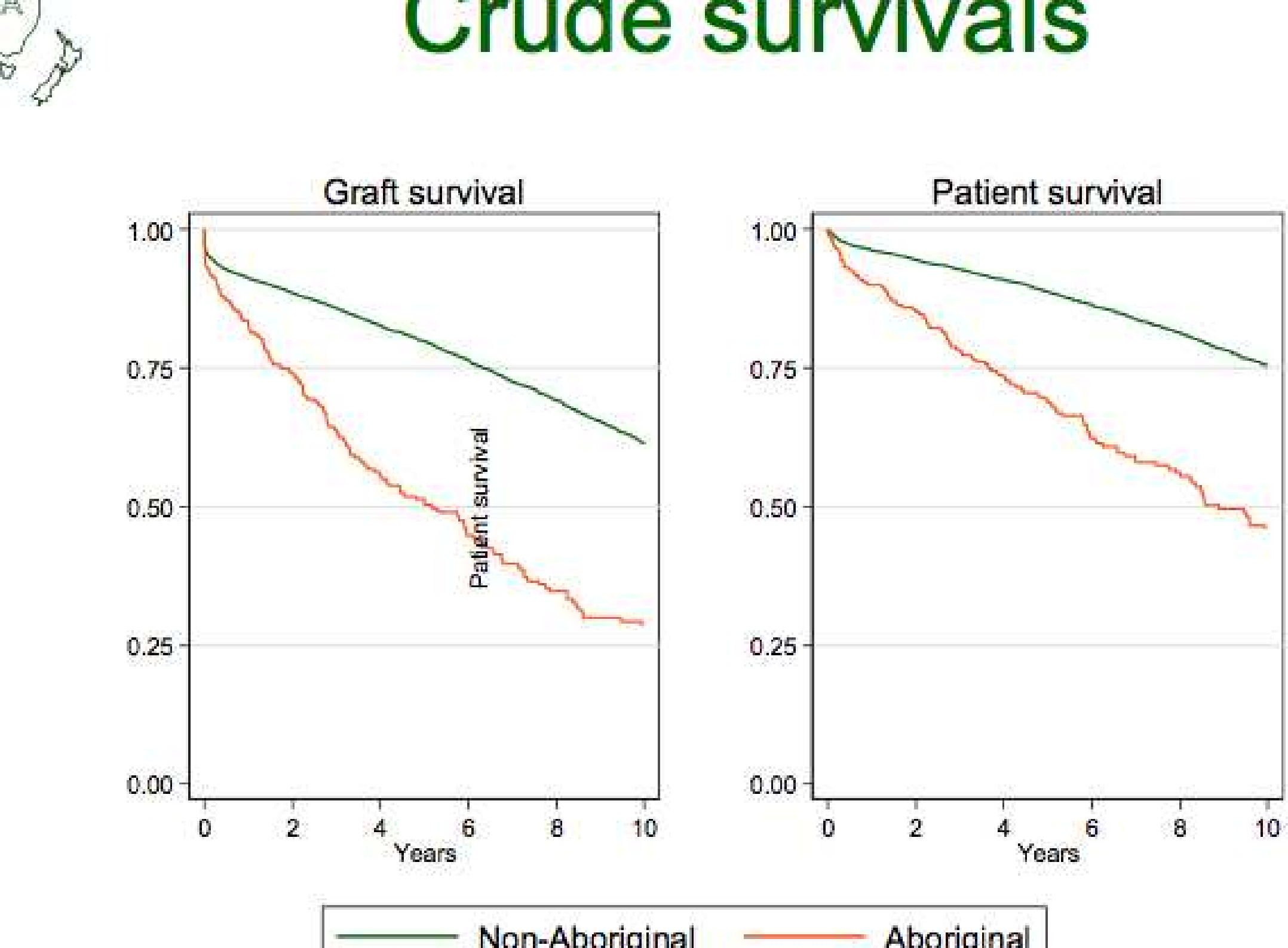
After the first month……

Dr Kevin Warr

