Comparison of pathological clotting using haematological, functional and morphological investigations in HIV-infected and HIV-uninfected patients with deep vein thrombosis

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Abstract

Background Patients infected with the human immunodeficiency virus (HIV) are more prone to systemic inflammation and pathological clotting, and many may develop deep vein thrombosis (DVT) as a result of this dysregulated inflammatory profile. Coagulation tests are not routinely performed unless there is a specific reason. Methods We recruited ten healthy control subjects, 35 HIV negative patients with deep vein thrombosis (HIV negative-DVT), and 13 HIV patients with DVT (HIV positive-DVT) on the primary antiretroviral therapy (ARV) regimen- Emtricitabine, Tenofovir and Efavirenz. Serum inflammatory markers, haematological results, viscoelastic properties (using thromboelastography-TEG) and scanning electron microscopy (SEM) of whole blood (WB) were used to compare the groups. Results DVT patients (HIV positive and HIV negative) have raised inflammatory markers. The HIV positive-DVT group has anaemia in keeping with anaemia of chronic disorders. DVT patients have a hypercoagulable profile on the TEG but no significant difference between HIV negative-DVT and HIV positive-DVT groups. The TEG analysis compared well and supported our ultrastructural results. Scanning electron microscopy of DVT patient’s red blood cells (RBCs) and platelets demonstrates inflammatory changes including abnormal cell shapes, irregular membranes and microparticle formation. All the ultrastructural changes were more prominent in the HIV positive-DVT patients. Conclusions It is well-known that HIV infection is linked to inflammation and inflammation is linked with the presence of a hypercoagulable state. The presence of DVT is also associated with inflammation. Whether HIV is the cause of the DVT is not certain. Although there were trends that HIV infected patients were more hypercoagulable on functional tests (viscoelastic profile) compared to HIV uninfected patients, there were no significant differences between the 2 groups. Morphologically there were inflammatory changes in patients with DVT. These ultrastructural changes,
specifically with regard to platelets, appear more pronounced in HIV infected patients which may contribute to increased risk for hypercoagulability and deep vein thrombosis.

Background

Clinical implications
HIV infected patients do have a hypercoagulable profile compared to HIV negative patients. Increased inflammation is present in patients with DVT. Ultrastructural analysis, using the scanning electron microscope, allows a more detailed coagulation profile, especially in HIV infected patients.

Human immunodeficiency virus and Acquired Immune Deficiency Syndrome (AIDS) prevalence is a world-wide pandemic and the Joint United Nations Programme on HIV/ Acquired Immune Deficiency Syndrome (UNAIDS) estimates that 1 million AIDS-related deaths occurred during 2016 (1) and 1.8 million [1.4 million–2.4 million] people became newly infected with HIV in 2017 (http://www.unaids.org/en/resources/fact-sheet). Although treatment of the infection with antiretroviral regimes (ARVs) is essential to addressing the pandemic, the condition is characterized by a large plethora of additional conditions associated, and also co-existing with the HIV infection, including the presence of systemic inflammation. Systemic inflammation is associated with an increase in circulating pro-inflammatory biomarkers, and is closely associated with an amplified propensity to form pathological blood clots (which is associated with hypercoagulability or an over-activated coagulation system) (2-8).

During HIV infection, various circulating inflammatory biomarkers, including cytokines interleukin (IL)-1β, IL-2, IL-6, IL-8, IL-10, IL-12p70, tumor necrosis factor (TNF)-α and also other pro-inflammatory biomarkers are present (9). An increase in these biomarkers are also present in cardiovascular disease (10, 11) and it is therefore not surprizing that HIV positive individuals are known to have an increased presence of cardiovascular complications (12, 13), including an increased risk to develop atherosclerosis and venous
thromboembolic disease (14) and also DVT (15-17). The presence of DVT is also classified as a systemic inflammatory process (18), and associated with pathological clotting and upregulated circulating inflammatory biomarkers (19).

The prevalence of developing a DVT in HIV positive individuals is increased two to ten times compared to the general population (20). HIV positive individuals also have a 43% increase in age-adjusted odds ratio for pulmonary embolism, a common complication of DVT, compared to HIV negative individuals (21). Multiple coagulation abnormalities have been reported in HIV positive patients such as decreased levels of protein C and S; and increased levels of von Willebrand factor (22-24). However, the association of these abnormalities with DVT is not always consistent (22, 25). Coagulation investigations are therefore not performed routinely in patients with HIV infection. Standard coagulation investigations are also not performed routinely as part of the management in patients with DVT, with the exception of a D-dimer which is used to assist with the diagnosis (26-28).

In the current paper, we therefore study the haematological profiles, including clotting and various inflammatory markers, in the presence of DVT in HIV positive and HIV negative individuals and compare the results to that of healthy individuals. We compare inflammatory markers for iron (iron saturation, transferrin and serum ferritin), fibrinogen, high-sensitive C-reactive protein (CRP), erythrocyte sedimentation rate (ESR) and haematology analyser results, together with viscoelastic properties of whole blood (WB) and platelet poor plasma (PPP). We also looked at ultrastructure of platelets and erythrocytes/red blood cells (RBCs) (using whole blood smears) with the SEM, as well as after thrombin was added to whole blood, to study clot structure.

Materials And Methods

The aim was to compare the inflammatory and haematological profile of HIV patients with
DVT to HIV negative patients with DVT. An analytical and descriptive prospective case control study was used from 2 Pretoria academic hospitals, Kalafong Provincial Tertiary and Steve Biko Academic Hospital. Ten healthy control subjects, 35 HIV negative patients with DVT (HIV negative-DVT), and 13 HIV patients with DVT (HIV positive-DVT) on the primary ARV regimen- Emtricitabine, Tenofovir and Efavirenz- were recruited for the study. For each individual, five blood tubes of venous blood were drawn (this included ethylenediamine tetraacetic acid, buffered tri-sodium citrate and serum separator tubes). The Research Ethic Committee, Faculty of Health Sciences, University of Pretoria, South Africa approved the study (Ethics reference number: 547/2015). Inclusion criteria for the healthy individuals were known HIV negative status and no medical history of any chronic diseases. Patients were included to the research groups if they had confirmed HIV status and confirmed symptomatic DVT on doppler ultrasound or comparative imaging. In order to minimise opportunistic infections as a confounding factor, HIV positive patients were only included with a World Health Organization Clinical stage 1 and CD4+ cells greater than 170 absolute number (per mm3). Exclusion criteria for the healthy individuals and for DVT patients include smoking, pregnancy; or the use of any inflammatory-, anticoagulant-, antiplatelet-, hormone replacement- or oral contraceptive- medication.

**Inflammatory marker analysis**

Serum iron (total iron in blood) levels were measured together with iron saturation, transferrin (iron binding protein) and serum ferritin (iron storage form). Serum iron levels were measured by a modification of the automated AAII-25 colorimetric method. Fibrinogen (quantitative measurement of functional fibrinogen by automated coagulation analysers), CRP (measured by latex-enhanced nephelometry) and ESR (measured by an automated ESR analyser) levels were also assessed.

**Haematology analysis**
A haematology analyser (Advia 2120i, Siemens Healthcare) was used to do full blood counts, and the analysis included white cell count (and its differential count), RBC count, haemoglobin level, haematocrit, mean corpuscular volume (MCV), mean corpuscular haemoglobin (MCH), the mean corpuscular haemoglobin concentration (MCHC), as well as platelet count and mean platelet volume (MPV).

**Viscoelastic properties of whole blood and platelet poor plasma using thromboelastography**

Citrated WB, as well as PPP were used. Whole blood, collected in a citrate tube, was centrifuged to obtain PPP (15 minutes at 3000g). Whole blood was used to assess the full coagulation process, while PPP was used to assess coagulation without the influence of platelets and RBCs on the viscoelastic properties of the clot. Calcium chloride was added to either WB or PPP and 7 different parameters measured, which included: reaction time (R-time), kinetic time (K-time), alpha angle, maximum amplitude (MA), maximum rate of thrombus generation (MRTG), time to maximum rate of thrombus generation (TMRTG) and total thrombus generation (TTG).

**Ultrastructure of platelets and red blood cells (RBCs)**

The ultrastructure of platelets and RBCs were studied after preparing whole blood smears for scanning electron microscopy (SEM). 10 µl of WB was placed directly on a glass microscope slide, followed by fixing in 2.5% glutaraldehyde, dehydration (as per usual SEM preparation) and mounting. Micrographs were taken with Zeiss Crossbeam 540 Field Emission Gun Scanning Electron Microscopy.

