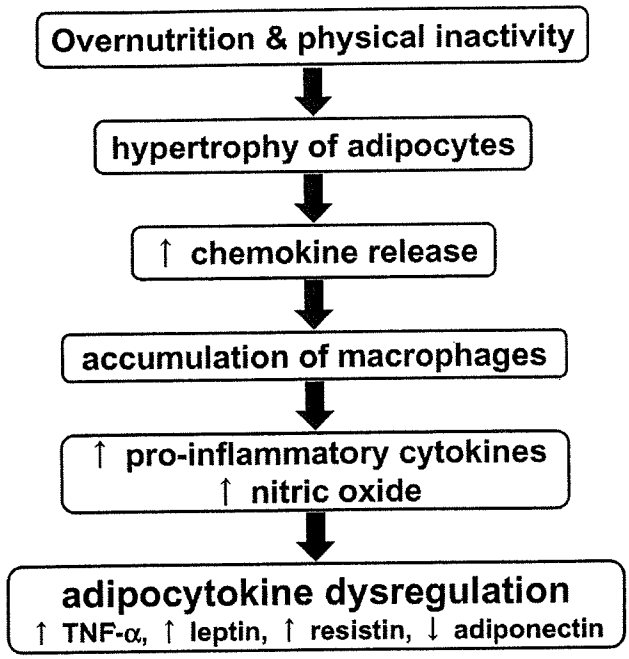

Fig. 1. Current hypothesis regarding the mechanism of adipocytokine dysregulation. *TNF-α*, tumor necrosis factor α

mainly by adipocytes. The expression of leptin in adipocytes is transcriptionally regulated, and is determined mainly by the status of energy stores in white adipose tissue and the size of adipocytes.[5] However, recent studies have confirmed that leptin is also expressed in other tissues such as skeletal muscles, stomach, ovaries, and liver.[36] Leptin plays a key role in the regulation of appetite and body weight. It also acts on the hypothalamus, altering energy intake by decreasing appetite and increasing energy expenditure via sympathetic stimulation of several tissues.[37] Mutations in the leptin gene cause obesity in rodents and human.[35,38]

Serum leptin concentrations correlate well with body weight and body fat mass, and are higher in women than in men even after adjustment for age and body mass index.[39]

Leptin resistance

Circulating leptin levels are elevated in obese subjects, but these subjects are resistant to the action of leptin. Leptin acts by binding to its receptor, Ob-R, and its gene is alternatively spliced into several isoforms. One of the splice variants, Ob-Re, is a soluble leptin receptor and binds to leptin to form a leptin–Ob-Re complex.[40] The complex formation can delay leptin clearance and thereby increase the availability of bioactive leptin.[41] In obese individuals, the serum free leptin level is high, and the Ob-Re level is low, resulting in a low leptin–Ob-Re complex level. A low serum Ob-Re level and low leptin–Ob-Re complex level can be markers of leptin resistance. However, excess Ob-Re is likely to inhibit free leptin function, because the complex cannot activate the transmembrane leptin receptor Ob-Rb.[40] Other groups have argued that diet-induced obesity causes downregulation of Ob-Rb and results in impairment of leptin signaling.[42,43]

Recent studies indicate that leptin can inhibit the orexigenic peptides (neuropeptide Y, agouti-related peptide) and stimulate the secretion of anorexigenic peptide (α-melanocyte-stimulating hormone) from arcuate melanocortin neurons of lean mice.[44] However, leptin failed to modulate the secretion of these peptides in high-fat-diet-induced obese (DIO) mice. Such resistance to leptin is due to increased levels of suppressor of cytokine-signaling protein 3 (a negative regulator of leptin signal transduction) in the arcuate nucleus in the hypothalamus of DIO mice. A reduction in diet fat content resulted in recovery of leptin responsiveness in DIO mice.

Leptin and liver diseases

In animal models, leptin prevents lipid accumulation in nonadipose tissues, such as skeletal muscles, pancreas, and liver, a concept referred to as lipotoxicity.[23] In the liver, leptin achieves its antilipogenic effects by lowering the expression of sterol regulatory element binding protein 1 (SREBP-1).[45] Patients with severe lipodystrophy present with hepatic steatosis and hepatocellular ballooning injury, similar to that seen in NASH, and recombinant leptin significantly reduces serum levels of triglycerides, transaminases, and liver fat content and improves hepatomegaly in these patients.[46]

Leptin injections in mice treated with carbon tetrachloride increased the expression levels of procollagen-I, transforming growth factor β1 (TGF-β1), and smooth muscle actin, a marker of activated hepatic stellate cells (HSCs), and eventually resulted in tissue fibrosis.[47] In the liver, leptin directly promotes fibrogenesis by stimulating the production of tissue inhibitor of metalloproteinase 1 via the Janus kinase/signal transducer and activator of transcription pathway in activated HSCs, which are a central player in liver fibrosis.[48] Moreover, leptin is described as a potent mitogen for HSCs and an inhibitor of apoptosis of HSCs through extracellular signal-regulated kinase (ERK) and the Akt-dependent pathway.[49] Activated HSCs acquire the ability of secrete leptin and are thought to further promote liver fibrosis.[50] In addition, leptin increases the expression of TGF-β1 in sinusoidal endothelial cells and Kupffer cells. In Zucker (*fa/fa*) rats, a naturally occurring functional leptin receptor-deficient animal, thioacetamide-induced hepatic fibrosis was prevented almost completely and induction of TGF-β1 and activation of HSCs were

abolished.[50] Considered together, the above results indicate that leptin and its functional receptor play a pivotal role in profibrogenic responses in the liver.

High serum leptin concentrations are present in cirrhosis patients.[30,34] However, despite high serum leptin concentrations in nonalcoholic fatty liver disease (NAFLD) patients, there is no relationship between leptin and the severity of hepatic fibrosis.[51] Moreover, leptin levels were initially found to be significantly higher in NASH patients than in controls matched for sex and body mass index (BMI), and correlated with the severity of hepatic steatosis but not with the severity of inflammation or fibrosis.[23] In another study, serum leptin levels and leptin receptor mRNA expression levels in the liver were not significantly different between patients with NASH and those with simple steatosis.[52] The relationship between serum leptin concentrations and the severity of liver fibrosis remains to be investigated.

Serum leptin levels were higher in CHC patients than controls,[53] and associated with the severity of fibrosis.[54] Serum leptin levels correlated with hepatic steatosis in patients infected with hepatitis C virus genotype 3 but not genotype 1.[55] In contrast, another study revealed that leptin levels do not correlate with fibrosis or severity of steatosis in CHC patients.[56] Considered together, these studies indicate that while serum leptin levels may be elevated in CHC patients, there is rather a conflicting relationship between serum leptin levels and liver histology in such patients.

There is a close relationship between BMI and a high mortality rate due to digestive cancers;[19] especially, obesity and HCC represent a particularly high risk.[20,57] The high plasma leptin levels in obesity may contribute to this phenomenon. Leptin acts as mitogen on many cell types in vitro, including HCC cells, via the ERK/mitogen-activated protein kinase (MAPK), and phosphatidylinositol 3-kinase (PI3K)/Akt pathway, and may facilitate progression to liver cancer in vivo.[58,59]

These findings suggest that leptin plays important roles in liver diseases such as attenuating hepatic steatosis, exacerbating liver fibrosis, and possibly promoting HCC growth. Further research needs to be conducted on the precise role of leptin in liver diseases.

Adiponectin

Adiponectin is an adipocyte-specific 28-kDa secreted protein expressed exclusively in adipose tissue.[4] However, recent studies have indicated that adiponectin is also produced by organs other than adipose tissue, such as bone marrow,[60] fetal tissue,[61] cardiomyocytes,[62] and hepatic endothelial cells.[31,63] However, the major source of plasma adiponectin in adults is adipocytes.

The protein contains a signal sequence and a collagen-repeat domain at the N terminus, and a C1q-like globular domain at the C terminus.[64] Adiponectin is present in a wide range of multimer complexes in plasma and assembles via its collagen domain into adiponectin trimers (low molecular weight), hexamers (middle molecular weight), and 12- to 18-mers [high molecular weight (HMW)].[64-66] The HMW forms appear to be responsible for insulin sensitivity and the anti-inflammatory effects of adiponectin.[65,67] Hydroxylation and glycosylation of the lysine residues within the collagen domain are critically involved in the regulation of HMW adiponectin formation.[68] The full-length adiponectin protein is proteolytically cleaved, with a smaller form including the globular domain, although in very small amounts.[69]

Adiponectin protein is present at high levels (range, 3–30 μg/ml) in plasma, accounting for about 0.01% of total plasma protein. Surprisingly, the plasma adiponectin level is inversely correlated with BMI in spite of its restricted expression in adipose tissue.[66] Especially, the plasma adiponectin level is low in subjects with visceral fat accumulation. Hypoadiponectinemia has been demonstrated to be independently associated with metabolic syndrome, including type 2 diabetes,[70] hypertension,[71] atherosclerosis,[72] and NASH.[25] Weight reduction results in a significant elevation of plasma adiponectin levels in humans.[70]

Why are plasma adiponectin levels low in obese subjects? While the exact mechanism is unknown, several theories have been postulated. TNF-α, one of the insulin resistance inducible factors, is upregulated in obese subjects, and suppresses the expression and plasma levels of adiponectin at the transcriptional level.[72] Production of reactive oxygen species (ROS) is selectively increased in adipose tissue of obese mice, accompanied by augmented expression of NADPH oxidase. Production of adiponectin is downregulated by elevated oxidative stress in adipose tissue. NADPH oxidase inhibitor reduces ROS production and increases adiponectin production in adipose tissue.[73] The frequency of a missense mutation at position 164 in the globular domain [Ile-164The (I164T)] is significantly higher in patients with type 2 diabetes and coronary artery disease than in normal control subjects.[74,75] Subjects with this mutation had significantly lower plasma adiponectin levels than those without it.

