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Research Article

CD8+ T-Cells Count in Acute Myocardial Infarction in HIV Disease in a Predominantly Male Cohort


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Human Immunodeficiency Virus- (HIV-) infected persons have a higher risk for acute myocardial infarction (AMI) than HIV-uninfected persons [1, 2]. This excess risk is predicted in part by immune status in those with HIV infection [1, 3, 4]. During the course of untreated HIV infection, CD4 T-cell counts decline. Among untreated and treated HIV-infected adults, lower CD4 T-cell counts are associated with greater risk of comorbid disease [5] including AMI risk or subclinical coronary atherosclerosis [1, 3, 4, 6, 7]. Traditional cardiovascular disease (CVD) risk assessment tools like the Framingham Risk scores do not account for immune status and therefore may inaccurately estimate CVD risk in the setting of HIV [8]. Identifying additional prognostic biomarkers of CVD risk may be useful for CVD risk prediction in the setting of HIV.

The association between CD8+ T-cell counts and incident AMI risk remains largely unexplored [4]. In a nested case-control study of the French Hospital Database on HIV [4], Lang and colleagues found that a high current CD8+ T-cell count is associated with increased AMI risk, independent of cardiovascular risk factors and antiretroviral therapy. This study did not have an HIV-uninfected control group and did not consider additional potential confounders, such as hemoglobin concentration, renal function, and hepatitis C viral infection.

Total CD8+ T-cell counts are often obtained during routine care of HIV-infected persons and are used in the calculation of a CD4+/CD8+ T-cell ratio, which provides information on immune status beyond CD4+ counts alone. We assessed the association between routinely available total CD8+ T-cell count and the risk of AMI in a large cohort of HIV-infected and HIV-uninfected persons, adjusting for common traditional cardiovascular risk factors as well as HIV-specific parameters.

We examined the association between CD8+ T-cells and AMI risk among 73,398 persons enrolled in the U.S. Veterans Aging Cohort Study-Virtual Cohort (VACS-VC) [9] who were free of cardiovascular disease at baseline date (April 2003). Participants were followed through December 2009 for a mean follow-up period of 4.98 years. Details regarding this cohort have been published previously [1]. Among HIV-infected participants, 18,289 had available baseline CD8+ T-cell counts at the time of enrollment of which 16,599 had both CD4+ and CD8+ data. There were 55,109 HIV-uninfected participants. The mean (±SD) age was approximately 48 (±9) years (HIV-infected) and 49 (±9) years (HIV-uninfected). Over 97 percent were men and 48 percent were African American. The outcome of interest was all incident AMI cases (nonfatal and fatal) in the VACS-VC that were completely managed in either VA or non-VA hospitals as previously described [1]. Briefly, incident AMI was defined using enzyme data, EKG charts, clinical data, 410 in-patient ICD-9 codes (Medicare), and/or death certificates.

The main independent variable of interest was the baseline total CD8+ T-cell count, which was analyzed separately as a continuous variable and categorically. CD8+ T-cell counts were available only for HIV-seropositive Veterans as they were obtained as part of routine clinical care. For the assessment as a continuous variable, the CD8+ T-cell count analysis was restricted to HIV-infected participants. As a categorical variable, study participants were classified as being either HIV-uninfected (the referent group) or HIV-infected with low, moderate, or high total CD8+ T-cells (based on tertiles). Using the same referent group, we then stratified these categories among HIV-infected people by baseline CD4+ T-cell count (≥500, 200–499, and <200 cells/mm³). The covariates included in the multivariable models were age, gender, race, high blood pressure (controlled/uncontrolled), diabetes, triglyceride levels, high density lipoprotein levels, low density lipoprotein levels, body mass index, smoking history, hepatitis C virus infection, estimated glomerular filtration rate, statin use, hemoglobin concentration, cocaine and alcohol abuse, and/or dependence as previously described [1]. We included missing covariate data in our analyses using multiple imputation techniques that generated five data sets with complete covariate values to increase the efficiency and robustness of the estimated hazard ratios. Stata version 12 was used for all statistical analyses and a P value of <0.05 was considered to indicate statistical significance.

