103-F083 to Q&A Group
At what stage of CKD progression do you consider an appropriate time for referral?

Answer:
Usually CKD Stage 4 or 5 is the appropriate time for referral. Ideally, it is best to receive a transplant before any form of dialysis. However, due to the shortage of organs, this is not possible in most cases.

311-F082 to Q&A Group
Is there a waiting period for prostate cancer?

Answer:
Yes, there is a waiting period for prostate cancer. It depends upon the stage of the cancer. If in situ, the likely waiting is for 2-3 yrs. The American Society for Transplantation has specific guidelines regarding the type and extent of the cancer and the waiting period required.

Waiting times for other cancers from the American Society for Transplantation:
- Breast cancer >5 years
- Colorectal Cancer >5 years (>2 years for Dukes Stage A or B1)
- Melanoma >5 years (>2 years in situ)
- Uterine Cervical Cancer >2 years (>5 years for more advanced cervical cancer)
- Bladder Cancer >2 years. No waiting for insitu bladder cancer and all non invasive papillary tumors of the bladder
- Kaposi sarcoma >2 years
- Leukemia >2 years
- Lung cancer >2 years
- Lymphoma >2 years (possible >5 years)
- Testicular cancer >2 years
- Thyroid cancer >2 years
- Skin cancer (nonmelanoma) 0-2 (no wait for basal cell carcinoma)

313-F082 to Q&A Group
Shouldn’t this number of yrs be transplant program specific?

Answer:
No, it is based on guidelines by the American Society for Transplantation. These are objective, evidence-based guidelines.

266-FO81 to Q&A Group
What is the waiting time for prostate ca?
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313-F082 to Q&A Group
The polling question was actually renal cell and different transplant centers have different wait times

120-F081 to Q&A Group
When a patient requires testing for pre transplant workup who is responsible to be billed for those tests, and if the patient has to travel to a transplant center but chooses to have the tests done near home, how is the billing for those tests handled?

Answer:
The Kidney Acquisition Cost Center (KACC), which is money allocated by Medicare is billed for the pre transplant work-up. Each center has KACC funds which are allocated for the pre transplant work up. When testing is done close to the patient’s home, this is a bit trickier. Billing for pts without Medicare will be submitted to their primary insurance.

If the patient has testing done closer to home, our center sends a letter to the doctor that instructs the testing facility to bill our center.

266-FO81 to Q&A Group
How long do they need to be on immunosuppressive therapy after failed transplant?

Answer:
Immunosuppressive therapy should be weaned very slowly to prevent acute rejection, especially steroids. Our center waits until dialysis has been started prior to weaning immunosuppression. We generally taper the steroids last. If the patient has been taking steroids long term, the patient should be monitored for signs of adrenal insufficiency, such as hypotension. Every center tapers immunosuppression a bit differently.

120-F081 and Q&A Group
Oxalosis is deposition of oxalate in the kidney leading to loss of renal function. It is a metabolic disorder. We have had 2 children with oxalosis. They take medication to prevent recurrence of the oxalosis in the transplanted kidney.

326-F082 to Q&A Group
Post transplant patients that present with both types of rejection early after transplant-how many can expect to gain function from the graft?

Answer:
This would vary according to the severity of the rejection and the ability to regain initial function after the rejection. Good control of blood pressure and blood glucose, if diabetic, may prolong the longevity of the graft. The way to get more function with a graft is to treat acute rejection with additional immunosuppressives, minimize exposure American Nephrology Nurses’ Association (ANNA)
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to calcineurin inhibitors and to control blood pressure and blood sugar and minimize exposure to toxic antibiotics, medications and dye studies.

324-F082 to Q&A Group
What is the oldest acceptable age of the donor?

**Answer:**
For live donors, some centers have chronological age limits. Our center usually defers donors age 60 and over. However, in an older recipient, sometimes an older donor with good kidney function is appropriate. The oldest acceptable age of the donor is more based on physiological age vs. chronological. However, if the donor is extremely healthy with an older recipient, we will accept over age 60. We have a living donor transplant scheduled next month between a donor who is 66 years old and her recipient husband who is 72 years old.

In the case of the older deceased donor, the surgeon often does a wedge biopsy to determine if the donor has adequate nephron mass to support the recipient.

