Functional MRI detects perfusion impairment in renal allografts with delayed graft function

Katja Hueper,1 Faikah Gueler,2 Jan Hinrich Bräsen,3 Marcel Gutberlet,1 Mi-Sun Jang,2 Frank Lehner,4 Nicolas Richter,4 Nils Hanke,2 Matti Peperhove,1 Petros Martirosian,5 Susanne Tewes,1 Van Dai Vo Chieu,1 Anika Großhennig,4 Hermann Haller,2 Frank Wacker,1 Wilfried Gwinner,2 and Dagmar Hartung1

1Institute for Diagnostic and Interventional Radiology, Hannover Medical School, Hannover, Germany; 2Department of Nephrology, Hannover Medical School, Hannover, Germany; 3Institute for Pathology, Hannover Medical School, Hannover, Germany; 4Department of General, Abdominal and Transplant Surgery, Hannover Medical School, Hannover, Germany; 5Section on Experimental Radiology, University of Tübingen, Tübingen, Germany; and 6Institute for Biostatistics, Hannover Medical School, Hannover, Germany

Submitted 18 February 2015; accepted in final form 28 April 2015

Hueper K, Gueler F, Bräsen JH, Gutberlet M, Jang M, Lehner F, Richter N, Hanke N, Peperhove M, Martirosian P, Tewes S, Vo Chieu VD, Großhennig A, Haller H, Wacker F, Gwinner W, Hartung D. Functional MRI detects perfusion impairment in renal allografts with delayed graft function. Am J Physiol Renal Physiol 308: F1444–F1451, 2015. First published April 29, 2015; doi:10.1152/ajprenal.00064.2015.—Delayed graft function (DGF) after kidney transplantation is not uncommon, and it is associated with long-term allograft impairment. Our aim was to compare renal perfusion changes measured with noninvasive functional MRI in patients early after kidney transplantation to renal function and allograft histology in biopsy samples. Forty-six patients underwent MRI 4–11 days after transplantation. Contrast-free MRI renal perfusion images were acquired using an arterial spin labeling technique. Renal function was assessed by estimated glomerular filtration rate (eGFR), and renal biopsies were performed when indicated within 5 days of MRI. Twenty-six of 46 patients had DGF. Of these, nine patients had acute rejection (including borderline), and eight had other changes (e.g., tubular injury or glomerulosclerosis). Renal perfusion was significantly lower in the DGF group compared with the group with good allograft function (231 ± 15 vs. 331 ± 15 ml·min⁻¹·100 g⁻¹, P < 0.001). Living donor allografts exhibited significantly higher perfusion values compared with deceased donor allografts (P < 0.001). Renal perfusion significantly correlated with eGFR (r = 0.64, P < 0.001), resistance index (r = −0.57, P < 0.001), and cold ischemia time (r = −0.48, P < 0.01). Furthermore, renal perfusion impairment early after transplantation predicted inferior renal outcome and graft loss. In conclusion, noninvasive functional MRI detects renal perfusion impairment early after kidney transplantation in patients with DGF.

MRI; renal perfusion; kidney transplantation; delayed graft function

Delayed graft function (DGF) is a significant diagnostic and clinical challenge in the early postoperative period after kidney transplantation. It occurs in 20–25% of patients in Europe and the United States after deceased donor transplantation and is defined as failure of an adequate serum creatinine (S-creatinine) decrease to occur or need for dialysis during the first week after transplantation (28, 29). In other countries where there are increased cold ischemia times, the DGF rate is as high as 70%. It has been shown previously that prolonged cold ischemia and increasing donor age contribute to DGF (5, 24). DGF is associated with an increased risk of acute allograft rejection, impaired long-term allograft function, and graft loss (24, 35). Therefore, early detection of DGF is urgently needed if we hope to initiate appropriate therapy and limit irreversible allograft damage.

