Table 2 Relationship between gB genotype and clinical outcome

	No. of collected samples	No. of sequenced samples	Genotype		P value[a]
			gB1	gB3	
Postnatally infected	31	28	24 (86%)	4 (14%)	
Healthy	23	20	19 (95%)	1 (5%)	
Others	8	8	5 (63%)	3 (37%)	
Congenitally infected	32[b]	31	19 (61%)	12 (39%)	0.035
Asymptomatic at birth	21	20	13 (65%)	7 (35%)	>0.05
Symptomatic at birth	11	11	6 (55%)	5 (46%)	0.038
Neurologic abnormalities	22	21	12 (57%)	9 (43%)	0.025
SNHL	19	18	9 (50%)	9 (50%)	0.009

[a] Comparison with the postnatally infected children

[b] Twins are counted as one sample

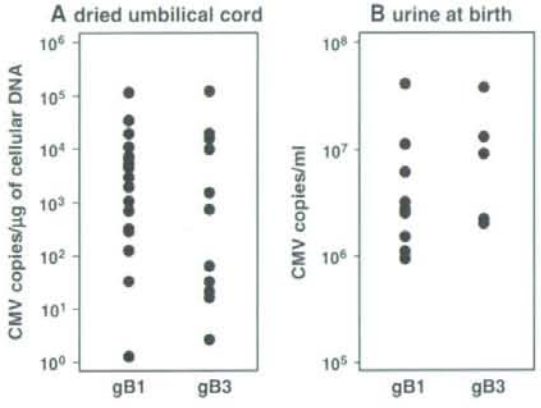

Fig. 3 Relationship between gB genotype and viral load in dried umbilical cord (**a** $n = 30$) and urine specimens (**b** $n = 14$). In (**a**), genotypes of some strains were based on the genotypes determined using urine specimens obtained from the same individuals

remaining 21 cases, the medical records of 11 subjects contained clinical findings that indicated neurological abnormalities, including mental development delay ($n = 9$) and/or SNHL ($n = 8$). Although the remaining ten infants with asymptomatic congenital infection have not yet exhibited any clinical abnormalities, their follow-up periods have not been long enough to observe any late-onset sequelae. The gB genotype distribution of strains from the 21 congenital cases with neurological abnormalities (there was insufficient material from one case for the analysis) indicated a significantly high prevalence of gB3 (43%) compared with the strains from the postnatally infected children ($P = 0.025$). The gB3 genotype was also significantly prevalent among the congenital cases with SNHL ($n = 18$) ($P = 0.009$) (Fig. 1d; Table 2).

In contrast to the gB gene, there were no significant differences in the genotype distributions of the UL144 and UL149 genes in the congenital cases with neurological abnormalities or with SNHL.

Absence of any relationship between viral load and genotype

Since the gB3 genotype was more prevalent in the congenital cases, we investigated the relationship between the gB genotype and viral load (Fig. 3). Copy numbers of CMV DNA in the dried umbilical cord specimens and those in urine specimens collected within a few days after birth were evaluated as viral loads. There was no observable relationship between gB genotype and viral load in the urine or dried umbilical cord specimens (Mann–Whitney U test, both $P > 0.05$). Furthermore, no relationship between genotype and viral load was noted for the other genes (data not shown).

Discussion

In this study, we investigated the relationship between the genotypes of the gB, UL144 and UL149 genes and the incidence and severity of congenital infection, and found that (1) CMV strains with any combination of genotypes could be vertically transmitted from mother to fetus, potentially causing neurological abnormalities, (2) the gB3 genotype was more prevalent in the congenital cases than in postnatally infected children ($P < 0.05$), particularly in congenital cases with SNHL ($P = 0.009$), (3) there was no relationship between gB genotype and viral load in congenital cases, and (4) the distribution of UL144 and UL149 genotypes had no bias for congenital infection.

Several studies on immunocompromised patients have identified infections with multiples strains of CMV [1, 13, 15, 18, 20, 40], and a recent study reported a relationship between multiple infection and more severe clinical manifestations in transplantation patients [13]. Using genotype-specific serologic assays, we and others demonstrated that pre-existing immunity did not protect against infection with strains of a different genotype [10, 20]. Multiple infection was observed only in a limited number of

congenitally infected newborns [5, 50], although multiple strains were identified in autopsy tissues from stillborn infants who died of congenital CMV infection [4]. This study did not find any obvious cases of multiple infection, although a more stringent approach, such as sequencing of a significant number of clones, should be performed to detect minor populations. Alternatively, genotype-specific serology would be useful to identify re-infection or multiple infections. In some immunocompromised patients, different strains were isolated from different sources; for example, the ocular fluid and blood, from the same individuals [33]. In this study, urine and dried cord specimens obtained from six congenitally infected newborns had identical sequences for the three genes examined. The urine specimen from one of the cases was collected 31 months after birth, indicating the stability of CMV sequences. Stability of the CMV sequences in the hypervariable regions over time in vivo has also been described [6, 45]. Although one study identified a nucleotide alteration over time [46], analysis of various gene sequences is required to distinguish spontaneous sequence alterations from reinfection with similar strains.

This study found that the gB3 genotype had a significant bias towards congenital infection as well as towards neurological abnormalities, such as SNHL. Differences in both T cell tropism and clinical outcome were reported for the gB genotypes [8, 15, 22, 28, 44, 47, 49]. However, several studies on immunocompromised patients did not find any connection between gB genotype and disease recurrence or the occurrence of invasive diseases [18, 43]. The effects of gB genotype on the clinical outcome of congenital infections have been also controversial [5, 7, 48]. It is unlikely that the inconsistent results are due to differences in the variable region in the gB gene submitted to analysis, because a previous study [42] confirmed an almost complete match, apart from some intragenic recombination, of the gB genotypes between the N-terminal region and the cleavage region. Geographical and demographical differences in the study populations, the lack of a proper control group for comparisons in some studies by others, and small population sizes might in part explain the inconsistent results. Geographic and demographic biases in the distribution of the gB genotypes have been reported in several studies [51], and this and other Japanese studies observed only limited numbers of the gB2 and gB4 strains in pediatric and transplantation populations [29, 46]. As the Japanese society is comprised of people with relatively uniform demographics and socioeconomic status, it is unlikely that selection of study subjects influenced the observations in the current study. In addition, in order to establish a control population, we collected specimens not only from congenital CMV cases but also from postnatally infected, generally healthy children. One critical factor that differentiated this study from others was the inclusion of the congenital cases with SNHL that were identified by a retrospective study on severe SNHL children, as this may engender bias in the make up of the congenital group.

Clinical outcome has been shown to be correlated with viral load in blood specimens [9]. However, the present study did not find any relationship between specific genotype and the viral load in urine or dried umbilical cord specimens from the congenital CMV cases, which is consistent with a previous report describing the absence of any association of specific UL144 and gB genotypes with the viral load in amniotic fluid specimens of congenital cases [2, 35].

We did not find any association between the UL144 and UL149 genotypes and the incidence of congenital infection or clinical outcome. Although Arav-Boger and colleagues reported an association between UL144 genotype and the outcome of congenital disease, the findings have not been supported by other researchers [2–4, 6, 25, 26, 34]. Our results also fail to support the notion of a significant association. Although it was reported recently that particular amino acid sequences of UL149 are associated with microcephaly and Hirschsprung's disease [21], this study did not find any correlation between these particular amino acid sequences and clinical outcomes.

In conclusion, this study indicates that any CMV strain, irrespective of its genotype, can be vertically transmitted from mother to fetus, potentially causing neurological sequelae. In future studies, it would be interesting to clarify whether gB genotype has any value as a prognostic indicator of CMV-associated neurological abnormalities.

