Why do we reject a graft? Role of indirect allorecognition in graft rejection

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CASE PRESENTATION

A 42-year-old Hispanic man had a history of end-stage renal disease secondary to malignant hypertension. He had been on hemodialysis for two years before receiving a 4-antigen mismatched, cadaveric renal allograft four years ago. Positive for cytomegalovirus (CMV), he received a CMV-negative kidney. His serologic hepatitis profile showed positive hepatitis B antibody but negative antigen, and negative hepatitis C antibody. His initial post-transplant course was complicated by delayed graft function and one episode of presumed acute rejection in the first two weeks post transplant, which responded to administration of a steroid pulse.

At discharge after transplantation, his serum creatinine level was at its nadir value of 1.1 mg/dl. Cyclosporine, azathioprine, and steroids were initiated and maintained. He developed post-transplant hypertension, which was managed with an angiotensin-converting-enzyme inhibitor. Approximately four months post transplant, he had another acute rejection episode, which was believed to be secondary to noncompliance with his medications, as reflected by erratic cyclosporine levels during his follow-up clinic visits. Subsequent to that episode, his renal transplant function had been relatively stable (serum creatinine in the 2.1 to 2.6 mg/dl range). But two years ago, progressive renal transplant dysfunction, as manifested by a slow, progressive rise in serum creatinine, developed; the decreasing renal function was associated with proteinuria (1 to 2 g/24 hr). The erratic cyclosporine levels and blood pressure readings led to the suspicion that he remained noncompliant with his medications.

A renal transplant biopsy one year ago (when his serum creatinine was 4.0 mg/dl and urinary protein-to-creatinine ratio was 1.2) showed evidence of chronic allograft nephropathy (Fig. 1). Specifically, the renal parenchyma was greatly distorted by widespread sclerosis. Most glomeruli were either globally or segmentally obsolescent or appeared hypoperfused. Extensive tubular atrophy was present. The interstitium was expanded by connective tissue and patchy mononuclear cell infiltrates. Isolated tubules showed evidence of tubulitis. Arteries revealed extensive intimal proliferation with near obliteration of the lumens. Small arteries and arterioles revealed concentric layers of connective tissue or prominent hyaline deposition in the wall. Several vessels showed signs of active inflammation of the intima (endothelitis). Results from the renal biopsy along with the progressive decline in renal function prompted a change in his medications from azathioprine to mycophenolic mofetil (Cellcept), but renal transplant dysfunction progressed, necessitating reinstitution of hemodialysis therapy.

DISCUSSION

Dr. Mohamed H. Sayegh (Research Director, Laboratory of Immunogenetics and Transplantation, Renal Division, Brigham and Women’s Hospital, and Associate Professor of Medicine, Harvard Medical School, Boston, Massachusetts, USA): This patient is a typical recipient of a cadaveric renal transplant who ultimately developed chronic allograft nephropathy that led to a second episode of end-stage renal disease. Although chronic allograft nephropathy has been recognized for years, only recently have researchers gone back to the bench to try to understand the pathophysiologic mechanisms of this poorly defined clinicopathologic entity. Chronic allograft nephropathy is clinically characterized by progressive organ dysfunction associated with proteinuria, hypertension, and somewhat typical morphologic changes of graft...
Nephrology Forum: Indirect allorecognition in graft rejection

The current understanding of allograft rejection has evolved beyond the classical view that isolated alloantigenic peptides, presented by MHC molecules, are recognized by T-cells. The dominant role of alloantigen-dependent factors in allograft rejection is well established and well documented. However, the role of indirect allorecognition mechanisms in graft rejection, particularly chronic rejection, is still not fully understood.

Arteriosclerosis, glomerulosclerosis, and variable degrees of interstitial inflammation, fibrosis, and tubular atrophy [1]. Not unique to the kidney, chronic allograft failure affects all solid organ allografts including the heart, lung and, to a lesser degree, the liver [1]. In fact, in other than liver transplant recipients in whom recurrent disease is a major problem, chronic allograft dysfunction is the major cause of graft loss after the first year post transplant. Several studies have established the clinical risk factors of chronic allograft failure. These factors include delayed graft function, acute rejection, infection (such as CMV), and “underimmunosuppression” with acute rejection, particularly recurrent and late episodes (beyond three months) [2–4].

Chronic allograft dysfunction is mediated by both alloantigen-dependent factors (recipient-donor incompatibility, acute rejection, underimmunosuppression) as well as alloantigen-independent factors (ischemia, hypertension, reduced nephron mass, hyperlipidemia, infection, drug nephrotoxicity) [2, 3, 5, 6]. The mechanisms through which alloantigen-independent factors contribute to graft dysfunction have not yet been defined [6]. But it is alloantigen-dependent mechanisms that predominate in initiating and propagating the injury that leads to chronic allograft loss. Perhaps the best evidence supporting a dominant role for alloantigen-dependent factors is the clinical observation that the half-life (defined as the time when 50% of grafts have failed after surviving the first year) of renal allografts decreases with decreasing degrees of HLA matching, that is, incompatibility, in living-related as well as in cadaveric grafts [7]. In addition, patients who demonstrate donor-specific hyporeactivity exhibit a very low incidence of chronic rejection [8].

