Table 3 Factors promoting the response to PEG-IFN and ribavirin in multivariate analysis

Factors	Odds ratio	95% Confidence interval	*P*
Male gender	3.50	1.71–7.17	0.001
$ICG_{15} \leq 13.5\%$	2.09	1.07–4.08	0.031
Ribavirin $\geq$ 11.1 mg/kg per day	2.17	1.11–4.25	0.024
Total PEG-IFN $\geq$ 80%	6.96	2.26–21.4	0.001
PEG-IFN/ribavirin $\geq$ 80%	12.66	2.32–71.4	0.003

more severe and less responsive to IFN in patients infected with HCV genotypes 1 and 4 than in those with HCV genotypes 2, 3 and 6 [18–22]. Likewise, high viral loads are associated with rapid progression of liver disease and poor response to IFN [23–25]. In our study, such viral factors were excluded in comparing the response to PEG-IFN and ribavirin between women and men. All the patients were infected with HCV genotype 1b in high viral loads (>100 kIU/ml).

Age influences the severity of chronic hepatitis C [9, 26], and disease progresses faster and response to antiviral therapy is poorer in older patients [23]. There were significant differences in age between female and male patients in our study. The women were older than the men [mean (range) 57 (30–69) years vs 50 (19–66) years, $P < 0.001$], and the proportion of patients $\geq$60 years was higher in women than in men (39% vs 19%, $P < 0.001$). Hence, the response to PEG-IFN and ribavirin was evaluated in patients aged $\geq$50 years and <50 years separately. There were no differences in the response between female and male patients <50 years, during and at the end of the 48-week treatment, as well as 24 weeks thereafter. However, ETR (55% vs 84%, $P < 0.001$) and SVR (22% vs 53%, $P < 0.001$) were gained significantly less often in women than men who were aged $\geq$50 years.

The influence of gender was observed, also, in patients aged $\geq$60 years and those aged 50–60 years. Hence, women would become less responsive than men to PEG-IFN and ribavirin after they had entered their fifties.

From a therapeutic notion, compliance with treatment can alter the response. Since ribavirin accumulates in erythrocytes and induces hemolysis, it is less tolerated in women who tend to be anemic than men without such an inclination [27]. At the baseline, women had lower levels of hemoglobin and ferritin than men. These would have been responsible for the lower tolerance to PEG-IFN and ribavirin in women than men in our study. In fact, $\geq$80% of the dose of PEG-IFN, ribavirin, or both, was tolerated less frequently in women than men ($P < 0.001$ for each). Even in the patients who had received $\geq$80% of the dose, however, the response to PEG-IFN and ribavirin was gained less frequently in women than in men. Again, the difference was due to a significantly lower response in female patients than in male patients aged $\geq$50 years, while the response was no different between those <50 years of age.

Taken altogether, the poorer response to PEG-IFN and ribavirin in women than in men was attributable to impaired response in the female patients aged $\geq$50 years. Older women with chronic hepatitis C, therefore, would be less responsive to the combined treatment with PEG-IFN and ribavirin currently in use. In support of this view, the response to human lymphoblastoid IFN for 24 weeks is dependent on gender and age [28]. The greatest physiological change precipitated in women by aging is a decreased serum concentration of bioavailable estrogen after they enter the menopause [29]. Estrogen has been shown to have an antifibrotic potential in both experimental and clinical studies. In experimental cirrhosis induced by dimethylnitrosamine in rats, administration of neutralizing antibodies to estradiol and ovariectomy enhanced fibrogenesis in female rats [30]. Hepatocytes have the receptor to estrogen [31], and myofibroblastic transformation in hepatic stellate cells of rats is inhibited in culture supplemented with this hormone [32]. Consequently, hepatic fibrosis progresses faster in menopausal women with chronic hepatitis C, and hormone replacement therapy may be able to prevent it [33]. Furthermore, in women aged $\geq$50 years, the number of estrogen receptor in hepatocytes decreases to one-half of that in those aged <50 years. This would stand in further support of the notion that the antifibrotic effects of decreased estrogen levels in patients aged $\geq$50 years with chronic hepatitis C would produce a lesser response to PEG-IFN and ribavirin.

Favorable effects of female sex hormones on hepatitis have long been suggested. Chronic hepatitis C is mild in menstruating women [34]; its activity is suppressed during pregnancy and enhanced after delivery [35]. The velocity of fibrosis progression is extremely low in young women exposed to HCV through mass-administration of immunoglobulin-D. Only two of 184 (1.2%) and four of 1,018 (0.4%) developed cirrhosis over 24 years and 20 years, respectively, in Irish and German studies [36, 37]. It does need to be pointed out, however, that the majority of women in those studies had not been followed beyond the menopause. There is a possibility that chronic hepatitis C may progress at a faster speed during their next few decades. Continued observations of them would be necessary to evaluate the validity of such an assumption.

Although decreased levels of estrogen can explain the enhanced activity of chronic hepatitis C in older women, as well as their concomitant resistance to PEG-IFN and ribavirin, it does not give an account of the better response in men than women who were aged $\geq$50 years. Feminization represented by gynecomastia is common in men

who have developed cirrhosis, and it can increase even in healthy men with age [38]. Possibly in the background of this phenomenon, circulating levels of free estrogen in men exceed those in women, after they enter their fifties, with margins widening with age [29]. It is tempting to speculate that elevated estrogen levels in men with chronic hepatitis C are responsible for their better response to the combination therapy than women who were aged $\geq$50 years. Whether or not such a speculation would hold would have to be evaluated by a comparison of estrogen levels between older men and women with chronic hepatitis C.

Although osteoporosis is an extrahepatic manifestation of chronic hepatitis C [39], hormone replacement therapy has been withheld for fear of potential hepatotoxicity. There is evidence, however, that oral contraceptives inhibit the progression of fibrosis in women [33]. It may lead to the possibility that the response to antiviral treatment in older women with chronic hepatitis C would be improve by substituting estrogen in them. The merit of hormone replacement therapy for them, of course, would need to be balanced against any harmful effects associated with it.

There are limitations in this study. All the patients were infected with genotype 1b in high viral loads. Hence, the results obtained may or may not be extended to patients with chronic hepatitis C who are infected with HCV of other genotypes in low viral loads. The influence of sex hormones needs to be substantiated by their determination in correlation with SVR. These limitations notwithstanding, the results obtained warrant a special caution in the treatment of women older than 50 years due to their lesser responsiveness to PEG-IFN and ribavirin.

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References

1. Cohen J. The scientific challenge of hepatitis C. *Science*. 1999;285:26–30. doi:10.1126/science.285.5424.26.
2. Alberti A, Chemello L, Benvegnu L. Natural history of hepatitis C. *J Hepatol*. 1999;31:S17–S24. doi:10.1016/S0168-8278(99)80369-9.
3. Alter HJ, Seeff LB. Recovery, persistence, and sequelae in hepatitis C virus infection: a perspective on long-term outcome. *Semin Liver Dis*. 2000;20:17–35. doi:10.1055/s-2000-9505.
4. Seeff LB. Natural history of chronic hepatitis C. *Hepatology*. 2002;36:S35–S46. doi:10.1002/hep.1840360706.
5. Feray C, Gigou M, Samuel D, et al. Influence of the genotypes of hepatitis C virus on the severity of recurrent liver disease after liver transplantation. *Gastroenterology*. 1995;108:1088–1096. doi:10.1016/0016-5085(95)90207-4.
6. Garcia-Samaniego J, Soriano V, Castilla J, et al. Influence of hepatitis C virus genotypes and HIV infection on histological severity of chronic hepatitis C. *Am J Gastroenterol*. 1997;92:1130–1134.
7. Pageaux GP, Ducos J, Mondain AM, et al. Hepatitis C virus genotypes and quantitation of serum hepatitis C virus RNA in liver transplant recipients: relationship with severity of histological recurrence and implications in the pathogenesis of HCV infection. *Liver Transpl Surg*. 1997;3:501–505. doi:10.1002/lt.500030504.
8. Kenny-Walsh E. Clinical outcomes after hepatitis C infection from contaminated anti-D immune globulin. Irish Hepatology Research Group. *N Engl J Med*. 1999;340:1228–1233. doi:10.1056/NEJM199904223401602.
9. Poynard T, Bedossa P, Opolon P. Natural history of liver fibrosis progression in patients with chronic hepatitis C. *Lancet*. 1997;349:825–832. doi:10.1016/S0140-6736(96)07642-8.
10. Vogt M, Lang T, Frosner G, et al. Prevalence and clinical outcome of hepatitis C infection in children who underwent cardiac surgery before the implementation of blood-donor screening. *N Engl J Med*. 1999;341:866–870. doi:10.1056/NEJM199909163411202.
11. McHutchison JG, Gordon SC, Schiff ER, et al. Interferon alfa-2b alone or in combination with ribavirin as initial treatment for chronic hepatitis C. *N Engl J Med*. 1998;339:1485–1492. doi:10.1056/NEJM199811193392101.
12. Fried MW, Shiffman ML, Reddy KR, et al. Peginterferon alfa-2a plus ribavirin for chronic hepatitis C virus infection. *N Engl J Med*. 2002;347:975–982. doi:10.1056/NEJMoa020047.
13. Hung CH, Lee CM, Lu SN, et al. Anemia associated with antiviral therapy in chronic hepatitis C: incidence, risk factors, and impact on treatment response. *Liver Int*. 2006;26:1079–1086. doi:10.1111/j.1478-3231.2006.01354.x.
14. Akuta N, Suzuki F, Kawamura Y, et al. Predictors of viral kinetics to peginterferon plus ribavirin combination therapy in Japanese patients infected with hepatitis C virus genotype 1b. *J Med Virol*. 2007;79:1686–1695. doi:10.1002/jmv.20979.
15. Sezaki H, Suzuki F, Kawamura Y, et al. Evaluation of long-term biochemical responses to combination therapy of interferon plus ribavirin in those infected with hepatitis C virus genotype 1b and high baseline viral load. *Hepatol Res*. 2007;37:787–792. doi:10.1111/j.1872-034X.2007.00132.x.
16. Conjeevaram HS, Fried MW, Jeffers LJ, et al. Peginterferon and ribavirin treatment in African American and Caucasian American patients with hepatitis C genotype 1. *Gastroenterology*. 2006;131:470–477. doi:10.1053/j.gastro.2006.06.008.
17. Poynard T, Marcellin P, Lee SS, et al. Randomised trial of interferon alpha2b plus ribavirin for 48 weeks or for 24 weeks versus interferon alpha2b plus placebo for 48 weeks for treatment of chronic infection with hepatitis C virus. International Hepatitis Interventional Therapy Group (IHIT). *Lancet*. 1998;352:1426–1432. doi:10.1016/S0140-6736(98)07124-4.
18. Tsubota A, Chayama K, Ikeda K, et al. Factors predictive of response to interferon-alpha therapy in hepatitis C virus infection. *Hepatology*. 1994;19:1088–1094.
19. Hadziyannis SJ, Sette H Jr, Morgan TR, et al. Peginterferon-alpha2a and ribavirin combination therapy in chronic hepatitis C: a randomized study of treatment duration and ribavirin dose. *Ann Intern Med*. 2004;140:346–355.
20. Hui CK, Yuen MF, Sablon E, Chan AO, Wong BC, Lai CL. Interferon and ribavirin therapy for chronic hepatitis C virus genotype 6: a comparison with genotype 1. *J Infect Dis*. 2003;187:1071–1074. doi:10.1086/368217.
21. Legrand-Abravanel F, Nicot F, Boulestin A, et al. Pegylated interferon and ribavirin therapy for chronic hepatitis C virus genotype 4 infection. *J Med Virol*. 2005;77:66–69. doi:10.1002/jmv.20414.
22. Yuen MF, Lai CL. Response to combined interferon and ribavirin is better in patients infected with hepatitis C virus genotype 6