**Statistical analysis**

Graphpad 5 was used to do one-way ANOVA analysis. A post-test to compare groups was performed using Tukey's multiple comparison test.

**Results**
Table 1 demonstrates the demographics of the study.

Table 1: Demographics

| Groups            | N  | Male | Female | Age- Mean | CD4 count-mean |
|-------------------|----|------|--------|-----------|----------------|
| Controls          | 10 | 6    | 4      | 30        | N/A            |
| HIV negative-DVT  | 35 | 11   | 24     | 51        | N/A            |
| HIV positive-DVT  | 13 | 2    | 11     | 41        | 511            |

N/A= not applicable

Inflammatory marker and haematological parameter analysis

Inflammatory marker analyses are shown in Table 2 and haematology analysis are shown in Table 3. Markers with no available results were excluded. The HIV negative-DVT group appeared to have anaemia when compared to the control group, but when adjusted for gender the HIV negative-DVT group still had haemoglobin mean values within the normal reference ranges for male and females, respectively; and but only the females had decreased serum iron, transferrin, and ferritin levels. The HIV positive-DVT group had anaemia and when adjusted for gender demonstrated low haemoglobin levels for both males and females (furthermore the females also had decreased red cell count, haematocrit, mean cell volume and mean cell haemoglobin concentration), as well as decreased levels of serum iron and transferrin in both genders. The changes in serum iron, transferrin and ferritin in the HIV positive-DVT group reflects low systemic iron status, but the raised serum ferritin (although not statistically significant) may be due to the inflammatory status of the individuals.

Inflammation is reflected, whether from the DVT or the HIV infection, by the raised CRP
and ESR. Surprisingly, the platelet count was not decreased in the HIV positive-DVT group. We expected this parameter, as well as the MPV to be markedly decreased, due to e.g. HIV thrombocytopenia, which is usually common amongst HIV patients, but in our sample this was not the case.

Table 2: Analysis of inflammatory markers using one-way ANOVA with Tukey’s multiple comparison test.

| Inflammatory marker (Normal reference range) | Control mean (std. dev) [range] | HIV negative-DVT mean (std. dev) [range] | HIV positive-DVT mean (std. dev) [range] | P value | Significant difference |
|---------------------------------------------|---------------------------------|--------------------------------------------|-------------------------------------------|---------|------------------------|
|                                             | {\% in normal range}            | {\% in normal range}                      | {\% in normal range}                      |         |                        |
| WCC (M: 3.92-10.40 x10^9/L F: 3.9-12.6 x10^9/L) | 5.272 (0.857) [3.98-6.67] {80.000} | 8.276 (2.375) [4.55-13.73] {94.286}   | 9.958 (7.783) [3.98-33.43] {83.330}   | 0.028   | -                      |
| CRP (<10mg/L)                               | 2.300 (2.359) [1-8] {100}       | 60.910 (59.130) [1-193] {28.125}       | 92.330 (76.610) [7-245] {8.333}       | 0.003   | Yes                    |
| ESR (0-10mm/hr)                             | 5.000 (4.598) [1-15] {77.778}   | 32.060 (36.590) [2-139] {46.875}       | 46.360 (38.310) [9-116] {9.091}       | 0.041   | -                      |
| Fibrinogen (2-4g/L)                         | 2.620 (0.722) [1.7-4.3] {70}    | 3.581 (1.258) [1-7] {67.742}           | 3.418 (1.216) [1.5-5.3] {63.636}      | 0.086   | -                      |
| Serum iron (M: 11.6-31.3 µmol/L)           | 18.010 (8.990)                  | 8.690 (6.279)                            | 6.110 (3.547)                            | 0.0002  | Yes                    |
### Transferrin

- **M (Male):** 2.15-3.65 μmol/L
- **F (Female):** 2.50-3.80 μmol/L

|  | Control mean | HIV negative-DVT mean | HIV positive-DVT mean | P value |
|---|--------------|------------------------|-----------------------|---------|
|  | [3-33] (90)  | [2-29] (23.333)         | [1.8-13] (10)         | 0.007   |
|  | 2.962 (0.733) | 2.348 (0.649) | 1.896 (0.848) |          |
|  | [2.26-4.49] (90) | [2.26-4.49] (50) | [0.59-3.22] (33.333) | -       |

### Iron Saturation

- **M (Male):** 20-50%
- **F (Female):** 15-50%

|  | Control mean | HIV negative-DVT mean | HIV positive-DVT mean | P value |
|---|--------------|------------------------|-----------------------|---------|
|  | [3-33] (90)  | [2-29] (23.333)         | [1.8-13] (10)         | 0.007   |
|  | 26.600 (15.170) | 17.740 (19.310) | 20.380 (28.250) |          |
|  | [3-53] (70)  | [3-97] (25.926)         | [2-88] (12.500)       | -       |

### Ferritin (µg/L)

- **M (Male):** 26-388 µg/L
- **F (Female):** 8-252 µg/L

|  | Control mean | HIV negative-DVT mean | HIV positive-DVT mean | P value |
|---|--------------|------------------------|-----------------------|---------|
|  | [3-33] (90)  | [2-29] (23.333)         | [1.8-13] (10)         | 0.007   |
|  | 147.600 (131.300) | 187.300 (237.600) | 240.400 (159.200) |          |
|  | [3-412] (80) | [1.3-1101] (77.778) | [7-487] (55.556) | -       |

### HIV=Human immunodeficiency virus, vs.=versus, WCC=white cell count, CRP=C-reactive protein, ESR=erythrocyte sedimentation rate.

**Table 3:** Analysis of haematological markers using one-way ANOVA with Tukey's multiple comparison test.

| Haematological marker (Normal reference range) | Control mean (std. dev) [range] | HIV negative-DVT mean (std. dev) [range] | HIV positive-DVT mean (std. dev) [range] | % in normal range | % in normal range | % in normal range | % in normal range | Significant difference | P value | Significant difference | Control vs. HIV negative-DVT | Control vs. HIV positive-DVT |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RCC | 5.264 (0.442) | 4.339 (0.918) | 3.728 (0.731) | 0.0003 | Yes | | | | | | | |
| Test | Normal Range                  | Value     | Lower Limit  | Upper Limit  | P-value | Status |
|------|-------------------------------|-----------|--------------|--------------|---------|--------|
| Hb   | M: 13.4-17.5 g/dL, F: 11.6-16.4 g/dL | 14.940 (1.520) | [12.3-16.4]  | [4.6-18.5]   | 9.800 (3.252) | 0.0008 |
|      |                               | 12.670 (3.230) | {100}        | {71.429}     | [4.1-16.7]  | {25}   |
| Hct  | M: 0.39-0.51 L/L, F: 0.34-0.48 L/L | 0.475 (0.048) | [0.392-0.543] | [0.175-0.617] | 0.320 (0.091) | 0.0004 |
|      |                               | 0.391 (0.092) | {80}         | {77.143}     | [0.159-0.517] | {33.333} |
| MCV  | M: 83.1-101.6fL, F: 78.9-98.5fL | 90.570 (9.424) | [74-108.2]   | [57.7-102.8] | 84.630 (11.190) | 0.183  |
|      |                               | 89.830 (7.854) | {80}         | {85.714}     | [63.1-103.6] | {75}   |
| MCH  | M: 27.8-34.8pg, F: 26.1-33.5pg | 28.490 (2.836) | [21.6-32.5]  | [15.3-36]    | 25.730 (5.107) | 0.047  |
|      |                               | 29.050 (3.705) | {70}         | {82.857}     | [15.5-33.5]  | {66.667} |
| MCHC | M: 33-35 g/dL, F: 32.7-34.9g/dL | 31.490 (1.501) | [29.2-33.8]  | [26.2-35.5]  | 30.250 (2.958) | 0.038  |
|      |                               | 32.230 (2.172) | {70}         | {45.714}     | [23.3-33.3]  | {33.333} |
| RCDW | M: 12.1-16.3%, F: 12.4-17.3%  | 14.360 (1.559) | [12.6-16.9]  | [11.9-22.1]  | 16.820 (3.077) | 0.040  |
|      |                               | 14.960 (2.371) | {90}         | {82.857}     | [12.1-22.8]  | {58.333} |
| Plt  | M: 171-388 x10⁹/L, F: 186-454 x10⁹/L | 232.900 (35.820) | [169-296]   | [36-690]     | 358.600 (182.500) | 0.087  |
|      |                               | 287.200 (128.200) | {149-796}   | {149-796}    | [149-796]    | {149-796} |
Thromboelastography

Table 4 shows a comparison of the WB and PPP TEG results between the various groups. The WB and PPP, in the HIV negative-DVT and HIV positive-DVT groups, is suggestive of clot hypercoagulability and it is reflected by a rapid R-time, K-time, MRTG and TMRTG. However, with regard to the WB, only the R-time and TMRTG in the HIV-DVT group compared to the control group; and only the TMRTG in the HIV negative-DVT group compared to the control group were statistically significant. The PPP only demonstrated a statistically significant difference with the K-time in both the DVT groups (HIV positive and HIV negative) compared to the control group. Interestingly, there were no significant differences in hypercoagulability between the HIV positive-DVT and the HIV negative-DVT groups.

