Antibiotics after Transplantation

Dr. Ramesh Prasad

Almost everyone has been prescribed an antibiotic at one time or another. An antibiotic is a special kind of medication that is used to fight an infection, typically a bacterial infection. It is taken for a limited period of time. For transplant patients there are some special considerations when it comes to taking an antibiotic, which we will briefly discuss.

Antibiotics are sometimes taken by transplant candidates (those patients who are being considered for a transplant but haven’t actually received one yet). Usually, this means that there is an active infection. Since it is generally unsafe to perform a transplant in this situation, it means that the transplant may have to be postponed until the infection has been completely cleared up. On the other hand, on occasion an antibiotic is taken to prevent an infection. Examples of this might include INH to prevent tuberculosis in someone previously exposed, or septra to prevent Pneumocystis jiroveci pneumonia (PJP) in a patient who has had it before. In that case, these can be continued through the transplant period and afterwards as well.

An antibiotic is prescribed at the time of surgery to prevent wound infection, often as a single dose. It is again often prescribed a few weeks later, at the time the urinary stent is removed. Almost all patients receive septra (or dapsone, in the case of septra or sulfa allergy) for one year after the transplant to prevent PJP. This is done because the immunosuppression is at its highest during this time. However, in general, any infection can occur at any time after the transplant.

Beyond these “routine” prescriptions of antibiotics, antibiotics are prescribed when there is a diagnosed infection. This could be a wound infection, urinary tract infection, or pneumonia, for example. In most instances, there has to be some documentation of an infection before an antibiotic is prescribed. It is very rare for us to call in a prescription for an antibiotic over the telephone based on a phone call from a patient. Since a doctor is not always available in the transplant clinic, it is best to go to your family doctor as soon as possible if you suspect an infection and are ill (fever, extreme fatigue or weakness, cough with sputum, urine burning, pain over the transplant, wound discharge, etc...) or to the Emergency Room if you are very ill. A sputum, urine, wound, and/or blood culture will be sent, to help determine the nature of the infection and the best antibiotic to use. It may be necessary to change the antibiotic in a few days, based on the culture result. Sometimes antibiotics are used in combination, for serious infections like endocarditis (infection of the heart valves).
Special precautions with regards to taking antibiotics includes knowing your current level of kidney function, since the dose of some antibiotics is reduced if your transplant is not working very well. Some antibiotics (like clarithromycin, or Biaxin®) should not be taken at all because they interact seriously with the transplant drugs. Some antibiotics like gentamicin and tobramycin, to name a few, are directly toxic to the kidney and should be used only with extreme care, if at all. Please check with us whenever you are prescribed an antibiotic, and let your pharmacist know that you are a transplant patient whenever you pick up a prescription. Finally, be sure to let anyone concerned know if you have any drug allergies. One of the most common groups of drugs that cause allergic reactions is antibiotics.

Antibiotics are very useful drugs, but they should not be used indiscriminately. Never share antibiotics with family members or friends since the reactions could be very serious, even fatal! Also, using an antibiotic for every infection (such as viral infections), even when they are not needed, can create serious microbial resistance. When resistance happens, options may be limited to using IV antibiotics to treat even simple infections. Antibiotics are among our best friends, as long as we don’t misuse them.

From the Editor’s Desk

Welcome to the Fall 2014/Winter 2015 issue of Transplant Digest. We take pride in delivering to you a variety of articles and features packed with information that will hopefully be useful to you at some point in your transplant experience. Since transplant is a longitudinal experience, lasting many years, we try our best to make sure that no one (donor, recipient, or interested provider) is ever left behind! Suggestions about future topics for inclusion are always welcome, and past issues which may contain an article of special interest to you are available upon request. As usual, articles from patients are also welcome. We really need your contributions since I expect many patients will carefully read them over.