Adiponectin receptor

Two receptors for adiponectin, AdipoR1 and AdipoR2, have been cloned.[76] These adiponectin receptors are considered to contain seven transmembrane domains, despite being structurally and functionally distinct from G protein-coupled receptors. AdipoR1 is ubiquitously

expressed and is abundantly expressed in skeletal muscle, whereas AdipoR2 is most abundantly expressed in the liver. AdipoR1 and AdipoR2 serve as receptors for globular and full-length adiponectin and activate adenosine monophosphate-activated protein kinase (AMPK), peroxisome proliferator-activated receptor-α (PPAR-α), and p38 MAPK signaling pathways.[77] Disruption of these receptors abolished adiponectin binding and its actions.[78] Insulin reduces the expression of AdipoR1 and AdipoR2 via a PI3K/Forkhead boxO1-dependent pathway in cultured hepatocytes or myocytes.[28,79]

T-cadherin serves as a receptor for the hexameric and HMW forms of adiponectin.[80] Because T-cadherin is a glycosylphosphatidylinositol-anchored extracellular protein, it may act as a coreceptor for an unidentified signaling receptor.

Adiponectin and NAFLD

Obesity is an independent risk factor in the development of NASH[21–23] and HCC,[19,34] and patients with NASH who progress to liver cirrhosis are at increased risk of HCC.[81] In the two-hit theory of NASH pathogenesis, the first hit of hepatic steatosis is followed by the second hit of oxidative injury, leading to inflammation and progression to fibrosis and HCC.[81,82] In the following paragraphs, we focus on the roles of adiponectin in the two-hit theory of NASH pathogenesis.

Adiponectin and hepatic steatosis

We found that hepatic steatosis, induced by a choline-deficient L-amino acid-defined (CDAA) diet, is more severe in adiponectin knockout mice than in wild-type mice.[83] The CDAA diet was used to induce a nutritional animal model of NASH.[84] Overexpression of adiponectin protein by adenovirus vector resulted in attenuation of hepatic steatosis. The lack of adiponectin in these mice enhanced the expression of two rate-limiting enzymes in fatty acid synthesis, acetyl-CoA carboxylase (ACC) and fatty acid synthase. Adiponectin is also known to stimulate mitochondrial β-oxidation by activation of AMPK and PPAR-α.[65,69] Activated PPAR-α upregulates carnitine palmitoyltransferase (CPT)-1, a rate-limiting enzyme in fatty acid oxidation. In addition, activated AMPK phosphorylates ACC and attenuates the activity of ACC. Inactivation of ACC leads to a decrease in the concentration of its product, malonyl-CoA (a potent inhibitor of CPT-1), and induces fatty acid oxidation in the liver. Moreover, adiponectin downregulates SREBP-1c, a master regulator of fatty acid synthesis.[85] Thus, adiponectin increases β-oxidation of free fatty acids and decreases de novo free fatty acids production within hepatocytes.[69,86] These effects protect hepatocytes against triglyceride accumulation. The hypoadiponectinemia in obese individuals could exacerbate hepatic steatosis, the first hit in NASH, through the absence of these effects of adiponectin.

Adiponectin and inflammation

Adiponectin at physiological concentrations attenuates the attachment of monocytes to endothelial cells by reducing TNF-α-induced expression of adhesion molecules such as vascular cell adhesion molecule 1, endothelial-leukocyte adhesion molecule-1 (E-selectin), and intercellular cell adhesion molecule 1.[72] Nuclear transcription factor, nuclear factor κB (NFκB), induces the expression of cytokines and adhesion molecules in the inflammatory process. Adiponectin suppresses TNF-α-induced NFκB activation and blocks TNF-α release in endothelial cells.[87]

C-reactive protein (CRP) is a potent marker of systemic inflammation, and its plasma level correlates negatively and significantly with adiponectin levels in humans.[88,89] CRP levels correlate with body weight and percentage of body fat,[90] and CRP mRNA is expressed in human adipose tissue and its levels correlate inversely with adiponectin gene expression in human adipose tissue.[88]

Patients with NASH are at increased risk of small intestinal bacterial overgrowth,[91] and lipopolysaccharide (LPS) is involved in the pathogenesis of NASH.[92,93] In a mouse model of LPS-induced acute hepatitis, we found that adiponectin protected against hepatic injury through inhibition of production of the proinflammatory cytokine TNF-α and induction of the anti-inflammatory cytokine IL-10 in Kupffer cells.[94] Lack of adiponectin accelerated LPS-induced liver injury, and the survival rate of adiponectin knockout mice after LPS administration was significantly lower than that of wild-type mice. Pretreatment of these mice with adiponectin reduced LPS-induced TNF-α production, and increased IL-10 production by Kupffer cells. These findings are in agreement with another study in which pretreatment of KK-Ay obese mice with adiponectin protected them from LPS-induced hepatic injury through modulation of TNF-α.[95] Other investigators have shown that adiponectin also suppresses macrophage function[96] and induces anti-inflammatory cytokines, such as IL-10 and IL-1RA, in human leukocytes.[97,98] In addition, adiponectin alleviates experimental T-cell-mediated hepatitis induced by concanavalin A in mice, and protects primary hepatocytes from TNF-α-induced death.[99] These results suggest that hypoadiponectinemia in obese subjects can thus lead to enhanced sensitivity of Kupffer cells to proinflammatory mediators such as LPS.

A recent study reported that adiponectin promotes clearance of early apoptotic cells by macrophages through a receptor-dependent pathway involving calre-

ticulin.[100] This novel function of adiponectin is similar to that of surfactant proteins and C1q, which serve as anti-inflammatory molecules by promoting the clearance of apoptotic cell debris.[101]

Adiponectin and oxidative stress

Obesity is regarded as a chronic inflammatory state. The associated hepatic lipid overload induces impairment of mitochondrial β oxidation, which may lead to the formation of ROS and lipid peroxidation products. ROS and lipid peroxidation in turn upregulate a series of proinflammatory cytokines,[102] causing further mitochondrial dysfunction and oxidative stress, thus contributing to the progression of liver injury.

Recent studies indicate that adiponectin can suppress oxidative stress,[103,104] and that systemic oxidative stress, as measured by urinary 8-epi-prostaglandin F2α, correlates strongly with hypoadiponectinemia.[105] Studies from our laboratories showed enhanced oxidative stress in adiponectin knockout mice in a CDAA diet-induced NASH mouse model.[83] Accumulating evidence suggests that alcohol-mediated upregulation of CYP2E1 may initiate lipid peroxidation via production of ROS.[106] CYP2E1 is upregulated in human liver in NASH,[107] and in a rodent model of NASH.[108,109] In our CDAA diet-induced NASH mouse model, CYP2E1 was induced in adiponectin knockout mice and adiponectin overexpression downregulated CYP2E1.[83] Moreover, thiobarbituric acid reactive substance, a marker of oxidative stress, and 8-hydroxydeoxyguanosine, a marker of oxidative DNA damage, were also increased in the livers of adiponectin knockout mice. Adiponectin knockout mice also showed significantly enhanced hepatic tumor formation compared with wild-type mice. Thus, adiponectin deficiency might enhance the level of oxidative stress through induction of CYP2E1 in the liver, allowing progression of liver injury in adiponectin-deficient mice.

TNF-α plays crucial roles in NASH progression,[110,111] and adiponectin suppresses TNF-α production.[96] In our study, we found significantly elevated serum levels of TNF-α in adiponectin knockout mice,[83] which may play a role in the progression of hepatopathology in adiponectin knockout mouse liver.

Adiponectin and fibrosis

In a clinical study of NASH patients, the fibrosis stage correlated significantly with low serum adiponectin levels.[29] We reported previously that adiponectin attenuates carbon tetrachloride-induced liver fibrosis.[112] Adiponectin suppressed the proliferation and migration of activated HSCs, which play central roles in liver fibrosis, and attenuated the effect of TGF-β1 on the expression of fibrogenic genes, and on nuclear translocation of Smad2 in HSCs. Other groups have reported that adiponectin induces apoptosis of activated HSCs,[113] and activated AMPK, which modulates the activated HSC phenotype.[114,115] These findings indicate that adiponectin has antifibrogenic properties in liver diseases through the suppression of activated HSC proliferation and fibrogenic function.

Inflammation and fibrosis of the liver have recently been reported in individuals with nonalcoholic fatty liver, which is frequently associated with obesity and type-2 diabetes. A considerable number of these patients develop liver cirrhosis, a clinical entity termed NASH. In addition, epidemiological studies have shown that obesity, which is associated with hypoadiponectinemia, is a risk factor for the development of liver fibrosis in patients with NASH, alcoholic liver disease, and CHC.[22–33] These results indicate that hypoadiponectinemia may be one reason obese patients are at high risk for development of liver cirrhosis.

Thus, adiponectin attenuates inflammation, oxidative stress, and proinflammatory cytokine production, which are considered the second hit in NASH. Moreover, adiponectin ameliorates liver fibrosis via suppression of activated HSC function, and might decelerate the progression of hepatocarcinogenesis via suppression of oxidative stress (Fig. 2).

Adiponectin and clinical studies in liver diseases

Adiponectin and NAFLD

In a study of 80 NASH patients, hypoadiponectinemia was independently associated with NASH and with more severe hepatic steatosis and necroinflammation.[25] Other reports have also indicated that plasma adiponectin levels are lower in NASH patients than in patients with simple steatosis.[26,27] Interestingly, the major hepatic adiponectin receptor AdipoR2 is underexpressed in fatty liver and in NASH patients, and *AdipoR2* gene expression correlates inversely with the severity of liver fibrosis.[27,28] After adjustment for age, sex, and BMI, plasma levels of adiponectin correlated inversely with the alanine transaminase level.[86] Musso et al.[29] reported that hypoadiponectinemia is a feature of NASH and may play a pathogenetic role in hepatic necroinflammation and fibrosis, independent of insulin resistance, visceral fat accumulation, serum TNF-α level, or dietary intake. In contrast, another study demonstrated the presence of hypoadiponectinemia in NAFLD patients but failed to find differences in the serum adiponectin concentration between patients with NASH and those with simple steatosis, and concluded that adiponectin concentration correlated inversely with insulin resistance.[116] Considered together, these results suggest that hypoadiponectinemia and underexpression of hepatic adiponectin receptor may play important roles in the clinical progression of NASH.