Table 4: TEG results of WB and PPP using one-way ANOVA with Tukey's multiple comparison test.
|                                | Whole blood analysis | Platelet poor plasma analysis |
|--------------------------------|----------------------|-------------------------------|
| **R-time (9-27min)**          | 8.280 (2.710)        | 7.810 (1.075)                 |
|                                | [5.2-13.7]           | [6.4-9.5]                     |
| **K-time (2-9min)**           | 4.240 (1.078)        | 4.760 (4.132)                 |
|                                | [3.2-6.9]            | [1.2-15]                      |
| **alpha angle (22-58 degrees)**| 53.700 (4.229)      | 65.870 (7.175)               |
|                                | [46.2-59.2]          | [53.5-76.6]                   |
| **MA (44-64mm)**              | 56.050 (6.555)       | 30.700 (6.503)                |
|                                | [45-63.5]            | [37.010 (9.468]               |
| **MRTG (0-10dcs)**            | 3.353 (1.053)        | 769.300 (168.000)             |
|                                | [1.6-4.79]           | [401.1-876.1]                 |
| **TMRTG (5-23min)**           | 12.550 (3.663)       | 669.900 (478.200)             |
|                                | [8.33-19.67]         | [322-1999]                    |
| **TTG (251-1014dcs)**         | 669.300 (168.000)    | 652.200 (406.700)             |
|                                | [401.1-876.1]        | [101.3-1830]                  |

- indicates no significant difference.
|                             | (44-64mm) | (21.5-41) | (10.1-51.8) | (15.960) | [16.6-70.3] |       |       |
|-----------------------------|-----------|-----------|-------------|----------|-------------|-------|-------|
| MRTG (0-10dcs)             | 6.145 (4.017) | 9.227 (3.753) | 9.607 (5.683) | 0.118    | -           |       |       |
| (2.32-15.32)               | [1.29-17.24] | [3.14-23.35] |             |          |             |       |       |
| TMRTG (5-23min)            | 9.392 (1.256) | 9.008 (3.804) | 7.133 (2.167) | 0.164    | -           |       |       |
| (7.67-11.67)               | [4.33-23]   | [2.83-9.67]   |             |          |             |       |       |
| TTG (251-1014dcs)          | 230.800 (69.280) | 310.400 (111.500) | 363.900 (312.200) | 0.213    | -           |       |       |
| [140.3-347.5]              | [56.03-537.5] | [100-1193]   |             |          |             |       |       |

TEG=Thromboelastography, HIV=Human immunodeficiency virus, vs.=versus, R=reaction, K=kinetics, MA=maximum amplitude, MRTG=Maximum rate of thrombus generation, TMRTG=Time to maximum rate of thrombus generation, TTG=Total thrombus generation, PPP=Platelet poor plasma.

**Scanning electron microscopy**

SEM micrographs of representative healthy RBCs and platelets are shown in Figure 1, while Figure 2 and 3 show SEM of RBCs and platelets in HIV negative-DVT and HIV positive-DVT patients.

**Discussion**

Both DVT groups (HIV negative and HIV positive groups) had parameters suggesting anaemia compared to the control group (Table 3). However, the RBC count, Hb and Hct levels in the HIV negative-DVT group, even though lower than the control group, are still within the normal reference ranges (30). The Hb and Hct in the HIV positive-DVT group were significantly lower than both the HIV negative-DVT and control groups; and lower than the normal reference ranges indicating an anaemia. Anaemia is commonly found in
HIV positive patients but the cause of the anaemia is not always clear (31-36). An inadequate erythropoietin feedback mechanism is suspected to be a major contributor in HIV-related anaemia (31). A low reticulocyte count is commonly found with associated polychromasias (abnormally high number of immature RBCs), indicating a possible under-producing bone marrow (31, 37-39). Other factors that contribute to HIV-associated anaemia, includes intestinal malabsorption, autoimmune haemolysis, bone marrow malignancies, blood loss and opportunistic complications (31, 33, 39, 40). Even with the decreased RBC count, Hb and Hct levels in the HIV negative-DVT group (as compared to the control group), there were no significant differences with MCV, MCH as well as MCHC (Table 3). The changes in the HIV negative-DVT group may support an anaemia typically associated with inflammation, also known as anaemia of chronic disorders (31, 41).

The RCDW is the coefficient of variation of RBC volume. The higher the value, the more anisocytosis (unequal RBC sizes) present. The RCDW of the HIV positive-DVT group was greater than the control and HIV negative-DVT groups (Table 3). A raised RCDW is commonly associated with a decrease in haemoglobin and MCV concentration; but with a raised CRP, fibrinogen and white cell count (42). This correlates with the haematological and inflammatory markers found in the HIV positive-DVT group (Table 2 and 3). RCDW is strongly associated with mortality. Patel and colleagues reported the all-cause mortality risk increases by 22% for every 1% increase in RCDW. Furthermore, the physiological association between RCDW and mortality has been hypothesised to be related to the systemic factors involved in inflammatory conditions and oxidative stress which affects erythrocyte maturation and degradation (42-44).

The ESR is the extent in which erythrocytes sediment in one hour (45). The ESR in both the HIV negative-DVT and HIV positive-DVT groups were raised compared to the control group (Table 2). In inflammatory conditions the ESR rises as the erythrocytes become
sticky and adhere to each other which can be seen as rouleaux formation (46-48). Fibrinogen, a high molecular weight plasma protein, is a crucial factor in the coagulation pathway (factor I). Increased fibrinogen levels are associated with thrombo-embolic events. Fibrinogen also has a role in inflammation as it tends to adhere to the membrane receptors of cells involved with inflammation. Fibrinogen can adhere to the RBCs, which becomes “heavier” resulting in an increased ESR and blood viscosity (49-56). The fibrinogen levels were greater (but not statistically significant) in the HIV negative-DVT and HIV positive-DVT groups compared to the control group (Table 2) which correlates with the raised ESR levels seen in both groups. Increase fibrinogen concentration in the inflammatory response can explain the raised fibrinogen concentration in the HIV positive-DVT group which contributed to the DVT. The concurrent use of ARV medication has not been shown to affect the fibrinogen concentration (57). The HIV negative-DVT group with a raised fibrinogen concentration is either due to the DVT resulting in the inflammatory response (and the raised fibrinogen concentration) or the raised fibrinogen concentration contributing to the DVT.

The WCC in the HIV positive-DVT group was statistically significantly raised compared to the control group (Table 2), although still within the normal reference range. Similar to patients with ischemic strokes, thromboembolism results in an inflammatory reaction with raised leukocyte count and CRP (58, 59). CRP, like the leukocyte count, is an important indicator of inflammatory conditions (60). HIV is usually associated with a decreased immune function. The elevated leukocyte count in these HIV positive-DVT patients may be due to the HIV infection itself or to opportunistic infections, regardless of whether the patient has a DVT or not. Also, with the ARV treatment HIV is suppressed and the lymphocytes, particularly the CD4 lymphocytes, increase in turnover (61-63). The concentration of CRP is increased by proinflammatory cytokines, interleukin 1 and 6 (64).
The HIV negative-DVT group has an inflammatory response to the DVT which is reflected by the statistically significantly raised CRP levels compared to the control group (Table 2). The same argument can be made for the raised CRP in the HIV positive-DVT group, however the CRP concentration (as well as fibrinogen) is commonly raised in HIV positive patients compared to the general population even without a DVT (65-69). The raised CRP in HIV positive-DVT patients (Table 2) indicates a sustained acute phase response (67). This was statistically significant in the HIV positive-DVT group compared to the control group. The CRP in the HIV positive-DVT group was almost double compared to the HIV negative-DVT group. Increasing CRP concentrations has been reported with HIV disease progression, and this increase does not appear to be affected by ARV treatment (64).

