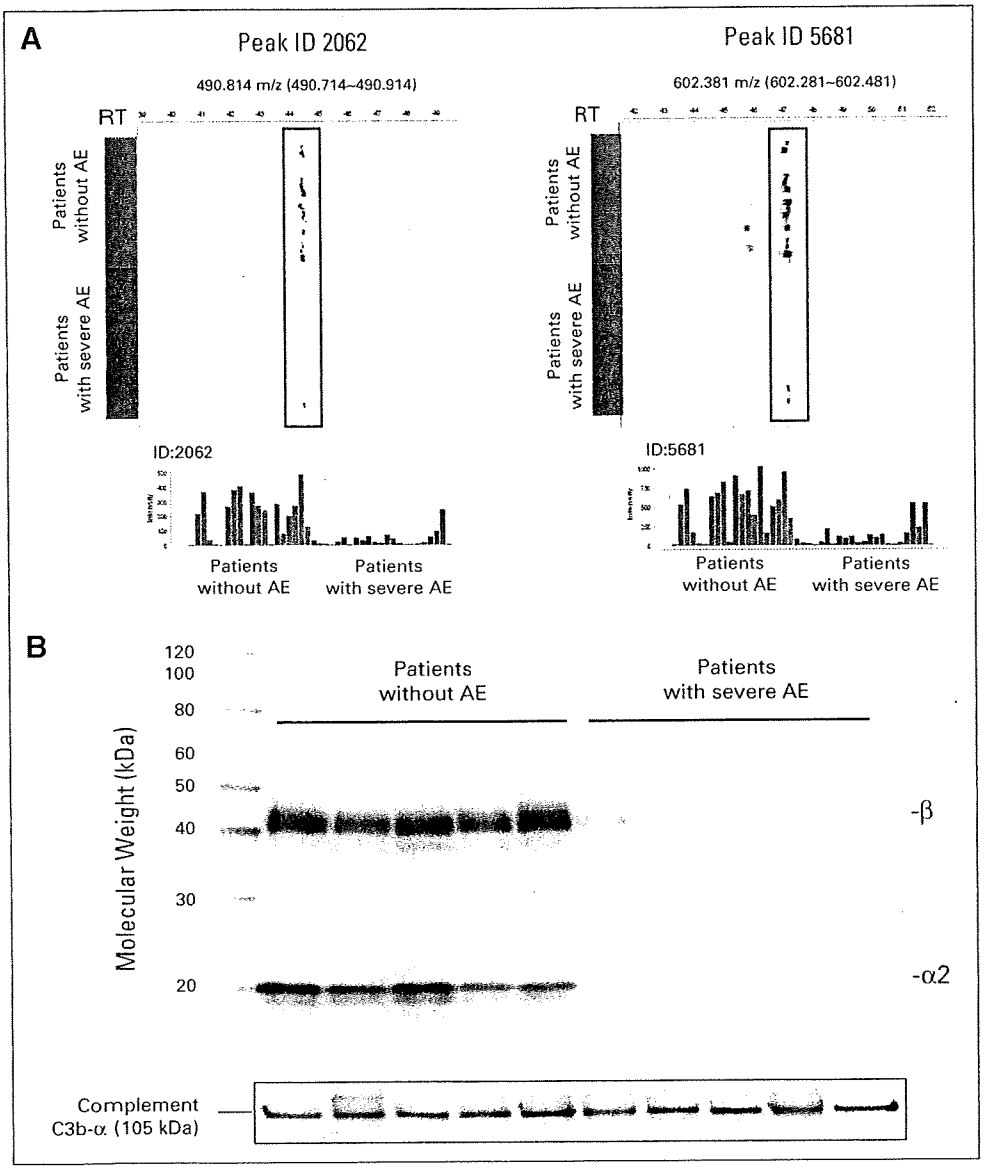

Fig 2. (A) Representative haptoglobin-derived mass spectrometry (MS) peaks in 47 triplicate liquid chromatography (LC)/MS runs (22 without adverse events [AEs], blue; and 25 with severe AEs, red) aligned along the retention time (RT) of LC (top). Columns represent the mean intensity of triplicates (bottom). (B) Detection of β- and α2-chains of haptoglobin and complement C3b-α (loading control) by immunoblotting.

from all of the clinical and laboratory data listed in Appendix Table A1 (available for 162 patients) and found that a combination of plasma haptoglobin level, haptoglobin phenotype, absolute neutrophil count (ANC), platelet count, and body-surface area (BSA) provided the lowest AIC value. The prediction model using this combination of parameters was significantly compromised when haptoglobin level and phenotype were excluded ($\chi^2 = 11.49, df = 3, P = .009$, likelihood ratio test). We estimated the independent contribution of each parameter to this prediction model and found that the baseline haptoglobin level was the second most important contributor to the model (Table 2).

On the basis of the results of multivariate logistic regression analysis, we constructed a nomogram in which the values of the five parameters (haptoglobin level, haptoglobin phenotype, ANC, platelet count, and BSA) are integrated into a single score (total point) to estimate the relative risk of having hematologic toxicities more severe than category II, category III, or category IV (Fig 4A). The area under the curve value for the prediction of categories III to IV was calculated to be 0.782 (95% CI, 0.711 to 0.843) in cohort M0 (Fig 4B). Predictive ability was confirmed in two independent validation cohorts, V1 and V2, that were not used for construction of the nomogram, with area under the curve values of 0.655 (95% CI, 0.546 to 0.754) and 0.747 (95% CI, 0.606 to 0.858), respectively (Fig 4B).

DISCUSSION

The early onset of severe AE necessitates dose reduction or postponement of treatment, leading to failure of chemotherapy.[30,31] In particular, the current gemcitabine monotherapy against advanced pancreatic cancer is mainly aimed at disease palliation, and thus, avoidance of life-threatening AEs is necessary. In this study, we first compared the plasma proteome of two groups of patients who showed distinct responses to the same protocol of gemcitabine therapy (Fig 1).

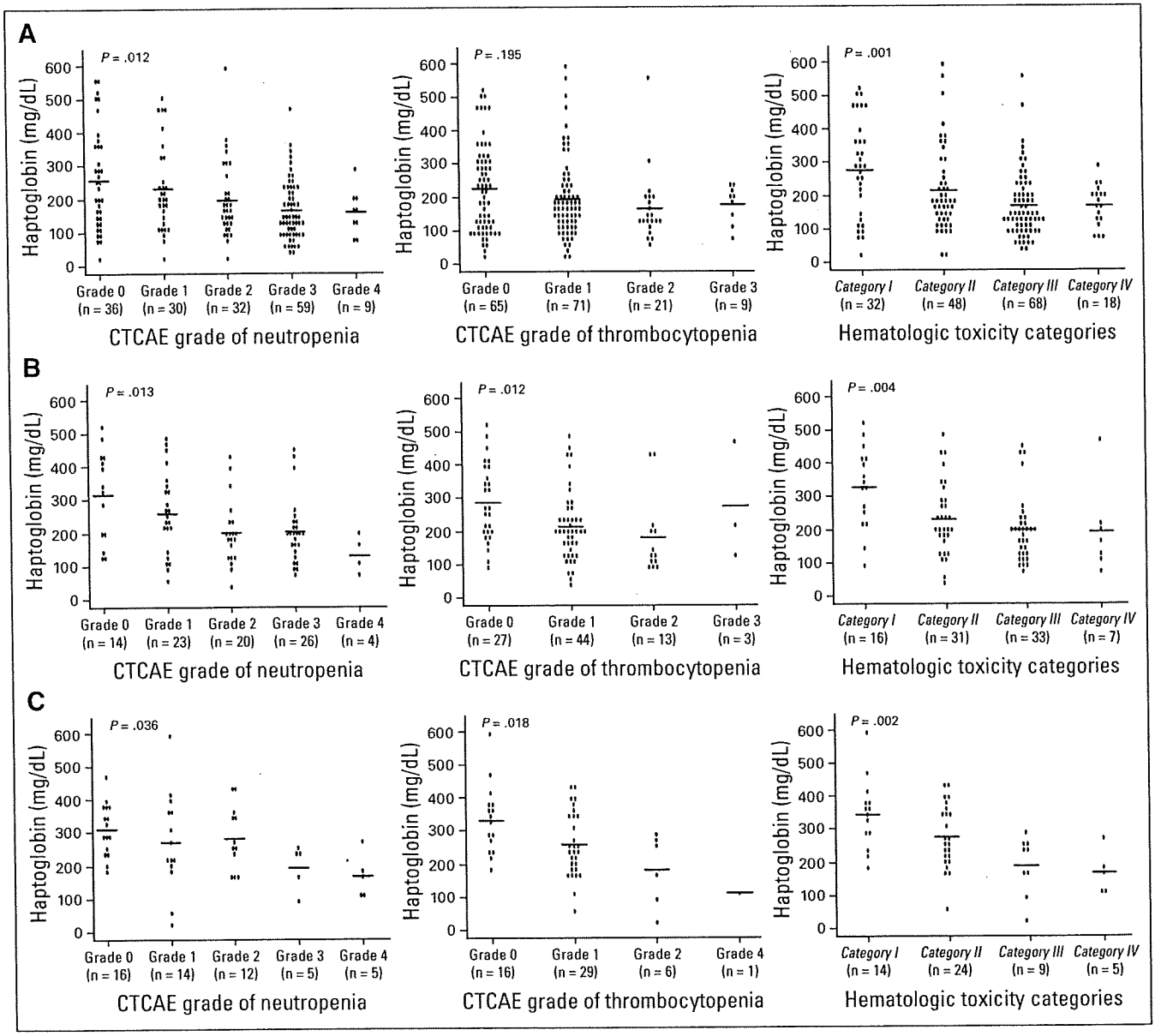

Fig 3. Plasma/serum haptoglobin levels according to the Common Terminology Criteria of Adverse Events (CTCAE; version 3.0). Grades of neutropenia (left), thrombocytopenia (middle), and hematologic toxicity categories (right) in the (A) modeling (M0), (B) validation-1 (V1), and (C) validation-2 (V2) cohorts. Horizontal lines represent the average levels of haptoglobin.

There was no significant difference in age distribution, Eastern Cooperative Oncology Group performance status, liver function, renal function, or prior chemoradiotherapy between the groups (Table 1 and data not shown), indicating that the occurrence of AEs does not merely reflect the general poor condition of patients but is based on certain biologic differences among individuals. We found that individuals who experienced severe AEs after administration of gemcitabine showed decreased baseline levels of plasma haptoglobin (Figs 1B and 2A), and this result was validated in three large cohorts using a different methodology (Fig 3 and Appendix Tables A1 to A3). Haptoglobin is an abundant plasma protein that usually cannot be measured by direct MS. However, constant depletion using an IgY-12 High Capacity Spin Column[32] allowed us to accentuate the differences in haptoglobin levels.

The molecular mechanisms that regulate the plasma haptoglobin level under physiologic and pathologic conditions are largely unknown. Haptoglobin is produced mainly in the liver, taken up by neutrophils, and stored within their cytoplasmic granules. Haptoglobin is released in response to a variety of stimuli, such as infection, trauma, and malignancy,[33] and modulates inflammatory responses. Tumor necrosis factor α induces the release of haptoglobin from neutrophils in vitro.[34] Interestingly, tumor necrosis factor α and its soluble receptors have been reported to be associated with an increased risk of hematologic toxicities.[12,35,36]

Table 2. Contribution of Parameters to Prediction of Hematologic Toxicities Associated With Gemcitabine

Factor	Odds Ratio*	95% CI	*P*
Haptoglobin level	0.71	0.53 to 0.97	.031†
Phenotype of haptoglobin (*v* Hp 2-2)			
Hp 2-1	0.61	0.31 to 1.21	.159
Hp 1-1	2.16	0.70 to 6.69	.180
Absolute neutrophil count	0.72	0.61 to 0.86	.0003†
Platelet count	0.63	0.39 to 1.01	.056
Body-surface area	3.86	0.63 to 23.76	.145

NOTE. A forward stepwise selection based on Akaike's Information Criterion was used to select parameters for multivariate analysis.
*Odds ratios are per 100 mg/dL increase for haptoglobin level, per 1,000/μL increase for absolute neutrophil count, per 10×10^{4}/μL increase for platelet, and per 1.00 m^2 increase for body-surface area.
†$P < .05$.

