Human metapneumovirus: a new respiratory pathogen

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Human metapneumovirus is a recently recognized pathogen of acute respiratory tract infection (ARI) in children as well as elderly and immunocompromised adults. The virus belongs to the family Paramyxoviridae, sub family Pneumovirinae and genus Metapneumovirus. Through genetic analysis it has been characterized into two groups A and B which are further divided into four sub-lineages. The virus is difficult to grow in tissue culture and hence reverse transcriptase-polymerase chain reaction (RT-PCR) for N and L gene is the method of choice for diagnosis. The virus has been seen in all countries with seasonal distribution in winter months for temperate and spring/summer for tropical countries. F gene is the most conserved among different lineages and efforts are underway to design recombination vaccine using F gene.


1. Introduction

Acute respiratory tract infections (ARI) are a leading cause of morbidity and mortality worldwide (Denny and Loda 1986; Hijazi et al 1996). Of the 10 million deaths of children less than 5 years of age throughout the world 1·9 million children died from acute lower respiratory tract infections (ALRI) in the year 2000, 70% of them in sub-Sahara Africa and South Asia (Williams et al 2002). Although the incidence rates of ARI are almost similar in both developed and developing countries, the mortality is higher in developing countries (Shapiro 1998). The risk of pneumonia is 3–6 times higher in children from developing countries (10–20%) as compared to developed countries (3–4%) (Victora et al 1999).

Approximately 0.5 million children die due to ALRI in India each year, accounting for one fourth of the 1.9 million global ALRI deaths (Reddaiah and Kapoor 1988; Ahmad et al 2000; Williams et al 2002).

All classes of micro organisms including viruses, bacteria and protozoa are capable of infecting the respiratory tract, but viruses and bacteria are the common pathogens. A variety of viruses, including, respiratory syncytial virus (RSV), influenza viruses, parainfluenza viruses, adenoviruses, coronavirus and picornaviruses, are associated with different respiratory syndromes in all age groups (Grondahl et al 1999; Weigl et al 2000). However, despite extensive diagnostic testing, a substantial portion of respiratory tract infections still cannot be attributed to any known pathogens. In about a third cases of ALRI (Liolios et al 2001) and a half of upper respiratory tract infections (URI) (Nokso-Koivisto et al 2002) no pathogen could be detected. These observations suggest that unknown pathogens may be responsible for a substantial proportion of respiratory tract disease.

Metapneumovirus is a recently discovered etiological agent of acute respiratory illness (ARI). It was first reported in 2001 from The Netherlands from nasopharyngeal aspirates (taken over a 20 year period) in 28 hospitalized children and infants with ARI having signs and symptoms similar to that of RSV infection (van den Hoogen et al 2001). The virus was found to be closely related to the avian pneumovirus, a member of the Metapneumovirus genus, and was called

**Keywords.** Acute respiratory infections; human metapneumovirus

Abbreviations used: ALRI, acute lower respiratory tract infection; APV, avian pneumoviruses; ARI, acute respiratory tract infection; CPE, cytopathic effect; hMPV, human metapneumovirus; RSV, respiratory syncytial virus; RT-PCR, reverse transcriptase-polymerase chain reaction; SARS, severe acute respiratory syndrome; SH, small hydrophobic
human metapneumovirus (hMPV) (van den Hoogen et al 2002). Although the virus was not isolated until recently, antibodies to the virus have been shown to be present in all persons ≥ 8 years of age in serum samples collected since 1958 (van den Hoogen et al 2001). Thus the virus is not a newly emerging pathogen and did not recently "jump" to the human population from an animal reservoir.

2. Virological characteristics

Genetic analysis of the virus showed that it is an RNA virus of the Paramyxoviridae family and Pneumovirinae subfamily along with RSV. The avian pneumoviruses (APV) (formerly turkey rhinotracheitis virus) is highly related to hMPV and these two viruses have been separated by taxonomists into a separate genus, Metapneumovirus (Lamb et al 2000).

