Message from the President of the Board of Eurotransplant International

Dear Colleagues,

During its meeting on May 30 the Board of Eurotransplant International decided to propose to the Council of Employees its two candidates for the positions of General Director and of Medical Director. The Council of Employees approved the Board’s proposal. It therefore gives me great pleasure to officially announce on behalf of the Board of Eurotransplant International that Dr. Arie Oosterlee has been nominated as General Director and Dr. Axel Rahmel as Medical Director. I announced to you previously that Mr. Wim van Zwet had been nominated as Financial / IT Director.

Dr. Arie Oosterlee is at present Medical Director of Leiden University Hospital while Dr. Axel Rahmel is active as cardiologist in the department of Cardiology and Cardiac Surgery at the Leipzig University Hospital in Germany.

I am fully convinced that this new Board of Directors will be able to take over the very responsible duties which Dr. Guido Persijn and Dr. Bernard Cohen have fulfilled with great success over the last 30 years.

I would like to take this opportunity to invite all of you to attend the annual Eurotransplant meeting on October 6 and 7, 2005. In contrast to previous meetings, this year the annual meeting will take place in Noordwijk on the North Sea coast. After the General Assembly meeting on Thursday afternoon, a special farewell meeting will be organised in honour of Dr. Persijn and Dr. Cohen, followed by a reception and a special farewell party. I hope that as many colleagues as possible will be able to come to Noordwijk. This will be an ideal occasion for all of you personally to express your thanks to both Directors for their many years of unconditional dedication to the Eurotransplant International Foundation.

Yves Vanrenterghem
President of the Board of Eurotransplant International
## PROCUREMENT ACTIVITIES

### PRELIMINARY PROCUREMENT ACTIVITIES IN EUROTRANSPLANT, JANUARY 1 - JUNE 30

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<td><strong>Kidney</strong></td>
<td>175</td>
<td>181</td>
<td>63</td>
<td>66</td>
<td>6</td>
<td>5</td>
<td>17a</td>
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<td>32f</td>
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<td>17d</td>
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<tr>
<td><strong>Heart + Lung</strong></td>
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<tr>
<td><strong>Lungs double</strong></td>
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<td>1606</td>
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<td>403</td>
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a. 4 pancreas-only, b. 12 pancreas-only, c. 24 pancreas-only, d. 6 pancreas-only, e. 3 pancreas-only, f. 18 pancreas-only, g. 24 pancreas-only, h. 6 pancreas-only, i. 2 pancreas-only

## TRANSPLANT ACTIVITIES

### PRELIMINARY TRANSPLANT ACTIVITIES IN EUROTRANSPLANT, JANUARY 1 - JUNE 30

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<td>170</td>
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<td>11</td>
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<td><strong>Heart</strong></td>
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<td>24</td>
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a. 4 pancreas-only, b. 28 pancreas-only, c. 14 pancreas-only, d. 6 pancreas-only, e. 31 pancreas-only, f. 15 pancreas-only, g. 1 pancreas-only
Henk Schippers became the first Eurotransplant Director in 1970. After 5 years, he was appointed as Secretary Treasurer of the Board until his death in 2003. Henk laid the foundations for the administration of Eurotransplant. He successfully completed negotiations with the insurance companies and began the international network, which is the hallmark of Eurotransplant.

**Purpose**

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 investigations at well recognized and respected (inter)national transplantation congresses or symposia, e.g. European Society for Organ Transplantation (ESOT).

**Eligibility**

Candidates (# 35 years) must have attained a masters or PhD degree, and at least have an appointment as a junior faculty member. Individuals at the Associate Professor level are not eligible. Clinicians must have finished their residency no more than five years prior to applying and investigators must have completed their post-doctoral training no more than five years prior to applying. Applications coming from the entire European region will be accepted.

**Terms**

The recipient will receive 2,000 Euro. This award will be made available to the individual applicant and must be used for direct expenses. A progress report will be required. Applicants can provide a paper, also after presentation at a specific meeting and the candidate chosen can use the money in the next year. The Eurotransplant International Foundation will retain the right to unilaterally cancel any awards for non-compliance or non-performance.

**Application procedure**

Candidates must submit:
- A completed curriculum vitae;
- An application letter for which purpose he/she will use the award;
- Applications must also contain a letter of nomination from a faculty sponsor who will accept responsibility for monitoring the awardee.
- Applications must be entirely in the English language.

One original and five collated copies of all parts of the application must be received on or before the due date at the Eurotransplant International Foundation in Leiden, Central Office.

Original signatures must be contained on one copy of the application.

Non-complying applications will be returned without review.

**Deadline**

The application deadline is AUGUST 31, 2005.

**Selection**

The selection committee, Board members of the Eurotransplant International Foundation, will consider all proposals. Decisions of the selection committee will be announced by SEPTEMBER 30, 2005.

**Award management**

Award payments will be made following written acceptance by awardee.
Change in status of awarded

Awards are to remain solely with the designated awardee and may not be transferred to any other person. If a recipient decides not to attend the anticipated congress, the award will be terminated as described above.

Inquiries

Direct all inquiries to:
Dr. Guido G. Persijn / Dr. Bernard Cohen
Eurotransplant International Foundation
P.O. Box 2304
2301 CH Leiden
The Netherlands
Tel: +31 71 5795795
Fax: +31 71 5790057
Email: schippersaward@eurotransplant.nl
Website: www.eurotransplant.nl

In memoriam of Dr. Martin Blümke, † 13.5.2005, executive physician of the German organ donation region North Rhine-Westphalia

"We have lost a colleague, a co-worker and a real good friend"

Dr. med. Martin Blümke (born May 11, 1957) died completely unexpectedly on May 13, 2005, from a brief but severe disease. He had been the executive physician of the organ donation region North Rhine-Westphalia. For a long time he had been committed to organ donation and to the Deutsche Stiftung Organtransplantation (DSO).

He studied medicine at the University of Essen and later Albert Ludwig University Freiburg. He got his medical degree in Freiburg with a thesis about immune-monitoring of transplanted patients. His first application was as an intern in the surgical department at the University Hospital in Freiburg. Already then, he dealt with the situation of transplantation medicine, of organ donation and of patients on the waiting lists. Due to his profound interest in organ donation and transplantation, he preferred a career as a transplant co-ordinator to further training in surgery. Being a co-ordinator meant to him being able to combine diverse areas of medicine.

Thanks to his high degree of flexibility and his unconventional way of thinking he often found solutions for difficult situations. His capacious empathy in dealing with people had helped many donor families to come to a stable decision. Thus, he managed to be the advocate of the patients on the waiting lists as well as of the donor families. He did not consider this to be a conflict but a chance to mediate in a humanly demanding situation.