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Novel Nonstructural Protein 4 Genetic Group in Rotavirus of Porcine Origin

To the Editor: Infection with group A rotavirus is the main cause of acute gastroenteritis in infants and young children worldwide and in young animals of many species, including piglets. In recent years, several epidemiologic studies designed to monitor the appearance of novel or atypical rotavirus antigenic types have provided evidence for the increasing antigenic diversity of group A rotaviruses (*1–3*). In addition to the 2 rotavirus classification systems, VP7 (G) and VP4 (P) genes, the virus can also be classified on the basis of the nonstructural glycoprotein 4 (NSP4)–encoding gene. Sequence analyses of the NSP4 gene indicated the presence of at least 5 distinct genetic groups among human and animal rotaviruses, termed A to E (*1*,*4*,*5*). Among human rotaviruses, the diversity of NSP4 genes has been restricted mainly to genetic groups A and B; only a few human strains possess genetic group C. Conversely, all 5 NSP4 genetic groups (A–E) have been identified in rotaviruses of animal origins. To our knowledge, porcine rotaviruses (PoRVs) have been reported to belong only to NSP4 genetic group B (*1*).

During an epidemiologic survey of PoRV from June 2000 through July 2001, a total of 175 fecal specimens were collected from diarrheic piglets from 6 different farms in Chiang Mai Province, Thailand. Of these, 39 (22.3%) specimens were positive for group A rotavirus (*6*). A novel and unusual PoRV CMP034 strain was isolated from a 7-week-old piglet during this survey. Molecular genetic characterization showed that the CMP034 strain carried a novel P[27] genotype with a new lineage of G2-like rotavirus genotype (*7*). We performed a molecular analysis of the NSP4 gene of this strain in comparison with those of other NSP4 gene sequences available in the GenBank database.

The full-length of NSP4 gene was amplified by NSP4–1a and NSP4–2b primer pairs (*8*). The PCR amplicon was sequenced in both directions by using the BigDye Terminator Cycle Sequencing kit (PerkinElmer-Applied Biosystems, Inc., Foster City, CA, USA) on an automated sequencer (ABI 3100; PerkinElmer-Applied Biosystems, Inc.). The sequence of CMP034 was compared with those of reference strains available in the National Center for Biotechnology Information GenBank database by using BLAST (www.ncbi.nlm.nih.gov/blast). The NSP4 nucleotide sequence of the CMP034 strain was deposited in GenBank under accession no. DQ534017.

The complete NSP4 nucleotide sequence of PoRV CMP034 strain was 750 bp and contained a single long open reading frame coding for a protein of 175 aa. Comparative analysis of the CMP034 NSP4 sequence with those of the 5 representative established genetic groups (A–E) showed the highest sequence identity, at 92.6% nt and 96.9% aa levels, with 1 PoRV strain, P21–5 (*9*). However, CMP034 and P21–5 shared a low degree of sequence identity with other NSP4 genetic groups. The NSP4 sequence identities of the CMPO34 and P21-5 strains ranged from 74% to 78% nt and 75%–79% aa levels with those of genetic group A; 77%–86% nt and 79%–86% aa levels with genetic group B; 69%–73% nt and 75%–78% aa levels with genetic group C; 62%–65% nt and 55%–60% aa levels with genetic group D; and only 43%–50% nt and 29%–33% aa levels with genetic group E. The phylogenetic tree confirmed that PoRV strains CMP034 and P21–5 were located exclusively in a separated branch, which was distantly related to the other 5 known NSP4 genetic groups (Figure). However, a bootstrap support for the separation of

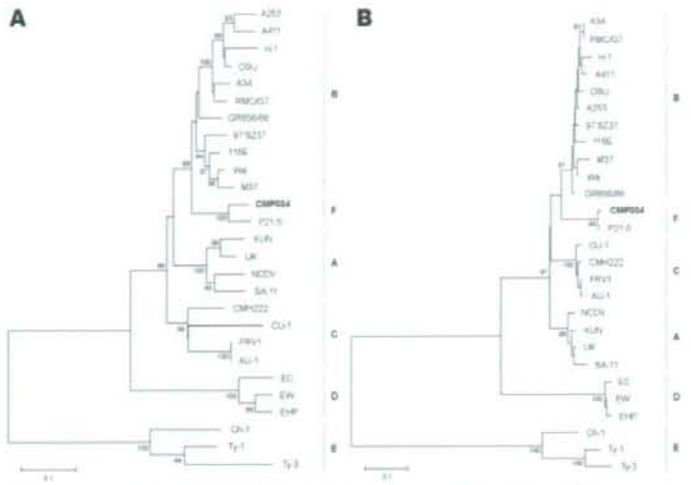

Figure. Phylogenetic analyses of the NSP4 nucleotide (A) and amino acid (B) sequences displaying the relationships between porcine rotavirus strain CMP034 (shown in **boldface**), P21–5, and other 5 known NSP4 genetic groups. Bootstrap values are shown at the branch nodes. Branch length for a 10% nucleotide difference is indicated at the bottom.

the gene into a separate lineage is very strong with nucleotide sequencing but weak by amino acid analysis in this phylogentic tree. Our finding indicates that PoRV strains CMP034 and P21–5 are likely a novel NSP4 genetic group and, therefore, tentatively proposed as a NSP4 genetic group F.

On the basis of the accumulated evidence of transmission of rotaviruses between pigs and other animal species, including humans, pigs are regarded as 1 potential reservoir for the emergence of unusual or novel strains of rotaviruses (*6*,*7*). In our study, the virus carried a novel NSP4 genetic group that has been isolated from a diarrheic piglet in Thailand. The NSP4 sequence analysis of our CMP034 strain revealed a PoRV strain closely related genetically to the NSP4 gene sequence of PoRV strain P21–5 isolated in Slovenia (*9*). PoRV strains CMP034 and P21–5 shared the same VP4 genotype as P[27] with over 90% aa sequence identity. The only difference observed between the 2 strains was that CMP034 belonged to the G2-like genotype whereas P21–5 belonged to G1 genotype. The relatedness between NSP4 sequences of strains CMP034 and P21–5 was confirmed by phylogenetic analysis, which showed that both CMP034 and P21–5 clustered closely together in a branch separated from those of other 5 NSP4 genetic groups. This finding suggests that NSP4 of PoRV strain CMP034 and P21–5 may have derived from the same ancestor. The isolation of 2 strains of rotaviruses with a close genetic relatedness of NSP4 gene from Thailand and Slovenia, 2 countries that are located in different continents, may indicate that this novel NSP4 genetic group has already been introduced into PoRVs worldwide. To verify this hypothesis, extensive epidemiologic surveillance of rotavirus in pigs may need to be conducted in several other regions of the world.

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PorB2/3 Protein Hybrid in *Neisseria meningitidis*

To the Editor: Class 2 and class 3 porin (PorB) proteins are the major proteins found in the outer membrane of *Neisseria meningitidis* (*1*); they function as porins, allowing the passage of small molecules through the outer membrane. PorB outer membrane proteins are transmembrane proteins with 8 predicted surface-exposed loops (I-VIII), which vary in length and in amino acid sequences. Several sequence analyses of these proteins have shown 4 regions with a high level of amino acid variability in loops I, V, VI, and VII (variable regions [VRs] 1–4) (*2*). The extensive antigenic variability of these proteins forms the basis of the *N. meningitidis* serotyping scheme (*3*,*4*). These 2 classes of proteins are mutually exclusive, and they are expressed by alternate alleles (*porB2* and *porB3*) at the *porB* locus (*1*).

All *N. meningitidis* strains received in the Spanish Reference Laboratory for *Neisseria* are routinely serotyped by whole-cell ELISA (*5*) with a set of monoclonal antibodies (MAbs) provided by the National Institute for Biological Standards and Control (South Mimms, UK) that includes the following serotypes: 1 (MN3C6B), 2a (5D4–5), 2b (MN2C3B), 4 (5DC4-C8G8), 14 (MN5C8C), 15 (8B5–5G9), and 21 (6B11F2B5). Those meningococci that appear as nonserotypeable (NT) are analyzed by sequencing the *porB* gene (*6*). In the case discussed here, in the sequencing of a NT strain, the *porB* gene showed an unusual sequence.

