Grey and white matter abnormalities in treated HIV-disease and their relationship to cognitive function

Jonathan Underwood[1], James H Cole[2], Matthan Caan[3], Davide De Francesco[4], Robert Leech[2], Rosan A. van Zoest[5], Tanja Su[3], Gert J Geurtsen[6], Ben A Schmand[6], Peter Portegies[7], Maria Prins[8], Ferdinand W.N.M. Wit[5,9,10] Caroline A Sabin[4], Charles Majoie[3], Peter Reiss[5,9,10] *Alan Winston[1] and *David J Sharp[2] for The Co-morBidity in Relation to Aids (COBRA) Collaboration

* Alan Winston and David Sharp contributed equally to this work.

[1]Division of Infectious Diseases, Imperial College London, UK

[2]Division of Brain Sciences, Imperial College London, UK

[3]Department of Radiology, Academic Medical Center, The Netherlands

[4]Department of Infection & Population Health, UCL, London

[5]Department of Global Health, Academic Medical Center, and Amsterdam Institute for Global Health and Development (AIGHD), Amsterdam, The Netherlands

[6]Department of Medical Psychology, Academic Medical Center, The Netherlands

[7]Department of Neurology, Academic Medical Center, The Netherlands

[8]Public Health Service Amsterdam

[9]HIV Monitoring Foundation, Amsterdam, the Netherlands

[10]Department of Internal Medicine, Division of Infectious Diseases, Academic Medical Center, Amsterdam, The Netherlands

Keywords: HIV, cognitive impairment, neuroimaging, diffusion tensor imaging, voxel-based morphometry

Running head: Structural brain changes in treated HIV

Corresponding author: Dr Jonathan Underwood, Clinical Trials Centre, Winston Churchill Wing, St Mary's Hospital, London, W2 1NY.

jonathan.underwood@imperial.ac.uk

Alternate contact: Prof Alan Winston, Clinical Trials Centre, Winston Churchill Wing, St Mary's Hospital, London, W2 1NY. a.winston@imperial.ac.uk

Key points

In successfully treated HIV-disease the prevalence of cognitive impairment is approximately 20%, which is lower than previous reports. Advanced neuroimaging suggests that white matter microstructural abnormalities rather than grey or white matter volume abnormalities are the likely underlying aetiology.

Abstract

Background

Long-term comorbidities such as cognitive impairment remain prevalent in otherwise effectively treated people-living-with-HIV. We investigate the relationship between cognitive impairment and brain structure in successfully treated patients using multi-modal neuroimaging from the Co-morBidity in Relation to AIDS (COBRA) cohort.

Methods

Cognitive function, brain tissue volumes and white matter microstructure were assessed in 134 HIV-positive patients and 79 controls. All patients had suppressed plasma HIV RNA at cohort entry. In addition to comprehensive voxelwise analyses of volumetric and diffusion tensor imaging, we used an unsupervised machine learning approach to combine cognitive, diffusion and volumetric data, taking advantage of the complementary information they provide.

Results

Compared to the highly comparable control group, cognitive function was impaired in four out of the six cognitive domains tested (median global T-scores: 50.8 vs. 54.2, $p<0.001$). Patients had lower grey but not white matter volumes, observed principally in regions where structure generally did not correlate with cognitive function. Widespread abnormalities in white matter microstructure were also seen, including reduced fractional anisotropy with increased mean and radial diffusivity. In contrast

to the grey matter, these diffusion abnormalities correlated with cognitive function. Multivariate neuroimaging analysis identified a neuroimaging phenotype associated with poorer cognitive function, HIV-infection and systemic immune activation.

Conclusions

Cognitive impairment, lower grey matter volume and white matter microstructural abnormalities were evident in HIV-positive individuals despite fully suppressive antiretroviral therapy. White matter abnormalities appear to be a particularly important determinant of cognitive dysfunction seen in well-treated HIV-positive individuals.

Introduction

As a result of modern combination antiretroviral therapy, HIV-infection is now a chronic disease with life expectancy approaching that of the general population [1]. Despite this, concerns remain regarding an increased prevalence of age-associated comorbidities and the possibility of an 'accelerated ageing' phenotype [2]. Cognitive impairment, which is associated with poorer clinical outcomes and higher mortality [3,4] reportedly affects up to 50% of HIV-positive individuals [5,6]. Yet, most data does not pertain to virologically suppressed cohorts, which are now the norm in Northern European settings [7] and hence there remains uncertainty about its aetiology.

One possibility is that cognitive impairment results from structural damage to brain regions that support cognition. Earlier work has described lower grey and white matter volumes in numerous locations in HIV-positive individuals [8-13]. Diffusion-weighted imaging, an advanced MRI technique, is more sensitive at revealing white matter abnormalities than volumetric measures in HIV-positive individuals [14-19]. However, the relationships between imaging abnormalities and cognitive function remain uncertain, particularly in well-treated patients, with several studies failing to report any associations [13,17,19,20].

Given the advances in HIV-medicine and neuroimaging techniques we recruited virally suppressed HIV-positive individuals and a demographically comparable HIV-negative control group into the EU-funded Co-morBidity in Relation to AIDS (COBRA) study. We determined the prevalence of cognitive impairment and its

relationships with grey and white matter abnormalities. Furthermore, we systematically investigated whether previously proposed sub-types of HIV-associated brain injury [21] were present using a multi-modal, 'machine-learning' approach. We tested the following hypotheses: i) despite successful antiretroviral therapy, HIV-positive individuals would exhibit cognitive impairment compared to an appropriate HIV-negative control population; ii) HIV-positive individuals would have lower grey and white matter volumes as well as multiple abnormalities on diffusion-weighted imaging; iii) cognitive impairment would be associated with abnormal brain structure; and iv) grey and white matter abnormalities would occur together and more commonly in HIV-positive individuals supporting the presence of a common pathogenic mechanism.

