microplate. Thereafter, hybridization was detected by staining with the streptavidin-horseradish peroxidase (HRP) conjugate.[15]

Amplifying and sequencing the S region of HBV-DNA

The entire aa sequence of MHR in the S region was amplified by two-stage PCR using genotype-specific primers. The outer primers for the amplification of the first fragment were 5′-TTTCCACCAAGCTCTGCAA-3′ (sense: nt 9–28) and 5′-TTCAGGGAATAACCCCATCT-3′ (antisense: nt 872–853) for genotype A, 5′-CTCCA CCACTTTCCA GACT-3′ (sense: nt 1–22) and 5′-CAACTCCCAATTACATATCCC-3′ (antisense: nt 899–879) for genotype B and 5′-TTACAGGCGGGG TTTTTCTT-3′ (sense: nt 70–89) and 5′-TACAGACTT GGCCCCCAATA-3′ (antisense: nt 771–752) for genotype C. The inner primers were 5′-AGAGTCAGGGGCC TGTATTTT-3′ (sense: nt 35–55) and 5′-AGGGAATAA CCCCATCACTTT-3′ (antisense: nt 869–849) for genotype A, 5′-TTCAAGATCCCAGAGTCAGG-3′ (sense: nt 24–43) and 5′-AGGGAATATCCCCACCTTTTT-3′ (antisense: nt 869–849) for genotype B and 5′-CGGGGTT TTCTTGTTGACA-3′ (sense: nt 77–97) and 5′-CCCAAT ACCACATCATCCATA-3′ (antisense: nt 758–738) for genotype C.

The first stage of amplification was carried out in a thermal cycler for 40 cycles (94°C, 1 min; 55°C, 1 min; 72°C, 1 min) in 100 μL reaction mixture containing 200 mM dNTPs, 1.0 mM each of primers and PCR buffer (50 mM KCl, 10 mM Tris-HCl (pH 8.3), 1.5 mM $MgCl_2$ and 0.001% (wt/vol) gelatin) and 2 U Ampli-Taq polymerase (Perkin Elmer Cetus, Norwalk, CT, USA). PCR products (2 μL) were subjected to the second stage of amplification under the same conditions as those in the first stage. Standard precautions to avoid contamination were taken during PCR, with a negative control serum sample included in each run.

Amplification products were purified on Wizard PCR preps DNA purification resin (Promega, Madison, WI, USA), and sequenced bidirectionally with a Dye Terminator Cycle Sequencing Ready Reaction kit (PE Applied Biosystems, Foster City, CA, USA) using the above-mentioned PCR primers. Sequencing was performed in an automated DNA sequencer (ABI 377; PE Applied Biosystems).

The nucleotide sequences of HBV isolates from the patients were compared with those of three reference HBV strains which are used for vaccine production.[16–18]

Phylogenetic trees were constructed with the Mega Program version 2.1 (Center for Evolutionary Functional Genomics, The Biodesign Institute, Tempe, AZ, USA) using the Kimura two-parameter matrix and the neighbor-joining method.[19] To confirm the reliability of phylogenetic tree analysis, boot-strap resampling, and reconstruction were carried out 500 times.

Hydrophobicity and secondary structure analysis

The hydrophobicity profile of the MHR of the S region was predicted by computer-assisted Kyte-Doolittle analysis (an estimate of hydrophobicity based on the bulk phase partitioning of side chain hydrophobicity alone)[20] with GENETYX-MAC software (version 10.1; Software Development, Tokyo, Japan).

The secondary structures of the amino acids in the same region were predicted by computer-assisted Robson[21] and Chou-Fasman analyses[22] with the GENETYX-MAC software.

Statistical analyses

Data were analyzed by the chi-squared test for categorical data and Student's *t*-test or the Mann–Whitney *U*-test for continuous variables. *P*-values less than 0.05 were regarded as statistically significant.

RESULTS

Distribution and clinical characteristics of HBV genotypes

HEPATITIS B VIRUS genotype was determined in the 48 patients with acute hepatitis B. Genotype A was detected in 11 (23%) patients, genotype B in 11 (23%) and genotype C in 26 (54%).

The clinical and demographic backgrounds of the patients with acute hepatitis B who were infected with HBV of different genotypes are shown in Table 1. The mean ages of all the groups were similar. The proportion of male to female patients was higher in genotype A infection than in genotypes B or C infection (100%, 73% and 64%, respectively: A *vs* B, $P = 0.22$; A *vs* C, $P = 0.01$; B *vs* C, $P = 0.16$). The maximum alanine aminotransferase (ALT) levels were lower in patients with genotype A infection than in patients with genotypes B or C infection (1646 ± 1123, 3085 ± 1119 and 2545 ± 981 IU/L, respectively: A *vs* B, $P = 0.01$; A *vs* C, $P = 0.03$; B *vs* C, $P = 0.89$). The maximum HBV-DNA levels were not significantly different between the

Table 1 Demographic and clinical differences among patients with acute hepatitis infected with HBV of distinct genotypes

Features	Genotypes of HBV			Differences (*P*-value)		
	A ($n = 11$)	B ($n = 11$)	C ($n = 26$)	A *vs* B	A *vs* C	B *vs* C
Age (years)	30.6 ± 7.5	28.1 ± 5.1	31.1 ± 9.1	0.41	0.87	0.33
Gender (M:F)	11:0	8:3	15:11	0.22	0.01	0.16
ALT (IU/L)	1646 ± 1123	3085 ± 1119	2545 ± 981	0.01	0.03	0.89
HBV-DNA (LGE/mL)	6.8 ± 1.7	6.6 ± 2.1	5.2 ± 1.2	0.60	0.23	0.06

ALT, alanine aminotransferase; HBV, hepatitis B virus.

genotypes (6.8 ± 1.7, 6.6 ± 2.1 and 5.2 ± 1.2 LGE/mL, respectively: A *vs* B, $P = 0.60$; A *vs* C, $P = 0.23$; B *vs* C, $P = 0.06$).

Amino acid sequence of the S region

The aa sequence of the S region between aa27 and aa203 was determined in the 48 sequences. Figure 1 shows a phylogenetic tree constructed using the 48 sequences and 15 published sequences (four for genotype A, three for genotype B, three for genotype C, one for genotypes D, E, F, G and H). Among the 48 sequences we studied, 11 were classified into genotype A, 11 into genotype B and 26 into genotype C.

The aa sequence of the region between aa101 and aa163 including MHR (aa111-aa156) was compared among 48 sequences and three HBV sequences (X01587, J02205 and huGK-14) currently used for anti-HBV vaccine production. As shown in Figure 2, the aa sequences of X01587 (used for Bimmugen) and J02205 (used for Heptavax) differed in eight amino acids (i.e. aa110, aa113, aa114, aa126, aa131, aa143, aa160 and aa161). The aa sequence of huGK-14, which is used for the HBV-vaccine Meinyu, differed from that of X01587 in six amino acids and from that of J02205 in two amino acids.

Nine of the 11 isolates classified into genotype A had the same aa sequence as J02205. The remaining two isolates (AB289727 and AB289728) differed from J02205 at aa161 (Fig. 2).

Ten of the 11 isolates classified into genotype B had the same aa sequence as J02205 except for two amino acids (aa114 and aa131). The remaining isolate had another aa substitution at aa112 (Fig. 2).

As shown in Figure 2, 22 of the 26 isolates classified into genotype C had the same sequence as X01587. The remaining four isolates (from patients 10, 24, 30 and 48) had the same sequence as X01587 except for one aa substitution at aa131; the threonine (aa131) of X01587 was substituted with proline for three isolates (AB289714, AB289720 and AB289736) and with alanine for one isolate (AB289701).

Hydrophobicity and secondary structure analysis

As mentioned above, the aa sequences of the MHR from four isolates differed from that of X01587 only at aa131. Furthermore, the aa sequence of the MHR differed between X01587 and J2205 in eight amino acids. We compared the hydropathy and secondary structure of the MHR among J02205, X01587 and two isolates with genotype C (one isolate with proline at aa131 and one with alanine at aa131). The results of Kyte-Doolittle hydropathy analysis based on the hydropathy index are shown in Figure 3. The substitution with alanine-131 was found to alter the patterns on the hydropathy plot, whereas the substitution with proline-131 was found to have little effect. A substitution with alanine-131 could increase the hydrophobicity of the first loop of the MHR, which may affect the antigenicity of HBV

The secondary structure of our isolate with alanine-131 by Chou-Fasman analysis predicted an α-helix configuration for the region from aa126 to aa135 instead of the β-configuration predicted for the same region of X01587. The predicted secondary structure of our isolate with proline-131 coincided with that of X01587. In contrast, by Robson prediction, the secondary structure of our isolate with alanine-131 coincided with that of X01587; however, that of our isolate with proline-131 was found to have lost a turn structure between aa131 and aa134, which was predicted for X01587.

