



NATCO, THE ORGANIZATION FOR TRANSPLANT PROFESSIONALS POSITION STATEMENT

LIVING DONOR TRANSPLANTATION

Statement of the Problem:

According to UNOS, there are over 80,000 people awaiting organ transplantation in the United States. Only 22,000 transplants were performed in the year 2000. The number of cadaver donors procured each year has remained stable for the last 10 years. Mortality on the waiting list is significant and expected to increase. These facts and the improved outcomes in living donor transplantation in all organs and age groups has led many centers to offer living donor transplant (LDT) to their adult as well as pediatric patients.

The idea of placing a healthy person at risk or harm without clear benefits seems to contradict the core principles of medicine, to do no harm. However, living donation has been a part of transplantation since its inception. Living donation has been the mainstay of donation in some countries where the concept of neurological death is not legal. In the United States, borne of necessity, it has been a routine in kidney and pediatric liver transplant. However, given the increased risk of adult living donor transplant in extra renal organs, transplant programs have to proceed with caution in pursuing a LDT program. Despite this ethical dilemma, many centers have embarked on LDT with excellent results. Adult and pediatric living donor kidney transplantation has been commonly accepted practices for over 10 years. In the year 2001 the number of living donor kidney transplants were comparable to the number of cadaveric kidney transplants and results were comparable. Among kidney and liver donors, most did not experience major complications or report diminished quality of life. They were able to return to pre-donation employment within a few weeks to a few months.

Despite these results, many in the public and in the medical community are reluctant to endorse living donor transplants of liver, pancreas and lung. The transplant community has been criticized for performing such transplants without regulation or standardization of living donor criteria and outcome monitoring.

Policy:

NATCO endorses the use of living donors for renal, liver, intestine, pancreatic and lung transplants by experienced transplant centers. Transplant centers need to balance the risk to the donor, the estimated success of the transplant, and the survival advantage to the recipient of living donation due to decreased waiting time. It is believed that each center must have the technical expertise to perform such operations and the resources available to care for the donor and recipient both pre- and post-operatively. In addition the transplant program needs to have specific protocols in place for evaluation of the living donor, education, informed consent, and outcomes monitoring. All potential donors should be mentally competent, willing to donate, free from coercion, medically well and adequately informed of the risk they are undertaking with living donation. Transplant centers should not be obligated to perform an operation that has limited chances for success; in this case the donor risk is not justified. All potential recipients of living donors should undergo a full evaluation and be suitable for transplantation. NATCO also supports the development of living donor registries to collect demographic and clinical data and monitor outcomes and complication rates.

Donor Evaluation:

All donors should be of legal age (emancipated minors may be considered under certain circumstances)

and medically evaluated to insure the donor to be a healthy individual without severe chronic medical illness. The standard donor evaluation should have the following key components:

- (1) A medical physician who is not currently involved with the care of the transplant recipient should evaluate the potential donor.
- (2) A transplant program-appointed donor advocate should be designated who has ultimate veto power.
- (3) The potential donor should be evaluated and determined to be free from current drug and alcohol abuse.
- (4) A psychosocial evaluation by a certified social worker or psychiatrist is necessary to :
 - a.) assess psychological , emotional, and social stability
 - b.) establish whether the potential donor is competent to give informed consent
 - c.) assess if the decision to donate is of free will and without coercion
 - d.) identify evidence of coercion

(1)Exclusions to donation include:

- a.) medical illness which makes the potential donor at greater risk for complications than the healthy adult
- b.) latent or chronic infection
- c.) cancer
- d.) significant laboratory abnormalities
- e.) anatomic abnormalities that may increase the risk of the operation in the donor and/or recipient
- f.) identified non altruistic motivation to donate
- g.) donor not capable of understanding the risks/benefits of the surgery

Informed Consent:

The informed consent process must make potential donors aware that the donation is completely voluntary and that consent can be withdrawn at any time. Living donation is an alternative to the cadaveric waiting list, which can always be accessed instead. Consent for the procedure should be obtained after the evaluation process so that the potential donor has time to think about their decision. Complications and risks should be reviewed on multiple occasions and consent given at least twice. Key points for the consent process include making the donor aware of:

1. the risk of death
2. the risk of surgical complications i.e., bleeding, hernia, etc.
3. the risk of complications due to general anesthesia
4. the risk of organ failure in the donor
5. the details of the actual surgery being performed
6. disease of the recipient and risk of recurrence i.e. hepatitis C, cancer, diabetic nephropathy
7. risk of blood transfusion and the transmission of blood borne infection acquired through transfusion
8. the risk of life-threatening infection as a result of the operation
9. unknown risk of long-term complications for liver, lung, pancreas and intestine donation due to lack of data
10. Impact on future health and life insurance availability and impact on employment status
11. additional organ specific risks related to the surgery

Donor Follow-up:

NATCO believes that all donors should have adequate post-operative care and access to medical care directly related to the donation and its complications indefinitely regardless of their ability to pay at the transplant center. It is believed that donors without medical and life insurance should be strongly encouraged and assisted to obtain adequate insurance. Complications related to living donation are not currently tracked in any standard fashion. We support the development of national/international registries to track such patients.

Financial Considerations:

Living donors should not personally bear any costs associated with the donation. However they should not profit from donation either. Paid donation should not be tolerated. Employers should

accommodate employees who need time off from work to recuperate from the donation process perhaps through the family leave act. In addition we support short-term disability to defray lost wages associated with the donation process.

Live Donor Organ Source:

Previously, live donors were biologically or emotionally related to the recipient of the organ. However currently many centers are evaluating “Non-Directed Donors” (Good Samaritan) and paired exchange organs. NATCO encourages transplant centers to pursue this development but should proceed with caution as the lack of a close emotional tie may increase the likelihood of inappropriate donation. However, with careful evaluation and education these options may increase our donor pool.

Adopted April 2002

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