This strain, isolated in Spain during 2006, was recovered from the cerebrospinal fluid of a patient with meningococcal disease. The *porB* gene sequence shows VR1–4, which is exclusive of PorB3 protein, and VR2-Eb, VR3–2ab, and VR4-Cc, which are typical of PorB2 (GenBank accession no. EF094023). A comparison of this new sequence with the available *porB* sequences in the *Neisseria*.org database (http://neisseria.org/nm/typing/porB) enabled a more detailed analysis of the fragments corresponding to *porB3* and *porB2* found in this sequence. The fragment from nt 1 to 213 was identical to the *porB3–193* allelic variant (VR1–4, VR2-Aa, VR3–7, VR4–14b), and the second part, with nt 233–972 identical to *porB2–99* (VR1-Dc, VR2-Eb, VR3–2ab, VR4-Cc). The region of 214–232 nt is identical in the 3 variants. Therefore, this is a true hybrid molecule, which appears to have arisen from recombinational events between *porB2–99* and *porB3–193* alleles. In fact, this finding has prompted the inclusion of a new family called porB2/3 hybrid in the *Neisseria*.org database to facilitate the collection of this type of *porB* sequences.

The most likely origin of the *porB2/3* hybrid (4, Eb, 2ab, Cc) is the acquisition of DNA that encodes a VR1–4 sequence by a meningococcus with a *porB2–99* allelic variant. It is less likely that DNA encoding the *porB* VR2-Eb, VR3–2ab, and VR4-Cc sequences was acquired by a meningococcus with the *porB3–193* allelic variant because a longer fragment of DNA would have been transferred.

In spite of the presence of a VR1–4, which should be recognized by the set of MAbs used, this strain appeared as NT. A Western blot assay using MAb type 4 showed a good recognition epitope-MAb. Therefore, the failure of MAbs to identify this strain may have been due to the limited accessibility of the epitope because of the alteration of the PorB protein, which might be affecting its conformation. Once again, genetic characterization should be a preferred method over phenotypic characterization for typing meningococcal strains. Molecular characterization of NT strains in other laboratories might clarify the true frequency of this event.

Intragenic recombination between porin genes of the same allelic family is likely occurring in nature because mosaic gene structure has been reported in *porB* genes. However, *porB2/3* recombinants have never been previously found in the nature. Given the known ability of meningococci to be transformed by DNA from other strains, it is surprising that occurrence of genuine *porB2/3* hybrids has not yet been documented. There is only a report of naturally occurring gonococci expressing a hybrid *porB1a*/*porB1b* (*7*) (PorB1a and PorB1b gonococcus porins, as in meningococci, are encoded by 2 families of diverged alleles of the *porB* gene [*8*]). Gonoccocal strains expressing the recombinant *por* genes appear to be particularly susceptible to the bactericidal effect of human serum (*9*). A similar situation might happen in *N. meningitidis*, with a selective disadvantage in the invasive process of these hybrid strains, explaining the rarity of naturally occurring hybrids. By contrast, mechanisms like this are frequently used by meningococci to avoid the immune response against ordinary antigens. The balance between advantages and disadvantages at this level would show the true implications of this event.

This finding is relevant regardless of its frequency in nature. This report suggests how frequent the recombination events should occur among the meningococcal population: even theoretical mutually exclusive genes can produce hybrid variants; such knowledge is an important step in the development of future vaccines based on protein formulations.

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Norovirus and Sapovirus Infections among Children with Acute Gastroenteritis in Ho Chi Minh City during 2005–2006

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Summary

A molecular epidemiological study on common diarrheal viruses was conducted in a children's hospital in Ho Chi Minh City between December 2005 and November 2006. Fecal samples were collected from 502 pediatric patients with acute gastroenteritis, and were screened for the presence of norovirus (NoV) and sapovirus (SaV). NoVs GII and SaVs were detected in 6.4% and 1.2% specimens, respectively, while there was no NoV GI found among studied samples. NoVs could be identified through the year, except in April and July, with the peak of detection rate (62.5%) during the rainy season. Conversely, four out of six (66.7%) of the SaV strains were identified during the dry season. Patients aged between 6 and 23 months were found to be more infected by NoVs. The overall mean severity score of norovirus-positive patients was 9.8 ± 3.6, and no significant difference of severity scores among patients belonged to different age groups, gender and place of living. The results of phylogenetic analysis showed the diversity of caliciviruses circulating in the area, and various types of recombination were identified among NoVs and SaVs detected. These results provide important information on calicivirus infections among Vietnamese children.

Key words: norovirus, sapovirus, clinical manifestations, recombinant, Vietnam.

Introduction

Norovirus (NoV) and sapovirus (SaV) are members of the family *Caliciviridae* (other two genera are *Lagovirus* and *Vesivirus*). The NoV and SaV strains are determined as the major causes of non-bacterial acute gastroenteritis in infants and young children [1, 2].

After being discovered through electron microscope in 1972 [3], NoVs were identified widely in epidemiological studies, and were the cause of outbreaks of gastroenteritis in various settings including hospitals [4, 5], schools [6, 7], cruise ships [8, 9], restaurants [10, 11] and day care centers [12, 13]. Sequence analyses of worldwide NoVs revealed that they are classified into seven distinct genogroups (GI to GVII), of these, GI, GII, GIV, GVI and GVII are known to infect humans [14]. NoV contains a positive-sense single-stranded RNA genome surrounded by an icosahedral capsid. The NoV genome contains three open reading frames (ORFs). The ORF1 encodes non-structural proteins, including NTPase, protease and RNA-dependent RNA polymerase (RdRp), OR2 encodes the capsid protein (VP1) and ORF3 encodes a minor structural protein (VP2).

SaV infects both children and adults, and have been found to cause outbreaks of gastroenteritis in kindergarten [15], hospital [16] and mental health care facility [17]. SaV- associated diarrhea is usually mild, compared to that caused by NoVs [18].

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TABLE 1
Primer pairs used to amplify NoVs and SaVs in this study

Primer	Target virus	Polarity	Sequence position (5' to 3')/reference strain	Amplicon size	Target region
G1SKF	NoV GI	+	5342-5361 (Norwalk/68)	330bp	Polymerase and capsid junction
G1SKR	NoV GI	−	5653-5671 (Norwalk/68)		
COG2F	NoV GII	+	5003-5028 (Lordsdale)	387bp	Polymerase and capsid junction
G2SKR	NoV GII	−	5367-5389 (Lordsdale)		
SLV5317	SaV	+	5083-5105 (Manchester)	434bp	Polymerase and capsid junction
SLV5719	SaV	−	5494-5516 (Manchester)		

NoV GI, norovirus GI; NoV GII, norovirus GII; SaV, sapovirus.

SaVs can be divided into five genogroups (GI to GV), among which, GI, GII, GIV and GV are identified within humans [19]. The SaV GI, GIV and GV genomes contain three ORFs, whereas the SaV GII genome contains two ORFs. ORF1 encodes all the non-structural proteins, including RdRp, and the major capsid protein (VP1). ORF2 encodes a small protein, and ORF3 encode a protein of unknown function [20].

Normally, in both NoV and SaV, the genogroup/genotypes are generally maintained across the three ORFs. A recombinant NoV or SaV can be defined as one that clusters with two distinct groups of strains when two different regions (normally the capsid and polymerase) of the genome are subjected to phylogenetic analysis. Since the first NoV recombinant, Snow Mountain strain [21], was reported, various naturally occurring recombinants in different types have been identified [22–25]. Likewise, the identification of SaV recombinants have been reported elsewhere [26–28].

In Vietnam, NoVs and SaVs were identified from several epidemiological surveillances, and are considered as the important agents of viral gastroenteritis in the country [29, 30]. The first Vietnamese NoV recombinants were reported from a surveillance during 1999–2000 [30], since then, neither data about calicivirus infections nor recombinant virus has been reported. A hospital-based surveillance was conducted in Ho Chi Minh City during 2005–2006 that investigated the presence of common viral agents causing diarrhea in children, has been described elsewhere [31]. In this study, we reported in details the detection of NoVs and SaVs in the surveillance mentioned above, and described the molecular characteristics of NoV and SaV strains detected. The clinical manifestations and the evaluation of disease severity in patients were also included.

Materials and Methods

Patients

Patients with acute gastroenteritis who either visited the out-patient ward or were admitted to the Department of Gastroenterology, Children's Hospital 1, Ho Chi Minh City from December 2005 to Novemer 2006, were recruited in the surveillance. Patients were examined by pediatricians, and the clinical symptoms of dehydration were assessed based on the WHO guideline [32]. A 20-point Vesikari's score was used to evaluate the disease severity in patients [33].

