Detection of Major Histocompatibility Complex Class I-Restricted, HIV-Specific Cytotoxic T Lymphocytes in the Blood of Infected Hemophiliacs

By Richard A. Koup, John L. Sullivan, Peter H. Levine, Doreen Brettlter, Anna Mahr, Gail Mazzara, Sara McKenzie, and Dennis Panicali

Major histocompatibility (MHC)-restricted, human immunodeficiency virus type one (HIV-1)-specific, cytotoxic T lymphocytes (CTLs) were detected in the peripheral blood mononuclear cells (PBMCs) of HIV-1-infected individuals. Using a system of autologous B and T lymphoblastoid cell lines infected with recombinant vaccinia vectors (VVs) expressing HIV-1 gene products, we were able to detect HIV-1-specific cytolytic responses in the PBMCs of 88% of HIV-1-seropositive hemophilic patients in the absence of specific complement. These cytolytic responses were directed against both HIV-1 envelope and gag gene products. The responses were resistant to natural killer (NK) cell depletion and were inhibited by monoclonal antibodies (MoAbs) to the T cell receptor, CD8 surface antigens, and MHC class I antigens, suggesting a classical MHC class I restricted, virus-specific CTL response.

Virus-specific major histocompatibility (MHC)-restricted cytotoxic T lymphocyte (CTL) activity is an effective mechanism through which the immune system can lyse virally infected cells during acute infection. In addition, these cells are believed to be important in controlling viral replication in chronic or persistent virus infections such as Epstein-Barr virus (EBV) or cytomegalovirus (CMV).

Infection with human retroviruses also appear to stimulate a virus-specific CTL response. Cytotoxic T lymphocyte lines specific for HTLV-I have been established from peripheral blood mononuclear cells (PBMCs) of individuals infected with this retrovirus. It has been hypothesized that CTLs specific for human immunodeficiency virus type one (HIV-1), the causative agent of AIDS, may play a role in controlling replication and spread of this human retrovirus in asymptomatic seropositive individuals. Recently, Walker et al succeeded in demonstrating the presence of T cells in PBMCs of HIV-1-seropositive homosexual men that specifically lyse autologous EBV-transformed B-lymphoblastoid cell lines (B-LCLs) that have been infected with recombinant vaccinia virus (VV) vectors expressing HIV-1 envelope, gag, and polymerase gene products. These responses appear to be MHC restricted.

Vectors are excellent tools for measuring virus antigen-specific CTL responses and have been used extensively in other viral systems. In addition, VV expressing HIV-1 envelope gene products are capable of stimulating HIV-1 envelope-specific CTL responses in vaccinated humans, chimpanzees, and macaques.

In the present study, we used a system of recombinant VV vectors to detect MHC class I-restricted, HIV-1-specific CTL responses in the PBMC of HIV-1-seropositive hemophiliac patients. In addition, we attempted to correlate the level of these responses with other known determinants of HIV-1 disease progression.

MATERIALS AND METHODS

Patient population. Approximately 150 patients with hemophilia are currently being followed at the New England Area Comprehensive Hemophilia Center, Worcester Memorial Hospital, MA, as part of an ongoing prospective study of immunoregulatory defects in hemophilia. All patients give informed consent before entering the study and are followed yearly. Approximately 90% of these individuals are seropositive by Western blot for antibodies to HIV-1; most seroconverted before 1983.

Lymphocyte separation. PBMCs were isolated from freshly drawn heparinized venous blood by centrifugation on Ficol-Paque (Pharmacia Fine Chemicals, Piscataway, NJ) density gradients. PBMC preparations contained 70% to 80% lymphocytes, 10% to 20% monocytes, and <20% polymorphonuclear leukocytes as determined by cell morphology.

Virus culture. HIV-1 was cultured from PBMC by a modification of previously published techniques. PBMCs were cocultivated with previously phytohemagglutinin (PHA)-stimulated PBMCs from normal healthy seronegative controls. Cells were maintained in RPMI 1640, supplemented with 20% heat-inactivated fetal calf serum (FCS) (GIBCO, Grand Island, NY) and 10% interleukin-2 (IL-2, Electronucleonics, Silver Spring, MD). Cultures were sampled twice weekly for HIV-1 p-24 antigen by enzyme immunoassay (EIA) (DuPont deNemours, Wilmington, DE) and HIV-1 genome by a nonisotopic in situ hybridization technique. Fresh PHA-stimulated blasts were added weekly, and cultures were maintained for 3 weeks before being considered negative.

