CD8+ T Lymphocytes in the Lung of Acquired Immunodeficiency Syndrome Patients Harbor Human Immunodeficiency Virus Type 1

By Gianpietro Semenzato, Carlo Agostini, Lucia Ometto, Renato Zambello, Livio Trentin, Luigi Chieco-Bianchi, and Anita De Rossi

Human immunodeficiency virus-1 (HIV-1) infection of CD8+ lymphocytes has been described in several in vitro culture systems, but whether CD8+ cells are a target and also serve as a reservoir for infection in vivo as yet is unknown. We addressed this issue in patients with acquired immunodeficiency syndrome (AIDS)-related lower respiratory tract chronic inflammation, which is characterized by a massive influx of CD8+ HIV-1-specific cytotoxic T lymphocytes (CTL). Proviral load in lung T lymphocytes and their subpopulations was evaluated by using the DNA-polymerase chain reaction (PCR) technique on cells retrieved by bronchoalveolar lavage. To avoid the possibility that the presence of HIV-1 DNA could be caused by contaminating CD4+ cells, serial dilutions of highly purified CD8+ cells were also analyzed by PCR. Our findings showed that lung CD8+ cells harbor and express HIV-1. To explore the possible mechanisms leading to pulmonary CD8+ lymphocyte infection, we evaluated CD4 gene expression on highly purified CD8+ cells by means of reverse transcriptase PCR. Despite the lack of membrane CD4 reactivity, we could show that CD8+ cells may express CD4 RNA. Coinfection of lung CD8+ cells harboring proviral HIV-1 sequences by viral agents capable of inducing CD4 expression (i.e., HHV-6) was not detected. Our data indicate that not only CD4+ T lymphocytes and macrophages, but also CD8+ cells, may represent a target and/or a reservoir for HIV-1 in vivo, and suggest that lung CD8+ lymphocytes could derive from precursors equipped with enough CD4 molecules to become HIV-1 permissive. Aside from the cell-to-cell contact between activated HIV-1 specific CTL and relevant targets, the infection of precursors could represent an additional mechanism accounting for the infection of pulmonary CD8+ cells and their functional impairment.

(C) 1995 by The American Society of Hematology.

MATERIALS AND METHODS

Study populations. Eleven HIV-1 seropositive patients (8 men and 3 women, average age 34 ± 11.3 years) were studied. According to the criteria for HIV-1--related disorders of the Centers for Disease Control, 1 patient had persistent generalized lymphadenopathy (PGL, group III), whereas 10 patients were classified in group IV, which includes subjects with clinical symptoms and signs of HIV-1 infection other than, or in addition to, lymphadenopathy (4 patients in subgroup IV-A, and 6 in subgroup IV-C1). BAL was performed to obtain a specific diagnosis of opportunistic infection, according to our study protocol for HIV-1 patients with pulmonary involvement. Pneumocystis carinii infection was detected in the BAL or transbronchial lung biopsy of all subgroup IV-C1 patients. In accordance with the guidelines of the Helsinki declaration, this invasive procedure was performed only for diagnostic purposes when a pulmonary complication was suspected.

Preparation of BAL cell suspensions. BAL was performed as previously described. Briefly, a total of 200 to 250 mL of saline solution was injected via fiberoptic bronchoscopy in 25-mL aliquots, with immediate vacuum aspiration after each aliquot. The fluid was filtered through gauze and its volume measured; 57.1% ± 6.6% of the injected fluid was recovered. BAL cells were then washed, resuspended in RPMI 1640 supplemented with 20 mmol HEPES and L-glutamine (Sigma Chemical Co, St Louis, MO), and counted. Macrophages, lymphocytes, neutrophils, and eosinophils were dif-
Table 1. Cell Retrieval by BAL, and the Percentage and Absolute Number of Alveolar Macrophages, Lymphocytes, CD4, and CD8 Cells in 11 HIV-1-Infected Patients

