Preconditions for warm organ preservation
Post, I.C.J.H.

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Appraisal of the porcine kidney autotransplantation model

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Abstract

Animal models are extensively being used for transplantation-related research, especially for kidney transplantation. Porcine kidney autotransplantation models are considered to be favorable regarding translatability to the human setting. The key determinants for translatability of the porcine model are discussed, comprising animal age, development, anatomy, anesthesia and surgical protocols, and perioperative care. With the detailed discussion of these determinants and the pitfalls in diagnosing animal discomfort, an attempt is made to provide a uniform porcine kidney autotransplantation model with tools to improve currently used models.
Introduction

The waiting list for a kidney transplant has exceeded 11,000 registrations in the Eurotransplant region and 93,353 in the United Nations Organ-Sharing network, emphasizing that kidney grafts are in high demand. The use of marginal kidney grafts such as from non heart-beating donors (NHBD) can alleviate organ shortage, but incorporates relatively high rates of delayed graft function (DGF) and primary non-function (PNF).\textsuperscript{1-3} This outcome is mainly exerted by the prolonged ischemic times in combination with reperfusion (ischemia/reperfusion (IR) injury) experienced by the NHBD kidney graft.\textsuperscript{1-3} A clinically relevant, reproducible animal kidney transplantation model is imperative to investigate and improve intervention and preservation strategies to unlock the full clinical potential of NHBD organs.\textsuperscript{4, 5} An autotransplantation model is highly suitable to isolate the effects of the intervention or preservation method from the possible effects of graft rejection.

Crucial for animal models is the translatability to the human setting in which trans-species extrapolation of small animal models (e.g. mice and rats) to humans can be precarious.\textsuperscript{6} Nonetheless, substantial research has been performed in these models, despite the differences in renal (micro-)anatomy, related technical difficulties, young age of animals (reflecting human infants), circadian rhythm-related issues, dosage/metabolism conversions, and differences in pharmacokinetics/pharmacodynamics.\textsuperscript{4, 5, 7-10} Most of these issues can be diminished by using the porcine model (see 'Discussion') for research relevant to the clinical transplantation setting.

We therefore present herein, current insights in the application of anesthetics, surgical techniques, and perioperative care for a porcine kidney autotransplantation model. Our goal is to provide a standard model of high reproducibility, employing the advantages of a large animal model, i.e. low cost, high availability, and comparable anatomy and physiology to the human setting. Special attention is paid to the anesthesiological, surgical, and postoperative aspects of this model.

Porcine characteristics and preoperative care

Several factors influence translatability and graft outcome of the porcine kidney autotransplantation model, including age, sex, housing, stress, and feeding. In the following sections, these specific factors are elucidated.
**Age and Sex**

Renal development in pigs differs from human kidney development. Where human kidneys are anatomically and functionally mature at gestational age, porcine kidneys are mature at 2 to 3 months (20-30 kg) of age.\(^{11,12}\) Thus, to translate porcine organ function to the human, adult setting, the age of the pig should at least be above 3 months. Furthermore, at 7 to 8 months of age (100-120 kg), pigs reach puberty during which androgens can influence IR injury by inhibiting non-androgen receptor-mediated processes.\(^{13}\) This inhibition leads to increased inflammation and functional kidney injury.\(^{14}\) Secondly, while a midline abdominal incision can be used for transperitoneal access to the retroperitoneum (see ‘Surgical considerations’), the male pigs’ midline urethral position hampers the latter and poses unnecessary infectious risks. Age and sex related endocrine factors should be considered in experimental designs while young piglets (20-30 kg) are developmentally equal to human infants regarding functional characteristics and anatomy of the kidney.\(^{12}\) Therefore, we pose an optimal age with female pigs for the autotransplantation model of 5 months (50 kg), representing comparable kidney function to adult humans.

**Housing & Stress**

Pigs are social and curious animals and need to be housed in enclosures that allow social interaction and stimulation of natural behavior (rooting) to reduce induction of stress. Putative floor areas per pig minimally encompass 1.08 m\(^2\), 1.35 m\(^2\), or 2.16 m\(^2\) for 25, 50, or 100 kg pigs, respectively.\(^{15}\) A reduction in recommended floor area per animal will result in poor growth due to an increase in stress levels.\(^{16,17}\) Stress has detrimental effects on animal well-being and transplantation outcome. A chronic stress response can be induced by transportation from supplier to animal facility and repetitive, yet minor threatening approaches to the pig.\(^{18,19}\) The stressed animal tends to dehydrate, lose weight, and undergo immunological and metabolic changes.\(^{20,21}\) Reperfusion dynamics after graft implantation can be altered by these influences, underscoring the need for proper animal management.\(^{18}\) A pre-pathological state of the cardiovascular and exocrine system, gastrointestinal tract, and adrenal medulla can be evoked by the chronic stress syndrome, or synonymously, wasted pig syndrome.\(^{22}\) Changes like thymus atrophy and enlarged adrenal glands are correlated with the pre-pathological state.\(^{23}\) Cortisol levels however, are proven inaccurate as stress indicator in a porcine model. Stressed pigs showed decreased plasma cortisol levels and plasma cortisol binding capacity.\(^{22}\) While cortisol levels are typically indicative for the amount of stress, it is proposed that wasting
Feeding and fasting

