THG1

Evaluation of Pneumocystis jirovecii (PJP) and Cytomegalovirus (CMV) Prophylaxis Duration in Kidney Transplant Recipients

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Introduction: Kidney transplant recipients face an increased risk of opportunistic infections due to the immunosuppressive medications necessary to prevent rejection of the transplanted kidney. At University Hospitals of Leicester NHS Trust (UHL), patients are routinely prescribed prophylaxis against Pneumocystis jirovecii pneumonia (PJP) with co-trimoxazole, or atovaquone if they are allergic or intolerant to co-trimoxazole or its components. This prophylaxis is typically continued for 6 months post-transplant, as this period carries the highest risk of PJP infection.
Additionally, patients with donor CMV-positive to recipient CMV-negative (D+/R–) serostatus are prescribed valganciclovir for 6 months to reduce the risk of cytomegalovirus (CMV) infection. Valganciclovir is also administered to patients receiving alemtuzumab (Campath) induction immunosuppression, unless both donor and recipient are CMV-negative. While these prophylactic treatments are crucial in preventing serious infections, prolonging their use beyond the recommended duration can increase tablet burden, elevate the risk of adverse effects such as myelosuppression and nephrotoxicity, and contribute to antimicrobial resistance.
This audit was conducted to evaluate compliance with UHL guidelines, specifically to determine whether co-trimoxazole/atovaquone and valganciclovir prophylaxis were appropriately stopped at 6 months post-transplantation.

Aim: To assess prescribing practices of co-trimoxazole/atovaquone and valganciclovir for PJP and CMV prophylaxis, respectively, in kidney transplant recipients, ensuring adherence to UHL guidelines.

Objectives: To establish whether new kidney transplant patients started on PJP and CMV prophylaxis had these medications discontinued appropriately at 6 months.

Audit Standard: All kidney transplant recipients initiated on PJP and CMV prophylaxis should have these medications stopped at 6 months, unless there is a clear clinical indication to continue.

Methodology: This retrospective audit reviewed data from January 2024 to December 2024. 57 patients were identified as having been started on co-trimoxazole/atovaquone, and 17 patients on valganciclovir, using a data collection tool developed by the Leicester Kidney Pharmacy Team. Patients who repatriated away from Leicester, deceased and those who required prolonged courses (e.g. those who had treatment for transplant rejection) were excluded from the audit. Data sources included transplant patient lists maintained by transplant coordinators, clinic letters, and a renal software system called Proton. Ethical approval was not required.

Results: Of the 57 patients on PJP prophylaxis, 13 (23%) continued treatment beyond the 6 month period. Similarly, 6 out of 17 patients (35%) prescribed valganciclovir extended beyond the recommended duration. No documented clinical reasons justified these prolonged courses.

Discussion: These findings highlight an issue with adherence to UHL guidelines regarding the duration of PJP and CMV prophylaxis. Among those on co-trimoxazole/atovaquone, 7 patients remained on treatment beyond 8 months. Possible causes include delayed or cancelled follow-up appointments, which may have led to missed medication reviews. 2 patients on valganciclovir continued treatment for over 8 months without documented reasons.
The results will be presented at the next transplant multidisciplinary team meeting to increase awareness and develop strategies to improve guideline adherence. A re-audit is planned to evaluate the impact of any changes implemented.

THG2

Impact of universal IGRA screening on detection of latent TB infection in kidney transplant candidates

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Background: Chronic kidney disease (CKD) patients undergoing kidney transplantation, post-transplant immunosuppressive therapy substantially impairs cell-mediated immunity, placing them at high risk of latent tuberculosis reactivation(Rohmah et al., 2024). British Thoracic Society (BTS) guidelines and the National Institute for Health and Care Excellence (NICE) in the UK advocate for targeted screening of high risk individuals (e.g., recent migrants from high incidence countries) because universal testing was considered unlikely to be cost effective (Milburn et al., 2010, National Institute for and Care, 2016). International consensus, recommend systematic screening for latent TB infection (LTBI) in all solid organ transplant candidates using interferon γ release assays (IGRAs) because of their superior specificity and convenience compared with the tuberculin skin test (TST)(Subramanian and Theodoropoulos, 2019, Chiu, 2024). Until July 2021, our programme offered post-transplant chemoprophylaxis to all high-risk individuals as standard practice. This approach was subsequently revised with the introduction of universal IGRA screening.

