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1 Maternal *HLA-G*01:01:01:04* protects from anti-HLA-class II immunization in pregnant
2 women

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22 Abbreviated Title: *HLA-G* haplotypes and anti-HLA immunization

23

24 Keywords: HLA-G, haplotypes, anti-HLA immunization, regulatory regions, pregnancy

25

26 Abbreviations: HLA: Human Leukocyte Antigen; CTL: Cytotoxic T-Lymphocyte; NK:
27 Natural Killer cells; ILT: Immunoglobulin-Like Transcript; KIR: Killer-cell Immunoglobulin-
28 like Receptor; sHLA-G: soluble HLA-G; UTR: UnTranslated Region; URR: Upstream
29 Regulatory Region; gDNA: genomic DNA

1 ABSTRACT

2 Factors determining anti-HLA immunization are poorly understood, although anti-HLA
3 immunization following pregnancy is well described.

4 The HLA-G molecule has been extensively described for its implication in immunological
5 tolerance, especially during pregnancy. Transplant studies show an association between *HLA-*
6 *G* haplotypes and alloimmunization.

7 Our aim was to investigate the association of *HLA-G* haplotypes with anti-HLA class I and II
8 immunization in a cohort of women having experienced one or more pregnancies and with no
9 transfusion history.

10 Maternal blood samples (n=270) collected at delivery and formerly screened for anti-HLA
11 antibodies, HLA-A and HLA-B antigens, were screened by NGS for *HLA-G* gene
12 polymorphism.

13 Univariate analysis further confirmed that the number of pregnancies was significantly
14 associated with anti-HLA class I immunization, whereas no other variable remained
15 significant after Bonferroni correction. Our results showed however that anti-HLA class II
16 immunization was associated with the number of children whereas the *HLA-G*01:01:01:04*
17 allele was protective against this immunization.

18

1 INTRODUCTION

2 The *HLA-G* molecule has been extensively described for its implication in immunological
3 tolerance, especially during pregnancy. Although it displays a restricted number of alleles,
4 many studies associated *HLA-G* alleles with differential level of tolerance in a challenging
5 immune situations such as pregnancies and transplantation outcome. Indeed *HLA-G* displays
6 few haplotypes (including 5'URR, coding and 3'UTR regions) associated with differential
7 protein expression patterns [1] and differential clinical outcome of immunosensitive events.
8 *HLA-G* alleles were associated with pregnancy complications [1] and recurrent miscarriages
9 [1] as well as with immunization and poor prognosis in lung transplant patients [1].

10 Alloimmunization, especially against HLA molecules, is also responsible for adverse effects
11 and acute rejection in blood transfusion and organ transplantation; including febrile non-
12 haemolytic transfusion reactions, immunological platelet refractoriness or transfusion-related
13 acute lung injury. The main cause of naturally occurring anti-HLA immunization is
14 pregnancy, with an extensively confirmed increased HLA antibody prevalence with a greater
15 number of pregnancies [1]. Anti-HLA antibodies are the most studied antibodies, but little is
16 known about non-HLA antibodies mainly directed against endothelial cells, and although this
17 field has been intensively studied, their prevalence and implication in physio-pathological
18 process remain unclear [1].

19 Biological and genetic factors determining anti-HLA immunization remain poorly understood
20 with the exception of HLA-A, B or DR antigens or eplets [1]. HLA immunogenicity during
21 pregnancy was found to be lower in women who experienced a prior miscarriage compared to
22 women who had a prior successful pregnancy [2]. Masson et al. analyzed genetic
23 polymorphisms implicated in humoral immunization, and none of the following parameters
24 influenced immunization rate: *HLA*-typing, *TLR4* gene polymorphisms D299G, T399I; *IL-6*
25 promoter polymorphism -174 C/G and *BAFF* intron G/T and promoter polymorphism -871
26 C/T [1]. In women having had only one successful pregnancy, there was a significant
27 association between *IL-6* promoter -174G/C and immunization [1]. *HLA-G* expression was
28 found to be lower in women with antibodies detectable both by CDC and Luminex than in
29 women with antibodies detected only by Luminex [1]. Such serological testing is however
30 poorly reproducible [3], whereas most HLA laboratories nowadays have DNA analysis
31 facilities making *HLA-G* studies a feasible option. Thus, *HLA-G* molecule may represent a
32 good complementary genetic predictive factor for anti-HLA immunization.

