

CLINICAL STUDIES

HBcrAg is a predictor of post-treatment recurrence of hepatocellular carcinoma during antiviral therapy

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Keywords

covalently closed circular DNA – HBcrAg – HCC recurrence – nucleot(s)ide analogue – portal vein invasion

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Abstract

Background/Aims: The recurrence rate of hepatitis B virus (HBV)-related hepatocellular carcinoma (HCC) is high even in patients receiving curative therapy. In this study, we analysed the risk factors for tumour recurrence after curative therapy for HBV-related HCC while under treatment with nucleot(s)ide analogues (NAs) by measuring serum HBcrAg and intrahepatic covalently closed circular DNA (cccDNA) levels to elucidate the viral status associated with HCC recurrence. **Methods:** We enrolled 55 patients who developed HCC during NA therapy and underwent either curative resection or percutaneous ablation for HCC. **Results:** Hepatocellular carcinoma recurred in 21 (38%) of the patients over a period of 2.2 (range, 0.2–7.4) years. In multivariate analysis, serum HBcrAg levels $\geq 4.8 \log U/ml$ at the time of HCC diagnosis (hazard ratio, 8.96; 95% confidential interval, 1.94–41.4) and portal vein invasion (3.94, 1.25–12.4) were independent factors for HCC recurrence. The recurrence-free survival rates of the high cccDNA group were significantly lower than those of the low cccDNA group only in patients who underwent resection ($P = 0.0438$). A positive correlation ($P = 0.028$; $r = 0.479$) was observed between the intrahepatic cccDNA and the serum HBcrAg levels at the incidence of HCC. **Conclusion:** HBcrAg is a predictor of the post-treatment recurrence of HCC during antiviral therapy. Serum HBcrAg and intrahepatic cccDNA suppression by NAs may be important to prevent HCC recurrence.

Worldwide, an estimated 400 million people are infected with hepatitis B virus (HBV) persistently, and one million people die of decompensated cirrhosis and/or hepatocellular carcinoma (HCC) annually (1, 2). Recently, oral nucleot(s)ide analogues (NAs) have been used as the mainstay therapeutic strategy against chronic hepatitis B. Five such antiviral agents have been approved, and range in the profundity and rapidity of HBV DNA suppression, barrier to resistance and side-effect profile (3–10). Lamivudine (LAM) was the first NA to be approved for treating chronic hepatitis B, followed by adefovir dipivoxil (ADV) and entecavir (ETV), in Japan. However, a major problem with long-term LAM treatment is the potential development of drug resistance, mainly caused by mutation of the tyrosine–methionine–aspartic acid–aspartic acid (YMDD) motif of reverse transcriptase (11, 12). For preventing breakthrough hepatitis induced by LAM-resistant mutants, additional ADV administration has been recommended (13, 14).

The methods for monitoring the treatment response include measurements of the serum alanine transaminase

(ALT) levels, HBV DNA levels, HBeAg and antibody levels, HBsAg and antibody levels and liver histology. Other serum markers have been reported to be useful for monitoring the effect of antiviral therapy (15, 16). Recently, a new assay was developed for detecting the HBcrAg, consisting of HBcAg, HBeAg and a 22 kDa precore protein coded with the precore/core gene (17, 18). Because NAs have no inhibiting action on the transcription and translation activities of viral mRNA, HBcAg- and HBeAg-related proteins continue to be produced for a certain period of time in spite of the achievement of adequate suppression of the viral DNA synthesis. Therefore, HBcrAg is a viral marker independent of HBV DNA for monitoring the antiviral effect of NAs (19). In addition, recent reports have indicated another interesting aspect of serum HBcrAg levels: these levels were found to be correlated with intrahepatic covalently closed circular DNA (cccDNA) levels and could be a surrogate marker of the intrahepatic cccDNA pool (20, 21). This phenomenon may be explained by the fact that the production of HBcrAg depends on the

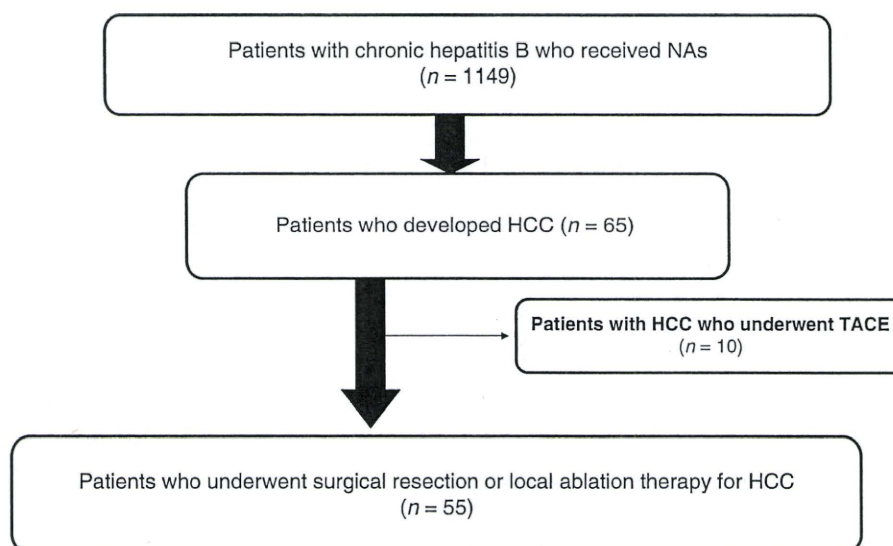


Fig. 1. The study protocol. HCC, hepatocellular carcinoma; NAs, nucleot(s)ide analogues; TACE, transcatheter arterial chemoembolization.

transcription of mRNA from cccDNA, and that cccDNA still remains in high levels during treatment with NAs.

Although patients with HBV-related cirrhosis have a significantly high risk of developing HCC, NA therapy can delay the progression of liver disease and reduce the risk of HCC in patients with cirrhosis by strong viral suppression (22, 23). Nevertheless, a few cases develop HCC during NA therapy at a constant rate (3–12%) (22, 24–26). The recurrence rate of HBV-related HCC after curative resection is estimated to be high, and is associated with viral factors, including HBeAg positivity and the viral load before surgery, besides host and tumour factors, but these findings were demonstrated in the absence of antiviral therapy (27–30). However, almost all patients, receiving NAs, showed negativity of serum HBV DNA. And so, we made the hypothesis that intrahepatic viral status, such as intrahepatic cccDNA and serum HBcrAg levels of its surrogate marker, might have an impact on tumour recurrence during NA therapy.

In this study, we examined the risk factors for tumour recurrence after curative resection and ablation for HBV-related HCC during NA therapy by measuring the serum HBcrAg and intrahepatic cccDNA levels with the aim to elucidate the viral status, persistent despite suppressive therapy, associated with HCC recurrence, in addition to the host and tumour factors reported in the past.

Patients and methods

Patients

Over a period of 13 years, from September 1995 to September 2008, 1149 patients with chronic hepatitis B received NA therapy, including LAM, ADV and ETV, at the Department of Hepatology, Toranomon Hospital, Metropolitan Tokyo. Of the 1149 patients, 65 developed

HCC after the start of NA therapy from February 2001 to June 2009. Of the 65 consecutive patients, 55 underwent radical therapy, including either resection or percutaneous ablation as the initial therapy for HCC. These 55 patients were enrolled in this cohort study (Fig. 1). The median duration from the start of NA therapy to the development of HCC was 2.2 (range, 0.2–7.4) years. The exclusion criteria were (i) patients co-infected with hepatitis C, delta or human immunodeficiency virus and (ii) a history of other liver diseases such as autoimmune hepatitis, alcoholic liver disease or metabolic liver disease.

The diagnosis of HCC was predominantly based on imaging, including dynamic computed tomography, magnetic resonance imaging and/or digital subtraction angiography. When the hepatic nodule did not show the typical imaging features, fine needle aspiration biopsy was performed, followed by histological examination and diagnosis. The physicians and surgeons usually discussed the preferred choice of treatment for each patient. Hepatic resection was mainly performed for patients categorized as Child–Pugh grade A or B liver function, and had no serious complications. Percutaneous ablation was performed for patients with surgical contraindications or for those who did not prefer to undergo hepatic resection by using two different devices: the cool-tip system (Tyco Healthcare Group LP, Burlington, VT, USA) and the radiofrequency tumour coagulation system (RTC system; Boston-Scientific Japan Co., Tokyo, Japan). The term curative treatment was used to indicate that no tumours were left in the remnant liver, irrespective of the width of the margin around the tumour, confirmed using intra-operative ultrasonography, combined ultrasonography and dynamic computed tomography 1 month after the resection or ablation. Serum samples were collected from all patients before and after

the treatment for HCC and stored in -80°C . Liver tissue from patients who underwent resection was collected, rapidly frozen and stored in -80°C . Written informed consent was obtained from each patient. The study protocol conformed to the ethical guidelines of the 1975 Declaration of Helsinki, as reflected in *a priori* approval by the institution's human research committee.

Antiviral therapy

Forty-seven patients received 100 mg LAM daily, and drug-resistant YMDD mutants developed in 26 (55%) of these patients, accompanied by an increase in HBV DNA ≥ 1 log copies/ml. Seventeen of the 26 patients received 10 mg ADV in addition to LAM (100 mg) daily. The remaining nine continued to receive LAM monotherapy because of the lack of approval for ADV administration in Japan at the time, but received ADV with LAM after approval was obtained during the HCC post-treatment period. Eight NA-naïve patients received 0.5 mg ETV daily. These antiviral therapies were continued after the resection or percutaneous ablation.

