

# CHIMERA

Published for Members of the American Society of Transplant Surgeons

Winter 2015

8<sup>th</sup> Annual Surgical  
Fellows Symposium:

Sun, S'mores, and Surgery



Our Mission:

*To advance the art and science of transplant surgery through  
leadership, advocacy, education, and training.*



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## Editor's Letter

Welcome to the Winter 2015 issue of the *Chimera*. This issue features the third appearance of our new column, "What's Your Perspective?" on page 8. We encourage you to let us know your thoughts on this issue's topics—HCV recurrence and living donor liver transplant—we'd like to publish those as well! If you would like to participate, please email your response to Diane Mossholder, Senior Manager, Communications, at [diane.mossholder@asts.org](mailto:diane.mossholder@asts.org).

In this issue, you'll also find a recap of the 8<sup>th</sup> Annual Surgical Fellows Symposium (page 12), reports from various transplant-related organizations, and all the latest committee news and reports (page 5).

The ASTS Communications Committee is working to make the *Chimera* more accessible and valuable to you. If you have ideas or comments, please let us know! This is your magazine, and we want to know what you would like to read—and how you would like to read it. Please send your comments to Diane Mossholder at [diane.mossholder@asts.org](mailto:diane.mossholder@asts.org) and she will pass them along to the committee for consideration.

Our next issue will feature special coverage of the 15<sup>th</sup> Annual ASTS State of the Art Winter Symposium in Miami, January 15–18, 2015, as well as updates on all the work the Society and its committees are doing.

Stay connected!

Sander S. Florman, MD

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### About the Cover

ASTS second-year transplant fellows gathered in San Diego, California, at the 8<sup>th</sup> Annual Surgical Fellows Symposium in October. The fellows benefited from the chance to learn from and talk with nationally recognized faculty experts and peers over three days of educational and networking sessions. Symposium highlights begin on page 12.

If you have a photograph you would like displayed on the cover of *Chimera*, please email it, along with a brief description, to Diane Mossholder, Senior Manager, Communications, at [diane.mossholder@ASTS.org](mailto:diane.mossholder@ASTS.org).

**CHIMERA**

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# President's Letter

Dr. Peter G. Stock

As we start the new year, it is always a good time to reflect on what we've accomplished and look ahead to where we are going. For ASTS, 2014 was a year of celebration, focus, and growth. Throughout 2014 we celebrated the Society's 40<sup>th</sup> anniversary, first with a gala at the Winter Symposium and then a reception at the World Transplant Congress. At these two events, 20 past presidents joined us for the festivities. I was especially grateful that our first president, Dr. Tom Starzl, joined us in San Francisco.

Redefining our mission, vision, and goals was another focus throughout 2014. The ASTS leadership underwent a strategic planning process to evaluate where the Society is today and plot a course for even greater success in the future. At the conclusion of this process, we emerged with a more focused mission statement: To advance the art and science of transplant surgery through leadership, advocacy, education, and training, as well as a new vision: Saving and improving lives with transplantation. To support the mission and vision, we identified five strategic goals: Advocacy, Research, Training & Professional Development, Optimal Patient Care, and Organizational Excellence. The projects and initiatives we undertake should support these tenets, which guide where we most need to focus our resources.

We are also expanding in areas where we know we can make the most difference. The training of transplant surgery fellows is a key focus of the Society, a tremendous responsibility to the field and the one area that our Society is clearly the best organization to undertake and oversee. As the pressure to shift from program accreditation to fellow certification grows, this area requires more effort and attention than ever before. The Fellowship Training Committee (Wendy Grant, Chair) worked hard through 2014 and continues efforts to develop a completion exam, work through issues relating to certifying fellows, and continue to refine and scrutinize the criteria for fellowship training program accreditation. I was pleased to attend the 8<sup>th</sup> Annual Surgical Fellows Symposium in San Diego last October, and I came away with a sense of optimism about the future of our field. You can read more about the symposium on page 12.

The Standards and Quality Committee (Stuart Greenstein, Chair) has been working hard with the American College of



I'm also looking forward to the Winter Symposium later this month. This year's theme, Transplant: The Ultimate Team Sport, promises to be a fun one, complete with a Committee Tailgate on Thursday night.

Surgeons on developing the Trans-QIP, which will be a transplant-focused module of the National Surgical Quality Improvement Program (NSQIP). When complete, Trans-QIP will help transplant surgeons meet qualified clinical data registry requirements regarding individual reporting required by CMS for covered Physician Fee Schedule services.

The CME (Richard Knight, Chair), Curriculum (Ken Washburn, Chair), and Fellowship Training Committees also put in some hard work with the ASTS staff in 2014 to develop the new Academic Universe, which will launch in the first quarter of this year. Converting the modules to play on iPads and making the integration with ASTS.org more seamless are just two of the many goals this project was undertaken to achieve. We had a sneak peek at the Fellows Symposium, and I can tell you that the new platform represents a major step forward in ease of use.

For 2015, I'm excited to see what develops in all these efforts. I'm also looking forward to the Winter Symposium later this month. This year's theme, Transplant: The Ultimate Team Sport, promises to be a fun one, complete with a Committee Tailgate on Thursday night. I hope you are planning to join us in Miami—there's still time to register!

This spring, we look forward to the American Transplant Congress, May 2-6 in Philadelphia. We'll also hold the 6<sup>th</sup> Annual Leadership Development Program September 27-30, so if you haven't already benefitted from this unique and intensive program, please mark your calendar!

What are you looking forward to in 2015? As I ponder the second half of my term as President, I would appreciate your thoughts on the Society's course for this year and beyond. You can reach me at [peter.stock@asts.org](mailto:peter.stock@asts.org).

