding pancreas, kidney-pancreas, and islet allocation. The Committee has been working in conjunction with the Patient Affairs Committee on this project in order to ensure that the information is relevant and understandable for the patient population.

6. Review Pancreas Primary Physician and Surgeon Bylaws

Public Comment: Spring 2015 (estimated)
Board Consideration: November 2015 (estimated)

The Committee continues its review and update of the pancreas and islet bylaws. Specifically the Committee has agreed upon clarifying language, analyzed the time periods associated with surgeon and physician procurements, is working to clarify language for pediatric programs who perform multivisceral transplants which include pancreata, as well as update the islet program and personnel requirements.

The Committee has provided updates to the Membership and Professional Standards Committee (MPSC) at its December 2013 and March 2014 in-person meetings. In addition, MPSC support staff have been actively involved in this project.

The Committee has also sought input and feedback from the Collaborative Islet Transplant Registry (CITR) regarding updates to the islet program and personnel requirements. CITR is in the midst of discussing their feedback and will present its feedback to the Committee in late spring/early summer 2014.

This project was originally scheduled to go out for fall 2014 public comment. However, the Joint Societies Working Group (JSWG) identified this project for their review. As such, the JSWG will review this project and give the Committee a recommendation. Once the Committee receives the JSWG's recommendation the Committee will incorporate the recommendation and proceed with the project. The JSWG does not have deadlines tied to its review so it is unknown when the Committee will receive the JSWG's recommendation. As such, this project is on hold until the Committee receives the JSWG's recommendation.

7. Investigating Characteristics Resulting in Improved PAK Outcomes

The purpose of the project was to draft a manuscript on risk factors associated with PAK outcomes. In support of this, the SRTR compiled data into a cohort entitled, "Pancreas-After-Kidney (PAK) Transplant Outcomes: Analysis of Risk Factors". The Committee reviewed the data and was unable to derive conclusions that warranted drafting a manuscript. As a result, the Committee closed the project.

Committee Projects Pending Implementation

8. Implementation of Pancreas Allocation System

Public Comment: Spring, 2010
Board Approval: November 2010
Implementation Date: August – October, 2014 (estimated)

The proposal for a new and efficient pancreas allocation system is scheduled to be implemented between August – October 2014. This allocation system creates waiting time qualifying criteria for kidney-pancreas candidates and places kidney-pancreas candidates and pancreas candidates on a combined match-run list.

The Committee and support staff are collaborating with the UNOS Communications and Instructional Innovations departments to create and disseminate communication and educational efforts to members about the new allocation system. Specifically, the Committee

established an “Implementation Subcommittee” to review documentation associated with the communication and educational efforts on the new allocation system. Notably, the Implementation Subcommittee has reviewed slide sets, the patient brochure, and an FAQ document, all of which focus on the new pancreas/kidney-pancreas allocation system.

Implemented Committee Projects

None

Review of Public Comment Proposals

The Committee reviewed six of the seventeen proposals released for public comment from March 2014 – June 2014.

9. Greater Consistency in Candidate and Deceased Donor HLA Typing Requirements Across Organ Types (*Histocompatibility Committee*)

The Committee supported this proposal overall. The Histocompatibility Committee asked for specific feedback on one element of the proposal, presenting two programming options for communicating donor HLA-DQA and –DPB. This specific feedback was requested because the Board of Directors previously defeated an earlier proposal to program optional fields for DQA and DPB into DonorNet® and Waitlist to be used for donor screening.

Option one included programming fields for HLA-DQA and –DPB in DonorNet® only. With this option, donors would not automatically be screened from candidates with unacceptable antigens to these HLA types. The HLA information would have to be reviewed by the candidate’s physician when making organ acceptance decisions, which would divert from the current programming in UNet. Several Committee members speculated there could be potential patient safety issues with this option, because the physician may not be aware of the need to view the additional HLA information. Others were concerned that this option may lead to an increase in organ discards resulting from unexpected positive crossmatches late in the organ allocation process.

Option two included programming DQA and DPB fields to capture donor HLA and candidate unacceptable antigens, and automatically screening incompatible candidates from donors.

The Committee indicated a strong preference for option two over option one, but if option two is not feasible, then the Committee supports option one at a minimum (13 in favor; 0 opposed; 2 abstentions).

