Introduction

Since last newsletter many things happened. For one thing it turned autumn. This is the season of harvesting, leaves turning and spiders diligently networking webs everyday.

The autumn season has more or less the same meaning for Eurotransplant. Interesting papers and presentations were harvested during the annual ET meeting, the General Assembly and the Presidential Symposium. ET members showing new colors on the dancefloor during the party and members networking with colleagues of the same or a neighbouring profession in the donation-transplantation chain.

These meetings mentioned above, were very well attended by all sections and subgroups of professionals involved in organ transplantation. Together they form a giant web of professional communities and member states. Since its start, Eurotransplant was all about exchanging ideas and experiences. Looking at how it is now, it still is.

The Eurotransplant network communicates with other networks, always present at the ET meeting with one or more representatives: like for instance the Global Alliance for Transplantation, the Croatian Transplant Community, organizations like CTS, ELTR, the Hungarian Ministry but also UK- and Scandia Transplant.

For me, one of the constructive elements of being part of Eurotransplant is that it serves a need for networking. Being among peers is stimulating: talking the same language & having fun together, i.e. sharing the same sense of humor. Networking is professionally essential: Sharing experiences and learning of new developments is an absolute necessity for professional growth. So my wish for you is: work the ET network and have fun in the process!

Arie Oosterlee
Director
### PRELIMINARY MONTHLY STATISTICS EUROTRANSPLANT JANUARY 01 - OCTOBER 31

#### NUMBER OF POST-MORTEM ORGANS USED FOR TRANSPLANTATION

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Calendar of Events

BRITISH TRANSPLANT SOCIETY 10TH ANNUAL CONGRESS
Manchester – United Kingdom
28 – 30 March 2007
For information: British Transplantation Society
Mrs. Sally Ros
Association House
South Park Road
Macclesfield, Cheshire, SK11 6SH
United Kingdom
Tel.: +44 1625 504 060
E-mail: sally@resourcesforassociations.co.uk
Website: www.bts2007.org.uk

THE AMERICAN TRANSPLANT CONGRESS 2007
San Francisco, CA, USA
May 5 – 9, 2007
For information:
American Transplant Congress (ATC)
Attn: Pam Ballinger
15000 Commerce Parkway, Suite C
Mt. Laurel, NJ 08054 USA
Tel.: +1 856 439 9986
Fax: +1 856 439 9982
E-mail: atc@ahint.com
Website: www.atcmeeting.org/

INITIATING A EUROPEAN PLATFORM ORGAN TRANSPLANTATION: ETHICAL, LEGAL AND PSYCHOLOGICAL ASPECTS
Towards a common European policy
Rotterdam, The Netherlands
April 1 – 4, 2007
For information: Secretariat Organizing Committee
Erasmus MC
Ms. Ilona van der Lee (D 408)
P.O. Box 2040
3000 ca Rotterdam
The Netherlands
Tel.: +31 10 463 46 07
Fax: +31 10 436 63 72
E-mail: secretariat@elpat.eu
Website: www.elpat.eu

13TH CONGRESS OF THE EUROPEAN SOCIETY FOR ORGAN TRANSPLANTATION (ESOT)
Prague, Czech Republic
September 29 – October 3, 2007
For information: Congress Secretariat:
Guarant International
Opletalova 22
110 00 Prague 1
Czech Republic
Tel.: +420 284 001 444
Fax: +420 284 001 448
E-mail: esot2007@guarant.cz
Website: www.esot2007.cz

27TH ISHLT ANNUAL MEETING AND SCIENTIFIC SESSIONS
San Francisco, USA
April 25 – 26, 2007
For information: ISHLT
Lisa Edwards, Director of Meetings
14673 Midway Road, Suite 200
Addison, TX 75001 - U.S.A.
Tel.: +1 972 490 9495
Fax: +1 972 490 9499
E-mail: lisa.edwards@ishlt.org
Website: www.ishlt.org

10TH ANNUAL CONGRESS
San Francisco – USA
November 11 – 14, 2007
For information: Mrs. Teresa Daly
E-mail: tdaly@giftoflifeinstitute.org
Website: www.isodp2007.org

ORGAN DONATION CONGRESS, 9TH ISODP AND 6TH ITCS
Philadelphia PA, USA
November 11 – 14, 2007
For information: Mrs. Teresa Daly
E-mail: tdaly@giftoflifeinstitute.org
Website: www.isodp2007.org
Presidential address, ET Meeting 2006

Highlights of the past year, plans for the next year

By Dr. Bruno Meiser

Eurotransplant

118.5 million people

ET – Winter Meeting Fügen, Jan 25–27, 2006

Winter Meeting 2007: Fügen, January 24–26

CCH: Bus mit Ärzten rammt Tiefgarage

Eurotransplant

118.5 million people
2006–2008: Councilor of The Transplantation Society
ET Representative, Global Alliance for Transplantation
Vice-Chair, GAT


6th anniversary of the cooperation Slovenia/Eurotransplant
5th Anniversary Slovenia-Transplant
First Meeting of the Slovenian Transplant Association
May 25, 2006

Negotiations for a cooperation agreement with Hungary

Welcome to the Eurotransplant International Foundation!

Kooperation agreement with Croatia

Zagreb 26.05.2006

118,5 million people

123 million people

118,5 million people
Visit of the Board of the Bundesärztekammer

Visit of the Board of the Bundesärztekammer

Please feel free to come over and visit the ET offices!

Number of visitors to the Eurotransplant website

October 2005 - October 2006

www.eurotransplant.nl
Verena Diepeveen-Huijsman, secretary of the Board

Wednesday, October 4, 2006

The Board welcomed Mrs. Mirela Bušić who is the Croatian observer in the Board. Since the start of the cooperation with the Republic of Croatia, already four livers were transplanted in Croatia. It is expected that the Republic of Croatia will become a full member of ET by next year.

The Board said goodbye to Prof. Hans van Hooff who joined the Board since 1994 and thanked him very much for all he did for ET over all these years.

Good progress is being made in achieving a cooperation agreement with Hungary. Negotiations will be continued aiming at starting the cooperation in 2007.

The Eurotransplant budget proposal 2007 was accepted. The budget proposal includes a number of new items being the introduction of MELD, the introduction of electronic donor reporting in all ET-countries (currently only Germany and the Netherlands use electronic data reporting) and the introduction of a number of structural and organizational improvements of the allocation process. The concept of a country specific mark-up to the base registration fee has been introduced.

The Board was informed that good progress in the following fields is being made regarding the development of a follow-up registry:

• contact with CTS and ELTR regarding data exchange;
• adaptation of the ET datawarehouse;
• feed-back to centers.

The winner of the 2006 Henk Schippers Young Investigators award is Dr. Peter Horn from the Medizinische Hochschule, Institut für Transfusionsmedizin, Hannover, Germany.

The Board discussed reports of two telephone conferences of the ET Liver Intestine Advisory Committee (ELIAC). Both conferences were mainly dedicated to the implementation of the MELD score which is expected to take place by December 2006. The ELIAC submitted a revised recommendation to the Board regarding assigning the T2 status to patients with hepatocellular carcinoma. RLAC02.05 revised was accepted by the Board.

