STUDIES ON THE T-CELL PHENOTYPES IN CHILDREN WITH KALA-AZAR IN FARS PROVINCE, IRAN

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ABSTRACT

The subpopulations of T-lymphocytes were studied in children with visceral leishmaniasis in the active stage of disease prior to treatment (n=28) and in controls (n=15) using specific monoclonal antibodies (Behring OKT3, OKT4 and OKT8). The percentage of total peripheral blood T-lymphocytes (CD3+ T-cells) in patients were within the same range as those of normal children (71.09± 1.07 vs 68.89± 1.29). The percentage of CD4+ T-lymphocytes showed a significant increase (P<0.005) in comparison with the control (53.92 ± 1.20 vs 45.59 ± 1.35). A decrease in the percentage of CD8+ T-lymphocytes (20.81 ± 0.71 vs 23.89 ± 0.72) was observed which was significant at (P<0.025). The ratio of CD4+/CD8+ T-lymphocytes was significantly increased at P<0.005 as the value of the ratio was 2.70 ± 0.17 for kala-azar patients and 1.91 ± 0.05 for the controls. The immunosuppression in kala-azar patients studied could be due to dysfunction of antigen specific T-cells and its subsequent effect on various cytokine release rather than changes in the phenotypic characters of these cells.


INTRODUCTION

Infantile kala-azar, a systemic disease caused by Leishmania donovani infantum is endemic in Iran. Visceral leishmaniasis in this region is characterized by pronounced abnormalities in host immune response, including hypergammaglobulinemia, reduced delayed-type hypersensitivity response to leishmanin and other antigens, and also high levels of circulating immune complexes. The mechanisms of depressed responsiveness remain unclear. However, the contribution of T-lymphocytes to the observed unresponsiveness has been reported. Previous studies in infantile kala-azar have demonstrated a reduction in the percentage of circulating T-cells and an elevation in the percentage of B-cells. In Mediterranean kala-azar in a recent investigation, a significant decrease in the number of CD4+ cells was observed as the number of cytotoxic suppressor CD8+ T-cells were increased. In Kenyan patients with visceral leishmaniasis, the total number of T-lymphocytes were within the same range as those of normal individuals, however the ratio of CD4+/CD8+ cells was inverted similar to Mediterranean kala-azar.

This paper reports findings of lymphocyte phenotypes during the active phase of visceral leishmaniasis in 28 patients in Shiraz, Iran.

PATIENTS AND METHODS

Twenty-eight patients with clinical symptoms compatible with kala-azar who referred to Shiraz hospitals
T-Cell Phenotypes in Kala Azar

Results for the patients and controls are expressed as mean ± SE. The student’s t-test was used to test for statistically significant differences between patients and control group.

**RESULTS**

The age and sex of the patients and controls are presented in Table I. The antibody titers of the patients ranged from 1/128 to 1/1024. The distribution included 1/128 (1), 1/256 (8), 1/512 (15) and 1/1024 (3) respectively and the titers of control sera were <1/64. Amastigotes were present in the bone marrow smears of the six patients studied.

A pronounced leukopenia was observed in patients as compared to the controls (4.48 ± 0.27 vs 8.27 ± 0.53 × 10^3/mm^3). The results of lymphocyte subsets are presented in Fig. 1. No significant differences were found in the percentage of CD3⁺ T-lymphocytes in patients as compared to the controls. A significant increase (P<0.005) was observed when OKT4 antibody was used for detection of CD4⁺ T-lymphocytes of the patients and controls (53.92 ± 1.20 vs 45.59 ± 1.35). In regard to T suppressor/cytotoxic or CD8⁺ T-lymphocytes, a significant decrease (P<0.025) was observed.

**Table I. Age and sex of the patients with kala-azar and the controls.**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Patients with kala-azar</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>age ± SD (yrs)</td>
<td>1.5 ± 0.99</td>
<td>2.56 ± 1.4</td>
</tr>
</tbody>
</table>