Methods: This retrospective audit included all 613 patients assessed for kidney transplantation between 2019 and August 2025. Candidates were stratified as “high-risk” (birth or prolonged stay in high-incidence country; prior TB exposure; radiological or immunosuppressive risk factors) or “low-risk.” Pre-2021, less systematic testing was carried out; post-2021, universal QuantiFERON-TB Gold interferon-γ release assay (QFT-IGRA)screening was implemented. Outcomes were screening uptake, IGRA positivity, and prophylaxis initiation, compared between periods and risk groups.

Results: Screening coverage increased from 44% pre-2021 to 89% post-2021 (high-risk: 65% → 95%; low-risk: 33% → 87%). Universal screening identified 10 IGRA-positive cases among low-risk candidates that would have been missed under the previous approach. Prophylaxis practice shifted from empiric treatment of high-risk candidates without confirmed infection to targeted treatment of IGRA-positive individuals. This reduced unnecessary drug exposure while maintaining protection against TB reactivation.

Conclusions: Universal IGRA screening significantly improves coverage and detects latent TB infection in kidney transplant candidates who would be missed by risk-based approaches. Prophylaxis should be reserved for IGRA-positive patients, balancing prevention of TB reactivation with minimisation of treatment-related toxicity. Routine universal IGRA testing, integrated with epidemiological risk assessment and chest imaging, should be adopted as standard in UK transplant candidate evaluation.

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THG3

Regional transplant goals through local coordination: Impact of a live donor coordinator at a non-transplanting centre

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Introduction
Living donor kidney transplantation offers superior outcomes compared with dialysis or deceased donor transplantation. However, donor identification and coordination in non-transplanting centres presents significant challenges due to complex communication requirements with transplanting units. We aimed to increase the number of donors who are referred to the transplanting unit for phase 2 of the live donor assessment process by 25% by the end of 2025, through the implementation of a dedicated Live Donor Co-ordinator role, early education, and streamlined referral pathways to transplanting centres. This initiative directly supports the West Midlands regional objective to increase overall living donor transplant rates to over 20 per million population (pmp) for all units in the Midlands by enhancing the donor pipeline and assessment efficiency across the region (Midlands Kidney Transplant).

Methodology
The Live Donor Co-ordinator role encompassed: (i) screening patients with advanced chronic kidney disease (CKD) approaching/ on renal replacement therapy (RRT), (ii) providing transplantation and live donor education (iv) organising blood test and phase 1 investigations (ECG, chest X-ray, echocardiogram, abdominal ultrasound), and (vi) nephrology referral to transplanting unit for phase 2. Interventions included improved transplant plan documentation, systematic patient screening for transplant suitability, transplant education sessions, and live donor information packs.
Additionally, Advanced Kidney Care colleagues (specialist nurses and doctors) were encouraged to discuss transplantation proactively and distribute live donor packs. The principle of “transplant first” was embedded in all patient and family discussions to ensure opportunities for live donor kidney transplant (LDKT) were maximised. Outcomes assessed were numbers undergoing initial education, phase 2 referral, and live donor nephrectomy.

Results:

Between 2022-2025, donor activity showed marked improvement. In 2022 (pre-coordinator), 35 potential donors received education, with 7 (20%) referred for phase 2 and 4 proceeding to nephrectomy. Post-coordinator implementation, education numbers were 41 (2023), 31 (2024), and 26 (2025). Phase 2 referrals increased from 7 (2022) to 8 (2023), 20 (2024, +186%), and 12 (2025), achieving a 71% increase by Q3-2025, substantially exceeding the 25% target. Live donor nephrectomies rose from 1 (2022) to 3 (2023), 6 (2024), and 10 (Q3-2025), representing a 10-fold increase from baseline. The unit's regional

target of 11 live transplants to contribute to the 20 pmp regional aim is approaching achievement by the end of the year, with 10 transplants completed by the end or 3rd quarter 2025 and three donor-recipient pairs awaiting scheduled transplantation.

