

Setting up of Renal Transplant Program in Private Setup: Our Experience

Wesh Ansari ^{a*}, Birendra Prasad Yadav ^a
and Kaish Warish Ansari ^a

^a Nepal Medicit Hospital, Baisepati Lalitpur, Nepal.

Authors' contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

Article Information

Open Peer Review History:

This journal follows the Advanced Open Peer Review policy. Identity of the Reviewers, Editor(s) and additional Reviewers, peer review comments, different versions of the manuscript, comments of the editors, etc are available here: <https://www.sdiarticle5.com/review-history/93017>

Original Research Article

Received: 25/08/2022

Accepted: 27/10/2022

Published: 03/11/2022

ABSTRACT

Renal diseases especially CKD (chronic kidney diseases) & ESRD (End stage renal diseases) incidence & prevalence is increasing day to day in developing as well as developed countries of world. Many modalities of treatment have been developed all over the world in the management of CKD. Developed countries have modern medical facilities especially renal replacement therapy like HD, CAPD & renal transplantation which benefits ESRD patients a lot. However in developing countries & poor countries patients have to struggle a lot to get such facilities and ultimately suffer with complications related to uremia. Renal transplantation brings significant improvement in quality of life [1]. Unfortunately renal transplantation has not flourished in many countries, especially in developing countries. Very low percentage of ESRD patients gets transplanted. There may be so many factors affecting renal transplantation [2-4]. This article focuses on setting up KT programme at Sumeru kidney hospital. The aim of this study is to highlight all the challenges faced to set up renal transplant programme. Total of 8 kidney transplants were done at this center within 6 months of time frame. Renal graft as well as patient survival was 100%. The complications recorded included fungal infection 1 out of 5, surgical re-exploration and acute rejection episodes remain nil. We can conclude that renal transplantation can lead to improved survival. But due to lack of awareness, donor accessibility, affordability, poor financial as well as legislative support,

*Corresponding author: Email: wesh786@gmail.com;

immunosuppression availability, government help in funding renal transplantation is unable to flourish to its full extent in private settings. Formulation of proper government legislation with proper funding at private setting will help to improve transplant utilization and better outcome.

Keywords: Renal failure; renal transplant; kidney transplant; ESRD.

1. INTRODUCTION

Kidney transplantation is one of the best treatment options for patients with ESRD. It brings patients renal function homeostasis to normal level & hence enhances quality of life. It is the most cost effective therapy. Especially in case rural area of Nepal, where maintenance dialysis is beyond the reach of most of the population. Nepal is multiethnic country with an estimated population of 29.14million (2020). Nepal is located in Asia, with surface area being 147 181 sq2 km. It has literacy of 64.7% and life expectancy of 67.7 years [5]. The per capita income (gross) isUS\$775.5.Governemnet of Nepal provides PHC (Primary health care) facilities at free of the cost to its all provincial, municipality, village health posts. However secondary & tertiary health centers provides services with minimal cost. Total expenditure on health per capita in 2019 was US\$53, is equal to 4.45% of GDP [6]. Nepal is a developing country. There is significant number of communicable as well as non-communicable diseases that badly affects its economy. Renal diseases like AKI, CKD is increasing day by day. There are so many factors contributing it as, Hypertension, DM (Diabetic nephropathy), chronic glomerulonephritis, Poor dietary habit, genetic diseases of kidney etc. It is estimated that about 10% of population is suffering from CKD annually, out of which 3 lakh develops into ESRD and need renal replacement therapy.

Ironically, hemodialysis is only available at tertiary centers of Nepal. Studies shows that around 4500 patients gets HD annually. And around 3 thousands patients get on adding per year [6–8]. The diagnosis of CKD is made by recurrent urinary proteinuria, decrease in GFR and radiological ecogenic poor CMD kidney. There is exponential increase in number of patients with CKD (Fig. 1).The ratio of young age between 20-50 years patients with CKD is increasing in higher rate than other age group [9-13]. This might be due to infection related chronic glomerulonephritis & hypertension induced renal damage in young age group. In one hand there is increasing rate in CKD patients and in other hand there is limited availability of resources in management of it has lead into health crisis especially regarding renal replacement therapy in our setting.

ESRD mortality is a very high about 50% ESRD. Hemodialysis remains the most prescribed modality of treatment of ESRD in our setting, reason being easily available, affordable and temporary measure of treatment. Around 70% of patients preferred HD, 5% Peritoneal dialysis, <1% were positive for renal transplantation surgery, others refused renal replacement therapy in our setting. Out of 70% those who selected HD were unable to maintain HD more than 12 weeks because of lack of availability of HD centre in rural areas of Nepal.

