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REPLACEDTHERAPEUTIC AND DIAGNOSTIC METHODS
USING TOTAL LEUKOCYTE SURFACE ANTIGENS

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1. INTRODUCTION

The present invention is directed to the
5 measurement of total leukocyte surface antigens, such
as T cell receptors and T cell differentiation
antigens or fragments thereof, and the application of
such measurements in the diagnosis and therapy of
diseases and disorders. The present invention is also
10 directed to the measurement of soluble leukocyte
antigens or fragments thereof, in conjunction with the
measurement of total leukocyte surface antigens and
the application of such dual measurements in the
diagnosis and therapy of diseases and disorders. The
15 measurement of such molecules, and preferably a
plurality of such molecules, can be used in monitoring
the effect of a therapeutic treatment, detecting
and/or diagnosing disease.

20

2. BACKGROUND OF THE INVENTION2.1. LEUKOCYTE SURFACE MOLECULES

Clusters of differentiation (CD) have been
established which define human leukocyte
differentiation antigens (Bernard and Boumsell, 1984,
25 Hum. Immunol. 11:1-10; Knapp et al., 1989, Immunol.
Today 10:253:258; Gebel et al., 1988, ASHI Quarterly
12:11; Leukocyte Typing III: White Cell
Differentiation Antigens. Ed., McMichael, A.J. 1987.
Oxford University Press. Oxford), by the comparison of
30 reactivities of monoclonal antibodies directed against
the differentiation antigens. The T cell surface
antigens, their classification into epitope-defined
subgroups, and their distributions on T cells have
35 been studied by use of monoclonal antibodies directed
against human T cells (Clark et al., 1983,

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Immunogenetics 18:599-615; Hansen et al., 1984, in
Leucocyte Typing, Bernard, A., et al., eds.,
Springer-Verlag, New York, pp. 195-212). Some of the
T cell clusters of differentiation and other cell
5 surface molecules are listed in Table I.

These cell surface markers serve as markers of
cell lineage, the identity of the functional T cell
subset to which the T cell belongs, and the activation
state of the T cell. Several of the cell surface
10 molecules have been studied in great detail, have been
found to be important in initiating and regulating
immune functions and are critical to communication
processes between immune cells.

15
TABLE I.
LEUKOCYTE SURFACE MOLECULES

20	Cell Surface Marker	Expression	Detection Monoclonal Antibodies	Refer- ences
	T cell Antigen Receptor	All T cells and T cell subsets	T40/25, α F1, β F1, δ TCS1, TCR δ 1, C γ M1	1,2,3, 4,5,6
25	CD1	Thymocytes & Langerhans Cells, Lukemia Cells	OKT6 NAI/34	
	NK cell receptor	NK cells	NC-37 specific antibodies	7
30	<u>Cell Adhesion Molecules</u>			
	CD2	All T cells	OKT11 Leu5 B67.1	8,9,10
	CD58 (LFA-3)	Leukocytes, epithelial	TS2/9	11
35	CD3	Pan T cell	OKT3 Leu4	12
	CD4	Helper/Inducer Subsets of T cells	OKT4 Leu3a	12

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	CD5	T.B subsets	UCHT2 T1	11
	CD7	T Cells	3A1	11
5	CD8	Supressor/ Cytotoxic Subsets of T cells	α Chain: OKT8 Leu2a β Chain: T8/2T8	13,14 14a
	<u>β2 integrins</u> LeuCAM	leukocyte cell adhesion molecules		11
10	CD11a (LFA-1)	myeloid, lymphoid		11,15
	CD11b (MAC-1 (CR3))	myeloid		11,15,1 6, 17,18,1 9
15	CD11c (CR4)	myeloid		11,15
	CD16 (FcR111)	Natural Killer, Macrophages Granulocytes	HUNK2 3G8	11
	CD21 (CR2)	B subset	B2 HB5	11,20
20	CD23 (FC ϵ R11)	B subset	MHM6 Blast-2	11
	CD25	TAC, IL-2 Receptor (Activated T Cells)	Anti-TAC 7G7/B6	21
25	CD30	Activated T, B Cells Reed-Steinberg Cells	Ki-1 HSR4	11
	CD35 (CR1)	Granulocytes, B cells, monocytes	YZ-1 J3D3	11,22
30	<u>β3 integrins</u> CD41 CD51			11,23 11,23
	<u>Homing Receptors</u> CD44	Leukocytes, brain	33-3B3	24
	Mel-14		GRHL1	25,26
35	<u>β1 integrins</u> D49a-f(VLA-1) VLA-2, VLA-3, VLA-4	Extra cellular Matrix (ECM)		27,23

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CD56 (NKH1,NCAM)	Natural Killer Activated lymphocytes	NKH1 Leu19	11
CD71	Transferring Receptor, Proliferating cells		11,28

List of References for Table I.

1. Brenner et al., 1984, J. Exp. Med. 160:541-551.
2. Henry et al., 1989, Hybridoma, 8:577.
3. Brenner et al., 1987, J. Immunol., 138:1502.
4. Wu et al., 1988, J. Immunol., 141:1476.
5. Band et al., 1987, Science 238:682.
6. Hochstenbach et al., 1988, J. Exp. Med. 168:761.
7. Evans, International patent publications #WO89/03394, #WO88/03395, & #WO88/03396 published April 20, 1989
8. Bierer et al., 1989, Annu. Rev. Immunol. 7:579-99.
9. Verbi et al., 1982, Eur. J. Immunol. 12:81-86.
10. Perussia et al., 1983, J. Immunol. 133:180.
11. Knapp et al., 1989, Immunol. Today 10:253.
12. Kung et al., 1979, Science 206:347-349.
13. Reinherz et al., 1979, Proc. Natl. Acad. Sci. USA 76:4061-4065.
14. Ledbetter et al., 1981, Monoclonal Antibodies and Tcell Hybridoma, Elsevier, North Holland, N.Y. pp 16-22.
- 14a. Shieu, L., et al., 1988, J. Exp. Med. 168(6):1993-2005.
15. Kishimoto et al., 1989, Adv. Immunol. 46:149-182.
16. Altieri & Edgington, 1988, J. Biol. Chem 263:7007-1
17. Wright et al., 1988, Proc. Natl. Acad. Sci. USA 85:7734-38.
18. Wright et al., 1989, J. Exp. Med. 169:175-83.
19. Russell & Wright, 1988, J. Exp. Med. 168:279-92.
20. Nemerow et al., 1985, J. Virol. 55:347-351.
21. Uchiyawa et al., 1981, J. Immunol. 126(4): 1393-1397.
22. Klickstein et al., J. Exp. Med. 165:1095-1112.
23. Hemler, 1990, Annu. Rev. Immunol. 8:365-400.
24. Berg et al., 1989, Immunol. Rev. 108:1-18.
25. Lasky et al., 1989, Cell 56:1045-55.
26. Haynes et al., 1989, Immunol. Today 10:423.

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27. Hynes, 1987, Cell 48:549.
28. Reinherz et al., 1980, Proc. Natl. Acad. Sci. USA, 77:1588-1592.

2.2. LEUKOCYTE SURFACE MOLECULE SPECIFIC ANTIBODIES

Over the last several years, antibodies to determinants of murine and human TCRs have been developed. Some of these antibodies appear to recognize all members of a V region family, some a subset of V regions within a family, and some a particular V region only (TABLE II). These TCR antibodies identify minor populations of peripheral blood T cells (1-5%) and subdivide T cells in a new way based on TCR V region usage.

TABLE II.

Name	Clone	Specificity	Immunogen	Reactivity	Ref ^a
β V5(a)	1C1	V β 5.2 and V β 5.3 Subfamilies	HPB	1-5% of PBL	1
β V5(b)	W112	V β 5.3 Subfamily subset of β V5(a)	HPB	0-3% of PBL	2
β V8(a)	16G8	V β 8 family	JURKAT	1-5% of PBL	2
β V12(a)	S511	V β 12 family	SEZARY	1-5% of PBL	3
β V6(a)	OT145	V β 6 family Allotypic V β 6.7 epitope	T-CLL	0-5% of PBL	4
α V2(a)	F1	V α 2 Subfamily	T-CLL	1-5% of PBL	5
$\alpha\beta$ V(a)	LC4	V β 5.1 Subfamily	SUP-T13	1-5% of PBL	6

List of References for Table II

- Boylston et al., 1986, J. Immunol. 137:741-744.
- Tian et al., 1989, FASEB J. 3:A486 Abstr.

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3. Bigler et al., 1983, J. Exp. Med. 158:1000-1005.
4. Posnett et al., 1986, Proc. Natl. Acad. Sci. U.S.A. 83:7888-7892.
5. Janson et al., 1989, Canc. Immunol. Immunother. 28:225-232.
- 5 6. Maecker & Levy, 1989, 1989 J. Immunol. 142:1395-1404.

These reagents have proven valuable in studying the repertoire of TCRs expressed under many in vivo and in vitro conditions. For example, in vitro stimulation of mononuclear cells with certain bacterial enterotoxins (superantigens) leads to the expansion of T cells expressing a limited number of TCR V β families (Kappler et al., 1989, Science 244:811-813). In vivo expansion of T cells bearing particular V β regions has been detected in certain animal models of autoimmune diseases.

Other antibodies recognize common determinants on all $\alpha\beta$ or $\gamma\delta$ TCRs. These include C γ M1, a monoclonal antibody which has been shown to specifically recognize the TCR- γ protein (Hochstenbach et al., 1988, J. Exp. Med. 168:761). This monoclonal antibody was generated against a constant-region encoded peptide and reacts with both C γ 1 and C γ 2 encoded TCR- γ chains. It appears to possess framework reactivity against all TCR- γ polypeptides.

TCR δ 1 (Band et al., 1987, Science 238:682) and δ TCS1 (Wu et al., 1988, J. Immunol. 141:1476) are monoclonal antibodies specific for the δ chain of the human $\gamma\delta$ TCR. Unlike clone specific or idiotypic anti-TCR antibodies, TCR δ 1 appears to identify all T cells which express the $\gamma\delta$ TCR. δ TCS1 identifies a minor subset of these $\gamma\delta$ T cells.

Additional monoclonal antibodies to the T cell receptor gamma and delta chains have also been



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reported (European Patent Publication #EP289252
Published November 2, 1988; International Patent
Publication #W088/00209 published January 14, 1988).

β FI (Brenner et al., 1987, J. Immunol.

5 138:1502-1509) is a murine monoclonal antibody
specific for a framework, i.e., common or
nonpolymorphic determinant on the β chain of the $\alpha\beta$
TCR and identifies all T cells expressing the $\alpha\beta$ TCR.
 α F1 (Henry et al., 1989, Hybridoma 8:577) is a
10 monoclonal antibody specific for a framework
determinant of the α chain and identifies all T cells
expressing the $\alpha\beta$ TCR.

Antibodies to CD4 have been widely described
15 (Kung, P.C., et al., 1979, Science 206:347-349) and
are commercially available. A series of such
antibodies reacting with non-competing epitopes on
the CD4 molecule have been described. Such a set has
been termed OKT4, OKT4A, OKT4B, OKT4C, OKT4D, OKT4E,
20 and OKT4F (Rao, P.E., et al., 1983, Cell. Immunol.
80:310).

Antibodies directed against the CD4 or CD8
antigens have been shown to block cell function.
Antibodies against CD4 block most helper T functions,
25 mixed lymphocyte reactions and induction of T helper
activity (Biddison et al., 1984, J. Exp. Med.
159:783). Antibodies against CD8 block the cytotoxic
activity of CD8 positive cytotoxic T lymphocytes
(Swain, S.L., 1981, Proc. Natl. Acad. Sci. U.S.A.
30 78:7101-7105). Antibodies against CD4 have also been
described that are capable of activating CD4-positive
T cells. CD4 is internalized upon treatment of the
cells with phorbol esters and resulting
phosphorylation (Hoxie, J.A., et al., 1986, J.
35 Immunol. 137:1194-1201).

Antibodies to CD35 (Wong et al., 1985, J.
Immunol. Methods 82:303; Yoon & Fearon, 1985,

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134:3332; Schrieber, US Patent # 4,672,044 issued June 9, 1987) have also been reported.

2.3. CLINICAL APPLICATIONS

5 These various lymphocyte cell surface markers
have enormous clinical application potentials for the
identification of lymphocyte populations and their
functional status (Krensky, A.M. and Clayberger, C.,
1985, Transplant. 39 (4):339-348; Kung, P.C., et
10 al., 1984, Monoclonal Antibodies in Clinical
Investigations, Clinical Biochemistry-Contemporary
Theories and Techniques, Vol. 3, Academic Press, pp.
89-115; Kung, P.C., et al., 1983, Int. J. Dermatol.
22(2):67-733; Cosimi et al., 1981, N. Engl. J. of
15 Med. 305:308; Knowles et al., 1983, Diagnostic
Immunol. 1:142; Hoffman, 1984, Amer. Biotechnol. Lab
2:39).

