SHARED CARE IN TRANSPLANT

CO-MANAGING THE KIDNEY TRANSPLANT RECIPIENT

Preventative care • Safe Prescribing • When to call transplant

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WHY IT MATTERS: THE VITAL ROLE OF FAMILY DOCTORS IN POST-TRANSPLANT CARE

CVD

↑ CVD

LEADING CAUSE OF DEATH & GRAFT LOSS

Family Doctor Role: Blood Pressure Control, Lipid Management, Lifestyle Counseling

INFECTION

↑ INFECTION: >50%

↑2X RISK OF DEATH

20% OF MORTALITY

Family Doctor Role: Early Detection, Vaccination, Antibiotic Stewardship

MALIGNANCY

↑ MALIGNANCY

2-3X HIGHER RISK

10X HIGHER RISK OF CANCER-RELATED DEATH

Family Doctor Role: Age-Appropriate Screening, Skin Checks, Symptom Monitoring

Should I Blame Nephrology? A Triage Guide

NEPHROLOGIST MANAGED
(Transplant Team)

Blame the Meds

- Tremor/headaches: CNI
- GI symptoms (nausea/bloating/diarrhea): MMF
- Leukopenia
- Recurrent UTIs/infections

Blame the Graft

- Graft pain: rejection, seromas
- Rise in Cr: ?rejection

VS

FAMILY DOCTOR MANAGED
(Primary Care)

- Fatigue
- CVD symptoms
- Anemia
- Malignancy screening
- Bone health
- DM management

CO-MANAGING INFECTION:
RISKS AND VACCINATION STRATEGIES

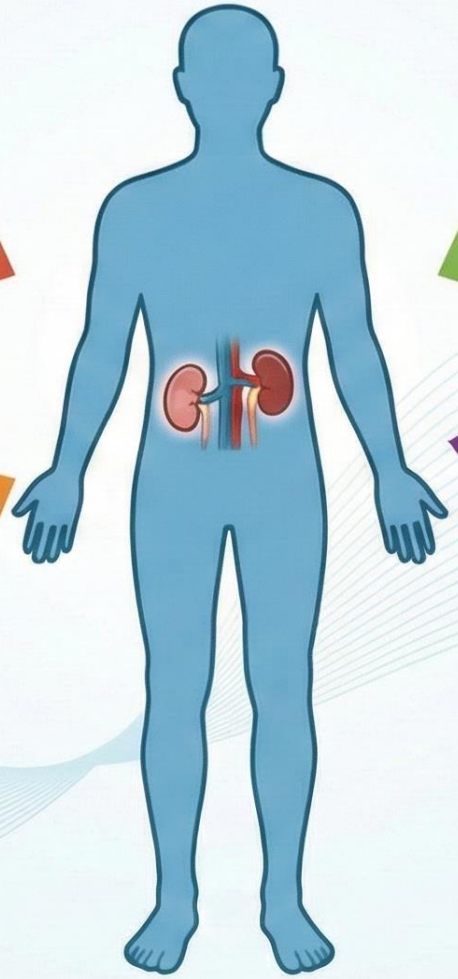
Post-Transplant Infection Risks:
Burden & Timing

Mortality Impact

Major Cause of Death

Timing: First 6 Months

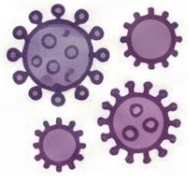
Most Frequent Period



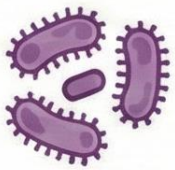
Common Infections

UTI URTI

Opportunistic Infections



Viral: VZV, HSV, CMV, EBV

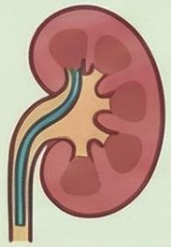


Bacterial: PJP, TB, Nocardia

Fungal: Aspergillus

ASYMPTOMATIC BACTERURIA POST-TRANSPLANT

EARLY PHASE (0-1/2 MONTHS)



