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Absence of Circulating Natural Killer and Primed CD8\(^+\) Cells in Life-Threatening Varicella

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Five pediatric patients with no history of immunodeficiency had a life-threatening course of varicella. Strikingly, natural killer (NK) cells were absent from the circulation in all children, and, despite active viral infection, up to 98% of the CD8\(^+\) cells were naive. Primary immunodeficiencies were excluded—NK cells and primed CD8\(^+\) cells reappeared in the circulation, granzymes were detectable in plasma early during infection, and no abnormalities could be detected in interleukin-15 receptor function. Our data indicate that varicella-zoster virus (VZV) has a unique capability to seclude primed CD8\(^+\) cells and NK cells from the circulating lymphocyte pool. This may be the consequence of an overwhelming immune response to VZV that is influenced by factors such as infectious dose, age, and the presence of maternal antibodies during infancy. Because both homozygous twin sisters in the study had a severe course of varicella, particular genetic factors may contribute to severe varicella.

Primary infection with varicella-zoster virus (VZV) results in varicella (chickenpox), a highly contagious disease characterized by fever, malaise, and a generalized vesicular rash (exanthem). After primary infection, the virus remains latent in dorsal root ganglia. In countries of temperate climates where VZV vaccination is not implemented in routine childhood vaccinations, such as The Netherlands, >95% of children become infected before they are 5 years old. Varicella is usually a benign and self-limiting illness, although it may lead to discomfort. Nonetheless, complications are seen in otherwise healthy children, such as bacterial superinfection of the cutaneous lesions, VZV pneumonia, cerebellar ataxia, and viral encephalitis [1]. In immunocompromised individuals, the risk of these complications is highly increased [1].

Before the appearance of the vesicular exanthem, abundant VZV replication is suppressed by the innate immune system. However, the innate immune system is incapable of containing the virus completely. The adaptive immune response is subsequently activated by the clonal expansion of VZV-specific T and B cells that interfere with viral replication and spread of the virus. VZV-specific CD4\(^+\) cells secrete cytokines, such as interleukin (IL)–2 and interferons (IFNs), and may exhibit major histocompatibility class II–restricted cytotoxicity [2–4]. So far, VZV-specific CD8\(^+\) cells could not be detected because of the paucity of experimental tools. Nevertheless, CD8\(^+\) cells are thought to constitute one of the main effector arms in the immune response and to be responsible for viral clearance and protection on reexposure. Studies of other persistent viruses have shown that, during primary infection, CD8\(^+\) cells expand and differentiate. CD8\(^+\) cells can be subdivided into functional subsets by use of markers such as CD45RA, the costimulatory molecule CD27 [5], and CCR7 [6]. During acute infection, virus-specific CD8\(^+\) cells show a CD45RA\(^-\)/CD27\(^-\)/CCR7\(^-\) phenotype and abundantly express perforin and proteases such as granzymes (Grs) [7].

NK cells are also believed to be important in the clearance of herpesvirus infections [8, 9]. Biron et al.
[10] described a female patient with a severe course of VZV infection accompanied by a complete absence of NK cells, which persisted after resolution of the infection. NK cells normally constitute up to 15% of circulating human lymphocytes. The development of NK cells is dependent on cell-to-cell contact between their progenitors and bone-marrow stromal cells, on cytokines such as IL-15, and on growth factors such as the Flt3 ligand and stem-cell factor [11]. Although the precise mechanisms of the activation of NK cells have yet to be resolved, it appears that the regulation of NK cell activity results from a balance between signals from activating and inhibitory receptors on the cell, the latter of which is dominant in steady state [12, 13].

We describe 5 children with a severe course of varicella who had symptoms that included generalized varicella, skin infection, pneumonitis, hepatitis, and encephalitis. None of these children had a history of recurrent infection or known immunodeficiency. Four of the children were admitted to the pediatric intensive care unit (PICU) of the Emma Children’s Hospital at the Academic Medical Center. After >4–12 weeks of intensive treatment, 4 of the children recovered, and the fifth child died of multiorgan failure. We studied functions and phenotypes of T and NK cells to investigate the incapability of these children to control the virus adequately.

