Table 3 Guidelines for the treatment with nucleos(t)ide analogs in patients with chronic hepatitis who are receiving lamivudine

Lamivudine	Less than 3 years	3 years or longer
HBV DNA		
<1.8 log copies/mL persistently	May be switched to entecavir 0.5 mg daily	Continued on lamivudine 100 mg daily
≥1.8 log copies/mL	VBT (−) May be switched to entecavir 0.5 mg daily	
	VBT (+) Adefovir 10 mg daily add-on lamivudine	Adefovir 10 mg daily add-on lamivudine

HBV, hepatitis B virus; VBT, virological breakthrough.

cavir. For this reason, patients are stratified by the duration of lamivudine treatment, less than 3 years and 3 years or more, as well as HBV DNA titers persistently below 1.8 log copies/mL and 1.8 log copies/mL or more, and separate treatment strategies have been worked out for the patients in each category. Because by far the majority of patients with a duration of lamivudine treatment of less than 3 years and HBV DNA titers of less than 1.8 copies/mL possess drug-resistant mutants in low frequencies, they are recommended to switch to entecavir 0.5 mg daily as soon as possible. Likewise, patients who have received lamivudine for 3 years or longer, but in whom drug-resistant mutants have never developed, are recommended to switch to entecavir 0.5 mg daily. By contrast, for patients in whom drug-resistant mutants have emerged already and who have undergone virological breakthroughs,[4] adefovir 10 mg daily add-on lamivudine is started for the purpose of stabilizing liver function.[5] In regard of the patients who have received lamivudine for 3 years or longer, those without drug-resistant mutants can stay on lamivudine 100 mg daily.

SUPPLEMENTS TO GUIDELINES FOR THE TREATMENT OF CHRONIC HEPATITIS B (PART I)

FOR THE FISCAL year 2008, the following three items have been added to previous guidelines for the treatment of chronic hepatitis B (Table 4).

1 In the treatment of patients with chronic hepatitis B, IFN is the first resort for those younger than 35 years, toward the eventual goal of gaining a "drug-free state". For the patients aged 35 years or older, persistently negative HBV DNA is the aim of nucleos(t)ide analogs, with the first choice being entecavir in their primary treatment. On the other hand, for patients with HBV mutants resistant to lamivudine and/or entecavir, combined treatment with adefovir and lamivudine is the principal rule (Table 3).[6–8]
2 Therapeutic responses to antiviral treatment are much different in patients with chronic hepatitis B who are infected with HBV of distinct genotypes. It is recommended therefore to determine HBV genotypes before making a decision on the treatment choice. In particular, the patients infected with HBV of genotype A or B respond to IFN in high rates, even if they are aged 35 years or older. For these reasons, IFN becomes the first choice in their antiviral treatment.
3 The duration of IFN treatment is 24 weeks basically. In the patients in whom the efficacy of IFN has been achieved with decrease in HBV DNA titers and normalization of ALT, the treatment duration is better extended to 48 weeks.

Table 4 Supplements to guidelines for the treatment of patients with chronic hepatitis B (part I)

1 Treatment of patients with chronic hepatitis B aims at a "drug-free state" by IFN-based therapies in those younger than 35 years, and at persistently negative HBV DNA in those aged 35 years or older, with entecavir as the first choice in the primary therapy. Lamivudine plus adefovir forms the basis for the treatment of HBV mutants resistant to lamivudine or entecavir.
2 In view of antiviral response much different in patients infected with HBV of distinct genotypes, it is desired to make treatment choices based on genotypes. In particular, because genotypes A and B respond to IFN with high efficacy, even in patients aged 35 years or older, IFN is recommended as the first treatment choice in these patients.
3 The duration of IFN is for 24 weeks basically, but extension to 48 weeks is recommended in patients who respond to IFN with decrease in HBV DNA titers and normalization of ALT levels.

ALT, alanine aminotransferase; HBV, hepatitis B virus; IFN, interferon.

Table 5 Supplements to guidelines for the treatment of patients with chronic hepatitis B (part II)

- Self-injection of IFN at home is recommended to patients, who are eligible to do it, for improving their quality of life.
- Treatment with nucleos(t)ide analogs should be continued in patients in whom cirrhosis or HCC has been cured.
- Antiviral treatment is considered in patients with ALT levels of ≥31 IU/L. To patients aged 35 years or older in whom viral replication persists, even to those with normal ALT levels, antiviral treatments are indicated. It is possible, however, to follow for outcomes in patients who are elderly or HBeAg-negative and in whom antiviral treatments are difficult, while they receive liver supportive therapy (e.g. SNMC, UDCA).
- In patients co-infected with HBV and HIV, entecavir cannot be used due to the possibility for emergence of HIV variants resistant to antiretroviral therapies.
- Immunosuppressive and anticancer drugs should be used with utmost caution, even in patients with low HBV DNA titers and normal ALT levels, because they can induce severe liver damage along with elevation in HBV DNA titers.

ALT, alanine aminotransferase; HBeAg, hepatitis B e-antigen; HBV, hepatitis B virus; HCC, hepatocellular carcinoma; IFN, interferon; SNMC, stronger neo-minophagen C; UDCA, ursodeoxycholic acid.

SUPPLEMENTS TO GUIDELINES FOR THE TREATMENT OF CHRONIC HEPATITIS B (PART II)

FURTHER, THE FOLLOWING six supplements have been added to the 2008 guidelines (Table 5).

To patients who are eligible, self-injection of IFN at home is recommended, taking into consideration their QOL. Because IFN-based therapies are not recommended for patients in whom HBV has been transmitted by perinatal infection, sequential treatment with IFN plus entecavir serves as another option in their antiviral treatment.

Treatment with nucleos(t)ide analogs should be extended to patients in whom cirrhosis or hepatocellular carcinoma (HCC) has been cured after successful therapies.

Antiviral treatment has to be considered in patients with ALT levels of 31 IU/L or more. Patients aged 35 years or older with normal ALT levels but in whom HBV replication persists, need to be considered for antiviral treatments. Elderly and HBeAg-negative patients, as well as those to whom the administration of antiviral drugs is difficult, can be followed regularly while they receive liver supportive therapy (e.g. stronger neo-minophagen C,[9] ursodeoxycholic acid [UDCA][10]).

Patients co-infected with HBV and HIV type 1 cannot receive entecavir due to the possibility of emergence of HIV mutants resistant to antiretroviral drugs.

Even in patients with low HBV DNA titers and normal ALT levels, HBV DNA loads can increase massively to induce severe liver damages in them, while they receive immunosuppressive or anticancer drugs. Hence, utmost caution should be exercised if they are to undergo antiviral treatments.

GUIDELINES FOR THE TREATMENT OF PATIENTS WITH CIRRHOSIS DUE TO HBV

TABLE 6 SUMMARIZES guidelines for the treatment of patients with type B cirrhosis. Patients with compensated or decompensated cirrhosis, who are infected with HBV, receive entecavir for persistent clearance of HBV DNA detectable by real-time polymerase chain reaction and normalization of aspartate aminotransferase as well as ALT levels. Combined lamivudine plus adefovir therapy are indicated for patients in whom HBV mutants resistant to lamivudine or entecavir have developed. Guidelines for maintaining liver function, for preventing the development of HCC, include liver supportive therapy with glycyrrhizin and UDCA, either alone or in combination. For treatment toward sup-

Table 6 Guidelines for treatment of type B cirrhosis

Principles
- Compensated: termination of HBV infection by antiviral treatment with entecavir as the mainstay.
- Decompensated: reversal to compensation and prevention of HCC.

Methods
(1) Eradication of HBV and normalization of ALT/AST (compensated and decompensated cirrhosis).
  a) Entecavir.
  b) Combined lamivudine and adefovir (for patients with HBV mutants resistant to lamivudine or entecavir).
(2) Maintenance of liver function (improvement of ALT/AST and albumin) for preventing HCC.
  a) Liver supportive therapy such as SNMC or UDCA.
  b) Branched chain amino acids (Livact).
(3) Supplementation with nutrients (for stabilizing liver function in decompensated cirrhosis).

ALT, alanine aminotransferase; AST, aspartate aminotransferase; HBV, hepatitis B virus; HCC, hepatocellular carcinoma; SNMC, stronger neo-minophagen C; UDCA, ursodeoxycholic acid.

pressing the development of HCC, branched chain amino acids (BCAA)[11] are implemented. Also, nutrient supplements are utilized for stabilizing liver function.

DISCUSSION AND CONCLUSION

THE STUDY GROUP for the Standardization of Treatment of Viral Hepatitis Including Cirrhosis, organized by the Ministry of Health, Labor and Welfare of Japan, has compiled a series of guidelines for the treatment of liver disease due to HBV and HCV ranging from chronic hepatitis to cirrhosis of various severities annually, since the fiscal year 2002. The principal aim of these guidelines is to decrease the incidence of HCC due to hepatitis virus infections in Japan. In accordance with this principle, supplements have been added to previous guidelines for the standardization of treatment of chronic viral liver disease every fiscal year. This article summarizes guidelines for the treatment of liver disease due to HBV. Guidelines for the treatment of liver disease due to HCV for the fiscal year 2008 are reported in the accompanying paper. They are formulated on evidence-based data that have been accumulated by members and cooperators of the study group. It will be necessary to improve these guidelines in the next fiscal year and henceforth, in accordance with many pieces of new evidence that are expected to evolve through enduring efforts and keen insights of members and cooperators of the study group.

