LIVER ADVISORY GROUP

LIVING DONOR LIVER TRANSPLANTATION STRATEGY WORKING GROUP

Meeting held on Tuesday 19th March 2019

NBS, 75 Cranmer Terrace, Tooting, London.

PRESENT (No Apologies)

Derek Manas (DM)	Chairman- Consultant surgeon Newcastle; Liver Advisory Fixed Time Working Group
Lisa Burnapp	Lead Nurse Living Donation NHSBT; Chair of LDLT Strategy writing group
Ahmed El-Sharkawy (by phone)	Consultant hepatologist, QEH Birmingham; writing group member
Krish Menon	Consultant surgeon, KCH London; writing group member
Varuna Aluvihare	Consultant hepatologist, KCH London
Chris Watson	Consultant surgeon, Addenbrooke's, Cambridge
Moira Perrin	Clinical Nurse Specialist, QEH Birmingham; writing group member
Julie Jeffery	Advanced Surgical Care Practitioner, St. James' Leeds; writing group member
Katie McGoohan	Clinical Nurse Specialist, St. James' Leeds

Aims of the meeting

- *Is there still a need for LDLT*
- *Is there still a need for a national strategy*
- *Are the current guidelines on indications for LDLT applicable*
- *What should we change in light of NMP and the 'opt-out' legislation*
- *What would expanding the indications look like*
- *How many centres should be designated*
- *What would be an appropriate a patient pathway*

AGREED OUTCOMES AND ACTIONS FROM MEETING

1. General comments

It was agreed that Living Donor Liver Transplantation (LDLT) should remain an option for patients with End Stage Liver Disease who are on a liver transplant waiting list in the UK. In light of the changing landscape, all members accepted that the current situation in which the procedures are performed as isolated events outside of an agreed strategic framework needed to be addressed.

2. Future Strategy

LDLT for both adults and children should be included in the post 2020 strategy for organ donation and transplantation as part of a new 'revised' strategy for liver transplantation (LT) overall. Over the past twenty years the types of donor livers available to recipients has changed significantly and the working group agreed that LDLT should be included as one of the many options being developed. This will ensure equity of access for patients to all forms of LT- including maximising the use of DCD organs, embracing current and new technologies such as normothermic regional perfusion (NRP) and machine perfusion (NMP, HOPE), as well as affording certain patients the opportunity to be considered for LDLT. Having all the options available will help facilitate any changing indications, allowing the opportunity for planned LT and improving the timeliness of LT where required.

3. Changing Indications

As part of a UK strategy for LT, indications for LDLT should become part of any future changes to the current UK liver advisory group (LAG) minimal listing criteria guidelines. At present 50% 5-year survival remains the standard to which all units operate. In reality all centres perform at a much higher level (70% 5-year survival). In addition the new NLOS may disadvantage selected cohorts of patients, including young adults, HCC without decompensated liver disease and re-transplant patients. The current increase in organ supply, expected to be favourably affected by the impending 'opt-out' approval and the advent of new technologies may be an opportunity to expand the current listing criteria for both deceased donor LT and LDLT. In addition, the listing criteria for LDLT do not necessarily have to be tethered to those for DDLT.

Having a viable LDLT option may help certain currently listed recipients such as:

- Long-waiting patients who are disadvantaged by current UK NLOS
- Small/low weight patients

In addition they may allow access to expanded criteria recipients who are currently denied transplantation;

- Hepatocellular carcinoma outside Milan criteria
- Cholangiocarcinoma in patients with primary sclerosing cholangitis
- Selected patients with liver only colorectal metastases
- Selected patients with NET metastases

4. Safety and Capacity

The working group recommended 3 centres be commissioned to provide LDLT initially, each paired with a non-LDLT transplanting centre for referral of suitable recipients. Identifying such recipients would depend on living donor availability, the indication for transplantation, the recipient's position with regards to other deceased donor options and the patient's wishes. The final decision would be agreed as a MDT outcome.

Patient pathways would be developed and agreed between designated LDLT transplanting and non-LDLT transplanting centres with shared governance and service level agreements for funding arrangements.

The working group agreed that a logical way forward would be for the 3 centres already providing paediatric LDLT to provide adult LDLT. (i.e. Birmingham, Leeds, King's,). This would offer good geographical spread and facilitate commissioning arrangements.

A UK Living Liver Donation multi-disciplinary network (as per the UK LKD Network) could be established to enhance local and regional leadership, share learning and support best practice.

5. Next Steps

The chair of the FTWU (DM), will take a paper to the May LAG meeting for approval.

If approved, it is proposed that LT is included in the post 2020 strategy for organ donation and transplantation (currently under development) and discussed with key commissioners in NHS England.

LAG is asked to consider the recommendations of the working group for approval.

D Manas

(28/4/2019)