

GRWR Correlates with the Metabolism of Tacrolimus After Pediatric Living Donor Liver Transplantation According to Donor CYP3A5 Polymorphism

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Abstract

Objectives: Tacrolimus is characterized by high pharmacokinetic variability in combination with a narrow therapeutic range. However, influence of donor CYP3A5 genotype and graft-to-recipient body weight ratio (GRWR) on tacrolimus' pharmacokinetics after pediatric living donor liver transplantation (LDLT) remains unclear.

Methods: A total of 174 LDLT recipients (<6y) were grouped according to donor CYP3A5 genotypes [non-expressor (NEX) or expressor (EX)] and GRWR [$<3.0\%$ (SFS, small-for-size) or $\geq 3.0\%$ (LFS, large-for-size)]: SFS/NEX (n=40), SFS/EX (n=38), LFS/NEX (n=48) and LFS/EX (n=48). Pharmacokinetics of tacrolimus and clinical outcomes were analyzed.

Results: Tacrolimus C₀ levels varied greatly among groups, although recipients started with the same initial dosage. LFS/EX recipients had significantly lower C₀ levels in comparison with those of other groups. The use of CYP3A5-EX grafts and a greater GRWR both resulted in significantly higher TAC dose requirements and lower C/D ratios. However, the significance of GRWR no longer exists 3 months after transplantation. The multivariate generalized linear mixed model analysis showed that donor CYP3A5 genotypes (F=11.876, P=0.01) and GRWR (F=4.631 P=0.033) were independent impact factors for C/D ratios 3, 7, 14 and 30 days after transplantation. Donor CYP3A5-EX genotype was associated with significantly increasing risks of infectious complications and significantly lower Cylex ATP values. However, no significant difference was observed in acute rejections among 4 groups.

Conclusions: Monitoring of C₀ levels alone is not reliable to guide tacrolimus administration. Donor CYP3A5 and GRWR both significantly affect tacrolimus pharmacokinetics after pediatric LDLT. The use of Cylex ATP tests would be helpful to avoid overimmunosuppression.

Introduction

Grafts from living donors have currently become the first choice for pediatric liver transplantation (LT) in Asian countries because of the severe shortage of deceased donor organs in children. In experienced transplant centers, living donor liver transplantation (LDLT) in children has satisfactory short-term and long-term outcomes with the 5-year graft survival rate reaching more than 85%¹⁻⁴. However, the long-term use of immunosuppressant brings a great challenge to post-transplantation medical management, which has to be balanced between the risks of overimmunosuppression, side effects and rejections.

Tacrolimus (TAC) is the most common calcineurin inhibitor used for the prevention and treatment of rejection in patients undergoing solid organ transplantation. High TAC exposure leads to increased risks of infections, renal injury or other toxic effects, while a low dosage of TAC may cause acute or chronic rejections, and even graft loss or death in severe cases. TAC has a narrow therapeutic range and a high inter-individual variability in terms of pharmacokinetics⁵⁻⁷. Especially in pediatric recipients, a 10-fold variability in blood concentration and pharmacokinetic parameters at a fixed dose is frequently observed. Our previous study found that the cytochrome P450 (CYP) 3A5 genotype in both recipients and donors

significantly affected TAC pharmacokinetics after LT in pediatric patients, of which donor CYP3A5 genotype was the major contributor accounting for 32.35%⁸. CYP3A5 is found in small intestine as well as in the liver⁹. Therefore, based on our clinical investigation, we speculate that a larger liver graft carries more CYP3A5 oxidoreductase, which could accelerate the TAC's clearance. However, how CYP3A5 genotypes and graft-to-recipient weight ratio (GRWR) influence TAC concentration/dose (C/D) ratio in pediatric recipients remains unclear. In this study, we aim to explore the role of donor CYP3A5 and GRWR on TAC's pharmacokinetics after LDLT in pediatric cases.

Patients And Methods

Patients

Children who underwent LDLT before the age of 6 years between June 2009 and December 2014 were included in further patient screening. Exclusion criteria are shown as below: 1) retransplantation (0 case); 2) combined organ transplantation (0 case); 3) diagnosis with malignant tumor (0 case); 4) graft loss or death within 1 month after LT (9 cases); 5) use of ciclosporin-based regimen as the initial immunosuppression regimen (1 case); 6) data missing (17 cases). Finally, 174 children and their corresponding donors were included in our study and categorized into 4 groups by GRWR and donor CYP3A5 genotype: the SFS (small-for-size)/NEX (non-expressor) group had a GRWR<3.0% and absence (*3/*3) of donor CYP3A5 (n=40); the SFS/EX (expressor) group had a GRWR<3.0% and presence (*1/*1 or *1/*3) of donor CYP3A5 (n=38); the LFS (large-for-size)/NEX group had a GRWR≥3.0% and absence of donor CYP3A5 (n=48); and the SFS/EX group had a GRWR≥3.0% and presence of donor CYP3A5 (n=48). The baseline characteristics and TAC's pharmacokinetic parameters were analyzed and compared between the 4 groups. This study was approved by the institutional review board of Renji Hospital, and written informed consents were obtained from all parents of recipients.

Immunosuppressive protocol

A dual drug regimen of TAC combined with methylprednisolone (4 mg/kg/day) was used as the initial immunosuppressive regimen. TAC was started on day 1 after LT with an initial dosage at 0.1-0.15mg/kg/day, and the target trough level (termed C₀ level) was 8-12 ng/ml during the first month after LT, 7-10 ng/ml from the 2nd to 6th month, 5-8 ng/ml from the 7th to 12th month, and around 5ng/ml thereafter. If TAC could not reach the target C₀ level despite a twice increase of dosage, patients would use a triple-drug regimen with mycophenolate mofetil added or switch to a cyclosporine-based regimen. The use of methylprednisolone was started at 10mg/kg during LT and at 4mg/kg on day 1 after LT. The dose of methylprednisolone was gradually tapered by 4 to 8mg per day, and maintained with prednisone 2.5 to 5 mg daily taken orally, which was withdrawn within 3 months after LT¹⁰.

TAC C₀ monitoring and C/D ratio assessment

One milliliter of ethylenediamine tetraacetic acid-treated venous whole blood was collected 12 hours after previous TAC administration. Blood TAC C₀ level was tested using the microparticulate enzyme

immunoassay (Abbott Co., Ltd, Tokyo, Japan). TAC's weight-adjusted doses and C0 levels were recorded after each blood test, and C/D ratios were calculated using the C0 levels (ng/ml) divided by the weight-adjusted dose (mg/kg/d), which was used as an alternative method for estimation of TAC clearance^{8,11,12}. TAC weight-adjusted doses and C/D ratios at 3 days, 7 days, 14 days, 1 month, 3 months, 6 months and 12 months after LT were included as primary endpoints in this study. If the TAC C0 level was not available at a given time point, the data were excluded from the analysis.