Discussion

The introduction of a Live Donor Co-ordinator in a non-transplanting centre has been associated with substantial improvements in progression from donor education to nephrectomy. The donor assessment process can be daunting, particularly as most prospective donors are previously healthy with little healthcare contact, and unexpected medical or psychological issues may emerge during work-up (Sharma et al., 2020). Consistent, clear communication and tailored emotional support are essential to minimise donor drop-out and enhance engagement. This highlights the critical role of early donor engagement, systematic screening, and co-ordinated referral in enhancing LDKT activity.The dedicated coordinator model addresses the inherent challenges of managing complex multi-centre pathways while maintaining donor momentum throughout assessment.

THG4

Clinical and cost-effective duration of CMV viral load monitoring in renal transplant patients in a single centre

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Introduction

CMV monitoring is vital in transplant patients to detect reactivation early and prevent serious complications such as tissue-invasive disease. However, over-testing can lead to unnecessary interventions and costs. Striking the right balance ensures timely detection while minimising patient burden, optimising outcomes, and using healthcare resources efficiently. We evaluated the results of CMV monitoring in our local cohort as set out in our current guidelines. The aim was to assess the efficacy of our current practice.

Methods

All renal transplant patients under hospital follow-up were identified and stratified according to their CMV risk category. High (D+R-) and low-risk (D-R-) groups were assessed over 10 years, while intermediate-risk patients (D+R+ and D-R+) were assessed over 5 years. Patient identification was based on nursing record books, with all laboratory and clinical data extracted from the Lorenzo electronic health record system. Results were systematically tabulated, and the cessation point for CMV monitoring was determined by visually identifying the time at which the rate of positivity decreased to a low level and remained stable.

Results

The results demonstrated that 613 CMV tests were performed in the low-risk cohort, yielding only a single positive result in ten years. This patient remained below the treatment threshold and subsequently reverted to negative, meaning that not a single case of treatable CMV was detected in this group over the study period.

In the high-risk group, approximately 20% of tests were positive within the first two years post-transplant, with a marked decline in positivity thereafter. The intermediate-risk group exhibited a comparable trend to the high-risk cohort, with early positivity followed by a decrease in later years. By 2 years post-transplant, positivity rates for the high-risk and intermediate group were 8.3% and 23% respectively, and by 3 years, it was 4.5% and 0% respectively. From 5 years post-transplant, positivity was zero in both groups.

Discussion

The results suggest that routine testing may be discontinued entirely for the low-risk group in our centre. For the intermediate and high-risk groups, routine testing could be safely discontinued after three years, with subsequent reliance on symptom monitoring only. Having established appropriate monitoring durations, the next step would be to determine the subtype of high-risk and intermediate-risk groups that can end monitoring earlier and evaluate the optimal frequency of monitoring. Streamlining testing allows healthcare

providers to focus monitoring on patients who truly need it, minimising unnecessary interventions and optimising hospital resources.

THG5

A successful implementation of a novel multidisciplinary weight management programme incorporating GLP-1 receptor agonists and psychological activation in patients with end-stage kidney disease and living with obesity

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Introduction:
At our centre, we have pioneered the United Kingdom's first multidisciplinary weight management clinic specifically tailored for renal patients. This innovative service integrates pharmacological therapy with GLP-1 receptor agonists alongside psychological, dietary, and physiotherapeutic interventions. The programme aims to address inequities in access to kidney transplantation by targeting obesity as a modifiable barrier to listing.
Methods:
The Kidney in Fitness for Transplantation (K-FIT) service, inaugurated in May 2024, employs a comprehensive multidisciplinary team (MDT) model encompassing clinician /transplant surgery, psychology, dietetics, physiotherapy, and renal pharmacology. Prior to enrolment, patients undergo psychological assessment to evaluate capability, opportunity, and motivation for behavioural change.
Eligible candidates participate in a structured 12-month programme comprising monthly consultations with a dietitian, physiotherapist, and pharmacist, supplemented by two psychological reviews and access to a Mood and Food Support Group. Semaglutide, a GLP-1 receptor agonist, is prescribed for up to 12 months as adjunctive therapy.
Inclusion criteria include an eGFR <15 mL/min/1.73m² and confirmation of obesity as the sole barrier to transplantation following completion of all other pre-transplant investigations. Patients must have a BMI >35 kg/m² or >27 kg/m² with truncal obesity (waist-to-height ratio >0.6) and demonstrate willingness to engage with all MDT components for a minimum of six months. Exclusion criteria include inability to commit to the programme, or significant medical contraindications.
Clinical metrics—including weight, BMI, waist circumference, grip strength, functional capacity, and Duke Activity Status Index (DASI)—are monitored longitudinally. Patient-reported outcomes and quality-of-life measures are also collected.
Results:
To date, 101 patients have been referred, with 75 undergoing psychological assessment. Of these, 46 patients were accepted into the programme; The cohort is demographically diverse, with 52% male and BAMI (black and ethnic minority) group percentage is 73% vs 27% white.
The average BMI was 35.8 kg/m²(27.9 – 45.6), waist circumferences average 115.7 cm (94 – 134) ,
Currently, 31 patients are actively engaged in the programme. Among 21 patients who have reached the six-month milestone, significant improvements in weight and functional status

