TEXTBOOK OF ORGAN TRANSPLANTATION

EDITED BY ALLAN D. KIRK

STUART J. KNECHTLE, CHRISTIAN P. LARSEN JOREN C. MADSEN, THOMAS C. PEARSON AND STEVEN A. WEBBER













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Textbook of Organ Transplantation

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History/Introduction

Introduction

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To understand organ transplantation is to understand all of modern medicine, and to practice organ transplantation is to comprehend the fundamental challenges of advanced healthcare delivery in general.

Although these introductory statements are biased by a lifetime of study and admiration of this field, they are not wholly derived of hyperbole. Indeed, when considered objectively, there are few serious students of medicine that would argue the principles they espouse.

Consider the most fundamental diagnosis of medicine: alive or dead. The objective determination of death has been conceived in large part in pursuit of ethical grounds for organ donation; the concepts of brain death are unarguably intertwined with clinical organ donation, and the transplant clinician must understand this most critical of states as much as anyone in any field. Similarly, beyond knowing what constitutes a living individual, the transplant professional is continuously defining where the individual resides by objectively demonstrating that most of what we are exists as parts in support of who we are. From a utilitarian standpoint, the vast majority of a person is replaceable! This concept is experienced in transplantation as a matter of fact, and the transplant professional's proximity to it provides a unique vantage point relative to other specialties. At a more granular level, the transplanter (a term used to avoid distinguishing between scientists, surgeons, nonsurgeons, and the numerous combinations thereof ubiquitous in the field of transplantation) uses biological definitions of individuality, namely molecular histocompatibility, as a daily tool of the trade. This fundamental biological characteristic has arisen through the study of transplantation and is as central to transplantation as brain death is to organ donation. From these high level examples, it is clear that the practicing transplanter more regularly deals in rather heady biological concepts than many other professions. That same characteristic applies to the most difficult of ethical concepts, as transplanters, more than any other specialists, must grapple daily with very practical applications of beneficence, justice, and utility.

Beyond the high-level concepts discussed above, the delivery of transplantation has emerged in such a way as to solidify its location in the core of the day-to-day details of medical practice. The nature of transplantation has always been to treat those with end stage illness, and while the etiology of the disease in question may be organ system specific, the consequences of any organ disease requiring transplantation become systemic in end stage. As such, transplanters have always had to treat the entire patient simply as a matter of practicality. The patient in fulminant hepatic failure not

infrequently has critical brain, cardiopulmonary and renal dysfunction, as well. While these resolve when the underlying liver failure is reversed (in a way so dramatic as to have been unimaginable before the advent of liver transplantation), the transplanter must understand these systems exceptionally well just to get the patient to the operation; he or she cannot be overly focused on an organ of choice. Similarly, given the complexity of post-transplant immunomodulatory management, the transplanter's need to maintain a role in primary care and rehabilitation eclipses that of most subspecialties. As the need to stay involved for immune management has combined with improving life spans of transplant recipients, the understanding of long-term health maintenance required of the transplanter far exceeds that required of any other subspecialist. The transplant surgeon knows far more about medical management of diabetes and hypertension than the general surgeon, and the transplant physician understands surgical complications and wound healing much better than their non-transplant counterparts. Additionally, patients with transplants get the same diseases as patients without transplants, and thus, any illness arising in a transplant recipient will (or at least should) involve a transplanter at some level. A reciprocal effect of the growth and success of transplantation has impelled transplantation to be a core aspect of almost all subspecialties. One cannot consider himself or herself a fully trained cardiologist, endocrinologist, gastroenterologist, intensivist, hepatologist, nephrologist, pediatrician, pulmonologist, or surgeon without at least rudimentary knowledge of transplantation.

Transplant pharmacology similarly has driven pharmacology in general. The concept of therapeutic immune suppression derives from transplant applications and the first clinically approved monoclonal antibody (muromonab) and engineered biologic (daclizumab) were introduced in transplantation. As transplant pharmacology is with rare exception, poly-pharmacy, the role of the clinical pharmacist has been a long-standing feature of transplant care delivery, a model that many other areas have since adopted.

