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the elimination of wild-type virus and its replacement by drug-resistant mutant virus. The half-life of cells infected with total virus (defective plus competent) determined by direct population sequencing and in situ RT expression was approximately 50-100 days. The half-life of cells harboring replication-competent virus determined by biological cloning and phenotypic resistance testing was biphasic, reflecting separate cell populations containing either transcriptionally-active or latent virus infection: approximately 90% of PBMCs containing replication-competent virus were eliminated within 14 days ($T_{1/2} < 5$ days), whereas another 1-10% of such cells persisted for at least 42 days. The results of these studies thus define three populations of virally-infected PBMCs. The largest population (approximately 450-800 cells per million) contains largely defective virus and exhibits a half-life of 50-100 days; a second population, much smaller (17-29 cells per million), contains actively replicating virus and is eliminated with a half-life of < 5 days, similar to lymphoreticular cells responsible for sustaining plasma viremia (*Nature* 373:117-126, 1995); a third population, still smaller (approximately 1 cell per 3.3 million), contains latent virus and exhibits a lifespan of at least 42 days. These findings indicate that although PBMCs harbor a predominately archival record of prior (abortive) viral infection, they also contain replication-competent genomes in both transcriptionally-active and latent states. These results provide a scientific framework with which to extend studies of viral and cellular dynamics into the lymphoreticular tissue compartments.

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"Quantitative Assessment of HIV Replication
and Variation *In Vivo*: Relevance to Disease
Pathogenesis and Response to Therapy"

Introduction

The natural history and pathogenesis of human immunodeficiency virus type-1 (HIV-1) infection are linked closely to the replication of virus *in vivo*¹⁻¹⁷. Clinical stage is significantly associated with all measures of virus load including infectious virus titers in blood, viral antigen levels in serum, and viral nucleic acid content of lymphoreticular tissues, peripheral blood mononuclear cells (PBMCs), and plasma (reviewed in ref. 18). Moreover, HIV-1 replication occurs preferentially and continuously in lymphoreticular tissues (lymph node, spleen, gut-associated lymphoid cells, and macrophages)^{11,19,20}; virus is detectable in the plasma of virtually all patients regardless of clinical stage^{6,10,13,21}; and changes in plasma viral RNA levels predict the clinical benefit of antiretroviral therapy (R. Coombs, unpublished). These findings emphasize the central role of viral replication in disease pathogenesis.

The current contract work entitled "Quantitative Assessment of HIV Replication and Variation *In Vivo*: Relevance to Disease Pathogenesis and Response to Therapy" (DAMD17-93-C-3146) addresses the following hypotheses: (i) HIV replication and expression, tissue burden, and genetic and biologic variability are viral parameters that are inseparably linked and which are directly related to the pathogenesis of AIDS, and (ii) Elucidation of viral pathogenesis and development of effective treatments and vaccines for HIV will be facilitated by better quantitative measures of virus replication *in vivo* and by experimental models that relate these measures of virus replication to clinically important changes in the viral envelope and reverse transcriptase genes. The specific aims that we are addressing are as follows:

1. To determine the biological and biophysical relationships between novel measures of HIV-1 replication and expression *in vivo* and to determine the potential value of these virologic parameters as surrogate markers for clinical endpoints in natural history and therapeutic

interventional trials.

2. To determine the rate and molecular characteristics of genetic change in HIV-1 envelope and reverse transcriptase (RT) genes in uncultured, PCR amplified strains of HIV-1 from patients with acute and early chronic infection (CDC stages I and II) and from later stage patients who have been treated with potent non-nucleoside RT inhibitors and have developed drug resistance. The goal of this aim is to determine the relationship between rates of viral replication measured by HIV-1 RNA, DNA, p24 Ag, and infectious virus production (specific aim #1) and the accumulation of genetic changes in specific viral genes whose products are under selective pressures *in vivo*.
3. To determine the biological and clinical consequences of HIV-1 genomic variation identified in aim #3 in regard to envelope function and antigenicity. The goal of this aim is to determine the pathogenic significance of these envelope changes by characterizing their biologic properties in the genetic background of biologically relevant proviral clones representing T-cell and monocyte tropic viruses that were obtained in the current contract period.

Body

We have made substantial progress in year 02 toward completing our objectives. Despite the obvious importance of viral replication in HIV-1 disease, relatively little quantitative information is available regarding the kinetics of virus production and clearance *in vivo*, the rapidity of virus and CD4⁺ cell population turnover, and the fixation rates of biologically-relevant viral mutations^{22,23}. This circumstance is largely due to the fact that previously available antiretroviral agents lacked sufficient potency to abrogate HIV-1 replication and methods to quantify virus and determine its genetic complexity were not sufficiently sensitive and accurate. We overcame these obstacles by treating subjects with new investigational agents that potently inhibit the HIV-1 reverse transcriptase (Nevirapine, NVP)²⁴ and

protease (ABT-538; L-735,524)^{25,26}; by measuring viral load changes using sensitive new quantitative assays for plasma virus RNA^{6,18,27}; and by quantifying changes in viral genotype and phenotype in uncultured plasma and PBMCs using automated DNA sequencing²⁸ and an *in situ* assay of RT function^{29,30}.

Virus production and clearance. Twenty-two HIV-1 infected subjects with CD4⁺ lymphocyte counts between 18 and 251/mm³ (mean \pm 1 S.D. = 102 \pm 75 cells/mm³) were treated with ABT-538 (n=10), L-735, 524 (n=8), or NVP (n=4) as part of phase I/IIA clinical studies. The design and clinical findings of those trials will be reported elsewhere (K. Squires *et al.*, in preparation; V. Johnson *et al.*, in preparation). Plasma viral RNA levels in the 22 subjects at baseline ranged from 10^{4.6} to 10^{7.2} molecules/ml (geometric mean of 10^{5.5}) and exhibited maximum declines generally within 2 to 4 weeks of initiating drug therapy (Figs. 1 and 2A). For ABT-538 and L-735,524 treated patients, virus titers fell by as much as 10^{3.9} fold (mean decrease of 10^{1.9} fold) whereas for NVP-treated patients virus fell by as much as 10^{2.0} fold (mean decrease of 10^{1.6} fold). The overall kinetics of virus decline during the initial weeks of therapy with all three agents corresponded to an exponential decay process (Fig. 1 and 2A).

The antiretroviral agents used in this study, despite their differing mechanisms of action, have a similar overall biological effect in that they block *de novo* infection of cells. Thus, the rate of elimination of plasma virus that we measured following the initiation of therapy is actually determined by two factors: the clearance rate of plasma virus *per se* and the elimination (or suppression) rate of pre-existing, virus-producing cells. To a good approximation, we can assume that virus-producing cells decline exponentially according to $y(t) = y(0)e^{-\alpha t}$, where $y(t)$ denotes the concentration of virus-producing cells at time t after the initiation of treatment and α is the rate constant for the exponential decline. Similarly, we assume that free virus $v(t)$ is generated by virus-producing cells at the rate $ky(t)$ and declines exponentially with rate constant u . Thus, for the overall decline of free virus, we obtain $v(t) = v(0)[ue^{-\alpha t} - \alpha e^{-ut}]/(u - \alpha)$. The kinetics are largely determined by the slower of the two decay processes. Since we have data only for the decline of free virus, and not for virus-producing cells, we cannot determine which of the two decay

