The Effect of Plasma Human Immunodeficiency Virus RNA and CD4+ T Lymphocytes on Growth Measurements of Hemophilic Boys and Adolescents

Margaret W. Hilgartner, MD; Sharyne M. Donfield, PhD; Henry S. Lynn, PhD; W. Keith Hoots, MD; Edward D. Gomperts, MD; Eric S. Daar, MD; David Chernoff, MD; Sunny K. Pearson, RN, BSN; and the Hemophilia Growth and Development Study

ABSTRACT. Objective. The investigation examined the associations of plasma human immunodeficiency virus (HIV) RNA and CD4+ T lymphocytes with weight, height, skeletal maturation, testosterone levels, and height velocity for hemophilic children and adolescents with HIV infection in the Hemophilia Growth and Development Study.

Study Design. Two hundred seven participants were evaluated over 7 years.

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Study Design. Two hundred seven participants were evaluated over 7 years.

Results. A threefold increment in baseline plasma HIV RNA was associated with a 0.98-cm decrease in height and a 1.67-kg decrease in weight; 100-cells/μL decrements in baseline CD4+ were associated with a 2.51-cm decrease in height and a 3.83-kg decrease in weight. Participants with high plasma HIV RNA (>3125 copies/mL) experienced significant delay in achieving maximum height velocity and lower maximum velocity compared with those with low viral load. The high CD4+ (>243)/low plasma HIV RNA group had earlier age at maximum height velocity compared with the other 3 groups and higher maximum height velocity compared with the low CD4+/high plasma HIV RNA and low CD4+/low plasma HIV RNA groups. Decrements in CD4+ were associated with decreases in bone age and testosterone level.

Conclusions. CD4+ and HIV RNA were important in predicting growth outcomes. Pediatrics 2001;107(4). URL: http://www.pediatrics.org/cgi/content/full/107/4/e56; hemophilia, physical growth, human immunodeficiency virus, immune function, human immunodeficiency virus RNA.

ABBREVIATIONS. HGDS, Hemophilia Growth and Development Study; HIV, human immunodeficiency virus; HAART, highly active antiretroviral therapy.

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sent children and adolescents who had survived with HIV infection for a period of ~7 years. Although enrolled participants necessarily excluded those who died before study inception, there is little evidence of bias introduced into the study because of selection or loss to follow-up of cohort participants. Analyses were conducted with data on height, weight, skeletal maturation, testosterone, CD4\(^+\) counts, and plasma HIV RNA. Height was measured every 6 months using a wall-mounted stadiometer, and weight was recorded every 6 months. Plasma HIV RNA measurements were available annually for 205 participants, and, therefore, a total of 205 participants with 1 to 7 annual height and weight measurements were included in the height and weight analyses. The height velocity analyses, however, used all available semianual and annual height measurements. Skeletal maturation (bone age) was assessed annually up to year 4 from films of the left hand and wrist. Films were read centrally at the Fels Institute, Wright State University. The Fels method\(^6\) was used in the Fels Institute, Wright State University, by the Fels method.\(^6\) One hundred seventy-nine participants with 1 to 5 bone age measurements were included in the bone age analysis. For testosterone, 1 sample from each participant was collected during the first 4 years of study; 169 individuals were included in the analysis.

HIV status was determined by an enzyme immunoassay, with confirmation by Western blot analysis. Testosterone was measured centrally (New York Presbyterian Hospital-Cornell Medical Center) by a specific radioimmunoassay using OP/08 antibody (Pantex, Division of BioAnalysis Inc, Santa Monica, CA). Lymphocyte subpopulations were quantitated centrally, using commercial monoclonal antibodies and direct 2-color immunofluorescence flow cytometry. Heparinized plasma stored at ~70°C was used for HIV RNA measurements using a branched DNA assay, Version 2.0 (Chiron Corporation, Emeryville, CA). The assay has a lower quantification limit of 500 copies/mL and is linear to concentrations as high as 1.6 \times 10^6 copies/mL (1 copy of HIV RNA = 1 molecule of HIV RNA).\(^7,8\)

