Comparison of the T-cell response to human cytomegalovirus (HCMV) as detected by cytokine flow cytometry and QuantiFERON-CMV assay in HCMV-seropositive kidney transplant recipients

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INTRODUCTION

Human cytomegalovirus (HCMV) infection/disease remains one of the most common infectious complications in patients receiving solid-organ transplantation. To reduce morbidity and mortality caused by HCMV infection, prophylactic and pre-emptive antiviral approaches are in use (Khoury et al., 2006, Limaye et al., 2006). T-cell-mediated immunity is believed to play a major role in controlling HCMV infection in the immunocompetent host (Revello et al., 2006; Lilleri et al., 2007) and preventing HCMV infection in solid-organ transplant recipients (SOTR) (Sester et al., 2001, Sacre et al., 2005, Gerna et al., 2011a, 2011b, Gabanti et al., 2014). Therefore, T-cell immunological monitoring may provide useful prognostic indications. In recent years, several methods have been developed to investigate the HCMV-specific T-cell response. Intracellular cytokine staining by cytokine flow cytometry (CFC) can measure both virus-specific CD4+ and CD8+ T-cells. Other methods, such as ELISPOT, can distinguish between the two T-cell subsets if peripheral blood mononuclear cells (PBMC) are depleted of either subset, or differentially stimulated (Calarota et al., 2014, Gabanti et al., 2016).

To monitor the T-cell response to HCMV infections in both immunocompetent and immunocompromised hosts (Lilleri et al., 2006, 2007, 2008, 2009; Gabanti et al., 2015), a method simultaneously measuring CD4+ and CD8+ T-cells by CFC-iDC was developed in our laboratory (Lozza et al., 2005). The commercially available QuantiFERON-CMV assay (QF-CMV, Qiagen, Hilden, Germany), which measures primarily IFN-γ released by CD8+ T-cells after stimulation with a pool of 22 short peptides from 6 HCMV proteins presented by several human leukocyte antigen (HLA) class I haplotypes (Walker et al., 2007), has already shown its utility in assessing the risk of HCMV reactivation in SOTR (Lisboa et al., 2012, Abate et al., 2013, Manuel et al., 2013). This study compared the performance of our CFC-iDC method with that of QF-CMV in predicting self-resolving low viral load (LVL) and high viral load (HVL) HCMV infections requiring treatment in a cohort of HCMV-seropositive kidney transplant recipients (KTR).
MATERIALS AND METHODS

Study population
From September 2013 to July 2016, 53 KTR were enrolled at our University Hospital. Induction therapy consisted of anti-thymocyte globulin (ATG) or anti-CD25 monoclonal antibody and steroids. Immunosuppressive therapy consisted of standard triple therapy including a calcineurin inhibitor, an antiproliferative drug, and steroids. The study was approved by our Institutional Review Board and patients gave their written informed consent.

Virological monitoring
Viral DNA was quantified in whole blood (DNAemia) weekly or twice a week (according to the severity of infection) by an in-house real-time PCR method (Gerna et al., 2006b), and was still expressed as DNA copies/mL blood. However, a recent still unpublished study showed that the conversion factor from DNA copies to International Units (IU) for blood samples was 0.42, thus indicating an approximate 2-fold difference between the two VL expression units (personal communication). However, since the DNA extraction method was changed in 2015, when the conversion factor was determined, and patient enrollment started in 2013, this study still expresses viral DNA in copies/mL whole blood.

Pre-emptive therapy (i.v. ganciclovir 5 mg/kg or oral valganciclovir 900 mg twice a day) was administered to HLV patients with DNAemia levels above the cut-off of 3x10^6 copies/mL blood (Lilleri et al., 2004, Gerna et al., 2011a, 2011b), and treatment was continued until two consecutive negative DNAemia results. Patients with LVL DNAemia resolved the systemic infection spontaneously. Tissue invasive disease (TID) in symptomatic patients was confirmed on tissue biopsy according to Ljunghman et al. (2017).