Initial electron microscopic examination revealed that the viral isolate had morphology similar to paramyxoviruses. Spherical enveloped particles have a mean diameter of ~200 nm. In addition, filamentous and pleomorphic particles are also present. The virion is surrounded by a lipid envelope derived from the plasma membrane of the host cell into which the three virus glycoproteins, the attachment (G), fusion (F), and small hydrophobic (SH) proteins, are inserted (Collins and Mottet 1993). The RNA genome associates with viral proteins to form the helical nucleocapsid (represented on the right and in the centre of the virion on the left in figure 1). The proteins consist of the nucleocapsid protein (N), the phosphoprotein (P), and the large polymerase (L) protein. The M2-1 transcriptional enhancer protein is also thought to be associated with the nucleocapsid. The nucleocapsid is surrounded by the matrix (M) protein, which forms a link between the nucleocapsid and the lipid membrane of the virus particle (Easton et al 2004).

3. Genome organization

Full length sequences of at least 4 hMPV genomes have been reported (van den Hoogan et al 2002; Biacchesi et al 2003; Herfst et al 2004). The negative sense non-segmented RNA genome of the virus is about 13 kb in length (Easton et al 2004). The hMPV genome is predicted to encode 9 proteins in the order 3-N-PM- F-M2-SH-G-L-5 (the M2 gene is predicted to encode 2 proteins, M2-1 and M2-2, using overlapping open reading frames, as in RSV) (van den Hoogan et al 2002) (figure 2). The genome also contains noncoding 3'leader which has the viral promoter, 5' trailer and intergenic regions, consistent with the organization of RSV (Herfst et al 2004). However there are some differences in the genome of APV/hMPV as compared to RSV, they lack the 2 nonstructural proteins NS1 and NS2.

![Figure 1](image-url)  
**Figure 1.** Schematic diagram of the pneumovirus particle (from Easton et al 2004).
Genus Pneumovirus: Respiratory syncytial virus
3' NSLNS2 P M SH G F M2 L 5'

Genus Metapneumovirus: Avian pneumovirus, Human metapneumovirus
3' N P M F F M2 SH G L 5'

Figure 2. Genomic organization of RSV and hMPV. (Modified from Easton et al 2004.)

located at the 3' end of RSV genomes. These proteins
counteract host interferons; therefore the lack of these genes
in the metapneumoviruses may have important implications
for the relative pathogenicity of these viruses compared with
RSV strains (Collins et al 2001). Sequence identity between
APV and hMPV open reading frames is 56% to 88% (van
den Hoogen et al 2002).

Although the function of each of the gene products has not
been formally tested, it is likely that the function of the proteins
can be predicted by comparison with other paramyxoviruses. The F (fusion), G (glycosylated) and
SH (short hydrophobic) proteins are integral membrane
proteins on the surface of infected cells and virion particles.
The F protein appears to be a classic viral fusion protein,
with a predicted nonfurin F1/F2 cleavage site near a
hydrophobic fusion peptide and 2 heptad repeats in the
extra cellular domain that facilitate membrane fusion. The
predicted G protein of hMPV exhibits the basic features of
a glycosylated type II mucin-like protein but interestingly
lacks the cluster of conserved cysteines sometimes termed
the “cysteine noose” that is found in the RSV and APV G
proteins. G gene of hMPV tends to be highly variable like
RSV G gene which may be due to host immune selection
pressure (Crowe 2004). The function of the SH proteins of
both the viruses remains unknown. The N (nucleoprotein),
P (phosphoprotein) and L (large, polymerase) proteins are replication proteins in the nucleocapsid, the M2-1 and M2-2
proteins are regulatory proteins and the M (matrix) protein
may coordinate viral assembly of viral nucleocapsids with
envelope proteins (Crowe 2004).

4. Genetic and antigenic diversity

The classification and naming of serotypes/serogroups,
genotypes, subgroups, strains, variants and isolates of
hMPV is still evolving. Based on genomic sequence and
phylogenetic analysis, there are two major genotypes of
hMPV, designated A and B (Biacchesi et al 2003; van den
Hoogen et al 2003). These analyses are based on sequencing
of the N, M, F, G, or L gene, and the genotype groupings
are concordant regardless of which gene is studied (Bastein
et al 2003; Biacchesi et al 2003; Boivin et al 2004; Peret
et al 2004). Full length sequences of genomes from viruses
representing the 2 major subgroups show that the diversity
between hMPV subgroup A and B sequences is greatest for
the SH and G proteins (59 and 37% identity, respectively),
(van den Hoogen et al 2002; Biacchesi et al 2003; Herfst et
al 2004) and is more than RSV subgroup A and B. hMPV
F protein, which is predicted to be the principal target of
protective antibodies, is more conserved in hMPV strains
than RSV. The overall level of genome nucleotide sequence
identity and aggregate proteome amino acid sequence
identity between the two hMPV subgroups were 80 and
90%, respectively, similar to the respective values for RSV
A and B groups (Hamelin et al 2004).