Genotyping of CYP3A5

The single nucleotide polymorphism of CYP3A5 at position 6986A>G (the *3 or *1 allele, rs776746) was tested for the 174 children and their corresponding donors. We extracted the genomic DNA from leukocytes using a QIAamp Blood Kit (Qiagen, Hilden, Germany). The PCR-based sequencing process and primer information were performed as described previously¹². The forward primer was 5'-ACTGCCCTTGCAGCATTTA-3', and the reverse primer was 5'-CCAGGAAGCCAGACTTTGA-3'. Briefly, the following program was utilized: 95°C for 10 min, 94°C for 30 s, 55°C for 30 s, 72°C for 60 s for total 40 cycles and finally 72°C for 7 min. Afterwards, products were purified with QIAquick PCR purification kit (Qiagen, Hilden, Germany) and the fragments were run on an ABI 3730XL Genetic Analyzer.

Immune function assay

CD4+T-lymphocyte functional assay (ImmuKnow, Catalogue no.4400, Cylex Inc., Columbia, MD) was performed for assessment of cellular immunity functions according to our previous study¹³. In Brief, 250ul whole blood was added to 750ul sample diluent to obtain 1000ul solution, and 100ul samples were incubated overnight (15-18h) with phytohemagglutinin stimulation in wells of a 96-well microtiter plate at 37°C in a 5% CO2 incubator. CD4+ T-cells were selected by magnetic particles coated with anti-human CD4 monoclonal antibodies within the microwells, and then lysed to release intracellular ATP. After the addition of luciferin/luciferase reagents into each wells of the plate, ATP values were measured using a luminometer to reflecting functional activity of lymphocytes. ATP values at 21 days after LT was analyzed in this study. We used pediatric ImmuKnow assay zones proposed by Hooper E et al¹⁴ for evaluation of over- or under-immunosuppression, and strong, moderate and low immune function corresponded to >395ng/ml, 175-395ng/ml and <175ng/ml, respectively.

Statistical analysis

SPSS 19.0 software (SPSS Inc. Chicago, IL, United States) was used for statistical analysis. P values<0.05 indicated statistically significant. All measurement data were tested for normality using the Shapiro-Wilk method. The independent-samples t-test analysis was used for variables with normal distribution, while the nonparametric statistical analysis (Mann-Whitney test) was applied to abnormal-distribution variables. Categorical data were analyzed using χ^2 test. The generalized linear mixed model (GLMM) was used to analyze each factor that might have influenced TAC C/D ratios, and any variables identified as statistically significant in the univariate GLMM analysis were included in the multivariate GLMM analysis to obtain independent factors affecting TAC C/D ratios. Logistic analysis was used to

study the correlations between CYP3A5 genotype and infection, rejection status respectively, then the relationship between CYP3A5 genotype and infection, rejection status respectively. The rejection-free survival rate was estimated using Kaplan-Meier method (the time interval between LT and the first episode of acute rejection), and differences between groups were compared using the log-rank test.

Results

Patient and donor characteristics

Detail frequencies of CYP3A5 genotypes in donors and recipients are shown in table 1. The CYP3A5 NEX and EX phenotypes were found in 88 (50.6%) and 86 (49.4%) donors, respectively, and were observed in 96 (55.2%) and 78 (44.8%) recipients, respectively. Allele frequencies in donors were 104 (29.9%) for *1 and 244 (70.1%) for *3, and those in recipients were 85 (24.4%) for *1 and 263 (75.6%) for *3, respectively. Table 2 shows recipient characteristics of the 4 groups. There were 86 (49.4%) boys and 88 (50.6%) girls, with a median age of 8.7 months (range from 4.8 to 71.5 months). The median body weight and height were 7.7kg (range from 5.1-28.0kg) and 66cm (range from 56-120cm), respectively. Pediatric end-stage liver disease (PELD) scores of <0, 0-9, 10-19 and ≥ 20 were seen in 15 (8.6%), 23 (13.2%), 77 (44.3%) and 59 (33.9%) patients, respectively. Sixty-four (36.8%) and 110 (63.2%) patients underwent LDLT in the first stage (2009-2012) and in the second stage (2013-2014), respectively. Table 3 shows characteristics of living donors in 4 groups. One hundred and sixty-six (95.4%) donors were parents, and 8 (4.6%) donors were grandparents. They included 74 (42.5%) men and 100 (57.5%) women, with a median age of 30 years (range from 20 to 56 years). The median body weight and height were 58kg (range from 39-90kg) and 165cm (range from 148-184cm), respectively. Moreover, patients receiving donor livers of NEX and EX phenotypes had median GRWR of 3.1% (range from 1.3 to 5.8%) and 3.0% (range from 1.2 to 5.7%), respectively.

TAC C0 levels

TAC dosages were adjusted according to target C0 levels at different time point after LT. However, we found that most C0 levels were outside the target ranges, and proportions of C0 levels within the target ranges were only 28.9%, 42.0%, 22.4%, 35.0%, 42.4%, 32.3% and 30.4% at 3 days, 7 days, 14 days, 1 month, 3 months, 6 months and 12 months after LT, respectively. Moreover, C0 levels varied greatly among SFS/NEX, SFS/EX, LFS/NEX and LFS/EX groups, even though recipients started with the same initial dosage. Figure 1 A-G shows TAC C0 level distributions in the 4 groups at 3 days, 7 days, 14 days, 1 month, 3 months, 6 months and 12 months after LT, respectively. At all time points, the SFS/NEX group tended to have the smallest proportions of C0 levels under the lower limit of target ranges and the largest proportions of C0 levels beyond the upper limit of target ranges, which indicated that the highest C0 levels were most likely to appear in NEX-graft recipients with a small GRWR. On the contrary, the LFS/EX group usually had the largest proportions of C0 levels under the lower limit of target ranges and the smallest proportions of C0 levels beyond the upper limit of target ranges, indicating a large GRWR combined with an EX-type graft brought about the lowest C0 levels. Twenty-seven children (15.5%)

converted into a cyclosporine-based regimen at a median duration of 22 days (range from 8 to 270 days) after LT, of which 18 cases (66.7%) were from the LFS/EX group. Mycophenolate mofetil was added at a median duration of 20 days (range from 4 to 232 days) after LT in 91 children (52.3%) (Table 4).

TAC dose requirement and C/D ratio

Compared with NEX-graft recipients, EX-graft recipients had a significant higher TAC dose requirement as well as a significant lower C/D ratio within 12 months after LT (figure 2). Furthermore, a $GRWR \geq 3.0\%$ was also associated with a significant higher TAC dose requirement and a significant lower C/D ratio from 3 days to 1 month after LT, but the significance lost between 3 to 12 months (figure 3). The TAC dose requirement and C/D ratios of SFS/NEX, SFS/EX, LFS/NEX and LFS/EX groups at different time points were shown in table 5 and 6, respectively. In contrast to the SFS/NEX group, a significant higher dose requirement and a significant lower C/D ratio were observed in the SFS/EX group and LFS/EX group from 3 days to 12 months after LT, and the significance was also shown in the LFS/NEX group within 3 months after LT. Thus, the use of EX-type graft and a larger GRWR facilitated TAC clearance and caused an increase in dosage, but the impact of GRWR vanished 3 months after LT. The difference in dosage requirement between SFS/NEX and LFS/EX groups at 12th month failed to reach statistical significance probably because of more than 1/3 of recipients having converted into a cyclosporine-based regimen in the LFS/EX group.