Happy New Year!

Peter G. Stock, MD, PhD  
ASTS President



# ASTS News

*The following are select recent developments in the Society, including topics discussed at the Fall Council Meeting in San Diego, California, October 16–17, 2014.*

## Business Meeting Drawing Winner



We are pleased to announce that Darla K. Granger, MD, is the recipient of the ASTS Business Meeting prize! She will receive complimentary all-access registration to the 15<sup>th</sup> Annual State of the Art Winter Symposium. Thanks to everyone who attended the ASTS Business Meeting in San Francisco!

## Communications



At the Fall Council meeting, the Council discussed *Chimera* readership and ways to most effectively communicate information to members. After much discussion about various channels, including video and social media, the Council tasked the Communications Committee with making the *Chimera* more modern and user friendly, maintaining the brand while increasing readership.

## Legislative



Dr. Stock reported on the October 1 visit to Capitol Hill by members of the Legislative Committee, led by Chair David J. Reich, MD, and the legislation they discussed. For more about this visit, please see the October issue of the Legislative and Regulatory Update at [ASTS.org/advocacy/legislative-issues/legislative-and-regulatory-update](http://ASTS.org/advocacy/legislative-issues/legislative-and-regulatory-update).

## Fellowship Training

The Transplant Surgery Certification Working Group's activities were discussed, including the development of a completion exam with a pass/fail rate. The recommendation to form an LLC for certification purposes was discussed, and the Council decided to proceed in a step-wise fashion, beginning with a completion exam at the end of fellowship training and continuing to explore the LLC option for 2015.

Fellowship Training Committee Chair Wendy J. Grant, MD, reported that the 2015 Match date will be June 17 and that the committee is working on a proposal for a living donor requirement for fellows.

## Consensus Conference on Training in HBP Surgery

In late October, ASTS, AHPBA (American Hepato-Pancreato-Biliary Association) and SSO (Society of Surgical Oncology) met in San Francisco to discuss training in Hepato-

pancreato-biliary across the three specialty training societies. This full day meeting focused on developing standard HPB training requirements with a patient-centered focus, which would be required regardless of which fellowship an individual completes. The goal among the societies was to develop these criteria with the intention of producing safe and competent HPB surgeons, who have common baseline HPB knowledge, with expertise in their field. The conference was held during the American College of Surgeons annual meeting and there were 229 registrants. Each society had fairly equal representation, and the planning committee will be drafting some initial criteria for the societies to vote on in the coming months. Additionally, the group will draft a white paper and submit it to each society's journal for review and potential publication. Stay tuned for future updates! ASTS Fellowship Training Program Directors will receive access to the webcasts once they become available.

## Standards and Quality Committee



The Standards and Quality Committee continues its work in partnership with the American College of Surgeons on developing a national transplant quality improvement program, TransQIP. The TransQIP will become a module of the ACS' National Surgical Quality Improvement Program (NSQIP). Variables and definitions are nearing completion, and a year-long alpha testing phase will begin in 2015 at 10 transplant centers.

## New Academic Universe



The CME, Curriculum, and Fellowship Training Committees have worked hard to review and develop content for the new Academic Universe, scheduled for launch in the first quarter of 2015. The new platform is designed to be readily accessible on tablets as well as desktop computers and will include robust tracking and reporting features for users.

## Kidney Advocacy Day

ASTS has committed to participating in Kidney Community Advocacy Day 2015 on Thursday, September 10, 2015. Fourteen organizations have already committed to participating in this collaborative event.

*The next ASTS Council meeting will be prior to the 15<sup>th</sup> Annual State of the Art Winter Symposium in Miami on January 14–15, 2015.*

# Transplant Center Policy Library

Streamline your transplant center operations with ASTS' dynamic subscription service of sample policies and templates designed to provide the building blocks you need to successfully manage and navigate the growing and changing regulatory and quality improvement environment.

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- Policy on Policies
- Vessel Storage
- Responsibility for Transport of Living Donor Organs
- Waitlist Management
- Multidisciplinary Teams
- Informed Consent
- Psychosocial Evaluation
- Adverse Events for Transplant
- QAPI Plan Template
- Patient Safety Contact Plan
- Living Donor: Psychosocial Evaluation for Living Donors
- Living Donor: Living Donor Selection Criteria
- Living Donor: Living Donor Consent for Evaluation
- Living Donor: Independent Living Donor Advocate





# 5<sup>th</sup> Annual Leadership Development Program

The 2014 ASTS Leadership Development Program took place in September, marking the 5<sup>th</sup> anniversary of this successful and valued ASTS business leadership education course. Each year, the planning committee introduces a little something new to the program. In 2014, attendees experienced the first ever Shark Tank Style competition judged by a panel of three judges: Dr. Marwan Abouljoud of Henry Ford Hospital; Kim Gifford, Executive Director of ASTS; and Jim Woodrum of the Kellogg School of Management. Three transplant center business scenarios were presented to three teams who had just two hours to prepare their pitches. The team leaders passionately presented their cases in front of the judges, and in the end Team 2, led by Shawn Pelletier and Vincent Casingal, took home the winning honors. Congratulations go out to all the team leaders and participants for a fun and educational evening.

Highlights of the 2014 Leadership Development Program included an in-depth presentation by Thomas Hamilton of CMS, a thorough presentation on transplant finance by Dr. Michael Abecassis, and a spirited debate on the SRTR from Drs. Dorry Segev and Jesse Schold. Huge thanks go out to the planning committee members: Dr. David Axelrod, Dr. Will Chapman, and Dr. Mike De Vera.



