

EAU Guidelines on Renal Transplantation

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1. INTRODUCTION

1.1 Aim and objectives

The European Association of Urology (EAU) Renal Transplantation Guidelines are intended to provide a comprehensive overview of the medical and technical aspects relating to renal transplantation. It must be emphasised that clinical guidelines present the best evidence available to the experts, but following guideline recommendations will not necessarily result in the best outcome. Guidelines can never replace clinical expertise when making treatment decisions for individual patients but rather help to focus decisions - also taking personal values and preferences/individual circumstances of patients into account. Guidelines are not mandates and do not purport to be a legal standard of care.

1.2 Panel Composition

The EAU Renal Transplantation Guidelines panel consists of an international multidisciplinary group of urological surgeons, a nephrologist and a pathologist. All experts involved in the production of this document have submitted potential conflict of interest statements, which can be referenced on the EAU website: www.uroweb.org/guideline/renal-transplantation/.

1.3 Available publications

A quick reference document, the Pocket Guidelines, is available in print. These are abridged versions that may require consultation in combination with the full text version. All are available through the EAU website: www.uroweb.org/guideline/renal-transplantation/.

1.4 Publication history

The EAU published the first Renal Transplantation Guidelines in 2003, with subsequent updates in 2004 and 2009. A comprehensive update of the 2009 document was published in 2017. The 2024 document was a limited update of the 2017 guidelines. The next update of the Renal Transplantation Guidelines will be published in 2027.

2. METHODS

2.1 Introduction

For the 2024 Renal Transplantation Guidelines, new and relevant evidence was identified, collated and appraised through a structured assessment of the literature. Broad and comprehensive literature searches covering the Renal Transplantation Guidelines were carried out, covering a time frame between 31 May 2020 and 1 April 2023. Databases searched included Medline, EMBASE, and the Cochrane Libraries. Detailed search strategies are available online: www.uroweb.org/guideline/renal-transplantation/.

Recommendations within the Guidelines are developed by the panels to prioritise clinically important care decisions. The strength of each recommendation is determined by the balance between desirable and undesirable consequences of alternative management strategies, the quality of the evidence (including certainty of estimates) and the nature and variability of patient values and preferences. This decision process, which can be reviewed in the strength rating forms that accompany each guideline statement, addresses several key elements:

1. the overall quality of the evidence that exists for the recommendation [1];
2. the magnitude of the effect (individual or combined effects);
3. the certainty of the results (precision, consistency, heterogeneity and other statistical or study related factors);
4. the balance between desirable and undesirable outcomes;
5. the impact and certainty of patient values and preferences on the intervention.

Strong recommendations typically indicate a high degree of evidence quality and/or a favourable balance of benefit to harm and patient preference. Weak recommendations typically indicate availability of lower quality evidence and/or equivocal balance between benefit and harm, and uncertainty or variability of patient preference [2].

2.2 Review and future goals

This document was subject to independent peer review prior to publication in 2017. Publications ensuing from systematic reviews have all been peer reviewed.

3. THE GUIDELINE

3.1 Organ retrieval and transplantation surgery

3.1.1 *Living-donor nephrectomy*

The endoscopic (laparoscopic) approach is the preferred technique for living-donor nephrectomy in established kidney transplant programmes [3]. Nevertheless, open surgery, preferably by a mini-incision approach, can still be considered a valid option, despite increased pain in the postoperative period [4].

Endoscopic living-donor nephrectomy (ELDN) includes:

- Pure or hand-assisted transperitoneal laparoscopy;
- Pure or hand-assisted retroperitoneal approach;
- Laparo-Endoscopic Single Site Surgery (LESS);
- Natural Orifice Transluminal Endoscopic Surgery-assisted (NOTES);
- Laparo-Endoscopic Single Site Surgery and robotic-assisted transperitoneal or retroperitoneal approach.

Strong evidence exists in support of laparoscopic living-donor nephrectomy (LLDN), including several systematic reviews and meta-analysis, which have compared the safety and efficacy of LLDN to open-donor nephrectomy. Laparoscopic living-donor nephrectomy is associated with similar rates of graft function and rejection, urological complications and patient and graft survival. However, measures related to analgesic requirements, pain, hospital stay and time to return to work are significantly better for laparoscopic procedures [5-8].

Standard LLDN is usually performed through 5 and 12mm ports, but has also been performed with 3 or 3.5mm ports [9]. According to a recent meta-analysis, hand-assisted LLDN is associated with shorter operative time and warm ischaemia, but equivalent safety and overall results [10]. Laparoscopic living-donor nephrectomy can also be performed with robotic assistance, with equivalent results according to a systematic review [11]. However, the numbers are still low and recent studies, including a meta-analysis, have reported higher complication rates for this approach [12, 13].

Laparoendoscopic single-site surgery nephrectomy enables the surgeon to work through a single incision - usually the umbilicus - with a multi-entry port. The same or a separate incision is then used for kidney withdrawal. Several retrospective and at least three prospective randomised trials demonstrated equivalent safety and results, with a trend towards less pain and better cosmetic results [14, 15]. However, LESS is considered a more technically demanding procedure when compared with classic LLDN and its role is yet to be defined.

Natural orifice transluminal endoscopic surgery-assisted transvaginal nephrectomy avoids the abdominal incision required for kidney extraction, aimed at minimising scarring and pain. Initial reports suggest that this approach is safe, however, experience with this technique is still highly limited [16].

Right LLDN has been considered more difficult, yielding inferior results. However, both left and right LLDN can be performed with equivalent safety and efficacy, according to large retrospective studies, systematic reviews and meta-analysis [17, 18].

Laparoscopic living-donor nephrectomy has brought attention to potential failures of various devices, such as endoscopic staplers and locking and non-locking clips, which are used to secure the renal hilum [17]. No scientific evidence is available showing that one device is safer than another for securing the renal artery [19-21]. However, the U.S. Food and Drug Administration (FDA) and the manufacturers of locking clips have issued a contraindication against their use in securing the artery during LLDN.

Summary of evidence	LE
Laparoscopic living-donor nephrectomy is associated with similar rates of graft function and rejection, urological complications and patient and graft survival to open nephrectomy.	1a
Measures related to analgesic requirements, pain, hospital stay and time to return to work are significantly better for laparoscopic procedures.	1a

Recommendations	Strength rating
Offer pure or hand-assisted laparoscopic/retroperitoneoscopic surgery as the preferential technique for living-donor nephrectomy.	Strong
Perform open living-donor nephrectomy in centres where endoscopic techniques are not implemented.	Strong
Perform laparo-endoscopic single site surgery, robotic and natural orifice transluminal endoscopic surgery-assisted living-donor nephrectomy in highly specialised centres only.	Strong

3.1.2 Organ preservation

In kidneys donated after cardiac death (DCD), evidence suggests that warm ischemia contributes to worse graft outcome. Donor hemodynamic parameters (systolic blood pressure, oxygen saturation and shock index, which is the heart rate divided by systolic blood pressure) may be predictors of delayed graft function (DGF) and graft failure. However, further studies are required to validate this [22]. The duration of asystolic warm ischaemia during procurement in DCD donors is associated with increased risk of graft failure. Overall, five-year graft failure (including primary graft non-function) was associated with longer asystolic warm ischaemia times [23]. Extraction time (beginning with aortic cross-clamp and ending with placement of the kidneys on ice) is a crucial factor for DGF. Incidents of DGF were 27.8% and 60% at up to 60 minutes and 120 minutes extraction time, respectively [24].

A retrospective study of 64,024 living donor kidney transplants found that CIT, human leukocyte antigen (HLA) mismatch, donor age, panel reactive antibody, recipient diabetes, donor and recipient body mass index (BMI), recipient race and gender, right nephrectomy, open nephrectomy, dialysis status, ABO incompatibility, and previous transplants were independent predictors of DGF in living donor kidney transplants [25].

Five-year graft survival among living-donor kidney transplant recipients with DGF was significantly lower than in those without DGF. Delayed graft function increased the risk of graft failure by more than 2-fold [25].

3.1.2.a Kidney storage solutions and cold storage

There are two main sources for kidney graft injury: ischaemia (warm and cold), and reperfusion injury. The aims of modern kidney storage solutions include: control of cell-swelling during hypothermic ischaemia; maintenance of intra- and extra-cellular electrolyte gradient during ischaemia; buffering of acidosis; provision of energy reserve; and minimisation of oxidative reperfusion injury. There is no agreement on which of the mechanisms is most important for post-ischaemic renal graft function [26]. No storage solution appears to combine all mechanisms. Euro-Collins was widely used previously but is no longer recommended.

Presently, the University of Wisconsin (UW) and histidine-tryptophan-ketoglutarate (HTK) solutions are equally effective and are standard for multi-organ or single-kidney harvesting procedures. HTK is characterised by low viscosity, low potassium concentration and low cost. The University of Wisconsin solution has been the standard static cold preservation solution for the procurement of liver, kidney, pancreas and intestine [27]. The University of Wisconsin, HTK and Celsior solutions have provided similar allograft outcomes in most clinical trials, however, some differences have become apparent in recent studies and registry reports [28, 29]. Marshall's hypertonic-citrate solution (MHCS) is also suitable for use in the preservation of human kidneys before transplantation [30]. In experimental studies of kidney preservation, HTK and UW retained a greater capacity to preserve endothelial structure and pH buffering function during warm ischaemia in comparison to MHCS and Celsior, particularly in uncontrolled DCD donors [31]. In the absence of a cost-utility analysis, the results of the meta-analysis from the randomised controlled trials (RCTs) comparing UW with Celsior and MHCS in standard cadaver donors indicate that these cold storage solutions are equivalent [32].

For living donors in whom immediate kidney transplantation is planned, perfusion with crystalloid solution is sufficient. Kidneys coming from DCD donors, especially uncontrolled donors, are high-risk marginal organs due to prolonged warm ischaemia periods, and require specific measures to diminish the rate of non-function or DGF. More than 60% of kidney grafts currently come from Expanded Criteria Donors (ECDs) (which refers to any donor aged > 65 years and/or donor aged > 55 years with any of the following: acute renal dysfunction, stroke or arterial hypertension) [33].

Summary of evidence	LE
University of Wisconsin and HTK solutions are equally effective and are standard for multi-organ or single-kidney harvesting procedures.	1b
A meta-analysis of RCTs indicated that UW and Celsior solutions are equivalent in standard cadaver donors.	1a

Recommendations	Strength rating
Use either University of Wisconsin or histidine tryptophane ketoglutarate preservation solutions for cold storage.	Strong
Use Celsior or Marshall's solutions for cold storage if University of Wisconsin or histidine-tryptophane-ketoglutarate solutions are not available.	Strong

3.1.2.b Duration of organ preservation

Cold ischaemia time must be as short as possible. Kidneys from ECDs after brain death (DBD) and DCD donors are more sensitive to ischaemia than standard-criteria donors. Kidneys from DBD donors should ideally be transplanted within an 18 to 21 hour period. There is no significant influence on graft survival within an 18-hour CIT [32, 34, 35]. Kidneys from DCD donors should ideally be transplanted within 12 hours [36], whilst kidneys from expanded-criteria donors should ideally be transplanted within 12 to 15 hours [37, 38].

3.1.2.c Methods of kidney preservation: static and dynamic preservation

Whichever method is used, cold storage is critical. The use of cold preservation as a therapeutic window to deliver pharmacological or gene therapy treatments could, from an investigational point of view, improve both short- and long-term graft outcomes [39]. Cooling reduces the metabolic rate of biological tissue, minimising continuous cellular processes that lead to depletion of ATP and accumulation of metabolic products. Reperfusion with oxygenated blood invokes ischaemia-reperfusion injury. Hypothermic perfusion does not enable normal cellular metabolic function or prevent depletion of energy stores [40]. However, it prevents the deleterious effects of simple cooling, particularly in the setting of prolonged warm-ischaemic time in uncontrolled DCD donors.

Two meta-analyses suggest that hypothermic machine perfusion reduces DGF compared with static cold storage [41, 42]. Outcomes for primary non-function (PNF) are less clear, but one meta-analysis limited to high-quality studies suggests a reduction in PNF rates with hypothermic machine perfusion [42]. A Cochrane systematic review and meta-analysis showed that hypothermic machine perfusion (HMP) reduced the risk of DGF when compared to static cold storage (CS) for kidneys from both DCD and DBD donors [43].

The increased demand for organs has led to the increased use of 'higher risk' kidney grafts. Kidneys from DCD donors or grafts coming from ECDs are more susceptible to preservation injury and have a higher risk of unfavourable outcomes [44, 45].

Dynamic - rather than static - preservation could allow for organ optimisation, offering a platform for viability assessment, active organ repair and resuscitation. Ex situ machine perfusion and *in situ* regional perfusion in the donor are emerging as potential tools to preserve vulnerable grafts. Preclinical findings have driven clinical organ preservation research that investigates dynamic preservation, in various modes (continuous, preimplantation) and temperatures (hypothermic, sub thermic or normothermic) [40].

Several methods of kidney preservation are available, including:

- Initial flushing with cold preservation solution followed by ice storage. However, the limitations of static CS in preserving marginal organs such as ECD kidneys has led to the increased use of dynamic methods.
- Current dynamic preservation strategies entering clinical practice and the different modalities of their use are: hypothermic machine perfusion, hypothermic regional perfusion, normothermic machine perfusion, normothermic regional perfusion, sub-normothermic machine perfusion and sub-normothermic regional perfusion [40].
- Continuous pulsatile HMP appears to be an effective preservation method for marginal organs, either initially or after a period of simple CS (shipping of suboptimal kidneys) [46].
- Some evidence shows that hypothermic dynamic preservation should be controlled by pressure and not flow, using low pressures to avoid pressure-related injury. The perfusion solutions used are specific and differ qualitatively from the CS solution [29].
- Nonoxygenated HMP of the kidney at low perfusion pressures (20-30 mmHg) has been shown to reduce DGF [41]. The largest RCT comparing simple CS with HMP of deceased donor kidneys showed an overall reduced risk of DGF and a survival benefit, most pronounced in ECD kidneys [47]. Hypothermic machine perfusion of kidneys from type III DCD donors decreased DGF with no impact on graft survival [44].
- Hypothermic machine perfusion reduces the risk of DGF in standard criteria DBD donor kidneys, regardless of cold ischaemia time [48].
- Increased vascular resistance and high perfusate injury marker concentrations are risk factors for DGF. They do not, however, justify discarding the kidney. The flow perfusion value appears to be an indicator of graft viability in uncontrolled DCD donors, particularly donors with a high creatinine level [49]. However, research is required to identify a strong and reliable measure for predicting kidney viability from machine perfusion [32]. Perfusion parameters (renal flow and renal vascular resistance) have low predictive values and should not be used as the sole criterion to assess viability of kidney grafts [50].
- The effect of oxygenated HMP was investigated in an RCT initiated by the Consortium on Organ Preservation in Europe on type III DCD kidneys and ECD kidneys [40]. Graft loss was significantly lower after oxygenated HMP compared to HMP [51]. No significant differences between the two groups were shown for DGF, PNF and patient death. No difference in eGFR at one year was observed between HMPO versus HMP. However, sensitivity analysis, accounting for all-cause graft failure, showed a higher eGFR in HMPO [51].
- A short period of normothermic machine perfusion (NMP) immediately prior to implantation has been shown to improve kidney graft function, replenish ATP and reduce injury in experimental models [52, 53].
- A retrospective study of normothermic regional perfusion (NRP) in uncontrolled DCD donors concluded that NRP appears to decrease graft failure when used as a preconditioning technique with subsequent HMP preservation in these donors [54].
- Active research is being developed on preservation of prolonged warm ischaemically damaged human kidneys (types I and II DCD) by means of *in situ* normothermic extracorporeal hemoperfusion with oxygenation and leukocyte depletion before procurement [55]. Oxygen carriage is achieved by using leukocyte-depleted blood. Potential advantages of this preservation technique are reduction in ischaemia-reperfusion injury, as well as the possibility of assessing organ viability.
- Currently there is one registered ongoing RCTs on preimplantation NMP using an oxygenated, sanguineous, normothermic perfusion solution (www.isrctn.com/ISRCTN15821205). However, kidney function can be evaluated during NMP by assessing macroscopic appearance of blood perfusion, renal blood flow and urine output [56].
- Continuous subnormothermic machine perfusion and controlled oxygenated rewarming has demonstrated improved creatinine clearance and preservation of structural integrity compared with continuous oxygenated HMP in a research setting [57].

