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DOI:

[10.1111/ajt.13843](https://doi.org/10.1111/ajt.13843)

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Document Version

Peer reviewed version

Citation for published version (Harvard):

Karangwa, SA, Dutkowski, P, Fontes, P, Friend, PJ, Guarrera, JV, Markmann, JF, Mergental, H, Minor, T, Quintini, C, Selzner, M, Uygun, K, Porte, RJ & Watson, CJE 2016, 'Machine Perfusion of Donor Livers for Transplantation: A Proposal for Standardized Nomenclature and Reporting Guidelines', *American Journal of Transplantation*. <https://doi.org/10.1111/ajt.13843>

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Checked 1/6/2016

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Received Date : 15-Feb-2016

Revised Date : 28-Mar-2016

Accepted Date : 19-Apr-2016

Article type : Original Article

Machine Perfusion of Donor Livers for Transplantation: A Proposal for Standardized Nomenclature and Reporting Guidelines

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This is an Accepted Article that has been peer-reviewed and approved for publication in the *American Journal of Transplantation*, but has yet to undergo copy-editing and proof correction. Please cite this article as an “Accepted Article”; doi: 10.1111/ajt.13843
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Running Title: Standardization of nomenclature and reporting of liver machine perfusion

Abbreviations:

MP- Machine perfusion, SCS – static cold storage, PRISMA - Preferred Reporting Items for Systematic Reviews and Meta-Analyses

ABSTRACT

With increasing demand for donor organs for transplantation, machine perfusion promises to be a beneficial alternative preservation method for donor livers; particularly those considered to be of sub-optimal quality, also known as extended criteria donor livers. Over the last decade, numerous studies researching MP of donor livers have been published and incredible advances have been made both in experimental and clinical research in this area. With numerous research groups working on MP, various techniques are being explored, often applying different nomenclature. The objective of this review is to catalog the

differences observed in the nomenclature used in the current literature to denote various MP techniques and in the manner in which methodology is reported. From this analysis, we propose a standardization of nomenclature on liver MP to maximize consistency, enable reliable comparison and meta-analyses of studies. In addition, we propose a standardized set of guidelines for the reporting of methodology of future studies on liver MP which will facilitate comparison as well as clinical implementation of liver MP procedures.

INTRODUCTION

In an effort to meet the demand for donor organs needed for transplantation, livers considered to be of sub-optimal quality and function are increasingly being transplanted. Given the increased vulnerability of these organs and the potential injury incurred during procurement and storage/transportation, machine perfusion (MP) is a promising alternative to static cold storage (SCS); the current standard of care in donor liver preservation. Following the first successful series of extra-corporeally perfused canine liver grafts performed by Brettschneider and Starzl et al in 1967 (1), machine perfusion has been explored as a method to achieve preservation of donor livers under conditions simulating normal *in-vivo* physiology in an attempt to minimize ischemia-related injury associated with static cold storage. Research into MP has established three major benefits; the capability to preserve donor organs whilst providing them with oxygen and nutrients at various temperatures (optimal and prolonged preservation), the ability to re-condition and optimize the function of donor organs, particularly extended criteria organs, with for instance oxygen perfusflation, de-fatting techniques for steatotic livers and pharmaceutical intervention (organ resuscitation and function recovery); and lastly, machine perfusion, at 37°C, provides the possibility of testing the function and viability of the organ prior to transplantation (*ex-situ* viability testing).

With the number of publications on liver MP to date exceeding 500, the last 10 years has seen an incredible advancement in both experimental and clinical research into donor liver MP. Several groups have been exploring different methods of MP with the major technique differences relating to the temperatures used, the provision of oxygen and whether the technique is flow or pressure controlled. Given that MP is a nascent technology with many technical aspects continuing to be explored, adapted and improved, the publications on MP have exhibited great discrepancies. These include the nomenclature used to describe the different MP techniques (abbreviations included), the temperatures considered to be hypo-, subnormo- or normothermic and the manner in which certain details of the methodology are reported. The absence of standardized nomenclature and guidelines for the reporting of technical details pertaining to MP gives rise to the relatively large variation that exists among studies. This makes it difficult to compare different studies, perform meta-analyses and in some cases, attempt to re-execute the methodology used.

With the number of clinical studies on MP of donor livers rapidly increasing, it is of importance that a consensus is reached on the nomenclature applied and on what necessary aspects of the methodology should be included in a paper. The objective of this review is to catalog the differences observed in the nomenclature used in the current literature to denote various techniques of liver MP and in the manner in which the methodology is described. From our analysis, we aim to address these discrepancies and propose recommendations for nomenclature and develop a standardized set of guidelines for reporting methodology for future studies on MP of donor livers.

METHODS

Literature search strategy

A comprehensive literature search for all published articles regarding machine perfusion of donor livers was performed using the PubMed, EMBASE, MEDLINE, Web of Science and The Cochrane Library databases. The final date of the search was the 17th of February 2015. In order to ensure all potentially relevant articles were included in the search, no

specific date limits were set. The search was conducted using the medical subject heading (MeSH) terms and Emtree key words “machine perfusion, machine preservation, liver transplantation, hepatic transplantation” combined with free text terms regarding machine perfusion of donor livers such as “hypothermic”, “normothermic”, “subnormothermic” etc.

Selection criteria and data collection

Study selection was performed independently by two authors (S.A.K and R.J.P) in a standardized fashion using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) method (2). Study inclusion was carried out in three phases; an initial title search was carried out whereby relevant titles were screened and studies whose titles were unrelated to the aims of this review were excluded. The abstracts of the remaining studies were then acquired and independently assessed for eligibility. Full papers of the abstracts regarded as potentially eligible were retrieved and underwent complete review and assessment until a final compilation of articles was made. For articles where an inconsistency between the two authors occurred, a discussion about these articles was held in order to reach to a consensus. **Figure 1** illustrates the study selection procedure and the inclusion and exclusion criteria.

Inclusion criteria

- All articles on machine perfusion of donor livers
- Fully accessible articles written in English and published in scientific journals
- Human & animal studies

Exclusion criteria

- Irrelevant to title and objective of review
- Non-English
- Articles about machine perfusion of other organs
- Full version inaccessible

Data extraction and analysis

The data from the included studies was assessed, with the main focus of these articles being the *materials and methods* section. The primary aim of this study was to investigate the manner in which the methodology of these studies was reported and to determine how certain aspects concerning the MP procedure were mentioned. The recommendations and guidelines that this review provides were extensively discussed and agreed upon by all authors of this paper.

RESULTS

Of the 2,265 articles identified from the initial literature search, 127 of these ultimately met all inclusion criteria. (**Figure 1**) These papers were published between 1997 and 2015 and constituted both animal and human clinical studies. From our analyses, we observed several differences in the manner in which the same type of machine perfusion techniques were referred to as well as marked variation in the temperatures used. In the paragraphs and tables below, we highlight and assess these differences as well as provide recommendations to establish uniformity in the manner in which data are reported.

1. Timing of Machine Perfusion

In all the studies reviewed in this paper, MP was conducted either for (almost) the entire duration of preservation phase of the transplantation process, or before or after a period of traditional SCS. A significant majority of the research groups whose studies included animal studies (3-34) and studies at which the donor and recipient center were the same location (35) nearly totally eliminated the SCS phase; thus perfusing donor organs immediately after procurement until the point of implantation. The rest of the studies; particularly most human studies, performed MP for various time periods after a few hours of SCS (during transport of the organs from the donor to recipient centers) or as a result of prolonged cold ischemia times due to various logistical or unforeseen circumstances.(36-50) Interesting to note, as opposed to performing MP for the entire preservation phase, the first clinical studies

conducted by Guarrera et al and Dutkowski et al chose to focus on exclusively conducting MP after a period of traditional SCS and immediately prior to implantation (< 2 hours prior).(35,40,45,46,51)

2. Nomenclature and Abbreviations Used to Identify the Type of Machine Perfusion

As the pioneering technique of MP, a number of different terms, as shown in **Table 1** below, have been used to describe hypothermic MP in the past two decades. Even though the majority of the studies mention the term “hypothermic” within the title and/or article itself, a number of papers simply use the term *machine perfusion*; without specific indication of the temperature used. Other types of MP include “subnormothermic” and “normothermic” perfusion. For all three major types of MP, despite referring to the same procedure, numerous abbreviations are used to describe the type of MP performed (**Table 1**).

