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Perspectives in immunosuppression management following post renal graft failure: a Portuguese national survey

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Background and Aims: The best approach to immunosuppression withdrawal post renal graft failure is controversial. Maintaining immunosuppressive therapy may preserve residual diuresis and prevent allosensitization, which is beneficial for a subsequent transplant. However, prolonged maintenance is associated with an increased risk of infection, metabolic side effects and neoplasia. No standardized protocol exists and immunosuppression is center and nephrologist dependent. Our aim was to document immunosuppression practices nationally amongst Portuguese nephrologists.

Method: A national survey of 5 short questions was conducted among residents and specialists in Nephrology in Portugal through email distribution by the Portuguese Society of Nephrology.

Results: We received a total of 90 responses, with 54.4% (n = 49) of participants working at a renal transplant unit. When faced with a patient returning to dialysis after graft loss, 66.7% (n = 60) immediately discontinue the antimitabolite, maintaining the calcineurin inhibitor and prednisolone, 33.3% (n = 30) maintain only the prednisolone and no respondent maintains mycophenolate mofetil or equivalent. Among those who maintain calcineurin inhibitors and steroids, 46.6% (n = 28) wean calcineurin inhibitor within 6 months to 1 year following graft loss, 23% (n = 14) discontinue calcineurin inhibitor within 3 to 6 months, and 30% (n = 18) discontinue calcineurin inhibitors before the first three months after graft loss. Considering steroids, 36.7% (N = 32) discontinue prednisone after one year post graft loss, and 64.3% (N = 58) of the Nephrologists maintain steroids indefinitely or until graft removal or steroid associated complications. The majority (83.3%, n = 75) agreed that the risk of the toxic rejection of the graft is the main factor deciding to maintain immunosuppression, followed by the possibility of re-transplantation (56.7%, n = 51) and the risk of infection was the major concern to withdrawal (55.6%, n = 50). All the participants considered this is an important or very important issue in kidney transplantation, that needs further investigation.

Conclusion: Immunosuppression management is one of the most challenging issues in patients with a failing or failed graft. Several working groups are being developed to discuss the best approach of the patients with a failing graft but only the British Transplantation Society have published guidelines. In this survey we can observe important disparity of different approaches, mostly physician/centre dependent. The current evidence is weak, calling the need for larger studies and a standardized protocol-based approach.