Asymptomatic urethritis and detection of HIV-1 RNA in seminal plasma

A J Winter, S Taylor, J Workman, D White, J D C Ross, A V Swan, D Pillay

Objective: To define risk factors for detection of HIV-1 RNA in semen in men attending the two largest HIV clinics in the West Midlands.

Methods: 94 HIV-1 seropositive men at any stage of infection donated matched semen and blood samples. 36 subjects (38%) were on no antiretroviral treatment, 12 (13%) were on dual therapy, and 46 (49%) were on three or more drugs. Median CD4 count was 291 cells × 10^3/µl. 87 subjects underwent a urethritis screen (Gram stained urethral smear and culture for gonococci, and LCR for Chlamydia trachomatis on first pass urine). Quantitative cell free HIV-1 RNA was determined by commercial nucleic acid sequence based assay with a lower detection limit of 800 copies/ml for semen and 400 copies/ml for blood. Independent risk factors for seminal HIV RNA detection were defined by logistic regression.

Results: In univariate analysis, subjects not taking antiretrovirals were 11 times more likely to shed HIV RNA (21/36 (58%) vs 6/58 (10%); p<0.0001). Seven subjects (8%) had urethritis (including one C trachomatis infection). Urethritis was significantly associated with detection of seminal HIV RNA (adjusted OR, 80.2; p=0.006), as was blood plasma viral load (adj OR, 19.3 per factor 10 increase; p<0.001) and age (adj OR, 1.16 per 1 year older; p=0.001). Antiviral treatment status, absolute CD4 and CD8 count, clinical stage, treatment centre, ethnicity, and risk factor were not independent predictors. No subject with undetectable blood viral load had detectable seminal HIV RNA.

Conclusion: Asymptomatic urethritis is independently associated with seminal HIV RNA shedding.

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Keywords: semen; nucleic acid sequence based amplification; HIV transmission

Introduction

Sexual transmission of HIV by males is determined in part by the amount of infectious HIV in the semen. HIV-1 RNA can be detected in the seminal plasma of the majority of HIV infected men and in general correlates with infectious HIV determined by cell culture and with the amount of HIV RNA in blood plasma. Antiretroviral treatment reduces seminal HIV RNA and seminal HIV proviral DNA in most patients, but a significant minority continue to shed HIV RNA. Symptomatic genital tract inflammation greatly increases seminal viral load, but the possible role of asymptomatic urethritis in increasing seminal HIV RNA levels has not been explored. We investigated this by measuring the amount of HIV RNA in the semen of HIV seropositive men who were free of genital tract symptoms and agreed to be tested for urethritis.

Methods

STUDY POPULATION, URETHRITIS SCREENING, SEMEN, AND BLOOD SAMPLES

Seropositive men attending one of two teaching hospital HIV treatment centres in Birmingham, were eligible to enter the study if they were free of genital tract symptoms and willing to provide a semen sample. Subjects were screened for non-specific urethritis, gonorrhoea, and Chlamydia trachomatis as follows. A urethral smear for Gram stain was obtained by inserting a plastic loop 2 cm into the distal urethra. “Urethritis” was defined as the presence of more than five pus cells per high power field. Gonococcal isolation was attempted by direct inoculation of urethral material onto selective medium, and the presence of C trachomatis plasmid DNA was investigated by ligase chain reaction (LCR) on first pass urine. Semen samples were provided by masturbation into a dry sterile container. A matched blood sample was obtained within 4 hours. Absolute CD4 and CD8 lymphocyte counts were determined by routine flow cytometry on a sample taken within 1 month of semen sampling. Clinical stage was assigned according to the 1993 Centers for Disease Control and Prevention (CDC) criteria. All participants gave fully informed consent and the study was approved by the local research ethics committee.