The Board also discussed and approved a rephrased recommendation by the Ethics Committee dealing with listing of non-resident patients (REC04.06 rephrased).

In order to formalize and standardize current twinning agreements in ET, the directors prepared three models for twinning agreements:

A. transplantation start-up and training program;
B. transplantation support program;
C. delegated responsibility for a specific transplantation program.

All three models were accepted by the Board.

Since over the years many things have changed in ET, among others institution of national legislation and national deviation on allocation rules, a delay in the decision making process has occurred. The Board discussed ways how to speed up the internal as well as the external decision making process in ET.

Another issue of discussion in the Board were the future perspectives of ET and its community. The discussion was concluded by the decision to organize a conference with representatives of all national authorities in ET. The ministers of health resp. their representatives will be invited to this conference which will be aiming at discussing ways how to strengthen ET’s position in several fields:

1. Improvement of the transparency and quality of ET’s services;
2. Investigation of possibilities to increase ET’s donor pool;
3. Acceleration of the development & decision making process of new allocation rules;
4. Enhancement of ET’s legislative and political position.

Next year, ET will celebrate its 40th anniversary. Several suggestions for the celebration were discussed and will be announced in the course of 2007.

Friday, October 6, 2006

The Board congratulated Prof. Günther Laufer from Innsbruck, Austria and Dr. Ioannis Mytilineos from Ulm, Germany with their re-elections as Board members A in the thoracic and tissue typing sections respectively. Prof. Rutger Ploeg from Groningen, the Netherlands was welcomed in the Board as the new member A in the kidney section.

The ET annual users meetings as well as the Presidential Symposium/Assembly were evaluated. All meetings were well attended. Most presentations were very interesting leading to active discussions.
**LIVER INTESTINE ADVISORY COMMITTEE**

**RLAC02.05 revised**

In order to be eligible for status T2, patients with hepatocellular carcinoma (HCC) must have been listed actively on the waiting list for ≥ 365 days. Accepted means of HCC diagnosis at time of listing are:

- biopsy-proven HCC, or
- AFP ≥ 400 ng/ml and proof of focal lesions, either one lesion ≥ 2 cm and ≤ 5 cm or ≤ 3 lesions ≤ 3 cm, with arterial hypervascularization by either spiral CT, MRI or angiography (<3 months old), or
- proof of focal lesions, either one lesion ≥ 2 cm and ≤ 5 cm or ≤ 3 lesions ≤ 3 cm, with arterial hypervascularization by two positive imaging techniques with either spiral CT, MRI or angiography (<3 months old). Positive imaging results are accepted if different imaging techniques are used.

After ≥ 365 days active waiting on the ET liver waiting list, the transplant center can send a T2 request to the ET office. The request for T2 must include the written report(s) of the PA or of the imaging procedure(s), preferably in English. At the time of T2 request this patient must be transplantable fulfilling the Milan criteria, i.e. either one tumor ≥ 2 cm to ≤ 5 cm in diameter or ≤ 3 tumors each ≤ 3 cm in diameter. Patients must be free of macroscopic vascular invasion and extrahepatic metastases. The T2 status will be granted by the ET medical staff on the basis of an ‘exceptional case’ as proposed by the transplant center.

Patients initially:
- inside the Milan criteria and, after treatment, show one lesion < 2cm or no lesion at all at time of the T2 request, are still considered to be a transplant candidate and can be evaluated by the ET medical staff.
- inside the Milan criteria and show lesion(s) exceeding the Milan criteria at time of the T2 request are presented to the ELIAC.
- outside the Milan criteria and fulfilling the criteria only after downstaging are presented to the ELIAC.

**ETHICS COMMITTEE**

**RECO4.06 (rephrased)**

In the light of the divergent definitions on non-residency in the ET countries, and to ensure equal treatment of patients and equal access of these patients to organ transplantation according to the ET policy, the Ethics Committee recommends that the number of non-resident registrations for patients (either first or repeat) for a liver or a thoracic (re)transplant should not exceed 5% of the total number of transplantations (either first or repeat) by this center in the preceding year. This rule should be respected in all member states of ET.

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**Guidelines regarding transmission of the rabies virus**

Following a case of rabies transmission via solid organ transplantation in Germany in the year 2005, the Eurotransplant Organ Procurement Committee (OPC) extensively discussed the problem of transmission of rare diseases. The discussions resulted in the formulation of guidelines which were approved by the Eurotransplant Board.

The following guidelines are to be followed and taken into account regarding transmission of the rabies virus through organ transplantation:

1. Transmission of rabies through organ transplantation is a very rare event.
2. Currently, no rapid blood or tissue tests are available which could reliably rule out the presence of rabies infection in brain dead organ donors.
3. Rabies vaccination for potential organ recipients is not recommended.
Chairman: Prof. Dr. Günther Laufer
Secretary: Verena Diepeveen-Huijsman

The meeting is attended by 130 participants.

Opening

The chairman opens the meeting and welcomes all participants.

Election of three Board members A

Since the Assembly chairman is one of the candidates for the election, this part of the meeting is chaired by Eurotransplant’s past president, Prof. Yves Vanrenterghem.

Kidney section

There is one vacancy for the position of Board member A in the kidney section. The position is vacant due to the fact that the current Board member A, Prof. Hans van Hooff from Maastricht (the Netherlands) will step down. There is one candidate for the vacancy: Prof. Rutger Ploeg from Groningen (the Netherlands) who is elected by the Assembly.

Thoracic section

According to the Eurotransplant Articles of Association, the current Board member A in the thoracic section, Prof. Günther Laufer from Innsbruck (Austria) has to be (re)elected. Since no other candidates applied for this position and Prof. Laufer had declared to be available for another term, he is re-elected by the Assembly.

Tissue typing section

According to the Eurotransplant Articles of Association, the current Board member A in the tissue typing section, Dr. J. Mytilineos from Ulm (Germany) has to be (re)elected. Since no other candidates applied for this position and Dr. Mytilineos had declared to be available for another term, he is re-elected by the Assembly.

Announcement of the winner of the Henk Schippers Young Investigators award

The Assembly chairman invites Eurotransplant’s president, Dr. Bruno Meiser to announce the 2006 winner. Dr. Meiser together with Mrs. Hanneke Siebers, the widow of the late secretary/treasurer, Henk Schippers, present Dr. Peter Horn from the Medizinische Hochschule Hannover in Germany with the 2006 Henk Schippers Young Investigators award. Dr. Horn is congratulated with this prize and is invited to present his data during the Eurotransplant winter meeting in Fügen (Austria), January 2007.

