Commentary: United Network for Organ Sharing policies work, but progress only occurs at the speed of a snail: A need for expeditious adjustments

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The first substantive United Network for Organ Sharing policy change to the allocation system since 2005 was implemented in 2018 with the goal of reducing waitlist mortality among the heterogeneous groups of patients previously clustered as status 1A. In this issue of the Journal, Singh and colleagues1 evaluate the impact of the new allocation system on waitlist and posttransplant outcomes in patients listed status 2.

The marked increase in use of temporary mechanical circulatory support (TMC), particularly intra-aortic balloon pump, facilitating a high transplant rate and shorter wait time while avoiding the necessity of bridging to transplant with a durable left ventricular assist device (LVAD), has been well documented.2,3 The current report confirms this trend with increasing use of microaxial pumps from 2019 to 2022. Not surprisingly, as an increasing number of patients are listed status 2, the wait time has increased (18 days vs 23 days, \( P < .001 \)) with waitlist mortality remaining stable, likely indicating increasing expertise with prolonged TMC support.

The more striking take-home message from this work is the ever-increasing status 2 listing by exception, most recently making up >40% of all status 2 heart listing. Even more remarkable is that >50% of status 2 patient upgrades to status 1 were done by exception. Although the high number of exception requests may reflect the inadequacy of the current system for accommodating the complexities of current patients with heart failure, it also may signify a systematic problem, with centers inappropriately justifying this status in order to avoid LVAD implantation. In the current system, patients with restrictive cardiomyopathy, adult congenital heart disease, those who are highly sensitized, and those in need of retransplantation are inadequately prioritized, particularly given their limited options for TMC or durable LVAD support.

The success of the new allocation system lies in its ability to allow patients to proceed directly to transplant if they are sufficiently hemodynamically compromised. Despite some increases in status 2 wait time, outcomes up to 6 months do not appear to be compromised. However, it is possible that the price in greater mortality for longer status 2 waitlist time has not been recognized yet. Excessive and potentially inappropriate status 2E and 1E will disadvantage the patients at a lower status or those who truly have a greater mortality without transplantation. We should continue to adjust and improve the current allocation system to create a more fair and equitable system. Hopefully, it will not take another decade to make this critical change.

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