Maastricht UMC+

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Voorbereiding op niertransplantatie; wat verandert er in de nieuwe richtlijn?

Papendal 2022

Maastricht UMC+

Disclosure belangen spreker	
(potentiële) Belangenverstrengeling	**Geen**
Voor bijeenkomst mogelijk relevante relaties met bedrijven[1]	
• Sponsoring of onderzoeksgeld[2] • Honorarium of andere (financiële) vergoeding[3] • Aandeelhouder[4] • Andere relatie, namelijk …[5]	• • • •

1 / 106 100%

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Transplantation®

KIDNEY DISEASE

KDIGO Clinical Practice Guideline on the Evaluation and Management of Candidates for Kidney Transplantation

ING GLOBAL OUTCOME

Indeling

Section 1: Access to Transplantation
Section 2: Age
Section 3: Pediatric issues
Section 4: Psychosocial Assessment
Section 5: Adherence
Section 6: Tobacco
Section 7: Surgical Issues including Obesity
Section 8: Diabetes
Section 9: Cause of End-Stage Kidney Disease (ESKD)
Section 10: Infections
Section 11: Malignancy
Section 12: Pulmonary Disease
Section 13: Cardiac Disease
Section 14: Peripheral Arterial Disease (PAD)
Section 15: Neurologic Disease
Section 16: Gastro-intestinal and Liver Disease
Section 17: Hematologic Disorders
Section 18: Bone and Mineral Metabolism
Section 19: Immunological Assessment

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Access to Transplantation

- Verwijs potentiele kandidaten 6 tot 12 maanden voor start dialyse met het doel om pre-emptief te transplanteren
    - ook bij postmortale niertransplantaties

- Wanneer patiënten een andere aandoening hebben, waarvoor transplantatie een optie is (bijv levercirrose, hartfalen), overweeg dan of een gecombineerde transplantatie een optie is

- Pre-emptieve transplantatie kan worden gepland bij eGFR <10 ml/min/1.73m^2 of eerder bij symptomen

- Patiënten zijn geschikt voor niertransplantatie wanneer wordt verondersteld dat niertransplantatie leidt tot een langere levensverwachting en/of toename van kwaliteit van leven.
    - Bij postmortale NTx dienen maatschappelijke belangen meegewogen te worden
    - Bij levende donatie is dit in samenspraak tussen donor en ontvanger

Age

SECTION 2: AGE

2.1: Consider age in the context of other comorbidities, including frailty, that may impact outcome when deciding about suitability for kidney transplantation *(Not Graded)*.

2.1.1: We recommend not excluding patients from kidney transplantation because of age alone *(1A)*.

- Leeftijd alleen is geen exclusie criterium, echter > 70jr wordt de meerwaarde van NTx onduidelijker.

Frailty

Clinical Frailty Scale*

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 Managing Well – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 Vulnerable – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with **all outside activities** and with **keeping house.** Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

- Clinical Frailty Scale >4
  - Korte multidomein screening

Psychosocial Assessment

- Gebruik meetinstrumenten zoals bijvoorbeeld de Psychosociale Screening Transplantatie (PST) om potentiele problemen in kaart te brengen
- Deze zijn echter niet bedoeld als eindoordeel

afdeling Nefrologie

Psychosociale Screening Transplantatie

Bij onvoldoende ruimte in het vak *Toelichting/ aandachtspunt* a.u.b. verder gaan in het vak *Verdere toelichting/ aanvulling* op pagina 4.

Invuldatum:
Naam patiënt:
Geboortedatum:

Ingevuld door:
Funkties:
[meerdere zorgverleners graag op één formulier]

Eerdere tx: Nee **Zo ja,wanneer:**

Welk orgaan?

