AST T3 Webinar on A Discussion of Risk in Living Kidney Donors – Additional Q&A
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1. Comparing ESRD risk profiles between non-related healthy non-donors and non-related donors seems to be a better comparison to avoid the confounding effect of family disease. [Comment]
Answer: The problem with such an analysis is the relatively recent implementation of routine use of non-related donors: small "N" with relatively short follow-up. The Norwegian study could not be done, and the "N" in the US study would be relatively small. In the future, such a comparison may become more feasible.

2. Based on the data presented and the perceived "liberalization" of the LD phenotype (increase in metabolic syndrome prevalence, smoking) is there a need for the creation of a more stringent and a nationally uniform set of criteria for acceptance for LD?
Answer: I question the "liberalization" hypothesis. At UAB, we are much more conservative than ever before in donor selection. The concept of "metabolic syndrome" didn't exist a decade ago, and only recently are we considering smoking a relative contraindication. Each week, we deal with "donors with issues" that require careful deliberation regarding candidacy; it is these donors that are problematic, not the ones that would be amenable to fixed standards or criteria. It is hard for me to envision more stringent standards (based on currently available evidence, not fears) that would allow sufficient flexibility to deal with fluid clinical situations.

3. How would you comment on changes in non-filtration function of native kidneys in living donors?
Answer: Clearly, living donors undergo reduction in nephron number; the phrase "25-35% reduction in GFR" is misleading as there is really 50% reduction offset by hyperfiltration of the remaining normal nephrons that leave the donor at 65-75% of original GFR. It is interesting in the Turin JASN study that eGFR over 60 was not associated with increased risk of ESRD. Our data regarding loss of GFR over time in donors is really based on cross-sectional observation; longitudinal studies in individual donors (ALTOLD) may offer interesting data regarding how these hyperfiltering but otherwise normal nephrons behave over time.

4. Do we have an obligation to work toward having long term Primary care coverage via governmental coverage as this is where the ERSD savings are occurring?
Answer: This is a bigger issue than the scope of our presentation, although when we proposed making donors eligible for Medicare in 2006, we were accused of offering undue enticements to coerce potential donors. It is hard to look at the list of financial disincentives we are required to inform potential donors of in 14.3.A.i and, at the same time, decry donor compensation.

5. This is for Bob and Arthur- are these new data going to affect your decision making for living donor candidacy and if so, how?
Answer: Not really. We are more troubled by potential for long-term risk in young black males (as outlined by Steiner et al). We are discussing smoking as an absolute contraindication, but how do you enforce? We already counsel not to smoke. The key is not necessarily a change in decision-making but ensuring adequate informed consent in light of new data.

6. In your opinion, would these results eventually discourage kidney donation from a non-directed donor (altruistic donor) due to increased risk of end stage renal disease?
Answer: No; if anything these data indicate risk is greatest in relatives; still a little unclear regarding magnitude, if any, of increased risk in non-related donors.

7. Perhaps the appropriate control group should be limited to non-donors who are first degree relatives of persons w/ ESRD in order to address the well-recognized familial clustering of ESRD?
Answer: This is the basis for the design of the ALTOLD study, although, enrollment criteria was liberalized to generate sufficient "N" to address the issues of concern.

8. Would you exclude donors with pre-diabetes?
Answer: Not a rule; quite frankly, this is a definition that seems to evolve, and really is a measurement of risk that is also evolving. This depends very much on associated co morbidity, family history, and other case-by-case variables. In general, we require normal glucose tolerance (FBS and 2hPPG) in all potential donors.

9. What specific health-promoting interventions do you utilize in your donor population?
Answer: At the time of evaluation, we promote smoking cessation, weight loss, healthy diets, etc. in our donors. Post-donation, we promote mandated post-op monitoring at the center level, healthy diet, and regular follow-up with their personal physician.