

Psychosocial support after simultaneous pancreas and kidney transplantation

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We read with interest the article by Otte on the review of pediatric liver transplantation based on 20 years of experience [1]. In this article, psychological and mental impact of pediatric liver transplantation was discussed. Likely, the similar situation may occur after simultaneous pancreas and kidney transplantation (SPK), as SPK is indicated exclusively for patients with uremic type I diabetes with long-standing disease history from younger age. We recently experienced a case of SPK transplant who required the removal of both kidney and pancreas allografts for organ failure secondary to hypochondriasis-induced medication non-compliance.

A 36-year-old female with type I diabetes and diabetic nephropathy was referred to our hospital as a candidate for SPK. The durations of diabetes treatment and dialysis were 26 years and 3.5 months, respectively. She was unmarried and lived with her mother. Her social history includes dropout from the college at second grade. She underwent uneventful SPK, received standardized immunosuppression including daclizumab, mycophenolate mofetil and tacrolimus. Her postoperative course was complicated by only minor gastrointestinal symptoms such as constipation, diarrhea and appetite loss; however, she claimed immediate nursing attention more than necessary during days and nights, and sometimes threatened discharge against medical advice. She was discharged on postoperative day 16 with normal blood glucose and good renal function.

During her outpatient follow-up visits, she became malnourished and was admitted to the hospital with severe abdominal pain. Work-up showed no apparent cause of the pain, and the patient recovered without any intervention. Renal function and blood glucose level were within normal limits. During subsequent outpatient follow-up visits, she showed worsening nutritional status, and she also presented with severe recurrent abdominal pain. Blood trough levels of tacrolimus were unmeasurable, and the diagnosis of acute rejection secondary to non-compliance was made. She underwent removal of kidney and pancreas grafts on the day 42 after transplantation. Histological examination revealed massive necrosis

of kidney and pancreas allografts secondary to severe acute rejection. She returned to insulin therapy and hemodialysis.

Psychosocial background of SPK patients is often complicated due to long-standing disease history. The adverse psychosocial consequences come from dependency on parents and medical personnel, unrelenting lack of respite from illness and continuous need for treatment, restricted diet and fluid intake, and multiple losses (disability, financial insecurity, loss of self-esteem, delayed independence, etc.) [2,3]. Additionally, psychosocial morbidity in transplant patients is common as the incidence of major depression and anxiety neurosis are 2–16% and 2–14%, respectively [2]. The patients sometimes develop poor coping and social skills that ultimately leads to frustration. These inappropriate behaviors may eventually lead to postoperative noncompliance and the loss of transplanted organs. Unfortunately, it is difficult to predict postoperative compliance as preoperative compliance does not necessarily reflect postoperative compliance [2,4–6]. So, it is important for physicians, transplant coordinators and other team members to recognize the signs of psychosocial morbidity in these patients. Addressing these issues earlier may prevent subsequent noncompliance and transplant organ loss.

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References

1. Otte JB. Paediatric liver transplantation – a review based on 20 years of personal experience. *Transpl Int* 2004; **17**: 562.
2. Trzepacz PT, Levenson JL, Tringali RA. Psychopharmacology and neuropsychiatric syndromes in organ transplantation. *Gen Hosp Psychiatry* 1991; **13**: 233.
3. Levy NB. Psychiatric considerations in the primary medical care of the patient with renal failure. *Adv Ren Replace Ther* 2000; **7**: 231.

Letter to the Editor

4. Leggat JE, Orzol SM, Hulbert-Shearon TE, *et al.* Noncompliance in hemodialysis: predictors and survival analysis. *Am J Kidney Dis* 1998; **32**: 139.
5. Shapiro PA, Williams DL, Foray AT, *et al.* Psychosocial evaluation and prediction of compliance problems and morbidity after heart transplantation. *Transplantation* 1995; **60**: 1462.
6. DiMartini A, Jain A, Irish W, *et al.* Outcome of liver transplantation in critically ill patients with alcoholic cirrhosis: survival according to medical variables and sobriety. *Transplantation* 1998; **66**: 298.