Methods

Participants

In total, 134 HIV-positive participants were recruited to the COBRA study from London (n=59) and Amsterdam (n=75). For a graphical illustration of the methods see supplementary figure 1. A demographically comparable HIV-negative control population was recruited from sexual health clinics and specific community groups (London: n=29; Amsterdam: n=50). Eligible participants were aged ≥45 with no significant neurological conditions, substance/alcohol abuse or moderate/severe depression (see supplementary data for specific exclusion criteria). All HIV-positive participants had to have plasma HIV RNA <50 copies/mL on antiretroviral therapy for >12 months prior to enrolment.

This study was approved by the institutional review board of the Academic Medical Center (AMC) (NL 30802.018.09) and a UK Research Ethics Committee (REC) (13/LO/0584 Stanmore, London). All participants provided written informed consent.

Neuropsychological tests

Participants completed a comprehensive neuropsychological test battery, assessing attention, executive function, language, memory, information processing speed and motor function (supplementary table 1). Raw scores were converted to standardised T-scores accounting for age and educational level with higher T-scores representing better cognitive function. Global T-score was the mean of the six domain T-scores. Three common classification methods, the HIV-associated neurocognitive disorder ('Frascati') criteria, the global deficit score (GDS) and multivariate normative comparison (MNC) were then applied according to published methods [22-24].

Neuroimaging acquisition

In London, images were acquired using a Siemens 3T Verio scanner with a 32-channel head coil (HIV-positive: n=59; HIV-negative: n=29) and in Amsterdam initially with a Philips 3T Intera with an 8-channel phased array head coil (HIV-positive: n=46; HIV-negative: n=20) and then using a Philips 3T Ingenia with a 16-channel head coil (HIV-positive: n=29; HIV-negative: n=30; both Philips Healthcare, Best, the Netherlands) due to a scanner upgrade (see supplementary data for scanning parameters).

Image processing

T1-weighted images were pre-processed using SPM12 (University College London, London, UK). Briefly, images were bias corrected, segmented into grey matter, white matter and cerebrospinal fluid (CSF) and volumes calculated. These were then registered to a custom template and normalised to Montreal Neurological Institute (MNI)-152 space using the Diffeomorphic Anatomical Registration using Exponentiated Lie algebra (DARTEL) algorithm [25].

Diffusion data were pre-processed using FMRIB Software Library v5.0.6 (FSL, FMRIB, University of Oxford). Briefly, images were corrected for eddy currents and head motion, non-brain tissue was deleted and the diffusion tensor model was fitted at every voxel. These were then registered to a custom template and standard space, using Diffusion Tensor Imaging ToolKit v2.3.1 [26]. Fractional anisotropy (FA), axial, mean and radial diffusivity maps for each participant were then 'skeletonised' using FSL and thresholded using FA ≥0.2 to exclude areas with considerable inter-individual variability prior to performing tract-based spatial statistics (TBSS) [27].

Statistical analyses

Group comparisons

Baseline group differences were assessed using chi-square, Fisher's exact, Wilcoxon rank sum and unpaired t-tests as appropriate. To account for variance associated with potential scanner and head coil differences, a three-level factor was entered into all models, an approach used previously in multisite studies of HIV-positive individuals

[8,20]. These analyses were performed using *R* v3.1.3, with p-values <0.05 considered statistically significant.

Voxelwise inference testing

Voxelwise group differences in grey and white matter volume and diffusion measures were calculated using the general linear model, adjusting for age, intracranial volume and scanner. Correction for multiple comparisons used permutation testing [28] (n=10,000) and threshold-free cluster enhancement (TFCE) [29]. Permutation-corrected p-values <0.05 were considered significant.

Combining imaging and cognitive data

For each cognitive domain, a multiple linear regression model was fitted with age, intracranial volume, scanner, HIV-status and either total grey matter volume or mean skeleton FA as independent variables and the relevant cognitive domain T-score as the dependent variable. Separate models with an additional HIV-status and imaging measure interaction term were also tested. To investigate the relationship between localised brain structure and cognitive function, voxelwise regressions were calculated using similar methods.

Cluster analysis

T1-weighting provides good contrast between grey and white matter for volumetric assessment, whereas diffusion-weighting provides information about white matter microstructure. To take advantage of this complementary information we used multivariate k-means clustering to test whether distinct groups could be identified

based on neuroimaging measures. As a dimension reduction step, each participant's brain was summarised into 109 regions using the Harvard-Oxford and International Consortium of Brain Mapping (ICBM) DTI-81 atlases. To ensure comparable distributions, these were then scaled before entering into the clustering model. To assess the optimal number of clusters, separate models with 2-10 clusters were calculated. These were compared using the Calinski-Harabasz index and the average silhouette width. The Duda-Hart test was used to confirm cluster structure to the data (i.e., k>1). Cluster stability was assessed using the Jaccard coefficient, calculated using bootstrapping with 10,000 resamples [30]. Cluster analyses were performed with the R package 'fpc' v2.1.9.

Results

Participants

At entry, all HIV-positive participants (n=134) had an undetectable plasma HIV RNA with a median (interquartile range) CD4+ cell count of 618 (472-806) cells/μL and duration of antiretroviral therapy of 12.5 (7.4-16.9) years. The HIV-negative group (n=79) was comparable to the HIV-positive group in: age, gender, education level, cardiovascular risk factors, smoking and recreational drug use. The HIV-positive group included a greater proportion of Black-Africans (table 1). One participant did not complete the full cognitive battery, and neuroimaging data was missing for n=5 participants (T1 not useable n=1, incomplete diffusion-MRI n=1, excessive motion artefact on diffusion-MRI n=3).

