Piero STRATTA

Nato a Torino, residente a Torino
Professore associato confermato
MED/14 Nefrologia

Facoltà di Medicina Chirurgia e Scienze della Salute
Dipartimento di Medicina Clinica e Sperimentale
Tel.: 0321 660 602 Fax: 0321 322 21
E-mail: piero.stratta@med.unipmn.it

CARRIERA ACCADEMICA: 2004-2006: Professore associato.
2006-2009 Professore associato confermato

INSEGNAMENTI. 1973 -2009: Nefrologia.Scuola di Specializzazione Nefrologia. Università di Torino
2004-2009: Patologia Integrata Medica. Nefrologia Corso di Laurea in Medicina e Chirurgia Università Piemonte Orientale
2004-2009 : Nefrologia. Medicina infermieristica applicata alla medicina specialistica: Corso di laurea in Scienze Infermieristiche
2004 – 2009 Nefrologia. Scuola di Specializzazione in Medicina Interna Università del Piemonte Orientale
2004- 2009 Nefrologia. Scuola di Specializzazione in Urologia Università Piemonte Orientale
2006 – 2009 Nefrologia Applicazioni Biotecnologiche e Cliniche Corso di Laurea in Biotecnologie Università Piemonte Orientale

CURRICULUM. Nato Torino1945. Laureato con lode in Medicina Chirurgia Università Torino 1970. Assistente della Divisione Nefrologia Dialisi Trapianto Cattedra Nefrologia Università Torino nel 1972; Aiuto nel 1982 ; Responsabile modulo "Diagnostica clinica, istopatologica malattie renali nel 1994 ;Dirigente Struttura Semplice nel 1998 . Dal 1973 ad oggi docente Scuola Specializzazione Nefrologia Università di Torino . Dal 2003 ad oggi Direttore Struttura Complessa Universitaria di Nefrologia e Trapianto Renale Azienda Ospedaliero - Universitaria Maggiore della Carità di Novara; 2006-2008 Direttore del Dipartimento di Nefrourologia e dei Trapianti renali; dal 2008 ad ora Direttore Responsabile del Progetto Trapianti dell'Azienda . Componente Tavolo Tecnico Scientifico della Regione Piemonte e Coordinatore aziendale per le " Malattie Rare ". Professore Associato di Nefrologia , Università Piemonte Orientale. Coordinatore Nazionale Gruppo di Studio SIN "Rene e gravidanza" (1994-1996) e "Immunopatologia Renale " (2001-2005) .Responsabile SIN per le Linee guida Nazionali " Rene e gravidanza" e "Diagnostica e Terapia delle Glomerulonefriti "(2005-2006). Socio Fondatore e Membro Direttivo (2005-2008) Associazione Inter-Regionale Trapianti. . Pubblicazioni Scientifiche 510 (178 Pub Med) Impact factor 354 Citation Index 745

CAMPI DI INDAGINE NELLA RICERCA. Glomerulonefriti primitive e secondarie ;Coinvolgimento renale nelle malattie sistemiche autoimmuni;Trapianto renale; Patologia renale della gravidanza;Rene e ipertensione.

TEMI CORRENTI DI RICERCA.

*Il trattamento della glomerulonefrite membranosa***.** Treatment of idiopathic membranous nephropathy is based on a 'symptomatic' therapy that includes ACE inhibitors or angiotensin II receptor antagonists, and on an 'aetiological' therapy aimed at modulating underlying immunological mechanisms. The role of the latter is still debated given the usually indolent course of disease; furthermore, traditional immunosuppressants would not have an impact on patient and renal survival according to a systematic review of literature. However, up to 40% of untreated patients eventually develop end-stage renal disease and remission of nephrotic syndrome protects patients from related life-threatening complications and is the strongest positive prognostic factor for long-term kidney function. Therefore, immunosuppressive therapy seems to be rational in high-risk patients with nephrotic syndrome or deteriorating renal function. This article outlines a possible role for each 'aetiological' therapy on the basis of available evidence in order to provide some practical recommendations. The first-line therapy is based on a 6-month regimen of alternating corticosteroids and an alkylating agent ('Ponticelli' regimen), whereas oral ciclosporin and intramuscular corticotrophin (adrenocorticotrophic hormone) are alternatives that provide comparable results in terms of remission of proteinuria, with a different adverse effect profile. New drugs are emerging as potential treatments, such as mycophenolate mofetil, tacrolimus, intravenous immunoglobulins and rituximab. Specific settings, such as chronic renal failure or elderly age, require a careful balance between benefits and toxicity of immunosuppression. The tailor-made use of this repertoire of drugs can provide a tool to achieve remission of proteinuria and modify the natural course of idiopathic membranous nephropathy.

