LONG TERM OBSERVATION OF DERMATOLOGICAL FINDINGS IN RENAL TRANSPLANT RECIPIENTS

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Cutaneous complications were observed in each immunosuppressed renal homograft recipient. The pre-existing skin disorders (desquamation, dehydration, exaggerated nitrogenous compounds and skin surface sugar concentrations) are aggravated after transplantation. One hundred and sixteen patients with 145 transplants (observation time 1–92 months, mean 32.4) were checked at regular intervals (1–8 weeks) for dermatological findings. The immunosuppressive regimen consisted of azathioprine and corticosteroids, and in 62 cases antilymphocyte globulin was administered in addition.

Skin infections were present in 104 patients. Mycotic infections in 85 recipients were mainly due to candida albicans and rarely caused by microsporum, epidermophyton, trichophyton and pityrosporum orbiculare. Viral infections occurred in 68 cases and were caused by the herpes simplex, verruca, herpes zoster, varicella and condylomata acuminata viruses. The occurrence of herpes simplex was associated with rejection episodes in 55%. Bacterial complications in 53 persons were a consequence of surgery or of impetiginised steroid acne.

Non-infectious cutaneous manifestations were seen in 108 cases. Cushingoid features manifested as purpura, altered fat distribution, facial erythema, telangiectasis, lipomatosis, steroid acne, striae, atrophic and friable skin, generalised dry skin, keratosis pilaris, ichthyosis and hirsutism.

Hair changes in 78% occurred as discernible scalp hair loss due to azathioprine therapy with a maximum between two and eight months after surgery. Following diffuse alopecia, hair regrew darker, more curly or grey.

Other dermatological disorders were diagnosed as benign, premalignant and malignant proliferations. Keratoacanthoma of the lower lip, leukoplakia of the tongue and de novo skin cancer were verified histologically. Malignancies depend on geographic, climatic and racial factors and increase with the time after transplantation. In one recipient cutaneous manifestations of facial lupus erythematoses were seen five years after starting immunosuppression.

Xanthelasmata in four cases were associated with hyperlipidaemia, and diminished with normalisation of lipid metabolism. Lichen urticatus with metastatic
calcification was found in 12 cases with pronounced pre-existing secondary hyperparathyroidism. Hyperhidrotic eczema was seen 12 times, ALG induced urticaria four times and dermatitis following lymphorrhoea from post-operative lymph-cysts three times.

Increased blood viscosity led to thrombosis of subcutaneous vessels in three persons, necessitating anticoagulant therapy.

Microscopic findings revealed the varied clinical picture of hypersensitivity vasculitis in four patients. In the course of high dose steroid therapy in one out of this group the small vessel vasculitis involved skin and muscle tissues with increase of creatine phosphokinase-MM-isoenzyme activities, lactic dehydrogenase and serum aldolase activities. The skin lesions tended to have some symmetry and predominated in the lower part of the body, were very painful and caused death by superinfection and septicaemia.

Cold intolerance of the front teeth, paradontosis and frequency of caries were striking too.

Regular dermatological assessment, adequate therapy and transient reduction of immunosuppressive agents may lower the high incidence of sometimes fatal complications.

References