Malaria and human immunodeficiency virus (HIV) coinfections are common in pregnant women in sub-Saharan Africa. The current study shows that placenta of malaria-infected women contain 3 times as much CC chemokine receptor 5 (CCR5) RNA as placenta of women without malaria. By immunohistochemistry, CCR5 maternal macrophages were seen in placenta from malaria-infected women but not in placenta from malaria-uninfected women. In addition, CCR5 also was found on fetal Hofbauer cells in placenta from both groups. Thus, malaria infections increase the potential reservoir for HIV in the placenta by increasing the number of HIV target cells.

Malaria and human immunodeficiency virus type 1 (HIV-1) are among the most prevalent infectious diseases in sub-Saharan Africa, and coinfections are common [1]. These coinfections may be of great significance in pregnant women, because it is possible that malaria may enhance mother-to-child transmission of HIV. In a recent study in The Gambia, vertical transmission rates for HIV-1 were twice as high during the rainy malaria season than during the dry season [2]. This may have been the result of an effect of malaria infection on viral replication. In vitro, exposure to malaria antigens causes increased HIV replication in peripheral blood mononuclear cells [3]. In Malawian adults, malaria infections were associated with 7-fold higher HIV virus loads [4].

HIV cell entry is complex. HIV requires the CD4 molecule plus another coreceptor for efficient entry. Several chemokine receptors, especially CXCR4 and CCR5, appear to be important coreceptors [5-9]. CCR5 appears to play an important role in mother-to-child transmission of HIV: black infants who are homozygous for a promoter polymorphism (59396T) were at a 6-fold higher risk of being infected than were heterozygotes or homozygotes [10]. However, little is known about the distribution of chemokine receptors in the placenta [11].

About 20%-25% of HIV-infected infants become infected within the uterus before delivery [12]. Infants infected in this manner might be unaffected by short-course antiretroviral therapies [11]. Because placenta of malaria-infected mothers often contain high numbers of macrophages [13, 14] and because placental macrophages can be reservoirs for HIV [15], we studied whether malaria infections might increase placental virus load and promote intrauterine transmission of HIV.

Materials and Methods

Study population. Placental biopsy specimens were obtained from participants in a prospective cohort study of primigravid women in Mangochi, Malawi, and were frozen directly in liquid nitrogen. This area of Malawi has high-level transmission of Plasmodium falciparum. Recruitment of subjects and methods of evaluation were done as described elsewhere [16, 17].

All available placental biopsy specimens from women with cord blood parasitemias were selected as the infected group (n = 23). For the control group, placenta were used from women who had no indication of malaria infection during pregnancy (n = 21). Hemoglobin levels were undetectable in the control group placenta, and none of the women from this group had positive antenatal or delivery parasitemia. Placental hemoglobin concentrations were determined as described elsewhere [18].

Ribonuclease protection assay. Total RNA was extracted from the placental biopsy specimens, as described elsewhere [16]. Two chemokine-specific riboprobe template sets, hCR-8 and hCD-1, were used (BD Pharmingen). The hCR-8 template set contained riboprobes specific for human STRL33, US28, CCR3, CCR5, CXCR4, CCR8, GPR15, GPR1, V28, CCR2b, L32, and GAPDH. The hCD-1 template set contained riboprobes specific for human TCRβ, TCRα, CD3e, CD4, CD8α, CD8β, CD19, CD14, CD45, L32, and GAPDH. All riboprobe syntheses and subsequent steps of probe purification, placental RNA (15 µg) probe hybridization,
RNase treatment, and purification of protected RNA duplexes were done as described elsewhere [16]. Protected RNA was resolved by gel electrophoresis, using the QuickPONT Rapid Nucleic Acid Separation System (NOVEX), according to the manufacturer’s instructions. Radiolabeled, protected RNA bands were visualized by using a phosphorimager (Storm series 400) and were quantified by using ImageQuant software (both from Molecular Dynamics), as described elsewhere [16, 19]. Each sample was analyzed in 2 separate experiments, and the relative phosphorimager values obtained were averaged. Duplicates were <20% of each other. Each probe was normalized against the internal housekeeping signal (L32), to control for variability in each assay, as described elsewhere [16].

Immunohistochemistry (IHC) and immunofluorescence. Frozen placental tissue sections were prepared, fixed, and stored, as described elsewhere [16]. A frozen lymph node biopsy specimen from a patient with malignant lymphoma was used as the positive control tissue. The incubations detailed below were done at room temperature.

