Toll-like Receptor Polymorphism Associations With HIV-1 Outcomes Among Sub-Saharan Africans


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Objective. We evaluated Toll-like receptors (TLRs) single nucleotide polymorphisms (SNPs) for associations with HIV-1 acquisition, set-point and disease progression in African couples.

Methods. Seven candidate and 116 haplotype-tagging SNPs (tagSNPs) were genotyped in 504 HIV-1 infected cases, and 343 seronegative controls.

Results. TLR9 1635A/G was associated with reduced HIV-1 acquisition among HIV-seronegative controls with high but not low HIV-1 exposure (odds ratio [OR] = 0.7; P = .03 and OR = 0.9, P = .5, respectively). TLR7 rs179012 and TLR2 597C/T reduced set-point; the latter modified by time since HIV-1 acquisition. TLR8 1A/G reduced disease progression.

Conclusions. TLR SNPs impact HIV-1 outcomes with epidemiologic factors modifying these relationships.

Keywords. Acute Infection; Genetics; Heterosexual HIV-1 transmission; Progression; Risk Factors; Viral load; Toll-like Receptors; HIV-1 set-point; HIV-1 acquisition.
HIV-1 Set-point and Disease Progression

Plasma HIV-1 RNA levels were determined using the COBAS AmpliPrep/COBAS TaqMan HIV-1 RNA assay, version 1.0 (Roche Diagnostics, Indianapolis, IN), with a quantification limit of 240 copies/mL. For seroconverters, HIV-1 set-point was defined as the average log10 plasma HIV-1 RNA measurement taken 4–18 months after infection (median = 6 measurements per person). For seroprevalent cases, set-point was based on consecutive measurements within 1 log10 copies/mL determined before antiretroviral therapy (ART) initiation or CD4 count < 200 cells/mm3 (median = 4 measurements per person). HIV-1 disease progression among seroprevalent cases was defined as time to (1) ART initiation, (2) CD4 count < 200 cells/mm3, or (3) death from medical causes.

Genotyping

DNA was isolated from archived blood using Puregene DNA purification (Qiagen, Valencia, CA), with genotyping using an Illumina Custom Oligo Pooled Assay for 124 SNPs (9 in TLR2, 13 TLR3, 22 TLR4, 40 TLR7, 25 TLR8, 3 TLR9, 4 MYD88, and 8 TIRAP). These included seven candidate SNPs previously associated with HIV-1 infection and 116 haplotype-tagging SNPs (tagSNPs) chosen to represent common variation across TLR genes (Supplementary Table 1). Haplotypes were inferred from the Yoruba HapMap population, and tagSNPs with minor allele frequency >5% were selected. Overall, six SNPs were excluded for >10% missing results (n = 3), for being monomorphic (n = 1), or failing Hardy-Weinberg Equilibrium (n = 1) or X-linked autosomal tests (n = 1). Of 847 genotyped samples, 15 were excluded for X-chromosome sex discrepancies and 5 for >10% genotypic missingness.

Statistical Analysis

HIV-1 acquisition analyses compared TLR genotypes in all seropositive cases to seronegative controls using logistic regression. Secondarily, an ‘extreme phenotype design’ was restricted to highly exposed seronegative controls to improve sensitivity [10]. Set-point analyses were performed using linear regression among all seropositive individuals, with interaction analyses by seroconverter or seroprevalent HIV-1 status to assess differential effects of TLR polymorphisms by time since infection. Finally, we determined associations of TLR variants with disease progression using Cox regression and Kaplan-Meier curves.

Regression models were conducted in the R GenABEL package (http://www.genabel.org/) and were adjusted for sex, age, acyclovir use and population stratification using principal components from a separate study [9]. X-chromosome SNP associations were evaluated combining all participants and separately for males and females. Evaluation of candidate SNPs represents confirmatory analyses of factors previously implicated in HIV-1 infection, therefore, we report uncorrected P-values for those SNPs. For exploratory analyses of 111 TLR tagSNPs we calculated Bonferroni-corrected P-values with a significance cutoff of $P_{\text{corrected}} < .00045$ ($\alpha = .05$). Since different inheritance models lack independence, we did not adjust P-values for testing multiple models.