	mee eens / ja	twijfel	mee oneens / nee	Toelichting/aandachtspunt
A: Kennis en inzicht in ziekteproces				
- De patiënt heeft kennis van zijn ziekteproces.	✓	◆	●	
- De patiënt heeft inzicht in zijn ziekteproces.				
B: Kennis en inzicht in niertransplantatie				
- Heeft reële verwachtingen van een leven met een Txnier.				
- De patiënt heeft inzicht in de risico's.				
C: Bereidheid en mogelijkheid tot behandeling				
- Is voldoende gemotiveerd om mee te werken aan de behandeling.				
- Is voldoende in staat om mee te werken aan zijn behandeling.				
D: Medicatie				
- Kan zelfstandig de medicatie beheren en op de juiste wijze innemen.				
- Indien nee, wie regelt dan de medicatie?				
E: Zelfstandigheid en Lichamelijk functioneren				
- De patiënt kan zelfstandig functioneren (bijv. ADL).				
- Indien nee: wie ondersteunt daarin?				
- Deze persoon heeft voldoende kennis t.a.v. een niertransplantatie.				
- De patiënt heeft lichamelijke beperkingen?				
Geen				
F: Middelengebruik				
- Patiënt gebruikt middelen.				Hoeveelheid:
- Welke middelen worden gebruikt ? Geen				
- Welke rol spelen deze in het leven van de patiënt (verslavingsproblematiek)?				

Surgical Issues including Obesity

- BMI < 30 is geen bezwaar voor NTx
- BMI 30-35 wisselende acceptatiecriteria in de verschillende centra, mede op basis van chirurgische expertise
- BMI 35-40 sterk advies voor gewichtsreductie middels hulp van diëtiste, indien niet succesvol evt bariatrie
- BMI >40 bariatrie, met voorkeur voor gastric sleeve vanwege de kans op secundaire oxalose bij Roux-Y

- Antistolling mag geen reden zijn om patiënten af te wijzen.
  - Duale plaatjesremming is gecontraindiceerd
  - Ticagrelor bij voorkeur omzetten, vanwege interactie met Tacrolimus
  - DOAC omzetten naar VKA
  - Verder afhankelijk van lokale richtlijnen

- Pre-operatieve beoordeling door transplantatie chirurg
    - Afhankelijk van lokale richtlijnen

- Indien urologische beoordeling nodig, kan dit in het eigen centrum plaatsvinden, tenzij specifieke situaties (zoals blaasaugmentatie of urostoma)

Diabetes

- Denk bij patiënten met DM 1 aan de simultane nier-pancreasTx
    - Verwijzen bij eGFR <30 ml/min
    - Indien levende donor: Nier plaatsen in linker fossa

- Geen standaard screening middels OGTT, maar bijv HbA1c of glucose, vooral wanneer dit relevant is voor immuunsuppressiva

Infections

Federatie Medisch Specialisten

Richtlijnendatabase

RICHTLIJNEN | ZOEK | NIEUWS | INSTRUCTIES | WERKWIJZE | OVER | CONTACT | APP | LOG IN | COVID-19

← Terug naar zoekresultaten

Tuberculosescreening voorafgaand aan immuunsuppressieve medicatie

+ VOLGEN

Initiatief: NVALT Aantal modules: 6

Bijlagen | Download richtlijn

Tuberculosescreening voorafgaand aan immuunsuppressieve medicatie

Zoeken binnen deze richtlijn

Startpagina - Tbc-screening immuunsuppressieva

Beoordeeld: 15-04-2019

Waar gaat deze richtlijn over?

Deze richtlijn gaat over patiënten bij wie wordt overwogen immuunsuppressieve medicatie voor te schrijven. Het beschrijft het screeningsbeleid bij immuunsuppressieve medicatie waarvan is aangetoond, of waarvan op grond van het werkingsmechanisme aannemelijk lijkt dat het het risico op (reactivatie van latente) tuberculose verhoogt (zie Algemene inleiding). Reactivatie van een latente