Experimental evidence from re-transplantation studies in rat models of chronic allograft rejection confirms the importance of alloantigen-dependent mechanisms, particularly in initiating the chronic rejection process [9]. Furthermore, data from several experimental animal models clearly indicate that induction of donor-specific tolerance prevents development of chronic rejection [10]. Therefore, this discussion will focus on alloantigen-dependent mechanisms of allograft dysfunction, particularly the role of indirect allorecognition mechanisms. In that regard it is important to clarify some poorly defined terminology that has been used in the literature. “Chronic allograft dysfunction” is a generic term that does not imply causation. “Chronic rejection,” on the other hand, implies an alloimmune-mediated process driven by the host reaction against graft antigens. “Immunologic” versus “non-immunologic” mechanisms have been used interchangeably with “alloantigen-dependent” versus “independent” mechanisms, respectively, although this terminology is not entirely accurate, as several alloantigen-independent factors mediate injury through inflammatory mechanisms that involve immune cells and/or their products [11, 12]. Therefore, the use of the terminology alloantigen-dependent versus alloantigen-independent is preferable. In this Forum, I will be mostly focusing on the role and mechanisms of indirect allorecognition in graft rejection, particularly chronic rejection.

Direct and indirect allorecognition

The primary initial event that ultimately leads to graft rejection is allorecognition (T-cell recognition of alloantigen), in particular, antigens of the major histocompatibility complex (MHC). Several other factors can contribute to the effector mechanisms of graft dysfunction and ultimately failure, however. Using gene knockout animals, Krieger et al showed that CD4+ T-cells are essential for initiating allograft rejection [13]. There are two distinct, yet not mutually exclusive, pathways of allorecognition by CD4+ T-cells [14–19]. In the so-called “direct” pathway, T-cells recognize intact allo-MHC molecules on the surface of donor antigen-presenting cells (APCs) (Fig. 2). Peptides, derived from endogenous proteins including MHC molecules, bound into the groove of the MHC play an important role in this mode of allorecognition [20]. In the so-called “indirect” pathway, T-cells recognize processed alloantigen presented as peptides by self APCs (Fig. 2). The basic premise for indirect allorecognition as a mechanism for initiation and/or amplification of allograft rejection is that donor alloantigens are shed from the graft, taken up by recipient APCs, and presented to T-cells. The findings in humans [21, 22] and in mice [23] that at least some of the peptides eluted from cell surface class-II MHC molecules represent MHC sequences suggest that processing of MHC molecules is a physiologic event in vivo.

Although no evidence has indicated that T-cells recognizing alloantigens via the direct versus indirect pathway are predetermined to be biologically different, from the standpoint of contribution to mechanisms of allograft rejection, these two pathways of allorecognition are distinct for the following reasons: first, differences exist in the microenvironment and locale of “professional” (bone-marrow-derived) APCs (donor versus self) at different times after transplantation; second, direct responses can be primary or primed (secondary) T-cell responses, while indirect responses are all primed (secondary) T-cell responses; third, there can be different effects of immunosuppressive or tolerance regimens on primary versus primed T-cell responses. Therefore, direct and indirect allorecognition need not be mutually exclusive pathways, as each is mediated by different sets of T-cell clones, and both can be involved in the rejection process simultaneously or at different times post transplantation. Mounting evidence indicates that indirect allorecognition, analogous to self-restricted T-cell recognition of nominal antigens, occurs during allograft rejection. I will return to this topic later.
The question is, what are the role and mechanisms of indirect allorecognition in rejection? Early acute allograft rejection might be mediated predominantly by the direct pathway, as the graft contains a significant number of donor-derived passenger APCs (particularly dendritic cells), which express a high density of MHC molecules and can provide the necessary co-stimulatory signals for full T-cell activation [19]. Later, when grafts lack passenger (donor) APCs, T-cells primed by the indirect pathway might play the dominant role in the process of chronic rejection [24]. Definitive evidence proving this hypothesis is lacking, however. Braun et al have demonstrated that “directly” primed CD4+ T-cell lines/clones could effect early acute rejection but not chronic rejection of passenger-cell-depleted renal allografts [25]. These studies suggest, but do not prove, an important role for indirect allorecognition in chronic rejection. Other evidence suggests a role for indirect allorecognition in chronic rejection comes from the clinical observation that nominal antigen (for example, viral) recognition, which is analogous to indirect allorecognition, is usually intact in transplant recipients undergoing maintenance immunosuppression, and that in-vitro T-cell responses to nominal antigen may correlate with chronic allograft rejection [26–28]. I will address this issue in a moment.

