

JOURNAL WATCH



INTRODUCTION

Welcome to the October 2025 edition of ISODP Journal Watch, where science, policy, and a little human drama collide in the world of organ donation and transplantation.

This month's lineup has everything: cutting-edge brain scans trying (and failing) to outsmart the good old-fashioned clinical exam; laws about life support and organ donation that line up about as neatly as IKEA screws after you've lost the instruction manual; and a U.S. survey showing that young, healthy people are still the hardest group to get registered as donors—yes, the same ones who'll give away their data to TikTok without blinking.

We've also got a Lancet deep dive into equity, reminding us that while transplantation is a global triumph, access is still wildly uneven. In Türkiye, coordinators share the headaches of family refusals driven by folklore, religion, and that one distant uncle who shows up at the worst possible time.

On the tech side, there's some serious "organ spa day" energy: liver and kidney machine perfusion being pitched as the future, if only the cost, logistics, and standardization hurdles can be smoothed out. And for the finale, Duke surgeons literally brought a pediatric heart back to life on a back table—because maybe a peer-reviewed publication of a technique adding some distance helps get us acceptance of reanimating paediatric hearts.

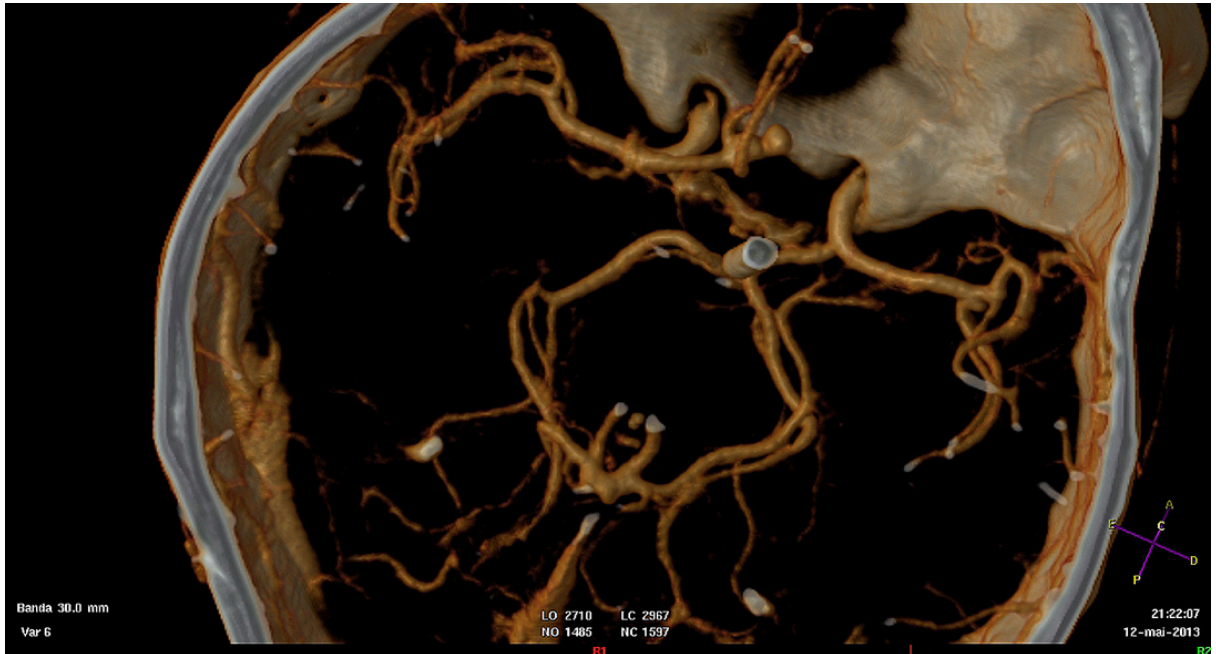
So buckle up: this edition is equal parts science, ethics, policy, and improvisation. As always, we serve it with a side of wit—because if we can't laugh a little while tackling the hardest questions in transplantation, we might just cry instead.

Dr. Thozama Siyotula
(Pediatric Surgeon)



Dr. David Thomson
(Critical Care and
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Computed Tomography Perfusion and Angiography for Death by Neurologic Criteria

Chassé, Michaël et al.

JAMA Neurology, June 13, 2025

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Ah, brain death testing: that awkward cocktail of neurology, ethics, and radiology where the stakes couldn't be higher. The Canadians have now delivered a 15-center, 282 patient blockbuster trial of CT perfusion and CT angiography to see if scanners can beat the good old bedside exam. Spoiler alert: the stethoscope still wins.

