AATB Physicians Council

2020 Updates

Roumen A. Hitchev MD, FACPE
V.P. & Chief Science Officer

Standards Committee
Scientific & Technical Affairs Committee

American Association of Tissue Banks®

Presenter

Dr. Roumen A Hitchev

1987-1990	Internship at the Bulgarian Military Medical Academy
1990-1994	Navy Hospital, Varna, Bulgaria
1994-1995	US Academy of Health Sciences, Ft Sam Houston, Texas, USA
1996-1998	Washington Regional Transplant Consortium, Washington DC, USA
1998-2001	Lions Eye/Tissue Bank & Research Foundation, Washington DC, USA
2001-2012	OTI, now Medtronic, NJ, USA
2013-2016	EU Project on Alignment in Tissues & Cells, Paris, France
2017-current	American Association of Tissue Banks, McLean VA, USA

American Association of Tissue Banks

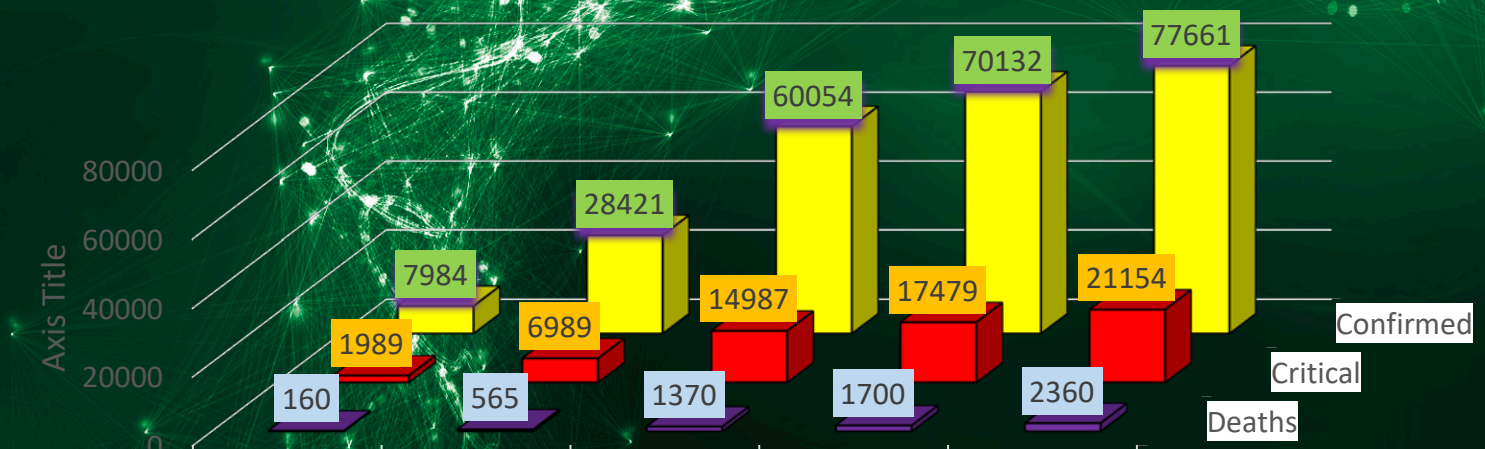
Dr. Roumen A Hitchev, MD
V.P. & Chief Science Officer

- A professional, non-profit, scientific and educational organization
- The only national accrediting institution for tissue banks in the US
- 120 accredited institutional members – OPOs, tissue banks, processors, biotech companies.
- 2 000 individual members.
- Over 39 000 donors per year.
- 4 million allografts for > 2 million tissue transplants
- >90% of US transplants - from AATB-accredited tissue banks
- >70% of allografts in the EU come from the US

Consent / Authorization for Donation
Legislative Models

1. **Opt-in** Model/Concept: **not** a donor unless opt in
   - => **informed consent** from a living donor
   - => **explicit authorization** from the LNOK of a deceased donor
   - => **broad spectrum** of LNOK (they know the wishes best)
2. **Opt-out** Model/Concept: **presumed** a donor unless opt out
   - => **soft** (NOK **can overrule** the law)
     - NOK *must be informed, but very **close circle** of family*
     - ***if no NOK, the law applies***
   - => **hard** (NOK **cannot overrule** the law)