Previously it was noted that increased levels of CRP and fibrinogen are independently highly predictive of 5 year mortality risk in HIV positive patients, especially where the CD4 count is low (70, 71).

Considering all the inflammatory markers (WCC, fibrinogen, CRP and ESR), each marker was statistically significantly raised in the HIV positive-DVT group compared to the control group, with the exception of fibrinogen (Table 2). In the HIV negative-DVT group compared to the control group, only CRP was statistically significantly raised. CRP may therefore be a more sensitive acute phase marker to differentiate an inflammatory condition between DVT patients (HIV negative and HIV positive) compared to healthy subjects. Interestingly, no inflammatory marker was statistically significantly raised in the HIV positive-DVT group compared to the HIV negative-DVT group.

The transferrin, serum iron and iron saturation levels reflects the amount of iron in the body. Transferrin is a plasma protein that transports iron in the blood (63), whereas ferritin is an intracellular structure capable of storing iron atoms. The concentration of serum ferritin is related to the reticuloendothelial iron stores (72). Serum ferritin and iron
concentrations are also indicators for acute phase responses to inflammation (72), although serum ferritin appears to be a better marker of inflammation than iron status (73).

Iron deficiency may be a contributor to anaemia in the HIV positive-DVT group in keeping with a low MCH and MCHC, although this is not reflected with the MCV which was within the normal reference range (Table 3) (74, 75). A low serum iron and transferrin level seen in the HIV positive-DVT group, but with a raised ferritin level (as compared to the control group), can be explained by an immunologically altered iron metabolism where the body has adequate or increased iron stores but is unable to utilize those stores (33, 38, 61, 62, 72, 76-78). This functional iron deficiency can be considered a host defence mechanism by withholding iron from possible pathogens (79, 80). However, as iron is required for normal immune function, iron deficiency can also increase the risk of infection (80).

Although the inflammatory RBC changes have been documented in non-communicable diseases, there are only a few reports of communicable diseases, specifically HIV, and the effect on RBCs and the coagulation system (81-86). Multiple abnormal RBC shape changes and membrane abnormalities were noted in the patients with DVT (HIV negative and HIV positive groups) (Figure 1 to 3). During inflammatory diseases, RBCs exposed to oxidative stress and inflammatory molecules undergoes biochemical membrane changes which can result in biophysical shape changes and eryptotic cells (87-95). Eryptosis is a co-ordinated suicidal death of the red blood cells, similar to apoptosis, that allows for the removal of defective, infected or potentially harmful cells before they undergo haemolysis (96-100). The abnormal RBCs present with an abnormal expression of phosphatidylserine, a cell membrane lipid, on the external membrane layer. RBCs that display phosphatidylserine also contribute to the hypercoagulation state and they provide a
prothrombotic surface for the formation of thrombin (41, 98, 101-112). Membrane vesicle formation and microparticle shedding (microscopic extracellular membranous structures) were also seen in both DVT groups. RBC-derived microvesicles or microparticles, is known to be associated with the expression of phosphatidylserine (113). RBC-derived microparticles appear to enhance thrombin generation resulting in a hypercoagulable state, such as in post transfusion DVT, sickle cell disease and haemolytic anaemia (114, 115). As the microparticle presence might also be associated with increased thrombin presence, the complement system can therefore also be activated and thereby enhance the systemic inflammatory response which is also a hypercoagulable state (116).

Microparticles are also thought to originate from CD4 lymphocytes (117). As the HIV virus infects CD4 lymphocytes, HIV positive patients may be more prone to developing microparticles and therefore enhancing the hypercoagulable state.

Whole blood with thrombin SEM analysis showed the incorporation of RBCs into the fibrin network. The incorporation of RBCs into the fibrin network stabilises and strengthens the clot by decreasing the permeability of fibrin and increasing the resistance to fibrinolysis (118-120). Healthy (discoid) RBCs in netted fibrin fibers are shown Figure 1C and 1D. However, in our HIV negative-DVT and HIV positive-DVT groups, the RBCs are trapped in a matted fibrin fiber network. During inflammation, fibrin fibres tend to increase in diameter and assume a matted rather than a netted appearance; while their viscoelasticity may also be influenced by the RBC inclusion in the fibrin network (101). Also, under conditions of low partial pressure of oxygen, acidosis and in response to mechanical deformation, RBCs release ATP and ADP activating platelets and promoting aggregation and release of platelet granules (115). This can happen as part of the HIV and DVT pathology. The (hyper) activation of platelets, together with an abnormal matted fibrin network, contracts the clot containing the trapped pathological RBCs into a tight package (Figure 3B and
The result is the formation of polyhedral cells, which is commonly found in DVT (121).

Platelet functioning depends on the quality and the quantity of the platelets (122).

Platelet count is a measure of the number of platelets in a volume of blood. Thrombocytopenia (low platelet count) is a common finding in HIV positive patients, whether it be due to increased destruction or decrease production of platelet cells (57). However, in this study both the HIV negative-DVT and HIV positive-DVT groups had a non-statistically significant increase in the platelet count ([Table 3](#)). It should be noted that platelet count is not always associated with an increased risk of DVT (123). The mean platelet volume measures the average size of platelets in the blood and is a common platelet activation marker (123-130). An elevated MPV is associated with low-grade inflammation as well as thrombosis (131). However, both HIV negative-DVT and HIV positive-DVT groups had a decrease in the mean platelet volume compared to the control group ([Table 3](#)). These results may be in keeping with a venous thrombosis where the thrombus is due to activation of the coagulation cascade instead of platelets (132). It should also be kept in mind that platelets shape and volume do vary, resulting in changes in MPV, even in healthy persons (130). Together with these results, the ultrastructure of platelets in the HIV positive-DVT group also have features different to that of the control group and the HIV negative-DVT group ([Figure 1B, 2D and 3D](#)). The control group and the HIV negative-DVT group have (hyper) activated platelet aggregates with smooth intact membranes, pseudopodia formation, openings of the open canalicular channels and membrane blebbing interspersed among smooth intact membranes. These are the typical morphological features of activated platelets seen in healthy individuals (133). The HIV positive-DVT patients have activated platelet aggregates which are also seen to have the same features; but with the addition of shrivelled aggregates with irregular membranes,
torn membrane surface and shedding of procoagulant vesicles. These features are suggestive of apoptosis, cell death, as was seen in the red blood cells. Similar ultrastructural changes in HIV patients were documented by Pretorius et al. in 2008 (81).

These ultrastructural changes may be due to altered viral infected megakaryocyte morphology or due to direct infection and damage by the HIV virus. The HIV virus may gain entry into the platelets by undergoing phagocytosis or through the openings of the open canalicular system channels (81, 134, 135). Regardless of the way of entry, platelets containing the HIV virus are activated. It is not clear if the platelets containing the virus facilitates viral replication and spreading; or assists in clearance of the virus (134). With the latter, the ultrastructural changes may be due to the immune response of the body resulting in antibody-induced destruction of the platelets (81). Antiretroviral medication has been shown to have platelet related effects such as a decreased prevalence of HIV associated thrombocytopenia but may have an increased bleeding risk (136). This increased bleeding risk may be explained by the ultrastructural changes seen on the SEM.

It is possible that the use of different ARV combinations may result in different morphological changes observed, however to standardize the results, only patients on the primary regimen were recruited for this study.

Our TEG analysis compared well and supported our ultrastructural results (Table 4). The HIV negative-DVT group compared to the control group showed significant differences with regards to TMRTG, while the HIV positive-DVT group compared to the control group, showed significant differences with regards to R-time, and the TMRTG. According to Pretorius and colleagues not all the parameters need be abnormal to indicate pathological coagulability and the degree of coagulability can be related to the number of parameters that are abnormal (5).

Both DVT groups (HIV negative and HIV positive), using whole blood, indicate a
hypercoagulable profile that has a rapid initiation and amplification, resulting in the rapid formation of thrombin. The TEG parameters in the HIV positive-DVT group compared to the HIV negative-DVT group indicate a hypercoagulable profile but there were no statistical significance in any of the parameters. Both the HIV negative-DVT and HIV positive-DVT groups have rapid R-times and K-times (Table 4), trapped RBCs between a matted (hypercoagulable) fibrin network were noted. Considering that pulmonary embolism can result in up to 10% mortality (137) and half of the patients with DVT may have non-symptomatic (silent) pulmonary embolism (138), the changes found on the TEG and SEM may provide for a risk of assessment of the DVT complicating to pulmonary embolism. (139)

Conclusion

It is well-known that HIV infection is linked to inflammation and inflammation is linked with the presence of a hypercoagulable state. The presence of DVT is also associated with inflammation. Whether HIV is the cause of the DVT is not certain. Although there were trends that HIV infected patients were more hypercoagulable on functional tests (viscoelastic profile) compared to HIV uninfected patients, there were no significant differences between the 2 groups. Morphologically there are inflammatory changes in patients with DVT. These ultrastructural changes, specifically with regard to platelets, appear more pronounced in HIV infected patients which may contribute to an increased risk for hypercoagulability and deep vein thrombosis.