Immunological monitoring
Immunological monitoring was scheduled in all KTR patients at 30, 60, 90, and 180 days after transplantation and concomitantly with the initiation of antiviral treatment in HLV patients (DNAemia peak). Each patient was tested at all time points by CFC-iDC (Lozza et al., 2005) and QF-CMV. Our in-house developed CFC-iDC assay was based on 24h co-culture of patient autologous immature dendritic cells (DC), which were infected with the endotheliotropic and leukotropic HCMV strain VR1814, with peripheral blood mononuclear cells. Then, both activated CD4+ and CD8+ T-cells were quantified by cytokine flow cytometry analysis of intracellular IFN-γ production (Lozza et al., 2005). Laboratory-adapted HCMV strains were found unable to infect DC (Gerna et al., 2005). The CFC-iDC cut-off predicting protection from HLV infection was found to be 0.4 HCMV-specific CD4+ and CD8+ T-cells/μL blood (Lozza et al., 2005, Gerna et al., 2011a, 2011b). The QF-CMV cut-off was 0.2 IFN-γ IU/mL, as reported by the manufacturer.

Statistical analysis
HCMV-specific CD4+ and CD8+ T-cells measured by CFC-iDC in KTR with LVL infection were compared with the relevant T-cell subset in patients with HLV infection by the Mann-Whitney U test. The same test was used to compare levels of IFN-γ detected by QF-CMV in the two patient groups. The chi-square test was performed to compare the prognostic performances of the two assays. The times of HCMV-specific T-cell immunity reconstitution, HCMV DNA appearance, peak, and disappearance were evaluated using Kaplan-Meier curves, which were compared by the log-rank (Mantel-Cox) test.

RESULTS

Clinical characteristics of the patients enrolled
The 53 KTR analyzed had a median age of 53 (21-70) years. The median follow-up duration was 190 (140-240) days. As illustrated in Table 1, 33 patients (62.3%) underwent a LVL self-resolving HCMV infection (protected patients), while 19 patients (35.8%) had a HVL systemic infection requiring antiviral therapy (non-protected patients). The majority of this subgroup (12/19, 63.1%) underwent a single episode of severe virus reactivation that resolved with antiviral therapy, while a minority developed relapsing infections requiring additional courses of treatment (4/19, 21.1%) or TID (gastrointestinal disease or pneumonia) concomitantly with HVL systemic infection (3/19, 15.8%). A single patient (1.9%) had gastrointestinal TID alone.

Protection from severe HCMV infection
The maximum sensitivity (capacity to identify protected patients) and specificity (capacity to identify non-protected patients) of the two assays were determined at the DNAemia peak (Table 2). In general, prognostic performances of the QF-CMV assay were slightly less efficient compared to CFC-iDC. However, these differences were not statistically significant (P>0.05).

Discrimination of HVL and LVL patients by the two assays
At the DNAemia peak, the number of HCMV-specific CD4+ and CD8+ T-cells detected by CFC-iDC in LVL patients was significantly higher than in HVL patients (Figure 1A). The same trend (higher IFN-γ levels in LVL patients) was observed with QF-CMV (Figure 1B). At the end of follow-up, this difference was markedly reduced (Figure 1C and D). However, while the great majority of LVL patients were above the immunological cut-off throughout the follow-up

<p>| Table 1 - Clinical characteristics of the kidney transplant recipients enrolled. |</p>
<table>
<thead>
<tr>
<th>No. patients</th>
<th>No. (%) patients with LVL infection</th>
<th>No. (%) patients with treated HVL infection</th>
<th>No. (%) patients with treated HVL infection + TID systemically</th>
<th>No. (%) TID in the absence of HVL infection*</th>
</tr>
</thead>
<tbody>
<tr>
<td>53</td>
<td>33 (62.3)</td>
<td>12 (22.6)</td>
<td>3 (5.7)</td>
<td>1 (1.9)</td>
</tr>
</tbody>
</table>

LVL, Low Viral Load; HVL, High Viral Load; TID, Tissue Invasive Disease; syst., systemic. *Presence of systemic specific T-cell immunity.

<p>| Table 2 - Prognostic performances of the two assays at DNAemia peak. |</p>
<table>
<thead>
<tr>
<th>Parameter (%)</th>
<th>CFC-iDC</th>
<th>QF-CMV</th>
</tr>
</thead>
<tbody>
<tr>
<td>sensitivity</td>
<td>91</td>
<td>85</td>
</tr>
<tr>
<td>specificity</td>
<td>84</td>
<td>63</td>
</tr>
<tr>
<td>PPV</td>
<td>91</td>
<td>80</td>
</tr>
<tr>
<td>NPV</td>
<td>84</td>
<td>71</td>
</tr>
</tbody>
</table>

Chi square test (P<0.05 for all 4 parameters); CFC-iDC, cytokine flow cytometry-infected dendritic cells; QF-CMV, Quantiferon-CMV; PPV, positive predictive value; NPV, negative predictive value.
QuantiFERON-CMV vs flow cytometry for HCMV T-cell response

Figure 1 - HCMV-specific T-cell response (A, B) at the DNAemia peak and (C, D) at the end of follow-up by (A, C) CFC-iDC and (B, D) QF-CMV, in KTR with HVL and LVL infection. Both assays revealed a significantly lower level of T-cell response in patients with HVL infection. This difference was markedly reduced at the end of follow-up with both assays. Dotted lines indicate cut-offs for both immune assays. Fig.1A reports patient codes #141, #147, and #151 (see Table 4), and #175 (see Table 5).