DISCUSSION

VACCINATION IS THE key to controlling HBV infection. In countries with a high prevalence of HBV infection, universal vaccination is effective not only for controlling viral infections but also for decreasing the incidence of hepatocellular carcinoma.[5,23] Even in

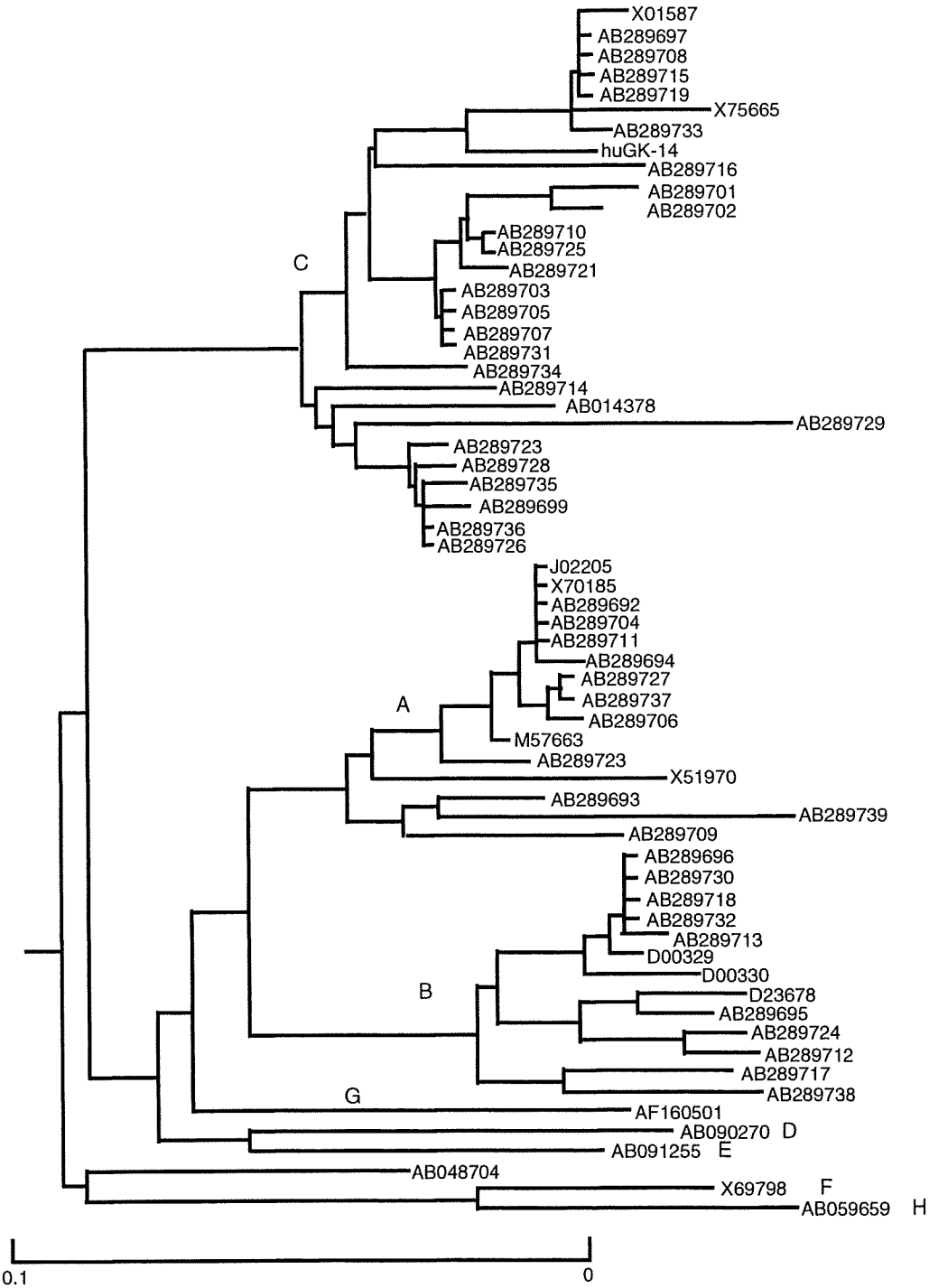

Figure 1 Phylogenetic tree constructed using hepatitis B virus (HBV)-DNA sequences of the *S* gene. The sequences include four with genotype A, four with genotype B, three with genotype C, and those recovered from the serum of 48 patients with acute hepatitis B. J02205 (genotype A) is used for the production of Heptavax and X01587 (genotype C) is used for the production of Bimmugen. The horizontal bar indicates the number of nucleotide substitutions per site. Accession numbers are shown for the isolates that have been deposited in the DDBJ/EMBL/GenBank databases. The accession numbers for the HBV sequences from the 48 patients are also shown.

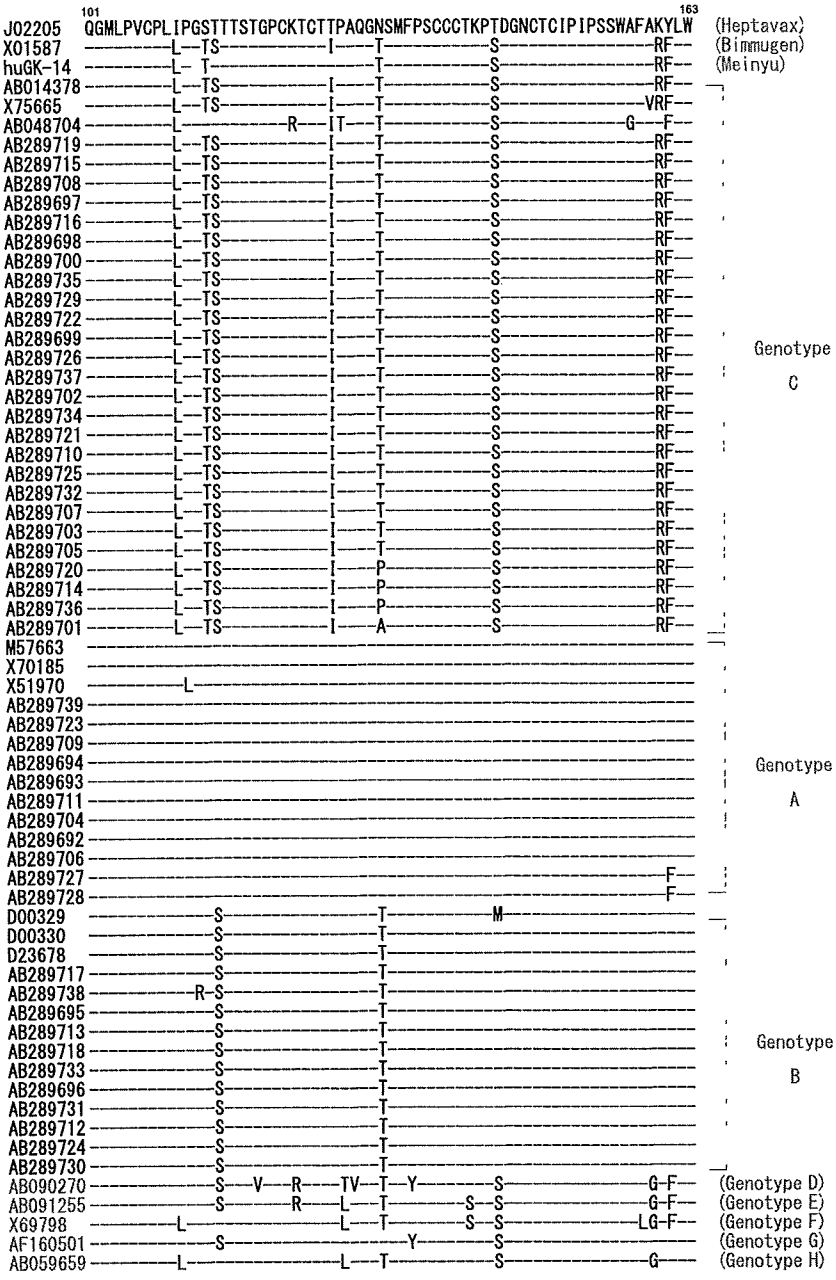

Figure 2 Comparison of amino acid sequences of the major hydrophilic region (MHR) of the *S* gene.

countries with a low prevalence of HBV infection, vaccination is very important for preventing mother-to-child transmission as well as patient-to-staff transmission.

HBV is classified into several genotypes that differ from one another in nucleotide sequence by more than 8% of the entire genome. The aa sequences of their phenotypes also differ among genotypes. The difference in the aa sequence of the 'a' determinant region may alter the three-dimensional structure and antigenicity, and may reduce the protectivity of HBV vaccines.

As mentioned above, the aa sequences of currently available recombinant vaccines differ from each other. J02205 and X01578 differ in eight amino acids (i.e. aa110, aa113, aa114, aa126, aa131, aa143, aa160 and aa161) between aa101 and aa163. Three (i.e. aa126, aa131 and aa143) of them are included in the MHR and may alter the hydropathy and three-dimensional

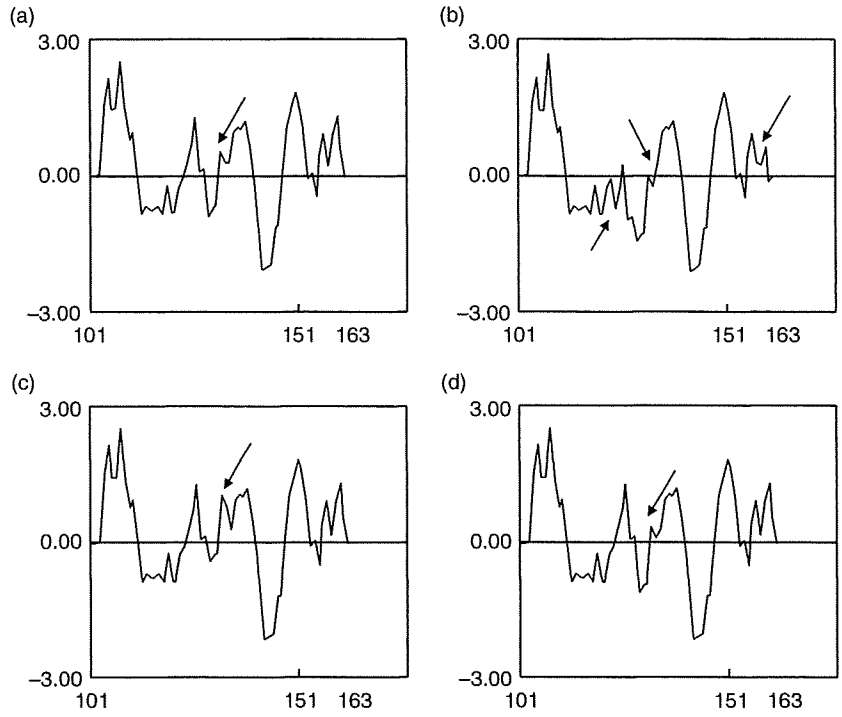

Figure 3 Hydropathy profile of the major hydrophilic region (MHR) of the *S* gene elaborated using the Kyte-Doolittle hydropathy index. Arrows show the positions of amino acids which are different among X01587, J02205, AB289701 (alanine-131) and AB289720 (proline-131). (a) X01587, (b) J02205, (c) AB289701 (alanine-131), (d) AB289720 (proline-131).

structure of the region. Therefore, the antibody produced against J02205 vaccines may not completely neutralize X01578 and vice versa. Indeed, previous studies showed that antibody profiles induced by recombinant vaccines produced from different genotypes are not identical with each other,[12] which suggests that antibodies produced by recombinant vaccines might not protect viral infection with different genotypes.

