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SCN SOCIETAT CATALANA DE NEFROLOGIA

Consorci Sanitari Integral

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Hospital de Sant Joan Despí Moisès Broggi

Estratègies per augmentar el trasplantament renal de donant viu

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¿ Por qué el trasplante renal de vivo ?

- Es la mejor opción terapéutica para el tratamiento de la insuficiencia renal crónica
- El riesgo de morbilidad y mortalidad del donante es extremadamente bajo
- La oferta de órganos de cadáver es insuficiente para cubrir toda la demanda y para conseguir que el tiempo de espera en diálisis sea razonablemente corto

¿ Por qué el trasplante renal de vivo ?

- Mejor adaptación del paciente (y su familia) a las actividades escolares, laborales y de ocio:

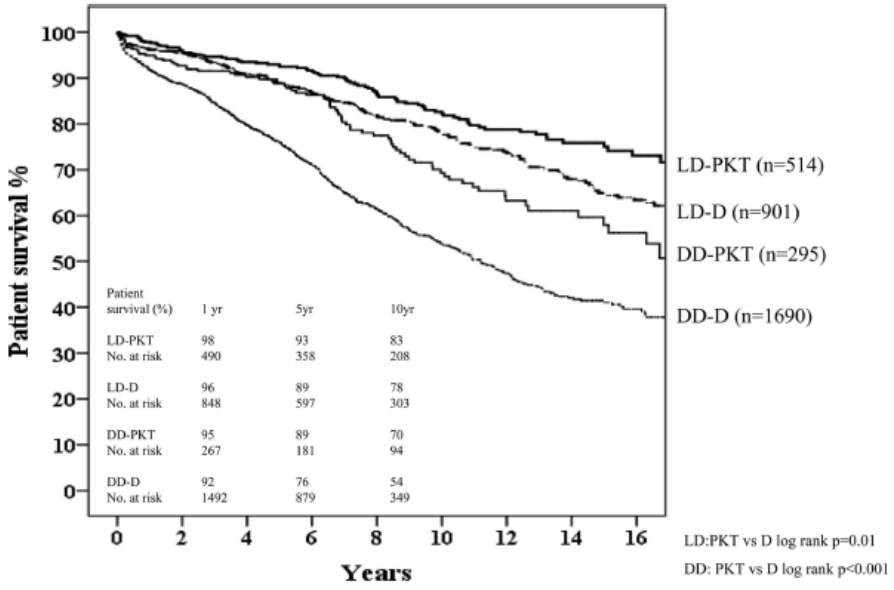
  Mejor Calidad de Vida

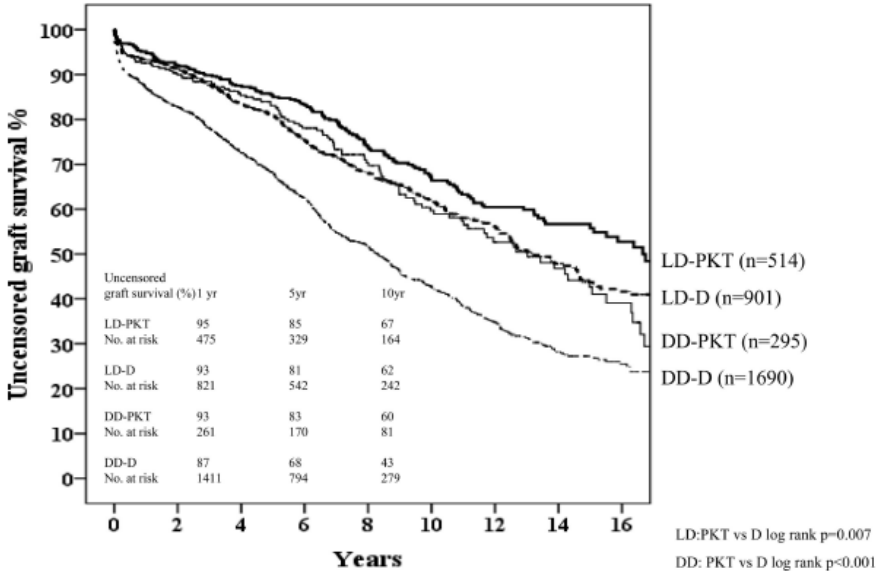
- Reducción del coste del tratamiento:

  Mejor Relación Coste / Beneficio

Experience From an Active Preemptive Kidney Transplantation Program—809 Cases Revisited

Bartlomiej J. Witczak,[1,4] Torbjørn Leivestad,[2] Pål Dag Line,[3] Hallvard Holdaas,[1] Anna V. Reisaeter,[1] Trond G. Jenssen,[1] Karsten Midtvedt,[1] Jan Bitter,[1] and Anders Hartmann[1]





Transplantation 2009

Experience From an Active Preemptive Kidney Transplantation Program—809 Cases Revisited