Uni- and Multi-variate analysis for TAC C/D ratio

A total of 18 variables that might have affected TAC C/D ratios were subject to univariate GLMM analysis one by one using C/D ratios 3, 7, 14 and 30 days after LT as outcome variables (repeated measures), including recipient age (<12 months, 12-36 months or ≥ 36 months), recipient gender, recipient weight (<7kg, 7-10 kg, or ≥ 10 kg), recipient height (< 70cm or ≥ 70 cm), recipients ABO blood group, ABO compatibility (identical, compatible or incompatible), PELD score (<0, 0-9, 10-19 or ≥ 20), primary diagnosis (cholestatic liver disease or other), previous Kasai procedure (with or without), graft weight (<250g or ≥ 250 g), GRWR (< 3.0% or $\geq 3.0\%$), recipients CYP3A5 genotype (EX or NEX), donor CYP3A5 genotype (EX or NEX), donor age (<40 years or ≥ 40 years), donor gender, donor body mass index (BMI) (< 18.5, 18.5-24.0 or ≥ 24.0), donor ABO blood group and donor-to-recipient relationship (father, mother, grandfather and grandmother). We found that 8 variables had significant impacts, including recipient age, recipient weight, recipient height, PELD score, GRWR, recipient CYP3A5, donor CYP3A5 and donor ABO blood group. Finally, the multivariate GLMM analysis showed that donor CYP3A5 ($F=11.876$, $P=0.01$) and GRWR ($F=4.631$, $P=0.033$) were independent impact factors for C/D ratios 3, 7, 14 and 30 days after LT (table 7). Similarly, the 18 aforementioned variables were subjected to uni- and multi-variate GLMM analyses again using C/D ratios 3, 6 and 12 months after LT as outcome variables (repeated measures), which revealed that donor CYP3A5 ($F=20.998$, $P<0.001$), recipient CYP3A5 ($F=5.363$, $P=0.022$) and the ABO compatibility ($F=4.159$, $P=0.018$) were independent impact factors for C/D ratios 3, 6 and 12 months after LT (table 8).

Post-transplant infections and acute rejections

A total of 90 (51.7%) children experienced one or more episodes of infections within 3 months after LT, in which incidences of bacterial infection, fungal infection, Epstein-Barr virus infection, cytomegalovirus infection and other infections were 35.1%, 5.2%, 16.1%, 16.1% and 2.3%, respectively. Posttransplant infections were classified according to 2012 International Guidelines for Management of Severe Sepsis and Septic Shock¹⁵. In comparison with the SFS/NEX group, significantly higher risks of sepsis were observed in both of the LFS/EX (25.0% vs. 52.1%, $P=0.010$) and SFS/EX groups (25.0% vs. 50.0%, $P=0.022$), but the LFS/NEX group merely showed a slight trend in the increasing risk of sepsis (25.0% vs. 39.6%, $P=0.147$) (table 9). Namely, recipient receiving an EX-graft suffered from much higher risks of sepsis within 3 months after LT, but the GRWR had a slight influence on posttransplant infections. Cylex ATP levels which are positively correlated with the cellular immunity activity provided a useful approach in monitoring posttransplant infections¹¹⁻¹³. As shown in figure 4A, the SFS/EX group [median: 241.0ng/ml; range from 45.1 to 577.7ng/ml; $P=0.0035$], the LFS/NEX group [median: 266.0ng/ml; range from 40.0 to 690.4ng/ml; $P=0.0029$] and the LFS/EX group [median: 236.5ng/ml; range from 40.0 to 935.0ng/ml; $P=0.0013$] all presented significantly lower Cylex ATP levels compared with the SFS/NEX group [median: 329.1ng/ml; range from 57.2 to 827.1ng/ml]. Meanwhile, we found that the LFS/EX group had the highest proportion of children with low immune functions (ATP value<175ng/ml), due to an increasing use of TAC doses to obtain satisfactory C0 levels (figure 4B). What's more, patients with donor CYP3A5 expressed (adjusted OR 2.04, CI 1.06-3.92, $p = 0.032$) was likely to have bacterial infection after LT (table 10). The results were adjusted by the conversion (to cyclosporine) or expansion (by adding MMF) of anti-rejection therapy.

Rejection-free survival rates in SFS/NEX, SFS/EX, LFS/NEX and LFS/EX groups were 67.0%, 52.6%, 66.1% and 59.8% at 1 year, 57.4%, 49.3%, 55.9% and 44.9% at 3 years, 55.0%, 44.7%, 54.1% and 43.8% at 5 years, respectively. No significant difference was observed in rejection-free survival rate between these groups (figure 5a, $P=0.6$). However, CYP3A5 expressed patients prone to have shorter rejection free survival time (figure 5b, $P = 0.3$)

Discussion

TAC's therapeutic use is complicated by its pharmacokinetic variability. The variable pharmacokinetic property of immunosuppressants may have a significant adverse effect on long-term outcomes after solid organ transplantation, secondary to an increased risk of acute and chronic rejections and drug toxicity. Thus, periodical monitoring of blood TAC C0 levels are recommended to judge whether TAC has reached the therapeutic window and detect possible rejections or overimmunosuppression. TAC's pharmacokinetics in transplantation is affected by various factors such as the patient age, ethnic groups, genetic factor, transplant organ type, co-administration with food or medication, gastrointestinal functions, small intestinal p-glycoprotein, etc¹⁶⁻²². In pediatric patients, TAC's oral absorption is inconstant, together with their reduced bioavailability and increased clearance in comparison with adult patients, resulting in a higher oral dose required to achieve target blood concentrations¹⁸. Moreover, small children may be expected to show more significant heterogeneity in TAC pharmacokinetic profiles,

which makes it very difficult to administer an appropriate initial dose for each individual⁸. These features lead to higher risks of organ rejections, toxicity and infections in pediatric patients.

TAC is metabolized by CYP3A enzymes into demethylated and hydroxylated metabolites, which catalyses metabolic reactions with extensive effects on the biological activities of drugs, pretoxic chemicals, and endogenous substances in human liver and small intestine²³. CYP3A5 accounts for more than half of the total CYP3A content in people who polymorphically express CYP3A5. People with a CYP3A5*1 allele (the wild type) have a high amount of CYP3A5 enzymes in the liver and small intestine. Ethnicity-dependent pharmacokinetic differences were reported in expression of CYP3A5, with African people (60%) characterized by more active CYP3A5 enzymes than white people (33%)^{19,24}. Our team has reported the expression rate of CYP3A5*1 and*3 alleles in Chinese population⁸, and data were verified in the present study that expression rate of CYP3A5 *1 in Chinese people was approximately 24-30%, and those who carried the *1 allele consisted of at least 40% of all cases. Based on our previous results, CYP3A5 genotypes in both donors and recipients had consistent influences on pharmacokinetic profile of TAC with contributions of 32.35% and 6.0% to the attributable variance in the C/D ratio, respectively⁸. It is understandable that the amount of CYP3A5 enzymes in liver grafts might be correlated with the graft size. In this study, we first verified an independently significant impact of GRWR on TAC C/D ratio in children undergoing LDLT using multivariate GLMM analyses. However, the liver graft size grows fast as regeneration of the liver until 3 months after LDLT, but the GRWR was negatively correlated with the regeneration rate^{25,26}, which explains why GRWR on C/D ratio lost its significance between 3 to 12 months.