As shown in Figure 2, the aa sequences of our isolates classified into genotype A are very close to the aa sequence of J02205. Therefore, the transmission of genotype A HBV is prevented by Heptavax which is made from J02205.

The aa sequences of our isolates classified into genotype B are the same as the aa sequence of J02205 except for one substitution at aa131. This aa, which is asparagine and is located in the first stem loop structure of the MHR, was substituted with threonine in our genotype B isolates. Because asparagine and threonine have an uncharged side chain and similar polarity, genotype B HBV infection may be prevented effectively by Heptavax.

The aa sequences of our isolates classified into genotype C were the same as that of X01587 except for four isolates having a substitution at aa131. Bimmugen, which is produced from X01587, may be effective for preventing genotype C HBV infections caused by those four isolates. However, Heptavax may not be effective for preventing genotype C HBV infection because of the difference in eight amino acids as described above.

The four isolates have proline or alanine instead of threonine-131, which has never been reported before. The polarities of threonine and proline/alanine are quite different. The Kyte-Doolittle hydropathy analysis suggests that substituting threonine at aa131 with alanine or proline would increase hydrophobicity, which may then lead to a change in antigenicity. Hou *et al.* reported that some blood donors who were tested negative for serum HBsAg had a substitution of isoleucine for threonine at aa131 in the S region.[24] They suggested that the structure and antigenicity of HBV may be altered by this substitution.

The secondary structure of our isolate with alanine-131 predicted by Chou-Fasman analysis suggested an α-helix configuration instead of a β-configuration in the region from aa126 to aa135. The secondary structure of our isolate with proline-131 predicted by Robson analysis suggested that this change causes the loss of a turn structure between aa131 and aa134. Some changes in the secondary structure can affect the three-dimensional structure of the protein and thus affect antigenicity. These results suggest that the transmission of the four

isolates with an aa substitution at aa131 may not be prevented by either Heptavax or Bimmugen.

However, the protective immunity elicited by HBV vaccines, which is usually polyclonal in nature, may not be totally lost or severely affected *in vivo* by the alteration of only a single amino acid in the 'a' determinant region.[25] Also, antibodies against regions outside the 'a' determinant region may be protective.[26] The protectivity of current vaccines may be elucidated by *in vitro* binding studies using polyclonal antibodies.

It was reported that some individuals immunized with recombinant vaccines are infected with HBV with or without mutations in the 'a' determinant region.[11,27,28] HBV isolates with amino acid substitutions at aa144[29–31] or 145[11,27,28] are known to be transmitted despite vaccination. Indeed, some chronic HBV carriers are reported to have HBV with such amino acid substitutions.[32,33] We were unable to find patients who had these substitutions in the present study. However, large-scale studies are necessary to elucidate the prevalence of 'vaccine-escape mutants' in patients with acute hepatitis B.

In conclusion, we have shown that the aa sequence of the MHR in the *S* gene of HBV is different among isolates from patients with acute HBV infection. Current vaccination may prevent the transmission of these HBV isolates, which should be further investigated.

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research articles Journal of proteome research

A Proteomics Method Revealing Disease-Related Proteins in Livers of Hepatitis-Infected Mouse Model

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In this post-genome era, a sensitive quantitative method is required for differential profiling analyses of clinical proteomes to understand the disease progress. Here, we adopt the FD-LC−MS/MS method, consisting of fluorogenic derivatization (FD), separation by liquid chromatography (LC), and identification by LC-tandem mass spectrometry (MS/MS), to reveal disease-related proteins in livers of hepatocarcinogenesis in transgenic (Tg) and non-transgenic (NTg) mice at three developmental stages. After 6 months, the expression of apoptosis-related proteins is suppressed. After 12 months, proteins related to respiration, the electron-transfer system, and anti-oxidation are significantly up-regulated. After 16 months, proteins related to defense, β-oxidation, and apoptosis are significantly suppressed. This fluctuating expression of proteins could explain the progression of hepatocarcinogenesis. The method would be useful for clinical proteomics analysis because of its high resolution, sensitivity, and reproducibility.

Keywords: DAABD-Cl • FD-LC−MS/MS method • core protein • hepatitis C • liver protein • fluorogenic derivatization

Introduction

Recent work in clinical proteomics has involved quantitative and comparative studies of mixture composition and/or the relative abundance of proteins under differing physiologically relevant conditions and differing experimental approaches, commonly referred to as differential profiling. Numerous approaches have been employed for protein quantification, including a one- or two-dimensional gel electrophoretic and liquid chromatographic (LC) method, followed by mass spectrometry (MS).[1−4] Each of the technical approaches has advantages and limitations. For example, gel-based methods are based on the densitometric quantification of proteins visualized using dyes on gel, followed by in-gel enzymatic digestion of the subject protein spots, with the resulting peptides then subjected to MS analysis. This approach has been widely practiced in proteomics studies because of its high resolution, which enables separating the protein isoforms and post-translational modifications. However, this method suffers from a lack of reproducibility, low sensitivity, low dynamic range, and difficulty in resolving proteins with extreme hydrophobicity or isoelectric points, among other issues.[2,3,5,6] In recent years, the introduction of differential gel electrophoresis (DIGE) using fluorescence reagents such as CyDye DIGE Fluor minimal dye[6−8] and saturation dye[9,10] has somewhat improved the reproducibility, sensitivity, and dynamic range.

LC-based methods offer flexibility of choice over a wide range of stationary and mobile phases to resolve complex biological samples at the protein or peptide level. In these methods, proteins are usually digested into peptides prior to separation by separation columns. The advantage of this approach is that the resolved peptides from the column can be directly introduced into an MS system. To obtain high sensitivity and quantification, the stable-isotope labeling reagents, that is, the isotope-coded affinity tag (ICAT),[11] the cleavable ICAT (cICAT),[3,12,13] and isobaric tags for relative and absolute quantitation (iTRAQ),[3,14] were developed and have gained in popularity. However, a major disadvantage of these strategies is that the obtained peptides cannot be correctly identified as any given protein. Moreover, low-abundance peptides are masked by high-abundance peptides with similar m/z ratios. Thus, for highly complex samples, such as tissue homogenates, these methods are not suitable for the quantification of specific low-abundance proteins unless extensive purification is employed before analysis.[2−4,12,13]

We recently reported a method for proteomics studies called the FD-LC−MS/MS method.[15−18] This method involves fluorogenic derivatization (FD) of proteins using fluorogenic reagents such as 7-chloro-*N*-[2-(dimethylamino)ethyl]-2,1,3-benzoxadiazole-4-sulfonamide (DAABD-Cl), followed by HPLC separation of the derivatized proteins, isolation of the subject proteins, enzymatic digestion of the isolated proteins, and identification of the proteins utilizing HPLC and tandem MS with a database-searching algorithm. The FD-LC−MS/MS method has unique features, differing from other proteome approaches in using a fluorogenic reagent to derivatize proteins

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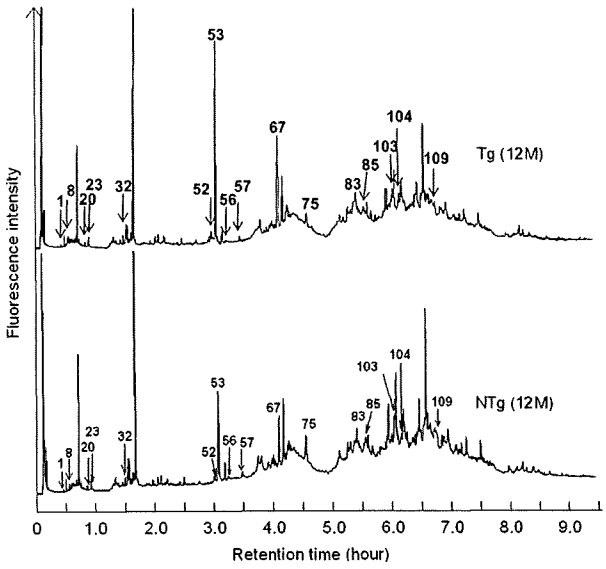

Figure 1. Chromatograms of proteins (8.0 μg protein) in mouse liver derivatized with DAABD-Cl. The chromatograms above and below were obtained from transgenic (12 months) and non-transgenic (12 months) mice, respectively. The altered peaks (106 proteins) between transgenic and non-transgenic mice were numbered, and as representatives, significantly altered peaks (15 proteins) and a peak (no. 53 for accuracy measurement) are described.

and HPLC to separate the derivatized proteins. The fluorogenic reagent is highly reactive and selective to thiols, is nonfluorescent itself, and is water-soluble, so there are few limitations to the complete derivatization of cysteine residues of proteins. The proposed method enables highly sensitive detection of derivatized proteins at the femtomol level,[17,18] whereas other derivatized reagents, such as CyDye DIGE Fluoro minimal dye, would have difficulty forcing the labeling reaction into saturation.[7,8] Separation by HPLC led to highly reproducible quantification. In addition, a protein can be isolated and identified from the corresponding peak fraction without losing any amino acid sequence information, including protein isoforms and post-translational modifications, because the isolated protein itself is digested into peptides following isolation by HPLC. Although this method has already identified more than 100 proteins in a soluble extract of *Caenorhabditis elegans*[15-17] and has identified altered proteins in the islet of Langerhans in dexamethazone-treated rats,[18] there have been no studies involving clinical proteomics analysis utilizing DAABD-Cl as a fluorogenic reagent. Therefore, we attempted to apply it to the quantification and differential profiling analysis of liver proteins taken from hepatitis C virus (HCV) core gene transgenic (Tg) and non-transgenic (NTg) as a model. HCV is the main cause of chronic hepatitis. Chronic hepatitis ultimately results in the progression of hepatocellular carcinoma (HCC). However, the mechanism of hepatocarcinogenesis associated with HCV infection is still unclear. K. Moriya et al. have suggested that the HCV core protein plays a critical role in the progression of HCC and that transgenic mice provide a good animal model for determining the molecular and pathological events in hepatocarcinogenesis with HCV infection.[19-22] Such mice have been investigated previously in terms of morphological and biochemical changes in HCV infection, so far. Therefore, this study investigated the long-term consequences of HCV core gene expression from the viewpoint of proteomics and evaluated the proposed method as the quantification and differential profiling analysis.

