selection criteria for LTx and treatment strategies is essential. This timely expert opinion will hopefully stimulate the community to talk about the new kid(s) in town.

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See Article page 865.

Commentary: In the aftermath, what awaits us?

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There are those of us who follow current events with rapacious interest, reading, watching, and searching for every piece of information on a topic, like say the pandemic of the last year and a half. A need to know in the moment. Others, and I would put myself in this category, prefer the aftermath. Let time pass and the fallout coalesce into what becomes a new reality. How has life changed by what we have been through?

We may now be in the aftermath of the pandemic; fingers crossed. As health care providers, and particularly as thoracic surgeons, we must now contend with what will most likely be an influx of coronavirus disease 2019 (COVID-19) survivors with end-stage pulmonary fibrosis. The expert opinion provided by Schaheen and colleagues¹ is valuable as it contains real insights from a busy and

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CENTRAL MESSAGE

In the aftermath of the pandemic, the field of lung transplant faces new challenges and realities.

highly successful transplant program. They also address some important unknowns.

When to bridge someone off extracorporeal membrane oxygenation (ECMO) is a fundamentally difficult question. I think all of us who have dealt repeatedly with these clinical scenarios would agree that recovery is preferable and should be pursued. Lung transplant is an option for these patients just as it has been for similar patients in the past who have suffered devastating lung injury from the flu. The sober statistics regarding long-term survival, however, mean that in reality these recipients are exchanging one acute illness (end-stage lung disease) for another more chronic problem (post-transplant management of their graft).

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What the authors offer is that lung transplant should be “...considered only when sufficient time has elapsed to exclude meaningful lung recovery.” Right on. But what does that mean? If I’m considering a patient on venovenous ECMO for transplant, I think you begin with age, as the capacity for recovery is greater in young people. If alternatively, they are in their fifth or sixth decade of life and have been on ECMO for 6 to 8 weeks with no progress but yet have not developed myopathies or renal dysfunction, then I think you begin the discussion of transplant earlier.

For those of us who perform transplants regularly, we have a healthy respect for pulmonary hypertension/right heart failure and what these variables represent in terms of short- and long-term outcomes. Thus, it is imperative that critical care teams engage their transplant colleagues early when a patient on venovenous ECMO is failing to make progress. Education is key, as they must know that

we don’t want to be bridging these patients off venoarterial ECMO or in the setting of liver and renal dysfunction.

Finally, COVID-19 has taken a disproportionate toll on our minority groups. We, as a lung transplant community, will be tasked with helping these underserved patients. Thus, we must be prepared to adapt and acknowledge that success post-transplant has as much to do with one’s social support and access to resources as it does the quality of the organ they receive. Welcome to the aftermath with new realities and new challenges. But one thing never changes: the field of lung transplant is never boring.

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