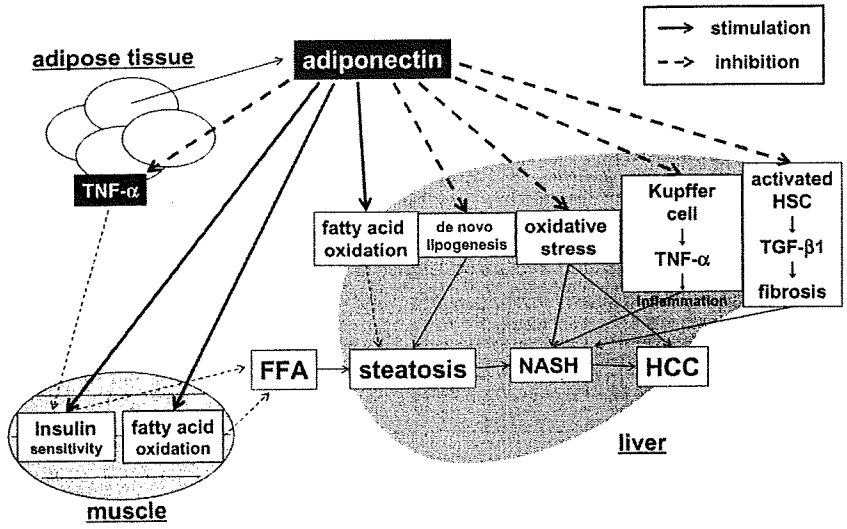

Fig. 2. Roles of adiponectin in NASH development. *Solid arrows*, stimulatory effects; *dotted arrows*, inhibitory effects. *NASH*, nonalcoholic steatohepatitis; *FFA*, free fatty acid; *HCC*, hepatocellular carcinoma; *HSC*, hepatic stellate cell; *TGF*-β1, transforming growth factor β1

Adiponectin and viral hepatitis

Currently, there is a great interest in the role of adiponectin in CHC. Serum adiponectin levels are higher in CHC patients than in those with chronic hepatitis B.[117] In CHC patients, hypoadiponectinemia correlates significantly with steatosis but not with the severity of fibrosis.[31-33] Hepatic steatosis is a common histological finding in CHC, with an incidence of 305–70%.[118,119] Hepatic steatosis in CHC correlates with progression of liver fibrosis,[17,120] and is a risk factor for HCC.[121] In addition, a recent report indicated that low serum adiponectin is an independent predictor of nonvirological response to interferon therapy in CHC patients.[33]

On the other hand, hyperadiponectinemia has been described in cirrhosis patients.[122,123] The liver is the main organ of adiponectin metabolism, and biliary secretion is involved in adiponectin clearance; accordingly, elevated plasma concentrations of adiponectin in advanced cirrhosis are due to decreased metabolism and biliary secretion of adiponectin.

Adiponectin and cancer

Recent studies showed that plasma adiponectin levels are inversely correlated with the risk of cancers.[124] In clinical studies, hypoadiponectinemia is correlated with colorectal cancer,[125,126] gastric cancer,[127] prostate cancer,[128] endometrial cancer,[129] and breast cancer.[130] In addition, in vitro studies revealed that adiponectin protein inhibits cell proliferation in cells lines originating from various types of cancer, including prostate cancer, HCC, breast cancer, leukemia, and esophageal cancer.[96,131-133] These studies emphasize the potential role of hypoadiponectinemia as a risk factor for various cancers.

Pharmacological and dietary interventions

The above findings suggest that hypoadiponectinemia in obese people may be an important risk factor for clinical progression of chronic liver diseases, and that upregulation of adiponectin signaling might be useful therapeutically by increasing plasma adiponectin levels or development of adiponectin receptor agonists. However, considering the high plasma levels of adiponectin, direct administration of adiponectin protein to individuals with liver diseases might not be a good strategy because of difficulties in maintaining high plasma concentrations. Thiazolidinediones elevate the promoter activity of adiponectin and increase the plasma concentration of adiponectin.[134] Adiponectin promoter has a functional PPAR-responsive element (PPRE) site.[135] Not only PPARγ but also PPARα ligands increase the expression of adiponectin through a PPRE site located in its promoter region.[136] Furthermore, PPARα agonist increases the expression of both AdipoR1 and AdipoR2 in adipocytes and macrophages.[137] Pioglitazone increases the ratio of HMW adiponectin/total adiponectin and increases the hepatic sensitivity to insulin.[138] These findings indicate that dual activation of PPARγ and PPARα intensifies adiponectin actions by increasing plasma levels of adiponectin, especially HMW adiponectin, and by increasing adiponectin receptors.

Blockade of the renin–angiotensin system (RAS) with angiotensin-converting enzyme inhibitors or angiotensin receptor blocker increases adiponectin concentrations.[139,140] However, the precise mechanism of increased plasma adiponectin level by RAS blockade remains incompletely unclear.

The effects of diet on plasma adiponectin concentration were recently reported. Dietary soy protein, lin-

oleic acid, and oolong tea increase plasma adiponectin levels in rodents and humans.[141–143] The molecular mechanism of these dietary effects on adiponectin levels remains unclear.

A recent study suggested that osmotin, a member of the PR-5 family of plant defense proteins, is a ligand for the yeast homolog of adiponectin receptor and has functional similarity to adiponectin.[144] Osmotin is abundant in plant tissues (seeds, fruits, vegetables) and is extremely stable; it remains active even when in contact with human digestive or respiratory systems.[144] Further research into similarities in adiponectin and osmotin functions may facilitate the development of potential adiponectin receptor agonists.

Collectively, in addition to weight reduction, the aforementioned pharmacological and dietary interventions can improve hypoadiponectinemia, and might be useful therapeutic approaches to attenuate metabolic syndrome.

TNF-α

TNF-α is a proinflammatory cytokine that was originally found to induce necrosis of tumors after acute bacterial infection. Its first link to obesity, insulin resistance, and chronic inflammation was made in a research paper that described significant elevation of TNF-α in adipose tissue of genetically obese mice (*db/db* mice).[145]

The adipose tissue of obese individuals is characterized by increased infiltration of macrophages and hypertrophied adipocytes.[10] Hypertrophied adipocytes release large quantities of free fatty acid (FFA) via macrophage-induced adipocyte lipolysis. FFA serves as a naturally occurring ligand for Toll-like receptor (TLR) 4.[146,147] FFA increases thereby the production of TNF-α in macrophages through the TLR4/ NFκB pathway. Thus, a vicious cycle is established.

Kupffer cells are the main producer of TNF-α in the liver, and LPS-induced activation of these cells enhances their production of TNF-α. In animal models, activation of Kupffer cells leads to induction of the TNF-α/TNF receptor signaling pathway, which is critically involved in the pathogenesis of liver fibrosis in NASH.[110] In addition, *ob/ob* mice, a model for NAFLD, overexpress TNF-α.[92] Treatment with anti-TNF antibody reduced the activity of Jun N-terminal kinase, which promotes insulin resistance, and decreased the DNA binding activity of NFκB, which accelerates inflammation, with a resultant improvement of NAFLD in *ob/ob* mice.

In human, TNF-α levels are increased significantly in simple steatosis and NASH, and correlate with hepatic fibrosis in NASH.[26] The gene expression of TNF-α and its receptor are significantly elevated in hepatic and adipose tissues of NASH patients.[21] Recently, a histologic scoring system, the NAFLD activity score (NAS), has been proposed that can assist in the diagnosis of NAFLD and may be useful for assessing the response to therapy.[148] Serum TNF-α levels significantly correlated with NAS score.[149] In Japanese NAFLD patients, polymorphisms in the TNF-α promoter region and serum level of soluble TNF receptor 2 significantly correlated with progression of NAFLD.[150] Moreover, administration of pentoxifylline, a TNF-α inhibitor, improved aminotransferase levels and the insulin resistance index assessed by homeostatic metabolic assessment (HOMA-IR) in NASH patients.[151,152]

Considered collectively, the above data from animal and human studies suggest that TNF-α plays important roles in the progression of NAFLD, including hepatic inflammation and fibrogenesis.

Resistin

Resistin is a member of the resistin-like molecule family of cysteine-rich secretory 12-kDa proteins. In mice, the expression of resistin is restricted to adipose tissue, and the expression of resistin is downregulated by thiazolidinedione and fasting.[6] Resistin leads to insulin resistance, and hyperresistinemia increases blood glucose and insulin levels in mice.[153] Resistin overexpression induces dyslipidemia characterized by high serum total cholesterol and triglyceride levels, and reduces high-density lipoprotein cholesterol concentration, which is commonly seen in metabolic syndrome.[154]

In humans, resistin expression in adipose tissue is very low, but it is mainly found in bone marrow and in macrophages.[155,156] Serum resistin concentrations are elevated in patients with NAFLD. Increased resistin levels correlate with histological severity of liver disease but not with insulin resistance.[24] Serum resistin levels are higher in obese than in lean individuals, but when adjusted for BMI, resistin levels do not correlate with insulin resistance.[157] The exact role of resistin in obesity and insulin resistance in humans remains elusive. More research is needed to clarify the role of resistin in humans.

Conclusions

We have summarized the recent advances in our understanding of the role of adipocytokines in liver diseases. Adipocytes produce and secrete various adipocytokines to control the functions of other organs, including liver. Production and secretion of adipocytokines are dynamically regulated by nutritional status. Overeating and physical inactivity results in obesity with visceral fat

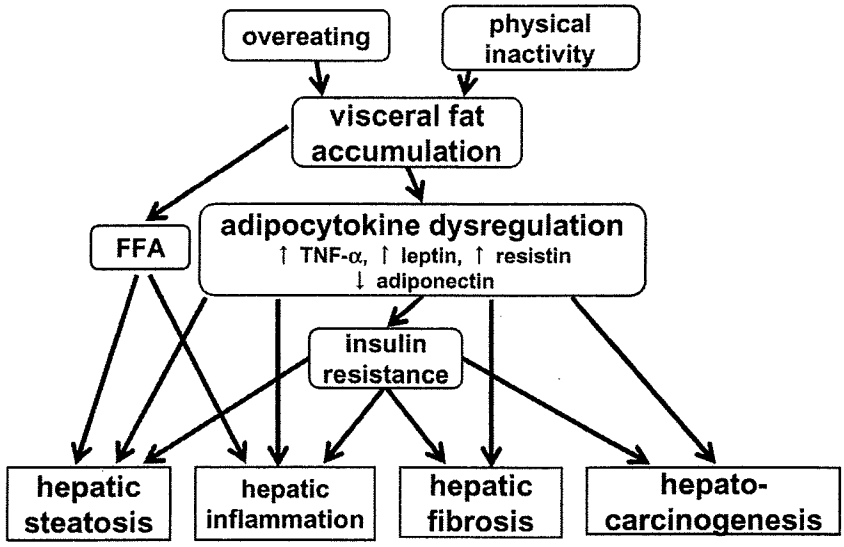

Fig. 3. Current hypothesis regarding the association between adipocytokines and liver diseases. Arrows, stimulatory effects

accumulation, a state of chronic low-grade inflammation. The inflammatory changes in obese adipose tissue induce adipocytokine dysregulation: an increase in offensive adipocytokines, TNF-α, IL-6, and resistin, and a decrease in the defensive adipocytokine adiponectin. Increased serum levels of TNF-α, resistin, and leptin, which are usually observed in obese subjects, may enhance steatosis, inflammation, fibrogenesis, or hepatocarcinogenesis in the liver. In addition, hypoadiponectinemia seems to enhance hepatic steatosis, inflammation, and fibrosis, as well as hepatocarcinogenesis (Fig. 3). Attenuation of proinflammatory adipocytokines or augmentation of the function of adiponectin might be an effective therapy for metabolic syndrome. Further clinical and experimental research should elucidate the relationship between adipocytokines and liver diseases.