Existing clinical methods of T cell typing
involve the use of monoclonal antibodies which define
20 T cell surface markers to detect the presence of
specific cell surface markers on the T cell surface.
Measuring the total numbers of T cells expressing a
marker on the surface or membrane has been useful for
the characterization and classification of lymphoid
25 malignancies (Greaves, M., et al., 1981, Int. J.
Immunopharmac. 3(3):283-300). Changes in the
relative percentage of T helper and T
suppressor/cytotoxic cells were found to be
associated with immune events in renal
30 transplantation due to viral infection (Colvin, R.B.,
et al., 1981, Proc. 8th Int. Congr. Nephrol., Athens,
pp. 990-996), autoimmune diseases (Veys, E.M., et
al., 1981, Int. J. Immunopharmac. 3(3):313-319), and
AIDS (Gupta, S., 1986, Clin. Immunol. Immunopathol.
35 38:93-100; Ebert, E.C., et al., 1985, Clin. Immunol.
Immunopathol. 37:283-297).

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The expression of T cell surface markers has also been used for the assessment of the immune status of patients. It has been established that by measuring the relative number of distinct, functional T cell subsets, and/or the relative number of activated T cells in peripheral blood or tissues, an assessment of the immunological condition of a patient is possible.

In an HIV-infected individual, the most useful single prognostic indicator for progression to overt AIDS is the absolute number of CD4⁺ T cells/mm³ of whole blood. Currently, accurate measurement of CD4⁺ T cells requires the use of a flow cytometer, both costly and not widely available. In addition, federal guidelines define eligibility for AZT administration to AIDS infected individuals solely on the basis of the CD4⁺ T cell count (a T cell count which drops below 500 CD4⁺ T cells/mm³) regardless of symptomology. The cell count cut off for pentamidine treatment is 200 cells/mm³. However, the costly and largely unavailable flow cytometer leaves a large population of clinicians and patients without the means of proper immune status evaluation and therefore AZT treatment.

If the CD4⁺ T cell count drops below 500 cells/mm³ (AZT treatment) or below 200 cells/mm³ (pentamidine treatment) (Cowley et al, June 25, 1990, Newsweek, pp. 23-27; Mills & Masur, August, 1990, Scientific American, pp. 50-57; Fahey et al., 1990, New Engl. J. Med. 322:166-72; Goedert et al., 1989, New Engl. J. Med. 321:1141-8), then the patient is indicated for therapeutic intervention.

The measurement of CD4 positive or CD8 positive T cells may be used to detect or diagnose disease, or monitor disease treatment as described in patents and publications US 4,709,015, US 4,725,543,

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US 4,361,550, US 4,908,203, WO91/10722, WO89/08143,
WO91/07985, EP 421,380, WO91/09966, WO91/03493,
EP 403,935, WO88/04327, US 4,695,459, and
US 4,649,106.

5

2.4. METHODS OF MEASURING LEUKOCYTE SURFACE MOLECULES IN A SAMPLE

The methods for detecting, staging or diagnosing
a disease, or monitoring the progress of therapy of a
disease discussed above require separation of the
10 components of a sample.

For example, methods of diagnosis or monitoring
of a patient with a disease may depend on detection
of the amount of a soluble leukocyte antigen, and
15 comparison of the amount of soluble leukocyte antigen
in the sample from a patient to the amount in a
sample from a normal individual or in the same
individual at an earlier time. See, e.g.,
publications WO 87/05912, and WO 90/04180. However,
20 the assay sample must be isolated from cells and
cellular debris, which is time consuming.

Prior to the instant invention, measurement of
the amount of leukocytes positive for a leukocyte
marker was carried out by direct analysis of cells.
25 To date, investigators have primarily measured the
amount of cell surface markers in enriched cell
populations derived from whole blood. This involved
separating whole blood into its serum (or plasma) and
cell constituents followed by enrichment of the
30 desired cells by procedures such as those involving
the lysis of red blood cells and subsequent isolation
of white blood cells on density gradients of
polymers, such as Ficoll-Hypaque. The enriched cell
populations can then be analyzed either by direct or
35 indirect immunofluorescence involving flow cytometers
or fluorescent microscopes, or alternatively lysed
with appropriate buffers followed by analysis of



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either the total lysate or membrane and cytosolic components individually. Limitations of these procedures include (1) the requirement for fresh samples, (2) the need to use enriched cell
5 populations rather than whole blood, (3) the requirements of expensive equipment, (4) the time involved in preparing the samples and (5) the need for fairly large sample sizes or cell numbers for analysis, since cells are lost during the sample
10 preparation steps and because flow cytometric analyses require that a statistically significant number of cells be analyzed for reliable measurements to be obtained. In diseases where the cells of interest are steadily declining, (for example, the
15 decrease in the number of CD4 cells during HIV infection and progression to AIDS) larger sample volumes must be used in order to obtain a significant number of cells to analyze in the enriched cell population.

20

3. SUMMARY OF THE INVENTION

The present invention overcomes the deficiencies of the prior methods of detecting leukocyte antigens and of estimating the number of cells positive for a
25 particular leukocyte marker by providing a reliable, quantitative, easy-to-use method to measure total amount of a leukocyte marker in a sample containing cells in the biological fluid in which the cells are obtained. Alternately, the sample can contain just
30 cells.

Surprisingly, it has been discovered that treatment of cells in a sample with concentrated detergent followed by dilution of the sample
solubilizes the total amount of leukocyte markers in
35 the sample. Thus, the method for determining the total amount of a leukocyte marker in a sample comprises adding a concentrated non-ionic detergent

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solution to the sample to form a detergent-treated sample, and allowing the detergent to lyse the cells, and/or disrupt membranes. Having released any intracellular and/or membrane bound marker in this manner, the total amount (i.e., inclusive of marker so released as well as any soluble marker that may be present originally in the sample) of leukocyte marker in the sample can be detected. After the cells have been lysed, the sample is diluted to reduce the detergent concentration. Detection of the amount of leukocyte marker in the sample is by immunological detection means, e.g., immunoassay.

Remarkably, measurements of total leukocyte markers can be used to determine the approximate number of leukocytes positive for the leukocyte marker, in a sample i.e., measurement of total leukocyte marker can be used to enumerate cells expressing that antigen with an appropriate correlation. Even more remarkable is the linearity of the correlation between the measurements obtained according to the method of the invention and cell counts achieved by conventional means. Hence, the instant invention represents a highly advantageous substitute for the more cumbersome methods of the prior art.

Measurements of total leukocyte markers are useful in monitoring the effectiveness of a treatment of a subject, in predicting therapeutic outcome or disease prognosis, and in evaluating and monitoring the immune status of patients. Measurements of total leukocyte markers can be accomplished by sandwich enzyme immunoassays where the samples are treated so that the total amount of a leukocyte marker present in membrane, intracytoplasmic and soluble compartments can be measured.

In particular embodiments, the invention is directed to the measurement of amounts of total CD4

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antigen. Total CD4 antigen measurements are particularly useful in diseases where the absolute number of CD4⁺ cells is the best indicator of disease prognosis or treatment outcome. Such diseases
5 include, but are not limited to, AIDS.

In another embodiment, the invention directed to the measurement of the total amount of CD8 antigen. Total CD8 antigen measurements are especially useful in diseases associated with modulation of the CD8⁺
10 subset of leukocytes. These include but are not limited to infectious disease, autoimmune disease, and transplantation rejection illness.

In yet another embodiment, the invention is directed to the measurement of the total amount of T
15 cell antigen receptor (TCR) present in a sample. Total TCR measurements can include the measurement of total TCR on all cells expressing any $\alpha\beta$ or $\gamma\delta$ TCR or can include the measurement of total TCR on
20 particular subsets of cells including, but not limited to, subsets expressing specific $V\alpha$, $V\beta$, $V\gamma$ and/or $V\delta$ peptides.

In a further embodiment, the invention is directed to the measurement of both the amount of
25 total leukocyte marker and the amount of the same soluble leukocyte marker and a comparison of the measured levels. The change in the total levels and soluble levels relative to one another during disease progression or disease treatment can be superior to
30 the measurement of either total or soluble levels alone. Such measurements are useful for the detection, diagnosis or monitoring of treatment of a disease or disorder.

In another embodiment, the invention provides for
35 the measurement of the total amount of two or more leukocyte markers, and comparison of the amounts of the markers. The relative amounts of the markers, or

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time dependent variation in the relative amounts of the markers during disease progression, can be used to detect, diagnose, or monitor treatment or progress of a disease or disorder. Significantly, the measurement of total leukocyte markers can be used to estimate the number of cells positive for each marker. The ratios of total leukocyte marker or approximate numbers of cells positive for each leukocyte marker can be compared with the same ratios in a normal individual, and this comparison used to detect, diagnose, or stage a disease or monitor treatment of a disease or disorder.

Simultaneous measurement of the total amount of a marker is an improvement over separately measuring the cell bound, cell lysate or soluble marker for the following reasons. Firstly, the measurement can include the total amount of markers present in all three compartments, not just the amounts present in one or two compartments. Secondly, the measurement of total markers is easier than other procedures that involve greater sample preparation, complex equipment and more steps. Thirdly, small quantities of sample, e.g., 100 μ l, and as little as 5-10 μ l of whole blood, can be directly analyzed in a simple immunoassay format without prior enrichment of the samples. The small volume of whole blood necessary has major benefits in pediatric applications with infants and small children. This represents a significant cost reduction per sample analyzed, and the elimination of an expensive equipment requirement, thereby making the analysis widely available to many laboratories or clinics. Fourthly, the measurement of total marker is an improvement, since it involves minimum sample preparation and does not create aerosols that are hazardous in the case of infectious samples from patients. Most important, for infectious samples such as those containing HIV,

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the solubilization procedure, i.e., treatment with concentrated detergent, inactivates the virus, thereby making subsequent analysis safer. Fifthly, the total marker assay does not require fresh
5 samples. Each patient sample can be treated and stored frozen. This is especially useful for a series of samples obtained from the same patient over a period of time as in a longitudinal study. Each sample can quickly be treated and frozen so that all
10 samples can be thawed and analyzed simultaneously. This is a definite improvement over flow cytometric analysis where the cells need to be fresh and intact. It also eliminates variance obtained in assay results that arise from interassay variability, since all of
15 the assays may be performed at one time.

3.1. DEFINITIONS

As used herein, the following terms will have the meanings indicated:

20	Total Leukocyte Marker	= the total amount of a leukocyte antigen or fragment thereof (including membrane-associated, intra- and extracellular) present in a sample.
25	WBCC	= White blood cell count
	AZT	= azido-deoxthymidine
30	HTLV III/LAV/HIV	= Human T cell Leukemia Virus Type I/Lymphadenopathy Associated Virus/Human Immunodeficiency Virus
	OPD	= O-phenylenediamine
35	mAb	= monoclonal antibody
	Spontaneous release	= release by normal or pathologic physiological processes of the cell

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AIDS = Acquired immunodeficiency
disease syndrome

TCAR = T cell antigen receptor

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4. DESCRIPTION OF THE FIGURES

FIG. 1. The measurement of total CD4 antigen in whole blood according to the method of the invention using a CELLFREE[®] CD4 assay (see Section 5.1, supra). The three curves represent the detection of total CD4
10 (O.D. 490) from the blood of three normal individuals.

FIG. 2. The correlation between total CD4 antigen as measured in a CD4 immunoassay according to the method of invention and the total number of CD4
15 positive cells/mm³ of blood. Total CD4 (O.D. 490) was measured from 2.5 μ l of whole blood from five different normal individuals using a CELLFREE[®] CD4 assay. The number of CD4 positive cells/mm³ was
20 measured in the blood samples three days after determination of total CD4 antigen from the samples. Thus, the number of total CD4⁺ cells/mm³ of blood appear lower than expected for normal individuals. However, the curve obtained shows a linear
25 relationship between total CD4 antigen and the number of CD4⁺ cells.

FIG. 3. The correlation between total CD4 antigen measured from whole blood of HIV-infected individuals and one normal control and total CD4⁺
30 cells/mm³ of blood. HIV-infected individuals are represented by a single square and the normals by the double square.

FIG. 4. The correlation between total CD4 antigen measured from whole blood of HIV-infected
35 individuals and normal controls and total CD4⁺ cells/mm³ of blood. HIV-infected individuals are

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represented by a single square and the normal by the double squares.

FIG. 5. Total CD4 antigen method standard curve.

FIG. 6. Comparison of the ability to enumerate
5 CD4 positive cells by the total CD4 antigen method
and by flow cytometry in 95 normal and disease
samples.

FIG. 7. Comparison of the ability to enumerate
CD8 positive cells by the total CD8 antigen method
10 and by flow cytometry in 86 normal and disease
samples.

FIG. 8. Cell associated CD8 (total CD8 antigen
minus soluble CD8 antigen) in whole blood of 30
normal and 11 cancer patients.

15 FIG. 9. Total T cell antigen receptor β chain
antigen in whole blood of a normal healthy donor.

FIG. 10. Total T cell antigen receptor V δ 1 chain
antigen and immunoassay standard curve.

