**SUMMARY**

**Introduction** Even in the modern era of kidney transplantation, the use of small grafts from pediatric cadaver donors remains controversial. This kind of transplantation is rare and, to date, limited data are presented. Major problems with infant kidney transplantation are difficulties in performing vascular anastomosis, vasospasm, renal vein thrombosis, and small infant kidneys with poor venous runoff. However, en bloc infant kidney transplantation could resolve these problems.

**Case outline** We report on transplantation of en bloc cadaver kidneys from an 18-month-old infant. The transplant recipient was a 32-year-old male, with a body weight of 65 kg. Abdominal ultrasonography showed kidneys growing, and no hydronephrosis, perirenal, or retroperitoneal collections were seen.

**Conclusion** Transplantation of infantile kidneys en bloc in our adult recipient provided good results. The follow-up will show the final effect.

**Keywords:** kidney transplantation, methods; dual kidney transplant; pediatric kidney donor; patient selection

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**INTRODUCTION**

Single infant kidney transplantation is technically more demanding; complications, as well as graft loss, are present more often, either due to injury at the beginning or later due to hyperfiltration [1, 2]. Transplantation of a pair of kidneys in the block constitutes a solution, and in the era of ever-increasing organ needs, it halves the number of potential recipients. Even in the modern era of kidney transplantation, the use of small grafts from pediatric cadaver donors remains controversial. This kind of transplantation is rare and, to date, limited data are presented. This was the first case of infant kidney cadaver transplantation to an adult recipient performed at our institution. We report a case of kidney transplantation from an 18-month-old infant to an adult man.

**CASE REPORT**

An 18-month-old male infant was diagnosed with brain death as a consequence of extreme dehydration. After parents' approval, organ procurement was planned. En bloc kidney procurement was performed, including both kidneys with segments of the aorta, inferior vena cava, and both ureters (Figure 1). Kidney perfusion was performed in situ with Euro-Collins solution (1,000 mL). Cold ischemia time was 13 hours. Kidney measurements were 5.7 × 4.2 × 1.7 cm and aortic and inferior vena cava diameter was about 10 mm.

A 32-year-old male (65 kg, 175 cm) with end-stage renal disease was chosen as the recipient, as no child with terminal kidney disease was compatible. The donor was A-positive, with 3/6 human leukocyte antigen compatibility and negative “cross-match” using complement dependent cytotoxicity. The patient was on hemodialysis for the previous four years (three times per week), with no diuresis, and his serum creatinine level was 1,052 mmol/L. Preoperative examination included abdominal ultrasonography, multislice computed tomography with pelvic angiography and intravenous urography. The operation was performed through the right Gibson incision. The kidneys were placed at both sides of the right iliac blood vessels: the left kidney in the right iliac fossa, and the right kidney below aortic bifurcation (Figure 2). End-to-side anastomosis of the infrarenal infant aorta and inferior vena cava and external iliac vessels with continuous GORE-TEX CV7 sutures (W. L. Gore & Associates, Inc., Newark, DE, USA) were performed. Suprarenal portions of the aorta and inferior vena cava were oversewn with continuous 5-0 nonabsorbable monofilament sutures. Separate anti-reflux uretero-cysto-neostomies with two J-J stents were made (Figure 3). Diuresis started after 15 minutes with good perfusion of both kidneys. In the postoperative period, diuresis was about 9 L/24 hours, and creatinine level fell to 200 mmol/L.
Abdominal ultrasonography showed kidneys’ enlargement (8 × 4 × 2 cm). Moreover, no signs of hydronephrosis, perirenal, or retroperitoneal collections were recorded. Good flow through arterial and venous anastomosis, and good perfusion of both kidneys were recorded by a color Doppler examination. Anti-thymocyte globulin, methylprednisolone, mycophenolate mofetil, and tacrolimus were used as immunosuppressive therapy. There were no surgical complications, postoperative recovery was uneventful, and the patient was discharged on the 15th postoperative day.

