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1 **Pre-transplant donor CD4<sup>+</sup> invariant NKT cell expansion capacity predicts**  
2 **the occurrence of acute graft-versus-host disease**

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44 **Running head:** Graft CD4<sup>+</sup> invariant NKT expansion predicts GVHD

45 **Key points:**

46 -Graft CD4<sup>+</sup> iNKT cell *ex vivo* expansion capacity is the best graft parameter capable of  
47 predicting the occurrence of acute GVHD after allogeneic stem cell transplantation from  
48 peripheral blood stem cells

49 -Donor CD4<sup>+</sup> iNKT cell expansion capacity test could be used to select the best donor before  
50 performing allogeneic stem cell transplantation with PBSC

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60

61 **ABSTRACT**

62 Clinically useful pre-transplant predictive factors of acute graft-versus-host-disease  
63 (aGVHD) after allogeneic hematopoietic stem cell transplantation (allo-SCT) are lacking. We  
64 prospectively analyzed HSC graft content in CD34<sup>+</sup>, NK, conventional T, regulatory T and  
65 invariant NKT (iNKT) cells in 117 adult patients before allo-SCT. Results were correlated  
66 with occurrence of aGVHD and relapse. In univariate analysis, iNKT cells were the only  
67 graft cell populations associated with occurrence of aGVHD. In multivariate analysis, CD4<sup>-</sup>  
68 iNKT/T cell frequency could predict grade II-IV aGVHD in bone marrow and peripheral  
69 blood stem cell (PBSC) grafts, while CD4<sup>-</sup> iNKT expansion capacity was predictive in PBSC  
70 grafts. ROC analyses determined the CD4<sup>-</sup> iNKT expansion factor as the best predictive  
71 factor of aGVHD. Incidence of grade II-IV aGVHD was reduced in patients receiving a graft  
72 with an expansion factor above versus below 6.83 (9.7% vs. 80%, p<0.0001), while relapse  
73 incidence at two years was similar (p=0.5).—The test reached 94% sensitivity and 100%  
74 specificity in the subgroup of patients transplanted with HLA 10/10 PBSCs without active  
75 disease. Analysis of this CD4<sup>-</sup> iNKT expansion capacity test may represent the first  
76 diagnostic tool allowing selection of the best donor to avoid severe aGVHD with preserved  
77 GVL effect after PB allo-SCT.

78

## 79 INTRODUCTION

80 Allogeneic hematopoietic stem cell transplantation (allo-SCT) is a curative procedure for  
81 malignant haematological disorders, due to the graft versus leukemia (GVL) effect, but is  
82 however often hampered by the occurrence of a life threatening acute (a) graft versus host  
83 disease (GVHD) (1). Therefore, one of the main challenges of allo-SCT remains to identify  
84 factors that would allow predicting the risk of aGVHD without impairing the GVL effect.  
85 Although several host and donor pre-transplant clinical, immunological and genetic  
86 characteristics have been well established as factors correlated to aGVHD (2), none of them  
87 can be used to select the best donor or to help deciding to perform or not SCT.  
88 Graft content in T cell subsets has been correlated to the risk of aGVHD, in particular naïve  
89 CD45RA<sup>+</sup> CD4<sup>+</sup> T cells (3), naïve and central memory CCR7<sup>+</sup> CD4<sup>+</sup> T cells (4), or CD8<sup>+</sup>  
90 effector memory (CD45RA-CD62L<sup>-</sup>) T cells (5). Immunoregulatory T cells such as  
91 CD4<sup>+</sup>CD25<sup>+</sup>FoxP3<sup>+</sup> CD127<sup>low</sup> regulatory T lymphocytes (Tregs) (6, 7) and invariant natural  
92 killer T (iNKT) cells (8-14) represent other cellular targets in order to regulate donor T cell  
93 alloreactivity in experimental mouse models. Some data suggest the involvement of these  
94 cells in humans as well (15-22). We previously reported that enhanced early post-transplant  
95 iNKT cell reconstitution from donor cells was correlated to reduced risk of aGVHD without  
96 impairment of the GVL effect (23) while Treg cell reconstitution was not. Likewise, graft  
97 content in CD4<sup>-</sup> iNKT cells, but not in Tregs, was associated to the risk of aGVHD in allo-  
98 SCT performed with peripheral blood stem cells (PBSCs) from HLA-identical siblings (24,  
99 25). Although these studies suggest a role of CD4<sup>-</sup> iNKT cells for the control and prediction  
100 of aGVHD, because of their great variability in terms of numbers, it is currently difficult to  
101 define a threshold of graft iNKT cell dose predicting with high specificity and sensitivity the  
102 risk of aGVHD. We show here that *in vitro* donor CD4<sup>-</sup> iNKT cell expansion capacity  
103 represents the best predictive factor of aGVHD without impairment of the GVL effect in allo-  
104 SCT performed with PBSC grafts.

105

## 106 PATIENTS AND METHODS

### 107 Patients

108 Between June 2010 and January 2014, 117 adult patients who underwent an allo-SCT in  
109 three transplant institutions (Saint Antoine, Necker and Pitié-Salpêtrière hospitals, Paris)  
110 entered the study. All patients and their sibling donors provided an informed consent for  
111 biological research purposes. The study was conducted according to the procedures of the  
112 Declaration of Helsinki and the local ethic committee rules. Diagnosis and grading of acute  
113 and chronic GVHD were performed as described (26, 27) by physicians in charge of the  
114 patients who were not aware of the results of laboratory tests.

### 115 Flow cytometry analysis

116 Analyses were performed on 117 HSC grafts (freshly harvested in 96 and from thawed cells  
117 in 21). Among those, 21 freshly harvested sibling donor blood cells drawn before  
118 mobilization of HSC by G-CSF were analyzed and compared to the corresponding HSC  
119 graft. Graft cell phenotype was performed in all 117 HSC grafts, while *ex vivo* iNKT  
120 expansion tests could only be performed on the 96 freshly harvested grafts. Post-transplant  
121 peripheral immune reconstitution was analyzed from 30 recipients on days 30±5, 60±5 and  
122 90±5 days after transplantation (**Figure S1**). In all analyses, mononuclear cells were isolated  
123 by density-gradient centrifugation (Ficoll-Paque™ PLUS, GE Helthcare). Cells were first  
124 stained with PBS57-loaded or empty-CD1d-tetramers (NIH Tetramer Core Facility) and with  
125 the following monoclonal antibodies: anti-CD3, -CD4, -CD8, -CD56, -CD25, -CD127, -  
126 CD45RA, - $\gamma\delta$ TCR, -CD161, -FoxP3, -Ki67 (eBioscience), anti-V $\alpha$ 7.2TCR (Biolegend). Data  
127 were acquired on a FACS Canto II flow cytometer using FACS Diva software (BD  
128 Biosciences), and were analyzed with the FlowJo software (Tree Star Inc). Lymphocyte  
129 subpopulations were analyzed within the lymphocyte gate on forward and side-scatter plots  
130 as described in **Figure S2**. iNKT cells were specifically detected by the co-expression of  
131 CD3 and PBS57-loaded CD1d-tetramer, Tregs were analyzed as described by Sakaguchi's

132 group (28) and Mucosal-associated invariant T (MAIT) cells were identified as previously  
133 reported (29). Results were expressed in absolute numbers or in terms of cell subtype/ $10^2$  or  
134  $10^3$  T lymphocyte ratios (**Table S1**). Since iNKT cells represent a rare population of T  
135 lymphocytes, data were considered as reliable when a minimum of  $1 \times 10^6$  mononuclear cells  
136 were stained and at least  $5 \times 10^4$  CD3<sup>+</sup> T cells with a minimum of 20 iNKT CD3<sup>+</sup> CD1d  
137 Tetramer<sup>+</sup> cells acquired. Doses of the different cell subtypes were extrapolated from the  
138 multiplication of CD3<sup>+</sup> T cell dose by the corresponding cell subtype/T cell ratio.

