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CORRESPONDENCE

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Reply: Validation of MELD 3.0 in 2 centers from different continents

Dear Editors,

We congratulate Duong et al. on exploring the knowledge gap in how allocation policies impact transgender and gender-diverse (TGD) populations with a goal of achieving a fair access to transplant for all candidates. Though still a minority of patients listed for liver transplant (LT), globally the TGD community is growing and is more prone to liver disease.[1] Consequently, hepatologists should expect to encounter TGD patients with end-stage liver disease more frequently in years to come.

MELD3.0 was developed with the intent of decreasing sex disparities in accessing liver transplant. Recently, Tanaka et al. showed that implementation of MELD 3.0 was associated with a sustained increase in organ offers for women. However, the rise in completed LTs was transient, with the estimated odds of transplant for women reverting to pre-policy levels by the end of follow-up.[2]

Therefore, the impact of MELD3.0 implementation on different sub-groups, including TGD candidates, is yet to be established.

Gender Affirming Hormone Therapy (GAHT) in TGD patients leads to substantial improvements in mental health and is generally safe from a hepatology perspective when used according to guidelines. However, it modifies body composition and lean muscle mass in TGD people, leading to opposing secondary changes in creatinine values (significant increase in transgender men-by 0.15 mg/dL at one year after starting GAHT; vs decrease in transgender women -by 0.05 mg/dL, NS).[3] These changes do not necessarily reflect true changes in renal function, and therefore its use in the MELD3.0 formula could introduce an error that affects prioritization. For instance, comparing MELD derived scores in transgender (male to female, with potentially greater muscle mass and height) with cisgender women would be interesting. It is worth exploring other allocation systems, such as GEMA, which substitutes creatinine for Royal Free GFR, a specific equation developed for cirrhotic patients.[4] Finally, body surface area (BSA) is associated with waitlist outcomes, with the smallest candidates being disadvantaged.[5] Therefore, BSA should be considered when assessing allocation systems in TGD populations.

As the authors mention, trying to fix one inequity could lead to another, and sex-based adjustments alone may be insufficient to address the nuances related to gender.

CONFLICTS OF INTEREST

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Abbreviations: BSA, body surface area; GAHT, Gender Affirming Hormone Therapy; GFR, glomerular filtration rate; LT, liver transplant; MELD, model for end stage liver disease; TGD, transgender and gender-diverse

Note: The title of this correspondence was updated post-publication to conform with journal style.

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