OPTN Thoracic Committee
Meeting Summary
December 12, 2019
Conference Call

Ryan Davies, MD, Chair
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Introduction

The Thoracic Committee met via Citrix GoTo teleconference on 12/12/2019 to discuss the following agenda items:

1. Review and discuss proposed policy language for the LAS Cohort Update project
2. Discuss article: An early investigation of outcomes with the new 2018 donor heart allocation system

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

1. Review and discuss proposed policy language for the LAS Cohort Update project

The Committee reviewed and discussed the proposed policy language for the LAS Cohort Update proposal going out for Spring 2020.

Summary of discussion:

One Workgroup member asked whether they have anything to discuss in terms of which model to use or data to review. SRTR clarified that they need the Workgroup to discuss which covariates or new data values to use in an updated LAS cohort update. SRTR also clarified that in terms of methodology, they only used current variables in the LAS when they re-ran the models. A Workgroup member supported looking closer at variables that have p-values close to one, and whether the Workgroup should include these variables in the models. For example, this member stated that diabetes may not be predictor of waitlist survival. Other members agreed, and stated that diabetes should not be included. Another suggestion was to not include cardiac index (CI). One member stated that the only candidates to be impacted by this would be those with a diagnosis of pulmonary hypertension. Also, having a low CI may predict better survival, and some candidates (like those with cystic fibrosis) might not have a right heart cath. In this way, some members were not sure this makes sense to include in the model. However, one member noted that most cystic fibrosis patients will have a right heart cath, and not an echo. Also, since CI is important for some candidates with idiopathic pulmonary hypertension, members concluded that it should be included for now (though there may be a minute impact on keeping it).

Another member supported adding new data elements to the LAS, and that such discussions should take place now. However, the Workgroup in general was not in support of this, and decided to discuss including new data elements as a part of a future project.

At one point, clarification was provided that Superior Vena Cava Syndrome (SVC) is only available for diagnosis group D candidates. A Workgroup member stated that it would be important to still include SVC, because fibrotic patients are included under group D. The issue is that the SVCs of these candidates are usually normalized due to their disease. The member stated that such patients are now put under "pulmonary fibrosis" which is making the data skewed. When asked whether this was common, and if

this patient population is growing, several members affirmed that it is a growing group. Because of this, the Workgroup agreed to include SVC.

In general, the Workgroup stated that they would find it useful to know how many patients the variables would affect, and how changing the variables would impact the patients. The Workgroup suggested gathering and sending this information out before the next meeting.

2. Discuss article: An early investigation of outcomes with the new 2018 donor heart allocation system

According to an article by Cogswell et al (2018), since the implementation of the new adult heart policy in October 2018, there has been a shift in listed and transplanted patients. This shift has coincided with an increased use of ECMO, temporary mechanical support devices, IABPs, decreased use of durable VADs, decrease in waitlist mortality and increase in post-transplant mortality. The Committee discussed these findings and their concerns.

Summary of discussion:

One Workgroup member stated that the article's methodology has some issues. For example, the article did not include patients listed prior to the policy changes. This means most of the patients who were transplanted after the change, were patients who were transplanted relatively quickly after their listing, and therefore, means they were likely the highest status patients and at an increased risk of dying post-transplant. The member went on to state that the results are not surprising, because ischemic time increases with distance.

The Workgroup member went on to explain that the OPTN has not done a post-transplant outcomes analysis because there has not been an appropriate amount of time for follow-up of patients. This could overestimate the mortality rate. The member also stressed that there is a balance between policy solutions and transplant hospital solutions; just because a patient is on a temporary support device does not mean they need to be transplanted; transplant hospitals are responsible for the post-transplant outcomes of their patients.

Another Workgroup member asked why it takes so long to get 6-month data from the OPTN. Clarification was provided that the OPTN wants to have complete follow-up information on the candidates. The follow-up information on the 6-month TRF allows transplant programs to have 60 day submission window. This therefore creates data lags. Clarification was also provided that UNOS staff have done a comparison of data from 10/18/2017 to 1/17/2018 versus 10/18/2018 to 1/17/2019. The results showed a 6 month patient survival analysis for a 3 month cohort that the OPTN has complete follow-up information on. The results showed no statistical change. However, in the pre-policy era, there were 45 deaths reported, whereby in the post-era there were 43 deaths reported. Based on the results presented, the Workgroup supported including the above comparison in the OPTN's response to the article.

Next steps:

The OPTN Thoracic Committee will compose a letter to JHLT in response to their article. The one- year heart monitoring report is scheduled for Spring 2020. Heart Subcommittee to continue working on addressing the increase in IABP use and IABP exceptions.

Upcoming Meeting
- December 19
- January 8 2020