1. Introduction

Human Immunodeficiency Virus- (HIV-) infected persons have a higher risk for acute myocardial infarction (AMI) than HIV-uninfected persons [1, 2]. This excess risk is predicted in part by immune status in those with HIV infection [1, 3, 4]. During the course of untreated HIV infection, CD4 T-cell counts decline. Among untreated and treated HIV-infected adults, lower CD4 T-cell counts are associated with greater risk of comorbid disease [5] including AMI risk or subclinical coronary atherosclerosis [1, 3, 4, 6, 7]. Traditional cardiovascular disease (CVD) risk assessment tools like the Framingham Risk scores do not account for immune status and therefore may inaccurately estimate CVD risk in the setting of HIV [8]. Identifying additional prognostic biomarkers of CVD risk may be useful for CVD risk prediction in the setting of HIV.

The association between CD8+ T-cell counts and incident AMI risk remains largely unexplored [4]. In a nested case-control study of the French Hospital Database on HIV [4], Lang and colleagues found that a high current CD8+ T-cell count is associated with increased AMI risk, independent of cardiovascular risk factors and antiretroviral therapy. This study did not have an HIV-uninfected control group and did not consider additional potential confounders, such as hemoglobin concentration, renal function, and hepatitis C viral infection.

Total CD8+ T-cell counts are often obtained during routine care of HIV-infected persons and are used in the calculation of a CD4+/CD8+ T-cell ratio, which provides information on immune status beyond CD4+ counts alone. We assessed the association between routinely available total CD8+ T-cell count and the risk of AMI in a large cohort of HIV-infected and HIV-uninfected persons, adjusting for common traditional cardiovascular risk factors as well as HIV-specific parameters.

2. Materials and Methods

We examined the association between CD8+ T-cells and AMI risk among 73,398 persons enrolled in the U.S. Veterans Aging Cohort Study-Virtual Cohort (VACS-VC) [9] who were free of cardiovascular disease at baseline date (April 2003). Participants were followed through December 2009 for a mean follow-up period of 4.98 years. Details regarding this cohort have been published previously [1]. Among HIV-infected participants, 18,289 had available baseline CD8+ data at the time of enrollment of which 16,599 had both CD4+ and CD8+ data. There were 55,109 HIV-uninfected participants. The mean (±SD) age was approximately 48 (±9) years (HIV-infected) and 49 (±9) years (HIV-uninfected). Over 97 percent were men and 48 percent were African American. The outcome of interest was all incident AMI cases (nonfatal and fatal) in the VACS-VC that were completely managed in either VA or non-VA hospitals as previously described [1]. Briefly, incident AMI was defined using enzyme data, EKG charts, clinical data, 410 in-patient ICD-9 codes (Medicare), and/or death certificates.

The main independent variable of interest was the baseline total CD8+ T-cell count, which was analyzed separately as a continuous variable and categorically. CD8+ T-cell counts were available only for HIV-seropositive Veterans as they were obtained as part of routine clinical care. For the assessment as a continuous variable, the CD8+ T-cell count analysis was restricted to HIV-infected participants. As a categorical variable, study participants were classified as being either HIV-uninfected (the referent group) or HIV-infected with low, moderate, or high total CD8+ T-cells (based on tertiles). Using the same referent group, we then stratified these categories among HIV-infected people by baseline CD4+ T-cell count (≥500, 200–499, and <200 cells/mm³). The covariates included in the multivariable models were age, gender, race, high blood pressure (controlled/uncontrolled), diabetes, triglyceride levels, high density lipoprotein levels, low density lipoprotein levels, body mass index, smoking history, hepatitis C virus infection, estimated glomerular filtration rate, statin use, hemoglobin concentration, cocaine and alcohol abuse, and/or dependence as previously described [1]. We included missing covariate data in our analyses using multiple imputation techniques that generated five data sets with complete covariate values to increase the efficiency and robustness of the estimated hazard ratios. Stata version 12 was used for all statistical analyses and a P value of <0.05 was considered to indicate statistical significance.

