Immunohistochemical Detection of Hypoxia-Inducible Factor-1α in Human Renal Allograft Biopsies

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Although it generally is accepted that renal hypoxia may occur in various situations after renal transplantation, direct evidence for such hypoxia is lacking, and possible implications on graft pathophysiology remain obscure. Hypoxia-inducible factors (HIF) are regulated at the protein level by oxygen-dependent enzymes and, hence, allow for tissue hypoxia detection. With the use of high-amplification HIF-1α immunohistochemistry in renal biopsies, hypoxia is shown at specific time points after transplantation with clinicohistologic correlations. Immediately after engraftment, in primarily functioning grafts, abundant HIF-1α is present and correlates with cold ischemic time >15 h and/or graft age >50 yr (P < 0.04). In contrast, a low HIF-1α score correlates with primary nonfunction, likely reflecting loss of oxygen consumption for tubular transport. Protocol biopsies at 2 wk show widespread HIF-1α induction, irrespective of histology. Beyond 3 mo, both protocol biopsies and indicated biopsies are virtually void of HIF-1α, with the only exception being clinical/subclinical rejection. HIF-derived transcriptional adaptation to hypoxia may counterbalance, at least partly, the negative impact of cold preservation and warm reflow injury. Transient hypoxia at 2 wk may be induced by hyperfiltration, hypertrophy, calcineurin inhibitor–induced toxicity, or a combination of these. Lack of detectable HIF-1α at 3 mo and beyond suggests that at this time point, graft oxygen homeostasis occurs. The strong correlation between hypoxia and clinical/subclinical rejection in long-term grafts suggests that hypoxia is involved in such graft dysfunction, and HIF-1α immunohistochemistry could enhance the specific diagnosis of acute rejection.


This paper utilizes immunohistochemical techniques to demonstrate widespread hypoxia of multiple causes in the first 3 months after transplantation, but correlates hypoxia only with clinical/subclinical rejection after 3 months. This paper is linked to an article by Kambhan et al. in this month’s issue of CJASN (pp. 135–142), which describes a new histologic system for identifying and scoring calcineurin inhibitor toxicity. Both findings have the potential to improve discrimination between rejection and calcineurin toxicity in transplant biopsies and allow more targeted therapy for a failing graft.

involved in metabolism, vascular tone, angiogenesis, cell cycle, iron metabolism, radical scavenging, erythropoiesis, inflammation, etc. (for reviews, see references [6,10]). There is sufficient amount of evidence to support the view that the HIF system is ubiquitous, instantaneously upregulated upon hypoxia, and short-lived upon reoxygenation and that many HIF target genes confer cell/tissue protection.

Detection of HIF activation in tissue sections requires immunohistochemical detection of nuclear HIFα. Previous studies in rats revealed the need for standardized fixation, special target retrieval, and high-amplification technique to obtain reliable results (11–20). With the use of various experimental models of global or regional renal hypoxia/ischemia, it has
been demonstrated that HIF-α activation corresponds with expected renal oxygen gradients and that hypoxia and hypoxic adaptation occur in a cell type– and stimulus-specific pattern (12,13,17,20).

In this study, we show such hypoxia and hypoxia adaptation in renal allograft biopsies using HIF-1α immunohistochemistry. Indeed, HIF-1α expression is demonstrated at various stages after engraftment and correlates well with clinical/histologic findings.

**Materials and Methods**

**Patients**

All renal transplant patients at the Charité University Clinic Virchow Campus were eligible for the study, provided that their biopsies were fixed as described next and initial immunosuppression included an antibody (daclizumab, basiliximab, anti-thymocyte globulin, or muromonab), a CNI (either cyclosporin A [Sandimmun optoral, Novartis, Basel, Switzerland] or tacrolimus [Prograf, Fujisawa, Osaka, Japan]), and a steroid (prednisolone or methyl-prednisolone). Combined transplants with a nonrenal organ were excluded.