have been observed. Twelve patients achieved their target weight therefore they are active on waiting list, with a mean weight reduction of 7.5% and a decrease in waist-to-height ratio from 0.72 to 0.61. DASI score showed difference of 3.21+, Physical Activity Vital Sign (mins) demonstrated difference of 54.94 +. Within this this period, three patients have successfully undergone kidney transplantation—one via living donation and two via deceased donor allocation.

Conclusion:

The K-FiT programme demonstrates that a structured, intensive, multidisciplinary approach can effectively facilitate weight loss and improve transplant eligibility in patients with end-stage kidney disease and living with obesity. This model offers a viable, non-surgical alternative to bariatric intervention and highlights the safety and efficacy of GLP-1 receptor agonists in this complex patient population. The integration of psychological activation and lifestyle modification is pivotal to its success and may serve as a blueprint for similar initiatives nationally and internationally.

THG6

Improving Early Detection of BKPyV in Kidney Transplant Recipients

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Introduction

Polyomavirus BK virus (BKPyV) infection is a significant risk factor for kidney transplant dysfunction and graft loss. The Transplant Society (TTS) recommends monthly BKPyV screening until month 9, then every 3 months until 2 years post-transplant. A baseline audit of this centre's compliance undertaken in March 2024 reported the majority (84%) of kidney transplant recipients (KTR) were not screened for BKPyV within the first 30 days post-transplant and none were screened consistently.

Methods

We undertook a quality improvement project addressing several barriers to BKPyV screening, including requesting issues, raising awareness of the correct blood bottles and education of staff and patients. Data was collected monthly and reported at the transplant multidisciplinary meeting.
Our centres compliance with the TTS recommendations was reaudited at 6 monthly intervals from March 2024 to August 2024, September 2024 to February 2025 and March 2025 to August 2025.

Results

Across the three audit cycles, variation was observed in both tests not being requested and tests requested but not completed. In the first cycle (March - August 2024), 17 monthly monitoring tests were not requested (82.2% compliance) and 7 were requested but not completed (92.7% compliance).
During the second cycle (September 2024-February 2025), performance improved, with only 4 tests were not requested (95.5%) and 6 requested but not done (93%) Three-monthly monitoring was introduced and compliance reached near 100%, with only one requested test not completed.
In the third cycle (March - August 2025), monthly monitoring declined slightly, (92.1% for both categories), while three-monthly monitoring, reached 95% compliance for not requested and 88.3% compliance for not completed.

In addition to compliance, outcomes related to BKPyV positivity were recorded in each cycle:

- First cycle (March - August 2024)
- 5 patients tested positive for the first time
- Average time to positivity: 3 months post-transplant

- Immunosuppression was reduced in all cases
- 1 patient remains positive
- 1 patient experienced graft failure with BKPyV positivity a contributory factor

 2. Second cycle (September 2024- February 2025)
- 5 new patients tested positive
- Average time to positivity: 4 months post-transplant
- Immunosuppression was reduced in all cases
- 3 patients remained positive

 3. Third cycle (March- August 2025)
- 3 new patients tested positive
- All became positive at 3 months post-transplant
- Immunosuppression was reduced in all cases
- All remained positive

Currently, a total of 7 out of 44 recipients under 2 years post -transplant were BKPyV positive, corresponding to a rate of 15.9%.

Discussion

This reaudit suggests there has been a significant improvement with early BKPyV screening allowing for timely reduction of immunosuppressive therapy as per guidelines. BKPyV positivity typically occurs at 3-4 months post-transplant. Findings from the re-audits highlights the importance of continued adherence to monitoring protocols and early immunosuppression adjustment is essential to optimise graft survival. A follow-up audit will be conducted annually to sustain improvements.

