A NEW SURGICAL PROCEDURE IN KIDNEY TRANSPLANTATION WITH A SHORT VEIN OF RENAL GRAFT

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OBJECTIVES
To choose the site of incision in kidney transplantation (KTx), traditionally, we usually use right iliac fossa (RIF) for the left renal graft (LRG), and other site for the right renal graft (RRG). If the renal vein is long enough, this classic procedure hasn’t problem. But in living donor and laparoscopic nephrectomy when the graft vein short, we have to prolong it. Some techniques using genital vein or internal saphene vein were reported. We choose a new procedure for RRG and for short renal graft vein, which were transplanted also on right graft on right site.

METHODS
This is a prospective study with control group of series of transplantation on living donor from 1998 to 2010 of Cho Ray Hospital (CRH). Patients (pts), with end stage chronic renal disease (ESRD), received the graft, devised to 2 groups. Group A: pts who received graft with short vein ≤20mm, transplanted on RIF no matter the graft is left or right kidney. A special technique to prolong the vein (by dissection the renal hilum), dissection and moving of right iliac vein (RIV) to the right side of the right external iliac artery, we also call it the vein dispositions procedure, VDP. Group B: pts who received graft with vein > 20mm, enough for normal transplantation, but always on RIF. Preoperative criteria and surgical team were the same for both 2 groups. Postoperative following up (FU): the vascular perfusion, kidney function.

RESULTS
There were 184 pts undergone the KTx, related donor were 97.7%. Group A: 56 pts, 16 females and 40 males, mean age is 35.3 ± 8.4 yo. Group B: 128 pts, 46 females and 82 males, mean age is 32.9 ± 9.5yo (no significant difference of age and sex of A and B group). Group A: received 13 left graft and 43 right graft; 11 pts with hilar dissection to prolong the vein (19.4%) and 45 pts with VAD (80.6%). Group B: received 128 left graft and 0 right graft, no need any hilar dissection to prolong the vein either VDP. No early surgical complications (bleeding, strangu liver, stretching). Postoperatively doppler ultrasound control of renal vein (mean FU: 3 years, range:1 to 6 years), venous blood flow were normal, there weren’t statistic significant between 2 groups (12.88±4.23 versus 12.36±3.51 cm/s, P>0,05); one year serum creatinine seemed better for group A (1.27±0,29 versus 1.29±0,33 mg/dL, P<0,05).

CONCLUSIONS
In the living donor kidney transplantation could perform on the RIF both for the LRG and also for the RRG, and were better for the short renal graft vein, no need to a graft to prolong the vein. It seems we need change the classic rule LRG for right side and RRG for left side.

References