Commentary: The changing face of risk management

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Central Message

Using organs from increased-risk donors does not jeopardize outcomes.

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In this issue of the *Journal*, Lehr and colleagues[1] have submitted an analysis of national data from the Scientific Registry and Transplant Recipients database pertaining to lung transplantations performed between 2006 and 2017. The authors proffer an analysis against a backdrop of high-volume transplantation and prerequisite experience in the field. To this end, they adjudicated recipient outcomes dichotomized by having received either ''high''- or ''increased''-risk organs, predicated on a recent switch in nomenclature by the US Public Health Service that recently took effect.[2]

The manuscript is timely and relevant as the transplant community grapples with a global paucity of donors and an increasingly compelling need to demystify and destigmatize ''high-risk'' donation to keep pace with demand(s) for organs. The piece is of substantial political import, particularly in the context of organ donation in an era of a devastating national opioid epidemic juxtaposed against an increasing incidence of intravenous drug abuse. These unfortunate events have culminated in establishing drug overdose as the major rival to trauma as the leading cause of death in people younger than 40 years and estimated at a staggering 57 per 100,000 in West Virginia.[3] As such, the work builds on a growing body of evidence.[4,5]

A glaring omission in this analysis, however, is the lack of a more specific, nuanced, definition of acute rejection. The tacit assumption that treatment of this rejection, within 1-year post-transplantation, qualifies as an objective secondary outcome may inadvertently result in the observation of a 100% event rate. Indeed, mild acute rejection is, arguably, a subjectively common, even ubiquitous, occurrence, somewhat underscoring the limitation inherent in an explicit assessment of rejection as a binary event rather than as a continuum. The clinical management and documentation are, in this vein, left to the discretion of the treating physician and, as such, are rife with subjective interobserver variability. The latter influences the estimation of both survival and rejection. Use of propensity matching notwithstanding, objective quantification of the risk of transmission, replete with long-term surveillance, would have likely proffered a more persuasive treatise. Furthermore, this may have prompted a more elaborate quantification of the actual threat posed by a positive nucleic acid test screen as it specifically pertains to communicable disease and bloodborne pathogens in the transplant population as a whole.

On an objective note, the low transmission rate lends further credence to the impetus to destigmatize the risk attributed to these donors. Contemporary patterns of use of intravenous drugs suggest that the numbers of ''increased-risk'' donors will continue to grow in the future. Despite the apparent controversy in optics, however, it is finally incumbent on the transplant community to alter views, moderate preconceived biases, and temper prejudice in this regard. In the absence of an entirely new mindset to accompany the new nomenclature, we will miss the opportunity to alleviate the catastrophic loss of precious young donors by the salvage of the equally precious lives of the growing number of candidates on the waitlist.

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