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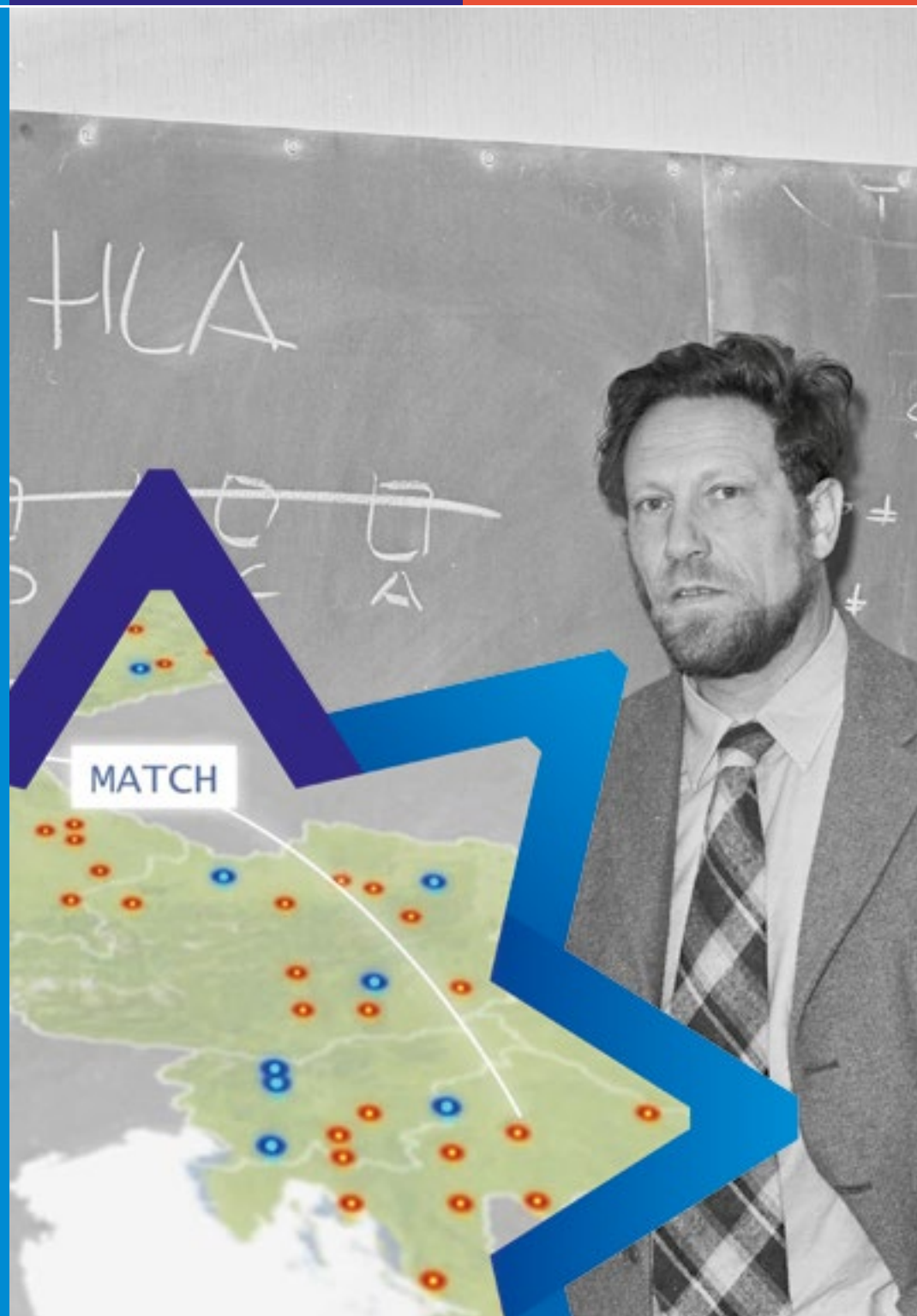


Photo:  
Prof. Dr. Jon J. van Rood  
founded Eurotransplant in 1967

# Statistics

## Preliminary Statistics Eurotransplant, 12 month period ending April 30

Number of transplants performed from deceased donors registered in period

TRANSPLANT COUNTRY	KI	BKI	LI	SLI	PA	KI + PA	HE	BLU	SLU	HE + BLU	LI + KI	SLI + KI	LI + PA	HE + KI	BLU + KI	HE + LI	BLU + LI	BKI + PA	TOTAL
2017 Austria	349	12	141	6	1	20	59	133	3	-	5	-	-	2	1	-	1	-	733
2016 Austria	312	16	140	1	2	25	60	122	3	-	4	-	-	1	-	-	1	-	687
2017 Belgium	426	-	242	3	34	10	69	130	4	2	16	-	-	-	1	-	-	-	937
2016 Belgium	426	3	236	4	44	10	78	100	2	-	10	1	-	3	1	-	4	-	922
2017 Croatia	161	1	120	-	-	6	33	-	-	-	2	-	-	-	-	-	-	-	323
2016 Croatia	190	-	134	-	-	8	41	-	-	-	-	-	-	-	-	-	-	-	373
2017 Germany	1334	12	707	82	6	83	276	291	29	6	17	3	2	2	-	2	2	1	2855
2016 Germany	1425	18	749	60	10	90	288	257	32	2	10	-	3	1	-	-	3	-	2948
2017 Hungary	290	-	76	-	-	7	55	-	-	-	2	-	-	-	-	-	-	-	430
2016 Hungary	309	1	90	-	-	9	60	-	-	-	5	-	-	-	-	-	-	-	474
2017 Netherlands	382	2	153	2	10	20	37	69	7	-	1	-	1	-	-	-	-	-	684
2016 Netherlands	424	1	144	7	9	21	45	63	12	1	2	1	-	-	-	-	-	-	730
2017 Slovenia	47	-	25	-	-	3	28	-	-	-	-	-	-	-	-	1	-	-	104
2016 Slovenia	53	-	26	-	-	6	29	-	-	-	-	-	-	1	-	-	-	-	115
2017 Non ET	-	2	-	-	-	-	3	3	-	-	-	-	-	-	-	-	-	-	8
2016 Non ET	-	-	-	-	-	-	3	3	-	-	-	-	-	-	-	-	-	-	6
2017 Total	2989	29	1464	93	51	149	560	626	43	8	43	3	3	4	2	3	3	1	6074
2016 Total	3139	39	1519	72	65	169	604	545	49	3	31	2	3	6	1	-	8	-	6255

He-Heart Ki-Kidney Pa-Pancreas Li-Liver SLU-Lung BKi-both Kidneys BLu-Both Lungs SLi-Split Liver

Number of organs used for transplantation from deceased donors registered in period

DONOR COUNTRY	AUSTRIA	BELGIUM	CROATIA	GERMANY	HUNGARY	LUXEMBOURG	NETHERLANDS	SLOVENIA	NON ET	TOTAL
2017 Kidney	387	454	195	1431	300	11	403	65	4	3250
2016 Kidney	347	479	221	1513	333	4	452	74	3	3426
2017 Heart	69	78	29	275	56	1	38	18	11	575
2016 Heart	78	76	42	277	64	2	48	17	9	613
2017 Liver	175	276	132	700	106	8	164	36	15	1612
2016 Liver	144	269	140	724	128	2	176	44	8	1635
2017 Lung	139	276	16	575	74	2	136	35	68	1321
2016 Lung	135	208	38	510	72	2	138	14	46	1163
2017 Pancreas	21	39	7	91	7	1	35	3	-	204
2016 Pancreas	29	40	8	98	10	1	45	6	-	237

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Eurotransplant Newsletter is a publication of the Eurotransplant International Foundation. The Eurotransplant communication department welcomes articles pertaining to organ donation, allocation and transplantation. If there are issues you would like to be discussed and/or presented in the Eurotransplant Newsletter, please send copy to: [communication@eurotransplant.org](mailto:communication@eurotransplant.org)

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# Introduction



With great pleasure we herewith send you the spring edition of our Newsletter. In this edition you can find a summary of the meeting of the Eurotransplant Board of September 2016 and January 2017 including approved recommendations. Also summaries of the discussions and recommendations as developed in the advisory committees in the second half of 2016, are available in this edition.

As you might be aware, the Eurotransplant Organ Procurement Advisory Committee (OPC) was recently renamed to OPCC and has updated its mission statement. Please find on page 34 in this edition an interview with the Chair of the OPCC, Prof. Dr. Dirk Ysebaert, wherein he shares his vision on the future work of this committee.

### **Croatia - 10 years member of Eurotransplant!**

In May 2017, it will be exactly 10 years ago that Croatia became a full member of the Eurotransplant cooperation. On this special anniversary, an interview with Dr. Mirela Bušić, National Transplant Coordinator at the Croatian Ministry of Social Affairs and Health is published in this edition. Please look up page 37 to read more on Dr. Bušić's experiences and what Croatia values about the 10 year international cooperation in the Eurotransplant network.

### **Jubilee Meeting**

We look forward to the 2017 Eurotransplant Jubilee Congress on the occasion of Eurotransplant's 50<sup>th</sup> anniversary. The Jubilee Congress will take place from October 4-6, 2017 in the beautiful Hotels van Oranje at Noordwijk in the Leiden area, where the heart of Eurotransplant lies. We are proud to announce in this edition of the Newsletter more information on the Congress on page 30. Further information and online registration are available online: [jubilee.eurotransplant.org](http://jubilee.eurotransplant.org)

### **CORE**

Last but not least, we would like to highlight the article on the development of CORE, the new software that will replace the current ENIS system on page 32.

We hope the contents of this Newsletter support your work and cooperation with us. Should you wish to comment on the Newsletter or if you have suggestions, please do not hesitate to contact us: [communication@eurotransplant.org](mailto:communication@eurotransplant.org)

We wish you a pleasant reading!

# Research for Allocation Development

*Column Peter Branger*

Eurotransplant collects, with the help of voluntary participating centres, valuable data on the recipients (waiting list), organ donors, the allocation process, the transplantation and the outcome of the transplantation. This transplant follow-up data is essential for continuous improvement of allocation rules and processes and allows Eurotransplant to be transparent and accountable for its activities.

## **Cooperation**

I would like to thank all of you for your cooperation. Since collaboration and knowledge sharing is what allows us to continuously improve our practices. We appreciate the mutual knowledge exchange and value all personal contacts. Especially, I would like to thank all the centres who submit the data to Eurotransplant. We are aware that in nowadays, sometimes vivid and hectic environments, administrative tasks are not always of highest priority. We are grateful for the participation of such a vast amount of centres and I would like to appeal to all centres to continue entering their data. With your effort and commitment we can all benefit and further ensure an optimal use of available donor organs.

## **Innovation**

We have recently started a development program to renew and innovate the applications of the Eurotransplant Registry. The current registry applications do no longer meet the functional, as well as technical, demands of Eurotransplant. In March 2017, a team of functional managers and external software developers started to renew the registry applications for all organs. This complete makeover will be an important improvement for the centers as well as for our activities in the field of allocation development.

## **Research**

The analysis of these datasets permit extensive scientific research. An example is the research of Dr. Georg Györi, Vienna, Austria who won last year's Henk Schippers Young Investigators award. Dr. Györi executed a study on the on 'Impact of dynamic changes in MELD score on survival after liver transplantation'. The datasets for this study were acquired from the Eurotransplant registry and allow to predict on the overall survival after orthotopic liver transplantation, based on the changes in the Liver MELD score during waiting time. Moreover, the analysis of registry data also contributes to Eurotransplant's organ advisory committees in defining and proposing adaptations of allocation rules and algorithms.

## **Opportunity**

Eurotransplant is continuously working on the improvement of its services, processes and methods. The new Registry applications will therefore be faster and the modern system is more user-friendly. Standardised datasets and the latest technique, allow centers to get even more actively involved in national and international projects. On a long run, Eurotransplant aims to offer automatic connections with other applications, systems and registries. Data exchange with other European registries will even better facilitate international research and assure the most optimal use of donor organs.