Summary of evidence	LE
A meta-analysis of RCTs comparing CS with HMP of deceased donor kidneys showed a reduced risk of DGF for HMP.	1a
Hypothermic dynamic preservation should be controlled by pressure and not flow, using low pressures to avoid pressure-related injury.	2a
Perfusion parameters (renal flow and renal vascular resistance) have low predictive values and should not be used as the sole criterion to assess viability of kidney grafts.	2b

Recommendations	Strength rating
Minimise ischaemia times.	Strong
Use hypothermic machine perfusion (where available) in deceased donor kidneys to reduce delayed graft function.	Strong
Hypothermic machine perfusion may be used in standard criteria deceased donor kidneys.	Strong
Use low pressure values in hypothermic machine perfusion preservation.	Strong
Hypothermic machine perfusion must be continuous and controlled by pressure and not flow.	Strong
Do not discard grafts based only on increased vascular resistance and high perfusate injury marker concentrations during hypothermic machine perfusion preservation.	Weak

3.1.3 Donor Kidney biopsies

Donor kidney biopsies can serve various purposes, including:

- histological assessment of organ quality prior to transplantation (often referred to as procurement or harvest biopsies);
- histological analysis of focal lesions, particularly in case of suspicion of neoplasia; and
- detection of donor-derived lesions as reference for subsequent post-transplant biopsies (often referred to as baseline, zero-time or implantation biopsies).

3.1.3.a Procurement Biopsies

3.1.3.a.1 Background and prognostic value

Procurement biopsies are used to detect tissue injury to aid in the decision of whether a deceased donor kidney is suitable for transplantation. These biopsies are most commonly performed in donors with clinical suspicion of chronic kidney injury (ECDs) [58].

Kidney discard in Europe is rarely based on histology findings [59], as procurement biopsies are not regularly performed for graft allocation in the Eurotransplant region [58]. However, because biopsy findings are the most common cause for discarding donor organs in the United States [60-63], their prognostic value has been analysed in numerous studies. A recently published systematic review of studies on donor kidney biopsies revealed a lack of prospective studies and marked heterogeneity regarding the type of lesions being assessed, their scoring, the definitions of post-transplant outcomes and the statistical methods employed [64]. Therefore, the published evidence suggests that the use of procurement biopsies for deciding on suitability for transplantation of donor kidneys may have some important limitations including the following [58, 64, 65]:

- There is no consistent association between histological lesions observed in donor kidney biopsies and post-transplant outcomes

The concept of procurement biopsies in elderly donors was introduced by a 1995 study. This study observed significantly worse outcomes in recipients of kidneys with >20% globally sclerotic glomeruli [66]. However, subsequent studies yielded highly variable results, and it cannot be concluded that glomerulosclerosis is independently associated with graft outcomes [64]. A similar variability was also observed for other potentially relevant lesions such as arterial injury, interstitial fibrosis and tubular atrophy, with each showing predictive value in some studies, but not in others [64].

- There is no agreement on prognostically relevant lesions and how they should be scored

Specific grading systems for donor kidney biopsies have not yet been developed. Lesion scoring in pretransplant biopsies is mostly based on the Banff consensus for post-transplant renal allograft pathology, which is supported by the 2007 Banff Conference report [67].

Many attempts have been made to use composite semiquantitative scoring systems to express the global extent of tissue injury in donor kidney biopsies. These scoring systems are based mostly on simple addition of the Banff scores for individual lesions - most commonly glomerulosclerosis, arteriolar hyalinosis, arterial intimal fibrosis, interstitial fibrosis and tubular atrophy - and rarely include clinical parameters such as donor age [68], serum creatinine values and donor hypertension [69].

A limited number of histological scoring systems are based on modelling analysis [68-72]. Only the Maryland Aggregate Pathology Index (MAPI) [72] scoring system and the Leuven donor risk score [68], use graft failure as their endpoint and have been independently validated in a second cohort. Other studies used surrogate clinical endpoints such as DGF [70] and estimated glomerular filtration rate (eGFR) at three months [71] to calculate

histological models. In addition, these models were not validated in independent cohorts. The variation in how the components are weighted to achieve the composite score and the various endpoints used can explain the conflicting conclusions in the literature [58, 64, 65].

- Due to the time constraints of organ allocation procurement, biopsies are mostly read on frozen sections by on-call pathologists, which might affect the diagnostic reliability of reported findings

This can have a substantial impact on the diagnostic reliability of the procedure, because frozen sections are prone to morphological artefacts that can impair the detection and scoring of potentially important lesions, such as arteriolar hyalinosis and interstitial fibrosis [73, 74]. Strong evidence is available showing that dedicated renal pathologists should examine formalin-fixed paraffin-embedded core-needle biopsies. Paraffin histology employing special stains is technically superior to frozen sections because morphological details are better preserved on paraffin sections than on frozen sections and potentially confounding artefacts can be avoided. Rapid processing of tissue for paraffin histology is technically feasible, but the respective protocols are not universally implemented and are not available on a 24/7 basis in most departments. Another source of variability is the professional experience of the pathologist in charge [75]. Procurement biopsies are commonly read by the on-call general pathologist, who often has no specific training in renal pathology. A recent study specifically addressing this issue found that the on-call pathologists tended to overestimate chronic injury in biopsies [76].

3.1.3.b Type and size of biopsy

Many transplant centres obtain wedge biopsies of donor kidneys rather than needle biopsies, due to the presumed higher risk of bleeding complications with needle biopsies. Wedge biopsies sample the cortex superficially, whereas needle biopsies reach deeper aspects of the cortex. Needle biopsies also allow sampling from different areas of the kidney. Submit 14 or 16 G needle biopsies as obtaining adequate biopsies with 18 G needles requires multiple cores [77]. Several studies comparing wedge with needle biopsies concluded that needle biopsies perform much better in the evaluation of vascular lesions, because interlobular arteries are rarely sampled in wedge biopsies. Both methods were comparable for glomerular or tubulointerstitial lesions [78-81]. Glomerulosclerosis has also been shown to be significantly more pronounced in the subcapsular zone compared with deeper areas of the cortex [82]. The problem of insufficient sampling of arteries and over-representation of (subcapsular) glomerular scars in wedge biopsies can only be avoided if particular attention is given to the correct performance of the biopsy, with a minimal depth of 5mm [83]. The predictive value of glomerulosclerosis increases significantly with higher numbers of glomeruli in the wedge biopsy, with ideally at least 25 glomeruli required for evaluation [80]. Limited evidence is available regarding complication rates in preimplantation biopsies.

For surgeons who are reluctant to take needle biopsies, the use of a skin punch biopsy device might be an attractive alternative. Skin punch biopsies measure 3mm in diameter and have a shorter length than needle biopsies, therefore avoiding injury to large-calibre arteries at the corticomedullary junction whilst still sampling tissue from deeper areas of the cortex [84].

3.1.3.c Summary of evidence and recommendations

Summary of evidence	LE
Individual histologic lesions such as glomerulosclerosis, arterial luminal narrowing or tubulointerstitial injury observed in donor kidney biopsies have limited prognostic value for long-term allograft survival.	3
Composite histological scoring systems provide a more comprehensive measure of overall organ damage. However, published scoring systems still lack independent validation and robust thresholds.	3
Size of the biopsy is of critical importance for its diagnostic value. An adequate biopsy reaches beyond the immediate subcapsular area (≥ 5 mm) and contains ≥ 25 glomeruli and \geq one artery. Needle biopsies, wedge biopsies or specimens obtained with a skin punch biopsy device will result in equally adequate biopsies if sampling is performed properly. Obtaining adequate biopsies with 18 G needles is difficult and requires multiple cores.	3

Recommendations	Strength rating
Do not base decisions on the acceptance of a donor organ on histological findings alone, since this might lead to an unnecessarily high rate of discarded grafts. Interpret histology in context with clinical parameters of donor and recipient, including perfusion parameters where available.	Strong
Use paraffin histology for histomorphology as it is superior to frozen sections; however, its diagnostic value has to be balanced against a potential delay of transplantation.	Strong
Submit 14 or 16 G needle core biopsies, wedge biopsies or skin punch biopsies for histopathology.	Weak
Procurement biopsies should be read by a renal pathologist or a general pathologist with specific training in kidney pathology.	Strong

3.1.3.d Implantation biopsies

Implantation biopsies are used to provide baseline information on donor-kidney injury for comparison with subsequent post-transplant kidney biopsies. Baseline biopsies can be essential for clear distinction between pre-existing damage and acquired lesions. Baseline biopsies are particularly valuable in cases of thrombotic microangiopathy, arteriolar hyalinosis or acute tubular injury. In contrast to procurement biopsies that are obtained at the time of organ harvesting, implantation biopsies are usually taken before implantation to cover potential effects of cold ischaemia time. Their diagnostic contribution has not been formally quantified in the literature, which might be due to the difficulties of measuring the value of implantation biopsies for improving diagnoses. Despite the lack of formal studies investigating their value, it seems very reasonable to perform implantation biopsies in deceased donor kidneys.

3.1.4 Living and deceased donor implantation surgery

3.1.4.a Anaesthetic and peri-operative aspects

Good communication between nephrologists, anaesthetists and surgeons is required for optimal anaesthetic and perioperative care of the renal transplant patient. Anaesthetic care of the living kidney donor [85] and renal transplant recipient [86] have been reviewed and recent guidelines from the European Renal Association-European Dialysis and Transplantation Association (ERA-EDTA) [87] are cross-referenced.

3.1.4.b Immediate pre-op haemodialysis

Routine use of haemodialysis immediately prior to renal transplantation is not indicated [87]. Hyperkalaemia is the most common indication for haemodialysis preoperatively. The risks of haemodialysis compared with medical therapy must be considered along with the risks of intraoperative fluid overload, electrolyte and acid-base disturbances, particularly where a deceased donor kidney is transplanted with a significant risk of DGF. Preoperative haemodialysis may initiate a pro-inflammatory state, delay surgery, increase the CIT and increase the risk of DGF [88].

Summary of evidence	LE
Preoperative haemodialysis has the potential to delay transplantation, increase CIT and increase the risk of DGF.	2

Recommendation	Strength rating
Use dialysis or conservative measures to manage fluid and electrolyte imbalance prior to transplant surgery, taking into consideration the likelihood of immediate graft function.	Weak

3.1.4.c Operating on patients taking anti-platelet and anti-coagulation agents

Many patients active on the transplant waiting list have vascular disease and/or a prothrombotic condition that should be risk-assessed prior to transplantation. Dual antiplatelet therapy is commonly given to patients with coronary artery stents for six to twelve months. Perioperative management plans for these patients should be discussed with a cardiologist so that the risks of withdrawal of the antiplatelet agent can be fully considered. Options for reversal of anticoagulation and postoperative anticoagulation should be discussed with a haematologist prior to patient listing.

Some patients will be active on a transplant waiting list whilst continuing to take antiplatelet and/or anticoagulation agents. The indication for antiplatelet or anticoagulation agents should be clearly documented for each individual. Potential increased risk of perioperative bleeding must be weighed against potential harm from arterial or venous thrombosis. In accordance with the American College of Chest Physicians and the European Society of Cardiology guidelines [89, 90], the literature suggests that continuing antiplatelet therapy with aspirin, ticlopidine or clopidogrel does not confer a significantly greater risk of peri/postoperative complications [91], however, the number of patients studied was low. If required, the effect of antiplatelet agents can be reduced with intraoperative platelet infusions.

Summary of evidence	LE
A retrospective single-centre case-control study in patients undergoing kidney transplantation concluded that continuing antiplatelet therapy with aspirin, ticlopidine or clopidogrel does not confer a significantly greater risk of peri/postoperative complications.	3

Recommendations	Strength rating
Consider continuing antiplatelet therapy in patients on the transplant waiting list.	Weak
Discuss patients who take antiplatelet and anticoagulation agents prior to transplant surgery with relevant cardiologist/haematologist/nephrologist.	Weak

3.1.4.d What measures should be taken to prevent venous thrombosis including deep vein thrombosis during and after renal transplant?

Perioperative administration of short-acting anticoagulation agents reduces perioperative risk of venous thrombosis (including in iliofemoral and renal veins). However, due to associated increased blood loss, administration requires knowledge of individual patient risk factors. None of the current major thrombosis prevention guidelines directly address thromboprophylaxis in the renal transplant perioperative period. A small RCT [92] showed no difference in early postoperative graft loss or thromboembolic complications with or without prophylactic anticoagulation. Those administered prophylactic anticoagulation had significantly lower haemoglobin, whilst those administered prophylactic unfractionated heparin had prolonged lymph drainage. Based on this study, routine pharmacological prophylaxis is not recommended in low-risk living donor recipients. Mechanical measures to decrease iliofemoral deep vein thrombosis (DVT) can be used where there is no contraindication due to peripheral vascular disease, particularly where there are concerns regarding bleeding risks with pharmacological prophylaxis.