Interestingly, weight-adjusted doses of TAC were often much higher in infantile recipients than in older children regardless of CYP3A5 genotypes, indicating a decrease of TAC clearance corresponding to children's growth. Small children usually require approximately twice as much as weight-adjusted doses of TAC in adults to achieve the same C₀ levels. However, younger children often tend to have a higher GRWR in LDLT using left lateral segment. The relationship between recipient age and GRWR probably plays an important role in pharmacokinetic variability of TAC over age, and this may explain why recipient age or weight are not independent impact factors on the TAC C/D ratio. In this study, results were much more explicit and reliable using multivariate GLMM analyses with C/D ratios in multiple levels (different time points after LT), which minimized the possible inter-level selection bias in single-level regression model. The recipient CYP3A5 genotype determines the amount of CYP3A5 protein in the small intestine, where TAC is absorbed. TAC is highly lipophilic and easily spreads into intestinal epithelial cells after oral administration. CYP3A5 enzymes in the small intestine reduce the oral bioavailability of TAC²⁷⁻²⁹. Consequently, recipient CYP3A5 genotypes show a tendency towards statistical significance regarding its impact on C/D ratio within 1 month after LT. It is noteworthy that 2 of the 5 ABO-incompatible LT recipients (40%) had switched to a cyclosporine-based regimen due to unsatisfactory TAC C₀ levels, so the significance of ABO compatibility in the multivariate GLMM analysis might be caused by the limited number of cases.

Our data show children with an EX-graft suffered from higher risks of infections after LT than those with a NEX-graft even if they have lower C0 levels of TAC, suggesting that the TAC C0 level is not a reliable index to truly reflect patients' situation of immunosuppression. However, this is probably related to the increasing doses of TAC to reach the target C0 levels in this group of patients. Alak et al³⁰ revealed that only 54.4% of the immunosuppression was ascribed to TAC after transplantation. TAC is metabolized by CYP3A enzymes into at least 4 major metabolites (M-I, M-II, M-III and M-IV) and at least 9 total metabolites, which might have dissimilar immunosuppressant activities. The most common metabolite is the 13-O-demethyl FK506 (M-I), and other metabolites include O-demethylated at the 31- and 15 positions (M-II and M-III, respectively) and hydroxylated at the 12 position (M-IV)³¹⁻³⁴. On the other hand, this study suggests that risks of acute rejections are not influenced by donor CYP3A5 genotype or GRWR. To further evaluate the immune functions status of recipients, we compared Cylex ATP values using CD4+T-lymphocyte functional assay after LT. As expected, the LFS/EX group who had the highest risk of infectious complications was associated with highest proportion of patients with the ATP value <175ng/ml, but the GRWR had less impact on incidence of infectious complications than donor CYP3A5 genotypes. Nonetheless, we recommend that donor CYP3A5 genotypes and the GRWR should be taken into consideration during administration of TAC after pediatric LDLT.

There are several underlying limitations in our study. First, data in this study were retrospectively reviewed from the pediatric LT database, and the sample size was subject to the nature of a single-center study. Second, disproportionate percentages of children who switched from TAC to cyclosporine across the 4 groups might cause selection bias in multivariate GLMM analyses. Third, amounts of TAC metabolites in recipients and CYP3A5 enzyme activities in donor livers were not measured in this study, and how TAC metabolites affect immune functions after pediatric LDLT still needs to be further clarified in a prospective study.

In conclusion, donor CYP3A5-EX type and a greater GRWR are both associated with significantly higher TAC dose requirements and lower C/D ratios after pediatric LDLT. However, significance of GRWR vanished after 3 months posttransplant. High doses of TAC in recipients with EX-grafts would result in increasing risks of infectious complications. Thus, monitoring of immune responses using Cylex ATP levels would be helpful to establish individualized immunosuppressant regimens.

Abbreviations

BMI, body mass index; C/D, concentration/dose; CSA, cyclosporine; CYP, cytochrome P450; D/R, donor/recipient; EX, expressor; GLMM, generalized linear mixed model; GRWR, graft-to-recipient body weight ratio; LDLT, living donor liver transplantation; LFS, large-for-size; LLS, left lateral segment; LT, liver transplantation; MHV, middle hepatic vein; MMF, mycophenolate mofetil; NEX, non-expressor; PELD, pediatric end-stage liver disease; PFIC, progressive familial intrahepatic cholestasis; SFS, small-for-size; TAC, tacrolimus.

Declarations

Acknowledgment:

None

Consent for publication:

Not applicable.

Ethics approval and consent to participate:

This study was performed in accordance with the Declaration of Helsinki and approved by the institutional review board of Renji Hospital. Written informed consents were obtained from all parents of recipients.

Competing interests:

The authors declare no conflicts of interest.

Availability of data and materials:

The datasets used and analysed during the current study available from the corresponding author on reasonable request.

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Tables

Table 1. CYP3A5 genotype distribution in 174 recipients and their donors

Donor CYP3A5 genotype	Recipient CYP3A5 genotype			Overall
	*1/*1 (EX)	*1/*3 (EX)	*3/*3 (NEX)	
*1/*1 (EX)	3	12	3	18 (10.3)
*1/*3 (EX)	3	43	22	68 (39.1)
*3/*3 (NEX)	1	16	71	88 (50.6)
Overall	7 (4.0)	71 (40.8)	96 (55.2)	174 (100.0)

Note: Data are expressed as number (%).

Table 2. Baseline characteristics of recipients

Variable	SFS/NEX group (n=40)	SFS/EX group (n=38)	LFS/NEX group (n=48)	LFS/EX group (n=48)
Age (month)	12.2 (5.7-71.5)	10.9 (5.7-63.4)	7.6 (5.1-22.2)	8.1 (4.8-53.6)
Gender				
Boy	24 (60.0)	19 (50.0)	20 (41.7)	23 (47.9)
Girl	16 (40.0)	19 (50.0)	28 (58.3)	25 (52.1)
Weight (kg)	9.3 (5.9-28.0)	9.0 (6.0-18.0)	6.9 (5.1-12.0)	7.0 (5.3-10.5)
Height (cm)	70 (60-120)	70.5 (58-108)	65 (56-76)	65 (57-88)
PELD score	13 (-9-28)	16 (-10-29)	17 (-2-36)	19 (-9-37)
ABO blood group				
A	16 (40.0)	8 (21.1)	11 (22.9)	10 (20.8)
B	9 (22.5)	12 (31.6)	13 (27.1)	13 (27.1)
O	9 (22.5)	16 (42.1)	19 (39.6)	19 (39.6)
AB	6 (15.0)	2 (5.3)	5 (10.4)	6 (12.5)
ABO compatibility				
Identical	30 (75.0)	32 (84.2)	39 (81.3)	35 (72.9)
compatible	9 (22.5)	4 (10.5)	8 (16.7)	12 (25.0)
Incompatible	1 (2.5)	2 (5.3)	1 (2.1)	1 (2.1)
Etiology				
Biliary atresia	31 (77.5)	35 (92.1)	47 (97.9)	47 (97.9)
Cholestatic liver cirrhosis	0	1 (2.6)	0	0
PFIC	2 (5.0)	0	0	1 (2.1)
Cryptogenic liver cirrhosis	0	1 (2.6)	0	0
Tyrosinemia	4 (10.0)	0	0	0
Abernethy syndrome	1 (2.5)	0	0	0
Glycogen storage disease	1 (2.5)	0	0	0
Caroli disease	0	0	1 (2.1)	0
Alagille syndrome	0	1 (2.6)	0	0
Niemann-Pick disease	1 (2.5)	0	0	0
Kasai procedure				