In this issue, topics such as antibiotics after transplantation, mental health, early wound management, different tacrolimus formulations, and taking out a kidney (nephrectomy) are given attention. If you are interested in working in transplantation, there is an article here for you. I would also like to take this opportunity to congratulate our Senior News Correspondent, Galo Meliton, RN, on being awarded a special volunteer pin from the Kidney Foundation of Canada. Congratulations Galo! The staff at Transplant Digest wish everyone a safe and pleasant winter.

Dr. Ramesh Prasad, Editor

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Taking out a Kidney: Is it Necessary?

Dr. Ramesh Prasad

A common question that gets asked before or after a transplant is: should my own kidney(s) or the transplant kidney be taken out? Obviously, this is a complex question for which there is no single answer. We will first address whether a “native” kidney needs to be taken out, followed by the situation with a transplant kidney.

Unlike in the case of a heart, lung, or liver transplant, it is not usually necessary to take out a native kidney before putting in a kidney transplant. This is because the transplant is placed in a different body location, in the groin and in the front of the body, far away from the two native kidneys which are high up in the loins and closer to the back. Therefore, in most cases a kidney transplant recipient actually has three kidneys: the two native kidneys and the transplant. Although all three are connected to the bladder by their own ureters, they do not touch each other. While it is true that the native kidneys have “failed”, they will not harm the new transplant. Moreover, even “failed” kidneys still function many times at 5-10% of normal. With a transplant, every percentage point of kidney function counts towards better health, so they are not removed unnecessarily. It is also a rather big operation that is preferably avoided.

Sometimes, however, one or both native kidneys do need to be removed. Examples of such situations include polycystic kidney disease where one or both kidneys are so large, that they need to be removed in order to make room for a transplant. Sometimes these polycystic kidneys continue to enlarge after the transplant, and need to be removed afterwards. Other situations where native kidneys need to be removed include cancer in the kidney(s), as well as multiple stones and recurrent infections, in extreme instances, very severe hypertension (high blood pressure) where multiple medications have failed.

Transplant kidneys are often taken out if they have failed right at the time of the transplant or shortly afterwards. This could happen if the kidney is clotted, or very rapidly rejected. It is quite unusual to take out a transplant kidney that has lasted for some time before failing. Again, cancer or recurrent infections might be a reason, but more often it is because “acute” rejection happens after the transplant drugs have been stopped. This can happen if these drugs are stopped too quickly after the transplant has failed. There is pain over the transplant, and there may be blood in the urine, or fever. If anti-rejection drugs do not work to reverse this, the transplant kidney is often removed. Finally, if a patient is getting a third transplant, one of the first two transplants will need to be removed since typically only one transplant can be placed in each groin.

If you have any questions about having a kidney removed, please discuss this with your transplant nephrologist. It is not a decision to be taken lightly. Often, you will meet with a transplant surgeon as well, before a final decision regarding surgery to remove the kidney is made.
Should I Use a Vitamin D Supplement?
Ambika Sharma, Pharmacy Student and Lucy Chen, Pharmacist

As the days begin to get shorter and sunlight becomes scarcer, you may be considering taking a vitamin D supplement. Vitamin D has received a great deal of attention in the media in recent years. But what does the scientific literature say?

When you read in the news that low vitamin D levels are associated with higher rates of heart disease, cancer, or other bad health outcomes, it's easy to think that a vitamin D supplement is the answer. However, this is not necessarily true. Having higher vitamin D levels may simply be a sign of – rather than the cause of – a healthier person. Someone who eats a healthy diet and does lots of outdoor exercise is likely to have good vitamin D levels and have good health overall.

This concept is similar to seeing a person with blonde hair and blue eyes. The person’s genes give him both blonde hair and blue eyes, just like healthy living gives a person both high vitamin D levels and good health overall. Dying your hair blonde will certainly not make your eyes blue. In the same way, taking a vitamin D supplement may not necessarily mean you will have better health.