Rapid, dietary adjustment-related sequela can induce a pro-inflammatory state in the gut of the pig. A calorie-adjusted diet from the pig-supplier can be provided to alleviate the effects on intestinal villi, organ weights, and cytokine expression. Due to high caloric demand of 8,410 kcal/day for a 50-kg pig, preoperative fasting should not evoke a physical response to starvation. A 6- to 8-hour fast of solid food is sufficient to empty the upper gastrointestinal tract owing to short intestinal transport times. In case a complete empty stomach and small intestine is desired, 12-hours fasting will suffice. Additionally, oro-esophageal gastric suction is an option. For emptying the spiral colon, a 28-hours fast whether combined with enemas or not, is advised. Application of enemas, however, requires animal training to avoid stress. Flavored sweet drinks, provided during fasting, help prevent hypoglycemia. Furthermore, water should never be withheld while drinking is linked to eating and vice-versa.

In summary, 50 kg female pigs are favorable for the autotransplantation model, minimizing androgenic influences and employing anatomically and functionally mature kidneys in a pre-pubertal state. The related age of 5 months provides a 1 to 2 months period on the lower- and higher-age range to prevent age-related influences. Acclimatization should encompass 5 to 7 days in housing that is stimulating natural behavior and is stress-free, whereas pre-operative fasting should be minimized and accompanied by sweet flavored drinks to prevent hypoglycemia.

Anesthesia

Anesthesia potentially has profound effects upon hemodynamics and the outcome of renal transplantation, underscoring the need for a uniform protocol. The currently applied anesthesia protocols in porcine studies decrease comparability through anesthesia-exerted effects upon transplantation outcome (Table 1). It is therefore imperative that a more uniform protocol is put in place to reduce animal
### Table 1. Anesthesia type, dose, and postoperative management in large animal models described in literature

<table>
<thead>
<tr>
<th>Premedication</th>
<th>Induction</th>
<th>Ventilation</th>
<th>Maintenance</th>
<th>Fluids</th>
</tr>
</thead>
<tbody>
<tr>
<td>IM: 0.5 mg atropine, 2 mg/ kg azaperone, 15 mg/ kg ketamine</td>
<td>IV: 10.5 mg/ kg eunarcon, 2-4 kg propofol</td>
<td>Orotracheal, volume-controlled</td>
<td>Continuous 220-230 mg/ h propofol, bolus 78.5 μg fentanyl intermittent</td>
<td>Isotonic saline 20-25 mL/ kg/ h</td>
</tr>
<tr>
<td>Nasal 0.2 mg/ kg midazolam</td>
<td>8 % sevoflurane</td>
<td></td>
<td></td>
<td>Unmentioned</td>
</tr>
<tr>
<td>IM: 5-6 mg/ kg stresnil</td>
<td>IV: 5-8 mg/ kg propofol, IM: 0.05 mg/ kg atropine, 0.01 mg/ kg buprenorphine</td>
<td>Endotracheal</td>
<td>1-5 % isoflurane, 2-4 L/ min O₂</td>
<td>Hartmann solution 50 mL/ kg/ 24 h up to 48 hrs PO</td>
</tr>
<tr>
<td>10 mg/ kg tiletamine, 7.5 mg/ kg zolazepam, 10 μg/ kg fentanyl</td>
<td>Unmentioned</td>
<td></td>
<td></td>
<td>Unmentioned</td>
</tr>
<tr>
<td>Unmentioned</td>
<td>Unmentioned</td>
<td></td>
<td></td>
<td>Unmentioned</td>
</tr>
<tr>
<td>IM: 10 mg/ kg ketamine, 2 mg/ kg midazolam, 0.15 mg/ kg pancuronium, 10 μg/ kg xylazine</td>
<td>IV: 0.3 mg/ kg atropine</td>
<td>Endotracheal</td>
<td>1-5 % isoflurane, 2-4 L/ min O₂</td>
<td>2 L 0.9 % NaCl PO first 24 hrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>20 % glucose, 0.9 % NaCl PO after day 1</td>
</tr>
<tr>
<td>Diuretics</td>
<td>Analgesia</td>
<td>PO(^1) antibiotics</td>
<td>Reference</td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
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<td></td>
</tr>
<tr>
<td>Use avoided</td>
<td>50 mg/ kg metamizol PO, 0.8 mg temgesic 3dd</td>
<td>Unmentioned</td>
<td>Zacherl(^{10})</td>
<td></td>
</tr>
<tr>
<td>Unmentioned</td>
<td>Unmentioned</td>
<td>Unmentioned</td>
<td>Baumert(^{69})</td>
<td></td>
</tr>
<tr>
<td>IV: 0.5 g/ kg</td>
<td>SC: 30 mL 0.5 % mannitol bupivacaine, IV: 5 μg/ kg buprenorphine 3-4 dd for up to 72 hrs</td>
<td>750 mg cefuroxime 2 dd up to 48 hrs</td>
<td>Nicholson(^{10})</td>
<td></td>
</tr>
<tr>
<td>Unmentioned</td>
<td>Unmentioned</td>
<td>Unmentioned</td>
<td>Badet(^{71})</td>
<td></td>
</tr>
<tr>
<td>IV: 40 mg furosemide after surgery</td>
<td>SC: 50 mg tramadol daily after surgery, 50 mg tramadol daily PO</td>
<td>500 mg ampicillin daily PO</td>
<td>Treckmann(^{72})</td>
<td></td>
</tr>
<tr>
<td>100 mL 50 % glucose after reperfusion</td>
<td>acetylsalicylic acid 1 g daily</td>
<td>IV: 500 mg ampicillin daily</td>
<td>Maathuis(^{73})</td>
<td></td>
</tr>
</tbody>
</table>
Table 1. Anesthesia type, dose, and postoperative management in large animal models described in literature

