A number of highly potent and broadly neutralizing antibodies (bNAbs) against the human immunodeficiency virus (HIV) have recently been shown to prevent transmission of the virus, suppress viral replication, and delay plasma viral rebound following discontinuation of antiretroviral therapy in animal models and infected humans. However, the degree and extent to which such bNAbs interact with primary lymphocytes have not been fully delineated. Here, we show that certain glycan-dependent bNAbs, such as PGT121 and PGT151, bind to B, activated T, and natural killer (NK) cells of HIV-infected and -uninfected individuals. Binding of these bNAbs, particularly PGT121 and PGT151, to activated CD4^+ and CD8^+ T cells was mediated by complex-type glycans and was abrogated by enzymatic inhibition of N-linked glycosylation. In addition, a short-term incubation of PGT151 and primary NK cells led to degranulation and cellular death. Our data suggest that the propensity of certain bNAbs to bind uninfected/bystander cells has the potential for unexpected outcomes in passive-transfer studies and underscore the importance of antibody screening against primary lymphocytes.
Glycan-dependent HIV-specific neutralizing antibodies bind to cells of uninfected individuals

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Introduction

Recent advances in antibody cloning technologies have led to the isolation of a number of highly potent and broadly neutralizing antibodies (bNAbs) against the human immunodeficiency virus (HIV). Some of these bNAbs have been shown in animal models and human studies to prevent transmission of virus (1–3), suppress viral replication (4–6), eliminate persistent viral reservoirs (7), enhance antigen presentation via formation of immune complexes (8, 9), and delay plasma viral rebound in infected individuals upon discontinuation of antiretroviral therapy (ART) (10, 11). Given that HIV cannot be eradicated by ART alone (12) and the consequent challenges associated with life-long treatment, the use of bNAbs represents a therapeutic alternative for achieving sustained virologic remission in the absence of antiretroviral drugs (13).

Some of the most potent bNAbs evaluated to date, that are considered appropriate for use in clinical trials, include the CD4 binding site-specific antibodies VRC01 and 3BNC117, as well as the V3 loop N332 glycan supersite-specific antibodies PGT121 and 10-1074 (14). These antibodies have recently been used in clinical trials involving passive transfer of single bNAbs (10, 11) or in combination (15) in HIV-infected individuals. Despite moderate to significant delays in time to plasma viral rebound following discontinuation of ART compared with historical controls, preexisting and/or emergent bNAb-resistant HIV necessitate the use of more potent and/or combinations of bNAbs that target multiple sites on HIV Env (10, 11, 15). In this regard, it is desirable to use a combination of bNAbs that does not react with HIV-uninfected lymphocytes in order to maximize their anti-HIV potentials and to prevent unintended antibody-mediated effector functions in vivo. It has been shown that some anti-HIV antibodies exhibit auto-/polyreactivity against cytoplasmic or nuclear self-antigens (16–20). Although the recent generation of HIV-specific bNAbs, including those that have been administered to humans, have not shown discernable auto-/polyreactivity when tested against a panel of self-antigens and cell lines (17), they have not been extensively screened for their capacity to bind to various subsets of lymphocytes derived from infected and uninfected individuals in the absence of antiretroviral drugs (13).

Results and Discussion

In order to characterize the binding capacity of bNAbs to various cell types, we first conducted flow cytometric analyses using an uninfected (CEM-NKR-CCR5) and an HIV-infected (CEM-IIIb) cell line. We used HIV-specific antibodies directed against various HIV Env epitopes, including the V3 loop N332 glycan supersite (PGT121 and 10-1074), CD4 binding site (VRC01 and 3BNC117), V1V2 apex (PG9 and PG16), as well as the gp41 membrane proximal external region (10E8). As shown in Figure 1A, all HIV-specific antibodies tested exhibited strong binding to HIV Env expressed on CEM-IIIb cells (73.0%–97.9%) compared with minimal binding to CEM-NKR-CCR5 cells (0.4%–4.6%). We then examined binding of bNAbs to B and T cell lines and nonlymphocytic primary cells/
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CONCISE COMMUNICATION

In this study, we examined the binding properties of broadly neutralizing antibodies (bNAbs) to T and B cells following T cell–dependent cellular activation. A significant increase in PGT121 binding to T and B cells was observed, irrespective of HIV status of the donor.

