Paired Exchange: A New Innovation in Live Donor Kidney Transplantation

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Abstract

Barriers to traditional living-donor kidney transplantation include ABO incompatibility and positive cross-match. Paired exchange kidney transplantation (PEKT) is a viable and increasingly popular method to increase live donation. We discuss the pros and cons as well as the various ways to achieve PEKT along with a review of existing literature. To achieve the full potential of PEKT, the transplant community at large needs to work toward a national kidney paired donation program along with a centralized financial intermediary.

Keywords: Live donor kidney transplantation; Paired exchange; Kidney transport

Introduction

Kidney transplantation is the treatment of choice for patients with end stage renal disease. Living donor kidney transplantation is associated with fewer post-operative complications and higher graft survival compared to deceased donor kidney transplantation. However, ABO incompatibility and positive cross match are barriers to traditional living donor transplantation in roughly one third of instances [1]. Desensitization therapies have been used to enable successful transplantation across incompatible donor-recipient pairs, but these procedures are associated with higher costs, complications and inferior long-term outcomes [2]. Paired-exchange kidney transplantation (PEKT) is an innovative approach that can overcome these hurdles which is becoming popular in the United States. Computer simulation modeling has shown that PEKT can lower costs with improved outcomes compared to desensitization [3]. The idea of PEKT was first proposed by Felix Rapaport in 1986 though first PEKT was performed in the United States in 2000 [4]. Based on the SRTR data, PEKT transplants became more evenly distributed across centers from 2006 to 2008 and the trend remained unchanged from 2008 to 2011 (Gini coefficient 0.91 for 2006, 0.76 for 2008 and 0.77 for 2011) [5]. In subsequent years, many transplant centers started participating in PEKT. In the United States, paired kidney donation increased from around 200 in year 2008 to greater than 400 in 2011 [6]. While Canada has established a single national kidney paired donation registry, United States currently has seven active multicenter registries in addition to single center registries. Individual centers tend to refer only difficult-to-match pairs, hence limiting the maximal benefit to other recipients. A consensus conference was convened in March 2012 that addressed challenges of PEKT and strongly emphasized the need for developing a single well-functioning national registry for PEKT [7].

How PEKT Works

PEKT enables a recipient with willing but incompatible donor to find a potential match from a larger donor pool. With centralization of the donor/recipient pool, it has become easier to find compatible donors across the country. Details of patient’s own HLA type as well as the antigens to which they react strongly are uploaded to enable virtual cross-matching, similar to the process followed for deceased donor kidney allocation [8]. PEKT could involve one or more pairs as shown in Figure 1. It could be a simple two way exchange where each recipient accepts kidney from each other’s willing donor (Figure 1a), a three-way exchange where donor of recipient A gives kidney to recipient B, donor of recipient B gives kidney to recipient C and donor of recipient C gives kidney to recipient A (Figure 1b) or the process can go on as a longer chain thus allowing multiple kidney transplants simultaneously.

Figure 1a: Two-way PEKT exchange

Figure 1b: Three way PEKT exchange

If a chain is initiated by an altruistic or non-directed donor, it could lead to multiple donations ending with a donor who is yet to donate, designated as a bridge donor (Figure 1c). This concept was introduced as Never Ending Altruistic Donor (NEAD) chains [9]. These transplants do not necessarily undergo simultaneously because of logistic issues and time involved in finding next compatible recipient. Sometimes, a bridge donor can end up donating to a patient on deceased donor waiting list, in a process called closed chain domino transplantation that can have a favorable impact for remaining wait listed patients hoping to receive deceased kidney transplant. Another type of PEKT is list-paired donation where willing but incompatible living donor donates kidney directly to a patient on deceased donor
list and in return for this, that donor’s incompatible recipient receives
a high priority on deceased donor wait list (Figure 1d) [1,10].

Figure 1c: NEAD chain where altruistic donor donates to recipient
A, Donor A donates to recipient B, Donor B becomes a bridge
donor for a future recipient

Figure 1d: List-paired donation

Concern for prolonged cold ischemia with donor kidney
transport

The traditional in-center kidney transplantation (ICKT) in which
donor and recipient undergo surgery in the same transplant center has
the potential advantage of minimizing cold ischemia time (CIT). In
PEKT involving multiple transplant centers, donor kidneys are
transported after procurement to the intended recipient’s transplant
center to make it more convenient for the donor who may prefer not
to travel long distances in the peri-operative period. There have been
concerns about this approach in terms of possible adverse graft
outcomes from the associated prolonged CIT including delayed graft
function (DGF) and risks of unforeseen delay in transportation of the organ.