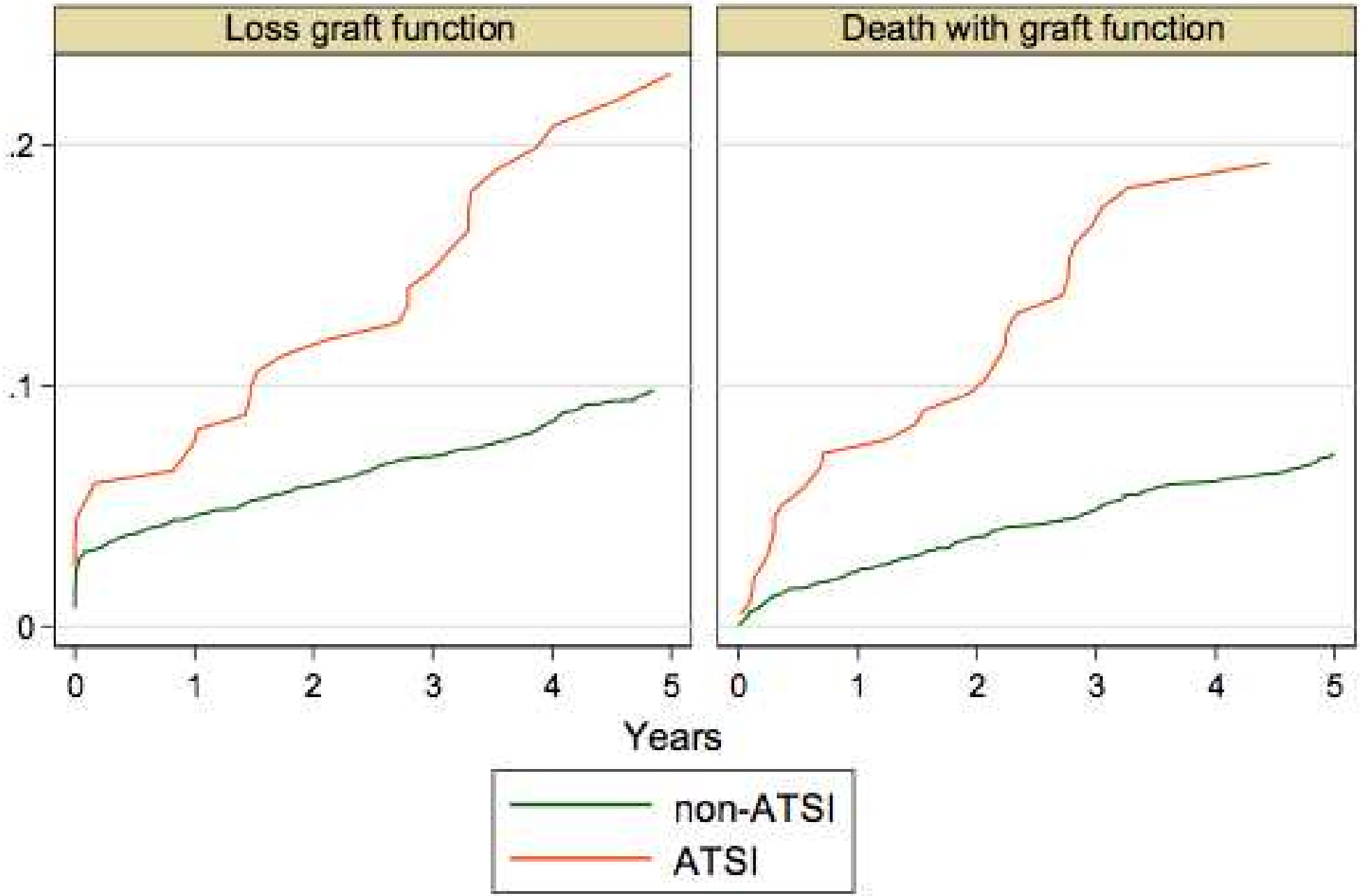
Royal Perth Hospital

A very short bedtime story…..

