OPTN Ad Hoc Disease Transmission Advisory Committee
Meeting Summary
October 13, 2020
Conference Call

Ricardo La Hoz, MD, FACP, FAST, FIDSA, Chair
Lara Danziger-Isakov, MD, MPH, Vice Chair

Introduction

The Ad Hoc Disease Transmission Advisory Committee met via Citrix GoToMeeting teleconference on 10/13/2020 to discuss the following agenda items:

1. Policy Oversight Committee Update
2. COVID-19 Update
3. Algorithm Severity Rules
4. Align OPTN Policies to the US Public Health Service (PHS) Guideline 2020
5. Closed Session: Confidential Peer Case Review

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

1. Policy Oversight Committee Update

DTAC Vice Chair presented an update from the Policy Oversight Committee on their current strategic priority workgroups and potential DTAC involvement.

Data summary:

Slides attached.

Summary of discussion:

A committee member asked if one of the DTAC pathologists should be involved in the POC strategic workgroup for biopsy practices. The committee Vice Chair explained that one already is on the workgroup and representing DTAC.

2. COVID-19 Update

UNOS medical director presented on the current state of COVID-19 in the United States and international organ transplantation networks.

Data summary:

Slides attached.

Summary of discussion:

Committee members discussed the effects of COVID-19 on the transplantation system. One member posed that so far all cases submitted as potentially donor-derived seem to be community or hospital-derived, but as the pandemic evolves, people who have acquired COVID in the past will likely become donors. The past Chair brought up that SARS-CoV-2 is on the DTAC *Pathogens of Special Interest* list in an attempt to assess the safety of using these organs, but that that the organs may not be used out of a fear of transmission. There may be acceptable organs being discarded, or not even offered if the donor

was previously positive, even if it was over 30 days ago. One committee person recommended the DTAC create a pathway for donors with a history of COVID to be reported and investigate the 45-day outcomes, and to use this data to develop education on the safety and usability of these organs.

The UNOS medical director commented that this will be important for the transplant community to find out, as there are millions who have acquired COVID within the country. Many will at some point become potential donors, and UNOS received an inquiry last week around the potential to collect data for PCR testing and viral load counts instead of just whether a test is positive or negative, since people have been shown to shed viral particles for a long period of time after they are no longer infectious. However, respiratory infectivity may not be equivalent to potential for transmission through an organ.

One committee member commented that if the committee were to investigate previously COVID-19 positive donors, the follow-up may need to be farther than 45 days out, and may be organ-specific in timing. Two committee members commented that their hospital has used donors who have recovered from COVID over 28 days ago with good outcomes, and that it would be good to have that data systemically collected. The Chair commented that the committee should try to collect this data at this point in the pandemic, when the transplants may be relatively uncommon, and that the longer DTAC waits the more frequent it will become and the harder it will be to measure that amount of data.

The CDC representative commented that there are some limitations to the pathogens of special interest reporting. If the donor is positive at the initial evaluation, but negative at the time of transplant, that wouldn't need to be reported. One committee member also commented that if the donor doesn't proceed to donation, it also doesn't need to be reported.

The UNOS medical director reminded committee members that the OPTN database was never intended as a clinical research database. The OPTN database is not intended to be altered for active study, not as a research study tool. There needs to be established criteria and outcomes as to why this data should be collected.

The CDC also commented that public health surveillance is generally not considered research for IRB purposes, and that UNOS could evaluate this under the consideration of public health surveillance.

Committee members also commented on including donor screening questions on the history of SARS-CoV-2 infection, antibody or antigen testing, as well as advising that these organs be transplanted into recipients who have recovered from COVID. One member also commented that there may be a difference between donors who are asymptomatic but have an incidental COVID-19 positive PCR.

Next steps:

The UNOS liaison will continue the discussion internally and with committee leadership as to what feasible options would be. At that point, we would put together a further discussion with the committee. In addition, the OPO leadership should be consulted if the primary concern is about donor utilization.

3. Algorithm Severity Rules

DTAC Chair presented on the discussion between committee members on potential changes to the current algorithm severity rules.

Data summary:

An update of proposed algorithm changes was given to committee members. The current proposed changes include more use of the option of "potential for late morbidity", and the Chair reviewed the change proposed in June.

Summary of discussion:

One member asked for clarification on the use of "severe", and if it primarily surrounds clinical manifestations, even if the condition itself is non-severe. Committee Chair answered that discussion between reviewers and the committee is important in deciding, but that the committee is looking for a more standardized process in the future.

