Human Cytomegalovirus (HCMV) Replication Dynamics in HCMV-Naive and -Experienced Immunocompromised Hosts

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Human cytomegalovirus (HCMV) can infect both HCMV-naive and -experienced transplant patients. In this study, the growth rate of HCMV in HCMV-naive hosts (1.82 units/day; 95% confidence interval [CI], 1.44–2.56 units/day) was shown to be significantly faster than the growth rate of virus in HCMV-experienced hosts undergoing recurrent infection (0.61 units/day; 95% CI, 0.55–0.7 units/day; P < .0001). The basic reproductive number (R0) for HCMV-naive liver transplant patients was 15.1 (95% CI, 8.9–44) but was only 2.4 (95% CI, 2.35–2.8) for HCMV-experienced transplant recipients, corresponding to an anti-HCMV immune efficacy of ~84%, despite immunosuppressive therapy. The R0 values suggest that an anti-HCMV drug or vaccine with an efficacy of >93% (95% CI, 89%–98%) is required to eliminate viral growth during infection of HCMV-naive liver transplant recipients, whereas lower efficacy levels are sufficient to reduce the R0 value to <1 in hosts with prior HCMV immunity.

Herpesviruses, including human cytomegalovirus (HCMV), have developed elaborate cellular and immune manipulation strategies to maintain the virus-host equilibrium [1]. Thus, HCMV infection of an immunologically naive (i.e., HCMV-seronegative) immunocompetent host is usually pathologically inconsequential, and, after establishment of latency, the host suppresses HCMV replication such that reactivations (recurrent infections) are also asymptomatic. However, among T cell–immunocompromised hosts, infection of both HCMV-naive and -experienced individuals can lead to high levels of viral replication and, in many instances, results in pathological consequences [2–4]. Recent data showed that HCMV replication in vivo is a highly dynamic process [5]. In antiviral intervention studies of HCMV similar to those of human immunodeficiency virus (HIV), hepatitis B virus (HBV), and hepatitis C virus (HCV) [6–9], the doubling time of HCMV in individuals with preexisting immunity against HCMV was ~1 day [5]. These data allowed models for the rationalization and prediction of antiviral drug resistance and virus load kinetics to be developed [10] and also can be used to identify individuals who are at risk of HCMV disease [11].

Subjects, Materials, and Methods

Human subjects. We selected 30 liver transplant recipients. A subset of these subjects (n = 25) was obtained from a cohort of liver transplant described elsewhere [14]. Inclusion criteria included the availability of frequent blood samples posttransplantation to accurately estimate viral growth rates. Hence, patients had a median of 2 samples taken each week (range, 1 sample every 3.5 days to 1 sample per week). Sampling occurred during initial and subsequent hospital stays and at once-weekly outpatient clinics until 3 months posttransplantation. HCMV infection was defined as the detection of HCMV DNA by polymerase chain reaction (PCR) in the blood posttransplantation. Preexisting immunity to HCMV was defined as a pretransplant serum sample containing HCMV IgG antibodies, as determined by EIA (Biokit). Ten patients were shown to be HCMV seronegative prior to transplantation and, thus, were assigned to the HCMV-naive category for further
analyses; the remaining 20 patients were already HCMV IgG positive prior to transplantation (HCMV-experienced category).

Virologic studies. DNA was extracted from samples of whole blood (200 μL) using DNA extraction columns (Qiagen), as described elsewhere [12, 14, 15]. All samples were analyzed for the presence of HCMV DNA, using a qualitative PCR system, and any positive samples were quantified using a quantitative-competitive PCR assay. The detection limit of this assay is 200 genomes/mL. Details of these procedures have been described extensively elsewhere [12–17].

HCMV dynamics during primary infection. The basic model for HCMV replication dynamics is based on that described elsewhere for HIV and HCV [9–18]. In brief, the dynamics of infected cells are given by the following equation: \( \frac{dI}{dt} = \beta IT - \delta I \), where \( I \) is the target cell number, \( t \) is time, \( \delta \) is the death rate of infected cells, \( \beta \) is the rate of new infections occurring within the uninfected cell population, and \( I \) is the number of infected cells.

