Procedures for Transplantation
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The transplant procedure begins with the patient’s primary treating physician making a referral to a transplant center. The center then begins the evaluation process to determine candidacy for transplantation, which in some cases requires an inpatient stay and in other cases can be done as an outpatient. This evaluation consists of different studies depending on the type of transplant required. Medical data, psychological data and sociological data are collected on each potential candidate, along with establishing and obtaining approval from the funding source. Of great importance is the severity of the illness, and availability of alternative options for treatment. Psychological evaluations are imperative because the team has to establish that the potential candidate is capable of handling the waiting, the procedure, and the rigid follow-up and maintenance care needed to maintain the graft. Sociological considerations are assessed to determine the availability of a primary caregiver who can provide the physical and emotional support, which is vitally important to the success of transplantation. Dr. Thomas A. Gonwa (Transplant ’97) noted that the transplant candidate is replacing one disease for the disease of transplantation, which is a life long commitment. Considering the severe organ shortage, the transplant team has to make certain that they are accepting the candidates that are the most likely to benefit from the transplant. Success of a transplant is measured by improvement in quality of life and the ability of the patient to return to work.

Once the evaluation is completed and the administrative and funding issues are established, the transplant team meets to review all the data available and determine candidacy. If accepted as a suitable candidate for transplantation, the candidate’s name is then placed on the donor waiting list with UNOS, and the search for an appropriate donor begins. In some cases such as kidney and lung transplants, a living related donor organ could be suitable for transplant, which will drastically reduce the waiting time. Living-related liver transplants can be done by implanting a portion of the liver, but only approximately 15% of transplant candidates qualify for this procedure. All other solid organ transplants require the use of a suitable cadaveric organ. The Milliman USA Research Report outlined the number of patients who died while on the waiting list by organ (1999 data). The list is as follows: kidney transplants 3,073; pancreas 18; kidney-pancreas 169; liver transplants 1,756; intestine 44; heart transplants 712; lung 591 and heart-lung 53 (2002 Milliman USA).

Once a suitable donor is located by the Organ Procurement Organization, the surgical team is put in place and the candidate is notified. The surgery typically must be done within a few hours after the donor organ is harvested. Recipients have to be available twenty-four hours a day from the time they are placed on the list until an organ is procured. Their conditions are monitored in order to maintain their candidacy and the status of their disease. Escalation of a candidate’s illness can move them to a higher status on the UNOS waiting list, and in some cases
Post-transplant care consists of maintaining the organ. Immuno-suppression is primary to maintaining a transplanted organ. The patient is monitored constantly for signs of rejection. The post-transplant hospital stay varies with the type of transplant procedure performed. Once discharged from the hospital, most transplant patients and their caregivers are housed in facilities provided at nominal cost by the transplant center. These facilities are located near the center and are staffed with trained personnel to offer medical and psychological support and consultation to the recipients. Patients must remain within a sixty-mile radius of the transplant center after discharge from the hospital for a period of time, in order to make daily, then weekly visits to the center for follow up care. The length of time varies according to the type of transplant and the health of the recipient, but the implication for the life care planner is obvious. Costs of outpatient housing during any time the patient is required to reside away from home and near the transplant center are to be included in the life care plan. Once a patient is allowed to return home, they are usually released back into the care of their primary physician, with periodic returns to the transplant center for evaluation. Transplant recipients of organs from a donor other than an identical twin, will have to be maintained on immunosuppressant medications for the remainder of their lives in order to prevent rejection.

Works Cited:
Gonawa, Thomas A., M.D., F.A.C.P., Associate Director of Transplant Services, Baylor University Medical Center, Dallas, Texas; presentation “Transplantation ‘97,” Current and Future Trends, Baylor University Medical Center an affiliate of Baylor Health Care System, A. Webb Roberts Center for Continuing Education, Dallas, Texas, January 29-31, 1997.