The following presentations were also given during the Assembly. Since they will be published in one of the issues of the ET Newsletter, there is no need to further elaborate on these presentations in this report:

- Presidential address by Dr. Bruno Meiser
- Directors report by:
  - Arie Oosterlee, general director
  - Axel Rahmel, medical director
  - Wim van Zwet, director finance/IT
- Introduction of the Eurotransplant candidate member: the Republic of Croatia by Ms. Mirela Bušić
- Global cooperation in transplantation: information on the Global Alliance for Transplantation by Prof. Yves Vanrenterghem

Prof. Laufer closes the meeting at 18:40 hrs by thanking all attendants for their active participation in this informative meeting.
The following reports from the Advisory Committees were discussed by the Eurotransplant International Board on October 4, 2006 in Leiden, the Netherlands

Report of the telephone conference of the Eurotransplant Liver Intestine Advisory Committee (ELIAC)

Chairman: Prof. Dr. J. Lerut
Secretary: Dr. T. Gerling

The ELIAC met Monday, July 10, 2006 in a telephone conference
Members present: 8 + 1 director + 1 IT representative
Members absent: 2

A. Announcements

The members are informed that the Board approved to change the name from ELAC to ELIAC for given reasons, and that the Board did not deem it necessary to extend the ELIAC with new permanent members regarding pediatric and/or intestinal representatives. The Board rather gave permission to invite external experts in case these topics would be on the agenda.

ET finally received written consent from the German Bundesärztekammer to implement RLAC02.05 (HCC) as of June 10, 2006.

B. Revision of RLAC02.05 (HCC)

The final version could be finalized following a thorough discussion.

RLAC02.05 revised
In order to be eligible for status T2, patients with hepatocellular carcinoma (HCC) must have been listed actively on the waiting list for ≥365 days. Accepted means of HCC diagnosis are:

- biopsy-proven HCC, or
- AFP ≥ 400 ng/ml and proof of focal lesions, either one lesion ≥2 cm and ≤5 cm or ≤3 lesions ≤3 cm, with arterial hypervascularization by either spiral CT, MRI or angiography (<3 months old), or
- proof of focal lesions, either one lesion ≥2 cm and ≤5 cm or ≤3 lesions ≤3 cm, with arterial hypervascularization by two positive imaging techniques with either spiral CT, MRI or angiography (<3 months old). Positive imaging results are accepted if different imaging techniques are used.

After ≥365 days active waiting on the ET liver waiting list, the transplant center can send a T2 request to the ET office. The request for T2 must include the written report(s) of the PA or of the imaging procedure(s), preferably in English. At the time of T2 request this patient must be transplantable fulfilling the Milan criteria, i.e. either one tumor ≥2 cm to ≤5 cm in diameter or ≤3 tumors each ≤3 cm in diameter. Patients must be free of vascular invasion and extrahepatic metastases. The T2 status will be granted by the ET medical staff on the basis of an 'exceptional case' as proposed by the transplant center.

Patients initially:
- inside the Milan criteria and, after treatment, show one lesion <2 cm or no lesion at all at time of the T2 request, are still considered to be a transplant candidate and can be evaluated by the ET medical staff.
- inside the Milan criteria and show lesion(s) exceeding the Milan criteria at time of the T2 request are presented to the ELIAC.
- outside the Milan criteria and fulfilling the criteria only after downstaging are presented to the ELIAC.

C. Functional Design of MELD-ELAS

The members are presented the latest draft version of functional design (FD) for allocation under MELD. The FD for the recertification schedule (phase 2) and the exceptions/auditing (phase 3) are still being worked on and will be presented to the ELIAC in due time.

Although ET takes its responsibility to comply with national wishes/laws, all members are asked to perform an objective check to support ET’s mission for delivering the best possible product and to report back their findings no later than July 28, 2006.

D. Livers from ECD and allocation to obligations

Allocation of extended criteria donors (ECD) can sometimes lead to delay at a moment when quick and efficient allocation is needed. With regard to the closing of obligations, patients from the center (Austria)/country receiving an obligation offer are ranked following HU/ACO and before elective national patients. Often, when ECD livers are offered, these offers are rejected because of the possible bad quality. The centers receiving offers know that they can await the next donor because an obligation is not closed unless a liver is accepted and transplanted.

It is therefore proposed to give the ET medical staff some freedom in their decision making process when it comes to
skipping obligation patients in order to gain time and to prevent an ECD organ from being lost. Following a lively discussion in which the use of criteria are discussed that could serve as a cut-off criterion, e.g. the German ECD criteria. As the members agree to avoid criteria that are not uniformly accepted, and in order to find an objective measure for the ET medical staff, it is decided that rescue allocation should be regarded higher that closing an obligation. Therefore, the ELIAC allows the ET medical staff to skip obligation patients in the allocation in case of imminent loss of an ECD organ once it was rejected in three different centers.

E. Miscellaneous

The members are informed that as of July 2006 the revised ENIS liver waiting list module has been implemented. As a consequence, all voluntary MELD updates can be performed through ENIS, and that the MrQ MELD/PELD module is therefore no longer necessary.

Report of the telephone conference of the Eurotransplant Liver Intestine Advisory Committee (ELIAC)

Chairman: Prof.Dr. J. Lerut
Secretary: Dr. T. Gerling

The ELIAC met on September 18, 2006
Members present: 8 + 1 Director + 1 IT representative
Members absent: 2

A. Announcements

Croatia is introduced as the new candidate member of Eurotransplant (ET). The status of the candidacy and its implications are explained and that a permanent membership will be evaluated by both parties at the end of the year of candidacy. In the planning of this ELIAC telephone conference meeting it was decided not to invite the Croatian colleague as only MELD-specific topics had to be discussed and decided upon. It was considered to be more appropriate, to introduce the new member during one of the following meetings that will take place in Leiden in person. Questions from the Croatian part can also better be answered in the upcoming workshop held in Croatia on September 22-24.

The secretary announced that the planning for the implementation of the electronic platform for the auditing part of the MELD-project was postponed until the 2nd quarter of 2007. Reasons are that, due to the deadline for the implementation of the MELD-allocation as of January 1st, 2007 all manpower had to be directed to the building of the allocation and recertification modules. Also, the auditing module is very complex to build and implementing unfinished business would rather harm the reputation of ET. Auditing will of course be continued after the implementation of MELD by approaching the auditors by fax or email.

Regarding RLAC02.05 (revised) (HCC) it is explained that this recommendation, although not yet officially approved by the Board, received preliminary approval for implementation by the ET directors. The reason was that this revised version of the recommendation, rather than being a new text, is a further specification supporting all participants in daily practice.

B. Progress report on the implementation of MELD

B.1 Implementation plan for MELD in ET

A complete implementation plan is presented explaining what ET intends to do and at what time in order to implement MELD as smoothly as possible. This involves training of ET personnel and remote users, the latter in two workshops to be held at ET in November and during the upcoming liver users meeting in October 2006. ET will strive to have each recipient on the waiting list with a valid (updated) MELD score so that at the time of implementation allocation can be performed immediately. Recipients whose MELD is missing at the time of implementation will be assigned MELD 6. Additionally, patient groups in the ET countries will be approached for meetings. First contacts have been laid in Belgium, Germany and the Netherlands. Currently, implementation is planned for December 16, 2006. The weekend was chosen because the whole computer system will have to be off the air for approximately half a day, which is not feasible on a regular working day.

