OPTN Pancreas Transplantation Committee
Meeting Summary
September 11, 2025
Conference Call

Dolamu Olaitan, MD, Chair
Ty Dunn, MD, MS, FACS, Vice Chair

Introduction

The OPTN Pancreas Transplantation Committee (the Committee) met via Teams teleconference on 09/11/2025 to discuss the following agenda items:

1. Operations and Safety Committee Workgroup Update
2. Public Comment Proposal: *Establish a Comprehensive Multi-Organ Allocation Policy*
3. New Project Discussion

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

1. Operations and Safety Committee Workgroup Update

The OPTN Operations and Safety Committee (OSC) Workgroup has been re-evaluating deceased donor testing requirements. Some members of the Pancreas Committee were on the Workgroup and shared the updated requirements, seeking the Committee's feedback on the updates.

Summary of presentation:

The following policies are being re-evaluated:

- Deceased Donor General Risk Assessment (Policy 2.8)
- Deceased Donor Infections Disease Testing (Policy 2.9)
- Additional Deceased Donor Testing (Policy 2.10)
- Required information for deceased kidney, liver, heart, and pancreas donors (Policies 2.11 A, B, C, and E)

The Workgroup is seeking the Committee's feedback on the following changes to policy 2.11.E (language still subject to change):

Policy 2.11.E: *Required Information for Deceased Pancreas Donors*

The host OPO must provide ~~all~~ the following ~~additional~~ information for all deceased donor pancreas offers:

1. Family history of diabetes (including Type 1 and Type 2)
2. Hemoglobin A1C, if ~~performed~~ requested by the transplant program
3. HLA information as follows: A, B, Bw4, Bw6, C, DR, DR51, DR52, DR53, DQA1, DQB1, DPA1, and DPB1 antigens prior to organ offers
4. Insulin ~~protocol~~ administration
5. Serum amylase, if available
6. Serum lipase
7. Serum lipase upper normal limit
8. Glucose

The Workgroup also sought the Committee's feedback on whether a "serum glucose" test (a required test in Policy 2.8) is the same as "glucose" test.

Summary of discussion:

The Committee agrees with the language as proposed. Additionally, the Committee notes that there is no difference between "glucose" and "serum glucose," therefore it is appropriate to standardize the language used.

Committee members raised concerns about the use of the word "required" in the policy title, especially since specific items—like Hemoglobin A1C (HbA1C) and glucose—were labeled differently within the policy itself. For example, HbA1C was listed as "if requested," and serum amylase as "if available." One member questioned why HbA1C had been downgraded from a required test to something optional, arguing that if a transplant program requests this information, it should be mandatory to provide it.

In response, the presenting member explained that the change was made to reflect differing opinions within the pancreas transplant community. While some clinicians view HbA1C as essential for evaluating pancreas donors, others find it less useful. To strike a balance, the policy language was softened to "if requested," allowing programs to ask for the data without making it a universal requirement.

An OPTN contractor staff member (staff) clarified that the enforcement of data requirements within the OPTN Computer System depends on the exact wording used in the policy—not the title. Terms like "if available" or "if requested" remove the system-level enforcement, giving transplant centers more flexibility.

A member suggested that HbA1C might still warrant stronger language, and asked the Committee to weigh in. The Vice Chair agreed that it's important to set clear expectations, but emphasized that missing data—such as HbA1C—should not prevent an organ offer from being sent. They agreed with the current phrasing, noting that it allows transplant programs to request the information while avoiding delays caused by hospital limitations. Overall, they endorsed the language as proposed by the Operations and Safety Committee Workgroup.

Another committee member expressed support for the proposed changes, noting that the added flexibility could help speed up the organ offer process. They appreciated that the policy language was designed to align with operational realities, especially in situations where certain data might not be immediately available.

The Chair echoed this support, pointing out that HbA1C is not universally used and may not be readily accessible at all donor hospitals. Because of this, removing the system-level requirement for HbA1C makes sense. Regarding glucose documentation, the Chair emphasized that any form of glucose measurement, whether from a serum test or a fingerstick, should be considered acceptable. Glucose is typically included in standard lab panels and is almost always available, so specifying the method of measurement is unnecessary.

