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 × 10^6/l. 87 subjects underwent a urethritis screen (Gram stained urethral smear and culture for gonococcus, 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 liquefied semen were separated by centrifugation (3000 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
Figure 1 Scatter plot showing relation between seminal and blood plasma viral load in 94 male subjects. Cut off for detection of plasma HIV RNA by NASBA assay (marked by dotted lines) was 800 copies/ml for semen and 400 copies/ml for blood. Those with both values at the lower limit (n=42) are shown as a single large circle; one of these had urethritis. Open symbol treated (on dual (n=12) or triple or greater (n=46) antiretroviral therapy). Solid symbol untreated (on no antiretroviral therapy). Large grey symbol indicates asymptomatic urethritis detected on urethral smear or C trachomatis DNA detected in first pass urine by LCR.

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>

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

Antiretroviral therapy of whom 12 were on dual nucleoside therapy alone and the remainder were on regimens which included HIV protease inhibitors or non-nucleoside reverse transcriptase inhibitors. Median CD4 count was 291 cells ×10^3/l (range 10–935) and 24 subjects (26%) were asymptomatic. The study groups in each centre were similar in terms of age, CDC stage, risk factor for HIV infection, median blood viral load, and treatment history. Eighty seven men (93%) agreed to the urethritis screen.

ASYMPTOMATIC URETHRITIS

Seven of 87 subjects (8%) had asymptomatic urethritis including one with urethral chlamydial infection. Subjects with urethritis were younger (mean age 29.3 years v 36.9 years; 95%CI for difference 2.9–12.4 years; p=0.005 by Student’s t test) but did not differ by CD4 count, clinical stage, or duration of HIV. Among the 53 subjects on antiretroviral treatment tested for urethritis, those with urethritis were over eight times more likely to shed HIV RNA than those without (2/3 with v 4/50 without; RR 8.3, p=0.03 by Fisher’s exact test).

CORRELATION BETWEEN SEMEN AND BLOOD HIV RNA AND ANTIRETROVIRAL TREATMENT

Overall, there was a significant correlation between blood and seminal plasma HIV viral load (n=94; Spearman’s ρ 0.601; p<0.001) (fig 1). In no case did we find seminal HIV RNA when blood plasma HIV RNA was undetectable. Antiretroviral therapy significantly reduced the likelihood of detecting seminal HIV RNA (see table 1). Of the six subjects taking antiretrovirals who had detectable seminal HIV RNA all had detectable blood HIV RNA and two had urethritis. Median seminal HIV RNA in these subjects was 11 000 copies/ml (range 2700–25 000), compared with a blood viral load of 1060 copies/ml (range 540–8100). All but one had initiated or changed therapy within the previous 6 weeks.

LOGISTIC REGRESSION ANALYSIS

Eighty seven subjects with complete data were included in the logistic regression analysis which allowed for urethritis, blood plasma viral load, antiviral treatment status, clinical stage, absolute CD4 and CD8 cell counts, treatment centre, age, risk factor for acquiring HIV, and ethnicity. Seminal HIV RNA detection was strongly associated with urethritis (odds ratio 80.2; 95% confidence interval 2.2–2097; p=0.008), blood plasma viral load (odds ratio 19.3 per factor of 10 increase; 95% CI,
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 *Chlamydia trachomatis* infection. Symptomatic genital tract inflammation increases seminal viral load, 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. 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.

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, CD4 count, or CD8 count 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 intermittently. 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 sperm or mononuclear cells, 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 JDRC, DW, and DP; and recruited patients; JW analysed and interpreted data and wrote the initial manuscript draft; DW and JDRC oversaw the study in each centre; JW developed techniques for seminal analysis with help from DP; AVS undertook the multivariate analysis and modelling. All authors commented on the final manuscript.