Materials and Methods

Transgenic Mice. The production of HCV core gene transgenic mice has been described.[19] Because HCC develops preferentially in male transgenic mice, male mice were used for analysis. Male non-transgenic littermates were utilized as controls. At least three mice were used in each experiment, with the data then subjected to statistical analysis. In the previous studies,[19,20] these transgenic mice developed hepatic steatosis, one of the characteristic histological features of chronic hepatic C, as early as 3 months of age. As the mice grew to 12 months of age, steatosis slowly progressed without neoplastic change. At the age of 16 months, one-fourth of the male mice had experienced hepatic tumors. Moreover, older transgenic mice (>12 months of age) morphologically exhibited an age-dependent increase in oxidative stress. Therefore, in this study, the transgenic and non-transgenic mice used were aged 6, 12, and 16 months, representing the early, medium, and late stages of hepatocarcinogenesis. Also, to exclude the influence of protein variations with advancing age, the amount of protein change due to HCV infection was calculated based on the Tg-to-NTg (Tg/NTg) ratio. All studies were performed according to the Helsinki Declaration and have passed our institutional review board.

Preparation of Sample and Determination of Total Proteins. Liver samples (100 mg) were homogenized in 500 μL of 10 mM CHAPS aq with a pestle on ice. The homogenate was centrifuged at 20 400*g* for 15 min at 4 °C. The supernatant was then collected and stored as a soluble fraction at −20 °C until use. The liver total proteins were determined with the Quick Start Bradford Protein assay kit (Bio-Rad Laboratories, Inc.) by following the written instructions. Bovine serum albumin was used as a protein standard.

FD and HPLC Conditions. The previous method[16] was used for the FD procedure for liver proteins with DAABD-Cl, except that the borate buffer was replaced with a pH 8.7 buffer solution (6.0 M guanidine hydrochloride, Tokyo Chemical Industry). Briefly, homogenized liver tissue was diluted with the CHAPS aq to 4.0 mg/mL, and 10 μL of the sample was mixed with 60 μL of a mixture of 0.83 mM Tris (2-carboxyethyl) phosphine hydrochloride (TCEP), ethylenediamine-*N,N,N′,N′*-tetraacetic acid sodium salt (Na_2EDTA), and 16.6 mM CHAPS in the pH 8.7 buffer solution; 25 μL of the buffer solution; and 5.0 μL of 140 mM DAABD-Cl in acetonitrile. After the reaction mixture was placed in a 40 °C water bath for 10 min, 3.0 μL of 20% trifluoroacetic acid (TFA) was added to stop the derivatization reaction. Twenty microliters of the reaction mixture (8.0 μg proteins) was injected into the HPLC system at a flow rate of 0.55 mL/min. The overall system consisted of a Hitachi L-7000 series HPLC system and a fluorescence detector (Jasco FP-2025 plus; λex. 395 nm; λem, 505 nm). Since the derivatives offer adaptable selectivity for the stationary phase, a protein column (Intrada WP-RP, 250 × 4.6 mm i.d., Imtakt Co.) with a column temperature of 60 °C was adopted to further improve the column separation. The mobile phases consisted of 0.15% TFA in acetonitrile/isopropanol/water (A) 9.0/1.0/90 and (B) 69/1.0/30. Mobile phase (C) was the same as (A), except with 0.20% TFA. The gradient condition was established with the following elution: 5.0% B and 1.0% C held for 5.0 min; to 30% B and 35% C in 30 min, and then held for 35 min; to 35% B and 35%

Table 1. Altered Proteins between Tg and NTg Mouse Livers for 6 Months[a]

peak number	Tg/NTg ratio	protein name	molecular mass (Da)	GI number[b]
		Down-Regulated		
		marker		
54	0.55	Major urinary protein (MUP)	20680	gi|295910
56	0.64*	MUP	17549	gi|53271
58	0.58	MUP	17549	gi|53271
55	0.63	Glial fibrillary acidic protein	46498	gi|14193690
		respiration		
52	0.52*	α-globin	15076	gi|49901
		electron-transfer system		
57	0.64	ATP synthase, H+ transporting, mitochondrial F0 complex, subunit d	18752	gi|16741459
		apoptosis		
1	0.54*	Eukaryotic translation elongation factor 1 α 1 (EF-1 α 1)	50140	gi|13278382
		glycolytic system		
77	0.74	PREDICTED: similar to Glyceraldehyde-3-phosphate dehydrogenase (GAPDH)	35789	gi|51768209
		other		
34	0.62	ND***		
		Up-Regulated		
		respiration		
27	1.28	α-globin	15076	gi|49900
29	1.28	α-globin	15076	gi|49900
37	1.35	α-globin	15076	gi|49900
		defense		
44	1.14	Cu/Zn-superoxide dismutase (SOD)	15955	gi|201006
75	1.69	Glycine *N*-methyltransferase	32712	gi|15679953
78	1.22	Aldo-keto reductase family 1, member C6	37024	gi|13487925
79	1.32	Glutathione S-transferase, mu 1	25953	gi|61402231
95	1.29	Glutathione S-transferase, α 3	25344	gi|31981724
		fatty acid metabolism (containing β-oxidation)		
35	1.43	Fatty acid-binding protein, hepatic (fragment)	10173	gi|90485
36	1.24	Fatty acid-binding protein, hepatic (fragment)	10173	gi|90485
42	1.37	Fatty acid-binding protein, hepatic (fragment)	10173	gi|90485
82	1.31	Acetyl-Coenzyme A acyltransferase 2 (mitochondrial 3-oxoacyl-Coenzyme A thiolase)	41831	gi|20810027
		apoptosis		
3	2.21	EF-1α1	50140	gi|13278382
		glycolytic system		
61	1.40	Fructose-bisphosphate aldolase B	39548	gi|15723269
99	1.36	Enolase 1, α non-neuron	47095	gi|12963491
		metabolism		
68	1.37	Carbonic anhydrase 3	29348	gi|31982861
		other		
26	1.41	Unnamed protein product	58587	gi|12852157
33	1.40	Unnamed protein product	57807, 58587, 57007, 52653	gi|12852157, gi|26345440, gi|2634914, gi|26349459
112	1.42	put. β-Actin (aa 27–375)	39161	gi|49868

[a] Peak numbers correspond to those in Figure 1. Asterisks indicate significant differences (two-tailed Student's *t* test, $*P \leq 0.05$, $** P \leq 0.01$). ***ND, not detected. [b] GI number is simply a series of digits that are assigned consecutively to each sequence record processed by NCBI. The GI system of sequence identifiers runs parallel to the accession.version system, which was implemented by GenBank, EMBL, and DDBJ in February 1999. Therefore, if the protein sequence changes in any way, it will receive a new GI number. (http://www.ncbi.nlm.nih.gov/Sitemap/samplerecord.html#ProteinIDB).

C in 70 min, then to 38% B and 35% C in 130 min; to 44% B and 55% C in 250 min, and then held for 50 min; to 47% B and 53% C in 330 min; to 60% B and 40% C in 480 min; to 70% B and 30% C in 520 min; and then to 90% B and 10% C in 570 min.

Because of the differential profiling of proteins in transgenic and non-transgenic mice, the corresponding peak heights in the different elution profiles were compared for each month age. The correspondence of the peak was judged not only from the specific retention time of the derivatives, but also confirmation of the protein following isolation and identification of the derivatives. The Tg/NTg ratio was also compared between three developmental stages to investigate the consequences of HCV core gene expression during the progression of hepatocarcinogenesis.

Identification of Derivatized Proteins. Each eluate of the subject proteins was concentrated to 5.0 μL under reduced pressure. The residue was diluted with 50 μL of 50 mM ammonium bicarbonate solution (pH 7.8) containing 0.50 U trypsin and 10 mM calcium chloride, and the resultant mixture was incubated for 2.0 h at 37 °C. The peptide mixture (20 μL) was directly subjected to a nanoLC–ESI-tandem MS spectrometer (HCT plus, Bruker Daltonics). Chromatography was performed using an Ultimate/Famos/Switchos suite of instruments (LC Packings, Dionex). The sample was loaded onto a nanoprecolumn (300 μm i.d. × 1.0 mm, C18 PepMap) in the