B.2 Transition from current ELAS to MELD-based ELAS

To ensure a clear-cut transition all patients should be provided with a MELD score at the time of implementation. Recipients without a MELD score will be assigned a MELD score of 6. Requests for SE and NSE can be sent in beginning with the day of implementation. The, MELD-specific waiting time will start the time of implementation, retaining the total waiting time accumulated until implementation. All recertification cycles will start on the day of implementation. With regard to exceptional cases T2 patients with a current standard exception (HCC, polycystic liver disease, metabolic diseases) at the time of implementation will be assigned the national SE matchMELD. In addition to that, all T2 patients with an exceptional status through an ELIAC audit, i.e. non-standard exception (NSE), will be assigned the national NSE matchMELD. The proposal is unanimously accepted by the ELIAC.
B.3 Determination of MELD equivalents

The proposal to adapt the latest UNOS data for MELD score equivalent (3-month probability of death on the waiting list) for the list of SE/NSE, i.e. initial matchMELD and upgrades after 90 days, is unanimously accepted by the ELIAC. After implementation ET would perform their own analyses in order to update the table.

In the discussion it is also proposed to ask centers to provide ET with postoperative pathology reports in cases of liver transplants for HCC, as is currently done with the HU liver recipients, which is unanimously accepted. In the past some recipients were transplanted under the HCC bonus MELD who proved not to have an HCC. Sending the pathology reports should help to ensure quality, particularly in this group especially taking into account, that based on the possibly wrong diagnosis of HCC these patients received the MELD-bonus increasing their chance to be transplanted quickly. The data gathered should help in refining the system in the future. It is agreed that ET should collect the data and when considered necessary also provide it to the national health authorities for evaluation.

B.4 Regular allocation of post-mortem livers between ET countries

To ensure transparent and fair allocation of livers between ET countries in the regular allocation in cases where no suitable recipient is found in the donor country, it is proposed to only apply the labMELD in the stratification of suitable recipients on the international match list. This proposal is unanimously accepted by the ELIAC.

B.5 Children registered under 12 years turning 12 years on the waiting list

In the course of defining the PELD alternative it was decided that recipients registered under 12 years would be assigned a pediatric matchMELD. The proposal to freeze a recipient’s (upgraded) pediatric matchMELD at the moment he turns 12 years, with no further updates, is unanimously accepted. This proposal would also be in analogy with the current rule in kidney allocation for pediatric recipients.

B.6 Continuation of pediatric SE upon reaching match-MELD specific age threshold

Three SE definitions know an age threshold. This makes it necessary to define the recipient’s status after reaching the age threshold while awaiting liver transplantation, similar to the problem described in B5. The proposal to freeze a recipient’s status at the moment he reaches the threshold is discussed. For PH1 (Oxalosis) the proposal is unanimously accepted. In non-metastatic hepatoblastoma and urea cycle disorder/organic academia the members issued some concern as to whether these recipients, although probably very few in numbers, should be allowed access to the HU group. It is suggested that this could lead to a “pollution” of the HU group in the sense that it might open up the doors to allowing more exceptions to this group. A way out of this problem suggested during the meeting is to upgrade these patients to MELD 40 instead of granting the HU-status. As decided earlier by the ELIAC, at this stage all SE lists have meanwhile been approved by all countries, this proposed change would mean that ET would have to go open the discussion in all countries again, potentially leading to a delay in the implementation. Following a lively discussion the members agree to ask the secretary, the chairman and the medical director to evaluate together an opportune moment to submit this suggestion. Until then the members agree to accept the proposal for these two diseases and that implementation should proceed with the lists that were approved.

C. 6th year of ELAS – status report

The ELIAC discussed the update of the yearly statistics. Noteworthy are: the number of HU transplantations remains stable, with only the number of acute re-transplantations in the group of adult recipients following a post-mortem transplantation showing an increase that could be due to the increased use of ECD livers. This will be subject to further investigations. The number of split liver transplantations continues to decrease particularly in Germany, resulting in an increase in living donation in the pediatric group. Regarding mortality on the waiting list it is explained that, after the increase in the 5th year, a slight decrease was observed. It was remarked that changes in allocation, such as the T2 priority will most likely lead to a change in listing policies, i.e. more severely ill patients are likely to be listed as they are those who receive priority. As a result, an increase in mortality must at least be anticipated. A similar development could continue under MELD due to the fact that disease severity is the basis for the recipient stratification.

D. Miscellaneous

The ELIAC members are reminded that next year will be ET’s 40th anniversary and that they might think about a special liver users meeting in 2007 as planning might have to start earlier with regard to possible speakers.
Part one

Ladies and gentlemen, members of the Assembly, dear audience,

For my first director’s report, which I am told must last no longer than 5 minutes, I would like to tell you a story. It starts like this:

“One upon a time, not so very long ago, an advertisement was placed in the Lancet. Candidates were being sought, for directors’ positions at the Eurotransplant International Foundation. Three candidates were finally selected and appointed. Two of them, Wim van Zwet and myself, started working on the first of September 2005. The third, Axel Rahmel started the first of October.

Where did they start working?

In Leiden at the Eurotransplant Office. This office supports the Eurotransplant community to fulfill its mission, to be a service organisation for transplant candidates through the collaborating transplant programs within the organisation. This service organisation provides services to transplant centres and their associated tissue typing laboratories and donor hospitals in:

Austria, Belgium, Germany, Luxembourg, The Netherlands, Slovenia and at the moment also for Croatia.

To produce these services, Eurotransplant manages the following three core processes:
I. Allocation,  
II. Algorithm development,  
III. Registry

What did Eurotransplant do, and how did we achieve it?

This past year Eurotransplant formed a community in the allocation of 2068 organs for 6753 transplant patients. The board authorised 16 recommendations and in doing so layed the basis for 13 new allocation algorithms. Eurotransplant’s registry acted upon numerous information requests, was involved in data-analysis for organ advisory committees, national authorities and individual transplant centers, helped develop the survival curve function for ET’s transplant centers and is actively involved in the ORS trial.

This significant feat was achieved due to a lot of cooperation and communication between the members of this community:

Communication
• Electronic data transfer between all German and Dutch transplant- and donor-centers and ET’s Leiden office (Schnittstelle and DPA)

• Web based reporting and feedback from ET to all TX-centers (donor reports and survival curves)

Cooperation
• Our cooperation is based on solidarity and trust. All donor organs are offered to the central donor pool out of solidarity for patients possibly high(-er) on the waiting list. The transplant-centers and national authorities are trusting ET to find matching donor organs for one’s own patients in time.
  - The results of this cooperation are remarkable. For instance the international exchange of donor organs within ET is 20% compared to 2% in the rest of Europe.
• Our cooperation seems to work. The average place on the waiting list of patients receiving a donor lung was approx. the 2nd place compared to i.e. the 11th which UNOS is proud of.

What kind of people did I find at ET?

The Leiden office forms a community within the Eurotransplant community. As 70 % of ET’s annual budget consists of salary costs, people are at the basis of the services that ET provides. On the 1st of October 2005 Axel, Wim and I were all working in Leiden. At that time our ET office offered work to 70 people.

I am afraid to tell you that since we started 23 people left our organisation. Fortunately 19 people took up their place actually representing more full time equivalents than the number of FTE’s that left.