Brainstem perfusion looked dazzlingly sensitive (98.5%), but specificity fell apart faster than a soggy croissant in Quebec (74%). Whole-brain perfusion fared better with a respectable 93/92 split. CT angiography? Let's just say it's good at showing arteries light up, less good at proving the lights are out.

Bottom line: these tools are reliable enough to support, but not to replace, clinical judgment. So, while neuroradiologists may squabble over maps of blood flow, the true heroes remain the intensivists at the bedside — clipboard in hand, apnea test at the ready. In other words, Watson may help, but Sherlock still solves the case.

Editor note: The comment that the “stethoscope still wins” does not completely work as it conflates circulatory death with brain death. Oh the tangled webs we weave!

Summary prepared by Dr. Stephen Murray

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Withdrawal of Life-Sustaining Treatment and Organ Donation After Circulatory Death: Consequences of Legislative Separation

Claire O'Callaghan & Brendan Parent

Journal of Law, Medicine & Ethics, July 22, 2025

Corresponding author: Claire O'Callaghan - claire.ocallaghan@sydney.edu.au

In the delicate dance of death, law, and logistics—what could possibly go wrong? Quite a lot, apparently. This paper spotlights how the US legal system has created two sets of rules—one for switching off the machines (WLST) and another for gifting organs—and then insisted they never speak to each other. The result? Patients end up in a bureaucratic “limbo period” where they can’t die until the paperwork interpretation catches up.

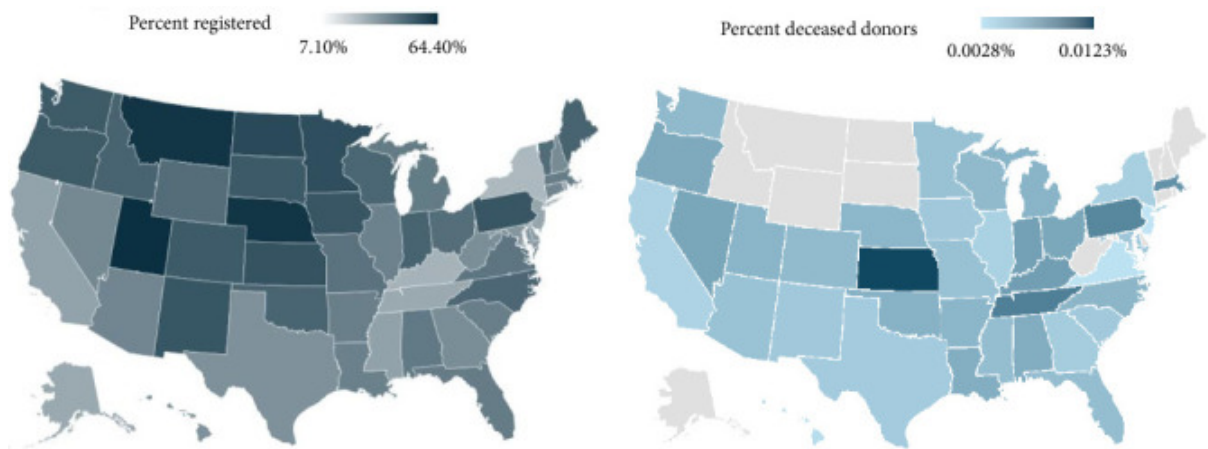
The paper highlights several recurring headaches: the “limbo period,” where withdrawal of life support is stalled to keep organs viable; dueling documents (advance directives vs. that little heart on the driver’s license); and the double-decision-maker debacle, where the person allowed to stop treatment isn’t the same one allowed to approve donation. Throw in operating-room logistics that bulldoze family rituals—“sorry, no pastor, no toys, no extended family, and by the way, we’re doing this at 2 a.m.”—and you’ve got a recipe for distrust.

The authors argue that while “decoupling” was designed to protect autonomy, it’s actually creating chaos, confusion, and resentment. Their prescription: merge and streamline the rules, train clinicians better, and stop making families feel like they need a PhD in health law to understand what’s happening at the bedside.

“If my final legacy is saving lives, can we at least skip the part where my family has to argue with three acronyms? HCDA, AGA, OPO—it’s less like healthcare and more like losing Scrabble tiles.”

Summary prepared by Dr. Seth Kimmel

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Latent Profiles of Deceased Organ Donation Registrants and Nonregistrants in the United States

Kirshenbaum, Ari et al.

