Retrospective Study from a Single Center in Romania of 347 Renal Transplant Patients Treated with Tacrolimus, Mycophenolate, and Steroids to Evaluate the Association Between Anti-HLA Antibodies and 5-Year Graft Survival

Background: Kidney transplantation is the most recommended treatment in chronic kidney disease. The recipient’s immune system reacts to a kidney graft as to an alloantigen by producing antibodies (anti-human leukocyte antigens [HLAs]). Although immunosuppressive therapy is used to overcome this problem, the long-term survival of a kidney graft after 5 years remains low. This retrospective study from a single center in Romania of 347 renal transplant patients treated with tacrolimus, mycophenolate, and steroids aimed to evaluate the association between anti-HLA antibodies and 5-year graft survival.

Material/Methods: Anti-HLA antibodies were screened and identified using the Luminex method, while tacrolimus levels were monitored using the chemiluminescent assay.

Results: Twenty-seven patients had pre-existing anti-HLA antibodies, while 320 patients did not. Of the 320 patients, 15% developed anti-HLA antibodies following kidney transplantation. The intrapatient minimum blood level of tacrolimus (cut-off value: 4.6 ng/mL) after transplantation was significantly associated with the risk of de novo anti-HLA antibodies \((P<0.001)\). In patients with or without de novo anti-HLA antibodies, the 5-year allograft survival rate was 77.1% vs 90.8% \((P=0.004)\). After Bonferroni correction, donor age \((P=0.001)\), and donor type \((P<0.0001)\) were statistically associated with the risk of allograft rejection.

Conclusions: This study showed that anti-HLA antibodies at 5 years after kidney transplantation were significantly associated with graft failure. The findings support previous studies and indicate that monitoring of anti-HLA antibodies should be considered in patients with renal transplant.

Keywords: Allografts • Graft Rejection • Graft Survival • HLA Antigens • Kidney Transplantation • Tacrolimus

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Background

Kidney transplantation significantly improves patient quality of life and allows socio-professional reintegration [1]. Kidney grafts can be transplanted either from brain-dead or living donors. Usually, kidney transplantation is possible when there is no anti-human leukocyte (HLA) donor-specific antibody incompatibility because of a high risk of hyperacute or acute kidney graft rejection [2-4]. However, this approach is associated with a reduced chance of highly immunized patients getting transplants that may prolong their life [5]. Orandi et al observed that patients with HLA incompatibility transplanted from living donors have a longer life expectancy than those who remain on a brain-dead donor waiting list [2]. In the case of transplantation with HLA incompatibility from a cadaveric donor, Krishnan et al have shown that long-term survival is similar to that of patients transplanted from brain-dead but HLA-matched donors [3].

Despite advances made in immunosuppressant development, not all patients have functional renal allografts after approximately 5 years [6]. The recipient’s immune system responds to the kidney transplant by producing anti-HLA antibodies, resulting in humoral rejection of the kidney allograft [7] and different outcomes in terms of graft survival rate [8-10]. Analyzing the dynamics of donor-specific anti-HLA antibodies in the immediate posttransplant period, Phillpott et al identified an increase in anti-HLA antibody levels in the first 2 weeks after kidney transplantation, followed by a slight decrease [10]. Reduction in anti-HLA antibodies could be due to strong immunosuppression, their clearance from the circulation by plasmapheresis [11], or prevention of CD20 B lymphocytes from turning into plasma cells using monoclonal antibodies, such as rituximab [12].

To avoid rejection, in addition to low-resolution HLA typing of both recipient and donor for all loci, pretransplantation screening for anti-HLA antibodies and the crossmatch test are performed [13,14]. Crossmatch, which is used to detect the presence of donor-specific alloantibodies in patients’ serum, eliminated the phenomenon of hyperacute renal allograft rejection but not chronic rejection [15]. Extensive anti-HLA antibody assessment allowed us to practice more virtual crossmatch in order to shorten the time [16].

