

SPECIAL FEATURE REVIEW

The complex existence of $\gamma\delta$ T cells following transplantation: the good, the bad and the simply confusing

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Gamma delta ($\gamma\delta$) T cells consist of ~4% of the total T cell population in human peripheral blood; however, they typically comprise a higher proportion of T cells in skin and mucosal epithelium.¹ $\gamma\delta$ T cells are a highly heterogeneous group of lymphocytes that display broad functional abilities, interacting with both innate and adaptive immune compartments. A body of evidence indicates that $\gamma\delta$ T cells are important in tissue homeostasis and repair, both in the skin and mucosa.² Mice deficient in $\gamma\delta$ T cells spontaneously develop inflammatory bowel disease³ and succumb to dextran sodium sulphate-induced colitis (reviewed by Nanno *et al.*⁴). In addition, through the production of TGF β , $\gamma\delta$ T cells limit damage to renal epithelial cells in a rat model of

Abstract

Gamma delta ($\gamma\delta$) T cells are a highly heterogeneous population of lymphocytes that exhibit innate and adaptive immune properties. Despite comprising the majority of residing lymphocytes in many organs, the role of $\gamma\delta$ T cells in transplantation outcomes is under-researched. $\gamma\delta$ T cells can recognise a diverse array of ligands and exert disparate effector functions. As such, they may potentially contribute to both allograft acceptance and rejection, as well as impacting on infection and post-transplant malignancy. Here, we review the current literature on the role and function of $\gamma\delta$ T cells following solid organ and hematopoietic stem cell transplantation.

Keywords: gamma delta T cells, transplant immunology, graft-versus-host disease

autoimmune-mediated glomerulonephritis⁵ and protect pulmonary epithelial cells from damage after ozone exposure.⁶ Furthermore, studies on antigenic tolerance in animal models have shown dependence on $\gamma\delta$ T cells.⁷

Gamma delta T cells are mediators of both anti-inflammatory and pro-inflammatory responses. $\gamma\delta$ T cells exert their effects largely through MHC-independent mechanisms and can be directly cytotoxic but can also be activated by other immune cells. Furthermore, $\gamma\delta$ T cells appear to be central in the control of post-transplant infection, particularly to cytomegalovirus (CMV). Their role in transplantation outcome remains unclear, with evidence suggesting they can be both effectors and suppressors of allogenic rejection, but nonetheless highlighting them as an important component of the post-transplant immune response.

$\gamma\delta$ T CELL RECEPTORS, LIGANDS AND EFFECTOR FUNCTIONS

Gamma delta T cells are controlled by a suite of cell-surface expressed molecules, including a T cell receptor (TCR) and several receptors more commonly associated with natural killer (NK) cells. The loci encoding the $\gamma\delta$ TCR genes are the T cell receptor gamma (TRG, encoding the gamma chain) and T cell receptor delta (TRD, encoding the delta chain).⁸ Largely analogous to classical $\alpha\beta$ T cells, TCR rearrangement is dependent on the expression of recombination activating genes (RAG). However, compared to $\alpha\beta$ T cells, the repertoire of $\gamma\delta$ V and J gene segments is restricted, with the TRG locus containing only 12 Variable (V) segment genes, of which 6 are functional, and the TRD locus containing eight functional V region genes. This is in comparison with $\alpha\beta$ T cells, which have 52 V β genes and 70 V α genes.⁹ Furthermore, of the TRD genes, only four of these are frequently used: V δ 1, V δ 2, V δ 3 and V δ 5. However, $\gamma\delta$ TCR still has extreme sequence variation because of a high degree of junctional diversity as a result of D segment rearrangement.¹⁰ Also, unlike $\alpha\beta$ T cells, the vast majority of $\gamma\delta$ T cells do not express either the CD4 or CD8 co-receptor. Important in the context of transplantation, $\gamma\delta$ T cells with different TCR localise to distinct regions. The vast majority of healthy adult peripheral blood $\gamma\delta$ T cells are V γ 9V δ 2, whereas $\gamma\delta$ T cells bearing V δ 1, V δ 3 or V δ 5 TCR are located in the skin, intestine, lung and liver.^{11,12}

In addition to their TCR, $\gamma\delta$ T cells express many receptors in common with NK cells. The NK cell receptor NKG2D is expressed on a large proportion of $\gamma\delta$ T cells and recognises the stress-inducible ligands MHC class I chain-related proteins (MIC)-A and (MIC)-B and UL16 binding proteins (ULBPs), many of which may be upregulated following transplantation.^{13–15} V δ 1 cells reportedly recognise MIC-A via both TCR and NKG2D, although TCR interactions were not involved in their cytotoxic activity¹⁶ (Table 1). Cytotoxic activity is also triggered by V γ 9V δ 2 $\gamma\delta$ T cells upon ligation of another NK cell receptor, DNAM-1¹⁷ (Table 1). Subsets of $\gamma\delta$ T cells also express other NK cell receptors, including NKp30, NKp44 and CD94-NKG2 receptors.¹⁸ Another important receptor also shared with NK cells is CD16, a low-affinity receptor for the constant region of IgG. The expression of CD16 allows $\gamma\delta$ T cells to recognise IgG opsonised pathogens or target cells without a strict requirement for TCR engagement.¹⁹

In contrast to $\alpha\beta$ T cells, $\gamma\delta$ T cells typically do not recognise ligands in the context of MHC molecules. Of the known ligands, V γ 9V δ 2 $\gamma\delta$ T cells are activated by phosphoantigens, which can be produced by microbes or as a result of malignant transformation,²⁰ whereas V γ 4V δ 5 TCRs bind to endothelial protein C receptor (EPCR)²¹ (Table 1). The ligands for V δ 1 cells have remained somewhat more elusive, but are reported to include MHC-like molecules, such as the CD1 family²² and MIC-A/B²³ (Table 1). Another member of the CD1 family, CD1d, is recognised by subsets of V δ 3 $\gamma\delta$ T cells,²⁴ whereas other subsets of V δ 3 cells recognise annexin A2²⁵ (Table 1). The ligands for TCR of other $\gamma\delta$ T cells are still largely undefined.

Interestingly, $\gamma\delta$ T cell effector function depends on their niche. For example, intestinal epithelium-resident $\gamma\delta$ T cells produce keratinocyte growth factor, contributing to the intestinal barrier health and homeostasis.²⁶ Firmly placed at the interface of innate and adaptive immunity, following recognition of ligands by the TCR and/or activating NK cell receptors, $\gamma\delta$ T cells are potent producers of pro-inflammatory cytokines (IFN- γ , TNF- α , IL-17) and can directly lyse infected or transformed cells via perforin- and granzyme-dependent mechanisms. Following activation, $\gamma\delta$ T cells can also induce several cell types into antigen-presenting cells, thereby promoting dendritic cell maturation, CD4⁺ and CD8⁺ T cell priming, as well as antibody production.²⁷ $\gamma\delta$ T cells can also produce inflammatory and chemotactic chemokines such as RANTES, CXCL10 and lymphotactin. They are also capable of cross-presenting antigens, thereby inducing CD8⁺ T cell responses.²⁸ In addition, $\gamma\delta$ T cells do not require TCR engagement for cytokine production. Instead, they can be activated to produce IL-17 by cytokines such as IL-1 β and IL-23.²⁹

In summary, given the complexity of receptors expressed, ligands bound and responses exerted by $\gamma\delta$ T cells, it is not surprising that they have been implicated as playing diverse roles in transplantation outcome.

