Renal transplant at KNH-A two years experience: lessons learnt

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Boston 1950’s
Risk Factors in CKD

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P

BP
Glycaemia
Dyslipidemia
Weight
Smoking
INFECTIONS: HCV, HIV, Malaria, schisto
Expensive

RRT

- 1990: 426,000
- 2000: 1,065,000
- 2010: 2,095,000
The dangers of rationing dialysis treatment: The dilemma facing a developing country

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The challenge

• Awareness
• Resources

• **Tourism/commercialization**
A Partnership between Novartis & Kenyatta National Hospital
Novartis & Kenyatta National Hospital partner to revamp the kidney transplant program

“Novartis and Kenyatta national Hospital unite forces to make KNH a centre of excellence and indeed a preferred centre of renal transplantation in Africa”

- To develop KNH capacity to perform Renal transplants
- To develop KNH as a centre of excellence
- Anchor Kenya as a preferred choice for transplant surgery in the region
- To encourage patients to seek local surgery.
Interlife year 2
2011 to achieve excellence level in KNH

Interlife will offer an affordable solution to improve quality of life of patients that suffer from Kidney failure

1. Capacity Building
2. Improve patients outcome
3. Affordability and access
4. Increase program awareness
Restarting a living donor kidney transplant program in Kenya: 23 transplants performed in less than one year.

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Excellent renal function evolution

Acute rejection was suspected and treated in 4 patients (17.4%)
Excellent results in first year

**Patient and Graft Survival**

- % survival
- Post-transplant months
- n=23
- 95.3%

**Serum Creatinine**

- sCR (μmol/L)
- Time post-transplantation:
  - 7d
  - 1m
  - 3m
  - 6m
  - 12m
In two years of interlife..

- **60 Transplants**

- **14 Doctors & nurses from KNH trained in Spain**

**Collaboration**
- Spanish Society of Transplantation
- Hospital Valdecilla
- Hospital Clinic Barcelona

- **Improved Quality of life**
Most prevalent cause of renal failure was CGN/HTN.
Age Distribution
Source of donors

- Siblings
- Mother
- Father
- Spouse
- Daughter
- Son
- Others
- Missing
Discarding pairs

- Medical: 17, 65%
- Surgical: 7, 27%
- Donor withdrawal: 2, 8%

Pie chart:
- Medical: 17, 65%
- Surgical: 7, 27%
- Donor withdrawal: 2, 8%
Medical reasons for discarding pairs

- CKBMD
- TB
- Proteinuria
- IGT
- Obesity
- GFR
- Alcoholism
- TXM
Peri-operative complications

- fluid overload
- ACS
- haematoma
- lymphocele
- urinary leak
- wound dehiscence
- hernia
- blood TX
- graft thrombosis
- urinoma
Challenges

- Capacity building.
- Waiting list management
- Improving efficiency in donor and recipient work up.
- Control CO and tissue typing investigations.
- Data processing and reporting-computer and software.
- Improving surgical techniques.
- Empowering referring nephrologists/protocol on donor assessment.
- Improving access to immunosuppression
Data management
computerization of the renal unit, a bridge to the future

- 5 computers connected
- Data management database
- First move towards the future
High risk recipients
SIMPLE LYMPHOCELE
2. CAP. 252  HUMAN TISSUE   (REV.1967)

CHAPTER 252

[HUMAN TISSUE ACT]

COMMENCEMENT : 1ST JANUARY 1967.
Sustaining a transplant program: what you need

• Resources
• A sound financial plan
• An exit plan with a self sustaining arrangement
• collaboration
• Team management
• Good will
• Adherence to set ethics
• Good diagnostics
Arc de tromphee
Thank you