Cystic Fibrosis pulmonary disease is not a contra-indication to live-related renal transplantation

Sir,
A 26-year-old male cystic fibrosis (CF) patient (delta F508 homozygous) presented with symptoms of a pulmonary exacerbation and was treated with aminoglycosides. His CF was complicated by pancreatic insufficiency, CF-related diabetes, a previous orthotopic liver transplantation (1996) for CF related liver disease and CF bronchiectasis. On this occasion it was noted that his serum creatinine had risen from 102 to 180 mmol/l. His intravenous treatment was curtailed, but his serum creatinine continued to increase to 447 mmol/l and he presented in frank pulmonary oedema requiring emergency dialysis. His other risk factors for renal failure included CF-related diabetes and regular use of tacrolimus (2 mg once daily) prescribed for immunosuppressive therapy following his orthotopic liver transplantation. He subsequently developed chronic renal failure and was treated with regular haemodialysis. This had disastrous consequences on his general CF health and his quality of life. Over 3 months his weight diminished from 67 (dry weight) to 59 kg. His malnutrition was compounded by nausea resulting from uraemia and a fluid restriction that made dietary supplementation difficult. He required frequent treatments for pulmonary exacerbations which could only be treated with reduce dose mono-therapy such that his FEV1 measurement diminished by 11. His CF-related diabetes become very difficult to manage due to erratic eating habits and increased pulmonary exacerbations resulting in regular hypoglycaemic episodes. His HbA1C was measured at 8%. He also developed a uraemia cardiomyopathy resulting in a reduced left ventricular ejection fraction of 38%.

After a case conference with the renal physicians, CF physicians and transplant surgeons, he was listed for a live-related renal donor transplant. The transplantation was uncomplicated. The patient and graft have survived their first year and of note there have been no episodes of graft rejection since the transplant was performed. His most recent serum creatinine, taken 12 months since transplantation, is 90 mmol/l. His pulmonary function has improved from 55% predicted (1.951) to 65% predicted (2.91). He has regained the 6 kg lost during dialysis and his pulmonary exacerbation frequency has reduced from eight to two per annum. His HbA1C has also improved to 4.9% reflecting better diabetic control.

This case highlights the fact that moderate CF pulmonary disease is not a contra-indication to renal transplantation and, on the contrary, live-related renal transplantation may have widespread benefits in CF patients with dialysis dependent renal failure in terms of general well being and likely improvement in survival [1,2].

Conflict of interest statement. This article has not been previously published in whole or part or abstract form and there are no conflicts of interest.

Interaction between voriconazole and tacrolimus in a kidney-transplanted patient

Sir,
Infections are common life-threatening complications of immunosuppressive therapy [1]. Among these, yeast infections are difficult to treat not only because of the pharmacokinetic properties of the antifungal agents, which inhibit the metabolism of calcineurin inhibitors, leading to drug interactions and potential nephrotoxicity [2]. Voriconazole is a broad-spectrum antifungal that inhibits the enzymes involved in ergosterol biosynthesis, thus blocking the production of ergosterol, which is a component of the fungal cell membrane. Voriconazole is a macrolide that acts by inhibiting the synthesis of RNA, thereby blocking protein synthesis and interfering with the viability of the fungal cell [3].

A 55-year-old male kidney transplant recipient was started on voriconazole for skin infection of the lower limbs due to Pseudallescheria boydii. End-stage renal failure secondary to medullary cystic kidney disease led to a cadaver renal transplantation 4 years earlier. His medical history also included severe bilateral peripheral vascular disease, ischaemic cardiomyopathy, arterial hypertension, chronic hepatitis C, osteoporosis, and hypercholesterolaemia. His treatment included tacrolimus 4 mg/day, prednisolone 7.5 mg/day, ciprofloxacin 1000 mg/day, cefadroxil 1000 mg/day, atenolol 2.5 mg od, furosemide 60 mg/day, lisinopril 20 mg/day, aspirin 100 mg/day, omeprazole 20 mg/day, pravastatin 20 mg/day, allopurinol 100 mg/day, dipyridamole 200 mg/day and molsidomine 16 mg/day.

Treatment with itraconazole was initiated 1 month before admission, concomitantly with a 50% reduction of the tacrolimus dosage (2 mg/day). Itraconazole was replaced by voriconazole after 1 month, because no clinical improvement had occurred. Upon start of oral voriconazole (4 mg/kg bid), tacrolimus trough level, previously stable and <12 ng/ml (aimed therapeutic interval: 5-12 ng/ml), increased markedly after 7 days (20 ng/ml after 10 days and 25 ng/ml after 17 days).


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