Expression of the Chemokine Receptor CXCR3 and Its Ligand IP-10 During Human Cardiac Allograft Rejection

Michael Melter, MD; Andrea Exeni, MD; Marlies E.J. Reinders, MD; James C. Fang, MD; Gearoid McMahon; Peter Ganz, MD; Wayne W. Hancock, MD; David M. Briscoe, MD

Background—Chemokines play an essential role in regulating the infiltration of leukocytes into allografts in experimental models. Little is known of their expression or function after human cardiac transplantation.

Methods and Results—We analyzed 169 sequential human endomyocardial biopsies by immunocytochemistry for infiltration by CD3+ T cells and the expression of the chemokine receptors CCR1, CCR3, CCR5, and CXCR3. In both cross-sectional and longitudinal analyses, the expression of each of the chemokine receptors correlated with the degree of CD3+ T-cell infiltration. In particular, the expression of CXCR3 was temporally and spatially associated with CD3+ T-cell infiltrates and correlated with the histopathological diagnosis of acute rejection (OR, 11.73 and 4.05, respectively; \( P<0.001 \)). Of 7 patients followed up longitudinally for 1 year, 4 with consecutive biopsies developed intimal thickening by intravascular ultrasound. In these patients, there was a trend for persistent expression of CD3- and CXCR3-expressing infiltrates in the later part of the first posttransplant year. The chemokines eotaxin, IP-10, lymphotactin, MCP-1, Mig, RANTES, and SDF-1 were examined in an additional 35 biopsies by RT-PCR. Eotaxin, lymphotactin, MCP-1, Mig, and SDF-1 were present in both normal and rejecting biopsies. However, the CXCR3 ligand IP-10, which was rarely expressed in normal biopsies, was markedly induced in acute rejection (OR, 19.43; \( P=0.01 \)).

Conclusions—The presence of CXCR3+ T cells and the CXCR3 ligand IP-10 within endomyocardial biopsies is strongly associated with acute rejection. The CXCR3–IP-10 interaction warrants consideration as a therapeutic target in the management of cardiac allograft recipients. (Circulation. 2001;104:2558-2564.)

Key Words: transplantation ■ chemokine ■ rejection

Multiple molecules, including families of adhesion molecules and chemokines, provide signals for the dynamic trafficking of leukocytes into allografts. Chemokines are proinflammatory cytokines that function as potent chemoattractants for leukocytes. They provide signals leading to selective recruitment of mononuclear cells at sites of inflammation that may be critical in the process of acute rejection. The chemokines eotaxin, IP-10, lymphotactin, MCP-1, Mig, RANTES, and SDF-1 were examined in an additional 35 biopsies by RT-PCR. Eotaxin, lymphotactin, MCP-1, Mig, and SDF-1 were present in both normal and rejecting biopsies. However, the CXCR3 ligand IP-10, which was rarely expressed in normal biopsies, was markedly induced in acute rejection (OR, 19.43; \( P=0.01 \)).

Several studies have demonstrated that chemokines participate in the inflammatory response within allografts. Indeed, it would appear from studies performed in experimental animal models that dysregulation of any one of a series of chemokines or chemokine receptors can limit the rejection reaction. In particular, recent studies comparing the effects of targeting various chemokine/chemokine receptor pathways experimentally with the use of knockout mice and neutralizing monoclonal antibodies have demonstrated that the IP-10–CXCR3 chemokine-chemokine receptor pathway is most important in acute rejection of cardiac allografts. Further identification of chemokines and chemokine receptors after human transplantation will likely provide information on...
whether these may be novel targets for therapeutic manipulation to limit rejection. In this study, we have analyzed the expression of 4 different chemokine receptors and 7 complementary chemokines in human cardiac allografts. Our findings are that CXCR3 and the CXCR3 ligand IP-10 are most significantly associated with acute rejection.