than genotype 1 in Hong Kong. *Intervirology*. 2006;49:96–98. doi:10.1159/000087270.
23. Kumada T, Toyoda H, Honda T, et al. Treatment of chronic hepatitis C with interferon alone or combined with ribavirin in Japan. *Intervirology*. 2006;49:112–118. doi:10.1159/000087273.
24. Liang TJ, Rehermann B, Seeff LB, Hoofnagle JH. Pathogenesis, natural history, treatment, and prevention of hepatitis C. *Ann Intern Med*. 2000;132:296–305.
25. Trepo C. Genotype and viral load as prognostic indicators in the treatment of hepatitis C. *J Viral Hepat*. 2000;7:250–257. doi: 10.1046/j.1365-2893.2000.00233.x.
26. Wali M, Harrison RF, Gow PJ, Mutimer D. Advancing donor liver age and rapid fibrosis progression following transplantation for hepatitis C. *Gut*. 2002;51:248–252. doi:10.1136/gut.51.2.248.
27. Takaki S, Tsubota A, Hosaka T, et al. Factors contributing to ribavirin dose reduction due to anemia during interferon alfa2b and ribavirin combination therapy for chronic hepatitis C. *J Gastroenterol*. 2004;39:668–673. doi:10.1007/s00535-003-1363-9.
28. Hayashi J, Kishihara Y, Ueno K, et al. Age-related response to interferon alfa treatment in women vs men with chronic hepatitis C virus infection. *Arch Intern Med*. 1998;158:177–181. doi: 10.1001/archinte.158.2.177.
29. Khosla S, Melton LJ 3rd, Atkinson EJ, O'Fallon WM, Klee GG, Riggs BL. Relationship of serum sex steroid levels and bone turnover markers with bone mineral density in men and women: a key role for bioavailable estrogen. *J Clin Endocrinol Metab*. 1998;83:2266–2274. doi:10.1210/jc.83.7.2266.
30. Yasuda M, Shimizu I, Shiba M, Ito S. Suppressive effects of estradiol on dimethylnitrosamine-induced fibrosis of the liver in rats. *Hepatology*. 1999;29:719–727. doi:10.1002/hep.510290307.
31. Rossini GP, Baldini GM, Villa E, Manenti F. Characterization of estrogen receptor from human liver. *Gastroenterology*. 1989;96:1102–1109.
32. Shiba M, Shimizu I, Yasuda M, Ii K, Ito S. Expression of type I and type III collagens during the course of dimethylnitrosamine-induced hepatic fibrosis in rats. *Liver*. 1998;18:196–204.
33. Di Martino V, Lebray P, Myers RP, et al. Progression of liver fibrosis in women infected with hepatitis C: long-term benefit of estrogen exposure. *Hepatology*. 2004;40:1426–1433. doi: 10.1002/hep.20463.
34. Sartori M, Andorno S, Rigamonti C, Grossini E, Nicosia G, Boldorini R. Chronic hepatitis C is mild in menstruating women. *J Gastroenterol Hepatol*. 2000;15:1411–1417. doi:10.1046/j.1440-1746.2000.02368.x.
35. Latt NC, Spencer JD, Beeby PJ, et al. Hepatitis C in injecting drug-using women during and after pregnancy. *J Gastroenterol Hepatol*. 2000;15:175–181. doi:10.1046/j.1440-1746.2000.02060.x.
36. Levine RA, Sanderson SO, Ploutz-Snyder R, et al. Assessment of fibrosis progression in untreated Irish women with chronic hepatitis C contracted from immunoglobulin anti-D. *Clin Gastroenterol Hepatol*. 2006;4:1271–1277. doi:10.1016/j.cgh.2006.05.028.
37. Wiese M, Berr F, Lafrenz M, Porst H, Oesen U. Low frequency of cirrhosis in a hepatitis C (genotype 1b) single-source outbreak in Germany: a 20-year multicenter study. *Hepatology*. 2000; 32:91–96. doi:10.1053/jhep.2000.8169.
38. Braunstein GD. Gynecomastia. *N Engl J Med*. 1993;328:490–495. doi:10.1056/NEJM199302183280708.
39. Carey EJ, Balan V, Kremers WK, Hay JE. Osteopenia and osteoporosis in patients with end-stage liver disease caused by hepatitis C and alcoholic liver disease: not just a cholestatic problem. *Liver Transpl*. 2003;9:1166–1173. doi:10.1053/jlts.2003.50242.

Sustained Virological Response Reduces Incidence of Onset of Type 2 Diabetes in Chronic Hepatitis C

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Diabetes is present in patients with chronic hepatitis C virus infection. The aim of this retrospective cohort study was to assess the cumulative development incidence and predictive factors for type 2 diabetes after the termination of interferon therapy in Japanese patients positive for hepatitis C virus (HCV). A total of 2,842 HCV-positive patients treated with interferon (IFN) monotherapy or combination therapy with IFN and ribavirin were enrolled. The mean observation period was 6.4 years. An overnight (12-hour) fasting blood sample or a casual blood sample was taken for routine analyses during follow-up. The primary goal was the onset of type 2 diabetes. Evaluation was performed by using the Kaplan-Meier method and Cox proportional hazard analysis. Of 2,842 HCV patients, 143 patients developed type 2 diabetes. The cumulative development rate of type 2 diabetes was 3.6% at 5 years, 8.0% at 10 years, and 17.0% at 15 years. Multivariate Cox proportional hazard analysis revealed that type 2 diabetes development after the termination of IFN therapy occurred when histological staging was advanced (hazard ratio 3.30; 95% confidence interval [CI] 2.06-5.28; $P < 0.001$), sustained virological response was not achieved (hazard ratio 2.73; 95% CI 1.77-4.20; $P < 0.001$), the patient had pre-diabetes (hazard ratio 2.19; 95% CI 1.43-3.37; $P < 0.001$), and age was ≥50 years (hazard ratio 2.10; 95% CI 1.38-3.18; $P < 0.001$). *Conclusion:* Our results indicate sustained virological response causes a two-thirds reduction in the risk of type 2 diabetes development in HCV-positive patients treated with IFN. (HEPATOLOGY 2009;49:000-000.)

Hepatitis C virus (HCV) is one of the more common causes of chronic liver disease in world. Chronic hepatitis C is an insidiously progressive form of liver disease that relentlessly but silently progresses to cirrhosis in 20% to 50% of cases over a period of 10 to 30 years.[1-3] In addition, HCV is a major risk for hepatocellular carcinoma (HCC).[4-8] Moreover, chronic HCV infection has been associated with a variety of extrahepatic complications such as essential mixed cryoglobulinemia, porphyria cutanea tarda, membranoproliferative glomerulonephritis, autoimmune thyroiditis, sialadenitis, and cardiomyopathy.[9-13] Lately, data supporting a link between type 2 diabetes mellitus (T2DM) and chronic hepatitis C infection have been reported.[14,15]

Although there is growing evidence to support the concept that HCV infection is a risk factor for developing T2DM, there have been a few interventional studies confirming this issue. This issue needs to be confirmed with a long-term follow-up of patients with high risk of developing diabetes. Thus, prospective studies including metabolic evaluations are clearly needed to clarify these issues.

With this background in mind, the cohort study was initiated to investigate the cumulative incidence and risk factors of T2DM after prolonged follow-up in HCV-infected patients treated with interferon (IFN) monotherapy or combination therapy with IFN and ribavirin. The strengths of the current study are the large numbers of patients included and the long-term follow-up of patients.

Patients and Methods

Patients. There were 5,890 patients diagnosed with chronic HCV infection and treated with IFN mono-

Abbreviations: CI, confidence interval; FPG, fasting plasma glucose; HCC, hepatocellular carcinoma; HCV, hepatitis C virus; IFN, interferon; SVR, sustained virological response; T2DM, type 2 diabetes mellitus.

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therapy or combination IFN + ribavirin therapy between September 1990 and March 2007 in the Department of Hepatology, Toranomon Hospital, Tokyo, Japan. Of these, 2,842 patients satisfied the following criteria: (1) no evidence of diabetes mellitus for 3 months after the termination of IFN (plasma glucose concentration <126 mg/dL [6.9 mmol/L] in the fasting state, <200 mg/dL [11.0 mmol/L] in casual state and/or 2 hours after a 75-g oral glucose load); (2) features of chronic hepatitis or cirrhosis diagnosed via laparoscopy and/or liver biopsy before the initiation of IFN therapy; (3) positivity for serum HCV RNA before the initiation of IFN therapy; (4) period of ≤1 year of IFN therapy; (5) negativity for hepatitis B surface antigen (HBsAg), antinuclear antibodies, or antimitochondrial antibodies in serum, as determined via radioimmunoassay or spot hybridization; (6) no evidence of HCC nodules as shown on ultrasonography and/or computed tomography; and (7) no underlying systemic disease, such as systemic lupus erythmatosus or rheumatic arthritis.

Patients who were taking medications known to alter glucose tolerance or had illnesses that could seriously reduce their life expectancy or their ability to participate in the trial were excluded from the study. Patients were classified as having normal glucose or pre-diabetes based on fasting plasma glucose (FPG), casual plasma glucose, or 2-hour plasma glucose. The normal glucose group was regarded as having an FPG of <100 mg/dL, casual plasma glucose of <140 mg/dL, and/or 2-hour plasma glucose of <140 mg/dL. The pre-diabetes group was regarded as having an FPG of 100-125 mg/dL, casual plasma glucose of 140-200 mg/dL, and/or 2-hour plasma glucose of 140-200 mg/dL.[16]

Next, we assessed predictive factors for T2DM in chronic hepatitis C patients treated with IFN. The physicians in charge explained the purpose and method of this clinical trial to each patient and/or the patient's family. Informed consent was obtained from all living patients included in the present cohort study. The study was approved by the Institutional Review Board of our hospital.

Outcome Measures. The primary outcome was T2DM, diagnosed by the use of the 2003 criteria of the American Diabetes Association.[16] These criteria include (1) casual plasma glucose ≥200 mg/dL; (2) FPG ≥126 mg/dL; (3) 2-hour post-glucose (oral glucose tolerance test) ≥200 mg/dL.

