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Liver Transplant in HIV Positive Patients: Our Experience

HOSPITAL ITALIANO de Buenos Aires

N Mañez[1], MD, A Smud[1], MD, I Staneloni[1], MD, A Valledor[1], MD, M Visus[2], BMC, G Greco[2], BMC, L Barcán[1], MD
Department of Internal Medicine, Infectious Diseases Section [1]. Department of Diagnosis, Central Laboratory, Bacteriology[2].
Hospital Italiano de Buenos Aires, Buenos Aires, Argentina.

noelia.manez@hiba.org.ar

Abstract

Background:
Control of HIV replication by HAART has allowed HIV positive patients (p.) to be reconsidered as transplant candidates. **Objectives:** To describe the clinical features and evolution of HIV+ p., who received a liver transplant (LT) in our center and to analyze complications and mortality rate.
Methods:
Single center, retrospective cohort study, of LT performed on HIV+ receptors. Survival was estimated with the Kaplan Meier method and was expressed as cumulative survival with 95% confidence intervals .
Results:
From July 2006 to December 2015, 14 LT were performed in 13 p. Age: median 45y (r: 37-56). Gender: M/F 11/2. Seven p. stopped HAART due to toxicity before transplant (Tx). CD4 at inclusion to the waiting list: 283/mm3 (r: 105-1233. Viral load (VL): 24,716 copies/ml (r: undetectable-152,113). Liver disease: 12 p. HCV, 3 associated to hepatocarcinoma (HCC) and one HBV + HCC. Time from inclusion to the waiting list until Tx: median 6.5 months (r: 0-26). MELD at inclusion to the list: mean 26 (r: 20-36). Nine p. had acute rejection (1 steroid-resistant). There was no graft loss due to rejection as sole cause, one p. required re-LT due to relapse of HCV plus biliary disease plus rejection. Relapse of HCV 100%. Time from LT to relapse: 6 months (r: 1-28), 5 of them were severe. Eight received treatment: 6 achieved sustained virologic response, one partial response, and one failure. None showed complications related to HIV. Nine p. switched HAART post Tx. In post-LT, all p. exhibited VL of HIV undetectable. Mean CD4 cells count at 6 months post-LT: 303 cel/mm and 12 months: 354 (r: 123-1,098).Three p. died: 2 due to HCV relapse, both with multiple organ failure, and another p. due to HCC relapse associated to HBV.
Conclusion:
LT is possible in our population, giving priority to an adequate selection of candidates for the waiting list and multi-disciplinary follow-up during post LT. Immunosuppression added by the LT had no consequences in the control of HIV infection. Despite the almost universal HCV relapse, even severe forms can be controlled with the currently available drugs. Mortality rate was lower in our series compared with published reports.

Background

Control of HIV replication by HAART has allowed HIV positive patients to be reconsidered as transplant candidates. Objectives of this study are to describe the clinical features and evolution of HIV+ patients, who received a liver transplant (LT) in our center and to analyze complications and mortality rate.

Methods

This is a single center, retrospective cohort study, of LT performed on HIV+ receptors. Survival was estimated with the Kaplan Meier method and was expressed as cumulative survival with 95% confidence intervals .

Results

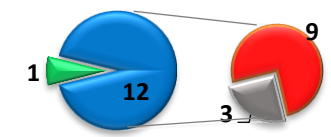
Pre Transplant

TX 14 13 11 2

Age: 45 y (r: 37-56)

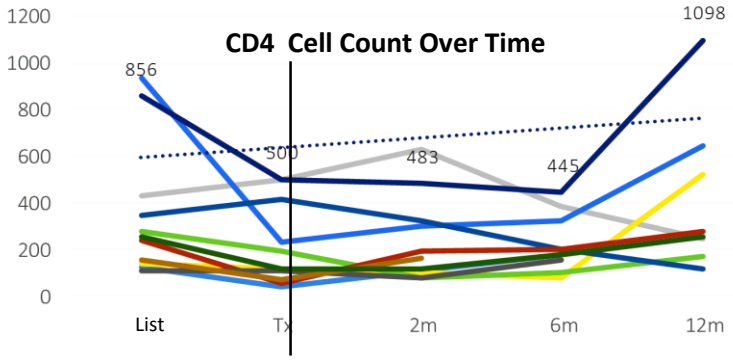
HAART 7

Liver Diseases



1 a: 7
1 b: 3
3 a: 1
Unknown : 1

Variable	Mean	Range
Time Hepatopathy at list	102 months	2-263
Time inclusion at Tx	6.5 months	0-26
MELD	26	20-36
Viral Load	24,716	<20- 152,113
CD4 Cells Count	283/mm³	105-1233



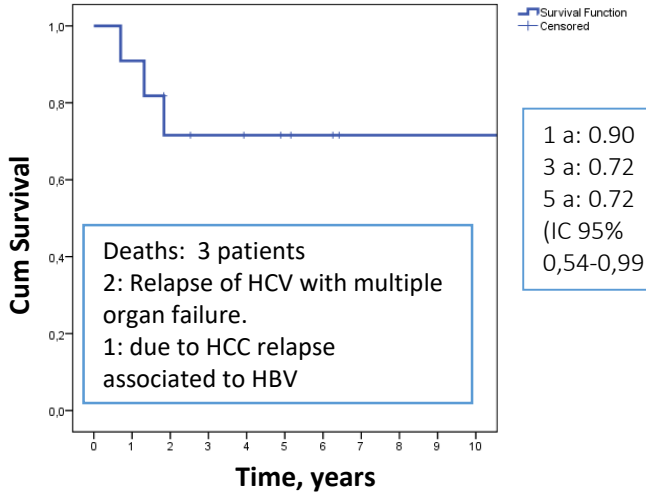
283/mm3 (105-1233)	226/mm (39-537)	271/mm3 (78-866)	288/mm3 (77-967)	303/mm3 (123-1098)

Post Transplant

Variables	Pt
Acute Rejection	9
Graft loss	0
Complications related to HIV	0
Switched HAART	9
VL undetectable	13

P	Relapse	Time of Tx	Treatment	Evolution
1	Mild	6 Months	No	Re Tx
2	**Severe**	15 Months	No	**Dead**
3	Mild	2 Months	IFN/RVB	RVS
4	Mild	10 Months	IFN/RVB	RVT
5	**Severe**	1 Months	IFN/RBV	RVT
6	Mild	2 Months	IFN/RVB	RVT(pl)
7	Mild	28 Months	IFN/RVB/BOC	RVS
8	**Severe**	7 Months	No	**Dead**
9	**Severe**	4 Months	IFN/RBV	RVS
10	Mild	2 Months	IFN/RVB/Tel	RVS
11	Mild	5 Months	No	Stable
12	Mild	5 Months	No	Stable
13	**Severe**	1 Months	RBV/SIM/DAC	NR

Survival Function in HIV (+) Patient whit Liver Transplant



Deaths: 3 patients
2: Relapse of HCV with multiple organ failure.
1: due to HCC relapse associated to HBV

1 a: 0.90
3 a: 0.72
5 a: 0.72
(IC 95% 0,54-0,99)

Conclusion:

LT is possible in our population, giving priority to an adequate selection of candidates for the waiting list and multi-disciplinary follow-up during post LT. Immunosuppression added by the LT had no repercussions in the control of HIV infection. Despite the almost universal HCV relapse, even severe forms can be controlled with the currently available drugs. Mortality rate was lower in our series compared with published reports.