Treatment of Acute T-cell mediated Renal Allograft Rejection

Biopsy
- Allograft biopsy should be performed prior to treatment, unless this will substantially delay in therapy

Initial therapy
- In view of the risks of HBV reactivation, specialist opinion for initiation of antiviral agents is to be considered in patients with positive anti HB core antibodies
- Pulse methylprednisolone 500 mg IV for 3 days, then oral prednisolone daily
- Increase dose of oral prednisolone after a steroid pulse then wean
- Switch from cyclosporine to tacrolimus aiming for levels of 8-12
- Add mycophenolate for those patients not already receiving this agent or those on azathioprine
- Restart or continue PJP and CMV prophylaxes.

Treatment for biopsy-proven steroid resistant or recurrent acute cellular rejection
- Thymoglobulin (ATG)
  - **Dosing**
    - Graft Rejection Prophylaxis: 1 – 1.5mg/kg/day (rounded off to nearest vial) for 3 – 9 days until CNI has been introduced and therapeutic levels achieved.
    - Steroid Resistant or moderate to severe transplant rejection: 1.5mg/kg/day for 7-14 days

References
Chadban S et al, KHA-CARI guidelines, Adaptation of the KDIGO Practice Guideline for the Care of Kidney Transplant Recipients, February 2012
Chon W, Acute renal allograft rejection: Treatment, UpToDate article, last updated June 13, 2014
Chon W, Clinical manifestations and diagnosis of acute renal allograft rejection, UpToDate article, last updated June 5, 2013
