POLICY POL203/1.1

Living Organ Donors Who Require A Transplant As A Direct Consequence Of Donation

This Policy replaces *POL203/1*	**Copy Number**
	Effective **17/07/15**

Summary of Significant Changes

Changed the name of Appeals Panel, and the review period for the policy

Policy

Executive Summary

1. Very rarely, living kidney or liver donors themselves require a transplant as a direct consequence of the donation.

2. Giving such donors priority to receive an organ transplant is justified to maintain confidence in living donation and reassure donors, their recipients and families that any adverse consequence of donation will be mitigated as far as possible.

3. The rights of the donor who requires a transplant must be balanced against others on the National Transplant List.

4. This policy applies to donors who meet the current requirement for listing and were eligible for NHS treatment at the time of donation and non-NHS eligible donors who have donated to a recipient who was NHS-eligible at the time of donation.

5. This policy applies to those who require a transplant as a direct consequence of having donated an organ.

6. For kidney recipients, priority will be given by awarding additional points in the National Kidney Allocation Scheme so that the donor will usually be at the top of the relevant tier of patients.

7. For liver recipients, those requiring a super-urgent transplant will be placed at the top of the waiting list for a suitable organ. For non-super-urgent recipients, the National Appeals Panel of the Liver Advisory Group will advise the Associate Medical Director for ODT as to how priority should be most appropriately given.

Living Organ Donors Who Require A Transplant As A Direct Consequence Of Donation

1 Background

1.1 NHSBT is responsible to the Secretaries of State for Health for the selection of patients and allocation of organs for transplantation from deceased donors.

1.2 Living donation has become an acceptable form of transplantation. However, such donation is not without risk to the donor. In very rare cases, living donors have themselves required a transplant as a consequence of having donated an organ.

1.3 The NHS delivers treatment on the basis of need rather than any deservedness or cause of the requirement of treatment. However, there are exceptions to this principle: for example, those who require access to NHS services as a direct consequence of active service in the military do have priority but this does not exceed the priority of others with a greater clinical need.

1.4 Most living donations are of a kidney; however, living liver donation also occurs. Rarely, a living liver donor may require an emergency transplant as a consequence of donation. It is possible that living liver donors may develop liver failure as a late consequence of donation (such as from ischemic damage or secondary biliary cirrhosis), although we are unaware of such a situation being described.

Although living lung donation has been undertaken worldwide, this is done very rarely and the probability that a living lung donor will require a transplant as a consequence of donation is very small indeed. Since living lung donation has not taken place in the UK, this policy will exclude living lung donation.

2 Aims of policy

2.1 This policy clarifies how NHSBT will allocate organs to those who require a transplant as a direct consequence of organ donation.

3 Justification

3.1 NHSBT agrees that where an individual requires a transplanted organ as a direct consequence of living organ donation, then it is reasonable to give that donor priority in the allocation system in order to maintain confidence in the living donation process and reassure living donors, recipients of living donor organs and their families that any adverse consequence of donation will be mitigated as far as is reasonably possible.

3.2 NHSBT recognises that the needs of the living donor who later requires a transplant must be balanced against others on the National Transplant List. This policy does give the living donor appropriate priority in the allocation process of organs from deceased donors, but not absolute priority.

3.3 This approach has been accepted as appropriate by the British Transplantation Society, the Department of Health and the relevant Organ Advisory Groups of NHSBT.

4 Purpose of policy

4.1 The aims of the policy are to define

- who is eligible for priority
- how priority would be given

4.2 Allocation policies are under constant review and therefore the details of how priority would be given may change.

5 Eligibility for priority

5.1 This policy applies only to those who require a solid organ transplant as a direct consequence of their having been a living organ donor.

5.1.1 This need may arise immediately after the donation process, (for example, following a surgical misadventure), or at a later date (for example, if a living donor subsequently develops a malignancy in the remaining kidney which requires nephrectomy, that donor would be eligible as, had donation not previously occurred, the donor would function well with the remaining kidney). In contrast, if a living donor subsequently develops glomerulonephritis resulting in end-stage renal disease, then that donor would not be eligible for priority under this policy as transplantation would be required irrespective of donation.

5.2 This policy applies only to those living donors who, at the time of donation are:

- eligible for NHS treatment and donate to an NHS-eligible recipient
- not eligible for NHS treatment but have donated to a recipient who is eligible for NHS treatment at the time of donation

5.3 This policy does not apply to non-NHS eligible living donors who have donated to a non-NHS eligible recipient.

5.4 The donor who requires a transplant as a consequence of donation must meet the current clinical eligibility criteria for receipt of a transplant and be placed on the National Transplant List by a designated transplant centre.

5.5 This policy applies to first and subsequent transplants and any other organ required as a direct consequence of living organ donation (for example, a living liver donor who requires an emergency liver transplant as a result of vascular thrombosis of the liver remnant and subsequently develops renal failure as a consequence of immunosuppressive treatment, would be eligible for priority for a renal graft).

6 Priority for kidney allocation

6.1 The current kidney allocation scheme is a national allocation system which incorporates several clinical factors. There are five tiers for allocation based on prioritising patients with a high degree of HLA match with the donor. A points system is then used to rank patients. This is based on several factors including waiting time, HLA matching and age difference between donor and recipient. Children are given priority in the system for clinical reasons, as transplantation allows catch-up of growth.

6.2 In order not to disadvantage those potential recipients with greater clinical need, who are young or, while highly sensitised, could be allocated a well-matched kidney, the living donor will be given waiting points equivalent to 8 years on the waiting list. This would effectively ensure that the patient was prioritised at the top of the relevant tier and thus allow the opportunity of receiving a suitable organ transplant in a relatively short period of time while not unduly disadvantaging other potential candidates who are high priority.

7 Priority for liver allocation

7.1 Super-urgent liver

Where a liver donor requires a liver transplant for the treatment of acute liver insufficiency as a consequence of donation, then the donor would be eligible for a super-urgent listing. The criteria for super-urgent listing are listed in the liver selection policy and cover those cases of acute liver failure where, without transplantation, death would be anticipated within 7 days.

7.1.1 Where there are two potential recipients on the National Transplant List with similar blood group and size requirements, then the living donor would get priority regardless of time on the liver transplant list.

7.2 Non-urgent listing

7.2.1 Should a living liver donor develop late-onset liver failure that meets the current criteria for liver transplant selection, then, while there is a centre-based allocation system, it would be expected that the patient would be the first candidate to be considered for an offered liver that meets the requirements of low risk, and blood group and size considerations.

7.2.2 If the allocation process is changed to a national allocation scheme, then the candidate will be given additional points, calculated to give that individual priority within the relevant group. This would be discussed with the Liver Advisory Group National Appeals Panel where representatives from all centres consider prioritising those cases which fall outside the agreed criteria. The recommendations from the National Appeals Panel would be put to the Associate Medical Director for the Directorate of Organ Donation and Transplantation who would make the final decision.

8 Review

8.1 This policy will be reviewed and revised every 3 years or when there is a change in relevant organ allocation policies.