OPTN Organ Procurement Organization (OPO) Committee

Meeting Summary
July 15, 2020
Conference Call

Diane Brockmeier, Committee Chair

Kurt Shutterly, Vice-Chair

Introduction

The Organ Procurement Organization (OPO) Committee (the Committee) met via Citrix GoToMeeting teleconference on 7/15/2020 to discuss the following agenda items:

1. Multi-Organ Transplant (MOT) Project Update
2. DCD Heart Perfusion
3. PHS Guideline Workgroup Update
4. New Member Orientation

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

1. Multi-Organ Transplant (MOT) Project Update

The Chair of the MOT Review Workgroup presented the proposed process that could be incorporated into changes to Policy 5.10.C:

Heart-Liver

- Status 1, 2, and 3 heart candidates should also get liver if MOT candidate is within 500 NM
- If no Status 1, 2, or 3 heart candidates, allocate liver alone to Status 1A, 1B or MELD/PELD 35 or higher
- If no Status 1, 2, and 3 heart candidates or Status 1A, 1B, or MELD/PELD 35 or higher liver candidates, OPO determines next steps for allocation

Lung-Liver

- Lung candidates with LAS of greater than 35 will also receive liver if MOT candidate is within 500 NM
- Lung candidates with LAS less than 35, allocate liver alone to Status 1A, 1B, MELD/PELD 35 or higher
- No lung candidates with LAS of greater than 35 or Status 1A, 1B, MELD/PELD 35 or higher liver candidates - OPO determines next steps for allocation

Summary of discussion:

A member inquired if this criteria assumes that OPOs will execute all match runs simultaneously. For example, if a center is managing a donor and waiting on an echo to determine availability of the heart, it's assumed that the OPO is not going to allocate the liver prior to that. The MOT Review Workgroup chair stated that that is correct - if there's a liver candidate on the match run, the OPO would notify the candidate's center that the thoracic organs are still being allocated.

A member inquired how many heart-liver and lung-liver transplants are done each year. United Network for Organ Sharing (UNOS) staff responded that there were 45 heart-liver transplants and 12 lung-liver transplants in 2019.

A member suggested that there be links to resources or alerts on the match run to help coordinators understand when and why they have to share organs this way. The Workgroup Chair mentioned that these resources and alerts have been discussed and sees an opportunity here, but there needs to be more discussion with UNOS Research and IT staff about the possibility of this.

A member expressed concern about centers not communicating until they become the primary offer. A member mentioned how important it is for there to be communication – if a center has a candidate that is number 10 on the heart list and also needs liver, there has to be communication about whether that potential recipient is a candidate for the donor.

A member inquired about how to handle the following situation: An OPO follows the proposed process using the MOT criteria and eventually places the liver with a liver-alone candidate and the heart with a heart alone candidate. Subsequently the heart candidate declines the heart and the next candidate on the heart list is a heart-liver candidate. The Workgroup Chair stated that in that instance, since the offer had already been made, the liver would go to the intended liver alone candidate. Another member mentioned that, currently in UNOS policy, there is language that covers this situation (i.e., if an offer is made, then the organ goes to that recipient).

2. DCD Heart Perfusion

The Committee Chair asked for Committee members' experiences regarding the following concerns:

- Member concern regarding time to prime pump - donor blood drawn following cardiac arrest
  a) Records indicate that the pump should prime in 2-3 minutes
- Time factor could impact liver utilization
  a) Liver was utilized although not by the originally intended team - who was concerned about the time delay.

Data was presented to the Committee to highlight how frequently this occurs. There were 12 DCD donors that had resulted in a heart transplant, but not a liver transplant. This was due to a variety of reasons, such as biopsy findings, donor liver didn't perform well on liver pump, lobe laceration, rule out, and vascular damage.

<u>Summary of discussion:</u>

Members mentioned that they had either no experience with DCD heart perfusion or hadn't had any issues or complaints.

Committee members mentioned that, when there has been issues, it was due to different organ time frames needing to be followed and a lack of communication. One member stated that their center has made it a point to discuss the various contingencies with all parties included in the process.

A member inquired about how much blood is being drawn. It was explained that it is 1.2 to 2 liters of blood being drawn for the perfusion machine.

A member mentioned that, on one occasion, they were presented with the option of a pre-extubation blood draw given the appropriate authorization, but decided to opt out.

A member stated that their center is also doing normothermic perfusion and putting the donor on bypass, which stabilizes the donor.

A member speculated removing or adding agonal phase time to the data because if a donor had an agonal phase time of 29 minutes versus 12 minutes, then the 90 seconds for the blood draw would affect these DCD donor organs differently.

3. PHS Guideline Workgroup Update

The following PHS Guideline modifications were presented to the Committee:

- Risk assessment of living and deceased donors
  a) Shorten risk criteria inclusionary timeframe from twelve months to one month
  b) Remove four risk criteria including hemodialysis and hemodilution
  c) Remove specific label (e.g. increased risk donor) to describe donors with risk factors for acute HIV, HBV, and HCV infection
- Living and deceased donor testing
  a) Add new required testing for all potential living and deceased organ donors:
     i) HIV: NAT
     ii) HBV: NAT
  b) Require deceased donor specimen collected within 96 hours before organ procurement
- Collection and storage of donor and recipient specimens
  c) Add OPO requirement to gather specimen for storage within 24 hours of organ procurement

Summary of discussion:

Members agreed that the change from the 24 hours to 96 hours requirement to have deceased donor specimen collected before organ procurement is an improvement; however, members still had the following concerns:

- Discordant results
- Sending two sets of specimen
- Pushback from centers because the results aren't back within 96 hours
- Would be difficult for OPOs that have a 20 hour turnaround time for results on average to meet this requirement
- Not sure if it will be possible to meet this requirement if there's intravenous drug abuse
  a) Currently the PHS Guideline Workgroup hasn't distinguished between donors with risk factors and donors without risk factors
- If language was less strict surrounding receiving results back before organ procurement then organ release would be the minimum change

A member inquired about 28 days still being the time requirement to have NAT testing done for living donors. A member explained that policy stated "at least within 28 days before organ procurement for living donors."

UNOS staff noted that the committee will have the opportunity to provide additional feedback during the upcoming public comment period.

4. New Member Orientation

UNOS staff welcomed new members of the Committee and reviewed their roles as Committee members and the resources that are available to them.

Summary of discussion:

No discussion.

Upcoming Meeting

- August 12, 2020 (teleconference)