Donor Deferral Considerations – COVID-19



	9-Jan	20-Jan	12-Feb	16-Feb	22-Feb
Deaths	160	565	1370	1700	2360
Critical	1989	6989	14987	17479	21154
Confirmed	7984	28421	60054	70132	77661

COVID-19 Impact on Transplantation
Donor Eligibility Considerations

Confirmed = 77 661

Deaths = 2 360

Case Fatality Rate = 3.04% (*SARS had CFR= 9-10%; MERS had a CFR=36%; Common Flu CFR = 0.1%)*

NEJM study: **138 confirmed => 55 (40%) seek H care => 36 (26%) admitted in ICU**

However: unknown cohort of **Minimally Symptomatic + Asymptomatic** may increase the denominator and thus bring down the CFR.

Flu pandemics of **1957, 1968, 2009** (swFlu) had **CFR = 0.8 – 1.2%** and R_0=1.5

Spanish Flu of **1918** had a **CFR = 2%** and **R_0=1-1.5**

Basic Reproduction Ratio of 2019-nCoV: **R_0 = 1.4 – 4.1** / Measles (Morbili): **R_0 = 12–18**

cFlu - **R_0 = 2-3** / Ebola **R_0 = 1.5 – 2.5** ; If **R_0>1** the outbreak expands; if **R_0<1** the outbreak declines.

COVID-19 Impact on Transplantation
Contributing Factors

Travel: 22,000 people from China enter USA per day.

Incubation: 2 – 14 days (5d average)

Asymptomatic & **Masked/Minimally Symptomatic transmission** (t^0-lowering meds)

Open Q's: is the virus replication-competent or just PCR identifiable? **RNAemia** is described in **30%** of patients, both critically, and non-critically ill.

Children typically present with fewer symptoms but may progress quickly to critically ill.

Vertical transmission – one case reported of tx from birth mother to newborn within 32 hours.

COVID-19 Impact on Transplantation
Donor Deferral / Exclusion Criteria

A. Criteria related to **exposure: 3 criteria** – 1 related to [travel-only] and 2 related to [travel + symptoms/exposure]
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1. Travel to **China** (regardless of symptoms). *Yes/No*

2. Travel to a **transmission area** *(CDC-designated active tx area)*, **and:**

a) Presentation of symptoms consistent with 2019-nCoV, e.g. unexplained fever, cough, diarrhea; or *(i.e. a fever accompanied by minimally enlarged cervical lymph nodes confirmed histologically to be caused by histiocytic necrotizing lymphadenitis, aka Kikuchi-Fujimoto disease, does not meet this sub-criterion)*

b) Exposure link to a suspected case-patient while in the designated area. *(the qualifier is based on "suspected case-patient", i.e. the suspicion must be qualified by a report filed by a provider/physician and it must be in the designated active transmission area)*

B. Criteria related to **infection: 2** *criteria in this group – one related to confirmed infection, and one related to symptoms.*

1. Test positive for 2019-nCoV *(Yes/No).*

2. Symptoms consistent with active 2019-nCoV, e.g. unexplained fever, cough, diarrhea in a patient with suspected 2019-nCoV infection. *(see comments above).*

Panel on Dementia

Roman Hitchev MD, Lennox Archibald, MD

- Federal regulations, § 1271.75(d) 20 state: "*Persons who have been **diagnosed** with dementia" should be determined to be ineligible*." [emphasis added] The rule-out criterion is based on the "***diagnosis***" of dementia.
- Must discern the difference between cases where dementia is documented as "***diagnosis of Dementia***" (defined by the FDA as a rule-out criterion) vs cases where dementia is listed as a "**differential diagnosis**".
- A "***diagnosis***" refers to a **confirmed identification** of a specific condition or disease, while "**differential diagnosis**" is just weighing the probability of one clinical condition vs another. Must also discern the difference between dementia and delirium, which is a temporary condition developed over a short period of time, requiring urgent care, and is not CJD-related.
- In addition, the term "***diagnosis***" is **not equal** to "***suspicion***" or "***exposure***". As an example, §1271.75(d)6 defines the rule-out criterion pertaining to HIV, HBV, and HCV as "*Persons who have been **exposed**"* to the virus, while §1271.75(d)15 defines the rule-out criterion pertaining to WNV as "***suspicion** of WNV infection*".
- AATB rule-out examples: "***suspected** Rabies*" (Appendix II, i.23); "***suspected** sepsis*" (Appendix II, i.24)
- The term "**diagnosis**" must be applied in its correct clinical meaning according to current clinical and diagnostic practices outlined in the latest **Diagnostic & Statistical Manual of Mental Disorders, 5th Edition** (**DSM-5**).