DISCUSSION

Modern transplant surgery is challenged with a lack of available organs needed for transplantation. This is the main reason why marginal donors are used more frequently for organ procurement. The main characteristics of these donors are increased transplantation risks, deficiency of functional nephrons, diabetes, hypertension, and the age of over 60 years. In recent years, more infant organ donors have been accepted for kidney procurement. In 1969, a report was submitted on the first successful transplantation of a pair of kidneys from a pediatric kidney donor to an adult [3]. Different techniques are being developed; Salehipour et al. [4] explain this in their paper. Small vascular and urethral anastomoses present a technical challenge for the surgeon. Small and immature kidney vascular vessels and large and mature vessels of the recipient make vascular anastomosis technically more difficult. This problem is overcome with end-to-side anastomoses of the infrarenal donor vena cava and aorta to the recipient vessels [5]. The other method is interposition grafting of the aorta and vena cava to the recipient vessels [6]. Moreover, tiny and underdeveloped ureters and strong adult urinary bladder detrusor make uretero-cysto-neostomy anastomosis very difficult. Venous thrombosis, the major complication and cause of kidney rejection was reported by García Buitrón et al. [7]. They noted that two of four en bloc renal transplants from pediatric donors aged less than one year were lost due to venous thrombosis.

Kayler et al. [8] had good results with the opposite technique, where distal parts of the infant aorta and inferior vena cava were oversewn and anastomoses were done with proximal parts of the mentioned vessels. The UCLA Renal Transplant Registry reported that a one-year graft survival rate after kidney transplantations obtained from 276 donors younger than three years was less than 54% [9]. Small infant kidneys with poor venous runoff make transplantation of one kidney to an adult insufficient. In 1967, Kelly et al. [10] showed that only one in five individual single kidneys transplanted to an adult recipient has an adequate function. Uemura et al. [11] found that kidneys from pediatric donors > 6 cm in size can be successfully transplanted as single kidneys. Sureshkumar et al. [12] suggested that pediatric donors weighing more than 10 kg were suitable for single-kidney transplantations. In some retrospective studies, it was noted that hyperfiltration remains the main problem with single infant kidney transplantations [13, 14]. Vascular hyperinfiltration injury can be reduced by dividing the blood flow into both small graft kidneys. In addition, the overall survival rate is significantly higher from paired kidneys compared to a single transplanted kidney [15]. Therefore, both kidneys were transplanted to
one recipient as en bloc transplantation. Enlargement of both kidneys after transplantation has also been noticed by other authors [14]. Another challenge for small organs is the creation of ureterocystostomy, so Lippman et al. [16] believe that poor surgical technique is a curve for urinary leakage, occurring secondary to necrotic ureter caused by inadequate blood supply [16]. However, successful transplantation of a pair of cadaveric renal kidneys aged six months with 4.75 cm in length performed by Huang et al. [13] once again demonstrates that it is possible to extend the marginal donor limit when it relates to the size of the organs and the donor’s age.

**CONCLUSION**

Transplantation of infantile kidneys en bloc in our adult recipient provided good results. This kind of transplantation is a good option, for it extends the number of marginal donors. The follow-up will show the final effect.

**REFERENCES**


**En bloc кадаверична трансплантација два бубрега са детета старости 18 месеци као даваоца на одраслог примаоца – приказ случаја и преглед литературе**

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**САЖЕТАК**

У модерној ери трансплантације бубрега, употреба мртвих дечјих даваоца у ендоваскуларним случајевима остале контроверзна. Оваква трансплантација је ретка и са мало објављених података. Главни проблеми код трансплантације са једним дејцем бубрегом су тешкоћа у креирању васкуларних анастомоза, спазам крвних судова, тромбоза реналне вене и мала величина дејца бубрега са недовољним венским протоком. Трансплантација два дејца бубрега „у блоку“ могла би да реши ове потенцијалне проблеме.

**Закључак**

Трансплантација парних дечјих бубрега „у блоку“ на одраслог примаоца у нашем случају је дала добре резултате. Преаћење ће показати копачне резултат.

**Кључне речи:** трансплантација бубрега, методе; трансплантација два бубрега, дете даваоца бубрега; селекција болесника