3. Results and Discussion

Survival free from AMI was different among HIV-uninfected and the three tertiles of HIV-infected people (P value <0.001, Figure 1). The poorest survival free of AMI was observed among those in the highest CD8+ T-cell tertile (>1065 cells/mm³). Increasing CD8+ T-cell counts were associated with a modest increase in AMI risk among HIV-infected people (HR per 100 CD8+ T-cells (95% CI): 1.03
We found evidence that the effect of CD8 T-cell count unmasked potentially important associations:

<table>
<thead>
<tr>
<th>Group</th>
<th>CD8 T-cell count</th>
<th>AMI risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV−</td>
<td>&lt;200 cells/mm³</td>
<td>Low</td>
</tr>
<tr>
<td>HIV+, CD8 &lt; 667</td>
<td>Medium</td>
<td></td>
</tr>
<tr>
<td>HIV+, CD8 667-1065</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>HIV+, CD8 &gt; 1065</td>
<td>Very High</td>
<td></td>
</tr>
</tbody>
</table>

Figure 1: Graph of Kaplan-Meier survival estimates of AMI development for different HIV/CD8 T-cell strata. Abbreviations used are HIV−, HIV-uninfected; HIV+, HIV-infected. All T-cell counts in cells/mm³. Difference in survival function equality based on Tarone-Ware and Peto-Peto-Prentice tests had a P value <0.001, df = 3.

In conclusion, high CD8 T-cell count among HIV-infected people was associated with increased acute myocardial infarction risk compared to uninfected people. The association between CD8 T-cell count and AMI appears to differ by CD4 T-cell count. CD8 T-cell count may add additional AMI risk stratification information beyond that provided by CD4 T-cell counts particularly among those with CD4 T-cell counts between 200 and 499 cells/mm³. These findings should be confirmed in future studies with data on CD8 T-cell counts among uninfected people and HIV-specific CD8 T-cell counts.

Conflict of Interests

Dr. Roger Bedimo reports serving as a consultant for AIDS Arms, Inc., and on the Scientific Advisory Boards of Merck & Co., Bristol Myers Squibb, ViiV Healthcare and Gilead Sciences. He also received grants (or grants are pending) from Merck & Co., Bristol Myers Squibb and Janssen Therapeutics. Dr. Adeel A. Butt reports grants paid (or grants are pending) to his institution for projects unrelated to the current project. Dr. Matthew S. Freiberg reports being a clinical investigator in the VA Healthcare System. Dr. Adam J. Gordon reports receiving book royalties from Cambridge University press and Web royalties from UpToDate. He also reports grants paid (or grants are pending) to his institution from the National Institutes of Health, VA Health services Research and Development and the Substance Abuse and Mental Health Services Administration. Dr. Kaku A. Soharmah reports owning stock in DexCom. Dr. Russell P. Tracy reports serving as a consultant for Merck, Tibotec-Johnson & Johnson and Abbott companies. He also gives expert testimony to Ashcraft & Gerel Attorneys at Law and Berman.
Table I: Acute myocardial infarction rates and risk and all-cause mortality rates by HIV status, CD8\(^+\) T-cell count, and CD4\(^+\) T-cell strata.