IHC single-staining procedure. Tissue sections were rehydrated in PBS (Life Technologies Gibco BRL) containing 0.1% bovine serum albumin (BSA, ELISA-grade; Sigma), were rinsed in deionized water, and then were incubated in 1% H2O2 (diluted in PBS and 0.1% BSA) for 30 min, to neutralize endogenous peroxidase activity. After slides were rinsed in deionized water and then in PBS and 0.1% BSA, samples were treated with 1:10 dilution of blocking serum (normal goat serum [BioGenex] diluted in PBS and 0.1% BSA) for 30 min. The slides were then exposed (for 30 min to 1 h) to 4 μg/mL anti-human CCR5 (clone 2D7), 2 μg/mL anti-human macrophage mannose receptor (clone 19.2), or 2 μg/mL anti-human macrophage CD68 (clone KP1). All were monoclonal antibodies purchased from Pharmingen. Purified mouse IgG1 (2 μg/mL), κ isotype standard (clone MOPC-21), was used as the control antibody for anti-CD68 anti-mannose receptor staining, whereas purified mouse IgG2a (4 μg/mL), κ isotype standard (clone C18.4), was used as a control for the anti-CCR5-specific antibody. After being treated with antibodies, the slides were rinsed with PBS and 0.1% BSA and then were incubated for 15 min with biotin-conjugated goat anti-mouse immunoglobulin-specific polyclonal antibody (Vector Laboratories) diluted 1:200. All antibody dilutions were done in common antibody diluent (BioGenex). The samples were rinsed in PBS and 0.1% BSA and were treated for 15 min with preformed avidin and biotinylated horseradish peroxidase macromolecular complex reagent (Vectorstain Elite; Vector Laboratories) diluted 1:100. Samples then were rinsed with PBS/0.1% BSA, were rinsed again with PBS only, and then were incubated with the substrate 3-amino-9-ethyl carbazole (Vector Laboratories) diluted 1:150, for 30 min. This and all subsequent incubations were done in the dark. Slides were washed with PBS, were incubated with prediluted anti-CD68 (Zymed) for 1 h, and then were washed with PBS again. The slides then were incubated with anti-mouse IgG-Texas Red (Vector Laboratories), 1:75, for 30 min, were washed with PBS, and then were washed with water. Coverslips were mounted with aqueous mounting media (Biomeda), and the slides were stored at −20°C until viewed under a fluorescent microscope.

Statistical analyses. Analyses of means, SDs, and 2-tailed Student t tests for unequal variances were done by use of Microsoft Excel 97.

Results

Placental mRNA receptor expression associated with malaria infection. Placental mRNA levels for CD4, CD14, CCR3, CCR5, and CXCR4 were quantitated by ribonuclease protection assay and were normalized to the housekeeping gene L32 (table 1). There was no difference in CD4 or CD14 expression between the control and infected groups, which suggests that there was no difference in the population sizes of either CD4+ T cells or macrophages and dendritic cells that are CD14+ [16]. Of interest, there was also no difference in expression levels for CXCR4, a coreceptor for T-tropic HIV. However, expression of CCR5, the coreceptor for M-tropic viruses, and CCR3 were increased ~3-fold in the infected placentas (P = .01 and P = .03, respectively).

Detection of CCR5 in placental tissue sections by IHC and immunofluorescence. Increased expression of CCR5 could facilitate virus entry into macrophages. However, since CCR5 is expressed on many cell types, we needed to know whether the increase in placental CCR5 mRNA corresponds to increased CCR5 expression on HIV-receptive cell types. Through IHC, we identified 2 distinct cell populations that expressed the coreceptor CCR5. In both the control and infected groups, the CCR5+ staining was most common on cells within the chorionic villous, which appeared to be Hofbauer cells (figure 1). Hofbauer cells are fetal macrophages located in the stroma that are known to express CD68 and the anti-mannose receptor [20, 21]. The same cells that stained with anti-CCR5 appeared

<table>
<thead>
<tr>
<th>Receptor</th>
<th>mRNA Levels, μg/mL</th>
<th>Ratio infected: uninfected</th>
<th>P</th>
</tr>
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<tr>
<td>CD4</td>
<td>0.166 ± 0.067</td>
<td>0.158 ± 0.056</td>
<td>1.05 NS</td>
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<tr>
<td>CD14</td>
<td>0.422 ± 0.112</td>
<td>0.412 ± 0.101</td>
<td>1.02 NS</td>
</tr>
<tr>
<td>CCR5</td>
<td>0.028 ± 0.032</td>
<td>0.009 ± 0.004</td>
<td>3.11 .01</td>
</tr>
<tr>
<td>CCR3</td>
<td>0.026 ± 0.031</td>
<td>0.009 ± 0.005</td>
<td>2.89 .03</td>
</tr>
<tr>
<td>CXCR4</td>
<td>0.091 ± 0.058</td>
<td>0.067 ± 0.018</td>
<td>1.36 .07</td>
</tr>
</tbody>
</table>

NOTE. Data are mean ± SD, unless otherwise indicated. NS, not significant.