Appendix II: Criteria for Preventing Transmission of RCDADs Through Transplantation of Human Tissue

13) persons with a **diagnosis of dementia** or any degenerative or demyelinating disease of the central nervous system (CNS) or other neurological disease of unknown etiology. A "*diagnosis of dementia*" must be based on the following documented clinical findings:

(i) Documented **clinical assessment of cognitive status showing cognitive impairment**;
(ii) Mini Mental State Examination (Cognitive and neuropsychologic testing) with a **MMSE score below 13**, or a **drop of 3 points** or more since previous exam, if performed;
(iii) Less than an 18-month history of cognitive impairment;
(iv) Neuromotor function assessment showing **neuromotor deficit**;
(v) Documented **exclusion of treatable causes** (showing that the patient underwent proper diagnostic evaluation for treatable causes, but none were found);

Note: Tissues from donors diagnosed with dementia, confirmed by gross and microscopic examination of the brain and other diagnostic means to be caused by cerebrovascular accident, brain tumor, head trauma, or toxic/metabolic dementia and who are confirmed not to have evidence of TSE on microscopic examination of the brain, *may* be acceptable based on an **evaluation of this information by the Medical Director**; *(MRI: **pulvinar sign** – hyperintensity in the pulvinar thalamic nuclei, Hockey Stick sign)*

Panel on anti-HBc-total Positive Donors

Chair: Lennox Archibald, MD

AATB Staff Liaison: Roman Hitchev, MD

Higher rates of anti-HBc-total positive results on **non-heart-beating donors** compared to **heart-beating organ donors** and blood donors (double the rate), i.e. **hemolysis** may cause **false positive** results.

Organ transplant surgeons routinely **accept anti-HBc** positive (HBV NAT negative) donors – no positive seroconversions on recipients.

When the **anti-HBc-total (IgM+IgG)** test was introduced for the HBV risk evaluation the positive rate was substantially increased.

Most positive results are caused by an **elevation of IgG** known to have **heterophilic antigen binding capacity**, i.e. can be elevated by medical conditions unrelated to HBV, while IgM may be negative.

Panel on anti-HBc-total Positive Donors

Chair: Lennox Archibald, MD

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False Positive Paradox, i.e. *statistical result where* ***false positive*** *tests (proven by ID-NAT, HBsAg, and clinical assessment) are* ***more probable than true positive*** *tests, occurring when the overall population has a low prevalence of the condition and the* ***prevalence rate is lower than the false positive rate***.

Prevalence of Viral Hepatitis in the US (*National Health and Nutrition Examination Surveys,* NHANES) is **0.3%**

The **false positive rate** for **anti-HBc** is **8.2%** (Smith et al, University of Arizona, Infectious Disease, Aug'2017).

Panel on anti-HBc-total Positive Donors

Chair: Lennox Archibald, MD

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False Positive Paradox calculation: In a population, in which the HBV prevalence is **0.3%**, the expected outcome of **1000 screened donors** would be:

True positive: 1000 x (0.30/100) = **3** screened donors would receive a true positive result

False positive: 1000 x (100 – 0.30)/100 x 8.2% = **82** screened donors false positive

Correctly negative: The remaining **915** = 1000 - (3 + 82) tests would be correctly negative.

Only **3** of the **85** total donors with a positive test result are actually infected. So, the probability of a donor testing positive for **anti-HBc** actually being infected is only **3.5%**.

False Positive Paradox: Out of **1000** donors screened and found **HBcAb positive**, **965** will be **false-positive** for **HBcAb-total** and rejected without any additional evaluation, and only **35** will be **true positive**.

Therefore, an expanded assessment of all serological evidence and clinical findings with regards to HBV, e.g. **HBsAb titers and ID-NAT testing** is justified.