Currently, Luminex technology is the most widely used method for the detection and identification of anti-HLA antibodies with high sensitivity (both before and after kidney transplantation) [17,18] and crossmatch testing (before kidney transplantation) [19]. Unlike enzyme-linked immunoassay, Luminex technology allows the simultaneous analysis of a very large number of analytes (up to several hundred) from a small sample volume, with applications in solid organ transplantation, hematopoietic stem cell transplantation, and transfusions [20], infectious diseases [21], autoimmune diseases [22], and cancer [23]. T-cell- and antibody-mediated rejection are 2 main histopathological findings in patients with graft rejection. While T-cell-mediated rejection has little effect on graft survival, antibody-mediated rejection presents microcirculation lesions because of mediated inflammatory cytokine, such as interferon gamma, affecting the graft functions [24].

In our opinion, the factors that influence kidney transplant outcomes are complex. Therefore, this retrospective study from a single center in Romania of 347 renal transplant patients treated with tacrolimus, mycophenolate, and steroids aimed to evaluate the association between anti-HLA antibodies and 5-year graft survival.

Material and Methods

A total of 347 patients (228 men and 119 women aged 18 to 65 years) who underwent kidney transplantation at Fundeni Clinical Institute were included in the analysis based on the following inclusion criteria: age >18 years, no positive crossmatch at the time of the kidney transplantation procedure, screening for the anti-HLA antibody appearance before and after transplantation, no previous donor-specific antibodies, or treatment with tacrolimus. No patient was excluded after applying these criteria. After the kidney transplant, all patients received triple immunosuppressive medication based on tacrolimus, mycophenolate, and prednisone. From the time of kidney transplantation until death or the end of the study period, all patients were monitored for anti-HLA antibodies, immunosuppressive regimens levels, and appearance of acute or chronic graft rejection.

Methods

Our research was undertaken with the approval of the Ethics Committee of the Fundeni Clinical Institute (no. 77883 from 2021), and written informed consent was obtained from all patients. According to the written informed consent, patients who agreed to be included in the present study were free to withdraw their consent without being charged, whenever they decided.

The presence of preformed and de novo anti-HLA antibodies was retrospectively analyzed in serum samples before transplantation and at 1 to 5 years after transplantation.

All the recipients had a compatible donor based on HLA genes. None of the recipients had preformed donor-specific antibodies.

Class I and class II HLA antibodies were screened with LABScreen Mixed12, lot 023 (One Lambda, Inc., Canoga Park, CA, USA) on FlexMap3d (Luminex Corporation, USA). The positive screening was followed by the identification of anti-HLA antibodies with...
Between January 2013 and December 2016 were included in the analysis. Based on pre-existing HLA antibodies, all patients were divided into 2 groups: patients with pre-existing HLA antibodies and patients without pre-existing HLA antibodies. In both groups, chronic glomerulonephritis was the leading cause of chronic renal insufficiency.

In the group without HLA antibodies, 36.9% of patients were women, 63.1% were men, and the average age was 46.7±11.6 years. The follow-up period for the patients included in this group was 4.8±0.7 years. Most kidney grafts were obtained from living-related donors (62.8%).

In the group with previous HLA antibodies, 37.0% of patients were men, and 63.0% were women, with an average patient age of 40.7±12.7 years. The follow-up period for the patients included in this group was 3.4±1.4 years. Most kidney grafts were obtained from cadaveric donors (55.6%).

At 5 years after transplantation, 48 (15%) patients with kidney transplants had de novo anti-HLA antibodies (Table 1). Twenty-two (6.87%) patients had de novo class I anti-HLA antibodies. De novo class II anti-HLA antibodies were observed in 37 (13.07%) patients (Table 2).

As shown in Table 3, antibody-mediated rejection was observed in 10 (20.83%) of the 48 patients from the group with de novo anti-HLA antibodies and in 7 (25.93%) of the 27 patients from the group with pre-existing anti-HLA antibodies. T-cell-mediated rejection was diagnosed in 13 (48.15%) of the 27 patients from the group with pre-existing anti-HLA antibodies and in 19 (39.58%) of the 48 patients from the group with de novo anti-HLA antibodies. Analysis of the possible outcomes showed that T-cell-mediated rejection and antibody-mediated rejection were not related to de novo anti-HLA antibodies.