Occurrence of indirect allorecognition

Initial studies in the mouse model showed that adoptive transfer of syngeneic plastic adherent splenocytes primed by the indirect pathway in vivo could sensitize a recipient to reject skin allografts in an accelerated fashion [29]. In another report, LEW (RT1b) rats primed by immunization with soluble class-I or class-II allo-MHC molecules derived from allogeneic DA (RT1.Aav1) rats produced antibodies to the soluble allo-MHC molecules and rejected specific skin allografts in an accelerated fashion [30]. Both those studies suggest that self-restricted T-cell recognition of processed allo-MHC molecules plays a role in allograft rejection. The availability of MHC sequences has allowed synthesis of MHC-derived peptides for studying the role and mechanisms of indirect allorecognition in graft rejection. Our initial studies focused on studying the immunogenicity of synthetic class-II MHC allopeptides in vivo [31]. Inbred LEW (RT1b) rats, used as responders, were immunized in the foot pad with a mixture of eight polymorphic synthetic (25mer) class-II MHC allopeptides. These sequences represent the full length of the hypervariable domains of RT1.Ba (DQ and I-A like) and RT1.Da (DR and I-E like) β chains of the WF (RT1b) rat. Responder T-cells harvested from popliteal and inguinal lymph nodes of immunized animals exhibited significant proliferation to the MHC allopeptides in vitro when presented by self APCs. In vivo, peptide-immunized LEW animals mounted significant delayed-type hypersensitivity (DTH) responses when challenged by the allopeptides, but more interestingly they also had significant DTH responses when challenged by allogeneic WF splenocytes, and not when challenged by syngeneic LEW or third-party allogeneic BN (RT1b) splenocytes. Follow-up studies on the immunogenicity of these synthetic class-II MHC allopeptides confirm the occurrence of self-MHC-restricted T-cell recognition of processed allo-MHC peptides during vascularized cardiac as well as renal allograft rejection [32, 33]. Splenic CD4+ T-cells, taken from LEW recipients of WF vascularized cardiac or renal allografts, proliferate to specific class-II MHC peptides presented by responder APCs. Our studies also demonstrate that not all polymorphic peptides are immunogenic. In fact, in LEW responders, only 2 of the 4 RT.1Bβ and 2 of the 4 RT1.Dαβ were immunogenic [31, 33], and immunogenicity of the individual peptides varied in different responder strains. These findings suggested to us that immunogenicity was determined by the responder MHC haplotype [33]. Benichou et al, using mouse class-II MHC allopeptides [34, 35]; Fabre and colleagues [36, 37] and Shirwan et al [38], using rat class-I MHC allopeptides; and Ghobrial et al, using soluble rat class-I MHC molecules [39], have reported similar results indicating the occurrence of indirect allorecognition during rejection of skin and vascularized allografts. More recently, we demonstrated indirect allorecognition in an experimental model of acute rejection due to discontinuation of immunosuppression [40]; this model mimics events in noncompliant patients. In summary, ample evidence indicates that indirect allorecognition occurs during allograft rejection. The question is, what is the role and function of T-cells activated via the indirect pathway in the process of allograft rejection?

Role and mechanisms of indirect allorecognition

Elegant studies by Auchincloss et al, using class-II MHC-deficient mice as donors in a skin allograft model, showed that indirect allorecognition by host CD4+ T-cells of donor class-I MHC antigens can initiate rapid skin allograft rejection [41], and that these cells can help generate cytotoxic T-lymphocytes against donor class-I MHC [42]. In a separate study, the same investigators showed that IgG alloantibody production is dependent on CD4+ T-cells recognizing peptides of donor antigens through the indirect pathway [43]. Dalloul et al, also using MHC knockout animals, showed that CD4+ T-cells can reject skin allografts through indirect allorecognition [44]. Taken together, these data strongly suggest that, in the absence of direct allorecognition, CD4+ T-cells primed by the indirect pathway can initiate allograft rejection, and that either class-I or class-II donor antigens can be recognized by CD4+ T-cells after processing and presentation by recipient class-II MHC molecules on self APCs.
Fig. 1. Graft morphology. (A) This photograph illustrates extensive tubular atrophy. Tubular basement membranes are thickened and the interstitium is expanded by connective tissue. (B) Arteries reveal extensive accumulation of connective tissue in the media and in the expanded intima, resulting in substantial narrowing of the lumen. (C) Glomeruli also reveal obsolescence of the capillary that results in global or segmental glomerulosclerosis. The collapsed capillaries often entrap hyaline material, as depicted in this glomerulus with segmental sclerosis (PAS stain, ×400; courtesy of Dr. H.G. Rennke, Department of Pathology, Brigham and Women’s Hospital and Harvard Medical School, Boston, MA, USA).
Studies with synthetic class-I MHC peptides derived from the DA rat strain showed that peptide-immunized LEW rats were capable of rejecting DA skin allografts in an accelerated fashion [45]. Furthermore, peptide-immunized recipients rejected renal allografts depleted of donor-derived interstitial dendritic cells [46]. These findings clearly demonstrate that indirect allorecognition contributes to the rejection of vascularized allografts.

