Summary
Histocompatibility Committee Conference Call
Friday, May 25, 2012
11:00am-12:20pm (ET)

Participants:

- Committee: Nancy Reinsmoen PhD, D(ABHI), David Kiger CHS, CHT, James Bowman III, MD, Lee Ann Baxter-Lowe PhD, ABHI, Brad Eisenbrey MD, PhD, Cathi Murphey PhD, CHS, DLM (ASCP), Dolly Tyan PhD, D(CASU), Paul Warner PhD, D (ABHI)
- OPTN: Ciara Samana, Anna Kucheryavaya, Gena Boyle, Darren Stewart, Wida Cherikh
- SRTR: Adrine Chung, Howard Gebel PhD, Ajay Israni, MS MD, Bert Kasiske MD, Jon Snyder PhD

Summary:

The Committee met by conference call to view presentations from SRTR on the results from updated Kidney Pancreas Simulated Allocation Model (KPSAM) runs and to offer feedback to the Kidney Transplantation Committee (Kidney Committee) on issues specific to histocompatibility (Exhibit A).

Committee members inquired about the data on the average kidney and kidney/pancreas transplants per run, wondering why there was variation in the data for each run. SRTR staff explained that the simulation models do not perfectly replicate reality. The results of each run are actually averages of 10 iterations. In each iteration, the kidneys become available in a different order, thereby affecting which candidates receive offers at certain points in time.

The Committee discussed at length data on kidney transplants by recipient age and expressed concerns over allocation changes that could result in a decrease in transplants for candidates over the age of 50. Staff from the Kidney Committee explained that the latest run results in a very small decrease in the number of transplants for this population and reminded the Committee that KPSAM does not take into account changes in acceptance behavior resulting from policy changes. SRTR staff added that the modeling software used does not account for changes in behavior but suggested that it may be helpful for future software to do so.

After viewing data on prioritization by CPRA between N3 and N4 (chart outlining difference in N3 and N4 models below) and the sliding scale proposal, Committee members noted the importance of ensuring that the new allocation model did not decrease transplants for highly sensitized patients.

N3	N4
KDPI longevity matching with the following: • Back-date dialysis time • Waiting time points based on fractional years (instead of anniversary points and relative ranking) • A2/A2B→B priority • No payback • National priority for CPRA ≥ 98% candidates • CPRA sliding scale • No DCD classification • Longevity matching (Top 20% survivors get first priority for top 20% DPI kidneys) • Regional sharing for marginal (KDPI >0.85) kidneys • Share 0.35 (pediatric priority for non-0 mm kidneys with KDPI <0.35) • Pediatrics barred from marginal kidneys unless 0mm or CPRA ≥ 98%	**N3 with the following replacing the national priority for CPRA ≥ 98% candidates:** • Local CPRA 100 • Regional CPRA 100 • National CPRA 100 • Local CPRA 99 • Regional CPRA 99 • Local CPRA 98

After viewing modeling of kidney transplants by recipients with CPRA values between 95-100% (see Figure 1 below), members of the Committee were concerned that, although the new N4 model seemed to increase the number of transplants for candidates with a CPRA of 99% and 100%, there was a disadvantage for candidates with a CPRA of 98%. According to several committee members, this disadvantage was largely due to the fact that the new model did not allow for regional sharing for candidates with a 98% CPRA.

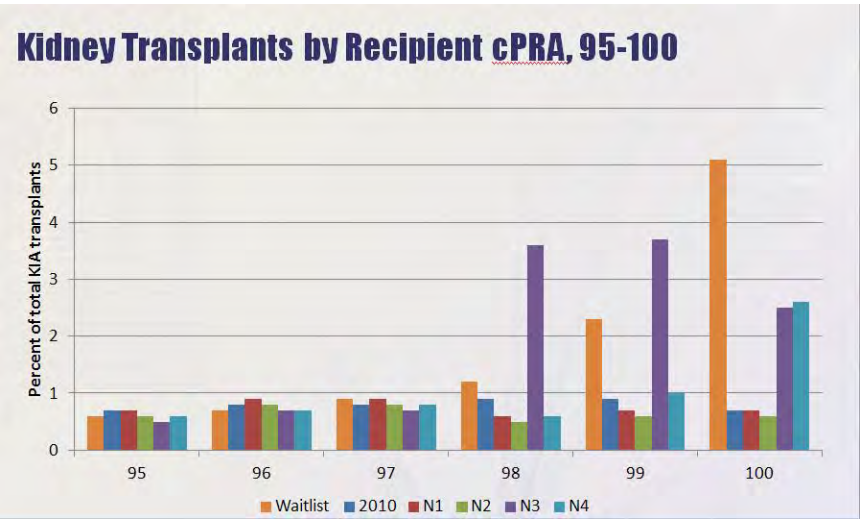

Figure 1: Kidney Transplants by Recipient cPRA, 95-100

Several members of the Committee voiced concern about potential unintended consequences of greater national sharing for highly sensitized patients and urged the Kidney Committee to consider increasing accountability in the system. The Committee noted that a prior data request revealed that a small population of centers had failed to transplant more than 40% of accepted kidneys into the intended recipient.

The Committee largely agreed that the new results from N4 were encouraging. The chair explained that the Histocompatibility Committee did not need to vote on the proposal, but instead the Committee should make some recommendations to the Kidney Committee. The Committee decided to offer support for the N4 proposal but to recommend that the Kidney Committee include the following: 1) regional sharing for candidates with a 98% CPRA; and 2) policy language that ensures more accountability for centers who misuse broader national sharing.

The Committee and staff then expressed their appreciation to the following members who were rolling off of the Committee on June 30, 2012:

- Massimo Mangiola Ph.D.
- Dimitri Monos Ph.D.
- Paul Warner Ph.D, D(ABHI)
- David Maurer PhD, D(ABHI)
- Sara Dionne Ph.D

The call ended at 12:20pm (ET).