Tolerance induction after organ transplantation, “delayed tolerance,” via the mixed chimerism approach
Planting flowers in a battle field

Yohei Yamada, Gilles Benichou, A. Benedict Cosimi and Tatsuo Kawai*
Massachusetts General Hospital; Transplant Center; Harvard Medical School; Boston, MA USA

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*Correspondence to: Tatsuo Kawai;
Email: tkawai@partners.org

Introduction
Based on our rodent studies on mixed chimerism,1,2 we initially developed a clinically relevant non-myeloablative preparative regimen that permits the induction of mixed chimerism and renal allograft tolerance when combined with simultaneous donor bone marrow transplantation (DBMT) in MHC fully-mismatched cynomolgus monkeys.3-5 This approach has been successfully extended to HLA matched6 or mismatched7 clinical kidney transplantation.

In murine models, the primary mechanism of tolerance induction through mixed chimerism was shown to be via thymic deletion. That is, donor derived dendritic cells (DC) migrate to the recipient thymus, where they induce negative selection of donor reactive T cell clones.1,8 Therefore, induction of stable mixed chimerism appeared to be a prerequisite for stable allograft tolerance through this strategy.1 However, the mixed chimerism induced in primates with our non-myeloablative regimen has always been transient in nature, but nevertheless, essential to induce renal allograft tolerance in this model. This led us to conclude that the mechanisms associated with induction of tolerance in primates include peripheral as well as central thymic deletion pathways.
Our original protocol requires treatment of subjects beginning six days prior to organ transplantation, which limits its applicability to living donor transplant recipients. Therefore, our next major goal has been to develop a strategy that is applicable to deceased donor organ transplantation. We initially evaluated regimens in which conditioning was begun within 24 hours of kidney transplantation (KTx). However, simple compression of the previously effective six-day therapeutic protocol into a 24-hour period failed to induce chimerism and also led to unacceptable toxicity. We thus developed a novel “delayed tolerance” approach, with which the recipient initially undergoes organ transplantation with conventional immunosuppression, followed by conditioning and donor bone marrow transplantation (DBMT) at a later date. This approach would potentially extend the applicability of our regimen to not only current recipients of deceased donor transplantation but also to any recipient of a previously transplanted allograft from either a living or deceased donor, if DBM is available. However, the “delayed tolerance” strategy has the theoretical disadvantage that donor-specific memory T cells (Tmem) might have been elicited despite administration of potent immunosuppressive agents during the interval between transplantation and attempted tolerance induction. Therefore, we have extensively monitored Tmem subsets and alloreactive Tmem responses in these studies.

Memory T Cell Responses Following Kidney Transplantation with Conventional Immunosuppression

Primates including monkeys subjected to these experiments typically exhibit rigorous heterologous Tmem responses even before KTx. In addition to naïve T cell responses, these preexisting Tmem that heterologously respond to alloantigens may further impair induction of chimerism and allograft tolerance. We thus monitored recipient Tmem responses by measuring γIFN or IL-2 production by ELISPOT. Somewhat unexpectedly, the initially high alloreactive Tmem responses appeared to decline after KTx in a time-dependent fashion. As shown in Figure 2, γIFN and IL-2 Tmem responses progressively fell after KTx and became almost undetectable by four months. Since third party Tmem responses were relatively preserved, this was not simply due to the global effects of immunosuppression. Development of such donor-specific Tmem hyporesponsiveness has also been reported in clinical KTx and is speculated to result from the interaction between recipient lymphocytes and tolerogenic graft parenchymal cells. An alternative explanation is memory T cell exhaustion by antigen exposure. The important point is that, if these ELISPOT results truly reflect the in vivo status of Tmem responses, induction of chimerism might be even easier when DBMT is delayed.

The Initial Conditioning Regimen that was Successful for Simultaneous Kidney and DBM Transplantation Failed to Induce Chimerism in the Delayed Tolerance Approach

In the delayed tolerance, recipients initially underwent KTx alone and were treated with conventional immunosuppression (tacrolimus, MMF and steroids). Four months later, the recipients received our standard conditioning regimen (low dose total body irradiation, local thymic irradiation, ATG and anti-CD40L mAb). With this regimen, recipients of simultaneous kidney and DBM transplantation (SKBMT) consistently developed multilineage chimerism and most achieved long-term survival without immunosuppression. In contrast, no recipients conditioned at four months with the same therapeutic regimen developed multilineage chimerism (Fig. 3C) and all rejected their previously well-functioning kidney allografts soon after discontinuation of
immunosuppression (Fig. 1B). Rapid homeostatic recovery of CD8 Tmem was observed (Fig. 3A) following conditioning in these recipients. This homeostatic recovery was faster than that observed in SKBMT (data not shown) leading us to conclude that CD8 Tmems had been insidiously activated by the kidney allograft but that this had not been detectable by ELISPOT monitoring of γIFN and IL-2.

