Autoimmune and Alloimmune Phenomena in Patients With Aplastic Anemia: Cytotoxicity Against Autologous Lymphocytes and Lymphocytes From HLA Identical Siblings

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We have studied peripheral blood lymphocytes of 117 patients with severe aplastic anemia and 237 healthy individuals for reactivity against autologous lymphocytes and/or lymphocytes from HLA-identical siblings using a 51Cr release assay. Lymphocytes from 29% of the patients exhibited reactivity against their own lymphocytes, while only 3% of lymphocytes from normal individuals showed such reactivity. Lymphocytes from 49% of the patients showed reactivity against lymphocytes from their HLA-identical siblings compared to 4% of normal individuals. Correlation existed between allogeneic and autologous reactivities ($p < 0.001$), suggesting a common pathway for cytotoxicity. Both reactivities showed an association with extremely low granulocyte counts ($p < 0.01$) and an inability of the patient’s mononuclear cells to stimulate in allogeneic mixed leukocyte culture ($p < 0.05$) as well as an inverse correlation with time from diagnosis ($p < 0.001$). At least two explanations exist for the transfusion-independent autologous and allogeneic cytotoxicities: (1) they could be epiphenomena secondary to the stem cell defect, such as the loss of a cell that suppresses (or regulates) naturally occurring cytotoxic cells, or (2) they may be involved in the cause of the disease.

Materials and Methods

This study included 117 patients with severe AA.

We have previously reported studies using the chromium release assay of lymphocyte-mediated cytotoxicity (LMC) to detect transfusion-related alloimmunization of lymphocytes from patients with severe aplastic anemia (AA).

In the course of these studies, we noted that lymphocytes from some patients were autototoxic, a phenomenon rarely seen with lymphocytes from normal individuals. Subsequently, with lymphocytes of recently diagnosed patients, we have observed an increased frequency of cytotoxicity against autologous lymphocytes. Further, lymphocytes of some patients who had never been transfused have also shown reactivity against lymphocytes of HLA-identical siblings. These observations, which will be described in this article, indicate an alteration in immunity that may be secondary to the disease process or may play a role in the etiology of the disease.

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RESULTS

Autoreactivity

Lymphocytes from 33 of 113 patients reacted against autologous lymphocytes (Fig. 1 and Table 1). Autoreactivity was found mainly with lymphocytes from patients with idiopathic aplastic anemia and with those from patients in whom the disease was thought to be due to drugs or chemicals. In contrast, lymphocytes from only 4 of 123 normal individuals had autologous reactivity of 3.5% $^{51}$Cr or greater ($p < 0.001$).

Alloreactivity

Lymphocytes from 56 of 114 patients reacted against lymphocytes from HLA-identical siblings (Fig. 2). The mean percent $^{51}$Cr release from lymphocytes of all 114 patients was 5.5% with a range of $-6.9$–28.2%. The mean percent $^{51}$Cr release of the positive assays (i.e., > 3.5%) was 10.7. Seventeen of the 114 patients were untransfused. The mean percent $^{51}$Cr release from their lymphocytes was 8.8% with a range of $-3.8$–28.2%. Ten of the 17 had reactive lymphocytes with mean $^{51}$Cr release of 13.8%. In contrast to findings with the aplastic patients, lymphocytes from only 5 of the 114 normal siblings had significant cytotoxicity against lymphocytes of the patients.

Because of the limitations in lymphocyte numbers and the fact that the patients underwent marrow transplantation soon after admission, only a few additional studies were carried out. The results of one

Table 1. Autologous Cytotoxicity of Lymphocytes of Patients With Aplastic Anemia

<table>
<thead>
<tr>
<th>Individuals Studied</th>
<th>Suspected Cause of Aplasia</th>
<th>No. of Individuals Assayed</th>
<th>No. With Positive Assay</th>
<th>Mean Percent Release (Range) of All Assays</th>
<th>Mean Percent Release (Range) of Positive Assays</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with aplastic anemia</td>
<td>Unknown</td>
<td>85</td>
<td>27</td>
<td>2.2 (4.8–19.0)</td>
<td>7.0 (3.6–19.0)</td>
<td>$p &lt; 0.001^*$</td>
</tr>
<tr>
<td></td>
<td>Drugs or chemicals</td>
<td>18</td>
<td>5</td>
<td>2.2 (3.0–14.9)</td>
<td>7.2 (4.4–14.9)</td>
<td>$p &lt; 0.001^*$</td>
</tr>
<tr>
<td></td>
<td>Hepatitis</td>
<td>7</td>
<td>1</td>
<td>0.9 (4.2–9.8)</td>
<td>9.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fanconi</td>
<td>3</td>
<td>0</td>
<td>0.2 (0.7–1.1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal HLA-identical siblings</td>
<td></td>
<td>93</td>
<td>3</td>
<td>$-0.3$ (9.8–13.1)</td>
<td>8.2 (4.7–13.1)</td>
<td></td>
</tr>
<tr>
<td>Normal unrelated controls</td>
<td></td>
<td>30</td>
<td>1</td>
<td>$-0.4$ (4.6–7.0)</td>
<td>7.0</td>
<td></td>
</tr>
</tbody>
</table>

