Travel Grant Report Form

Name and origin of applicants

Einar Gude, Rikshospitalet, Oslo

Purpose granted

Study visits to transplant centers

Amount granted

23,500.- DK

Time and place of visit

Rigshospitalet, Copenhagen 5-6 May 2014

Toronto General Hospital, Toronto, Canada 10-26 May 2014

Report

We have collaborated with Copenhagen in previous heart transplant studies and developed a good relation. Two day visit included evaluation of HTx candidates and evaluation of LVAD candidates for listing of HTx. There were four newly transplanted patients with uncomplicated post-op time and out-patient clinic.

In Toronto, Canada a huge cardiac center included own transplant unit for heart, kidney, liver etc. After a nice introduction to the transplant colleagues we discovered that Oslo transplant more hearts (n=30-35) than Toronto (n=25-30), but had an increasing amount of LVADs due to decreasing donor availability. They had good logistics with intensive care, transplant unit and ward before they discharge the patient home at a much earlier stage than we do (longer ward, patient hotel).

Biopsies were performed by own invasive personnel without any patient responsibility. Staff were not satisfied with this solution based on tradition. There was an own LVAD ward with specially trained

nurses for post-op and complications. They had a destination program not governmentally funded, so cases needed private finance or apply for grants.

Evaluation

Copenhagen have good logistics with own HTx, heart failure and LVAD dept. We want that too. Transplant rates have a negative trend and Danmark have a challenge in donor recruitement. All patients seem to have confidence in personnel that was experienced and well trained.

Toronto had a personnel structure with staff as supervisors and fellows working less independent than junior doctors in Norway. All patients were seen by fellows during the day and “rounded” by staff and fellows in the afternoon. Most decisions were made at that time, too late in the day. They had minimal use of balloon pump. Their organization of transplant dept with all organs was good for collaboration, but created a number of supervision from other specialities like nephrologists, neurologists, infectious disease personnel. After a while I realized that staff got an addition to salary for every supervision made at outpatient clinic, inpatient ward and as well as supervision for other organ transplants. This for sure made number of supervisions too high. The transplant department had own transplant infectious disease specialists.

They had limited use of mTors, mostly sirolimus, as everolimus was not approved. They found great interest in our SCHEDULE trial performed at our five Scandinavian transplant centers and hope that the trial may approve everolimus in North-America.

They discharged their heart transplant patients much earlier than we do, and relied on family care and own supplied transport back and forth to outpatient controls.

LVAD patients were mostly bridge to HTx candidates, but many patients developed complications that made them non transplantable. All patients were informed that LVAD was a bridge to decision, but long waiting time for HTx made accumulated complication rates rather high.