Table 2. Altered Proteins between Tg and NTg Mouse Livers for 12 Months[a]

peak number	Tg/NTg ratio	protein name	molecular mass (Da)	GI number[b]
		Down-Regulated		
		respiration		
29	0.64	α-globin	15076	gi|49900
		defense		
75	0.56	Glycine *N*-methyltransferase	32712	gi|15679953
76	0.72	Glutathione *S*-transferase, mu 1	25953	gi|61402231
91	0.79	Methionine adenosyltransferase I, α	43481	gi|19526790
		fatty acid metabolism (containing β-oxidation)		
36	0.74	Fatty acid-binding protein, hepatic	10173	gi|90485
40	0.80	Fatty acid-binding protein, hepatic	10173	gi|90485
102	0.77	Peroxisomal acyl-CoA oxidase	74608	gi|2253380
		metabolism		
68	0.75	Carbonic anhydrase 3	29348	gi|31982861
105	0.80	Aldehyde dehydrogenase family 1, subfamily A1	54447	gi|7304881
		amino acid synthesis		
80	0.61	4-Hydroxyphenylpyruvate dioxygenase	45054	gi|849053
		other		
106	0.68	Heat-responsive protein	18462	gi|1255116
		Up-Regulated		
		marker		
55	1.52	Glial fibrillary acidic protein	46498	gi|14193690
56	1.23	MUP	17549	gi|53271
58	1.68	MUP	17549	gi|53271
70	1.51	α-Fetoprotein	47195	gi|191765
		respiration		
4	2.50	Hemoglobin, β adult major chain	15738	gi|31982300
66	1.45	Hemoglobin, β adult major chain	15738	gi|31982300
67	1.98*	Hemoglobin β	15653	gi|229301
27	2.27	α-globin	15076	gi|49900
28	2.43	α-globin	15076	gi|49900
30	1.70	α-globin	15076	gi|49901
31	1.64	α-globin	15076	gi|49900
51	2.12	α-globin	15076	gi|49900
53	2.05	α-globin	15076	gi|49902
		electron-transfer system		
20	1.85*	ATP synthase, H+ transporting, mitochondrial F1 complex, epsilon subunit	5834	gi|13385484
57	1.56*	ATP synthase, H+ transporting, mitochondrial F0 complex, subunit d	18752	gi|16741459
		protein synthesis		
10	2.43	Ribosomal protein L28	15700	gi|56541228
46	2.33	Ribosomal protein S16	16319	gi|70920
		defense		
9	1.80	SOD	15955	gi|201006
11	2.28	SOD	15752	gi|226471
15	1.24	SOD	15955	gi|201006
18	1.96	SOD	15955	gi|201006
44	1.85	SOD	15955	gi|201006
12	1.42	60S Ribosomal protein	24692	gi|899445
43	1.31	Thioredoxin 1	11668	gi|6755911
50	1.99	Chain C, Crystal Structure Of Macrophage Migration Inhibitory Factor	12365	gi|5542287
69	1.60	D-Dopachrome tautomerase	13069	gi|6753618
71	2.24	Albumin 1	68648	gi|19353306
73	2.11	Albumin 1	68648	gi|19353306
89	1.63	Albumin 1	68648	gi|19353306
83	1.47**	Betaine-homocysteine methyltransferase (BHMT)	44992	gi|62533211
90	2.17	Methionine adenosyltransferase I, α	43481	gi|19526790
100	1.25	Glycine *N*-methyltransferase	32712	gi|15679953
		fatty acid metabolism (containing β-oxidation)		
7	1.95	3-Ketoacyl-CoA thiolase B	43968	gi|18043769
35	1.27	Fatty acid-binding protein, hepatic - (fragment)	10173	gi|90485
41	1.28	Fatty acid-binding protein, hepatic - (fragment)	10173	gi|90485
82	1.32	Acetyl-Coenzyme A acyltransferase 2 (mitochondrial 3-oxoacyl-Coenzyme A thiolase)	41831	gi|20810027
		apoptosis		
1	2.86	EF-1α1	50139	gi|13278381
2	2.79	EF-1α1	50140	gi|13278382
3	1.64	EF-1α1	50140	gi|13278382
8	2.02	Ribosomal protein S29, isoform 1	6672	gi|22267962
24	2.06	Ribosomal protein L14	23549	gi|13385472

Table 2. (Continued)

peak number	Tg/NTg ratio	protein name	molecular mass (Da)	GI number[b]
		glycolytic system		
59	2.96	Fructose-bisphosphate aldolase B	39548	gi|15723268
62	1.21	Fructose-bisphosphate aldolase B	39548	gi|15723268
77	1.39	PREDICTED: similar to GAPDH	35789	gi|51768209
112	1.64	Lactate dehydrogenase 1, A chain	36475	gi|6754524
		metabolism		
21	1.79	TI-225	14167	gi|1167510
22	2.02	TI-225	14167	gi|1167510
32	2.02	Cystatin B	11039	gi|6681071
72	3.23	Carbonic anhydrase 3	29348	gi|31982861
104	1.83*	Acetaldehyde dehydrogenase (ALDH)	54410	gi|9755362
110	1.82	Aldh2 protein	56502	gi|13529509
115	1.90	Malate dehydrogenase (EC 1.1.1.37)	31692	gi|164543
116	2.10	Argininosuccinate lyase	51707	gi|19526986
		signal transduction		
47	1.70	Phosphatidylethanolamine binding protein	20847	gi|9256572
		amino acid synthesis		
74	2.21	Glycine-*N*-acyltransferase	34076	gi|22122359
		other		
5	2.02	ND***		
6	1.99	ND***		
118	1.97	ND***		
19	3.56	γ-actin	40992	gi|809561
23	1.40*	Diazepam binding inhibitor, splice form 1b	15219	gi|67511482
39	2.80	Saposin	61353	gi|249387
45	2.13	Unnamed protein product	58587, 57007, 52653, 49471	gi|12852157, gi|26345440, gi|26349141, gi|26349459,
49	1.42	Peptidylprolyl isomerase A	17960	gi|71051228
103	1.53*	Sorbitol dehydrogenase precursor	40066	gi|1009706
117	3.03	Unnamed protein product	57614	gi|52787

[a] Peak numbers correspond to those in Figure 1. Asterisks indicate significant differences (two-tailed Student's t test, $^*P \leq 0.05$, $^{**}P \leq 0.01$). ***ND, not detected. [b] GI number is simply a series of digits that are assigned consecutively to each sequence record processed by NCBI. The GI system of sequence identifiers runs parallel to the accession.version system, which was implemented by GenBank, EMBL, and DDBJ in February 1999. Therefore, if the protein sequence changes in any way, it will receive a new GI number. (http://www.ncbi.nlm.nih.gov/Sitemap/samplerecord.html#ProteinIDB).

injection loop, and washed using 0.10% TFA in 2.0% acetonitrile at 30 μL/min using the Switchos pump. Peptides were then separated on a nanoflow column (75 μm i.d. × 15 cm, C18 PepMap) at a flow rate of 170 μL/min, employing a gradient from 5.0% to 60% buffer B (0.10% formic acid in 80% acetonitrile) over a period of 35 min (A buffer: 0.10% formic acid in 2.0% acetonitrile). One-second MS/MS scans were performed on each precursor ion. Ions observed with m/z between 350 and 1250 were fragmented with capillary energies from 1300 to 1800 V. The proteins were identified in accord with the previous method.[15,17] There were several candidates with the same score for the unnamed protein products (peak numbers 33 and 45).

Statistical Analysis. Results are expressed as the mean ± SD. The significance of the difference in means was determined by a two-tailed Student's t test.

Results and Discussion

Validation of The FD-LC–MS/MS Method. With the FD-LC–MS/MS method, more than 500 peaks were obtained from an extract of mouse liver tissue derivatized with DAABD-Cl. Typical chromatograms derived from transgenic and non-transgenic mice are depicted in Figure 1. Only the proteins which expression was estimated to fluctuate between transgenic and non-transgenic mice on the same months were identified after isolation, tryptic digestion, and LC–MS/MS identification of arbitrarily selected peak fractions (113 proteins). As a result, 106 proteins differed between transgenic and non-transgenic mice from 6 to 16 months of age, as summarized in Tables 1–3. The total protein amount required for quantification and identification was only 8.0 μg per injection, and identification of even low-abundance proteins was possible with 40 μg of total protein per injection into an HPLC column. In general, proteome analysis of biological samples labeled with CyDye, ICAT, cICAT, or iTRAQ requires from dozens to hundreds of micrograms of protein samples.[3,7–10,11,13,14,28] The accuracy of the method was acquired based on the reproducibility of the peak heights using peaks 53, 83, and 32 as representatives of the high, medium, and low peaks obtained from each individual mouse. The relative standard deviation (RSD, %) for each between-day peak was less than 16 (high peak), 17 (medium peak), and 23% (low peak) (n = 3). The reproducibility of the retention time was also calculated using peak 32. The between-day RSD was 0.41% (n = 3). As an additional benefit, the simple apparatus, consisting of a pump, a column, and a fluorescence detector, does not require a complex facility for operation. In this study, we attempted a comprehensive profiling analysis of an 11-h operation to evaluate the utility of the method. After the elution time of a subject protein has been determined, it will be possible to reduce the analysis time for an arbitrary analysis of the subject protein by re-optimizing the separation conditions. It would also be possible to reduce the overall analysis time if we could develop a higher-performance column.

Table 3. Altered Proteins between Tg and NTg Mouse Livers for 16 Months[a]

