Authors have nothing to disclose with regard to commercial support.

with normalized left ventricular function should be assessed for donation.

Although we strongly agree with their comment, we also emphasize that young donors with or without cardiopulmonary resuscitation must be subjected to hormonal resuscitation and optimal hemodynamic management, as described in the past.[4] Ejection fraction measured at the time of procurement, 4 days later in the experience of Galeone and colleagues,[1] remains the final deciding factor in deciding whether to use the donor heart.

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OLD EUROPE CAREFULLY LOOKS AT A NEW HEART: CARDIAC ARREST–RESUSCITATED DONORS SHOULD NOT BE TURNED DOWN FOR HEART TRANSPLANT AT FIRST GLANCE

Reply to the Editor:

Expansion of organ donor criteria is an essential strategy to implement the limited organ availability; reluctance exists in accepting organs for transplantation from donors who sustained a cardiac arrest because of the concern that warm ischemic injury could negatively influence graft and patient survival. We showed that history of cardiac arrest resuscitation in donors with a preserved left ventricular function at the time of organ procurement does not affect early and late outcomes of heart recipients.[1] We also found

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a significantly better long-term survival in recipients receiving an organ from a cardiac arrest–resuscitated donor (CARD), probably because of the younger age of donors who sustained a cardiac arrest in our series, as well as the ischemic preconditioning effect of cardiac arrest. Donors with a history of cardiac arrest are considered as marginal donors and usually refused as heart donors. Our results demonstrated that donors with a history of cardiac arrest should not be excluded a priori from heart transplantation; however, they need to be carefully evaluated because not all CARDs are suitable for heart transplant; in our experience, CARDs with poor left ventricular function and higher inotropic support were obviously turned down for heart transplantation.

Previous reports similarly showed that a short period of warm ischemia due to cardiac arrest does not negatively affect recipients' outcome,[2,3] and recently a case series has been published on 3 successful adult heart transplants from non–heart-beating donors.[4]

Expansion of donor criteria, including the use of CARDS, use of non–heart-beating donors, and development of optimal preservation and perfusion techniques to minimize organ injury and improve organ recovery after cardiac arrest, is required to increase the number of organs available for heart transplantation and reduce the unacceptable discrepancy between the growing number of recipients waiting for transplantation and the ongoing shortage of organs.

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