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Super paramagnetic iron oxide MRI shows defective Kupffer cell uptake function in non-alcoholic fatty liver disease

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ABSTRACT

Background The pathogenesis of non-alcoholic fatty liver disease (NAFLD) is incompletely understood. Kupffer cells (KCs), phagocytic liver-resident macrophages, provide a protective barrier against egress of endotoxin from the portal to the systemic circulation. It is not known if KC phagocytic function is impaired in NAFLD. Super-paramagnetic iron oxide (SPIO) magnetic resonance imaging is a comparative technology dependent on KC phagocytic function.

Objective To evaluate KC uptake function, in patients and experimental animals with NAFLD, using SPIO.

Methods Abdominal CT and histological examination of liver biopsy specimens were used to estimate the degree of steatosis in patients with NAFLD and controls with chronic hepatitis C. SPIO-MRI was then performed in all patients. Normal rats fed a methionine-choline-deficient diet to induce non-alcoholic steatohepatitis (NASH), the more severe stage of NAFLD, and obese, insulin resistant, Zucker *fa/fa* rats with steatohepatitis, were also studied with SPIO-MRI and analysed for hepatic uptake of fluorescent microbeads. Immunohistochemical analysis evaluated the numbers of KCs in patients and rat livers.

Results Relative signal enhancement (RSE), inversely proportional to KC function, was higher in patients with NAFLD than in controls and with the degree of steatosis on CT. RSE also positively correlated with the degree of steatosis on histology and was similarly higher in rats with induced severe NAFLD (NASH). On immunohistochemistry, defective phagocytic function was the result of reduced phagocytic uptake and not due to reduced KC numbers in rats or patients with NAFLD.

Conclusions KC uptake function is significantly impaired in patients with NAFLD and experimental animals with NASH, worsens with the degree of steatosis and is not due to a reduction of KC numbers.

Non-alcoholic fatty liver disease (NAFLD), is now the most common cause of chronic liver disease in industrialised nations.[1 2] It may progress to cirrhosis.[3] The pathogenesis of NAFLD is incompletely understood but may involve hyper-endotoxaemia, and indeed obesity and type 2 diabetes, commonly present in NAFLD, are associated with endotoxaemia.[4] It was also recently reported that serum endotoxin levels were elevated, compared with controls, in mice fed a methionine-choline-deficient (MCD) diet to induce non-alcoholic steatohepatitis (NASH)—the more severe stage of NAFLD.[5] In addition, serum endotoxin levels in patients with NAFLD are greater than in patients without liver disease,[6] and others have shown raised serum levels of lipopolysaccharide-binding protein (LBP) in patients with NAFLD and more so in patients with NASH.[7] Finally, LBP mRNA levels in the livers of rats with high-fat diet-induced NASH were elevated compared with controls.[8] As Gao and colleagues[8] concluded in their study, therefore, the mechanism of injury in NAFLD may be related to increased levels of endotoxin. This observed hyper-endotoxaemia might be secondary to reduced clearance of endotoxin in NAFLD, possibly caused by an impaired Kupffer cell (KC) uptake function, at least in animal models of NAFLD,[5 9] resulting in overproduction of, and increased sensitivity to, cytokines such as tumour necrosis factor α and interleukin 1β from KCs.[10 11]

KCs are phagocytic macrophages resident in the liver which provide the predominant protection against the egress of endotoxin from the portal to the systemic circulation.[12] The status of KC uptake function in patients with NAFLD is unknown. This has, in part, been owing to an absence of methods to study this parameter reliably in situ. The introduction, however, of super-paramagnetic iron oxide (SPIO) allows such direct studies.

SPIO is a liver-specific magnetic resonance imaging (MRI) contrast agent for detecting hepatocellular carcinoma (HCC).[13 14] The technique relies on the ability of KCs to take up SPIO particles. Since KCs are absent in HCC, differential uptake of SPIO particles allows radiological separation of normal liver from HCC lesions. Following intravenous SPIO, uptake by KCs leads to reduced signal intensity (SI) on T2 MRI sequences, such that, HCC which have no KCs show a high SI. Conversely, areas with abundant KCs show a low T2 SI. In normal liver, therefore, there is a low T2 SI.[15–17] Since the SI with SPIO depends on uptake by KCs of SPIO contrast, SPIO can serve as a surrogate marker of KC uptake function.

In this study, we used SPIO-MRI to test the hypothesis that patients with NAFLD have impaired KC uptake function. To investigate the underlying mechanisms and ascertain that impaired KC uptake function was not due to a reduction in KC numbers, we then used SPIO along with ingestion of fluorescent microbeads in rats fed an MCD diet as a model of NASH, a severe stage of NAFLD[18 19] and in obese, insulin resistant, steatohepatitic Zucker *fa/fa* rats, as an additional

model of NASH. In addition, immunohistochemical analysis with a KC-specific antibody and computerised-image analysis evaluated the number of KCs in livers of rats fed an MCD diet and in liver biopsy specimens from patients with NAFLD.

Our results show that both in an animal models of severe NAFLD—that is, NASH, and in patients with NAFLD, KC uptake function is impaired. This impairment is not due to a reduction in KC numbers. These findings may explain why there is a hyper-endotoxaemic state in NAFLD and suggest that strategies to enhance KC uptake function and/or reduce endotoxin levels may be of benefit in treating NAFLD.

MATERIALS, PATIENTS AND METHODS

Animals

Six-week-old male Wistar rats were fed either an MCD diet (Oriental Yeast, Tokyo, Japan, n=16) or a normal diet (n=16) for 12 weeks. Obese Zucker *fa/fa* rats (18 weeks old male, n=8) known to have insulin resistance and steatohepatitis served as another model of NASH, with their lean controls. All animal experiments were approved by our local animal use committee.

SPIO contrast agent

Resovist (Nihon Schering, Osaka, Japan) used as the SPIO contrast agent is a hydrophilic colloidal solution of SPIO coated with carboxydextran (γ-Fe_2O_3/$C_6H_{11}O_6$-($C_6H_{10}O_5$) n-$C_6H_{11}O_5$).[20]

Animal MRI

All animal MRI examinations were performed, using a Varian Unity INOVA NMR console coupled to a Sun Microsystems host computer running VNMR 6.1 C software (Varian, Palo