peak number	Tg/NTg ratio	protein name	molecular mass (Da)	GI number[b]
		Down-Regulated		
		respiration		
4	0.41	Hemoglobin, β adult major chain	15738	gi|31982300
67	0.69	Hemoglobin β	15653	gi|229301
53	0.70	α-globin	15076	gi|49902
108	0.70	Quinnoid dihydropteridine reductase	25554	gi|21312520
		protein synthesis		
101	0.54	Regucalcin	33385	gi|6677739
		defense		
16	0.69	SOD	15955	gi|201006
65	0.64	Manganese superoxide dismutase	24662	gi|53450
40	0.53	Thioredoxin 1	11668	gi|6755911
63	0.72	Glutathione peroxidase (GSHPx-1) (Cellular glutathione peroxidase)	22268	gi|121666
75	0.49*	Glycine *N*-methyltransferase	32712	gi|15679953
79	0.61	Glutathione S-transferase, mu 1	25953	gi|61402231
83	0.69	BHMT	44992	gi|62533211
95	0.61	Glutathione *S*-transferase, α 3	25344	gi|31981724
97	0.51	Chain B, Glutathione *S*-Transferase Yfyf Cys 47-Carboxymethylated Class Pi, Free Enzyme	23350	gi|2624496
		fatty acid metabolism (containing β-oxidation)		
36	0.69	Fatty acid-binding protein, hepatic (fragment)	10173	gi|90485
82	0.58	Acetyl-Coenzyme A acyltransferase 2 (mitochondrial 3-oxoacyl-Coenzyme A thiolase)	41831	gi|20810027
107	0.70	Acetyl-Coenzyme A acyltransferase 1	43926	gi|18700004
85	0.32*	Hydroxyacyl-Coenzyme A dehydrogenase/3-ketoacyl-Coenzyme A thiolase/enoyl-Coenzyme A hydratase (trifunctional protein), β subunit (HADHB)	51353	gi|13542763
102	0.58	Peroxisomal acyl-CoA oxidase	74608	gi|2253380
		apoptosis		
3	0.69	Eukaryotic translation elongation factor 1 α 1	50140	gi|13278382
8	0.58*	Ribosomal protein S29, isoform 1	6672	gi|22267962
		glycolytic system		
61	0.79	Fructose-bisphosphate aldolase B	39548	gi|15723269
98	0.42	Enolase 1, α non-neuron	47095	gi|12963491
99	0.58	Enolase 1, α non-neuron	47095	gi|12963491
		metabolism		
32	0.46**	Cystatin B	11039	gi|6681071
68	0.80	Carbonic anhydrase 3	29348	gi|31982861
72	0.53	Carbonic anhydrase 3	29348	gi|31982861
109	0.30**	PREDICTED: Carbamoyl-phosphate synthetase 1 (CPS1)	165705	gi|51705066
84	0.50	Argininosuccinate synthetase	46555	gi|6996911
		signal transduction		
87	0.65	Electron transferring flavoprotein, α polypeptide	35018	gi|13097375
		amino acid synthesis		
80	0.39	4-Hydroxyphenylpyruvate dioxygenase	45054	gi|849053
		other		
38	0.54	Histidine triad nucleotide binding protein 1	13768	gi|33468857
49	0.71	Peptidylprolyl isomerase A	17960	gi|71051228
64	0.69	Nit protein 2	30483	gi|12963555
86	0.64	γ-actin	40992	gi|809561
96	0.50	Unknown (protein for IMAGE:6414729)	50209	gi|53734652
103	0.70	Sorbitol dehydrogenase precursor	40066	gi|1009706
106	0.68	Heat-responsive protein	18462	gi|1255116
48	0.59	Unnamed protein product	65586	gi|12859782
		Up-Regulated		
		respiration		
37	1.33	α-globin	15076	gi|49900
		fatty acid metabolism (containing β-oxidation)		
35	1.60	Fatty acid-binding protein, hepatic (fragment)	10173	gi|90485
		other		
17	1.30	ND***		
33	1.34	Unnamed protein product	57807, 58587, 57007, 52653	gi|12852157, gi|26345440, gi|2634914, gi|26349459

[a] Peak numbers correspond to those in Figure 1. Asterisks indicate significant differences (two-tailed Student's *t* test, *$P \leq 0.05$, **$P \leq 0.01$). ***ND, not detected. [b] GI number is simply a series of digits that are assigned consecutively to each sequence record processed by NCBI. The GI system of sequence identifiers runs parallel to the accession.version system, which was implemented by GenBank, EMBL, and DDBJ in February 1999. Therefore, if the protein sequence changes in any way, it will receive a new GI number. (http://www.ncbi.nlm.nih.gov/Sitemap/samplerecord.html#ProteinIDB).

Differential Profiling. Differential profiling analysis was performed using liver tissue from HCV core gene transgenic and non-transgenic mice as model samples to evaluate the feasibility of the FD-LC–MS/MS method for clinical proteomics. To investigate the differential expression of proteins in transgenic and non-transgenic mice, the heights of the peaks corresponding to specific retention times were compared for each month of age, with 106 altered proteins observed. The differentially expressed proteins were classified by age, regulation and function (see Tables 1–3). Tg/NTg ratios over 1.2 were defined as up-regulated, and those below 0.8 were defined as down-regulated. Many proteins were up- or down-regulated during the progression of HCV-associated liver disease. Fifteen proteins were significantly altered in their levels of protein contents (Figure 2). At the age of 6 months, there were fewer down-regulated proteins than up-regulated (9 vs 19 proteins). In contrast, many kinds of proteins were different between transgenic- and non-transgenic mice at 12 months, with 11 proteins being down-regulated and 65 being up-regulated. At 16 months, there were more down-regulated proteins than in any other months (39 proteins), but only a small minority (four) of proteins were up-regulated.

The remarkable decrease in major urinary protein (MUP) and eukaryotic translation elongation factor 1 α 1 (EF-1α1) seen in Figure 2a represents an early event in the progression of HCV-associated liver disease (at 6 months). MUP has been known as a negative tumor marker.[23] Suppression of EF-1α1 expression prevents the induction of apoptosis, with the regulation reflected in an antiapoptotic mode.[24] Although one of the α-globin peaks (peak no. 52) decreased significantly, the other three peaks of α-globin (peak nos. 27, 29, and 37) tended to increase (see Table 1). The expression of α-globin has been shown to be up-regulated in apoptotic stimuli.[25] Therefore, the phenomenon might be considered a trend in apoptosis at this stage. Another observation made at the age of 6 months was the up-regulation of enzymes related to β-oxidation.

At 12 months of age, proteins related to respiration, the electron-transfer system, and defense against reactive oxygen species (ROS) were significantly up-regulated (Figure 2b). Moreover, a majority of proteins involved in respiration, protein synthesis, defense, apoptosis, the glycolytic system, and metabolism were more up-regulated than the changes observed at 6 months (Table 2).

Finally, at 16 months, proteins related to defense, β-oxidation, and apoptosis significantly decreased. Cystatin B[26] and carbamoyl-phosphate synthetase 1 (CPS1)[27] are known to be down-regulated in tumor and/or carcinoma and exhibited a significant decrease with the proposed method (Figure 2c). It was also established that various biological functions such as respiration, protein synthesis, defense, and metabolism tended to decline (Table 3).

As a whole, the investigation of the differential expression of proteins in transgenic and non-transgenic mice revealed that many proteins related to biological functions such as respiration, protein synthesis, defense, β-oxidation, and apoptosis fluctuate during the progression of chronic hepatitis C. These changes may reflect a gross effect derived from the loss of liver function in the various stages of chronic hepatitis in HCV infection.

Additionally, these data support, from the viewpoint of proteomics, the former results obtained from morphological and biochemical observation.[19–21] For example, previous reports suggested that HCV core protein might affect a specific pathway in the lipid metabolism.[19,21] In fact, the core protein has a specific effect on lipid metabolism; fat droplets are formed and accumulate in the liver, leading to steatosis. An analysis of the composition of these lipid droplets determined that the concentration of carbon 18 monosaturated (C18:1) fatty acids, such as oleic and vaccenic acid, significantly increased in the livers of transgenic mice as well as in chronic hepatitis C patients.[21] In the present study, hydroxyacyl-Coenzyme A dehydrogenase/3-ketoacyl-Coenzyme A thiolase/enoyl-Coenzyme A hydratase (trifunctional protein) β subunit (HADHB), which catalyzes fatty-acid metabolism, significantly decreased after 16 months (Figure 2). However, at 12 months, other enzymes associated with β-oxidation tended to increase (Table 2: peak nos. 7 and 82). In addition, up-regulation of ATP synthase led to an increase in the synthesis and metabolism of fatty acid at 12 months (Figure 2). Furthermore, acetaldehyde dehydrogenase (ALDH), which catalyzes the acetaldehyde metabolism, tended to be up-regulated in the same month (Figure 2). The metabolic reactions of fatty acid and acetaldehyde generate $NADH_2^+$, and the overexpression then causes suppression of both metabolisms. Hence, these results suggest that the fatty-acid metabolism may become milder and resulted from the multiple protein changes related to β-oxidation, ATP synthase, and acetaldehyde metabolism with the progression of HCV-associated liver disease.

Previous reports also suggested that HCV core protein might alter the oxidant/antioxidant state in the liver.[20] The reports demonstrated that there is no significant difference in the levels of lipid peroxidation at 3 and 12 months of age, resulting in cellular and tissue damage by ROS. In contrast, after 16 months, the peroxidation and hydrogen peroxide levels increased remarkably and the levels of total and reduced glutathione, which plays an important role as an antioxidant, decreased. While, our results demonstrate that enzymes related to the antioxidant effect, such as betaine-homocysteine methyltransferase (BHMT) and Cu/Zn-superoxide dismutase (SOD), were up-regulated in transgenic mice at 12 months (Table 2: defense). Subsequently, up to 16 months, a decrease in BHMT and glycine *N*-methyltransferase related to the methylation cycle was observed (Figure 2). The decrease in these enzymes led to a deficiency of adenosylmethionine, impairing mitochondrial function and generating oxidative stress in the liver.[29,30] It has recently been shown that a chronic deficiency of adenosylmethionine in the liver results in the spontaneous progression of steatohepatitis and HCC.[31] In addition, the down-regulation of glycine *N*-methyltransferase would inhibit the synthesis of glutathione resulting in a shift to the oxidizing state, thereby reducing cell proliferation and increasing apoptosis.[32] Therefore, the observed expression of antioxidants might reflect direct oxidative stress status; although at 12 months the up-regulated antioxidants protected against oxidative stress, the oxidative stress might become dominant by the deficiency of antioxidants among the progression of liver disease. Also, these results, derived from both studies, strongly suggest that HCV core protein induces ROS in an age-dependent manner. After 16 months, a biochemical[20] and proteomic analysis revealed a lack of glutathione, suggesting that supplying glutathione might be more effective than SOD in the progression of HCC in the late stage. Although a further animal experiment should be required for reliable clarification of the hepatocarcinogenesis mechanism, the proposed method was demonstrated to be extremely