Laboratory Investigation. Anti-HCV was detected using a second-generation enzyme-linked immunosorbent assay (ELISA II; Abbott Laboratories, North Chicago, IL). HCV-RNA was determined by the Amplicor method (Cobas Amplicor HCV Monitor Test, version 2.0; Roche, Tokyo, Japan). Hepatitis B surface antigen was tested via radioimmunoassay (Abbott Laboratories, Detroit, MI). The used serum samples were stored at −80°C at the first consultation. Diagnosis of HCV infection was based on detection of serum HCV antibody and positive RNA. Height and weight were recorded at baseline, and the body mass index was calculated as weight (in kg)/height (in m^2).

Evaluation of Liver Cirrhosis. Liver status of the 2,842 patients was mainly determined via peritoneoscopy and/or liver biopsy. Liver biopsy specimens were obtained using a modified Vim Silverman needle with an internal diameter of 2 mm (Tohoku University, Kakinuma Factory, Tokyo, Japan), fixed in 10% formalin, and stained with hematoxylin-eosin, Masson's trichrome, silver impregnation, and periodic acid-Schiff after diastase digestion. The size of specimens for examination was more than six portal areas.[17]

Follow-up. The starting time of follow-up was 3 months after the termination of IFN therapy. After that, patients were followed up monthly to tri-monthly in our hospital. Physical examination and biochemical tests were conducted at each examination together with regular check-up. An overnight (12-hour) fasting blood sample or a casual blood sample was taken for routine analyses. These included aminotransferase activities, total cholesterol, platelet counts, and serum HCV RNA level. Three hundred twenty-four patients were lost to follow-up; because the appearance of T2DM and death was not identified in these patients, they were considered as censored data in the statistical analysis.[18] Moreover, patients retreated with antiviral agents were regarded as withdrawals at the time of starting the retreatment of antiviral agents.

Statistical Analysis. The cumulative appearance rate of T2DM was calculated from 3 months after the termination of IFN treatment to the appearance of T2DM using the Kaplan-Meier method. Differences in the development of T2DM were tested using the log rank test. Independent factors associated with the incidence rate of T2DM were analyzed by the Cox proportional hazard model. The following 11 variables were analyzed for potential covariates for incidence of T2DM at the time of termination of IFN therapy at our hospital: age, sex, state of liver disease (chronic hepatitis or liver cirrhosis), body mass index, glucose level, aspartate aminotransferase level, alanine aminotransferase level, type of IFN, total dose of IFN, efficacy of IFN therapy, hypertension, triglyceride level, and total cholesterol level. A P value of less than 0.05 was considered significant. Data analysis was performed using SPSS 11.5 for Windows (SPSS, Chicago, IL).

Results

Patient Characteristics. Table 1 shows the characteristics of the 2,842 HCV-positive patients treated with

Table 1. Patient Characteristics

N	2,842
Sex (male/female)	1,778/1,064
Age (years)	51.8 ± 9.0
Height (cm)	163.8 ± 9.1
Body weight (kg)	62.7 ± 11.7
Body mass index	23.3 ± 3.2
Blood pressure (systolic/diastolic, mm Hg)	128 ± 18/77 ± 12
HCV genotype (1b/2a/2b/other)	744/752/290/56
HCV RNA level (KIU/mL)	593 ± 540
Staging (non-LC/LC)	2,649/193
Blood glucose level (normal/prediabetes)	2,601/241
Fasting plasma glucose (mg/dL)	87 ± 24
Triglyceride (mg/dL)	166 ± 31
Total bilirubin (g/dL)	102 ± 56
AST (IU/L)	74 ± 63
ALT (IU/L)	116 ± 102
IFN monotherapy*/combination therapy†	2,417/425
Efficacy of treatment (SVR/non-SVR)	1,175/1,667
Follow-up period (years)	6.4 ± 5.0

Data are expressed as the number of patients or mean ± standard deviation.

Abbreviations: ALT, alanine aminotransferase; AST, aspartate aminotransferase; LC, liver cirrhosis; SVR, sustained virological response.

*Outbreak of IFN monotherapy: recombinant IFN-α2a, 304 cases; recombinant IFN-α2b, 235 cases; natural IFN-bα, 1,355 cases; natural IFN-β, 522 cases; total dose of IFN = 598 ± 170 MU.

†Outbreak of combination therapy: recombinant IFN-α2b + ribavirin, 175 cases; total dose of IFN = 537 ± 196 MU; total dose of ribavirin = 182 ± 69 g; pegylated IFN-α2b + ribavirin, 250 cases; total dose of pegylated IFN = 4.28 ± 1.17 mg; total dose of ribavirin = 232 ± 60 g.

IFN monotherapy or combination therapy with IFN and ribavirin. The sustained virological response (SVR) rate was 36.7% (886/2417) in IFN monotherapy and 68% (289/425) in IFN + ribavirin therapy. Thus, the number of patients with SVR was 1,175. The mean period after the termination of antiviral drugs was 6.4 years.

Incidence of T2DM in Patients with HCV. A total of 143 patients (102 men and 41 women) developed T2DM during a mean observation period of 6.4 years. Of these, 26 were SVR and 117 were non-SVR. The cumulative development rate of T2DM was determined to be 3.6% at 5 years, 8.0% at 10 years, and 17.0% at 15 years using the Kaplan-Meier method (Fig. 1). The factors associated with the incidence of T2DM in all 2,842 patients treated with IFN therapy are shown in Table 2.

Multivariate Cox proportional hazard analysis revealed that type 2 diabetes development after the termination of IFN therapy occurred when histological staging was advanced (hazard ratio 3.30; 95% confidence interval [CI] 2.06-5.28; $P < 0.001$), sustained virological response was not achieved (hazard ratio 2.73; 95% CI 1.77-4.20; $P < 0.001$), patient had pre-diabetes (hazard ratio 2.19; 95% CI 1.43-3.37; $P < 0.001$), and age was >50 years (hazard ratio 2.10; 95% CI 1.38-3.18; $P < 0.001$). SVR causes a two-thirds reduction of development of T2DM in patients treated with IFN. In addition to SVR, age ≥50 years, liver cirrhosis, and pre-diabetes contribute to a high risk of developing diabetes. The cumulative development rates of T2DM based on difference of age, efficacy of the IFN therapy, histological diagnosis, and glucose level at the starting time of follow-up are shown in Fig. 2.

Fig. 3 shows the impact of reduction due to SVR on the incidence of T2DM in patients with ≥50 years, liver cirrhosis, or pre-diabetes. When patients with age ≥50 years, liver cirrhosis, and pre-diabetes have SVR after IFN therapy, SVR could statistically reduce the onset of T2DM compared with those without SVR.

Discussion

We have described the development incidence of diabetes after the termination of antiviral therapy in HCV-positive patients treated with IFN therapy in the present study. Diabetes has been reported in less than 0.08% of patients treated with IFN[19,20]; thus, to exclude diabetes originating from IFN-related side effects, patients without diabetes for 3 months after the termination of IFN were enrolled in the present study. The present study indicates that the annual incidence of T2DM for a prolonged follow-up after the termination of IFN therapy among HCV patients is 0.8% to 1.0%. The present study was limited by a retrospective cohort trial. We started the present study in 1991 based on the diabetes mellitus criteria published by Fajans.[21] However, after that, diabetes mellitus criteria were revised. We thus rechecked the diagnosis of T2DM based on the diabetes mellitus criteria of 2003 in patients seen prior to 2003.[16] Because of rechecking the diagnosis of T2DM on the basis of diabetes mellitus criteria in 2003, the present study was regarded as a retrospective cohort study. However, the patients were

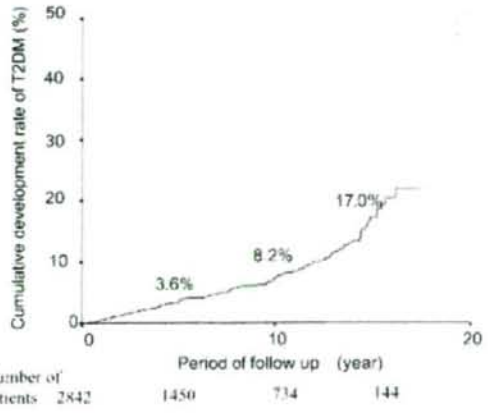

Fig. 1. Cumulative development rate of T2DM in patients treated with IFN.

Table 2. Predictive Factors for T2DM Development

Variables	Univariate Analysis		Cox Regression	
	HR (95% CI)	P Value	HR (95% CI)	P Value
Age, years (≥50/<50)	2.55 (1.74-3.73)	<0.001	2.10 (1.38-3.18)	<0.001
Sex (female/male)	0.84 (0.59-1.19)	0.318		
Body mass index (≥25/<25)	1.44 (0.98-2.08)	0.057		
HCV load (KIU/mL, ≥1,000/<1,000)	0.67 (0.43-1.03)	0.069		
Genotype (1/2)	0.73 (0.50-1.06)	0.098		
ALT (IU/L, ≥50/<50)	1.83 (1.14-2.94)	0.012		
Glucose level (prediabetes/normal)	2.25 (1.53-3.33)	<0.0001	2.19 (1.43-3.37)	<0.001
Triglyceride (mg/dL, ≥150/<150)	1.66 (0.93-2.98)	0.088		
Cholesterol (mg/dL, ≥220/<220)	1.56 (0.62-3.95)	0.346		
Histological diagnosis (LC/non-LC)	4.03 (2.55-6.36)	<0.0001	3.30 (2.06-5.28)	<0.001
Combination of ribavirin (−/+)	1.53 (0.99-2.38)	0.058		
Type of IFN (α/β)	0.88 (0.57-1.35)	0.882		
Total dose of IFN (MU, ≥500/<500)	0.91 (0.59-1.40)	0.672		
Efficacy (non-SVR/SVR)	2.73 (1.77-4.20)	<0.0001	2.78 (1.75-4.41)	<0.001

Data are expressed as the median (range).
Abbreviations: ALT, alanine aminotransferase; HR, hazard ratio; LC, liver cirrhosis.

prospectively followed. Another limitation of the study was that patients were treated with different types of antiviral therapy (IFN monotherapy or combination IFN + ribavirin therapy) for different duration (4 to 52 weeks). This heterogeneity makes it difficult to interpret the results of the study. On the other hand, the strength of the present study is the long-term follow-up in the large numbers of patients included.