SAMPLE PROCESSING, QUANTITATION OF HIV RNA

Samples of blood and liquified semen were separated by centrifugation (3 000 rpm, 10 minutes) within 6 hours. Aliquots of plasma were stored at −70°C and analysed within 12 months. Quantitative HIV RNA in seminal and blood cell free plasma was determined with a commercial nucleic acid sequence based assay (NASBA; NucliSens HIV-1 QT; Organon Teknika). Samples were processed according to the manufacturer’s instructions, except that an additional microcentrifugation step (13 000 rpm, 20 minutes) was required to pellet all seminal cells, and, to reduce inhibition, only 100 µl of seminal plasma was used. The lower
Table 1  Detection of semen and blood plasma HIV RNA according to antiretroviral treatment status

<table>
<thead>
<tr>
<th>Antiretroviral treatment (n=58)*</th>
<th>No antiretroviral treatment (n=36)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median blood plasma viral load (log_{10} copies/ml; median (range))</td>
<td>2.6 (2.6 to 5.0)</td>
</tr>
<tr>
<td>Median semen plasma viral load (log_{10} copies/ml; median (range))</td>
<td>2.9 (2.9 to 4.4)</td>
</tr>
<tr>
<td>Proportion of subjects with detectable seminal plasma HIV RNA</td>
<td>6/58 (10%)</td>
</tr>
</tbody>
</table>

Cut off for detection of plasma HIV RNA by NASBA assay was 800 copies/ml for semen and 400 copies/ml for blood.

*Number of drugs: dual therapy (n=12), triple therapy or greater (n=46).
†by Mann–Whitney U test.
‡by Fisher’s exact test.
Urethritis and seminal HIV RNA 

2.6–144; p<0.001) and age (odds ratio 1.16 per 1 year older; 95% CI 1.05–1.28; p=0.001). The remaining factors were not independently associated with seminal HIV RNA detection.

Discussion

In this group of 94 HIV seropositive men independent risk factors for detection of seminal HIV RNA were the presence of asymptomatic urethritis, an increase in blood viral load and older age. Eight per cent of subjects tested had unsuspected asymptomatic urethritis, including one with C trachomatis infection. Symptomatic genital tract inflammation increases seminal viral load,1–6 but sufferers are likely to seek treatment and reduce sexual activity. Asymptomatic infections which remain undetected will blunt any impact of antiretroviral treatment in reducing sexual transmission of HIV. Not only will they increase seminal HIV RNA shedding, but patients who acquire sexual infections are the very ones most likely to be engaging in less safe sex, and are therefore more likely to transmit HIV.

In parallel with other reports, we found that subjects whose blood HIV viral load responded well to antiretroviral therapy also exhibited good suppression of HIV in the seminal compartment.3–5 At particular risk of seminal HIV RNA shedding were subjects who had recently changed therapy because of antiretroviral failure. These subjects had comparatively high seminal HIV RNA loads compared with blood. This has major implications for transmission of drug resistant HIV, given that HIV resistance can develop independently in the seminal fluid compartment.12 Nucleic acid sequencing of the reverse transcriptase and protease genes from seminal plasma HIV RNA in these subjects is in progress. In contrast with other workers we found no independent effect of clinical stage,13 CD4 count,14 or CD8 count14 on detection of seminal HIV.

There are a number of difficulties in interpreting such cross sectional studies of seminal HIV RNA. Firstly, a proportion of men shed seminal HIV RNA intermittingly.15 16 In spite of this we demonstrated a clear correlation between seminal HIV RNA and blood plasma RNA. It is possible that some of our subjects who had undetectable seminal HIV RNA could have shed cell free HIV at another time. Secondly, although our assay detection limit was 800 copies/ml, it is possible that sexual transmission of HIV could occur at even lower levels of seminal HIV RNA. Thirdly, HIV-1 proviral DNA can be found in semen associated with sperm17 or mononuclear cells18 and this may contribute to transmissibility. We would emphasise that patients taking antiretroviral therapy who have undetectable viral loads should continue to assume that they could transmit HIV infection. We conclude that enhanced awareness of and routine testing for sexually transmitted infections within HIV care settings is essential.

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Contributors: ST and AJW designed the study with assistance from JDCR, DW, and DP; and recruited patients; JAW analysed data and wrote the initial manuscript draft; DW and JDCR oversaw the study in each centre; JW developed techniques for semen analysis with help from DP; ANV undertook the multivariate analysis and modelling. All authors commented on the final manuscript.


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