

Management of adenovirus (ADV) infections

Susanne Matthes-Martin, Tobias Feuchtinger,
Peter Shaw, Dan Engelhard, Per Ljungman



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 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/ μ l 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: sings 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:

(BII)

- 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/ μ l PB)

Adults:

(BIII)

- 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