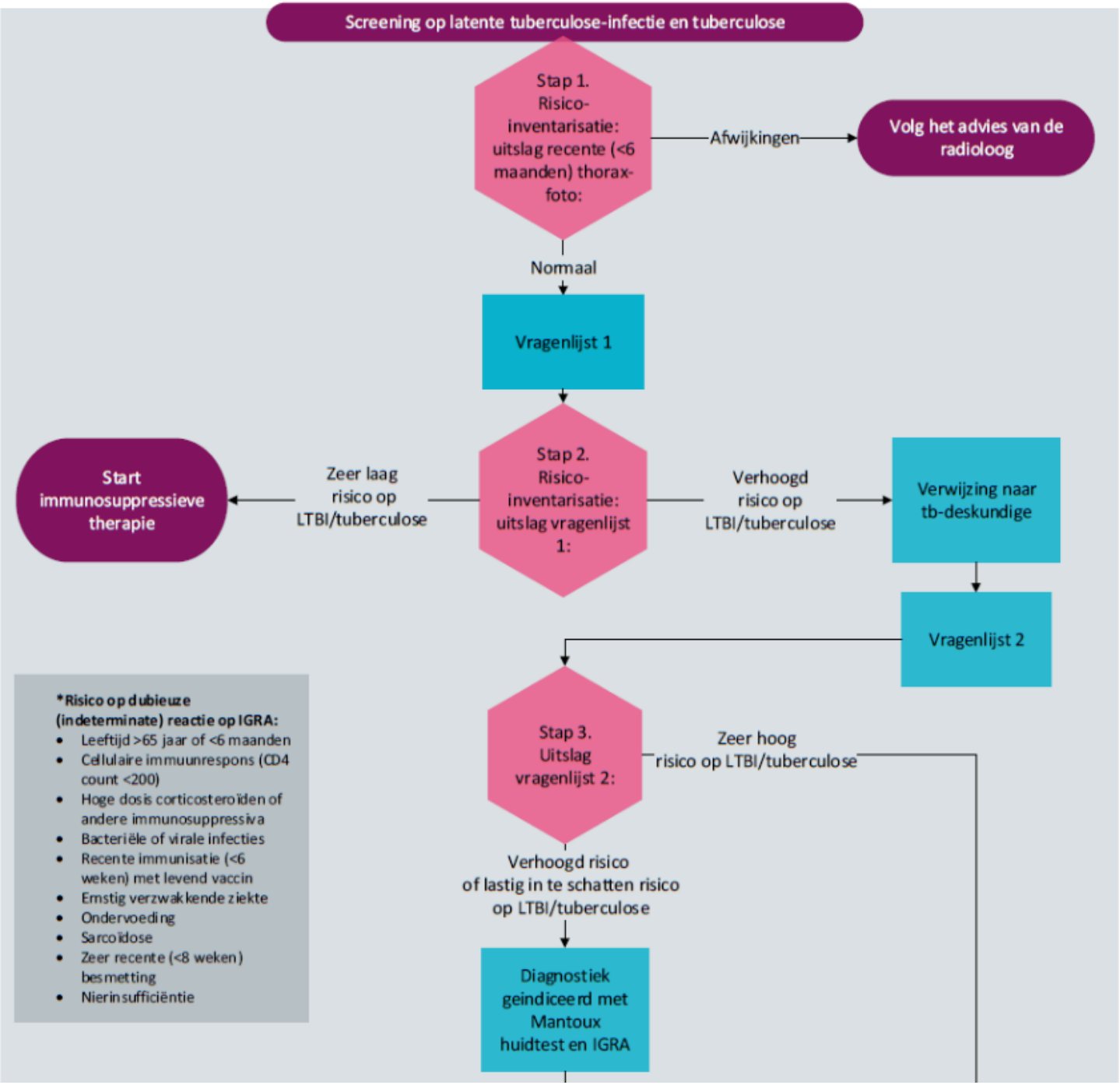
Nederlandse Federatie voor Nefrologie

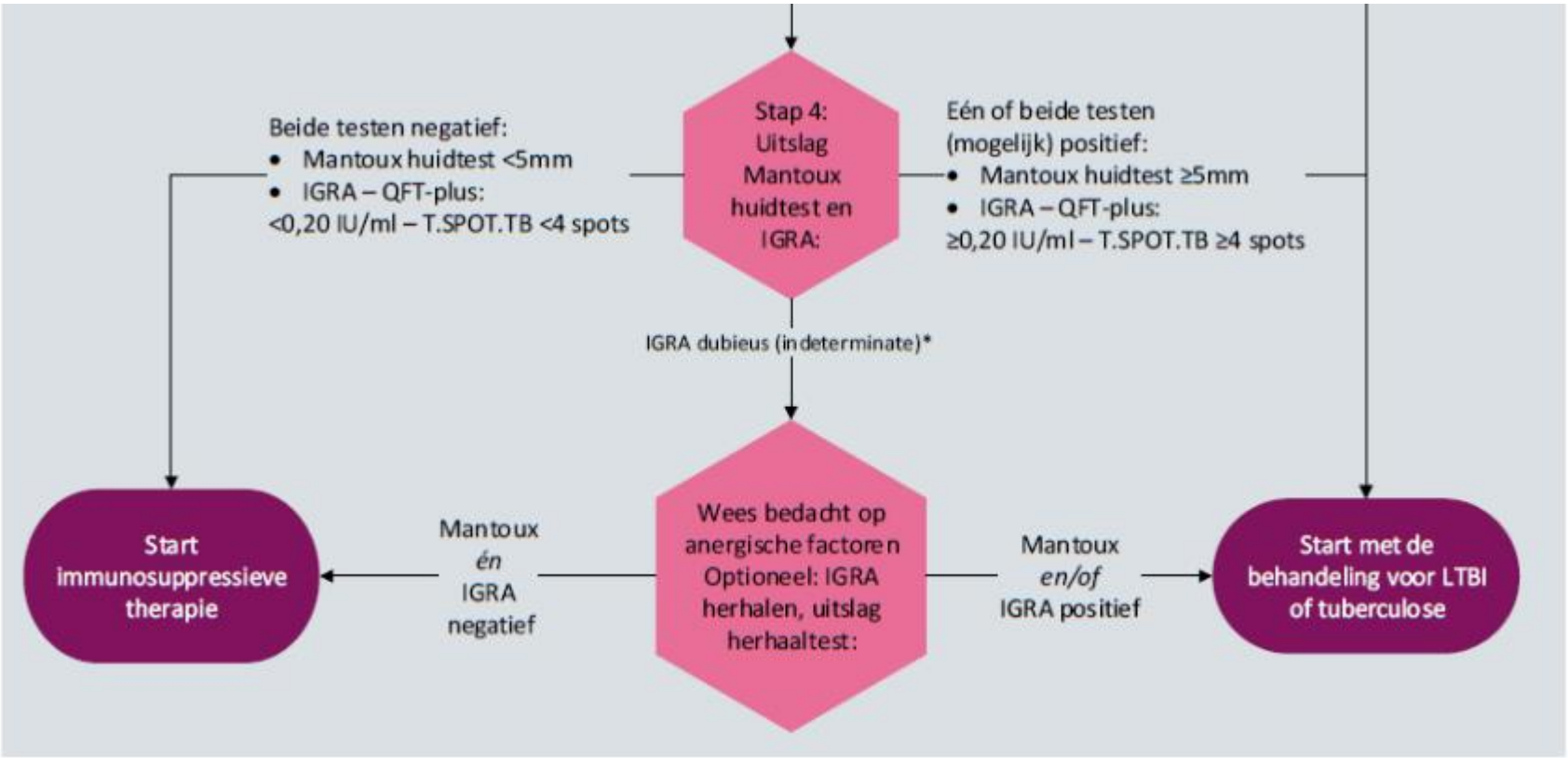
LO
nie
vol

HOME
COVID-19
OVER DE NFN
LEDEN
RICHTLIJNEN
Definitieve richtlijnen

LONT Vaccinatie pre-niertransplantatie voor volwassenen, NTV 2022

NTV richtlijn


Screening op latente tuberculose-infectie en tuberculose
Stap 1. Risico-inventarisatie: uitslag recente (<6 maanden) thorax-foto:
Afwijkingen
Volg het advies van de radioloog
Normaal
Vragenlijst 1
Stap 2. Risico-inventarisatie: uitslag vragenlijst 1:
Zeer laag risico op LTBI/tuberculose
Start immunosuppressieve therapie
Verhoogd risico op LTBI/tuberculose
Verwijzing naar tb-deskundige
Vragenlijst 2
Stap 3. Uitslag vragenlijst 2:
Zeer hoog risico op LTBI/tuberculose
Verhoogd risico of lastig in te schatten risico op LTBI/tuberculose
Diagnostiek geindiceerd met Mantoux huidtest en IGRA
*Risico op dubieuze (indeterminate) reactie op IGRA:
Leeftijd >65 jaar of <6 maanden
Cellulaire immuunrespons (CD4 count <200)
Hoge dosis corticosteroïden of andere immunosuppressiva
Bacteriële of virale infecties
Recente immunisatie (<6 weken) met levend vaccin
Ernstig verzwakkende ziekte
Ondervoeding
Sarcoïdose
Zeer recente (<8 weken) besmetting
Nierinsufficiëntie



