

In a 5 month period, April to August 2016, there were 45 reported Incidents where the Heart was mentioned as one of the Key words. This is largely in line with other recent reports– in the previous 6 months there were 49 Incidents

9 Incidents were related to damaged heart valves, either when the lungs alone were being retrieved, or when the heart itself was being taken for tissue only. Damage at the time of lung retrieval is discussed in the lung section of the meeting

11 further Incidents were completely unrelated to the heart

Of the 25 real “Heart” Incidents:

Donation - 5 One was really a communication problem between the SNOD and the centre, resulting in the wrong urgent patient being transplanted. A patient at another centre was apparently disadvantaged, but in practice the heart was too small.

On 4 Occasions the NORS CT team was mobilized much too early, with subsequent waiting times of between 4 and 7 hours. These problems all relate to the new NORS arrangements and will be collated at the National Retrieval Group in November.

Retrieval – 10 (compared with 17 in previous 6 months)

A donor had a history of travel to the Dominican Republic, a country at risk of Zika Infection. There was nothing to suggest past or current infection – the donor was young and appeared perfectly fit. Advice was that the risk was low. However, the recipient surgeon insisted on a negative PCR prior to retrieval. This resulted in a considerable delay, approaching 12 hours, but eventually a PCR was done at Porton Down – and was negative

Because the retrieval surgeon had been waiting all night, there was further delay whilst he was replaced. Subsequently there was damage to the donor heart – see below. A different, perhaps realistic, view of the infection risks, coupled with better planning, might have prevented many of the retrieval delays and considerable inconvenience to the NORS team.

There was one important case of damage during extraction, with opening of both the right atrium and dividing the left atrium within a few mm of the AV groove. The problem was recognised by the implanting surgeon, and problems averted. One heart was almost lost when there was loss of control of the divided innominate vein, with massive blood loss.

Other Incidents involved delay in leaving the donor theatre because of incomplete paperwork and incorrect packing of organs, including the cool box having to be re-closed by a taxi driver

At a donor where only the CT team were present at the time of cross-clamp, the abdominal organs all having been declined, the Team did not take spleen or lymph nodes

Transplantation - 5

Most of these centered around delayed acceptance or decision making, either because more than one donor was being considered, or because there were surgical differences of opinion: One of these is reproduced as an example of poor decision making annoying other retrieval and transplant teams

Cardiac transplant centre received a heart offer for an urgent recipient.

The cardiac transplant surgeon advised that the centre provisionally accepted the heart. He requested that the heart was offered on as the intended recipient was a complex recipient with a high PRA and acceptance would only be confirmed after cardiovascular assessment by a scout.

In the interim the cardiac transplant centre also received a heart offer for an urgent recipient inpatient on a BiVAD.

The cardiac transplant surgeon advised he considered the possibility of the cardiac transplant centre accepting 2 hearts for transplant. The rationale being that the 2 hearts would both be transplanted within working hours, with the required numbers of clinical staff to safely undertake 2 heart transplants.

Several conversations then took place with the multi disciplinary team as to whether this would be feasible.

The multi disciplinary team considered the timings that would be associated with travel from the Donor to Recipient Centre (in excess of 2.5 hours), packing of the heart and donor heart explant time (the intended recipient was a complex 5th time re-do with a long term LVAD which would require double consultant input).

Estimated cold ischemic time was estimated at greater than 3.5 hours.

After protracted discussions within the multi disciplinary team a consensus was reached that the cardiac centre would decline the offer on logistics due to the potential long ischemic time and ability to safely undertake two heart transplants simultaneously or overlapping.

All this took 7 hours!

Transplant Support – 5

Some of these were trivial, with minor listing errors and two revolved around confusion as to which NORS teams were available

There remains confusion when there are fast track and European offers, and this should be discussed. It was previously decided that simultaneous offers would be made to all centres, and that answering first would have the organ, but this may not be the most efficient routine