

Prudence and the kidney transplantation

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Received for publication: 02/10/2015

Accepted: 14/10/2015

The significant improvement in transplantation outcomes in the past 40 years is mostly related to the development of new immunosuppressive drugs, as well as to the fantastic advances in imaging diagnostic tools and laboratory tests – especially those for bacterial and viral identification. The development of new, more specific treatments for these infections also contributes, and the efficient treatment for hepatitis C is the latest strong example. However, we are hardly dealing with the unpredictable side effects of immunosuppressive drugs, which may be interpreted as a kind of “daily micro-poisoning”.

The need for organ replacement exceeds by far the number of organs available for transplantation, and this gap is likely to become wider in the future, due to the decrease of suitable organ donors and the rising incidence of vital organ failure related to higher life expectancy and prevalence of chronic diseases, such as diabetes. Therefore, centres are changing traditional policies for accepting donors. Although controversial, modalities for harvesting kidneys after cardiac deaths have been developed and are routinely applied in many institutions. Consequent to the use of marginal donors, the quality of transplanted organs is decreasing and outcomes might be compromised. Additionally, the criteria for accepting organs from unrelated kidney donors have been expanded in order to minimize organ shortage. In that scenario, the criteria for allocation of those organs are continuously under study.

Although kidney transplantation programmes have been initiated in every continent, mostly in regions with well-regulated transplant legislation, many countries have no resources or well developed logistics to provide a continuous programme to offer this modality

to every citizen. Those geographic, economic, social and cultural disparities have to be considered when implementing new modalities of organ donation, and efforts to improve new programmes should not be deviated by adopting initially appealing and apparently easy solutions. Their societies must be very prudent when considering the expansion of the number of living donors by increasing the acceptance of non-related donation or establishing large chains of paired donation programmes. The same applies to the expansion of donor pool by using organs recovered from donors after circulatory cardiac death. Such cautiousness is justified considering that transplantation programmes are very susceptible to public reactions, especially in the case of failures and legal disputes related to those new modalities. Historically, few unorthodox decisions directly influenced public perception and trust in the transplant programmes, reducing family consent for organ donation. Transparency is necessary, but prudence means more than that. Prudence involves the use of all available resources to reduce any possible misinterpretation in a way that compromises the chance of patients on the waiting list. Those concepts of prudence should always be taken in consideration, but are particularly relevant to areas where transplant programmes are still under development.

Conflict of interest statement: None declared.

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