



Advancing Transfusion and
Cellular Therapies Worldwide

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To: AABB Members

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Re: Mitigating the Anti-CD38 Interference with Serologic Testing

Summary

A class of therapeutic agents for multiple myeloma, monoclonal antibodies to CD38, can result in interference with blood bank serologic tests and thereby cause delays in issuing Red Blood Cell (RBC) units to patients receiving these agents. To minimize these delays, hospitals should set up procedures to inform the transfusion service when patients start receiving these agents. Considerations for the transfusion service, both before and after initiation of anti-CD38 therapy, are detailed below.

The AABB Clinical Transfusion Medicine Committee has developed this bulletin to provide background information and guidance to members regarding anti-CD38 interference with serologic testing.

Association Bulletins, which are approved for distribution by the AABB Board of Directors, may include announcements of standards or requirements for accreditation, recommendations on emerging trends or best practices, and/or pertinent information. This bulletin contains information and recommendations. No new standards are proposed.

Background

Anti-CD38 monoclonal antibodies are a treatment for multiple myeloma

CD38 is an integral membrane protein that is highly expressed on myeloma cells that has been shown to be an effective target antigen for monoclonal antibody therapies. There are currently two anti-CD38 monoclonal antibodies approved by the Food and Drug Administration, daratumumab and isatuximab. However, there are other anti-CD38 monoclonal antibodies under development and in trials. **In addition, new off label uses for anti-CD38 monoclonal antibodies are coming into clinical practice.**

Of note, anti-CD38 may cause a small decrease in hemoglobin in vivo (~1 g/dL), but severe hemolysis has not been observed among treated patients.^{3,6}

Anti-CD38 monoclonal antibodies interfere with blood bank serologic tests

In addition to immune cells, CD38 is weakly expressed on red cells. Anti-CD38 binds to CD38 on reagent RBCs, causing panreactivity in vitro.^{2,3} Plasma samples from anti-CD38-treated patients consistently cause positive reactions in indirect antiglobulin tests (IATs), antibody detection (screening) tests, antibody identification panels, and anti-human globulin (AHG) crossmatches. Agglutination due to anti-CD38 may occur in all media (eg, saline, low ionic strength saline, polyethylene glycol), and with all IAT methods (eg, gel, tube, solid phase). Agglutination reactions caused by anti-CD38 are usually weak (1+), but stronger reactions (up to 4+) may be seen in solid-phase testing. However, anti-CD38 does NOT interfere with ABO/RhD typing or with immediate-spin crossmatches.

Other notes on anti-CD38 serologic interference:

- **Dithiothreitol (DTT)-treated cells eliminate the interference.**^{2,7}
- Adsorptions using either untreated or ZZAP-treated cells fail to eliminate the interference.
- Anti-CD38 may result in a positive IgG direct antiglobulin test (DAT) and autocontrols tested in antibody identification panel.
- Some rare dominant Lu(a-b-) cells are not reactive in the presence of anti-CD38, potentially giving the false impression that the patient has a Lutheran-related antibody.^{4,5}
- Positive IATs can be observed for up to six months after anti-CD38 is discontinued.^{1,3}
- ~~Anti-CD38 may cause a small decrease in hemoglobin in vivo (~1 g/dL), but severe hemolysis has not been observed among treated patients.~~^{3,6}

Anti-CD38 interference can cause delays in issuing RBCs

If the transfusion service is unaware that a patient has received anti-CD38, the following scenario may occur when the patient's sample is tested:

| <u>Test</u> | <u>Negative (no interference)</u> | <u>Positive (reactive with all cells)</u> | <u>Negative or positive</u> |
|--------------------------------------|-----------------------------------|---|-----------------------------|
| <u>ABO/RhD typing</u> | <u>X</u> | <u>N/A</u> | <u>N/A</u> |
| <u>Antibody detection ("screen")</u> | <u>N/A</u> | <u>X</u> | <u>N/A</u> |
| <u>Antibody identification</u> | <u>N/A</u> | <u>X</u> | <u>N/A</u> |
| <u>DAT</u> | <u>N/A</u> | | <u>X</u> |
| <u>IS crossmatch</u> | <u>N/A</u> | <u>X</u> | <u>N/A</u> |
| <u>AHG crossmatch*</u> | <u>X</u> | <u>N/A</u> | <u>N/A</u> |

*AHG crossmatch compatible with DTT-treated cells

- ~~1. ABO/RhD typing: no issues.~~
- ~~2. Antibody detection (screening) test: all cells positive.~~
- ~~3. Antibody identification panel: all cells positive (autocontrol may be negative).~~
- ~~4. DAT: positive or negative.~~
- ~~5. AHG crossmatches: positive with all RBC units tested.~~
- ~~6. Adsorptions: panreactivity cannot be eliminated.~~

This leads to delays in issuing RBCs to the patient. In some cases, the anti-CD38 interference could mask the presence of a clinically significant alloantibody.

Recommendations

To avoid problems with transfusion, hospitals should set up procedures to inform the transfusion service whenever any patient is scheduled to begin taking anti-CD38.

BEFORE a patient begins taking anti-CD38:

- A baseline type and screen should be performed.
- In addition, a baseline phenotype or genotype is recommended. **Genotyping can be performed after the patient receives anti-CD38.**

AFTER a patient begins taking anti-CD38:

- ABO/RhD typing can be performed normally.
- For antibody detection (screening) and identification, dithiothreitol (DTT)-treated cells can be used to eliminate the interference.^{2,7}
 - Because DTT treatment destroys Kell antigens, K-negative units should be provided unless the patient is known to be K-positive.
 - Antibodies against other DTT-sensitive blood group antigens (anti-k, anti-Yt^a, anti-Do^a/Do^b, etc) will not be detectable when the antibody screen with DTT-treated cells is performed; such antibodies are encountered infrequently, however.

Crossmatch

- For patients with a negative antibody screen using DTT-treated cells, an electronic or immediate-spin crossmatch with ABO/RhD-compatible, K-matched units may be performed.
- For patients with known alloantibodies, phenotypically or genotypically matched RBC units may be provided.^{6,8}
 - As some typing antisera require the use of AHG, phenotyping should be performed before the patient receives anti-CD38.
 - ~~Genotyping can be performed either before or after the patient receives anti-CD38.~~
 - AHG crossmatches with phenotypically or genotypically matched units will still be incompatible.
 - ~~Some clinically significant antibodies may be missed with the use of uncrossmatched phenotypically or genotypically matched units, although this will occur infrequently.~~
- Alternatively, an AHG crossmatch may be performed using DTT-treated donor cells (K-matched units).

Other notes on issuing blood for transfusion

- **Some clinically significant antibodies may be missed with the use of uncrossmatched phenotypically or genotypically matched units, although this will occur infrequently.**
- If an emergency transfusion is required, uncrossmatched ABO/RhD-compatible RBCs may be given per local blood bank practices.

Future/alternative approaches to mitigating the anti-CD38 interference

It is possible to neutralize anti-CD38 in plasma and eliminate the interference using either recombinant soluble human CD38 or daratumumab idiotype antibody.^{2,3} Neither reagent is widely available at this time, and additional validation would be needed. In principle, soluble CD38 could be used to neutralize any anti-CD38, while different idiotype antibodies would be needed to neutralize different CD38 therapeutic antibodies. Finally, antigen-typed cord cells have been used for the antibody screen as an alternative to DTT-treated cells.⁹

References

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