Cognitive function

Cognitive impairment was more prevalent in the HIV-positive group, regardless of the method used: GDS: 18.0% vs. 3.8% (odds ratio [95% confidence interval] 5.58 [1.86-24.1], $p<0.01$); Frascati: 18.0% vs. 3.8% (5.58 [1.86-24.1], $p<0.01$); MNC: 19.5% vs. 2.5% (9.36 [2.68-59.2], $p<0.001$). The HIV-positive group scored lower than the control group in the domains of attention, executive function, motor function and processing speed (Fig. 1, $W_{210}>6300$ and $p\leq0.01$ for all). Only 1.5% of the HIV-positive group and 1.2% of controls fulfilled the criteria for HIV-associated dementia.

Brain tissue volumes and diffusion measures

HIV-positive individuals had lower total grey matter volume than controls (table 2). There was a significant negative correlation between age and grey matter volume ($r=-0.31$, $p<0.0001$) but no significant age and HIV-status interaction ($t_{205}=0.45$, $p=0.65$). Voxelwise analysis demonstrated lower grey matter volume in the HIV-positive group, located principally in the intracalcarine and supracalcarine cortices (Fig. 2). In contrast, total white matter volume was not significantly different between the groups ($p=0.59$), nor were there any significant voxelwise differences.

Despite comparable white matter volumes, HIV-positive individuals had lower FA and higher mean and radial (but not axial) diffusivity than controls (table 2). There were age-associated changes to all diffusion metrics ($r=-0.36$, 0.45, 0.45 and 0.40 for FA, mean, radial and axial diffusivity respectively, $p<0.0001$ for all) but no significant interactions between age and HIV-status ($p>0.5$ for all). Voxelwise analyses revealed widespread abnormalities in FA, mean and radial diffusivity in

HIV-positive individuals with a similar pattern of change to the whole brain diffusion metrics (Fig. 2).

In the HIV-positive group, grey and white matter volumes and mean FA were not associated with known duration of untreated HIV-infection, duration of antiretroviral therapy, current or nadir CD4+ cell counts or CD4+:CD8+ cell count ratio ($p>0.15$ for all). However, there were trends for patients with prior AIDS to have lower grey matter volume (difference 14.3 mL, $t_{128}=1.9$, $p=0.06$) and lower mean FA (difference 0.0059, $t_{128}=1.7$, $p=0.08$).

HIV-associated brain injury and cognitive function

Across patients and controls, larger grey matter volumes were associated with better cognitive performance. Total grey matter volume was positively correlated with executive function, motor function and global T-scores with no significant interactions between HIV-status and cognitive T-scores (table 3). Voxelwise analyses were then performed allowing regional differences in the relationship between brain structure and cognition to be explored. Spatial correspondence between the regions of grey matter correlated with cognitive function and the previously described HIV-associated grey matter volume reduction was generally modest, but greatest for executive function (Fig. 3, supplementary table 2).

Across both groups, higher FA was associated with greater cognitive performance. FA averaged across the main white matter tracts was positively correlated with attention, executive function, processing speed and global T-scores (table 3). There

were no interactions between HIV-status, FA and cognitive T-scores. Across both groups, using a voxelwise approach, FA was positively correlated with attention, executive function, motor function and processing speed and global T-scores in many regions, primarily in the body and genu of the corpus callosum. In contrast to the grey matter volume results, these were similar to white matter tracts with reduced FA in the HIV-positive group (Fig. 3, supplementary table 2).

Cluster analysis

Using k-means clustering, two groups were identified that were stable with resampling (mean Jaccard coefficient 0.99). Other cluster models (i.e. k>2) were much less stable (mean Jaccard coefficient <0.7). In the two-cluster model, cluster one (n=99) had higher grey matter volume and higher mean FA in all regions, whereas cluster two (n=109) had lower grey matter volume and lower mean FA in all regions. HIV-positive individuals were more likely to be members of cluster two, 61.2% vs. 36.4% (odds ratio 2.74 [1.53-4.98], p<0.001, Fig. 4). Furthermore, subjects in cluster two were older (median 59.3 vs 54.6 years, W_{206}=3634, p<0.001) and had significantly poorer cognitive function in the domains of attention, executive function, motor function and processing speed (Fig. 5, W_{205}≥6307, p≤0.03 for all). Importantly, these cognitive differences between members of clusters one and two were not due to demographic differences, as the cognitive T-scores are adjusted for age and educational level. Although there were no significant differences in current and nadir CD4+ cell counts (p=0.10 and 0.17), HIV-positive individuals in cluster two had lower CD4+:CD8+ ratios (0.82 vs. 1.06, W_{132}=2666, p=0.01) and were older (58.6 vs 53.2 years, W_{132}=1380, p<0.001) than those in cluster one.

Discussion

We demonstrate that HIV-positive individuals have evidence of cognitive impairment, lower grey matter volume and widespread white matter microstructural abnormalities despite successful antiretroviral treatment. Generally, the grey matter volume reduction associated with HIV-infection was modest and did not occur in regions where brain structure correlated with cognitive function. In contrast, HIV-associated white matter abnormalities were widespread and found in many of the white matter tracts whose structure correlated with cognitive function. These findings extend previous work [13,17,19,20] by showing that white matter structure is correlated with cognitive impairment in chronic HIV-infection. Our findings suggest that the pathophysiology of cognitive impairment in treated HIV-disease is predominantly due to white matter microstructural injury and support the use of FA as a biomarker to identify HIV-associated brain injury. Furthermore, we consistently showed a lack of interaction between HIV-status, age and neuroimaging biomarkers which suggests *static* rather than *active* brain injury in well-treated patients. However, longitudinal data are required to confirm this.

The prevalence of cognitive impairment in well-treated HIV-positive patients has been uncertain. Although early studies reported high rates of cognitive impairment in chronically treated patients [5,6,31], some studies have failed to observe this [32]. In our study, both study groups were high performing with nearly 40% having some form of tertiary education, which may explain the relatively low prevalence of cognitive impairment. Furthermore, the use of methods less likely to classify high numbers of individuals with cognitive impairment such as MNC [33], in comparison with a demographically-comparable control group and sustained suppression of

viraemia in the patient group are likely to have contributed to the relatively low prevalence of HIV-associated cognitive impairment.