Follow-up and HCC recurrence

The patients were followed for liver function and virological markers of HBV infection monthly, as well as blood counts and tumour makers including α -fetoprotein and des- γ -carboxylprothrombin. They also underwent ultrasonography or helical dynamic computed tomography every 3 months. Cirrhosis was diagnosed by laparoscopy or liver biopsy or by the clinical data, imaging modalities and portal hypertension. The median observation period after HCC treatment for the entire cohort was 2.7 years (range, 0.3–8.4 years). HCC recurrence was diagnosed by the typical hypervascular characteristics on angiography and/or histological examination with fine needle biopsy specimens, in addition to certain features on computed tomography and ultrasonography.

Markers of HBV infection

HBeAg was determined by enzyme-linked immunosorbent assay using a commercial kit (HBeAg EIA; Institute of Immunology, Tokyo, Japan). HBV DNA was quantitated using the Amplicor monitor assay (Roche Diagnostics, Tokyo, Japan) with a dynamic range over 2.6–7.6 log copies/ml or COBAS TaqMan HBV v.2.0 (Roche Diagnostics) with a dynamic range over 2.1–9.0 log copies/ml. Serum HBV DNA levels were measured using the Amplicor assay at both the start of NA therapy and the diagnosis of HCC and using the TaqMan assay at the diagnosis of HCC. For statistical analysis, the value of that HBV DNA was tentatively set at 2.1 if HBV DNA levels were under 2.1 log copies/ml. HBV genotypes were determined serologically by the combination of epitopes expressed on the pre-S2 region product, which is specific for each of the seven major genotypes (A–G), using a commercial kit (HBV Genotype EIA; Institute of

Immunology). YMDD mutants were determined by polymerase chain reaction-based enzyme-linked mini-sequence assay using a commercial kit (Genome Science Laboratories, Tokyo, Japan).

HBcrAg measurement

Serum HBcrAg levels were measured using a CLEIA HBcrAg assay kit (Fujirebio Inc., Tokyo, Japan) with a fully automated analyser system (Lumipulse System; Fujirebio Inc.) as described previously (21). In brief, 150 μl of serum was incubated with 150 μl of pretreatment solution containing 15% sodium dodecyl sulphate at 60°C for 30 min. After heat treatment, 120 μl of pretreated specimen was added to a ferrite microparticle suspension in an assay cartridge. Ferrite particles were coated with monoclonal antibody mixture (HB44, HB61 and HB114) against denatured HBcAg, HBeAg and the 22 kDa precore protein. After 10 min of incubation at 37°C and washing, further incubation was carried out for 10 min at 37°C with alkaline phosphatase conjugated with two kinds of monoclonal antibodies (HB91 and HB110) against denatured HBcAg, HBeAg and the 22 kDa precore protein. After washing, 200 μl of substrate solution [3-(2'-spiroada-mantan)-4-methoxy-4-(3'-phosphoryloxy)phenyl-1,2-dioxetane disodium salt] (Applied Biosystems, Bedford, MA, USA) was added to the test cartridge, which was then incubated for 5 min at 37°C . The relative chemiluminescence intensity was measured, and the HBcrAg concentration was calculated by a standard curve generated using a recombinant pro-HBeAg (amino acids –10 to 183 of the precore/core gene product). The HBcrAg concentration was expressed in U/ml, which is defined as the immunoreactivity of 10 fg/ml of recombinant pro-HBeAg. In this study, the HBcrAg values were expressed as log U/ml, and the cut-off value was set at 3.0 log U/ml. For the statistical analyses, HBcrAg-negative cases were calculated as 3.0 log U/ml.

Intrahepatic cccDNA measurement

Intrahepatic cccDNA levels were analysed as described previously (21). In brief, liver specimens surrounding the tumour tissue were obtained and stored at -80°C before DNA extraction. HBV DNA was extracted using a QIAamp DNA Mini Kit (Qiagen KK, Tokyo, Japan). The concentration of purified DNA was based on the absorbance at 260 nm. For this study, two oligonucleotide primers cccF2 (5'-cgtctgtgccttctcatctga-3', nucleotides 1424–1444) and cccR4 (5'-gcacagcttgaggcttgaa-3', nucleotides 1755–1737) and probe cccP2 (5'-VIC-accatttatgcctacag-MGB-3', nucleotides 1672–1655) were designed using PRIMER EXPRESS software (Applied Biosystems, Foster City, CA, USA) to flank the direct repeat region between the hepatitis B core and the polymerase gene. The use of cccF2 and cccR4, oligonucleotide primers spanning the direct repeat region of the HBV genome, allows the polymerase chain reaction of native viral DNA in the

Dane particle to block the amplification of products, because the partially double-stranded HBV DNA is disrupted in the direct repeat region. Twenty-five microlitres of extracted DNA (0.5 µg) was detected with the sequence detector system (ABI 7900HT; Applied Biosystems) in 50 µl of a PCR mixture containing TaqMan universal PCR Master Mix (Applied Biosystems), 300 nmol of each primer and 250 nmol of the probe. After initial activation of uracil-*N*-glycosylase at 50 °C for 2 min, AmpliTaq Gold (Applied Biosystems) was activated at 95 °C for 10 min. The subsequent PCR conditions consisted of 45 cycles of denaturation at 95 °C for 15 s, and annealing and extension at 60 °C for 90 s per cycle (SRL Inc., Tokyo, Japan).

Statistical analyses

Standard statistical measures and procedures were used. Correlations between two variables were tested using Pearson's correlation analysis. Cox regression analysis was used to assess significant associations of the risk factors with tumour recurrence after HCC treatment. All factors found to be at least associated with recurrence ($P < 0.05$) were tested by multivariate analysis. Independent factors, associated with HCC recurrence, were calculated using stepwise Cox regression analysis. The cumulative recurrence-free survival rates after HCC treatment were analysed using the Kaplan–Meier method, and differences in the curves were tested using the

log-rank test. A P value of < 0.05 in a two-tailed test was considered significant. Data analysis was performed with SPSS version 11.0 (SPSS Inc., Chicago, IL, USA).

Results

Patient characteristics at the start of NA therapy and HCC incidence

Table 1 presents a comparison of the patient characteristics at the start of NA therapy and the time of HCC diagnosis. Almost all the patients (93%) enrolled in this study had HBV genotype C. One patient had genotype B, and the genotypes of three patients could not be determined. The rate of HBV DNA disappearance from serum in all the patients was 64% (35/55; Amplicor monitor assay, $< 2.6 \log$ copies/ml) and 51% (28/55; TaqMan assay, $< 2.1 \log$ copies/ml), that of aspartate aminotransferase (AST) normalization (< 32 IU/L) was 56% (31/55) and that of ALT normalization (< 42 IU/L) was 71% (39/55) at the incidence of HCC. YMDD mutants were detected in 30 of 47 patients at the beginning of LAM monotherapy, and virological breakthrough (VBT), accompanied by an increase in HBV DNA ($\geq 1 \log$ copies/ml), occurred in 26 patients with YMDD mutants by the diagnosis of HCC. Seventeen of these patients received ADV with LAM. No resistant mutation to ADV (rtA181T/S, rtN236T) occurred in patients receiving the combination therapy. Further, no drug-resistant mutant

Table 1. Patient characteristics at the start of nucleot(s)ide analogue therapy and the incidence of hepatocellular carcinoma

Characteristics	Start of NA therapy	Time of HCC Dx
Age (years)	51 (32–73)	54 (35–75)
Gender (male:female)	45:10	45:10
AST level (IU/L)	69 (27–195)	31 (16–207)
ALT level (IU/L)	78 (23–368)	29 (10–267)
Platelet count ($10^5/\text{mm}^3$)	11.4 (3.1–31.3)	12.9 (3.6–30.1)
Serum albumin level (g/dl)		3.8 (3.1–4.4)
Serum bilirubin level (mg/dl)		0.9 (0.4–2.4)
Prothrombin time (%)		90.8 (59–112)
Indocyanine green retention rate at 15 min (%)		14.5 (4–53)
Child–Pugh (A:B)		49:6
HBV genotype		
C	51 (93%)	51 (93%)
Others	4	4
HBeAg (+)	29 (53%)	23 (42%)
HBV DNA (log copies/ml)	7.1 (< 2.6 to > 7.6)	< 2.1 (< 2.1 to 8.5)
HBcrAg level (log U/ml)	6.6 (3.3 to > 6.8)	5.0 (< 3.0 to > 6.8)
Antiviral agents (LAM:LAM+ADV:ETV)	47:0:8	30:17:8
Duration of NA therapy before the incidence of HCC (years)		2.2 (0.2–7.4)
α -fetoprotein level (ng/dl)	6 (2–263)	4 (1–282)
Des- γ -carboxylprothrombin level (mAU/ml)		22 (< 10 –933)
Tumour diameter (mm)		22 (7–60)
Tumour number (solitary:multiple)		50:5
Portal vein invasion (positive:negative)		49:6
TNM stage (I:II:III:IV)		25: 24: 5: 1
HCC treatment (resection:ablation)		37:18

Values are expressed as the median and range (parenthetically) or the number and percentage (parenthetically).

ADV, adefovir dipivoxil; ETV, entecavir; HBV DNA, hepatitis B virus DNA; HCC, hepatocellular carcinoma; LAM, lamivudine; NA, nucleot(s)ide analogues.

was detected in the NA-naïve patients receiving ETV monotherapy.

Correlation between serum HBcrAg and serum HBV DNA levels at the incidence of HCC

The median serum HBcrAg value was 6.6log U/ml (range, 3.3 to > 6.8) at the start of NA therapy and 5.0log U/ml (range, < 3.0 to > 6.8) at the time of HCC diagnosis. We observed a positive correlation ($P < 0.001$; $r = 0.610$) between the levels of HBcrAg and HBV DNA in serum at the time of HCC diagnosis (Fig. 2A).

