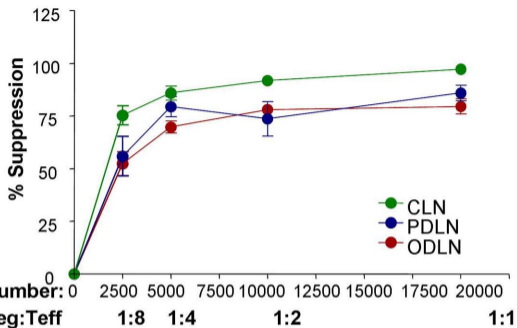
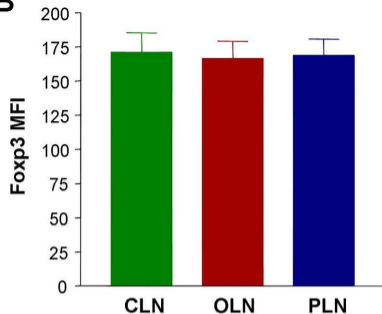
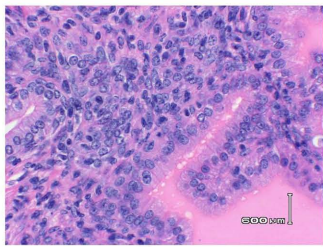


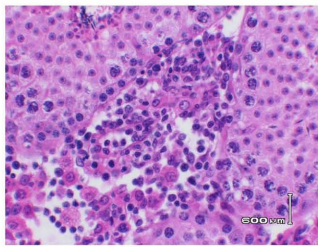
Supplemental Figure 1. Histopathology and autoantibodies in d3tx recipients of Treg. (A) Normal histology of the ovary from d3tx recipients of ovarian draining LN Treg. (B) Severe AOD, present in recipients of Treg from non-draining LN, includes loss of ovarian follicles and presence of ovarian lymphocytic infiltration. (Hematoxylin and eosin stain, x100). (C) Positive serum oocyte antibody by indirect immunofluorescence (x100). (D and G) Normal histology of prostate (D) and lacrimal gland (G) from d3tx recipients of draining LN Treg. (E) Severe EAP, present in recipients of Treg from lacrimal gland LN, shows heavy inflammation and loss of glandular secretion. (H) Severe DA in recipients of Treg from prostate LN, shows germinal center formation within lymphoid infiltrate, and loss of lacrimal glands. (Hematoxylin and eosin stain, x100). (F) Positive serum prostate antibody by indirect immunofluorescence (x100).

A**B**

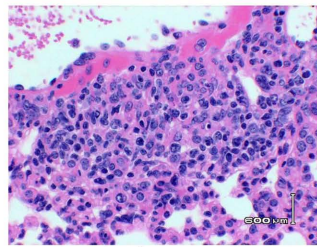
Supplemental Figure 2: Treg from normal cervical LN (CLN), ovarian LN (OLN), and prostate LN (PLN) have comparable in vitro function and levels of Foxp3 expression. A: CD4+ CD25+ Treg were used to suppress CD3 Ab-induced proliferation of pooled LN CD4+ CD25- at different Treg:T effector cell (Teff) ratios. B: The MFI of Foxp3 of Treg from individual LN was determined by flow cytometry. Data are representative of the results of three experiments.



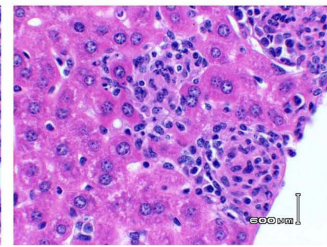
Prostate



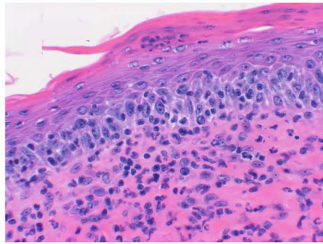
Testes



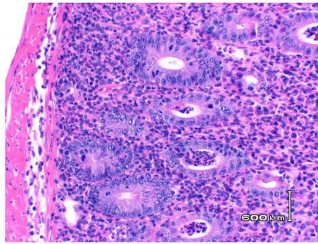
Lung



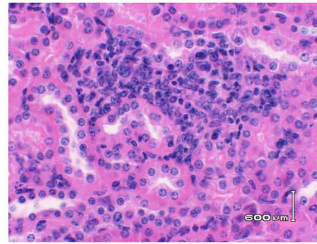
Liver



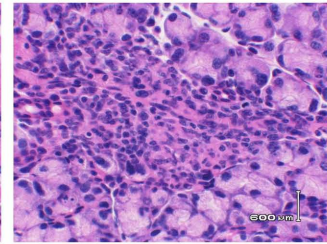
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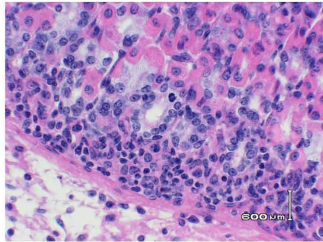
Large Bowel



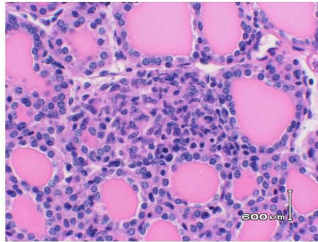
Kidney



Lacrimal Gland



Stomach



Thyroid

Supplemental Figure 3: Illustration of histopathologic findings in B6 RAG^{-/-} recipients of CD4⁺CD25⁻ T cells from individual LN of wild type B6 donors. Prostate: Monocytic infiltration mainly in lateral and posterior lobes. Testes: Interstitial monocytic infiltration. Lung: peribronchial and perivascular monocytic infiltration. Liver: portal inflammation with granulomas. Skin: hyperkeratosis, epidermal and dermal inflammation. Large bowel: Heavy monocytic and neutrophilic infiltration with crypt abscesses. Kidney: Monocytic tubulitis. Lacrimal gland: Periductal inflammation. Stomach: Monocytic inflammation at base of gastric glands. Thyroid: Focal monocytic inflammation. All: hematoxylin and eosin, x400; large bowel x200.