The means by which transplantation has been practiced is turning out to be prophetic for healthcare's ongoing evolution. Transplantation has always been a multidisciplinary craft, as evidenced by the inclusive nature of the depiction of the first successful transplant (see Figure 1.5, Chapter 1). From the start of the field, surgeon and non-surgeon physicians, nurses, allied health professionals, and basic scientists have mingled with a symbiotic fluidity that has typically exceeded that in other fields of medicine. Transplantation has not *become* a team sport, it *always has been* a team

sport, and as such has stood as a tested example of the way forward for healthcare delivery. At a higher hierarchical level, transplantation has long ago adopted means of healthcare delivery that are just now emerging as vogue: elements of accountable care networks, capitated payment plans, pay for performance agreements, public/private partnerships, and rationing algorithms have been in place for transplantation for decades, and again, other fields of medicine can look to transplantation as a source for data on how these health services models are likely to perform.

In a similar vein, transplantation has led the way in terms of keeping track of outcomes on a local and national level, using these data to provide objective means of charting the future. The limited availability of donors and the life-or-death nature of the diseases treated, no doubt, have stimulated the desire to measure and improve the field. While other fields may have differences in the degree of these basic restraints (scarcity and severity) at some level they are applicable, and the model of transplant clinical databases has much to teach other areas of medicine. Transplantation has been aggressive in reporting its complications, and this has led to fundamental revelations in the biology of cancer, infectious diseases, metabolic syndrome, and numerous conditions. Basic physiology has also derived incalculably from the natural experiment of organ replacement.

With all this said, the breadth and depth of content implied by a textbook aiming to cover organ transplantation as a whole might be considered daunting. However, it is no more so than the challenges routinely faced in our field: replacing one person's heart with that of another, operating within the Venn diagrams of alloand protective immunity, ethically allocating scarce donor organs, paying for it all . . .

Thus, this textbook has been created with the opening sweeping statements at its heart. It is not meant to cover everything to its maximal depth (there are texts dedicated exclusively to each of most of the topics covered in this text), but rather is designed to provide a reasonable introduction to most of what transplanter's do. It is arranged with topics presented in an order that a clinician might encounter them. Basic concepts are presented first, moving from requisite historical and general scientific concepts to transplant-specific biology and the fundamental principles of alloimmunity and immune modulation. Beginning, as do all transplants, with donor considerations, the clinical sections of the text then proceed through pre-operative, operative, and post-operative topics. Each of these sections contain chapters specific to the major organ systems presented in order of clinical volume: kidney, liver, heart, lung, pancreas and islet, intestinal and multivisceral, and in selected areas, vascularized composite transplantation. Within the pre-operative section, specific chapters related to the complex management of critically ill patients with end stage organ disease are presented, including intensive care and artificial life support devices. A technique for each major operation is presented in the operative section, acknowledging that there are numerous ways to do everything. The goal is to provide the fundamental starting point for the surgeon, and a reasonable idea of the scope of a procedure for the non-surgeon. The postoperative section includes organ specific post-transplant management, including acute and chronic management issues, as well as substantial attention to immune management and its consequences, particularly infectious and malignant complications. Rejection, being a central diagnosis

driving much of a patient's post-operative care, is presented in two ways: from its organ-specific histopathological definition, and from an organ-specific clinical management vantage. The postoperative section ends with current accountings of long-term outcomes for each transplanted organ type.

We have chosen to provide a specific section dedicated to pediatric transplantation. While much of the biology and conduct mirrors that of adult transplantation, there are numerous areas, particularly related to indications, technical nuances and complications that clearly are unique to children. Indeed, the pediatrician will find the pediatric section to be a very satisfactory primer for transplantation in children in and of itself, complete with its own introductory comments.

As discussed above, the infrastructure and organizational requirements, ethical principles, and administrative guidelines for transplantation are exceptional examples of similar issues now facing the healthcare community at large. As such, the Textbook closes with sections dealing with these issues, both to provide the student of transplantation with transplant-specific knowledge of "how things get done", and to provide the general student of an example of how they might be done in other fields.

The overall goal of this textbook is to bring together a reasonable representation of modern transplantation in all its complexity into a single place. It is anticipated that there are several settings in which such a reference work will be useful. For the graduate or medical student, resident, or allied health trainee, this will serve as a centralized touchstone to help them orient their thoughts and prepare for rotations in transplantation. For non-transplant professions whose practice involves the care of patients awaiting or following a transplant, such as cardiologists, endocrinologists, gastroenterologists, hepatologists, nephrologists and pulmonologists, this will provide sufficient information to help in following patients and understanding when referral is prudent. Indeed, there are two chapters specifically directed toward the concerns of the community physician. For the established transplanter, the knowledge here will be useful when considering aspects of transplantation not typically encountered: for example information about heart transplantation for a kidney transplanter; clinical information for the basic scientist (or vice versa); or background information about a topic to aid in the interpretation of an article in the primary literature. Finally, for the transplant unit or hospital administrator, the content herein will provide substantial subject matter information helpful in organizing and staffing transplant cost centers, and understanding the contribution margins and risks derived from clinical transplant practices.