33 To get further insight into the association of *HLA-G* haplotypes with immunization, we
34 recently investigated *HLA-G* phylogeny with regards to inflammatory response [1]. Our
35 results split *HLA-G* haplotypes phylogenetically into four main clades respectively containing
36 (1) *HLA-G*01:01:02:01*, *G*01:01:02:02*, *G*01:05N* and *G*01:06* (associated with haplotype
37 *H10*); (2) *G*01:04:01* and *G*01:04:04* (*H23*); (3) *G*01:03:01:02* (*H21*, *H20* and *H19*) and
38 (4) *G*01:01:01:01* and *G*01:01:01:05* (*H01*, *H02*, *H03*, *H04*, *H05*, *H46*, *H47*, *H49*, *H54*).
39 Whereas *HLA-G* alleles associated with poor prognosis in transplantation, pregnancy or
40 inflammatory disease were grouped in clades 1, 2 and 3, some of the *HLA-G* alleles in the
41 fourth clade were associated with a protective effect against inflammation [1].

42 The main goal of this study was to confirm the association of *HLA-G* phylogeny with
43 differential immunological tolerance induction. We thus investigated *HLA-G* haplotype
44 association with the presence of anti-HLA antibodies in women who had experienced one or
45 more pregnancies but who had no transfusion history.

1 MATERIAL AND METHODS

2 **Population and sample collection**

3 Two hundred and seventy women having had one or more pregnancies were included in the
4 study. None of these women had any history of transfusion. Maternal blood samples and
5 umbilical cord samples were collected at delivery [1]. Patient data (age, number of children,
6 pregnancies and miscarriages) are given in Table 1. The study was designed in collaboration
7 with the Besançon Cord Blood Bank (Etablissement Français du Sang) and carried out in
8 accordance with the recommendations of Besançon Hospital's Ethics Committee with written
9 informed consent from all subjects. All subjects gave written informed consent in accordance
10 with the Declaration of Helsinki. The protocol was approved by the Besançon Hospital's
11 Ethics Committee.

12 ***HLA-G* analysis and HLA typing**

13 Maternal DNA was sequenced for *HLA-G* gene from position -1983 to +3447 by Next
14 Generation Sequencing (NGS). PCR fragments were sequenced using an NGS platform
15 (MiSeq, Illumina, The Netherlands) [1].

16 *HLA-G* NGS data were analyzed using PolyPheMe (Xegen, France). *HLA-G* allelic
17 assignment at 8 digits was based on the HLA sequences listed in the official IMGT/HLA
18 database 3.28.0 [4]. All polymorphic variations from position -1983 to -1 in 5'UTR and from
19 +2540 to +3447 in 3'UTR, *i.e.* 37 SNPs, 1 base deletion, 1 base insertion and a 14bp insertion
20 were used for haplotype estimation using PHASE. *HLA-G* haplotype identification numbers
21 were coded according to [1]. Allelic and haplotype frequencies were estimated using an EM
22 algorithm implemented in the Gene [Rate] computer tools [5].

23 Both maternal and child DNA were typed for HLA-A and HLA-B at a low resolution level by
24 Luminex™ technology (One Lambda LABType® SSO, InGen, France), complete procedure
25 is described in [1]. HLA-C, DR or DQ were not investigated.

26 Latest child/paternal HLA-A and HLA-B mismatch were deduced from mother and latest
27 child HLA-A and HLA-B typing results. Maternal *IL-6* -174 C/G genotype results obtained
28 by Snap Shot were included in this study, complete procedure is described in [1].

29 **HLA antibody testing**

30 Each serum was screened for anti-HLA antibodies using two techniques: the standard CDC
31 method (for anti-class I antibodies) and the Luminex screening kits (for anti-class I and class
32 II antibodies), complete procedure is described in [1].

33 **Statistical analysis**

34 Missing data led to the exclusion of the concerned sample from further analyses. No multiple
35 imputation was used. Analysis were performed using GRAPH PAD Prism 5 software (CA,
36 www.graphpad.com), SPSS 24.0 software (SPSS Inc., Chicago) and SAS 9.4 (SAS Institute
37 Inc. Cary, USA).

