Tissue Donor Eligibility Trends and Challenges

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Biggest change was Medicare act of 2009—no more reimbursement for hospital-acquired infections.

Since then, we’ve seen a huge spike in “sepsis” and “SIRS” in medical records.

MDs are no longer just keeping sepsis in the back of their minds. They are writing it in the chart, and then, whereas they used to drop it when ruled out by BCXs, etc., they are leaving it on the active problem list in case it develops later.

Teaching hospitals also have residents and students writing daily progress notes on patients and differential diagnoses/working problem list are often wide and items are not dropped when ruled out.

EBAA standards 2012:

- Contraindications to transplant: Infection
- Active viral encephalitis of unknown origin or progressive encephalopathy (e.g., subacute sclerosing panencephalitis, progressive multifocal leukoencephalopathy, etc.)
- active bacterial or viral meningitis;
- active bacterial or fungal endocarditis
- Screening for FDA Defined Relevant Communicable Disease Agents and Diseases
- The FDA defines communicable disease agents and diseases considered relevant (Ref. Appendix I). Tissue from persons exhibiting risk factors for, clinical evidence of, or physical evidence of relevant communicable disease and high risk behavior associated with relevant communicable disease must not be used for transplant purposes (Ref. Appendix II).

FDA 2007: high communicable disease risk factors:

- Persons who are deceased and have a documented medical diagnosis of sepsis that is not explained by other clinical conditions at the time of death. An eye bank should make a determination on how to routinely handle situations of clinical history proximal to death in which sepsis was suspected at the time of admission or part of a differential diagnosis during admission in which the patient may have been shown through clinical data not to be septic prior to death.
FDA Screening Measures

Clinical evidence of infection; and

• Two of the systemic inflammatory response criteria to infection if unexplained:
  – Temperature of > 100.4°F (38°C);
  – Heart rate > 90 beats/min;
  – Respiratory rate > 20 breaths/min or PaCO2 < 32; or
  – WBC > 12,000 cells/mm², < 4,000 cells/mm², or > 10% immature (band) forms.

• More severe signs of sepsis include unexplained hypoxemia, elevated lactate, oliguria, altered mentation, and hypotension.

• Positive (pre-mortem) blood cultures might be associated with the above signs.

• Physical evidence of sepsis, such as unexplained generalized rash or fever.

Define SIRS here...

Reiterate it is a DX of exclusion, and should not be made when there are clear clinical problems that may manifest as SIRS....
Usually, 24 hours of ABX and evidence of some kind of defervescence is all we need to rule out sepsis at TOD in the truly septic patient. Patients with severe sepsis should thus receive a broad-spectrum, intravenous regimen that is effective for both gram-negative and gram-positive bacteria, and they should receive it as quickly as possible.

Recovery from severe sepsis or septic shock is unlikely, even with appropriate antimicrobial therapy and diligent ICU care, if the patient has an undrained abscess or obstructed viscus.

Delirium vs Dementia

- Definitions of Each
- Healthcare Climate and Impact on Misdiagnosis
- Alzheimer’s vs Senile Dementia
- 12 month rule
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Exotic Diseases
- Ebola
- Mumps Outbreak
- Dengue
- Hemorrhagic Fevers
- Chikungunya

Autopsy Issues
- Timely Release
- Provisional Results
- Medical Director Interventions
  - Call to ME for “verbal”
  - Chart Review

Delayed Autopsy Reports

Lecture Outline
- Cause of Death Issues
- Paper Sepsis
- Delirium vs Dementia
- Flu vs Viremia
- Exotic Diseases (i.e. Ebola)
- Delayed Autopsy Reports
- Follow-up information
- Ancillary test results