Directed Donation: One Centers Experience

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ABSTRACT

Directed Donation increases patients chances of receiving a transplant. A donor family can donate to a specific person or a specific transplant center. UNOS and our local OPO do not track the rate of successful directed deceased donations due to the low occurrence. Our transplant center has completed 8 directed donation cases.

INTRODUCTION

- A 51 year old married, Caucasian male. He presented to LVHN Transplant Center on August 5th, 2014 with his wife for his Pre Kidney Transplant Evaluation. He works as a Correctional Officer.
- A 18 yeaer old single, caucasian male. He was struck by a vehicle while walking on the side of the road. He was pronounced brain dead.

CONCERNS:

- ESRD - not on dialysis. GFR 19.
- Emphysema - Managed by PCP.
- Sleep Apnea - Managed by PCP.
- Bipolar disorder. He follows with psychiatrist every 6 months and therapist monthly. Patient remains stable on current medications.
- Obesity – Current weight 323 lbs, goal weight of 300 lbs given.
- Seizures

PLAN:

- Transplant Evaluation Requirements given: echocardiogram, colonoscopy, PSA, PFT results, records from seizure, records from ankle fracture, clearance from psychiatrist, goal weight 300 lbs.
- On August 5, 2014, at about 1000, our surgeon received a call from our local Organ Procurement Organization. They told our surgeon that our patient's son had abeen admitted to a local hospital after he was struck by a vehicle while walking on the side of the road. His son was now pronounced brain dead and the family had made the decision to direct the donation to our patient.

OBJECTIVE

The patient will be listed on the National Kidney Transplantation Waiting List and will receive the directed donation of his son's kidney.

METHOD

It was determined that we did not need the psychiatry clearance as the patient was in current treatment for bipolar and was well controlled. The decision was made that due to the circumstance of the donation, that his current weight would be adequate. The transplant surgeon called the on call nephrologist at the donor hospital, and asked him to order a stat echo and ABO on the recipient. The transplant coordinator contacted the OPO coordinator on site and made them aware of the attempt to move forward with the donation. The OPO coordinator was told that the recipient required an echo and ABO, and that he will be getting those done at the donor hospital. Transplant coordinator spoke with the wife who was extremely tearful but stated this is what they both wanted to do. The coordinator then called our hospital lab and asked how we could get his blood from the donor hospital to us at the recipient hospital. They stated that our local courier does pick up there, but would not drop off until later that day. Transplant Coordinator explained that we would need the blood for the crossmatch as soon as possible and couldn't wait till later. After many calls to both the courier service and the lab, they coordinated a stat pickup at the donor hospital and a drop-off directly at recipient hospital. Transplant coordinator spoke with the donor hospital lab and made them aware of the situation. At first, there was resistant to getting this coordinated quickly, however, after speaking with the supervisor a plan was put into place. The ABO was drawn at 1245. Transplant coordinator would call the donor hospital lab when the patient was headed there to get blood work drawn, and then again for them to call transplant coordinator when the blood sample left their hospital. At that time, the cardiology department at the donor hospital was called to explain the urgency of the situation in completing the echocardiogram of the recipient. The echocardiogram tech had the cardiologist stat read the echo results and she would fax them to the transplant department. She would then call transplant coordinator when all the tests were complete. Once the echo result was faxed over to our office, the surgeon reviewed the results. The results were normal with an EF 60%. The confirmatory ABO came back a few minutes later and he was listed on the kidney transplant wait list at 1441.

Transplant coordinator verified with the patient that he wanted to continue to move forward. He stated yes, that his son was a donor on his license and he would be honored to have his son's kidney. Patient was told that the lab still had to see if he was compatible with his son's kidney. It was then figured out that the HLA lab would need nodes to do the cross match because the donor received more than 10 U of blood and /or fluid. Early morning on 8/16/14 the donor OR was scheduled, transplant coordinator called and spoke with the patient. He was told that he will be admitted to our hospital closer to the end of the donor's OR. The patient and his wife were planning to stay with their son until he was wheeled to the OR. Transplant Coordinator was also in touch with the local OPO and they were aware of the situation and knew to call when the nodes left the OR with the courier. This happened at approximately 1030. The patient was then called and told to go to the hospital to be admitted. Cross match was resulted approximately 1520, and donor and recipient were compatible. The transplant started at approximately 1830 on 8/16/14.

SUMMARY

Multidisciplinary approach was utilized using both donor hospital and recipient hospital in achieving a directed donation from a son to his father. Since the transplant, the patient has been compliant with medications and office visits. First few office visits, he was here with his wife and she appeared to be tearful and overwhelmed, but didn't verbalize much. The patient appears to be coping well and continues with psychiatric follow up. It has now been 2 years since his transplant. RB is currently 286 lbs, 2 months post gastric sleeve. Current creatinine is 1.14. His son donated both kidneys, liver, and tissue. Team work and efficiency resulted in a successful directed donation in spite of obstacles.