This first edition has emerged slowly, hindered somewhat by the substantial inertia of its scope. At some point, completeness has given way to practicality, and it is hoped that this same property will aid in its continuation—it is not, and may never be, "done". As the Textbook will be published in an electronic format, it will allow for continuous updates, and it is planned that approximately 10% of the content will be updated annually, making this a perpetually current resource. It will not replace the primary literature, but will be a constant source of information on which to base readings from the primary literature. Future enhancements linking the Textbook directly to the primary literature, particularly journals published by Wiley-Blackwell, are underway, and should provide a new paradigm for textbook utility.

CHAPTER 1

A Brief History of Clinical Organ Transplantation

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Introduction

Transplantation is one of the most visible and influential medical accomplishments of the twentieth century. Arising from technical advances and insights of the early twentieth century, the concept that transplantation was technically feasible gave rise to earnest investigations into its physiological barriers by a small number of visionary investigators driven by recognized clinical problems. From their descriptions of the genetic and immunological basis for graft rejection and the pioneering work of the first transplant surgeons, the clinical practice of transplantation rapidly became interwoven into the fabric of clinical care, not only from a practical standpoint but also as an example of the immense possibilities and challenges inherent in advanced medical practice. Multiple concepts now taken for granted in modern medical practice, such as immunosuppression, monoclonal antibody use, and indeed the concept of death as a definable state, have their origins in transplantation. Numerous modern ethical quandaries also trace their roots to problems introduced by transplantation.

The history of transplantation has been the subject of numerous books, and while its in-depth treatment is not practical in this text, it is important to make evident the major contributions that brought the field to where it stands currently: a prime example of the power of science and medicine combined for a common good. This chapter will provide the reader with a reasonable orientation to the history of the field, referring to more definitive works when necessary and to other chapters in this text. In doing so it will serve as an important introduction to the subject of organ transplantation in general. Throughout this textbook, more specific historical references will be introduced in individual chapters.

The concept of transplant surgery

The idea of organ transplantation is a surgical concept based on an understanding of anatomy and the physiological requirements of an organ to stay viable and fulfil its biological role. Its origins relate to intuitive concepts of like replacing like that date back hundreds of years, including the oft cited Catholic miracle of Cosmos and Damian. However, its serious pursuit arose independently from work conducted in a number of European countries in the early twentieth century, the products of which led to the kidney as the chief candidate for speculations on organ transplantation. Kidney failure was a relatively common fatal condition, the physiological role of the kidney was understood and the kidneys were well defined anatomically. Importantly, it was recognized that one well-

functioning organ was sufficient to maintain an individual in good health for a normal lifespan. The kidney's essential anatomical connections, namely a single artery and vein and a urinary drainage vessel, were apparently sufficient for it to perform its physiological role. Nerves, lymphatic and fascial connections, although important, did not seem to be essential. At the beginning of the twentieth century, Alexis Carrel (Figure 1.1) devised a method of joining blood vessels together surgically [1], a technique that became the subject of his 1912 Nobel Prize in Physiology or Medicine. Carrel himself used this technique to show that a kidney could be removed and transplanted and would function after restoration of the arterial in-flow and venous out-flow, provided these surgical procedures were undertaken expeditiously, since a prolonged period without a blood circulation led to irreversible damage from ischaemia.

In cats and dogs Carrel and Guthrie proved the technical feasibility of the operation and also observed that moving a kidney from an animal to another site in the same animal could result in longterm survival of the kidney and the animal after removal of the opposite kidney [2]. However, transplanting a kidney from one individual to another, after a short period of satisfactory kidney function, was soon doomed to failure. Carrel recorded this observation, but at that time there was no explanation for the fairly rapid failure of what are now called renal allografts [3]. Priority for the transplantation of a kidney in a human patient has been claimed and disputed by a number of surgeons and their historians. Transplants to the brachial or femoral vessels of human kidneys or animal kidneys to humans were described. The early claims and a critical discussion of these unsuccessful experiments can be found in Dr. Francis Moore's book Transplant [4]. None of them functioned for a long period of time and with hindsight the procedures were premature in relation to the knowledge that was gradually accumulating from Carrel and Guthrie's experiments.

