

What to do with a failed renal allograft: take it or leave it?

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We read with great interest the recent article by Schleicher *et al.* [1] on the impact of a failed allograft nephrectomy on the outcome of retransplantation. We would like to congratulate the authors on their work, but we have some criticisms to be discussed. First, we think that the conclusion that graft nephrectomy adversely affected graft survival after retransplantation was not supported by the data. As the baseline characteristics were not balanced between the two groups, a multivariate analysis on independent risk factors for graft loss was performed. The 95% confidence interval for the relative risk associated with pretransplant nephrectomy ranged from 0.9 to 5.1 (thus including 1.0), which means that this was not a statistically significant risk factor.

Second, we noticed that several important risk factors that clearly differed between both groups, such as multiple retransplantations and donor type (living versus deceased), were not included in the multivariate analysis. Third, the authors suggest that the higher panel reactive antibody (PRA) levels in the nephrectomy group were the result of nephrectomy. It can also be argued that a higher degree of immune reactivity towards the failed graft more often resulted in symptoms (pain, anemia), and consequently in nephrectomy. In this regard, it would be interesting to know the cause of loss of the primary graft (immunological versus nonimmunological) in each group. Moreover, we think that the detection of anti-HLA antibodies after nephrectomy does not necessarily have a negative impact on the results of retransplantation, as a detailed analysis of the immune reactivity of the transplant candidate may aid in optimal definition of acceptable HLA mismatches. Fourth, it was not clear from the paper whether death with a functioning graft was included as graft loss. Ideally, a death-censored analysis of graft survival should be performed too.

We analyzed the data of 145 patients who experienced failure of their first renal allograft in our center and were

retransplanted with ($n = 70$) or without ($n = 75$) prior transplantectomy. After extensive correction for differences in baseline characteristics in multivariate analysis, we found no effect of transplantectomy on patient survival, graft survival, death-censored graft survival, incidence of delayed graft function, and acute rejection rate after the second transplantation.

Until now, all studies dealing with the influence of failed allograft nephrectomy on the outcome of a retransplantation have a retrospective design. For reasons of the conflicting results and the unavoidable bias related to retrospective studies, we think that the time has come to conduct a multicenter prospective randomized controlled study on pre-emptive removal of an asymptomatic failed renal allograft.

Conflicts of interest

The authors declare no conflicts of interests.

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Reference

1. Schleicher C, Wolters H, Keschull L, *et al.* Impact of failed allograft nephrectomy on initial function and graft survival after kidney retransplantation. *Transpl Int* 2011; **24**: 284.