Value of Different Assays for Detection of Human Cytomegalovirus (HCMV) in Predicting the Development of HCMV Disease in Human Immunodeficiency Virus-Infected Patients

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In the present prospective study, five blood tests for detection of human cytomegalovirus (HCMV), nucleic acid sequence-based amplification (NASBA) for detection of early (immediate-early antigen) and late (pp67) mRNA, PCR for detection of HCMV DNA (DNA PCR), culture, and pp65 antigenemia assay, and culture and DNA PCR of urine and throat swab specimens were compared for their abilities to predict the development of disease caused by HCMV (HCMV disease). Of 101 human immunodeficiency virus (HIV)-infected patients with ≤100 CD4+ lymphocytes per mm3, 25 patients developed HCMV disease. The pp65 antigenemia assay (sensitivity, 50%; specificity, 89%) and DNA PCR of blood (sensitivity, 69%; specificity, 75%) were most accurate in predicting the development of HCMV disease within the next 12 months. Both blood culture and late pp67 mRNA NASBA had high specificities (91 and 90%, respectively) but low sensitivities (25 and 13%, respectively). The sensitivities of urine culture, DNA PCR, throat swab specimen culture, DNA PCR, and NASBA of blood for detection of the immediate-early antigen were 73, 87, 53, 67, and 63%, respectively, and the specificities were 58, 46, 76, 60, and 72%, respectively. The positive predictive values of all tests, however, were low and did not exceed 50%. In conclusion, virological screening by these qualitative assays for detection of HCMV is of limited value for prediction of the development of HCMV disease in HIV-infected patients.

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of monitoring HCMV mRNA for the immediate-early antigen (IEA) and mRNA for the late pp67 antigen by NASBA for the development of HCMV disease was investigated. The results were compared with those of culture and DNA PCR of blood, urine, and throat swab specimens and a pp65-antigenemia assay with blood from 101 HIV-infected patients considered to be at risk for the development of HCMV disease on the basis of CD4 lymphocyte counts of ≤100/mm³.

MATERIALS AND METHODS

Patients. Between March 1993 and November 1996, HIV-infected patients from the AIDS Clinic of the Slotervaart Hospital in Amsterdam, The Netherlands, with CD4 lymphocyte counts of ≤100/mm³ were asked to participate in this study. All participating patients gave written informed consent. Patients with a history of prior HCMV disease were included, provided that they had not received medication for HCMV disease within 3 months prior to study entry. All participants underwent a complete physical examination, were seen by an ophthalmologist with experience in HIV disease, and had a chest X-ray taken to rule out active HCMV disease at study entry. All patients already had or were offered prophylactic treatment for Pneumocystis carinii pneumonia and treatment for HIV infection. The treating physicians, including the ophthalmologists, were not informed of the test results for any patient during follow-up.

Diagnosis of HCMV disease. Patients were considered to have HCMV reinitis if retinal abnormalities were caused by HCMV, which was seen upon examination of the retina through a dilated pupil (19). Gastrointestinal disease, including esophagitis, colitis, and cholangitis, was confirmed by endoscopy and histological examination of biopsy specimens with detection of one or more inclusion bodies and/or by immunohistochemical detection of HCMV antigens. Retinal neovascularization was diagnosed on the basis of typical findings upon medical history and physical examination together with detection of HCMV by DNA PCR of cerebrospinal fluid and recovery after treatment for HCMV infection. In addition, other findings that could possibly explain the illness were excluded. HCMV-related retinopathy was diagnosed whenever the medical history and physical examination were suggestive of adrenal insufficiency, as confirmed by typical laboratory abnormalities and recovery after treatment for HCMV infection.

Collection of samples. At the start of the study and at each follow-up visit, scheduled every 2 to 3 months, whole blood (10 ml of heparinized blood and 10 ml of EDTA-anticoagulated blood), freshly donated urine, and a throat swab specimen (which was placed in viral culture medium) were collected and were immediately processed for culture, pp65 antigenemia assay, and qualitative DNA PCR.

