Allogeneic Leukocytes But Not Therapeutic Blood Elements Induce Reactivation and Dissemination of Latent Human Immunodeficiency Virus Type 1 Infection: Implications for Transfusion Support of Infected Patients

By Michael P. Busch, Tzong-Hae Lee, and John Heitman

Various immunologic stimuli and heterologous viral regulatory elements have been shown to increase susceptibility to, and replication of, human immunodeficiency virus type 1 (HIV-1) in lymphocytes and monocytes in vitro. Transfusion of allogeneic blood components from heterologous donors constitutes a profound immunologic stimulus to the recipient, in addition to being a potential route of transmission of lymphotropic viral infections. To investigate the hypothesis that transfusions, and particularly those containing leukocytes, activate HIV-1 replication in infected recipient cells, we cocultured peripheral blood mononuclear cells (PBMC) from three anti-HIV-1–positive individuals with allogeneic donor PBMC, as well as partially purified populations of donor lymphocytes, monocytes, granulocytes, platelets, and red blood cells (RBC) and allogeneic cell-free plasma. Allogeneic PBMC induced a dose-related activation of HIV-1 expression in vivo infected cells, followed by dissemination of HIV-1 to previously uninfected patient cells. Activation of HIV-1 replication was observed with donor lymphocytes, monocytes, and granulocytes, whereas no effect was seen with leukocyte-depleted RBC, platelets, or plasma (ie, therapeutic blood constituents). Allogeneic donor PBMC were also shown to upregulate HIV-1 expression in a "latent" infected cell line, and to increase susceptibility of heterologous donor PBMC to acute HIV-1 infection. Studies should be performed to evaluate whether transfusions of leukocyte-containing blood components accelerate HIV-1 dissemination and disease progression in vivo. If so, HIV-1–infected patients should be transfused as infrequently as possible and leukocyte-depleted (filtered) blood components should be used to avoid this complication.

HUMAN immunodeficiency virus type 1 (HIV-1) infection progresses through an acute phase of active viremia, followed by establishment of a chronic infection of the recipient, in addition to being a potential route of transmission of lymphotropic viral infections. To investigate the hypothesis that transfusions, and particularly those containing leukocytes, activate HIV-1 replication in infected recipient cells, we cocultured peripheral blood mononuclear cells (PBMC) from three anti-HIV-1–positive individuals with allogeneic donor PBMC, as well as partially purified populations of donor lymphocytes, monocytes, granulocytes, platelets, and red blood cells (RBC) and allogeneic cell-free plasma. Allogeneic PBMC induced a dose-related activation of HIV-1 expression

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with substantial transfusion requirements. To investigate this possibility, we characterized the kinetics of HIV-1 expression and dissemination in PBMC from HIV-1–infected persons after cocultivation with various transfused blood components. We also studied the effect of allogeneic blood components on induction of HIV-1 from a latently infected cell line, and on the kinetics of acute HIV-1 infection of PBMC in vitro. Our results indicate that both reactivation and enhanced dissemination of HIV-1 occur after heterogenous leukocyte exposure.

**MATERIALS AND METHODS**

**Preparation of blood components from normal donors.** Blood was obtained from three anti–HIV-1-negative volunteer whole blood donors at Irwin Memorial Blood Centers (IMBC) and processed according to routine blood bank protocols. Platelet-rich plasma (PRP) was prepared by centrifugation at 1,000 RPM for 10 minutes. Platelets were concentrated from PRP by centrifugation at 2,000 RPM for 10 minutes, and resuspended in RPMI-1640 media (GIBCO, Grand Island, NY) at 10^7 cells/mL. Supernatant plasma was passed through a 0.2-μm filter to remove residual cells and large cellular fragments. A portion of the packed red blood cells (RBC) was subjected to filtration (Pall RC50; Pall Biomedical Products, Glen Cove, NY) to remove leukocytes. PBMC and granulocytes were separated from the remaining packed RBC using a commercially available separation media (Sepratech Corp, Oklahoma City, OK). A portion of the PBMC were further separated into enriched lymphocyte (nonadherent) and monocyte (adherent) fractions by overnight incubation in plastic tissue culture flasks. These enriched cell preparations were determined to be composed of at least 95% granulocytes, lymphocytes, and monocytes, respectively, by flow cytometric analysis. PBMC and lymphocyte fractions were treated with mitomycin C (0.25 mg/mL) immediately before use to prevent their replication (and infection) in vitro. The inability of these cells to survive/replicate was determined by measuring their concentration and viability in separately maintained cultures of each cell preparation. Each cell fraction was washed twice in phosphate-buffered saline (PBS) and resuspended at 1 × 10^7 cells/mL in RPMI-1640 media before use in coculture experiments. In one experiment, 1 × 10^6 PBMC from one donor were stimulated for 3 days with phytohemagglutinin (PHA) before mitomycin C treatment.