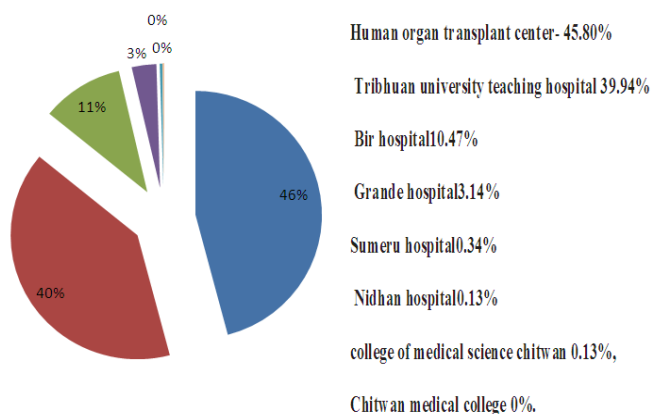


Fig. 1. Percentage of End-stage renal disease (ESRD) patients (NEPAL)

Only less than 0.5% selected Continuous ambulatory peritoneal dialysis. Kidney transplantation (KT) was started in TUTH, Nepal since 2008, after then total 7 centers started KT. In total, 8 recognized centers for KT, 3 are government hospitals, 5 are private hospitals. In last 11 years total 1436 KT has been done successfully. Out of total KT, less than 5% were done in private settings. Kidney transplantation is considered as gold standard modality of renal replacement therapy for ESRD patients. The reason for its superiority is because of its cost effectiveness, improving quality of life and increase in duration of life after KT.

KT is recognized as one of the best modality of treatment for ESRD patients. As renal transplantation warrants normal quality of life and cost effective it dominates all other forms of renal replacement therapies. Moreover, it reduces total hospital visit & stay [1–4,13]. However renal transplantation has its own limitation, like high financial cost, increase in number of patient but shortage for donor, immunosuppression availability, organ trafficking. This article is aimed in reviewing the setting up for transplant program in private set up of Nepal, with the objective of highlighting the outcome and challenges. So that ethically & culturally acceptable solution can be identified and shorted out without compromising the standard.

2. METHODS

Retrospective analysis for the eight renal transplant cases was done. All the cases were operated from the 8th July 2019–Jan 2020 in Sumeru hospital Dhapakhel, which is dedicated hospital for treatment for kidney diseases. Donor selection were to those who were compatible blood group with recipient. Through history & examination was made, cardiovascular, gynecological, ENT, dental & psychiatric fitness were taken. For all the female patients, pap smear & mammography was done. PSA was done in male aged greater than 50 years old. To assess cardiovascular status of patients coronary angiography was performed in all the recipients aged greater than 50 years & DM. To assess donor renal status, 24 hour urine protein, DTPA renal scintigraphy was done. Diabetics with creatinine level >1.5 mg/dl & 24hr urinary protein >500 mg were excluded as donor. CT angiography was done to assess the renal anatomy of donor for donor nephrectomy. Serology for hepatitis B, C, HIV, CMV (IgG, IgM), EBV was done in all the cases. Tuberculosis

screening was done by chest x-ray & AFB staining. Immunological work up includes; HLA (Human leukocyte antigen), PRA (panel reactive antigen), DSA (Donor specific Antibodies), CDC (Complement dependent cytotoxicity). Open donor nephrectomy was done in all the cases. Renal vessels were anastomosed in end to side manner. And uretero-neocystostomy was carried out over 6fr COOK DJ stent in modified Liche-Gregoir technique. On average donor was discharged on 5th day and recipient on 8th days after surgery. DJ stent was removed after 2 wks. Recipients were administered with inj. Methylprednisolone 500 mg on the day of surgery. In all recipients, Inj. ATG at dose of 1.5 mg/kg of body wt with three doses given on the 0, 1 and 2nd post operative day was preferred. Apart from that, Tab. Tacrolimus (TAC, 0.1 mg/kg in BID dose) were initiated. Tab Mycophenolate Mofetil Sodium (500mg BD) and Methylprednisolone (20mg OD) was added in immunosuppressive regime. The dose of Tacrolimus was adjusted as per TAC level. For first 2 weeks, 8–10 ng/mL; 2–6 weeks 6–8 ng/mL; 6–24 weeks, 5–7 ng/mL; beyond six months and 3–5 ng/mL. To prevent from oral thrush all recipient received co-trimazole mouth drops, similarly oral valgancyclovir for three was given to prevent from cytomegalovirus infection and oral Trimethoprim-sulfamethoxazole (80 mg–400 mg) was given for three months as prophylaxis of Pneumocystis pneumonia infection. Both donor and recipient were closely followed throughout patient department. Patients were monitored through renal function, complete blood count, urine analysis & sonography as per Kidney Disease Improving Global Outcomes (KDIGO) guideline. Outcomes was measured as postoperative base line creatinine and estimated glomerular filtration rate (eGFR) [14].