Peter Branger



# Summary Board meeting I

Date: September 28, 2016  
Venue: Engelberthahoeve Restaurant, Leiden, the Netherlands  
Chairman: B. Meiser  
Secretary: L. van Hattum  
Members present: 21  
Members excused: 0

The Board discussed the implementation of recommendations. There are several recommendations and policies awaiting implementation. Most of these recommendations are still pending reply from Germany. Since there is no procedure in place how to deal with countries that do not approve of a recommendation, the Board decided to draft such a procedure.

The Board re-appointed Meiser as President of the Board for a new period of three years. The Board re-appointed Bos as ethicist for a new period of two years.

The Board received an update on the progress of the CORE and COLD projects:

The Board was informed that the contract with eProseed, the external partner which will assist with the realization of the CORE project, has been signed. As a second step, a contract needs to be negotiated for the rest of the project. The second milestone of the project is the clinical data part. The company Marand from Slovenia has been selected to provide a modern system that can easily be adjusted. Two proofs of concept have been done with a very satisfying result. It is estimated that this contract can be signed in October.

The COLD project will be executed as planned. With representatives from Slovenia, Hungary and Croatia it has been discussed that the national donor systems need to be adjusted for COLD. The building of COLD will start January 2017, as it largely depends on the progress of the CORE project of which the contract will be signed in October. The time needed for adaptation of the national donor systems after the implementation of COLD within ET is approx. 6-8 months.

Branger informed the Board on the progress made in the jubilee project. There are four work packages in this project, of which each provided an update. The Board thanked all participants of the project, especially those in the office, for all their work so far.

Samuel provided the Board with an update on the Registry activities. At the moment there is work done concerning a replacement for the current registry applications, which are more or less end of life. As decided by the Board in May, a complete new system for the registry has to be decided upon and installed. This takes time and the new system also has to work together with CORE. Therefore for the moment a quick solution, a so called "walking skeleton" application for all organs is favored, that will keep the current registry running until a new system is found.

The center reports on survival completeness rates (as agreed upon by the Board) have been sent out and Eurotransplant received positive feedback from quite some centers in return. It is hoped that the information on the completeness will stimulate the delivery of missing data to ET.

As decided by the Board in October 2015, a new formed Registry Working Group will be established, whereas each Advisory Committee will nominate one representative to. The Board appoints Rogiers as chair of this working group.

With regard to the upcoming national German registry, further discussions have to take place to determine the future cooperation.



Branger informed the Board that, according to the Board decision, Eurotransplant took part in the proposal (call for tender) for the European EDITH project. So far the EU has not yet decided if this project will take place.

The Board discussed the cooperation with Romania. The Letter of Intent between Eurotransplant and Romania expired September 24, 2016. The Board evaluated the result of the agreement. As also discussed in the framework of the long-term strategy, the Board decided to terminate the possibility of twinning agreements between one Eurotransplant center and a non- Eurotransplant center, and instead draft an agreement to be signed by Eurotransplant itself and the other non-ET country. This new type of contract will be introduced in 2017.

Meiser, Branger, Van Raemdonck and Laufer will arrange a meeting with the Romanian Minister of Health to discuss the issues in place and a possible cooperation. Eurotransplant will offer its help in improving the local structure. The Board decides that for now no more cooperation with the aim of a twinning agreement will be offered.

Regarding the cooperation with the Trentino region in south Tirol, Eurotransplant has discussed with all parties that all offers from Trentino should go to Eurotransplant and not only to Innsbruck, as the Eurotransplant area is much larger than Innsbruck alone and other patients could also benefit from this cooperation. A draft contract has been sent to Italy to establish cooperation between Eurotransplant and Trentino.

The Board also discussed the cooperation with the Bozen region in South Tirol. If there is an organ offer from that region, a match per organ has to be generated between high urgent Eurotransplant and Italian patients based on waiting time information. If after the comparison the organ has to go to Italy, Eurotransplant needs to delete this donor from the system and it becomes untraceable. Furthermore, this is manual work, which is prone to mistakes and something ET in general wants to avoid. Nevertheless, since the decision where the organ goes should not be left to Innsbruck, the Board unanimously decided that Eurotransplant has to make the comparisons in these cases. If an organ is allocated to Italy, a pay back is created. However, the pay back organs were always first offered to Innsbruck which considered these offers as centers specific offers. It has been agreed with Innsbruck that in case no suitable recipient is available, the pay-back offers are being reported to Eurotransplant.

Eurotransplant received a letter from the Croatian Minister of Health concerning a proposed protocol agreement between Croatia and Bosnia-Herzegovina, Macedonia and Montenegro in the field of organ donation and transplantation. There are a few problems with this agreement that the Board does not agree with, particularly the low donation rate in these countries. A letter will be send to Croatia that Eurotransplant will not support these agreements until a well-functioning donor program is established.

Meiser informed the Board that in the past, the President of the Board used to be an active member A. Several years ago, the position was made independent from being member A to make the President more independent from an organ group and overcome the necessity for re-election as member A in the Assembly meeting. He proposed to do the same for the position of the Vice- President. After a lengthy discussion the Board approves this proposal and a respective change of the Articles of Association.

The future governance structure of Eurotransplant was discussed. With the proposed structure, there will be a Board of Medicine and Science and a Board of Administration. The end responsibility for the management of the foundation lies with the general director and the management team, supervised by a Board of supervision. They can delegate certain tasks to one of the different Boards. As Eurotransplant is a Dutch foundation, it has to abide to the Dutch law. It still needs to be investigated if the proposal can be installed according to the Dutch law. The Board voted and decided to move the end responsibility for the foundation to the management in the new structure. After checking the new proposal with the Eurotransplant lawyer and a Dutch notary the proposal will be re-discussed in January.

Valkering reported on the finances. The budget proposal was discussed in the financial committee meeting. The most important developments in the organization are the development of a long term strategy, realizing the information backbone and the CORE project. The organization is reaching its maximum abilities to perform all services and projects with the current workforce.

The financial reserves are on a moderate level but due to investments in IT and Registry (as agreed by the Board in May), the reserves will further decrease and might lead to a situation of limited financial flexibility in 2017.

The Henk Schippers Investigation Award Committee has selected Georg Gyori from Vienna, Austria as winner of the 2016 award on this article *“Impact of dynamic changes in MELD score on survival after liver transplantation – a Eurotransplant registry analysis”*.

A cross-over living donation kidney program has started in Belgium. As the Belgian law does not cover cross-over transplantation, the law will be adapted. The Board will discuss in January if this should be a service performed by Eurotransplant in the future or if this is a national matter.

The Board was informed that the main tenant of the office where the Eurotransplant office is located will be moving out of the building at the end of 2016, leaving it in most parts empty. Eurotransplant therefore faces challenges in the housing area. At the moment, it cannot be predicted if Eurotransplant needs to move to another location.

Closing, the Board thanked Schareck for his support during his years on the Board as this was his last Board meeting.

The following policies have been discussed and approved by the Board:

## EUROTRANSPLANT KIDNEY ADVISORY COMMITTEE

### **R-KAC02.16 – Indications for high urgent kidney transplantation**

In specific situations a high urgency (HU) status can be requested if one of the following criteria is met:

1. Imminent lack of access to either hemodialysis or peritoneal dialysis;
2. Severe bladder problems (hematuria, cystitis etc.) due to kidney graft failure after simultaneous kidney+pancreas transplantation, provided that the pancreas graft is bladder-drained and functioning adequately;
3. Severe (uremic) polyneuropathy (only non-German countries);
4. Other indications can be granted in exceptional cases if 2/3 of the eligible ETKAC members support the request.

### **R-KAC03.16 – Kidney-after-other organ transplantation (KA00) bonus (rephrased)**

In addition to the option of performing a combined transplantation with kidney (heart, lung, liver, intestine or pancreas) the option of a kidney-after-other organ transplant should be made possible in selected cases.

If a patient is listed for another organ in combination with a kidney transplant, the center can decide to perform a simultaneous other organ + kidney transplant or a kidney-after-other organ transplant.

In the latter case the patient gets 500 extra points in the kidney allocation system (ETKAS) or priority in the old for old kidney allocation system (ESP) fulfilling the following 2 conditions:

1. The patient was:
  - a) listed on the kidney waiting list prior to the other organ transplant OR
  - b) not listed on the kidney waiting list prior to the other organ transplantation, but the patient had been on dialysis for at least 6 weeks prior to the other organ transplantation.
2. The patient still is or became chronic dialysis dependent in the period of 90 to 360 days after the other organ transplantation.

All other requests for the kidney-after-other organ bonus are to be audited and granted by the ETKAC.

The 500 extra points expire after the kidney transplantation has been performed.

### **R-KAC05.16 – Exclusion of AM and immunized patients from EA and rescue allocation**

It is not allowed to select an immunized patient as defined as >5 % PRA or a patient included in the AM program via the Extended Allocation (EA – recipient oriented rescue allocation) or via rescue allocation.

### **R-KAC06.16 – Blood group rules in kidney allocation**

Kidneys should be allocated to ABO identical patients. An exception should be made for:

- The Acceptable Mismatch (AM) program: kidneys should be allocated to **ET compatible** patients;
- Combined organ patients: kidneys should be allocated according to the ABO blood group rule of the leading organ;
- Rescue allocation of kidney-only: selection of patients should be ABO identical. The effect of the change in blood group rules should be evaluated after 5 years.

### **P-KAC07.16 – Allocation to immunized ESP patients**

If the HLA type of the donor is known at time of allocation both non-immunized and immunized patients should be included, and if the HLA type of the donor is not known at time of allocation only non-immunized patients should be included.

## **EUROTRANSPLANT LIVER ADVISORY COMMITTEE**

### **P-LAC02.16 - Intestine – Audit procedure for intestine High Urgency status**

Each country within Eurotransplant may provide one auditor specialized in intestinal failure or intestinal transplantation for the intestine High Urgency audit group.

### **R-LAC03.16 – Intestine – HU Intestine status**

In case only one or non-standard venous access possibility remains (appropriate documentation needs to be provided) a HU intestine status can be requested for isolated intestine transplantation, intestine and kidney transplantation or modified multivisceral transplantations after audit by 2 intestine auditors outside of the requesting country.

### **R-LAC02.16 - Intestine – Intestine allocation scheme**

Allocation sequence of isolated intestine transplantation, intestine and kidney transplantation or Modified multivisceral transplantation will be:

- Donor < 46 kg
  - o **HU intestine**
  - o ACO (approved combined organs)
  - o Pediatric recipients in the donor country (ABO-identical before ABO-compatible, then according to waiting time)
  - o Pediatric recipients in the other ET countries (ABO-identical before ABO-compatible, then according to waiting time)
  - o Adult recipients in the donor country (ABO-identical before ABO-compatible, then according to waiting time)
  - o Adult recipients in the other ET countries, (ABO-identical before ABO-compatible, then according to waiting time)
- Donor ≥ 46 kg
  - o **HU intestine**
  - o ACO
  - o Elective T patients in the donor country, ABO-identical before ABO-compatible, then ranked by waiting time.
  - o Elective T patients in the other ET countries, ABO-identical before ABO-compatible, then ranked by waiting time

A donor less than 46 kg will be regarded as a pediatric donor. Recipients listed below 16 years of age will be regarded as a pediatric recipient, regardless of their age at time of the intestine offer.

### **R-LAC05.16 – Intestine – HU liver request in case of impending intestinal failure in a patient on the liver waiting list**

In case a timely liver transplantation is expected to avoid the necessity of an intestine transplantation, HU liver status can be granted after audit by the ELIAC in which the advice of the intestine auditor group will be obtained. The advice of the intestine audit group will be sent to the ELIAC for information.

### **R-LAC06.16 – Intestine – HU liver request for recipients also in need of intestine**

HU liver status can be granted to recipients in need of transplantation of combined intestine and liver grafts or multivisceral grafts (including liver and intestine) in case of documented diffuse necrosis of one or more of these organs (due to vascular thrombosis) after audit by the ELIAC (of which one intestine auditor).

