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The Well Transplant Patient

Martin S. Zand

Primary Care of the Well Transplant Patient

While some may consider the phrase “well transplant patient” an oxymoron, the tremendous success of solid organ transplantation over the last 15 years belies this assertion. More solid organ transplants are performed each year, with fewer rejections and increased longevity. One year graft survival rates for heart, kidney, liver, pancreas and lung transplants have all improved dramatically. Similarly, both short- and long-term patient survival have increased markedly. Even for non-lifesaving kidney and pancreas transplants, it is now clear that those who receive a transplant will have a better quality and longer life. This improvement in outcomes has also led to transplantation of older individuals not previously considered candidates. Thus, the technical success of transplantation has led to sustained growth in the number of patients with a stable organ transplant (Fig. 1).

It is estimated that there are over 180,000 solid organ transplant recipients living in the United States today, a prevalence of almost 0.1% of the population. The vast majority of these meet our definition of the well transplant recipient: a person who is greater than 1 year post-transplant with stable graft function and a relatively fixed long-term immunosuppression regimen. Indeed, most of these individuals are relatively healthy and see their transplant physician only every 6-12 months. Despite the improved long-term health of transplant recipients, however, the transplant literature has not kept up with guidelines and practical protocols for their care. As the incidence of acute organ rejection and infection have improved, hypertension, cardiovascular disease, diabetes, and other more insidious health issues have become common concerns.

Although often asked to function as such, the transplant physician may not be the best primary care provider. While many transplant recipients consider their primary care provider to be the

transplant team, transplant providers may not consider it their role to treat hypertension, arrange for routine malignancy and cardiovascular screening tests, or manage diabetes care. The improved health and the experience of having a life-threatening illness “cured” by transplantation may lull recipients and their healthcare providers into a false sense of “health” security. Both patients and primary care providers may not recognize the need to systematically address general health maintenance after transplantation.

Increasingly, transplant recipients receive most of their medical care from primary care physicians and community based specialists. Often, these providers may not have ready access to practical advice, current practice protocols, or consultation from a transplant internist. Furthermore, many of us who specialize in transplant medicine find it a daunting task to keep current with the changes in general medical management of diabetes, osteoporosis, erectile dysfunction and other conditions. We hope that these articles will serve as a useful reference, and begin to fill this void for transplant specialists and community based physicians alike.

In this issue of *Graft*, we have assembled a practical compendium of articles addressing the long-term care of the well transplant patient. The management of diabetes, hypertension, and hyperlipidemia are reviewed in separate articles, with an emphasis on practice algorithms. Baden and Katz provide a balanced review of the diagnosis and management of long-term infectious complications. Suresh discusses practical management of post-transplant osteoporosis, while Demme and Hijazi discuss the management of post-transplant anemia and erythrocytosis. Evaluation of erectile dysfunction, a common but under-appreciated post-transplant complication, is thoroughly reviewed by Erturk and Davis. The diagnosis and management of common psychiatric conditions in the well transplant recipient is discussed by Nickels, with an emphasis on

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WELL TRANSPLANT PATIENT:

A recipient of a solid organ transplant who (1) is greater than one-year post-transplant, (2) has stable allograft function, (3) has a relatively fixed immunosuppression regimen, and has no acute medical problems.

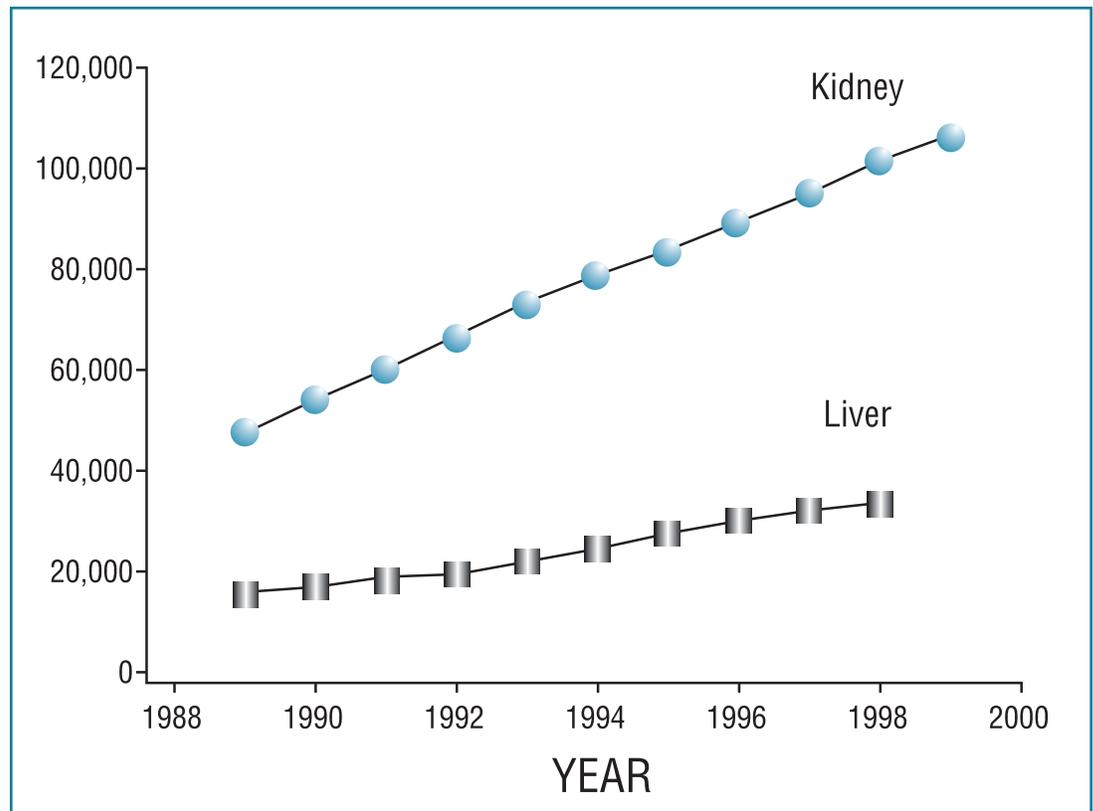


Figure 1. Growth of well transplant patients for kidney and liver transplantation. Data abstracted from the USRDS 1999 Annual Data Report, Table F.6.1 and the UNOS 2000 annual OPTN report.

understanding the process of transplantation from the patient's point of view. Finally, Anaizi reviews the specific medication interactions that occur in transplant recipients and provides a useful framework for understanding their mechanisms.

While developing this issue of *Graft*, we have curbed the temptation to be over inclusive. Some topics have, therefore, been omitted. For example, pregnancy in the well transplant patient is not addressed in this issue, but can be found in an excellent review article by Armenti, et al² in a previous issue of *Graft*. Other more specialized topics such as managing immunosuppression, treating malignancy in the transplant recipient, and common post transplant neurologic conditions are left for future authors to address.

The recommendations expressed in these manuscripts are the opinions of the authors, and do not reflect an endorsement by *Graft*. Many of the manuscripts provide treatment algorithms. These recommendations are of a general nature,

and may not apply to specific patients with unique clinical circumstances.

REFERENCES

1. System USRD. USRDS 1999 Annual Data Report: National Institutes of Health, **National Institute of Diabetes and Digestive and Kidney Diseases, 1999.**
2. Armenti VT, Moritz MJ, Radomski JS, et al. Pregnancy and transplantation. ***Graft* 2000; 3:59-63.**

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