One representative brought up that IWDT (intervention without disease transmission) should not have the option for "severe", as if there are symptoms of disease it would not be IWDT.

One committee member brought up an example of CMV being a good candidate for IWDT, non-severe but potential for late morbidity, if the current manifestations of the disease are non-severe.

Next steps:

The Committee would like to continue the discussion on potential rules for the severity algorithm.

4. Align OPTN Policies to the US Public Health Service (PHS) Guideline 2020

DTAC immediate past Chair presented on the public comment reception of the proposal, as well as potential changes.

Discussion: Living Donor Specimen Storage

The immediate past chair brought up that she doesn't think that 2 aliquots of serum stored for 10 years for a living donor is going to be a significant burden on programs, based on freezer sizes. A UNOS staff member brought up that one of the major concerns expressed about living donor specimen storage was the issue of consent and perception by the donors, not just the cost. The Chair brought up that one of the concerns in the PHS revisions process was that a separate consent for donors with increased risk factors caused stigma and could lead to lower organ utilization, and possibly in this case lower rates of living donation. He proposed that instead the committee educate that the samples will only be used during investigation of suspected donor-derived disease. The former chair said that consent could be left to center discretion, along with their other living donor consents.

One DTAC member brought up that OPOs are storing samples for 10 years for deceased donors. In addition, living donors are often very motivated, and he didn't believe that it would dissuade them from donating. A Living Donor Committee staff member interjected that both the Living Donor Committee and Patient Affairs Committee had brought up concerns that the policy for living donor specimen storage could lead to lower rates of living donation. The CDC interjected that they did not believe that if somebody is willing to donate an organ, that additional testing or storage would deter them. They also stated that this is a current requirement for blood donors and yet many people still donate blood. The Living Donor Committee chair stated that while she would have still been willing to donate, she has heard from many committee members that there is some patient pushback and there could be loss of donors. In addition, the 10-year requirement did not seem data-driven to the committee, and they were concerned both about logistics and cost for the storage of these specimens. The OPTN informed consent process for living donation would definitely need to include a portion on specimen storage.

The DTAC past chair said that she believes people are worried about the living donor specimen storage requirement just because it's new. Living donors are already tested for infectious disease, but the last time HIV was transmitted it was from a living donor. In addition, testing requirements for living donors are still more relaxed—infectious disease tests are only required within 28 days' pre-transplant instead of 96 hours like for deceased donors. It also keeps the living donors from needing to go back to the hospital for testing if there is a suspected transmission. The current chair brought up that there needs to be an investigation and evaluation of suspected disease transmissions if there is to be trust in the

system. The Living Donor Committee chair said that she would like to take the discussion back to her committee the following day. The DTAC past chair said that DTAC and the CDC have given a clear commitment to continue to evaluate these policies, and any unintended consequences. In addition, all of the concerns allow for more targeted education. The HRSA representative stated that the HRSA Office of General Council looked into the question of use of these samples, and that the storage is protected through both federal and state privacy laws.

A UNOS representative explained that the Living Donor Committee had a leadership call that morning, and that living donor consent is very extensive in OPTN policy, with the aim of protecting living donors. Not having a consent for specimen storage would be inconsistent with the rest of living donor policies, and may be concerning. This would not need to be a separate consent like is currently in policy for the PHS guideline consent. Committee members were in agreement that it made sense in that context, and unanimously agreed that it would be good to write into policy. Committee members wanted to clarify that the specimens would be used for investigation of "potential disease transmissions" so that it would cover both donor-derived infections and malignancies. In addition, they wanted to make sure that it would be clear that these specimens are HIPAA-protected.

Discussion: Deceased Donor Infectious Disease Testing Within 96 Hours of Procurement

One DTAC committee member, an OPO representative, brought up that the OPO community is greatly concerned about the 96 hours' testing window prior to OR due to the fluidity of recovery times. He brought up that cross-clamp time is going to be much more difficult on OPOs to predict than OR entry time, since there can be intra-operative delays and the surgery will have already started, such as for biopsies. While OR times can be delayed due to logistical and recipient issues, it's a more predictable time than cross clamp. In addition, he cited that the cost of re-running donor infectious disease testing could be 1600 or more per case. At his specific OPO, he only identified 16 times this would have happened out of >600 cases, but he has heard from colleagues who are more aggressive about early testing that this could be almost a quarter of their donors. He also brought up concerns due to differing results and when those results would be back, and the potential issues that could cause. In addition, would the OPO be required to re-run all infectious disease testing, or only negative testing?