### 139 **Functional studies of iNKT cells**

140 Mononuclear cells from freshly harvested peripheral blood, BM or PBSC grafts were  
141 cultured in 24-well plates at a density of  $1 \times 10^6$  cells per well in 2mL of RPMI-1640 medium  
142 supplemented with 10% fetal bovine serum (FBS), 100U/mL penicillin and streptomycin,  
143 200mM L-glutamine, and 10mM HEPES (All from Life Technologies). Alpha-  
144 galactosylceramide (KRN7000, Avanti Polar Lipids) was added at 100 ng/mL at the onset of  
145 culture, followed 24h later by rhIL-2 at 845U/mL (ImmunoTools). After 2 weeks, cells were  
146 collected, washed extensively before surface staining, as described above and represented in  
147 **Figure S3**. The expansion factor was calculated by dividing the number of each cell subset  
148 obtained on Day 15 by the number of cells on Day 0.

### 149 **Statistical analyses**

150 Statistical analyses were performed using the R program (30). Means were compared using  
151 the non-parametric Wilcoxon and proportions using the Fisher exact or Chi-square tests, as  
152 appropriate. Correlations between continuous variables were calculated using the non-  
153 parametric Spearman's rank correlation test. Overall survival (OS) was measured from the  
154 date of HSCT to the date of death from any cause or of last follow-up. Non-relapse mortality  
155 (NRM) was defined as death occurring in continuous complete remission (CR). None of the  
156 patients were lost of follow-up and all were censored at date of death or last-follow-up.  
157 Median follow up of patients alive was 681 days (range 153-1348).

158 Univariate and multivariate Cox proportional hazards models were analyzed using the  
159 survival package (31). OS curves were established using the Kaplan-Meier method and  
160 statistical differences in survival distributions according to baseline parameters and the  
161 expansion factor of CD4<sup>+</sup> iNKT cells were assessed using the logrank test. Cox proportional  
162 hazard model was used for multivariate analysis. CD4<sup>+</sup> iNKT/10<sup>3</sup> T frequency and CD4<sup>+</sup>  
163 iNKT expansion factor covariates were log transformed to ensure a normal distribution. The  
164 martingale residuals versus the log-transformed covariates were well distributed around the 0  
165 ordinate line, with no trend or particular shape observed. Acute GVHD occurred in all  
166 patients before day 100 and was analyzed as a time-dependent covariate in the Cox model.  
167 Stepwise regression consisting of alternating forward and backward elimination steps was  
168 used to find the most parsimonious set of significant covariates using the Bayesian  
169 Information criterion (BIC). The internal validation of the multivariate analysis was assessed  
170 using a bootstrap method.

171 In order to assess the ability of the expansion factor of CD4<sup>+</sup> iNKT cells to predict aGVHD,  
172 the value of that factor and actual development of aGVHD were subjected to receiver  
173 operating characteristic (ROC) curve analysis (32) using the ROCR package (33). A  
174 bootstrap method was used to calculate the 95% confidence interval of the AUC of ROC  
175 curves.

176 A p-value of 0.05 was considered statistically significant for all analyses, except for  
177 univariate analysis including multiple biological parameters associated with the occurrence of  
178 acute GVHD in which an adjusted p-value of 0.0017, corresponding to 0.05/30 factors, was  
179 applied. Two-sided tests were used in all analyses.

180

## 181 RESULTS

### 182 Patients, treatment assignments and transplant outcomes

183 Clinical characteristics for the 117 patients included in the study are summarized in **Table 1**.

184 Median age at transplantation was 49.7 years for recipients and 42.4 years for donors. A  
185 majority of patients (66%) received an allogeneic HSCT for acute leukemia. Sixty nine  
186 (59%) received an allograft from an HLA-identical sibling, 42 (36%) from a matched  
187 unrelated donor and 6 (5%) from a mismatched unrelated donor. HSC were obtained from  
188 unmanipulated BM in 33 (28%) or PBSC in 84 (72%) transplanted patients. The choice of  
189 conditioning was dependent on the underlying disease, recipient's age and co-morbidities:  
190 myeloablative conditioning (MAC) for patients in CR under 50 years of age and without co-  
191 morbidities (42%), conventional reduced intensity conditioning (RIC) for patients above 50  
192 years or presenting co-morbidities (47%), and sequential-based RIC regimen (34) for  
193 refractory diseases (11%). Altogether, 63 (54 %) patients received an *in vivo* T cell depletion  
194 with ATG-Thymoglobuline (total dose 5 mg/kg), mainly with unrelated PBSCs or with  
195 fludarabine-busulfan RIC.

196 With a median follow up of 15 months (range 1-45), cumulative incidence (CI) of grade II-  
197 IV aGVHD was 25% (95% CI, 14-38%) at day 100. At 2 years, CI of NRM was 14.5% (95%  
198 CI, 3-35%), CI of chronic GVHD was in 57% (95% CI, 47-66%), relapse incidence was 35%  
199 (95% CI, 22-48%) and OS was 64 % (95% CI, 53-73%).

### 200 Graft cell content and iNKT subsets' expansion capacities of donor grafts

201 In all 117 HSC grafts, we measured graft cell content in CD34, CD56 NK, CD3 T, total CD4  
202 T, CD45RA<sup>+</sup> and CD45RA<sup>-</sup> CD4 T, CD8 T,  $\gamma\delta$  T, MAIT, total, naïve and memory Tregs, and  
203 total iNKT cells, as well as CD4<sup>+</sup> and CD4<sup>-</sup> iNKT cell subsets. CD4<sup>+</sup> and CD4<sup>-</sup> iNKT cell  
204 expansion was carried out in 96 freshly harvested grafts (77 from PB and 19 from BM stem  
205 cells) (**Table S1**). The frequencies of total iNKT and CD4<sup>-</sup> iNKT cells among T cells were  
206 similar between PBSC and BM grafts, while the frequency of the minority CD4<sup>+</sup> iNKT cell

207 subtype was slightly higher in BM than in PBSC grafts ( $p=0.02$ ) (**Table S2**). Because PBSC  
208 contained one log higher number of T cells than BM grafts, all iNKT cell subset doses were  
209 increased in PBSCs ( $p<0.0001$ ) (**Table S2**). *Ex vivo* expansion capacities of both CD4<sup>+</sup> and  
210 CD4<sup>-</sup> iNKT cells were higher in PBSC as compared to BM grafts ( $p<0.05$ ) (**Table S2**). Age  
211 of donor had a negative impact on the frequency and dose of CD4<sup>+</sup> iNKT cells ( $p=0.049$ ), but  
212 not on CD4<sup>-</sup> iNKT cells (**Table S3**).

#### 213 **Graft parameter and pre-transplant factors associated with the occurrence of grade II-** 214 **IV aGVHD**

215 In univariate analysis, in the total cohort of patients, those who developed grade II-IV  
216 aGVHD received a graft with higher frequencies of CD45RA<sup>+</sup> CD4<sup>+</sup> T cells ( $p=0.045$ ), lower  
217 frequencies of total, CD4<sup>+</sup> and CD4<sup>-</sup> iNKT cells ( $p=0.001$ ,  $p=0.021$  and  $p=0.0005$ ,  
218 respectively), and lower doses of total and CD4<sup>-</sup> iNKT cells ( $p=0.027$  and  $0.025$ ,  
219 respectively) (**Table 2 and Figure S4**). Functional analyses of iNKT cell subsets showed  
220 significantly reduced expansion capacities of the CD4<sup>-</sup> iNKT cells in patients developing  
221 grade II-IV aGVHD ( $p=0.0007$ ). None of the other graft parameters analyzed including total,  
222 naïve and memory Tregs were associated with the occurrence of acute GVHD. The only pre-  
223 transplant parameter associated with a higher risk of developing grade II-IV aGVHD was the  
224 use of an unrelated donor ( $p= 0.00004$ ) (**Table 2**).

