Association of Plasma Eicosanoid Levels With Immune, Viral, and Cognitive Outcomes in People With HIV

Author(s):
Pragney Deme, Ph.D.; Mohammed Moniruzzaman, Ph.D.; David Moore, Ph.D.; Robert Heaton, Ph.D.; Ronald Ellis, M.D.; Ph.D.; Scott Letendre, M.D.; Norman Haughey, Ph.D.

Corresponding Author:
Norman Haughey, nhaughe1@jhmi.edu

This is an open access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives License 4.0 (CC BY-NC-ND), which permits downloading and sharing the work provided it is properly cited. The work cannot be changed in any way or used commercially without permission from the journal.

Neurology® Published Ahead of Print articles have been peer reviewed and accepted for publication. This manuscript will be published in its final form after copyediting, page composition, and review of proofs. Errors that could affect the content may be corrected during these processes.
Contributions:
Pragney Deme: Drafting/revision of the manuscript for content, including medical writing for content; Study concept or design; Analysis or interpretation of data; Additional contributions: prepared figures, performed statistical analyses, reviewed and edited the manuscript. - Mohammed Moniruzzaman: Drafting/revision of the manuscript for content, including medical writing for content; Analysis or interpretation of data; Additional contributions: prepared figures, performed statistical analyses, reviewed and edited the manuscript. - David Moore: Drafting/revision of the manuscript for content, including medical writing for content; Study concept or design; Analysis or interpretation of data; Additional contributions: prepared figures, performed statistical analyses, reviewed and edited the manuscript. - Robert Heaton: Drafting/revision of the manuscript for content, including medical writing for content; Study concept or design; Analysis or interpretation of data; Additional contributions: prepared figures, performed statistical analyses, reviewed and edited the manuscript. - Scott Letendre: Oversaw all aspects of experimental design, analyses, data interpretation, and manuscript preparation. - Ronald Ellis: Provided samples from the CHARTER cohort, contributed to interpretation of data and editing of the manuscript. - Mohammed Moniruzzaman: Provided samples from the CHARTER cohort, contributed to the analysis of cognitive testing data, interpretation of data and editing of the manuscript. - David Moore: Provided samples from the CHARTER cohort and directs the HNRC at UCSD. Edited the manuscript - Robert Heaton: Provided samples from the CHARTER cohort, oversaw sample collection and contributed to interpretation of data and editing of the manuscript. - Ronald Ellis: Provided samples from the CHARTER cohort, contributed to interpretation of data and editing of the manuscript - Scott Letendre: Oversaw all aspects of experimental design, analyses, data interpretation, and manuscript preparation. - P. Deme and M. Moniruzzaman contributed equally.
aspects of experimental design, analyses, data interpretation, and manuscript preparation. - Norman Haughey
Scott Letendre: Drafting/revision of the manuscript for content, including medical writing for content; Major role in the acquisition of data; Study concept or design; Analysis or interpretation of data; Additional contributions: prepared figures, performed statistical analyses, reviewed and edited the manuscript. - Pragney Deme prepared figures, interpreted experimental findings and wrote the initial draft of the manuscript. - Mohammed Moniruzzaman Provided samples from the CHARTER cohort, contributed to the analysis of cognitive testing data, interpretation of data and editing of the manuscript. - David Moore Provided samples from the CHARTER cohort and directs the HNRC at UCSD. Edited the manuscript - Robert Heaton Provided samples from the CHARTER cohort, oversaw sample collection and contributed to interpretation of data and editing of the manuscript. - Ronald Ellis Provided samples from the CHARTER cohort, contributed to interpretation of data and editing of the manuscript - Oversaw all aspects of experimental design, analyses, data interpretation, and manuscript preparation. - Norman Haughey

Norman Haughey: Drafting/revision of the manuscript for content, including medical writing for content; Major role in the acquisition of data; Study concept or design; Analysis or interpretation of data; Additional contributions: prepared figures, performed statistical analyses, reviewed and edited the manuscript. - Pragney Deme prepared figures, interpreted experimental findings and wrote the initial draft of the manuscript. - Mohammed Moniruzzaman Provided samples from the CHARTER cohort, contributed to the analysis of cognitive testing data, interpretation of data and editing of the manuscript. - David Moore Provided samples from the CHARTER cohort and directs the HNRC at UCSD. Edited the manuscript - Robert Heaton Provided samples from the CHARTER cohort, oversaw sample collection and contributed to interpretation of data and editing of the manuscript. - Ronald Ellis Provided samples from the CHARTER cohort, contributed to interpretation of data and editing of the manuscript - Oversaw all aspects of experimental design, analyses, data interpretation, and manuscript preparation.

Figure Count:
6

Table Count:
1

Search Terms:
[34] HIV dementia, [144] HIV, [199] All Neuropsychology/Behavior

Acknowledgment:
We would like to thank Dr. Ratnam Bandaru for his technical contributions to this work that included mass spectrometric analysis, and to Cynthia Lo for her assistance in preparing demographic tables. We would also like to thank Drs. Richard Skolasky, Florin Vaida, and Ian Abramson for additional statistical support.

Study Funding:
This study was funded by AA0017408, MH077542, MH075673, AG034849 (NJH and JCM), MH071150 (NS), DA61427, MH61427, NS56883 (LC), MH22005, HHSN271201000027C, and HHSN271201000030C (CNS HIV Anti-Retroviral Therapy Effects Research (CHARTER) Study (IG & SL).

Disclosures:
The authors report no relevant disclosures.