Effector mechanisms of transplant rejection involve cellular, delayed-type hypersensitivity (DTH) responses, cell-mediated cytotoxicity, and humoral components [19, 47]. Once fully activated, CD4+ T-helper cells produce cytokines that orchestrate various effector arms of the alloimmune response (Fig. 2). Activated CD4+ T-cells provide help for CD8+ T-cells, B-cells, and monocytes by secreting cytokines and by initiating cell-cell contact-dependent mechanisms. Activated monocytes release a variety of noxious agents that mediate tissue injury. B-cell alloantibody production ultimately results in complement and cell-mediated cytotoxicity. Activated CD8+ T-cells kill graft cells in an antigen-specific manner through direct recognition of class-I MHC molecules on target donor cells. Therefore, CD4+ T-cells activated via the indirect pathway may effect allograft rejection by DTH and alloantibody-mediated mechanisms independent of direct allorecognition. First, we examined whether priming through the indirect pathway by immunization with donor-derived MHC allopeptides could accelerate acute rejection in an experimental vascularized cardiac allograft model in the rat [48]. We immunized LEW recipients of WF heterotopic cardiac allografts with a mixture of the immunogenic (25mer) WF MHC class-II peptides (RT1.Db1-25, RT1.Dbβ20-44, RT1.Bb1-25, and RT1.Bbβ20-44) in complete Freund’s adjuvant seven days before transplantation. The control group was immunized with adjuvant and saline or with a mixture of the nonimmunogenic peptides in adjuvant. The animals received cyclosporine, 5 mg daily for seven days; immunosuppression was discontinued thereafter. Animals immunized with the immunogenic peptides rejected their allografts in an accelerated fashion; animals immunized with the nonimmunogenic peptides or adjuvant did not develop accelerated allograft rejection. No difference existed in the time course of the rejection process when recipients were challenged with third-party BN cardiac allografts, so we deduced that the effect observed was a specific response to donor class-II MHC peptide priming. Additional studies showed that priming with the immunogenic RT1.Dbβ (HLA-DR-like) peptides, and specifically with the most immunogenic single peptide (RT1.Dbβ, residues 20-44), was responsible for the observed acceleration of the rejection process [48].

Morphologic evaluation of cardiac allografts harvested from animals at the time of rejection revealed interstitial cellular rejection of significantly greater intensity in the accelerated compared with the control groups. Interestingly, in addition to the severe interstitial cellular rejection, animals primed with the immunogenic class-II MHC peptides had severe vascular rejection compared with control animals. Specifically, allografts harvested from immunogenic class-II MHC allopeptide-primed recipients showed classic morphologic features of vascular rejection with necrotizing arteritis, including fragmentation of the elastica, fibrinoid necrosis, and a mild peri-adventitial mixed cellular infiltrate. Allografts from this group showed deposition of IgG (predominantly IgG2b), C3, and fibrin throughout the vasculature. By contrast, acute rejection in unprimed rats was cellular in nature, with normal vessels on histologic examination, and essentially no endothelial deposition of IgG, C3, or fibrin. Our morphologic and immunohistologic data suggest an important role for alloantibodies in the accelerated vascular rejection observed in animals primed with immunogenic donor class-II MHC allopeptides.

We also examined the T-cell proliferative response to the peptides in primed and control animals. Interestingly, we observed lymphocyte proliferation against peptides known to be immunogenic in both the peptide-immunized animals and in the animals primed in vivo by the transplanted organ, as previously described [32, 33]. However, the degree of proliferation to the peptides was significantly higher in the peptide-immunized group. Thus, peptide immunization markedly increased the precursor frequency of allopeptide-reactive T-cells compared with that seen in vivo priming as a result of rejecting a graft [48]. This increased precursor frequency might play an essential role in initiating the effector mechanisms that accelerate the rejection process (Fig. 3).

To study DTH mechanisms, we generated alloreactive T-cell clones by in vivo priming via the indirect pathway [49]. Inbred LEW rats were primed in vivo by immunization in the foot pad with the immunogenic synthetic class-II MHC allopeptide (RT1.Dbβ, residues 20-44). This is the same peptide that alone is effective in priming animals to accelerate allograft rejection [48]. One week later, we harvested the primed lymphocytes from the draining lymph nodes, and established an RT1.Dbβ20-44 T-cell line by repeated stimulation with RT1.Dbβ20-44 peptide presented by responder APCs. The T-cell line proliferated significantly to the RT1.Dbβ20-44 peptide but not to a specificity control peptide derived from the RT1.B locus (RT1.Bβ20-44) when presented by self APCs. In addition, the T-cell line produced significant amounts of IFN-γ but not IL-4 upon restimulation with the RT1.Dbβ20-44 peptide. By limiting dilution, we then generated T-cell clones from this Th1 line. Flow cytometric analysis with specific monoclonal antibodies showed that all RT1.Dbβ20-44-specific T-cell clones were CD4+. Six clones proliferated specifically to the RT1.Dbβ20-44 peptide and produced IFN-γ but not IL-4 when restimulated with RT1.Dbβ20-44 peptide in vitro (that is, Th1 clones).
Using RT-PCR transcript analysis with specific rat TCR Vβ primers, we showed that all these clones expressed Vβ 9 TCR transcripts. These clones are self-restricted and do not proliferate to intact donor (WF) cells in vitro; thus, they recognize RT1u alloantigens through the indirect pathway only. We then injected naïve LEW animals with 25 to 30 × 10⁶ cells intraperitoneally of one of the RT1.Dβ20-44-specific T-cell clones (clone 2F4). Five days later, the animals were challenged with RT1.Dβ20-44 in the ear to check for DTH responses. These animals mounted significant DTH responses to the allopeptide, but not to control antigen. More interestingly, LEW animals injected with the 2F4 clone had significant DTH response to re-challenge with irradiated allogeneic WF spleen cells, but not to syngeneic LEW or third-party BN splenocytes. This was the first demonstration that MHC allopeptide-specific Th1 cell clones transfer a DTH response. The specific response to WF cells indicates processing and presentation of allo-MHC by self APCs in vivo.