225 Cumulative incidence of grade II-IV aGVHD at day 100 in patients receiving a graft with an  
226 iNKT cell dose below or above the median for total iNKT cells was 33% versus 17%  
227 ( $p=0.028$ ). However, when p-value was adjusted to the multiple tests performed in univariate  
228 analysis, the remaining significant factors associated to the occurrence of aGVHD were  
229 frequencies of total iNKT cells, frequency and expansion capacity of CD4<sup>-</sup> iNKT cells and  
230 type of donor ( $p\leq 0.00017$ ).

231 Analyses performed separately between patients transplanted with BM and PB confirmed the  
232 correlation between frequencies of total and CD4<sup>-</sup> iNKT cells and occurrence of aGVHD in

233 both subgroups of stem cell source, but the association with the CD4<sup>+</sup> iNKT expansion factor  
234 was only observed in the PBSC group (Tables S3 and S4).

235 In multivariate analysis, among all the graft parameters analyzed, the only two associated  
236 with an independent reduced risk of developing grade II-IV aGVHD were the frequency of  
237 CD4<sup>+</sup> iNKT cells (Odd ratio (OR)=0.56, 95% confidence interval (CI)= 0.38-0.84, p=0.0048)  
238 and the expansion factor of CD4<sup>+</sup> iNKT cells (OR=0.72, 95% CI= 0.55-0.82, p<0.001)  
239 (**Table 3, Model 1**). The use of matched unrelated donors (MUD) and progressive disease  
240 (PD) status at transplant were the other pre-transplant factors associated with an increased  
241 risk of grade II-IV aGVHD (OR=8.16, 95% CI=3-22.1, p<0.0001 for MUD and OR=10, 95%  
242 CI=3-33.5, p=0.00017 for PD) (**Table 3, Model 1**). Predictive value of these factors on the  
243 occurrence of severe aGVHD was confirmed in an internal validation test by using the  
244 bootstrap method (**Table 3**).

245 In a Cox model taking into account the stem cell source and after adjusting to donor type and  
246 disease status at transplantation, the graft CD4<sup>+</sup> iNKT/T frequency could significantly predict  
247 the occurrence of grade II-IV aGVHD in both PB and BM transplants, but the CD4<sup>+</sup> iNKT  
248 expansion factor was only significant in PBSC grafts (**Table 3, Model 2**).

#### 249 **Determination of the best graft factor and threshold predicting aGVHD occurrence**

250 Using ROC analyses, the predictive value in the global population of patients with available  
251 iNKT expansion tests of the whole model including CD4<sup>+</sup> iNKT frequency and expansion  
252 factor, donor type and disease status at SCT was high with an area under the curve (AUC) of  
253 0.927 (95% CI: 0.86-0.994) (**Figure 1A**). However, because such model remains complex for  
254 clinical application, we sought to determine which of the graft CD4<sup>+</sup> iNKT frequency or  
255 expansion factor might be the most useful. In this objective, we compared the sensitivity and  
256 specificity of these two parameters to predict the occurrence of grade II-IV aGVHD in the  
257 total population of patients and in the subgroups of patients transplanted with BM or PB stem

258 cells (**Table 4A**). Both factors were highly sensitive (>90%) but the CD4<sup>+</sup> iNKT expansion  
259 factor provided the best specificity in all subpopulations of patients analyzed.

260 In the total population of 96 patients with available functional iNKT tests, the CD4<sup>+</sup> iNKT  
261 expansion factor could discriminate the risk of grade II-IV aGVHD at day 100, with an AUC  
262 of 0.767 (**Table 4A and Figure 1B**). A CD4<sup>+</sup> iNKT expansion factor cut-off of 6.83 provided  
263 the best balance between sensitivity and specificity, with 94% true and 36% false positive  
264 rates. Pre-transplant characteristics of patients transplanted with a graft providing a CD4<sup>+</sup>  
265 iNKT expansion factor below or above the 6.83 threshold were comparable except for  
266 increased siblings in the good expander group (73.5% vs 30%, p=0.00037) (**Table S6**). Using  
267 this cut-off point, 16 patients out of 20 (80%) with a CD4<sup>+</sup> iNKT expansion factor below 6.83  
268 experienced grade II-IV aGVHD, while only 9 out of 76 (12%) with CD4<sup>+</sup> iNKT expansion  
269 factor above 6.83 did so (**Figure 1C**). In contrast, relapse incidence at 2 years was  
270 comparable between the two groups (31% vs. 35%, p=0.50) (**Figure 1D**), as well as  
271 incidence of chronic GVHD (CI at 2 years of 68% vs. 55%, p=0.45) (**Figure 1E**). In this  
272 series of patients, 25 developed a grade II and 4 a grade III-IV aGVHD, of whom only 4  
273 patients died of acute and 2 of chronic GVHD. At two years, NRM and OS therefore were  
274 comparable between the two groups of patients (17.2% versus 10.4%, p=0.53, and 67%  
275 versus 63%, p=0.58, respectively) (**Figure 1F and 1G**, respectively).

276 In the subgroup of patients transplanted with PBSC grafts with available iNKT expansion  
277 tests (n=77), the AUC of the expansion test was 0.772 (**Table 4A**). Using an expansion factor  
278 cutoff of 8.7, 12 of 15 (80%) patients with an expansion factor below 8.7 developed grade II-  
279 IV aGVHD compared to 6 of 62 (10%) patients above the threshold (p<0.001). These two  
280 subgroups of patients had otherwise comparable relapse risk, non relapse mortality and  
281 overall survival (data not shown).

282

283 **Correlation between graft CD4<sup>-</sup> iNKT expansion factor, other graft characteristics and**  
284 **post-transplant iNKT reconstitution**

285 We compared the different graft characteristics in patients who received a graft with a CD4<sup>-</sup>  
286 iNKT cell expansion factor above (n=76) or below (n=20) the previously determined  
287 threshold of 6.83 in the total population of patients. The CD4<sup>+</sup> iNKT cell expansion factor  
288 was also higher in grafts with a CD4<sup>-</sup> iNKT cell expansion factor  $\geq 6.83$  in comparison to  
289 those below that threshold (p=0.03) (**Figure 2A**). Grafts with a higher expansion capacity of  
290 CD4<sup>-</sup> iNKT cells contained similar doses of CD34<sup>+</sup> HSC, NK cells, CD3<sup>+</sup>, CD4<sup>+</sup>, CD8<sup>+</sup>,  $\gamma\delta^+$   
291 and regulatory T cells than grafts with a lower expansion capacity but higher doses of MAIT  
292 cells (p=0.01) (**Figure 2B**). Grafts with enhanced CD4<sup>-</sup> iNKT expansion capacity had also  
293 significantly higher frequencies and doses of total and CD4<sup>-</sup> iNKT cells (p<0.05 for all)  
294 (**Figure 2C and 2D**). Patients who received a graft with a CD4<sup>-</sup> iNKT cell expansion factor  
295 above 6.83 (n=21) had higher levels of total PB iNKT cells on day 30, 60 and day 90 (p<0.05  
296 for all) post-transplantation than those with a CD4<sup>-</sup> iNKT expansion factor < 6.83 (n=9)  
297 (**Figure 2E**).