Yes	16 (40.0)	19 (50.0)	21(43.8)	14(29.2)
No	24 (60.0)	19(50.0)	27(56.3)	34(70.8)
Transplant stage				
2009-2012	18(45.0)	20 (52.6)	17 (35.4)	9 (18.8)
2013-2014	22 (55.0)	18 (47.4)	31 (64.6)	39 (81.3)

Note: Data are expressed as number (%) or median (range). GRWR, graft-to-recipient body weight ratio; PELD, pediatric end-stage liver disease; PFIC, progressive familial intrahepatic cholestasis.

Table 3. Donor characteristics

Variable	SFS/NEX group (n=40)	SFS/EX group (n=38)	LFS/NEX group (n=48)	LFS/EX group (n=48)
Age (year)	30 (20-54)	30 (21-56)	29 (22-51)	31 (21-50)
Gender				
Male	19 (47.5)	18 (47.4)	22 (45.8)	15 (31.3)
Female	21 (52.5)	20 (52.6)	26 (54.2)	33 (68.8)
Weight (kg)	57 (39-90)	56 (39-76)	60 (42-81)	60 (40-85)
Height (cm)	163 (150-183)	165 (152-179)	167 (150-180)	164 (148-184)
BMI (kg/m ²)	21.1 (16.7-29.1)	20.6 (16.9-26.3)	21.6 (17.5-28.0)	22.9 (16.0-26.6)
D/R relationship				
Parent	39 (97.5)	36 (94.7)	45 (93.7)	46 (95.8)
Grandparent	1 (2.5)	2 (5.3)	3 (6.3)	2 (4.2)
Graft weight (g)	230 (140-420)	220 (130-345)	263 (190-370)	258 (180-395)
GRWR (%)	2.5 (1.3-3.0)	2.3 (1.2-3.0)	3.8 (3.0-5.8)	3.5 (3.0-5.7)
Graft type				
LLS	33 (82.5)	33 (86.8)	46 (95.8)	41 (85.4)
Reduced LLS	1 (2.5)	1 (2.6)	2 (4.2)	6 (12.5)
Left lobe without MHV	1 (2.5)	1 (2.6)	0	0
Left lobe with MHV	5 (12.5)	3 (7.9)	0	0
Right lobe without MHV	0	0	0	1 (2.1)

Note: Data are expressed as number (%) or median (range). BMI, body mass index; D/R donor/recipient; GRWR, graft-to-recipient weight ratio; LLS, left lateral segment; MHV, middle hepatic vein.

Table 4. Change of immunosuppressive regimens

	SFS/NEX group (n=40)	SFS/EX group (n=38)	LFS/NEX group (n=48)	LFS/EX group (n=48)
FK506-to-CSA conversion				
Case number (%)	2 (5.0)	6 (15.8)	1 (2.1)	18 (37.5)
Starting days after LT	143 (15-270)	32 (8-122)	14	22 (10-75)
Additional use of MMF				
Case number	17 (42.5)	30 (78.9)	16 (33.3)	29 (60.4)
Starting days after LT	20 (5-57)	22 (6-140)	20 (4-84)	18 (5-232)

Note: Data are expressed as number (%) or median (range). CSA, cyclosporine; MMF, mycophenolate mofetil; LT, liver transplantation.

Table 5. Comparison of TAC dose requirement among the 4 groups

Posttransplant time	TAC dose requirement (mg/kg/d)			
	SFS/NEX group (n=40)	SFS/EX group (n=38)	LFS/NEX group (n=48)	LFS/EX group (n=48)
3 days	0.11 (0.09-0.13)	0.12 (0.11-0.16)*	0.14 (0.13-0.17)**	0.14 (0.12-0.15)**
7 days	0.10 (0.06-0.13)	0.12 (0.08-0.16)**	0.13 (0.08-0.17)**	0.18 (0.13-0.20)**
14 days	0.13 (0.08-0.17)	0.21 (0.12-0.26)**	0.17 (0.14-0.24)**	0.25 (0.18-0.28)**
1 month	0.18 (0.10-0.23)	0.22 (0.17-0.32)**	0.23 (0.19-0.27)**	0.25 (0.21-0.32)**
3 months	0.14 (0.11-0.17)	0.23 (0.18-0.28)**	0.18 (0.13-0.22)**	0.22 (0.20-0.24)**
6 months	0.10 (0.07-0.12)	0.18 (0.13-0.23)**	0.11 (0.07-0.14)	0.16 (0.10-0.18)**
12 months	0.07 (0.04-0.09)	0.11 (0.08-0.16)**	0.05 (0.04-0.09)	0.08 (0.04-0.12)

Note: Data are expressed as median (lower quartile-upper quartile). * indicates P<0.05 compared with the SFS/NEX group; ** indicates P<0.01 compared with the SFS/NEX group.

Table 6. Comparison of TAC C/D ratio among the 4 groups

Posttransplant time	TAC C/D ratio (ng/ml)/(mg/kg/d)			
	SFS/NEX group (n=40)	SFS/EX group (n=38)	LFS/NEX group (n=48)	LFS/EX group (n=48)
3 days	113.7 (99.2-150.0)	62.5 (43.4-100.3)**	74.4 (59.9-100.0)**	51.5 (43.2-82.2)**
7 days	104.9 (70.2-192.0)	75.3 (40.7-117.4)**	70.4 (57.2-102.4)**	41.1 (31.1-76.8)**
14 days	69.1 (51.8-132.4)	31.6 (24.8-59.1)**	42.4 (33.6-58.0)**	28.1 (20.3-46.4)**
1 month	59.7 (33.8-89.2)	31.7 (18.9-49.0)**	34.9 (25.6-50.8)**	20.5 (16.2-28.7)**
3 months	71.1 (53.4-91.8)	30.3 (20.6-47.5)**	53.8 (42.5-68.7)**	27.3 (21.9-37.1)**
6 months	75.6 (60.8-103.7)	34.0 (27.4-47.8)**	69.0 (46.0-95.1)	41.3 (29.2-47.3)**
12 months	80.0 (57.3-92.8)	42.0 (29.6-63.5)**	79.1 (56.0-136.0)	49.5 (41.0-85.7)**

Note: Data are expressed as median (lower quartile-upper quartile). * indicates P<0.05 compared with the SFS/NEX group; ** indicates P<0.01 compared with the SFS/NEX group.

