Conclusion: Ventilator support and/or acute renal failure at the time of LT are major predictors of mortality but complex recipients/donors relationships may moderate these associations, as demonstrated by our CART analysis.

O78 FRENCH CONTROLLED DONATION AFTER CIRCULATORY DEATH (DCDD) PROGRAM: FIRST RESULTS
C. Antoine10,16, M. Videoen10, B. Ricou12, D. Doraz1, G. Cheisson2, L. Martin-Lefèvre1, L. Durand10, E. Savoye13, G. Karam1, O. Skworon1, E. Sávier7, B. Barrou5, P. Comité De Pilotage10
1CHPOT; 2Urologie, CH Annecy, Annecy; 3CHPOT, CHU Bicêtre, Kremlin Bicêtre; 4CHPOT, CH La Roche sur Yon, La Roche Sur Yon; 5CHPOT; 6Urologie, CHU Nantes, Nantes; 7Chirurgie hépato-biliaire; 8CHPOT; 9Urologie, CHU Pitié La Salpêtrière, Paris; 10DPGOT, Agence de la biomédecine, Saint Denis La Plaine, France

The national protocol for the cDCD program authorized in France since 2014 includes selection criteria as donor age <50 years, functional warm ischemia time (WIT) <30 min (liver), <90 min (lung), <120 min (kidney), in situ kidney perfusion performed by normothermia regional perfusion (nRP), machine perfusion use (except liver) and short cold ischemia times (CIT). Only non-urgent recipients awaiting a 1st transplant were eligible.

The aim of this study was to compare primary non function (PNF), delayed graft function (DGF) and length of stay in hospital after kidney transplantation (KTR) according to 2 types of donors: cDCD (53 KTR from 12/2014 to 5/2016) and brain death donors (DBD) aged <60 years (3756 KTR from 1/2013 to 4/2016), only for patients awaiting 1st transplant.

Out of 60 potential cDCD donors, 29 have been retrieved, mean age 48 years. Causes of death were mainly hypoxic brain damage (45%) and trauma/head injury (26%). Procurement failure are secondary to Relative’s opposition (30%), agonal delay >180 min (7.6%) and logistical problem (7.6%). Mean IVIT are 30 min (kidney), 21 min (liver) and 85 min (lung). nRP was used in all utilized donors after mean circulatory arrest delay of 25 min. Mean renal CIT is 10.7 h.

Rate of PNF (2%), mean creatinin (150 vs 176 µmol/l) and renal clearance (54 vs 47 ml/min) at discharge are comparable. DGF rate (3.4% vs 19.5%), mean WIT (16.5 years). The first results of deceased donor kidney transplantation could be proposed.

These good results ensue from national and consensual protocol, with aim to limit war ischemia times and injuries, thanks to nRP use, optimal graft preservation and recipient selection. cDCD program represents an optimal and additional source of valuable transplants.

O79 350 PEDIATRIC LIVING DONOR LIVER TRANSPLANTATIONS
A. Pire, C. De Magnée, B. D’Hondt, M. Janssens, R. Reding
3.Cliniques universitaires Saint Luc, Bruxelles, Belgium

Introduction: Due to the shortage of and/or lack of access to deceased donors, living donor liver transplantation (LDLT) has contributed to allow the transplantation of children in a timely fashion regarding the evolution of their diseases. We reviewed our 23 years experience in LDLT.

Patients and Methods: Between July 1993 and December 2015, 350 LDLT were performed (median age: 1.25 years; range: 0.3–21.8 years). The first indication for LT was biliary atresia (n = 218, 62%).

Results: No mortality or persisting disability was encountered in the 350 living donors of this series. Overall patient and graft survival in the recipients were 96% and 95% at one year, and 94% and 92% at five years, respectively. The retransplantation rate was 8/350 (2.3%), including two children who finally died. No ABO-incompatible graft was lost in this series. To better evaluate our learning curve, the results were further analyzed considering five eras. A striking feature was the progressive increase of the proportion of LDLT (Total paediatric LT along the eras as follows: 1993-7: 57/152 (38%); 1998-2001: 38/100 (38%); 2002-7: 66/161 (41%); 2008-11: 80/101 (79%); 2012-15: 108/122 (88%). When comparing 1993-7 and 2007-11 eras, 5 year patient and graft survival rates increased from 89% to 96%, and 86% to 96%, respectively.