Methods for evaluating renal allograft function have changed little in the last decade; we mainly rely on repetitive measurements of S-creatinine or cystatin C and renal ultrasound with measurement of the resistance index. Kidney biopsy is recommended in patients with DGF to identify the reason for graft dysfunction and to distinguish acute kidney injury (AKI) from rejection episodes to deliver antirejection treatment. Biopsies are invasive, however. They are stressful for the patient and associated with complications (e.g., bleeding, arteriovenous fistula, femoral vein thrombosis) in up to 10–15% of cases (9, 27). Furthermore, as only small tissue samples are obtained, biopsies may not always allow us to detect renal allograft pathology; i.e., there are sampling errors (31). The resistance index, which reflects intrarenal vascular resistance and compliance, is measured by Doppler ultrasound. It has been reported to be increased in patients with renal allograft dysfunction early after transplantation (4, 6) and to predict allograft survival (4, 15, 25), but results vary from operator to operator, and they are influenced by extrarenal factors such as age, atherosclerosis, and arterial stiffness (16, 23).

Arterial spin labeling (ASL) is a noninvasive functional MRI technique which allows renal perfusion to be quantified without administration of a contrast agent by using water protons of the arterial blood as an endogenous tracer (8, 20, 21). ASL perfusion values have been shown to correlate with single-photon emission-computed tomographic renal perfusion measurements (8), renal plasma flow measured by PAH clearance (26), and renal perfusion measured by dynamic contrast-enhanced MRI (34) in native kidneys.

Since renal perfusion impairment is a hallmark of the pathogenesis of DGF (24), ASL may be valuable for assessment of patients with allograft dysfunction in the early posttransplantation period. The purpose of this study was to compare renal perfusion changes in patients early after kidney transplantation detected by functional contrast-free MRI to renal function,
allograft histology in biopsy samples, and renal outcome 1 yr after transplantation.

MATERIALS AND METHODS

Patients. The prospective study was approved by the local institutional review board, and written informed consent was obtained from all participants. Between July 2012 and April 2014, 46 selected adult kidney transplant recipients were included in the study. Patient characteristics, medical histories, and transplantation details were recorded. The clinical follow-up period was 6 mo in all subjects recruited and 12 mo in 39/46 patients. One patient was lost to follow-up, and six patients have not yet reached the 12-mo follow-up point. DGF was defined as a failure of S-creatinine to decrease by at least 10% daily on 3 consecutive days or need for dialysis during the first week after transplantation.

MRI protocol and analysis. MRI was performed in patients 4–11 days after kidney transplantation using a 1.5-T magnet (MAGNETOM Avanto, Siemens Healthcare). T2-weighted turbo spin echo sequences were acquired in axial and coronal planes to assess renal morphology. For renal perfusion measurement, a flow-alternating inversion recovery (FAIR) true FISP ASL technique was used as described previously (18, 21). In brief, images were acquired in an oblique sagittal orientation to avoid covering the aorta or the pelvic arteries. Images were obtained after global and slice-selective inversion pulses using the following parameters: TR/TE = 4.6/2.3 ms, TI = 1,200 ms, flip angle = 70°, averages = 30, FOV = 340 × 340 mm², matrix = 128 × 128, slice thickness = 5 mm, and acquisition time = 4.5 min. In addition, a proton density true FISP image without inversion was acquired to determine the equilibrium magnetization. Motion artifacts were compensated by registration of individual MRI images, and parameter maps of renal perfusion were calculated with Matlab (version 7.11.0.584, MathWorks, Natick, MA) according to

\[ f = \frac{\lambda}{2T1} \frac{\Delta M(TI)}{M_0} \exp \left( \frac{T1}{T1} \right) \]

as described previously, where \( \Delta M \) is the signal difference between FAIR images with global and slice-selective inversion, \( M_0 \) is the equilibrium magnetization per unit mass, and \( \lambda \) is the blood-tissue water partition coefficient, which was set to 80 ml/100 g (18, 21). Three regions of interest were placed manually on perfusion maps into the renal cortex in the top, middle, and bottom third of the kidney by one author who was blinded to clinical, laboratory, and histological outcome data, and mean perfusion was calculated. Visible perfusion defects of renal parenchyma were identified and were excluded from the analysis. To evaluate intraobserver variability, a second reader, who was blinded to the results of the first reader and clinical data, analyzed renal perfusion in 20 randomly selected patients.

Clinical data. S-creatinine was determined daily during the first 3 days after kidney transplantation as well as 6 wk and 3, 6, and 12 mo thereafter. Glomerular filtration rate (eGFR) was calculated based on S-creatinine according to the MDRD formula (19). Urine output, blood pressure, and immunosuppressive medication including serum levels of calcineurin inhibitors (cyclosporine or tacrolimus) were determined on the day of MRI.