To derive clinical applicability from these basic findings, we constructed a model (nomogram) that estimates the possibility of occurrence of hematologic AE before administration of gemcitabine (Fig 4A and Appendix Fig A4). The significance of the model was further confirmed in two independent validation cohorts (Fig 4B). Although its accuracy was far from perfect, the model seems to be practically sufficient for identifying individuals who are likely to suffer from hematologic toxicities after administration of gemcitabine. Various cytotoxic or molecular targeting agents have been tested in combination with gemcitabine in phase III trials, but no apparent additional therapeutic benefit has been demonstrated.[5,6,9,10] The application of this model to patient selection may improve the outcome of such trials. We are now trying to identify new biomarkers that can predict the efficacy of gemcitabine treatment using a similar strategy.

The phenotypes of haptoglobin have been reported to be associated with different hemoglobin-binding, antioxidative, and prostaglandin synthesis–initiating activities.[33] Although haptoglobin phenotype was not significantly associated with hematologic toxicities (Table 1 and Appendix Tables A1 to A3), the average levels of haptoglobin differed among individuals with different phenotypes (Appendix Fig A3), as described previously.[33] For this reason, haptoglobin phenotype was selected in the prediction model by AIC analysis (Table 2). BSA has been repeatedly selected as one of the multivariate parameters for predicting the AEs of anticancer therapies in other studies,[14,37] suggesting a potential lack of accuracy in calculating individually optimized drug dose based solely on BSA, as pointed out previously.[38,39]

In conclusion, we have revealed that a decreased level of haptoglobin is the second most significant factor predicting hematologic toxicities associated with gemcitabine monotherapy after ANC (Table 2). Measurement of haptoglobin is now established as a laboratory test and could be readily incorporated into routine oncologic practice. However, the predictive significance of haptoglobin was revealed only in a retrospective population from a single institution and must, therefore, be validated in an independent prospective multi-institutional study. It was not determined in this study whether haptoglobin could be a predictive biomarker for the AEs of other chemotherapeutic agents. To improve the accuracy of prediction, the discovery of new biomarkers with higher specificity and sensitivity will be necessary. While bearing all these limitations in mind, the present findings may provide novel insights not only into the molecular mechanisms by which gemcitabine causes hematologic toxicities, but also into new avenues for the development of new chemotherapeutic agents with lower toxicity.

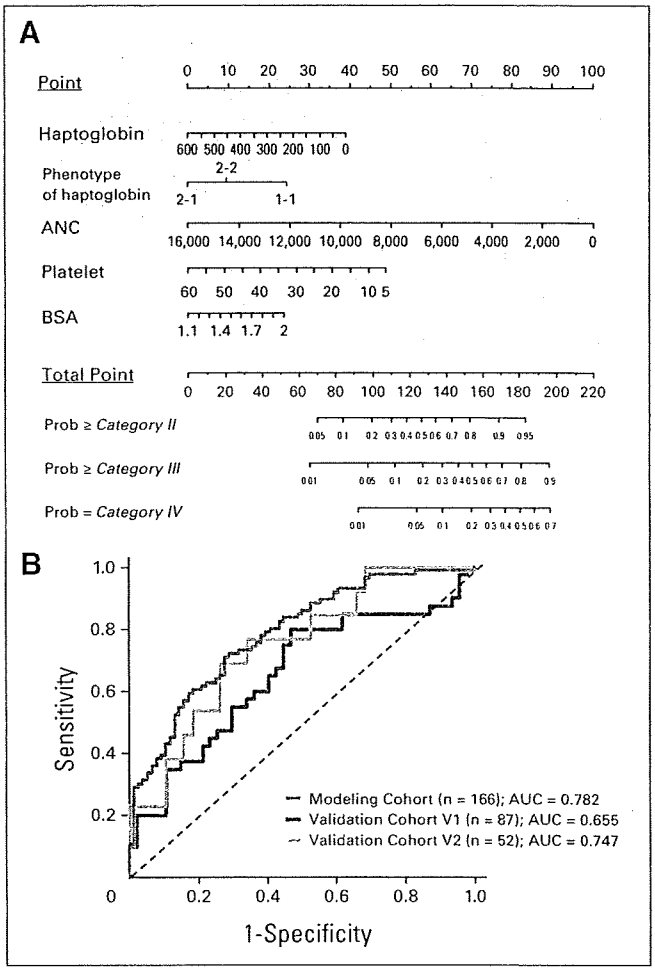

Fig 4. (A) Nomogram to estimate the risk of hematologic toxicities more severe than category II (top), category III (middle), and category IV (bottom). Please see Appendix Figure A4 and its legend for usage. (B) Receiver operating characteristic (ROC) analysis of nomogram for the prediction of category III and IV hematologic toxicities in the modeling (gray), validation-1 (V1; blue), and validation-2 (V2; gold) cohorts. ANC, absolute neutrophil count; BSA, body-surface area; AUC, area under the curve.

AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

Although all authors completed the disclosure declaration, the following author(s) indicated a financial or other interest that is relevant to the subject matter under consideration in this article. Certain relationships marked with a "U" are those for which no compensation was received; those relationships marked with a "C" were compensated. For a detailed description of the disclosure categories, or for more information about ASCO's conflict of interest policy, please refer to the Author Disclosure Declaration and the Disclosures of Potential Conflicts of Interest section in Information for Contributors.

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DOES PROLONGED BILIARY OBSTRUCTIVE JAUNDICE SENSITIZE THE LIVER TO ENDOTOXEMIA?

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ABSTRACT—Biliary obstructive jaundice (OJ) is an important clinical consideration concerning high bacteremic risk. Hepatocyte apoptosis is one of the causes of cholestatic liver injury. The aim of the current study was to examine the precise pathway and time course of hepatocyte apoptosis during OJ with LPS administration and to determine if OJ sensitizes the liver to endotoxemia. Male C57BL/6 mice were subjected to bile duct ligation and division and were administered with LPS at 3 (OJ3) or 14 (OJ14) days after surgery. Fas ligand expression, poly (adenosine diphosphate–ribose) polymerase p85 fragment immunohistochemistry, activation of caspases 3, 8, and 9, serum alanine aminotransferase levels, and hepatic adenosine triphosphate (ATP) contents were examined. Survival after LPS administration in male C57BL/6 or gld/gld (Fas ligand–deficient) mice was determined. The expression of Fas ligand increased during OJ. After LPS administration, the expression of cleaved caspases 3 and 8 increased in Sham3, Sham14, OJ3, and OJ14 mice, and it significantly increased in OJ14 compared with other mice. Poly (adenosine diphosphate–ribose) polymerase p85 immunohistochemistry showed significant hepatocyte apoptosis after LPS administration in OJ14 mice relative to OJ3. In OJ14 with LPS administration, ATP contents significantly decreased and alanine aminotransferase levels increased. Hepatocyte apoptosis was decreased in gld/gld OJ14 mice compared with C57BL/6 OJ14. All C57BL/6 OJ14 mice with LPS died, but survival in gld/gld OJ14 significantly ameliorated. In prolonged OJ with LPS administration, hepatocyte apoptosis depending on Fas ligand expression significantly increased in association with a decrease in ATP contents, thus resulting in liver necrapoptosis.

KEYWORDS—Apoptosis, liver failure, transcription factor, death signal, Fas ligand

ABBREVIATIONS—ALT–alanine aminotransferase; ELISA–enzyme-linked immunosorbent assay; OJ–obstructive jaundice; PARP–poly (adenosine diphosphate–ribose) polymerase; T-BIL–total bilirubin

INTRODUCTION

Biliary obstructive jaundice (OJ) due to malignancy of the biliary tract or biliary inflammation is associated with liver dysfunction and susceptibility to infection (1–3). Biliary infection concomitant with biliary obstruction, which raises the intraductal pressure in the bile duct, may cause cholangitis due to either cholangiovenous or cholangiolymphatic reflux (4). In addition, the presence of OJ has been reported to increase the postoperative bacteremic risk, and performance of extended hepatectomy increased the risk, suggesting that when patients having biliary carcinoma with OJ undergo extended hepatectomy, risk of infectious complication significantly increased (5). Belghiti et al. (6) also analyzed operative risks and showed that the mortality of patients with OJ was extremely high (21%) as compared with that of patients with a normal liver function. Therefore, in clinical settings, association between OJ, infection, and liver dysfunction needs to be clarified.

In OJ, bile acids accumulate to cause hepatocyte apoptosis, which has been shown to be involved in Fas (7, 8). Fas ligand (FasL) and TNF-α–associated death domains promote binding of procaspase 8 and subsequent proteolytic activation of catalytic caspase 8, which is known as the type 1 signaling pathway. Caspase 8 is able to directly activate caspase 3, which is an executioner caspase, leading to apoptosis (9). Conversely, the type 2 signaling pathway is the onset of the mitochondrial permeability transition, leading to cytochrome *c* release (10). The cytochrome *c* complex proteolytically activates caspase 9, and subsequently activates caspase 3 (11). Although the occurrence of hepatocyte apoptosis has been shown in OJ, the time course of activation of caspases and the precise mechanism leading to hepatocyte apoptosis during OJ and OJ with LPS administration have not yet been thoroughly elucidated. Furthermore, in models of liver injury, hepatocytes often show the morphological features of apoptosis and necrosis, for which the term "necrapoptosis" has been coined (12). There seems to be several cellular determinants that shift the balance from one pathway to the other. Apoptosis requires adenosine triphosphate (ATP), and a switch from apoptosis to necrosis occurs when cells are devoid of ATP (12). The aim of the current study was to determine whether hepatocyte apoptosis with subsequent liver injury during OJ is augmented after LPS administration and to determine the precise pathway leading to apoptosis/necrapoptosis. The present study investigated the expression of caspase 3, 8, and 9, immunohistochemistry of poly (adenosine diphosphate–ribose) polymerase (PARP) p85 fragment, hepatic ATP contents, histology, liver injury, and survival in the short and prolonged periods of OJ with LPS administration.

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MATERIALS AND METHODS

Male C57BL/6 or gld/gld (FasL-deficient) mice (Japan SLC, Inc. Hamamatsu, Japan) weighing 22 to 27 g were housed in a controlled environment, exposed to a 12-h light/dark cycle, and provided with commercial chow and water *ad libitum*. This project was approved by Chiba University Animal Care and Use committee and was in compliance with the National Institutes of Health guidelines.

Bile duct ligation and LPS administration model

The cholestatic mouse model was used; male C57BL/6 or gld/gld mice were anesthetized with sodium pentobarbital (60 mg/kg, administered i.p.), and the common bile duct was isolated after laparotomy. The common bile duct was ligated at three sites and divided between the proximal double and the distal single ligation. Sham-operated mice underwent the same procedure without bile duct ligation and division. At 3 or 14 days after sham surgery or bile duct ligation and division, jaundiced or sham-operated mice were anesthetized with sodium pentobarbital and LPS (4 mg/kg; *Escherichia coli*; Sigma Aldrich, St. Louis, Mo) in 0.1 mL sterile saline, or sterile saline (0.1 mL) was injected via the lateral tail vein. Mice were killed at 3 h after LPS or sterile saline administration, and liver tissue and blood samples were taken for analysis. Survival was also examined after LPS administration.

Analysis of apoptosis and histological examination

Liver tissue specimens were obtained, and sections of formalin-fixed, paraffin-embedded liver samples were stained with hematoxylin-eosin to assess the degree of liver injury. To evaluate hepatocyte apoptosis, immunohistochemistry was performed for PARP p85 fragment, which is cleaved by caspase 3 from PARP (116 kd; Promega, Madison, Wis; original magnification, 200×). To calculate the apoptotic index of PARP p85 fragment, the number of stained and unstained hepatocytes was counted in five random fields (400×). Comparative staining with Meyer hematoxylin was also performed.