Simpkins et al. [11] analyzed united network of organ sharing
database and found no adverse effects of CIT up to eight hours on one
year kidney allograft function, rates of acute rejection or long-term
graft survival in 38,467 living donor kidney recipients despite a slightly
increased risk for developing DGF. On the contrary, analysis of United
States renal data system showed association between prolonged CIT
and risk of developing DGF. AR, prolonged hospital stay and reduced
graft survival in deceased donor kidney transplant recipients [12]. The
difference in the implications of prolonged CIT on living versus
deceased donor kidneys could partly be explained by the susceptibility of
decesed donor kidneys to injury associated with brain death, effect
of inflammatory milieu, stress hormones and prolonged warm
ischemia time that is exacerbated by prolonged CIT. Immediate graft
function and better allograft survival with living donor kidney
transplantation could be attributed to the controlled environment at the time of procurement of a high quality kidney from a
living donor under anesthesia which makes the impact of modest increase in CIT minimal. Segev et al. [13] reported no DGF and
excellent immediate graft function despite a median CIT of 7.2 hours
in 56 live donor transplants where kidneys were transported to the
intended recipient. In our single center experience, CIT for the
transported kidneys was 13.1 ± 6.6 hours without any adverse
outcomes in patients undergoing PEKT [14]. Others have also
reported CIT ranging from 8 to 14 hours with no appreciable adverse
effects on the transported organs [15].

Disadvantage for blood group O recipients

Since candidates with blood group O are universal donors, these
kidneys are compatible for other blood group recipients as long as
cross-match is negative, resulting in scarcity of blood group O donors
in PEKT for blood group O recipients. Gentry et al proposed to
courage compatible pairs to enter in PEKT to expand the donor pool
and circumvent this issue. If compatible pairs are included in
PEKT, blood group imbalance can be corrected. Only 30% of
incompatible pairs have O donors, 61% of incompatible pairs have O
recipients. Amongst compatible pairs, 67% have O donors and one
third of these donate to non-O recipients. The recipients of compatible
pair might also benefit from participating in PEKT by finding a
younger donor or by avoiding a high immunologic risk donor/
recipient combination such as child to mother or husband to wife [16].

Outcomes of ICKT versus PEKT

One-year graft and patient survival as well as allograft function, AR
rates and incidence of proteinuria were similar between PEKT and
ICKT groups in our single center experience (14). This was despite a
significantly longer CIT and higher PRA in the PEKT group. Similar
results were reported on two year follow up with respect to death-
censored graft survival (97.1% versus 97.6%, p=ns), patient survival
(97.1% versus 94.8%, p=ns) and rejection rates (8.7% versus 9.9%) in
PEKT versus living related kidney transplantation [17,18]. Five and
ten year allograft survival rates (86.3% versus 82.3%, p=ns) were
similar in exchange versus non exchange groups undergoing living
kidney donation [19].

Financial and ethical considerations

PEKT is more cost effective as compared to continuing dialysis or
implementing desensitization protocols for highly sensitized patients.
If a national kidney paired exchange program is established in USA, it
would save $750 million annually [3,20]. Insurance companies and
private payers are reluctant to pay for evaluation of a potential donor
unless eventual transplantation to the “given” recipient could be
guaranteed. If a financial intermediary for PEKT is established similar
to organ procurement organization for deceased donors, financial
pressures currently limiting adoption of national program could be
overcome [21]. In order to pay for evaluation of potential donors,
donor travel or kidney transport, donor nephrectomy, professional
fees, donor complications, follow up, and administrative fees for
running PEKT program, it was proposed to develop a national kidney
paired donation standard acquisition charge (KPD-SAC). SAC would
represent average cost of a realized donor and would be paid by each
recipient center to the donor center [7]. This model is preferred by
several commercial insurance payers [22].

Many programs participating in PEKT believe that kidneys from
living donors are of comparable quality. Chan et al. showed that with
the exception of recipients aged 18-39 years, who had the best
outcomes with donors aged 18-39 years, living donors aged between
18-64 years has minimal effect on allograft survival [23]. Some
programs have implemented limits such that they would not match
donors to a recipient more than 20 years younger than the candidate’s incompatible donor [24].

There have been ethical concerns with PEKT. One of the biggest benefits to the donor is emotional satisfaction in helping out a loved one, which is theoretically lessened if kidney is given to an unrelated, anonymous recipient. Also, the quality of donor kidney and the transplant outcomes might be totally different in two different recipients that could cause frustration and anger in living donors and might negatively impact the decision to participate in exchange programs.

Other potential concern with NEAD chains is donor reneging when bridge donor backs out and refuses to donate when the incompatible recipient has already received transplant via another pair [25]. There have also been concerns about coercion with PEKT where the donors are unable to use ‘incompatibility’ as an excuse to avoid donation and cannot withdraw at a later date especially when their incompatible recipients have already received transplant via PEKT [26-28]. It has been proposed to institute “time limits” to prevent donor reneging, limit open PEKT and encourage bridge donors to donate to patients on deceased donor wait list [28].

Conclusion

PEKT seems to be a very practical and cost effective approach of dealing with problems of organ shortage and donor-recipient incompatibility for patients with end stage renal disease. Transplant program should be encouraged to participate in PEKT to expand the donor pool. Transplant community should actively work towards the goal of establishing a national kidney paired donation program overcoming the financial and logistic barriers.

References