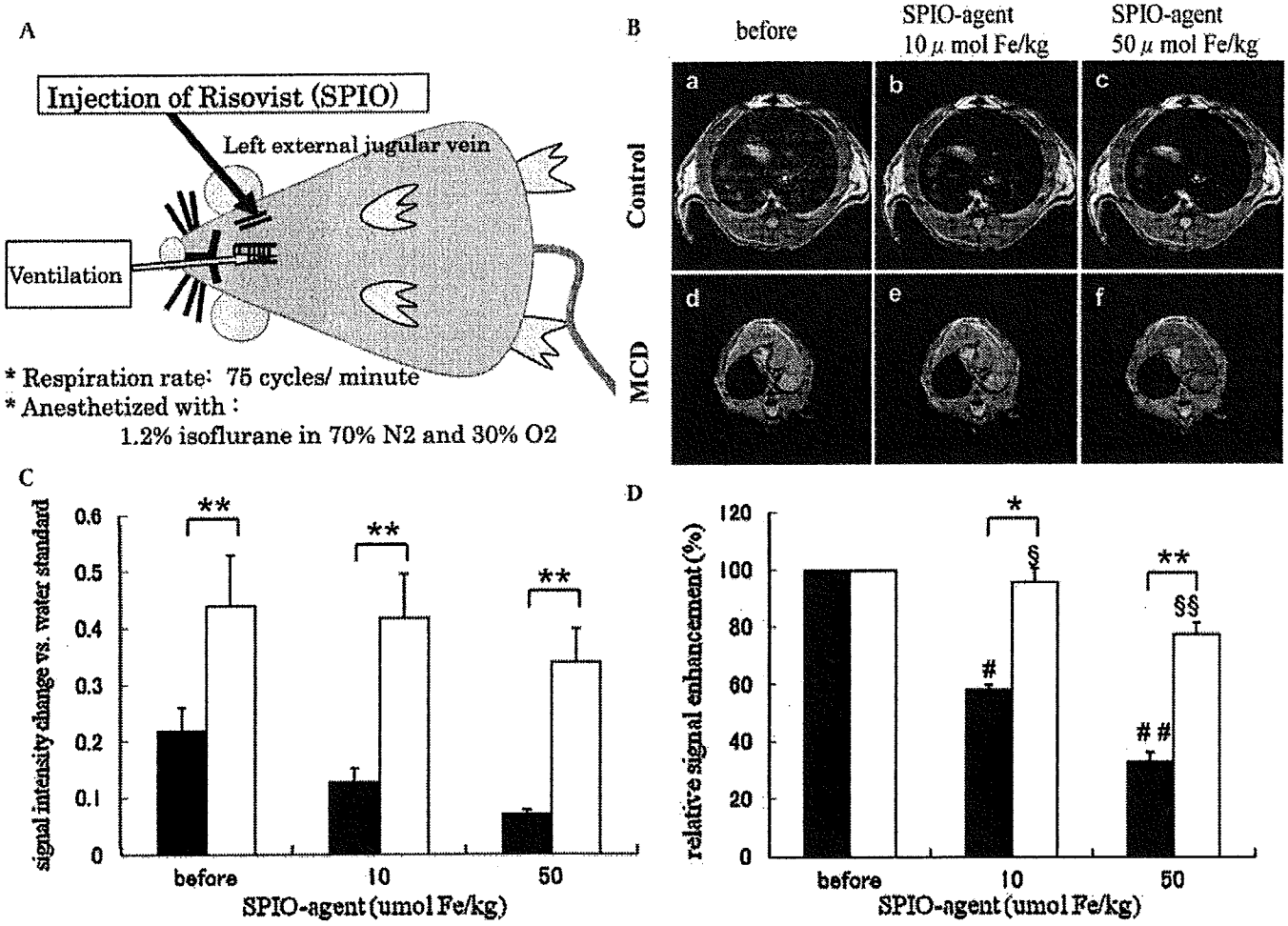

Figure 1 Rat super-paramagnetic iron oxide (SPIO)-MRI studies. (A) Schema of the rats SPIO-MRI experiment. The rats were tracheotomised, intubated and anaesthetised with 1.2% isoflurane in 70% N_2 and 30% O_2 during the MRI experiments. Ventilation rate was adjusted to 75 cycles/min for synchronising with the gating apparatus of the MRI. SPIO contrast was administered via a cannulated left external jugular vein. (B) Representative MR images of rat SPIO studies. After SPIO administration, the signal intensity (SI) of control rats dramatically decreased, whereas little signal reduction was seen in rats fed a methionine-choline deficient (MCD) diet. (C) Changes of SI in rat livers. Signal reduction occurred in control (n=4) and rats fed an MCD diet (n=4), respectively, after injection of SPIO (**p<0.01). ■, control rats; □, rats fed an MCD diet. (D) Here, SI was compared as a relative signal enhancement (RSE; %). After infusion of SPIO (10 μmol Fe/kg), a substantial reduction of SI was seen in control rats (RSE=100% vs 58.0±2.0%, #p<0.05), whereas there was no statistically significant reduction in RSE in the livers of rats fed an MCD diet (RSE=100% vs 95.4±4.7%, §p>0.05). With SPIO at 50 μmol Fe/kg a more marked reduction in RSE, than was seen at 10 μmol Fe/kg, was seen with control rats (100% vs 32.5±3.6%, n=4, ##p<0.05) compared with rats fed an MCD diet (100% vs 77.3±3.7%, n=4, §§p<0.05). Furthermore, there was a clear and statistically significant difference in RSE between control and rats fed an MCD diet at either of the SPIO concentrations, with the RSE of the rats fed an MCD diet being consistently higher than controls (95.4±4.7% vs 58.0±2.0%, *p<0.05 at SPIO 10 μmol Fe/kg, and 77.3±3.7% vs 32.5±3.6%, **p<0.05 at SPIO 50 μmol Fe/kg). ■, control rats; □, rats fed an MCD diet.

Alto, California, USA) equipped with a 18.3 cm horizontal-bore 7.05 Tesla superconducting magnet (Oxford Instruments, UK).[21 22] To minimise bulk motion artefacts, data acquisitions were gated to respiration using a home-made mechanical switch activated by the ventilator piston at inspiration. This gating apparatus synchronised the rat respiration and the start of pulse sequence. The rats were anaesthetised, tracheotomised and ventilated with 800 ms/respiration cycle (figure 1A).

MR images were obtained using a spin-echo (SE) sequence. Repetition time (TR) was determined by the respiration rate and the number of multislice, and was 4800 ms (=800 ms×6 slices). Unenhanced MR images of the liver were first obtained, and then MRI was performed 15 min after the injection of SPIO (10 μmol Fe/kg body weight or 50 μmol Fe/kg body weight) via the left external jugular vein.

SI values of the liver parenchyma in the region of interest (over 100 pixels) were normalised to the standard deviation of background noise and expressed as signal-to-noise ratio. SI of the whole liver was measured on each MR image, and the relative signal enhancement (RSE) of the rat liver was calculated using the following equation: RSE (%)=SIpost/SIpre×100, where SIpre and SIpost are the signal intensities of the whole liver parenchyma before and after injection of SPIO respectively.[16]

Evaluation of accumulation of fluorescent microspheric beads in rat livers

Rats fed an MCD diet (n=6) and control rats (n=6) or Zucker *fa/fa* rats (n=4) were deeply anaesthetised with pentobarbital sodium (25–50 mg/kg, Nembutal; Abbott Laboratories) administered intraperitoneally, and Fluoresbrite YG carboxylate microspheres 2.00 μm (2.5% slide-latex, Polyscience, Warrington, Pennsylvania, USA) were injected via a left external jugular vein catheter. One hour after injection, the animals were re-anaesthetised, and their livers removed. The number of accumulated microspheres in 10 high-power fields was counted by fluorescent microscopy.

Kupffer cells in liver sections

Liver sections were stained for the presence of KCs with ED2 monoclonal antibody (BMA Biomedicals AG, Switzerland).[23] The number of KCs per field area of digital photomicrographs was quantified with a computerised image analysis system (Macintosh MacSCOPE version 2.591).[18]

Patients

Twenty-six patients (14 women/12 men) with elevated transaminases and a diagnosis of NAFLD on abdominal ultrasonography, and 10 patients with chronic hepatitis C (five women/five men) and four healthy volunteers as controls, participated in this study. Patients with known use of methotrexate, tamoxifen, corticoids, insulin or alcohol in excess of 20 g per day and patients with other known causes of liver disease, including viral hepatitis, haemochromatosis, Wilson disease and autoimmune liver diseases, were excluded from this study. Informed consent was obtained for SPIO-MRI, abdominal CT, liver biopsy or laboratory tests. Twenty-six patients with NAFLD consented to an abdominal CT scan to quantify the degree of hepatic steatosis, defined as a liver/spleen ratio (L/S ratio): <0.9 moderate to severe hepatic steatosis and ≥0.9 mild hepatic steatosis.[24] Liver biopsies were also performed in 20 patients with NAFLD: 13 (seven women/men men) of these fulfilled criteria diagnostic for NASH.[25]

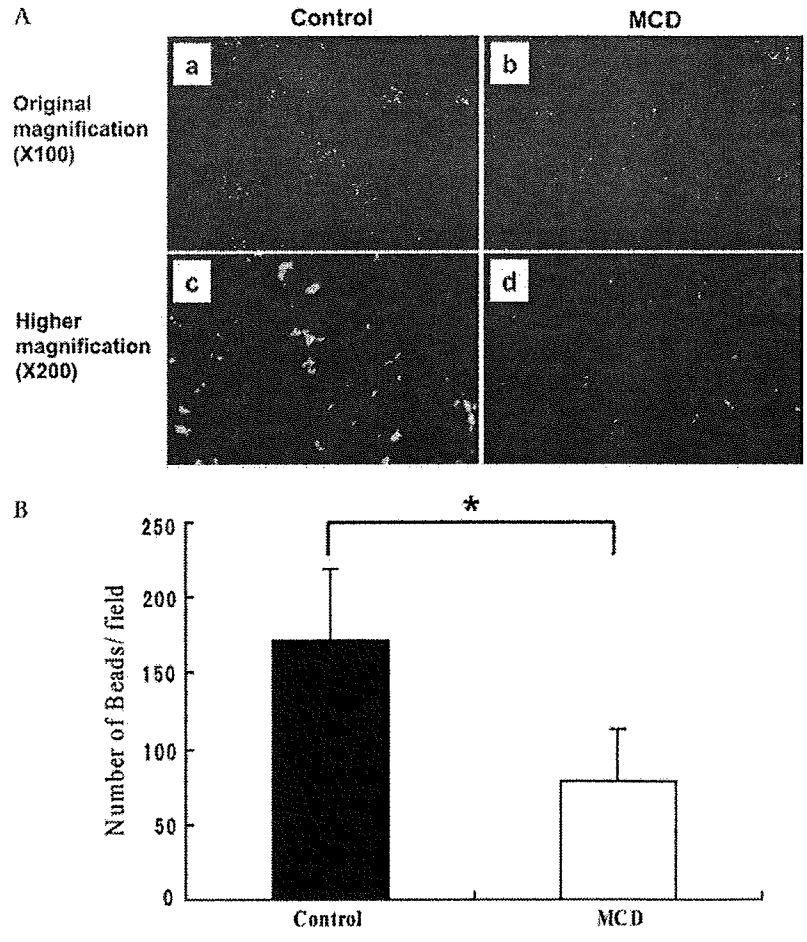

Figure 2 Uptake of fluorescent microspheric beads by Kupffer cells. (A) Uptake of microbeads in a liver section as judged by fluorescent microscopy. Fluorescent microbeads formed large aggregates in control livers, whereas the beads were disseminated in the livers of rats fed a methionine-choline deficient (MCD) diet. (B) The number of fluorescent microbeads taken up in liver sections of control and rats fed an MCD diet. The number of fluorescent beads in livers of rats fed an MCD diet was fewer than that in control rat livers (171.33±48.37/field in control rats (n=6), 78.63±34.8/field in rats fed an MCD diet (n=6), *p<0.005). ■, control rats; □, rats fed an MCD diet.

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Patient MRI

MRI examinations were performed on a 1.5 T MRI system (Signa Horizon, GE Medical Systems, USA) using a body phased array coil. Unenhanced T1- and T2-weighted images of the whole liver were obtained as routine. SPIO (8 μmol Fe/kg body weight) was injected via the antecubital vein. Fast imaging was performed using the SPGR (spoiled gradient recalled acquisition in the steady state) technique at 200/20/20 degree (TR/TE/flip angle) in suspended respiration to analyse the uptake of SPIO by the liver. Whole-liver images were acquired within 15 s.

The parameters used were field of view, 320×320 mm; slice thickness, 7.0 mm; interslice gap, 3.0 mm, phase×frequency matrix, 128×256; and number of acquisitions, one. SPGR imaging was repeated at multiple time points (pre-contrast, 40 s, 2, 3, 5, 10, 15, 20, 25 and 30 min after injection of SPIO). The RSE was calculated as above.

Histological examination

Haematoxylin and eosin stained liver biopsy specimens of patients with NAFLD were scored according to the NASH Clinical Research Network Scoring System[24] by two pathologists blinded to the patients' clinical data. An NAFLD Activity Score (NAS) of ≥5 was classified as NASH and ≥3 as non-NASH.[25]

KCs in patients' liver biopsy specimens

KCs in liver biopsy specimens were detected by staining with anti-CD68 (KP-1, DAKO)[18] and quantified as above.[18]

Statistical analysis

Results are presented as mean±SD for continuous data or as numbers for categorical data. A univariate analysis was conducted using the Mann–Whitney U test to assess the significance between the two groups based on the quantitative data. Qualitative data were compared using Fisher's exact test. Spearman's coefficient of correlation was used to evaluate the relationship between the two groups. Statistical significance was accepted at $p<0.05$. All analyses were performed using Stat View.