Additionally, for subnormothermic and normothermic MP, a major difference lay in the additional emphasis of whether these perfusions were performed extra corporeally or not.

3. Temperatures used during machine perfusion

Although, in general, three types of MP can be recognized (i.e. hypothermic, subnormothermic and normothermic), we noted marked inconsistency in the actual temperatures denoted by these terms. The following findings are summarized in (**Table 2**). A number of papers (7,15,52,53), despite including a description of the technique of MP, fail to specify what particular temperatures were used in their respective studies whilst some descriptions use arbitrary and unspecific terms such as “warm”, “cold” or “room temperature” (23,33,39,54,55) to denote the temperatures used during MP. Twenty-six of the 58 (45%) studies on hypothermic MP reported perfusing the livers at 4°C whereas the rest perform MP at different temperatures within the 0 – 10°C range. All studies on subnormothermic MP were generally conducted at temperatures between 20 and 30°C. However, the majority of these studies reported using 20°C or 21°C which in all cases was what the authors referred

to as being room temperature. Normothermic MP was primarily carried out at the physiological body temperature of humans or the animal of study although small discrepancies were seen in the temperatures stated as being the physiological body temperature of the different animals.

3. Other aspects of methodology

In addition to the discrepancies in temperature, analysis of the literature exhibited variation in the description of certain technical aspects of the machine perfusion procedure. For instance, seven studies lack a clear description of whether the liver underwent single (via the hepatic artery or portal vein) or dual perfusion.(16,23,24,56-59) As opposed to the vast majority (92%) of the studies which stipulated whether they made use of a pressure or flow controlled system and provided specifications of the settings they used, a number of studies fail to specify this.(7,12,16,24,56,59-65) All studies that provided oxygenation during MP explicitly stated this in the methodology, however a number of studies went further to specifically outline the details such as the O₂/CO₂ mixture or the oxygen tension (2,3,5,6,44,64-67,71-73,76,84,99,100,101,108,119,123) as opposed to simply mentioning the presence of an oxygenator within the MP system.(6,11,18,20,22,24,59,60,62,64-71) Lastly, a significant number of the studies also clearly mentioned the type of pump used during MP (2,3,5,6,26,64-67,72-74,76,84,99-101,108,119,120,123,127), which gives an indication of the flow pattern through the liver.

DISCUSSION

In an effort to initiate and facilitate a standardization of nomenclature as well as to establish guidelines on the experimental and clinical reporting of machine perfusion of donor livers, this systematic literature review assessed the differences in the nomenclature, temperatures and techniques currently used and reported in published articles.

1. *The Timing of Machine Perfusion*

Given that the timing and duration of MP during the entire preservation and transportation period is essentially correlated to the specific benefits MP is intended to provide to the organ, it is important that the period at which MP is performed is specified; for instance, organ reconditioning and optimization can be applied either prior to or after static cold storage whereas viability testing is generally performed shortly before implantation.

It is evident from the reviewed literature that machine perfusion can be performed mainly at three particular time points; (1) immediately after organ procurement, before the organ is stored on ice for transportation (pre-static cold storage), (2) (shortly) before organ implantation, especially in instances with longer cold ischemia times (post-static cold storage) and (3) for the entire preservation period between procurement and implantation, thus (nearly) eliminating the need for SCS. In the case of the latter method, we propose the term “preservation MP”. When applying preservation MP, a short period of SCS is still required during and immediately after organ procurement, when the organ is prepared for connection to the perfusion device, and shortly before implantation to avoid warm ischemia during the anastomosis time. We thus propose to use the term preservation MP when the time period of SCS either before or after MP is less than a *maximum* of 3 hours (**Figure 2**).

This 3 hour time frame is based on the experience of the authors of this paper with various techniques of machine perfusion. It was generally agreed that in reality it normally takes approximately 1.5 to 2 hours from the point of in-situ cold flush, donor hepatectomy, back table procedure to connection of the organ onto the perfusion device. However, there are a number of cases in which this may be delayed; for example in livers with aberrant arterial vasculature which requires vascular reconstructions and thus extra back table time is needed before the liver can be connected to the device. This 3 hour time frame is therefore the recommended maximum time period that allows for unavoidable circumstances that may cause a delay before machine perfusion can be started. Similarly, it generally takes 40-60 min to make the vascular anastomoses in the recipient until reperfusion can be initiated.

When this is added to the time needed to take a donor liver off the machine, flush out machine perfusion fluid, remove the cannula's and perform the last back table work (i.e. trimming of vessels and preparation of the venacava in the donor for piggy back anastomosis), one may expect a total time period of 1-3 hours before graft reperfusion in the recipient occurs. Therefore this 3 hours of SCS reflect a maximum time period. If the duration of SCS is longer than 3 hours and MP is applied either prior (immediately after procurement) or after SCS (short before implantation), we propose to call this "pre-SCS MP" and "post SCS MP", respectively.

2. Nomenclature and Abbreviations

A number of different terms and abbreviations have been used in the observed studies describing generally similar MP methods. In some of these cases, a few aspects such as oxygenation or single/dual perfusion may have differed and were incorporated. In order to minimize confusion and tackle the heterogeneity in the nomenclature, we believe that authors of future publications should avoid adapting other aspects of perfusion into the nomenclature and retain simplicity. Given the importance of specifying certain aspects of MP performed, the choice to use certain terms in the title and throughout the publication remains within the discretion of the author although it is advised that the use of the standardized abbreviations for the respective types of MP; HMP (hypothermic machine perfusion), MMP (mid-thermic machine perfusion), SMP (sub-normothermic machine perfusion), and NMP (normothermic machine perfusion) be maintained.

3. Temperature Ranges

As described in the Results section, experiments conducted on MP of donor livers have generally been performed at three temperature ranges; hypothermically at 0-10°C, sub-normothermically at 20-33°C and normothermically at 35-38°C (depending on the species used in study). Based on common practice of the various research groups working on liver

MP and following a discussion with the authors involved in this review, the following classification of the standardized temperature ranges is proposed.

Hypothermic MP (0 – 12°C)

All studies involving hypothermic MP so far have been conducted at temperatures of 10°C and below with the major reason being that the rate of metabolism and enzymatic reactions in mammalian cells decreases to rates as low as 20% or even less (128,129) (**Figure 3**). The benefit of HMP is that it minimizes preservation injury whilst improving organ viability and for oxygenated livers, replenishes adenosine tri-phosphate (ATP) stores. The reason for proposing 12°C as the cut-off point for hypothermic MP is because the rates of numerous energy dependent reactions of liver mitochondrial enzymes exhibit a significant change at 12.5°C. (130)

Midthermic MP (13 – 24°C) and Subnormothermic MP (25 – 34°C)

The term *subnormothermic* has been considered for temperature ranges varying between 12°C and 35°C even though in the majority of studies in which the temperature was referred to as subnormothermic, MP was performed at 20-22 °C. This broad temperature range shows a great difference in the rate of metabolism at, for example 12°C as compared to 33°C (**Figure 2**). Furthermore, it can be argued that temperatures as low as 15, 18 or 20 °C are too low to be considered as *subnormothermic* as not only does this term suggest being slightly below normal body temperature, but at such low temperatures a living person would be defined as (extremely) hypothermic. Whereas at higher temperatures such as 30-33°C, the rate of metabolism increases close to 70% of the normal rate at body temperature (**Figure 3**). Based on this, we propose to use the term *mid-thermic* (13 – 24°C) to distinguish the lower temperatures (0–12°C) from the less physiologically abnormal subnormothermic temperature range (25-34°C).