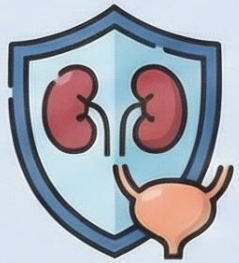
Treat Asymptomatic Bacteruria
(due to retained stent)

STENT REMOVED
(1–2 MONTHS)

LATER PHASE (>1-2 MONTHS)

AVOID TREATMENT for Asymptomatic Bacteruria

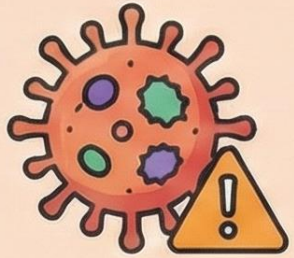
NO BENEFIT



- Does NOT reduce symptomatic UTI
- Does NOT prevent pyelonephritis
- Does NOT prevent rejection

Based on RCT data

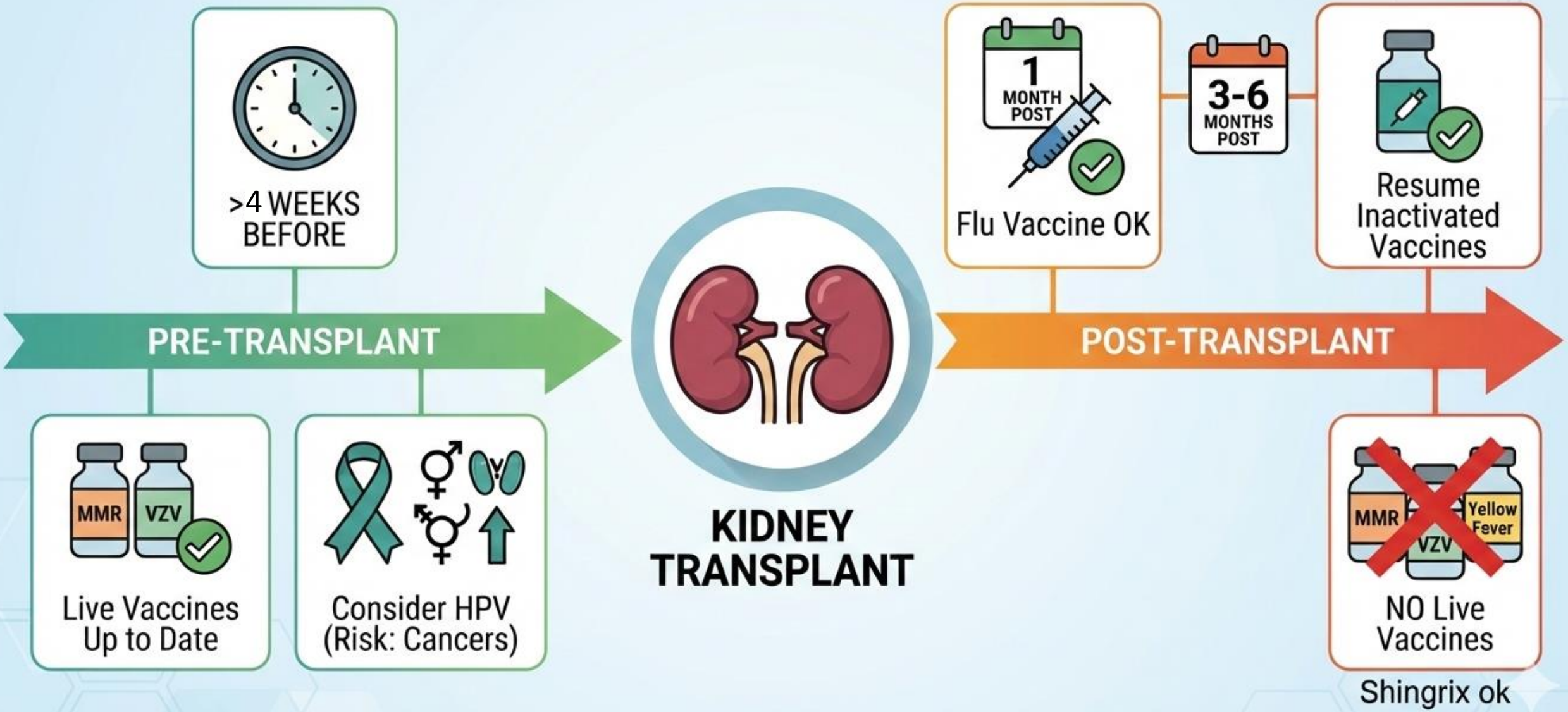
MDRO RISK



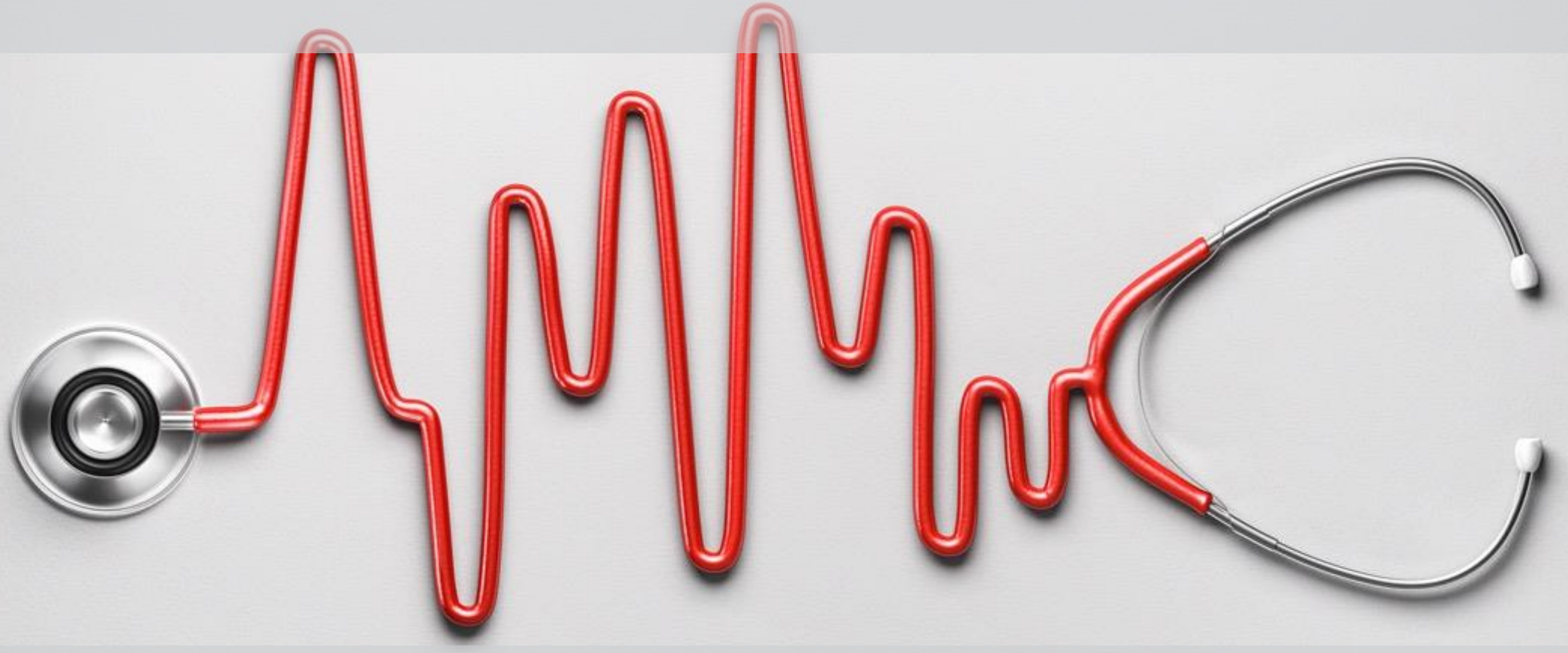
- Unnecessary antibiotics drive resistance
- Increases risk of Multi-Drug Resistant Organisms

FOCUS ON TREATING SYMPTOMATIC INFECTIONS.
AVOID TREATING ASYMPTOMATIC BACTERURIA TO PRESERVE ANTIBIOTIC EFFICACY.