38 Biological and genetic data frequencies between anti-HLA class I immunized women, anti-
39 HLA class II immunized women and non-immunized women were compared with Chi-square
40 tests. The presence of anti-HLA class I antibodies and anti-HLA class II antibodies were
41 independently tested in univariate analyses according to biological data (women's age,

1 number of pregnancies, number of children delivered, number of miscarriages, sex of the
2 latest child) and according to genetic data (*HLA-G* alleles and *HLA-G* haplotypes, *IL-6* -174
3 C/G genotype, HLA-A and HLA-B antigen, latest child/paternal HLA-A and HLA-B antigen
4 mismatch). HLA-A and HLA-B antigens and latest child/paternal HLA-A and HLA-B
5 mismatches were included for their association with allo-immunization because of the
6 Linkage Disequilibrium between *HLA-G* and *HLA-A* loci and *HLA-A* and *HLA-B* [1]. *IL-6* -
7 174 C/G genotype was included in the study since it was described as being significantly
8 associated with immunization in women having had only one successful pregnancy [1].

9 Bonferroni correction for multiplicity testing procedure was applied and variables with p-
10 values below 0.001 in univariate analyses were further investigated in multivariate regression
11 analysis. The hazard ratios were estimated by using Firth's penalized partial likelihood
12 approach. Association results are expressed as odds ratio (OR) and confidence intervals of
13 95% (CI 95%).

14 RESULTS

15 Anti-HLA class I and class II immunization data according to biological characteristics are
16 shown in Table 1. Univariate analyses showed no difference between anti-HLA-I immunized
17 and anti-HLA-I non-immunized women, or between anti-HLA-II immunized and anti-HLA-II
18 non-immunized women according to age or gender of latest child. Anti-HLA-I and anti-HLA-
19 II immunization were associated both with the number of pregnancies and the number of
20 children (both $p < 0.0001$) but not with miscarriages; the association of miscarriages with anti-
21 HLA-II immunization did not reach significance after Bonferroni correction ($p = 0.007$).

22 *HLA-G* allelic frequency and characteristics of estimated *HLA-G* haplotypes with a frequency
23 above 1% are shown in Table 2. Most *HLA-G* haplotypes with a frequency above 1% display
24 an exclusive association with an *HLA-G* allele defined at high resolution, i.e. 8 digits.

25 The characteristics of anti-HLA class I and class II antibody groups according to *HLA-G*
26 alleles and haplotypes are shown in Table 3.

27 Univariate analyses showed no significant difference between anti-HLA-I immunized and
28 anti-HLA-I non-immunized women according to HLA-A and HLA-B antigens (data not
29 shown), *IL-6* G/C genotype (data not shown), *HLA-G* allele or haplotype, and latest
30 child/paternal HLA-A and HLA-B mismatch (data not shown) after Bonferroni correction.

31 None of these variables displayed any significant differences either between women with anti-
32 HLA-II antibodies and anti-HLA-II non-immunized women (data not shown), except the
33 *HLA-G* allele *G*01:01:01:04* and haplotype *H03*. This allele was never observed in anti-
34 HLA-II immunized women whereas it were present in 11.5% of anti-HLA-II non-immunized
35 women.

36 Of note, variables that did not reach significance after Bonferroni correction and were thus not
37 included in multivariate analyses were the following for anti-HLA class I antibody presence:
38 *H03-G*01:01:01:04*, B*13 and B38, and for anti-HLA class II presence: *H19-*
39 *G*01:03:01:02*, A*29, A*31, B*18, B*57, B*60, paternal mismatch B*51 and paternal
40 mismatch B*62 (Table 2). It should be noted that *HLA-G*01:03:01:02* was the only allele
41 observed for *HLA-G*01:03*.

42 Multivariate analysis was performed by logistic regression hazard modeling using Firth's
43 penalized partial likelihood approach with variables showing significant p-values after

1 Bonferroni correction. One variable of those displaying high correlation was chosen (either
2 number of pregnancies or number of children for biological variables, and either *H03* or
3 *G*01:01:01:04* for genetic variables). Anti-HLA class II immunization displayed significant
4 association with number of children ($p < 0.0001$, hazard ratio: 1.725; CI 95%: 1.1339-2.223)
5 whereas *G*01:01:01:04* allele was significantly protective against anti-HLA class II
6 immunization ($p = 0.0422$, hazard ratio: 0.0422; CI 95%: 0.003-0.0899) (Table 4).