Normothermic MP (35 - 38°C)

The term *normothermic* should refer to the normal core body temperature of the species used in the study, i.e. 37°C for human and rodent studies and 38°C in studies with porcine models.

4. *Ex-vivo* or *Ex-situ* MP

An additional aspect of MP that demonstrated particular variation in the literature was the referral of MP as being performed “*ex-vivo*” or “*ex-situ*”. Given that MP involves perfusion of donor livers outside the body of a deceased donor, the term “*ex- vivo*” which, refers to “outside of the living body”, does not seem appropriate. Therefore, the term “*ex-situ*”, which refers to “outside original location/position”, is proposed as a more representative description of what occurs during MP.

Other Technical Aspects and Reporting Guidelines

Along with discrepancies in the nomenclature and temperature ranges, reporting of other aspects, particularly technical aspects belonging to methodology were observed. Given the ongoing advancement in the field of MP, it is important that certain methodological aspects are explicitly stated to ensure that studies can be reproduced as well as objectively compared with each other. Moreover, with more clinical trials currently being performed, this will facilitate future meta-analyses with maximum validity and reliability. The authors of this review reached a consensus on various aspects of the MP procedure that were considered fundamental and developed a checklist that can be utilized and referred to when preparing a report on liver MP (**Table 3**). Important aspects in this checklist include clear descriptions of the flushing technique, all the technical aspects of the MP procedure, type of perfusion fluid used, and clarification of the time point, duration and temperatures at which MP is conducted. Furthermore, in order to make valid comparisons of experimental outcomes, the manner in which data is presented and described, particularly in the *results* section of publications, is important. The selection of (clinically) relevant endpoints during machine

perfusion was not the objective of this paper but the reader is referred to other recent reviews that have summarized the various types of biomarkers that can be used during MP for graft viability assessment (72,73). Naturally, in clinical trials traditional outcome parameters such as graft and patient survival rates, as well as hepatic and systemic postoperative complications will be relevant endpoints. In case of DCD liver transplantation, a major clinical endpoint should be the incidence of postoperative biliary complications.

CONCLUSION

As experimental and clinical research into MP of donor livers advances, a standardization of nomenclature and reporting of technical aspects of MP is required to minimize heterogeneity and to facilitate more reliable and valid comparison analyses of studies. We hope this paper provides a useful overview on current nomenclature and will be helpful in reporting of future research studies on liver MP.

Disclosure

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

FIGURE LEGENDS

Figure 1. Flow chart illustrating study selection and inclusion procedure. Irrelevant titles included studies mainly involving *in-vivo* perfusion (and not machine perfusion), *in-vitro* cell studies, follow-up studies on machine perfusion or studies involving analysis of data from studies on machine perfusion of donor livers without including the machine perfusion procedure description in the methodology.

Figure 2. Charts illustrating classification of the timing of machine perfusion. Machine perfusion (MP) conducted within 3 hours of organ procurement and followed by a period of static cold storage (SCS) is considered as Pre-SCS MP, whereas that performed after a period of at least 3 hours of SCS preservation prior to implantation as Post-SCS MP. Additionally, MP can be performed between periods of SCS. Duration of SCS and Preservation MP conducted within the 3 hour windows on either end of the procedure remains unspecified and can be widely varied. Lastly MP can also be performed for the entire preservation period (immediately after organ procurement until just before implantation).

Figure 3. Graphic presentation of the change in the rate of metabolism with decreasing temperature. Based on Van't Hoff's principle (expressed as $Q_{10} = (k_2 / k_1)^{10/(t_2 - t_1)}$), this graph demonstrates the significantly reduced metabolism at hypothermic temperatures (0 -12°C). The vertical lines in the graphs indicate the lower endpoint of temperature ranges of the different types of MP proposed. Abbreviations: NMP; normothermic machine perfusion (35-38°C); SMP, subnormothermic machine perfusion (25-34°C); MMP, mid-thermic machine perfusion (13-24°C); HMP, hypothermic machine perfusion (0-12°C)

REFERENCES

- (1) Yanaga K, Makowka L, Lebeau G, Hwang RR, Shimada M, Kakizoe S, et al. A new liver perfusion and preservation system for transplantation research in large animals. *J Invest Surg* 1990;3(1):65-75.
- (2) Moher D, Shamseer L, Clarke M, Ghersi D, Liberati A, Petticrew M, et al. Preferred reporting items for systematic review and meta-analysis protocols (PRISMA-P) 2015 statement. *Syst Rev* 2015 Jan 1;4:1-4053-4-1.
- (3) Berendsen TA, Bruinsma BG, Lee J, D'Andrea V, Liu Q, Izamis ML, et al. A simplified subnormothermic machine perfusion system restores ischemically damaged liver grafts in a rat model of orthotopic liver transplantation. *Transplant Res* 2012 May 9;1(1):6-1440-1-6.

(4) Berendsen TA, Bruinsma BG, Puts CF, Saeidi N, Usta OB, Uygun BE, et al. Supercooling enables long-term transplantation survival following 4 days of liver preservation. *Nat Med* 2014 Jul;20(7):790-793.

(5) Boehnert MU, Yeung JC, Bazerbachi F, Knaak JM, Selzner N, McGilvray ID, et al. Normothermic Acellular Ex Vivo Liver Perfusion Reduces Liver and Bile Duct Injury of Pig Livers Retrieved After Cardiac Death. *American Journal of Transplantation* 2013 JUN;13(6):1441-1449.

(6) Carnevale ME, Balaban CL, Guibert EE, Bottai H, Rodriguez JV. Hypothermic machine perfusion versus cold storage in the rescuing of livers from non-heart-beating donor rats. *Artif Organs* 2013 Nov;37(11):985-991.

(7) Compagnon P, Clement B, Campion JP, Boudjema K. Effects of hypothermic machine perfusion on rat liver function depending on the route of perfusion. *Transplantation* 2001 Aug 27;72(4):606-614.

(8) Dutkowski P, Furrer K, Tian Y, Graf R, Clavien PA. Novel short-term hypothermic oxygenated perfusion (HOPE) system prevents injury in rat liver graft from non-heart beating donor. *Ann Surg* 2006 Dec;244(6):968-76; discussion 976-7.

(9) Dutkowski P, Schonfeld S, Odermatt B, Heinrich T, Junginger T. Rat liver preservation by hypothermic oscillating liver perfusion compared to simple cold storage. *Cryobiology* 1998 Feb;36(1):61-70.

(10) Fujiyoshi M, Taketomi A. Sub-normothermic machine perfusion preservation for graft selection and therapy in a mouse liver transplantation model. *Hepatology* 2014;60:241A-241A ER.

(11) Gringeri E, Bonsignore P, Bassi D, D'Amico FE, Mescoli C, Polacco M, et al. Subnormothermic Machine Perfusion for Non-Heart-Beating Donor Liver Grafts Preservation in a Swine Model: A New Strategy to Increase the Donor Pool? *Transplant Proc* 2012 SEP;44(7):2026-2028.

(12) Habib MM, Hafez TS, Parkes HG, Seifalian AM, Fuller BJ, Davidson BR. A comparison of bile composition from heart-beating and non-heart-beating rabbit organ donors during normothermic extracorporeal liver perfusion: experimental evaluation using proton magnetic resonance spectroscopy. *Transplant Proc* 2004 Dec;36(10):2914-2916.