Fecal samples collection and virus detection

A total of 502 fecal samples were collected from studied patients (one specimen from each patient). The fecal specimens from the outpatients were collected at the out-patient ward or from the inpatients within 24 h after admission and stored at −20°C until use. They were prepared as a 10% suspension in distilled water and the viral RNA genomes were extracted from the fecal suspension with a QIAamp Viral RNA Mini kit (QIAGEN®, Hilden, Germany) according to the manufacturer's instruction. The presence of NoVs and SaVs in fecal specimens was determined by RT-multiplex PCR [34]. Three primer pairs, G1SKR–G1SKF, COG2F–G2SKR and SLV5317–SLV5749 [34] were used to amplify NoVs GI, NoVs GII and SaVs, respectively (Table 1). PCR products were electrophoresed in a 1.5% agarose gel, followed by staining with ethidium bromide for 20 min, and then visualized under ultraviolet light. The results were recorded by photography.

Nucleotide sequencing and phylogenetic analysis

All of NoVs and SaVs detected in this study were subjected to nucleotide sequencing by using the Big Dye Terminator Cycle Sequencing kit version 3.1 and an ABI Prism 310 Genetic Analyzer (Applied Biosystems, Inc.) according to the manufacturer's instruction. Primer pairs mentioned above were used as sequencing primers, generating a partial nucleotide sequence, including both polymerase region and the capsid region [34]. Similarities of the sequenced strains with other strains were assessed by BLAST search using the default options (DNA DataBank of Japan). Multiple sequence alignments were

TABLE 2
Monthly distribution of NoVs and SaVs detected from children with acute gastroenteritis in the Children's Hospital 1, Ho Chi Minh City, during 2005–2006

Seasonality	Dry season					Rainy season						Dry	Total (%)
	Dec 05	Jan 06	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	
No of specimens	20	30	43	57	30	53	32	17	30	32	60	98	502 (100)
No (%) of NoVs	2 (10.0)	1 (3.3)	2 (4.7)	4 (7.0)	0 (0)	3 (5.7)	2 (6.3)	0 (0)	6 (20.0)	4 (12.5)	5 (8.3)	3 (3.1)	32 (6.4)
No (%) of SaVs	0 (0)	1 (3.3)	2 (4.7)	0 (0)	1 (3.3)	1 (1.9)	0 (0)	0 (0)	1 (3.3)	0 (0)	0 (0)	0 (0)	6 (1.2)

NoV, norovirus; SaV, sapovirus. 62.5% of NoVs were identified in the rainy season.

calculated using the CLUSTALX program, and the phylogenetic trees were constructed by the neighbor-joining method with the MEGA 3.1 software package [35], and using different NoVs and SaVs sequences available in GenBank for comparison and as outgroups.

Accession numbers

The selected nucleotide sequences of Vietnamese NoVs and SaVs strains described in this study have been deposited in GenBank under accession numbers EU137732–EU137739.

Results

Detection of NoVs and SaVs

Among 502 fecal specimens collected during the 1-year surveillance, NoVs GII were determined in 32 (6.4%) specimens, and SaVs were detected in six (1.2%) specimens. Fifteen and four specimens showing positive with NoV and SaV, respectively, were found to be in mixed infection with other viral pathogens. There was no NoV GI found in this study. Regarding seasonal pattern, NoVs could be identified through the year, except in April and July. Twenty out of 32 (62.5%) of the NoVs were detected during the rainy season, which usually begins in May and ends in October in the southern part of Vietnam, including Ho Chi Minh City. Conversely, four out of six (66.7%) of SaV strains were identified during the dry season (Table 2).

Characteristics of the NoV and SaV-positive patients

The Table 3 showed the characteristics of positive cases with NoVs and SaVs. Twenty-eight and four patients showing positive with NoVs and SaVs, respectively, had adequate medical records for further analyses. To characterize the age distribution, all patients were classified into five different age groups (<6, 6–11, 12–23, 24–35 and >35 months old). NoV patients were neither found in <6 nor in >35 months of age, while 27 out of 28 NoV patients were between 6 and 23 months of age. Similarly, three out of four SaV cases were classified into either 6–11 or 12–23 months age group. Majority of NoV patients (22/28, 78.6%) were male, however, three out of four SaV patients were female. Although the surveillance was conducted in a children's hospital in Ho Chi Minh City, only 11/28 (39.3%) cases lived in the city, the remaining 17/28 (60.7%) of NoV patients came from various provinces in the southern part of Vietnam.

Clinical signs and symptoms of NoV infections

Seventeen patients showing monoinfection with NoV [31] were selected for analysis of the clinical manifestations, among them 15 medical records were enough data for further analyses. The main clinical signs and symptoms observed in children with NoV infection were diarrhea (100%), watery stool (93.3%), vomiting (66.7%), highest temperature $\geq$38.5°C (33.3%), coughing (26.7%) and coryza (6.7%). The mean duration of diarrhea and vomiting were 4.4 ± 3.9 days and 1.5 ± 1.7 days, respectively, and the maximum episodes of diarrhea and vomiting were 6.5 ± 2.5 times per day and 3.3 ± 2.8 times per day, respectively (Table 4).

Evaluation of severity in patients showing monoinfection with NoV by using a 20-point numerical score showed that the mean severity score of NoV positive patients was 9.8 ± 3.6. The severity scores were analyzed further by age groups, gender, place of living (Ho Chi Minh City and non-Ho Chi Minh City residents), time of collection (during rainy and dry season) and status of patients (hospitalized and non-hospitalized patients) (Table 3). Obviously, the mean severity scores of patients belonging to some groups were observationally lower than those of other groups (e.g., patients who were 12–23 months old, or patients who lived in Ho Chi Minh City); however, the difference was not statistically significant ($p > 0.05$). The only significant difference was observed between inpatients and outpatients, with the mean severity scores in each group being 10.82 ± 3.49 ($N = 11$) and 7.0 ± 2.45 ($N = 4$), respectively ($p < 0.05$). A comparison of the mean severity scores between monoinfection cases and

TABLE 3
Attributes of NoV positive cases[a] and mean severity score of patients in each group

	Distribution of patients by									
	Age (months)				Gender		Place of living		Patient status	
	<6	6–11	12–23	24–35	>35	Male	Female	HCMC[b]	Others	Inpatient	Outpatient
No. (%) of NoV cases	0 (0)	10 (35.7)	17 (60.7)	1 (3.6)	0 (0)	22 (78.6)	6 (21.4)	11 (39.3)	17 (60.7)	21 (75)	7 (25)
Vesikari's score[c]		11.4 ± 4.28 ($N = 5$)	8.67 ± 3.16 ($N = 9$)	12.0 ($N = 1$)		9.7 ± 3.97 ($N = 10$)	10.0 ± 3.16 ($N = 5$)	8.2 ± 1.92 ($N = 5$)	10.6 ± 4.06 ($N = 10$)	10.82 ± 3.49[d] ($N = 11$)	7.0 ± 2.45[d] ($N = 4$)

[a]Data based on 28 complete medical records.
[b]HCMC, Ho Chi Minh City.
[c]Data based on 15 medical records of patients who showed monoinfection with NoV.
[d]$P < 0.05$.

TABLE 4
Clinical signs and symptoms of patients who showed monoinfection with NoV during a one-year surveillance in Ho Chi Minh City, 2005–2006

Signs and symptoms	NoV infection cases
Diarrhea	100%
Watery stool	93.3%
Vomiting	66.7%
Temperature ≥ 38.5°C	33.3%
Coughing	26.7%
Coryza	6.7%
Mean duration of diarrhea	4.4 ± 3.9 days
Mean duration of vomiting	1.5 ± 1.7 days
Maximum episodes of diarrhea/day	6.5 ± 2.5 times per day
Maximum episodes of vomit/day	3.3 ± 2.8 times per day

mixed infection cases was also performed, however, the difference was not statistically significant (data not shown).

Only one medical record from two patients showing monoinfection with SaV was available, therefore, description of the clinical features of SaV infection in this study was not performed.