Total grey matter volume was lower in the HIV-positive group with reductions occurring primarily in the intracalcarine and supracalcarine cortices. Previous studies in populations with variable suppression of HIV-replication have described more widespread grey matter volume reductions [8,10,12]. However, the locations where we observed abnormalities are consistent with regions of greatest neuronal [34] and grey matter volume [11] loss observed in untreated HIV-infection. Together with the trend for those with prior AIDS to have the lowest grey matter volume, our findings suggest these regions are the earliest affected during the course of HIV-infection and that further atrophy may be prevented with successful treatment.

Diffusion-weighted imaging showed widespread evidence of HIV-associated white matter microstructural injury, with the disparity in radial but not axial diffusivity suggestive of white matter demyelination [35]. The characteristics and location of this injury are consistent with histopathological reports from the pre-antiretroviral era, where myelin damage was found in the central white matter [36]. The decoupling of diffusion abnormalities and white matter atrophy is interesting and has been reported previously in HIV-positive individuals with relatively preserved immunity (mean CD4+ 613 cells/uL) [17]. Together with the trend for the most severe abnormalities to occur in patients with prior AIDS, our findings suggest that diffusion abnormalities may reflect historical damage prior to antiretroviral therapy initiation and that progression to white matter atrophy may be aborted with sustained suppression of HIV-replication. Although cardiovascular disease may also be implicated in well-

treated patients [37], this is unlikely to explain the observed group differences, given the similarity in measured cardiovascular risk factors between groups. As we report cross-sectional data, we are unable to resolve the issue of whether these imaging changes reflect historical damage or an on-going pathological process.

The HIV-associated microstructural injury occurred in white matter tracts correlated with cognitive function. In contrast, the HIV-associated grey matter volume reduction generally did not occur in brain regions correlated with cognitive function. Although this could reflect the cognitive battery we employed, these data suggest that white matter abnormalities may be a more important determinant of cognitive impairment in treated HIV-disease. White matter abnormalities of this type correlate with cognitive function in other disease states [38], and are thought to disrupt the synchronised functioning of large-scale, distributed brain networks that cognition depends on.

Using a multivariate approach to examine individual differences in volumetric *and* diffusion data simultaneously, we identified a brain phenotype that was associated with ageing, cognitive dysfunction, and HIV-status. Furthermore, this phenotype was associated with lower CD4+:CD8+ ratios. This biomarker of immune activation has previously been associated with other age-related comorbidities in well-treated cohorts [39]. Our findings suggest that persistent immune activation may also be associated with brain injury, which may reflect the legacy of prolonged untreated infection as normalisation of this ratio has been associated with earlier antiretroviral therapy initiation [40].

Our study benefits from comprehensive neuropsychological, volumetric and diffusion assessments in patients and demographically-appropriate controls. However, our study has a number of limitations. Whilst our cohort is not representative of the *entire* HIV-positive population, it is representative of older HIV-positive adults receiving care in a Northern European setting where over 90% are successfully treated [7]. Cohort studies are potentially limited by unmeasured differences confounding group comparisons. This is particularly an issue when studying HIV-positive populations and age-related comorbidities given high rates of smoking, alcohol and recreational drug use. We limited this by recruiting a comparable control population but unmeasured differences between the two groups may remain. One previous study of virally suppressed patients [41], which used different MRI modalities, may have had a less comparable control group (81% of the HIV-positive group vs 47% of the HIV-negative group were male), which may lead to an overstatement of the HIV association. Differences in scanner and head coil parameters between sites may potentially confound multi-site neuroimaging studies, however, bias was minimised by adjusting for these factors in our models. Furthermore, restricting the analyses to data acquired in London only resulted in HIV associations of a similar magnitude and direction as the entire study population (supplementary table 3), giving confidence that scanner differences did not bias our main findings. Cluster analysis may split the participants into potentially arbitrary groups and the ‘good’/’bad’ brain phenotype may, in reality, be more of a continuum. Although exploratory, we found excellent internal validity by demonstrating a high level of cluster stability with resampling and good external validity by the associations of cluster membership with age, HIV-status, cognitive function and markers of systemic immune activation.

To conclude, HIV-infection was associated with both lower grey matter volume and white matter microstructural injury. Cognitive impairment, present in approximately 20% of cases, was most clearly associated with white matter abnormalities. Grey and white matter abnormalities tended to occur together suggesting a common aetiology for HIV-associated brain injury, which may be related to prolonged untreated infection and immune activation, in common with other non-AIDS comorbidities.

Funding

This work was supported by a European Union Seventh Framework Programme grant to the Comorbidity in Relation to AIDS (COBRA) project (FP-7-HEALTH 305522, all authors), National Institute for Health Research (NIHR) Professorship (NIHR-RP-011-048; DJS), NIHR Imperial Biomedical Research Centre, the Netherlands Organisation for Health Research and Development (ZonMW) (grant number 300020007) & Stichting AIDS Fonds (grant number 2009063), Nuts-Ohra Foundation (grant number 1003-026) and unrestricted scientific grants from: ViiV Healthcare, Gilead Sciences, Janssen Pharmaceutica N.V. Bristol-Myers Squibb (BMS), and Merck & Co to the AGE$_h$IV cohort study, as well as investigator initiated grants from BMS, Gilead Sciences, Janssen, Merck and ViiV Healthcare to the POPPY cohort study.