Methods

Patients

Chemokine Receptor Study

We collected 179 biopsies from 16 cardiac allograft recipients (2 female, 14 male) during routine visits to the transplant clinic during the initial posttransplant year. In total, 169 were of sufficient quality and included 105 biopsies with normal histology, 6 with evidence of ischemic injury, and 57 with acute rejection (27 with International Society of Heart and Lung Transplant [ISHLT] grade 1, 13 with ISHLT grade 2, and 17 with ISHLT grade 3). One biopsy had evidence of both ischemic injury and acute rejection (ISHLT grade 1). Biopsies were taken at a median time of 118 days after transplantation (range, 4 days to 1 year). The median age of the recipients was 52 years (range, 36 to 64 years) at the time of transplantation. In addition, a total of 120 consecutive biopsies from 10 of these patients (2 female, 8 male) were analyzed longitudinally on a per-patient basis. None of the patients died or lost the graft.

Chemokine Study

RNA was prepared from 44 randomly selected biopsies within 4 weeks of collection. Biopsies were taken at a median time of 2.4 years after transplantation (range, 6 days to 14.4 years) from recipients (4 female, 40 male). The age of the recipients ranged from 19 to 64 years (median, 49 years) at the time of transplantation (range, 4 days to 1 year). The median age of the recipients was 52 years (range, 36 to 64 years) at the time of transplantation. One patient died with a graft failure 122 days after transplantation. A random biopsy was taken from the remaining allograft of this patient on a per-patient basis. None of the patients died or lost the graft.

Tissue Collection and Analysis

Endomyocardial biopsies (EMBs) were taken on all patients after transplantation as part of routine posttransplant care. A random biopsy was taken at a median time of 2.4 years after transplantation (range, 6 days to 14.4 years) from recipients (4 female, 40 male). The age of the recipients ranged from 19 to 64 years (median, 49 years) at the time of transplantation (range, 4 days to 1 year). The median age of the recipients was 52 years (range, 36 to 64 years) at the time of transplantation. One patient died with a graft failure 122 days after transplantation. A random biopsy was taken from the remaining allograft of this patient on a per-patient basis. None of the patients died or lost the graft.

Tissue Collection and Analysis

Endomyocardial biopsies (EMBs) were taken on all patients after heart transplantation as part of routine posttransplant care. A random portion of 1 specimen was used as the study biopsy and was stored at −80°C for later immunocytochemistry or for RNA extraction. Diagnostic specimens taken at the same time were processed for histology. The protocol for tissue collection was approved by the Human Research Committee at the Brigham and Women’s Hospital, Boston, Mass.

Intravascular Ultrasound

Intravascular ultrasound (IVUS) was performed at baseline and at 1 year after transplantation as previously described.9 Images were acquired at 3 to 7 random sites along the artery of interest, and sites from both studies were matched by use of angiographic landmarks. IVUS analysis was performed on digitized images with offline software (TapeMeasure, INDEC). Measurements included the intimal area index (IAI) (IAI = intimal area/[(intimal area + lumenal area)]) and maximal intimal thickness (MT; greatest radial intimal thickness). Progression of intimal pathology between IVUS studies was defined as a mean delta (Δ) IAI ≥5% or MT ≥150 μm.

Antibodies

Murine monoclonal antibodies used for immunocytochemistry included anti-human CXCR3 (1C6), CCR1 (2D4), CCR3 (7B11), and CCR5 (2D7) (Millennium Pharmaceuticals); anti-human CD3 (Pan-T3; DAKO); and K16/16 (nonspecific mouse IgG, a gift of M. Gimbrone, Brigham and Women’s Hospital) as a negative control.

Immunocytochemistry

Immunocytochemistry was performed on 4-μm cryostat sections as previously described.10,11 Primary antibodies were diluted in PBS and incubated with the sections overnight at 4°C in a humidified container. Subsequently, specimens were incubated with a species-specific peroxidase-conjugated secondary antibody, counterstained in hematoxylin, and mounted in glycerol-gelatin. Control specimens were incubated in nonspecific mouse IgG and medium alone.

Scoring System

Cellular staining was scored by 3 independent observers (M.M., A.E., and D.M.B.) as follows: 0=no stain, 1=minimal rare individual cells, 2=1 focal infiltrate, 3=multipolar infiltrates, and 4=diffuse infiltration, as previously described.10 Minor differences in scores were resolved by conference.