HBcrAg was detectable in 23 (82%) of 28 patients with undetectable HBV DNA levels using TaqMan assay and was > 4.8log U/ml in eight (29%) of 28 patients. In contrast, serum HBV DNA was detectable in spite of undetected HBcrAg in only two patients. Then, we examined the correlation between the serum HBcrAg levels at the time of HCC diagnosis and the antiviral effect. The median duration of on-treatment undetected serum HBV DNA was 1.1 years (range, 0.1–4.8) before the first diagnosis of HCC. As shown in Figure 2B, we observed a significant negative correlation between the levels of HBcrAg in serum at the time of HCC diagnosis and the duration of undetected HBV DNA in

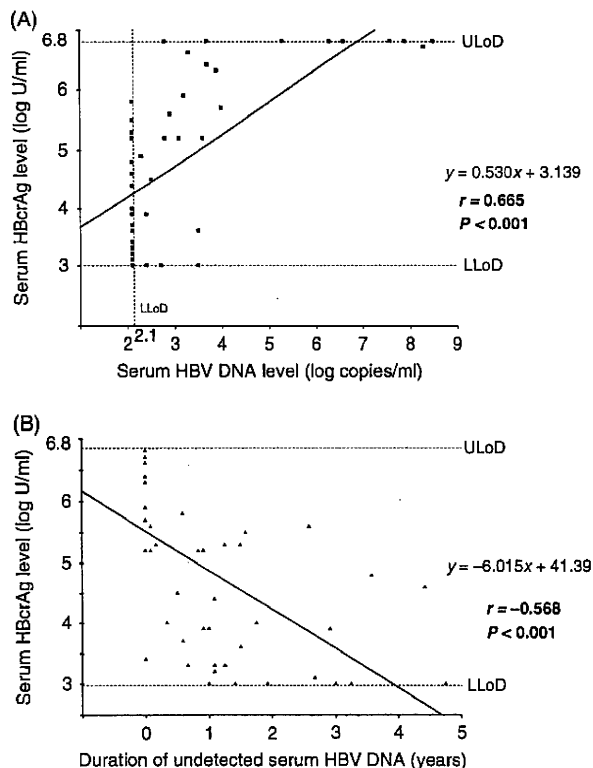


Fig. 2. (A) Correlation between serum HBcrAg and hepatitis B virus DNA (HBV DNA) levels at the time of hepatocellular carcinoma (HCC) diagnosis for each patient. (B) Correlation between serum HBcrAg levels at the time of HCC diagnosis and the duration of undetected serum HBV DNA (< 2.6log copies/ml).

serum just before the first diagnosis of HCC ($P < 0.001$; $r = -0.568$).

Factors associated with HCC recurrence

Hepatocellular carcinoma recurred in 21 (38%) of the 55 patients, 17 (46%) of 37 patients who had undergone resection and four (22%) of 18 patients who had undergone ablation. Because a proportion of patients who had undergone resection with TNM Stage II or over (24 of 37 patients) was greater than ablation (six of 18), there were more patients who had HCC recurrence after resection than ablation. Eight factors were associated with the recurrence in univariate analysis: HBeAg positivity at the start of NA therapy, HBV DNA ≥ 2.1 log copies/ml, HBcrAg level ≥ 4.8 log U/ml, AST level ≥ 50 IU/L, ALT level ≥ 40 IU/L, tumour multiplicity, portal vein invasion at the time of HCC diagnosis and HCC treatment. In the multivariate analysis, HBcrAg level ≥ 4.8 log U/ml and portal vein invasion were independent risk factors for the recurrence of HCC (Table 2). The cumulative recurrence-free survival rates in patients with ≥ 4.8 log U/ml HBcrAg levels at the time of HCC diagnosis were 70% at 1 year, 35% at 3 years and 28% at 5 years. In contrast, the rates in patients with < 4.8log U/ml HBcrAg levels were 96% at 1 year, 89% at 3 years and 89% at 5 years. The recurrence-free survival rates of the high HBcrAg group (≥ 4.8 log U/ml) were significantly lower than those of the low HBcrAg group (< 4.8log U/ml; $P < 0.001$), as shown in Figure 3A. Then, the cumulative recurrence-free survival rates in patients with ≥ 2.1 log copies/ml HBV DNA levels at the time of HCC diagnosis were 70% at 1 year, 44% at 3 years and 39% at 5 years. In contrast, the rates in patients with < 2.1log copies/ml HBV DNA levels were 93% at 1 year, 76% at 3 years and 76% at 5 years. The recurrence-free survival rates of the positive HBV DNA group (≥ 2.1 log copies/ml) were significantly lower than those of the negative HBV DNA group (< 2.1log copies/ml; $P = 0.007$), as shown in Figure 3B. The cumulative recurrence-free survival rates were 33% at 1 year and 33% at 2 years with portal vein invasion, and 87% at 1 year, 73% at 2 years and 64% at 3 years without invasion. Three of the six patients with portal vein invasion died of recurrent HCC.

Correlation between intrahepatic cccDNA and serum HBV DNA levels at the incidence of HCC

We measured intrahepatic cccDNA using liver specimens from 22 of 37 patients who underwent resection. The median intrahepatic cccDNA value was 4.2log copies/ μ g (range, 3.0–5.0). As shown in Figure 4A and B, we observed significant positive correlations between the levels of intrahepatic cccDNA and HBV DNA in serum ($P = 0.019$; $r = 0.486$) and between the levels of intrahepatic cccDNA and HBcrAg in serum at the time of HCC diagnosis ($P = 0.028$; $r = 0.479$). Twenty-eight patients who underwent resection had early- or intermediate-stage

Table 2. Risk factors for hepatocellular carcinoma recurrence

Factors	Univariate analysis		Multivariate analysis	
	Hazard ratio (95% CI)	<i>P</i>	Hazard ratio (95% CI)	<i>P</i>
Start of NA therapy				
Age (≥ 50 years)	1.79 (0.65–4.91)	0.257		
Gender (female)	0.98 (0.32–2.97)	0.981		
HBeAg(+)	2.85 (1.03–7.88)	0.044		
HBV DNA (≥ 6.0 log copies/ml)	1.75 (0.50–6.07)	0.378		
AST level (≥ 50 IU/L)	1.09 (0.42–2.85)	0.862		
ALT level (≥ 70 IU/L)	1.09 (0.42–2.85)	0.862		
Platelet count ($< 1.2 \times 10^5$ cells/mm ³)	2.56 (0.96–6.85)	0.061		
α -fetoprotein level (≥ 100 ng/ml)	0.99 (0.13–7.66)	0.996		
Time of HCC diagnosis				
Duration of NA therapy (≥ 2 years)	1.19 (0.49–2.88)	0.698		
HBeAg(+)	1.53 (0.63–3.70)	0.343		
HBV DNA (≥ 2.1 log copies/ml)	3.36 (1.32–8.55)	0.011		
HBcrAg level (≥ 4.8 log U/ml)	10.6 (2.45–46.1)	0.002	8.96 (1.94–41.4)	0.005
YMDD mutants (present:absent)	0.84 (0.35–2.03)	0.838		
AST level (≥ 50 IU/L)	2.44 (1.01–5.89)	0.047		
ALT level (≥ 40 IU/L)	2.44 (1.01–5.87)	0.047		
Platelet count ($< 10^5$ cells/mm ³)	2.20 (0.81–6.02)	0.123		
Serum albumin level (< 3.5 g/dl)	1.39 (0.53–3.63)	0.505		
Serum bilirubin level (≥ 1.5 mg/dl)	1.11 (0.62–2.00)	0.713		
Prothrombin time ($< 80\%$)	2.23 (0.51–9.82)	0.286		
Child–Pugh (B)	0.70 (0.16–3.04)	0.634		
Indocyanine green retention rate at 15 min ($\geq 30\%$)	0.58 (0.17–1.99)	0.389		
α -fetoprotein level (≥ 100 ng/ml)	1.81 (0.74–4.44)	0.194		
Des- γ -carboxylprothrombin level (≥ 100 mAU/ml)	2.09 (0.81–5.39)	0.129		
Tumour size (≥ 21 mm)	2.02 (0.81–5.07)	0.133		
Tumour number (multiple)	3.94 (1.29–12.1)	0.016		
Portal vein invasion	5.39 (1.69–17.2)	0.004	3.94 (1.25–12.4)	0.019
TNM stage (\geq II)	2.08 (0.85–5.10)	0.110		
HCC treatment (resection)	3.10 (1.05–9.09)	0.041		

The bolded numbers: statically significant.

ALT, alanine transaminase; AST, aspartate aminotransferase; CI, confidence interval; HBV DNA, hepatitis B virus DNA; NA, nucleot(s)ide analogues; YMDD, thymosine–methionine–aspartic acid–aspartic acid.

HCC (tumour diameter < 50 mm, absence of vascular invasion and well/moderately differentiated). In 17 of these patients, the intrahepatic cccDNA levels were measured using the resected specimens. The recurrence-free survival rates of the high cccDNA group (≥ 4.3 log copies/ μ g) were significantly lower than those of the low cccDNA group (< 4.3 log copies/ μ g; $P=0.0438$), as shown in Figure 4C.

Comparison of the serum HBcrAg levels and the patient characteristics

We examined whether the serum HBcrAg levels at the time of HCC diagnosis were correlated with the baseline parameters before antiviral therapy. The HBcrAg levels were compared with the baseline HBeAg-positive and HBeAg-negative status and with the baseline HBV DNA levels ≥ 6.0 log and < 6.0 log copies/ml (Fig. 5). The HBcrAg levels were significantly higher in patients who were positive for HBeAg (median value: 5.6 vs. 3.6log U/ml; $P=0.001$) and the baseline HBV DNA levels ≥ 6.0 log copies/ml (median value: 5.2 vs. 3.3log U/ml;

$P=0.012$). There was no correlation between the other baseline parameters at the start of NA therapy and the serum HBcrAg levels at the time of HCC diagnosis. Then, we examined whether the serum HBcrAg levels at the time of HCC diagnosis were associated with on-treatment drug resistance during antiviral therapy. Figure 6 shows the comparison of the serum HBcrAg levels at the time of HCC diagnosis with or without the emergence of YMDD mutants and VBT before the development of HCC. The HBcrAg levels were marginally higher in patients with emergent YMDD mutants (median value: 5.2 vs. 3.8log U/ml; $P=0.051$) and significantly higher in those with VBT (median value: 5.2 vs. 3.9log U/ml; $P=0.006$). There was no correlation between serum HBcrAg at the time of HCC diagnosis and age of patients or tumour factors.

