

Approaching horizontal equity in liver transplant from a racial and ethnic perspective

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I recently read the article, “*Selection of patients with hepatocellular cancer: a difficult balancing between equity, utility, and benefit*” by Alessandro Vitale and Quirino Lai, published in *Translational Gastroenterology and Hepatology* (2017;2:75) (1). I think that the authors succeeded in their goal of identifying a fair window for determining transplant benefit for patients with hepatocellular carcinoma and nonmalignant liver diseases; they balance utility and urgency in a way that I feel is fitting for end-stage liver disease. However, I would like to expand on their assessment of equity within transplant. In this work, the authors consider equity within transplant as it relates to vertical equity between patients with different levels of disease progression, as well as horizontal equity between patients with and without liver cancer. While these authors established a good theoretical framework for horizontal equity, I think that when applying it to reality, this principle needs to be broken down to better represent certain populations dealing with disparate access to liver transplant.

Specifically, the abstract concept of horizontal equity does not fully account for the problems experienced by those of ethnic and racial minorities in need of organ transplant. Certain liver diseases, such as viral hepatitis and non-alcoholic fatty liver disease, are found at higher rates in minority communities (2). Both African American and Hispanic individuals experience higher rates of mortality from end stage liver disease when compared to non-Hispanic whites (3). Additionally, African American individuals have a higher prevalence of hepatocellular carcinoma and tend to present at a later stage of disease development (4). The higher morbidity of liver diseases among minority populations

already sets them up to be in a disadvantaged position when it comes to liver transplant. While race itself is not a criterion in determining donor acceptability, one is more likely to find matching blood type and HLAs in matched race donor-recipient pairs. A great need exists, but pervasive organ donation myths and medical mistrust among certain minority populations make acquiring donor livers more difficult (5). Not only does misinformation about liver transplant prevent donation, but livers that are donated may be geographically separated from their ideal recipients. The Share 35 policy attempts to mitigate waiting list mortality by sharing organs across a wider geographic area, but Hispanic patients still have a significantly longer waiting time than other ethnicities (3). In many ways, race and ethnicity play a role in access to liver transplant.

As Vitale and Lai discuss, equitable treatment is essential when deciding on liver transplant recipients. Horizontal equity can be viewed through a myriad of lenses, but examining how race and ethnicity play a role in access to liver transplant is vital to achieving true equity. We must acknowledge and correct for disparities in what groups of people have access to this lifesaving treatment.

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Footnote

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