RESULTS

Rats with experimentally induced NASH have reduced KC uptake function

Figure 1B shows representative MR images of rats fed a control or MCD diet with and without infusion of SPIO. Images were scarcely affected by motion artefact (a). In the absence of SPIO, livers of rats fed an MCD diet (d) had a higher SI than control rats (a). After SPIO (10 μmol Fe/kg), SI in control livers dramatically decreased (b), whereas little signal reduction was seen in livers of rats fed an MCD diet (e). Similarly, after 50 μmol Fe/kg SPIO, the SI of the control livers almost disappeared (c), with minimal signal reduction in MCD-fed rats (f).

Figure 1C shows quantitatively the changes in SI in control or MCD-fed rats, depicted qualitatively in figure 1B above. Signal intensities were standardised using the SI of water as an external standard. At baseline there was a statistically significant difference between the SI of control and MCD-fed rats (0.22±0.04 vs 0.44±0.09, $p<0.01$). After infusion of 10 and 50 μmol Fe/kg

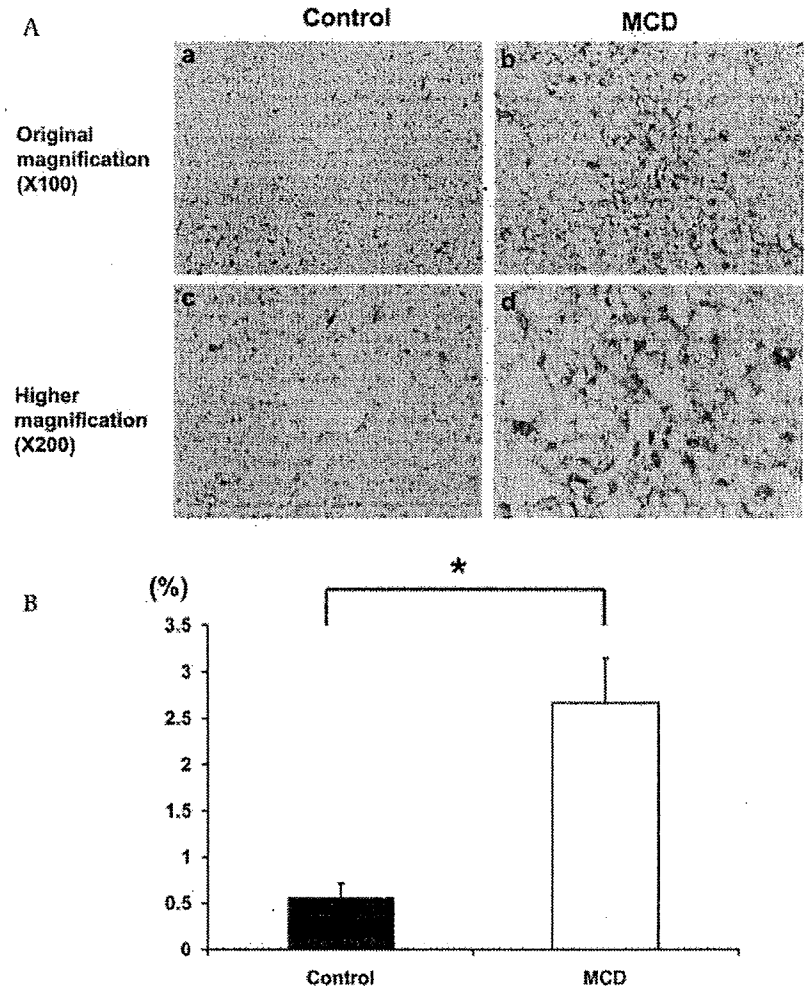

Figure 3 The number of Kupffer cells (KCs) in the livers of rats fed a methionine-choline deficient (MCD) diet. (A) Immunostaining of KCs in liver sections. The number of KCs in the livers of rats fed an MCD diet was increased compared with that of controls. (B) The area occupied by KCs cells estimated by image analysis in the livers of rats fed an MCD diet (2.6675±0.4795%, n=6) is clearly shown to be increased compared with that of control rats (0.5606±0.1541%, n=6, *p<0.0001). ■, control rats; □, rats fed an MCD diet.

SPIO, this difference was accentuated and a greater SI reduction was seen in controls than in MCD-fed rats (0.13±0.03 vs 0.42±0.08 at 10 μmol Fe/kg SPIO and 0.069±0.009 vs 0.337±0.063 at 50 μmol Fe/kg SPIO, p<0.01), with minimal change of SI in the MCD-fed at each SPIO dose.

To more accurately compare the uptake function of KCs observed with an MCD diet, SIs were calculated as the RSE (figure 1D), with the RSE at baseline set at 100%. After infusion of SPIO (10 μmol Fe/kg), a substantial reduction of SI was observed in controls (RSE=100% vs 58.0±2.0%, p<0.05), whereas there was no significant reduction in RSE in rats fed an MCD diet (RSE=100% versus 95.4±4.7%, p>0.05). With infusion of SPIO at 50 μmol Fe/kg a more marked reduction in RSE, than was seen at 10 μmol Fe/kg, was found with controls (100% vs 32.5±3.6%, p<0.05) compared with rats fed an MCD diet (100% vs 77.3±3.7%, p<0.05). Furthermore, there was a clear and statistically significant difference (p<0.05) in RSE between control rats and rats fed an MCD diet at either of the SPIO concentrations, with the RSE of the rats fed an MCD diet being consistently higher than controls (95.4±4.7% vs 58.0±2.0%) at SPIO 10 μmol Fe/kg, and (77.3±3.7% vs 32.5±3.6%) at SPIO 50 μmol Fe/kg. Therefore, uptake function of KCs in rats fed an MCD diet is impaired compared with that in control rats.

Similarly, as shown in online supplementary figure 1, the RSE of SPIO-MRI in Zucker *fa/fa* rats was significantly higher than that of their lean littermates (59.5±12.5% vs 47.2±11.7% at SPIO 10 μmol Fe/kg, p<0.05, and 27.0±9.8% vs 18.2±9.0% at SPIO 50 μmol Fe/kg, p<0.05) indicating that KC uptake function in the livers of obese, insulin-resistant, steatotic Zucker *fa/fa* is impaired compared with that of controls and so validating the results with the rats fed an MCD diet as above.

Uptake of fluorescent beads by KCs is reduced in experimental NASH

To confirm this suggested impairment of KC uptake function in our experimental models of NASH, fluorescent microspheric beads were now infused into the rats fed an MCD diet and Zucker *fa/fa* rats and the number of fluorescent beads in their livers enumerated to reflect clearance function of KCs.[13] Qualitatively, figure 2A shows that the fluorescent microspheric beads in the livers of rats fed an MCD diet were fewer (figure 2A, b and d) than in controls (figure 2A, a and c). Furthermore, the beads formed large aggregates in control livers (figure 2A, a and c), whereas they were disseminated in the MCD-fed rats liver (figure 2A, b and d). Quantitatively, there were fewer fluorescent beads in the livers of rats fed an MCD diet than in controls (171.33±48.37/field (n=6), controls vs 78.63±34.8/field (n=6), rats fed an MCD diet, p=0.003, figure 2B).

We also examined the correlation between the extent of hepatic steatosis and KC uptake function, and between NASH activity and KC uptake function in MCD-fed rats. Online supplementary figure 2 shows that the number of phagocytosed microbeads in the livers of rats fed an MCD diet after 12 weeks (78.63±34.81/field) was no different from that after 4 weeks of the MCD diet (75.15±6.69/field, p=0.873). The extent of steatosis was similar between rats at 12 weeks and 4 weeks, although the extent of hepatic fibrosis and inflammation were more severe at 12 weeks than at 4 weeks. Furthermore, the number of microbeads taken up after 2 weeks of the MCD diet (non-NASH with mild steatosis, 131.02±22.75/field) was higher than that at 4 weeks (severe hepatic steatosis, 75.15±6.69/field, p<0.01). These data suggests that KC uptake function in rats is not influenced by NASH activity or severity but rather by the extent of hepatic steatosis.

As with the rats fed an MCD diet, accumulation of fluorescent microbeads in the livers of steatotic Zucker *fa/fa* rats (online supplementary figure 3A) was significantly lower than that of their lean littermates (173.94±10.84/field vs 221.01±11.11/field, n=4, p<0.005; online supplementary figure 3B). Thus, the uptake function of KCs is reduced in experimental NASH.

KCs numbers in livers of rats fed an MCD diet are increased compared with controls

We next evaluated the number of KCs in the livers of rats fed an MCD diet by immunohistochemical staining with ED2 monoclonal antibody without infusion of fluorescent beads. The number of KCs in the livers of rats fed an MCD diet was significantly increased compared with control livers (figure 3A, a–d). In addition, the morphological appearance of the KCs was altered and they appear enlarged in the livers of MCD-fed rats (figure 3A, c and d). To quantity the number of KCs, the area occupied by KCs was estimated by image analysis. The area occupied by KCs in the livers of rats fed an MCD diet was clearly increased compared with that of control rats (2.6675±0.4795% (n=6) vs 0.5606±0.1541% (n=6), p<0.0001, figure 3B). Therefore, the impairment of KC uptake function in the MCD model of NAFLD is functional and is not due to a reduction in the numbers of KCs.

SPIO-MRI in patients with NAFLD

KC uptake function is impaired in patients with NAFLD

To determine the applicability of these animal studies to NAFLD, we now evaluated, using SPIO-MRI, the uptake function of KCs in the livers of patients with NAFLD and chronic hepatitis C (CH-C) as controls. The clinical characteristics of the CH-C and NAFLD groups are shown in table 1. Patients with NAFLD were younger and had higher body mass indices, calculated as weight (kg) divided by height (m) squared, than those with CH-C.