<table>
<thead>
<tr>
<th>Premedication</th>
<th>Induction</th>
<th>Ventilation</th>
<th>Maintenance</th>
<th>Fluids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unmentioned</td>
<td>2-5 % halothane, 8 L/ min O₂, IM: 0.6 mg atropine, IV: 10-20 mg diazepam</td>
<td>Intubation</td>
<td>0.5-1 % halothane, 2-4 L/ min NO, IV. 0.5-1 mg fentanyl, 10 mg/kg/h ketamine, thiopentone if necessary</td>
<td>1 L 4 % dextrose, 0.18 % saline, 0.5-1 L 10 % dextrose, PO day 1-2: 1-2 L 10 % dextrose, 0.18 % saline</td>
</tr>
<tr>
<td>IM: 2 mg/ kg xylazine, 8 mg/kg tiletamine/zolazepam</td>
<td>Unmentioned</td>
<td>Endotracheal</td>
<td>1 % isoflurane, 50 % O₂ and room air</td>
<td>40 mL/kg plasmalyte A (total) per-op, 20 mL/kg/day plasmalyte A until 36 hrs PO</td>
</tr>
<tr>
<td>Unmentioned</td>
<td>15 mg/kg ketamine, 0.02 mg/kg atropine</td>
<td>Mechanical ventilation, volume-controlled</td>
<td>2 % halothane, fentanyl, pancuronium bromide</td>
<td>Unmentioned</td>
</tr>
<tr>
<td>IM: 10-15 mg/ kg ketamine, 1-1.5 mg/kg dormicum, 0.25-0.5 mg/25 kg atropine</td>
<td>Mask: 2-4 % isoflurane, O₂ 2-3 L</td>
<td>Orotracheal, volume-controlled 10-15 mL/kg/min, O₂:air 1:3 (40-45 % O₂ arterial pO₂ 220 mmHg), 12-18 breathes per min, cutt-off pressure 20 mmHg</td>
<td>IV: 5-10 μg/kg/hr sufentanil, 10-15 mg/kg/hr ketamine, 1-2 mg/kg/hr dormicum, 0.1-0.15 mg/kg/hr pavulon; bolus 3-5 μg/kg sufentanil, 0.2-0.6 mg/kg dormicum, 0.04-0.06 mg/kg pavulon, 2-4 mg/kg ketamine, 80 μg/kg medetomidine</td>
<td>5-10 mL/kg/hr 0.9 % NaCl if needed. PO day 1, 2: 500 mL 5 % glucose and 500 mL 0.9 % NaCl</td>
</tr>
</tbody>
</table>
### Table 1 (continued).

<table>
<thead>
<tr>
<th>Diuretics</th>
<th>Analgesia</th>
<th>PO antibiotics</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5 g/ kg mannitol</td>
<td>IV &amp; IM: temgesic as required</td>
<td>IV: 40 mg gentamycin, 1 gr ampicillin per-op and PO day 1, ampicillin 1 g 2 dd PO day 2</td>
<td>La Manna²⁴</td>
</tr>
<tr>
<td>100 mL 20 % mannitol</td>
<td>8 μg/ kg/ h fentanyl per-op, IV: 0.3 mg/ kg/ 12 h buprenorphine until 60 hrs PO</td>
<td>2 g cefazoline per-op</td>
<td>Jochmans²⁵</td>
</tr>
<tr>
<td>Unmentioned</td>
<td>Unmentioned</td>
<td>Unmentioned</td>
<td>Lledo-Garcia²⁶</td>
</tr>
<tr>
<td>None</td>
<td>IM: 2 mL Finadyne PO, IV: 0.02-0.04 mg/ kg temgesic until 72 hrs PO 2 dd or prolonged when needed, aspecic 500 mg daily, lactulose 5 mL 2 dd</td>
<td>IV: 500 mg augmentin 2 dd</td>
<td>This article</td>
</tr>
</tbody>
</table>
Table 1. Anesthesia type, dose, and postoperative management in large animal models described in literature