*Shark Tank Judges: from left, Kim Gifford, Marwan Abouljoud, Jim Woodrum*

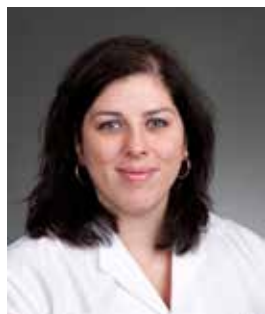


*Shark Tank Team Leaders: from left, Marwan Kazimi, Christie Gooden, Shawn Pelletier, Vincent Casingal, Jonathan Fisher, Liise Kayler.*



# What's Your Perspective?

## HCV Recurrence



**Caroline Rochon, MD, FACS**  
Transplant and Hepatobiliary  
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Because the treatment of HCV recurrence after liver transplantation, a major cause

of graft loss, has shown such disappointing results over the years, transplant programs have tried to attack the recurrence problem with prevention strategies first and desperate therapeutic attempts second. Transplant surgeons anticipate HCV recurrence even before the surgery begins. Several donor factors have been identified with higher potential for HCV recurrence post transplantation and most transplant centers will not accept the same organs for HCV positive recipients that they would for recipients with other indications for transplant.

Many studies have identified multiple donor factors as being associated with higher/earlier HCV recurrence, the most important being increased donor age and higher percentage of steatosis in the graft. The decision to avoid transplanting HCV recipients with older/fatter grafts varies from center to center. How old is too old and how fat is too fat is a matter of preference, but the practice remains universal: prevent recurrence by judicious graft selection. As a consequence, HCV positive candidates can have a longer wait for transplant or a lower transplant rate than candidates without the disease. Other strategies employed in the post-transplant setting involve avoidance of over immunosuppression or episodes of acute rejection (easier said than done).

In theory, HCV positive liver transplant recipients can be treated with a pre-emptive approach immediately following transplantation or with a recurrence-based approach when liver damage is diagnosed. The advantages of pre-emptive or early post-transplant treatment are that serum HCV-RNA levels are characteristically low and significant histological graft damage is virtually absent. Although these factors predict a favorable response, this therapeutic approach had traditionally been difficult to manage because of poor tolerability and reduced efficacy of the pegylated interferon/ribavirin combination. Thus, the preferred strategy is usually to delay antiviral treatment until histological evidence of recurrent post-transplant HCV-related chronic hepatitis is established.

This evidence is sometimes found on biopsies ordered to investigate clinical abnormalities or on protocol biopsies often done at 1 year post transplantation. The algorithms for care vary greatly between institutions but most centers will treat patients with clinical and histological signs of recurrence and at least Grade 3 or 4 inflammation or stage II fibrosis in the liver graft tissue. In this setting, treatment with a combination of Pegylated Interferon plus ribavirin is associated with an overall sustained virological response (SVR) of about 30%.<sup>1</sup>

The recent introduction of direct-acting antivirals, including drugs that inhibit protease, polymerase and other non-structural proteins, heralds a new era in HCV treatment. In the post-transplant phase, triple therapy, with either telaprevir or boceprevir faces multiple challenges.<sup>2</sup> Post-transplant HCV recipients are often “difficult to treat” patients, either because they were prior non responders or they had a high blood HCV RNA. Still, improved outcomes are expected with the new drugs. Triple therapy with these agents is now being investigated. While the data are still very preliminary, reports show that 70 to 90% of patients are virus free at 12 weeks.<sup>3</sup> Infectious and hematologic complications are frequent and drug levels need to be monitored very carefully due to drug-drug interactions between calcineurin inhibitors and protease inhibitors.

Therefore, from my perspective, the increased risk of HCV recurrence post-transplant with older, more steatotic donor grafts is offset by the better ability we now have to treat recurrent disease, even if recurrence is still considered an off label indication.

We also have to wonder, in the era of these new drugs, whether it is wise to wait a full year before protocol biopsies and whether it is worth waiting for stage 2 fibrosis on biopsy to treat. Outcomes may be improved with earlier treatment of HCV recurrence; one might even talk of “recurrence prevention.” As we develop expertise with interferon-free direct acting antiviral therapy, like with sofosbuvir for example, lowering the feared risk of rejection while on treatment, we should all discuss how ethical it is to let the virus damage any graft at all and whether all HCV recipients should be treated preemptively post transplantation.<sup>4</sup> Such approaches seem particularly appropriate if the team decided to forfeit the traditional prevention strategies like avoidance of older donor grafts. In short, the fight against HCV may be won by breaking the barriers to transplantation, being more liberal with graft acceptance and treating preemptively all grafts before the virus begins to damage the new liver...from my perspective.

*continues on page 10*



# What's Your Perspective?

## Living Donor Liver Transplantation in the United States: why isn't it growing?



**Julie Heimbach, MD**  
Mayo Clinic  
Rochester, Minnesota

There were 252 cases of living donor liver transplantation (LDLT) performed in the United States in 2013, comprising just 4% of the total liver transplant volume for this year and very similar to the number performed over the past several years.<sup>1</sup> By contrast, there were more than 300 LDLTs performed at just one center in Seoul, South Korea, in 2013. There are several centers across Asia which are performing similarly high annual volumes.<sup>2,3</sup> Given the critical shortage of available deceased donor liver allografts as well as the increasing waitlist mortality, understanding the reason for the low utilization of LDLT in the United States is an important step toward trying to provide increased access to transplant for patients suffering from the potentially lethal complications of end-stage liver disease.

