Supplementary Table 4. Clinical experiences of porcine islet xenotransplantation [8]

Islet source	Recipient	Islet type	Islet number	Site	Immunosuppression	Clinical outcome
Landrace	T1DM with kidney transplant (n=10)	Fetal ICC	200,000–1,000,000 ICCs	Kidney capsule or intraportal	ATG, 15-deoxyspergualin, cyclosporin, prednisolone, azathioprine	Detection of small amounts of porcine C-peptide in urine and insulin and glucagon positive cells in renal capsule
Xeno-1	T1DM (n=22)	Neonatal	55,000 IEQ/kg	Hepatic artery	Cyclosporine, prednisolone, MMF, tacrolimus, sirolimus, OKT-3	Transient reduction of insulin requirement in six patients
New Zealand breed	T1DM (n=23)	Neonatal with Sertoli cells	13,000–20,000 IEQ/kg	Subcutaneous macro-device	None	Sustained reduction of insulin requirement in half of the patients up to 4 years
Cross-white breed	T1DM (n=1) with kidney transplant (n=1)	Neonatal, encapsulated	15,000 IEQ/kg	Intraperitoneal	None (n=1) and cyclosporine, prednisolone, azathioprine	Maximum 30% reduction of insulin requirement and detection of insulin positive cells in the capsule at 9.5 years after transplantation
Auckland Island	T1DM (n=8)	Neonatal, encapsulated	5,000 and 10,000 IEQ/kg	Intraperitoneal	None	Improved HbA1c at <7.0% for >600 days and reduction of the frequency of hypoglycemic unawareness
Auckland Island	T1DM (n=14)	Neonatal, encapsulated	5,000, 10,000, 15,000, and 20,000 IEQ/kg	Intraperitoneal	None	Improved HbA1c at <7.0% in four out of 14 patients and reduction of the frequency of hypoglycemic unawareness

T1DM, type 1 diabetes mellitus; ICC, islet cell-like clusters; ATG, anti-thymoglobulin; IEQ, islet equivalent; MMF, mycophenolate mofetil; OKT-3, orthoclone-muromonab-CD3; HbA1c, glycosylated hemoglobin.