Interleukin 8 Concentrations in Donor Bronchoalveolar Lavage: Impact on Primary Graft Failure in Double Lung Transplant

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Purpose of the study was to determine concentrations of interleukin 8 (IL-8) in the bronchoalveolar lavage (BAL) fluid from donor lungs and assess the role of IL-8 levels in the development of primary graft failure.

Patients and Methods. Twenty patients who received a double lung transplant were studied. A series of data, including BAL fluid concentrations of IL-8, were collected for the donors. Data collected for the recipients included arterial blood gases after 6, 24, and 48 hours, and intubation time. Patients with a ratio of PaO2 to the fraction of inspired oxygen (FiO2) of less than 300 during the first 48 hours were diagnosed with primary graft failure. IL-8 levels were determined by enzyme-linked immunosorbent assay.

Results. Fifteen of the 20 donors were men. The cause of brain death was trauma in 9 donors, 7 were smokers, 13 required inotropic support, and pathogens were isolated in the BAL fluid of 18. The median age was 35 years (interquartile range [IQR], 23.5-51.25 y), the median ventilation time was 1 day (IQR, 1-2 d), the median PaO2/FiO2 was 459.5 (IQR, 427-510.25), and the median IL-8 concentration in BAL fluid was 49.01 ng/L (IQR, 786-94.05 ng/mL).

Ten of the recipients were men and the median age was 48.43 years (IQR, 25.4-56.81 y). The median ischemic time was 210 minutes (IQR, 176.25-228.75 min) for the first lung and 300 minutes (IQR, 273.75-333.73 min) for the second lung. The median PaO2/FiO2 ratio for the implant at 6, 14, and 48 hours was 129 (IQR, 190.25-435), 363.5 (IQR, 249-434.75), and 370.5 (IQR, 243.25-418.25), respectively. The median intubation time was 39.5 hours (IQR, 19.25-68.5 h) and the correlation with IL-8 values was positive: higher IL-8 concentrations in BAL fluid correlated with longer ventilation times (Spearman rank correlation, ρ=0.007; p=0.583). Five patients developed primary graft failure; IL-8 concentrations were significantly higher in these patients than in those whose grafts did not fail (Mann-Whitney test, P=0.003).

Conclusion. High IL-8 concentrations in donor BAL fluid lead to longer ventilation time in the recipients and favor the development of primary graft failure after lung transplant.

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Introduction

Primary graft failure remains to be the main cause of perioperative and early mortality in lung transplant recipients. This acute lung injury occurs in the immediate perioperative period as a result of a series of events inherent in lung transplants. Its clinical manifestations include severe hypoxemia, and x-ray studies show alveolar infiltrates (pulmonary edema). The patient must be kept on mechanical ventilation, and the factors that may condition it or that may affect the subsequent course of the transplant patient are inflammation and infection, sepsis, and graft failure once acute rejection, obstruction of venous anastomosis, reperfusion lung injury, and IL-8 concentrations in BAL fluid. The mechanism of ischemia-reperfusion lung injury is complex and not yet fully understood. It is the result of the interaction between potent inflammatory mediators and various cell types. Among the mediators, the interleukins (IL), particularly IL-8, appear to play an important role in the development of primary graft failure.

Lung transplantation, however, is a complex process suggesting that the optimal use of oxygen and its subsequent reperfusion in the recipient. The mechanism of ischemia-reperfusion lung injury is highly complex and is not yet fully understood. It is the result of the interaction between potent inflammatory mediators and various cell types. Among the mediators, the interleukins (IL), particularly IL-8, appear to play an important role in the development of primary graft failure.

The objective of our study was to determine IL-8 concentrations in fluid from BAL of the donor lung and to assess the role of IL-8 levels in the development of primary graft failure.

Patients and Methods

Patients

This prospective study enrolled 20 patients who underwent a sequential double lung transplant in La Fe University Hospital, Valencia, Spain between November 2005 and December 2006.

All the lung donors were ideal, according to generally accepted criteria. The lungs were extracted in accordance with the protocol of La Fe University Hospital, Valencia, Spain and were preserved using a low-potassium solution at 4°C.

BAL was performed immediately before implantation by instilling 20 mL of saline solution into both main bronchi. All the samples were processed and stored at −80°C for subsequent analysis.

In the immediate postoperative period, arterial blood gas values (ratio of PaO2 to the fraction of inspired oxygen [FiO2]) were recorded at 6, 24, and 48 hours after implantation. Recipient intubation time in this period was also noted. Patients with a PaO2/FiO2 ratio of less than 300 during the first 48 hours were diagnosed with primary graft failure once acute rejection, obstruction of venous anastomosis, cardiogenic pulmonary edema, and pneumonia had been ruled out.

Determination of Interleukin 8

All the samples were processed and stored at −80°C for subsequent analysis. IL-8 levels were determined by enzyme-linked immunosorbent assay (ELISA, R&D Systems, Inc, Minneapolis, Minnesota, USA).

Statistical Analysis

Donor and recipient characteristics were described using the usual statistics for central tendency and dispersion (median and interquartile range [IQR]). Associations between the donor variables and IL-8 concentrations were evaluated using the Spearman rank correlation coefficient (\( r \)) and the Mann-Whitney test for continuous and categorical variables, respectively. Logistic regression was used for multivariate analysis. Statistical significance was established at \( P \) less than .05 for all analyses.