298 **Determination of the most appropriate allo-SCT context in which the CD4<sup>-</sup> iNKT**  
299 **expansion test can predict aGVHD**

300 Since occurrence of grade II-IV aGVHD was also associated with progressive disease status  
301 at transplant (**Table 3**), we performed ROC analyses in the 79 patients allografted in non-  
302 progressive disease with an HLA 10/10 matched donor. In comparison to the whole  
303 population, the value of the graft CD4<sup>-</sup> iNKT expansion factor AUC in the prediction of  
304 grade II-IV aGVHD was improved in this subgroup of patients (AUC=0.90) (**Table 4B**). In  
305 this context, the predictive value of the test was confirmed to be limited for BM grafts  
306 (AUC=0.679) but optimal for PBSC grafts (AUC=0.986), with 94% sensitivity and 100%  
307 specificity (**Table 4B and Figure 3**). In the predominant group of patients transplanted with  
308 HLA compatible PBSCs and non progressive disease at transplant (n=60), ten of the 14

309 patients (71%) who received a graft with a CD4<sup>+</sup> iNKT expansion factor below the threshold  
310 of 8.7 developed grade II-IV aGVHD, while none of the 46 patients having received a graft  
311 with a CD4<sup>+</sup> iNKT expansion factor above that threshold did so ( $p < 0.0001$ ) (**Figure 3**).

312 We finally compared the CD4<sup>+</sup> iNKT cell expansion factor from the HSC graft to that  
313 obtained from PBMC from the same donor before the administration of G-CSF (**Table S7**).

314 Although the expansion factor was often higher in the graft, the two tests could similarly  
315 predict the risk of occurrence of aGVHD in all 21 cases tested.

316

317 **DISCUSSION**

318 This study confirms the value of iNKT cells as predictors of aGVHD after allo-SCT in  
319 humans. As reported in the context of allo-SCT performed with PBSC from HLA-identical  
320 sibling donors without *in vivo* T cell depletion (25), our study confirms, that the HSC graft  
321 content in total and CD4<sup>+</sup> iNKT cells represents the only graft cell subtype associated with the  
322 occurrence of grade II-IV aGVHD. In multivariate analyses, we show that higher graft CD4<sup>+</sup>  
323 iNKT T frequencies are associated with reduced risk of aGVHD in BM grafts, while both  
324 graft CD4<sup>+</sup> iNKT frequency and expansion factor could independently predict the occurrence  
325 of aGVHD in PBSC grafts. ROC curves show that the *ex vivo* expansion factor of CD4<sup>+</sup>  
326 iNKT cells represents the best predictive factor for the occurrence of aGVHD in allo-SCT  
327 performed with PBSCs. This iNKT functional test reaches its optimal predictive capacity  
328 with 100% specificity in allo-SCT performed with HLA 10/10 matched PBSC grafts for non-  
329 progressive hematological malignant diseases, which represents the majority of the  
330 indications of allogeneic SCT. Similar predictive value was also observed when the test was  
331 performed from donor's peripheral blood before G-CSF mobilization. Thus, this test could  
332 allow to easily select the best donor if different siblings or unrelated donors are available  
333 before PB allo-SCT.

334 In line with the study of Chaidos et al. who reported, in allo-SCT performed without ATG, a  
335 reduced incidence of aGVHD at day 180 post-transplant in the group of patients receiving a  
336 dose of total iNKT cells above the median (31% versus 61%, p=0.014) (25), we observed  
337 reduced incidence of aGVHD at day 100 post-transplant in patients receiving a total dose of  
338 iNKT cells above the median (17% versus 33%, p=0.028). These observations contrast with  
339 the study of Malard et al., who did not find a significant correlation between iNKT cell dose  
340 and aGVHD incidence in a series of 80 RIC allo-SCT performed with PBSC and ATG (20%  
341 versus 25%, above and below the total iNKT median dose, respectively, p=0.53) (35). In  
342 contrast with other T cells, iNKT cells are spared by the use of total lymphoid irradiation

343 (TLI) and ATG in mice and humans (36-38). Thus, iNKT/T cell frequencies seem more  
344 meaningful to be analyzed, in particular in the context of clinical use of ATG. Unfortunately,  
345 such analysis has not been performed in Malard's study.

346 As described by others (39), the proportions of iNKT cells after G-CSF mobilization were  
347 similar between PBSC and BM grafts. However, iNKT cell doses were significantly  
348 increased in PBSC, and G-CSF mobilized iNKT cells were more prompt to expand in  
349 response to rhIL-2 and  $\alpha$ -GalCer, possibly due to reduced antigen presenting cell numbers in  
350 BM versus PB. This may explain the absence of predictive value of the CD4<sup>-</sup> iNKT cell  
351 expansion factor from BM grafts on the occurrence of aGVHD. We also observed that  
352 frequencies, doses and expansion capacity of CD4<sup>-</sup> iNKT cells were not correlated with  
353 donor age, whereas numbers of CD4<sup>+</sup> iNKT cells declined with donor's age, a phenomenon  
354 explained by the dependence of CD4<sup>+</sup> iNKT cells on thymic output, while CD4<sup>-</sup> iNKT cells  
355 can undergo peripheral homeostatic expansion (40, 41).

356 Although the frequency of iNKT cells and their *ex vivo* expansion capacity in the presence of  
357 IL-2 and  $\alpha$ -GalCer are known to be very variable between individuals (40-42), the reasons  
358 are poorly understood. Croudace et al. showed that poor proliferative responses of iNKT cells  
359 to IL-2 and  $\alpha$ -GalCer were not dependent on the type and concentration of the CD1d ligand  
360 used, nor to the disappearance of iNKT cells during the 14-day culture period, but could be  
361 partially salvaged by the addition of IL-4 (42). The expansion factor of CD4<sup>+</sup> iNKT cells was  
362 higher in grafts with a CD4<sup>-</sup> iNKT expansion factor above 6.83 in comparison to those below  
363 that threshold. Thus, the difference of CD4<sup>-</sup> iNKT cell expansion in the presence of rhIL-2  
364 and  $\alpha$ -GalCer in healthy donors might be due to distinct CD4<sup>+</sup> iNKT cells response to IL-2,  
365 which might subsequently, directly or indirectly impact on the expansion of to the CD4<sup>-</sup>  
366 iNKT cell subset. It has been shown that murine iNKT cells undergo a bystander expansion  
367 and activation depending on IL-2 produced by alloreactive T cells after allo-SCT (43). We  
368 observed an enhanced early post-transplant iNKT cell recovery in patients who received a

369 graft with higher *ex vivo* CD4<sup>-</sup> iNKT cell expansion capacities. These data confirm our  
370 previous report correlating post-transplant iNKT cell recovery with the occurrence of  
371 aGVHD (23), and suggest that the *ex vivo* expansion test of CD4<sup>-</sup> iNKT cells can reflect and  
372 predict the *in vivo* expansion capacities of these cells.

373 In our study, grade II-IV aGVHD occurred in 25 patients and 4 of them developed grade III-  
374 IV aGVHD, which was lethal in 2 cases. Although the CD4<sup>-</sup> iNKT cell expansion factor  
375 could highly predict the occurrence of aGVHD, no impact on NRM and OS was observed.  
376 Despite a very low risk of aGVHD, patients who received a graft with a CD4<sup>-</sup> iNKT cell  
377 expansion factor above 6.83 had preserved GVL effect without increased relapse risk,  
378 possibly due to the unaffected development of chronic GVHD. This observation was in line  
379 with preserved GVL effect observed in patients with higher iNKT cell recovery after allo-  
380 SCT in other studies (21, 23).

381 The mechanisms by which human CD4<sup>-</sup> iNKT cells can control GVHD while preserving the  
382 GVL effect remain to be determined. By comparison to CD4<sup>+</sup> iNKT cells, their CD4<sup>-</sup>  
383 counterparts kill dendritic cells (DCs) and reduce the maturation of monocyte-derived DCs  
384 (25, 44). Whether they can induce Tregs or modulate the cytokine orientation of allogeneic T  
385 cell responses, as reported for murine iNKT cells in mouse models of GVHD (37, 45), will  
386 require further studies.

