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Commentary: UNOS policies work but progress only occurs at the speed of a snail: A need for expeditious adjustments

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None of the authors have any relevant Conflicts of Interest

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Central Message: The current UNOS allocation policy needs to be remedied expeditiously.

Central Picture Legend: Drs. Reyentovich, Smith, and Moazami

The first substantive UNOS policy change to the allocation system since 2005 was implemented in 2018 with the goal of reducing waitlist mortality amongst the heterogenous groups of patients previously clustered as Status 1A. In this issue of the Journal, Singh and colleagues evaluate the impact of the new allocation system on waitlist and post-transplant outcomes in patients listed status 2.¹

The marked increase in utilization of temporary mechanical circulatory support (TMC), particularly IABP, facilitating a high transplant rate and shorter wait time, while avoiding the necessity of bridging to transplant with a durable LVAD, has been well documented.²,³ The current report confirms this trend with increasing utilization of micro axial pumps from 2019-2022. Not surprisingly, as an increasing number of patients are listed status 2, the wait time has increased (18 days vs 23 days, p<0.001) 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 patients 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 may also signify a systematic problem with centers inappropriately justifying this status in order to avoid LVAD implantation. The problem of excessive exception requests is compounded by the fact that the
patients will automatically get listed under the requested status until it is reviewed by the regional review committees. In these cases, it is conceivable that a patient may be transplanted under the higher and possibly unapproved status. This is particularly concerning regarding Status 1E in which case transplant can occur within days. The new allocation policy was meant to reduce the number of exceptions; in this account it is clearly failing. Furthermore, in the current system, patients with restrictive cardiomyopathy, adult congenital heart disease, those who are highly sensitized, and those in need of re-transplantation 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 six months do not appear to be compromised. However, it is possible that the price in higher mortality for longer status 2 wait list 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 higher 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.
References