This last year the three of us have had the opportunity to get to know the people who work here, and in the process, we had a lot of fun.

What kind of people did we meet? We met a variety of people with different backgrounds and different skills, but with 2 striking similarities:
• Very dedicated to supporting the transplant community
• Very experienced

The organisation, which is lead by us, is managed by an excellent management team.

The management team represents:
• The medical staff
• The department for allocation and medical administration
• The IT department
• Finance and accounting
• Human resource management
• The secretariat
Where are we now?
For a newcomer, my evaluation is that the Leiden office was very much focused on just getting the job done and developing new ways of doing things. The employees were mostly oriented inwardly at servicing clients within the Leiden office.

Tasks, responsibilities and projects were organised in a loose and flexible way, with few formalised planning and control systems.

ET is a service organisation. Quality is in the eye of the beholder, and the beholder is you. You are being or going to be more involved – than you were used to – in defining quality aspects of our services. We will have to communicate and cooperate well with you to achieve this.

Where do we want to go?
For 2007 the following goals are aimed at improving cooperation and communication within the Eurotransplant community, within the Leiden office, with national communities & authorities and last but not least with new communities, like Croatia.

1. Strengthening ET’s internal organisation
   - Clarification of the role, tasks and responsibilities of departments:
   - Enhancement of project management skills
   - Clarification concerning decision making process within ET
     - Development and introduction various planning & control cycles
     - Decentralisation of responsibilities to middle management

2. Improvement of the transparency and quality of ET’s services
   - Quality assurance and safety management systems throughout ET;
   - Roll out of electronic donor data input systems in Belgium Luxemburg, Austria and Slovenia;
   - Clarification of responsibilities of ET with transplant centres;

3. Investigation of possibilities to increase ET’s donor pool
   - Active expansion policy towards former “Eastern” Europe
   - Clarification of ET’s twinning-arrangements models

4. Acceleration of the development process of allocation-algorithms
   - Upgrading and ‘flexibilization’ of our ENIS-system:
     - A faster less labour intensive way of automating allocation rules;
     - Less complex to realise country/ organ specific wishes.

5. Enhancement of ET’s legislative and political position
   - Proactive lobby towards Brussels

Having come to the end of my little story I would like to finalise by stating that if we all cooperate and communicate well, we will find a way to achieve these goals, and in doing so, I expect we will be entering an ocean of opportunities.

Thank you very much!

Arie Oosterlee

Part two

IT & Financial Directors Report
By Wim van Zwet

What has been implemented in 2005/2006?

- Donor profiles / Extended Criteria Donors
- Revised Urgency status Thoracic allocation
- ENISI – HLA / Immunology module
- ENISI – Waitinglist modules (all organs)
- Electronic donor reporting (DPA / Schnittstelle)
- Survival graphs / follow-up (patient & graft)
- Croatia
- MELD (december 2006)

General Developments:

- User focus
  - Internet / web based access
  - Individualization
- Influence of national adaptation
- Process driven systems

Eurotransplant challenges for the future years

- Stepwise approach for new countries
- Country specific wishes regarding matches
- Acceleration of development process
- Transparancy
- Simulation
- Userfriendly access
- Increased insight in the process
- Electronic Donor Reporting
What will be new in 2007??

- User focus:
  - Implementation of a web portal for access to the ET software portfolio
  - New developments with JAVA-HTML
- Influence national adaptations:
  - Investigate possibilities for more flexible architecture of match algorithms
- Process Driven Systems:
  - ENIS-Q project
  - Roll-out of DPA

Enis remains ET’s backbone

Electronic Data Exchange

- Donor Data Input by donor centre (DSO + NTS)
- Donor & Patient Data Retrieval By TX Centre

Web based (www.donordata.eu)

Eurotransplant – Activities 2005

- Income only from registration fees
- How is it spend?

Eurotransplant – Activities 2005

Developments in Registration fee & Inflation

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Eurotransplant – Activities 2005

Income only from registration fees

How is it spend?

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Part three

Medical Directors Report

By Dr. Axel Rahmel

Topics

- Waiting list
- Donation
- Transplantation

Kidney Waiting List and Transplants

Eurotransplant 1969 – 2005

Donors reported in Eurotransplant

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Liver Waiting List and Transplants

Eurotransplant 1995 – 2005

Liver Waiting List and Transplants

Organ donation – Eurotransplant 2005

- Waiting list
- Donation
- Transplantation

- Topics
- Waiting list
- Donation
- Transplantation

* Including kidney and islet transplant donors.
Croatia, Eurotransplant’s Candidate Member
By Mirela Bušić MD, National Transplant Coordinator

Croatia
**Statistics for Croatia**

- 4.4 million inhabitants
- 20 donor hospitals
- 4 transplant center
- 10 transplant programs

**Legislation**

- 1980 Act on transplants – informed consent
- 1988 Amended – presumed consent
- 2004 Act on transplants – presumed consent

Non-donor registry – 1668 persons (3.7%)

Family approach still common practice

30% of reported donors lost due to family objection

**Transplant Centers in Croatia**

Rijeka University Clinical Center
Zagreb University Clinical Center
Merkur University Hospital, Zagreb
Dubrava University Hospital, Zagreb

**Rijeka University Clinical Center**

- 1971 kidney transplant
- 2006 liver transplant

**Zagreb University Clinical Center**

- Heart, liver, kidney transplant program
- Reference tissue typing center

**Merkur University Hospital, Zagreb**

- Solid organs
- Multi-organ transplants

**Dubrava University Hospital, Zagreb**

- Heart transplant program
- The highest donor rate

**Hospital care facilities Transplant coordinators network**

- University hospital
- General hospital
- Transplant centers

**National Coordination office**

- Maintain the National Waiting list
- Maintain the National Non-donor registry
- Allocation of organs
- Coordinate the international exchange of organs
- Processing overall data on donation and transplantation...

**National waiting list**

- Kidney: 700
- Liver: 53
- Heart: 18
- Kidney-pancreas: 17
- Kidney-liver: 3

---
Croatia, Eurotransplant’s Candidate Member

Donor activities 2000–2005

Heart transplant 1988–2005

Transplant activities 2006

Donors reported 60
Donors realised 42
Family refusal 13
Kidney transplant 79
Liver transplant 33
Kidney pancreas 10
Heart transplant 10

International cooperation benefits
- wider pool of donors
- better organ matching

Eurotransplant 120 million inhabitants
Croatia 4.4 million inhabitants

Signing the Agreement between Ministry of Health and Social Welfare and Eurotransplant
May 26 2006

Stepwise approach: selected patient groups
- high urgent patient, AMM, Pediatric patients

HLA MATCH DISTRIBUTION – kidney only (N=171)
(Evaluation: January 1, 2004 – December 31, 2005)

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Kidney waiting list

Liver Transplant 1990–2005

Kidney Transplant 1991–2005

Stepwise approach: selected patient groups
- high urgent patient, AMM, Pediatric patients
High urgent liver patients

- 4 HU Croatian patients received organs
  (3 whole livers, 1 split liver)
- 3 livers sent to Eurotransplant