Doppler ultrasound. Ultrasound of the renal transplant was performed by a nephrologist or transplant surgeon within the first and second week after transplantation as described previously (25). The renal resistance index (RI) was measured in two or three proximal segmental arteries and was calculated from peak systolic velocity \( (V_{\text{max}}) \) and minimal diastolic velocity \( (V_{\text{min}}) \) according to the formula

\[ \text{RI} = 1 - \frac{V_{\text{min}}}{V_{\text{max}}} \]

The RI in the early postoperative period was available in 38/46 patients.
Renal function measured by eGFR 7 days after transplantation was positively correlated with renal perfusion measured by MRI (r = 0.57, P < 0.001, Fig. 2). Representative perfusion maps can be seen in Fig. 1. Living donor grafts exhibited higher perfusion values compared with deceased donor grafts (339 ± 19 vs. 243 ± 14 ml·min⁻¹·100 g⁻¹, P < 0.001), and renal perfusion significantly correlated with cold ischemia time (r = −0.48, P < 0.01). Furthermore, slightly lower perfusion values were observed in patients with acute renal allograft rejection at histology vs. patients with DGF but without signs of an acute allograft rejection (202 ± 35 vs. 246 ± 14 ml·min⁻¹·100 g⁻¹, not significant, P = 0.14, Fig. 1D).

Renal perfusion measured by MRI was positively correlated with eGFR on the day of MRI (r = 0.64, P < 0.001, Fig. 2A) and was negatively correlated with RI (r = −0.57 P < 0.001, Fig. 2B). In addition, renal perfusion significantly correlated with the number of dialysis sessions required in the first and second week after transplantation (r = −0.63, P < 0.001), with cold ischemia time (r = −0.48, P < 0.01, Fig. 2C), and recipient age (r = −0.42, P < 0.01). Serum levels of cyclosporine or tacrolimus, number of human leukocyte antigen mismatches, blood pressure, and recipient height and weight did not correlate significantly with renal perfusion.

The best diagnostic performance to detect patients with DGF was achieved by renal perfusion below a Youden-selected threshold of 278 ml·min⁻¹·100 g⁻¹ with a sensitivity and specificity of 81% (95% CI [61%;93%]) and 75% (95% CI [51%;91%]), respectively (Youden index at threshold 56%,