Le complicanze neoplastiche in corso di trapianto renale . Post-transplant malignancies (PTM) occur in a percentage as high as 50% in patients followed 20 yr and have become a main cause of mortality and are expected to be the first cause of death within the next 20 yr in kidney transplant recipients. PATIENTS AND METHODS: We analyzed the PTM incidence in our kidney transplant recipients, and its main risk factors. The records of 400 patients (min follow up = one yr) have been retrospectively reviewed and categorized into three groups: patients without any tumor, with a non-melanoma skin cancer and with a solid or hematologic cancer. A cancer-free multivariate survival study was performed stratified by age, sex,

immunosuppressive therapy, time on dialysis, body mass index (BMI), smoke, diabetes and nephropathy. RESULTS: Thirty patients developed PTM: 12 non-melanoma skin cancer, three lymphomas and 15 solid malignancies (seven genitourinary, three lung, two breast, two gastrointestinal and one sarcoma). The mean age at diagnosis was 55 yr, with a mean time from transplant of 27 months. We observed six deaths and two graft losses. Non-melanoma skin cancer-free survival and the solid/hematologic cancer-free survival was 99.5% and 98.5% at one yr, and 95.2% and 94.6% at five yr, respectively. At univariate analysis, age and induction therapy were significant risk factors for both types of PTM, while only recipient age significantly increased the risk of all PTM, and anti CD25 significantly reduced the risk of non-melanoma skin cancer at the multivariate study. CONCLUSIONS: These data confirm the role of age and induction strategies in modulating the risk of neoplasia. To look for which strategies might reduce the PTM risk, including a personalized therapy to minimize the effects of chronic immunosuppressant, will be a crucial goal.

Miglioramento della sopravvivenza dei pazienti con vasculite sistemica e coinvolgimento renale Immunosuppressive treatment has changed the prognosis of renal vasculitis over time, but improvement in prognosis is difficult to analyze in different historical periods, and can be better demonstrated by comparison with life expectancy of sex- and age-matched people. Long-term survival of 101 patients diagnosed with systemic vasculitis at our center from 1975 to 2002 was retrospectively evaluated in comparison with that of the Region's age- and sex-matched population. Patient and kidney survival significantly increased over time. Multivariate analyses showed that risks of patient and renal death decreased by 10% and 7%, respectively, at each year of follow-up, and increased by 6.3% and 5.2% for each year of age. Relative survival significantly improved over time, approaching that of the general population for cases diagnosed after 1993, mainly in women < 60 years (from 0.671 at 5-years in the first period to 0.916 in the last period), while 5-year-relative-survival was still 0.530 and 0.682 in men and women greater than 60 years, respectively. Poisson-based multinomial analyses confirmed the significant risk of the first periods of diagnosis and of dialysis in worsening of the relative survival of patients compared to that of the general population. Life expectancy in patients with renal vasculitis has improved over time, paralleling a significant increase in steroid pulse/cyclophosphamide association therapy and an earlier diagnosis due to the introduction of the ANCA test. Relative survival has considerably improved, and now approaches that expected in the general population for women, but not for men.

Il ruolo dell'epatite B occulta nei pazienti in lista di attesa di trapianto renale. Occult hepatitis B virus (HBV) infection can be defined as the long-lasting persistence of viral genomes in the liver tissue, and sometimes also in the serum at low levels of viremia in individuals with undetectable HBV surface antigen (HBsAg). Viral replication can be reactivated by immunosuppressive therapies or immunologic diseases, leading to the development of typical hepatitis B. METHODS: All patients on the waiting list for renal transplantation at the only 2 transplant centers in our region (Piemonte, Italy) were checked for the presence of occult HBV infection by an highly sensitive quantitative HBV-DNA polymerase chain reaction (PCR) assay (nested PCR); the only exclusion criterion was HBsAg-positivity. The enrollment lasted from October 1, 2006, to May 31, 2007. The prospective follow-up will continue for 5 years. RESULTS: HBV-DNA sequences were detected in blood samples from 10 of 300 cases examined (3.3%), being more frequent among Asian (1/3; 33.3%) and African (1/16; 6.25%) subjects as compared with the Caucasians (8/281; 2.8%; P = .011), among anti-hepatitis C virus (HCV) positive versus HCV negative patients (3/32 [9.3%] vs 7/268 [2.6%]; P = .004) and mainly among patients with a previous history of overt liver diseases (3/22 [14%] vs 7/278 [2.5%]; P = .019). HBV-DNA sequences became undetectable at 1 month after renal transplantation in 3 patients; the follow-up is in progress for these and the other patients. CONCLUSION: Occult HBV infection occurs in patients undergoing renal transplantation. Longer observation and prospective studies will clarify the clinical impact of this occult infection on transplant outcomes and the possibility of viral reactivation related to immunosuppressive therapy.