Examining why this practice is highly successful in in Asia, while far less prevalent in the United States, may best be done by elucidating differences between these regions and then determining whether these differences are likely to influence the growth of LDLT. The first and most obvious difference is the availability of deceased donor transplant. While this option is extremely limited in many Asian countries, in the United States the incredible altruism of donor families and individuals who joined donor registries prior to their death, as well as an efficient allocation system, has provided access to LT for more than 130,000 people since 1988 and to nearly 50 percent of the active waitlist in 2013.<sup>1</sup> For a variety of reasons, deceased donor organ transplantation has not been nearly as successful in many Asian countries, though important strides forward are being made.<sup>2,3</sup> In the United States, the possibility of deceased donor transplant influences both patient and, perhaps more importantly, provider preference. It may be more difficult for patients to accept the remarkable gift of living donor transplant knowing it comes with the need for their loved one to recover from a major surgery and to incur the risk of serious complications when there is the hope (no matter how unrealistic) of a potential alternative.

This hope is similar to the core American value that anyone can rise to the top if they just persevere. Even though there

are multiple possibilities for patients waiting for LT—patients can stay the same with ongoing complications such as ascites, encephalopathy, bleeding, and/or recurrent infections, or they can get sicker. If they get sicker, they may get a high enough score to be transplanted, they may get too sick to undergo transplantation, or they may die. While a patient's history, etiology of liver disease, and MELD score can sometimes be helpful in predicting these outcomes, there is certainly no crystal ball. Patients know if they chose to undergo LDLT, their donor will undergo a major surgical procedure and will feel unwell for a period of time, and they know that there is a possibility of serious complications. If the patient is willing to just keep waiting and is tough enough, the loved one could be spared this suffering. Hepatologists and surgeons also hold on to this hope for a deceased donor transplant, as we would always prefer to have one patient at risk instead of two. Even though we know the data, we are very good at remembering that one time when our lower MELD patient had an opportunity to get a transplant with an increased risk donor or last minute re-allocation. If there is no access to deceased donor transplantation, then the choice is between continued suffering (and ultimately death) or living donor transplant. This burden of perceived choice can be a heavy one, not only for the donor and recipient but also for the physicians.

A second difference in the United States is that the relatively small number of LDLTs are spread over a relatively large number of centers. Both the living donor hepatectomy and the transplant are technically demanding procedures, with a well-documented learning curve.<sup>4</sup> Beyond the learning curve, however, is the level of assurance for surgeons that comes from doing something over and over and over again. Not only does this impact surgeons, but it also may be easier for hepatologists to recommend and easier for patients to accept when it is perceived as the standard or at least a very common option, rather than the exception. The Asian countries which have adopted this practice so successfully have several large centers with a concentrated experience, built upon a long tradition of very complex and technically demanding hepatobiliary surgery.

Another barrier to a more widespread adoption of LDLT in the United States is the impact to the donor, which is not only physical and emotional, but also financial. Unlike many other countries, the United States lacks national health care; therefore, if a patient's ability to remain employed is threatened by the donation process, not only is their livelihood at risk, but also, even more importantly, their health coverage, plus potentially

*continues on page 10*

Caroline Rochon, MD, FACS  
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ASTS is pleased to make a copy of *History of the American Society of Transplant Surgeons On the Occasion of Its 40<sup>th</sup> Anniversary* available to each ASTS member at no charge. If you did not pick up your copy at the World Transplant Congress, please visit [ASTS.org/book](http://ASTS.org/book) and designate where you want it sent. We will mail your copy within 3-4 weeks. If you would like

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Julie Heimbach, MD  
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the health coverage for their family. Concerns about pre-existing conditions and lack of future insurability may have been reduced with the adoption of the Affordable Care Act, though given the complexity of the new system and reports of health care coverage being denied post donation, there is continued uncertainty.<sup>5</sup> In addition, the impact of lost wages combined with out of pocket expenses, especially given the long distances many donors need to travel to get to transplant centers, can be quite substantial. The potential impact to the donors' physical and emotional health is significant and likely quite similar whether donation occurs in the United States or in Asia, although it may be reduced by careful evaluation and robust support systems.

What is the path forward? Highlighting current waitlist outcomes for LT candidates combined with continued cumulative experience with LDLT gradually being gained by centers across the United States, as well as continued careful reporting of donor and recipient outcomes, will hopefully foster the growth of LDLT in the United States. Advances like laparoscopic assisted mobilization and laparoscopic hepatectomy may also be of benefit in more widespread acceptance. Eliminating the financial disincentives to donation should also be of paramount importance. Reimbursement of living donor expenses, as is currently provided under the National Living Donor Assistance Center, should be expanded to include all donors who request such assistance. Options for ensuring access to health care coverage for all living donors should also be explored, whether this is through individual state exchanges or through other national programs. Finally, during National Donate Life Month, we should designate a special recognition event for living organ donors which would serve the dual purpose of highlighting the heroism of living donors as well as raising awareness for this option...from my perspective.

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# ASTS Across the Field

## People and Places

**Douglas W. Hanto, MD, PhD**, is now at Vanderbilt University. He was formerly with Washington University in St. Louis School of Medicine.

In October 2014, **Bhargav Mistry, MD**, performed his 500th organ transplant since his arrival at Sanford Health in Fargo in 2000. Additionally, 2014 marks the 25th year of transplant surgeries in Fargo, North Dakota.

**Vincent P. Casingal, MD**, is now Chief, Division of Abdominal Transplant Surgery at Carolinas Medical Center. He has been on faculty at Carolinas Medical Center since 2006.