processes is rate-limiting. However, the half-life ($T_{1/2}$) of *neither* process can exceed that of the two combined. With these considerations in mind, we estimated the elimination rate of plasma virus and of virus-producing cells by three different methods: (i) first-order kinetic analysis of that segment of the viral elimination curve corresponding to the most rapid decline in plasma virus, generally somewhere between days 3 and 14; (ii) fitting of a simple exponential decay curve to all viral RNA determinations between day 0 and the nadir or inflection point (Fig. 1); and (iii) fitting of a compound decay curve that takes into account the two separate processes of elimination of free virus and virus-producing cells, as described above. Method (i) gives a $T_{1/2}$ of 1.8 ± 0.9 days; method (ii) gives a $T_{1/2}$ of 3.0 ± 1.7 days; and method (iii) gives a $T_{1/2}$ of 2.0 ± 0.9 days for the slower of the two decay processes and a very similar value, 1.5 ± 0.5 days, for the faster one. These are averages (± 1 S.D.) for all 22 patients. Method (iii) arguably provides the most complete assessment of the data, whereas method (ii) provides a simpler interpretation (but slightly slower estimate) for virus decline because it fails to distinguish the initial delay in onset of antiviral activity due to the drug accumulation phase, and the time required for very recently infected cells to initiate virus expression, from the subsequent phase of exponential virus decline. There were no significant differences in the viral clearance rates in subjects treated with ABT-538, L-735,524, or NVP, and there was also no correlation between the rate of virus clearance from plasma and either baseline CD4⁺ lymphocyte count or baseline viral RNA level.

Virus turnover -- Direct population sequencing. As an independent approach for determining virus turnover and clearance of infected cells, we quantified serial changes in viral genotype and phenotype with respect to drug resistance in the plasma and PBMCs of four subjects treated with NVP (Fig. 2). NVP potently inhibits HIV-1 replication but selects for one or more codon substitutions in the RT gene^{24,31,32}. These mutations result in dramatic decreases (up to 1000-fold) in drug susceptibility and are associated with a corresponding loss of viral suppression *in vivo*³². Genetic changes resulting in NVP-resistance can thus serve as a quantifiable molecular marker of virus turnover. A rapid decline in plasma

viral RNA was observed following the institution of NVP therapy and this was associated with a reciprocal increase in CD4⁺ lymphocyte counts (Figs. 2A and B). Both responses were of limited duration, returning to baseline within 6-20 weeks in these four patients. The proportion of virus in uncultured plasma and PBMCs that contained NVP resistance-conferring mutations (Fig. 2C) was determined by direct automated nucleotide sequencing of viral nucleic acid (Fig. 3), as previously described²⁸. We first validated this method by reconstitution experiments, confirming its sensitivity for detecting RT mutants that comprise as little as 10% of the overall virus population. Defined mixtures of wildtype and mutant HIV-1 RT cDNA clones (differing only at the second base position of codon 190) were amplified and sequenced (Fig. 3A). Varying proportions of wildtype and mutant viral sequences present in the original DNA mixtures (mutant composition: 0%, 10%, 25%, 50%, 75%, and 100%) were faithfully represented in the relative peak-on-peak heights (and in the relative peak-on-peak areas) of cytosine (C) and guanine (G) residues at the second base position within this codon. Ratios of (mutant)/(mutant+wildtype) nucleotide peak heights expressed in arbitrary fluorescence units were as follows (predicted/observed): 0%/<10%; 10%/18%; 25%/29%; 50%/49%; 75%/71% and 100%/94%.

We next determined the ability of direct population sequencing to quantify wild-type and mutant viral RNA genomes in clinical specimens. Fig. 3B shows the sequence chromatograms of RT codons 179-191 from virions pelleted directly from uncultured plasma specimens of subject 1625 before (day -7) and after (days +28 and +140) the initiation of NVP therapy. At day -7, all codons within the aminoterminal half of the RT gene (codons 1-250), including those shown, were wild-type at positions associated with NVP resistance^{31,32}. However, after only 28 days of NVP therapy, the wild-type plasma virus population was completely replaced by a NVP-resistant mutant population differing from the wild-type virus at codon 190 (glycine to serine substitution). After 140 days of drug therapy, this codon had evolved further such that the plasma virus population consisted of an equal mixture of two drug-resistant strains, one containing G190S and the other containing G190A. There were no other NVP resistance-conferring mutations

detectable within the viral RT gene.

In all four subjects evaluated by direct viral population sequencing (Fig. 4), specific NVP resistance-conferring mutations within the RT gene could be unambiguously identified and subsequently confirmed by molecular cloning, expression, and drug susceptibility testing. In all cases, mutant virus increased rapidly in the plasma and virtually replaced wild-type virus after only 2-4 weeks of NVP therapy (Fig.2C). By analysing the rate of accumulation of resistant mutants in the plasma population, we could obtain an independent estimate of the turnover rate of free virus. The rise of drug-resistant mutant virus is influenced substantially by the preceding increase in the CD4⁺ cell population (which provides additional resources for virus production³³) and therefore follows complex dynamics. However, we could obtain an estimate of these dynamics by making simplifying assumptions. We assume that wildtype virus declines exponentially with a decay rate α and that the drug-resistant mutant increases exponentially with the rate β . Thus, the ratio of mutant to wild-type virus increases exponentially at the combined rate $\alpha + \beta$. Our genetic RNA (cDNA) data allow us to estimate this sum. Knowing α from our data on virus decline, we get $\beta \approx 0.27$, or a 32% daily virus production (average over 4 patients). Assuming that mutant virus rises exponentially, this corresponds to a doubling time of approximately 2 days which is in excellent agreement with the measured elimination half-life of 2.0 ± 0.9 days for plasma virus (Figs. 1 and 2A). Turnover of viral DNA from wild-type to drug-resistant mutant in PBMCs was delayed and less complete compared to plasma virus, reaching levels of only 50-80% of the total PBMC-associated viral DNA population by week 20 (Fig. 2C). Measurement of the time required for resistant virus to spread in the PBMC population allowed us also to estimate the half-life of infected PBMCs. After complete turnover of mutant virus in the plasma pool, we may assume that PBMCs infected with wild-type virus decline exponentially at a rate d , whereas cells infected by mutant virus are generated at a constant rate, but also decline exponentially at rate d . With these simplifying assumptions, the rate at which the frequency of resistant virus in the PBMC population increases provides an estimate for the parameter d and hence for

the half-life of infected PBMCs. We obtained a half-life of approximately 50-100 days. This means that the average half-life of infected PBMCs is very long and of the same order of magnitude as the half-life of uninfected PBMCs^{34,35}. Based on the long half-life of PBMCs, and the fact that these cells harbor predominantly wild-type virus at a time (days 14-28) when most virus in plasma is mutant, we conclude that most PBMCs contribute comparatively little to plasma virus load. Instead, other cell populations, most likely in the lymphoreticular system^{11,19,20}, must be the major source of virus production.

Direct sequence analysis of viral nucleic acid revealed not only rapid initial turnover in viral populations but also continuing viral evolution with respect to drug resistance mutations. In subject 1625 (Figure 4, top panel), wild-type virus in plasma was completely replaced after 28 days of NVP therapy by mutant virus (G190S) which in turn evolved by day 140 into a mixture of G190S and G190A. In subject 1624 (Figure 4, middle panel), two codon changes conferring NVP-resistance occurred. A G190A substitution appeared in plasma virus at day 14 and a Y181C appeared at day 42. Similarly, in subject 1605 (not shown), a Y181C mutation appeared in plasma at day 14 and a Y188L mutation at day 28. The sequential changes in plasma virus were mirrored by similar changes in PBMCs at later timepoints. In subject 1619, the pattern of resistance changes was even more complex (Fig. 4, bottom panel). By day 14, approximately 70% of plasma virus contained a G190A mutation. By day +28, this mutant population was largely replaced by virus containing a Y188F/L substitution. By day 84, still another major shift in the viral quasispecies occurred, this time resulting in a population of viruses containing mutations at both Y181C and G190A. Finally, by day 288 the viral population in plasma consisted exclusively of a mutant exhibiting a single tyrosine to isoleucine substitution at position 181 (Y181I); mutations at codons 188 and 190 were not present in this virus population. All of these amino acid substitutions at RT codons 181, 188, and 190 were shown in our own *in situ* expression studies and by others^{31,32,36} to confer high level NVP resistance. The direct sequence analyses thus demonstrate that major changes in the HIV-1 quasispecies occur quickly and continuously in response to selection pressures and that these changes are

reflected first and most prominently in the plasma virus compartment.

