




LETTER TO THE EDITORS

It is not only extending donor criteria: it is extending the donor pool. A cross-sectional survey from the European Society of Organ Transplantation



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Dear Editors,

As part of the TLJ2.0 organised by the European Society of Organ Transplantation (ESOT), our working group surveyed transplant professionals' attitudes towards expanding the donor pool, barriers and interventions to overcome these. The survey was posted for three weeks in July–August, 2020, via the ESOT's social media platforms.

A total of 135 participants, consisting mainly of surgeons (34%), transplant coordinators (30%), physicians (15%) and intensivists (4%) completed the survey (Table 1). Most respondents worked in the field for >20 years (34%), 6–10 years (20%) or 11–15 years (19%). The main European countries of practice were the Netherlands (16%), the United Kingdom (10%), Italy (8%), Sweden (7%) and Spain (4%) (Q1–3).

History of cancer (Q4). The 88% felt that the history of leukaemia was not a contraindication to donate, although 15% suggested a multi-disciplinary team decision. Some stressed the need for explicit recipient consent (4%) or clearly stating the risks to the recipient (3%). Two respondents considered the history of leukaemia as a contraindication.

HIV+ donor for HIV+ recipient (Q5). The 77% would accept grafts from HIV+ donors for HIV+ recipients. An evaluation of risks/benefits of this procedure and/or need for further tests was frequently mentioned.

Establishment of clinical protocols to support decision-making was deemed of great value, and respondents not willing to proceed stated it was too risky or referred to country-specific contraindications.

Table 1. Description of the survey questions

Survey questions	Responses (n)
Q1. Please indicate your country	135
Q2. What is your profession?	135
Q3. How many years of experience do you have?	135
Q4. You are on duty as a responsible for the liver transplant unit and you receive a call offering a graft. Clinical history: 35 years old, traumatic brain injury, 4 ICU days. Past history of Leukaemia (as a teenager), 15 years free of disease. Suppose there is a rare blood group and that you have a patient pending for transplantation for more than 2 years because of the blood group. Would you accept this graft?	97
Q5. Some countries are grafting HIV+ donors for HIV+ recipients. In order to expand the donor pool. Would you be in favour of this option?	86
Q6. Are you in favour of the use of HCV+ donors in HCV– recipients?	86
Q7. Did your hospital put transplant activities on hold during the COVID-19 pandemic?	83
Q8. Has your hospital defined a plan to support the continuity of transplant programs?	83
Q9. Do you have any experience with ICOD? What is the major barrier to implement this practice?	80
Q10. According to your experience, when do you usually start the donor management/treatment in a DBD donor?	78

HCV+ donor for HCV– recipient (Q6). The 59% would accept grafts from HCV+ donors for HCV– recipients, mainly due to the availability of effective anti-viral treatment. Respondents against accepting these grafts reported it was not a justifiable additional risk to patients, and stated ethical concerns and expensive treatment.

Continuation of transplantation programmes during the COVID-19 pandemic (Q7–8): During the COVID19 outbreak, 60% of the respondents' centres put their transplant activity on hold. This was done for a short time or certain donor categories, e.g. living or older donors, or recipients, e.g. patients with acute indications. The mean reason for closure was shortage of ICU beds, staff or testing capacities. The 78% stated that their hospital has defined a national or local continuation plan.

Intensive care to facilitate organ donation (ICOD) and its barriers (Q9). Only 38% had experience with ICOD.

Identified barriers were financial and organisational, lack of public knowledge regarding brain death, lack of competent staff, and ethical and legal country-specific barriers.

Donor management of a DBD donor (Q10). Respondents were equally divided between those who begin when switching from curative treatment to palliative care, and those who wait for determination of brain death.

In summary, many transplant professionals were willing to accept donors with an additional risk of transmission of infectious or malignant disease although there was no consensus on clinical pathways [1–3]. Many centres closed during the height of the pandemic and now have continuation plans in place [4–6]. Despite ICOD's potential to increase the donor pool [7,8], the majority of respondents had no experience. The uncertainties highlighted by the survey will be further explored in an opinion paper that is currently in preparation by the working group.

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