387 In conclusion, despite the limitations due to the heterogeneity of our series of patients and the  
388 need for prospective validation studies, we describe a clinically useful and relevant tool that  
389 could predict at the individual level the occurrence of aGVHD without impairment of the  
390 GVL effect after allo-SCT performed with PBSC grafts. Therefore, this test could easily be  
391 used to select the best donor before transplantation and/or to adapt post-transplant  
392 immunosuppressive treatments in the recipient.

393

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405 **Authorship contributions:**

406 *Designed the study: MTR, MB, OH*

407 *Collected the data: MTR, MB, TC, FS, DS, AB*

408 *Provided patients data: MTR, FS, AG, DS, AB, EP, SNK, MM, OH*

409 *Provided materials and expertise in cell phenotyping: HTN, MC, OL*

410 *Analyzed the data: MTR, MB, NB, SU, OH*

411 *Wrote and commented on the manuscript: MTR, MB, MM, NB, SU, OH*

412 *All authors approve the final manuscript*

413 **Disclosure of Conflict of interest**

414 The authors declare no financial conflict of interest.

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- 417 1. Ferrara JL, Levine JE, Reddy P, Holler E. Graft-versus-host disease. *Lancet*. 2009;373(9674):1550-61.
- 418 2. Nash RA, Storb R. Graft-versus-host effect after allogeneic hematopoietic stem cell transplantation:
- 419 GVHD and GVL. *Curr Opin Immunol*. 1996;8(5):674-80.
- 420 3. Chang YJ, Zhao XY, Huo MR, Huang XJ. Expression of CD62L on donor CD4(+) T cells in allografts:
- 421 correlation with graft-versus-host disease after unmanipulated allogeneic blood and marrow transplantation.
- 422 *Journal of clinical immunology*. 2009;29(5):696-704.
- 423 4. Yakoub-Agha I, Saule P, Depil S, Micol JB, Grutzmacher C, Boulanger-Villard F, et al. A high
- 424 proportion of donor CD4+ T cells expressing the lymph node-homing chemokine receptor CCR7 increases
- 425 incidence and severity of acute graft-versus-host disease in patients undergoing allogeneic stem cell
- 426 transplantation for hematological malignancy. *Leukemia*. 2006;20(9):1557-65.
- 427 5. Loschi M, Porcher R, Peffault de Latour R, Vanneaux V, Robin M, Xhaard A, et al. High number of
- 428 memory t cells is associated with higher risk of acute graft-versus-host disease after allogeneic stem cell
- 429 transplantation. *Biol Blood Marrow Transplant*. 2015;21(3):569-74.
- 430 6. Edinger M, Hoffmann P, Ermann J, Drago K, Fathman CG, Strober S, et al. CD4+CD25+ regulatory T
- 431 cells preserve graft-versus-tumor activity while inhibiting graft-versus-host disease after bone marrow
- 432 transplantation. *Nat Med*. 2003;9(9):1144-50.
- 433 7. Trenado A, Sudres M, Tang Q, Maury S, Charlotte F, Gregoire S, et al. Ex vivo-expanded
- 434 CD4+CD25+ immunoregulatory T cells prevent graft-versus-host-disease by inhibiting
- 435 activation/differentiation of pathogenic T cells. *J Immunol*. 2006;176(2):1266-73.
- 436 8. Hashimoto D, Asakura S, Miyake S, Yamamura T, Van Kaer L, Liu C, et al. Stimulation of host NKT
- 437 cells by synthetic glycolipid regulates acute graft-versus-host disease by inducing Th2 polarization of donor T
- 438 cells. *J Immunol*. 2005;174(1):551-6.
- 439 9. Kuwatani M, Ikarashi Y, Iizuka A, Kawakami C, Quinn G, Heike Y, et al. Modulation of acute graft-
- 440 versus-host disease and chimerism after adoptive transfer of in vitro-expanded invariant Valpha14 natural killer
- 441 T cells. *Immunol Lett*. 2006;106(1):82-90.
- 442 10. Morris ES, MacDonald KP, Rowe V, Banovic T, Kuns RD, Don AL, et al. NKT cell-dependent
- 443 leukemia eradication following stem cell mobilization with potent G-CSF analogs. *J Clin Invest*.
- 444 2005;115(11):3093-103.
- 445 11. Yang J, Gao L, Liu Y, Ren Y, Xie R, Fan H, et al. Adoptive therapy by transfusing expanded donor
- 446 murine natural killer T cells can suppress acute graft-versus-host disease in allogeneic bone marrow
- 447 transplantation. *Transfusion*. 2009.
- 448 12. Pillai A, Teo P, George T, Mukhopadhyay A, Dejbakhsh-Jones S, Strober S. Alloantigen recognition is
- 449 critical for CD8 T cell-mediated graft anti-tumor activity against murine BCL1 lymphoma after myeloablative
- 450 bone marrow transplantation. *Bone Marrow Transplant*. 2007;40(5):487-97.
- 451 13. Leveson-Gower DB, Olson JA, Sega EI, Luong RH, Baker J, Zeiser R, et al. Low doses of natural
- 452 killer T cells provide protection from acute graft-versus-host disease via an IL-4-dependent mechanism. *Blood*.
- 453 2011;117(11):3220-9.
- 454 14. Kuns RD, Morris ES, Macdonald KP, Markey KA, Morris HM, Raffelt NC, et al. Invariant natural
- 455 killer T cell-natural killer cell interactions dictate transplantation outcome after alpha-galactosylceramide
- 456 administration. *Blood*. 2009;113(23):5999-6010.
- 457 15. Magenau JM, Qin X, Tawara I, Rogers CE, Kitko C, Schlough M, et al. Frequency of
- 458 CD4(+)/CD25(hi)FOXP3(+) regulatory T cells has diagnostic and prognostic value as a biomarker for acute
- 459 graft-versus-host-disease. *Biol Blood Marrow Transplant*. 2010;16(7):907-14.
- 460 16. Ukena SN, Velaga S, Geffers R, Grosse J, Baron U, Buchholz S, et al. Human regulatory T cells in
- 461 allogeneic stem cell transplantation. *Blood*. 2011;118(13):e82-92.
- 462 17. Kawano Y, Kim HT, Matsuoka K, Bascug G, McDonough S, Ho VT, et al. Low telomerase activity in
- 463 CD4+ regulatory T cells in patients with severe chronic GVHD after hematopoietic stem cell transplantation.
- 464 *Blood*. 2011;118(18):5021-30.
- 465 18. Zorn E, Kim HT, Lee SJ, Floyd BH, Litsa D, Arumugarajah S, et al. Reduced frequency of FOXP3+
- 466 CD4+CD25+ regulatory T cells in patients with chronic graft-versus-host disease. *Blood*. 2005;106(8):2903-11.
- 467 19. Di Ianni M, Falzetti F, Carotti A, Terenzi A, Castellino F, Bonifacio E, et al. Tregs prevent GVHD and
- 468 promote immune reconstitution in HLA-haploidentical transplantation. *Blood*. 2011;117(14):3921-8.
- 469 20. Koreth J, Matsuoka K, Kim HT, McDonough SM, Bindra B, Alyea EP, 3rd, et al. Interleukin-2 and
- 470 regulatory T cells in graft-versus-host disease. *N Engl J Med*. 2011;365(22):2055-66.
- 471 21. de Lalla C, Rinaldi A, Montagna D, Azzimonti L, Bernardo ME, Sangalli LM, et al. Invariant NKT cell
- 472 reconstitution in pediatric leukemia patients given HLA-haploidentical stem cell transplantation defines distinct
- 473 CD4+ and CD4- subset dynamics and correlates with remission state. *J Immunol*. 2010;186(7):4490-9.
- 474 22. Beziat V, Nguyen S, Exley M, Achour A, Simon T, Chevallier P, et al. Shaping of iNKT cell repertoire
- 475 after unrelated cord blood transplantation. *Clin Immunol*. 2010;135(3):364-73.