Panel on anti-HBc-total Positive Donors

Chair: Lennox Archibald, MD

AATB Staff Liaison: Roman Hitchev, MD

A positive result for **anti-HBc-total** does not necessarily mean HBV exposure or infection if **HBsAg & ID-NAT** test negative; in addition, a positive **anti-HBs** is typically the result of a vaccination.

Anti-HBc-total (IgM + IgG)- **IgG** is known with **heterophilic antigen binding capacity**, i.e. may get elevated for reasons not related to HBV.

A recent study: immunoassays used in HBcAb tests may be influenced by **endogenous, natural, polyreactive heterophilic antibodies that cross-react with the assays**, or **autoantibodies**, together with **other unsuspected binding proteins** that are unique to the individual. A variety of **antigenic stimuli** can interfere with the **reaction between analyte and reagent antibodies** in an immunoassay, resulting in false positive or negative values.

Another study showed that low-level results in radio-immunoassays caused by **anti-HBc-IgM** reflect the **unspecific activation of immature B lymphocytes** that is **not related to previous exposure** to **HBV,** i.e. determination of classes and subclasses of anti-HBc provides a tool for discriminating positive anti-HBc results not caused by HBV exposure.

Panel on anti-HBc-total Positive Donors

Chair: Lennox Archibald, MD

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Dietary supplements with a high content of **biotin**, incl. **Vit.B7**, **Vit.B8**, **Vit.H**, or **Coenzyme R**, is known to interfere with Biotin-Based immunoassays (BBAs) applied in approximately **60% of the procedures** in the US, among which is the **anti-HBc-total test**, according to a study published by Archives of Pathology and Laboratory Medicine, Vol.141, Nov 2017.

In a recent paper, Hinsekamp et al[9] have reviewed the **adverse reactions** and events related to **musculoskeletal allografts** which is the most demanded tissue. They analyzed medical literature, reports from professional organizations and tissue banks. Wang et al[10] used FDA's MedWatch reporting system to review reports on adverse events attributed to allografts of several kinds of tissue, during 2001-2004. **No cases of hepatitis B transmission were reported**.

A BMJ-published study in 2002 confirmed that **liver transplant** recipients of **anti-HBc positive** livers who were **anti-HBs positive** pre-transplant, and who did not receive prophylaxis, **did not** experience **de novo infection**.

