

**Struttura Complessa:** NEFROLOGIA

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To the Editor  
World Journal of Transplantation

**Manuscript Number:** 38578

Dear Editor,

Here we are submitting an updated version of our invited Observational Study “Renal transplants from older deceased donors: is pre-implantation biopsy useful? A monocentric observational clinical study”.

We thank you and Reviewers for comments; we have taken advantage of suggestions to make appropriate changes which we hope may have somehow improved the article.

We send you 2 copies of the updated article, one with visible corrections (deletions and, in red, additions) and the second one fully clean.

One general comment concerns the single editor’s suggestion we have seen by the Track Changes System, i.e. the request for Article Highlights at the end of the discussion: we think it adds great redundancy, considering that there already exist an abstract, a “core tip” paragraph, a “Conclusion” at the end of discussion, and an “Audio core tip”. Anyway, we have written it, feel free to maintain or delete it at your choice.

We have also added in the Title page the “open-access” statement, as indicated by the “Guidelines for Manuscript Revision”

Following are detailed responses (intercalated in red) to each of the Reviewers’ comments:

**1. Reviewer’s code:** 02844701

study limitations : Kidney Donor Profile Index (KDPI) and Kidney Donor Risk Index (KDRI) NOT used in allocation SKT vs DKT. Please add in brief about KDPI and KDRI utility for allocation of SKT vs DKT

We have added in Table 2 KDPI and KDRI data for donors in each category, we have indicated in the Results (pg. 10) correlations of these indices with histological score and donor characteristics, and we have made comments in the Discussion (pg. 13). Donor age was the strongest determinant of these indices, much more than renal function. Histological score did

not correlate with both of them (data detailed in the text). We have also compared outcome of SKT vs DKT within the group of donors with the highest ranges of KDPI (90 to 100) and KDRI (1.9 or higher): there were no significant differences. Since our focus was on biopsy predictive value, we did not add this data in the paper, and plan to do further work on this topic within a larger series of donors.

**Reviewer's code:** 00503199

only minor comment: Abstract, results:  $1.71 \pm 0.69$  and  $1.69 \pm 0.63$  mg/dL

Thank you for positive evaluation. The missing "and" has been added.

**2. Reviewer's code:** 00057859

The authors presented an interesting study on a highly debated field in kidney transplantation, the role of pre-transplant biopsy to evaluate the suitability of graft. The authors confirmed the limited role of biopsy in the evaluation of graft with normal function and /or anatomy. It could be of interest to know, if possible, how many grafts were discarded basing on histological analysis.

We are unable to answer this point, since most donors were from other Hospitals and the Regional Agency allotted to our Center only donors already considered suitable to transplant. We had data only of transplants which have been done. Moreover, the design of our study was not aimed at analyzing discard/acceptance rate by histological vs alternative criteria, but simply to compare outcome according to histological score of grafts and allocation modality.

Moreover, giving that the authors would restrict the criteria for DKT, they should suggest in which condition DKT should be preferred to SKT.

We have more directly commented on this point in the discussion (see pg. 13-14); just to sum up, DKT should rescue grafts unacceptable for SKT and not compete with SKT. We think that DKT should not be a choice for any donor with preserved renal function. Thus, our previous statement that "... donors with pre-existing marginal renal function and anatomy should be the main candidates to histological evaluation" has been further detailed with the concept that main aim of such evaluation should be to reducing discard, so that "... a level of at least up to 2 for any individual score should be allowed, summing up to a total of 8 as acceptable score for DKT" (pg. 14).

We hope that our article will be found suitable for publication in present form.

On behalf of all Authors, best regards

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