Minutes of the Fourth meeting of the Technical Advisory Group for Liver Transplantation

Date: 10/04/2013
Time: 3.00 pm
Venue: Anaesthesia Office, Tower 2, 5th Floor, Rajiv Gandhi Government General Hospital, Chennai 600 003

Participants

1. Dr. J. Amalorpavanathan, Convenor, Transplant Co-ordination Programme
2. Mr. C.E. Karunakaran, NNOS
3. Dr. V. Paari, MIOT Hospital, Chennai
4. Dr. Ajitabh Srivastav, MIOT Hospital, Chennai
5. Dr. Kannan Thiru, MIOT Hospital, Chennai
6. Dr. A.R. Venkateswaran, Government Stanley Hospital, Chennai
7. Dr Manoharan, Government Stanley Hospital, Chennai
8. Dr. C.E. Eapen, Christian Medical College, Vellore
9. Dr. Fredrick Vyas, Christian Medical College, Vellore
10. Dr. Jeyamani.R. Christian Medical College, Vellore
11. Dr. Uday Zachariah, Christian Medical College, Vellore

Representatives from Apollo Hospital, Chennai and Global Hospital, Chennai were unable to attend.

Dr. C.E. Eapen welcomed the gathering

The following issues (circulated in advance) were discussed and decided upon.

S.No.	Issue	Decision
1.	**Splitting donor liver** (for adult to adult transplantation) Can a split feasible liver be allocated out of turn on debt return basis?	It was decided to stick to the existing policy of leaving it to the individual hospital to decide whether to split a local or allocated share liver. All participating hospitals are encouraged to actively consider splitting when donor and recipient conditions permit. Hospitals are encouraged to co-ordinate with each other in this endeavour. It remains the prerogative of the individual hospital to decide on recipients.
2.	**Paediatric liver donor allocation**	It was decided to stick to existing policy (as above). Encourage all hospitals to consider splitting (as above). To sensitize all participating hospitals towards paediatric transplant, each hospital is requested to provide the number of patients on paediatric waiting list on a monthly basis, which can be then be circulated to all.

		After discussion no consensus was reached on the definition of a paediatric donor with regards to age, ie. ? <12 years / ?<16 years. To treat a <45 kg person as an exclusive paediatric donor was not accepted by the group.
3.	**Criteria for supra-urgent listing in liver transplantation**	It was decided that the current indications for supra urgent listing viz, Primary Non Function (PNF), Hepatic Artery Thrombosis (HAT) and Fulminant Hepatic Failure (FHF) remain unchanged. However, to be on the supra urgent list, the duration for PNF was accepted as within 7 days post-transplant and in HAT within 14 days post-transplant. It was agreed that a sincere attempt be made to rule out underlying chronic liver disease before FHF is diagnosed. It was clarified that patients with FHF need not be on a ventilator at time of listing on the supra-urgent list. It was also clarified that Wilson's disease presenting as FHF is acceptable on the supra urgent list.
4.	**Combined liver-kidney transplant** Whether a requirement of minimum six weeks on dialysis be mandated for combined liver-kidney transplants	The decision regarding specific indication for liver-kidney transplant, being complex, is at present left to the individual hospital. It was decided that while local organs can be used for combined transplant, there will be no out of turn allotments on return basis. If a share liver is allotted to a hospital and combined transplant required, then the share kidney will also go to the same hospital. It was clarified that a patient requiring combined liver-kidney transplant will be on the liver waiting list.
5.	**Allocation of local and share livers based on priority** Explanation for each hospital's prioritization policy and subsequent organ allocation	As per the GO that mandates each hospital maintain a priority list of recipients, it was decided that participating hospitals submit online to the Convener each week their priority list of recipients with diagnosis and MELD scores.
6.	**Low MELD** Should local and share livers be offered only if MELD score > 15 (with accepted exceptions)	It was agreed that on principle a 'suitable' recipient get the donated liver to ensure optimal organ utilization. An India specific scenario of refractory ascites (with no TIPSS option) was brought up for discussion in addition to the existing exceptions to MELD score during listing.

		It was decided that if a patient is transplanted at MELD <15, then the hospital justify this at is the next subcommittee meeting.

Meeting concluded at 5.00 pm.