

OPTN/UNOS Thoracic Organ Transplantation Committee
Meeting Summary
March 19, 2015
Conference Call

Joe Rogers, MD, Chair
Kevin Chan, MD, Vice Chair

Discussions of the full committee on March 19, 2015 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/>.

Review of Public Comment Proposals

1. Proposal to Require Re-Execution of the Match Run When a Deceased Donor's Infectious Disease Results Impact Potential Recipients Based upon Screening Preferences (Ad Hoc Disease Transmission Advisory Committee)

The Thoracic Committee agreed this is a well-thought out proposal with a sound solution.

2. Proposal to Address the Requirements Outlined in the HIV Organ Policy Equity Act (Organ Procurement Organization Committee)

The Thoracic Committee questioned what safeguards will be in place to prevent inadvertent placement of thoracic organs from HIV+ donors into HIV- recipients. The OPO Committee representative explained that only transplant centers with IRB approval will be permitted to list their kidney and liver candidates to receive organs from HIV+ donors, and thoracic candidates will not appear on any of these match runs.

3. Clarify Policy Language and Process for Individual Wait Time Transfer (Patient Affairs Committee)

The Thoracic Committee determined this is a well-considered policy. The Committee questioned whether the requirement that the transplant center communicate to the candidate that the wait time has been transferred is something that can be monitored. The Patient Affairs Committee staff liaison ensured the Thoracic Committee that this proposal can be monitored.

4. Proposal to Establish Pediatric Training and Experience Requirements in the Bylaws (Pediatric Transplantation Committee)

After reviewing the proposal, the Thoracic Committee voiced a number of concerns. First, the experience for the heart and lung programs is disparate. The data show that 20 out of 42 lung transplant centers would not currently meet criteria. This is disconcerting because a number of these programs might be performing transplants for adolescent lung recipients. The Thoracic Committee therefore believes this policy might have a negative impact on adolescent candidates and decrease their access to transplant. One Thoracic Committee member did point out that the maps showing the number of centers that would qualify under the new bylaws are based on center volumes not surgeon volumes, and that the bylaws for surgeon volumes will be much easier to meet.

Some members of the Thoracic Committee also do not find the data showing the relationship between outcomes and experience to be compelling, and argued that the data reveal a relationship between outcomes and volumes in infants, not all pediatric

patients less than 18. One member of the Committee explained that the data cannot show the relationship between outcomes and volumes for lungs because the number of cases is too small, but the data showing the relationship between outcomes and volumes in other organs is convincing. Adolescents in particular have the highest risk of rejection, non-compliance, and shortest graft survival, and they therefore require a transplant team that is experienced in handling adolescent cases. The bylaws should therefore focus more on center volume instead of surgeon volume.

Another Thoracic Committee member expressed concern about the number of highly trained pediatric pulmonologists and the potential number of pediatric lung transplant programs. Centers will be required to hire a pediatric pulmonologist, but there are insufficient pediatric pulmonologists trained in transplantation. Additionally, there may be centers that would hire a pediatric pulmonologist that would only be performing adolescent, not infant, transplants anyway. While pediatric transplantation teams are very important, it is also important that the patient is cared for by experienced surgeons and physicians.

The Thoracic Committee suggested that the age cut-off of 18 is not appropriate. The Committee suggested there are ways to justify an age cut-off lower than 18, perhaps based on size/weight or the ability to perform certain technical procedures on the patient. Even if these bylaws apply to all programs treating all candidates less than 18, the Committee suggested including an exception in the bylaws, albeit an exception with limited application so that it doesn't become the norm.

5. Proposal to Improve UNetSM reporting of Aborted Procedures and Non-Transplanted Organs (Living Donor Committee)

The Thoracic Committee reviewed this proposal because of its potential impact on living lung donors, but does not have any comments.

6. Proposed ABO Blood Type Determination, Reporting and Verification Policy Modifications (Operations and Safety Committee)

The Thoracic Committee reviewed this proposal and does not have any comments.

Upcoming Meetings

- April 9, 2015
- June 11, 2015