Consistent with data from in vivo and in vitro studies of low passage clinical strains of HCMV, we assumed that most infections occur through a cell-cell route. The experimentally determined growth rate \( (r) \) represents the increase in HCMV load in blood per day, such that \( I(t) = I(0)e^r t \), where \( e \) is the natural base of the logarithm. To estimate the initial growth rate of HCMV \( (r_0) \), virus load levels, derived from the dynamic model when target cell numbers were relatively well maintained, were used in the exponential growth equation. The initial viral doubling time \( (t_D) \) was determined from the slope of virus load over time.

The number of new infections derived from a single infected cell when target cells are unlimited is equivalent to \( R_0 \). To estimate \( R_0 \) for HCMV, we used 2 models used previously for HIV [18]. The first model used a fixed time delay \( (\tau) \) of 24 h between infection of the new cell and production of infectious virions. The model provides an estimate of \( R_0 \) according to the following equation: \( R_0 = 1 + (r/\delta) e^\tau \). The second model assumes that there is no time delay between initial and subsequent infection of susceptible target cells. Under these conditions, \( R_0 \) is given by the following equation: \( R_0 = 1 + (r/\delta) \).

In addition to calculating \( R_0 \) from the experimentally determined viral growth rate, the corresponding values of \( r \) derived from the model \( (r_m) \) and the initial growth rate \( (r_i) \) derived from the model were also used to determine the robustness of the estimates of \( R_0 \) obtained during the later stages of HCMV growth. In the absence of reliable in vivo estimates of the target cell number for HCMV during active infection, the values of \( R_0 \) calculated from the experimental data represent minimal estimates for \( R_0 \).

HCMV dynamics during infection of HCMV-experienced hosts. Recent models describing the dynamics of viral replication and cytotoxic T cell responses [19] were adapted for HCMV. The revised model for the growth of HCMV-infected cells during infection of HCMV-experienced individuals is therefore given by the following equation: \( \frac{dI}{dt} = \beta IT - \delta I - pE \), where the descriptors \( I, \beta, T, \) and \( \delta \) are the same as those in the basic primary infection model (see above), but the term \( pE \) reflects the removal of infected cells via the action of cytotoxic T lymphocytes (CTL); \( E \) is the number of HCMV-specific effector CTL, and \( \rho \) is the proportion of CTL-mediated lysis of infected target cells. The rate of increase of HCMV load in blood during recurrent infection was used to calculate the viral growth rate, as described above. Similarly, the \( r \) value before target cell depletion was estimated from the dynamic model. \( R_0 \) values were calculated using the fixed-delay and instantaneous models outlined above, using viral growth rates determined experimentally or from the model. In all models, multiple iterations were used, with a time interval of 0.1 day, to generate predicted virus load patterns in HCMV-naive and -experienced liver transplant recipients.

Statistical comparisons were performed between groups using the Student’s \( t \) test. The correlation between the modeled virus loads and experimentally determined loads was performed using regression methods of the log-transformed data. Comparison of peak virus load levels was performed after log transformation of the data. \( P < .05 \) was regarded as significant.

Results

HCMV replication kinetics in HCMV-naive and -experienced hosts. HCMV replication dynamics were investigated in a population of 30 liver transplant recipients with active HCMV replication. The viral doubling time of HCMV in patients with or without specific previous immunity to HCMV is shown in figure 1. The mean growth rate of virus during infection of HCMV-naive individuals was 1.82 units/day (95% confidence interval [CI], 1.44–2.56 units/day), corresponding to a viral doubling time of 0.38 units/day (~9 h; 95% CI, 0.27–0.48 units/day). Infection of patients with preexisting HCMV immunity was associated with a significantly slower viral growth rate (0.62 unit/day; 95% CI, 0.54–0.71 unit/day) and viral doubling time (1.12 days; 95% CI, 0.99–1.25 days; \( P < .0001 \)).

![Figure 1](https://academic.oup.com/jid/article-abstract/185/12/1723/900607)  
**Figure 1.** Doubling time of human cytomegalovirus (HCMV) during infection of liver transplant recipients in the presence \( (n = 10) \) or absence \( (n = 20) \) of preexisting HCMV immunity. The horizontal line for each group represents the mean value for the group; the shaded box indicates the 95% confidence interval of the mean. The vertical bars indicate the minimum and maximum values present within each data set.
HCMV naive (lower in patients with preexisting immunity than those who were previous studies [12, 14, 15], peak virus loads were significantly without preexisting immunity to HCMV. As expected from our plant recipients was 0.97 log_{10} genomes/mL blood (95% CI, mL blood (4).

