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Intestinal transplantation: The anesthesia perspective

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Intestinal transplantation is a complex and challenging surgery. It is very effective for treating intestinal failure, especially for those patients who cannot tolerate parenteral nutrition nor have extensive abdominal disease. Chronic parental nutrition can induce intestinal failure associated liver disease (IFALD). According to United Network for Organ Sharing (UNOS) data, children with intestinal failure affected by liver disease secondary to parenteral nutrition have the highest mortality on a waiting list when compared with all candidates for solid organ transplantation. Intestinal transplant grafts can be isolated or combined with the liver/duodenum/pancreas. Organ Procurement and Transplantation Network (OPTN) has defined intestinal donor criteria. Living donor intestinal transplant (LDIT) has the advantages of optimal timing, short ischemia time and good human leukocyte antigen matching contributing to lower postoperative complications in the recipient. Thoracic epidurals provide excellent analgesia for the donors, as well as recipients. Recipient management can be challenging. Thrombosis and obstruction of venous access may be common due to prolonged parenteral nutrition and/or hypercoagulability. Thromboelastography (TEG) is helpful for managing intraoperative product therapy or thrombosis. Large fluid shifts and electrolyte disturbances may occur due to massive blood loss, dehydration, third spacing etc. Intestinal grafts are susceptible to warm and cold ischemia and ischemia-reperfusion injury (IRI). Post-reperfusion syndrome is common. Cardiac or pulmonary clots can be monitored with transesophageal echocardiography (TEE) and treated with recombinant tissue plasminogen activator. Vasopressors may be used to ensure stable hemodynamics. Post-intestinal transplant patients may need anesthesia for procedures such as biopsies for surveillance of rejection, bronchoscopy, endoscopy, postoperative hemorrhage, anastomotic leaks and thrombosis of grafts etc. Asepsis, drug interactions between anesthetic and immunosuppressive agents and venous access are some of the anesthetic considerations for this group.

Stem cell transplantation: Emerging hope for sickle cell disease patients

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Sickle cell disease remains a disease of public health importance particularly in West Africa with 2-3% of the Nigerian population living with the disease and 25% being carriers of sickle cell trait. Despite the advocacy programme on prevention, the prevalence of sickle cell disease does not seem to have changed. Early detection through prenatal and neonatal screening and novel therapies such as chronic transfusion and use of hydroxyurea have helped in preventing complications and thus prolonged the life span of patients with sickle cell disease. Stem cell transplantation is a potential cure for patients with sickle cell disease and our institution has over 2000 adult and 800 paediatric sickle cells patients and many more are still joining the pool. My focus on transplantation medicine is linked to the large cohort of these patients who might be able to lead a normal life if successfully transplanted. Currently, very few of the patients who can afford the transplant are referred to abroad. We intend to establish a sickle cell centre which will incorporate the transplant centre. I have a short exposure/training locally in bone marrow transplant in sickle cell. The recent success reported by National Institute of Health (NIH) will offer the opportunity to our adult sickle cell patients to lead a normal life. Therefore, I look forward to available cutting edge science and opportunities in the field of transplantation during the conference.

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