EVIDENCE FOR $\gamma\delta$ T CELLS IN ADVERSE OUTCOMES FOLLOWING TRANSPLANTATION

A large proportion of the research implicating $\gamma\delta$ T cells in adverse outcomes following transplantation comes from small animal models (Figure 1). Although $\gamma\delta$ T cell phenotypes and

Table 1. Human $\gamma\delta$ T cell ligands and co-expressed receptors

$\gamma\delta$ TCR subset	Anatomical location	TCR ligand	Co-expressed receptors	References
V γ 9V δ 2	PB	Phosphoantigens	NKG2D, DNAM-1	17,20
V δ 1	PB, skin, gut, spleen, liver	CD1 family, MIC-A/B, ULBPs	NKG2D, NKp30, CD16	16,19,22,23
V δ 3	PB, liver	CD1d		24
V γ 8V δ 3	PB	Annexin A2		25
V γ 4V δ 5	PB	Endothelial protein C receptor		21

MIC, MHC class I chain-related protein; PB, peripheral blood; TCR, T cell receptor; ULBPs, UL16 binding proteins.

function in mice and humans are broadly consistent, there are also distinct differences between species, most notably the types of TCR ligands that have been identified (Table 2).

In small animal models, $\gamma\delta$ T cells have been implicated in playing a role in ischaemia-reperfusion injury (IRI). This has been demonstrated by reduced IRI in TCR $\gamma\delta$ -deficient mice in a model of kidney transplantation³⁰ and the observation that IL-17A, produced by $\gamma\delta$ T cells, is elevated in a mouse model of cardiac transplantation.³¹ However, the proposed mechanisms differ between the studies, with $\gamma\delta$ T cells either inducing the recruitment $\alpha\beta$ T cells into the allograft,^{30,32} or alternatively by inducing neutrophil recruitment through the production of IL-17.³¹ The production of IL-17 from $\gamma\delta$ T cells also is reported to contribute to acute and chronic allograft dysfunction in small animal models of skin,³³ heart^{34–36} and lung³⁷ transplantation. However, in the mouse model of lung transplantation, despite being potent producers of intragraft IL-17, there was no effect of $\gamma\delta$ T cell depletion on the development of acute rejection or fibrosis.³⁷ In addition, the literature is void of a link between IL-17 producing $\gamma\delta$ T cells and rejection following solid organ transplantation in humans.

There is also a disconnect between animal studies and human transplantation with respect to the role of $\gamma\delta$ T cells in graft-versus-host disease (GvHD) following hematopoietic stem cell transplantation (HSCT). Early animal studies linked $\gamma\delta$ T cells to the progression of GvHD. For example, Blazar and others³⁸ created a transgenic mouse model where a large proportion of T cells expressed the $\gamma\delta$ TCR. These transgenic cells proliferated and killed mismatched cells *in vitro*. Moreover, when the transgenic cells were infused into mismatched mice following bone-marrow transplantation, they infiltrated GvHD target tissues, indicating their capacity to cause pathology.³⁸ Another early study in mice revealed

that depletion of $\gamma\delta$ T cells resulted in reduced GvHD.³⁹ However, the evidence for $\gamma\delta$ T cells contributing to GvHD following HSCT in humans is varied. While some studies showed that higher numbers of $\gamma\delta$ T cells were correlated with increased incidence of acute GvHD,^{40,41} other studies have either found no correlation between numbers of $\gamma\delta$ T cells and GvHD⁴² or that lower numbers were associated with increased incidence of GvHD.⁴³ However, it is also possible that only specific subsets of $\gamma\delta$ T cells adversely contribute to GvHD, notably V δ 2 $\gamma\delta$ T cells which were implicated in the study by Viale *et al.*⁴⁰

Interestingly, these same V δ 2 $\gamma\delta$ T cells may also be associated with poorer outcomes following solid organ transplantation. Yu *et al.*⁴⁴ showed higher proportions of V δ 2 cells in liver transplant patients with acute allograft rejection. Similarly, lower proportions of V δ 2 $\gamma\delta$ T cells were observed in operationally liver transplant recipients, having not received immunosuppression for at least 12 months.⁴⁵ However, these findings need to be interpreted with caution as an expansion of V δ 1 $\gamma\delta$ T cells (thereby decreasing the proportion of V δ 2 $\gamma\delta$ T cells) was observed following liver and kidney transplantation, regardless of immunosuppression treatment. It is possible that V δ 1 T clonotypes expand in the blood as a result of post-transplant infections, such as CMV, as reported in healthy individuals⁴⁶ and following transplantation.

While $\gamma\delta$ T cells may contribute to the control of post-transplant infection to enhance clinical outcomes, the co-expression of CD16 may allow them to participate in antibody-mediated rejection. One study found the expansion of CD16⁺ $\gamma\delta$ T cells in kidney transplant patients with donor-specific antibodies was associated with renal dysfunction.⁴⁷ However, in patients without donor-specific antibodies, such $\gamma\delta$ T cells seem to be correlated with positive outcomes following transplantation, because of their ability to control CMV.