Western blot analysis

Liver tissue specimens were obtained and immediately frozen in liquid nitrogen. Frozen liver specimens were homogenized in lysis buffer (10 mM HEPES [pH 7.9], 150 mM NaCl, 1 mM ethylenediaminetetraacetic acid, 0.6% NP-40, 0.5 mM phenylmethylsulfonyl fluoride, 1 μg/mL leupeptin, 1 μg/mL aprotinin, 10 μg/mL soybean trypsin inhibitor, and 1 μg/mL pepstatin) on ice. The homogenates were sonicated and centrifuged at 5,000 rpm to remove cellular debris. The total protein concentration of each sample was measured by a bicinchoninic assay kit using bovine serum albumin as a reference standard (Pierce Chemical Co. Rockford, Ill). Liver lysates were subjected to

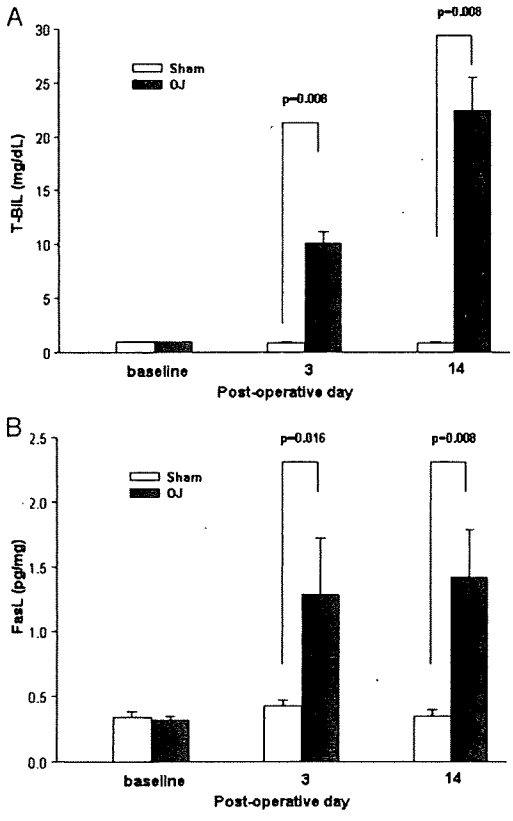

FIG. 1. **A, Serum T-BIL levels were analyzed.** B, The protein expression of FasL was analyzed by tissue ELISA. Samples were obtained from the normal, Sham3, Sham14, OJ3, and OJ14 mice. Data are mean ± SEM. No significant difference was observed in the T-BIL levels or the FasL expression among the normal (baseline), Sham3, and Sham14 mice. For all groups, n = 5.

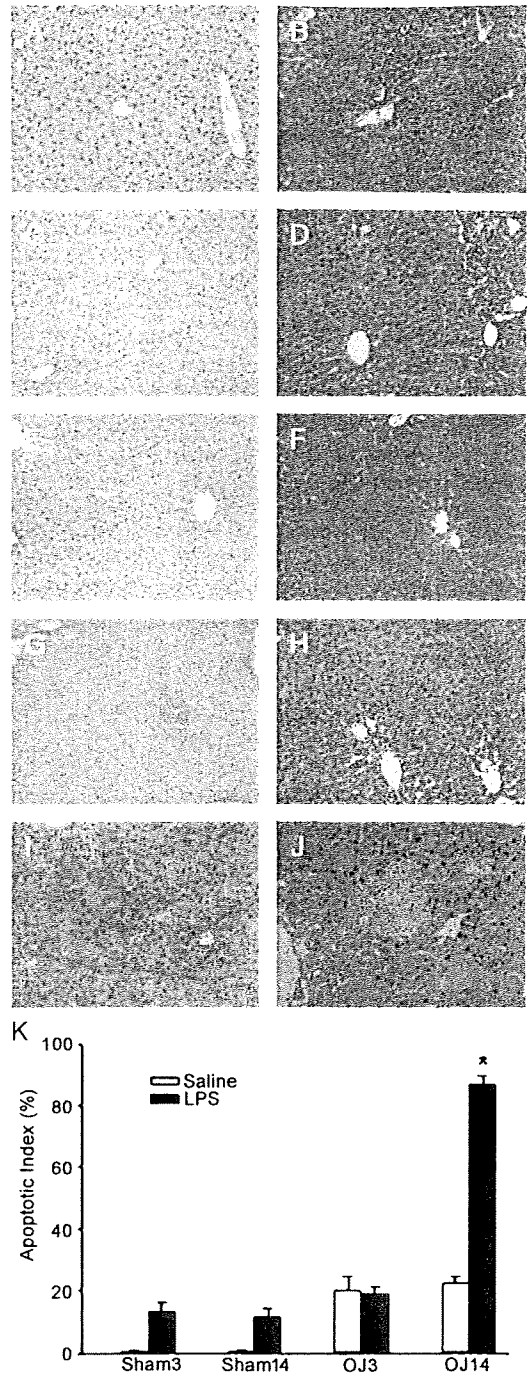

FIG. 2. **Hepatic apoptosis and histological findings after LPS administration.** Apoptosis was assessed by PARP p85 fragment immunohistochemistry (A, C, E, G, and I; original magnification, 200×). Liver histopathology was evaluated by hematoxylin-eosin staining (B, D, F, H, and J; original magnification, 200×). Liver tissue obtained from sham-operated mice at 3 h after saline administration (A and B) and Sham3 (C and D), Sham14 (E and F), OJ3 (G and H), and OJ14 (I and J) at 3 h after LPS administration. K, Apoptotic index of PARP p85. To calculate the apoptotic index, the number of stained and unstained hepatocytes was counted in five random fields (original magnification, 400×). Data are mean ± SEM. $^*P <$ 0.001 vs. other mice. For all groups, n = 6.

the XV PANTERA system (DRC, Tokyo, Japan). Samples were electrophoresed in a precast 15% XV PANTERA gel and transferred to a polyvinylidene difluoride membrane. Nonspecific binding sites were blocked with Tris-buffered saline (TBS; 40 mM Tris [pH 7.6] and 300 mM NaCl) with 0.1% Tween 20 containing 5% nonfat dry milk for 1 h at room temperature. Membranes were then incubated with antibodies to rabbit polyclonal antimouse actin, caspases 3, 8, and 9 (Santa Cruz Biotechnology, Santa Cruz, Calif), in TBS Tween 20. After five washes in TBS Tween 20, the membranes were incubated with horseradish peroxidase–conjugated donkey antirabbit immunoglobulin G. The immunoreactive proteins were detected by enhanced chemiluminescence according to the manufacturer's instructions, and the quantification data were analyzed with the image analysis software program (National Institutes of Health image, Bethesda, Md).

Blood and tissue analysis

Blood was obtained by cardiac puncture at the time of killing. Serum samples were analyzed for alanine aminotransferase (ALT) as indices of hepatocellular injury and serum total bilirubin (T-BIL) concentrations using a diagnostic kit (WAKO Pure Chemical Industries, Osaka, Japan). A quantitative assessment of FasL in the liver was made as described elsewhere (13). Briefly, liver tissue specimens were obtained and were immediately frozen. Frozen liver tissue was homogenized in 10 volumes of homogenization buffer (10 mM ethylenediaminetetraacetic acid, 2 mM phenylmethylsulfonyl fluoride, 0.1 mg/mL soybean trypsin inhibitor, 1.0 mg/mL bovine serum albumin, 0.02% sodium azide, and 0.2 μl/mL protease inhibitor cocktail [1,000 × stock; 1 mg/mL leupeptin, 1 mg/mL aprotinin, and 1 mg/mL pepstatin]). After incubating for 2 h at 4°C, the homogenate was centrifuged at 12,500 × *g* for 10 min. The supernatant was removed and centrifuged again to obtain a clear lysate. Total protein concentration of each sample was determined as described for Western blot, and samples were dispensed for enzyme-linked immunosorbent assay (ELISA) for the assessment of FasL according to the manufacturer's instructions (R&D Systems, Inc., Minneapolis, Minn). The concentration was calculated per mg total protein.

Hepatic ATP content

Liver tissue specimens were obtained and were immediately frozen. Adenosine triphosphate concentrations present in whole liver lysates were determined by using the Firefly luciferase ATP determination kit (Invitrogen, Carlsbad, Calif). Samples were prepared according to the manufacturer's instructions. Luminescence was determined using a luminometer (Berthold Technologies, Bad Wildbad, Germany), and values were calculated based on an ATP standard curve.

Statistical analysis

All data are expressed as the mean ± SEM. Comparisons between two groups were analyzed using a Mann-Whitney *U* test. Comparisons between

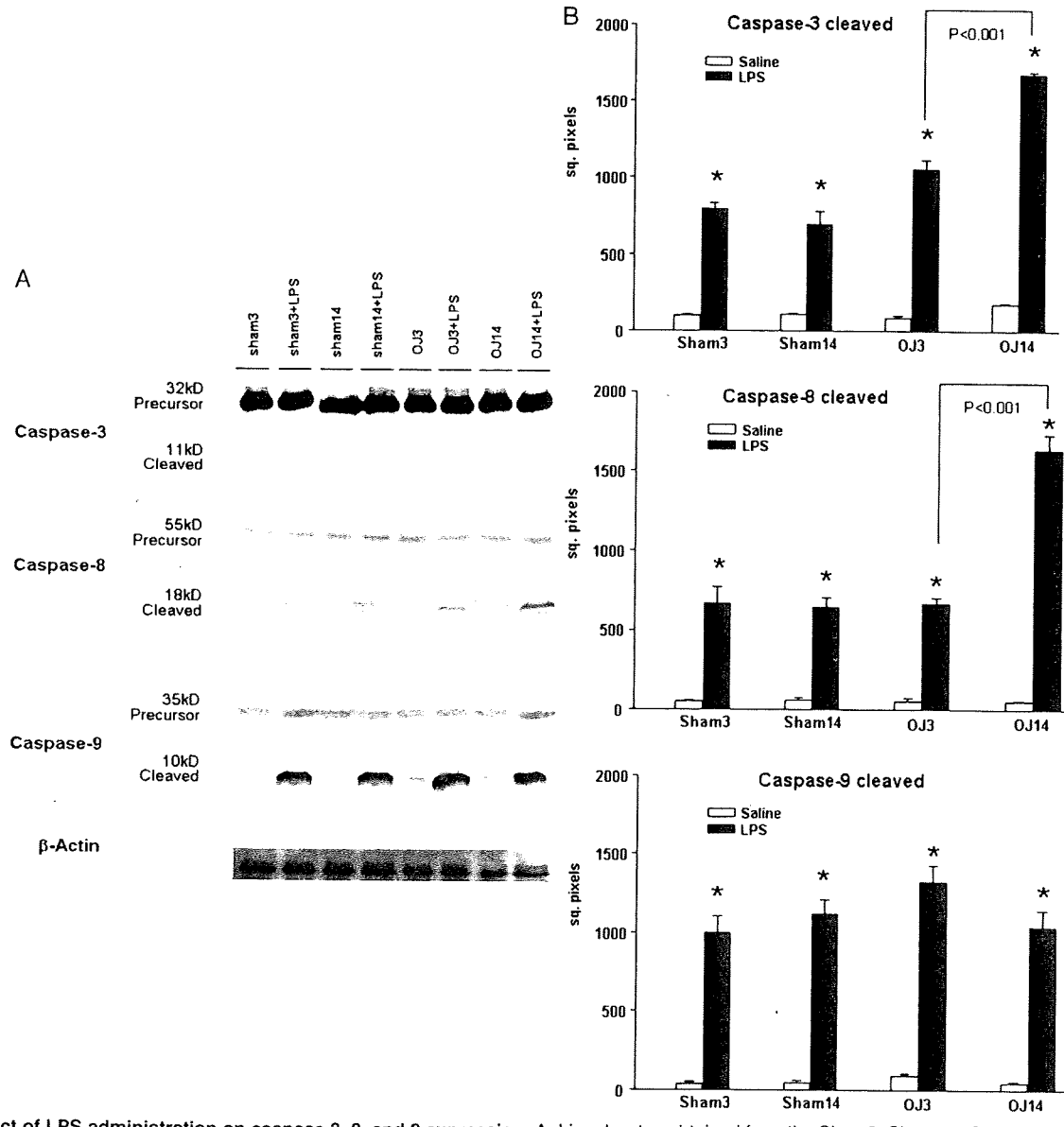

FIG. 3. **Effect of LPS administration on caspase 3, 8, and 9 expression.** A, Liver lysates obtained from the Sham3, Sham14, OJ3, and OJ14 at 3 h after LPS or saline administration was analyzed by Western blot. B, Results were quantitated by an image analysis of an autoradiogram. Data are mean ± SEM. *$P < 0.001$ vs. saline treatment. For all groups, n = 3.

multiple groups were analyzed with a one-way ANOVA, and individual group means were then compared with the Student-Newman-Keuls test. Overall survival was calculated by the Kaplan-Meier method, and comparisons were evaluated using the log-rank test. Differences were considered to be significant when $P < 0.05$.