7 DISCUSSION

8 Anti-HLA immunization is a main issue in blood transfusion and organ transplantation.
9 Pregnancy is the main source of HLA sensitizing events: half to two thirds of pregnant
10 women seem to develop anti-HLA antibodies [1].

11 HLA-G is extensively reported to play a pivotal role in fetomaternal tolerance and
12 transplantation outcome [3]. We previously showed that *HLA-G* haplotypes, i.e. SNPs
13 associated in Linkage Disequilibrium, (1) remain preserved between populations with
14 different geographical origins, (2) can reliably be used to predict sHLA-G levels, (3) are
15 associated with alloimmunization and inflammation in transplantation and inflammatory
16 disease and (4) are grouped into four main clades, three of which contain alleles associated
17 with lower immunotolerance whereas the fourth seems to be associated with higher
18 immunotolerance [1].

19 In this study, we aimed to confirm whether *HLA-G* haplotypes could be a predictive genetic
20 risk or protective factor for anti-HLA immunization and may help clinicians to estimate the
21 risk of rejection in each single case, while considering the consequences of performing the
22 graft or not.

23 We thus investigated *HLA-G* haplotype association with anti-HLA immunization in women
24 having experienced pregnancy but with no transfusion or transplant history.

25 We performed *HLA-G* genetic analysis on 270 maternal blood samples collected at delivery
26 and tested for anti-HLA antibodies. Statistical analysis included variables reported to be
27 associated with anti-HLA immunization such as the number of pregnancies, number of
28 children, number of miscarriages, HLA-A and HLA-B antigen typing and paternal HLA-A
29 and HLA-B mismatch.

30 We found that *H03-HLA-G*01:01:01:04* was the only genetic variable to remain significantly
31 associated with anti-HLA class II immunization after Bonferroni correction ($p > 0.001$). Its
32 protective value against anti-HLA class II immunization remained significant in multivariate
33 analysis including the number of pregnancies ($p = 0.0422$). However, it should be noted that
34 since only 22 women presented *HLA-G*01:01:01:04*, an accidental better HLA class II
35 matching of mothers and children in this group is not excluded. Furthermore, when anti-HLA
36 class I immunization is considered, for which latest child/paternal mismatch displayed no
37 significant results, this same *HLA-G* allele was found to be protective ($p = 0.031$) but it was
38 not included in multivariate analysis because of Bonferroni correction.

39 Although this study was not designed to decipher the biological mechanism leading to our
40 results, it seems to support our previous work on phylogenetic analysis of *HLA-G* alleles
41 defined at high resolution. Phylogenetic structure of *HLA-G* sequences consisted of four main
42 clades which may reflect HLA-G tolerogenic properties; indeed each clade displayed specific
43 transcription factor sites and coding sequence variations [1]. The conservation of *HLA-G*
44 sequences worldwide suggests that those which lowered immunotolerance might provide an

1 advantage in specific contexts [6]. Tolerogenicity would come from HLA-G binding with the
2 ILT-2 receptor on B cells and thus limiting their proliferation, differentiation and
3 immunoglobulin secretion [1].

4 In pregnancy, reduced expression of HLA-G seemed to be associated with complications,
5 such as miscarriage or preeclampsia. Interestingly, women with preeclampsia harbor higher
6 concentrations of cellular fetal microchimerism and anti-paternal allo-antibodies [1].

7 Masson *et al.* showed, in the same cohort as this study, that anti-HLA immunization increased
8 with the number of pregnancies and of children delivered but they could not find any
9 association with HLA-A and HLA-B antigens. Only the -174 G/C polymorphism in the *IL-6*
10 promoter (located on chromosome 7) was associated with a lower risk of anti-HLA antibody
11 development among primiparous pregnant women with no history of miscarriage [1]. Our
12 analysis further confirmed their main results. We did not find any association with HLA-A,
13 HLA-B or their paternal mismatch, on the contrary to Piacasdia *et al.* who showed that HLA-
14 B*14 and HLA-B*51 were associated with a lower risk of anti-HLA antibody development
15 after pregnancy, while having the A*11 allele seemed to represent a higher risk in a cohort of
16 161 pregnancy-only sensitizing events [1].

