

Appendix 3: A brief summary of some of the main features of Rejection post liver transplant

| Previous terminology | Preferred terminology | Principle histological features | Diagnostic methods | Management |
|----------------------------|--|--|---|--|
| (Acute) cellular rejection | T-cell mediated rejection (TCMR) Early defined as <6 months Late defined as > 6 months | Portal inflammation Bile duct inflammation damage Venous endothelial inflammation Centrilobular inflammation and necrosis (in severe cases) | Liver function tests Liver biopsy | High doses of pulsed steroids Consider MMF if not already on the drug Increase target drug levels for CNI therapy |
| (Acute)humoral rejection | (Acute) antibody mediated rejection (AMR) | Microvasculitis Portal eosinophilia Portal vein endothelial hypertrophy Eosinophilic venulitis | Liver function tests Immunology Liver biopsy All four criteria required for definite diagnosis: 1. Compatible histology 2. Positive serum DSA 3. Diffuse (>50%) C4d staining 4. Exclusion of other possible causes | Treat as TCMR rejection in mild forms Moderate to severe – consider plasmapheresis and IVIg with or without anti B-cell therapy. |
| Chronic rejection | Chronic rejection | Bile duct loss Loss of arterioles in portal tracts. Obliterative arteriopathy in large and medium-sized arteries. Cholestasis in late stages. | Liver function tests Liver biopsy | Consider MMF if not already on the drug Increase target drug levels for CNI therapy. Consider anti B cell therapy in cases of “acute ductopenic rejection” |