<table>
<thead>
<tr>
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<th>Maintenance</th>
<th>Fluids</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC: 0.02 mg/ kg buprenorphine</td>
<td>3 mg/ kg pentothal</td>
<td>Intubation</td>
<td>0.5-2 % isoflurane in O₂</td>
<td>Unmentioned</td>
</tr>
<tr>
<td>Unmentioned IM: 2 mg/ kg ketamine, IV: 0.1 mg/kg pancuronium bromide, 25 mg/kg pentobarbital</td>
<td>Intubation, 20 mL/kg, 12 cycles/min</td>
<td>50 % O₂ &amp; NO, bolus pentobarbital and pancuronium bromide as needed</td>
<td>10 mL/kg Ringer’s lactate</td>
<td></td>
</tr>
<tr>
<td>Unmentioned 25 mg/kg thiopental</td>
<td>Positive-pressure, mechanical ventilation</td>
<td>2 % isoflurane, NO 2 L/min, O₂ 2 L/min</td>
<td>30-35 mL/kg/hr electrolytes per-op, 800 mL/day electrolytes until PO day 3</td>
<td></td>
</tr>
<tr>
<td>Unmentioned 5 mg/kg pentothal</td>
<td>Unmentioned</td>
<td>1 % isoflurane in 40 % O₂</td>
<td>Unmentioned</td>
<td></td>
</tr>
<tr>
<td>SC: 0.02 mg/ kg buprenorphine IV: 2 mg/kg ketamine, 0.2 mg/kg diazepam</td>
<td>Unmentioned</td>
<td>Isoflurane in 100 % O₂</td>
<td>Unmentioned</td>
<td></td>
</tr>
</tbody>
</table>

1PO: postoperative
2IM: intramuscular
3IV: intravenous
4NO: nitric oxide
5OR: operation
6SC: subcutaneous
7per-op: perioperative
Table 1 (continued).

<table>
<thead>
<tr>
<th>Diuretics</th>
<th>Analgesia</th>
<th>PO antibiotics</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV: 50 mg furosemide, 500 mg/ kg mannitol</td>
<td>epidural: 0.1 mg/ kg morphine</td>
<td>IV: 500 mg cefazolin per-op</td>
<td>Lin&lt;sup&gt;35&lt;/sup&gt;</td>
</tr>
<tr>
<td>Unmentioned</td>
<td>Unmentioned</td>
<td>50 mg/ kg cefazolin 1 dd until PO day 2</td>
<td>Inoue&lt;sup&gt;36&lt;/sup&gt;</td>
</tr>
<tr>
<td>IV: 1.25 gr mannitol, 10 mg furosemide</td>
<td>Unmentioned</td>
<td>1 g cefazolin per-op</td>
<td>Tahara&lt;sup&gt;37&lt;/sup&gt;</td>
</tr>
<tr>
<td>Unmentioned</td>
<td>Unmentioned</td>
<td>Unmentioned</td>
<td>Salomon&lt;sup&gt;38&lt;/sup&gt;</td>
</tr>
<tr>
<td>Unmentioned</td>
<td>epidural: 0.1 mg/ kg morphine</td>
<td>22 mg/ kg cefazolin per-op</td>
<td>Polyak&lt;sup&gt;39&lt;/sup&gt;</td>
</tr>
</tbody>
</table>
discomfort, facilitate animal handling, and minimize influential effects on hemodynamics, inflammation, and kidney graft.

**Premedication**

Premedication aims to relieve anxiety, stabilize autonomous reflexes, facilitate animal handling, and reduce the dose of general anesthetics needed during induction and maintenance of anesthesia, ideally without cardiovascular influences. Combinations of intramuscular (IM) or intravenous (IV) benzodiazepines with dissociative anesthetics (e.g. ketamine, tiletamine) or azaperone (butyrophenon derivative) combined with a dissociative agent provide cardiovascular stable premedication. IM atropine (as anticholinergic agent) is often added to blunt vagal airway reflexes as broncho-secretion and salivation to aid intubation. Undesirable in this experimental setting are alpha 2-agonists (e.g. xylazine, medetomidine) due to potent cardiovascular side effects and reduction in sympathetic tone. However, a low-dose of these drugs (40 μg/kg) in combination with low-dose midazolam (0.2 mg/kg) showed minimal side effects. Furthermore, alpha 1-agonists block norepinephrine-release at renal terminal nerve endings in rats, preventing acute ischemic renal failure. Consequently, low alpha 2-selectivity (i.e. xylazine with relatively low alpha 2/alpha 1-selectivity) exerts relatively high alpha 1-stimulation, potentially leading to ischemic renal effects.

**Induction**

Continuous IV-access throughout the surgical procedure is facilitated using an auricular IV-catheter or central venous catheter for sustainable access. Induction of general anesthesia can be achieved using inhalants or injectables, where halothane, as a volatile inhalation anesthetic, sensitizes the myocardium and induces anesthesia slowly due to a relatively high blood/gas partition coefficient. Furthermore, while being capable of relatively fast induction of anesthesia without sensitizing the myocardium, isoflurane and sevoflurane have shown to execute anti-inflammatory and anti-necrotic effects in vitro in proximal tubular cells. Injectable induction comprises hypnotics (e.g. thiopental and propofol), dissociatives (e.g. ketamine and tiletamine), and opioids (e.g. sufentanil). After adequate reduction of swallowing reflexes and jaw muscle tension, orotracheal intubation still is arduous because of typical anatomical characteristics of the porcine oropharynx. These comprise a long soft palate, pharyngeal diverticulum, angular, caudoventrally positioned, slit-like vocal cords, and sigmoidal laryngeal passage. Furthermore, high susceptibility for laryngospasms and hypoxia makes careful preoxygenation prior to
intubation crucial.  