Based on the sequence analysis of two surface glycoprotein encoding genes namely F and G genes each of
the major lineages are further subdivided into two genetic
sub-lineages known as A1, A2 and B1, B2, the significance
of this diversity is unclear at this time (Boivin et al 2004;
van den Hoogen et al 2004) (figure 3). In a recent report
Huck and colleagues have reported a new sub lineage within
the A lineage. Previously reported A2 lineage is found to
consist of two clusters namely, A2a and A2b. Among all the
sub-lineages of hMPV the A2 sub-lineage shows the greatest
diversity (Huck et al 2006).

The genetic diversity in hMPV strains also affects
antigenic diversity, but to what extent has not been resolved.
Studies with experimental infection of animals have
suggested that the two lineages exhibited 48% antigenic
relatedness based on reciprocal cross-neutralization assay
with post-infection hamster sera (Skiodopoulos et al
2004). However cross protection studies in hamsters and
nonhuman primates have shown that each strain provided a
high level of resistance to reinfection with the homologous
or heterologous strain, supporting the conclusion that the
two hMPV genetic lineages are highly related antigenically
and are not distinct antigenic subtypes or subgroups (Herfst
et al 2004; Skiodopoulos et al 2004; van den Hoogen et
al 2004). hMPV F protein is a major antigenic determinant
that mediates extensive cross-lineage neutralization and
protection (MacPhail et al 2004; Skiodopoulos et al
2004). The extent of cross-protection in rodents cannot
be extrapolated directly to the human situation because
the animals are only semi permissive hosts for hMPV
replication. Although difficult to assess, the extent of
cross-protection is important to estimate because vaccine
developers will choose to develop either a monovalent or a
bivalent vaccine formulation based on this factor.

5. Clinical features of infection

hMPV has been associated with ARI in all age groups, with
more severe diseases occurring in young children, elderly
individuals and immunocompromised hosts.
Figure 3. Phylogenetic trees constructed based on the (A) partial F gene (Open reading frame [ORF] position 780–1,221) or (B) the complete G coding region (start G ORF to start L ORF). Trees were generated by maximum likelihood analysis using 100 bootstrap values. The four prototype viruses are shown in boldface, with ovals drawn around them (from van den Hoogan et al 2004).
The virus causes a variety of clinical syndromes in children that are typical of the paramyxoviruses, including upper and lower respiratory tract illnesses. The clinical characteristics of hMPV infections are not distinctive, thus, differentiating it from other respiratory viruses on clinical grounds is not possible (Stockton et al. 2002). A study conducted at Vanderbilt University Medical Center on the association of the virus in a cohort of 2000 subjects of age 0–5 years, followed during a 25-year period revealed that hMPV was associated with common cold (complicated by otitis media in one third), bronchiolitis, pneumonia, that hMPV was associated with common cold (complicated by otitis media in one third), bronchiolitis, pneumonia, cough and exacerbation of reactive airway disease (Williams et al. 2004). The clinical profile of illness caused by hMPV was similar to that caused by RSV. In outpatients with ALRI, hMPV was detected in 12% of cases, which was second only to RSV (Williams et al. 2004). Hoarseness has also been observed more frequently in hMPV infection as compared to RSV (Falsey et al. 2003). Further compared with RSV infections, the children who develop hMPV infection are somewhat older, and the severity of disease is usually somewhat less than RSV (Boivin et al. 2003; Peiris et al. 2003; van den Hoogan et al. 2003; Viazov et al. 2003).

