IMPROVEMENT OF RENAL FUNCTION BY CONVERSION OF TACROLIMUS TO EVEROLIMUS 3 MONTHS AFTER KIDNEY TRANSPLANTATION.

No registrations found.

Ethical review	Positive opinion
Status	Pending
Health condition type	-
Study type	Interventional

Summary

ID

NL-OMON24603

Source
NTR

Brief title
Conversion from tacrolimus to everolimus in renal

Health condition

Kidney transplant recipients
Tacrolimus
Everolimus
Niertransplantatie patiënten

Sponsors and support

Primary sponsor: Erasmus Medical Center
Source(s) of monetary or material Support: Erasmus Medical Center
Novartis

Intervention

Outcome measures

Primary outcome

For this conversion study renal function is the primary endpoint. Mean MDRD clearances will be compared between tacrolimus and everolimus treated patients at month 12. Also changes in MDRD clearances within individual patients in the tacrolimus and everolimus treated patients between month 3 and 12 will be compared.

Secondary outcome

1. Incidence of acute rejection between month 3 and month 12;

2. Renal histology, including signs of calcineurin inhibitor related nephrotoxicity, at month 12;

3. Graft survival;

4. Adverse events;

5. Correlation between drug exposure parameter and incidence of rejection or toxicity after month 3.

Study description

Background summary

Rationale:

The most important problem after kidney transplantation is the occurrence of chronic interstitial fibrosis (IF) and tubular atrophy (TA), which leads to graft loss. Tacrolimus induced nephrotoxicity importantly contributes to the development of IF/TA. By converting tacrolimus maintenance therapy to everolimus the nephrotoxic side effects of this drug will be eliminated tacrolimus and renal function may be preserved.

Objective:

To investigate if conversion of tacrolimus-based immunosuppression to everolimus-based immunosuppression results in preservation of renal function as compared to continued tacrolimus-based immunosuppression. In addition to renal function also changes in renal histology following conversion of tacrolimus-based immunosuppression to everolimus-based immunosuppression will be studied.

Study design:

A randomized, controlled parallel study: At three months after transplantation patients will be randomised for continuation of tacrolimus or conversion to everolimus maintenance therapy.

Intervention:

One group will continue tacrolimus three months after transplantation and the other group will be converted to everolimus three months after transplantation.

Main study parameters/endpoints:

Renal function is the primary endpoint. Mean
glomerular filtration rate (GFR; calculated by use of the MDRD formula) will be compared between tacrolimus and everolimus treated patients at month 12. In addition, differences in MDRD GFR within individual patients in the tacrolimus and everolimus treated patients between month 3 and 12 will be compared.

Study objective

The most important problem after kidney transplantation is the occurrence of chronic interstitial fibrosis (IF) and tubular atrophy (TA), which leads to graft loss. Tacrolimus induced nephrotoxicity importantly contributes to the development of IF/TA. By converting tacrolimus maintenance therapy to everolimus the nephrotoxic side effects of this drug will be eliminated tacrolimus and renal function may be preserved.

Study design

Month 3 after kidney transplantation.

Intervention

Conversion of tacrolimus-based immunosuppression to everolimus-based immunosuppression three months after kidney transplantation. At three months after transplantation patients will be randomized for continuation of tacrolimus or conversion to everolimus maintenance therapy.

Contacts

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Eligibility criteria

Inclusion criteria

1. Treatment with immunosuppressive therapy consisting of tacrolimus, corticosteroids and mycophenolate mofetil at 3 months after transplantation;

2. Patients who have given written informed consent to participate in the study.

Exclusion criteria

1. Acute rejection episodes less than 4 weeks prior to randomization;

2. Proteinuria ≥ 1.0 g/day;

3. GFR ≤ 30 mL/min;

4. Recipient of multiple organ transplants;

5. Recipient of ABO incompatible allograft or a positive cross-match;

6. Patient who is human immunodeficiency virus (HIV) positive;

7. Patient who received an allograft from a Hepatitis B surface Antigen (HBsAg) or a Hepatitis C Virus (HCV) positive donor;

8. Patient with severe allergy requiring acute (within 4 weeks of baseline) or chronic treatment that would prevent patient from potential exposure to everolimus, or with

hypersensitivity to drugs similar to everolimus (e.g. macrolides);

9. Patient with severe hypercholesterolemia or hypertriglyceridemia that cannot be controlled;

10. Patient with white blood cell (WBC) count ¡Ü 2,000 /mm3 or with platelet count ≤ 50,000 /mm3;

11. Patients with ongoing wound healing problems, clinically significant infection requiring continued therapy or other severe surgical complication in the opinion of the investigator;

12. Presence of intractable immunosuppressant complications or side effects;

13. Females of childbearing potential who are planning to become pregnant, who are pregnant and/or lactating, who are unwilling to use effective means of contraception.

Study design

Design

Study type:	Interventional
Intervention model:	Parallel
Allocation:	Randomized controlled trial
Masking:	Open (masking not used)
Control:	Active

Recruitment

NL

Recruitment status:	Pending
Start date (anticipated):	25-10-2010
Enrollment:	250
Type:	Anticipated

Ethics review

Positive opinion

Date:	06-09-2010

Application type: First submission

Study registrations

Followed up by the following (possibly more current) registration

No registrations found.

Other (possibly less up-to-date) registrations in this register

No registrations found.

In other registers

Register	ID
NTR-new	NL2436
NTR-old	NTR2545
Other	EudraCT : 2010-019398-14
ISRCTN	ISRCTN wordt niet meer aangevraagd.

Study results

Summary results
N/A