Use of the serum reactivity against *Toxoplasma gondii* excreted–secreted antigens in cerebral toxoplasmosis diagnosis in human immunodeficiency virus-infected patients

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Despite the development of serological and molecular methods in recent years, the diagnosis of cerebral toxoplasmosis in human immunodeficiency virus (HIV)-infected patients still presents difficulties. In the present study, we investigated whether cerebral toxoplasmosis induced changes in the reactivity of serum toward *Toxoplasma gondii* excreted–secreted antigens (ESA) in order to develop an assay for evaluating HIV-infected patients with cerebral toxoplasmosis. The antigen selection was based on those produced by tachyzoites, since it is the form of the organism responsible for disseminating the infection, as well as stimulation of the humoral and cellular immune responses. By using an ELISA containing pooled ESA recovered from infected culture supernatants with tachyzoites-RH strain (ESA-ELISA), we found that ESA had a high specificity for sera from patients with cerebral toxoplasmosis. The reactions were compared with an ELISA using crude tachyzoites antigen, widely used in traditional serology. The assays were performed on 293 serum samples separated as follows: 100 sera from patients with cerebral toxoplasmosis and AIDS (symptomatic), 99 sera from individuals with chronic toxoplasmosis (asymptomatic) and 94 sera from healthy individuals without toxoplasmosis (control). The crude tachyzoites antigen in ELISA was able to distinguish both groups of sera with toxoplasmosis, as similar reactivity were observed in sera from patients with cerebral toxoplasmosis and those from chronic individuals. In contrast, ESA-ELISA distinguished sera from symptomatic and asymptomatic individuals (three times more reactive in the former group, 12.6 versus 4.2). The assays were reproducible based on immunoblotting and statistical analysis. These data suggest the utility of ESA-ELISA in the diagnosis of cerebral toxoplasmosis in HIV-infected patients, since it provided clear evidence that anti-ESA antibodies are present principally in patients with active infection. The absence of a significant amount of antibodies distingushed the patients without clinical symptoms of infection.

**INTRODUCTION**

*Toxoplasma gondii* is an intracellular parasite that is able to infect all mammalian cells. During the chronic phase, the parasites persist encysted in brain and muscle, and the host develops life-long protective immunity against reinfection (Dubey, 1996, 1998; Hill et al., 2005). The active secretion of antigens by *T. gondii* may be an essential part of the low-grade stimulation or boosting of the immune system, as these antigens have been shown to stimulate an antibody as well as a T-cell response (Duquesne et al., 1990; Carruthers, 2002). A group of the most important of these antigens has been documented as parasite excreted–secreted antigens (ESA), which represent the majority of the circulating antigens in sera from hosts with acute toxoplasmosis (Cesbron-Delauw & Capron, 1993; Tilley et al., 1997). When released by tachyzoites they are highly immunogenic (Prigione et al., 2000; Carruthers, 2002) and induce protective immunity, either antibody dependent or cell mediated (Zenner et al., 1999). CD4+ T cells specific for ESA may be involved in the maintenance of long-term immunity in healthy chronically infected individuals. However, when an immunodeficiency appears, such as AIDS, the low levels of CD4+ T cells cause parasite proliferation and a symptomatic disease such as cerebral toxoplasmosis develops; this being the most frequent
reactivation of the latent infection (Montoya & Liesenfeld, 2004; Hoffmann, 2005).

Cerebral toxoplasmosis remains a prevalent disorder of the central nervous system, particularly among severely immunosuppressed human immunodeficiency virus (HIV)-infected patients (Antinori et al., 2004). This situation is critical in resource-limited settings, where the highly active antiretroviral therapy (HAART) is not available. In Brazil, despite a HAART programme being used, cerebral toxoplasmosis still accounts for high mortality and morbidity (Vidal et al., 2005).

In spite of the fact that a definitive diagnosis of cerebral toxoplasmosis requires demonstration of tachyzoites in brain biopsy or necropsy, in clinical practice treatment is usually initiated upon a presumptive diagnosis (based on clinical and radiological features). Recently, the inclusion of PCR in cerebral toxoplasmosis diagnosis has been shown to be an important tool (Cohen, 1999; Bastien, 2002; Bretagne, 2003; Vidal et al., 2004; Colombo et al., 2005), but it is still unavailable in most of the developing countries. As a significant portion of the world population is infected with T. gondii, the serological diagnosis is not so relevant in defining a cerebral toxoplasmosis diagnosis, but some studies suggested that high titres might be indicative of the active disease or a higher risk of developing it (Derouin et al., 1996; Hellerbrand et al., 1996; Colombo et al., 2005).