Optimizing Vaccine Strategy Around Kidney Transplant



CVD PREVENTION:



ADDRESSING THE LEADING POST-TRANSPLANT RISK

CVD Burden & Risk Profile in Transplantation

50% of Deaths

Leading Cause of Mortality Post-Transplant

TRADITIONAL RISKS

- Advanced Age
- Smoking History
- Hypertension (HTN)
- Dyslipidemia

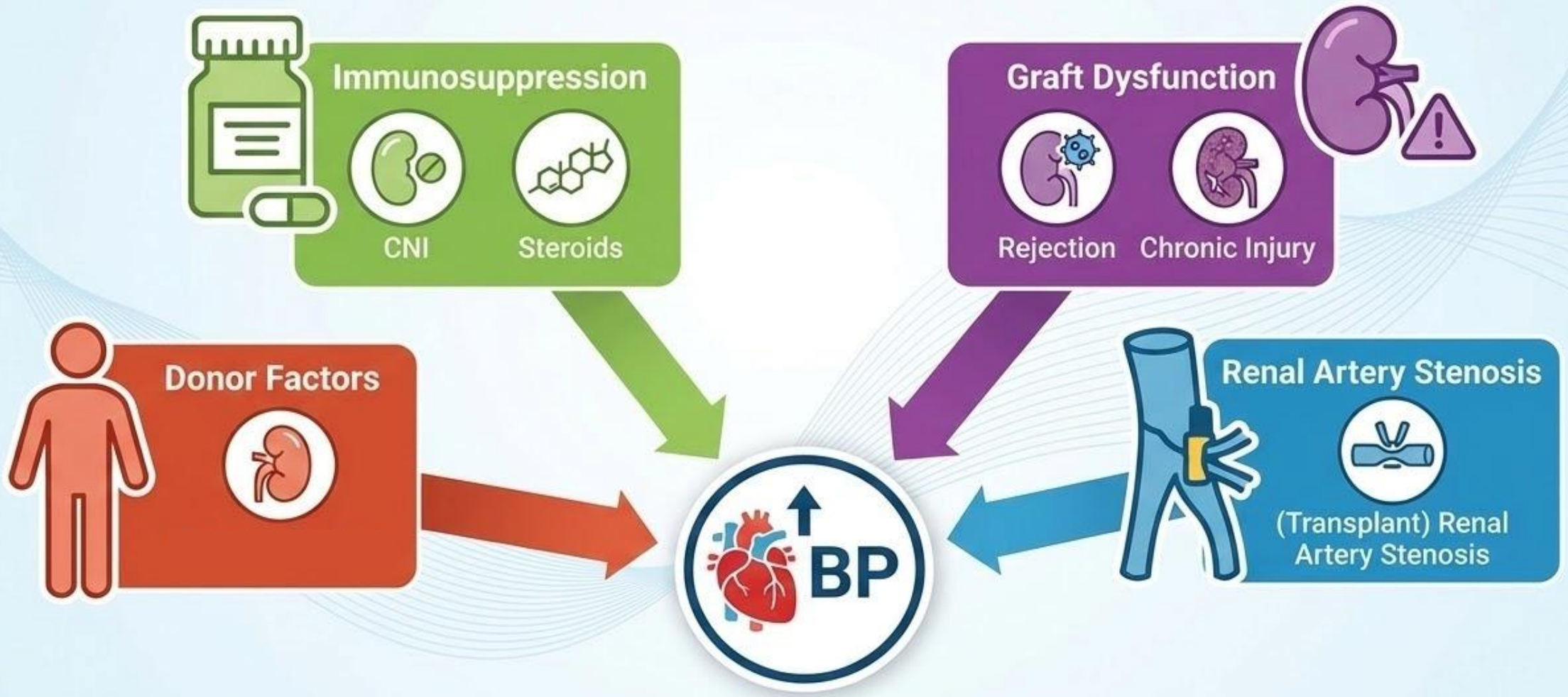
TRANSPLANT SPECIFIC

- NODAT (New Onset Diabetes)
- Suboptimal Graft Function (CKD)
- Immunosuppression (Dyslipidemia)
- Weight Gain

