ISHLT
A Society that Includes Basic Science, the Failing Heart, & Advanced Lung Disease

ISHLT Response to OPTN Concepts for Modifying Multi-Organ Policies

The International Society for Heart and Lung Transplantation (ISHLT) appreciates the opportunity to comment on the policy proposal "Concepts for Modifying Multi-Organ Policies."

ISHLT acknowledges exisiting OPTN policies that prioritize the allocation of multiple organs from the same donor to multi-organ (MOT) candidates based on specific criteria. This historical approach has been grounded in the intention to maximize the impact of each donation, potentially saving the lives of multiple transplant recipients. However, it is also crucial to appreciate that allocating more than one organ to a single candidate should be carefully evaluated against the broader opportunity to allocate lifesaving organs to multiple potential transplant recipients.

It is imperative to underscore two essential considerations on MOT: The need for promoting access to transplant for candidates experiencing failure in multiple organs, and recognizing the challenges they face in finding suitable matches. The fact that receiving organs from the same donor, as opposed to different donors, may mitigate the candidate's immune system response, reducing the risk of organ rejection.

ISHLT acknowledges the potential benefit for kidney-alone recipients yet, the committee is concerned about the impact on MOT candidates, emphasizing the need for a balanced and well-considered approach. Considering the existing evidence concerning the allocation of MOT and kidney-alone recipients with low KDPI, coupled with a thorough analysis of the estimated effects of the proposed policy adjustments, our initial assessment leads to the concern that there is inadequate evidence to justify additional priority beyond what exists in current policy.

The data provided shows that only a small (<1%) percentage of 0-34 KDPI donors had both kidneys allocated to a MOT, suggesting that a requirement to allocate the second kidney to a kidney alone recipient would have a minimal overall impact. However, we acknowledge the potential benefit that the proposed policy adjustments may provide to the pediatric population currently on the transplant waitlist. In light of this consideration, we endorse the view that pediatric candidates should be prioritized, aligning with the overarching principles of fairness and consistency embedded in existing allocation policies.

Finally, candidates in need of MOT involving heart and/or lung transplantation face significant challenges due to life-threatening conditions and complications stemming from advanced heart and/or lung diseases. Again, while cases of this nature are anticipated to not be substantial, categorizing candidates without immediately life-threatening organ failure, such as KP, in the MOT candidate population may introduce ethical complexities and pose potential adverse consequences to MOT candidates involving heart and lung.

In summary, ISHLT recognizes the importance of addressing the needs of specific recipient groups, but it is also crucial to avoid unintended consequences that may negatively impact other vulnerable populations. ISHLT considers reasonable that at least one organ from a 0-35 KDPI kidney donor be offered to pediatric candidates. However, despite not anticipating a substantial impact based on the current available data, ISHLT wishes to express concerns regarding the potential implications of further

modifications to the existing system, particularly prioritizing the allocation of kidneys over MOT recipients.

ISHLT remains committed to fostering equitable and ethical organ allocation practices that prioritize the well-being of all eligible transplant candidates.

ISHLT Level of Support: Take a Neutral Position