HIV Update in Laboratory Testing

Patricia Slev, PhD, D(ABCC)
Objectives

• Explain the advances in HIV diagnostics, including fourth generation Ag/Ab combination HIV screening assays

• Describe the new CDC HIV diagnostic algorithm

• Explain appropriate testing algorithm and understand interpretation of laboratory results for HIV
Questions

• What is a fourth generation HIV screening assay (describe)
• Is there a rapid test that detects both HIV Ag & Ab (true or false)
• Preliminary results from a rapid test must proceed to confirmation with the Western blot (true or false)
Updated HIV Testing Guidelines

CDC, APHL together offer recommendations for HIV testing, based on the best available scientific evidence. READ MORE
Estimated that only 19% of HIV-infected individuals in the US have undetectable HIV viral load.
2006 CDC Guidelines
“Universal Testing”

- Routine HIV voluntary, not based on risk

- Opt-Out option to decline, general consent for care includes HIV testing

- Population 13 - 64 years old

- Venue inpatient services, ED, urgent care, STD clinics, substance abuse and correctional facilities
Grade A Recommendation for Routine HIV Testing in individuals 15-65 yrs of age

Impact - Reimbursement
Human Immunodeficiency Virus

Types
- HIV-1
- HIV-2

Groups
- Major
- Non M/Non O
- Outlier

Subtypes/Clades

Circulating Recombinant Forms (CRF)

chimpanzee

sooty mangabey
HIV Distribution
HIV-2
(prior recommendations)

Persons at risk for HIV-2 infection include

- Sex partners of a person from a country where HIV-2 is endemic
- Sex partners of a person known to be infected with HIV-2
- People who received a blood transfusion or a nonsterile injection in a country where HIV-2 is endemic
- People who shared needles with a person from a country where HIV-2 is endemic or with a person known to be infected with HIV-2
- Children of women who have risk factors for HIV-2 infection or are known to be infected with HIV-2

HIV-2 testing is also indicated for

- People with an illness that suggests HIV infection (such as an HIV-associated opportunistic infection) but are not HIV-1 positive
- People for whom HIV-1 Western blot exhibits the unusual indeterminate test band pattern of gag (p55, p24, or p17) plus pol (p66, p51, or p32) in the absence of env (gp160, gp120, or gp41)

- **HIV Cases**
  166 confirmed cases between 1988-2010; 0.01% of all HIV cases in the US
  81% people born in West Africa; most positive on HIV-1 Western blot
HIV Infection Course

Adapted from Roche and Siemens slides
HIV Serological Response

Typical response following infection

- HIV p24 Antigen
- gag anti-HIV
- env anti-HIV
- pol anti-HIV

Weeks following infection

years
“Traditional” HIV Diagnostic Algorithm

1. Screen
   - immunoassay (EIA/CIA)
   - rapid tests

2. Confirmation for HIV-1
   - Western blot (98%)
   - IFA
   - Nucleic Acid Amplification Test *

*Note: TMA format, qualitative assay only FDA approved nucleic acid amplification test (NAAT) for diagnosis and confirmation. There are no viral load tests approved for diagnosis
*Could be an IgM sensitive Ab immunoassay if Ag/Ab combination assay is unavailable

AACC. Clinical Laboratory News. 2010
Rapid Test – Point of Care

- Most are equivalent to 2\textsuperscript{nd} gen assays
- One kit Ag/Ab combo (not incorporated in the algorithm)
- One kit approved for in-home testing
- Sample types
  - plasma, serum, whole blood, oral fluid
  - unprocessed sample types (oral fluid & whole blood) are CLIA waived, all others are moderately complex
OraQuick® Advance

- Synthetic gp-41 (HIV-1)
- Synthetic gp-36 (HIV-2)
- Goat anti-human IgG

Photograph from CDC: www.cdc.gov/hiv/rapid_testing
HIV-1/HIV-2 Differentiation Assay