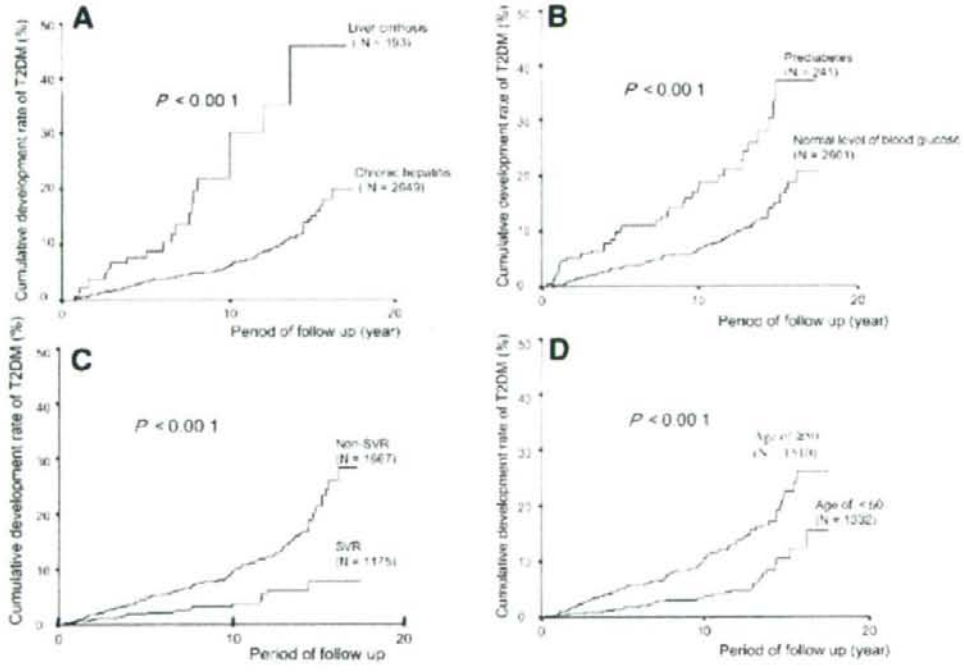

Fig. 2. Cumulative development rate of T2DM in patients treated with IFN. (A) Cumulative development rate of T2DM based on difference of hepatic fibrosis. (B) Cumulative development rate of T2DM based on the difference of glucose level. (C) Cumulative development rate of T2DM based on the difference of efficacy. (D) Cumulative development rate of T2DM based on the difference of age.

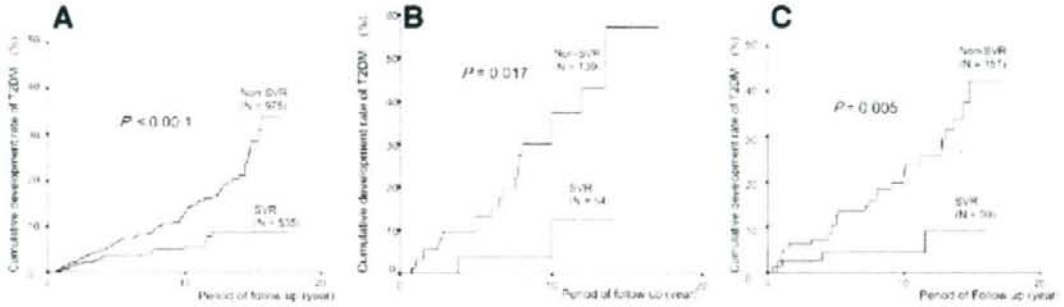

Fig. 3. Cumulative development rate of T2DM in patients with SVR or without SVR after IFN therapy. (A) Cumulative development rate of T2DM based on SVR or non-SVR in patients with age ≥50 years. (B) Cumulative development rate of T2DM based on SVR or non-SVR in patients with liver cirrhosis. (C) Cumulative development rate of T2DM based on the difference of SVR or non-SVR in patients with pre-diabetes.

The present study shows several findings with regard to development of T2DM after the termination of antivirus agents for HCV positive patients. First, the T2DM development rate in the non-SVR group was higher than that in the SVR group. The SVR caused a two-thirds reduction in the onset of T2DM in the course of posttreatment follow-up. That SVR reduced the onset of diabetes mellitus in HCV patients is in accordance with the data reported by Simó et al.[22] and Romero-Gómez et al.[23] Though the role of HCV in the pathogenesis of diabetes mellitus remains speculative, the following possible mechanisms have been reported: (1) patients with HCV have a tendency to attain insulin resistance[24]; (2) in transgenic mice, the expression of HCV core protein is associated with insulin resistance and T2DM development[25]; and (3) SVR in HCV patients reduces insulin resistance and onset of the incidence of abnormal glucose value.[26] Thus, it is accepted that clearance of HCV reduces the onset of T2DM.

Second, in addition to persistence of HCV, the present study suggests that aging, histological progression, and pre-diabetes enhanced the onset of T2DM in patients with HCV infection. However, when HCV was eradicated even in patients with age ≥50 years, pre-diabetes, or liver cirrhosis, the cumulative development rate of T2DM decreased.

T2DM is increasing dramatically in many Asian nations, including Japan, over the past decades.[27] It is widely accepted that 7 to 8 million people are affected by diabetes mellitus in Japan. Approximately 8% to 10% of adults in Japan have T2DM. In general, T2DM is associated with a genetic predisposition, but it is also strongly influenced by lifestyle-related factors, such as eating habits and/or physical activity.[28-33] The risk factors associated with T2DM include family history, age, sex, obesity, smoking, and physical activity. T2DM occurred in elderly patients compared to young patients. Life expectancies are long in Japan; thus, in the near future, a large number of patients with HCV will be >60 years of age. Therefore, it is apparent that the incidence of T2DM will increase in HCV-positive patients.

T2DM is a serious, costly disease. Treatment for T2DM may prevent some of its devastating complications, but does not usually restore normoglycemia or eliminate all the adverse consequences.[28,29] Moreover, HCV patients with T2DM are at major risk for HCC.[34] On the efficacy of IFN therapy, it has been reported that T2DM reduces HCV eradication via combination IFN + ribavirin therapy.[26] Thus, it should be considered whether HCV-positive patients should be treated with antiviral drugs in the histological nonprogression stage and at a non-elderly age for prevention of T2DM onset. If SVR obtained via antiviral therapy for HCV cannot only prevent progression to liver cirrhosis or HCC but also prevent the development of diabetes, the potential impact of IFN therapy is quite significant.

In conclusion, this retrospective study suggests that the annual incidence of T2DM among patients with HCV is 0.8% to 1.0%. Our results indicate that SVR causes a two-thirds reduction of T2DM development in HCV-positive patients treated with antiviral drugs.

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References

1. Kiyosawa K, Furuta S. Review of hepatitis C in Japan. J Gastroenterol Hepatol 1991;6:383-391.
2. Alter MJ, Margolis HS, Krawczynski K, Judson FN, Mares A, Alexander WJ, et al. The natural history of community acquired hepatitis C in the United States. N Engl J Med 1992;327:1899-1905.
3. van Rossum TG, Vulto AG, de Man RA, Brouwer JT, Schalm SW. Review article: glycyrrhizin as a potential treatment for chronic hepatitis C. Aliment Pharmacol Ther 1998;12:199-205.

4. Colombo M, Kuo G, Choo QL, Donato MF, Del Ninno E, Tommasini MA, et al. Prevalence of antibodies to hepatitis C virus in Italian patients with hepatocellular carcinoma. Lancet 1989;2:1006-1008.
5. Hasan F, Jeffers LJ, De Medina M, Reddy KR, Parker T, Schiff ER, et al. Hepatitis C-associated hepatocellular carcinoma. HEPATOLOGY 1990;12: 589-591.
6. Kew MC, Houghton M, Choo QL, Kuo G. Hepatitis C virus antibodies in southern African blacks with hepatocellular carcinoma. Lancet 1990;335: 873-874.
7. Tsukuma H, Hiyama T, Tanaka S, Nakao M, Yabuuchi T, Kitamura T, et al. Risk factors for hepatocellular carcinoma among patients with chronic liver disease. N Engl J Med 1993;328:1797-1801.
8. Ikeda K, Saitoh S, Koida I, Arase Y, Tsubota A, Chayama K, et al. A multivariate analysis of risk factors for hepatocellular carcinogenesis: a prospective observation of 795 patients with viral and alcoholic cirrhosis. HEPATOLOGY 1993;18:47-53.
9. Gumber SC, Chopra S. Hepatitis C: a multifaceted disease- review of extrahepatic manifestations. Ann Intern Med 1995;123:615-620.
10. Johnson RJ, Gretch DR, Yamabe H, Hart J, Bacchi CE, Hartwell P, et al. Membranoproliferative glomerulonephritis associated with hepatitis C virus infection. N Engl J Med 1993;328:465-470.
11. Pawlotsky JM, Roudot-Thoraval F, Simmonds P, Mellor J, Ben Yahia MB, André C, et al. Extrahepatic immunologic manifestations in chronic hepatitis C and hepatitis C virus serotypes. Ann Intern Med 1995;122:169-173.
12. Boadas J, Rodríguez-Espinosa J, Enriquez J, Miralles F, Martínez-Cerezo FJ, González P, et al. Prevalence of thyroid autoantibodies is not increased in blood donors with hepatitis C virus infection. J Hepatol 1995;22:611-615.
13. Agnello V, Chung RT, Kaplan LM. A role for hepatitis C virus infection in type II cryoglobulinemia. N Engl J Med 1992;327:1490-1495.
14. Imazeki F, Yokosuka O, Fukai K, Kanda T, Kojima H, Saisho H. Prevalence of diabetes mellitus and insulin resistance in patients with chronic hepatitis C: comparison with hepatitis B virus-infected and hepatitis C virus-cleared patients. Liver Int 2008;28:355-362.
15. Arao M, Murase K, Kusakabe A, Yoshioka K, Fukuzawa Y, Ishikawa T, et al. Prevalence of diabetes mellitus in Japanese patients infected chronically with hepatitis C virus. J Gastroenterol 2003;38:355-360.
16. Genuth S, Alberti KG, Bennett P, Buse J, Defronzo R, Kahn R, et al. Expert Committee on the Diagnosis and Classification of Diabetes Mellitus. Follow-up report on the diagnosis of diabetes mellitus. Diabetes Care 2003;26:3160-3167.
17. Desmet VJ, Gerber M, Hoofnagle JH, Manns M, Scheuer PJ. Classification of chronic hepatitis: diagnosis, grading and staging. HEPATOLOGY 1994; 19:1513-1520.
18. Fleming TR, Harrington DP, O'Brien PC. Designs for group sequential tests. Control Clin Trials 1984;5:348-361.
19. Fabris P, Betterle C, Greggio NA, Zanchetta R, Bosi E, Biasin MR, et al. Insulin-dependent diabetes mellitus during alpha-interferon therapy for chronic viral hepatitis. J Hepatol 1998;28:514-517.
20. di Cesare E, Previti M, Russo F, Brancatelli S, Ingemi MC, Scoglio R, et al. Interferon-alpha therapy may induce insulin autoantibody development in patients with chronic viral hepatitis. Dig Dis Sci 1996;41:1672-1677.
21. Fajans S. Classification and diagnosis of diabetes. In: Rifkin H, Porte D, eds. Diabetes Mellitus: Theory and Practice. 4th ed. New York: Elsevier, 1990:346-356.
22. Simó R, Lecube A, Genescà J, Esteban JI, Hernández C. Sustained virological response correlates with reduction in the incidence of glucose abnormalities in patients with chronic hepatitis C virus infection. Diabetes Care 2006;29:2462-2466.
23. Romero-Gómez M, Fernández-Rodríguez CM, Andrade RJ, Diago M, Alonso S, Planas R, et al. Effect of sustained virological response to treatment on the incidence of abnormal glucose values in chronic hepatitis C. J Hepatol 2008;48:721-727.
24. Romero-Gómez M. Insulin resistance and hepatitis C. World J Gastroenterol 2006;12:7075-7080.
25. Shintani Y, Fujie H, Miyoshi H, Tsutsumi T, Tsukamoto K, Kimura S, et al. Hepatitis C virus infection and diabetes: direct involvement of the virus in the development of insulin resistance. Gastroenterology 2004;126:840-848.
26. Romero-Gómez M, Del Mar Viloria M, Andrade RJ, Salmerón J, Diago M, Fernández-Rodríguez CM, et al. Insulin resistance impairs sustained response rate to peginterferon plus ribavirin in chronic hepatitis C patients. Gastroenterology 2005;128:636-641.
27. Waki K, Noda M, Sasaki S, Matsumura Y, Takahashi Y, Isogawa A, et al. Alcohol consumption and other risk factors for self-reported diabetes among middle-aged Japanese: a population-based prospective study in the JPHC study cohort I. Diabet Med 2005;22:323-331.
28. Thuluvath PJ, John PR. Association between hepatitis C, diabetes mellitus, and race. a case-control study. Am J Gastroenterol 2003;98:438-441.
29. Mehta SH, Brancati FL, Strathdee SA, Pankow JS, Netski D, Coresh J, et al. Hepatitis C virus infection and incident type 2 diabetes. HEPATOLOGY 2003;38:50-56.
30. Wild S, Roglic G, Green A, Sicree R, King H. Global prevalence of diabetes: estimates for the year 2000 and projections for 2030. Diabetes Care 2004;27:1047-1053.
31. UK Prospective Diabetes Study (UKPDS) Group. Intensive blood-glucose control with sulphonylureas or insulin compared with conventional treatment and risk of complications in patients with type 2 diabetes (UKPDS 33). Lancet 1998; 352:837-853.
32. UK Prospective Diabetes Study (UKPDS) Group. Effect of intensive blood-glucose control with metformin on complications in overweight patients with type 2 diabetes (UKPDS 34). Lancet 1998;352: 854-865.
33. Elbein SC. The search for genes for type 2 diabetes in the post-genome era. Endocrinology 2002;143:2012-2018.
34. Veldt BJ, Chen W, Heathcote EJ, Wedemeyer H, Reichen J, Hofmann WP, et al. Increased risk of hepatocellular carcinoma among patients with hepatitis C cirrhosis and diabetes mellitus. HEPATOLOGY 2008;47:1856-1862.