**PATIENTS, MATERIALS, AND METHODS**

**Patients.** Five children with a severe course of varicella were admitted to the Emma Children’s Hospital at the Academic Medical Center (index patients). Four of these children were admitted to the PICU because of respiratory and circulatory failure. The cohort included 1 female homozygous set of twins, of which 1 child was admitted to the PICU (patient 4), whereas the other child had a severe, yet not life-threatening, course of varicella (patient 5). The children differed in age and sex (table 1). According to the clinical scoring system of Vazquez et al. [14], rash, character of the lesions, height of fever, and systemic signs and a subjective assessment of the patient’s appearance determined the severity of varicella. According to this scoring system, all children were categorized as having “severe disease” caused by VZV (i.e., >16 points; table 1). Treatment consisted of intravenous acyclovir, with or without intravenous immunoglobulins, along with medication for respiratory and circulatory support. Blood samples were obtained from the patients at early (within 10 days) and late (4–6 weeks) time points after the appearance of exanthem.

We included 3 children with varicella who were admitted to the PICU because of respiratory and circulatory failure caused by complications (bacterial superinfections) as control subjects for our index patients. One of these children (4 months old) had <50 vesicles and epiglottis. Blood cultures from this patient were positive for *Haemophilus influenzae* type b (Hib); she had been vaccinated once for Hib in the past. The second child (11 months old) had bilateral lobar pneumonia; blood cultures were positive for *Streptococcus pneumoniae*. The third child (2 years old) was admitted with blood culture–positive septic shock caused by group A β-hemolytic streptococci spreading from impetiginized vesicles. These patients had a rash of <200 vesicles and looked severely ill. All 3 patients had “moderately severe disease” (i.e., 14 points) [14]. A second group of control subjects (diagnosed and monitored at the outpatient care unit) consisted of children with mild varicella (severity score, 6.2; n = 8; mean age, 3.8 years) [14]. Blood samples from these control subjects were collected and stored when permitted by parental consent.

**Determination of VZV-specific CD4+ cells by intracellular cytokine staining.** Peripheral blood mononuclear cells (PBMCs) were isolated by use of standard density-gradient centrifugation techniques with Lymphoprep (Nycomed; Pharma). PBMCs were cryopreserved until use and thawed according to standard procedures. VZV-specific CD4+ cell frequencies were determined as described elsewhere [4]. In brief, PBMCs were stimulated for 6 h with VZV antigen (20 μL/mL; Microbix Biosystems), the final 5 h in the presence of brefeldin A (10 μg/mL; Sigma Chemical), and costimulated with anti-CD28 (2 μg/mL; CLB 15E8; Sanquin) and anti-CD49d (1 μg/mL; BD Biosciences). Next, cells were

### Table 1. Characteristics of the patients.

<table>
<thead>
<tr>
<th>Patient (sex)</th>
<th>Age at onset of varicella</th>
<th>Admissiona</th>
<th>Symptoms</th>
<th>Severity scoreb</th>
<th>Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (M)</td>
<td>8 months</td>
<td>4</td>
<td>Vesicular rash, pneumonitis, hepatitis, encephalitis</td>
<td>30</td>
<td>Acyclovir, IVIG, clindamycin</td>
</tr>
<tr>
<td>2 (M)</td>
<td>10 months</td>
<td>7</td>
<td>Vesicular rash, pneumonitis, hepatitis</td>
<td>25</td>
<td>Acyclovir, IVIG, clindamycin</td>
</tr>
<tr>
<td>3 (F)</td>
<td>5 years</td>
<td>5</td>
<td>Vesicular rash, encephalitis, multiorgan failure</td>
<td>30</td>
<td>Acyclovir, IVIG, clindamycin</td>
</tr>
<tr>
<td>4c (F)</td>
<td>11 months</td>
<td>2</td>
<td>Vesicular rash, pneumonitis, hepatitis</td>
<td>24</td>
<td>Acyclovir, clindamycin</td>
</tr>
<tr>
<td>5c (F)</td>
<td>11 months</td>
<td>1</td>
<td>Vesicular rash, pneumonitis</td>
<td>16</td>
<td>Acyclovir</td>
</tr>
</tbody>
</table>

**NOTE.** IVIG, intravenous immunoglobulins.

a Days after onset of rash; the no. of lesions remained <500 in all cases.

b According to Vazquez et al. [14], mild disease, <7 points; moderately severe disease, 8–15 points; severe disease, >18 points on a scale to assess severity of varicella.

c Homozygous twins.
Figure 1. Varicella-zoster virus (VZV) load in blood during the course of varicella. High VZV loads were detected in blood from patient 3 during the early phase of varicella (within 10 days after appearance of the exanthem) and remained high throughout the infection. VZV loads were observed in blood from patients 1, 4, and 5 that were comparable to those in control subjects (pediatric patients with a mild course of varicella). No data were available for patient 2. Differences of VZV loads between the patient groups were not statistically significant. Early, within 10 days after the appearance of the vesicular exanthem. Late, 4–6 weeks after the appearance of exanthem.

