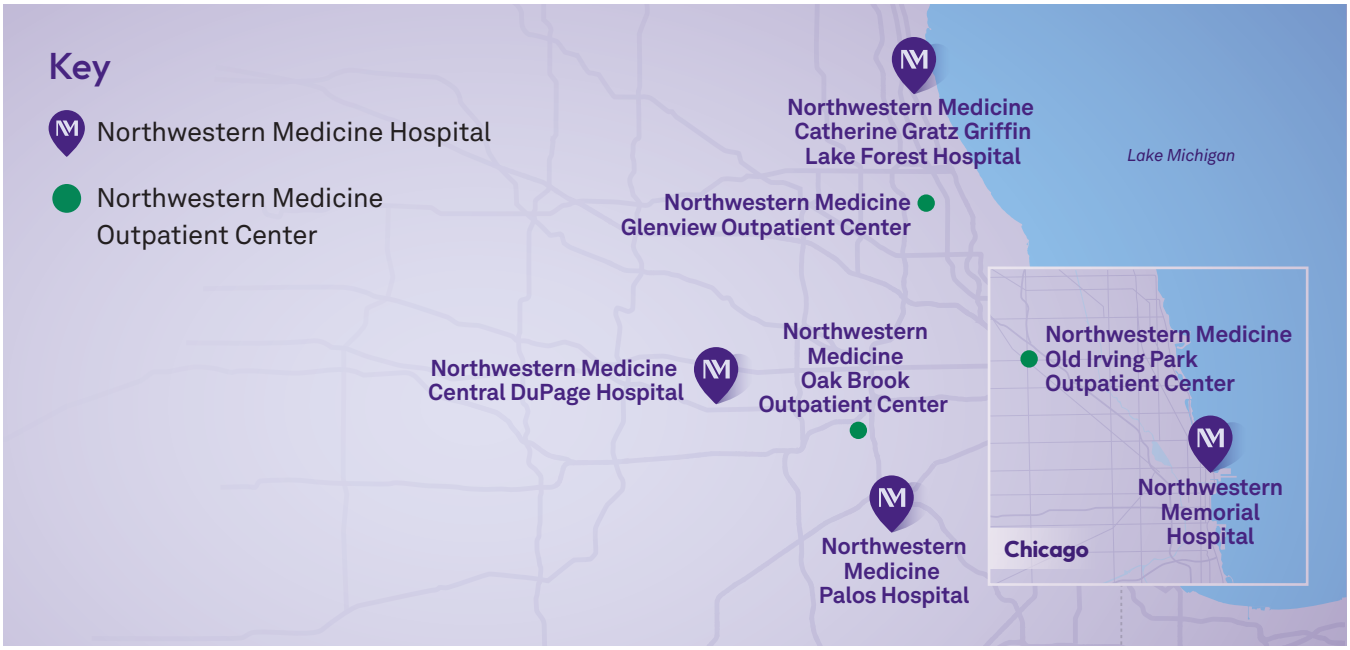
Northwestern Medicine®

Canning Thoracic Institute

Lung Transplant Program

For referrals, call **312.695.LUNG** (5864)

In 2025, we completed 131 transplants, making us one of the top four centers in the U.S. with the shortest average waitlist time of just four days.



Meet the team

Ambalavanan Arunachalam, MD

Chitaru Kurihara, MD

Joseph Bailey, MD

Ankit Bharat, MD

Brad Bemiss, MD

Alan Betensley, MD

Anthony Joudi, MD

Amanda Kamar, MD

Catherine Myers, MD

Kevin Tsiu, MD

Mrinalini Venkata Subramani, MD

Krishnan Warrior, MD

Faith Lloyd, APRN

Jennifer Wright, APRN

Continued >

Timing of transplant referral

Early referrals are key to overcoming potential barriers for transplant.

- A patient may be a lung transplant candidate when both of the following apply:
  - They have progressive disease despite being on optimal medical therapy.
  - Expected survival in the next two years is less than 50%.
- The patient must be sick enough to justify the risks of transplantation, **but** healthy enough to survive transplant surgery.
- Initiate referral before the need for transplant becomes urgent.
- We can monitor patients with your team for disease progression.

Indications for common diseases include:

COPD

- BODE score 7 to 10 or FEV<20% pred
- Presence of moderate to severe pulmonary hypertension
- Three or more severe exacerbations over the past year
- Chronic hypercapnia (Paco2>50mmHg)
- Poor quality of life

Interstitial lung disease (ILD)

- Referral should be made at the time of diagnosis
- Evidence of ILD on imaging
- Need for supplemental O2 at rest or with exertion
- Evidence of pulmonary hypertension
- FVC less than 80% predicted or DLCO less than 40% predicted
- Decline in FVC more than 10% or DLCO more than 15% in 6 months
- Hospitalizations for ILD

Cystic fibrosis (CF) and non-CF bronchiectasis

- FEV1<25% or >30% decline in lung function in FEV1 over 12 months
- Recurrent exacerbation requiring IV antibiotics
- PH on echo and/or right heart catheterization
- FEV1<40% with one of the following: 6 mwd <400m, paco2>50mmHg, malnutrition, hemoptysis, pneumothorax

Pulmonary arterial hypertension

- Serial risk assessment and response to vasodilator therapy
- Prognostic models: REVEAL 2.0 score of >8 despite appropriate therapy; 2015 ESC/ERS with “intermediate” or “high risk” category
- Unable to achieve “low risk” status despite maximal PAH therapy within 6 months
- IV or SC prostacyclin therapy initiation

ARDS

- About 4 to 6 weeks of maximal support with evidence of irreversible lung damage with single organ failure
  - Cleared viral infection

26-2520 POD/0526