In the treatment of chronic hepatitis B, novel therapeutic strategies have continued to evolve in previous guidelines. In guidelines of the fiscal year 2008, diverse new treatment arms are introduced for gaining the eventual goal of the "drug-fee state".

The Study Group for the Standardization of Treatment of Viral Hepatitis Including Cirrhosis has been drafted and displayed on the web site (www.jsh.or.jp/medical/index.html [in Japanese]) as well, guidelines for the treatment of a spectrum of liver diseases due to HBV, ranging from chronic hepatitis to cirrhosis of various severities for the fiscal year 2008. In view of the eventual goal of decreasing the incidence of HCC due to HBV infection, supplementation and adjustment are appended to previous guidelines, and new guidelines have been introduced to the treatment of cirrhosis due to HBV infection. As a general rule, antiviral treatments are the mainstay in guidelines for the treatment of chronic hepatitis B. In addition to them, it is necessary to always keep in mind the fundamental concepts of these guidelines. It is our sincere hope that, for the treatment of each patient, readers will conduct their clinical practice on the basis of these concepts, and then refer to appropriate individual guidelines, when they make decisions regarding treatment strategy, on a case-by-case basis. With respect to guidelines for the treatment of patients with cirrhosis, above all, expected achievable outcomes have to be taken into account in making treatment choices.

We can foretell that there is no end to the treatment of patients with chronic hepatitis and cirrhosis due to HBV, as it will keep evolving and improving in future guidelines. The enduring efforts of doctors and scientists, in pursuit of this goal, will fill in wide social and economic gaps in medical practices being served to the nation, and produce substantial and efficient interest in the medical economy on a national basis. In conducting treatment of patients with liver disease due to HBV infection, according to these guidelines, many new and unforeseen facets may surface that will require further improvements. Hence, it will be necessary to evaluate the therapeutic efficacy of these guidelines, and revise or add necessary supplements to them as required in the future.

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Hepatology Research 2010 doi: 10.1111/j.1872-034X.2009.00634.x

Review Article

Guidelines for the treatment of chronic hepatitis and cirrhosis due to hepatitis C virus infection for the fiscal year 2008 in Japan

Hiromitsu Kumada,[1] Takeshi Okanoue,[2] Morikazu Onji,[3] Hisataka Moriwaki,[4] Namiki Izumi,[5] Eiji Tanaka,[6] Kazuaki Chayama,[7] Shotaro Sakisaka,[8] Tetsuo Takehara,[9] Makoto Oketani,[10] Fumitaka Suzuki,[11] Joji Toyota,[12] Hideyuki Nomura,[13] Kentaro Yoshioka,[14] Masataka Seike,[15] Hiroshi Yotsuyanagi,[16] Yoshiyuki Ueno[17] and The Study Group for the Standardization of Treatment of Viral Hepatitis Including Cirrhosis, Ministry of Health, Labour and Welfare of Japan

[1]Department of Hepatology, Toranomon Hospital, Tokyo, [2]Department of Gastroenterology and Hepatology, Saiseikai Suita Hospital, Suita, [3]Department of Gastroenterology and Metabology, Ehime University Graduate School of Medicine, Ehime, [4]Department of Internal Medicine, Gifu University, Gifu, [5]Department of Gastroenterology and Hepatology, Musashino Red-Cross Hospital, Musashino, [6]Department of Internal Medicine, Shinshu University, Matsumoto, [7]Department of Medicine and Molecular Science, Division of Frontier Medical Science, Programs for Biomedical Research, Graduate School of Biomedical Science, Hiroshima University, Hiroshima, [8]Department of Gastroenterology and Hepatology, Fukuoka University School of Medicine, Fukuoka, [9]Department of Gastroenterology and Hepatology, Osaka University, Osaka, [10]Department of Digestive and Lifestyle-related Disease, Health Research Human and Environmental Science, Kagoshima, [11]Department of Hepatology, Toranomon Hospital, Tokyo, [12]Department of Gastroenterology, Sapporo Kosei General Hospital, Sapporo, [13]The Center of Liver Disease, Shin-Kokura Hospital, Kitakyusyu City, [14]Division of Liver, Biliary Tract and Pancreas Disease, Department of Internal Medicine, Fujita Health University, Aichi, [15]Department of Internal Medicine, Faculty of Medicine, Oita University, Oita, [16]Department of Infectious Disease, University of Tokyo, Tokyo, and [17]Division of Gastroenterology, Tohoku University Graduate School of Medicine, Sendai, Japan

In the 2008 guidelines for the treatment of patients with chronic hepatitis C, pegylated interferon (Peg-IFN) combined with ribavirin for 48 weeks are indicated for treatment-naive patients infected with hepatitis C virus (HCV) of genotype 1. Treatment is continued for an additional 24 weeks (72 weeks total) in the patients who achieve early virological response (EVR) with a decrease in HCV RNA titer by 2 logs or more from the baseline within 12 weeks, but who fail to clear HCV RNA detectable by real-time polymerase chain reaction (PCR) by 36 weeks. Re-treatment is aimed to either eradicate HCV or normalize transaminase levels for preventing the development of hepatocellular carcinoma (HCC), taking into consideration causes for the failure in the initial treatment. It is necessary to choose treatment goals between the clearance of HCV and normalization or stabilization of alanine aminotransferase (ALT) as well as α-fetoprotein (AFP) levels. For patients with compensated cirrhosis, the clearance of HCV RNA is aimed toward improving histological damages and decreasing the development of HCC. The recommended therapeutic regimen is the initial daily dose of 6 million international units (MIU) IFN continued for 2–8 weeks that is extended to longer than 48 weeks, if possible. IFN dose is reduced to 3 MIU daily in patients who fail to clear HCV RNA by 12 weeks for preventing the development of HCC. Splenectomy or embolization of the splenic artery is recommended to patients with platelet counts of less than $50 \times 103/mm^3$ prior to the commencement of IFN treatment. When the prevention of HCC is at issue, not only IFN, but also liver supportive therapy such as stronger neo-minophagen C, ursodeoxycholic acid, phlebotomy, branched chain amino acids (BCAA), either alone or in combination, are given. In patients with decompensated cirrhosis, by contrast, reversal to compensation is attempted. Standard IFN-α or IFN-β is given to the patients infected with HCV-1 in high viral loads (≥5 log IU/mL), and either IFN-α or Peg-IFN to all the others, for gaining the sustained virological response. For maintaining liver function and preventing HCC, BCAA,

Correspondence: Dr Hiromitsu Kumada, Department of Hepatology, Toranomon Hospital, 1-3-1 Kajigaya, Takatsu-ku, Kawasaki City 213-8587, Japan. Email: kumahiro@toranomon.gr.jp
Received 26 October 2009; revision 4 November 2009; accepted 11 November 2009.

phlebotomy and nutrient supplements are implemented, in addition to conventional liver supportive therapy. Such comprehensive guidelines are hoped to standardize the treatment of patients with chronic hepatitis and cirrhosis due to HCV infection, toward their longevity and improved quality of life.

Key words: chronic hepatitis, cirrhosis, hepatocellular carcinoma, hepatitis C virus, interferon, liver supportive therapy, pegylated interferon, ribavirin

INTRODUCTION

SINCE THE FISCAL year 2002, guidelines for the treatment of patients with viral hepatitis have been compiled annually by the Study Group for the Standardization of Treatment of Viral Hepatitis Including Cirrhosis, under the auspice of the Ministry of Health Labor and Welfare of Japan, recruiting many specialists from all over the nation. They have been improved every year with many supplementary issues that have evolved, as our understanding of various aspects of viral hepatitis deepens and treatment options widen with time. For the fiscal year 2008, guidelines have been worked out for a comprehensive standardization of the treatment of chronic hepatitis and cirrhosis due to infection with hepatitis C virus (HCV) in Japan. It is hoped that these guidelines will be accepted widely and implemented for helping as many patients as possible who suffer from sequelae of persistent HCV infection.

Here, we relate excerpts of the 2008 guidelines for the treatment of patients with HCV-induced liver disease covering a wide range from those with normal aminotransferase levels to those with decompensated cirrhosis.

GUIDELINES FOR THE PRIMARY TREATMENT OF PATIENTS WITH CHRONIC HEPATITIS C

TABLE 1 SUMMARIZES the antiviral therapy of treatment-naive patients with chronic hepatitis C. In comparison with previous guidelines, the duration of combined treatment with pegylated interferon (Peg-IFN) and ribavirin is extended to 48–72 weeks for patients infected with HCV of genotype 1 in high viral loads (HVL: ≥5 log IU/mL by the Japanese criteria).[1,2] For patients infected with HCV of genotype 2 in HVL, Peg-IFN-α2b and ribavirin for 24 weeks are indicated. To patients with HCV-1 in low viral loads (LVL: <5 log IU/mL), either the standard IFN (not conjugated with polyethylene glycol) for 24 weeks, or the weekly monotherapy with Peg-IFN-α2a for 24–48 weeks, is given.[3] Patients with HCV-2 in LVL receive either the standard IFN for 8–24 weeks, or the weekly monotherapy with Peg-IFN-α2a for 24–48 weeks.

