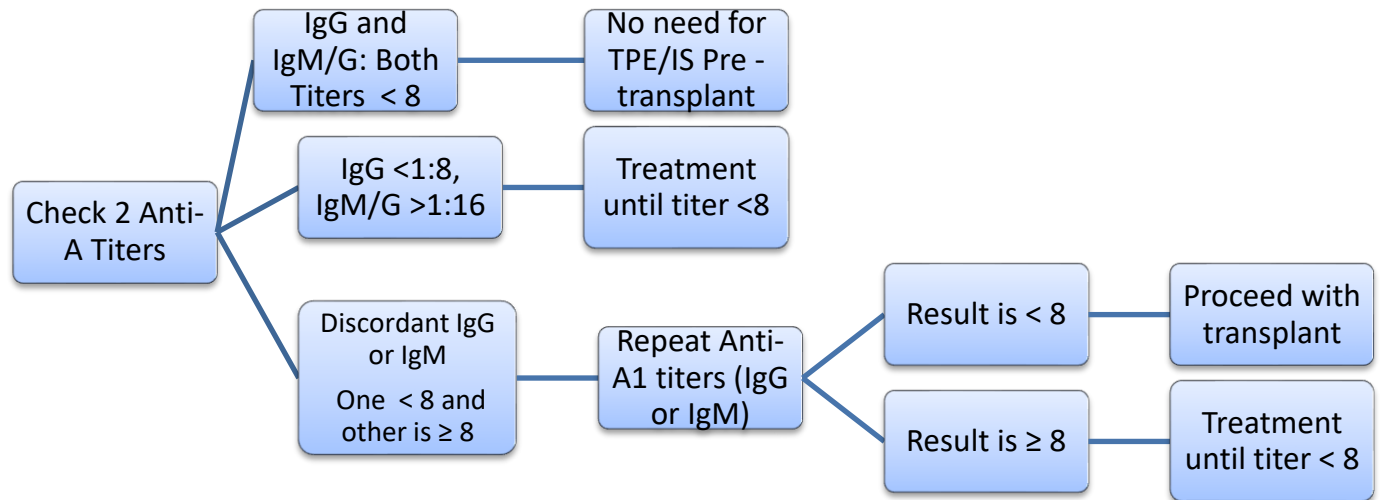


Guidelines: Anti-A Titer Monitoring for A2 (Non-A1) to O and non-A1/non-A1B to B Living Donor Kidney Transplants (case by case basis when NKR option is not available)

1. Written consent from candidates regarding willingness to accept Non-A1 Kidney (include consent in both nephrology and surgery H&P at time of transplant)
2. Confirm candidate eligibility every 90 days in UNET
3. High Risk of rejection and graft loss if recipient anti-A1 IgG titer is >1:8 (also concern from elevated anti-A1 IgM titer; Norman et.al). Monitor titer levels for candidate eligibility as mentioned in #4

4. Pre-Transplant Anti-A1 Titer Monitoring:

Check 2 anti-A titers AT TIME OF INITIAL EVALUATION and monitor quarterly



Anti-A Titer Monitoring for A1 to O Kidney Transplants

5. Pre-Transplant Desensitization Treatment (if Anti A1 Titers are \geq 8):

(Cedar Sinai based protocol)

- 1 month prior to transplant – Initiate MMF 500mg po BID
- 2 weeks prior to transplant – Rituximab 375mg/m² IV X 1; Premed with Tylenol 650mg PO and Benadryl 25mg PO
- INITIATE Plasma Exchange (PLEX) 1.5 PV AT LEAST 48 HOURS AFTER RITIUXIMAB X 5 sessions given every other day, with the last session between 24-72 hours prior to transplant. Check anti-A titer prior to each pheresis session.
REPLACEMENT FLUID: 5% Albumin. FFP BASED ON FIBRINOGEN/INR LEVEL.
- Following final PLEX – IVIG 2gm/kg IV X 1

6. Induction IS: 5 doses of ATG + Solumedrol per SOC protocol

7. Maintenance IS: TAC/MMF/Prednisone 5 mg daily (after taper)

8. Post-Transplant Anti-A1 Titer Monitoring:

- Monitor anti-A titers on POD 1, 2, 3, 5, 7, 10, 14, 30, 60, 90, 180, 270, and 365 and whenever clinically indicated due to renal allograft dysfunction
- If anti-A1 titer increases \geq 16, treatment as above to reduce the titer

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