- Rapid test
  2 Ags for HIV-1 (gp41); 1 Ag for HIV-2 (gp36)
- Geenius
  2 Ags for HIV-2 (gp36, gp140)
  4 Ags for (p24, gp41-O&M, gp160, p31)
<table>
<thead>
<tr>
<th>HIV-1/HIV-2 Differentiation Assays</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Multispot</strong></td>
</tr>
<tr>
<td>• No bar code</td>
</tr>
<tr>
<td>• Interpretation - visual</td>
</tr>
<tr>
<td>• 30 minutes</td>
</tr>
<tr>
<td>• No result storage</td>
</tr>
<tr>
<td><strong>Geenius</strong></td>
</tr>
<tr>
<td>• Bar code</td>
</tr>
<tr>
<td>• Interpretation – automated</td>
</tr>
<tr>
<td>• 30 minutes</td>
</tr>
<tr>
<td>• Result is stored</td>
</tr>
</tbody>
</table>

[The University of Utah Department of Pathology logo] [ARUP Laboratories logo]
HIV Ab Screening Assays (3rd gen – IgM and IgG)

- Third generation assays (IgG/IgM); antigen sandwich assay
- Detect HIV infection on day 22
- Detect HIV-1/HIV-2 and HIV-1 group O depending on the assay
- Several automated platforms

RNA (viral load)

HIV IgM

HIV IgG

3rd gen
HIV Antigen/Antibody Combination Assays
(4th gen – p24 Ag/IgM/IgG)

- Detect both HIV-1 (group O) and HIV-2 antibodies and p24 antigen
- Do not distinguish between Ab+ or Ag+
- Do not differentiate between HIV-1 and HIV-2
- Only two FDA–cleared assays

Earlier Detection of HIV Infection: (4th generation)

Detects infection at 2.5 - 3.0 weeks, 5 days earlier than 3rd gen
## Combo Ag/Ab & Acute HIV Infection (4th generation)

<table>
<thead>
<tr>
<th>Acute HIV patient</th>
<th>Days from 1st bleed</th>
<th>HIV-1 RNA copies (mL)</th>
<th>GS HIV Combo Ag/Ab</th>
<th>Historical results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HIV-1/HIV-2 EIA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HIV-1 EIA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>WB</td>
</tr>
<tr>
<td>1</td>
<td>0</td>
<td>&gt;500,000</td>
<td>R</td>
<td>NR</td>
</tr>
<tr>
<td></td>
<td>56</td>
<td></td>
<td>R</td>
<td>NR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Neg</td>
</tr>
<tr>
<td>2</td>
<td>0</td>
<td>183,850</td>
<td>R</td>
<td>NR</td>
</tr>
<tr>
<td></td>
<td>16</td>
<td></td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td></td>
<td>42</td>
<td></td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td></td>
<td>19</td>
<td></td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>&gt;500,000</td>
<td>R</td>
<td>NR</td>
</tr>
<tr>
<td></td>
<td>21</td>
<td></td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td></td>
<td>64</td>
<td></td>
<td>RR</td>
<td>R</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Pos</td>
</tr>
</tbody>
</table>

Adapted from Bentsen et al. Journal of Clinical Virology 2011.
## HIV Combo Ag/Ab Specificity

(4th generation)

<table>
<thead>
<tr>
<th>Low Risk Population</th>
<th>Number tested</th>
<th>HIV Ag/Ab Combo</th>
<th>Repeatedly reactive Samples</th>
<th>Specificity (#negative/total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health insurance applicants</td>
<td>2000</td>
<td>6 (0.30%)</td>
<td>2</td>
<td>99.8%</td>
</tr>
<tr>
<td>Normal blood donors</td>
<td>2000</td>
<td>0 (0.0%)</td>
<td>NT</td>
<td>100%</td>
</tr>
<tr>
<td>Pregnant women</td>
<td>1000</td>
<td>2 (0.20%)</td>
<td>1</td>
<td>99.9%</td>
</tr>
<tr>
<td>Military recruits</td>
<td>1000</td>
<td>3 (0.30%)</td>
<td>1</td>
<td>99.8%</td>
</tr>
<tr>
<td>Healthy pediatric subjects</td>
<td>100</td>
<td>0 (0.0%)</td>
<td>NT</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>6100</td>
<td>11 (0.18%)</td>
<td>4</td>
<td>99.89%</td>
</tr>
</tbody>
</table>