Target cell lines. Autologous B-LCL were created by incubation of PBMCs with supernatant from the EBV-producing marmoset cell line B95.8 (ATCC No. CRL-1612). Autologous T-lymphoblastoid cell lines (T-LCLs) were created by cocultivation of PBMCs with supernatant from the EBV-producing marmoset cell line B95.8 (ATCC No. CRL-1612).
PHAs of B-LCLs or T-LCLs were infected or mock infected with VVs (NYCBH, 140/env/160, 141/gag/55) at a multiplicity of infection of 10 according to the methods of McMichael et al.16 Sixteen hours later, the cells were washed and incubated with 100 μCl Na2 (51CrO4) (New England Nuclear) at 37°C for 60 minutes, washed twice with phosphate-buffered saline (PBS), and resuspended, after viability determination with trypan blue exclusion, to 1 x 10⁶ cells/mL in RPMI 1640 with 10% FCS. One hundred-microliter aliquots of target cell suspension were then dispensed into wells of 96-well round-bottom microtiter plates. To each well, 100 μL of previously NK cell-depleted effector cells were added to each well for a final E:T ratio of 50:1. After incubation and harvesting as described previously, percentage of specific cytolysis was calculated as previously described.

Statistical analysis. Data expressed in Figs 1 through 4 represent means and n refers to the number of samples tested. Where present, error bars represent SEM. Significance was determined when appropriate by analysis of variance (ANOVA), and statistical significance was defined as P < 0.05.

RESULTS

VV vector expression analysis. Expression analysis of VV vector expression was performed previously.20 Vector 140/env/160 and 141/gag/55 were published previously. Vector 140/env/160 produces immunoreactive bands at gp-41, 120, and 160 in B-LCLs by radioimmuno-precipitation, and both B-LCLs and T-LCLs infected with this vector will form syncytia with c8166 cells when cocultivated for four hours. Vector 141/gag/55 produces a single immunoreactive band at p-55 in infected B-LCLs, and HIV-1 gag antigen is detectable in B-LCL and T-LCL supernatants by antigen EIA eight to 24 hours after infection.

HIV-1–specific cytolysis against B-LCLs. In a standard chromium release assay, no HIV-1–specific cytolysis of autologous B-LCL targets could be detected in the PBMCs of six HIV-1–seronegative controls assayed at E:T ratios of up to 50:1 (Fig 1). In contrast, HIV-1–specific cytolysis of autologous B-LCL targets infected with 140/env/160 or...
141/gag/55 was clearly demonstrable in the PBMCs of 17 HIV-1-seropositive hemophilia patients (Fig 1). These responses were significantly greater than the responses against NYCBH-infected targets (P < .01) and were clearly demonstrable in 15 of the 17 (88%) seropositive patients tested to date. PBMCs from seven of the 17 seropositive patients mediated greater cytotoxicity against gag-expressing B-LCL targets than against envelope-expressing targets. Only one patient showed greater cytotoxicity against envelope than against gag-expressing targets; the rest of the patients showed similar cytotoxicity against both HIV-1 protein-expressing targets. Assays were discarded from analysis if spontaneous release was >30%.

**HIV-1-specific cytolysis against T-LCLs.** Since B-LCLs from HIV-1-seropositive individuals secrete HIV-1-specific IgG27 which could mediate cytolysis against targets expressing HIV-1 proteins through antibody-dependent cell-mediated cytotoxicity (ADCC), PBMCs from six seropositive hemophilia patients were assayed for their ability to mediate cytosis against autologous T-LCLs infected with recombinant VV vectors. As shown in Fig 2, T-LCL targets expressing HIV-1 gag or envelope antigens also serve as appropriate targets for HIV-1-specific cytolsis. Although the degree of specific cytosis noted against HIV-1 protein-expressing T-LCL targets was not statistically significantly greater than the cytosis noted against vaccinia-expressing T-LCL targets in this small number of assays and was less than that noted against B-LCL targets, other work in our laboratory has shown T-LCLs to be fairly resistant to T cell lysis and extremely resistant to NK cell lysis (B. Tomkinson, R. Koup, unpublished observations, November 1987). Since B-LCL targets appear to be more sensitive to cytosis than T-LCL targets, all further reported study results involve autologous B-LCL targets only.