Crude survivals



Components of graft survival



ANZDATA, all grafts 1/1/01 to 31/12/11

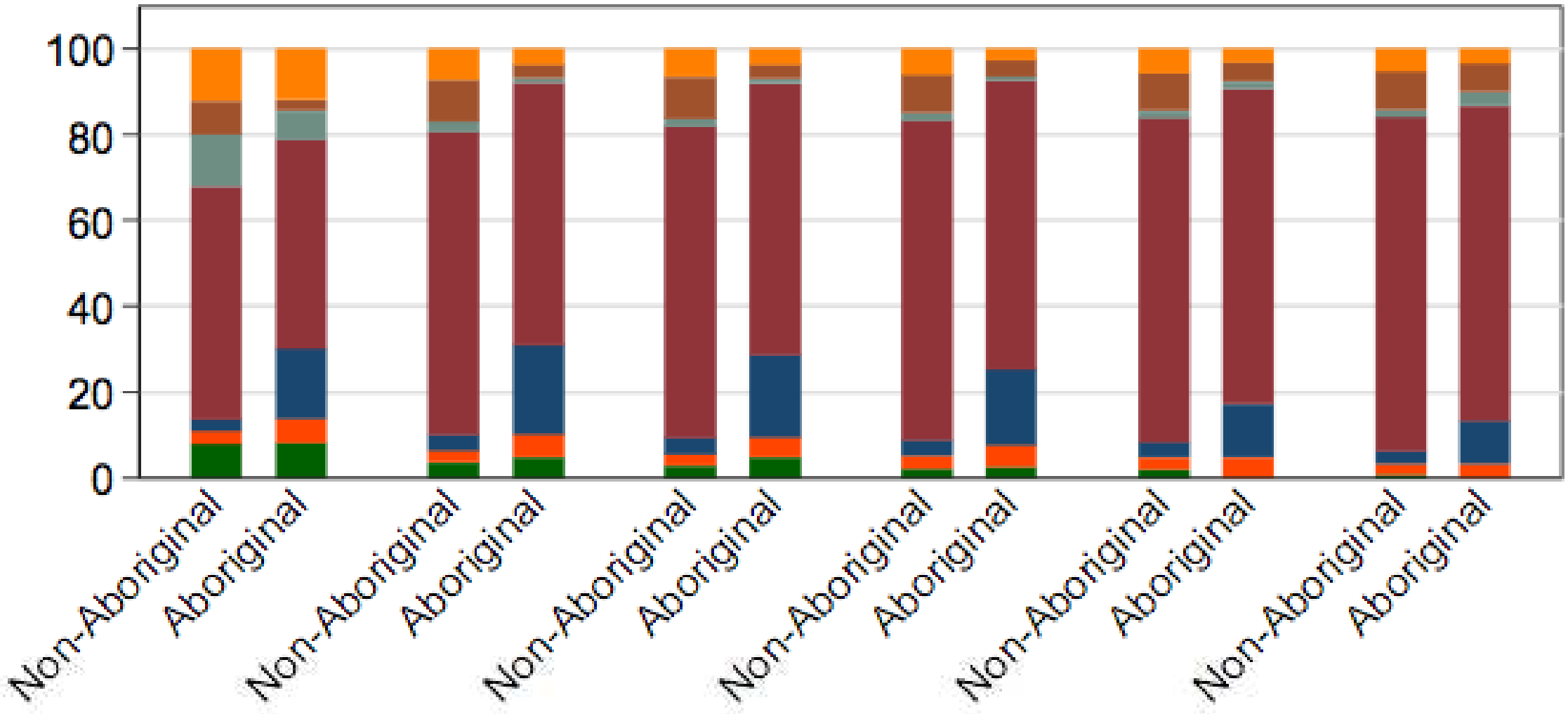
Non ATSI

1 year	91% (87-94)
2 year	90% (87-93)
5 year	82% (77-86)