### **R-LAC07.16 - Intestine – ACO status request including pancreas for anatomical reasons**

In case of an ACO request for multivisceral transplantations or modified multivisceral transplantations (including intestine and pancreas), where the pancreas is requested for anatomical reasons, a request with justification regarding the need of the pancreas has to be included. The request will be reviewed by 2 auditors from ELIAC, of which one intestine auditor. In case of split decision an intestine specialist from the intestine auditor group will be asked as third auditor. Notification will be made to EPAC.

In case of ACO for multivisceral transplantations or modified multivisceral transplantations (including intestine and pancreas) with need of the pancreas for endocrine reasons an audit by ELIAC (of which one intestine auditor) and by EPAC will be made.



#### **P-LAC08.16 - Intestine – Intestine and pancreas procurement**

In case at procurement of both intestine and pancreas proper procurement of both organs is not possible, the intestine graft has priority. In such cases a report is sent to ELIAC and to EPAC by the procuring surgeon.

#### **P-LAC09.16 - Intestine – Blood group preference in intestine offers**

The intestine transplant center has the option to either accept ABO-identical offers only or ABO-identical and ABO-compatible offers.

#### **P-LAC10.16 - Intestine – minimum of standard vessels in the toolkit**

The minimum of standard vessels in the toolkit in case of separate transplantation of liver, pancreas and intestine for transplantation should be:

- Intestine: iliac vessels (artery and vein) and bifurcation
- Pancreas: iliac vessels (artery and vein) and bifurcation
- Liver: common hepatic artery, celiac trunk
- Cannulation in the donor should be done at the level of the aorta

In case all three organs are going to be procured the liver center has to be informed about the limitation in the toolkit at time of acceptance.

#### **R-LAC04.13 – MARS therapy (rephrased)**

This recommendation has already been agreed upon by the Board and the national competent authorities. As for implementation a period of validity of the data needed for MELD is necessary, the recommendation has been adapted .

*If MARS therapy is registered in ENIS, the MELD score (the most recent MELD score before the start of MARS) will be valid for 7 days. After day 7, the center will need to re-confirm that the patient is still on MARS. If the center states that MARS is no longer used, a new MELD score must be entered in the system. If MARS is still in use, the MELD score validity will be prolonged for 7 days. After 7 days, the center once again needs to re-confirm that the patient is still on MARS.*

### **EUROTRANSPLANT THORACIC ADVISORY COMMITTEE**

#### **P-ThAC04.16 – Heart and heart+lung STOP rule**

In case of a donor from Germany: stop with offering the heart+lung block after the last national patient with a high CAS value and thereafter reserve the lungs for the patients on the lung transplant list.

In case of a donor from Austria, Belgium, Croatia, Hungary, Luxembourg, the Netherlands or Slovenia, stop offering the heart+lung block after the last national heart+lung patient has received an offer and thereafter reserve the lungs for the patients on the lung transplant list.

### **EUROTRANSPLANT TISSUE TYPING ADVISORY COMMITTEE**

#### **R-TTAC03.16 – Mandatory donor retyping in recipient center**

In order to prevent allocation or transplantation on basis of an incorrect donor HLA typing to an immunized patient the recipient centre must perform an HLA retyping of the donor in case of an immunized recipient.

### **EUROTRANSPLANT BOARD**

#### **P-ET01.16 – Approval for listing for combined organ transplantation.**

The decision to register a patient on the waiting list for a combined transplantation should be taken in consultation by the transplant specialists of all organs involved.

### **EUROTRANSPLANT FINANCIAL COMMITTEE**

#### **P-FC03.16 – Budget proposal 2017**

The Financial Committee recommends the Board to approve the budget proposal for 2017.

# Reports Advisory Committees I

The following reports from the Advisory Committees were discussed by the Eurotransplant International Board on September 28, 2016 in Leiden, the Netherlands.

*Please note that all reports from the Advisory Committees can be found on the Eurotransplant member website under the section 'Board & Committees'. Please use your personal login and password to access the member website.*

## Eurotransplant Kidney Advisory Committee (ETKAC)

Date: June 8, 2016  
Venue: Eurotransplant office  
Chairman: Prof.Dr. Uwe Heemann  
Secretary: Ineke Tieken, MD  
Members present: 14 + 1 external advisor + 3 ET staff members  
Members excused: 2

### 1. Recommendations / policies

R-KAC02.16 – Indications for high urgent kidney transplantation  
R-KAC05.16 – Exclusion of AM and immunized patients from EA and rescue allocation  
R-KAC06.16 – Blood group rules in kidney allocation

### 2. Topics discussed

#### A. ERA-EDTA update

The required data for the ERA-EDTA study “Does kidney transplantation improve patient survival compared to dialysis in the current era in Western Europe?” are not easy to get due to the fact that the information has to be gathered and linked from different databases (e.g. ERA EDTA, ET and national registries). These different databases do not have a common identifier.

A presentation was given about which steps were taken in the process towards linkage of anonymized data from different databases. Currently trials are performed with data of one Belgian transplant center and good progress was made. The following steps to be made are linking data of an entire country (Belgium) and other countries (the Netherlands and Austria).

#### B. R-KAC03.16 – KALT bonus

The proposed recommendation on KALT was not approved by the Board based on the reducing of the creatinin clearance from 15 to 10 ml/min. The ETKAC agreed upon that creatinin clearance must be changed into chronic dialysis.

In addition the ETKAC decided that the current three separate recommendations (thoracic, pancreas and kidney after liver) are to be combined in one recommendation. The changes will be prepared and discussed in the next ETKAC meeting.

Besides that the ETKAC discussed who is the responsible for registering and judging whether a patient can be registered on the waiting list for a combination of organs. In the non-German countries there are no regulations for this issue, for which reason the ETKAC members agreed that this should be formulated in a recommendation.

### *C. R-KAC02.16 – HU indications*

The proposed recommendation on HU indications was not approved by the Board based on the decision time. The recommendation has been adjusted on this point. The rephrased recommendation (R-KAC02.16) was discussed and agreed upon by the ETKAC.

### *D. R-KAC05.16 – Exclusion of AM and immunized patients from EA and rescue allocation*

The ETKAC is of the opinion that extended allocation and rescue offers should not be accepted for immunized and Acceptable Mismatch patients. The proposed recommendation (R-KAC05.16) was agreed upon.

### *E. R-KAC06.16 – Blood group rules in kidney allocation*

Despite the kidney allocation is ABO blood group identical, the blood group ABO-0 patients still have longer waiting times. The ETKAC discussed the issue of kidneys that were allocated from ABO-0 to other blood groups via combined transplant or via the AM program. Based on analysis the ETKAC decided that the blood group rule in the AM allocation must be changed from ABO compatible to ET compatible. The recommendation (R-KAC06.16) was agreed upon.

Furthermore the ETKAC wants to discuss with the EPAC to change the current ABO compatible blood group rule in rescue allocation for pancreas + kidney patients into (preferably) ABO identical blood group allocation.

### *F. Progress on the adaptation of the kidney allocation system*

Due to the fact that not all analyses were available yet it was decided that another meeting is to be planned in order to discuss the adaptation of the kidney allocation system.

### *G. Machine perfusion in the Netherlands*

On behalf of the NTS apologies were made for not informing the ETKAC prior to the implementation of the machine perfusion in the Netherlands. Analysis (approximately 4 months) of the NTS showed that since the start 3 out of 82 kidneys that were put on the machine had to be taken off due to the fact that they were allocated to a transplant center outside the Netherlands. One kidney remained on the machine during transport to another country.

The ETKAC concluded that this is not how international cooperation should work and asked for more details on the outcome of the transplants. Besides that statements must be made on:

- the official meaning of the ETKAC;
- rules to be followed by countries within ET for international exchange;
- the ET policy regarding actions taking place in one country but potentially affecting other member states.

### *H. Study proposal*

Rescue allocation vs. recipient oriented extended allocation (Suwelack / Wahba) –

The study was already accepted but the question was whether this study should be performed ET wide. The ETKAC agreed upon that this study should be performed ET wide, because the information is very valuable for ET as well.

### *I. Wait listing of migrants and refugees*

The problems the different countries face with regard to the large number of migrants and refugees in respect of organ transplantation were briefly discussed.

## Eurotransplant Tissue Typing Advisory Committee (TTAC)

Date: September 1, 2016  
Venue: Leiden University Medical Center, Leiden, the Netherlands  
Chairman: Prof.Dr. Frans Claas  
Secretary: Dr. Sebastiaan Heidt  
Members present: 9 + 1 ET staff member + 1 guest  
Members excused: 2

### 1. Recommendations / policies

R-TTAC03.16 – Mandatory donor retyping in recipient center  
The recommendation is presented in a separate document.

### 2. Topics discussed

#### *A. Allocation to ESP patients*

The TTAC adapted P-KAC01.15 on request of the ETKAC.

#### **P-KAC07.16 Allocation to ESP patients**

If the HLA type of the donor is known at time of allocation both non-immunized and immunized patients should be included, and if the HLA type of the donor is not known at time of allocation only non-immunized patients should be included.

#### *B. Comparison of German rules (BÄK Richtlinien) with ET rules on histocompatibility*

The German rules on histocompatibility work were compared to the rules of ET as described in chapter 10 of the ET manual. Three important deviant points between the two documents:

- Mandatory virtual cross match in Richtlinien but not yet in ET;
- HLA-DP typing in Richtlinien, but not yet in ET;
- Interpretation of positive B cell cross match as risk factor

Implementation of the Richtlinien will take one year. When the vPRA is started this year all tissue typing labs must enter the unacceptable antigens of their patients as soon as possible. During a period of one year the cross matches in the donor center will still be performed as usual. Based on the proper assignment of unacceptable antigens, these cross matches at the donor center should theoretically be negative. During this one-year period, the performance of unacceptable antigen assignment will be monitored by ET/ETRL by further scrutinizing every positive cross match at donor centers. Once unacceptable antigen assignment is performed properly, this allows the introduction of a virtual cross match.

The Richtlinien will now be scrutinized by the German organ specific committees.

#### *C. Mandatory donor retyping in recipient center*

Recommendation R-TTAC02.16 on mandatory retyping of organ donors was not accepted by the Board due to the fact that the retyping will then be performed multiple times and has therefore been reformulated:

#### **R-TTAC03.16 – Mandatory donor retyping in recipient center**

In order to prevent allocation or transplantation on basis of an incorrect donor HLA typing to an immunized patient, the recipient center must perform an HLA retyping of the donor in case of an immunized recipient.

#### *D. Definition of HI (PRA >50%) on the heart waiting list in Germany*

In Germany heart transplant candidates with a PRA >50% get priority in allocation, and cross match results can be ignored. A letter will be drafted to the Stäko (president, heart and lung working groups)

stating that this rule is unfair (due to priority of PRA >50% patients and no consequence of positive cross match) and scientifically unsound. The %PRA should not be used and unacceptable antigens should be used for heart transplant recipients.

#### *E. Periodic evaluation of TT center performance by ETRL*

The performance of the ET affiliated Tissue Typing labs in daily practice should be monitored as additional quality control to the existing External Proficiency Testing. The ETRL should get information on typing errors, immunized patients on the waiting list without unacceptable antigens defined, and positive cross matches from ET. This performance in real life should be reported to the TT labs in the form of an additional ETRL certificate, which can then be evaluated by the EFI inspector. A summary in ET Annual Report will be given annually.

## Eurotransplant Kidney Advisory Committee (ETKAC)

Date: September 5, 2016  
Venue: Eurotransplant office  
Chairman: Prof.Dr. Uwe Heemann  
Secretary: Ineke Tieken, MD  
Members present: 13 + 1 external advisor + 3 ET staff members  
Members excused: 3

### 1. Recommendations / policies

R-KAC03.16 – Kidney-After-Other-Organ (KA00) bonus  
P-KAC07.16 – Allocation to immunized ESP patients

### 2. Topics discussed

#### *A. R-KAC03.16 – Kidney-After-Other-Organ (KA00) bonus*

In previous meetings of the ETKAC it was decided that

- The current three separate recommendations (kidney after liver, thoracic organ or pancreas) must be combined in one recommendation.
- Dialysis should be mentioned in the recommendation instead of creating clearance.