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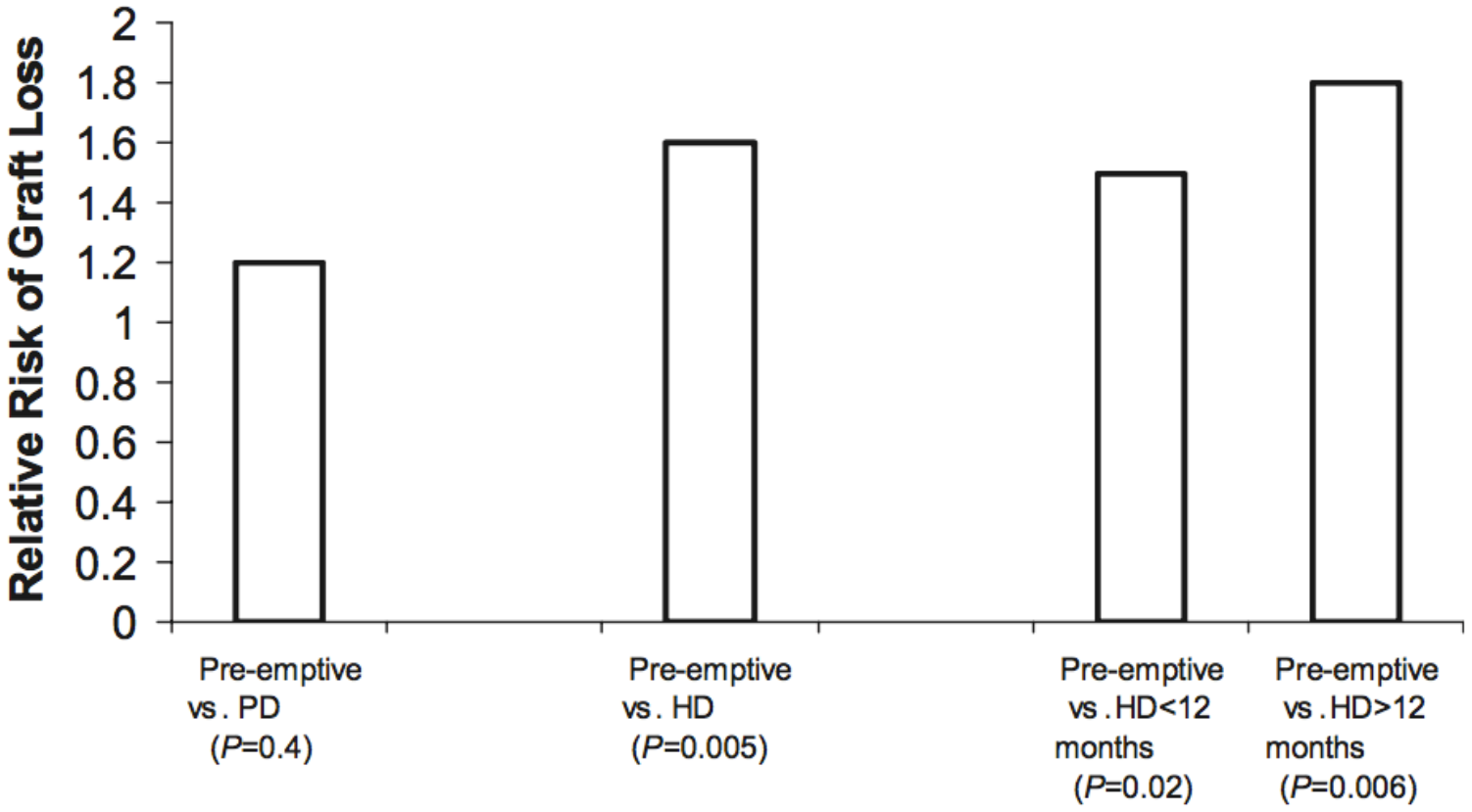
TABLE 2. Multivariable Cox regression (enter method) analyses of risk factors for mortality, uncensored graft loss, and death-censored graft loss after kidney transplantation (n=3400)

	Risk factors for mortality		Risk factors for uncensored graft loss		Risk factors for death-censored graft loss	
	HR	*P*	HR	*P*	HR	*P*
Age	1.07	<0.001	1.03	<0.001	0.99	<0.001
Donor age	1.01	0.001	1.01	<0.001	1.03	<0.001
Male gender	1.07	0.323	1.03	0.635	0.92	0.349
PKT	0.75	0.001	0.74	<0.001	0.79	0.017
Deceased donor	1.38	<0.001	1.36	<0.001	1.38	0.001
Diabetes	2.05	<0.001	1.57	<0.001	1.48	0.001
HLA-DR mismatch	1.31	<0.001	1.28	<0.001	1.37	<0.001
PRA positivity	1.44	0.005	1.27	0.044	1.45	0.032
Time period 2 vs. 1[a]	0.62	<0.001	0.66	<0.001	0.72	0.001

[a] Time period 1 is from January 1989 to June 1998 and period 2 is from July 1998 to December 2007.
HR, hazard ratio; PKT, preemptive kidney transplantation; PRA, panel reactive antibody.

Transplantation 2009

Effect of pretransplantation dialysis on graft survival of living donor grafts in pediatric recipients