We recently focused our studies on generating T-cell clones from animals primed in vivo by rejection of vascularized allografts, because this is the physiologic pathway of priming to donor-derived peptides [50]. We generated self-restricted class-II MHC allopeptide-specific T-cell clones (to the same peptide, RT1.Dβ20-44) from the spleen and kidney of LEW (RT1b) rats undergoing acute rejection of MHC-incompatible WF (RT1u) renal allografts. All the clones that specifically proliferated to the peptide (RT1.Dβ20-44) were CD4+ and produced IFN-γ but not IL-4 upon restimulation with the peptide in vitro. The Th1 clones from splenic and renal T-cell lines of rejecting animals expressed a restricted TCR Vβ repertoire: Vβ 4, 8.2, or 9. In comparison, the clones generated from T-cell lines of RT1.Dβ20-44-immunized LEW rats all expressed TCR Vβ 9 only. Adoptive transfer of T-cell clones expressing TCR Vβ 9 or Vβ 8.2 to naïve LEW animals elicited significant DTH responses after challenge with the RT1.Dβ20-44 peptide or allogeneic WF (RT1b) splenocytes. By contrast, TCR Vβ 4-expressing clones elicited no DTH response. These data indicate that not all Th1 clones are pathogenetic; some clones transfer DTH responses while others do not. This important observation might explain why priming animals with the RT1.B peptides, although immunogenic, did not accelerate allograft rejection [48]. The exact reasons why a clone is not pathogenetic are unknown, but preliminary studies suggest that pathogenicity is related to affinity of the particular TCR binding to the peptide + MHC complex on APCs [50].

In summary, CD4+ T-cells primed by donor peptides via the indirect pathway help monocytes and B-cells to effect DTH responses and produce donor-specific allo-antibodies, respectively. These cellular and humoral mechanisms contribute to graft rejection. It is also possible that such CD4+ T-cells help activate CD8+ cytotoxic T-cells which, through direct allore cognition of class-I MHC-bearing donor cells, contribute to allograft destruction by cytotoxicity [40].

**Human studies**

The first report of self-restricted T-cell recognition of processed allo-MHC in humans was published by de Koster et al, who produced T-cell clones primed by a synthetic peptide derived from the hypervariable domain of the β chain of HLA-DR3 (residues 67–85) [51].
clones were capable of proliferating to the allo-MHC peptide presented by self HLA-DP class-II molecules. Liu et al used synthetic MHC peptides (20-25mer) derived from the hypervariable domain of DRβ1*0101 to establish in vitro a T-cell line from an HLA-DR11/DR12 responder that recognized a specific MHC allopeptide (residues 21–42) in the context of self class-II MHC [52]. This line also was capable of recognizing cells expressing DRβ1*0101, from which the peptide sequences were derived in the presence of autologous APCs, or in the absence of autologous APCs only when expressed together with DR11. These data thus suggest the self-restricted recognition of processed allo-MHC. Responder cells were shown to be CD4+ and were inhibited by specific anti-DR11 monoclonal antibody. Restricted TCR Vβ usage by the responding cell line also was noted [53].

Lessons learned from these in-vitro studies and in-vivo animal studies utilizing synthetic MHC peptides have been extended into the human transplant arena. Liu and colleagues have demonstrated donor-specific MHC allopeptide T-cell reactivity in humans with recurring episodes of acute cardiac allograft rejection [54]. More interesting was the demonstration of shifting T-cell responses to different allopeptides with time. Such a change in the pattern of T-cell responses has been termed epitope switching or spreading and can occur to peptides representing alternative regions within a given MHC β chain hypervariable region (intramolecular spreading) or alternatively, to peptides representing different MHC chains (intermolecular spreading) [54]. An important observation in these human studies is that indirectly primed T-cells are present at a much lower precursor frequency than are directly primed T-cells. In fact, Liu et al calculated that their peptide sequences were derived from the hypervariable domain of DRβ1*0101, from which the peptide sequences were derived in the context of self class-II MHC [52].