Discussion

In this study, we examined whether the intrahepatic cccDNA and HBcrAg levels as substitutes for cccDNA are associated with HCC recurrence in patients who

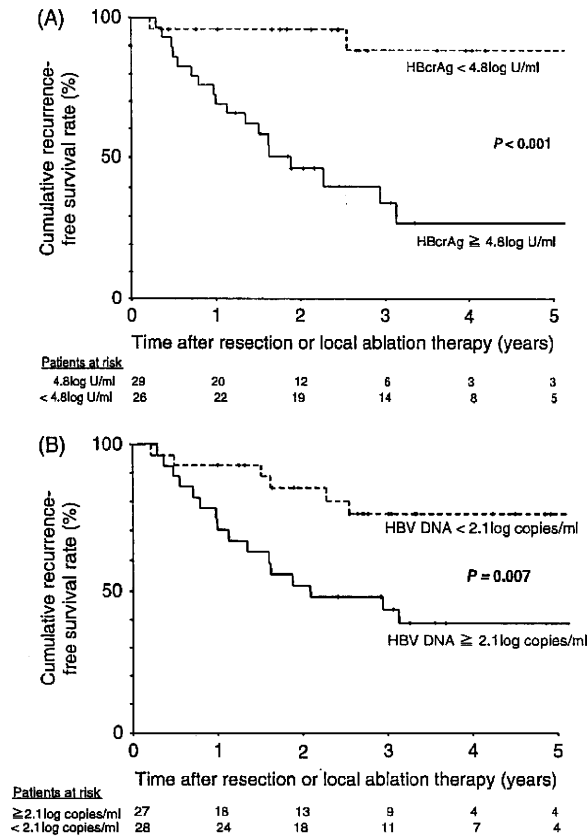


Fig. 3. (A) Kaplan-Meier life table for the cumulative recurrence-free survival rates by the serum HBcrAg levels and comparison by the log-rank test. (B) Kaplan-Meier life table for the cumulative recurrence-free survival rates by the serum hepatitis B virus DNA (HBV DNA) levels at the time of hepatocellular carcinoma (HCC) diagnosis for each patient and comparison by the log-rank test.

developed HCC after the commencement of NA therapy and underwent radical therapy for HCC. The recurrence rates of HCC were high in patients with high levels of intrahepatic cccDNA and serum HBcrAg. In particular, HBcrAg levels were measurable by using serum samples and clinically useful.

Nucleot(s)ide analogues, including LAM, ADV and ETV, are widely used for the treatment of chronic hepatitis B, and reportedly reduce the development of HCC in such patients (22, 23). Although few events of HCC development occur during NA therapy (24–26), analysis of a large number of patients is needed to examine the risk factors for HCC. We could clarify the risk factors associated with the development of primary HCC after radical therapy by enrolling patients who underwent radical therapy for HCC in spite of their small number. High HBV loads in serum have been reported to be associated with HCC recurrence after resection or radical therapy in NA-naïve patients (27–31), but no study has demonstrated the viral risk factors of recurrence in patients receiving NAs. The novel finding of this study is that serum HBcrAg and

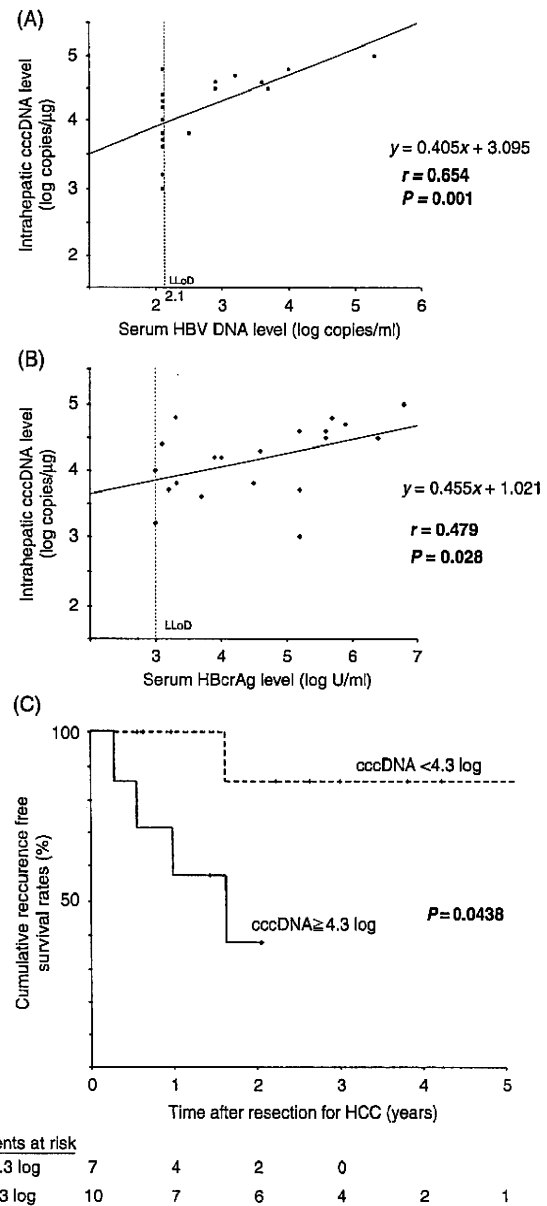


Fig. 4. (A) Correlation between intrahepatic covalently closed circular DNA (cccDNA) and serum hepatitis B virus DNA (HBV DNA) levels at the time of hepatocellular carcinoma (HCC) diagnosis for each patient who underwent resection ($n = 22$). (B) Correlation between intrahepatic cccDNA and serum HBcrAg levels at the time of HCC diagnosis. (C) Kaplan-Meier life table for the cumulative recurrence-free survival rates by the intrahepatic cccDNA levels in patients with early- or intermediate-stage HCC ($n = 17$).

intrahepatic cccDNA levels are predictors of HCC recurrence in patients radically treated for HCC during NA therapy.

In this study, the serum HBV DNA levels at the time of HCC diagnosis were associated with recurrence by univariate analysis. However, the serum HBcrAg level was the only viral factor associated with recurrence in multivariate analysis. There are two possible reasons for the

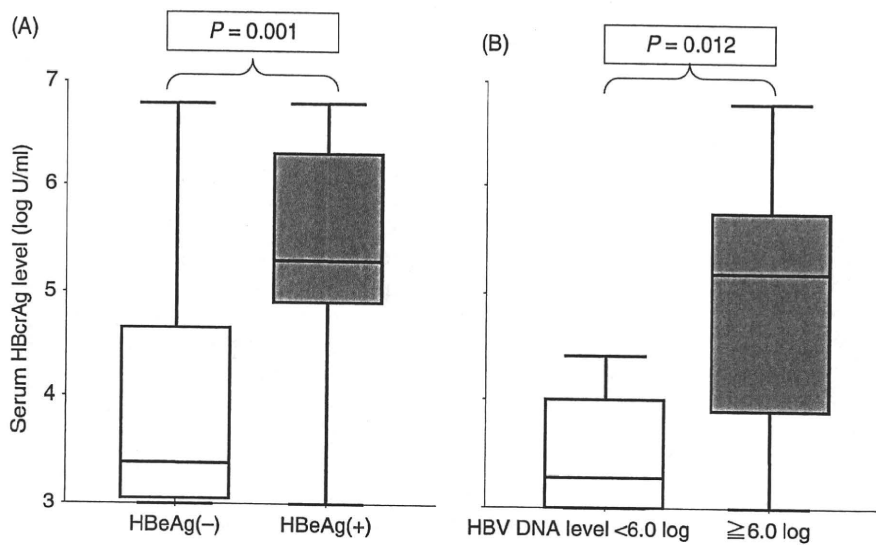


Fig. 5. Comparison of serum HBcrAg levels at the time of hepatocellular carcinoma diagnosis by the characteristics at the start of nucleot(s)ide analogue therapy (A) in patients with or without HBeAg and (B) in those with hepatitis B virus DNA (HBV DNA) levels < 6.0log or ≥6.0log copies/ml.