Phylogenetic analysis of NoV strains and identification of various recombinations

All of the 32 NoV strains detected in this study were successfully determined nucleotide sequence with the amplified fragments, which included both polymerase and capsid region. Phylogenetic analysis based on the capsid region revealed that 16/32 (50%) NoV strains clustered within the GII.4, and 13/32 (40.6%) strains belonged to the GII.3b cluster, according to the classification reported by Phan *et al.* [14]. One strain, HCMC91, clustered together with GII.12 NoV strains (96% nucleotide identity with the Chitta strain), and other two strains, HCMC204 and HCMC311, belonged to the GII.6 cluster (95% nucleotide identity with the SaitamaU17 strain). Interestingly, these two Vietnamese GII.6 strains did not group with any GII.6 NoV strains from sublineage a to d, therefore, clustered into a novel sublineage, tentatively called GII.6e (Fig. 1).

To verify the sequence identities of the GII strains, an additional phylogenetic analysis of Vietnamese NoV strains and other reference strains based on the polymerase region was performed (Fig. 2). All of the 16 capsid-based GII.4 NoV strains maintained their genotype in the polymerase region, however, other strains bored a different either genotype or subgenotype when polymerase-based grouping was carried out. Twelve out of the 13 capsid-based GII.3b NoV strains clustered into the GII.3a lineage,

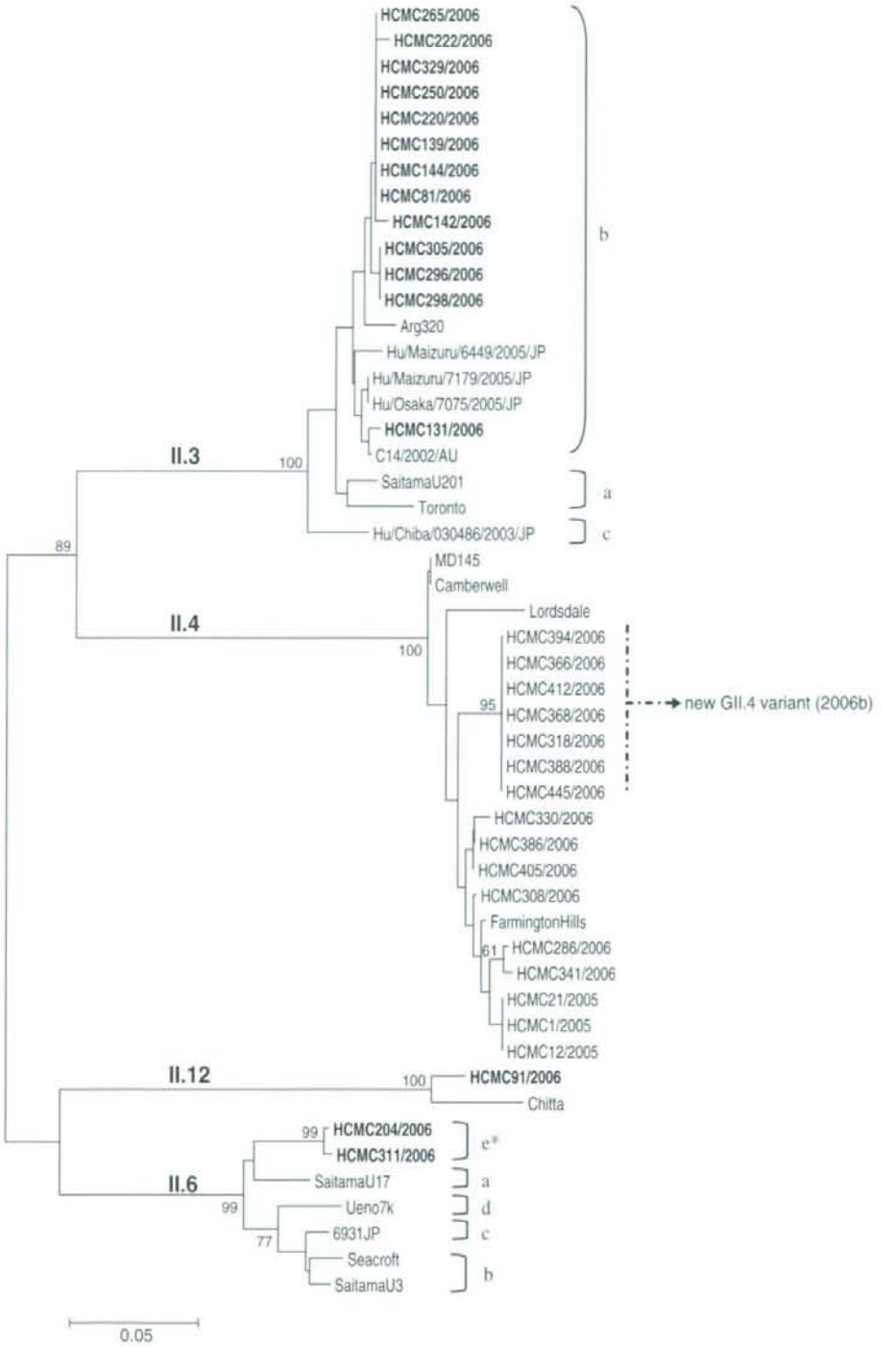

FIG. 1. Phylogenetic tree of the capsid region of 32 Vietnamese NoVs and other reference NoV strains available from GenBank. Vietnamese recombinant strains are in bold face. Genotypes and subgenotypes are indicated. Bootstrap values >75% are shown at the brach nodes.

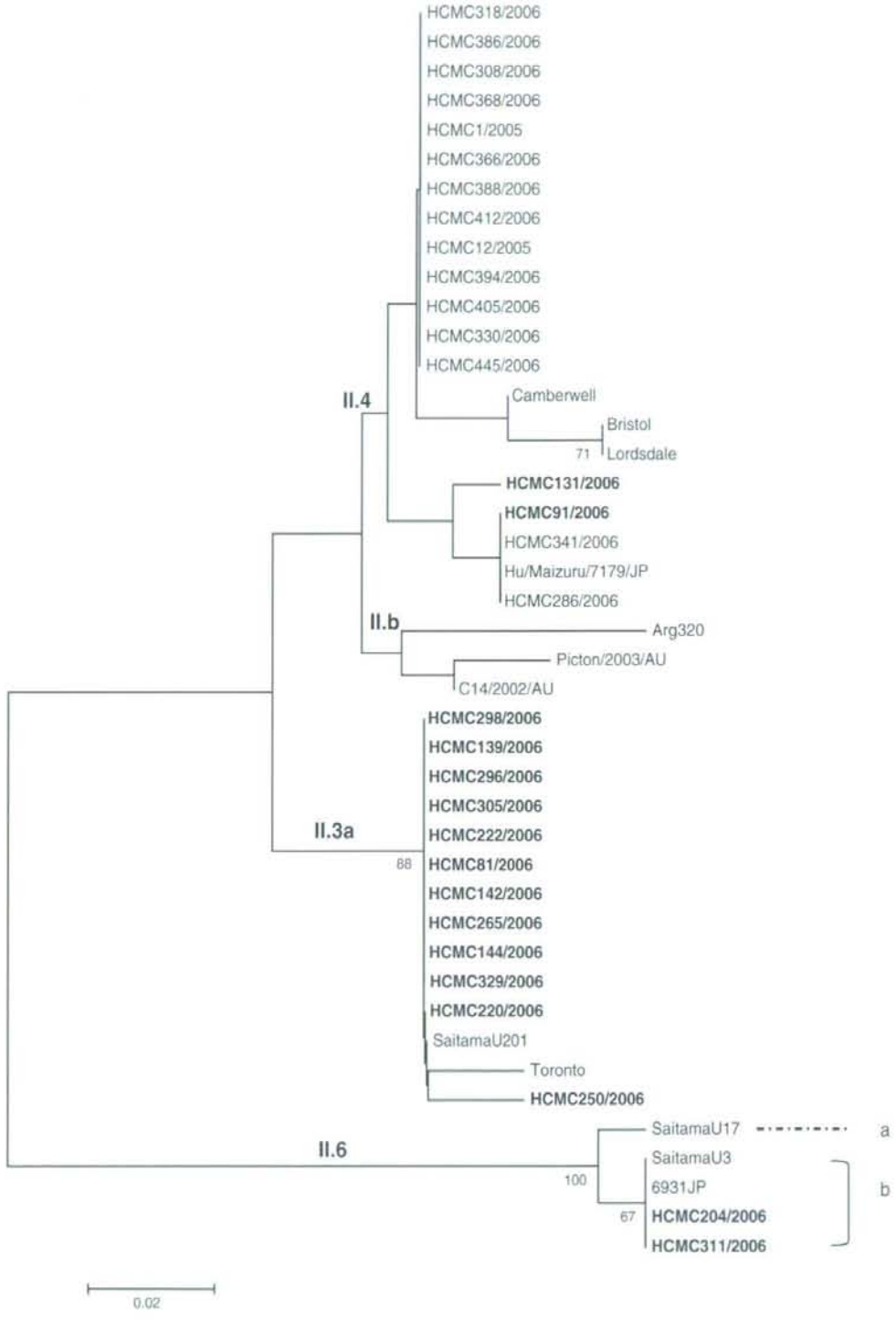

FIG. 2. Phylogenetic tree of the polymerase region of 32 Vietnamese NoVs and other reference NoV strains available from GenBank. Vietnamese recombinant strains are in bold face. Genotypes and subgenotypes are indicated.