Luckily, many scientists have done studies on vitamin D supplements and their effect on a large variety of health outcomes, ranging from heart disease to diabetes to cancer prevention. Recently, a very large umbrella review – in which scientists compile results from many small individual studies – was published in the British Medical Journal (BMJ). This umbrella review found that vitamin D is good for lowering parathyroid hormone (PTH) in patients with kidney disease. There was a hint of evidence that vitamin D supplements might help with colon cancer, heart disease, blood pressure, and diabetes. However, one could not say for sure. There was not enough evidence to decide if vitamin D supplements prevent infection.

Some scientists studied vitamin D supplementation in people with kidney transplants specifically. Studies in animals found that vitamin D can optimize the immune system, decrease inflammation, decrease kidney rejection, and improve kidney function. Unfortunately, when these studies were done in humans, the results were not so positive. Most studies have not shown that vitamin D supplements benefit the kidney specifically.
At the transplant clinic, we test the vitamin D level in your blood regularly. Based on this and other test results, your doctor may recommend a vitamin D supplement for you. Although vitamin D supplements have not been proven beyond a doubt to prevent cancer, protect the heart, or prevent infection, there are still good reasons your doctor may prescribe vitamin D supplements.

- For patients with osteoporosis, who are also taking calcium supplements
- For patients with high parathyroid hormone (PTH) levels in the blood
- For patients with low calcium and low phosphate levels in the blood (commonly after parathyroidectomy surgery)

Most kidney transplant patients take vitamin D3. You can get it easily and cheaply at any pharmacy without a prescription. This form of vitamin D is made from animal source. If you are a vegan, you can ask the doctor to give you a prescription for ergocalciferol or vitamin D2 which is made from plants. The doctor may also prescribe activated forms of vitamin D such as calcitriol for some patients.

Overall, the scientific literature shows that taking vitamin D is helpful if you have osteoporosis, low calcium or high PTH levels. But they probably do not make a big difference on immune function, kidney function, heart health, diabetes and cancer risk. These health benefits are largely theoretical. On the other hand, vitamin D is generally quite safe to use if you are interested in trying it. If you are thinking about using vitamin D, it is a good idea to tell the transplant team first so we can monitor your blood tests accordingly. Having too much vitamin D in your body could increase calcium levels, which may damage your kidney in severe cases.

This diagram shows how vitamin D works in your body.
At St. Michael’s we have been using once-daily tacrolimus –ER or Advagraf® as part of our immunosuppressive regime since July 2009. Prior to that time, Prograf®, or twice-daily tacrolimus was the immunosuppressive agent of choice. Our decision to switch formulations was based on clinical trials that were conducted at St. Michael’s, in addition to other centers that helped bring Advagraf to market(1). Since there was a level of comfort with this agent at St. Michael’s, it was easy to introduce it early into clinical practice for de-novo renal transplant recipients. In fact, St. Michael’s was one of the first transplant programs to use Advagraf, and today we have the largest North American clinical experience with this agent. In 2010-2011 we made the decision to convert existing patients who were on Prograf to Advagraf.

Why did we make these decisions, and what have we learned?
To answer these questions, it is important to understand the differences between Prograf and Advagraf. First, these agents have the exact same biological effects on the immune system. There is no difference in how they work to protect the kidney transplant against rejection. Nor is the side effect profile between the two dissimilar. The difference lies in what is known as the “pharmacokinetic profile”. Prograf must be taken twice a day with two peaks of tacrolimus in the blood about 2 hours after the medication is taken. The second peak however is smaller. Advagraf, by design is only taken once a day, and there is no “peak”. It turns out that for most people the exposure over a 24-hour period is the same for both formulations. In clinic we estimate this exposure by measuring the “Prograf” or “Advagraf” blood level in the morning prior to taking the medication. These levels are very important in helping us determine the correct dose for each individual patient. Too little can result in rejection of the kidney, whereas too much can cause side effects including kidney damage. One benefit of Advagraf over Prograf is that since it only needs to be taken once per day in the morning, there is no chance of missing the evening dose and putting the kidney at risk. Another benefit, which will be discussed shortly, may be that Advagraf allows for better kidney function than Prograf.