**Statistical Methods**

Linear mixed effects regression models were fitted to examine the individual effects of plasma HIV RNA and also the joint effects of baseline and repeated CD4\(^+\) and plasma HIV RNA on height, weight, and bone age, while adjusting for the effects of age and ethnicity. Plasma HIV RNA measurements were log-transformed, while CD4\(^+\) levels were square root transformed to better comply with the normality assumptions of the models. Empirical spatial exponential covariance structures were used to model the correlation between the repeated height, weight, and bone age measurements. The longitudinal CD4\(^+\) and plasma HIV RNA measurements were partitioned into a baseline component and a change-from-baseline component to quantify both the cross-sectional effect at baseline and the longitudinal effect. Both components were then entered as predictors for each of the 3 mixed effects regression models.\(^9\)

For analyzing the relationship between immune function and height velocity, each individual’s repeated CD4\(^+\) and plasma HIV RNA values were first averaged over time. The resulting mean values were then dichotomized into low and high groups according to the median values of 243 cells/\(\mu\)L and 3125 copies/mL to provide a clinically straightforward interpretation of average CD4\(^+\) and plasma HIV RNA effects on height velocity. For each of the low/high CD4\(^+\) and plasma HIV RNA categories, a 4-parameter logistic growth curve\(^10\) was fitted using the SAS NLINMIX Macro (SAS, Cary, NC)\(^11\) with age as the predictor. The height velocity function was then obtained by taking the derivative of the estimated logistic growth function. Comparisons of the maximum velocities and the corresponding ages were performed using asymptotic Wald tests.

For the analysis of testosterone, CD4\(^+\) and plasma HIV RNA measurements taken at the corresponding visit when testosterone levels were measured were used as predictors. Linear regression was then used to model the relationship between CD4\(^+\) and plasma HIV RNA and the square root transformed testosterone levels, while adjusting for the effects of age and ethnicity.

**RESULTS**

**Height**

Before controlling for CD4\(^+\), a threefold increment in baseline plasma HIV RNA was associated with a 1.65-cm decrease in height (\(P < .001\)). With CD4\(^+\) included in the model, threefold increments in baseline plasma HIV RNA were associated with a 0.98-cm decrease in height (\(P = .036\)), whereas 100-cells/\(\mu\)L decrements in CD4\(^+\) were associated with a 2.49-cm decrease in height (\(P < .001\)). Plasma HIV RNA and CD4\(^+\) changes from baseline, however, did not contribute to predicting height (\(P = .09\) and \(P = .44\), respectively).

**Weight**

Without adjusting for CD4\(^+\), a threefold increment in baseline plasma HIV RNA was associated with a 2.67-kg decrease in weight (\(P < .001\)). With CD4\(^+\) included in the model, threefold increments in baseline plasma HIV RNA were associated with a 1.67-kg decrease in weight (\(P = .012\)), whereas 100-cells/\(\mu\)L decrements in baseline CD4\(^+\) were associated with a 3.83-kg decrease in weight (\(P < .001\)). One hundred-cells/\(\mu\)L decreases in CD4\(^+\) changes from baseline were also associated with a 1.04-kg decrease in weight (\(P < .019\)), but plasma HIV RNA changes from baseline were not predictive of weight changes (\(P = .27\)).

**Height Velocity**

Participants with high plasma HIV RNA (>3125 copies/mL) experienced a significant delay in achieving their maximum velocity (age = 13.2 years; \(P < .001\)) and also a lower maximum velocity (5.79 cm/year; \(P = .005\)) compared with those with low viral load (age = 12.5 years; maximum velocity = 7.11 cm/year; Fig 1). When the CD4\(^+\) effect was also considered, the high CD4\(^+\) (>243)/low plasma HIV RNA group had an earlier age at maximum velocity compared with the other 3 groups and also higher maximum velocity compared with the low CD4\(^+\)/high plasma HIV RNA and low CD4\(^+\)/low plasma HIV RNA groups (Table 1; Fig 2).