He decisively contributed to establishing the liver and pancreas transplantation program and the kidney transplantation program of living donors in Freiburg. His work did not end with the explantation of organs but only when he could convince himself of the well being of the organ recipients.

He continued his medical scientific studies in the field of immune-monitoring and published numerous scientific reports as author and co-author. Martin Blümke had been involved with designing and organizing of scientific meetings such as the first European transplantation course in co-operation with the University of Strasbourg, the annual congress of the German Transplantation Society (DTG) in Freiburg and many organ donation workshops for health care professionals and for the public. Dr. Blümke also was a member in scientific societies, among others he had been in the board of ETCO. His studies about evaluating organs with extended donor criteria remains unfortunately unfinished. He was convinced that an application of perfusion systems in marginal organs should become available for transplantation.

Many of us have lost a nice colleague and friendly co-worker, others a good friend and long time companion. He leaves his wife and two children. He was well-known for his spontaneous comments, his sense of humour, and his attentiveness and friendliness, all of which remain unforgettable. Moreover his personality and his work will stay exemplarily for many of us.
Introduction

Hi, I am Marjan Slot and I joined the Eurotransplant Medical Staff in February 2005. After finishing Medical School in Groningen, the Netherlands, I moved to Maastricht (dept. of Clinical and Experimental Immunology) to do a PhD on atherosclerosis in patients with ANCA-associated vasculitis, in addition to follow-up studies I had performed in Groningen on patients with vasculitis. In December 2004, my PhD project was finished (although my thesis is not yet), and I decided to turn in a different direction and apply for a job at Eurotransplant. So far, I am very glad I made this choice and I hope to be here for quite some time. Currently I am involved in keeping the Eurotransplant website up-to-date. Furthermore, I am the new secretary of the Eurotransplant Pancreas Advisory Committee in succession to Klasien Dijkstra.

IMPORTANT NOTIFICATION

To all members of the Eurotransplant website: www.eurotransplant.nl:

As of July 1, 2005, we will start deploying the ENIS application over the internet. This will enable use of ENIS from any workstation connected to the internet. Please note that in September 2005 we will stop using the current Citrix Metaframe/SecuRemote system.

You can find the requirements for your PC and connection on our website: www.eurotransplant.nl/helpdesk

The logon process will be more simple and safe. You will logon only once via the SSO server (Single Sign On)

Your username is: johndoe
Your password is: asap1234

This SSO server will ask you the first time you logon to create a new password with a minimum length of 6 characters and at least two digits. (For example: et2tx4). Each six months you will be asked to change your password. Also, after 6 months of no activity your account will be disabled and 3 months later the disabled accounts will be removed.

For questions, please contact Ms Maya de Beer at mbeer@eurotransplant.nl.

MELD/PELD registration module in ENIS

By: Dr. T. Gerling

The current ET Liver Allocation System (ELAS) was implemented in July 2000, introducing the concept of patient-specific allocation. In February 2002 the United Network for Organ Sharing (UNOS) in the U.S. implemented the Mayo-End-stage-Liver-Disease (MELD) and Pediatric-End-stage-Liver-Disease (PELD) scores for adult and pediatric transplant candidates, respectively, in their liver allocation system (see www.unos.org). In April 2003, the ET Liver Advisory Committee (ELAC) recommended to implement MELD in ET (RLAC01.03), confirmed and accepted by the ET Board in June 2003. As a result, transplant candidates 12 years or older will be stratified on the waiting list by their calculated MELD score. For the group of transplant candidates younger than 12 years the ET Board entrusted the ELAC in January 2004 to elaborate a PELD alternative to accommodate this group of patients in the future MELD-based ELAS.

In order to prepare the transplant centers and to collect MELD/PELD related data, ENIS offers since May 28, 2005 the possibility to collect these data for patients on the liver waiting list. Data entry is:
- mandatory for all new registrations for a first organ transplantation (liver);
- optional for all re-registrations, patients awaiting multiple organ transplantation (e.g. liver + other organ) and all patients registered before May 28, 2005 and still on the waiting list

NB PELD will not be implemented in the future MELD-based ELAS. Yet it was decided to collect PELD and MELD data for patients younger than 12 years.

The MELD/PELD user manual with a detailed description of the registration module can be found in the Library of the Member Site at www.eurotransplant.org.

1 Voluntary recertification

As both scores reflect a continuous scale, i.e. disease progression after registration on the waiting list, all patients should be updated in a regular fashion with the interval based on their last score.

In the current test phase starting May 28, 2005, data entry is only mandatory at the time of initial registration of the recipient for his/her first organ transplant, i.e. on the liver
waiting list. After the initial registration, centers can now voluntarily update their patients while on the waiting list by entering new lab data.

It is therefore that we encourage you to follow the recertification schedule. Firstly, if you follow the schedule, you and your colleagues can get used to the procedure on the level of your administration. Secondly, the more data you enter the better the analyses that can be performed from Eurotransplant data.

**MELD recertification schedule**

<table>
<thead>
<tr>
<th>MELD score</th>
<th>Status recertification every</th>
<th>Lab values must not be older than</th>
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</thead>
<tbody>
<tr>
<td>≥25</td>
<td>7 days</td>
<td>2 days</td>
</tr>
<tr>
<td>≥19 and &lt;25</td>
<td>1 month</td>
<td>7 days</td>
</tr>
<tr>
<td>≥11 and &lt;19</td>
<td>3 months</td>
<td>14 days</td>
</tr>
<tr>
<td>&lt;11 and &gt;0</td>
<td>12 months</td>
<td>30 days</td>
</tr>
</tbody>
</table>

**PELD recertification schedule**

<table>
<thead>
<tr>
<th>PELD score</th>
<th>Status recertification every</th>
<th>Lab values must not be older than</th>
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<tbody>
<tr>
<td>≥25</td>
<td>14 days</td>
<td>3 days</td>
</tr>
<tr>
<td>≥19 and &lt;25</td>
<td>1 month</td>
<td>7 days</td>
</tr>
<tr>
<td>≥11 and &lt;19</td>
<td>3 months</td>
<td>14 days</td>
</tr>
<tr>
<td>&lt;11</td>
<td>12 months</td>
<td>30 days</td>
</tr>
</tbody>
</table>

NB After implementation of MELD in liver allocation, probably in 2006, recertification will be mandatory and patients that have not been recertified according-ly will then be downgraded to their last lower score.

2 Data entry

Please remember that MELD is calculated for recipients 12 years of age or older, whereas PELD is calculated for recipients younger than 12 years of age.