One milliliter of the whole-blood specimen was added to 9 ml of lysis buffer (4.7 M guanidinium thiocyanate, 46 mM Tris [pH 6.4], 20 mM EDTA, 1.2% sodium dodecyl sulfate, 0.1 M ethylene glycol betaine, and 0.5 M magnesium chloride). After centrifugation at 400 × g for 20 min at 4°C, the supernatant was removed, and the cell pellet was washed once with PBS. The cell pellet was resuspended in PBS–1% bovine serum albumin (BSA; Sigma) to give a final cell density of 5 × 10⁶ cells/ml. The cell suspension was then fixed (10 min at room temperature) in 2% paraformaldehyde (818715.0100; Merck, Darmstadt, Germany). After centrifugation (at 2000 × g for 5 min) and three washings of the cell pellet with PBS, the cell pellet was resuspended in 10 ml of phosphate-buffered saline (PBS), the whole leukocyte suspension was resuspended in 3 ml of Earle's HEPES buffer with 10% fetal bovine serum (EH-10%; Life Technology, Paisley, United Kingdom), and the whole leukocyte suspension was scored for IEA mRNA by NASBA for IEA mRNA and pp67 mRNA

HCMV cultures. For the detection of infectious HCMV, two conventional cell culture protocols were performed as described below. In brief, the bunny coat of heparinized whole blood was obtained by centrifugation at 120 × g for 10 min. The leukocytes were then separated by adding 9 ml of 0.85% (wt/vol) NaCl solution (pH 7.4; prepared in house) to the buffy coat and were incubated for 5 min at 4°C to rupture the remaining erythrocytes. After centrifugation at 400 × g for 5 min and three washings of the cell pellet with 10 ml of phosphate-buffered saline (PBS), the whole leukocyte suspension was resuspended in 3 ml of Earle's HEPES buffer with 10% fetal bovine serum (EH-10%; Life Technology, Paisley, United Kingdom). Hybrids were visualized with a Chemiluminescence-based detection was used according to the protocol of the manufacturer (ChonabCMV; Biotech). The quantification of pp65 antigen-bearing cells was achieved under a light microscope by counting the number of positively stained leukocytes and the total number of leukocytes per slide by using an eye piece with a counting grid. The results were given as the total number of positive leukocytes/total number of leukocytes × 10⁷, which is equal to the number of positive leukocytes/10⁷.

NASBA for IEA mRNA and pp67 mRNA. For the analysis by NASBA, 1 ml of the lysed whole-blood suspension, which equals 100 µl of the whole-blood input sample at 101, was used. Processing of blood specimens for isolation of HCMV IEA and late (pp67) mRNA and monitoring of the expression of CMV IEA and late (pp67) mRNA by NASBA (Organon Teknika) were done as recently described by Blok et al. (2, 3). The primers CMV IEA-1.5 (T7 primer [sequence, 5'-AAGGCTG-3']) for NASBA for IEA mRNA and pp67 mRNA.

Statistical analysis. For each test the sensitivity, specificity, positive predictive value (PPV), and negative predictive value (NPV) were determined, using standard formulas, by comparing the test results for patients who developed HCMV disease with those for patients who did not. Relative risks and likelihood ratios (sensitivity/1-specificity) were calculated with 95% confidence intervals (CIs). Initially, the sensitivity, specificity, PPV, NPV, relative risk, and likelihood ratio for the development of HCMV disease within 12 months were determined for each test on the basis of the first available test result for all patients. As the pp65 antigenemia assay provides a quantitative result, the cutoff value for a positive pp65 antigenemia test result was determined by the sensitivity and the characteristic curve. By using such an analysis, the cutoff value with the highest combination of specificity and sensitivity can be distinguished. The value of repeat testing for the identification of patients who develop HCMV disease was determined by dividing the patients into those who had never had a positive test result and those with a positive test result on at least one follow-up. Relative risk, likelihood ratio, sensitivity, specificity, PPV, and NPV were again determined for each test.
Results

Characteristics of the study population. A total of 116 patients entered the study. Of these patients, 15 were excluded from further analysis: 1 had received maintenance treatment for HCMV-related meningoencephalitis within 3 months prior to study entry and 14 were diagnosed with HCMV disease at the time of inclusion.