**Bone Age**

Without CD4\(^+\), a threefold increment in baseline plasma HIV RNA was associated with a 0.22-year decrease in bone age (\(P = .004\)). However, after controlling for CD4\(^+\), both the baseline plasma HIV RNA effect (\(P = .128\)) and the longitudinal plasma HIV RNA effect (\(P = .386\)) were not significant. In contrast, 100-cells/\(\mu\)L decrements in baseline CD4\(^+\) were associated with a 0.39-year decrease in bone age (\(P = .002\)), whereas 100-cells/uL decreases over time were associated with a 0.21-year decrease in bone age (\(P = .018\)). Ethnicity was also an important covariate for bone age, where on average, the bone age of whites was 0.67 years lower (\(P = .001\)) than of nonwhites.

**Testosterone**

Before controlling for CD4\(^+\), a threefold increment in baseline plasma HIV RNA was associated with a 1.55-ng/dL decrease in testosterone level (\(P = .002\)). But after controlling for CD4\(^+\), plasma HIV RNA no longer had an effect, although 100-cells/\(\mu\)L decrements in CD4\(^+\) were associated with a 4.61-ng/dL decrease in testosterone level (\(P = .008\)).
Antiretroviral Therapy

Antiretroviral therapy was not a significant covariate for any of the 3 outcomes. Although 86% of study participants received antiretroviral therapy at some time during follow-up, there was minimal use of highly active antiretroviral therapy (HAART). Only 9 participants were treated with protease inhibitor-containing 3 drug regimens during the 7 years of the current investigation, 5 of the 9 having treatment onset <6 months before the final follow-up point.

DISCUSSION

Previous reports from the HGDS have documented reductions in height, height velocity, bone age, and sexual maturation for HIV-infected compared with HIV-uninfected study participants.2-3 The delays in bone age and pubertal maturation suggest that part of the growth failure seen in HIV-infected children can be attributed to pubertal delay.3 Earlier studies of children with hemophilia and HIV reported poor growth in children before the

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**TABLE 1.** Maximum Height Velocity and Age at Maximum Height Velocity for CD4<sup>+</sup> and Plasma HIV RNA Category

<table>
<thead>
<tr>
<th>Category</th>
<th>Maximum Velocity (cm)</th>
<th>Age at Maximum Velocity</th>
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<tr>
<td>High CD4&lt;sup&gt;+&lt;/sup&gt;/low plasma HIV RNA</td>
<td>7.38</td>
<td>12.47</td>
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<tr>
<td>High CD4&lt;sup&gt;+&lt;/sup&gt;/high plasma HIV RNA</td>
<td>6.89</td>
<td>13.13</td>
</tr>
<tr>
<td>Low CD4&lt;sup&gt;+&lt;/sup&gt;/low plasma HIV RNA</td>
<td>5.65</td>
<td>14.45</td>
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<tr>
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<td>5.28</td>
<td>13.32</td>
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<tr>
<th>Comparison With High CD4&lt;sup&gt;+&lt;/sup&gt; Low Plasma HIV RNA</th>
<th>Maximum Velocity Difference</th>
<th>Age Difference</th>
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<tbody>
<tr>
<td>High CD4&lt;sup&gt;+&lt;/sup&gt;/high plasma HIV RNA</td>
<td>−0.49</td>
<td>0.66</td>
</tr>
<tr>
<td>(P = .3660)</td>
<td>(P = .0418)</td>
<td></td>
</tr>
<tr>
<td>Low CD4&lt;sup&gt;+&lt;/sup&gt;/low plasma HIV RNA</td>
<td>−1.73</td>
<td>1.98</td>
</tr>
<tr>
<td>(P = .0020)</td>
<td>(P &lt; .0001)</td>
<td></td>
</tr>
<tr>
<td>Low CD4&lt;sup&gt;+&lt;/sup&gt;/high plasma HIV RNA</td>
<td>−2.10</td>
<td>0.85</td>
</tr>
<tr>
<td>(P &lt; .0001)</td>
<td>(P = .0065)</td>
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onset of HIV-related symptoms,\textsuperscript{12,13} and a subsequent prospective study reported growth failure as a strong prognostic variable for HIV disease progression in HIV-infected children with hemophilia.\textsuperscript{5} Previous investigations of HIV-infected cohorts have examined basal metabolic rate or resting energy expenditure in detail.\textsuperscript{14–18} Although resting energy expenditure was not measured in the HGDS, extensive endocrine evaluations were performed that showed normal thyroid function and insulin-like growth factor-1 levels suggesting that secondary or inadequate caloric intake or the malnutrition of severe illness were not the cause of growth abnormalities and pubertal development.\textsuperscript{4}

