respect to lung allocation. This is hard work and I laud all those involved in improving our allocation systems. I suspect I will witness many further improvements before the end of my career.

References

1. U.S. Department of Health and Human Services. Organ procurement and transplantation network; final rule. *Fed Regist* 42 CFR part 121. 1999;56649-566616.

2. Glazier A. The lung lawsuit: a case study in organ allocation policy and administrative law. *J Health Biomed L*. 2018;XIV:139-48.
3. Haywood N, Mehaffey JH, Kilbourne S, Mannem H, Weder M, Lau C, et al. Influence of broader geographic allograft sharing on outcomes and cost in smaller lung transplant centers. *J Thorac Cardiovasc Surg*. 2022;163:339-45.
4. U.S. Department of Health and Human Services. Organ procurement and transplantation network; continuous distribution. Available at: <https://optn.Transplant.Hrsa.Gov/governance/policy-initiatives/continuous-distribution/>. Accessed October 8, 2020.

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Commentary: All politics are local. The impact of the new organ allocation system on a lung transplant center

David P. Mason, MD

Haywood and colleagues¹ at the University of Virginia lung transplant program describe in their manuscript “Impact of Broader Geographic Sharing on Outcomes and Cost in Smaller Lung Transplant Centers” the effect of national changes that were made in lung distribution and implemented on November 24, 2017. Before this time, lungs for potential adult recipients were allocated according to donation service area (DSA), with prioritization of allocation to patients in the local DSA according to their lung allocation score (LAS). The DSA system of distribution was felt to be unfair because lungs were being offered to less-sick patients in a local DSA whereas sicker patients, even in close proximity but in another DSA, were passed over. Theoretically, this system could be contributing to increased waitlist deaths. Hence, the DSA allocation system was replaced by a system whereby lungs were first allocated by LAS to adult recipients within a 250 mile radius around the donor hospital.

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CENTRAL MESSAGE

Change from a donor service area system of lung distribution to one based on proximity to the donor hospital impacts individual transplant centers in unpredictable ways.

When considering this new system, all transplant centers were asking themselves the exact questions that Haywood and his colleagues attempt to answer in this manuscript. How will these nationally implemented changes impact my program on a local level? More specific questions included the following: (1) Will the geographic location of our program disadvantage us? (2) Will we need to travel further to obtain lungs? (3) Will these changes lead to more deaths on our waitlist? (4) Will it cost us more money to transplant?

The authors answered many of these questions at their own center, and some of the answers that are published here are concerning. The number of transplants that they performed in an equivalent time frame before and after implementation of the new system did increase. Travel distance, travel cost, and total procurement costs increased. Waitlist mortality increased. Of greatest concern, the

waitlist mortalities they observed after conversion to the new system all occurred in patients with very high LAS scores, the very patients the new system was designed to help.

The results of the authors' findings are difficult to generalize among other transplant centers. The authors argue that they are disadvantaged by the relatively small size of their transplant program, its rural location, and service of the socioeconomically disadvantaged. They also cite the challenges of competing with other larger transplant centers within a 250-mile radius.

However, it seems that every transplant center, not just their own, struggles to deal with its own unique set of challenges presented by the new system. This observational study cannot control for the multitude of variables related to organ distribution and transplantation. These include program reputation, quality of local organ procurement agencies, cultural donation patterns, patient referral patterns, competing transplant programs, and local population size to name just a few.

The 1-year report published by the Organ Procurement and Transplantation Network Thoracic Transplantation Committee looked at the early national results after removal of DSA as a unit of a lung allocation.² Although there were some statistically significant differences between pre- and post-era metrics, the jury is still out on the overall impact of the change. More data, including 1-year post-transplant survival, will need to be analyzed. What is certain is that changes in national donation policy clearly impact each of our transplant programs individually and differently.

References

- Haywood N, Mehaffey JH, Kilbourne S, Mannem H, Weder M, Lau C, et al. Impact of broader geographic allograft sharing on outcomes and cost in smaller lung transplant center. *J Thorac Cardiovasc Surg.* 2022; 163:339-45.
- Monitoring of the lung allocation change, 1 year report. Removal of DSA as a Unit of Allocation. OPTN Thoracic Transplantation Committee. Available at: https://optn.transplant.hrsa.gov/media/2815/20190116_thoracic_committee_report_lung.pdf. Accessed September 15, 2020.

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Commentary: The cost of drawing the line: Lung transplant programs in the post-donor service area era

Ramiro Fernandez, MD, Jesse Rappaport, MD, and Usman Ahmad, MD

Almost 3 years have passed since the emergency change in lung allocation policy in November 2017 that replaced the donor service area (DSA) with a 250 nautical mile radius as the first unit of lung allocation. The Organ Procurement and Transplantation Network Thoracic Transplantation

CENTRAL MESSAGE

Broader sharing has increased travel distance and cost. National waitlist mortality has remained stable in the early period. Innovative strategies are needed to overcome the shortcomings of this model.

Committee has monitored outcomes very closely, most recently reporting on 2-year outcomes since the change.¹ Meanwhile, individual transplant centers have begun reporting their experiences. While the overarching goal is

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