The decision to convert existing Prograf patients to Advagraf in 2010 was in part based on the concern that generic Prograf was coming to the Canadian market. Although as a program we were not concerned about a single generic Prograf, we were worried that patients might be getting multiple generic “Prografs” where the pharmacokinetic profiles might be different. That means that a given patient’s blood level with one generic Prograf might differ if he or she were given a different generic Prograf the next time they went to the pharmacist, before the next clinic visit. As stated earlier, the blood levels of these drugs are very important in maintaining a healthy kidney transplant. In the U.S. there are 6 generic “Prografs” on the market.

Some important research done at St. Michael’s with Advagraf
We published our first clinical experience with Advagraf in 2013 when we compared the last year of Prograf use to the first year of Advagraf use at St. Michael’s. This study showed that dosing was similar, and there was no difference in rejection rates nor side effects, and also the renal function was similar. We demonstrated an advantage for Advagraf in that its use required fewer dose adjustments to achieve the desired blood levels compared to Prograf (2).
In a publication looking at almost 500 patients at St. Michael’s who were converted from Prograf to Advagraf, we learned that certain ethnic groups such as East Asians tended to require a higher dose of Advagraf, after having being switched from Prograf to maintain the same blood level. Ten percent of patients required a decrease in Advagraf dose compared to Prograf (3). Currently we are studying the genetic make up of patients who required a significant dose increase compared to those who did not.

With respect to kidney function, there were reports in the literature that some patients demonstrated improvement in renal function on Advagraf versus Prograf. Why might this be the case? As mentioned earlier using Prograf results in 2 blood peaks in a day, Advagraf has a lower single peak. The peak level in the blood can reduce blood flow to the kidney. That is why high levels of either Prograf or Advagraf can lead to worsening kidney function, and why we pay so much attention to the blood levels of these agents. We had the opportunity to study Advagraf and Prograf in healthy volunteers in a very controlled environment. We measured kidney blood flow and kidney function in these subjects over a 24 hour period at 3 times: on no medication, on Advagraf and on Prograf in a randomized fashion. Our results demonstrated that with equal drug exposure, the renal blood flow was significantly better with Advagraf than with Prograf, and there was a trend towards better renal function with Advagraf (4).

Lastly, there have been numerous publications that demonstrate that “adherence” was improved when switching patients from twice-daily Prograf to once-daily Advagraf with some evidence for less rejection.

In summary, St. Michael’s has been North American leader in the use of Advagraf, and our clinical experience has been very positive. Local research with this agent has helped to improve the lives of solid organ transplant recipients world-wide. We are very grateful to the transplant patients at St. Michael’s who have participated in these and other important clinical research trials.

References:
Making an Informed Choice: Education Central in Transplant Decisions

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Patient Perspective
In theory, organ transplants aren’t particularly difficult things to understand. A transplant is the removal of a non-functioning or ill-functioning organ, for one that works. In practice though, organ donation is an extremely complex undertaking, and one where the importance of patient education cannot be overemphasized.

Trying to cope with the consequences and symptoms of a failing organ is difficult enough, but attempting to do so while navigating the complexity and stress of an organ transplant is doubly difficult. Linda Mele was first diagnosed with polycystic kidneys at 17 years old; Linda was told that she could expect kidney failure later in life and while the onset of problems didn’t come as a surprise, it was still difficult to deal with. “With my condition, kidney function is affected by the growth of cysts,” says Linda. “As the cysts grow the condition gets worse. The average kidney is about 10cm in diameter, mine were the size of footballs. I wouldn’t be surprised if I cracked a couple of ribs.”

