

OPTN/UNOS Pediatric Transplantation Committee
Meeting Summary
December 17, 2014
Conference Call

Eileen Brewer, MD, Chair
William Mahle, MD, Vice Chair

Discussions of the full committee on December 17, 2014 are summarized below and will be reflected in the committee's next report to the OPTN/UNOS Board of Directors. Meeting summaries and reports to the Board are available at <http://optn.transplant.hrsa.gov>.

Committee Projects

1. Pediatric Transplant Training and Experience Considerations in the Bylaws

On December 10, 2014, the MPSC reviewed the Committee's pediatric Bylaws proposal and voted to approve it for public comment (24-Support, 12-Oppose, 0-Abstentions). The Chair summarized the MPSC members' discussion prior to the vote. Those opposed voiced concerns similar to those that have been raised throughout the Bylaw development process and that the Committee has systematically worked through. These concerns included the definition of a pediatric patient as less than 18 years old, access to pediatric transplantation, and quality of evidence to support either a patient safety concern or the proposed transplant caseload requirements. Those in support said that this proposal is the best progress made toward developing pediatric requirements in 20 years. The Chair encouraged the MPSC to allow this proposal to receive the benefit of broader consideration and feedback in public comment.

As the group was aware, the Chair presented the proposal to the MPSC without an exception for emergency transplants. The Committee had discussed proposing an exception that would allow a transplant program without an approved pediatric exception to register and perform a transplant in a patient less than 18 years old in an emergency. The MPSC would retrospectively review any instance to ensure the appropriateness of the action taken. However, such an exception would represent a departure from the current standard that OPTN members must fully meet program and program component requirements in order to perform transplants. Transplant programs are also adept at transporting critically-ill patients to qualified programs where they will be best served. Therefore, the Chair recommended that the Committee not propose an emergency exception at this time.

The Research Analyst presented data regarding the frequency of emergency transplants for pediatric recipients. The Research Analyst said that from January 1, 2005 to September 30, 2014, only 24 pediatric recipients at 21 transplant hospitals were removed for "deceased donor emergency." This included 14 pediatric liver recipients, 5 pediatric heart recipients, and 5 pediatric kidney recipients. Of the 24 pediatric recipients, 10 were 0-5 years old at time of transplant, 5 were 6-11 years old, and 9 were 12-17 years old. However, the Committee has had several discussions regarding how to define an emergency transplant, and the definition may be broader than those reported with the "deceased donor emergency transplant" removal code. For instance, emergency liver transplants may be defined as Status 1A transplants with fulminant liver

failure, hepatic artery thrombosis (HAT), or primary nonfunction (PNF). Between September 2005 and August 2014, there were 591 Status 1A pediatric liver recipients with fulminant liver failure, HAT, or PNF at 69 transplant hospitals. Committee members expressed support for excluding an emergency exception from the proposal but requested that descriptive data regarding emergency transplants be readily available to respond to questions during public comment.

The Committee began a final review of the proposed pediatric Bylaws language. No modifications were made to the proposed language prior to the Committee's vote. The Chair and Liaison answered questions regarding the conditional pathway. Only one of the key personnel members may qualify under the conditional pathway. Unlike the conditional pathway for transplant programs that currently exists in the Bylaws, which is reserved for key personnel changes, a new pediatric component may be established using the conditional pathway. When asked why a currency requirement was not explicit for the primary pediatric physician pathways, and the Liaison confirmed that a pediatric-specific currency requirement was already present in the pathways the proposed language references.

A couple of issues the Committee identified with the existing Bylaws will be forward to the Joint Societies Work Group (JSWG) that is completing a comprehensive review of membership requirements.

Prior to the Committee's vote on the language, the patient representative on the Committee reminded the group that parents look to the OPTN to set standards for quality medical care and that establishing pediatric requirements is a responsibility the OPTN has to the public. The Committee voted to approve this proposal (12-Support, 0-Oppose, 0-Abstentions).

Other Significant Items

The Chair and Vice Chair of the Vascularized Composite Allograft (VCA) Committee presented on the implications of VCA for pediatrics. Much like the history of solid organ transplantation, as the field of VCA continues to advance for adult patients, programs are exploring opportunities to benefit pediatric patients. Significant ethical issues exist that the VCA Committee will continue to discuss with the Pediatric Transplantation Committee and others, including assessing risk and benefit during the patient selection process. The VCA Committee will also partner with the Pediatric Transplantation Committee if it identifies the need for pediatric VCA membership requirements.

Upcoming Meetings

- December 17, 2014
- January 21, 2015
- March 18, 2015