Journal of Transplantation, July 18, 2025

Corresponding author: Ari Kirshenbaum - akirshenbaum@smcvt.edu

Why do some people happily check the box to be an organ donor, while others treat it like agreeing to marry a vampire? This study tried to answer that eternal question by using latent profile analysis—a statistical technique fancy enough to sound like magic but really just grouping people by shared quirks.

The authors discovered four personalities hiding in the data. First up, the “Altruistic Advocates”: people who are already signed up, trust doctors, and probably bake cookies for strangers. Next, the “Cautious Supporters”: they like the idea of donation but can’t quite shake the fear that surgeons are lurking with ice packs in the hallway. Then we have the “Skeptical Nonregistrants”: heavy on mistrust, protective of body integrity, and not in the mood for medical institutions. Finally, the “Detached Nonregistrants,” a group that seems to have missed the memo altogether—low knowledge, low interest, and probably low Wi-Fi signal.

The bottom line? Trust, altruism, and low fear of organ misuse are what push people toward registration. Concerns about cultural norms, body integrity, and (let’s be honest) general suspicion keep others away. The lesson is clear: one blanket public campaign won’t cut it. To move the needle, we need to tailor our messaging—reassure the cautious, educate the detached, and maybe just give the skeptics a nice long coffee break until they’re ready.

Limitations? Yes—self-reported surveys and cross-sectional data. But as a map of the organ donation landscape, this is sharp and useful. And at least now, when someone tells you “I’m just not into it,” you can politely think: “Ah, a Detached Nonregistrant. Bless their heart.”

Summary prepared by Dr. Bill Colbert

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Policy innovations to advance equity in solid organ transplantation

Jaure, Allison et al.

The Lancet, July 26, 2025

Corresponding author: Allison Jaure- allison.jaure@sydney.edu.au

“If equity were an organ, it would still be on the waiting list.”

Equity in transplantation—the ultimate global group school project. Some countries don’t even have a classroom (Category 1), others are just borrowing notes from abroad (Category 2), while a lucky few sit in Category 5 with their well-funded labs, registries, and coffee machines that actually work

Jaure and colleagues remind us that miracles in organ preservation and personalised immunosuppression won’t mean much if only the VIP lounge gets access. In Africa, home to 17% of the world’s people, less than 1% of global transplants are done. Meanwhile, high income countries hoard transplants like they’re Taylor Swift tickets.

Solutions? Pay living donors back for their lost wages, build national registries that actually track equity, use telemedicine to reach rural patients, and stop making allocation policies that look like they were designed by a game show producer. Spain gets applause for its national coordination model; South Africa for HIV-positive to HIV-positive kidney transplantation. But in too many places, your chance at a transplant still depends on your postcode, your income, or your ancestry.

“We’ve cured rejection with precision immunology—great! Now, how about curing rejection from the insurance company?”

Summary prepared by Dr. George Hicks

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Organ procurement coordinators' experiences with family refusals in cadaveric organ donation: a qualitative analysis

Hicran Karataş & Şener Balas

BMJ Open, April 17, 2025

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This study from Türkiye sat down with 30 organ procurement coordinators and asked the million-dollar question: why do families say no to organ donation? The answers? Religion, folklore, family dynamics, and, of course, that one uncle who thinks he knows everything.

Religious concerns: some families worry their loved one won't resurrect in one piece. There are perceived struggles with lack of spare parts. Folklore wasn't much better—TV-fueled rumors of organ theft and miracle awakenings. Families see a brain-dead patient with a heartbeat and go, "Looks fine to me, Doc—ever heard of a coma?"