476 23. Rubio MT, Moreira-Teixeira L, Bachy E, Bouillie M, Milpied P, Coman T, et al. Early  
477 posttransplantation donor-derived invariant natural killer T-cell recovery predicts the occurrence of acute graft-  
478 versus-host disease and overall survival. *Blood*. 2012;120(10):2144-54.

479 24. Rosenzweig M, Dhedin N, Maury S, Bensimon G, Landau DA, Norol F, et al. Regulatory T cell  
480 content in the bone marrow graft does not predict the occurrence of acute GVHD. *Biol Blood Marrow*  
481 *Transplant*. 2010.

482 25. Chaidos A, Patterson S, Szydlo R, Chaudhry MS, Dazzi F, Kanfer E, et al. Graft invariant natural killer  
483 T-cell dose predicts risk of acute graft-versus-host disease in allogeneic hematopoietic stem cell transplantation.  
484 *Blood*. 2012;119(21):5030-6.

485 26. Przepiora D, Weisdorf D, Martin P, Klingemann HG, Beatty P, Hows J, et al. 1994 Consensus  
486 Conference on Acute GVHD Grading. *Bone Marrow Transplant*. 1995;15(6):825-8.

487 27. Shulman HM, Sullivan KM, Weiden PL, McDonald GB, Striker GE, Sale GE, et al. Chronic graft-  
488 versus-host syndrome in man. A long-term clinicopathologic study of 20 Seattle patients. *Am J Med*.  
489 1980;69(2):204-17.

490 28. Miyara M, Yoshioka Y, Kitoh A, Shima T, Wing K, Niwa A, et al. Functional delineation and  
491 differentiation dynamics of human CD4+ T cells expressing the FoxP3 transcription factor. *Immunity*.  
492 2009;30(6):899-911.

493 29. Martin E, Treiner E, Duban L, Guerri L, Laude H, Toly C, et al. Stepwise development of MAIT cells  
494 in mouse and human. *PLoS Biol*. 2009;7(3):e54.

495 30. R Development Core Team. R : A language and environment for statistical computing. 2006 [cited  
496 ISBN 3-900051-07-0, URL <http://www.R-project.org/>].

497 31. Therneau TM, Grambsch PM. *Modeling Survival Data: Extending the Cox Model*. . Springer New  
498 York. 2000(ISBN 0-387-98784-3).

499 32. Tosteson TD, Buonaccorsi JP, Demidenko E, Wells WA. Measurement error and confidence intervals  
500 for ROC curves. *Biometrical journal Biometrische Zeitschrift*. 2005;47(4):409-16.

501 33. Sing T, Sander O, Beerenwinkel N, Lengauer T. ROCR: visualizing classifier performance in R.  
502 *Bioinformatics*. 2005;21(20):3940-1.

503 34. Schmid C, Schleuning M, Ledderose G, Tischer J, Kolb HJ. Sequential regimen of chemotherapy,  
504 reduced-intensity conditioning for allogeneic stem-cell transplantation, and prophylactic donor lymphocyte  
505 transfusion in high-risk acute myeloid leukemia and myelodysplastic syndrome. *J Clin Oncol*.  
506 2005;23(24):5675-87.

507 35. Malard F, Labopin M, Chevallier P, Guillaume T, Duquesne A, Rialland F, et al. Larger number of  
508 invariant natural killer T cells in PBSC allografts correlates with improved GVHD-free and progression-free  
509 survival. *Blood*. 2016;127(14):1828-35.

510 36. Pillai AB, George TI, Dutt S, Teo P, Strober S. Host NKT cells can prevent graft-versus-host disease  
511 and permit graft antitumor activity after bone marrow transplantation. *J Immunol*. 2007;178(10):6242-51.

512 37. Pillai AB, George TI, Dutt S, Strober S. Host natural killer T cells induce an interleukin-4-dependent  
513 expansion of donor CD4+CD25+Foxp3+ T regulatory cells that protects against graft-versus-host disease.  
514 *Blood*. 2009;113(18):4458-67.

515 38. Lowsky R, Takahashi T, Liu YP, Dejbakhsh-Jones S, Grumet FC, Shizuru JA, et al. Protective  
516 conditioning for acute graft-versus-host disease. *N Engl J Med*. 2005;353(13):1321-31.

517 39. Morris ES, MacDonald KP, Hill GR. Stem cell mobilization with G-CSF analogs: a rational approach  
518 to separate GVHD and GVL? *Blood*. 2006;107(9):3430-5.

519 40. Baev DV, Peng XH, Song L, Barnhart JR, Crooks GM, Weinberg KI, et al. Distinct homeostatic  
520 requirements of CD4+ and CD4- subsets of Valpha24-invariant natural killer T cells in humans. *Blood*.  
521 2004;104(13):4150-6.

522 41. Jing Y, Gravenstein S, Chaganty NR, Chen N, Lysterly KH, Joyce S, et al. Aging is associated with a  
523 rapid decline in frequency, alterations in subset composition, and enhanced Th2 response in CD1d-restricted  
524 NKT cells from human peripheral blood. *Experimental gerontology*. 2007;42(8):719-32.

525 42. Croudace JE, Curbishley SM, Mura M, Willcox CR, Illarionov PA, Besra GS, et al. Identification of  
526 distinct human invariant natural killer T-cell response phenotypes to alpha-galactosylceramide. *BMC*  
527 *immunology*. 2008;9:71.

528 43. Jukes JP, Wood KJ, Jones ND. Bystander activation of iNKT cells occurs during conventional T-cell  
529 alloresponses. *Am J Transplant*. 2012;12(3):590-9.

530 44. Liu TY, Uemura Y, Suzuki M, Narita Y, Hirata S, Ohyama H, et al. Distinct subsets of human  
531 invariant NKT cells differentially regulate T helper responses via dendritic cells. *Eur J Immunol*.  
532 2008;38(4):1012-23.

533 45. Schneidawind D, Pierini A, Alvarez M, Pan Y, Baker J, Buechele C, et al. CD4+ invariant natural killer  
534 T cells protect from murine GVHD lethality through expansion of donor CD4+CD25+FoxP3+ regulatory T  
535 cells. *Blood*. 2014;124(22):3320-8.

536

537 **Figure legends**

538 **Figure 1: ROC analysis and according to the expansion factor of CD4<sup>+</sup> iNKT cells**

539 (A) ROC analysis of the whole model including donor type, disease status at transplantation, graft  
540 CD4<sup>+</sup> iNKT/T frequency and expansion factor in predicting the occurrence of grade II-IV acute  
541 GVHD in the total population of patients (B) ROC analysis of the expansion factor of CD4<sup>+</sup> iNKT  
542 cells in predicting the occurrence of grade II-IV acute GVHD in the total population of patients.  
543 Choice of the 6.83 cut-off point determining the best sensitivity and specificity (94% true positive rate  
544 and 36% false positive rate. Cumulative incidence of (C) grade II-IV acute GVHD, (D) relapse, (E)  
545 chronic GVHD, (F) non relapse mortality (NRM), and (G) probability of overall survival (OS)  
546 according to the CD4<sup>+</sup> iNKT expansion factor (<6.83 in dashed line and ≥ 6.83 in continuous line) in  
547 the total population of patients. Comparisons are performed with the log-rank test.

