Rapid Communication

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.

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ferratically 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
F/H gradient separations, as described. The resulting nonrosetting
cell population was composed of more than 95% macrophages,
whereas the rosetting population contained more than 99% T cells,
as determined by positivity on nonspecific esterase staining and the
percentage of CD3+, CD19+, and CD16+ cells.

CD8 cells were further purified from the T-cell suspension by a
two-step sequential depletion using magnetic separations over col-
lums (Mini MACS; Miltenyi Biotech, Sunnyvale, CA), as de-
scribed. Briefly, the T-cell suspensions were incubated for 30 min-
utes at 4°C with magnetic beads coated with anti-CD4 MoAb (Leu3).
The cells rosetting with the antibody-coated beads were then iso-
lated, and removed by applying a magnetic system on the outer
wall of the columns. The CD4-depleted cell population was further
incubated with anti-CD8 MoAb (Leu2a)-coated microbeads for 45
minutes at 4°C, and the CD8+ rosetting cells immobilized on the
columns were then collected. By means of this multistep selection
procedure, we obtained enough CD8+ cells to perform molecular
analyses in 4 cases (8 to 11 in Table 2). The purity of the CD8+ lymphocyte populations thus obtained exceeded 99%, with virtually
no detectable residual CD4+ cells (see Fig 1); viability was more
than 99%, as judged by the trypan blue exclusion test.

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 10^2 A301

### 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 % x10^4/mL</th>
<th>BAL Lymphocytes % x10^6/mL</th>
<th>BAL CD4+ Lymphocytes % x10^6/mL</th>
<th>BAL CD8+ Lymphocytes % x10^6/mL</th>
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<tr>
<td>1</td>
<td>IV-A</td>
<td></td>
<td>369</td>
<td>55</td>
<td>45</td>
<td>0.7</td>
<td>92</td>
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<td></td>
<td>57</td>
<td>95</td>
<td>5</td>
<td>3.5</td>
<td>88</td>
</tr>
<tr>
<td>3</td>
<td>IV-C1</td>
<td></td>
<td>53</td>
<td>98</td>
<td>2</td>
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<td>60</td>
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<tr>
<td>4</td>
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<td>12</td>
<td>88</td>
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<tr>
<td>5</td>
<td>III</td>
<td></td>
<td>342</td>
<td>35</td>
<td>17</td>
<td>3.6</td>
<td>70</td>
</tr>
<tr>
<td>6</td>
<td>IV-A</td>
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<td>450</td>
<td>83</td>
<td>17</td>
<td>3.6</td>
<td>70</td>
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<td>27</td>
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<td>0.7</td>
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<tr>
<td>11</td>
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<td>817</td>
<td>50</td>
<td>48</td>
<td>4.7</td>
<td>94</td>
</tr>
<tr>
<td>Controls</td>
<td></td>
<td></td>
<td>150.6 ± 35.1</td>
<td>90.2 ± 5.1</td>
<td>135.2 ± 29.4</td>
<td>8.0 ± 1.6</td>
<td>25.4 ± 1.7</td>
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Abbreviation: CDC, Centers for Disease Control.

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

<table>
<thead>
<tr>
<th>HIV-1 Proviral DNA</th>
<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>
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<tbody>
<tr>
<td></td>
<td>1</td>
<td>396</td>
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<td>-</td>
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<td></td>
<td>4</td>
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<td>57</td>
<td>388</td>
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<td></td>
<td>5</td>
<td>9</td>
<td>29</td>
<td>750</td>
<td>-</td>
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<td></td>
<td>6</td>
<td>7</td>
<td>6</td>
<td>114</td>
<td>-</td>
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<tr>
<td></td>
<td>7</td>
<td>191</td>
<td>400</td>
<td>569</td>
<td>-</td>
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<td></td>
<td>8</td>
<td>32</td>
<td>4</td>
<td>-</td>
<td>9</td>
</tr>
<tr>
<td></td>
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<td>212</td>
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<td>-</td>
<td>162</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>36</td>
<td>73</td>
<td>-</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>252</td>
<td>3</td>
<td>-</td>
<td>52</td>
</tr>
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</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.
sensitivity of PCR in 8E51 cell samples was the detection of as few as 1 to 10 HIV-1 copies in 10^5 cells; samples containing 10 HIV-1 cells (corresponding to 10 HIV-1 proviruses) were invariably positive.\textsuperscript{12,17,18} The amplified products were quantified by densitometer analysis (Ultrascan LX Enhancer Laser Densitometer; LKB, Bromma, Sweden). The relationship between OD values and the number of 8E51 cells (proviruses) was tested by linear regression analysis using a biomedical computer program (Statistical Analysis System Institute, Cary, NC). In this set of experiments, optical density (OD) values were linearly related up to 5,000 HIV copies for 10^5 cell equivalents of RNA was incubated at 42°C for 30 minutes with 50 pmol of antisense primer SK69,\textsuperscript{14} 1 mmol/L of each dNTP, 1 U of RNase inhibitor, 2.5 U of reverse transcriptase (RT) (Perkin-Elmer), 50 mmol/L KCl, 10 mmol/L Tris-HCl, and 5 mmol/L MgCl_2 in a total volume of 20 \mu L. RT was inactivated by incubation for 5 minutes at 99°C. The total volume of each RT reaction was subjected to 30 cycles of PCR (30 seconds at 94°C, 30 seconds at 56°C, 30 seconds at 72°C) in the presence of 50 pmol of each of the primers SK68 and SK69, 20 nmol of each dNTP, 2.5 U of Taq polymerase, 50 mmol/L KCl, 10 mmol/L Tris-HCl, and 2 mmol/L MgCl_2 in a total volume of 100 \mu L. Thirty microliters of each amplified sample was electrophoresed and transferred to Nytran filters. Hybridization was achieved with 5' and 32P-labeled SK70' oligonucleotide probe as described elsewhere.\textsuperscript{19} RNA from 8E51 cells was used as a positive control of the PCR reaction.

