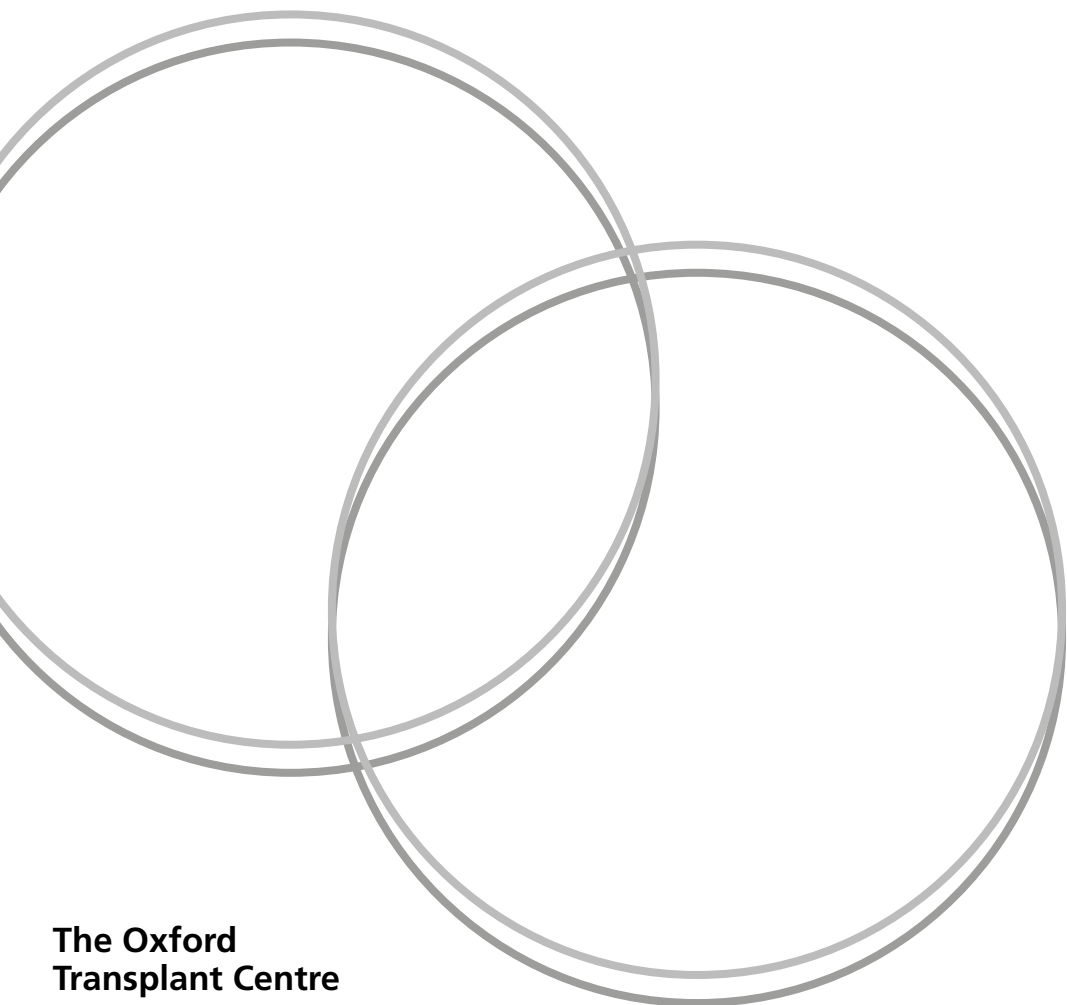




Oxford University Hospitals  
NHS Foundation Trust

# Your Islet Transplant

Information for patients



The Oxford  
Transplant Centre

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## **Introduction**

This booklet is intended to give you information about Islet Cell Transplantation. You'll also be given information by the Transplant Team and the Transplant Nurse Specialists during your clinic appointments.