**Preparation of PBMC from HIV-1–positive individuals.** Blood was obtained from three anti–HIV-1-seropositive persons, two of whom were asymptomatic, while one had lymphadenopathy, oral candidiasis, and a diffuse erythematous skin rash. PBMC were obtained using lymphocyte separation medium (Sepratech Corp) and washed twice in PBS. The number of viable cells was determined by trypan blue exclusion and hemacytometer counting. Cells were resuspended at 2 × 10^7/mL in RPMI-1640 media containing 0.5% penicillin, 1% glutamine, and 5% fetal bovine serum (no interleukin-2 [IL-2]) and placed in tube cultures at 4 × 10^6 PBMC/2 mL. Negative control cultures were maintained in this nonstimulating media. The viable cell number in the nonstimulated cultures was determined by measuring their concentration and viability in a standard curve generated by parallel evaluation of a serial dilution of a commercially available p24 antigen standard. Cell-free virus infection studies. A high-titer stock of cell-free HIV-1 was prepared from the supernatant of HIV-1–infected MT-2 cells. Serial dilutions of virus (100 μL) of this supernatant were inoculated onto duplicate 1 mL cultures containing 2 × 10^6 PHA-stimulated or nonstimulated PBMC from each of two normal donors, as well as duplicate cultures containing an equal mixture of 1 × 10^6 nonstimulated cells from each normal donor. Polybrene (2 μg/mL; Sigma, St Louis, MO) was included in the media during the 12-hour virus inoculation, after which the cells were washed.
and the cultures monitored for HIV-1 replication as described above.

RESULTS

When PBMC from each of the three HIV-1-infected individuals were cultured under conditions of minimal stimulation (5% serum and no PHA), no detectable viral antigen expression was observed either associated with cultured cells or released into the supernatant fluid (Fig 1A, no stimulation). Quantitation of HIV-1-proviral DNA from nonstimulated cultures showed that HIV-1 gag DNA concentration (ie, the proportion of cells harboring provirus) remained unchanged (at 1 to 4 infected cells per 100,000 PBMC) relative to that found in uncultured PBMC for up to 2 weeks in culture (not shown). In contrast, PHA stimulation of HIV-1-infected patients' PBMC resulted in a dose-dependent activation of HIV-1 replication, as evidenced by high-level expression of gag antigen in culture supernatants (Fig 1A), and a progressive increase in the proportion of cells testing positive for HIV-1 gag antigens by immunocytochemistry and for HIV-1 DNA by dilutional PCR analysis (see below).

Coculture of PBMC from the three HIV-1-seropositive patients with mitomycin C-treated allogeneic PBMC resulted in an induction of viral expression similar to that observed after PHA stimulation (Fig 1B). Allogeneic PBMC from three different normal donors (RE, FS, and MB) were similar in their ability to induce HIV-1 expression from the three seropositive patients' PBMC. The heterologous leukocyte-induced activation was dose-dependent, with markedly enhanced viral replication occurring after coculture with 10⁷ normal donor PBMC, low-level viral stimulation with 10⁵ normal PBMC, and no detectable viral replication after coculture with 10³ or fewer PBMC (Fig 1B). In one experiment, prior PHA activation of normal donor PBMC enhanced their ability to induce HIV-1 reactivation at the 10⁵ cell input (not shown). Induction of viral gag protein expression was also observed after coculture of 2 × 10⁶ PBMC from one of the infected patients with 1 × 10⁷

Fig 1. Effect of allogeneic donor blood constituents on HIV replication in PBMC of a seropositive individual. No detectable viral antigen expression was observed when infected patient PBMC were cultured under conditions of minimal stimulation (5% serum and no supplemental IL-2 or PHA), whereas PHA stimulation of PBMC resulted in a dose-dependent induction of HIV-1 p24 antigen in culture supernatants (A). Coculture of PBMC from three normal donors (RE, FS, and MB) with patient PBMC induced p24 antigen expression in a dose-dependent manner (B). Induction of HIV p24 antigen expression was also observed after coculture of infected patient PBMC with allogeneic donor lymphocytes, monocytes, and granulocytes (C), whereas heterologous donor RBC, platelets, and plasma showed no effect (D).
mitomycin C-treated allogeneic donor lymphocytes, monocytes, or granulocytes (Fig 1C). In contrast, coculture with either $1 \times 10^7$ heterologous donor RBC or platelets showed no effect on HIV-1 expression or proviral load above that seen with the nonstimulated control cultures. Similarly, addition of heterologous donor plasma at a 5% final concentration failed to induce detectable HIV-1 expression (Fig 1D).