A CDC representative brought up that HCV positive donors are at higher risk for also being HIV or HBV positive, and the donor could have tested positive for one blood-borne viral illness but still be in the window period for another.

Another OPO representative brought up that there can be unexpected OR delays due to traumas or other emergencies for any OPO that does not have their own surgical center. He agrees with the policy in theory, but is concerned that it may be difficult to execute. A HRSA representative said that there needs to be some sort of timeframe in policy for this testing, and that OPOs will need to plan accordingly. A CDC representative added that in the original version of the PHS proposal, the timeframe was 72 hours and the CDC then lengthened it and allowed repeat testing to be pending at time of transplant in response to community feedback.

The DTAC Chair stated that these policies should really have recipients at the core, both their safety and their trust in the system. Some donor-derived transmissions generate a large amount of publicity and undermine public trust in transplantation. It is also important that DTAC be able to evaluate the impact of this policy on OPOs and their costs for repeat testing.

One committee member brought up that the OPOs also have to respect the wishes of the family members, who sometimes give them a date to be completed by for a patient's funeral. Another committee member brought up that OR delays could also lead to delays in medically urgent patients receiving organs.

One committee member asked if DTAC had any data on the rate of picking up a true positive result by testing a recipient a few days later. Another member responded that there had been multiple HCV cases the committee adjudicated that had been negative at time of testing, but the CDC tested a sample drawn at time of procurement that was positive. The CDC agreed and said that as HCV is becoming more common, and more donors are being utilized, this situation is one that the PHS guideline is looking to minimize.

Discussion: HBV Vaccination Data Collection

The committee was in agreement to mandate HBV surface antibody results be collected to document HBV immunity status. There was some division on how to document HBV vaccination status, and whether a question on whether or not a transplant program was aware of if a candidate was vaccinated might provide useful, actionable data or not. The committee was in agreement that data on vaccination is important, as HBV is the second most commonly transmitted disease by transplantation. One committee member proposed adding a timeframe to the data field, such as whether or not a patient had received an HBV vaccination or booster within X number of years.

Discussion: Universal Post-Transplant Testing

The DTAC Past Chair discussed that the AST had raised concerns on the potential financial burdens on transplant programs for universal post-transplant testing if the testing is not covered by insurance. Committee members were in agreement that this proposed change is an improvement, even if they might also recommend HBV testing at 6 months. The Vice Chair proposed that they proceed with the language as written, and evaluate if there are any gaps in testing for recipients during the policy evaluation period.

Next steps:

The Committee will further discuss and vote on the proposed language changes at their October 26th meeting.

5. Closed Session: Confidential Peer Case Review

Summary of discussion:

The Committee had a closed session of confidential medical peer review of potential derived transmission events.

Upcoming Meetings

- October 26, 12 PM EST, Teleconference

Open Session Attendance

- **Committee Members**
  - Ann Woolley
  - Avinash Agarwal
  - Charles Marboe
  - Deb Levine
  - Gary Marklin
  - Heather Stevenson-Lerner
  - Helen Te
  - Jason Goldman
  - Kelly Dunn
  - Lara Danziger-Isakov
  - Marian Michaels
  - Meenakshi Rana
  - Raymund Razonable
  - Ricardo La Hoz
  - Saima Aslam
  - Stephanie Pouch
- **HRSA Representatives**
  - Jim Bowman
  - Marilyn Levi
- **CDC Staff**
  - Jefferson Jones
  - Pallavi Annambhotla
  - Sridhar Basavaraju
- **UNOS Staff**
  - Brian Plucinski
  - Cassandra Meekins
  - Courtney Jett
  - Craig Connors
  - Darby Harris
  - Darren Di Battista
  - David Klassen
  - Emily Ward
  - Emily Womble
  - Kristine Althaus
  - Leah Slife
  - Lindsay Larkin
  - Nicole Benjamin
  - Shannon Edwards
  - Susan Tlusty
- **Other Attendees**
  - Heather Hunt

Closed Session Attendance

- **Committee Members**
  - Ann Woolley
  - Avinash Agarwal
  - Charles Marboe
  - Deb Levine
  - Gary Marklin
  - Heather Stevenson-Lerner
  - Helen Te
  - Jason Goldman
  - Lara Danziger-Isakov
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