17 This preliminary study seems to confirm the role of HLA-G in inflammation and immune
18 control; it needs however to be completed by a larger number of patients to get a better insight
19 into the nature of the association with each individual HLA locus. We previously reported a
20 strong linkage disequilibrium of both *HLA-A* and *HLA-F* with *HLA-G* [1]; such extended
21 HLA class I haplotypes may represent even more pertinent predictive values, notably HLA-F
22 which is shown to play an important part in immune regulation [7]. This descriptive study
23 would also benefit from investigating into biological mechanisms leading the association of
24 *HLA-G* phylogeny with differential immunological tolerance induction.

1 CONFLICT OF INTEREST

2 The authors declare that they have no conflict of interest.

3 AUTHOR CONTRIBUTIONS

4 Conception or design of the work: MS, CP, JC, PT, JMR, JDC

5 Acquisition, analysis and interpretation of data: MS, CP, JC, AD, JP, PT, JMR, JDC

6 Drafting the work or revising it critically for important intellectual content: MS, CP, JC, AD,
7 JP, PT, JMR, JDC

8 Final approval of the version to be published MS, CP, JC, AD, JP, PT, JMR, JDC

9 Agreement to be accountable for all aspects of the work in ensuring that questions related to
10 the accuracy or integrity of any part of the work are appropriately investigated and resolved:
11 MS, CP, JC, AD, JP, PT, JMR, JDC

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16

1 Table 1. Women's data under study. Age, sex of latest child, number of pregnancies, children and miscarriages are given for all women, anti-HLA
 2 class I immunized, anti-HLA class I non-immunized, anti-HLA class II immunized and anti-HLA class II non-immunized women; p-values under
 3 0.001 are in bold.
 4

	All	Anti-HLA class I immunized	Anti-HLA class I non-immunized	p-value	Anti-HLA class II immunized	Anti-HLA class II non-immunized	p-value
Number of patients (%)	270	100 (37.1)	170 (62.9)		70 (26.0)	200 (74.0)	
Age (yrs) (median and range)	29.3 [18-42]	29.7 [19-40]	29.0 [18-42]	0.176	29.9 [19-41]	29.0 [18-42]	0.209
Sex of latest child sex (Male %)	51.5	55	49.4	0.375	59.4	48.8	0.126
Pregnancies (median and range)	2.1 [1-6]	2.4 [1-6]	1.9 [1-6]	> 0.001	2.6 [1-6]	1.9 [1-6]	> 0.001
1 (%)	35.2	20.0	44.1	> 0.001	14.5	42.3	> 0.001
2 (%)	36.3	45.0	31.2	0.022	39.1	35.3	0.570
3 (%)	15.2	16.0	14.7	0.774	23.2	12.4	0.032
4 (%)	10.0	14.0	7.6	0.092	17.4	7.5	0.018
5 (%)	2.6	4.0	1.8	0.264	4.3	2.0	0.288
6 (%)	0.7	1.0	0.6	0.703	1.4	0.5	0.426
Children (median and range)	1.6 [1-5]	1.96 [1-4]	1.5 [1-5]	> 0.001	2.0 [1-4]	1.58 [1-5]	> 0.001
1 (%)	48.1	31.0	58.2	> 0.001	26.1	55.7	> 0.001
2 (%)	38.1	49.0	31.8	0.005	50.7	33.8	0.013
3 (%)	10.0	13.0	8.2	0.208	17.4	7.5	0.018
4 (%)	3.3	7.0	1.2	0.010	5.8	2.5	0.186
5 (%)	0.4	0.0	0.6	0.442	0.0	0.5	0.557
Miscarriages (median and range)	0.41 [0-3]	0.44 [0-2]	0.39 [0-3]	0.437	0.59 [0-2]	0.35 [0-5]	0.007
0 (%)	67.0	64.0	68.8	0.416	55.1	71.1	0.014

<i>1 (%)</i>	25.6	28.0	24.1	0.480	30.4	23.9	0.281
<i>2 (%)</i>	6.7	8.0	5.9	0.501	14.5	4.0	0.003
<i>3 (%)</i>	0.7	0.0	1.2	0.276	0.0	1.0	0.406

1

1 Table 2. Characteristics of *HLA-G* haplotypes estimated with a frequency above 1% (ID: identification number according to [1], N: Number, Fq:
 2 Frequency).