- Isoniazide dagelijks x 9 maanden
- Isoniazide en Rifampicine dagelijks x 4 maanden
- Rifampicine dagelijks x 4 maanden (bij INH intolerantie/resistentie)

Malignancy

- Alle screening volgens het bevolkingsonderzoek
- Geen standaard PSA bij iedereen
    - Bij aanwijzingen voor erfelijkheid
        - 3 familieleden óf
        - 2 eerste of tweede graads familieleden < 55jr

COMPREHENSIVE REVIEW

AJT

Pretransplant solid organ malignancy and organ transplant candidacy: A consensus expert opinion statement

David P. Al-Adra[1] | Laura Hammel[2] | John Roberts[3] | E. Steve Woodle[4] |

COMPREHENSIVE REVIEW

AJT

Preexisting melanoma and hematological malignancies, prognosis, and timing to solid organ transplantation: A consensus expert opinion statement

David P. Al-Adra[1] | Laura Hammel[2] | John Roberts[3] | E. Steve Woodle[4] |

Mammacarcinoom

TABLE 1 Recommended wait time for SOT candidates with a prior history of breast cancer

Risk/stage	5-Year disease-specific survival[18,19]	Time interval to transplant	Additional considerations
LOW RISK DCIS Stage I	97%-99%	No wait time necessary[a]	-Hormone receptor negative disease may have a slightly higher risk of recurrence in the first 2-3 years
INTERMEDIATE RISK Stage II	90%-99%	1-2 years NED[a]	-Hormone receptor negative disease may have a slightly higher risk of recurrence in the first 2-3 years
HIGH RISK Stage III	66%-97%	3-5 years NED[a]	-Hormone receptor negative disease may have a slightly higher risk of recurrence in the first 2-3 years -Inflammatory breast cancer likely has a higher risk of recurrence and worse survival
PROHIBITIVE RISK Stage IV	32%-38%	Not a SOT candidate	

Standard oncologic treatments are based on those recommended in the NCCN (National Comprehensive Cancer Network) Breast Cancer guidelines (www.nccn.org). Breast cancer stages are based on the *prognostic stage groups* specified in the AJCC's Staging Manual, 8th edition. Anatomic stage groups are not necessarily equivalent to the corresponding prognostic stage groups and should not be applied here. DCIS: ductal carcinoma *in situ*.

NED: no evidence of disease.

[a]After completion of all standard treatments. Endocrine therapy does not need to be completed prior to transplant, as this is an oral medication that is fairly well tolerated with few serious side effects and often continues for 5-10 years.

Colon carcinoom

TABLE 2 Recommended wait time for SOT candidates with a prior history of colon cancer

Risk/stage	Recurrence-free survival 5 years[41,46]	Time interval to transplant	Additional considerations
LOW RISK Stage I (T1 or T2, N0, M0)	91%	1 year	*Low-risk features:* - MSI without BRAF mutation *High-risk features:* - LVI or PNI - Mucinous or Signet Histology - Poorly differentiated histology - Bowel obstruction - Tumor perforation - <12 lymph nodes examined *Tumor deposits considered as N+ disease *Consider chemotherapy prior to transplantation for high-risk stage II disease *Patients with stage III disease should complete chemotherapy
LOW INTERMEDIATE RISK Stage II (T3, N0, M0)	72%	2 years, consider longer if high-risk features present	
HIGH INTERMEDIATE RISK Stage II (T4, N0, M0) Stage III (Any T, N+, M0)		3 years, 5 years if high-risk features present	
HIGH RISK Stage IV (Any T, Any N, M+)	13%	5 years NED	SOT not recommended prior to 5 years; see special consideration regarding resectable CRC metastasis

Abbreviations: RFS, recurrence-free survival; LVI, lymphovascular invasion; PVI, perineural invasion; MSI, microsatellite instability; CT, computed tomography; CAP, chest, abdomen and pelvis; CEA, carcinoembryonic antigen; NED, no evidence of disease.

