OPTN Pancreas Transplantation Committee
Meeting Summary
May 5, 2025
Conference Call

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

Introduction

The OPTN Pancreas Transplantation Committee (the Committee) met via Cisco Webex teleconference on 05/05/2025 to discuss the following agenda items:

1. Match Run Analysis: Medical Urgency

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

1. Match Run Analysis: Medical Urgency

OPTN Contractor staff (staff) presented the medical urgency dashboard that was developed by UNOS staff. This tool aims to aid the Committee in decision making for continuous distribution (CD) attribute weights, with initial focus directed towards the weight of the medical urgency attribute.

Summary of presentation:

Staff presented two possible main approaches for the Committee to consider:

- Low weight approach: Assign a relatively low weight to medical urgency initially, giving some priority to urgent candidates while more data is collected on pancreas medical urgency.
- High weight approach: Assign a high weight equal to that of the CPRA, Pediatrics, and Prior Living Donor attributes, giving medically urgent candidates significant priority—even over nearby non-urgent candidates with otherwise similar profiles.

Staff, using match run analysis, showed the original attribute weights without medical urgency and compared these to three new scenarios where medical urgency was given 5%, 10%, and 16% of the score, with the other weights rescaled accordingly. With a 5% weight, urgent candidates score slightly higher but still overlap with non-urgent ones. At 10%, the scores spread further apart. At 16%, there's a separation, with urgent candidates having significantly higher median scores.

Summary of discussion:

The Committee indicated a preference to finalize the medical urgency criteria before conducting additional match run analysis and determining the weight of the medical urgency attribute.

A member asked if there is any estimate of how many candidates would be considered medically urgent. Staff explained that for the match run analysis, they used data from the last quarter of 2024 and estimated that 25% of candidates were medically urgent. This estimate was based on published research about the percentage of people with Type 1 diabetes who have impaired awareness of hypoglycemia.

However, staff emphasized that the actual percentage of medically urgent candidates could be higher or lower, but there isn't enough data yet to know for sure.

Another member asked whether medical urgency points are scaled or simply assigned as a yes/no value in these scenarios. Staff clarified that, for now, medical urgency is treated as a binary factor—either a candidate is medically urgent or not. This approach reflects the Committee's discussions so far. However, as more data becomes available and understanding of pancreas medical urgency improves, the Committee may choose to reconsider and adjust this in future updates to the continuous distribution system.

A member asked how the consideration of medical urgency might affect travel distance for organ offers, and whether an increase in travel distance would be an acceptable result. Another member questioned whether this impact could even be predicted right now, since there is no data on how the proposed medical urgency criteria would affect the waitlist. A representative from SRTR expressed concern about the difficulty of estimating how many candidates would qualify as medically urgent, due to the lack of data. They noted that while assumptions could be made based on how common impaired awareness of hypoglycemia is among people with diabetes, there's no way to know how many of these individuals are actually on the transplant waitlist. The Chair added that the actual percentage of medically urgent candidates is probably lower than the 25% estimate used in the model. They explained that only about 5–7.5% of the U.S. population has Type 1 diabetes, so the number of those who also have impaired awareness of hypoglycemia—and meet the medical urgency criteria—is likely even smaller.

The Vice Chair recommended looking at match run analyses that assume 1%, 5%, and 10% of candidates are medically urgent, because using 25% might make the data harder to interpret. They also suggested that it would be better to create a survey and collect real data on how common impaired awareness is before deciding how much weight to give this attribute.

One member expressed concern that the Committee still hasn't defined what medical urgency means, even though they have been discussing it for several years. They asked what specific data would be needed to make a final decision. The Chair suggested that Committee members could review their current waitlists to see how common impaired awareness of hypoglycemia is based on the proposed criteria, looking at data over 6 months to a year. They also noted that a formal plan for this review would need to be created and that this work would be done outside of the OPTN purview.

Staff explained that the weight assigned to medical urgency must be decided before the final CD proposal, since the composite allocation score (CAS) for each candidate depends on these attribute weights. They also suggested a possible approach of starting with a conservative weight for medical urgency. As more data is gathered and better understood, the Committee can later decide to increase the weight or adjust other attribute weights as needed.

The SRTR representative shared concerns about the sudden impact that adding medical urgency could have, especially if 25% of candidates are given this priority right away. They worried this could cause negative reactions from the transplant community. They suggested that using a sliding scale for medical urgency points might help address these concerns. They also emphasized the importance of making sure the criteria for medical urgency are well-defined first, and that the weight is set high enough to prioritize only the truly urgent candidates—without a large portion of the waitlist suddenly qualifying. Staff noted that this feedback matches what they've heard from endocrinology experts, who recommended starting with stricter criteria and expanding them gradually if needed.

At the end of the meeting, the Committee chose not to take a straw poll. Members said they wanted to finish discussing and finalizing the medical urgency criteria before reviewing more match run data.

Next steps:

The Committee will finalize discussions regarding the medical urgency criteria. Staff will rescale the match run analysis for future conversations.

Upcoming Meetings

- June 2, 2025

Attendance

- **Committee Members**
  - Asif Sharfuddin
  - Colleen Jay
  - Diane Cibirk
  - Dean Kim
  - Mallory Boomsma-Kempf
  - Patrick McGlone
  - Neeraj Singh
  - Oyedolamu Olaitan
  - Piotr Witkowski
  - Shehzad Rehman
  - Stephanie Arocho
  - Rupi Sodhi
  - Girish Mour
  - Todd Pesavento
  - Ty Dunn
- **SRTR Representatives**
  - Bryn Thompson
  - Jon Miller
  - Raja Kandaswamy
- **UNOS Staff**
  - Stryker-Ann Vosteen
  - Dzhuliyana Handarova
  - Cole Fox
  - Lindsay Larkin
  - Ross Walton
  - Keighly Bradbrook
  - Asma Ali