Butani L & Perez VR, Transplantation 2011;91: 447–451

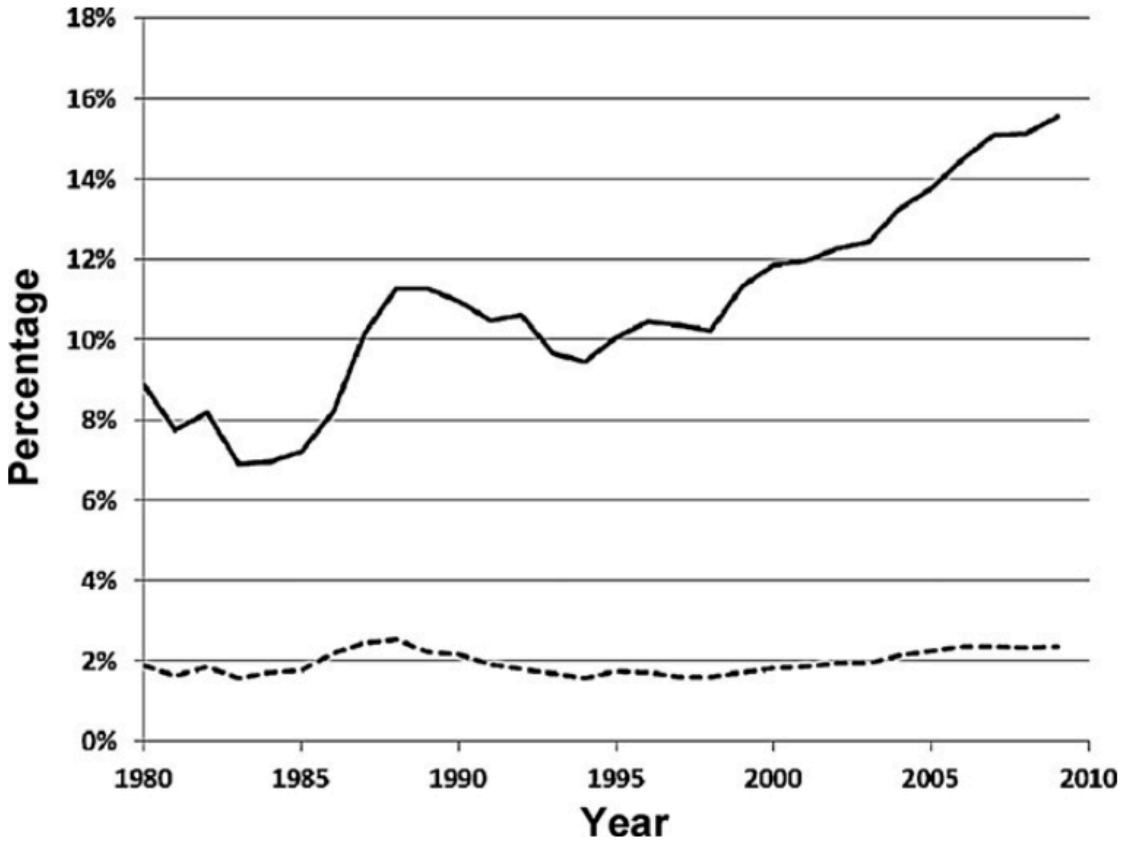
Preemtive transpslantation in diabetic patients

Recipient Characteristic	RR (*P* Value), PreKT vs Non-PreKT	
	Mortality	Graft Failure
Type 1		
Living donor KTA	0.57 (.002)	0.85 (.23)
Deceased donor KTA	0.88 (.53)	0.99 (.96)
Deceased donor SPK	0.50 (<.001)	0.79 (.01)
Type 2		
Living donor KTA	0.65 (.007)	0.81 (.09)
Deceased donor KTA	0.92 (.63)	1.04 (.80)

Abbreviations: KTA, kidney transplantation alone; PreKT, preemptive kidney transplantation; SPK, simultaneous pancreas-kidney.

Becker et al, Arch Intern Med. 2006

Trends in preemptive kidney transplantation in the United States from 1980 to 2009



% Trasplantes anticipados

% IRC que inician TRS con un trasplante anticipado

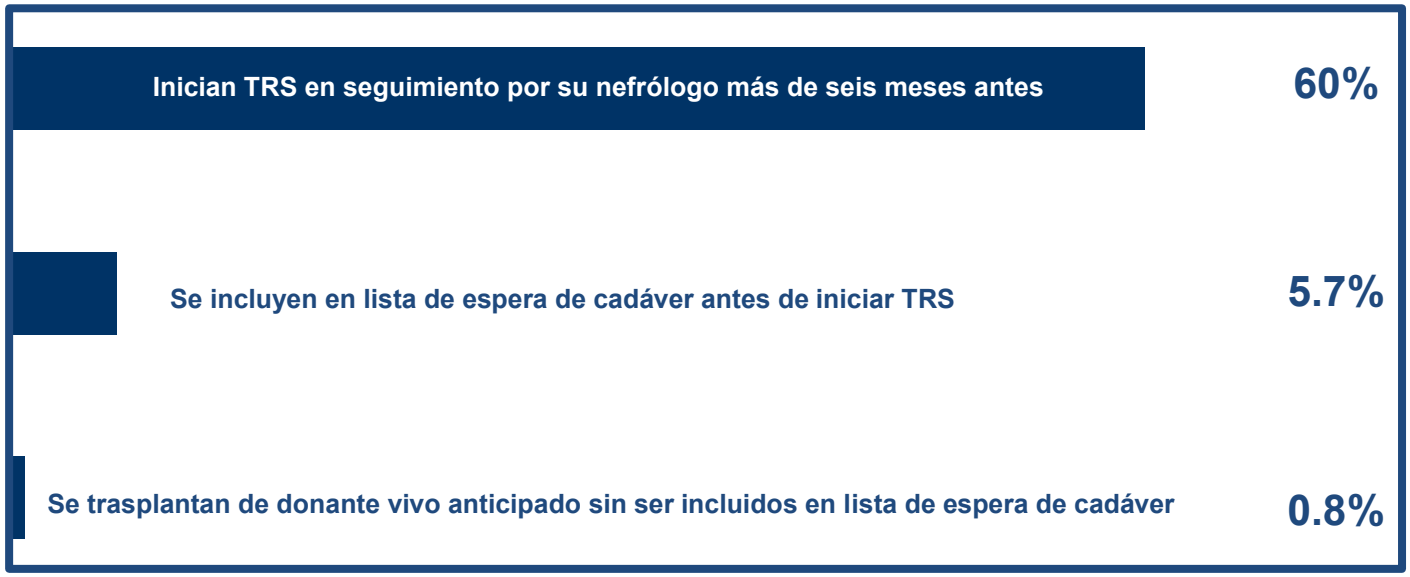
Huang Y & Samaniego M, Néphrologie & Thérapeutique 8 (2012) 428–432

