Recipients and Recipient Transplant Coordinators

April 2014
Helen Tincknell
Lead Nurse Recipient Coordination
NHSBT
UK Transplanting Centres

- 24 Kidney
- 8 Pancreas
- 8 Liver
- 7 Heart & Lung
- 4 Small bowel/Multi visceral
- 250 Recipient Coordinators in the UK
RTC Role

- Point of contact from referral
- Coordinating Tx assessment
- Preparing the pt and family physically and emotionally
- Education
- Informed consent & Listing
- Maintaining & monitoring whilst listed
- Organ offers, sending out the NORS team & setting up Tx
- Organ outcome
- Post Tx follow up until graft loss or death
Recipient Coordination

- Trust/Board employed.
- Usually sit in surgical/transplant directorate.
- Banding dependent on the role in particular Trust (7-8).
- Advanced practitioners
- Nurse led clinics
- Nurse prescribing
- 80% cover on call rota

- Usually organ specific in the day time.
- Deceased donation
  - Liver
  - Kidney
  - Pancreas
  - Heart
  - Lung
  - Small bowel/multi visceral

- Live donation
  - Kidney
  - Liver
UK Lead Roles

Pancreas
Christine Jansen
Edinburgh and
Dawn Chapman Cardiff

Cardio thoracic
Jane Nuttall
Wythenshawe
Cheryl Riotto
Papworth

Small bowel
Lydia Holdaway
Oxford
Carly Bambridge
Kings London

Liver
Helen Aldersley Leeds

Kidney
Richard Bowen
Nottingham

Liver
Wendy Littlejohn
London
Solid Organ Transplantation

• Heart
• Lungs
• Pancreas
• Liver
• Kidneys
• Small bowel (stomach, colon & abdominal wall)
Number of deceased donors and transplants in the UK, 1 April 2003 - 31 March 2013, and patients on the active transplant lists at 31 March

### Number of deceased donors and transplants in the UK, 1 April 2003 - 31 March 2013

<table>
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<th>Year</th>
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**Source:** Transplant activity in the UK, 2012-2013, NHS Blood and Transplant
Number of deceased and living donors in the UK, 1 April 2003 - 31 March 2013

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Patient outcomes one year after listing for transplant

Urgent heart patients and super-urgent liver patients excluded
Urgent and Super Urgent Listing

- **Super Urgent Liver**
  - Less than 48hrs to live
  - Gravely ill
  - Very strict criteria to list
  - Offered the first liver that becomes available

- **Urgent Heart**
  - Strict criteria
  - 78% of all hearts last year were transplanted into urgent patients
  - National review currently
Why Do Pts Need a Kidney Transplant?

- Polycystic kidney
- Diabetic
- Autoimmune disease
- Viral damage
- Drug induced renal failure
- Pre-emptive transplant

What we do know is that it is more cost effective to transplant than stay on dialysis and patients survive longer if transplanted.
Life on Dialysis

Your tests reveal that you are retaining fluids!
Transplant survival, by donor type
(Event: kidney graft failure or patient death)

- **Living at 20 years**: 51% (45%-57%)
- **DBD**: ~13% (12-15%)
- **DCD at 10 years**: 63% (59%-67%)

Observation window: 2010 to 2012

Median estimates:
- **DBD**: ~13 years
- **Living**: ~20 years

30 year estimates:
- **DBD**: ~13% (12-15%)
Why Do Pts Need a Liver Transplant?

- Autoimmune diseases e.g. PSC
- Acute liver failure
- Chronic liver failure, any cirrhosis due to
  - ALD
  - NAFLD
  - Viral hep B,C or D
  - Haemochromatosis
  - Congenital diseases
- Liver tumours within criteria
Liver continued...

- Wilson’s disease
- Congenital fibrosis
- Cystic fibrosis
- Intractable puritus
- Polycystic liver disease
- Familial amyloid polyneuropathy
- Sickle cell disease
- Other variant syndromes

- Paediatrics
- Wilson’s
- Glycogen storage syndrome
- Bud chiari
- Porto-pulmonary hypertension
- Caroli’s syndrome
- Metabolic liver disease
- And the list goes on......
Waiting For a Liver Transplant

- Listed if 50% survival chance at 5yrs
- Routine and super urgent lists
- Must full fill the criteria
- Can be removed if their situation changes
- Acites, pain, bleeding, decompensating, nausea, itching, HCC growing

1 in 5 will die waiting
Liver Donor

- Cause of death
- Ischaemic damage
- LFTs trend and history
- BMI
- PMH
- Contraindications
  - Acute hepatitis
  - Cirrhosis
  - Portal vein thrombosis
What is critical to transplantation?

• Tissue typing of donor asap
• Identification of recipient
• Organ function pre admission
• Sequential data to show improvement/decline
• Complete as possible assessment and data set

• Timings
• Theatre, asystole, cross clamp
• CIT time
• National named allocation for some organs
• Need to mobilise recipient, prep for theatre, dialysis, cross match, scans = hours
• May have difficult explant to coordinate with retrieval.
Small Bowel and Multivisceral Tx

- Short gut
- Ischaemic disaster
- Crohn’s disease
- Congenital disorders
- Visceral myopathy
- Gastropareisis
- FAP
- PN LD
- Renal failure
- Medical mistakes!
What Does that Mean for the Patient?

- Not being able to eat with your family/friends
- 12 hours of PN a day
- Pain
- Nausea/Vomiting
- Risk of life threatening infection
- Stoma
- Venting tubes
- Fistulae
- Lack of energy
- Poor QoL
SB/MV Donor; need to know

- Bld group and TT
- Ht / Wt, girth & BMI
- Abdominal surgery
- PMH
- Trauma, free gas
- Ischaemic injury
- Location
- Timings
What are we looking for?

- Patient can be listed for
  - Small bowel
  - And maybe....
  - Liver
  - Pancreas
  - Kidney
  - Stomach
  - Colon
  - Abdominal wall
Why Might we Need Abdominal Wall?

- Very small abdominal cavity
- Multiple laparotomies and scaring
- Abdominal fistulae
- Multiple stomas sites

**Possible solutions**
- Delayed closure
- Porcine graft
- Pedicle from the thigh
- Fascia
- Abdominal wall
Abdominal Wall Transplant
Small Bowel Retrieval

- Send their own consultant led team
- Drugs via NG tube
- Responsible for all abdominal organs
- Recipient in and prep for theatre as retrieval begins
- Evisceration of recipient starts when retrieval team viewed organs and all OK
- Cross clamp time important to keep CIT to min
- CIT 6hrs max
Unique

- National programmes
- Long journey times
- Theatre set up extensive
- Difficult explants
- Unpredictable delays
- May request additional vessels
Coordinating

- Collect more information
- ITU bed (liver/small bowel)
- Accept organ
- Duty office
- Timings
- Transport
- Tissue typing
- Recipient
- Ward
- Junior Drs
- Theatres
- haematology
- Pathology
- Transplanting team
KEY MESSAGES

• Task force has improved donation rates
• ToTT2020 has ambitious targets
• Working together to facilitate donation and quality transplantation
• Advisory groups constantly improving outcomes

• Timing can be critical
• Each organ has got the ability to transform/save lives
• Survivability to key good outcomes
• Information transfer crucial to quality
• BAME donation
Web Site

- www.odt.nhs.uk
- Allocation
- Selection
- Contraindications
- Waiting list figures
- Survival figures
- Centre specific figures
THANKYOU