Preprint DOI:

Received Date:
2022-01-28
ABSTRACT

Objective. To determine if plasma eicosanoid levels are associated with immune, viral, and cognitive outcomes in people with the human immunodeficiency virus (PWH).

Methods. We measured 42 eicosanoids in a longitudinal study of 95 PWH and 25 demographically comparable uninfected participants. Routine clinical chemistry, virologic, immune markers and a neuropsychological test battery assessing seven cognitive domains was administered to all participants at two study visits over an average of 6.5 months.

Results. Plasma eicosanoid concentrations were elevated in PWH (n=95) compared to seronegative controls (n=25) (100% prediction power at 5% FDR, \( \alpha = 0.0531 \)) and in PWH were negatively associated with lower current and nadir CD4 lymphocyte counts. Higher levels of eicosanoids were associated with impairments in working memory, verbal fluency, and executive function. Higher plasma viral load was associated with elevated pro-inflammatory eicosanoids (24% prediction power at 5% FDR, and 42.4% prediction power at 10% FDR, \( \alpha = 0.10 \)). Longitudinal analyses showed that eicosanoid levels were correlated with viral load and with plasma creatinine. Despite associations of eicosanoids with viral loads, elevated plasma eicosanoids were similar in virally suppressed and not-fully suppressed PWH.

Conclusions. These data show that HIV infection is associated with a robust production of eicosanoids that is not substantially reduced by antiretroviral therapy (ART). The
sustained elevation of these oxylipins in PWH despite ART may contribute to an accelerated aging phenotype that includes earlier than expected brain and peripheral organ damage.

Key Words: HIV, HAND, eicosanoids, plasma, inflammation

Introduction

Antiretroviral therapy (ART) has proven to be effective in controlling replication of the human immunodeficiency virus (HIV)\(^1\). Despite the efficacy of ART to suppress viral replication, immune dysfunction, chronic inflammation, organ damage and cognitive impairment (CI) are still apparent in many people with HIV (PWH)\(^2\). Although the precise mechanisms for these residual pathologies have been elusive, considerable clinical and experimental evidence has associated chronic inflammation with immune dysfunction and damage to multiple organ systems including brain\(^3\).

It is well known that the inflammatory cytokines elevated in PWH are largely, but not completely, reduced with suppressive ART \(^4\). However, very little is known about the impact of ART on eicosanoid metabolism. Eicosanoids are bioactive lipids derived from the metabolism of polyunsaturated fatty acids (PUFAs) that are processed in one of three major pathways: Cyclooxygenase, lipoxygenase, or cytochrome p450 epoxide pathways that each produce multiple biologically active metabolites. Eicosanoids play important roles in the regulation of numerous physiological responses including those associated with vascular function, inflammation, and immune modulation \(^5\) (among others). Two papers in the early 1990s reported elevated CSF levels of the eicosanoids PGE2, PGF2α, PGD2, LTB4, and TXB2 in ART naïve PWH compared to HIV negative control participants \(^6, 7\). Since that time, a number of studies have identified elevated
levels of COX-1 and COX-2 metabolic products including prostaglandins, prostacyclins
and thromboxanes in HIV model systems and in human samples from PWH, but no
studies to date have addressed the potential dysregulation of lipoxygenase and
cytochrome p50 epoxide metabolic pathways in HIV. Likewise, the effects of ART on
eicosanoid metabolism in PWH are unknown, as are the associations of eicosanoids
with cognition in PWH. Here we performed an extensive analysis of plasma eicosanoids
with a focus on lipoxins and epoxides in ART-naïve PWH, ART suppressed PWH, and
uninfected healthy controls and report associations with clinical chemistry and cognitive
functions.

Materials and Methods

Human plasma sample collection.

Plasma samples from PWH were obtained from the CNS HIV Anti-Retroviral Therapy
Effects Research (CHARTER) study. Participant selection was based on a case review
of ~3,500 clinical visits from 430 study participants as previously described. In brief,
neurocognitive change was defined using a multivariable change score approach. A Z-
score was generated for each of 15 neuropsychological variables that reflects how well
or poorly the participant performed at follow-up, relative to the expectation for someone
with the same baseline neuropsychological and other relevant characteristics. Z-scores
were summed to provide a summary regression change score. The central 80 % of the
summary regression change score distribution was defined as cognitively “stable”. The
top 10 % were defined as cognitively ‘improved’ and the bottom 10 % defined as
cognitively ‘declined’. All participants were carefully assessed for neuromedical and
neuropsychiatric comorbidities and excluded if confounds not related to HIV were likely
to be primary contributors to cognitive impairment as previously described.
Standard Protocol Approvals,Registrations, and Patient Consents.

The collection of human plasma samples was approved by the Institutional Review Board (IRB) at each performance site. All participants provided informed consent for all study procedures, including future use of their stored specimens and data for research.

Neuropsychological testing.

Neuropsychological testing was conducted by trained neuropsychometricians and consisted of tests covering seven cognitive domains: executive function, learning and delayed recall, working memory, verbal fluency, speed of information processing, and motor skills. The best available normative standards were used to convert the scores to demographically-corrected standard scores (T-scores), which correct for effects of age, education, sex and ethnicity. The presence and severity of CI was determined using the Global Deficit Score (GDS) approach, where a GDS≥0.5 was impaired. All follow-up visits were corrected for practice effects.

