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REPLY: Does Overtreatment of Heart Transplantation Candidates Exist?

William F. Parker, MD[*], **Allen S. Anderson, MD**, **Elbert S. Huang, MD**, **Edward R. Garrity Jr.**, and **Matthew M. Churpek, MD, PhD**

[*]University of Chicago 5841 S. Maryland Avenue, MC 6076 Chicago, Illinois 60637

We thank Dr. Rajagopalan and colleagues for their letter regarding our work (1). We agree that the Organ Procurement and Transplant Network (OPTN) cardiogenic shock criteria (2) are problematic, and our purpose was not to explicitly advocate for these rules. In a prior publication, we have shown that the OPTN shock criteria fail to predict waitlist survival and will block hundreds of patients per year from high-priority status, potentially leading to unintended consequences (3). As we state in the current paper, we "anticipate that centers will shift practices and use more surgically placed mechanical circulatory support devices, which would be exempt from the shock requirement" (1).

However, we do not believe the limitations of the OPTN shock criteria significantly alter the primary interpretation of our results, which is that substantial variation in the treatment of adult heart transplant candidates exists (1). More than 40% of centers in our study very rarely treated noncardiogenic shock candidates with high-dose inotropes or intra-aortic balloon pumps, instead listing them as status 1B with low-dose inotropes or status 2 with no support. In contrast, the 28 centers in the top quartile were responsible for most (60%) of the potential overtreatment. We therefore disagree with the claim of Dr. Rajagopalan and colleagues that the use of high-dose inotropes on nonshock candidates is a "well-accepted practice." With regard to their proposition that differences in the use of ventricular assist devices explain the intercenter variation, we would point out that we explicitly excluded candidates supported with left ventricular assist devices in our calculations.

Finally, we found this statement by the letter writers notable: "These patients may not meet the definition of cardiogenic shock, but they are not being overtreated. With the current allocation system, they are getting proper treatment to facilitate transplantation." The OPTN ethics committee recently published a white paper on the manipulation of waitlist priority through the escalation of medical therapies (4). They conclude that "while physicians' fiduciary duty to 'do all they can' for their patients is understandable, the practice of initiating, augmenting, or maintaining therapeutic measures that are not otherwise indicated for the sole purpose of advancing a patient's status on the waitlist is contrary to the OPTN/UNOS's ethical principles of organ allocation, and is thus not ethically supported by the transplant system." Although the heart allocation system has its flaws, we agree with the OPTN that deliberate manipulation of the ranking system is unethical.

william.parker@uchospitals.edu, Twitter: @WF_Parker.

Please note: The authors have reported that they have no relationships relevant, to the contents of this paper to disclose.

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