You can enter multiple questionnaires per transplant candidate (see recertification) or create new questionnaires for new or existing transplant candidates.

After entering all mandatory items the MELD/PELD score is calculated and appears in a field in the questionnaire.

NB The calculated score is not yet used in liver allocation.

3 Data history

By clicking in your questionnaire all previously calculated MELD/PELD scores for this patient are shown in a pop-up window. This window cannot be printed. For a printed version refer to chapter 6 Report of this manual.

While in the questionnaire you can view all previously entered data for each separate laboratory parameter. Place the cursor in the corresponding parameter field and click and a pop-up window appears.

6 Report

Two reports are available in the module. One contains the data from the active questionnaire, another gives an overview for all historical questionnaires.
Living organ donation: Law to remain in place
By Richter-Kuhlmann, Eva A.
Deutsches Ärzteblatt (Journal of the German Medical Association) 102, Issue 12 dated 25.03.2005, Page A-792 / B-668 / C-624

Commission recommends only slight modifications. There should be improvements to the protection afforded to living organ donors and to recipients, but the German Transplantation Act does not need fundamental modification. This is according to the recommendations of the Commission of Inquiry, “Law and Ethics in Modern Medicine”, made in its interim report presented to the Bundestag President Wolfgang Thierse on 17 March. A majority of the commission’s members voted to continue to outlaw anonymous living donation or pool models for organ swapping. Crossover donation should only be possible in the case of a particularly close relationship between donor and recipient. The principle of subsidiarity should continue to apply unchanged. In other words, removal of organs from living donors is only permissible if no organ is available from a cadaveric donation (see “Assistance for relatives” elsewhere in this magazine). Unified living organ donation commissions should be set up in the federal states along with an independent patients’ attorney, a register for living donations and legal financial and insurance safeguards for living donors. The commission was decisive in its rejection of demands for additional incentive schemes. Trade in organs should continue to be a criminal offence.

Israels Flock to China for Death Row Organ Transplants
Naharnet, Beirut, updated 11 June 2005

Dozens of Israelis are flocking to China every month for bargain basement transplant operations using organs retrieved from executed Chinese prisoners, an Israeli newspaper has reported. Some 30 Israelis, desperate for a life-saving transplant donor, go to China every month for transplants, mainly for kidneys, said the Maariv newspaper.

“It costs 30 percent less than in Colombia, the transplanted organs are excellent quality and the follow-up medical care among the best in the world,” one Israeli official was quoted as saying by the newspaper.

“If I had never had my kidney transplant in China, I would already be dead... A Chinese sentenced to death saved my life,” Abraham Sasson, from the Israeli Red Sea resort of Eilat told Maariv after a recent trip to China.

Swisstransplant and EOEO
By: Diane Moretti, National Transplant Coordinator
Bulletin SwissTransplant, No. 28, 2005-06-30

Swisstransplant has been a member of the European Organ Exchange Organisations (EOEO) since seven years; it is through this organisation that we have imported many organs over the past years.

The EOEO is a group of organisations from within a number of countries in Europe who share common quality standards in organ donation and who agree to offer organs, for which no recipient can be found, to patients in other European countries in order to avoid the waste of precious organs and to safeguard human life. So far the active members are from France, Eurotransplant, Italy, Portugal, Spain, Swisstransplant, Scandiatransplant and United Kingdom.

The participating organisations have functions and responsibilities of a national transplant organisation. In addition, the countries of this organisation must meet the standard of the Council of Europe regarding transplantation, in particular as far as safety and ethics.

The overall purpose of the group is confined to agreeing harmonious relationships and arrangements that will encourage the safe, expedient offer of organs not required in the originating country to patients in other countries in the EOEO group. They regularly review current working arrangements and agreeing amendments as necessary and proposing the need for new or different standards.

To be a member of EOEO the country must have law on consent for donation and an official waiting list for recipients and clear allocation rules with the control of procurement and priority of internal use of organs before exportation.

This year’s annual meeting was held in Warsaw, Poland, Conrad Müller, Director of Swisstransplant and Diane Moretti, National Transplant Coordinator were present. Swisstransplant will host the upcoming meeting in 2007 and welcomes the members of EOEO.
Abstracts

Long-term follow-up of double kidney transplantation using a score for evaluation of marginal donors*.
By Heiner H. Wolters1, Daniel Palmes1, Stefan Heidenreich1, Christian August2, Jens Brockmann1, Norbert Senninger1 and Karl-Heinz Dietl4

1. Department of General Surgery, Muenster University Hospital, Germany.
2. Department of Internal Medicine D/Nephrology, Muenster University Hospital, Muenster; Germany.
3. Institute of Pathology, Muenster University Hospital Muenster, Germany.
4. Department of General Surgery, Raphaelsklinik Muenster – Akademisches Lehrkrankenhaus of Muenster University Hospital, Muenster, Germany.

To face the problem of organ shortage, marginal grafts from 36 donors which had been refused for single transplantation were used for double-kidney transplantation (D-KTX).

The reasons for rejection of these kidneys for single transplantation in other centers in the Eurotransplant community were various. In some cases, especially in the early period of our program, it was age only which stopped others from transplantation, in other cases, it was the rising creatinine before harvesting the organs. As long as an internationally accepted definition of “marginal donor” does not exist, donors are defined as “marginal donors” whenever kidneys are refused by other centers because of supposed impaired kidney function as a result of donor age, creatinine, hypotensive periods to harvest and others.

The residual kidney function was evaluated by the Muenster double kidney score. In a 5-year period kidneys from 57 marginal donors were transferred to our center. According to the Muenster double kidney score, the kidneys were distributed to single, double or refusal of transplantation. Sixteen male and 20 female donors were used for D-KTX (70+/-9.3 years, range 53-86). Thirty-six recipients (23 male, 13 female; 60.5+/-6.9 years) were double-grafted within a mean cold ischemic time of 19.3+/-3.4 h. Immunosuppression varied according to human leukocyte antigen (HLA)-mismatch. Graft and patient survival was observed up to 5 years. Initial graft function rate was 69%. Two recipients had a primary nonfunction (5.5%) and nine recipients suffered from delayed graft function (DGF; 25%). One-, 2-, 3-year creatinine values were 1.6 +/- 0.5, 1.9 +/- 0.6 and 2.2 +/- 0.7 mg/dl, respectively. One-, 2-, 3-, 4- and 5-year function rate was 93.7%, 93.5%, 81.8%, 76.4% and 55%, respectively (n = 32, 31, 22, 17 and 9). Acute rejection rate was 19%. 4 grafts were lost to chronic rejection (months 22, 25, 28, 48). Six (16%) died in long-term follow-up because of pneumonia (n = 2), carcinoma of the lung (n = 1), cardial complications (n = 2) and multiorgan failure (n = 1). D-KTX is a safe way to face the problem of organ shortage. However, a score for preoperative evaluation of marginal kidneys for single, dual or refusal of transplantation is essential.

