Nutrition and immune function in human immunodeficiency virus infection

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The triad of human immunodeficiency virus (HIV) infection, nutritional status and immune function are intimately related, each factor having effects on the others. The dominant effect in this three-way relationship is the effect of HIV infection on nutritional status, an effect which, until the advent of potent anti-retroviral drugs, has been manifest primarily as wasting. Recently, more complex metabolic abnormalities have become apparent, particularly fat redistribution syndromes, hyperlipidaemia and hypercholesterolaemia. For the converse effect, the effect of nutritional state on HIV disease progression, there is good evidence that clinical outcome is poorer in individuals with compromised nutrition. However, the beneficial effects of nutritional support have been more difficult to demonstrate. For macronutrients, effective macronutrient supply improves survival in severely-malnourished individuals and may have beneficial effects in less-severely-affected individuals. Micronutrient deficiencies appear to be involved in modifying clinical HIV disease and may also be associated with enhanced mother-to-child transmission of virus, particularly in developing countries. Intervention trials in this setting are currently under way. In conclusion, the interaction of HIV infection and nutrition is of great importance not just because of the major impact that HIV infection has on nutritional state, but also because strategies to improve nutritional status, both quantitatively and qualitatively, may have a beneficial effect on the clinical and immunological course of the disease.

HIV infection: AIDS: Nutritional status: Wasting: Micronutrients

The impact of human immunodeficiency virus on nutritional state

Wasting in human immunodeficiency virus infection

Until a few years ago, when effective anti-retroviral treatment became available, the dominant clinical nutritional effect of HIV was wasting. In recognition of the clinical importance of wasting in HIV disease progression, unexplained weight loss was included as an acquired...
immune deficiency syndrome (AIDS)-defining diagnosis in the Centers for Disease Control (1987) criteria for AIDS. In some individuals with HIV infection wasting occurs progressively over long periods of time, often over many years, and such chronic progressive wasting is often associated with chronic gastrointestinal disease (Macallan et al. 1993). In our experience, a more common pattern of wasting is characterized by acute intermittent episodes of weight loss lasting several weeks or months at a time. Such acute episodes of wasting are often associated with acute opportunistic infections (Fig. 2; Macallan et al. 1993). Fortunately, such infective episodes have become less common since the widespread introduction of prophylactic anti-infectives such as co-trimoxazole which has dramatically reduced the incidence of pneumocystis carinii pneumonia. From patterns of weight change similar to that seen in Fig. 2, one may make a number of observations regarding the pathophysiology of HIV-related wasting. First, HIV per se does not necessarily induce a wasting state. Infected subjects may remain weight stable for many years, even in the absence of anti-retroviral treatment. Second, opportunistic infections appear to be a major precipitant of weight loss, and their prevention, diagnosis and prompt treatment are therefore of major importance in preventing wasting. Third, anabolism or weight recovery is still possible in such patients with effective treatment of the secondary precipitating event (Macallan et al. 1993).

Underlying such wasting are a number of metabolic disorders which HIV appears to induce. All areas of intermediary metabolism appear to be affected, including energy balance, carbohydrate metabolism, protein metabolism and lipid metabolism, although the relative contributions of each remains unclear (Macallan, 1998). A full discussion is not possible here, but abnormalities such as accelerated whole-body protein turnover, altered carbohydrate metabolism and hyperlipidaemia are characteristic of infection (Hommes et al. 1991a,b; Grunfeld et al. 1992; Hellerstein et al. 1993; Macallan et al. 1995a). However, the final common denominator of wasting must be negative energy balance. Our studies of energy balance in HIV-infected individuals, albeit in the era before effective anti-retroviral treatment, demonstrated that weight loss is the consequence not of accelerated or excessive energy expenditure but a consequence of reduced energy intake (Macallan et al. 1995b; LA Sheehan, DC Macallan & GE Griffin, unpublished results). Such observations demonstrate the importance of maintaining energy intake in managing patients with HIV infection (Fig. 3).

