

Candidates ultimately excluded from living donation for any reason may experience feelings of emotional distress, disappointment and guilt, frustration from inability to control one's own body and health, and in the case of planned donation to a spouse or dependent, caregiver burden or ongoing impact of the intended recipient's illness on the donor's lifestyle.⁷⁵ The transplant program should assist excluded donor candidates who have difficulty accepting their candidacy decision in receiving needed psychosocial support or psychiatric help.

In approximately 5% of living kidney donor transplants the recipient or their graft does not survive the first year. Understandably, poor recipient outcomes can be a source of stress and disappointment to the donor, and the transplant program should provide postdonation psychosocial support at such times. In some studies, but not others, poor recipient outcomes have been associated with poor psychosocial outcomes in donors.^{413,414,439-443} In one study, most of the adverse recipient events were beyond the first year posttransplant.⁴¹⁴ Most donors will not experience poor short- or long-term medical or psychosocial outcomes after donation, but for those who do, the transplant program should participate to ensure that the donor receives psychosocial support or psychiatric help. The responsibility to ensure that donors receive psychological support when outcomes are poor is also described in a prior guideline.⁴⁰⁹ The Declaration of Istanbul states that all donors should be offered psychosocial services as a standard component of follow-up,⁴²¹ and the CARI guideline recommends follow-up of the psychosocial impact of living kidney donation for every living donor during the first year after donation.⁴⁰⁹ Incomplete or inconsistent follow-up after the early postdonation period may lead to under-recognition of donation-related psychosocial problems in the longer-term. Models for the collection of long-term psychosocial outcomes after donation exist internationally, including the European Living Donation and Public Health (EULID) project, an 11-nation registry that uses an online tool for reporting follow-up information included psychosocial and socioeconomic outcomes.⁴⁴⁴ The national Swiss Living Donor Health Registry (SOL-DHR) follows donors lifelong and includes an 8-Item Short-Form (SF-8) and social-status questionnaire.⁴⁴⁵

RESEARCH RECOMMENDATIONS

- Better define the optimal processes and content of the psychosocial evaluation. For example, there are emerging efforts to help standardize the psychosocial evaluation through the development of semi-structured evaluation tools.⁴⁴⁶
 - Duerinckx et al,⁴⁰⁸ on behalf of the Ethical Legal Psychological Aspects of Transplantation Organization, summarized surveys or tools used for psychometric testing in the donor candidate evaluation from prior guidelines, consensus statements and transplant program protocols such as mood questionnaires, personality interviews and drug abuse screening. The type, number and content of tools described in prior guidelines were variable.
 - The same group also recently provided a conceptual framework for the key elements in the psychosocial evaluation of living kidney donor candidates, including assessment of: i) motivation (eg, coercion, ambivalence); ii) the presence of psychopathology (eg, cognitive disturbance, mood or

anxiety disorder); iii) available social resources (eg, social support, workplace support); and iv) information disclosure, understanding and risk processing (eg, elements of informed consent).⁴⁴⁷

- Determine which components of the psychosocial interview should be structured to cover relevant material while addressing the unique needs and questions of a given donor candidate.
- Perform clinical trials to compare evaluation approaches, acceptance criteria, and interventions to minimize the risk of poor postdonation psychological outcomes.
 - For example, in a recent randomized trial of 113 potential kidney donors with some evidence of residual ambivalence to donation, it was suggested that motivational interviews (vs additional health education or standard care) reduced ambivalence to donation, anxiety symptoms, unexpected family-related problems, and the risk of negative physical symptoms after donation.⁴¹⁷

CHAPTER 17: ACCEPTABLE SURGICAL APPROACHES FOR DONOR NEPHRECTOMY

Except in the case of Recommendations 17.3 and 17.7, the ERT search parameters did not identify evidence from eligible studies pertinent to the recommendations in chapter 17 and therefore the following recommendations are “Not Graded.”

- 17.1: Renal imaging (eg, computed tomographic angiography) should be performed in all donor candidates to assess renal anatomy before nephrectomy.
- 17.2: The surgeon should have adequate training and experience for the surgical approach used for the donor nephrectomy.
- 17.3: We suggest that “mini-open” laparoscopy or hand-assisted laparoscopy by trained surgeons should be offered as optimal approaches to donor nephrectomy. However, in some circumstances, such as for donors with extensive previous surgery and/or adhesions, and at centers where laparoscopy is not routinely performed, open nephrectomy (flank or laparotomy) may be acceptable. (2D)
- 17.4: Robotic, single-port, and natural orifice transluminal nephrectomy should generally not be used for donor nephrectomy.
- 17.5: Nontransfixing clips (eg, Weck Hem-o-lok) should not be used to ligate the renal artery in donor nephrectomy; instead, renal artery transfixation by suture ligature or anchor staple within the vessel wall should be used.
- 17.6: In the absence of reasons to procure the right kidney (vascular, urological or other abnormalities), the left kidney should be procured in laparoscopic donor nephrectomy because of the relative technical ease associated with a longer venous pedicle.
- 17.7: We suggest laparoscopic procurement of the right rather than the left living donor kidney may be performed if the surgeon has adequate training and experience. (2D)
- 17.8: Procurement of a living donor kidney with 3 or more arteries should only be undertaken by surgeons with adequate experience.
- 17.9: A donor candidate with atherosclerotic renal artery disease or fibromuscular dysplasia involving the orifices of both renal arteries should not donate.

RATIONALE

The choice of surgical approach and the organ for procurement (left vs right kidney) should take into consideration the experience of the surgeon as well as any renal functional, parenchymal, vascular or urological abnormalities. Relevant outcomes to consider in comparing surgical approaches