



The High Risk Recipient

Road to Nowhere: Are There Patients That Should Not Be Transplanted? Pro

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The increasing success of kidney transplantation over the past few years has led to the consideration of transplant for higher risk recipients. However, it also has become increasingly clear that not all people benefit from a kidney transplant. A major question facing both patients and transplant teams is: which people with renal failure should be considered transplant candidates?

Currently there are more than 300,000 people on dialysis in the United States. Only 70,000 are on the UNOS/OPTN waiting list suggesting that nephrologists already have decided that the vast majority of patients on dialysis are not transplant candidates. Despite this, there are increasing numbers of older, high-risk candidates on the waiting list. For example, the number of candidates over the age of 70 has tripled over the past 3 years. Many older patients referred for a kidney transplant commonly ask transplant physicians: “Doctor, should I get a kidney transplant?” The answer to this question is more complex than the title given for this debate, but in many instances the appropriate answer is “No”.

An evidence-based approach to this question has been developed by the UNOS/OPTN Kidney Committee. Over the past 3 years, this group has attempted to quantify the benefit of kidney transplantation as Life Years From Transplant (LYFT) which compares survival with a deceased donor kidney transplant to survival with remaining on dialysis. The LYFT calculations are based on actual patient data and uses objective, medical criteria. While many factors were found to be important in determining a candidate’s LYFT, the age of the recipient and the presence of diabetes were the most important.

It is my belief that LYFT and other objective measures of the benefit of kidney transplantation will help patients make more informed and appropriate decisions regarding what is best treatment plan for their renal failure. LYFT models suggest that older, diabetic candidates may get very little benefit from kidney transplantation and thus might consider remaining on dialysis instead of undergoing transplantation. LYFT models also suggest that deceased donor kidney transplantation should not be performed preemptively but as near to dialysis as possible. LYFT also suggests that current listing practices may be appropriate in that patients over 80 years of age are rarely listed for transplantation. While not yet available, LYFT scores also can be developed for living donor kidney transplantation and may further improve patient information and choice in this area.

For some patients with kidney failure, kidney transplantation offers little health benefit and much risk. Using LYFT and other outcomes models, we can begin to help patients decide if kidney transplantation is the right decision for them.



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In the formative years of liver transplantation, Starzl, Calne, Bismuth and Pichlmayr and other pioneers efforts during the 60-ies, 70-ies, 80-ies and early 90-ies, all efforts to transplant a patient were justified. Only by doing so could what eventually crystallized into what today is regarded as reasonable indications. But also contra indications.

Absolute contra indications can be dealt with quite simple. It is the relative ones that cause difficulties. Relative contra indications can and must never be financial. Instead the discussion must centre on complex and very difficult issues. An incomplete list would include to provide patient and family with false hope; to use an organ for a patient with marginal (how do we define marginal?) chances of survival when the organ can be used for someone else with a 80 to 90% survival; to save a patient's life when the resultant quality of life may be of poor.

The easy way out for a surgeon is to transplant every patient, never have to say no - "we must save the patient's life". Remember, there are outcomes much worse than death. Such as for a patient to be chronically confined to a bed, to a ventilator, in a nursing home or mentally damaged. Not only does the patient suffer but also the family, which often results in guilt ridden next of kin and broken up marriages.

We must treat the patients as it is ourselves or our own family members lying in that bed.