Virus turnover -- *In situ* RT gene expression and drug susceptibility testing. Because direct sequence analysis of viral mixtures provides only semiquantitative information and does not distinguish between viruses with functional versus defective RT genes, we employed another method for quantifying virus turnover in uncultured plasma and PBMC compartments. Full-length RT genes were amplified by PCR, cloned into pLG18-1, expressed in *E. coli*, and tested individually for enzymatic function and NVP susceptibility by *in situ* assay^{29,30}. Table 1 shows the results of these analyses. For subject 1625 at day -7, 100% (80/80) of RT clones from plasma and 100% (163/163) of RT clones from PBMCs expressed enzyme that was sensitive to NVP inhibition. By day 14, however, 62% of plasma-derived clones expressed enzyme that was resistant to NVP, and by days 28, 84, and 140, 100% were resistant. Conversely, at day 14, 0% of PBMC-derived clones expressed NVP-resistant enzyme, and even after 28, 84, and 140 days, only 48-75% of clones were resistant. Similar results were obtained for the other study subjects (see Table 1). Thus, the kinetics of virus population turnover determined by a quantitative RT *in situ* expression assay corresponded closely with those determined by direct population sequencing (Figures 2C).

Virus turnover -- Infectious virus drug susceptibility testing. Plasma and PBMCs are known to harbor substantial proportions of defective or otherwise noninfectious virus^{6,37}. To determine if the viral genomes represented in *total* viral nucleic acid (Fig. 4 and Table 1) corresponded to infectious virus with respect to NVP resistance-conferring mutations, we co-cultivated PBMCs from three of the study subjects (1605, 1624, 1625) with normal donor lymphoblasts in order to establish primary virus isolates. The RT genes of these cultured viruses, obtained before and after therapy, were cloned (see legends to Fig. 3 and Table 1) and sequenced in their entirety (V. Johnson and G. Shaw, submitted). RT codons associated with NVP susceptibility were completely concordant in cultured and uncultured virus strains. Furthermore, the virus isolates exhibited NVP susceptibility profiles³⁸ consistent with their genotypes.

Quantitative Analysis of Replication-Active, Latent, and Defective Forms of HIV-1 Provirus in Peripheral Blood. HIV-1 load *in vivo* is comprised of cell-free virus as well as substantial numbers of replication-active, latent, or defective viral genomes, all of which likely play a role in disease pathogenesis. The studies described above have emphasized the dynamics of virus turnover in plasma and the clinical benefits associated with decreases in plasma viremia following antiretroviral therapy. Yet, antiretroviral regimens which maximally impact all viral "compartments" are likely to result in the greatest therapeutic gains and the longest delay in the development of drug resistance. It is thus essential to elucidate the numbers and half-lives of cell populations harboring active, latent, or defective viral forms. We utilized a combination of biologic (phenotypic) and genetic approaches to quantify these viral forms in peripheral blood mononuclear cells (PBMCs). Three subjects ($CD4^+$ cells 20-200/mm³) were studied before and 14, 28, 42, and 140 days after initiation of Nevirapine (NVP) antiretroviral therapy. At baseline, the total viral DNA content of PBMCs determined by QC-PCR ranged from 450-800 molecules per 10⁶ cells. Infectivity titers determined by biological cloning ranged from 17-29 infectious units per 10⁶ total cells. After initiation of NVP therapy, infectious PBMC-associated virus titers fell significantly more (30-fold) than did the total number of HIV-1 DNA positive cells (2-fold). Clearance rates of specific virally-infected cell populations were determined by quantifying the elimination of wild-type virus and its replacement by drug-resistant mutant virus. The half-life of cells infected with total virus (defective plus competent) determined by direct population sequencing and *in situ* RT expression was approximately 50-100 days. The half-life of cells harboring replication-competent virus determined by biological cloning and phenotypic resistance testing was biphasic, reflecting separate cell populations containing either transcriptionally-active or latent virus infection: approximately 90% of PBMCs containing replication-competent virus were eliminated within 14 days ($T_{1/2} < 5$ days), whereas another 1-10% of such cells persisted for at least 42 days. The results of these studies thus define three populations of virally-infected PBMCs. The largest population (approximately 450-800 cells per million) contains largely defective virus

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CD4⁺ lymphocyte dynamics. Changes in CD4⁺ lymphocyte counts during the first 28 days of therapy could be assessed in 17 of our patients (Fig. 2B and data not shown). CD4⁺ cell numbers increased in every patient by between 41 and 830 cells/mm³. For the entire group, the average increase was 186 ± 199 cells/mm³ (mean \pm 1 S.D.), or $268 \pm 319\%$ from baseline. Since CD4⁺ lymphocytes increase in numbers because of (i) exponential proliferation of CD4⁺ cells in peripheral tissue compartments, and/or (ii) constant (linear) production of CD4⁺ cells from a pool of precursors, we analyzed our data based on each of these assumptions. The average percentage increase in cell number per day (assumption i) was $5.0 \pm 3.1\%$ (mean \pm 1 S.D.). The average absolute increase in cell number per day (assumption ii) was 8.0 ± 7.8 cells/mm³/day. Given that peripheral blood contains only 1/50th of the total body lymphocytes³⁵ and that the average total blood volume is approximately 5 liters (5×10^6 mm³), an increase of 8 cells/mm³/day implies an overall steady-state CD4⁺ cell turnover rate (where increases equal losses) of $(50) \times (5 \times 10^6 \text{ mm}^3) \times (8 \text{ cells/mm}^3/\text{day})$, or 2×10^9 CD4⁺ cells produced and destroyed each day.

Conclusions

Previously, it was shown that lymphoreticular tissues serve as the primary reservoir and site of replication for HIV-1^{11,19,20} and that virtually all HIV-1 infected individuals, regardless of clinical stage,

exhibit persistent plasma viremia in the range of 10^2 to 10^7 virions per milliliter⁶. However, the dynamic contributions of virus production and clearance, and of $CD4^+$ cell infection and turnover, to the clinical "steady-state" were obscure, although not unanticipated^{22,23,39}. The present report demonstrates by virus quantitation and mutation fixation rates that the composite lifespan of plasma virus and of virus-producing cells is remarkably short ($T_{1/2} = 2.0 \pm 0.9$ days). This holds true for patients with $CD4^+$ lymphocyte counts as low as 18 cells/mm³ and as high as 355 cells/mm³ (Figs. 1 and 2; G. Shaw, unpublished). Importantly, these findings were made in patients treated with three different antiretroviral agents having two entirely different mechanisms of action and using three different experimental approaches for assessing virus turnover. The viral kinetics observed thus cannot be explained by a unique or unforeseen drug effect or a peculiarity of any particular virologic assay method. Moreover, when new cycles of infection are interrupted by potent antiretroviral therapy, plasma virus levels fall abruptly by an average of 99%, and in some cases by as much as 99.99% (10,000-fold). This result indicates that the vast majority of circulating plasma virus derives from continuous rounds of *de novo* virus infection, replication, and cell turnover, and not from cells that produce virus chronically or are latently-infected and become activated. The identity and location of this actively replicating cell population is not known but appears not to reside in the PBMC pool, consistent with prior reports^{11,19,20}. Nevertheless, PBMCs traffic through secondary lymphoid organs and to some extent are in equilibrium with these cells³⁵. It is thus possible that a small fraction of PBMCs^{8,9,14-17}, like a small fraction of activated lymphoreticular cells²⁰, could contribute importantly to viremia.