Table 1 Comparison of clinical characteristics of patients with chronic hepatitis C (CH-C) and non-alcoholic fatty liver disease (NAFLD)

	CH-C (n=10)	NAFLD (n=26)	p Value
Female/male	5/5	14/12	0.842
Age (years)	61.4±9.88	48.2±17.5	<0.05
BMI (kg/m^2)	22.9±2.7	31.1±6.8	<0.01
RBC (×10^4/μl)	428.0±40.1	464.4±50.3	<0.05
Ht (%)	40.0±3.8	42.6±4.2	0.099
Plt (×10^4/μl)	19.5±8.4	21.2±6.1	0.422
WBC (×10^3/μl)	4.724±1.321	6.260±1.967	<0.05
ALT (U/l)	41.6±22.3	82.2±62.2	0.056
AST (U/l)	40.3±17.4	55±35.0	0.184
LDH (U/l)	185.1±26.0	214.2±54.7	0.124
ALP (U/l)	255.6±88.5	227.9±56.8	0.209
γ-GTP (U/l)	28.1±13.4	60.8±36.2	<0.05
T-Bil (mg/dl)	0.58±0.24	0.84±0.32	<0.05
TP (g/dl)	7.76±0.37	7.39±0.47	<0.05
Alb (g/dl)	4.29±0.13	4.44±0.29	0.089
PT (%)	82.0±9.2	87.5±11.6	0.104
T-cho (mg/dl)	173.4±37.9	192.0±35.4	0.177
TG (mg/dl)	135.3±61.3	160.1±72.6	0.572
FPG (mg/dl)	101.4±11.9	108.8±34.9	0.498

Patients with NAFLD were younger and had higher BMI than those with CH-C (p<0.05). Alb, albumin; ALP, alkaline phosphatase; ALT, alanine transaminase; AST, aspartate aminotransferase; BMI, body mass index; FPG, fasting plasma glucose; Ht, haematocrit; γ-GTP, γ-glutamyltransferase; LDH, lactate dehydrogenase; Plt, platelets; PT, ????; RBC, red blood cells; T-Bil, total bilirubin; T-cho, total cholesterol; TG, triglycerides; TP, ????; WBC, white blood cells.

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The liver MRI images before and after SPIO in patients with CH-C or NAFLD are shown in figure 4A. As shown, the SI of the liver images in CH-C decreased within 15 min after injection of SPIO. However, only a slight reduction of SI was seen in livers with NAFLD. We next compared the RSE in patients with CH-C and NAFLD. As shown, figure 4B, RSE in NAFLD was significantly higher than in controls (20.87±6.23% (n=26) vs 10.13±1.31% (n=10), $p<0.0001$), indicating that KC uptake function is impaired in NAFLD. Furthermore, we also studied SPIO-RSE in healthy volunteers (n=4). The RSE of healthy volunteers was almost the same as that of patients with CH-C (online supplementary figure 4B), but was demonstrably lower than that of patients with NAFLD (online supplementary figure 4A, $p=0.0011$).

KC uptake function in NAFLD worsens with the degree of hepatic steatosis

We next evaluated the relationship between RSE and degree of hepatic steatosis determined on abdominal CT. The RSE in patients with NAFLD with mild hepatic steatosis was significantly lower than in patients with moderate to severe hepatic steatosis (16.77±4.44% (n=8) vs 23.77±6.29% (n=14), $p<0.05$, figure 4C). Since the RSE is inversely proportional to KC function—that is, the larger the RSE, the worse the KC function, these results suggest therefore that KC uptake function worsens with the degree of hepatic steatosis in NAFLD.

We now sought to determine if KC uptake function was also related to the degree of steatosis on biopsy. We observed a strong positive correlation between the degree of hepatic steatosis and RSE on SPIO-MRI in the livers of patients with NAFLD (figure 4D, $r=0.757$, $p<0.0005$, n=20), confirming that the degree of KC uptake dysfunction in NAFLD is related to the extent of hepatic steatosis.

We also determined if age might have influenced the RSE on SPIO-MRI in our study. As shown in our online supplementary figure 5A, there was no significant correlation between age and RSE in the CH-C cohort. However, there was a significant correlation between age and RSE in patients with NAFLD

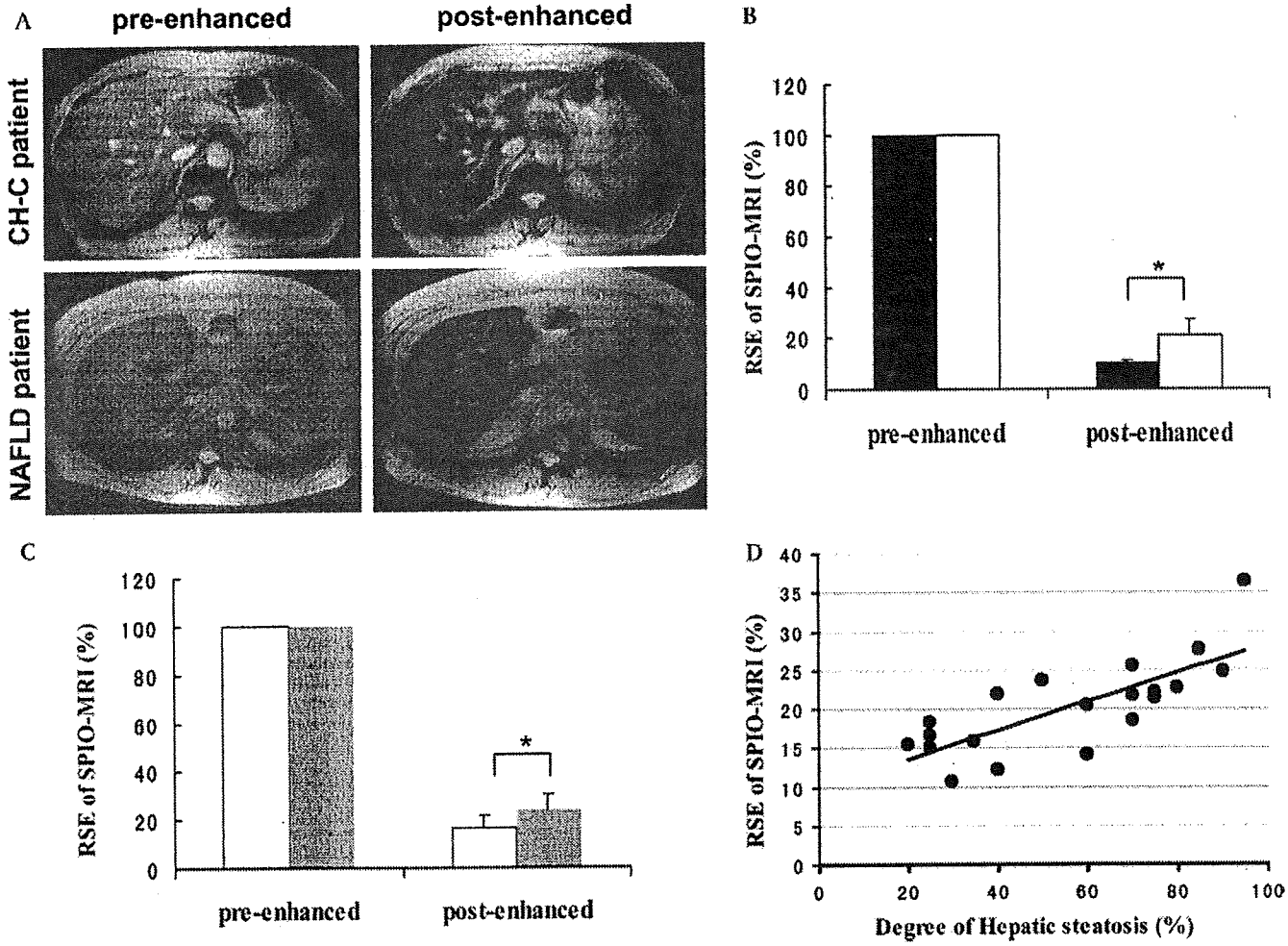

Figure 4 Super-paramagnetic iron oxide (SPIO)-MRI in patients with non-alcoholic fatty liver disease (NAFLD). (A) Representative MRI images of a patient with NAFLD and another with chronic hepatitis C (CH-C), pre-enhancement and post-enhancement with SPIO. (B) The relative signal enhancement (RSE) of the livers of patients with NAFLD and CH-C controls. RSE in the NAFLD group was statistically higher than in the CH-C control group (20.87±6.23% (n=26) vs 10.13±1.31% (n=10), *$p<0.0001$). ■, CH-C; □, NAFLD. (C) Relationship between the RSE and the degree of hepatic steatosis on abdominal CT. The RSE of patients with NAFLD who had mild hepatic steatosis was remarkably lower than that in patients with NAFLD who had moderate to severe hepatic steatosis (16.77±4.44% (n=8) vs 23.77±6.29% (n=14), *$p<0.05$). □, NAFLD with mild hepatic steatosis; ▩, NAFLD with moderate to severe hepatic steatosis. (D) Relationship between degree of hepatic steatosis and RSE of SPIO-MRI in patients with NAFLD. A strong positive correlation was observed between the degree of hepatic steatosis and the RSE on SPIO-MRI in the livers of patients with NAFLD ($r=0.757$, $p<0.0005$, n=20).

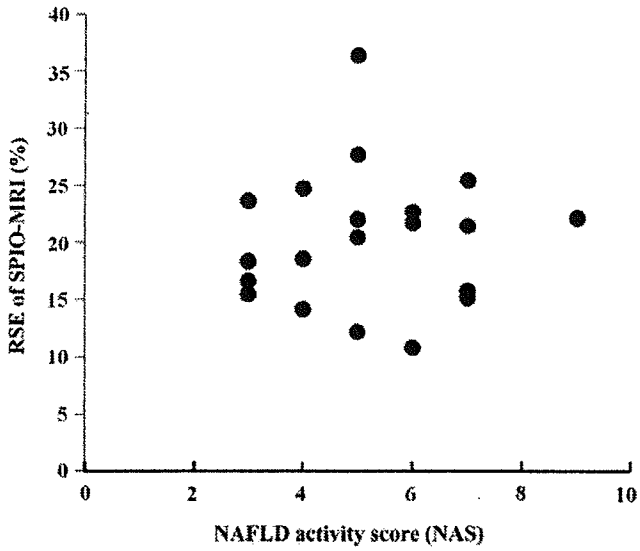

Figure 5 The relationship between non-alcoholic fatty liver disease (NAFLD) activity score (NAS) and relative signal enhancement (RSE) in patients with NAFLD. With NAS, 13 patients out of 20 were diagnosed as having the non-alcoholic steatohepatitis stage of NAFLD. The RSE of super-paramagnetic iron oxide (SPIO)-MRI in the 20 patients with NAFLD was not correlated with NAS (r=0.0682, p=0.8072, n=20).

