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Outcome of Pancreatic Graft in "Pancreas after Kidney Transplant" with BK/JC viremia: A Case Report

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Introduction

Pancreas after kidney (PAK) transplant represents an excellent therapeutic option for selected patients with CKD and IDDM with good outcome.

BK virus nephropathy (BKVN) was reported in up to 7.5% of patients after SPK.

Its management by reduction in immunosuppression might predispose to pancreatic graft rejection.

Case report

A 36-year-old lady who had type I diabetes with diabetic nephropathy, underwent ABO compatible left iliac cadaveric renal allotransplant with 5 HLA mismatches and no DSA on 12/12/2021.

She received thymoglobulin induction and was kept on steroid, mycophenolate and tacrolimus with stable renal function around 90 umol/l.

On 16/02/2023, she underwent cadaveric pancreatic allotransplant -enteric drainage- with 4 HLA mismatches and no DSA. She received thymoglobulin induction and was kept on the same maintenance therapy with relatively higher tacrolimus level (9-11 ng/ml).

In July 2024, during routine quarterly surveillance, BK/JC viremia was detected with significant viral load, reached peak 749339 copies/ml, Mycophenolate dose was halved, with biweekly monitoring of pancreatic enzymes and PRA. Unfortunately, there was no response, therefore MMF was discontinued and two doses of IVIG were given.

Kidney biopsy was done in October 2023-in view of graft dysfunction- revealed ATN and ruled out PyVAN.

Case report

In January 2024, BK/JC viremia nadir viral load was 960 copies/ml but pancreatic enzymes started to rise in February 2024, serum amylase reached peak 282 U/L, lipase 1113 U/L. Thorough investigations- PRA, CMV, c-peptide, endogenous insulin assay, HBA1C- came normal. Moreover, pancreas was normal by ultrasound and MRI without exogenous insulin requirement.

Mycophenolate was re-introduced with small dose (Myfortic^{R} 180mg BD).

Empirically, pulse steroid was given while arranging for pancreatic biopsy that showed ACR GII with negative C4d. Thymoglobulin 6 mg/kg was planned.

After receiving first dose 1.5 mg/kg, her BK viral load was rising (493585 copies/ml) together with JC PCR (80018 copies/ml). Case discussed with patient regarding risk/ benefit of anti-rejection and final plan was to stop thymoglobulin, to give IVIG 2gram/kg and to keep patient on steroid, Tacrolimus and Everolimus.

Currently, amylase/ lipase came down to normal levels with minimal insulin requirement and normal renal function

Conclusion

Rejection episodes along with BK/JC viraemia/ nephropathy is a big challenge requiring vigilant and careful adjustment of anti-rejection and maintenance immunosuppression

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