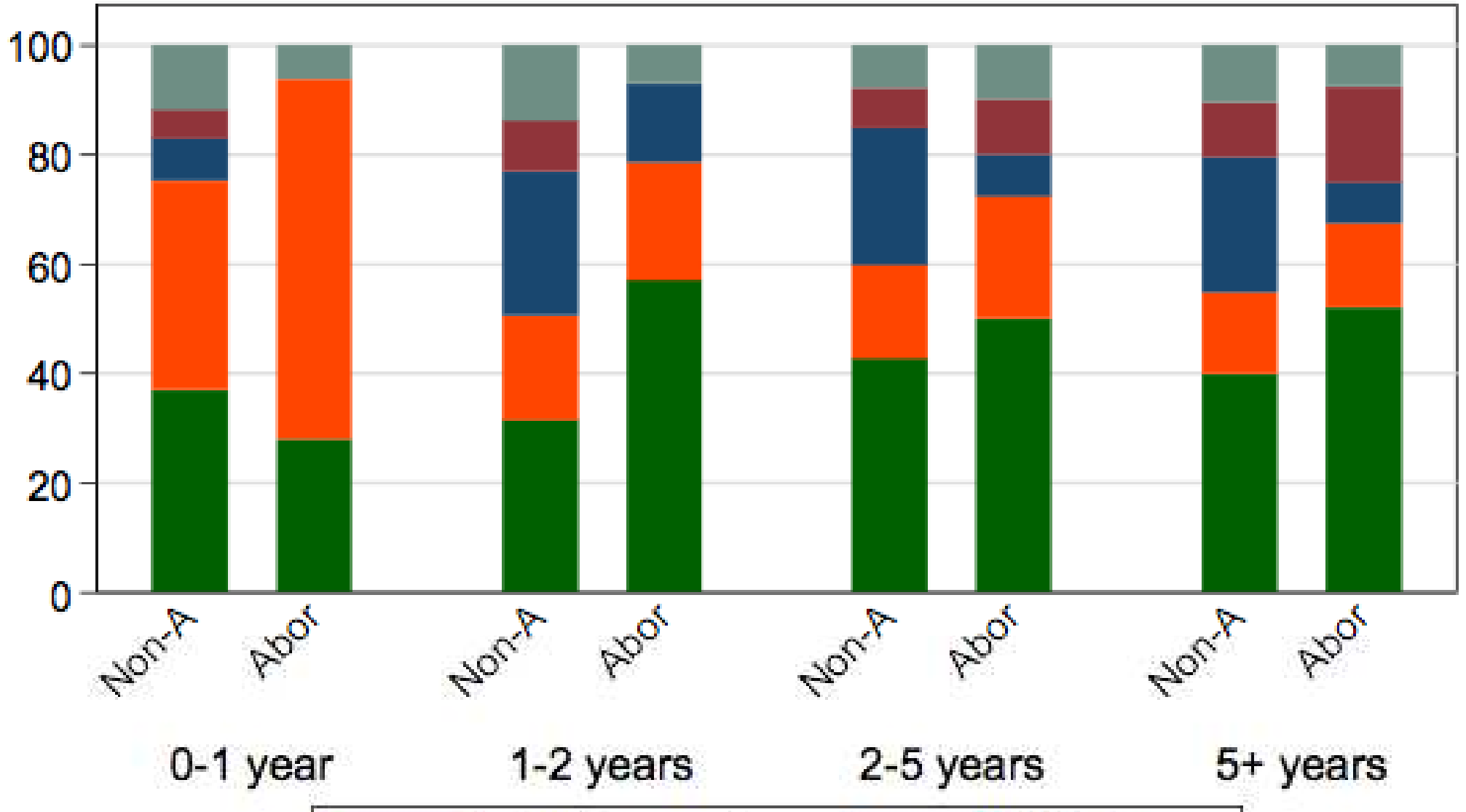
ATSI

1 year	83% (69-90)
2 year	70% (55-82)
5 year	53% (36-67)