Next, we examined the kinetics of PGT121 binding to B cells and T cells of HIV-infected and -uninfected individuals following cellular stimulation. An increase of PGT121 binding to B cells occurred on day 1 and remained the same after anti-CD3 antibody stimulation of PBMCs (Figure 2A). In contrast, as shown in Figure 2B, C, and D, PGT121 binding to CD4+ and CD8+ T cells increased over time, with maximal levels of binding occurring on day 3. We then compared the effect of B cell–specific (anti-human IgM/A/G) and T cell–specific (anti-CD3) stimulation on binding of PGT121 to corresponding cell types. When compared with the unstimulated condition (media alone), 2-day stimulation of B cells led to a
significant increase in PGT121 binding, whether the stimulus was anti-IgM/A/G ($P = 0.0003$) or anti-CD3 antibody ($P = 0.0073$; Figure 2D). In addition, while PGT121 binding to T cells was low in the absence of cellular activation or with the B cell stimulus, stimulation with anti-CD3 antibody significantly increased the binding of PGT121 to CD4+ ($P < 0.0001$) and CD8+ ($P = 0.0001$) T cells (Figure 2, E and F). These data suggest that expression of the ligand(s) for PGT121 on B and T cells could be modulated by direct and, to a certain extent, indirect cellular activation.

In order to further delineate the binding properties of PGT121 on T cells, we evaluated different subsets of CD4+ T cells and activation markers prior to and following stimulation of enriched CD4+ T cells with anti-CD3 antibody. As shown in Supplemental Figure 3A, the lowest binding of PGT121 was observed on naive cells, and the highest on CD4+ T cells with effector phenotypes. Furthermore, PGT121 binding was associated with expression of activation marker CD25 (86.6% of PGT121+ cells) and CD69 (67.6% of PGT121+ cells) (Supplemental Figure 3B), further supporting the observation that PGT121 preferentially binds to activated CD4+ T cells.

PGT121 has previously been shown to bind HIV Env gp120 in a complex-type N-glycan–dependent manner (21), a finding that prompted us to investigate the glycan dependency of PGT121 binding to the B and T cells of HIV-uninfected individuals. First, we used EBV-transformed B cell lines derived from HIV-infected or uninfected individuals as well as from 2 siblings with a congenital disorder of glycosylation type IIb (CDG-IIb), a genetic disease associated with mutations in mannosyl-oligosaccharide glucosidase (22). While PGT121 bound to a median of 17.6% of EBV-transformed B cells from donors without CDG-IIb, it only bound to 2.51% of the EBV-transformed B cells from the CDG-IIb donors ($P = 0.0256$, Figure 3A), suggesting that N-linked glycosylation is involved in the binding of PGT121 to B cells. In order to further evaluate the role of glycans in PGT121 binding to T cells, we stimulated CD4+ T cells of HIV-uninfected individuals in the absence and presence of kifunensine, an α-mannosidase I inhibitor that blocks processing of glycoproteins resulting in an accumulation of high-mannose rather than complex glycans. As shown in Figure 3B, binding of PGT121 to activated CD4+ T cells was significantly decreased in the presence of kifunensine ($P = 0.0156$), suggesting that PGT121 interacts with complex-type glycans expressed on the surface of uninfected targets. Similarly, stimulation of PBMCs in the presence of kifunensine led to a substantial decrease of PGT121 binding to B and CD4+ and CD8+ T cells (Figure 3C). Of note, the binding of 10-1074 on B and T cells increased in the presence of kifunensine (Supplemental Figure 4A), confirming preferential binding of the antibody to high-mannose glycans (21). Binding of PG16 was not affected by the presence of kifunensine (Supplemental Figure 4B). Collectively, these results demonstrate that PGT121 recognizes complex-type glycans on the surface of B and activated T cells of HIV-uninfected individuals and that its binding can be modulated by an agent that alters the composition of glycans following cellular activation.
As shown in Figure 4, A and B, stronger binding compared with human IgG was observed when freshly isolated NK cells were incubated with PGT121 (P = 0.0006) or PGT151 (P = 0.0006) but not 3BNC117 (P > 0.9999) (Figure 4B). Inclusion of the Fc-receptor blocker did not completely abrogate binding of PGT121 and PGT151 to NK cells, suggesting that these glycan-dependent antibodies interact with antigens expressed on targets (Supplemental Figure 7). We further investigated the functional consequence of binding of PGT121 and PGT151 to NK cells. NK cell degranulation (CD107a) and death (staining with a nucleic acid dye, Sytox) were measured following short periods of incubation (2 and 6 hours, respectively). Binding of PGT151 to NK cells resulted in the highest level of degranulation (median 15.8%) compared with human IgG (P = 0.00018), PGT121 (P = 0.00018), and 3BNC117 (P = 0.00018) (Figure 4, A and C). Of note, the subset of NK cells undergoing degranulation upon interaction with PGT151 showed phenotypes associated with higher cytolytic activities (Supplemental Figure 8). Additionally, incubation of PGT151 with NK cells led to a marked increase in cell death (median 17.6%) compared with human IgG (P = 0.00018), PGT121 (P = 0.00018), and 3BNC117 (P = 0.00018) (Figure 4, A and D). Collectively, these data suggest a propensity for certain complex-type glycan-dependent bNAbs to interact with uninfected/bystander lymphocytes.