Summary of evidence	LE
A small RCT (n = 75) showed no difference in early postoperative graft loss or thromboembolic complications with or without prophylactic anticoagulation.	1b

Recommendation	Strength rating
Do not routinely give postoperative prophylactic unfractionated or low-molecular-weight heparin to low-risk living donor transplant recipients.	Weak

3.1.4.e Is there a role for peri-operative antibiotics in renal transplantation?

Prophylactic perioperative antibiotics are generally used in renal transplant surgery, but the optimal antibiotic regimen is not known and increasing antibiotic resistance may hamper their effectiveness in this setting. A multicentre, prospective RCT showed no difference at one month in surgical site, bacterial, fungal or viral infection between those receiving a single-dose broad-spectrum antibiotic at induction of anaesthesia, compared to those receiving antibiotic 12 hourly for 3-5 days [93]. A retrospective comparison of perioperative intravenous cefazolin prophylaxis compared to no antibiotic showed no difference in infectious complications (surgical site, urinary tract, bacteraemia or central catheter-related infection) in the first month after renal transplantation [94].

Summary of evidence	LE
A multicentre prospective RCT showed that the incidents of surgical site infection and urinary tract infection were similar in those receiving a single dose broad spectrum antibiotic at induction of anaesthesia and those receiving antibiotic 12 hourly for 3-5 days.	1b

Recommendation	Strength rating
Use single-dose rather than multi-dose perioperative prophylactic antibiotics in routine renal transplant recipients.	Strong

3.1.4.f Is there a role for specific fluid regimes during renal transplantation and central venous pressure measurement in kidney transplant recipients?

Careful peri- and postoperative fluid balance is essential for optimal renal graft function. There is no evidence determining if crystalloids or colloids are better for intravenous fluid management during renal transplant surgery, however, colloids may be immunogenic. If normal saline (0.9%) is used, monitoring for metabolic acidosis is recommended in the perioperative period. A prospective double-blind RCT compared normal saline to lactated Ringer's solution as intraoperative intravenous fluid therapy. Serum creatinine at day three post-surgery did not differ between the two groups. However, Ringer's lactate caused less hyperkalaemia and metabolic acidosis than normal saline. Balanced solutions may be the optimal and safer option for intraoperative intravenous fluid therapy [95].

Central venous pressure (CVP) measurement helps anaesthetists guide fluid management. A small prospective non-blinded RCT compared two normal (0.9%) saline regimens: constant infusion (10-12mL/kg-1/h-1 from start of surgery until reperfusion) and central venous pressure-based infusion (target CVP appropriate to stage of operation) [96]. Central venous pressure directed infusion produced a more stable haemodynamic profile, better diuresis and early graft function. Directed hydration may decrease DGF rates and CVP measurement may help optimise early graft function.

Summary of evidence	LE
A small (n = 51) prospective RCT found that use of Ringer's lactate solution was associated with less hyperkalaemia and acidosis compared with normal saline in patients undergoing kidney transplantation.	1b
A small (n = 40) prospective RCT comparing constant infusion versus CVP found that CVP produced a more stable haemodynamic profile, better diuresis and early graft function.	1b

Recommendations	Strength rating
Optimise pre-, peri- and post-operative hydration to improve renal graft function.	Strong
Use balanced crystalloid solutions for intra-operative intravenous fluid therapy.	Weak
Use target-directed intra-operative hydration to decrease delayed graft function rates and optimise early graft function.	Strong

3.1.4.g Is there a role for dopaminergic drugs, furosemide or mannitol in renal transplantation?

Low-dose dopamine (LDD) has been used in renal transplantation due to a perceived improvement in urine output and early graft function. The use of LDD in kidney donors is outside the scope of this section. Conflicting results prevent a consensus statement on routine use of LDD in transplant recipients. A small (n = 20) prospective randomised cross-over study in deceased donor renal transplantation suggested significant improvements in urine output and creatinine clearance in the first nine hours post-surgery without adverse events [97]. By contrast, a retrospective comparison of LDD in the first twelve hours post-deceased donor renal transplantation showed no difference in diuresis or kidney function but those administered LDD (n = 57) had increased heart rates, longer intensive therapy unit stay and higher six-month mortality than those not treated with LDD (n = 48) [98].

Considerable variation exists in the use of diuretics during renal transplant recipient surgery and there is little evidence to suggest any benefit from their use [99]. No evidence on the use of mannitol during renal transplant recipient surgery was found during the panel's literature search. Use of mannitol in kidney donors is outside the scope of this section.

Summary of evidence	LE
A retrospective comparative study of LDD treated versus non-treated renal transplantation patients concluded that LDD administration did not improve kidney function in the first twelve hours post renal transplantation, but did result in increased heart rates, longer intensive therapy unit stay and higher six-month mortality in those receiving LDD.	2b

Recommendation	Strength rating
Do not routinely use low-dose dopaminergic agents in the early post-operative period.	Weak

3.1.5 **Surgical approaches for first, second, third and further transplants**

Transplant (bench/back-table) preparation is a crucial step in the transplantation process. The kidney must be inspected whilst on a sterile ice slush, removing perinephric fat, when possible, to permit inspection of the quality of the organ and to exclude exophytic renal tumours. Biopsy of the kidney on the back table can be performed to help in the multifactorial decision-making process regarding the quality and usage of the kidney for both single and/or dual transplantation. Suspicious parenchymal lesions also require biopsy. Section 3.1.3 discusses techniques for intraoperative kidney biopsy .

The number, quality and integrity of renal vessels and ureter(s) should be established and lymphatics at the renal hilum ligated. The quality of the intima of the donor renal artery should be evaluated. Branches of the renal artery not going to the kidney or ureter(s) should be tied.

In deceased donor kidney transplantation, the quality of the aortic patch should be determined. If severe atheroma of the patch, ostium or distal renal artery is seen, the aortic patch and/or distal renal artery can be removed to provide a better-quality donor renal artery for implantation. Section 3.1.5.1 discusses back-table reconstruction of multiple donor arteries. The length of the renal vein should be evaluated. Renal vein branches should be secured/tied.

For a deceased donor right kidney, lengthening the renal vein on the back table can be performed if required using donor inferior vena cava [100]. Techniques for lengthening a short living donor right renal vein from donor gonadal vein or recipient saphenous vein require pre-operative planning and specific consent (as discussed in Section 3.1.5.1).

The length, quality and number of the ureter(s) should be established. The peri-pelvic and proximal peri-ureteral tissue in the 'golden triangle' should be preserved.

Recommendation	Strength rating
Assess the utility (including inspection) of the kidney for transplantation before commencement of immunosuppression and induction of anaesthesia for deceased donor kidney transplantation.	Strong

3.1.5.a **Single kidney transplant - living and deceased donors**

The standard surgical approach for first or second single kidney transplant (SKT) operations remains open kidney transplant (OKT). Emerging surgical technologies using minimal access surgical approaches have been developed and the various surgical approaches (minimally invasive open, laparoscopic and robot-assisted) were compared in a systematic review [101].

In most first or second single kidney transplant (SKT) operations, an extraperitoneal approach to either iliac fossa should be used as the operative approach. No evidence is available to prefer placement of a left or right kidney into either iliac fossa [102]. Peri-iliac vessel lymphatics should be ligated to try and prevent postoperative lymphocele. Appropriate segments of iliac artery and vein should be mobilised to facilitate appropriate tension-free vascular anastomoses and the final positioning of the transplanted kidney. No evidence is available supporting the benefits of cooling the kidney surface during implantation [103].

Recommendations	Strength rating
Choose either iliac fossa for placement of a first or second single-kidney transplant.	Weak
Ligate peri-iliac vessel lymphatics (lymphostasis) to reduce postoperative lymphocele.	Weak

A variety of techniques have been described to help with the anastomosis of a short renal vein, which is most common with a right kidney, particularly from a living donor. To achieve equivalent outcomes with right kidneys, appropriate surgical technical manoeuvres may be required to optimise right kidney implantation.

Several studies suggest marginally worse outcomes with use of the right compared to left kidney. Two large registry studies demonstrate a slightly higher risk of early graft failure using right compared to left kidneys from living donors [104-106]. A registry study of 2,450 paired kidneys, donated after cardiac death, observed with right kidneys: more early surgical complications; an increased risk in DGF (Odds Ratio [OD] 1.46); and inferior one year graft survival (OD 1.62), but not at subsequent time points [105]. However, surgical techniques used to compensate for a right kidney, anastomosis time and surgeon experience were not recorded. A recent registry study of 87,112 deceased-donor kidney recipient pairs reported a modest increase in DGF (adjusted OD 1.15) and all-cause graft failure (adjusted hazard ratio 1.07), within the first six months, associated with use of the right kidney, but there was no association with recipient mortality [107]. Furthermore, data from cohort studies [101, 103] and one registry study [104] suggest equivalent outcomes with either left or right deceased donor kidneys. Meta-analysis of data from one RCT and fourteen cohort studies suggested equivalent graft outcomes [108]. Overall, these findings do not support declining an organ for kidney transplantation based on laterality of the kidney offered.

Techniques to manage a short renal vein can be addressed in the donor and/or recipient. Ligation of an internal iliac veins/veins may be necessary to elevate the iliac vein and avoid tension on the renal vein anastomosis [102]. Transposition of the iliac artery and vein may enhance the position for the venous anastomosis [109]. The right renal vein may be lengthened. With deceased donor kidneys, lengthening of the renal vein is usually done using donor inferior vena cava (IVC) [110]. In living donors, lengthening of the renal vein can be achieved using donor gonadal vein retrieved at donor nephrectomy [111] or with recipient saphenous vein [112], although both require specific consent and in general the other aforementioned techniques are preferred.

Summary of evidence	LE
Prospective cohort studies demonstrated that: <ul style="list-style-type: none"> transposition of the recipient iliac vein is an appropriate technical solution to compensate for the short length of the renal vein in right kidney LDN (n = 43); the living donor right kidney renal vein can be successfully lengthened using donor gonadal vein (n = 17) or recipient saphenous vein (n = 19). 	3

Recommendation	Strength rating
Assess the length of the donor renal vein and if it is short consider one of a variety of surgical techniques to optimise the venous anastomosis.	Weak

A history suggesting previous iliac or femoral vein thrombosis should initiate pre-operative imaging to establish patency of one iliac vein and the IVC. An intra-operative finding of an unexpected iliac vein and/or vena cava thrombosis may lead to abandonment of implantation. With pre-operative planning, native renal (orthotopic) or superior mesenteric vein or gonadal vein collaterals can be used.

The external or common iliac arteries are equally good for arterial anastomosis. The internal iliac artery is more often affected by atherosclerosis than the external or common iliac arteries. End-to-side anastomosis of donor renal artery to recipient external and/or common iliac artery is recommended in general over an end-to-end anastomosis to the internal iliac artery. The only RCT comparing these techniques suggests no difference [113]. However, the study was limited by small numbers and a high (8%) overall renal artery thrombosis rate.

The sites of the vascular anastomosis should be chosen carefully according to the length of the renal artery and vein to avoid kinking of the vessels when the kidney is placed into its final location, usually in the iliac fossa. The site of the arterial anastomosis should avoid atheromatous plaques in the iliac artery to decrease the risk of iliac artery dissection. The intima of the donor and recipient arteries should be checked prior to commencing the arterial anastomosis to ensure that there is no intimal rupture/flap. If this is found, it must be repaired prior to, or as part of, the arterial anastomosis.

A Carrel patch is usually maintained on a deceased donor renal artery, although the patch can be removed if there is severe ostial atheroma/stenosis (with good quality proximal renal artery) or if the length of the renal artery is too long for the appropriate implantation site on the iliac artery (which is more common with the right renal artery).

Multiple renal arteries supplying a deceased donor kidney can be maintained on a Carrel patch (of appropriate length) and implanted as a single anastomosis. In living-donor transplantation, multiple renal arteries require a variety of strategies to achieve optimum re-perfusion [99]. Two arteries can be implanted separately or, to achieve a single anastomosis:

- a very small second artery (particularly if supplying the upper pole) can be sacrificed;
- the two arteries can be joined together (as a trouser graft); or
- the smaller artery can be anastomosed onto the side of the main artery (end-to-side anastomoses).

A lower polar artery can be revascularised by means of anastomosis to the inferior epigastric artery [114]. In living donor transplantation in which three or more donor arteries exist, consideration should be given to alternate kidney donors. In circumstances using a living-donor kidney with three or more donor arteries, strategies include a combination of the above techniques or, after obtaining appropriate consent, use an explanted (recipient's own) internal iliac artery graft [115] or saphenous vein graft [116].

In cases in which an iliac artery prosthetic replacement has been carried out previously due to severe symptomatic iliac atheroma, the renal artery should be implanted into the prosthesis. Administration of systemic heparin should be considered prior to clamping of a vascular prosthesis [117].

A variety of sutures and suturing techniques for the vascular anastomosis are described, but in general practice, a 5/0 and 6/0 non-absorbable monofilament polypropylene suture(s) are used for the renal vein and renal artery anastomosis. Nevertheless, no evidence is available to recommend one suturing technique over another to prevent, for example, transplant artery stenosis. The use of an expanded polytetrafluoroethylene suture compared to standard polypropylene suture may reduce blood loss due to a better needle/thread ratio [118].

In third or further transplants, the surgical approach must be planned preoperatively so that appropriate arterial inflow and venous outflow exists with adequate space to implant the new kidney [119, 120]. Nephrectomy of an old transplant kidney may be required prior to transplantation or at the time of transplantation [119]. Mobilisation of the common or internal iliac artery, internal iliac vein or IVC may be required. An intraperitoneal approach (via the iliac fossa or midline) may be required [121]. Orthotopic transplantation is rarely needed [119, 122].

Evidence suggests that minimising the anastomosis time and/or rewarming time results in reduced DGF [123]. The effect on long-term graft function is uncertain but may also be impacted by short anastomosis time [124].