20 5. DETAILED DESCRIPTION OF THE INVENTION

The present invention is directed to the
measurement of total leukocyte surface antigens,
total T cell differentiation antigens, or related
total markers or fragments thereof, and the use of
25 such measurements in the diagnosis and therapy of
diseases and disorders.

The measurement of total markers according to the
invention is valuable in cell enumeration, cell
typing, monitoring the effect of a therapeutic
30 treatment on a subject, detecting and/or diagnosing a
disease in a subject, in predicting therapeutic
outcome or disease prognosis and in evaluating and
monitoring immune status of patients. A plurality of
total markers can be measured, such as total CD4
35 antigen and total CD8 antigen. In a preferred
embodiment in relation to AIDS, assays are configured



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such that total CD4 and total CD8 antigens can be measured simultaneously.

As used herein, the term "total" shall mean the total amount of the marker present in the sample.

5 For example, in a particular sample such as a sample that comprises whole blood, the total marker includes the amount of marker present in the cell membrane, intracytoplasmic and soluble serum compartments. The soluble compartment can include both spontaneously
10 released soluble marker as well as soluble recombinant markers that may have been administered as a therapeutic treatment. In another sample, such as in a sample that comprises cells in tissue culture, the total marker includes the amount of
15 marker present in the membrane, intracytoplasmic and cell culture media compartments of the sample. In yet another embodiment in which the sample comprises a tissue, e.g., a biopsy specimen, the total marker includes the amount of marker present in the
20 membrane, intracytoplasmic and interstitial compartments.

As used herein, the term "compartment" modified by membrane, intracytoplasmic, and soluble elements of a sample refers to the total amount of all
25 membrane, the total amount of intracytoplasmic contents, and the total amount of soluble material included in the sample.

As used herein, the term "leukocyte marker" refers to an antigen or polypeptide found on the cell
30 surface of a leukocyte. Such markers include but are not limited to cell surface antigens, CD (clusters of differentiation) antigens, receptors, or other cell surface polypeptides or proteins. The term leukocyte marker is further intended to include an
35 immunologically active fragment, e.g., an epitope, of the foregoing molecules. The leukocyte markers for detection according to the present invention, and the



particular cells known to express these markers, are summarized in Table I in Section 2.1, supra. In specific embodiments, the leukocyte marker can be CD4, CD8 or T cell antigen receptor (TCAR).

5 As used herein, the term "leukocyte" refers to the usual meaning of that terms, i.e., immune associated cells derived from hematopoietic stem cells, such as lymphocytes (B cells and T cells) and myeloid lineage cells (neutrophils, macrophages,
10 eosinophils, megakaryocytes, erythrocytes, mast cells).

As used herein, a "sample" refers to a collection of cells in the milieu in which they were obtained, i.e., a biological fluid, or to membrane and/or
15 intracytoplasmic components of the cells. Total leukocyte antigens may be measured in samples derived from a biological fluid, e.g., whole blood, plasma, serum, blood cells, saliva, urine, synovial fluid, pleural effusions, tumor and tissue infiltrates,
20 amniotic fluid, spinal fluid or cranial fluid. In another embodiment, the biological fluid may be cell culture fluid. The sample can comprise tissue, including interstitial fluid. Preferably when the sample is a tissue sample, the tissue is treated to
25 disrupt the connective tissue matrix, e.g., by trypsin digestion or homogenization. In another embodiment, the sample comprises cells derived from the foregoing sources.

30 5.1. DETECTION AND MEASUREMENT OF TOTAL LEUKOCYTE MARKER

The total amount of a leukocyte marker exists in three compartments: the membrane, intracytoplasmic and released/soluble compartments ("total leukocyte
35 marker"). The invention includes immunoassays that simultaneously measure the total amount of a leukocyte marker present in all three compartments or



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in the membrane and/or intracytoplasmic compartment, depending upon how the sample is prepared.

To determine the total amount of a leukocyte marker, an "original" sample, such as whole blood or blood cells, is first treated to solubilize the cellular components (step 1). The preferred method of solubilizing the cells in the sample without interfering with immunospecific binding is to treat the cells with a concentrated non-ionic detergent or detergents to lyse the cells efficiently, thus forming a "detergent-treated" sample. After the cells have been lysed the detergent-treated sample is diluted prior to assay.

Non-ionic detergents for use in present invention include but are not limited to Triton X-100, Nonidet P-40 (NP-40), Tween-20, CHAPS, to mention a few. In a preferred embodiment, cells are solubilized with Triton X-100, Nonidet P-40, Tween-20 and/or CHAPS. In a more preferred embodiment, cells are solubilized with concentrated detergent to give a final detergent concentration of about 2% to about 4% in the detergent-treated sample.

According to the invention, the total volume of non-ionic detergent added to the sample should not dilute out any leukocyte marker in the sample. Preferably, the volume of detergent does not exceed about 25% of the sample volume; more preferably, it does not exceed about 20%. The non-ionic detergent or detergents can be added to the original sample neat, or they can be prepared in a concentrated solution. In addition to the non-ionic detergent or detergents, the concentrated detergent solution can comprise distilled water or buffer. The concentration of non-ionic detergent or detergents in the solution will preferably be 5 times, and more preferably 6 times the final concentration of the

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non-ionic detergent or detergents after addition to the sample, i.e., in the detergent-treated sample.

In an even more preferred embodiment, more than one non-ionic detergent is used to lyse the cells.

5 For example, a high concentration of Tween-20 and Triton X-100, or Triton X-100 and NP-40, or NP-40 and Tween-20 can be used. The concentration of each detergent ranges from about 1% to about 2% after addition to the sample; the total concentration of
10 detergent in the detergent-treated sample ranges from about 2% to about 4%. More preferably the total detergent concentration ranges from about 2% to about 3%; and even more preferably from about 2% to about 2.5%. In a specific embodiment, the final detergent
15 concentration in the sample is 1.5% Triton X-100 and 1% NP-40. This is concentration preferred if both CD4 and CD8 are to be assayed.

In another embodiment, the detergent concentration is a concentration that inactivates
20 virus, especially HIV. It is a particular advantage of the invention that the lytic concentration of non-ionic detergent, such as the preferred ranges set forth above, is also a virus-inactivating concentration.

25 Other methods of solubilizing cells, e.g., repeated freeze-thaw cycles, sonication, hypotony, or the addition of lower concentrations of detergents, are not as effective. Ionic detergents such as SDS are not effective, since SDS interferes with the
30 subsequent antibody-antigen binding.

After solubilization for at least about one minute, preferably for about one to about five minutes, the sample is diluted with buffer (step 2)
35 prior to analysis in an immunoassay. The dilution can be 2-fold; preferably it is 5-fold or greater. The buffer is chosen to be compatible with the immunoassay for detecting the leukocyte antigen.



Buffers preferred for various immunoassays are well known in the art. In a specific embodiment, sample buffer is 1% bovine serum albumin, 0.25% NP-40 and 0.01% thimerosal in phosphate buffered saline (PBS).

- 5 The present method is not limited by the amount of sample available. In one embodiment, about 100 μ l of a detergent-treated sample of whole blood may be assayed for total leukocyte antigen. In a more preferred embodiment, about 2.5 to about 25 μ l of a
10 detergent-treated sample of whole blood may be used. Similar amounts of a sample of culture suspension, pleural effusion, or other biological fluid can be used. The actual amount of sample assayed can be varied by adjusting the dilution factor.
- 15 Determination of specific parameters can be accomplished by a simple dilution series assay, and is well within the level of ordinary skill in the art.

- 20 Furthermore, a solubilized sample may be stored frozen so that samples taken at different times may be assayed in a single experiment. In one embodiment, the sample is stored at about -20°C. In a preferred embodiment, the sample is stored at about -70°C.

- 25 Any method of detecting and measuring leukocyte antigens may be used in the practice of this invention. Such methods include but are not limited to competitive and non-competitive assay systems using techniques such as radioimmunoassays, ELISA
30 (enzyme linked immunosorbent assay), "sandwich" immunoassays, immunoradiometric assays, fluorescent immunoassays, and protein A immunoassays, to name but a few. U.S. Patents Nos. 4,845,026, issued July 4, 1989, entitled "Assay Systems for Detecting Cell-Free
35 T Cell Antigen Receptor Related Molecules and Clinical Utilities of the Assays" and No. 5,006,459, issued April 9, 1991, entitled "Therapeutic and



Diagnostic Methods Using Soluble T Cell Surface Molecules" teach preferred methods of immunoassay. Their teachings are incorporated herein by reference.

In a preferred embodiment, a sandwich enzyme immunoassay can be used. One description of such an embodiment follows: An antibody (capture antibody, Ab1) directed against the leukocyte marker is adsorbed onto a solid substratum. The leukocyte marker present in the sample binds to the antibody, and unreacted sample components are removed by washing. An enzyme-conjugated antibody (detection antibody, Ab2) directed against a second epitope of the leukocyte marker binds to the antigen captured by mAb1 and completes the sandwich. After removal of unbound Ab2 by washing, a substrate solution is added to the wells. A colored product is formed in proportion to the amount of antigens present in the sample. The reaction is terminated by addition of stop solution and absorbance is measured with a spectrophotometer. A standard curve can be prepared from known concentrations of the leukocyte marker, from which unknown sample values can be determined.

In a preferred embodiment for the measurement of total CD8 antigen levels, anti-CD8 mAbs 4C9 and 5F4 can be used as the capture and detection antibodies, respectively, in a sandwich enzyme immunoassay; in a more preferred embodiment, a CELLFREE® CD8 assay (T Cell Sciences, Inc., Cambridge, MA) can be used (described in U.S. Patent 5,006,459; see Section 8, infra). In a preferred embodiment for the measurement of total CD4 antigen levels, anti-CD4 mAbs 8F4 and R2B7 can be used as the capture and detection reagents, respectively, in a sandwich enzyme immunoassay; in a more preferred embodiment, a CELLFREE® CD4 assay (T Cell Sciences, Inc., Cambridge, MA) can be used (described in International Patent Publication WO 90/04180; see



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Sections 6 and 7, infra). In a preferred embodiment for the measurement of total V δ 1 antigen levels, anti-TCR δ mAbs TCR δ 1 and δ TCS1 can be used in a sandwich enzyme immunoassay (see Section 9, infra).

- 5 In a preferred embodiment for the measurement of total β TCR antigen levels, anti- β TCR mAbs β F1 and W4 can be used in a sandwich enzyme immunoassay (see Section 10, infra). The foregoing antibodies have been deposited with the ATCC, as described in Section 10, infra.

- Various procedures known in the art may be used for the production of antibodies to leukocyte marker. Such antibodies include but are not limited to polyclonal, monoclonal, chimeric, single chain, Fab
15 fragments and an Fab expression library. For the production of antibodies, various host animals, including but not limited to rabbits, mice, rats, etc., may be immunized by injection with a leukocyte marker. In one embodiment, leukocyte marker may be
20 conjugated to an immunogenic carrier. In another embodiment, leukocyte marker epitope, e.g., a hapten, is conjugated to a carrier. As used herein, an "epitope" is a fragment of an antigen capable of specific immunoactivity, e.g., antibody binding.
25 Various adjuvants may be used to increase the immunological response, depending on the host species, including but not limited to Freund's (complete and incomplete), mineral gels such as aluminum hydroxide, surface active substances such as
30 lysolecithin, pluronic polyols, polyanions, peptides, oil emulsions, keyhole limpet hemocyanin, dinitrophenol, and potentially useful human adjuvants such as BCG (bacille Calmette-Guerin) and
35 Corynebacterium parvum.

Monoclonal antibodies to leukocyte marker may be prepared by using any technique which provides for

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the production of antibody molecules by continuous cell lines in culture. These include but are not limited to the hybridoma technique originally described by Kohler and Milstein, (1975, Nature 256: 495-497), the more recent human B-cell hybridoma technique (Kosbor et al., 1983, Immunology Today 4:72) and the EBV-hybridoma technique (Cole et al., 1985, Monoclonal Antibodies and Cancer Therapy, Alan R. Liss, Inc., pp. 77-96). In an additional embodiment of the invention, monoclonal antibodies specific for leukocyte marker may be produced in germ-free animals utilizing recent technology (PCT/US90/02545). According to the invention, human antibodies may be used and can be obtained by using human hybridomas (Cote et al., 1983, Proc. Nat'l. Acad. Sci., U.S.A. 80:2026-2030) or by transforming human B cells with EBV virus in vitro (Cole et al., 1985, in Monoclonal Antibodies and Cancer Therapy, Alan R. Liss, pp. 77-96). In fact, according to the invention, techniques developed for the production of "chimeric antibodies" (Morrison et al., 1984, Proc. Nat'l. Acad. Sci. U.S.A. 81:6851-6855; Neuberger et al., 1984, Nature 312:604-608; Takeda et al., 1985, Nature 314:452-454) by splicing the genes from a mouse antibody molecule specific for leukocyte marker together with genes from a human antibody molecule of appropriate biological activity can be used; such antibodies are within the scope of this invention.