To evaluate whether glycan-dependent HIV-specific bNAbs, particularly PGT151, bind to T cells in vivo, we used humanized mice as described in the Supplemental Methods. We observed significantly higher levels of PGT151 binding to CD4+ T cells (median 48.4% and 27.9%, respectively) and CD8+ T cells (median 42.8% and 36.2%, respectively) (Supplemental Figure 5, D–F). Of note, the binding of PGT151 to B and CD4+ and CD8+ T cells of HIV-uninfected individuals in the absence of activating stimuli. Anti-CD3 antibody stimulation of PBMCs enhanced binding of PGT151 and VRC26.09 to CD4+ (median 48.4% and 27.9%, respectively) and CD8+ T cells (median 42.8% and 36.2%, respectively) (Supplemental Figure 5, D–F). Of note, the binding of PGT151 to B and CD4+ and CD8+ T cells significantly decreased when cells were stimulated in the presence of kifunensine (Figure 3D). These data suggest a propensity for certain complex-type glycan-dependent bNAbs to interact with uninfected/bystander lymphocytes.

As shown in Figure 4, A and B, stronger binding compared with human IgG was observed when freshly isolated NK cells were incubated with PGT121 (P = 0.0006) or PGT151 (P = 0.0006) but not 3BNC117 (P > 0.9999) (Figure 4B). Inclusion of the Fc-receptor blocker did not completely abrogate binding of PGT121 and PGT151 to NK cells, suggesting that these glycan-dependent antibodies interact with antigens expressed on targets (Supplemental Figure 7). We further investigated the functional consequence of binding of PGT121 and PGT151 to NK cells. NK cell degranulation (CD107a) and death (staining with a nucleic acid dye, Sytox) were measured following short periods of incubation (2 and 6 hours, respectively). Binding of PGT151 to NK cells resulted in the highest level of degranulation (median 15.8%) compared with human IgG (P = 0.00018), PGT121 (P = 0.00018), and 3BNC117 (P = 0.00018) (Figure 4, A and C). Of note, the subset of NK cells undergoing degranulation upon interaction with PGT151 showed phenotypes associated with higher cytolytic activities (Supplemental Figure 8). Additionally, incubation of PGT151 with NK cells led to a marked increase in cell death (median 17.6%) compared with human IgG (P = 0.00018), PGT121 (P = 0.00018), and 3BNC117 (P = 0.00018) (Figure 4, A and D). Collectively, these data suggest a propensity for certain bNAbs, such as PGT151, to bystander/uninfected cells could potentially lead to abnormalities/impairment of immune cells.

A major emphasis of current efforts in HIV therapeutic research is to achieve ART-free virologic remission in infected individuals. These efforts include the use of HIV-specific bNAbs to delay or prevent plasma viral rebound and to allow...
Despite evidence of strong binding of complex-type glycan-dependent bNAbs to various lymphocyte populations in both HIV-infected and -uninfected individuals, the outcomes may not necessarily be deleterious (i.e., induction of antibody-dependent cell-mediated cytotoxicity, ADCC). Indeed, we were not able to demonstrate NK cell–mediated ADCC against activated CD4+ or CD8+ T cells despite high levels of PGT121/PGT151 binding ex vivo (Supplemental Figure 9). However, our data demonstrated that incubation of primary NK cells with PGT151 rapidly led to autodegranulation and cell death, suggesting that certain bNAbs could potentially mediate deleterious effector functions against immune cells ex vivo.

Our findings have potentially important implications for the use of bNAbs in the treatment and prevention of HIV infection. Although the auto-/polyreactivity of bNAbs is typically determined by their capacity to bind a panel of nuclear and cytoplasmic self-antigens, more physiologically relevant targets, such as those expressed with or without activation on lymphocytes of healthy donors, should be considered. The potential unintended consequences of passive transfer of such antibodies should be evaluated in preclinical studies prior to the clinical use of current and newly developed HIV-specific bNAbs.

**Methods**

Please see the Supplemental Methods for detailed experimental procedures.
Study subjects. Leukapheresed products were collected from HIV-infected and -uninfected individuals in accordance with clinical protocols approved by the Institutional Review Board (IRB) of the NIH. All study subjects provided informed consent.

Author contributions
JB, SM, and TWC designed the research. JB, EWR, KEC, VS, JSJ, EDH, KRG, AH, SM, and TWC performed the research. XC, SDS, CL, NDR, and JRM contributed research materials. JB, SM, and TWC analyzed the data. JB, SM, and TWC wrote the manuscript.

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