The demographic characteristics of the remaining 101 patients are shown in Table 1. Ten patients (9.9%) were HCMV immunoglobulin G antibody negative. None of these patients had received HCMV treatment at any time prior to study entry, and no patient had a history of previous HCMV disease. Two patients were on HAART at the time of study entry, and no patient had a history of previous HCMV disease. The median follow-up time to study entry and 14 were diagnosed with HCMV disease at the start of the study, HCMV became detectable on at least 1), cholangitis (n = 1), adrenalitis (n = 1), and radiculomyelitis (n = 1), colitis (n = 4), esophagitis (n = 1), cholangitis (n = 1), adenalin (n = 1), and radiculomyelitis (n = 1). The median time to the development of HCMV disease was 10.6 months (IQR, 8.8 to 16.0 months). The patients who were HCMV immunoglobulin G antibody negative and the four patients on HAART remained free of HCMV disease during follow-up. Seventy-two patients died after a median follow-up of 12.9 months (IQR, 9.5 to 19.3 months), and four patients were lost to follow-up. Eighteen of these 72 patients had developed HCMV disease and died a median of 4.1 months (IQR, 3.0 to 5.6 months) after the diagnosis of HCMV disease. Since most patients died at home and postmortem examinations were not routinely performed, some patients may have had clinically unrecognized HCMV disease. However, in only one of the five patients who did undergo a postmortem examination and who had not developed HCMV disease during his life, a duodenal ulcer was found, and this was possibly caused by HCMV. This patient also suffered from visceral Kaposi's sarcoma and a non-Hodgkin's lymphoma, the combination of which was thought to have been the cause of death.

PPVs, NPVs, and relative risk for the development of HCMV disease over the next 12 months by testing a single sample. Calculations of the predictive value of each assay for the development of HCMV disease over the next 12 months were based on results of a sample taken at the start of the study. Of the 25 patients who developed HCMV disease, 16 developed HCMV disease within 1 year after study entry. As the pp65 antigenemia assay result was quantified as numbers of positive leukocytes per 10^5 leukocytes counted, a cutoff level of 6 positive leukocytes/10^5 leukocytes was determined by using a receiver-operating characteristic curve; a result above the cutoff was given a positive score. The test results for patients who did and who did not develop HCMV disease over the next 12 months are presented in Table 2.

DNA PCR and culture of urine had the highest sensitivities (87 and 73%, respectively), but the specificities of these tests were low. Blood culture and NASBA for pp67 mRNA were not very sensitive but had higher specificities (91 and 90%, respectively). The sensitivities of the NASBA for IEA mRNA detection (63%), DNA PCR with blood (69%), and DNA PCR with throat swab specimens (67%) were comparable, but the specificity of the DNA PCR with throat swab specimens was lower than the specificity of the NASBA for IEA mRNA detection and DNA PCR with blood. The combined value of sensitivity and specificity favored the pp65 antigenemia assay, with a likelihood ratio of 4.6 (95% CI, 2.1 to 10.9). The PPV for the development of HCMV disease over the next 12 months was low for all assays and did not exceed 50%. The PPV was highest for the pp65 antigenemia assay (47%) and the DNA PCR with blood (35%). The NPV, on the other hand, was fairly high for all tests, ranging from 86% (blood culture) to 95% (DNA PCR with urine). Thus, patients with no detectable HCMV by any test were unlikely to develop HCMV disease in the near future. The NPV of the pp65 antigenemia assay was slightly lower than the NPV of the DNA PCR with blood (90 versus 93%). The combined value of PPV and NPV (relative risk) favored the pp65 antigenemia assay and qualitative DNA PCR with blood (Fig. 1A).

Repeat testing for prediction of HCMV disease. The median number of follow-up samples per patient-year of follow-up was 6.4 (IQR, 4.9 to 8.0) among patients who developed HCMV disease and 5.9 (IQR, 4.8 to 7.0) among patients who did not develop HCMV disease (P = 0.34 by the Wilcoxon two-sample test).

For many patients who initially had negative test results at the start of the study, HCMV became detectable on at least one occasion during follow-up, regardless of the development of HCMV disease (Table 3). Although an increase in the sensitivity of each test for the detection of HCMV disease was observed by repeat testing, the specificity of each test decreased. The pp65 antigenemia assay and blood culture had the highest likelihood ratios (2.5 and 2.7, respectively), mainly because these tests were more specific, while they were less sensitive than DNA PCR with blood. NASBA for IEA mRNA detection, and both culture and DNA PCR with urine and throat swab specimens at detecting HCMV disease. During...
follow-up, a positive result of each test except the DNA PCR with urine was significantly associated with the development of HCMV disease (Fig. 1B), with culture of urine having the highest relative risk for the development of HCMV disease (12.0; 95% CI, 1.7 to 85.3). However, upon repeat testing the PPV of a positive test result during follow-up for the subsequent development of HCMV disease was still less than 50% for all tests.

