AST T3 Webinar "Management of the Failing Kidney Allograft"

Additional Q&A

Speaker: Martha Pavalakis, MD • Beth Israel Deaconess Medical Center
Moderator: Tarek Alhamad, MD • Washington University School of Medicine

Q: Given that graft nephrectomy can never remove all the allomaterial (vascular pedical remains after intracapsular nephrectomy), can immunosuppression ever be fully weaned without risk of sensitization?

A: That is an interesting question. I have no data on the risks of vascular pedical leading to sensitization. The only paper reflecting timing of post-nephrectomy sensitization is by Del Bello, Clin J Am Soc Nephrol 2012; 7: 1310–1319.

Q: Which agent is preferable (CNI or MMF type drugs) for maintenance of immunosuppression after allograft failure? Data?

A: There is no data and no uniform practice. In the paper by Baliss, Clin Transplant 2013: 27: 895–900. 75% of respondents said that weaning was up to physician discretion.

Q: Do you have suggestions to optimize coordination of care with referring nephrologist?

A: We are trying to come up with guidelines in the Kidney & Pancreas Community of Practice. But starting with reading the British Transplant Society guidelines and maybe holding a ½ day conference with your referring nephrologists to brainstorm. Andrews, Transplantation 2014;98: 1130.

Q: Why do you choose urine output of less or more than a litre as a discriminator for weaning immunosuppression - understanding impact on the need for ultrafiltration in oligoanuric renal failure do you look at middle molecule clearance in any way eg B2 microglobulin?

A: Just a guess based on what amount of urine makes life easier for the dialysis patient in terms of fluid restriction, and no.

Q: Do you have any data on the infectious complications in patients maintained on full immunosuppression with a failed allograft (those that are expected to be retransplanted)

*A: No, Johnston, J Am Soc Nephrol 18: 1331–1337, 2007 is the closest thing we have to data, but the authors suggest "**The role of continued immunosuppression and vascular access creation was not assessed and should be addressed in future studies**."*

Q: If no side effects in particular, why do you chose to stop MMF first?

A: It's the drug we usually hold when someone comes in with severe infection. Just a practice, not data derived.