(13) Hessheimer AJ, Fondevila C, Maathuis MHJ, Munoz J, Taura P, Calatayud D, et al. Hypothermic oxygenated perfusion improves hepatocellular but causes kupffer and endothelial cell injury in porcine DCD liver transplant. *Am J Transplant* 2012 /;12:131.

(14) Tolboom H, Pouw RE, Izamis M, Milwid JM, Sharma N, Soto-Gutierrez A, et al. Recovery of Warm Ischemic Rat Liver Grafts by Normothermic Extracorporeal Perfusion. *Transplantation* 2009 JAN 27;87(2):170-177.

(15) Jain S, Lee CY, Baicu S, Duncan H, Xu H, Jones Jr. JW, et al. Hepatic function in hypothermically stored porcine livers: Comparison of hypothermic machine perfusion vs cold storage. *Transplant Proc* 2005 /;37(1):340-341.

(16) Jamieson RW, Zilvetti M, Roy D, Hughes D, Morovat A, Coussios CC, et al. Hepatic steatosis and normothermic perfusion-preliminary experiments in a porcine model. *Transplantation* 2011 Aug 15;92(3):289-295.

(17) Knaak JM, Spetzler VN, Goldaracena N, Boehnert MU, Bazerbachi F, Louis KS, et al. Subnormothermic ex vivo liver perfusion reduces endothelial cell and bile duct injury after donation after cardiac death pig liver transplantation. *Liver Transpl* 2014 Nov;20(11):1296-1305.

(18) Liu Q, Berendsen T, Izamis M-, Uygun B, Yarmush ML, Uygun K. Perfusion Defatting at Subnormothermic Temperatures in Steatotic Rat Livers. *Transplant Proc* 2013 NOV;45(9):3209-3213.

(19) Liu Q, Nassar A, Farias K, Buccini L, Baldwin W, Mangino M, et al. Sanguineous normothermic machine perfusion improves hemodynamics and biliary epithelial regeneration in donation after cardiac death porcine livers. *Liver Transpl* 2014 Aug;20(8):987-999.

(20) Matsuno N, Obara H, Watanabe R, Iwata S, Kono S, Fujiyama M, et al. Rewarming Preservation by Organ Perfusion System for Donation After Cardiac Death Liver Grafts in Pigs. *Transplant Proc* 2014 MAY;46(4):1095-1098.

(21) Nassar A, Liu Q, Farias K, D'Amico G, Tom C, Grady P, et al. Ex vivo normothermic machine perfusion is safe, simple, and reliable: results from a large animal model. *Surg Innov* 2015 Feb;22(1):61-69.

(22) Obara H, Matsuno N, Enosawa S, Shigeta T, Huai-Che H, Hirano T, et al. Pretransplant Screening and Evaluation of Liver Graft Viability Using Machine Perfusion Preservation in Porcine Transplantation. *Transplant Proc* 2012 MAY;44(4):959-961.

(23) Lauschke H, Olschewski P, Tolba R, Schulz S, Minor T. Oxygenated machine perfusion mitigates surface antigen expression and improves preservation of predamaged donor livers. *Cryobiology* 2003 Feb;46(1):53-60.

(24) Olschewski P, Tolba R, Akbar S, Minor T. Use of HTK solution for hypothermic machine perfusion: An alternative for the preservation of less than optimal donor livers? - An experimental study in rats. *Transplant Proc* 2003 /;35(2):767.

(25) op den Dries S, Karimian N, Weeder PD, Porte RJ. Normothermic acellular machine perfusion and bile duct injury in pig livers retrieved after cardiac death. *Am J Transplant* 2013 Dec;13(12):3289.

(26) Op Den Dries S, Wiersma-Buist J, Leuvenink HGD, De Boer MT, Lisman T, Porte RJ. Hypothermic oxygenated machine preservation of livers from donation after cardiac death: Does it reduce bile duct Injury? *Liver Transplant* 2012 /;18:S184.

(27) 't Hart NA, der van Plaats A, Leuvenink HGD, van Goor H, Wiersema-Buist J, Verkerke GJ, et al. Determination of an adequate perfusion pressure for continuous dual vessel hypothermic machine perfusion of the rat liver. *Transplant Int* 2007 APR;20(4):343-352.

(28) Vekemans K, Liu Q, Brassil J, Komuta M, Pirenne J, Monbaliu D. Influence of flow and addition of oxygen during porcine liver hypothermic machine perfusion. *Transplant Proc* 2007 OCT;39(8):2647-2651.

(29) Xu H, Berendsen T, Kim K, Soto-Gutierrez A, Bertheium F, Yarmush ML, et al. Excorporeal Normothermic Machine Perfusion Resuscitates Pig DCD Livers with Extended Warm Ischemia. *J Surg Res* 2012 APR;173(2):E83-E88.

(30) Luer B, Koetting M, Efferz P, Minor T. Role of oxygen during hypothermic machine perfusion preservation of the liver. *Transpl Int* 2010 Sep;23(9):944-950.

(31) Fondevila C, Hessheimer AJ, Maathuis MJ, Munoz J, Taura P, Calatayud D, et al. Hypothermic Oxygenated Machine Perfusion in Porcine Donation After Circulatory Determination of Death Liver Transplant. *Transplantation* 2012 JUL 15;94(1):22-29.

(32) Reddy S, Greenwood J, Maniakin N, Bhattacharjya S, Zilvetti M, Brockmann J, et al. Non-heart-beating donor porcine livers: the adverse effect of cooling. *Liver Transpl* 2005 Jan;11(1):35-38.

(33) Brockmann J, Reddy S, Coussios C, Pigott D, Guirriero D, Hughes D, et al. Normothermic perfusion: a new paradigm for organ preservation. *Ann Surg* 2009 Jul;250(1):1-6.

(34) Schlegel A, Graf R, Brockmann J, Clavien P, Dutkowski P. Rescue of Liver Grafts After Cardiac Arrest: First Study Comparing Warm Versus Cold Machine Perfusion Strategies in Rodent Models of Liver Transplantation. *Transpl Int* 2013 NOV;26:52-52 ER.

(35) Guarrera JV, Henry SD, Samstein B, Odeh-Ramadan R, Kinkhabwala M, Goldstein MJ, et al. Hypothermic Machine Preservation in Human Liver Transplantation: The First Clinical Series. *American Journal of Transplantation* 2010 FEB;10(2):372-381.

(36) Sutton ME, op den Dries S, Karimian N, Weeder PD, de Boer MT, Wiersema-Buist J, et al. Criteria for viability assessment of discarded human donor livers during ex vivo normothermic machine perfusion. *PLoS One* 2014 Nov 4;9(11):e110642.

(37) op den Dries S, Karimian N, Sutton ME, Westerkamp AC, Nijsten MWN, Gouw ASH, et al. Ex vivo Normothermic Machine Perfusion and Viability Testing of Discarded Human Donor Livers. *American Journal of Transplantation* 2013 MAY;13(5):1327-1335.

(38) op den Dries S, Karimian N, Porte RJ. Normothermic Machine Perfusion of Discarded Liver Grafts. *American Journal of Transplantation* 2013 SEP;13(9):2504-2504.

(39) Martins P, Bruinsma B, Farmer A, Berendsen T, Izamis ML, Yeh H, et al. Subnormothermic machine perfusion for recovery and viability testing of the discarded human liver. *Transpl Int* 2013 /;26:316.

(40) Graham JA, Guarrera JV. "Resuscitation" of marginal liver allografts for transplantation with machine perfusion technology. *J Hepatol* 2014 Aug;61(2):418-431.

(41) Henry SD, Arrington BO, Nachbar E, Samstein B, Emond JC, Guarrera JV. Hypothermic Machine Perfusion Attenuates Molecular Markers of Preservation Injury in Human Liver Transplantation. *American Journal of Transplantation* 2010 APR;10:107-108 ER.