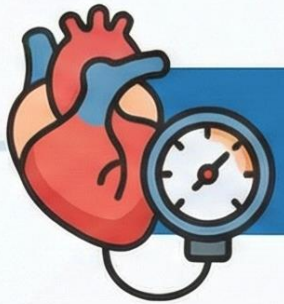
⚠ Statin & Calcineurin Inhibitor (CNI) Management

Caution: Competition for CYP3A4 metabolism. Start low, go slow to reduce risk of toxicity and myopathy

Post-Transplant Hypertension: Contributing Factors



Hypertension in Transplant



80% Prevalence

THE TARGET

< 130 / 80

SAFE PRESCRIBING

Avoid Non-DHP CCB

PHARMACOTHERAPY

1st LINE

CCB

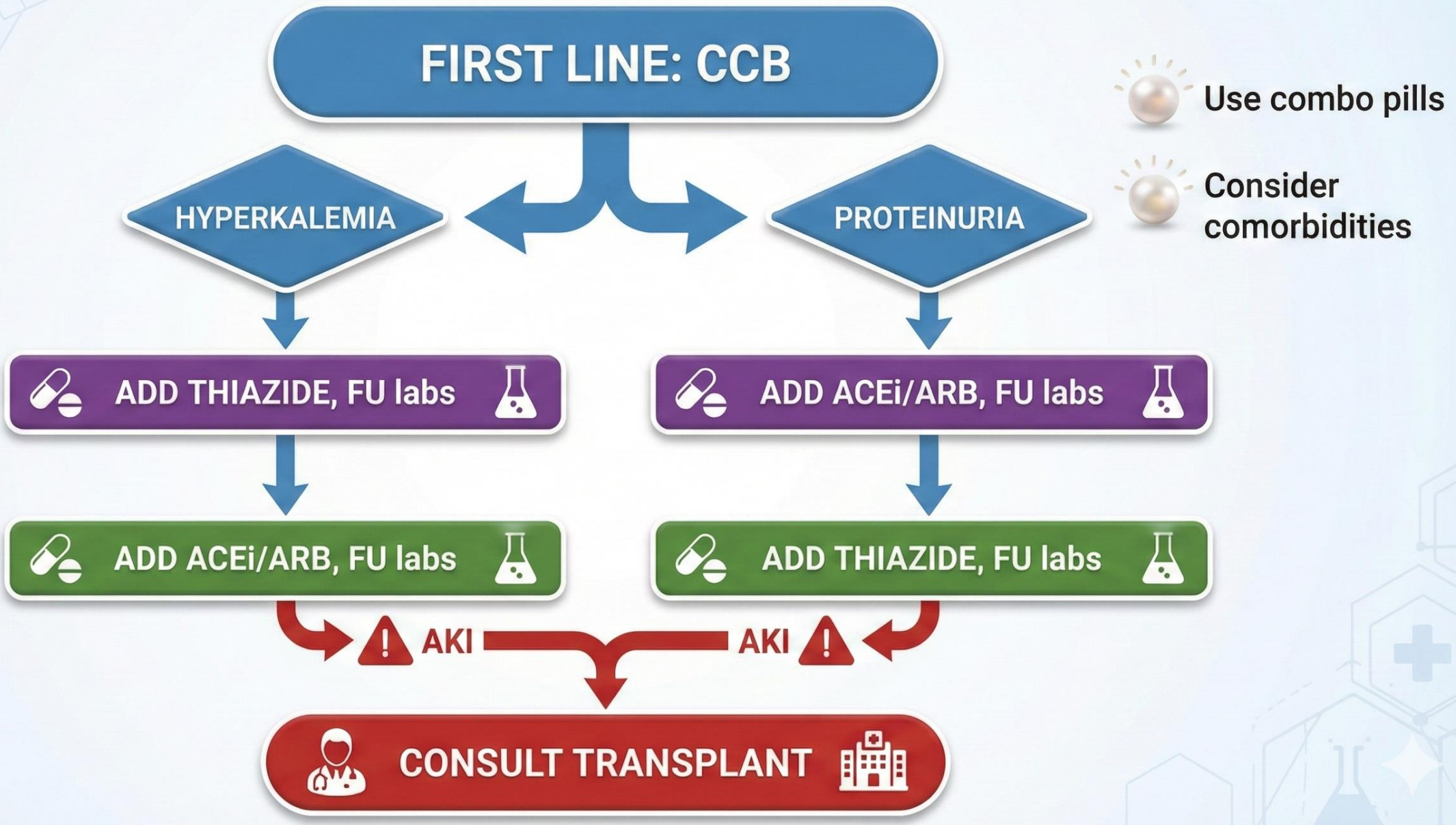
Counteracts CNI-related renal hypoperfusion