In memoriam Professor Mario Caetano Pereira

Dear friends:

I feel sad to tell you that our dear friend Professor Mario Caetano Pereira, National Coordinator from 1994 till 2004, has died last Tuesday morning.

The Portuguese Organization of Transplantation (OPT) and all committed with Donation and Transplantation fields in our Country lost the Colleague that have created and properly driven the projects of our Organization during this period.

Kind regards,

José Fernando Teixeira
(Ex) Assessor of the National Coordinator
**Transmission of Rabies Virus from an Organ Donor to Four Transplant Recipients**

*By Arjun Srinivasan MD, et al.*

In *N Engl J Med* 352;11, March 17, 2005

**Background.** In 2004, four recipients of kidneys, a liver, and an arterial segment from a common organ donor died of encephalitis of an unknown cause.

**Methods.** We reviewed the medical records of the organ donor and the recipients. Blood, cerebrospinal fluid, and tissues from the recipients were tested with a variety of assays and pathological stains for numerous causes of encephalitis. Samples from the recipients were also inoculated into mice.

**Results.** The organ donor had been healthy before having a subarachnoid hemorrhage that led to his death. Encephalitis developed in all four recipients within 30 days after transplantation and was accompanied by rapid neurologic deterioration characterized by agitation, delirium, seizures, respiratory failure, and coma. They died an average of 13 days after the onset of neurologic symptoms. Mice inoculated with samples from the affected patients became ill seven to eight days later, and electron microscopy of central nervous system (CNS) tissue demonstrated rhabdovirus particles. Rabies-specific immunohistochemical and direct fluorescence antibody staining demonstrated rabies virus in multiple tissues from all recipients. Antibodies against rabies virus were present in three of the four recipients and the donor. The donor had told others of being bitten by a bat.

**Conclusions.** This report documenting the transmission of rabies virus from an organ donor to multiple recipients underscores the challenges of preventing and detecting transmission of unusual pathogens through transplantation.

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**5-Year-Results of a Calcineurin Antagonist-Free Immunosuppression in Elderly Recipients of Renal Allografts from Elderly Cadaver Donors**

*By H. Arbogast, H. Hückelheim, J.N. Hoffman, W.D. Illner, M. Guba and W. Land*

University of Munich, Grosshadern, Germany

Baskent University Ankara, Turkey / Munich-Taufkirchen, Germany

In *Dialysis, Transplantation and Burn, Vol. 16; No. 2, Suppl. June 2005, page 34*

With the aim to improve the inferior outcomes in elderly recipients of kidneys from elderly cadaver donors, we applied and investigated a therapeutic regimen consisting of Calcineurin-inhibitor-free, mycophenolate mofetil (MMF) – based immunosuppressive induction/maintenance protocol. In this article, we report the long-term results of this clinical trial. 89 recipients (mean age: 63.8 y) of kidneys from cadaver donors (mean age: 66.8 y) were consecutively recruited for this 5-year, prospective, open, single centre, pilot trial. Induction therapy consisted of MMF and steroids in conjunction with a short course (4-10 days) of rabbit ATG. Maintenance treatment was performed with MMF/stereoids or MMF alone under strict therapeutic drug monitoring by aiming target MPA-through levels between 2 – 6 mg/mL. Cumulative 5-year patient and renal allograft survival was 87.69% and 69.81%, respectively. Acute rejection episodes occurred in 23.6% (21 patients). Long-term function of the old renal allografts proved to be satisfactory as reflected by serum Creatinine-values of 1.53 mg/dl and Urea-values of 57.9 mg/dl at 5 years. Application of a nephrotoxicity- and atherogenicity-free, MMF-based immunosuppressive induction/maintenance protocol in elderly recipient of kidneys from elderly cadaver donors leads to improved long-term outcomes which are comparable with data from young recipients who have received allografts from young cadaver donors.

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**Congratulations**

Communication of the University Klinik in Giessen, Germany

The kidney transplant team at the University of Giessen would like to announce the 500th kidney transplantation performed on May 10, 2005. The 18 year old recipient was the first child who got a donor heart in Giessen in June 1988 at the age of 2 years. The patient, who received the kidney of his father, shows an excellent graft function and feels very well.

We would like to thank all the members of the staff in Leiden for help and continuous support, the members of the Deutsche Stiftung Organtransplantation for their work in the field of organ donation, all the contributing members of the transplant community and last but not least our colleagues at the Giessen University, especially in the Departments of Surgery (Prof. Dr. W. Padberg), Immunology (Prof. Dr. G. Bein), Endocrinology (Prof Dr. R. Bretzel) and Nephrology (PD. Dr. H.W. Birk, Prof. Dr. R. Weimer).
The Board members were presented with several candidates for the positions of general- and medical director. After elaborative discussions, the two final candidates were chosen. Further negotiations with each of them will hopefully be finalized in the course of the month June 2005 which would enable each of them to start in the early fall of this year.

Next topic of discussion were the Annual Accounts 2004 which were approved by the Board.

The (re)-election of current and new Board members A as well as the (re)-election of the chairman of the Assembly were discussed. The members who are eligible for re-election will be asked whether they are willing to be nominated for another term.

The Board’s attention was drawn to an initiative by The Transplant Society to establish a Global Alliance for Transplantation (GAT). The Board is of the opinion that the initiative, which aims at standardization of world wide data collection, should be supported. This issue will again be discussed at the next Board meeting.

The continuation of the ET winter meeting in Fügen was also discussed. The Board members do understand Prof. Margreiter’s decision to resign from the organization of this meeting, but they are pleased that Prof. Laufer is prepared to continue the organization.

Reports of the ET Thoracic Advisory Committee (EThAC) and Kidney Advisory Committee (ETKAC) were discussed. The EThAC submitted proposals regarding equal AB0 blood group rules for thoracic organs in all ET countries (RThAC04.05 and RThAC06.05). The ETKAC furthermore discussed and introduced new rules for lung and heart/lung allocation (RThAC05.05). The ETKAC discussed inclusion in ENISi of a conversion model for translation from ICD-10 codes into EDTA codes. Pediatric allocation was again discussed, however still no decision was taken.