GUIDELINES FOR THE RE-TREATMENT OF PATIENTS WITH CHRONIC HEPATITIS C

FOR PATIENTS WHO receive re-treatment, first, it is imperatively prerequisite to: (i) identify factors for non-response to previous treatments; and (ii) decide whether to aim for clearance of HCV or to prevent the progression of hepatitis that can accelerate the development of hepatocellular carcinoma (HCC), and this can be monitored by alanine aminotransferase (ALT) and α-fetoprotein (AFP) levels toward normalizing or stabilizing their levels (Table 2).[4] Second, IFN combined with ribavirin is the mainstay of re-treatment of patients with chronic hepatitis C. Third, long-term IFN monotherapy is recommended to patients who are not indicated to IFN/ribavirin or who have failed to respond to the combination therapy. However, some patients do

Table 1 Guidelines for the primary treatment of patients with chronic hepatitis C

Genotypes	Genotype 1	Genotype 2
Viral loads		
High viral load ≥5.0 log IU/mL ≥300 fmol/L ≥1 Meq/mL	• Peg-IFN-α2b (Peg-Intron) + ribavirin (Rebetol) for 48–72 weeks • Peg-IFN-α2a (Pegasys) + ribavirin (Copegus) for 48–72 weeks	• Peg-IFN-α2b (Peg-Intron) + ribavirin (Rebetol) for 24 weeks
Low viral load <5.0 log IU/mL <300 fmol/L <1 Meq/mL	• Standard IFN for 24 weeks • Peg-IFN-α2a (Pegasys) for 24–48 weeks	• Standard IFN for 8–24 weeks • Peg-IFN-α2a (Pegasys) for 24–48 weeks

Peg-IFN, pegylated interferon.

Table 2 Guidelines for Re-treatment of chronic hepatitis C

Principles
Selection has to be made between termination of HCV infection and normalization/stabilization of ALT as well as AFP levels (toward preventing aggravation of liver disease and development of HCC), after evaluating factors for non-response in the primary IFN treatment.

1 "IFN plus ribavirin" is the mainstay of re-treatment of patients who have failed to respond to the primary IFN therapy.
2 Long-term IFN is recommended to patients in whom ribavirin is not indicated or who have failed to respond to IFN/ribavirin; self-injection at home is approved for IFN-α (not for Peg-IFN).
3 Patients who are not indicated to IFN or have failed to improve ALT and AFP levels, in response to IFN, receive liver supportive therapy (SNMC, UDCA) and phlebotomy, either alone or in combination.
4 For preventing aggravation of liver disease (and development of HCC), ALT levels need to be controlled within 1.5 × ULN in patients in stage 1 fibrosis (F1), and as far as possible, 30 IU/L or lower in those in fibrosis stages 2–3 (F2/F3).
5 In treatment combined with ribavirin, dose and mode need to be selected, taking into consideration factors contributing to the response, such as age, sex, progression of liver disease, mutations in the HCV genome (amino acid substitutions in the core protein [aa70/aa91] and ISDR) and HCV RNA titers determined by the real-time PCR.

[5] AFP, α-fetoprotein; ALT, alanine aminotransferase; HCC, hepatocellular carcinoma; HCV, hepatitis C virus; ISDR, xxx; PCR, polymerase chain reaction; Peg-IFN, pegylated interferon; SNMC, stronger neo-minophagen C; UDCA, ursodeoxycholic acid; ULN, upper limit of normal.

not tolerate IFN due to side-effects or their complicating morbidities. In addition, IFN monotherapy does not always improve ALT levels. Such patients need to receive liver supportive therapy including stronger neo-minophagen C (SNMC)[5] and ursodeoxycholic acid (UDCA),[6] as well as phlebotomy, either alone or in combination. Therapeutic target ALT levels are: (i) within ×1.5 the upper limit of normal (ULN) for patients in fibrosis stage 1 (F1); and (ii) less than 30 IU/L in those in fibrosis stages 2 or 3 (F2/F3), as far as possible.

SUPPLEMENTS TO GUIDELINES FOR THE TREATMENT OF CHRONIC HEPATITIS C

FOR THE FISCAL year 2008, the following items were supplemented to the treatment of chronic hepatitis C (Table 3).

1 The treatment of patients infected with HCV-1 in HVL with Peg-IFN/ribavirin for 72 weeks is modified by the early virological response (EVR) within 12 weeks after the start. Patients in whom HCV RNA levels decrease to less than 1/100 of the baseline but who fail to clear HCV RNA detectable by real-time polymerase chain reaction (PCR) are monitored further. Patients in whom HCV RNA is cleared by 36 weeks are continued on Peg-IFN/ribavirin for an additional 24 weeks (72 weeks total).[1,2]
2 Patients with HCV-1 in HVL who fail to clear HCV RNA detectable by real-time PCR but in whom ALT levels normalize are continued on Peg-IFN/ribavirin until 48 weeks, so that normalized ALT levels endure longer after the completion of therapy.[7]
3 Patients who are not indicated to Peg-IFN/ribavirin, or who have failed to respond to previous treatments, receive long-term IFN monotherapy. During the first 2 weeks, IFN in the conventional dose is given daily or three times a week. Patients who do not clear HCV RNA during the maximal treatment period of 8 weeks receive half the conventional dose of IFN indefinitely.[8]

Table 3 Supplements to guidelines for chronic hepatitis C

1 Criteria for extending the duration of Peg-IFN/ribavirin (to 72 weeks) in patients infected with HCV-1b in HVL: patients in whom HCV RNA levels decrease to <1/100 of the baseline by 12 weeks but do not become undetectable by real-time PCR, but who clear HCV RNA within 36 weeks, treatment is continued for an additional 24 weeks (72 weeks total).
2 Patients with HCV-1b in HVL who fail to lose HCV RNA detectable by real-time PCR, but in whom ALT levels normalize by 36 weeks, Peg-IFN/ribavirin is given till 48 weeks for maintaining normalized ALT levels long after the completion of treatment.
3 Long-term IFN monotherapy in patients who are not indicated to Peg-IFN/ribavirin, or have failed to respond to it: the usual dose of IFN daily or three times in week is given for the first 2 weeks, and when HCV RNA does not disappear within the maximal duration of 8 weeks, long-term treatment with half the usual dose of IFN is continued indefinitely.

ALT, alanine aminotransferase; HCV, hepatitis C virus; HVL, high viral loads; PCR, polymerase chain reaction; Peg-IFN, pegylated interferon.

Table 4 Guidelines for the treatment of patients with normal ALT levels toward preventing the development of HCC

Platelets	$\geq 150 \times 10^3/mm^3$	$<150 \times 10^3/mm^3$
ALT		
≤30 IU/L	• Follow for ALT every 2–4 months. • If ALT levels elevate, start antiviral treatments taking into consideration the possibility of SVR and risk for HCC.	• Liver biopsy, if possible, and consider antiviral treatments for patients in ≥F2A2. • Follow for ALT every 2–4 months, and consider antiviral treatments when ALT levels elevate, for patients without biopsy.
31–40 IU/L	• Consider antiviral treatments for patients younger than 65 years.	• Start treatments for chronic hepatitis C. • Select treatments according to genotypes, viral load, age of patients, etc.

ALT, alanine aminotransferase; HCC, hepatocellular carcinoma; SVR, sustained virological response.

GUIDELINES FOR THE TREATMENT OF PATIENTS WITH CHRONIC HEPATITIS C IN NORMAL ALT LEVELS

AS IN PREVIOUS guidelines, patients with chronic hepatitis C having normal ALT levels are stratified into four groups by ALT levels and platelet counts (Table 4). Patients with chronic hepatitis C who have normal ALT levels are reported to gain the sustained virological response (SVR) to antiviral treatments comparably frequently as those having elevated ALT levels. Taking this into consideration, patients with ALT levels of less than 30 IU/L and platelet counts of $150 \times 10^3/mm^3$ or more are followed for ALT every 2–4 months. If ALT levels increase in them, antiviral treatments are considered based on the possibility of resolving HCV infection and the risk for developing HCC. In view of significant fibrosis present in patients with platelet counts of less than $150 \times 10^3/mm^3$, they are recommended to receive liver biopsy, if this is possible. Patients in fibrosis stage F2 or higher are evaluated for the indication to antiviral treatments. Patients with ALT levels between 31 and 40 IU/L are classified by platelet counts. Antiviral treatments are considered in those aged 65 years or less who have platelet counts of $150 \times 10^3/mm^3$ or more, while guidelines for patients with chronic hepatitis are applied to those with platelet counts of less than $150 \times 10^3/mm^3$.[9,10]

GUIDELINES FOR THE TREATMENT OF PATIENTS WITH CIRRHOSIS DUE TO HCV

PATIENTS WITH COMPENSATED cirrhosis who are not infected with HCV-1 in HVL receive either IFN-β or IFN-α (Table 5). Since the fiscal year 2008, IFN-α has been approved for the treatment of patients infected with HCV-1 in HVL, with the aim of resolving infection and normalizing ALT as well as AFP levels by long-term therapy. Treatment duration was set at 1 year or longer, and because the longer the treatment duration the higher the SVR rate, 36 weeks has been recommended as the optimal treatment duration. Because the normalization of ALT/AST is important, even in patients who fail to clear HCV infection by these therapeutic regimens, treatment is better conducted for maintaining normal ALT/AST levels. Guidelines for maintaining liver function for preventing the

Table 5 Guidelines for treatment of type C cirrhosis

Principles
- Compensated: termination of HCV infection
- Decompensated: reversal to compensation and prevention of HCC

Methods
(1) Eradication of HCV and normalization of ALT/AST (for patients with compensated cirrhosis).
   a) HCV-1b in HVL (≥5 log IU/mL)
      IFN-α (Sumiferon)
   b) Others
      IFN-α (Sumiferon)
      IFN-β (Feron)
(2) Maintenance of liver function (improvement of ALT/AST and albumin) for preventing HCC.
   a) Liver supportive therapy
      Stronger neo-minophagen C (SNMC), ursodeoxycholic acid (UDCA), etc.
   b) Branched chain amino acids (BCAA [Livact])
   c) Phlebotomy
(3) Supplementation with nutrients (for stabilizing liver function in decompensated cirrhosis).