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Original Article

Two flavonoids extracts from *Glycyrrhizae radix* inhibit *in vitro* hepatitis C virus replication

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Aim: Traditional herbal medicines have been used for several thousand years in China and other Asian countries. In this study we screened herbal drugs and their purified compounds, using the Feo replicon system, to determine their effects on *in vitro* HCV replication.

Methods: We screened herbal drugs and their purified extracts for the activities to suppress hepatitis C virus (HCV) replication using an HCV replicon system that expressed chimeric firefly luciferase reporter and neomycin phosphotransferase (Feo) genes. We tested extracts and 13 purified compounds from the following herbs: *Glycyrrhizae radix*; *Rehmanniae radix*; *Paeoniae radix*; *Artemisiae capillari spica*; and *Rhei rhizoma*.

Results: The HCV replication was significantly and dose-dependently suppressed by two purified compounds, isoliquiritigenin and glycycoumarin, which were from *Glycyrrhizae radix*. Dose-effect analyses showed that 50% effective concentrations were 6.2 ± 1.0 μg/mL and 15.5 ± 0.8 μg/mL for isoliquiritigenin and glycycoumarin, respectively. The MTS assay did not show any effect on cell growth and viability at these effective concentrations, indicating that the effects of the two compounds were specific to HCV replication. These two compounds did not affect the HCV IRES-dependent translation nor did they show synergistic action with interferon-alpha.

Conclusion: Two purified herbal extracts, isoliquiritigenin and glycycoumarin, specifically suppressed *in vitro* HCV replication. Further elucidation of their mechanisms of action and evaluation of *in vivo* effects and safety might constitute a new anti-HCV therapeutics.

Key words: hepatitis C virus, herbal drugs, replicon

INTRODUCTION

HEPATITIS C VIRUS (HCV) infects 170 million people worldwide and is characterized by chronic liver inflammation and fibrogenesis leading to end-stage liver failure and hepatocellular malignancy.[1,2] The difficulty in eradicating HCV is attributable, in part, to limited treatment options against the virus. Currently, combination therapy using pegylated interferon-alpha (IFN) and ribavirin has been used worldwide.[3–5] The success rates, however, are almost half of patients treated. Furthermore, these therapies carry a significant risk of serious side effects. Thus, the development of alternative therapeutic agents against HCV is our high priority goal.

We have reported an HCV subgenomic replicon that expresses chimeric luciferase reporter "Feo" protein.[6] This Feo replicon supports stable and high levels of autonomous HCV RNA replication in transfected cells. Furthermore, the level of luciferase correlates well with levels of HCV RNA production, so that luciferase can be used as a reliable surrogate marker for HCV replication. This chimeric reporter replicon system has contributed the discovery of novel anti-HCV substances such as cyclosporins,[7–9] short interfering RNA,[10,11] interferon-gamma[12] and HMG-CoA reductase inhibitors.[13,14]

Traditional herbal drugs have been used for several thousand years in China and other Asian countries. Although these pharmacological activities are not fully

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Table 1 List of herbal drugs and their purified extracts

Herbal drug	Purified compound
Glycyrrhizae radix	Isoliquiritigenin
	Glycycoumarin
	Isoliquiritin
	Licuroside
Paeoniae radix	Paeoniflorin
	1,2,3,6-tetra-O-galloyl-β-D-glucose
Rhei Rhizoma	Rhein 8-O-β-glucoside
Rehmanniae radix	Acteoside
	Martynoside
	Isoacteoside
Artemisiae capillari spica	Demethoxycapillarisin
	3,4-di-o-galloylquinic acid
	Acteosyringone

characterized, they also have been safely used for many clinical conditions in Japan. For example, Sho-saiko-to (TJ-9; Xiao-Chae-Hu-Tang in Chinese), an oral medicine, which consists of seven herbal components (*Bupleuri radix, Pinelliae tuber, Scutellariae radix, Ginseng radix, Grycyrrhhizae radix, and Zingiberis rhizoma*),[15] has been clinically used for the treatment of chronic viral liver disease. It has been reported to regulate the cytokine production system in patients with hepatitis C[16] and to prevent the development of HCC in patients with non-B cirrhosis.[17] *Glycyrrhizin*, the major component of *Glycyrrhizae radix* (licorice), has also been used for the treatment of chronic hepatitis in Japan, known to have an alanine transaminase-lowering effect.[18,19] Despite the clinical effects of these herbal drugs, they did not suppress the HCV replication *in vitro*.[15]

In the present study, we applied the Feo replicon system to screen the herbal drugs and their purified compounds for their effects on *in vitro* HCV replication. Here, we show that two purified compounds from the herbal extracts specifically and substantially suppressed HCV replication.

MATERIALS AND METHODS

Purified compounds (Table 1)

THIRTEEN COMPOUNDS WERE purified from five herbal drugs: *Glycyrrhizae radaix; Rhemanniae radix; Paeoniae radix; Artemisiae Capillari Spica;* and *Rhei Rhizoma* (Table 1; Tsumura, Tokyo, Japan). These extracts were prepared at concentrations of 5 mg/mL in dimethyl sulfoxide (DMSO), then stored at −20°C until use. Recombinant human interferon (IFN) alpha-2b was obtained from Schering-Plough (NJ, USA).

Cell culture

A human hepatoma cell line, Huh7, was maintained in Dulbecco's modified Eagle's medium (Sigma, MO, USA) supplemented with 10% fetal calf serum at 37°C under 5% CO_2. Huh7 cells expressing the HCV replicon were cultured in a medium containing 200 μg/mL G418 (Wako, Osaka, Japan).

HCV subgenomic replicon construct

An HCV subgenomic replicon plasmid, pHCV1bneo-delS,[20] was reconstructed by substituting the neomycin phosphotransferase gene with a fusion gene comprising the firefly luciferase and neomycin phosphotrasnferase (pRep-Feo) (Fig. 1a). RNA was synthesized from pRep-

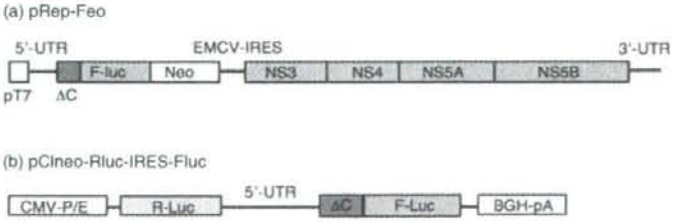

Figure 1 HCV subgenomic replicon and reporter plasmid constructs. (a) An HCV subgenomic replicon plasmid, pRep-Feo, was reconstructed from HCV1bneo-delS by replacing the neomycin phosphotransferase (Neo) gene with a fusion gene comprising the firefly luciferase (Fluc) and Neo, which we designated as "Feo"[6]. NS, nonstructural region; pT7, T7 promoter; 3' UTR, 3' untranslated region. (b) A plasmid, pCIneo-Rluc-IRES-Fluc, was constructed to analyze HCV-IRES-mediated translation efficiency . The plasmid, expressing a bicistronic RNA, in which *Renilla* luciferase (Rluc) was translated in a cap-dependent manner and firefly luciferase (Fluc) was translated by HCV-internal ribosome entry site (IRES)-mediated initiation, was stably transfected into Huh7 cells.

Feo and transfected into Huh7 cells. After culture in the presence of G418, cell lines stably expressing the replicon were established.[10,21]

HCV-IRES reporter construct

A plasmid, pCIneo-Rluc-IRES-Fluc, was used to analyze HCV internal ribosome entry site (IRES)-mediated translation efficiency (Fig. 1b).[22] The plasmid, expressing a bicistronic RNA, in which *Renilla* luciferase (Rluc) was translated in a cap-dependent manner and firefly luciferase (Fluc) was translated by HCV-IRES-mediated initiation, was stably transfected into Huh7 cells. After culture in the presence of G418, Huh7/CRIF cells were established.[9] Activities of the HCV-IRES-mediated translation were measured by culture of Huh7/CRIF cells in the presence of drugs and by dual luciferase assays after 48 h.

Luciferase assays and measurements of antiviral activity

Huh7/Rep-Feo cells were cultured with various concentrations of herbal extracts or compounds. Levels of HCV replication were quantified by internal luciferase assay after 48 h of culture. Luciferase activities were quantified using a luminometer (Promega, WI, USA) and the Bright-Glo Luciferase Assay System (Promega). Assays were performed in triplicate and the results were expressed as means ± SD as percentages of the controls. The 50% effective concentrations (EC50) were calculated using probit method. The determination of EC50 was performed three times, and presented as mean ± SD in each compound.

