Lung Transplant Candidacy in 2015: Greater Access, Tougher Questions

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In this issue of the Ontario Thoracic Review, my colleague Dr. Matthew Binnie highlights the evolution of lung transplantation from an experimental procedure offered only to a select few to a mainstay of treatment for end-stage lung disease. This is good news for many patients who have access to this lifesaving therapy despite older age or the presence of some comorbidities. We now have evidence that lung transplantation dramatically improves health-related quality of life for patients of all ages and indications.

Many other recent changes have improved access to transplantation in Ontario and beyond, including our ability to support the sickest patients to transplantation with advanced life support modalities such as extracorporeal membrane oxygenation (ECMO), the advent of the Ontario Telemedicine Network which has made initial consultation more convenient for patients and perhaps emboldened respirologists to refer less straightforward candidates to our program, and the Transplant Patient Expense Reimbursement (TPER) Program which provides limited financial assistance to candidates who must relocate to Toronto for listing (http://www.giftoflife.on.ca/resources/pdf/TPER%20Backgrounder.pdf).

All these positive developments have created new challenges for the lung transplant team and for referring physicians. Selecting lung transplant candidates used to be pretty straightforward; advanced age or any other significant medical problem such as coronary artery disease would exclude patients from transplantation. Today, we struggle to make consistent candidacy decisions in the face of multiple comorbidities. Research focusing on frailty and body composition may move us away from the “eyeball test” to more evidence-based prediction of transplant benefit.

For referring respirologists, urgent phone calls to the lung transplant program were once a necessary last step before engaging rapidly deteriorating patients and their families in discussions of palliative and end-of-life care. Today, such desperate calls may actually be the first step towards successful transplantation. Moreover, we recognize that palliative care and transplantation are not mutually exclusive and in fact our program partners extensively with the palliative care team to support patients to transplantation. However, we worry that fast-track assessment and transplantation of very sick patients from advanced life support is depriving more stable patients of scarce donor lungs even though such patients may have better short and long-term outcomes, and have often spent many months in Toronto preparing for transplantation at great financial and emotional cost.

There are no easy answers to these questions, but that is part of what makes transplantation such a fascinating and rewarding field. Every week brings new ethical and medical dilemmas, which challenge us to make the best possible use of the rare gifts that have been entrusted to us by donors and their families. If donor lungs were available for everyone who needed them, candidacy decisions would be less difficult. Techniques to expand donor lung availability such as ex vivo lung perfusion and donation after cardiocirculatory death have improved access to lung transplantation, but each year many Ontarians still die waiting. Ontario residents can register their intent to donate and learn more about organ donation at https://beadonor.ca.
References


