ASHI's Official Response to the UNOS/OPTN Proposals

1. Re: Update HLA equivalency tables - Comments from the AMERICAN SOCIETY FOR HISTOCOMPATIBILITY & IMMUNOGENETICS (ASHI)

ASHI's National Clinical Affairs Committee's Co-Chairs and Organ Transplant section members reviewed these proposed changes and agree with the UNOS Histocompatibility Committee that updates that include more molecular equivalent types are really needed. However, there are important modifications to these proposed changes that need to be made, as follows:

1) In addition to changing DQA, DQB and DPB to DQA1, DQB1 and DPB1, DR should be changed to DRB1 (DR51/52/53 are listed separately)

2) The new list of molecular types that are now called "antigens" seems to be somewhat arbitrary since many of these are not listed as separate "antigens" by the WHO or in the most recent edition of the "HLA Dictionary" and only some of these are frequently associated with the production of allele-specific antibodies; for example, A*02:02, A*02:04, A*02:05 and A*02:06 that are listed in the proposed Equivalence Tables are not separate "antigens". As another example, it is not clear why Table 4-4 lists B1502 and 1511 and not 1501, 1503, 1510, and 1518 but 1501 and 1503 are listed on the Unacceptable antigen equivalency Table 4-7. Similarly, why is 1518 not listed on the Unacceptable antigen equivalency Table 4-7 while 1501, 1502, 1503, 1510, 1511, 1512, 1513, 1516 are listed on this table? And, the omission of some relatively common types in some places can cause problems. For example, if a donor is reported as having B*15:03, a candidate listed as B72 would not have a zero mismatch for that type and a candidate with B72 as an unacceptable antigen would not be excluded. It is particularly distressing that so many of the Broad antigens listed as unacceptable antigens in proposed Tables 4-6 to 4-13 don't have any molecular alleles listed as equivalents at all. For example, a patient with B14 listed as an unacceptable antigen, has donor equivalent antigens listed as B14, B64 and B65 but B*14:01 and B*14:02 are missing.

One way to avoid all the missing types in the currently proposed tables would be to include all the alleles listed as "**common**" in the current list of "common and well documented alleles"*(http://cwd.immunogenomics.org*), including the common DQA1 and DPB1 types in all the proposed Tables. Otherwise it could be necessary to add at least some of the missing types and re-submit the proposal for public comment again.

3) Table 4-4 should have B*50:02 listed as an equivalent Donor Antigen for a candidate with B45 and Table 4-7 should have B*50:02 listed as an equivalent donor antigen for a patient with B45 listed as unacceptable; similarly, Table 4-5 should have DRB1*11:17 listed as an equivalent Donor Antigen for a candidate with DR14 and Table 4-9 should have DR*11:17 listed as an equivalent unacceptable antigen for a patient with DR14 listed as an unacceptable antigen;

4) Table 4-8 should include the correct antigen names for C locus types (e.g., Cw4 in addition to C04) as required by WHO nomenclature to distinguish HLA types from complement types; all tables should use correct nomenclature for all alleles (e.g., A***02:01** not A 0201)

5) Table 4-14 should not indicate that DR53 is equivalent to DR4, 7 and 9 since there are many DR7 haplotypes with null DR53 alleles and this unfairly calculates the cPRA.

2. Re: Proposal to Revise KPD priority points - Comments from the AMERICAN SOCIETY FOR HISTOCOMPATIBILITY & IMMUNOGENETICS (ASHI)

ASHI's National Clinical Affairs Committee's Co-Chairs and Organ Transplant section members reviewed these proposed changes and agree with the UNOS Kidney Transplant Committee that updates for the KPD priority points are really needed. However, there are two modifications to these proposed changes that we believe need to be made, as follows:

1) For the evaluation of the success of the proposal (page 22), please also add monitoring the actual change in the proportion of transplants with zero A, B, DRB1 mismatches

2) Sections referring to "chains" would be less confusing if they referred to "intended paired donor" or "intended paired recipient". For example, in section 13.9B we would suggest changing:

In OPTN KPD chains, each matched donor recovery must be scheduled to occur within 21 days from the date the matched donor's paired candidate receives a transplant. However, a KPD candidate-donor pair has the option to either have surgery within 24 hours of one another or refuse the match.

To:

In OPTN KPD chains, each matched donor recovery must be scheduled to occur within 21 days from the date the donor's intended paired candidate receives a transplant. However, a KPD intended candidate-donor pair has the option to either have surgery within 24 hours of one another or refuse the match.

3. Re: Proposal to Increase committee terms to three years - Comments from the AMERICAN SOCIETY FOR HISTOCOMPATIBILITY & IMMUNOGENETICS (ASHI)

ASHI's National Clinical Affairs Committee's Co-Chairs and Organ Transplant section members reviewed these proposed changes and do NOT support the proposal to change the terms of ALL UNOS Committee members. Some highly qualified proposed new members might balk at the scope of that initial commitment. Without changing that scope, to enhance continuity, committee members who contribute significantly can be asked to serve a second 2-year term but ineffective members can be easily replaced.