

# Psychosocial Burdens of a Renal Transplant Recipient with COVID-19

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## Abstract

The impact of COVID-19 on transplant recipients is yet to be fully understood. Apart from the physical implications, little has been discussed regarding the psychosocial burden it exerts on the already chronically ill patients. Here, we discuss a case of a 40-year-old male who received kidney transplantation 2 years ago and has tested positive for COVID-19. At the time of admission, he presented with mild symptoms and subsequently developed fever for which he had been managed conservatively. However, a comprehensive approach addressing psychosocial, emotional, and spiritual domains from a palliative care physician's perspective is often overlooked, whether in times of COVID-19 or not and this report aims to identify and assess such gaps.

**Keywords:** Burden, COVID-19, palliative, psychosocial, transplant

## INTRODUCTION

Transplant recipients and their families have experienced years of suffering physically and mentally, from the initial days through the disease progression, then the anticipation itself that hangs regarding the success or failure of the surgery and dealing with complications thereafter, not to mention the financial burden. Quarantine measures in this outbreak have extensive negative consequences for mental health.<sup>[1]</sup> Approaches to attenuate the psychosocial impact should be an integral component of crisis response during pandemic conditions.<sup>[1]</sup>

## CASE REPORT

The case under discussion is a 40-year-old male, who underwent living-related renal transplantation 2 years ago (mother–donor) with a dialysis vintage of 8 months due to long-standing hypertension which progressed to end-stage renal disease. His native kidney disease was unclassified and he had received antithymocyte globulin induction and was on maintenance immunosuppression of tacrolimus, mycophenolate mofetil, and prednisolone. There were no immediate postoperative complications and he attained a

baseline serum creatinine of 1.2–1.3 mg/dL. Currently, he is on maintenance immunosuppressive therapy with oral tacrolimus, azathioprine, and prednisolone in addition to his antihypertensive medications. The patient tested positive on May 5, 2020, and was referred to our quarantine facility the following day. At the time of admission, he was afebrile with a history of occasional cough; therefore, symptomatic treatment was instituted. On May 10, 2020, he developed fever recorded at 102°F. On examination, vitals were within normal limits, no graft tenderness, dysuria, oliguria, or hematuria. Follow-up investigations revealed mild rise in serum creatinine along with a slight decrease in the leukocyte and platelet counts. Chest X-ray was within normal limits. Due to episodically continuing fever, lack of critical care monitoring services in our quarantine facility, and anticipation of clinical deterioration in such a high risk patient, he was transferred to another center where he was

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reviewed by the nephrology team and immunosuppression was modified. As of today (May 20, 2020), the patient is clinically stable, his fever has responded, graft function has improved to the baseline, and the blood counts have recovered.

Our task at hand was to lend an ear in order to provide any assistance that could improve his general well-being and quality of life. The issues were discussed mostly through telecommunication during his stay with us and thereafter.

### Anxiety, fear, depression, and sleep

The patient was anxious for multiple and justified reasons, one of them being discontentment of the treatment received at our quarantine facility. He felt he required and deserved more attention from the team, given his relevant history. Moreover, the results of his blood tests had not been disclosed to him initially. He feared his kidneys were failing and this led him into a depression-like state. Eventually, his sleep was disturbed as well due to the constant worry which only worsened with time.

### Routine disruption

His regular follow-up with his treating physician could not be continued which worried him tremendously; however, after proper counseling and consultation with our nephrologist, he was reassured. There is also disruption of his daily physical activities and is significant considering his paramilitary background.

### Social support and isolation

Our patient is an only child of one living parent, and as it is customary practice in most parts of the country, his mother (70 years old) resides with his family. She leads in matters of household-, economic-, and health-related issues and is also one of his caretakers along with his wife. His immediate family comprises his wife and three sons who are all dependent on him. His family lives in the neighboring state while he based himself in the camp; therefore, the longing to see and spend time with them had already been established prior to his social isolation. He seeks comfort and solace for his loneliness by staying in constant touch with his family through phone calls and videoconferences and occasional meditation. He enjoys the support of his family and peers.

### Emotional, financial, and spiritual burden

During the few conversations we had, we could gather he is emotionally stable. He did not share any financial burdens with us. His belief and attitude toward the next life, as he is a practicing Hindu, shed some light on his spiritual concerns, where he hopes not to be a victim again of such illnesses and also wished he could freely perform his daily devotions and prayers without any hindrance.

The cumulative consequence of all these factors over several years and more substantively to be diagnosed with COVID-19, only added to his preexisting pain.

## DISCUSSION

Renal transplantation is proven to be the best treatment modality in chronic kidney diseases; however, the incidences of acute and chronic graft rejections are still reported.<sup>[2,3]</sup>

Little is studied about symptom prevalence in transplant recipients. Apart from evidence-based maintenance immunosuppression, patients require a holistic management of other physical and psychosocial symptoms.<sup>[2]</sup>

Palliative care needs to be integrated in the routine care to achieve better health outcomes, greater patient satisfaction, and improvement in the quality of life, by participation in shared decision-making and care plan prioritized by the patient and family preferences.<sup>[4,5]</sup>

In patients with high morbidity and symptom burden, communicating and prognosticating about goals of care and conservative options would be beneficial early on. Advanced care planning and future goal of care must be culturally appropriate and should start early in the course of disease. The decision to withhold dialysis against continuing it and to initiate conservative management in poor outcome patients can be made early according to the patient's preference.<sup>[6]</sup>

Transplantation and COVID-19 together cause significant psychological and social issues. Institutions must make a protocol in prioritizing posttransplant patients for their management during COVID-19 and, thus, provide holistic care of their symptoms and good psychosocial intervention facilities to these patients.

### Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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### Conflicts of interest

There are no conflicts of interest.

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