**Renal Allograft Biopsies**

**Timing.** Open postengraftment biopsies were obtained between 25 and 40 min after the vascular anastomoses, which corresponded with the time required for ureteral suturing and surgical hemostasis. Thereafter, protocol biopsies were obtained between days 10 and 14 (so-called 2-wk protocol biopsy) and during months 4 to 6 (3-mo protocol biopsy). Indicated biopsies were obtained whenever considered necessary on a clinical basis. In general, for logistic reasons, biopsies were performed at noon or in the early afternoon.

Between June 1, 2003, and April 30, 2005, a total of 197 biopsies were obtained according to the study fixation protocol detailed in the previous paragraph: 39 postengraftment biopsies, 49 2-wk protocol biopsies, 55 3-mo protocol biopsies, and 54 indicated biopsies (owing to a significant rise in serum creatinine, for definition see the Materials and Methods section). There was no biopsy-related graft loss in this series.

**Fixation.** Immediately after the biopsy, the cores were transferred into plastic vials that contained 4% buffered formalin (Sigma, Deisenhofen, Germany). After 15 to 20 min of fixation at room temperature, the vial was placed in ice to slow/stop fixation. Specimens were kept on ice until transfer into a graded ethanol series for paraffin embedding. We found out that this procedure allowed both HIF staining and satisfactory routine morphology. Paraffin embedding usually was performed at 1 to 3 h after the biopsy but occasionally the morning after.

**Morphologic Studies.** Three-micron paraffin sections served for either routine histologic stainings or for immunohistochemistry.

**Routine Histology.** Biopsy sections were stained for routine histology with hematoxylin and eosin, periodic acid-Schiff, Masson, and silver methenamine. Only representative biopsies that contained seven or more glomeruli, renal medulla, and at least one artery were included. Biopsies were scored by the same investigator (B.R.) according to the Banff 97 working classification of renal allograft pathology (21). Immunohistochemistry for HIF-1α was performed as described previously (12,13). In brief, deparaffinized sections were cooked in target-retrieving solution (TRS; Dako, Hamburg, Germany) in a pressure cooker. Mouse anti-human HIF-1α antibody (a67; Novus Biologicals, Littleton CO; dilution of 1:10,000) and a CSA kit (Dako) were used. Signals were obtained with the help of the peroxidase technique using diaminobenzidine as a chromogen. Kidneys of rats that were kept for 4 h in a hypoxic chamber (12) served as positive controls. Omission of the first antibody or use of mouse-derived non–HIF-directed first antibodies served as negative controls. Only nuclear staining was considered positive. Immunohistochemistry for HIF-1α proved highly reliable in this material in that (1) background was virtually absent, (2) staining was strictly nuclear, and (3) staining was reproducible in parallel sections.

Semiquantitative assessment of HIF-1α signals was performed according to the following HIF score: 0, no HIF signals; 1, one to two HIF-positive tubules per biopsy; 2, three to five HIF-positive tubules per biopsy; 3, six to 10 HIF-positive tubules per biopsy; 4, 11 or more HIF-positive tubules per biopsy. HIF-positive glomeruli and clusters of interstitial cells were counted as positive tubules. In addition, HIF score was adjusted for the length of the biopsy core (in mm) according to the formula HIF scoreadjusted = HIF score × biopsy length/7. Because comparative results were achieved with both the adjusted and the nonadjusted HIF scores, data are presented as nonadjusted HIF score only.

**Definitions**

**Histologic Groups.** Unremarkable was defined as absence of significant tubulitis, vasculitis, interstitial inflammation, glomerulopathy, interstitial fibrosis, tubular atrophy, mesangial matrix increase, and vascular or arteriolar changes (t0, v0, i0, g0, c0, t0, cg0, mm0, cv0, and ah0, according to the Banff 97 classification). Acute rejection was defined as interstitial inflammation with tubulitis (equal to or greater than type IA acute rejection, according to the Banff 97 classification) as the single histologic diagnosis, together with a significant rise in serum creatinine (for definition of the latter see previous paragraph). Subclinical acute rejection was defined as histologic appearance of acute rejection but absence of significant rise in serum creatinine. Other histology was defined as any changes other than acute rejection or unremarkable histology. This group included biopsies with prominent isometric tubular vacuoles, interstitial fibrosis, tubular atrophy, tubular calcifications, arteriolaropathy, and glomerulopathy.