CFC-iDC, cytokine flow cytometry using HCMV-infected dendritic cells as a stimulus; QF-CMV, QuantiFERON-CMV; IFN-γ, interferon-gamma; pts, patients; HVL, high viral load; LVL, low viral load; IND, indeterminate result (<0.2 INF-γ IU/mL in the CMV tube and <0.5 IU/mL in the mitogen tube); IU, international units.

Figure 2 (A) and (B) - Kaplan-Meier curves. The time required to reach protective (according to established cut-offs) levels of HCMV-specific T-cell immune responses in KTR with HVL infection was significantly greater compared to patients with LVL infection. This difference is greater for CFC-iDC than QF-CMV (P<0.0001 vs P<0.01). (C): HCMV viral load at DNAemia peak was above the cut-off of 3x10^5 copies/mL blood in KTR with HVL infection and below in patients with LVL infection. At the end of follow-up, no significant difference was detected between the two patient groups, both below the DNAemia cut-off.

CFC-iDC, cytokine flow cytometry using infected dendritic cells as a stimulus; pts, patients; HVL, high viral load; LVL, low viral load; QF-CMV, QuantiFERON-CMV
with both assays, the number of HVL patients reaching the relevant immunological cut-off at the end of follow-up shifted from 3/19 (16%) to 13/19 (68%) by CFC-iDC with a >50% rise, while a rise by QF-CMV was limited to 21% (from 7/19, 37% to 11/19, 58%).

**Kinetics of immune reconstitution and DNAemia in LVL and HVL patients**

Both CFC-iDC and QF-CMV confirmed the significantly delayed reconstitution of immunity in HVL compared to LVL patients, as illustrated by the Kaplan-Meier curves (Figure 2 A, B, and Table 3).

In addition, in patients with HVL infection, DNAemia appeared and peaked significantly earlier, while the median DNAemia peak was about 100 times higher (Table 3 and Figure 2C), whereas the median time to DNAemia disappearance was not significantly different (Table 3, P=0.15). Finally, a marked decrease in DNAemia levels was observed in both patient groups at the end of follow-up (Figure 2C).

**Table 3 - DNAemia and HCMV-specific immune response kinetics according to the two assays.**

<table>
<thead>
<tr>
<th>Patients with DNAemia appearance</th>
<th>DNAemia peak</th>
<th>DNAemia disappearance</th>
<th>Median days to reach protective cut-off (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCMV infection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LVL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>median days (range)</td>
<td>median VL (copies/mL blood, range)</td>
<td>median days (range)</td>
<td>(5-167)</td>
</tr>
<tr>
<td>HVL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>median days (range)</td>
<td>median VL (copies/mL blood, range)</td>
<td>median days (range)</td>
<td>(6-61)</td>
</tr>
<tr>
<td>P</td>
<td>&lt;0.01</td>
<td>0.04</td>
<td>&lt;0.0001</td>
</tr>
</tbody>
</table>

VL, viral load; HVL, high viral load; LVL, low viral load; CFC-iDC, cytokine flow cytometry-infected dendritic cells; QF-CMV, QuantiFERON-CMV.

**Table 4 - Patients with systemic HVL infection and apparently protective HCMV immune response according to the CFC-iDC assay (cut-off: 0.4 CD4+/CD8+ T-cells/µL).**