Experimental data when virus loads increased to tems, provided a viral dynamic model that closely paralleled the maximum virus load achieved during active infection. The rate of viral growth, preexisting immunity also suppressed to the peak of viremia were plotted.

Mean and 95% confidence interval for HCMV loads measured prior attained during surveillance was used to normalize all patients, and the mean and 95% confidence interval for HCMV loads measured prior to the peak of viremia were plotted.

Differences in maximum HCMV load attained in HCMV-naive and -experienced hosts. To assess the influence of pre-existing immunity on the maximum level of HCMV load attained during an active infection, we analyzed the mean difference in maximum (peak) HCMV load (ΔV_{max}) between patients with or without preexisting immunity to HCMV. As expected from our previous studies [12, 14, 15], peak virus loads were significantly lower in patients with preexisting immunity than those who were HCMV naive (P = .015). The mean ΔV_{max} for the liver transplant recipients was 0.97 log_{10} genomes/mL blood (95% CI, 0.4–1.54 log_{10} genomes/mL blood). Thus, in addition to reducing the rate of viral growth, preexisting immunity also suppressed the maximum virus load achieved during active infection.

Calculation of R_{0} for HCMV during primary and recurrent infection. The experimentally determined growth rate during infection of HCMV-naive liver transplant recipients was used to calibrate a basic dynamic model of HCMV replication. The death rate of HCMV-infected cells derived from our previous studies, coupled with values of β comparable to other viral systems, provided a viral dynamic model that closely paralleled the experimental data when virus loads increased to >200 genomes/mL blood (r^2 = 0.94; P = .0002; figure 2). The model developed for the replication dynamics in patients with preexisting HCMV immunity included an additional term corresponding to the death rate of infected cells due to CTL lysis. This model produced the appropriate decrease in both viral growth rate and peak virus load and provided a good fit to the experimental data (r^2 = 0.90; P = .007). The virus load kinetics derived from the dynamic models for the liver transplant recipients are shown in figure 3. It should be noted that these models need to satisfy multiple constraints, namely differences in the replication rate in the HCMV-naive and -experienced hosts and differences in peak virus load attained during infection. The close agreement between the experimental and modeled values for viral growth rate, viral doubling time, and change in peak virus load are shown in table 1.

Estimates of R_{0} values for HCMV during infection of HCMV-naive or -experienced hosts were determined from the experimentally determined initial viral growth rate (r) and also from the initial viral growth rate (r_{0}) estimated from the model when target cells were not depleted (i.e., when virus loads were <200 genomes/mL blood). These results are shown in table 2. In the fixed-delay model, mean R_{0} values derived from the r of HCMV were 15.1 and 2.4 for infection of HCMV-naive and -experienced liver transplant recipients, respectively. When r values determined from the dynamic models were used, very similar values for R_{0} were obtained (table 2). The dynamic models indicated that, when HCMV loads are 200–5000 genomes/mL blood, target cells have not been substantially depleted; hence, r \approx r_{0}.

The differences in R_{0} values between HCMV-naive and -experienced hosts show that preexisting immunity against HCMV in liver transplant recipients has an antiviral efficacy of 84%. In addition, these estimates for R_{0} show that an anti-HCMV drug or vaccine must be ≥93.3% (95% CI, 89%–98%) effective to reduce R_{0} to <1 in HCMV-naive liver transplant recipients and ≥58.3% (95% CI, 57.5%–64%) to reduce R_{0} to <1 in HCMV-experienced patients.

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Table 1. Comparison of experimental and modeled values for human cytomegalovirus (HCMV) growth \( r \) and doubling time \( t_d \) in liver transplant recipients with (HCMV experienced) or without (HCMV naive) infection and difference in peak virus load (\( \Delta V_{\text{max}} \)) between these 2 populations.