3. RESULTS

Eight kidney transplants were performed in Sumeru hospital. All patients were first-degree relatives (husband, wife, siblings, father, mother, children). Human leukocyte antigen (HLA) Tissue typing was performed in Arogya foundation in all patients. In our all cases cost for per-operative, operative and post-operative expenses were borne by patients themselves. 100% (Table 1). Initial immunosuppressant consisted of INJ. ATG (@1.5 mg/kg) 3 dose, tacrolimus, mycophenolate sodium, methyl-prednisolone. Antibiotic (Meropenem). Transplant outcome for graft and patient survival was 100%.

Table 1. Baseline demographic and clinical characteristics of the recipient

Variables n= 8	Recipient		Donor	
	Mean \pm SD		Mean \pm SD	
Age (years)	Mean = 34.3 \pm 8.45 Range 23–45yrs		Mean = 31.6 \pm 8.16 Range 23–45yrs	
Gender	Frequency	Percent	Frequency	Percent
Male	6	75.0	6	75.0
Female	2	25.0	2	25.0
Cause of ESRD				
Hypertension	6	75.0	6	75.0
IgA Nephropathy	1	12.5	1	12.5
Pre-emptive transplant	1	12.5	1	12.5
CMV (IgG) positive				
Yes	8	100.0	8	100.0

Table 2. Laboratory parameters

	Mean \pm SD
Pre-operative Duration of haemodialysis	4 HOURS
Laboratory parameters	
Haemoglobin(gm/dl)	9.9
Albumin (gm/dl)	2.1
Calcium 2.5 _ 1.7 mmol/L	2.1
Phosphorus 5.7 _ 2.1 mg/dl	3.9
Alkaline phosphatase 168.7 _ 80.2 IU/L	124
iPTH 190.6 _ 165.7 pg/mL	177.5

3.1 Funding for Transplantation in Nepal

Funding of kidney transplant pre operative investigations, surgery & postoperative maintenance is beared by patients or their relatives in private settings, while in government settings, all expenses are sourced from ministry of health & population Nepal. But because of long queue in government set up, patients have to wait long before they get transplanted (average waiting 6 month to 1 year).

3.2 Immunosuppressive Regime

Immunosuppressive regime include induction with polyclonal antibody INJ. ATG total 3 dose and Calcineurin inhibitor-based triple drug therapy as tacrolimus (3.5mg BID), mycophenolate sodium (30 mg/kg TDS), methylprednisolone as maintenance regime.

3.3 Transplant Outcome

Patient & graft survival was100%. Invasive candidiasis was seen in 1 patient who was treated successfully.

4. DISCUSSION

In Nepal, Human organ transplant act 2055 BS (1998 AD) was passed to regulate activities pertaining to the extraction of an organ from human body. According to this act only closely related relatives were allowed to donate their organ. First kidney transplantation was successfully done in 2008 at TUTH (Tribhuvan University Teaching Hospital) [7]. Although renal transplantation are successfully conducted there are some many limitation related to HLA laboratory and Immune fluorescence staining for renal biopsies are still not available in many hospitals.

To prevent the commercialization & monetary involvement in organ transplantation, human organ transplant act was re-modified in 2073BS Nepal. The outcome of transplantation is solely based on immunological status of recipients, HLA tissue-typing, Cross matching, Donor specific antibodies & panel-reactive antibodies. 50% matching at loci A, B DR is acceptable and categorized as low immunological risk. Patients with hepatitis B,C,HIV positive are not accepted at our setting. Preparation of recipient included; controlled hypertension, optimized diabetes

mellitus, and overall good cardiovascular status. Recipients must be adequately dialyzed (3 times a week). All the transplant centers generally investigate donors and recipient at its own center. Moreover, HLA typing is not available at all the centers, many centers have to rely on other centers for it. Immunosuppressive regime include triple drug induction regimes that includes: Tacrolimus alone with Mycophenolatemofetil-Sodium (MMF-s) and Prednisolone. These regimes were used in our cases, while induction was made by administration of polyclonal antibodies (ATG).

4.1 Challenges of KT in Private Hospitals

Kidney transplant was first undertaken in august 2008 in a TUTH hospital Kathmandu.

Till now, eight units have successfully carried out renal transplantation in Nepal. Transplant program has been successfully done in government hospital with good financial, manpower & legislative support but in private setting because of the lack of financial support it have not achieved remarkable outcome [15].

Major challenge related to transplantation in our setting is financial & donor availability. Majority of patients belongs to poor class & hardly afford transplant cost. Voluntary donation of organ from relative is not easy for every family & becomes really hard to convince for it. Moreover donor has poor knowledge regarding donation & its outcome [16,17]. In a number of instances, long duration of waiting list in government hospitals is another important factor that patients are bound to search for other transplant centers. Immunological as well as some viral markers done at other center with heavy cost is another challenging part. This delays the surgical preparation. Development of laboratories by government sector will reduce cost as well the time.