<table>
<thead>
<tr>
<th>Regression model(^a)</th>
<th>Independent variable(^b)</th>
<th>(N) (% of HIV+)(^c)</th>
<th>AMI rate (95% CI)(^d)</th>
<th>HR (95% CI)</th>
<th>(P) value</th>
<th>Mortality rates (95% CI)(^q)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Per 100 CD8(^+) cells (HIV+ only)</td>
<td>18,289</td>
<td>18.49 (16.95–20.17)</td>
<td>1.00</td>
<td>Ref</td>
<td>18.63 (18.10–19.17)</td>
</tr>
<tr>
<td></td>
<td>HIV-uninfected</td>
<td>55,109</td>
<td>18.49 (16.95–20.17)</td>
<td>1.00</td>
<td>Ref</td>
<td>18.63 (18.10–19.17)</td>
</tr>
<tr>
<td></td>
<td>HIV + All CD4(^+) strata</td>
<td>18,289</td>
<td>18.49 (16.95–20.17)</td>
<td>1.00</td>
<td>Ref</td>
<td>18.63 (18.10–19.17)</td>
</tr>
<tr>
<td></td>
<td>CD8(^+) &lt; 667</td>
<td>5,987 (32.74)</td>
<td>26.08 (20.70–32.86)</td>
<td>1.45 (1.12–1.88)(^e)</td>
<td>0.005</td>
<td>36.13 (30.00–46.51)</td>
</tr>
<tr>
<td></td>
<td>CD8(^+) 667–1065</td>
<td>6,185 (33.82)</td>
<td>26.98 (21.81–33.37)</td>
<td>1.54 (1.21–1.96)(^f)</td>
<td>&lt;0.001</td>
<td>38.54 (36.23–41.00)</td>
</tr>
<tr>
<td></td>
<td>CD8(^+) &gt; 1065</td>
<td>6,117 (33.45)</td>
<td>32.20 (26.50–39.14)</td>
<td>1.82 (1.46–2.28)(^g)</td>
<td>&lt;0.001</td>
<td>40.89 (38.49–43.45)</td>
</tr>
<tr>
<td>II</td>
<td>HIV-uninfected</td>
<td>55,109</td>
<td>18.49 (16.95–20.17)</td>
<td>1.00</td>
<td>Ref</td>
<td>18.63 (18.10–19.17)</td>
</tr>
<tr>
<td></td>
<td>HIV + CD4(^+) ≥ 500</td>
<td>5,422</td>
<td>18.49 (16.95–20.17)</td>
<td>1.00</td>
<td>Ref</td>
<td>18.63 (18.10–19.17)</td>
</tr>
<tr>
<td></td>
<td>CD8(^+) &lt; 667</td>
<td>1,097 (20.23)</td>
<td>24.00 (14.70–39.18)</td>
<td>1.30 (0.76–2.20)(^h)</td>
<td>0.339</td>
<td>28.08 (24.05–32.78)</td>
</tr>
<tr>
<td></td>
<td>CD8(^+) 667–1065</td>
<td>1,971 (36.35)</td>
<td>26.68 (18.76–37.93)</td>
<td>1.51 (1.03–2.21)(^i)</td>
<td>0.037</td>
<td>24.83 (21.89–28.17)</td>
</tr>
<tr>
<td></td>
<td>CD8(^+) &gt; 1065</td>
<td>2,354 (43.42)</td>
<td>28.68 (20.96–39.26)</td>
<td>1.69 (1.21–2.36)(^j)</td>
<td>0.002</td>
<td>30.66 (27.57–34.10)</td>
</tr>
<tr>
<td></td>
<td>HIV + CD4(^+) 200–499</td>
<td>6,730</td>
<td>21.54 (14.32–32.42)</td>
<td>1.22 (0.80–1.87)(^k)</td>
<td>0.360</td>
<td>43.88 (39.72–48.48)</td>
</tr>
<tr>
<td></td>
<td>CD8(^+) &lt; 667</td>
<td>1,491 (20.23)</td>
<td>24.00 (14.70–39.18)</td>
<td>1.30 (0.76–2.20)(^h)</td>
<td>0.339</td>
<td>28.08 (24.05–32.78)</td>
</tr>
<tr>
<td></td>
<td>CD8(^+) 667–1065</td>
<td>2,447 (36.36)</td>
<td>26.08 (18.81–36.16)</td>
<td>1.47 (1.03–2.09)(^l)</td>
<td>0.034</td>
<td>37.68 (34.27–41.42)</td>
</tr>
<tr>
<td></td>
<td>CD8(^+) &gt; 1065</td>
<td>2,382 (35.40)</td>
<td>28.68 (20.96–39.26)</td>
<td>1.69 (1.21–2.36)(^j)</td>
<td>0.002</td>
<td>30.66 (27.57–34.10)</td>
</tr>
<tr>
<td></td>
<td>HIV + CD4(^+) &lt; 200</td>
<td>4,447</td>
<td>21.54 (14.32–32.42)</td>
<td>1.22 (0.80–1.87)(^k)</td>
<td>0.360</td>
<td>43.88 (39.72–48.48)</td>
</tr>
<tr>
<td></td>
<td>CD8(^+) &lt; 667</td>
<td>2,389 (53.72)</td>
<td>32.16 (22.86–45.23)</td>
<td>1.82 (1.26–2.64)(^n)</td>
<td>0.001</td>
<td>107.13 (100.36–114.35)</td>
</tr>
<tr>
<td></td>
<td>CD8(^+) 667–1065</td>
<td>1,171 (26.33)</td>
<td>29.60 (18.65–46.97)</td>
<td>1.80 (1.10–2.94)(^o)</td>
<td>0.019</td>
<td>67.40 (60.56–75.02)</td>
</tr>
<tr>
<td></td>
<td>CD8(^+) &gt; 1065</td>
<td>887 (19.94)</td>
<td>27.89 (16.19–48.02)</td>
<td>1.51 (0.85–2.67)(^p)</td>
<td>0.158</td>
<td>63.32 (55.81–71.85)</td>
</tr>
</tbody>
</table>

