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P022 -A retrospective review of the management of patients with a failing kidney transplant.

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Introduction:

With the increasing number of kidney transplant recipients, failing grafts are progressively common. There is evidence that patients with failing transplant recipients receive sub-optimal care in preparation for further renal replacement therapy (RRT) with dialysis or another transplant.

Methods:

We conducted a retrospective review of the pathway of care and the outcomes for the patients with a failing kidney transplant between April 2013 and March 2016. Patients whose transplant failed within the first 3 months were excluded from analysis. The data were collected from the renal database, electronic patient records and medical notes. The documentation of discussion regarding failing transplant was accepted as date of start of pathway.

Results:

Demographics - 60 patients.

Duration of transplant - average of 13 years (3months to 40years).

34 men, 26 women.

Average age was 58 years (26 to 87 years).

Outcomes - 29 (48%) patients had repeat education regarding RRT options and 10 (17%) were followed up in a multi-disciplinary low clearance clinic.

RRT Modality - 6 patients transferred out of the unit and no follow-up data was available. 12 (18%) patients died before needing further RRT. 5 (7.5%) patients had a pre-emptive transplant. 10 (17%) started peritoneal dialysis (PD) and 27 (45%) haemodialysis (HD). 9 patients had unplanned start to dialysis.

Access - Of the patients starting haemodialysis (n=27), 5 started with a pre-existing fistula (AVF) and 5 started with a newly created AVF {10 (31%) had a permanent access}. Of the 22 patients starting HD with a catheter, 11 (50%) had permanent access at 3 months (AVF 6, AVG 2, PD catheter 3), 75% at 6 months (AVF 8, AVG 3, PD catheter 6) and 100% at 1 year. 6 (18%) patients starting HD changed to PD during this period.

Transplantation – 5 had a pre-emptive transplant. At the time of start of dialysis 7(16%) were unsuitable, 4(10%) active and 10(23%) having work up. By the end of 3 months 11(26%) were active and that increased to 22(51%) by 12 months.

Mortality - At the end of follow-up, 18 (27%) patients had died (malignancy – 7, infection – 1, 18 – not known).

Conclusion:

British Transplant Society (BTS) guidelines recommend that joint transplant/advanced kidney care should be initiated at least 6 to 12 months before the anticipated need for dialysis or re-transplantation or when graft estimated glomerular filtration rate (eGFR) falls below 20 ml/min. Where appropriate, re-transplantation

should be undertaken when eGFR of the recipient with a failing kidney transplant has fallen to 10-15 ml/min. 'Vascular Access for Haemodialysis' recommends formation of an arteriovenous fistula (AVF) at a minimum of three months prior to starting haemodialysis and probably not more than one year before the expected date of dialysis. This retrospective audit highlights some good practice (pre-emptive transplantation, timely access referral, access to PD), but also demonstrates significant challenges (high mortality, HD start with a line, delay in transplant work up, delayed transfer to PD) in providing a good care to the patients with failing transplant.