RESULTS

Serum bilirubin levels and hepatic FasL expression

We assessed serum levels of T-BIL after bile duct ligation and division, and the T-BIL levels were elevated in mice at 3 days after bile duct ligation and division (OJ3) and significantly increased in mice at 14 days after bile duct ligation and division (OJ14) relative to that in mice at 3 days after the sham operation (Sham3) and at 14 days after the sham operation (Sham14), respectively (n = 5; Fig. 1A). Because apoptosis in OJ has been known to be involved in Fas stimulation (8), we analyzed the FasL expression in whole liver lysates during OJ by ELISA. The FasL expression significantly increased in OJ3 and OJ14 mice in comparison to the Sham3 and Sham14, respectively (n = 5; Fig. 1B).

Liver apoptosis, histological examination, and apoptotic pathway after LPS administration

Because PARP p85 fragment is an indicator for apoptosis, immunohistochemistry for PARP p85 fragment was performed to investigate whether hepatocyte apoptosis was induced. Poly (adenosine diphosphate–ribose) polymerase–positive apoptotic cells increased in OJ3 and OJ14 mice relative to the Sham3 and Sham14 (n = 6, respectively). At 3 h after LPS administration, significant hepatocyte apoptosis occurred in OJ14 mice relative to the OJ3 mice (Fig. 2, A, C, E, G, I, and K).

To assess whether hepatic injury increased after LPS administration, we examined histology by hematoxylin-eosin staining. Histological observations showed that a little focal necrosis was evident in OJ14 mice, whereas it more strongly increased in OJ14 mice at 3 h after LPS administration (Fig. 2, B, D, F, H, and J).

To determine the precise apoptosis pathway, we performed Western blot analysis to examine expression of precursor and cleaved caspases 3, 8, and 9. The expression of cleavage of caspases 3 and 8 at 3 h after LPS administration in OJ14 mice (n = 3, respectively) was increased more than those of the Sham3, Sham14, and OJ3 mice at 3 h after LPS administration (n = 3, respectively; Fig. 3, A and B). However, expression of cleavage of caspase 9 did not differ among the Sham3, Sham14, OJ3, and OJ14 after LPS administration (n = 3, respectively; Fig. 3, A and B).

Hepatic ATP content and serum ALT levels after LPS administration

Because apoptosis requires ATP, and a switch from apoptosis to necrapoptosis or secondary oncotic necrosis occurs when cells lack ATP (14), we assessed hepatic ATP content to determine whether apoptosis and necrapoptosis are induced in jaundiced mice after LPS administration. In OJ3 mice, ATP content significantly decreased and remained decreased in OJ14 relative to the Sham3 and Sham14, respectively (Fig. 4A; n = 6, respectively). At 3 h after LPS administration, ATP content significantly decreased in OJ14 mice in comparison to that in OJ3, Sham3, and Sham14, respectively (Fig. 4). Furthermore, ATP content in OJ14 mice with LPS treatment significantly decreased relative to OJ14 mice with saline treatment. On the contrary, ATP content after LPS administration in OJ3 mice was not statistically significantly different from mice with saline treatment (Fig. 4A). To determine whether hepatic injury was increased during OJ with LPS administration, we assessed serum levels of ALT. Serum ALT levels increased in OJ3 and OJ14 mice in comparison to the Sham3 and Sham14. At 3 h after LPS administration, serum ALT levels significantly increased in OJ14 mice in comparison to that in OJ3 (Fig. 4B).

Reduction in liver apoptosis after LPS administration in gld/gld mice

Because FasL has been known to activate death receptor leading to hepatocyte apoptosis and FasL increased during OJ in the current study, we used gld/gld mice that do not express FasL to investigate whether hepatocyte apoptosis occurred in OJ was induced by Fas. Number of PARP-positive apoptotic cells in gld/gld mice decreased in OJ3 and OJ14 mice relative to the wild-type mice (data not shown). In gld/gld mice, hepatocyte apoptosis significantly decreased after LPS administration in OJ14 mice relative to the wild-type mice (Fig. 5; n = 6, respectively).

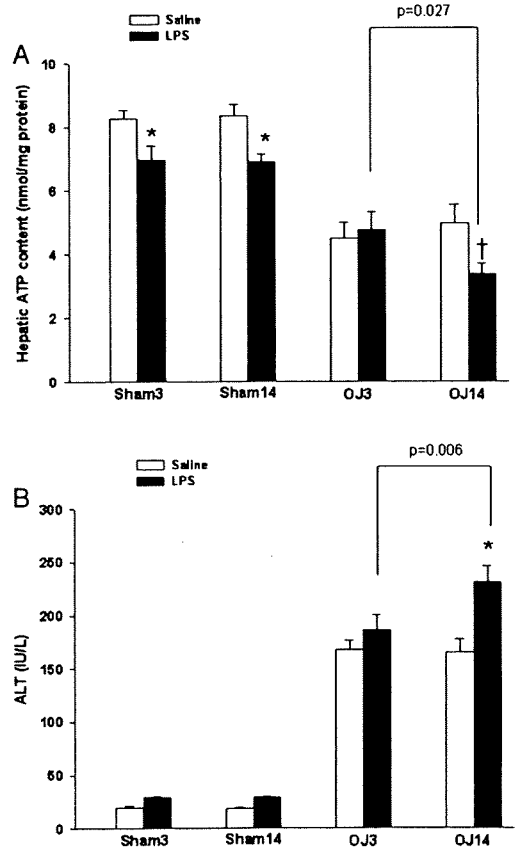

FIG. 4. **Effect of LPS administration on the liver ATP content and liver injury.** A, Hepatic ATP content was assessed by luminescence. Data are mean ± SEM. $^*P = 0.022$ vs. saline treatment. $^\dagger P = 0.034$ vs. saline treatment. For all groups, n = 6. B, Hepatocellular injury defined by serum levels of ALT. Data are mean ± SEM. $^*P < 0.001$ vs. saline treatment. For all groups, n = 6. Samples were obtained from the Sham3, Sham14, OJ3, and OJ14 mice at 3 h after LPS or saline administration.

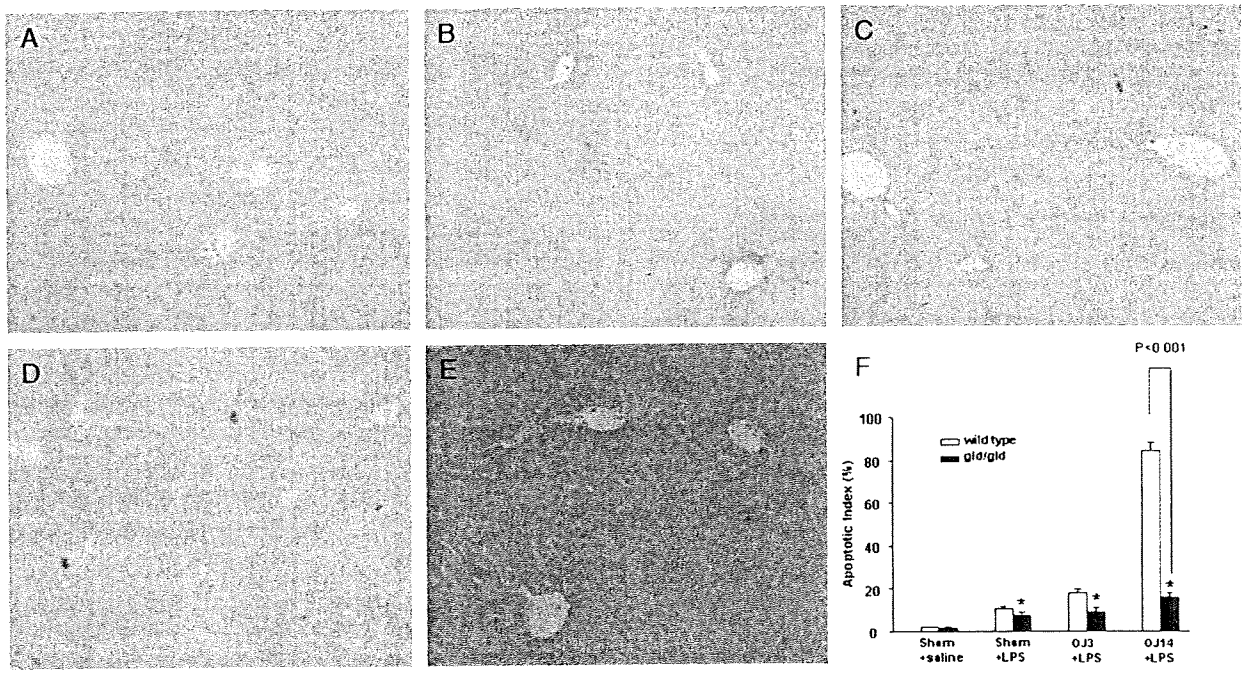

FIG. 5. **Hepatic apoptosis after LPS administration in gld/gld (FasL-deficient) mice.** Apoptosis was assessed by PARP p85 fragment immunohistochemistry (original magnification, 100×). Liver tissue obtained from the Sham14 (A) gld/gld mice at 3 h after saline administration. Liver tissue obtained from the Sham14 (B), OJ3 (C), and OJ14 (D) gld/gld mice at 3 h after LPS administration. Liver tissue obtained from OJ14 wild type (E) at 3 h after LPS administration. G, Apoptotic index of PARP p85. To calculate the apoptotic index, the number of stained and unstained hepatocytes was counted in five random fields (400×). Data are mean ± SEM. No significant difference was observed in the apoptotic index between the Sham3 and Sham14 gld/gld mice after LPS or saline administration. *$P < 0.001$ vs. wild-type mice. For all groups, n = 6.

Survival after LPS administration in OJ

To determine the susceptibility to endotoxemia in OJ, wild-type and gld/gld mice were subjected to LPS administration (n = 5, respectively). The sham-operated mice receiving LPS were all alive longer than 24 h after LPS administration. OJ3 mice receiving LPS administration were all alive longer than 24 h after LPS administration, but all OJ14 mice receiving LPS administration died within 24 h after LPS administration. The survival rate in OJ14 gld/gld mice receiving LPS administration was significantly better than that in OJ14 wild-type mice receiving LPS administration (Fig. 6).

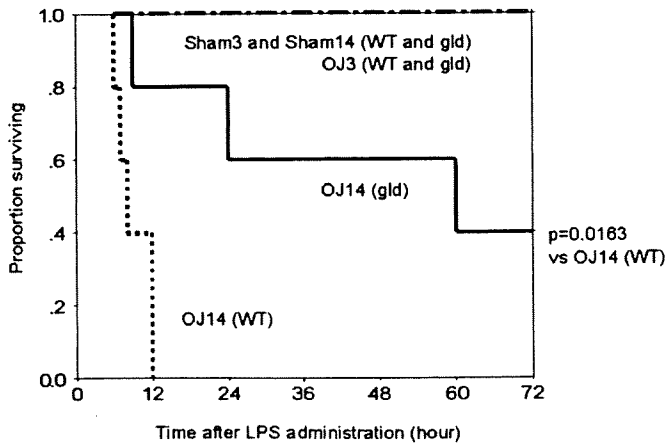

FIG. 6. **Survival after LPS administration in wild-type and gld/gld mice.** The Sham3, Sham14, OJ3, and OJ14 mice were treated with LPS administration (4 mg/kg, i.v.). For all groups, n = 5. Comparisons of overall survival were performed using the log-rank test.

DISCUSSION

Patients with OJ have bacteremic risk and may die of cholangitis or postoperative organ dysfunction after extended hepatectomy (15, 16). Acute cholangitis progresses from local infection to the systemic inflammatory response syndrome, leading to septic organ dysfunction. In contrast, Cherqui et al. (17) demonstrated that major liver resections without preoperative biliary drainage are safe in most patients with OJ. Although the morbidity rate in jaundiced patients was high in the study of Cherqui et al. (17), mortality rate was not so high. Their strategy was that surgery for jaundiced patients should be performed as soon as possible, suggesting that short periods of OJ might not affect remnant liver function after hepatectomy. Therefore, it is important to investigate whether hepatocyte injury differs over the time course of OJ with endotoxemia. Hepatocyte apoptosis has been defined as one of the causes of cholestatic liver injury (18, 19). An apoptotic body is engulfed by Kupffer cell, which stimulates ligand death, leading to cholestatic liver injury (20). The cholestatic liver is also known to be vulnerable to infection (21). Therefore, the current study showed that prolonged OJ sensitized the liver to LPS, thus leading to severe apoptosis and secondary necrosis (necrapoptosis).