According to the invention, techniques described for the production of single chain antibodies (U.S. Patent 4,946,778) can be adapted to produce a leukocyte marker-specific single chain antibody. An additional embodiment of the invention utilizes the techniques described for the construction of Fab expression libraries (Huse et al., 1989, Science 246:1275-1281) to allow rapid and easy identification

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of monoclonal Fab fragments with the desired specificity for leukocyte marker.

Antibody fragments which contain sites specific for leukocyte marker may be generated by known techniques. For example, such fragments include but are not limited to: the $F(ab')_2$ fragments which can be produced by pepsin digestion of the antibody molecule and the Fab fragments which can be generated by reducing the disulfide bridges of the $F(ab')_2$ fragments.

The above-described method can also be used to assay any total leukocyte surface marker, e.g., the markers described in Sections 2.1 supra. For example, and not by way of limitation, total CD4, total CD8, or total TCR may be measured in the practice of this invention. In another embodiment, a plurality of two or more total leukocyte surface molecules or markers can be measured. In yet a further embodiments, the relative amount of one marker can be compared to another.

5.2. ENUMERATION OF LEUKOCYTES POSITIVE FOR A MARKER

The measurement of a total leukocyte marker according to the invention provides a method to enumerate the number of leukocytes that are positive for the leukocyte marker in a sample. In another embodiment, the activity of a leukocyte marker in an assay can be compared to the activity of a standard that comprises a known number of cells positive for the leukocyte marker.

This aspect of the invention is based on the discovery that the total leukocyte marker level in a sample, which is proportioned to the activity of the leukocyte mark in an assay for the leukocyte marker, correlates directly with the number of cells positive for that marker. As shown in an Example, infra



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(Section 7), the correlation between the number of CD4+ cells determined according to the present invention and the number of cells determined by fluorescence-activated cell sorting (FACS) has a correlation coefficient of 0.946, which indicates that enumeration of a leukocyte marker-positive cell by the total leukocyte marker method of the invention can be as reliable as enumeration by flow cytometry. Furthermore, as pointed out in the Summary of the Invention, supra, the present methods do not require complicated sample preparation, careful storage conditions, or expensive analytical equipment.

In another embodiment, the amount of leukocyte marker in the membrane and/or intracytoplasmic compartments of a sample, i.e., not including soluble leukocyte marker, correlates with the number of cells in the sample. As shown in an Example, Section 8 infra, the correlation between the number of cells positive for a leukocyte marker and the amount of leukocyte marker in the membrane and intracytoplasmic compartments is good.

According to the present invention, the number of cells positive for a leukocyte marker in a sample can be determined by (1) determining the total amount of leukocyte marker in a sample, and (2) calculating the total number of cells positive for the leukocyte marker from the total amount of leukocyte marker. In one embodiment, the calculation can be made by extrapolating from a standard curve of total leukocyte marker versus total number of cells positive for the leukocyte marker. In another embodiment, a formula can be derived from a standard curve, and the total amount of leukocyte marker plugged into the formula. In yet another embodiment, only the activity of the assay for a total leukocyte marker is used to calculate the total number of cells positive for the marker. In this embodiment, the

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total amount of leukocyte marker is reflected in the relative activity in the detection assay. The method of calculating a total number of cells, e.g., extrapolation or a formula, remains the same.

5 The present invention provides simple, straightforward methods to calculate a standard. In one embodiment, the total amount of leukocyte marker relates to the total number of cells positive for the marker. In a more preferred embodiment, a linear
10 regression analysis of the total leukocyte marker to total cell number positive for the marker is performed. The linear regression analysis can yield a straight line curve, an estimate of error, and a formula for calculating total cell number from total
15 leukocyte marker amount.

In another embodiment, the activity of the leukocyte marker in the detergent-treated sample can be detected by immunological detection means and compared with an assay of a known amount of leukocyte
20 marker in a standard sample, and the number of cells positive for the leukocyte marker determined from the comparison. In a more preferred embodiment, the activity in an assay of the leukocyte marker in the detergent-treated sample can be compared with the
25 activity in an assay of the leukocyte marker in a standard containing a known number of cells positive for the marker, and the number of cells positive for the leukocyte marker in the sample determined from the comparison.

30 In another embodiment, the correlation of total leukocyte marker with cell number positive for that marker can be corrected for an excess amount of leukocyte marker in the soluble or total compartment. The amount of soluble leukocyte marker can be assayed
35 by the same immunological detection means, e.g., using the same immunoassay. The amount of soluble marker can be subtracted from the amount of total



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marker. The corrected cell-associated leukocyte marker value can correlate more accurately with the cell count. In a specific embodiment, the total number of CD8⁺ cells correlates with the total amount
5 of CD8 minus soluble CD8 (see Section 8, *infra*).

In preparing a standard, total cell number can be independently determined by any means known in the art, e.g., FACS, immunofluorescence microscopy, and complement lysis assays, to mention a few. In a
10 preferred embodiment, the independent total cell number is obtained by FACS.

A total CD4 assay may be used to estimate the number of CD4⁺ T cells in a patient sample. The estimate of the number of CD4⁺ T cells in a sample
15 can be used for diagnosis or monitoring of a therapeutic treatment, e.g., for AIDS patients.

In a preferred embodiment, CD8⁺ cells can be enumerated by measuring the total amount of CD8 antigen in the sample and subtracting the amount of
20 soluble CD8 antigen in the same sample. Such an analysis yields information on both the immune system activation and the CD8⁺ cell count.

In yet a further embodiment the total number of T cells positive for $\alpha\beta$ or $\gamma\delta$ TCAR can be determined.
25 Similarly, the total number of T cells positive for subsets of $V\alpha$, $V\beta$, $V\gamma$ or $V\delta$ can be determined. Thus, whole blood samples can now be analyzed quickly, safely and reliably for the number of specific subsets of T cells.

30

5.3. KITS

The reagents necessary for the practice of the present invention can be conveniently provided in a
35 kit. The essential elements of a kit of the invention are a concentrated non-ionic detergent solution and a means for immunologically detecting the presence of an antigen.

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The kit can comprise any immunological detection means known in the art, e.g., those discussed in Section 5.1., supra. Preferably the immunological detection means are a first capture antibody specific
5 for a leukocyte marker, and a second detectable antibody specific for the leukocyte marker. The first antibody can be provided on a solid support, such as a glass or plastic bead, membrane, a plastic stick, a microwell, a glass or plastic test tube, or
10 other solid supports known in the art for immunoassays. Alternatively, the first antibody can be provided for later immobilization. The first and second antibodies can be provided as a lyophilized preparation for reconstitution, or as a concentrated
15 solution. The second antibody can be detectable by labeling means. In a preferred embodiment, the labeling means is an enzyme.

The detergent solution is provided in a container having sufficient volume to hold the amount of
20 solution necessary for the number of assays contemplated by the kit. Preferably the detergent solution comprises two or more non-ionic detergents. In a preferred embodiment, the detergent solution comprises 9% Triton X-100 and 6% NP-40 in distilled
25 water. That particular detergent concentration is optimum with respect to an assay for both CD4 and CD8.

Preferably the kit comprises a leukocyte marker standard, either in solution or lyophilized for
30 reconstitution. More preferably, the kit comprises a standard comprising a known number of cells positive for the leukocyte marker of interest. Thus, the activity in an assay for the leukocyte marker in an unknown sample can be directly compared with a known
35 sample, and the number of cells in the unknown sample that are positive for the leukocyte marker enumerated thereby.

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The kit can further comprise a reagent reactive with label, when the second antibody is detectable by attachment of a label to the antibody. For example, when the label is an enzyme, the kit can provide the enzyme substrate. The kit can also provide a dilution buffer, in final concentration, high concentration for dilution, or dry for reconstitution.

In yet a further embodiment, a kit provides immunological detection means for more than one leukocyte antigen. In a preferred embodiment, the kit comprises immunological detection means for both CD4 and CD8.

5.4. METHODS OF DIAGNOSIS AND MONITORING OF A DISEASE

5.4.1. METHODS OF DIAGNOSIS

In another embodiment of the present invention, measurement of a total leukocyte marker can be used to detect, diagnose or stage a disease or disorder in a subject. The measured amount of the total leukocyte marker is compared to a baseline level, i.e., the amount of total leukocyte marker in normal individuals. This baseline level can be the amount which is established to be normally present in the body fluid of subjects prior to the onset of disease or the amount present during remission of disease.

Disease or disorders which may be detected, diagnosed or staged in a subject according to the present invention include but are not limited to those listed in Table III.

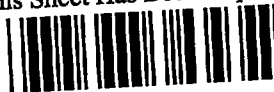


TABLE III

DISEASES AND DISORDERS WHICH MAY BE DETECTED AND/OR
DIAGNOSED AND/OR MONITORED IN A SUBJECT ACCORDING TO
THE PRESENT INVENTION

- 5 I. Infectious Diseases Induced by virus
- Herpesvirus
 - Cytomegalovirus
 - Epstein-Barr Virus
 - HTLV-I
 - HTLV-III / LAV / HIV (AIDS)
- 10 II. Cancer
- B or T cell leukemia
 - HTLV-I- associated adult T cell leukemia
 - B or T cell lymphoma
 - Burkitt's lymphoma
 - Hairy cell leukemia
 - Sezary syndrome
 - 15 - Hodgkin's disease
 - Chronic lymphocytic leukemia
 - Non-Hodgkin's lymphoma
 - B-cell acute lymphoblastic leukemia
 - Solid tumors
- 20 III. Autoimmune Diseases
- Rheumatoid arthritis
 - Diabetes
 - Multiple sclerosis
 - Systemic lupus erythematosus
- IV. Organ Allograft Rejection

25

The methods for detecting diseases or disorders based on the number of cells in a sample from the patient that are positive for a leukocyte marker are discussed in Section 2.3 supra and in the references cited therein. Those methods can be practiced by the present methods of the invention more cheaply and easily than heretofore thought possible.

30 In one embodiment, the amount of total CD4 antigen can be used to enumerate CD4 positive cells which in turn can be used to diagnose AIDS. In the past, the diagnosis of AIDS was determined when a



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patient who was HIV-positive demonstrated CD4 positive cell counts of <500 cells/mm³ in the presence of one or more opportunistic infections. This definition of AIDS is expected to change to HIV-positive in the presence of <200 cells/mm³ whether or not opportunistic infections are present (see Section 2.3., supra).

Responses to viral infections can also be monitored by measuring total CD8 levels in a patient. For example, patients infected with herpes virus or an AIDS virus can present modified levels of total CD8. In other embodiments, total levels can be measured in transplant patients, and used as a diagnostic indication of allograft rejection. Detection of increased levels of total CD8 can be associated with rheumatoid arthritis and infectious diseases such as EBV-induced mononucleosis. Detection of elevated levels of a CD8 antigen can indicate the involvement of significant numbers of suppressor/cytotoxic T cells with a specific pathological event, distinct from immune activation.

In yet another embodiment, the measurement of total CD4 in a cell culture can be relied on as an indication of the CD4⁺ phenotype of the lymphocytes present. For example, CD4⁺ leukemias or lymphomas can be classified using total CD4 antigen measurements. In a further embodiment, the measurement of total CD4 antigen can be used to detect CD4⁺ cells and to enumerate them. Similar embodiments of the invention include the measurement of total CD8 antigen to classify CD8⁺ leukemias or lymphomas, to detect CD8⁺ cells and to enumerate them.

5.4.2. METHODS OF MONITORING

The present invention provides a method for monitoring the effect of a therapeutic treatment on a

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subject who has undergone the therapeutic treatment. This method comprises measuring at suitable time intervals the amount of a total leukocyte marker. Any change or absence of change in the amount of the
5 total leukocyte marker can be identified and correlated with the effect of the treatment on the subject.

In one embodiment, total CD4 can be measured (and CD4⁺ cells enumerated) and used in the
10 prediction of therapeutic outcome of AIDS patients following administration of therapeutic compounds such as AZT, interferon or CD4.

In another embodiment, total CD8 antigen can be measured and correlated with disease progression or
15 treatment outcome.

Measurement of total T cell antigen receptor can be especially useful in monitoring the effectiveness of treatment with agents such as T cell receptor specific antibodies. In specific
20 embodiments, the total TCR antigen in a specific subset of T cells expressing specific variable regions can be measured and correlated with treatment outcome.

The therapeutic treatments which may be
25 evaluated according to the present invention include but are not limited to radiotherapy, drug administration, vaccine administration, immunosuppressive or immunoenhansive regimens, etc. The immunosuppressant regimens include, but are not
30 limited to administration of drugs such as Cyclosporin A, chlorambucil, cyclophosphamide, or azathioprine, and anti-T cell antibody such as anti-T3 monoclonal antibody, anti-T cell antigen receptor antibody, and anti-thymocyte globulin, etc.
35 The immunoenhansive regimens include, but are not limited to administration of interleukin-1,



interleukin-2, interleukin-4 and other T cell growth factors.

