

27 July 2020

## **BRIEF19**

*A daily review of covid-19 research and policy.*

### **RESEARCH BRIEFING**

#### **A decline in heart transplants due to covid-19, the waitlist actually dwindles.**

Another area of medicine affected by the pandemic: organ transplants. A [Brief Report](#) published in *JAMA Cardiology* focused on the rate of heart transplants during the covid-19 shutdown this spring. Taking data from the United Network for Organ Sharing (UNOS), researchers looked at adult candidates for transplant. Inactivations (i.e. cancellations) and additions to the waitlist along with heart transplants performed over eight weeks were compared to an eight week period during the pre-covid period.

UNOS is broken up into 8 regions: Northwest, North Midwest, Great Lakes, Northeast, Mid-Atlantic, Southwest, South Midwest and Southeast. During the study period, there was a 75 percent increase in waitlist inactivations (343 versus 600). Patients were given the option of reporting to researchers whether the inactivation was related to covid-19 concerns or not. Of those who inactivated plans for a transplant, 67 percent were reported as being a result of covid-19 precautions and concerns. The highest region of inactivation was the Northeast (91 percent) followed by the Southwest (81 percent). A 38 percent decrease in additions to the transplant waitlist was also observed. Similarly to inactivations, the region with the largest decrease in additions was Northeast, where a 69 percent decrease was found (31 additions during the covid-19 period, down from 101 during the pre-covid “control” comparison period). One region, “South Midwest”, actually saw a waitlist addition increase of 8.5 percent, increasing slightly from 47 before to 51 during the covid-19 period. Not surprisingly, the number of heart transplant surgeries decreased by 26 percent nationwide during the covid study period (525 transplants took place during the pre-covid19 versus just 389 during the covid-19 period). No significant regional variation was seen with respect to this decrease in surgeries. The largest declines occurred at the end of March,

The researchers suggested several factors contributing to these declines. One primary concern is on the donor side. There is the possibility that individuals who otherwise would have been suitable organ donors might have had covid-19 at the time of their death. Even in the absence of infections, it is likely that the lack of ability to test potential donors was a supply-limiting factor. Additionally, decreased intensive care unit space was another likely factor. While these data may not be unexpected given our knowledge of how covid-19 has affected hospital capacity, what cannot yet be calculated **are** the costs to those waiting on the heart transplant lists hoping for a life-saving match.

*—Christopher Sampson, MD, FACEP*

## **POLICY BRIEFING**

### **The CDC updates its isolation guidelines.**

Last week the Centers for Disease Control and Prevention (CDC) [updated](#) its isolation guidelines based on updated epidemiologic data. The new supporting evidence essentially shows that viral load and the chances of replication-capable transmission (i.e. contagion) decreases after symptom onset. The data also suggest that serologic evidence of infection—blood tests for antibodies which indicate prior infection and which likely imply some level of immunity—may persist for months. To date there have been no confirmed documented cases of reinfection, though experts have debated whether some patients who recovered from covid-19 who later had similar symptoms and who retested positive for SARS-CoV-2 were actually reinfected, or whether the causes of these second illnesses were unrelated, but just occurring in patients who were still shedding detectable though not contagious levels of the novel coronavirus.

Based on all of this, the CDC’s new recommendations are as follows: for most coronavirus infections, isolation may be terminated ten days after symptom onset and twenty four hours after the last occurrence of a fever; those with confirmed infections who never display symptoms may now cease quarantine ten days after their first positive test. In general, serology-based decisions (blood tests for antibodies) to end quarantine are only recommended in severely immunocompromised patients and in consultation with infectious disease experts, or when the results would indicate that it would be safe to discontinue isolation before the ten day period had elapsed. The CDC is discouraging routine serologic retesting within three months, with exceptions for patients who develop new symptoms without an alternate explanation. Finally, serologic testing should not be used to establish presence or absence of infection. *The Centers for Disease Control and Prevention*

—Joshua Lesko, MD

### **Continued PPE needs and shortages.**

The head of the Federal Emergency Management Agency (FEMA), has [told](#) Congress that the country has “a ways to go” before enough personal protective equipment (PPE) is available to keep pace with demand. The warning cites a combination of factors, including continued reliance on foreign production and lack of supply transparency. As *Brief19* has [previously](#) reported, healthcare groups have petitioned FEMA to clarify and make public production and distribution chains, as well as create a centralized database to track local and regional shortages and to better identify replenishment sources. Such opacity in the supply chain tends to hit private practices harder than hospitals and larger healthcare systems. Independent practitioners often do not have the benefit of pre-existing large scale distribution channels. Against this backdrop, the American Medical Association and other health groups have continued to push the Trump administration to further invoke the Defense Production Act to increase the domestic supply, as the cold and flu season begins to loom. *Various*

—Joshua Lesko, MD

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*Brief19* is a daily executive summary of covid-19-related medical research, news, and public policy. It was founded and created by frontline emergency medicine physicians with expertise in medical research critique, health policy, and public policy.