OPTN Organ Procurement Organization Committee
Multi-Organ Policy Review Workgroup
Meeting Summary
June 29, 2020
Conference Call

Kurt Shutterly, Workgroup Chair

Introduction

The OPTN Multi-Organ Policy Review Workgroup (the Workgroup) met via Citrix GoToMeeting teleconference on 06/29/2020 to discuss the following agenda items:

1. Review of Flow Chart
2. Next Steps

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

1. Review of Flow Chart

The Workgroup chair reviewed the allocation criteria for heart-liver candidates:

- Status 1, 2, or 3 heart candidates should also get liver if Multi-Organ Transplant (MOT) candidate within 500 NM
- No Status 1, 2, or 3 heart candidates within 500 NM, allocate liver alone to Status 1A, 1B, or MELD/PELD 35 or higher candidates
- No Status 1, 2, or 3 heart candidates or liver Status 1A, 1B, MELD/PELD 35 or higher liver candidates - OPO determines next steps, allocates according to organ-specific policies

Summary of discussion:

A member inquired about whether, before proposing new policies or modifying current policy, if there would be a review on how changes would affect existing policies. United Network for Organ Sharing (UNOS) staff affirmed that the review process occurs during policy development. It was explained that future policy language, such as with continuous distribution, can be modified to align with the revised MOT policy and that the reason for the current distances in the MOT criteria was to best match the current heart, lung, and liver allocation sequences.

A member inquired whether the difference in waitlist mortality between heart-liver/lung-liver candidates with a low MELD score and liver alone candidates with a MELD score of 35 had been discussed. A member stated that it would make sense not to bypass Status 1A, 1B, or MELD/PELD 35 as long as the mortalities were similar, but the MELD for combined organ candidates does not reflect the mortality for isolated organs. If a candidate is listed for a heart-liver or lung-liver, their mortality may still be pretty high.

A member offered the example of liver-intestine. Candidates had high mortality because they needed an intestine and a liver, but could never be prioritized appropriately without significantly adding points in order for the candidates to be competitive with liver alone candidates.

The Workgroup chair stated that the workgroup isn't currently discussing mortality. A member suggested that it would be helpful information to create the appropriate prioritization for liver allocation.

A member explained that the Ethics Committee white paper discusses appropriately risk-stratifying patients in order to prioritize them, meaning candidates with higher mortality should be preferentially given an organ over another organ group and it should be the same for MOT criteria. Heart-liver Status 1, 2, and 3 candidates have a lower mortality than most of the higher MELD score liver-alone candidates and this workgroup should create a system that alternates between liver and heart-liver candidates trying to match mortality rates or the MOT criteria isn't appropriately distributing these organs based on the needs of the patients.

A member stated that liver-alone mortality unfavorably compares to heart-liver mortality – Status 1A liver-alone candidates with a MELD/PELD score of 35 or greater have mortality of about 200 patients per 100 wait-years which is greater than all of the heart candidates' waitlist mortality, except maybe Status 1. The member also suggested looking at more granular MELD score data since candidates with MELD scores in the 30's also have high mortality. A member countered by stating that, with MOT candidates, it would be hard to get granular MELD score data because there are so few candidates (45 heart-liver recipients in 2019), but may be possible for single organ candidates.

A member expressed concern about solely prioritizing candidates based on mortality because it doesn't account for different levels of access experienced by MOT candidates. MOT candidates only have certain donors that are suitable for them, so if they don't get access to a donor because of a sick liver patient, that may be their only access for a long time. And these Status 1, 2, and 3 heart-liver candidates are also very sick and in need of hospitalization. A member also stated that liver candidates with a higher MELD score receive more offers than heart-liver candidates.

A member mentioned that the Workgroup needs to consider the new liver allocation policy and if the mortality has gone down as a result. It was emphasized that livers aren't staying local anymore, but instead are going to sicker candidates.

A member argued that, while this is true, prioritizing MOT candidates over high MELD score liver candidates would incentivize programs to perform MOT transplants to get their patients higher on the waitlist. A member stated that programs, especially heart-liver programs, would need more than just increased prioritization to be incentivized to perform MOT transplants. These transplants are very complicated and the desired post-transplant outcomes are difficult to achieve.

A member suggested not having MOT policies and allowing organ procurement organizations (OPO) to decide how to allocate to multi-organ candidates. A member explained that this could cause OPOs to only work with their local transplant centers. Another member stated that, regardless of the policy, OPOs just want some type of guidance when it comes to allocating the organs.

A member inquired about the collection and analysis of progression data – whether candidates move up or down in statuses and how long they stay at each status. UNOS staff explained that they weren't aware of any reports that examined this progression data, but, when waitlist mortality is measured, it does account for how much time candidates spend in each status. SRTR staff also mentioned that, currently for each organ type, they maintain a waitlist mortality and transplant rate models. For some organ pairs the models include indicators for whether the candidate is concurrently listed for a MOT. For example, liver candidates also listed for a heart have a 2.4 times higher transplant rate than those candidates listed for liver alone.

2. Next Steps

The Workgroup will reach out to the Heart, Liver, and Lung Committees for additional feedback on the heart-liver and lung-liver MOT allocation criteria.

Upcoming Meetings

- TBD