The Oxford Transplant Centre and Nuffield Department of Surgery have a long and internationally recognised history of islet transplant research and have performed the largest number of Islet Transplants in the UK to date.

## **What do the Islet cells do?**

Islet cells are found in the pancreas. The pancreas is in the abdomen (tummy), behind the stomach. A donated pancreas is processed to release the Islet cells. There is more information on this in the section 'What happens when I am called in?' in this booklet.

Islet cells are endocrine cells. These sorts of cells make hormones. Hormones are chemicals that enter the bloodstream and do a particular job. The most well-known of the hormones made by the pancreas are insulin and glucagon.

When you digest food and drink, carbohydrate is broken down into glucose (a type of sugar). This passes into your blood and with the help of insulin, it is used to feed the cells of the body. If there is not enough insulin, or even none at all, the cells of the body cannot be fed and start to die. This results in damage to a lot of bodily systems.

Glucagon helps to increase blood glucose levels if they are too low.

The Islet cells make up just 2% of the pancreas and send insulin and glucagon into the blood stream to stabilise glucose levels in the blood.

In people with Type 1 diabetes, the cells which produce insulin are destroyed by the body's immune system, meaning the body can no longer make insulin for itself. There is also evidence that the cells making glucagon also do not work as well as for people without diabetes.

# Where do transplants come from?

## **Cadaveric donor pancreas for Islet transplants**

'Cadaveric donor transplant' or 'deceased donor transplant', is used to describe a transplant organ that has come from someone who has died. For islet transplant, this organ is the pancreas.

There are two types of deceased donor: Deceased after Brain Death (DBD) and Deceased after Circulatory Death (DCD).

Permission (consent) for organ donation is always asked from the donor's relatives, even if the donor's wishes about organ donation were already known.

## **Deceased after Brain Death (DBD) donors**

DBD donors are patients who have suffered permanent and irreversible brain injury. They are classed as "brain stem dead". Special clinical tests are done to confirm that there is no brain activity.

Once these tests have been done, and brain stem death has been confirmed, a DBD donor is legally declared dead.

Such donors can be kept on a life support machine right up to the point when organs can be removed for transplantation. The donor will be taken to the operating theatre and their pancreas and other organs for donation can be removed while their heart is still beating.

## **Deceased after Circulatory Death (DCD) donors**

DCD donors are patients whose organs are removed soon after cardiac arrest, when their heart has stopped beating. These patients have usually had a brain injury but are not brain stem dead. They would not survive off, so a decision has been made to withdraw life-support treatment.

The donor is taken to the operating theatre and taken off life-support. The donor usually dies a short time later from cardiac arrest. As soon as this has happened, the organs for donation are removed before they start to deteriorate.

The most recent survey of UK data by NHSBT (National Health Service Blood and Transplant) suggests that success rates for DCD donor transplants are very similar to those for DBD donor transplants.

### **High risk donors**

Occasionally organs are used from donors with a history of intravenous drug abuse (injecting drugs), high risk activity for sexual disease, or certain cancers.

There are guidelines from the Advisory Committee on the Safety of Blood, Tissues and Organs (SABTO) for the use of organs from such donors. These organs are usually from young donors and work very well.

There have been very rare reports of infection or cancer being present in a donor organ which was not diagnosed before transplant and was passed on to the recipient.

All types of donor organs can transmit infections, including human immunodeficiency virus (HIV), hepatitis B, hepatitis C, hepatitis E or malaria.

All donors are screened for these diseases and their medical history is reviewed to reduce the risk of disease is being passed over. If we consider a donor to be a higher risk than normal (for example a known history of infection or cancer) we will discuss this with you before your transplant to help you decide if you wish to proceed.

## Who can have a transplant?

Islet Cell Transplantation is a treatment option for people with type 1 diabetes who are having serious problems with hypoglycaemia (low blood glucose). It is used in a small number of people where using diabetes technology (insulin pumps and/or Continuous Glucose Monitoring) has not helped to resolve these problems.

