Table 2. Correlation between IRRDR polymorphism and patients' demographic characteristics

Factor	IRRDR≥6	IRRDR≤5	p value
Age, mean ± SD	58.71 ± 8.44	59.61 ± 10.30	0.71
Sex, male/female	17/7	18/26	0.02
Body weight, kg	59.87 ± 9.56	58.20 ± 11.92	0.56
Platelets, $\times 10^4/mm^3$	17.22 ± 5.5	14.96 ± 4.71	0.16
Hemoglobin, g/dl	14.25 ± 1.48	13.55 ± 1.77	0.11
γ-GTP, IU/l	49.50 ± 44.29	55.60 ± 65.60	0.69
GPT, IU/l	47.54 ± 33.09	49.33 ± 34.78	0.84
HCV-RNA, KIU/ml	2,070.21 ± 1,720.27	2,038.57 ± 1,963.05	0.95
HCV core antigen, fmol/l	6,750.87 ± 6,859.82	9,320.52 ± 10,636.48	0.30

IRRDR = Interferon/ribavirin resistance-determining region; γ-GTP = γ-guanosine triphosphate; GPT = glutamic pyruvate transaminase.

Table 3. Correlation between NS5A and core protein polymorphisms and ultimate virological responses of patients treated with PEG-IFN/RBV

Protein	Factor	Total[a]	SVR[b]	Non-SVR	Null-response	Relapse (ETR-relapse *plus* breakthrough)	p value		
							SVR vs. non-SVR	SVR vs. null-response	SVR vs. relapse (ETR-relapse *plus* breakthrough)
NS5A	IRRDR≥6	24	18 (75)[c]	6 (25)	3 (12.5)	3 (12.5)	<0.0001	0.005	0.0006
	IRRDR≤5	44	11 (25)	33 (75)	14 (32)	19 (43)			
	Ala^{2360}	18	12 (67)	6 (33)	1 (5)	5 (28)	0.026	0.016	0.2
	Non-Ala^{2360}	50	17 (34)	33 (66)	16 (32)	17 (34)			
	ISDR≥2	18	10 (56)	8 (44)	6 (33)	2 (11)	0.27	1.0	0.048
	ISDR≤1	50	19 (38)	31 (62)	11 (22)	20 (40)			
Core	Wild-core (Arg^{70}/Leu^{91})	33	18 (55)	15 (45)	5 (15)	10 (30)	0.1	0.07	0.27
	Non-wild-core	35	11 (31)	24 (69)	12 (34)	12 (34)			
	Gln^{70}	21	5 (24)	16 (76)	8 (38)	8 (38)	0.06	0.04	0.19
	Non-Gln^{70}	47	24 (51)	23 (49)	9 (19)	14 (30)			
	Met^{91}	19	7 (37)	12 (63)	5 (26)	7 (37)	0.59	0.74	0.75
	Non-Met^{91}	49	22 (45)	27 (55)	12 (24)	15 (31)			

SVR = Sustained virological response; ETR = end-of-treatment response; IRRDR = interferon/ribavirin resistance-determining region; Ala^{2360} = alanine at position 2360; ISDR = interferon sensitivity-determining region; Arg^{70} = arginine at position 70; Leu^{91} = leucine at position 91; Gln^{70} = glutamine at position 70; Met^{91} = methionine at position 91.

[a] Total number of isolates with a given factor.

[b] Number of SVR, non-SVR, null-response or relapse (ETR-relapse *plus* breakthrough) cases with a given factor.

[c] Values in parentheses are percentages.