The magnitude of ongoing virus infection and production required to sustain steady-state levels of viremia is extraordinary: Based on a virus $T_{1/2}$ of 2.0 days and first-order clearance kinetics ($v(t) = v(0)e^{-\alpha t}$, where $\alpha = 0.693/T_{1/2}$), 30% or more of the total virus population in plasma must be replenished *daily*. For a typical HIV-1 infected individual with a plasma virus titer equaling the pretreatment geometric mean in this study ($10^{5.5}$ RNA molecules per ml / 2 RNA molecules per virion = $10^{5.2}$

virions/ml) and a plasma volume of 3 liters, this amounts to $(0.30) \times (10^{5.2}) \times (3 \times 10^3) = 1.1 \times 10^8$ virions per day (range for all 22 subjects = 2×10^7 to 7×10^9). Even this may be a substantial underestimate of virus expression since virions may be inefficiently transported from the interstitial extravascular spaces into the plasma compartment and viral protein expression alone (short of mature particle formation) may result in cytopathy or immune-mediated destruction. Because the half-life of cells producing the majority of plasma virus cannot exceed 2.0 days, at least 30% of these cells must also be replaced *daily*. In our patients, we estimated the rate of CD4⁺ lymphocyte turnover to be, on average, 2×10^9 cells per day, or about 5% of the total CD4⁺ lymphocyte population depending on clinical stage. This rapid and ongoing recruitment of CD4⁺ cells into a short-lived virus-expressing pool likely explains the abrupt increase in CD4⁺ lymphocyte numbers that is observed immediately following the initiation of potent antiretroviral therapy and suggests the possibility of successful immunological reconstitution even in late-stage disease if effective control of viral replication can be sustained.

The kinetics of virus and CD4⁺ lymphocyte production and clearance reported here have a number of biological and clinical implications. First, they are indicative of a dynamic process involving continuous rounds of *de novo* virus infection, replication, and rapid cell turnover that likely represents a primary driving force underlying HIV-1 pathogenesis. Second, the demonstration of rapid and virtually complete replacement of wild-type virus by drug-resistant virus in plasma after only 14-28 days of drug therapy is a striking example of the capacity of the virus for biologically-relevant change. In particular, this implies that HIV-1 must have enormous potential to evolve in response to selection pressures as exerted by the immune system³⁹. Although other studies⁴⁰⁻⁴² have provided some evidence that virus turnover occurs sooner in plasma than in PBMCs, the data presented here shows this phenomenon most clearly. A similar experimental approach involving the genotypic and phenotypic analysis of plasma virus could be helpful in identifying viral mutations and selection pressures involved in resistance to other drugs, immune surveillance, and viral pathogenicity. Third, the difference in lifespan between virus-producing

cells and latently-infected cells (PBMCs) suggests that virus expression *per se* is directly involved in CD4⁺ cell destruction. The data do not suggest an "innocent bystander" mechanism of cell killing whereby uninfected or latently-infected cells are indirectly targeted for destruction by adsorption of viral proteins or by autoimmune reactivities.

Although we have emphasized that most virus in plasma derives from an actively-replicating short-lived population of cells, latently-infected cells that become activated or chronically-producing cells which generate proportionately less virus (and thus don't contribute substantially to the plasma virus pool) may nonetheless play an important role in HIV-1 pathogenesis. Based on *in situ* analyses²⁰, these cells far outnumber the actively-replicating pool and the diversity of their constituent viral genomes represents a potentially important source of clinically relevant variants, including those conferring drug resistance. In future studies, it will be important not only to discern the specific elimination rates of free virus and of the most actively producing cells but also the dynamics of virus replication and cell turnover in other cell populations and in patients at earlier stages of infection. Such information will be essential to developing a better understanding of HIV-1 pathogenesis and a more rational approach to therapeutic intervention.

References

1. Ho DD, Moudgil T, Alam M. Quantitation of human immunodeficiency virus type 1 in the blood of infected persons. *N Engl J Med* 1989;321:1621-1625.
2. Coombs RW, Collier AC, Allain J-P, et al. Plasma viremia in human immunodeficiency virus infection. *N Engl J Med* 1989;321:1626-1631.
3. Saag MS, Crain MJ, Decker WD, et al. High-level viremia in adults and children infected with human immunodeficiency virus: relation to disease stage and CD4+ lymphocyte levels. *J Inf Dis* 1991;164:72-80.
4. Clark SJ, Saag MS, Decker WD, et al. High titers of cytopathic virus in plasma of patients with symptomatic primary HIV-1 infection. *N Engl J Med* 1991;324:954-960.
5. Daar ES, Moudgil T, Meyer RD, Ho DD. Transient high levels of viremia in patients with primary human immunodeficiency virus type 1 infection. *N Engl J Med* 1991;324:961-964.
6. Piatak M, Jr, Saag MS, Yang LC, et al. High levels of HIV-1 in plasma during all stages of infection determined by competitive PCR. *Science* 1993;259:1749-1754.
7. Piatak M, Jr, Luk K-C, Saag MS, et al. Viral dynamics in primary HIV-1 infection. *Lancet* 1993;341:1099.
8. Schnittman SM, Greenhouse JJ, Lane HC, Pierce PF, Fauci AS. Frequent detection of HIV-1 specific mRNAs in infected individuals suggests ongoing active viral expression in all stages of disease. *AIDS Res Hum Retro* 1991;7:361-367.
9. Michael NL, Vahey M, Burke DS, Redfield RR. Viral DNA and mRNA expression correlate with the stage of human immunodeficiency virus (HIV) type 1 infection in humans: evidence for viral replication in all stages of HIV disease. *J Virol* 1992;66:310-316.
10. Winters MA, Tan LB, Katzenstein DA, Merigan TC. Biological variation and quality control of plasma human immunodeficiency virus type 1 RNA quantitation by reverse transcriptase polymerase chain reaction. *J Clin Microbiol* 1993;31:2960-2966.
11. Pantaleo G, Graziosi C, Butini L, et al. Lymphoid organs function as major reservoirs for human immunodeficiency virus. *Proc Natl Acad Sci USA* 1991;88:9838-9842.
12. Connor RI, Mohri H, Cao Y, Ho DD. Increased viral burden and cytopathicity correlate temporally with CD4+ T-lymphocyte decline and clinical progression in human immunodeficiency virus type 1 infected individuals. *J Virol* 1993;67:1772-1777.
13. Bagnarelli P, Menzo S, Valenza A, et al. Molecular profile of human immunodeficiency virus type 1 infection in symptomless patients and in patients with AIDS. *J Virol* 1992;66:7328-7335.
14. Bagnarelli P, Valenza A, Menzo S, et al. Dynamics of molecular parameters of human