Acknowledgements

We would like to thank all the participants in the study for their time and effort. In addition we would like to thank the POPPY and AGE$_h$IV study teams at their respective sites:

Academisch Medisch Centrum, Universiteit van Amsterdam - *Department of Global Health and Amsterdam Institute for Global Health and Development (AIGHD)*: P. Reiss, F.W.N.M. Wit, J. Schouten, K.W. Kooij, R.A. van Zoest, B.C. Elsenga, F.R. Janssen, M. Heidenrijk, W. Zikkenheiner. *Division of Infectious Diseases*: M. van der Valk. *Department of Experimental Immunology*: N.A. Kootstra, A.M. Harskamp-Holwerda, I. Maurer, M.M. Mangas Ruiz, A.F. Girigorie. *Department of Medical Microbiology*: J. Villaudy, E. Frankin, A. Pasternak, B. Berkhout, T. van der Kuyl. *Department of Neurology*: P. Portegies, B.A. Schmand, G.J. Geurtsen, J.A. ter Stege, M. Klein Twennaar. *Department of Radiology*: C.B.L.M. Majoie, M.W.A. Caan, T. Su. *Department of Cell*

Biology: K. Weijer. *Division of Endocrinology and Metabolism*: P.H.L.T. Bisschop. *Department of Experimental neuroendocrinology*: A. Kalsbeek. *Department of Ophthalmology*: M. Wezel. *Department of Psychiatry*: I. Visser, H.G. Ruhé.

Alma Mater Studiorum Universita di Bologna -*Department of Experimental, Diagnostic and Specialty Medicine:* C. Franceschi, P. Garagnani, C. Pirazzini, M. Capri, F. Dall'Olio, M. Chiricolo, S. Salvioli.

Erasmus Universitair Medisch Centrum Rotterdam - *Department of Genetics:* J. Hoeijmakers, J. Pothof.

GGD Amsterdam/Public Health Service Amsterdam -*Cluster of Infectious Diseases, research department***:** M. Prins, M. Martens, S. Moll, J. Berkel, M. Totté, S. Kovalev.

Göteborgs Universitet - M. Gisslén, D. Fuchs, H. Zetterberg.

Imperial College of Science, Technology and Medicine - *Department of Medicine, Division of Infectious Diseases*: A. Winston, J. Underwood, L. McDonald, M. Stott, K. Legg, A. Lovell, O. Erlwein, N. Doyle, C. Kingsley. *Department of Medicine, Division of Brain Sciences, The Computational, Cognitive & Clinical Neuroimaging Laboratory:* D.J. Sharp, R. Leech, J.H. Cole.

Stichting HIV Monitoring - S. Zaheri, M.M.J. Hillebregt, Y.M.C. Ruijs, D.P. Benschop.

Stichting Katholieke Universiteit Nijmegen -D. Burger, M. de Graaff-Teulen.

Università degli studi di Modena e Reggio Emilia - *Department of Medical and Surgical Sciences for Children & Adults*: G. Guaraldi.

Universität Konstanz - *Department of Biology*: A. Bürkle, T. Sindlinger, M. Moreno-Villanueva, A. Keller.

University College London - *Research Department of Infection and Population Health:* C. Sabin, D. de Francesco.

Vlaams Instituut voor Biotechnologie - *Inflammation research center:* C. Libert, S. Dewaele.

Some of this work has previously been presented orally at the Conference on Retroviruses and Opportunistic Infections 2016 (abstract 148) and at the British HIV Association Annual Conference (abstract O12).

Potential conflicts of interest

AW has received honoraria or research grants from or been a consultant or investigator in clinical trials sponsored by Abbott, Boehringer Ingelheim, Bristol-Myers Squibb, Gilead Sciences, GlaxoSmithKline, Janssen-Cilag, Roche, Pfizer and ViiV Healthcare. PR reports grants from Gilead Sciences, grants from ViiV Healthcare, grants from Janssen Pharmaceutica, grants from Bristol Myers Squibb, grants from Merck & Co, during the conduct of the study; other from Gilead Sciences, other from Janssen Pharmaceutica, other from ViiV Healthcare, outside the submitted work. RZ has received travel grants from Bristol-Myers Squibb and Gilead Sciences, and was a speaker at an event sponsored by Gilead Sciences for which her institution received remuneration. None of the other authors have potential conflicts of interest for the submitted work.

References

1. May MT, Gompels M, Delpech V, et al. Impact on life expectancy of HIV-1 positive individuals of CD4+ cell count and viral load response to antiretroviral therapy. AIDS **2014**; 28:1193–1202.

2. Schouten J, Wit FW, Stolte IG, et al. Cross-sectional comparison of the prevalence of age-associated comorbidities and their risk factors between HIV-infected and uninfected individuals: the AGEhIV cohort study. CLIN INFECT DIS **2014**; 59:1787–1797.

3. Lescure F-X, Omland LH, Engsig FN, et al. Incidence and impact on mortality of severe neurocognitive disorders in persons with and without HIV infection: a Danish nationwide cohort study. CLIN INFECT DIS **2011**; 52:235–243.

4. Hinkin CH, Castellon SA, Durvasula RS, et al. Medication adherence among HIV+ adults: effects of cognitive dysfunction and regimen complexity. Neurology **2002**; 59:1944–1950.

5. Heaton RK, Franklin DR, Ellis RJ, et al. HIV-associated neurocognitive disorders before and during the era of combination antiretroviral therapy: differences in rates, nature, and predictors. J Neurovirol **2011**; 17:3–16.

6. Robertson KR, Smurzynski M, Parsons TD, et al. The prevalence and incidence of neurocognitive impairment in the HAART era. AIDS **2007**; 21:1915–1921.

7. England PH. HIV in the United Kingdom: 2014 Report. Public Health England, 2014.

8. Becker JT, Maruca V, Kingsley LA, et al. Factors affecting brain structure in men with HIV disease in the post-HAART era. Neuroradiology **2012**; 54:113–121. Available at: http://www.scopus.com/inward/record.url?eid=2-s2.0-84857051873&partnerID=40&md5=e74e36e2712b761e6797f7f5f965c077.

