Sarem Journal of Medical Research. Volume 9, Issue 1, Spring 2024: 1- 3

What Should We Do with Negative WBC Cross match after Lymphocyte Therapy?

ARTICLE INFO

Article Type

Editorial letter

Authors

AboTaleb Saremi[1,2 *]

1- Sarem Gynecology, Obstetrics and Infertility Research Center, Sarem Women's Hospital, Iran University of Medical Science (IUMS), Tehran, Iran.
2- Sarem Cell Research Center (SCRC), Sarem Women's Hospital, Tehran, Iran.

Corresponding Authors:
AboTaleb Saremi; Sarem Fertility & Infertility Research Center (SAFIR), Sarem Women's Hospital, Iran University of Medical Sciences (IUMS), Tehran, Iran.
Address: Sarem Women Hospital, Basij Square, Phase 3, Ekbatan Town, Tehran, Iran. Postal code: 1396956111, Phone: +98 (21) 44670888, Fax: +98 (21) 44670432.

Received: 21 April 2024
Accepted: 19 May 2024
e Published: 04 December 2024

Article History

Editorial

Introduction: Cross matching is a way for your healthcare provider to test your blood against a donor's blood to make sure they are fully compatible. It's essentially a trial transfusion done in test tubes to see exactly how your blood will react with potential donor blood. Blood from the donor and recipient are mixed. If the recipient's cells attack and kill the donor cells, the cross match is considered positive. This means the recipient has antibodies "against" the donor's cells. If the cross match is negative, the pair is considered compatible. Certainly! Let's delve deeper into the implications and management considerations when dealing with a negative WBC cross match after lymphocyte therapy in the context of transplantation.

[Downloaded from saremjrm.com on 2026-11-18]

[DOI: 10.66224/sjrm.9.1.1]

Understanding a Negative WBC Cross match

A negative WBC crosshatch signifies that the recipient's serum does not contain detectable antibodies against the donor's white blood cells (WBCs), specifically lymphocytes in this case. This result is crucial in the context of transplantation because it suggests a reduced risk of antibody-mediated rejection due to pre-existing antibodies against donor antigens.

Implications for Transplantation Management

1. Risk Assessment and Planning

• Lower Risk of Antibody-Mediated Rejection (AMR): A negative WBC cross match generally indicates a lower risk of AMR, particularly hyper acute or acute AMR, which can be triggered by pre-formed antibodies against donor antigens.

• Decision to Proceed with Transplantation: A negative cross match is reassuring and supports the decision to proceed with transplantation, as it suggests that the lymphocyte therapy has effectively reduced or eliminated pre-existing sensitization.

2. Post-Transplant Monitoring

• Vigilant Observation: Despite a negative cross match, close monitoring post-transplant is essential. This includes monitoring for signs of rejection (both cellular and antibody-mediated), graft function, and overall patient well-being.

• Routine Assessments: Regular assessments of renal function (in the case of kidney transplantation), immunosuppressive drug levels, and surveillance biopsies may be indicated depending on clinical protocols.

3. Immunosuppressive Therapy

• Tailoring Therapy: The immunosuppressive regimen may be adjusted based on the cross match results and other immunological assessments. While a negative cross match reduces the immediate concern for AMR, maintenance immunosuppression remains crucial to prevent cellular rejection and long-term graft loss.

• Balancing Risk: The goal is to achieve adequate immunosuppression to prevent rejection while minimizing the risk of infection and drug-related complications.

4. Long-term Considerations

• Development of De Novo Antibodies: Despite a negative pre-transplant cross match, patients can develop de novo antibodies post-transplant. Long-term monitoring for the development of new antibodies and their impact on graft survival is necessary.

• Patient Education and Follow-up: Patients should be educated about the signs and symptoms of rejection and the importance of adhering to their immunosuppressive regimen. Regular follow-up appointments are crucial to assess graft function and overall health.

Managing a negative WBC (white blood cell) cross match after lymphocyte therapy in pregnant women involves careful consideration of both maternal and fetal well-being, as well as the implications for the transplant itself. Here's a detailed approach based on clinical guidelines and considerations:

1. Monitoring and Follow-Up

• Maternal Monitoring: Regular monitoring of maternal health is crucial to assess transplant function, immunosuppressive therapy efficacy, and overall well-being. This includes assessing renal function (in case of kidney transplant) and managing immunosuppressive medications to maintain stable graft function without compromising maternal health. Therefore, continual assessment of maternal health, including renal function (if relevant to the transplant type), blood pressure, and overall well-being, is essential. Regular follow-up appointments should be scheduled to monitor for signs of rejection or complications related to pregnancy and transplantation.

• Fetal Monitoring: Close fetal monitoring through regular ultrasound examinations and fetal growth assessments is essential to detect any potential adverse effects related to the transplant or immunosuppressive therapy. Consultation with maternal-fetal medicine specialists may be necessary to optimize fetal outcomes. Also, Collaboration with obstetricians for regular fetal monitoring (e.g., ultrasound scans, fetal heart rate monitoring) is crucial to assess fetal growth, development, and well-being throughout pregnancy.