List Of Abbreviations

ARV- Antiretroviral therapy
AIDS- Acquired Immune Deficiency Syndrome
CRP- C-reactive protein
DVT - Deep vein thrombosis

ESR - Erythrocyte sedimentation rate

Haem - Haematological

Hb - Haemoglobin

HIV - Human immunodeficiency virus

IL - Interleukin

K-time - kinetic time

MA - Maximum amplitude

MCH - Mean corpuscular haemoglobin

MCHC - mean corpuscular haemoglobin concentration

MCV - Mean corpuscular volume

MPV - Mean platelet volume

MRTG - Maximum rate of thrombus generation

Plt - Platelet count

PPP - Platelet poor plasma

RBCs - Red blood cells

RCC - Red cell count

RCDW - Red cell distribution width

R-time - Reaction time

SEM - Scanning electron microscopy

TEG - Thromboelastography

TMRTG - Time to maximum rate of thrombus generation

TNF - tumor necrosis factor

TTG - total thrombus generation

UNAIDS - Joint United Nations Programme on HIV/ Acquired Immune Deficiency Syndrome
WB- Whole blood
WCC- White cell count

Declarations

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Author contributions

BSJ and EP conceived the experiments; BSJ and JNG conducted the experiments; BSJ and EP analysed the results. All authors reviewed and approved the manuscript.

Availability of data and materials

The dataset(s) supporting the conclusions of this article are available from the authors.

Competing interests

The authors declare no competing interests.

Ethics approval and consent to participate

The Human Research Ethics Committee, Faculty of Health Sciences, University of Pretoria, South Africa approved the study (reference number: 547/2015). Consent was obtained from each participant. Consent was also obtained from the Chief Executive Office of each hospital.

Consent for publication
Consent obtained from each patient/person.

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**References**

1. Harding R. Palliative care as an essential component of the HIV care continuum. The Lancet HIV. 2018;5(9):524-530.

2. de Villiers S, Swanepoel A, Bester J, Pretorius E. Novel Diagnostic and Monitoring Tools in Stroke: an Individualized Patient-Centered Precision Medicine Approach. Journal of atherosclerosis and thrombosis. 2015;23:493-504.

3. Page MJ, Bester J, Pretorius E. The inflammatory effects of TNF-alpha and complement component 3 on coagulation. Scientific reports. 2018;8(1):1812.

4. Pretorius E, Lipinski B. Thromboembolic ischemic stroke changes red blood cell morphology. Cardiovascular pathology: the official journal of the Society for Cardiovascular Pathology. 2013;22(3):241-2.

5. Pretorius E, Swanepoel AC, De Villiers S, Bester J. Blood clot parameters: Thromboelastography and scanning electron microscopy in research and clinical practice. Thrombosis research. 2017;154:59-63.

6. van Rooy MJ, Duim W, Ehlers R, Buys AV, Pretorius E. Platelet hyperactivity and fibrin clot structure in transient ischemic attack individuals in the presence of metabolic syndrome: a microscopy and thromboelastography study. Cardiovascular diabetology. 2015;14:86.

7. Bester J, Matshailwe C, Pretorius E. Simultaneous presence of hypercoagulation and increased clot lysis time due to IL-1β, IL-6 and IL-8. Cytokine. 2018:S1043-
8. Bester J, Pretorius E. Effects of IL-1β, IL-6 and IL-8 on erythrocytes, platelets and clot viscoelasticity. Scientific Reports. 2016;6:32188.

9. Wada NI, Jacobson LP, Margolick JB, Breen EC, Macatangay B, Penugonda S, et al. The effect of HAART-induced HIV suppression on circulating markers of inflammation and immune activation. AIDS (London, England). 2015;29(4):463-71.

10. Siti H N, Kamisah Y, Kamsiah J. The role of oxidative stress, antioxidants and vascular inflammation in cardiovascular disease (a review). Vascular pharmacology. 2015;71:40-56.

11. Khambhati J, Engels M, Allard-Ratick M, Sandesara PB, Quyyumi AA, Sperling L. Immunotherapy for the prevention of atherosclerotic cardiovascular disease: Promise and possibilities. Atherosclerosis. 2018;276:1-9.

12. Teer E, Essop MF. HIV and Cardiovascular Disease: Role of Immunometabolic Perturbations. Physiology (Bethesda, Md). 2018;33(1):74-82.

13. Deeks SG, Tracy R, Douek DC. Systemic effects of inflammation on health during chronic HIV infection. Immunity. 2013;39(4):633-45.

14. Baker JV, Brummel-Ziedins K, Neuhaus J, Duprez D, Cummins N, Dalmau D, et al. HIV replication alters the composition of extrinsic pathway coagulation factors and increases thrombin generation. Journal of the American Heart Association. 2013;2(4):e000264.

15. Vululi ST, Bugeza S, Zeridah M, Ddungu H, Openy AB, Frank M, et al. Prevalence of lower limb deep venous thrombosis among adult HIV positive patients attending an outpatient clinic at Mulago Hospital. AIDS research and therapy. 2018;15(1):3.

16. Malek J, Rogers R, Kufere J, Hirshon JM. Venous thromboembolic disease in the HIV-infected patient. The American journal of emergency medicine. 2011;29(3):278-82.
17. Louw S, Jacobson BF, Buller H. Human immunodeficiency virus infection and acute deep vein thromboses. Clinical and applied thrombosis/hemostasis: official journal of the International Academy of Clinical and Applied Thrombosis/Hemostasis. 2008;14(3):352-5.

18. Reiter M, Bucek RA, Koca N, Dirisamer A, Minar E. Deep vein thrombosis and systemic inflammatory response: a pilot trial. Wiener klinische Wochenschrift. 2003;115(3-4):111-4.

19. Mosevoll KA, Johansen S, Wendelbo Ø, Nepstad I, Bruserud Ø, Reikvam H. Cytokines, Adhesion Molecules, and Matrix Metalloproteases as Predisposing, Diagnostic, and Prognostic Factors in Venous Thrombosis. Frontiers in medicine. 2018;5:147.

20. Aquila AM. Deep Venous Thrombosis. Journal of Cardiovascular Nursing. 2001;15(4):25-44.

21. Malek J, Rogers R, Kufera J, Hirshon JM. Venous thromboembolic disease in the HIV-infected patient. The American Journal of Emergency Medicine. 2011;29(3):278-82.

22. Kiser KL, Badowski ME. Risk factors for venous thromboembolism in patients with human immunodeficiency virus infection. Pharmacotherapy. 2010;30(12):1292-302.

23. Jacobson MC, Dezube BJ, Aboulafia DM. Thrombotic complications in patients infected with HIV in the era of highly active antiretroviral therapy: a case series. Clin Infect Dis. 2004;39(8):1214-22.

24. Jong E, Louw S, Meijers JC. The hemostatic balance in HIV-infected patients with and without antiretroviral therapy: partial restoration with antiretroviral therapy. AIDS Patient Care STDS. 2009;23(12):1001-7.

25. Aboulafia D. An update on HIV-associated venous thromboembolism in the era of highly active antiretroviral therapy. J Coagul Disord. 2010;2:49-56.

26. Goldhaber SZ, Bounnameaux H. Pulmonary embolism and deep vein thrombosis.
Lancet. 2012;379(9828):1835-46.

27. Di Nisio M, van Es N, Büller HR. Deep vein thrombosis and pulmonary embolism. The Lancet. 2016;388(10063):3060-73.

28. Büller HR, ten Cate-Hoek AJ, Hoes AW, et al. SAFely ruling out deep venous thrombosis in primary care. Annals of Internal Medicine. 2009;150(4):229-35.

29. Pretorius E, Bester J, Vermeulen N, Alummoottil S, Soma P, Buys AV, et al. Poorly controlled type 2 diabetes is accompanied by significant morphological and ultrastructural changes in both erythrocytes and in thrombin-generated fibrin: implications for diagnostics. Cardiovascular diabetology. 2015;14:30.