*Difference between percent release from patient lymphocytes as compared to that from lymphocytes from normal individuals (two-sided Mann-Whitney U test).
Correlation Between Autoreactivity and Alloreactivity

Correlation existed between autoreactivity and alloreactivity \((p < 0.001)\). Lymphocytes from 27 patients were reactive against both autologous and sibling lymphocytes and those from 52 were negative against both. Lymphocytes from 4 patients were reactive against autologous lymphocytes only, and those from 27 were reactive against sibling lymphocytes only.

LMC Reactivity and Time From Diagnosis

The median time from diagnosis to study for patients with lymphocyte reactivity was 1 mo as compared to 3 mo for patients with lymphocytes lacking reactivity \((p < 0.01)\). The median time from diagnosis for patients with lymphocyte reactivity against autologous lymphocytes was 0.75 mo as compared to 2.5 mo for patients without autologous lymphocyte reactivity \((p < 0.001)\). For 10 transfused patients with lymphocyte reactivity against autologous lymphocytes or lymphocytes of allogeneic siblings, the median time from diagnosis was 0.6 mo as compared to 1.0 mo in 7 transfused patients without lymphocyte reactivity (no significant difference, \(p < 0.3\)).

Reactivity of the patient’s lymphocytes at specific times following diagnosis was also analyzed. Mean percent \(^{51}\text{Cr}\) releases and standard deviations, calculated from the reactivity of each patient’s lymphocytes against either autologous or allogeneic sibling lymphocytes (whichever was greater), are illustrated in Fig. 4. A significant inverse correlation between LMC reactivity and time from diagnosis was found \((p < 0.001\) by coefficient of correlation).

The data illustrated in Fig. 4 are a reflection of the average magnitude of \(^{51}\text{Cr}\) release at various times after diagnosis. In Fig. 5, the frequency of reactivity against autologous lymphocytes at the various times is illustrated. A significant inverse correlation with time from diagnosis was found with this analysis.
Similarly, lymphocytes from 24 of 33 (73%) patients studied within 1 mo of diagnosis had reactivity against HLA-identical sibling lymphocytes compared to those from 32 of 81 (39%) patients studied 1 mo or later ($p < 0.001$).

**LMC Reactivity and Ability to Stimulate in MLC (Table 3)**

We have previously reported that cells from 28 of 53 (40%) patients with severe AA showed impaired ability to stimulate lymphocytes from unrelated individuals in MLC. Of the patients in this report, 4 were among the 53 patients previously tested in MLC for the ability of their cells to stimulate. Furthermore, reactivity in autologous lymphocytes (LMCR) correlated inversely with ability to stimulate in MLC for 110 patients (65%) of the additional patients in this report failed to stimulate allogeneic cells at a level of at least 50% of that of their HLA-identical siblings.

An inverse correlation was found between ability to stimulate and LMC reactivity (Table 3). Lymphocytes from only 7 of 33 (21%) patients with autologous reactivity could stimulate, while those from 31 of 80 (39%) of patients without autologous reactivity could stimulate ($p < 0.05$). Lymphocytes from only 9 of 56 (19%) patients with allogeneic reactivity could stimulate.