RNA Extraction and RT-PCR

Total RNA was isolated from the frozen EMBs by homogenization with the Ultraspec RNA Isolation System (Biotex Laboratories, Inc) according to the manufacturer’s instructions. cDNA was prepared and PCR was performed with standard techniques as described12 and the following specific primers: RANTES: sense, 5'-AAG GCC CCT CAT TCA TCA G-3'; antisense, 5'-TTC CTT GGA AAA TGG CIT TG-3'; IP-10: sense, 5'-AGA GGA GGA ACC TCT AGC AGC-3'; antisense, 5'-CCT CTG TGT GGT CCA CCA TT-3'; lymphotactin: sense, 5'-CTG ATC CTG GCC CTC CTT-3'; anti- sense, 5'-GGC TTG TCC TTC ATG ATG TT-3'; MCP-1: sense, 5'-AGT CCA ACC AAG GTT TGT GC-3'; antisense, 5'-GGC TTC TG AAG GTG TCC GC-3'; Mig: sense, 5'-TTA AAC AAT TTT CCC CAA GC-3'; antisense, 5'-CTG TTG TGA GTG GGA GTG GG-3'; RANTES: sense, 5'-ACC ATG AAG GTC TCC GCG-3'; antisense, 5'-TTG ATG TTC AGG AAC GAC TCT CCA-3'; and SDF-1: sense, 5'-AAC AGA CAA GTG TGC ATT GAC C-3'; antisense, 5'-AGG TAC AGG GCA TGG ATG AA-3'. PCR reactions were performed under the following conditions: 1 cycle at 94°C for 5 minutes, followed by 40 cycles at 94°C for 1 minute, 60°C for 1 minute, and 72°C for 1 minute. The last cycle was extended to 7 minutes at 72°C. mRNA extracted from peripheral blood mononuclear cells served as positive control. Positive control for RT-PCR was the amplification of β-actin (Stratagene), and negative controls were the amplification of non–reverse-transcribed mRNA. Amplified products were resolved by electrophoresis, and band densitometry was analyzed with an AlphaImager 2000 system (Alpha Innotech Corp). Bands with a negligible signal (area under each peak <200) were considered negative. Other bands were positive. Samples with a negligible β-actin signal were excluded from analysis.

Statistical Analysis

Analyses were performed with SPSS for Windows 9.0. Logistic regression analysis was used to estimate the statistical significance of the relationship between categories. All results are presented as ORs with a 95% CI. Values of P<0.05 were considered statistically significant. Correlation was analyzed by the Kendall’s τ-b test and was considered as significant when P<0.05.

Results

Chemokine Receptor Expression in Normal Human Cardiac Allograft Biopsies

A total of 169 EMBs were analyzed by immunocytochemistry for the expression of CD3 T-cell infiltrates and for the expression of the chemokine receptors CCR1, CCR3, CCR5,
and CXCR3. Of these, 105 (62%) were histologically normal with no evidence of ischemic injury or allograft rejection. Although most normal biopsies had no infiltrates, others had evidence of isolated cells expressing CCR1, CCR5, and CXCR3 (Table 1). CXCR3 localized to individual cells, and CCR1 localized to small foci of infiltrates and a few sparsely distributed cells. CCR5 staining was weak and was restricted to rare, isolated cells. In contrast, CCR3 was expressed diffusely on granules within the cytoplasm of multiple resident cells (large macrophage and dendritic-like cells) in many normal biopsies (Figure 1f). CD3 T-cell infiltrates were also present in many (40%) of these normal EMBs as single sparse cells or as isolated infiltrates (scores generally ≤1).

Chemokine Receptors in EMBs With CD3 T-Cell Infiltrates and Acute Rejection

In a cross-sectional analysis of all 169 biopsies, high grades of CD3 T-cell infiltrates (scores ≥2) were strongly associated with the presence of rejection (OR, 5.08; P<0.001; Table 1), especially moderate to severe rejection episodes accompanied by myocyte necrosis (OR, 7.8; P<0.001). Figure 1 illustrates the pattern of chemokine receptor expression in rejecting biopsies. CCR1 and CCR5 were expressed

Table 1. CD3 T-Cell Infiltrates (Score ≥2), Chemokine Receptor Expression (Score ≥2), and Histopathological Diagnosis of Rejection