- immunodeficiency virus type 1 activity in vivo. *J Virol* 1994;68:2495-2502.
15. Graziosi C, Pantaleo G, Butini L, et al. Kinetics of human immunodeficiency virus type 1 (HIV-1) DNA and RNA synthesis during primary HIV-1 infection. *Proc Natl Acad Sci USA* 1993;90:6405-6409.
 16. Patterson BK, Till M, Otto P, et al. Detection of HIV-1 DNA and messenger RNA in individual cells by PCR-driven in situ hybridization and flow cytometry. *Science* 1993;260:976-979.
 17. Saksela K, Stevens C, Rubinstein P, Baltimore D. Human immunodeficiency virus type 1 mRNA expression in peripheral blood cells predicts disease progression independently of the numbers of CD4+ lymphocytes. *Proc Natl Acad Sci USA* 1994;91:1104-1108.
 18. Cao Y, Ho DD, Todd J, et al. Clinical evaluation of branched DNA signal amplification for quantifying HIV type 1 in human plasma. *AIDS Res Hum Retro* 1995;11:353-361.
 19. Pantaleo G, Graziosi C, Demarest JF, et al. HIV infection is active and progressive in lymphoid tissue during the clinically latent stage of disease. *Nature* 1993;362:355-358.
 20. Embretson J, Zupancic M, Ribas JL, et al. Massive covert infection of helper T lymphocytes and macrophages by HIV during the incubation period of AIDS. *Nature* 1993;362:359-362.
 21. Aoki-Sei S, Yarchoan R, Kageyama S, et al. Plasma HIV-1 viremia in HIV-1 infected individuals assessed by polymerase chain reaction. *AIDS Res Hum Retro* 1992;8:1263-1270.
 22. Coffin JM. Genetic diversity and evolution of retroviruses. *Curr Top Microbiol Immunol* 1992;176:143-164.
 23. Wain-Hobson S. The fastest genome evolution ever described: HIV variation in situ. *Curr Opin Gen Dev* 1993;3:878-883.
 24. Merluzzi VJ, Hargrave KD, Labadia M, et al. Inhibition of HIV-1 replication by a nonnucleoside reverse transcriptase inhibitor. *Science* 1990;250:1411-1413.
 25. Kempf DJ, Marsh KC, Denissen JF, et al. ABT-538 is a potent inhibitor of human immunodeficiency virus protease and has high oral bioavailability in humans. *Proc Natl Acad Sci USA* 1995;92:2484-2488.
 26. Vacca JP, Dorsey BD, Schleif WA, et al. L-735,524: An orally bioavailable human immunodeficiency virus type 1 protease inhibitor. *Proc Natl Acad Sci USA* 1994;91:4096-4100.
 27. Mulder J, McKinney N, Christopherson C, Sninsky J, Greenfield L, Kwok S. Rapid and simple PCR assay for quantitation of human immunodeficiency virus type 1 RNA in plasma: application to acute retroviral infection. *J Clin Microbiol* 1994;32:292-300.
 28. Larder BA, Kohli A, Kellam P, Kemp SD, Kronick M, Henfrey RD. Quantitative detection of HIV-1 drug resistance mutations by automated DNA sequencing. *Nature* 1993;365:671-673.

29. Prasad VR, Goff SP. A novel in situ colony screening method to detect human immunodeficiency virus reverse transcriptase activity expressed in bacteria. Isolation of pseudorevertants of reverse transcriptase mutants. *J Biol Chem* 1989;264:16689-16693.
30. Saag MS, Emini EA, Laskin OL, et al. A short-term clinical evaluation of L-697,661, a non-nucleoside inhibitor of HIV-1 reverse transcriptase. *N Engl J Med* 1993;329:1065-1072.
31. Richman D, Shih CK, Lowy I, et al. Human immunodeficiency virus type 1 mutants resistant to nonnucleoside inhibitors of reverse transcriptase arise in tissue culture. *Proc Natl Acad Sci USA* 1991;88:11241-11245.
32. Richman DD, Havlir D, Corbeil J, et al. Nevirapine resistance mutations of human immunodeficiency virus type 1 selected during therapy. *J Virol* 1994;68:1660-1666.
33. McLean AR, Nowak, MA. Competition between zidovudine-sensitive and zidovudine-resistant strains of HIV. *AIDS* 1992;6:71-79.
34. Michie CA, McLean A, Alcock C, Beverley PC. Lifespan of human lymphocyte subsets defined by CD45 isoforms. *Nature* 1992;360:264-265.
35. Sprent J, Tough DF. Lymphocyte life-span and memory. *Science* 1994;265:1395-1400.
36. Balzarini J, Karlsson A, Sardana VV, Emini EA, Camarasa M-J, De Clercq E. Human immunodeficiency virus 1 (HIV-1)-specific reverse transcriptase (RT) inhibitors may suppress the replication of specific drug-resistant (E138K) RT HIV-1 mutants or select for highly resistant (Y181C - C181I) RT HIV-1 mutants. *Proc Natl Acad Sci USA* 1994;91:6599-6603.
37. Meyerhans A, Cheynier R, Albert J, et al. Temporal fluctuations in HIV quasispecies in vivo are not reflected by sequential HIV isolations. *Cell* 1989;58:901-910.
38. Japour AJ, Mayers DL, Johnson VA, et al. Standardized peripheral blood mononuclear cell culture assay for determination of drug susceptibilities of clinical human immunodeficiency virus type 1 isolates. The RV-43 Study Group, the AIDS Clinical Trials Group Virology Committee Resistance Working Group. *Antimicrob Agents Chemother* 1993;37:1095-1101.
39. Nowak MA, Anderson RM, McLean AR, Wolfs TFW, Goudsmit J, May RM. Antigenic diversity thresholds and the development of AIDS. *Science* 1991;254:963-969.
40. Simmonds P, Zhang LQ, McOmish F, Balfe P, Ludlam CA, Leigh Brown AJ. Discontinuous sequence change of human immunodeficiency virus (HIV) type 1 env sequences in plasma viral and lymphocyte-associated proviral populations in vivo: Implications for models of HIV pathogenesis. *J Virol* 1991;65:6266-6276.
41. Smith MS, Koerber KL, Pagano JS. Zidovudine-resistant human immunodeficiency virus type 1 genomes detected in plasma distinct from viral genomes in peripheral blood mononuclear cells. *J Inf Dis* 1993;167:445-448.

42. Zhang Y-M, Dawson SC, Landsman D, Lane HC, Salzman NP. Persistence of four related human immunodeficiency virus subtypes during the course of zidovudine therapy: Relationship between virion RNA and proviral DNA. *J Virol* 1994;68:425-432.
43. Myers G, Korber B, Berzofsky JA, Smith RF. *Human Retroviruses and AIDS 1993*. Theoretical Biology and Biophysics Group 10, Los Alamos, New Mexico.
44. Shaw GM, Hahn BH, Arya SK, Groopman JE, Gallo RC, Wong-Staal F. Molecular characterization of human T-cell leukemia (lymphotropic) virus type II in the acquired immune deficiency syndrome. *Science* 1984;226:1165-1171.

