

In conclusion, MD is a form of hypertrophic gastropathy that presents with digestive symptoms and protein loss. In medical treatment-refractory cases, total gastrectomy should be considered an option.

Ethical considerations

The authors declare that no experiments were conducted on humans for this research. We utilized the protocols for obtaining patient information from our work center's database, preserving patient anonymity, so informed consent was not requested. This study meets the current bioethical research regulations.

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Conflict of interest

The authors declare that there is no conflict of interest.

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Liver transplantation from a donor with multidrug-resistant *Acinetobacter baumannii* infection. Is it a risk?[☆]



Trasplante hepático de un donador con infección por *Acinetobacter baumannii* multidrogorresistente. ¿Representa un riesgo?

Orthotopic liver transplantation (OLT) is the treatment of choice for patients with end-stage liver disease, acute liver failure, hepatocellular carcinoma, and other liver diseases.¹

However, the mortality rate for patients on the liver transplant waiting list has increased due to high demand and organ scarcity worldwide, including Mexico.² To resolve this problem, efforts have been made to broaden the potential donor pool, including some donors considered “high risk” or marginal; for example, donors with positive blood cultures, whose organs can be safely transplanted, with the exception of those with sepsis and multiorgan failure at the time of procurement.³

We present herein the case of an OLT recipient whose donor had confirmed bacteremia due to multidrug-resistant (MDR) *Acinetobacter baumannii* (A. *baumannii*).

A 66-year-old man, whose current disease appeared in 2016, characterized by general malaise, variceal bleeding, ascites, and grade II hepatic encephalopathy. He was diagnosed with cirrhosis of the liver due to metabolic dysfunction-associated fatty liver disease (MAFLD), after ruling out other etiologies. Two years after his disease onset, the patient developed three lesions under 4 cm, consistent with hepatocellular carcinoma. He received three sessions

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of locoregional treatment with transarterial embolization, with no complications. Six months after the final treatment, the patient maintained the Milan criteria and was evaluated for liver transplantation, with no contraindications. He was placed on the waiting list in 2019.

After three years on the waiting list, with no recurrence of hepatocellular carcinoma, the patient was offered an organ from a 56-year-old female donor. Overweight was her only comorbidity, and her blood group was compatible with his. The donor died from a hemorrhagic stroke and was maintained in the intensive care unit. Two days before brain death occurred, she had presented with fever. MDR *A. baumannii* that was only sensitive to tigecycline developed in her blood cultures. Treatment with that agent was begun and the central venous catheter was removed approximately 36 h before liver procurement.

After a brief pretransplant evaluation of the donor, with laboratory tests and a macroscopically normal liver, the risks presented by the blood cultures were discussed with the patient and he accepted them. The transplant was performed in May of 2022. As preventive measures, the blood cultures were repeated in the donor the day of the procurement and baseline blood cultures were carried out on the recipient, the results of which were negative. Antimicrobial prophylaxis with tigecycline for seven days was indicated. The patient had an excellent posttransplant recovery. During his hospital stay, the patient did not present with fever or signs of systemic inflammatory response, nor was modification of the traditional immunosuppression regimen necessary. He was discharged eight days after the procedure and currently has no complications at month 10 of follow-up.

Even though organ transplantation is considered a life-saving procedure, it is not without risks. One of the goals of liver transplant programs is to minimize the risk for unanticipated disease transmission between donors and recipients, in order to reduce posttransplant morbidity/mortality, which has been reported at up to 22%.⁴

A variety of pathogens, such as viruses, bacteria, fungi, mycobacteria, and parasites, can be transmitted by the donor. A review of the literature showed that the definition of infection in organs from donors varies according to the hospital center, which explains the wide range of cases of infection (from 2.2% to 23%). Despite those differences, case series have demonstrated that bacterial infection transmission from the donor to the recipient is not common, reaching 6.2%.⁵

In our case report, the organ came from a female donor with documented MDR *A. baumannii* bacteremia. The recipient had excellent posttransplant progression, with no infectious complications, and antibiotic treatment was maintained for seven days.

At present, numerous cases of solid organ transplantation from donors with positive blood cultures have been reported in the literature, and survival results are equal to those reported in noninfected organs (Table 1).

Nevertheless, Tong et al.⁶ described a cohort of patients that underwent liver transplantation. Eighty-two patients were infected, 12 (14.6%) of whom had donor-derived infections. Five of those patients were infected with *A. baumannii* and three of them died. Mularoni et al.⁷ described a series in which four out of 14 recipients of organs from donors with infection/colonization caused by resistant Gram-negative bacilli presented with transmission of said bacteria. Those four recipients had not received treatment against isolates in the donor. The rest of the recipients received at least seven days of adequate treatment in the immediate posttransplant period.

In a context in which the quantity of organ donors is precarious, it is important to take advantage of any opportunity that implies obtaining a graft for patients on the waiting list, which can include an infected donor. The presence of bacterial infections in the potential donor does not preclude liver donation. Effective treatment should be started in the donor, and possible infectious foci controlled (changing of central venous catheters, arterial lines, etc.). Communication with the procurement team should be established, so that effective antimicrobial treatment is administered to the recipient.

Ethical considerations

The present scientific letter rigorously meets the ethical considerations required for bioethical research, was authorized by the corresponding ethics committee. Importantly, to protect patient privacy, informed consent was not obtained, given that no personal information that could identify the patient was included in the content of the article.

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Conflict of interest

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Table 1 Case reports of solid organ transplants from donors with *Acinetobacter baumannii*.