Sample preparation

Each plasma sample (200 µl) was spiked with deuterium labelled internal standards representing several major classes of eicosanoids: AA-d8, 13-HODE-d4, 15(S) HETE-d8, LXA4-d5, PGB2-d4 and LTC4-d5 (1 µg/ml each). Solid-phase extraction (SPE) of eicosanoids was performed using Trace N, 15 mg, 10 µm columns (SPEware Corporation, Baldwin Park, CA) connected to a positive pressure SPE CEREX® SYSTEM 48 processor (SPEware Corporation, Baldwin Park, CA). Columns were preconditioned using 2 ml of methanol followed by 2 ml of water. Samples were loaded onto columns, washed with 2 ml of water and methanol mixture (95:5, v/v) then eluted with 1 ml of pure methanol. Methanol eluent was dried under a stream of nitrogen using a
Multivap nitrogen evaporator (Model 118, Organomation Associates Inc. Berlin, MA, USA) and stored at –80˚C. Dried extracts were re-suspended in pure methanol just prior to analysis.

**Eicosanoids analysis by LC-MS/MS**

Plasma eicosanoids levels were measured by LC-ESI-MS/MS. Chromatographic separation was performed by reverse-phase liquid-chromatography using a Luna 3 µm C18 250 x 2mm column (Phenomenex, Torrance, CA), coupled to a Shimadzu liquid chromatography (LC) (Shimadzu Scientific Instruments, Inc., Columbia, MD). Eluted samples were introduced into a triple stage quadrupole linear ion trap (4000QTRAP) mass spectrometer (Applied Biosystems, Foster City, CA) using multiple reaction monitoring in negative electrospray ionization mode (-ESI). Instrument control and data acquisition were performed using Analyst 1.5.1 software. Data processing was performed using Multiquant 1.2 Software (Applied Biosystems, Foster City, CA).

**Statistical Analyses**

Since imputation of values below the limit of detection with a constant value can adversely impact statistical analyses by increasing the likelihood of biased parameter estimations that distort sample distribution, and impair statistical power, in this study, undetectable values for each eicosanoid were replaced with a left-censored stochastic minimal value approach which imputes data by random draws from a gaussian distribution centered in the minimal value which was estimated as being the qth quantile of the observed values (imputeLCMD package in R). Two-group comparisons were done using the Wilcoxon test, and multiple group comparisons were accomplished using the Kruskal-Wallis test with Dunn’s test for post-hoc comparisons. Correlation analyses were
performed using Spearman’s rank correlation method, and the p-values were corrected using Benjamin-Hochberg's (B-H) method for multiple comparison tests. The value of the effect size is considered low if the value of Spearman’s r correlation value was around 0.1, medium if around 0.3 and large if it is greater than 0.5. p-values less than 0.05 were considered statistically significant. The power analysis was performed using MetaboAnalyst 5.0 to estimate sample size and the effect size of the current study data to achieve prediction power greater than 80% at 5% FDR.

**Results**

**Participant characteristics**

The present study included 120 participants grouped from baseline cognitive function as: (i) HIV seronegative (n=25), (ii) HIV cognitively normal (n=41), and (iii) HIV cognitively impaired (n=54). Age and sex matched plasma from healthy control participants (HIV seronegative, n= 25) were obtained from the Johns Hopkins University performance site. Demographic and clinical characteristics of the participants for cross-sectional analyses are summarized in table 1, ART naïve vs ART stable in eTable 1, and longitudinal analyses in eTable 2. In cross sectional analyses, nadir CD4 was lower in HIV cognitively impaired compared with HIV cognitively normal (p<0.024). Average age, current CD4, plasma viral load, and AIDS status were not statistically different between the groups (table 1). There were overall group differences in current CD4 levels (p<0.028), with HIV stably impaired cognition>HIV stably normal cognition>HIV worsening cognition >HIV impaired cognition, and plasma viral load (p<0.032) with HIV impaired cognition>HIV worsening cognition>HIV stably impaired cognition>HIV stably normal cognition, when participants were arranged according to longitudinal change in cognition (eTable 2).
Baseline associations between plasma eicosanoids, HIV status, and ART

We detected and quantified 42 individual eicosanoids in plasma that were categorized based on the precursor molecule from which they were derived. These included metabolites of (i) eicosapentaenoic acid (EPA), (ii) docosahexaenoic acid (DHA), (ii) arachidonic acid (AA), and (iv) linoleic acid (LA). The vast majority of eicosanoids detected (38 of 42) were elevated in PWH compared to HIV seronegatives (figure 1A). These included the EPA metabolites 5-HEPE, 8-HEPE, 9-HEPE, 11-HEPE, 12-HEPE, 15-HEPE, 18-HEPE, and 8, (9)-EpETE (figure 1B); DHA metabolites 4-HDoHE, 8-HDoHE, 10-HDoHE, 11-HDoHE, 13-HDoHE, 14-HDoHE, 16-HDoHE, 17-HDoHE, and 19(20)-EpDPF (figure 1B); AA metabolites 5-HETE, 8-HETE, 9-HETE, 11-HETE, 12-HETE, 15-HETE, 15-OxoETE, 8,9-DiHETE, 5,12-DiHETE, 5,15-DiHETE, HXB3, LXA4, 8, (9)-EET, 11, (12)-EET, 14, (15)-EET, TXB2 (figure 1C); and the LA metabolites 9-HODE, 13-HODE, 9,10-EpOME, and 15-HETE (figure 1D). The data shown prediction power of 100% at 5% FDR; $\alpha=0.0531$. Several of these EPA metabolites including 8-HEPE, 9-HEPE, and 11-HEPE were below detectable limits in the majority of HIV seronegatives and were well above detectable limits in plasma from PWH. These data demonstrate that HIV infection is associated with a robust increase in plasma eicosanoids. When we separated groups based on ARV use there were no group differences in plasma eicosanoids between ART naïve and PWH stably treated with ART (figure 2A-D). These data suggest that HIV infection is associated with a robust increase in plasma eicosanoids that is not fully resolved by ART.
Baseline associations between plasma eicosanoids and cognition