Maintenance

Maintenance of anesthesia by inhalation and/ or IV anesthetics via the ear vein or central venous catheter potentially exerts side effects during prolonged exposure. Halothane, for instance, combines the aforementioned sensitization of the myocardium with possible induction of malignant hyperthermia. Low-flow technique sevoflurane anesthesia can cause renal toxicity by forming compound A (fluoromethyl-2,2-difluoro-1-(trifluoromethyl)vinyl ether) as degradation product by contact with carbon dioxide absorbents with a strong base. IV-protocols are applied using opioids, dissociative agents, or benzodiazepines and muscle relaxants (Table 2). Propofol has even greater anti-inflammatory and protective effects compared to sevoflurane. Ropivacaine, as epidural anesthetic, enhances the sensory block without compromising cardiovascular stability in isoflurane anesthetized pigs. While hemodynamic side effects can be circumvented by well designed anesthesia protocols, the depth of anesthesia should be carefully monitored and supported (e.g. fluid, inotropic, and vasopressor therapy) to safeguard a proper renal perfusion pressure of 40 to 60 mmHg.

Recovery

For smooth and rapid postoperative recovery, correction of core body temperature, acid-base disturbances, and replenishment of the animal’s energy stores is advised. Preferably, the correction is performed in combination with short-acting anesthetics or antagonizing agents. Furthermore, sedatives can prevent anxiety and stress in the acute postoperative phase for which purpose low dose selective alpha-2-agonists (e.g. medetomidine) can be used. At this stage of the procedure; a stress-free recovery outweighs the potential cardiovascular side effects of the sedative.

Recommendations

A robust protocol should be based on maintaining anesthetic depth, securing vital parameters, and animal comfort while minimizing influential effects and side effects. Based upon literature and our experience, the following protocol is suggested for graft retrieval or implantation.

The use of a mixture of ketamine, midazolam, and atropine IM in the neck as premedication followed by a brief administration of isoflurane to allow positioning of an auricular cannula and orotracheal tube, proved rapid and without side effects.
Table 2. Animal and preoperative specifications of large animal autotransplantation models

<table>
<thead>
<tr>
<th>Animal</th>
<th>Nr.</th>
<th>Breed</th>
<th>Gender</th>
<th>Weight</th>
<th>Accl.</th>
<th>Fasting</th>
<th>Survival</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pig</td>
<td>10</td>
<td>White LR(^1)</td>
<td>Male</td>
<td>25 (16-46)</td>
<td>UM(^2)</td>
<td>24 hrs</td>
<td>20 hrs</td>
<td>Zacherl(^3)</td>
</tr>
<tr>
<td>Pig</td>
<td>150</td>
<td>Large White US(^5)</td>
<td>Male</td>
<td>46-49</td>
<td>UM</td>
<td>14 days</td>
<td>Baumert(^4)</td>
<td></td>
</tr>
<tr>
<td>Pig</td>
<td>20</td>
<td>Large White</td>
<td>Female</td>
<td>35-70</td>
<td>UM</td>
<td>14 days</td>
<td>Nicholson(^5)</td>
<td></td>
</tr>
<tr>
<td>Pig</td>
<td>16</td>
<td>White US</td>
<td>Female</td>
<td>25</td>
<td>UM</td>
<td>7 days</td>
<td>UM</td>
<td>Badet(^6)</td>
</tr>
<tr>
<td>Pig</td>
<td>34</td>
<td>German LR</td>
<td>Female</td>
<td>27</td>
<td>UM</td>
<td>7 days</td>
<td>Treckman(^7)</td>
<td></td>
</tr>
<tr>
<td>Pig</td>
<td>15</td>
<td>German LR</td>
<td>Female</td>
<td>20-30</td>
<td>UM</td>
<td>7 days</td>
<td>Maathuis(^8)</td>
<td></td>
</tr>
<tr>
<td>Pig</td>
<td>12</td>
<td>Large White US</td>
<td>Female</td>
<td>24-51</td>
<td>UM</td>
<td>12 hrs</td>
<td>UM</td>
<td>10 days</td>
</tr>
<tr>
<td>Pig</td>
<td></td>
<td>Yorkshire LR</td>
<td>Female</td>
<td>48-52</td>
<td>UM</td>
<td>12 hrs</td>
<td>UM</td>
<td>8 days</td>
</tr>
<tr>
<td>Minipig</td>
<td>14</td>
<td>Laboratory US</td>
<td>Female</td>
<td>35-40</td>
<td>UM</td>
<td>7 days</td>
<td>UM</td>
<td>14 days</td>
</tr>
<tr>
<td>Dog</td>
<td>12</td>
<td>Mongrel Male</td>
<td>15-20</td>
<td>7 days</td>
<td>Overnight</td>
<td>14 days</td>
<td>Lin(^11)</td>
<td></td>
</tr>
<tr>
<td>Dog</td>
<td>14</td>
<td>Mongrel US</td>
<td>9-15</td>
<td>UM</td>
<td>UM</td>
<td>3 days</td>
<td>Inoue(^12)</td>
<td></td>
</tr>
<tr>
<td>Dog</td>
<td>20</td>
<td>Hybrid Female</td>
<td>11-13</td>
<td>UM</td>
<td>Overnight</td>
<td>14 days</td>
<td>Tahara(^13)</td>
<td></td>
</tr>
<tr>
<td>(am. Foxhound, Labrador, Beagle)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dog</td>
<td>18</td>
<td>Beagle US</td>
<td>3-4 Years</td>
<td>24 hrs</td>
<td>UM</td>
<td>3 days</td>
<td>Salomon(^14)</td>
<td></td>
</tr>
<tr>
<td>Dog</td>
<td>12</td>
<td>Mongrel US</td>
<td>15-22</td>
<td>7 days</td>
<td>Overnight</td>
<td>7 days</td>
<td>Polyak(^15)</td>
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\(^1\)Nr.: number of animals used in the study, \(^2\)Weight: in kilograms unless mentioned as age, \(^3\)Accl.: Acclimatisation period, \(^4\)LR.: landrace, \(^5\)UM.: unmentioned, \(^6\)US.: unspecified, \(^7\)Am.: American.