2. Immunosuppressive Management

• Immunosuppression Adjustment: The immunosuppressive regimen should be tailored to balance the need for graft acceptance and maternal health with fetal safety. Drugs such as corticosteroids, calcineurin inhibitors (e.g., tacrolimus, cyclosporine), and antimetabolites (e.g., azathioprine, mycophenolate mofetil) may be used, with careful consideration of their teratogenic potential and impact on pregnancy outcomes. The immunosuppressive regimen should be tailored to maintain adequate suppression of the maternal immune response to prevent rejection while considering fetal safety. This often involves adjusting medication dosages and monitoring drug levels closely to balance efficacy with minimizing potential fetal risks.

• Drug Levels Monitoring: Regular monitoring of immunosuppressive drug levels is essential to maintain therapeutic concentrations while minimizing potential fetal exposure and toxicity. Use of immunosuppressive agents with favorable safety profiles during pregnancy, such as calcineurin

[Downloaded from saremjrm.com on 2026-11-18]

[DOI: 10.66224/sjm.9.1.1]

inhibitors (e.g., tacrolimus), is preferred. Avoidance of medications with known teratogenic effects is crucial.

3. Cross match Monitoring

• Interpretation of Negative Cross match: A negative WBC cross match indicates a lower risk of antibody-mediated rejection due to pre-existing antibodies against the donor's lymphocytes. This is generally favorable for maternal outcomes but does not eliminate the need for ongoing monitoring.

4. Antenatal Care

• Multi-disciplinary Approach: Collaborate closely with obstetricians, transplant specialists, neonatologists, and other relevant specialists to ensure comprehensive care and management throughout pregnancy.
• Educational Support: Provide thorough education to the patient regarding the potential risks and benefits of immunosuppressive therapy during pregnancy, emphasizing the importance of adherence to medical recommendations and scheduled follow-up appointments.

5. Delivery Planning

• Delivery Timing: Discuss delivery planning with obstetricians and transplant specialists to optimize maternal and fetal outcomes. Timing of delivery should consider both gestational age and maternal health status, aiming for the optimal balance between fetal maturity and transplant stability. Delivery planning should involve a multidisciplinary team including transplant specialists, obstetricians, neonatologists, and anesthesiologists. The timing and mode of delivery should be based on both maternal and fetal indications, taking into account the stability of the maternal transplant and fetal well-being.
• Perioperative Management: Plan for perioperative management that considers the effects of anesthesia, potential impact on graft function, and ongoing immunosuppressive therapy adjustments as needed. Close monitoring postpartum is crucial to manage any potential changes in immunosuppressive needs and to assess the impact of pregnancy on graft function.

6. Postpartum Care

• Resumption of Pre-Pregnancy Therapy: After delivery, adjust immunosuppressive therapy as necessary to pre-pregnancy levels to maintain graft stability while considering breastfeeding compatibility and postpartum recovery.
• Long-term Follow-Up: Schedule regular follow-up appointments to monitor maternal health, graft function, and immunosuppressive therapy requirements postpartum. Regular long-term follow-up of both maternal graft function and maternal health is essential to monitor for late complications of transplantation and to optimize long-term outcomes.

For detailed guidance and evidence-based management strategies in pregnant transplant recipients, the following resources are recommended:

• Saremi AT, Sanaye Naderi M, Pooladi A, Younesi B, Lashgari P, Zare A. Evaluations of WBC Cross-match Results after Lymphocyte Immunization in Women with Recurrent Spontaneous Abortion in Sarem Women's Hospital. Sarem Journal of Medical research. 2017 Dec 10;2(4):19-23.
• **Clinical Transplantation:** Principles and Practice by Abhinav Humar, Mark L. Sturdevant, David A. Axelrod, and Arthur J. Matas.
• **Kidney Transplantation - Principles** and Practice edited by Stuart J. Knechtle, Lorna P. Marson, and Peter J. Morris.
• **American Journal of Transplantation:** Articles on transplantation immunology, outcomes, and management strategies.
• **"Pregnancy in Solid Organ Transplant Recipients"** in UpToDate, which provides comprehensive reviews on immunosuppressive therapy during pregnancy and management strategies for maternal and fetal health.
• **Clinical Transplantation:** Principles and Practice by Abhinav Humar, Mark L. Sturdevant, David A. Axelrod, and Arthur J. Matas. This textbook covers various aspects of transplantation management, including considerations in special populations such as pregnant women.
• **Kidney Transplantation - Principles** and Practice edited by Stuart J. Knechtle, Lorna P. Marson, and Peter J. Morris. This book includes chapters on pregnancy in kidney transplant recipients and immunosuppressive strategies.
• **American Journal of Transplantation:** Articles on transplantation in pregnancy, immunology, and outcomes in special populations.

These resources provide in-depth guidance on the interpretation of crosshatch results, immunosuppressive strategies, and long-term management of transplant recipients. For specific protocols and guidelines, consulting institutional protocols and expert consensus statements is recommended. By adhering to these principles and guidelines, healthcare providers can optimize outcomes for both the mother with a transplant and her developing fetus, ensuring comprehensive care throughout pregnancy and beyond. Always consult institutional protocols and guidelines specific to your clinical setting for the most appropriate management strategies.

[Downloaded from saremjrm.com on 2026-11-18]

[DOI: 10.66224/sjm.9.1.1]