We next compared the baseline plasma levels of eicosanoids with cognitive impairment status in PWH. We found that plasma levels of most eicosanoids were elevated in both HIV cognitively normal, and HIV cognitively impaired compared to HIV seronegative (figure 3A-D). Eight EPA metabolites 5-HEPE, 8-HEPE, 9-HEPE, 11-HEPE, 12-HEPE, 15-HEPE, 18-HEPE, and 8, (9)-EpETE were elevated in HIV cognitively normal and HIV cognitively impaired compared to HIV seronegative (figure 3A). DHA was decreased, and 10 DHA metabolites including 4-HDoHE, 8-HDoHE, 10-HDoHE, 11-HDoHE, 13-HDoHE, 14-HDoHE, 16-HDoHE, 17-HDoHE, and 19(20)-EpDPF were elevated in HIV cognitively normal and HIV cognitively impaired compared to HIV seronegative (figure 3B). We did not observe group differences in AA, but all 16 AA metabolites 5-HETE, 8-HETE, 9-HETE, 11-HETE, 12-HETE, 15-HETE, 15-OxoEETE, 8,9- DiHETE, 5,12-DiiHETE, 5,15-DiiHETE, HXB3, LXA4, 8, (9)-EET, 11, (12)-EET, 14, (15)-EET, and TXB2 were elevated in HIV cognitively normal and HIV cognitively impaired compared with HIV seronegative (figure 3C). Four of 6 LA metabolites including 9-HODE, 13-HODE, 9,10-EpOME, and 15-HETrE were also elevated in HIV cognitively normal and HIV cognitively impaired compared with HIV seronegative (figure 3D). The data showed prediction power of 35% at 5% FDR; \( \alpha = 0.05 \), and 100% prediction power at 10% FDR; \( \alpha = 0.10 \). These data demonstrate that the majority of plasma eicosanoids are elevated in PWH regardless of cognitive status.

Baseline associations of plasma eicosanoids with virologic and immunologic markers

In exploratory analyses we found negative associations between baseline plasma levels of eicosanoids and current CD4 (8 EPA, 7 DHA, 15 AA, 4 LA), nadir CD4 (9 DHA, 6

Copyright © 2022 The Author(s). Published by Wolters Kluwer Health, Inc. on behalf of the American Academy of Neurology.
EPA, 15 AA, 4 LA), one AA (TXB2) metabolite was associated with creatinine, one LA (12,13 diHOME) metabolite was associated with bilirubin, one EPA and one AA metabolite were associated with AST, one DHA, and two AA metabolites were associated with ALT. One DHA (4-HDoHE) metabolite was associated with cholesterol, HDL (1 DHA, 7 AA, 1 LA), a single DHA metabolite was associated with WBC, one EPA and one DHA metabolite were associated with RBC, HGB (2 EPA, 3 DHA, 1LA), HCT (1 EPA, 3DHA, 1LA), 3 DHA metabolites were associated with MCHC, 2 DHA metabolites were associated with platelets, total lymphocyte count (4 DHA, 9 EPA, 13 AA, 4 LA ), and a single LA metabolite was associated with basophil (figure 4). There were also positive associations between eicosanoids and age (1EPA, 2DHA, 1AA), education (3 DHA, 3 EPA), glucose (1 AA), calcium (1 EPA, 4 DHA, 2 AA, 4 LA), 1 AA and 1 LA metabolite associated with total protein, a single AA metabolite was associated with triglyceride levels, a single AA metabolite was associated with platelet count, neutrophil counts (1EPA, and 3AA), and eosinophil count associated with (3 DHA, 1 AA, and 1 LA) (figure 4). The most robust associations show that low current CD4, nadir CD4, HDL and total lymphocyte counts are associated with higher levels of pro-inflammatory eicosanoids. They also show that higher calcium levels and neutrophil counts are associated with higher levels of plasma eicosanoids (figure 4). Many of these associations did not remain following FDR correction with the exceptions of current and nadir CD4 association with multiple eicosanoids (eFigure 1). The data shown prediction power of 100% at 5% FDR; α=0.02.

We further compared the plasma eicosanoids level in HIV seronegative participants, virally suppressed (<50 copies/mL) PWH and not-fully suppressed (≥50 copies/mL) individuals (figure 5). Elevated plasma eicosanoids were similar in virally suppressed
and not-fully suppressed individuals and none of the eicosanoids measured were different between these two groups. These data suggest that the majority of plasma eicosanoids are elevated in PWH regardless of viral suppression.