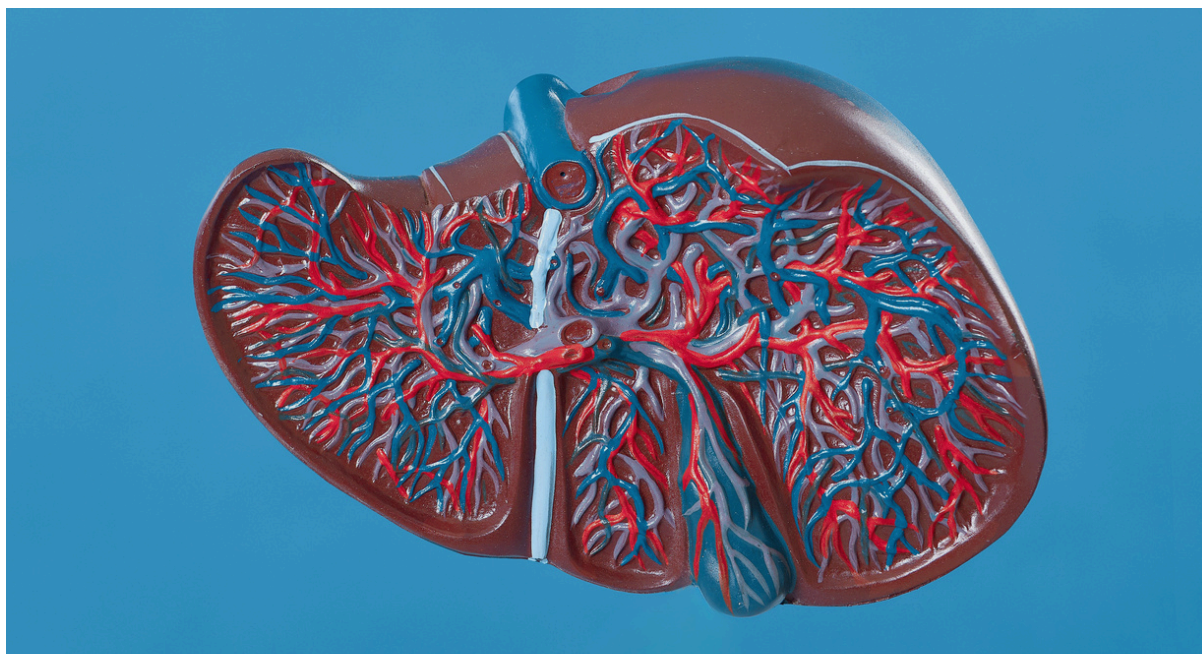
Then there's the "recipient receiving" problem. Families want to pick who gets the organs: "Kidney to a 12-year-old, please. Oh, and make sure the liver goes to a marathon runner from my religion with good morals." Coordinators, bound by law and sound ethical principles, have to say no—cue disappointment and refusals.

And family dynamics? One cousin who only showed up at weddings suddenly becomes the Minister of Organs and vetoes everything.

"Apparently, the biggest barrier to donation isn't science, it's the family WhatsApp group."

Summary prepared by Dr Bill Colbert

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The IDEAL framework for machine perfusion in liver transplantation

Van Leeuwen, Otto et. al

Nature Reviews Gastroenterol Hepatol, June 16, 2025

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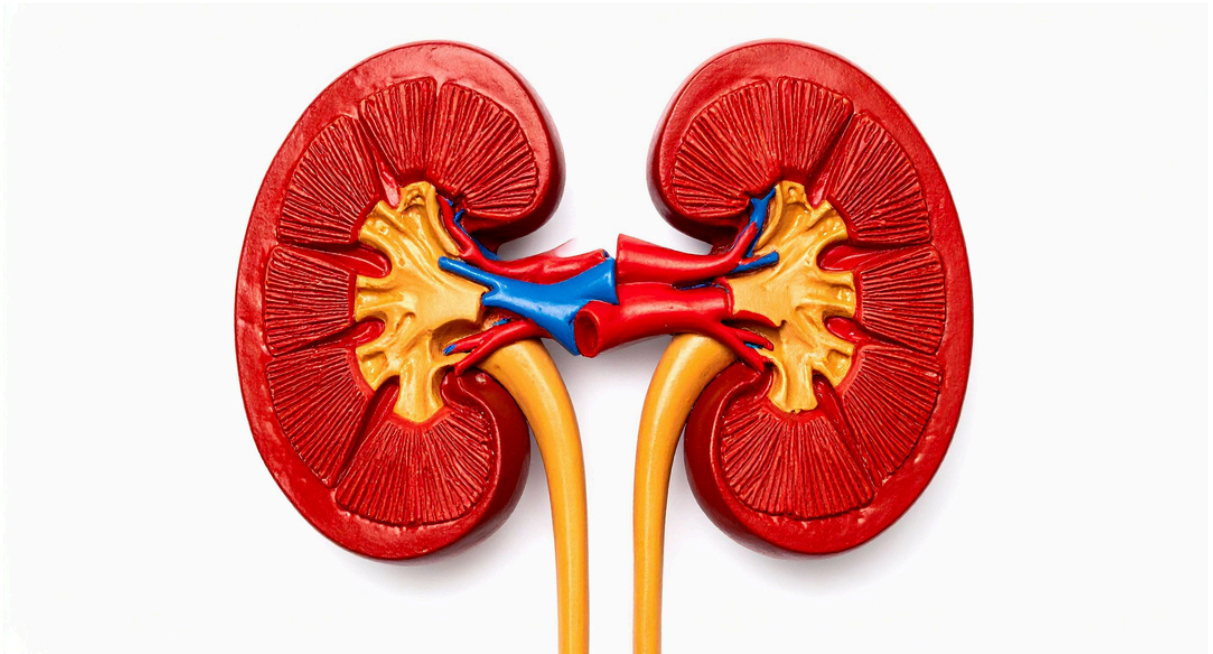
Liver transplantation has a problem: more marginal donor livers and fewer perfect ones, which means surgeons keep playing “will it or won’t it” with every graft. Enter machine perfusion (MP)—the high-tech treadmill and juice bar for your liver before it hits the OR.