---

### Table 1. Patient characteristics, transplantation details, and clinical data

<table>
<thead>
<tr>
<th></th>
<th>Initial Graft Function (n = 20)</th>
<th>Delayed Graft Function (n = 26)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recipient data</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age, yr</td>
<td>48.8 ± 3.8</td>
<td>58.9 ± 2.1</td>
<td>P = 0.026</td>
</tr>
<tr>
<td>Sex female</td>
<td>9/20 (45.0%)</td>
<td>7/26 (26.9%)</td>
<td>ns, P = 0.23</td>
</tr>
<tr>
<td>Height, cm</td>
<td>172 ± 3</td>
<td>174 ± 2</td>
<td>ns, P = 0.51</td>
</tr>
<tr>
<td>Weight, kg</td>
<td>68.1 ± 3.4</td>
<td>83.7 ± 3.6</td>
<td>P = 0.003</td>
</tr>
<tr>
<td>Hypertension</td>
<td>19/20 (95.0%)</td>
<td>23/26 (88.5%)</td>
<td>ns, P = 0.62</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>1/20 (5.0%)</td>
<td>5/26 (19.2%)</td>
<td>ns, P = 0.21</td>
</tr>
<tr>
<td>Coronary artery disease</td>
<td>2/20 (10.0%)</td>
<td>10/26 (38.5%)</td>
<td>P = 0.043</td>
</tr>
<tr>
<td>Peripheral artery occlusive disease</td>
<td>0/20 (0%)</td>
<td>6/26 (23.1%)</td>
<td>P = 0.029</td>
</tr>
<tr>
<td><strong>Donor data</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age, yr</td>
<td>55.5 ± 2.9</td>
<td>60.2 ± 2.8</td>
<td>P = 0.25</td>
</tr>
<tr>
<td>Sex female</td>
<td>14/20 (70.0%)</td>
<td>12/24 (50.0%)</td>
<td>ns, P = 0.23</td>
</tr>
<tr>
<td>Height, cm</td>
<td>171 ± 1</td>
<td>173 ± 2</td>
<td>ns, P = 0.29</td>
</tr>
<tr>
<td>Weight, kg</td>
<td>83.0 ± 4.7</td>
<td>80.1 ± 3.2</td>
<td>ns, P = 0.60</td>
</tr>
<tr>
<td>S-creatinine, μmol/l</td>
<td>67.7 ± 4.9</td>
<td>116.0 ± 19.8</td>
<td>P = 0.025</td>
</tr>
<tr>
<td>Living donors</td>
<td>9/20 (45%)</td>
<td>6/26 (23.1%)</td>
<td>ns, P = 0.20</td>
</tr>
<tr>
<td><strong>Transplantation details</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HLA mismatches, no. of antigens</td>
<td>2.6 ± 0.5</td>
<td>2.9 ± 0.3</td>
<td>ns, P = 0.65</td>
</tr>
<tr>
<td>Cold ischemia time deceased donor transplantation, h</td>
<td>12.2 ± 1.1</td>
<td>13.3 ± 1.1</td>
<td>ns, P = 0.55</td>
</tr>
<tr>
<td>Cold ischemia time living donor transplantation, h</td>
<td>2.6 ± 0.2</td>
<td>2.4 ± 0.1</td>
<td>ns, P = 0.45</td>
</tr>
<tr>
<td>Immunosuppressive regime with cyclosporin</td>
<td>8/20 (40.0%)</td>
<td>15/26 (57.7%)</td>
<td>ns, P = 0.37</td>
</tr>
<tr>
<td>Cyclosporin A level, μg/l</td>
<td>125 ± 8</td>
<td>129 ± 10</td>
<td>ns, P = 0.77</td>
</tr>
<tr>
<td>Immunosuppressive regime with tacrolimus</td>
<td>12/20 (60%)</td>
<td>11/26 (42.3%)</td>
<td>ns, P = 0.37</td>
</tr>
<tr>
<td>Tacrolimus level, μg/l</td>
<td>8.9 ± 0.6</td>
<td>10.4 ± 1.7</td>
<td>ns, P = 0.43</td>
</tr>
<tr>
<td><strong>Clinical data posttransplantation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systolic blood pressure, mmHg</td>
<td>143 ± 6</td>
<td>141 ± 5</td>
<td>ns, P = 0.71</td>
</tr>
<tr>
<td>Diastolic blood pressure, mmHg</td>
<td>81 ± 3</td>
<td>78 ± 2</td>
<td>ns, P = 0.45</td>
</tr>
<tr>
<td>Urine output, ml/24 h</td>
<td>3,330 ± 314</td>
<td>2,288 ± 248</td>
<td>P = 0.011</td>
</tr>
<tr>
<td>Hemodialysis</td>
<td>0/20 (0%)</td>
<td>16/26 (61.5%)</td>
<td>P &lt; 0.001</td>
</tr>
<tr>
<td>No. of hemodialysis sessions per patient</td>
<td>0</td>
<td>1.62 ± 0.4</td>
<td>P &lt; 0.001</td>
</tr>
<tr>
<td>Graft loss</td>
<td>0/20 (0%)</td>
<td>3/26 (11.5%)</td>
<td>ns, P = 0.25</td>
</tr>
</tbody>
</table>

Values are means ± SE. HLA, human leukocyte antigen. Levels of immunosuppressive drugs, blood pressure, and urine output represent values on the day of MRI. The number of hemodialysis sessions is given for the first and second weeks. Resistance index was measured 1–2 wk after transplantation.
The sensitivity of renal perfusion measurement to identify patients who required more than two hemodialysis sessions was 100% (95% CI [54%; 100%]), and the specificity was 80% (95% CI [64%; 91%]) at a threshold of 236 ml·min⁻¹·100 g⁻¹ (Fig. 2).

Renal perfusion and renal outcome after 1 yr. After 12 mo, DGF patients were reevaluated and divided into two groups based on their renal function measured by eGFR: one group improved over time and reached eGFR ≥30 ml/min; the other group continued to have impaired renal function 12 mo after transplantation with eGFR <30 ml/min (Fig. 3A). In addition, three patients did not reach the 12-mo time point due to allograft nephrectomy because of severe thrombotic microangiopathy (TMA) and mycotic allograft nephritis 9 days and 6 wk after transplantation, respectively. One patient with transplant glomerulosclerosis, severe tubular atrophy, and graft fibrosis died before the scheduled nephrectomy due to cerebral infarction followed by sepsis 5 mo after transplantation.