**Plasma eicosanoids are negatively associated with performance on working memory tasks in exploratory analyses.**

We next determined in exploratory analyses if baseline plasma levels of eicosanoids were cross-sectionally associated with cognition in PWH. There were no associations between baseline plasma eicosanoid levels and global deficit score, speed of information processing (SIP), learning, recall or motor function. Several eicosanoids were negatively associated with verbal fluency, executive function, and working memory. Seven eicosanoid metabolites (3 DHA, 3 AA, 1 LA) were associated with verbal fluency, 4 eicosanoid metabolites (2 EPA, 2 DHA) were associated with executive function, and a striking 30 eicosanoid metabolites (5 EPA, 7 DHA, 13 AA, 5 LA) were associated with working memory performance (figure 6A). When we only included HIV cognitively normal in the analysis, we observed only a small number of associations between plasma eicosanoids and cognitive domain performance. A single AA metabolite was negatively associated with global deficit score, one EPA and one AA metabolite were negatively associated with executive function (figure 6B). There were also positive associations between eicosanoids and global deficit score (1 DHA, and 1 LA), SIP (1 LA), and motor function (1 EPA, 1 AA, 1 LA) (figure 6B). However, when we only included HIV cognitively impaired in the analysis, a negative association of 4 eicosanoids (3 DHA, 1AA) with verbal fluency, and 13 eicosanoids (3 EPA, 9 AA, and 1LA) with working memory performance remained (figure 6C). There were also positive associations between eicosanoids and learning (2 DHA), and recall (3 DHA, 3 AA, 1 LA) (figure 6).
These findings suggest that elevated plasma levels of eicosanoids in PWH may be associated with worse performance on neuropsychological tests assessing working memory, and to a lesser extent verbal fluency, and executive function. None of these associations remained following FDR correction (eFigure 2). The data shown prediction power of 100% at 5% FDR ($\alpha=0.0419$).

Longitudinal associations between plasma eicosanoids, cognition and plasma markers

In initial longitudinal analyses, we sought to determine if plasma eicosanoid levels at baseline were prognostic indicators of cognitive function at the next study visit. All but one plasma eicosanoids were similar between all groups (eFigure-3A-D). The DHA metabolite 17-HDoHE was elevated at baseline in plasma of HIV improving cognition compared to HIV stably normal cognition (eFigure-3B). These data are consistent with the protective and anti-inflammatory properties of these omega 3 DHA metabolites and suggests that plasma levels of most eicosanoids are not prognostic indicators for change in cognition.

We next determined if plasma levels of eicosanoids accompanied changes in cognition using plasma samples from visit 2. None of the eicosanoids measured at visit 2 were different across the four HIV change groups (eFigure-4A-D). The data shown prediction power of 2% at 5% FDR ($\alpha=0.05$), and a maximum prediction power of 37% at $\alpha=0.297$. These findings suggest that plasma eicosanoid levels are not associated with changes in cognition after the change in cognitive function has occurred.
When we looked at associations between change in virologic / blood markers and change in plasma eicosanoid concentrations we found positive associations between change in viral load and change in 6 of the 42 eicosanoids that included the 1 EPA metabolite 15-HpEPE; 3 DHA metabolites 13-, and 17-HDoHE, and DHA; 1 AA metabolite AA; and 1 LA metabolite 9,10-diHOME (eFigure 5). There were similarly strong positive associations between change in plasma creatinine and change in 35 of the 42 eicosanoids that included the 9 EPA metabolites 5-HEPE, 8-, 9-, 11-, 12-, 15-, 8,(9)-EpETE, 15-OxoETE, and 15-HpEPE; 9 DHA metabolites 4-, 10-, 11-, 13-, 14-, 16-, 17-HDoHE, 19, 20-EpDPE, and DHA; 14 AA metabolites 5-, 8-, 9-, 11-, 12-, 15-HETE, 8,(9)-, 11,(12)-, 14,(15)-EET, 5,(15)-, 5,(12) DiHETE, HXB3, 8,(9)-DiHETrE and AA; 3 LA metabolites 13-HODE, 9,10-EpOME, and 15-HETrE (eFigure 5). A single positive association was found between change in the LA metabolite 9,10-diHOME and bilirubin, and 3 LA metabolites (9-, 13-HODE, and 12,13-diHOME) were positively associated with change in triglyceride levels (eFigure 5). There were 2 negative associations found between change in LDL levels and 2 LA metabolites that included 9,10- and 12,13-diHOME. Two negative associations between white blood cell count and 2 eicosanoids that included DHA, and AA. There were six negative associations between hemoglobin and one EPA metabolite (5-HEPE), 4 DHA (11-, 13-, 17-HDoHE, and DHA), and one AA metabolite included AA. Two negative associations between neutrophil and 1 EPA (12-HEPE), and one DHA (8-HDoHE) metabolite were also observed (eFigure 5). Looking at change in eicosanoid levels and change in virologic/blood markers we found that 6 of 42 eicosanoids were positively correlated with plasma viral load, and 35 of 42 eicosanoids were positively correlated with creatinine (eFigure 5). The most robust associations suggest that increases in plasma viral load were strongly associated with increases in plasma eicosanoids, reductions in kidney function (as suggested by creatinine reductions). None of these associations remained following FDR correction (eFigure 6).
The data shown prediction power of 24% at 5% FDR ($\alpha=0.05$), and a maximum prediction power of 42.4, at 10% FDR; $\alpha=0.10$.