Adapted from Bentsen et al. Journal of Clinical Virology 2011.
False Positive Immunoassay Results

- Vaccinations
  - flu
  - rabies
- HIV vaccine trials
- Autoimmune disease
- Heterophile Antibodies
- Other viral infections
Screening Test

- Sensitivity = 96% and Specificity = 99.8%

\[
\text{Sensitivity} = \frac{TP}{TP + FN}
\]

\[
\text{Specificity} = \frac{TN}{TN + FP}
\]

- But we need to know the predictive value
Supplemental/Confirmatory Testing

• Assume the infection rate is 1 per 500

• Testing 10,000 random subjects will yield
  – 20 false repeatedly reactive
  – 19 true repeatedly reactive
  – 9,960 true nonreactives
  – 1 false nonreactives

• Therefore, $PV^+ = 49\%, PV^- = 99.99\%$

• Testing needed to separate repeat reactives
Confirmation by Western Blot

CDC Interpretation Criteria
- Positive: presence of 2 of 3 cardinal bands
- Negative: absence of all bands
- Indeterminate: does not meet + or - criteria
Why Not the Western Blot?

- **Diagnostic Limitations**
  - indeterminate/inconclusive results, require follow-up
  - insensitive compared to current screening assays
  - HIV-2 misclassification

- **Practical Limitations**
  - access
  - expense
  - turn around time

- **High Specificity for HIV Infection**
Western Blot “Indeterminate”

- Indeterminate results may be due to
  - infected but in the “window”
  - advanced disease, AIDS
  - HIV vaccinated
  - infected with HIV-2
  - uninfected, cross reactivity
    - viral or non-viral bands, recent flu and rabies vaccinations, multiple pregnancies, recipients of multiple transfusions, autoimmune disease
    - study followed 99 blood donors – 91 stable indeterminate Western blot patterns over 30 months

- Indeterminate results require follow-up
  - repeat Western blot – 3 indeterminate results spanning 6 months = negative nucleic acid amplification test (NAAT)
Sensitivity of HIV Assays

Detection of HIV by Diagnostic Tests

 Symptoms
 p24 Antigen
 HIV RNA
 HIV EIA*
 Western blot

Weeks Since Infection

0 1 2 3 4 5 6 7 8 9 10

*3rd generation, IgM-sensitive EIA
*2nd generation EIA
*viral lysate EIA

After Fiebig et al, AIDS 2003; 17(13):1871-9
Detecting HIV Infection and Current Assays

HIV-1 vs HIV-2 and Western Blot

Percentage of specimens with each HIV-1 Western blot band in 114 specimens collected from persons infected with HIV-2 and 1761 specimens positive for HIV-1 by Western blot and Multispot HIV-1/HIV2 assay.

<table>
<thead>
<tr>
<th>Band</th>
<th>HIV-2 (n=114)</th>
<th>HIV-1 (n=1761)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Present</td>
<td>Present but weak</td>
</tr>
<tr>
<td>p17</td>
<td>18.4</td>
<td>93.9</td>
</tr>
<tr>
<td>p24</td>
<td>14.9</td>
<td>4.4</td>
</tr>
<tr>
<td>p31</td>
<td>66.7</td>
<td>1.8</td>
</tr>
</tbody>
</table>

HIV-2 Infection Classification by Western Blot

Comparison of two HIV-1 Western blot interpretive criteria applied to specimens collected from 114 persons known to be infected with HIV-2.ª

<table>
<thead>
<tr>
<th>Current CDC HIV-1 WB criteriaª</th>
<th>Alternative HIV-1 WB criteria + , n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Negative</td>
</tr>
<tr>
<td>Negative</td>
<td>1 (0.9)</td>
</tr>
<tr>
<td>Indeterminate</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Positive</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Total</td>
<td>1 (0.9)</td>
</tr>
</tbody>
</table>

