ASN *Kidney News* Commentary

Transition of Care after Allograft Failure

By Itunu Owoyemi

Transplantation remains the best treatment modality for kidney failure. Despite the significant improvement in immunosuppression and reduction in acute rejection rates, allograft failure with return to dialysis is common (1). Infection and cardiovascular disease are the two major causes of mortality after returning to dialysis (2). It is important to carefully optimize immunosuppression management due to the need to balance the risk of infection and mortality with continuation on dialysis versus the chronic inflammatory state and increased sensitization to allograft major histocompatibility complex (MHC) antigens with discontinuation of immunosuppression (3).

The American Society of Transplantation-Kidney Pancreas Community of Practice (AST-KPCOP) established a work group to study Kidney Recipients with Allograft Failure, Transition of Kidney Care (KRAFT). AST-KPCOP conducted a survey among adult transplant providers covering 49% of transplant centers across the United States. The survey was performed to evaluate current practices that highlighted the need to standardize immunosuppression management after graft failure as well as effective transition of care in clinical practice (4). Only 22% of the respondents mentioned that a majority of their patients with failing allografts were relisted for another kidney transplant before starting dialysis. Most of the respondents reported their decision to wean off immunosuppression was most importantly based on the availability of a living donor, followed by risk of infection, risk of sensitization, frailty, and side effects of the medications. The most common approach for tapering immunosuppression was to initially discontinue the antimetabolite (such as mycophenolate mofetil or azathioprine). The survey also showed that 25% of the respondents would use urine volume/residual kidney function as a guide for weaning immunosuppression. Whereas a paucity of data exists for tapering immunosuppression based on urine volume, survival benefit has been demonstrated in recipients who remained on immunosuppression with residual kidney function (5). Most of the respondents referred patients for nephrectomy when there were persistent signs and symptoms of rejection.

The survey highlighted the varying care of the failing transplant and the need to have high value and collaborative care in clinical practices. The KRAFT study group later proposed a comprehensive shared-care model for improved collaboration between transplant providers and general nephrologists to improve clinical outcomes with management of the failing allograft outlined in the *American Journal of Transplantation* (6). ■

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