(online supplementary figure 5B). In addition, the younger patients with NAFLD had more severe hepatic steatosis than the older patients in our study (online supplementary figure 5C). Therefore, RSE in NAFLD patients is influenced not by age but by the degree of hepatic steatosis.

KC uptake function is not related to NAFLD activity score

To now determine the relationship between the severity of NAFLD, as judged by the NAS and RSE, liver biopsies were scored according to the NASH Clinical Research Network Scoring System.[25] Accordingly, 13 of the 20 patients with NAFLD were classified as having NASH. The NAS was then correlated with RSE. As shown in figure 5, there was no correlation between the RSE and NAS, suggesting that KC uptake function may not be related to histological severity of NAFLD.

Reduced KC uptake function in NAFLD is not dependent on a reduction on the number of KCs

As with the rat studies, we now sought to determine if the apparent KC dysfunction in NAFLD was secondary to a lowering of the number of KCs. To this end we stained for the presence of KCs by immunohistochemistry and quantified the numbers by image analysis. There was no correlation ($p>0.05$) between the severity of steatosis and number of KCs, nor between the number of KCs and RSE (figure 6A–C). Therefore, the observed reduction in KC uptake function in NAFLD is not dependent on a reduction in KC numbers.

Reduced KC uptake function in NAFLD is not dependent on reduced hepatic blood flow

It is plausible that the changes in RSE in patients with NAFLD and CH-C were due to changes in the liver's microcirculation since fat accumulation in hepatocytes is associated with increases in hepatocyte cell volume which may compromise the hepatic sinusoidal space.[26] To ensure that changes in RSE in patients with NAFLD and CH-C were not due to changes in microcirculatory blood flow, we therefore compared the change in RSE with, time after injection of SPIO, in both patient groups. RSE gradually decreased in both groups after injection of SPIO and had reached a plateau by 15 min (figure 7). Consequently, differences at 15 min were reasonably chosen as standard in all the human studies above and observed differences between the NAFLD and control groups are unlikely, therefore, to be the result of changes in the microcirculation.

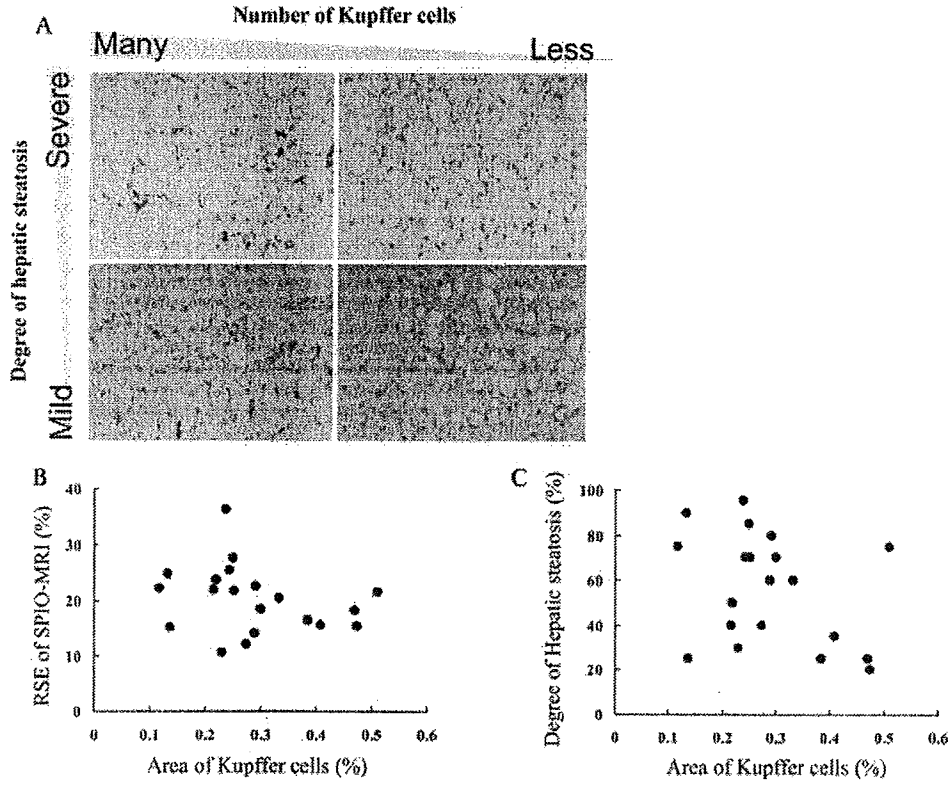

Figure 6 The number of Kupffer cells (KCs), degree of hepatic steatosis and relative signal enhancement (RSE) in patients with non-alcoholic fatty liver disease (NAFLD). (A) Four typical histological patterns based on the degree of fatty droplets and the number of KCs in the liver of patients with NAFLD. (B) The relationship between the area occupied by KCs estimated by image analysis and the RSE on super-paramagnetic iron oxide (SPIO)-MRI in patients with NAFLD. There was no correlation between these parameters (r=−0.252, p=0.287, n=20). (C) The relationship between the degree of hepatic steatosis and the area occupied by KCs in the livers of patients with NAFLD. No correlation between the degree of hepatic steatosis and the number of KCs was seen (r=−0.345, p=0.141, n=20).

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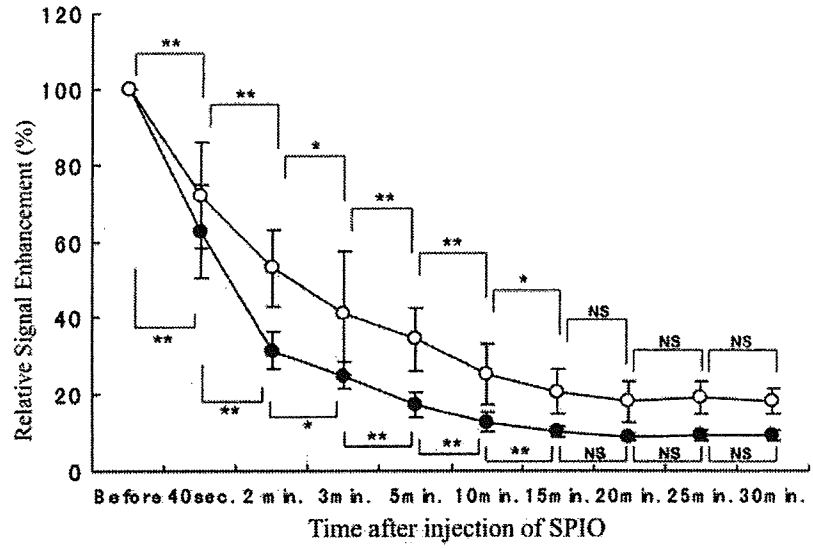

Figure 7 Changes in relative signal enhancement (RSE) in patients with non-alcoholic fatty liver disease (NAFLD) and chronic hepatitis C (CH-C) with time after injection of super-paramagnetic iron oxide (SPIO). RSE gradually decreased in both groups after injection of SPIO and had reached a plateau by 15 min (●, CH-C: n=10, ○, NAFLD, n=26, *p<0.05, **p<0.01).

DISCUSSION

In this study, using SPIO-MRI technology in experimental liver studies, we have shown conclusively that rats and patients with NAFLD have impaired KC uptake function. The importance of these findings lies in the fact that hyper-endotoxaemia may be implicated in the pathogenesis of NAFLD since KCs through their uptake properties provide the predominant protective barrier against the egress of endotoxin from the portal to the systemic circulation.[27] Reduced KC uptake function may, therefore, lead to higher endotoxin levels in the systemic circulation, as has been observed in patients with NAFLD and in animal models of NASH.[7 23 28] Given that overproduction of, and increased sensitivity to, cytokines such as tumour necrosis factor α and interleukin 1β from KCs[10 28] is also implicated in the pathogenesis of NAFLD, failure of KCs to clear endotoxin because of defective uptake function may further drive the production of these proinflammatory cytokines by KCs.

The impairment of KC uptake function was not due to a decrease in the number of KCs because these were raised both in experimental NASH livers compared with controls, and in patients with NAFLD compared with CH-C controls. In addition, KC uptake function as assessed by SPIO-MRI, in healthy volunteers was not different from that of patients with CH-C, but was different from that of patients with NAFLD. The reduced KC uptake function in patients with NAFLD, however, worsened with the degree of hepatic steatosis but, intriguingly though, was not related to the NAS. The mechanisms underlying this unexpected finding form part of ongoing studies in our group. We also compared the RSE on SPIO-MRI between the NASH (NAS ≥5; n=13) and non-NASH groups (NAS ≤4; n=7), and between the NASH and simple steatosis groups (NAS <4). We found no differences between the NASH group (21.04±6.79%) and non-NASH group (18.73±4.01%, p=0.485), nor between the NASH group (21.04±6.79%) and the simple steatosis group (18.53±4.45%, p=0.486).

Our animal data support previous studies that have shown defective KC uptake function in models of NASH.[9] In addition, Moriyasu *et al*[29] using ultrasonography showed reduced KC uptake function in patients with NASH. However, while ultrasonographic evaluation of KC function may be influenced by altered hepatic microcirculation, the SPIO-MRI methods described here have controlled for possible microcirculatory changes.

A possible criticism of our study is that we did not directly measure endotoxin levels in our patients with NAFLD and thus the reduced uptake function may not be of pathophysiological significance. However, if it is accepted that endotoxin is of importance in NAFLD and that KCs, as argued above, provide the main defensive barrier to endotoxin, then in the presence of defective KC uptake function, endotoxin levels would be expected to rise, as has indeed been shown.[6 7] The mechanism underlying the observed reduction in human KC uptake function remains to be investigated but may be related to defective leptin signalling, as previously described in models of NASH[9 30 31] or it may be related to saturation of uptake mechanisms by, for example, KC engulfment of apoptotic bodies or erythrocytes, as has been previously observed in NASH.[32 33]

In conclusion, we have shown using an SPIO-MRI technique that KC uptake function is defective in experimental NAFLD and in patients with NAFLD. This defective uptake function may be responsible for the observed raised levels of endotoxin that have previously been implicated in the pathogenesis of NAFLD.

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Patient consent Obtained.

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