ALT, alanine aminotransferase; AST, aspartate aminotransferase; HCC, hepatocellular carcinoma; HCV, hepatitis C virus; HVL, high viral loads; IFN, interferon.

development of HCC include liver supportive therapy with glycyrrhizin[5] and UDCA,[6] either alone or in combination. For treatment toward suppressing the development of HCC, branched chain amino acids (BCAA)[11] or phlebotomy are adopted. Also, nutrient supplements are applied for stabilizing liver function.

SUPPLEMENTS TO GUIDELINES FOR THE TREATMENT OF CIRRHOSIS DUE TO HCV

THE FOLLOWING ITEMS have been appended to supplement guidelines for the treatment of type C cirrhosis (Table 6).

1 For treatment of type C cirrhosis with IFN, the initial dose of 6 million international units (MIU) daily is continued as long as possible (2–8 weeks). Thereafter, long-term IFN for 48 weeks or longer is desired as in the treatment of chronic hepatitis C.
2 In the treatment of type C cirrhosis, patients who fail to achieve EVR with the clearance of HCV RNA from serum within 12 weeks should receive long-term IFN at a dose of 3 MIU.
3 For patients with type C cirrhosis who have platelet counts of less than $50 \times 10^3/mm^3$, splenectomy or embolization of the splenic artery is desirable before commencing IFN therapy, after the efficacy of IFN has been evaluated thoroughly.[12]
4 For preventing the development of HCC, improvement in ALT, AST and AFP levels are aimed. Toward this end, not only IFN, but also liver supportive therapy (SNMC and UDCA), phlebotomy and BCAA are used, either alone or in combination.

Table 6 Supplements to guidelines for type C cirrhosis

1 To start with, IFN for compensated cirrhosis is desired at 6 MIU daily for 2–8 weeks, as far as possible, and to continue for 48 weeks or longer, as for chronic hepatitis C.
2 In patients with compensated cirrhosis who fail to clear HCV RNA within 12 weeks on IFN, long-term therapy at 3 MIU should be considered for preventing HCC.
3 In patients with platelet counts $<50 \times 10^3/mm^3$, splenectomy or embolization of splenic artery is recommended before re-treatment, and after thorough evaluation has been made on the response to IFN to be expected.
4 For the prevention of HCC, not only IFN, but also liver supportive therapy (SNMC, UDCA, etc.), phlebotomy and branched chain amino acids, either alone or in combination, are recommended for improving ALT/AST and AFP levels.

AFP, α-fetoprotein; ALT, alanine aminotransferase; AST, aspartate aminotransferase; HCC, hepatocellular carcinoma; HCV, hepatitis C virus; IFN, interferon; MIU, million international units; SNMC, stronger neo-minophagen C; UDCA, ursodeoxycholic acid.

DISCUSSION AND CONCLUSION

THE STUDY GROUP for the Standardization of Treatment of Viral Hepatitis Including Cirrhosis, organized by the Ministry of Health, Labor and Welfare of Japan, has compiled a series of guidelines for the treatment of liver disease due to HCV ranging from chronic hepatitis to cirrhosis of various severities for the fiscal year 2008. The principal aim of these guidelines is to decrease the incidence of HCC due to HCV infection in Japan. In accord with this principle, supplements have been added to previous guidelines for the standardization of treatment of chronic hepatitis C. They are prepared on evidence-based data that have been accumulated by members and cooperators of the study group. It is necessary to improve these guidelines in the next fiscal year and thereafter, in accordance with many pieces of new evidence that are expected to emerge through enduring efforts of members and cooperators of the study group.

In the treatment of chronic hepatitis C, the duration of antiviral treatments is extended to 72 weeks, which has been approved as of the fiscal year 2008, and criteria for the eligibility of extended treatment duration are clearly defined. Long-term antiviral treatments, extended up to 72 weeks, are hoped to increase the SVR even further. In addition, comprehensive guidelines for the treatment of cirrhosis have been improved with substantial additions, and their criteria for the indication made explicit.

The Study Group for the Standardization of Treatment of Viral Hepatitis Including Cirrhosis has drafted, and also displayed online (www.jsh.or.jp/medical/index.html [in Japanese]), guidelines for a spectrum of liver diseases due to HCV, from chronic hepatitis to cirrhosis of various severities. In view of the eventual goal of decreasing the incidence of HCC due to HCV infection, supplementation and adjustment are appended to previous guidelines, and new guidelines have been constructed for the treatment of cirrhosis due to HCV infection. As a general rule, antiviral treatments constitute the main body of guidelines for the treatment of chronic hepatitis C. Furthermore, the fundamental concept of these guidelines would need to be kept in mind always. It is our sincere hope that, for the treatment of each patient, readers will base their clinical practice on these guidelines, and refer to appropriate

individual guidelines, when they make a decision on the treatment strategy, on a case-by-case basis. With respect to guidelines for the treatment of patients with cirrhosis, above all, expected achievable outcomes have to be taken into account in treatment choice.

It is our sincere desire that treatment of patients with chronic hepatitis and cirrhosis due to HCV will proceed following these guidelines. Efforts along these lines will rectify a wide gap in medical treatment served to the nation and raise substantial and efficient interest in the medical economy on the national basis. In practicing treatment according to these guidelines, it will be necessary to evaluate their therapeutic efficacy, and revise or add necessary supplements to them as required in the future.

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消化器病学の進歩

—原点から未来への情報発信—

第94回日本消化器病学会総会記念誌

Ⅲ. 複合領域

編集　第94回日本消化器病学会総会会長　飯田　三雄

発行　財団法人 日本消化器病学会

高齢者C型慢性肝炎に対する治療法の選択

中川美奈[1)2)]／坂本直哉[1)2)]／渡辺　守[1)]

東京医科歯科大学　1)附属病院・消化器内科　2)大学院医歯学総合研究科・分子肝炎制御学講座

Ⅰ．はじめに

高齢化社会が進むにつれわが国におけるC型慢性肝炎，肝硬変患者の平均年齢は上昇し，高齢患者からの肝癌発生が増加している中で，高齢者における適切な治療法の確立が急務である．C型肝炎の自然経過をみると，平均8～10年で線維化ステージは1段階上昇し，線維化が進むにつれ発癌率が上昇すること，症例により進展度の早い群と遅い群が存在することが報告されているが[1,2]，高齢者の中でも進展群，特に発癌リスクの高い高度線維化症例では，積極的にインターフェロン(IFN)による治療介入をする必要があると考えられる．

しかし，一方でC型慢性肝炎に対するIFN療法は副作用による中止・減量で十分な投薬量を確保できないことが治療効果の低下につながることが報告されるようになり，高齢者C型慢性肝炎に対するIFN療法の適応基準が問題となっている．そこで今回われわれは高齢者におけるIFN療法の有効性と安全性につき検討を行った．

Ⅱ．高齢者におけるIFN療法の有効性と安全性

2004年12月より当院および関連施設(お茶の水リバーカンファレンス共同研究参加施設)でIFN治療を導入したC型慢性肝炎542例のうち，最終効果判定可能であった338例を対象とした．65歳以上の高齢者は78例で全体の23％を占めていた．治療群の内訳はPEG-IFN/Riba 48週療法239例，同24週療法67例，PEG-IFNα2a単独療法32例．高齢者と非高齢者における治療効果，副作用による投薬量の調節状況，安全性などにつき比較検討を行った．統計解析はχ^2検定を行った．

治療終了後6か月の時点でHCVが陰性化した症例を著効(SVR)と判定すると，PEG-IFN/Riba 48W治療では非高齢者44％に対し高齢者32％，PEG-IFN単独48W治療では非高齢者78％に対し高齢者44％といずれも有意差は認めないものの1年間という長期の治療においては高齢者でSVR低下の傾向を認めた．(その後現在までの解析では症例数の増加によりPEG-IFN/Riba 48W治療では高齢者で有意($p<0.05$)に治療効果が低下することが明らかになった．)　一方，PEG-IFN/Riba 24W治療では非高齢者69％に対し高齢者62％と高齢者でも比較的良好なSVRが得られた(図1)．

副作用に関しては全体で48例の副作用による中止を認めたが，非高齢者では12.3％，高齢者では20.5％と高齢者で多い傾向にあった．(その後現在までの解析では高齢者で有意($p<0.05$)に副作用が多いことが明らかになった．)しかし，いずれの群でも重篤な副作用は認めず，中止理由も高齢者，非高齢者ともにほぼ同様で，最も多いのは食欲不振，倦怠感であった．

Ⅲ．PEG-IFN/Riba 48W療法

PEG-IFN/Riba 48W療法について詳細な検討を行った．症例239例の投薬状況をみると治療完遂は186例(78％)，治療中止は53例(22％)であった．治療完遂症例でも減量なしは77例と全体の32％であり，治療導入した約半数の症例で副作用により投薬の減量を必要とした．薬剤投薬量について非高齢者と高齢者で比較検討を行うと，男女ともに高齢者のほうが予定投薬量の80％以