**NK cell resistance of measured cytosis.** To ensure that the measured cytosis in these assays was not mediated solely by NK cells, either through ADCC or lymphokine-activated killer (LAK) cell lysis, PBMCs from ten seropositive patients were depleted of NK cells by antibody-dependent, complement-mediated lysis. Of these ten patients, seven had adequate (>20%) HIV-1 gag-specific cytosis and three had adequate HIV-1 envelope-specific cytosis to assess the effect of NK cell depletions. As shown in Fig 3, although NK cell depletion had a significant effect on lysis of K562 cells, HIV-1-specific cytosis against gag- and envelope-expressing B-LCL targets was only inhibited 23% and 15%, respectively, indicating that most of these cytolytic responses were not mediated by

**Fig 1.** Cytotoxicity v B-LCL targets. Cumulative data from CTL assays on six HIV-1-seronegative and 17 HIV-1-seropositive hemophilia patients whose PBMCs were reacted against autologous B-LCLs infected with NYCBH (VAC), 141/gag/55 (GAG), or 140/env/160 (ENV), in a six-hour chromium release assay.

**Fig 2.** Cytotoxicity v B-LCL and T-LCL targets. Cumulative data from CTL assays on HIV-1-seropositive hemophilia patients, six of whose PBMCs were reacted against autologous T-LCLs infected with NYCBH (VAC), 141/gag/55 (GAG), or 140/env/160 (ENV), and 17 of whose PBMCs were reacted against autologous B-LCLs similarly infected. Left panel is a duplicate of right panel in Fig 1 and is reproduced for comparison.

**Fig 3.** Effect of NK cell depletion of effector cells on specific cytosis. Effector cells were depleted of NK cells through M Ab-dependent, complement-mediated lysis. All effector cells were reacted against autologous B-LCLs infected with VV vectors, and K-562 cells were included as controls. Mean virus-specific cytosis before depletion was as follows: gag, 38% (n = 7); envelope, 24% (n = 3). Mean cytosis before depletion was 43% (n = 7) against K562 targets. All assays were performed at an E:T ratio of 50:1.
NK cells. In addition, the low level of cytolysis noted against NYCBH-infected B-LCL targets was inhibited almost completely by NK cell depletion (75%) and probably represents a slight NK cell sensitivity of these virally infected cell (data not shown).

MoAb inhibition studies. To determine the cellular origin and MHC restriction of the cytolytic responses remaining after NK cell depletions, MoAbs were added to the CTL assays to inhibit specific cytolysis. PBMCs from four patients had >15% gag-specific cytolysis, and PBMCs from one patient had >15% envelope-specific cytolysis after NK cell depletion; the results of MoAb inhibitions on these five individuals are shown in Fig 4. MoAbs used were OKT3 which is directed against the CD3 protein of the T-cell receptor and inhibits antigen-specific T-cell-dependent killing.28 OKT8 which is directed against the CD8 surface antigen, W6/32 which is directed against common determinants on MHC class I molecules and inhibits cytolysis by class I-restricted CTL clones.28,29 and OKIα1 which is directed against common determinants on MHC class II molecules and inhibits cytolysis by class II-restricted CTL clones.29 OKT1 was used as a control, being directed against a pan T-cell marker, CD5, and does not affect T-cell-mediated cytolysis.28,30

As is expected of cytolysis mediated by virus-specific, MHC class I-restricted CTLs, the HIV-1-specific cytolysis against autologous targets expressing gag proteins was inhibited by MoAbs OKT3, OKT8, and W6/32, but not OKT1 or OKIα1, and the specific cytolysis against envelope-expressing targets appear to follow a similar pattern (Fig 4). This inhibition of cytolysis does not represent a nonspecific phenomenon as cytolysis by CD4-positive, class II-restricted, dengue virus-specific CTL clones is inhibited by these same OKT3 and OKIα1 preparations, but not by the W6/32 or OKT8 preparations (I. Kurane, personal communication, April 1988).

Correlations to clinical predictors of disease progression. All 17 of the seropositive hemophiliac patients described in this study were asymptomatic, falling into CDC group II or III classifications.31 When the level of gag- or envelope-specific CTL responses in these individuals was compared with absolute CD4 or CD8 lymphocyte counts or ratios of helper to suppressor cells, no positive correlations could be determined. However, when we compared the level of gag- or envelope-specific CTL with the ability to detect HIV-1 in PBMC cultures, PBMCs that did not yield HIV-1 in culture appeared to have more vigorous CTL responses than PBMCs that did yield virus on cocultivation (Table 1). This difference did not reach statistical significance (P < .1, gag; P < .3, env) in this small patient population, however.

