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Commentary: Fishing for organs in a small fishing hole: What should we throw back and who should decide?

Thomas M. Egan, MD, MSc

In this issue of the *Journal*, van Raemdonck and colleagues¹ from Leuven offer their perspective on the results of a provocative and encouraging single-center clinical trial that showed the early safety of transplanting a small number of hearts (n = 8) and lungs (n = 36) from brain-dead donors infected with hepatitis C virus (HCV) into consented HCV-naïve waitlisted patients.² This clinical trial adds to a growing number of studies showing that HCV-infected donors can be safely transplanted because of effective therapy for HCV. This is good news for all waitlisted transplant recipients, because the opioid crisis has produced a dramatic increase in brain-dead donors and controlled donation after circulatory determination of death donors; many are infected with HCV and/or other transmissible viral infections (hepatitis B virus [HBV] and HIV).³

van Raemdonck and colleagues point out that although this study (and others⁴⁻⁶) demonstrate the safety of transplanting organs from HCV donors, the data are short-term. “Longer term data are needed to fully define the risk-benefit of this approach and more studies should be conducted before HCV RNA+ donors can be considered as “acceptable risk” donors in solid organ transplantation.” They stress the importance of performing these transplants under institutional review board–approved protocols with “informed consent.” How do you inform patients about

CENTRAL MESSAGE

Organs from HCV-infected donors can be transplanted and treated but expose recipients and others to infection risks. Other viruses are more controversial. Who should decide whether to proceed?

unknown risks? Who decides what is acceptable risk? The report of Woolley and colleagues² was accompanied by a poignant editorial from a cardiologist who happily received a heart from an HCV-infected donor.⁷

van Raemdonck and colleagues' viewpoint is important because of the unanswered questions it evokes (full disclosure: Dirk is my good friend). HBV donors without viremia are now routinely used in vaccinated recipients with HBV antibodies. What about viremic HBV donors? These are often declined. If the intended recipient is vaccinated, what is the risk of infection? Even if infection occurs, what is worse? Having your life extended and improved by a transplant and acquiring HBV, or dying on the waiting list? What about HIV+ donors? It is considered acceptable to transplant these into HIV+ recipients. There are antiretroviral therapies that have normalized life expectancy in HIV-infected individuals. Faced with death on a waiting list, on mechanical ventilation or extracorporeal membrane oxygenation, or a failing ventricular assist device, is acquiring HIV today worse than the alternative certain death? Who decides, when so many risks are unknown? The patient staring at the grim reaper, his/her team of caring physicians (who would likely have different opinions), health insurance companies, who will bear much of the cost, or governments, based on

From the Division of Cardiothoracic Surgery, Department of Surgery, and School of Medicine, University of North Carolina at Chapel Hill, Chapel Hill, NC.

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Address for reprints: Thomas M. Egan, MD, MSc, University of North Carolina at Chapel Hill, 3040 Burnett-Womack Bldg, Chapel Hill, NC 27599-7065 (E-mail: thomas_egan@med.unc.edu).

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well-meaning legislators? It is not only the recipient assuming risk. Organ transplant exposes hundreds of health care workers to these viruses. If transmitted, their intimate partners (present and future) are at risk, including partners of the recipient. Their conclusion is correct: the risk of being infected by a transmissible disease should be balanced against the risk of dying prematurely. However, the patient must weigh in. It's complicated and can only be resolved by greatly increasing the number of organs for transplant, making the fishing hole larger, increasing the number of fish, and throwing fewer back.

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