Management of adenovirus (ADV) infections

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**ADV: Definitions I**

- **Primary infection:** First infection in infancy and childhood
- **Reactivation:** Endogenous reactivation in immunocompromized patients
- **Reinfection:** Infection with a new subtype.
- **Systemic infection / viremia:** Positive PCR, virus isolation or Ag detection in blood
- **Local infection:** Positive PCR, virus isolation or Ag detection in body fluids.
**ADV: Definitions II**

- **Probable disease**: Infection plus symptoms and signs without histological confirmation
  - Detection of ADV in stool + enteritis
  - Detection of ADV in urine + nephritis
  - Detection of ADV in PB + fever
  - enteritis
  - hepahopathy
  - nephritis
  - together with negative diagnostic tests indicative for bacterial or fungal infection

- **Proven disease**: Infection plus symptoms related to the infection and histological confirmation
  - Detection of ADV in organ biopsy
  - Detection of ADV in cerebrospinal fluid
  - Multiple organ failure, high viral load in PB and detection of ADV in autopsy
**ADV Infection: high risk patients**

**Children:**
- allo-SCT with in-vivo or ex-vivo T-cell depletion
- allo-SCT with unrelated donor graft
- allo-SCT with unrelated cord blood graft
- severe (Gr III-IV) Graft versus Host Disease
- severe lymphopenia (< 300 CD3+ cells/µl PB)

**Adults:**
- post allo-SCT haploidentical donor or unrelated cord blood graft
- severe (Gr III-IV) Graft versus Host Disease
- treatment with Alemtuzumab
ADV Infection in the immunocompromized host: signs and symptoms

• Fever
• Enteritis
• Hepathopathy
• Nephritis
• Retinitis
• Encephalitis
Recommendation ADV: diagnostic techniques

- PCR is fast and has higher sensitivity and specificity compared to culture or IF (AII)

- Quantitative PCR is more predictive for lethal disease (AII)

- Quantification in stool samples helps to identify patients (primarily children) at risk for viremia (BIII)

- Subtyping of adenovirus might yield additional information

- Quantitative PCR - either commercial or in-house (validated by round-robin tests) is the current gold standard and should be used (A II)
**ADV: diagnostic studies**

- High incidence of ADV-infection post allo-SCT in children
- Low incidence of ADV-infection post allo-SCT in adults.
- Incidence increases with degree of immunosuppression both in adults and children
- High mortality in case of ADV-viremia
- ADV infection is a rare event following autologous SCT
- No screening studies available for children with chemotherapy
- Single cases of lethal ADV hepatitis in children with ALL
**Recommendation ADV-screening in allo SCT (children):**

- Quantitative PCR-screening on PB is recommended on an at least weekly basis to patients at risk (AII)
- Screening is not routinely recommended in patients receiving matched sibling grafts (BII)
- Length of screening should be adapted according to degree of immune reconstitution (BIII)

**Recommendation ADV-screening in allo SCT (adults):**

- Routine screening is not routinely recommended in standard risk patients (BII)
- For high risk patients screening should be considered (BIII)
- Length of screening should be adapted according to degree of immune reconstitution (CIII)
**Recommendation ADV-screening in auto SCT and chemotherapy:**

- no viral screening warranted (BII)
- quantitative PCR in case of clinical suspicion (BIII)

**Recommendation ADV-monitoring in case of viremia:**

- In patients with ADV-viremia viral load should be monitored by quantitative PCR at least once weekly (AII)
**ADV: Prophylactic virostatic treatment**

No data on cidofovir or ribavirin

Ganciclovir:
- Bruno et al 2003: lower incidence of ADV infection in patients receiving prophylactic ganciclovir
- Avivi et al 2004: trend towards lower incidence

**Recommendation prophylactic treatment:**

Prophylactic antiviral therapy is not recommended (BIII)
ADV recommendation for preemptive treatment of asymptomatic viremia:

Goal: To prevent ADV disease

Indication to start preemptive treatment:

**ADV viremia plus presence of at least one risk factor**

**Children:**

- allo-SCT with in-vivo or ex-vivo T-cell depletion
- allo-SCT with unrelated donor graft
- allo-SCT with unrelated cord blood graft
- severe (>) Gr II) Graft versus Host Disease
- severe lymphopenia (< 300 CD3+ cells/µl PB)

**Adults:**

- post allo-SCT haploidentical donor or unrelated cord blood graft
- Gr III-IV acute Graft versus Host Disease
- following treatment with Alemtuzumab

Viral loads should be monitored during therapy (BIII)
ADV recommendation for treatment indication:

Indication to start treatment: (BIII)

- Proven ADV disease

- Probable ADV disease
Adenovirus – treatment options

• Antiviral drugs
  • Cidofovir
  • Ribavirin
  • Ganciclovir
  • CMX001 (oral lipid derivate of cidofovir; non-licensed)

• Other options
  • Iv Ig
  • Transfer of adenovirus specific T-cells (experimental)
  • Reduction/withdrawal of immunosuppression
**ADV recommendation for treatment I:**

- **Iv. cidofovir is recommended as first line therapy (BIII)**
  - Studies of preemptively given cidofovir suggests efficacy in reducing viral load
  - No clear data to support that preemptive cidofovir reduces the incidence of ADV disease
  - No clear data regarding efficacy in treating adenovirus disease
  - Varying doses and schedules have been used most commonly 5 mg/kg weekly (2-3 doses) thereafter every other week. There is no evidence supporting one particular schedule
  - Supportive measures should be taken with oral probenecid hyperhydration, and if possible avoidance of other nephrotoxic drugs at day of cidofovir administration (BIII)
**ADV recommendation for treatment II:**

- Ribavirin is not generally recommended for adenovirus infection but can be considered in cases with type C infections especially in patients with decreased renal function (CIII)
- Consider the addition of iv Ig (BIII)
- Immunosuppression should be reduced whenever possible (AII)
- For systemic adenovirus disease, virus specific CTLs can be considered if available (B III)
Future developments

• Lower risk for ADV-associated disease and ADV-associated mortality has been shown in the presence of ADV-specific T-cells

• Safety and feasibility of adenospecific T-cell transfer has been shown (Feuchtinger et al. BJH 2006; Leen et al, Nature Medicine 2006)

• Adenospecific T-cell transfer is a promising strategy but there are still limited data on efficacy and further studies are needed (Leen et al Blood 2009; Feuchtinger et al. 2009)

• Multispecific CTLs are in development

• CMX001, a cidofovir lipid conjugate, has shown efficacy in a phase II study