The association of tacrolimus blood level with de novo HLA antibody production and rejection was studied. The ROC test was used to determine the cut-off value of the tacrolimus blood level. Only a tacrolimus blood level lower than 4.6 ng/mL was associated with de novo HLA antibody positivity. The area under the ROC curve (used to determine the cut-off values of 4.6 ng/mL; Figure 1) was 0.85, with a 95% confidence interval (CI) of 0.80 to 0.88 and P<0.05 (Figure 2). The tacrolimus blood level (P=0.2376) was not associated with the rate of allograft rejection.

We also analyzed the possible association of donor age, donor type, recipient age, and de novo HLA antibodies with kidney rejection in both groups. In patients without previous sensitization, only donor age (odds ratio [OR]=1.07, P=0.001) and donor type “cadaveric donor” (P<0.0001) were associated with higher rates of allograft rejection, while recipient age (P=0.048), after applying Bonferroni correction, did not remain significant.
In patients with previous sensitization, only donor type “living” (P < 0.001) was associated with higher rates of allograft rejection, while donor age (P = 0.06) and recipient age (P = 0.481) was not.

In the groups of patients without previous anti-HLA antibodies, the death-censored renal graft survival rates were 95.8% vs 98.9% (1 year), 89.6% vs 97.1% (2 years), 85.4% vs 95.2% (3 years), 81.3% vs 92.6% (4 years), and 77.1% vs 90.8% (5 years) (Figure 3, Table 4). The graft survival rate was significantly lower in recipients with de novo anti-HLA antibodies 5 years after transplantation (P=0.004, hazard ratio=4.0251) (Tables 5, 6).

In the groups of patients with previous anti-HLA antibodies, the death-censored renal graft survival rates were 96.3% (1 year), 92.6% (2 years), 88.9% (3 years), 77.8% (4 years), and 74.1% (5 years). When comparing both patient groups, we observed that there was a significant difference between survival distributions 5 years after kidney transplantation (P=0.0286) (Figure 4).

Only 4 patients with previous anti-HLA antibodies and 8 patients without previous HLA sensitization developed donor-specific HLA antibodies after kidney transplantation. In our patients, there was no significant difference between survival distributions 5 years after kidney transplantation in patients with donor-specific antibodies and those without (P=0.754).

### Table 2. Prevalence of posttransplant de novo HLA antibodies.

| HLA antibodies | Patients n (%) |
|----------------|----------------|
| Total          | 320 (100%)     |
| Not detected   | 272 (85%)      |
| Detected       | 48 (15%)       |
| Class I        |                |
| Not detected   | 298 (93.13%)   |
| Detected       | 22 (6.87%)     |
| Class II       |                |
| Not detected   | 283 (86.93%)   |
| Detected       | 37 (13.07%)    |

### Table 3. Outcome in patients with or without de novo HLA antibodies.

|                      | With preexisting HLA antibodies n=27 | With de novo HLA antibodies n=48 | P value |
|----------------------|--------------------------------------|----------------------------------|---------|
| T-cell-mediated rejection | 13 (48.15%)                          | 19 (39.58%)                      | 0.627   |
| Antibody-mediated rejection | 7 (25.93%)                          | 10 (20.83%)                      | 0.775   |

HLA – human leukocyte antigen.

### Table 1. Characteristics of patients with a kidney transplant.

|                      | Patients with pre-existing HLA antibodies | Patients without pre-existing HLA antibodies | P value |
|----------------------|------------------------------------------|---------------------------------------------|---------|
| n (%)                | n=27 (7.78%)                             | n=320 (92.22%)                             |         |
| Age (mean±SD)        | 40.96±11.65                              | 46.72±11.61                                |         |
| Sex                  |                                          |                                             |         |
| Male n (%)           | 10 (37.03%)                              | 219 (68.44%)                               |         |
| Female n (%)         | 17 (62.97%)                              | 101 (31.56%)                               |         |
| Donor type           |                                          |                                             |         |
| Cadaveric donor n (%)| 15 (55.55%)                              | 139 (43.44%)                               | 0.311   |
| Living related donor n (%) | 12 (44.45%)                           | 181 (56.56%)                               |         |
| Tacrolimus (mean±SD) | 5.9±1.55                                 | 6.22±1.68                                  | 0.017***|

*, a significant association, between ages and presensitization; ***, a significant association, between sex and presensitization; ***, a significant association, between tacrolimus and presensitization. HLA – human leukocyte antigen.
Discussion