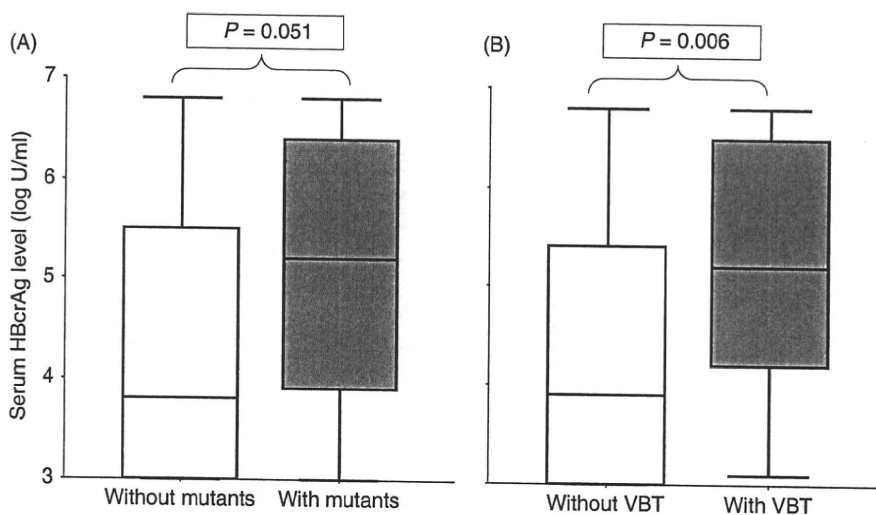


Fig. 6. Comparison of serum HBcrAg levels at the time of hepatocellular carcinoma (HCC) diagnosis (A) with or without tyrosine-methionine-aspartic acid-aspartic acid mutants and (B) virological breakthrough (VBT) before the development of HCC.

different results between past studies and the current study. Although serum HBV DNA was undetectable using TaqMan assay at the time of HCC diagnosis in 51% of the patients, who received NAs, serum HBcrAg was undetectable in only 18% of these patients. The other reason is that it was easy to identify the viral risk factors (e.g. HBeAg positivity) by measuring the serum HBcrAg level because the detection of HBcrAg enables the detection of HBcAg, HBeAg and the 22kDa precore protein coded with the precore/core gene. The high recurrence rate of HCC after curative resection and ablation is attributable to two principal characteristics: intrahepatic metastasis and *de novo* multicentric carcinogenesis (32). It is assumed that a high viral load increases the risk of

multicentric recurrence in the liver remnant in patients without optimal viral suppression by NA therapy. Recently, it was reported that the HBV load is associated with late recurrence over 2 years (30). On examining our cohort as per the recent report, high HBcrAg levels were found to be associated with late recurrence (data not shown). Consequently, we consider that HBcrAg is a more useful marker of HBV-related HCC recurrence than HBV DNA during NA therapy.

Nucleot(s)ide analogues are potent inhibitors of HBV replication, and can induce a rapid and drastic reduction in peripheral HBV DNA, seroclearance of HBeAg and remission of hepatic inflammation. Because of the stability of cccDNA in infected cells, the decline of

intrahepatic cccDNA levels is slower than that of serum HBV DNA levels during NA administration (15, 16). We found that suppression of cccDNA by NAs could prevent the development of recurrent primary HCC. Because cccDNA provides the template for pregenomic and viral messenger RNA-encoded viral proteins (33–35), the transcriptional activity of cccDNA may induce carcinogenesis. Further research is required to validate this hypothesis. Serum HBcrAg can be a surrogate marker of the intrahepatic cccDNA pool because of the viral proteins transcribed through messenger RNA from cccDNA (20, 21). Therefore, we consider that serum HBcrAg reflects the intrahepatic viral status more accurately than serum HBV DNA. Recently, Chan *et al.* (36) showed that serum HBsAg quantification could reflect intrahepatic cccDNA in patients treated with peginterferon and LAM combination therapy. They also indicated that reduction in HBsAg had good correlation with reduction in cccDNA. We tried to measure HBsAg levels at the start of NA therapy and the time of HCC diagnosis using a commercial assay (chemiluminescent immunoassay). However, HBsAg levels declined very slowly during NAs monotherapy in this study (data not shown). Brunetto *et al.* (37) showed that mean reduction for 48 weeks in HBsAg was 0.02logIU/ml in patients treated with LAM monotherapy, different from peginterferon therapy. Meanwhile, the median reduction from the start of NA to the diagnosis of HCC in HBcrAg was 1.4logU/ml in this study (Table 1). It seems that HBcrAg is a superior on-treatment risk predictor (e.g. tumour recurrence) to HBsAg during NAs monotherapy in terms of reduction of titres in each assay. HBcrAg is also more useful in terms of needless to serum sample dilution. As HBcrAg levels can be measured from serum samples, they are clinically useful, compared with the measurement of cccDNA, which requires liver specimens. It is not practical to carry out liver biopsy and the measurement of cccDNA for patients who have normal AST/ALT levels and viral suppression during antiviral therapy. Liver specimens cannot be also taken from patients who undergo ablation therapy for HCC. The measurement of serum HBcrAg levels in these patients is helpful to indirectly estimate the status of intrahepatic cccDNA. In the future, it is necessary to investigate whether HBcrAg in patients receiving NAs can be a predictor of primary carcinogenesis.

Previous studies have indicated that the rates of intrahepatic cccDNA loss and serum HBcrAg loss differ from serum HBV DNA loss under NA therapy, with the former two being much slower (15, 16, 19). In this study, the period of serum HBV DNA loss was longer, with lower intrahepatic cccDNA and serum HBcrAg levels (Fig. 2B). Therefore, these findings suggest that a long period of time is required to prevent the development of recurrent primary HCC by viral suppression under antiviral therapy. In contrast, the serum HBcrAg levels at the time of HCC diagnosis were higher in patients with emergent LAM-resistant mutants and subsequent VBT

than in patients without mutants and VBT (Fig. 6). This result suggests that it is important to administer a potent NA early for drug-resistant strains and suppress viral replication to prevent subsequent carcinogenesis. Although we evaluated the relationship between the development of primary HCC and serum HBcrAg levels by a case-control study, the serum HBcrAg levels at the commencement of NA therapy and 1 year later were not associated with the development of primary HCC (unpublished data). This finding is attributable to the slow decline of the serum HBcrAg levels during antiviral therapy. The measurement of HBcrAg at intervals of 3–6 months may be helpful to predict the development of HCC. However, further studies are needed to confirm the finding.

In summary, HBcrAg is a predictor of the post-treatment recurrence of HCC during antiviral therapy. Measurement of the serum HBcrAg level is simple and useful because it reflects the intrahepatic viral status. Further, intrahepatic cccDNA and serum HBcrAg suppression by NAs is important to prevent HCC recurrence.

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Original Article

New classification of dynamic computed tomography images predictive of malignant characteristics of hepatocellular carcinoma

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Aim: The aim of this study was to elucidate whether the histopathological characteristics of hepatocellular carcinoma (HCC) can be predicted from baseline dynamic computed tomography (CT) images.

Methods: This retrospective study included 86 consecutive patients with HCC who underwent surgical resection between January 2000 and September 2008. The arterial- and portal-phase dynamic CT images obtained preoperatively were classified into four enhancement patterns: Type-1 and Type-2 are homogeneous enhancement patterns without or with increased arterial blood flow, respectively; Type-3, heterogeneous enhancement pattern with septum-like structure; and Type-4, heterogeneous enhancement pattern with irregular ring-like structures. We also evaluated the predictive factors for poorly-differentiated HCC, specific macroscopic type of HCC (simple nodular type with extranodular growth [SNEG] and confluent multinodular [CMN]) by univariate and multivariate analyses.

Results: The percentages of poorly-differentiated HCC according to the enhancement pattern were three of 51

nodules (6%) of Type-1 and -2, three of 24 (13%) of Type-3, and eight of 11 (73%) of Type-4. The percentages of SNEG/CMN according to the enhancement pattern were 12 of 51 nodules (24%) of Type-1 and -2, 13 of 24 (54%) of Type-3, and five of 11 (45%) of Type-4. Multivariate analysis identified Type-4 pattern as a significant and independent predictor of poorly-differentiated HCC ($P < 0.001$) while Type-3 pattern was a significant predictor of SNEG/CMN ($P = 0.017$).

Conclusion: Heterogeneity of dynamic CT images correlates with malignant characteristics of HCC and can be potentially used to predict the malignant potential of HCC before treatment.

Key words: confluent multinodular type, dynamic computed tomography, hepatocellular carcinoma, poorly-differentiated hepatocellular carcinoma, radiofrequency ablation, simple nodular type with extranodular growth type.

INTRODUCTION

HEPATOCELLULAR CARCINOMA (HCC) is a common malignancy worldwide, and the incidence rate is increasing in Japan as well as in the USA.¹⁻³ Chronic viral hepatitis and liver cirrhosis following infection with hepatitis B virus (HBV) and hepatitis C virus (HCV) play important roles in the development of

HCC.^{4,5} The incidence of HCC in patients with HCV-related cirrhosis is estimated at 5–10% per annum, and it is one of the major causes of death, especially in Asian countries.⁵ Among the available treatment options for HCC, surgical resection is generally considered a potentially curative method and could provide a satisfactory long-term outcome.⁶⁻¹³ Recent advances in imaging procedures have led to increased detection of early-stage HCC and improved survival because of the greater number of patients identified in whom curative hepatic resection is possible.^{14,15} However, for patients who are not suitable for surgical treatment for several reasons (e.g. lack of sufficient liver function for surgical resection), percutaneous local therapy is another therapeutic option. Various methods, such as percutaneous ethanol

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injection (PEI), percutaneous acetic acid injection (PAI), cryotherapy, percutaneous microwave coagulation therapy (PMCT) and radiofrequency ablation (RFA) are available for local therapy. In addition to surgical resection, local ablation therapy especially RFA is considered potentially curative for HCC and provides better long-term outcome.¹⁶ However, despite the high complete necrosis rate in RFA, some patients show tumor recurrence within 1 year, either local recurrence or new tumor formation. A series of studies discussed the predictive factors involved in tumor recurrence and seeding including tumor size, subcapsular lesion, α -fetoprotein (AFP) levels, tumor staging and histopathological grading of HCC.^{17,18} Another study has reported that the specific macroscopic type of HCC relevant to microvascular invasion on histopathological examination could help predict recurrence, and that this is especially true for simple nodular type with extranodular growth (SNEG) and confluent multinodular type (CMN) tumors.¹⁹ For the above reasons, it is important to determine the histopathological grade and macroscopic type of HCC before the application of local ablation therapy.

One aim of the present study was to determine whether malignant characteristics of HCC (especially poorly-differentiated HCC, SNEG and CMN) can be diagnosed by dynamic computed tomography (CT) images obtained before treatment. We reported previously that angiographic hypervascularity corresponds with thick-walled, nuclei-rich, and slender-shaped non-triadial vessels (named "Type II vessels") identified by immunohistochemical staining for α -smooth muscle actin (α -SMA).²⁰ The other purpose of the present study was to correlate heterogenic enhancement pattern of the arterial- and portal-phase dynamic CT images with the distribution patterns of α -SMA-positive non-triadial vessels in HCC.

