

# Minutes of CTAG Heart and Lung Allocation Teleconference

## Monday 9<sup>th</sup> December 2013, 15:00 to 16:00

**Present:** Guy MacGowan – Chair (GM)  
 Nick Banner – Deputy CTAG Chair (NB)  
 Paul Corris – Chest Physician, Freeman Hospital, Newcastle (PC)  
 David Crossland – Cardiologist, Freeman Hospital, Newcastle (DC)  
 John Dark – National Clinical Lead for Governance, NHSBT (JD)  
 Jenny Lannon – Statistics & Clinical Studies, NHSBT (JL)  
 Sern Lim – Cardiologist, Queen Elizabeth Hospital, Birmingham (SL)  
 Steven Shaw – Cardiologist, Wythenshawe Hospital, Manchester (SS)  
 Jasvir Parmar – Chest Physician, Papworth Hospital, Cambridge

**In attendance:** Trudy Monday – Clinical & Support Services, ODT (TM)

**Apologies:** James Neuberger – Associate Medical Director, ODT  
 Jayan Parameshwar – Cardiologist, Papworth Hospital, Cambridge (JP)  
 Mark Petrie – Physician, Golden Jubilee National Hospital, Glasgow  
 Steven Tsui – CTAG Chair  
 Rajamiyer Venkateswaran – Surgeon, Wythenshawe Hospital, Manchester

		<b>ACTIONS</b>
<b>1.</b>	<b>Introduction and background</b>	
	<p>NHSBT have been reviewing selection and allocation policies for all solid organ advisory groups to ensure that they are fair and transparent. S Tsui has asked GM to reconvene the Heart Allocation Working Group to discuss two related issues that have arisen:</p> <ul style="list-style-type: none"> <li>• There is concern that it is very difficult to find heart and lung blocks for patients requiring heart and lung transplantation (not necessarily urgent patients).</li> <li>• There have been several cases recently where adult congenital patients who do not fall within the current heart allocation criteria cannot get access to urgent hearts. These cases currently have to go through an urgent appeals process.</li> </ul> <p>A proposal document had been circulated by GM and DC in response to these issues, and discussion today is hoped to establish agreement on the criteria and guiding principles.</p> <p>Points highlighted:</p> <ul style="list-style-type: none"> <li>• The underlying principal is to allocate organs to the sickest patients.</li> <li>• Important to look also at benefit from transplant, and ensure patients have reasonable survival potential. The onus should be on transplant centres to ensure that survival data remain within accepted limits.</li> </ul>	
<b>2.</b>	<b>Discussion regarding listing heart and lung recipients (Guy MacGowan and Jas Parmar introducing proposals)</b>	
	Discussion about how this could be implemented. A non-urgent system for heart and lung allocation would be very difficult to	

	<p>implement without unfairly disadvantaging other non-urgent patients on the heart transplant waiting list.</p> <p>It was agreed that a system for allocation of urgent heart lung blocks to selected patients could be piloted. There was concern that this could adversely affect numbers of heart transplants, and also survival from transplanting complicated patients would be less than favourable (though not all attendees agreed with this last comment).</p> <p>As a starting point it was agreed that we would consider a system whereby patients with adult congenital heart disease who meet criteria for urgent heart transplantation but need a heart lung block could be urgently listed for heart and lung transplantation. This is a pilot scheme and would be audited for numbers of transplants and results.</p> <p>There is potential to expand this programme at a later date for other diagnoses such as pulmonary hypertension. The criteria for urgent listing for heart transplantation have recently been recommended to change, and will also include recommendations from the 3<sup>rd</sup> agenda item of this meeting below.</p>	
<b>3.</b>	<b>Discussion regarding urgent listing of patients with adult congenital patients (David Crossland to introduce proposals for objective prognostic criteria for these patients)</b>	
	<p>Proposal from David Crossland for Urgent Listing of Adult Congenital Patients: In patients with Adult Congenital Heart Disease and heart failure there is little evidence to stratify risk of death by a particular time in ACHD patients – though experience has shown that from our assessment data that all the patients falling into the groups below have a high (approx 50%) 6 month mortality:</p> <p>All urgently listed patients should be in hospital.</p> <p>1) Refractory arrhythmias (atrial and ventricular).</p> <p>2) Worsening heart failure in patients not suitable for inotropes/mechanical support or in patients who have been started on inotropes and the inotropes have been stopped because of deterioration in condition attributable to the inotrope.</p> <p>Clinical heart failure should be associated with any of a) deteriorating renal function (creatinine double from baseline) with structurally normal kidneys b) worsening hepatic function (doubling of transaminases from baseline) without established liver disease c) Volume overload not responding to intravenous diuretics and requiring ultra filtration.</p> <p>3) Fontan or right heart failure patients with protein losing enteropathy (diagnosed from faecal alpha 1 antitrypsin), not suitable for inotropes/mechanical support who have required monthly or more frequent admissions for the preceding 3 months for intravenous diuretics/albumin infusion/ascites drainage.</p> <p>4) Fit current urgent listing criteria discussion of above proposals: Broad agreement in principal for these proposals, but more specifics</p>	

	needed about dosage of diuretics, criteria for abnormal renal and hepatic function mentioned above. David Crossland to circulate email with more specific proposals.	<b>DC</b>
<b>4.</b>	<b>Summary and Discussion</b>	
	<p>An urgent heart lung allocation system is required for selected patients with adult congenital heart disease requiring heart lung transplantation, and specific criteria for urgent heart listing for selected patients with adult congenital heart disease.</p> <p>Outcomes: concern over transplanting very sick patients with such a scarce resource of donor organs which could result in poor outcomes. Consider frailty index (Jasvir Parmar has since circulated some data about how this is used in lung patients). Dr Banner has suggested including the heart and lung results in standard CUSUM curves for heart transplant results.</p> <p>In a separate email Dr Parameshwar has suggested that we adopt the extended urgent criteria for heart transplantation for adult congenital heart disease to other diagnoses, such as restrictive and hypertrophic cardiomyopathy that are currently disadvantaged in a similar fashion as they do not respond to inotropes and may be poor mechanical support candidates. GM to email all attendees with this proposal.</p>	<b>GM</b>