After kidney transplantation, the incidence of patients with anti-HLA antibodies was relatively small (15%), similar to the incidence observed in a study of 2185 patients by Terasaki and Ozawa (14.7%) [28]. The administration of calcineurin inhibitors in the early posttransplantation period could protect against the development of de novo anti-HLA antibodies [29,30]. However, studies have shown that a lower tacrolimus trough level is associated with the development of de novo anti-HLA antibodies [29,31,32]. Marked intrapatient variability in tacrolimus trough levels may be a major risk factor for de novo anti-HLA antibodies [33-35]. In our clinical experience, the intrapatient minimum level of tacrolimus (cut-off value: 4.6 ng/mL) after transplantation was associated with the production of de novo anti-HLA antibodies. Two other studies identified tacrolimus trough levels associated with HLA antibody production in different types of organ transplantation. Kaneku et al [36] reported that tacrolimus trough levels <3 ng/mL could be associated with de novo anti-HLA antibodies after liver transplantation. Furthermore, tacrolimus trough levels lower than 3.2 ng/mL after kidney transplantation were found to be linked with de novo anti-HLA antibody presence in a center for kidney disease and transplantation in Japan [37]. Despite health improvements in patients with chronic kidney disease, there are many complex immune aspects that still remain to be solved, such as de novo anti-HLA antibodies and immunosuppressive treatment adverse effects [38].

Five years after kidney transplantation, our patients with de novo anti-HLA antibodies had significantly lower long-term death-censored graft survival than those without HLA antibodies (P<0.05). Also, de novo anti-HLA antibodies have been shown to have a significant clinical impact on long-term graft survival in other studies [39-41]. Terasaki et al [41] observed that since 2003 there has been a better rate of graft survival. The graft survival rates were also lower in patients with de novo HLA antibodies than in patients with no anti-HLA antibodies in the study conducted by Süsal et al [42]. These findings could be related to the use of immunosuppressive drugs and improved monitoring guidelines for the prevention and management of posttransplant complications (eg, immunosuppressive drug toxicity, viral infections, diabetes, malignancy, low level of immunosuppressive drugs [43-45], and anti-HLA antibody appearance).

In the present study, between patient groups, there was a significant difference between survival distributions 5 years after kidney transplantation (P=0.0286). However, de Sousa et al did not find any significant differences in terms of graft survival in patients with and without previous HLA sensitization [8]. There are also many factors that can affect the outcomes of kidney transplantation. One such factor is donor age: older age of the donor can adversely affect immediate graft function and long-term outcomes [46]. In our study, age was not linked with HLA antibody production, probably because recipients over 65 years of age are still uncommon in Romania, but age was associated with graft loss 5 years after kidney transplantation.
Cadaveric donor was another independent factor of the graft loss 5 years after kidney transplantation. Increased recipient age (older than 65 years) or cadaveric donors were also identified as independent risk factors for the development of chronic renal allograft failure in White patients [46,47]. In contrast, age had no effect on 5-year graft survival in a cohort of 627 kidney transplant patients [48].

The immune system has developed strategies for determining whether cells are “self” or “non-self” (foreign) by evaluating

Figure 3. The survival graft rates in patients without preformed anti-human leucocyte antigen (HLA) antibodies.

Table 4. Graft survival rates in patients without preexisting anti-HLA antibodies.

| Survival time (years) | Negative HLA antibodies | Positive de novo HLA antibodies | Overall |
|-----------------------|--------------------------|---------------------------------|---------|
|                       | Survival proportion      | Standard error                  | Survival proportion | Standard error | Survival proportion | Standard error |
| 1                     | 0.989                    | 0.00633                         | 0.958              | 0.0288         | 0.984              | 0.00693        |
| 2                     | 0.971                    | 0.0102                          | 0.896              | 0.0441         | 0.959              | 0.011          |
| 3                     | 0.952                    | 0.0129                          | 0.854              | 0.0509         | 0.938              | 0.0135         |
| 4                     | 0.926                    | 0.0158                          | 0.813              | 0.0563         | 0.909              | 0.016          |
| 5                     | 0.908                    | 0.0175                          | 0.771              | 0.0607         | 0.888              | 0.0177         |

Endpoint: Observed n 25
Expected n 30.9
Observed/Expected 0.8082 2.171

HLA – human leucocyte antigen. The survival proportions for the groups with and without de novo HLA antibodies, as well as the overall survival proportion, are presented at each year from the moment of transplantation.
HLA genes which are extremely polymorphic and differ from one individual to another [36].