Types of donation
There are two major types of organ donation — living and deceased. Obviously, with

Linda Mele and husband Brian Fearon vacationing in Jamaica, five years after Brian donated his kidney to Linda.
deceased donation there is a greater variety of organs that can be transplanted; what matters isn’t so much the age of the organ, but more that it is healthy. According to the Kidney Foundation of Canada, more than “two dozen people can be helped by a single donor.” Living donation is a completely voluntary act. It usually involves immediate family members or related donors. Living unrelated donation is also possible with a suitable match.

As Linda’s kidney function decreased, her medical team made attempts to slow the disease’s progress. “I was put on a low-potassium, low-sodium diet to prolong my kidney function.” says Linda. Eventually though, Linda’s kidney function deteriorated to the point where only a transplant would save her life. “We weren’t even looking at that avenue until they brought it up. My sister was ineligible but as it turned out, after a lot of testing, Brian (her husband) was a match.” Upon hearing the news, Brian immediately took the decision to go under the knife, and not long after, was in the operating room.

“Nothing short of a miracle” After surgery, Linda insisted on seeing Brian, who was lying in recovery from his operation earlier that morning. “They wheeled Linda into my room; I was in a lot of pain but I’ll never forget the look on her face. She had colour, rosy cheeks, colour in her eyes — I had gotten so used to seeing her dull, hazy eyes... seeing the change was nothing short of a miracle. I knew it was the right decision right there,” says Brian.

**Role of education**
Galo Meliton is a Renal Transplant Nurse Coordinator at St. Michael’s Hospital in Toronto, and is passionate about the role that education plays in the transplant process. “Education can make or break the transplant. You have to encourage families to get involved, because their involvement is key to success,” says Galo.

One key resource in educating patients and families is the Transplant Companions program. The program educates patients and caregivers about the process both pre- and post-transplant. Facilitated learning sessions are the program’s central focus, with organ donors and recipients giving unique insights into the transplant experience. Healthcare professionals benefit from the program too, receiving a variety of helpful resources and information to bolster their support of transplant patients. “Patients and family need to know what’s going to happen and what is required of them, how they can help.” So, we tell them about what to expect, pre- and post-transplant, what the transplant will look like, post-surgical issues and of course, we talk about transplant drugs, like anti-rejection medications,” says Galo.

**Transplant Companions**
Like Galo, Brian and Linda are anxious to stress the importance of patient education and the Transplant Companions program. “In terms of making the decision to go for testing and donating my kidney... education was the first part of that. I learned that donating may actually improve my life expectancy (people who donate kidneys often live longer than those who don’t due to the necessity for improved lifestyles). Education for us was so beneficial that we feel the urge to give that back,” says Brian. For Linda, education was important in understanding what she could do for herself to improve her quality of life. “I learned about diet, exercise, and trying to live a normal life — with limitations of course. I know to take time off when I need it, and if I have something planned to rest up for that,” says Linda.

“But Brian gave me a generous gift, one that I’ll never forget for the rest of my life.”
1. **How should I take care of my incision after discharge? Does it need to be dressed?**

When you go home from the hospital, you should watch your wound for signs of infection. If you notice it looks red, puffy, or blood or pus comes from it, call the Transplant Office right away. You do not need to have a dressing on the wound unless you have been told to put one. Some people like to put something over the wound so it does not rub on clothing, but you should leave it open to the air as much as possible, to help it heal. A little bit of swelling under the incision is usually normal as well, but let the Transplant Clinic know if it is increasing in size.

2. **Should I wear my seatbelt? It is uncomfortable.**

YES! Always wear your seatbelt. You are not exempt from obeying the law. If the seatbelt feels uncomfortable, you may put a pillow or cushion over your transplant site, as long as you are safely secured.

3. **Am I allowed to shower or bathe? Swim?**

When you go home from the hospital, you are allowed to have a light shower. Let the water run over the incision, and pat it dry immediately. Do not sit in the bathtub or go swimming for three months after the transplant.