30. Lawrie D, Coetzee LM, Becker P, Mahlangu J, Stevens W, Glencross DK. Local reference ranges for full blood count and CD4 lymphocyte count testing. Samj South African Medical Journal. 2009;99(4):243-8.

31. Kreuzer KA, Rockstroh JK. Pathogenesis and pathophysiology of anemia in HIV infection. Annals of Hematology. 1997;75(5-6):179-87.

32. Bain BJ. The haematological features of HIV infection. British Journal of Haematology. 1997;99(1):1-8.

33. Castella A, Croxson TS, Mildvan D, Witt DH, Zalusky R. The bone marrow in AIDS. A histologic, hematologic, and microbiologic study. American journal of clinical pathology. 1985;84(4):425-32.

34. Stanley SK, Kessler SW, Justement JS, Schnittman SM, Greenhouse JJ, Brown CC, et al. CD34+ BONE-MARROW CELLS ARE INFECTED WITH HIV IN A SUBSET OF SEROPOSITIVE INDIVIDUALS. Journal of Immunology. 1992;149(2):689-97.

35. Kaczmarski RS, Davison F, Blair E, Sutherland S, Moxham J, McManus T, et al. DETECTION OF HIV IN HEMATOPOIETIC PROGENITORS. British Journal of Haematology. 1992;82(4):764-9.
36. Moses AV, Williams S, Heneveld ML, Strussenberg J, Rarick M, Loveless M, et al. Human immunodeficiency virus infection of bone marrow endothelium reduces induction of stromal hematopoietic growth factors. Blood. 1996;87(3):919-25.

37. Frontiera M, Myers AM. PERIPHERAL-BLOOD AND BONE-MARROW ABNORMALITIES IN THE ACQUIRED-IMMUNODEFICIENCY-SYNDROME. Western Journal of Medicine. 1987;147(2):157-60.

38. Mir N, Costello C, Luckit J, Lindley R. HIV-DISEASE AND BONE-MARROW CHANGES - A STUDY OF 60 CASES. European Journal of Haematology. 1989;42(4):339-43.

39. Spivak JL, Bender BS, Quinn TC. HEMATOLOGIC ABNORMALITIES IN THE ACQUIRED IMMUNE-DEFICIENCY SYNDROME. American Journal of Medicine. 1984;77(2):224-8.

40. Camaschella C. How I manage patients with atypical microcytic anaemia. British Journal of Haematology. 2013;160(1):12-24.

41. Straat M, van Bruggen R, de Korte D, Juffermans NP. Red Blood Cell Clearance in Inflammation. Transfusion Medicine and Hemotherapy. 2012;39(5):353-60.

42. Patel KV, Ferrucci L, Ershler WB, Longo DL, Guralnik JM. Red Blood Cell Distribution Width and the Risk of Death in Middle-aged and Older Adults. Archives of Internal Medicine. 2009;169(5):515-23.

43. Douglas SW, Adamson JW. ANEMIA OF CHRONIC DISORDERS - STUDIES OF MARROW REGULATION AND IRON-METABOLISM. Blood. 1975;45(1):55-65.

44. Weiss G, Goodnough LT. Medical progress: Anemia of chronic disease. New England Journal of Medicine. 2005;352(10):1011-23.

45. Miller A, Green M, Robinson D. SIMPLE RULE FOR CALCULATING NORMAL ERYTHROCYTE SEDIMENTATION-RATE. British Medical Journal. 1983;286(6361):266-.

46. Skalak R, Zarda PR, Jan KM, Chien S. MECHANICS OF ROULEAU FORMATION. Biophysical Journal. 1981;35(3):771-81.
47. Brigden ML. Clinical utility of the erythrocyte sedimentation rate. American Family Physician. 1999;60(5):1443-50.

48. Andresdottir MB, Sigfusson N, Sigvaldason H, Gudnason V. Erythrocyte sedimentation rate, an independent predictor of coronary heart disease in men and women - The Reykjavik study. American Journal of Epidemiology. 2003;158(9):844-51.

49. Pretorius E, Kell DB. Diagnostic morphology: biophysical indicators for iron-driven inflammatory diseases. Integrative Biology. 2014;6(5):486-510.

50. Cho Y-I, Cho DJ. Hemorheology and Microvascular Disorders. Korean Circulation Journal. 2011;41(6):287-95.

51. Kesmarky G, Kenyeres P, Rabai M, Toth K. Plasma viscosity: A forgotten variable. Clinical Hemorheology and Microcirculation. 2008;39(1-4):243-6.

52. Rampling MW, Meiselman HJ, Neu B, Baskurt OK. Influence of cell-specific factors on red blood cell aggregation. Biorheology. 2004;41(2):91-112.

53. Walton BL, Byrnes JR, Wolberg AS. Fibrinogen, red blood cells, and factor XIII in venous thrombosis. Journal of Thrombosis and Haemostasis. 2015;13:S208-S15.

54. Lominadze D, Dean WL. Involvement of fibrinogen specific binding in erythrocyte aggregation. Febs Letters. 2002;517(1-3):41-4.

55. Carvalho FA, Connell S, Miltenberger-Miltenyi G, Pereira SV, Tavares A, Ariens RAS, et al. Atomic Force Microscopy-Based Molecular Recognition of a Fibrinogen Receptor on Human Erythrocytes. Acs Nano. 2010;4(8):4609-20.

56. De Oliveira S, Vitorino de Almeida V, Calado A, Rosario HS, Saldanha C. Integrin-associated protein (CD47) is a putative mediator for soluble fibrinogen interaction with human red blood cells membrane. Biochimica Et Biophysica Acta-Biomembranes. 2012;1818(3):481-90.

57. Osime EO, Oresanja OO, Okwara BU. Packed cell volume Platelet count, PT, PTTK and
Fibrinogen concentration of HIV positive patients on antiretroviral drugs. Pakistan Journal of Medical Sciences. 2015;31(6):1533-6.

58. Fox EA, Kahn SR. The relationship between inflammation and venous thrombosis - A systematic review of clinical studies. Thrombosis and Haemostasis. 2005;94(2):362-5.

59. Chirinos JA, Heresi GA, Velasquez H, Jy W, Jimenez JJ, Ahn E, et al. Elevation of endothelial microparticles, platelets, and leukocyte activation in patients with venous thromboembolism. Journal of the American College of Cardiology. 2005;45(9):1467-71.

60. Gabay C. Mechanisms of disease - Acute-phase proteins and other systemic responses to inflammation (vol 340, pg 448, 1999). New England Journal of Medicine. 1999;340(17):1376-.

61. Zon LI, Groopman JE. HEMATOLOGIC MANIFESTATIONS OF THE HUMAN IMMUNE-DEFICIENCY VIRUS (HIV). Seminars in Hematology. 1988;25(3):208-18.

62. Boelaert JR, Weinberg GA, Weinberg ED. Altered iron metabolism in HIV infection: Mechanisms, possible consequences, and proposals for management. Infectious Agents and Disease-Reviews Issues and Commentary. 1996;5(1):36-46.

63. Waldvogel-Abramowski S, Waeber G, Gassner C, Buser A, Frey BM, Favrat B, et al. Physiology of Iron Metabolism. Transfusion Medicine and Hemotherapy. 2014;41(3):213-21.

64. Lau B, Sharrett AR, Kingsley LA, Post W, Palella FJ, Visscher B, et al. C-reactive protein is a marker for human immunodeficiency virus disease progression. Archives of Internal Medicine. 2006;166(1):64-70.

65. Dolan SE, Hadigan C, Killilea KM, Sullivan MP, Hemphill L, Lees RS, et al. Increased cardiovascular disease risk indices in HIV-infected women. Juids-Journal of Acquired
Immune Deficiency Syndromes. 2005;39(1):44-54.

66. Arinola OG, Adedapo KS, Kehinde AO, Olaniyi JA, Akiibinu MO. Acute phase proteins, trace elements in asymptomatic human immunodeficiency virus infection in Nigerians. African journal of medicine and medical sciences. 2004;33(4):317-22.

67. Noursadeghi M, Miller RF. Clinical value of C-reactive protein measurements in HIV-positive patients. International Journal of Std & Aids. 2005;16(6):438-41.

68. Madden E, Lee G, Kotler DP, Wanke C, Lewis CE, Tracy R, et al. Association of antiretroviral therapy with fibrinogen levels in HIV-infection. Aids. 2008;22(6):707-15.

69. Reingold JS, Wanke C, Kotler DP, Lewis CE, Tracy R, Heymsfield S, et al. Association of HIV infection and HIV/HCV coinfection with C-reactive protein levels - The Fat Redistribution and Metabolic Change in HIV Infection (FRAM) study. Jaids-Journal of Acquired Immune Deficiency Syndromes. 2008;48(2):142-8.