5
5.4.3. METHODS OF DIAGNOSIS OR MONITORING
OF THERAPY BASED ON DETECTION OF
A PLURALITY OF LEUKOCYTE MARKERS

10 The present invention also provides for the
detecting or diagnosis of disease, or the monitoring
of treatment by measuring a plurality (at least two)
of total leukocyte markers. For example, a plurality
15 of T cell markers either in total form, for example
but not limited to CD4 and CD8, and TCAR to mention
but a few, can be measured to diagnose, detect, or
monitor treatment of diseases or disorders. Such
diseases or disorders include those indicated in
15 Table III. Total marker levels can represent a
measure of immune system function, paralleling
disease course or treatment efficacy. In a preferred
embodiment, the prognostic indicator is the observed
change over time in different marker levels relative
20 to one another, rather than the absolute levels of
the markers present at any one time. Since CD4, CD8
and TCAR are indicators of the immune system
function, they should provide a much improved measure
of the relative health of the immune system during
25 various stages of disease or disorders.

In a particular embodiment, diseases and
disorders caused by HIV (the causative agent of AIDS)
infection may be monitored by measurements of a
30 plurality of leukocyte surface markers. AIDS
therapies include the treatment of AIDS patients with
drugs such as AZT (azido-deoxythymidine), γ or β
interferons, and with soluble CD4, or its fragments
and derivatives. In another embodiment, the efficacy
35 of potential AIDS vaccines, such as gp120 peptides
can be tested by monitoring a plurality of markers.
Practitioners in AIDS therapy very much need a



procedure that can be used to monitor the efficacy of these treatments or vaccines. To date, the levels of the HIV antigen p24 have not proved sensitive enough. Total CD4 relative to total CD8 can be detected in
5 HIV-infected patients with different manifestations of disease, providing a sensitive immunoassay to monitor AIDS therapies and vaccines. The measurement of total CD4 and total CD8 is an inexpensive and easy immunoassay format and is a valuable clinical tool
10 for predicting disease prognosis and treatment outcome in AIDS patients. Detection of total CD4 and CD8 according to the method of the invention antigen provides a particularly useful way to follow HIV infection and AIDS therapy since the relative level
15 of CD4 positive T cells decrease dramatically relative to the total number of CD8 positive cells in the progress of AIDS etiology.

In a preferred aspect, the approach that can be taken is to determine the levels of total CD4 and
20 total CD8 levels in longitudinal time studies and to compare these values with a baseline level. The baseline level can be either the level of the marker present in normal, disease-free individuals or the level present in a patient prior to treatment, during
25 remission of disease, or during periods of stability. These levels can then be correlated with the disease course or treatment outcome.

The present invention also provides for the detection or diagnosis of disease or the monitoring
30 of treatment by measuring the amounts of total leukocyte marker and of soluble leukocyte marker in a sample and comparing the two measurements. The change in the levels of the leukocyte markers relative to one another can be an improved prognostic
35 indicator. In one embodiment, the level of soluble CD8 (a measure of immune system activation, see International Patent Publications WO 87/05912



published October 8, 1987 and WO 90/04180 published April 19, 1990) is compared with the level of CD8 antigen obtained by subtracting the amount of soluble CD8 antigen from the amount of total CD8 antigen (e.g., the difference yields cell membrane bound plus cytoplasmic CD8, which is equivalent to cell-associated total CD8). Such a comparison gives information on the relative level of immune system activation and on changes in the number of cells in the CD-positive cell subset, both useful in the monitoring of disease progression or treatment. In a preferred embodiment, both the soluble and total CD8 antigen levels can be determined using one immunoassay configuration, but with different sample treatment before assay.

The instant invention will be further clarified by the following Examples, which are provided as purely exemplary of the invention and are not intended as limiting of the invention.

6. EXAMPLE: A TOTAL CD4 ANTIGEN ASSAY

The present example demonstrates the development of an assay that correlates total CD4 values with the number of CD4⁺ T cells in a sample.

6.1. MATERIALS AND METHODS

6.1.1. SAMPLE PREPARATION

Samples. Patient samples included 26 sero-positive HIV-infected individuals and 13 healthy adult volunteers. Blood was obtained by venipuncture into a blood collection tube.

Sample Treatment. Prior to assay, whole blood samples were treated as follows.



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Step 1:

100 μ l of anticoagulated blood was removed from the blood collection tube and mixed with 20 μ l of concentrated 6X detergent (6% Triton X-100, 6% NP-40 in distilled water) in a 12 x 75 mm glass tube. This mixture was then incubated for one minute at room temperature. After one minute the treated sample was either used in a CD4 immunoassay or stored at -70°C until assayed. Samples stored at -70°C were allowed to thaw at room temperature before use.

Step 2:

Prior to assaying the treated samples in a CD4 immunoassay, the samples were diluted as indicated in the results section with sample buffer (1% bovine serum albumin, phosphate buffered saline, 0.25% NP-40 and 0.01% thimerosal) to dilute the concentration of detergent. Total sample volumes added to the immunoassay were maintained at 50 μ l.

6.1.2. CD4 IMMUNOASSAY

Total CD4 antigen was measured in a CD4 specific immunoassay (see International patent publication WO 87/05912 published October 8, 1987) involving a one-step, three hour format using microtiter plates that had been precoated with capture antibody overnight. Briefly, each well of a 96 well microtiter well plate was coated with 100 μ l of murine anti-CD4 coating antibody in phosphate-buffered saline (PBS) overnight at 4°C. Any remaining protein-binding sites were blocked with 300 μ l per well of blocking buffer (0.5% casein, 0.008% NP-40, 0.005% EDTA in PBS) for 2 hours at 37°C. The wells were washed three times with 350 μ l per well of wash buffer (PBS, pH 7.4, with 0.05% Tween 20). After aspirating the final wash buffer from the wells, 50 μ l of horseradish peroxidase (HRP)

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conjugated murine monoclonal anti-human CD4 antibody
(in PBS with 15% FCS and 0.15% NP-40) and 50 μ l of
sample or standard were added to each well of the
microtiter plate in duplicate. The combined volume
5 of sample and HRP conjugated antibody was 100 μ l.
Samples and antibodies were incubated for 3 hours at
room temperature. After washing the plate as
described above, 100 μ l of OPD substrate (OPD
tablets, BioDesign Intl, Catalogue # A45104T,
10 dissolve 1 tablet in 4 ml citrate buffer-peroxide,
BioDesign Intl, Kennebunkport, Maine, Catalog number
A45105B) was added to all the wells and incubated for
30 minutes at room temperature. At the end of this
last incubation, 50 μ l of 2 N H₂SO₄ was added to each
15 well to stop the reaction and absorbance of each well
was read at 490 nm. Results were plotted as values
obtained for each sample at O.D. 490 against total
CD4⁺ cells/mm³ or sample volume. Correlation
20 coefficients were calculated using linear regression
analysis.

Whole blood samples from normal and HIV-infected
patients were assayed for absolute CD4⁺ T-cells/mm³
using the formula:

25
$$\text{Abs. CD4}^+ \text{ T cells/mm}^3 = \text{WBC} \times \% \text{ Lymphocyte} \times \% \text{ CD4}^+ \text{ T cells.}$$

WBC (White blood cell count) was determined using
30 a hemacytometer. % Lymphocyte was determined by a
differential count, and %CD4⁺ T cells were determined
using the Ortho cytofluorograph II and Leu-3a
(anti-CD4) fluorescein-conjugated antibody (Becton
Dickinson, Mountain View, CA.)

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6.2. EXPERIMENTAL RESULTS

Experiment 1: Measurement of total CD4 antigen in whole blood. This study was conducted to determine whether detergent treatment of whole blood would yield reliable measurements of total CD4 antigen in a CD4 immunoassay. Samples of whole blood were treated with a 6x detergent solution using a ratio of 20 μ l detergent to 100 μ l anticoagulated whole blood. Serial dilutions were made of these samples to produce a series of samples containing decreasing amounts of total CD4 antigen. These samples were then analyzed in the CD4 assay to determine which dilutions produced values that were linear with sample dilution. As the assay configuration became saturated with excess CD4, the optical density values representing total CD4 values became nonlinear.

The results of this experiment can be seen in Figure 1. Total CD4 preparations made from three healthy volunteers were treated with concentrated non-ionic detergent, and diluted in serial 1:2 increments (from 1/2 to 1/32). Sample volumes were maintained at 50 μ l by dilution into sample buffer. Linear regression analysis demonstrated that samples containing less than 20 μ l and preferably 5-10 μ l of detergent treated whole blood were optimal for total CD4 measurement as they fell within the linear range. Samples containing greater than 20 μ l of whole blood saturated the assay and total CD4 could not be accurately determined.

Experiment 2: Specificity of the total CD4 antigen measurement. The ability of an anti-CD4 antibody to block the total CD4 signal detected in whole blood samples of three normal controls is presented in Table IV. The assay was run as described above, except that before adding the HRP-conjugated murine anti-CD4 monoclonal antibody to



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the wells, 5 μ l of the unconjugated murine anti-CD4 monoclonal antibody used in the coating procedure was added to the wells, followed by the HRP-conjugated antibody. Samples were diluted with sample diluent to a final volume of 50 μ l. The unconjugated antibody was able to block total CD4 detection by 50%, 51% and 51% in samples #1, 2, and 3, respectively, at the level of competing antibody used. This demonstrates the specificity of the assay to detect total CD4. Other proteins released during detergent lysis of the whole blood samples (such as hemoglobin) did not interfere with the assay.

TABLE IV

15 SPECIFICITY OF TOTAL CD4 DETECTION IN DETERGENT
TREATED WHOLE BLOOD

O.D. 495

	<u>sample #</u>	<u>10 μl*</u>	<u>10 μl + anti-CD4**</u>	<u>%inhibition</u>
20	1	0.433	0.216	50%
	2	0.928	0.472	51%
	3	0.833	0.422	51%

25 * 10 μ l of detergent treated whole blood prepared from normal uncoagulated whole blood

 ** 5 μ l of the anti-CD4 coating antibody from the CD4 assay was also added to compete for binding.

30 **Experiment 3: Enumeration of cell number using total CD4 values.** This study was done to determine whether the measurement of total CD4 levels in treated whole blood samples would correlate with absolute CD4 positive cell numbers. Data in Figure 2 demonstrate a statistically significant correlation between total CD4 measured in whole blood samples and the total number of CD4⁺ cells/mm³ of blood ($r=0.904$)..

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Samples measured in this assay contained 2.5 μ l of detergent treated whole blood diluted to a final volume of 50 μ l from a total of five normal controls. The normal range of CD4⁺ cells/mm³ is 800-1000 cells/mm³. The normal values in this assay appear lower than usual due to the fact that the WBC count used to determine the number of CD4 cells/mm³ was performed on the uncoagulated blood samples three days after the CD4 assay was run. The relationship between total CD4 detected in the assay and the total CD4⁺ cells/mm³ for each individual was determined by linear regression analysis and a statistically significant r value of 0.904 was obtained. This indicates that the measurement of total CD4 antigen can be used to directly enumerate CD4 positive cells.

Experiment 4: Enumeration of CD4⁺ cells in HIV-infected and normal individuals using measurements of total CD4 antigen. After the properties of the total CD4 method were established using healthy donors, further study was conducted to establish a relationship between the total CD4 as measured in the ELISA to the total number of CD4⁺ T cells in HIV infected individuals.

The total CD4 antigen values of HIV-infected individuals and normals were determined using the total CD4 method on two separate occasions. The result of these experiments are presented in Figures 3 and 4. Ten μ l of whole blood samples diluted to a total sample volume of 50 μ l from either the disease group or control group were used to determine the total CD4 antigen values. The total CD4⁺ cells/mm³ cells was determined on fresh uncoagulated blood samples on the day of the CD4 assay.

Both Figures 3 and 4 demonstrate a statistically significant correlation between total CD4 antigen measured in the assay and the total CD4⁺ cells/mm³ for

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both the HIV-infected group (single squares) and the control group (double squares) ($r = 0.860$ and 0.867 for Figures 3 and 4, respectively). Thus, the measurement of total CD4 antigens from detergent
5 treated whole blood accurately reflects the absolute number of CD4⁺ T-cells in whole blood for both normal and HIV infected individuals.

6.3. DISCUSSION

10 As described herein, we have developed a method that measures the level of total CD4 antigen in a patient sample. Whole blood samples were detergent treated and assayed using a CD4 immunoassay in a one-step, three hour format. It was demonstrated
15 that total CD4 antigen could be detected in whole blood samples of normal individuals by a simple detergent lysis step and CD4 immunoassay. Optimal detection could be measured using $10 \mu\text{l}$ or less of detergent treated whole blood samples. Accurate and
20 reproducible measurements can be obtained from $2.5 \mu\text{l}$ to $5 \mu\text{l}$ of whole blood. The detection of total CD4 antigen was specific as a murine anti-CD4 monoclonal antibody was capable of blocking the total CD4
25 antigen signal when added to the assay format. The release of other proteins during detergent treatment of whole blood did not interfere with the specificity of the assay. It was further demonstrated that the total CD4 antigen values obtained in the ELISA
30 correlated with the total CD4⁺ T cells/ mm^3 in the whole blood of normal donors ($r=0.9$).