**Good Quality of Donor Kidneys.** Postengraftment Banff 97 chronicity score not greater than c10, c0, g0, mm0, cv0, or ah0.

**Primary Graft Function.** Primary graft function was determined by graft urine output of at least 30 ml during each of the first 3 h after completion of the vascular anastomoses. Urine was collected through a mono-J silastic ureter stent.

**Significant Rise in Serum Creatinine.** Significant rise in serum creatinine was determined to be a change in creatinine of either 0.5 mg/dl or 30% above baseline level.

**Statistical Analyses**

Data were stored and processed using the Crunch 4.0 statistics software (Oakland, CA) and are presented as means ± SEM. Nonpaired test, Pearson χ² analysis, one-way ANOVA for multiple comparisons with post hoc Newman-Keuls test, and simple correlations between variables were applied as indicated. Statistical significance was set at P < 0.05.

**Results**

**Postengraftment Biopsies**

All postengraftment biopsies were of good histologic quality (for definition, see the Materials and Methods section). Vascular patency of the transplant was confirmed by Doppler ultrasound in all study patients immediately after surgery. HIF immunostaining varied among biopsies, ranging from 0 to +4. In strongly stained samples, abundant HIF1α appeared in both cortex and medulla (Figure 1), clearly showing that cold ischemia followed by warm reflow causes widespread hypoxia in
renal grafts. Signals located predominantly in tubular profiles (mostly collecting ducts) and glomeruli but some capillary endothelial and tubulointerstitial cells were stained as well.

Underlying renal disease of the recipient (n/H11005H11005H1100512 for glomerulonephritis, n/H11005H11005H110056 for polycystic renal disease, n/H11005H11005H110054 for ureteral obstruction/reflux, n/H11005H11005H110053 for interstitial nephritis, n/H11005H11005H110054 for nephrosclerosis, n/H11005H11005H110057 for diabetes, and n/H11005H11005H110053 for unclear renal disease) did not correlate with HIF expression (data not shown).

As expected, cold ischemic time (CIT) inversely correlated with primary function \((R=0.41, P=0.001)\). Primary graft function correlated with HIF-1\(\alpha\) score: In nonfunctioning kidneys, HIF-1\(\alpha\) score \((0.42 \pm 0.20, n=7)\) was significantly lower than in functioning kidneys \((1.59 \pm 0.23; n=32; P<0.001, t\ test)\). As illustrated in Table 1, all 13 kidneys with strongly positive HIF score (range 2 to 4) were functioning, whereas all seven primarily nonfunctioning kidneys were among the 26 kidneys with low HIF score of 0 to 1. This contradictory pattern fits well with our observations that abolished glomerular filtration paradoxically ameliorates renal hypoxia as tubular workload and, hence, oxygen consumption decreases (22–26).

Although it generally is accepted that donor age and CIT predispose to reflow injury, neither CIT alone nor donor age alone correlated with HIF. Noteworthy, in clinical practice, no clearcut thresholds seem to exist for CIT and donor age. Conceivably, short CIT can compensate, at least partly, for advanced donor age and vice versa, thereby reducing postengraftment hypoxia and HIF. We hypothesized that such compensation no longer will exist beyond a certain limit of donor age or CIT, and, consequently, hypoxia and HIF will occur. Indeed, primary functioning grafts with either donor age >50 yr or CIT >15 h exhibited more HIF (HIF score 2.25 \pm 0.33 (SEM) versus 1.20 \pm 0.38 in the group with donor age \(\leq\)50 yr and CIT \(\leq\)15 h \((P=0.023; Table 2). As shown in Table 2 and Figure 2, all of the 12 kidneys with donor age >50 yr or CIT >15 h were HIF positive. By contrast, in the group with donor age \(\leq\)50 yr and CIT \(\leq\)15 h, six of 20 were HIF negative \((P=0.035, Pearson \chi^2\ analysis)\).

