

sensitive issue [3]. Since 2012, 16 combinations of these procedures have been performed in the Netherlands [4]. Literature mentions 16 Belgian cases between 2005 and 2013 [5, 6]. This limited number can be the result of lack of knowledge about this subject among health-care professionals or because of practical, ethical and/or legal considerations. Performing this combination has possible advantages, both in number as well as in transplant outcomes. By describing a recent case in our centre, we will try to outline the state of the art in the Netherlands and disseminate knowledge about the possibilities and limitations of organ donation after active euthanasia.

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## PP10

### SEEKING TRANSPARENCY ON ALLOCATION OF KIDNEYS FROM DECEASED DONORS

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Kidney transplantation is the preferred treatment for many end stage renal disease patients; however, the small number of organs for transplantation does not allow all patients to have access to this scarce resource. An allocation system for deceased donor kidneys should be anchored to transparent policies and rules. It should take into account the relationship between supply and demand, hence seeking a balance between the higher net benefit of survival that can be provided by a particular organ and the transplant candidates' waiting time (as well as the probability of being transplanted). Nowadays, many deceased donor distribution protocols are based on candidates' waiting time (or time on dialysis) not taking into account graft and patient post-transplant survival. The Portuguese deceased donor kidney allocation scheme is based on a system of points assigned to each possible receptor given a specific potential donor, similarly to other systems implemented in the US or the UK. However, the key factor in organ allocation is time on dialysis (first

come, first served basis). The point system from the Portuguese rules for the selection of donor-recipient pair in transplantation with cadaveric donors is opaque and tends to over select patients with longer time on dialysis. These rules have also been associated with an augmentation in the number of acute rejections. As an alternative to the existing allocation system, we propose a colour system classification (Table 1) that will allow clinicians to know the position of a particular patient in the access to kidney transplantation at all times. Within each colour group, the candidates order will be determined taking into account the number of HLA compatibilities with the donor and, if a tie still persists, the decision is made by the time on dialysis. By setting only four colour groups on the basis of justice (time on dialysis and probability of transplantation) and, within each of these groups, candidates are ordered based by efficiency (HLA compatibilities); the proposed criteria meant to be balanced. This proposed new allocation system for kidney transplantation has the advantage of being more transparent than the current Portuguese rules; with it, clinicians can explain to the patient in a more intuitive manner how far they are from being transplanted. Also, the realization that patients classified as green will likely wait too long for an organ, can easily sway them toward the solution of transplantation with a living donor.

Table 1. Kidney allocation colour system

Not ECD		ECD	
Recipients ≤ 65 years old	Clinically Urgent	RED	Clinically Urgent
	cPRA ≥ 85% or ToD ≥ 3 <sup>rd</sup> Quartile <sup>1</sup>	ORANGE	cPRA ≥ 85% or ToD ≥ 3 <sup>rd</sup> Quartile <sup>1</sup>
	cPRA ≥ 50% or ToD ≥ Median <sup>1</sup>	YELLOW	cPRA ≥ 50% or ToD ≥ Median <sup>1</sup>
	cPRA < 50% and ToD < Median <sup>1</sup>	GREEN	cPRA < 50% and ToD < Median <sup>1</sup>
		Recipients > 65 years old	

ECD – Extended Criteria Donor; cPRA – calculated PRA; ToD – Time on dialysis  
<sup>1</sup> – wait listed patients' time from first dialysis to transplantation

## PP11

### COMMON MISCONCEPTIONS ABOUT THE ROLE OF NURSES IN DECEASED ORGAN DONOR REFERRAL IN JOHANNESBURG, SOUTH AFRICA

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Introduction: In South Africa (SA) death rates in hospitals are attributed to many causes, including hypertensive head bleeds and traumatic injuries. Yet, the referral of potential deceased heart-beating organ donors is