(42) Henry S, Arrington B, Chen SW, Lee HT, Emond JC, Guarrera JV. Hypothermic Machine Perfusion Reduces Molecular Damage Cascades in Human Liver Transplantation. *Hepatology* 2009 OCT;50(4):637A-637A ER.

(43) Guarrera J, Estevez J, Boykin J, Boyce R, Rashid J, Sun S, et al. Hypothermic machine perfusion of liver grafts for transplantation: Technical development in human discard and miniature swine models. *Transplant Proc* 2005 JAN-FEB;37(1):323-325.

(44) Guarrera JV, Henry SD, Chen SWC, Brown T, Nachber E, Arrington B, et al. Hypothermic Machine Preservation Attenuates Ischemia/Reperfusion Markers After Liver Transplantation: Preliminary Results. *J Surg Res* 2011 MAY;167(2):E365-E373.

(45) Guarrera JV, Henry SD, Samstein B, Reznik E, Musat C, Lukose TI, et al. Hypothermic Machine Preservation Facilitates Successful Transplantation of "Orphan" Extended Criteria Donor Livers. *American Journal of Transplantation* 2015 JAN;15(1):161-169.

(46) Henry SD, Nachber E, Tulipan J, Stone J, Bae C, Reznik L, et al. Hypothermic Machine Preservation Reduces Molecular Markers of Ischemia/Reperfusion Injury in Human Liver Transplantation. *American Journal of Transplantation* 2012 SEP;12(9):2477-2486.

(47) Bae C, Henry SD, Guarrera JV. Is extracorporeal hypothermic machine perfusion of the liver better than the 'good old icebox'? *Current Opinion in Organ Transplantation* 2012 APR;17(2):137-142.

(48) Tulipan JE, Stone J, Samstein B, Kato T, Emond JC, Henry SD, et al. Molecular expression of acute phase mediators is attenuated by machine preservation in human liver transplantation: preliminary analysis of effluent, serum, and liver biopsies. *Surgery* 2011 Aug;150(2):352-360.

(49) Henry SD, Guarrera JV. Protective effects of hypothermic ex vivo perfusion on ischemia/reperfusion injury and transplant outcomes. *Transplant Rev* 2012 APR;26(2):163-175.

(50) Bae C, Pichardo EM, Huang H, Henry SD, Guarrera JV. The Benefits of Hypothermic Machine Perfusion Are Enhanced With Vasosol and alpha-Tocopherol in Rodent Donation After Cardiac Death Livers. *Transplant Proc* 2014 JUN;46(5):1560-1566.

(51) Dutkowski P, Schlegel A, de Oliveira M, Muellhaupt B, Neff F, Clavien P. HOPE for human liver grafts obtained from donors after cardiac death. *J Hepatol* 2014 APR;60(4):765-772.

(52) Butler AJ, Rees MA, Wight DG, Casey ND, Alexander G, White DJ, et al. Successful extracorporeal porcine liver perfusion for 72 hr. *Transplantation* 2002 Apr 27;73(8):1212-1218.

(53) Bessems M, Doorschodt BM, Kolkert JLP, Vetelainen RL, van Vliet AK, Vreeling H, et al. Preservation of steatotic livers: A comparison between cold storage and machine perfusion preservation. *Liver Transplant* 2007 /;13(4):497-504.

(54) Reddy SP, Bhattacharjya S, Maniakin N, Greenwood J, Guerreiro D, Hughes D, et al. Preservation of porcine non-heart-beating donor livers by sequential cold storage and warm perfusion. *Transplantation* 2004 May 15;77(9):1328-1332.

(55) Hara Y, Akamatsu Y, Maida K, Kashiwadata T, Kobayashi Y, Ohuchi N, et al. A new liver graft preparation method for uncontrolled non-heart-beating donors, combining short oxygenated warm perfusion and prostaglandin E1. *J Surg Res* 2013 Oct;184(2):1134-1142.

(56) Jain S, Xu H, Duncan H, Jones J, Zhang J, Clemens M, et al. Ex-vivo study of flow dynamics and endothelial cell structure during extended hypothermic machine perfusion preservation of livers. *Cryobiology* 2004 JUN;48(3):322-332.

(57) Lee CY, Jain S, Duncan HM, Zhang JX, Jones, Jon W., Jr, Southard JH, et al. Survival transplantation of preserved non-heart-beating donor rat livers: preservation by hypothermic machine perfusion. *Transplantation* 2003 11/27;76(10):1432-1436.

(58) Nagrath D, Xu H, Tanimura Y, Zuo R, Berthiaume F, Avila M, et al. Metabolic preconditioning of donor organs: defatting fatty livers by normothermic perfusion ex vivo. *Metab Eng* 2009 Jul-Sep;11(4-5):274-283.

(59) Xu H, Zhang JX, Jones JW, Southard JH, Clemens MG, Lee CY. Hypothermic machine perfusion of rat livers preserves endothelial cell function. *Transplant Proc* 2005 /;37(1):335-337.

(60) Boncompagni E, Gini E, Ferrigno A, Milanese G, Gringeri E, Barni S, et al. Decreased apoptosis in fatty livers submitted to subnormothermic machine-perfusion respect to cold storage. *Eur J Histochem* 2011 Nov 18;55(4):e40.

(61) Dutkowski R, Graf R, Clavien P. Rescue of the cold preserved rat liver by hypothermic oxygenated machine perfusion. *American Journal of Transplantation* 2006 MAY;6(5):903-912.

(62) St Peter SD, Imber CJ, Lopez I, Hughes D, Friend PJ. Extended preservation of non-heart-beating donor livers with normothermic machine perfusion. *Br J Surg* 2002 May;89(5):609-616.

(63) Uchiyama M, Kozaki K, Nemoto T, Degawa H, Matsuno N, Kubota K, et al. Liver transplantation from non-heart-beating donors: effect of machine perfusion preservation and pentoxifylline. *Transplant Proc* 1998 Nov;30(7):3798-3800.

(64) Uchiyama M, Matsuno N, Hama K, Iwamoto H, Narumi Y, Kikuchi K, et al. Comparison between nonpulsatile and pulsatile machine perfusion preservation in liver transplantation from non-heart-beating donors. *Transplant Proc* 2001 Feb-Mar;33(1-2):936-938.

(65) Vairetti M, Ferrigno A, Rizzo V, Richelmi P, Boncompagni E, Neri D, et al. Subnormothermic Machine Perfusion Protects Against Rat Liver Preservation Injury: A Comparative Evaluation With Conventional Cold Storage. *Transplant Proc* 2007 /;39(6):1765-1767.

(66) Tarantola E, Bertone V, Milanese G, Ferrigno A, Neri D, Barni S, et al. Preservation of obese rat livers by subnormothermic machine perfusion protects dipeptidylpeptidase-IV activity and expression in the biliary tree. *Dig Liver Dis* 2012 /;44:S24.

(67) Tarantola E, Bertone V, Milanese G, Gruppi C, Ferrigno A, Vairetti M, et al. Dipeptidylpeptidase-IV activity and expression reveal decreased damage to the intrahepatic biliary tree in fatty livers submitted to subnormothermic machine-perfusion respect to conventional cold storage. *European Journal of Histochemistry* 2014;58(3):176-184.

(68) Shigeta T, Matsuno N, Huai-Che H, Obara H, Mizunuma H, Hirano T, et al. A Basic Consideration for Porcine Liver Preservation Using a Novel Continuous Machine Perfusion Device. *Transplant Proc* 2012 MAY;44(4):942-945.

(69) Obara H, Matsuno N, Shigeta T, Hirano T, Enosawa S, Mizunuma H. Temperature Controlled Machine Perfusion System for Liver. *Transplant Proc* 2013 JUN;45(5):1690-1692.