It is interesting that, as illustrated in Table 1, there was a statistically nonsignificant trend for fewer episodes of acute rejection during the first month after engraftment in strongly HIF-immunostained kidneys. With a greater patient number, the link between early HIF and rejection indeed might show significance.

**Two-Week Protocol Biopsies**

To avoid possible confounding factors, at the 2-wk time point, we investigated only well-functioning grafts, and clinically indicated biopsies were excluded from this analysis. Strong and abundant HIF-1\(\alpha\) appeared in both cortex and medulla of almost all 2-wk protocol biopsies (Figures 3, A and

![Post-engraftment biopsies](image.png)

**Table 1. Postengraftment biopsies (overall data summary)**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Highly Positive HIF-1(\alpha) (Score 2 to 4)</th>
<th>Low/Negative HIF-1(\alpha) (Score 0 to 1)</th>
<th>(p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of patients</td>
<td>13</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>HIF score</td>
<td>2.9 (\pm) 0.2</td>
<td>0.6 (\pm) 0.1</td>
<td>0.0001</td>
</tr>
<tr>
<td>Primary function</td>
<td>13/13 (100%)</td>
<td>19/26 (73%)</td>
<td>0.04(c)</td>
</tr>
<tr>
<td>CIT (h)</td>
<td>11.5 (\pm) 7.0</td>
<td>12.1 (\pm) 5.6</td>
<td>NS</td>
</tr>
<tr>
<td>Donor age (yr)</td>
<td>44.8 (\pm) 9.9</td>
<td>41.85 (\pm) 13.4</td>
<td>NS</td>
</tr>
<tr>
<td>Living donor</td>
<td>3/13 (23%)</td>
<td>4/26 (15%)</td>
<td>NS</td>
</tr>
<tr>
<td>Acute rejection &lt;1 mo after engraftment</td>
<td>3/13 (23%)</td>
<td>12/26 (46%)</td>
<td>0.16(e) (NS)</td>
</tr>
</tbody>
</table>

\(a\)CIT, cold ischemic time; HIF, hypoxia-inducible factor.

\(b\)\(t\) test.

\(c\)Pearson \(\chi^2\) analysis.
No significant differences in HIF score occurred between histologic groups. The data clearly show that widespread graft hypoxia occurs at 2 wk after engraftment. Nevertheless, because postengraftment biopsies also exhibit HIF-1α/H9251, it remains uncertain whether hypoxia is persistent throughout the first 2 wk or rather appears de novo.

Three-Month Protocol Biopsies
This set of biopsies was obtained at 3 mo after engraftment and beyond (mostly between 3 and 6 mo after transplantation). In sharp contrast with the previous time points, 3-mo protocol biopsies in most cases were void of HIF-1α (Figures 3, B and E, and 5; Table 3), with the only exception of subclinical acute rejection. It is interesting that at the same time point (3 mo after engraftment and beyond), protocol biopsies with acute rejection reveal strong HIF-1α signals in glomeruli, tubules, and interstitial cells (C and F). It is interesting that at the same time point (3 mo after engraftment and beyond), protocol biopsies with subclinical acute rejection but no other histologic entity are positive for HIF-1α as well (data not shown). Magnification, ×400.

Clinically Indicated Biopsies
For avoidance of possible confounding factors, the analysis included only indicated biopsies that were performed at 3 mo after engraftment and beyond. At this time point, baseline graft function and medication are fairly stable. This group contains biopsies that were mandated by a significant rise in serum creatinine but obtained within a similar time frame as in the 3-mo protocol biopsies.