Summary of evidence	LE
A small RCT (n = 38) comparing end-to-end anastomosis to the internal iliac artery versus end-to-side anastomosis to the external iliac artery found that both techniques showed similar results in the postoperative period and at three-years follow-up.	1b
Cohort studies have demonstrated that third or further transplants are a valid therapeutic option with reasonable short- and long-term patient and graft survival.	3

Recommendations	Strength rating
Use the external or common iliac arteries for an end-to-side arterial anastomosis to donor renal artery.	Weak
Use an end-to-end anastomosis to the internal iliac artery as an alternative to external or common iliac arteries.	Weak
Check the intima of the donor and recipient arteries prior to commencing the arterial anastomosis to ensure that there is no intimal rupture/flap. If this is found, it must be repaired prior to/as part of the arterial anastomosis.	Strong
Preoperatively plan the surgical approach in third or further transplants to ensure that appropriate arterial inflow and venous outflow exists with adequate space to implant the new kidney.	Strong

3.1.5.b Robot-assisted kidney transplant surgery

Robot-assisted kidney transplant (RAKT) surgery using living donor kidneys has now been evaluated in multicentre prospective non-randomised studies (using IDEAL consortium principles) [125]. Single-centre prospective non-randomised studies are ongoing, addressing RAKT using deceased donor kidneys. Both transperitoneal and extra-peritoneal approaches for RAKT are described. Potential advantages of RAKT may exist (decreased postoperative pain, incision length and lymphocele rate). Potential issues with RAKT are the exclusion of recipients with severe atherosclerosis or third (or further) kidney transplants, a higher than expected rate of DGF and a small number of reported early arterial thromboses despite carefully selected cases [126]. The learning curve for RAKT has been reported to be 35 cases for experienced surgeons in a retrospective multicentre series of 187 patients undergoing RAKT [127]. Complication and DGF rates decreased significantly and plateaued after the first 20 cases. The rate of Clavien-Dindo grade III/IV complications was 14% during the first ten RAKTs, but only 3% after this [127]. The rate of arterial graft thrombosis (1.6%) was comparable with that for open kidney transplant (0.5-3.5%) [127]. A ten-year single-centre retrospective analysis of 239 obese RAKT patients concluded that RAKT can be safely performed in obese patients with minimal risk of developing a surgical site infection [128]. A graft failure rate of 7.1% was reported during follow-up, mainly due to acute rejection. Patient and graft survival was 95% and 93% at three years, respectively [128]. Evidence is too premature to recommend RAKT outside of appropriately mentored prospective studies.

3.1.5.c Dual kidney transplants

Dual kidney transplant (DKT) is performed when the quality of a single deceased-donor kidney is thought to be insufficient for appropriate long-term graft function and that the outcome with both kidneys would be better. A variety of surgical techniques have been described to implant the pair of donor kidneys [129]. These include unilateral extra-peritoneal (UEP) or intraperitoneal (UIP) and bilateral extra-peritoneal (BEP) or intraperitoneal (BIP) that can be performed by means of a midline [130] or two lateral incisions.

The aim of a unilateral approach is to leave the contralateral iliac fossa intact for future transplantation in the event of graft loss and to reduce CIT for the second kidney transplant [131]. The unilateral approach may require mobilisation and division of the internal iliac vein to facilitate the two renal veins to iliac vein anastomoses. Modifications of the unilateral technique include single renal artery and vein anastomoses (with bench reconstruction) to further reduce CIT for the second kidney [132-134]. Dual kidney transplant takes longer and has higher blood loss than SKT, regardless of the technique used. Data suggest shorter operative time and hospital stay with UEP compared to BEP [135], but other data suggest similar outcomes from all DKT techniques. No RCT exists to recommend one technique for all patients or situations.

En-bloc retrieval is performed when kidneys are retrieved from children weighing < 15kg.

Depending on the size of the donor kidney and size and weight of the adult recipient(s), *en-bloc* transplantation of the two kidneys may be performed or, if appropriate, the aorta and IVC patch can be divided for SKT [136].

3.1.5.d Ureteric implantation in normal urinary tract

Ureteric anastomotic techniques described for renal transplant recipients with no underlying urological abnormality include extravesical (Lich-Gregoir) or intravesical (Leadbetter-Politano) ureteroneocystostomy and ureteroureterostomy using native ureter. A meta-analysis [137] of two RCTs and 24 observational studies favoured the extravesical Lich-Gregoir technique to an intravesical approach leading to reduced overall complications (specifically urine leak, stricture and post-operative haematuria). Fewer urinary tract infections (UTIs) were observed with the extravesical approach when compared with the intra-vesical technique in one RCT [138]. Pyelo- or uretero-ureterostomy to the ipsilateral native ureter has been described as a primary technique in recipients with non-refluxing native ureters [139]. A meta-analysis suggested ureteric stricture, obstruction, and stone formation were more common after uretero-ureterostomy whereas vesicoureteral reflux and UTIs were more common after uretero-neo-cystostomy [140].

The donor ureter should be kept as short as possible with periureteric fat preserved to ensure adequate ureteric blood supply. The location on the bladder to position an extravesical anastomosis was shown in one small RCT to be advantageous at the posterior bladder rather than anterior position to facilitate future endoscopic manipulation if required, and reported less hydronephrosis post stent removal [141]. In cases in which the donor ureter has been damaged at retrieval then pyelo-native ureterostomy or pyelo-neo cystostomy can be performed. Monofilament absorbable sutures should be used for the urinary anastomosis to prevent stone formation around the suture material [142].

Summary of evidence	LE
A meta-analysis of two RCTs and 24 observational studies favoured the extravesical Lich-Gregoir technique for reduced overall complications.	1a
A multicentre prospective comparison study found the incidence of overall complications was similar for pyelo- and uretero-ureteral anastomosis and that for both procedures no graft was lost due to urological complications.	2b

Recommendations	Strength rating
Perform Lich-Gregoir-like extravesical ureteric anastomosis technique to minimise urinary tract complications in renal transplant recipients with normal urological anatomy.	Strong
Pyelo/uretero-ureteral anastomosis is an alternative especially for a very short or poorly vascularised transplant ureter.	Strong

Transplant ureteric anastomosis can be performed with or without a ureteric stent. If a stent is placed, a second procedure is generally required for removal. A Cochrane review [143] concluded that stents are recommended to reduce major urological complications, particularly urinary leak. The optimal timing for stent removal has yet to be defined [144]. A meta-analysis of five RCTs including 568 kidney transplantation patients showed a significant reduction in UTIs for early (≤ 7 days) versus late removal (≥ 14 days) [145]. No significant differences were observed between the two groups in relation to postoperative complications, such as ureteral stricture, ureteral obstruction and ureteral leakage [145]. A second meta-analysis including 3,612 patients also reported a significant reduction in UTIs with early stent removal (< 3 weeks) versus late removal (> 3 weeks) [146]. No significant differences were observed between the two groups regarding the incidents of ureteral stenosis and ureteral leakage [146].

Most commonly, stents are removed with local anaesthetic flexible cystoscopy unless there is a need to combine with another procedure warranting general anaesthetic. Various techniques to reduce the morbidity of a second procedure involve tying the stent to the catheter or use of percutaneous stents [147].

Recommendation	Strength rating
Use transplant ureteric stents prophylactically to prevent major urinary complications.	Strong

Duplex ureters are not infrequently identified at organ retrieval/kidney benching or during work-up for LDN [148, 149]. Duplex ureters can be anastomosed together and then joined to the bladder as one unit (double pant) or kept as two separate anastomoses. This also applies to the two single ureters in DKT in adults or with en-bloc transplantation from paediatric donors. The arguments for two separate ureteric anastomoses to the bladder are that an already tenuous blood supply may be further compromised with added suturing and handling, and if there is an issue with one ureter, the other should remain unaffected. The advantages to forming one single (two ureter) anastomosis to the bladder are that only one cystotomy is needed, which may be faster, and complications may be reduced. There is a lack of high-quality evidence relating to duplex ureters.

Recommendation	Strength rating
Use the same surgical principals for single ureters to manage duplex ureters and anastomose them either separately or combined.	Strong

3.1.5.e Transplantation/ureteric implantation in abnormal urogenital tract

The following points should be considered when performing kidney transplantation in the abnormal urogenital tract:

- In patients with an ileal conduit, a kidney transplant can be placed upside down to align the ureter to the conduit and avoid a redundant ureter [150].
- The technique used to implant transplant ureter(s) into an ileal conduit is the same as the method used with native ureter(s) (Bricker, Wallace).
- In bladder augmentation or continent pouches, ureters should be implanted using a tunnel technique or extravesically (Lich-Gregoir). The latter is favoured in most patients.
- In patients with a Mitrofanoff catheterisable stoma or continent ileocaecal pouch with catheterisable stoma, consideration should be given to the positioning of the catheterisable stoma (umbilical or iliac fossa - usually right side) with clear communication with the transplant surgeons so that the position of any future transplant kidney is not compromised. If an intraperitoneal placement of a future kidney

transplant is likely, placement of a Mitrofanoff exiting in the iliac fossa is preferable at the umbilicus. If a future kidney transplant is likely in the right iliac fossa, placement of a Mitrofanoff exiting at the umbilicus or left iliac fossa may be preferable.

3.1.6 Donor complications

Living-donor nephrectomy, like any other intervention, is potentially associated with complications and mortality. However, the fact that the operation is performed on a healthy individual amplifies the relevance of any complications. Potential complications should be included in the process of informed consent.

Reported surgical mortality is 0.01% to 0.03% with no apparent alteration due to changes in surgical techniques or donor selection in recent years [151, 152]. According to a systematic review (190 studies) and meta-analysis (41 studies) on complications in minimally invasive LDN, reporting on a total of 32,308 LDNs, intraoperative complications occur in 2.2% (the most common being bleeding in 1.5% and injury to other organs in 0.8%) and postoperative complications occur in 7% (infectious complications in 2.6% and bleeding in 1%) [151]. Conversion to open surgery was reported in 1.1%, half due to bleeding and half due to injury to other organs. Surgical re-interventions occurred in 0.6%; the majority due to bleeding or to evacuate a haematoma [151]. A low trigger for conversion or re-operation should be observed to minimise the risk of serious complications.

A review looked for complications in 14,964 LDNs performed in the United States from 2008 to 2012 and found an overall perioperative complication rate of 16.8%, gastrointestinal (4.4%), bleeding (3.0%), respiratory (2.5%), surgical/anaesthesia-related injuries (2.4%), and 'other' complications (6.6%). Among the sample, 2.4% required intensive care and in-hospital mortality was 0.007% [12].

Major Clavien Classification of Surgical Complications grade IV or higher affected 2.5% of donors. Risk factors for Clavien grade IV or higher events included obesity (adjusted odds ratio [aOR] 1.55, $p = 0.0005$), pre-donation haematologic (aOR 2.78, $p = 0.0002$), psychiatric conditions (aOR 1.45, $p = 0.04$) and robotic nephrectomy (aOR 2.07, $p = 0.002$). An annual centre volume > 50 (aOR 0.55, $p < 0.0001$) was associated with lower risk [12].

3.1.6.a Long-term complications

Long-term complications are mostly related to the single-kidney condition. Renal function in living donors decreases after donation before improving for many years. However, in the long run, it shows signs of slight deterioration [153-155]. There is a steady increase in the incidence of proteinuria; hypertension post-transplant having been shown as the main cause of increased albumin excretion [156]. A meta-analysis found that obesity (BMI > 30) is associated with a significantly lower eGFR and higher blood pressure and proteinuria one year after donation [157]. A study looking at the Norwegian Living Kidney Donor Registry found an increased long-term risk of ischaemic heart disease in live kidney donors when compared with a healthy control group eligible to be donors [158].

The overall incidence of end-stage renal disease (ESRD) (0.4-1.1%) does not differ from the general population [153, 154, 159, 160]. According to a recent large retrospective study, the majority of ESRD developing after living kidney donation is due to new-onset disease that would have affected both kidneys [161]. However, there are some identified risk factors for deterioration of renal function after donation. According to a study that evaluated 119,769 live kidney donors in the United States, obese (BMI > 30) living kidney donors have a 1.9-fold higher risk for ESRD compared to their non-obese counterparts [162]. Long-term risk of death is no higher than for an age- and comorbidity-matched population [152, 159].

Health related quality of life (HRQoL), including mental condition, remains on average better than the general population after donation [159, 160, 163]. However, some donors experience significant deterioration in their perceived QoL [163]. While global HRQoL is comparable or superior to population normative data, some factors identifiable around time of donation including longer recovery, financial stressors, younger age, higher BMI, lower education, smoking and higher expectations prior to donation, may identify donors more likely to develop poor HRQoL, providing an opportunity for intervention [159, 160, 163]. It is of paramount importance that a careful risk-benefit assessment be carried out and that proper information be given to the prospective donor. This should also include recommendations on health-promoting behaviour post-donation [164].

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Summary of evidence	LE
A systematic review and meta-analysis of complications in minimally invasive LDN concluded that the techniques used for minimally invasive LDN are safe and associated with low complication rates.	1a
Survival rates and risk of end-stage renal disease are similar to those in the general population, whilst donor HRQoL remains on average better than the general population.	2b

Recommendations	Strength rating
Restrict living-donor nephrectomy to specialised centres.	Strong
Offer long-term follow-up to all living kidney donors.	Strong

3.1.7 Recipient complications

3.1.7.a General complications

Surgical complications during and after kidney transplantation may expose the recipient to an increased risk of morbidity and mortality. The incidence and management of such complications is therefore of primary importance [137, 144, 165-177]. In this section, we describe in detail the most common surgical complications in renal transplantation.

3.1.7.b Haemorrhage

Haematomas are usually a minor complication in renal transplantation. Their incidence is reported to be between 0.2-25% [178, 179]. Small and asymptomatic haematomas do not usually require any intervention. In case of larger haematomas, clinical signs and symptoms due to external pressure with graft dysfunction and/or thrombotic graft vessel complications can be present. These cases can be treated with percutaneous drainage under computed tomography (CT) or ultrasound (US) guidance or may require surgical treatment [178].

3.1.7.c Arterial thrombosis

Transplant renal artery thrombosis is a rare complication with a prevalence ranging of 0.5-3.5% [180]. Usually, it is a consequence of a technical error during the anastomosis although other causes may be related to both the donor and recipient's artery condition (i.e. atherosclerosis), intimal rupture during kidney harvesting, acute rejection episodes, external compression by haematoma or lymphocele, hypercoagulable state, severe hypotension, and toxicity of immunosuppressive agents (cyclosporine or sirolimus) [181]. The clinical manifestations are acute reduction of urine output and the elevation of renal function tests, often resulting in graft loss [178]. The diagnosis is obtained with eco-colour-doppler [178]. Surgical exploration is usually recommended to evaluate the status of the graft. In the rare event the graft appears salvageable, a thrombectomy must be performed. In this situation, the iliac artery is clamped and an arteriotomy versus a dissection of the vascular anastomosis must be performed to remove the clot. The graft can be flushed in-situ and re-vascularised [178]. Unfortunately, in the majority of the situations, the graft is not perfused and therefore an allograft nephrectomy must be performed [178, 182]. Alternatively, thrombolytic agent administration through a catheter directly into the transplant renal artery can be an efficient treatment, after the first ten to fourteen post-transplantation days [178].