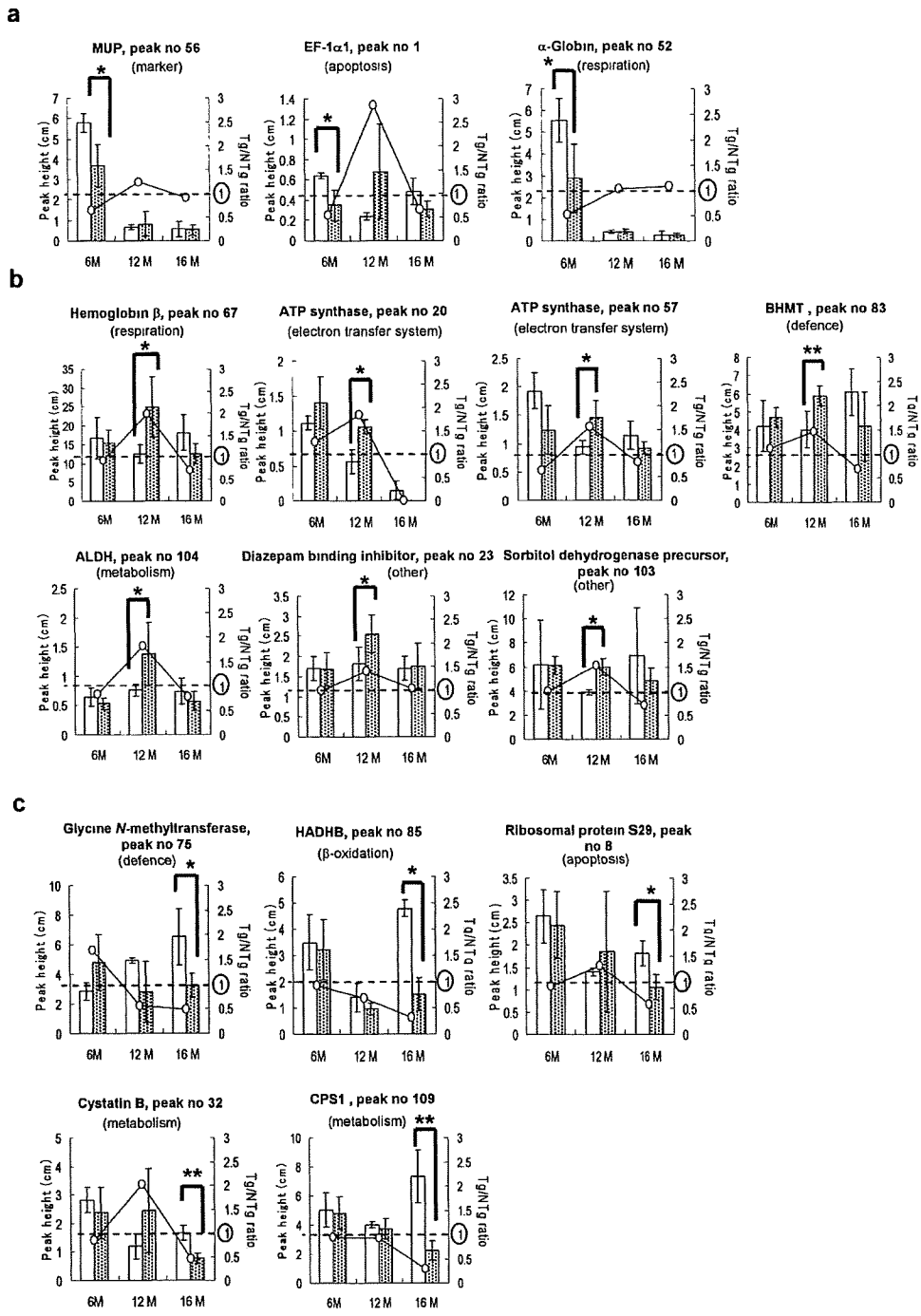

Figure 2. Comparison of peak heights between transgenic (Tg; gray bar) and non-transgenic (NTg; white bar) mice, and the Tg-to-NTg ratio (open circle) from 6 months (6M) to 16 months (16M). Significantly altered proteins are seen at 6M (a), 12M (b), and 16M (c). Peak numbers correspond to those in Figure 1. Mean values ± SD are plotted. Asterisks indicate significant differences (two-tailed Student's *t* test of all data points, $*P \leq 0.05$, $**P \leq 0.01$).

useful for understanding biotransformation from the viewpoint of proteomics. Also, the data obtained in this experiment could support the understanding of hepatocarcinogenesis with HCV infection in terms of proteomics in addition to the morphological and biochemical observations mentioned above.

Conclusions

The proposed method demonstrated for the first time the existence of several event-marker proteins at the three progression stages of hepatocarcinogenesis in transgenic mice. It should be stressed that the FD-LC–MS/MS method would also

be worthwhile for clinical proteomics analysis, as a supplement to gel- and LC-based methods.

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Review

Hepatitis C as a systemic disease: virus and host immunologic responses underlie hepatic and extrahepatic manifestations

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Key words: extrahepatic legion, HCV, immunoglobulin

Introduction

Hepatitis C virus (HCV) causes liver diseases. Approximately 2 million people in Japan and approximately 170 million people worldwide are infected with HCV, and they often suffer from chronic hepatitis, followed by hepatic cirrhosis, leading to hepatic cancer. It was determined relatively soon after the discovery of HCV that HCV infection does not involve the liver only. Other than hepatitis, many complicating diseases of the organs and tissues other than the liver, referred to as extrahepatic lesions, occur in association with HCV infection (Table 1). This review provides an overview of typical extrahepatic lesions associated with hepatitis C.

Cryoglobulinemia

Cryoglobulins are abnormal immunoglobulins that solidify into white deposits at 4°C and liquefy at 37°C.[1] The etiology of cryoglobulinemia in HCV infection has not yet been clarified. However, the involvement of apoptosis suppression by B lymphocytes, which produce monoclonal IgM, induced by the association of *bcl-2* and *IgJ(H)* as a result of the translocation of chromosome t(14:18), is suspected. Intrahepatic growth of CD5- and CD81-positive B lymphocytes has been observed, suggesting monoclonal IgM induction as a possible cause.[7]

Cryoglobulins are classified into three types, namely, monoclonal cryoglobulins (type I), polyclonal cryoglobulins (type III), and mixed cryoglobulins (type II). Cryoglobulinemia associated with HCV infection mainly involves the mixed type. More specifically, it involves monoclonal IgM and polyclonal IgG antibodies having rheumatoid factor activity.[8,9]

The clinical symptoms of essential mixed cryoglobulinemia (EMC) include purpura, arthralgia, and renal impairments.[10] Renal impairments are particularly known for showing membranoproliferative glomerulonephritis histologically and progressing to renal insufficiency.[11] Approximately 80% of EMC patients are infected with HCV.[12] When the high-sensitivity gel diffusion method is used, cryoglobulins are detected in 70% of patients chronically infected with HCV.[13] Many patients with HCV-associated cryoglobulinemia show subclinical symptoms, but the incidence of EMC is highest as an extrahepatic complication of hepatitis C.

Interferon (IFN) therapy has been used for HCV-associated cryoglobulinemia.[14] Misiani et al.[15] reported that, following the administration of IFN to 25 patients with HCV-associated cryoglobulinemia, cryoglobulinemia symptoms improved in 15 patients after the start of treatment but that the symptoms recurred after treatment ended. The combination of IFN and ribavirin has become standard therapy for chronic hepatitis C. It has also been used to treat HCV-associated cryoglobulinemia, with particular efficacy expected in patients for whom IFN monotherapy is ineffective. Zuckerman et al.[16] reported that the administration of both IFN and ribavirin to nine EMC patients who had not responded to IFN monotherapy alleviated cryoglobulinemia in all and improved clinical symptoms in seven of the nine patients.

In addition, for patients with severe cryoglobulinemia, antiviral therapy based on IFN and combination therapy with a steroid or an immunosuppressant are considered effective.[17] Other treatment strategies, including plasma exchange therapy[17] and splenectomy,[18]

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Table 1. Extrahepatic manifestations of chronic hepatitis C

Complication	Pathogenesis	Prevalence of HCV antibody (%)	Treatment with antiviral drug	References
Cryoglobulinemia	Apoptosis suppression of B lymphocytes. monoclonal IgM production caused by translocation of chromosome t(14:18)	50–90	Interferon Pegylated Interferon plus ribavirin	1–17
Renal impairment	Accumulation of an immune complex formed by monoclonal or polyclonal IgM-κ with rheumatoid factor activity produced by HCV-infected B lymphocytes in the glomerular vascular endothelium and mesangium	10–60	Interferon Pegylated Interferon plus ribavirin	18–26
Myocardial impairment	Involvement of host immunologic responses to HCV, particularly human MHC class II antigen	6–10	Not reported	27–31
Porphyria cutanea tarda	Reduced activity of uroporphybrinogen decarboxylase associated with an excessive deposition of iron in the liver induced by HCV infection	60–100	Interferon	32–37
Sjögren's syndrome	Involvement of host immunologic responses to HCV	0–45	Not reported	38–43
Lichen planus	Involvement of HCV-specific T cells	0–65	Interferon	44–63
Oral cancer	Unknown	70–100 (HCV-RNA)	Not reported	64–65
Diabetes mellitus	Involvement of insulin resistance and insulin secretory deficiency. Disruption of tyrosine phosphorylation of IRS-1. Involvement of TNF-α	50	Not reported	66–77
Malignant lymphoma	Involvement of *myc* gene mutation in some cryoglobulinemia patients	0–33	Interferon Pegylated Interferon plus ribavirin	78–94
Autoimmune thyroid disease	Involvement of LKM1	10	Not reported	95–102
Idiopathic interstitial pneumonitis	Involvement of activated T lymphocytes and eosinophils	28	Not reported	103–107
Mooren's ulcer	Unknown	Unknown	Not reported	108–114

HCV, hepatitis C virus; MHC, major histocompatibility; IRS, insulin receptor substrate; TNF, tumor necrosis factor; LKM1, liver/kidney microsomal antibody 1

have also been attempted, and future development of these strategies is promising.