548 **Figure 2: Graft content and post-transplant iNKT recovery according to the graft CD4<sup>+</sup>**  
549 **iNKT expansion factor**

550 Graft characteristics and post-transplant iNKT reconstitution were analyzed in two groups according  
551 to their graft CD4<sup>+</sup> iNKT expansion factor (exp.fact.): ≥ 6.83 (grey) or < 6.83 (white) (A) Graft CD4<sup>+</sup>  
552 iNKT expansion factor, (B) Graft cell subset frequencies, (C) Graft iNKT cell subset frequencies, and  
553 (D) Graft iNKT cell subset doses. Results are presented as mean ± SEM. (E) Recipient peripheral  
554 blood levels of total iNKT cells on days 30, 60 and 90 post-transplantation according to CD4<sup>+</sup> iNKT  
555 expansion factor. Means were compared with unpaired t test. ns=non significant.

556 **Figure 3: ROC analysis and cumulative incidence of grade II-IV aGVHD in the**  
557 **subgroup of patients allografted at non-progressive disease with an HLA 10/10 PBSC**  
558 **graft**

559 (A) ROC analysis of the expansion factor of CD4<sup>+</sup> iNKT cells in predicting the occurrence of grade II-  
560 IV acute GVHD in the subpopulation of patients allografted with non-progressive disease with an  
561 HLA 10/10 PBSC graft (n=60, AUC=0.986) Determination of the 8.7 cut-off point providing the best  
562 sensitivity and specificity (94% true positive rate and 0% false positive rate). (B) Cumulative  
563 incidence of grade II-IV acute GVHD according to the CD4<sup>+</sup> iNKT expansion factor in this subgroup  
564 of patients (<8.7 in dashed line, and ≥ 8.7 in continuous line). Comparisons are performed with the  
565 Log-rank test.  
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567 **Tables**

568

569 **Table 1. Patients' characteristics at transplant**

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<b>Baseline parameters</b>	<b>All patients</b>
All patients (numbers, %)	117 (100%)
<b>Gender</b>	
Male	76 (65 %)
Female	41 (35 %)
<b>Age of recipient (years)</b>	
Median (range)	49.7 (16.5-69)
<b>Age of donor (years)</b>	
Median (range)	42.4 (18.2-66.4)
<b>Hematological disease</b>	
AML	58
ALL	19
MPD	6
MDS	11
Lymphoma	15
Myeloma	7
AA	1
<b>Disease status at transplant</b>	
CR	68 (58 %)
PR or SD	36 (31 %)
PD	13 (11%)
<b>Donor</b>	
Sibling	69 (59 %)
Unrelated 10/10 HLA-matched	42 (36 %)
Unrelated 9/10 HLA-matched	6 (5 %)
<b>Donor/recipient gender matching</b>	
Female to male	27 (23 %)
other	90 (77 %)
<b>HSC source</b>	
Bone marrow	33 (28%)
Peripheral blood	84 (72 %)
<b>Conditioning regimen</b>	
MAC	49 (42%)
RIC	68 (58%)
<b>In vivo T-cell depletion</b>	
No	54 (46 %)
Yes	63 (54 %)
<b>GVHD prophylaxis regimen</b>	
CsA + MTX	49 (42 %)
CsA + MMF	52 (44.5 %)
CsA alone	16 (13.7 %)
<b>CMV risk</b>	
Low	24 (20.5 %)
Intermediate	67 (57.3 %)
High	26 (22.2 %)

AA: aplastic anemia, AML: acute myeloid leukemia, ALL: acute lymphoid leukemia, CsA: cyclosporine A, MDS: myelodysplastic syndrome, MMF: mycophenolate mofetil, MPD: myeloproliferative disease, MTX: methotrexate, AA: aplastic anemia, CR: complete remission, PR: partial remission, PD: progressive disease, MAC: myeloablative conditioning, RIC: reduced intensity conditioning, HSC: hematopoietic stem cells, PBSC: peripheral blood stem cells. CMV reactivation risks were determined according to the donor (D) and recipient (R) serology as follows: D-/R-: low risk, D+/R+ or D+/R-: intermediate risk, D-/R+: high risk.

**Table 2: Univariate analysis of parameters associated with the development of a GVHD**

Parameter	aGVHD 0-I		aGVHD II-IV		p-value <sup>ω</sup>
	Mean	SD	Mean	SD	
<b>Graft cell subset frequencies (cell subset number/10<sup>3</sup> T-cells)</b>					
CD4 <sup>+</sup> T	611.59	110.5	599.29	98.13	0.582
<b>CD45RA<sup>+</sup>CD4<sup>+</sup> T</b>	<b>277.13</b>	<b>101.6</b>	<b>314.73</b>	<b>96.71</b>	<b>0.045</b>
CD45RA <sup>-</sup> CD4 <sup>+</sup> T	329.37	89.8	284.56	91.52	0.089
CD8 <sup>+</sup> T	367.3	95.5	371.42	82.93	0.747
γδ <sup>+</sup> T	68.01	88.8	76.19	78.9	0.308
T regs	12.13	9.1	9.6	7.14	0.313
Naïve T regs	2.85	4.3	2.34	2.63	0.863
Memory T regs	9.37	6.6	7.46	6.11	0.192
NK	117.07	165.2	94.48	55.94	0.834
MAIT	29.07	27.5	21.92	13.62	0.429
<b>Total iNKT</b>	<b>1.94</b>	<b>2.6</b>	<b>0.87</b>	<b>1.06</b>	<b>0.0016</b>
<b>CD4<sup>+</sup> iNKT</b>	<b>0.56</b>	<b>1</b>	<b>0.32</b>	<b>0.47</b>	<b>0.021</b>
<b>CD4<sup>-</sup> iNKT</b>	<b>1.38</b>	<b>1.8</b>	<b>0.55</b>	<b>0.78</b>	<b>0.00059</b>
<b>Graft cell subset doses (x10<sup>6</sup>/kg)</b>					
CD34 <sup>+</sup>	4.96	2.3	4.53	2.57	0.317
CD3 <sup>+</sup> T	170.2	134	202.5	151	0.263
CD4 <sup>+</sup> T	103.73	87.7	119.68	94.09	0.315
<b>CD45RA<sup>+</sup>CD4<sup>+</sup> T</b>	<b>48.96</b>	<b>45.2</b>	<b>67.22</b>	<b>57.51</b>	<b>0.193</b>
CD45RA <sup>-</sup> CD4 <sup>+</sup> T	55.84	48.7	55.25	42.84	0.704
CD8 <sup>+</sup> T	62.67	56.6	72.01	59.83	0.579
γδ <sup>+</sup> T	15.9	28.8	21.2	69.86	0.782
T regs	1.93	2.1	2.07	2.55	0.722
Naïve T regs	0.4	0.7	0.52	0.94	0.919
Memory T regs	1.56	1.7	1.55	1.88	0.679
NK	19.61	31.9	18.43	14.59	0.519
MAIT	4.5	6.8	4.88	6.41	0.789
<b>Total iNKT</b>	<b>0.27</b>	<b>0.4</b>	<b>0.17</b>	<b>0.29</b>	<b>0.027</b>
CD4 <sup>+</sup> iNKT	0.09	0.2	0.05	0.08	0.066
<b>CD4<sup>-</sup> iNKT</b>	<b>0.2</b>	<b>0.3</b>	<b>0.12</b>	<b>0.24</b>	<b>0.025</b>
<b>Expansion factor of iNKT cell subsets</b>					
CD4 <sup>+</sup> iNKT expansion factor	471.81	614.8	366.55	648.98	0.07537
<b>CD4<sup>-</sup> iNKT expansion factor</b>	<b>88.71</b>	<b>104.1</b>	<b>36.32</b>	<b>63.31</b>	<b>0.00007</b>
<b>Pre-transplant clinical factors</b>					
Recipient age	47.56	14.5	45.99	13.73	0.525
Donor age	42.31	13.5	38.09	12.18	0.118
	<b>Nb</b>	<b>%</b>	<b>Nb</b>	<b>%</b>	<b>p-value</b>
Disease status at HSCT					0.085 <sup>χ</sup>
CR/PR/SD*	81	92.1	23	79.3	
PD	7	7.9	6	20.7	
<b>Donor type</b>					<b>0.00004<sup>ψ</sup></b>
<b>HLA identical sibling</b>	<b>62</b>	<b>70.5</b>	<b>7</b>	<b>24.1</b>	
<b>Matched unrelated</b>	<b>23</b>	<b>26.1</b>	<b>19</b>	<b>65.6</b>	
<b>Mismatch unrelated</b>	<b>3</b>	<b>3.4</b>	<b>3</b>	<b>10.3</b>	
Female to male					
HSC source					0.813 <sup>χ</sup>
PBSC	64	72.7	20	69	
Bone marrow	24	27.3	9	31	
Conditioning regimen					1 <sup>χ</sup>
MAC	37	42	12	41.4	
RIC	51	58	17	58.6	
In vivo T cell depletion					1 <sup>χ</sup>
Yes	47	53.4	16	55.2	
No	41	46.6	13	44.8	
CMV risk					0.799 <sup>χ</sup>
High	19	21.6	7	24.1	
Other	69	78.4	22	75.9	