Realtime RT-PCR analysis

Total cellular RNA was extracted from cultured cells or liver tissue using ISOGEN (Nippon Gene, Tokyo, Japan). Two μg of total cellular RNA was used to generate cDNA from each sample using the SuperScript II reverse-transcriptase (Invitrogen, CA, USA). The replicon RNA expression levels were measured using the Applied Biosystems 7500 Fast Realtime PCR System (Applied Biosystems, CA, USA) and QuantiTect SYBR Green PCR Kit (QIAGEN, CA, USA). Sequences of a pair of primers has been described elsewhere.[23]

Northern blottings

Expression of HCV subgenomic RNA was detected as previously reported.[24] Total cellular RNA was extracted from cells using ISOGEN (Nippon Gene, Tokyo, Japan). Fifteen micrograms of the total cellular RNA was electrophoresed on a 1.0% denaturing agarose-formaldehyde gel and was transferred to a Hybond-N+ nylon membrane (Amersham-Pharmacia Biotech, Sweden). The upper part of the membrane, which contained the HCV replicon RNA, was hybridized with a digoxigenin-labeled probe that was specific for the full-length replicon sequence, and the lower part of the membrane was hybridized with a probe specific for beta-actin. The signals were detected in a chemiluminescence reaction using a Digoxigenin Luminescent Detection Kit (Roche, Germany) and visualized using a Fluoro-Imager (Roche).

Western blottings

Western blotting was done as reported previously.[24] Thirty micrograms of total cell lysate was separated using NuPAGE 4–12% Bis-Tris gels (Invitrogen, CA, USA) and blotted onto an Immobilon polyvinylidene difluoride membrane (Roche). The membrane was incubated with the primary antibodies followed by a peroxidase-labeled anti IgG antibody, and visualized by chemiluminescence reaction (BM Chemiluminescence Blotting Substrate; Roche). The antibodies used were anti-NS5A (BioDesign, ME, USA), anti-core (provided by Dr. Wakita), and anti-beta-actin antibodies (Sigma).

MTS assays

To evaluate cell viability, MTS (dimethylthiazol carboxymethoxyphenyl sulfophenyl tetrazolium) assays were performed using a Cell Titer 96 Aqueous One Solution Cell Proliferation Assay (Promega) according to manufacturer's directions.

HCV-JFH1 virus cell culture

An *in vitro* transcribed HCV-JFH1 RNA[25] was transfected into Huh7.5.1 cells.[26] Naïve Huh7.5.1 cells were subsequently infected by culture supernatant of the JFH1-RNA transfected Huh-7.5.1 cells, and subjected to culture in the presence of drugs. Culture medium was collected serially and HCV core antigen was measured using a chemiluminescence enzyme immunoassay (CLEIA) according to the manufacturer's protocol (Lumipulse Ortho HCV Antigen; Ortho-Clinical Diagnostics, Tokyo, Japan). Cellular virus expression was measured by the Western blotting using anti-core antibodies.[27]

Statistical analyses

Statistical analyses were performed using Student's *t*-test. *P*-values of less than 0.05 were considered statistically significant.

RESULTS

Suppression of HCV replication by purified herbal extracts, isoliquiritigenin and glycycoumarin

TO SCREEN THE herbal drugs and these purified extracts (Table 1) for their antiviral effects against HCV replication, Huh7/Rep-Feo cells were cultured with various concentrations of 5 herbal extracts; *Glycyrrhizae radaix, Rhemanniae radix, Paeoniae radix, Artemisiae capillari spica, and Rhei rhizoma*, and 13 compounds purified from these herbal extracts. Levels of HCV replication were quantified by internal luciferase assay after 48 h. None of the herbal extracts showed any effects on HCV replication (data not shown). On the other hand, among the 13 purified compounds, isoliquiritigenin and glycycoumarin, which were purified from *Glycyrrhizae radix*, suppressed replication of HCV replicon in a dose-dependent manner. The EC50s were 6.2 ± 1.0 and 15.5 ± 0.8 μg/mL for isoliquiritigenin and glycycoumarin, respectively (Figs 2a,3a). The MTS assay did not show any effect on cell growth and viability (Fig. 2b), indicating that the antiviral action of the two compounds is not due to cytotoxic or antiproliferative effects. Huh7/Rep-Feo cells were cultured with various concentrations of isoliquiritigenin and glycycoumarin, and the dose-effect correlation and time courses of replicon expression were measured by luciferase assay. After addition of each compounds, suppressive effect of the HCV replicon lasted for 48 h in a dose and time-dependent manner (Fig. 3b).

Realtime-RT-PCR and Western blotting analyses

In the realtime RT-PCR analysis and Northern blot analyses, levels of the replicon RNA decreased in a dose-dependent manner following treatment with isoliquir-

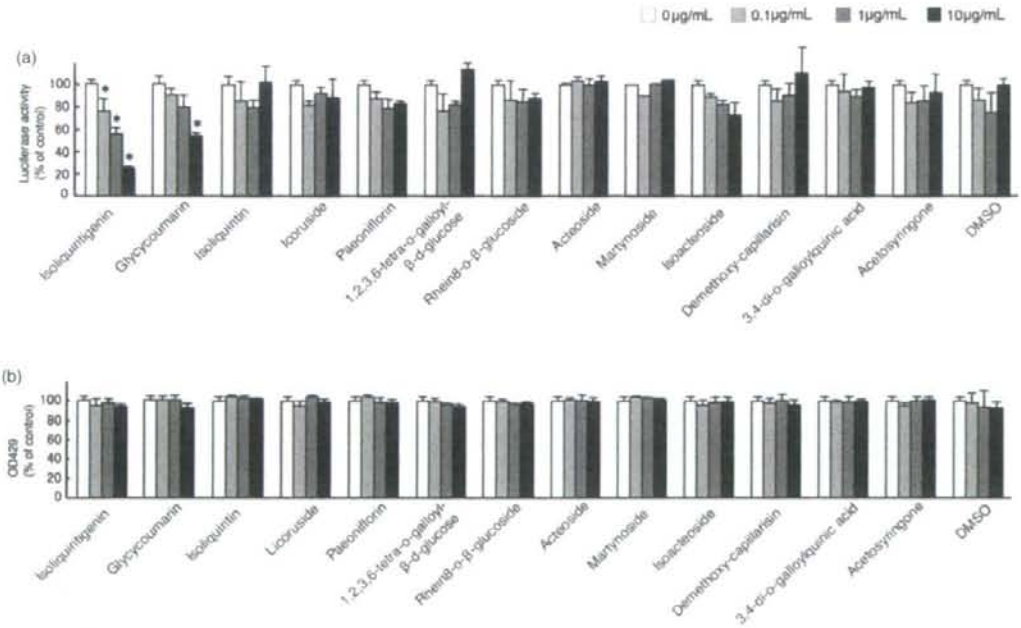

Figure 2 Effects of purified extracts from herbal drugs on expression of HCV replicon. (a) Huh7/Rep-Feo cells, which constitutively express the HCV Feo replicon, were cultured in the presence of 13 compounds at concentrations of 0, 0.1, 1, and 10 μg/mL. The internal luciferase activities were measured after 48 h of culture. Assays were performed in triplicate. Error bars indicate mean ± SD. Asterisks indicate p-values of less than 0.05. (b) MTS assay of Huh7/Rep-Feo cells cultured with the concentrations of 13 compounds indicated. Error bars indicate mean ± SD.

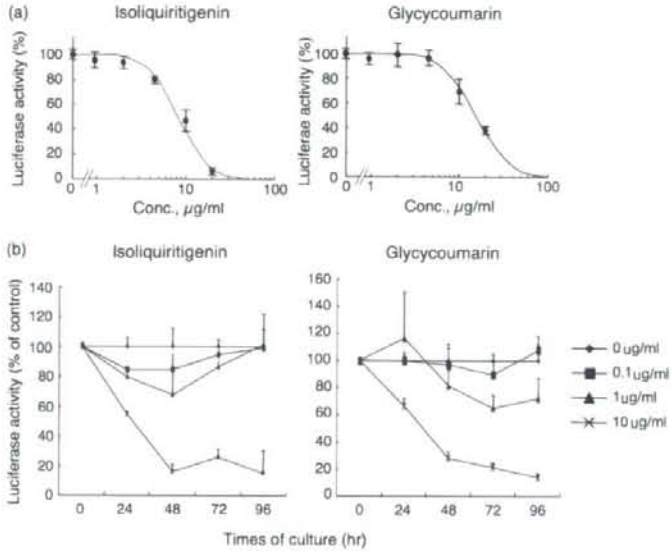

Figure 3 Dose- and time-dependent suppression of HCV replication by isoliquiritinenin and glycycoumarin. (a) Relative log (dose)-response plots for isoliquiritigenin or glycycoumarin. Error bars indicate mean ± SD of triplicate analyses. Calculated probit curves are overlaid in each plot. (b) Huh7/Rep-Feo cells were cultured with the concentrations of isoliquiritigenin and glycycoumarin indicated. The internal luciferase activities were measured at times of culture indicated. Assays were performed in triplicate. Error bars indicate mean ± SD.

itigenin and glycycoumarin (Fig. 4a,b). Similarly, in Western blot analysis, the HCV non-structural protein, NS5A, which was translated from the HCV replicon, decreased by corresponding amounts in response to treatment with isoliquiritigenin and glycycoumarin (Fig. 4c). Densitometric analysis of NS5A protein showed that the intracellular levels of the virus protein in Huh7/Rep-Feo cells correlated well with the luciferase activities.

Absence of synergistic anti-HCV effects of interferon-alpha with isoliquiritigenin or glycycoumarin

To determine whether IFN and these two compounds have a synergistic inhibitory effect on the replicon, Huh7/Rep-Feo cells were cultured with combinations of IFNα-2b and isoliquiritigenin or glycycoumarin at various concentrations. The relative dose-inhibition curves of IFN were plotted under each fixed concentrations of isoliquiritigenin or glycycoumarin of 0, 0.1, 1, 10 μg/mL, respectively (Fig. 5). The curves did not show synergy of the two compounds and IFN against the HCV replicon. To see whether the action of isoliquiritigenin and glycycoumarin involve interferon-Jak/STAT-ISRE pathway, we conducted ISRE reporter assays. We transfected the p-55C1BLuc plasmid in Huh7 cells and cultured the cells in the presence of isoliquiritigenin or glycycoumarin. After 12 h of incubation, those drugs did not activate ISRE-promoter activities (data not shown). These results suggested that the action of the compounds on the intracellular replication of HCV replicon was independent of the IFN-ISRE pathway.

Isoliquiritigenin and glycycoumarin do not suppress the HCV IRES-dependent translation

We next determined whether these two compounds suppress HCV IRES-dependent translation, we used Huh7 cell line that had been stably transfected with pCIneo-Rluc IRES-Fluc (Huh7/CRIF; Fig. 1b). Treatment of these cells with isoliquiritigenin or glycycoumarin resulted in no significant change of the internal luciferase activities at concentrations of these two compounds that suppressed expression of the HCV replicon (Fig. 6a). The MTS assay did not show any effect on cell growth and viability at concentrations used in this assay (Fig. 6b).

