

# News from the TTAC

Meeting February 22, 2018

**Members present:** Marie-Paule Emonds, Blanka Vidan-Jeras, Renate Zunec, Anika Szilvasi, Gottfried Fischer, Nils Lachmann, Bouke Hepkema, Jan de Boer (ET) , Sebastiaan Heidt, Frans Claas

## Relevance B cell crossmatch in the donor center

- Several donor centers perform a B cell crossmatch in parallel with the crossmatch on unseparated cells. A positive B cell crossmatch should not be considered a contra-indication for allocation of the kidney to a patient from another transplant center.
- Reason: many positive B cell crossmatches are due to antibodies not directed against HLA and these are clinically not relevant.
- Therefore the crossmatch result should be reported as **negative** to Eurotransplant in case only the B cell crossmatch is positive.
- You can add a remark that the B cell crossmatch was positive

## The use of CDC for antibody identification

- Since the introduction of luminex based screening assays, some centers (outside ET) have skipped the use of CDC and use only the results of bead based assays for the definition of antibody specificities and unacceptable mismatches .

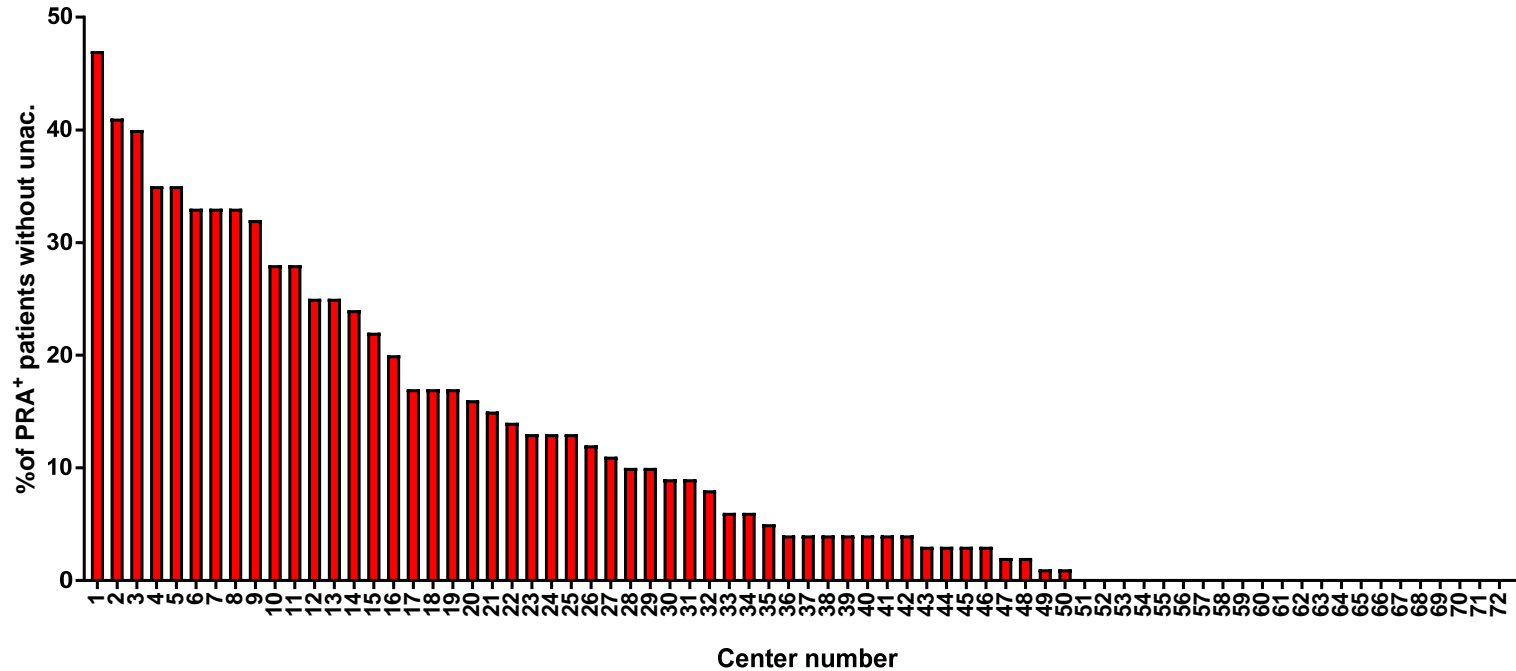
The opinion of the TTAC is that the combination of CDC with luminex is a better tool to define the clinically relevant antibody specificities than only bead based assays and recommends to continue CDC screening next to bead based assays.