4. **My partner and I want to have sex. Is this OK for the incision?**

It is understandable that improved kidney function can restore sexual desire quickly. It is not advisable to have sex at least until the incision is fully healed, which means usually for about a month. Besides sexual desire, fertility can also be restored very quickly after transplant in both men and women. You must use reliable contraception for the first year. If you have any doubts, ask the transplant team.

5. **What kind of exercise is permitted in the first month after transplant?**

Walking is excellent exercise for the first month after transplant. Until the wound has healed, do not lift anything heavier than 2 kg. After this, you should not lift anything heavier than 5 kg at once for the first 2-3 months after surgery. Ask the transplant doctor or nurse about when you can start lifting heavier things, and also for some general exercise advice.

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**Post Transplant Chat - Wound Management**

*Sarah Mattok RN, Fernanda Shamy RN, Michelle Gabriel RN, Thelma Carino RN, Jennie Huckle RN*

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6. I would like to travel. What will happen with the metal detector at the airport?

You should generally stay in the country for the first year after your transplant. If you must travel earlier than this, please talk to the transplant team. You will likely not set off the metal detector at the airport, but if you are screened, let them know if you still have staples. Also, avoid long drives where you have to hold your urine for too long.

7. I am noticing some oozing from the wound. What should I do? If there is a smell, what does it mean?

Some oozing, if it is clear, from the wound may be normal. Call the transplant office if the ooze is new or changes in color or consistency, or if there is new pain or a fever. A bad smell may be a sign of infection. Please call the transplant clinic for advice or go to your local doctor right away. Tests of the fluid can be done to see if it is body water (“serous”), pus, or urine. The fluid can also be sent for culture. An ultrasound may be ordered to look for a fluid collection underneath the incision.

8. I think the wound is opening up. What should I do?

Go to the Emergency Room!

9. My wound has unfortunately opened up. How long will it take to heal? Is there anything I can do to make it heal faster?

Everybody heals differently. An open wound may need to be packed and suctioned, and require dressings for a long time. This could take many months. Antibiotics may be needed if there is an infection. To help with the healing, it is important to follow your doctor’s advice. You should also eat a healthy diet, stop smoking, and make sure your blood sugars are well-controlled if you have diabetes.

10. When are my staples usually removed? Where? Is this time the same for everybody?

Staples are usually removed about 3 or 4 weeks after your surgery. Everybody heals differently, so the transplant nurses will look at your wound when you come for clinic visits, and will remove the staples when they are ready to come out, in the clinic. Often, not all the staples are removed at once.
Why the Mental Health of Live Donors Matters

Courtney Sas, MSW RSW

People often question the rationale for assessing the mental state of live kidney donors. A thorough medical screening process is currently in place, so why does the transplant team also screen for psychological, emotional and social suitability?

Assessing the psychosocial stability of prospective live donors is important for three reasons:

(i) To ensure that the donor is capable of giving informed consent and that the decision to donate is being made freely;
(ii) To plan for the most effective care, both pre- and post-surgery; and
(iii) To remedy treatable issues in donors who otherwise would have simply been turned down.

To address these elements, many factors need to be taken into account, such as the donor’s current living situation, developmental history, relationship history with the transplant recipient, financial status, motivation to donate, vulnerability, support structure, mental health history and coping skills.

Firstly, this information allows us to confirm that the donor truly understands the donation process and
legitimately wants to participate. It also helps the team social worker plan for surgery and recovery as well as ensure arrangements have been made for children, work and finances. After surgery it is important to have a practical, emotional and financial support system in place. Accordingly, expectations, both realistic and unrealistic, are reviewed and discussed with every donor.

Exploring coping skills allows the social worker to determine if the potential live donor can cope effectively with the stress of transplantation both before and after surgery. For example, after surgery, there is often a shift of attention from the donor to the recipient. Therefore, it is important to prepare prospective donors for the potential outcomes and to explore which coping skills would be most effective for them.