Utilization of preemptive or early (< 3months) kidney transplantation in different countries in 2009

	Total incident ESKD patients	Number of preemptive or early KT[a]	% of incident ESKD patients with preemptive or early KT[a]
Norway	527	93	17.6
France	1995	213	10.7
The Netherlands	1865	193	10.3
Denmark	659	48	7.3
Sweden	1064	77	7.2
The U.K.	6204	412	6.6
Australia	2337	118	5.0
Austria	1132	42	3.7
Canada	5375	187	3.5
Spain	4452	152	3.4
New Zealand	567	18	3.2
Romania	2188	52	2.4
The U.S.	116 395	2759	2.4
Italy	4130	67	1.6
Belgium	2049	25	1.2
Greece	2071	7	0.3
Finland	432	1	0.2

Huang Y & Samaniego M, Néphrologie & Thérapeutique 8 (2012) 428–432

Kidney Transplantation as Primary Therapy for End-Stage Renal Disease: A National Kidney Foundation/Kidney Disease Outcomes Quality Initiative (NKF/KDOQI™) Conference



- Menos del 7% de los pacientes son evaluados y considerados candidatos para Tx antes de iniciar TRS
- 39% de pacientes evaluados para Tx antes de iniciar TRS se trasplantan anticipadamente (1/3 con riñón de cadáver)
- Globalmente, 2.5% de pacientes incidentes se trasplantan anticipadamente

Abecassis et al, Clin J Am Soc Nephrol 2008

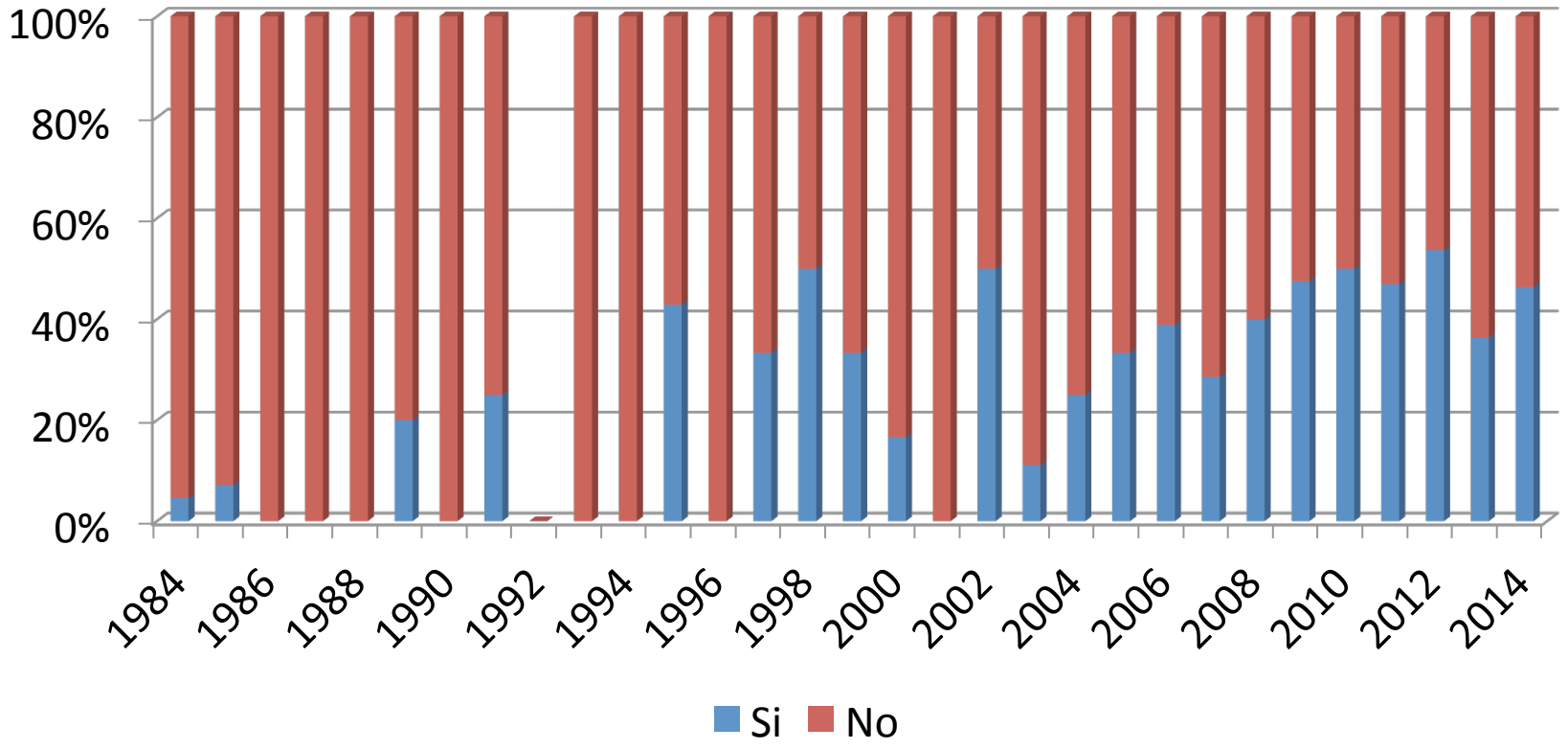
Kidney Transplantation as Primary Therapy for End-Stage Renal Disease: A National Kidney Foundation/Kidney Disease Outcomes Quality Initiative (NKF/KDOQI™) Conference

Table 3. Recommendations of the NKF/KDOQI Conference on Early Transplantation[a]

