

**OPTN/UNOS Thoracic Organ Transplantation Committee
Meeting Minutes
December 21, 2017
Teleconference**

**Kevin Chan, MD, Chair
Ryan Davies, MD, Vice Chair**

Introduction

The Thoracic Committee met via Citrix GoToTraining teleconference on December 21, 2017 to discuss the following agenda items:

1. Required Policy Changes: Heart-Lung Policy

The following is a summary of the Thoracic Committee's discussions:

1. Required Policy Changes: Heart-Lung Policy

Summary of discussion:

The Committee continued its discussion of heart-lung allocation policy from December 14, 2017. Heart-lung transplant policy needs to be reviewed and changed in order to align it with the Executive Committee's emergency change to remove the DSA as a unit of allocation and replace it with a 250 nautical mile circle. Currently, heart-lung sharing is dependent on DSA. When a heart-lung candidate is allocated a heart, the lung from the same deceased donor must be allocated to the heart-lung candidate. When the heart-lung candidate is allocated a lung, the heart from the same deceased donor may only be allocated to the heart-lung candidate if no suitable Status 1A isolated heart candidates are eligible to receive the heart. A heart-lung guidance document was released previously to aid in the execution of heart-lung policy under the DSA system.

In short, inconsistencies arise between geographic sharing for heart versus lung within the approved but not yet implemented policy. Heart still uses DSA, and heart zones are also defined differently than lung zones. In effect, toggling between the heart match and the lung match now presents challenges due to the geographic inconsistencies between the two organs. It was decided previously by the Committee that the heart should still pull the lung when following the heart match list. Should the lung pull the heart requiring following the lung match list, the Committee suggested a construct where the lung candidate may pull the heart unless there is urgency on behalf of a heart candidate within a certain distance. The Committee therefore recommended the following changes to the heart-lung policy: *if a heart potential transplant recipient (PTR) requires a lung, the OPO must offer the lung from the same deceased donor to the heart PTR according to Policy 6.6.D. If a lung PTR in allocation classification 1 through 12 according to Policy 10.4.C requires a heart, the OPO cannot offer the heart from the same deceased donor to that lung PTR until after the heart has been offered to all heart and heart-lung PTRs in allocation classifications 1 through 4 according to Policy 6.6.D.*

Outstanding questions that need answered by the committee are as follows:

- How far down the lung side of the list (through 250 nautical miles or through 500 nautical miles)?
- How far down the heart side of the list (through classification 4 or through classification 6)?
- On the heart side, "isolated heart candidates" is mentioned. Is that explicit, or is it meant for any heart or heart-lung candidate on the heart side?

- How should the heart-lung allocation from pediatric donors be handled?
- What should happen after the first round of offers?

For pediatric donor lungs, the major issue is that the first unit of allocation goes through Zones A, B, and C. Respectively, this is 250, 500, and 1,000 nautical miles. This creates geographic inconsistencies with the new policy. In order to create consistencies, the recommended changes to heart-lung policy for pediatric donors is as follows: *if a heart potential transplant recipient (PTR) requires a lung, the OPO must offer the lung from the same deceased donor to the heart PTR according to Policy 6.6.E. If a lung PTR in allocation classification 1 through 10 according to Policy 10.4.D requires a heart, the OPO cannot offer the heart from the same deceased donor to that lung PTR until after the heart has been offered to all heart and heart-lung PTRs in allocation classifications 1 through 12 according to Policy 6.6.E.*

The Committee considered whether to include policy for the OPO following the first classification, including the following options: continue to offer the heart and lung bloc according to the remaining classifications in Table 6-7 or Table 6-8; continue to offer the heart and lung bloc according to remaining classifications in Table 10-9 or Table 10-10; or offer the heart to heart candidates, but not heart-lung candidates, according to the remaining classifications in Table 6-7 or Table 6-8, and offer the lung(s) to lung candidates according to Table 10-9 or Table 10-10. However, the Committee noted that heart-lung allocation rarely occurs beyond the geographic zones already designated in their proposed construct, so it may not be necessary to provide prescriptive policy for the OPOs beyond what the heart-lung policy covers.

Next week, the Committee will meet again to discuss final topics, such as sensitized candidates, and potentially finalize the proposal. If additional time is needed by the Committee, January 4, 2018 has been designated as an additional day for the Committee to meet via teleconference.

Upcoming Meeting and Next Steps

- December 28, 2017
- January 16, 2018 – TSAM Results Review
- Regional Meetings begin February 1, 2018 through March 21, 2018

Attendance

- **Committee Members**
 - Kevin Chan
 - Ryan Davies
 - Rocky Daly
 - Greg Ewald
 - James Gleason
 - Jeff Goldstein
 - Shelley Hall
 - Bert Kasiske
 - Erika Lease
 - Nirav Raval
 - Tania Sherrod
 - Kurt Shutterly
 - Maryam Valapour
 - Tim Whelan
 - Maryjane Farr
 - Jonathan Hammond
 - Donna Mancini
 - Masina Scavuzzo
- **HRSA Representatives**
 - Joyce Hager
- **SRTR Staff**
 - Katie Audette
 - Monica Colvin
- **OPTN/UNOS Staff**
 - Liz Robbins
 - Angel Carroll
 - Rebecca Lehman
 - Shyni Mohan
 - Leah Slife
 - Alison Wilhelm