Note that DGF patients with better renal function after 12 mo (eGFR ≥30 ml/min) had significantly higher renal perfusion early after transplantation (259 ± 16 ml·min⁻¹·100 g⁻¹) than DGF patients with persistent severe impairment of renal function eGFR <30 ml/min or graft loss (163 ± 22 ml·min⁻¹·100 g⁻¹, P < 0.01, Fig. 3B). Renal allograft perfusion impairment below 186 ml·min⁻¹·100 g⁻¹ in DGF patients predicted graft loss or severe impairment of renal function (eGFR <30 ml/min) 1 yr after transplantation, with a sensitivity of 75% (95% CI [35%; 97%]) and a specificity of 92% (95% CI [62%; 100%]) (Fig. 3C).

For comparison, renal fibrosis quantified by the sirius red-positive tubulointerstitial area in indicated biopsy specimens early after transplantation was highest in patients with graft loss or persistent severe reduction of eGFR <30 ml/min after 1 yr compared with patients without DGF or better renal function (28.1 ± 3.4 vs. 10.3 ± 6 vs. 20.3 ± 2.9%, not significant, Fig. 4).
DISCUSSION

We noninvasively quantified renal allograft perfusion using functional MRI early after kidney transplantation and demonstrated that renal perfusion is significantly impaired in patients with DGF compared with patients with adequate initial graft function. Renal perfusion significantly correlated with renal function, RI, and cold ischemia time, and was predictive of DGF and the need for dialysis early after transplantation. In addition, renal allograft perfusion impairment early after transplantation was less severe in DGF patients with better outcome (eGFR ≥30 ml/min) than in DGF patients with persistent severe impairment of renal function (eGFR <30 ml/min) or graft loss 1 yr after transplantation.

Currently, kidney allograft imaging and follow-up of renal function impairment is mainly done by Doppler ultrasound with measurement of the RI. RI measurement is easy and inexpensive to perform and can be done repetitively without stressing the patient. However, recently the value of RI for assessment of renal allograft pathology has been questioned (23). In a longitudinal follow-up study of 321 renal allograft recipients who had repetitive Doppler ultrasound investigations along with protocol biopsies at 3, 12, and 24 mo after kidney transplantation, an elevated RI was not associated with allograft histology and the need for dialysis. The strongest determinant for elevated RI in these transplanted patients was the recipient’s age. The authors concluded that the RI, which is strongly dependent on aortic pulse pressure and aortic stiffness, is related to recipient hemodynamics rather than allograft pathology (23). Nonetheless, discriminating different reasons for initial nonfunction or DGF is still a major challenge in kidney transplantation, and further effort is needed to develop more advanced noninvasive imaging techniques.

In the last several years, functional MRI techniques in addition to ASL such as blood oxygen level dependency (BOLD) imaging or diffusion-weighted imaging have been identified as promising noninvasive techniques to evaluate renal allograft function and pathology (2, 11, 17, 18, 32). Nonetheless, the functional MRI techniques and in particular perfusion imaging by ASL, are not routinely available and not yet accepted as standard imaging tests for examination of renal allograft pathology. Therefore, studies with clearly defined patient populations and a detailed comparison of MRI parameters with clinical data and the standard diagnostic tests such as creatinine/eGFR, ultrasound, and renal biopsy are of importance to establish noninvasive functional MRI as a routine technique for evaluation of graft perfusion and to identify groups of patients, who will benefit from the new diagnostic imaging technique. In this study, we evaluate renal perfusion changes by ASL for the first time in a clearly defined group of patients in the first and second week after kidney transplantation compared with the presence of DGF, renal function, renal histology after indicated biopsies, and outcome at 12 mo. This is of great clinical importance as DGF has a high prevalence and portends a high risk for complications such as acute rejection, impaired long-term allograft function, and graft loss (10).