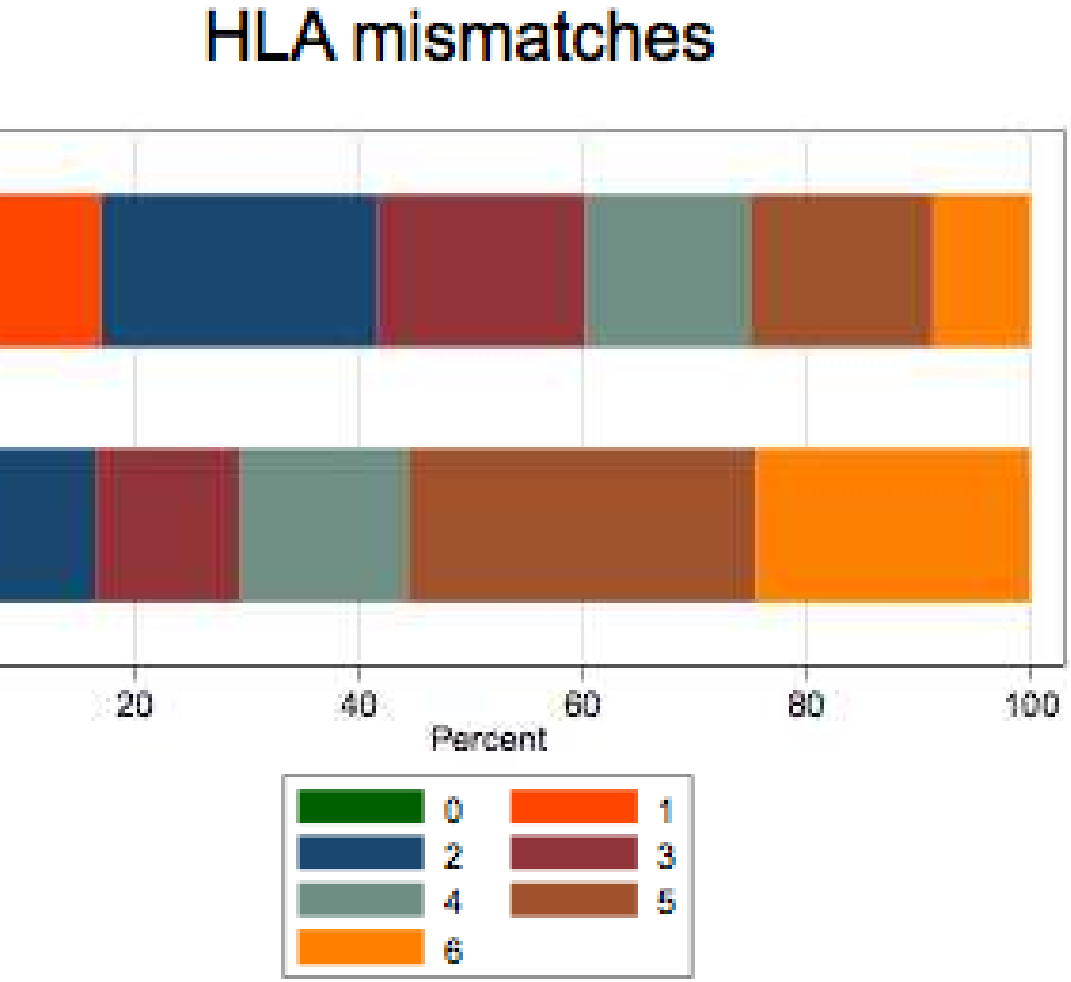
Causes of graft failure

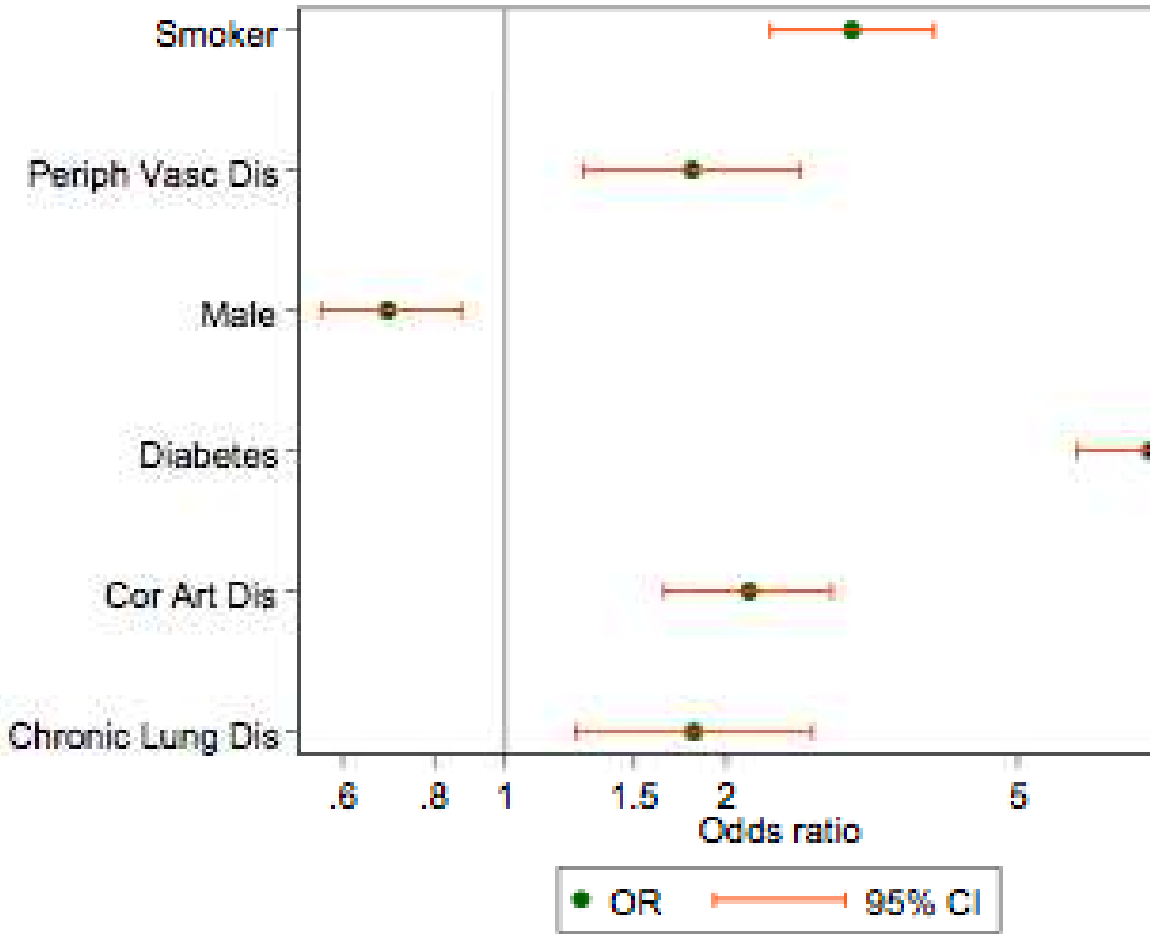


Causes of death



Confounders





ATA Registry, DD1 transplant Australia 1991-2011

DGF/ Rejection rates

DGF more common among Aboriginal recipients

- Crude OR 1.70 [1.33-2.18]
- Adjusted OR 1.49 [1.14-1.96]

- Rejection (in first 6 months) also more common
  - Crude OR 1.55 [1.19-2.02]
  - Adjusted OR 1.54 [1.16-2.07]

22 yo Female from Bidyadanga

Feb 2012

- Unwell post dental surgery for tooth abscess, Cr 2300
- PHx nil
- FHx Abundant
- US small echogenic kidneys
- Haemodialysis via tunneled catheter then AVF in Perth
- Activated on TWL Jan 2013

Feb 2013

- 1st Cadaveric Tx
- Immediate graft function
- Tac & MMF

Reimplantation for failed ureteric anastamosis

Urosepsis

Protocol biopsy NAD, Cr 92

une 2013

Discharged home for follow up by Regional Nephrologist in Broom

Missed appointment as had “gone bush”

uly 2013

UTI and graft dysfunction

After treatment of UTI ongoing graft dysfunction

Perth where biopsy revealed 1A rejection

Rejection treated and continued on steroids

Follow up biopsy NAD and Cr 100

37 yo Male Bidyadanga

April 2004

A/CRF (diabetes) transferred RFDS to Perth, did not recover function and commenced dialysis via tunnelled catheter

Feb 2005

Returned to Broome for satellite HDx

Aug 2005 HHDx in Bidyadanga

Sept 2008

DGF, 6/6 mismatch, Tac/MMF/Pred, discharge Cr 180

October 2008

Returned home against advice, Cr 120

uly 2009

- Osteomyelitis/discitis T7-8 with cord compression resulting in incomplete paraplegia
- DAMA from Rehab

Feb 2010

- Transfer to Perth Cr 2000
- Ceased immunosupression, ?when
- Biopsy revealed AMR with poor prognosis
- Reintroduction of IS with planned wean