Poly (adenosine diphosphate–ribose) polymerase p85 fragment, which results from caspase cleavage of PARP (116 kd), has been established as a hallmark of apoptosis (22, 23). The occurrence of hepatocyte apoptosis defined by immunohistochemistry for PARP p85 fragment after LPS administration was significantly enhanced in prolonged OJ. In an *in vitro* study, toxic bile salts cause hepatocyte apoptosis in a Fas- and

TRAIL-dependent manner (7, 24), and Fas has been reported to be involved in hepatocyte apoptosis in OJ (8, 25). The Fas-associated death domain promotes binding of procaspase 8 and its proteolytic activation to catalytic caspase 8. If sufficient amounts of caspase 8 are generated at the receptor, caspase 8 can directly activate procaspase 3 (9). Along with these findings, FasL expression increased during OJ, thus suggesting that Fas-FasL interaction is likely to play a role in hepatocyte apoptosis in OJ. The blockade of FasL using gld/gld mice reduced hepatocyte apoptosis, suggesting that FasL plays a crucial role in enhancing hepatocyte apoptosis in OJ with LPS administration.

The observation that caspase 9 activity is similarly increased in the Sham3, Sham14, OJ3, and OJ14 after LPS administration suggests that the mitochondrial permeability transition occurs by LPS administration. This is supported by the observation that in hepatocytes, the receptor signal needs to be amplified through mitochondria (18, 26). The balance between ATP depletion after the mitochondrial permeability transition and ATP generation determines the fate of cells as apoptotic or necrotic death (27). In the current study, hepatic ATP content significantly decreased, and PARP p85 fragment was strongly increased in OJ14 mice with LPS administration relative to the other mice. In acute cholestasis, Fas signaling and other alternations may lead to severe mitochondrial dysfunction and ATP depletion (28). This, along with the finding that the activation of PARP after cellular insults consumes a large amount of positive nicotinamide adenine dinucleotide, and in an effort to resynthesize positive nicotinamide adenine dinucleotide, may cause a massive ATP depletion (14). These findings suggest that prolonged OJ with LPS administration induces massive hepatic apoptosis and ATP depletion that in turn switches the cellular response to secondary oncosis (necrapoptosis), which is consistent with the findings that serum ALT levels were the highest and that focal necrosis was evident in the histopathological findings. OJ14 gld/gld mice after LPS administration prolonged survival in comparison to the wild-type mice, thus suggesting that the reduction in hepatocyte apoptosis caused by the blockade of FasL may contribute to attenuating subsequent necrapoptosis in prolonged OJ with LPS.

Concerns remain that enormous differences in hepatocyte apoptosis and the induction of caspase 8 after LPS administration were found between the short and prolonged periods of OJ (OJ3 and OJ14), although no significant difference was observed in the FasL expression between the OJ3 and OJ14 mice before LPS administration. These results suggested that other effects may also be at work to induce massive hepatocyte apoptosis in the prolonged periods of OJ. One possible candidate is TNF-α. TNF-α–associated death domains are known to promote the binding of procaspase 8 and subsequent proteolytic activation of catalytic caspase 8 (7, 25). The TNF-α expression in the OJ14 mice significantly increased after LPS administration relative to that observed in OJ3 mice, although there was no significant difference between the two groups before LPS administration (personal observation). It thus seems likely that TNF-α plays a certain role in the induction of hepatocyte apoptosis.

Fas ligand expression in normal tissues is restricted to T lymphocytes, macrophages, the cornea, the iris, ciliary bodies, the retina, and Sertoli cells (29, 30). The FasL expression in the current data seems to mirror our previous reports concerning hepatic accumulation of T lymphocytes and macrophages in OJ (31). Fas ligand is reported to play another role in induction of proinflammation (32). Furthermore, Canbay et al. (20) demonstrated that cholestatic liver injury tended to deteriorate after Kupffer cell engulfment of apoptotic bodies, which promotes inflammation and fibrogenesis. Thus, significant hepatocyte apoptosis is likely to induce inflammatory mediators. Our previous study showed that IL-1 significantly increased in OJ14 mice relative to OJ3 after LPS administration (31). This observation is consistent with the findings of Kennedy et al. (33), demonstrating an increased secretion of proinflammatory cytokines after LPS administration in the prolonged OJ. The increased expressions of proinflammatory mediators such as TNF-α and IL-1β may therefore enhance the systemic inflammatory responses, which may lead to a fatal outcome (34). Along with these findings, survival after LPS administration in the gld/gld mice intermediately ameliorated, but not completely, thus suggesting that prolonged periods of OJ may have other effects on survival in endotoxemia that are independent of FasL. Taken together, these data suggest that, in a clinical setting, longer biliary OJ may therefore increase organ dysfunction in endotoxemia that is caused by massive hepatocyte apoptosis and necrapoptosis. Up until recently, the mortality rates in severe cholangitis have still been reported to be more than 10%, and preoperative cholangitis is also known to be one of the risk factors of organ failure after hepatectomy (35). To reduce the risk, biliary drainage might therefore be an effective treatment modality in selected patients with OJ. However, the importance of preoperative biliary drainage has never been conclusively demonstrated in humans with OJ undergoing surgery. Furthermore, it is well known that an obstructive bile duct that has a biliary drainage tube put in place to relieve jaundice may increase the risk of infection. Therefore, some randomized clinical trials are presently underway to elucidate the necessity of biliary drainage in patients with OJ undergoing pancreatic head resection (36). From the current data, when patients undergo major hepatic resection, relief of biliary obstruction before surgery might therefore be required in patients who have prolonged cholestasis.

In conclusion, the current data suggested that the occurrence of hepatocyte apoptosis and secondary necrosis may differ during the time course of OJ with endotoxemia caused by FasL expression, caspase 8 activation, and significant ATP depletion. As a result, the liver in prolonged OJ may be fragile and therefore cause excessive apoptosis and necrapoptosis with endotoxemia.

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Preoperative GATA3 mRNA Expression in Peripheral Blood Mononuclear Cells is Up-Regulated in Patients With Postoperative Infection Following Hepatobiliary Pancreatic Surgery

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Background. **Aggressive hepatobiliary pancreatic surgery has been associated with high complication rates. Correlations of Th1/Th2 balance and toll-like receptor (TLR) 2/4 expression with postoperative infection following surgery were prospectively evaluated.**

Methods. **Plasma concentrations of interleukin (IL)-6, IL-10, soluble lymphocyte activation gene (sLAG)-3, and soluble CD30 were determined by enzyme-linked immunosorbent assay, and expression levels of T-bet, GATA-3, TLR2, and TLR4 mRNA in peripheral blood mononuclear cells were assayed by reverse transcription-polymerase chain reaction perioperatively in 56 consecutive patients who underwent hepatobiliary pancreatic surgery.**

Results. **Of the 56 patients, 30 patients had postoperative infection. Postoperative plasma levels of IL-6 and IL-10 were significantly higher in patients with postoperative infection than in those without infection ($P < 0.05$). Plasma soluble CD30 level and GATA-3 mRNA expression level were significantly higher preoperatively, and remained higher by postoperative d 7 in patients with postoperative infection ($P < 0.05$). Soluble lymphocyte activation gene levels were not significantly different between the two groups. T-bet mRNA expression level was significantly higher on postoperative d 3, 7, and 14 in patients with postoperative infection ($P < 0.05$). Preoperative expression levels of GATA-3 mRNA correlated significantly with those of TLR2 and TLR4 mRNA ($P < 0.05$).**

Conclusions. **These results suggest that in patients with postoperative infection, Th1/Th2 balance shifts toward Th2 dominance preoperatively.**

Key Words: **hepatobiliary pancreatic surgery; postoperative infection; Th1/Th2 balance; T-bet; GATA3; TLRs; soluble CD30.**

INTRODUCTION

An aggressive surgical approach to achieve R0 resection has resulted in improved survival for patients with advanced hepatobiliary pancreatic malignancies [1, 2]. However, aggressive hepatobiliary pancreatic surgery, especially extended liver resection and radical pancreaticoduodectomy have been associated with high complication rates of 40% to 50% [1, 3–5]. Most common complications following major hepatobiliary pancreatic surgery are septic complications, including cholangitis, wound infection, pneumonia, intra-abdominal abscess, fistula, and septicemia [1, 3–5].

It has been reported that sever trauma and hemorrhage cause prolonged immunosuppression and increase the susceptibility to sepsis [6, 7]. In humans, major trauma causes a marked decrease in interleukin (IL)-12 and interferon-gamma production and an increase in IL-4 and IL-10 production by peripheral blood mononuclear cells (PBMCs), and shifts the type 1/2 helper T cell (Th1/Th2) balance toward Th2 dominance, promoting the susceptibility to infection [8–10]. Furthermore, it has been reported that sever inflammation induces alternatively activated macrophages with no antibacterial capabilities, whereas mild inflammation induces classically activated macrophages, effector cells for the antibacterial innate immunity

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against pathogens [11]. In patients undergoing an aggressive surgery, therefore, sever tissue injury due to complicated surgical procedures and perioperative blood transfusion may also modulate the innate and adapted immune response of the host, and induce systemic anergy resulting in postoperative septic complications [12].

Toll-like receptors (TLRs) play a pivotal role not only in innate immune response but also in regulation of Th1/Th2 balance [13]. It is well known that recognition of specific pathogen associated molecular patterns is mediated primarily by TLRs [13]. Also, the type of TLR stimulation during the initial phase of immune activation determines the polarization of the adaptive immune response [13]. It has been reported that TLR2 expression on CD14+ peripheral blood monocytes is significantly up-regulated in patients with cirrhosis [14]. Furthermore, tissue expression of TLR-4 in the small intestine and liver is up-regulated in patients with obstructive jaundice [15]. These reports suggest that, in patients undergoing hepatobiliary pancreatic surgery, underlying hepatobiliary diseases potentially modulate TLRs expression and Th1/Th2 balance in the perioperative period.

The purpose of this study is to assess the effects of hepatobiliary pancreatic surgery on expression level of the principal transcription factors for the differentiation of Th1/Th2 (T-bet and GATA-3 mRNA) and TLR2/4 mRNA in PBMCs, and to clarify the association of these immunological parameters with postoperative infectious complications following surgery.

PATIENTS AND METHODS

From September 2005 through May 2006, 56 consecutive patients undergoing surgery for hepatobiliary pancreatic malignancy were studied (24 women, 32 men; age range 38 to 81 y, median 63.5). The subjects included 19 patients with primary liver cancer (hepatocellular carcinoma in 14, intrahepatic cholangiocellular carcinoma in 5), 4 patients with hepatic metastases (from colorectal cancer in 3, gastric cancer in 1), 16 patients with biliary tract cancers (bile duct cancer in 12, gallbladder cancer in 4), 14 patients with pancreatic invasive ductal carcinoma, 2 patients with intraductal papillary mucinous neoplasm, and 1 patients with duodenal cancer. Of the 56 patients studied, 28 had normal hepatic parenchyma, 8 had cirrhotic liver, and 20 had jaundiced liver. All of the jaundiced patients underwent biliary drainage before surgery (percutaneous transhepatic biliary drainage in 14, endoscopic naso-biliary drainage in 4, endoscopic retrograde biliary drainage in 2). Drainage interval ranged from 11 to 65 d with median interval of 44 d. Of the 20 patients, 18 had positive bile culture before surgery. Hepatobiliary pancreatic surgeries performed in these patients included 4 extended right hepatectomies, 2 right hepatectomies, 5 extended left hepatectomies, 2 left hepatectomies, 11 sectionectomies, 9 segmentectomies, 19 pancreaticoduodenectomies, and 4 distal pancreatectomies. All of the patients had intraperitoneal closed drainage placed and received prophylactic antibiotics just before and after operation, and twice a day on postoperative d 1 and 2. Thirty-eight patients received cefmetazole sodium 2000 mg/d while 18 patients with positive bile culture received effective antibiotics according to the sensitivity of isolated bacterial species. Patients with postoperative infection received additional antibiotic treatment according to the sensitivity of the bacterial species isolated from infection site. No patient was on total parenteral nutrition before surgery. All patients were on total parenteral nutrition for at least 3 d after surgery before starting oral intake.