Maintenance of anesthesia with sufentanil, ketamine, midazolam, pancuronium, or analogs minimizes hemodynamic influences in the animal. Postoperative IM administration of medetomidine and local bupivacaine allows time for skin closure and a smooth recovery.

**Surgical considerations**

Autotransplantation entails unilateral graft retrieval, removal of the contralateral kidney, and subsequent graft implantation, potentially followed by survival. The experimental, surgical procedures for animals may differ from those used in the clinical settings for
humans. Clinical NHBD kidney retrieval mostly comprises a transperitoneal, multi-organ donation procedure and for living related donation a lumbar, hand-assisted laparoscopic approach. Kidney graft implantation in humans occurs mainly in the iliac fossa via an inguinal approach and retroperitoneal route, using the external iliac artery and vein for the vascular anastomoses. In the porcine model, the transperitoneal approach is used while the vascular anastomoses are constructed using the caval vein and native renal artery, respectively. The porcine susceptibility for intestinal complications requires an adapted surgical protocol regarding handling of the intestines and vascular anastomoses.

**Pre-nephrectomy**

At first, sustainable vascular access can be obtained via tunneling and exteriorizing a jugular catheter to the dorsum of the neck, allowing facile and relatively stress-free blood sampling during the survival period. Hereafter, exposure of the paralumbar region is easily performed via a midline laparotomy, circumventing bilateral lumbar incisions (for contralateral kidney collection, see ‘nephrectomy and graft implantation’) and thus reducing postoperative discomfort.

Pre-existent intussusceptions are common in pigs and therefore, abdominal inspection prior to nephrectomy is important. Intestinal manipulation (e.g. retraction using surgical gauzes) is to be performed with great care and exteriorization avoided in view of the increased susceptibility for intestinal edema and ischemia.\(^{21}\) Furthermore, intestinal post-operative fibrin deposits and adhesions can be avoided using a wetted fine cloth instead of gauzes.

**Nephrectomy and graft implantation**

Graft implantation in the iliac fossa is not advised in the pig because it hampers postoperative mobility of the animal. Implantation in the contralateral retroperitoneal area is preferred, avoiding unnecessary re-exploration of the previous nephrectomy site in the retroperitoneum. The left kidney provides a long renal vein and the possibility of dissection of the renal artery at the aortal origin (Figure 1). Access to the retroperitoneal area and renal vascular hilus using a cautery knife prevents excessive lymph leakage and postoperative accumulation while pigs show higher lymphatic flow compared to humans.\(^{41}\) Closing the retroperitoneum after nephrectomy with matrass sutures prevents lymphalocele formation and intestinal adhesions, and is therefore highly recommended.\(^{42}\)
Prior to graft implantation, careful peritoneal and intestinal inspection is advised to identify possible complications as intussusceptions. The contralateral retroperitoneum is opened and lifted at the vascular hilus of the kidney, in order to be able to create a pouch for stabilization of the graft with the ureteral catheter and to prevent intestinal adhesions when the peritoneum is closed over the graft. Contralateral (right) nephrectomy is subsequently performed similarly as the left nephrectomy, providing room for placement of the kidney graft in the peritoneal pouch.

Dissection of the right renal artery distally at the cranio-caudal bifurcation facilitates anastomosis to the graft renal artery. Flushing the arterial stump with heparin

Figure 1.
Schematic illustration of the nephrectomy and transplantation procedure with A) the normal situation, B) after left nephrectomy where *marks the careful opened retroperitoneum, C) after contralateral (right) nephrectomy with preservation of maximal arterial length, D) transplantation of the cranial to caudal flipped left kidney, E) close-up of the new vascular situation, and F) the final anatomical situation. See Appendix 1, page 202 for the color image.
solution prior to completing the anastomosis is imperative in view of the pigs’ markedly increased coagulative tendency in comparison to humans. Cranio-caudal reversal of the graft conveniently exposes the renal vein simplifying the vascular anastomoses. An end-to-side anastomosis of the graft renal vein to the caval vein is constructed using a running Prolene® 7-0 suture, and an end-to-end anastomosis is performed for the renal artery using a running Prolene® 7-0 suture.