**Table 3. Patient Characteristics and LMC of Autologous Lymphocytes and Those From HLA-Identical Siblings**

<table>
<thead>
<tr>
<th>Patient Characteristics</th>
<th>Positive (10)</th>
<th>Negative (7)</th>
<th>$p$ if Significant</th>
<th>Positive (33)</th>
<th>Negative (80)</th>
<th>$p$ if Significant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to stimulate in MLC*</td>
<td>2</td>
<td>4</td>
<td>7</td>
<td>31</td>
<td>&lt;0.05†</td>
<td></td>
</tr>
<tr>
<td>Sex of patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
<td>5</td>
<td>20</td>
<td>47</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>6</td>
<td>2</td>
<td>14</td>
<td>35</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (median yr)</td>
<td>17</td>
<td>15</td>
<td>16</td>
<td>19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood cell values (median/cu mm)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total WBC</td>
<td>2,100</td>
<td>2,700</td>
<td>&lt;0.1‡</td>
<td>1,600</td>
<td>2,100</td>
<td>&lt;0.01‡</td>
</tr>
<tr>
<td>Granulocytes</td>
<td>150</td>
<td>700</td>
<td></td>
<td>100</td>
<td>250</td>
<td></td>
</tr>
<tr>
<td>Platelets</td>
<td>13,000</td>
<td>10,600</td>
<td>20,500</td>
<td>14,300</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymphocytes</td>
<td>1,900</td>
<td>1,800</td>
<td>1,400</td>
<td>1,700</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCT (mean %)</td>
<td>20</td>
<td>22</td>
<td>25.5</td>
<td>24.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of patients with infection at admission</td>
<td>30</td>
<td>29</td>
<td>26</td>
<td>34</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of patients with history of</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Androgen treatment</td>
<td>30</td>
<td>57</td>
<td>45</td>
<td>62</td>
<td>&lt;0.05</td>
<td></td>
</tr>
<tr>
<td>Prednisone treatment</td>
<td>80</td>
<td>57</td>
<td>67</td>
<td>57</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection</td>
<td>10</td>
<td>0</td>
<td>45</td>
<td>52</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Ability of lymphocytes from patients with AA to stimulate lymphocytes of healthy unrelated individuals when tested in mixed leukocyte culture: patients whose lymphocytes were able to stimulate at a level of at least 50% of that of their HLA-identical siblings.

†Chi-square analysis.

‡Mann-Whitney U test.
late as compared to those from 30 of 58 (52%) of patients without allogeneic reactivity \( (p < 0.001) \). However, lymphocytes from 2 of 10 (20%) untransfused patients with reactivity could stimulate, which is not significantly different from the 4 of 7 (57%) untransfused patients without lymphocyte reactivity whose lymphocytes could stimulate.

**Correlation of LMC Reactivity With Clinical Features**

A number of patient characteristics was studied for possible association with LMC reactivity (Table 3). Only autologous and allogeneic tests of untransfused patients were considered in these analyses to eliminate any influence of sensitization due to preceding blood transfusions. Granulocyte numbers were significantly lower in patients with autoreactive lymphocytes than in those without \( (p < 0.01) \) and were also significantly lower in untransfused patients who had allorreactive lymphocytes \( (p < 0.1) \). However, granulocyte numbers were extremely low in all of these patients. The percentage of patients who had received androgens prior to study was significantly lower in those who had autoreactivity than in those who did not \( (p < 0.05) \).

None of the other patient characteristics in Table 3 was associated with LMC reactivity. HLA-A and B antigens and ABO types of the patients were also studied for correlations with LMC, and no association was found (data not shown).

**DISCUSSION**

Lymphocytes from approximately one-third of the 117 patients in the present study were reactive in LMC against autologous lymphocytes compared to lymphocytes from 3% of 123 healthy individuals. Similarly, lymphocytes from half of the 117 patients showed cytotoxicity to lymphocytes from their healthy HLA-identical siblings, a phenomenon observed with lymphocytes from only 4% of 114 healthy individuals. This indicates an alteration in immunity in one-third to one-half of lymphocytes of patients with AA that is only rarely seen with lymphocytes of healthy individuals. Autologous and allogeneic reactivities were concordant on a statistical basis, though approximately one-third of the patients had lymphocytes reactive in one assay and not the other. This suggests a common pathway for cytotoxicity in many instances. Further support for a common cause for autologous and allogeneic lymphocyte reactivities is provided by the fact that both showed an association with extremely low granulocyte counts and an inability of the cells to stimulate in MLC as well as an inverse correlation with time from diagnosis. Transfusion-induced sensitization to non-HLA antigens may have been responsible for some of the allogeneic reactivity, as suggested by the observation that lymphocyte reactivity to cells from the HLA-identical marrow donor and marrow graft rejection were correlated in patients studied more than 1 mo after diagnosis. The current data fail to show an apparent correlation between a history of preceding transfusions and alloreactivity in the LMC assay. Lymphocytes from 56% of untransfused and 47% of transfused patients were reactive in this assay. It must be pointed out that lymphocytes from most untransfused patients in the present study were tested for LMC reactivity within 1 mo of diagnosis, while those of most transfused patients were tested beyond 1 mo of diagnosis. More transfused and untransfused patients need to be studied at comparable time intervals after diagnosis to determine the contribution of transfusions to the alloreactivity in the LMC assay. The effect of transfusions cannot explain the autologous reactivity by lymphocytes from transfused patients nor both autologous and allogeneic reactivities by lymphocytes from untransfused patients. Clearly, other explanations must be sought.

