Ebola Virus RNA in Semen from an HIV-Positive Survivor of Ebola

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Ebola virus is known to persist in semen of male survivors of Ebola virus disease (EVD). However, maximum duration of, or risk factors for, virus persistence are unknown. We report an EVD survivor with preexisting HIV infection, whose semen was positive for Ebola virus RNA 565 days after recovery from EVD.

In March 2015 in Liberia, unprotected sexual intercourse was strongly suspected in the transmission of Ebola virus disease (EVD) from a male survivor of EVD to his female partner (1). Results of Ebola RNA sequence analysis for a semen sample from the survivor 199 days after onset of illness and blood samples from the female patient were consistent with direct transmission.

In July 2015, the Liberian Ministry of Health established the Men’s Health Screening Program to offer semen testing for Ebola virus and behavioral counseling on safe sexual practices to male survivors of EVD to the Ebola response (2). We report a survivor of EVD who had a preexisting HIV infection whose semen was positive for Ebola virus RNA 565 days after recovering from this disease.

On August 27, 2014, a 48-year-old man with a history of HIV infection who was receiving antiretroviral therapy was admitted to an Ebola treatment unit (ETU) in Monrovia, Liberia, with a 1-week history of fever, chills, and weakness and a 2-day history of vomiting and diarrhea. The next day, he had a positive result for Ebola virus in blood by real-time reverse transcription PCR (RT-PCR), with a cycle threshold (Ct) of 32.39. While in the ETU, he continued his antiretroviral therapy. The patient was discharged on September 8, 2014, after showing a negative result for Ebola virus in blood by RT-PCR.

When the patient was first given a diagnosis of infection with HIV-1 in October 2009 (CD4 cell count 46/µL) (Figure), he was given ART with zidovudine/lamivudine/nevirapine and trimethoprim/sulfamethoxazole for prophylaxis against opportunistic infections. On March 25, 2010, he was given a diagnosis of co-infection with HIV-1 and HIV-2, and his ART regimen was changed to zidovudine/lamivudine/lopinavir plus ritonavir because HIV-2 strains are typically resistant to non-nucleoside reverse transcription inhibitors, such as nevirapine. His CD4 cell count 4 months before admission to the ETU was 459/µL on April 24, 2014. His only measured CD4 cell count after recovery

![Figure.](image-url) Ebola virus RNA detected by RT-PCR in semen samples from an HIV-positive survivor (48-year-old man) of Ebola virus disease, Monrovia, Liberia, 2009–2016. RT-PCR cycle threshold (Ct) values for Ebola virus VP40 and NP gene targets are reported by days from the patient’s discharge from the ETU to collection of a semen specimen. A gene target is considered detected if the Ct is <40. If gene amplification is not demonstrated within 40 cycles, then the gene target is considered undetectable and no Ct is reported. All undetectable results are indicated as Ct values of 40. CD4 cell counts per microliter were 46 on October 20, 2009; 48 on November 12, 2009; 358 on March 25, 2010; 358 on April 22, 2010; 563 on November 22, 2010; 824 on January 22, 2013; 459 on April 24, 2014; and 529 on August 9, 2016. The patient had a CD4 cell count of 529/µL 699 days after discharge from the Ebola treatment unit. On November 12, 2009, the patient was given an ART regimen of zidovudine/lamivudine/nevirapine. On April 22, 2010, the ART regimen was changed to zidovudine/lamivudine/lopinavir plus ritonavir. ART, antiretroviral therapy; Ct, cycle threshold; ETU, Ebola treatment unit; NP, nucleoprotein, RT-PCR, reverse transcription PCR; VP40; viral structural protein 40.

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The prolonged period during which Ebola virus RNA was detected in this patient adds to evidence (2–4) that there is heterogeneity in duration of Ebola virus persistence in semen among survivors of EVD. Although etiology of this heterogeneity is unclear, possible explanations for this patient include age-associated effects (2), attenuated clearance caused by dual HIV infection, immunosuppression from etiologies other than HIV, severity of acute illness, or unknown host genetic factors. Although the patient had an adequate CD4 cell count, chronic inflammation, immune system dysregulation, and accelerated immunosenescence in well-controlled HIV patients have been described and are clinically manifested as early cardiovascular disease, neurocognitive disorders, metabolic syndrome, and non–AIDS-associated cancers (5). Therefore, co-infection with HIV might play a role in persistence of Ebola virus in semen, despite an adequate clinical response to ART.

Because HIV infection is treatable and testing is readily available in West Africa, semen testing programs for Ebola virus should consider offering HIV testing to male survivors of EVD with persistently detectable Ebola virus in semen. Furthermore, HIV care was interrupted during the Ebola outbreak in West Africa because of closure of clinics and interruption of ART distribution (6). This case-patient had a favorable outcome for EVD despite being HIV positive, which emphasizes the need for continuing treatment for HIV infection in the setting of a large-scale Ebola outbreak. In addition, this case highlights the need for a better understanding of the role that co-infection with HIV might play in persistent detection of Ebola virus RNA in male survivors of EVD.

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References


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Treatment Failure of Dihydroartemisinin/ Piperaquine for Plasmodium falciparum Malaria, Vietnam

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