Panel on anti-HBc-total Positive Donors

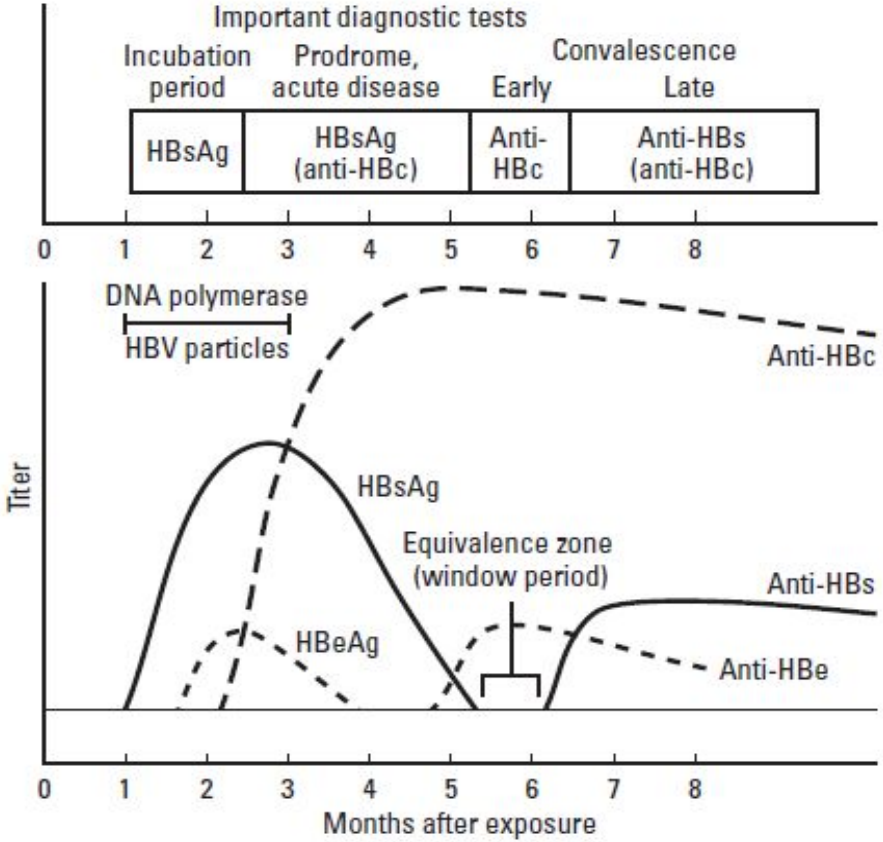
Roman Hitchev MD, Lennox Archibald, MD

Conclusion: considerable percentage of screened donors testing **HBsAg-negative,** HBV **ID-NAT-negative,** and **positive for anti-HBc-total (IgG+IgM)** are **false positive** on the anti-HBc-total test due to IgG elevation for reasons unrelated to HBV. Distinguishing false positive anti-HBc from true positive anti-HBc results is critically important because:

a) **Considerable number of eligible donors are rejected due to false positive results (96.5% of the screened HBcAb positive donors are false positive);**

b) **On the other side of the argument,** the **HBcAb** marker is the only marker (besides HBeAb) covering the window period when both **HBsAg** and **HBsAb** may not be detectable. This **underlines the value of HBsAb** testing because if positive, the window period moves out of the equation. Because individual IgM testing is more sensitive than the total (IgM+IgG) testing and can yield false-positives too, **a positive HBsAb provides additional reassurance for high level of immunity and that the case does not fall in the window period**.

Therefore, comprehensive assessment of **all serological markers AND clinical findings** is warranted. (**EU approach: HBsAb titers >10 IU/L and > 100 IU/L**)


Important diagnostic tests
Incubation period
Prodrome, acute disease
Convalescence
Early
Late
HBsAg
HBsAg (anti-HBc)
Anti-HBc
Anti-HBs (anti-HBc)
0 1 2 3 4 5 6 7 8
DNA polymerase
HBV particles
Anti-HBc
Titer
HBsAg
Equivalence zone (window period)
Anti-HBs
HBeAg
Anti-HBe
0 1 2 3 4 5 6 7 8
Months after exposure

Panel on Rule-out Microorgansim List Reduction for Skin Grafts

Chair: James Alexander, MD

AATB Liaison: Roman Hitchev, MD

Initial TB assessment (Panel): to remove some **non-category III** organisms (**BSL-1** & **BSL-2**), e.g. ***Enterococcus*** (***VSE***), ***common fungi*** and ***yeast***, from the unacceptable list for skin intended for barrier skin transplant.

Clinical Assessment (burn surgeons): the rule-out list should include ***MRSA***, ***Group-A Strep***, ***Gram-negatives*** (not normal skin flora) as well as ***Clostridia***, ***Enterococcus*** & ***fungi*** (not normal skin flora).

Considerations: **(i)** Revisiting the rule-out microorganism list would **add risk** and should be considered **only if the scope of the problem with skin discards is substantial enough to justify the added risk**.

(ii) The notion of **sterilizing skin** is not widely held in the USA and only supported by a few establishments that use **radiation** and/or **glutaraldehyde** to treat the skin - **not good for graft vascularization**, accepted only when skin sterility is important/relevant.

(iii) Should **coordinate** any reduction **with burn surgeons** providing care for **immunocompromised patients** with heavily colonized wounds & multi-resistant organisms.

(iv) Experience from **orthopedic** surgery applications is **not applicable** to critically ill patients - most of the orthopedic grafts are **terminally sterilized** and used in **non-immunocompromised** patients.

Panel on Rule-out Microorgansim List Reduction for Skin Grafts

Chair: James Alexander, MD

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Many microorganisms considered "***environmenta***l" in the high humidity environment of the burn unit, e.g. **fungi** – **Aspergillus**, **Pseudomonas** and **Serratia** **can kill** burn patients or make them gravely ill.

The notion that burn surgeons use **prophylactic agents targeting environmental** organisms **or systemic** prophylactic **antifungals** routinely for surgery (autologous or allografting) is **incorrect**.

The burn surgeon may **not** be OK with allograft skin that tested positive for **Klebsiella**, **E Coli**, or **Acinetobacter**? Would they even know or be required to **sign a "*release based on tissue utility*"** in which they accept responsibility for using skin with these organisms?