Training program

Leiden, 23th August
Workshop; Opatija 21-23 September

Acceptable mismatch program

- Started as of 1st September 2006
- Registration procedure is running

Workshop
Opatija, 21-23th September 2006

Kidney transplant waiting list (N~700) % PRA
(2005, as per December 31)

<table>
<thead>
<tr>
<th>PRA</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5%</td>
<td>598</td>
<td>84</td>
</tr>
<tr>
<td>6-84%</td>
<td>98</td>
<td>14</td>
</tr>
<tr>
<td>≥85%</td>
<td>14</td>
<td>2</td>
</tr>
</tbody>
</table>

Perspective

Croatia
Eurotransplant Full Member

Long-term cooperation

- Higher quality of transplant services
- Shorter waiting times

Special Thanks

Thanks to Eurotransplant president, directors,
Boardmembers and all other Eurotransplant
collaborators for their strong support throughout the entire process

Actions taken after Agreement

- 2 new full time
  Transplant Coordinators
- EFI Accreditation of
tissue typing labs in Zagreb
  and Rijeka
- Croatian representatives are
nominated as observers in
the ET Committees
- Supporting training programs
  have been launched
Global Alliance for Transplantation
An initiative of The Transplantation Society
By Yves Vanrenterghem

The GAT planning process: wide consultation
planning meetings 2004–2006

Global Alliance Board Composition
- The Transplantation Society
- International Society of Heart Lung Transplantation
- International Liver Transplant Society
- International Society of Nephrology
- European Society of Organ Transplantation
- American Society of Transplantation
- American Society of Transplant Surgeons
- Latin American Society of Transplantation
- Middle East Society of Transplantation
- Asian Society of Transplantation
- United Network for Organ Sharing
- Scientific Registry for Transplant Recipients
- Eurotransplant
- United Kingdom Transplant Authority
- Organisation Nacionales Trasplante
- Corporate Sponsors of The Transplantation Society
- World Health Organisation (Observer status with the Council of TTS)

Agreements: mission
“To advance the safe, effective and ethical practice of transplantation for all patients in need”

Agreements: Strategic intentions
1. To establish strategies of donation and transplantation that optimise the treatment and outcomes of organ, tissue, and cell transplantation
2. To promote organ, tissue, and cell donation to make transplantation more widely available for people in need
3. To ensure that transplantation is provided within appropriate ethical guidelines and standards
4. To endorse and/or establish institutional and professional guidelines for proper delivery of transplantation services
5. To establish educational programs that broadly disseminate expertise and standards in transplantation
6. To develop systems and standards for data collection allowing analysis, dissemination, and validation of the outcomes of transplantation activities
7. To promote research and evidence based transplantation practices within the context of best available resources
8. To increase transparency, awareness and knowledge about donation and transplantation by disseminating information to the general public
9. To engage and communicate with national, regional and international governmental health and regulatory authorities and other relevant community stakeholders
Agreements: Priorities

1. Facilitation of high quality relationships with and between stakeholders
   - defined as ensuring that mutual benefit is the basis upon which governments, agencies, partners and supporters sustain their association with GAT
2. Quality of Information
   - defined as fostering transparency through the global collection, analysis and dissemination of high quality information on donation, allocation and the outcome of transplantation of all organs, tissues and cells for/for/with all stakeholders
3. Alignment of Education Systems and Processes
   - defined as the manner in which education and training is developed and expertise shared in transplantation globally.
4. Fostering Professional Guidelines
   - defined as fostering the development, maintenance and implementation of evidence-based global practice guidelines and consensus statements in the provision and management of transplantation

Agreements: Key result areas & programs

Agreements: It will take time

Operational Plan 2006–2007

1. Advisory Board Meetings
2. Transplant Registries Forum
3. Centres of Excellence Program
4. Guidelines
   - 1. Care of the Transplant Recipient
   - 2. Deceased Donation

The Eurotransplant Duty Office can be reached 24 hours per day at 0031 71 5795795.

Please note that all phone calls to the Duty Office and the Medical Staff are logged and recorded. Recording of these conversations is in accordance with Dutch Law.
Informing Eurotransplant on procurement and transplant procedures

Dear colleagues,

Recently, it occurred several times that the Eurotransplant duty desk was not – or at a late moment – informed about the fact that organs were not procured, or a planned transplantation had not taken place. In the meanwhile, patients for whom these organs had been accepted had the status ‘Accepted’ in our ENIS system. Patients with the status ‘Accepted’ will not appear on later matches anymore. This means that the patients in these cases might miss organ offers!

In order to prevent that patients miss out on organ offers, Eurotransplant urgently asks all transplant coordinators and transplant centers to inform us as quick as possible when organs are not procured or a planned transplantation has been cancelled!

Thank you for your continuous cooperation!

Sincerely yours,

Dr. Axel Rahmel
Medical Director

Mrs. Klasien Dijkstra
Head of Allocation

What is MELD?
The Model for End-stage Liver Disease (MELD) scoring system was developed by the Organ Procurement and Transplantation network (OPTN)/United Network for Organ Sharing (UNOS) and implemented in the U.S. in February 2002. The calculation of an individual’s MELD score is based on three objective lab values, i.e. International Normalized Ratio (INR), creatinin and bilirubin. MELD aims at stratifying patients by their disease severity estimating their 3-month probability of death on the waiting list. A high MELD score indicates severe illness, thus a candidate in urgent need of transplantation. Candidates are stratified in a descending order, starting with the recipient with the highest MELD. The lowest MELD is 6, and MELD scores exceeding 40 are capped at 40 in the matching. MELD is only applied in the matching in elective transplantable (T) patients, i.e. High Urgency (HU) recipients and those with status Approved Combined Organ (ACO) remain in a separate urgency for international allocation not based on MELD.

MELD formula
The formula applied in Eurotransplant is:

\[
MELD = 0.957 \times \log_{e}(\text{creatinin mg/dL}) + 0.378 \times \log_{e}(\text{bilirubin mg/dL}) + 1.120 \times \log_{e}(\text{INR}) + 0.643
\]

The following is important:
- Calculated MELD scores are multiplied by 10 and rounded to the nearest whole number;
- Laboratory values entered <1.0 are set to 1.0;
- Maximum S-Creatinin in the MELD score equation is 4.0 mg/dl; in S-Creatinin values >4.0 mg/dl formula calculates '0.957 x Log\(_e\)(4.0)'; a positive answer to ‘Had dialysis twice within a week prior to S-Creatinin test?’ results in a creatinin value set at 4.0 mg/d.

MELD in Eurotransplant
After implementation in UNOS, MELD was discussed in the ET Liver Intestine Advisory Committee (ELIAC), and by April 2003 a recommendation was issued advising the application of MELD for liver allocation in ET. This recommendation was accepted by the ET Board. The
ELIAC’s working group paid two visits to UNOS in 2003 to gain first hand information on MELD and its impact on daily practice. The ELIAC’s task was then to define a MELD-based liver allocation system adapted to the specific needs in ET, and to find a PELD alternative because PELD was not intended to be used.

Towards the end of 2005 all issues were resolved and the ET Board decided in January 2006 to have MELD implemented in ET at the latest by January 1, 2007.

