NHS Blood and Transplant

Kidney Advisory Group
ODT Clinical Governance Report July 2022

1. Status – Confidential

2. Action Requested

KAG 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: 24th January 2020
Reference: ODT-INC-4569

What was reported?
A recipient had previously received a live donor kidney and several years later was re-listed with updated unacceptable antigens. During routine checks by the transplant centre's H&I laboratory it was noticed that the updated unacceptable antigens had been merged with the unacceptable antigens listed on the patient's previous registration. Once this had been identified this was corrected on the recipient's record.
Investigation findings and learning:
Previous offers were reviewed to ascertain if there was any patient disadvantage, and it was identified that the recipient had missed a kidney offer. The recipient was prioritised as per the kidney allocation policy and a short time later they received an offer and were subsequently transplanted.

It was identified that this was one of several similar reports that had been highlighted. A review of the process took place and IT solutions were explored. It was agreed that validation fields must be implemented so that when a transplant centre registers a patient the validation will flag any merge of unacceptable antigens with previous records prior to submission of a registration so that a centre can amend if they wish to. This was discussed with both internal and external stakeholders involved in the process. The proposal was agreed by KAG Chair and shared at KAG in Spring 2022. The IT fix has been accepted and is planned for release later this month.

Date reported: 23rd December 2021
Reference: ODT-INC-5998

What was reported?
It was reported that eight months post donation a kidney recipient developed a rapid growing tumour in the transplanted kidney and developed metastatic disease. The patient has since died.
Investigation findings and learning:
The other transplant centres (liver and left kidney) and tissue and eye services were informed of the finding by NHSBT. Investigation found that lesions had been identified on the transplanted liver post-transplant and a biopsy confirmed a malignancy with similar pathology to the right kidney recipient. Post-transplant a mass was also identified in the left transplanted kidney and as above, the biopsy confirmed a malignancy with similar pathology to the right kidney recipient. The transplant centres all confirmed that the pathology of the malignancy was unusual and difficult to characterise. The pathology was similar in all three recipients therefore it was concluded that this was highly likely to be a donor derived malignancy. Investigation concluded that all information and processes were adhered to, and all known donor information was communicated at the time of offering and organ acceptance. The left kidney recipient has had a nephrectomy and both the liver and left kidney recipients are being manged under the care of the clinical teams. Donor transmitted malignancies, although rate, are a known risk of transplantation. We are exploring if there is any shared learning and if this is identified we will share with KAG as appropriate.

5. Requirement from KAG

Note this report

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