<table>
<thead>
<tr>
<th>Patients</th>
<th>Code No.</th>
<th>CDC Stage</th>
<th>Cell Recovery x10^6 mL</th>
<th>Alveolar Macrophages %</th>
<th>x10^9 mL</th>
<th>BAL Lymphocytes</th>
<th>BAL CD4+ Lymphocytes %</th>
<th>x10^9 mL</th>
<th>BAL CD8+ Lymphocytes %</th>
<th>x10^9 mL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>IV-A</td>
<td>369</td>
<td>55</td>
<td>203</td>
<td>45</td>
<td>168</td>
<td>0.7</td>
<td>1.1</td>
<td>92</td>
<td>152</td>
</tr>
<tr>
<td>2</td>
<td>IV-C1</td>
<td>57</td>
<td>95</td>
<td>54</td>
<td>5</td>
<td>3</td>
<td>3.5</td>
<td>0.02</td>
<td>88</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>IV-C1</td>
<td>53</td>
<td>98</td>
<td>52</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>0.05</td>
<td>60</td>
<td>0.6</td>
</tr>
<tr>
<td>4</td>
<td>IV-C1</td>
<td>412</td>
<td>12</td>
<td>36</td>
<td>88</td>
<td>262</td>
<td>1.6</td>
<td>4</td>
<td>92</td>
<td>204</td>
</tr>
<tr>
<td>5</td>
<td>III</td>
<td>342</td>
<td>35</td>
<td>119</td>
<td>65</td>
<td>222</td>
<td>0.8</td>
<td>1.5</td>
<td>75</td>
<td>425</td>
</tr>
<tr>
<td>6</td>
<td>IV-A</td>
<td>450</td>
<td>83</td>
<td>373</td>
<td>17</td>
<td>76</td>
<td>3.6</td>
<td>0.6</td>
<td>70</td>
<td>53</td>
</tr>
<tr>
<td>7</td>
<td>IV-C1</td>
<td>777</td>
<td>27</td>
<td>209</td>
<td>73</td>
<td>567</td>
<td>0.8</td>
<td>1.5</td>
<td>75</td>
<td>425</td>
</tr>
<tr>
<td>8</td>
<td>IV-C1</td>
<td>110</td>
<td>52</td>
<td>68</td>
<td>48</td>
<td>52</td>
<td>2.6</td>
<td>0.5</td>
<td>87</td>
<td>45</td>
</tr>
<tr>
<td>9</td>
<td>IV-A</td>
<td>75</td>
<td>48</td>
<td>36</td>
<td>52</td>
<td>39</td>
<td>1</td>
<td>0.04</td>
<td>91</td>
<td>28</td>
</tr>
<tr>
<td>10</td>
<td>IV-A</td>
<td>425</td>
<td>62</td>
<td>263</td>
<td>38</td>
<td>161</td>
<td>0.7</td>
<td>1.1</td>
<td>78</td>
<td>125</td>
</tr>
<tr>
<td>11</td>
<td>IV-C1</td>
<td>817</td>
<td>50</td>
<td>408</td>
<td>48</td>
<td>392</td>
<td>4.7</td>
<td>18</td>
<td>94</td>
<td>368</td>
</tr>
</tbody>
</table>

Controls: 150.6 ± 35.1

Abbreviation: CDC, Centers for Disease Control.

Ferentially counted in cytocentrifuged smears stained with Wright-Giemsa (Table 1).

BAL T-cell subsets were characterized by monoclonal antibodies (MoAbs) of the OK (Ortho Pharm, Raritan, NJ) and Leu (Becton Dickinson, Sunnyvale, CA) series, including CD2 (OKT11), CD3 (Leu 4, OKT3), CD4 (Leu 3, OKT4), and CD8 (Leu 2, OKT8). The frequency of cells positive for the above MoAbs was determined by flow cytometry, as described. Cells were analyzed using a FACScan (Becton Dickinson) and fluorescein isothiocyanate (FITC)- and phycoerythrin (PE)-conjugated MoAbs; data were processed using the Consort 30 and Lysys programs (Becton Dickinson). Table 1 reports the differential counts of the T lymphocyte subsets retrieved by BAL in the individual patients.

Purification of alveolar macrophages (AMs), lung T cells, and CD8 cells. AMs and lung T cells were enriched from the entire mononuclear cell suspension by rosetting with neuraminidase (Sigma)-treated sheep red blood cells (SRBC) followed by repeated cyto centrifugation smears stained with Wright-Giemsa. AMs and lung T cells were enriched from the entire mononuclear cell suspension by rosetting with neuraminidase (Sigma)-treated sheep red blood cells (SRBC) followed by repeated centrifugation smears stained with Wright-Giemsa.