10. Proposal to Align OPTN Policies with the 2013 PHS Guideline for Reducing Transmission of HIV, HBV, and HCV Through Solid Organ Transplantation (*Ad Hoc Disease Transmission Advisory Committee*)

Committee members inquired how the 28-day time period (where all living potential donors should be tested for HIV, HBV, and HCV as close as possible to the date of the organ recovery operation, but at least within the 28-day time period prior to surgery) was determined. UNOS staff and a HRSA representative explained that initially, the Committee looked at the one-week requirement and determined that 7 days was too short of a time period due to the logistics of the required testing that had to be performed. Therefore, the Committee decided to extend the time period to 28 days. A Committee member agreed that 7 days was too short a time period but explained that her center could complete the required testing within two weeks.

The Committee voted in support of the proposal as written (14 in favor, 0 opposed, 0 abstentions).

11. Proposal to Modify ABO Determination, Reporting, and Verification Requirements (Operations and Safety Committee)

One of the Committee members asked if there have been recent incidents with ABO incompatibility, because if there had not been recent incidents then he did not see the purpose behind the proposal. The Operations and Safety Committee representative confirmed there had been a recent incident but could not share the details due to peer review privileges. In addition, UNOS staff explained that current studies show there have been recent near misses that also supports the need for this proposal.

The Operations and Safety Committee representative further explained that the goal of the proposal is to fill in any policy gaps and ensure that Operations and Safety related policies are in alignment with CMS, and to ensure consistent practice across OPOs and Transplant Centers. The representative explained that this proposal will create consistent and firm processes, and with consistent and firm processes in place, OPOs and transplant centers will be able to avoid potential adverse incidents.

A Committee member explained that it is not the OPO's responsibility to perform a deceased donor organ recovery verification, since the OPO does not know what the recipient's ABO is except from what the OPO sees on the match-run. The Committee member further explained that transplant program representatives do not arrive at the operating room with printouts of their recipients ABOs. In other words, the proposed policy may be inconsistent with practice. The member explained that he supports the proposal, and supports any safety measure, but he does not believe that the proposal aligns with current practice.

The Operations and Safety Committee representative explained that this proposal is an effort to create consistent practice and that by the nature of the verification process it has to be done in partnership with the OPO and transplant center. Further, the burden of proof for documentation resides with the OPO.

The Committee member explained that he does not support the idea that the OPO has the burden of proof on the ABO verification because the OPO does not have source documentation to compare the donor's ABO to the candidate's ABO, and that burden cannot be on OPOs. The member wants to make sure that the CMS language and proposed policy language does not state that it is the OPO's responsibility to ensure there is ABO compatibility between the donor and the recipient, beyond executing a match run and allocating the organ. The member explained that OPOs do not perform an ABO verification service, while in the donor's operating room, for the intended recipient.

The Committee voted in support of the proposal pending clarification on what is sufficient practice for OPO's to comply with the recipient ABO verification process (13 in favor, 0 opposed, 0 abstentions).

12. Proposal to Modify ABO Subtyping References for Consistency (Operations and Safety Committee)

The Committee voted in support of the proposal as long as the language is consistent with the new kidney allocation policy (13 in favor, 0 opposed, 0 abstentions).

13. Proposal to Allow MPSC Recommendation to the Board of Directors for Approval Consideration of a Non-qualifying Transplant Program Applicant in a Geographically Isolated Area (*Membership & Professional Standards Committee*)

Committee members expressed a concern about creating the option for an exception when there are currently criteria in which transplant professionals and hospitals must abide by (i.e. the Bylaws and Policies).

Another member noted that the Pancreas Committee previously made recommendations to the MPSC about what constitutes inactivity for pancreas transplant programs, and this scenario seems to encompass a pancreas transplant program that is egregiously inactive. A Committee member explained that he felt uncomfortable making such a large exception for a program that is clearly inactive. A member suggested that programs, like the one the proposal is set up for, could be put on a probation status or a limited status with temporary approval.

The MPSC representative reiterated that the proposal is only to set up a process where the Board of Directors can receive an exceptional recommendation from the MPSC. The MPSC representative explained that he was confident, should the proposal be approved, the Board of Directors (or as the MPSC) would impose a conditional approval on programs that utilize the exception process.

