

LETTER TO THE EDITOR**Emerging evidence to support not always “just saying no” to SARS-CoV-2 positive donors***To the Editor,*

We are gratified to see the broad discussion of our manuscript, “Use of SARS-CoV-2 infected deceased organ donors: Should we always ‘just say no?’” and the companion manuscript by Shah et al, “Utilization of deceased donors during a pandemic: an argument against using SARS-CoV-2 positive donors.”^{1,2} Our viewpoint argues that the risk of SARS-CoV-2 transmission from asymptomatic or minimally symptomatic donors is likely very low. For selected patients with imminently life-threatening organ failure, transplants from deceased donors with asymptomatic or mild SARS-CoV-2 infection may offer a favorable risk/benefit balance, although factors beyond transmission risk must also be considered. Recently, two case reports of non-transmission from SARS-CoV-2 infected donors (1 platelet donor, 1 living liver donor) have been published which support our position.

In “COVID-19 transmission and blood transfusion: A case report,” Cho et al³ describe a patient with aplastic anemia treated with anti-thymocyte globulin and cyclosporine who received a platelet transfusion from an asymptomatic donor who was diagnosed with SARS-CoV-2 infection two days after donation. Despite intensive immunosuppression, the recipient never developed SARS-CoV-2 infection, as assessed by four tests for SARS-CoV-2 over a period of 2 weeks.

In “A case of coronavirus disease-2019- infected liver transplant donor,” Hong et al⁴ report a case of a living donor liver transplant from a mildly symptomatic donor with SARS-CoV-2 infection. The donor had a febrile illness for one day prior to donation and was subsequently diagnosed during contact tracing from a known large local transmission event. Liver histopathology showed preserved architecture without inflammation, and retrospective SARS-CoV-2 RT-PCR from the donor's liver tissue and blood were negative. The recipient received induction immunosuppression with basiliximab and methylprednisolone and began maintenance immunosuppression with tacrolimus and mycophenolate mofetil. No symptoms of SARS-CoV-2 infection developed, and respiratory and blood specimens were negative for SARS-CoV-2 RNA on seven and five tests, respectively, over a period of 15 days.

Our viewpoint also acknowledges the importance of minimizing risk to healthcare workers when considering transplants from SARS-CoV-2 positive donors. In the report from Hong et al⁴ there were no nosocomial transmissions to healthcare workers related to this infected organ donor. Thirty-two staff who interacted with the donor were monitored for 14 days. None developed symptoms or tested positive for SARS-CoV-2.

These case reports provide important, albeit limited, evidence that transmission does not inevitably occur through donation from SARS-CoV-2 infected donors. To date, there have been no reports of donor-derived infection with SARS-CoV-2. As programs seek to resume and scale up transplantation services, we hope that discussion of this important topic and serious consideration of the accumulating evidence will continue. We encourage providers to share their experience with the use (intended or unintended) of organs from SARS-CoV-2 infected donors, so that the transplant community may better understand potential transmission risks.

Sincerely,

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DISCLOSURE

The authors of this manuscript have no conflicts of interest to disclose as described by the *American Journal of Transplantation*.

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