TABLE 5
Molecular characteristics of NoVs strains detected among patients with acute gastroenteritis in the Children's Hospital 1, Ho Chi Minh City, during 2005–2006

Strain	Collection date[a]	Polymerase		Capsid		Type of recombination
		Genogroup/genotype	Representative	Genogroup/genotype	Representative	
HCMC1	Dec	II.4		II.4		
HCMC12	Dec	II.4		II.4		
HCMC21	Jan	II.4		II.4		
HCMC81	Feb	II.3a	Toronto	II.3b	Arg320	Intersubgenotype
HCMC91	Feb	II.4	Lordsdale	II.12	Chitta	Intergenotype
HCMC131	Mar	II.4	Lordsdale	II.3b	Arg320	Intergenotype
HCMC139	Mar	II.3a	Toronto	II.3b	Arg320	Intersubgenotype
HCMC142	Mar	II.3a	Toronto	II.3b	Arg320	Intersubgenotype
HCMC144	Mar	II.3a	Toronto	II.3b	Arg320	Intersubgenotype
HCMC204	May	II.6b	SaitamaU3	II.6e	N/A	Intersubgenotype
HCMC220	May	II.3a	Toronto	II.3b	Arg320	Intersubgenotype
HCMC222	May	II.3a	Toronto	II.3b	Arg320	Intersubgenotype
HCMC250	Jun	II.3a	Toronto	II.3b	Arg320	Intersubgenotype
HCMC265	Jun	II.3a	Toronto	II.3b	Arg320	Intersubgenotype
HCMC286	Aug	II.4		II.4		
HCMC296	Aug	II.3a	Toronto	II.3b	Arg320	Intersubgenotype
HCMC298	Aug	II.3a	Toronto	II.3b	Arg320	Intersubgenotype
HCMC305	Aug	II.3a	Toronto	II.3b	Arg320	Intersubgenotype
HCMC308	Aug	II.4		II.4		
HCMC311	Aug	II.6b	SaitamaU3	II.6e	N/A	Intersubgenotype
HCMC318	Sep	II.4		II.4		
HCMC329	Sep	II.3a	Toronto	II.3b	Arg320	Intersubgenotype
HCMC330	Sep	II.4		II.4		
HCMC341	Sep	II.4		II.4		
HCMC366	Oct	II.4		II.4		
HCMC368	Oct	II.4		II.4		
HCMC386	Oct	II.4		II.4		
HCMC388	Oct	II.4		II.4		
HCMC394	Oct	II.4		II.4		
HCMC405	Nov	II.4		II.4		
HCMC412	Nov	II.4		II.4		
HCMC445	Nov	II.4		II.4		

N/A, not applicable.

whereas the other strain, HCMC131, grouped with other GII.4 strains when polymerase-based grouping was performed. This type of recombination, GII.3b/GII.4, was similar to that of the NoV recombinant strain 5017/04/JP, which was reported formerly [36]. Similarly, the capsid-based GII.12 strain, HCMC91, bored a different genotype, GII.4 when a BLAST search was performed in the polymerase region. This strain also shared best identity, 96%, with the well-known GII.4/GII.12 recombinant strain SaitamaU1 [22] in both the polymerase and capsid region, demonstrating that HCMC91 was also a recombinant virus. Regarding two capsid-based GII.6e strains, HCMC204 and HCMC311, the polymerase-based phylogenetic tree clearly showed that they clustered together with other NoV strains into the GII.6b sublineage, therefore, these two Vietnamese strains were GII.6b/GII.6e recombinant strains. Altogether, half of the NoV (16/32) strains identified in this study were determined as recombinant viruses (Table 5).

Phylogenetic analysis of SaV strains and the identification of a novel recombination

Results of nucleotide sequencing of the 434 bp PCR product allowed us to analyze the molecular characteristics of both polymerase and the capsid region of SaV strains detected. Among six Vietnamese SaV strains, genotype GI.1, GI.2 and GII.1 were identified in two, one and one strain, respectively, and all of these four SaV strains maintained the same genogroup/genotype across polymerase and the capsid region (Fig. 3). However, the remaining two strains, HCMC86 and HCMC180, showed different genotypes when the polymerase-based and capsid-based phylogenetic analyses were conducted. These two SaV strains shared 100% nucleotide identity,

