Guidelines Issued on Evaluating Kidney Donors

BY ROBERT FINN
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SAN FRANCISCO — A panel of 70 transplant professionals has published a consensus document on the psychosocial evaluation of living unrelated kidney donors, Dr. Francis L. Delmonico reported at the American Transplant Congress.

The guidelines are intended to help transplant centers exclude donors who are unsuitable for a variety of nonmedical reasons, such as coercion, unrealistic expectations, and psychological disorders. "The objective was to assess the characteristics of a prospective unrelated donor that might either increase the risk or serve as a protective factor against a poor donor psychosocial outcome," said Dr. Delmonico, professor of surgery at Harvard Medical School, Boston.

Describing the current situation as "an era of changing donor-recipient relationships," Dr. Delmonico said that the guidelines will likely allow transplant centers to be "somewhat more secure in proceeding ahead in very careful assessment and within an ethical framework."

The new guidelines are the result of a meeting convened in May 2006 by the United Network for Organ Sharing in collaboration with the American Society of Transplant Surgeons and the American Society of Transplantation. That panel recommended several revisions to earlier consensus statements on living donors and offered a new list of required components for the psychosocial evaluation of living unrelated kidney donors. (See box.)

The new document notes that biologically unrelated donors constitute 35% of the living kidney donors in the United States. Among living donors, the percentage without a biologic or close emotional relationship to the recipient rose from 6.5% to 23% between 1996 and 2006 (Am. J. Transplant. 2007;7:1047-54).

Some of the factors that would tend to increase the risks of living unrelated kidney donation are significant psychiatric symptoms or disorders; substance abuse or dependence; a lack of health insurance; a limited capacity to understand risks; motives reflecting a desire for recognition; a subordinate relationship to the patient, such as employee or employer; or an expectation of secondary gain.

Several other factors would tend to decrease the risk, including financial resources that could cover unexpected costs, realistic expectations about the donation experience, little or no ambivalence, a history of medical altruism, an absence of recent significant life stressors, and support from family for the donation.

In its changes to earlier consensus statements, the panel noted that novel forms of donor solicitation, such as Internet sites, point to an increased need to ascertain that the prospective donor was not pressured and does not expect financial gain.

This meeting was cosponsored by the American Society of Transplant Surgeons and the American Society of Transplantation. ■

Assessing Unrelated Prospective Donors

The following are the required components of psychosocial evaluations for living unrelated kidney donors, as agreed to by a panel convened by the United Network for Organ Sharing, the American Society of Transplant Surgeons, and the American Society of Transplantation:

► **History and current status.** Assess factors such as the prospective donor's educational level, employment, legal offense history, and citizenship.

► **Capacity.** Ensure that the prospective donor's cognitive status and capacity to comprehend information are not compromised.

► **Psychological status.** Determine whether the prospective donor has ever had any psychiatric disorders.

► **Relationship with the transplant candidate.** How close is the relationship, and would the transplant impose expectations or perceived obligations?

► **Motivation.** Determine the voluntariness of the proposed donation. Is it consistent with past behaviors and values? Is it free of coercion, inducements, ambivalence, impulsivity, and ulterior motives?

► **Donor knowledge, understanding, and preparation.** Does the prospective donor understand potential short- and long-term risks, including recuperation time and financial ramifications?

► **Social support.** Evaluate familial, social, and employer support networks available to the prospective donor.

► **Financial suitability.** Determine whether the prospective donor is financially stable and has resources available to cover expected and unexpected donation-related expenses.

Source: Am. J. Transplant. 2007;7:1047-54.

Does OSA Raise Gestational Diabetes Risk?

BY ROBERT FINN
San Francisco Bureau

SAN FRANCISCO — Pregnant women who have obstructive sleep apnea have a 2.3-fold increased risk of gestational diabetes and a 4.2-fold increased risk of pregnancy-induced hypertension, compared with women without the sleep disorder, according to a poster presentation at the International Conference of the American Thoracic Society.

Previous research has suggested that obstructive sleep apnea (OSA) may induce systemic hypertension and diabetes mellitus in the general population, but the connection was much less clear in pregnant women, investigator Dr. Michael S. Nolledo of the Robert Wood Johnson Medical School, Princeton, N.J., said in a press briefing.

"A lot of times for patients who are pregnant and for ob.gyns., sleep-disordered breathing is not on the radar screen," he said. When a woman who's pregnant goes to see her obstetrician, the physician asks a zillion things but almost never inquires about risk factors for sleep apnea.

Dr. Nolledo suggested that physicians dealing with women with gestational diabetes or pregnancy-induced hypertension (PIH) should inquire about sleep-disordered breathing, especially because OSA is so simple to treat with continuous positive airway pressure (CPAP).

"It may be a condition that you need treatment for just for the time you're carrying your baby," he said. "Once you deliver, the sleep apnea may resolve."

Dr. Nolledo acknowledged, however, that his study contains no direct evidence that treating sleep apnea will improve PIH or gestational diabetes.The study relied on data from the 2003 National Inpatient Sample, sponsored by the Agency for Healthcare Research and Quality. This large database includes all inpatient records from a sample of about 20% of U.S. community short-stay hospitals and provides weights to calculate national estimates.

Using this database, the investigators calculated that there were 3,979,840 deliveries in the United States in 2003, of which 167,227 were complicated by gestational diabetes and 300,902 were complicated by PIH. The overall rate of sleep apnea for these women was 1.14/10,000—but that rate was 4.01/10,000 among women with gestational diabetes and 5.52/10,000 among women with PIH.

In an interview, Dr. Nolledo acknowledged that the overall rate of OSA recorded in the database is much lower than the 2%-4% rate of OSA estimated for the general population. He attributed this in part to the failure of physicians to ask their pregnant patients about sleep-disordered breathing. ■