Plasma HIV RNA and CD4\textsuperscript{+} T lymphocytes have been established as independent predictors of progression to acquired immunodeficiency syndrome and death in many studies including the HGDS.\textsuperscript{19–23} Data from infants and children enrolled in AIDS Clinical Trials Group 152 also suggested that plasma HIV RNA and CD4\textsuperscript{+} had independent effects for predicting growth failure.\textsuperscript{24} In the current report, plasma HIV RNA had a significant impact on height and weight but not on height velocity, bone age, or testosterone, after controlling for CD4\textsuperscript{+}. Furthermore, baseline immune function was more important in predicting outcome than were changes from baseline. Such results may be influenced by the fact that the children and adolescents in the HGDS had already been infected with HIV for \textasciitilde7 years at the time of the first viral load measurement, a duration that is several years longer than the cohorts investigated in some other studies.\textsuperscript{25,19} In addition, analytical and biological variability in the plasma HIV RNA and CD4\textsuperscript{+} measurements may impact the conclusions of the analysis.\textsuperscript{26} Had the HGDS been designed to quantify the measurement variability in plasma HIV RNA and CD4\textsuperscript{+} T lymphocytes, these estimates of variability then could be incorporated in an analysis controlling for the effects of measurement error.\textsuperscript{27}

The results from analyses of height velocity suggest that the effects of CD4\textsuperscript{+} and plasma HIV RNA on growth were evident throughout childhood and adolescence. In addition, the data indicate that, in general, CD4\textsuperscript{+} count was a more precise predictor of growth outcome in this group of HIV-infected hemophiliac children and adolescents than was plasma HIV RNA. Because so few participants were treated with HAART, it is not likely that the extreme diminution in HIV RNA levels associated with HAART could explain this finding. Rather, the observation is consistent with the explanation that CD4\textsuperscript{+} may serve as a composite reflection of all antecedent plasma HIV RNA levels in the period of infection; and in the current study, CD4\textsuperscript{+} may be more reflective of the

![Graph](image_url)
pathophysiology of both the host and his organ system functions than plasma HIV RNA.

APPENDIX

The following individuals are the Center Directors, Study Coordinators or Committee Chairs of the study: Childrens Hospital Los Angeles, E. Gomperts, W.-Y. Wong, F. Kaufman, M. Nelson, S. Pearson; New York Presbyterian Hospital-Cornell Medical Center, M. Hilgartner, S. Cunningham-Rundles, I. Goldberg; University of Texas Medical School, Houston, W. K. Hoots, K. Loveland, M. Cantini; The National Institutes of Health, National Institute of Child Health and Human Development, A. Willoughby, Robert Nugent; New England Research Institutes, Inc, S. McKinlay; Rho, Inc, S. Donfield; Baylor College of Medicine, C. Contant, Jr; University of Iowa Hospitals and Clinics, C. T. Kisker, J. Stehrens, S. O’Connor, J. McKillip; Tulane University, P. Siros; Children’s Hospital of Oklahoma, C. Sexauer, H. Husbti, F. Kiplinger, S. Hawk; Mount Sinai Medical Center, S. Arkin, A. Forster; University of Nebraska Medical Center, S. Swindells, S. Richard; University of Texas Health Science Center, San Antonio, J. Mangos, A. Scott, R. Davis; Children’s Hospital of Michigan, J. Lusher, I. Warrier, K. Baird-Cox; Miltion S. Hershey Medical Center, M. E. Eyster, D. Ungar, S. Neagley; Indiana Hemophilia and Thrombosis Center, A. Shapiro, J. Morris; University of California-San Diego Medical Center, G. Davignon, P. Mollen; and Kansas City School of Medicine, Children’s Mercy Hospital, B. Wicklund, A. Mehrhof.

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