The rephrased recommendation on kidney after other organ transplant (R-KAC03.16) was discussed in the ETKAC and unanimously agreed upon.

#### *B. P-KAC07.16 – Allocation to immunized ESP patients*

In the meeting on January 11, 2016 the ETKAC did not agree with the policy (P-KAC01.15) and asked the TTAC to rephrase based on the comments by the ETKAC. The rephrased policy (P-KAC07.16) was discussed in the ETKAC and unanimously agreed upon.

#### *C. EU project – Proteotrans*

The ETKAC was informed about the project and was asked to participate as experts to discuss possible outcome results. The project PROTEOTRANS (Proteome-based donor-recipient stratification to allocate for kidney transplantation) will investigate the central hypothesis that specific proteome evaluation of kidney donors and recipients generates a personalized therapy, leading to novel concepts for disease-mechanism based patient stratification to improved outcome after kidney transplantation.



#### *D. Registry items*

Eurotransplant holds two different data completeness overviews, the survival completeness and the record completeness. Currently Eurotransplant only uses the survival completeness but the question was; "when would the follow up record of a patient be complete?". Which items do the ETKAC think necessary and are important besides the survival items? If the set of items are defined then it will be possible to define the record completeness. The ETKAC was asked to give input on the items for the next ETKAC meeting in order to make a decision in this next meeting upon the items for record completeness.

#### *E. Progress on the adaptation of the kidney allocation system*

A presentation was given by Bomans on the method of the simulation. Both, the proposed new allocation and the current system were adjusted in order to compare both systems. In the selection of donors and recipients adjustments were made (e.g. exclusion of DCD, 65+ donors, living etc) and on the number of kidneys that were available. Due to the adjustments both systems could be compared on e.g. the number of HLA matches, which patients were transplanted etc. but could not reflect the real or future situation.

Furthermore an overview was given on the data that the simulation generated.

Balance showed that mainly the Netherlands would import kidneys, but that most kidneys move to other countries for 0 mismatch or DR+. The import of kidneys in the Netherlands would probably be based on the exclusion of DCD and living donors.

The average number of HLA mis-match was 2,3 in reality and 1,6 in the simulation calculated overall. The waiting times per recipient category showed that in the comparison a pediatric patient would wait approximately 1 year longer. The young adult (16-54 yrs) would wait shorter (1 year) whereas the older adult wait longer (2 years). Patients with a long waiting time would probably even wait longer. In all categories the HLA match improved.

The discussion on the simulation and the limitations of the simulations concluded in a request to perform another simulation which is closer to the reality with the following improvements:

- Take living transplantation into account
- Inclusion DCD
- Inclusion 65+ donors which kidneys are transplanted to patients < 65 years
- Simulation of death
- Simulation of re-transplants
- Availability of kidneys and discarding of kidneys

The members agreed that a publication on the simulation will help in convincing the public on the proposal of the new kidney allocation, if it should be agreed upon.

Besides that a calibration of the system and the different runs, although the donors were selected randomly, would be necessary.

Although a new simulation was requested a voting was done on the proposal of the new kidney allocation in case the data of the new simulation does not differ from the already known data.

The ETKAC agreed unanimous in this voting on the proposal for the new kidney allocation.

## Eurotransplant Liver Advisory Committee (ELIAC)

Date: September 7, 2016  
Venue: Teleconference  
Chairman: X.Rogiers  
Secretary: M. van Rosmalen  
Members present: 7  
Members excused: 1

### 1. Recommendations and policies

#### **Policy P-LAC02.16 Intestine – Audit procedure for intestine High Urgency status**

Each country within Eurotransplant may provide one auditor specialized in intestinal failure or intestinal transplantation for the intestine High Urgency audit group.

- Approved by the ELIAC

#### **Recommendation: R-LAC03.16 Intestine – HU intestine status**

In case only one or none standard venous access possibility remains (appropriate documentation needs to be provided) a HU intestine status can be requested for isolated intestine transplantation, intestine and kidney transplantation or modified multivisceral transplantations after audit by 2 intestine auditors outside of the requesting country.

- Approved by the ELIAC

#### **Recommendation: Intestine – Special priority for pediatric intestine recipients in case of pediatric donors**

In case of a pediatric donor distinction should be made for a 'Special priority group' for pediatric recipients. This 'Special priority group' should receive priority above the T status recipients, after an audit by intestine auditors.

- The recommendation will be postponed due to further defining of the criteria

#### *Regarding allocation algorithm:*

#### **Recommendation: R-LAC04.16 Intestine – Intestine allocation scheme**

*Allocation sequence of isolated intestine transplantation, intestine and kidney transplantation or Modified multivisceral transplantation will be:*

- Donor < 46 kg

- HU intestine
- ACO
- Pediatric recipients in the donor country (ABO-identical before ABO-compatible, then according to waiting time)
- Pediatric recipients in the other ET countries (ABO-identical before ABO-compatible, then according to waiting time)
- Adult recipients in the donor country (ABO-identical before ABO-compatible, then according to waiting time)
- Adult recipients in the other ET countries, (ABO-identical before ABO-compatible, then according to waiting time)

- Donor  $\geq$  46 kg
  - HU intestine
  - ACO
  - Elective T patients in the donor country, ABO-identical before ABO-compatible, then ranked by waiting time.
  - Elective T patients in the other ET countries, ABO-identical before ABO-compatible, then ranked by waiting time

A donor less than 46 kg will be regarded as a pediatric donor. Recipients listed below 16 years of age will be regarded as a pediatric recipient, regardless of their age at time of the intestine offer.

- Approved by the ELIAC

#### *Regarding HU liver status:*

#### **Recommendation: R-LAC05.16 Intestine – HU liver request in case of impending intestinal failure in a patient on the liver waiting list**

In case a timely liver transplantation is expected to avoid the necessity of an intestine transplantation, HU liver status can be granted after audit by the ELIAC in which the advice of the intestine auditor group will be obtained. The advice of the intestine audit group will be sent to the ELIAC for information.

- Approved by the ELIAC

#### **Recommendation: R-LAC06.16 Intestine – HU liver request for recipients also in need of intestine**

HU liver status can be granted to recipients in need of transplantation of combined intestine and liver grafts or multivisceral grafts (including liver and intestine) in case of documented diffuse necrosis of one or more of these organs (due to vascular thrombosis) after audit by the ELIAC (of which one intestine auditor).

- Approved by the ELIAC

#### *Regarding the ACO status:*

#### **Recommendation: R-LAC07.16 Intestine – ACO status request including pancreas for anatomical reasons**

In case of an ACO request for multivisceral transplantations or modified multivisceral transplantations (including intestine and pancreas), where the pancreas is requested for anatomical reasons, a request with justification regarding the need of the pancreas has to be included. The request will be reviewed by 2 auditors from ELIAC, of which one intestine auditor. In case of split decision an intestine specialist from the intestine auditor group will be asked as third auditor. Notification will be made to EPAC.

In case of ACO for multivisceral transplantations or modified multivisceral transplantations (including intestine and pancreas) with need of the pancreas for endocrine reasons an audit by ELIAC (of which one intestine auditor) and by EPAC will be made.

- Approved by the ELIAC

#### *Other:*

#### **Policy: P-LAC08.16 Intestine – Intestine and pancreas procurement**

In case at procurement of both intestine and pancreas proper procurement of both organs is not possible, the intestine graft has priority. In such cases a report is sent to ELIAC and to EPAC by the procuring surgeon.

- Approved by the ELIAC

**Policy: P-LAC09.16 Intestine – Blood group preference in intestine offers**

The intestine transplant center has the option to either accept ABO-identical offers only or ABO-identical and ABO-compatible offers.

- Approved by the ELIAC

**Policy: P-LAC10.16 Intestine – Minimum of standard vessels in the toolkit**

The minimum of standard vessels in the toolkit in case of separate transplantation of liver, pancreas and intestine for transplantation should be:

- Intestine: iliac vessels (artery and vein) and bifurcation
- Pancreas: iliac vessels (artery and vein) and bifurcation
- Liver: common hepatic artery, celiac trunk
- Cannulation in the donor should be done at the level of the aorta

In case all three organs are going to be procured the liver center has to be informed about the limitation in the toolkit at time of acceptance.

- Approved by the ELIAC

The policy for an auditor guideline for HU re-transplantation cases of HAT is still under discussion.

## 2. Topics

### *A. Intestine allocation consensus meeting*

On June 22, 2016 the intestine allocation consensus meeting took place in Leiden, the Netherlands. Intestine experts from the Eurotransplant member states were present to discuss the current intestine allocation scheme and to draft proposals for improvements of the allocation. An EPAC member was present to represent the pancreas allocation, an ELIAC member was present to represent the liver allocation. During the ELIAC of June 28, 2016 the texts for the recommendations were further defined. It concerns 17 recommendations and policies in total, of which the first group was presented in the ELIAC of September 7, 2016 (see above).

The second group of recommendations and policies concern (in random order): the definition of an extended intestine donor, the definition of graft failure, a common diagnosis list and follow up items for the Eurotransplant registry, the performance of a (virtual) cross match, consent for procurement of additional requirements as colon or stomach and a recommendation regarding the abdominal fascia. These drafts will be worked out by the intestine consensus group and brought in the ELIAC.

### *B. Recommendation R-LAC04.13 MARS therapy – definitions*

A proposal was sent around regarding the duration of the MELD score in case of MARS therapy.

Proposal: If MARS therapy is registered in ENIS, the MELD score (the most recent MELD score before the start of MARS) will be valid for 7 days. After day 7 the center will need to re-confirm that the patient is still on MARS. If the center states that MARS is no longer used, a new MELD score must be entered in the system. If MARS is still in use, the MELD score validity will be prolonged for 7 days. After 7 days the center once again needs to re-confirm that the patient is still on MARS.

The ELIAC approves this proposal.

### C. HU liver

The HU liver procedure will be digitalized in the near future.

The HU liver request forms have been merged and a third option –re-transplantation >14 days- has been added. The INR values will be adapted according to the literature.

### D. Study proposal: Sequel of Eurotransplant / LUMC study Blok

The study *A decade of MELD allocation within Eurotransplant: effect on waiting list mortality and transplantation outcome* by a Eurotransplant coworker in 2012 requires more in depth analysis before publication, amongst others an outcome analysis per country. Since this analysis is important but can also have a large impact, it needs the backup of the specific countries represented in the ELIAC. The protocol is send around for input, the required data will be provided. The results of the study will be provided to the ELIAC before publication.

### E. Eurotransplant Annual Meeting 2016

The program of the liver session of the Annual Meeting 2016 will be:

- 1) Prospects of machine perfusion (Porte, Groningen)
- 2) Outcome of the split liver transplantations in Hamburg (Herden, Hamburg)
- 3) Hepatopulmonary syndrome and/or portopulmonary hypertension (Raevens, Gent)

### F. Miscellaneous

- OPC representative:  
A new ELIAC representative needs to be appointed. It will be scheduled for the agenda of the next ELIAC.
- Wintermeeting 2017  
During the Winter Meeting in Alpbach on January 26 and 27 2017, an extra ELIAC meeting will be held on January 26 from 10.00-14.00 hrs. The agenda needs to be determined.



# Summary Board meeting II

Date: January 25, 2017  
Venue: Alpbach Congress Center, Alpbach, Austria  
Chairman: Meiser  
Secretary: Van Hattum  
Members present: 19  
Members excused: 2

Christian Margreiter (Innsbruck, Austria) and Jacques Pirenne (Brussels, Belgium) were welcomed as new Board members in the Pancreas and Liver section.

The budget proposal for 2017 has been discussed with the financiers and was approved. An analysis will be made into the clearing house transport costs for organs that have been accepted but not transplanted, and will be presented in the next meeting. It has been estimated that at the end of 2017 Eurotransplant will have a limited cash level. The Board voted and unanimously approved the 2017 budget proposal.