HIV-1 detection and expression in BAL cell suspensions. The amount of HIV-1 proviral copies in patient cells was determined by the PCR technique, as described, using serial dilutions of 8E51 cells that contain one proviral copy per cell as a standard reference curve. Briefly, 8E51 cells were serially diluted in 1 x 10^5 A301 HIV-1-negative cells; amplification by PCR was accomplished directly on 1 x 10^5 lysed cells in 100 µL of reaction mixture containing 50 pmol of each of the primers SK29 and SK30, 40 µmol of each deoxynucleotide triphosphate (dNTP), 2.5 U of Taq DNA polymerase (Perkin-Elmer, Norwalk, CT), 50 mM/L KCI, 10 mM/L Tris-HCl (pH 8.3), and 1.5 mM/L MgCl2. Target DNA was amplified using a DNA thermal cycler (GeneAmp PCR System 9600; Perkin-Elmer); 30 cycles were performed, each of 30 seconds at 94°C, 30 seconds at 56°C, and 30 seconds at 72°C. To control the reaction and the quality of the DNA to be amplified, PC03/PC04 primers specific for the β-globin gene were used. Thirty microliters of each amplified sample were electrophoresed on agarose gel and transferred to Nytran filters (Amersham Int, Little Chalfont, Buckinghamshire, UK). Hybridization was achieved with a 5' end 32P-labeled SK31 oligonucleotide probe, as described; filters were exposed to x-ray films for 24 hours. Under our experimental conditions, the

Table 2. Viral Burden in Unfractionated BAL Cells and Highly Purified AMs, BAL T Cells, and CD8 Cells

<table>
<thead>
<tr>
<th>Patients</th>
<th>Copies/10^6 Unfractionated BAL Cells</th>
<th>Copies/10^6 Purified AMs</th>
<th>Copies/10^6 Unfractionated T Cells</th>
<th>Copies/10^6 Enriched CD8 Cells</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>396</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>2</td>
<td>9</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>3</td>
<td>8</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>4</td>
<td>108</td>
<td>57</td>
<td>388</td>
<td>—</td>
</tr>
<tr>
<td>5</td>
<td>9</td>
<td>29</td>
<td>750</td>
<td>—</td>
</tr>
<tr>
<td>6</td>
<td>7</td>
<td>6</td>
<td>114</td>
<td>—</td>
</tr>
<tr>
<td>7</td>
<td>191</td>
<td>400</td>
<td>569</td>
<td>—</td>
</tr>
<tr>
<td>8</td>
<td>32</td>
<td>4</td>
<td>—</td>
<td>9</td>
</tr>
<tr>
<td>9</td>
<td>212</td>
<td>55</td>
<td>—</td>
<td>162</td>
</tr>
<tr>
<td>10</td>
<td>36</td>
<td>73</td>
<td>—</td>
<td>33</td>
</tr>
<tr>
<td>11</td>
<td>252</td>
<td>3</td>
<td>52</td>
<td>—</td>
</tr>
</tbody>
</table>

— Samples not available.

* The incompleteness of data in the table is a consequence of the fact that it is unrealistic to obtain absolutely pure populations of CD4 and CD8 cells from the lung at the same time and in the same sample. We chose to enrich for CD8 cells, because this subset represented the target of our research.
following a two-step sequential depletion procedure with magnetic microspheres, the CD8+ T cells obtained from the BAL of four HIV-1-infected subjects (cases 8 to 11; two from subgroup IV-A and two from subgroup IV-C) were more than 99% pure, and contained less than 0.01% residual CD4+ cells (Fig 1). We found (Table 2, cases 8 to 11) that lung CD8+ cells harbor detectable amounts of HIV-1 DNA sequences (9, 162, and 52 proviral copies/100,000 cells, respectively), of the PCR. Amplification of HTLV-I and HTLV-II sequences was performed exactly as reported elsewhere.22

RESULTS AND DISCUSSION

HIV-1 expression in unfractionated BAL cell populations, AMs, and pulmonary T cells is reported in Table 2. Although HIV-1 DNA sequences could be demonstrated in all unfractionated BAL cell samples, the degree varied, with the viral burden ranging from 7 to 396 proviral copies/100,000 cells. Analysis of AMs and T-cell--enriched populations (Table 2, cases 4 to 7) disclosed that HIV-1 DNA was present in both, but the difference in the proviral load among the cell subsets was striking because in all cases 10^9 BAL T cells harbored higher quantities of HIV-1 DNA copies than 10^6 AMs. This finding was unexpected because, as seen in Table 1, BAL T cells accounting for the alveolitis in the lungs of AIDS patients are mainly T lymphocytes that express the CD8+ phenotype.23

