

**Société Belge de Transplantation  
Belgische Transplantatie Vereniging  
Belgian Transplantation Society**

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# **PROGRAMME & ABSTRACTS**

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**Thursday, 5 March 2009**

**- Brussels -**

# ABSTRACTS

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## Session 2 (Room 2: 9h00-10h30)

### *Kidney – Pancreas / Liver – Intestine*

- . **Bonaccorsi-Riani E**, HCV and liver transplantation – the role of minimal immunosuppression: results of a prospective, randomized, double-blind, placebo-controlled study.
- . **Darius T**, Denies E, Monbaliu D, Aerts R, Van Steenberghe W, Roskams T, Cassiman D, Verslype C, Laleman W, Vanrenterghem Y, Kuypers D, Evenepoel P, Bammens B, Claes K, Nevens F, Pirenne J. Polycystic liver and kidney disease: liver transplantation alone or combined liver kidney transplantation ?
- . **Liu Q**, Vekemans K, Heedfeld V, Wylin T, Brassil J, Demuylder P, Theunis B, Vercruyce J, Pirenne J, Monbaliu D. Viability testing of extended-criteria donor livers during hypothermic machine perfusion.
- . **Pirenne J**, Monbaliu D, Aerts R, Desschans B, Liu Q, Cassiman D, Verslype C, Van Steenberghe W, Nevens F. Biliary strictures after liver transplantation: risk factors and prevention by donor epiprosthenol treatment.
- . **Decker E**, Coimbra C, Weekers L, Detry O, Honoré P, Squifflet JP, Meurisse M, De Roover A. A retrospective monocentric review of simultaneous pancreas kidney transplantation.
- . **de Jonge H**, Naesens M, Vanrenterghem Y, Kuypers DR. The pregnane X receptor (NR112) C-25385T single nucleotide polymorphism does not affect tacrolimus pharmacokinetics in a large cohort of renal transplant recipients.
- . **Ghisdal L**, Broeders N, Wissing KM, Saidi A, Bensalem T, Mbaba mena J, Lemy A, Wijns W, Pradier O, Hoang AD, Mikhalski D, Donckier V, Cochaux P, El Housni H, Abramowicz M, Vereerstraeten P, Abramowicz D. Thrombophilic factors do not predict outcomes in patients receiving a renal transplantation after 2000.
- . **Milicevic M**, Weekers L, Grosch S, Bonvoisin C, Krzesinski JM. Cardiovascular status in kidney graft recipients and its impact on graft survival: a single center retrospective analysis over 16 years.
- . **Troisi R**, Sainz-Barriga M, Giacomoni A, Montalti R, Lauterio A, Slim AO, De Carlis L, de Hemptinne B. Morbidity of biliary complication in LDLT is enhanced by ductoplasty irrespectively of the operative approach: a comparison between two different institutional experiences.

impact of maneuvers aimed at better flushing/preserving peribiliary vascular plexus and biliary mucosa: addition of Epoprostenol (Ep) {Flolane}-potent vasodilator & platelet inhibitor normally produced by endothelial cells- in the pressurized (100 mmHg) UW preservation solution; this protocol was applied to all locally procured livers since 01/09/1999. Incidence of BS was 19.1% (77/403). Average time of diagnosis was 253 days (7 days-1002 days). In univariate analysis (Fisher exact & Chi X2; T-test & Mann Whitney-U test, significance set at <0.05), absence of flushing of donor bile ducts, import vs locally procured liver, and rejection were risk factors for BS. On the contrary, following factors were protective: donor cardiac arrest followed by resuscitation (suggesting an ischemic preconditioning effect) and Ep/pressurization. Patients with higher postTx peak of transaminase, bilirubine, alkaline phosphatase, and  $\gamma$ -GT were at higher risk for later development of BS. Donor-hypotension, -age, and -ICU stay, type of preservation, positive cross-match, cold & warm ischemia times, sequential vs simultaneous portal/arterial reperfusion, and CMV infection were no risk factors for BS. In multivariate analysis (significance set at <0.01), only Ep-pressurization appeared to protect from BS. In conclusion, this study makes 2 novel points: 1. Patients with high(er) transaminase and cholestasis early postTx are at higher risk of developing BS later and should be closely monitored; 2. Donor maneuvers aimed at better flushing/preserving peribiliary vascular plexus and biliary mucosa (Ep-pressurization of preservation solution) protect from BS. If confirmed in a randomized prospective trial, this protocol should be routinely implemented.

#### **A RETROSPECTIVE MONOCENTRIC REVIEW OF SIMULTANEOUS PANCREAS KIDNEY TRANSPLANTATION.**

Decker E, Coimbra C, Weekers L, Detry O, Honoré P, Squifflet JP, Meurisse M, De Roover A. Service de Chirurgie Abdominale et Transplantation, CHU de Liège, Belgium.

**Background:** Pancreas transplantation has emerged as an effective treatment for patients with type 1 diabetes associated with end-stage renal disease. In this paper, we review a consecutive series of simultaneous pancreas-kidney (SPK) transplantations performed in our institution over a 6 years period.

**Methods:** The study population included 22 patients (15 males and 7 females) who underwent SPK transplantation between 2001 and 2007. The mean recipient age was 47 (26-63). Eighteen patients suffered from type 1 and 4 from type 2 diabetes. The mean donor age was 33 (14-56). The mean of HLA histocompatibility matching was 2.1(1-5). Mean renal and pancreatic cold ischemia time were respectively 7h42 and 8h52, Immunosuppressive treatment consisted of basiliximab induction followed by a triple association (tacrolimus, mycophenolate mofetil and prednisone). Mean hospital stay was 20 days (11-52).

**Results:** Among 22 recipients, patient survival rate was 86% after a mean follow-up of 44 months (17-88). Two patients died in the immediate post-operative period: 1 from disseminated intravascular coagulation (DIC) and multi-systemic failure in the immediate postoperative period and 1 from pulmonary embolism at home 45 days after surgery. A third patient died from pulmonary infection after 48 months with functional grafts. Early postoperative complication associated with kidney graft was one case of vascular thrombosis that needed POD 1 graft withdrawal. After a second renal transplantation 2 days later, she developed an acute rejection successfully treated by plasmapheresis and Rituximab. The patient with DIC suffered both from kidney and pancreas graft thrombosis. Other early complications associated with pancreas transplant included 2 cases with immediate reperfusion defects that led to early vascular thrombosis in one patient and duodenal graft fistula in the other patient. These two cases needed pancreas graft withdrawal. For the 19 patients currently alive, kidney graft survival was 95% (18/19). Only one patient lost his kidney secondary to rejection due to non compliance. Pancreas graft survival was 84% (16/19). Graft loss was due to rejection for two patients (including the case of non compliance) and pancreatic fistula in one case.

**Conclusion:** SPK is a valid therapeutic option for patients with insulin-dependent diabetes and renal failure from diabetic nephropathy. In our series, patient, kidney and pancreas graft survival were respectively 86%, 82% and 73% after a mean follow-up of 44 months. Main complications of SPK transplantation occur in the immediate postoperative period consecutive to vascular or rejection processes.