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aGVHD: acute GVHD, iNKT: invariant NKT cells, CR: complete remission, HSC: hematopoietic stem cells, MAC: myeloablative conditioning, MAIT: mucosa associated invariant T cells, PBSC: peripheral blood stem cells, , PD: progressive disease, PR: partial remission, RIC: reduced intensity conditioning, D: standard deviation, SD\*: stable disease ,T regs: regulatory T cells, Ψ: fisher exact test, χ: chi2 test, ω: Wilcoxon test.

625 **Table 3. Cox analysis and internal validation test of predictive factors of grade II-IV**  
 626 **acute GVHD development**  
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Baseline parameters	Multivariate analysis <sup>§</sup>			Bootstrap analysis
	HR	95% CI	p <sup>#</sup>	Median [95% CI]
<b>Model 1 (all grafts)</b>				
<b>Donor type</b>				
HLA identical sibling	1			
<b>Matched unrelated</b>	<b>8.16</b>	<b>3 -22.1</b>	<b>3x10<sup>-5</sup></b>	<b>16.9 [4.54 – 187]</b>
<b>Mismatched unrelated</b>	<b>3.2</b>	<b>0.68-15.5</b>	<b>0.14</b>	4.9 [0 –695]
<b>Disease status at transplant</b>				
CR/PR or SD	1			
<b>PD</b>	<b>10</b>	<b>3-33.5</b>	<b>0.00017</b>	<b>18.5 [4.1 – 199]</b>
<b>Stem cell source</b>				
PB	1			
BM	2.61	0.93-7.33	0.068	1.62 [0.33 – 7.9]
<b>CD4<sup>+</sup> iNKT/10<sup>3</sup> T frequency</b>				
	<b>0.56</b>	<b>0.38-0.84</b>	<b>0.0048</b>	<b>0.49 [0.23 – 0.79]</b>
<b>CD4<sup>+</sup> iNKT expansion factor</b>				
	<b>0.72</b>	<b>0.55-0.82</b>	<b>0.00013</b>	<b>0.65 [0.49 – 0.82]</b>
<b>Model 2*</b>				
<b>CD4<sup>+</sup> iNKT/10<sup>3</sup> T frequency</b>				
<b>PB</b>	<b>0.66</b>	<b>0.49-0.89</b>	<b>0.0005</b>	
<b>BM</b>	<b>0.47</b>	<b>0.26-0.84</b>	<b>0.01</b>	
<b>CD4<sup>+</sup> iNKT expansion factor</b>				
<b>PB</b>	<b>0.59</b>	<b>0.46-0.75</b>	<b>1.94x10<sup>-5</sup></b>	
BM	0.81	0.53-1.24	0.34	

628 *BM: bone marrow, CI: confidence interval, CR: complete remission, HR: hazard ratio, NA: non applicable, PB: peripheral*  
 629 *blood, PD: progressive disease, PR: partial remission, SD: stable disease, , #Time dependant Cox model, § Variables*  
 630 *included in the Cox model were: HSC source, donor type, donor and recipient age, disease status at transplant, use of in*  
 631 *vivo T cell depletion, and the following graft parameters: total iNKT/10<sup>3</sup> T, total iNKTx10<sup>6</sup>/kg, CD4<sup>+</sup> iNKT/10<sup>3</sup> T, CD4<sup>+</sup>*  
 632 *iNKT /10<sup>3</sup> T, CD4<sup>+</sup> iNKTx10<sup>5</sup>/kg CD45RA<sup>+</sup>CD4<sup>+</sup>T/10<sup>3</sup> T, CD45RA<sup>-</sup>CD4<sup>+</sup>T/10<sup>3</sup> T, CD4<sup>+</sup> iNKT expansion factor. Data of CD4<sup>+</sup>*  
 633 *iNKT/10<sup>3</sup> T frequency and CD4<sup>+</sup> iNKT expansion factor were analyzed as log transformed continuous variables. \* Model 2,*  
 634 *which analyzes the interactions between stem cell source and the mentioned graft iNKT parameters, was adjusted to donor*  
 635 *type and disease status at SCT.*

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644 **Table 4: ROC analyses in all patients and subgroups**

Graft factor	PT N	GVHD events	Cut off	Sensitivity (%)	Specificity (%)	AUC 2.5th percentile	AUC	AUC 97.5th percentile
<b>A. All patients</b>								
<b>CD4<sup>+</sup> iNKT/10<sup>3</sup> T</b>								
Total population	117	29	0.13	92	44.8	60	<b>71.3</b>	82.7
Total BM grafts	33	9	0.14	95.8	44.4	51.5	73.8	96.2
Total PBSC grafts	84	20	0.13	90.7	45	57.2	70.7	84.3
Total population with expansion factor analyzed	96	25	0.13	91.5	52	62	<b>73.8</b>	85.7
<b>CD4<sup>+</sup> iNKT expansion factor</b>								
Total population with expansion factor analyzed	96	25	6.83	94.4	64	63.6	<b>76.7</b>	89.8
Total BM grafts with expansion factor analyzed	19	7	6.83	91.7	57.1	38.5	<b>67.9</b>	97.2
Total PBSC grafts with expansion factor analyzed	77	18	8.7	94.9	66.7	61.2	<b>77.2</b>	93.2
<b>B. Patients transplanted with HLA matched donor, non progressive disease, expansion factor analyzed</b>								
<b>CD4<sup>+</sup> iNKT/10<sup>3</sup> T</b>								
PBSC and BM grafts	79	17	0.13	91.9	52.9	55.0	<b>69.1</b>	83.2
BM grafts	19	7	0.14	91.7	57.1	51.5	<b>73.8</b>	96.2
PBSC grafts	60	10	0.13	92	50	58	<b>76.2</b>	94.1
<b>CD4<sup>+</sup> iNKT expansion factor</b>								
PBSC and BM grafts	79	17	6.83	93.5	82.4	80.3	<b>90</b>	99.8
BM grafts	19	7	6.83	91.7	57.1	38.5	<b>67.9</b>	97.2
PBSC grafts	60	10	8.7	94.0	100	96.4	<b>98.6</b>	100

645 *AUC: area under the curve, BM: bone marrow, GVHD events: grade II-IV acute GVHD, N: number, PBSC:*  
646 *peripheral blood stem cells, PT: patient*

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