The covariates included in the multivariable models (hazard ratios not shown) were age, gender, race, high blood pressure (controlled/uncontrolled), diabetes, triglyceride levels, high density lipoprotein levels, low density lipoprotein levels, body mass index, smoking history, hepatitis C virus infection, estimated glomerular filtration rate, statin use, hemoglobin concentration, cocaine and alcohol abuse, and/or dependence.

\(^{a}\)CD8\(^+\) and CD4\(^+\) T-cell counts were measured in cells/mm\(^3\).

\(^{b}\)While all 18,289 HIV-infected participants had baseline CD8\(^+\) T-cell count measurements, 1,690 of them lacked baseline CD4\(^+\) T-cell counts. Thus, these persons were excluded from analyses involving both CD4\(^+\) and CD8\(^+\) T-cell counts.

\(^{c}\)AMI rates were measured per 10,000 person years.

\(^{d}\)All-cause mortality rates were measured per 10,000 person years.

\(^{e}\)versusf \(P\) value comparing these hazard ratios was <0.001.

\(^{f}\)versusg \(P\) value comparing these hazard ratios was <0.01.

\(^{g}\)versush \(P\) value comparing these hazard ratios was 0.026.

\(^{h}\)versusi \(P\) value comparing these hazard ratios was <0.01.

\(^{i}\)versusj \(P\) value comparing these hazard ratios was <0.001.

\(^{j}\)versusk \(P\) value comparing these hazard ratios was 0.092.

\(^{k}\)versusl \(P\) value comparing these hazard ratios was <0.001.

\(^{l}\)versusm \(P\) value comparing these hazard ratios was <0.01.

\(^{m}\)versusn \(P\) value comparing these hazard ratios was 0.022.

\(^{n}\)versuso \(P\) value comparing these hazard ratios was <0.001.

\(^{o}\)versusp \(P\) value comparing these hazard ratios was <0.004.

\(^{p}\)versusq \(P\) value comparing these hazard ratios was <0.001.

\(^{q}\)All-cause mortality rates were measured per 10,000 person years.
Russo & Sulick Attorneys at Law firms and is the owner of Haematologic Technologies. All other authors declare that there is no conflict of interests regarding the publication of this paper.

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