Table 2. Postengraftment biopsies with primary function

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Donor Age ≤50 yr and CIT ≤15 h</th>
<th>Donor Age &gt;50 yr and/or CIT &gt;15 h</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of patients</td>
<td>20</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>HIF score</td>
<td>1.2 ± 0.4</td>
<td>2.25 ± 0.3</td>
<td>0.023</td>
</tr>
<tr>
<td>CIT (h)</td>
<td>9.5 ± 1.0</td>
<td>12.9 ± 2.2</td>
<td>0.17</td>
</tr>
<tr>
<td>Donor age (yr)</td>
<td>38 ± 3</td>
<td>50 ± 3</td>
<td>0.014</td>
</tr>
<tr>
<td>Living donor</td>
<td>4 (20%)</td>
<td>3 (25%)</td>
<td>NS</td>
</tr>
<tr>
<td>Acute rejection &lt;1 mo after engraftment</td>
<td>7 (35%)</td>
<td>4 (33%)</td>
<td>NS</td>
</tr>
</tbody>
</table>

Figure 2. HIF-1α expression in postengraftment renal allograft biopsies. DA, donor age; CIT, cold ischemic time. Grafts with primary function have higher HIF scores when compared with nonfunctioning grafts. Among functioning grafts, DA >50 yr and/or CIT >15 h correlated with higher HIF scores.

Figure 3. HIF-1α immunohistochemistry in protocol and indicated biopsies of renal allografts. At 2 wk after engraftment, most protocol biopsies exhibit marked HIF-1α upregulation in both cortex (A) and medulla (D). Signals mostly locate in glomeruli and tubules, but some interstitial cells are stained as well. At 3 mo after engraftment and beyond, unremarkable protocol biopsies are void of HIF-1α (B and E). However, at 3 mo after engraftment and beyond, indicated biopsies with acute rejection reveal strong HIF-1α signals in glomeruli, tubules, and interstitial cells (C and F). It is interesting that at the same time point (3 mo after engraftment and beyond), protocol biopsies with subclinical acute rejection but no other histologic entity are positive for HIF-1α as well (data not shown). Magnification, ×400.
HIF scores were comparable with the 3-mo protocol biopsies in that only grafts with acute rejection exhibited strong and abundant HIF-1α (Figures 3, C and F, and 6; Table 3), averaging 3.1 ± 0.2 (P < 0.001 versus all other groups, ANOVA). Again, both the borderline rejection group and kidneys that were defined as other histologic changes (as outlined previously) mostly were HIF negative.

Discussion

To our knowledge, this is the first report on HIF-1α protein upregulation in human renal biopsies. The transplant situation provides a well-defined focus of hypoxic injury to relatively unremarkable renal tissue and allows repeated studies to define the evolution of the HIF activation in conjunction with clinical parameters. The major findings are as follows: (1) HIF-1α is upregulated abundantly in postengraftment biopsies (Figure 1); (2) HIF-1α is absent in primarily nonfunctioning grafts (Figure 1); (3) in functioning grafts, HIF-1α is higher in older kidneys (>50 yr) and/or after prolonged ischemic period (>15 h; Figure 2); (4) HIF-1α is activated in protocol biopsies that are obtained at 2 wk after transplantation, irrespective of histology (Figures 3 and 4); (5) beyond 3 mo after transplantation, both protocol and indicated biopsies generally are void of HIF-1α (Figures 3 and 5); (6) the only exceptions to the observation in (5) are both clinical and subclinical acute rejection, which show marked HIF-1α upregulation at 3 mo from transplantation and beyond (Figures 3, 5, and 6).