Human MPV infection is not restricted to the very young children but also occurs in adults and elderly subjects. In adults it usually causes flu like illness and colds (Boivin et al. 2002). In fragile elderly hMPV causes more severe disease than in healthy elderly or young adults (Falsey et al. 2003). In a study among 10 elderly of > 65 years of age who had underlying illness, 4 developed pneumonitis and 2 died due to hMPV infection (Boivin et al. 2002).

Immune status of infected subjects is also important in determining the severity of illness. hMPV infection has been reported in immunocompromised individuals. In 3 patients with acute lymphoblastic leukemia who had ALRI, hMPV was the sole pathogen detected and one of them died (Pelletier et al. 2002). hMPV infection has also been reported in HIV infected children but it is not clear if the severity of illness is more in this group (Madhi et al. 2003).

Respiratory virus infections are often associated with recurrent wheezing in children and exacerbations of asthma in older patients. Acute wheezing and asthma exacerbations have been associated with hMPV infection in some studies (Jarti et al. 2002; Peiris et al. 2003) but all studies have not shown this association (Rawlinson et al. 2003). In some studies in children with asthma hMPV was found more frequently than RSV (Peiris et al. 2003; van den Hoogen et al. 2003).

A study by Vicente et al (2006) suggested that hMPV genotype A might be more pathogenic than genotype B, causing greater clinical severity in children whereas no differences in disease severity associated with either genotype (Agapov et al 2006) was observed in another study.

6. Co-infections
Because the seasonal distributions of hMPV and RSV overlap, the potential for dual infection exists. Several studies have found hMPV –RSV co-infection rate of approximately 5-10% (Esper et al. 2004; Viazov et al. 2003; Williams et al. 2004; Xepapadaki et al. 2004). However, Greensill et al. (2003) reported that 70% of RSV-infected children who required intensive care in Liverpool, United Kingdom, were co-infected with hMPV, suggesting that dual infection with RSV and hMPV may predispose for severe infection particularly in otherwise healthy children. In another study from the United Kingdom, hMPV and RSV co-infection conferred an increased risk of admission to the pediatric intensive care unit (Semple et al. 2005). However, such synergistic association has not been found in other, population-based and case-control studies of hospitalized children (Boivin et al. 2003; Esper et al. 2003; Maggi et al. 2003). The possible synergistic interaction between hMPV and the severe acute respiratory syndrome (SARS) coronavirus has been recently postulated during the 2003 SARS outbreak in Canada and Hong Kong as many individuals were found to have co-infection with hMPV (Chan and Li 2003; Poutanen et al. 2003). On the other hand, such synergy between hMPV and SARS was not confirmed in experimental macaque models (Fouchier et al. 2003). In one case report, in an infant who had SARS, fatal encephalitis was correlated with hMPV infection as hMPV RNA was detected post-mortem in brain and lung tissue (Schildgen et al. 2005).

7. Re-infections
Cases of severe hMPV infections in adults (Boivin et al. 2002) and reinfection in immunocompromised subjects (Pelletier et al. 2002) suggest that, despite the universal infection in childhood, new infections can occur throughout life due to incompletely protective immune responses and/or acquisition of new genotype. Since severe disease is seen mainly in pediatric patients, it suggests that naturally acquired infection induces partial protection against the disease. However, it should be emphasized that there is no cross – protection among the virus strains. A recent report has described a child who suffered from two episodes of hMPV infection during a one month period, each caused by a different strain (Vargas et al. 2004).

