OPTN Kidney Transplantation Committee
Medical Urgency Subcommittee
Meeting Summary
November 15, 2019
Conference Call

Vince Casingal, MD, Chair
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Introduction

The OPTN Kidney Transplantation Committee's Medical Urgency Subcommittee met via Citrix GoToTraining teleconference on 11/15/2019 to discuss the following agenda items:

1. Medical Urgency Review: How We Got Here
2. Available Medical Urgency Metrics
3. Public Comment Feedback
4. Current Practices and Discussion
5. Next Steps

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

1. Medical Urgency Review: How We Got Here

The Subcommittee reviewed the historical development of the medical urgency issue.

Summary of data:

During the Committee's geography project, the Committee determined that medical urgency policies would have to be addressed in an allocation system without donation service areas (DSAs). Under current practice, exceptions can be made for a medically urgent candidate if all transplant programs within a DSA agree the candidate is medically urgent. DSAs have their own criteria and practices, and if a candidate is deemed medically urgent, they receive the offer first on the next compatible organ regardless of the order of the match run.

In the proposed allocation system, there will be a 250 NM unit of allocation and the use of DSA will be removed. It may be impractical for any given center to contact every center within 250 NM for approval for an exception for a medically urgent candidate. In addition, circles could overlap, because every circle is drawn with the donor hospital at the center. Every donor hospital has a different 250 NM circle with different transplant programs contained within. The Committee agreed that creating a "Medically Urgent" classification in allocation tables could help address this problem, but qualifications, review, and priority of that classification remain undecided.

2. Available Medical Urgency Metrics

The Subcommittee then reviewed current available UNOS data on medical urgency, and medical urgency practices from other countries.

Summary of Data:

In current kidney allocation, no points or explicit priority is associated with candidates in medical urgent status. Currently, kidney candidates can be transplanted under medical urgency without having medical

urgent status, or can have medical urgent status and be transplanted within Kidney Allocation System (KAS) classification priority, so there are some challenges in how UNOS can analyze this phenomenon currently.

Based on available data, Organ Procurement Organizations (OPOs) bypassed candidates due to medical urgency of another candidate for about 10 per year (57 (0.2%) of 32,204 deceased kidney donors during 2010-2014). There are about 100 kidney transplants per year to recipients with some indication of medical urgency. However, this does not mean 100 per year were transplanted as medically urgent candidates. Bypasses, transplants, and registrations involving medical urgency were not concentrated in just a few centers or DSAs.

Medical urgency priority is utilized in some form by allocation systems worldwide. There is variability in indication of medical urgency depending on circumstance. Due to this variability, there are little reliable standardized data available as determinations can be practice dependent.

Summary of Discussion:

A Subcommittee member commented this review of current practices highlights the need for public trust among participating centers.

3. Public Comment Feedback

The Subcommittee reviewed the public comment feedback received in relation to medical urgency.

Summary of Data:

The Kidney Committee sought public comment feedback to help define what qualifies a candidate as medically urgent. Two key characteristics consistently emerged:

- Candidate has lost vascular access
- Candidate cannot (or no longer) be dialyzed

There were varying opinions on how many physicians should sign off on a candidate's medically urgent condition and on medical urgency classification priority in relation to highly-sensitized candidates, pediatric candidates, and prior living donor candidates. There was a comment from the OPTN Organ Procurement Organization (OPO) Committee about asking whether candidates within the medical urgency classification were ABO identical or compatible. There was a comment from the American Society of Transplant Surgeons (ASTS) that waiting time should be used to prioritize a candidate when two medically urgent candidates appear on the same match run. Region 9 stated that the Committee should implement a time limit as to how long a candidate can be listed as medically urgent.

4. Current Practices and Discussion

The Subcommittee reviewed current practices from other regions and OPOs.

Summary of Data:

The Subcommittee reviewed current practices provided by Region 1, OneLegacy, LifeSource, Gift of Hope, Donor Network West, and Carolina Donor Services. Some donation service areas (DSAs) do not have documented practices for medical urgency, citing the rarity of such occasions. Some transplant programs manually get approval from all other transplant programs within the DSA without a procedural review. The numerous protocols currently used illustrates there's a wide variety of current practices among OPOs.

<u>Summary of Discussion:</u>

A Subcommittee member reiterated the lack of clear cut criteria emphasizes there's a sense of community trust.

5. Next Steps

The Subcommittee was informed presuming the Board passes the Kidney Committee's *Eliminate the Use of DSA and Region in Kidney Allocation* proposal, the goal will be to implement that change within a 12 month implementation timeline. The goal is to have this new medically urgent policy implemented at the same time as the new allocation policies.

The Subcommittee will discuss factors that could hinder implementation and examine examples of other review boards in the OPTN on the November 18 call.

Upcoming Meetings

- November 18, 2019 – Teleconference
- November 25, 2019 – Teleconference
- November 26, 2019 – Teleconference