



ASTS Responses to OPTN Proposals Open for Public Comment

September 28, 2022

Continuous Distribution of Kidneys and Pancreata Update

The American Society of Transplant Surgeons (ASTS) is pleased to provide the following feedback for the OPTN Kidney and Pancreas Transplantation Committees on the Continuous Distribution of Kidneys and Pancreata Update.

When considering the current 250nm sharing circles, it must be noted that the two proximity points are unnecessary in this circle and tends to hamper transplants to rural patients listed at their nearby rural transplant centers—that is, further from the busier urban trauma donor hospitals. ASTS believes we have moved too far away from allocating with a major importance on the longevity of the transplant survival. This will only result in need for re-transplant in the near future. We believe that we need to balance this with the post-transplant survival metric as an overall system goal. Putting a great deal of emphasis on highly sensitized candidates generally leads to more re-transplants and a shorter graft survival.

Additionally, prior living donors should have rapid access to transplant, if required. This is a cornerstone of our living donor efforts that may result in many more transplants than deceased donor organs utilized for this prior living donor population.

Highly sensitized patients have been given unfairly rapid access to transplant with known decreased long-term survival. Patients with CPRA < 99.9 should no longer be at the very top of the allocation list as their time to transplant has been shown to be much shorter than the average patient. The increased allocation points were created to make access fair and equal, not to overly advantage higher CPRA candidates. Highly sensitized patients should not have access to top 20% KDPI organ donors unless they have an EPTS in the top 20%.

Additionally, we urge the Committees to include a discussion on equity of access for those awaiting their first versus subsequent deceased donor organ.

Specific Comments to Continuous Distribution Committee Update

Table 1: Kidney

3rd row: ASTS would agree with some sort of continuous longevity matching using KPDI and the unabridged EPTS.

4th row: Blood Type: please remove the current unfair advantage of Blood Type B candidates listed for non-A1 donors. These B candidates should simply be intermixed with the A candidates, not put at the

top of the A list. We believe your newly proposed point system for B candidates who can access non-A1 donors should do this.

KAL safety net: ASTS agrees that safety net patients should have access to top 20 KDPI only for those with EPTS in top 20%.

Last row: ASTS would suggest no point difference within the 250nm initial allocation circle, that is, all points receive the same number of proximity points. Between 250 and 500nm, the ASTS would support a slope down to 25%, with a gradual slope out from 500nm.

Table 2: Pancreas, KP, Islets

Proximity Efficiency: we would suggest no point difference within the 250nm initial allocation circle, that is, all points receive the same number of proximity points. Between 250 and 500nm should be a second set of similar allocation points, then no additional points outside of 500 nm.

Medical Urgency: All candidates listed for Medical Urgency must have documentation completed before being granted such status. The Kidney Committee should set an upper limit of expected Medical Urgency Candidates a year (example 0.5% or less of waiting list). Programs that list more than this number should have all listings reviewed.

HLA Matching: IF DR matching does not limit access to minority populations, then DR matching should be encouraged due to increased longevity of grafts and decreased sensitization.

ASTS agrees with a continuous KDPI and EPTS allocation system. We understand that actual curves have not been created. We would support that Top 20% KDPI curves highly prioritize Top 20% EPTS candidates and perhaps give some access to Top 21 to 40%, but no access above EPTS 40%. KDPI over 75% should be the reciprocal of the Top 20% KDPI organs giving preferred access to EPTS above 80 candidates and then to 61 to 80 EPTS candidates. The extended EPTS scoring system from the original LYFT simulations will likely need to be used with more variables to differentiate the over 20 EPTS candidates.

ASTS agrees with simply giving pediatric candidates low KDPI values. From numerous publications, many pediatric graft losses are due to non-compliance, so an accurate EPTS will likely be difficult to construct with acceptable variables.

CPRA: ASTS would like the Kidney Committee / SRTR to closely look at the high amounts of CPRA points given to those with CPRA > 90 and < 99.9%. There appears to be an unfair rapid access to patients receiving more than a couple of CPRA points with the larger 250nm circle as the number of available kidneys is now greater for initial level of allocation. The CPRA scale should be created to allow equal access, but not more rapid access for sensitized patients.

Pediatric priority: We caution the Kidney Committee not to encourage the use of less optimal donor grafts (KDPI over 35%) for pediatric candidates. It is truly rare that with the current 250nm circles, a pediatric candidate does not receive a Top 35% KDPI offer within a reasonable time frame (unless highly sensitized). For centers who believe they are not receiving offers, they should review the offers with their team.

ASTS agrees with waiting time being kept linear throughout and not making it unnecessarily complicated. We agree with keeping waiting time accumulation starting at eGFR 20 ml/min pre-dialysis as incentive to refer early for transplantation which may increase living donor transplant options.

KAL: ASTS agrees with access to Top 20% KDPI organs for candidates with EPTS Top 20%.

Proximity Efficiency: ASTS would suggest no point differential for sharing within 250nm of the donor hospital as this is usually the distance for driving compared to flying for longer distances. Giving points within the 250nm circle, such as within 50nm simply advantages the transplant centers closer to the trauma hospitals, and unnecessarily disadvantages patients and transplant centers in more rural areas that are still within driving distance of the donor hospital. The few hours of driving add very little to the cost of transportation or to the CIT, has no impact on graft survival, and was not supported by the AHP exercise. The proximity points within a 250nm area only serves to disadvantage those who live further from trauma/donor hospitals and wait longer than those patients whose transplant center is closer to the donor hospital. This can result in an outcome that favors patients who have the means to drive further to large metropolitan hospitals to gain waiting time points over those who are forced to stay at their nearby transplant center that may be rural. (An example of this is the waiting time differential for patients at Augusta Health (MCG) compared to the Atlanta centers which are closer to the major trauma/donor hospitals.)

For higher KDPI organs, more efficient placement will likely occur if you limit the number of patients who can be listed by a center for high KPDI organs at any one time, so the centers have more incentive to use the higher KPDI organs into the appropriate patients on their waiting list. Again, giving large number of points to centers nearer the donor hospitals will give these centers' patients an unfair advantage over rural hospitals' patients.

En Bloc kidneys require much more work effort and skill to implant with a higher risk of thrombosis. The KDPI should be set to reward, not punish, utilization of these organs giving transplant centers some leeway for increased risk of thrombosis.

Released organs: First, the definition of a 'released organ' is not very clear in the document provided. Please provide a clear definition. It appears to be a declined organ once the organ has already arrived at a transplant center. If this is the definition, then proximity points for efficiency of placing released kidneys should be based on KDPI and time from crossclamp as lower KDPI organs are usually easy to place.

ASTS Position: Neutral/Abstain