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Huntington Beach
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Newport Beach
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World
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Death by Geography

Patients' chances of getting new organs in time to save their lives vary vastly based on where they live. The situation is most dire for people needing livers.

By Alan Zarembo, Times Staff Writer
June 11, 2006

In the world of organ transplantation, location is everything.

After waiting more than a decade for a liver, Jonathan Van Vlack was deteriorating. His gut swelled with fluid, and toxins accumulating in his blood made him forget his own name.

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Still, he wasn't sick enough — not in New York, where about 2,000 people statewide were vying for the same scarce livers.

"He's having a very difficult time right now," his wife, Laura, nervously e-mailed a friend in March 2005. "We really need that liver to come."

It never did. Van Vlack died in December, on his 53rd birthday.

Frank Evanac was stalled in the same line. By age 53, he had been waiting four years for a liver, and he needed a kidney as well.

After getting a tip at a Fourth of July party, however, he gave up on New York. Without telling his doctors, he moved in with his sister outside Jacksonville, Fla., and joined a new waiting list.

Fourteen days later, a surgeon sewed in his new liver and kidney.

Two very sick men. Two locations. Two fates.

The national transplant system has long prided itself on the principle of fairness: Organs should go to the sickest or those who have suffered the longest.

So sacred is this code that violations forced three transplant programs in California to close in the last seven months: At St. Vincent Medical Center in Los Angeles, the staff took a liver designated for one patient and gave it to another person further down the waiting list. At UC Irvine, viable livers were refused as waiting patients died. At Kaiser Permanente in Northern California, hundreds of kidney patients hastily reassigned to a new program were pushed back in line.

But a far greater inequity is inherent in the U.S. transplant system: When, and sometimes whether, you get an organ depends largely on where you are.

For transplantation purposes, the U.S. is divided into 58 territories, each with its own supply of organs and demand for surgeries. To protect local access to organs, most donated within a territory go to patients waiting there, even if sicker patients are waiting elsewhere.

This design has led to deep disparities, because supply and demand are not evenly spread across the country.

In big cities, for example, social blight boosts disease rates — and thus the need for organs — but makes it more difficult to recruit donors. At the same time, transplant centers in less crowded territories are often choosier about who joins their waiting lists. Varying ethnic compositions, car accident rates and the skill of organ recovery agencies all play into whether a territory is flush or deprived.

Sometimes all that separates a wait of years from one of months is a line on a map.

Take the Hudson River. On the New Jersey side, patients much less sick than Van Vlack routinely receive transplants. In Manhattan, patients must reach the brink of death.

The boundaries often defy logic. Even though it has just 28 patients waiting for livers, UC Davis gets first choice of most of the organs recovered in its territory, a circle surrounding Sacramento with a population of 2.4 million people.

It is an island of privilege in a sea of need. The rest of Northern California is a single territory with a population of 11.1 million, with 1,975 people awaiting livers.

These geographic inequities exist for all organs. But the consequences are most dire for liver patients. Kidney patients can survive on dialysis for years, and drugs and artificial devices can help keep heart patients alive.

PHOTO GALLERY
For one man, a new lease on life
(Carolyn Cole / LAT)

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