Subclinical Avian Influenza A(H5N1) Virus Infection in Human, Vietnam

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Laboratory-confirmed cases of subclinical infection with avian influenza A(H5N1) virus in humans are rare, and the true number of these cases is unknown. We describe the identification of a laboratory-confirmed subclinical case in a woman during an influenza A(H5N1) contact investigation in northern Vietnam.

In 2012, a debate was published in Science about the number of humans who have experienced subclinical infection with avian influenza A H5 and how this unknown denominator could affect the case-fatality rate reported by the World Health Organization (1,2). The controversy rests, to a large extent, on interpretation of serologic tests used to detect prior H5 infection and the paucity of virologically confirmed subclinical or mild cases. Here we describe a case of subclinical avian influenza A H5 infection, confirmed both virologically and serologically.

The Case

The subclinical case was detected in 2011 during a contact investigation of a 40-year-old man suspected of having influenza A(H5N1) virus infection. The man’s household had sick poultry that were consumed by household members. The chickens roamed close to the sleeping area of the household members. The index case-patient, his daughter, and his daughter-in-law were involved in slaughtering and household members. The index case-patient had fever, and his daughter-in-law were involved in slaughtering and household members. The index case-patient, his daughter, and his daughter-in-law were involved in slaughtering and household members. The index case-patient, his daughter, and his daughter-in-law were involved in slaughtering and household members. The index case-patient, his daughter, and his daughter-in-law were involved in slaughtering and household members.

On day 5 of illness of the index case-patient, a contact investigation was initiated. Throat swab specimens were collected from 4 household members and 1 close contact of the index case-patient: his spouse (age 47 years), daughter (age 18 years), daughter-in-law (age 25 years), and grandson (age 1 year) and an unrelated man (age 43 years). None of the contacts had signs or symptoms. Infection control measures were initiated, and all household members were given oseltamivir (75 mg/d) for 1 week and instructed to seek immediate health care if fever or respiratory symptoms developed. Results of HI testing of serum samples collected during the acute illness phase of the index case-patient were negative.

The human throat swab samples were tested by conventional RT-PCR. The sample from the index case-patient’s daughter, collected 6 days after the woman had slaughtered a chicken, was positive for influenza A/H5 by real-time RT-PCR, and virus was recovered on day 10 of inoculation on MDCK cells (online Technical Appendix). The virus was identified by sequencing as influenza A/H5, clade 2.3.2.1. The woman had no signs or symptoms at the time the throat swab was collected, nor did she report any symptoms to health authorities during the subsequent week. Chickens were also tested, and 4 chickens in the commune tested positive for influenza A(H5N1) virus by RT-PCR of throat and cloacal swab specimens.

Repeat throat swab specimens collected from the 4 household contacts 6 days after the initial collection yielded negative test results for influenza/H5. Serologic testing showed seroconversion only in the woman with subclinical infection; her HI titer increased from <20 to 160 against both clade 2.3.4 and 2.3.2.1 viruses (Table 1). During a second contact investigation 1 month later, 20 other members of the commune were screened by RT-PCR of throat swab specimens and serologic testing. All results were negative for influenza A(H5N1) virus.

The full genome of the identified virus strain (A/CM32/2011) was sequenced (online Technical Appendix) and confirmed to be clade 2.3.2.1 by using the Highly Pathogenic H5N1 Clade Classification Tool (3). The open reading frames of the genes were translated and aligned with all clade 2.3.2.1 sequences available from

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A(H5N1) virus in ferrets (49x26) contains the N170D (49x352) samples compared with the avian samples. A/CM32/2011 (49x364) No amino acid changes were preferentially seen in human (49x400) between the clade consensus and A/CM32/2011 were com- (49x424) changes specific to human infection, the differences be- (49x448) sequences showed a high homology between the samples, (49x472) phylogenetic analysis of clade 2.3.2.1 from Vietnam se- (49x484) no acid changes are summarized in Table 2 (Appendix, (49x496) the Influenza Research Database (www.fludb.org). Ami- (49x527) virus infection belonged to influ- (49x545) were initially detected (49x647) recent clade 2.3.2.1 has evolved (49x648) in early 2012 (49x648) in southern Vietnam, with 4 confirmed cases reported (50x519) index case (49x527), but it is unclear whether serologic (49x648) study using early collection of swab samples and paired (49x658) of infection but must be confirmed by a second serologic (49x667) that this strain represents a less virulent form of influenza (49x675) humans.

In our investigation, the case-patient with subclinical infection was treated with oseltamivir while she was asymptomatic, which may explain why she did not develop clinical disease. Studies using human volunteers indicate that seasonal influenza virus shedding may occur ≈24 hours before symptom onset in 25%–30% of patients (9). Likewise, community cohort studies show presymptomatic shedding and asymptomatic shedding in 15%–20% of patients infected with seasonal influenza viruses and with influenza A(H1N1)pdm09 virus (10–12). Oseltamivir is known to prevent disease when given before inoculation in human volunteers and to shorten duration and lessen the severity of illness in natural infection (13), but we found no evidence in clinical and volunteer studies from the literature suggesting that oseltamivir may prevent clinical illness once detectable infection has been established, as we found in this subclinical case (13,14). The patient we investigated probably was exposed during slaughtering of a chicken 6 days before her positive throat swab was collected. However, because chickens in the commune tested positive at the time of the contact investigation, ongoing exposure to influenza A(H5N1) cannot be excluded as the source of infection. Furthermore, the patient may not have reported symptoms to the health authorities for personal reasons.