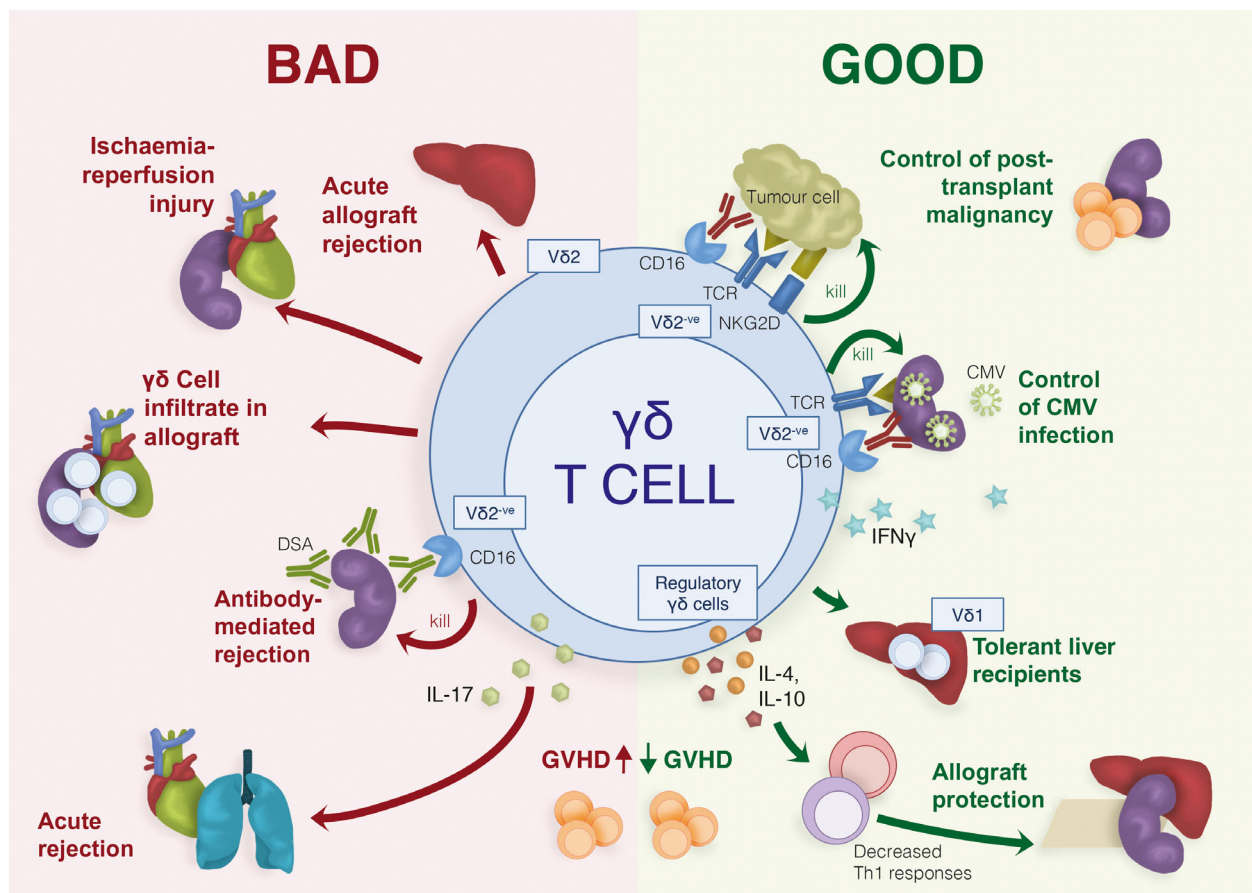


Figure 1. Gamma delta T cells in transplantation: the good, the bad and the simply confusing. Adverse and favorable associations between $\gamma\delta$ T cells and outcomes following transplantation have been reported. Left: ‘Bad’ outcomes in animal studies include ischaemia-reperfusion injury (in heart and kidney), and acute rejection of heart and lung allografts via IL-17-mediated mechanisms. Other adverse outcomes in humans include the presence of $\gamma\delta$ T cell infiltration in kidney and heart allografts; the presence of V δ 2 $\gamma\delta$ T cells in patients with liver allograft rejection; antibody-mediated rejection mediated by V δ 2-negative (V δ 2⁻) $\gamma\delta$ T cells via recognition of donor-specific antibodies (DSA) through CD16, and an *increased* incidence of graft-versus-host disease (GvHD). Right: ‘Good’ outcomes include *decreased* GvHD incidence; increase in V δ 1-positive (V δ 1⁺) infiltration in tolerant liver recipients; secretion of IL-4 and IL-10 leading to allograft protection (observed in skin, kidney and liver); control of cytomegalovirus (CMV) infection by V δ 2⁻ cells via IFN γ and the killing of infected cells through their T cell receptor (TCR) or CD16 engagement; and control of post-transplant malignancies by V δ 2⁻ cells which recognise tumor cells through CD16, TCR or other receptor engagements.

EVIDENCE FOR $\gamma\delta$ T CELLS IN FAVORABLE OUTCOMES FOLLOWING TRANSPLANTATION

$\gamma\delta$ T cells in the control of post-transplant CMV infection

$\gamma\delta$ T cells have been implicated in the control of several pathogens, including tuberculosis, bacterial meningitis, human immunodeficiency virus and hepatitis C virus.⁸ However, CMV is the most common infectious complication following transplantation and $\gamma\delta$ T cells are emerging as a

significant player in the immunity to CMV. Following murine CMV (MCMV) infection, $\gamma\delta$ T cells prevented an increase in viral load in all organs and were as effective as $\alpha\beta$ T cells at controlling viral load in the lungs.⁴⁸ The same authors also showed that transfer of MCMV-induced $\gamma\delta$ T cells into mice lacking innate and adaptive lymphocytes rescued the animals from MCMV-induced death, indicating that $\gamma\delta$ T cells were important in the response to MCMV.⁴⁸ Another study confirmed that $\gamma\delta$ T cells can effectively control MCMV in the absence of CD4⁺ T cells, CD8⁺ T cells and B cells.⁴⁹

Table 2. A comparison of mouse and human $\gamma\delta$ T cells

	Mouse	Human	References
Tissue distribution	0.5–10% of lymphocytes in secondary lymphoid organs and blood; higher in intestinal epithelium, skin, reproductive organs	0.5–10% of lymphocytes in secondary lymphoid organs and blood, lung, skin, liver; higher in intestinal epithelium	75–78
Predominant TCR V gene segment by location	V γ 1, V γ 4 in blood; V δ 1 in skin, mucosa of the female reproductive tract, lung; V δ 4 in intestinal epithelium	V δ 2 in blood; V δ 1 in peripheral tissues	12,79,80
Effector functions	Direct cytotoxicity; can produce a broad spectrum of cytokines associated with Th1, Th2, Th17 and T reg	Direct cytotoxicity/ADCC; can produce a broad spectrum of cytokines associated with Th1, Th2, Th17 and T reg	19,65,81–85
TCR ligands	CD1d-restricted phospholipids; Qa1-restricted peptides; direct recognition of viral proteins (e.g. HSV-1 glycoprotein I)	V δ 2-phosphoantigens (butyrophilin-dependent); V δ 1-stress-induced self-antigens (e.g. MIC-A/B); glycolipids presented by CD1c/d	86–93
NGG2D ligands	Rae-1, H60, MULT1	MIC-A/B, ULBP1-6	94–98
NGG2A ligands	Qa-1 (inhibitory)	HLA-E (inhibitory)	99–101
Role in anti-CMV response	$\gamma\delta$ T cells provide protection from CMV-induced death	V δ 2 [−] $\gamma\delta$ T cells show effector functions against CMV-infected cells	48,56,102

ADCC, antibody-dependent cell-mediated cytotoxicity; CMV, cytomegalovirus; MIC, MHC class I chain-related protein; TCR, T cell receptor.