THG7

Increasing transplant listing within the Advanced Kidney Care (AKC) Clinic – a Transform AKC Quality Improvement (QI) Project

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Introduction

Transplantation is the gold-standard renal replacement therapy (RRT) for suitable patients[1]. Suitable patients should be active on the transplant list within 6 months of the anticipated RRT start. Discussions around transplantation should start when a patient has an estimated glomerular filtration rate (eGFR) of 20ml/min/1.73m2.

In September 2024, only 3.8% of our AKC patients (excluding conservative management (CM) patients) were active on the transplant list and 59.6% had no transplant status recorded.

Our aim is for at least 25% of AKC patients with an eGFR <15ml/min/1.73m2 on a potential transplant listing pathway to be active on the transplant list by March 2026.

QI methodology

We started our project in October 2024. We process mapped our transplant assessment pathway, outlining key steps, highlighting problems, and identifying potential change ideas. We engaged with key stakeholders, including our local kidney patient association. We used a Plan-Do-Study-Act cycle approach to our tests of change.

We identified patients within the AKC cohort with eGFR <20ml/min/1.73m2 and excluded CM patients. We recorded the percentage of patients with a documented transplant status.

We identified patients within the AKC cohort with eGFR <15ml/min/1.73m2 and excluded CM patients and those who were permanently unsuitable for transplantation. We recorded the percentage of patients who were active on the transplant list.

We recorded several measures monthly including the number of AKC patients referred for transplant work-up.

Change 1: focus on recording transplant status on our renal electronic patient record, Clinical Vision. We updated the status at the AKC Quality Assurance meetings.

Change 2: update Clinical Vision categories for the Transplant Status field. This highlighted reasons why patients were not transplant listed and provided insight into barriers to transplantation.

Change 3: redesign the transplant referral process into a concise guideline. This aimed to increase awareness of required investigations for transplant workup and prompt clinicians to organise investigations at time of referral.

Results

The completeness of transplant status recording for AKC patients with eGFR <20ml/min/1.73m2 improved from 45.1% to 92.4% (Figure 1), and was maintained at >80% for 5 months.

The percentage of AKC patients with eGFR <15ml/min/1.73m2 on a potential transplant listing pathway and active on the waiting list has improved from 9.8% to 12.2% (Figure 2).

The median number of referrals for transplant work-up from AKC was 9.5/month (Figure 3). This has increased to 17 referrals in the last month but we need further observation to confirm this improving trend.

Discussion

We have improved our data accuracy, seen a rise in transplant referral numbers, and an increase in the percentage of AKC patients active on the waiting list. Our next steps are to (1) focus on earlier requesting of investigations by clinicians, (2) working to minimise delay to transplant listing for cardiology reasons, (3) implement a weight management service focussing on patients who need to achieve weight loss for transplant listing.

Acknowledgement: Transform AKC in partnership with Kidney Care UK.

Reference

[1] NHS England. (2017). Transplant First: Timely Listing for Kidney Transplantation. Available from NHS England [Accessed 2025, September 14].

THG8

A Service Evaluation of Pre-Transplant Patients' Medication Needs: Implementation of an Innovative Pharmacy Technician–Led Service During the Transplant Listing Period

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Background

Medicines optimisation is a patient-centred approach that ensures the right patient receives the right medication at the right time, improving outcomes, minimising risks, and supporting shared decision-making. Traditionally, medication reviews in secondary care are conducted only at the point of hospital admission, often resulting in complex medicines reconciliations and interventions during a stressful period for the patient. Earlier intervention in the pre-transplant period may help reduce this burden. While several service reviews describe pharmacist-led approaches, there is limited literature exploring the role of the wider pharmacy multidisciplinary team.

Aim

- To evaluate the medication and adherence issues faced by patients prior to kidney transplant listing.
- To assess whether such reviews and interventions fall within the professional scope of pharmacy technicians.

Method

A pilot study was undertaken at one of the UK's largest kidney transplant centres between 1/6/2025 and 31/8/2025. A medication barrier questionnaire, designed to identify patients requiring intervention, was incorporated into the standard transplant registration process and administered by the transplant coordinator nursing team. Completed questionnaires were reviewed by a pharmacist and pharmacy technician, who determined whether an intervention was required and by whom.