The problem of long waiting double listed non-resident patients had come closer to a solution. However, after the ETKAC meeting it appeared that in Belgium there is again no consensus on the supposed solution to give these patients the choice either to remain on the ET waiting list or to remain on the Italian waiting list. A clear point of view by the Belgian Transplant Council is still awaited.

The ETKAC furthermore concluded that ET should be ‘passive reluctant’ towards ‘traffic’ of patients, i.e. patients from one ET country on the waiting list of another ET country. This conclusion was supported by the Board.

Following two cases of hyperacute rejection of kidneys allocated to immunized ESP patients, the Board asked the ET Tissue Typing Advisory Committee to discuss this problem in its meeting and to come up with a proposal for change of the current rules.

The Board was informed that the ET Annual Report 2004 is ready to be printed.

<table>
<thead>
<tr>
<th>THORACIC ADVISORY COMMITTEE</th>
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<tr>
<td><strong>RThAC04.05</strong></td>
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<tr>
<td>Hearts should be allocated first to ET compatible (AB0-0 to AB0-0 and -B) patients and then to AB0 compatible (AB0-0 to AB0-0,-B,-A and -AB) patients.</td>
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<td><strong>RThAC05.05</strong></td>
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<tr>
<td>Lungs (and Heart-Lungs) should be allocated:</td>
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<td>first to International HU patients (access to foreign country list if negative HU balance and negative total balance)</td>
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<tr>
<td>then to National HU patients and International HU patients (access to foreign country list if negative total balance)</td>
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<td>then to National U patients (only in Germany)</td>
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<td>then to National Approved Combined Organ (ACO) patients</td>
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<td>then to National elective patients</td>
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<tr>
<td><strong>RThAC06.05</strong></td>
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<tr>
<td>Lungs (and Heart-Lungs) should be allocated first to ET compatible (AB0-0 to AB0-0 and -B) patients and then to AB0 compatible (AB0-0 to AB0-0,-B,-A and -AB) patients.</td>
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<th>FINANCIAL COMMITTEE</th>
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<tr>
<td><strong>RFC01.05</strong></td>
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<tr>
<td>The FC recommends the Board to approve the ET Annual Accounts 2004.</td>
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Only the three following reports of the Advisory Com- mittees were discussed by the Eurotransplant International Board on May 30, 2005 at the Eurotransplant office.

Report of the meeting of the Eurotransplant Thoracic Advisory Committee (EThAC)

Chairman: Prof. Dr. G. Laufer Secretary: Dr. J. Smits

The EThAC met on Tuesday, May 17, 2005

Members present: 10 + 1 director + 1 IT representative + 1 external advisor

Members absent: 3

A. ABO blood group rules for heart allocation

In order to improve the chances for patients with blood group ABO-B to receive a transplant in time and in order to improve the country imbalances the EThAC proposes to apply a two-tier ABO rule (RThAC04.05).

B. Discussion on country balance for lungs

In order to improve the chances for HU patients to receive a transplant in time, the EThAC formulated a new lung allocation scheme (RThAC05.05). Furthermore, the EThAC formulated new ABO blood rules for lung and heart-lung allocation (RThAC06.05).

C. Heart post-transplant follow-up database

The quality of the post-transplant database has deteriorated, one of the reasons is that data submission via the CITRIC meta-frame is not experienced as very user friendly. In order to facilitate the remote data entry by the centers and in order to keep up with new technologies the IT department of ET has created a web based data entry system for the purpose of collecting post-transplant data.

D. Progress report on establishment of clinical profiles for lung transplant candidates (MrQ)

The EThAC agreed on the principle of a mandatory collecting of data for the purpose of evaluating the benefit of the UNOS lung allocation score for patients on the ET waiting list.

During the next EThAC meeting the final list will be agreed upon.

E. Criteria for withdrawing the HU foreign approval status

The Dutch EThAC representative elaborated on two cases where a heart was lost due to mismanagement by the receiving center and therefore requested to establish criteria for withdrawing the HU foreign approval status. This issue will be further discussed in a next EThAC meeting.

F. Program for annual ET Heart & Lungs meeting

All EThAC members were invited to submit suggestions to the EThAC secretary.

G. Miscellaneous

The EThAC members were asked whether they want to receive future agenda’s and enclosures by e-mail. Although there was no consensus decision, as a trial, next meeting’s documents will be sent by e-mail and not by regular mail.

Report of the meeting of the Eurotransplant Kidney Advisory Committee (ETKAC)

Chairman: Dr. J. de Fijter Secretary: Dr. G. Persijn

The ETKAC met on Wednesday, May 11, 2005

Members present: 13 + 1 external advisor + 1 IT representative

Members absent: 3

A. Progress report on implementation of translation of ICD-10 into EDTA codes

The ETKAC was presented with a solution for twelve missing EDTA codes, which will now enable translation from ICD-10 codes into EDTA codes. A conversion module will be included in ENISi which will be implemented by the beginning of 2006. In order to avoid extra workload, the ETKAC has chosen to implement the conversion module as of the start of ENISi rather than to implement it now.

B. Update on immunized and retransplant ESP patients

In 2003, immunized and retransplant kidney patients ≥ 65 years were included in the ESP program, implementation of which rule was however withdrawn by the Netherlands in the course of 2004.

The ETKAC’s attention was now drawn to two cases in which kidneys of immunized ESP patients were acutely rejected. These cases occurred since no unacceptable antigens were taken into account and no immunologist was consulted. The lesson to be learned is that ESP kidneys should only be allocated to immunized and retransplant ESP patients after the donor HLA typing is known, after storage of unacceptable antigens in ENIS and involvement of the immunologist in the decision making process.

C. Progress report on long waiting Belgian non-resident patients from Italy

The ETKAC has again come some closer to a solution for the long waiting non-resident patients on the ET waiting list. The only Belgian center with double listed Italian patients has now accepted a Belgian Transplant Council and ET proposal to send these patients a letter in which they are offered the choice between remaining on the ET waiting or on the Italian waiting list.

D. Discussion on Dutch renal patients on the Belgian wait- ing list

The ET president’s question whether Dutch dialysis
patients who are transplanted in Belgium are counted as Belgian or Dutch patients for the national balance, led to an extensive discussion in the ETKAC. It appeared from the discussion that ‘traffic’ of patients, living near (but also far from) country borders, also takes place in the other ET countries. The only solution to counter this problem is the existence of a clear definition of a resident patient. The ETKAC concluded the discussion by the decision to await a Council of Europe report which is dealing with the establishment of a non-resident definition. For the time being, ET should be ‘passive reluctant’ in introducing solutions for this relative small number of patients. The ETKAC secretary added to the discussion that the situation also exists the other way around: a donor with e.g. the Dutch nationality is reported by e.g. a Belgian center and as a consequence counted as a Belgian donor (in 2004, three Dutch donors were reported by Belgian donor centers resulting in ten organ transplants).