Rectum carcinoom

TABLE 3 Recommended wait time for SOT candidates with a prior history of rectal cancer

Risk/stage	Recurrence-free survival 5 years[41,46]	Time interval to transplant	Additional considerations
LOW RISK Stage I (T1 or T2, N0, M0) Full oncologic resection	85%–88%	1 year, consider 2 years if high-risk features present	*Low-risk features:* - MSI without BRAF mutation - Upper 1/3 rectum or rectosigmoid *High-risk features:* - LVI or PNI - Mucinous or Signet Histology - Poorly differentiated histology - Bowel obstruction - Tumor perforation - <12 lymph nodes examined - Lower 1/3 of rectum - Incomplete mesorectal excision *Tumor deposits considered as N+ disease *Patients with stage II and III disease should complete trimodaility treatment (chemoradiotherapy, surgery and chemotherapy) unless elimination of one of these is deemed appropriate after multidisciplinary discussion *For patients who have undergone preoperative radiotherapy, response to treatment is highly prognostic. Complete and nearly complete responders have much lower risk for recurrence than those with poor response
LOW INTERMEDIATE RISK Stage I (T1, N0, M0) Local Excision	78%–88%	2 years	
HIGH INTERMEDIATE RISK Stage II (T3 or T4, N0, M0) Stage III (Any T, N+, M0)	70%	3 years, 5 years if high-risk features present	
HIGH RISK Stage IV (Any T, Any N, M+)	14%	5 years NED	SOT not recommended prior to 5 years; see special consideration regarding resectable CRC metastasis

Abbreviations: RFS, recurrence-free survival; LVI, lymphovascular invasion; PVI, perineural invasion; MSI, microsatellite instability; CT, computed tomography; CAP, chest, abdomen and pelvis; CEA, carcinoembryonic antigen; NED, no evidence of disease.

Prostaat carcinoom

TABLE 4 Recommended wait time for SOT candidates with a prior history of prostate cancer

Risk/stage	Survival[60,62,64]	Time interval to transplant	Additional considerations
VERY LOW RISK	<1% risk of mets/death over 15 years	None	Surveillance is strongly recommended
- PSA<10 ng/ml			
- 3 or fewer cores of Gleason 6 (grade group 1); no greater than 50% of individual core			Extenuating circumstances may require treatment
- T1c-T2a			
LOW RISK	~2-3% risk of mets/ death over 15 years	None	Surveillance is strongly recommended
- PSA<10 ng/ml			
- Gleason 6 (not meeting very low-risk criteria)			Extenuating circumstances may require treatment
- T1c-T2a			
LOW-VOLUME INTERMEDIATE RISK - One of the following criteria: PSA >10 ng/ ml, Gleason 7 (grade group 2 or 3), T2b	<5% risk of mets/death over 15 years	If surveillance, no wait time If treatment initiated, and nomogram (www.nomograms.org) predicts cancer-specific death over the next 15 years <10%, no wait time	Surveillance or treatment, depending on patient and cancer characteristics
HIGH-VOLUME INTERMEDIATE RISK, HIGH RISK or VERY HIGH RISK - PSA >20 ng/ml or high-volume Gleason 7 or any Gleason 8-10, T3	20-70% risk of mets/ death over 15 years	If treatment initiated, and nomogram predicts cancer-specific death over the next 15 years <10%, no wait time	Treatment
METASTATIC CASTRATION-SENSITIVE	Median survival ~5-6 years	If stable disease for 2 years with prolonged estimated life expectancy, may consider transplant	Best systemic therapy +/- local treatment
METASTATIC CASTRATION-RESISTANT	Median survival 2-3 years	Not a SOT candidate	Best systemic therapy

Abbreviation: PSA, prostate specific antigen.

Renaalcelcarcinoom

TABLE 5 Recommended wait time for SOT candidates with a prior history of renal cell carcinoma

Stage	Recurrence-free survival 5 years[69,73–75]	Time interval to transplant
T1a (≤4 cm), N0, M0	95%-98%	No wait time
T1b (>4 cm ≤7 cm), N0, M0	91% for FG 1/2 80%-82% for FG 3/4	FG 1-2: no wait time FG 3-4: 1-2 years
T2 (7-10 cm), N0, M0	80%	2 years
T3, N0, M0	43%-80%	Minimum of 2 years, then reassess
T4, N0, M0	28%-55%	Minimum of 2 years, then reassess
Any T, Node positive, Metastatic disease	0%-32%	Not a candidate (if solitary metastasis +resected, tumor board discussion on candidacy)
Any T with sarcomatoid and/or rhabdoid histologic features	15%-27%	Not a SOT candidate
Collecting duct or Medullary RCC	<10%	Not a SOT candidate

Abbreviations: RCC, renal cell carcinoma; FG, Fuhrman grade (Grade 1: inconspicuous nucleoli at ×400 magnification and basophilic, Grade 2: clearly visible nucleoli at ×400 magnification and eosinophilic, Grade 3: clearly visible nucleoli at ×100 magnification, Grade 4: extreme pleomorphism or rhabdoid and/or sarcomatoid morphology).