Over time, if blood glucose readings are regularly low, people can lose the ability to recognise the warning signs of hypoglycaemia (hypo or low blood glucose).

As a result, their blood glucose levels can drop to dangerously low levels without any warning, which can be life-threatening. This is called hypo unawareness.

A successful transplant can help you to get back an awareness of hypoglycaemia (and lose the fear of hypoglycaemia).

The aim of islet transplantation is fewer severe hypo episodes, fewer severe hypo episodes while able to maintain a lower average blood glucose (HbA1c), and better quality of life.

The aim of an islet cell transplant is **NOT** to remove the need for insulin injections completely.

However, if this happens, it is a big bonus. In some cases, people have freedom from insulin injections for up to 1 year and very occasionally for more than 5 years. Most will need to continue with injected insulin.

### **Islet transplant may be suitable for:**

- Those over 18 years old.
- Those who have had type 1 diabetes for over 5 years
- Those who have an undetectably low C-peptide is a marker of the body's ability to make insulin.
- Those who have had frequent episodes of hypo over at least 1 year, with at least 2 episodes of severe hypo (e.g. coma, seizure or needing help from someone else) in the last year.
- Those with no kidney problems.
- Those with normal liver function tests.

## **When islet transplant may not be suitable**

An islet transplant is not currently an option for the following groups of people:

- Those whose hypos can be resolved by providing appropriate support including the use of diabetes technologies.
- Those with severe heart disease: when the risks of transplantation would outweigh the benefit.
- Those with a recent history of cancer.
- Those who need very large doses of insulin for their body weight.
- Any woman planning a pregnancy in the immediate future.



## Assessment

At your first appointment, you will have a thorough medical assessment with a transplant consultant, diabetes consultant and Transplant Nurse Specialist.

During the visit you will have blood tests and an assessment of your diabetes.

You will be asked to make an appointment with your dentist if you have not seen them recently.

After your transplant you will take anti-rejection medications which can change the body's ability to fight infections. So, it is very important to have good dental hygiene to avoid dental infections and other problems with your teeth or gums.

If you are not currently registered with a dentist, you can call NHS 111 for advice on finding a NHS dentist in your area.

If you are a woman, we will need you to be up to date with appropriate general health screening. This includes mammography (breast screening) every 3 years for woman over the age of 50 and cervical smear tests every 3 to 5 years between the ages of 24 and 64. These should be arranged through your GP.

After you have discussed the transplant with the consultants, if you still want to be considered for an islet transplant you will need to have some screening tests to make sure you have no other conditions that would make a transplant unsuitable.

### **These tests may include:**

- Liver ultrasound – to check for liver anatomy.
- Chest X-ray.
- ECG (electrocardiogram) – this can often be done at your GP surgery. It is a basic tracing of your heart and only takes a few minutes.
- MPS (myocardial perfusion scan) – this is done in a hospital. This measures the amount of blood in your heart muscle at rest and during exercise to make sure that all areas of your heart have a good blood supply.

# Getting onto the waiting list

## How do I get onto the waiting list?

Your test results are taken to a monthly meeting of surgeons, islet specialists, diabetologists and Transplant Nurse Specialists and your case is discussed thoroughly.

If it is agreed that you are suitable, you will be put onto the national transplant waiting list.

The Transplant Nurse Specialists will contact you after this meeting and let you know the result.

Sometimes some patients are felt to be not suitable to receive a transplant. In this case, your care would be referred back to your original diabetologist. The reason for the decision will be fully explained to you.

## How long will I be on the waiting list?

Once you are on the waiting list, there is an average waiting time of around a year.

The choice of who is called in for transplant is based on several details, including how long they have been on the waiting list.

The process of matching a recipient to a suitable donor is carried out through a national allocation scheme.

Oxford will receive offers of potential pancreas donors for you from the central NHSBT (National Health Service Blood and Transplantation) Hub. This is the organisation that oversees all transplantation in the UK.