Renal impairments

Reported renal impairments associated with HCV infection include membranoproliferative glomerulonephritis, membranous nephropathy, mesangial proliferative glomerulonephritis, Henoch-Schönlein purpura nephritis, and tubulointerstitial nephritis.[19]

Membranoproliferative glomerulonephritis, in particular, is considered a typical example of hepatic disease involving renal impairment associated with HCV and is referred to as HCV-associated nephritis. In 1993, Johnson et al.[11] first reported on eight patients with HCV infection complicated by membranoproliferative glomerulonephritis.[11] The incidence of HCV-associated nephritis developing as a complication of hepatitis C has not been confirmed. In a study of 188 autopsied cases of chronic hepatitis C, Arase et al.[20] reported that 11.2% of patients exhibited membranoproliferative glomerulonephritis, 2.7% membranous nephropathy, and 17.6% mesangial proliferative glomerulonephritis. The pathogenic mechanism underlying HCV-associated nephritis is considered to be the accumulation of an immunocomplex formed by monoclonal or polyclonal IgM-κ with rheumatoid factor activity produced by HCV-infected

peripheral blood B lymphocytes in the glomerular vascular endothelium and mesangium.[21]

Histopathological features of HCV-associated nephritis are similar to those of typical membranoproliferative glomerulonephritis type I, but the former sometimes show cryoglobulin deposition.[22] In essential cryoglobulinemia and nephrotic syndrome with a rheumatoid factor, HCV-associated nephritis is suspected; therefore, the presence or absence of HCV infection should be determined.

IFN therapy has been reported to be efficacious for HCV-associated nephritis.[23,24] Johnson et al.[23] reported that the administration of IFN to 14 patients with HCV-associated nephritis improved proteinuria, but they observed a relapse of nephritis in association with HCV reexpression after the end of IFN therapy in many patients.[23] Recently, IFN and ribavirin combination therapy, which shows a low relapse rate, has been tested.[25,26] Sabry et al.[26] reported on the effectiveness of IFN and ribavirin combination therapy administered to 16 patients with HCV-associated nephritis for whom IFN monotherapy had proved ineffective; a follow-up study is awaited. Steroid and cyclophosphamide have been used for immunosuppression therapy, but satisfactory results using an immunosuppressant alone have not yet been obtained.[27] Because patients with HCV-associated nephritis have been reported to have a poor prognosis,[11] early establishment of a therapeutic procedure based mainly on IFN and ribavirin combination therapy is desirable.

Myocardial impairments

Myocardial impairments for which a causal relationship with HCV infection has been suspected to date include dilated cardiomyopathy, hypertrophic cardiomyopathy, arrhythmogenic right ventricular dysplasia cardiomyopathy, and chronic myocarditis.[28–30]

A study by Matsumori[28] observed positivity for serum anti-HCV antibody in 6.3% (42/663) of patients with hypertrophic cardiomyopathy and in 10.6% (74/697) of patients with dilated cardiomyopathy. These positivity rates were higher than the rate (2.4%) observed among age-matched Japanese blood donors.[28] Positive- and negative-strand HCV RNAs were detected in cardiac muscle samples of these patients, indicating potential intramyocardial HCV multiplication.[29,30] HCV RNA has also been detected in cardiac muscle samples of patients with arrhythmogenic right ventricular dysplasia cardiomyopathy and chronic myocarditis, indicating that HCV potentially plays an important role in the onset of myocardial impairments.[32]

With regard to the cause of myocardial impairments associated with HCV, the involvement of host immunologic responses to HCV, particularly that of the human major histocompatibility (MHC) class II antigen, has been suggested.[30] There are many patients with normal liver enzyme levels among hepatitis C patients with a concomitant myocardial impairment.[28] No established therapy is currently available, but the use of IFN-based antiviral therapy should be considered.

Porphyria cutanea tarda

Porphyria cutanea tarda is an acquired condition in which patients exhibit solar photosensitivity and hepatic damage owing to decreased activity of uroporphyrinogen decarboxylase in the liver.[33] The involvement of alcohol, excess iron, and medications for hepatic impairments in porphyria cutanea tarda was previously considered. However, because HCV infection has been observed in 60%–100% of cases of porphyria cutanea tarda, the involvement of HCV infection in the pathogenesis of porphyria cutanea tarda is suspected.[34]

The mechanism underlying the pathogenesis of porphyria cutanea tarda associated with HCV infection has not yet been clarified. It is assumed, however, that porphyria cutanea tarda results from reduced uroporphyrinogen decarboxylase activity associated with excessive deposition of iron in the liver as a result of HCV infection.[34]

The efficacy of IFN therapy for the treatment of porphyria cutanea tarda has been demonstrated, in addition to avoidance of sun exposure, abstention from alcoholic beverages, and blood letting. Okano et al.[38] reported that IFN therapy given to porphyria cutanea tarda patients with HCV infection led to transaminase normalization, HCV RNA disappearance, and normalization of porphyrin and ferritin levels with improvement of clinical symptoms, including vesicle formation and hypertrichosis. These results demonstrate the efficacy of IFN therapy for porphyria cutanea tarda.

Sjögren's syndrome

Sjögren's syndrome is an aggregate of symptoms characterized by insufficient tear production by the lacrimal glands and insufficient saliva production by the salivary glands because of exocrine lymphocyte infiltration, causing dryness of the eyes and mouth. Patients with Sjögren's syndrome are classified roughly into two groups, those exhibiting only dryness and those exhibiting both dryness and connective tissue disease symptoms such as arthralgia.[39]

An association of Sjögren's syndrome with viral infection has been reported for some time, and 0%–45% of Sjögren's syndrome patients test positive for

anti-HCV antibody.[40] Differences in the anti-HCV antibody positivity rate are attributed to regional differences in the HCV infection rate. Koike et al.[41] verified that transgenic mice with the 1b HCV envelope genotype developed sialadenitis resembling Sjögren's syndrome. Takamatsu et al.[42] detected HCV RNA in salivary gland tissue from anti-HCV antibody-positive patients with Sjögren's syndrome by reverse transcriptase-polymerase chain reaction (RT-PCR) analysis. Arreita et al.[43] performed in situ hybridization of 19 salivary gland tissue samples obtained from eight anti-HCV antibody-positive patients and 11 anti-HCV antibody-negative patients with chronic sialoadenitis or Sjögren's syndrome, and detected HCV RNA in all salivary gland tissue samples from the anti-HCV antibody-positive patients. Moreover, the HCV-infected salivary gland epithelium showed viral multiplication.[43] These reports indicate that HCV plays some role in the development of sialoadenitis in Sjögren's syndrome, but it has not yet been determined whether HCV itself or immunologic responses to HCV infection induce sialoadenitis.

Current therapies for Sjögren's syndrome mainly aim to alleviate the symptoms. Artificial lacrimal fluid and artificial saliva are used to alleviate dryness, and a nonsteroidal anti-inflammatory drug or a steroid is administered for treatment of fever and articular symptoms.[39] There are no reports regarding the efficacy of IFN therapy for HCV-associated sialadenitis,[44] and it is necessary to establish a treatment protocol in the future on the basis of accumulated case reports.

Lichen planus

Lichen planus is an inflammatory disease associated with abnormal chronic dermal and intraoral keratinization of unknown etiology. The assumed causes of lichen planus include viral or bacterial infection, immunologic responses, circulatory disorder, allergy, mental stress, abnormal autonomic function, medication, and glucose metabolism disorder.[45,46]

There are many reports of a relationship between lichen planus and HCV infection, but the anti-HCV antibody positivity rate in lichen planus shows marked regional differences, ranging from 0% to 65%.[47–53] HCV reproduction in the skin and oral mucosal epithelium has been examined by in situ hybridization and RT-PCR analysis.[54–56] HCV-specific T cells are reported to be associated with the pathogenesis of lichen planus,[57] but its pathogenesis is not associated with HCV level, genotype, or pathologic severity.[58,59]

The intravenous administration of a glycyrrhizinate preparation has been demonstrated to have efficacy for treatment of HCV-associated lichen planus.[60] Antiviral therapy based on IFN has also been attempted recently and has been reported to be effective,[61] but other investigators have reported that IFN is a lichen-planus-inducing factor[62] or that it can be aggravating factor.[63] No definite conclusion on the effectiveness of IFN against lichen planus is possible. Nagao et al.[64] reported that when intraoral lichen planus lesions in chronic hepatitis C patients administered IFN were observed over time, no macroscopic changes were observed in the lesions 1 year after the end of IFN administration, but that macroscopic and histological improvements were observed 3 or more years after the end of IFN administration. They also assumed that, since positive-strand HCV RNA was detected in the oral mucous membrane of some patients despite the demonstration of histological recovery from lichen planus following IFN therapy, host immunologic responses to HCV infection were related to the development of oral lichen planus.[64] The early establishment of a treatment procedure for lichen planus is desired, because lichen planus is also considered to be a precancerous condition.[45,46]

Oral cancer

A relationship between HCV infection and oral cancer was first reported by Nagao et al.[65] They showed that the HCV infection rate was higher in oral cancer patients than in esophageal, gastric, or colorectal cancer patients.[65] The HCV infection rate has also been found to be higher in patients with cervical squamous cell carcinoma than in controls.[66] When HCV-RNA was examined in cancer tissues from 17 oral cancer patients by RT-PCR analysis, positive-strand HCV RNA was detected in all anti-HCV antibody-positive patients and negative-strand HCV RNA was detected in 71.4% of the anti-HCV antibody-positive patients.[55] These findings interestingly indicate the possibility of HCV multiplication in cancer tissue. No definite conclusion has been arrived at regarding the relationship between oral lichen planus and oral cancer. However, because lichen planus is considered precancerous, as mentioned above, oral examination is also important for patients with chronic hepatitis C.

Diabetes mellitus

In 1994, Allison et al.[67] reported a relationship between HCV-associated cirrhosis and diabetes mellitus, because the rate of diabetes mellitus complication in patients with both cirrhosis and HCV infection was 50%, which is much higher than that (9%) in patients with cirrhosis but without HCV infection. A large-scale epidemiologic survey showed that the rate of non-insulin-dependent