Increased Referral Project

This title refers to a project that is being planned in Scotland, following experience in the NE.

The standard, NHSBT developed, approach on referral of a potential DCD donor is for the SNOD to attend the ITU, look at the data, talk to the family etc. For a donor who almost certainly won't proceed to donation because of a variety of what in practice add up to a contraindication, this wastes a lot of time and probably alienates ITUs. ITUs quote delay in decision making a major cause for not referring DCD donors.

Lynn Robson and her colleagues in the NE have been operating an alternative system, by which the SNOD will ascertain from either local or distant centres, whether there is any point in even going to the ITU. She has assembled a list of conditions in the donor - eg death from withdrawal of treatment after diagnosis of ischaemic bowel, in an older patient - where nobody ever seems to take the organs. Her list is more inclusive than the "official" contraindications from James Neuberger. It is actually an application of "common sense".

The result of this process appears to be a much higher rate of referral than other parts of the UK, and potentially more actual donors. Whilst it is possible that a potential donor organ might be lost, it is more than outweighed by the increased referrals and increased confidence of ITUs.

There is now a plan to trial a similar scheme in Scotland. SNODs and the local transplant centres in the NE already have experience of the system, but we need to know if it will work in an area with no previous experience.

To aid in implementation, we have developed a set of practical contraindications, based on Lynn's work, and added some for the lung. The ITU will either be told there is a contraindication, based on the standard set, and the additional ones on the list, or the SNOD will call centres about a dubious donor. <u>There is an undertaking that the SNOD will give the ITU a decision within three hours.</u>

We wish to seek your comments on the "common sense" contraindications in the attachment. In addition, we want your opinion as to whether we can use Newcastle (who receive all the initial DCD lung donor offers from Scotland) as a filter. Ie, if the lung is turned down by the local team it should not be offered around the country.

This idea has the support of Steve Clark and his colleagues, but clearly has implications for CTAG.
Please remember this applies only to DCD donors.
We would like your views on the contraindications for the lung listed below.

Suggested Criteria for automatically refusing a potential organ *from a DCD donor* at the time of referral:

All organs
Combination of Age over 60 and any one of:

- Ruptured Abdominal Aortic Aneurysm
- Proven Ischaemic Bowel
- Out of Hospital Arrest with documented "downtime" >30 minutes
- Proven Sepsis – Positive Blood culture plus use of a vasoconstrictor

Liver
Age >70 *and* travel time to implant centre > 2 hours

Kidney
Age > 75 *and* Donor already on CVVH for > 24 hours

Lungs
Saturations by oximetry persistently less than 90 on any FIO2
Proven Chest Infection – purulent, blood stained secretions, on treatment for
+ve culture and abnormal X-ray
Age > 55 *and* smoking >20/day *and* abnormal X-ray

For Decision

We seek your approval, that for a trial period of one year, to begin at a date to be finalised this autumn, DCD offers from Scotland who fall into the above categories, are not offered at all. In addition, if the Newcastle team turn down the lung, it is not then offered nationally.

John Dark, Lesley Logan
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