

OPTN Kidney Committee

Meeting Summary

March 16, 2020

Conference Call

Vince Casingal, MD, Chair
Martha Pavlakis, MD, Vice Chair

Introduction

The OPTN Kidney Transplantation Committee met via Citrix GoTo teleconference on 3/16/2020 to discuss the following agenda items:

1. COVID-19 Discussion

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

1. COVID-19 Discussion

The Committee discussed the issues facing the transplant community in light of the Covid-19 pandemic.

Data Summary:

The OPTN is collaborating with some societies to develop consistent guidance for the transplant community. The Committee is being asked to provide feedback on some of the following questions:

- What is established and agreed upon in the community?
- What are the questions that [members of the Committee] need answered?
- What is the best mode of communication?

In addition, the Committee could provide questions, concerns, and suggestions to inform the guidance being developed by UNOS and the societies.

Some additional questions for consideration:

- How is your center handling living donor transplants? What is being considered elective?
- How are you managing listing new patients, patients waiting, and patients transplanted?
- What is the ability for testing in your area? Turnaround time? Availability? Requirements?
- What messaging will help members focus on their unique population and patient care instead of metrics/compliance?
- What policies or metrics are most concerning at this time?

Summary of discussion:

A UNOS staff member explained the context of the committee's discussions. The societies and UNOS would like to better understand the top questions, concerns and issues members have in order to shape the guidance being created.

The Chair expressed the importance of the sound medical judgement of the committee members especially given the current scarcity of data.

One member expressed concern about patient communication. The member noted that as a living donor, their center has not communicated what they should do for their upcoming appointment.

One member shared that their program in Colorado has suspended all living donor transplants for both liver and kidney, as well as all elective operations. The program has discussed potentially suspending evaluations and will move to make as many as possible via telehealth. The program is continuing with post-transplant visits particularly for those within the first 30 days post-operation, however switching those that are further out to telehealth.

One member shared that their program in Illinois has also suspended all living donor transplants as well as evaluations. The program is continuing with post-transplant visits via telehealth. However, the program is having difficulty working with their organ procurement organization (OPO) to have testing for deceased donor transplants. This is particularly challenging because the state requires all testing to go through the health department, a process which takes two days and is too long for an organ.

One member shared an OPO perspective. the largest lab in Nevada doing cadaveric testing just notified that they have the ability to do testing for COVID-19. The member expressed that there is great variability in transplant programs expectations. Some programs won't take any organs that haven't been tested; however, others are willing to consider risk factors and only require testing for those with certain risk factors. The member explained that the turnaround for the testing is now a matter of hours instead of days. However, Nevada hasn't started sending samples yet so don't have specific information

One member shared that living donor transplants for kidney is also suspended at their center in Washington. Their OPO is doing COVID-19 testing on all deceased donors, however the sensitivity of testing is unclear. There is concern about testing deceased donor recipients as testing is too slow and turnaround is often 1-2 days. At the moment, their program won't accept an organ unless there are two negative tests. There was a story about an emergency room (ER) doctor who tested negative once but then came back and tested positive later on. The member wondered if there is a cogent argument for patients that are stable on dialysis and the decision to give them a kidney transplant and expose them to high immunosuppressants. The member also wondered if you have a healthy 30 year old and there is a kidney available, do you transplant them? The member observed lots of organs being passed on over the weekend.

The Chair asked if any offers were being passed on for deceased donor transplants.

One member from a pediatric program in Michigan shared that their program has also postponed living donor transplants. Specifically the member had a transplant scheduled in the next few days that was postponed. The member had the same question as the previous member regarding the benefit of transplanting stable dialysis patients vs the risk of placing them on immunosuppressants during this pandemic. The candidate is a pediatric candidate who has been on dialysis her whole life and there is some sort of urgency. There is some concern about what the health care burden will be and adding to it with patients who could wait another month for transplant. The member wondered should we hold off in order to be stewards of social distancing and minimize the health care burden.

The Vice Chair gave an example of a patient that if not transplanted will need to come in for hemodialysis for 3 times a week and so their program had considered a living donor transplant. The program felt the risk is unknown for the recipient due to the fact that the patient faces risk of catching the disease from dialysis as well as post-transplant immunosuppression. The member was concerned of the risk to the donor. Because this donor was a family member to the recipient, they likely would take on any risk to provide a transplant.

One member shared that all the healthcare programs in their Washington area have shut down elective cases, including neurosurgery, orthopedics, etc, to make room in the hospital. The member shared that for the majority of the kidney cases, the risk/benefit is unknown even for those who are undergoing regular dialysis out of the home – even if you could mitigate the initial risk of receiving COVID-19 from

the donor, you still have close follow up for several months. Undertaking this risk is more understandable for heart/liver transplants or kidney/liver transplants and patients who have lost dialysis access but what about stable kidney patients.

The Chair shared that in their region of North Carolina, there are no cases in their hospital and testing is available with a turnaround of 24 hours. In response to the previous member's question, the Chair expressed that there are different answers for different communities especially for those in a high endemic area. The Chair shared that kidney transplants can be just as life-saving as heart and liver in the long run. Their center feels that if there may be situations where they can safely place a kidney, and other situations where patient safety may be an issue. The Chair expressed that UNOS and societies should support decisions of programs to suspend living donor transplants particularly for a high endemic area and not have consequences to the programs.