9. Towgood KJ, Pitkanen M, Kulasegaram R, et al. Mapping the brain in younger and older asymptomatic HIV-1 men: frontal volume changes in the absence of other cortical or diffusion tensor abnormalities. Cortex **2012**; 48:230–241. Available at: http://www.scopus.com/inward/record.url?eid=2-s2.0-84856224039&partnerID=40&md5=3bebc13914eeab54eb4f1188c8cbecc6.

10. Chiang M-C, Dutton RA, Hayashi KM, et al. 3D pattern of brain atrophy in HIV/AIDS visualized using tensor-based morphometry. NeuroImage **2007**; 34:44–60.

11. Thompson PM, Dutton RA, Hayashi KM, et al. Thinning of the cerebral cortex visualized in HIV/AIDS reflects CD4+ T lymphocyte decline. Proc. Natl. Acad. Sci. U.S.A. **2005**; 102:15647–15652.

12. Küper M, Rabe K, Esser S, et al. Structural gray and white matter changes in patients with HIV. J. Neurol. **2011**; 258:1066–1075.

13. Ances BM, Ortega M, Vaida F, Heaps J, Paul R. Independent Effects of HIV, Aging, and HAART on Brain Volumetric Measures. JAIDS Journal of Acquired Immune Deficiency Syndromes **2012**; 59:469–477.

14. Corrêa DG, Zimmermann N, Doring TM, et al. Diffusion tensor MR imaging of white matter

integrity in HIV-positive patients with planning deficit. Neuroradiology **2015**;

15. Leite SCB, Corrêa DG, Doring TM, et al. Diffusion tensor MRI evaluation of the corona radiata, cingulate gyri, and corpus callosum in HIV patients. Journal of Magnetic Resonance Imaging **2013**; 38:1488–1493.

16. Nir TM, Jahanshad N, Busovaca E, et al. Mapping white matter integrity in elderly people with HIV. Hum Brain Mapp **2014**; 35:975–992.

17. Stebbins GT, Smith CA, Bartt RE. HIV-Associated Alterations in Normal-Appearing White Matter. JAIDS Journal of … **2007**;

18. Stubbe-Drger B, Deppe M, Mohammadi S, et al. Early microstructural white matter changes in patients with HIV: a diffusion tensor imaging study. BMC Neurol **2012**; 12:23. Available at: http://www.scopus.com/inward/record.url?eid=2-s2.0-84869150827&partnerID=40&md5=1ccebb22507a530cd73b505b4f6b6519.

19. Su T, Caan MWA, Wit FWNM, et al. White matter structure alterations in HIV-1-infected men with sustained suppression of viraemia on treatment. AIDS **2015**; Publish Ahead of Print:1.

20. Jernigan TL, Archibald SL, Fennema-Notestine C, et al. Clinical factors related to brain structure in HIV: the CHARTER study. J Neurovirol **2011**; 17:248–257.

21. Brew BJ. Evidence for a change in AIDS dementia complex in the era of highly active antiretroviral therapy and the possibility of new forms of AIDS dementia complex. AIDS **2004**; 18:75.

22. Antinori A, Arendt G, Becker JT, et al. Updated research nosology for HIV-associated neurocognitive disorders. Neurology **2007**; 69:1789–1799.

23. Carey CL, Woods SP, Gonzalez R, et al. Predictive validity of global deficit scores in detecting neuropsychological impairment in HIV infection. J Clin Exp Neuropsychol **2004**; 26:307–319.

24. Huizenga HM, Smeding H, Grasman RPPP, Schmand B. Multivariate normative comparisons. Neuropsychologia **2007**; 45:2534–2542.

25. Ashburner J. A fast diffeomorphic image registration algorithm. NeuroImage **2007**; 38:95–113.

26. Wang Y, Gupta A, Liu Z, et al. DTI registration in atlas based fiber analysis of infantile Krabbe disease. NeuroImage **2011**; 55:1577–1586.

27. Smith SM, Jenkinson M, Johansen-Berg H, et al. Tract-based spatial statistics: voxelwise analysis of multi-subject diffusion data. NeuroImage **2006**; 31:1487–1505.

28. Winkler AM, Ridgway GR, Webster MA, Smith SM, Nichols TE. Permutation inference for the general linear model. NeuroImage **2014**; 92:381–397.

29. Smith SM, Nichols TE. Threshold-free cluster enhancement: addressing problems of smoothing, threshold dependence and localisation in cluster inference. NeuroImage **2009**; 44:83–98.

30. Hennig C. Cluster-wise assessment of cluster stability. Computational Statistics & Data Analysis **2007**;

31. Heaton RK, Clifford DB, Franklin DR, et al. HIV-associated neurocognitive disorders persist in the era of potent antiretroviral therapy: CHARTER Study. Neurology **2010**; 75:2087–2096.

32. McDonnell J, Haddow L, Daskalopoulou M, et al. Minimal cognitive impairment in UK HIV-positive men who have sex with men: effect of case definitions and comparison with the general population and HIV-negative men. J. Acquir. Immune Defic. Syndr. **2014**; 67:120–127.

33. Su T, Schouten J, Geurtsen GJ, et al. Multivariate normative comparison, a novel method for more reliably detecting cognitive impairment in HIV infection. AIDS **2015**; 29:547–557.

34. Everall IP, Luthert PJ, Lantos PL. Neuronal number and volume alterations in the neocortex of HIV infected individuals. J. Neurol. Neurosurg. Psychiatr. **1993**; 56:481–486.

35. Song S-K, Sun S-W, Ju W-K, Lin S-J, Cross AH, Neufeld AH. Diffusion tensor imaging detects and differentiates axon and myelin degeneration in mouse optic nerve after retinal ischemia. NeuroImage **2003**; 20:1714–1722.