MELD definitions used in Eurotransplant
In matching procedures it will be necessary to make a distinction between e.g. a calculated MELD score and those that were exceptional cases. In this regard, the following expressions are introduced:

<table>
<thead>
<tr>
<th>MELD</th>
<th>Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>lab MELD</td>
<td>MELD scores calculated after data entry of lab values or downgraded lab MELD scores if not recertified (see below).</td>
</tr>
<tr>
<td>pediatric MELD</td>
<td>PELD alternative for children &lt;12 years of age.</td>
</tr>
<tr>
<td>exceptional MELD</td>
<td>MELD scores granted for either standard (SE) or non-standard exceptions (NSE).</td>
</tr>
<tr>
<td>match MELD</td>
<td>The MELD score applied in the match, i.e. either lab MELD, pediatric MELD or exceptional MELD. In all cases in the benefit of the patient, i.e. the highest valid MELD at time of matching.</td>
</tr>
</tbody>
</table>

Exceptional cases
Candidates can, at the initiative of the transplant center, be requested an exceptional MELD score if the individual’s disease severity is not accurately reflected by lab MELD. Two categories were created, i.e. standard exceptions (SE) and non-standard exceptions (NSE), respectively.

| standard exceptions (SE) | The group of SE comprises, among others, hepatocellular carcinoma (HCC), FAP, polycystic liver disease and small-for-size syndrome. The list of diseases and their criteria was defined in national committees and can vary between ET countries. SE requests can be submitted through a newly built web application, and notification on acceptance/denial of the request is online. |
| non-standard exceptions (NSE) | A small group of recipients’ disease severity is neither reflected by lab MELD nor are they eligible for SE. These recipients will be evaluated by a national audit group on a case-by-case basis. Requests for NSE can be submitted through the website before they are sent to the national audit group. |

Currently only the Netherlands and Belgium will install a national audit.

Diseases currently defined as an SE comprise (per country):

<table>
<thead>
<tr>
<th>SE disease</th>
<th>A</th>
<th>B/L</th>
<th>G</th>
<th>NL</th>
<th>SLO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholangiocarcinoma</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Cystic fibrosis</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>FAP</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Hepatopulmonary syndrome (HPS)</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Porto-pulmonary hypertension (PoPH)</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Primary hyperoxaluria Type 1 (PH1)</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Polycystic liver disease (PLD)</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Hepatocellular carcinoma (HCC)</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Non-metastatic hepatoblastoma*</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Urea cycle disorder/organic academia*</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Small-for-size syndrome following LTx</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
</tbody>
</table>

* diseases with the same definition in all countries.

Recertification of lab MELD
Lab MELD has a ‘best before date’, i.e. it must be recertified at intervals to prove that a patient deserves to be in a lab MELD. Centers receive notification of individual recertification dates:
- at time of initial or re-registration (pop-up in ENIS);
- at set intervals before end of the period (2-30 days before expiry; see below) by email.

After data entry a new lab MELD is calculated, resulting in a new lab MELD and a new lab MELD period starts immediately. Centers will be supported in daily waiting list management, i.e. each of their recipients’ individual schedule (date of next recertification etc.) can be found in a center worklist. With the help of this list transplant centers have constant access to the status of their recipients. The lab MELD should be recertified as follows:

<table>
<thead>
<tr>
<th>MELD</th>
<th>LabMELD expires after</th>
<th>Notification before expiry date</th>
<th>Lab values at data entry must not be older than</th>
</tr>
</thead>
<tbody>
<tr>
<td>MELD ≥ 25</td>
<td>7 d</td>
<td>2d</td>
<td>48 h</td>
</tr>
<tr>
<td>MELD ≤ 24, &gt;18</td>
<td>30 d</td>
<td>7d</td>
<td>7 d</td>
</tr>
<tr>
<td>MELD ≤ 18, ≥ 11</td>
<td>90 d</td>
<td>14 d</td>
<td>14 d</td>
</tr>
<tr>
<td>MELD ≤ 10</td>
<td>365 d</td>
<td>30 d</td>
<td>30 d</td>
</tr>
</tbody>
</table>

The recertification schedule is applicable at all times, i.e. even if recipients are in HU, ACO or NT. An (un)recertified lab MELD is important because a recipient could be:
- placed from HU into transplantable (T), e.g. due to improved clinical condition. Then this recipient will need to be placed on the waiting list in a current (un)recertified MELD;
- temporarily not transplantable (NT) and, upon reactivation to T, will need an (un)recertified MELD score to participate in the match again.
Missed a recertification?
In case a recertification was not performed by the transplant center, this recipient will be downgraded to the immediate previous lower MELD score. If no immediate previous lower MELD is known, then this recipient is assigned MELD 6.
If two consecutive recertifications are missed, then this recipient is assigned MELD 6.

Voluntary update of lab MELD
A candidate’s status in ENIS should at all times reflect the current clinical status. Therefore, any change in a candidate’s status should be entered immediately, as the result might have direct consequences on an individual’s chance for a timely transplantation.

Reconfirmation exceptional MELD
Each recipient that has been granted the status of either SE or NSE must be reconfirmed every 90 days. Reconfirmation implies that centers must, again through the MELD web application, reconfirm that their recipient still fulfills the criteria (SE) or is again accepted by the national audit (NSE). If SE criteria are met or the NSE status is granted by the audit, respectively, this recipient will receive an upgrade. The procedure of reconfirmation and upgrade can be repeated until transplantation.

PELD alternative
The group of recipients younger than 12 years at time of (re)registration will automatically have an pediatric MELD applied. This pediatric MELD is upgraded automatically every 90 days until transplantation. Once a recipient with a pediatric MELD turns 12 years while still awaiting liver transplantation, then his (upgraded) pediatric MELD is frozen at the moment of his 12th birthday and will be kept until transplantation; upgrades are no longer possible. Adolescents between 12 years and younger than 16 years are still pediatric recipients, nonetheless, they must register with the lab MELD and the recertification schedule applies. The current ‘pediatric bonus’ is maintained under MELD, i.e. all recipients younger than 16 years are defined as pediatric recipients and receive offers before adult recipients.

Waiting time
In the current allocation system, waiting time proved to be a weak discrimination factor to make a distinction between the very sick and less sick patients. Therefore, under the new MELD-based system, waiting time is only used as a tie breaker. After stratifying patients according to their MELD score first, you can have two or more recipients with the same MELD score. It is then that waiting time comes into play. At time of matching the following fraction of waiting time is calculated: time spent in current MELD, time spent previously in same or any higher MELD and HU. The fraction will then help to further stratify recipients, as those with the longest fraction are ranked first among those with the same MELD score. Only if two or more recipients not only have the same MELD at time of matching, but also the same waiting time fraction, then the total waiting time is used as the final tie breaker. The recipient with the longest total waiting time as of registration will then be ranked first. This process is repeated for all recipients with the same MELD in every matching procedure. It is therefore not possible to predict a place on the waiting list as this procedure depends on the composition of the match list that again depends on the actual donor.