<table>
<thead>
<tr>
<th></th>
<th>No Rejection (n=105), %</th>
<th>Rejection (n=57), %</th>
<th>OR</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD3+</td>
<td>40</td>
<td>77</td>
<td>5.08</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>CXCR3+</td>
<td>34</td>
<td>68</td>
<td>4.05</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>CCR1+</td>
<td>20</td>
<td>28</td>
<td>1.56</td>
<td>0.25</td>
</tr>
<tr>
<td>CCR3+</td>
<td>45</td>
<td>61</td>
<td>1.88</td>
<td>0.06</td>
</tr>
<tr>
<td>CCR5+</td>
<td>28</td>
<td>39</td>
<td>1.70</td>
<td>0.13</td>
</tr>
</tbody>
</table>

Figure 1. Chemokine receptor expression in human cardiac allografts. Representative photomicrographs of expression of CD3 (a), CCR1 (b), CCR5 (c), CXCR3 (d), and CCR3 (e) in biopsies with evidence of rejection. f, Expression of CCR3 in granules of resident cells in normal allografts. CCR3 was expressed on 2 populations of cells: resident cells within noninfiltrated grafts and infiltrating mononuclear cells in biopsies with evidence of rejection. Magnification: ×200 (a through c) and ×400 (d through f).

Figure 2. Association among chemokine receptor expression and CD3 T-cell infiltrates in human cardiac allografts. Plotted are percentages of biopsies with minimal or no staining (score 0 to 1; gray bars, negative) or moderate to intense staining (score 2 to 4; black bars, positive) for CCR1 (A), CCR3 (B), CCR5 (C), and CXCR3 (D) correlated with degree of CD3 T-cell infiltrates.
on focal infiltrating mononuclear cells (Figure 1b and 1c) but varied in intensity at sites of infiltrates. CCR1 was most intense at sites of focal infiltrates and was strongly associated with the degree of CD3+ T-cell infiltrates (OR, 8.42; P<0.001; Figure 2). The expression of CCR5 was more diffuse, being present on multiple cells within biopsies with CD3+ T-cell infiltrates with a variable intensity of staining. Occasionally, CCR5 was notably absent in biopsies with evidence of infiltrates (Figure 2). Overall, the expression of CCR1 and CCR5 was at low levels and did not correlate with the presence of acute rejection.

As noted, CCR3 was evident on resident cells within many normal biopsies (Figures 1 and 2). However, in rejection, CCR3 was present both on these resident cells and on the inflammatory infiltrate. CCR3-expressing cells appeared to be most intense at sites of focal infiltrates (Figure 1e). Thus, even though baseline scores for CCR3 were generally ≥1, the expression of CCR3 increased in association with CD3+ T-cell infiltrates (OR, 2.98; P<0.001; Figure 2) and in association with acute rejection (OR, 1.88; P=0.06; Table 1).

In contrast, CCR3 expression was temporally and spatially localized to areas of T-cell infiltrates. Furthermore, the distribution of staining of CXCR3 was similar to that found for CD3 inasmuch as ~30% to 50% of CD3+ infiltrates within each biopsy expressed high levels of CXCR3 (Figures 1d and 3). However, the intensity of cellular staining of CXCR3 was greater in some biopsies than in others. In cross-sectional analyses, we found the expression of CXCR3 to be most prominent in biopsies with CD3+ T-cell infiltrates (OR, 11.73; P<0.001; Figure 2) and to be strongly associated with all grades of acute rejection (OR, 4.05; P<0.001; Table 1).

Longitudinal Analysis of Chemokine Receptor Expression

We also assessed the temporal expression of CD3+ T-cell infiltrates and chemokine receptors in consecutive EMBs in 10 cardiac allograft recipients (median, 12 biopsies per patient; range, 11 to 14). Overall, infiltration by CXCR3-, CCR1-, and CCR5-expressing cells increased and decreased temporally in association with CD3+ T-cell infiltrates. Figure 4 illustrates the pattern of CD3+ T-cell infiltrates and CXCR3-expressing cells in EMBs from 2 representative patients over the period of the study. One patient (Figure 4A) had 8 biopsies with evidence of rejection, 7 of which were associated with myocyte necrosis (5 were ISHLT grade 3, 2 were grade 2, and 1 was grade 1 rejection). In this patient, each rejection episode was associated with infiltration of the EMB with multifocal/diffuse CXCR3+-expressing infiltrates (score ≥2) in association with CD3+ T-cell infiltrates. The other patient (Figure 4B) had 4 biopsies associated with rejection, albeit less severe (2 had ISHLT grade 2 and 2 had grade 1 rejection). CXCR3+-expressing infiltrates were again present in the EMB during each rejection episode, although the degree of infiltration was less marked with less severe rejection episodes.