36. Gray F, LESCS M-C, KEOHANE C, et al. Early Brain Changes in HIV Infection: Neuropathological Study of 11 HIV Seropositive, Non-AIDS Cases. J. Neuropathol. Exp. Neurol. **1992**; 51:177.

37. Brew BJ. Has HIV-associated neurocognitive disorders now transformed into vascular cognitive impairment? AIDS **2016**; 30:2379–2380.

38. Medina D, DeToledo-Morrell L, Urresta F, et al. White matter changes in mild cognitive impairment and AD: A diffusion tensor imaging study. Neurobiology of Aging **2006**; 27:663–672.

39. Mussini C, Lorenzini P, Cozzi-Lepri A, et al. CD4/CD8 ratio normalisation and non-AIDS-related events in individuals with HIV who achieve viral load suppression with antiretroviral therapy: an observational cohort study. The Lancet HIV **2015**; 2:e98–106.

40. Serrano-Villar S, Sainz T, Lee SA, et al. HIV-infected individuals with low CD4/CD8 ratio despite effective antiretroviral therapy exhibit altered T cell subsets, heightened CD8+ T cell activation, and increased risk of non-AIDS morbidity and mortality. PLoS Pathog. **2014**; 10:e1004078.

41. Granziera C, Daducci A, Simioni S, et al. Micro-Structural Brain Alterations in Aviremic HIV+ Patients with Minor Neurocognitive Disorders: A Multi-Contrast Study at High Field. PLoS ONE **2013**; 8:e72547. Available at: http://eutils.ncbi.nlm.nih.gov/entrez/eutils/elink.fcgi?dbfrom=pubmed&id=24039777&retmode=ref&cmd=prlinks.

Tables titles and legends

Table 1**.** Baseline characteristics of the study cohort.

	HIV-positive (n=134)	**HIV-negative (n=79)**	***p-value***
Age (years**)**, median (IQR)	55 (51, 62)	57 (52, 64)	0.24
Gender, n (%)			0.79
Female	9 (6.7%)	6 (7.6%)	
Male	125 (93.3%)	73 (92.4%)	
Ethnicity, n (%)			0.03
Black-African	16 (12.0%)	2 (2.6%)	
White	117 (88.0%)	76 (97.4%)	
Sexuality, n (%)			0.45
MSM	104 (77.6%)	59 (74.7%)	
Bisexual	10 (7.5%)	4 (5.1%)	
Heterosexual	18 (13.4%)	16 (20.2%)	
Years of education, median (IQR)	14 (13-16)	16 (14-17)	0.23
Cardiovascular disease, n (%)			
Hypertension	56 (42.1%)	30 (38.5%)	0.66
Myocardial infarction	2 (1.5%)	3 (3.8%)	0.36
Type 1 diabetes	0 (0%)	0 (0%)	N/A
Type 2 diabetes	10 (7.5%)	5 (6.3%)	1.00
BMI (kg/m^2), median (IQR)	24.6 (22.6-27.4)	24.6 (23.3-28.4)	0.30
Total cholesterol (mmol/L), median (IQR)	5.28 (5.11-5.45)	5.33 (5.11-5.55)	0.51
HDL cholesterol (mmol/L), median (IQR)	1.26 (1.07-1.50)	1.30 (1.07-1.57)	0.51
LDL cholesterol (mmol/L), median (IQR)	2.99 (2.83-3.16)	3.14 (2.83-3.16)	0.30
Triglycerides (mmol/L), median (IQR)	1.70 (1.15-2.53)	1.51 (1.07-2.25)	0.20
Smoking status, n (%)			0.24
Current smoker	40 (29.9%)	20 (25.3%)	
Ex-smoker	58 (43.2%)	29 (36.7%)	
Never smoked	36 (26.9%)	30 (38.0%)	
Alcohol consumption, n (%)			0.04
Current drinker	104 (77.6%)	71 (89.9%)	
Previous drinker	18 (13.4%)	3 (3.8%)	
Never drunk	12 (9.0%)	4 (5.1%)	
Use of recreational drugs in past 6 months, n (%)	44 (32.8%)	18 (22.8%)	0.16
CD4+ count (cells/µL), median (IQR)	618 (472-806)	900 (692-1174)	<0.01
CD4+:CD8+ cell count ratio, median (IQR)	0.84 (0.60-1.12)	2.01 (1.44-2.64)	<0.01
Nadir CD4+ count (cells/µL), median (IQR)	180 (90-250)	N/A	
Years since HIV diagnosis, median (IQR)	15.0 (9.1-20.0)	N/A	
Duration of antiretroviral therapy (years), median (IQR)	12.5 (7.4-16.9)	N/A	
HIV RNA viral load < 200 copies/mL, n (%)	134 (100%)	N/A	
Prior clinical AIDS, n(%)	42 (31.3%)	N/A	
Likely route of HIV transmission, n (%)		N/A	
MSM	115 (85.8%)		
Heterosexual sex	15 (11.2%)		
IVDU/Blood product	1 (0.8%)		
Unknown	3 (2.2%)		

P-values calculated using the chi-squared test, Fisher's exact and Wilcoxon rank sum tests as appropriate. Hypertension was defined by either: three measurements of systolic BP ≥140 mmHg; three measurements of diastolic BP ≥90 mmHg or use of blood pressure lowering medication. Abbreviations: HDL – high-density lipoprotein, LDL – low-density lipoprotein, MSM – men who have sex with men, IQR – interquartile range.

Table 2. Volumetric and diffusion imaging measurements.