Patients identified as needing support were contacted either at home or during a subsequent outpatient clinic appointment. A full medication history was taken, appropriate interventions implemented, and an agreed personalised medication action plan documented in the patient's hospital record. This record would then be available when the patient is admitted for transplant. Interventions were delivered by pharmacy technicians where appropriate, with escalation to a pharmacist if required.

Results

Of 23 patients listed for deceased donor transplantation during the pilot, 9 (39%) required intervention. Of these 9 interventions, 8 (88%) were successfully completed and implemented by pharmacy technicians with only 1 patient (12%) requiring pharmacist escalation (Table 1).

Conclusion/Discussion

This pilot demonstrates that pharmacy technicians are well-placed within the multidisciplinary team to deliver the majority of pre-transplant medication interventions. With appropriate training and governance, they can effectively identify, manage, and escalate issues when necessary.

Early identification and resolution of medication concerns ensured patients felt informed, empowered, and engaged in their care, with clear action plans in place ahead of surgery. Wider implementation of this service to include the living donor programme and transplant centre referring units, has the potential to reduce medication non-adherence and post-transplant readmissions.

THG9

Transplant listing status of peritoneal dialysis patients

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Introduction

Peritoneal dialysis (PD) is a low cost, autonomous, and effective renal replacement therapy (RRT) choice and in some instances, a bridge to transplantation. While dialysis is an important alternative for those who cannot receive transplant, RRT of choice in patients with end stage renal disease (ESRD) remains (pre-emptive) renal transplant. The clinical practice guideline by the UK renal association recommends demonstrable equity of access to deceased donor (DD) renal transplantation. We reviewed all prevalent PD patients in our unit to ensure that they had been considered for transplantation and to identify current transplant status, to ensure optimal access to transplantation for this population.

Methods

A list of adult patients on PD was obtained from the renal electronic database. Demographic and outcome data were retrieved from the IT system, recorded and analysed in Microsoft Excel. Clinic letters and clinical notes were reviewed to identify reasons for non-referral, transplant status and reasons for suspension on transplant list.

Results

The prevalent number of patients on PD was 123: 53 females (43.1%) and 70 males (56.9%). The median age of the population was 62 (IQR 46-77) and 77 (62.6 %) were British. Out of the total PD population, 120 (97.6 %) individuals had discussion relating to transplantation, while 3 (2.4 %) did not. Of the 120 individuals who had discussion relating to transplant, 56 (46.7%) were referred for consideration of transplant listing. The reasons for non-referral are as shown below (Table 1). We classified reasons for non-referral into modifiable or non modifiable. Of the patients who were referred for consideration of transplant listing, 31 were listed for transplant (55%) with 25 (45%) patients still undergoing work up. Of those listed, 21 (68%) remained active and 10 (32%) were suspended. Anaemia was the most common reason for suspension (n = 6, 60%). Most individuals had one (n = 4, 40%) or two (n = 4, 40%) reasons for suspension and two individuals had three reasons. Only one individual did not have any documentation relating to transplant discussion.Ethnicity data was reviewed but due to small numbers of non-white patients, we were unable to identify any trends from these data.

Discussion

All but one patient on PD were offered access to renal transplantation. About half the population were found unsuitable, while the other half were either still in work up or found both medically and surgically suitable and were subsequently activated. There were a few modifiable reasons identified for those not referred. Suspensions for those previously activated were all temporary, pending medical optimisation. Unfortunately, our small and heterogeneous data set lead to limited data on equity. The outcome of this audit is to

optimise management of anaemia in patients who have been listed and investigate delays in the listing process to identify where these lies.

THG10

Methenamine Hippurate Prophylaxis for Recurrent UTIs in Kidney Transplant Recipients: A Retrospective Evaluation.