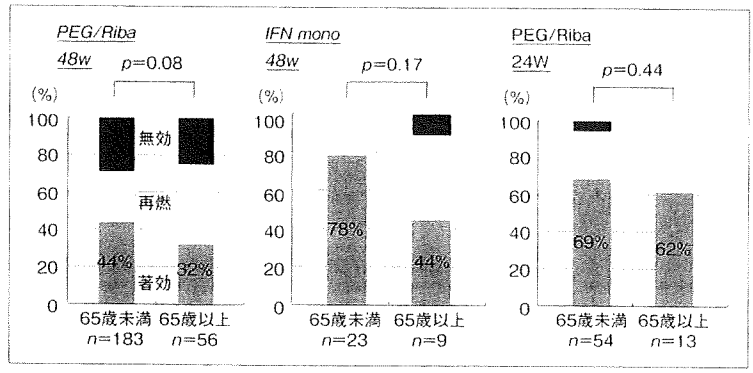

図1　治療効果(ITT解析)

治療終了後6か月の時点でHCVが陰性化した症例を著効(SVR)と判定すると，PEG-IFN/Riba48週治療では非高齢者44%に対し高齢者32%，PEG-IFN単独48週治療では非高齢者78%に対し高齢者44%といずれも有意差は認めないものの48週治療においては高齢者でSVR低下を認めた．一方，PEG-IFN/Riba24週治療では非高齢者69%に対し高齢者62%と高齢者でも比較的良好なSVRが得られた．

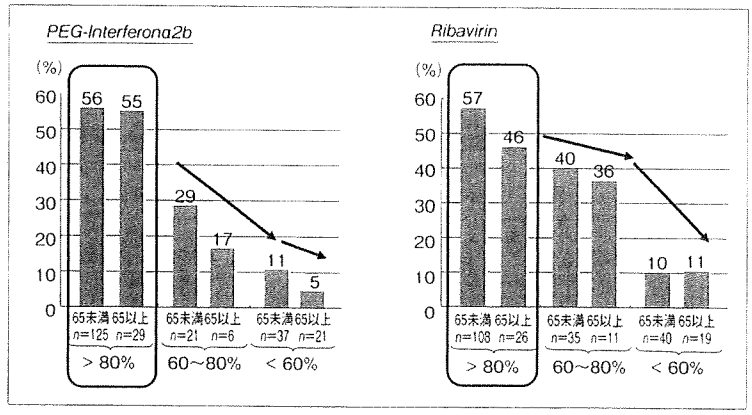

図2　薬剤投薬量と著効率(SVR)

PEG-IFNおよびRibavirinの予定投薬量を80%以上，60~80%，60%以下の3群に分けて，非高齢者と高齢者でSVRを比べると，80%以上投与できた症例ではSVRはともに良好であったが，PEG-IFNでは80%以下，Ribavirinでは60%以下の投薬量になるとSVRは著明に低下することがわかった．

上を投与できた症例は少なく，高齢者では中止・減量により半数以上の症例で予定投薬量を十分確保できていないことがわかった．PEG-IFNおよびRibavirinの予定投薬量を80%以上，60~80%，60%以下の3群に分けて，非高齢者と高齢者でSVRを比べると，80%以上投与できた症例ではともにSVRは良好であったが，PEG-IFNでは80%以下，Ribavirinでは60%以下の投薬量になるとSVRは著明に低下することがわかった(図2)．

SVRに関与する因子についてSVR群とnonSVR群に分けて単変量解析をするとF因子，Hb値，Plt値，ISDR変異数，薬剤投薬量が抽出され，これらの因子のうち治療前パラメーターである4つの因子に関して多変量解析を行うと，ISDR変異数とHb値が抽出され，治療開始前の効果予測に重要であると思われた．

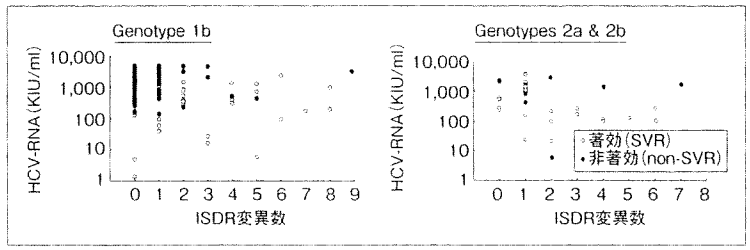

図3 ISDR変異数と治療効果(1)

ISDR変異数と治療効果の関係を治療完遂例で解析すると，Genotypeに関係なく変異数の多い症例でSVRが多い傾向にあり，PEG-IFN/Riba併用療法においてはISDR変異数が2以上の症例で良好な治療効果が得られることがわかった．

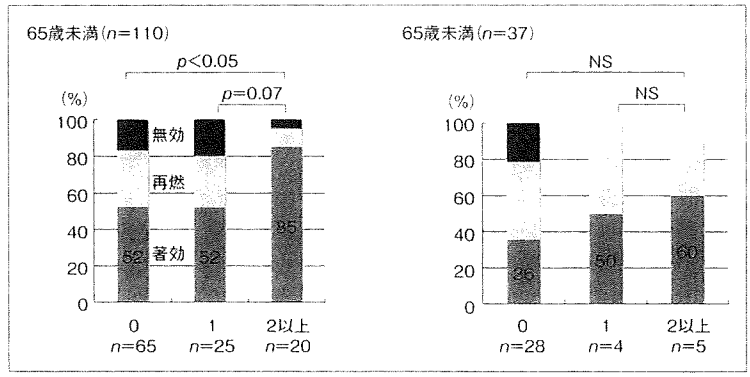

図4 ISDR変異数と治療効果(2)

今回の解析症例におけるISDR変異数と治療効果の関係をみると，高齢者では症例数が十分でなく有意差は認めないもののISDR変異2以上の症例でSVRの上昇を認め，非高齢者では有意差をもってISDR2以上の症例で治療効果は良好であった($p<0.05$)．

Ⅳ. ISDR変異数と治療効果

C型肝炎ウイルスは約9.6kbの長さの1本鎖RNAウイルスで，HCV増殖に関与する非構造蛋白質の一つであるNS5A蛋白質の変異がIFN感受性に関与していること，さらにIFN著効例ではNS5A内の領域(aa2209-2248)に多数のアミノ酸変異を認めたのに対して，IFN無効例ではほとんど変異を認めないことを，現在山梨大学におられる榎本信幸先生らが報告され，この領域をinterferon sensitivity determining region(ISDR)と命名した[3]．ISDRは分子機序は不明ながらIFN感受性やHCVウイルス量と相関し，HCVレプリコン増殖にも密接に関与することが報告されている[4]．

当院で過去10年ほどの間にISDRを測定した787例の解析では，ISDR変異数が2以上の症例の割合は，高齢者と非高齢者いずれの年代でもほぼ同等であり，全体の20～30%の割合でみられることがわかった．

ISDR変異数と治療効果の関係を治療完遂例で解析すると，Genotypeに関係なく変異数の多い症例でSVRが多い傾向にあり，PEG-IFN/Riba併用療法においてはISDR変異数が二つ以上の症例で良好な治療効果が得られることがわかった(図3)．Genotype 2ではISDR変異のないwildタイプであっても比較的良好な治療効果が得られるが，難治とされるGenotype1高ウイルス量症例ではISDR変異数は非常に有用な治療効果予測因子である．今回の解析症例におけるISDR変異数と治療効果の関係をみると，高齢者では症例数が十分でなく有意差は認めないもののISDR変異が

二つ以上の症例でSVRの上昇を認めることがわかった(図4).

その後の解析ではISDR変異数が一つ以下と二つ以上の2群に分けて治療効果を解析すると,ISDR変異数一つ以下の群では再燃症例が多く治療効果が低下するため,最終効果判定ではISDR変異数二つ以上の症例で有意に良好なSVRが得られた($p<0.01$).

また,ISDR同様にSVR予測因子として注目されているコア抗原変異についても解析を施行したところ,全体ではdouble Mutantの症例でSVRが低い傾向にあるが,男女別に解析をすると男性では変化はなく,女性においてdouble Mutant症例で有意にSVRの低下と無効症例の増加を認めた($p<0.05$).

V. おわりに

高齢者では薬剤の中止・減量が多く,非高齢者に比べてSVRは低下する.治療導入の必要性を十分検討すると同時に,宿主因子(F因子,Hb直),ウイルス因子(ISDR,コア変異)による治療効果予測を事前に行ったうえでIFN導入について検討することが重要である.また,ひとたびIFN導入した症例では,治療完遂を目指し,十分な薬剤投与量を確保することが著効率の向上に寄与すると考えられる.