Currently, there is no information about the utility of ESA in distinguishing the cerebral toxoplasmosis in HIV-infected patients. Thus, we evaluated whether sera from patients with cerebral toxoplasmosis specifically recognize ESA and whether this recognition decreases in asymptomatic individuals. The assays were carried out by ELISA using tissue culture cell supernatants infected with tachyzoites RH strain.

**METHODS**

**Patients and samples.** The capability of ESA proteins in distinguishing symptomatic toxoplasmosis was determined by assaying 293 serum samples separated in three groups. Group I, called ‘symptomatic sera’, was composed of sera from 100 patients with cerebral toxoplasmosis and AIDS. Group II, ‘asymptomatic sera’, was composed of sera from 99 individuals with asymptomatic toxoplasmosis. Group III, ‘control sera’, was composed of sera from 94 healthy individuals with negative serology for toxoplasmosis. All HIV-infected patients were admitted and treated at Emilio Ribas Institute of Infectious Diseases, a tertiary teaching hospital in Sao Paulo, Brazil. The sera were previously analyzed by indirect immunofluorescence test and ELISA in the Laboratory of Toxoplasmosis, Instituto Adolfo Lutz. Each serum sample was dissolved in 90 % (v/v) glycerol buffered with 0.5 M carbonate/bicarbonate, pH 9.5, as additive, and stored at −20 °C until use. ELISA and immunoblotting standardizations were determined using a panel of 30 well-known sera (from 10 healthy individuals, 10 sera-positive individuals and 10 cerebral toxoplasmosis patients). The diagnosis of cerebral toxoplasmosis in HIV-infected patients was based on: (1) progressive neurological deficits, (2) contrast-enhancing mass lesion(s) on computed tomography scans, and (3) successful response within 2 weeks to specific treatment (Portegies et al., 2004). In addition, all patients had at least one positive PCR of blood and/or cerebrospinal fluid for T. gondii, as previously described (Vidal et al., 2004; Colombo et al., 2005). Blood samples for serological diagnosis and PCR were collected from AIDS patients before or until the third day of the specific therapy for toxoplasmosis. The institutional review boards of the ethics committees of the Instituto de Infectologia Emilio Ribas and Instituto Adolfo Lutz ethically approved this study.

**T. gondii and antigens.** T. gondii RH tachyzoites were grown and maintained in Swiss mice ascites by intraperitoneal inoculation. Every 3 or 4 days after infection, the peritoneal fluids from infected mice were collected in PBS, pooled and centrifuged at 1000 g for 10 min. The parasite pellets were washed twice, counted, and suspended in PBS pH 7.2, at different concentrations for infecting tissue cultures and preparing antigens for conventional ELISA. Alternatively, tachyzoites were maintained in Vero cells (ATCC CCL – 81), at 37 °C, 5 % CO2, in Eagle’s medium (Gibco) containing 292 mg L-glutamine l−1, 110 mg sodium pyruvate l−1, 1 g glucose l−1, 2.2 g sodium bicarbonate l−1, 100 000 U penicillin l−1, 133 mg streptomycin l−1 and 10 % fetal bovine serum. The tissue culture parasites were used for immunoblotting and the culture infected cell supernatants were used in ESA recovery.

For conventional ELISA, the crude tachyzoite antigen was obtained by sonication of tachyzoites (10 cycles of 1.0 A min−1, for 5 min, with 2 min intervals). The crude antigen was dissolved in 0.3 M NaCl and the protein concentration was determined. For immunoblotting, the crude tachyzoite antigen was prepared from 1 x 107 tissue culture tachyzoites solubilized in 50 µl SDS-PAGE sample buffer, containing 2 % SDS, 50 mM Tris/HCl, 5 % 2-mercaptoethanol, 10 % (v/v) glycerol, and 0.01 % bromophenol blue, boiled and run in 10 % polyacrylamide-SDS gels. ESA were used in immunoblotting and ELISA (ESA-ELISA). The proteins were recovered from tachyzoite-infected culture supernatant. For infection with 1 x 107 tachyzoites ml−1, Vero cells were previously washed three times and the medium was replaced by another aliquot of medium without fetal bovine serum. After 48 h post-infection, culture supernatants were harvested, filtered through a 0.22 µm-pore-size filter and 10 µg protease-inhibitor cocktail ml−1 added, containing (per ml): 20 µm 4-(2-aminoethyl) benzenesulfonyl fluoride, 10 µm EDTA, 1,3 µm bestatin, 0.14 µm E-64, 10 nm leupeptin, 3 nm aprotinin (Sigma). The supernatants, referred to as ESA were concentrated in a Speed Vac (RC 10.09; Jouan) for 4 h and dialysed against PBS overnight at 4 °C. Traces of serum were further observed in ESA preparations, by SDS 10 % PAGE, despite washing the Vero cells before T. gondii infection. Thus, ESA concentrations were determined by dilution for use in ESA-ELISA and immunoblotting.

