Draft Document

Guidelines for Super-Urgent listing of lung transplant candidates

Super urgent listing may be considered in suitable transplant candidates in whom survival without transplantation is likely to be less than 90 days.

The purpose of reducing the high waiting list mortality amongst these critically ill patients should drive measures aimed at timely allocation of donor organs. However, this should be balanced against maintaining the standard of good post transplant outcomes. It is imperative, therefore, to carefully consider every individual case in the local MDT: if a consensus on futility is reached, access to appropriate palliative and end of life care should be facilitated instead.

It is envisaged that ALL super urgent candidates will be receiving inpatient treatment and will continue to fulfil current transplant acceptance criteria; in particular, they must remain free of major sepsis. The daily review process will also allow consideration of delisting a patient who has deteriorated to a clinical status out with these guidelines.

The aim is to try and identify a rapidly deteriorating patient listed for transplantation before the need for extracorporeal support but will include such patients.

Requests for super urgent listing may be considered in:

1. A patient who has been accepted for lung transplantation and requires ECMO or Novalung support in keeping with National Guideline (to be finalised).

2. A patient who has been accepted for transplantation but develops any <u>one</u> of the following characteristics:

PAH patient

- Worsening refractory right heart failure as defined by increasing fluid retention despite optimal medical management with disease modifying therapy and diuretics
- Requirement for continuous IV inotropic support
- Recent RHC RAP>20mmHg and CI <2.0l/min/m2 despite optimisation of therapy. RHC data need to be recent, within 2-3 months of request to add to super urgent list

IPF Patient

- Persisting hypoxia (PO_2 <8 kPa) despite continuous O2 at 10 l/min
- Refractory right heart failure despite all pharmacological interventions to support the right ventricle

COPD Patient

- Worsening hypoxia and hypercapnia requiring increasing oxygen demand of >10 L/min and chronic NIV
- pH persistently <7.30 despite optimal continuous NIV
- Refractory right hear failure despite all pharmacological interventions to support the right ventricle

CF patient

- Worsening hypoxia and hypercapnia requiring increasing oxygen demand of > 10L/min and chronic NIV
- pH persistently <7.30 despite optimal continuous NIV
- Refractory right heart failure despite all pharmacological interventions to support the right ventricle
- Ongoing episodes of Massive haemoptysis despite bronchial embolisation

In addition, a centre can make a request for super-urgent listing, of a patient outside the above criteria, to an Appeals Panel consisting of one representative/deputy from each centre.

- Representatives need to be available and responsive.
- The nominated representative should be the Centre Director with a nominated respiratory physician as the deputy.
- CTAG chair or deputy will email the nominated representatives with details of the appeal with an instruction to feedback within 24 hours.
- CTAG Chair or deputy will make the final decision based on the majority opinion. The decision does not need to be unanimous.
- Patients will not be placed on the super-urgent waiting list until the appeals panel has approved the registration.
- Centres will need to provide CTAG chair with names and contact details for their nominated representative and deputy. In the event, both centre representatives are simultaneously absent, the role should be delegated internally and the program director should notify CTAG chair of contact details for this person.

Additional notes

- Patients should be removed from the super-urgent list when the local MDT concludes the patient does not have a reasonable chance of intermediate survival; for example, 50% chance of surviving 3 years post-transplant.

- Prospective data collection for super-urgent registrations will be implemented (locally and submitted to NHSBT on a specific registration form) and ALL registrations will be retrospectively validated every 6 months to ensure compliance with agreed criteria and gauge impact on activity and survival.
- At time of listing, the centre should specify minimum and maximum TLC limits for male and female donors for each super-urgent patient and will only be offered lungs from donors within this range.
- Equal priority is assigned to all patients on the super urgent list, irrespective of requirement for extracorporeal support.
- There will be no prioritisation by blood group in the allocation of organs to super-urgent patients.
- Super-urgent patients will be ranked by waiting time only.
- Paediatric patients can be listed on the super-urgent scheme under the same criteria and any exceptions can be referred to the appeals panel. There will be no ranking by patient age group. However, all organs not utilised nationally for super urgent candidates, may subsequently be offered first to paediatric patients (allocation sequence currently being examined by the LAWG).

Proposed interim offering sequence summarised in diagram below.