Summary of evidence	LE
The diagnosis of renal artery thrombosis depends on eco-colour-Doppler followed by surgical exploration to assess the status of the graft.	2b
Thrombectomy in case of a viable graft and allograft nephrectomy in case of a non-viable graft are the treatment options for renal artery thrombosis.	2b

Recommendations	Strength rating
Perform ultrasound-colour-Doppler in case of suspected graft thrombosis.	Strong
Perform surgical exploration in case of ultrasound finding of poor graft perfusion.	Strong
Perform a surgical thrombectomy in case of a salvageable graft if arterial thrombosis is confirmed intraoperatively.	Weak
Perform an allograft nephrectomy in case of a non-viable graft.	Strong

3.1.7.d Venous thrombosis

Transplant renal vein thrombosis is an early complication (prevalence 0.5-4%) and one of the most important causes of graft loss during the first postoperative month [183]. The aetiology includes technical errors and/or difficulties during surgery [178] and the hypercoagulable state of the recipient [184, 185]. Colour flow Doppler ultrasonography shows absence of venous flow with an abnormal arterial signal (usually a plateau-like reversed diastolic flow). Moreover, it is common to see an enlargement of the graft due to venous congestion [186]. Surgical exploration is usually recommended despite the fact that the majority of cases will result in graft loss. In those cases in which the venous thrombosis has not resulted in kidney loss at surgical exploration, a venotomy can be performed with surgical thrombectomy after clamping the iliac vein. Alternatively, an explantation and subsequent reimplantation can be considered [178]. Thrombolytic agents can also be used, however, their results have not been satisfactory [178, 187, 188].

Summary of evidence	LE
The diagnosis of renal vein thrombosis depends on colour flow Doppler ultrasonography followed by surgical exploration to assess the status of the graft.	2b
Thrombectomy in case of a viable graft and allograft nephrectomy in case a non-viable graft are the treatment options for renal vein thrombosis.	2b

Recommendations	Strength rating
Perform ultrasound-colour-Doppler in case of suspected graft thrombosis.	Strong
Perform surgical exploration in case of ultrasound finding of poor graft perfusion.	Weak
If venous thrombosis is confirmed intraoperatively, perform a surgical thrombectomy in case of a salvageable graft or an allograft nephrectomy in case of a non-viable graft.	Weak
Do not routinely use pharmacologic prophylaxis to prevent transplant renal vein thrombosis.	Strong

3.1.7.e Transplant renal artery stenosis

The incidence of transplant renal artery stenosis is 1-25% [189, 190]. Risk factors include small calibre and atherosclerosis of the donor artery, trauma to donor artery at procurement, absence of arterial patch, suturing technique (interrupted vs. continuous), and damage to the iliac artery during transplantation [191, 192]. The incidence of transplant renal artery stenosis is more common at the site of the anastomosis [191, 192]. It can be suspected in case of arterial hypertension refractory to medical treatment and/or an increase in serum creatinine without hydronephrosis or urinary infection (30). The diagnosis is performed by using colour Doppler ultrasound, showing a peak systolic velocity (PSV) of >200 cm/s in the graft renal artery [191]. In cases of doubt, a magnetic resonance angiogram or a CT angiogram can be performed [193]. It is important to determine whether the stenosis is haemodynamically significant. Usually, a stenosis of over 50% is considered a risk for kidney impairment [194]. In case of mild stenosis (< 50%) and absence of symptoms with no deterioration of the allograft, the management is normally conservative, although, a strict follow-up with colour Doppler ultrasound and clinical parameters must be adopted due to the possible risk of graft failure [191]. In cases of clinically significant stenosis and/or > 50% on colour Doppler ultrasound, a confirmatory angiogram should be performed. If confirmed and if a decision to treat is taken, treatments include percutaneous transluminal angioplasty/stent or surgical intervention. Interventional radiology is typically the first choice, although patients considered

unsuitable for radiological angioplasty due to recent transplant, multiple, long and narrow stenosis, or after failure of angioplasty may benefit from surgical treatment [191, 192].

Summary of evidence	LE
Suspect transplant renal artery stenosis in case of refractory arterial hypertension and/or increasing serum creatinine without hydronephrosis/infections.	3
The diagnosis for transplant renal artery stenosis is by colour Doppler ultrasound, showing a peak systolic velocity (PSV) of > 200 cm/s in the graft renal artery.	2a
Interventional radiology is the first-line treatment option for transplant renal artery stenosis. However, in patients considered unsuitable for radiological angioplasty, surgical treatment can be considered.	3

Recommendations	Strength rating
Perform ultrasound-colour-Doppler to diagnose an arterial stenosis, in case of undetermined results on ultrasound consider a magnetic resonance or computed tomography angiogram.	Strong
Perform percutaneous transluminal angioplasty/stent, if feasible, as first-line treatment for an arterial stenosis.	Strong
Offer surgical treatment in case of recent transplant, multiple, long and narrow stenosis, or after failure of angioplasty.	Strong

3.1.7.f Arteriovenous fistulae and pseudo-aneurysms after renal biopsy

Percutaneous biopsy may result in arteriovenous (AV) fistulae and/or intrarenal pseudoaneurysms in 1-18% of cases [195]. The aetiology of the AV fistula is related to the simultaneous injury of adjacent arterial and venous branches. A pseudoaneurysm occurs when only the arterial branch is damaged. Both conditions are diagnosed with colour Doppler ultrasound [178]. The majority of AV fistulae are asymptomatic, resolving in one to two years spontaneously, whilst approximately 30% of them persist and become symptomatic. Typically, the symptoms of AV fistulae are hypertension, haematuria and graft dysfunction due to shunting between arterial and venous vessels. There is an increased risk of spontaneous rupture in case of enlarging pseudoaneurysms. For both AV fistulae and pseudoaneurysm, angiographic selective or super-selective embolisation represents the treatment of choice [196]. Partial or radical allograft nephrectomy is currently considered the last option [178].

Recommendations	Strength rating
Perform a ultrasound-colour-Doppler if a arteriovenous fistulae or pseudoaneurysm is suspected.	Strong
Perform angiographic embolisation as first-line treatment in symptomatic cases of arteriovenous fistulae or pseudoaneurysm.	Strong

3.1.7.g Lymphocele

Lymphocele is a relatively common (1-26%) complication [197]. There is a significant aetiological association with diabetes, mammalian target of rapamycin (mTOR) inhibitors (i.e. sirolimus) therapy, and acute rejection [198]. For large and symptomatic lymphocele, laparoscopic fenestration is associated with the lowest overall recurrence (8%) and complication (14%) rate compared to open surgery and aspiration therapy [199]. Placement of a percutaneous drain (i.e. pigtail) is an option with a success rate as high as 50% [163]. Percutaneous aspiration can be performed, although the recurrence rate can be as high as 95% [199] with an increased risk of local infection (6-17%) [199]. Furthermore, sclerosant agents such as ethanol, fibrin sealant, gentamicin or octreotide reduce the recurrence rate compared to simple aspiration [199, 200].

Recommendations	Strength rating
Perform percutaneous drainage placement as the first treatment for large and symptomatic lymphocele.	Strong
Perform fenestration when percutaneous treatments fail.	Strong

3.1.7.h Urinary leak

Urinary leakage occurs in 0-9.3% of cases [201]. Anastomotic urine leaks can be ureteral or vesical [202]. Ureteral necrosis and/or suture failure are the most important causes [203, 204]. Non-technical risk factors include recipient age, number of renal arteries, site of arterial anastomosis, occurrence of acute rejection episodes, bladder problems, and immunosuppressive regimen [205]. Urinary leak can be suspected based on the urine output and the creatinine level in the drain fluid [203]. To decrease the risk of ureteral necrosis, it is important to preserve vascularisation of the distal ureter [203]. Furthermore, the routine use of a JJ stent is recommended [204, 206]. The management of urinary leak depends on the location (renal pelvis, proximal or distal ureter or bladder), the time of appearance and the volume of the leak. For early and low-volume urine leaks, the treatment may be conservative (i.e. urethral catheter, percutaneous nephrostomy or JJ stent) [207]. In case of failure of the conservative management or massive leak, surgical repair must be undertaken. Ureteral reimplantation directly to the bladder or to the native ureter provide similar results [140, 207].

Summary of evidence	LE
Suspect urinary leakage based on the urine output and the creatinine level in the drain fluid.	3
For early and low-volume urine leaks, conservative management can be considered.	3
Surgical repair should be undertaken when conservative management fails, or massive urine leak occurs.	2b

Recommendations	Strength rating
Manage urine leak by JJ stent and bladder catheter and/or percutaneous nephrostomy tube.	Strong
Perform surgical repair in cases of failure of conservative management.	Strong

3.1.7.i Ureteral stenosis

Ureteral stenosis is a common complication in recipients, with an incidence of 0.6-10.5% [208]. Early stenosis (within three months of surgery) is usually the result of surgical technique or compromised ureteral blood supply during surgery. Late stenosis (after > six months) is provoked by infection, fibrosis, progressive vascular disease and/or rejection [203, 209]. Clinically significant ureteral stricture should be considered when persistent hydronephrosis on ultrasound occurs in association with impaired renal function. The first approach in the management of stricture is the placement of a percutaneous nephrostomy tube with an antegrade pyelogram [208]. The following treatment options depend mainly on the timing, recoverable kidney function, anatomy of the stricture, patient body habitus/comorbidities, and surgeon preference.

Strictures < 3cm in length can be treated endoscopically either with percutaneous balloon dilation or antegrade flexible ureteroscopy and holmium laser incision. In this scenario, the success rate approaches 50%, although maximum success is obtained for strictures < 1cm [210-212]. In case of a recurrence after a primary endourological approach and/or stricture > 3cm in length, surgical reconstruction should be performed [209], including direct ureteral reimplantation, pyelovesical reimplantation (with or without psoas hitch and/or Boari flap) or in cases with a normal native ureter, ureteroureterostomy [213, 214]. Long-term graft and patient survival are not significantly affected [215].

Summary of evidence	LE
Clinically significant ureteral stricture should be considered when persistent hydro-nephrosis on ultrasound occurs in association with impaired renal function.	3
The first approach in the management of a stricture is the placement of a percutaneous nephrostomy tube with an antegrade pyelogram.	2b
Strictures < 3cm in length can be treated endoscopically.	3
For strictures > 3cm in length, or those that have reoccurred following a primary endourological approach surgical reconstruction should be performed.	2b

Recommendations	Strength rating
In case of ureteral stricture, place a nephrostomy tube for both kidney decompression and stricture diagnosis via an antegrade pyelogram.	Strong
Manage strictures < 3cm in length either with surgical reconstruction or endoscopically (percutaneous balloon dilation or antegrade flexible ureteroscopy and holmium laser incision).	Strong
Treat late stricture recurrence and/or stricture > 3cm in length with surgical reconstruction in appropriate recipients.	Strong

3.1.7.j Haematuria

The incidence of haematuria ranges from 1-34% [201]. According to the literature, the Lich-Gregoire technique provides the lowest incidence of haematuria. Moreover, meticulous haemostasis during reimplantation results in minimal bleeding [137, 201, 202]. Bladder irrigation is the first-line treatment. Some cases require cystoscopy with evacuation of clots and/or fulguration of bleeding sites [201].

3.1.7.k Reflux and acute pyelonephritis

The frequency of vesicoureteral reflux is 1-86% [201, 216]. Acute graft pyelonephritis occurs in 13% of graft recipients. Patients with lower tract urinary infections and cytomegalovirus (CMV) infection present a higher risk of acute graft pyelonephritis [217]. Endoscopic injection of dextranomer/hyaluronic acid copolymer may be the first approach for treatment of vesicoureteral reflux associated with acute pyelonephritis, with a success rate ranging from 57.9% after the first injection to 78.9% after the second injection [218]. Ureteral re-implantation or pyelo-ureterostomy with the native ureter is a viable second treatment option [213].

Recommendation	Strength rating
Use an endoscopic approach as first-line treatment for symptomatic reflux.	Weak

3.1.7.l Kidney stones

Urolithiasis occurs in 0.2-1.7% of recipients [219, 220]. The most frequent causes are hyper filtration, renal tubular acidosis, recurrent UTIs, hypocitraturia, hyperuricaemia, hyperuricemia, excessive alkaline urine, persistent tertiary hyperparathyroidism and ureteral strictures [221, 222]. Another risk factor can be urinary anastomosis, with the lowest stone rate using Lich-Gregoir technique [220]. The most frequent clinical signs are fever, increased serum creatinine level, decreased urine output, and haematuria. Pain is usually not referred to due to impaired innervation. A US examination usually provides the diagnosis, although a CT of the kidneys, ureters and bladder may be required to confirm the location and size of the stone [221]. The management depends on the location and size of the stone and the presence of obstruction. In case of obstructive stones, first-line treatment includes placement of a nephrostomy tube, or in some occasions a JJ stent [223]. Extracorporeal shock wave lithotripsy (ESWL) is usually considered the first approach for stones < 15mm with stone-free rates varying between 40 and 80%, depending on the location of the stone [223]. Ureteroscopy, including antegrade and retrograde approaches, can be considered for stones < 20mm, with a success rate of up to 67% [139, 220, 224]. For larger stones (> 20mm), percutaneous nephrolithotomy (PNL) can be offered with high overall effective stone-free rates. In cases of large impacted stones, uretero-ureteral anastomosis, pyelo-ureteral anastomosis or ureterovesical reimplantation may provide excellent results for both stone and ureteral obstruction [220].

Summary of evidence	LE
Extracorporeal shockwave lithotripsy should be considered as the first-line treatment option for stones < 15mm.	2b
Antegrade/retrograde ureteroscopy and percutaneous nephrolithotomy may be considered as treatment options, as they provide high stone-free rates.	2b
For larger stones (> 20mm), PNL can be offered with a high overall effective stone-free rate.	2b

Recommendations	Strength rating
Evaluate the causes of urolithiasis in the recipient.	Strong
Treat ureteral obstruction due to a stone with a percutaneous nephrostomy tube or JJ stent placement.	Strong
Perform shockwave lithotripsy or antegrade/retrograde ureteroscopy for stones < 15mm.	Strong
Perform percutaneous nephrolithotomy for stones > 20mm.	Weak

3.1.7.m Wound infection

Wound infections occur in approximately 4% of cases. Risk factors include recipients > 60 years, high BMI, anaemia, hypoalbuminaemia and long surgical times (>200min) [225]. Bacteria commonly involved are *Enterobacteriaceae*, *Staphylococcus aureus* and *Pseudomonas* [213]. The following can decrease wound complication rates [225]:

- subcutaneous sutures;
- predialysis transplantation;
- sealing or ligation of lymphatic trunks;
- prophylactic fenestration;
- reducing corticosteroid load;
- avoiding sirolimus/everolimus therapy.

3.1.7.n Incisional hernia

Incisional hernia occurs in approximately 4% of open kidney transplantations. Risk factors include age, obesity, diabetes, haematoma, rejection, re-operation through the same transplant incision and use of m-TOR inhibitors. Mesh infection is a risk factor for incisional hernia recurrence [226]. Open and laparoscopic repair approaches are safe and effective [226].

