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**Range of outcomes reported in kidney transplantation trials**

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Tue, 3/31 10:18AM • 3:22

**SUMMARY KEYWORDS**

patients, enormously, trial, rejection, infection, immune response, endpoint, dampen, top, remains, answer, rejection rate, surrogate, transplant, problem, recurrent infections, dialysis, guarantees, life expectancy

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We are required to dampen down the immune response in order to prevent rejection. And if you've generally dampened down the immune response, it will take you a greater risk of infection and cancer. So it's a double edged sword. The only thing you're really interested in is the length of life of a transplant and the length of life of the patient. Unfortunately, most people live most constructs live for many years, most patients live for many years. And so it's not feasible to do a trial that uses either of those parameters of the endpoint, because it would just take decades to get an answer. So you try and find a surrogate for those. And of course, there isn't unanimity on what the best surrogate is. Should it be crashing at one year? Should it be rejection rate, should it be biopsy based? So that's why there's there's a variety of different endpoints over recent years. Very powerful in Utah, our trial approach has been to pool a number of different studies, and therefore have the power increase because we've got many, many more patients being analysed.

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Clearly there's an extent to which no two trials are the same. And so it's a compromise with respect to consistency. But you increase the power enormously and therefore are able to answer questions that you weren't previously able to do. And so having something like the company database, or some sort of way of pulling things together for meta analyses, has really allows us to address questions that are really very, very relevant to patients. And so it's a major advance and something that's really only been very commonly in use for the past 15 years. So it's very easy to be a bit depressed by the fact that we still have infections in our transport patients and do some patients dial this and all So but no, there's no guarantees to class last forever.

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But I think he has to put that into perspective. But for example, the 1980s, one year survival of the graph was 60%. Now, it's probably about 92%. So we've moved enormously over the course of the past few years. And while there's more to be done, I feel very positive about how much we've improved, not just the life expectancy of our patients, but also the quality of their life. We felt so much to be complacent, there's more we can do. We need to understand issues like chronic rejection, her best thing is on top of antibody mediated rejection, which still remains a significant problem in which interventions are very, very limited and relatively ineffective.

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And we need to get on top of the problem of recurrent infections. That is a problem for our patients are nonetheless one has to see some context We've made enormous strides over the course of the past few decades. And transplantation remains absolutely fantastic treatment for an individual with end stage kidney disease and to be able to get them off dialysis and transplant them is, as I say, not only to prolong the life expectancy, but it significantly improves the quality of their life.