## Towards virtual crossmatching

- In the future ET would like to skip shipment of sera and crossmatches in donor centers. This is only possible if the % PRA is replaced by unacceptable mismatches. Furthermore, donor typing must be extended to HLA-DQ-A and HLA-DP-A and –B.
- A recommendation on the introduction of a vPRA rather than % PRA has already been accepted by the board of ET.
- A new recommendation will be made aiming at **extension of the donor typing within ET, which means that future donor typing must include DQ-A and DP.**

## Some statistics from the ETRL

- Sensitized patients (current PRA>5%) without any unacceptables defined



## Some statistics from the ETRL

- Typing completeness for donor organs allocated to AM patients

- HLA-C and HLA-DQ typing

	2016			2017		
	typed	offer	perc.	typed	offer	perc.
C	840	869	97%	620	625	99%
DQ	853	869	98%	615	625	98%

- Serological split typing

	2016		2017	
	typed	perc.	typed	perc.
B15	105	69%	101	86%
B40	96	85%	53	92%
Cw3	180	38%	142	51%
DQ1	493	100%	340	100%
DQ3	406	76%	281	89%

## Replacement of the term vPRA by: ET cRF

- The term virtual PRA (vPRA) is very confusing. It is based on the original use of the term % PRA, reflecting the percentage panel donors reactive in the CDC screening with the serum of the patient.
- The term vPRA reflects the chance that a positive crossmatch will be obtained with a donor from the Eurotransplant donor population.
- In the UK they have introduced the term cRF (calculated reaction frequency).
- Proposal: in order to define that the calculated frequency is based on the donor population of ET, the TTAC proposes to use the term **ET cRF**

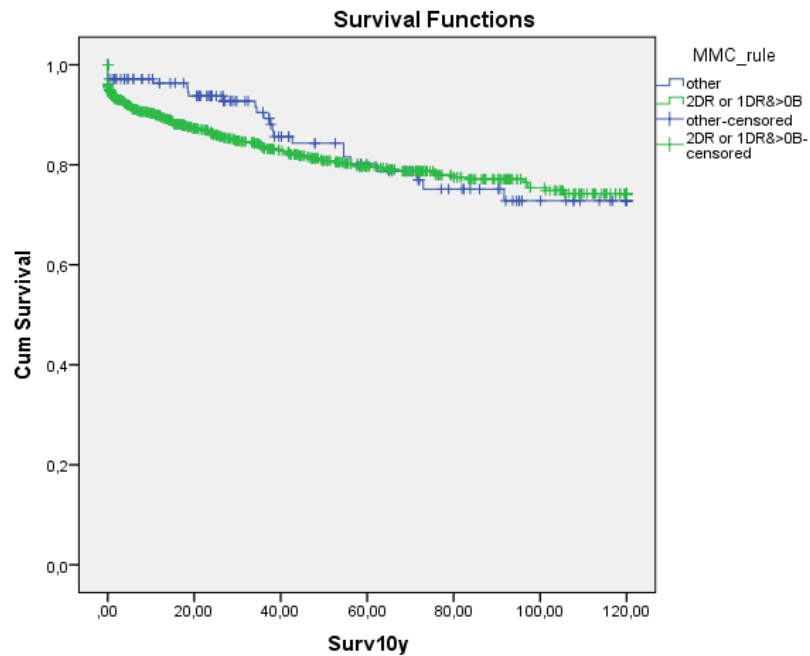
## Minimal match criteria for AM patients

- Currently minimal match criteria apply for patients included in the AM program: at least 2 DR or 1DR+ 1 B match is required. Only for patients with a lower chance than 0.1% to be transplanted with a donor from ET , the minimal match criteria are not applied.
- Consequence, many offers will not be granted because of the minimal match criteria (>400 in the last 2 years). However, a recent analysis does not show any influence of the minimal match on graft survival.



## Effect of 2 HLA-DR or 1 HLA-B + 1 HLA-DR match

- No survival benefit of patients transplanted with minimal match criteria



MMC: N=832

No MMC: N=141

2016/2017

Number of AM advices given: 1293

Number of patients with negative  
advice based on MMC: **417**

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- **Proposal TTAC: skip the minimal match criteria and evaluate the effect of this new policy after 2 years.**