Conclusions: Our results indicate: (1) the increasing recourse to LDLT at our pediatric LT program; (2) the safety of living donor surgery and management; (3) the improvement of overall results of LDLT along the eras; (4) the judicious use of ABO-incompatible LDLT due to an adequate protocol for isoagglutinin depletion. A detailed assessment of the risks/benefits balance of steroid-free immunosuppression in pediatric LT is ongoing.

O80 EFFECT OF THE DIFFERENT SENSITIZATION EVENTS ON HLA ALLOIMMUNIZATION AND ACCESS TO TRANSPLANTATION IN KIDNEY TRANSPLANT CANDIDATES
4. CHU de Montpellier, Montpellier, France

HLA allo-immunization is caused by sensitization events such as transusions, pregnancies or previous transplantsations. The objective of our work was to analyze the consequences of each sensitization event on HLA immunization and on access to transplantation.

We investigated HLA immunization (by Luminex single bead Ag, One lambda, positivity if MFI > 1000) of 461 patients registered on the waiting list between 01/01/2009 and 31/12/2013, with only one type of sensitization event (123 transfused, 68 with pregnancies, 19 previous transplants) or without sensitization event (251 patients; control group).

The percentage of immunized patients was respectively 41% in the control group, 39% in the transfused group, 59% in group pregnancy, 89% in the transplantation group (p < 0.001) for class I HLA antibodies, 26%, 25%, 43% and 83% (p < 0.001) for class II HLA antibodies. The mean number of anti-HLA specificities (class I and class II) was respectively 1.6 ± 3.0; 2.2 ± 6.1; 8.5 ± 15.5; 27.4 ± 8.9 (p < 0.001). Mean MFI were 2385 ± 1991; 2245 ± 1729; 3036 ± 3375; 5697 ± 4784 (p < 0.001) for class I HLA antibodies and 4346 ± 4346; 9102 ± 6870 (p < 0.001) for class I HLA antibodies. Calculation Panel Reactive Antibodies were 10%, 12%, 35% and 65% (p < 0.001) for the different groups respectively. At 01.05.2016, 89% in the control group, 85% in the group transfused, 85% in the group pregnancy but only 47% in the group transplantation were transplanted (p < 0.001). Mean waiting time (month) was 20.3 ± 16.0, 23.6 ± 18.7, 24.8 ± 18.2 et 29.1 ± 20.3 in the different groups respectively (p = 0.006).

HLA immunization risk depends on the sensitization event. Previous transplantations had the strongest effect on HLA immunization and significantly restricted the access to a new transplant, followed by pregnancies. The prevalence of HLA sensitization in the transfusion group is not very different compare to the group without classical sensitization event.

O81 A CONSECUTIVE SERIES OF 125 CONTROLLED DCD-LIVER TRANSPLANTATIONS
O. Detrey2, N. Meurisse2, M.F. Hans2, M.H. Delbouillé2, J. Monard2, A. Derover2, J. Joris1, A. Kaba1, P. Honore2
1Service d’Anesthésie & Réanimation; 2Service de Chirurgie & Transplantation, CHU Liege, Liege, Belgium

Introduction: Donation after circulatory death (DCD) has been proposed to partially overcome the organ donor shortage. DCD-LT remains controversial, with reported increased risk of graft loss and retransplantation. The authors retrospectively reviewed a single centre experience with controlled DCD-LT in a 14-year period.

Patients and Methods: 125 DCD-LT were consecutively performed between 2003 and 2016. All donation and procurement procedures were performed as controlled DCD in operative rooms. Data are presented as median (ranges). Median donor age was 56 years (16–84). Most grafts were flushed with HTK solution in the first part of experience, and more recently with IGL1. Allocation was centre-based. Median follow-up was 52 (1–164) months. No patient was lost to follow-up.

Results: Median total DCD warm ischemia was 19 min (9–39). Median cold ischemia was 238 min (105–576). Patient survivals were 90.2%, 77.5% and 74.5 % at 1.3 and 5 years, respectively. Graft survivals were 87.7%, 76.3% and 73.2% at 1.3 and 5 years, respectively. Biliary complications included anastomotic strictures and extrahepatic main bile duct ischemic obstruction, that were managed either by endoscopy or hepatico-jejunostomy. No PNF was observed in this series and one graft was lost due to ischemic cholangiopathy. Discussion: In this series, DCD LT appears to provide results similar to classical LT. Short cold ischemia and recipient selection with low MELD score may be the keys to good results in DCD LT, in terms of graft survival and avoidance of ischemic cholangiopathy.

Abstracts of the 16th Annual Congress of the French Speaking Society of Transplantation

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