307-F081 to Q&A Group
Should pts have a parathyroidectomy prior to transplant? Why or why not?
It is not routine for pts to require parathyroidectomy prior to transplant. This is dependent on the PTH levels and their response to appropriate medical interventions done first.

258-F081 to Q&A Group
What range do the surgeons want the BP to be post op? Please address both for patients requiring dialysis and those who don’t.

**Answer:**
Initially post transplant, surgeons wish to avoid any semblance of hypotension. Hypotension can cause clotting in the renal vein and the transplant would die of anoxia. Therefore, if the BP runs 150/90 initially, our center may not treat this. We begin to get concerned with BPs of 160-170/100. This is the same for patients on dialysis. Avoid aggressive fluid removal to avoid hypotension.

324-F081 to Q&A Group
In a pregnant person that has had a pregnancy with elevated PRAs post delivery...what is the wait time and are they at risk for longer waits. Anyone with an elevated PRA, whether because of pregnancy, blood transfusions, or other reasons, will typically wait longer and be more difficult to find a match for than someone who has a low PRA. There is no way to determine what the exact wait time will be.

307-F081 to Q&A Group
American Nephrology Nurses’ Association (ANNA)
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Should Sensipar be stopped prior to transplant? Why or why not?

**Answer:**
We do not stop Sensipar prior to the transplant at our center.

**Celess Tyrell to All**
To all those asking questions via this chat box, remember you are welcome to ask over the phone! If a question is not answered tonight, and you asked via this chat, we will do our best to get you the answer post conference.

**331-F084 to Q&A Group**
When you stated that to be on the list if you had Hepatitis C, the Hepatic C had to have been treated. What happens if they were a non-responder to the treatment regime? They are considered a non-responder and may potentially receive a kidney from a Hepatitis C positive donor.

**324-F082 to Q&A Group**
There are concerns regarding multiparas in regards to blood donations—many centers defer them. Are there considerations currently with this population donating organs?

**Answer:**
No, I am not aware of any special considerations for organ donors who are multiparas.

**266-FO81 to Q&A Group**
Can you explain the protocol for antibody depletion in a failed transplant and severe rejection patient?

**Answer:**
Immune globulin (IVIg), which is high titered antibody therapy, is used to decrease innate antibody production. The theory behind this is that the body senses that there are high numbers of circulating antibodies after the administration of IVIg and stops making them. Some programs also perform plasmapheresis and give the monoclonal antibody Rituximab®.

**319-F082 to Q&A Group**
What about the use of Apheresis in rejection?
Apheresis may be used when focal segmental glomerulosclerosis (FSGS) is recurring in the graft and also may be used for antibody mediated rejection. Unfortunately, in many instances, it only improves graft function for a short time. Apheresis is extremely immunosuppressive and the patient should be on prophylaxis against opportunistic infections.
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338-F081 to Q&A Group
What is the current cost (annually) for immunosuppressant drugs?

Answer:
At our center, all patients are discharged with preventative treatment against the CMV virus. The cost of the antiviral drug, Valcyte®, is about $1000/month. Acyclovir may be given instead if the patient and graft are negative for the CMV virus, and is quite inexpensive. We give the prophylaxis for 3 months. The cost of the immunosuppressives the first few months, when dosages are higher, is about $2000/month at our center, not including the antiviral therapy. That is why it is vital to ensure that patients have adequate insurance coverage prior to transplantation to pay for the medication.

There is not much that can be done to treat chronic rejection—perhaps switch around immunosuppression and some programs may use plasmapheresis and IV Immune Globulin.

A post biopsy bleed would require an abdominal ct scan to ascertain the extent of the bleed. The patient would likely be given FFP and blood if the hct has decreased.

Our center stops the Sensipar initially after transplant, but we may add it on later if the PTH is high.

The sera of the person who has been pregnant is screened monthly for antibodies and would be monitored for a declining PRA.

A patient can go back to PD after transplant if the transplant does not function initially. Usually lower volumes are used initially. However, this may be center specific and dependent on how the surgery was done. Some centers may have the pt receive hemodialysis temporarily.
Getting Patients Charged Up and Tuned Up for Transplant  
Q&A Chat Session

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Gail Dewald to Q&A Group  
I know of patients that are on more than one list waiting for a deceased donor. Is being on multi-listed provide the patient a better chance of a kidney sooner?

