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Surgical Outcomes of Renal Transplant: A retrospective case-control Study

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When compared to maintenance dialysis, kidney transplantation is the therapy of choice for chosen individuals with end-stage renal disease, boosting not only their longevity but also their quality of life. In 2016, 2.094 renal transplants were conducted in Germany, with expected half-lives of 14 and 22 years for deceased and living donor grafts, respectively. As a result, today's surgeons are dealing with a rising number of renal transplant recipients who require elective or emergency surgery due to graft-related surgical issues. Renal transplant recipients undergoing graft-unrelated abdominal surgery are a special group since they are continuously immunocompromised, putting them at risk for infectious complications. Recent research demonstrates that data on postoperative mortality and morbidity in renal transplant recipients is inconsistent. After graft-unrelated surgical procedures, whether elective or emergency.

Description

As a result, the goal of our research was to critically assess our own kidney transplant patient outcomes in contrast to a non-transplanted control group. At the University Medical Center's Department of General and Visceral Surgery, we conducted a retrospective monocentric and controlled cohort study. The study was approved by the University's Medical Faculty's ethics committee and carried out in accordance with the principles of the Declaration of Helsinki and the International Council for Harmonization (ICH) recommendations for good clinical practise (GCP). The study was included into a WHO-approved primary registry. All data was kept fully secret, with only study personnel having access. The STROCSS criteria were used to report the findings [1].

The search feature of the electronic patient management system "Prometheus" was used to collect data. Patients who had the international classification of diseases code for kidney transplantation and were treated in the Department of General and Visceral Surgery between 2005 and 2015 were separated. On the basis of inclusion and exclusion criteria, raw data was manually collected and analysed for possibly appropriate patients. The electronic patient curve in "Copra" and available documentation in "Prometheus" were used to examine all patients who were eligible for inclusion. In a pre-formatted table, data was collected anonymously. Patients who had received other organ transplants, as well as combination transplants and those who needed renal replacement treatment were excluded. All types of abdominal wall and abdominal surgery not connected to adult patients' transplanted kidneys was a candidate for inclusion Two writers were responsible for the creation of the control group. We chose non-transplant patients with normal renal function who had abdominal surgery at the University Hospital's Division of General and Visceral Surgery between 2005 and 2015. The type of operation had to match the transplanted group's operations [2].

As a condition for inclusion, the equality of operation encryption was established. Renal impairment and previous organ transplantation were both criteria for exclusion. We used the electronic search mechanism to look for encryption, similar to how kidney transplant patients generate data. The patient's inclusion and exclusion criteria were reviewed, and suitable patients were placed in the control group. The following complications have been reported: urinary tract infection, urinary retention, pneumonia, postoperative bleeding, hematoma, adrenal insufficiency, pulmonary embolism, extremity vascular occlusion, cardiac decompensation, myocardial infarction, abdominal stoma complications, lymphoid fistula, intestinal fistula, mechanical ileus, intestinal perforation, acute mesenteric ischemia, peritonitis, ana All of the complications listed are included in the overall number of complications collected. The following complications have also been added to the list of surgical complications [3].

Infection of the wound, pneumonia, intraabdominal abscess, peritonitis, anastomotic leaking, ischemia or perforation of the intestine, ileus Urinary tract infection, surgical haemorrhage, abdominal stoma complication, abdominal wound dehiscence. The modified Clavien classification of postoperative complications was used to categorise problems, and the diagnosis was made either clinically or using appropriate diagnostic criteria. Pneumonia and thromboembolism were radiologically confirmed. Intraabdominal problems such as abscesses, ischemia, fistula (lymph or intestine) and mechanical ileus were also detected radiologically. Blood examination and sonography were used to diagnose bleeding. Clinically and sonographically, hematoma and urine retention were verified. Laboratory testing was used to diagnose kidney or adrenal problems [4].

Urinalysis confirmed the presence of urinary tract infections. Anastomotic leaking was discovered during revision surgery or via endoscopy. After emptying purulent secretions from the wound, the diagnosis of a wound infection was made. The presence of a fascia dehiscence with intestine prolapse was the cause of abdominal wound dehiscence. Wedge resections and non-anatomic resections of the liver, anatomic resections of the liver, right or left hemihepatectomy, segmental resections of small bowel, all types of colectomy and rectal resection, gastrointestinal continuity restoration surgery, esophagectomy, gastrectomy, pseudocystojejunostomy, pancreatic necrosectomy, cystic kidney nephrectomy, spleen Adhesiolysis, creation of ascending stoma, appendectomy, cholecystectomy, diagnostic laparoscopy, exploratory laparotomy (without further resection), suture of duodenum, restoration of ileostomy, hernia (inguinal, navel, scar) re-pair with or without mesh, stoma revision, and removal of retroperitoneal hematoma were defined as minor operations. All hernia repairs and stoma revisions were classified as extraabdominal operations [5].

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Conflict of Interest

None

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