Overview

Useful For
Serial monitoring of CD4 T cell count in HIV-positive patients

Useful for follow-up and diagnostic evaluation of primary cellular immunodeficiencies, including severe combined immunodeficiency

T-cell immune monitoring following immunosuppressive therapy for transplantation, autoimmunity, and other immunological conditions where such treatment is utilized

Assessment of T-cell immune reconstitution post hematopoietic cell transplantation

Early screening of gross quantitative anomalies in T cells in infection or malignancies

Method Name
FlowCytometry, SinglePlatform(CD3, CD4, CD8, CD45)

NY State Available
Yes

Specimen

Specimen Type
Whole Blood EDTA

Shipping Instructions
It is recommended that specimens arrive within 24 hours of draw. Draw and package specimen as close to shipping time as possible.

Necessary Information
Date of draw is required.

Specimen Required
For serial monitoring, we recommend that specimen draws be performed at the same time of day.

Container/Tube: 4 mL Lavender top (EDTA)

Specimen Volume: 3 mL

Collection Instructions: Send specimen in original tube. Do not aliquot.

Specimen Minimum Volume
0.2 mL

Reject Due To

<table>
<thead>
<tr>
<th>Gross hemolysis</th>
<th>Reject</th>
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<tbody>
<tr>
<td>Gross lipemia</td>
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Document generated July 25, 2020 at 4:30pm CDT
Specimen Stability Information

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<td>72 hours</td>
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Clinical and Interpretive

Clinical Information

Lymphocytes in peripheral blood (circulation) are heterogeneous and can be broadly classified into T cells, B cells, and natural killer cells. There are various subsets of each of these individual populations with specific cell-surface markers and function. This assay provides absolute (cells/mcL) and relative (%) quantitation for total T cells and CD4+ and CD8+ T-cell subsets, in addition to a total lymphocyte count (CD45+). Each of these lymphocyte subpopulations have distinct effector and regulatory functions and are maintained in homeostasis under normal physiological conditions. Each of these lymphocyte subsets can be identified by a combination of 1 or more cell surface markers. The CD3 antigen is a pan-T cell marker, and T cells can be further divided into 2 broad categories, based on the expression of CD4 or CD8 co-receptors.

The absolute counts of lymphocyte subsets are known to be influenced by a variety of biological factors, including hormones, the environment, and temperature. The studies on diurnal (circadian) variation in lymphocyte counts have demonstrated progressive increase in CD4 T-cell count throughout the day, while CD8 T cells increase between 8:30 a.m. and noon with no change between noon and afternoon. (1) Circadian variations in circulating T-cell counts have been shown to be negatively correlated with plasma cortisol concentration. (2-4) In fact, cortisol and catecholamine concentrations control distribution and, therefore, numbers of naive versus effector CD4 and CD8 T cells. (2) It is generally accepted that lower CD4 T-cell counts are seen in the morning compared to the evening and during summer compared to winter. (5)

These data, therefore, indicate that timing and consistency in timing of blood collection is critical when serially monitoring patients for lymphocyte subsets.

Abnormalities in the number and percent of CD3, CD4, and CD8 T cells have been described in a number of different disease conditions. In patients who are infected with HIV, the CD4 count is measured for AIDS diagnosis and for initiation of antiviral therapy. The progressive loss of CD4 T-lymphocytes in patients infected with HIV is associated with increased infections and complications. The Public Health Service has recommended that all HIV-positive patients be tested every 3 to 6 months for the level of CD4 T-lymphocytes.

Basic T-cell subset quantitation is also very useful in the evaluation of patients with primary cellular immunodeficiencies of all ages, including follow-up for newborn screening for severe combined immunodeficiency and immune monitoring following immunosuppressive therapy for transplantation, autoimmunity, or any other relevant clinical condition where immunomodulatory treatment is used, and the T-cell compartment is specifically affected.