(70) Imber CJ, St Peter SD, Lopez de Cenarruzabeitia I, Pigott D, James T, Taylor R, et al. Advantages of normothermic perfusion over cold storage in liver preservation. *Transplantation* 2002 Mar 15;73(5):701-709.

(71) Den Dries SO, Karimian N, Sutton ME, Westerkamp AC, Nijsten MWN, Gouw ASH, et al. Successful ex-vivo normothermic machine perfusion and viability testing of discarded human donor livers. *Transplant Int* 2013 /;26:337.

(72) Verhoeven CJ, Farid WR, de Jonge J, Metselaar HJ, Kazemier G, van der Laan LJ. Biomarkers to assess graft quality during conventional and machine preservation in liver transplantation. *J Hepatol* 2014 Sep;61(3):672-684.

(73) Schlegel A, Kron P, Dutkowski P. Hypothermic Oxygenated Liver Perfusion: Basic Mechanisms and Clinical Application. *Curr Transplant Rep* 2015;2(1):52-62.

(74) Kim JS, Boudjema K, D'Alessandro A, Southard JH. Machine perfusion of the liver: maintenance of mitochondrial function after 48-hour preservation. *Transplant Proc* 1997 Dec;29(8):3452-3454.

(75) Manekeller S, Schuppius A, Stegemann J, Hirner A, Minor T. Role of perfusion medium, oxygen and rheology for endoplasmic reticulum stress-induced cell death after hypothermic machine preservation of the liver. *Transplant Int* 2008 FEB;21(2):169-177.

(76) Monbaliu D, Heedfeld V, Liu Q, Wylm T, van Pelt J, Vekemans K, et al. Hypothermic Machine Perfusion of the Liver: Is It More Complex than for the Kidney? *Transplant Proc* 2011 NOV;43(9):3445-3450.

(77) Monbaliu D, Liu Q, Libbrecht L, De Vos R, Vekemans K, Debbaut C, et al. Preserving the morphology and evaluating the quality of liver grafts by hypothermic machine perfusion: a proof-of-concept study using discarded human livers. *Liver Transpl* 2012 Dec;18(12):1495-1507.

(78) Monbaliu D, Liu Q, Libbrecht L, De Vos R, Vekemans K, Detry O, et al. Preservation of normal morphology of human livers after 24 hours of hypothermic machine perfusion. A first-in-man study. *Transplant Int* 2011 /;24:151.

(79) Monbaliu D, Vekemans K, De Vos R, Brassil J, Heedfeld V, Qiang L, et al. Hemodynamic, biochemical, and morphological characteristics during preservation of normal porcine livers by hypothermic machine perfusion. *Transplant Proc* 2007 OCT;39(8):2652-2658.

(80) Monbaliu DR, Debbaut C, Hillewaert WJ, Laleman WJ, Sainz-Barriga M, Pirenne J, et al. Flow competition between hepatic arterial and portal venous flow during hypothermic machine perfusion preservation of porcine livers. *Int J Artif Organs* 2012 Feb;35(2):119-131.

(81) Op den Dries S, Sutton ME, Karimian N, de Boer MT, Wiersema-Buist J, Gouw AS, et al. Hypothermic oxygenated machine perfusion prevents arteriolonecrosis of the peribiliary plexus in pig livers donated after circulatory death. *PLoS One* 2014 Feb 14;9(2):e88521.

(82) OpdenDries S, Leuvenink H, De Boer MT, Lisman T, Porte RJ. Hypothermic oxygenated machine preservation of donor livers after prolonged ischemia in a porcine model of donation after cardiac death. *HPB* 2012 /;14:482.

(83) Henry SD, Tulipan JE, Stone J, Samstein B, Kato T, Emond JC, et al. Quantification of inflammatory biomarkers in perfusion effluent collected during the first liver machine perfusion clinical trial. *Am J Transplant* 2011 /;11:454-455.

(84) Henry SD, Arrington B, Samstein B, Chen SWC, Goldstein MJ, Emond JC, et al. Preservation/Reperfusion Injury Is Attenuated by Hypothermic Machine Perfusion in Human Liver Transplantation. *American Journal of Transplantation* 2009;9:234-234 ER.

(85) Jain S, Lee SH, Korneszczyk K, Culberson CR, Southard JH, Berthiaume F, et al. Improved preservation of warm ischemic livers by hypothermic machine perfusion with supplemented University of Wisconsin solution. *Journal of Investigative Surgery* 2008;21(2):83-91.

(86) Jomaa A, Gurusamy K, Siriwardana PN, Claworthy I, Collier S, de Muylder P, et al. Does Hypothermic Machine Perfusion of Human Donor Livers Affect Risks of Sinusoidal Endothelial Injury and Microbial Infection? A Feasibility Study Assessing Flow Parameters, Sterility, and Sinusoidal Endothelial Ultrastructure. *Transplant Proc* 2013 JUN;45(5):1677-1683.

(87) Liu Q, Vekemans K, van Pelt J, Pirenne J, Himmelreich U, Heedfeld V, et al. Discriminate Liver Warm Ischemic Injury During Hypothermic Machine Perfusion by Proton Magnetic Resonance Spectroscopy: A Study in a Porcine Model. *Transplant Proc* 2009 OCT;41(8):3383-3386.

(88) Liu Q, Vekemans K, Iania L, Komuta M, Parkkinen J, Heedfeld V, et al. Assessing warm ischemic injury of pig livers at hypothermic machine perfusion. *J Surg Res* 2014 JAN;186(1):379-389.

(89) de Rougemont O, Breitenstein S, Leskosek B, Weber A, Graf R, Clavien P, et al. One Hour Hypothermic Oxygenated Perfusion (HOPE) Protects Nonviable Liver Allografts Donated After Cardiac Death. *Ann Surg* 2009 NOV;250(5):674-683.

(90) Dutkowski P, Odermatt B, Heinrich T, Schonfeld S, Watzka M, Winkelbach V, et al. Hypothermic oscillating liver perfusion stimulates ATP synthesis prior to transplantation. *J Surg Res* 1998 Dec;80(2):365-372.

(91) Schlegel A, Graf R, Clavien P-, Dutkowski P. Hypothermic oxygenated perfusion (HOPE) protects from biliary injury in a rodent model of DCD liver transplantation. *J Hepatol* 2013 /;59(5):984-991.

(92) Schlegel A, Graf R, Kron P, Clavien P-, Dutkowski P. Warm or cold machine perfusion to rescue DCD liver grafts prior to transplantation. *Br J Surg* 2014 JUN;101:18-19 ER.

(93) Schlegel AA, Graf R, Clavien P-, Dutkowski P. Hypothermic Oxygenated Machine Perfusion (HOPE) prevents biliary injury after transplantation of DCD liver grafts. *Liver Transplant* 2013 /;19(6):S86.

(94) Schlegel A, de Rougemont O, Graf R, Clavien P, Dutkowski P. Protective mechanisms of end-ischemic cold machine perfusion in DCD liver grafts. *J Hepatol* 2013 FEB;58(2):278-286.

(95) Schlegel A, Dutkowski P. Role of hypothermic machine perfusion in liver transplantation. *Transpl Int* 2014 05/23.

(96) Schlegel A, Kron P, Graf R, Clavien P, Dutkowski P. Hypothermic Oxygenated Machine Perfusion (HOPE) Down-Regulates the Immune Response in a Rat Model of Liver Transplantation. *Liver Transplantation* 2014 JUN;20:S137-S138 ER.

(97) Lu L, Rao J, Zhou H, Wang X. Effect of continuous hypothermic oxygenated machine perfusion (CHOP) on liver graft from donors after cardiac death (DCD) following liver transplantation. *Hepatology* 2014;60:829A-829A ER.