3.1.8 Urological malignancy and renal transplantation

3.1.8.a Malignancy prior to renal transplantation in the recipient

Standard procedure for transplant candidates includes systematic screening for the presence of any active/latent cancer or a history of cancer. In candidates with a history of urological cancer, it can be challenging to decide if patients are suitable for transplantation, and if so, how long the waiting period prior to transplantation should be. To date, the waiting period has been primarily based on the Cincinnati Registry, which takes into account the type of tumour and the time between its treatment and kidney transplantation. However, the Cincinnati Registry has potential drawbacks, as it does not consider the epidemiology of tumours or that diagnostic and therapeutic procedures/tests have changed over time and that prognostic tools have improved. Additionally, treatment and the staging of the disease are not defined.

According to a systematic review the risk of tumour recurrence was similar between transplantation (n = 786) and dialysis (n = 1,733) populations for renal cell carcinoma (RCC) and prostate cancer (PCa). This was especially true for low grade/stage PCa, for which the risk of recurrence was low and consistent with nomograms [227]. For low stage/grade RCC, the recurrence rate was significant for both dialysis and renal transplantation. However, recurrences were actually contralateral RCC with no impact on patient or graft survival [227].

Testicular cancer had a low risk of recurrence, but case reports highlighted the possibility of late recurrence even for stage I tumours [227].

For urothelial carcinoma, studies were mainly related to upper urinary tract carcinomas in the context of aristolochic acid nephropathy, for which the rate of synchronous bilateral tumour was 10-16% and the rate of contralateral recurrence was 31-39% [227].

These findings imply that a kidney transplant candidate with a history of appropriately treated low stage/grade PCa (PSA \leq 10, Gleason score \leq 6 and T1/T2a) or low-grade T1 RCC could be listed for renal transplantation without any additional delay compared to a cancer-free patient. However, as the level of evidence was low, more studies are needed to standardise waiting periods before renal transplantation.

Summary of evidence	LE
Renal Cell Carcinoma	
The recurrence rates for transplanted vs. dialysed patients at < 1, 1-5, and > 5 years were 0-8% vs. 0%, 0-27% vs. 0-9% and 0-41% vs. 0-48%, respectively.	2b
Overall five-year survival rates for transplantation vs dialysed patients were 80-100% vs. 76-100%, respectively.	
Prostate Cancer	
The recurrence rates for transplantation patients at < 1 and > 5 years were 0-9% and 4-20%, respectively.	2b
Overall, 1 to 5-year survival rates for transplantation patients ranged from 62% to 100%.	

Recommendation	Strength rating
List for renal transplantation patients with a history of appropriately treated low stage/grade renal cell carcinoma or prostate cancer without additional delay.	Weak

3.1.8.b Malignancy prior to renal transplantation in the potential donor kidney

In the general population, RCC constitutes 3% of all malignancies, with the incidence being highest in patients aged > 60 years. The current increasing age of donors may lead to a higher number of incidental RCCs found in donor kidneys and could theoretically decrease the number of kidneys suitable for transplantation. The main surgical approach to these kidneys is *ex vivo* tumour excision on the back-table with an oncological margin, frozen section biopsy, bench surgery renorrhaphy and, finally, transplantation in the conventional fashion [228].

A systematic review assessed the effectiveness and harms of using kidneys with small renal tumours, from deceased or living donors, as a source for renal transplantation and it reported that five year overall and graft survival rates were 92% and 95.6%, respectively [228]. Tumour excision was performed *ex-vivo* in all cases except for two (107/109 patients), and the vast majority of excised tumours were RCCs (88/109 patients) with clear-cell subtype - the most common form [228]. This systematic review, although with low-level evidence, suggested that kidneys with small renal masses are an acceptable source for renal transplantation and do not compromise oncological outcomes with similar functional outcomes to other donor kidneys.

Summary of evidence	LE
Tumour excision was performed <i>ex-vivo</i> in all cases except for two (107/109 patients).	2b
Overall survival rates at one, three and five years were 97.7%, 95.4% and 92%, respectively.	
Mean graft survival rates at one, three and five years were 99.2%, 95% and 95.6%, respectively.	

Recommendation	Strength rating
Do not discard a kidney for potential transplantation on the basis of a small renal mass alone.	Weak

3.1.8.c Malignancy after renal transplantation

Cancer development after kidney transplant has become a major problem, as it is one of the main causes of death in this population. Urological cancers have an increased incidence after kidney transplantation, due in part to the increasing age of recipients and their prolonged survival after transplantation.

Treatment of localised PCa following kidney transplantation is challenging due the presence of the kidney graft in the pelvic cavity close to the prostate. Two systematic reviews reported that oncological outcomes following PCa treatment in kidney transplant recipients are comparable to the nontransplanted population [229, 230] and surgery (radical prostatectomy) carried out in tertiary high-volume referral centres was the treatment choice in 75-85% of patients [229, 230]. Marra *et al.* reported cancer-specific survival rates of 96.8% for surgery, 88.2% for radiotherapy with androgen-deprivation therapy and 100% for brachytherapy at mean follow-up of 24 months [230]. Hevia *et al.* reported five-year cancer-specific survival of 97.5% for surgery, 87.5% for external beam radiation and 94.4% for brachytherapy [229].

Summary of evidence	LE
Surgery (radical prostatectomy) was the most frequently performed treatment for localised PCa after kidney transplant.	2b
Overall oncological outcomes following PCa treatment in kidney transplant recipients were comparable to the nontransplanted population.	2b

Recommendations	Strength rating
Be aware of the presence of a kidney transplant in the pelvis and the possibility of subsequent transplants when planning treatment for prostate cancer.	Strong
Refer kidney transplant patients with prostate cancer to an integrated transplant urology centre.	Strong

3.1.9 **Matching of donors and recipients**

Histocompatibility antigens show remarkable polymorphism and human leukocyte antigen (HLA) matching is still very important in kidney transplantation, as transplant outcome correlates with the number of HLA mismatches [231-234]. Human leukocyte antigen incompatibility can result in proliferation and activation of the recipient's CD4+ and CD8+ T-cells with concomitant activation of B-cell alloantibody production. This may lead to cellular and humoral graft rejection. Matching should concentrate on HLA antigens, which impact outcome. Human leukocyte antigens A, B and C, as well as DR must be determined in all potential recipients and donors according to current guidelines and national allocation rules [231-236]. Additionally, it is recommended to determine the HLA-DQ antigens of donor and recipient. Furthermore, HLA-DP antigen characterisation may be performed, particularly for sensitised recipients [231-236].

All patients registered for renal transplantation must have their serum screened for anti-HLA antibodies, which are particularly common after pregnancy, previous transplant, transplant rejection and blood transfusions [231-236]. Thorough pretransplant testing for HLA antibodies must be performed according to current recommendations [231-236]. Sera from potential organ recipients should be screened for HLA-specific antibodies every three months, or as stipulated by the national and/or international organ-exchange organisations [231-236]. In addition, screening for HLA-specific antibodies should be carried out at two and four weeks after every immunising event, e.g. blood transfusion, transplantation, pregnancy and graft explantation [231-236]. Highly sensitised patients should have prioritised access to special allocation programmes [233, 234, 236], such as the Euro-transplant acceptable mismatch (AM) programme [237]. A careful analysis of HLA antibody specificities must be carried out to avoid unacceptable HLA antigens and to determine acceptable HLA antigens in potential donors, who are expected to give a negative cross-matching result. The definition of unacceptable HLA antigens should be implemented according to local allocation rules and international recommendations [231-235, 238]. The information on unacceptable HLA antigens should be highlighted with the patient's details in the database of the national kidney-sharing programme, preventing the unnecessary transport of kidneys to recipients with high antibody sensitivity.

To avoid hyperacute rejection (HAR), adequate (e.g. CDC, virtual) cross-matching tests must be performed before each kidney and combined kidney/pancreas transplantation in accordance with national and international recommendations [231-234, 236].

Laboratories that provide HLA-testing, HLA antibody testing and cross-matching for transplant centres must have valid accreditation to ensure accuracy and reliability [225, 226, 231-233]. They must follow the standards of national and international organisations, such as the European Federation for Immunogenetics [236].

Previously, compatibility for ABO blood group antigens and HLA antigens was of critical importance in kidney transplantation. This may change in the future, e.g. in the United States allocation system A2 and A2B donors are transplanted into B recipients [234]. To avoid an increasing imbalance between supply and demand in deceased donor kidney transplantation in O recipients, ABO identity is demanded by several organ allocation organisations with a few exceptions, e.g. as in zero HLA-A+B+DR-mismatch kidneys [234, 235]. With the introduction of antibody elimination methods, potent immunosuppression and novel agents (e.g. anti B-cell drugs), successful ABO-incompatible living donor transplantations with good long-term outcomes are possible [239, 240]. However, higher costs and infection rates have been described.

Even the barrier of a positive cross-match due to preformed HLA antibodies is under discussion with newer 'desensitisation' techniques available in cases with available living donors [241, 242]. Success rates are lower, antibody-mediated rejections are frequent, but survival may be better compared to waiting list survival on dialysis. While this is a rapidly evolving field, further research is needed to define standard protocols. Until then, such 'desensitisation' protocols are experimental and patients undergoing desensitisation should be treated in specialised centres, where outcomes are documented. Patients should be informed adequately of the risks and limitations and alternative strategies (e.g. acceptable mismatch programmes, cross-over transplantation and donor chains) should be discussed.

Summary of evidence	LE
Human leukocyte antigen matching is very important in kidney transplantation as transplant outcome correlates with the number of HLA mismatches. Matching should concentrate on HLA antigens, which impact outcome.	3
In accordance with national and international recommendations adequate (e.g. CDC, virtual) cross-match tests must be performed before each kidney and combined kidney/pancreas transplantation to avoid hyperacute rejection.	3

Recommendations	Strength rating
Determine the ABO blood group and the human leukocyte antigen A, B, C and DR phenotypes for all candidates awaiting kidney transplantation.	Strong
Test both the donor and recipient for human leukocyte antigen DQ. Human leukocyte antigen DP testing may be performed for sensitised patients.	Strong
Perform thorough testing for HLA antibodies before transplantation.	Strong
Perform adequate cross-match tests to avoid hyperacute rejection, before each kidney and combined kidney/pancreas transplantation.	Strong

3.1.10 **Immunosuppression after kidney transplantation**

The principle underlying successful immunosuppression is 'the balance of survival'. Practitioners must prescribe a dosage of drug high enough to suppress rejection without endangering the recipient's health. Increased understanding of immune rejection has led to the development of safe modern immunosuppression agents [243, 244], which suppress sensitised lymphocyte activity against a transplant. Immunosuppression is particularly important during the initial post-transplant period when there is a high incidence of early post-transplant rejection.

In later postoperative stages, 'graft adaptation' occurs, resulting in the very low rejection rates seen in maintenance patients. Rejection prophylaxis should therefore be reduced over time by steroid tapering and gradual lowering of calcineurin inhibitor (CNI) [243-245].

Non-specific side effects of immunosuppression include a higher risk of malignancy and infection, particularly opportunistic infections [243-245]. All immunosuppressants also have specific dose-dependent side effects. Current immunosuppressive protocols aim to reduce drug-specific side effects using a synergistic regimen. A truly synergistic regimen allows profound dose reductions of immunosuppressive drugs, thus reducing side effects whilst still maintaining efficacy due to the synergistic effects of the immunosuppressants.

The currently recommended standard initial immunosuppression regime provides excellent efficacy with good tolerability [243-246]. Most patients receive this initial immunosuppression regimen, which consists of:

- calcineurin inhibitors: preferably tacrolimus, alternatively cyclosporine;
- mycophenolate: MMF or enteric-coated mycophenolate sodium [EC-MPS];
- steroids: prednisolone or methylprednisolone; and
- induction therapy: preferably basiliximab in low- and standard-risk patients and anti-thymocyte globulin (ATG) in high-risk patients).

This multidrug regimen reflects the current standard of care for the majority of transplant recipients worldwide [243-245] and may be modified according to local needs and immunological risk. This standard regimen is likely to change as new immunosuppressive drugs and new treatment regimens are developed [243-245]. In addition, any initial drug regimen will need to be tailored to the individual needs of a patient, as suggested by the appearance of side effects, lack of efficacy or protocol-driven requirements.

Recommendation	Strength rating
Perform initial rejection prophylaxis with a combination therapy of a calcineurin inhibitor (preferably tacrolimus), mycophenolate, steroids and an induction agent (either basiliximab or anti-thymocyte globulin).	Strong

3.1.10.a Calcineurin inhibitors

Both cyclosporine and tacrolimus have significant side effects that are hazardous to the graft and patient [243-250]. Most importantly, both are nephrotoxic [251, 252], and long-term use is an important cause of chronic allograft dysfunction [253], eventually leading to graft loss or severe chronic kidney disease in recipients of non-renal organs. Both CNIs are considered to be 'critical dose' drugs, so that any deviations from exposure can lead to severe toxicity or failure of efficacy. Due to the narrow therapeutic window and the potential for drug-to-drug interaction, CNIs should be monitored using trough levels, which provide a reasonable estimate for exposure [250].

Meta-analysis of tacrolimus and cyclosporine has demonstrated similar outcomes with respect to overall patient and graft survival [243-249, 254-256]. Tacrolimus provided better rejection prophylaxis and was associated with better graft survival, when censored for death in some analyses. Renal function was favourable for tacrolimus-treated patients in numerous trials [254, 257-261]. Therefore, both CNIs can be used for the effective prevention of acute rejection, but due to higher efficacy tacrolimus is recommended by current guidelines as first-line CNI [244].

Several different formulations are available for both CNIs [250, 262-270]. Tacrolimus once-daily dosing seems to be preferred by patients and is associated with better adherence and lower pharmacokinetic variability [250, 271, 272]. Precautions (e.g. close surveillance and determination of drug levels) should be instituted after conversion from one formulation to another [270, 273-277]. In case of specific side effects of a CNI (e.g. hirsutism, alopecia, gingival hyperplasia, diabetes and polyoma nephropathy) conversion to another CNI can be a successful strategy to reduce side effects [243-245, 278]. Due to differences in the efficacy and safety profile, the choice of CNI should include the individual risks and benefits for each patient.

Despite their side effects, CNIs have been a cornerstone of modern immunosuppressive regimens for more than thirty years as they have resulted in an exemplary improvement in kidney graft survival [243, 244]. Future protocols aim to minimise or even eliminate CNIs [245, 248, 250, 279-282]. However, until such strategies provide superior outcomes, CNIs remain the standard of care [243, 244, 283]. For severe CNI-related side effects, CNI withdrawal, replacement or profound reduction may be needed [243, 245, 248, 279, 280]. Special attention should be paid to maintenance patients, who may need less CNIs than previously thought [243, 245, 250, 280, 281, 284].