Author	Year	Transplanted organ(s)	Clinical course	Management	Outcome
Cohen et al. ⁸	2006	4 kidneys 1 liver 3 lungs 2 hearts from donors with septic shock due to <i>A. baumannii</i>	A kidney transplant recipient had acute rejection that responded to treatment. No patient had positive <i>A. baumannii</i> cultures	Meropenem	Except for one heart transplant (that failed due to primary graft failure), all were still alive on posttransplant day 60
Martins et al. ⁹	2012	Lung	Pneumonia with positive <i>A. baumannii</i> cultures on multiple occasions. Required amines, invasive ventilation and presented with kidney failure	Amikacin and polymyxin B, as well as reduced immunosuppression	Died on posttransplant day 61
Sözen et al. ⁵	2008	Liver and 2 kidneys in different recipients Liver and 2 kidneys (different recipients)	None in the three recipients Not specified	Teicoplanin, netromycin, and cefoperazone/sulbactam Empiric antibiotic therapy	No isolation in cultures in the three recipients The cultures of the 3 recipients were negative
Bardossy et al. ¹⁰	2020	Lung Liver and 2 kidneys (different recipients)	No clinical manifestations and/or infection. On day 12 alveolar lavage culture was positive for <i>A. baumannii</i> Not specified	Tigecycline IV for 19 days and colistin for 45 days Empiric antibiotic therapy	Graft colonized by <i>A. baumannii</i> up to 6 months after transplant but with no function alterations The cultures of the 3 recipients were negative

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Intraluminal radiofrequency ablation as stricture management in biliary-enteric anastomosis[☆]



Manejo de una estenosis de la anastomosis bilioentérica con ablación por radiofrecuencia intraluminal

There are cases of biliary strictures that are difficult to manage through conventional methods. Intraluminal radiofrequency ablation (RFA) is a novel treatment modality that has been used in cases of malignant biliary strictures and in some cases of benign biliary strictures.¹

A 69-year-old man had a past medical history of perihilar cholangiocarcinoma (Bismuth IIIa classification) and underwent extensive right hepatectomy with segmental resection of the portal vein and biliary reconstruction through Roux-en-Y hepaticojejunal anastomosis. One year after the procedure, he presented with the complication of biliary-enteric anastomotic stricture, manifesting as episodes of recurrent cholangitis. The patient was first managed through multiple sessions of percutaneous transhepatic balloon dilation and the placement of percutaneous biliary drains. Despite the initial success of those interventions, biliary-enteric anastomotic stricture continued to recur. After discussing the case with a multidisciplinary team, intraluminal RFA was considered a management alternative for said refractory stricture. Under anesthesia with orotracheal intubation, percutaneous transhepatic cholangiography was performed to locate the stricture site and percutaneous transhepatic cholangioscopy was carried out, using SpyGlass[™] DS, which was advanced under direct vision, taking biopsies, to rule out neoplastic recurrence (Fig. 1A and B). The biliary drainage catheter the patient previously had was a 12 Fr catheter and did not require dilations. In the same procedure time, a 0.035"/260 cm hydrophilic guidewire was advanced until reaching the stricture. An 8 Fr Habib[™] EndoHPB catheter, with two distally placed electrodes, was then advanced over the guidewire. Once the correct position of the electrodes over the stricture site was corroborated through fluoroscopy, RFA was carried out, with no complications. The energy configuration

in the generator was 10 watts, with a duration of 90 s. The patient was already receiving antibiotics due to suspected acute cholangitis. The histopathologic result of the biopsies reported only chronic inflammatory changes. In a later control cholangiography, a patent anastomosis was observed, and so the percutaneous biliary drain was removed (Fig. 2). At 10 months from management, the patient has had no recurrences of biliary-enteric anastomotic stricture.

Biliary-enteric anastomoses are performed to re-establish bile duct continuity with the small bowel in surgeries, such as pancreatoduodenectomies, liver transplants, and biliary repair surgeries. Stricture of the biliary-enteric anastomosis is considered an uncommon complication of the procedure and is reported to occur in

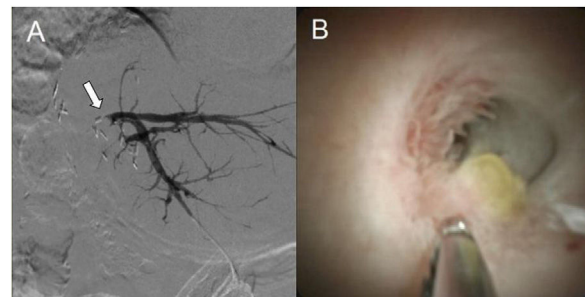


Figure 1 (A) Percutaneous transhepatic cholangiography prior to intraluminal RFA, in which no passage of the contrast agent to the intestinal segment, through the biliary-enteric anastomotic stricture, is observed (arrow). (B) Spyglass[™] image of the biliary-enteric anastomotic stricture, with biopsies taken with SpyBite[™].

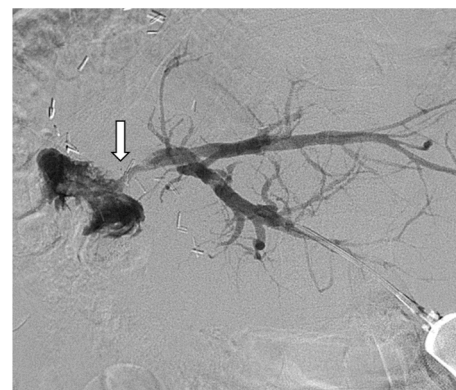


Figure 2 Percutaneous transhepatic cholangiography after treatment with intraluminal RFA, now with adequate contrast agent passage into the intestinal lumen (arrow).

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