(98) Uchiyama M, Matsuno N, Nakamura Y, Iwamoto H, Hama K, Narumi K, et al. Usefulness of preservation by machine perfusion of liver grafts from non-heart-beating donors-a porcine model. *Transplant Proc* 2003 Feb;35(1):105-106.

(99) Lee CY, Zhang JX, deSilva H, Cogger RN, Clemens MG. Heterogeneous flow patterns during hypothermic machine perfusion preservation of livers. *Transplantation* 2000 Dec 27;70(12):1797-1802.

(100) Bessems M, Doorschodt B, Dinant S, de Graaf W, van Gulik T. Machine perfusion preservation of the pig liver using a new preservation solution, polysol. *Transplant Proc* 2006 JUN;38(5):1238-1242.

(101) Bessems M, Doorschodt B, Hooijschuur O, van Vliet A, van Gulik T. Optimization of a new preservation solution for machine perfusion of the liver: Which is the preferred colloid? *Transplant Proc* 2005 JAN-FEB;37(1):329-331.

(102) Bessems M, Doorschodt B, van Vliet A, van Gulik T. Improved rat liver preservation by hypothermic continuous machine perfusion using Polysol, a new, enriched preservation solution. *Liver Transplantation* 2005 MAY;11(5):539-546.

(103) Bessems M, Doorschodt B, van Vliet A, van Gulik T. Machine perfusion preservation of the non-heart-beating donor rat livers using polysol, a new preservation solution. *Transplant Proc* 2005 JAN-FEB;37(1):326-328.

(104) Gringeri E, Polacco M, D'Amico FE, Scopelliti M, Bassi D, Bonsignore P, et al. A New Liver Autotransplantation Technique Using Subnormothermic Machine Perfusion for Organ Preservation in a Porcine Model. *Transplant Proc* 2011 MAY;43(4):997-1000.

(105) Bruinsma BG, Sridharan GV, Weeder PD, Avruch JH, Yeh H, Markmann JF, et al. Dynamic characterization of human livers during ex vivo machine perfusion. *Hepatology* 2014 /;60:200A.

(106) Bruinsma B, Sridharan G, Weeder P, Izamis M, Martins P, Yeh H, et al. Indicators of liver viability in the ex vivo perfused human liver. *Transplantation* 2014 2014/07;98:373-374.

(107) Bruinsma BG, Yeh H, Ozer S, Martins PN, Farmer A, Wu W, et al. Subnormothermic machine perfusion for ex vivo preservation and recovery of the human liver for transplantation. *Am J Transplant* 2014 /;14(6):1400-1409.

(108) Bruinsma BG, Berendsen TA, Izamis M, Yarmush ML, Uygun K. Determination and extension of the limits to static cold storage using subnormothermic machine perfusion. *Int J Artif Organs* 2013 NOV;36(11):775-780.

(109) Vairetti M, Ferrigno A, Carlucci F, Tabucchi A, Rizzo V, Boncompagni E, et al. Subnormothermic Machine Perfusion Protects Steatotic Livers Against Preservation Injury: A Potential for Donor Pool Increase? *Liver Transplantation* 2009 JAN;15(1):20-29.

(110) Vairetti M, Ferrigno A, Carlucci F, Tabucchi A, Rizzo V, Boncompagni E, et al. Subnormothermic machine perfusion protects steatotic liver graft: Implications for organ transplantation. *Transplant Int* 2007 SEP;20:280-280 ER.

(111) Tolboom H, Izamis ML, Sharma N, Milwid JM, Uygun B, Berthiaume F, et al. Subnormothermic machine perfusion at both 20 degrees C and 30 degrees C recovers ischemic rat livers for successful transplantation. *J Surg Res* 2012 Jun 1;175(1):149-156.

(112) St Peter SD, Imber CJ, Kay J, James T, Friend PJ. Hepatic control of perfusate homeostasis during normothermic extracorporeal preservation. *Transplant Proc* 2003 Jun;35(4):1587-1590.

(113) Op Den Dries S, Karimian N, Sutton M, Westerkamp A, Nijsten M, Gouw A, et al. Successful ex-vivo normothermic machine perfusion and viability testing of discarded human donor livers. *Am J Transplant* 2013 /;13:519.

(114) Izamis M-, Tolboom H, Uygun B, Berthiaume F, Yarmush ML, Uygun K. Resuscitation of Ischemic Donor Livers with Normothermic Machine Perfusion: A Metabolic Flux Analysis of Treatment in Rats. *PLoS ONE* 2013 2013/07;8(7).

(115) Den Dries SO, Karimian N, Sutton M, Kuipers M, Leuvenink H, Lismart T, et al. Normothermic oxygenated machine preservation reduces reperfusion injury of DCD livers but seems less useful in DBD livers: A comparative study in a rat model. *Liver Transplant* 2013 /;19(6):S202.

(116) Den Dries SO, Karimian N, Sutton ME, Kuijpers M, Leuvenink HGD, Lismart T, et al. Normothermic machine preservation reduces bile duct injury in DCD livers: A comparative study in a rat model. *Transplant Int* 2013 /;26:57.

(117) Tolboom H, Milwid JM, Izamis ML, Uygun K, Berthiaume F, Yarmush ML. Sequential cold storage and normothermic perfusion of the ischemic rat liver. *Transplant Proc* 2008 JUN;40(5):1306-1309.

(118) Tolboom H, Pouw R, Uygun K, Tanimura Y, Izamis M, Berthiaume F, et al. A model for normothermic preservation of the rat liver. *Tissue Eng* 2007 AUG;13(8):2143-2151.

(119) Hafez TS, Habib MM, Seifalian AM, Fuller BJ, Davidson BR. Near-infrared spectroscopic assessment of mitochondrial oxygenation status--comparison during normothermic extracorporeal liver perfusion by buffer only or buffer fortified with washed red blood cells: an experimental study. *Transplant Proc* 2004 Jun;36(5):1265-1267.

(120) Fondevila C, Hessheimer AJ, Maathuis MJ, Muñoz J, Taurá P, Calatayud D, et al. Superior preservation of DCD livers with continuous normothermic perfusion. *Ann Surg* 2011 12;254(6):1000-1007.

(121) van der Plaats A, Maathuis MH, 't Hart NA, Bellekom AA, Hofker HS, van der Houwen EB, et al. The Groningen hypothermic liver perfusion pump: functional evaluation of a new machine perfusion system. *Ann Biomed Eng* 2006 Dec;34(12):1924-1934.

(122) 't Hart N, van der Plaats A, Leuvenink H, van Goor H, Wiersema-Buist J, Verkerke G, et al. Hypothermic machine perfusion of the liver and the critical balance between perfusion pressures and endothelial injury. *Transplant Proc* 2005 JAN-FEB;37(1):332-334.

(123) Dirkes MC, Post ICJH, Heger M, van Gulik TM. A Novel Oxygenated Machine Perfusion System for Preservation of the Liver. *Artif Organs* 2013 AUG;37(8):719-724.

128. Belzer FO, Southard JH. Principles of solid organ preservation by cold storage. *Transplantation* 1988 04;45(673-676)

129. Nishino H, Nakaya J, Nishi S, Kurosawa T, Ishibashi T. Temperature-Induced differential kinetic properties between an initial burst and the following steady state in membrane-bound enzymes: studies on lathosterol 5-desaturase. *Arch Biochem Biophys*. 1997 Mar 15;339(2):298-304.

130. Michaelleen P. Lee and Adrian R. L. Gear. The Effect of Temperature on Mitochondrial Membrane-linked Reactions. *J. Biol. Chem.* 1974 249: 7541-7549.