Not all offers are suitable, and many are declined by the transplant team if they do not meet important conditions. If this happens, you remain on the waiting list for a better match. We will not inform you of every declined offer.

## **What happens while I am on the waiting list?**

Your local diabetes specialist will continue to look after you. If there is any significant change in your medical condition, the transplant unit will need to be told.

Big changes in your health could mean you are suspended temporarily from the waiting list until the transplant team is sure you are fit enough for the transplant.

You **must** also tell the Transplant Nurse Specialists of any changes to your contact details or any dates that you are not available for transplant e.g. holidays or planned hospital admissions.

If the transplant coordinator cannot get hold of you by telephone on the day, you could miss out on a transplant.

If you are unable to attend for a transplant due to being away or being unwell, you will be suspended temporarily from the waiting list until you are home again or better.

While you are on the waiting list, you must send monthly blood samples to our Tissue Typing Department. This is to make sure we have an up to date record of antibodies in your blood. This is important for matching you with a suitable donor.

These can be taken at routine diabetes appointments or at your GP surgery. Tissue Typing will send you the blood bottles and the packaging to send the samples back in, but you will need to pay for the postage.

If we do not have an up-to-date sample available in the laboratory, this may prevent or delay a transplant if you are called in.

## **What happens when I am called in?**

A lot will have happened before you are called in. The quality of the donor pancreas will have already been decided upon by a consultant doctor and has been accepted and processed to obtain the islets.

### **Processing the donor pancreas**

Once the pancreas is taken out of the donor, it is sent to a specialist laboratory. The islet cells are carefully removed using special enzymes that digest away the rest of the pancreas. After the islet cells have been removed and checked, they are put into a culture medium and allowed to rest. They are re-checked a second time to make sure that they are stable and useable. Finally, they are put into an infusion, like a fluid drip bag, and this liquid is what will be dripped into you.

You will only be called in when the islet team are happy that enough islets of good quality have been isolated from a donor pancreas.

### **Receiving the call**

You will receive a call from a transplant coordinator. This person is not necessarily a Transplant Nurse Specialist, but is responsible for contacting a recipient to bring them in.

The transplant coordinator will ask you about your general health and check for recent infections. If you have an active infection, we would be unable to transplant you because of the effect of anti-rejection medication on the immune system.

The transplant coordinator will give you advice about eating and drinking before transplant, as you will need to stop a few hours before the procedure. You will be asked to come to the Transplant Ward at the Churchill Hospital in Oxford.

It is important that you arrive as soon as possible and by your own transport if you can. We can provide transport to bring you in, but if the transplant does not go ahead, we will not be able to provide transport home again.

The transplant coordinator will have a very limited time in which to contact you, so it is vital that you are always contactable and that you have given us your current telephone number.

There may be times when we call you in, but the transplant cannot go ahead. This can be because we have received new information about your donor, or there are fewer islets than we thought. We understand that this can be emotionally difficult, and we will do our best to keep you informed.

## **What happens on the ward?**

When you arrive on the ward a nurse will show you to your bed. They will ask some questions about your general health and diabetes. A doctor will examine you to make sure you are in good health for the transplant, and you will have blood samples taken.

A small cannula (a line) will be put into a vein in your hand or arm and an insulin infusion with a sugar solution drip will be started to make sure that your blood glucose levels are well controlled.

When you arrive at the hospital, you may have an extra blood test for a 'cross match'. This is to double-check your compatibility with the donor. The test needs to be negative so the transplant can go ahead. If it is positive, it means that you are not compatible with the donor this time round. It does not mean you will never have a transplant, but it means we need to wait for a better match.

While you are waiting for the final tests to be ready, the ward staff will do an ECG (tracing of the electrical activity of the heart) and you will be asked to sign a consent form for the transplant.

If there is anything that you do not understand or would like further information about, please ask before signing the consent form.

### **Consent**

It is very important that we have your consent before we start surgery. We cannot go ahead without it. We need to make sure that you understand what is being done and the risks involved. The doctor will go over this with you.