Thus far, evidence of subclinical influenza A(H5N1) virus infections has been collected on the basis of serologic testing only (1), but it is unclear whether serologic testing reliably detects subclinical cases. According to the World Health Organization, MN titers ≥80 are indicative of infection but must be confirmed by a second serologic test because of the possibility of cross-reactivity (7). The interpretation of results from a single serum sample is limited by the specificity or sensitivity of serologic tests, and viral shedding times may mean that infected cases may be missed. Estimating the incidence of asymptomatic influenza A(H5N1) virus infection in humans exposed to sick poultry or human case-patients requires further careful study using early collection of swab samples and paired acute and convalescent serum samples.

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**Table 1. HHI and MN assay titers for serum samples from woman with subclinical influenza A(H5N1) virus infection, Vietnam, 2011**

<table>
<thead>
<tr>
<th>Clade and sample</th>
<th>HHI</th>
<th>MN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clade 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First sample, day 5</td>
<td>&lt;20</td>
<td>ND</td>
</tr>
<tr>
<td>Second sample, day 11</td>
<td>40</td>
<td>&lt;10</td>
</tr>
<tr>
<td>Third sample, day 41</td>
<td>40</td>
<td>&lt;10</td>
</tr>
<tr>
<td>Clade 2.3.2.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First sample, day 5</td>
<td>&lt;20</td>
<td>ND</td>
</tr>
<tr>
<td>Second sample, day 11</td>
<td>80</td>
<td>80</td>
</tr>
<tr>
<td>Third sample, day 41</td>
<td>160</td>
<td>160</td>
</tr>
<tr>
<td>Clade 2.3.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First sample, day 5</td>
<td>&lt;20</td>
<td>ND</td>
</tr>
<tr>
<td>Second sample, day 11</td>
<td>80</td>
<td>40</td>
</tr>
<tr>
<td>Third sample, day 41</td>
<td>160</td>
<td>40</td>
</tr>
</tbody>
</table>

*Sample days are days since disease onset in index case-patient. HHI, horse hemagglutination inhibition; MN microneutralization; ND, not done.*
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Dr Mai Quynh Le is a virologist and the head of the National Influenza Center of Vietnam at the National Institute of Hygiene and Epidemiology in Hanoi. Her research interests are the evolution and co-evolution of animal and human influenza viruses and zoonotic infectious diseases.

References


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Technical Appendix

Detailed Methods

Influenza Isolation

A 100 μL sample inoculated onto MDCK cells (Madin-Darby canine kidney cells-American Type Culture Collection-ATCC, USA), which were maintained in minimum essential medium (MEM) supplemented with 5% newborn calf serum (Sigma, St. Louis, MO, USA) and antibiotics at 37°C in 5% CO₂. All experiments were performed in a biosafety level 3 containment laboratory at NIHE, Hanoi. MDCK cells were checked daily for cytopathic effects (CPE) and virus was harvested and stored in −80°C when CPE reached 80%.

Serology

Haemagglutination inhibition (HI) assays were performed as described (1) by using receptor-destroying enzyme (RDE) treated patient and reference sera at a starting dilution of 1:20, 8 HA units of virus (in 50 μL), and 1% v/v horse erythrocytes. The viruses, inactivated by 1% β propiolactone (BPL), used were: A/Vietnam/HN 30408/2004, A/HN 30850/2005, and A/CM32/2011, representing clade 1, clade 2.3.4, and clade 2.3.2.1, respectively. HI titers were read up to 60 minutes after the addition of erythrocytes and reported as the reciprocal of the highest serum dilution causing complete inhibition of agglutination.

Microneutralization (MN) assays were performed according to WHO protocols, using 100 x TCID₅₀ of live viruses as above (2). Virus was incubated with 2-fold serial dilutions of sera starting at 1:10 and then incubated with MDCK cells overnight before virus quantitation by ELISA to detect influenza nucleoprotein. The titer was reported as the reciprocal of the highest dilution that reduced infection by at least 50%.
Sequencing

The RNA was isolated from the virus (1st passage) isolated from the subclinical case and used for an 8-segment RT-PCR to generate the full length 8 influenza segments as described previously (3). The RT-PCR reaction was performed with primers common-uni12R (5’-GCCGGAGCTCTGCAGATATCAGCRAAAGCAGG-3’), and common-uni13 (5’-CAGGAAACAGCTATGACAGTAGAAACAAGG-3’) using the One-Step RT-PCR kit High Fidelity (Invitrogen, NY, USA). The cDNA was sheared (Adaptive Focused Acoustics, Covaris, USA) to yield fragments ranging from 300 to 1000 bp and y-primers from the Rapid library 454 kit (Roche, USA) were ligated to the fragments with use of an automated SPRI works Fragment Library System II (For Roche GS FLX* DNA Sequencer) according to the manufacturer’s protocol (Beckman Coulter, CA, USA). The quantity of properly ligated fragments was determined based on the incorporation efficiency of the fluorescent primers using a FLUOstar OPTIMA (BMG Labtech, Germany). Emulsion PCR, bead recovery and enrichment were performed manually according to the manufacturer’s protocol. The sample was sequenced by the Laboratory of Genome Analysis at the Academic Medical Center (Amsterdam, The Netherlands).

The resulting reads were analyzed as described before (3) and used to generate a consensus sequence for each segment. Since the coverage of the larger segment was relatively low, an additional PCR was performed for the PA, PB1 and PB2 segments and sequenced with standard Sanger sequencing using degenerate primers for H5N1 (4). The resulting consensus sequences were analyzed with the blast and H5N1 clade identifier at IRD site (5). All available clade 2.3.2.1 sequences were compared with the sample sequence. The differences between the samples and the clade 2.3.2.1 consensus were subsequently compared to Asian avian human H5N1 samples.

References