Table 7 Uni- and Multi-variate analyses of variables that significantly affected TAC C/D ratios 3, 7, 14 and 30 days after LT

Significant variables	Univariate analysis		Multivariate analysis	
	F value	P value	F value	P value
Recipient age	15.907	<0.001	/	/
Recipient weight	11.064	<0.001	/	/
Recipient height	10.150	0.002	/	/
PELD score	6.096	0.001	/	/
GRWR	17.105	<0.001	4.631	0.033
Donor CYP3A5	12.311	0.001	11.876	0.01
Recipient CYP3A5	21.781	<0.001	/	/
Donor ABO blood group	2.874	0.038	/	/

Note: GRWR, graft-to-recipient weight ratio; PELD, pediatric end-stage liver disease; TAC, tacrolimus; C/D, concentration-dose; LT, liver transplantation.

Table 8 Uni- and Multi-variate analyses of variables that significantly affected TAC C/D ratios 3, 6 and 12 months after LT

Significant variables	Univariate analysis		Multivariate analysis	
	F value	P value	F value	P value
ABO compability	4.168	0.018	4.159	0.018
Donor CYP3A5	40.665	<0.001	20.998	<0.001
Recipient CYP3A5	28.398	<0.001	5.363	0.022

Note: TAC, tacrolimus; C/D, concentration-dose; LT, liver transplantation.

Table 9. Comparison of infectious complications within 3 months among the 4 groups

Infection	SFS/NEX group (n=40)	SFS/EX group (n=38)	LFS/NEX group (n=48)	LFS/EX group (n=48)
No infection	24 (60.0)	17 (44.7)	25 (52.1)	19 (39.5)
Local infection	6 (15.0)	2 (5.3)	4 (8.3)	4 (8.3)
Sepsis	10 (25.0)	19 (50.0)*	19 (39.6)	25 (52.1)*
No organ dysfunction	10	15	14	23
With Organ dysfunction	0	4	5	2

Note: * indicates P<0.05 compared with the SFS/NEX group.

Table 10 Associations between CYP3A5 genotype, GRWR and rejection status and infection

	Rejection status				Infection			
	Unadjusted OR (95% CI)	P value	Adjusted OR (95% CI)	P value	Unadjusted OR (95% CI)	P value	Adjusted OR (95% CI)	P value
Recipient CYP3A5 genotypes								
Non-expressor	REF.	REF.	REF.	REF.	REF.	REF.	REF.	REF.
Expressor	0.997 (0.57-1.82)	0.99	0.95 (0.52-1.74)	0.86	1.376 (0.75-2.49)	0.308	1.37 (0.75-2.51)	0.305
Donor CYP3A5 genotypes								
Non-expressor	REF.	REF.	REF.	REF.	REF.	REF.	REF.	REF.
Expressor	1.46 (0.80-2.67)	0.21	1.33 (0.67-2.53)	0.87	1.87 (1.02-3.43)	0.043	2.04 (1.06-3.92)	0.032
GRWR								
≤ 3%	REF.	REF.	REF.	REF.	REF.	REF.	REF.	REF.
≥ 3%	1.14 (0.63-2.08)	0.66	1.01 (0.53-1.91)	0.98	1.67 (0.91-3.04)	0.095	1.78 (0.94-3.38)	0.077

Figures

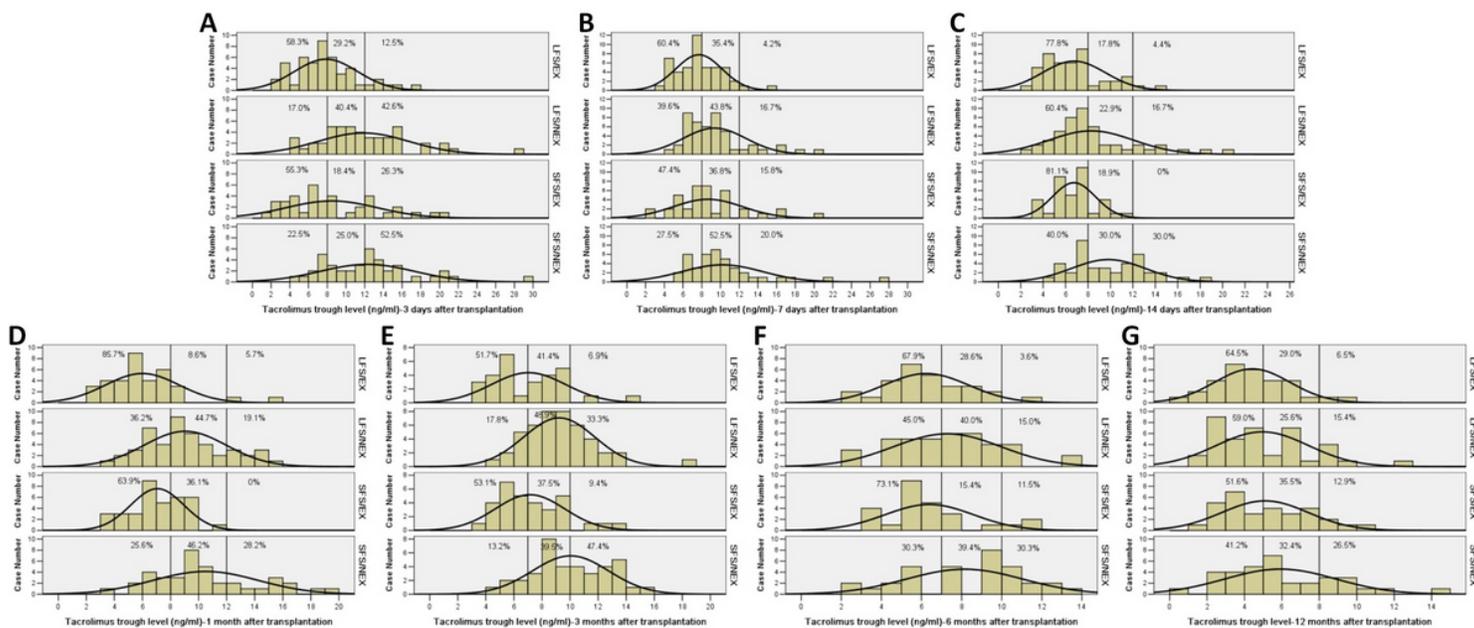


Figure 1

Comparison of tacrolimus trough level distributions among 4 groups at different time points. A. 3th days; B. 7th days; C. 14th days; D. 1th month; E. 3th months; F. 6th months. G. 12th months. Percentages indicate proportions of patients in different groups whose trough level is under the lower limit, within the target range or beyond the upper limit. The area between two vertical lines denotes the target range. The curves are normal distribution curves.

