Confidential

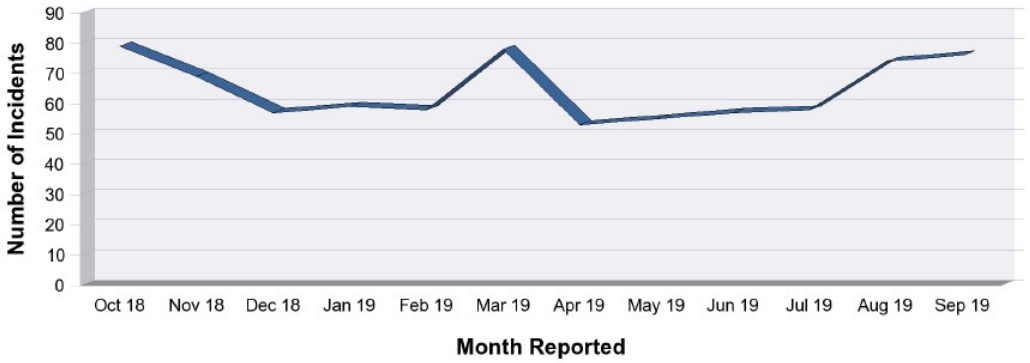
Liver Advisory Group
ODT Clinical Governance Report November 2019

1. Status – Confidential

2. Action Requested

LAG are requested to note the findings within this report.

3. Data



4. Learning from reports

Below is a summary of the findings and learning from key clinical governance reports submitted to ODT:

Date reported: 4th May 2019 & 10th July 2019
Reference: INCs 3944 & 4118

What was reported
INC 3944 Reported to Clinical Governance as a query regarding split liver allocation process. Left lateral segment and right lobe accepted by centres. Centre who had accepted the left lateral segment requested segment IV as needed whole left lobe. Discussion with surgeon who had accepted the right lobe: they agreed to relinquish their offer to support this. Discussions with centre who were 2nd on the left lateral allocation list (and so would have been next to receive the left lateral offer) and they were also in agreement of decision. INC 4118 Centre were considering fast-track offer of right liver lobe; ultimately declined on anticipated cold ischaemic time. Team had liaised with left lateral segment accepting centre over timings. The splitting centre highlighted that they

wished to use the liver as a 'whole' in their 15-year-old intended recipient. The centre who were considering the right lobe offer queried whether this was correct in relation to liver splitting agreements.
Investigation findings
Following these reported incidents around liver splitting and large paediatric donors there have been discussions with the LAG chair. It was agreed that if the accepting left lobe centre decide their patient needs more than a left lateral then they have the right to dictate this (index case) and the centre accepting the right lobe need to be informed. This may mean that the right lobe will not be usable for the nominated right lobe recipient due to size; the left lobe recipient has primacy and therefore this is acceptable. The right lobe would be fast tracked, however due to the size it may not be accepted. It was reiterated that the left lobe accepting centre is not able to state they wish the whole liver, but may require more than the left lateral segment which may by default lead to the right lobe not being transplantable.
Learning
A change to reflect the above has been requested for inclusion in the Deceased Donor Liver Distribution & Allocation Policy (POL196) and was further highlighted for discussion at the LAG Core Group meeting on 25th October. The aim is that this is approved at the next Transplant Policy Review Committee. Will be progressed by NHSBT statistician. The relevant Hub Operations offering and allocation process will also be updated to ensure all are aligned.

Date reported: 14th June 2019
Reference: INC 4066

What was reported
Liver split and right lobe accepted. Uneventful recipient hepatectomy at the right lobe centre with minimal blood loss. At reperfusion there was significant bleeding from a cut surface of liver through very visible patent vessels reported as not ligated at the time of split. Blood loss of approximately 5 litres with haemodynamic instability of patient; secured by suturing of the vessel and packing. Recipient developed early hepatic artery thrombosis (HAT) within 12 hrs and required early re-transplant.
Investigation findings
Information supplied by both the implanting right lobe surgeon and the Clinical Lead from the splitting centre. The implanting surgeon of the right liver lobe

explained that on inspection of the liver, prior to transplantation, the graft appeared ready for implantation. The implanting surgeon spoke to the liver splitting surgeon on two occasions and the information provided reassured the implanting surgeon that the liver lobe was useable and that no further reconstruction or repair was required on the back table before implantation. On arrival of the liver lobe the implanting surgeon has explained that there was nothing seen prior to implantation that was of concern and the liver was transplanted. The implanting surgeon has highlighted that there were time pressures for implantation as the liver had a long journey from the splitting centre and the focus was to keep the cold ischemic time to a minimum. Damage to the right liver lobe as described above is a known risk of liver splitting.
Learning Agreement by both surgeons is that it is the responsibility of the implanting surgeon to check the lobe is 'leak free' prior to implantation and that the final responsibility lies with the implanting surgeon to ensure that the graft is safe to implant.

5. Requirement from LAG

Note findings in this report.

Author

Sarah Jones
Clinical Governance Manager