2nd LINE

RAASi

Disrupts graft monitoring. Avoid in first 3-6 mo

Practical Pharmacotherapy Ladder



NEPHROLOGY'S NEW PILLARS IN CKD

SGLT2i (CREDENCE, DAPA-CKD, EMPA-KIDNEY)

- Slows CKD progression
- Reduces albuminuria
- Improves CV outcomes

ns-MRA (Finerenone: FIDELITY)

- Synergistic proteinuria improvement
- Significant CV risk mitigation in T2D-CKD

GLP1RA (FLOW, LEADER)

- Landmark reduction in primary kidney endpoints and MACE
- Provides metabolic and weight management

THE POST-TRANSPLANT DATA GAP

Observational Evidence

- SGLT2i likely safe (stable eGFR, low UTI risk)
- GLP1RA effective (PTDM, weight)
- Trend: Improved CV/renal outcomes

The RCT Paradox

Transplant recipients STRICTLY **EXCLUDED** from landmark CKD trials.

Gaps

Safety/proteinuria reduction observed, but CRITICAL DEARTH of RCT evidence for graft survival & long-term CV outcomes.

CKD vs Transplant: Evolution of Care

ASPECT	CKD	TRANSPLANT
BP TARGET	< 130/80 Consider <120/80	< 130/80
FIRST LINE BP AGENT	ACEi/ARB + THIAZIDE	Often CCB Reserve ACEi/ARB for >6mo
PROTEINURIA REDUCTION	ACEi/ARB + SGLT2i DM: MRA, GLP1RA	ACEI: no clear benefit, still used SGLT2i: “off label” observational evidence, RCT pending
CVD PROTECTION	RF management: lipids, HTN ACEI/ARB SGLT2i GLP1RA	RF management: lipids, HTN Others not studied, observational evidence to date
DIABETES MANAGEMENT	Low GFR restricts options	Increased GFR expands options Caution: SGLT2i, GLP1RA

TRANSITION

POST-TRANSPLANT MALIGNANCY

RISKS AND PREVENTION

POST-TRANSPLANT MALIGNANCY: BURDEN & SCREENING

HIGH BURDEN OF ILLNESS

SIGNIFICANTLY INCREASED RISK

~15% MORTALITY

VIRALLY DRIVEN CANCERS ESPECIALLY INCREASED

CERTAIN CANCERS >5X RISK:

Kaposi sarcoma | Non-melanoma skin cancer | Non-Hodgkin lymphoma | Liver | Anogenital

MOST COMMON:
SCC (Squamous Cell Carcinoma)

SCREENING: FAMILY DOCTOR FOCUS

EVIDENCE LACKING IN TRANSPLANT POPULATION

SUGGESTED APPROACH:

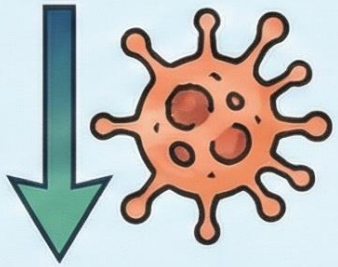
AGE/GENDER APPROPRIATE SCREENING

+ SKIN CHECKS

The Importance of Skin Checks

SCREENING GAP & BENEFIT

Adherence is LOW (45%)



Screening REDUCED advanced Ca (35%)

ROOM FOR IMPROVEMENT

FAMILY DOCTOR ROLE

SUNTRAC Tool: Risk Stratify

Derm Clinic Capacity Issues

FAMILY DOCTORS: KEY TO FILLING THE GAP

Reference: Chan AW et al 2019, AM J transplant

SAFE PRESCRIBING

AVOIDING DRUG INTERACTIONS

TACROLIMUS DRUG INTERACTIONS

INCREASE LEVELS (TOXICITY)