Certain challenges, such as depression, financial stress, marital problems, active psychosis and substance abuse may prevent a prospective donor from donating. However, the psychosocial assessment gives prospective donors the opportunity to overcome such challenges where possible. In fact, a potential donor’s psychiatric condition does not always prevent donation. In such cases, we seek input from our team’s consulting psychiatrist and the potential donor’s mental health care providers in the community.

Finally, the safety of everyone involved is our top priority every time a team social worker conducts a psychosocial assessment. Assessing the mental state of prospective live donors is one part of a team effort to ensure the best outcomes for everyone in each and every transplant.

(a non-invasive ultrasound that looks at the blood vessels supplying the legs) requires the patient to eat Jell-O with no fruit, any flavour (the Jell-O raises the gas in the abdomen) and the “background noise” is therefore minimized and the vessels are visualized more effectively. It would be very helpful in moving the process along if the referring center could also provide the ECG (electrocardiogram) tracing and chest x-ray if already available; otherwise, we can send the transplant candidate to our respective departments at St. Michaels Hospital.

We will continue to attempt a “one-stop-shop” approach for patient testing and consultation assessments and minimize the number of visits to complete the workup. If additional tests are required after any of the specialists’ visits (Transplant Nephrologist, Transplant Surgeon or Anesthesia), we may consider following up on such requirements provided the potential recipient is agreeable to this plan.
Transplantation is an area in health care that sounds glamorous. The medical technology to perform the transplant is very sophisticated on the one hand, but most post-transplant care is actually down-to-earth medical practice. A large number of health care professionals of all varieties are required to make the transplant a success. This in turn provides a number of job opportunities for people who find transplant especially fascinating and would like to consider a career in transplantation.

Lab technicians do most of the work involved in testing laboratory samples from transplant patients and donors, both before and after the transplant, using a variety of complicated tests with advanced equipment. Transplant coordinators act as liaisons between transplant centres. Transplant administrators are responsible for ensuring that scarce organs are used responsibly and efficiently. In the operating room, technicians and medical technologists, anesthesiologists, nurses, and surgeons all play critical roles. After the transplant on the ward, administrative assistants, nurses and nurse practitioners, nursing aides, pharmacists, dieticians, and social workers all serve the patient in their own special ways. In the transplant clinic, clerical assistants, nurse and nurse practitioners, and doctors, besides many of the others already listed all provide care to patients. Transplant is the perfect example of collaboration in medicine. It is quite possible that up to 100 people are required to make a single transplant a success! Since so many transplants are done each year, there is an opportunity to interact with a lot of interesting people, if that kind of thing appeals to you.

If you are interested in a career in transplantation, ask one of the staff in the Transplant Clinic about this during one of your visits. Depending on the area which you or a relative are interested in, we can either answer some of your basic questions or refer you to the right people.

Welcome and Farewell!

We would like to welcome the following additions to our team:

- Michelle Gabriel, part-time nurse in the Post-Transplant clinic. Michelle came from the Southern Alberta Transplant Program.
- Senyo William and Mercedes Ward, clerical staff.

We would like to wish well the following staff as they move on to a different path:

- Thelma Carino, RN has moved to a casual position after more than 10 years of being a part time staff in the post-transplant clinic.
- Imelda Lo has moved to a casual position. She has accepted a full time nursing position closer to home.
- Alyson Martinez, Registered Dietitian, has accepted a role in the Pediatrics department.
- Rania Sobhan, clerical staff, has accepted a full time position in the Cardiovascular department.
During the Kidney Foundation of Canada’s 50th anniversary, a special pin from the Ontario Branch has been created to serve to honour significant contributions and achievements of the Foundation’s volunteers and other supporters/partners. Galo Meliton, RN was this year’s recipient of the special 50th Anniversary Volunteer Pin. His dedication was celebrated with a certificate and 50th Anniversary pin at the Volunteer Celebration in Toronto on June 25, 2014.