8. Pathogenesis
The conventional model of attachment for the members of subfamily Pneumovirinae including genus Pneumovirus and Metapneumovirus involves the interaction of viral
G protein with a molecule or molecules on the host cell surface (Levine et al.1987). While the precise nature of the cellular receptor and mechanism of entry has not been identified, current evidence suggests that one or more cellular glycosaminoglycans or heparin-like molecules are involved in virus attachment and entry (Feldman et al. 2000). Following G-protein-mediated attachment, the F glycoprotein promotes pH-independent fusion between the cell membrane and the virus envelope. For the F protein to become functional, it has to be cleaved by cellular proteases, and the hydrophobic amino terminal region of the F1 component then promotes the fusion process, which introduces the internal components of the virion into the cytoplasm of the host cell, where the remainder of the infectious cycle takes place. Recent experimental work using primates (chimpanzees, cynomolgus and rhesus macaques, African green monkeys) and small animals (hamsters, cotton rats, mice and ferrets) has been performed to characterize the pathogenesis associated with this viral infection; hMPV replicates to a various extent in the upper and lower respiratory tracts of these experimental animals, although clinical symptoms after intranasal challenge have only been observed in chimpanzees, Cynomolgus macaques and BALB/c mice so far (van den Hoogen et al. 2001; Alvarez et al. 2004; Kuiken et al. 2004; Skiadopoulos et al. 2004; Hamelin et al. 2005). In BALB/c mice and cotton rats, time course studies have indicated that peak viral titers are found around day 4-5 after infection and decrease thereafter (Alvarez et al. 2004a) and Hamelin et al. (2005), have demonstrated that hMPV may present an initial biphasic replication pattern in lungs of BALB/c mice, with hMPV RNA still detectable more than 180 days after infection. Such persistence could be explained by an aberrant T helper cell type 2-like immune response, with impaired virus clearance after primary hMPV infection (Alvarez and Tripp 2005).

Significant pulmonary inflammatory changes have been found in BALB/c mice and cotton rats (Alvarez et al. 2004; Hamelin et al. 2005). Interestingly significant inflammatory changes were still present in the cotton rat animal model more than 21 days after viral challenge (Hamelin et al. 2005). Increase in many cytokines and chemokines such as interleukin IL-2, IL-8, IL-4, INF-γ, macrophage inflammatory protein 1α and monocyte chemotactic protein has been observed in the lungs or bronchoalveolar lavage of both mice and cotton rats in response to hMPV challenge (Alvarez et al. 2004, Hamelin et al. 2005). In humans, hMPV infection has also been associated with an increase of IL-8 in upper respiratory tract secretions and with chronic inflammatory changes of the airways, with presence of, intra alveolar foamy and hemosiderin-laden macrophages (Laham et al. 2004, Vargas et al. 2004). When compared with RSV, hMPV infections in humans seem to induce lower levels of inflammatory cytokines such as IL-12, tumor necrosis factor α, IL-6 and IL-1β (Laham et al. 2004). Thus far, no experimental human volunteer studies have been reported.

9. Epidemiology

Since its initial description in 2001, hMPV has been isolated from individuals of all ages with ARI, and has been identified in every continent. hMPV infections have been documented in Europe [United Kingdom (Stockton et al. 2002); Finland (Jartti et al. 2002), Italy (Maggi et al. 2003), France (Freymuth et al. 2003), Germany (Viazov et al. 2003), Spain (Vicente et al. 2003), Norway (Dollner et al. 2004)]; America, Canada (Boivin et al. 2002), United States (Esper et al. 2003, Falsey et al. 2003), Brazil (Cuevas et al. 2003) Australia (Nissen et al. 2002), Asia (HongKong (Peiris et al. 2003), Japan (Ebihara et al. 2004), Korea (Kim and Lee 2005) Thailand (Samransamruajkit et al. 2005) and Africa [Yemen, (Al-Sonboli et al. 2005), South Africa (Ludewick et al. 2005)]. In a preliminary study from Pune in India hPMV was found in 5 of 26 children with ARI (Rao et al. 2004). In a study of children seen in a large referral hospital in Delhi hMPV was detected in 12% of ARI cases by reverse transcriptase-polymerase chain reaction (RT-PCR) (Banerjee et al. 2007).

Role of hMPV in ARI has been evaluated in many studies mostly using molecular methods. In young hospitalized children hMPV has been detected in 5-10% of ARI cases. (Peret et al. 2002; Bastein et al. 2003; Boivin et al. 2003; Esper et al. 2003, 2004; McIntosh and McAdam 2004). However in one study from Italy the rates of hospitalizations due to hMPV infection varied from 7-43% (Maggi et al. 2003). The rates of detection of hMPV in adults are usually lower than children with rates of about 3% in general community (Stockton et al. 2002).

It is interesting to note that detection rates of hMPV have generally been higher in retrospective studies than in prospective studies, an observation consistent with a degree of selection bias. This indicates that large prospective studies are needed in order to clarify the role of hMPV in various clinical conditions (Hamelin et al. 2004).