Consistent with current literature, DGF patients in this study had typical risk factors to develop DGF such as a higher percentage of deceased donor kidney grafts, higher donor S-creatinine levels, a higher percentage of coronary artery and
peripheral artery occlusive diseases of the recipient, and higher recipient body weight (24, 28). Renal perfusion was significantly reduced in DGF patients, well correlated with renal function, and early perfusion impairment predicted the development of DGF and the need for dialysis early after transplantation. As there is an overlap of the perfusion values between patients with and without DGF, in an individual patient it is not possible to predict the presence of DGF by perfusion measurement. Nonetheless, renal perfusion measurement may help to risk stratify the patients and to evaluate the cause of renal dysfunction early after transplantation. In addition, renal perfusion negatively correlated with the RI. The RI measured serially in the early period after kidney transplantation has been shown to be a valuable, noninvasive, widely available, and

![Graph A](image)

![Graph B](image)

![Graph C](image)

Fig. 3. Renal outcome until 1 yr after transplantation compared with renal allograft perfusion early after transplantation. A: courses of eGFR (MDRD formula) in patients with initial allograft function (●) as well as in the subgroups of DGF patients with better renal function with eGFR ≥30 ml/min 1 yr after transplantation (∆) and with persistent severe impairment of renal function with eGFR (<30 ml/min) or graft loss (○) are depicted. Significant differences between the subgroups of DGF patients are shown. B: differences of renal perfusion early after transplantation in the 3 groups are depicted. C: ROC curve analysis demonstrates the predictive value of early renal perfusion measurement for renal outcome 1 yr after transplantation. AUC and sensitivities and specificities at the Youden selected threshold are given. Significant differences are indicated after adjustment for multiple comparisons with the Sidak method: *P < 0.05. **P < 0.01. ***P < 0.001.

![Image](image)

Fig. 4. Renal allograft fibrosis. Sirius red stains to visualize collagen fibers are shown in representative biopsy specimens for the group with initial graft function, DGF with better (eGFR ≥30 ml/min), and with inferior outcome (eGFR <30 ml/min) 1 yr after transplantation. In addition, mean sirius red-positive tubulointerstitial area after exclusion of large vessels and glomeruli in the groups is shown. In the DGF group with inferior outcome, collagen expression was higher than in the groups with initial graft function and the group of DGF patients with better outcome.
cost-effective marker for determining renal graft function; an increased RI early after transplantation is associated with impaired renal function and inferior renal outcome (1, 4, 15). However, the RI is strongly user dependent with high interobserver variation and is limited due to patient-related factors such as tachycardia, tachypnea, recipient arteriosclerosis, and arteriovenous fistulas due to prior renal biopsies. Furthermore, RI is measured in the segmental arteries and direct quantification of renal perfusion in the tissue on a regional basis, as it is performed with functional MRI, is not possible. Thus, in difficult situations such as in patients with an unclear impairment of graft function, in specific pathologies such as thrombotic microangiopathy or in the case of inconclusive ultrasound and biopsy results (e.g., sampling error), renal perfusion measurement may be advantageous in elucidating renal pathology. By MRI, focal perfusion defects can be visualized and distinguished from general impairment of renal perfusion. Furthermore, in patients with a high risk of bleeding complications due to anticoagulant therapy, functional MRI may characterize graft pathology and facilitate therapy decisions while reducing the need for renal biopsies. Allografts from living donors exhibited significantly better renal perfusion than those from deceased donors in the early postoperative phase. These findings are compatible with the fact that DGF is closely related to ischemia-reperfusion injury of the transplant, which is characterized by inflammation, tissue edema, and renal perfusion impairment (3). As cold ischemia time was substantially shorter for living vs. deceased donor allografts, presumably less ischemia-reperfusion injury occurred, thus contributing to better graft perfusion in this group. Consequently, an inverse correlation between cold ischemia time and renal perfusion was observed. The close relationship of renal perfusion impairment to ischemia time has previously been demonstrated in a mouse model of ischemia-reperfusion injury (14). Consistent with our results, Heusch et al. (12) recently found significantly lower renal perfusion by functional MRI in patients with severely reduced renal allograft function (eGFR ≤30 ml/min) than in patients with eGFR >30 ml/min. These authors also found that there was a close correlation between renal perfusion and eGFR in patients with variable time intervals between MRI and kidney transplantation (3 days to 11 yr) (12). Eisenberger et al. (7) examined 15 renal allograft recipients 5–19 days after transplantation by diffusion-weighted imaging. They demonstrated significantly reduced perfusion fraction of diffusion in patients with allograft dysfunction and a significant correlation of the perfusion fraction with eGFR. As the perfusion fraction of diffusion has been shown to be closely related with renal perfusion measured by ASL (13), their results are consistent with our findings in allografts early after transplantation.