In the immediate post-transplant period. Concomitant with the occurrence of acute coronary artery vasculopathy was significantly higher in patients who displayed persistent alloreactivity late after transplantation (after six months) than in patients who showed no alloreactivity after the first six months after transplantation. Epitope spreading was observed with an increased frequency in patients developing vasculopathy in less than two years, compared with patients without vasculopathy [56]. These studies and our own observations in renal transplant recipients [55] demonstrate that indirect allorecognition correlates with, and might play a key role in, chronic rejection.

**SUMMARY**

Taken together, these experimental observations in animals as well as humans have led to the formulation of a hypothesis linking MHC-allopeptide-primed T-cells and chronic rejection (Fig. 4). Small numbers of indirectly primed T-cells are present and targeted against a restricted repertoire of immunodominant peptides in the immediate post-transplant period. Concomitant with the possible decline in the importance of directly primed T-cells with time post engraftment [40, 57], the precursor frequency of indirectly primed T-cells continues to be low grade. In addition, naïve CD4+ T-cells recognize new epitopes, by a yet unclear mechanisms, and are continuously becoming activated while immunosuppression is being reduced. Activated CD4+ T-cells provide help and in turn activate the effector mechanism of allograft destruction, namely, monocytes/macrophages (DTH),

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*Adapted from Ref. 48

*P < 0.0001
B-cells (alloantibodies), and endothelial and smooth muscle cells. Through complex cellular and molecular mechanisms [58], which include tissue injury, healing, and repair, the grafts develop morphologic changes of chronic rejection that lead to clinical organ dysfunction and failure.

We can draw several implications from this working hypothesis. First, to prevent chronic allograft rejection, we need to specifically target the indirect pathway. In addition, it is likely that such interventions will have to be introduced at a relatively early stage prior to epitope
shifted. Several strategies hold promise in that regard. In particular, strategies targeted at blocking CD28-B7 and/or CD40L-CD40 T-cell co-stimulatory activation have been shown to prevent development [59–64] and even interrupt progression [65] of chronic rejection in experimental animals. Interestingly, targeting T-cell co-stimulatory activation also might be effective in ameliorating injury mediated by alloantigen-independent mechanisms of graft dysfunction, such as ischemia/reperfusion injury [11, 12]. Obviously, the applicability of these rodent studies needs to be confirmed in large animals [66] before clinical trials in humans are begun.

**QUESTIONS AND ANSWERS**

**Dr. Nicolaos E. Madias (Chief, Division of Nephrology, New England Medical Center, Boston, Massachusetts):** Thank you for this wonderful presentation. Can you expand on the determinants of the immunogenicity of processed allo-MHC antigens? What might be the mechanism of the epitope spreading you described as a function of time?

**Dr. Sayegh:** I could hypothesize on potential mechanisms. One possibility, for example, is that acute rejection, infections (such as CMV), or potentially ischemic injury to the graft can upregulate MHC expression. This upregulation can lead to increased shedding of MHC molecules, which in turn can result in a different type pattern of peptide reactivity because hidden epitopes are now exposed. In addition, changes in immunosuppression or other factors with time can affect T-cell recognition of different epitopes. The bottom line is that the precise mechanisms of epitope spreading remain unknown.

**Dr. Madias:** It would appear that both the distribution and the timing of expression of the various costimulatory signals are of importance. What do we know about the mechanism of expression of B7 molecules on activated APCs and endothelium and of CTLA4 inhibitory receptors on activated T-cells?

**Dr. Sayegh:** We know, for example, that cytokines are important in controlling the upregulation of costimulatory molecules. We recently published two studies in which we looked at ischemic injury and its effect on B7 expression [11, 12]. Both studies were in a setting in which there was no alloimmune response. We found that renal ischemic injury not only upregulates MHC expression but also upregulates B7 expression. When we gave animals with ischemic injury to their kidneys systemic CTLA4Ig, we ameliorated the ischemic reperfusion injury in the absence of an alloimmune response. We think this decrease in reperfusion injury is because of inhibition of the cytokine/chemokine surge. Not a lot is known about how regulates CTLA4 upregulation. This is a very important area because if we can figure a way to use a physiologic pathway to terminate the immune response for therapeutic purposes, it may have significant clinical relevance to several immune-mediated diseases.

**Dr. Madias:** Since CTLA4 provides an inhibitory signal to activated T-cells, what about a strategy of blocking the B7-CD28 pathway but allowing the engagement of B7-CTLA4 or even enhancing the expression of CTLA4 inhibitory receptor on activated T-cells?

**Dr. Sayegh:** This is a very important issue as well. If you target B7, then you are actually inhibiting both pathways, CD28 and CTLA4. In certain circumstances, delaying the administration of CTLA4Ig is more effective than giving it early on. Our hypothesis is that this delay allows CTLA4 to be expressed on T-cells. We have recent data showing that if we block CTLA4, we can abrogate the beneficial effects of CTLA4Ig [68]. It is possible that the timing of expression of CTLA4 vis-a-vis B7 blockade is a critical issue.