The long-term strategy 2017-2022 was discussed. In a special Board meeting to be scheduled in March/April the Board will further develop the details and set priorities. In the May meeting, a final strategy plan will be discussed and possibly approved.

The Board discussed a possible new governance structure of Eurotransplant. Multiple scenarios have been discussed with the Board, Council, Management Team and notary. The details will be further developed in an additional Board meeting in March/April.

The progress of several projects was discussed. The CORE Cold and Jubilee program are on schedule. A benchmark will be performed to measure the workload of the Eurotransplant IT staff compared to other organizations to see if the number of employees is sufficient. The call for tender for the EU project EDITH has been assigned to Eurotransplant. ET is work leader for work package 3, building a registry for kidney transplant recipients.

International cross over programs for living kidney donation have been discussed. The current application is experiencing problems. A new application needs to be build or bought as soon as possible in order to develop a service for living donation to all Eurotransplant member states/centers.

The Board was informed on the registry activities. A Scientific Registry Working Group has been established to discuss the registry strategy, to prioritize study proposals, to support data completeness and data disclosure. The renewal of the registry application will start in the coming weeks. The Board decided that Eurotransplant will apply for the call for tender for the German transplant registry.

The Organ Procurement Committee (OPC) received approval from the Board to change its name into Organ Process Chain Committee (OPCC) and the Board has agreed with the new mission statement of the OPCC.

The Board has elected Guba as new chair of the Eurotransplant Liver and Intestine Committee (ELIAC) and Wagner as new chair of the Eurotransplant Information Services Working Group (ISWG).

The Minister of Health of Serbia attended this part of the meeting and expressed the willingness of Serbia to cooperate with Eurotransplant on a close level and to aim for a preliminary membership in the future. The Board discussed the possible cooperation with Serbia. From the list of prerequisites for preliminary membership Serbia already fulfills several, but not all. Serbia declared its dedication to also fulfill the other prerequisites. The Board voted and declared its support for preliminary membership if all conditions are met.

For years, Eurotransplant has offered centers the possibility to start a twinning agreement with a center in a non-Eurotransplant country to support them in establishing a transplant program. The currently active twinning agreements will all expire in 2017. The Board decided to stop the support for setting up twinning agreements and to install a new Teaching and Training Agreement (TTA) option as of 2017 which will be an agreement between Eurotransplant and a non-Eurotransplant country rather than between a ET and a non-ET center. Further details will be worked out in the coming months.

The Board discussed a letter from the DTG concerning the cooperation between the two Boards and decided to invite the DTG Board for a combined meeting in March/April in Frankfurt to discuss all issues.

The selection committee for the 2016 Henk Schippers Young Investigator Award was installed and will consist of Berlakovich, Claas, Van Raemdonck, Margreiter and Wagner.

Reports of the Eurotransplant Liver Committee (ELIAC), Eurotransplant Pancreas Advisory Committee (EPAC), Eurotransplant Thoracic Advisory Committee (EThAC) and Organ Procurement Committee (OPC) were discussed. The reports of these meetings will be published in the next issue of the Eurotransplant Newsletter.

The following policies and recommendations have been discussed and approved by the Board:

#### *R-LAC01.17 – Primary hyperoxaluria type 1 (rephrased)*

*The diagnosis primary hyperoxaluria type 1 should be proven either via a liver biopsy showing an AT deficit, or phenotypically and confirmed by genetic analysis showing a homozygous or heterozygous mutation for primary hyperoxaluria type 1.*

#### *R-PAC02.16 – Adapted categories of pancreas donors*

*Pancreas donors can be divided into two categories, according to the agenda and BMI which may differ from country to country.*

⇒ Donor organs which should be allocated to all pancreas recipients

- DBD donors aged <60 years with BMI <30 kg/m<sup>2</sup>
- DCD donors aged <50 years with BMI <30 kg/m<sup>2</sup>

Tiers:

1. SU recipients
2. Vascularized pancreas recipients according to the EPAS match
3. Recipient oriented extended allocation
4. A. Pancreas islet recipients (non-German recipient countries, non-German donor)  
B. Rescue (German center, German donor)

⇒ Donor organs which should not be allocated to all pancreas recipients

- All donors aged >60 years and/or with BMI >30 kg/m<sup>2</sup>
- DCD donors aged >50 years with BMI >30 kg/m<sup>2</sup>

Tiers:

1. SU recipients
2. A. Pancreas islet recipients (non-German recipient countries, non-German donor)  
B. Recipient oriented extended allocation (German center, German donor)  
C. Rescue (German center, German donor)

#### *P-ThAC05.16 – Mandatory LAS and LASplus items*

In order to complete the registration for a lung transplant, all LAS and LASplus waiting list and posttransplant items should be provided to Eurotransplant at time of listing for a lung transplant.

### *P-ThAC06.16 – ECLS re-evaluation*

If a patient on ECLS has to be re-evaluated within 6 days after getting on ECLS the pre-ECLS settings on blood gases, oxygen and ventilator demands should be entered. If the re-evaluation takes place after at least 7 days or more the current ventilator requirements, oxygen demands and blood gases should be entered. If weaning attempts have been made they have to be documented. In case of a calculated LAS that does not reflect the current clinical situation the center may request an eLAS. If the eLAS request is accepted the LAS value equivalent to the 99th percentile of the waiting list has to be applied. This rule applies for all indication.

### *P-OPC01.17 – Labeling of cross-match material*

The following identification items for cross-match material are mandatory:

1. ET Donor number
2. Blood group
3. Date of donation\*

\* Date of donation: the time the donor is reported to Eurotransplant as indicated on the donor report

# Reports Advisory Committees II

The following reports from the Advisory Committees were discussed by the Eurotransplant International Board on January 25, 2017 in Alpbach, Austria.

Please note that all reports from the Advisory Committees can be found on the Eurotransplant member website under the section 'Board & Committees'. Please use your personal login and password to access the member website.

## Eurotransplant Pancreas Advisory Committee (EPAC)

Date: September 29, 2016  
Venue: Holiday Inn, Leiden, the Netherlands  
Chairman: Prof.Dr. Wolfgang Schareck  
Secretary: Jan de Boer, MD  
Members present: 10 + 2 ET staff members +1 medical director  
Members excused: 1

### 1. Recommendations / policies

The EPAC discussed one topic, that resulted in a recommendation to the Board:

The recommendation "R-PAC02.16 Adapted Categories of pancreas donors" was unanimously approved and will be sent to the Board as a separate document.

### 2. Topics discussed

#### A. Report of intestine meeting of June 22, 2016

The outcome of the intestine meeting is discussed. One recommendation (R-LAC07.16: Intestine – ACO status request including pancreas for anatomical reasons) and two policies (P-LAC08.16 Intestine – Intestine and pancreas procurement & P-LAC10.16 Intestine – minimum of standard vessels in the toolkit) are discussed and approved by the EPAC.

#### B. EPAC representation in the ISWG

The EPAC has appointed Dr. Peter Schenker as representative in the ISWG.

#### C. DBD pancreas donor categories

In the Netherlands the age limit for DBD donors of vascularized pancreas was widened to 60 years in 2011. In all other countries the upper age for DBD donors of vascularized pancreas is 50 years.

All countries but Belgium are interested in adopting this policy. This leads to the formulation of R-PAC02.16

#### D. Review of pancreas audits

The EPAC reviewed 3 audits that resulted in a split decision. One case stood out, this case was audited by 1 EPAC member and 2 substitute members. After ample discussion the majority of the EPAC members disagreed with the outcome of the audit (patient listed on the active pancreas waiting list). As the substitute members are responsible for this decision they will be asked for motivation of their decision. The case will be again discussed next meeting.

#### E. Miscellaneous

The ETKAC formulated a policy that, even in extended or rescue allocation, ABO identical transplantation should be preferred. The EPAC is of the opinion that the situation for the pancreas is quite different from that of the kidney. In addition, adopting this policy would result in too little benefit for the ABO-0 recipients. The EPAC decides not to adopt this policy.

## Eurotransplant Liver Advisory Committee (ELIAC)

Date: November 22, 2016  
Venue: Hilton conference venue, Schiphol, the Netherlands  
Chairman: X.Rogiers  
Secretary: M. van Rosmalen  
Members present: 7  
Members excused: 2

### 1. Recommendations and policies

#### **R-L AC03.13 (rephrase) Primary hyperoxaluria type 1**

The diagnosis primary hyperoxaluria type 1 should be proven either via a liver biopsy showing an AGT deficit, or phenotypically and confirmed by genetic analysis showing a homozygous **or heterozygous** mutation for primary hyperoxaluria type 1.

- Approved by the ELIAC

The policy for an auditor guideline for HU re-transplantation cases of HAT is still under discussion.

### 2. Topics

#### *A. Feedback from the national representatives*

The HU liver request form was under discussion in Germany. The ELIAC strongly agrees that that the HU criteria should be uniform for all Eurotransplant member states, since the allocation of high urgency recipients is international, as well as the audit group. The ELIAC recognizes the concerns regarding the present definitions for HU criteria and is in favor of having an allocation consensus meeting on the HU criteria, involving all Eurotransplant member states in order to review the current HU criteria and if necessary adapt the criteria.

Belgium raises the question if the Eurotransplant member states would profit from a joint effort of an allocation consensus meeting for the SE criteria for HCC. Questions to be discussed are amongst others whether a 'ceiling' for SE MELD points should be installed and whether factors reflecting biological behavior of the tumor should be taken into account. The ELIAC agrees to set up this meeting.

#### *B. Analysis recommendation R-LAC03.10- Ferritin and cholinesterase*

An overview was shown of the data completeness of ferritin and cholinesterase of transplanted recipients as provided by the statistical department of Eurotransplant. Since the completeness is very low (14% at most), no analysis could be performed. Two ELIAC members will make a protocol for a Eurotransplant broad study.

#### *C. Policy P-LAC01.16 Guideline for hepatic artery thrombosis*

The draft policy is a guideline, meant as tool for the liver auditors and not meant to be a strict rule.

The policy is meant for the cases of HAT within 14 days post liver transplantation which are in need of an urgent retransplantation. As written in the draft policy, exceptions are allowed in case of strong and well documented arguments for impending life-threatening liver failure.

It is discussed how to handle the HU requests that might be declined by the auditors. A solution must be found for these patients who do not fulfill the criteria as proposed in the draft policy.

The possibility of an extra urgency status below the current HU and above ACO for 'less time-strict' HU's (e.g. stable recipients with HAT) was declined by several national representatives after national discussion.

A new formulation of the policy should be drafted in order to make extra clear which patient is eligible: the patient with a HAT with documented impending liver failure.



A national solution for requests not fulfilling the criteria could be to install a SE or request a NSE. This is to be discussed if the policy is drafted by the ELIAC.

#### D. Recommendation R-LAC03.13 - Primary hyperoxaluria type 1

During the ELIAC meeting of December 16, 2015 recommendation R-LAC03.13 concerning SE for Primary hyperoxaluria type 1 was discussed. The question arose if the recommendation should only concern patients with a homozygous mutation or also patients with a heterozygous mutation.

This topic was to be discussed in the national committees.

The ELIAC agrees to adapt the recommendation (heterozygous) for all countries.

