Cautionary Tales
in Organ Donation and Transplantation

NHS Blood and Transplant

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Introduction

As you all know, ODT receive incidents from all those involved in the organ donation and transplantation pathway, from SNODs and Transplant Centres, to Laboratories and Administration Support Staff. To ensure incident reporting and the outcomes and actions taken following these reports are benenficial to everyone, we want to ensure that the system works for all and that every one can input into improvements. As such, we recently sent a survey to all stakeholder areas to gain feedback and comments on incident reporting, investigating and most importantly shared learning.

Firstly thank you to everyone that took the time to complete – the response rate was high and we received over 150 responses. Over the course of the next few weeks and months we will be reviewing all the feedback and comments. Whilst we can't promise to be able to implement all of the suggestions, on intial review there are many good ideas and feedback and we and will start to implement many of these to improve the process for all involved.

As always, a reminder to report any incidents, including 'near misses' that have the potential to improve patient safety or donor family experiences via the on-line link:

https://www.organdonation.nhs.uk/IncidentSubmission/Pages/IncidentSubmissionForm.aspx

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Histopatholgy – Again…

Histopathology remains an ongoing complex issue and we have continued to receive a number of different reports related to this area, from arranging the biopsy, to communication issues at both the donation and transplant ends.

One of the most recent cases related to a young donor where a lung nodule was identified by the abdominal NORS surgeon after the cardiothoracic (CT) team left theatre. They felt it may be suspicious and discussed with the CT team who whilst thought the nodule was highly unlikely to be suspicious due to the donor details, advised if the NORS surgeon wished to send for histopathology to do so. Following this, subsequent discussions were had to arrange the processing of the sample.

Due to the limited availability of histopathology services and lack of clear process, those present at the retrieval did what they felt was best at the time and the sample was sent to a non-specialist area. However, due to significant assumptions around communication, key individuals were not informed of significant facts overnight.

Whilst the accepting liver centre were informed of a lung nodule biopsy being taken, again, due to assumptions of who had been told what information, this was not further explored prior to the patient being transferred to theatre. The biopsy was also documented on the liver HTA A form; however, this was not questioned prior to the patient being transferred to theatre. At the point the accepting surgeon became aware and raised concerns the patient's procedure had commenced.

Following the verbal results that the lung nodule was a suggestive of carcinoma, the recipient procedure was aborted. All organs were declined and the liver patient returned to the ward prior to hepatectomy or transplant. The subsequent and results were that there was no evidence of malignancy.

Learning point

- Due to the lack of current national process, communication remains the key in any histopathology discussions
- Where ever possible, biopsies should be sent to a specialist transplant centre who can review the results in the context of the donor information and expertise
- As every one has a different understanding, avoid assumptions, confirm whose who, whose doing what and what the expectations are
- Agree who is passing on the clinical information and to whom
- Where rapid histopathology can be performed, unless exceptional circumstances or time critical, patient procedures should not be started until histopathology is available
- A working group including representatives from NORS, SNODs, Transplant Centres, Histopathology, and Duty Office are currently working on a national process and request form that will help guide practice
- This group are also looking at a wider availability of the services, however this will very much be a longer-term project

And again…

Many of the cases reported around histopathology relate to the difficulties and communication issues that occur at the time of retrieval. There have however been several cases where biopsies have been taken with an agreement to process at an accepting centre and on inspection at that centre a decision made not to process as urgent, or not at all.

Whilst if the clinical decision is made that a biopsy result is not required, this may not seem to be a problem. What does become problematic is that other centres may be awaiting the results prior to transplant or may not want to proceed to transplant without the results, potentially leading to the loss of organs or opportunity to transplant.

In one such case the accepting liver centre requested a sample of a suspicious lesion be sent with the liver. As per agreed process, the other accepting centres were informed that a suspicious lesion had been found and biopsied. The accepting liver surgeon then made a risk-benefit decision for the selected recipient and decided to proceed without histopathology results. The sample was then sent to be processed as routine. This decision was not communicated to the Duty Office or SNOD at the time and therefore the other accepting centres were unable to make an informed timely decision to either transplant or offer the organs back to be fast tracked.

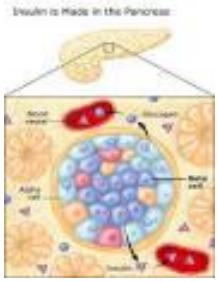
One of the accepting renal centres was in fact awaiting the results of the biopsy prior to transplant. Due to the prolonged timescale, the centre made a risk-benefit decision not to transplant and the kidney was offered on. It was subsequently declined by all centres due to the lack of histopathology result.

Learning point

- Due to the lack of current national process, communication remains the key in any histopathology
- Whilst following a risk assessment a biopsy result may not be required for transplantation of one organ, other centres may be awaiting the results prior to proceeding
- If a decision is made not to process a sample that is sent with an organ, the Duty Office must be informed as soon as the decision is made to allow for all other centres to be informed and discussion to occur to facilitate safe transplantation

Islet Transplantation: There's still a need for vessels!

KIDNEY-PANCREAS, PANCREAS ONLY AND ISLET MATCHING RUN



There have been a number of occasions over the last 12 months where vessels have not been sent with a pancreas, usually with no real consequences. In the most recent of these cases however, despite significant attempts to locate vessels from another source this was not possible and a transplantable organ was lost.

On investigating these cases it has come to light that if a pancreas is allocated for an islet graft, vessels are often not sent as they are not deemed necessary; at first look this is right - if a pancreas has been allocated for islets, vessels are not needed. Also, historically, if a pancreas was allocated for islets it meant that the organ had been declined for solid organ transplantation. Therefore, no vessels were required.

Pancreas and islet allocation changed a number of years ago; kidney–pancreas, solid pancreas, *and* islet graft patients are now all included on the one matching run. This means that whilst an organ may be offered for islets to a named patient, if it is subsequently declined on arrival at the centre it may be re offered or fast tracked and accepted for solid organ transplant. If the vessels have not been included due to the initial allocation for an islet graft this may jeopardise the solid organ transplant.

Learning point

- Due to changes in the allocation a pancreas may be offered for solid transplantation after islets
- Therefore, whenever a pancreas is retrieved, whether for pancreas or islets, vessels should always be sent to avoid a loss of an organ
- The most up to date pancreas allocation policy can be found here: http://www.odt.nhs.uk/pdf/pancreas_allocation_policy.pdf

Update - Length of Donation Process

Many of you will be aware that we are working through a series of actions to reduce the length of the donation pathway. Following on from the workshop earlier this year you will now begin to receive updates on the steps we are taking to shorten the pathway.

Last week we implemented in collaboration with CTAG, a new Cardiothoracic heart and lung allocation policy. Its early day's yet but initial findings are that this has significantly reduced the time taken to offer and allocate CT organs.

Further updates to follow on:

- Introduction of the pager one system for all CT organ offers
- Strict adherence to the 45-minute guidance for organ offering
- Enhanced retrieval trial