DISCUSSION

The present study was designed to confirm and extend the observations of Walker et al8 that HIV-1-specific CTL responses directed against envelope, and to a lesser degree, gag gene products were detectable in PBMCs of HIV-1-seropositive subjects in the absence of in vitro stimulation. Our results support the observation of Walker et al with some significant differences. Our studies have detected much more vigorous CTL responses against gag-expressing targets in this hemophiliac population than in the homosexual population studied by Walker et al.8 This could relate to differences in the immune response to HIV-1 in these two distinct populations, differences in the stage of disease at which the responses were measured, or subtle differences in the level of gag antigen expression by the different VV vectors used in these two studies. We therefore believe this to be the first description and characterization of high-level gag-specific CTL activity in PBMCs of seropositive individuals.
The level of virus-specific CTL measured in these studies is without precedent in other persistent viral infections, including the related human retrovirus HTLV-I. These high and sustained responses may be a result of constant in vivo stimulation of CTL by ongoing viral replication, or the measured responses may not represent true MHC-restricted CTL responses but instead represent the activity of either NK cells or killer cell-mediated ADCC. As would be expected in bulk PBMC assays, more than one mechanism may be contributing to the measured cytosis. The responses measured by Walker et al appear to be T cell mediated, whereas similar responses measured against targets absorbed with gp-120 by Weinhold et al appear to be NK cell mediated. Our studies indicate that a small but distinct proportion (15% to 25%) of the measured HIV-1-specific cytosis can be eliminated by depleting effectors of cells bearing the CD16 phenotype. Cells of this phenotype mediate cell killing through direct mechanisms or through ADCC. We believe that the former mechanism is most likely responsible for the low level of NK-cell sensitivity observed in this previous study that we previously showed to be T cell mediated, whereas the envelope-specific responses may be mediated by both class I and class II-restricted CTL since incomplete inhibition of killing was noted with class I-specific antibodies.

Several prognostic indicators of disease progression from the asymptomatic state to AIDS-related complex (ARC) or AIDS have been described, including loss of antibody to p-24, appearance of p-24 antigen in serum, loss of CD4 lymphocytes, and decrease in helper to suppressor ratio. We previously described the ability to isolate HIV-1 from the PBMCs of asymptomatic HIV-1-seropositive hemophiliac patients as being strongly predictive of disease progression. The inability to isolate HIV-1 from the PBMCs of asymptomatic seropositive hemophiliac patients may correlate with more vigorous HIV-1-specific CTL responses. Although this association does not yet reach statistical significance, we hope to confirm or deny this initial observation as we continue to follow this patient population. The presence of circulating HIV-1-specific CTL in these virus culture-negative but seropositive hemophiliac patients indicates that they have been infected with live virus and not just immunized with inactive virus. In addition, the high level of CTL response in these patients from whom HIV-1 cannot be isolated may be indicative of low-level virus replication that is controlled by an effective immune response.

In summary, we confirmed the findings of previous investigators and detected HIV-1-specific CTL responses in PBMCs of infected hemophilia patients in the absence of in vitro stimulation. Most of these cytolytic responses appear to be NK cell resistant, T cell mediated, and MHC class I restricted. These responses are directed against both HIV-1 gag and envelope antigens, and the generation of these responses in vivo may be one way in which the human immune system can adequately deal with this devastating infection.

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REFERENCES


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Table 1. HIV-1-Specific CTL Responses in Culture-Negative and Culture-Positive Hemophilia Patients

<table>
<thead>
<tr>
<th>Patient</th>
<th>VAC</th>
<th>GAG</th>
<th>ENV</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV-1 culture-negative (n = 8)</td>
<td>8.9 ± 3.2</td>
<td>51.1 ± 7.1</td>
<td>36.9 ± 7.2</td>
</tr>
<tr>
<td>HIV-1 culture-positive (n = 9)</td>
<td>4.9 ± 1.3</td>
<td>33.4 ± 6.3</td>
<td>27.7 ± 3.7</td>
</tr>
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Comparison of level of virus-specific CTL lysis with ability to isolate HIV-1 from PBMCs. Cultures were performed for 3 weeks and sampled twice weekly for HIV-1 p-24 antigen by EIA and HIV-1 genome by in situ hybridization. Virus-specific CR assays were run at an E:T ratio of 50:1; data are mean ± SEM.
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