Peripheral venous blood samples were collected from all patients before surgery (baseline measurements), immediately after surgery (d 0), and on postoperative d 1, 3, 7, and 14. Whole blood samples were collected into the cell preparation tube (BD Vacutainer CPT; Becton Dickinson, Franklin Lakes, NJ), and plasma and PBMCs were isolated. Plasma concentrations of interleukin IL-6, IL-10, soluble lymphocyte activation gene (sLAG) -3, and soluble CD30 (sCD30) were determined by enzyme-linked immunosorbent assay (ELISA), and expression levels of T-bet, GATA-3, TLR2, and TLR4 mRNA in PBMCs were assayed by the quantitative reverse transcription-polymerase chain reaction (RT-PCR).

Interactions of these immunological parameters and perioperative clinical parameters with postoperative infectious complications were analyzed. Perioperative clinical parameters included age, gender, hepatic histology, indocyanine green retention at 15 min (ICG R15), serum albumin level, total cholesterol level, cancer stage, operative procedures, operating time, blood loss, and length of postoperative hospital stay. This protocol was approved by the Ethics Committee of our institute. Informed consent was obtained from all patients studied.

Definition of Postoperative Infectious Complications

The definitions of infectious complications were as follows: pneumonia, lobar pneumonia with culture positive sputum; intra-abdominal abscess, radiologically proven abscess cavity with culture positive fluid; wound infection, the wound is broken down, gaping or completely dehisced; and cholangitis, fever (>38°C) and culture positive bile. Infectious complications were bacteriologically confirmed in all patients. Dysfunctions of the respiratory, renal, hepatic, cardiovascular, hematologic, and neurological systems were defined as the PO2:FiO2 ratio less than 150, serum creatinine level more than 350 μmol/L, serum bilirubin level more than 240 μmol/L, hypotension or the need for inotropic support, platelet count less than $5 \times 104/\mu L$, and coma or obtundation, respectively.

PBMCs Sampling

The cell preparation tube combines a blood collection tube containing sodium citrate as an anticoagulant with a Ficoll-Hypaque density fluid and a polyester gel barrier, which separates the two liquids (BD Vacutainer; Becton Dickinson). Whole blood samples collected into the cell preparation tube were subjected to density gradient centrifugation. Isolated plasma samples were stored at −80°C until tested. The isolated PBMCs were washed twice with phosphate-buffered saline and the cells counted. The PBMCs were resuspended at 5×10^6/mL in freezing media (90% heat inactivated fetal calf serum, 10% dimethyl sulfoxide) and stored at −80°C until tested.

Measurement of Plasma Cytokine Levels

Plasma levels of IL-6 and IL-10 were determined using ELISA kit purchased from R and D Systems (Minneapolis, MN). sLAG-3 was determined using ELISA development kit purchased from Apotech Corporation (Epalinges, Switzerland). sCD30 was determined using ELISA kit purchased from Bender Med Systems (Vienna, Austria).

RNA Isolation, cDNA Synthesis, and Quantitative RT-PCR

Total RNA from PBMCs was extracted by the Qiagen spin column method (RNeasy mini kit; Qiagen, Tokyo, Japan) exactly as described in the manufacturer's protocol manual. cDNA was synthesized from total RNA using the T-Primed First-Strand Kit for RT-

PCR (Amersham Biosciences United Kingdom, Little Chalfont, United Kingdom). Expression of T-bet, GATA3, TLR2, TLR4, and glyceraldehyde-3-phosphate dehydrogenase (GAPDH) mRNA, a house-keeping gene, was detected by the quantitative RT-PCR method using Light-Cycler with Light Cycler-Fast Start DNA Master SYBR Green I kit (Roche Diagnostics, Mannheim, Germany). RT-PCR was performed with the following primer sets; T-bet: forward 5′-GTCAATTCCTTGGGGGAGAT-3′, reverse 5′-TCATGCTGACTGCTCGAAAC-3′, GATA3: forward 5′-CTGGCCACAGTTGTTTCATG-3′, reverse 5′-GCAACTGGTGAACGGTAACA-3′ TLR2: forward 5′-AGAACAATGATGCTGCCA-3′, reverse 5′-CAGCTCTCAGATTTACCCAA-3′, TLR4: forward 5′-CCTGGACCTGAGCTTTAATC-3′, reverse 5′-CTGATATGCCCCATCTTCAA-3′, and GAPDH: forward 5′-ACCCAGAAGACTGTGGATGG-3′, reverse 5′-TTCTAGACGGCAGGTCAGGT-3′. The conditions for quantitative RT-PCR were as follows: PCR was performed with an initial denaturation step at 95°C for 10 min, followed by 45 cycles denaturation at 95°C for 10 s, annealing for 10 s (at 55°C for TLR2, 58°C for TLR4 and T-bet, 60°C for GATA3), extension at 72°C for 7 s, and GAPDH under the aforementioned conditions, except with extension at 72°C for 8 s. TLR2, TLR4, T-bet, GATA3, and GAPDH mRNA levels were determined as the absolute number of copies normalized against GAPDH mRNA copy number.

Statistical Analysis

Results are expressed as mean ± SD. Paired and unpaired Student's *t*-tests were used to analyze paired and unpaired samples, respectively. The χ^2 method was used to assess significance between proportions. Simple linear regression analysis was performed to assess the correlations between the immunological and clinical parameters. Binary logistic regression analysis was used to define associations between the immunological and clinical parameters and clinical outcome. For this analysis, countable variables were divided into two groups by using the median value as a cutoff point. A *P*-value < 0.05 was considered statistically significant.

RESULTS

Postoperative Infectious Complications

Thirty of the 56 subjects developed postoperative infectious complications, including wound infection in 18, intra-abdominal abscess in 18, cholangitis in 6, pneumonia in 5. All of the 30 patients with postoperative infection had surgical site infection (SSI). SSI was superficial incisional in 3, deep incisional in 1, and organ/space infection in 26. Of the 30 patients with postoperative infection, 4 had organ dysfunction. One patient had a single failing organ (hepatic system) and survived. The remaining 3 patients had multiple organ dysfunctions. The failing organs were respiratory system in 3, hepatic system in 3, renal system in 3, cardiovascular system in 2, hematologic system in 2. Of the 3 patients, 2 died within 30 d after surgery. Overall morbidity and mortality rates for all patients in the study were 54% and 4%, respectively.

Perioperative and Operative Parameters

Patients with postoperative infection had significantly lower serum albumin level ($P = 0.0359$), longer operation time ($P = 0.0060$), larger volume of blood loss at the operation ($P = 0.0056$), and longer length of postoperative hospital stay ($P = 0.00001$) than those without postoperative infection. There were no significant differences between the two groups as to age, gender ratio, hepatic histology, ICG R15, total cholesterol, cancer stage, and operative procedures (Table 1). In 8 of the 18 patients with preoperative positive bile culture, bacteria isolated from bile was responsible for

TABLE 1

General Characteristics of the Patients

Parameters	Patients with postoperative infection ($n = 30$)	Patients without postoperative infection ($n = 26$)	*P* value
Age (y)	64.0 ± 9.1	64.1 ± 11.4	N.S.
Gender (male/female)	19/16	13/8	N.S.
Hepatic histology (Normal: cirrhosis: jaundice)	10: 5: 15	18: 3: 5	N.S.
Preoperative biliary drainage (yes/no)	14/16	6/20	N.S.
ICG R15* (%)	13.7 ± 7.3	17.7 ± 11.7	N.S.
Albumin* (g/dL)	3.7 ± 0.5	4.0 ± 0.5	0.0359
Total cholesterol* (mg/dL)	166.6 ± 50.3	188.8 ± 52.1	N.S.
Cancer stage (UICC) (Stages I, II: Stages III, IV)	4: 26	6: 20	N.S.
Operative procedure (Liver: Pancreas)	14: 16	16: 10	N.S.
Operation time (min)	472 ± 135	326 ± 108	0.0060
Blood transfusion (yes/no)	11/19	6/20	N.S.
Blood loss (g)	1665 ± 1753	735 ± 518	0.0056
Hospital stay (d)	50.6 ± 24.0	23.7 ± 11.6	0.0001

Notes. Results are presented as mean ± SD or ratio. Student's *t*-test was used to analyze unpaired samples. The χ^2 method was used to assess significance between proportions.

Normal = normal liver parenchyma; cirrhosis = cirrhotic liver; jaundice = jaundiced liver; ICG-R15 = indocyanine green retention at 15 min; UICC = International Union Against Cancer; Liver = liver resection; pancreas = pancreatoduodenectomy or distal pancreatectomy.

* Preoperative values.

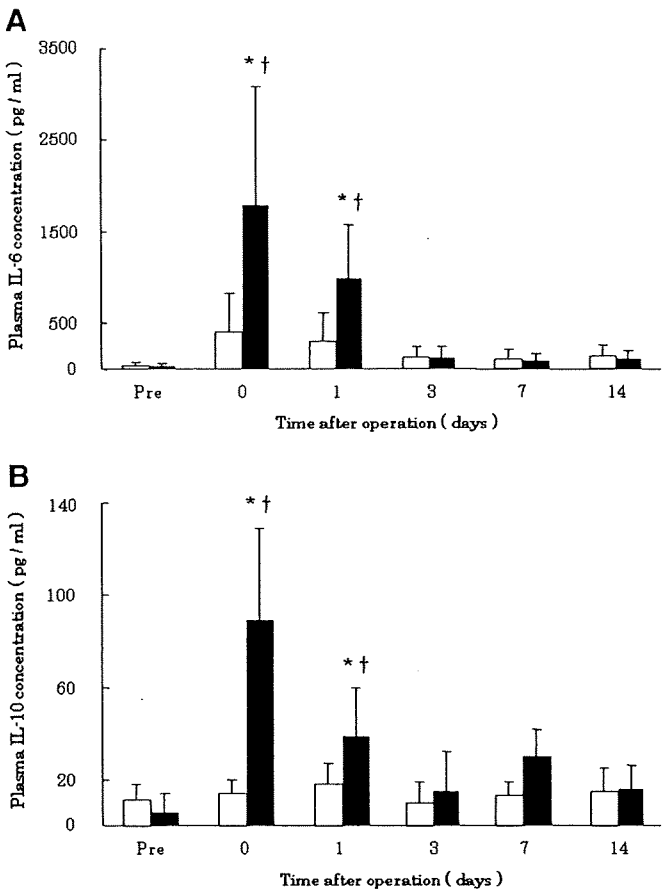

FIG. 1. Mean plasma concentrations of IL-6 (A) and IL-10 (B) following hepatobiliary pancreatic surgery. Open bars, patients without postoperative infection; filled bars, patients with postoperative infection. Error bars correspond to ± SD. *$P < 0.05$ *versus* patients without postoperative infection, †$P < 0.05$ *versus* preoperative value.

SSI. However, the incidence of postoperative infection was not affected by preoperative biliary drainage (Table 1). Eleven patients (37%) in the group with postoperative infection and 6 patients (23%) in the group without postoperative infection required blood transfusion ($P = 0.270$) (Table 1).

Plasma Concentrations of IL-6 and IL-10

Changes in plasma concentrations of IL-6 and IL-10 are presented in Fig. 1. Preoperative plasma concentrations of IL-6 and IL-10 were not significantly different between patients with postoperative infection and those without postoperative infection. Hepatobiliary pancreatic surgery resulted in a striking elevation of plasma IL-6 and IL-10 levels on postoperative d 0 and 1 compared with preoperative values ($P < 0.001$), followed by rapid declines ($P < 0.001$). Postoperative plasma IL-6 concentration was significantly higher in patients with postoperative infection than in those without postoperative infection on postoperative d 0 and 1 ($P < 0.01$) (Fig. 1A). Postoperative plasma IL-10 concentration was also significantly higher in patients with postoperative infection than in those without postoperative infection on postoperative d 0 and 1 ($P < 0.01$) (Fig. 2B). Plasma IL-6 level on postoperative d 0 correlated significantly with blood loss ($r = 0.489$, $P = 0.0004$) and operation time ($r = 0.454$, $P = 0.0012$). Plasma IL-10 level on postoperative d 0 correlated significantly with blood loss ($r = 0.577$, $P < 0.0001$) and operation time ($r = 0.310$, $P = 0.0358$).

