WCN-24 AB-849 MIXED REJECTION WITH CONSIDERABLE VASCULAR INVOLVEMENT OF THE HILIAR VESSELS: AN UNUSUAL PRESENTATION OF ALLOGRAFT REJECTION REQUIRING GRAFT NEPHRECTOMY

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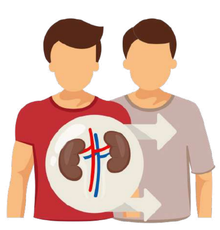
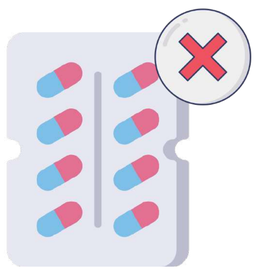
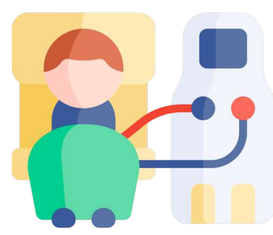
48 years
CKD since 2004



KT deceased donor in 2007
SCr: 1.2 mg/dl
IS: prednisone, cya and MPA

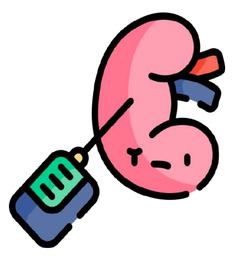


Irregular adherence since 2020. July 2022
sCr: 1.8 mg/dl



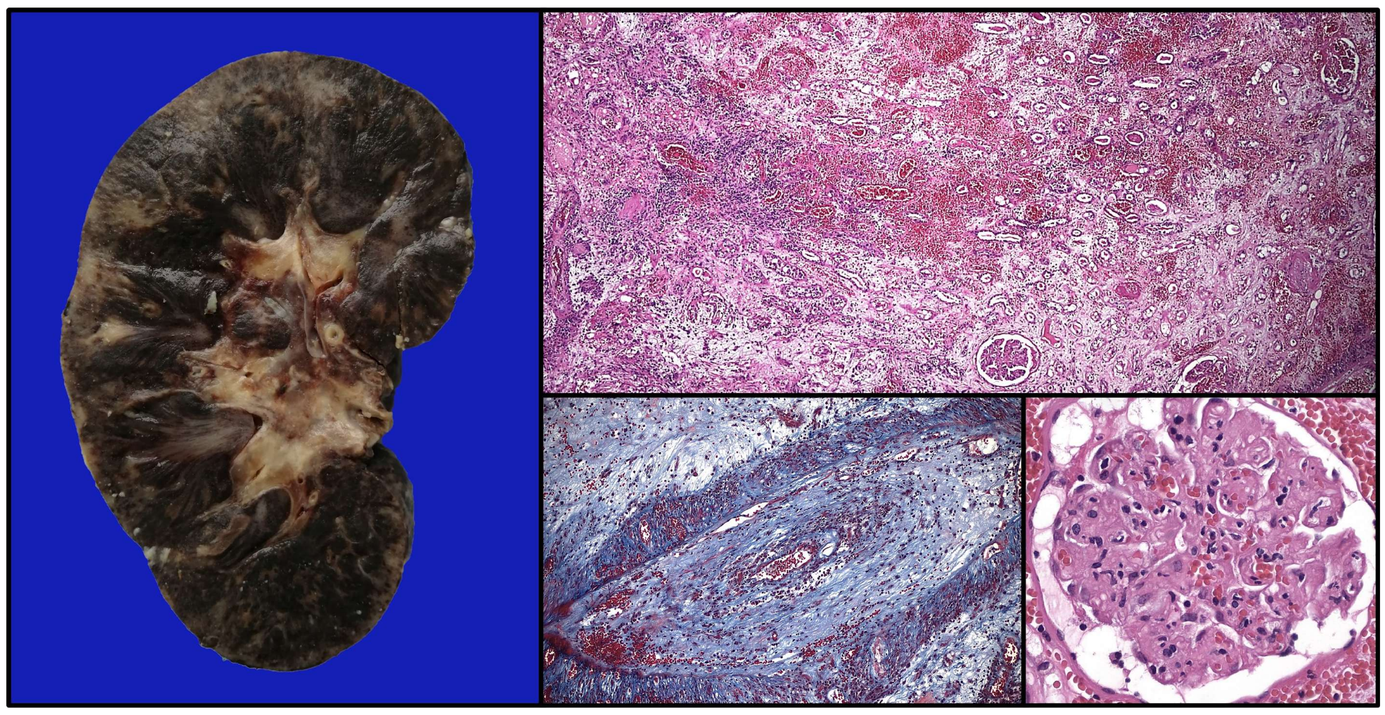
In October 2022 decrease in urine output, nausea, sCr 14.8 mg/dl and start of RRT

Active interstitial tubular rejection (I3, T3) with vascular component (V2) with humoral component (G3, PTC3, V2), superimposed on chronic changes (CG2, I-IFTA2, CI2, CT2). C4D3+ in peritubular capillaries. Interstitial fibrosis grade II (30%). **Although fibrosis is not greater than 50%, the degree of edema, inflammation and interstitial hemorrhage causes practically total loss of the renal parenchyma.**



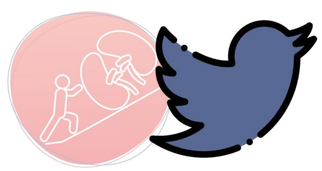
Tx: Steroids without renal function recovery.
In January 2023 with macroscopic hematuria and urinary tract infection with graft intolerance syndrome and graft nephrectomy

Macroscopically, irregular dark red specimen with a hemorrhagic appearance. Active glomerular thrombotic microangiopathy, diffuse interstitial hemorrhage with coagulative necrosis, endotheliitis and endarteritis occluding the capillary lumens; in the hilum and renal sinus with inflammatory infiltrate affecting the entire thickness of the hilar vessels.



Conclusion: Vascular involvement helps predict kidney graft survival. The degree and extent of the vascular lesions should be clarified to treat allograft rejection and even consider the possibility that vascular lesions may reach the larger renal artery and explain the acute deterioration of renal graft function.

KT: kidney transplantation, SCr: seric creatinine
IS: immunosupresion, MPA: mycophenolic acid,
Cya: cyclosporine, RRT: renal replacement therapy
Tx: treatment



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