Maine Medical Center
Maine Transplant Program
Policies and Procedures
Tasks to be Performed Around Deceased Donor Transplantation

Tasks to be performed around deceased donor transplantation

Patient is admitted by transplant surgery

Nephrology is consulted to provide medical care peritransplantation

Preadmission

1. On call nephrologist/fellow informed by on call surgeon or coordinator of potential admission for deceased donor transplantation
2. One Call blast notification activated by on call coordinator.
3. Patient advised to present to MMC fasting without delay. Timing of most recent dialysis elucidated.
4. Preadmission orders including labs to be entered by the surgical transplant team.

On patient arrival to MMC

1. Patient checks into admitting
2. Goes directly to lab for pretransplant blood work
3. Then goes to R5
4. R5 notifies surgical team, renal fellow and/or attending nephrologist
5. Meets nephrology, surgery, nursing teams
6. Patient undergoes ECG, CXR, Betadine shower

Pretransplantation:

1. Review most recent transplant evaluation/reevaluation note
    a. TR until 12/16
    b. Epic/Phoenix after 12/16
2. History and physical with attention to recent infections, transfusions, vaccinations, CV symptoms, performance status
3. Assess access
4. Review labs
5. Decide on need for dialysis:
    a. Indication for pre Tx dialysis: K>5.5, Wt more than 2 kg above EDW
    b. If PD: send PD fluid for WBC, Cx and drain peritoneum before going to OR
    c. Discussion with surgery about OR availability and timing of Tx
    d. Dialysis initiated without delay when necessary
        i. Heparin free versus low dose
        ii. Goal to leave patient ~1 kg above EDW
        iii. Abbreviating hemodialysis OK to minimize cold ischemic time
6. Risk stratification to be done in conjunction with surgery
    a. Immunologic risk: All patients receive rATG at least 1.5 mg/kg and MPred protocol
        i. If low hemodynamic risk may receive rATG 3mg/Kg in the OR
    b. Thrombotic risk: standard/intermediate or high. Driven by surgery
    c. Infectious risk: can be done post tx
    d. PHS-IRD: check recipient HBV, HCV and HIV PCR **before** going to OR (Surgeon)
    e. Comorbidity assessment
7. Medication reconciliation

8. Nephrologist reviews SRTR outcome data:
    a. Physician and patient sign, date and time (document to be obtained from website https://mainehealth.org/-/media/mainehealth/pdfs/clinical-guidelines-and-resources/maine-transplant-program/deceased-donor-documentation/srtr-jan-5-2018-program-summary-psr-mmc.pdf?la=en)
9. Nephrologist completes inclusion and exclusion criteria (document to be obtained from website https://mainehealth.org/-/media/mainehealth/pdfs/clinical-guidelines-and-resources/maine-transplant-program/deceased-donor-documentation/05212018-mtp-inclusion-exclusion.pdf?la=en) or through epic smart phrase .mtpinclusioncriteria
    a. Sign, date and time essential
10. Surgeon obtains consent for transplantation

Post Transplantation

See patient in PACU

1. Access volume status of patient. Consider if needs dialysis or diuresis.
2. Assess BP control
3. Assess urine output
4. Reassess access
5. Obtain ultrasound (unless anuric pretransplant and polyuric post transplant)
    a. Assess RIs
    b. Confer with surgery immediately if there is a problem
6. Management of hyperkalemia
    a. Kayexalate contraindicated
    b. Diurese (or kaliurese) with Lasix/bumex
    c. Dialysis for refractory K>6.5/ECG changes
7. Immunosuppression: MPred protocol and MMF. Use order sets. Don't start tac right away
8. Medication reconciliation. Yes, do it again.

Last reviewed 10/3/2018