When renal perfusion between the subgroups of DGF patients with and without rejection were compared, we observed a trend toward lower perfusion values in patients with an acute rejection (including borderline changes), but this was not statistically significant. Perhaps this was due to the limited number of patients with acute rejection, and the fact that mostly mild changes were observed at a very early time point after kidney transplantation. This may be associated with only a small additional decrease in renal perfusion compared with patients with DGF alone. Renal perfusion in both DGF groups, with and without acute rejection, was significantly lower than in grafts that were initially functional. Using a rat model of renal transplant rejection, Wang et al. (33) found strongly reduced kidney perfusion in animals with acute rejection compared with animals that had isogenic transplants and had grafts that were initially functional. However, in animal studies severe rejection was induced with dense inflammatory infiltrates. Consequently, the animals cannot be compared with humans whose early signs of rejection include limited leukocyte infiltration.

One patient in our study had biopsy-proven TMA, which was characterized by strong impairment of renal perfusion (87 ml-min⁻¹·100 g⁻¹). This finding is of particular interest because TMA is a severe complication after kidney transplantation (22), which is often difficult to diagnose even with renal allograft biopsies. Thus ASL might be helpful in identifying patients with TMA and estimating the severity of renal perfusion impairment. This hypothesis needs further investigation.

In DGF patients with persistent severe impairment of renal function (eGFR <30 ml/min) or graft loss 1 yr posttransplantation, early perfusion impairment was significantly stronger than in DGF patients with better renal outcome (eGFR ≥30 ml/min) after 1 yr. Furthermore, reduced renal perfusion (<186 ml-min⁻¹·100 g⁻¹) predicted inferior renal outcome with a sensitivity of 75% and a specificity of 92% in the group of DGF patients, thus showing the predictive value of MRI perfusion measurement in the early posttransplantation period. Of note, allograft histology revealed a higher degree of renal fibrosis early after transplantation in allografts with an inferior outcome.

Our study has limitations. First, the number of patients is relatively small and the follow-up period may be too short to give detailed insights into the prognostic value of early renal perfusion measurement by ASL. Second, MRI results could only be correlated with histological findings in 19 patients with impaired renal function, since not all patients required biopsies. Third, reliable quantification of renal perfusion was possible in the renal cortex, but not in the renal medulla as the signal-to-noise ratio was not sufficient to measure perfusion changes in the medulla, where the perfusion is substantially lower compared with the cortex. Improvement of ASL to allow quantification of small perfusion changes in the medulla is desirable and of clinical importance, as pathophysiological effects of renal ischemia-reperfusion injury are most pronounced in this renal compartment.

In conclusion, renal perfusion measured by functional MRI is reduced in patients with DGF, correlates well with renal function, and is predictive of renal allograft function 1 yr after transplantation. Thus noninvasive perfusion quantitation with functional MRI may help us detect renal damage in selected transplant recipients soon after their surgeries.

ACKNOWLEDGMENTS

We thank Michael J. Brownstein for help in editing the manuscript.

GRANTS

This work was supported by the German Federal Ministry of Education and Research, IFB Tx Hannover Medical School (reference no. 01EO0802).

DISCLOSURES

K. Hueper reports grants from Deutsche Forschungsgemeinschaft (DFG), Rebirth-Cluster of Excellence and research collaboration with Siemens Health-
care, outside the submitted work. F. Gueler reports grants from Federal Ministry of Education and Research (BMBF) and DFG, outside the submitted work. M. Gutberlet reports grants from Rebirth-Cluster of Excellence, German Center for Lung Research (DZL), and research collaboration with Siemens Healthcare, outside the submitted work. F. Wacker reports grants from BMBF, DZL, Promedicus, Ltd., DFG, Rebirth-Cluster of Excellence, and Siemens Healthcare, outside the submitted work. D. Hartung reports grants from Rebirth-Cluster of Excellence, outside the submitted work.

AUTHOR CONTRIBUTIONS


REFERENCES