One explanation is that autologous and allogeneic reactivity could be epiphenomena secondary to the stem cell defect of AA. The lack of stem cells would lead not only to reduced or absent production of granulocytes, platelets, and red blood cells but also of mononuclear blood cells. The rates of their disappearance from the peripheral blood would be a function of their natural lifespans. Early in the course of AA, there might be disappearance of mononuclear subpopulation(s) suppressing (or regulating) naturally occurring cytotoxic cells. Monocytes can function as suppressor cells and are also known to be efficient stimulators in MLC. The lack of suppression would lead to the observed cytotoxicity against autologous mononuclear cells and those of the HLA-identical siblings. The nature of the target cell is unknown. The finding of cytotoxicity against lymphocytes from the HLA-identical sibling in the absence of autologous cytotoxicity can perhaps be explained by disappearance of the target cell population from the blood of some patients with AA. As time after diagnosis increases, the incidence and magnitude of autologous and/or allogeneic cytotoxicities decreases, which, according to this hypothesis, would most likely to due to a gradual disappearance of the effector cell population from the circulation as well. The naturally occurring cytotoxicity is not due to natural killer (NK) reactivity, since 26 patients of the present study were tested for NK activity, and no correlation with autocytotoxicity was found.

Another explanation for our findings is that the autoimmune and alloimmune phenomena in some
In recent years, several in vitro studies have provided evidence that some cases of AA may be mediated by immunologic mechanisms. Following the original report by Kagan et al.,\(^8\) several laboratories have reported that lymphocytes from patients with severe AA are capable of inhibiting both committed granulocytic (CFU-C) and erythroid (CFU-E) stem cell growth.\(^9\)-\(^11\) However, a study by Singer et al. showed that lymphocytes from multiply transfused patients tested against cells from unrelated individuals were probably reactive against histocompatibility differences related to sensitization by transfusion rather than to the etiology of the disease.\(^12\) Inhibition of CFU-E formation by mononuclear cells “sensitized” by transfusion was also demonstrated in studies involving health DLA-identical canine littermates.\(^23\) However, Singer et al. subsequently studied 16 untransfused patients and found that three possessed lymphocytes that significantly inhibited CFU-C growth of marrow from HLAmatched siblings.\(^24\) Ascensao et al.,\(^9\) in a study of the patient described by Kagan et al.,\(^8\) found that CFU-C growth of the patient’s marrow was described by the addition of antithymocyte globulin, suggesting that T cells might be involved. Torok-Storb et al. have recently found that erythroid colony growth (BFU-E) from peripheral blood cells of 6 of 34 patients with aplastic anemia failed to grow until T cells from the patients had been removed.\(^25\) Moreover, growth of the colonies was inhibited when T cells from the patients were added back to the culture. These data suggest that an immune mechanism may play a role in the pathogenesis of AA in a small proportion of the patients.

Evidence from in vivo observations also suggest that some cases of AA may be mediated by an immunologic mechanism. Patients with severe AA given a simple infusion of marrow from a monozygous twin usually recover, suggesting that the disease is due to a stem cell defect caused by a toxic mechanism no longer present in the patient.\(^26\) However, several patients have now been observed who did not recover after a simple infusion of marrow from a monozygous twin but did recover following immunosuppressive condition with large doses of cyclophosphamide and a second infusion of marrow from the twin.\(^27\)-\(^28\) Further, a number of patients have now been observed to recover function of their own marrow following immunosuppressive therapy either with or without an infusion of allogeneic marrow.\(^29\)-\(^34\) Finally, it has been known for a long time that a small fraction, perhaps 10%, of patients will undergo a “spontaneous” remission after a few weeks or months. Evidently, in these patients, the pathogenetic mechanism must have been transient. Perhaps an immunogenic stimulus, which might have been the patients’ own stem cells with a viral or chemical hapten, disappeared so that the immunologic reaction faded away. If enough normal stem cells escaped the immunologic assault, recovery could then ensue.

The data presented here indicate a cytotoxic reaction, which was most evident soon after diagnosis and progressively less evident thereafter. A transient cytotoxic insult of this type would help to explain some of the contradictory information cited above. There is an obvious need for study of more patients at the time of onset of the disease. Unfortunately, symptoms do not usually develop until extensive marrow damage has occurred. Physicians should be particularly alert for those patients who do seek medical help early in the course of the disease so that appropriate studies can be carried out before transfusions have to be given.

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