APPENDIX

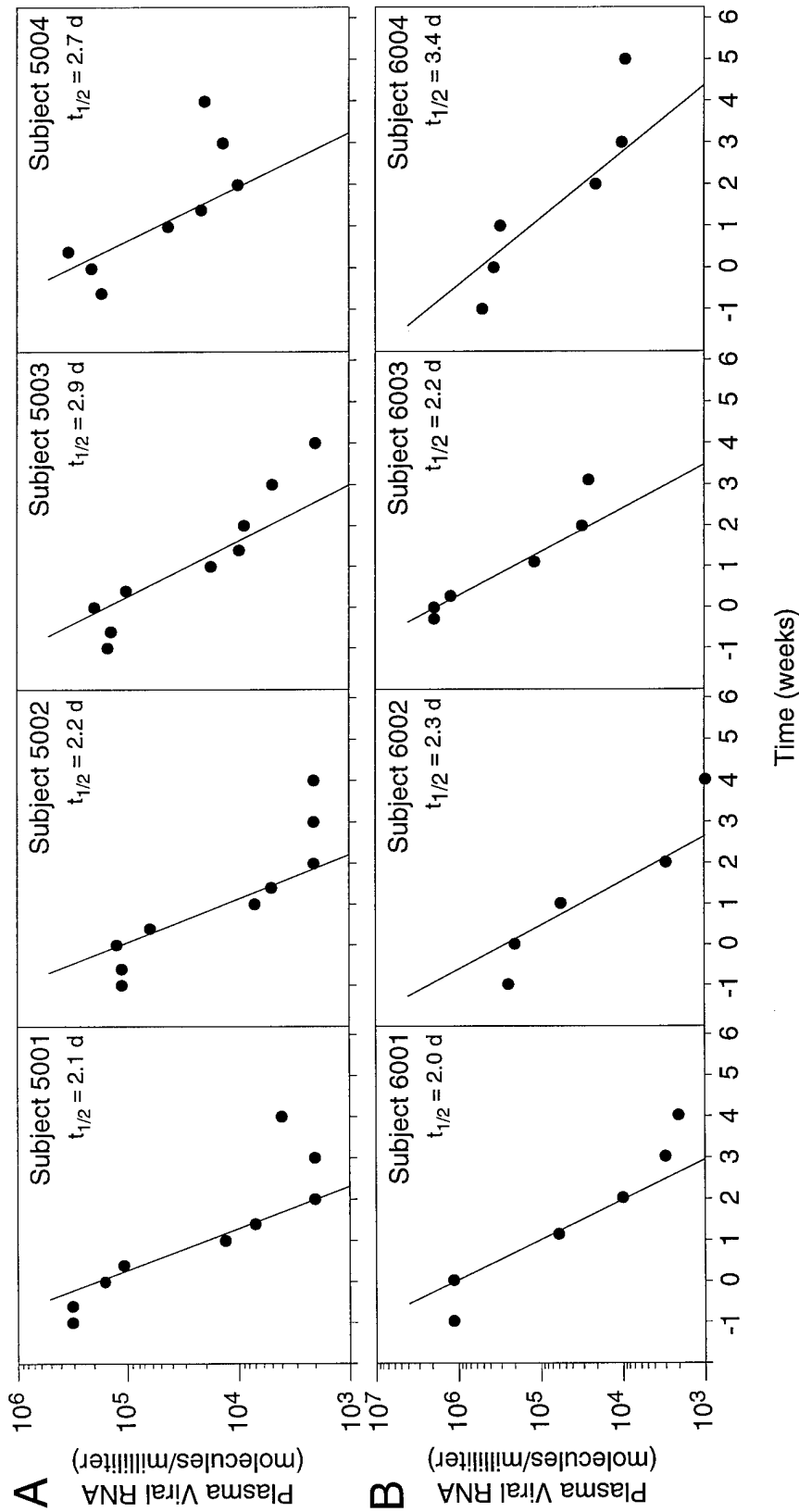


FIG 1. Plasma viral RNA determinations in representative subjects treated with the HIV-1 protease inhibitors ABT-538 (panel A) and L-735, 524 (panel B). METHODS. Subjects had not received other antiretroviral agents for at least 4 weeks prior to therapy. Treatment was initiated at week 0 with 400-1200 mg/d of ABT-538 or 1600-2400 mg/d of L-735,524 and was continued throughout the study. Viral RNA determinations were performed by modified bDNA¹⁸ (panel A) or RT-PCR²⁷ (panel B) assays and confirmed by QC-PCR⁶. Shown are the least squares fit linear regression curves for data points between days 0 and 14 indicating exponential (first-order) viral elimination.

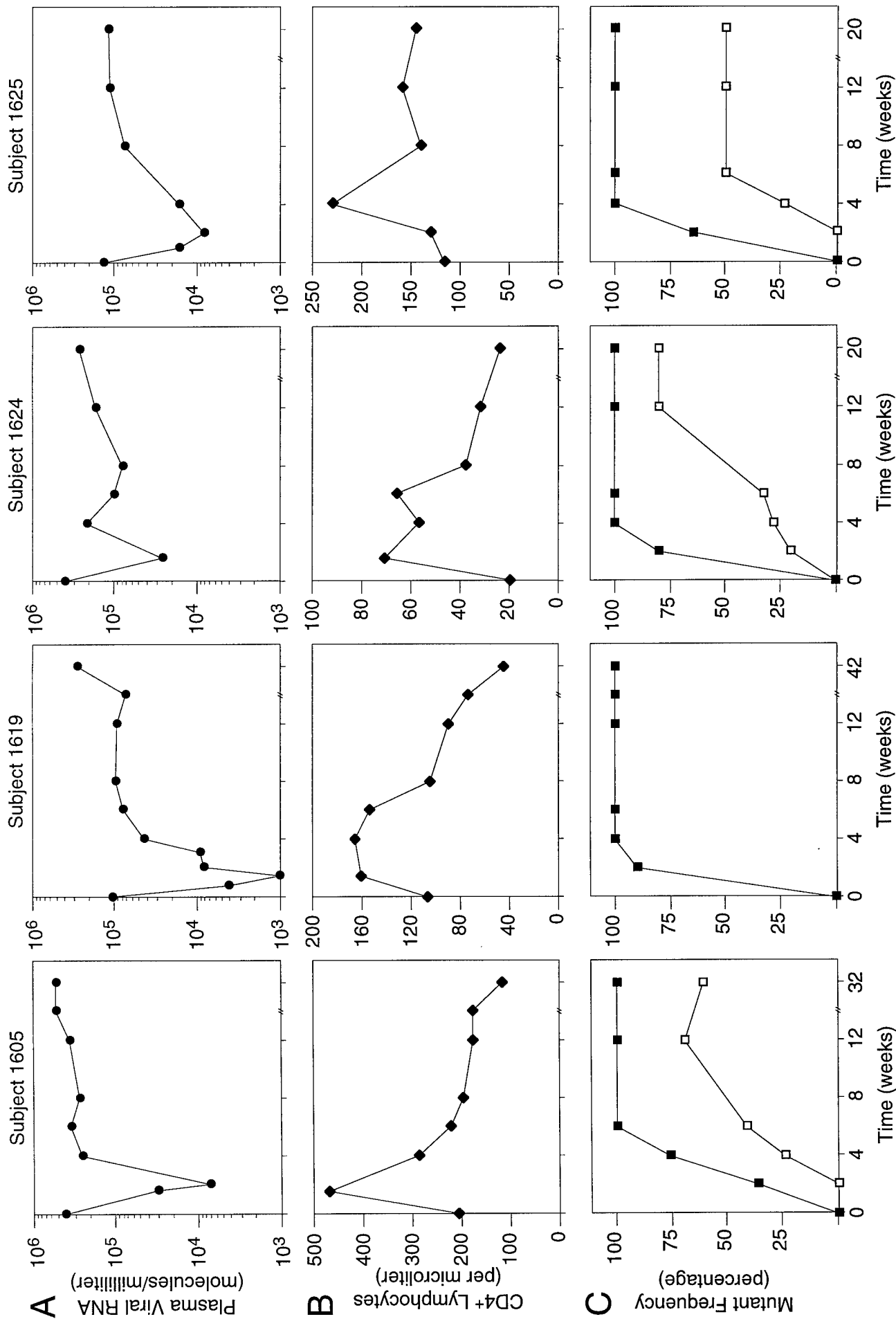


FIG 2. Plasma viral RNA determinations (panel A), CD4+ lymphocyte counts (panel B), and percentages of mutant viral genomes in plasma and PBMCs (panel C) of subjects initiating treatment with NVP. **METHODS.** Subjects were participants in a clinical protocol assessing the effects of NVP when added to existing treatment with ddI (subject 1605) or ddI + zidovudine (subjects 1619, 1624, 1625). Treatment with NVP was initiated at week 0 using 200 mg/day and was increased to 400 mg/day after 2 weeks. ddI and zidovudine dosages were 400 mg/day and 300-600 mg/day, respectively. Viral RNA determinations (●-) were performed by QC-PCR assay⁶. CD4+ lymphocytes (-◆-) were quantified by flow cytometry. Frequencies of viral genomes containing NVP resistance-associated mutations in plasma (-■-) and PBMCs (-□-) were determined by automated DNA sequence analysis as described in the legend to Fig. 3, with each data point representing the average of 3-6 independent determinations.

