AST T3 Webinar 'An Update on Current Concepts in Donor Specific Antibody Testing'
Additional Q&A

Speaker: Peter Nickerson, MD, FRCPC, FCAHS • University of Manitoba
Moderator: Leo Riella, MD, PhD • Harvard Medical School

1. **Q: Do you have a reference/published data from CTR of virtual crossmatch predicting negative flow xm @98.6%? If so, could you email me at tumer004@umn.edu Thank you. Gizem Tumer**

   A: Sorry we have not published yet

2. **Q: What is your opinion about the role of preemptive PE + IVIG on the fisrts week post-transplant?**

   A: In our program if we are going to cross any level of DSA we will use IVIG and add PE if higher levels (e.g. FCXM positive). All such patients receive Thymo, FK, MMF, Pred.

3. **Q: How about the other possibility that we are dealing with atypical TCMR that attacks the microcirculation. We also know that neither of ptc, g, or cg is highly specific or sensitive for AMR and any injury to the endothelium including cytotoxicity can also cause this?**

   A: Yes, as was mentioned it is also possible that microcirculation inflammation in the absence of a detectable HLA DSA is related to a TCMR. One should also consider non-HLA antibodies (eg. MICA Ab, AT1R Ab, anti-endothelial, etc.)

4. **Q: What is your take on the subset of patients pre transplant that are flow cross match negative, DSA positive (EDTA treated and prozone effect removed) - would you still recommend PE/IVIG or can they undergo standard transplant with induction with anti-thymocyte globulin, tac/cellcept/pred maintenance and close DSA monitoring and follow up post-transplant?**

   A: This comes down to center specific practices. If there is a definite DSA present with a negative FCXM, our program typically uses IVIG alone. Whether this is required or not has never been evaluated in an RCT.

5. **Q: is there any data regarding cross reactivity of IVIG given as desensitization altering DSA**

   A: Yes, high dose IVIG can interfere with the assay so this must be taken into account.

6. **Q: Is there any level of DSA that you don't do desensitization?**

   A: This is program specific and requires adequate lab and system support (e.g. HLA lab, histopathology, and PE availability). In our own program, with Canada having a Kidney Paired Donation Program and a Highly Sensitized Kidney Sharing Program, the need to cross DSA has diminished greatly. If we are going to cross a DSA we will not cross a CDC positive DSA.