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Early Post-Operative Non-Occlusive Ischemic Colitis in a BK Virus Nephropathy Retransplant Patient: A Case Report

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Objectives : To report a rare and life-threatening early postoperative non-occlusive ischemic colitis (NOMI) in a kidney retransplant patient with BK Virus Nephropathy

Methods : A 58-year-old male who underwent a second kidney transplant following a rigorous desensitization regimen including Rituximab, plasmapheresis, and intravenous immunoglobulin (IVIG). Induction therapy consisted of rabbit anti-thymocyte globulin (rATG), with maintenance immunosuppression provided by Tacrolimus, Mycophenolate, and steroids. Initial postoperative recovery was unremarkable, with serum creatinine improving from 5.36 mg/dL to 1.73 mg/dL. However, on postoperative day 2, the clinical course was abruptly complicated by sudden intestinal obstruction. While initial endoscopy showed GERD and diffuse non-specific colitis, the patient rapidly deteriorated into septic shock with abdominal distention.

Results : Emergency exploratory laparotomy revealed generalized fecal peritonitis from cecal and proximal ascending colon perforations secondary to non-occlusive ischemic colitis (NOMI). Management required a right hemicolectomy, double-barrel ileostomy, and extensive peritoneal lavage. The postoperative course involved intensive care for *Klebsiella pneumoniae* sepsis, requiring mechanical ventilation and vasopressor support. Despite the severity of NOMI-induced perforation and septic shock, the patient responded to multidisciplinary intervention. He was eventually discharged in stable condition with preserved renal function—achieving a creatinine of 0.52 mg/dL—and did not require dialysis. At discharge, graft function remained stable on Tacrolimus 0.5 mg once daily and Prednisone 30 mg twice daily. Outpatient monitoring has since confirmed a stable creatinine trend.

Conclusions : This case underscores that the management of repeat transplants requires a delicate balance between aggressive immunosuppression to prevent rejection and the mitigation of catastrophic surgical and infectious complications. The rapid onset of NOMI suggests that the hemodynamic stress of transplant surgery, compounded by intensive desensitization, creates a narrow therapeutic window. Ultimately, successful outcomes depend on rapid surgical intervention, vigilant multidisciplinary critical care, and aggressive monitoring for viral recurrence to preserve graft longevity.