RESULTS

Study Participants

Among genotyped individuals, 343 were HIV-1 seronegative controls (243 with high and 100 with lower exposure) and 504 were seropositive cases (129 seroconverter and 375 seroprevalent) (Supplementary Table 2). Approximately 75% of cases and controls were from East Africa. Overall, cases and controls had similar sex distributions with 160 (47%) controls and 265 (52%) infected cases being female ($P = .2$). HIV-1 exposure scores ranged from 0 to 7 and were similar among seroconverters and highly exposed controls (median = 5 [IQR: 3–5] vs 5 [IQR: 5–6]) but were lower among low exposure controls (2 [IQR: 1–3], $P < .001$). Highly exposed controls were similar to seroconverters in age (31 vs 30 years, $P = .4$), but had lower prevalence of male circumcision (33% vs 43% $P = .2$) and increased frequency of any unprotected sex (50% vs 44%, $P = .3$). Compared to low exposure controls, highly exposed controls were more likely to report unprotected sex (50% vs 22%, $P < .001$) and to have HIV-1 infected partners with higher HIV-1 levels (5.0 vs 3.9 log10 copies/mL, $P < .001$).

Follow-up among HIV-1 seronegative controls was similar among participants with high and low exposure (21 [IQR: 15–24] vs 21 months [IQR: 18–24], respectively). Among, HIV-1 seroconverters, median time before the first seropositive HIV-1 test was 9 months (IQR: 3–15) and median post-seroconversion follow-up was 12 months (IQR: 12–12). Median follow-up for HIV-1 seroprevalent cases was 22 months (IQR: 17–24).

TLR Associations With HIV-1 Acquisition

Comparing HIV-1 infected cases to all seronegative controls, the candidate TLR9 1635G allele was associated with reduced HIV-1 acquisition risk (OR = 0.8; 95% CI, 0.6–0.9; $P = .04$). The association was stronger when cases were compared to highly exposed controls (OR = 0.7, 95% CI, 0.5–0.9; $P = .03$) but was lost when compared to low exposure controls (OR = 0.9, 95% CI, 0.6–1.5; $P = .5$) (Figure 1A).

TLR Associations With HIV-1 Set-point

Median plasma HIV-1 set-point among all cases was 4.7 log10 copies/mL (IQR: 4.1–5.2) and was similar among seroprevalent (4.8; IQR: 4.4–5.3) and seroconverter cases (4.5; IQR: 3.6–5.0). The TLR7 rs179012 G allele, a haplotype-tagging intronic SNP, was associated with 0.4 log10 copies/mL lower set-points (95% CI, 0.2–0.6; $P_{\text{corrected}} = .03$), regardless of duration of infection (Table 1). This association was stronger among females ($\beta = –.5$;
95% CI, −7.7, −7.2; \( P = .0002 \)) but not males (\( \beta = −.3; 95\% \text{ CI}, −.6, −.01; \ P = .05 \)). Homozygosity of the candidate TLR2 597 T allele was associated with lower set-point among seroprevalent cases (\( \beta = −.4; 95\% \text{ CI}, −1, −.7; \ P = .005 \)), but not seroconverters (\( \beta = .3; 95\% \text{ CI}, −.4, 1.1; \ P = .4 \))(interaction \( P\text{-value} = .02 \)).

**TLR Associations With HIV-1 Progression**

At enrollment, HIV-1 seroprevalent cases with the candidate non-synonymous TLR8 1A/G polymorphism had higher median CD4+ T cells/mm\(^3\) (442; IQR: 334–636) than those with the AA genotype (405; IQR: 325–535) and this association was significant under a dominant model of inheritance (\( \beta = 49.3; 95\% \text{ CI}, 2.6–96.1; \ P = .04 \)). When evaluating associations with HIV-1 disease progression, TLR8 1A/G was protective among all participants (hazard ratio [HR] = 0.7; 95% CI, 0.4–1.0; \( P = .05 \)) and was stronger among females (HR = 0.5; 95% CI, 0.3–0.9; \( P = .03 \))(Figure 1B). This association remained after participants with ART initiation or death as their disease progression end-point were removed.

**DISCUSSION**

Innate immune responses through TLR signaling may be important in HIV-1 infection. We found that polymorphisms in TLR2 and TLR7 were associated with HIV-1 set-point, TLR8 with disease progression, and TLR9 with HIV-1 acquisition. These relationships may be modified by HIV-1 exposure levels and duration of HIV-1 infection, providing a potential context for understanding previous study results.