3

Haplotype ID		Associated allele	GenBank accession number	N	Fq
<i>H01</i>	TCTGTGAGAAATGCGTAGAG*ACAAACGGCGCGGCDCGCCCCACG	<i>G*01:01:01:01</i>	MG825364	145	26.9
<i>H10</i>	CACAGGTACATCGGTAA*ACCAGGGGAACATGITCCCGAGG	<i>G*01:01:02:01</i>	MG825359	112	20.7
		<i>G*01:06</i>	MG825360	28	5.2
		<i>G*01:05N</i>	MG825361	12	2.2
		<i>G*01:01:02:02</i>	MG825362	3	0.6
<i>H04</i>	TCTGTGAGAAATGCGTAGAG*ACAAACGGCGCGGCDCGCCCCACG	<i>G*01:01:01:05</i>	MG825356	46	8.5
<i>H02</i>	TCTGTGAGAACGCGTAGAG*ACAAACGGCGCGGCDCGCCCCACG		MG825358	38	7.0
<i>H23</i>	TCCAGAAACATCGGTAA*ACCAGGGGAACGTGDTCCCGACG	<i>G*01:04:01</i>	MG825349	37	6.9
		<i>G*01:04:04</i>	MG825348	7	1.3
<i>H16</i>	CACAGGTACATCGGTAA*ACCAGGGGAACGTGITCATGACG	<i>G*01:01:03:03</i>	MG825347	22	4.1
<i>H03</i>	TCTGTGAGAACGCGCTTAGAG**CAACGGCGCGGCDCGCCCCACA	<i>G*01:01:01:04</i>	MG825363	22	4.1
<i>H21</i>	TCCGGGAGCGCTTAGAGG*AGAAGAAAGTGTGITCCTGACG	<i>G*01:03:01:02</i>	MG825350	8	1.5
<i>H20</i>	TCCGGGAGCGCTTAGAGGAGAAGAAAGTGTGITCCTGACG		MG825354	8	1.5
<i>H19</i>	TCCGGGAGCGCTTAGAGGACAAGAAAGTGTGITCCTGACG		MG825357	7	1.3

4

5

1 Table 3. Characteristics of immunized and non-immunized anti-HLA class I and anti-HLA class II groups for *HLA-G* allele and haplotype
 2 frequencies; p-values under 0.001 are in bold.

3

	All	Anti-HLA class I non-immunized	Anti-HLA class I immunized	p-value	Anti-HLA class II non-immunized	Anti-HLA class II immunized	p-value
<i>HLA-G</i> allele carrier							
<i>G*01:01:01:01</i>	49.3	51.8	45.0	0.172	52.0	41.4	0.105
<i>G*01:01:01:02</i>	0.4	0.0	1.0	0.370	0.0	1.4	0.256
<i>G*01:01:01:03</i>	0.7	1.2	0.0	0.396	1.0	0.0	0.553
<i>G*01:01:01:04</i>	8.5	11.2	4.0	0.031	11.5	0.0	0.001
<i>G*01:01:01:05</i>	28.5	26.5	32.0	0.202	28.0	30.0	0.396
<i>G*01:01:01:06</i>	0.4	0.0	1.0	0.370	0.0	1.4	0.256
<i>G*01:01:02:01</i>	38.1	38.2	38.0	0.537	38.0	38.6	0.477
<i>G*01:01:02:02</i>	1.1	1.8	0.0	0.248	1.5	0.0	0.411
<i>G*01:01:03:03</i>	8.5	8.8	8.0	0.503	9.5	5.7	0.252
<i>G*01:01:05</i>	0.4	0.6	0.0	0.630	0.5	0.0	0.744
<i>G*01:01:12</i>	0.4	0.6	0.0	0.630	0.5	0.0	0.744
<i>G*01:01:15</i>	0.4	0.6	0.0	0.630	0.5	0.0	0.744
<i>G*01:03:01:02</i>	8.1	8.2	8.0	0.571	6.5	12.9	0.075
<i>G*01:04:01</i>	16.3	15.3	18.0	0.338	16.0	17.1	0.453
<i>G*01:04:04</i>	3.0	2.4	4.0	0.337	2.0	5.7	0.118
<i>G*01:05N</i>	4.4	5.9	2.0	0.114	5.5	1.4	0.142
<i>G*01:06</i>	10.7	8.8	14.0	0.131	11.0	10.0	0.528
<i>G*01:10</i>	0.7	1.2	0.0	0.396	1.0	0.0	0.553
<i>HLA-G</i> haplotype carrier							
<i>H01</i>	46.7	49.4	42.0	0.146	48.0	42.9	0.318
<i>H02</i>	14.1	12.4	17.0	0.189	13.0	17.1	0.233

