



## Pediatric Liver Transplant

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### **Abstract:**

The goals of post-transplant management are to manage and treat postoperative complications, and develop a balanced long-term immunotherapy regimen that minimizes infection and side effects but controls rejection. While modern immunosuppressant regimens have reduced rates of graft loss due to rejection, they impart major risks for infection, growth failure, metabolic complications, and malignancy. There is significantly more post-transplant morbidity and mortality from infection than from rejection, particularly in infants. This has led to a trend toward minimization of immunosuppression, which is supported by evidence that some rejection facilitates graft tolerance and thus is not necessarily always harmful.

Post-transplant complications are divided into those that occur in the first 3–12 months (“early”), and these are relatively common, and those occurring after 12 months (“late”), which are generally uncommon. Most “early” complications relate to surgical issues, and/or immunosuppression, most notably infection, vascular complications of the graft, and biliary leaks. Infection is the most common cause of post-transplant mortality. Rejection does occur but usually responds to treatment with steroid pulse dosing, and appears not to contribute to either graft or patient mortality. “Late” complications include biliary strictures, which are uncommon and generally respond to percutaneous biliary dilatation and stent procedures. Most late complications are primarily related to the effects of long-term immunosuppression, notably infections such as EBV and associated PTLN, and side effects of immunosuppression such as renal dysfunction, hypertension, and immune dysregulation.

Oral Presentation, N 6

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