Van Leeuwen and friends use the IDEAL framework to tell the story of MP like a five-act play. In the Idea phase, scientists hooked pig livers up to pumps and said, “Look, it still works!” Then came Development: cue biomarker obsession and normothermic regional perfusion for DCD donors. The Exploration stage was multicenter trials where everyone tried it out, nodded politely, and agreed the livers looked happier. Now we’re in Assessment—aka “bring on the randomized controlled trials,” because anecdotes don’t get you published in NEJM. Finally, the Long-term phase asks the awkward questions: Is it worth the money? Who pays? And can we agree on one standard recipe instead of every center using their own liver smoothie mix?

Bottom line: machine perfusion could turn fragile, high-risk livers into reliable grafts and spare patients from complications. But until we have big trials and shared protocols, it’s a bit like buying a self-driving car that still asks you to hold the wheel—impressive, but not exactly the future we promised everyone yet.

Summary prepared by Dr. Jon Carlin

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Opportunities and challenges with the implementation of normothermic machine perfusion in kidney transplantation

Rabelink, Ton et al.

Nature Communications, July 25, 2025

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Kidney transplantation is already like speed-dating: you've got a few precious hours to decide if this organ is "the one." The trouble is, many kidneys never even make it to the first date—18,000 of them were discarded in the US in 2023 alone. Enter normothermic machine perfusion (NMP), which is essentially a spa day for kidneys. Hook them up to warm oxygenated blood, let them breathe, even make them pee a little, and voilà: you can see if they're transplant-worthy before you commit.

The upsides sound dreamy. NMP might turn "hard-to-place" kidneys into life-savers, extend preservation so surgery isn't a 3 a.m. fire drill, and even open the door to "kidney tune-ups" with targeted drugs while they're on the pump. Imagine organ rehab meets Formula 1 pit stop.

But here come the plot twists. Kidneys are divas—they filter, concentrate, secrete, and reabsorb—and building a machine that lets them mimic all that is no small feat. No one agrees on the best solution to pump through them (blood? plasma? mystery juice?), and hauling around bags of red blood cells adds cost and hemolysis headaches. Clinical trials? Still early days, with a randomized controlled trial showing some win in the delayed graft function space.

And portable devices? Just starting to hit more broadly. In other words, it's not quite the iPhone moment yet—more like the flip-phone era of kidney perfusion.

The bottom line: NMP could change kidney transplantation from frantic crisis management into a semi-elective, optimized science. But until then, surgeons will keep waking up at 2 a.m., and kidneys will keep playing hard to get.

Summary prepared by Dr. Manahil Malik

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On-Table Reanimation of a Pediatric Heart from Donation after Circulatory Death

Kucera, John et al.

The New England Journal of Medicine, July 16, 2025

Corresponding author: Joseph Turek – joseph.turek@duke.edu

When you're three months old with heart failure, waiting for a transplant is less "cute baby milestone" and more "grim stopwatch." Up to 20% of infants die on the list, and current devices like LVADs carry their own risks. Enter the Duke team, who decided if hospitals won't allow normothermic regional perfusion (NRP) because of ethics, they'd invent something new: on-table reanimation

Here's how it works: once circulatory death is declared and the stand-off period passes, the donor heart is removed, hooked up to a custom back-table circuit (pump, oxygenator, vent, and a repurposed gynecology collection bag—yes, really), and coaxed into beating again like nothing happened. In this case, a 1-month-old donor's heart was revived in under 2 minutes, beating happily in sinus rhythm outside the body. After just over 5 minutes of doing this it was then cooled, transplanted into a 3-month-old with dilated cardiomyopathy, and three months later, the kid was home, stable, and still pumping strong.

Summary prepared by Dr Still Knocks

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