<i>H03</i>	8.1	10.6	4.0	0.042	11.0	0.0	0.001
<i>H04</i>	16.7	15.9	18.0	0.386	16.5	17.1	0.492
<i>H05</i>	1.9	1.8	2.0	0.612	2.0	1.4	0.621
<i>H06</i>	0.4	0.0	1.0	0.370	0.0	1.4	0.256
<i>H08</i>	0.4	0.6	0.0	0.630	0.5	0.0	0.744
<i>H09</i>	0.4	0.6	0.0	0.630	0.5	0.0	0.744
<i>H10</i>	50.0	48.8	52.0	0.353	50.5	48.6	0.500
<i>H11</i>	0.4	0.0	1.0	0.370	0.0	1.4	0.256
<i>H13</i>	1.1	1.8	0.0	0.248	1.5	0.0	0.411
<i>H16</i>	8.1	8.2	8.0	0.571	9.0	5.7	0.293
<i>H19</i>	2.2	1.2	4.0	0.138	0.5	7.1	0.005
<i>H20</i>	3.3	4.7	1.0	0.094	3.5	2.9	0.585
<i>H21</i>	3.0	2.9	3.0	0.622	2.5	4.3	0.334
<i>H23</i>	16.3	15.3	18.0	0.338	15.5	18.6	0.312
<i>H26</i>	0.4	0.0	1.0	0.370	0.5	0.0	0.744
<i>H28</i>	0.4	0.6	0.0	0.630	0.5	0.0	0.744
<i>H31</i>	0.4	0.6	0.0	0.630	0.5	0.0	0.744
<i>H32</i>	0.4	0.6	0.0	0.630	0.5	0.0	0.744
<i>H36</i>	0.7	0.6	1.0	0.604	0.5	1.4	0.447
<i>H38</i>	0.4	0.6	0.0	0.630	0.5	0.0	0.744
<i>H44</i>	0.4	0.6	0.0	0.630	0.5	0.0	0.744
<i>H46</i>	1.1	0.6	2.0	0.309	1.5	0.0	0.411
<i>H48</i>	0.4	0.6	0.0	0.630	0.5	0.0	0.744
<i>H49</i>	0.4	0.0	1.0	0.370	0.0	1.4	0.256
<i>H52</i>	0.4	0.6	0.0	0.630	0.5	0.0	0.744
<i>H53</i>	0.4	0.6	0.0	0.630	0.5	0.0	0.744
<i>H54</i>	0.7	0.0	2.0	0.136	1.0	0.0	0.553

H56	0.4	0.6	0.0	0.630	0.5	0.0	0.744
H58	0.4	0.0	1.0	0.370	0.0	1.4	0.256
H61	0.4	0.6	0.0	0.630	0.5	0.0	0.744
H63	0.4	0.6	0.0	0.630	0.5	0.0	0.744
H71	0.4	0.6	0.0	0.630	0.5	0.0	0.744
H72	0.4	0.6	0.0	0.630	0.5	0.0	0.744
H73	0.4	0.0	1.0	0.370	0.0	1.4	0.256

1 Table 4. Associated factors for anti-HLA class II immunization according to logistic
2 regression on number of pregnancies and HLA-G*01:01:01:04 (HR, hazard ratio; CI,
3 confidence interval).

4

	Estimated HR (95% CI)	p-value
Pregnancies	1.725 (1.339-2.223)	0.0001
HLA-G*01:01:01:04	0.049 (0.003-0.899)	0.0422

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