Table 2. NK cells in varicella-zoster virus (VZV)–induced life-threatening varicella, compared with those in varicella complicated by bacterial super- or coinfection.

<table>
<thead>
<tr>
<th>Infection</th>
<th>Severe VZV disease (n = 5)</th>
<th>Complicated VZV disease (n = 3)a</th>
<th>Age of control subjectsb</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>&lt;1 year (n = 34)</td>
</tr>
<tr>
<td>Severity scorec</td>
<td>22</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NK cells, cells/μL</td>
<td>20 ± 20</td>
<td>510 ± 100</td>
<td>.001</td>
</tr>
<tr>
<td>NK cells, % lymphocytes</td>
<td>0.9 ± 0.6</td>
<td>10.2 ± 3.4</td>
<td>.020</td>
</tr>
<tr>
<td>Convalescent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NK cells, cells/μL</td>
<td>230 ± 90</td>
<td>520 ± 320</td>
<td>.06</td>
</tr>
<tr>
<td>NK cells, % lymphocytes</td>
<td>6.5 ± 3.6</td>
<td>10.1 ± 8.1</td>
<td>.35</td>
</tr>
</tbody>
</table>

NOTE. Data are mean ± SD.

a Patients (n = 3) with epiglottis, pneumococcal pneumonia, and group A β-hemolytic streptococcal septicemia, respectively.

b The control subjects were of mixed racial background.

c Severity score according to Vazquez et al. [14]: mild disease, <7; moderate, 8–15; and severe, >16.
Figure 2. Disturbed pattern of NK cells and primed CD8+ cells in peripheral blood from patients. During the early phase of infection ("early"), NK cells (A, gated on CD3+ lymphocytes; nos. indicate the percentage of CD3+CD56+ cells within the total lymphocyte pool) and primed CD8+ cells (B, gated on CD8+ cells) were absent from peripheral blood from patients, despite acute viral infection, whereas these cells appeared in peripheral blood during the late phase of infection ("late"). NK cells and primed (i.e., CD45RA+CD27+, CD45RA−CD27+, or CD45RA−CD27−) CD8+ cells were detectable in peripheral blood at all time points after varicella-zoster virus infection in 1 of the representative pediatric control subjects, who had a mild course of varicella. C, Normal distribution of CD4+ cells throughout the infection. For patients, "early" refers to within 10 days and "late" to 4–6 weeks after the appearance of the vesicular exanthem. Because control subjects with mild varicella resolved the infection within 1 week, "early" refers to 0–3 days and "late" to 7–10 days after the appearance of exanthem in these children.
labeled cells were cultured in 24-well plates at concentrations of 0.5–1 × 10⁶ cells/mL in culture medium in the presence or absence of IL-15 (10 ng/mL; R&D Systems) for 5 days.

**Gr ELISA.** Cell-free plasma samples were collected from heparin-anticoagulated blood from the patients. ELISAs to measure the levels of GrA and GrB were performed as described elsewhere [16].

**NK cell cytotoxicity assay.** The target cell line K562 was prepared by labeling it with ⁵¹Cr (Amersham Pharmacia Biotech) for 1 h at 37°C in 5% CO₂. ⁵¹Cr-labeled target cells were incubated in triplicate with NK cells at various effector:target ratios for 4 h at 37°C in 5% CO₂. Spontaneous release was determined by the incubation of labeled target cells with medium and maximal release by incubation with NP40 solution. Supernatants were harvested and counted in a γ-radiation detector. The percentage of specific lysis was calculated from the following formula: percentage specific lysis = [(experimental release−spontaneous release)/(maximal release−spontaneous release)] × 100%.

**Statistics.** Where applicable, differences in means between groups were determined by Student’s t test. P < .05 was considered to be statistically significant. All analyses were done by use of SPSS (version 11.5; SPSS).