70. Tien PC, Choi Al, Zolopa AR, Benson C, Tracy R, Scherzer R, et al. Inflammation and Mortality in HIV-Infected Adults: Analysis of the FRAM Study Cohort. Jaids-Journal of Acquired Immune Deficiency Syndromes. 2010;55(3):316-22.

71. Chaudhary M, Kashyap B, Gautam H, Saini S, Bhalla P. Role of C-reactive protein in HIV infection: A pilot study. Viral Immunology. 2008;21(2):263-6.

72. Fitzsimons EJ, Brock JH. The anaemia of chronic disease - Remains hard to distinguish from iron deficiency anaemia in some cases. British Medical Journal. 2001;322(7290):811-2.

73. Kell DB, Pretorius E. Serum ferritin is an important inflammatory disease marker, as it is mainly a leakage product from damaged cells. Metallomics. 2014;6(4):748-73.

74. Urrechaga E, Hoffmann JJML, Izquierdo S, Escanero JF. Differential diagnosis of microcytic anemia: the role of microcytic and hypochromic erythrocytes.
75. Stoltzfus RJ. Defining iron-deficiency anemia in public health terms: A time for reflection. Journal of Nutrition. 2001;131(2):565S-7S.

76. Fuchs D, Hausen A, Reibnegger G, Werner ER, Wernerfelmayr G, Dierich MP, et al. IMMUNE ACTIVATION AND THE ANEMIA ASSOCIATED WITH CHRONIC INFLAMMATORY DISORDERS. European Journal of Haematology. 1991;46(2):65-70.

77. Perkocha LA, Rodgers GM. HEMATOLOGIC ASPECTS OF HUMAN IMMUNODEFICIENCY VIRUS-INFECTION - LABORATORY AND CLINICAL CONSIDERATIONS. American Journal of Hematology. 1988;29(2):94-105.

78. Minchella PA, Armitage AE, Darboe B, Jallow MW, Drakesmith H, Jaye A, et al. Elevated Hepcidin Is Part of a Complex Relation That Links Mortality with Iron Homeostasis and Anemia in Men and Women with HIV Infection. Journal of Nutrition. 2015;145(6):1194-201.

79. Nemeth E, Tuttle MS, Powelson J, Vaughn MB, Donovan A, Ward DM, et al. Hepcidin regulates cellular iron efflux by binding to ferroportin and inducing its internalization. Science. 2004;306(5704):2090-3.

80. Jonker FAM, van Hensbroek MB. Anaemia, iron deficiency and susceptibility to infections. Journal of Infection. 2014;69:S23-S7.

81. Pretorius E, Oberholzer HM, Smit E, Steyn E, Briedenhann S, Franz CR. Ultrastructural changes in platelet aggregates of HIV patients: A scanning electron microscopy study. Ultrastructural Pathology. 2008;32(3):75-9.

82. Pretorius E, Smit E, Oberholzer HM, Steyn E, Briedenhann S, Franz RC. Investigating the ultrastructure of platelets of HIV patients treated with the immuno-regulator, Canova: a qualitative scanning electron microscopy study. Histology and Histopathology. 2009;24(4):399-405.
83. Jackson BS, Mokoena T. Comparison of the therapeutic dose of warfarin in HIV-infected and HIV-uninfected patients: a study of clinical practice. Bmj Open. 2017;7(2).

84. Majluf-Cruz A, Silva-Estrada M, Sanchez-Barboza R, Montiel-Manzano G, Trevino-Perez S, Santoscoy-Gomez M, et al. Venous thrombosis among patients with AIDS. Clinical and Applied Thrombosis-Hemostasis. 2004;10(1):19-25.

85. Haagaard AK, Lund TT, Birch C, Ronsholt F, Troseid M, Ullum H, et al. Discrepant coagulation profile in HIV infection: elevated D-dimer but impaired platelet aggregation and clot initiation. Aids. 2013;27(17):2749-58.

86. Ronsholt FF, Gerstoft J, Ullum H, Johansson PI, Katzenstein TL, Ostrowski SR. Thromboelastography on plasma reveals delayed clot formation and accelerated clot lyses in HIV-1 infected persons compared with healthy controls. Bmc Infectious Diseases. 2015;15.

87. Nordell AD, McKenna M, Borges AH, Duprez D, Neuhaus J, Neaton JD, et al. Severity of Cardiovascular Disease Outcomes Among Patients With HIV Is Related to Markers of Inflammation and Coagulation. Journal of the American Heart Association. 2014;3(3).

88. Pretorius E, Olumuyiwa-Akeredolu O-oO, Mbotwe S, Bester J. Erythrocytes and their role as health indicator: Using structure in a patient-orientated precision medicine approach. Blood Reviews. 2016;30(4):263-74.

89. Swanepoel AC, Pretorius E. Scanning electron microscopy analysis of erythrocytes in thromboembolic ischemic stroke. International Journal of Laboratory Hematology. 2012;34(2):185-91.

90. Santos-Silva A, Rebelo I, Castro E, Belo L, Catarino C, Monteiro I, et al. Erythrocyte damage and leukocyte activation in ischemic stroke. Clinica Chimica Acta. 2002;320(1-2):29-35.
91. Robinson JM. Reactive oxygen species in phagocytic leukocytes. Histochemistry and Cell Biology. 2008;130(2):281-97.

92. Pretorius E, Bester J, Vermeulen N, Alummoottil S, Soma P, Buys AV, et al. Poorly controlled type 2 diabetes is accompanied by significant morphological and ultrastructural changes in both erythrocytes and in thrombin-generated fibrin: implications for diagnostics. Cardiovascular Diabetology. 2015;14.

93. Pretorius E, du Plooy J, Soma P, Gasparyan AY. An ultrastructural analysis of platelets, erythrocytes, white blood cells, and fibrin network in systemic lupus erythematosus. Rheumatology International. 2014;34(7):1005-9.

94. Pretorius E, Swanepoel AC, Buys AV, Vermeulen N, Duim W, Kell DB. Eryptosis as a marker of Parkinson's disease. Aging-Us. 2014;6(10):788-819.

95. Bester J, Soma P, Kell DB, Pretorius E. Viscoelastic and ultrastructural characteristics of whole blood and plasma in Alzheimer-type dementia, and the possible role of bacterial lipopolysaccharides (LPS). Oncotarget. 2015;6(34):35284-303.

96. Lang KS, Myssina S, Brand V, Sandu C, Lang PA, Berchtold S, et al. Involvement of ceramide in hyperosmotic shock-induced death of erythrocytes. Cell Death and Differentiation. 2004;11(2):231-43.

97. Sirachainan N, Thongsad J, Pakakasama S, Hongeng S, Chuansumrit A, Kadegasem P, et al. Normalized coagulation markers and anticoagulation proteins in children with severe beta-thalassemia disease after stem cell transplantation. Thrombosis Research. 2012;129(6):765-70.

98. Kempe DS, Akel A, Lang PA, Hermle T, Biswas R, Muresanu J, et al. Suicidal erythrocyte death in sepsis. Journal of Molecular Medicine-Jmm. 2007;85(3):269-77.

99. Lang F, Lang E, Foeller M. Physiology and Pathophysiology of Eryptosis. Transfusion Medicine and Hemotherapy. 2012;39(5):308-14.
100. Lang F, Qadri SM. Mechanisms and Significance of Eryptosis, the Suicidal Death of Erythrocytes. Blood Purification. 2012;33(1-3):125-30.

101. Litvinov RI, Weisel JW. Role of red blood cells in haemostasis and thrombosis. ISBT science series. 2017;12(1):176-83.

102. Schroit AJ, Zwaal RFA. TRANSBILAYER MOVEMENT OF PHOSPHOLIPIDS IN RED-CELL AND PLATELET MEMBRANES. Biochimica Et Biophysica Acta. 1991;1071(3):313-29.

103. Pajic-Lijakovic I. Erythrocytes under osmotic stress - modeling considerations. Progress in Biophysics & Molecular Biology. 2015;117(1):113-24.

104. Thevenin BJM, Low PS. KINETICS AND REGULATION OF THE ANKYRIN-BAND-3 INTERACTION OF THE HUMAN RED-BLOOD-CELL MEMBRANE. Journal of Biological Chemistry. 1990;265(27):16166-72.