Following kidney transplantation in humans, reactivation of CMV drives a persistent expansion of $\gamma\delta$ T cells expressing predominantly V δ 1 and V δ 3 TCR, collectively referred to as V δ 2-negative $\gamma\delta$ T cells⁵⁰ (Figure 1). Their expansion parallels that of CMV-specific CD8⁺ T cells,⁵¹ often resulting in an increase from 1% of circulating T cells to more than 10% of the total lymphocyte count.⁵² The expanded CMV-specific V δ 2-negative $\gamma\delta$ T cells persisted for more than 1 year in kidney transplant recipients⁵³ and their presence correlated with the resolution of viraemia, whereas their absence was associated with recurrent CMV disease.⁵⁴ Similar to CMV-specific CD8⁺ T cells, CMV-specific $\gamma\delta$ T cells possess an effector memory phenotype, in contrast to CMV-negative patients, where they exhibited a naive phenotype.⁵⁵ Both effector memory V δ 2-negative $\gamma\delta$ T cells and CMV-specific CD8⁺ $\alpha\beta$ T cells of CMV-infected renal transplant patients produced high levels of perforin, granzyme B, and expressed the activating NK cell receptor NKG2D. They appeared to be fully differentiated effector cells with a lower surface expression of CD28 compared to naive T cells.⁵² Not only do effector memory V δ 2-negative $\gamma\delta$ T cells have the same differentiated effector phenotype as CD8⁺ $\alpha\beta$ T cells, but they expand more rapidly in patients with CMV reactivation as opposed to primary CMV infection, which suggests that they may have an adaptive memory function.⁵⁵ The persistent expansion of V δ 2-negative $\gamma\delta$ T cells following CMV infection, coupled with their differentiation into an effector/memory phenotype with expression of cytotoxic agents, implies that $\gamma\delta$ T cells respond to CMV in an adaptive manner similar to cytotoxic CD8⁺ T cells. Like CD8⁺ T cells, recognition of CMV-infected targets by V δ 2 negative $\gamma\delta$ T cells is TCR-dependent, although this occurs independent of MHC.⁵⁶ The nature of the ligand(s) for V δ 2-negative $\gamma\delta$ T cells remains unknown but may include EPCR.²¹ However, EPCR expression is not upregulated by CMV infection and recognition of target cells by EPCR-reactive clones requires costimulatory ligands.²¹

Unlike CD8⁺ $\alpha\beta$ T cells, V δ 2-negative $\gamma\delta$ T cells may have the capacity to contribute to CMV immune control via antibody-dependent cell-mediated cytotoxicity (ADCC). CD16 is expressed by the majority of CMV-induced $\gamma\delta$ T cells, whereas it is expressed only by a small amount of V δ 2-negative $\gamma\delta$ T cells in renal transplant patients without CMV, suggesting that CD16 on V δ 2-

negative $\gamma\delta$ T cells is upregulated in the response to CMV.¹⁹ However, the presence of CD16⁺ V δ 2-negative $\gamma\delta$ T cells may be problematic in transplant recipients with donor-specific antibodies because of their ability to lyse antibody-coated target cells.⁵¹

The expansion of CMV-specific V δ 2-negative $\gamma\delta$ T cells was first observed in kidney transplant recipients but has subsequently been shown to occur in heart and lung transplant recipients⁵⁷ and following HSCT.⁵⁸ Longitudinal monitoring of $\gamma\delta$ TCR repertoires in HSCT patients using next-generation sequencing revealed that the CMV-induced V δ 2-negative $\gamma\delta$ T cells were clonal in nature.⁵⁹ Reactivation of CMV following HSCT induced significant changes in both the TRG (TCR γ) and TRD (TCR δ) repertoires. There were no public or shared sequences specific to CMV, as individual patients had distinct clonal $\gamma\delta$ TCR responses to CMV, although there was some homology.⁵⁹ Another study also showed that the TRD repertoire had reduced diversity in patients with CMV, further demonstrating the remarkable impact CMV can exert on $\gamma\delta$ T cells.⁶⁰

$\gamma\delta$ T cells in the control of post-transplant malignancies

Interestingly, in addition to their antiviral function, CMV-induced V δ 2-negative $\gamma\delta$ T cells have been associated with reduced occurrence of skin and solid cancers in kidney transplant patients.⁶¹ Patients who had not experienced CMV infection either prior to or following transplantation, and therefore lacked CMV-induced $\gamma\delta$ T cells, experienced a higher rate of malignancies. The expansion of CMV-specific V δ 2-negative $\gamma\delta$ T cells was associated with reduced cancer occurrence, and these CMV-specific V δ 2-negative $\gamma\delta$ T cells were shown to be able to kill tumor cells as efficiently as CMV-infected cells *in vitro*.⁵¹ Akin to recognition of CMV-infected cells, the killing of tumor targets by V δ 2-negative $\gamma\delta$ T cells was dependent on TCR engagement.⁵⁶ This implies that CMV infection and transformation causes the upregulation of a common antigen that is recognised by the TCR of V δ 2-negative $\gamma\delta$ T cells. This phenomenon is not restricted to kidney transplant patients, as CMV-associated V δ 2-negative $\gamma\delta$ T cells show anti-leukaemic effects following HSCT.^{62,63} However, the anti-leukaemic effector functions of V δ 1-positive $\gamma\delta$ T cells were only partially dependent on TCR and strongly

dependent on the expression of B7-H6, a ligand for the NK cell receptor NKp30.⁶⁴

V δ 2-positive $\gamma\delta$ T cells, in particular the V γ 9V δ 2 subset, have also been found to exert anti-tumor effects. V γ 9V δ 2 cells isolated from the blood of patients following HSCT can be expanded *in vitro* and efficiently lyse lymphoid and myeloid targets.⁶³ This subset is selectively expanded *in vitro* by phosphoantigen stimulation following exposure of cells to zoledronic acid.¹⁸ The *in vivo* activity of the V γ 9V δ 2 subset can be further boosted by direct infusion of zoledronic acid to the patient. These features have seen clinical trials of V γ 9V δ 2 $\gamma\delta$ T cells in cell therapy for the treatment of solid tumors and haematological malignancies.¹⁸

Additionally, CD16⁺ V γ 9V δ 2 $\gamma\delta$ T cells have been shown to lyse lymphoma, chronic lymphocytic leukaemia and breast cancer cells coated with antibodies via ADCC.⁶⁵ Moreover, $\gamma\delta$ T cells were shown to have a beneficial role against refractory leukaemia by specifically targeting the recipient's cancer cells without GvHD.⁶⁶ Taken together, the data suggest that $\gamma\delta$ T cells are efficient in controlling post-transplant malignancies by multiple mechanisms including direct recognition of tumor antigens, ADCC and through the recognition of stress-associated antigens.