**RESULTS**

**VZV load in blood samples.** VZV loads in blood samples from patients 1, 4, and 5, obtained during the early phase of infection, were within the range of loads observed in pediatric patients with a mild to moderate course of varicella (figure 1). Loads decreased during the course of infection to background levels similar to those observed in control subjects after resolution of the infection (figure 1). In contrast, the VZV load in patient 3 was high during the early phase of infection, and, although the load decreased, it remained high throughout the course of infection. VZV loads were not determined in serial blood samples from patient 2. Taken together, the differences between the index patients and the control patients with mild to moderate VZV infection did not reach statistical significance.

**Disturbed distribution of CD8⁺ and NK cells in blood during the early phase of VZV infection.** With regard to humoral immunity, immunoglobulin spectra were normal. The patients had developed normal antibody responses to childhood vaccinations (diphtheria–tetanus toxoids–pertussis–polio-Hib at age 2, 3, 4, and 11 months for all patients or mumps-measles-rubella at age 14 months for patient 3). VZV-specific IgM and IgG could be detected in blood from the patients at the time of admission (before treatment with immunoglobulins) and 3–4 months after convalescence (data not shown).

Because T cells and NK cells play a key role in control of VZV infection, the presence and differentiation of these cells were studied. Significantly lower levels of NK cells were found in the 5 index patients, compared with those in the 3 patients admitted to the PICU because of circulatory and respiratory failure caused by bacterial superinfection during acute varicella (table 2; P = .001, absolute numbers; P = .02 percentages). Furthermore, NK cells were detectable in children with a mild course of varicella (figure 2A). The levels of NK cells in the index patients normalized during convalescence (table 2). Although the index patients had an acute viral infection, the majority of CD8⁺ cells found during the early phase of infection were of the naive subset (i.e., CD45RA⁺CD27⁺). Significantly lower levels of primed CD8⁺ cells were detectable in the index patients, compared with those in the control patients in the PICU (table 3). Furthermore, in control patients with a mild course of varicella, CD8⁺ cells showed a primed phenotype (i.e., CD45RA⁻CD27⁺, CD45RA⁻CD27⁻, or CD45RA⁺CD27⁺) and

Table 3. **T cell subsets in varicella-zoster virus (VZV)–induced life-threatening varicella, compared with varicella complicated by bacterial super- or coinfection.**

<table>
<thead>
<tr>
<th>Cell subset</th>
<th>VZV disease</th>
<th>Age of control subjects &lt;1 year&lt;sup&gt;a&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Acute severe&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Convalescent&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>CD4⁺</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naive (CD45RA⁺CD27⁺)</td>
<td>89.6 ± 3.3</td>
<td>88.4 ± 6.4</td>
</tr>
<tr>
<td>Memory (CD45RA⁺CD27⁺)</td>
<td>9.5 ± 3.5</td>
<td>10.6 ± 7.2</td>
</tr>
<tr>
<td>Effector/memory (CD27⁻)</td>
<td>1.2 ± 0.5</td>
<td>1.4 ± 1.1</td>
</tr>
<tr>
<td>CD8⁺</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naive (CD45RA⁺CD27⁺)</td>
<td>92.6 ± 3.4</td>
<td>75.0 ± 11.0</td>
</tr>
<tr>
<td>Memory (CD45RA⁺CD27⁺)</td>
<td>5.0 ± 1.6</td>
<td>17.6 ± 12.6</td>
</tr>
<tr>
<td>Effector/memory (CD27⁻)</td>
<td>1.8 ± 1.6</td>
<td>4.8 ± 3.6</td>
</tr>
</tbody>
</table>

**NOTE.** Data are mean ± SD.

<sup>a</sup> Patients (n = 3) with epiglottis, pneumococcal pneumonia, and group A β-hemolytic streptococcal septicemia, respectively; P values are derived from Student’s t test of acute severe VZV disease vs. complicated VZV disease.

<sup>b</sup> Age of control subjects <12 months, n = 16; mixed racial background; P values are derived from Student’s t test on acute severe VZV disease vs. age of control subjects <1 year.
Lack of Cytotoxic Cells in Severe VZV

Figure 3. Secretion of granzymes (Gr) A and B in plasma. During the early phase of varicella-zoster virus infection, all patients secreted GrA and GrB in plasma. High levels of these cytolytic proteins were detected in plasma from patient 1, compared with the pediatric control subjects (who had mild varicella). The levels of Gr secretion normalized in these patients during the course of infection. At both the early and the late time point, the differences in Gr concentrations between the patient groups were not statistically significant. Early, within 10 days after the appearance of the vesicular exanthem. Late, 4–6 weeks after the appearance of exanthem. Dotted horizontal line, detection limit of ELISA.