Blaascarcinoom

TABLE 6 Recommended wait time for SOT candidates with a prior history of bladder cancer

Bladder cancer history	2-Year local recurrence from baseline trans urethral resection of bladder tumor[77,80,81]	Time interval to transplant
NMIBC low risk[a]	19%	6 months
Intermediate risk[b]	39%	6 months
High risk[c]	38%	2 years
MIBC, postradical cystectomy	25%-37%	2 years
MIBC, postchemoradiation	25%-30% (10 year)	Not a SOT candidate

Abbreviations: NMIBC, nonmuscle invasive bladder cancer; MIBC, muscle invasive bladder cancer.

[a]Low risk - solitary, ≤3 cm, low grade, Ta tumor, absence of carcinoma in situ (CIS).

[b]Intermediate risk - solitary tumor >3 cm, recurrence within 12 months with low-grade Ta tumor, multifocal low-grade Ta tumor, low-grade T1 tumor, or high-grade tumor <3 cm.

[c]High risk - any CIS, high-grade Ta tumor >3 cm, high-grade T1 tumor, multifocal high-grade Ta tumor, any recurrent high-grade Ta tumor, CIS, variant histology, lymphovascular invasion, high-grade prostatic urethral involvement, recurrence after BCG intravesical therapy. Although 2-year recurrence rate is lower than intermediate risk, the progression rate to muscle invasion is higher.

Gynaecologische maligniteit

TABLE 7 Recommended wait time for SOT candidates with a prior history of gynecological cancer

5-Year recurrence risk[92–94]	Type and stage	Time interval to transplant
LOW RISK <5% risk of recurrence	Stage IA/IB, grade 1-2 endometrial cancer without lymph-vascular space invasion Stage IA/IB/IC grade 1-2 epithelial ovarian cancer Stage IA1, IA2 squamous/adenocarcinoma of the cervix	No waiting period after completion of primary treatment
INTERMEDIATE RISK 5%-15% risk of recurrence	Stage I/II endometrial cancer +risk factors[a] Stage IB squamous/adenocarcinoma of the cervix	2-3 years after completion of treatment
HIGH RISK >30% risk of recurrence	Serous, clear cell, or carcinosarcoma of uterus (all stages) Stage III grade 1-3 endometrioid cancer of the uterus Stage II/III epithelial ovarian cancer Stage II/III squamous cell/adenocarcinoma cervical cancer	5 years after completion of treatment
VERY HIGH RISK >80% chance of recurrence	Stage IV endometrial cancer (all grades) Recurrent or metastatic endometrial cancer Stage IV epithelial ovarian cancer (any grade) Recurrent ovarian cancer Stage IV squamous cell/adenocarcinoma of the cervix Metastatic or recurrent cervical cancer	Not a SOT candidate

[a]Risk factors: Older age, lymph-vascular space invasion, grade 2 or 3 endometrioid, deeply invasive tumor.

Longcarcinoom - NSCLC

TABLE 8 Recommended wait time for SOT candidates with a prior history of lung cancer

Stage	Tumor and node	5-Year survival (%)[101,102]	Work-up Pre-SOT	Time interval to transplantation	Additional considerations
I	T1aN0	92	PET-CT; consider biopsy post SBRT	≥3 years	
	T1bN0	83	PET-CT; consider biopsy post SBRT	≥3 years	
	T1cN0	77	PET-CT; consider biopsy post SBRT	3-5 years	5-year recurrence-free survival is safest
IB	T2aN0	68	PET-CT	5 years	
IIA	T2bN0	60	PET-CT	5 years	
IIB	T3 N0	53	PET-CT	5 years	
IIIA		36	PET-CT	5 years	Special caution with N2 disease
IIIB		26	N/A	N/A	Not a SOT candidate
IIIC		13	N/A	N/A	Not a SOT candidate
IVA		10	N/A	N/A	Not a SOT candidate
IVB		0	N/A	N/A	Not a SOT candidate

Abbreviations: SOT, solid organ transplantation; PET-CT, positron emission tomography-computed tomography; SBRT, stereotactic body radiation therapy.