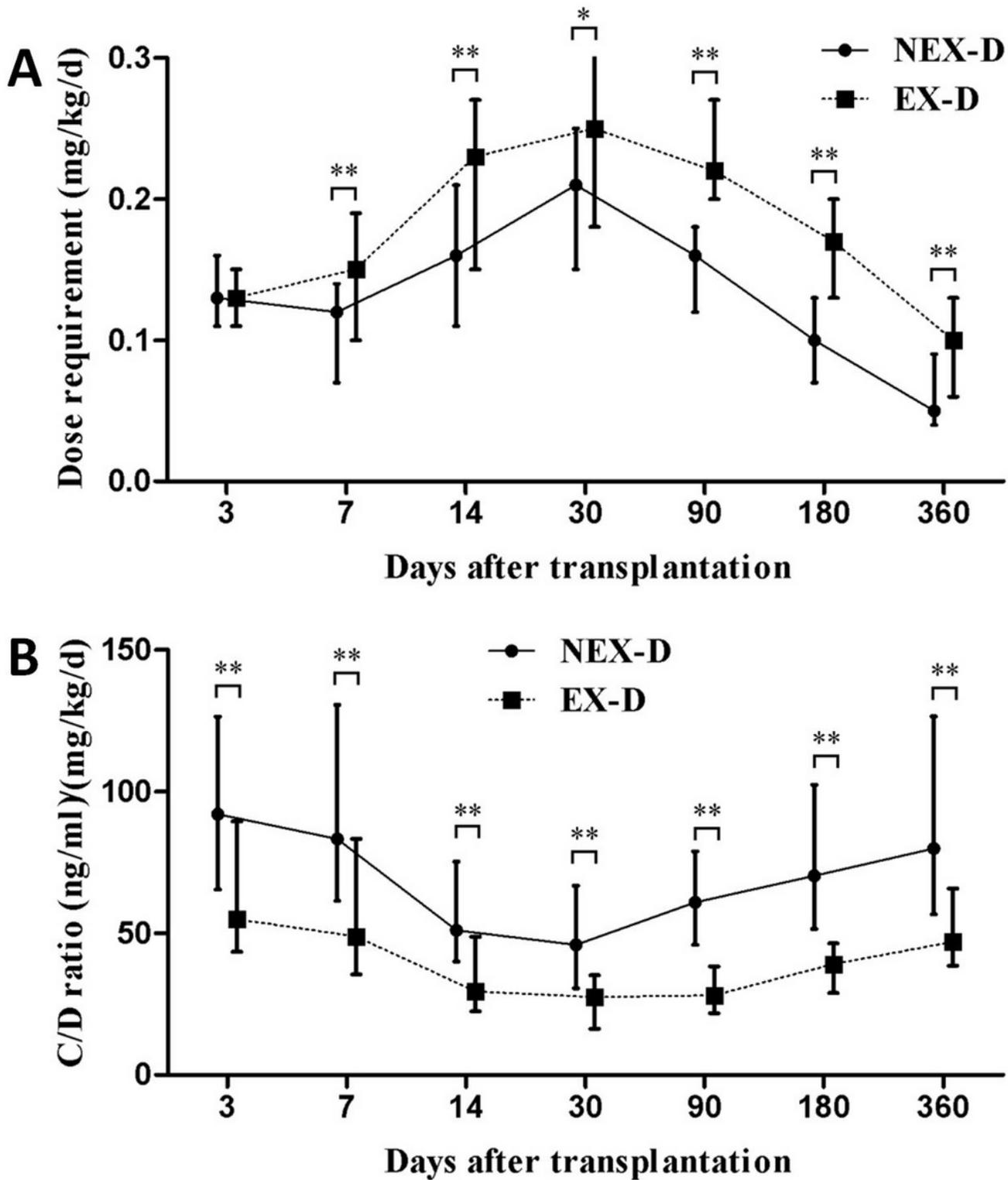


Figure 2

Comparison of tacrolimus dose requirements (A) and C/D ratio (B) between NEX- and EX-grafts recipients. The whiskers mark quartiles; * indicates $P < 0.05$ between 2 groups; ** indicates $P < 0.01$ between 2 groups.

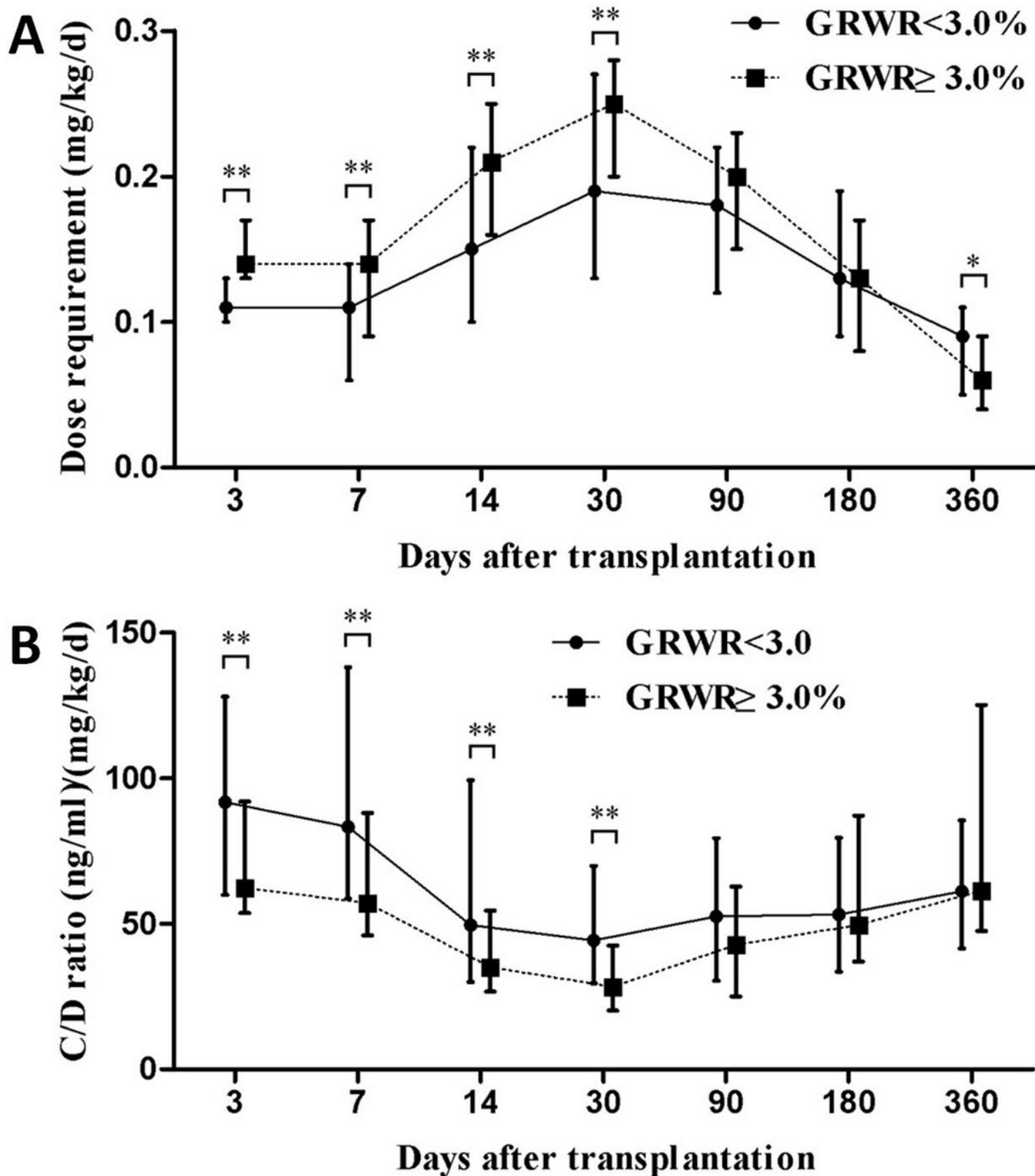


Figure 3

Comparison of tacrolimus dose requirements (A) and C/D ratio (B) between recipients with GRWR < 3.0% or GRWR ≥ 3.0%. The whiskers mark quartiles; * indicates P < 0.05 between 2 groups; ** indicates P < 0.01 between 2 groups.