The presence of proviral DNA in circulating CD8+ cells was previously reported in vitro models only, and attempts to infect highly purified populations of CD8+ cells directly have been unsuccessful to date.24-27 To investigate whether lung CD8+ cells might represent an in vivo target for HIV-1 infection, highly enriched cell suspensions of BAL CD8+ lymphocytes were analyzed for the presence of proviral HIV-1 DNA. After repeated CD4+ cell depletions by rosetting with magnetic microspheres, the CD8+ T cells obtained from the BAL of four HIV-1--infected subjects (cases 8 to 11; two from subgroup IV-A and two from subgroup IV-C) were more than 99% pure, and contained less than 0.01% residual CD4+ cells (Fig 1). We found (Table 2, cases 8 to 11) that lung CD8+ cells harbor detectable amounts of HIV-1 DNA sequences (9, 162, 33, and 52 proviral copies/100,000 cells, respectively). When values obtained in enriched cell subsets were calculated per 10^6 unfractionated BAL cells according to the cell percentage in BAL suspension, we found that the sum of HIV-1 DNA copies in AMs and T-cell populations was always higher than that obtained directly on the unfractionated 10^6 BAL cells. Conversely, the sum of values ob-
tained in lung CD8+ cells and AMs were in all but one (case 10) lower than that observed directly on the unfractionated 10^5 BAL cells. Although these considerations might indicate that most of the proviral DNA in the lung is contained within the CD4+ lymphocytes, possibly in a CD4 subset underrepresented in the unfractionated BAL cells, PCR analysis directly performed on the CD8+ cell subset showed that this population carries HIV-1 DNA (Table 2).

To avoid the possibility that contaminating CD4+ cells might have accounted for this finding, PCR analysis was performed on serial dilutions of CD8+ cells obtained as above, as well as of BAL and AM cells. As shown in Fig 2B, in two representative patients, one with high (case 9) and one with low (case 10) viral burden, PCR findings were positive in unseparated BAL preparations, CD8, and AM cell samples at a 10^4 cell dilution. The negative PCR findings at a 10^3 cell dilution of case 9’s BAL and CD8 cell samples, which carried 212 and 162 HIV-1 copies/10^5 cells, respectively (Fig 2B), may be partially explained by the PCR sensitivity, but could also indicate a nonlinear distribution of HIV-1 provirus/cell. This last possibility was strengthened by the finding that the intensity of the PCR signals in the diluted serial samples was not linearly related to the number of amplified cells (Fig 2B). Because HIV-1 DNA was detected at a 10^3 cell dilution, we could rule out the possibility that our PCR results were caused by contaminating CD4+ cells, which were less than 1 in this sample dilution.

To determine whether the BAL CD8+ cell infection was quiescent or productive, we studied HIV-1 expression by RT-PCR. RNA from CD8+ cells of case 9 was retrotranscribed in vitro, and cDNA was amplified with primers specific for the gene encoding the structural protein of the viral envelope. As shown in Fig 2C, positive PCR results were observed at both 10^5 and 10^6 cell equivalents of starting RNA. Although the RT-PCR we performed was not quantitative, it is evident that the intensity of the PCR signals was consistently lower (<100-fold in OD values) than that detected in the corresponding 10^5 and 10^6 positive 8E51 cell controls. These findings were compatible with the lower number of cells carrying HIV-1 in the patient’s CD8 cell sample (162 HIV-1 copies/10^5 cells) compared with the 8E51 cell control (1 HIV-1 copy/cell), and clearly proved that HIV-1 RNA was present in the CD8+ cells.

Our data definitely show that lung CD8+ cells harbor and express HIV-1, and thus indicate that not only CD4+ but also CD8+ cells may represent an in vivo reservoir for HIV-1. This finding prompts several considerations regarding the pattern of infectivity of HIV-1 and the pathways of tissue spread. Like other tissue macrophages, AMs represent a reservoir for monocytotropic HIV-1 strains from which new viral variants may be generated. This event and the concomitant in situ release of cytokines is likely to cause a slow, but progressive impairment in local immune surveillance, ultimately leading to the development of pulmonary complications. Besides confirming the hypothesis that HIV-1 infection of AMs plays a central role in the pathogenesis of lung involvement, our data also suggest an unexpected in vivo infectivity of HIV-1 toward the pulmonary CD8+ cell population.

