URINARY TRACT INFECTION IN RENAL TRANSPLANT RECIPIENTS: EXPERIENCE OF A SINGLE DEPARTEMENT

LETAI F, S1, Ben Salem, M1,2, Hamouda, M2, Letaief, A2, Aloui, S2, Skhiri, H2
1Fatouma Bourguiba Hospital, nephrology, kairouan, Tunisia, 2Fatouma Bourguiba hospital, Nephrology, Monastir, Tunisia

Introduction: Urinary tract infection (UTI), is the most common cause of infectious complications in kidney transplant recipients. These infections remain suspect due to their impact on graft survival and therefore on the morbidity and mortality of this population. These can occur at any time but with the highest incidence in the first 3-6 months after transplantation. Our aims were as follow: 1. Assess the prevalence of UTI in kidney transplant recipients. 2. Identify the risk factors for UTI in kidney post transplantation. 3. Study the microbiological profile and therapeutic attitudes of these UTIs.

Methods: This is a descriptive and analytical retrospective study, carried out between January 2017 and November 2019 at the renal transplant unit in the nephrology department of Fatouma Bourguiba Hospital in Monastir. We included all kidney transplant patients hospitalized during this period.

Results: During this period 360 patients were hospitalized. UTI was diagnosed in 32 patients. The average age of our population was 35.5 ± 9.6 years with a sex ratio of 1. The prevalence of UTI in kidney transplant recipients was estimated at 8.8%. The graft acute pyelonephritis was the most frequent presentation. The most incriminated germs were the bacillus gram negative (BGN) represented mainly by Klebsiella pneumoniae (47.7%). The most prescribed antibiotics were carbapenem in 34% of cases followed by third generation cephalosporin (3G) mainly cefotaxime (21.5%). The only UTI risk factor found in our study with a statistically significant p was ureteric vesic urethral reflux complicating a kidney transplant.

Conclusions: Several other risk factors have been identified in the literature not objectived in our study, their recognition is important to identify kidney transplant recipients who are more likely to develop urinary tract infections and to minimize the risk with personalized care.

No conflict of interest

RENAI PROGNOSIS OF HEMOLYTIC UREMIC SYNDROME IN ADULTS

Bouaffif, H1, Haji, M1, Triqui, C1, Kazdagli, H1, Nasri, I1, Hedri, H1, Barbourch, S1, Ben Hamida, F1, Garsone, I1, Ben Abdallah, T1
1Charles Nicolle hospital, Medecine A, tunis, Tunisia, 2Charles Nicolle hospital, Medecine A, Tunis, Tunisia, 3Charles Nicole hospital, Medecine A, Tunis, Tunisia

Introduction: Hemolytic uremic syndrome (HUS) is caused by intrarenal thrombotic microangiopathy, leading to high blood pressure and acute renal failure. The most common form of HUS is secondary to shiga toxin-producing bacteria, typically Escherichia coli. Atypical HUS (aHUS) has been used to classify any HUS not caused by shiga toxin. It is characterized by the triad of thrombocytopenia, microangiopathic hemolytic anemia, and acute renal failure. The aim of our study was to determine the clinical features and the renal prognosis of the HUS occurring in adults.

Methods: We conducted a retrospective study of 19 patients over a period of 27 years (1990-2017) in our nephrology department.

We defined hypertension as an increase in systolic blood pressure > 140 mmHg and/or diastolic blood pressure > 90 mmHg on the basis of the European Society of cardiology.

We defined anemia as a hemoglobin levels lower than 13 g/100ml for adult males, 12 g/100ml for adult females non pregnant, 11 g/100ml for adult females pregnant.

We defined thrombocytopenia as platelets levels lower than 150000/mm3.

AKI is defined as any of the following (Not Graded): Increase in SCR by X0.3 mg/dl (X26.5 lmol/l) within 48 hours or Increase in SCR to X1.5 times baseline, which is known or presumed to have occurred within the prior 7 days or Urine volume o0.5 ml/kg/h for 6 hours on the basis of KDIGO.

We included patients aged over 16 years old with biopsy proven thrombotic microangiopathy. We collected the following parameters: age, gender, co morbidities, clinical exam, biological assessment, treatment.

Results: We included 19 patients. There were 15 men (79%) and 4 women (21%), sex ratio 3.75 with a median age 36 years old (19-60). The inaugural symptoms were dominated by headaches in 52% of cases. It was associated to malignant high blood pressure. The median of PAM was 143 mmHg. And the median of PAS was 120 mmHg, the median platelets was 110000/mm3. The median creatinine at diagnosis was 786 mmol/l (350 – 1940 mmol/l). The blood smear revealed schizocytes in 11 cases (58%). The median hemoglobin was 6.3 g/dl (4.5 – 7.8 g/dl). The haptoglobin level in 7 patients was low in 3 cases. The median platelets was 110000/mm3 (45000 – 143000). The serum complement C3 was consumed in 64% of cases. A glomerular thrombotic microangiopathy was objectified in 42% of cases.

For the etiologies, the HUS was related to gene mutations, pregnancy, infections, cancer in respectively 21%, 5%, 10% and 5% of cases. For the other cases the cause remains unknown.

The treatment combined corticosteroid therapy (1mg/Kg/j) in all cases with plasma exchanges in 26% of cases.