**CD4-mRNA detection by RT-PCR.** The same RT-PCR protocol described above was used to investigate the presence of CD4-mRNA in highly purified CD8+ cells; the primer pair used was CD4.1 and CD4.2, and the oligonucleotide probe was CD4.3.\textsuperscript{19} Samples underwent 35 PCR cycles, each of 50 seconds at 94°C, 50 seconds at 58°C, and 1 minute at 72°C. RNAs extracted from MOLT-3 CD4+ and Raji B cells were used as the positive and negative controls, respectively, of the PCR.

**HHV-6 and HTLV-I/II detection by PCR.** We investigated the presence of HHV-6 or HTLV-I/II sequences in patient cells using the PCR technique. Sample preparation and reagent concentrations for the PCR were the same as described for HIV-1 DNA PCR. Briefly, to amplify HHV-6 sequences, 30 cycles of PCR were performed using the HHV-6.1/HHV-6.2 primer pair,\textsuperscript{22} each cycle consisted of 1 minute at 95°C, 1 minute at 55°C, and 1 minute and 30 seconds at 72°C. HHV-6.3 was used as the oligonucleotide probe for the detection of amplified samples. The pZVH14 plasmid\textsuperscript{21} was used as the positive control of the PCR. Amplification of HTLV-I and HTLV-II sequences was performed exactly as reported elsewhere.\textsuperscript{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 10^5 BAL T cells harbored higher quantities of HIV-1 DNA copies than 10^5 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.\textsuperscript{23}

The presence of proviral DNA in circulating CD8+ cells was previously reported in in vitro models only, and attempts to infect highly purified populations of CD8+ cells directly have been unsuccessful to date.\textsuperscript{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, and 52 proviral copies/100,000 cells, respectively). When values obtained in enriched cell subsets were calculated per 10^5 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 10^5 BAL cells. Conversely, the sum of values ob-
LUNG CD8+ T CELLS HARBOR HIV-1

A

8E51 cells

105 bp -

B

BAL cells

CD8- cells

AM cells

105 bp -

105 bp -

C

RT+

RT-

142 bp -

Fig 2. HIV-1 detection and expression on BAL cells. (A) Quantitative determination of HIV-1 proviral copies by PCR. Serial dilutions of 8E51 cells, which contain 1 provirus/cell, were processed by PCR; the amplified products (105 bp) were hybridized with a specific 32P-labeled probe, and quantified by densitometer analysis. A standard curve was obtained by plotting OD values against the cell (provirus) number. The negative control was represented by HIV-1 uninfected A301 cells. (B) Distribution of HIV-1 DNA in BAL cell subset of two representative patients, case 9 (upper panel) and case 10 (lower panel). Serial dilutions of total BAL cells, AMs, and CD8- cells were analyzed by PCR as reported in (A). The number of HIV-1 copies/10^6 cells was obtained by interpolation of OD values with the reference curve. (C) HIV-1 expression in CD8- cells. RNA was extracted from CD8- cells of patient 9; 1 x 10^5 and 1 x 10^3 cell equivalents of RNA were 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 10^3 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 10^6 and 10^5 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 monocytophagocytic HIV-1 strains from which new viral variants may be generated. This event and the consequent 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. It is 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 an HIV-infected patient 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. 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 coinfected 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.

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REFERENCES

25. De Maria A, Pantaleo G, Schnittman SM, Grenhouse JJ, Ba-
Infection of CD8+ T lymphocytes with HIV. Requirement for interaction with infected CD4+ cells and induction of infectious virus from chronically infected CD8+ cells. J Immunol 146:2220, 1991
CD8+ T lymphocytes in the lung of acquired immunodeficiency syndrome patients harbor human immunodeficiency virus type 1

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