RENAL TRANSPLANT - AN EARLY EXPERIENCE

Dear Sir,

Malik et al in their article 'Renal Transplant : An Early Experience (MJAFI 1994; 50 : 197-201.) have raised some very pertinent questions on whom to accept as a kidney donor, the duration of haemodialysis in HBsAg positive patients with end-stage renal disease and the offering of second renal transplant to cases of chronic rejection.

To maintain the altruistic nature of organ donation and to prevent trafficking in human organs under the guise of emotionally related or philanthropic donors the Government of India has enacted 'The Transplantation of Human Organs Bill', applicable to the states of Goa, Himachal Pradesh and Maharashtra and in the Union territories. The bill states that 'no human organ removed from the body of a donor before his death shall be transplanted into a recipient unless the donor is a near relative of the recipient'. Near relative means spouse, son, daughter, father, mother, brother or sister. Other live donors can only be considered with prior sanction from an 'Authorisation Committee' to be constituted by the Central Government. The details of this committee are yet to be spelt out. What is more important is that the Bill has recognized the concept of and provided legal safeguards for diagnosing 'Brain death' and carrying out cadaveric organ transplantation [1]. With the increasing shortage of human organs being experienced every year, it is now time for us in the Armed Forces to formulate within the framework of the Bill our own cadaveric organ donation programme.

The second question the authors have raised is on HBsAg positivity vis a vis long term haemodialysis. In asymptomatic HBsAg carrier state 15% - 20% patients have been reported to become negative on long term maintenance haemodialysis [2]. After renal transplant in these patients, many workers have noticed increased morbidity and mortality from chronic active hepatitis and hepatic failure while others have demonstrated similar patient and graft survival in HBsAg positive and negative patients [3]. However definite contraindications to renal transplant in this group of patients are active hepatitis B infection and progressive liver disease [4]. Liver biopsy is useful in excluding patients with pathological changes suggestive of chronic active hepatitis, but when biopsy is not feasible other serological markers

including HBeAg are useful in selecting asymptomatic HBsAg positive patients for renal transplant [5].

In our centre at Army Hospital Delhi Cantt, we have been accepting HBsAg positive patients with end-stage renal disease for renal transplantation. Of the four patients transplanted, one has died of acute liver cell failure while the other three are doing well.

The authors have expressed doubts on offering a retransplant to patients who have rejected the first kidney graft. Second and subsequent renal allografts do pose peculiar problems, particularly due to the risk of sensitization occurring from the first graft in addition to other sources such as blood transfusions and pregnancy. However with a little more attention to immunological matching many workers have shown a second living allograft to do as well as the first [6] and 1-year survival of cadaveric regrafts to be just around 10% less than the first cadaveric graft [7]. Therefore, where indicated, a retransplant should be considered as a viable option in management of chronic rejection.

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