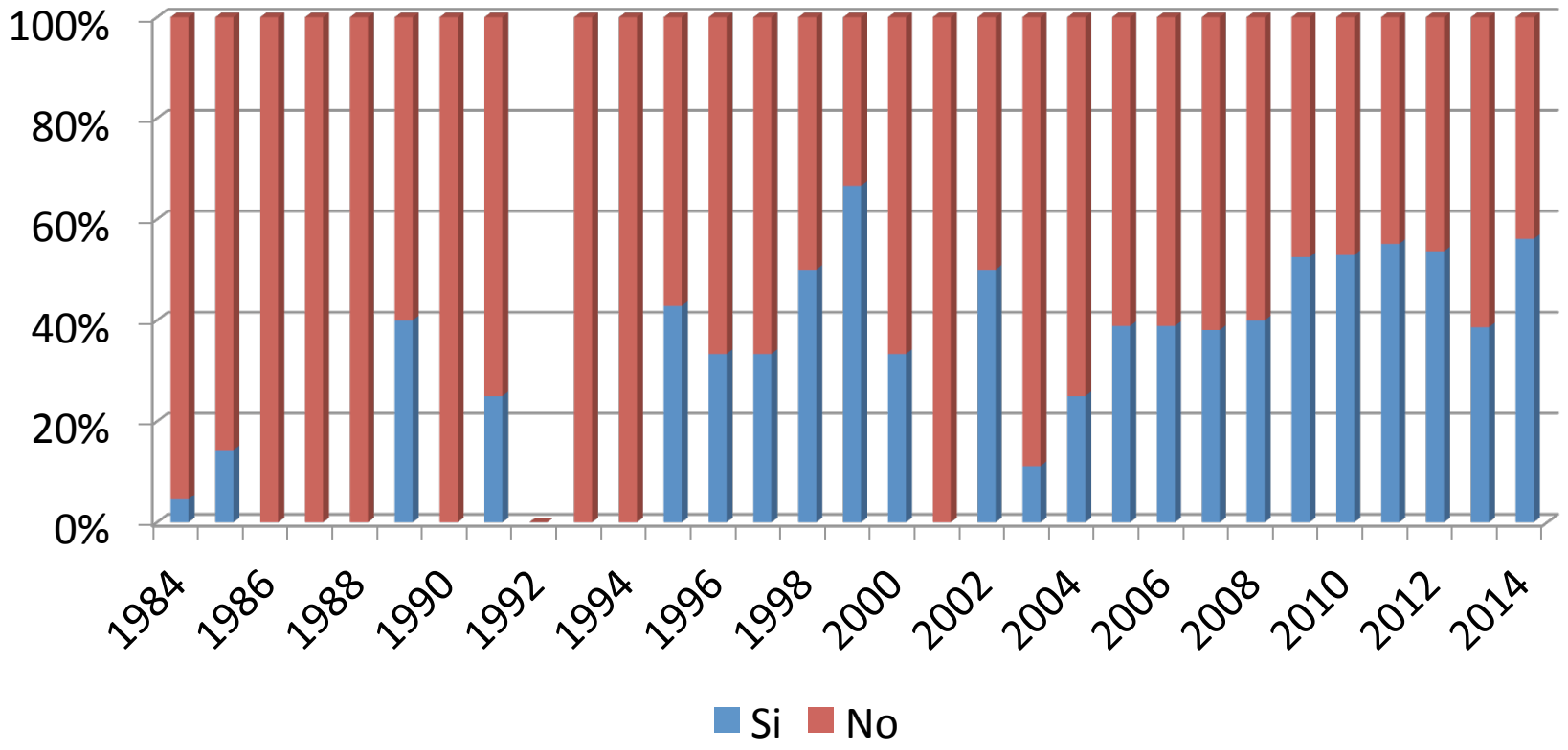
Clinical Recommendations	Financial Recommendations
Increase access to preemptive transplantation by promoting early patient education (CKD stage 3) regarding transplantation as an RRT option; promoting early referral (CKD stage 4) to a transplant center; promoting knowledge regarding LD kidney transplantation among patients with CKD and providers	Modify eligibility for Medicare ESRD to begin at late stage 4 or early stage 5 CKD (eGFR ≤15 to 20 ml/min)
Improve efficiency of evaluation at transplant centers and of communication between transplant centers and referring physicians: staffing adequate to make 6 wk from referral to listing as the standard	Improve funding for support services in CKD clinics: education regarding transplantation as modality of RRT; accelerated processing time for Medicare enrollment; social services
Increase percentage of LD transplants performed preemptively from 26 to 50%	Support Part B premium reimbursement by third parties (as with COBRA)
Create benchmarks to measure performance: preemptive referral and transplantation rates for nephrologists and dialysis providers; evaluation time and preemptive transplant rates for transplant centers	Promote measures to increase availability of kidneys for transplantation: provide adequate funding for the Organ Donation Recovery and Improvement Act; a national program to protect LD from financial disincentives and health risks associated with donor nephrectomy
	Increase resource availability for: posttransplantation care;