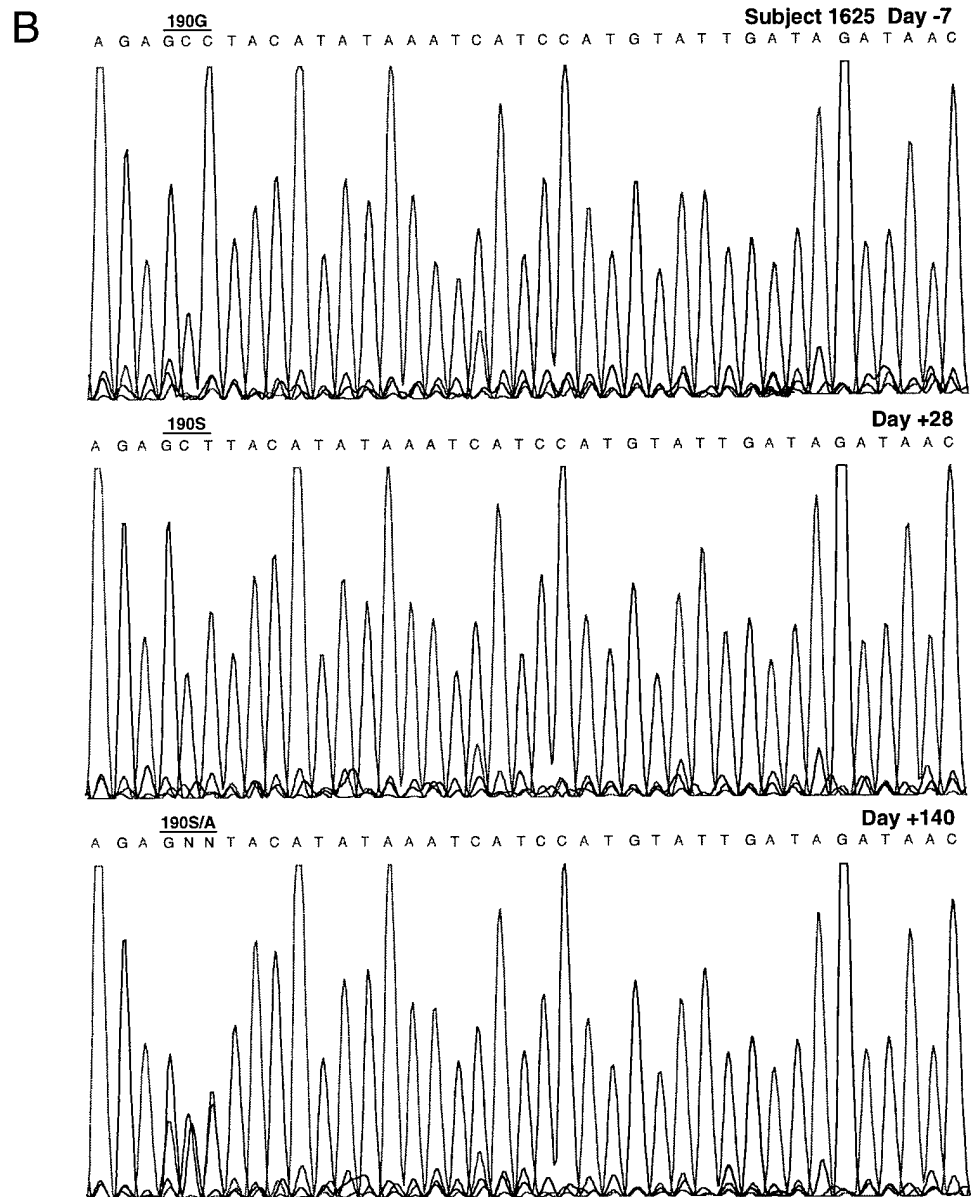
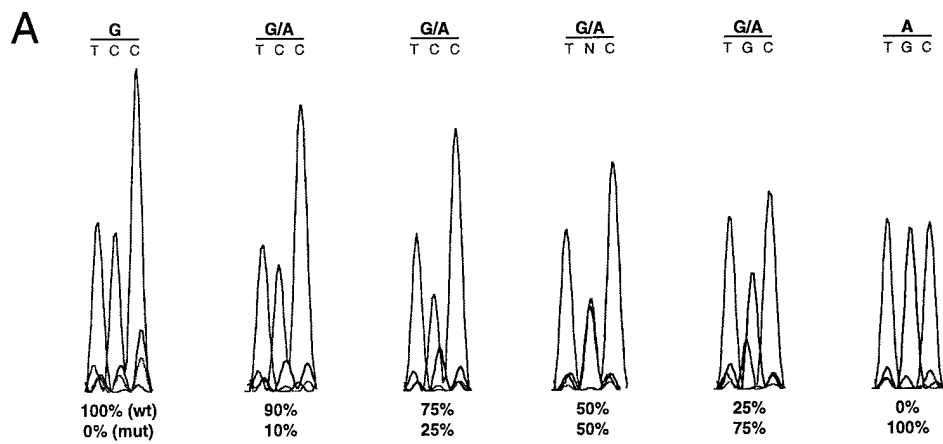


FIG 3 (Legend follows on next page)