Summary of evidence	LE
Meta-analysis of tacrolimus and cyclosporine has demonstrated similar outcomes with respect to overall patient and graft survival, however, tacrolimus provided better rejection prophylaxis and renal function.	1a
Due to differences in the efficacy and safety profile, the choice of CNI should take into account the immunological risk, characteristics, concomitant immunosuppression and socioeconomic factors of the recipient.	1

Recommendations	Strength rating
Use calcineurin inhibitors for rejection prophylaxis as they represent current best practice pending publication of long-term results using newer agents.	Strong
Use tacrolimus as first-line calcineurin inhibitor due to its higher efficacy.	Strong
Monitor blood-levels of both cyclosporine and tacrolimus to allow appropriate dose adjustment of calcineurin inhibitors.	Strong

3.1.10.b Mycophenolates

The mycophenolates, MMF and EC-MPS, are based on mycophenolic acid, which inhibits inosine monophosphate dehydrogenase (IMPDH) [285-289]. This is the rate-limiting step for the synthesis of guanosine monophosphate in the *de novo* purine pathway. As the function and proliferation of lymphocytes is more dependent on *de novo* purine nucleotide synthesis compared to other cell types, IMPDH inhibitors may provide more-specific lymphocyte-targeted immunosuppression. The co-administration of mycophenolate with prednisolone and CNI has resulted in a profound reduction of biopsy-proven rejections [243, 246, 285-289]. Mycophenolic acid is not nephrotoxic; however, it inhibits bone marrow function and may cause CMV infections and gastrointestinal side effects, particularly diarrhoea [243, 246, 285-289]. There is also a higher incidence of polyoma nephropathy, particularly when mycophenolate is combined with tacrolimus [290].

Both MPA formulations are equally effective with an almost identical safety profile [241, 280, 283, 285-288], though some prospective studies suggest a better gastrointestinal side-effect profile for EC-MPS in patients who have suffered from MMF-related gastrointestinal complaints. Firm evidence from prospective randomised studies, however, is lacking [285-289, 291].

Some guidelines recommend mycophenolic acid [244]. Standard doses in combination with cyclosporine are MMF 1g or EC-MPS 720mg twice daily, although higher initial doses have been suggested [243, 244, 285-289]. Despite its frequent use with tacrolimus, insufficient evidence is available to support the optimal dosage for this combination [243, 285, 287, 288, 292]. Tacrolimus has no influence on MPA exposure and leads to approximately 30% higher MPA exposure compared to cyclosporine. Most transplant centres use the same starting dose as in cyclosporine-treated patients. Dose reductions are frequent, however, particularly due to gastrointestinal side effects. Weak evidence suggests that MPA dose reductions are associated with inferior outcomes, especially in cyclosporine treated patients [286-288, 293, 294]. Due to the high incidence of side effects, some centres perform a protocol-driven MPA dose reduction in tacrolimus treated patients [285, 287]. Regular monitoring for polyoma (BK virus) is recommended in patients given MPA combined with tacrolimus [243, 290].

Due to a higher incidence of CMV disease with MPA [289], either CMV prophylaxis or a pre-emptive strategy with regular screening for CMV viraemia should be instituted [243, 295]. Cytomegalovirus prophylaxis with antiviral medications (e.g. valganciclovir) should be used routinely in CMV-positive recipients and in CMV-negative recipients of CMV-positive organ transplants, because prophylaxis has recently been shown to reduce CMV disease and CMV-associated mortality in solid organ transplant recipients, and leads to better long-term graft survival in kidney allograft recipients.

The benefit for MPA drug monitoring is uncertain and currently not recommended for most patients [285, 287, 288, 296].

In maintenance patients, the potency of MPA can be used for successful steroid withdrawal in most patients [297], or for substantial dose reductions of nephrotoxic CNIs, which may lead to better renal function [243-246, 248, 280, 298]. Although there have been several studies of the potential for CNI-free protocols with MPA and steroids, complete CNI avoidance or withdrawal over the first three years has been associated with a substantially increased rejection risk and even worse outcomes in prospective randomised studies [243, 245, 280]. In contrast, CNI withdrawal under MPA and steroids appeared to be safe in long-term maintenance patients beyond five years post-transplant and resulted in improved renal function [243, 245, 248, 280, 298, 299].

Summary of evidence	LE
The co-administration of MPA with prednisolone and CNI has resulted in a profound reduction of biopsy-proven rejections.	1
Both MPA formulations, MMF and EC-MPS, are equally effective with a nearly identical safety profile.	1
Due to a higher incidence of CMV disease with MPA, either CMV prophylaxis or a pre-emptive strategy with regular screening for CMV viraemia should be instituted.	1

Recommendation	Strength rating
Administer mycophenolate as part of the initial immunosuppressive regimen.	Strong

3.1.10.c Azathioprine

Mycophenolate is now routinely used as a primary therapy in place of azathioprine in most units worldwide. In comparison to azathioprine, mycophenolate reduced rejection rates significantly in prospective randomised trials [243, 244, 246, 285-289]. Although a large prospective study found that azathioprine may produce acceptable results in a low-risk population [300], azathioprine is usually reserved for patients who cannot tolerate MPA [243, 244, 285, 286, 288]. When added to dual therapy with cyclosporine and steroids, a meta-analysis found no significant benefit for azathioprine with respect to major outcome parameters [301].

Recommendation	Strength rating
Azathioprine may be used in a low-risk population as an immunosuppressive drug, especially for those intolerant to mycophenolate formulations.	Weak

3.1.10.d Steroids

Steroids have numerous side effects [243-245, 297], particularly with long-term use. Most practitioners still consider steroids (either prednisolone or methylprednisolone) to be a fundamental adjunct to primary immunosuppression, even though successful steroid withdrawal has been achieved in the vast majority of patients in many prospective randomised trials [243, 245, 246, 297, 302, 303]. The risk of steroid withdrawal depends on the use of concomitant immunosuppressive medication, immunological risk, ethnicity and time after transplantation. Although the risk of rejection diminishes over time, potential benefits may be less prominent after a prolonged steroid treatment period [243-246, 297]. Recent studies suggest similar efficacy but less diabetes after early steroid withdrawal or steroid minimisation in low-risk patients treated with tacrolimus, MPA and induction (either basiliximab or ATG) [304, 305].

Recommendations	Strength rating
Initial steroid therapy should be part of immunosuppression in the perioperative and early post-transplant period.	Strong
Consider steroid withdrawal in standard immunological risk patients on combination therapy with calcineurin inhibitors and mycophenolic acid after the early post-transplant period.	Weak

3.1.10.e Inhibitors of the mammalian target of rapamycin

The immunosuppressants, sirolimus and everolimus inhibit the mammalian target of rapamycin and suppress lymphocyte proliferation and differentiation [243, 279, 306-308]. They inhibit multiple intracellular pathways and block cytokine signals for T-cell proliferation. Similar effects are seen on B cells, endothelial cells, fibroblasts and tumour cells. m-TOR inhibitors are as effective as MPA when combined with CNIs in preventing rejection [243, 246, 279, 306-309]. However, m-TOR inhibitors exhibit dose-dependent bone marrow toxicity [243, 279, 306-308]. Other potential side effects include hyperlipidaemia, oedema, development of lymphoceles, wound-healing problems, pneumonitis, proteinuria, and impaired fertility.

The extensive side-effect profile is responsible for inferior tolerability compared to MPA and potential differences in outcome in early years when higher doses were used [310-315].

To date, no prospective comparative studies have been carried out on the m-TOR inhibitors sirolimus and everolimus [316]. Both m-TOR inhibitors have a nearly identical side-effect profile and differ mainly in their pharmacokinetic properties [243, 279, 306-308, 317]. Sirolimus has a half-life of approximately 60 hours, is given once a day and is licensed for prophylaxis in kidney recipients only. Everolimus has a half-life of approximately 24 hours, is licensed for kidney, liver and heart recipients and is given twice a day. Everolimus is licenced for use with cyclosporine and can be given simultaneously with cyclosporine, while sirolimus should be given four hours after cyclosporine. The pharmacological drug-drug interaction with cyclosporine is far less relevant for tacrolimus, resulting in the need for a higher starting dose of m-TOR inhibitors in combination with tacrolimus [260, 318, 319]. Sirolimus is also licensed in combination therapy with steroids for cyclosporine withdrawal from combination therapy with cyclosporine.

Due to the narrow therapeutic window and the risk of drug-drug interactions, therapeutic monitoring of trough levels is recommended [243, 279, 306-308, 317].

When combined with CNIs, antimicrobial prophylaxis for *Pneumocystis jirovecii* pneumonia should be administered for one year following transplantation, e.g. low-dose cotrimoxazole [243, 306-308]. Most importantly, combination therapy with CNIs aggravates CNI-induced nephrotoxicity, although m-TOR inhibitors themselves are non-nephrotoxic [243]. Several studies suggest less-favourable outcomes and increased drug discontinuations due to adverse events for this combination, especially if CNIs are maintained at standard dosages [243, 246, 248, 260, 309, 311, 312, 320-325]. Calcineurin inhibitor dosage should therefore be substantially reduced in combination therapy with m-TOR inhibitors, which seems to have no impact on efficacy, due to the highly synergistic potential of this combination therapy [279, 306-308, 314, 317].

Several studies suggest m-TOR inhibitors cannot replace CNIs in the initial phase after transplantation due to lower efficacy and a less-favourable side-effect profile, particularly wound healing problems and lymphoceles [241, 243, 244, 276, 300, 301, 306, 308, 316]. Other trials suggest that m-TOR inhibitors may replace CNI at later stages, e.g. three months after transplantation, with improvements in renal function, predominately in cyclosporine treated patients [243, 245, 246, 248, 258, 279, 306-308, 311, 312, 314, 326-328]. It is unclear if there is a real benefit in comparison to patients on tacrolimus and MPA [258, 327]. However, there is an increased risk of rejection and development of HLA antibodies [243, 245, 258, 279, 329], which may be offset by the benefit of the non-nephrotoxic immunosuppression. Patients treated with m-TOR inhibitors are less likely to develop leucopenia and opportunistic viral infections, particularly developing fewer CMV infections compared to MPA [260, 311, 314, 324-326, 330].

Proteinuria and poor renal function at conversion are associated with inferior outcomes [243, 245, 279, 306-308]. Conversion from CNIs is not advisable in patients with proteinuria > 800mg/day, and a cautious and individual approach should be followed in patients with GFR < 30mL/min.

Due to an antiproliferative effect and a lower incidence of malignancy in patients treated with m-TOR inhibitors, conversion from CNIs to m-TOR inhibitors may be beneficial for patients who develop malignancy after transplantation or who are at a high risk for the development of post-transplant malignancy or skin cancer [243, 245, 279, 306-308, 313-315, 331-334]. Several studies and case reports have suggested that patients with Kaposi sarcoma under CNI therapy benefit from conversion to an m-TOR inhibitor [332].

In summary, m-TOR inhibitors are not recommended as initial immunosuppressive therapy due to their side-effect profile and higher discontinuation rates [244]. However, m-TOR inhibitors are a well-studied alternative treatment option.

Summary of evidence	LE
Combination therapy with CNIs aggravates CNI-induced nephrotoxicity. Therefore, CNI dosage should be substantially reduced in combination therapy with m-TOR inhibitors, which seems to have no impact on efficacy, due to the highly synergistic potential of this combination therapy.	1
Take into consideration impaired wound healing and prophylactic surgical measures when m-TOR inhibitors are used as part of the initial immunosuppressive regimen or when patients treated with m-TOR inhibitors undergo major surgery.	1
When combined with CNIs, antimicrobial prophylaxis for <i>P. jirovecii</i> pneumonia should be administered for one year following transplantation.	1
Conversion from CNIs is not advisable in patients with proteinuria > 800mg/day, and a cautious and individual approach should be followed in patients with GFR < 30 mL/min.	1

Recommendations	Strength rating
The m-TOR inhibitors may be used to prevent rejection in patients who are intolerant to standard therapy.	Weak
Significantly reduce calcineurin inhibitor dosage in a combination regimen with m-TOR inhibitors to prevent aggravated nephrotoxicity.	Strong
Do not convert patients with proteinuria and poor renal function to m-TOR inhibitors.	Strong
Monitor blood-levels of both sirolimus and everolimus to allow for appropriate dose adjustment.	Strong

3.1.10.f Induction with Interleukin-2 receptor antibodies

Basiliximab, a high-affinity anti-interleukin-2 (IL-2) receptor monoclonal antibody, is approved for rejection prophylaxis following organ transplantation [243, 244, 246, 335-339]. Basiliximab is given before transplantation and on day four post-transplant. The drug is safe, and IL-2 receptor antibodies have been shown in RCTs to reduce the prevalence of acute cellular rejection by approximately 40% [243, 244, 246, 335-337]. Meta-analyses [246, 335-337] have confirmed the efficacy, and although no positive effect on patient or graft survival could be demonstrated, large retrospective cohort studies and recent large prospective studies suggest such a benefit [243, 244, 340, 341]. Several large controlled trials support the efficacy and safety of quadruple therapy with tacrolimus, mycophenolate and steroids. Interleukin-2 receptor antibodies may allow early steroid withdrawal [297], although higher rejection rates were described in some studies. Most importantly, IL-2 receptor antibodies allow a substantial reduction in CNIs or steroids, while maintaining excellent efficacy and renal function [243-246, 304, 335-337]. Therefore, this regimen is proposed as first-line immunosuppression in patients with low to normal immunological risk [244, 341].

Recommendation	Strength rating
Use interleukin-2 receptor antibodies for induction in patients with normal immunological risk in order to reduce incidence of acute rejection.	Weak

3.1.10.g T-cell-depleting induction therapy

Prophylactic immunosuppression regimens in many countries, particularly the United States, use potent T-cell-depleting 'induction' treatments [243, 244, 246, 335, 340, 342-345]. Most commonly ATG is used for prevention of rejection in immunological high-risk patients, as supported by meta-analysis [341] and recommended by guidelines [244, 346]. In addition, these potent biological agents are used for the treatment of severe, steroid-resistant rejection episodes [342, 345].

Use of T-cell-depleting antibodies in immunological low-risk patients has not been associated with improved long-term outcomes, but with an increased risk of severe opportunistic infections and malignancy, particularly post-transplant lymphoproliferative disease [243, 244, 246, 335, 341-343]. Some centres use these agents to provide effective rejection prophylaxis in order to facilitate steroid withdrawal [304, 340, 344].

