ASTS Responses to OPTN Proposals Open for Public Comment

September 28, 2022

Continuous Distribution of Livers and Intestines Concept Paper

The American Society of Transplant Surgeons (ASTS) appreciates the opportunity to provide the following feedback to the OPTN Liver and Intestinal Organ Transplantation Committee.

Which attributes should the Committee continue to consider for inclusion in the first iteration of continuous distribution?

The five attributes listed are consistent. Since Medical Urgency is the primary factor in current allocation, it would be difficult to change that to a less weighted attribute.

Are there other attributes the Committee should consider that are not included in the list provided above?

In the sub-score for Post-Transplant Survival, the Committee states they are attempting to reduce futile transplants; however, this is difficult to quantify. An idea would be to *de-emphasize patients with calculated MELD scores above 40.* MELD score is capped at 40, but we recognize it is capped because the benefit of transplant may diminish if the patient is sicker than that. De-emphasizing patients with scores above 40 may reduce futile transplants.

In the sub-score for Patient Biology, they are looking for characteristics for difficult to match and complex transplants. Blood type, size mismatch and re-transplants are all appropriate variables. We suggest *portal vein thrombosis* be an additional variable added to this.

In the Placement Efficiency Sub-score, we feel donor factors should be considered for proximity points. Livers from donors aged above 70 and DCD livers cannot tolerate prolonged ischemic times, so recipients closer to the donor should be given additional points.

As for social determinants of health (SDH), inclusion is fraught with problems but inclusion of post-transplant survival without consideration of SDH runs the significant risk of further disadvantaging underserved populations. Some form of inclusion in the first iteration is important.

Are there any attributes that exist in current policy that should not be included in continuous distribution?

Attempts to introduce the HCC stratification score and the OPOM are too complex and as yet untested rigorously enough to introduce these in first iteration of the continuous distribution; HLA matching and sarcopenia scores should also not be included. The HLA matching does not significantly make a difference, and the sarcopenia scoring is very subjective. Similarly, Social Determinants of Health (SDH)

are very hard to quantify and will unnecessarily complicate this system if introduced. Further refinement of the MELD score, as has been done in the past, may be more palatable.

In the sub-score for Patient Access, "willingness to accept a split liver" is considered one of the variables for priority and we suggest that this score *only* play into the Composite Score when a split liver is being offered.

Any other feedback on the plan to develop continuous distribution of livers and intestines.

We are still in the experimental phase of using liver pumps for transport and storage. This may allow for longer ischemic times and use of more marginal organs. This has not yet figured into any calculation of score points. The Committee needs to do an analysis of this for the future.

ASTS Position: Neutral/Abstain