<table>
<thead>
<tr>
<th>Group, parameter</th>
<th>Experimental value (95% CI)</th>
<th>Modeled value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HCMV naive</td>
<td></td>
</tr>
<tr>
<td>( r/\text{day} )</td>
<td>1.82 (1.44–2.56)</td>
<td>1.84</td>
</tr>
<tr>
<td>( t_d ) days</td>
<td>0.38 (0.27–0.48)</td>
<td>0.37</td>
</tr>
<tr>
<td></td>
<td>HCMV experienced</td>
<td></td>
</tr>
<tr>
<td>( r/\text{day} )</td>
<td>0.61 (0.55–0.70)</td>
<td>0.60</td>
</tr>
<tr>
<td>( t_d ) days</td>
<td>1.12 (0.99–1.25)</td>
<td>1.15</td>
</tr>
<tr>
<td>( \Delta V_{\text{max}} \log_{10} \text{genomes/mL} )</td>
<td>0.97 (0.4–1.54)</td>
<td>0.94</td>
</tr>
</tbody>
</table>

NOTE. CI, confidence interval.

Discussion

The present study of the HCMV growth rate in the early phases of viral replication in immunocompromised hosts has allowed for the first estimates of \( R_0 \) for HCMV to be obtained. These results demonstrate that preexisting immunity against HCMV reduces both the replication rate (thus increasing viral doubling time) and the peak virus load attained during active infection and thus extend our previous studies in this area. Importantly, these data illustrate that, despite the immunocompromised state of these solid-organ recipients following transplantation, the residual immune system still has functional capacity to modulate HCMV replication.

Dynamic models that paralleled the experimentally determined growth rate were generated. Modification of the HCMV-naive model by incorporating removal of infected cells through a cytotoxic T cell–mediated mechanism produced good agreement with the lower rate of viral growth and reduction in peak virus load observed during infection of patients with preexisting HCMV immunity. These models should facilitate the development of more-sophisticated models incorporating our improved knowledge of CD4+ and CD8+ T cell responses against HCMV in vivo [20–22]. The calculation of \( R_0 \) allows for an assessment of the number of newly infected cells arising from a single infected cell during the course of an infection. The natural dynamics of HCMV show that, in the early stages, the growth rate of virus approaches to \( R_0 \), whereas, at much later stages, target cell depletion results in a decrease in the viral growth rate and underestimates the \( R_0 \) value. For most patients studied here, we calculated the growth rate of the virus at the earliest stages of active HCMV replication, and estimates of \( R_0 \) thus should accurately reflect its true value. Consistent with this assumption was the use of the dynamic model to provide estimates of \( r \) and, hence, \( R_0 \) when no target cell depletion had occurred. These growth rate values produced \( R_0 \) values which were very similar to those obtained using \( r \).

Knowledge of \( R_0 \) values for HCMV in different contexts can be used to estimate the immune system’s efficacy in inhibiting HCMV replication in HCMV-experienced, compared with HCMV-naive, hosts and the efficacy of anti-HCMV therapy required to reduce \( R_0 \) to \( <1 \) and, hence, to eliminate active HCMV infection. In the case of the former, using a biologically plausible fixed-delay model for estimating \( R_0 \), the immune system reduces \( R_0 \) from 15.1 to 2.4 among liver transplant recipients, corresponding to an immune efficacy of 84%. Although these residual \( R_0 \) values are still above the critical \( R_0 \) level of 1, they demonstrate that the immune system makes a substantial contribution toward controlling HCMV replication, even in immunocompromised hosts. Indeed, this result explains why HCMV disease is predominantly found in patients undergoing primary infection. To completely control HCMV replication, the \( R_0 \) values indicate that an anti-HCMV drug or vaccine administered during the early stages of infection in an HCMV-naive host has to be \( \geq 93.3\% \) effective to fully inhibit viral growth. However, in HCMV-experienced hosts, this efficacy level is reduced to \( \geq 58.3\% \). Previous work from our laboratory has shown that the efficacy of intravenous (iv) ganciclovir (Gcv) at a dose of 5 mg/kg 2×/day is \( \sim 91.5\% \) (95% CI, 89%–94%). Hence, this dose of Gcv would be expected to reduce growth substantially in HCMV-naive liver transplant recipients (\( R_0 = 1.28 \); efficacy, 91.5%). Nevertheless, during infection of HCMV-naive liver transplant recipients, a growth rate at the upper end of the confidence interval would yield \( R_0 \) values \( >15.1 \), and, in some cases, an apparent initial inability of iv Gcv to control HCMV replication thus could be observed after initiating therapy, illustrating that antiviral resistance is not the only explanation for apparent therapeutic failure [24].