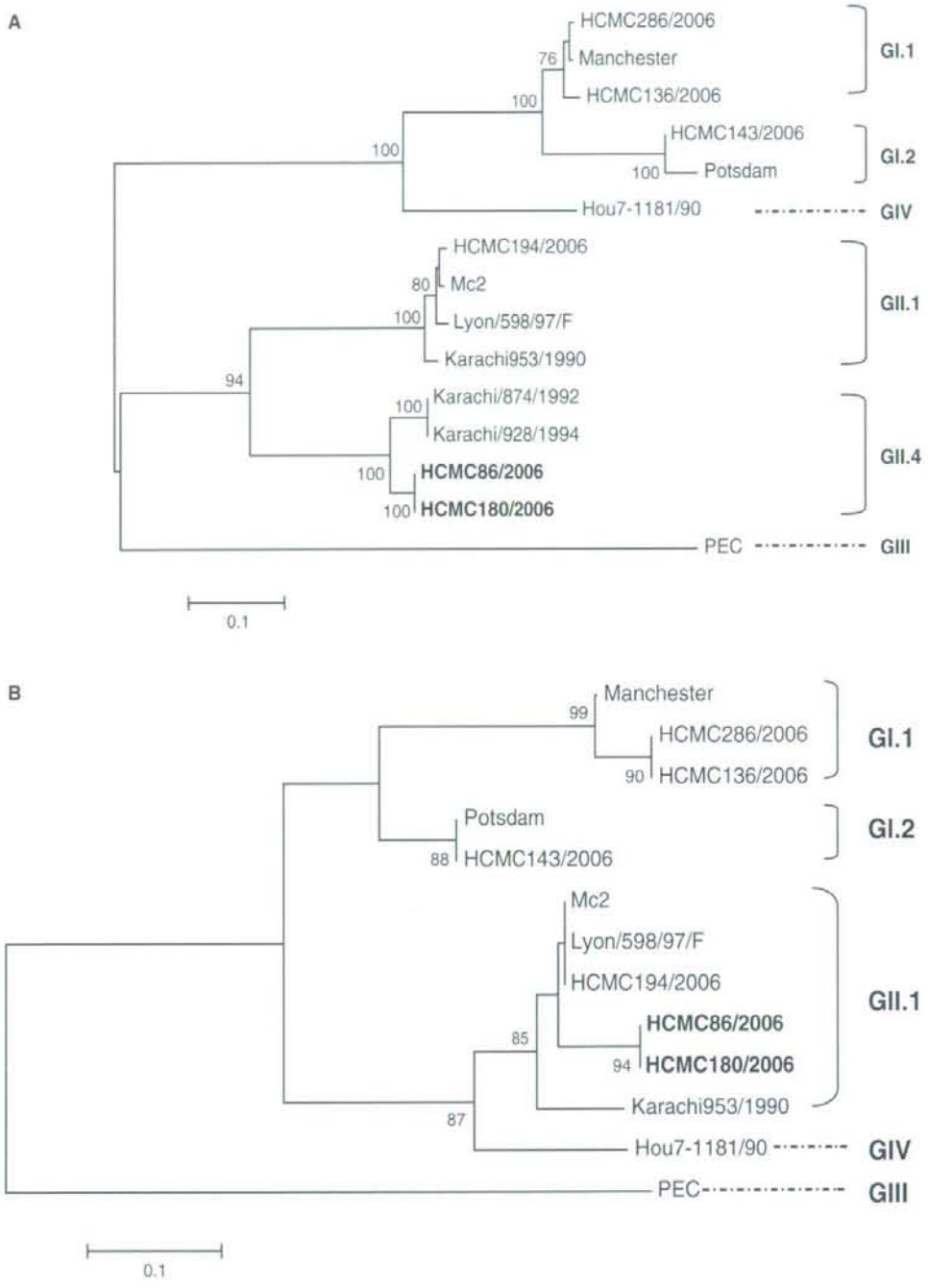

FIG. 3. Phylogenetic tree of the (**A**) capsid and (**B**) polymerase region of 32 Vietnamese SaVs and other reference SaVs. Two Vietnamese SaVs strain, HCMC86 and HCMC180, showed different genotypes when polymerase-based and capsid-based phylogenetic trees were constructed.

which indicates that they are the same strain. Nucleotide comparison showed that HCMC86 and HCMC180 had best identities (89.8–94.2%) with GII.1 strains in the polymerase region; however, they had higher homology with two Pakistani GII.4 SaV strains (Karachi/874 and Karachi/928) than GII.1 strains (94.2% vs. 67.7–68.1%) when a capsid-based comparative analysis was performed (Table 6).

TABLE 6
Percentage nucleotide homology of the polymerase and capsid region[a] of Vietnamese SaV strains and other reference strains

	I/1			I/2		IV	II/1			II/4			III
	Manchester	HCMC286	HCMC136	Potsdam	HCMC143	Hou7-1181	Mc2	HCMC194	Lyon/598	HCMC86	HCMC180	Karachi/874	Karachi/928	PEC
Manchester		99.2	97.4	80.8	81.5	65.7	48.9	49.6	49.6	49.6	49.6	48.5	48.5	45.4
HCMC286	97.1		97.4	81.2	81.9	66.0	48.9	49.6	49.6	49.2	49.2	48.2	48.2	45.4
HCMC136	97.1	100		80.4	80.4	65.3	48.9	49.6	49.6	48.5	48.5	48.2	48.2	45.4
Potsdam	84.0	81.1	81.1		97.1	63.1	46.0	45.3	46.0	44.3	44.3	42.9	42.9	41.4
HCMC143	84.0	81.1	81.1	100		63.8	47.1	46.4	47.1	46.0	46.0	44.6	44.6	40.7
Hou7-1181	73.9	72.4	72.4	73.9	73.9		46.7	47.1	47.5	49.2	49.2	47.1	47.1	40.8
Mc2	72.4	69.5	69.5	76.8	76.8	85.5		98.9	98.2	68.1	68.1	67.3	67.3	43.5
HCMC194	68.1	65.2	65.2	72.4	72.4	81.1	95.6		97.8	68.1	68.1	67.3	67.3	43.2
Lyon/598	72.4	69.5	69.5	76.8	76.8	85.5	100	95.6		67.7	67.7	67.0	67.0	44.6
HCMC86	71.0	71.0	71.0	75.3	75.3	84.0	94.2	89.8	94.2		100	94.2	94.2	45.7
HCMC180	71.0	71.0	71.0	75.3	75.3	84.0	94.2	89.8	94.2	100		94.2	94.2	45.7
Karachi/874[b]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		100	45.0
Karachi/928[b]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		45.0
PEC	50.7	50.7	50.7	55.0	55.0	50.7	52.1	49.2	52.1	52.1	52.1	N/A	N/A	

Best identities results of HCMC86 and HCMC180 are in shaded.
[a]Nucleotide homology of polymerase region is shown in the lower left, and capsid region is in the upper right. Genogroups and genotypes are also indicated.
[b]The nucleotide sequences of the polymerase region of Karachi/874 and Karachi/928 are not available.

The phylogenetic analysis also indicated clearly that HCM86 and HCM180 clustered into two different genotypes when polymerase-based and capsid-based nucleotide phylogenetic trees were constructed. Altogether, these two Vietnamese SaV strains are GII.1/GII.4 recombinant strains.

Discussion

In this study, we reported the detection of NoVs and SaVs among diarrheic children in the Children's Hospital 1, Ho Chi Minh City, during 2005–2006. With the overall detection rate of 6.4% and 1.2%, respectively, NoVs and SaVs continued to be viral agents causing acute gastroenteritis in children in the southern part of Vietnam. Although these detection rates were slightly lower than those of the studies in developed countries [37, 38], the results in this study were similar to those of the epidemiological studies conducted previously at the same hospital [29, 30], and also comparative with other surveillances in other developing countries [39, 40]. Despite difference of time, the detection of NoVs and SaVs with similar proportions in the southern part of Vietnam indicated that these viruses have circulated stably in the area. NoV GI was not found in this study, and this result was in agreement with the previous study [29]. The absence of NoV GI in epidemiological surveillance was also reported elsewhere [18, 34]. The primer sets using in this study have been used to screen caliciviruses in other surveys, and they successfully identified NoV GI in the studied samples. Therefore, the inability to detect NoV GI strains in this study might have resulted from the absence of this virus within the collected fecal specimens.

In temperate climate countries, NoVs are usually identified in the winter time [36, 38], whereas in tropical countries, the seasonal pattern of NoVs is not clear. In this survey, NoVs was found all year round, except in April and July. Moreover, 62.5% of NoVs were detected from May to October, indicated that this virus prevailed during the rainy season. This result was concordant with that of the previous study during 2002–2003 [29], and slightly different from the result of the 1999–2000 survey, in which, NoVs prevailed at the end of the rainy season and the first half of the dry season [30]. However, the results of the 1999–2000 survey based on the specimens that were negative for other common viral agents, therefore, the absence of NoVs strains, if any, which were mixed infection with other viruses, might make the feature of monthly distribution of NoVs incomplete.

NoV GII.4 was the most common (50.0%) genotype among NoV strains detected in this study. Previous studies in Ho Chi Minh City also found NoV GII.4 in 78% and 82.1% of samples [29, 30], confirming the predominance of this genotype.