Table 4. Varicella-zoster virus (VZV)-specific CD4+ cells.

<table>
<thead>
<tr>
<th>Patients</th>
<th>Early, %</th>
<th>Late, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index</td>
<td>0.02</td>
<td>0.10</td>
</tr>
<tr>
<td>1</td>
<td>0.03</td>
<td>0.06</td>
</tr>
<tr>
<td>2</td>
<td>0.00</td>
<td>0.05</td>
</tr>
<tr>
<td>3</td>
<td>0.02</td>
<td>0.06</td>
</tr>
<tr>
<td>4</td>
<td>0.00</td>
<td>0.02</td>
</tr>
<tr>
<td>5</td>
<td>0.00</td>
<td>0.02</td>
</tr>
<tr>
<td>Mild VZV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control 1</td>
<td>0.23</td>
<td>0.05</td>
</tr>
<tr>
<td>Control 2</td>
<td>0.13</td>
<td>0.03</td>
</tr>
</tbody>
</table>

NOTE. Nos. indicate the percentages of specific interferon-γ/CD69+ cells within the CD4+ cell population. From 2 control subjects, serial samples were available at identical time points as those tested in the index patients. Early, within 10 days after the appearance of exanthem; late, 4–6 weeks after the appearance of exanthem.

Delayed appearance of VZV-specific CD4+ cells in blood.

The VZV-specific immune response was studied by use of a functional assay in which VZV-specific CD4+ cells were detected by the up-regulation of CD69 and the production of IFN-γ after in vitro stimulation with a VZV lysate (VZV antigen) [4]. Only very low frequencies of VZV-specific CD4+ cells could be detected in blood from 3 of the patients during the early phase of infection when we used this assay, whereas these cells were absent from the circulation in the other 2 patients (table 4). Increased frequencies of virus-specific CD4+ cells were detected during the late phase of infection, after treatment with antiviral therapy (table 4). In contrast, these cells were already detectable...
Figure 4. Proliferation of CD8+ cells and NK cells on interleukin (IL–15) stimulation. A, Stimulation with IL-15 resulting in proliferation of CD8+ cells on day 5 of culture (thick line) but no proliferation of CD8+ cells cultured in medium only (thin line). CD8+ cells in peripheral blood during the late phase of infection ("late") exhibited increased proliferative potential, compared with CD8+ T cells during the early phase of infection ("early"). B, Proliferation on stimulation with IL-15 of NK cells that appeared in peripheral blood from patients during the late phase of infection. Data from 1 representative patient (patient 3) are shown. CFSE, 5-(and-6)-carboxyfluorescein diacetate succinimidyl ester.

during the early phase of VZV infection in blood from pediatric patients with a mild course of varicella.

Proper function of the IL-15 receptor. Signaling of IL-15 through the IL-15 receptor is important in the maturation and differentiation of NK and CD8+ cells. CD8+ cells from the patients were able to proliferate on stimulation with IL-15, as was demonstrated by the dilution of CFSE on day 5 of culture, whereas no proliferation was detected when cells were stimulated with medium (figure 4A). CD8+ cells obtained during the late phase of infection exhibited higher proliferative capacity on stimulation with IL-15 than did CD8+ cells obtained during the early phase of infection. Furthermore, NK cells (which were only detectable during the late phase of infection) proliferated on stimulation with IL-15 (figure 4B).

NK cell cytotoxicity. The cytotoxicity of NK cells appearing in blood obtained from the patients during the late phase of infection was determined by K562 lysis. NK cells from all patients were capable of lysing K562 at levels comparable to NK cells derived from pediatric control subjects (figure 5; data from 1 representative control subject are shown).

DISCUSSION

We have described the immune response of 5 patients with a life-threatening—and, in 1 case, fatal—course of varicella. Most strikingly, NK cells and primed CD8+ cells were nearly absent from the circulation during the early phase of primary VZV infection, whereas these cells could be detected in control patients with varicella who were admitted to the PICU because of bacterial super- or coinfection. The absence of these cells, which appear to be crucial in antiviral defense [7, 8, 17, 18], may have resulted from a primary defect in the development or differentiation of these cells. Several observations in our patients excluded this possibility. First, CD8+ and NK cells from the patients proliferated on stimulation with IL-15, a key factor in the differentiation and homeostasis of these cells [19–24], which excluded defects in IL-15–Rα, IL-2–Rβ, the common γ-chain (CD132), or signaling molecules coupled to this receptor [25]. Second, GrA and GrB were detectable in plasma from the patients during the early phase of infection, which suggests that primed CD8+ cells and NK cells were functionally present. Third, primed CD8+ cells and NK cells reappeared in the circulation during convalescence.