**Determination of T-cell Phenotypes**

Five mL of blood was drawn from patients and the controls, mixed with EDTA and layered on 0.3 mL of ficoll-Hypaque gradient using the method described by Boyum (1968). The leucocyte-rich layer was washed thrice in cold Hanks’ solution and resuspended at 4 × 10^6/mL in cold RPMI 1640 medium. The T-cell phenotypes from patients and the controls were determined by adding specifically-defined monoclonal antibodies (OKT3, OKT4 and OKT8 monoclonal antibodies, Behring, Germany) to 100 µL of cell suspensions. These antibodies included 40 µL OKT3, 20 µL OKT4, 20 µL OKT8 and 20 µL of normal mouse serum which was used as the control. These antibodies were used to determine lymphocyte subsets, which included total T-cells (CD3⁺) helper/inducer T-cells (CD4⁺) and suppressor/cytotoxic T cells (CD8⁺), respectively. The cells were incubated at 4°C for one hour with gentle shaking after 30 minutes and then washed three times in Hanks’ balanced salt solution. 20 µL of fluorescein-isothiocyanate (FITC)-labelled goat anti-mouse immunoglobulin (Behring, Germany) was added to the cell pellet and incubated for another 30 minutes at 4°C with gentle shaking of the tubes after 15 minutes. After three washings, the cells were examined under the bright light for visual counting and then under UV light for membrane fluorescence and the percentage of positive cells were determined.

**Skin test**

All patients were tested intradermally with 0.1 mL of leishmanin (Institute Pasteur, Tehran, Iran). The dermal reaction was read 24 and 48 hours after skin test. The criteria for reactivity were erythema and induration of ≥ 6 mm at the site of skin test. The leishmanin used was also tested in many cases of cutaneous leishmaniasis and controls; satisfactory reactions were observed.

**Indirect Fluorescent Antibody Test**

IFA test was performed according to the method described previously and reciprocal titer of at least 1/128 with bright fluorescence was considered positive.

**Statistical analysis**

The results of lymphocyte subsets are presented in Table I. The antibody titers of the patients ranged from 1/128 to 1/1024. The distribution included 1/128 (1), 1/256 (8), 1/512 (15) and 1/1024 (3) respectively and the titers of control sera were <1/64. Amastigotes were present in the bone marrow smears of the six patients studied.

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All the patients studied demonstrated a negative leishmanin test.

**DISCUSSION**

Visceral leishmaniasis is prevalent in Iran; the causative agent is called *L. infantum* as the majority of cases are children in the pediatric age group.

Studies in man and experimental animals suggest that cellular immunity is of primary importance in limiting pathogenesis of visceral leishmaniasis. Suppression of cell-mediated immunity occurs through increase in CD8+ T-cell or changes in cytokine production. Cytokines are capable of activating macrophages which can eliminate the intracellular organisms including Leishmania amastigotes.

Our findings demonstrated an increase in the percentage of CD4+ lymphocytes and a decrease in the percentage of CD8+ T-lymphocytes. These results are in contrast with the findings of Sciotto et al. who reported reduction in the level of CD4+ T-cell with an increase in the level of CD8+ T-cells during active phase of disease in six children with Mediterranean visceral leishmaniasis. In cases of visceral leishmaniasis from Kenya, Koech et al. also reported a higher proportion of CD8+ T-cells in patients than in the controls, although the total number of T-cell in patients and the controls were similar.

The lack of T-cell response in vitro to specific and non-specific antigens and low levels of IL-2 and γ-interferon in acute phase of visceral leishmaniasis which has been demonstrated by other investigators indicate the absence of positive delayed-type hypersensitivity to leishmanin in these patients. An analysis of in vitro T-cell response in Indian kala-azar confirms the present findings as these investigators demonstrated that even depletion of CD8+ T-cells did not reverse the specific unresponsiveness in these patients. The present studies indicate that immunosuppression in these patients could be possibly attributed to the lack of proper T-cell functions rather than merely changes in the phenotypic characteristic of these cells.

Although visceral leishmaniasis is also associated with hypergammaglobulinemia and decreased complement components, it has been demonstrated that the serum components and the adherent cells do not contribute significantly to cell-mediated suppression in this disease.

For further understanding of the nature of immune suppression in kala-azar, the functional disturbances of T-cells cannot be ignored during acute phase of infection. More studies on the level of various cytokines, particularly the changes in the level of IL4 and as a result, increase in the synthesis of IgE and selective enhancement of some of the IgG isotypes in indicated during acute phase of infection as these patients have a very low level of γ-interferon.

As peripheral blood lymphocytes present only 2% of the total lymphocyte pool in the normal adult human body, it will be interesting to study the lymphocyte subsets in the organs mainly affected such as spleen, liver and bone marrow of kala-azar patients.

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**REFERENCES**

4. Sacks DLS, Lotalal SN, Shrivastava JM, Blackwell and Neva
T-Cell Phenotypes in Kala Azar


