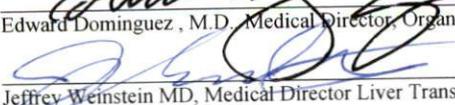


 <b>The Transplant Institute</b> METHODIST DALLAS <b>Methodist Dallas Medical Center</b>	<b>Title:</b> Selection Committee Criteria	<b>Effective Date:</b> 05/2003
	<b>Section:</b> Liver	
<b>Approved by:</b> <hr/> Lori Kautzman M.D., Surgical Director Liver Transplant  <hr/> Edward Dominguez, M.D., Medical Director, Organ Transplant Infectious Disease  <hr/> Jeffrey Weinstein MD, Medical Director Liver Transplant 	<b>Revision Date(s):</b> 05/2003; 06/2007; 07/2007; 01/2015; 10/2017; 12/2018; 03/01/2022; 04/01/2025	<b>Next review Date:</b> 04/2028

**Purpose:** To ensure timely and uniform selection of patients for liver transplant listing

**Policy:**

**Indications for Liver Transplantation**

Adult patients requiring liver transplantation are expected to have failed all other appropriate medical and/or surgical options resulting in end stage liver disease with a life expectancy of less than twelve months.

- 1) Decompensated cirrhosis: Child-Pugh class B or C (or Child-Pugh class A cirrhosis with refractory ascites, spontaneous peritonitis or variceal bleeding unresponsive to endoscopic therapy or a shunt procedure) secondary to:
  - Alcoholic liver disease
  - Chronic hepatitis
  - Viral hepatitis
  - Autoimmune hepatitis
  - Drug-induced hepatitis
  - Metabolic liver disease, including but not limited to:
    - Hemochromatosis
    - Alpha-1-antitrypsin deficiency
    - Wilson's disease
    - Cystic fibrosis
  - Cryptogenic liver disease
  - Cholestatic liver disease
    - Primary sclerosing cholangitis
    - Primary biliary cirrhosis
    - Autoimmune cholangitis
    - Secondary sclerosing cholangitis
  - Sarcoidosis
  - Hepatic venous outflow obstruction (e.g. Budd-Chiari Syndrome)
  - Non-Alcoholic Steatohepatitis
- 2) Fulminant Hepatic Failure
- 3) Primary Hepatic Neoplasm
  - Unresectable benign neoplasm
  - Hepatocellular carcinoma (single lesion < 6 cm OR no more than 3 lesions total with largest lesion < 5 cm and total tumor diameter not > 9 cm OR per current UNOS or regional guidelines. No evidence for vascular invasion or extra-hepatic disease) • *Neuroendocrine*
- 4) Hepatic Allograft Failure secondary to:
  - Hepatic artery / portal vein thrombosis

- Primary allograft rejection
  - Refractory allograft rejection
    - Acute Rejection
    - Chronic rejection with vanishing bile ducts
    - Refractory biliarystrictures
- 5) Refractory Cholangitis:
- Chronic rejection with vanishing bile ducts
  - Secondary sclerosing cholangitis
  - Ischemic cholangitis
- 6) Congenital hepatic fibrosis
- 7) Polycystic liver disease

## **Contraindications to Liver Transplantation**

### 1) Absolute Contraindications

- Active substance abuse (excluding cannabis products)
- Advanced cardiopulmonary disease
- Noncompliance with previous medical regimens or evidence of a psychiatric disease which is likely to interfere significantly with compliance. (Patients being listed for transplantation must demonstrate reasonable ability to comply with long-term post-transplant medical and dietary regimens which includes keeping appointments, obtaining transportation to the transplant center as needed, and maintaining overall adequate support mechanism through family and/or friends).
- Metastatic cancer (except some neuroendocrine cancers)
- Extrahepatic cancer (other than local skin cancer)
- Cholangiocarcinoma
- Severe pulmonary hypertension refractory to treatment (mean PA pressure >35mm Hg)
- Technical defects (e.g. widespread intraabdominal venous thrombosis)
- Severe (uncontrolled) extrahepatic sepsis
- Severe hypoxemia unrelated to HPS that would not be corrected by transplant