HLA proteins play key roles in immune function, including antigen presentation proteins or complement system components [49]. For successful kidney transplantation, HLA markers must be matched between the organ donor and recipient [50]. When the immune system detects foreign antigens, a series of processes involving T cells and B cells occur that can lead to anti HLA antibodies production [51]. The appearance of HLA alloantibodies is attributed to the exposure of the recipient's immune system to foreign HLA molecules in multiple pregnancies, transfusions, or previous transplants. Antibody responses begin with the activation of B cells, with specific immunoglobulin-like surface receptors that bind to epitopes on immunizing antigens [52]. Their interactions with helper T cells result in proliferation, affinity maturation, and immunoglobulin class switching, and eventually, differentiation into antibody-producing plasma cells [53]. The immunogenetic relationship between the antibody producer and the immunizing allele affects the antibody response to a mismatched epitope [54]. Previous research has revealed that antibodies to HLA are linked to poor kidney transplant outcomes [55,56]. However, this does not fully explain why some patients have a functional graft even after 5 years, while others, transplanted

![Figure 4. Survivals rate according to status of human leucocyte antigen (HLA) immunization before kidney transplantation.](image)

| Factor | Negative HLA antibodies | Positive HLA antibodies |
|--------|--------------------------|-------------------------|
| Negative HLA antibodies | –  | 4.0251 |
| Positive HLA antibodies | 0.2484 | 0.09612 to 0.6421 |

HLA – human leukocyte antigen. In the non-HLA previous sensitized group, the estimated relative risk of the event of kidney graft loss occurring in the subgroup with de novo anti-HLA antibodies is 4.0251 greater than in the subgroup with no HLA antibodies.

Table 5. Comparison of survival curves (log-rank test).

| Chi-squared | 8.2623 |
| Degree of freedom | 1 |
| Significance | P=0.004 |

Statistically, the 2 survival curves differ significantly (P<0.05). Thus, development of de novo human leucocyte antigen (HLA) antibodies has a significant influence on survival time of kidney graft.

Table 6. Hazard ratios with 95% confidence interval in patients without preformed anti-HLA antibodies.
under the same conditions, reject the graft. Many transplant centers use desensitization methods, such as plasmapheresis, intravenous immunoglobulin, and bortezomib, to remove anti-HLA antibodies [57], but these efforts have often limited success and are expensive.

The major limitations of our study were the small number of patients and the short follow-up time. As a result, changes in transplant procedures and immunosuppression over time may have led to an overestimation of survival in our study [58]. Other limitations are represented by the kits used to analyze the anti-HLA antibodies that are suitable for identifying the target protein but lack the possibility of quantifying the antibody levels and the mean fluorescence intensity cut-off value, which may differ from values used in other laboratories. However, this is the first report of the association between immunosuppressive therapy and the production of de novo anti-HLA antibodies after transplantation and graft survival in the Romanian population.

Future studies should address the above-mentioned limitations to determine if increasing the number of patients and follow-up time will confirm our findings.

References:

1. Muduma G, Shuso FC, Dam S, et al. Patient survey to identify reasons for non-adherence and elicitation of quality of life concepts associated with immunosuppressant therapy in kidney transplant recipients. Patient Prefer Adherence. 2016;10:27-36
2. Orandi BJ, Luu X, Massie AB, et al. Survival benefit with kidney transplants from HLA-incompatible live donors. N Engl J Med. 2016;374(10):940-50
3. Krishnan N, Abimbola A, Machan N, et al. HLA antibody incompatible renal transplantation: Long-term outcomes similar to deceased donor transplantation. Transplant Direct. 2021;7(8):e732
4. Alelgm T, Ahmed MM, Bobosha K, et al. Kidney transplantation: The challenge of human leukocyte antigen and its therapeutic strategies. J Immunol Res. 2018;2018:596740
5. Claey S, Vermeire K. Immunosuppressive drugs in organ transplantation to prevent allograft rejection: Mode of action and side effects. J Immunol Sci. 2019;3(4):14-21
6. Kalluri HV, Hardinger KL. Current state of renal transplant immunosuppression: Present and future. World J Transplant. 2012;2(4):51-68
7. Zhang R. Donor-specific antibodies in kidney transplant recipients. Clin J Am Soc Nephrol. 2018;13(1):182-92
8. de Sousa MV, González AC, Zoliner RL, Mazzali M. Effect of preformed or de novo anti-HLA antibodies on function and graft survival in kidney transplant recipients. Am Transplant. 2018;18(4):457-66
9. Zecher D, Bach C, Staudner C, Böger CA, et al. Characteristics of donor-specific anti-HLA antibodies and outcome in renal transplant patients treated with a standardized induction regimen. Nephrol Dial Transplant. 2017;32(4):730-37
10. Phillips M, Daga S, Higgins R, et al. Dynamic behaviour of donor specific anti-HLA antibodies in the early period following HLA incompatible kidney transplantation. Transplant Int. 2022;35:10128
11. Yamada C, Ramon DS, Cascalho M, et al. Efficacy of plasmapheresis on donor-specific antibody reduction by HLA specificity in post-kidney transplant recipients. Transfusion. 2015;55(4):727-35; quiz 726
12. Casan IML, Wong I, Northcott MI, Opal S. Anti-CD20 monoclonal antibodies: Reviewing a revolution. Hum Vaccin Immunother. 2018;14(12):2820-41
13. Althaf MM, El Kossi M, Jin JK, Sharma A, Halawa AM. Human leukocyte antigen typing and crossmatch: A comprehensive review. World J Transplant. 2017;7(6):339-48
14. Peacock S, Briggs D, Barnardo M, et al. BSHI/BTS guidance on crossmatch before deceased donor kidney transplantation. Int J Immunogenet. 2022;49(1):22-29
15. William RM, Fiona H, Darren L. Tissue typing, crossmatching and the allocation of deceased donor kidney transplants. In: N Hakim, M Haber, D Maluf, editors. Transplantation Surgery. New York: Springer; 2021:31-50
16. Jamshidian Tehrani N, CeramiZadeh B, Malekhosseini SA, et al. Virtual cross-matching in kidney transplantation, Shiraz experience in development of a web-based program. Int J Organ Transplant Med. 2021;12(2):20-25
17. Faresjo M. A useful guide for analysis of immune mediators in cancer by fluorochrome (Luminex) technique. Methods Mol Biol. 2020;2108:3-13
18. Colombo MB, Haworth SE, Poli F, et al. LumineX technology for anti-HLA antibody screening: evaluation of performance and of impact on laboratory routine. Cytometry B Clin Cytom. 2007;72(6):465-71
19. Pandey P, Pande A, Mishra S, et al. Significance of LumineX-crossover match assay and its mean fluorescence intensity – a retrospective observation in 380 renal transplant cases. Pli Przegl Chir. 2022;94(2):38-48
20. Lachmann N, Todorova K, Schulz H, Schönermann C. LumineX® and its applications for solid organ transplantation, hematopoietic stem cell transplantation, and transfusion. Transfus Med Hemother. 2013;40(3):182-89
21. Glushakova LG, Alto BW, Kim MS, et al. Multiplexed kit based on LumineX technology and achievements in synthetic biology discriminates Zika, chikungunya, and dengue viruses in mosquitoes. BMC Infect Dis. 2019;19(1):418
22. Auger J, Panemangalore R, Yarde M, et al. 384-well multiplexed lumineX cytokine assays for lead optimization. J Biomol Screen. 2016;21(6):548-55
23. Kupcova SH, Vodickova KK, Vodicka P. LumineX® cytokine assay and its mean fluorescence intensity – a retrospective observation in 380 renal transplant cases. Pli Przegl Chir. 2022;94(2):38-48
24. Halloran PF, Reeve JP, Pereira AB, et al. Antibody-mediated rejection, T-cell-mediated rejection, and the injury-repair response: new insights from the Genome Canada studies of kidney transplant biopsies. Kidney Int. 2014;85(2):258-64
25. Talt BD. Detection of HLA antibodies in organ transplant recipients – triumphs and challenges of the solid phase bead assay. Front Immunol. 2016;7:570