Melanoom

TABLE 1 Recommended wait time for SOT candidates with a prior history of melanoma

Pathological stage	5-year MSS[12]	Appropriate treatment pretransplantation	Time interval to transplant	Additional considerations
In situ	99%	Wide local excision	No wait time necessary	Follow-up 3 months post-SOT
Stage IA (T1a)	99%	Wide local excision	1 year	
Stage IB (T1b or T2a)	97%	Wide local excision plus SLNB	1 year	If positive SLNB at time of diagnosis, imaging as for Stage IIA disease
Stage IIA (T2b or T3a)	94%	Wide local excision plus SLNB	1 year	Imaging of the brain, CAP Imaging of the neck for those with head/neck melanoma primary
Stage IIB (T3b or T4a)	87%	Wide local excision plus SLNB	2–4 years	Imaging as above
Stage IIC (T4b)	82%	Wide local excision plus SLNB	2–4 years	Imaging as above
Stage IIIA (T1-2a, N1a or 2a)	93%	Wide excision plus SLNB plus lymph node dissection	1–2 years	Imaging as above Oncology referral
Stage IIIB (T0-3a and N1a/b/c, N2a/b)	83%	Wide excision plus SLNB plus lymph node dissection Adjuvant therapy with CKI	2–4 years	Imaging as above Oncology referral
Stage IIIC (T3b-4b and N2b/c-N3b/c)	69%	Wide excision plus SLNB plus lymph node dissection, Adjuvant therapy with CKI	At least 5 years	Imaging as above Oncology referral (no consensus was possible for this group)
Stage IIID (T4b and N3a-3c)	32%	Wide excision plus SLNB plus lymph node dissection Adjuvant therapy with CKI	At least 5 years	Oncology referral (no consensus was possible for this group)
Stage IV	15%–20%	Wide excision plus SLNB plus lymph node dissection Adjuvant therapy with CKI	At least 5 years	Oncology referral (no consensus was possible for this group)

Abbreviations: MSS, melanoma-specific survival; SLNB, sentinel lymph node biopsy; CKI, checkpoint inhibitor; CAP, chest, abdomen, and pelvis.

Lymfoom

TABLE 2 Recommended wait time for SOT candidates with a prior history of hematological malignancies

Histology	Survival/relapse data	Time interval to transplant	Additional considerations
Diffuse large B cell lymphoma	Survival is equivalent to age- and sex-matched general population after EFS24 and PFS24 achieved[27,28]	2 years	
Follicular lymphoma	No added mortality when compared to age- and sex-matched general population after EFS24 achieved[29,30]	2 years	
Peripheral T cell lymphoma, NOS	23% relapse within 5 years of EFS24, 78% 5-year survival after EFS24 achieved[32]	2 years	
Burkitt lymphoma	0.6% relapse after EFS24 achieved[33]	2 years	
Hodgkin lymphoma	10% relapse at 10 years after EFS24 achieved[31]	2 years	PET scan negative patients after initial treatment have a low rate of relapse
Monoclonal B cell lymphocytosis	N/A	No wait time	
Chronic lymphocytic leukemia	83% 5-year survival untreated[36]	2–3 years after treatment	Consider if in remission with no CLL-IPI scores >4

Abbreviations: EFS24, event-free survival at 24 months; PFS24, progression-free survival at 24 months.

Cardiac disease

- Asymptomatische patiënten met hoog risico of verminderde inspanningstolerantie: non-invasieve screening op coronairlijden (2C)
- Bij asymptomatische patiënten met bekend coronairlijden geen revascularisatie om periOK events te verminderen (1B)
- Revisie > 70jr en/of instabiel: jaarlijks
- Revisie > 65jr en/of stabiel: iedere 2 jaar
    - Vaker op indicatie

Peripheral Arterial Disease

- Bij vaatlijden blanco CT en duplex
  - CT met contrast indien geen restdiurese

- Afhankelijk van lokale richtlijnen ook beeldvorming bij patiënten zonder evident vaatlijden

- Anastomose op vaatprothese mogelijk, ter beoordeling van transplantatie chirurg

Marielle Gelens

Leden van het LONT

Richtlijnen commissie NFN