<table>
<thead>
<tr>
<th>Pt. code</th>
<th>CFC-iDC (HCMV-specific T-cells/µL)</th>
<th>QF-CMV [IFN-γ (IU/mL)]</th>
<th>Systemic HCMV HVL infection</th>
<th>Induction/ immunosuppression regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CD4+</td>
<td>CD8+</td>
<td>DNAemia peak (days post-tx)</td>
<td>Peak DNAemia level (copies/mL blood)</td>
</tr>
<tr>
<td>#141</td>
<td>7.4</td>
<td>32.8</td>
<td>0.00</td>
<td>93</td>
</tr>
<tr>
<td>#147</td>
<td>0.6</td>
<td>2.5</td>
<td>0.00</td>
<td>47</td>
</tr>
<tr>
<td>#151</td>
<td>8.5</td>
<td>25.1</td>
<td>0.00</td>
<td>63</td>
</tr>
</tbody>
</table>
| Pt., Patient; HVL, high viral load; TID, tissue-invasive disease; CFC-iDC, cytokine flow cytometry-infected dendritic cells; QF-CMV, QuantiFERON-CMV; ATG, anti-thymocyte globulin; MPRE, methylprednisolone; MMF, mofetil mycophenolate; CyA, cyclosporine A; FK506, Tacrolimus.

**Table 5 - Patients with HVL infection and apparently protective immune response according to the QF-CMV assay (cut-off: 0.2 IFN-γ IU/mL).**

<table>
<thead>
<tr>
<th>Pt. code</th>
<th>CFC-iDC (HCMV-specific T-cells/µL)</th>
<th>QF-CMV [IFN-γ (IU/mL)]</th>
<th>Systemic HCMV HVL infection</th>
<th>Induction/ immunosuppression regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CD4+</td>
<td>CD8+</td>
<td>DNAemia days post-tx</td>
<td>HCMV DNAemia (copies/mL blood)</td>
</tr>
<tr>
<td>#152</td>
<td>0.1</td>
<td>9.3</td>
<td>0.63</td>
<td>57</td>
</tr>
<tr>
<td>#160</td>
<td>0.3</td>
<td>1.0</td>
<td>2.77</td>
<td>91</td>
</tr>
<tr>
<td>#163</td>
<td>0.3</td>
<td>6.2</td>
<td>&gt;10.00</td>
<td>65</td>
</tr>
<tr>
<td>#169</td>
<td>0.3</td>
<td>0.2</td>
<td>3.34</td>
<td>76</td>
</tr>
<tr>
<td>#175</td>
<td>2.2</td>
<td>0.2</td>
<td>1.49</td>
<td>73</td>
</tr>
<tr>
<td>#193</td>
<td>0.1</td>
<td>1.4</td>
<td>1.80</td>
<td>69</td>
</tr>
<tr>
<td>#197</td>
<td>0.1</td>
<td>0.4</td>
<td>1.60</td>
<td>91</td>
</tr>
</tbody>
</table>

Pt., Patient; HVL, high viral load; CFC-iDC: cytokine flow cytometry-infected dendritic cells; QF-CMV, QuantiFERON-CMV; ATG, anti-thymocyte globulin; MPRE, methylprednisolone; MMF, mofetil mycophenolate; CyA, cyclosporine A; FK506, Tacrolimus.
Discrepancies between the immune response detected by the two assays and HVL infection
CFC-iDC misidentified 3/19 (16%) patients (#141, #147, #151) with HVL infection as protected (Figure 1 and Table 4). These patients were correctly considered at risk for severe infection by QF-CMV assay. In addition, patient #175 (Figure 1 and Table 5) had HCMV-specific CD4+ but not CD8+ T-cells above the cut-off (and, thus, was considered non-protected). In the great majority of patients, specific CD4+ were flanked by specific CD8+ T-cells. Instead, when specific CD8+ appeared earlier than specific CD4+ T-cells, patients appeared to be non-protected until reconstitution of specific CD4+ T-cells.

On the other hand, QF-CMV misidentified 7/19 (37%) patients with HVL infection as protected (Table 5), due to an HCMV-specific immune response far above the QF-CMV cut-off for the majority (6/7) of them throughout the follow-up (see as an example Pt. #152, Figure 3). However, CFC-iDC correctly identified all of these patients at risk for HVL infection (Table 5).

As for LVL patients, at the DNAemia peak, 3/33 (9%) were indicated as non-protected by CFC-iDC vs 5/33 (15%) by QF-CMV (Figure 1). However, none of these patients underwent severe infection episodes requiring treatment.

**TID**
Three patients with HVL developed TID (gastrointestinal and pneumonia) concomitantly with the peak of systemic infection (Table 1). The single case of TID (gastrointestinal disease) detected among LVL patients in this study confirms that local tissue infection (5x10^5 DNA copies/1x10^5 antrum cells) may occur in the absence of HVL (DNAemia undetectable at time of organ infection) and in the presence of a valid systemic T-cell response detected along the duration of infection by both CFC-iDC (HCMV-specific CD4+ T-cells 1-8 µL, and CD8+ T-cells >10/µL) and QF-CMV (consistently >10 IFN-γ IU/mL).