### 2) Relative Contraindications

- Intrahepatic infections
- Less than 6 months abstinence from alcohol use
- Multiple uncorrectable congenital anomalies
- Pulmonary arterial hypertension (mean PA pressure > 35 mm Hg)
- Inadequate financial resources
- Inadequate psychosocial support mechanisms
- HgbA1C > 8

### 3) Other Prohibitive Factors

- Severe hemodynamic compromise refractory to vasopressor support or associated with multi-organ failure
- Brain death

## **Tobacco Use Protocol**

### 1) Non-Emergent - Standard Care

- All patients will be advised to stop smoking.
- All patients will sign The Patient Transplant Agreement and The Patient Responsibility Agreement; both forms include information about the programs' tobacco abstinence guidelines.

- If the patient, physician, or social worker identifies tobacco use, the patient will be given smoking cessation assistance material and referrals.
  - If the patient, physician, or social worker identifies tobacco use, the patient will follow recommendations set forth by the transplant team
- 2) Emergent Cases -Fulminant/Acute Liver Failure
- If the patient is unable to sign The Patient Transplant Agreement and The Patient Responsibility Agreement, a family member/support person will sign the forms. Forms signed by the family member/support person will then be signed by the patient prior to discharge from the hospital after transplant.
  - The transplant Selection Committee will evaluate emergent patients who are currently using tobacco and recommendations will be made on a case by case basis.
- 3) Tobacco Screening
- All patients are subject to random tobacco toxicity/urine screen.
  - Positive tobacco screens or refusal to screen will be viewed as non-compliance and could jeopardize patient's active listing status. The transplant Selection Committee discusses non-compliance behaviors. Recommendations will be made on a case by case basis.

### Substance Abuse Protocol

- 1) Non-Emergent - Standard Care
- All patients will sign The Patient Transplant Agreement and The Patient Responsibility Agreement; both forms include information about programs' drug and alcohol abstinence guidelines.
  - If a history of substance abuse is identified by the patient, physician, or social worker, the patient will sign The Substance Abuse Agreement and follow the regulations set forth by the transplant team.
    - If deemed necessary by the transplant team, the patient will be referred to an appropriate substance abuse program.
    - The patient will provide documentation of treatment program attendance.
    - The patient will sign a release of information with the substance abuse facility to disclose the patient's progress to the transplant team.
    - Patients with an extensive substance abuse history will be referred for a psychological evaluation.
  - All patients must complete a drug and alcohol toxicity screen during evaluation.
  - All patents are subject to random drug and alcohol testing.
- 2) Emergent Cases-Fulminant/Acute Liver Failure
- If the patient is unable to sign The Patient Transplant Agreement and The Patient Responsibility Agreement, a family member/support person will sign the forms. Forms signed by the family member/support person will then be signed by the patient prior to discharge from the hospital after transplant.
  - The transplant Selection Committee will evaluate emergent patients with history of substance abuse and recommendations will be made on a case by case basis.
- 3) Positive Drug or Alcohol Test after Listing
- Patient and referring physician are notified of positive drug or alcohol toxicity screen by the transplant coordinator. Transplant coordinator will remind patient of abstinence requirement and transplant agreement and inform patient that they are removed from the active waiting list.
  - Patient placed in Status 7. Patient status discussed at next Selection Committee meeting.
  - Referral to a drug/substance abuse program or treatment facility by the social worker.

- Patient signs a release of information for the substance abuse program to communicate patient's progress to the transplant team

**BMI considerations for Transplant**

Relative Contraindications for Liver Transplant:

- 1) BMI >40 with any one of the following:
  - Renal insufficiency (defined by Creatinine Clearance <30 cc/min)
  - Diabetes mellitus
  - Cardiovascular disease
  - Portal vein thrombosis
  - Multiple upper abdominal surgeries

Listing is determined on a case by case basis by the Selection Committee and clearance by two Transplant Surgeons should be considered

Note: MDMC will not discriminate against an organ transplant recipient solely on the basis of an individual's disability