**Ron Shapiro, MD**, is the new surgical director of the Kidney and Pancreas Transplant Program at The Mount Sinai Hospital's Recanati/Miller Transplantation Institute. He was most recently Professor of Surgery and the Robert J. Corry Chair in Transplantation Surgery at the Thomas E. Starzl Transplantation Institute at the University of Pittsburgh School of Medicine.

### ASTS Welcomes Chelsey J. Gordon as Education Assistant



Chelsey Gordon is the new ASTS Education Assistant. She is a recent graduate of James Madison University, where she earned a degree in Health Sciences with a concentration in Public Health Education. Previously, Chelsey worked at the Loudoun County Health Department first as an intern and later as a Program Administrator for health outreach programs in the community. Chelsey provides support for education and fellowship programs.



# ASTS Career Center

Looking for your next career move or a new hire?  
Look no further than the ASTS Career Center

The ASTS Career Center at [careercenter.ASTS.org](http://careercenter.ASTS.org) enables employers to post, manage, and update their job listings and company profile anytime day or night, with online payment for faster service. It also allows job seekers to apply for posted jobs or upload their resumes for employers to view.

Employers have the opportunity to post job openings on not only the ASTS Career Center, but also selected sites through the National Healthcare Career Network (NHCN), an integrated network of nearly 300 associations formed to connect healthcare employers with highly qualified candidates in numerous specialties.





## ASTS 8<sup>th</sup> Annual Surgical Fellows Symposium:

# Sun, S'mores, and Surgery

Fifty-six transplant surgery fellows and 30 faculty gathered at the Kona Kai Hotel in San Diego October 17–19, 2014, for spirited discussions, networking, and educational presentations.

Friday, October 17, was devoted to the pancreas and immunology, including some contentious debates over the case studies. The day wrapped up with the Mentor Networking Dinner outside in a courtyard so attendees could enjoy the lovely San Diego evening.

Saturday began with Thomas G. Peters, MD, giving an overview of ASTS history, followed by ASTS President Peter G. Stock,



MD, PhD, moderating a rapid-fire kidney discussion. Amid the talks on kidney transplantation were Michael J. Englesbe, MD, giving advice on transitioning from fellowship to faculty (get a financial planner, stay humble, and remember why you do it) and a discussion of the job market.

The Job Discussion panel, consisting of Dr. Englesbe, Wendy J. Grant, MD, Richard M. Ruiz, MD, and Benjamin Samstein, MD, walked fellows through such topics as how to handle job offers that aren't a match, taking the time to find the right job, doing

## Thanks!

ASTS gratefully acknowledges the support of Novartis Pharmaceuticals as a Gold Level Sponsor for the 8<sup>th</sup> Annual Surgical Fellows Symposium.



homework before interviews, and the art of self promotion (while staying classy).

During the lunch break, fellows broke into teams and worked on their case studies. They then left the sunny bayside courtyard to go back inside for the afternoon sessions.

Dr. Stock gave his President's Message, "Getting High and Hypoxic and Surviving a Career in Transplant Surgery," immediately after lunch, talking about the changing job market and keeping balance in life. He told the story of going climbing in the Soviet Union, getting delayed by an avalanche, and being

**Dr. Stock told the story of going climbing in the Soviet Union, getting delayed by an avalanche, and being two weeks late for his own fellowship.**





two weeks late for his own fellowship. This led to his advice to make sure the people you work with are a good fit. He also urged the fellows to embrace the luster of transplantation and take advantage of what ASTS has to offer, including networking and the Leadership Development Program.

Kim M. Olthoff, MD, then gave her insights into “Building (and Keeping) the Perfect Transplant Team,” followed by the kidney case discussions. That evening, after the Peer Networking Dinner, several fellows and faculty went down to the beach for a bonfire and s’mores to finish off the day.

Sunday began with case study preparations over breakfast, then a quick survey of the fellows’ knowledge of and intent to apply for ASTS Research Grants. After that, Charles M. Miller, MD, gave a talk on choosing the right liver for the right patient. Alan N. Langnas, DO, spoke about “The Complex Liver Operation and

### Thank you to all those whose hard work made the symposium such a success, including:

Amy R. Evenson, MD – Program Planning Committee Chair

Elmhadi A. Elkhammas, MBBS – Planning Committee

Andre A. Dick, MD, MPH – Planning Committee

Wendy J. Grant, MD – Chair, Fellowship Training Committee and Program Advisor

Ryutaro Hirose, MD, Co-chair, Fellowship Training Committee and Program Advisor





Pushing the Envelope,” followed by James J. Pomposelli, MD, PhD, giving a talk on “Split and Partial Liver: Technical Aspects and Program Preparation.”

Douglas G. Farmer, MD, gave an overview of intestinal transplantation, and then the liver case discussions wrapped up the symposium.

## Recognition Award Recipients

*ASTS Congratulates the Recipients of the 2015 Recognition Awards*



### Advanced Transplant Provider Award

Connie White-Williams, PhD, RN, FAAN  
University of Alabama at Birmingham



### Francis Moore Excellence in Mentorship in the Field of Transplantation Surgery Award

Carlos O. Esquivel, MD, PhD  
Stanford University School of Medicine



### Vanguard Prize

Karim Halazun, MD  
Emory University

Standing the Test of Time :  
Outcomes of a Decade of  
Prioritizing Patients with HCC,  
Results of the UNOS Natural  
Geographic Experiment



### Vanguard Prize

Paulo Martins, MD, PhD  
University of Massachusetts

Injury of Peribiliary Glands  
and Vascular Plexus before  
Liver Transplantation Predicts  
Formation of Non-anastomotic  
Biliary Strictures

**Be sure to attend the Recognition Awards Presentation at the ASTS Winter Symposium, Saturday, January 17, at 6 p.m. on the Americana Lawn.**

**American Society of Transplant Surgeons**

**15<sup>TH</sup> Annual  
STATE OF THE ART  
WINTER SYMPOSIUM**

**TRANSPLANT**

**The Ultimate Team Sport**

**January 15–18, 2015  
Loews Miami Beach Hotel**

Registration is still available online at  
[www.ASTS.org](http://www.ASTS.org)

On-site registration will also be available. The ASTS  
Registration booth is located in the Americana Foyer,  
Level 2 of the Loews Miami Beach Hotel.