FIG 3. Quantitative detection of HIV-1 drug resistance mutations by automated DNA sequencing. Panel A: DNA sequence chromatograms of RT codon 190 from a defined mixture of wild-type (wt) and mutant (mut) HIV-1 cDNA clones differing only at the second base position of the codon. Sequences shown were obtained from, and therefore are presented as, the minus (non-coding) DNA strand. For example, the minus strand TCC sequence shown corresponds to the plus strand codon GGA (glycine, G). Similarly, the minus strand TGC sequence corresponds to the plus strand codon GCA (alanine, A). The single letter amino acid code corresponds to the plus strand DNA sequence. Mixed bases approximating a 50/50 ratio are denoted N. Panel B: DNA sequence chromatograms of RT codons 179-191 (again displayed as the minus strand sequence) derived from plasma virion-associated RNA of subject 1625 before (day -7) and after (days +28 and +140) the initiation of NVP therapy. Codon changes resulting in amino acid substitutions at position 190 are indicated for the plus strand. For example, the GCC minus strand sequence at position 190 (day -7) corresponds to GGC (glycine, G), and the GCT minus strand sequence at position 190 (day +28) corresponds to AGC (serine, S) in the respective plus strands. METHODS. Mixtures of wt and mut cDNA clones (panel A) were prepared and diluted such that first round PCR amplifications were performed with 1000 viral cDNA target molecules per reaction. HIV-1 RNA was isolated from virions pelleted from *uncultured* plasma specimens (panel B), as described¹⁸. cDNA was prepared using Moloney murine leukemia virus reverse transcriptase (GIBCO BRL)⁶ and an oligonucleotide primer corresponding to nucleotides 4283 to 4302 of the HXB2 sequence⁴³. The full-length viral reverse transcriptase gene (1680 bp) was amplified by means of a nested polymerase chain reaction (PCR) using conditions and oligonucleotide primers (outer primers: nt 2483-2502 and 4283-4302; inner primers: nt 2549-2565 and 4211-4229), previously reported³⁰. Subgenomic fragments of the RT gene were also amplified using combinations of the following oligonucleotide primers: (5') 2585-2610; (5') 2712-2733; (3') 2822-2844; (3') 3005-3028; (3') 3206-3228; (3') 3299-3324; (3') 3331-3350; (3') 3552-3572; and (3') 3904-3921. All 3' primers incorporated the universal primer sequence for subsequent dye-primer sequence analysis. The HIV-1 copy number in every PCR reaction was determined (100-10,000 copies). A total of three to six separate PCR amplifications of primary patient material was performed on each sample using different combinations of primers and representative chromatograms are shown. Rarely, codon interpretation was ambiguous. In the day +140 plasma sample from subject 1625 (bottom of panel 3B), the complementary (plus) strand could read: AGC(serine), GCN(alanine), ACN(threonine), AGA/AGG(arginine), or GGN(glycine). In this case, we sequenced 7 full-length RT molecular clones and found them to encode only serine or alanine. Sequencing was performed using an automated ABI 373A sequenator and the Taq Dye Primer Cycle Sequencing Kit (ABI). Sequence analysis was performed using Sequencher (Gene Codes Corp.) and Microgenie (Beckman) software packages, and base pair mixtures were quantified by measuring relative peak-on-peak heights, as described²⁸.

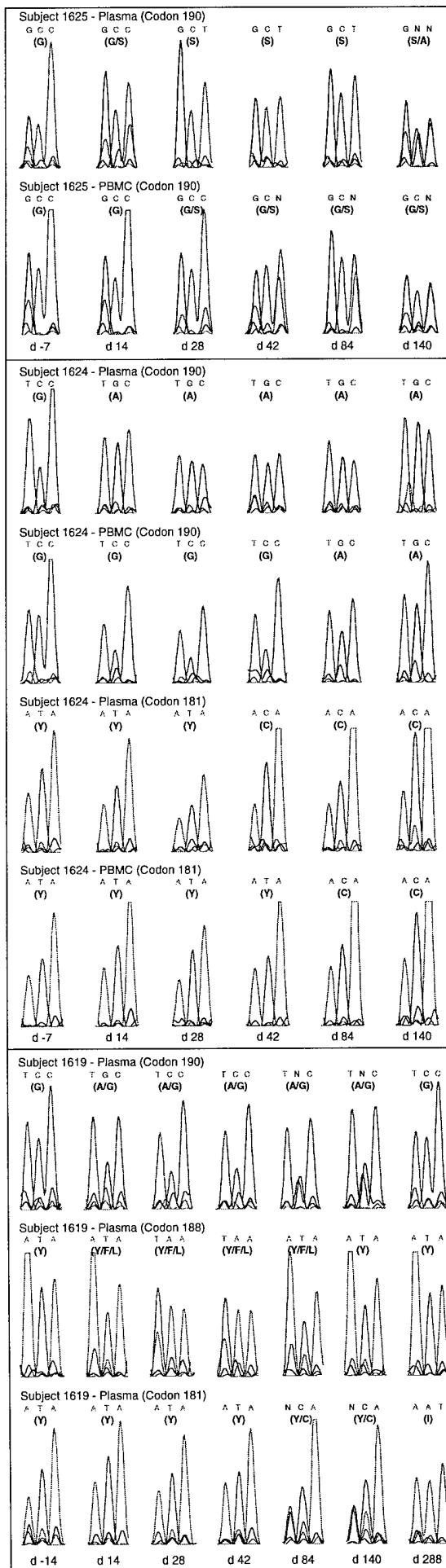


FIG 4. Quantitative detection of HIV-1 drug resistance mutations by automated DNA sequencing in plasma viral RNA (cDNA) and PBMC-associated viral DNA populations before and after the initiation of NVP on day 0. As in Fig. 3, minus strand sequences are shown along with single letter amino acid codes of the corresponding plus strand sequence. Mixed bases approximating a 50/50 ratio are denoted N. METHODS. HIV-1 cDNA was prepared from virions pelleted from uncultured plasma as described in Fig. 3. Viral DNA was isolated from uncultured PBMCs, as described⁴⁴. The full-length viral reverse transcriptase genes as well as subgenomic fragments were amplified and sequenced as described in Fig. 3. The HIV-1 copy number in every PCR reaction was determined (100-10,000 copies). A total of three to six separate PCR amplifications of primary patient material was performed on each sample using different combinations of primers and representative chromatograms are shown. Some sequences were determined from both coding and non-coding DNA strands to ensure the accuracy of quantitative measurements.

Subject	Specimen	Functional Clones	NVP-Sensitive Clones	NVP-Resistant Clones
1625	Plasma day-7	80	80 (100%)	0 (0%)
	+14	72	27 (38%)	45 (62%)
	+28	57	0 (0%)	57 (100%)
	+84	67	0 (0%)	67 (100%)
	+140	86	0 (0%)	86 (100%)
1625	PBMC -7	163	163 (100%)	0 (0%)
	+14	121	121 (100%)	0 (0%)
	+28	258	134 (52%)	124 (48%)
	+84	133	43 (32%)	90 (68%)
	+140	261	65 (25%)	196 (75%)
1624	Plasma -7	19	19 (100%)	0 (0%)
	+14	34	4 (12%)	30 (88%)
	+28	79	6 (8%)	73 (92%)
	+140	27	0 (0%)	27 (100%)
1624	PBMC -7	24	24 (100%)	0 (0%)
	+14	34	29 (85%)	5 (15%)
	+28	52	42 (81%)	10 (19%)
	+140	87	26 (30%)	61 (70%)
1605	PBMC -7	31	31 (100%)	0 (0%)
	+140	31	11 (35%)	20 (65%)
1619	Plasma -14	79	79 (100%)	0 (0%)
	+28	41	0 (0%)	41 (100%)
	+140	38	0 (0%)	38 (100%)

TABLE 1. *In situ* functional analysis of HIV-1 RT clones. Full-length RT genes were amplified by PCR from uncultured plasma and uncultured PBMCs as described in the legend to Fig. 3. DNA products were cloned into the *EcoRI* and *HindIII* sites of the bacterial expression plasmid pLG18-1^{29,30}. The expression plasmids were screened for the presence of functional RT and tested *in situ* for susceptibility to NVP inhibition at 3000 nM concentration (approximately 50-75 fold greater than the IC₅₀)^{24,31,32}. To ensure accuracy in distinguishing RT genes which encoded NVP-resistant versus sensitive enzymes, and to confirm the identification of specific NVP resistance-conferring RT mutations obtained by the direct sequencing method (Figs. 3 and 4), we determined the complete nucleotide sequences of 21 cloned RT genes which had been phenotyped in the *in situ* assay (V. Johnson and G. Shaw, submitted). There was complete concordance between the phenotypes and genotypes of these 21 clones with respect to NVP resistance-conferring mutations as well as complete concordance between direct viral population sequences and clone-derived sequences at NVP resistance-conferring codons.