une 2010

- Painful graft and macrohaematuria with resultant graft nephrectom
- HDx in Perth with frequent admissions as a result of fluid

2002

Referred with decline in GFR, hypertension and on Ix atrophic (R) kidney

2005

Re referred with poorly controlled BP, Cr 260, not taking medications

uly 2007

Reached ESRF and commenced CAPD

September 2007

Home on PD

uly 2008

NSTEMI and CABG

Feb 2009

May 2011

- Cadaveric Tx, DGF, 6/6 mismatch, Tac/MMF/Pred, discharge Cr 200

Complications

- AF, anticoagulation with warfarin
- Neutropaenia (MMF)
- Pseudomonas pneumonia
- Graft dysfunction due to Tx artery stenosis

Sept 2011

- Returned home to KNX, Cr 150

May 2012

- BK positive resulting in reduction in IS

Biopsy recommended

April 2013

Cr 300

Biopsy demonstrated BKVAN

Sirolimus & leflunomide

Cr 280

Long lead time usually in an urban setting and familiarity with system

Rigorous assessment and reassessment and education

Allocation algorithms that maximise benefit

Dedicated team of Tx Physicians, surgeons & nurses

Expertise in Tx related isssues

Regular follow up and careful monitoring

Familiarity & no isolation

ost Tx

Rigorous long term follow up with patient “buy in”

Standardised protocols

Assessment done “remotely” with few short visits to Tx centre

Education

Familiarity

Patient selection (fairness & equity vs best outcome

Relocation to urban centre with associated problems

Poor match and increased rates AR & DGF

Over immunosupression?

Comorbidity

ost Tx

Frequent pressure to return prematurely

ost Tx

Follow up of results, outcomes, progress

Communication

Database enabled

Adherance to protocols

Lack of funding for regular Tx physician review

Underutilisation of telehealth