Transplant biology

In the 1940s and 50s, Morten Simonsen in Denmark and William Dempster in London independently described experiments similar in nature to those of Carrel and Guthrie and long-term, life-sustaining function of autografts was confirmed. However, experimental allografts were shown to fail universally and a second kidney transplanted from the same donor to the same recipient was destroyed almost instantaneously. These observations were the culmination of many years of painstaking research by Simonsen and Dempster, who also reported on the use of cortisone in renal

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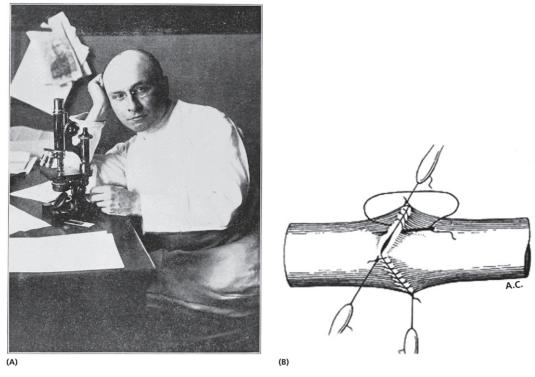


Figure 1.1. (A) Alexis Carrel, widely considered the father of surgical transplantation for his development of (B) the techniques for vascular anastomoses, an accomplishment recognized by the 1912 Nobel Prize in Physiology or Medicine.

allograft recipients. Both workers described histological changes that occurred in renal allografts. The renal cortex became infiltrated with neutrophils, eosinophils, macrophages, lymphocytes and pyronin-positive plasma cells, and these inflammatory changes were accompanied by necrosis of nephrons. Both Simonsen and Dempster felt that it was likely that the cells originated from the grafted organ and were in fact a graft-against-host reaction [5,6]. Subsequently, using a newly developed isotope labelling technique it was shown by Porter and Calne that most of the infiltrated cells came from the recipient [7].

At the time that these experiments were being performed by Simonsen and Dempster in canine renal allografts, Peter Medawar (Figure 1.2) and his colleagues had studied the biology of rejection of skin grafts in rabbits and mice. The first set of grafts became infiltrated with leukocytes after a few days, the graft becoming necrotic after 7-10 days. A second set of grafts from the same donor were usually destroyed immediately and never achieved a capillary circulation. They were called 'white grafts'. The immune nature of skin graft rejection was proved beyond doubt by Medawar's group [8], and from their experiments it seemed likely that kidney grafts between identical twins would behave like skin grafts between identical twins and, provided the surgery was satisfactory, would be accepted without any immune reaction. From this scientifically established basis reciprocal skin grafting should differentiate identical from non-identical cattle twins, and Medawar and his colleagues were confident that this would be straightforward. However, they were astonished, and presumably initially disappointed, when the non-identical cattle twins accepted skin grafts in the same way that grafts were accepted between identical cattle twins [9]. They became aware of studies of non-identical cattle twins by Ray Owen who had observed that non-identical cattle twins frequently had blood

groups of more than one type, circulating in apparently healthy animals [10]. This would be equivalent to a human having some red cells Group A and some Group B, which was know not to occur because of natural antibodies. Owen described the unusual status of their red cells blood groups as 'chimeric' from the fanciful resemblance to the mythical ancient Greek animal with organs derived from different species (Figure 1.3).

Medawar and his colleagues, Billingham and Brent, then set about performing a series of carefully controlled experiments between inbred strains of mice. The individuals of each strain after many sibling matings would be regarded as identical or 'isologous' individuals, so skin grafts were accepted between members of each inbred strain. However, grafts from a given strain transplanted into individuals of a different strain would be rejected, by what was later called the 'allograft' reaction.

Based on these observations in the cattle twins, Medawar's group found that injecting cells from one inbred strain into the foetus of another strain, although a formidable technical achievement, resulted in some survivors, which were then rendered 'tolerant' to grafts from the strain that donated the tissue (Figure 1.2B) [11]. They later found that this tolerance could also be reproduced with neonatal animals, where the technical challenges were still grave but less demanding than in the foetus. This discovery of 'specific immunological tolerance' was awarded the Nobel Prize in Medicine or Physiology and was a fundamental advance in immunology and also raised the practical question of whether the plasticity of the developing foetal immunological system could be reproduced in an adult, at least temporarily while a graft was performed, although it would be important that normal immunity would later be restored. Another factor of importance observed by Medawar's group was that if lymphocytes were included in the donor inoculum they