

CLINICAL CASES — SESSION 7 — SATURDAY, FEBRUARY 12

CC 01 EBV NEGATIVE PTLD AND GVHD – TO INCREASE OR DECREASE IMMUNOSUPPRESSION

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An 18 month old girl underwent modified- multivisceral-transplantation (MMVTx) and was discharged within 6 weeks. She developed papules on her hand and developed a florid skin rash suggestive of Graft-versus-Host-Disease (GVHD) 12 weeks after MMVTx. Her immunosuppression was increased, but rash continued to progress. She had extensive blistering of skin and was treated with high dose steroids without any response. She was recommenced on PN and she developed abnormal liver function tests (LFT's). She was then commenced on Basiliximab and Infliximab treatment after haematology consultation. Despite increasing her Tacrolimus (trough level of 12–15), her GVHD of skin and liver (maximum bilirubin of 500 micromol/l) progressed. At the same time she was noted to have abdominal lymphadenopathy on CT scan abdomen. Her EBV PCR was found to be negative and she underwent an abdominal lymphadenectomy. She was demonstrated to have polymorphic PTLD (CD20 negative) on histopathological examination. Her immunosuppression was decreased (trough levels of tacrolimus 6–8). We elected to ignore the EBV negative PTLD (after oncology consultation) and not to treat with Rituximab or any other form of chemotherapy to prevent the development of opportunistic infection. Her GVHD progressed and she received mesenchymal stem cells. She was maintained on a target trough levels of tacrolimus 6–8. Her GVHD improved but she developed immune mediated hemolytic anaemia and thrombocytopenia needing multiple blood and platelet transfusion. She did not respond to IV Immunoglobulins and was treated with Rituximab (4 courses) to which she eventually responded. Six months later, her GVHD has completely resolved, she does not have abdominal lymphadenopathy, she is no longer jaundiced and has no evidence of hemolytic anaemia. She however still remains dependent on PN. This case demonstrates the importance of multidisciplinary team working and appropriate use of immunosuppression to manage a complex case with rare complications.

CC 02 FATAL SMALL FOR SIZE SYNDROME AFTER RIGHT LOBE DONATION

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A 39-year old man wanted to give a part of his liver for his father who suffered from terminal cirrhosis from unknown origin. He underwent the full pre donation work-up, including MRI with normal bile duct anatomy, CT evaluating the volume of the right lobe at 1050 ml and left lobe at 400 ml, and liver biopsy demonstrating a light (15%) macrovesicular steatosis. Both procurement and transplantation procedures were uncomplicated. Within 24 hours, the donor became jaundiced with reduction of liver function. A second-look laparotomy was performed on day 5 demonstrating a congestive liver remnant. 48 hours later, the patient developed peritonitis, and a colonic perforation at the hepatic flexure was surgically demonstrated and closed. Eight days later the patient developed recurrent colonic perforation at the same site, and an ileocolonic resection with terminal ileostomy was performed. The patient had to be re-operated during the night for continuous bleeding. One month later, while recovering in the ward, he developed ileal perforation secondary to volvulus, and a new ileostomy was constructed after bowel resection. He remained toxic and underwent exploratory laparotomy that excluded another septic source. He was improving when he developed acute cytotoxicity. CT showed a total necrotic liver remnant despite open portal vein, hepatic artery and hepatic veins. The patient was then listed for HU liver transplantation. After 48 hours the first offer was a steatotic liver that was accepted. The patient was then unstable, with diffuse bleeding. He had several cardiac arrest during the hepatectomy. He was supported by ECMO and hemofiltration. The graft did not function related to the instability of the recipient who was bleeding diffusely and finally died in the ICU when the ECMO was stopped due to impossibility to improve despite maximal ICU care.

Methods: A 25 years old female patient with chronic hepatitis B virus infection underwent multivisceral transplantation in December 2005. Basic immunosuppression consisted of thymoglobulin, methylprednisolone and steroids. After good initial function with normal graft biopsy, a severe acute rejection with biopsy proven complete epithelial destruction occurred on postoperative day 28 following a preceding one-time low tacrolimus level (0 ng/ml). After immediate high-dose intravenous treatment with total 6.5 g methylprednisolone, thymoglobulin for 15 days and liver-

Conclusion: ITx and MVTx have been established. Modifications in immunosuppressive management, calcineurin modifications in immunosuppressive strategies including withdrawal reduction have accounted for significant advances in post-transplant patient and graft outcome, currently reaching 50% at 1 and 3 years, respectively.