![Graph A](image1.png)

**FIG. 1.** (A) Relative risk for the development of HCMV disease within the next 12 months after a single positive test result for a sample taken at the start of the study. (B) Relative risk for the development of HCMV disease after at least one positive test result for samples taken during follow-up. ψ, infinite relative risk as NPV was 100%.

### TABLE 2. Test results for a single sample taken at start of study from 101 patients

<table>
<thead>
<tr>
<th>Test and result</th>
<th>No. of patients who developed HCMV disease within 1 yr ($n = 16$) (sensitivity [%])</th>
<th>No. of patients who did not develop HCMV disease within 1 yr ($n = 85$) (specificity [%])</th>
<th>Likelihood ratio$^a$ (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NASBA for IEA mRNA detection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>10 (63)</td>
<td>24</td>
<td>2.2 (1.3–3.7)</td>
</tr>
<tr>
<td>Negative</td>
<td>6</td>
<td>61 (72)</td>
<td></td>
</tr>
<tr>
<td>DNA PCR with blood</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>11 (69)</td>
<td>21</td>
<td>2.8 (1.7–4.6)</td>
</tr>
<tr>
<td>Negative</td>
<td>5</td>
<td>64 (75)</td>
<td></td>
</tr>
<tr>
<td>pp65 antigenemia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>8 (50)</td>
<td>9$^b$</td>
<td>4.6 (2.1–10.9)</td>
</tr>
<tr>
<td>Negative</td>
<td>8</td>
<td>73 (89)</td>
<td></td>
</tr>
<tr>
<td>NASBA for pp67 mRNA detection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>4 (25)</td>
<td>8$^c$</td>
<td>2.6 (0.9–7.7)</td>
</tr>
<tr>
<td>Negative</td>
<td>12</td>
<td>76 (90)</td>
<td></td>
</tr>
<tr>
<td>Blood culture</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>2$^d$ (13)</td>
<td>8</td>
<td>1.4 (0.3–6.0)</td>
</tr>
<tr>
<td>Negative</td>
<td>13</td>
<td>77 (91)</td>
<td></td>
</tr>
<tr>
<td>Urine culture</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>11$^d$ (73)</td>
<td>35$^e$</td>
<td>1.8 (1.2–2.6)</td>
</tr>
<tr>
<td>Negative</td>
<td>4</td>
<td>49 (58)</td>
<td></td>
</tr>
<tr>
<td>DNA PCR with urine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>13$^d$ (87)</td>
<td>45$^e$</td>
<td>1.6 (1.2–2.1)</td>
</tr>
<tr>
<td>Negative</td>
<td>2</td>
<td>39 (46)</td>
<td></td>
</tr>
<tr>
<td>Throat swab specimen culture</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>8$^d$ (53)</td>
<td>20</td>
<td>2.2 (1.2–4.1)</td>
</tr>
<tr>
<td>Negative</td>
<td>7</td>
<td>64$^e$ (76)</td>
<td></td>
</tr>
<tr>
<td>DNA PCR with throat swab specimen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>10$^d$ (67)</td>
<td>34</td>
<td>1.6 (1.1–2.6)</td>
</tr>
<tr>
<td>Negative</td>
<td>5</td>
<td>50$^e$ (60)</td>
<td></td>
</tr>
</tbody>
</table>

$^a$ The likelihood ratio was determined as a combined measure of sensitivity and specificity: likelihood ratio = sensitivity/1 – specificity.

$^b$ For three patients who did not develop HCMV disease, no result of the pp65 antigenemia assay was available.

$^c$ For one patient who did not develop HCMV disease, no test result was available.