The Vice Chair agreed, adding that requiring a specific type of glucose data could create unnecessary barriers. They supported keeping the language broad to ensure clinical flexibility and avoid delays in the offer process.

Next steps:

The feedback will be taken to the OSC Workgroup and taken into consideration as they develop their final proposal recommendations.

2. Public Comment Proposal: *Establish a Comprehensive Multi-Organ Allocation Policy*

The Committee received a presentation from the Co-Chair of the Multi-Organ Transplantation Committee (MOT) on their proposal *Establish Multi-Organ Allocation Policy*.

Summary of discussion:

The Committee's feedback for the proposal to be posted on the OPTN website:

The OPTN Pancreas Committee thanks the OPTN Ad Hoc Multi-Organ Transplantation Committee for its work and dedication to developing policy on multi-organ allocation. The Committee would be in support of the proposal should the following issues be incorporated into a final proposal:

The Committee encourages thorough and robust post-implementation monitoring with a focus on dual organ transplant outcomes as well as pancreas allocation within the proposed tables, as there is risk of an increase in pancreas non-utilization.

The Committee recommends that in rare cases of a kidney candidate with CPRA 100% who also needs a pancreas, the pancreas should follow the kidney as required share, ensuring that highly sensitized KP candidates are not disadvantaged due to being ranked at a lower stratum on the allocation tables.

The Committee recommends extensive educational offerings be made available to OPOs and transplant centers, especially in scenarios where organ availability changes just before procurement (i.e. in the OR).

The Chair expressed appreciation for the proposal, emphasizing its potential to bring greater consistency to organ allocation practices. They noted that the approach appeared fair, particularly for pediatric and kidney-pancreas (KP) candidates. It was mentioned that historically, multi-organ transplants have been prioritized over KP cases, but the new model introduces a more balanced framework. That said, they noted some pediatric candidates may still rank above KP when KP receives only 15% of the allocation.

One committee member raised a question about the logistics of kidney allocation. They asked whether one kidney would be designated for heart or liver candidates, while the other would be reserved for kidney-alone or KP candidates. In response, the MOT Co-Chair explained that the MOT committee had initially considered splitting kidneys between lists but ultimately found that approach inequitable. Instead, the proposed system runs all match sequences simultaneously, offering organs in order of medical urgency. For example, a liver would be offered to a status 1 liver candidate, and if that candidate also requires a kidney, it would be included in the offer. The process would then continue through the remaining organ match runs.

The same member sought further clarification on how the Organ Procurement Organization (OPO) would prioritize among heart, liver, and lung candidates. The Co-Chair explained that the MOT Committee used a value prioritization exercise (VPE) to determine the relative urgency of each organ type. This exercise informed the development of seven distinct allocation plans, which will guide the OPO in determining the order in which offers should be made.

A committee member raised concerns about fairness and long-term outcomes in the proposed allocation model. They emphasized the importance of comparing results from dual-organ transplants to those from safety net transplants, pointing to data showing that high-quality kidneys used in dual-organ procedures often lead to poorer outcomes, such as higher rates of primary non-function (PNF) and graft

failure. They expressed their concern that this can disadvantage candidates waiting for kidney-alone or KP transplants.

The member also warned about the risk of increased pancreas non-utilization. Because kidneys are frequently allocated before reaching pancreas candidates, the pancreas may be left without a paired kidney, potentially leading to non-use. They referenced an example from the presentation where a high-quality pancreas would likely be go unplaced due to how kidneys were allocated.

Another concern they raised was the possibly high number of retransplants, as about one-third of the kidney transplant waitlist, which they felt suggests that current practices may prioritize transplant volume over durability and long-term success.

The Co-Chair acknowledged these concerns and explained that the MOT committee had prioritized medical urgency and access to therapies over long-term organ function when designing the allocation framework. They noted that pancreas placement is rare before KP candidates, and the new allocation tables aim to improve visibility and increase offer rates for KP. The Co-Chair agreed that post-implementation monitoring will be critical, especially for multi-organ cases, to ensure the policy performs as intended.