It might be OK modifying the list to be more specific to allow skin testing positive for **Staph epidermidis**, but **not** **MSSA** or **MRSA**, perhaps also **Enterococci species** but **not** **VRE**. In addition, **Gram-negatives**, **mold**, **fungi**, **group A Strep**, **Clostridia** need to remain on the rule-out list. However, are tissue banks going to bear the cost of sensitivity testing?

Panel on Rule-out Microorgansim List Reduction for Skin Grafts

Chair: James Alexander, MD

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Liability exposure: if the burned allograft recipient became **septic (or died)** from an organism not cultured from his/her own wounds or another source within the hospital but **cultured by the skin bank from the donor tissue prior to release**, the tissue bank must be prepared to **justify the eligibility determination** based on the specific culture results.

Considering the comments provided by surgeons and the current requirements of AATB Standard **K2.320**, a tentative revision should be discussed jointly by experts in tissue banking and burn surgeons, and consensus should be reached before a recommendation is made to the Standards Committee with regards to a reduction of the rule-out microorganisms.

Panel on Rule-out Microorgansim List Reduction for Skin Grafts

Chair: James Alexander, MD

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K2.320 Final/Pre-Packaging Cultures

Except for *autologous* and *reproductive tissues*, all *tissue* to be released for human *transplantation shall* have representative microbiological cultures obtained which includes testing to detect bacteria and fungi. … Except as described for *skin* (S) below, no *allografts* contained within the *processing batch may* be released for *transplantation* if post-*processing* final sterility test results show organism contamination. *Allograft* rework is permitted with an established program *validated* to eliminate the organism identified.

(S) Representative fresh or *cryopreserved skin* samples *shall* be cultured for the presence of fast-growing fungal organisms. Fresh or *cryopreserved skin shall* **not** be used for *transplantation* if any one of the following is detected at final culture:

1) *Staphylococcus aureus;* ***(Staph Epidermidis may be acceptable based on MD evaluation)***

2) Streptococcus pyogenes (group A strep.);

3) Enterococcus species **if VRE**;

4) gram-negative bacilli;

5) Clostridium; and

6) Fungi (yeasts, molds).

Sepsis

If "**sepsis**" or "**rule-out-sepsis**" or "**urosepsis**" is present somewhere in the available medical records:

⇒ additional notes must provide **clinical context**, e.g. **inflammatory response syndrome**, **ketoacidosis**, **Procalcitonin**, etc. If **no blood culture** was ordered – probably it is NOT sepsis.

⇒ **2 to 3 blood cultures** must be ordered.

⇒ Statistical data from one hospital system in CA shows that in a randomly selected time period **100%** of the **ER admissions** had **sepsis as a working Dx**.

⇒ The cause of death is an important piece of data. If you have sepsis as a cause of death – it is probably a true sepsis.

⇒ But if the cause of death is a **stroke** with "**rule out sepsis**" mentioned as a differential diagnosis in a medical report, the chances of a true sepsis are very low.

Pneumonia

Pathology data from **147 cases** **of Pneumonia as COD** autopsied at the University of Florida:

- Only **9.7%** were **confirmed** while **90.3%** - determined to have **heart failure as a cause of death**. Pneumonia is an infection of the alveolae. It is imperative to **assess the entire clinical picture**, e.g. history, physical, imaging, labs as there **may be various reasons to have fluid in the lung unrelated to pneumonia**.
- A **cardiac arrest followed by CPR** almost always comes with some **infiltrate as a result of the CPR**.
- **Atelectasis** in patients who have spent **prolonged time in a hospital post-surgery** is frequently misdiagnosed as pneumonia.
- Must be "**significant active infection**" i.e. F1.120(1) Infectious Disease Risk Review.
- If relevant medical records show pneumonia, but all **blood cultures** are negative, further evaluation is necessary on a case-by-case basis. However, bronchopneumonia may be confirmed even with negative blood culture – assess the entire clinical picture.
- Definitive diagnosis of pneumonia **requires microscopic examination**.
- A community acquired pneumonia that leads to the patient's death without significant underlying or accompanying conditions is the scenario that should cause concern with the Medical Director.