Plasma Concentrations of sLAG-3 and sCD30

Perioperative plasma concentrations of sLAG-3 and sCD30 are presented in Fig. 2. Plasma concentration of sLAG-3 was not significantly different between patients with postoperative infection and those without postoperative infection throughout the study. Plasma concentration of sLAG-3 was not affected by surgery in both groups (Fig. 2A). Preoperative plasma concentration of sCD30 was significantly higher in patients with postoperative infection than in those without postop-

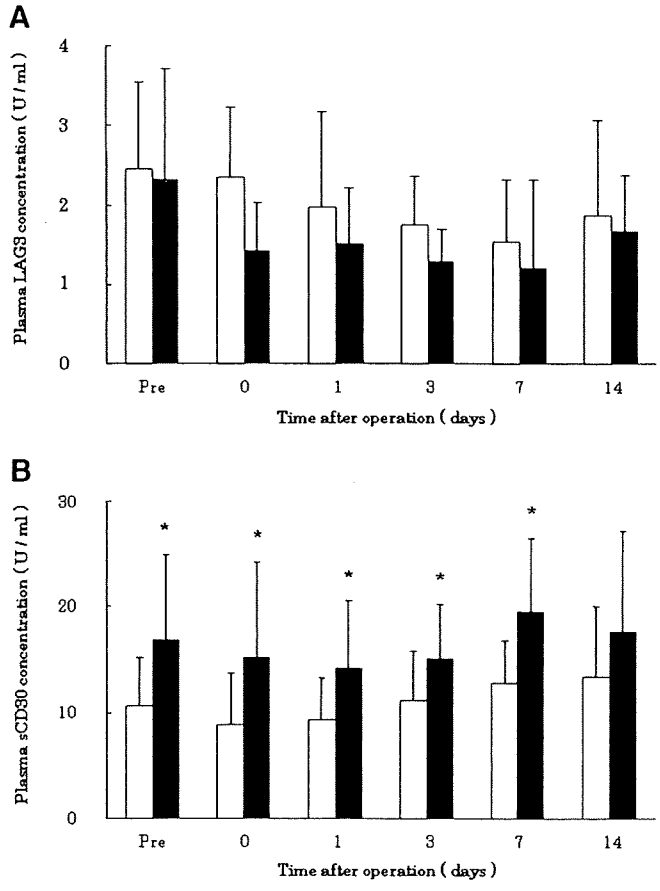

FIG. 2. Mean plasma concentrations of sLAG-3 (A) and sCD30 (B) following hepatobiliary pancreatic surgery. Open bars, patients without postoperative infection; filled bars, patients with postoperative infection. Error bars correspond to ± SD. *$P < 0.05$ *versus* patients without postoperative infection.

erative infection (16.8 ± 2.7 U/mL *versus* 10.6 ± 1.0 U/mL; $P = 0.0023$). Postoperative plasma concentration of sCD30 was also significantly higher in patients with postoperative infection than in those without postoperative infection on postoperative d 0, 1, 3, and 7 ($P < 0.001$). There were no significant changes in plasma sCD30 levels after surgery compared with preoperative value in both groups (Fig. 2B). Preoperative sCD30 level was not affected by cancer stage, and correlated significantly with length of postoperative hospital stay ($r = +0.45$, $P = 0.0011$). Preoperative sCD30 level did not correlate with depth of SSI.

Expressions Level of T-bet and GATA3 mRNA in the PBMCs

Expression level of the T-bet and GATA3 mRNA in PBMCs are presented in Fig. 3. Preoperative expression level of the T-bet mRNA in PBMCs was not significantly different between patients with postoperative infection and those without postoperative infection. Postoperative expression level of the T-bet mRNA in PBMCs was significantly higher in patients with postoperative infection than in those without postoperative infection on postoperative d 3 (0.086-fold ± 0.039-fold T-bet/GAPDH mRNA copy number *versus* 0.017-fold ± 0.003-fold T-bet/GAPDH mRNA copy number; $P = 0.0102$), d 7 ($P = 0.0401$), and d 14 ($P = 0.0087$). There were no significant changes in expression levels of T-bet mRNA after surgery compared with preoperative values in both groups (Fig. 3A). Preoperative expression level of the GATA3 mRNA in PBMCs was significantly higher in patients with postoperative infection than in those without postoperative infection (0.265-fold ± 0.041-fold GATA3/GAPDH mRNA copy number *versus* 0.171-fold ± 0.051-fold GATA3/GAPDH mRNA copy number; $P = 0.0106$). Postoperative expression level of the GATA3 mRNA in PBMCs was also significantly higher in patients with postoperative infection on postoperative d 0, 3, and 7 ($P < 0.05$). Postoperative expression level of the GATA3 mRNA in PBMCs was significantly lower on postoperative d 0 compared with preoperative value in patients with postoperative infection ($P = 0.001$) (Fig. 3B). Preoperative expression level of GATA-3 mRNA in PBMCs was not affected by cancer stage, and correlated significantly with length of postoperative hospital stay ($r = +0.33$, $P = 0.0446$). Preoperative expression level of GATA-3 mRNA in PBMCs did not correlate with depth of SSI.

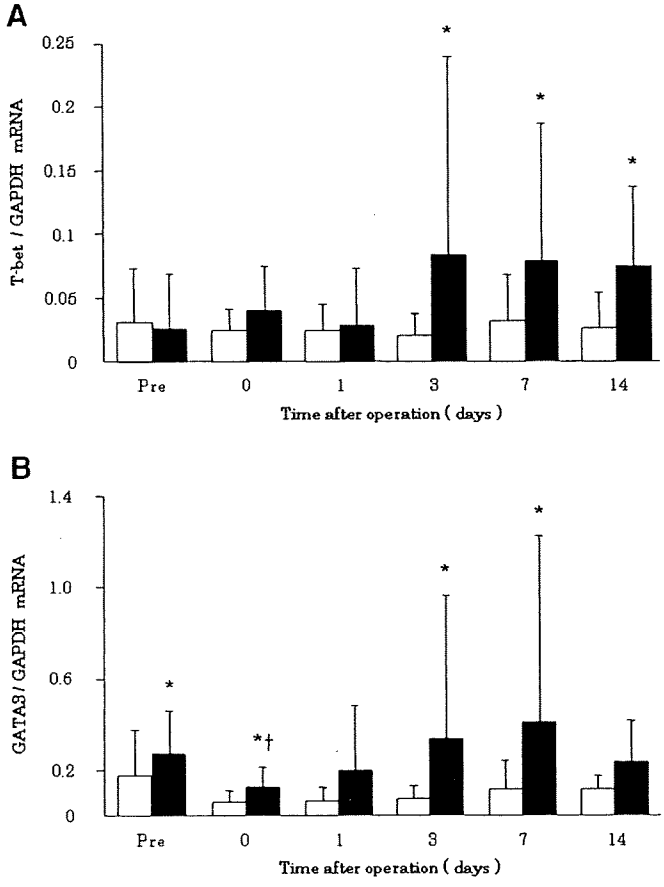

FIG. 3. Expression of T-bet (A) and GATA3 (B) mRNA in PBMCs from patients undergoing hepatobiliary pancreatic surgery. Open bars, patients without postoperative infection; filled bars, patients with postoperative infection. Error bars correspond to ± SD. *$P < 0.05$ *versus* patients without postoperative infection, †$P < 0.05$ *versus* preoperative value.

Expressions Level of TLR2 and TLR4 mRNA in PBMCs

Expression level of the TLR2 and TLR4 mRNA in PBMCs are presented in Fig. 4. Preoperative expression levels of the TLR2 and TLR4 mRNA in PBMCs were not significantly different between patients with postoperative infection and those without postoperative infection. There were no significant changes in expression levels of TLR2 and TLR4 mRNA after surgery compared with preoperative values in both groups (Fig. 4). Postoperative expression level of the TLR2 mRNA in PBMCs was significantly higher in patients with postoperative infection than in those without postoperative infection on postoperative d 3 (1.83-fold ± 0.52-fold TLR2/GAPDH mRNA copy number *versus* 0.536-fold ± 0.090-fold TLR2/GAPDH mRNA copy number; $P = 0.0042$) (Fig. 4A). Postoperative expression level of the TLR4 mRNA in PBMCs was significantly higher in patients with postoperative infection than in those without postoperative infection on postoperative d 3 (0.172-fold ± 0.079-fold TLR4/GAPDH mRNA copy number *versus* 0.047-fold ± 0.012-fold TLR4/GAPDH mRNA copy number; $P = 0.0455$) and d 14 ($P = 0.0440$) (Fig. 4B). Preoperative expression levels of TLR2 and TLR4 mRNA in PBMCs were not affected by liver cirrhosis or obstructive jaundice.

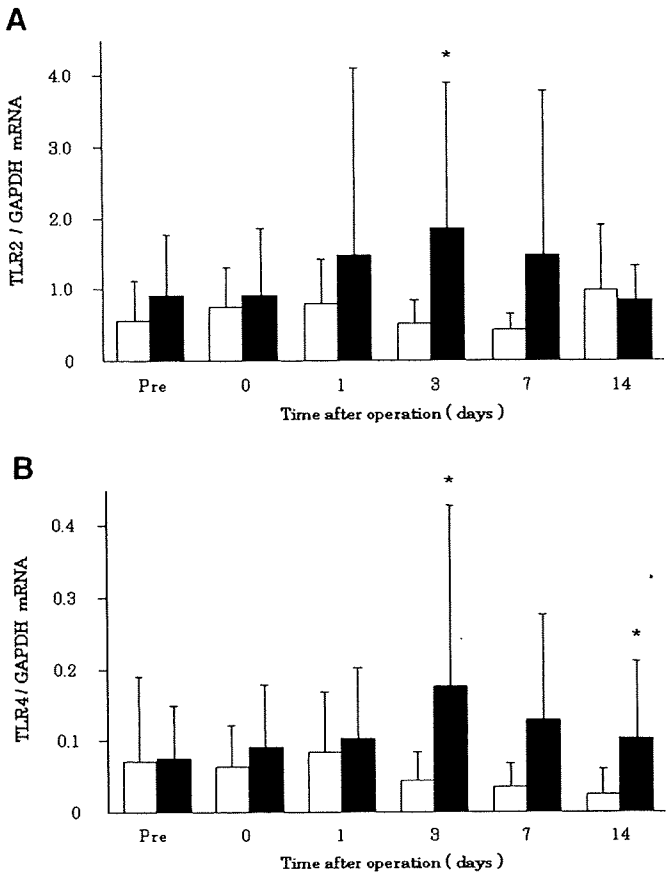

FIG. 4. Expression of TLR2 (A) and TLR4 (B) mRNA in PBMCs from patients undergoing hepatobiliary pancreatic surgery. Open bars, patients without postoperative infection; filled bars, patients with postoperative infection. Error bars correspond to ± SD. *$P < 0.05$ *versus* patients without postoperative infection.

Correlation of T-bet and GATA-3 mRNA Expression with TLRs mRNA Expression

Preoperative expression levels of GATA-3 mRNA in PBMCs correlated significantly with those of TLR2 mRNA ($r = +0.45$, $P = 0.0042$) and TLR4 mRNA ($r = +0.34$, $P = 0.0380$) (Fig. 5). Preoperative expression levels of T-bet mRNA in PBMCs did not correlate significantly with those of TLR2 and TLR4 mRNA.

Predisposing Factors for Postoperative Infections

Logistic regression analysis was used to determine the most significant predisposing factors for postoperative infection. In univariate logistic regression analyses, postoperative infection was significantly associated with preoperative sCD30 > 9.69 U/mL (OR, 4.3; $P < 0.0170$), blood loss >691 g (OR = 4.3; $P = 0.0145$), operation time >402 min (OR, 2.6; $P = 0.0471$) (Table 2). These significant variables were included in a multivariate regression analysis. In this analysis, sCD30 on preoperative period >9.69 U/mL (OR, 5.4; $P = 0.0436$), blood loss >691 g (OR, 8.0; $P = 0.0147$) were the significant factors connected to postoperative infection (Table 2).