Isoliquiritigenin and glycycoumarin suppress HCV-JFH1 virus cell culture

The demonstrated inhibitory effects isoliquiritigenin and glycycoumarin on HCV subgenomic replication were validated further by using HCV-JFH1 cell culture system.[25] As shown in Figure 7a, treatment of the cells with the two compounds suppressed time-dependent

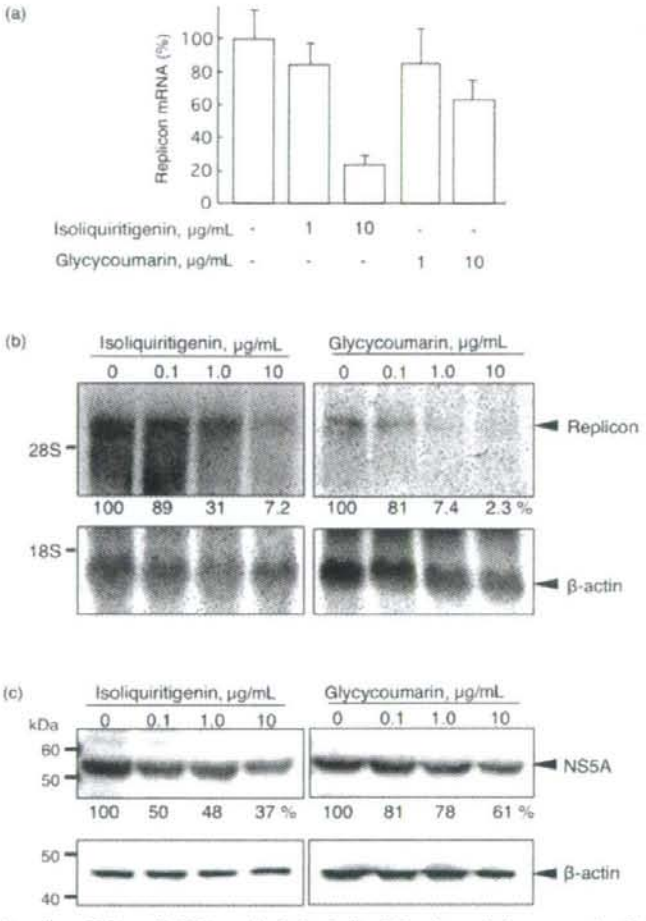

Figure 4 Suppression of replicon RNA and NS5A synthesis by isoliquiritigenin and glycycoumarin. Huh7/Rep-Feo cells were cultured with indicated concentrations of two compounds, isoliquiritigenin and glycycoumarin, and harvested at 48 hr after exposure. (a) Real-time RT-PCR analyses. (b) Northern-blot hybridization. Fifteen micrograms of total cellular RNA was electrophoresed in each lane. The upper part of the membrane containing the hepatitis C virus replicon RNA was hybridized with a digoxigenin-labeled probe specific for the replicon sequence, and the lower part was hybridized with beta-actin probe. Densitometry for replicon RNA was performed and indicated as percents of drug-negative control. (c) Western blotting. Thirty micrograms of total cellular protein was electrophoresed in each lane. Densitometry of NS5A protein was performed and indicated as percents of drug-negative control.

increase of HCV core antigen in the medium. In all time points, core antigen levels were significantly lower in culture that were treated with isoliquiritigenin and glycycoumarin than the untreated culture. The effect of glycycoumarin was partly reversed on day six probably due to chemical instability of the compound. Consistently, the Western blot showed that the cellular HCV core protein expression was substantially suppressed by treatment with isoliquiritigenin and glycycoumarin (Fig. 7b).

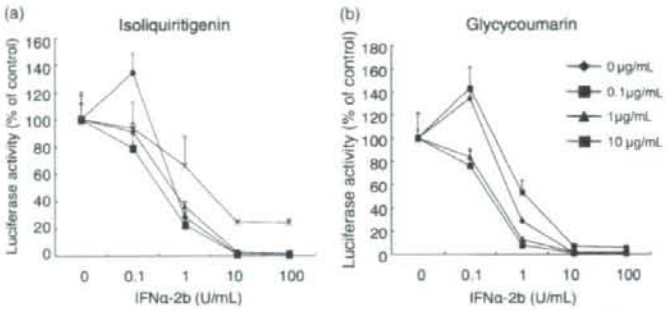

Figure 5 Effects of (a) isoliquiritigenin and (b) glycycoumarin used in combination with interferon(IFN)-α on HCV replication. Huh7/Rep-Feo cells were cultured with combinations of IFN-α-2b and isoliquiritigenin or glycycoumarin at concentrations indicated. The internal luciferase activities were measured after 48 h of culture. Assays were performed in triplicate. Error bars indicate mean ± SD. Plots of 100% in each curves represent replicon expression levels that were treated with indicated amounts of isoliquiritigenin or glycycoumarin and without IFN.

DISCUSSION

THE PRESENT STUDY demonstrates that two purified herbal extracts, isoliquiritigenin and glycycoumarin, isolated from *Glycyrrhizae radix*, suppress replication of an HCV replicon (Fig. 2). Northern and Western blot analyses reveal that both RNA synthesis and its translation were reduced by the two compounds in dose- and time-dependent manners (Figs 3,4). The two drugs did not show activation of type-I interferon-dependent, ISRE-mediated transcription or synergistic action with interferon-alpha on HCV replication (Fig. 5,6), which suggests that the anti-HCV effects of the compounds are independent of interferon-antiviral mechanisms. Finally, we have demonstrated that the two compounds show inhibitory effects on HCV virus cell cultures (Fig. 7).

Flavonoid is a class of plant pigment, found in wide range of green vegetables and fruits. They are classified into flavon, flavonol, flavanone, flavanol, isoflavone, chalcone, anthocyanin and catechin, according to their molecular structures. Many flavonoids have various biological functions such as antibacterial,[28] antioxidative and anticarcinogeninc activities.[29] Isoliquiritigenin is a simple chalcon derivative and found in licorice and vegetables including shallots and bean sprouts. Isoliquiritigenin has several biochemical activities similar to other flavonoids. It has various biochemical activities such as antioxidative and superoxide scavenging activities,[30] an antiplatelet aggregation effect,[31] an inhibitory effect on aldose reductase activity,[32] estrogenic properties[33] and selective inhibition of H2 receptor-mediated signaling.[34]

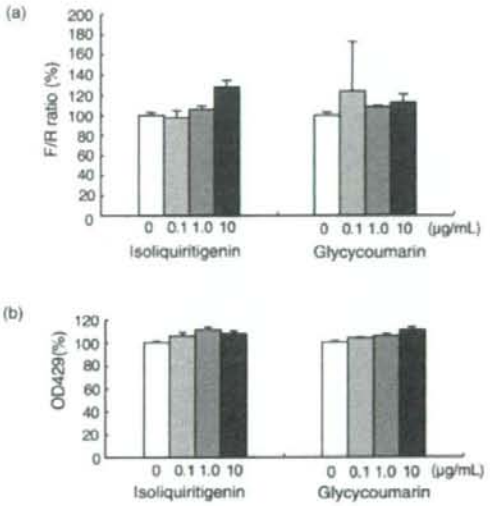

Figure 6 Isoliquiritigenin and glycycoumarin do not influence the HCV IRES-mediated translation. A bicistronic reporter gene plasmid, pCIneo-Rluc-IRES-Fluc, was stably trasfected into Huh7 cells (Huh7/CRIF, *see* the Methods). (a) Dual luciferase assay. The cells were cultured with isoliquiritigenin or glycycoumarin at the concentrations indicated, and dual luciferase activities were measured after 48 h of treatment. Values are displayed as ratios of Fluc to Rluc. Error bars indicated mean ± SD. (b) MTS assay of Huh7/neo-Rluc-IRES-Fluc cells cultured with isoliquiritigenin or glycycoumarin at the concentrations indicated. MTS assays at 48 h after treatment with each drug were performed in triplicate. Error bars indicate mean + SD.

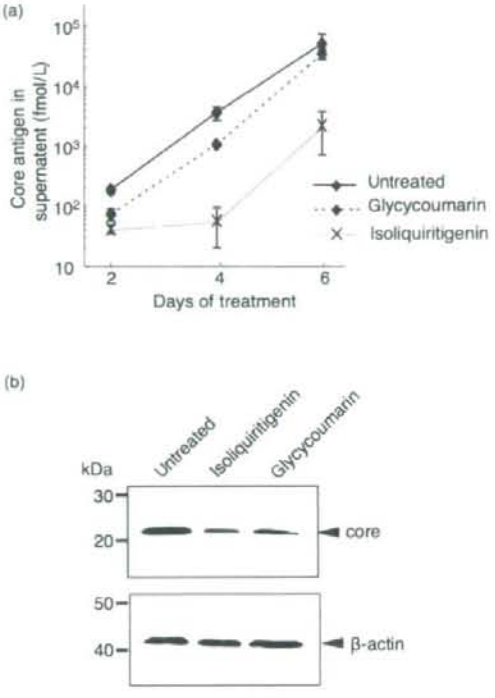

Figure 7 Suppresion of HCV-JFH1 virus expression by *isoliquiritigenin and glycycoumarin*. (a) Naïve Huh 7.5.1 cells were infected with culture supernatant of HCV-JFH1-infected cells and were subjected to culture in the presence of indicated drugs. Culture supernatants were collected at indicated days, and HCV core antigen was measured. Assays were done in triplicate and indicated as mean ± SD. (b) Cells were harvested at day 6, and Western blotting was performed using anti-core and anti-beta-actin antibodies.

Extracts of a licorice root, *Glycyrrhizae radix*, show anti-inflammatory properties in chronic and acute liver inflammation,[35] and are widely and extensively prescribed in Japan as Strong Neominophagen C (SNMC). A major ingredients of *Glyzyrrizae radix* are glycyrrhizin and liquiritin. However, glycyrrhizin and liquiritin did not suppress HCV replication, suggesting that the commercially available SNMC will not elicit antiviral effects against HCV. On the other hand, there have been reports on the pharmacological action of glycycoumarin. Glycycoumarin displays antibacterial properties in the upper respiratory tract in infections such as *Streptococcus pyogenes*, *Haemophilus infuenzae* and *Moraxella catarrhalis*,[36] and methicillin-resistant *Staphylococcus aureus*,[37] but the mechanisms of action is unclear.

To our knowledge, there have been no reports on the serum concentration of glycycoumarin and isoliquiritigenin in patients taking medicines or dietary supplements containing *Glyzyrrizae radix*. However, therapeutic doses of 3–12 g per day of powdered root have been suggested for pathological conditions including chronic hepatitis, muscle cramp, acute gastritis, and urolithiasis. Thus, further studies are required to assess the human exposure to these flavonoids, the pharmacological dose-dependent properties and the tissue distribution and drug kinetics.

Considering the current status of limited therapy options for HCV infection and their unsatisfactory outcomes, large scale screening of anti-HCV molecules for the development of novel antiviral therapies is called for. In the present study, we have screened Chinese herbal extracts for the ability to suppress HCV replication, and identified two extracts, isoliquiritigenin and glycycoumarin, which specifically suppressed HCV replication. These results suggest that these agents will be a promising for use in the stabilization of HCV replication and active liver inflammation. In addition, further investigations of the action of these drugs on the expression, processing or maturation of HCV proteins may elucidate new aspects of the viral infection and replication and may constitute novel molecular targets for anti-HCV chemotherapeutics.