**ASTS Trainee registration  
is complimentary!**

**For more information visit**

**[www.ASTS.org](http://www.ASTS.org)**



## Education Corner

*A roundup of educational and CME activities offered by ASTS*



### 2015 Winter Symposium: Credits Available

This year, the ASTS 15<sup>th</sup> Annual State of the Art Winter Symposium will feature sessions offering credits to satisfy Category I CME Part 2 self-assessment requirements established by the American Board of Surgery (ABS) Maintenance of Certificate (MOC) Program. The ASTS CME Committee created this program based on the success of the pilot ASTS MOC Part II program at last year's Winter Symposium. For more information, visit [ASTS.org/winter-symposium](http://ASTS.org/winter-symposium).

A primary goal of the CME committee is to develop best-in-class educational offerings that help you meet your ABS MOC requirements one part at a time.

### ASTS 6<sup>th</sup> Annual Leadership Development Program: Save the Dates!



The 2015 Leadership Development Program will be held September 27—30 at the Kellogg School of Management at Northwestern University in Evanston, Illinois.

Learn more at [ASTS.org/LDP](http://ASTS.org/LDP).



### Images in Transplantation

Did you know that the American Journal of Transplantation (AJT) feature titled “*Images in Transplantation*” provides Category I CME and self-assessment credits toward Part 2 of the American Board of Surgery (ABS) Maintenance of Certification (MOC) Program? Images in Transplantation is a monthly CME activity featured in the AJT that explores images illustrating a case-based clinical problem providing learners up-to-date developments in the science of images in transplantation. Now you can look, learn, and earn credits to help meet your ABS MOC Part 2 requirements.

For more information, go to [www.amjtrans.com/view/0/cme.html](http://www.amjtrans.com/view/0/cme.html).

### New Trans-SAP Modules on the Way



New Trans-SAP modules are being prepared for the new Academic Universe platform, scheduled for launch in early 2015. Trans-SAP is an online program to help transplant surgeons and physicians meet the American Board of Surgery (ABS) MOC Part 2: Lifelong Learning and

Self-Assessment requirements. These CME activities consist of selected peer-reviewed journal-based articles with self-assessment multiple-choice pre- and post-test questions and answers. Each article has clear educational objectives and covers relevant clinical topics in transplantation. Each activity provides Category I CME and self-assessment credits toward Part 2 of the ABS MOC Program.

To learn more about Trans-SAP, visit [ASTS.org/education/trans-sap-moc](http://ASTS.org/education/trans-sap-moc).



## Join The Conversation

CenterSpan is where your colleagues go to discuss transplantation and immunology topics.

Don't be left out!

Sign up at  
[www.ASTS.org](http://www.ASTS.org) today.



## OPTN/UNOS Board Meeting/Election Slate

The OPTN/UNOS Board of Directors met November 12-13 in St. Louis. It approved a set of policy requirements for medical/psychosocial evaluation and informed consent procedures for living donation of kidney, liver, lung, intestine, and pancreas. It also approved revised policies for donor testing and screening, vessel storage, and informed consent for potential recipients to help minimize the risk of transmitting blood-borne infectious disease through transplantation, conforming to guidance issued in 2013 by the Public Health Service.

Other key action items approved by the Board included:

- Policy revisions to cap the assignment of a liver exception score at 34 for candidates with hepatocellular carcinoma (HCC) and to delay HCC exception score assignment
- A clarification to vascularized composite allograft (VCA) transplant program membership requirements, directing programs to specify the type(s) of VCA transplantation they intend to perform
- Guidance documents on general principles of pediatric organ allocation, allocation of heart/lung combinations, donor screening for seasonal and geographically endemic infectious diseases, and authorization protocols for VCA donation

An executive summary listing all Board actions is available on the OPTN website: <http://optn.transplant.hrsa.gov/converge/members/executiveSummary.asp>.

The Board also ratified a slate of nominees for election to open positions for the 2015-2016 Board term. Voting materials, including an election ballot and brief biographical sketches of nominees, will be sent to voting representatives of OPTN/UNOS member institutions in early 2015. The slate of nominees is available on the OPTN website: <http://optn.transplant.hrsa.gov/news/nominees-chosen-for-2015-board-of-directors-election/>.

## Liver Distribution Discussion Ongoing

Nearly 500 people participated in the public forum hosted by the OPTN/UNOS Liver and Intestinal Organ Transplantation Committee on September 16 to discuss liver distribution concepts. Video highlights of the forum and slide presentations given by forum speakers are available on Transplant Pro: <http://transplantpro.org/liver-concept-forum-held-sept-16/>.

The committee met the following day and identified four areas for additional study and recommendations:

- Refining metrics of access disparity and ways to optimize distribution
- Identifying financial implications of alternative sharing methods
- Addressing transportation/logistical issues associated with potential broader sharing
- Increasing liver donation and utilization

Ad hoc subcommittees have been formed to address the first three topics. These subcommittees include current committee members as well as non-committee members with expertise in these topics. The topic of increasing liver donation and utilization is being addressed by a subcommittee of the current committee. The groups are meeting by conference call through April 2015 to develop consensus-based recommendations.

