



**FIGURE 337-2** A typical algorithm for early posttransplant care of a kidney recipient. If any of the recipient or donor “high-risk” factors exist, more aggressive management is called for. Low-risk patients can be treated with a standard immunosuppressive regimen. Patients at higher risk of rejection or early ischemic and nephrotoxic transplant dysfunction are often induced with an antilymphocyte globulin to provide more potent early immunosuppression or to spare calcineurin nephrotoxicity. \*When there is early transplant dysfunction, prerenal, obstructive, and vascular causes must be ruled out by ultrasonographic examination. The panel reactive antibody (PRA) is a quantitation of how much antibody is present in a candidate against a panel of cells representing the distribution of antigens in the donor pool.

**TABLE 337-4** THE MOST COMMON OPPORTUNISTIC INFECTIONS IN RENAL TRANSPLANT RECIPIENTS

Peritransplant (<1 month)	Late (>6 months)
Wound infections	<i>Aspergillus</i>
Herpesvirus	<i>Nocardia</i>
Oral candidiasis	BK virus (polyoma)
Urinary tract infection	Herpes zoster
Early (1–6 months)	Hepatitis B
<i>Pneumocystis jiroveci</i>	Hepatitis C
Cytomegalovirus	
<i>Legionella</i>	
<i>Listeria</i>	
Hepatitis B	
Hepatitis C	

The importance of blood cultures in such patients cannot be overemphasized because systemic infection without obvious foci is common. Particularly ominous are rapidly occurring pulmonary lesions, which may result in death within 5 days of onset. When these lesions become apparent, immunosuppressive agents should be discontinued, except for maintenance doses of prednisone.

Aggressive diagnostic procedures, including transbronchial and open-lung biopsy, are frequently indicated. In the case of *P. jiroveci* (Chap. 244) infection, trimethoprim-sulfamethoxazole (TMP-SMX) is the treatment of choice; amphotericin B has been used effectively in systemic fungal infections. Prophylaxis against *P. jiroveci* with daily or alternate-day low-dose TMP-SMX is very effective. Involvement of the oropharynx with *Candida* (Chap. 240) may be treated with local nystatin. Tissue-invasive fungal infections require treatment with systemic agents such as fluconazole. Small doses (a total of 300 mg) of amphotericin given over a period of 2 weeks may be effective in fungal infections refractory to fluconazole. Macrolide antibiotics, especially