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Post-transplant renal anaemia: a call to action from a national study in routine clinical practice

Jose Portoles[1,2], Marta Crespo[2,3], Emilio Rodrigo[2,4], Maria Asuncion Sancho Calabuig[2,5], Nuria Montero[2,6], María Auxiliadora Mazuecos Blanca[2,7], Alex Gutierrez Dalmau[8,9] and Julio Pascual[2,10]

[1]HU Puerta de Hierro, Madrid, Spain
[2]TRANSNEMIA Group, Madrid, Spain
[3]HU del Mar, Barcelona, Spain
[4]HU Marques de Valdecilla, Santander, Spain
[5]HU Peset, Valencia, Spain
[6]HU Bellvitge, Barcelona, Spain
[7]HU Puerta del Mar, Cadiz, Spain
[8]HU Miguel Servet, Zaragoza, Spain
[9]TRANSNEMIA Group, Majadahonda, Spain
[10]HU Doce de Octubre, Madrid, Spain

Background and Aims: Post-transplant anaemia (PTA) is common, frequently unnoticed and carries associated risks. Current guidelines consider the same treatment recommendations and goals for these patients as for chronic kidney disease-non dialysis (CKD-NDD). Previous reports demonstrated low awareness and management that could improve. **Aims**: To describe current anaemia management, goals, and adherence to guidelines in a representative sample of kidney transplant (KT) recipients.

Method: Retrospective nationwide multicentre study including patients from 8 KT hospitals. Nephrologists collected demographics, comorbidities, KT data and immunosuppressive therapy and data related to anaemia management (laboratory values, previously prescribed treatments, and subsequent adjustments) from electronic medical records. We classified as early anaemia that within the first 6 months. The European statement on KDIGO guidelines was the reference for definitions, drug prescriptions and targets.

Results: We included 297 recipients with PTA aged 62.8 y (SD 13.6) and 60% male. They had received a graft from donors after cardiac death or brain death) (61.6%. 31.1% respectively) a median of 2.5 years [0.5-8.7] before. A total of 158 patients were on treatment with erythropoietin stimulating agents (ESAs) and the distribution of haemoglobin (Hb) and iron are summarized in Table 1. Among 110 patients on ESA treatment but without iron prescription, 44 had an indication to receive iron and 30 of them had absolute iron deficiency (ID).

Only 39/158 patients exceeded the ESA resistance index (ERI) limit, and this condition was more frequent in early PTA (26.1 vs 9.2%). Absolute or functional ID accounted for the majority of ESA resistance (28.2 vs 17.1; $p < 0.001$).

Conclusion: Hemoglobin levels in these patients are within the upper KDIGO. Iron therapy continues to be underused (especially intravenous), while iron deficiency and prior events explain most of ESA hyporesponsiveness. We identify missed opportunities for accurate prescription targeting and adherence to guidelines.

Table 1: Patients on ESA treatment classified according to Hb and Iron targets.

Patients on ESA	Absolute ID	Functional ID	No ID	All
Hb <10 g/dl	1 (0.6)	1 (0.6)	16 (10.1)	18 (11.4)
Hb 10-12 g/dl	7 (4.4)	13 (8.2)	51 (32.3)	71 (44.9)
Hb 12-13 g/dl	6 (3.8)	14 (8.9)	22 (13.9)	42 (26.6)
Hb > 13 g/dl	2 (1.3)	3 (1.9)	22 (13.9)	27 (17.1)
All	16 (10.1)	31 (19.6)	111 (70.3)	158 (100)

Note: n (percentage over entire group of ESAs treated patients); ID: Iron deficiency; Hb: Haemoglobin.