METHODS

Study population

FROM JANUARY 2000 to September 2008, 340 patients were diagnosed with HCC and received surgical resection as initial treatment in the Department of Hepatology, Toranomon Hospital, Tokyo, Japan. Among the 340 patients, 86 patients satisfied the following criteria: (i) triple-phase dynamic CT study was performed before surgical resection; (ii) preoperative diagnosis of a solitary HCC with a maximum tumor diameter of 50 mm; (iii) no evidence of extrahepatic metastases as confirmed by imaging studies (CT, ultra-

sonography [US] and chest X-ray) before procedure; (iv) no history of other malignancies; and (v) no preoperative chemotherapy including transcatheter chemoembolization. Accordingly, 86 patients with HCC who were underwent surgical resection for HCC were retrospectively evaluated for the relationship between heterogeneous enhancement pattern of the arterial- and portal-phase dynamic CT images and histopathological malignant characteristics of HCC. The observation starting point was the time of the first surgical resection for HCC.

Imaging analysis of HCC and definition of enhancement pattern

Before surgery, triple-phase contrast-enhanced CT was performed in all patients. In these studies, 95 mL of 350 mg I/mL Iomeprol (Iomeron 350, Eisai, Tokyo), as the contrast medium, was rapidly injected i.v. at 0.06 mL/kg bodyweight/s. Phase-1, -2, and -3 imaging were performed at 25, 60 and 180 s after the start of injection, respectively. The axial images were reconstructed at intervals of 5 mm. The enhancement pattern on the arterial- and portal-phase dynamic CT was classified into one of four types and the four enhancement types on the original images were converted into simplified images (Fig. 1). The Type-1 pattern represented a "homogeneous enhancement pattern with no increase in arterial blood flow"; the entire image was uniform during the arterial phase and portal phase. The Type-2 pattern represented "homogeneous enhancement pattern with increased arterial blood flow"; the entire image was uniform during the arterial phase and portal phase. The Type-3 pattern represented "heterogeneous enhancement pattern with septum-like structure"; with heterogeneous enhancement and septum-like formation in the arterial phase, while the septum-like structure resembled a near-uniform tumor tissue periphery in the portal phase. The Type-4 pattern represented "heterogeneous enhancement pattern with irregular ring-like structures" in the arterial phase; marked by the presence of irregularly-shaped ring areas of enhancement and areas of little blood flow relative to the periphery of the tumor tissue, and in the portal phase, by areas of reduced blood flow. The enhancement pattern on the arterial- and portal-phase dynamic CT was determined by three expert hepatologists blind to the pathological result.

Histopathological features

Tumor differentiation was graded histologically according to the classification of the Liver Cancer Study Group of Japan.²¹ Macroscopic classification of nodular type

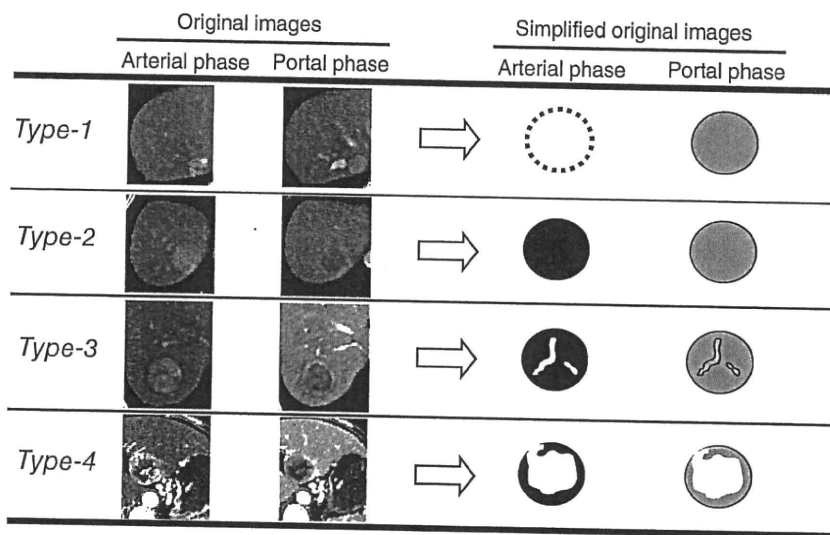


Figure 1 Sample of original dynamic computed tomography images and simplified images for each enhancement pattern.

HCC was based primarily on the definition of Kanai *et al.*²² and the Liver Cancer Study Group of Japan:²¹ small nodular type with indistinct margin (SNIM type, indistinct margins and containing portal tracts); simple nodular type (SN type, round nodule with clear margin); simple nodular type with extranodular growth (SNEG type, similar to the SN type with extranodular growth); confluent multinodular type (CMN type, nodular lesion consisting of a cluster of small and confluent nodules); and infiltrative type (IF type, nodular lesion with irregular and indistinct margins). The histopathological diagnosis of HCC was established by consensus of at least two pathologists and three hepatologists.

Immunohistochemical staining

Part of the liver specimen was soaked in neutral formalin solution immediately after resection and fixed for 24–48 h. Paraffin-embedded fixed specimens were sliced into 2 μm thick sections. After deparaffinization,

the sections were immunostained with α-SMA monoclonal antibody (Actin, α-smooth muscle, clone 1A4; Ventana Medical Systems, Tucson, AZ, USA) using an automated system (BenchMark; Ventana Medical Systems). When a round, oval or slender ring-shaped structure was identified in the α-SMA-immunostained specimen, it was regarded as an abnormal new blood vessel irrespective of its site in the liver, provided it was unrelated to the portal area. Therefore, we regarded such ring-shaped α-SMA-stained structures as non-triadial vessels and defined them as “positive neovascularity”. We have also reported thick-walled, nuclei-rich, and slender-shaped α-SMA-positive vessels (Fig. 2a “HE staining”, Fig. 2b “α-SMA staining”) in HCC tissue that were closely related to angiographic hypervascularity.²⁰ This type of blood vessel was termed “Type-II vessel”. To understand the relation between the findings on dynamic CT and immunohistochemical pattern, we analyzed the relationship between Type-4 pattern and the distribution of Type-II vessels.

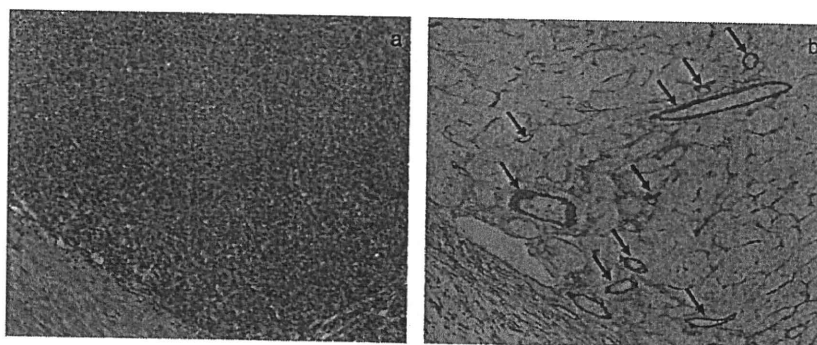


Figure 2 (a) Hematoxylin–eosin staining of hepatocellular carcinoma tissue. (b) Immunohistochemical staining for α-smooth muscle actin (α-SMA) of the same slice shown in (a). Solid arrows: typical Type II vessels. (Original magnifications: [a] ×100; [b] ×100.)

Table 1 Clinical profile and laboratory data of 86 patients with HCC

Sex (M : F)	57:29
Age (years)	62 (35–80)
Background of liver disease	
Hepatitis B surface antigen positive	26
Anti-HCV antibody positive	50
Both negative	10
Status of liver function	
Child–Pugh classification (A/B/C)	83/3/0
Preoperative image diagnosis of HCC	
Tumor diameter (mm)	23 (9.0–50)
Portal vein invasion (yes/no)	0/86
Laboratory data	
Platelet count ($\times 10^4/\mu\text{L}$)	13.0 (4.0–30.1)
Albumin (g/dL)	4.0 (3.1–4.3)
Bilirubin (mg/dL)	1.0 (0.3–1.7)
AST (IU/L)	43 (18–386)
Prothrombin time (%)	91 (60–124)
ICG-R15 (%)	19 (3.0–68)
AFP ($\mu\text{g/L}$)	13 (1.0–5541)
DCP (AU/L)	19 (4.0–1650)

AFP, α -fetoprotein; AST, aspartate aminotransferase; DCP, des- γ -carboxy prothrombin; HCC, hepatocellular carcinoma; HCV, hepatitis C virus; ICG-R15, indocyanine green retention rate at 15 min.

Clinical background and laboratory data

Table 1 summarizes the clinical profile and laboratory data of 86 HCC patients in this study. The male : female ratio was 1.97:1. HCV antibody was detected in 58.1% of the patients, and 96.5% patients were classified as Child–Pugh A but none of the patients was classified as Child–Pugh C. Based on preoperative image analysis, the median tumor diameter was 23 mm and none of the patients had portal vein tumor invasion. Furthermore, the median levels of AFP and des- γ -carboxy prothrombin (DCP) were 13 $\mu\text{g/L}$ and 19 AU/L, respectively.

Statistical analysis and ethical considerations

The factors associated with poorly-differentiated HCC, SNEG and CMN were analyzed by the χ^2 -test and Fisher's exact test. The independent factors associated with preoperative diagnosis of poorly-differentiated HCC were identified by multivariate logistic regression analysis. The potential predictive factors for poorly-differentiated HCC, SNEG and CMN were age, sex, hepatitis B surface antigen (HBsAg), HCV antibody, platelet count, aspartate transaminase (AST), albumin, bilirubin, AFP, DCP, prothrombin activity, indocyanine

green retention rate at 15 min (ICG-R15), and tumor size. Several variables were transformed into categorical data consisting of two or three simple ordinal numbers for univariate and multivariate analyses. All factors that were at least marginally associated with poorly differentiated HCC, SNEG and CMN ($P < 0.10$) in univariate analysis were entered into a multivariate logistic regression analysis. Significant variables were selected by the stepwise method. A two-tailed P -value less than 0.05 was considered significant. Data analysis was performed using the SPSS ver. 11.0 software.

