Introduction and aim of the work

Renal transplantation represents one of the striking developments in medicine during the last century. Over the past 30 years it has passed from an experimental and largely unsuccessful procedure to the treatment of choice in most patients with end stage renal failure. The modern and continuing period of kidney transplantation (kid. Tx) began in the late 1950s. However, two earlier periods of interest in the clinical and experimental transplantation can be detected; one surprisingly in the first decade of of the last century and the other in the early 1950s ***(Morris, 1998)***.

Chronic liver disease is a frequent complication affecting about 15 % of the renal allograft recipients ***(Rao and Anderson, 1992).*** Infection with hepatitis B and C viruses is the predominant cause of hepatic dysfunction. Earlier studies have documented that renal transplant patients with chronic viral hepatitis have a significant increase in mortality from hepatic failure and concomitant sepsis ***(Rao and Jennie Ma, 1996)***. So, when liver cirrhosis has developed, renal transplant recipients are at risk of infections and liver failure with ascites, coagulation abnormalities, cholestasis, and jaundice ***(Kreis and Legendre, 1998)***.

Kidney transplantation in HBV positive patients is associated with increases in HBV replicative markers. The survival disadvantage in HBs Ag-positive recipients usually did not become apparent until 8 years after transplantation ***(Huang, 1997)***. Moreover, HCV infection is sometimes associated with what's called mixed cryoglobulinemia with well-characterized pattern of glomerular disease termed cryoglobulinemic glomerulonephritis ***(D'Amico, 1998)***. However, ***Pereira et al., (1998)*** studied the effect of HCV infection and renal transplantation on survival in ESRD and concluded that HCV infection before renal transplantation is associated with an increased risk

of death irrespective of whether patients remain on dialysis or undergo transplantation. However, ***Pessa and Wright, (1997)*** stated that HCV infection may contribute to long-term morbidity and mortality in renal transplant recipients. Again, ***Cosio et al., (1996)*** stated that 30 % of patients with acute or chronic transplant glomerulopathy have HCV antibodies.

Schistosomiasis is a major disease of public health importance in some parts of the world. It was estimated that over 600 million people are thought to be exposed to infection. Also, over 200 million person are actually infected ***(Sobh, 2000)***. Nephropathy usually complicates hepatosplenic schistosomiasis. There is a positive correlation between the duration of schistosomal infection and renal involvement. This involvement has been observed clinically as well as in extensive experimental study ***(Sobh, 2000)***.

In a long term follow up study for the impact of schistosomiasis on patient and graft function after kidney transplantation by ***Khaled et al., (1999)***, he reported that no difference was found in the incidence and frequency of early and late acute rejection episodes as well as chronic rejection between schistosomal and control groups attributing this to the use of higher doses of cyclosporin needed for the schistosomal patients.

The aim of our work was to study and clarify the effect the pretransplant liver function and the aetiology of liver disease on the short-term outcome of renal transplantation in patients with chronic renal failure.