prolong biologic treatment in pediatric patients, we cannot make a generalized statement recommending early surgical treatment for these patients. An individualized decision made by the pediatric gastroenterologist, surgeon, patient, and parents of the patient is critical. At the same time, their study\(^1\) can be used as a reference to bring up an intellectual discussion for parents to understand the potential risks of failed medical therapy in pediatric patients. As for stopping the biologics within 12 weeks before surgery, this is something with which we agree.\(^2\) We are very liberal about staging the ileal pouch procedure with an initial subtotal colectomy and an end ileostomy rather than creating an ileal pouch under sub-optimal conditions. With this approach, we decreased our perioperative anastomotic complications.\(^2\) We recommend being liberal with a low threshold for an initial colectomy in the era of the biologics and staging the ileal pouch anal anastomosis procedure. We are concerned about Drs Pellino and Selvaggi’s opinion of using routine mucosectomy and hand-sewn anastomosis. We do believe a stapled anastomosis provides better functional outcomes, quality of life, and fewer septic complications compared with hand-sewn anastomosis.\(^3\) We have also shown that a mucosectomy is not assurance for proof of safety preventing neoplastic activity. Our experience showed that patients undergoing a mucosectomy and hand-sewn anastomosis are also prone to develop cancer.\(^3\) Doing a hand-sewn anastomosis can actually preclude us from a proper surveillance by bringing the pouch through the anal canal and covering the mucosectomized anal transitional zone, which can harbor leftover columnar epithelium that has a potential for neoplastic progression. However, we recommend a mucosectomy and hand-sewn anastomosis in patients with dysplasia, early-stage cancer of the lower rectum, or in familial adenomatous polyposis patients whose anal transitional zones are carpeted with polyps.\(^5-7\)

In conclusion, we thank our colleagues for their interest in our article, and stapled ileal pouch-anal anastomosis is our preferred technique when it is technically feasible. Stapled anastomosis provides better function, fewer complications, and potentially more reliable surveying of the ileal pouch and the anal canal.

REFERENCES

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The Migrated Liver Transplantation Candidate: Waitlist Time Affects Mortality

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We congratulate Dr Kohn and her colleagues\(^1\) for their article, “The migrated liver transplantation candidate: insight into geographic disparities in liver distribution.” It raises a topic that has rarely been discussed in the literature, but is speculated on by many transplantation centers that deal with the burden of organ shortage. We are concerned, however, that the analysis performed here lends itself only to speculation and guessing, rather than a deeper understanding of the forces that affect transplant wait times, patient psychology, geographic disparity, and transplant center behavior. Their raw comparison of 279 patients receiving transplants at Massachusetts General Hospital (MGH) vs 44 patients who sought dual listing elsewhere, provides little control over confounding factors, and the authors provide limited insight into these forces.

First, the 2 patient cohorts are very different patient populations. The biologic Model for End-Stage Liver Disease (MELD) score of those patients having transplants at MGH should be presented. A mean MELD score of 30 derived from patients at MGH, in whom 50.9% had exceptional points, does not compare with a mean MELD...
score of 19.6 derived from a patient cohort without exception points. With a mean biologic MELD score of 19.6, these patients clearly received a survival benefit for early transplantation\(^2\) and felt the strong need to seek faster listing elsewhere. The number of patients having transplants at MGH, who received MELD exception points driven by hepatocellular carcinoma (HCC) was not reported. It has been clearly established that the current allocation scheme favors those patients with HCC without any true actuarial correlation to either waitlist mortality or drop off,\(^3,4\) and survival for this cohort is higher than in those patients listed for non-HCC indications.\(^5\) Perhaps patients who received exception point listing should have been excluded from the analysis entirely.

Second, the authors failed to disclose the wait time for those patients once they were successfully dual listed, but rather reported only the wait time accrued at MGH. We think there was incomplete representation of the data by listing only the wait time held at MGH because it was unclear how long these patients were on the MGH list before seeking evaluation at another center.

Third, according to the article, 883 patients were listed at MGH, with only 323 patients receiving transplants over an 8-year period of time. The fate of the remaining 560 patients (63\%) was not reported. Further investigation into the number patients who were removed from the waitlist and the reasons why they were removed may provide insight into which patients receive transplants at MGH and which patients needed to migrate. These data will provide a clearer intention-to-treat analysis for all patients with end-stage liver disease seen at MGH.

In summary, as presented in this article, the only interpretation of these data is that patients who do not receive MELD exception points are subjected to long wait times and should seek dual listing sooner. As the discussion of geographic disparity matures, it is paramount for the transplant community to balance waitlist mortality with long-term post-transplant survival and outcomes.

REFERENCES


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