

## DISCUSSION

LECLERC-CHALVET (Lyons): Dr. Dubernard told us about the antilymphocyte serum. As this serum comes from our Institute, I would very much like to add something. The serum, as such, is not used any more but the globulin, in order to prevent an overloading with foreign protein. But something which did not come out in this lecture or in the paper of Dr. Traeger is that the antilymphocyte globulin still today constitutes a danger which until now could not be overcome. At the same time that the antilymphocyte titre mounts, we find a haemagglutinating titre which can be got rid of only by agglutinating with a sevenfold amount of human erythrocyte, and we found lately the statistical danger of infective hepatitis is very real. Different steps are being taken, but today the use of antilymphocyte serum is a calculated risk, and I would very much like to ask Dr. Fries what experiences he has in this particular respect.

FRIES (Lyons): Le problème de la toxicité des globulines antilymphocytaires doit être discuté au cours de la table ronde; cependant, dans notre expérience nous n'avons observé ni toxicité hématologique ou hépatique, ni aucune complication virale.

VAN ROOD (Leyden): Three questions: the first one to Dr. Viñas. I did not quite get your arguments for putting in the kidney while you knew antibodies were in the recipient, which reacted with the leucocytes of the donor. There is quite good evidence that in such cases you can see the picture you have described to us, and I wonder if you could again give us the reason why, in the presence of these antibodies, you put this kidney in.

On the interesting work on the dog antilymphocyte serum presented by Dr. Dubernard, I must say I perhaps missed the point, but if you do skin grafts to assess the effectiveness of the antilymphocyte serum, could you give us some details on that point?

Finally, on the paper of Dr. Fries, I was of course very interested in all of your data and especially in the leucocyte-group data, but I would like again to stress here that it is impermissible to pool, as I think you have done, data from related and unrelated people.

VIÑAS (Barcelona): As we said in the paper, we had only one donor. Furthermore, there are some cases of persisting antibodies in whom afterwards there was no reaction against the graft.

VAN ROOD (Leyden): Is there literature for that?

VIÑAS (Barcelona): Yes. I have a personal communication from Terasaki, that they have made a transplant in the Denver unit to another patient in the same condition, with a very good result.

DUBERNARD (Lyons): In previous experiments, the ALS we used was demonstrated to be very effective to prolong the survival of renal (Dr. Pichlmayr) and hepatic (Dr. Mikaeloff) allografts.

FRIES (Lyons): Je suis entièrement d'accord avec le Dr. Van Rood pour reconnaître que le terme compatibilité a une signification bien différente selon qu'il s'agit de sujets apparentés ou non; nous avons simplement voulu exprimer nos résultats d'une manière comparable à celle utilisée par Rapaport, de façon à mieux étudier l'effet du sérum antilymphocyte en comparaison avec les résultats des transplantations effectuées sans sérum antilymphocyte.

UNIDENTIFIED MEMBER: Coming back to the paper by Dr. Viñas, he suggested several possible

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ways of treating the hyperacute rejection. However, I think that this condition should not be treated but, as implied by Dr. Van Rood, avoided. This can be done by having all prospective recipients investigated for circulating antibodies against leucocytes, and if such are present, to have them tested against the prospective donor.

DUBERNARD (Lyons): In relation with Dr. Viñas' paper, I would like to show 3 slides demonstrating that humoral factors may be involved in allograft rejection even when antibodies are not present prior to transplantation. In these experiments, recipients were immunized with renal allograft. The graft was removed from the recipients 7 days after transplantation (their own kidneys left in place). Serum was collected from these recipients 15–21 days post-transplantation (7 or 14 days after removal of the graft) and was reinjected directly into the renal artery of the original donor. Lymphocytotoxic antibodies and haemagglutinins were appearing in the serum after removal of the graft. Renal functional troubles were seen in every case, and they could be moderate or acute. Pathological aspects varied from acute necrosis similar to those shown by Dr. Viñas to mononuclear cell infiltrate as in typical rejection.