Most hMPV infections occur in < 5 years of age, with children <2 years of age being most at risk for serious hMPV infections. In one study the peak was seen at 4–6 months of age (van den Hoogen et al. 2004). However, hMPV infections tend to occur in slightly older children compared to RSV (Peiris et al. 2003; van den Hoogen et al. 2003).

The activity of hMPV in temperate climates peaks between December and February (Maggi et al. 2003; van den Hoogen et al. 2003) where as in subtropics it peaks in spring-summer (Peiris et al. 2003). The peak of activity of hMPV at any given location often coincides with or follows the peak of RSV activity (Boivin et al. 2003; Esper et al. 2004).
Outbreaks of hMPV are to be a local phenomenon unlike influenza virus, where two or three strains spread across the globe each year. Strains of hMPV differ from community to community, and strains identified in one location may be quite similar to strains identified in other locations in different years. For example, the prototype strain identified in The Netherlands is genetically similar to strains identified in Australia; New Haven, Connecticut and Quebec, Canada in different years (Esper et al 2004). We in Delhi also found that 2 lineages of hMPV circulated during the same season i.e. in 2005-06 A2b and B1 lineages were seen with A2b being the predominant genotype where as in 2006-07 B1 and B2 were found to co-circulate with predominance of B1 (Broor S, et al, unpublished data).

Although formal transmissions studied have not been carried out, transmission most likely is through large particle respiratory secretions and fomites as is true for RSV (Human Metapneumovirus 2006). Nosocomial transmission has been reported in hospital setting (Pieris et al 2003).

9.1 Seroepidemiology
Presence of hMPV antibodies in serum samples obtained in 1958 showed that the virus has been circulating for at least for the past 50 years in The Netherlands (van den Hoogen et al 2001). By the age of 5 years, >90% of individuals screened have evidence of hMPV infection. The seroprevalence of hMPV specific antibody in adults is nearly 100% (van den Hoogen et al 2001, Leung et al 2005). The hMPV-specific antibodies in infants <3 months of age has been detected in >90% of the cases tested, indicating that maternally derived antibodies are present in young children (Leung et al 2005). Whether these hMPV specific antibodies protects against infection or lessens the severity of illness is not known.

10. Diagnosis

10.1 Virus isolation
hMPV replicates poorly in conventional cell culture and is relatively difficult to isolate. Many strains show reliable cytopathic effect (CPE) in tertiary monkey kidney cell line/LLCMK-2 cells (Peret et al 2002). The CPE is quite variable, some strains show syncyitia formation and other only produce rounding (Boivin et al 2002). CPE is usually observed after 10-21 days (mean 17 days). Confirmation of CPE is done by RT-PCR or indirect immunofluorescence staining using hMPV specific antibodies.

Recent reports have shown that hMPV can replicate efficiently in Hep-2 cells but does not produce good CPE. van den Hoogen et al (2004) reported that Vero cell clone 118 is permissible for expression of virus from all four lineages and CPE is easier to observe. Many laboratories are now using this cell line for routine virus isolation (van den Hoogen et al 2004). In addition shell vial culture for rapid isolation of hMPV has also been described (Reina et al 2007). They showed that shell vial culture using commercial LLCMK-2 cells should be a method for isolating hMPV from respiratory samples in pediatric population.

10.2 Direct immunofluorescence assay
Direct immunofluorescence assay (DFA) using virus specific antibodies is a rapid method to detect respiratory viruses and is commonly used in diagnostic laboratories. Commercially available hMPV specific antibodies have been developed for direct immunofluorescence assays, though this method may not be as sensitive as RT-PCR for the detection of hMPV (Ebihara et al 2005, Landry et al 2005, Percivalle et al 2005).

10.3 Molecular diagnostics
Because of the unavailability of rapid antigenic detection assays in the past and slow growth in tissue culture molecular methods have become the method of choice for the diagnosis of hMPV infection. Cote et al (2003) reported that primers that bind regions of the N and L genes are highly sensitive for the detection of hMPV strains of both genotypes. However, it is reported that the P gene of hMPV is an ideal target for the molecular detection and genotyping as P gene provides the conserved region for designing RT-PCR primers and adequate variability to permit the accurate genotyping of the virus into 2 main lineages and 4 sub-lineages (Mackay et al 2004).