**Discussion**

HIV infection results in a robust inflammatory response with increased plasma levels of cytokines, chemokines and eicosanoids (see 4 for a review). A prominent role for these inflammatory mediators is to regulate the immune response to HIV infection. ART suppresses HIV replication, largely stabilizes immune function and decreases levels of most (but not all) cytokines and chemokines. However, the possible effects of ART on eicosanoid metabolism have not been studied. Here we provide evidence that ART may not substantially reduce elevated levels of eicosanoids in PWH, suggesting that a sustained immune dysregulation with ART may involve chronically elevated levels of proinflammatory eicosanoids. Plasma eicosanoid levels were negatively associated with current CD4, nadir CD4, and lymphocyte counts. Eicosanoids with pro-inflammatory effects (LA and AA metabolites) were positively associated with plasma viral load. Longitudinal analyses showed that eicosanoid levels rise in accordance with viral load and with plasma creatinine, implicating elevations of eicosanoids with impairments in kidney function. Despite the associations of eicosanoid levels with viral loads, elevated plasma eicosanoids were similar in virally suppressed (<50 copies/mL) and not-fully suppressed (>50 copies/mL) individuals. These data suggest that HIV infection is associated with a robust production of eicosanoids that is not substantially reduced by ART, and is associated with impairments in cognition, immune dysregulation, and damage to peripheral organs.
Eicosanoids are a family of bioactive lipids produced primarily through the metabolism of AA, LA, EPA, and DHA. These bioactive lipids serve a wide variety of signaling functions including regulation of the inflammatory response, immune function, vasodilation/constriction, among others (see 5 for a recent review). Eicosanoid metabolism is complex, often involving multiple metabolic steps within a single cell. Each of the metabolites produced in a metabolic pathway have independent functions, with some metabolites produced later in series opposing the functions of earlier metabolites, thus serving to limit the duration of some physiological responses such as an inflammatory reaction. However, prolonged activation of these metabolic pathways under conditions such as those produced by HIV infection can result in a deregulated inflammatory and immune response. Although we cannot precisely determine a mechanism for this sustained eicosanoid response in ART treated PWH from our results, there is a considerable amount of evidence that the gut microbiome may play an important role. CD4+ cells lining the gut are largely lost with HIV infection and do not fully reestablish with ART. This loss of CD4+ cells in PWH increases gut permeability and results in bacterial derived LPS leaking into circulation 17. LPS in addition to viral infection are potent activators of toll like receptors (TLR) that are linked with eicosanoid metabolism.

TLRs belong to a family of pattern recognition receptors that play key roles in initiating an innate immune response that involves a rapid activation of arachidonic acid metabolism in leukocytes, platelets, and dendritic cells 18, 19 (among others). The HIV coat protein gp120 interacts with TLR2 and TLR4 in the presence of heparan sulfate 20, and inhibits activation of TLR9 in plasma dendritic cells (this latter effect presumably limits the ability of the host to produce some antiviral and inflammatory mediators) 21.
HIV ssRNA binds and activates TLR7 and TLR8 in mononuclear cells during viral internalization\textsuperscript{22,23}. Following HIV infection the expression of both TLR2 and TLR4 are increased in monocyte derived macrophages, PBMCs, and dendritic cells\textsuperscript{24,25}. A number of other viral components interact with TLRs including p17 and gp41 that activate TLR1 and TLR2, p24 activates TLR2 and TLR6\textsuperscript{26}, and Tat directly binds TLR4 mRNA to more than double its half-life with a resultant decrease in TLR4 expression\textsuperscript{27}. Although it is not entirely clear which viral components contribute to the maintenance of the eicosanoid response in virally suppressed PWH, there is a great deal of evidence suggesting that non-structural proteins such as Tat continue to be produced despite viral suppression\textsuperscript{28}.

In addition to initiating an innate immune response, eicosanoids play important roles in regulating the interactions between innate and adaptive immune responses including activation, proliferation, migration, differentiation, antibody and cytokine production in lymphocytes and other leukocytes\textsuperscript{29}. In this study we found a negative association between current CD4 count and plasma eicosanoids levels, and a positive association between viral load and eicosanoid levels. The association between high viral loads and low CD4 counts is a common finding in PWH, as the virus replicates in and kills CD4+ T cells. Presumably, a higher viral load would also increase the production of eicosanoids through activation of TLRs as described above, but it is also possible that eicosanoids directly regulate the activity of CD4+ cells. Both CD4+ and CD8+ cells express enzymes for arachidonic acid metabolism including COX1, COX2, 5-LOX, and PGG2\textsuperscript{30}. PGE2 can differentially regulate apoptosis and inhibit proliferation depending on the subpopulation and activation status of CD4 and CD8 cells\textsuperscript{31}. LTB4 signaling though BLT1 promotes activation, cytokine production, chemotaxis, endothelial adhesion and
migration of macrophages and CD4+ cells into tissues including brain. Indeed, elevated numbers of macrophages and T cells in brain parenchyma of PWH is a common finding. We also observed that ART did not substantially reduce circulating levels of eicosanoids in addition to a negative association with low nadir CD4. Together these data suggest that the initial damage to the immune system may have long-term consequences that delimit the eicosanoid response to viral infection. Indeed, low nadir CD4 has been consistently associated with faster disease progression and worse cognitive outcomes in multiple cohorts of PWH.

While the mechanisms responsible for a deregulated eicosanoid response are likely multifactorial, in exploratory analyses we found evidence for reduced antioxidant capacity as evidenced by a negative association between plasma bilirubin and eicosanoid levels. Bilirubin is a powerful antioxidant that suppresses inflammation by inhibiting the activities of secretory phospholipase A₂ (sPLA₂)₃⁶, ₃⁷. Secretory PLA₂ is responsible for the production of AA from membrane phospholipids that are subsequently metabolized into numerous pro-inflammatory eicosanoids through the COX, LOX, or CYP pathways. It is also possible that reduced bilirubin levels contribute to increased eicosanoids indirectly through a disinhibition of inducible nitric oxide synthase (iNOS). Bilirubin has been shown to inhibit hepatic iNOS expression and nitric oxide (NO) production in response to endotoxin in rats, and previous studies have shown that NO increases the production of eicosanoids. NO together with cGMP promote COX-2 expression and the production of PGE₂ in human granulosa cells through CREB signaling and PGE₂ has been shown to further promote NO production though IFNγ in cultured rat microglia. In PWH a negative association of bilirubin and cardiovascular disease, insulin resistance and DNA damage have been previously
reported \textsuperscript{43, 44}. These data combined with the current findings suggest that reduced levels of circulating bilirubin may contribute to the over production of eicosanoids.