**HLA typing and immunological findings**
HLA-A and B alleles were recovered for 52/53 patients and matched with those included in the QF-CMV panel (Walker et al., 2007). Among the 8 patients with less than 2 matching alleles, only 3 (37.5%) had a specific immune response for at least one time-point, whereas of the 44 patients with ≥2 alleles, as many as 40 (91%) had a positive immune response (Table 6).

Overall, 9/52 (17.3%) patients never had a positive response with QF-CMV throughout the follow-up (see as an example Pt. #182, Figure 4), whereas CFC-iDC detected

<table>
<thead>
<tr>
<th>Table 6 - HLA alleles and immune response according to the two assays.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>HLA-A and -B allele no. shared with those included in the QF-CMV panel</th>
<th>Pt. no. (%)**</th>
<th>Pt. no. (%) with HCMV-specific immune response**</th>
</tr>
</thead>
<tbody>
<tr>
<td>CFC-iDC</td>
<td>QF-CMV</td>
<td></td>
</tr>
<tr>
<td>≥ 2</td>
<td>44 (85)</td>
<td>44 (100)</td>
</tr>
<tr>
<td>&lt;2</td>
<td>8 (15)</td>
<td>8 (100)</td>
</tr>
<tr>
<td>total</td>
<td>52</td>
<td>43</td>
</tr>
</tbody>
</table>

Pt., patient; CFC-iDC, cytokine flow cytometry-infected dendritic cells; QF-CMV, QuantiFERON-CMV.

*, HLA typing unknown for one patient;
**, at least at one time-point during follow-up.
HCMV-specific CD4+ and CD8+ T-cells above the relevant cut-offs in all 9 patients at least once during follow-up.

**DISCUSSION**

The objective of this study was to compare the prognostic performances of two immunological assays investigating the T-cell response to HCMV infection in a group of HCMV-seropositive KTR. As mentioned above, the in-house assay (CFC-iDC) was developed more than 10 years ago (Lozza et al., 2005), while the QF-CMV assay is commercially available (Walker et al., 2007). There are some major differences between the two assays:

1) **CFC-iDC** detects both HCMV-specific CD4+ and CD8+ T-cells, whereas **QF-CMV** detects primarily CD8+ T-cells;
2) **CFC-iDC** unlike **QF-CMV** assay results with any HLA type;
3) **CFC-iDC** requires 6-7 days, whereas **QF-CMV** requires only 2 days to complete;
4) **CFC-iDC** requires a flow cytometer and fresh or thawed PBMCs, whereas **QF-CMV** assay utilizes whole blood to stimulate T-cells prior to measuring by ELISA IFN-γ released in plasma.

Patients were divided into two groups: those (n=33, 62%) with a DNAemia level below the cut-off for pre-emptive therapy (LVL patients); and those (n=19, 36%) with a peak DNAemia level above the cut-off (HVL patients) (Lilleri et al., 2004, Gerna et al., 2011a, 2011b). According to the protocol currently in use in our Department, all of the latter patients were treated with antiviral therapy prior to the onset of clinical symptoms (Gerna et al., 1998) and until DNAemia disappearance. The DNAemia cut-off was originally established by showing that, in comparison with the previously defined antigenemia cut-off of 100 pp65-pos/2x10^5 PBL, it could provide positive and negative predictive values as robust as those provided by antigenemia (Lilleri et al., 2004; Gerna et al., 2007).

As for the HCMV-specific T-cell cut-offs, a ROC analysis in a prospective study monitoring HCMV-specific CD4+ and CD8+ T-cells in SOTR indicated that the cut-offs of 0.4 T-cells/µL blood for both T-cell subsets provided maximum predictive values (Gerna et al., 2006a). These cut-offs are currently in use in our Department, and similar values have been reported by others (Benmarzouk-Hidalgo et al., 2011).

This study found a statistically significant difference with CFC-iDC assay when considering LVL and HVL patient groups for both HCMV-specific CD4+ and CD8+ T-cells, which were consistently higher in number in the LVL group. A similar statistically significant difference was observed with QF-CMV assay when considering the plasma levels of IFN-γ. However, in the case of discrepant results, one assay consistently identified as at risk for HVL infection all patients misidentified as protected by the other assay, thus suggesting that in case of discrepancy between immunological results of either assay and viral load level, the alternative assay could help clarify the discrepancy.