A HRSA representative pointed out that there is a large gap between the fixed criteria in the Bylaws and the appeals process which members may utilize should the member not fulfill the fixed criteria. Therefore, this proposal creates a narrowly construed middle ground in which non-compliant members have a process in which to be re-considered.

The Committee did not support the proposal as written (4 in favor, 4 opposed, 2 abstentions).

14. Proposed Membership and Personnel Requirements for OPTN Designation & Approval of Intestine Transplant Programs (*Liver and Intestinal Organ Transplantation Committee*)

The Committee voted to support the proposal as written (10 in favor, 0 opposed, 0 abstentions).

Other Committee Work

15. Islet Data

The Committee leadership aims to address current challenges within islet transplantation. The Committee has been working on re-establishing contact with CTR in order to maintain an exchange between OPTN data and islet outcomes data. As such, the Committee leadership met with a CTR representative to discuss the status of data sharing on islet outcomes. CTR was agreeable with exchanging information and is currently working on drafting an agreement to reflect their end of the exchange.

16. National Pancreas Offers Analysis

At the OPTN/UNOS Executive Committee meeting on May 18, 2007, the Executive Committee gave the Organ Center (OC) exclusive responsibility to make national kidney, kidney-pancreas, and pancreas offers. The Executive Committee communicated this decision through the May 23, 2007, System Notice (System Notice). Subsequently, the

national kidney offer portion of this decision was documented in kidney policy and remains documented in kidney policy to this day. However, the national kidney-pancreas and pancreas offer of this decision was only documented in the System Notice. In pertinent part, the System Notice stated:

Effective Wednesday, May 23, 2007, all kidney, kidney-pancreas, and pancreas offers that extend beyond regional placement will be made exclusively by the UNOS Organ Center. This decision was approved by the Executive Committee as a temporary process change until more specific screening criteria can be programmed and the system can be modified to allow OPOs to access and use Organ Center screening resources. Those OPOs that make electronic organ offers beyond their DSA will turn over organ placement to the Organ Center upon reaching national-level candidates on the match.

Since May 21, 2007, the OC has been charged to make national kidney-pancreas and pancreas offers. However, from a technological perspective, the System Notice was outdated since most OPOs currently have the technological resources to make national kidney-pancreas and pancreas offers itself. More importantly, there was no policy that supports the national pancreas offers or national kidney-pancreas offers aspect of the System Notice. In addition, current data suggests that both OPOs and the OC are making both national pancreas and kidney-pancreas offers.

As such, the Pancreas Transplantation Committee decided it was an appropriate time to re-address the System Notice by clarifying the discrepancy between practice and policy. The Committee discussed several potential options and analyzed supporting data. Since current data suggests that both OPOs and the OC are making both national pancreas and kidney-pancreas offers, and current advancements in technology make it feasible for OPOs to make the national pancreas and kidney-pancreas offers itself, the Committee voted in support of rescinding the pancreas and kidney-pancreas aspect of the System Notice and allow both OPOs and the OC to make national pancreas and kidney-pancreas offers.

Since the Executive Committee initially charged the OC to make national pancreas and kidney-pancreas offers through the System Notice, the Pancreas Transplantation Committee sought the Executive Committee's support and approval to rescind the applicable portion of the System Notice. The Executive Committee voted in support of the Pancreas Transplantation Committee's recommendation to rescind the applicable portion of the System Notice and thereby permit both the OPOs and the Organ Center to make national pancreas and kidney-pancreas offers. In other words, the Organ Center no longer retains exclusive authority to make national pancreas and kidney-pancreas offers. However, an OPO may utilize the Organ Center should the OPO defer a national pancreas or kidney-pancreas offer to the Organ Center. This decision was communicated through a System Notice.

OPTN/UNOS Pancreas Transplantation Committee

Meeting Summaries

The Committee held meetings on the following dates:

- October 8, 2013
- December 13, 2013
- January 22, 2014
- February 5, 2014
- March 12, 2014

Meetings summaries for this Committee are available on the OPTN website at:
<http://optn.transplant.hrsa.gov/members/committeesDetail.asp?ID=69>