Законодателни принципи в Донорството

Чл. 20, ал.1 ЗТОТК (Изм. - ДВ, бр. 71 от 2006 г.) ***„Всеки дееспособен български гражданин, както и чужденец, дългосрочно пребиваващ в Република България, има право приживе да изрази изрично писмено несъгласие за вземане на органи, тъкани и клетки след смъртта си.”*** Несъгласието се документира в здравноосигурителната книжка на индивида по чл.20,ал.4 и в служебния регистър на ИАТ по чл.20,ал.7 ЗТОТК.

- Действието „***израз на несъгласие***” по чл.20 като „***право на всеки дееспособен гражданин***”, ако бъде реализирано от титуляра на това право, **би довело до изключването на опцията „донорство” спрямо конкретното лице**.

- Законът **НЕ предвижда процедура за изразяване на съгласие**, **нито за представяне на доказателства в полза на „съгласието“, тъй като то е „*естественото, предлежащо и фундаментално състояние и модел на поведение дефинирано от Закона*“.**

- От гледна точка на регулаторно-законодателната практика, съществуват **само две основания правото за отказ от дадена опция да бъде скрепено чрез законодателен акт:**

(i) **ако опцията, която се отказва, е водеща „по дефолт”, т.е. прилага се автоматично при възникването на определено квалифициращо събитие; и**

(ii) **ако трябва да се гарантира равнопоставеност на всеки гражданин спрямо правото на отказ.**

NB! Законодателят решава **коя опция е водеща** в зависимост от преобладаващия обществен интерес (***preponderance of public interest***)

Законодателни принципи в Донорството

Общоприетата дефиниция[1] на принципа ***„Презумпция за съгласие”***, залегнал в повечето законодателства на страните-членки на ЕС е:

„Публична политика или законодателство, които предлагат на всеки дееспособен гражданин възможността да изрази своето несъгласие да бъде донор на органи и тъкани и да документира това свое несъгласие пред компетентен публично-отговорен орган. Приема се, че всеки починал, който отговаря на клиничните и законови критерии за донорство, и не е регистрирал отказ, е съгласен да бъде донор[8].” *(UNOS/OPTN Committee on Presumed Consent Law)*

[1] J. Michael Dennis, Ph.D. (Chair), Ernest E. Hodge, MD, Ruud AF Krom, MD, Ph.D., Robert M. Veatch, Ph.D. An Evaluation Of The Ethics Of Presumed Consent And A Proposal Based On Required Response - A Report of the Presumed Consent Subcommittee OPTN/UNOS Ethics Committee

Законодателни принципи в Донорството

ЗТОТК алокира принципа „**тежест на доказване**” (*Onus Probandi*) върху опцията „**отказ от донорство**”, а принципа „**водещ по презумпция**” (*Benefit of Assumption*) - върху опцията „**донорство**”.

Юридически принцип: *„този, който не носи тежестта на доказване (onus probandi), се явява водещ по презумпция” (He who does not carry the burden of proof carries the benefit of assumption).*

ЗТОТК не изисква информираното съгласие на индивида (нито на неговите близки) като условие (доказателство) за реализирането на опцията „донорство” защото „тежестта на доказване” лежи върху опцията „отказ” и дори **не предвижда възможност за регистриране на съгласие за донорство приживе, а само на несъгласие**.

Ако при потенциален донорски случай екипът започне да **търси изпълнението на условия над тези определени по Закона**, вкл. да изисква **доказателства за съгласието** на донора или да иска **съгласието на близките** като условие за реализиране на случая, **се пренебрегва Закона** защото починалият приживе не е имал законовата възможност да изрази съгласие, а е разчитал на предлежащата опция на Закона (в противен случай той щеше да е регистрирал отказ). **След като Законът вече е определил реда, по който се прилагат двете основни опции (донорство или отказ) и индивидът се е съобразил с този ред приживе, е абсолютно недопустимо да се поставят допълнителни условия след смъртта му, когато той вече няма възможността да изпълни тези условия.**

Законодателни принципи в Донорството
Основен принцип: Колаборация

При всеки случай на настъпване на смърт на пациент в лечебно заведение за болнична помощ, независимо дали е със/ или без статут по чл.13,ал.1, би трябвало да се извърши първичен скрининг спрямо най-общите критерии за донорство. При това:

Ако лечебното заведение **е получило разрешение по чл.13,ал.1** ЗТОТК, то би могло да извърши **вземането и присаждането** на органи, тъкани и клетки, а **преработката и предоставянето** на тъкани и клетки би трябвало да се извърши **от тъканна банка по Чл.13,ал.2** ЗТОТК, с която болницата има споразумение за сътрудничество по чл.15а,ал.1 ЗТОТК; или

Ако лечебното заведение **не е получило разрешение по чл.13,ал.1** ЗТОТК, то експертизата, вземането, обработката, преработката и предоставянето на взетите тъкани и клетки би следвало да бъдат извършени от **тъканна банка**, лицензирана по **чл.13,ал.2** ЗТОТК, а кондиционирането на евентуалните **органни** донори, вземането и присаждането на **органите** – от лечебно заведение за болнична помощ, получило разрешение по **чл.13,ал.1** ЗТОТК, с което болницата има **споразумение** за сътрудничество по чл.15а,ал.1 ЗТОТК.

И в двата случая органи и тъкани могат да бъдат предоставяни за присаждане само на лечебни заведения за болнична помощ, които са получили съответните разрешения по **чл.13,ал.1** ЗТОТК.

Законодателни принципи в Донорството

Ако случаят **не** отпадне по първични критерии (възраст, инфекциозен статус и др.), би трябвало **квалифицирано лице да направи клинична преценка** на индикациите за донорство, и ако липсват контраиндикации, да се направи **проверка в здравната книжка и служебния регистър** на ИАТ, тъй като по презумпцията на Закона, починалият **е потенциален донор до установяване на евентуален негов отказ** в здравноосигурителната му книжка по **чл.21,ал.1,т.1 ЗТОТК**, и/или в служебния регистър на ИАТ по **чл.21,ал.1,т.2 ЗТОТК**. Неизвършването на такава преценка и проверка, при липса на медицински контраиндикации за донорство, би означавало **игнориране на потенциала за донорство априори и нарушение на принципите на Директива 2004/23/ЕС**.

Законодателни принципи в Донорството

За да се документира изпълнението на изискването на **чл.21,ал.1,т.3** ЗТОТК за **„задължително уведомяване”,** формата по **Приложение-4** към **Наредба-12** дава възможност или за подпис от страна на близките, или за подписи на двама свидетели в случай, че близките откажат да подпишат, т.е. **процедурата допуска и сценарий, при който липсва подписа на близките върху въпросната форма**.

Следователно **наличието на подписа на близките върху формата по Приложение-4 към Наредба-12 не е задължителен реквизит**, без който донорската процедура спира. Той **просто е един от възможните атрибути към доказателството, че близките са уведомени при случаите**, при които **изискването „задължително уведомяване” е изпълнимо и приложимо**, а именно – **когато има близки** по чл.21,ал.1,т.3 ЗТОТК, **т.е. има кой да бъде уведомен**.

Освен това, има и още един сценарий, при който се допуска липсата на подпис върху формата без това да отменя донорската опция: когато близките са **уведомени по телефона**, но не са се явили в „разумно краткия срок” за да предявят отказ и подишат формата. Налагащият се извод е, че законодателният мотив зад изискването за „задължително уведомление” е пряко и неотменимо свързан с изискването **да се даде възможност на посочените близки да отменят водещата алтернатива – донорството**. Тук възникват няколко въпроса във връзка с реални и сравнително чести житейски ситуации:

Законодателни принципи в Донорството

При **установена липса на близки**, валидирана чрез болничната документация, показания от други близки или познати на починалия или други източници на информация, донорският случай **не може да бъде отменен**, тъй като резултатът от този факт е, че **няма кой да отмени водещата по презумпцията на Закона алтернатива** – донорството.

Мотивът на законодателя да изиска „задължителното уведомяване" на посочените близки в чл.21 не е заради самия акт на уведомяване, а заради правните последствия, условени от акта на уведомяване, а именно - за **да се даде възможност на тези близки да предявят отказ от донорството, и то в „разумно кратък срок"** определен от лекаря. Сред тези правни последствия обусловени от акта на уведомяване по чл.21,ал.1,т.3 ЗТОТК **законът не предвижда искането или даването на съгласие**.