Please ask any questions you have at any time. The Transplant Nurse Specialists can help you feel ready and confident on the subject.

Please see page 24 for more specific potential risks of Islet transplantation.

## **What happens during the transplant operation?**

The islet cell transplant is a sterile procedure that takes place in the radiology (X-ray) department at the Churchill Hospital, because it is guided by X-rays. It involves draining the bag of islets into a large vein.

You will be given pain relief medication during the procedure, and a medication is available to help you relax if you need it.

To prepare for the transplant you will be given a local anaesthetic injection to numb a small area of skin on the upper right-hand side of your abdomen. A radiologist will use ultrasound and X-rays to find the large portal vein in the liver.

Using a needle, the radiologist will put a small tube through your skin and into the portal vein. The position of this tube is checked with X-rays. The bag of islet cells is attached to this tube and are slowly infused into the big vein into the liver. It may take up to 30 minutes. Once the islets have been infused, the tube is removed, and the small puncture wound is covered.

## **Where will I be cared for after my transplant?**

You will be taken to the Transplant Ward once the transplant is complete. You may have some discomfort after the transplant, but you will be given pain relieving medications.

After the transplant, your blood glucose levels are carefully controlled, and you will stay on the insulin infusion that was started before the transplant. This is because the islet cells need to have a chance to settle into their new environment and it is important not to stress them with high blood glucose levels. Your blood glucose levels will be checked with regular finger prick tests.

Because the transplant is done by injecting into a large blood vessel and there is a risk of bleeding, your pulse and blood pressure will be checked often and the puncture site will be checked for any signs of bleeding or inflammation.

You will also have blood tests and an ultrasound scan of your liver during the 24 hours after transplant.

## **How long will I stay in hospital?**

How long you need to stay in hospital will depend on your progress after the transplant. The usual length of stay is about 2 to 3 days.

You will spend time learning about your new medications and how to take care of yourself when you are discharged home.

You will go home on your normal insulin. Sometimes your insulin doses may be adjusted.



## What medications do I need to take?

Your immune system protects your body from attack by bacteria and viruses. It will see the new islet cells as invaders and will try to destroy them; this is called rejection. To protect your transplanted islets from rejection by your immune system, you will need to take powerful medications called immunosuppressant or anti-rejection medication.

Although these medications protect your new islet cells from rejection, they can also reduce your ability to fight some infections.

This means that you will also need to take other medications (transplant co-medications) that will protect you from infections you could be more vulnerable to.

The dose of the immunosuppressant medication will be reduced over time, but you will need to take these medicines for as long as your transplant is functioning. If you were to stop taking the immunosuppressant medications, your new islet cells would be rejected by your body and stop working.

The most common immunosuppressant medications used for islet cell transplantation are Tacrolimus (Adoport) and Mycophenolate. These medications will be adjusted according to your specific needs.

On clinic days, it is very important that you **DO NOT** take your morning dose of Tacrolimus until you have had blood tests in clinic.

This is because one of the clinic blood tests is to check the amount of Tacrolimus in your blood. This blood test result helps the doctors decide what dose you need to be on.

During the transplant, we also use medications called Induction Agents. Usually with an islet cell transplant you will have an Induction Agent called alemtuzumab (Campath). Induction Agents are very strong and provide extra help to stop your body from rejecting the transplanted cells in the first few months.

As with all medications, there are some side-effects. However, it is important to remember that you may not experience all or any of these.

**Do not** stop taking your anti-rejection medications if you have side effects. Please speak to a member of the transplant team if you are having problems, as there may be an easy solution.

Common side-effects of Tacrolimus and Mycophenolate are listed below.

More detailed information about immunosuppressants and transplant co-medications can be found in the 'Caring for your transplant' booklet, which is available from the Transplant Nurse Practitioners you will see in clinic after transplant. Their contact details are in the 'Useful Contacts' section of this booklet.

