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EDITORIAL COMMENT

Comment to: "Renal retransplantion: risk factors and results"

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Renal transplantation has become an effective form of treatment for end-stage renal failure. Unfortunately, as a consequence of immunological and nonimmunological pathogenic mechanisms, chronic allograft dysfunction is responsible for the loss of a large proportion of kidney grafts after several years and return to dialysis. Renal retransplantation offers hope for recipients who have had a renal graft fail. The overall number of retransplant candidates has increased for all organs and account for 11% to 13% of all wait-listed candidates for all organs in each year between 1990 and 2007. Repeat transplants represented 12.0% of all transplants in 1990 and 9.5% in 2007. During the same period, the number of repeat transplant candidates increased from 2,322 to 4,553 for kidney and the number of repeat transplants increased from 1,293 to 1,867 for kidney. The rate of allograft survival was almost uniformly superior for first transplants compared with repeat transplants, with the exception of deceased donor kidney transplantation, for which the unadjusted 5-year allograft survival rate was similar for first and second transplants (70% vs. 69%, p=0.5).[1] However, there are few reports dealing with the outcome, risk factors and the management of patients who have lost their grafts and have been retransplanted. Arce and colleagues have addressed a very important question about risks factors and outcome after renal retransplantation.[2] The investigators primary finding is that survival after renal retransplantation is at least equivalent to that after the first renal transplant. Acute rejection is still playing a role for graft loss after the second transplant. Finally, the authors did not find any difference in the complications between the first and second transplant. Their message is that the risk of graft failure following retransplantation is not significantly higher than that observed for primary transplants. Improvement should be directed to better immunosuppresion protocol to prevent acute rejection.

References

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