The study protocol was approved by the Human Ethics Review Committee of Toranomon Hospital.

RESULTS

Distribution of enhancement patterns and proportions of histopathological types

PREOPERATIVE IMAGE ANALYSIS of 86 HCC patients showed the following results: Type-1 in 10 (11%) patients; Type-2 in 41 (48%) patients; Type-3 in 24 (28%) patients; and Type-4 in 11 (13%) patients. Furthermore, the percentages of poorly-differentiated HCC according to the enhancement pattern were zero of 10 (0%) patients with Type-1, three of 41 (7%) with Type-2, three of 24 (13%) with Type-3, and eight of 11 (73%) with Type-4. The percentages of SNEG/CMN according to the enhancement pattern were 12 of 51 nodules (24%) of Type-1 and -2, 13 of 24 (54%) of Type-3, and five of 11 (45%) of Type-4 (Table 2).

Correlation between preoperative features and diagnosis of poorly-differentiated HCC

We also investigated the factors that correlated with preoperative diagnosis of poorly-differentiated HCC. Univariate analysis showed the type of enhancement pattern (Type-4, Type-3 or other enhancement pattern, $P < 0.001$), tumor size ($< 35 \text{ mm}/\geq 35 \text{ mm}$, $P = 0.005$), serum AST level ($< 40 \text{ IU}/\geq 40 \text{ IU}$, $P = 0.069$) and serum DCP level ($< 30 \text{ AU/L}/\geq 30 \text{ AU/L}$, $P = 0.079$) to correlate with preoperative diagnosis of poorly-differentiated HCC. These parameters were entered into multivariate logistic regression analysis. The percentage of poorly-differentiated HCC was significantly higher for large-size HCC ($\geq 35 \text{ mm}$, risk ratio 14.72, 95% confidence interval [CI] 1.15–188.10) and Type-4 enhancement pattern (risk ratio 12.86, 95% CI 1.56–105.94) (Table 3).

Correlation between preoperative features and diagnosis of SNEG and CMN types

We also investigated the factors associated with the development of SNEG and CMN types of HCC. Univariate

Table 2 Distribution of enhancement patterns and frequency of each macroscopic type and poorly-differentiated HCC by histological examination

Enhancement pattern	No. of nodules	Poorly-differentiated HCC	Distribution of macroscopic type according to the enhancement pattern					
			SNIM	SN	SNEG	CMN	IF	
Type-1	10/86 (11%)	0/10 (0%)	5/10 (50%)	3/10 (30%)	1/10 (10%)	0/10 (0%)	1/10 (10%)	
Type-2	41/86 (48%)	3/41 (7%)	2/41 (5%)	27/41 (66%)	7/41 (17%)	4/41 (10%)	1/41 (2%)	
Type-3	24/86 (28%)	3/24 (13%)	0/24 (0%)	11/24 (46%)	10/24 (42%)	3/24 (13%)	0/24 (0%)	
Type-4	11/86 (13%)	8/11 (73%)	0/11 (0%)	6/11 (55%)	3/11 (27%)	2/11 (18%)	0/11 (0%)	

CMN, confluent multinodular type; HCC, hepatocellular carcinoma; IF, infiltration type; SN, simple nodular type; SNEG, simple nodular type with extranodular growth; SNIM, small nodular type with indistinct margin.

Table 3 Results of multivariate logistic regression analysis for predictive factors of poorly-differentiated hepatocellular carcinoma according to preoperative factors

Factors	Category	Hazard ratio (95% confidence interval)	P-value
Tumor size (mm)	1: <35	1	
	2: ≥35	14.72 (1.15-188.10)	0.039
Type of enhancement pattern	1: Type-1 and -2	1	
	2: Type-3	1.19 (0.17-8.43)	0.87
	3: Type-4	12.86 (1.56-105.94)	0.001

ate analysis identified the following three factors that correlated with SNEG/CMN type: age (<65/≥65 years, $P=0.030$), type of enhancement pattern (Type-4, Type-3 or other enhancement pattern, $P=0.055$) and tumor size (<35 mm/≥35 mm, $P=0.060$). These parameters were entered into multivariate logistic regression analysis. The percentage of SNEG/CMN types of HCC was significantly higher for Type-3 enhancement pattern (risk ratio 3.82, 95% CI 1.28-11.44) and age less than 65 years (risk ratio 3.57, 95% CI 1.29-9.90) (Table 4).

Cumulative recurrence rate according to each enhancement pattern

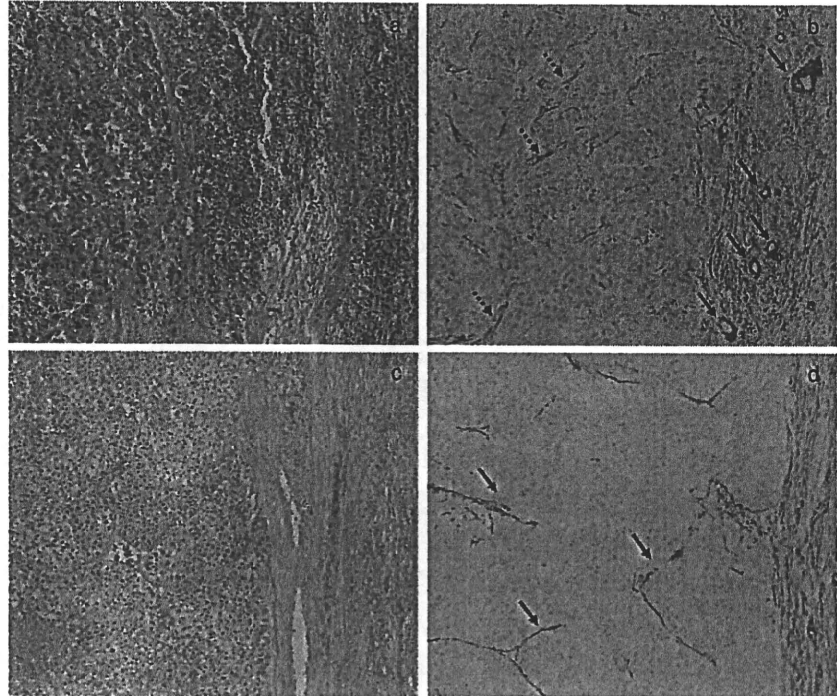
During a median observation period of 4.8 years, 46 (54%) out of 86 patients developed HCC recurrence in all patients. The cumulative recurrence rates after the surgical resection for HCC according to each enhancement pattern were 14% at the end of the first year, 44% at the third year and 54% at the fifth year for patients with Type-1 and -2 enhancement patterns; 13% at the first year, 28% at the third year and 38% at the fifth year

Table 4 Results of multivariate logistic regression analysis for predictive factors of SNEG and CMN types of HCC

Factors	Category	Hazard ratio (95% confidence interval)	P-value
Type of enhancement pattern	1: Type-1 and -2	1	
	2: Type-3	3.82 (1.28-11.44)	0.017
	3: Type-4	2.43 (0.60-9.86)	0.213
Age (years)	1: ≥65	1	
	2: <65	3.57 (1.29-9.90)	0.014

CMN, confluent multinodular type; HCC, hepatocellular carcinoma; SNEG, simple nodular type with extranodular growth.

Figure 3 (a) Hematoxylin–eosin staining of hepatocellular carcinoma (HCC) tissue. (b) Immunohistochemical staining for α -smooth muscle actin (α -SMA) of the same slice shown in (a). Solid arrows: typical Type II vessels. Dotted arrows: α -SMA-positive vessels, which are atypical for Type II vessels. Note that the typical Type II vessels tended to be located in the peripheral parts of the HCC. (c) Hematoxylin–eosin staining of HCC tissue. (d) Immunohistochemical staining for α -SMA of the same slice shown in (c). Solid arrows: α -SMA-positive vessels, which are atypical for Type II vessels. HCC tissue exhibited thick trabecular pattern, and α -SMA-positive vessels were recognized in the gaps of the trabecular pattern. In this tumor, few typical Type II vessels were detected, and most α -SMA-positive vessels were atypical for Type II vessels. (Original magnifications: [a] $\times 100$; [b] $\times 100$; [c] $\times 100$; [d] $\times 100$.)



for patients with Type-3 enhancement pattern; and 9% at the first year, 52% at the third year and 84% at the fifth year for patients with Type-4 enhancement pattern. There was no difference with statistical significance among each enhancement pattern ($P = 0.163$).

Cumulative survival rate according to each enhancement pattern

The cumulative survival rates after the surgical resection for HCC according to each enhancement pattern were 100% at the end of the first year, 96% at the third year and 85% at the fifth year for patients with Type-1 and -2 enhancement patterns; 100% at the first year, 100% at the third year and 83% at the fifth year for patients with Type-3 enhancement pattern; and 100% at the first year, 100% at the third year and 86% at the fifth year for patients with Type-4 enhancement pattern. There was no statistical significance on survival rate among each enhancement pattern ($P = 0.758$).

Correlation between immunopathological findings and HCC enhancement patterns

Dynamic CT examination revealed ring-like enhancement pattern (Type-4) in 11 of 86 (13%) patients. We examined the distribution of Type II vessel in 11 nodules of Type-4. Seven of these nodules showed

heterogeneous distribution of typical Type II vessels (Fig. 3a,b). The tumor tissue in one of these nodules exhibited a thick trabecular pattern and typical Type II vessels were not present in the tumor (Fig. 3c,d). The other three nodules contained large necrotic areas in the tumor and a homogeneous distribution of Type II vessels.