E. Kidney allocation to pediatric recipients
The pediatric external advisor again plead to establish a young-for-young program. The ETKAC was again reluctant and again would first like some questions to be answered, such as exact number of pediatric patients on an active waiting list status, number of ex pediatric patients not yet transplanted, effect of mandatory exchange, effect of only matching on HLA-DR identity or compatibility. Furthermore, the ETKAC asked the EPAC to discuss prioritization of kidney allocation to pediatric kidney recipients above kidney-pancreas allocation to adults in case of ≤10 years donors. With regard to IT involvement, it was stated that establishment of a young-for-young program is possible but that increasing the number of points for children would the easiest and fastest solution. The ETKAC will discuss this topic at the next ETKAC meeting again.

F. Program annual ET kidney meeting (October 7, 2005)
The ETKAC agreed upon the following program:
- Update of tolerance protocol Kiel
- Analysis of five years ESP
- First results on newly to start machine perfusion trial (ORS)
- ETKAS update 1996 – 2005
- State of the art on Mannheim
dopamine study

The proposed lecturers will be or have already been invited.

G. Expansion of donor profiles
The ETKAC discussed and agreed upon the introduction of an expanded donor profile in order to optimize the allocation procedures for so-called ‘difficult-to-allocate’ organs.

H. Miscellaneous
The following issues were briefly addressed:
- Participation of foreign patients in the Dutch crossover program.
- Possibility for a study on the transplant survival influence of the time interval between brain death diagnosis and kidney explantation in relation to ischemia time.
- The TTAC will prepare a proposal to double the points for patients with an homozygous HLA phenotype.

Report of the meeting of the Eurotransplant Financial Committee (FC)
Chairman: Prof.Dr. A. van Montfort
Secretaries: Dr. B. Cohen / W. van Zwet

The FC met on Wednesday, April 27, 2005
Members present: 6
Members absent: 0

The Annual Accounts for the year 2004 have been discussed by the FC. The exploitation balance for the year amounts to a positive balance of € 5.866. The financial effects of the change in the management structure as of September 1, 2005 have been fully provided for in the Annual Accounts. Besides some minor changes, the FC recommends approval of the Annual Accounts 2004 (RFC01.05).

The FC was given an update of the status of the discussions regarding the 2005 registration tariff. The 2005 registration fee has been approved by the German health insurance companies (Krankenkassen) with only minor adaptation. In addition, the Krankenkassen agreed to increase the number of guaranteed registrations.

The discussions with the Krankenkassen regarding the implementation of MELD are still ongoing. It is expected that the Krankenkassen will attempt to delay the implementation for financial reasons.

The level of the tariff for the organ exchange with Germany has, without success so far, been under discussion with the DSO since 2003. Upon instigation of the Überwachungs Kommission of the Bundesärztekammer, the issue has to be discussed with the Krankenkassen. This will take place by the end of May 2005. ET is of the opinion that the German tariff, which has been in effect without change since 1995, needs to be adapted to get in line with the tariffs charged by Belgium, Austria and Slovenia (the German tariff is approximately 35% lower).

Please note:
The following reports of the Advisory Committees have not yet been discussed by the Eurotransplant International Board and will be discussed at the next Board meeting on October 6, 2005.

Report of the meeting of the Eurotransplant Liver Advisory Committee (ELAC)
Chairman: Prof.Dr. J. Hauss
Secretary: Dr. T. Gerling

The ELAC met on Tuesday, March 8, 2005
Members present: 8 + 1 IT representative + 1 Director
Members absent: 2 + 1 external advisor

A. Evaluation of T2 priority
After the implementation of the T2 priority on September 17, 2003 the percentage of transplantations performed in
T2 patients in the first year after implementation remained stable in Austria, the Netherlands and Slovenia. Yet, numbers rose in Belgium (54% after vs. 33% before implementation) and Germany (52% vs. 23%). The representatives from these countries confirm that this increase is due to the fact that the patient population transplanted ever since the change in T2 priority has changed. Under the current rule centers in these two countries register patients on the waiting list who would not have been listed under the old rules. Another reason is that hepatologists now seem more confident to transplant sicker patients as the results are good. Austria, the Netherlands and Slovenia report no change in habit regarding the registration of patients in T2. Following an intensive discussion all members agree that the implementation of the T2 priority has achieved its primary goals to place the sickest patients on top of the waiting list, which was implemented as a first step towards a MELD-based liver allocation. After the first year of implementation this measure has already led to a reduced overall mortality, and particularly in the T2 group. All ELAC members agree not to change the current T2 criteria.

Nonetheless, the group of recipients with a hepatocellular carcinoma (HCC) have not yet been harboured well in the ET liver allocation system ELAS. All ELAC members agree that some of these patients should be eligible for T2 as they show good post-transplantation results when selected carefully. Patients with a stage-T2 HCC currently receive bonus points in UNOS’ MELD-based liver allocation. In ET this small group of patients accounts for about 7% of all patients on the ET liver waiting list. A proposal previously discussed within the Belgian Liver Intestine Committee (BLIC) is presented. According to the proposal, HCC patients would be eligible for T2 after one year actively on the waiting list with a proven history of HCC.

B. Progress report on implementation of the MELD score
Two issues are discussed before further planning of the MELD score can take place. The first is the PELD alternative for the group of recipients younger than 12 years. The ad hoc working group is preparing a consensus meeting to be held at ET in April or May 2005. Results will be presented to the ELAC shortly after the consensus meeting for final approval. The second issue is the financing of the new MELD-based liver allocation in ET. The status of negotiations with the German Health Council (BfK) and the German health care insurers are presented. The ELAC advises to start negotiations with the other countries accordingly. It is again confirmed that the implementation of MELD will not change existing allocation rules as e.g. in Austria and Slovenia. It is pointed out that, similar to the current urgency classification, one uniform urgency system is needed in ET to be able to allocate livers on the international waiting list once a liver cannot be allocated in one of the ET countries.

C. Intestine progress report
As intestine allocation falls under the auspices of the ELAC, an update on intestine transplantation since the implementation of the intestine allocation rules (RLAC03.03) in 2003 is presented. It is concluded that intestine allocation and transplantation still suffers from several growing pains. Among these are the lack of experienced surgeons for both explantation and transplantation, the lack of centers performing intestine transplantsations and a still very small waiting list fluctuating between 10 and 15 patients, of which 60–80% are NT. It was in this respect that in July 2004 a pan-European intestine waiting list was initiated. Offers for intestines are shared between the Etablissement Francais de Greffes (EfG), Swisstransplant, OCATT (Barcelona), ONITp (Bologna) and ET. Despite this effort, and mostly due to the expected long cold ischemia time of the graft, intestines have so far not been exchanged between these countries. Nonetheless, it is felt that this initiative should be continued to help overcome some of the growing pains to help establish intestine transplantation.

