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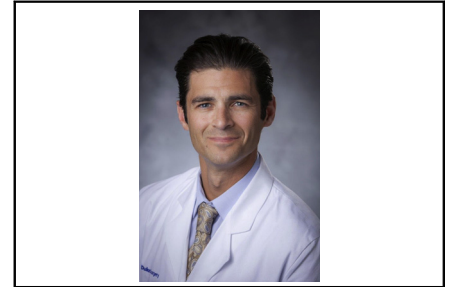
## Commentary: Something gained, nothing wasted

Jacob A. Klapper, MD, FACS

Last month, I got an organ offer for a patient in his mid-'60s with sarcoidosis. My immediate reaction was: "Uh oh." I reviewed the particulars and then opened the computed tomography scan image and there they were: calcified hilar nodes...check, pleural thickening...check, upper lobe consolidation with some cavitory elements...check. Not good.

Terada and colleagues<sup>1</sup> present the outcomes from a series of unplanned single-lung transplants (SLTs). Reading this article was undoubtedly intriguing, but those feelings were intermixed with a real sense of unease and dread. Their results are commendable, and the patients who underwent unplanned SLT did well long term, but I have 2 thoughts. First, this article should not be used as a justification for unplanned SLT. Second, with high-resolution modern imaging in addition to our understanding of the clinical features of a high-acuity patient, it is difficult to envision 31 instances in which such a clinical situation would present itself.

Of course, there will be those times when a procurement goes awry and a lung is unusable, but those are rare in general and in this work by Terada and colleagues<sup>1</sup> specifically. Overall, the main issue that led to these unplanned SLTs were recipient-related and, in my opinion, some of the rationale used is highly debatable. For instance, contending that after 3 or 4 hours the benefits of the second lung are offset by the need for massive transfusion and the attendant consequences therein is dubious. If the first side was arduous and the bypass time has reached 4 hours, you probably have arrived at the point of needing multiple units of



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### CENTRAL MESSAGE

In the case of an unplanned single lung transplant, a valuable organ will be invariably wasted.

product anyway. The argument that this discarded organ can then be offered up for ex vivo lung perfusion and subsequent placement is a bit farfetched. The takers for a lung that has been on ice for many hours followed by a short interval on ex vivo lung perfusion is about as long as the line of publishers interested in Woody Allen's memoir.

Ultimately, a "trend toward a greater application of unplanned SLT over the past decade"<sup>1</sup> is a trend in the wrong direction. Why? Because, as the authors acknowledge, there does appear to be a survival advantage to a double lung transplant (DLT) and secondly a good lung is, in all likelihood, going to be wasted. Thus, this article turns the focus back on patient selection and the operative approach to difficult cases. Again, I argue you can most often readily predict which cases these would be and if there is any question about the feasibility of a completing a DLT then the obligation is to list that patient for an SLT...or not at all. And if the decision is to offer a DLT, deliberate pneumolysis, early devascularization of the lung, and the use of venoarterial extracorporeal membrane oxygenation as opposed to full bypass can all facilitate completion of the intended operation.

Lung transplant is tough, unforgiving, and humbling. For the previously mentioned patient, we completed a harrowing, taxing, blood operation. He received 2 lungs as planned. In my opinion, something was gained, but most importantly nothing was wasted.

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1. Terada Y, Takahashi T, Hachem RR, Liu J, Witt CA, Byers DE, et al. Clinical features and outcomes of unplanned single lung transplants. *J Thorac Cardiovasc Surg.* 2022;162:1650-9.e3.