Abecassis et al, Clin J Am Soc Nephrol 2008

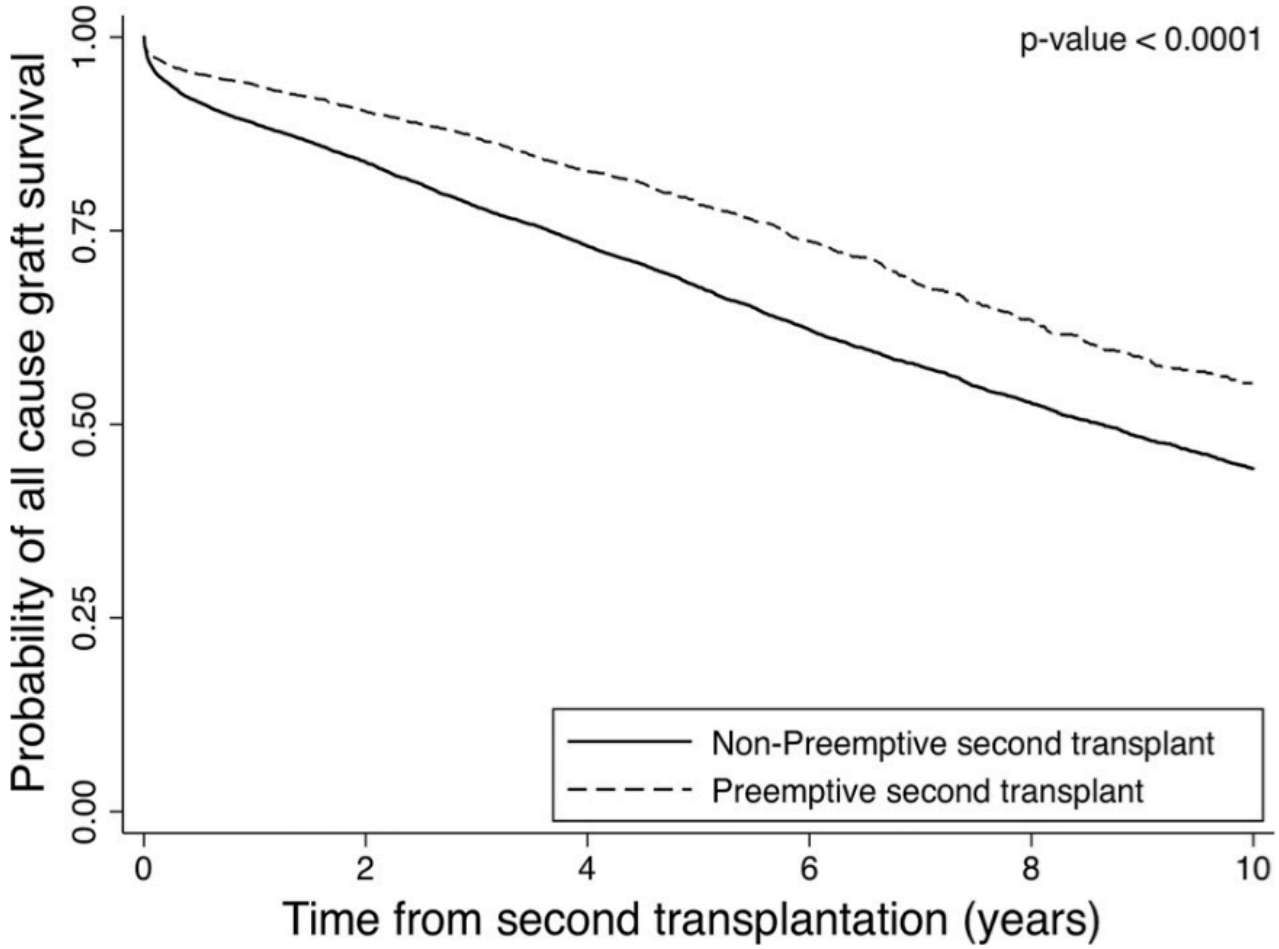
Primer trasplante renal de donante vivo anticipado (sin diálisis) 1984 - 2014



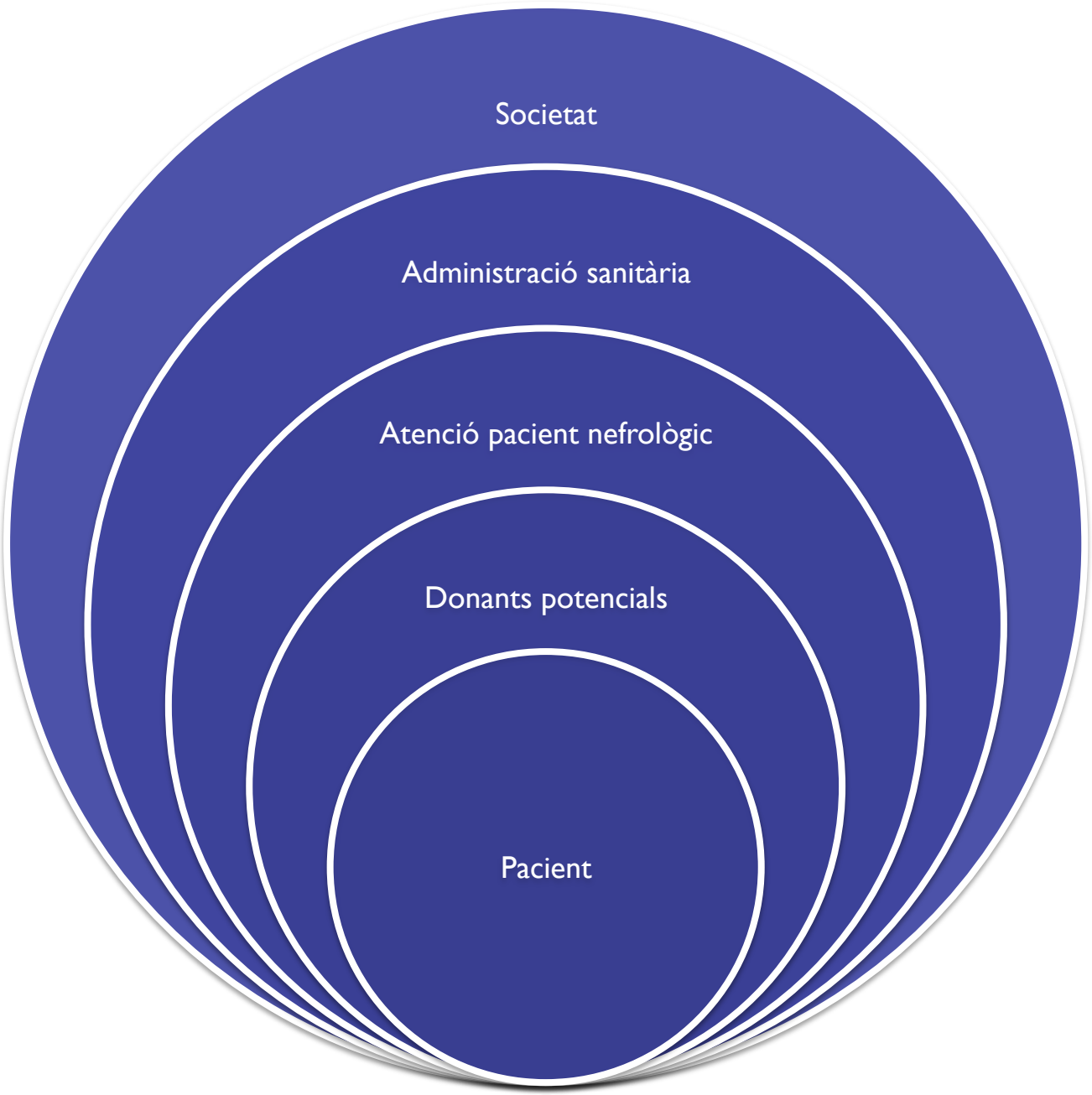
Primer trasplante renal de donante vivo anticipado (Diálisis < 3 meses) 1984 - 2014