**ELISA and immunoblotting.** The sera were tested by ELISA using two antigens. ESA was used at dilution 1:5–1:40 (for each batch of ESA prepared) (ESA-ELISA). The conventional ELISA was carried out using the crude tachyzoite antigen at a concentration of 1 µg ml−1 (this antigen is frequently used in conventional diagnosis). The reactions were performed with microtitre polystyrene plates (flat bottom, low binding: Corning). Each plate was incubated overnight at 4 °C with the wells containing the antigen dissolved in 0.1 ml 0.1 M NaHCO3, pH 8.5. Unbound antigen was removed by washing the plates with PBS pH 7.2 containing 0.05 % Tween 20 (PBST). The free binding sites were blocked by treating the wells with 5 % skimmed milk/PBS. After 30 min, 50 µl each serum sample diluted 1 : 200 in 5 % skimmed milk/PBS was added to the wells and incubated for 60 min at 37 °C. After five washes with PBST, the plates were incubated for a further 60 min at 37 °C with horseradish peroxidase-conjugated goat anti-human IgG (Sigma) diluted 1 : 10 000 in 5 % skimmed milk/PBS. After a new wash cycle with PBST, substrate solution (0.1 M citric acid, 0.2 M Na2HPO4, 0.05 % o-phenylenediamine, 0.1 % H2O2) was added to each well, and the plates were left to stand at room temperature in the dark for
30 min. Colour development was stopped by adding 50 μl 2 M H₂SO₄ and the absorbance was measured with an ELISA reader (Multiscan; Labsystems) with a 492 nm filter. The reactions were previously standardized with 30 sera described above. Different dilutions of ESA (1:10 to 1:800) on the microtitre plates, different conjugate dilutions (1:2500 to 1:20000) and different serum dilutions (1:50 to 1:400) were tested (data not shown). Each serum sample was assayed in duplicate. The absorbance values were subtracted from the background, and the arithmetic mean was calculated. The cut-off was calculated in each reaction using a sera panel from 20 healthy individuals.

For immunoblotting, ESA and lysed tachyzoites (20 μl per strip) were boiled and fractionated by run 10% SDS-PAGE (Laemmli, 1970). The proteins were transferred to nitrocellulose membranes (Towbin et al., 1979), cut into 3–4 mm wide strips, blocked for 1 h with 5% skimmed milk/PBS. Bound antibodies were visualized after incubation for 1 h at room temperature with goat horseradish peroxidase-conjugated anti-human IgG diluted (1:500) in 5% skimmed milk/PBS. The optimal working dilution was also determined for serum samples (1:200) and conjugate (1:10 000), and the intra- and inter-assay reproducibility was determined. These experimental conditions yielded the greatest difference in absorbance between positive and negative samples. For immunoblotting, the standardization assays were performed with ESA. The optimal working dilution for solubilization (20–30 μl) was 4:1 in SDS-PAGE sample buffer. The optimal working dilution was also determined for serum samples (1:50) and conjugate (1:500).

Next, we analysed the reactivity of the sera for both antigens. The same batch of sera was assayed in parallel for both antigens in order to maintain the same laboratory conditions. The crude tachyzoite antigen is largely used for ‘in house’ conventional ELISA and commercial kits. We assayed the serum samples from all groups and the results, shown in Fig. 1(a), were expressed in ELISA relative values as described in Methods. The mean ELISA relative value for sera from the control group was 0.5 ± 0.02 (mean ± s.e.). In contrast, the values for serum samples from patients of groups I and II were 8.7 ± 0.29 and 8.2 ± 0.26, respectively. Student’s t-test revealed that both groups are statistically similar (P>0.05). As expected, serum samples collected from groups I or II patients were reactive with crude tachyzoite antigen (Fig. 1b, strip 1) in immunoblotting, giving similar intensities (Fig. 1b, strips I and II).