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nature genetics

Genome-wide association of *IL28B* with response to pegylated interferon-α and ribavirin therapy for chronic hepatitis C

Yasuhito Tanaka[1,18], Nao Nishida[2,18], Masaya Sugiyama[1], Masayuki Kurosaki[3], Kentaro Matsuura[1], Naoya Sakamoto[4], Mina Nakagawa[4], Masaaki Korenaga[5], Keisuke Hino[5], Shuhei Hige[6], Yoshito Ito[7], Eiji Mita[8], Eiji Tanaka[9], Satoshi Mochida[10], Yoshikazu Murawaki[11], Masao Honda[12], Akito Sakai[12], Yoichi Hiasa[13], Shuhei Nishiguchi[14], Asako Koike[15], Isao Sakaida[16], Masatoshi Imamura[17], Kiyoaki Ito[17], Koji Yano[17], Naohiko Masaki[17], Fuminaka Sugauchi[1], Namiki Izumi[3], Katsushi Tokunaga[2] & Masashi Mizokami[1,17]

The recommended treatment for patients with chronic hepatitis C, pegylated interferon-α (PEG-IFN-α) plus ribavirin (RBV), does not provide sustained virologic response (SVR) in all patients. We report a genome-wide association study (GWAS) to null virological response (NVR) in the treatment of patients with hepatitis C virus (HCV) genotype 1 within a Japanese population. We found two SNPs near the gene *IL28B* on chromosome 19 to be strongly associated with NVR (rs12980275, $P = 1.93 \times 10^{-13}$, and rs8099917, 3.11×10^{-15}). We replicated these associations in an independent cohort (combined *P* values, 2.84×10^{-27} (OR = 17.7; 95% CI = 10.0–31.3) and 2.68×10^{-32} (OR = 27.1; 95% CI = 14.6–50.3), respectively). Compared to NVR, these SNPs were also associated with SVR (rs12980275, $P = 3.99 \times 10^{-24}$, and rs8099917, $P = 1.11 \times 10^{-27}$). In further fine mapping of the region, seven SNPs (rs8105790, rs11881222, rs8103142, rs28416813, rs4803219, rs8099917 and rs7248668) located in the *IL28B* region showed the most significant associations ($P = 5.52 \times 10^{-28}$–2.68×10^{-32}; OR = 22.3–27.1). Real-time quantitative PCR assays in peripheral blood mononuclear cells showed lower *IL28B* expression levels in individuals carrying the minor alleles ($P = 0.015$).

Hepatitis C is a global health problem that affects a significant proportion of the world's population. The World Health Organization estimated that in 1999, there were 170 million HCV carriers worldwide, with 3–4 million new cases appearing each year. HCV infection affects more than 4 million people in the United States, where it represents the leading cause of cirrhosis and hepatocellular carcinoma as well as the leading cause of liver transplantation[1].The American Gastroenterological Association estimated that drugs are the largest direct costs of hepatitis C[1].

The most effective current standard of care in patients with chronic hepatitis C, a combination of PEG-IFN-α with ribavirin, does not produce SVR in all patients treated. Large-scale studies on 48-week-long PEG-IFN-α/RBV treatment in the United States and Europe showed that 42–52% of patients with HCV genotype 1 achieved SVR[2–4], and similar results were found in Japan. However, older patients (greater than 50 years of age) had a significantly lower rate of SVR due to poor adherence resulting from adverse events and laboratory-detectable abnormalities such as neutropenia and thrombocytopenia[5,6]. Specifically, various well-described side effects (such as a flu-like syndrome, hematologic abnormalities and adverse neuropsychiatric events) often necessitate dose reduction, and 10–14% of patients require premature withdrawal from interferon-based therapy[7]. To avoid these side effects in patients who will not be helped by the treatment, as well as to reduce the substantial cost of PEG-IFN-α/RBV treatment, it would be useful to be able to predict an individual's response before or early in treatment. Several viral factors, such as genotype 1, high baseline viral load, viral

[1]Department of Clinical Molecular Informative Medicine, Nagoya City University Graduate School of Medical Sciences, Nagoya, Japan. [2]Department of Human Genetics, Graduate School of Medicine, The University of Tokyo, Tokyo, Japan. [3]Division of Gastroenterology and Hepatology, Musashino Red Cross Hospital, Tokyo, Japan. [4]Department of Gastroenterology and Hepatology, Tokyo Medical and Dental University, Tokyo, Japan. [5]Division of Hepatology and Pancreatology, Kawasaki Medical College, 577 Matsushima, Kurashiki, Japan. [6]Department of Internal Medicine, Hokkaido University Graduate School of Medicine, Sapporo, Japan. [7]Molecular Gastroenterology and Hepatology, Kyoto Prefectural University of Medicine, Kyoto, Japan. [8]National Hospital Organization Osaka National Hospital, Osaka, Japan. [9]Department of Medicine, Shinshu University School of Medicine, Matsumoto, Japan. [10]Division of Gastroenterology and Hepatology, Internal Medicine, Saitama Medical University, Saitama, Japan. [11]Second department of Internal Medicine, Faculty of Medicine, Tottori University, Yonago, Japan. [12]Department of Gastroenterology, Kanazawa University Graduate School of Medicine, Kanazawa, Japan. [13]Department of Gastroenterology and Metabology, Ehime University Graduate School of Medicine, Ehime, Japan. [14]Department of Internal Medicine, Hyogo College of Medicine, Nishinomiya, Japan. [15]Central Research Laboratory, Hitachi Ltd., Kokubunji, Japan. [16]Gastroenterology and Hepatology, Yamaguchi University Graduate School of Medicine, Yamaguchi, Japan. [17]Research Center for Hepatitis and Immunology, International Medical Center of Japan Konodai Hospital, Ichikawa, Japan. [18]These authors contributed equally to this work. Correspondence should be addressed to M.M. (mmizokami@imcjk2.hosp.go.jp).

Received 29 June; accepted 21 August; published online 13 September 2009; doi:10.1038/ng.449

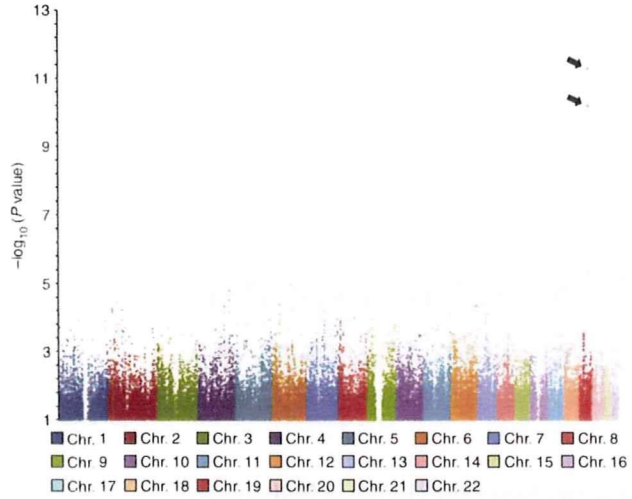

Figure 1 Genome-wide association results with PEG-IFN-α/RBV treatment in 142 Japanese patients with HCV (78 NVR and 64 VR samples). *P* values were calculated by using a χ^2 test for allele frequencies. The dots with arrows for chromosome 19 denote SNPs that showed significant genome-wide associations ($P < 8.05 \times 10^{-8}$) with response to PEG-IFN-α/RBV treatment.

kinetics during treatment, and amino acid pattern in the interferon sensitivity–determining region, have been reported to be significantly associated with the treatment outcome in a number of independent studies[8–10]. Studies have also provided strong evidence that ~20% of patients with HCV genotype 1 and 5% of patients with genotype 2 or 3 have a null response to PEG-IFN-α/RBV. No definite predictor of this resistance is currently available that make it possible to bypass the initial 12–24 weeks' treatment before deciding whether treatment should be continued. If a reliable predictor of non-response were identified for use in patients before treatment initiation, then an estimated 20%, including those who have little or no chance to achieve SVR, could be spared the side effects and cost of treatment.

Host factors, including age, sex, race, liver fibrosis and obesity, have also been reported to be associated with PEG-IFN-α/RBV therapy outcome[11,12]. However, little is known about the host genetic factors that might be associated with the response to therapy: thus far only a few candidate genes, including those encoding type I interferon receptor-1 (*IFNAR1*) and mitogen-activated protein kinase–activated protein kinase 3 (*MAPKAPK3*), have been reported to be associated with treatment response[13,14]. We describe here a GWAS for response to PEG-IFN-α/RBV treatment.

We conducted this GWAS to identify host genes associated with response to PEG-IFN-α/RBV treatment in 154 Japanese patients with HCV genotype 1 (82 with NVR and 72 with virologic response (VR), based on the selection criteria as described in Online Methods). We used the Affymetrix SNP 6.0 genome-wide SNP typing array for 900,000 SNPs. A total of 621,220 SNPs met the following criteria: (i) SNP call rate ≥95%, (ii) minor allele frequency (MAF) ≥1% and (iii) deviation from Hardy-Weinberg equilibrium (HWE) $P \geq 0.001$ in VR samples. After excluding 4 NVR and 8 VR samples that showed quality control (QC) call rates of <95%, 78 NVR and 64 VR samples were included in the association analysis. **Figure 1** shows a genome-wide view of the single-point association data based on allele frequencies. Two SNPs located close to *IL28B* on chromosome 19 showed strong associations, with a minor allele dominant model (rs12980275, $P = 1.93 \times 10^{-13}$, and rs8099917, $P = 3.11 \times 10^{-15}$, respectively), with NVR to PEG-IFN-α/RBV treatment (**Table 1**). The rs8099917 lies between *IL28B* and *IL28A*, ~8 kb downstream from *IL28B* and ~16 kb upstream from *IL28A*. These associations reached genome-wide levels of significance for both SNPs in this initial GWAS cohort (Bonferroni criterion $P < 8.05 \times 10^{-8}$ (0.05/621,220)). The frequencies of minor allele–positive patients were much higher in the NVR group than in the VR group for both SNPs (74.3% in NVR, 12.5% in VR for rs12980275; 75.6% in NVR, 9.4% in VR for rs8099917). Notably, individuals homozygous for the minor allele were observed only in the NVR group. The VR group, as compared to the NVR group, showed genotype frequencies closer to those in the healthy Japanese population[15], yet the minor allele frequencies were slightly higher in the transient virologic response (TVR) group (23.1%, 15.4%) than in the SVR group (9.8%, 7.8%) (**Table 1**). We applied the Cochrane-Armitage test on all the SNPs and found a genetic inflation factor, λ, of 1.029 for the GWAS stage (**Supplementary Fig. 1**).We also carried out principal component analysis in 142 samples for the GWAS stage together with the HapMap samples (CEU, YRI, CHB and JPT) (**Supplementary Fig. 2**); this suggested that the effect of population stratification was negligible.