A comparison between the total CD4 antigen obtained in the CD4 ELISA and the total number of CD4⁺ T Cells/ mm^3 of whole blood yielded a
35 statistically significant correlation in both HIV-infected individuals and normals. This comparison was determined on two separate occasions

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using two different groups of HIV-infected individuals and normals. Both comparisons yielded statistically significant correlations between total CD4 antigen values and total CD4⁺ T cells/mm³ (r=0.86 and 0.87). Since the measurement of total CD4 antigen accurately reflects the number of CD4 positive cells, the total CD4 method can be used to enumerate CD4 positive cells and to determine the numbers of CD4 positive cells in disease diagnosis or monitoring of treatment, etc.

7. EXAMPLE: ENUMERATION OF CD4 POSITIVE LYMPHOCYTES IN PERIPHERAL BLOOD BY THE TOTAL CD4 METHOD

This Example outlines further development and characterization of the total CD4 method for enumeration of CD4 positive cells. The method consists of 3 steps: treatment of samples with concentrated detergent, dilution of the concentrated detergent lysate and CD4 immunoassay.

7.1. MATERIALS AND METHODS

Samples: Ninety-five samples of whole blood were collected in EDTA containing vacutainer tubes and mixed thoroughly. Samples were analyzed for white blood cell count and differential and CD4⁺ lymphocytes by flow cytometry.

Sample Treatment: Samples were treated as described in section 6, except for the following:

30 Step 1:

1 volume of concentrated detergent solution was added to 5 volumes of fresh EDTA whole blood, followed by gentle mixing. Usually 100 μ l of whole blood was treated with 20 μ l of detergent solution. A comparison of detergents of various concentrations indicated that the best results were obtained using a combination of detergents such as TWEEN-20 with



Triton X-100 or Triton X-100 with NP40. Any of the three detergents alone was not as effective. The detergent treated sample (100 μ l sample plus 20 μ l concentrated detergent) yielded to a final combined
5 detergent concentration of 2.5%. The optimal detergent solution for measuring both total CD4 and total CD 8 using the same concentrated detergent solution was 9% Triton-X100 and 6% NP40 (15% total in the concentrated detergent solution) which
10 corresponded to 1.5% Triton X100 and 1% NP40 (2.5% total) in the treated sample. In other experiments, the final concentration of the detergents in the treated sample was similarly effective over a range of at least 1-2% Triton X100 combined with 1-1.5%
15 NP40.

Other methods of lysis, solubilization or disruption of cells including hypotonic treatment with distilled water, sonication, or addition of detergent at lower final concentrations (e.g. one
20 detergent at 1% concentration in the treated sample) were tested and found not effective.

Step 2:

After 5 minutes, 100 μ l of treated sample was diluted with 400 μ l of dilution buffer to yield a 1:5
25 dilution. Fifty μ l of this diluted sample (about 10 μ l of whole blood) was used for each assay well. The assay configuration allowed whole blood volumes of 5-25 μ l to be measured, since the resulting values fell within the range of the standard curve. Blood
30 volumes above or below these amounts yielded values that fell outside the range of the standard curve. The importance of step 2 is the dilution of the detergent concentration in the treated sample to prevent "stripping" in the following assay and loss
35 of signal. Samples corresponding to 50 μ l of whole blood performed poorly in the CD4 immunoassay because the resulting values were outside the assay range,



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and because the detergent concentration was disruptive to the antibody sandwich formation or stability.

Assay. Samples were stored at -70°C prior to
5 assay. The samples were assayed in the one-step sandwich immunoassay as described in section 6. Total CD4 values were determined from a standard curve. Standards were soluble, recombinant CD4 antigen prepared by removing the transmembrane region
10 of the CD4 gene, followed by expression of the truncated gene in mammalian cells and recovery of recombinant CD4 antigen in the supernatant of the cell culture (see International Patent Publications W088/01304 and W089/02922).

15

7.2. EXPERIMENTAL RESULTS

Experiment 5: A standard curve for the total CD4 antigen method was generated using culture supernatant containing recombinant CD4 receptor (see
20 figure 5). For the assay configuration used, the standard range was determined to be 0 to 200 units/ μl with a correlation coefficient of 0.999.

Experiment 6: Specificity of the assay for the CD4 antigen. Blood samples were drawn from 4 normal
25 volunteers and treated as follows: A sample from each was analyzed for white blood cell count and differential (the percentage of WBCs that were lymphocytes; see the formula in Section 6.1.2). The rest of the sample was divided; one-half was depleted
30 of CD4⁺ cells by absorption with anti-CD4 coated Dynabeads (Dynal, Inc. Great Neck, N.Y.) while the other half was untreated. The depleted and untreated samples were again divided and one fraction analyzed
35 by flow cytometry while the other was treated using the total CD4 method. CD4 positive cell number was calculated from the white blood cell count, lymphocyte differential, and percentage of CD4 cells

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by flow cytometry using the formula described in Section 6.1.2. The comparison of CD4 positive cell number to total CD4 antigen is given in Table V.

5

TABLE V.
Specificity of the Total CD4 Antigen
Assay for CD4 Antigen

	Untreated Fractions		Depleted Fractions	
	Flow Cytometry cells/ μ l	Total CD4 Antigen units/ μ l	Flow Cytometry cells/ μ l	Total CD4 Antigen units/ μ l
1	71	320	0	7
2	934	445	0	11.5
3	1109	345	40	15
4	912	395	45	15

Both the flow cytometry and the total CD4 methods indicated the removal of CD4 positive cells from all depleted fractions indicating that the assays were specific for the CD4 receptor.

Experiment 7: Assay dilution and linearity. This study was done to further verify assay sensitivity. Whole blood samples from normal volunteers were collected in EDTA. A and a portion of each was depleted of CD4 positive cells to serve as the sample diluent in order to keep the sample matrix as normal as possible. Samples were prepared neat and at 1/2, 1/4 and 1/8 dilutions with concentrated detergent; and run in the CD4 immunoassay. Table VI shows the results of this experiment on 6 different samples. Values are presented as raw data as run in the assay. The zero value represents the assay value obtained for the depleted portion used as sample diluent. This value is included in the calculations of expected values.

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TABLE VI
Dilution and Linearity of Assay

	Sample	Dilution	Units Detected	Units Expected	Percent Recovery
5	585	Neat	64	64	100
		1:2	35	35.5	99
		1:4	24	21	114
		1:8	14	14	100
		0	7		
10	586	Neat	89	89	100
		1:2	58	51	114
		1:4	34	31	110
		1:8	22	21	105
		0	11.5		
15	593	Neat	79	79	100
		1:2	38	41	91
		1:4	26	22	119
		1:8	22	24	92
		0	16		
20	598	Neat	63	63	100
		1:2	40	39	103
		1:4	30	27	111
		1:8	26	21	124
		0	15		
25	599	Neat	69	69	100
		1:2	36	42	86
		1:4	28	28	100
		1:8	22	22	100
		0	15		
30	600	Neat	65	65	100
		1:2	36	40	90
		1:4	27	27	100
		1:8	21	21	100
		0	15		
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These results indicate that normal whole blood samples dilute linearly in the assay. The assay background is <20 units. Neat normal samples fall in the middle of the assay range, so dilution of even 1:2 should be rarely necessary.

- 5 Experiment 8: Cell enumeration using the total CD4 method. This study confirmed that it was possible to enumerate CD4 positive cells in whole blood by the total CD4 method. Both flow cytometry and total CD4 antigen assays were run by Maryland Medical Laboratory on normal
- 10 and abnormal blood specimens that were less than 24 hours old. Flow cytometry was performed on a Coulter Epics Flow Cytometer; the CD4 immunoassay was read using a Molecular Devices VMAX ELISA reader. Samples with low CD4 positive cell counts were selected from HIV positive specimens.
- 15 Cells were dually stained with anti-CD4 and anti-CD2 antibodies in order to make sure that the cells counted by Flow were CD4 positive T cells. A total of 95 samples (46 normal and 49 abnormal) were assayed for white blood cell number, lymphocyte differential, and percent CD2⁺CD4⁺ cells
- 20 by flow cytometry and for the amount of CD4 by the total CD4 antigen method. The number of CD4⁺ T lymphocytes was calculated from the cell count, differential and flow data and compared to the data obtained from the total CD4 method by linear regression. The distribution of the two types of
- 25 samples was:

46 Normals

CD4+ T cell Number	500-1600	cells/ μ l
total CD4 antigen	222- 600	units/ml

30

49 Abnormals

CD4+ T cell Number	1- 690	cells/ μ l
total CD4 antigen	48- 295	units/ml

35

The results of the linear regression analysis are shown in Figure 6, where units/ml from the total CD4 antigen method are compared to cells/ μ l from the flow analysis.

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The slope of the line (0.26) and Y-intercept (89.7) define the linear regression curve equation $Y = 0.26X + 89.7$, where the total CD4 antigen units/ml is calculated to be 0.26 times the total number of cells/ μ l plus 89.7. The correlation coefficient for the comparison is 0.946, which indicates that enumeration of CD4 positive cells via the total CD4 antigen method is as reliable as the same enumeration by flow cytometry.

10

7.3. DISCUSSION

The quantitation of CD4 receptor protein in treated samples of whole blood has been shown to be equivalent to flow cytometry for the enumeration of CD4 positive T lymphocytes ($r=0.946$). For the configuration of the assay used, sensitivity is 100 units/ml or 50 cells/ μ l, which allows the total CD4 antigen method to be used over a wide range (50-1600 cells/ μ l) of samples. In the 95 samples tested, the possible presence of CD4 positive monocytes did not interfere with the assay results. Since only 10 μ l of whole blood is needed per test, the total CD4 method will be useful for detecting CD4⁺ T cells in samples that are difficult to obtain. The total CD4 method can be run in laboratories without access to flow cytometry. The method is simple and can be completed in less than 4 hours. Samples can be treated quickly and assayed immediately or treated and stored frozen for batch testing. Such batch testing of longitudinal patient samples following a course of treatment is not subject to the errors obtained with flow cytometry measurements where samples are run separately on different days. The detergent treatment step of the total CD4 method also provides the added benefit of inactivating enveloped viruses which increases operator safety.

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8. EXAMPLE: ENUMERATION OF CD8 POSITIVE
CELLS BY THE TOTAL CD8 METHOD

8.1. MATERIALS AND METHODS

5 **Samples:** Patient samples included 49 sero-positive HIV-infected individuals and 46 healthy adult volunteers with CD8⁺ cell counts ranging from 28 to 2983 cells/ μ l.

10 **Sample Treatment:** Whole blood samples were prepared as described in Section 7, supra. Two hundred μ l of concentrated detergent solution (9% Triton-X100 and 6% NP-40) were added to 1 ml of whole blood. Following gentle mixing, the sample was diluted 1:5 (50 μ l treated sample plus 200 μ l diluent) with diluent before assay. Treated samples were stored at -70°C prior to assay.

15 **Assay.** Total CD8 was measured in detergent treated whole blood in a CELLFREE® CD8 immunoassay (T cell Sciences, Inc.) using a one-step, three hour format. Briefly, each well of a 96 well microtiter plate was coated with 100 μ l of the murine anti-CD8 coating antibody in phosphate-buffered saline overnight at 4°C. The coating
20 buffer was removed and 300 μ l of blocking buffer (0.5% casein, 0.008% NP-40, 0.005% EDTA in PBS) were added per well and incubated for 2 hours at 37°C. After washing the wells three times with 400 μ l of wash buffer (PBS, pH 7.4, with 0.05% Tween 20), 50 μ l of horseradish peroxidase (HRP)
25 conjugated murine monoclonal anti-human CD8 antibody (10% FCS, 0.025% thimerosal, 0.01% gentamicin, 0.05% tween in Tris Buffered Saline, TBS) were added to all wells except those used as blanks. Fifty μ l of CD8 standard or treated whole blood was added to 200 μ l of diluent (1% bovine serum
30 albumin, phosphate buffered saline, 0.25% NP-40 and 0.01% thimerosal) and 50 μ l of this were added to the appropriate microtiter wells. The plate was covered with plate sealer and incubated for three hours at 20°C with shaking at 150
35 rpms. After washing the plate as described above, 100 μ l of OPD substrate were added to all the wells, and the plate was incubated at 20°C for 30 minutes. Fifty μ l of 2 N H₂SO₄ were added to all wells to stop the reaction and absorbance



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was read at 490 nm. A standard curve (correlation >0.999; range 0-2300 units/ μ l; assay background <100 units) was constructed by plotting O.D. against the concentration of the standards. The concentration of total CD8 in the whole
5 blood samples was then determined from the standard curve. Correlation coefficients were calculated using linear regression analysis.

Whole blood samples from normal and HIV-infected patients were assayed for absolute CD8⁺ T-cells/mm³ using
10 the formula:

$$\text{Abs. CD8}^+ \text{ T-cells/mm}^3 = \text{WBC} \times \% \text{ lymphocyte} \times \% \text{ CD8}^+ \text{ T cells.}$$

WBC (white blood cell count) was determined using a
15 hemacytometer. % Lymphocyte was determined by a differential count, and %CD8⁺ T-cells were determined using the Ortho cytofluorograph II and Leu-2a (anti-CD8) fluorescein conjugated antibody (Becton Dickinson, Mountain View, CA.)