**Dr. Andrew S. Levey (Division of Nephrology, New England Medical Center):** It seems to me that you have shown very nicely the indirect pathway of allorecognition in various models. However, I’m not sure that you clearly differentiated its relative importance in acute versus chronic rejection, although your presentation suggests that you favor the hypothesis that it might be a dominant and unsuppressed mechanism in chronic rejection. Would you agree that the clinical data that you presented prove that the indirect mechanism of allorecognition occurs but doesn’t discriminate whether this is important in acute versus chronic rejection?

On a broader scope, it seems to me that acute and chronic rejection clearly differ with regard to pathologic patterns and the immune effector pathways, but is there any evidence that the initiation of the injury differs? Is it possible that both direct and indirect allorecognition occur in all phases of rejection? Does the separation of acute and chronic rejection as clinical entities make any difference?

**Dr. Sayegh:** Yes, I do believe there is a difference. There’s a fundamental pathophysiologic difference that we don’t understand very well and that is at least manifested by the different morphology and pathology that we see. Let me go back to the issue of the relative contribution of each pathway. I do believe that both pathways are operative in the acute setting. In fact, as I said before, available data support strongly the contribution of the indirect pathway to acute rejection. But I favor the hypothesis that in the acute setting, because of the high number of antigen-presenting cells in donor organs like dendritic cells, which express high-density MHC and costimulatory molecules, the direct pathway is dominant. We know at the precursor frequency levels that T-cells responding via the direct allorecognition pathway are much higher in number than those responding via the indirect pathway. In the chronic phase, the importance
of the direct pathway is reduced. For example, we know that the graft lacks donor APCs several weeks after transplantation. The endothelial cell can function as a direct APC, but some data from heart transplant patients showed that many patients with chronic rejection are “tolerant” to the direct response, as suggested by the precursor frequency analysis against donor cells [57]. Because these patients cannot mount a direct response, the chronic rejection that occurs must be driven by indirect allorecognition.

At this moment, we cannot definitively answer the question of what is the relative contribution of direct versus indirect alloresponses to acute versus chronic rejection. My fundamental point is that a pathway exists that has been forgotten for years—indirect allorecognition—and that it probably plays a major role in chronic rejection. To exaggerate a bit for effect, I don’t think anybody cares substantially anymore about acute rejection; the major problem now is chronic rejection.

Dr. Madias: Is there cross-talk between the two pathways of allorecognition? Is it possible for recipient APCs to provide costimulation of T-cells that have been primed by the direct allorecognition pathway?

Dr. Sayegh: Yes, this is called trans-costimulation. If the T-cell gets a costimulatory signal from the same APC, it’s called “costimulation in cis.” The two pathways do talk to each other. The best demonstration of this is at the endothelial cell level. The endothelial cell is of donor origin, while the monocytes and T-cells are of recipient origin; they go through the endothelium to reach the graft. Indeed, recent data in collaboration with the laboratory of Dr. Briscoe at Children’s Hospital in Boston show that endothelial cells can promote indirect allorecognition [69].

Dr. John T. Harrington (Dean, Tufts University School of Medicine, Boston, Massachusetts): I have two questions. Could you give me your best estimate of the quantitative degree of importance of the indirect allorecognition pathway in chronic rejection? Is it 50/50, 90% direct, 90% indirect, or is there no way of knowing? Second, are there clinical methods that would allow us to serially measure the degree of inhibition of the indirect allorecognition pathway?

Dr. Sayegh: To answer your first question, these studies have not been done. However, we hypothesize that indirect allorecognition is the predominant pathway in chronic rejection. Whether the direct response also contributes remains unknown.

We have more data now that have not been published yet. In work similar to our rat studies, we generated T-cell lines and clones from patients. We took these cell lines from stable patients and those with chronic rejection. We found that in patients with chronic rejection, the T-cell lines secrete TH1 cytokines (IL-2, IFN-γ). The stable patients, however, secrete TH2 cytokines (IL-4, IL-10). We are trying to simplify this method and generate what we call “mini” T-cell lines to develop new immuno-surveillance assays of transplant patients. The answer to your second question is yes, there are ways to serially measure the degree of inhibition of the indirect pathway, but they are not very well developed.

Dr. Andrew J. King (Division of Nephrology, New England Medical Center): One strategy that has been employed over the years, and especially prior to the introduction of cyclosporine, was pre-transplant donor blood transfusion. There is evidence of a beneficial effect of this approach in preventing solid organ rejection, particularly with one-haplotype-matched transfusion heart transplant recipients. Could you speculate on how this might work in relation to your model? Could this practice in some way inhibit epitope shifting?

Dr. Sayegh: It has been known for years that if you give donor antigen in the form of bone marrow or blood transfusion, you can induce tolerance in the recipient animal. The limited data in humans have not been reproducible. The implication of our studies is that if one does not induce tolerance to the indirect response, prolonged survival is likely, but the patient will probably end up developing chronic rejection. This also means that any tolerance strategy that succeeds in preventing acute and chronic rejection has to induce tolerance to both direct and indirect responses. In recent studies, we showed that administration of donor antigen was necessary to induce tolerance and prevent chronic rejection [70].

