

## **OPTN Pancreas Transplantation Committee**

### **Meeting Summary**

**March 17, 2021**

**Conference Call**

**Silke Niederhaus, MD, Chair**  
**Rachel Forbes, MD, Vice Chair**

### **Introduction**

The Pancreas Transplantation Committee (the Committee) met via Citrix GoToMeeting teleconference on 3/17/2021 to discuss the following agenda items:

1. Public Comment Proposal Presentation: Clarify Multi-Organ Allocation Policy
2. Public Comment Proposal Presentation: Modify the Deceased Donor Registration (DDR) Form
3. Feedback Requested: Data Advisory Committee (DAC) Refusal Codes Project

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

#### **1. Public Comment Proposal Presentation: Clarify Multi-Organ Allocation Policy**

The Committee was provided an overview of the OPTN Organ Procurement Organization (OPO) Committee's Clarify Multi-Organ Allocation Policy proposal. Members provided the below feedback.

##### Summary of discussion:

Most pancreata transplanted are kidney-pancreas (KP) transplants and a policy like this would potentially lessen the number of KPs available for allocation, which would generally increase pancreas discards. The Committee expressed that this should be monitored in order to see how many KPs turn into pancreas alone transplants because the kidneys were allocated with other organs.

A member expressed concern that, while the number of multi-organ transplants for current modeling is small, expanding to 500 nautical miles (NM) could allow for more multi-organ candidates to be ranked ahead of a kidney or KP candidate. The importance of monitoring was again emphasized, especially since kidney candidates have the longest waiting time and KP candidates have high waitlist mortality.

A member noted that this policy doesn't recognize the acute kidney injury experienced by those Status 4 heart candidates, who are also probably more likely to have chronic heart disease that has compromised their kidneys further.

A member reiterated that each of these extra dual listed renal transplants removes an offer for either a KP or kidney alone patient. Most of these patients have very long waiting times, longer than thoracic or liver patients, and this needs to be balanced in multi-organ allocation.

The Committee agrees with the changes made to the multi-organ allocation policy and believes this a good starting point. The Committee emphasized that their above concerns would be addressed during the next phase of the project, when eligibility criteria and safety nets are discussed. Members believe that a heart safety net option would be beneficial in fairly allocating kidneys to heart-kidney, KP and kidney alone candidates.

## **2. Public Comment Proposal Presentation: Modify the Deceased Donor Registration (DDR) Form**

The Committee was provided an overview of the OPTN Organ Procurement Organization (OPO) Committee's Modify the Deceased Donor Registration (DDR) Form proposal.

### Summary of discussion:

Members reviewed the following sections of the DDR and provided the following feedback:

#### *Recovery date*

The Committee agreed that removing recovery date from the DDR is reasonable since there hadn't been major discrepancies between recovery date and cross clamp time within the past 5-10 years.

#### *Citizenship*

A member noted that the value of the citizenship field is being able to recognize another county's generous citizens.

The Committee agreed that the citizenship field could be a barrier to donation and it's still possible to appreciate the generosity of non-citizens without capturing this data.

#### *Donor management*

A member stated that almost all hospitals have electronic records, so it would be more beneficial if a center could upload a medication administered record (MAR), which includes date, time, and dosage, for the last 24 hours. This would also prevent centers from having to re-enter this data.

#### *Number of transfusions during terminal hospitalization*

A member mentioned that the number of transfusions matters more than total volume because each transfusion may have come from a different donor.

Members agreed that keeping the number of transfusions and adding total volume would be appropriate to consider.

#### *Cocaine/Other drug use*

A member stated that, from a heart donor perspective, a center would be interested in knowing if there was a history of drug use, as it relates to cocaine and opioids, even if it's not recent. A member emphasized that history of drug use also affects the kidneys.

The Committee agreed with the change to these two questions and emphasized the need for alignment with the current Donor Risk Assessment.

#### *Chagas and Tuberculosis history*

A member stated that the issue with Chagas is that a patient doesn't have to have a positive PCR; they could have a positive antibody, and the center would be worried about reactivation in the recipient. This is important from an infectious disease standpoint in order to have as much detail as possible to prevent donor transmission.

A member emphasized that Chagas is one of the pathogens of interest that is collected with the Centers for Disease Control and Prevention (CDC), so, while the number of cases may be small, there is still an impact.

Another member noted that, often, donor history is not well known. When speaking with family members of donors, they often don't know if the donor had been treated.

The Committee agreed it would be reasonable to continue to collect Chagas and Tuberculosis history questions and to try to get more information if the family indicates they are aware of it.

#### *Organ recovery section*

The Committee agreed this would be relevant information to keep in the DDR.

#### *Clinical infection confirmed by culture*

A member suggested that, if a patient has positive cultures, it be helpful to include the antimicrobials, if they've been treated for those cultures, what they've received, and for how long, since that is often relevant on the recipient end.

The Committee agreed this information would be helpful and also noted this would be captured in the MAR discussed in the donor management section.

### **3. Feedback Requested: Data Advisory Committee (DAC) Refusal Codes Project**

The Committee continued their previous discussion on the OPTN Data Advisory Committee's (DAC) Refusal Codes Project.

#### Summary of discussion:

The Committee reviewed the final two categories of refusal codes and provided the following feedback:

#### *Organ Specific Reasons*

A member suggested that the code "Warm ischemic recovery time too high" should be changed to "Warm ischemic recovery time too long".

A member noted that, for pancreas preservation, there isn't currently pumping; however, different centers only accept certain kinds of preservation solution. The member suggested adding "preservation solution not favorable" as a sub-code under organ preservation. Members agreed with adding a specified text field with this sub-code so the preservation solution could be listed.

#### *Other*

Members agreed that it is helpful to have the code "Disaster/Emergency/Epidemic/Pandemic" for both candidates and donors because there could be disasters that only affect certain parts of the country. A member also noted that, as seen with COVID-19, practice patterns varied by transplant center and weren't solely based on the pandemic.

There were no additional comments. The meeting was adjourned.

### **Upcoming Meetings**

- April 7, 2021 (teleconference)

## Attendance

- **Committee Members**
  - Silke Niederhaus
  - Rachel Forbes
  - Antonio Di Carlo
  - Ken Bodziak
  - Nicolae Leca
  - Parul Patel
  - Randeep Kashyap
  - Todd Pesavento
  - Tracy McRacken
- **HRSA Representatives**
  - Marilyn Levi
  - Raelene Skerda
- **SRTR Staff**
  - Bryn Thompson
  - Jonathan Miller
  - Nick Salkowski
- **UNOS Staff**
  - Joann White
  - Rebecca Brookman
  - Ross Walton
  - Adel Husayni
  - Leah Slife
  - Nang Thu Thu Kyaw
  - Robert Hunter
  - Sarah Konigsburg
- **Other Attendees**
  - Diane Brockmeier