20

8.2. EXPERIMENTAL RESULTS

Experiment 1. The specificity and linearity of the assay for CD8 were determined using similar depletion and dilution studies as described in Section 7. Total CD8
25 antigen values were obtained from whole blood of 43 normal and 43 HIV-infected, sero-positive individuals and compared to the total number of CD8⁺ T-cells/mm³ of whole blood. Table VII summarizes the population statistics for the normal and abnormal samples by flow cytometry and the total
30 CD8 method. The normal samples have a linear correlation of $r=0.772$ and the HIV⁺ samples have a linear correlation of $r=0.718$.

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TABLE VII

AVERAGE RANGE FOR 45 NORMAL PATIENT SAMPLES

26 patients were male 19 patients were female

ages ranged from 23-69 years ages ranged from 18-65 years

5	Samples	WBC*	%Lymph	%CD8*	#CD8*	Total CD8 units/ml
	average	6.48	31	23	483	949
	2 STD	3.04	10	14	181	343
10	High	10.2	41	42.3	898	2300+
	Low	4.0	22	8.2	173	423

AVERAGE RANGE FOR 49 HIV+ PATIENT SAMPLES

45 patients were male 4 patients were female

15 ages ranged from 24-65 years ages ranged from 21-43 years

20	Samples	WBC*	%Lymph	%CD8*	#CD8*	Total CD8 units/ml
	average	4.66	36	55	871	1368
	2 STD	5.76	26	28	1050	1244
	High	19.9	61	79.5	2983	2300+
	Low	1.0	0.2	12.7	28	364

25

Figure 7 demonstrates a statistically significant correlation between total CD8 antigen measured in the assay and the total number of CD8+ cells ($r=0.75$). In this study of 86 individuals, it was found that when total CD4 values were normal, so were total CD8 values. As CD4 values declined in HIV+ patients, the total CD8 values varied widely. Samples with low CD4 (<180 units/ml) and low CD8 values generally had low white blood cell counts as well. The HIV+ patients had some of the highest CD8 counts, perhaps to replace their diminished CD4+ T cells.

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Experiment 2. Although it would be possible to enumerate CD8 positive cells using the total CD8 method of experiment 1 ($r=0.75$), this quantitation was not as accurate as the enumeration of CD4 positive cells by the total CD4 method ($r=0.946$). Since activation of CD8 positive cells results in the release of large amounts of soluble CD8 antigen, it is likely that the levels of sCD8 were affecting the correlation of total CD8 antigen levels with CD8 positive cell counts. To test this hypothesis, total CD8 antigen and soluble CD8 antigen were measured in 30 normal and 11 cancer (mainly melanoma and lymphoma) whole blood samples. Total CD8 antigen measurements were made as described above with the detergent treatment, dilution and immunoassay, and soluble CD8 levels were determined directly by immunoassay of plasma preparations. The same CD8 immunoassay was used for both the total CD8 antigen and soluble CD8 antigen. Since one volume of plasma (sample size) has twice the amount of plasma as an equivalent sized sample of whole blood, the soluble CD8 amounts in plasma were divided by two. The amount of cell associated CD8 (membrane bound plus cytoplasmic) was determined by subtracting the soluble levels of CD8 (divided by two) from the amount of total CD8 antigen. The results of this analysis are shown in Figure 8. Linear regression analysis of this data gave an improved correlation coefficient of 0.859 as compared to 0.75 for total CD8 antigen alone. Cell enumeration could be more accurately quantitated from the equation:

$$Y \text{ (cells/mm}^3\text{)} = 1.1X \text{ (units/ml total CD8 antigen)} + 7.4.$$

8.3. DISCUSSION

As described herein, we have developed a total CD8 method that measures the level of total CD8 antigen in a patient sample. Whole blood samples were detergent treated, diluted, and assayed using a CD8 immunoassay in a one-step, three hour format. Total CD8 antigen values obtained in the total CD8 method correlated with total

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CD8⁺ T-cell number ($r=0.75$) in whole blood. A significant improvement in the ability to enumerate CD8⁺ cells in whole blood was found when the level of soluble CD8 antigen (released from activated cells) was subtracted from the level of total CD8 antigen ($r=0.859$). Monitoring the relationship of soluble and total antigen provided improved information on cell count and immune activation. Thus, the total CD8 assay alone, or in combination with other soluble or total marker assays, can be used to monitor the immune profile of patients.

9. EXAMPLE: ENUMERATION OF TCAR POSITIVE CELLS BY TOTAL TCR METHODS

15 Total TCAR β Experiments. An assay to detect total T cell antigen receptor (TCAR) β chain or total V β 5 specific TCAR chain was performed using detergent treated whole blood samples in a total TCR method. Briefly, wells in a 96 well plate were coated with 5 μ g/ml of coating antibodies which consisted of either a negative control antibody (δ TCS1 which is specific for the V δ 1 region of the $\gamma\delta$ T cell receptor), or W76 which recognizes the constant region of the β chain (C β) or a V β 5 specific monoclonal antibody such as W112 (Tian et al., 1989, FASEB J. 3:A486 Abstr). A horseradish peroxidase conjugated (HRP)- β F1 antibody, which recognizes a different epitope of the β chain constant region (C β) than W76, was used as the detection antibody. Whole blood lysates were prepared as described in Section 7, supra. The assay format was similar to that described in U.S. patent no. 4,845,026, issued July 4, 1989 and entitled "Assay Systems for Detecting Cell-Free T Cell Antigen Receptor Related Molecules and Clinical Utilities of the Assays." In addition, a one-step, three hour format as described in Section 7, supra, was performed with similar results.



Twenty-five μ l of whole blood lysate was diluted in 75 μ l of sample diluent for a starting dilution of 1:4. O.D. values from the negative control wells were subtracted from all values obtained (negative control wells using δ TCS1 as the coating antibody averaged 0.10 and blank wells which had no antibody averaged 0.095).

The results of the total TCAR assay can be seen in figure 9. TCAR β chain was optimally detected at dilutions of 1:4 and 1:8. V β 5 specific TCAR was detected at low levels (1:16 dilution) as well. Lower levels of V β 5 were expected, since the V β 5 positive subset of cells represents only a small portion of all β TCAR positive T cells. The assay demonstrated good specificity as the background O.D. was no higher when the control antibody δ TCS1 was used as the coating antibody as compared to O.D.s obtained from blank wells which contain no coating antibody (0.100 and 0.095 respectively).

These data demonstrate that a total TCAR method can be used to detect the total amount of TCR β chain in a whole blood sample by using two monoclonal antibodies which recognize different regions of the constant region of the β chain. The total amount of β chain is an indication of the total amount of β positive T cells in the sample. Furthermore, specific subsets such as the V β 5 family, which represent only 1-5% of the total TCAR β chains in normal blood, can be detected.

Total TCAR V δ 1 Experiments. The treatment of samples was similar to that of section 7 with a concentrated detergent solution of 9% Triton X-100 and 6% NP40 in 1x PBS that was added to whole blood at a ratio of 200 μ l concentrated detergent solution to 1 ml whole blood. Samples were then diluted 1:2 prior to immunoassay. The immunoassay procedure was similar to the CD4 or CD8 immunoassay except with antibody TCR δ 1 as capture antibody and δ TCS1 as detection antibody. The



TCAR δ positive cell line PEER was used as a positive control. A standard curve was generated with the units arbitrarily assigned based upon a PEER cell sample preparation stored at -70°C and assigned a value of 20,000 units. The specificity of the assay for TCAR δ chain was determined using an antibody-affigel stripping procedure. Affigel 10 was coupled to either BSA, anti-CD8 antibody 4C9 (an isotype control antibody), δTCS1 , $\text{TCR}\delta 1$, $\text{V}\delta 2$ or $\text{V}\gamma 2$ at 1 mg/ml concentration. A 50/50 slurry was made of each sample. Three hundred μl of a detergent treated PEER cell sample was added to 50 μl of each antibody-affigel slurry. The sample/gels were incubated for 1 hour at 4°C . The samples were then centrifuged for 5 minutes at 10K. The supernatant fluid was removed and added to 50 μl more of the antibody-affigel slurries. The samples/gels were incubated for another hour at 4°C . This process was repeated for a total of three sample/affigel incubations. After the last centrifuge spin, the supernatants were removed and run in the assay as samples. The supernatants were not diluted 1:2 prior to assay, because the PEER sample was diluted 1:25 in sample diluent buffer before the antibody-affigel stripping. Samples that were not stripped with antibody-affigel were kept at 4°C while the other samples were being stripped. The only two antibodies to completely strip the TCR δ reactivity from the samples were the TCAR δ chain specific antibodies δTCR1 and $\text{TCS}\delta 1$, indicating that the assay was specific for TCR δ chain. When 8 samples were run in the total TCAR δ chain method, total TCAR δ ranged from 55 to 108 units (Figure 10). These all fell at the lower end of the standard curve.

The success of these total TCAR methods for measuring total β or total δ TCR antigen amounts can be extended to total $\text{V}\alpha$, total $\gamma\delta$, total $\alpha\beta$ or to total $\text{V}\gamma$,



and related subset assay procedures as well. Detection of the total amount of the above β and δ antigens is useful in cell typing and in correlating specific V region expression to disease state or treatment outcome.

5

10. DEPOSIT OF HYBRIDOMAS

The following hybridoma cell lines, producing the indicated monoclonal antibody, have been deposited with the American Type Culture Collection, Rockville, Maryland, and have been assigned the listed accession numbers:

	<u>Accession Hybridoma Number</u>	<u>Monoclonal Antibody</u>	
15	Cell line 4C9	4C9 (anti-CD8)	HB 9340
	Cell line 5F4/7B12	5F4/7B12 (anti-CD8)	HB 9342
	Cell line 8F4	8F4 (anti-CD4)	HB 9843
	Cell line R2B7	R2B7 (anti-CD4)	HB 9842
	Cell line 8A3.31	8A3.31 (β F1)	HB 9283
20	Cell line δ TCS1	δ TCAR3= δ TCS1	HB 9578
	Cell line W112	W112(V β 5)	HB 9927
	Cell line W4F.5B	W4F.5B (anti-C β)	HB 9282
	Cell line 5A6.E9	TCR δ 1	HB 9772

25

The present invention is not to be limited in scope by the cell lines deposited since the deposited embodiments are intended as single illustrations of one aspect of the invention and any cell lines which are functionally equivalent are within the scope of this invention. Indeed, various modifications of the invention in addition to those shown and described herein will become apparent to those skilled in the art from the foregoing description and accompanying drawings. Such modifications are intended to fall within the scope of the appended claims.

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Various references are cited herein, the disclosures of which are incorporated by reference herein in their entireties.

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International Application No: PCT/

/

MICROORGANISMS

Optional Sheet in connection with the microorganism referred to on page _____, line _____ of the description *

A. IDENTIFICATION OF DEPOSIT *

Further deposits are identified on an additional sheet ☒ *

Name of depository institution *

American Type Culture Collection

Address of depository institution (including postal code and country) *

12301 Parklawn Drive
Rockville, MD 20852

Date of deposit *

March 3, 1987

Accession Number *

HB 9340

B. ADDITIONAL INDICATIONS * (leave blank if not applicable). This information is continued on a separate attached sheet ☐

C. DESIGNATED STATES FOR WHICH INDICATIONS ARE MADE * (if the indications are not for all designated States)

D. SEPARATE FURNISHING OF INDICATIONS * (leave blank if not applicable)

The indications noted below will be submitted to the International Bureau later * (Specify the general nature of the indications e.g., "Accession Number of Deposit")

E. ☒ This sheet was received with the international application when filed (to be checked by the receiving Office)
(Authorized Officer)☐ The date of receipt (from the applicant) by the International Bureau is

was

(Authorized Officer)

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5929-153-228 PCT-472

Form PCT/RO/134 (con'td)

American Type Culture Collection
12301 Parklawn Drive
Rockville, MD 20852

Date of Deposit: March 3, 1987	Accession No. HB 9342
Date of Deposit: September 28, 1988	Accession No. HB 9843
Date of Deposit: September 28, 1988	Accession No. HB 9842
Date of Deposit: November 21, 1986	Accession No. HB 9283
Date of Deposit:	Accession No. HB 9578
Date of Deposit: December 15, 1988	Accession No. HB 9927
Date of Deposit: November 21, 1986	Accession No. HB 9282
Date of Deposit: July 27, 1988	Accession No. HB 9772

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**SUBSTITUTE SHEET**

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What is claimed is:

1. A method of determining the total amount of a leukocyte marker in an original sample suspected
5 of having the leukocyte marker, which original sample contains cells and a biological fluid in which cells are obtained, comprising:
 - (a) adding a non-ionic detergent to the original sample to form a detergent-treated
10 sample;
 - (b) allowing the detergent to lyse the cells therein;
 - (c) diluting the detergent-treated sample by at least 2-fold; and
 - 15 (d) determining the amount of leukocyte marker in the detergent-treated sample by immunological detection means and calculating the total amount of leukocyte marker in the original sample therefrom.
20
2. The method according to claim 1 in which the non-ionic detergent concentration in the detergent-treated sample is about 2% to about 4%.
- 25 3. The method according to claim 1 in which the non-ionic detergent comprises more than one non-ionic detergent.
- 30 4. The method according to claim 1 or claim 3 in which the non-ionic detergent is selected from the group consisting of Triton X-100, Nonidet P-40, Tween-20 and CHAPS.
- 35 5. The method according to claim 1 in which the non-ionic detergent comprises Triton X-100 at a concentration of about 1% to about 2% and Nonidet P-40 at a concentration of about 1% to about 2%,

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which concentrations of Triton X-100 and Nonidet P-40 are their respective concentrations in the detergent-treated sample.