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REFERENCES

1 Alter MJ. Epidemiology of hepatitis C. *Hepatology* 1997; **26**: 62S–65S.
2 Tong MJ, el-Farra NS, Reikes AR, Co RL. Clinical outcomes after transfusion-associated hepatitis C. *N Engl J Med* 1995; **332**: 1463–6.
3 Fried MW, Shiffman ML, Reddy KR *et al*. Peginterferon alfa-2a plus ribavirin for chronic hepatitis C virus infection. *N Engl J Med* 2002; **347**: 975–82.

4 Hadziyannis SJ, Sette H Jr, Morgan TR *et al.* Peginterferon-alpha2a and ribavirin combination therapy in chronic hepatitis C: a randomized study of treatment duration and ribavirin dose. *Ann Intern Med* 2004; **140**: 346–55.
5 Hayashi N, Takehara T. Antiviral therapy for chronic hepatitis C: past, present, and future. *J Gastroenterol* 2006; **41**: 17–27.
6 Tanabe Y, Sakamoto N, Enomoto N *et al.* Synergistic inhibition of intracellular hepatitis C virus replication by combination of ribavirin and interferon-alpha. *J Infect Dis* 2004; **189**: 1129–39.
7 Watashi K, Hijikata M, Hosaka M, Yamaji M, Shimotohno K. Cyclosporin A suppresses replication of hepatitis C virus genome in cultured hepatocytes. *Hepatology* 2003; **38**: 1282–8.
8 Nakagawa M, Sakamoto N, Enomoto N *et al.* Specific inhibition of hepatitis C virus replication by cyclosporin A. *Biochem Biophys Res Commun* 2004; **313**: 42–7.
9 Nakagawa M, Sakamoto N, Tanabe Y *et al.* Suppression of hepatitis C virus replication by cyclosporin a is mediated by blockade of cyclophilins. *Gastroenterology* 2005; **129**: 1031–41.
10 Yokota T, Sakamoto N, Enomoto N *et al.* Inhibition of intracellular hepatitis C virus replication by synthetic and vector-derived small interfering RNAs. *EMBO Rep* 2003; **4**: 602–8.
11 Kapadia SB, Brideau-Andersen A, Chisari FV. Interference of hepatitis C virus RNA replication by short interfering RNAs. *Proc Natl Acad Sci USA* 2003; **100**: 2014–18.
12 Frese M, Schwarzle V, Barth K *et al.* Interferon-gamma inhibits replication of subgenomic and genomic hepatitis C virus RNAs. *Hepatology* 2002; **35**: 694–703.
13 Ikeda M, Abe K, Yamada M, Dansako H, Naka K, Kato N. Different anti-HCV profiles of statins and their potential for combination therapy with interferon. *Hepatology* 2006; **44**: 117–25.
14 Kim SS, Peng LF, Lin W *et al.* A cell-based, high-throughput screen for small molecule regulators of hepatitis C virus replication. *Gastroenterology* 2007; **132**: 311–20.
15 Kanda T, Yokosuka O, Imazeki F *et al.* Inhibition of subgenomic hepatitis C virus RNA in Huh-7 cells: ribavirin induces mutagenesis in HCV RNA. *J Viral Hepat* 2004; **11**: 479–87.
16 Yamashiki M, Nishimura A, Suzuki H, Sakaguchi S, Kosaka Y. Effects of the Japanese herbal medicine "Sho-saiko-to" (TJ-9) on in vitro interleukin-10 production by peripheral blood mononuclear cells of patients with chronic hepatitis C. *Hepatology* 1997; **25**: 1390–7.
17 Oka H, Yamamoto S, Kuroki T *et al.* Prospective study of chemoprevention of hepatocellular carcinoma with Sho-saiko-to (TJ-9). *Cancer* 1995; **76**: 743–9.
18 Arase Y, Ikeda K, Murashima N *et al.* The long term efficacy of glycyrrhizin in chronic hepatitis C patients. *Cancer* 1997; **79**: 1494–500.
19 van Rossum TG, Vulto AG, Hop WC, Schalm SW. Glycyrrhizin-induced reduction of ALT in European patients with chronic hepatitis C. *Am J Gastroenterol* 2001; **96**: 2432–7.
20 Guo JT, Bichko VV, Seeger C. Effect of alpha interferon on the hepatitis C virus replicon. *J Virol* 2001; **75**: 8516–23.
21 Tanabe Y, Sakamoto N, Enomoto N *et al.* Synergistic inhibition of intracellular hepatitis C virus replication by combination of ribavirin and interferon- alpha. *J Infect Dis* 2004; **189**: 1129–39.
22 Itsui Y, Sakamoto N, Kurosaki M *et al.* Expressional screening of interferon-stimulated genes for antiviral activity against hepatitis C virus replication. *J Viral Hepat* 2006; **13**: 690–700.
23 Sakamoto N, Sato C, Haritani H *et al.* Detection of hepatitis C viral RNA in sporadic acute non-A, non-B hepatitis by polymerase chain reaction. Its usefulness for the early diagnosis of seronegative infection. *J Hepatol* 1993; **17**: 28–33.
24 Yamashiro T, Sakamoto N, Kurosaki M *et al.* Negative regulation of intracellular hepatitis C virus replication by interferon regulatory factor 3. *J Gastroenterol* 2006; **41**: 750–7.
25 Wakita T, Pietschmann T, Kato T *et al.* Production of infectious hepatitis C virus in tissue culture from a cloned viral genome. *Nat Med* 2005; **11**: 791–6.
26 Zhong J, Gastaminza P, Cheng G *et al.* Robust hepatitis C virus infection in vitro. *Proc Natl Acad Sci USA* 2005; **102**: 9294–9.
27 Sekine-Osajima Y, Sakamoto N, Nakagawa M *et al.* Development of plaque assays for hepatitis C virus and isolation of mutants with enhanced cytopathogenicity and replication capacity. *Virology* 2008; **371**: 71–85.
28 Arima H, Ashida H, Danno G. Rutin-enhanced antibacterial activities of flavonoids against Bacillus cereus and Salmonella enteritidis. *Biosci Biotechnol Biochem* 2002; **66**: 1009–14.
29 Musonda CA, Chipman JK. Quercetin inhibits hydrogen peroxide (H2O2)-induced NF-kappaB DNA binding activity and DNA damage in HepG2 cells. *Carcinogenesis* 1998; **19**: 1583–9.
30 Haraguchi H, Ishikawa H, Mizutani K, Tamura Y, Kinoshita T. Antioxidative and superoxide scavenging activities of retrochalcones in Glycyrrhiza inflata. *Bioorg Med Chem* 1998; **6**: 339–47.
31 Tawata M, Aida K, Noguchi T *et al.* Anti-platelet action of isoliquiritigenin, an aldose reductase inhibitor in licorice. *Eur J Pharmacol* 1992; **212**: 87–92.
32 Aida K, Tawata M, Shindo H *et al.* Isoliquiritigenin: a new aldose reductase inhibitor from glycyrrhizae radix. *Planta Med* 1990; **56**: 254–8.
33 Tamir S, Eizenberg M, Somjen D, Izrael S, Vaya J. Estrogen-like activity of glabrene and other constituents isolated from licorice root. *J Steroid Biochem Mol Biol* 2001; **78**: 291–8.

34 Kim DC, Choi SY, Kim SH *et al.* Isoliquiritigenin selectively inhibits H(2) histamine receptor signaling. *Mol Pharmacol* 2006; **70**: 493–500.
35 Finney RS, Somers GF. The antiinflammatory activity of glycyrrhetinic acid and derivatives. *J Pharm Pharmacol* 1958; **10**: 613–20.
36 Tanaka Y, Kikuzaki H, Fukuda S, Nakatani N. Antibacterial compounds of licorice against upper airway respiratory tract pathogens. *J Nutr Sci Vitaminol (Tokyo)* 2001; **47**: 270–3.
37 Hatano T, Shintani Y, Aga Y, Shiota S, Tsuchiya T, Yoshida T. Phenolic constituents of licorice. VIII. Structures of glicophenone and glicoisoflavanone, and effects of licorice phenolics on methicillin-resistant Staphylococcus aureus. *Chem Pharm Bull (Tokyo)* 2000; **48**: 1286–92.

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HEPATOLOGY

Inhibition of hepatitis C virus infection and expression *in vitro* and *in vivo* by recombinant adenovirus expressing short hairpin RNA

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adenovirus vector, hepatitis C virus, RNA interference.

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Abstract

Background and Aim: We have reported previously that synthetic small interfering RNA (siRNA) and DNA-based siRNA expression vectors efficiently and specifically suppress hepatitis C virus (HCV) replication *in vitro*. In this study, we investigated the effects of the siRNA targeting HCV-RNA *in vivo*.

Methods: We constructed recombinant retrovirus and adenovirus expressing short hairpin RNA (shRNA), and transfected into replicon-expressing cells *in vitro* and transgenic mice *in vivo*.

Results: Retroviral transduction of Huh7 cells to express shRNA and subsequent transfection of an HCV replicon into the cells showed that the cells had acquired resistance to HCV replication. Infection of cells expressing the HCV replicon with an adenovirus expressing shRNA resulted in efficient vector delivery and expression of shRNA, leading to suppression of the replicon in the cells by $\sim 10^{-3}$. Intravenous delivery of the adenovirus expressing shRNA into transgenic mice that can be induced to express HCV structural proteins by the Cre/*lox*P switching system resulted in specific suppression of virus protein synthesis in the liver.

Conclusion: Taken together, our results support the feasibility of utilizing gene targeting therapy based on siRNA and/or shRNA expression to counteract HCV replication, which might prove valuable in the treatment of hepatitis C.

Introduction

Hepatitis C virus (HCV), which affects 170 million people worldwide, is one of the most important pathogens causing liver-related morbidity and mortality.[1] The difficulty in eradicating HCV is attributable to limited treatment options against the virus and their unsatisfactory efficacies. Even with the most effective regimen with pegylated interferon (IFN) and ribavirin in combination, the efficacies are limited to less than half of the patients treated.[2] Given this situation, the development of safe and effective anti-HCV therapies is one of our high-priority goals.

RNA interference (RNAi) is a process of sequence-specific, post-transcriptional gene silencing that is initiated by double-stranded RNA.[3,4] Because of its potency and specificity, RNAi rapidly has become a powerful tool for basic research to analyze gene functions and for potential therapeutic applications. Recently, successful suppression of various human pathogens by RNAi have been reported, including human immunodeficiency viruses,[5,6] poliovirus,[7] influenza virus,[8] severe acute respiratory syndrome (SARS) virus[9] and hepatitis B virus (HBV).[10–13]

We and other researchers have reported that appropriately designed small interfering RNA (siRNA) targeting HCV genomic RNA can efficiently and specifically suppress HCV replication *in vitro*.[14–19] We have tested siRNA designed to target the well-conserved 5′-untranslated region (5′-UTR) of HCV-RNA, and identified the most effective target, just upstream of the translation initiation codon. Furthermore, transfection of DNA-based vectors expressing siRNA was as effective as that of synthetic siRNA in suppressing HCV replication.[14]

In this study, we explored the further possibility that efficient delivery and expression of siRNA may be effective in suppression and elimination of HCV replication and that delivery of such