The alternate therapeutic management strategy for HCMV in immunocompromised hosts is via antiviral prophylaxis [25, 26]. The dose of Gcv used for prophylaxis (1 g by mouth 3×/day)

Table 2. Estimates of the basic reproductive number (\( R_0 \)) for human cytomegalovirus (HCMV) in naive or immune patients, based on experimental and modeled viral growth rates.

<table>
<thead>
<tr>
<th>HCMV immune status</th>
<th>HCMV growth rate, units/day</th>
<th>( R_0 ) no delay</th>
<th>( R_0 ) 24-h delay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Observed (95% CI) Modeled*</td>
<td>Observed (95% CI) Modeled</td>
<td>Observed (95% CI) Modeled*</td>
</tr>
<tr>
<td>Naive</td>
<td>1.82 (1.44–2.56) 1.85</td>
<td>3.3 (2.9–4.3) 3.4</td>
<td>15.1 (8.9–44.0) 16.3</td>
</tr>
<tr>
<td>Experienced</td>
<td>0.61 (0.55–0.70) 0.60</td>
<td>1.8 (1.7–1.9) 1.8</td>
<td>2.4 (2.35–2.8) 2.46</td>
</tr>
</tbody>
</table>

NOTE. For an explanation of the difference between “\( R_0 \), no delay” and “\( R_0 \), 24-h delay,” see Subjects, Materials, and Methods. CI, confidence interval.

* Determined when target cells were not depleted.
has an efficacy of ~46.5% (95% CI, 45%–47.5%) against wild-type strains of HCMV [10] and, therefore, will reduce the viral growth rate in both HCMV-naive and -experienced hosts. However, the resultant $R_0$ values after therapy in the liver transplant recipients would be 8.1 (HCMV-naive) and 1.31 (HCMV-experienced); therefore, at this dose of Gcv, viral growth in the HCMV-experienced host will be substantially inhibited. However, because $R_0$ in the naive host remains >1, viral growth will continue throughout the period of prophylaxis, such that, after prophylaxis is stopped, a late resurgence in viral growth will occur predominantly in HCMV-naive patients. Late HCMV infection and disease has indeed been described as an emerging clinical problem among liver transplant recipients after the cessation of oral Gcv prophylaxis [26]. The different $R_0$ values in the liver transplant recipients help explain why acyclovir, a drug with only moderate potency against HCMV, did not significantly reduce HCMV disease in these patients, compared with preemptive Gcv therapy [27].

These are a paucity of estimates of $R_0$ for acute viral infections in the human host. Recently, the primary dynamic parameters for HIV and HBV replication during acute infection have been published [18, 28], and it is interesting to compare these values with those obtained in the present study of HCMV dynamics (table 3). The early increase in HCMV load in liver transplant recipients is comparable to acute HIV infection, although peak virus load is lower during primary HCMV infection. Using the fixed-delay model, the $R_0$ value of HCMV in HCMV-naive individuals is ~22% lower than the $R_0$ value of acute HIV infection but substantially higher than the corresponding value for HBV.

In HCMV-experienced hosts, the doubling time of HCMV (~1.1 days) is substantially slower than that in acute HIV infection. However, it is faster than the doubling time observed for HIV in patients with preexisting immunity to HIV (~1.7 days) and the doubling time during acute HBV infection (~3.7 days).

In conclusion, we have defined, for the first time, $R_0$ values for HCMV replication in immunocompromised hosts with or without specific prior immunity to HCMV. These data further emphasize the rapid replication rate of HCMV in vivo and illustrate that HCMV is more similar to HIV than to HBV during infection of HCMV-naive individuals. These results also provide insight into the quantitative effects of the antiviral immune response and the efficacy levels of anti-HCMV therapy required to inhibit viral replication in different contexts. In addition, they define correlates of immune protection useful for successful vaccine development against HCMV.

### References