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P191 -Wound complications in early post-transplant period are associated with higher body mass index and poorer transplant outcome

Sr Claire Milner¹, Dr Iain Moore¹

¹South Tees Hospitals NHS Trust, Middlesbrough, United Kingdom

We are a tertiary referral renal unit, covering a population of just over 1 million. We have a central renal unit and satellite clinics in 5 other centres. Currently we have 569 kidney transplant recipients; approximately 200 attend clinic follow-up centrally and the rest attend satellite renal clinics.

We have 45-50 new transplant (Tx) recipients per annum, a high proportion of which are live donor transplants. The early post-Tx clinic functions as a multi-disciplinary clinic. Our specialist nursing team are skilled in post-Tx education, diabetes monitoring and wound management. They maintain close links with community nursing colleagues to ensure best outcome for our Tx recipients.

Transplant recipient care is transferred back to us 7-10 days post-operatively. Patients attend our post-Tx clinic for up to 6 months post-surgery. Normally, 8-14 patients attend twice weekly. Patients are subsequently transferred back to their referring nephrologist's clinic.

Over the last 2 years, we identified an increasing problem with wound healing post-Tx. We felt this was likely due to a high prevalence of diabetes and raised BMI in our catchment area. We documented specific wound input, Tx function, Erythropoietin Stimulating Agent (ESA) and IV Iron usage over a 6 month period to assess effect of wound complications on Tx outcome.

Over a 6 month period between 1st May and 1st November 2018, 19 of our patients received a Tx. There was no difference in induction agent and all were managed with a triple regime of Prednisolone, Tacrolimus and Mycophenolate Mofetil.

Five patients required intensive wound management. Three of these had cadaveric kidneys, 2 had live donors. The average body mass index (BMI) was 31.54 (range 26.5-39.6); 3 recipients required ESA treatment, 1 also requiring IV Iron. One recipient had pre-existing type 2 Diabetes. Average eGFR at entry to Tx clinic was 47.2ml/min; average eGFR at discharge was 40.2ml/min.

Of the other 14 recipients, 7 had cadaveric kidneys and 7 had live donors. The average BMI was 27.3 (range 23.1-32.1), 1 had ESA treatment (this patient had had an SPK) and 2 others had IV iron. Two patients had pre-existing Type 2 diabetes, 1 had a successful pancreas Tx (SPK). Average eGFR at entry to Tx clinic was 59.3 ml/min; average eGFR at discharge was 60.9ml/min.

It seems clear, despite the small numbers in our study, a complicated wound post-Tx is associated with a higher BMI and lower eGFR. Diabetic status did not seem significant. The wound care group received increased ESA support.

Complex wound care post-Tx may lead to poorer outcomes in eGFR, increased use of ESA and poorer patient experience. Particular emphasis is required to target rising BMI in our transplant-listed patients. We plan to introduce an annual review clinic for our transplant-listed cohort to help combat BMI becoming an issue while on the list.