There is a strong association between peripheral immune activation, inflammation, eicosanoid metabolism, and neurological dysfunction that is apparent in multiple neurodegenerative conditions that includes a rich literature on roles for eicosanoids in regulating cognitive performance \textsuperscript{45-47}. Peripheral immune activation and inflammation is known to activate brain resident glia with consequent increases in the expression of PLA2, the rate-limiting enzyme in AA production. In the current study we found a negative correlation between most of the plasma eicosanoids we measured and working memory, with a smaller number of eicosanoids showing a negative correlation with executive function. In exploratory analyses, the observation that worse performance on tasks assessing working memory and executive functions were associated with higher levels of almost all eicosanoids suggests a deregulated inflammatory response, despite the production of eicosanoids whose function is to limit the duration and extent of the response. In addition to prominent roles for eicosanoids in inflammation, they also play important roles in vasal tone and platelet activation. For example, HETEs exhibit prohypertensive effects through vasoconstriction and an antihypertensive effects through natriuresis \textsuperscript{48, 49}. Platelet activation and apoptotic pathways are increased in PWH, despite virologic suppression \textsuperscript{50}, and thrombocytopenia is a common finding in PWH. In addition to roles in vascular and tissue repair, they play central roles in innate immune activation by directly interacting with leukocytes and secreting cytokines and chemokines. These data suggest that elevated eicosanoids in PWH may directly contribute to cognitive impairments, but also may restrict neurovascular flow and promote platelet activation.
While we believe the findings from this study provide a potential mechanistic explanation for sustained inflammation in virally suppressed PWH, there are some shortcomings. The study was conducted with a relatively small number of samples from PWH that were obtained from a single cohort. The PWH of this study were almost exclusively male. Based on known sex differences in the prevalence and etiology of autoimmune diseases, inflammatory diseases, and neurodegenerative conditions, the associations of eicosanoids with clinical outcomes and cognition that we report here, may not be directly applicable to HIV infected women. Future studies should reevaluate potential roles of eicosanoids as drivers of sustained inflammation in a larger sample size obtained from multiple cohorts with diverse demographics and risk factors.

Conclusions
Our findings suggest that HIV infection is associated with a robust increase in plasma eicosanoids that is not resolved by ART. Although there was an association between low nadir CD4, low current CD4, high viral load and elevated eicosanoids, those individuals with viral suppression below detectable limits did not completely resolve plasma eicosanoid levels. Elevated eicosanoids were associated with poorer cognitive performance. Our data suggest an impairment in the self-limiting aspects of an inflammatory eicosanoid response.

Supplementary Figures and Tables -- [http://links.lww.com/WNL/C210](http://links.lww.com/WNL/C210)
References


Figure legends

Figure 1. Baseline analysis of plasma eicosanoids in PWH and healthy seronegative control participants. Box plots show (A) Eicosapentaenoic acid (EPA) metabolites, (B) Docosahexaenoic acid (DHA) metabolites, (C) Arachidonic acid (AA) metabolites, and (D) Linoleic acid (LA) metabolites. Data show median and range with individual data points. HIV seronegative (n=25), PWH (n=95). *=p<0.05, **=p<0.01, ***=p<0.001. Non-parametric Wilcoxon signed-rank test with Benjamini-Hochberg FDR correction performed for two group comparisons.
Figure 2. Baseline analysis of plasma eicosanoids in healthy seronegative control participants and PWH who are ART naïve or on a stable ART regimen. Box plots show (A) Eicosapentaenoic acid (EPA) metabolites, (B) Docosahexaenoic acid (DHA) metabolites, (C) Arachidonic acid (AA) metabolites, and (E) Linoleic acid (LA) metabolites.
metabolites. Data show median and range with individual data points. HIV seronegative (n=25), ART stable (n=66), ART naïve (n=29) * p<0.05, ** p<0.01, *** p<0.001 increased compared to HIV seronegative. ### p<0.001 decreased compared to HIV seronegative. Kruskal-Wallis test with Dunn’s post-hoc comparison test performed for three group comparisons.

A. EPA metabolites

B. DHA metabolites

C. AA metabolites

D. LA metabolites
Figure 3. Baseline analysis of plasma eicosanoids in healthy seronegative control participants, cognitively normal, and cognitively impaired PWH. Box plots show (A) Eicosapentaenoic acid (EPA) metabolites, (B) Docosahexaenoic acid (DHA) metabolites, (C) Arachidonic acid (AA) metabolites, and (E) Linoleic acid (LA) metabolites. Data show median and range with individual data points. HIV seronegative (n=25), HIV_{CN} = cognitively normal (n=41), and HIV_{CI} = cognitively impaired (n=54) *=p<0.05, **=p<0.01, ***=p<0.001 increased compared to HIV seronegative. #=p<0.05, ##=p<0.01 decreased compared to HIV seronegative. Kruskal-Wallis test with Dunn’s post-hoc comparison test performed for three group comparisons.
Figure 4. Correlation plot showing the relationships of plasma eicosanoid levels to demographic, virologic, and clinical markers. The value of effect size of spearman’s correlation and the direction of the relationship is depicted by color from 1.0 in dark blue to -1.0 in dark red. The value of the effect size is considered low if the value of $r$ is around 0.1, medium if around 0.3 and large if $r$ is greater than 0.5. The vast majority of
effect sizes in this analysis were in the medium to high value range. *=p<0.05, **=p<0.01 and ***=p<0.001. Spearman’s rank correlation.