Table 1 Significant association of two SNPs (rs12980275 and rs8099917) with response to PEG-IFN-α/RBV treatment

					Null responder (NVR[a], *n* = 128)			Responder (VR[a], *n* = 186)			Responder (SVR[a], *n* = 140)			NVR vs. VR		NVR vs. SVR	
dbSNP rsID	Nearest gene	MAF[b] (allele)	Allele (1/2)	Stage	11	12	22	11	12	22	11	12	22	OR (95% CI)[c]	*P* value[d]	OR (95% CI)[c]	*P* value[d]
rs12980275	*IL28B*	0.15 (G)	A/G	GWAS	20 (25.6)	54 (69.2)	4 (5.1)	56 (87.5)	8 (12.5)	0 (0.0)	46 (90.2)	5 (9.8)	0 (0.0)	20.3 (8.3–49.9)	1.93×10^{-13}	26.7 (9.3–76.5)	7.41×10^{-13}
				Replication	10 (20.0)	37 (74.0)	3 (6.0)	101 (82.8)	21 (17.2)	0 (0.0)	73 (82.0)	16 (18.0)	0 (0.0)	19.2 (8.3–44.4)	5.46×10^{-15}	18.3 (7.6–44.0)	8.37×10^{-13}
				Combined	30 (23.4)	91 (71.1)	7 (5.5)	157 (84.4)	29 (15.6)	0 (0.0)	119 (85.0)	21 (15.0)	0 (0.0)	17.7 (10.0–31.3)	2.84×10^{-27}	18.5 (10.0–34.4)	3.99×10^{-24}
rs8099917	*IL28B*	0.12 (G)	T/G	GWAS	19 (24.4)	56 (71.8)	3 (3.8)	58 (90.6)	6 (9.4)	0 (0.0)	47 (92.2)	4 (7.8)	0 (0.0)	30.0 (11.2–80.5)	3.11×10^{-15}	36.5 (11.6–114.6)	5.00×10^{-14}
				Replication	11 (22.0)	37 (74.0)	2 (4.0)	108 (88.5)	14 (11.5)	0 (0.0)	78 (87.6)	11 (12.4)	0 (0.0)	27.4 (11.5–65.3)	9.47×10^{-18}	25.1 (10.0–63.1)	1.00×10^{-14}
				Combined	30 (23.4)	93 (72.7)	5 (3.9)	166 (89.2)	20 (10.8)	0 (0.0)	125 (89.3)	15 (10.7)	0 (0.0)	27.1 (14.6–50.3)	2.68×10^{-32}	27.2 (13.9–53.4)	1.11×10^{-27}

[a]NVR, null virologic response; VR, virologic response; SVR, sustained virologic response. The 186 VRs consisted of 46 transient virologic response (TVRs) and 140 SVRs. [b]Minor allele frequency and minor allele in 184 healthy Japanese individuals[15]. The MAF of the SNPs in SVR is similar to that of TVR group, whereas that of NVR is much higher (76.6%). [c]Odds ratio for the minor allele in a dominant model. [d]*P* value by χ^2 test for the minor allele dominant model.

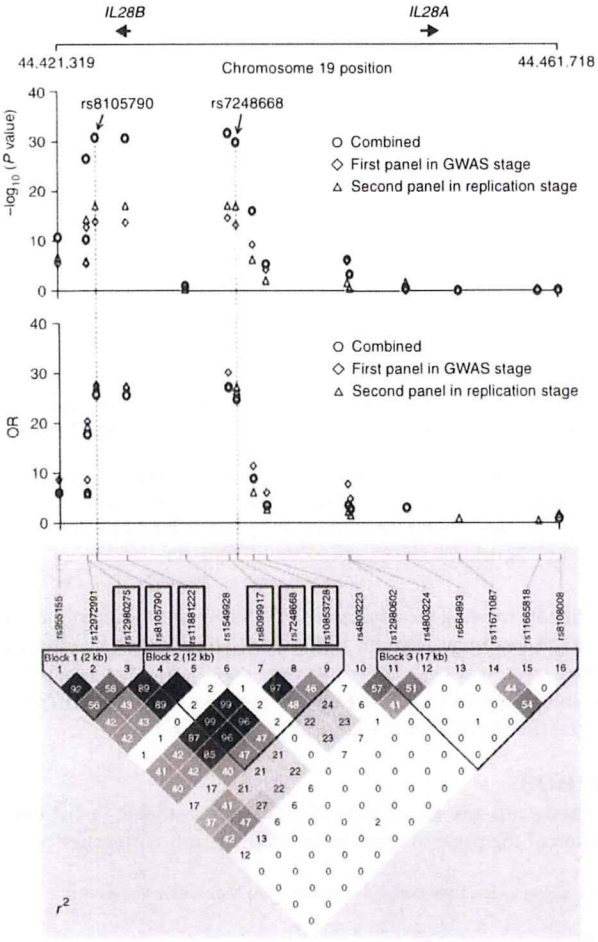

Figure 2 Genomic structure, *P* value and OR plots in association analysis and LD map around *IL28B* and *IL28A* (chr.19, nucleotide positions 44421319–44461718; build 35). *P* values by the χ^2 test for minor allele dominant effect model are shown for the first panel of 142 samples in the GWAS stage, the second panel of 172 samples in the replication stage, and the combined analysis. Below are estimates of pairwise r^2 for 16 SNPs selected in the replication study using a total of 314 Japanese patients with HCV treated with PEG-IFN-α/RBV. Boxes indicate the significantly associated SNPs with response to PEG-IFN-α/RBV treatment both in the GWAS stage and in the replication stage. Dotted lines indicate the region with the strongest associations from the positions of rs8105790 to rs7248668.

We analyzed the region of ~40 kb (chr. 19, nucleotide positions 44421319–44461718; build 35) containing the significantly associated SNPs (rs12980275 and rs8099917) using Haploview software for linkage disequilibrium (LD) and haplotype structure based on the HapMap data for individuals of Japanese ancestry. The LD blocks were analyzed using the four-gamete rule, and four blocks were observed (**Supplementary Fig. 3**). We selected 16 SNPs for both replication study and high-density association mapping, including tagging SNPs estimated on the basis of the haplotype blocks, one SNP located within *IL28B* (rs11881222) and the significantly associated SNPs from the GWAS stage (rs12980275 and rs8099917) (**Supplementary Table 1**).

To validate the results of the GWAS stage, 16 SNPs selected for the replication stage, including the original SNPs, were genotyped using the DigiTag2 assay in an independent set of 172 Japanese patients with HCV treated with PEG-IFN-α/RBV treatment (50 NVR and 122 VR samples), together with the first panel of 142 samples analyzed in the GWAS stage (**Supplementary Table 1**). The associations of the original SNPs were replicated in the replication cohort of 172 patients ($P = 5.46 \times 10^{-15}$, OR = 19.2 for rs12980275; $P = 9.47 \times 10^{-18}$, OR = 27.4 for rs8099917; **Table 1**). The combined *P* values for both stages reached 2.84×10^{-27} (OR = 17.7; 95% CI = 10.0–31.3) and 2.68×10^{-32} (OR = 27.1; 95% CI = 14.6–50.3), respectively (**Table 1**). Notably, when we compared the SVR ($n = 140$) with the NVR group ($n = 128$), the original two SNPs (rs12980275 and rs8099917) again showed strong associations: both *P* values and ORs were similar to those observed in the comparison between VR and NVR, and the combined *P* values for both stages reached 3.99×10^{-24} (OR = 18.5; 95% CI = 10.0–34.4) and 1.11×10^{-27} (OR = 27.2; 95% CI = 13.9–53.4), respectively (**Table 1**). Comparing SVR ($n = 140$) versus NVR plus TVR ($n = 174$), we again found that these SNPs were significantly associated ($P = 1.71 \times 10^{-16}$, OR = 8.8; 95% CI 5.1–15.4 for rs12980275; $P = 1.18 \times 10^{-18}$, OR = 12.1; 95% CI 6.5–22.4 for rs8099917, **Supplementary Table 2**), suggesting that these SNPs would predict NVR as well as SVR before PEG-IFN-α/RBV therapy.