105. Davis LH, Otto E, Bennett V. SPECIFIC 33-RESIDUE REPEAT(S) OF ERYTHROCYTE ANKYRIN ASSOCIATE WITH THE ANION-EXCHANGER. Journal of Biological Chemistry. 1991;266(17):11163-9.

106. Burton NM, Bruce LJ. Modelling the structure of the red cell membrane. Biochemistry and Cell Biology. 2011;89(2):200-15.

107. Grey JL, Kodippili GC, Simon K, Low PS. Identification of Contact Sites between Ankyrin and Band 3 in the Human Erythrocyte Membrane. Biochemistry. 2012;51(34):6838-46.

108. Czogalla A, Sikorski AF. Do we already know how spectrin attracts ankyrin? Cellular and Molecular Life Sciences. 2010;67(16):2679-83.

109. Cunha SR, Mohler PJ. Ankyrin protein networks in membrane formation and stabilization. Journal of Cellular and Molecular Medicine. 2009;13(11-12):4364-76.

110. Devaux PF, Herrmann A, Ohlwein N, Kozirov MM. How lipid flippases can modulate membrane structure. Biochimica Et Biophysica Acta-Biomembranes. 2008;1778(7-
8):1591-600.

111. Clark MR. Flippin' lipids. Nature Immunology. 2011;12(5):373-5.

112. Powell RJ, Machiedo GW, Rush BF, Dikdan G. OXYGEN FREE-RADICALS - EFFECT ON RED-CELL DEFORMABILITY IN SEPSIS. Critical Care Medicine. 1991;19(5):732-5.

113. Mallat Z, Benamer H, Hugel B, Benessiano J, Steg PG, Freyssinet JM, et al. Elevated levels of shed membrane microparticles with procoagulant potential in the peripheral circulating blood of patients with acute coronary syndromes. Circulation. 2000;101(8):841-3.

114. Koch CG, Li L, Sessler DI, Figueroa P, Hoeltge GA, Mihaljevic T, et al. Duration of red-cell storage and complications after cardiac surgery. New England Journal of Medicine. 2008;358(12):1229-39.

115. van Beers EJ, Schaap MCL, Berckmans RJ, Nieuwland R, Sturk A, van Doormaal FF, et al. Circulating erythrocyte-derived microparticles are associated with coagulation activation in sickle cell disease. Haematologica-the Hematology Journal. 2009;94(11):1513-9.

116. Zecher D, Cumpelik A, Schifferli JA. Erythrocyte-Derived Microvesicles Amplify Systemic Inflammation by Thrombin-Dependent Activation of Complement. Arteriosclerosis Thrombosis and Vascular Biology. 2014;34(2):313-20.

117. Eyal A, Veller M. HIV and venous thrombotic events. South African Journal of Surgery. 2009;47(2):54-6.

118. Wohner N, Sotonyi P, Machovich R, Szabo L, Tenekedjiev K, Silva MMCG, et al. Lytic Resistance of Fibrin Containing Red Blood Cells. Arteriosclerosis Thrombosis and Vascular Biology. 2011;31(10):2306-U343.

119. Varin R, Mirshahi S, Mirshahi P, Klein C, Jamshedov J, Chidiac J, et al. Whole blood clots are more resistant to lysis than plasma clots - greater efficacy of rivaroxaban.
120. Pretorius E, Lipinski B. Thromboembolic ischemic stroke changes red blood cell morphology. Cardiovascular Pathology. 2013;22(3):241-2.

121. Cines DB, Lebedeva T, Nagaswami C, Hayes V, Massefski W, Litvinov RI, et al. Clot contraction: compression of erythrocytes into tightly packed polyhedra and redistribution of platelets and fibrin. Blood. 2014;123(10):1596-603.

122. Reikvam H, Steien E, Hauge B, Liseth K, Hagen KG, Storkson R, et al. Thrombelastography. Transfusion and Apheresis Science. 2009;40(2):119-23.

123. Braekkan SK, Mathiesen EB, Njolstad I, Wilsgaard T, Stormer J, Hansen JB. Mean platelet volume is a risk factor for venous thromboembolism: the Troms circle divide study. Journal of Thrombosis and Haemostasis. 2010;8(1):157-62.

124. Coban E, Yazicioglu G, Avci AB, Akcit F. The mean platelet volume in patients with essential and white coat hypertension. Platelets. 2005;16(7):435-8.

125. Nadar SK, Blann AD, Kamath S, Beevers DG, Lip GYH. Platelet indexes in relation to target organ damage in high-risk hypertensive patients - A substudy of the Anglo-Scandinavian Cardiac Outcomes Trial (ASCOT). Journal of the American College of Cardiology. 2004;44(2):415-22.

126. Papanas N, Symeonidis G, Maltezos E, Mavridis G, Karavageli E, Vosnakidis T, et al. Mean platelet volume in patients with type 2 diabetes mellitus. Platelets. 2004;15(8):475-8.

127. Nadar SK, Lip GY, Blann AD. Platelet morphology, soluble P selectin and platelet P-selectin in acute ischaemic stroke - The West Birmingham Stroke Project. Thrombosis and Haemostasis. 2004;92(6):1342-8.

128. Greisenegger S, Endler G, Hsieh K, Tentschert S, Mannhalter C, Lalouschek W. Is elevated mean platelet volume associated with a worse outcome in patients with
acute ischemic cerebrovascular events? Stroke. 2004;35(7):1688-91.

129. Martin JF, Bath PMW, Burr ML. INFLUENCE OF PLATELET SIZE ON OUTCOME AFTER MYOCARDIAL-INFARCTION. Lancet. 1991;338(8780):1409-11.

130. Vagdatli E, Gounari E, Lazaridou E, Katsibourlia E, Tsikopoulou F, Labrianou I. Platelet distribution width: a simple, practical and specific marker of activation of coagulation. Hippokratia. 2010;14(1):28-32.

131. Gasparyan AY, Ayvazyan L, Mikhailidis DP, Kitas GD. Mean Platelet Volume: A Link Between Thrombosis and Inflammation? Current Pharmaceutical Design. 2011;17(1):47-58.

132. Prandoni P. Venous and arterial thrombosis: Two aspects of the same disease? European Journal of Internal Medicine. 2009;20(6):660-1.

133. Swanepoel AC, Nielsen VG, Pretorius E. Viscoelasticity and Ultrastructure in Coagulation and Inflammation: Two Diverse Techniques, One Conclusion. Inflammation. 2015;38(4):1707-26.

134. Gresele P, Falcinelli E, Sebastiano M, Baldelli F. Endothelial and platelet function alterations in HIV-infected patients. Thrombosis Research. 2012;129(3):301-8.

135. Youssefian T, Drouin A, Masse JM, Guichard J, Cramer EM. Host defense role of platelets: engulfment of HIV and Staphylococcus aureus occurs in a specific subcellular compartment and is enhanced by platelet activation. Blood. 2002;99(11):4021-9.

136. Metcalf Pate KA, Mankowski JL. HIV and SIV Associated Thrombocytopenia: An Expanding Role for Platelets in the Pathogenesis of HIV. Drug discovery today Disease mechanisms. 2011;8(1-2):e25-e32.

137. Sandler DA, Martin JF. Autopsy Proven Pulmonary Embolism in Hospital Patients: Are We Detecting Enough Deep Vein Thrombosis? Journal of the Royal Society of
138. Meignan M, Rosso J, Gauthier H, Brunengo F, Claudel S, Sagnard L, et al. Systematic lung scans reveal a high frequency of silent pulmonary embolism in patients with proximal deep venous thrombosis. Arch Intern Med. 2000;160(2):159-64.

139. Jackson BS, Pretorius E. Pathological Clotting and Deep Vein Thrombosis in Patients with HIV. Seminars in thrombosis and hemostasis. 2019;45(2):132-40.

Figures
Figure 1

Scanning electron microscopy micrographs of (A) representative healthy RBCs, (B) a representative healthy platelet and (C and D) after addition of thrombin to whole blood, where fibrin fibres are formed over the discoid RBCs with no cellular distortion.
Figure 2

Representative scanning electron microscopy micrographs of RBCs from HIV negative-DVT patients. (A) Whole blood with thrombin, showing RBC entrapped in fibrin matter, (B) RBCs agglutinated to each other (no thrombin), (C) higher magnification showing agglutinated plasma proteins attached to the RBC membrane and (D) a hyperactivated platelet.
Figure 3

Representative scanning electron microscopy micrographs of RBCs and platelets from HIV positive-DVT patients. (A) RBC with pathological membrane; (B and C) whole blood with thrombin, showing RBCs trapped in dense matted fibrin deposits and (D) a hyperactivated platelet.