Suppression of post-transplant immune responses by $\gamma\delta$ T cells

$\gamma\delta$ T cells may also contribute to favorable outcomes through suppression of immune responses. Lower proportions of CD8⁺ regulatory $\gamma\delta$ T cells were found in the blood of renal transplant recipients with acute or chronic rejection.⁶⁷ Similarly, higher numbers of CD8⁺ regulatory $\gamma\delta$ T cells in renal allografts were associated with prolonged survival in a rat model of renal transplantation.⁶⁸ The proposed mechanism is through the production of IL-4 and IL-10 from CD8⁺ regulatory $\gamma\delta$ T cells, which acts to effectively dampen Th1 responses. Supporting this notion, improved graft survival was associated with expansions of $\gamma\delta$ T cells and the increased production of IL-4 and IL-10 in an animal model of skin transplantation.⁶⁹ IL-4 in turn has a profound effect on the $\gamma\delta$ T cell population and favors the survival of IL-10-producing V δ 1 cells.⁷⁰ Improved survival in this model was lost following the administration of an antibody to $\gamma\delta$ TCR. Interestingly, the production of IL-10 from V δ 1 $\gamma\delta$

T cells has been hypothesised to induce operational tolerance following paediatric liver transplantation.⁷¹ Likewise, higher proportions of regulatory V δ 1 $\gamma\delta$ T cells that co-expressed CD4 and CD25 were found in the blood of tolerant adult liver transplant recipients.⁴⁵ Therefore, both animal models and human studies indicate regulatory $\gamma\delta$ T cells can positively contribute to engraftment following transplantation, possibly by the production of IL-4 and/or IL-10.

An increase in regulatory $\gamma\delta$ T cells also reportedly reduces the occurrence of GvHD following HSCT. Novel subsets of regulatory $\gamma\delta$ T cell that express Foxp3 were associated with lower GvHD in HSCT patients.⁷² Interestingly, the Foxp3-positive subsets utilised both V δ 1 and V δ 2 TCR segments, and a follow-up study narrowed the effective subset to be CD27⁺V δ 1⁺.⁷³ However, in direct contrast, grafts containing higher proportion of CD8⁺ $\gamma\delta$ T cells were associated with increased incidence of GvHD.⁷⁴ Therefore, as reported in the above section, the role of $\gamma\delta$ T cells in the prevention or promotion of GvHD following HSCT is far from clear.

CONCLUSIONS AND FUTURE DIRECTIONS

$\gamma\delta$ T cells represent an under-researched population of immune cells with the propensity to significantly contribute to adverse and positive outcomes following transplantation, via both innate and adaptive pathways (Figure 1). However, as the underlying cause of transplantation and the infectious insults following transplantation vary widely between recipients, the role of $\gamma\delta$ T cells needs to be carefully evaluated in the specific context.

Adverse functions of $\gamma\delta$ T cells appear to be largely linked to the production of IL-17. On the one hand, CD16⁺, CMV-specific cells may exert ADCC on transplanted cells coated in donor-specific antigens, thereby contributing to antibody-mediated rejection. On the other hand, these same CMV-specific $\gamma\delta$ T cells effectively control viral replication and post-transplant malignancies. Furthermore, other $\gamma\delta$ T cell subsets can efficiently suppress adaptive immune responses and aid in immune tolerance following transplantation. The role of $\gamma\delta$ T cells in preventing or promoting GvHD following HSCT is highly controversial and may be dependent on different subsets exerting opposite effects.

Although the role of particular subsets of $\gamma\delta$ T cells is dependent on the individual context, it is clear these cells are an active and dynamic component of the transplant environment. An identification of the ligands for $\gamma\delta$ T cells will significantly aid in harnessing their therapeutic potential following transplantation. Indeed, more research is required to unveil specific subsets of $\gamma\delta$ T cells with a view to develop novel therapies that can meaningfully contribute to positive outcomes following transplantation.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

REFERENCES

1. Minculescu L, Sengelov H. The role of $\gamma\delta$ T cells in haematopoietic stem cell transplantation. *Scand J Immunol* 2015; **81**: 459–468.
2. Nielsen MM, Witherden DA, Havran WL. $\gamma\delta$ T cells in homeostasis and host defence of epithelial barrier tissues. *Nat Rev Immunol* 2017; **17**: 733–745.
3. Inagaki-Ohara K, Chinen T, Matsuzaki G et al. Mucosal T cells bearing TCR $\gamma\delta$ play a protective role in intestinal inflammation. *J Immunol* 2004; **173**: 1390–1398.
4. Nanno M, Shiohara T, Yamamoto H et al. $\gamma\delta$ T cells: firefighters or fire boosters in the front lines of inflammatory responses. *Immunol Rev* 2007; **215**: 103–113.
5. Wu H, Knight JF, Alexander SI. Regulatory $\gamma\delta$ T cells in Heymann nephritis express an invariant V γ 6/V δ 1 with a canonical CDR3 sequence. *Eur J Immunol* 2004; **34**: 2322–2330.
6. King DP, Hyde DM, Jackson KA et al. Cutting edge: protective response to pulmonary injury requires $\gamma\delta$ T lymphocytes. *J Immunol* 1999; **162**: 5033–5036.
7. Ke Y, Pearce K, Lake JP et al. $\gamma\delta$ T lymphocytes regulate the induction and maintenance of oral tolerance. *J Immunol* 1997; **158**: 3610–3618.
8. Lawand M, Dechanet-Merville J, Dieu-Nosjean MC. Key features of $\gamma\delta$ -T-cell subsets in human diseases and their immunotherapeutic implications. *Front Immunol* 2017; **8**: 761.
9. Arden B, Clark SP, Kabelitz D et al. Human T-cell receptor variable gene segment families. *Immunogenetics* 1995; **42**: 455–500.
10. Davis MM, Bjorkman PJ. T-cell antigen receptor genes and T-cell recognition. *Nature* 1988; **334**: 395–402.
11. Carding SR, Egan PJ. $\gamma\delta$ T cells: functional plasticity and heterogeneity. *Nat Rev Immunol* 2002; **2**: 336–345.
12. Bonneville M, O'Brien RL, Born WK. $\gamma\delta$ T cell effector functions: a blend of innate programming and acquired plasticity. *Nat Rev Immunol* 2010; **10**: 467–478.