5 6. The method according to claim 1 in which the concentration of non-ionic detergent in the detergent-treated sample is a virus-inactivating concentration of non-ionic detergent.

10 7. The method according to claim 1 in which the non-ionic detergent is allowed to lyse the cells for at least about 1 minute.

 8. The method according to claim 1 in which
15 the detergent-treated sample is stored at about -20° or less after step (b).

 9. The method according to claim 8 in which
20 the detergent-treated sample is stored at about -70° or less.

 10. The method according to claim 1 in which
the original sample is selected the group consisting
of whole blood, plasma, serum, blood cells, saliva,
25 urine, synovial fluid, pleural effusions, tumor and
tissue infiltrates, amniotic fluid, spinal fluid,
cranial fluid, tissue, and tissue culture fluid.

 11. The method according to claim 10 in
30 which the sample is whole blood.

 12. The method according to claim 1 in which
the immunological detection means is selected from
the group consisting of radioimmunoassay, enzyme-
35 linked immunoassay, "sandwich" immunoassay,
immunoradiometric assay, fluorescence immunoassay and
protein A immunoassay.

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13. The method according to claim 12 in which the immunological detection means is a "sandwich" immunoassay.

5 14. The method according to claim 1 in which the leukocyte marker is selected from the group consisting of CD4, CD8 and T cell antigen receptor.

15 15. The method according to claim 1 in which the leukocyte marker is CD4 and in which the immunological detection means is a sandwich immunoassay employing a first antibody 8F4, deposited with the ATCC and assigned accession no. HB 9843, and a second antibody R2B7, deposited with the ATCC and assigned accession no. HB 9842.

20 16. The method according to claim 1 in which the leukocyte marker is CD8 and in which the immunological detection means is a sandwich immunoassay employing a first antibody 4C9, deposited with the ATCC and assigned accession no. HB 9340, and a second antibody 5F4/7B12, deposited with the ATCC and assigned accession no. HB 9342.

25 17. The method according to claim 1 in which the leukocyte marker is a β T cell antigen receptor, and in which the immunological detection means is a sandwich immunoassay employing a first antibody selected from the group consisting of V β 5-specific antibody W112, deposited with the ATCC and assigned accession no. HB 9927, and C β -specific antibody W4F.5B, deposited with the ATCC and assigned accession no. HB 9282, and a second antibody 8A3.31 (β F1), deposited with the ATCC and assigned accession
35 no. HB 9283.

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18. The method according to claim 1 in which the leukocyte marker is a δ T cell antigen receptor, and in which the immunological detection means is a sandwich immunoassay employing a first antibody
5 TCR δ 1, deposited with the ATCC and assigned accession no. HB 9772, and a second antibody δ TCS1, deposited with the ATCC and assigned accession no. HB 9578.

19. A method for determining the total
10 amount of a leukocyte marker in an original sample suspected of having the leukocyte marker, which original sample contains cells, comprising:
(a) adding a non-ionic detergent to the sample to form a detergent-treated sample;
15 (b) allowing the detergent to lyse the cells therein;
(c) diluting the detergent-treated sample by at least 2-fold; and
(d) determining the amount of leukocyte
20 marker in the detergent-treated sample by immunological detection means and calculating the total amount of leukocyte marker in the original sample therefrom.

25 20. A method for enumerating the approximate number of leukocytes that are positive for a leukocyte marker in an original sample comprising:
(a) determining the amount of total
30 leukocyte marker in the original sample according to the method of claim 1, 3, 5, 13 or 19; and
(b) calculating the approximate number
of cells positive for the leukocyte marker in
the original sample from the total amount of
35 leukocyte marker determined in step (a).

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21. The method according to claim 20 further comprising

(i) separately measuring the amount of soluble leukocyte marker in the original sample; and

(ii) subtracting the amount of soluble leukocyte marker in the original sample from the amount of total leukocyte marker in the original sample determined in step (a); and, in step (b) calculating the approximate number of cells positive for the leukocyte marker in the original sample from the remainder in step (ii).

22. The method according to claim 21 in which the leukocyte marker is CD8.

23. A method for enumerating the approximate number of leukocytes that are positive for a leukocyte marker in an original sample comprising:

(a) adding a non-ionic detergent to the original sample to form a detergent-treated sample;

(b) allowing the detergent to lyse the cells therein;

(c) diluting the detergent-treated sample by at least 2-fold;

(d) detecting the activity of the leukocyte marker in the detergent-treated sample by immunological detection means; and

(e) comparing the activity of the leukocyte marker in the detergent treated sample with the activity in a standard sample, which standard sample comprises a known number of cells positive for the leukocyte marker.

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24. A method for enumerating the approximate number of leukocytes that are positive for a leukocyte marker in a sample comprising:

(1) determining the total amount of leukocyte marker in the sample according to the method of claim 19; and

(2) calculating the approximate number of cells positive for the leukocyte marker from the total amount of leukocyte marker determined in step (1).

25. The method according to claim 20 or 24 in which the calculation of step (b) is a calculation selected from the group consisting of:

(i) extrapolating standard curve of amount of the leukocyte marker versus number of leukocytes positive for the leukocyte marker; and

(ii) multiplying the total amount of leukocyte marker by a correction factor m and adding a correction factor b according to the formula:

leukocyte number = m (total leukocyte marker) + b

26. A method for diagnosing, detecting or staging a disease comprising detecting in a sample from a patient suspected of having the disease the total amount of a leukocyte marker according to the method of claims 1, 3, 6, 13 or 19 and comparing the amount so detected to the amount of the total leukocyte marker in normal individuals, a difference in amounts indicating a disease state.

27. A method for diagnosing, detecting or staging a disease in a patient suspected of having the disease comprising enumerating the approximate

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number of leukocytes that are positive for a leukocyte marker in a sample from the patient according to the method of claim 20, 23 or 24 and comparing the approximate number of leukocytes with
5 the number of the leukocytes found in a normal individual, a difference in the numbers indicating a disease state.

28. The method according to claim 26 or 27
10 in which the leukocyte marker is selected from the group consisting of CD4, CD8 and T cell antigen receptor.

29. The method according to claim 28 in
15 which the leukocyte marker is CD4 and the disease is selected from the group consisting of acquired immunodeficiency syndrome (AIDS), AIDS related complex, and CD4⁺ leukemia or lymphoma.

20 30. The method according to claim 30 in which the leukocyte marker is CD8 and the disease is selected from the group consisting of AIDS, transplantation rejection, rheumatoid arthritis, and infectious disease.

25

31. A method for diagnosing, detecting or staging a disease in a patient suspected of having the disease comprising

30 (a) measuring in an original sample from the patient the total amount of at least two leukocyte markers according to the method of claim 1, 3, 5, 13 or 19;

35 (b) determining the ratio or ratios of the amounts of the leukocyte markers measured in step (a); and

(c) comparing the ratio or ratios of the leukocyte markers determined in step (b) to the

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same ratio or ratios in a normal individual, a difference in the ratios indicating a disease state.

5 32. A method of diagnosing, detecting or staging a disease in a patient suspected of having the disease comprising:

10 (a) enumerating the approximate numbers of leukocytes that are positive for at least two leukocyte markers in a sample from the patient according to the method of claim 20, 23 or 24;

 (b) determining the ratio or ratios of leukocytes positive for each of the leukocyte markers enumerated in step (a); and

15 (c) comparing the ratio or ratios of leukocytes determined in step (b) to the ratio or ratios in a normal individual, a difference in the ratios indicating a disease state.

20

33. The method of claims 31 or 32 in which the leukocyte markers are CD4 and CD8 and the disease is AIDS.

25

34. A method for monitoring the effect of a therapeutic treatment for a disease comprising detecting in a sample from a patient undergoing therapeutic treatment for the disease comprising detecting the total amount of a leukocyte marker according to the method of claims 1, 3, 5, 13 or 19 and comparing the amount so detected to the amount of the total leukocyte marker in normal individuals, a difference in amounts indicating a change in the disease state.

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35. A method for monitoring the effect of a therapeutic treatment for a disease in a patient

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undergoing therapeutic treatment for the disease comprising enumerating the approximate number of leukocytes that are positive for a leukocyte marker in a sample from the patient according to the method
5 of claim 20, 23 or 24 and comparing the approximate number of leukocytes with the number of the leukocytes found in a normal individual, a difference in the numbers indicating a change in the disease state.

10

36. The method according to claim 34 or 35 in which the leukocyte marker is selected from the group consisting of CD4, CD8 and T cell antigen receptor.

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37. The method according to claim 36 in which the leukocyte marker is CD4 and the disease is selected from the group consisting of acquired immunodeficiency syndrome (AIDS), AIDS related
20 complex, and CD4⁺ leukemia or lymphoma.

38. The method according to claim 36 in which the leukocyte marker is CD8 and the disease is selected from the group consisting of AIDS,
25 transplantation rejection, rheumatoid arthritis, and infectious disease.

39. A method for monitoring the effect of a therapeutic treatment for a disease in a patient
30 undergoing therapeutic treatment for the disease comprising

(a) measuring in a sample from the patient the total amount of at least two leukocyte markers according to the method of
35 claim 1, 3, 5, 13 or 19;

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(b) determining the ratio or ratios of the amounts of the leukocyte markers measured in step (a); and

5 (c) comparing the ratio or ratios of the leukocyte markers determined in step (b) to the same ratio or ratios in a normal individual, a difference in the ratios indicating a change in the disease state.

10 40. A method of monitoring the effect of a therapeutic treatment for a disease in a patient undergoing therapeutic treatment for the disease comprising:

15 (a) enumerating the approximate numbers of leukocytes that are positive for at least two leukocyte markers in a sample from the patient according to the method of claim 20, 23 or 24;

20 (b) determining the ratio or ratios of leukocytes positive for each of the leukocyte markers enumerated in step (a); and

25 (c) comparing the ratio or ratios of leukocytes determined in step (b) to the ratio or ratios in the patient at an earlier time difference in the ratios indicating a change in the disease state.

30 41. The method of claims 39 or 40 in which the leukocyte markers are CD4 and CD8 and the disease is AIDS, and in which an increase in the ratio of CD4 to CD8 positive leukocytes in the patient relative to the patient at an earlier time is indicative improvement of the disease.

35 42. A kit for determining the total amount of a leukocyte marker in a sample comprising:

(a) a concentrated non-ionic detergent solution; and

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(b) immunological detection means
specific for the leukocyte marker;
each in a suitable container.

- 5 43. The kit of claim 42 in which the
concentrated non-ionic detergent solution comprises
9% Triton X-100 and 6% Nonidet P-40 in distilled
water.
- 10 44. The kit of claim 42 in which the
immunological detection means is a sandwich
immunoassay.
- 15 45. The kit of claim 42 which further
comprises a standard comprising a known number of
cells positive for the leukocyte marker.
- 20 46. The kit of claim 42 which comprises
immunological detection means for more than one
leukocyte marker.
- 25 47. The kit of claim 42 in which the
leukocyte marker is CD4 and in which the
immunological detection means is a sandwich
immunoassay employing a first antibody 8F4, deposited
with the ATCC and assigned accession no. HB 9843, and
a second antibody R2B7, deposited with the ATCC and
assigned accession no. HB 9842.
- 30 48. The kit of claim 42 in which the
leukocyte marker is CD8 and in which the
immunological detection means is a sandwich
immunoassay employing a first antibody, 4C9,
deposited with the ATCC and assigned accession no.
35 HB 9340, and a second antibody 5F4/7B12, deposited
with the ATCC and assigned accession no. HB 9342.



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49. The kit of claim 44 in which the
leukocyte marker is a β T cell antigen receptor, and
in which the immunological detection means is a
sandwich immunoassay employing a first antibody
5 selected from the group consisting of V β 5-specific
antibody W112, deposited with the ATCC and assigned
accession no. HB 9927, and C β -specific antibody
W4F.5B, deposited with the ATCC and assigned
accession no. HB 9282, and a second antibody 8A3.31
10 (β F1), deposited with the ATCC and assigned accession
no. HB 9283.

50. The kit of claim 42 in which the
leukocyte marker is a δ T cell antigen receptor, and
15 in which the immunological detection means is a
sandwich immunoassay employing a first antibody
TCR δ 1, deposited with the ATCC and assigned accession
no. HB 9772, and a second antibody δ TCS1, deposited
with the ATCC and assigned accession no. HB 9578.
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