**Anti-retroviral therapy and nutritional state**

Recently there have been major changes in the clinical face of HIV infection, and we have now entered the era of so-called ‘highly-active anti-retroviral therapy’ (HAART). The full impact of such therapy on wasting is yet to be seen, but several early studies have been published. Weight recovery is frequently seen in patients responding to HAART (Force et al. 1997; Teixeira et al. 1997; Silva et al. 1998; Stricker & Goldberg, 1998). However, in most studies there are still some individuals who fail to gain weight or still continue to lose weight. For example, in a large study of patients commencing treatment with indinavir, after a median of 176 d on treatment, body weight had increased in 119 of 160 patients (74.4 %), had not changed in thirteen (8.1 %) and had fallen in twenty-eight (17.5 %), relative to baseline (Carbonnel et al. 1998). Furthermore, some investigators have found that cohorts of patients starting anti-retroviral therapy, including a protease inhibitor, fail to regain weight as a whole group (Fig. 4; Schwenk et al. 1999). This overall lack of a positive trend masks the observation that some individuals in the cohort did gain weight after commencing therapy. At 14 weeks 13 % (n 8) of the patients showed a positive weight gain trend (> 5 %/100 d) and at 28 weeks this percentage had risen to 21 (n 13). However, at the same time points 3 % (n 2) and 11 % (n 7) of the patients respectively demonstrated significant (> 5 %/100 d) negative weight trends (Schwenk et al. 1999).

Thus, it appears that even in the era of HAART wasting does continue to remain a clinical problem, albeit far less commonly than previously, and may become more of a problem if viral resistance to such drugs becomes an increasing clinical complication.

**Fig. 2.** Acute weight loss episodes in an individual with human immunodeficiency virus infection progressing to acquired immune deficiency syndrome (AIDS). PCP, pneumocystis carinii pneumonia; CMV, cytomegalovirus. (From Macallan et al. 1993.)

**Fig. 3.** Relationship between energy expenditure, energy intake and weight loss in patients with AIDS. (m), Intake; (m), balance; (m), expenditure. Values are means and standard deviations represented by vertical bars for the following no. of patients: rapid loss n 7, slow loss n 21, weight stable n 16, weight gain n 7. (From Macallan et al. 1995b.)
lipodystrophy (Carr et al. 1998a). The features of this syndrome include the redistribution of body fat away from subcutaneous areas, particularly facial fat deposits, with a concurrent accumulation of fat in the visceral compartment or in the dorso-cervical fat pad (Carr et al. 1998b; Lo et al. 1998; Miller et al. 1998). As a consequence, abdominal swelling may develop, whilst peripheral tissues such as limbs and face become grossly ‘wasted’. At the same time, plasma triacylglycerols are often grossly increased, sometimes dramatically, to levels at which pancreatitis is likely (Henry et al. 1998b; Sullivan et al. 1998). In addition, there are reports of premature atherosclerosis in individuals on HAART (Behrens et al. 1998; Gallet et al. 1998; Henry et al. 1998a; Laurence, 1998; Vittecoq et al. 1998). Thus, it appears that, although anti-retroviral treatment does result in clinical improvement in overall nutritional state, not all metabolic abnormalities are reversed, and patients on therapy may still require further investigation and management of their metabolic syndrome.

**The impact of nutrition on human immunodeficiency virus disease**

*Nutrition and human immunodeficiency virus disease progress* 

The impact of nutrition on HIV disease is a part of the model (Fig. 1) which is more difficult to define. In order to address this aspect, let us first consider whether an effect of malnutrition on HIV disease progression can be demonstrated. Despite this situation, several studies do address the question of whether nutrition intervention has an impact on clinical outcome, and I will cite examples to illustrate the findings.

**Modification of the inflammatory response**

One area of interest is whether nutrients can be used to modify the inflammatory response to HIV infection. n-3 Fatty acids are known to have an anti-inflammatory effect. One large clinical trial of such fatty acids in patients with AIDS had a disappointing impact on clinical outcome, having no effect on weight trend or serum cytokines, even though triacylglycerol concentrations were modified, as expected (Hellerstein et al. 1996).

**Micronutrients and human immunodeficiency virus disease**

The impact of micronutrients on HIV disease progression has also been an area of great interest. Several studies have shown an association between disease progression and micronutrient status. For example, Baum et al. (1995) showed an association between development of vitamin A or B12 deficiency with a reduction in CD4+ cell count; conversely they found that normalization of vitamin B12, or indeed Zn, was associated with an increase in CD4+ cell count. However, there are difficulties in interpreting plasma vitamin levels, particularly since they are affected by the acute-phase response and are susceptible to changes in binding proteins. Similarly, there are difficulties in interpreting the impact on clinical outcome when surrogate markers such as CD4+ cell count are used as indices of efficacy. Some investigators have chosen to look at micronutrient intake rather than plasma levels. For example, Tang et al. (1993) demonstrated that high intakes of vitamin C, thiamin or
niacin were associated with a reduced relative risk of disease progression, whereas high intakes of Zn were associated with an increased risk of disease progression. Vitamin A intake appeared to have a ‘U’-shaped relationship with outcome, both very high and very low intakes being associated with poorer outcome (Tang et al. 1993).

