

**OPTN Kidney Transplantation Committee  
Kidney-Pediatric Workgroup  
Meeting Summary  
September 14, 2020  
Conference Call**

**Vincent Casingal, MD, Chair  
Martha Pavlakis, MD, Vice Chair**

## **Introduction**

The Kidney-Pediatric Workgroup (the Workgroup) met via teleconference on 09/14/2020 to discuss the following agenda items:

1. Data Review
2. Policy Solution Discussion
3. Data Request Introduction

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

### **1. Data Review**

The Workgroup reviewed data related to pediatric kidneys classified as Sequence C.

#### Data summary:

In 2019, 155 donors fell within the group that the workgroup is considering targeting, namely pediatric donors greater than 18 kilograms with a KDPI between 35%-85%.

#### Summary of discussion:

There were no questions from the Workgroup.

### **2. Policy Solution Discussion**

The Workgroup discussed details of a potential policy solution.

#### Summary of discussion:

A member of UNOS staff asked the Workgroup if they felt that the previously discussed solution of allocating pediatric kidneys greater than 18 kilograms with a KDPI between 35%-85% similar to Sequence B organs would allow for enough increased pediatric priority while also avoiding an influx of undesirable high KDPI offers to pediatric candidates.

One member commented in support and noted that the total number of donors in this niche group in 2019 was 155 which would not take away a large number from adult candidates. Another member noted the same thing that the total in 2019 was about 1.5% of the deceased donor list. The member commented that while not always necessary, sometimes it is beneficial for pediatric candidates as far as matching size and other factors to have access to a pediatric donor.

UNOS staff asked if the Workgroup thought the new sequence should mirror the current classification order of Sequence B. One member noted that if en bloc pediatric kidneys are currently allocated according to Sequence A then maybe these pediatric kidneys should as well. The Chair noted that there

is some debate in the community about whether or not there are benefits for size matching in allocating pediatric donors to pediatric candidates. There seems to be evidence that the KDPI of these kidneys does not fully represent the quality of these organs but it is difficult to say to what extent and therefore if they are similar to Sequence A organs with KDPI between 0%-20%. Since it is unclear if all these kidneys are the same quality as Sequence A, perhaps it is more conservative to allocate similar to Sequence B and therefore allow for increased pediatric access to pediatric donors.

The Vice Chair commented that either sequence seemed reasonable and that she would rely on the experience of pediatric surgeons who use these organs to provide feedback on the most appropriate sequence. A member who works as a pediatric surgeon commented that while these organs may not be the most suitable for all pediatric candidates, there is a subpopulation of pediatric candidates who can really benefit from the anatomical advantages of a pediatric donor and would not be concerned with a KDPI between 35%-85%. The member concluded that either sequence would allow those candidates greater access to these organs.

The Chair noted that from his experience these organs are really high quality but require some technical knowledge in order to transplant which means they are not the most suitable for every candidate. The Chair agreed that the new sequence could mirror either A or B.

UNOS staff commented that there are a similar amount of pediatric donors that fall into Sequence B and that the Workgroup would need to explain to the community the rationale for the new sequence order, particularly if it mirrored sequence A. One member noted that if the new sequence would mirror Sequence A then it would make the most sense that all pediatric donors follow that pattern rather than retaining some kidneys in the Sequence B order.

The Chair noted that mirroring Sequence B gives the benefit of increased pediatric priority, however mirroring Sequence A would likely require a greater renovation to how KDPI assesses pediatric donor kidneys entirely. The Chair expressed support for the former. Several other members spoke in support as well.

UNOS staff noted that Sequence B does not include the option of dual allocation in the same way as Sequence C. In the last six months, only one pediatric donor over 18 kilograms with a KDPI between 35%-85% was allocated with the dual option. Does the Workgroup feel that dual allocation should be an option in the new sequence?

The Chair responded that it would be good to keep dual allocation as a safety net option. Several other members spoke in support as well.

UNOS staff asked the Workgroup if the new sequence should mask KDPI similar to en bloc allocation. UNOS staff explained that en bloc KDPI is less accurate because KDPI is a measure of a single kidney but en bloc allocation is composed of two kidneys. The Vice Chair was in opposition to masking the KDPI by noting that en bloc is a different scenario due to allocating more than one organ. The Chair also agreed with the Vice Chair.

One member asked if a center who has a listing practice which limits offers to only under 35% KDPI would be able to receive offers for these organs whether masked or not. UNOS staff explained that even if the KDPI is masked from a program, it is still a factor considered by the system. Therefore, a program would need to adjust its listing practices either way.

One member asked if this group of organs would have a specific option to opt-in similar to en bloc allocation. UNOS staff responded that would be something for the Workgroup to discuss and decide. The member expressed that programs with pediatric candidates would be most interested to opt-in to receiving offers from this select group of organs while not receiving offers from the adult donors

categorized in Sequence C. UNOS staff noted they will discuss this idea internally and get back to the Workgroup with more details.

UNOS staff asked if programs with pediatric candidates often limit offers to a certain KDPI threshold. One member mentioned that their program limits most offers to under 35% but allow a select few to receive offers up to 85%. Several members expressed that being able to opt out of adult donor offers in Sequence C would be very beneficial so that programs could change their filters and listing practices to accept this niche group of Sequence C organs without also receiving offers from adult donors.

Next steps:

The Workgroup will discuss a potential SRTR data request at the next meeting now that there is consensus on a policy solution.

**3. Data Request Introduction**

The Workgroup was planning to discuss what potential data elements to include on an SRTR data request but did not get to this agenda item.

**Upcoming Meeting**

- October 19, 2020 – Kidney-Pediatric Workgroup Meeting

## Attendance

- **Workgroup Members**
  - Arpita Basu
  - Caitlin Shearer
  - Jim Kim
  - John Barcia
  - Khashayar Vakili
  - Martha Pavlakis
  - Abigail Martin
  - Vincent Casingal
- **HRSA Representatives**
  - Marilyn Levi
  - Raelene Skerda
- **SRTR Staff**
  - Nick Salkowski
- **UNOS Staff**
  - Amanda Robinson
  - Ben Wolford
  - Betsy Gans
  - Jennifer Musick
  - Joann White
  - Kiana Stewart
  - Lauren Mauk
  - Lauren Motley
  - Lloyd Board
  - Matthew Prentice
  - Melissa Lane
  - Roger Brown
  - Roger Vacovsky
  - Shannon Edwards
  - Tina Rhoades
  - Nicole Benjamin