Discussion: Acute Humoral Rejection has been described rarely to occur with de novo production of DSAs. Usually less than 10% of C4D positive biopsy samples show features suggestive of ATN. Conventional regimes for treatment of AMR include IVIG + Plasmapharesis +/- Rituximab. We are reporting this case for the unexpected nature of the clinical setting in which he developed Antibody mediated rejection and for the use of Plasmapharesis with rATG as an economically viable and efficacious alternative treatment regimen for Acute Antibody-mediated rejection.

080

URETERAL HERNIATION LEADING TO INTERMITTENT OBSTRUCTIVE UROPATHY IN A RENAL ALLOGRAFT RECIPIENT

*Author(s) -Rajiv Mukha, **Elsa Thomas**, Nitin Kekre, Ninan Chacko, Antony Devasia*

Urology, CMC Vellore

A 44-year-old male underwent live related allograft renal transplantation three years ago for stage V chronic kidney disease secondary to unknown cause. The immunosuppression was with cyclosporine, azathioprine and prednisolone and the nadir creatinine of 1.5 mg/dl was reached one week postoperatively. This remained stable for 30 months when the creatinine began to fluctuate intermittently between 1.5 mg/dl and 2.2 mg/dl. He noticed a reducible swelling in the lower third of the transplant scar that was confirmed to be an incisional hernia. Ultrasonogram showed graft hydro-ureteronephrosis. Magnetic resonance urogram revealed an incisional hernia involving the lower third of the transplant scar, containing the mid-portion of the transplant ureter and compressing the distal ureter at the neck of the hernial sac, causing hydroureteronephrosis. At exploration, the ureter was found to be in the wall of the hernial sac compressed by the adjacent omentum. The ureter was released from the adherent sac and found to be draining freely. The hernia was repaired using a prolene mesh. After surgery, the serum creatinine returned to 1.5mg/dl and a follow up diuretic renogram showed free drainage . Ureteral obstruction is a known complication after renal transplantation, often resulting in obstructive uropathy. This requires re-do reimplantation, percutaneous diversion, or dilatation and stenting. Ureteroinguinal hernias are rare, with about 130 cases reported in the world literature 1. Sliding inguinal hernias containing the ureters have been reported in renal allografts with six reports in literature 2. We report a case of obstructive uropathy secondary to ureteral herniation into an incisional henia sac following renal allograft transplantation. To our knowledge this is the first such report in medical literature. 1. Michelle Elizabeth Brand, MD, Steven Brooks, CST, CFA, Karen Brooks-Searle, MD, Robert M. Esterl, Jr., MD. Ureteroinguinal hernia: a rare cause of ureteral obstruction. Case report March 2006, surgicalroundsonline.com. 2. Leandro H. Otani, MD, Shri K. Jayanthi, PhD, Rodrigo S. Chiarantano, MD, Andre M. Amaral, MD, Marcos R. Menezes, PhD and Giovanni G. Cerri, PhD. Sonographic Diagnosis of a Ureteral Inguinal Hernia in a Renal Transplant. J Ultrasound Med. 2008 Dec; 27(12):1759-65.

081

LAPAROSCOPIC LIVE DONOR NEPHRECTOMY : A SINGLE CENTRE EXPERIENCE

S Sharma, S Chaturvedi, R Mahesvari, A Srivastava, R Kapoor, M S Ansari, P Ranjan

SGPGI, Lucknow

AIM -To describe our experience with transperitoneal laparoscopic live donor nephrectomy

Donors wereaccepted between ages18 and 65years after a comprehensive workup to rule out any medical risk factors, from January 2000 to December 2009, 662 cases (193 M: 469 F) were successfully completed laparoscopically. In the initial part of the series, closed Transperitoneal technique using Veress needle was used to create Pneumoperitoneum. Later on, Open Hasson technique for port placement was used. The vessels were clipped using a pair of Hem-o-lok clips and the kidney was retrieved by hand assistance. In the initial part of the series, lumber muscle cutting incision was used, and later on, Pfannensteil muscle splitting incision was used.

Results: The mean age of the donors was 40.4 ± 11.6 years, operativeduration 150-210 min, mean warm ischaemia time 3.8 min (range 2-7 min), blood loss 50-125ml, analgesic requirement 150-330 mg of tramadol, pain score range 2-5 (on visual analogue scale) and hospital stay (3.14days). Re- exploration was required in eight patients. Trocar induced bowel injury in two, and bleeding in six cases. Conversion was required in 15 patients. Diaphragmatic injury and hydrothorax occurred in two patients which were managed conservatively. Overall complication rate was 11.78% in the entire series including single mortality. Majority of conversions and complications including mortality were seen in initial 50 cases. Pfannensteil incision was aesthetically pleasing, less painful and more acceptable to the patients. The overall costs incurred to the donor is 650-700 USD, including hospital stay.

Conclusion: Transperitoneal laparoscopic live donor nephrectomy can be safely performed, and is cost effective with use of double Hem-o-lok clips. Open Hasson technique should be preffered for the initial port placement. Pfennenteil muscle splitting incision is aesthetically superior.