In our study, TLR9 1635A/G was 1.4-times more prevalent among HIV-1 exposed seronegative controls than infected cases. This is the first report of an association between this SNP and reduced HIV-1 acquisition, but is consistent with previous protective associations with HIV-1 progression and set-point [2, 6]. We did not find an association between this SNP and disease progression or set point. This may be due to differences in ethnicity (African vs Caucasian) or background characteristics (heterosexual, MSM or IDU) of these study populations. Perinatal HIV-1 transmission studies found this locus to associate with increased acquisition risk, possibly reflecting differences in heterosexual and vertical transmission [7]. One possible reason for protective effects of this SNP among adults is that it may overcome HIV-1 gp120 suppression of IFN-\( \alpha \) responses to TLR9 agonists in pDCs, thereby maintaining production of antiviral and inflammatory responses against HIV-1 [11]. This association was more pronounced when comparing HIV-1 infected cases to controls with high, but not low, HIV-1 exposure, demonstrating that detection of host risk factors for sexual HIV-1 acquisition may be influenced by exposure levels among seronegative participants [10].

We found TLR2 and TLR7 SNP associations with HIV-1 set-point. The TLR2 597C/T SNP was associated with 0.4 log\(_{10}\) copies/mL lower viral load among HIV-1 seroprevalent cases but not among recent seroconverters, suggesting that effects of
this SNP may vary over the course of infection. Although TLR2 recognizes bacteria, fungi, and parasites, it could influence responses to HIV-1 by enhancing chronic immune activation through translocation of gut-associated microbial factors [12].

TLR7 rs179012 was associated with 0.4 log10 copies/mL lower set-point among all HIV-infected participants. One hypothesis for similar TLR7 associations during early and chronic infection is that trafficking of HIV-1 to early endosomes instead of lysosomes elicits chronic immune activation through persistent release of IFN-α in the absence of pro-inflammatory cytokines [13], resulting in more targets for HIV-1 throughout acute and chronic infection. A recent study of TLR signaling pathways suggests that responses to a TLR2 agonist varied by duration of infection; in contrast, TLR7 agonist responses were detectable during acute and chronic infection [14]. Further studies may elucidate how TLR signaling through these variant receptors impact plasma HIV-1 levels throughout infection.

Finally, consistent with previous studies, TLR8 1A/G was associated with slower HIV-1 progression due to CD4+ T cell decline [4]. This SNP is associated with elevated TNF-α, reduced IL-10 production, and elevated prostaglandin E2 and leukotriene B4, which are associated with reduced HIV-1 replication and disease progression [4].

An advantage of our study was having longitudinal data from both partners in heterosexual African HIV-1 serodiscordant couples, including chronically infected individuals, HIV-1 seroconverters, and HIV-1 exposed seronegative individuals with varying exposure levels. This allowed us to evaluate if TLR SNP associations differed by time since HIV-1 infection and to consideration of common variants among East and southern Africans. Second, selecting tagSNPs from Yorubans could limit representation of common variants among East and southern Africans.

Two previous GWA studies, including one among participants from our study, did not identify TLR SNP associations with HIV-1 acquisition or set-point [9, 15], but did not consider a priori information regarding TLR associations with HIV-1 outcomes and applied rigororous multiple testing corrections for all SNPs. In our GWA, we had 80% power to detect associations with relative risks >3.2 for variants with minor allele frequency = 5% and, thus, may have missed modest associations.
In the current candidate gene study, we sought to confirm associations for candidate SNPs and were powered to detect modest associations. Additionally, both GWA studies used standard GWAS chips designed for European populations and less than half of the variants considered in the current analysis of Africans were analyzed. Lower linkage disequilibrium in Africans could accentuate the impact of missed variants.

In summary, our results further suggest that TLR polymorphisms alter the course of HIV-1 acquisition and infection. However, validation in other study populations or through functional assays is needed. Research designed to evaluate functional mechanisms might test how these polymorphisms influence pro-inflammatory cytokine levels and IFN-α following stimulation with TLR agonists. An integrated evaluation of innate immune functional pathways mediating these phenotypes may identify new targets for HIV-1 preventative and therapeutic interventions.

Supplementary Data

Supplementary materials are available at The Journal of Infectious Diseases online (http://jid.oxfordjournals.org/). Supplementary materials consist of data provided by the author that are published to benefit the reader. The posted materials are not copyedited. The contents of all supplementary data are the sole responsibility of the authors. Questions or messages regarding errors should be addressed to the author.

Notes


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