D. Liver allocation from extended criteria donors (ECD)
The issue of ECD liver organs and their allocation in ET is discussed. Among others, the chairman of the ELAC, who is also the chairman of the German Transplantation Society (DTG), is frequently confronted with questions regarding the modality of liver allocation in such cases in ET. This discussion was also fuelled by the presentation of Malagà in Føgen in January 2005 where he gave the impression that there existed an ‘organ rescue club’ which allowed few centers in ET to receive such ECD livers. The secretary explains that such ‘club’ does not exist, as ECD organs are potentially offered to all centers in ET. The modality of the so-called rescue allocation (by definition a center offer) applies to all organs and all decisions as to when and where ECD organs are offered through rescue allocation are taken by ET medical staff. Many factors have to be taken into account in the decision making process, e.g. whether the liver still has to be procured or has yet been explanted, the duration of cold storage (CIP), organ quality (e.g. age, virology, histology), the location of an organ (shipped to center outside donor hospital/still in donor hospital), logistics (available modes of transport, weather etc.). Irrespective of all these factors centers will first be chosen trying to follow the match list as closely as possible. Only if then no suitable recipient is found or no time is left, regional centers will be chosen. Furthermore, offers can also be done in a competitive fashion, i.e. more than one center receives an offer at the same time and the first to accept is allocated the organ.

Report of the telephone conference of the Eurotransplant Pancreas Advisory Committee (EPAC)
Chairman: Prof. Dr. J. van Hooff
Secretaries: Dr. M. Slot / Mrs. V. Diepeveen

The EPAC met on Tuesday, May 17, 2005 in a telephone conference
Members present: 8 + 1 director + 1 IT representative
Members absent: 1

The EPAC members said goodbye to Klasien Dijkstra as EPAC secretary and welcomed Małgorzata Slot as her successor. Dijkstra was thanked for all the work she did for the EPAC.
A. Progress report on implementation of recommendations
The EPAC was informed that the BÄK approved RPAC01.04 (transplanting another patient in case of insufficient islet yield) and RPAC03.04 (assigning the SU status at the time a next injection for islet patients is needed). However, written confirmation has not been received yet. Although one of the German representatives has the impression that harmonization between ET and BÄK allocation rules is moving slightly forward, ET still has to continue sending reminders to the BÄK to make sure that ET recommendations are discussed.

B. Update on long waiting islet patients
In order to counter the problem of very long waiting islet patients, in analogy to the thoracic organ and liver situation, the EPAC secretary suggested to maximize the waiting time to three years. The EPAC was however of the opinion that first the average waiting time of this category of patients should be investigated. Since only a very small number of patients is involved, the EPAC concluded that the waiting time regulations should not be changed for the time being.

C. Establishment of HIT program for highly immunized and retransplant pancreas patients
Prof. Claas had submitted two proposals (establishment of AM or HIT program) to solve the problem of highly immunized and retransplant pancreas patients, the latter proposal of which was already chosen during the previous EPAC meeting in November 2004. The EPAC members were now asked to finally approve establishment of a HIT program for this category of patients. The EPAC indeed agreed with the proposal which will now be developed by the EPAC secretary and the ETRL representative.

D. Requirements for organ registration screens in ENISi
Several improvements for the pancreas recipient registration were discussed. The EPAC agreed with the suggested changes.

E. Proposal for prospective analysis of PAncreas Suitability Score
The EPAC secretary was asked to evaluate the possibilities for a prospective trial testing the usability of the PAncreas Suitability Score (PASS) system which was developed by Prof. Schareck. ET’s biostatistician Dr. JMA Smits was asked for her comments on the proposed PASS. After discussion, it was decided that a retrospective study is needed to study the different factors and their categories in a large group of donors. Several factors, especially post-transplant factors, may be added in the PASS. Four expert surgeons will make a proposal. Furthermore, follow-up data is not complete. Prof. Schareck will make an e-mail proposal and the PASS will be further discussed at the next meeting.

F. Program of the annual ET pancreas meeting, October 2005
Several proposals were made, but no final decision was taken yet.

G. Expansion of donor profiles
The EPAC discussed and agreed upon the introduction of an expanded donor profile in order to optimize the allocation procedures for so-called ‘difficult-to-allocate organs’.

H. Miscellaneous
The following topics were briefly discussed:
1. Non-residents and Approved Combined Organ (ACO) status; the EPAC postponed the discussion on this issue until more clarity on the general non-resident discussion can be given by the Board.
2. SU status for islet retransplantation; in view of the fact that the second and third islet injection is given after 4 to 6 weeks after the preceding injection, the EPAC concluded that the period to be on SU should be maximized to 4 months.
3. The ETKAC requested the EPAC to discuss prioritization of kidney allocation to pediatric kidney recipients above kidney+pancreas allocation to adults in case of ≤10 years donors. The EPAC is however of the opinion that weight of the donor may be more important than age. This issue will be further discussed at the next EPAC meeting.
4. Some EPAC members are interested in pancreas procurement for islet and whole organ transplantation using the double layer method; The EPAC was asked permission to discuss with Prof. Ploeg the possibilities of combining the newly to start ORS trial with the investigation of possibilities to implement the two layer method. Permission was granted. The issue will be further discussed at the next EPAC meeting.

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Report of the meeting of the Eurotransplant Organ Procurement Committee (OPC)

Chairman: Prof.Dr. J-P. Squifflet
Secretaries: Dr. J. de Boer / Mrs. V. Diepeveen

The OPC met on Thursday, May 12, 2005
Members present: 10
Members absent: 4

In absence of the OPC chairman, Prof. Bechstein, the vice-chairman, Prof. Squifflet, chairs the meeting.

A. Criteria for compromised donors
The OPC is informed that representatives of the Deutsche Stiftung Organtransplantation (DSO) and ET staff members, the so-called Medizinische Kontaktgruppe (MKG) meet regularly. Regarding compromised donors, the MKG formulated guidelines which should be regarded as recommended procedures without legal binding. These guidelines were approved by the DSO and ET management. These guidelines concern recommendations regarding donation/allocation from donors <5 years, donors with malignant diseases and donors with known (IV) drug abuse and/or positive virology. The OPC regards these recommendations as a practicable tool for the time being and a step forward in the good direction to establishment of criteria for compromised donors.