It is also helpful as a preliminary screening assay for gross quantitative anomalies in T cells, whether related to malignancies or infection.

Reference Values

The appropriate age-related reference values will be provided on the report.
Interpretation
HIV treatment guidelines from the US Department of Health and Human Services and the International Antiviral Society USA Panel recommend antiviral treatment in all patients with HIV infection, regardless of CD4 T-cell count. (7,8) Additionally, antibiotic prophylaxis for *Pneumocystis jiroveci* infection and other opportunistic infections is recommended for patients with CD4 counts below 200 cells/mcL.

Cautions
*T-cell counts should be appropriately interpreted in context of the clinical presentation and other immunological parameters and relevant laboratory test results.*

For serial monitoring of T-cell numbers it is recommended that the patient be evaluated at the same time of the day to account for diurnal variation.

For follow-up of infants identified by newborn screening for severe combined immunodeficiency (SCID) and severe T-cell lymphopenia, SCID should be considered as a potential diagnosis in infants with fewer than 300 autologous CD3 T cells/mcL. Infants with 300 to 1,500 autologous CD3 T cells/mcL may have leaky SCID, Omenn syndrome, or variant SCID, depending on other clinical and molecular features.

T-cell lymphopenia in infants identified by newborn screening for SCID is defined as having up to 1,500 autologous CD3T cells/mcL.

This assay should not be used for diagnosing T-lymphocytic malignancies or evaluation of T-cell lymphocytosis of unknown etiology, though the latter may be identified through this assay in a screening assessment. In such cases, test LCMS / Leukemia/Lymphoma Immunophenotyping, Flow Cytometry, Varies will be recommended, which includes a hematopathology review.

Also, when diagnostically assessing lymphocyte subsets (quantitatively) in any of the above clinical contexts, it may be more useful to order the T-cell, B-cell and natural killer cell quantitation assay rather than the T-cell subset quantitation alone, as it excludes B-and natural killer-cell counts.

Clinical Reference


**Performance**

**Method Description**

The T cell surface marker assay uses monoclonal antibodies to identify the various membrane antigens, and flow cytometry to enumerate the number of cells expressing these differentiation antigens. CD14 is used to exclude monocytes, thereby improving accuracy and enhancing the purity of the lymphocyte population. The results are reported as the percent of lymphocytes that are total T cells (CD3+), CD3+CD4+ T cells, and CD3+CD8+ T cells, along with the absolute number of each cell type per microliter of blood. The assay is a 5-color, no-wash procedure and the absolute counts are calculated from internal bead standards. The total CD45+ lymphocyte count (reported as thousand cells per microliter) and the CD4:CD8 ratio are also reported.(Hoffman RA, Kung PC, Hansen WP, Goedstien G: Simple and rapid measurement of human T lymphocytes and their subclasses in peripheral blood. Proc Natl Acad Sci USA 1980;77:4914-4917; US Department of Health and Human Services: Guidelines for performance of CD4+ T-cell determinations in persons with human immunodeficiency virus infection. MMWR 46 no. RR-2:1997, pp1-29)

**PDF Report**

No

**Day(s) and Time(s) Test Performed**

Monday through Sunday

**Analytic Time**

Same day/1 day

**Maximum Laboratory Time**

2 days

**Specimen Retention Time**

4 days

**Performing Laboratory Location**

Rochester

**Fees and Codes**

**Fees**

- Authorized users can sign in to Test Prices for detailed fee information.
- Clients without access to Test Prices can contact Customer Service 24 hours a day, seven days a week.
- Prospective clients should contact their Regional Manager. For assistance, contact Customer Service.

**Test Classification**

This test was developed using an analyte specific reagent. Its performance characteristics were determined by Mayo Clinic in a manner consistent with CLIA requirements. This test has not been cleared or approved by the U.S. Food and Drug Administration.

**CPT Code Information**

86359-T cells, total count
86360-Absolute CD4/CD8 count with ratio

**LOINC® Information**

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