Table 1. Nomenclature and abbreviations currently used for the different types of liver machine perfusion

Type of Machine Perfusion	References
Hypothermic (oxygenated) machine perfusion (HMP)	(1-8) (6,7,15,22,24,26,30,31,35,41-46,48-50,56,69,74-88)
Hypothermic oxygenated perfusion (HOPE)	(8,9,13,34,51,61,89-96)
Continuous Hypothermic Oxygenated Machine Perfusion (CHOP)	(97)
Machine perfusion (MP) or Machine Perfusion Preservation (MPP)	(53,57,63,64,98-103)
Cold Perfusion	(23)

Subnormothermic machine perfusion (SMP)	(11,104)
Subnormothermic machine perfusion (SNMP)	(3,10,18,39,105-108)
Subnormothermic ex-vivo liverperfusion (SNEVLP)	(17)
Subnormothermic machine perfusion (MP20)	(60,65-67,109-111)
Normothermic machine perfusion (NMP)	(16,19,21,25,29,36-38,40,62,70,71,112-116)
Normothermic extracorporeal perfusion (NELP)	(12,14,117-119)
Normothermic extracorporeal perfusion (NECMO)	(120)
Normothermic ex-vivo liver perfusion (NEVLP)	(5)
Warm perfusion	(33,54,55,62)

Table 2. Various temperatures currently used for the different types of liver machine perfusion

Hypothermic temperatures	References
0 - 4° C	(121)
1 - 3° C	(122)
2 ± 1° C	112
3 - 5° C	50
3 – 6° C	47,48
4° C	4,(8,50,53,89,100-103,123)
4 - 6° C	27,29,30,41,63
4 - 8° C	12,21,63
5° C	114
5 - 8° C	115-118
8° C	60,61
8 - 10° C	119
10° C	24,49,53-57,120,121
Subnormothermic temperatures	
20°C	69-71,81,83,85,114,122
21°C	11,72-75,77,123,124
25°C	76
33°C	78
20° - 30° C	82
Normothermic temperatures	
Porcine 38°C	89,90,95,109
Human 35.5 – 37.5°C	108
Rat 36.5 – 37°C	125
Human/rabbit/rat 37°C	9,52,91-94,100-102,106,126
Rat 37.5°C	(14,114,118)
(porcine) 39°C	86
“Warm”	8,96,97,127

Table 3. Checklist with recommended guidelines for reporting of relevant aspects of the methodology used in liver machine perfusion

<p>1. Phase of preservation</p>	<ul style="list-style-type: none"> • Timing <ul style="list-style-type: none"> ➢ Pre-SCS MP ➢ Preservation MP ➢ Post-SCS MP • Duration of MP <ul style="list-style-type: none"> ➢ Specified in hours/ minutes
<p>2. Environment and Temperature</p>	<ul style="list-style-type: none"> • <i>In situ</i> <ul style="list-style-type: none"> ➢ (Normothermic) Regional perfusion • <i>Ex situ</i>: <ul style="list-style-type: none"> ➢ Hypothermic MP (0 – 12°C) ➢ Midthermic MP (13 – 24°C) ➢ Subnormothermic MP (25 – 34°C) ➢ Normothermic MP (35 – 38°C)
<p>3. Technical aspects</p>	<ul style="list-style-type: none"> • Single or dual vessel perfusion (hepatic artery/ portal vein) <ul style="list-style-type: none"> ➢ Continuous or pulsatile flow • Pressure or flow controlled perfusion <ul style="list-style-type: none"> ➢ Computerized or manually controlled system • Perfusion temperature <ul style="list-style-type: none"> ➢ Specify temperature in °C ➢ Specify any significant temperature changes during MP (e.g. gradual rewarming) • Temperature control <ul style="list-style-type: none"> ➢ Automated or manual • Type of pump <ul style="list-style-type: none"> ➢ Roller / centrifugal / peristaltic
<p>4. Perfusion fluid composition and oxygenation</p>	<ul style="list-style-type: none"> • Perfusion fluid components <ul style="list-style-type: none"> ➢ Full description of the composition of the perfusion fluid used* • Oxygenation <ul style="list-style-type: none"> ➢ Ambient air, pure (100%) oxygen, or carbogen, other mixture • Heparin, antibiotics and nutrients

	<ul style="list-style-type: none">• Any other interventions e.g. drugs etc.
5. Pre- and Post-MP phase	<ul style="list-style-type: none">• Is organ flushed before and/or after MP?<ul style="list-style-type: none">➢ Which fluid is used and how much?➢ At what temperature?• Specify vessels used in flushing of the organ

*Both at baseline as well as compounds that are continuously or intermittently administered during perfusion.

Figure 1

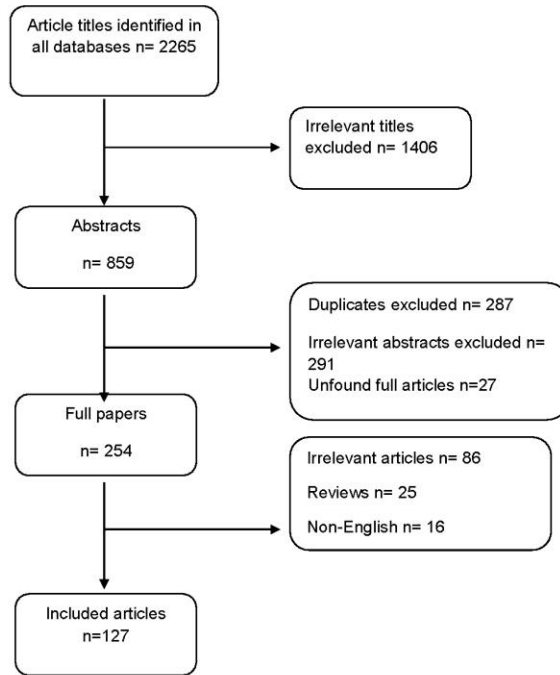


Figure 2

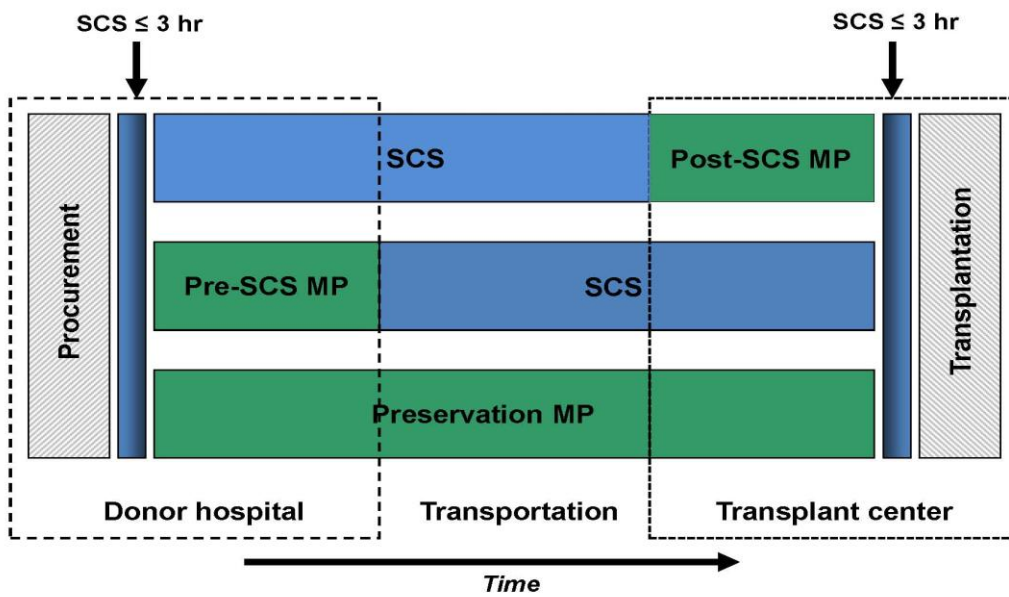


Figure 3