**HIF-1α Is Upregulated in Postengraftment Biopsies**

It has been the general belief that cold storage of donor kidneys followed by warm reflow leads to hypoxic graft damage (for review, see reference [27]), but it is not until this study that hypoxia has been demonstrated clearly in this setting. Somewhat surprising, HIF-1α is absent in grafts with primary nonfunction. One might expect that primary nonfunction would associate with greater hypoxic reflow damage and, hence, with more HIF. However, reduced or even abolished glomerular filtration leads to a paradoxical increase in renal oxygen tensions as tubular workload for reabsorption declines. To underscore that during acute injury GFR reduction may serve for renal structural preservation, Thurau and Boylan (28) coined the term “acute renal success,” and, certainly, both in vivo and ex vivo studies of medullary thick ascending limb injury have documented this extensively (22–25). Grafts with primary nonfunction are at greater risk for early acute rejection, supporting the view that nonspecific cell injury promotes specific alloimmunologic events (29–33). It is tempting to speculate that HIF upregulation might reduce immunogenicity of parenchymal cells. Noteworthy, there was a trend for less early acute rejections (within 1 mo) in kidneys with postengraftment HIF-1α activation. Lack of statistical significance may owe to interpatient variation in several acknowledged determinants of early acute rejection (e.g., donor age, CIT, number of HLA mismatches, preexisting recipient HLA antibodies, immunosuppression). Functioning kidneys of donors beyond 50 yr or with CIT >15 h exhibit more pronounced HIF-1α, indicating enhanced hypoxia adaptational responses. Noteworthy, in clinical practice, successful engraftment may occur far beyond these limits. HIF activation provides a reasonable explanation for this phenomenon in that HIF-derived transcriptional adaptation might ameliorate, at least partly, reflow injury and improve graft outcome.

**HIF-1α Activation in 2-Wk Protocol Biopsies, Irrespective of Their Histology**

Most of the well-functioning grafts displayed marked HIF activation at 2 wk after transplantation, the reason for which remains unclear. One possible explanation is hyperfiltration of the renal allografts with consequently increased workload for solute reabsorption, increased oxygen consumption, and hypoxia. A second possible explanation is graft hypertrophy. Growth hormones that promote hypertrophy have been shown to modulate HIF via phosphatidylinositol-3-kinase and mitogen-activated protein kinase (for review, see reference [34]). A third possible explanation is acute CNI-induced toxicity, which may cause renal hypoxia (35–43). Unfortunately, this plausible explanation cannot be tested by comparison with patients who were not given CNI, because all study patients were receiving this treatment at 2 wk after transplantation. A fourth possible explanation is HIF upregulation by inflammatory cytokines, which were shown to modulate HIF (for reviews, see references [44,45]. Indeed, at 2 wk after transplantation, there is considerable influx of blood-derived cells into the kidney (46,47). However, because at this time point HIF-1α is independent of histology, we suggest that inflammation is unlikely to be the cause for HIF upregulation. Location of tubular HIF-1α showed a predilection for collecting ducts throughout the clinical/histologic groups, which is in accordance with our previous observations in several experimental models (12,13,17,19,20).
Finally, it is uncertain whether 2-wk graft hypoxia occurs de novo or persists since transplantation.

Stable Long-Term Allografts Are Void of HIF-1α

At 3 mo after transplantation, most renal allografts have reached a functional and structural equilibrium. In general, CNI as one possible cause of renal toxicity/hypoxia are being delivered at lower dosages, as compared with the early post-transplantation period. Not surprising, such grafts are virtually void of HIF-1α, which is in concordance with our results in normal rat kidneys (12–20).

Low or even very low oxygen tensions physiologically exist in kidney zones such as the papilla, the outer medulla, or the medullary rays (for review, see reference [48]. Sophisticated counterbalance mechanisms help to restore renal oxygen homeostasis (49), and some researchers have proposed that HIF physiologically takes part in this fine-tuning network (50,51). However, evidence for HIF upregulation in normal kidneys is inconsistent (for review, see reference [6]). Possible explanations for such conflicting results are differences between species, tissue fixation, or detection methods used.

In this study, we use a HIFα detection technique that has proved sensitive, robust, and reliable in a considerable number of studies on various rat and human tissues. With this method, HIFα immunosignals were undetectable in normal tissues (12–20). Therefore, we propose that either oxygen homeostasis is preserved in normal rat and human kidneys or our detection technique is insensitive for potentially physiologic HIFα. With strict definition of hypoxia as an oxygen imbalance (rather than simply low oxygen tension), we believe that our detection method may help to identify pathologic oxygen imbalance, as it has done so in multiple experimental situations. Consequently, absence of HIF1α in long-term stable grafts may indicate that their oxygen homeostasis is preserved.