An uretero-cutaneostomy is performed using a large (18-20 Fr) urinary catheter for urine collection to prevent twisting or blockage by protein deposits. The catheter is tunneled through the abdominal wall via a premarked point below the ribcage into the retroperitoneal pouch. It is important not to lift the ureter ventrally to prevent occlusion of the arterial and venous branches to the grafts dorsal pole.

Posttransplantation
Flushing and inspection of the abdominal cavity with warm saline prevents the aforementioned fibrin deposits and potential intestinal complications during the survival period. Closure of the abdominal wall is best performed with a running suture (PDS II® 1.0) to withstand pressure on the wound when the pig is standing. Freeing the skin from the underlying connective tissue to decrease wound tension (undermining) will increase postoperative pain significantly and should be discouraged. Post-operative urine collection during survival is possible (without a metabolic cage) using a “pig-jacket” (KARUNO, Figure 2), designed to hold a 4-L urinary bag. The jacket allows overnight urine collection without the risk of overfilling and pressure rise in the renal pelvis and calices.

Postoperative management and analgesia
Recovery from general anesthesia is usually highly stressful at which time the natural instinct of the animal is to flee. It is therefore advisable to transfer the pig to its individual housing when it is almost able to stand and to assist the animal in assuming an upright position to alleviate stress and prevent pulmonary complications (e.g. hyperventilation, stridor). When returned to the pen, water must be available for reasons addressed in section ‘Feeding and Fasting’. Postoperatively, the pig frequently demands intake stimulation for which sweet flavored treats can be offered. When intake falls short despite these stimulants, IV fluids or glucose are administered as additives up to the third or fourth postoperative day via the jugular catheter. The increase in intake and indication for glucose
IV can be based upon blood glucose levels. Taking the abovementioned considerations into account, the first three to four postoperative days can be characterized as an intensive care period. Postoperative analgesia in this period is of utmost importance to provide basal welfare conditions for the animal, at the same time creating optimal conditions for the assessment of kidney function in the early postoperative phase.

Figure 2.
The KARUNO pig jacket that enables 4-liter urine collection without the use of metabolic cages.

Non-steroidal anti-inflammatory drugs (NSAID) like flunixin, meloxicam, and ketoprofen have shown to be effective analgesics in the pig.\textsuperscript{51, 52} Whereas renal effects of meloxicam (selective COX 2-inhibition) and ketoprofen (nonselective COX 1- and 2-inhibition) in anesthetized normovolemic piglets have shown significant differences in urinary flow; selective COX 2-inhibition did not alter renal function when compared to a placebo group.\textsuperscript{53} Nonselective COX-inhibition led to significant decreases in glomerular filtration rate (GFR) and renal blood flow (RBF). Clinical evidence suggests that the risk of acute kidney injury may be lower using selective COX-2 inhibitors.\textsuperscript{54} If normotension cannot be adequately maintained, the risk of decreased GFR and RBF is increased.

Using systemic opioids as postoperative analgesia, like buprenorphine, has shown to be effective in pigs, although high dosages are necessary for adequate analgesic effects. Importantly, gastrointestinal side effects like constipation or ileus could interfere
during this period, especially as pigs appear to be very susceptible to gastrointestinal complications after abdominal surgery. Fortunately, laxatives as lactulose or movicol have a sweet taste and will therefore be readily consumed by pigs. Postoperative analgesia using epidural morphine has been described in pigs after abdominal surgery and potentially unlocks a new era of postoperative pain management in laboratory animals. Although a particularly interesting development would be the implementation of ‘depodur’ as a long-acting epidural formulation, avoiding the use of systemic opioids and their impact on intestinal motility. Tramadol has been reported to improve the quality of induction and improve duration of anti-nociception in ketamine-xylazine anesthesia in young pigs. However, as a major downside, this analgesic treatment cannot be complemented with opioids when desired. Due to this disadvantage and the possible renal side effects resulting from NSAID, we recommend using opioids in the post-operative phase. Finally, pigs should be mobilized and receive proper fluid management in combination with the aforementioned to prevent gastro-intestinal complications as obstipation.

**Recommendations for monitoring and maintaining porcine health**

Maintenance of a high quality of porcine health is indispensable throughout transplantation procedures to minimize variations in the transplantation results. The most important elements to secure the health condition of the pig are delineated in this paragraph.

Pigs are unaccustomed to restraining associated with the physical examinations as should be performed prior to each experiment. Therefore, visual inspection is relatively important to avoid physiological changes caused by the excitement of handling. If physical contact is necessary, the observations should be judged in relation to the amount of stress the pig is experiencing. As mentioned in the section ‘Housing & Stress’, chronic stress syndrome develops rapidly, and therefore, regular and at least preoperative inspections are performed taking account of attentiveness, posture, skin color, nutritional status, body condition, wounds, and other striking abnormalities such as diarrhea, coughing, sneezing, visible nasal discharge, or swollen joints. Impaired mobilization causes a problematic welfare assessment in the survival period. Vocalizations, interestingly, are an important indicator of health and should therefore be compared pre- and post-operatively. Furthermore, pigs should react promptly to noises and movements. Abnormalities and changes of these physical parameters should lead to exclusion from the experiment.