Real time PCR has also been described for hMPV which allows amplification and quantitation of this pathogen in clinical samples. Real-time RT-PCR is a powerful method to detect hMPV and other respiratory viruses. The assay has been developed to detect the N gene of all known hMPV lineages (Maertzdorf et al 2004) and real time RT-PCR targeting the N and / or L gene is more sensitive, specific, and rapid method to detect this virus in clinical samples than conventional RT-PCR (Mackay et al 2003). Nucleic acid sequence based amplification assay (NASBA) targeting the M gene has also been developed for detection of hMPV infection in respiratory specimens (Dare et al 2007).

10.4 Serology
Enzyme-linked immunosorbent assay (ELISA) can also be used for hMPV serological testing using the hMPV-infected
cells (Falsey et al 2003, Hamelin et al 2005). Recently, ELISA methods using viral N or F protein expressed in prokaryotic (Hamelin and Boivin 2005) or recombinant vesicular stomatitis virus (VSV) (Leung et al 2005) and recombinant baculovirus system (Liu et al 2007) have been developed to detect antibodies against hMPV. Use of these assays in sero-epidemiologic studies might be helpful for detection of antibody response against hMPV infections thus increasing the understanding of the human immune responses to hMPV and permitting better understanding of the epidemiology of this virus. However, since infections with hMPV are universal, serologic testing for diagnosis can only help if four fold increases in antibody titers or seroconversion is demonstrated (Prins and Wolthers 2004).

11. Vaccine candidates and animal models

The development of a safe and effective vaccine to protect against hMPV is a reasonable goal. Several promising vaccine candidates have been tested in animal models. A live recombinant human parainfluenza virus that contains the hMPV F gene has been shown to induce hMPV-specific antibodies and to protect experimental animals from hMPV challenge (Skiadopoulos et al 2004).

A chimeric bovine/human parainfluenza virus 3 expressing the hMPV F elicits neutralizing antibodies against both Parainfluenza virus and hMPV (Tang et al 2005). However, the results of these animal challenge studies should be interpreted cautiously. There are many limitations of the small-animal model for testing potential hMPV vaccines, not the least of which is that the pathogen is highly host restricted. The safety and efficacy of a recombinant hMPV vaccine may be difficult to predict. Chimeric hMPV/avian pneumovirus recombinant viruses in which the N or P gene of hMPV was replaced with the corresponding gene from avian pneumovirus are attenuated in African green monkeys (the P gene chimera is 10- to 1,000-fold more attenuated than the N chimera), though both are as immunogenic as wild-type hMPV (Pham et al 2005). This represents another strategy for the development of recombinant attenuated live hMPV vaccines.

12. Therapy

Other than influenza virus, antiviral therapy for respiratory viruses has not shown tremendous potential. It is unknown what role the host’s inflammatory response plays during hMPV disease. Nonetheless, antiviral compounds have been tested with hMPV.

The antiviral activity of ribavirin to inhibit the replication of hMPV is equivalent to that observed with RSV (Wyde et al 2003). Other compounds, such as NMSO3, a sulphated sialyl lipid that has been shown to have potent antiviral activity against RSV in tissue culture cells, have been shown to have anti-hMPV activity in vitro (Wyde et al 2004). It is likely that an hMPV-neutralizing monoclonal antibody for prophylaxis of high-risk infants (similar to the anti-RSV F humanized monoclonal antibody currently used for prevention of severe RSV disease) will be developed and tested. The progress towards an effective antiviral strategy for hMPV is currently limited by the scant data on pathogenesis of the virus in the natural host.

13. Conclusions

Since the discovery of hMPV in 2001, the virus has been identified worldwide. hMPV is a common respiratory pathogen, particularly in infants and young children. The virus is associated with both upper and lower respiratory tract infections and may be a trigger for asthma. There are two major genotypes of hMPV, whether these genotypes represent distinct serotypes remains controversial. The major challenges faced by the medical and scientific communities are: the understanding of the pathogenesis of hMPV disease and the development of a safe and effective vaccine to protect against infection and disease caused by this newly recognized respiratory virus.

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