Certainly, it does appear that some individuals with HIV infection develop moderate to severe micronutrient deficiency, and that this deficiency affects their clinical state; such patients should clearly receive adequate vitamin supplementation. Extrapolating such selective use of vitamin supplements to universal supplementation for all HIV-infected individuals is a strategy which is more difficult to justify from the available evidence. However, large clinical studies designed to prove the value of universal supplementation are almost impossible to perform in the current changing clinical climate and are unlikely to be forthcoming. Micronutrients, of course, are normally ingested with macronutrients as part of food; wasting, which by definition is indicative of micronutrient deficiency, is therefore likely to be a useful marker of micronutrient deficiency and thus, in my opinion, it is wasting patients who should be selectively targeted for micronutrient supplementation.

**Micronutrients and mother-to-child transmission of human immunodeficiency virus**

One area of particular interest in terms of the place of micronutrients in HIV disease is their potential role in modifying mother-to-child transmission of HIV around the time of childbirth. This possibility is particularly pertinent in the developing world where vertical transmission is a common mode of transmission, and where such interventions are affordable compared with very expensive anti-retroviral therapy. A recent study from Africa showed that vitamin A deficiency was very common among pregnant women, and that the degree of deficiency correlated strongly with the risk of transmission from mother to baby (Fig. 5; Semba et al. 1994). Comparable results were observed in a similar study in two metropolitan areas in the USA (Greenberg et al. 1994). These observations have given rise to several studies involving micronutrient supplementation.

Fig. 5. Vitamin A status and risk of mother-to-child transmission of human immunodeficiency virus. (From Semba et al. 1994.)

Table 1. Effect of multivitamin (MV) and vitamin (vit) A supplementation during pregnancy in human immunodeficiency virus-infected women in Tanzania.* (from Fawzi et al. 1998)

<table>
<thead>
<tr>
<th>MV</th>
<th>Relative risk of adverse outcome</th>
<th>95 % CI</th>
<th>Statistical significance:</th>
<th>P</th>
<th>Vit A</th>
</tr>
</thead>
<tbody>
<tr>
<td>MV</td>
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<td>95 % CI</td>
<td>Statistical significance:</td>
<td>P</td>
<td>Vit A</td>
</tr>
<tr>
<td>Child variables</td>
<td>Fetal death</td>
<td>0.61</td>
<td>0.39–0.94</td>
<td>0.02</td>
<td>NS (P = 0.59)</td>
</tr>
<tr>
<td></td>
<td>Low birth weight (&lt; 2500 g)</td>
<td>0.56</td>
<td>0.38–0.82</td>
<td>0.002</td>
<td>NS (P = 0.54)</td>
</tr>
<tr>
<td></td>
<td>Preterm birth (&lt; 37 weeks)</td>
<td>0.61</td>
<td>0.38–0.96</td>
<td>0.03</td>
<td>NS (P = 0.70)</td>
</tr>
<tr>
<td></td>
<td>Small-for-gestational age</td>
<td>0.57</td>
<td>0.39–0.82</td>
<td>0.002</td>
<td>NS (P = 0.29)</td>
</tr>
<tr>
<td>Maternal variables</td>
<td>MV</td>
<td>no MV</td>
<td>P†</td>
<td>Vit A</td>
<td>No vit A</td>
</tr>
<tr>
<td></td>
<td>Maternal CD4+</td>
<td>Change at 6 weeks post partum</td>
<td>+167</td>
<td>+112</td>
<td>&lt; 0.001</td>
</tr>
</tbody>
</table>

* The study included 1075 pregnant women randomized to four arms: placebo; multivitamin (no vitamin A); vitamin A; multivitamin with vitamin A.
† Statistical significance of difference.
demonstrated the importance of nutritional support in severe macronutrient deficiency, and this is an area which should not be neglected.

Conclusion

The interaction of nutrition, immunity and HIV is clearly both complex and important. The impact of HIV infection on nutritional state is marked and has been a major clinical feature of the disease for many years. The pattern of metabolic changes seen is altering, particularly with the advent of potent drugs active against HIV, which may have their own metabolic impact. Nutritional intervention represents one potential means to modify disease progression. In terms of micronutrients much of the evidence remains unclear, but the impact of vitamin A and multivitamins in the developing world is an area of great clinical importance, and new information is currently emerging. Where there is macro-nutrient deficiency there now appears to be no doubt that appropriate nutrition support can have a major impact on morbidity and mortality; such support may also result in improvements in immune function, as discussed earlier in this meeting (Chandra, 1991, 1997; RK Chandra, personal communication).

References


Centers for Disease Control (1987) Revision of the CDC case surveillance definition for acquired immunodeficiency syndrome. Mortality and Morbidity Weekly Review 36, Suppl. 1S, 3S–14S.


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