#### E. Study proposals

Study	Requestor	Study and discussion in the ELIAC
ELIAC 2016.01	Schnitzbauer	<p>Study proposal: <i>A registry based analysis of the influence of perioperative renal replacement therapy on the recurrence of hepatocellular carcinoma following liver transplantation.</i></p> <p>After discussion the ELIAC is in doubt regarding the feasibility of the study proposal. The requestor will be asked for a Prove of Concept. Study proposal is not approved for now.</p>
ELIAC 2016.02	Ritschl	<p>Study proposal: <i>Liver age and recipient age on outcome after liver transplantation</i></p> <p>Discussion: The study proposal concerns German and Austrian center and is initiated by GBC. However, Austria was not informed about this study beforehand. The requestor would need to contact AWG, AIB and AGA to discuss the participation of Austria. The ELIAC agrees to support the study, on the provision that the Austrian liver transplantation centers have been informed and agreed.</p>
ELIAC 2016.03	Umgelter	<p>Study: <i>Disparities in liver transplantation waiting-list outcome between patients with and without exceptional MELD in the Eurotransplant MELD-countries</i></p> <p>Discussion: Umgelter presents the design of the study and the analysis done. The results reflect the effect of standard and non-standard exceptions on transplantation. The ELIAC supports the results of the study. The paper will be send to the chairman of the ETEC to check whether ethical approval before publication is needed. The ELIAC proposes to publish the paper with a combined batch authorships for all centers.</p>

Study	Requestor	Study and discussion in the ELIAC
ELIAC 2016.04	de Boer (Jacob)	<p>Study proposal: <i>Validation of Donor and Recipient Risk Models for Prediction of Outcome after Liver Transplantation in the Eurotransplant Region</i></p> <p>Discussion: de Boer presents the study proposal. No registry action is required for this study; the data regarding the 13.500 recipients can be derived from the Eurotransplant registry. The ELIAC agrees with the proposal</p>
ELIAC 2016.05	de Boer (Jacob)	<p>Study proposal: <i>Validation of the (simplified) recipient risk index for wait list mortality.</i></p> <p>Discussion: de Boer presents the study proposal. No registry action is required for the study; the data regarding the 22.500 recipients can be derived from the Eurotransplant registry. It is remarked that conclusions drawn on the efficacy of several allocation 'scores' can be limited in a MELD based allocation database. To make such claims one should use a database not based on MELD. The investigator will redesign the study protocol. The adjusted proposal will be presented in an upcoming ELIAC.</p>
ELIAC 2016.06	Porte	<p>Studies: <i>Machine perfusion (HOPE, DHOPE en COR-NMP)</i></p> <p>Discussion: Porte presents the outline of the trials. The COR-NMP involves Dutch DBD livers of poor quality accepted via regular allocation in the Netherlands. The risk is mentioned of livers on the perfusion machine not being transplanted in the Netherlands after all (for diverse reasons as recipient is NT or withdraws consent) and sequentially not being accepted outside of the Netherlands. The ELIAC is aware and agrees with the trial. The ELIAC is very interested in the outcome.</p>
ELIAC 2016.07	Blok	<p>Study proposal: <i>Long-term survival of liver transplant recipients and allografts in the Eurotransplant region; effect of donor age liver age and recipient age on outcome after liver transplantation.</i></p> <p>Discussion: de Boer presents the study proposal on behalf of Blok. It is remarked that biliary complications are not registered in the Eurotransplant registry. This could result in a 'hidden morbidity'. Blok will receive the draft protocol from ELIAC study 2014.01 <i>Liver transplantation with donors ≥ 80 years old - Limit of organ acceptance or future routine?</i> for use and/or cooperation. If still required, Blok will receive the data from the Eurotransplant registry. The ELIAC agrees with the proposal.</p>
Req 553-1.2016	Czigany	<p>Request for endorsement of: <i>Survey based analysis and literature review on technical aspects of liver transplantation within the Eurotransplant community.</i></p> <p>Discussion: The ELIAC would like to endorse this survey.</p>

The study A decade of MELD allocation within Eurotransplant: effect on waiting list mortality and transplantation outcome by Blok (referred to as MELD study) was discussed in the ELIAC of September 7, 2016. It was agreed upon to have a more in depth analysis before publication, including an outcome analysis per country. Preliminary results will be sent around for internal (confidential) discussion. It will most likely be presented during the ELIAC at the Winter Meeting 2017.

#### *F. Eurotransplant Winter Meeting 2017*

For the liver work shop there is time scheduled for 3 presentations:

1. HU split decisions (van Rosmalen, ET)
2. ELIAC study 2016.03 Disparities in liver transplantation waiting-list outcome between patients with and without exceptional MELD in the Eurotransplant MELD-countries (Umgelter, München)
3. To be determined

Note: it has been decided to have two presentations only.

There will be an ELIAC meeting during the winter meeting on January 26, 2017.

#### *G. Miscellaneous*

##### *a) Registry Working Group*

A new scientific registry working group will be installed. Rogiers will be chairman. Two ELIAC members are interested.

Note: It has been decided to allow two participants per organ advisory committee. Both interested ELIAC members have been informed.

##### *b) OPC representative*

One ELIAC member is willing to participate within the OPC on behalf of the ELIAC but is not allowed according to the Articles of Association since a colleague from the same transplant program within the same country is participating in the OPC. No OPC representative could be appointed.

## Eurotransplant Organ Procurement Committee (OPC)

Date: December 14, 2016  
Venue: Eurotransplant office  
Chairman: Prof.Dr. D. Ysebaert  
Secretary: Ms. S.Y. Marks, MD  
Present: 12 + 6 ET staff members + 4 observers  
Excused: 3 members + 1 observers

### 1. Recommendations / Policies to the Board

#### **Policy P-OPC01.17 - Labeling of Cross Match Material**

*See added enclosure policy.*

### 2. Topics discussed

#### *A. Feedback*

##### **COLD**

The new Clinical Data System is the reason the COLD project has been delayed by about 3 months. This system was recently bought and will be the basis for all the donor and recipient related medical data.

Time frame COLD: ET will start building COLD in the first quarter of 2017 (specifications are almost done). The system is expected to be done by the end of the first / second quarter of 2017, then the ET member states have indicated that they will need about 6-8 months to adapt their donor reporting systems. The whole system could be completely functional by the end of 2017 if all donor reporting systems have been modified to the COLD specifications.

#### ***Donors changed from DCD to DBD 01.01.2011 – 12.12.2016***

Country	Year						
	2011	2012	2013	2014	2015	2016	Total
<b>Belgium</b>	2	4	2	2	3	6	<b>19</b>
<b>Luxembourg</b>	0	0	0	0	0	1	<b>1</b>
<b>Netherlands</b>	1	0	1	2	1	1	<b>6</b>
<b>Total</b>	<b>3</b>	<b>4</b>	<b>3</b>	<b>4</b>	<b>4</b>	<b>8</b>	<b>26</b>

There is an increase in DCD to DBD donors in Belgium. These figures will be discussed in the Be-OPC.

#### ***New name and mission statement OPC***

*See added enclosure.*

#### *B. HU liver pay back costs*

The cost of the HU liver pay back system for Croatia is a topic that has been discussed in several different committee meetings (ELIAC, OPC) over the past few years. A presentation on the financial aspects was presented by Valkering. See solution slide 8, in included power point. The Croatian representative agreed to discuss the options with his colleges in Croatia and let ET know which option would suite them best. Then this would be discussed in the next Board Meeting.

#### *C. ET Manual Chapter 9 The Donor*

In the meeting of May 11th 2016 it was decided to update Chapter 9 of the Manual, The Donor, and remove the Donor Management and Procurement Guidelines. The sections on Donor Management and Procurement Guidelines were to be minimized and only specific agreements needed to be included. The new content of the manual was discussed and accepted. The new chapter version will be published.

#### *D. WIT Time Points CORE*

The definition of warm ischemic time (WIT) has been discussed in the OPC several times. The definition is mostly relevant for donation after circulatory death (DCD).

Each country has different procedures regarding DBD and DCD and the warm ischemic time is differently interpreted, the difference between two time points does not always have the same or clear definition. i.e. alive and asystolic (death). Recent research has shown that there is a grey area between these absolute endpoints and that the time span between these endpoints is important for the ischemic injury of the organs and therefore for outcome after transplantation. Important characteristics of this time span are the measurements of saturation and blood pressure.

The following items were proposed and agreed upon:

1. Withdrawal of life support (date and time point)
2. Saturation under 80% (percentage O<sub>2</sub>)
3. Mean arterial blood pressure under 50mmHg (number mmHg) Only use MAP not systolic blood pressure
4. Circulatory arrest (mean ABP=0) (time point)
5. Declaration of death (according to National policy) (date and time point)
6. Start of cold (or in future maybe warm) perfusion (date and time point)
7. Cross clamp aorta (date and time point)

These items will be incorporated in CORE and included in the ET Manual, Chapter 9, the Donor.

#### *E. Blood Vial Labeling*

For content description see point 1 of this Report. This is regarded as the quickest and most feasible short term solution. Another options was also discussed:

##### System: Scan labels cross-match material

There is a scanning code system that is used mainly in the blood banking world. This option is presented first. Ashford of the ICCBBA (International Council for Commonality in Blood Banking Automation, Inc.) gives a presentation, via Skype, on the history of the ICCBBA and ISBT 128 (coding system).

Key Elements of ISBT 128 are:

- Globally unique donation identification number supports global traceability
- Standard terminology for describing MPH0 (Medical Products of Human Origin)
- International product codes
  - Same code used by multiple processors supports biovigilance activities
- Standard bar coding of information (donation number, product code, other key information)

ET will look into the option of introducing the ISBT 128 system in the ET area in the future. This proposal will include amongst other things; what the system can do, are there more options, can it be used for our need, implementation consequences and costs. This proposal can then be presented to the National Competent Authorities to see if all wish to use this system and will be willing to implement it.

#### *F. Miscellaneous*

The DSO has sent a letter to the OPC regarding adaptations the DSO has made to the Organ Report Forms. It is legally required to have a qualified surgeon present at every procurement. This will be documented on the Organ Report Form, as indicated on the form included as enclosure to the letter. This letter also asks the OPC to revise this form in general. It is indicated that we can use this form for all ET countries and can remove "For Germany only", if the other member states agree.

# Henk Schippers Young Investigator Award 2017

Henk Schippers became the first Eurotransplant Director in 1970 and laid the foundations for the administration of Eurotransplant. He successfully completed negotiations with the insurance companies and initiated the international network, which is now a hallmark of Eurotransplant. To commemorate his pioneering work for Eurotransplant a young investigator award in his name was established in 2003.

The purpose of this award is to encourage young clinical and/or scientific investigators to pursue a career in the field of organ and tissue transplantation. It is our hope that this research will be invigorated by the work of young, talented individuals supported by stable multi-year funding. The Henk Schippers Young Investigator Award is especially meant to enable the investigator to present his/her results of clinical and/or scientific organ transplantation related investigations at well recognized and respected international transplantation congresses or symposia.

## Application procedure

Applications for the Henk Schippers Young Investigator Award can be submitted – in writing – until June 1, 2017. Applications will be reviewed by an international committee. Please visit the website for more details: [jubilee.eurotransplant.org](http://jubilee.eurotransplant.org)



The 2016 HSYIA winner: Dr. Georg Györi from the Medical University in Vienna, Austria.

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# Eurotransplant Award 2017

2017, Eurotransplant will celebrate its 50th anniversary. We intend to celebrate this by making an award available for an individual or individuals who have contributed in a significant way in solving the many issues Eurotransplant is facing, and who has performed this work in one of the countries collaborating in Eurotransplant. The Eurotransplant Award will be presented during the Jubilee Congress.

## Application procedure

Candidates for the Eurotransplant Award should be submitted – in writing – until June 1, 2017. Applications will be reviewed by an international committee. Please visit the website for more details: [jubilee.eurotransplant.org](http://jubilee.eurotransplant.org)



The last award winner in 2012; Dr. Mirela Busic from Zagreb, Croatia



# Eurotransplant Jubilee Congress







**Eurotransplant**  
Together on a life-saving mission

**October 4-6, 2017**

Noordwijk - the Netherlands

[jubilee.eurotransplant.org](http://jubilee.eurotransplant.org)

# Jubilee Congress Eurotransplant: 50th anniversary

October 4-6, 2017 in Noordwijk (Leiden area), the Netherlands

## Register now!

*Join us from October 4-6, 2017 in Noordwijk (Leiden area), the Netherlands*

This year, it has been exactly 50 years that Eurotransplant was founded. On this special milestone, a Jubilee Congress is organized from October 4-6, 2017 in Noordwijk (Leiden area), the Netherlands.