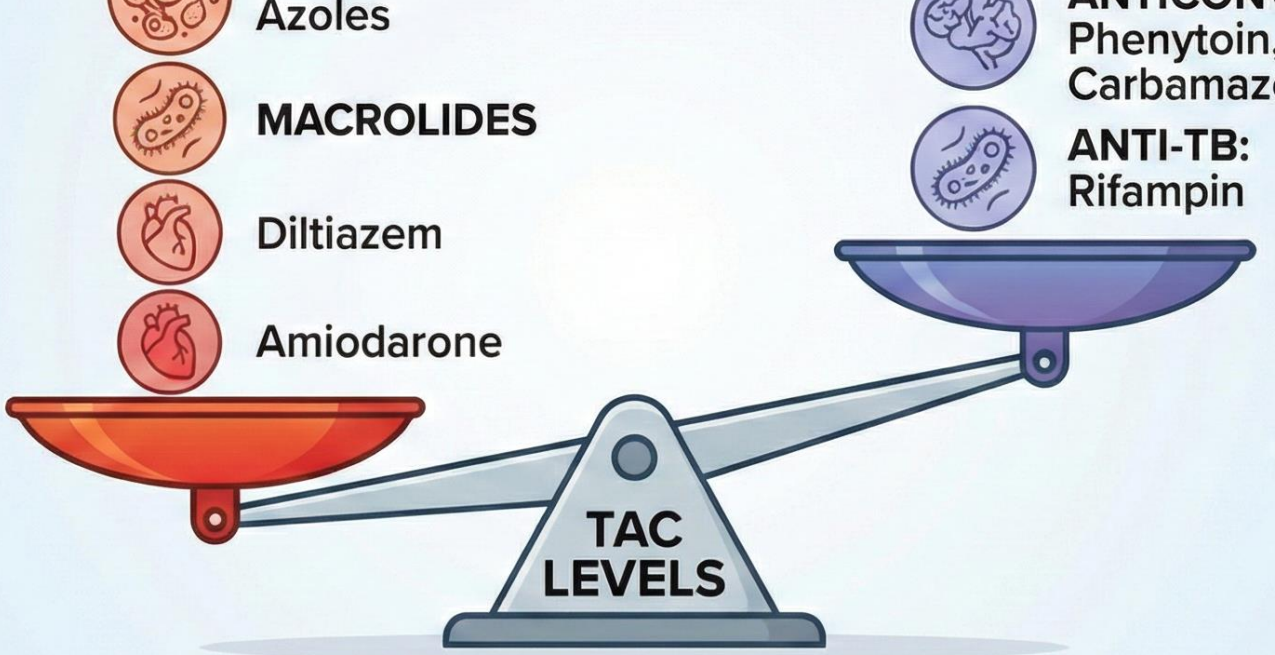
ANTIVIRAL: Paxlovid

ANTIFUNGALS: Azoles

MACROLIDES

Diltiazem

Amiodarone



ANTIFUNGAL: Caspofungin

ANTICONVULSANTS: Phenytoin, Carbamazepine

ANTI-TB: Rifampin

DECREASE LEVELS (REJECTION)

AVOID ENTIRELY (WITH CYCLOSPORINE): LOVASTATIN, SIMVASTATIN, PITAVASTATIN

Shared Care: Key Points

CVD Prevention

Address the **leading cause** of post-transplant death

Target **BP < 130/80**

Manage lipids and glucose aggressively

Screening & Vaccines

High skin cancer risk: **annual derm checks**

Maintain age-appropriate cancer screening

Ensure up to date (inactivated) vaccinations

Safe Prescribing

Check Tac interactions: pharmacy is your friend

Avoid NSAIDs

Transplant-specific risks: SGLT2i, GLP1RA

When to Call Transplant

Unexplained **Creatinine rise (>20%)**

Recurrent infections

Complications of immunosuppression

Uncontrolled HTN

Questions?

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