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Background:
Recurrent Urinary Tract Infections (UTIs) is a serious complication for immunosuppressed kidney transplant recipients, threatening both patient health and graft survival
This centre implemented a new prophylactic protocol. This protocol prioritizes the use of Methenamine Hippurate as the first-line prophylaxis before escalation to prophylactic antibiotics. This approach aims to reduce infection rates and preserve graft function while minimizing antibiotic resistance.
The amended NICE Guidelines (December 2024) state that the committee has endorsed methenamine Hippurate as a suitable alternative to daily antibiotic prophylaxis for patients with recurrent UTIs. This recommendation is reflected in our local adult urogynaecology clinical guidelines, which now also advocate the use of methenamine as a prophylactic antiseptic in the management of UTIs.
Methods:
This retrospective review aimed to evaluate the clinical efficacy of Methenamine prophylaxis in 23 patients with a history of recurrent UTIs, defined as 3 or more infections per year.
Data was collected from electronic medical records for a 12- month period prior to Methenamine initiation up to 12 months. (range 2 -12 months)
We compared:

- Change in annualized UTI incidence rate
- Reduction in antibiotic prescriptions
- Improvement in patient reported urinary symptoms
- Treatment tolerability
- Episodes of AKI

Results:
The analysis of outcomes for the 23 patients prescribed Methenamine prophylaxis for > 3 months reveals a positive response in a significant portion of the cohort.

- Complete resolution of UTIs and urinary symptoms occurred in 11 patients (48%). Of these, five have maintained complete remission for over 12 months. The remaining 6 individuals have been on treatment for < 12 months but have not had any further symptoms.
- An additional two patients (9%) reported a significant reduction in both infection frequency and symptom severity and remain on therapy after 12 months.
- Out of those 13 patients who have full/partial of response, there were 5 episodes of AKI in the 12 months prior to initiation, with no episodes of AKI since starting the methenamine.

- Seven patients (30%) experienced no clinical improvement. Of these, three discontinued Methenamine within 3–6 months due to persistent infections, and four remain under ongoing evaluation, including referral to urology.
- Three patients (13%) ultimately required escalation to prophylactic antibiotics following inadequate response to Methenamine. All three subsequently achieved symptom resolution.

Methenamine was generally well tolerated across the cohort

Conclusion:

The implementation of a Methenamine Hippurate prophylactic protocol for Kidney transplant recipients has demonstrated considerable clinical efficacy, successfully reducing or eliminating UTI burden in a majority (57%) of our patient cohort. This strategy effectively supports our dual objectives of preserving graft function/prevention of AKI and mitigating antibiotic resistance. However, the 30% non-response rate indicates that Methenamine is not a panacea. These findings highlight the importance of a structured protocol that incorporates timely escalation to antibiotic prophylaxis for non-responders, ensuring all patients receive effective care.

THG11

Post Transplant Diabetes Mellitus and Type 2 Diabetes Mellitus – Are we treating them differently?

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Introduction

Post transplant diabetes mellitus (PTDM) and type 2 diabetes mellitus (T2DM) are distinct entities but share similar management principles. Both require careful titration of anti-glycemic medication while balancing the transplant related risks such as nephrotoxicity and drug-drug interactions. This is often further complicated by changes in renal function of the transplant, steroid-induced hyperglycemia, and recent study findings of cardiovascular and renal benefits of certain classes of diabetic drugs such as SGLT2 inhibitors.
We aimed to ascertain whether there are any differences between medication regimes between kidney transplant recipients (KTR) with PTDM and those with pre-existing T2DM.

Methods

This observational cross-sectional study identified all KTR that were on diabetes medications from our renal database cv5. KTR with T2DM were identified by diabetes medications. PTDM was determined as patients who had diabetic drugs after their transplant, but not before. Individual drugs were sorted according to drug class groups. KTR with T1DM were excluded. All medications initiated within 30-days of kidney transplant were also excluded. Demographic data, eGFR and HbA1c were collected. Statistical analysis was performed with R 4.4.0. Level of significance $p<0.05$.

Results

151 KTR in our centre were on diabetes medication. 10 people with T1DM that were excluded. 45 KTR identified as T2DM before receiving kidney transplant and 106 developing PTDM. Overall, 60% were male with 40% female. The median age was 63 years (range 30-89), with 38% KTRs mainly identifying as Asian. The median time to receiving the first diabetes medication was 7.6 (0.8 – 75.2) months after the transplant, with T2DM KTR receiving their first diabetes medication 53 (79 – 25) months prior to transplant. HbA1c was significantly different between PTDM and T2DM 54mmol/mol and 46mmol/mol, respectively ($p < 0.01$).

