The kidney transplant process is composed of multiple phases, each of which is part of a synergetic program of care focused on a single, overall goal: the delivery of exceptional outcomes to patients, their families, and referring physicians.
Kidney Transplant Program Interim Surgical Director Justin Parekh, M.D., adds that the enhancements to the donor aspects of the program help put patients at ease. “We’re ensuring that donors get the best possible care so their recipients can rest assured their loved one is not taking on any undue risk on their behalf.”

First-in-Texas fellowship
An additional development in the Kidney Transplant Program in 2017 was the opening of a transplant nephrology fellowship at UT Southwestern – the first in Texas. The one-year training program allows fellows to gain experience in the evaluation and management of living kidney donors and kidney transplant recipients and their potential complications. Training in transplant immunology, transplant pathology, renal imaging, biopsy, and infectious diseases is also emphasized, as well as understanding the principles of candidate selection for renal transplantation, including multi-organ transplants.

Combined organ transplants – liver/kidney, heart/kidney, lung/kidney – remain a strength of the Kidney Transplant Program, with three lung/kidney transplants performed within the past year alone, along with five liver/kidney.

Being part of an academic medical center and a robust solid-organ transplant program contributes to the kidney program’s ability to handle complicated allocation of multi-organ transplants, Dr. Tanriover notes.

“If patients have kidney failure, we assess them and decide if they need a combined transplant or not,” he says. “If so, our synergistic approach enables us to expertly handle multi-organ procedures from start to finish.”

Dr. Parekh echoes that thought. “Being part of an academic medical center and a collaborative transplant effort is perhaps the greatest strength of our program,” he says. “This obviously includes combined organ transplants but also extends to patients with complex problems in other areas – neurologic, cardiac, immunologic, and endocrine, for example. We can help those patients.”

Difference makers
Aside from expertise, the Kidney Transplant Program offers something else not seen at every transplant center: personalized service.

“In some transplant centers, patients are seeing a different provider each time they come to the clinic. That’s not the case at UT Southwestern,” Dr. Tanriover says. “Here, patients are assigned to one physician and they are followed by the same people throughout their surgery and care. That makes a real difference.”

Personalized care extends to referring physicians as well. Dr. Tanriover adds. “It’s very easy for referring physicians to contact us. They have our numbers. Communication and knowing the details of a referred patient’s care are important to us.”

CASE STUDY
A 45-year-old man presented with polycystic kidney disease (PKD) complicated by pain, hematuria, and early satiety.

Originally diagnosed at age 30, the patient spent the next 15 years suffering progressive renal failure along with increasing abdominal pain and fatigue. His disease progressed to the point where his kidneys occupied most of his abdomen, taking up so much space he could barely eat.

With kidney failure on the horizon, the patient was able to leverage the strengths of UT Southwestern’s PKD clinic – which guided the management of his symptoms and chronic kidney disease and provided genetic counseling to help him and his family – and then utilize the clinic’s close relationship to the UTSW Kidney Transplant Program.

Through multidisciplinary care and the generosity of his half-brother, UTSW was able to arrange for a living donor transplant. Careful testing proved the brother was an appropriate donor with no risk for PKD. The surgical team also consulted with the patient and his nephrologists and developed a plan that would address his renal failure and the terrible discomfort caused by his massive kidneys. In a single operation, the patient had successful living donor transplant and removal of his diseased kidneys. The patient left the hospital four days after surgery and has returned to an active lifestyle – working and running marathons.

PKD is the result of a genetic mutation that can affect multiple family members. Early detection and management are critical. A true multidisciplinary approach can help patients by offering both medical management of the disease and surgical options that range from cyst removal to nephrectomy to transplantation. UTSW is leading the way in treatment of this disease, developing therapies to thwart the progression of PKD, thereby preventing renal failure and the need for surgical intervention.
The practice of using combination induction and maintenance immunosuppressive agents to optimize post-transplant outcomes has become increasingly widespread.

IL-2 receptor antagonist (IL2-RA) is recommended as a first-line agent for induction therapy in renal transplantation. However, this remains controversial in deceased donor renal transplantation (DDRT) maintained on tacrolimus (TAC)/mycophenolic acid (MPA) with or without steroids.

We studied the 74,627 patients on the United Network for Organ Sharing Registry who received DDRT from 2000 to 2012 and who were maintained on TAC/MPA at hospital discharge to compare outcomes of IL2-RA and other induction agents. We initially divided the cohort into two groups on the basis of steroid use at the time of discharge: steroid (59,010) versus no steroid (15,617).

Each group was stratified into induction categories: IL2-RA, rabbit antithymocyte globulin (r-ATG), alemtuzumab, and no-induction. The main outcomes were incidence of acute rejection within the first year and overall graft failure post-transplantation.

Acute rejection within the first year and overall graft failure within five years of transplantation were more common in the no-induction category in the steroid group, and in the IL2-RA category in the no steroid group. Compared with IL2-RA, outcomes in the steroid group were similar among induction categories, except that acute rejection was significantly lower with r-ATG. In the no steroid group, compared with IL2-RA, odds of acute rejection with r-ATG and alemtuzumab were lower, and r-ATG was associated with better graft survival.

In DDRT, compared with IL2-RA induction, no induction was associated with similar outcomes when TAC/MPA/steroids were used. r-ATG seems to offer better graft survival over IL2-RA in steroid avoidance protocols.

“I decided to become a living donor in honor of my father, who I lost in 2013 to kidney failure. I called UT Southwestern and told them ‘I want to donate a kidney; you tell me who to give it to.’”

— Susana Margraf
Kidney Transplant Donor

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To refer a patient to UT Southwestern for transplant, call 877-391-1528 (Heart, Lung) or 877-392-1528 (Kidney, Liver).
Answered 24/7 by a registered nurse.

Solid Organ Transplant Program
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utswmed.org/transplant