The problem of a patient who is in a certain country not supposed to be reported as an organ donor since he has a contra-indication in this country (e.g. virology, tumor,
The 3rd issue that is addressed regarding compromised donors concerns a German regulation to expand the donor profiles for all patients on the waiting list. The reason behind this idea is to optimize the allocation procedures for compromised donors. The items to be included in the donor profiles of all patients concern virology, meningitis, tumors, IV drug abuse whereas for liver patients some additional items should be put in the donor profile. For Germany this regulation will be implemented by September 1, 2005. The question now is whether this regulation should also be implemented for the other ET countries.

The OPC members are of the opinion that this should not be decided by the ET Advisory Committees but by the national transplant societies.

B. Revision of ET quality forms
The OPC was presented with a proposal for classification of information regarding the abdominal quality forms. It was agreed upon that all OPC members will carefully read the forms and send their comments and suggestions to the OPC secretary within 20 working days.

The OPC received a proposal to create a checkbox on the quality form that should be marked in case of no problems. In case problems are faced, the whole form should be filled out.

This suggestion was not supported by all OPC members since they are of the opinion that the aim of quality forms is to collect data both on procurement and organ quality. These data can only be collected if the forms are filled out completely in any case.

C. Certification of transplant coordinators (TC’s)
One of the questions to be answered after the previous OPC meeting was with what intention the ET Directors put forward the proposal for certification of TC’s. The answer is that it is not the intention to set criteria for individual TC’s but that the TC’s employment institutions submit a declaration that their acting TC’s are certified.

From the OPC discussion it becomes clear that the working systems regarding TC certification differ from country to country. Moreover, in some ET countries there are several types of TC’s.

It is felt by the OPC that if an ET certification system for TC’s should be established, first a task description and a profile should be made, which is considered not to be the OPC’s competence. The OPC is of the opinion that as long as national transplant centers accept their TC’s, that there is no objection.

D. Donor screening with regard to rare transmittable diseases
This topic was put on the agenda following a case of rabies transmission via solid organ transplantation.

It was pointed out that for rabies no testing method is available and that the risk for transmission of rabies must be accepted since the chance for transmission is very, very small. With regard to screening for rare transmittable diseases in general, the financial consequences of testing methods in relation to the occurrence of rare transmittable diseases should be taken into account. Another issue that should be considered is the timeframe between testing results and donor procedure which will in most cases be too long, resulting in a loss of donors.

The OPC members conclude that a certain risk should be accepted. It should be included in the ET manual that ET cannot give any guarantee of non-transmission and that the physician in charge of the recipient is always responsible for accepting an organ.

E. Program of the annual ET organ procurement meeting
The OPC decided on the following program:

- Transmission of rare diseases Prof.Dr. G. Kirste / DSO
- Conditioning of the donor Prof.Dr. J. van der Hoeven, Nijmegen
- Donor genotype study N.N.
Calendar of Events

IPTA 3RD WORLD CONGRESS ON PEDIATRIC TRANSPLANTATION
August 6 – 9, 2005
Innsbruck, Austria
For information: International Pediatric Transplant Association
15000 Commerce Parkway, Suite C
Mt. Laurel, NJ 08054 USA
tel.: +1 856 439 0500
fax: +1 856 439 0525
e-mail: IPTA@ahint.com
website: www.IPTAonline.org

16TH EUROPEAN CONGRESS OF IMMUNOLOGY
1ST JOINT MEETING OF EUROPEAN NATIONAL SOCIETIES OF IMMUNOLOGY
6 – 9 September, 2005
Paris, France
For information: ECI 2006
12 rue de la Croix-Faubin
75011 Paris
France
e-mail : eci2006@colloquium.fr
website : www.eci-paris2006.com

8TH INTERNATIONAL XENOTRANSPLANTATION CONGRESS
2ND INTERNATIONAL SYMPOSIUM ON ABO INCOMPATIBILITY IN TRANSPLANTATION
September 10 – 14, 2005
Göteborg, Sweden
For information: Inspiro Event
Kastellgatan 1
413 07 Göteborg
Sweden
Tel.: +46 31 136 504
Fax: +46 31 137 504
e-mail: ixa2005@inspiroevent.se
website: www.Ixa2005.com

IX CONGRESS OF THE MEXICAN SOCIETY OF TRANSPLANT
XIX CONGRESS OF THE LATIN AMERICAN AND CARIBBEAN SOCIETY OF TRANSPLANT
October 11 – 15, 2005
Cancún, Mexico
For information: Sociedad Latinoamérica y del Caribe de Trasplantes
tel.: +52 55 56 27 69 00
fax: +52 55 54 40 48 20
e-mail: slact@aol.com
website: www.stalyc.org

12TH CONGRESS OF THE EUROPEAN SOCIETY FOR ORGAN TRANSPLANTATION (ESOT)
14TH CONGRESS OF THE EUROPEAN TRANSPLANT COORDINATORS ORGANIZATION (ETCO)
15 -19 October, 2005
Geneva, Switzerland
For information: MCI Congress
Rue de Lyon 75
PO Box 502
1211 Geneva 13
Switzerland
tel.: +41 22 33 99 626
fax: +41 22 33 99 621
e-mail: esot2005@mci-group.com
website: www.esot2005.org

8TH CONGRESS OF THE ISODP (INTERNATIONAL SOCIETY FOR ORGAN DONATION AND PROCUREMENT)
5TH CONGRESS OF THE ITCS (INTERNATIONAL TRANSPLANT COORDINATORS SOCIETY)
December 3 – 7, 2005
Gramado, RS, Brazil
For information: Congress secretariat VJS
Rua Vieira de Castro, 150 / 501
CEP 90040-320 – Santana
Porto Alegre – RS – Brazil
tel.: +55 51 3330 1134
fax: +55 51 3301134
e-mail: isodp2005@vjs.com.br
website: www.isodp2005.com.br
This year there are 3 reasons to attend, particularly the Assembly and the Presidential Symposium:

- we will say goodbye to our directors dr. Bernard Cohen and dr. Guido Persijn
- the presidency of Eurotransplant will be passed on by prof. dr. Yves Vanrenterghem to dr. Bruno Meiser
- you can get to know our future directors dr. Arie Oosterlee, dr. Axel Rahmel and Wim van Zwet

Join us for this special meeting at a special location:

Hotels van Oranje, situated directly at the beach of Noordwijk.

Registration is possible online at www.eurotransplant.nl, or call us for registration forms.
The 2005 Eurotransplant annual Meeting will take place on October 6 - 7, 2005.