At the same time, we tested the same sera in ESA-ELISA. The ELISA relative values are shown in Fig. 1(c). The mean value for sera from control group was 0.5 ± 0.02. Group I (symptomatic) had high values (12.6 ± 0.74). In contrast, group II (asymptomatic) showed a mean value of 4.2 ± 0.21. Student’s t-test showed that both groups are statistically different (P<0.05). These results were con-
firmed by immunoblotting, as shown in Fig. 1(d). Sera from group I reacted well with ESA (Fig. 1d, strip I), while sera collected from group II failed to do so.

The data presented in Fig. 2 show the distribution of ELISA relative values for sera obtained after testing the reactivity using the crude tachyzoite lysate and ESA in ELISA. The linear regression clearly indicates that the sera from chronic individuals were more reactive against the crude tachyzoite lysate than ESA. The correlation index was 0.48 (Fig. 2a). In contrast, the linear regression shown in Fig. 2(b) indicates that sera from patients with cerebral toxoplasmosis had high reactivity with ESA compared with those with crude tachyzoite lysate. The correlation index was 1.4.

DISCUSSION

Despite development of serological and molecular methods in recent years, the diagnosis of cerebral toxoplasmosis in HIV-infected patients still presents difficulties. In clinical practice, specific treatment is usually initiated in response to a presumptive diagnosis, which is based on clinical and radiological features (Luft & Remington, 1992). Thus, the employment of the T. gondii proteins of the serological diagnosis seems to be a promising tool.

It is known that T. gondii invasion initiates a lytic cycle leading to cell and tissue destruction that is a hallmark feature of Toxoplasma pathology. This process is rapid, dynamic, and relies on the secretion of numerous secretory proteins from micronemes, rhoptries and dense granules (Carruthers, 2002). Despite significant progress in studying these proteins, only a limited number of secretory proteins have been discovered (ToxoDB: the T. gondii genome resource, accessed in September 2007; http://www.toxodb.org/toxo/home.jsp) (Zhou et al., 2005). In addition, as we showed recently, a great genetic variability has been observed between the T. gondii isolates of patients (Ferreira et al., 2008). For this reason, we decided to use pooled ESA recovered from tachyzoite-infected culture supernatants as antigen because each protein could elicit the host immune system by antibody production.

The vast majority of infected immunocompetent individuals with latent infection by toxoplasmosis remain asymptomatic. Despite the presence of T. gondii antibodies, they have no or a low number of circulating tachyzoites. In general, these antibodies are determined in conventional serology, using total extract of tachyzoites as antigen, which consists of cytoplasmic and membrane components. When we used this antigen (crude tachyzoite antigen) in ELISA, similar reactivity was shown between sera from patients with cerebral toxoplasmosis and those from patients with latent infection (mean value of the ratio of the relative absorbance). These results suggest that this antigen, widely used in conventional diagnosis, failed to distinguish the two groups of sera.

In an earlier study we have shown that the majority of the patients with cerebral toxoplasmosis have high anti-T. gondii IgG titres with high avidity, suggesting that the reactivation of the latent infection observed in immunocompromised patients occurs in the secondary immune response (Colombo et al., 2005). In this phase, numerous tachyzoites are released from the quiescent cysts and a considerable proportion of ESA are released, eliciting the specific immune response to these antigens. In this case, these patients present antibodies for both ESA and total crude tachyzoites antigens. ESA-ELISA distinguished sera from patients with the active disease (cerebral toxoplasmosis and positive PCR). These sera were three times more reactive than those from seropositive individuals (12.6 to 4.2). These data were reproducible based on the immunoblotting results, showing that ESA constitute an excellent serological marker for the diagnosis of cerebral toxoplasmosis in HIV-infected patients.

Even though the majority of patients with cerebral toxoplasmosis develop high titres of anti-T. gondii
antibodies (Derouin et al., 1996; Hellerbrand et al., 1996; Colombo et al., 2005), some also show a humoral response deficiency and no antibodies are detected (Luft & Remington, 1992; Skiest, 2002; Vidal et al., 2005). In this study, six patients with cerebral toxoplasmosis confirmed by a positive PCR of blood had a negative immunofluorescence test (for both IgG and IgM antibodies) and ELISA (both antigens) (data not shown). In this case ESA-ELISA also failed in diagnosing the active infection, confirming the caveats of serological diagnosis in a reduced subset of patients.

In summary, our results suggest that anti-ESA antibodies are present in patients with HIV-related cerebral toxoplasmosis, whereas the absence of a significant amount of antibodies distinguished the patients without clinical symptoms of infection. ESA-ELISA can be used for the diagnosis of cerebral toxoplasmosis in association with clinical and radiological information, providing a simple methodology to be used in countries with high prevalence of latent toxoplasmosis in the general population.

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