$^d$ For one patient who developed HCMV disease, no test result was available.
Test results during follow-up for patients who developed HCMV disease. For 20 of the 25 patients who developed HCMV disease, samples were drawn at the time of diagnosis of HCMV disease. Not all patients who tested positive at least once during follow-up were also positive at the time of diagnosis of HCMV disease. NASBA for detection of IEA mRNA was positive for 16 of 20 patients (80%). DNA PCR with blood was positive for 15 of 20 patients (75%). The pp65 antigenemia assay was positive for 10 of 18 patients (55.6%), while for 2 patients no test result was available due to the availability of an insufficient number of leukocytes after sample preparation. Blood culture was positive for 10 of 19 patients (52.6%); for 1 patient no test result was available. The NASBA assay for detection of pp67 mRNA was positive for 11 of 20 patients (55%). The urine culture was positive for 10 of 18 patients (55.6%), and the DNA PCR with urine was positive for 15 of 18 patients (83.3%), while no urine samples were taken from 2 patients. The throat swab culture was positive for 15 of 19 patients (78.9%), and the DNA PCR with throat swab specimens was positive for 17 of 19 patients (89.5%). No throat swab was taken from one patient.

The time between the first positive test result and the development of HCMV disease differed considerably between the assays. At a median of 4.5 months (IQR, 3.2 to 8.5 months), 3.1 months (IQR, 1.9 to 6.6 months), and 4.7 months (IQR, 2.1 to 9.2 months) before the development of HCMV disease, the NASBA for pp67 mRNA detection, blood culture, and pp65 antigenemia assay, respectively, became positive. The other assays became positive much earlier before diagnosis of HCMV disease: NASBA for IEA mRNA detection, 9.2 months (IQR, 4.1 to 11.3 months); DNA PCR with blood, 9.4 months (IQR, 4.6 to 12.8 months); urine culture, 9.2 months (IQR, 3.6 to 18.4 months); DNA PCR with urine, 9.7 months (IQR, 6.7 to 18.4 months); culture of throat swab specimen, 8.8 months (IQR, 4.4 to 13.2 months); and DNA PCR with throat swab specimen, 9.1 months (IQR, 5.5 to 15.0 months).

However, after testing positive before the development of HCMV disease, a considerable number of patients again had negative test results during further follow-up. For the NASBA for IEA mRNA detection this was observed for 10 of 20 patients (50%), for DNA PCR with blood this was observed for 11 of 20 patients (52.4%), for the pp65 antigenemia assay this...
was observed for 8 of 18 patients (44.4%), for the NASBA for detection of pp67 mRNA this was observed for 9 of 20 patients (45%), for blood culture this was observed for 8 of 20 patients (40%), for urine culture this was observed for 7 of 18 patients (38.9%), for DNA PCR with urine this was observed for 12 of 18 patients (66.7%), for culture of throat swab this was observed for 8 of 19 patients (42.1%), and for DNA PCR with throat swab specimens this was observed for 6 of 19 patients (31.6%).

**DISCUSSION**

In the prospective study described here five different blood tests, including detection of early and late mRNAs by NASBA and two tests with urine and throat swab specimens for the detection of HCMV, were compared to establish the most accurate test for the identification of HIV-infected patients who will go on to develop HCMV disease. So far, other studies that have evaluated a limited number of available tests for the detection of HCMV have shown that, in particular, the pp65 antigenemia assay and DNA PCR with blood or plasma may identify patients who will develop HCMV disease, while culture of blood and urine appeared to be of less value (9, 18, 21, 24, 27, 29).

For patient management, assays accurate in predicting the development of HCMV disease may contribute to the decision to start prophylactic or preemptive treatment against HCMV in individual patients. We therefore assessed the value of a single test result as well as the results of repeat tests for the identification of patients who will develop HCMV disease. On the basis of a single test result, the pp65 antigenemia assay and DNA PCR with blood were highly associated with the development of HCMV disease within 1 year, whereas the results of a single test by conventional blood culture, a NASBA assay for pp67 mRNA detection, and DNA PCR with throat swab specimens were not. The DNA PCR with blood was more sensitive than the pp65 antigenemia assay, but the pp65 antigenemia assay was more specific and had a higher PPV for the development of HCMV disease. By using the likelihood ratio, the probability of a positive test result while getting the disease can be related to the probability of a positive test result while not getting HCMV disease. The pp65 antigenemia assay had a higher likelihood ratio than the DNA PCR with blood. When multivariate logistic regression analysis was used, including data for all tests with a positive or negative result, the only remaining test with a significant relative risk for the development of HCMV disease was the pp65 antigenemia assay (data not shown).

