

OPTN Pancreas Transplantation Committee

Meeting Summary

June 17, 2020

Conference Call

Silke Niederhaus, MD, Chair
Rachel Forbes, MD, Vice Chair

Introduction

The Pancreas Transplantation Committee (the Committee) met via Citrix GoToMeeting teleconference on 6/17/2020 to discuss the following agenda items:

1. Updates on Alaska Proposal & Pancreas Allocation Proposal
2. Review & Discussion: Continuous Distribution Timeline

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

1. Updates on Alaska Proposal & Pancreas Allocation Proposal

The Committee was updated on the Distribution of Kidneys and Pancreata from Alaska and Eliminate the use of DSA and Region in pancreas allocation policy proposals.

Summary of discussion:

Distribution of Kidneys and Pancreata from Alaska Proposal

This proposal was unanimously approved by the Board of Directors on 6/8/2020.

Eliminate the use of DSA and Region in pancreas allocation policy Proposal

IT has been working diligently and the implementation of this proposal is still scheduled for December 2020.

There were no comments or questions.

2. Review & Discussion: Continuous Distribution Timeline

The Committee reviewed the timeline for and discussed next steps on the continuous distribution project.

Summary of discussion:

The proposed timeline for the continuous distribution was presented to the Committee as follows:

- Phase 1 – identifying and characterizing attributes
 - Begins 7/2020 and spans from 2-4 months
- Phase 2 – concept paper
 - Begins between 9/2020 and 11/2020
 - Ends between 9/2021 and 4/2022
 - Greatest risk for timeline variability
- Phase 3 – public comment
 - Winter 2022 or Fall 2022 public comment cycle
- Phase 4 – framework, modeling, and final proposal

- Begins Winter or Fall 2022 public comment cycle
- Ends December 2022, June 2023, December 2023, or June 2024

A member inquired about how the Committee will move forward with pancreas continuous distribution compared to kidney-pancreas (KP) continuous distribution. United Network for Organ Sharing (UNOS) staff explained that the Committee would first focus on pancreas continuous distribution and, then, work with the Kidney Committee to discuss any attributes that involve KP allocation. A member emphasized the importance of working alongside the Kidney Committee since 80% of pancreas transplants also include kidneys.

It was also mentioned that the majority of this work would start in July 2020.

The Committee discussed the following attributes that could be considered in the pancreas continuous distribution model:

- Simultaneous Pancreas-Kidney (SPK) transplants
 - How long candidate has been on dialysis
 - How long candidate has had End-Stage Renal Disease with GFR less than 20
 - Consider developing threshold limit for how much time they spend with blood sugar in hypoglycemic state or out of target range
- Type 1 Diabetics on dialysis
 - Have incredibly higher mortality rate than non-diabetics
 - Consider developing medical urgency criteria (similar to what the Kidney Committee recently proposed) for pancreas
 - Argument for priority for diabetics: diabetic kidney candidates actually get a disadvantage because they are more likely to not have an EPTS below 20
- Age
 - Tread on age very carefully - estimated post-transplant survival for kidney, can maybe develop something similar for pancreas
 - Really an increase in time before the patient is listing for an SPK because of better treatment, such as intensive insulin treatment, but it doesn't avoid secondary complications – it just increases the time until the patient develop it
- Hypoglycemic unawareness
- Start date (listing)
- Sensitization
- Donor matching
- Superior Mesenteric Vein (SMV) matching

Many members expressed concern about the potential decrease of utilization of the pancreas if KP transplants were listed on the kidney list. A member suggested arguing that KP transplants are separate from kidney and should have their own list because patient acuity is different and you can't compare someone with pancreatic and renal failure to someone with just renal failure alone and use the same prioritization scheme. A member mentioned that there's a risk with more kidney transplants taking over if the lists are combined, resulting in less pancreas transplants.

Another member suggested, if it's necessary to use one list for both KP and kidney, giving a certain degree of points to candidates in need of a pancreas so that you almost drive all the kidney with the pancreas instead of letting it go to a non-diabetic candidate. A member proposed looking at the number of life-years gained by receiving a pancreas transplant and then converting it to number of years on dialysis that would translate into points.

A Scientific Registry of Transplant Recipients (SRTR) employee explained that, in a point based system, there is always going to be a large number of points that can be rewarded to candidates in order to prioritize them. The SRTR employee inquired whether it is the goal of the Committee to prioritize all KP candidates above kidney candidates, meaning the lowest priority KP candidate will have more priority than the highest priority kidney candidate, or if there will be overlap. It was also noted that, if the lowest priority KP candidates are prioritized over the highest priority kidney candidates, there will be offers that centers are unlikely to accept for reasons, such as proximity or logistics, and it may make more sense to move those below some high probability of acceptance kidney alone offers.

Members stated that, in essence, they want a single pancreas list where the pancreas pulls the kidney for KP transplants. It was mentioned that this would be similar to the heart-kidney list where the heart pulls the kidney and centers aren't obligated to give up the kidney but most do. A member emphasized that the pancreas should be viewed as multi-organ and prioritize them like heart-kidney and liver-kidney. It was noted that isolating pancreas is insinuating that pancreas transplants aren't important.

Members agreed that KP transplants are going to be complicated to incorporate into continuous distribution because of all the different and organ-specific factors. It was also noted that the Committee could manage KP transplants better if all pancreas transplants (solitary or combination) stayed in one list with criteria established by the Committee as opposed to being on two different allocation lists. The Committee also wouldn't have much purview over KP allocation if it stays on the kidney list.

3. Wrap-Up & Next Steps

The Committee discussed next steps on upcoming projects.

Summary of Discussion:

The Committee reviewed the following updates:

- Call for volunteers to join the following Workgroups:
 - Continuous Distribution Workgroup
 - Rework Graft Failure Definition Workgroup
 - Medical Priority Workgroup
 - Cross Organ Rules Workgroup (Organ Procurement Organization Committee Workgroup)
- The Committee will begin to formally discuss attributes for pancreas continuous distribution during their next committee meeting.

Upcoming Meetings

- July 15, 2020 (teleconference)