ASTS Responses to OPTN Proposals Open for Public Comment

March 15, 20203

Identify Priority Shares in Kidney Multi-Organ Allocation - Concept Paper

How do transplant professionals recommend improving equity in access to transplant between kidney-alone and kidney multi-organ transplant (MOT) candidates?

Kidney transplant alone (KTA) candidates make up much of the volume of patients on the solid organ transplant waitlist, the longest wait time, and their "medical necessity" is often underestimated since we have HD as an option, as waitlist mortality is still a significant occurrence and an increasingly important outcome measure. We should consider the impact to this group of patients as it relates to kidneys being allocated for MOT.

Should OPOs be required to offer kidneys to some kidney-alone candidates prior to offering kidneys to multi-organ candidates? If yes – what characteristics should prioritize kidney-alone candidates for offers prior to multi-organ candidates?

Yes, during allocation, many OPOs "hold" kidneys for possible MOT scenarios and do not prioritize timely allocation. Many kidneys can wait, but ischemic time especially matters for:

- Pediatric recipients (and its potential effect on DGF)
- Higher KDPI kidneys

Allocating kidneys *after* cross clamp is not an ideal time to be dealing with an unplaced organ.

Also, there are scenarios where access to kidney should be prioritized over MOT as it relates to access to future organ offers.

- Highly sensitized KTA
- Highly sensitized simultaneous pancreas and kidney (SPK)

Should prior living donors receive offers prior to kidney multi-organ candidates?

Yes, the numbers of these patients are very low and given the nature of kidney donation to save lives, they should receive priority over most MOT.

Should some or all pediatric kidney-alone candidates get additional priority for low KDPI kidneys relative to kidney multi-organ candidates?

Yes, children needing a kidney transplant should be a top priority and should get priority over most MOT.

In the absence of policy relating to kidney laterality, how do OPOs currently decide when to offer the left vs. right kidney?

Currently choice is usually given to the MOT candidate center.

Should the OPTN develop policy on when to offer the left vs. right kidney?

Yes, choice should be given to the kidney alone candidate or SPK candidate in most circumstances.

Is it appropriate for policy to distinguish an organ offer order between liver-kidney, heart-kidney, lung-kidney, and pancreas-kidney candidates?

Liver-kidney (SLK), heart-kidney (SHK), lung-kidney should be viewed similarly as the kidney is not the primary live saving organ for the transplant; rather it's the liver, heart, or lung. For an SPK it can be viewed differently, as the lifesaving organ is more often the kidney.

If so, what data should be used to inform such an allocation order?

Kidney outcomes in SPK recipients generally surpass kidney alone outcomes in many instances, however kidney outcomes in liver-kidney, heart-kidney, lung-kidney typically do not surpass kidney alone outcomes in these MOT situations. We should consider utility and long-term outcomes in more of the decision making. As one example, it is not uncommon that a kidney is allocated to a low status SLK or SHK over a pediatric recipient who will likely have more life years served from receiving that kidney.

How can the OPTN provide the necessary level of direction for multi-organ allocation without impinging upon the ability of OPOs to place organs efficiently?

Prioritizing pediatric, prior living donors and highly sensitized kidney alone and SPK recipients will go a long way to achieve more equity for kidney candidates and increase the efficiency and utilization of kidney placement.

Potential Specific Proposed Solutions:

1) If a match run has patients with 100% PRA. One kidney should be mandatory to the KTA list.

2) If a match run has a patient with 98-100% PRA on the SPK list. One kidney should be reserved for this population.

3) High priority (status 1) SHK, and MELD>35 SLK should likely remain a priority.

4) If no medically urgent SLK and SHK, before its moved move to lower priority MELD or status, then one kidney should be preserved for: pediatrics, previous living donor.

5) Medically urgent KTA should always be offered a kidney.

6) 2 hours before scheduled OR, any kidneys not offered to MOT should be primary offer to KTA list. (No more "holding", for a MOT backup)

ASTS Position: Strongly Support