Figure 5. Baseline plasma eicosanoids in healthy seronegative control participants and PWH with virally suppressed (<50 copies/mL) and not-fully suppressed (>50 copies/mL) individuals. Box plots show (A) Eicosapentaenoic acid (EPA) metabolites, (B) Docosahexaenoic acid (DHA) metabolites, (C) AA metabolites, and (D) Linoleic acid (LA). Data show median and range with individual data points. HIV seronegative (n=25), Viral load <50 copies (n=43) and Viral load >50 copies (n=52). *=p<0.05, **=p<0.01, ***=p<0.001 increased compared to HIV seronegative. Kruskal-
Wallis test with Dunn’s post-hoc comparison test performed for three group comparisons.
Figure 6. Correlation plots showing the relationships of plasma eicosanoid levels to global cognitive function and performance in individual cognitive domains. (A) Relationship of baseline plasma eicosanoid levels in all HIV infected patients to overall cognitive function (global), and performance in verbal, executive function, speed of information processing (SIP), learning, recall, working memory, and motor function. (B) Relationship of baseline plasma eicosanoid levels in cognitively normal HIV infected patients (HIV$_{CN}$) to overall cognitive function (global), and performance in the indicated cognitive domains (C) Relationship of baseline plasma eicosanoid levels in cognitively impaired HIV infected patients (HIV$_{CI}$) to overall cognitive function (global), and performance in the indicated cognitive domains. The value of effect size of Spearman’s correlation and the direction of the relationship is depicted by color from 1.0 in dark blue to -1.0 in dark red. The value of the effect size is considered low if the value of r is around 0.1, medium if around 0.3 and large if r is greater than 0.5. The vast majority of effect sizes in this analysis were in the medium value range. *=p<0.05 and **=p<0.01. Spearman’s rank correlation.
Table 1 Baseline clinical and demographic characteristics

<table>
<thead>
<tr>
<th>Baseline characteristics</th>
<th>HIV$_{SN}$ (n=25)</th>
<th>HIV$_{CN}$ (n=41)</th>
<th>HIV$_{CI}$ (n=54)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (Years)</td>
<td>42.26 (12.55)</td>
<td>44.12 (9.54)</td>
<td>45.17 (7.78)</td>
</tr>
<tr>
<td>Education (Years)</td>
<td>nd</td>
<td>13.05 (1.96)</td>
<td>13.11 (2.73)</td>
</tr>
<tr>
<td>Sex (Male)</td>
<td>56</td>
<td>92.7</td>
<td>77.8</td>
</tr>
<tr>
<td>Ethnicity (Caucasian)</td>
<td>60</td>
<td>78</td>
<td>79.6</td>
</tr>
<tr>
<td>AIDS</td>
<td>nd</td>
<td>63.4</td>
<td>74.1</td>
</tr>
<tr>
<td>Current CD4 (cells/mm$^3$)</td>
<td>nd</td>
<td>389.73 (226.38)</td>
<td>450.09 (280.67)</td>
</tr>
<tr>
<td>Nadir CD4 (cells/mm$^3$)</td>
<td>nd</td>
<td>192.85 (194.08)</td>
<td>162.24 (160.85)</td>
</tr>
<tr>
<td>Current ART</td>
<td>nd</td>
<td>68.3</td>
<td>74.07</td>
</tr>
<tr>
<td>Plasma viral load ($\leq$50 copies/mL)</td>
<td>nd</td>
<td>69.2</td>
<td>72.2</td>
</tr>
<tr>
<td>CSF viral load ($\leq$50 copies/mL)</td>
<td>nd</td>
<td>40.5</td>
<td>40.7</td>
</tr>
</tbody>
</table>

Data are expressed as % mean (± SD) as appropriate, nd=no data, HIV$_{SN}$= HIV seronegative, HIV$_{CN}$= HIV Cognitively normal, and HIV$_{CI}$= HIV Cognitively impaired.
Association of Plasma Eicosanoid Levels With Immune, Viral, and Cognitive Outcomes in People With HIV
Pragney Deme, Mohammed Moniruzzaman, David Moore, et al.

Neurology published online July 18, 2022
DOI 10.1212/WNL.0000000000200945

This information is current as of July 18, 2022

Updated Information & Services
including high resolution figures, can be found at:
http://n.neurology.org/content/early/2022/07/18/WNL.0000000000200945.full

Subspecialty Collections
This article, along with others on similar topics, appears in the following collection(s):
All Neuropsychology/Behavior
http://n.neurology.org/cgi/collection/all_neuropsychology_behavior
HIV
http://n.neurology.org/cgi/collection/hiv
HIV dementia
http://n.neurology.org/cgi/collection/hiv_dementia

Permissions & Licensing
Information about reproducing this article in parts (figures,tables) or in its entirety can be found online at:
http://www.neurology.org/about/about_the_journal#permissions

Reprints
Information about ordering reprints can be found online:
http://n.neurology.org/subscribers/advertise