13. Quiroga I, Salio M, Koo DD et al. Expression of MHC class I-related Chain B (MICB) molecules on renal transplant biopsies. *Transplantation* 2006; **81**: 1196–1203.
14. Hankey KG, Drachenberg CB, Papadimitriou JC et al. MIC expression in renal and pancreatic allografts. *Transplantation* 2002; **73**: 304–306.
15. Suarez-Alvarez B, Lopez-Vazquez A, Gonzalez MZ et al. The relationship of anti-MICA antibodies and MICA expression with heart allograft rejection. *Am J Transplant* 2007; **7**: 1842–1848.
16. Yin S, Zhang J, Mao Y et al. Vav1-phospholipase C- γ 1 (Vav1-PLC- γ 1) pathway initiated by T cell antigen receptor (TCR $\gamma\delta$) activation is required to overcome inhibition by ubiquitin ligase Cbl-b during $\gamma\delta$ T cell cytotoxicity. *J Biol Chem* 2013; **288**: 26448–26462.
17. Toutirais O, Cabillic F, Le Fric G et al. DNAX accessory molecule-1 (CD226) promotes human hepatocellular carcinoma cell lysis by V γ 9V δ 2 T cells. *Eur J Immunol* 2009; **39**: 1361–1368.
18. Pistoia V, Tumino N, Vacca P et al. Human $\gamma\delta$ T-cells: from surface receptors to the therapy of high-risk leukemias. *Front Immunol* 2018; **9**: 984.
19. Couzi L, Pitard V, Sicard X et al. Antibody-dependent anti-cytomegalovirus activity of human $\gamma\delta$ T cells expressing CD16 (Fc γ R11a). *Blood* 2012; **119**: 1418–1427.
20. Constant P, Davodeau F, Peyrat MA et al. Stimulation of human $\gamma\delta$ T cells by nonpeptidic mycobacterial ligands. *Science* 1994; **264**: 267–270.
21. Willcox CR, Pitard V, Netzer S et al. Cytomegalovirus and tumor stress surveillance by binding of a human $\gamma\delta$ T cell antigen receptor to endothelial protein C receptor. *Nat Immunol* 2012; **13**: 872–879.
22. Bai L, Picard D, Anderson B et al. The majority of CD1d-sulfatide-specific T cells in human blood use a semiinvariant V δ 1 TCR. *Eur J Immunol* 2012; **42**: 2505–2510.
23. Xu B, Pizarro JC, Holmes MA et al. Crystal structure of a $\gamma\delta$ T-cell receptor specific for the human MHC class I homolog MICA. *Proc Natl Acad Sci USA* 2011; **108**: 2414–2419.
24. Mangan BA, Dunne MR, O'Reilly VP et al. Cutting edge: CD1d restriction and Th1/Th2/Th17 cytokine secretion by human V δ 3 T cells. *J Immunol* 2013; **191**: 30–34.
25. Marlin R, Pappalardo A, Kaminski H et al. Sensing of cell stress by human $\gamma\delta$ TCR-dependent recognition of annexin A2. *Proc Natl Acad Sci USA* 2017; **114**: 3163–3168.
26. Yang H, Antony PA, Wildhaber BE et al. Intestinal intraepithelial lymphocyte $\gamma\delta$ -T cell-derived keratinocyte growth factor modulates epithelial growth in the mouse. *J Immunol* 2004; **172**: 4151–4158.
27. Petrasca A, Doherty DG. Human V δ 2⁺ $\gamma\delta$ T cells differentially induce maturation, cytokine production, and alloreactive T cell stimulation by dendritic cells and B cells. *Front Immunol* 2014; **5**: 650.
28. Brandes M, Willimann K, Bioley G et al. Cross-presenting human $\gamma\delta$ T cells induce robust CD8⁺ $\alpha\beta$ T cell responses. *Proc Natl Acad Sci USA* 2009; **106**: 2307–2312.
29. Sutton CE, Lalor SJ, Sweeney CM et al. Interleukin-1 and IL-23 induce innate IL-17 production from $\gamma\delta$ T cells, amplifying Th17 responses and autoimmunity. *Immunity* 2009; **31**: 331–341.
30. Savransky V, Molls RR, Burne-Taney M et al. Role of the T-cell receptor in kidney ischemia-reperfusion injury. *Kidney Int* 2006; **69**: 233–238.
31. Zhu H, Li J, Wang S et al. Hmgb1-TLR4-IL-23-IL-17A axis promote ischemia-reperfusion injury in a cardiac transplantation model. *Transplantation* 2013; **95**: 1448–1454.
32. Hochegger K, Schatz T, Eller P et al. Role of $\alpha\beta$ and $\gamma\delta$ T cells in renal ischemia-reperfusion injury. *Am J Physiol Renal Physiol* 2007; **293**: F741–F747.
33. Li Y, Huang Z, Yan R et al. V γ 4 $\gamma\delta$ T cells provide an early source of IL-17A and accelerate skin graft rejection. *J Invest Dermatol* 2017; **137**: 2513–2522.
34. Itoh S, Nakae S, Axtell RC et al. IL-17 contributes to the development of chronic rejection in a murine heart transplant model. *J Clin Immunol* 2010; **30**: 235–240.
35. Kimura N, Nakae S, Itoh S et al. Potential role of $\gamma\delta$ T cell-derived IL-17 in acute cardiac allograft rejection. *Ann Thorac Surg* 2012; **94**: 542–548.
36. Itoh S, Kimura N, Axtell RC et al. Interleukin-17 accelerates allograft rejection by suppressing regulatory T cell expansion. *Circulation* 2011; **124**: S187–S196.
37. Wu Q, Gupta PK, Suzuki H et al. CD4 T cells but not Th17 cells are required for mouse lung transplant obliterative bronchiolitis. *Am J Transplant* 2015; **15**: 1793–1804.
38. Blazar BR, Taylor PA, Panoskaltis-Mortari A et al. Lethal murine graft-versus-host disease induced by donor $\gamma\delta$ expressing T cells with specificity for host nonclassical major histocompatibility complex class Ib antigens. *Blood* 1996; **87**: 827–837.
39. Ellison CA, MacDonald GC, Rector ES et al. $\gamma\delta$ T cells in the pathobiology of murine acute graft-versus-host disease. Evidence that $\gamma\delta$ T cells mediate natural killer-like cytotoxicity in the host and that elimination of these cells from donors significantly reduces mortality. *J Immunol* 1995; **155**: 4189–4198.
40. Viale M, Ferrini S, Bacigalupo A. TCR $\gamma\delta$ positive lymphocytes after allogeneic bone marrow transplantation. *Bone Marrow Transplant* 1992; **10**: 249–253.
41. Pabst C, Schirutschke H, Ehninger G et al. The graft content of donor T cells expressing $\gamma\delta$ TCR⁺ and CD4⁺foxp3⁺ predicts the risk of acute graft versus host disease after transplantation of allogeneic peripheral blood stem cells from unrelated donors. *Clin Cancer Res* 2007; **13**: 2916–2922.
42. Cela ME, Holladay MS, Rooney CM et al. $\gamma\delta$ T lymphocyte regeneration after T lymphocyte-depleted bone marrow transplantation from mismatched family members or matched unrelated donors. *Bone Marrow Transplant* 1996; **17**: 243–247.
43. Yabe M, Yabe H, Hattori K et al. Transition of T cell receptor $\gamma\delta$ expressing double negative (CD4⁻CD8⁻) lymphocytes after allogeneic bone marrow transplantation. *Bone Marrow Transplant* 1994; **14**: 741–746.
44. Yu X, Liu Z, Wang Y et al. Characteristics of V δ 1⁺ and V δ 2⁺ $\gamma\delta$ T cell subsets in acute liver allograft rejection. *Transpl Immunol* 2013; **29**: 118–122.
45. Martinez-Llordella M, Puig-Pey I, Orlando G et al. Multiparameter immune profiling of operational tolerance in liver transplantation. *Am J Transplant* 2007; **7**: 309–319.