DISCUSSION

A VARIETY OF potentially curative therapies is currently available for HCC. However, except for surgical resection, a potential risk of tumor dissemination always exists in patients who receive such therapies. Therefore, in order to use the most suitable therapy for the individual patient, it is important to predict the potential risk of HCC before treatment.

Previously reported, to predict poorly differentiated HCC and macroscopic type of SNEG and CMN is especially important for good therapeutic progress.^{17–19} In our study, Type-4 enhancement pattern was identified as an independent predictive factor of poorly-differentiated HCC. Patients who show Type-4 enhancement pattern in preoperative dynamic CT study are at higher risk of poorly-differentiated HCC (about 13-fold) than Type-1 and -2 enhancement patterns. On

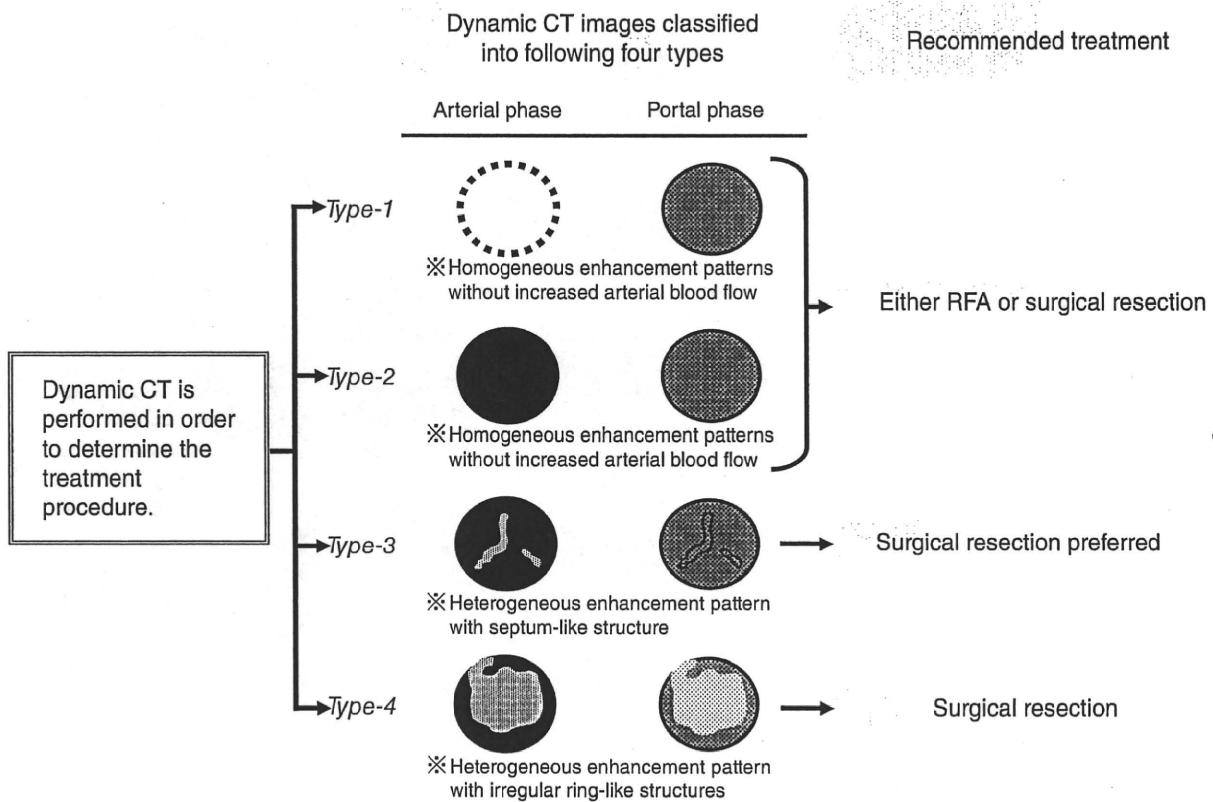


Figure 4 Treatment strategy for hepatocellular carcinoma according to a new classification of dynamic computed tomography (CT) images. RFA, radiofrequency ablation.

the other hand, Type-3 enhancement pattern was an independent predictor of SNEG and CMN, with higher risk (~fourfold) than Type-1 and -2 enhancement patterns. These results could be important for the selection of suitable therapy.

On the other hand, as previously reported, patients with SNEG and CMN have a high complication rate of poorly-differentiated HCC.²² However, in this study, there was no statistical relation between SNEG/CMN and Type-4 enhancement pattern that had statistical relation with poorly-differentiated HCC. One possible cause which brought this result is that the present study size is too small. Therefore, future studies are needed of larger size to reconsider this point.

Although the present study included only a small sample number of Type-4 enhancement pattern, the results showed that this pattern was associated with α -SMA staining pattern. Based on the results of the present study, at least three explanations were considered for the Type-4 enhancement pattern: (i) non-equal distribution of α -SMA-positive Type II vessels;

(ii) the thick trabecular pattern and lack of typical Type II vessels; and (iii) large necrotic tissue in the HCC nodule. It is clear from this examination that the cause of Type-4 enhancement pattern is not dependent on tissue necrosis only but other factors may be involved including Type II vessels. Admittedly, the present results do not fully explain the pathomechanism of Type-4 enhancement pattern. Further studies are needed to determine the main mechanism of this enhancement pattern.

With respect to prognosis after curative surgical resection based on each enhancement pattern, there are no significant differences among the four groups regarding recurrence and survival rate in this study. However, this study group mostly received curative therapy of "surgical resection" for HCC treatment. Therefore, we are currently investigating local recurrence and survival rate after RFA therapy based on this classification.

The present study included HCC only. However, heterogeneous enhancement resembling the Type-4 enhancement pattern is recognized in other hepatic

tumors (e.g. cholangiocellular carcinoma [CCC] and fibrolamellar HCC [F-HCC]). It is noteworthy, however, that these tumors are rare in chronic hepatitis or liver cirrhosis compared with HCC. CCC comprises 4.4% of primary liver cancers,^{23,24} while F-HCC forms only 0.68% of liver tumors in Japan. Thus, detection of heterogeneous enhancement pattern on dynamic CT images should be considered first to represent HCC with highly malignant potential.

Therefore, we indicate our treatment strategy for HCC according to a new classification of dynamic CT images (Fig. 4). The present results indicate that for patients with Type-4 or Type-3 enhancement patterns on dynamic CT images who have adequate liver reserve to allow any treatment including surgical resection, the above information could be used as an index to prioritize surgical resection. Especially, in patients with Type-4 enhancement pattern, we strongly recommend surgical resection.

In conclusion, the present study demonstrated a strong relationship between Type-4 and -3 enhancement pattern and malignant characteristics of HCC. The management of HCC with Type-4 and -3 enhancement pattern should include a thorough therapeutic approach including surgical resection.

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Original Article

Administration of interferon for two or more years decreases early stage hepatocellular carcinoma recurrence rate after radical ablation: A retrospective study of hepatitis C virus-related liver cancer

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Background: Since hepatocellular carcinoma often recurs after surgical resection or radiofrequency ablation, we analyzed a retrospective large cohort of patients with small hepatocellular carcinoma caused by hepatitis C virus (HCV).

Methods: Among 379 patients with HCV RNA-positive small hepatocellular carcinoma (multiple up to three nodules, 3 cm or less each), 77 received interferon-alpha injection and 302 received no anti-viral therapy.

Results: Four patients (5.2%) attained sustained virological response (SVR). Cumulative recurrence rates in the treated and untreated groups were 41.1% and 57.5% at the end of the third year, and 63.0% and 74.5% at the fifth year, respectively ($P = 0.013$). Fifth year-recurrence rates in treated group were 25.0% in SVR, 85.7% in biochemical response, 71.1% in no response, and 46.7% in patients with continuous administration. When four patients with SVR were excluded, recurrence

rates in short-term interferon therapy (<2 years) and long-term therapy (≥ 2 years) were 46.2% and 39.3% at the third year, and 66.2% and 57.4% at the fifth year, respectively ($P = 0.012$). Multivariate analysis showed that long-term interferon therapy significantly decreased recurrence rate (hazard ratio for interferon <2 years 0.80, interferon ≥ 2 years 0.60, $P = 0.044$), after adjustment with background covariates including indocyanine green retention rate ($P = 0.018$), alpha-fetoprotein ($P = 0.051$), and tumor treatment ($P = 0.066$).

Conclusion: A long-term administration of low-dose interferon significantly decreased recurrence of hepatocellular carcinoma after surgical resection or radiofrequency ablation.

Key words: hepatitis C, hepatocellular carcinoma, Interferon, prevention, recurrence

INTRODUCTION

HEPATOCELLULAR CARCINOMA (HCC) remains one of the most common cancers, and cause of cancer death, worldwide. Since the recurrence rate of HCC is high even after potentially curative therapies with surgical resection or radiofrequency ablation (RFA) therapy, suppression of recurrence is of great impor-

tance for prolonging the life of patients with hepatitis C virus (HCV)-related liver disease. This high recurrence rate, after curative therapy, was explained by occult intra-hepatic metastasis of HCC or by multi-centric carcinogenesis in the setting of chronic viral hepatitis or liver cirrhosis.^{1,2}

Interferon (IFN) is effective in reducing hepatocellular carcinogenesis rate through suppression of necro-inflammatory process and in eliminating HCV in some patients with chronic hepatitis C and cirrhosis. Although IFN proves to be valuable in suppression of the risk of carcinogenesis in many literatures,³⁻⁵ only several reports mentioned the efficacy of IFN in the suppression of tumor recurrence or in prolongation of survival period after ablation of HCC⁶⁻¹². We once

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