As for the role of HCMV-specific CD4+ and CD8+ T-cells in protecting against HCMV disease in transplant recipients, a correlation between the presence of HCMV-specific T-cells and absence of HCMV disease was reported in several clinical studies (Sester et al., 2002; Sester et al., 2005; Gerna et al., 2006; Mattes et al., 2008; Kumar et al., 2009). Some studies reported a pivotal role for HCMV-specific CD4+ T-cells in controlling HCMV infection (Sester et al., 2001). Using peptide-conjugated MHC class I tetramers, a correlation between CD8+ T-cells and protection has been reported (Gratama et al., 2001, 2010), whereas other studies have questioned this conclusion (Crough et al., 2007). During the last decade, we have repeatedly confirmed in SOTR that...
protection from HCMV disease is first guided by specific CD4+ T-cells, while specific CD8+ T-cells complete protection with their cytotoxic activity (Gabanti et al., 2014). In the present study, CFC-iDC quantified both HCMV-specific CD4+ and CD8+ T-cell subsets, thus allowing risk prediction for HCMV disease in the presence of HVL, whereas QF-CMV primarily detected specific CD8+ T-cells, and appears slightly less specific in predicting HCMV disease risk. In other words, in the absence of specific CD4+ T-cell reconstitution, specific CD8+ T-cells do not protect from HCMV HVL infection (Gabanti et al., 2014). In most patients of this study, a level of specific CD4+ T-cells below the relevant immune cut-off in the presence of a specific CD8+ T-cells level markedly above the relevant immune cut-off did not protect against HVL. Thus, the number of specific T-cells of either CD4+ or CD8+ subset above the immune cut-off was not able per se to protect most patients from HVL infection, in the absence of the number of specific T-cells of the other subset above the relevant immune cut-off.

As expected, the time to reach immune reconstitution was comparable and relatively short for both CFC-iDC and QF-CMV in LVL patients, whereas this time was markedly delayed with both assays in HVL patients. Overall, while the median time to DNAemia appearance and peak was significantly shorter in LVL patients with HVL, the time to DNAemia disappearance was not significantly different from that of LVL patients (P=0.15).

In 5/8 (63%) patients sharing fewer than 2 alleles with the QF-CMV panel, detection of the immune response was precluded, while in patients sharing ≥2 alleles only 4/44 (9%) patients yielded negative results. These findings suggest that, as expected, allele mismatching may markedly impact on QF-CMV results. The basis for the immune response in the 3 patients with one or no allele matches may reside in the partial cross-stimulation of CD4+ T-cells by the peptide pool (Gabanti et al., 2016), or in an excess expansion of a few HCMV-specific CD8+ T-cell clones recognizing the HLA-matched peptide present in the QF-CMV assay.

Finally, it is worthwhile mentioning the case of TID that was associated with LVL infection. The peculiarity of HCMV infection in a case like this resides in the uniqueness of a severe local infection occurring in the absence of virus dissemination and in the presence of an efficient T-cell response (Gerna et al., 2012, Gabanti et al., 2015). A similar occurrence in hematopoietic stem cell transplant recipients was previously reported (Gabanti et al., 2015). In conclusion, both immunological assays appear able to monitor HCMV infection satisfactorily in the great majority of KTR. CFC-iDC assay appears slightly preferable to the QF-CMV since:

1. It shows a slightly higher (but not significantly) specificity;
2. It yields fewer discrepant results;
3. Due to the patient HLA-A and -B mismatching with alleles included in the QF-CMV assay panel, CFC-iDC detected HCMV-specific CD4+ and CD8+ T-cells in all 9 patients never yielding a positive response by QF-CMV throughout the post-transplant period.

Finally, both immunological techniques may be used as an adjunct measurement in pre-emptive therapy decision-making, and namely in predicting new HCMV infection episodes in the post-transplant period. Result concordance between the two immunological assays represents the most reliable parameter in predicting either protection from or risk for HCMV HVL infection.

**Abbreviations**

KTR, kidney transplant recipients; LVL, low viral load; HVL, high viral load; CFC-iDC, cytokine flow cytometry-detected dendritic cells; QF-CMV, QuantiFERON-CMV; SOTR, solid-organ transplant recipients; TID, tissue invasive disease

**Acknowledgments**

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**Competing interests**

The authors have no conflicts of interests to declare.

**Ethical approval**

The Study protocol was approved by the Institutional Review Board of the Fondazione IRCCS Policlinico San Matteo (Procedure 20100005459).

**References**