More detailed analysis of the allogeneic PBMC cocultures enabled us to discriminate two phases of viral replication, the first characterized by activation of viral expression in in vivo infected patient cells, and the second by dissemination of infection in vitro to previously uninfected patient cells. Data from a representative experiment are summarized in Fig 2A, with corresponding semiquantitative PCR and immunocytochemistry data presented in Fig 2B and C, respectively. Semiquantitative PCR analysis of uncultured cells from this patient showed that approximately 1 in 25,000 PBMC (4 in 100,000) harbored HIV-1 DNA (Fig 2B, day 0). However, less than 1 in 100,000 cells expressed HIV-1 p18 or p24 antigens detectable by immunocytochemical analysis (Fig 2C, day 0). Three days after exposure to allogeneic donor PBMC, the proportion of cells harboring HIV-1 DNA was essentially unchanged (at approximately 1 infected cell per 25,000 input PBMC). However, we now observed low-level expression of p24 antigen in the culture fluid, and gag antigens became detectable on the surface of a proportion of cells comparable to that determined to harbor HIV-1 DNA by PCR analysis (Fig 2A, B, and C, day 3). This early phase was thus consistent with reactivation of HIV-1 provirus expression in vivo infected cells. By day 7, and continuing through day 10, dissemination of infection was observed, as evidenced by a progressive increase in the proportion of cells harboring HIV-1 DNA and gag proteins, and an increase in the concentration of extracellular p24 antigen (virion production) (Fig 2A, B, and C, days 7 and 10). It is important to note that quantitation of the proportion of cells harboring viral antigen or DNA, as observed in this experiment, reflects viral infection and expression in PBMC derived from the HIV-1-infected patient only. Pretreatment of the normal donor leukocyte preparations with mitomycin C immediately before their addition into cocultures precluded their ability to propagate beyond 3 days. This was shown by monitoring parallel cultures of mitomycin C-treated donor PBMC alone, which showed that less than 2% of input donor cells were present and viable after 3 days of culture. Furthermore, inoculation of a control culture of these cells (both with and without

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**Fig 2.** Allogeneic leukocyte induction of HIV replication is biphasic. Quantitative PCR analysis of uncultured cells from this patient showed approximately 1 in 2.5 x $10^4$ (4 per 100,000) PBMC infected with HIV-1 before culture (A and B, day 0). However, less than 1 in 100,000 cells expressed HIV-1 p18 or p24 antigens detectable by immunocytochemical analysis (A and C, day 0). Three days after exposure to allogeneic PBMC, the proportion of cells harboring HIV-1 DNA was unchanged, although gag antigens were now detectable on the surface of a small proportion of cells (C, day 3) and low-level p24 antigen was present in the culture fluid (A, day 3). By day 7, and continuing through day 10, viral dissemination was observed, as evidenced by a progressive increase in the proportion of patient cells harboring HIV-1 DNA and gag proteins. Note that values for number of cells per reaction are based on hemocytometer counting and dilution factors. HLA-DQα signal endpoints are at the 2.5 x $10^4$ cell input level for each dilution series, but are of unequal intensity due to cell clumping with dilutions of intact, cultured PBMC. U1.1 represents $1 \times 10^6$ U1.1 cells (positive control).

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prior PHA stimulation) with a high-titer HIV-1 stock confirmed that these cells could not support HIV-1 infection, whereas virus grew readily in the stimulated donor PBMC in the absence of mitomicin C treatment. Rendering the allogeneic donor cells nonviable and incapable of supporting viral replication enabled us to conclude that the observed increase in the proportion of HIV-1–DNA and gag antigen-positive cells was the result of dissemination of infection from in vivo infected cells to previously uninfected patient cells, rather than the spread of virus to allogeneic normal donor cells.