### HIV-1 /HIV-2 Differentiation Assay vs Western Blot

<table>
<thead>
<tr>
<th></th>
<th>HIV 1/2 Diff Assay Positive</th>
<th>HIV1/2 Diff Assay Negative</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Row %</td>
<td>N</td>
</tr>
<tr>
<td>WB positive</td>
<td>8670</td>
<td>99.9%</td>
<td>8</td>
</tr>
<tr>
<td>WB negative</td>
<td>3</td>
<td>15.8%</td>
<td>16</td>
</tr>
<tr>
<td>WB indeterminate</td>
<td>23</td>
<td>36.5%</td>
<td>40</td>
</tr>
<tr>
<td>Total</td>
<td>8696</td>
<td>99.3%</td>
<td>64</td>
</tr>
</tbody>
</table>

Adapted from Torian et al. Journal of Clinical Virology 2011.
NAAT for HIV Diagnosis

- Transcription Mediated Amplification (TMA)
- Screening of high-risk populations
- Known exposure such as needle-stick
- Testing patients with acute HIV-1 symptoms and known exposure
- Screening of newborn babies born to infected mothers
- HIV vaccine studies
- Resolution arm for new screening algorithms
## TMA vs Real-time PCR Tests

<table>
<thead>
<tr>
<th></th>
<th>TMA</th>
<th>Real Time (1)</th>
<th>Real Time (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sensitivity</strong></td>
<td>30 copies/ml</td>
<td>40 copies/ml</td>
<td>20 copies/ml</td>
</tr>
<tr>
<td><strong>Genotypes</strong></td>
<td>A-O</td>
<td>A-O</td>
<td>A-G</td>
</tr>
<tr>
<td><strong>Amplicon control</strong></td>
<td>Strand Capture</td>
<td>Closed</td>
<td>UTP/UNG, closed</td>
</tr>
<tr>
<td><strong>Automation</strong></td>
<td>No (U.S.)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>FDA approval</strong></td>
<td>Diagnosis</td>
<td>Monitor</td>
<td>Monitor</td>
</tr>
</tbody>
</table>
Molecular Take-Home Points

• Only TMA format is approved for HIV diagnosis. Automation may eventually occur.

• Viral Load tests may have equivalent “analytic performance” compared to TMA. Guidelines stirred interest in claims for diagnosis. Process will be slow.

• Very few LDT HIV-2 RNA assays available.
Rapid Tests

1. HIV-1/HIV-2 Ag/Ab combination immunoassay (recommended, sensitive 3rd gen allowed)

   (+) (−)

2. HIV-1/HIV-2 Differentiation Assay

   HIV-1 (+) HIV-2 (−) HIV-1 (−) HIV-2 (+) HIV-1 (+) HIV-2 (%) HIV-1 (−) or IND, HIV-2 (−)

   HIV-1 Ab HIV-2 Ab HIV- Abs undifferentiated

3. HIV-1 NAAT

   (+) (−)

   Acute HIV-1 Negative for HIV-1
HIV Summary

- New algorithm encourages use of HIV Ag/Ab combo assay to improve detection of acute HIV infection
  - Only two lab platforms currently available for Ag/Ab Combo assays
  - Sensitive 3rd gen allowed
- New algorithm replaces the Western blot supplemental testing with HIV-1/HIV-2 discriminatory assay to improve detection of HIV-2 infection
  - Only one rapid test platform can discriminate between HIV-1 and HIV-2 infection
  - Interpretation for the differentiation assay depends on use (screen vs supplemental)
  - Indeterminate results are possible
HIV Summary

• NAAT is formally incorporated into the algorithm
  – There is only one qualitative molecular assay approved for HIV diagnosis, TMA format, that is not automated and therefore not readily available
  – NAAT are designed to detect HIV-1
  – NAAT for HIV-2 are not FDA–cleared

• Rapid tests must proceed to 4th gen lab test, the starting point in the algorithm
  – including preliminary positive samples with Ag/Ab 4th gen rapid test
  – rapid tests are no longer confirmed with Western blot
Thank you!