Results

Donors

Fifteen donors were men and 5 were women. The median age was 35 years (IQR, 23.5-51.25 y). The cause of brain death was...
trauma in 9 cases and nontrauma in 11 cases. Seven donors were active smokers at the time of death. Ventilation time was 1 day (IQR, 1–2 d). The median PaO2/FiO2 ratio was 459.5 (IQR, 427–510.25). Thirteen donors required inotropic support to maintain hemodynamic stability. Pathogens were isolated in the BAL fluid of 18 donors. The median IL-8 concentration in BAL fluid was 49.01 ng/mL (IQR, 7.86–94.05 ng/mL).

**Recipients**

Ten of the patients were men and 10 were women. The median age was 48.43 years (IQR, 25.4–68.51 y). The lung disease that made the transplant necessary was of septic origin in 8 cases and nonseptic origin in the remaining 12 cases. A sequential double lung transplant procedure was performed in all cases, with a median ischemic time of 210 minutes (IQR, 176.25–228.75 min) for the first lung and 300 minutes (IQR, 273.75–333.73 min) for the second lung. The PaO2/FiO2 ratios at 6, 24, and 48 hours after transplant were 329 (IQR, 190.25–435), 363.5 (IQR, 249–434.75), and 370.5 (IQR, 243.25–418.25), respectively.

**Relationship Between Interleukin 8 Levels and the Clinical Characteristics of the Donor, Intubation Time of the Recipient, and the Development of Primary Graft Failure**

No association was found between the clinical characteristics of the donor and levels of IL-8 in the BAL fluid (Table 1).

The median recipient intubation time was 39.5 hours (IQR, 19.25–68.5 h) and the correlation with IL-8 values was positive: higher IL-8 concentrations in BAL fluid correlated with longer ventilation times (\( \rho = 0.583, P = .007 \)) (Figure 1).

Five patients developed primary graft failure; 2 of these died in the immediate postoperative period (Table 2). These patients had received lungs from donors in whom the IL-8 concentrations in BAL fluid were significantly higher than in donated lungs transplanted to patients who did not develop primary graft failure (Mann-Whitney test, \( P = .003 \)) (Figure 2).

**Discussion**

This study has shown that high IL-8 concentrations in the BAL fluid from donor lungs are associated with longer ventilation time in the transplant patient and favor the development of primary graft failure after lung transplant.

Obtaining organs for transplant—particularly lungs—is very difficult. Current criteria for selecting lung donors are based on

![Figure 1](http://www.archbronconeumol.org)

**Figure 1.** Concentration of interleukin 8 (IL-8) in the donor bronchoalveolar lavage (BAL) fluid and recipient intubation time (Spearman rank correlation, \( \rho = 0.338, P = .007 \)).

![Figure 2](http://www.archbronconeumol.org)

**Figure 2.** Concentration of interleukin 8 (IL-8) in the donor bronchoalveolar lavage (BAL) fluid and primary graft failure (Mann-Whitney U test, \( P = .032 \)).
clinical data such as age, smoking, and arterial blood gases, radiology and bronchoscopy findings, and physical examination of the lung on extraction. Most of these criteria, however, have not been rigorously evaluated and are based more on clinical impressions than on solid evidence. Although marginal donors may provide acceptable results, primary graft failure continues to be a serious problem even when donors are classified as ideal.

Primary graft failure has been associated almost exclusively with ischemic injuries that occur during the preservation and subsequent reperfusion of the lung. Although the mechanism of ischemia-reperfusion lung injury is not yet fully understood, it is highly complex, the result of the interaction between potent inflammatory mediators and different cell types. IL-8 is a potent proinflammatory mediator in the activation and recruitment of neutrophils at the sites where acute inflammatory processes occur and, together with other interleukins, appears to play an important role in the development of primary graft failure. High levels of proinflammatory cytokines in the immediate post-transplant period have been shown to correlate significantly with the development of primary graft failure. Lung transplantation, however, is a complex process, and it would not be surprising if its success or failure were affected by other factors, including the donor. Many studies have analyzed the impact of donor characteristics on the transplant outcome. Few, however, have examined the biological status of the donor lung and its impact on primary graft failure.

Some authors have found a significant correlation between blood concentrations of specific cytokines and the hormone depletion that takes place after brain death. An acute lung injury histologically characterized by neutrophilic pulmonary infiltrates, identical to that found in primary graft failure, has been reported in patients with isolated brain injury; this has led some authors to question the inflammatory state of the lung in organ donors. Fisher et al., after analyzing 12 lungs before extraction and 15 ischemic lungs, showed that high concentrations of IL-8 in the BAL fluid of ideal lung donors influenced the subsequent development of primary graft failure. A recent study by Kaneda et al. described a model for predicting perioperative mortality in which the IL-6/IL-10 ratio obtained by analyzing messenger RNA from donor lung biopsies affected mortality. In our study, high levels of IL-8 in BAL fluid had an impact on mechanical ventilation time. Furthermore, patients who developed primary graft failure showed significantly higher levels of IL-8.

In conclusion, our limited experience leads us to agree with Fisher et al. that certain donors classified as ideal may have subclinical lung injuries that are expressed by the elevated BAL fluid concentrations of IL-8 that develop with ischemia and reperfusion of the graft. This may partly explain why, despite the effort to achieve ideal lung preservation, primary graft failure continues to affect lung transplant outcomes. It is therefore necessary to develop new strategies that allow biological evaluation of the donor lung before implantation. Also needed are treatment options that minimize the effect of the inflammatory cascade in the period immediately after transplantation.

References