Among the mechanisms that make pulmonary CD8+ cells susceptible to HIV-1 infection in vivo, an obvious explanation stems from recent in vitro studies showing that HIV-1 transmission may occur through cell-to-cell contact between persistently infected CD4+ cells and CD8+ lymphocytes. In this regard, Plata et al demonstrated that pulmonary MHC-restricted CTL recognize and lyse HIV-1 infected CD4+ target cells, including autologous AMs and lung CD4+ fibroblasts. Because it was recently shown that HIV-1 can spread to CD8+ CTL during the process of killing in vitro, it is thus conceivable that the repeated contact occurring in the lung microenvironment between activated HIV-1-specific CTL and relevant targets could ultimately lead to the infection of CD8+ cells. If this were the case, the net effect of the presence of HIV-1 in lung CD8+ lymphocytes, as shown by our findings, could account for a progressive
decrease in pulmonary HIV-1-specific CTL activity, which characterizes the endstage disease. Further longitudinal studies on a series of patients in different stages of the HIV infection are needed to define whether the intensity of viral burden in CD8⁺ cells plays a central role in the progressive loss of the in situ cytotoxic activity, and thus in the progression of the pulmonary disease.

An additional, and not necessarily alternative, hypothesis to explain the susceptibility of CD8⁺ lymphocytes to HIV-1 infection rests on the fact that these cells derive from precursors that coexpress CD4 and CD8 antigens at a distinct stage of differentiation in vivo. In view of the recent suggestion that secondary lymphoid follicles of the lung act as reservoirs for HIV-1, it is possible that HIV-1-infected CD8⁺ lymphocytes might originate from virgin T cells that transiently coexpress CD4 and CD8 in the secondary lymphoid tissues before relevant antigenic stimulation takes place. In this light, and prompted by the observation that the double-positive (CD4⁺/CD8⁺) peripheral T-cell subset in HIV-infected patients was increased, we evaluated the frequency of double-positive BAL lymphocytes in 35 HIV-1-infected patients; no increase in this subset was found, and the mean double-positive CD4⁺/CD8⁺ cells in the BAL of our case series was 0.1% ± 0.04%.

To further test the hypothesis that we were dealing with CD8⁺ cells derived from double-positive CD4⁺/CD8⁺ cells that have shed the CD4 molecule during their differentiation, we evaluated CD4 gene expression on highly purified CD8⁺ cells obtained from a patient (case 11 in Table 1) with a CD8⁺ high-intensity alveolitis (Fig 3A); we found detectable amounts of RNA for the CD4 molecule (Fig 3B). In other words, despite the lack of membrane CD4 reactivity, this CD8⁺-enriched cell fraction expressed CD4 molecule RNA, further supporting the above concept that these cells might originate from mature T cells that had transiently coexpressed the CD4 and CD8 determinants.

We and others previously demonstrated that HTLV-I-transformed CD8⁺ cell lines are susceptible to in vitro infection by HIV-1. Moreover, Lusso et al found that HHV-6 induces CD4 antigen expression on CD8⁺ cells, thus allowing their in vitro infection by HIV-1 strains. To evaluate whether these viral agents make the pulmonary CD8⁺ cells susceptible to HIV-1 infection, we tested BAL T cells...
for the presence of HHV-6 and HTLV-I/HTLV-II sequences. As reported in Fig 4, we were unable to find any HTLV-I/HTLV-II proviral DNA, nor any HHV-6 DNA.

In conclusion, this study provides the demonstration that CD8+ lymphocytes represent a potential cell target for HIV-1 not only in vitro but also in vivo. In addition, our findings seem to indicate that a particular CD8 cell population expressed enough CD4 molecules during its in vivo development to become permissive to the subsequent HIV-1 infection. In turn, the presence of HIV-1 in the infected cells may have downregulated the expression of the CD4 molecule itself on the cell membrane.39 To fully understand whether this double-positive subpopulation is implicated in HIV-1 infection spread to the lung, the HIV-1 burden should be quantified during the development of the pulmonary CTL immune response. However, our data do not exclude the possibility that coinfection of pulmonary T cells by the above cited or other viral agents before their memory differentiation step could lead to an increased CTL precursor sensitivity to HIV-1 infection.

ACKNOWLEDGMENT

The authors thank their colleagues from the Departments of Infectious Diseases and Pulmonary Medicine of the Padua Hospital, in particular Drs P. Cadrobbi and A. Cipriani, who contributed to this project by allowing the study of their patients and performing the bronchoscopy. We are thankful to Prof D. Collavo for reviewing the manuscript. We also thank Dr Antonella Milani and Sandra Cagnin for their expert technical assistance and Patricia Segato for help in the preparation of the manuscript.

REFERENCES


25. De Maria A, Pantaleo G, Schnittman SM, Grenhouse JJ, Ba-


CD8+ T lymphocytes in the lung of acquired immunodeficiency syndrome patients harbor human immunodeficiency virus type 1

G Semenzato, C Agostini, L Ometto, R Zambello, L Trentin, L Chieco-Bianchi and A De Rossi