Recommendation	Strength rating
T-cell-depleting antibodies may be used for induction therapy in immunologically high-risk patients.	Weak

3.1.10.h Belatacept

Belatacept is a fusion protein that effectively blocks the CD28 co-stimulatory pathway and thereby prevents T-cell activation [279, 347-350]. Belatacept is administered intravenously and is indicated for use as part of a CNI-free regimen together with basiliximab induction, mycophenolate and corticosteroids. Long-term data from three randomised studies of *de novo* kidney transplant recipients demonstrated better renal function versus cyclosporine-based immunosuppression, although rates and grades of acute rejection were higher for belatacept in the first year post-transplant [243, 246, 259, 279, 349-355]. Better graft survival was observed in patients receiving a standard deceased or living-donor kidney, while similar graft survival rates were found with ECDs. Interestingly, patients treated with belatacept had better-preserved histology and developed less donor-specific antibodies (DSA) compared to cyclosporine [356]. The long-term safety profile of patients treated with belatacept was similar to cyclosporine controls, fewer patients treated with belatacept developed metabolic complications or discontinued treatment due to adverse events [347, 348]. In addition, the option of converting patients (either stable patients or due to CNI- or m-TOR-associated toxicity) was explored with promising initial results [347, 348, 352, 357-359]. Specific safety signals include a higher rate of post-transplant lymphoproliferative disorder (particularly in Epstein-Barr virus (EBV) negative patients), more herpes infections and tuberculosis in patients from endemic areas [279, 347-350]. Belatacept was approved in the United States and in Europe for EBV-positive patients but is not yet available in many countries. Additional studies are ongoing to fully explore the value of this compound.

Recommendation	Strength rating
Belatacept may be used for immunosuppressive therapy in immunologically low-risk patients who have a positive Epstein-Barr virus serology.	Weak

3.1.11 Immunological complications

Immunological rejection is a common cause of early and late transplant dysfunction [244, 360-364]. There is great variation in the timing and severity of rejection episodes and how they respond to treatment. Today, two main types of immunological reactions are distinguished: T-cell-mediated rejections (TCMRs) and antibody-mediated rejections (ABMRs) [244, 360-362, 365]. Antibody-mediated rejection and TCMR may be diagnosed together; a situation known as mixed acute rejection. Antibody-mediated rejection may occur as hyperacute rejection (HAR), active rejection or chronic rejection. Chronic ABMR is considered one of the leading causes of late graft loss.

The ultimate standard for the diagnosis of rejection is transplant biopsy [244], because it is impossible to differentiate acute rejection based solely on clinical indicators from other causes of renal dysfunction (e.g. acute tubular necrosis, infection, disease recurrence or CNI nephrotoxicity). Therefore, all rejections should be verified by means of renal biopsy and biopsies should be classified according to the most recent Banff criteria [366], which are the basis for prognosis and treatment [242, 360, 363]. Renal transplant biopsy should be conducted preferably under US control, using an automated needle biopsy system (e.g. Tru-Cut biopsy gun) [244, 360] with a 16 G needle to assure specimen adequacy. The biopsy procedure is considered safe, but complications such as bleeding and AV fistulas may occur [244, 367, 368]. The reported risk of major complications (including substantial bleeding, macroscopic haematuria with ureteric obstruction, peritonitis or graft loss) is approximately 1%. The most important contraindications are anticoagulant therapy including antiplatelet agents and uncontrolled hypertension.

Summary of evidence	LE
There must be routine access to US-guided biopsy of the transplant and sufficient expertise in the hospital pathology department to allow a rapid and clear-cut diagnosis of rejection or other type of allograft dysfunction.	2
Steroid treatment for rejection may start before the renal biopsy is performed.	2

Recommendations	Strength rating
Monitor transplant recipients for signs of acute rejection, particularly during the first six months post-transplant.	Strong
Take regular blood samples in addition to regular monitoring of urine output and ultrasound examinations in order to detect graft dysfunction during hospitalisation.	Strong
Immediately rule out other potential causes of graft dysfunction in cases of suspected acute rejection. An ultrasound of the kidney transplant should be performed.	Strong
Perform a renal biopsy, graded according to the most recent Banff criteria, in patients with suspected acute rejection episodes.	Strong
Only if contraindications to renal biopsy are present, can 'blind' steroid bolus therapy be given.	Strong
Test patients who suffer acute rejection as soon as possible for anti-HLA antibodies against the graft.	Strong
Reassess the immunosuppressive therapy of all patients with rejection, including patient adherence to the medication, which is of particular importance in late rejections.	Strong

3.1.11.a Hyperacute rejection

Hyperacute rejection is the most dramatic and destructive immunological attack on the graft [231, 244, 360, 361]. This type of rejection results from circulating, complement-fixing IgG antibodies, specifically reactive against incompatible donor antigen, which engages with and destroys the vascular endothelium within minutes or hours after vascularisation. Hyperacute rejection occurs in ABO-incompatible grafts due to the presence of high titres of pre-existing isoantibodies against blood group antigens. In ABO-matched grafts, HAR is mediated by antidonor HLA IgG antibodies. With the development of the cross-matching test before transplantation, HAR has become an extremely rare complication [231]. Imaging and histology reveal generalised infarction of the graft, which must be treated using graft nephrectomy. Therefore, prevention is crucial, either by avoidance of high isoantibodies against incompatible blood group antigens in case of an ABO-incompatible renal transplant and/or by performing regular cross-match before transplantation (see Section 3.1.8).

Recommendation	Strength rating
Prevent hyper-acute rejection by adequate ABO blood group and HLA matching of donor and recipients.	Strong

3.1.11.b Treatment of T-cell-mediated acute rejection

As only a few randomised trials have investigated various treatment options for this clinical problem, therapy is mainly based on empirical experience rather than on clinical evidence [244, 345, 360, 369]. Parenteral methylprednisolone (500mg to 1g) should be given intravenously as one pulse per day for three days. Anuria or a steep rise in the serum creatinine may indicate steroid-refractory rejection and the need for another three-day course of pulsed methylprednisolone therapy [244, 360]. In addition, baseline immunosuppression should be optimised to ensure adequate drug exposure [244, 360, 369]. In severe rejection, a conversion from cyclosporine to tacrolimus and/or from azathioprine to mycophenolate is recommended [244, 360].

T-cell depleting biological agents such as ATG may be given in severe steroid-refractory cases [244, 342, 345, 360, 369]. If biological agents are used, other immunological suppression should be adapted and daily T-cell monitoring should be considered to minimise the dose of the biological agent [342]. Before immunosuppression is intensified, especially before the use of T-cell depleting agents, the prognosis of the graft should be assessed critically against the risks of the aggravated immunosuppression. The patient should be counselled adequately.

Recommendations	Strength rating
Use steroid bolus therapy as first-line treatment for T-cell-mediated rejection in addition to ensuring adequate baseline immunosuppression.	Strong
In severe or steroid-resistant rejection, use intensified immunosuppression, high-dose steroid treatment, and eventually T-cell depleting agents.	Strong

3.1.11.c Treatment of antibody mediated rejection (ABMR)

Treatment of ABMR relies mainly on retrospective studies and empirical treatment guidelines [370]. Consensus is that it is important to classify the clinical and histological phenotype of the rejection to make adequate treatment decisions [370]. Important clinical factors are time of rejection (early acute < 30 days post-transplant versus late), preformed versus *de novo* donor-specific antibodies (DSA) and histology (active versus chronic rejection).

For active ABMR due to pre-existing DSA treatment with a steroid bolus (at least three days of 500mg/day) in combination with intravenous immunoglobulin (IVIG) and plasmapheresis or immunoadsorption is recommended. Intravenous immunoglobulin (IVIG) [244, 360, 371-376] may modulate and/or suppress antibody production. Intravenous immunoglobulin alone seems insufficient for effective treatment and IVIG is used today in a multimodal regimen. Dosages vary widely from 0.2-2.0g/kg of bodyweight, and no comparative studies (e.g. on the dose or optimal concomitant immunosuppression) have been published. Retrospective and prospective case series clearly suggest efficacy of antibody removal using plasmapheresis or immune-adsorption columns [244, 360, 371-376], although details of the procedures vary widely. Adjunctive therapies such as complement inhibitors, rituximab or splenectomy might be considered in severe early acute cases. Despite controversial data on the utility of anti-CD20 antibody [244, 345, 360, 371-376], rituximab can also be considered an adjunctive therapy in late active ABMR according to expert consensus. Although T-cell-depleting agents such as ATG appear to have limited value, they are frequently used during mixed acute rejection [241]. However, retrospective series suggests aggravated toxicity, when rituximab is combined with ATG [377] or steroids [345]. Furthermore, many centres will optimise maintenance therapy with mycophenolate and steroids and sufficient tacrolimus trough levels should be achieved [244, 360, 371-373, 376].

Chronic AMR due to pre-existent DSA has no specific treatment recommendations except for optimisation of maintenance therapy and eventually IVIG as an adjunctive treatment with a low level of evidence. In patients presenting with *de novo* DSA, optimisation of maintenance immunosuppression is recommended, and non-adherence should be addressed and managed accordingly. If histology shows active ABMR plasmapheresis, rituximab and IVIG can be considered potential adjunctive agents without good evidence from clinical trials. If biopsy demonstrates pure chronic ABMR, no special treatment is recommended due to lack of convincing data, except for IVIG as a potential treatment option without firm evidence. Treatment for chronic ABMR appears to be less successful [360, 371, 373].

In summary, several regimens have proven some efficacy in ABMR. However, apart from a beneficial effect of early antibody removal, the lack of firm evidence does not permit evidence-based recommendations for treatment. Consequently, prevention of ABMR by adequate pre-transplant screening, regular DSA monitoring, avoidance of suboptimal immunosuppression and reinforcement of adherence are crucial [231, 360, 375, 378].

Recommendation	Strength rating
Treatment of antibody-mediated rejection should include antibody elimination.	Strong

3.1.12 Follow-up after transplantation

Long-term graft function is of critical importance for the success of a transplant [244, 245]. Therefore, regular long-term follow-up by experienced transplant physicians is essential to detect complications or graft dysfunction early and reassure adherence to the immunosuppressive regimen. Complications of immunosuppression occur frequently, including specific complications of the various drugs, as well as overimmunosuppression (namely opportunistic infections and malignancy) [244, 245]. The risk of cancer and cardiac disease is several-fold higher in transplanted patients than in the general population. Cancer is a cause of significant morbidity and mortality in the transplanted population [244, 379, 380]. Cardiovascular disease is the most frequent cause of death in renal allograft recipients [244, 381, 382]. Other important long-term problems are non-adherence [383], the development of anti-HLA antibodies, recurrence of the original disease and CNI-associated nephrotoxicity [244, 245].

3.1.12.a Chronic allograft dysfunction/interstitial fibrosis and tubular atrophy

Many patients lose their grafts due to chronic allograft dysfunction [244, 245, 384]. Histology will usually reveal a chronic process of interstitial fibrosis and tubular atrophy (IF/TA) [385]. Some patients will have immunological chronic ABMR [386], as discussed in Section 3.1.11.3. Interstitial fibrosis and tubular atrophy take months or years to develop and are heralded by proteinuria and hypertension, with a simultaneous or delayed rise in serum creatinine level over months [244, 384, 385]. It is likely that IF/TA is more common in patients who have had early attacks of acute rejection or infection. The main differential diagnosis is chronic nephrotoxicity [387], which is common in patients receiving CNIs, and pre-existing and/or aggravated chronic kidney damage from a marginal donor kidney [244, 384, 385].

Diagnosis is by renal biopsy [244, 384]. In patients diagnosed early - particularly if there is evidence for CNI toxicity- disease progression may be slowed by conversion to a CNI-free regimen [201-203, 263, 264]. Conversion to m-TOR inhibitors is an option for patients without significant proteinuria (< 800mg/day), but moderate renal function [243-245]. Alternatively, successful conversion to a mycophenolate-based regimen has been described, especially in patients beyond the first three years post-transplant [243, 245, 280]. In case of intolerance to m-TOR inhibitors or MPA, conversion to belatacept or an azathioprine-based regimen may be successful, although the higher risk of rejection warrants close surveillance [359]. If the risk of rejection seems too high, another option is substantial reduction of CNI under the protection of MPA [245, 280].

In patients with proteinuria, intervention with an angiotensin-converting enzyme inhibitor or angiotensin II receptor blocker [244, 384] together with tight blood pressure control may slow down renal progression. Other supportive measures include the treatment of hypertension, hyperlipidaemia, diabetes, anaemia, acidosis and bone disease [244]. However, ultimately, the patient will require another transplant (if fit enough to go on the transplant waiting list) or dialysis therapy.

Summary of evidence	LE
Regular long-term follow-up by experienced transplant physicians is essential to detect complications or graft dysfunction early and reassure adherence to the immunosuppressive regimen.	4
Annual screening should include a dermatological examination, cardiovascular history and exam, tumour screening (including a nodal examination, faecal occult screening, chest X-ray, gynaecological and urological examination) and an abdominal US, including US of the native and transplanted kidney. If appropriate, further diagnostic tests should be prompted to treat or slow down the progression of any identified complication.	4
In patients diagnosed early with IF/TA, particularly if there is evidence of CNI toxicity, disease progression may be slowed by conversion to a CNI-free regimen. If the risk of rejection seems too high, another option is substantial reduction of CNI under the protection of MPA.	1
Supportive measures should aim to adequately treat the consequences of chronic kidney disease (e.g. anaemia, acidosis or bone disease).	4

Recommendations	Strength rating
Provide lifelong regular post-transplant follow-up by an experienced and trained transplant specialist at least every six to twelve months.	Strong
Advise patients on appropriate lifestyle changes, potential complications and the importance of adherence to their immunosuppressive regimen.	Strong
Regularly monitor (approximately every four to eight weeks) serum creatinine, estimated glomerular filtration rate, blood pressure, urinary protein excretion, immunosuppression and complications after renal transplantation. Changes in these parameters over time should trigger further diagnostic workup, including renal biopsy, a search for infectious causes and anti-HLA antibodies.	Strong
Perform an ultrasound of the graft, in case of graft dysfunction, to rule out obstruction and renal artery stenosis.	Strong
In patients with interstitial fibrosis and tubular atrophy undergoing calcineurin inhibitor (CNI) therapy and/or with histological signs suggestive for CNI toxicity (e.g. arteriolar hyalinosis or striped fibrosis), consider CNI re-reduction or withdrawal.	Strong
Initiate appropriate medical treatment, e.g. tight control of hypertension, diabetes, proteinuria, cardiac risk factors, infections and other complications according to current guidelines.	Strong

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5. CONFLICT OF INTEREST

All members of the EAU Renal Transplantation Guidelines Panel have provided disclosure statements on all relationships that they have that might be perceived to be a potential source of a conflict of interest. This information is summarised below and also publicly accessible through the EAU website: www.uroweb.org/guidelines/.

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