**CD8 Depletion Facilitates the Development of Donor Cell Chimerism**

Since the faster homeostatic recovery of CD8 Tmem seemed to prevent induction of chimerism, we added anti-CD8 mAb to the conditioning regimen. This modified regimen significantly delayed homeostatic recovery of CD8 Tmem (Fig. 3B) and most recipients (11/13) successfully developed mixed chimerism (Fig. 3C). If death from infectious complications is censored, approximately 70% of recipients survived long-term following withdrawal of all immunosuppression (Fig. 1A). These observations suggest that, although not detected by ELISPOT, CD8 Tmem had been activated during the four months following KTx despite the administration of immunosuppression potent enough to prevent rejection of the kidney.

More recently, we have evaluated replacing anti-CD8 mAb in the conditioning regimen with LFA-3/IgG1 (LFA3Ig) antibody. CD8 Tmems had been activated by the kidney allograft but that this had not been detectable by ELISPOT monitoring. CD8 Tmems had been activated by the kidney allograft but that this had not been detectable by ELISPOT monitoring of γIFN and IL-2. LFA3Ig modulates the function of CD2 (+) and depletes efficiently primed CD95 (+) effector Tmem in vivo. This molecule mediates cognate interactions between cells expressing human CD2 and CD16 to activate cells, increase extracellular signal-regulated kinase phosphorylation, upregulate cell surface expression of the activation marker CD25, and induce release of Granzyme B.14-17 Three recipients treated with the modified regimen with LFA3Ig but with no anti-CD8 mAb successfully developed chimerism and achieved long-term survival (manuscript in preparation).

**Inflammation Is Detrimental to Tolerance Induction**

Since our results suggested that Tmem activation occurs after KTx, we speculated that a shorter interval between organ transplantation and DBMT might limit this response and increase the likelihood of inducing allograft tolerance. Therefore, we evaluated DBMT at one month after KTx in an attempt to identify the optimal timing of DBMT. As we anticipated, chimerism induction in recipients who received DBMT earlier after KTx was more successful. All seven recipients who received DBMT at one month developed excellent chimerism (data not shown). The fact that two of 13 recipients who received DBMT at four months failed to develop any detectable chimerism, suggested that Tmem activation might indeed be lower earlier after KTx. However, to our surprise, no recipients of DBMT at one month achieved renal allograft tolerance (Fig. 1C) despite consistently successful induction of chimerism. The state of the inflammatory milieu during the pretransplant period has been shown to impact the molecular phenotype and function of alloreactive T cells.18,19 We therefore hypothesized that higher proinflammatory responses during the earlier post-transplant period adversely affected tolerance induction. RT-PCR analyses of the peripheral blood mononuclear cells revealed that mRNA levels of proinflammatory cytokines in the recipients who received DBMT at one month were significantly higher than those who received DBMT at four months. LUMINEX assay also showed higher IL-6 and IL-17 levels in the one month group. These results suggest that the presence of higher proinflammatory cytokines is detrimental to tolerance induction.
Conclusion

Tolerance induction several months after organ transplantation (delayed tolerance) is feasible via the mixed chimerism approach with additional modifications to mitigate Tmem responses that have been induced by the transplanted allograft. Timing of delayed DBMT also appeared to be critical for successful induction of allograft tolerance, which is affected by higher inflammatory responses during the early post-transplant period.

References


Figure 3. Lymphocyte subset and chimerism induction in the Delayed Protocol. (A) In recipients treated with the conditioning regimen without anti-CD8 mAb, rapid homeostatic recovery of CD8+ Tmem was observed after day 5. CD4+ T cells were not completely deleted with a nadir around 100/mm3. (B) By adding humanized anti-CD8 mAbs to the conditioning regimen, CD8 Tmems were effectively suppressed until day 30. CD4 Tmem levels were even higher after administration of the modified regimen. (C) All recipients who received the delayed protocol at 4 mos without anti-CD8 mAbs (4M) failed to develop chimerism. By adding humanized anti-CD8 mAbs to the conditioning regimen, recipients consistently developed multilineage chimerism despite the presence of residual CD4 Tmem.