DISCUSSION

In the present study, to evaluate Th1/Th2 balance, expression level of T-bet and GATA-3 mRNA in PBMCs, and circulating levels of sLAG-3 and sCD30 were determined. T-bet is essential for the development of Th1 cells, and GATA-3 performs an equivalent role in Th2 development [16]. These transcription factors are up-regulated in several cells that produce type 1 and type 2 cytokines and can be analyzed readily by RT-PCR using total RNA isolated from mixed cell populations, thereby providing a surrogate marker of Th1/Th2 cytokine balance under a variety of conditions [17, 18]. LAG-3 is a member of the immunoglobulin superfamily that is selectively transcribed in human activated

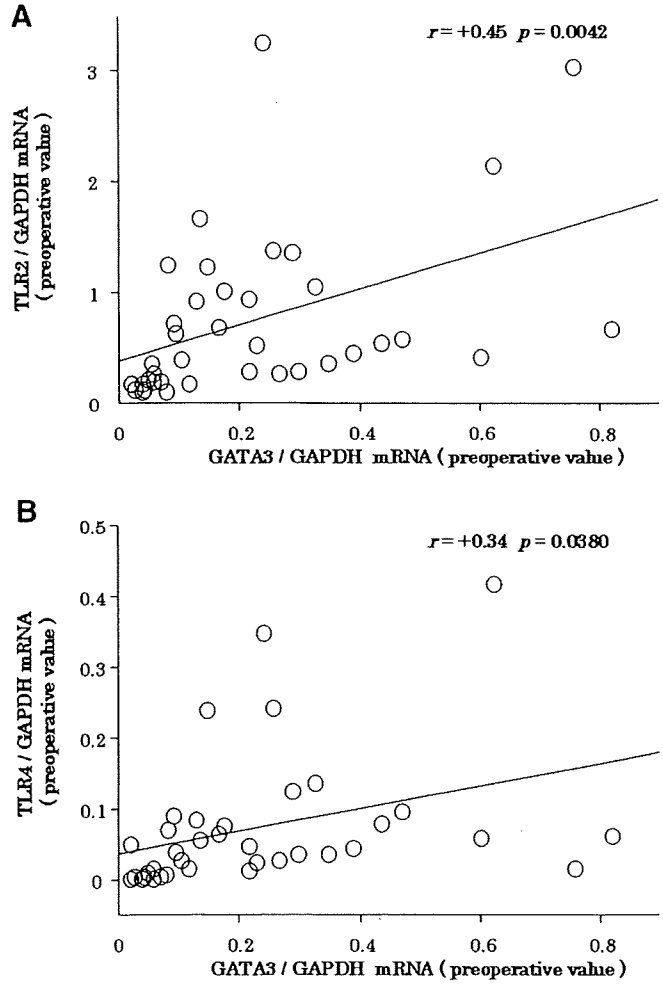

FIG. 5. Correlation of preoperative GATA3 mRNA expression with preoperative TLR2 (A) and TLR4 (B) mRNA expression; r is the coefficient of correlation and P is the statistical significance calculated according to the simple regression analysis.

TABLE 2

Results of Regression Analyses Examining Effects of Prognostic Factors on Postoperative Infection Following Hepatobiliary Pancreatic Surgery

Variable	Univariate analyses		Multivariate analyses	
	OR (95% CI)	*P* value	OR (95% CI)	*P* value
Albumin* > 3.95 g/dL	0.5 (0.2–1.6)	0.2867		
sCD30* > 9.69 U/mLl	5.2 (1.5–17.4)	0.0082	19.1 (1.5–235)	0.0211
Operation time > 402 min	5.3 (1.6–16.8)	0.0069	2.7 (0.4–20.7)	0.3317
Blood loss > 691 g	5.1 (1.6–16.4)	0.0070	36.9 (2.7–511)	0.0071

OR = Odds ratio; CI = confidence interval.
* Preoperative values.

T and natural killer cells [19]. LAG-3 expression by activated CD4+ human T cells appears to be preferentially associated with the differentiation/activation pathway leading to the production of interferon-gamma [19]. CD30 is a 120 kD membrane glycoprotein that belongs to the tumor necrosis factor superfamily. Th1 clones expressed poor or no CD30 mRNA, and showed low or undetectable expression of both membrane and sCD30 protein, whereas Th2 clones showed both CD30 mRNA and membrane CD30 and released substantial amounts of sCD30 [20]. Thus, circulating sLAG-3 and sCD30 could be a potential serological marker of Th1/Th2 balance [21, 22].

In the present study, patients with postoperative infection showed up-regulation of GATA-3 mRNA expression before surgery and postoperative d 0, up-regulation of both GATA-3 and T-bet mRNA expression on postoperative d 3 and 7, and up-regulation of T-bet mRNA expression on postoperative d 14, compared with those without postoperative infection. These results suggest that Th1/Th2 balance of the patients with postoperative infection was shifted toward Th2 dominance before surgery and immediately after surgery, equilibrated by coexpression of Th1 and Th2 response on postoperative d 3 and 7, and finally shifted toward Th1 dominance 2 wk after surgery. Circulating sCD30 levels reflected the perioperative changes in expression level of GATA-3 mRNA, whereas T-bet failed to reflect expression level of T-bet mRNA.

It has been reported that in cancer patients the Th1/Th2 balance shifts toward Th2 dominance, which may promote cancer metastasis and the susceptibility to infection [23, 24]. However, in the present study, preoperative GATA-3 mRNA expression and circulating sCD30 levels were not affected by cancer stage. Malnutrition also polarizes Th0 cells toward a Th2 phenotype [25, 26]. In the present study, preoperative serum albumin level was significantly lower in patients with postoperative infection. Therefore, malnutrition might be one of the causes of preoperative Th2 dominance. Preoperative immunonutrition potentially corrects impaired Th1/Th2 balance and decreases postoperative morbidity rate [27]. TLRs may also play a pivotal role in regulation of Th1/Th2 balance [13]. In the present study, preoperative GATA-3 mRNA expression was correlated with TLR2 mRNA expression. This result suggests that TLR2 might take part in pathophysiology of preoperative Th2 dominance. It seems likely that subclinical infection might up-regulate TLR2 and GATA-3 mRNA expression [14]. However, precise mechanism remains obscure.

It has been reported that in patients undergoing thoracic esophagectomy for cancer, postoperative major infection is closely associated with preoperative suppression of cell-mediated immunity [28, 29]. Also in the present study, preoperative Th2 dominance might suppress the cell-mediated immunity, and result in postoperative infection. Correlations of GATA-3 mRNA expression and circulating sCD30 levels with duration of postoperative hospital stay support this hypothesis.

In the present study, expression of GATA-3 and T-bet mRNA, especially GATA-3 mRNA, seemed to be depressed on postoperative d 0 compared with preoperative values. It has been reported that in the early postoperative period, surgical stress induces the down-regulation of the Fas-mediated apoptotic response in neutrophils [30]. Contrarily, surgical trauma induces both up-regulation of death-signaling factors and down-regulation of survival-signaling factors, resulting in a high frequency of apoptosis of CD4(+) and CD8(+) cells [31]. Thus, in the early postoperative period, numbers and function of lymphocytes are depressed, while those of neutrophils increase [29, 32]. These phenomena should be taken into account to evaluate expression levels of T-bet and GATA-3 mRNA in the early postoperative period [33].

In humans, major injury shifts the Th1/Th2 balance toward Th2 dominance. Furthermore, there is a reciprocal relation between diminished Th1 function and increased Th2 function at approximately 1 wk after major injury [8–10]. However, in the present study, even in the patients with postoperative infection, postoperative Th2 dominance was not observed after surgery, excluding postoperative d 0, despite preoperative

Th2 dominance. It has been reported that Th2 cytokines are produced in response to surgical stress, and potentially modulate postoperative immune response, rendering patients susceptible to infection [34]. Also in the present study, postoperative IL-6 and IL-10 levels were correlated with surgical stress and postoperative infection. However, following the peak levels of these cytokines, T-bet mRNA expression was up-regulated on postoperative d 3, resulting in coexpression of Th1 and Th2 response followed by Th1 dominance 2 wk after surgery. These results suggest that increased levels of circulating Th2 cytokines do not play a major role in postoperative alteration of Th1/Th2 balance. Up-regulation of T-bet mRNA expression in patients with postoperative infection might be induced by organisms responsible for postoperative infection, including gram-positive and -negative bacteria and fungi [35, 36]. It has been reported that in patients with postoperative infection, a broad range of cytokines, chemokines, and stress hormones, including inflammatory and anti-inflammatory mediators, are detected in the circulation immediately after surgery [37]. These mediators might also take part in postoperative alteration of Th1/Th2 balance. Regardless of the mechanism, appearance of Th1 response in patients with postoperative infection seems to be a favorable immune response facilitating bacterial clearance [10, 38].

In the present study, expression levels of TLR2 and TRL4 mRNA in PBMCs were determined. It has been reported that although TLR1 and TLR6 are expressed in all cell types of immune cells, including monocytes, polymorphonuclear leukocytes, T and B cells, and natural killer cells, TLR2, TLR4, and TLR5 are expressed in myelomonocytic elements [39, 40]. Therefore, expression levels of TLR2 and TRL4 mRNA in PBMCs potentially reflect TLR2 and TRL4 expression of monocytes [40].

It has been reported that TLR2 expression of monocytes is significantly up-regulated in patients with cirrhosis [14, 41], while expression of TLR4 mRNA in PBMCs is down-regulated [41]. Moreover, tissue expression of TLR4 in the small intestine and liver is up-regulated in patients with obstructive jaundice [15]. These changes of TLR2 and TLR4 expression potentially modulate perioperative innate and adaptive immune response [13, 35, 36]. In the present study, however, preoperative expression of TLR2 and TLR4 mRNA in PBMCs was not affected by liver cirrhosis or obstructive jaundice. These results might depend on the fact that patients undergoing liver resection did not have severe cirrhosis, and all patients with obstructive jaundice underwent biliary drainage before surgery.

Effects of surgical stress on monocyte expression of TLR-2 and TLR-4 are controversial. It has been reported that in patients undergoing open heart surgery, monocyte expression of TLR-2 and TLR-4 is up-regulated on postoperative d 1 and d 2 [42]. By contrast, it has reported that TLR2 and TLR4 expression on monocytes are down-regulated by operation, and show the lowest values on postoperative d 3 and 1, respectively [43]. These contrasting results may depend upon the methodology of the flow cytometric gating technique used [44]. In the present study, expression of TLR2 and TLR4 mRNA was up-regulated on postoperative d 3 in patients with postoperative infection compared with patients without postoperative infection. It has been reported that monocytes from patients with sepsis exhibited higher TLR-2 and TLR-4 expression than cells from controls [45]. Furthermore, it has been reported that IL-6 up-regulates TLR-4 expression of isolated monocytes, tumor necrosis factor-alpha significantly down-regulates TLR-4 mRNA expression, whereas stimulation with IL-8 or IL-10 had no significant effects [46]. Therefore, it seems likely that increased IL-6 level and postoperative bacterial infection might up-regulate TLR-2 and TLR-4 mRNA expression in patients with postoperative infection. It has been reported that TLRs ligands specifically promote bacterial phagocytosis in human monocytes through induction of a phagocytic gene program [47]. Therefore, as well as up-regulation of Th1 response, up-regulation of TLR2 and TLR4 expression seems to be a favorable immune response facilitating bacterial clearance in patients with bacterial infection.

The present study revealed that intraoperative blood loss is also closely associated with postoperative infection independent of preoperative Th2 dominance. It has been reported that allogeneic blood transfusion potentially causes immunosuppression, which is associated with postoperative bacterial infection [48]. It has also been reported that intraoperative transfusion of packed red cells induces IL-6 and IL-8 release in patients [49, 50]. However, pathophysiology of blood transfusion induced immunosuppression remains obscure.

CONCLUSIONS

The conclusions are as follows: (1) that preoperative Th1/Th2 balance is shifted toward Th2 dominance in patients with postoperative infection compared with those without infection, (2) that hepatobiliary-pancreatic surgery increases Th1 response after surgery, resulting in coexpression of Th1 and Th2 response followed by Th1 dominance, (3) that expression of TLR2 and TLR4 mRNA in PBMCs is up-regulated after surgery in patients with postoperative infection compared with patients without infection, and (4) that hepatobiliary pancreatic cancer patients with preoperative high expression of GATA-3 mRNA and sCD30 can be identified as a higher risk population in the postoperative period.

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