The Vice Chair emphasized the importance of post-implementation monitoring, especially for pancreas patients, noting these are often kidney patients with specialized needs. They raised a concern about how the proposed allocation tables might affect highly sensitized KP candidates, specifically those with a Calculated Panel Reactive Antibody (CPRA) of 100%. Under the current proposal, these candidates are ranked below kidney-alone candidates and may not receive a kidney unless they are listed separately as kidney-alone. The Vice Chair suggested this may be a legacy policy issue, where allocation is driven more by waiting time than by sensitization level.

Another member agreed and clarified that KP candidates with CPRA 100% should be prioritized over non-sensitized candidates, just as CPRA 100% kidney-alone candidates are. They questioned whether the pancreas categories in the allocation tables should be structured to mirror the kidney categories, to ensure fairer prioritization.

The Vice Chair added that the current classification groups all KP candidates with CPRA ≥80% together, which prevents highly sensitized KP patients from competing effectively with kidney-alone candidates. Unless a kidney remains available and reaches the pancreas list, these KP candidates are often left with no option but to accept a kidney-alone transplant.

In response, the MOT Co-Chair acknowledged the concern and explained that the allocation tables were designed to prioritize single-organ candidates where appropriate, based on how rarely certain match types appear. They agreed to bring the issue back to the MOT Committee for further review.

A member suggested that in these rare cases of highly sensitized KP candidates, the pancreas should be allowed to follow the kidney when the kidney is allocated at a higher priority. This would help ensure that these candidates receive both organs when clinically appropriate. The Vice Chair supported the idea.

The member also noted that their center often registers KP candidates for kidney-alone as well, since the pancreas tends to receive lower priority and candidates may miss out on national sharing benefits. Another member added that although CPRA 100% KP candidates are uncommon, they face significant challenges in competing for organs. Members noted that many transplant centers treat KP and kidney-alone candidates as part of a shared pool, and the allocation system should reflect that reality.

The Vice Chair shared that they also counsel CPRA 100% patients to list for both kidney-alone and KP, since receiving a kidney-alone may be their best chance to get off dialysis. They then raised a logistical question about how offer acceptance works when organ availability changes during procurement. They described a scenario where a multi-organ transplant falls apart in the operating room, and a kidney becomes available. They asked whether a pancreas-alone offer would still be honored if a kidney later became available.

In response, the MOT Co-Chair clarified that even under current policy it is not allowed to hold organs for potential multi-organ candidates and this would remain the rule under proposed policy. Once an offer is accepted, it is binding and cannot be withdrawn, even if additional organs become available during procurement. If circumstances change, the organ procurement organization (OPO) should refer back to the MOT allocation table to guide next steps.

Both the Chair and Vice Chair expressed appreciation for the work done by the MOT Committee, acknowledging the complexity of the proposal. The Vice Chair also praised the thoughtful sequencing of pediatric and KP candidates in the allocation tables, describing the framework as well-balanced.

Next steps:

The Committee's discussion will be summarized into feedback for the MOT Committee and submitted for public comment.

3. New Project Discussion

There was no time to cover this agenda item. It will be discussed during the next meeting.

Upcoming Meetings

- October 14, 2025
- November 11, 2025
- December 9, 2025

Attendance

- **Committee Members**
  - Colleen Jay
  - Dean Kim
  - David Lee
  - Mallory Boomsma-Kempf
  - Neeraj Singh
  - Muhammad Yaqub
  - Oyedolamu Olaitan
  - Shehzad Rehman
  - Stephanie Arocho
  - Girish Mour
  - Ty Dunn
- **SRTR Representatives**
  - Bryn Thompson
  - Jon Miller
- **UNOS Staff**
  - Stryker-Ann Vosteen
  - Lindsay Larkin
  - Sarah Roache
  - Joann White
- **Other**
  - Lisa Stocks