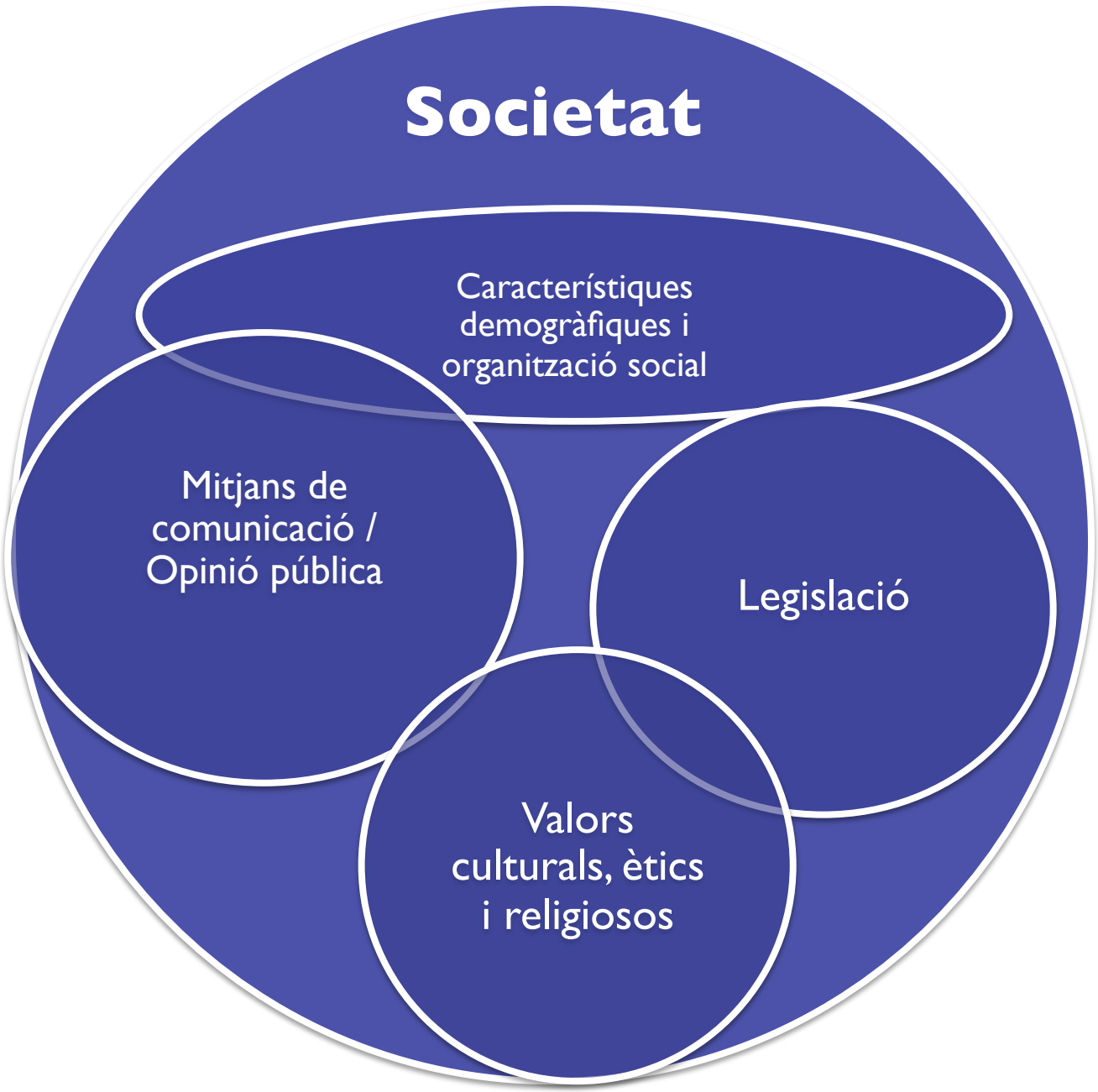


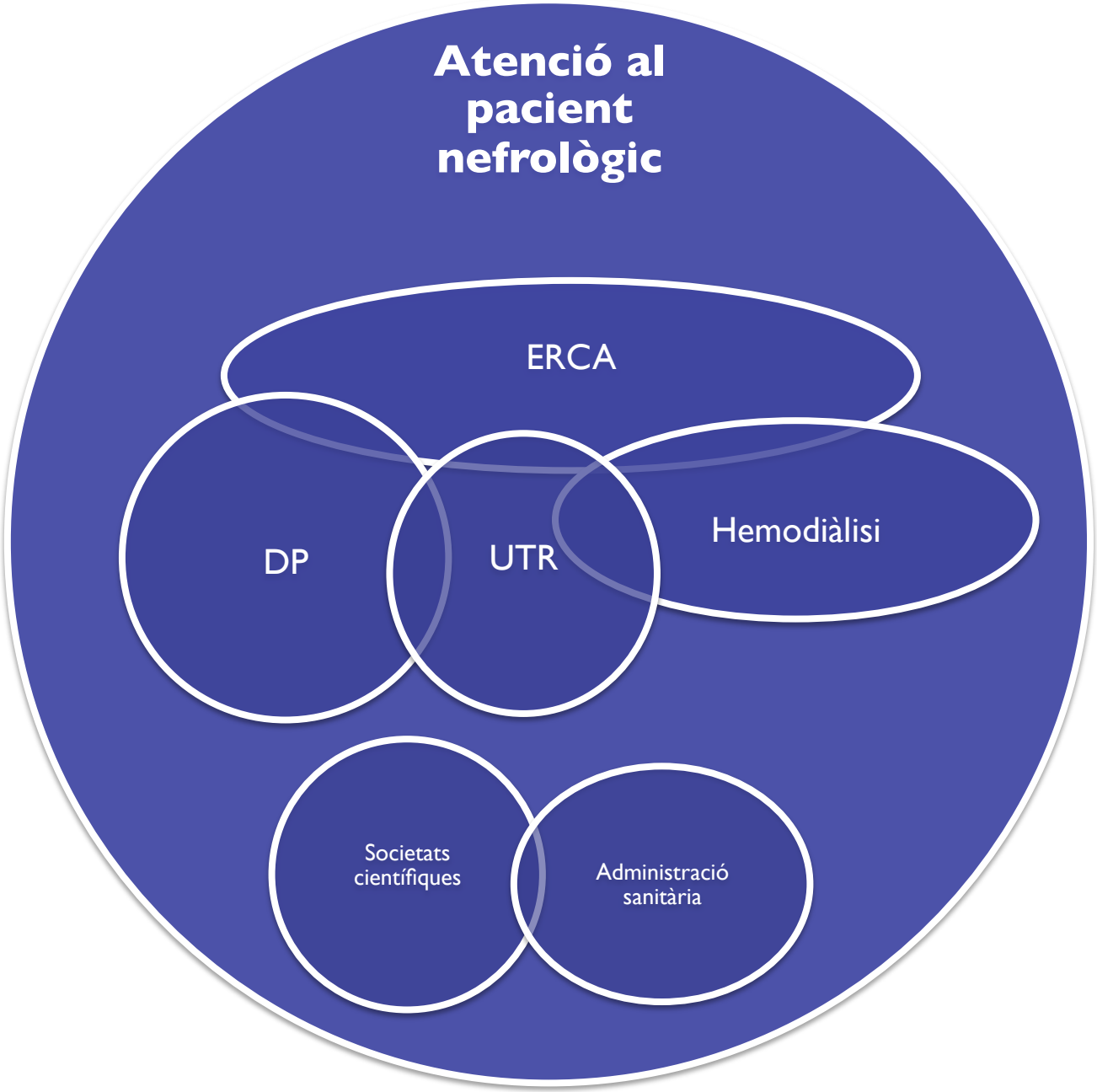
Graft survival rates in preemtive vs non-preemptive second kidney transplants



Johnston O et al, Transplantation 2013;95: 705Y710)


Societat
Administració sanitària
Atenció pacient nefrològic
Donants potencials
Pacient


Societat
Característiques demogràfiques i organització social
Mitjans de comunicació / Opinió pública
Legislació
Valors culturals, ètics i religiosos


Atenció al pacient nefrològic
ERCA
DP
UTR
Hemodiàlisi
Societats científiques
Administració sanitària

Aproximació al donant potencial

- Nefròleg de referència o ERCA
- UTR
- Iniciativa individual del donant o donants
- Iniciativa del pacient

Punts clau en l'organització del programa

- Adequada dotació i organització de la UTR
- Equip quirúrgic solvent i motivat
- Agilitat en la planificació dels estudis clínics
- Complicitat i col·laboració de tots els professionals

Recomanacions per impulsar el trasplantament anticipat (pre-diàlisi)

- Col·laboració entre ERCA i UTR
- Remetre els pacients amb un interval suficient (GFR 20 mL/min)
- No implementar accés vascular/DP fins descartar la possibilitat de trasplantament anticipat
- Potenciar el retrasplantament anticipat

Accions per fomentar la donació

- Conscienciació dels nefròlegs
- Accions informatives a pacients i familiars
  - Guies
  - Seminaris informatius
  - Inclusió del Tx de donant viu en les opcions a triar com a primera tècnica de TRS
- Promoció institucional

Conclusions

El trasplantament renal de donant viu:

- És necessari
- És cost-efectiu
- Beneficia a pacients d'un ampli rang d'edat

- Aquestes avantatges es maximitzen amb el trasplantament anticipat

Conclusions

Requisits:

- Equip motivat
- Bona organització assistencial
- Complicitat dels professionals de l'hospital
- Col·laboració dels nefròlegs de ERCA

Moltes gràcies