Moreover Induction agents (ATG), Immunosuppressant & Antiviral drugs are also imported from other countries this increases the cost more than the expected. Surgical and medical expertise are required to develop transplant center, but relatively low number of cases may decrease the over all sustainability of any transplant programmers. Government development of national transplant centers with free of cost transplant services is good initiative. But establishment of private hospital centers & allowing transplantation programmers supported

by government in establishment of private transplant centers to run at cost synonymous to government setting that would not only improve the outcome rather decrease burden on government hospitals , which may be counterproductive.

This will bring a better exposure of medical professional in all the transplant centers. It will enhance the quality and quantity of transplant as a whole. It will bring easy access to poor patients to benefit from transplant service in emerging country like Nepal.

5. CONCLUSION

Kidney transplantation has improved a lot in private hospitals of Nepal. It is cost effective & easily accessible to all. Transplantation has increased the survival of ESRD patients. But, financial support and availability of laboratory needs to be improved. National Health insurance coverage for renal transplantation should be improved. It is important to speed up the process of enactment of relative kidney transplant legislation in Nepal in conjunction with the Deceased donation act to increase the transplantation rate, but also to prevent commercialism and organ trafficking. Formation of private transplant centers; allowing transplant program to run at cost synonymous to government setting that would not only improve the outcome rather decrease burden on government hospitals , which may be counterproductive.

CONSENT

Informed written consent was taken from all our patients before study.

ETHICAL APPROVAL

As per international standard or university standard written ethical approval has been collected and preserved by the author(s).

COMPETING INTERESTS

Authors have declared that no competing interests exist.

REFERENCES

1. Arogundade FA, Abd-Essamie MA, Barsoum RS. Health related quality of life in emotionally related kidney

- transplantation: deductions from a comparative study. Saudi J Kidney Dis. Transplant. 2005;16: 311–320.
2. Haller M, Gutjahr G, Kramar R et al. Cost-effectiveness analysis of renal replacement therapy in Austria. Nephrol Dial Transplant. 2011;26:2988–2995.
 3. Domínguez J, Harrison R, Atal R. Cost-benefit estimation of cadaver kidney transplantation: the case of a developing country. Transplant Proc. 2011;43:2300–2304.
 4. Garcia GG, Harden P, Chapman J. The global role of kidney transplantation. Am J Nephrol. 2012; 35:259–264.
 5. The World Bank. 2013 World Development Indicators. [Cited 26 March 2013] Available: <http://data.worldbank.org/country/Nepal>
 6. The Kathmandu Post. 2011 Per capita income up. [Cited 26 March 2013.] Available: <http://www.ekantipur.com/the-kathmandu-post/2011/07/07/money/per-capita-income-up/223737.html>
 7. Chalise PR, Shah DS, Sharma UK et al. Renal transplantation in Nepal: the first year's experience. Saudi J Kidney Dis Transpl. 2010;21:559-64. Available: <http://www.who.int/countries/npl/en/>
 8. United Nations General Assembly. Political declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. A/66/L.1; September 16, 2011.
 9. Couser WG, Remuzzi G, Mendis S et al. The contribution of chronic kidney disease to the global burden of major non-communicable diseases. Kidney Int. 2011; 80:1258–70.
 10. Sakhuja V, Sud K. End-stage renal disease in India and Pakistan: Burden of disease and management issues. Kidney Int. Suppl. 2003;83: S115–18.
 11. Modi GK, Jha V. The incidence of end-stage renal disease in India: A population-based study. Kidney Int. 2006; 70: 2131–3.
 12. Kafle RK. Current trends of transplantation in Nepal. JNRT 2009;2: 89–93.
 13. Hirachan P, Kharel T, Shah DS. Renal replacement therapy in Nepal. Hemodial. Int. 2010;14: 383–6.
 14. Glazier AK, Delmonico FL. The declaration of Istanbul is moving forward by combating transplant commercialism and trafficking and by promoting organ donation. Am J Transplant. 2012;12:515–516.
 15. Shah D, Shrestha S, Kfle MP. Renal transplantation in Nepal: Beginning of a new era! Nepal. Nephrology. 2013;18:369–375.
 16. Institute of Medicine. Renal transplant service. [Cited 26 March 2013.] Available: http://www.iom.edu.np/index.php?option=com_content&view
 17. Chalise PR, Shah DS, Sharma UK et al. Renal transplantation in Nepal: The first year's experience. Saudi J Kidney Dis Transpl. 2010;21: 559–64.

© 2022 Ansari et al.; This is an Open Access article distributed under the terms of the Creative Commons Attribution License (<http://creativecommons.org/licenses/by/4.0>), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Peer-review history:

The peer review history for this paper can be accessed here:
<https://www.sdiarticle5.com/review-history/93017>