



# First Experience of Simultaneous Pancreas Kidney Transplantation from Cadaveric Donor

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## INTRODUCTION

The main goal of pancreatic transplantation is to ameliorate insulin-dependent diabetes and achieve complete independence from injected insulin. Simultaneous pancreatic-kidney (SPK) transplantation is the primary option when a patient has diabetic nephropathy and is eligible for a kidney transplant. Combined kidney and pancreas transplantation is performed in patients with renal failure as a complication of insulin-dependent diabetes mellitus (also known as type I diabetes). Candidates for kidney and pancreas transplantation are currently on dialysis or may require dialysis in the near future. After combined kidney and pancreas transplantation, dialysis is not required because the kidneys can filter waste products out. A transplanted pancreas produces insulin to control diabetes. If you have type I diabetes and renal failure, or if your doctor determines that renal failure is onset, a double transplant may be considered as a treatment option. Based on your general health and the results of your pre-transplant tests, you can decide if you need a double transplant. A pre-transplant evaluation includes a complete physical examination, a consultation with the transplant coordinator and surgeon, and a battery of tests including a heart and bladder exam.

## DESCRIPTION

Complications immediately following surgery include clotting of new pancreatic arteries or veins (thrombosis), inflammation of the pancreas (pancreatitis), infection, bleeding, and rejection. Rejection can occur instantly or at any time in the patient's life. This is because the transplanted pancreas is from another organism and the recipient's immune system sees this as an attack and tries to fight it. Organ rejection is a serious condition and should

be treated immediately. To prevent this, patients must take immunosuppressant. Drugs are used in combination and usually consist of cyclosporine, azathioprine, and corticosteroids. However, because episodes of rejection can be repeated throughout a patient's lifetime, the precise choice and administration of immunosuppressive drugs may need to be adjusted over time. Tacrolimus may be given instead of cyclosporine, and mycophenolate mofetil may be given instead of azathioprine. The prognosis after pancreatic transplantation is very good. Recent years have seen improved long-term success and reduced risk. One year after transplantation, over 95% of all patients are still alive and 80%-85% of all pancreases are still functioning. After transplantation, patients require lifelong immunosuppression. Immunosuppression increases the risk of many types of infections and cancer. It is unclear whether other steroids, commonly used as immunosuppressant can be replaced. The donor pancreas is usually placed in the lower right part of the patient's abdomen. Blood vessels from the new pancreas are connected to human blood vessels. The donor duodenum is connected to the patient's bowel or bladder. The pancreas transplant surgery takes about 3 hours.

## CONCLUSION

This surgery is usually done at the same time as a kidney transplant in diabetic patients with kidney disease. About 6 hours of work in total. Euglycemia also ameliorates diabetic glomerulopathy and reduces proteinuria. On the other hand, CNI use can cause nephropathy and reduce creatinine clearance. SPK recipients may not survive well the effects of euglycemia on nephropathy. In diabetic KTA recipients, diabetic nephropathy is progressively reducing renal transplant survival, and many studies suggest that PAH transplantation may prevent accelerated di-

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abetic glomerulopathy in these patients, thereby reducing renal transplant survival. Have been shown to improve survival in some studies show that PTA can preserve kidney function, but it takes at least 5 years for pancreatic transplantation to reverse diabetic nephropathy lesions.

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## **CONFLICT OF INTEREST**

The authors declare no conflict of interest.