Require Notification of Human Leukocyte Antigen (HLA) Typing Changes

OPTN Histocompatibility Committee
Purpose and Proposal

- **Purpose**
  - Ensure better patient safety through early notification of critical HLA typing changes
  - Incorrect candidate, recipient, or donor HLA typing has the potential to lead to serious adverse events

- **Proposal**
  - Policy to require immediate reporting of critical HLA typing changes
An HLA critical discrepancy is a difference among non-equivalent values at one or more loci. This applies to donor, candidate, and recipient critical discrepancies.

In 2019, there were 48 critical discrepancies in HLA typing that had the potential to lead to adverse patient safety events.

Among the 27 patient safety reports related to HLA typing in the past two years, many cited delayed notifications.

Current policy does not require notification of typing changes to the host OPO or accepting transplant programs.
Member Actions

- All notifications are recommended to be as soon as possible
- Notification and documentation are required once the laboratory is certain of the correct typing

<table>
<thead>
<tr>
<th>Member</th>
<th>Notifies</th>
<th>Within</th>
<th>For</th>
</tr>
</thead>
<tbody>
<tr>
<td>Histo lab</td>
<td>OPO</td>
<td>1 hour</td>
<td>Donors</td>
</tr>
<tr>
<td>Histo lab</td>
<td>Transplant Program</td>
<td>5 days</td>
<td>Candidates</td>
</tr>
<tr>
<td>OPO</td>
<td>Transplant Programs</td>
<td>12 hours, or before procurement</td>
<td>Donors</td>
</tr>
</tbody>
</table>
What do you think?

- Should an automated electronic notification be included in implementation?
- Is it feasible to create policies for cases between procurement and transplant?
- Are the proposed notification timeframes reasonable?
- Should it be required to re-execute a match run if there is a critical HLA discrepancy?