To further study the effect of allogeneic cell interaction on the induction of expression of HIV-1 in latently infected cells (reactivation), we used the U1.1 monocytic cell line that harbors two integrated copies of HIV-1 provirus per cell. In the absence of stimulation by the phorbol ester PMA, only a small percentage (1% to 3%) of these cells express HIV-1 antigens detectable by immunocytochemistry and only a low level of virus is detectable in culture supernatant. After stimulation with PMA, a high proportion (>25%) of U1.1 cells was induced to express detectable viral antigen, and cell-free virus products (ie, supernatant p24 antigen levels) increased markedly (Fig 3A). When \(2 \times 10^6\) U1.1 cells were cocultured with \(1 \times 10^7\) mitomicin C-treated normal donor PBMC, the proportion of antigen-positive cells increased from 2% to more than 15%, and extracellular virus production (as evidenced by p24 antigen in the culture supernatant) increased markedly (Fig 3B). This effect was observed by 1 day of culture, and was not associated with any change in proviral copy number per cell (not shown), indicating that the effect was due to enhanced transcription and/or translation of latent viral sequences and not superinfection. Because this monocytic cell line lacks T-cell receptors, the induction is presumably secondary to cytokine release from PBMC rather than direct activation via cell-to-cell contact. No stimulation of viral replication was seen after the addition of allogeneic donor RBC, platelets, or plasma to U1.1 cultures.

We next investigated the effect of allogeneic leukocyte interactions on the increasing susceptibility of quiescent PBMC to initial HIV-1 infection. Serial 10-fold dilutions of cell-free virus were inoculated into replicate cultures containing \(2 \times 10^6\) PHA-stimulated or nonstimulated PBMC from each of two normal donors, as well as a coculture containing a mixture of \(1 \times 10^6\) nonstimulated PBMC from each of these donors. Prior coculture of heterologous PBMC increased the susceptibility of these cells to HIV-1, relative to unstimulated cells, both in terms of a 1 log increase in the endpoint dilution of virus stock yielding detectable viral replication (Table 1) and the kinetics of viral replication at several infectious doses (Fig 4). The stimulatory effect of allogeneic cells, vis-a-vis enhancing susceptibility of PBMC to acute HIV-1 infection, was similar to that seen after PHA-induced activation of the individual PBMC preparations.

**DISCUSSION**

Although coculture of PBMC from seropositive patients with stimulated normal donor PBMC has become the

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**Table 1. Allogeneic Leukocyte Interaction Facilitates Acute HIV-1 Infection of PBMC**

<table>
<thead>
<tr>
<th>PBMC Source</th>
<th>PHA</th>
<th>Dilution of HIV-1&lt;sub&gt;38&lt;/sub&gt; Stock Inoculum</th>
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<tbody>
<tr>
<td>MB</td>
<td></td>
<td>(10^2)</td>
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<tr>
<td>MB</td>
<td>+</td>
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<td>FS</td>
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<td>FS</td>
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<td>+++</td>
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<tr>
<td>MB/FS</td>
<td>−</td>
<td>+++</td>
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MB and FS represent \(2 \times 10^6\) PBMC from two unrelated, HIV-1-negative donors. MB/FS represents a mixed culture of \(1 \times 10^6\) cells from donors MB and FS. Viral replication was graded as follows: −, no p24 antigen detected through 11 days of monitoring; +/−, low-level (<100 pg/mL) detection of p24 antigen at 11 days; +, high-level p24 antigen (>100 pg/mL) first detected at 11 days; ++, high levels of antigen by day 7; ++++, high levels of antigen by day 3.
LEUKOCYTE-INDUCED REACTIVATION OF HIV-1

standard method for efficient isolation of HIV-1, the possible clinical consequences of this practice (ie, transfusion of leukocyte-containing blood components into infected individuals) and its potential disease consequences (ie, accelerated viral replication/dissemination in vivo) have not been widely considered or studied. However, there is extensive literature documenting varied immunologic consequences of allogeneic transfusion. For example, Schechter et al showed that transfusion of blood components containing allogeneic leukocytes precipitates the appearance of transformed lymphoblasts in recipient peripheral blood.41 While in general this lymphocyte activation appears to be clinically insignificant, the proliferation of donor lymphocytes in an immunosuppressed or haploype-matched recipient may result in fatal graft-versus-host disease.42 On the other hand, proliferation of recipient lymphocytes responding to donor cells leads to alloimmunization with its varied clinical consequences.43

Although less recognized, both experimental and clinical data support an effect of donor-recipient leukocyte interactions after transfusion on transmission and reactivation of viral infections. For example, in the murine CMV model system, the rate and kinetics of both primary CMV infection and CMV reactivation are markedly enhanced after transfusion of allogeneic as opposed to syngeneic whole blood.44,45 In humans, there are numerous studies documenting reactivation of CMV after blood transfusion.46 Although virus reactivation has usually been attributed to a nonspecific immunosuppressive effect of transfusion,47,48 we believe it may result from direct (cell contact-mediated) or indirect (cytokine-mediated) stimulation of latently infected recipient cells by transfused allogeneic leukocytes.49,50 Indeed, the widely recognized phenomenon of transfusion-induced immunosuppression may itself, at least in part, be the consequence of donor leukocyte-induced reactivation of latent recipient viral infections.

