OPTN Operations and Safety Committee
ABO Workgroup
Meeting Minutes
October 3, 2019
Conference Call

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Introduction

The ABO Workgroup (the Workgroup) met via Citrix GoToMeeting teleconference on 10/3/2019 to discuss the following agenda items:

1. Policy Language Discussion
2. Guidance Document Framework

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

1. Policy Language Discussion

The Workgroup reviewed and discussed the proposed policy language to *OPTN Policy 2.6: Deceased Donor Blood Type Determination and Reporting*.

Summary of discussion:

The Workgroup Chair reviewed the proposed changes with the workgroup. The statement, "The host OPO must develop and comply with a written protocol to resolve conflicting primary blood type results" was moved below the listed deceased donor blood samples. Conflicting and indeterminate blood types was included in the statement.

There were no comments or questions to this change. The workgroup reviewed the next paragraph, "Records of blood transfusion prior to specimen collection must be reviewed to assess the impact of any blood products on donor blood typing, including the determination whether non-identical ABO compatible blood products were given." The workgroup was asked their opinion of whether this statement should be included in policy or more appropriate to include in the guidance document.

The Workgroup Chair stated that it is a standard for every OPO in the country to look at records of blood transfusion of any donor. If this is not in policy now, it should be. The Workgroup Chair suggested a change in the statement to take out "including the determination whether non-identical ABO compatible blood products were given".

A member asked if there should be a timeframe outlined in the policy. The Workgroup Chair stated that the statement should specify that the blood specimen records should be from the course that lead to the individual being a donor. The language was changed to "current admission course" to encapsulate the timeframe.

The Workgroup Chair continued by asking the workgroup their thoughts on the statement, "If there are conflicting subtype results, the subtype results must not be reported to the OPTN Contractor and the deceased donor must be allocated based on the primary blood type". Since two ABO results are

required, what if there were three results where one was indeterminate, should there be concern on the reliability of the results.

A member stated that with the consequences of the results being incorrect, this would raise a concern. The Workgroup Chair agreed and suggested the statement should include "conflicting or indeterminate subtype results".

The Workgroup Chair continued with the next statement, "Indicate the same blood type and subtype (if used for allocation) on the two test results". There are circumstances where there are more than two tests done. The Workgroup agreed on changing item 3 of *OPTN Policy 2.6.C: Reporting of Deceased Donor Blood Type and Subtype* to include "all available" and to include "If the results are conflicting or indeterminate, the OPO should refer to their written protocol as outlined above" to item b. The Workgroup Chair stated that this language would be refined.

Next steps:

The Workgroup will continue to refine their ABO policy language.

2. Guidance Document Framework

The Workgroup reviewed and discussed each drafted section of the guidance document.

Summary of discussion:

The Workgroup Chair reviewed the first section "Conventional Methods for ABO determination". There were no comments or suggestions for this section.

The Workgroup Chair continued with the next section, "Factors Impacting ABO typing Reliability" and asked whether the term "transfusion" should be used rather than "massive transfusion". A member stated that "massive" is relative to the size of the individual receiving the transfusion. Similarly, there are mixed fields present just from a few transfusions. The workgroup agreed with this.

A member asked that with the discussion of the criteria of transfusions, such as the different sizes and certain amount of units within 24 hours, should this information be included in the guidance document? Another member stated that the American Association of Surgery and Trauma (AAST) defines massive transfusion as 10 units of red cells in 24 hours. The definition is adult centric and may not be the definition that the guidance should use. The workgroup had looked at the various definitions of massive transfusions but there is caution of whether massive transfusion should be used in the guidance document to avoid causing confusion.

A member asked if the AAST's definition should be used in the guidance with a caveat statement saying that although this is a recognized reference from trauma, massive transfusion can be based on patient characteristics such as age, size, weight, etc. The Workgroup Chair agreed with this but cautioned that those reading the guidance document may create confusion since it was agreed not to use the term "massive transfusion". The workgroup agreed that since the term "massive transfusion" is not being used, the term "large volume" in the definition should be taken out.

The Workgroup Chair asked if there should be a statement that there is no data that suggests when a patient may revert back to their natural blood type. The workgroup agreed that this statement should be included to show that this was researched and there is not definitive evidence.

The Workgroup Chair continued to the next section, "Acceptable ABO and Transfusion Sources". The workgroup agreed that historical data could be used to validate current results but should not be used as source documents for the current entry.

A member stated that policy language does not state that historical samples could not be used. The Workgroup Chair stated that the language could be changed within the guidance document and that ideally, the blood samples used would be two new samples.

UNOS staff stated that there may be confusion from perspective of the individual of donor vs. transfusion recipient being an issue that has been reviewed from a member compliance standpoint. When looking at an individual receiving a transfusion, the safe choice is O, whereas this is not a safe choice if that individual then becomes a donor.

A member stated that it would need to be clear that this is discussing a blood recipient vs. an organ donor and that the ABO may not be the same.

The Workgroup Chair continued by reviewing the "Practices to Resolve Donor ABO Typing Conflicts" section of the guidance document. The Workgroup Chair stated that this section will include some context for instances where a donor could be considered as an ABO type AB. There would be additional guidance to the process such as consulting the medical director, considering forward and reverse typing, and transfusion history blood types.

The Workgroup Chair asked members their thoughts on when there are conflicting results, these cases should be reported as a patient safety event (non-punitively) to determine how often these types of cases are happening.

A member stated that the Membership and Professional Standards Committee (MPSC) attempted to collect more information for these cases but it was proven challenging to do so. The Workgroup Chair stated that this would be worthy of further discussion.

There were no additional comments or questions. The meeting was adjourned.

Next steps:

The Workgroup will continue to refine the ABO guidance document.

Attendance

- **Workgroup Members**
  - Chris Curran
  - Eugenia Steffans
  - Dean Henderson
  - Helen Nelson
  - Marty Sellers
  - Bill Lane
  - David Marshman
  - Nikole Neidlinger
  - Laura O'Melia
  - Jennifer Reese
  - Helen Nelson
- **HRSA Representatives**
  - Raelene Skerda
  - Robert Walsh
- **UNOS Staff**
  - Robert Hunter
  - Joann White
  - Alice Toll
  - David Klassen
  - Robert Patterson
  - Leah Slife
  - Elizabeth Suskind
  - Nicole Benjamin
  - Allen Bienaime