Dr. King: In your review of chronic rejection, you referred to the characteristic vascular lesion with intimal proliferation and an inflammatory response. What is the nature of the cells in that lesion? Are these T-cells with CD4+ markers? Are there CD8+ cells there?

Also, you implied that antibody production and B-cells play a role in this chronic rejection process. Is there any evidence that antibody-mediated responses are occurring within the histologic lesion itself?

Dr. Sayegh: The intimal lesions themselves reflect predominantly smooth muscle cell proliferation. The smooth muscle cells around the intima proliferate and expand and they push the intima inside. Immunohistologic staining reveals the presence of CD4+ T-cells and monocytes/macrophages but not a lot of CD8+ cells. Dr. David Adams and Dr. Mary Russell have looked at the transition in cell expression in the lesion. Early on, you find mostly CD4+ T-cells, some monocytes, no or very few CD8+ T-cells; with progression of the lesion, there are usually more monocytes/macrophages, and fewer CD4+ T-cells. The IgG antibodies play a very important role; in fact, studies using the more refined ELISA assay show that you can correlate anti-donor IgG responses with the appearance of chronic rejection [71]. We think that this antibody response is a surrogate for CD4+ indirect alloresponses, as previously shown [43].
Dr. Annamaria Kausz (Division of Nephrology, New England Medical Center): Evidently, some data suggest that the half-life of HLA-identical kidney transplants was better in 1974 than in 1996. Could this be due to the effect of cyclosporine nephrotoxicity?

Dr. Sayegh: The number of these patients was very small, and thus a firm conclusion cannot be drawn.

Dr. Kausz: You mentioned brain death as a possible cause of antigen-independent allograft dysfunction. Is there an immunologic mechanism behind that?

Dr. Sayegh: We recently published a paper on this issue [72]. We used a rat model of so-called “explosive” brain death. These animals developed shock and hypotension, hypoperfusion of the organs, and severe ischemic injury. The organs of these animals showed upregulation of inflammatory cytokines and chemokines within hours after the injury.

Dr. Bertrand L. Jaber (Division of Nephrology, New England Medical Center): If one assumes that alloantigen cell-surface shedding is a prerequisite for indirect allorecognition, what are the factors that determine cell-surface shedding besides acute rejection?

Dr. Sayegh: This has not been studied.

Dr. Jaber: It has been shown that many of the membrane-bound cytokine receptors are cleaved off the cell surface to become soluble following activation of metalloproteinases. It would be interesting to examine whether cell-surface shedding of alloantigens is indeed regulated by putative metalloproteinases. The possible modulation of this phenomenon by metalloproteinase inhibitors could lead to the development of new therapeutic strategies that limit indirect allorecognition.

Dr. Sayegh: Yes. In support of that hypothesis, we know through association studies that levels of soluble donor MHC molecules correlate with chronic rejection.

Dr. King: One strategy employed in patients who have been labeled as having chronic rejection has been the transition from cyclosporine to other immunosuppressive agents such as FK506 or mycophenolate. Do you think that that maneuver is a useful strategy? If so, does the efficacy relate to increased immunosuppression?

Dr. Sayegh: It is certainly more immunosuppression. There is no proof that this strategy works, however. The most interesting study is one that came from the University of Maryland, where they showed that if you switch patients with renal transplants and chronic rejection from azathioprine to mycophenolate, renal function improves (abstract, Weir et al, Transplantation 67:S82, 1999). What we do not know is whether this improvement occurred because there was an effect on the progression of chronic rejection or because of reduction in the cyclosporine dose.

Dr. Madias: Does administration of CTLA4Ig affect peripheral T-cell or B-cell populations or in-vitro T-cell responsiveness?

Dr. Sayegh: It binds to B7 molecules and causes T-cell anergy in vitro. There are no data regarding a direct effect on B-cells.

Dr. Harrington: When you were talking about the immunogenicity of some of the peptides, you mentioned that a difference in only two amino acids led to a different degree of immunogenicity. Do we know anything about the structure of those particular proteins and how that minimal quantitative amino acid difference leads to such a powerful functional difference?

Dr. Sayegh: We have gone beyond that and split the peptides into two peptides. Each one has only one amino acid difference, and you get the same immune response with one amino acid difference between donor and recipient [50]. That’s not unusual because these are probably linear structures that are being recognized and bound to HLA molecules of the recipient APCs. What is being recognized as foreign is the substituted amino acid. The T-cell receptor thus needs only to encounter one polymorphic amino acid to mount an immune response. This phenomenon has been shown in mutation studies. You can substitute only one amino acid in a molecule and yet induce a vigorous immune response. This is not inconsistent at all.

Dr. Madias: Could you please comment on the most promising strategies for induction and maintenance of tolerance and the potential mechanisms involved?

Dr. Sayegh: There are several strategies to try to induce tolerance, but some of the clinically promising ones include blocking T-cell costimulation, donor bone marrow chimerism, donor-specific transfusions coupled with immunomodulatory strategies, and some humanized monoclonal antibodies [73]. The translation of these strategies from small animals in the laboratory to primates and humans remains an elusive goal.

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