One member worried what the risk is of transmission in the dialysis units, due to the high number of patients in a small area who are normally at high risk of viral infection.

One member from Washington noted that the first deaths in Seattle were in a dialysis unit and they were also nursing home patients. These deaths resulted in new standards for workers in the dialysis units. The member wondered how you compare the risk with staying on dialysis vs being transplanted and if there is any data from Italy regarding this. The member noted that there were no reports of recently transplanted recipients catching the virus but rather recipients who were several years post operation.

Another member agreed that it would be nice to get comments from Italy. The member considered that most likely there are no transplants being done due to an overwhelming of the system.

One member from Georgia shared that the American Society of Transplant Surgeons (ASTS) listserv is helpful. They shared that Italy has shut down all of living donor transplants. They expressed that even though it seems there are differences in the country between high and low endemic areas, it appears that the virus is widespread. The member expressed the belief that the community should approach transplant practices together. The member felt that telehealth isn't a good option for recent transplants or living donors. The member felt that the community should suspend living donations all together and only do deceased donor transplants for people who have an elevated medical need.

One member from Pennsylvania shared that they are still doing transplants. All living donor transplants have been postponed since a week ago. Still accepting deceased donors, preference to local organs with no indications of infection. Surgeons are being choosy, preference for younger living donors. Even though physicians think we could push off these transplants for a couple weeks, there is the possibility this may last for a couple months. What are the repercussions for postponing for several months? That will have huge impacts on patients and families and the system

The Chair expressed support for the encouragement to transition to telehealth where appropriate but cautioned to avoid using the phrase "unnecessary visits" because physicians don't do unnecessary visits

One member asked if anyone on the call is still doing living donor transplants or if everyone had suspended their program.

One member in California shared that their program has not planned on suspending, but with the schedule and cancellations there are not many liver or kidney scheduled for the next two weeks. We are still transplanting deceased donors but being more conservative. The member shared that their OPO is not testing donors but are leaving it up to the donor hospitals. In Northern CA, they are testing all donors. The member shared that the county hospital ER was doing a pilot and testing everyone with flu symptoms for COVID-19 until they ran low on tests. The ER saw a huge spike in cases and have stopped

asking the travel questions to triage patients and rather gone straight to separating those patients who present with upper respiratory symptoms from others and testing them. The member expressed a hope to begin testing all organs as they believe it will last a while and it may not be possible to stop transplanting all together.

Another member shared that no one really knows the extent of the virus in the community because the testing has been so low. Even parts of Washington only recently began ambulatory testing. The member expressed the belief that the transplant community should not make clinical decisions about transplant based on the prevalence in a community because the number of cases may not reflect reality.

The Chair noted that most members were expressing lots of caution in their approach to transplant. The Chair wondered what help do transplant centers need the most at the moment.

One member referenced a Johns Hopkins email that provided guidance as a model.

One member noted that it would be nice to have a recommendation for OPOs regarding testing and suggested that there could be a recommendation on testing all deceased donors.

Another member agreed with the suggestion. The member expressed that there are lots of questions about availability of testing, sensitivity of the tests, turnaround time, and the results. These questions are creating a lot of uncertainty among the community.

Another member agreed with this statement. The member has heard a lot of questions about disease acquisition by patients. The member supported putting out uniform testing guidelines and reporting.

A member from an OPO agreed. The member felt it would make it easier on OPOs if there is a consensus among centers about what tests they expect. The member added that consensus and guidance from UNOS would be helpful but it would be most helpful from the transplant centers.

The Vice Chair expressed a desire to see the performance checks delayed or some communication reassuring transplant programs that if their transplant rates plummet, there wouldn't be consequences.

The Chair agreed and added that living donor checkups may also qualify for delays.

Another member shared that the cautious approach is temporary and there will need to be flexibility as the situation is constantly evolving. Another member agreed that the situation is incredibly dynamic and agreed with the suggestion for uniform testing guidance. The member found this call with members across the country very helpful and suggested having another call more frequently than monthly.

One member brought up the issue of patient communication. The member wondered what communications are patients receiving about what offers to accept and for post-transplant patients what actions they should or should not do in terms of daily activities. Another member responded that one of the transplant societies has a living document that addresses many of those questions. The previous member wondered who is sharing that document with patients.

The Chair shared that their program had established a phone tree in order to maintain communication with patients.

One member in Virginia shared that their program is scheduled for a routine UNOS audit next week that is proceeding as normal. However the member felt that UNOS should consider suspending those because members are so occupied with the pandemic. The Chair expressed that it is unacceptable.

One member familiar with the UNOS board believed that the site surveys would be virtual.

The previous member shared that even virtual audits are too much.

A member of HRSA shared that they will take that feedback back to UNOS.

A member of UNOS staff shared that the former “in-person” meeting is now virtual. Most likely this meeting will be shorter but the time and agenda is subject to change. This meeting will be significant for the voting items for public comment and board proposals.

Next steps:

UNOS staff will take this feedback to the OPTN.

Upcoming Meetings

- March 20, 2020
- April 2, 2020

