NHS BLOOD AND TRANSPLANT

MINUTES OF THE URGENT HEART AND LUNG TELECON 14:00PM – 15:00PM 13TH AUGUST

PRESENT: Mr S Tsui, **Chair**
Dr M Al-Aloul, Chest Physician, Wythenshawe Hospital, Manchester
Mr N Al-Attar, Surgeon, Golden Jubilee Hospital, Glasgow
Dr N Banner, Cardiologist, Harefield Hospital, Middlesex
Dr M Burch, Cardiologist, Great Ormond Street Hospital, London
Dr M Carby, Chest Physician, Harefield Hospital, Middlesex
Prof Paul Corris, Director of Cardio-Pulmonary Transplantation, Newcastle
Mr J Dunning, Consultant Cardiothoracic Surgeon, Papworth
Dr J Lannon, Statistics & Clinical Studies, NHSBT
Mr S Lim, Cardiologist, Queen Elizabeth Hospital, Birmingham (SL)
Mr J Mascaro, Surgeon, Queen Elizabeth Hospital, Birmingham
Dr G MacGowan, Consultant Cardiologist, Newcastle
Prof J Neuberger, Associate Medical Director, ODT
Dr J Parameshwar, Cardiologist, Papworth Hospital, Cambridge
Dr J Parmar, Chest Physician, Papworth Hospital, Cambridge
Mr A Simon, Director of Heart and Lung Transplantation, Harefield
Dr H Spencer, Chest Physician, Great Ormond Street Hospital, London
Dr M Winter, (NSD) National Services Division, Scotland
Mr N Yonin, Consultant Cardiothoracic Surgeon, Birmingham

IN ATTENDANCE:

Ms A McEvoy, Clinical & Support Services, ODT

APOLOGIES:

Prof J Dark, ODT National Clinical Lead for Governance and Organ Utilisation, ODT
Mr R Venkateswaran, Surgeon, Wythenshawe Hospital, Manchester

ACTION

Introduction

S Tsui welcomed everyone and explained that decisions were required as to whether urgent heart-lung listing/allocation criteria should be introduced and, if so, what these should be? He referred to the minutes of the meeting in September 2014, which were inconclusive.

Do we need an urgent heart-lung allocation scheme?

1

Overall agreement that there should be some sort of system.

2. Criteria

1.1 HAWG had previously suggested ACHD patients only as a trial and would assess 1-2 years later with the possibility to extend the criteria to other patients.

1.2 The other option would be to allow all disease groups but all go through an adjudication panel. This would be difficult for the adjudication panel due to the numbers that could be involved.

3. Disease Groups

J Neuberger stated that there were 2 issues – selection and allocation. After some discussion, S Tsui stated that there was no intention to exclude any disease groups. There was concern that, once the adjudication panel accepted a specific case, this would set a precedent.

G McGowan noted that allowing only one disease group would not provide equal access. However, it was agreed that the ACHD group of patients are unambiguous. Therefore this would provide a good starting point – these patients have not been favoured for any other reason. N Banner noted that heart-lung transplants could be a heavy use of organs. It would make sense to start with a small group and ACHD patients forms a well defined group. However, we would still need an adjudication panel to ensure consistency. This could be reviewed at a later date.

J Neuberger stated that he would support any clinically justifiable decision but it would be useful to have recommendations regarding acceptable restrictive criteria for a patient to go to the adjudicating panel.

4. Numbers

M Carby suggested we limit the number of heart-lung transplants. However, it was agreed that it would be difficult to put a number on the system.

The Payback System had already been trialled for the UHAS but this did not work. It was agreed that there was no feel for the overall number of patients that need an urgent heart-lung transplant. J Lannon suggested retrospective analysis of data already collected but this was not considered an accurate reflection of the true demand as many would not have been referred in the past as there was no mechanism to list them urgently.

5. Any Other Business

H Spencer asked how the system would work with Paediatric cases and it was agreed that it would be sensible to follow the same principle as for adults.

6. Urgent Heart Versus Urgent Lung Scheme

Consideration had been given for urgent heart patients that need lungs, but urgent lung patients who also need a heart need to be considered as well.

P Corris noted that outcomes for heart-lung transplants are generally worse than for bilateral lungs.

J Parameshwar suggested that we should centralise heart-lung transplants to one centre to maximise experience and expertise.

The scheme would be restrictive to start with and no more than 4 or 5 urgent heart lung transplants per year could be expected this way. **S Tsui**

S Tsui concluded the discussions as follows

1. **Do we need an urgent heart-lung allocation scheme?**

   YES

2. **Do we need a super-urgent heart-lung allocation scheme?**

   NO

3. **If so, what are the urgent/super-urgent listing criteria?**

   A) ***A patient with ACHD who could only be served by heart lung transplant and meets one of the criteria for listing under the SUHAS or UHAS***

   B) All patients should be presented to an Adjudication Panel which will use the experience to develop and evolve additional criteria

4. **How do we prioritise patients on this scheme versus those on the SUHAS, UHAS, SULAS and ULAS?**

   Behind the SUHAS and SULAS, within the UHAS, above the ULAS

Organ Donation and Transplantation Directorate **August 2015**