The respiratory rate of pigs of 50 kg ranges from 25 to 40 breaths per minute.
whereas heart rates vary from 75 to 110 (peak 140) beats per minute in a stable surrounding. Body temperature varies between 38.5 to 39.5 °C while temperatures above 41 °C should be lowered using wetted or alcohol soaked towels due to the pigs’ inability to sweat. Hypothermic pigs will bend their legs under their body and show pale skin with rough, raised hairs. Healthy pigs, in contrast, will lie comfortably in a sternal or lateral position with their legs stretched.

Proper acclimatization and minimizing the number of caretakers will facilitate postoperative handling as it needs to be emphasized that pigs are generally very susceptible to changes in their environment. Solitary pigs tend to refrain from eating and demand extra stimulation, underscoring the need to synchronize behavior with pen mates. Mobilization in the pen or, advisably, a larger area, will stimulate bowel movement and enhance wellbeing as experienced during our animal experiments. Sounds (e.g. radio, caretakers) help filter noises from outside and reduce stress, whereas thorough perioperative cleaning of pens increases stress due to loss of a familiar surrounding. Postoperative food and water intake should be strictly controlled as an aberrant pattern is considered an indicator of discomfort and stress.

In summary, close clinical observations, minimal changes in caretakers, sounds, smells, and stimulation of feeding and mobilization in the postoperative phase will minimize variations in outcome. This careful control of porcine health will greatly enhance the quality of the experiment and subsequent outcome.

Discussion

Although the kidney autotransplantation model is often deemed established, the way it is applied greatly influences the outcome of a transplantation study. A standardized use of type of animal, weight, sex, preoperative- and anesthetic protocols would not only be beneficial for the animals, but also improves comparability of studies among various research groups (Table 2).

Similarity between human and animal anatomy and physiology is the basis for devising a proper large animal model, along with other aspects such as the availability of pathogen-free (SPF) animals, low costs, and complexity of care and housing. Historically, large animal models comprise non-human-primates (NHP), dogs, mostly beagle or mongrel, and pigs. NHP seem closest to man, however, intranal renal anatomy differs between species in form and number of renal pyramids. Furthermore, NHP are expensive regardless of their SPF-status, and only a minimum of pathogens are excluded
in SPF-animals.\textsuperscript{64} In addition, NHP require specialized care and housing and, most importantly, institutes and individuals are often faced with societal condemnation and protest emanating from the use of NHP for research purposes.

Dogs feature a dissimilar anatomy in the arterial supply to the renal dorsal pole (comprising multiple supplying arteries) as compared to humans and display resilience to IR injury potentially resulting in misrepresentative extrapolations to the clinical setting.\textsuperscript{65, 66} Furthermore, to obtain comparable size and morphology of the renal pelvis and calices, dogs taller than 70 cm must be used.\textsuperscript{67} SPF-status animals are plenty, but costs remain sixfold that of pigs (personal communication, Harlan, The Netherlands; van Beek Topigs BV, Lelystad, The Netherlands). Knowledge of housing and care is widespread, but as with NHP, societal pressure contributes to the decline in the use of dogs.\textsuperscript{5}

In pigs, basic renal function is comparable to man, but distal bifurcation of the renal artery is in cranio-caudal direction instead of antero-dorsally in man, resulting in a different orientation of the kidneys’ avascular plane.\textsuperscript{12, 45, 46, 67, 68} Despite these differences, the susceptibility of pigs to ischemia reperfusion-induced organ damage is equal to that of man and societal resistance to the use of pigs for research is limited due to its large-scale agricultural use. This keeps costs low and availability high, creating an advantage of the porcine model above the NHP or canine model.

The impact of age, sex, surgical and anesthesiological techniques of which potential pharmaceutical interactions are most prominent, are challenging when using pigs. Underreporting of the details of the models used in literature is a major issue in interpretation of transplantation results (in 10 of 15 models; Table 2). Despite their side effects, isoflurane was applied in 7 and halothane in 3 of 13 models in which inhalant anesthesia was applied for maintenance of anesthesia. The use of diuretics after transplantation of the graft clouds renal function, but has been used in 6 models. Postoperative systemic morphine or its analogs requires the use of laxatives to prevent obstipation, but this was not mentioned in all models reported. This suggests that not only underreporting is an issue but also incorrect implementation of the model.

In conclusion, the female pig of 50 kg, or 5 months of age, is highly suitable for the kidney autotransplantation model. Using properly designed perioperative protocols, confounding effects on transplant outcome can be minimized. We have provided guidelines for perioperative care, anesthesia and surgical techniques proposing a more uniform use of the porcine kidney autotransplantation model. A standardized method will facilitate future planning of large animal studies in renal transplantation research and provides a basis to compare results of different research groups.
References


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