Alternatively, the absence of these cytotoxic cells from the circulation could be the consequence of redistribution to target sites. A major caveat of studies of human viral infections is the limitation of compartments that can be studied, which
are largely restricted to the circulating pool of immune cells. The majority of NK cells and primed T cells express chemokine receptors, such as CCR5 and CXCR3, whereas they do not express the secondary lymphoid homing receptor CCR7 [6, 7, 26]. This pattern of chemokine receptor expression enables them to migrate from the circulation to inflamed tissue to eliminate virus-infected cells [27–30]. The distribution of virus-specific cells in peripheral blood may therefore differ from that in target sites [31, 32]. Indeed, several studies have suggested that primed cells may be sequestered from the circulation during viral infection. Virus-specific T cells have been shown to be present at higher frequencies in nonlymphoid tissue than in lymphoid tissue during acute infection in murine models [31, 33]. A few studies of hepatitis B and C virus infections in humans have shown that the percentages of virus-specific T cells are higher in the liver, which is the major target site of these viruses, than in the circulation [34–36].

As our results show, significantly fewer primed CD4+ cells were observed during the early phase of infection in the index patients. A low number of VZV-specific CD4+ cells appeared in the circulation after intensive antiviral treatment, with an extensive delay, compared with that in patients who had mild varicella. These data are consistent with studies that have shown that, during the acute phase of HIV and symptomatic cytomegalovirus (CMV) infection, virus-specific CD4+ cells are kept out of the circulation and only appear after control of the virus by antiviral therapy [37, 38].

The absence of primed CD8+ cells and NK cells from the circulation during life-threatening varicella in our patients seems, at present, to be unique to VZV, given that, in CMV and HIV infection, primed CD8+ cells are detectable in the circulation, regardless of therapeutic intervention [37, 39]. Whereas the targeting of CD4+ cells by CMV, HIV, and VZV from the circulation probably only involves virus-specific CD4+ cells, all primed CD8+ cells were absent from the circulation during the early phase of severe, but not mild, courses of varicella. We therefore suggest that, in some cases, VZV may be able to seclude primed CD8+ cells and NK cells from the circulation.

The patients described in the present study probably had an overwhelming immune response to VZV that was accompanied by high levels of chemokines at the inflamed sites, which led to the targeting of cytotoxic cells at these sites. Because chemokine receptors that enable migration to target sites are present not only on VZV-specific CD8+ cells but also on the majority of primed CD8+ cells, cytotoxic cells of broad antigenic specificities may be sequestered from the circulation. Only after the normalization of the chemokine levels by spontaneous recovery or intervention with antiviral therapy might these cells be enabled to return to the circulation. In addition, the ongoing infection may lead to the exhaustion of primed CD8+ cells and NK cells because of a disturbed balance between the generation of these cells and apoptosis [40–42]. NK cells were absent not only from the circulation during the early phase of infection but also from bone marrow (<100 NK cells/106 cells [n = 3] vs. mean ± SD, 2480 ± 960 NK cells/106 cells in bone marrow from pediatric control subjects [n = 7]), whereas they could be cultured from CD34+-selected hematopoietic stem cells in vitro for the patients from whom sufficient bone marrow was obtained (patients 1 and 3; H. Spits, Academic Medical Center, Amsterdam, The Netherlands, unpublished observation). Although it has never been described, the infection of NK cells by VZV may induce the apoptosis of these cells. However, the restriction of this phenomenon to only NK cells seems implausible.

Severe courses of varicella are rare in otherwise healthy children. Primary VZV infection during infancy has been defined as one of the risk factors for developing complicated varicella [43], which may partly explain the severity of the disease in 4 of our patients. In addition, infectious viral dose, the duration of antigen exposure, and passive protection by maternal antibodies during infancy may influence the induction of the antiviral immune response and, thereby, the severity of the course of varicella. Furthermore, genetic factors may contribute to the outcome of VZV infection, given that both homozygous twin sisters included in the present study developed a complicated course of varicella.

Acknowledgment

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