* Calculated from the ratio of volume of signal to that of L32, a housekeeping gene, in the same lane on the gel.
Immunohistochemical staining for CD68 and CC chemokine receptor 5 (CCR5) in chorionic villi in placentas from malaria-infected and nonparasitized mothers. Placental sections were stained with control IgG (A and B), anti-CD68 (C and D), and anti-CCR5 (E and F). A, C, and E, Samples from a malaria-infected mother; B, D, and F, samples from a control placenta. CD68 staining pattern of stromal cells, which are consistent with tissue macrophages or Hofbauer cells, is similar to CCR5 staining in both types of placentas. Original magnification, ×400.

to stain with anti-CD68 (figure 1C and 1D) and anti-mannose receptor (not shown) but not with control IgG (figure 1A and 1B). Intervillous maternal macrophages also stained positively for CCR5 (figure 2G–2I) but were found only in the placentas from malaria-infected women. CCR5 is expressed on maternal macrophages containing intracellular hemozoin and on macrophages with no hemozoin. Similar appearing clusters of intervillous macrophages also stained with anti-CD68 (figure 2D–2F), as expected [14], but not control IgG (figure 2A–2C).

To establish the identity of the CCR5⁺ cells, we doubly stained sections by immunofluorescence with anti-CCR5 and anti-CD68. Anti-CD68 was used to identify both maternal macrophages and Hofbauer cells. All CCR5⁺ intervillous cells were CD68 positive (figure 3A and 3B), confirming that they were indeed macrophages. All CCR5⁺ Hofbauer cells were CD68 positive (figure 3C and 3D) in both infected (shown) and uninfected placentas (not shown). There was no staining with any of the control antibodies (not shown).

Discussion

In this study, we compared CCR5 expression in placentas from malaria-infected and uninfected women. In both types of placentas, CCR5 is expressed on fetal Hofbauer cells. In addition, maternal macrophages express CCR5 in the malaria-infected placentas. As determined on the basis of RNA levels, CCR3 and CCR5 expression is increased 3-fold by malaria infection. The increase appears to be selective, since there is no increase in CD4, CD14, or CXCR4 RNA.

This is the first study, to our knowledge, of CCR5 expression in situ in placentas. The observation of CCR5 on maternal macrophages and fetal Hofbauer cells is consistent with pre-
Figure 2. Immunohistochemical staining for CD68 and CC chemokine receptor 5 (CCR5) of individual and clusters of intervillous mononuclear cells in placenta from malaria-infected mother. Cells were stained with control IgG (A–C), anti-CD68 (D–F), or CCR5-specific IgG (G–I). Brown spots are hemozoin pigment. Original magnification, ×1000.

vious studies of HIV-infected mothers, which demonstrated the presence of HIV in these cells by IHC and in situ hybridization [1, 22, 23]. The presence of CCR5 on both these cell types lends credence to the possibility that they are involved in intrauterine transmission of HIV.

There are several reasons to believe that CCR5 is important in mother-to-child transmission of HIV in Africa. First, almost all strains of HIV that are transmitted in this manner are CCR5-trophic (M-trophic, R5) [24, 25]. Second, offspring of HIV-infected black mothers who are homozygous for a CCR5-promoter polymorphism have a 6-fold higher risk of being infected at birth [10]. Thus, increases in placental CCR5 might indeed be of clinical relevance in mother-to-child HIV transmission.

There was no apparent difference between infected and uninfected placentas in the distribution or staining intensities of CCR5+ Hofbauer cells. The major difference appeared to be that CCR5+ maternal macrophages were present in the malaria-infected group but were not present in the malaria-uninfected group. Thus, it is likely that the difference in CCR5 RNA levels between the 2 groups was due to its expression by maternal macrophages. Previous studies have shown that malaria infections lead to the accumulation of maternal macrophages in the placenta [13, 14]. In aggregate, evidence suggests that malaria causes an increase in HIV-receptive maternal macrophages within the placenta.

A modest number of maternal macrophages was seen in sec-
Figure 3. Immunofluorescence double staining for CD68 (red) and CC chemokine receptor 5 (CCR5; green). Shown are an intervillous macrophage stained for CD68 (A) and CCR5 (B) and a Hofbauer cell stained for CD68 (C) and CCR5 (D). Original magnification, ×1000 (oil immersion).

In this study, CCR5 was found on macrophages both with and without hemozoin. The presence of hemozoin within the macrophage is evidence that the cell had previously phagocytosed either an intact malaria-infected erythrocyte or fragments of parasites. Thus, our data suggest that phagocytosis of parasite material does not directly induce CCR5. This contrasts with our previous study, in which tumor necrosis factor-α and interleukin-8 were expressed only in placental hemozoin-laden maternal macrophages [16]. This suggests that CCR5 induction may be indirectly induced by the proinflammatory cytokines elicited in the placenta by malaria infections. Alternatively, CCR5 expression may be in a dynamic state of up-regulation and down-regulation on inflammatory cells during recruitment.

In conclusion, CCR5 expression is increased in placentas of malaria-infected women. Further studies are needed to determine whether this increased expression could contribute to intrauterine transmission of HIV. If such an association is found, it is possible...
that interventions to prevent maternal malaria might aid in the prevention of mother-to-child HIV transmission.

Acknowledgments

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References