46. Davey MS, Willcox CR, Joyce SP et al. Clonal selection in the human V δ 1 T cell repertoire indicates $\gamma\delta$ TCR-dependent adaptive immune surveillance. *Nat Commun* 2017; **8**: 14760.
47. Bachelet T, Couzi L, Pitard V et al. Cytomegalovirus-responsive $\gamma\delta$ T cells: novel effector cells in antibody-mediated kidney allograft microcirculation lesions. *J Am Soc Nephrol* 2014; **25**: 2471–2482.
48. Khairallah C, Netzer S, Villacreses A et al. $\gamma\delta$ T cells confer protection against murine cytomegalovirus (MCMV). *PLoS Pathog* 2015; **11**: e1004702.
49. Sell S, Dietz M, Schneider A et al. Control of murine cytomegalovirus infection by $\gamma\delta$ T cells. *PLoS Pathog* 2015; **11**: e1004481.
50. Dechanet J, Merville P, Berge F et al. Major expansion of $\gamma\delta$ T lymphocytes following cytomegalovirus infection in kidney allograft recipients. *J Infect Dis* 1999; **179**: 1–8.
51. Couzi L, Pitard V, Moreau JF et al. Direct and indirect effects of cytomegalovirus-induced $\gamma\delta$ T cells after kidney transplantation. *Front Immunol* 2015; **6**: 3.
52. Couzi L, Pitard V, Netzer S et al. Common features of $\gamma\delta$ T cells and CD8⁺ $\alpha\beta$ T cells responding to human cytomegalovirus infection in kidney transplant recipients. *J Infect Dis* 2009; **200**: 1415–1424.
53. Dechanet J, Merville P, Lim A et al. Implication of $\gamma\delta$ T cells in the human immune response to cytomegalovirus. *J Clin Invest* 1999; **103**: 1437–1449.
54. Kaminski H, Garrigue I, Couzi L et al. Surveillance of $\gamma\delta$ T cells predicts cytomegalovirus infection resolution in kidney transplants. *J Am Soc Nephrol* 2016; **27**: 637–645.
55. Pitard V, Roumanes D, Lafarge X et al. Long-term expansion of effector/memory V δ 2 $\gamma\delta$ T cells is a specific blood signature of CMV infection. *Blood* 2008; **112**: 1317–1324.
56. Halary F, Pitard V, Dlubek D et al. Shared reactivity of V δ 2⁺ $\gamma\delta$ T cells against cytomegalovirus-infected cells and tumor intestinal epithelial cells. *J Exp Med* 2005; **201**: 1567–1578.
57. Couzi L, Lafarge X, Pitard V et al. $\gamma\delta$ T cell expansion is closely associated with cytomegalovirus infection in all solid organ transplant recipients. *Transpl Int* 2011; **24**: e40–e42.
58. Knight A, Madrigal AJ, Grace S et al. The role of V δ 2-negative $\gamma\delta$ T cells during cytomegalovirus reactivation in recipients of allogeneic stem cell transplantation. *Blood* 2010; **116**: 2164–2172.
59. Ravens S, Schultze-Florey C, Raha S et al. Human $\gamma\delta$ T cells are quickly reconstituted after stem-cell transplantation and show adaptive clonal expansion in response to viral infection. *Nat Immunol* 2017; **18**: 393–401.
60. Arruda LCM, Gaballa A, Uhlin M. Graft $\gamma\delta$ TCR sequencing identifies public clonotypes associated with hematopoietic stem cell transplantation efficacy in acute myeloid leukemia patients and unravels cytomegalovirus impact on repertoire distribution. *J Immunol* 2019; **202**: 1859–1870.
61. Couzi L, Levaillant Y, Jamai A et al. Cytomegalovirus-induced $\gamma\delta$ T cells associate with reduced cancer risk after kidney transplantation. *J Am Soc Nephrol* 2010; **21**: 181–188.
62. Scheper W, van Dorp S, Kersting S et al. $\gamma\delta$ T cells elicited by CMV reactivation after allo-SCT cross-recognize CMV and leukemia. *Leukemia* 2013; **27**: 1328–1338.
63. Airoidi I, Bertaina A, Prigione I et al. $\gamma\delta$ T-cell reconstitution after HLA-haploidentical hematopoietic transplantation depleted of TCR- $\alpha\beta$ ⁺/CD19⁺ lymphocytes. *Blood* 2015; **125**: 2349–2358.
64. Di Lorenzo B, Simoes AE, Caiado F et al. Broad cytotoxic targeting of acute myeloid leukemia by polyclonal delta one T cells. *Cancer Immunol Res* 2019; **7**: 552–558.
65. Tokuyama H, Hagi T, Mattarollo SR et al. V γ 9 V δ 2 T cell cytotoxicity against tumor cells is enhanced by monoclonal antibody drugs—rituximab and trastuzumab. *Int J Cancer* 2008; **122**: 2526–2534.
66. Lamb LS Jr, Musk P, Ye Z et al. Human $\gamma\delta$ ⁺ T lymphocytes have *in vitro* graft vs leukemia activity in the absence of an allogeneic response. *Bone Marrow Transplant* 2001; **27**: 601–606.
67. Malan Borel I, Racca A, Garcia MI et al. $\gamma\delta$ T cells and interleukin-6 levels could provide information regarding the progression of human renal allograft. *Scand J Immunol* 2003; **58**: 99–105.
68. Zhou J, Appleton SE, Stadnyk A et al. CD8⁺ $\gamma\delta$ T regulatory cells mediate kidney allograft prolongation after oral exposure to alloantigen. *Transpl Int* 2008; **21**: 679–687.
69. Gorczynski RM, Chen Z, Hoang Y et al. A subset of $\gamma\delta$ T-cell receptor-positive cells produce T-helper type-2 cytokines and regulate mouse skin graft rejection following portal venous pretransplant preimmunization. *Immunology* 1996; **87**: 381–389.
70. Mao Y, Yin S, Zhang J et al. A new effect of IL-4 on human $\gamma\delta$ T cells: promoting regulatory V δ 1 T cells via IL-10 production and inhibiting function of V δ 2 T cells. *Cell Mol Immunol* 2016; **13**: 217–228.
71. Koshiha T, Li Y, Takemura M et al. Clinical, immunological, and pathological aspects of operational tolerance after pediatric living-donor liver transplantation. *Transpl Immunol* 2007; **17**: 94–97.
72. Gao L, Xuan L, Wu X et al. Increase of regulatory $\gamma\delta$ T cells reduces the incidence of acute graft-versus-host disease after allogeneic hematopoietic stem cell transplantation. *Blood* 2016; **128**: 1.
73. Xuan L, Wu X, Qiu D et al. Regulatory $\gamma\delta$ T cells induced by G-CSF participate in acute graft-versus-host disease regulation in G-CSF-mobilized allogeneic peripheral blood stem cell transplantation. *J Transl Med* 2018; **16**: 144.
74. Stikvoort A, Gaballa A, Solders M et al. Risk factors for severe acute graft-versus-host disease in donor graft composition. *Biol Blood Marrow Transplant* 2018; **24**: 467–477.
75. Vroom TM, Scholte G, Ossendorp F et al. Tissue distribution of human $\gamma\delta$ T cells: no evidence for general epithelial tropism. *J Clin Pathol* 1991; **44**: 1012–1017.
76. Hayday AC. $\gamma\delta$ T cells: a right time and a right place for a conserved third way of protection. *Annu Rev Immunol* 2000; **18**: 975–1026.
77. Wisniewski AV, Cain H, Magoski N et al. Human $\gamma\delta$ T-cell lines derived from airway biopsies. *Am J Respir Cell Mol Biol* 2001; **24**: 332–338.
78. Kenna T, Golden-Mason L, Norris S et al. Distinct subpopulations of $\gamma\delta$ T cells are present in normal and tumor-bearing human liver. *Clin Immunol* 2004; **113**: 56–63.