The development of transplant coronary artery disease (TCAD) was evaluated in 7 patients by IVUS (Table 2). Four patients had evidence of an increased ΔMT (median ΔMT, 300 μm; range, 270 to 350 μm), whereas 3 patients had no change in intimal thickening between the baseline examination and 1-year study. Representative patients are illustrated Figure 4. We analyzed whether persistent infiltration with both CD3+ and CXCR3+ expressing infiltrates was associated with TCAD. Coinfiltration with both CD3+ and CXCR3+ expressing infiltrates (Figure 4C) occurred often in the first 6 posttransplant months. However, persistence of both CD3+ and CXCR3+ cells in biopsies in the third and fourth posttransplant quartiles was associated with the devel-

### TABLE 2. Median Overall Annual Scores for CD3+ T-Cell Infiltrates, Chemokine Receptors, and ISHLT Grade of Rejection: Association With the Development of TCAD

<table>
<thead>
<tr>
<th>Patient</th>
<th>CD3</th>
<th>CXCR3</th>
<th>CCR1</th>
<th>CCR3</th>
<th>CCR5</th>
<th>Rejection</th>
<th>ΔMT*, μm</th>
<th>CMV†</th>
<th>CMV Rx†</th>
</tr>
</thead>
<tbody>
<tr>
<td>J.A.</td>
<td>3 (1–4)</td>
<td>2 (1–3)</td>
<td>2 (0–4)</td>
<td>1 (0–3)</td>
<td>1 (1–3)</td>
<td>0 (0–3)</td>
<td>270</td>
<td>R+/D+</td>
<td>–</td>
</tr>
<tr>
<td>M.E.</td>
<td>3 (2–3)</td>
<td>2 (1–3)</td>
<td>1 (0–1)</td>
<td>2 (1–3)</td>
<td>3 (2–3)</td>
<td>1 (0–3)</td>
<td>310</td>
<td>R–/D–</td>
<td>–</td>
</tr>
<tr>
<td>C.O.</td>
<td>3 (1–4)</td>
<td>3 (2–4)</td>
<td>1 (0–4)</td>
<td>2 (0–3)</td>
<td>1 (0–3)</td>
<td>2 (0–3)</td>
<td>290</td>
<td>R+/D+</td>
<td>+</td>
</tr>
<tr>
<td>W.I.</td>
<td>1 (0–3)</td>
<td>2 (0–3)</td>
<td>1 (0–3)</td>
<td>2 (0–3)</td>
<td>2 (0–3)</td>
<td>1 (0–3)</td>
<td>350</td>
<td>R–/D–</td>
<td>–</td>
</tr>
<tr>
<td>A.U.</td>
<td>2 (1–3)</td>
<td>1 (0–3)</td>
<td>0 (0–3)</td>
<td>1 (1–3)</td>
<td>1 (0–3)</td>
<td>0 (0–2)</td>
<td>0</td>
<td>R+/D+</td>
<td>–</td>
</tr>
<tr>
<td>B.A.</td>
<td>1 (0–3)</td>
<td>1 (0–3)</td>
<td>0 (0–1)</td>
<td>0 (0–2)</td>
<td>1 (0–2)</td>
<td>0 (0–1)</td>
<td>0</td>
<td>R-/D–</td>
<td>–</td>
</tr>
<tr>
<td>B.O.</td>
<td>1 (0–3)</td>
<td>2 (0–3)</td>
<td>0 (0–2)</td>
<td>2 (1–3)</td>
<td>1 (1–3)</td>
<td>0 (0–2)</td>
<td>0</td>
<td>R+/D?</td>
<td>–</td>
</tr>
</tbody>
</table>

*Scores range from 0 to 4.
†Change in maximal thickness in the first posttransplant year.
‡Recipients and donors were either cytomegalovirus (CMV) positive (R+ and D+) or negative (R– and D–) by serology. CMV therapy (Rx) was given to 1 patient (+) who became symptomatic.
opment of TCAD \((R=0.65, P<0.001)\). These findings are consistent with our previous observations that persistent intragraft immunological events in the third and fourth posttransplant quartiles identify patients at an increased risk for the development of TCAD.\(^{13}\)