T2DM KTR were more likely to be on insulin compared to PTDM KTR 35% vs 84%, respectively ($p < 0.01$). In contrast, patients with T2DM were more likely to be on metformin 63% vs 33%, respectively ($p < 0.01$). There was no significant difference in KTR with T2DM or PTDM prescribed gliclazide 45% vs 33%, respectively ($p = 0.23$), SGLT2 inhibitors 26% vs 15%, respectively ($p = 0.21$). There is generally low prescribing of GLP-1 agonists within this cohort, with PTDM at 3% and T2DM at 2% ($p = 0.99$) receiving this cardio, renal, and metabolic protective therapy.

PTDM and T2DM had no statistically significant difference in terms of diabetic medication burden ($p = 0.15$) (Figure 1). Significantly more PTDM KTR were managed by a single agent compared with T2DM KTR ($p<0.01$). In contrast more T2DM KTR were on insulin compared to PTDM KTR ($p<0.001$).

Discussion

KTR with T2DM were more likely to receive insulin therapy and less likely to receive first-line metformin post transplantation than those with PTDM. For the former, kidney transplant may be an opportunity to review insulin and consider de-escalating therapy, especially within those with eGFR ≥ 30 ml/min/m². HbA1C was significantly better controlled in PTDM KTR than T2DM emphasizing the need for T2DM KTR to be reviewed and optimized following transplantation.

THG12

Type 2 Diabetes Mellitus management pre and post transplantation - have we got it right?

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THURSDAY - Moderated Poster Session, HALL Q, March 12, 2026, 10:00 - 11:00

Introduction

Type 2 diabetes mellitus (T2DM) is a leading cause of end-stage kidney disease (ESKD). As kidney function declines, glycemic control becomes increasingly complex as there is a reduction in insulin excretion and first-line medications, such as metformin are contraindicated due to low eGFR. Many patients are therefore typically on insulin at ESKD. Post transplantation the majority of kidney transplant recipients (KTR) achieve eGFR >30mls/min/1.73m2 making them eligible to return to oral medications and/or deescalate diabetes medication to reduce medication burden while maintaining glycaemic control. We aimed to determine our centres management of T2DM pre and post transplantation.

Methods

This observational retrospective study determined KTRs with pre-existing T2DM in our centre. KTR with Post transplant DM and T1DM were excluded. Data was extracted from cv5 renal database. Demographics, renal profile, and full medication history were examined to identify diabetes medication regime pre and post kidney transplantation. Diabetic medications were sorted into different groups and coded: Metformin (M), Gliclazide (G), DPP4 (D), SGLT2i (S) to enable regimens to be documented. Statistical analysis was completed using R 4.5.1. Level of significance $p<0.05$.

Results

47 KTR with T2DM with 66% (31/47) male; 34% female. Median age 66 years (range 41–82 years). Ethnicity; 21% Caucasian, 23% Black, 44.7% Asian. Age, sex or ethinicity did not affect the number of medications T2DM KTR were on (Table 1).
Pre-transplant T2DM regimens without insulin showed; 1 KTR had no medications (glimpiride was stopped 2 years prior to transplant), 16 KTR on 1 diabetes medication (G, D,S) with the most common regieme being Gliclazide alone having 13 KTRs, 3 KTR on 2 diabetes medication (M+G, G+D), and 1 KTR on 3 diabetes medication (M+G+D) (Figure 1). For those on insulin, there were 19 KTR on insulin alone, 6 KTR on insulin and 1 oral medication (I+M, I+G, I+D), and 1 KTR on insulin and 3 oral medications (I+M+G+D) (Table 2). After transplantation, 10 KTRs no longer required diabetes medications, 4 KTR on 1 oral medication (G, D), 3 KTR on 2 oral medications (M+G), and 2 KTR on 3 oral medications (M+G+D, M+G+S). The most common regime was insulin alone with 12 KTRs, 11 KTR on insulin with 1 oral medication (I+M, I+G, I+D, I+S), and 5 KTR on insulin with 2 oral medications (I+G+D, I+M+G). There was a significant increase in Metformin use post transplantation $p<0.05$ (Table 3).

Discussion

Glycaemic control is maintained in T2DM with a limited number of agents as GFR declines with many being contraindicated in low GFRs. Post transplant KTR with T2DM on the whole have GFRs that facilitate reintroduction of different agents despite the increased burden of immunosuppression on glycemic control. Our study shows 8% of KTR T2DM no longer required insulin and 21% did not require any medications. A review of diabetes medications is essential to be had post transplantation to reduce/stop insulin and replace/start other agents that are no longer contraindicated due to eGFR.