79. Itohara S, Farr AG, Lafaille JJ et al. Homing of a $\gamma\delta$ thymocyte subset with homogeneous T-cell receptors to mucosal epithelia. *Nature* 1990; **343**: 754–757.
80. Hayes SM, Sirm A, Jacob S et al. Role of IL-7 in the shaping of the pulmonary $\gamma\delta$ T cell repertoire. *J Immunol* 1996; **156**: 2723–2729.
81. Michel ML, Pang DJ, Haque SF et al. Interleukin 7 (IL-7) selectively promotes mouse and human IL-17-producing $\gamma\delta$ cells. *Proc Natl Acad Sci USA* 2012; **109**: 17549–17554.
82. Ness-Schwickerath KJ, Jin C, Morita CT. Cytokine requirements for the differentiation and expansion of IL-17A- and IL-22-producing human $V\gamma 2V\delta 2$ T cells. *J Immunol* 2010; **184**: 7268–7280.
83. Ramstead AG, Jutila MA. Complex role of $\gamma\delta$ T-cell-derived cytokines and growth factors in cancer. *J Interferon Cytokine Res* 2012; **32**: 563–569.
84. Lafont V, Sanchez F, Laprevotte E et al. Plasticity of $\gamma\delta$ T cells: impact on the anti-tumor response. *Front Immunol* 2014; **5**: 622.
85. Paul S, Lal G. Regulatory and effector functions of gamma-delta ($\gamma\delta$) T cells and their therapeutic potential in adoptive cellular therapy for cancer. *Int J Cancer* 2016; **139**: 976–985.
86. Vidovic D, Roglic M, McKune K et al. Qa-1 restricted recognition of foreign antigen by a $\gamma\delta$ T-cell hybridoma. *Nature* 1989; **340**: 646–650.
87. Sciammas R, Bluestone JA. HSV-1 glycoprotein I-reactive TCR $\gamma\delta$ cells directly recognize the peptide backbone in a conformationally dependent manner. *J Immunol* 1998; **161**: 5187–5192.
88. Davies A, Lopez-Briones S, Ong H et al. Infection-induced expansion of a MHC Class Ib-dependent intestinal intraepithelial $\gamma\delta$ T cell subset. *J Immunol* 2004; **172**: 6828–6837.
89. Dieude M, Striegl H, Tyznik AJ et al. Cardiolipin binds to CD1d and stimulates CD1d-restricted $\gamma\delta$ T cells in the normal murine repertoire. *J Immunol* 2011; **186**: 4771–4781.
90. Uldrich AP, Le Nours J, Pellicci DG et al. CD1d-lipid antigen recognition by the $\gamma\delta$ TCR. *Nat Immunol* 2013; **14**: 1137–1145.
91. Siegers GM, Lamb LS Jr. Cytotoxic and regulatory properties of circulating $V\delta 1^+$ $\gamma\delta$ T cells: a new player on the cell therapy field? *Mol Ther* 2014; **22**: 1416–1422.
92. Sandstrom A, Peigne CM, Leger A et al. The intracellular B30.2 domain of butyrophilin 3A1 binds phosphoantigens to mediate activation of human $V\gamma 9V\delta 2$ T cells. *Immunity* 2014; **40**: 490–500.
93. Nerdal PT, Peters C, Oberg HH et al. Butyrophilin 3A/CD277-dependent activation of human $\gamma\delta$ T cells: accessory cell capacity of distinct leukocyte populations. *J Immunol* 2016; **197**: 3059–3068.
94. Gasser S, Orsulic S, Brown EJ et al. The DNA damage pathway regulates innate immune system ligands of the NKG2D receptor. *Nature* 2005; **436**: 1186–1190.
95. Zingoni A, Molfetta R, Fionda C et al. NKG2D and its ligands: “one for all, all for one”. *Front Immunol* 2018; **9**: 476.
96. Silva-Santos B, Strid J. Working in “NK Mode”: natural killer group 2 member D and natural cytotoxicity receptors in stress-surveillance by $\gamma\delta$ T cells. *Front Immunol* 2018; **9**: 851.
97. Norell H, Moretta A, Silva-Santos B et al. At the Bench: preclinical rationale for exploiting NK cells and $\gamma\delta$ T lymphocytes for the treatment of high-risk leukemias. *J Leukoc Biol* 2013; **94**: 1123–1139.
98. Lopez-Soto A, Huergo-Zapico L, Acebes-Huerta A et al. NKG2D signaling in cancer immunosurveillance. *Int J Cancer* 2015; **136**: 1741–1750.
99. Vance RE, Kraft JR, Altman JD et al. Mouse CD94/NKG2A is a natural killer cell receptor for the nonclassical major histocompatibility complex (MHC) class I molecule Qa-1 (b). *J Exp Med* 1998; **188**: 1841–1848.
100. Sullivan LC, Clements CS, Beddoe T et al. The heterodimeric assembly of the CD94-NKG2 receptor family and implications for human leukocyte antigen-E recognition. *Immunity* 2007; **27**: 900–911.
101. Rapaport AS, Schriewer J, Gilfillan S et al. The inhibitory receptor NKG2A sustains virus-specific CD8⁺ T cells in response to a lethal poxvirus infection. *Immunity* 2015; **43**: 1112–1124.
102. Ehl S, Schwarz K, Enders A et al. A variant of SCID with specific immune responses and predominance of $\gamma\delta$ T cells. *J Clin Invest* 2005; **115**: 3140–3148.



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