### **Tacrolimus (Adoport)**

- hair loss
- headaches
- shaky hands
- upset stomach (usually when first taking this medicine) and loose stools
- sleep disturbances
- increase in blood pressure
- mood changes
- an increase in blood sugar.

### **Mycophenolate**

- the most common side-effect is a drop in white blood cell count. This puts you at risk of infection. We will monitor your blood count and adjust your medication if needed
- upset stomach including diarrhoea, nausea and vomiting
- a rash.

## **Self-medication training**

On the Transplant ward after the transplant, you will begin to learn about your new medications. These will be printed on a medication record card. The pharmacist will see you to go through them and explain what they do and how to take them.

You will be closely supervised by the ward nurses as you start to take your medications.

Once you are confident with taking your new medications, and the nursing staff are happy that you are taking them correctly, you will be able to take your medications on your own, like you will at home.

This training is to help you become familiar and confident with taking all your new medications before you go home.

## **Long-term immunosuppression medication**

Taking immunosuppressant medication can put you at a higher risk of developing some forms of cancer, such as lymphoma (cancer of the lymph nodes/glands) and skin cancer.

Most cancers are likely to be treatable if found in early, but sadly some can be fatal. You will be monitored closely after your transplant, and most cancers (if they develop) can be detected at an early and potentially treatable stage.

Approximately 8 out of every 100 islet cell transplant patients are likely to develop skin cancer. Almost all these cancers will be treatable and are unlikely to be fatal.

The risk of skin cancer can be reduced by having regular skin examinations, by using sun block cream (at least factor 50) and covering up under bright sunlight.

It is a good idea to examine your skin each month and let your medical team know about any changes, suspicious new moles, rashes, strange growths, warts, etc.

More information can be found in the 'Caring for your transplant' booklet, which is available from the Transplant Nurse Practitioners you will see in clinic after transplant. Their contact details are in the 'Useful Contacts' section of this booklet.

## What happens when I am discharged from hospital?

Once you have been discharged from the hospital you will still be monitored closely, by attending regular outpatient clinics, where you will see a diabetology consultant and a Transplant Nurse Practitioner.

We recommend that you buy a blood pressure monitor, thermometer and weighing scales before you are called in for transplant, as you will need these after you are discharged, so that you can monitor your own health at home. Unfortunately, these are not supplied on the NHS.

You will need close monitoring of your glucose using a continuous glucose monitor (CGM), as you will need to check it more often to begin with after the transplant.

You will need to check:

- 7 times a day for first month.
- After the first month, 4 times a day until 3 months post-transplant.
- After 3 months, as clinically indicated – your consultant will guide you on this.

### **Clinics:**

Clinics are held in the Oxford Centre for Diabetes and Endocrinology (OCDEM). This is on the same site as the Churchill Hospital.

Patients from the Birmingham area can choose to have their clinics moved to the University Hospitals Birmingham NHS Trust, if this is more convenient.

- You will be seen every week in the first month after transplant.
- All being well, clinics are reduced to monthly until the end of the first year.
- Once one year is reached, clinics are every 4 to 6 months, depending on clinical condition.

All of this depends on how well you are doing.

In clinic, your health and blood glucose control will be examined. You will have the chance to discuss any worries or problems you may have, and blood tests will be taken, including a Tacrolimus level test.

Remember! **DO NOT** take your morning dose of Tacrolimus before clinic blood tests. Bring your medications with you to take after the blood tests.

At 6 months and then each year after transplant, islet function is checked with a **Meal Tolerance Test (MTT)**.

- This takes about 90 minutes and will take place during a clinic appointment. You will need to be nil by mouth from midnight the night before.
- You are allowed to have water.
- Continue to take any basal (background) insulin (either by pump or pen injection), but do not take any fast-acting insulin.
- Blood glucose level must be 8mmol/L or lower for a MTT to take place.
- You will be given a glucose and protein supplement to drink, and then blood samples are taken after 90 minutes.

## Fertility and pregnancy

You can have sex after transplant once you feel comfortable to do so.