Marked HIF-Activation in Clinical/Subclinical Rejection

Unexpected, beyond 3 mo after transplantation, the only histologic conditions that were associated with HIF activation were clinical and subclinical acute rejection (following the Banff

### Table 3. HIF-1α score in protocol and clinically indicated biopsies

<table>
<thead>
<tr>
<th>Histology</th>
<th>2-Wk Protocol Biopsy</th>
<th>3-Mo Protocol Biopsy</th>
<th>3-Mo Indicated Biopsy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unremarkable</td>
<td>3.07 ± 0.27 (n = 15)</td>
<td>0.97 ± 0.18 (n = 32)</td>
<td>— (n = 0)</td>
</tr>
<tr>
<td>Acute rejection</td>
<td>2.73 ± 0.32 (n = 15)</td>
<td>2.9 ± 0.50a (n = 10)</td>
<td>3.14 ± 0.22b (n = 21)</td>
</tr>
<tr>
<td>Borderline rejection</td>
<td>2.86 ± 0.55 (n = 7)</td>
<td>0.75 ± 0.48 (n = 4)</td>
<td>0.6 ± 0.60 (n = 5)</td>
</tr>
<tr>
<td>Others</td>
<td>2.75 ± 0.39 (n = 12)</td>
<td>0.78 ± 0.36 (n = 9)</td>
<td>0.62 ± 0.16 (n = 26)</td>
</tr>
</tbody>
</table>

aP < 0.003 versus other groups, ANOVA.
bP < 0.0001 versus other groups, ANOVA.

Figure 5. HIF-1α score in 3-mo protocol biopsies. In protocol biopsies (of well-functioning grafts) that were obtained at 3 mo after engraftment and beyond, HIF-1α expression is significantly increased only in the histologic subgroup of (subclinical) acute rejection.

Figure 6. HIF-1α score in indicated biopsies at 3 mo after engraftment and beyond. In indicated biopsies (as a result of a significant rise in serum creatinine of either 0.5 mg/dl or 30% above baseline level) that were obtained at 3 mo after engraftment and beyond, HIF-1α expression is increased significantly only in the histologic subgroup of (clinical) acute rejection.
features with acute transplant rejection (53)—Peeters—Pettis—a T cell–mediated inflammation that shares some common
magnetic resonance imaging. Second, in experimental arthri-
cently showed that renal medullary oxygenation is reduced
cultures that were kept under 21% oxygen (for reviews, see
kines and growth factors were shown to induce HIF in cell
because hypoxia-unrelated factors such as inflammatory cyto-
biopsies and help to decide for antirejection therapy.

The concept of rejection-induced renal hypoxia is backed by
two independent observations: First, Sadowski et al. (52) re-
ently showed that renal medullary oxygenation is reduced
during acute rejection, using blood oxygen level–dependent
magnetic resonance imaging. Second, in experimental arthri-
itis—a T cell–mediated inflammation that shares some common
features with acute transplant rejection (53)—Peeters et al. (54)
showed HIF-1α upregulation in conjuntion with the hypoxia
marker pimonidazole.

Acute tubular rejection is widespread but not diffuse, mean-
ing that because of sampling error, histology sometimes may
miss the diagnosis (55). Furthermore, clinical evolution and
response to steroid pulses is hardly predictable in subclinical
acute rejection, as well as with borderline changes (56). It is
tempting to assume that complementary HIF-1α immuno-
chemistry could enhance the diagnostic yield of renal allograft
biopsies and help to decide for antirejection therapy.

Conclusion

In human renal transplants, hypoxia and hypoxic adaptation
seem widespread during the first 2 wk after engraftment. By
contrast, graft hypoxia is uncommon in the long term and is
associated with clinical/subclinical rejection. HIF-1α immuno-
chemistry could be a complementary diagnostic tool in
subclinical or ambiguous cases of acute cellular rejection.

Acknowledgments

This study was supported by funds from Harvard Medical Faculty
Physicians at Beth Israel Deaconess Medical Center (Boston, MA) and
by the Russell Berrie Foundation and D-Cure, Diabetes Care (Jerusa-
lem, Israel).

The technical skills of Gertrud Gruber, Yvonne Naumann, and Anna
Skrobecka are greatly appreciated.

Disclosures

None.

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