It has been reported that quantification of the HCMV load may improve the ability to identify patients who will develop HCMV disease (4, 12, 24, 27, 29). The pp65 antigenemia assay, in contrast to the other tests used in this study, allows an indirect quantification of HCMV load by counting the number of antigen-bearing cells. A threshold level of six antigen-positive cells was used to assign a positive result. This may explain why the antigenemia assay was more predictive of the development of HCMV disease than the DNA PCR. Still, however, it should be stressed that the predictive value of the pp65 antigenemia assay was low, since less than 50% of the patients with a positive test result went on to develop HCMV disease.

The detection of late pp67 mRNA by NASBA in a single sample was not associated with the development of HCMV disease in the near future. Although this test was highly specific, it had a low sensitivity and a low PPV for the development of HCMV disease. This is in contrast to the findings for a group of renal transplant patients, for whom the detection of late mRNA by NASBA was highly predictive and specific for the onset of HCMV disease (3). Gozlan et al. (14), who earlier described an indirect method for the detection of HCMV late mRNA by RT-PCR, found it to be a highly specific and only a slightly less sensitive marker than the pp65 antigenemia assay and DNA PCR with blood for the diagnosis of HCMV disease in HIV-infected patients. However, no data on its value in predicting HCMV disease are available.

DNA PCR with urine, culture of urine, DNA PCR with throat swab specimens, and culture of throat swab specimens were all highly sensitive tests for the identification of patients who will go on to develop HCMV disease, but their specificities were low. This suggests that many HIV-infected patients with low CD4 lymphocyte counts may at times shed HCMV in urine or the throat without subsequently developing HCMV disease. Repeat testing during follow-up increased the sensitivity of each test for the identification of patients who will develop HCMV disease. However, an increasing number of patients who did not develop HCMV disease also had positive test results during follow-up. Overall, each test (except DNA PCR with urine), when positive at least once during follow-up, was significantly associated with the development of HCMV disease, but again, the PPVs of these tests did not exceed 50%. The observation that for each test approximately 50% of the patients who developed HCMV disease had negative test results after a positive test result further attenuates the relevance of repeat testing.

For most patients, HCMV was already detectable by the different assays months before HCMV disease developed. In addition, some patients had negative test results at the time of diagnosis of HCMV disease after they had been positive on an earlier occasion. This confirms the findings of Shinkai et al. (27), who demonstrated that peak HCMV DNA levels occurred months before the development of HCMV disease in some patients, while at the time of diagnosis of HCMV disease few or no DNA copies were found. Therefore, one may speculate that viral seeding of an organ takes place months before HCMV disease develops. Ultimately, local host defense mechanisms determine to what extent clinical symptoms develop. Two observations may support this concept. First, it was shown that in 91% of patients with HCMV retinitis, DNA PCR with ocular fluid was positive, while only 44% of these patients had positive results by DNA PCR with blood (10). Second, patients with HCMV retinitis may develop a transient intraocular inflammation after the institution of combination antiretroviral therapy, possibly reflecting an improved immune response against HCMV (33). Therefore, the finding of HCMV in other clinical specimens like blood, urine, and throat swabs may not accurately reflect disease progression in an organ where the virus ultimately resides.

HCMV disease is most likely to develop in patients with less than 50 CD4 lymphocytes/mm². This study also included patients with 50 to 100 CD4 lymphocytes/mm². However, a subanalysis that included the test results for only 66 patients with 50 CD4 lymphocytes/mm² or less essentially revealed identical sensitivities, specificities, and relative risks for the development of HCMV disease for each assay.

In summary, the results indicate that, if any of the tests are useful, the pp65 antigenemia assay and DNA PCR with blood are the most useful tests for the identification of those patients who will develop HCMV disease over time. However, when considering the result of a single test by DNA PCR with blood or the pp65 antigenemia assay, only 60 to 70% of patients with HCMV disease will be accurately identified and less than half of the patients who test positive will actually develop HCMV disease in the near future. Furthermore, many patients with a
negative test result will still develop HCMV disease. These results indicate that screening for HCMV in HIV-infected patients by any of the reported qualitative assays is of limited value for the management of HCMV disease.

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