Memorandum

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To: Interested Parties

From: Thomas G. Peters, M.D., F.A.C.S., F.A.S.N.
The Methodist Medical Center Professor of Surgery in Transplantation
University of Florida Health Science Center, Jacksonville

Re: United Network for Organ Sharing Proposal on Kidney Allocation`

I write regarding the issue of kidney allocation to increase and expand the life of the donor organ (kidney) and the recipient of that organ—a concept previously termed: *life years following transplantation* (LYFT). There is discussion that the LYFT concept would give an advantage to younger patients awaiting kidney transplantation, and a suspicion that older patients might, therefore, be disadvantaged. My personal views, based upon four decades of active practice, follow.

The use of scarce organs to give the maximum life years after transplantation is not just a sensible allocation policy; it would, I believe, disadvantage no one. Most persons would understand that younger deceased donor kidneys should be allocated to younger patients since the kidney and its recipient may both have a long life span; the current allocation system does that. The concern arises, however, that patients in an age range of about 45 to 55 would only be offered extended criteria organs or those organs which would not serve the older patient well. I believe that this likely is not so. For example, in examining the current proposal, it is simple to see that a potential recipient aged 55 might often be given a kidney from a 40 year old donor.

Further, I have confidence in the concept because current data show clearly that placement of expanded criteria or older kidneys into older patients can result in very good outcomes. Most such recipients go on to gain normal or near normal kidney function, live longer free of dialysis, and simply die years after transplant of some unrelated cause. While there are individual exceptions to this, the outcomes of kidney transplantation as determined by the best study methods available confirm that such good outcomes are expected and do, indeed, occur.

There is another reason to consider LYFT, particularly as it pertains to the older potential recipient. Many transplant centers are reluctant to use expanded criteria organs for any kidney transplant recipient; some centers will not even consider transplantation for the elderly. In my own program, I have transplanted "older" kidneys to older recipients for many years and have seldom seen anything but good outcomes. The idea of "age matching" donors and recipients has been an informal part of the kidney transplant professional community for decades. The hope with the current concept would be that more and more older donors supply suitable organs which are increasingly accepted by centers not now transplanting the elderly. Should that occur, and I believe that it would, older recipients actually may be advantaged because good kidneys, now wasted, would come to be more widely accepted, as they should.

There is a misconception that expanded criteria organs are, by definition, "bad kidneys". The scrutiny applied to such kidneys is far greater than that applied to standard donors. Surgeons will not use such a kidney unless details of the anatomy, surgical recovery, biopsy results, and (when available) values related to pump perfusion are fully disclosed and known. They can be excellent organs in every regard. So, I would urge that all support the idea that allocation based upon conceptual LYFT be implemented. Ultimately, a well designed system of allocation that affords the longest life to the most patients will serve everyone best. Clearly, as 2011 unfolds, America does not yet have such a system in place. The current methods were implemented with the best intentions. Now, the chance for refinement and improvement can have far-reaching, positive effects.