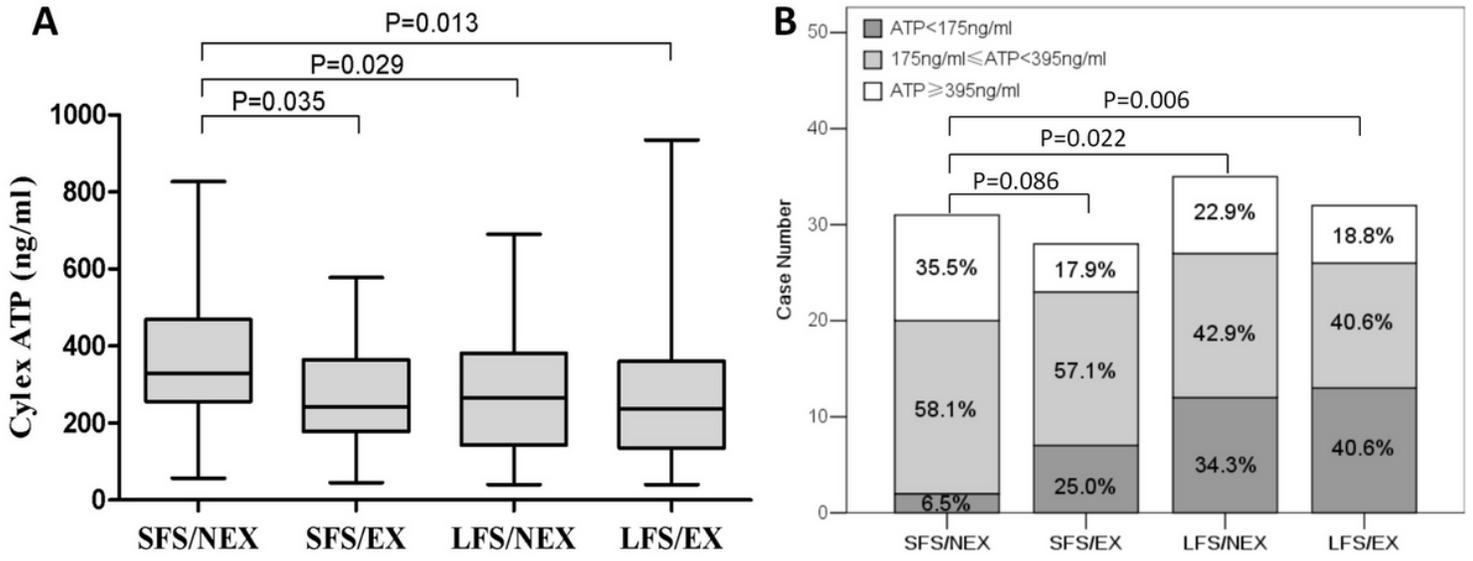


Figure 4

Comparison of Cylex ATP values among different groups. A. Box-plots of Cylex ATP values (The boxes mark median values and quartiles, and the whiskers mark maximum and minimum values). B. Proportions of patients with strong, moderate and low immune functions. Low immune response: ATP < 175 ng/ml; moderate immune response: 175 ng/ml ≤ ATP < 395 ng/ml; strong immune response: ATP ≥ 395 ng/ml.

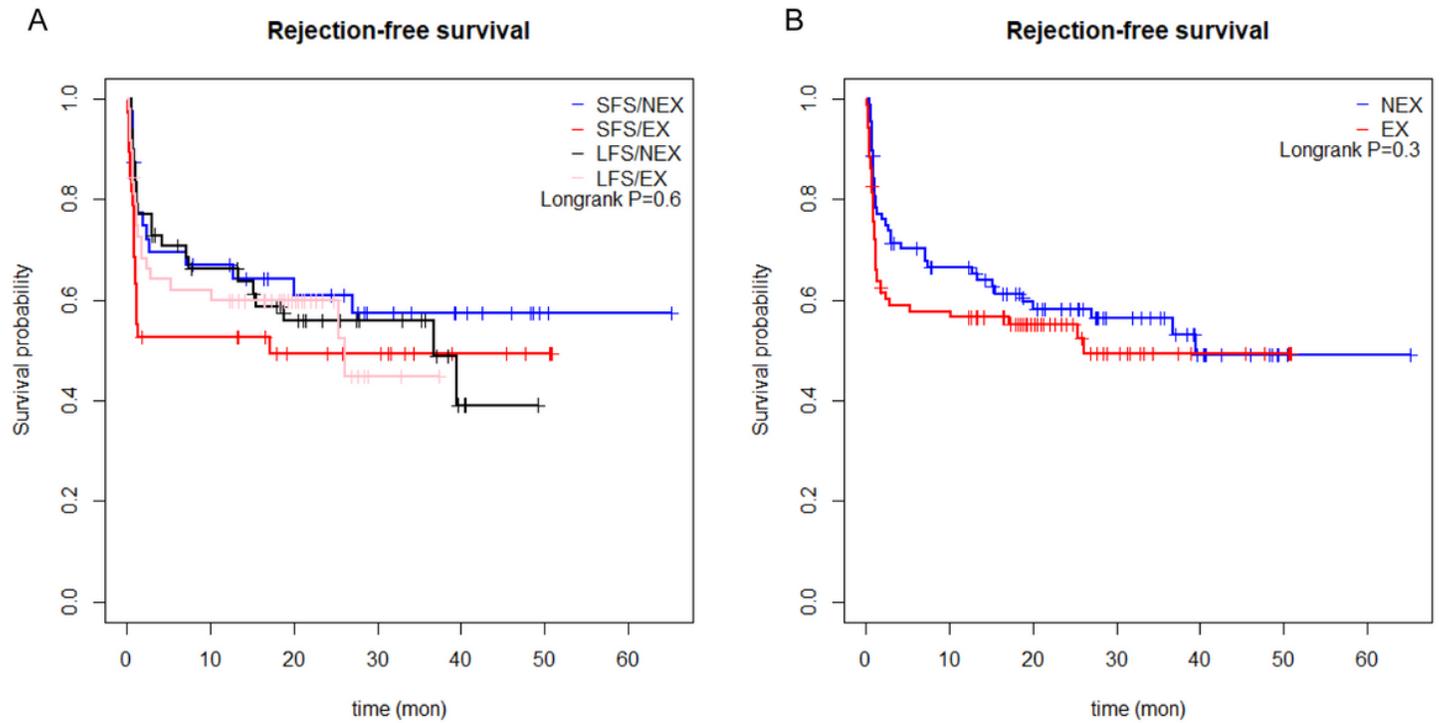


Figure 5

A. Comparison of postransplant rejection-free survival rates among different groups (P=0.6). B. Comparison of postransplant rejection-free survival rates between patients with donor CYP3A5 expressed

or non-expressed (P=0.3).