	Volumetric measures				
Imaging measure	**HIV-positive**	**HIV-negative**	**Difference (95% CI)**	**t_{206}**	***p*-value**
Grey matter volume (mL)	659	673	13.7 (2.3-25.1)	2.37	0.02
White matter volume (mL)	479	476	2.4 (-6.4-11.2)	-0.54	0.59
	Diffusion measures				
Imaging measure	**HIV-positive**	**HIV-negative**	**Difference (95% CI)**	**t_{202}**	***p*-value**
Fractional anisotropy	0.477	0.484	0.007 (0.002-0.012)	2.92	<0.01
Mean diffusivity (mm^2/s)	705	696	8.5 (1.2-15.8)	-2.27	0.02
Radial diffusivity (mm^2/s)	503	493	10.3 (2.7-17.9)	-2.66	<0.01
Axial diffusivity (mm^2/s)	1,108	1,103	4.9 (-2.5-12.3)	-1.31	0.19

Least squares means, a potentially better estimate of the true population mean for each neuroimaging measure by HIV-status and 95% confidence intervals (CI) – adjusted for age, intracranial volume and scanner type. Subscript indicates degrees of freedom for the t-statistic.

Table 3. Associations between cognitive function and imaging parameters.

	Grey matter volume regression estimate (T-score/mL)			HIV-grey matter interaction	
Cognitive domain	**Estimate**	**(95% CI)**	***p*-value**	**t_{203}**	***p*-value**
Attention	0.035	(-0.001-0.072)	0.06	1.91	0.06
Executive function	0.041	(0.013-0.068)	<0.01	0.75	0.45
Memory	0.010	(-0.016-0.037)	0.43	-0.67	0.50
Motor function	0.029	(0.001-0.057)	0.04	0.69	0.49
Processing speed	0.017	(-0.010-0.043)	0.21	0.76	0.45
Global	0.026	(0.006-0.046)	0.01	1.34	0.18

	Fractional anisotropy regression estimate (T-score/unit FA)			HIV-fractional anisotropy interaction	
Cognitive domain	**Estimate**	**(95% CI)**	***p*-value**	**t_{199}**	***p*-value**
Attention	0.099	(0.013-0.187)	0.03	-1.67	0.09
Executive function	0.073	(0.008-0.139)	0.03	-0.62	0.54
Memory	0.035	(-0.028-0.097)	0.27	-0.53	0.60
Motor function	0.079	(0.013-0.144)	0.02	1.25	0.21
Processing speed	0.092	(0.031-0.152)	<0.01	-0.41	0.68
Global	0.062	(0.014-0.110)	0.01	-0.63	0.53

Multiple linear regression estimates for grey matter volume and fractional anisotropy by cognitive domain adjusted for age, intracranial volume and scanner type. In addition, HIV-status and neuroimaging measure interaction statistics for each cognitive domain.

Figures titles and legends

Figure 1. Boxplots of demographically adjusted cognitive domain T-scores by HIV-status.

P-values calculated using the Wilcoxon rank sum test.

Figure 2. Voxelwise analyses of volumetric and diffusion measures.

A) Grey matter voxel based morphometry group comparison. Areas with significantly ($p<0.05$) lower grey matter volume coloured by t-statistic (red/yellow) - corrected for multiple comparisons and adjusted for age, intracranial volume and scanner. Significant differences are overlaid on the Montreal Neurological Institute 152 T1 brain image.

B) White matter tract-based spatial statistics group comparison. Areas of significantly ($p<0.05$) lower fractional anisotropy (FA), higher mean diffusivity (MD) and higher radial diffusivity (RD) are coloured red-yellow, light blue and dark blue by t-statistic respectively - corrected for multiple comparisons and adjusted for age, intracranial volume and scanner. Significant differences overlaid on the white matter skeleton (green) and the mean fractional anisotropy image (greyscale).

Abbreviations: FA: fractional anisotropy; MD: mean diffusivity; RD: radial diffusivity.

Figure 3. Correspondence between HIV-associated brain injury and regions correlated with cognitive function.

A) Voxel-wise analysis depicting regions of grey matter volume significantly lower in the HIV-positive group vs. HIV-negative group (red), positively correlated with cognitive function T-scores (green) and overlap (yellow) - corrected for multiple comparisons and adjusted for age, intracranial volume and scanner. Statistical images overlaid on MNI 152 T1. There were no voxelwise associations between language T-scores and grey matter volume.

A) Voxel-wise analyses depicting regions of fractional anisotropy significantly lower in the HIV-positive group vs. HIV-negative group (red), positively correlated with cognitive function T-scores (green) and overlap (yellow) - corrected for multiple comparisons and adjusted for age, intracranial volume and scanner. Statistical images overlaid on the mean fractional anisotropy image. There were no voxelwise associations between language or memory T-scores and FA.

Figure 4. K-means cluster analysis results by HIV-status.

A) Visualisation of the correlation matrices for the regions of cortical and subcortical grey matter volume (Harvard-Oxford atlas) and white matter fractional anisotropy (International Consortium of Brain Mapping DTI-81 white matter labels) used in the k-means clustering analysis for the HIV-positive and HIV-negative groups. The correlation coefficient is represented by the colour of the box (scale to the right of the figure).

B) Principle component plot showing the separation of the clusters based on the k-means clustering analysis of parcellated grey matter and mean fractional anisotropy data for the HIV-negative controls on the left (circles) and HIV-positive participants on the right (triangles). Cluster one (orange) had higher grey matter volume and higher fractional anisotropy for each region whereas cluster two (green) had lower grey matter volume and lower fractional anisotropy for each region. HIV-positive individuals were more likely to be members of the lower grey matter volume and lower fractional anisotropy cluster (odds ratio [95% confidence intervals]: 2.74 [1.53-4.98]).

Figure 5. K-means cluster analysis and cognitive function.

Jitterplot of cognitive domain T-scores grouped by k-means cluster analysis. Cluster one represents the cluster with higher total grey matter volume (GMV) and higher mean white matter skeleton fractional anisotropy (FA) in each region whereas cluster two represents the cluster with lower total grey matter volume and lower mean white matter skeleton fractional anisotropy in each region. Black lines represent medians for each cluster with p-values calculated using the Wilcoxon rank sum test.