An additional public forum is planned to share the subcommittees' recommendations and again gather professional and public input to guide policy development. The forum date has not been established as of press time but could occur in May 2015; registration details will be forthcoming as soon as they are available. For additional information, send an e-mail to [liver@unos.org](mailto:liver@unos.org).

### **Revised Kidney, Pancreas Allocation Systems Implemented; Resources Available**

On December 4, significant revisions were implemented to OPTN kidney allocation policy. They are intended to enhance the effectiveness of kidney transplantation and improve access for biologically disadvantaged candidates.

On October 30, revisions were implemented to pancreas and kidney-pancreas transplantation. They are intended to optimize access for pancreas candidates without adversely affecting kidney-only candidates and to reduce the complexity of offers involving kidneys.

A variety of training sessions and informational resources are available to help transplant programs manage the transition to the new systems, as well as educate transplant patients and their families about them. For a listing of resources, visit Transplant Pro: <http://transplantpro.org/resources/professional-resources/>.

### **Lung Allocation System Revisions to be Implemented in February**

Modifications to lung allocation policy will be implemented in February 2015. They include new data variables to calculate the lung allocation score (LAS), new LAS defaults for missing or expired data, and additional diagnoses within the existing diagnosis groupings.

UNOS will offer a webinar for transplant professionals in January on changes to the lung system and is developing additional resources to help clinicians and transplant patients understand the revised policy. Additional information about the policy is available on Transplant Pro: <http://transplantpro.org/heartlung/>.

### **Policy Development Schedule Revised**

In 2015, UNOS will implement a new schedule of policy development activities to promote greater efficiency in developing and considering proposed actions.

Under the new schedule, Board meetings will take place at 6-month intervals (in early June and early December). The dates of committee and Regional meetings and of public comment periods will also be adjusted to allow committees more time to consider public input and finalize recommendations to be presented to the Board.

Dates of all upcoming scheduled meetings are listed on the searchable Calendar of Events in Transplant Pro: <http://transplantpro.org/resources/calendar/>. Public comment sessions will be standardized to 60-day periods. The next public comment period will begin January 27 and conclude March 27.

### **UNOS Member Quality Department Formed**

UNOS has established a Department of Member Quality, combining the previously separate departments of Evaluation & Quality and Membership. The department plays a fundamental role in supporting the OPTN/UNOS Membership and Professional Standards Committee (MPSC) through monitoring of member institution qualifications, compliance, and performance.

The department will be headed by a director and will have two assistant directors, one supervising operational activities (compliance and safety investigation, member applications, quality monitoring, and MPSC operations) and the other supervising monitoring activities (site survey, allocation analysis, and performance analysis).



# LIVING DONORS

## **Funding Renewed for Nationwide Program to Reduce Financial Disincentives for Living Organ Donors**

The University of Michigan (UM), in partnership with the American Society of Transplant Surgeons (ASTS) and Arbor Research Collaborative for Health, are pleased to announce they have been selected to continue operating the National Living Donor Assistance Center (NLDAC). Funding for this program was renewed by the Health Resources and Services Administration, U.S. Department of Health and Human Services, which will provide up to \$3.5 million yearly for up to five years.

“We are extremely happy that we can continue to provide assistance for living organ donors who provide the gift of life to others,” said Program Director Akinlolu Ojo, MD, PhD, Professor of Medicine at the University of Michigan. Arbor Research will join ASTS and UM to enhance the applicant experience and identify areas for enhanced program efficiency. “We look forward to making improvement to this already successful program,” said Arbor Research President and NLDAC Program Deputy Director Robert Merion, MD.



For more information, call 888-870-5002.  
NLDAC is located in the national office of ASTS

**Helping Low Income  
Individuals on Transplant  
Wait List**

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**Living Donors Receive  
AMEX Card to Pay Travel  
Expenses**

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**Eligibility is based on  
300% HHS Poverty  
Guidelines of Recipient  
Household Income**

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**Since 2007:  
5101 Applications  
Received  
2568 Surgeries Complete**

### **NATIONAL LIVING DONOR ASSISTANCE CENTER**

2461 S Clark Street, Suite 640,  
Arlington, VA 22202

[Livingdonorassistance.org](http://Livingdonorassistance.org)





# Organ Donation & Transplantation Alliance

## Now Available: Saving and Healing Lives Educational Training Course

The Organ Donation and Transplantation Alliance unveiled a new online educational training course on organ donation entitled “Saving and Healing Lives Through Organ and Tissue Donation—Continuing Our Healthcare Mission.” Organizations and health care professionals that are working to improve the donor management and family care process across their donation service areas are encouraged to take the opportunity to view, learn from, and share this educational training course.

The training course is available on the Alliance website, [www.organdonationalliance.org](http://www.organdonationalliance.org).

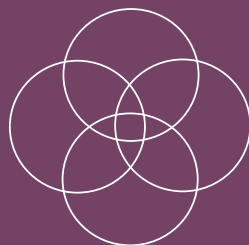
The online training course includes information on:

- Honoring the gift of life
- Donation process
- Donation pathways

The training course was created to help participants:

- Identify the roles of different members of the multidisciplinary team of professionals in the donation process
- Explain how full clinical management of critically ill or dying patients can preserve their ability to become organ donors, which otherwise would be lost if treatments were limited
- Differentiate myths from facts regarding the donation process
- Examine how collaboration between an OPO and the clinical team leads to a more successful donation process

This training course is intended for health care professionals, including medical, nursing, respiratory, and ancillary students, physicians and nurses,



## About the Alliance

The Organ Donation and Transplantation Alliance is a non-profit, independent organization comprised of a consortium of national organizations critical to the organ donation and transplantation process whose main goal is to eliminate deaths on the national organ transplant wait list. Alliance members include the American College of Healthcare Executives, the American Hospital Association, the American Society of Transplantation, the American Society of Transplant Surgeons, the Association of Organ Procurement Organizations, the Society of Critical Care Medicine, the Joint Commission, and the United Network for Organ Sharing. The Alliance is positioned to bring together diverse stakeholders to align, support, and advance initiatives all focused on saving lives through organ donation and transplantation.

