Is "Old" Ever Too Old for Transplant?

In recent years, the 60- to 80-year-old age group on the kidney transplant waiting list has increased dramatically, decreasing their chances of ever receiving a kidney. Yet studies show that even those older than 70 can decrease their chance of death and increase the length of their life with a kidney transplant.

Evaluating elderly patients for a transplant should be an "exaggeration" of evaluating younger patients, said Gabriel Danovitch, medical director for the Kidney and Pancreas Transplant Program at the University of California, Los Angeles. Physicians should rule out coronary artery disease, other cardiovascular disease, and cancer. Patients should also have good mobility, muscle strength, and nutritional status. He emphasized an assessment that looks at 'biological age' of the individual rather than chronological age.

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Danovitch spoke about "Transplantation in the Elderly: Is Old Ever Too Old?" at the Renal Week 2010 session, "What to Do with Medically High-Risk Kidney Transplant Candidates" in November.

Even in highly selected patients, "not surprisingly, the older you are, the more likely you are to die," Danovitch said. But graft survival does not appear to suffer with increased age of recipients. There is also a drop-off in the incidence of acute rejection in older transplant patients, presumably owing to a less aggressive or functional immune system. However, this is balanced out largely by the fact that older donor age is associated with acute rejection and older recipients tend to get older kidneys.

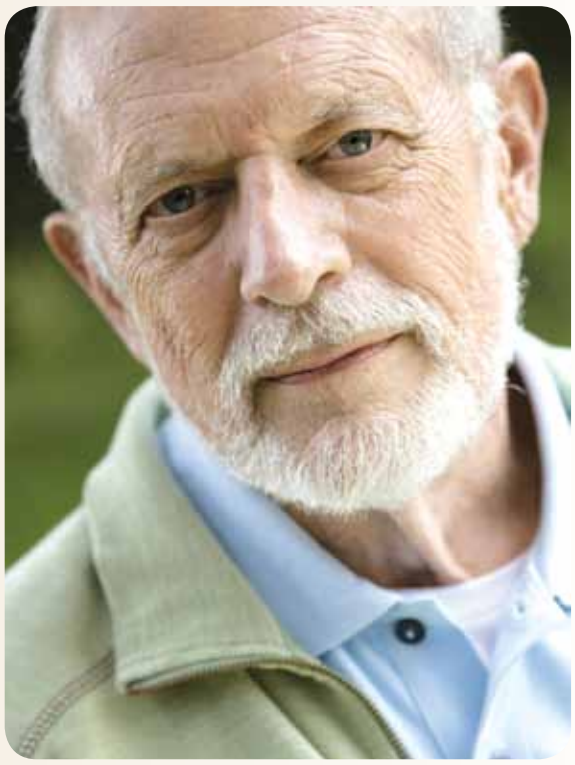
"It's important for elderly patients waiting for deceased donor kidneys to remember that they will get kidneys of lower quality," said Danovitch.

The dilemma for nephrologists, then, is whether or not to encourage living donation as a solution, when those living donors are likely to be the patient's children or even grandchildren. "We must think about, 'What are the ethical issues in transplanting younger donors into older patients who probably won't live much longer?' "

"Many elderly patients don't want to turn to their children," Danovitch said. "But they also don't want to wait eight to 10 years for a poor quality deceased donor kidney." Currently, 10 percent of living donor kidneys go to people more than 65 years old, and that percentage appears to be increasing.

Among the increased risks for elderly transplant patients are infections, surgery complications, pharmacokinetic vulnerability, and lymphomas due to immunosuppression.

Danovitch summed up the hard-learned lessons about elderly transplants from his own practice:



"Choose your patients carefully, make sure they know what they are getting into, do not take their immune systems for granted, and watch out for covert infections." He also noted that better research protocols targeted to the elderly population were needed as the numbers of these patients are likely to continue to increase.

Transplant policy session highlights continued need to create equitable, ethical, and cost-effective measures for transplant recipients and donors

By Caroline Jennette

Speakers at a "Controversies in Organ Transplant Policy" session at Renal Week 2010 described a range of issues affecting both kidney donors and recipients.

Gabriel Danovitch, MD, director of the Kidney Transplant Program at UCLA, described the steps taken this year by the Declaration of Istanbul Custodian Group (DICG) to create a framework of "muscles and tendons" across the "skeleton" of the Declaration. The Declaration of Istanbul was created in 2008 by representatives of scientific and medical bodies from around the world to protect the poor and vulnerable from the negative effects of transplant tourism and organ trafficking.

Although the Declaration has been widely accepted and endorsed by all major transplant organizations, it is not a legal document. The DICG works to monitor, implement, and enforce the principles laid out in the Declaration and has split into six task forces covering various organ trafficking and tourism aspects. While Danovitch would like to see greater widespread acceptance, using the Declaration of Helsinki as a goal, he said tremendous progress has already been made since the Declaration was published. For more information, visit www.declarationofistanbul.org.

Roger Evans, PhD, president and CEO of the United Network for the Recruitment of Transplantation Professionals, described the ongoing struggle to pass legislation providing Medicare reimbursement for immunosuppressive medication to transplant recipients who are only Medicare-eligible due to their end stage renal disease after three years. Evans laid out an argument for lifetime coverage using data recently published in the *Clinical Journal of the American Society of Nephrology* (PMID: 20847093) describing the economic burden of "cost-related nonadherence" (CRN). In a nationwide transplant center survey done by Evans and colleagues, 70 percent of patients reported having problems paying for medication, and 68 percent reported deaths and graft losses attributable to cost-related immunosuppressive medication nonadherence.

Alan Leichtman, MD, medical director of Kidney and Pancreas Transplant Programs at the University of Michigan, discussed alternative systems for deceased donor allocation. The National Organ Transplant Act (NOTA), instituted in 1984, requires the Organ Procurement and Transplantation Network (OPTN) to determine medical criteria ensuring equitable organ allocation, which for kidneys is currently based on HLA status, wait time accrual, sensitization, and donor kidney type (standard vs. extended criteria).

The current system has been highly criticized as being a subjective process not accounting for special needs, inequities in access, and differences in outcomes across populations, in stark contrast to the original NOTA mandate. Leichtman reviewed current, proposed allocation policy changes including a new kidney allocation score (KAS) based on expected life years from transplant (LYFT score), time on dialysis, sensitization, and a donor profile index. Other alternatives to the current system include removing the allocation system all together, using a lottery-based system, or basing allocation on social and economic (versus medical) conditions. For more information on the proposed system, visit: http://optn.transplant.hrsa.gov/kars.asp.