Answer:  
Yes, this is particularly advantageous to people with a more rare blood type, such as blood group B. However, it is controversial as individuals often have to repeat testing to be on more than one list, which costs the Medicare or private insurance system more money. Also, sensitized patients may be transplanted a bit sooner if multiply listed.

Peggy Gerlach to Q&A Group  
If someone has Leiden Factor 5 with history or DVTs and PEs automatically excluded from KTP?

Answer:  
If the patient is on anticoagulation, it is preferential to have a live donor transplant so the anticoagulation can be stopped in anticipation of the transplant. The risk of bleeding is higher in a deceased donor transplant when the patient is on coumadin. When patients are called in for deceased donor transplants and are on coumadin, the elevated INR needs to be decreased with plasma infusions and the administration of vitamin K. Some centers prefer not to do deceased donor transplants on people on coumadin or plavix due to the increased risk of bleeding.

Jean Colaneri to All  
In EBG negative patients who are at higher risk for PTLD due to primary EBV infections, is there any prophylaxis for EBV that can be given to the patient?

Jean Colaneri to All  
Our center keeps all EBV negative recipients on acyclovir indefinitely to prevent an EBV infection which may result in post transplant lymphoproliferative disease (PTLD).

Patricia Weiskittel to All  
Even with EBV positive patients propylaxis with acyclovir or valacyclovir is utilized for at least the first 90 days post transplant and with any rejection therapy.

503-F084 to Q&A Group  
How long is the heparin should be reduced post transplant
Getting Patients Charged Up and Tuned Up for Transplant
Q&A Chat Session

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Answer:
I would consult with the nephrologist regarding this. However, since it is possible to dialyze heparin free, using frequent saline rinses of the dialyzer, I would recommend going totally heparin free post transplant. In addition, at our center, we monitor the PT/PTT for several days post-transplant to assess for any undetected coagulopathy.

Jean Colaneri to All
How long does your transplant center recommend post transplant recipients wait until taking the flu vaccine or pneumovax?

Answer:
Our center recommends waiting about a year due to the lack of antibody response. The vaccines will not necessarily harm transplant recipients, there is just a lack of efficacy. We use thymoglobulin induction for most patients and this prevents the formation of antibodies for several months after it is given.

Marycela Tamez to Q&A Group
What about blood transfusion without a bleed for a hgb 9.0

Answer:
The need for blood transfusions depends on the clinical status of the patient. It depends on their coronary risk and other factors. We would be more likely to transfuse if the anemia could increase the risk of an MI or if the patient is hypotensive, short of breath, or dizzy. We generally don’t transfuse until the hgb is around 25-26 or so.

Marycela Tamez to Q&A Group
I heard that they build antigens antibodies which make them harder to match for transplant?

Answer:
When the patient is highly sensitized, meaning they have many antibodies, it becomes much harder to find an acceptable kidney for them. Sensitized means that the panel of reactive antibodies (PRA) is high. We have some patients on our list who are 100% sensitized or 100% PRA.

The sensitized patient waits many years on the UNOS list. Some centers use immune globulin, plasmapheresis or Rituximab® to decrease antibody titers.

503-F084 to Q&A Group
Wouldn’t someone over age 65 still have Medicare coverage for tx meds?

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**Answer:**
Individuals over age 65 qualify for Medicare based on their age and this coverage continues and is not lost after 3 years.

**503-F084 to Q&A Group**
Can you speak to BK nephropathy?

**Answer:**
BK nephropathy is caused by the Polyoma (also called the BK or JC) virus, which is opportunistic. Polyoma is a normal viral inhabitant of the urinary tract. It is an opportunistic infection in the face of immunosuppression given to transplant recipients. It can cause nephropathy if it is not detected in the early stages.

Our center screens the blood of transplant recipients for the Polyoma PCR titer each month. When the viral titer rises, we decrease the dose of CellCept that the patient is taking. This allows the immune system to rid the body of the virus and then CellCept can be resumed at a later date. We follow serial titer levels monthly and monitor for a decrease.

This protocol prevents the BK virus from harming the kidney. It seems to work very well.