We kindly suggest you mark your calendar and schedule time to participate in this special event! It will be our great pleasure to welcome you and we look forward to reflect together on what has been achieved in 50 years of successful cooperation and international organ exchange as well as to discuss future developments.

## Preliminary program outline

We are pleased to announce that the preliminary program outline is now available on the jubilee website. Besides organ specific sessions, the program will also address ethical aspects, political challenges and the many forms of cooperation within and outside Eurotransplant – and even outside of Europe – that have been formed since the start. For additional information, please visit our Jubilee website.

## Registration is open! [www.jubilee.eurotransplant.org/registration](http://www.jubilee.eurotransplant.org/registration)

*Online registration and hotel room reservation is now possible via the jubilee website. We recommend to register early, to ensure a hotel room of your preference will be available in the congress venue.*

*The Hotels van Oranje offers preferential negotiated rates for attendees of the Jubilee Congress. A wide range of accommodation categories is available offering a suitable option for all.*

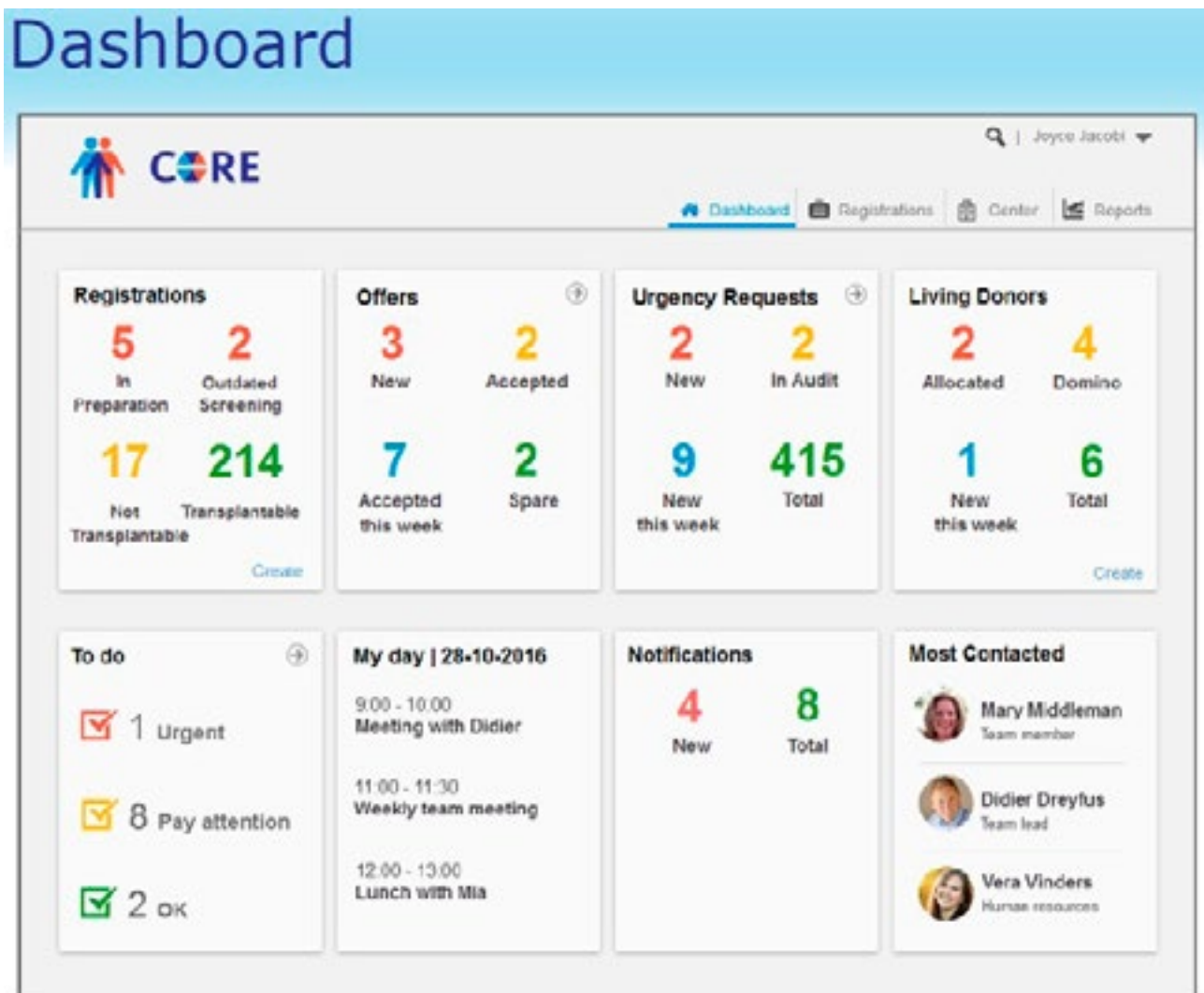
# Update CORE



CORE is the successor of the current Eurotransplant Network Information System (ENIS) and comprises of several projects to completely rebuild the modules for patient registration, waiting list status management, lab results and allocation.

## Progress Highlights

The first sprints (a two-week iteration period of software development) have been performed and resulted in a first version of recipient registration forms and a dashboard. The design was first tested by internal users in Leiden and afterwards the models and screens have been published on the online CORE User forum for feedback by external system users (members of the CORE user group Recipient).



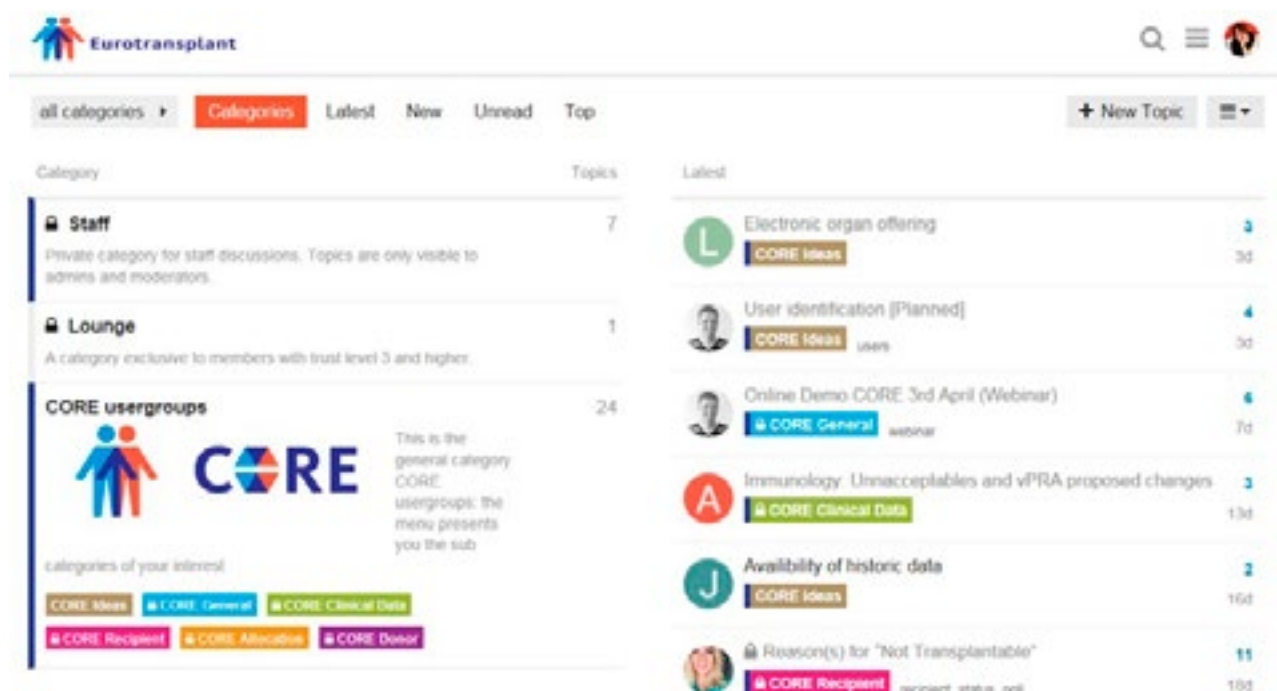
Core Dashboard

Development of clinical models has also commenced and with support from an external modeling expert, the first OpenEHR! clinical models are implemented. The aim of CORE is to make use of clinical data more consistently within the different domains by using the same definitions. Clinical models in CORE are developed based on input of users, the current fields in ENIS and the results of the European EFRETOS project.

## Online Userforum

The CORE Online Userforum ([userforum.eurotransplant.org](http://userforum.eurotransplant.org)) was launched in February to facilitate users of the (future) CORE system in providing input, give feedback and participate in dialogue throughout the development process. For this purpose, User Groups have been formed for the different processes and users from all ET member countries have already registered in one or more of the groups to participate in discussion on the following topics:

- Clinical Data (focuses on all clinical data of donors and recipients, including connectivity hospital systems and CORE)
- Recipient (registration procedure recipient)
- Ideas is there for users to post ideas and suggestions
- General is there for general topics that concern all users
- Donor (not operational in current phase)
- Allocation (not operational in current phase)



### [CORE User Forum](#)

Should you not have registered for the User Forum yet or if you are interested to learn whether your center is already represented in the CORE User Groups, please visit the ET Member Website/CORE section/User Groups where you find all information on user interaction in the CORE project.

## Implementation planning

The first implementation of CORE software is scheduled for Spring 2017. It will be delivered to a single (kidney only) center for testing and approval. Subsequently, implementation can take place in more kidney only centers. This has the advantage of gradually exposing results to end-users. During the implementation period, defects can be corrected, improvements can be made and functionalities can be added. The aim of this approach is that a mature application can be provided to the Eurotransplant community.

## More on CORE

Each quarter, a CORE online newsletter is distributed and published on the Eurotransplant member site with comprehensive news about the progress of the CORE system. You can find these newsletters and other information in the section CORE. Please note that access to the Eurotransplant member site is provided to registered members by entering your personal login and password ([www.eurotransplant.org](http://www.eurotransplant.org)). Should you have questions on the CORE project or when you would like to register for the online Userforum, please send an email to: [core@eurotransplant.org](mailto:core@eurotransplant.org)

# “A challenge we face together”



The OPC was founded in 1994 as one of the eight Eurotransplant advisory committees. Its initial task was to prepare and advice on the definition and implementation of new rules for organ procurement and sharing.

However, with the introduction of the ‘EU directive 2010/45/EU on standards of quality and safety for human organs intended for transplantation’ and with the adaptation of the Eurotransplant mission in 2012, also the demands towards the OPC shifted. It became more important to focus on a more precise donor and organ characterization and the quality of this data, as well as scientific research in order to improve the quality of organ exchange and allocation. Moreover, a significant aspect became the accurate documentation of all events that occur in the timeline from donor recognition till transplantation. Besides, if you look back on the actual activities which have been done by the OPC in the last few years, these are actually also way broader than our initial mission.

Therefore, we concluded it was a good moment to prepare a more suitable mission statement.

The OPC put less focus on the donor organ recovery (such as donor management, organ procurement), as this has been taken over by National Organ Procurement Organizations. However, the ET community was concerned with the documentation and assessment of events and risks within the organ process chain.

**“The OPCC advises the Board and Eurotransplant community in a joint concerted action on any aspect in the organ process chain.”** – renewed mission of the Organ Process Chain Committee

## *Introduction of the Organ Process Chain Committee*

Eurotransplant’s Advisory Committees and Working Groups have an important role in the field of allocation development. Recently the ‘Organ Procurement Committee’(OPC) renewed its mission, vision and adapted its name, which was approved by the Board in January 2016.

Prof. Dr. Dirk Ysebaert, you have recently introduced a name change of the OPC to ‘Organ Process Chain Committee’. Could you tell us a bit more about why you suggested to make this move?

**Could you specify the mission statement a bit more? You aim to give advice ‘on any aspect in the organ process chain’ – which aspects exactly can we place here?**

In the early days, the organ was procured, stored on ice and transported to the transplant center. But nowadays it's a more complex process, because of new technologies - for example in the field of organ preservation. So you could describe it more as a chain of events, a timeline which we are focusing on.