Analisi e valutazione della qualità della vita nei pazienti sottoposti a trapianto di rene.

Kidney transplantation not only drastically improves the life-expectancy of hemodialyzed patients, but it also affords psychological and social advantages with improvements in short- and long-term personal and working lives. Quality of life (QoL) is one of the parameters of psychological well-being. There is an improvement of QoL from pre- to posttransplant, but it is not to the level of healthy samples. The aim of this study was to examine QoL in older renal transplant recipients. All recipients older than age 60 were included, with a minimum follow-up of 12 months. To measure QoL, the nationally standardized ShortForm-36 (SF-36) questionnaire was administered. The SF-36 responses by our patients were compared with national age- and gender-appropriate norms, and also between genders. The enrolled population included 19 women (36.5%) and 33 men (63.5%), with a mean age of 66.8 years (range, 60-73 years). Enrolled women reported significant limitations compared to gender- and age-matched norms in social activities (42.11 vs 70.58), perception of pain (22.11 vs 59.17), and general health perception (39.58 vs 48.69). Enrolled men reported significant limitations compared to gender- and age-matched norms in social activities (46.59 vs 78.35), perception of pain (18.18 vs 73.62), psycho-physical energy (50.15 vs 67.88), and general health perception (37.33 vs 61.66). No significant differences were noted between the genders. This study clearly showed how the psychological state was not as good as the clinico-physical recovery following renal transplantation in older recipients.

PUBBLICAZIONI PIÙ RECENTI. (2008-2009)

P. STRATTA, Structure-activity relationships of low molecular weight heparins expose to the risk of achieving inappropriate targets in patients with renal failure. Curr Med Chem. 2009;16(23):3028-40.

P. STRATTA, The missing medullary sponge kidney. Kidney Int. 2009 Aug;76(4):459-60

P. STRATTA, Idiopathic membranous nephropathy: management strategies. Drugs. 2009;69(10):1303-17

P. STRATTA, Is Renal Living- Donor Transplantation Indicated in Adult Patients with Orthotopic Ileal Neobladder? Lessons Learned from a Clinical Case. Eur Urol. 2009 May 19.

P. STRATTA, Prevalence and clinical relevance of occult hepatitis B virus infection in patients on the waiting list for kidney transplantation. Transplant Proc. 2009 May;41(4):1132-7.

P. STRATTA, ACE genotype, body weight changes and target organ damage in renal transplant recipients. J Nephrol. 2008 Nov-Dec;21(6):879-86.

P. STRATTA, Primary hyperoxaluria: report of an Italian family with clear sex conditioned penetrance. Urol Res. 2008 Dec;36(6):309-12

P. STRATTA, Improvement in relative survival of patients with vasculitis: study of 101 cases compared to the general population. Int J Immunopathol Pharmacol. 2008 Jul-Sep;21(3):631-42

P. STRATTA, Quality of life in renal transplant patients over 60 years of age. Transplant Proc. 2008 Jul-Aug;40(6):1865-6.

P. STRATTA, Gadolinium-enhanced magnetic resonance imaging, renal failure and nephrogenic systemic fibrosis/nephrogenic fibrosing dermopathy. Curr Med Chem. 2008;15(12):1229-35. Review.

P. STRATTA Images in clinical medicine. Green urine. N Engl J Med. 2008 Mar 13;358(11):

P. STRATTA Malignancy after kidney transplantation: results of 400 patients from a single center. Clin Transplant. 2008 Jul-Aug;22(4):424-7

P. STRATTA Life-threatening systemic flare-up of systemic lupus erythematosus following influenza vaccination. Lupus. 2008;17(1):67-8.

Orario di Ricevimento
Lunedì – Venerdì ore 13-14 e su appuntamento
Direzione SCDU Nefrologia e Trapianto renale AOU Maggiore della Carità di Novara (Tel 03213733798-03213733796)