Chemokine Gene Expression in EMBs With and Without Evidence of Rejection

We next evaluated the expression of the chemokines eotaxin, IP-10, lymphotactin, MCP-1, Mig, RANTES, and SDF-1 within EMBs. Because expression of chemokines is reliably assessed at the mRNA level, we collected an additional number of allograft biopsies prospectively so that mRNA expression could be examined from fresh biopsy samples. A total of 35 biopsies were analyzed. Overall, we found that the expression of IP-10 and RANTES was strongly associated with the histopathological diagnosis of rejection \((OR, 19.43, P=0.01; \text{ and } OR, 7.88, P=0.02, \text{ respectively}; \text{ Table 3 and Figure 5A and 5B})\). In contrast, the expression of eotaxin, lymphotactin, MCP-1, Mig, and SDF-1 was not associated with rejection \((\text{Table 3 and Figure 5C})\). Intragraft expression of IP-10 and RANTES was most easy to detect because each gene was either absent or present in the study biopsies \((\text{as illustrated in Figure 5A})\). This contrasted the expression patterns of MCP-1 and Mig, which were rarely expressed at all, and the expression of eotaxin, lymphotactin, and SDF-1, which were present in most biopsies examined. Together, our findings of enhanced mRNA expression of the CXCR3 ligand IP-10 and the CCR1 ligand RANTES is consistent with a functional role for these chemokines with chemokine receptors in human cardiac allograft rejection.

Discussion

In this study, we found that the chemokine receptors CCR1, CCR3, CCR5, and CXCR3 are expressed in association with CD3\(^+\) T-cell infiltrates in human cardiac allografts. Further-

**TABLE 3. Chemokine Gene Expression and the Histopathological Diagnosis of Rejection**

<table>
<thead>
<tr>
<th></th>
<th>No Rejection ((n=26)), %</th>
<th>Rejection ((n=9)), %</th>
<th>OR</th>
<th>(P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eotaxin</td>
<td>41</td>
<td>44</td>
<td>1.16</td>
<td>0.86</td>
</tr>
<tr>
<td>IP-10</td>
<td>29</td>
<td>89</td>
<td>19.43</td>
<td>0.01</td>
</tr>
<tr>
<td>Lymphotactin</td>
<td>58</td>
<td>44</td>
<td>0.59</td>
<td>0.49</td>
</tr>
<tr>
<td>MCP-1</td>
<td>0</td>
<td>0</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>Mig</td>
<td>4</td>
<td>11</td>
<td>3.12</td>
<td>0.44</td>
</tr>
<tr>
<td>RANTES</td>
<td>31</td>
<td>78</td>
<td>7.88</td>
<td>0.02</td>
</tr>
<tr>
<td>SDF-1</td>
<td>69</td>
<td>89</td>
<td>3.56</td>
<td>0.27</td>
</tr>
</tbody>
</table>
Infiltration with CXCR3 cells and the expression of the CXCR3 ligand IP-10 are closely associated with the diagnosis of acute rejection. CCR1 was also expressed on infiltrates, and the CCR1 ligand RANTES was present in high levels in allografts undergoing rejection. These findings are likely of clinical value in the monitoring of patients after transplantation. Moreover, our findings may be of mechanistic significance in that both IP-10 and RANTES are potent chemoattractants for antigen-activated T cells.1,2,14,15 Studies using knockout mice have demonstrated the importance of CCR1 in mononuclear cell recruitment during the development of acute allograft rejection.5 Furthermore, allografts from CCR1-deficient mice are rejected normally.22 Hence, in contrast to the CXCR3–IP-10 pathway, the role of RANTES in vivo is likely to be in amplifying the alloresponse rather than as a requisite event in allograft rejection.

In summary, this is the first study to define the expression of chemokine receptors and chemokines in human cardiac allografts. Our findings are consistent with recent studies performed in animal models and are suggestive of a close association between the expression of CXCR3 and its ligand IP-10 with CD3+ T-cell infiltrates and acute cardiac allograft rejection. Persistence of CXCR3 expression on infiltrates suggests that this molecule may play a functional role in the rejection of human cardiac allografts.

Acknowledgments

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References

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