As mentioned before, more specific characterization is an important first step in the process. This makes it easier for the different transplant centers to reach an informed decision on whether or not to accept an organ.

So next to donor and organ characterization, it is also significant to thoroughly document all the events in the chain from donor to recipient. This chain also includes transport-related issues concerning organ quality. These days, the organs do not only travel by car or by plane, they are often accompanied by a machine.

In addition, we do need to be more informed on organ traceability: We need to have more information on what happened with discarded organs. Additionally, in a later stage it is valuable to receive immediate feedback on the quality of recovered organs and their function. Good documentation of 'Serious Adverse Events/ Reactions' is another factor playing a role. So all of this is necessary in order to set up a quality circle within the Eurotransplant organization regarding donor and organ characterization. This is necessary to support the main task of Eurotransplant which is optimal organ allocation. This quality circle is again necessary to perform high-level donor research and to further help to develop the most optimal use of all donor organs.

### **Can you give examples on what the OPCC is currently working on?**

Currently we are working on the definition of functional warm ischemia. In the past we only knew cold ischemia and the warm ischemia related to the implantation time. But with the evolution of DCD donor, we need better definitions on different types of warm ischemia. There are various opinions on this topic, so we have to form an objective definition.

Another topic we are working on concerns the technical aspects of preservation machines. More data has to be delivered to Eurotransplant on the effects of the various machines. We do have survival data and functional data in the registry and now we do have to

couple it with donor and organ identification. The application of the various machine preservation techniques strongly differs per machine, situation and country.

### **What is in your opinion the future vision for the OPCC?**

Well, I guess it is not really a vision, but a challenge which we face together.

Overall, in the last years we noticed a decline in the quality of the donor organs. Therefore we have to put more energy and focus on the optimization of the donor circumstances before the organ is explanted. I do believe that here in this setting there is an enormous potential for improvement, which is largely underused at this moment.

I am aware that this is a sensitive field, touching legal and ethical issues, but it could offer a lot of potential in the future. We do need to broaden our options if we want to overcome the hurdles of declining donor organ quality.



Prof. Dr. Dirk Ysebaert, Antwerpen, Belgium,  
chairman "Organ Process Chain Committee"



# Eurotransplant receives 2017 Award for Organ Donation from Belgian Transplantation Society (BTS)

## Belgian Transplantation Society

The BTS is a scientific organization bringing together all the players in the field of organ donation and transplantation in Belgium. The seven transplant centres of the country are represented by physicians, transplant coordinators and nurses. The BTS describes itself as an intermediary between health professionals, patients and competent authorities in Belgium.

## BTS Award for Organ Donation

The BTS acknowledges the important work carried out in Belgium by various associations to promote organ donation. These parties make it possible that every year around several hundred patients on the waiting list are transplanted in Belgium. Therefore an annual award is handed out by the BTS.

## BTS Congress 2017

During this year's annual congress in Brussels on March 16, 2017, the BTS came 'to honour those [in Belgium] without whom solid organ transplantation could not be realized'.

The first prize was awarded to the Belgian Transplant Coordinators section, who do an outstanding job promoting organ donation and help to create a link between the transplant centres and partner hospitals.

The Eurotransplant International Foundation had the honour to receive this year's award second prize on the occasion of its 50th anniversary. The decision of the jury was influenced by the fact that Eurotransplant is constantly working on improving organ allocation and cross-border exchange of deceased-donor organs. Moreover, Eurotransplant helps to coordinate the work in the transplant centres with the goal of efficiently allocating donated organs.

Dr. Undine Samuel, as a representative of the organisation, accepted the award in Brussels: "We want to thank the whole BTS Board for the kind invitation and for the great honour of receiving the BTS award! We are all very pleased with it and look forward to continue our good cooperation in the interest of all patients in the Eurotransplant region that require a life-saving organ transplantation."



# 10 year anniversary: Croatia joining Eurotransplant

**In 2007 Eurotransplant welcomed Croatia as a new member state. At that time Croatia was not yet an European Union member country and had a donation rate of approx. 12 donors per million population. Over the ten years of Eurotransplant membership, Croatia boosted its donation and transplantation rates. Although these are currently already the highest within Eurotransplant, Croatia still improves its organ donation and transplantation system. The Croatian deceased organ donation and transplantation program belongs to the world's best performing.**

**Dr. med. Mirela Bušić was appointed National Transplant Coordinator in 2001. Since then she has been providing leadership for the successful development of a self-sufficient organ donation and transplantation program in Croatia. She was involved in the 2007 agreement negotiations and Croatian preparation for the Eurotransplant membership. She has been acknowledged with the Eurotransplant Award in 2012 for her great contribution and effort in the development of a deceased organ donation and transplantation program that benefits not only Croatian but also all Eurotransplant patients. For the Eurotransplant Newsletter, Bušić looks back at the mutual cooperation.**

**What are the most important changes in organ donation and transplantation in Croatia since joining Eurotransplant?**

The Eurotransplant membership has greatly contributed to the improvement of various aspects of the Croatian organ donation and transplantation system.

I would say that the most important influence from the Eurotransplant membership has been witnessed in the allocation system. The search for the best organ match has become more sophisticated and at the same time more transparent, objective and evidence-based oriented. So it is no surprise that our professionals, patients and general public welcomed it wholeheartedly.

Additionally, the Eurotransplant membership provides fine-tuning and a balanced exchange of organs between Eurotransplant member countries. The end result is an optimized and highly effective management of donated organs, which in turn increased the trust and confidence of both patients and professionals in a fair organ allocation process.

**How do you experience and value the international cooperation in the Eurotransplant network in the past 10 years?**

After a decade of successful cooperation, I can say that Eurotransplant fulfilled our high expectations and justified its renowned and well-deserved reputation of excellence in the organ allocation field.

**Can you tell more about the development of organ transplantation in Croatia?**

In the past 10 years Croatia has boosted its organ donation rate from 12 to 40 (donors pmp) and transplantation rate from 20 to 90 (transplants pmp). Our transplantation and coordination teams have contributed to Eurotransplant with their fresh perspectives, enthusiasm and energy which hopefully present an inspiration and challenge for our colleagues from other Eurotransplant countries to do the same.



Former Croatian Minister of Health and Social Welfare, Assistant Prof. Dr. Neven Ljubičić and the President of Eurotransplant, Prof. Dr. Bruno Meiser sign the contract on May 25, 2007 during a ceremony in Zagreb.



**What do you see as the greatest benefit of Croatia Transplant being a member of Eurotransplant?**

The more structured, evidence-based and transparent allocation system. But even more important: An excellent opportunity for all of us to grow together and learn from each other through the exchange of best practices among Eurotransplant countries.

**Do you have recommendations for improvement or adaptations in the future regarding the international cooperation and organ exchange in Eurotransplant?**

Eurotransplant is facing different challenges regarding the harmonized implementation of EU Directives' requirements on quality and safety, especially in the context of Eurotransplant's potential enlargement and accession of new countries.

Additionally, as an international organization responsible for a highly sensitive field, Eurotransplant is continuously challenged by an array of country specific requirements, financial, political and ethical constraints, emerging research and innovative technology solutions. All those requirements can be successfully addressed only by an ongoing, strengthening of Eurotransplant's experts' skills and capacities, by maintaining and further developing a sustainable structure and by making their management model even more effective.

I believe that Eurotransplant, next to all the qualities mentioned above, has a huge and unique expertise, knowledge and skills, which are crucial for providing leadership. This is necessary for creating a solid platform for organ allocation and a transplantation follow-up system at an EU level, now and in the future.

**How do you look at the future of Croatia Transplant? - In which areas do you see the biggest challenges ahead?**

The greatest challenge ahead would be to ensure the sustainability of the so far achieved organ donation and transplantation rates. An additional challenge would be the DCD program implementation in Croatia.

**- In which areas do you expect success?**

We are excited for the challenges ahead and are confident we will successfully deal with them. We have already proven that dreams can come true and that anything is possible. Why stop dreaming?

**Are you going to 'celebrate' this milestone moment of 10 years membership?**

Yes of course! We are preparing something special and we would very much like you to join us on that grand occasion!



Dr. med. Mirela Bušić, National Transplant Coordinator, Croatia

# Leiden office – staff changes

## Eurotransplant welcomes:



### *Onno Huijgen – application consultant*

On February 1st, 2017 Onno joined Eurotransplant as an application consultant. He already worked in this area in his previous job and is looking forward to be part of the Eurotransplant team. In his role as an application consultant, Onno will for example build new software contributing to the process of organ allocation.



### *Sharon Vossen – junior allocation & waiting list officer*

On February 1st, 2017 Sharon started working as a junior allocation & waiting list officer. Before joining Eurotransplant, she obtained a degree in social care and worked in a centre for people who suffer from epilepsy. Sharon started the intensive 6-months training course for new organ allocation officers at Eurotransplant with great enthusiasm.



### *Herman de Jonge – application consultant*

Herman joined Eurotransplant as an application consultant in February 2017. Last year he completed an education program for Java programming. Before that, Herman used to work as an application developer at the Municipal Health services. He aims to deliver a valuable contribution with his recently gained knowledge about Java.



### *Marcel Broekman – IT engineer*

Marcel joined the IT department in March, 2017. He started off his career as a lighting technician but his great interest in ICT led him to change his career path. In his new role at Eurotransplant, Marcel has joined the Infrastructure team, which is responsible for the management and day-to-day operation of the various software and hardware which is used at Eurotransplant.



### *Julia Hagnaars – Eurotransplant physician*

On March 1, 2017, Julia was welcomed as a new member of the medical staff. Before she joined Eurotransplant, she worked as a surgical resident in training. Once she has finished the intensive training program at Eurotransplant, she will replace Susan Marks as the Secretary of the OPCC. Julia is looking forward to bring her practical medical knowledge to the Leiden office.



### *Jeannet Brink – Datawarehouse Consultant*

Jeannet joined Eurotransplant on May 1, 2017 as a Datawarehouse Consultant. In her previous job she gained experience as an information analyst and developer. With her technical background, Jeannet looks forward to deliver a valuable contribution and support the Eurotransplant team.

## Eurotransplant said goodbye to:

01-02: Esther Prikker-Paats, HR officer

01-03: Susan Marks, Eurotransplant physician

# Calendar of Events

## **2017 Joint International Congress of ILTS, ELITA & LICAGE**

May 24 - 27, 2017, Prague, Czech Republic  
For information visit <http://2017.ilsts.org/>

## **16<sup>th</sup> International Congress of IPITA**

June 20 – 23, 2017, Oxford, UK  
For information visit <http://www.ipita2017.org/>

## **2nd Annual Kidney Congress**

August 28-30, 2017, Philadelphia, USA  
For information visit  
<http://kidney.conferenceseries.com/>

## **2017 Organ Donation Congress**

September 6 – 9, 2017, Geneva, Switzerland  
For information visit <http://www.isodp2017.org>

## **18<sup>th</sup> Congress of the European Society for Organ Transplantation**

September 24 – 27, 2017, Barcelona, Spain  
For information visit <http://esot2017.esot.org/>

## **Jubilee Congress Eurotransplant: 50<sup>th</sup> anniversary**

October 4 – 6, 2017, Noordwijk, The Netherlands  
For information visit <http://jubilee.eurotransplant.org/>

## **26<sup>th</sup> Kongress Deutsche Transplantationsgesellschaft (DTG)**

October 25 – 28, 2017, Bonn, Germany  
For information visit <http://www.dtg2017.de>

## **Eurotransplant Winter Meeting**

January 24 - 26, 2017, Alpbach, Austria  
For information visit <https://www.eurotransplant.org/wintermeeting/>

## **Combined NTV & BTS Annual Meeting 2018**

March 15 – 16, 2018, Rotterdam, The Netherlands  
For information visit <http://www.transplant.be> or  
<https://www.transplantatievereniging.nl/>

## **Eurotransplant International Foundation**

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