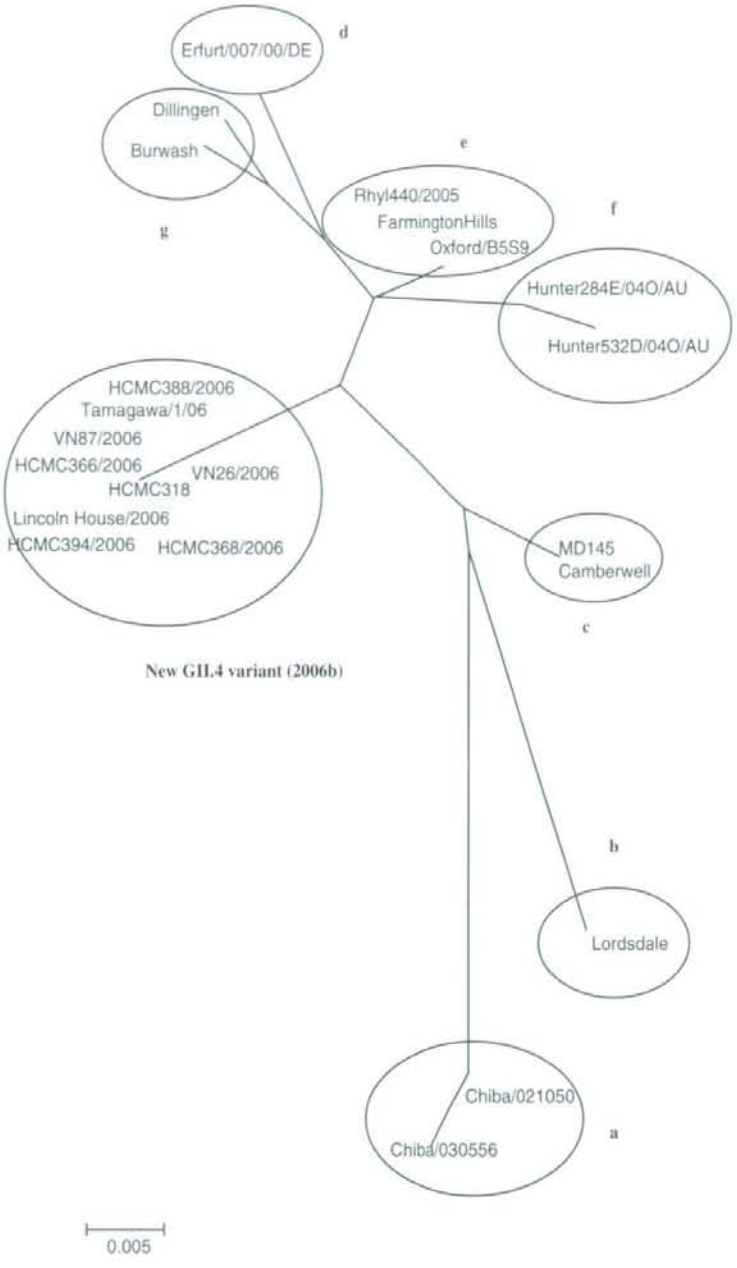

FIG. 4. Unrooted phylogenetic tree of new NoV GII.4 variant identified in this study and other GII.4 lineages. Vietnamese NoVs detected from another study [41], VN26 and VN87, as well as other reference strains, Tamagawa/1/06 and Lincoln House/2006, are included. The classification is based on Phan *et al.* [14].

However, 7 out of 16 Vietnamese GII.4 strains in this study belonged to a distinct cluster which has been determined as a novel GII.4 variant, 2006b [41] (Figs 1 and 4). These strains were firstly identified in September, and continued to be detected until the end of the surveillance, suggesting that these viruses have been continuing to prevail in this area in the coming year. Different genotypes of NoVs and SaVs were determined in this study, and among them, several genotypes have not been reported formerly in Vietnam (NoV GII.6, SaV GI.2 and GII.4). Of interest, SaV GII.4 was only

reported in two unique Pakistani strains collected in 1992 and 1994, respectively [42]. On the other hand, the 'new variant' designated GII.b NoVs, which has been detected in Europe in the beginning of 2000s and then identified in Asia [36, 38, 43, 44], could not be found in this study. A larger number of specimens, as well as an attempt to collect fecal samples from different places in Vietnam is needed for confirming the absence of this virus in the country.

Although detected in several epidemiological studies, and being considered as important viral agent causing acute gastroenteritis in young infants and children, this was the first time, to our knowledge that the clinical manifestations of NoV infections were described in Vietnamese pediatric patients. The clinical features of NoV-associated acute gastroenteritis observed among patients in this study were similar to those of other reports, including diarrhea with watery stool, vomiting and fever [18, 20]. Although the results of this study were comparable to another study conducted in Japan [18], the mean duration of diarrhea and maximum episodes of diarrhea per day in Vietnamese children were observationally higher than those of Finnish children (4.4 days vs. 2 days, 6.5 times/day vs. 4 times/day) [45]. The difference might be explained by the population studied. In this study, we collected samples from patients who sought to the hospital, whereas the survey carried out in Finland was a community-based study. Therefore, although both were classified as moderately severe diseases (8–10 points) [45], the mean severity score in Vietnamese patients was obviously higher than that of Finish children (9.8 vs. 8).

A comparative analysis was performed in order to see the difference in severity among several groups of patients, however, only the mean scores were statistically different between inpatients and outpatients. This situation was also observed among astrovirus positive patients described previously [31].

The clinical manifestation of SaV infection in this study could not be demonstrated because only one medical record among two SaV monoinfection cases was available. This patient suffered from an 8-day diarrhea, with maximum episode of diarrhea was 20 times per day and high fever up to 39°C. This feature was much different from other reports, which described SaV-associated diarrhea to be a mild disease. More clinical data on larger number of patients are needed in order to identify properly the clinical features of SaV infection in Vietnamese children.

RNA recombination plays a key role in virus evolution and it shapes a good deal of the virus diversity [46]. Recombinant NoV strains were increasingly found in epidemiological surveillances throughout the world [22, 23, 38, 43], including Vietnam [30]. In this survey, various types of recombination in NoVs were identified. Of interest, the GII.6b (polymerase)/GII.6e (capsid) recombination was first reported in this study. Similarly, the recombinant GII.1/GII.4 SaV strain detected in this survey has not been described elsewhere. Half of NoV strains, and one out of six SaV strains were identified as recombinant viruses, thus indicates that recombination is not a rare event, and the caliciviruses circulating in Vietnam have a trend to be more diverse.

The results of this study highlight the impact of caliciviruses in diarrheal diseases among children in Ho Chi Minh City, and are the first to describe the clinical manifestations of NoV infections in Vietnamese children. The data of nucleotide analysis from this study could provide useful information for knowledge on caliciviruses characteristics.

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Risk for HIV-1 infection is not associated with Repeat-Region polymorphism in the DC-SIGN neck domain and Novel Genetic DC-SIGN Variants among North Indians

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Abstract

Background: Several genetic factors have been related to HIV-1 resistance, the homozygosity for a mutation in CCR5 gene (CCR5Δ 32 allele) is presently considered the most relevant one. The C-type lectin, DC-SIGN efficiently binds and transmits HIV-1 to susceptible cell *in trans* thereby augmenting the infection. A potential association of the DC-SIGN neck domain repeats polymorphism and risk of HIV-1 infection is currently under debate.

Methods: Genetic risk association study was conducted in HIV-1 exposed seronegative (HES; $n=50$) individuals, HIV-1 seronegative (HSN; $n=314$) healthy control and HIV-1 infected seropositive patients (HSP; $n=190$) for polymorphism in neck domain of DC-SIGN gene. The DC-SIGN genotypes were identified by PCR from DNA extracted from peripheral blood and confirmed by sequencing. Fisher exact or χ^2 test was used for statistical analysis.

Results: One HSN and HSP individual who were heterozygous (7/8) with respect to DC-SIGN repeat regions were found. The DC-SIGN neck repeat polymorphism among North Indian individuals was not associated with susceptibility to HIV-1 infection. Furthermore, inheritance study of heterozygous mutation (7/8) in HSN individual's family showed that one parent, two brothers, one sister and one daughter were heterozygous (7/8) for DC-SIGN mutant allele. Sequence analyses of DC-SIGN exon 4 repeat region of randomly selected 25 North Indian individuals from HSP, HSN and HES revealed four conserved intronic mutations. These mutations were at nucleotide position 1283, 1306, 1308 upstream and 1906 downstream of the DC-SIGN exon 4 repeat region when compared with the wild type sequence (NCBI Acc. No. AF209479).

Conclusion: The polymorphism in DC-SIGN neck repeats region was rare and not associated with HIV-1 susceptibility among North Indians. Sequencing analysis of DC-SIGN gene confirmed four novel genetic variants in intronic region flanking exon 4 coding region.

Keywords: DC-SIGN; Innate immunity; HIV-1 infection; Intron; Exon; DC-SIGN gene

1. Introduction

Genetic polymorphism in human genes can influence the risk for HIV-1 infection and disease progression [1,2]. There are some individuals who remain seronegative despite high risk and/or multiple exposures to HIV-1 [3,4]. Although several factors have been related to HIV-1 infection resistance, the possible genetic mechanism underlying this resistance is the homozygous presence of a 32 bp deletion in CCR5 gene (CCR5 Δ32), i.e. the main co-receptor used by the macrophage (M)-tropic strain of the virus to infect peripheral blood mononuclear cells [5].

The dendritic cell receptor, DC-SIGN (dendritic cell-specific ICAM-3 grabbing non-integrin, encoded by CD209) is a type II membrane associated C-type lectin that binds HIV-1 envelope glycoprotein gp120 in a CD4-independent manner and function

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