Fertility often improves after transplantation, so it is important to use reliable contraception after transplant. We would recommend using 2 methods together, e.g. condoms, oral tablets, implant or depot contraception.

We recommend waiting one or two years before trying for a baby and that you discuss this with the transplant team first, as your anti-rejection medications may need to be changed.

Mycophenolate and valganciclovir must **NOT** be taken during pregnancy. They are both toxic to the baby and cause deformities.

## Infections

Because immunosuppressant medication lowers your immune system, you will be at greater risk of infections. Infections can also be more serious and possibly last longer than before the immunosuppressant medication.

You are the most vulnerable for the first three to six months after your transplant.

Chicken pox may cause a serious illness while you are on immunosuppression medication. Before we add you to the transplant list, we will check your immunity to chicken pox. If you are not immune, we will ask your GP to vaccinate you.

Even if you do have immunity, you will still need to avoid close contact with anyone who has chicken pox or shingles.

More information on infections can be found in the 'Caring for your transplant' booklet, which is available from the Transplant Nurse Practitioners you will see in clinic after transplant. Their contact details are in the 'Useful Contacts' section of this booklet.

# What are the risks of islet cell transplantation?

All medical procedures, including transplant, have the potential for problems to happen during the procedure and afterwards. The most common problems are listed below:

- **Bleeding.** You will be given a medication called heparin to thin your blood. This is given to prevent a clot developing in the portal vein. The heparin is given with the islets and also later on the Transplant Ward as a drip or by subcutaneous injections (small injections just under the skin). Bleeding inside the abdomen, and sometimes from the skin where the islet infusion tube was put in, is rare. Bleeding or bruising is usually minor and stops without treatment. However, if it becomes more serious you may need an operation to stop it.
- **Thrombosis.** This is when clots form in your blood stream. This can be serious as it can stop blood flow in a blood vessel, which can lead to strokes, difficulty breathing or heart attacks.
- **Pain**
- **Infection.** Most infections can be treated and the risk of dying due to infection is probably less than 2 in every 100 people on immunosuppressant medication over 6 years.
- **Damage to liver or gall bladder**
- **Side effects of immunosuppression.**  
See 'What medications do I need to take?'
- **Rejection.** This means your new islets stop producing insulin and blood glucose levels are less controlled. This can happen at any time after transplant. It is expected that 7 out of 10 people will still have some clinical benefit from their transplant after 5 years.

## **Transplant statistics:**

Data collected by the National Health Service Blood and Transplant service (NHSBT) between 1st April 2016 and 31st March 2020 showed an 81% survival rate of the islets transplant after a year. From data collected between 2011 and 2020, it showed a 55% survival rate for islet transplants after 5 years.

In the data collected between 1st April 2016 to 31st March 2020, the average recorded HbA1c in islet transplant recipients dropped from 64mmol/mol before transplant to 48mmol/mol at 1 year post-transplant.

There is also data on insulin use from the NHSBT figures. The average dose of insulin before transplant was 0.42 units/kg. At 6 months post-transplant the average dose dropped to 0.21 units/kg and then increased slightly at 1 year post-transplant with an average dose of 0.26 units/kg.

## **Repeat transplantation**

A second transplant is usually required to “top up” the number of transplanted islets to improve blood glucose control.

If this is needed, you are placed on a priority waiting list.

## **What happens if I feel unwell at home?**

### **Transplant Nurse Practitioners:**

These nurses take care of you after transplant.

These nurses can be contacted Monday to Friday, 8am to 4pm  
Telephone: 01865 228 662

If you have a problem outside of these hours, you can speak to a qualified nurse on the **Transplant Ward:**

Telephone: 01865 235 010 or 01865 235 011



# Important points to remember

## Change of circumstances

When you are listed on the transplant waiting list, please tell the Transplant Nurse Specialist immediately of any change in your circumstances such as holidays, change of address, telephone number, or if you are admitted to any hospital:

Telephone: 01865 228 658 or 01865 228 657

Email: [ouh-tr.oxfordpancreastransplant@nhs.net](mailto:ouh-tr.oxfordpancreastransplant@nhs.net)

## Monthly blood samples of antibody screening

Once you are on the transplant list it is vital that you have monthly blood samples so that we have up to date information about your antibody levels.