Exchange of organs between ET countries
If a liver cannot be allocated in the donor country in the regular allocation, then this organ is offered to recipients on the international liver waiting list. Under MELD, stratification is exclusively based on the current (un)recertified lab MELD. National SE/NSE status will not be applied internationally in order to rule out the influence of variances in SE and/or NSE criteria between the ET countries. The only exception is the pediatric MELD that is applied in the international allocation.

Implementation and transition from current ELAS to MELD
The transition will be performed on December 16, 2006 applying all lab MELD scores known at that time. Before implementation, centers will receive two letters providing an overview of recipients on their waiting list where MELD data are missing. Centers will be asked to enter missing MELD data so that each patient has a MELD score at the time of implementation. Centers can, of course, also update existing MELD scores if they differ from the one known in ENIS. Recipients without a lab MELD at time of transition will be assigned MELD 6.
The only exceptions will be made for recipients in T2 with:
- a T2 standard exception (HCC, polycystic liver disease, FAP, PH1) and awaiting liver transplantation on the day of transition;
- an exceptional status that was granted by the ELIAC in an audit (except in countries where NSE is not allowed);
- pediatric recipients under the age of 12 years at time of implementation will be assigned the initial pediatric MELD.

Further planning
- Scheduled implementation of MELD: December 16, 2006 (subject to change).
- Three interactive workshops for administrators will be held on November 13, November 23 and November 27, 2006 at the central office of Eurotransplant in Leiden.
- A tutorial will be provided through the ET member site (www.eurotransplant.nl) explaining the functionality of the MELD web application in a short film. Please check the website for further information regarding the tutorial.
- ET and ENIS manual will be provided to users on time before implementation.
In Eurotransplant, about 20 % of the organs cross the borders, therefore it is very important to provide information about the donor and the organs that can be understood by the recipient centers, leaving as little as possible room for misunderstanding. The reporting doctors and coordinators should do their utmost to provide the donor information, including information from others, such as the radiologist, in the English language, or the information from others at least in an English summary.

Recently an article on this was published in the Newsletter, emphasizing the English language is the official language within ET.

As is shown in two diagrams, especially in Germany, but also in Austria and in the Netherlands, free text in ‘other diagnostics’ is mostly written in the native language, which is not the English one. In all reports from Luxembourg and Slovenia, and in most of the reports from Belgium the correct, English language is used.

**Abstract**

**Viral hepatitis as chance for extended donor criteria for liver transplantation**

*By: Prof. Dr. med. H.H.-J. Schmidt, Transplantationshepatologie Universitätsklinikum Münster*

The clinical success of liver transplantation within the last decades justifies this procedure as standard treatment for acute and chronic liver failure, but also for distinct inherited metabolic diseases, which may not affect the liver at all. The accumulating knowledge on diagnosing and treating liver diseases resulted in both improved quality of life and prolonged survival in liver transplant recipients, but also in an increased spectrum of indications for liver transplantation and therefore, an increased demand for organ donation. The shortage of donor organs is closely linked to prolonged waiting time for liver transplantation and increased morbidity and mortality, subsequently. Thus patients with the need for liver transplantation require an individual evaluation for potential extended donor criteria to counterbalance waiting time.

Liver transplant candidates have to be checked for the presence of viral hepatitis, which is important as differential diagnosis, but also to identify the need for vaccination.

Hepatitis C is one of the leading etiologies for patients to be transplanted in Europe. Patients with hepatitis C have post transplant an increased rate of complications, and therefore, a reduced graft survival rate.

**Anti-HCV positive donor liver**

Patients with viral hepatitis C usually reinfect the donor liver, and therefore, suffer from hepatitis C also after liver transplantation. Retrospective data underline, that the transplantation of a hepatitis C infected organ into a hepatitis C negative recipient results in a remarkable increased morbidity and mortality, subsequently. Thus patients with the need for liver transplantation require an individual evaluation for potential extended donor criteria to counterbalance waiting time.

Liver transplant candidates have to be checked for the presence of viral hepatitis, which is important as differential diagnosis, but also to identify the need for vaccination.
transplantation is very variable. Usually there is little information on HCV RNA and medical history in organ donors at time of donation. Therefore, anti-HCV organs may reflect active hepatitis or a status after hepatitis C. The latter donors have immunocompetency against viral hepatitis C. Although it is very speculative, HCV positive patients receiving an immunocompetent anti-HCV liver may develop immunocompetency. The drawback of receiving an anti-HCV positive graft is the infection of another viral subtype, which may complicate the hepatitis C especially once a genotype 1 HCV is newly introduced into the graft recipient. This in turn may result in an acute hepatitis. However, commonly the coincidence of two viruses tend to result in less inflammatory liver disease. The longterm outcome is not known.

**Anti-HBc positive donor liver**

Hepatitis B is usually well controlled prior and post transplantation using nucleoside analoga; in selected cases treatment with interferon and immunoglobulins result in cure of hepatitis B. Anti-HBc IgG positive grafts bear the chance of hepatitis B infection of the recipient in about 10%, once anti-HBs is negative; mostly anti-HBc IgG positive grafts represent a status after hepatitis B infection, therefore, there is no risk of infection. With this background we initiated a program on anti-HBc positive liver being transplanted into recipients carrying already the hepatitis B virus. Again, prerequisite is the presence of unacceptable waiting time for transplantation predicted for the hepatitis B carrying recipient and the proof of an anti-HBc positive donor liver with the lack of any evidence of liver disease. Since each hepatitis B patient receives as standard therapy immunoprophylaxis for hepatitis B in addition to nucleoside analoga, we don’t expect any different transplant and post transplant outcome. However, there are no longterm data available. A coexisting hepatitis D has to be excluded in the donor (anti-HDV) to avoid any superinfection with HDV in the recipient.

**Coinfections HIV/HCV and HIV/HBV**

Liver transplantation is nowadays justified in HIV infected patients, since overall survival rates have tremendously improved and are comparable with diabetes mellitus type 2. Inclusion criteria in these patients have to be evaluated very strictly. Coinfections of hepatitis B and C are commonly present in HIV patients and therefore, increasingly contribute to the mortality in this patient cohort. To circumvent in Münster the discussion on organ allocation for HIV infected patients at time of organ shortage, we offer these patients the allocation of anti-HCV positive grafts and anti-HBc positive grafts, respectively.

**Perspectives**

Each patient who is accepted for liver transplantation has to be evaluated for his individual prognosis and timing of liver transplantation. Donor criteria have to be individually chosen based on the needs of the transplant candidate. Once extended criterias may apply, the patient has to be advised, since the patient has to decide upon this critical issue. This approach serves the goal to reduce unacceptable waiting times to receive a graft. Patients with acceptable waiting time should not be offered these extended criterias, unless we can guarantee the lack of any disadvantages. We all have to achieve that optimal donor organs are allocated for optimal transplant candidates having acceptable waiting times. Therefore, organ donation has to be evaluated also in the state of viral hepatitis B or hepatitis C carriers. Liver biopsy is mandatory to exclude morphologically liver disease in such a setting. This in Münster established program is transferable to some extent to the transplantation of other solid organs.

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**References:**