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Tacrolimus Without Antilymphocyte Induction Therapy Prevents Pancreas Loss From Rejection in 123 Consecutive Patients

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THERE HAS BEEN considerable controversy whether antilymphoid induction therapy is necessary in organ transplant recipients who receive tacrolimus-based immunosuppression.

METHODS

This report analyzes 123 consecutive patients who received pancreas transplants between July 1994 and July 1997, 106 in combination with kidney transplantation. Immunosuppression included intravenous tacrolimus 0.05 mg/kg for 5 to 7 days followed by an initial oral dose of 0.15 mg/kg twice a day. The tacrolimus dose was adjusted daily to achieve whole blood trough levels of 20 to 25 ng/mL (first 2 weeks), 15 to 20 by 1 month, 10 to 15 by 3 months, and 7 to 12 by 6 months. Patients also received tapering steroid doses and azathioprine during the first half of the series and mycophenolate mofetil during the second half.¹

RESULTS

Survival rates were patient 98%, kidney 94%, and pancreas 83% (median follow-up 18 months). Three patients lost graft function at 6, 9, and 20 months from chronic rejection. One patient, who was highly sensitized and whose lymphocytotoxic cross-match turned positive postoperatively, lost the graft at 3 weeks from an antibody-mediated rejection.

Other losses were nonimmunologic, nine of which were secondary to an ischemic/reperfusion injury leading to thrombosis within a few days after transplantation. There were no losses from acute cellular rejection.

SUMMARY

In this series, antilymphoid induction therapy did not appear to be necessary to prevent early graft loss from rejection. In addition, we have followed cytomegalovirus (CMV) antigenemia (pp65) for CMV infection. Although some patients developed a positive antigenemia in the seropositive to negative donor-recipient combinations, only one patient had a prolonged febrile course for 1 week.

REFERENCE

1. Corry RJ, Egidi MF, Shapiro R, et al: *Transplant Proc* 29:642, 1997

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