You will be informed when you are active on the transplant waiting list and Tissue Typing will send you a pack with blood bottles for you to fill. You can do this at your GP practice or diabetes unit.

The blood bottles will need to be sent in the padded envelopes provided, and by first class post to the hospital.

Please send blood samples on a Monday, Tuesday, or Wednesday.

If the blood samples are sent any later in the week they will not reach us in time and will be too old to test.

## If you change your mind

If you decide a transplant is not for you, please let the Transplant Nurse Specialists know immediately so we can take you off the waiting list.

## Transport arrangements for your transplant

If you are called in for a transplant, it is important that you have a plan in place to get to the Churchill Hospital as soon as possible. This could be at any time of the day or night.

If you need transport into the hospital, we can provide this. However, if the transplant does not go ahead, we **cannot** provide transport home and you will need to organise this.

If you think you might have problems arranging transport, please discuss this with us.

# Useful contact telephone numbers and addresses

## **The Oxford Transplant Centre**

Churchill Hospital  
Old Road, Headington  
Oxford OX3 7LE  
Telephone: 01865 225 355

## **Churchill Hospital switchboard**

Telephone: 00300 304 7777

## **Transplant Nurse Specialists (pre-transplant queries)**

Telephone: 01865 228 658 or 01865 228 657  
Email: [oxfordpancreastransplant@ouh.nhs.uk](mailto:oxfordpancreastransplant@ouh.nhs.uk)

## **Transplant Nurse Practitioners (post-transplant queries)**

Telephone: 01865 228 662  
Email: [posttransplantnurses@ouh.nhs.uk](mailto:posttransplantnurses@ouh.nhs.uk)

# Useful links

## **NHSBT patient information site**

[www.nhsbt.nhs.uk/organ-transplantation](http://www.nhsbt.nhs.uk/organ-transplantation)

## **Useful website on many aspects of diabetes:**

[www.diabetes.org.uk](http://www.diabetes.org.uk)

## **A charity that organises sports and social events for transplant recipients:**

[www.transplantsport.org.uk](http://www.transplantsport.org.uk)

## **This website has some great advice to get you moving again, even straight after a transplant:**

[www.wtgf.org/refitforlife/welcome](http://www.wtgf.org/refitforlife/welcome)

## **Skin cancer websites**

### **British Association of Dermatologists:**

[www.bad.org.uk](http://www.bad.org.uk)

### **Cancer Research UK sun care information:**

[www.cancerresearchuk.org/about-cancer/causes-of-cancer/sun-uv-and-cancer](http://www.cancerresearchuk.org/about-cancer/causes-of-cancer/sun-uv-and-cancer)

### **Skin Care in Organ Transplant Patients:**

[www.scopenetwork.net](http://www.scopenetwork.net)

## **Wider Information**

### **Legal advice**

Debt, unemployment and housing advice for people on low incomes and benefits. Free and confidential advice paid by legal aid.

Telephone: 03453 454 345

[www.gov.uk/civil-legal-advice](http://www.gov.uk/civil-legal-advice)

### **Information on finding a local NHS dentist or contact NHS Direct on 111:**

[www.nhs.uk/nhs-services](http://www.nhs.uk/nhs-services)

### **More general information on transplantation:**

[www.organdonation.nhs.uk](http://www.organdonation.nhs.uk)

## Further information

If you would like an interpreter, please speak to the department where you are being seen.

Please also tell them if you would like this information in another format, such as:

- Easy Read
- large print
- braille
- audio
- electronic
- another language.

We have tried to make the information in this leaflet meet your needs. If it does not meet your individual needs or situation, please speak to your healthcare team. They are happy to help.

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