[organdonationalliance.org](http://organdonationalliance.org)

ancillary support staff, health care administrators, and organ procurement personnel, or anyone involved in the organ donation process. The online training course serves as an introduction to organ donation that should be used for educational purposes and program development. Continuing education credits, including CME and CEPTC credits, are being offered to those who view the online training course and complete a post test.

## Quality Improvement Task Force – Joint Commission Standards Review Committee

A small workgroup, composed of representatives from the Joint Commission, ASTS, AST, AOPO, the Alliance, and other key stakeholders convened on November 17 to review and discuss the findings from the recently completed standards evaluation tool, which assessed some of the existing Joint Commission standards related to organ and tissue donation.

A total of 189 individuals responded to the evaluation tool, representing 64 OPOs, 58 transplant centers, 60 donor hospitals, and 7 other organizations. The workgroup met to review and discuss all the evaluation results and offered recommendations to the Joint Commission on whether the standards should be updated or modified. The Joint Commission will take into consideration all the information presented and will conduct an internal review of the proposed recommendations and provide follow-up to this workgroup in the near future.

## Donor Intervention Research Expert Panel

More than 30 individuals representing ASTS, AST, AOPO, HRSA, ACOT, ODRC, the Alliance, and other leading donor research and donor management

# Organ Donation & Transplantation Alliance

experts convened on November 19–20 to finalize action steps and supporting materials to implement donor intervention research infrastructure and processes. The intent of this meeting was to:

- Articulate process and model elements of centralized review of donor intervention protocols
- Clarify implications related to donor and family authorization/consent
- Outline process for informed consent in the recipient and reach consensus as to appropriate procedure
- Address informed consent issues regarding the effect of research

on organs that are not receiving the direct impact of the research protocol

- Identify and leverage areas of alignment among similar efforts in the community

It was a very productive meeting during which the expert panel identified three workgroups charged with developing a framework for establishing:

1. Donor research consent guidelines
2. Recipient research consent guidelines
3. A centralized oversight review board

The group anticipates that the final Research Roadmap will be completed by May 2015.

The Alliance produces resources and conducts several of these key activities under a cooperative agreement from the Health Resources and Services Administration (HRSA). For more information about other upcoming Alliance sponsored events, webinars, or available resources, please visit our website at [www.organdonationalliance.org](http://www.organdonationalliance.org).

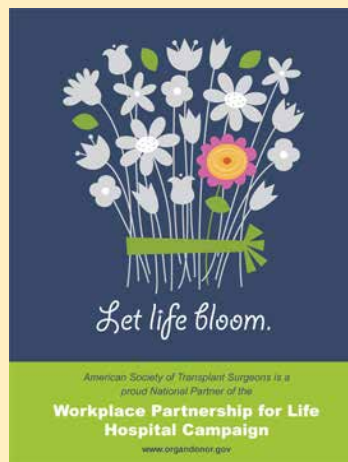
## Workplace Partnership for Life Campaign Enters Year 4

Year 4 of the Workplace Partnership for Life Hospital Campaign runs from August 2014 through April 2015, with goals of:

- 100,000 registry enrollments
- More enrollees
- Active participation among enrollees

This dynamic collaboration continues to energize a nationwide network of advocates for organ, eye, and tissue donation. To date, enrollment includes:

- 1,286 hospitals and transplant centers
- 58 organ procurement organizations—100% enrollment of OPOs
- 26 hospital associations
- 24 Donate Life America partners



Last year, 538 partners earned gold, silver, or bronze recognition for their excellent work promoting enrollment in state organ donor registries. [See the full list of partners recognized.](#)

This year's campaign offers partners another opportunity to earn recognition. The updated Hospital Campaign Toolkit materials include the campaign guide and scorecard, featuring more than 40 ideas for activities. It provides an easy way to record actions and earn points. It also includes:

- Templates for letters and emails
- PSAs
- Newsletter items
- Presentations

*For more information, or questions about enrollment in the Hospital Campaign, contact [donation@hrsa.gov](mailto:donation@hrsa.gov).*

# **ASTS MEMBERS: BE THE FIRST TO KNOW!**

## STAY ON TOP OF YOUR CENTER'S PERFORMANCE WITH RAPID

### **RAPID: Real-time Analytics and Process Improvement Dashboard**

RAPID is an open-source software originally developed at Northwestern Medicine Comprehensive Transplant Center and distributed through ASTS at no charge to its members. RAPID provides outcomes and quality dashboards to individual transplant centers relevant to UNOS and SRTR reporting. The system is easily extensible and sufficiently generic to support future evolution to center specific or SRTR reporting.

**For more information, see the RAPID webpage at**

**<http://asts.org/rapid>**





## 2014 Foundation Contributors

ASTS is grateful to the following individuals for their support of the Foundation of the ASTS in 2014. Visit [ASTS.org](http://ASTS.org) to learn about the Foundation and its projects or make a contribution.

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## New Members

For more information on becoming a member visit [ASTS.org](http://ASTS.org)  
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