Among the newly analyzed SNPs in the replication study, six (rs12980275, rs8105790, rs11881222, rs8099917, rs7248668 and rs10853728) showed significant associations both in the GWAS stage ($P < 8.05 \times 10^{-8}$) and in the replication stage ($P < 0.0031$ (0.05/16)) after Bonferroni correction. These SNPs are located within a 15.7-kb region that includes *IL28B* (**Fig. 2** and **Supplementary Table 1**). In particular, the strongest associations with NVR were observed for four SNPs, rs8105790, rs11881222, rs8099917 and rs7248668, that are located in the downstream flanking region, the third intron and the upstream flanking region of *IL28B*. The combined *P* values for these polymorphisms were 1.98×10^{-31} (OR = 25.7; 95% CI = 13.9–47.6), 2.84×10^{-31} (OR = 25.6; 95% CI = 13.8–47.3), 2.68×10^{-32} (OR = 27.1; 95% CI = 14.6–50.3) and 1.84×10^{-30} (OR = 24.7; 95% CI = 13.3–45.8), respectively (**Supplementary Table 1**). We then sequenced this region to identify further variants and found three SNPs (rs8103142, rs28416813 and rs4803219) located in the third exon, the first intron and the upstream flanking region of *IL28B*, and a few infrequent variations. These SNPs also showed strong associations in the combined dataset of 128 NVR and 186 VR samples ($P = 1.40 \times 10^{-29}$, OR = 26.6 for rs8103142; $P = 5.52 \times 10^{-28}$, OR = 22.3 for rs28416813; $P = 2.45 \times 10^{-29}$, OR = 23.3 for rs4803219; **Supplementary Table 3**). We also performed LD and haplotype analyses with seven SNPs. These SNPs were in strong LD, and the risk haplotype showed a level of association similar to those of individual SNPs ($P = 1.35 \times 10^{-25}$, OR = 11.1; 95% CI = 6.6–18.6) (**Table 2**). These results suggest that the association with NVR was primarily driven by one of these SNPs.

Table 2 Association analysis of response to treatment by *IL28B* haplotype

SNP							Frequencies			
rs8105790	rs11881222	rs8103142	rs28416813	rs4803219	rs8099917	rs7248668	NVR group	VR group	*P* value	OR (95% CI)
T	**A**	**T**	C	C	T	G	0.543	0.942	1.81×10^{-32}	0.1 (0.04–0.12)
C	**G**	**C**	G	T	G	A	0.387	0.054	1.35×10^{-25}	11.1 (6.6–18.6)

Association analysis of haplotypes consisting of seven SNPs with response to PEG-IFN-α/RBV treatment in 314 Japanese patients with HCV. Boldface letters: rs11881222 (third intron); rs8103142 (third exon).

Table 3 Factors associated with NVR by logistic regression model

Factors	Odds ratio	95% CI	*P* value
rs8099917 (G allele)	37.68	16.71–83.85	<0.0001
Age	1.02	0.98–1.07	0.292
Gender (Female)	3.32	1.49–7.39	0.003
Re-treatment[a]	1.12	0.55–2.33	0.750
Platelet count	0.93	0.87–1.01	0.080
Aminotransferase level	1.00	0.99–1.00	0.735
Fibrosis stage[20]	1.10	0.73–1.66	0.658
HCV-RNA level	1.01	0.99–1.02	0.139

[a]Re-treatment, non-response to previous treatment with interferon-α (plus RBV).

To examine the relative contribution of factors associated with NVR, we used a logistic regression model. One tagging SNP located within *IL28B* (minor allele of rs8099917) was the most significant factor for predicting NVR, followed by gender (**Table 3**). Clinically, viral factors such as HCV genotype and HCV RNA level are important for the outcome of PEG-IFN-α/RBV therapy. Indeed, mean HCV-RNA level was significantly lower in SVR (SVR versus TVR, $P = 0.002$; SVR versus NVR, $P = 0.016$; **Supplementary Table 4**). Mean platelet count and the proportion of mild fibrosis (F1–F2) were significantly higher in SVR than in NVR.

Real-time quantitative PCR assays in peripheral blood mononuclear cells revealed a significantly lower level of *IL28* mRNA expression in individuals with the minor alleles (**Fig. 3**), suggesting that variant(s) regulating *IL28* expression is associated with a response to PEG-IFN-α/RBV treatment. *IL28B* encodes a cytokine distantly related to type I (α and β) interferons and the interleukin (IL)-10 family. This gene and *IL28A* and *IL29* (encoding IL-28A and IL-29, respectively) are three closely related cytokine genes that encode proteins known as type III IFNs (IFN-λs) and that form a cytokine gene cluster at chromosomal region 19q13 (ref. 16). The three cytokines are induced by viral infection and have antiviral activity[16,17]. All three interact with a heterodimeric class II cytokine receptor that consists of IL-10 receptor beta (IL10Rβ) and IL-28 receptor alpha (IL28Rα, encoded by *IL28RA*)[16,17], and they may serve as an alternative to type I IFNs in providing immunity to viral infection.

Notably, a recent report showed that the strong antiviral activity evoked by treating mice with TLR3 or TLR9 agonists was significantly reduced in both $IL28RA^{-/-}$ and $IFNAR^{-/-}$ mice, indicating that IFN-λ is important in mediating antiviral protection by ligands for TLR3 and TRL9 (ref. 18). IFN-λ induced a steady increase in the expression of a subset of IFN-stimulated genes, whereas IFN-α induced the same genes with more rapid and transient kinetics[19]. Therefore, it is possible that IFN-λ induces a slower but more sustained response that is important for TLR-mediated antiviral protection. This might be one of the ways that a genetic variant regulating *IL28* expression influences the response to PEG-IFN-α/RBV treatment. Further research will be required to fully understand the specific mechanism by which a genotype might affect the response to treatment.

In conclusion, the strongest associations with NVR were observed for seven SNPs, rs8105790, rs11881222, rs8103142, rs28416813, rs4803219, rs8099917 and rs7248668, that are located in the downstream flanking region, the third intron, the third exon, the first intron and the upstream flanking region of *IL28B*. Further studies following our report of this robust genetic association to NVR may make it possible to develop a pre-treatment predictor of which individuals are likely to respond to PEG-IFN-α/RBV treatment. This would remove the need for the initial 12–24 weeks of treatment that is currently used as a basis for a clinical decision about whether treatment should be continued. That would allow better targeting of PEG-IFN-α/RBV treatment, avoiding the unpleasant side effects that commonly accompany the treatment where it is unlikely to be beneficial, and reduce overall treatment costs. Because of the small number of samples in this study, we plan to conduct a further prospective multicenter study to establish these SNPs as a clinically useful marker.

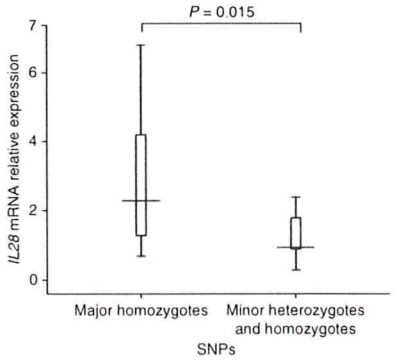

Figure 3 Quantification of *IL28* mRNA expression. The expression level of *IL28* genes was determined by real-time quantitative RT-PCR using RNA purified from peripheral blood mononuclear cells. Distribution of relative gene expression levels was compared between the individuals homozygous for major alleles ($n = 10$) and the heterozygous or homozygous individuals carrying minor alleles ($n = 10$) of rs8099917 by using the Mann-Whitney *U*-test. The bars indicate the median. All samples were obtained from HCV-infected patients before PEG-IFN-α/RBV therapy.

METHODS

Methods and any associated references are available in the online version of the paper at http://www.nature.com/naturegenetics/.

Note: Supplementary information is available on the Nature Genetics website.

ACKNOWLEDGMENTS

This study was supported by a grant-in-aid from the Ministry of Health, Labour, and Welfare of Japan (H19-kannen-013). This study is based on 15 multicenter hospitals throughout Japan, in the Hokkaido area (Hokkaido University Hospital), Kanto area (Saitama University Hospital; Konodai Hospital; Musashino Red Cross Hospital; Tokyo Medical and Dental University Hospital), Koshin area (Shinshu University Hospital; Kanazawa University Hospital), Tokai area (Nagoya City University Hospital), Kinki area (Kyoto Prefectural University of Medicine Hospital; National Hospital Organization Osaka National Hospital; Hyogo College of Medicine Hospital) and Chugoku/Shikoku area (Tottori University Hospital; Ehime University Hospital; Yamaguchi University Hospital; Kawasaki Medical College Hospital). We thank Y. Uehara-Shibata, Y. Ogasawara, Y. Ishibashi and M. Yamaoka-Sageshima (Tokyo University) for technical assistance; A. Matsumoto (Shinshu), K. Naiki (Saitama), K. Nishimura (Kyoto), H. Enomoto (Hyogo), K. Oyama (Tottori) and the Ochanomizu Liver Conference Study Group for collecting samples; M. Watanabe (Tokyo Medical and Dental University), S. Kaneko (Kanazawa University) and M. Onji (Ehime University) for their advice throughout the study; and H. Ito (Aichi Cancer Center) for conducting statistical analyses.

AUTHOR CONTRIBUTIONS

Study design and discussion: Y.T., N.N., N.M., K.T., M.M.; sample collection: Y.T., M.K., K.M., N.S., M.N., M.K., K.H., S.H., Y.I., E.M., E.T., S.M., Y.M., M.H., A.S., Y.H., S.N., I.S., M.I., K.I., K.Y., F.S., N.I.; genotyping: N.N.; statistical analysis: N.N., A.K., K.I.; quantitative RT-PCR: M.S.; manuscript writing: Y.T., N.N., K.T., M.M.

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