Our findings further implicate cell activation as an important element driving HIV-1 replication and dissemination. Although numerous investigators have presented in vitro data suggesting that a variety of factors (eg, UV irradiation, alloantigens, cytokines, and heterologous viral infections) can upregulate HIV-1 replication, validation of the clinical significance of these findings has proven difficult. In contrast, the allogeneic leukocyte-induced activation described in the current study can be tested directly by quantitative analysis of HIV-1 replication and its consequences (eg, CD4 cell counts) in blood collected from infected persons before and after the transfusion of cellular blood components. We are now in the process of conducting this study. If a clinically significant in vivo effect is demonstrated, it would represent important evidence confirming the importance of immunologic stimulation in activating HIV-1 replication.

It is noteworthy that our experimental design, in which allogeneic cells were rendered incapable of propagation and infection before their introduction into cocultures, allowed us to discriminate reactivation of latent provirus in vivo infected cells from dissemination of infection among the patients’ cells ex vivo. By documenting the spread of virus from infected to noninfected patient cells, we were able to confirm that the peripheral blood of infected individuals contains a substantial population of cells that, if activated, are highly susceptible to HIV-1 infection.51,52 The fact that these cells were as yet uninfected in vivo presumably relates to their quiescent phenotype and to viral and immunologic regulatory elements that maintain a relatively low level of viral replication and circulating free virus during the asymptomatic phase of infection.53 It would be interesting to characterize the relative sizes of the infected versus susceptible PBMC pools in patients at varying clinical stages, and in serial samples collected from single individuals over the course of infection or after treatment with antiviral or immunomodulating therapy. Careful evaluation of the capacity of immunologic elements (eg, CD8+ cells, HIV-1 antibody) and antiviral agents (eg, azidovudine, soluble CD4) to control or block the reactivation versus the dissemination phases of infection after in vitro allogeneic cell stimulation of infected patient PBMC would also be of interest.

The finding that leukocytes expressing HLA class I and II
antigens but not therapeutic blood constituents (RBC, platelets, plasma) lacking those antigens are responsible for “turning on” HIV-1 expression in infected allogeneic cells in a dose-related fashion has practical implications. In our experiments, ratios of donor leukocytes to patient PBMC exceeding 1 to 10 resulted in HIV-1 reactivation. Efficient leukocyte depletion filters (so-called third generation filters), capable of producing RBC or platelet components with less than $5 \times 10^9$ residual leukocytes, are now widely available.\textsuperscript{56} Exclusive transfusion of components that have been leukocyte-depleted using these third generation filters prevents, or at least markedly delays, alloimmunization.\textsuperscript{5,57} This clinical observation suggests that these products may not contain the threshold number of leukocytes necessary to trigger recipient virus reactivation. These newer leukocyte-depleted products also appear to prevent CMV transmission, and may therefore reduce transmission of viruses capable of transactivating HIV-1 expression.\textsuperscript{58} Should further study of HIV-1-infected recipients substantiate the clinical importance of transfusion-induced activation of HIV-1, it would be important to rapidly determine whether the use of currently available leukocyte-depleted products prevents this complication.

In conclusion, we have shown that allogeneic donor leukocytes harbored in cellular blood components can markedly upregulate HIV-1 expression and dissemination in infected PBMC ex vivo. If these observations are corroborated in vivo, they would have important implications for transfusion therapy of HIV-1 infected persons: (1) therapies that induce anemia, and hence necessitate transfusion support, should be avoided or minimized\textsuperscript{46}; (2) use of erythropoietin and, when possible, autologous transfusions should be encouraged\textsuperscript{59}; and (3) leukocyte-depleted (filtered) blood components, if shown to be effective at preventing this complication, should be used when administering transfusions to HIV-1-infected patients. Finally, the effects of allogeneic leukocytes in transfusions on other latent or chronic viral infections (eg, herpes viruses, HTLV-I/II, hepatitis viruses, etc) should be further investigated both in vitro and in vivo. If reactivation of recipient infections proves to be a general phenomenon, the current trend toward routine implementation of filtered, leukocyte-depleted blood components should be expedited.

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REFERENCES

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