Correlation between Core Polymorphism and Treatment Responses

Recently, it was reported that polymorphism at positions 70 and/or 91 of the core protein of HCV-1b correlates with and predicts the treatment outcome of Japanese patients treated with PEG-IFN/RBV combination therapy [8, 9]. We aimed to test the consistency of this observation among our patient cohort. The result revealed that among 33 patients infected with HCV isolates of wild-core (Arg^{70}/Leu^{91}), 18 (55%), 15 (45%), 5 (15%) and 10 (30%) patients were SVR, non-SVR, null-response and relapse (ETR-relapse *plus* breakthrough), respectively (table 3; fig. 1). On

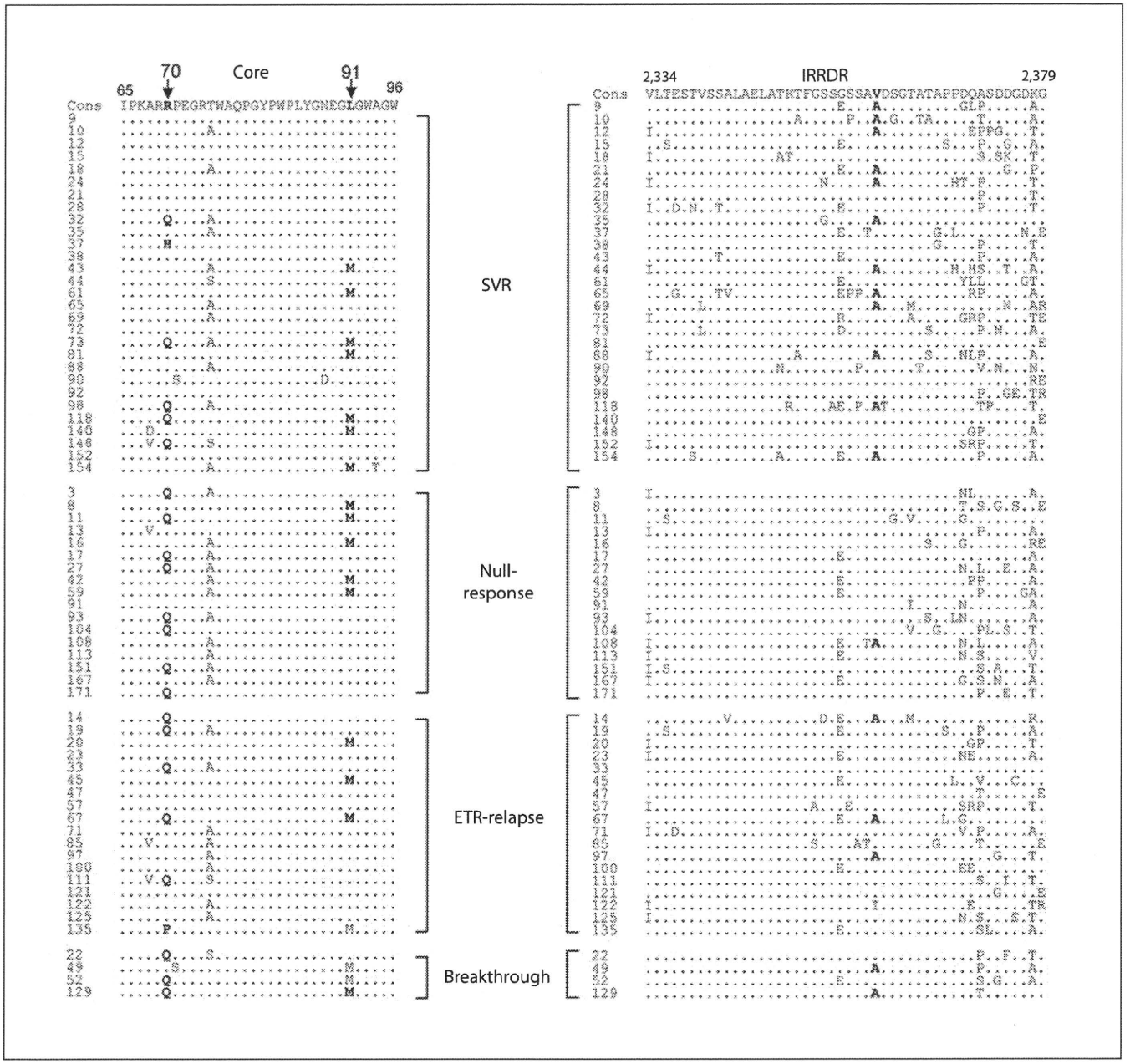

Fig. 1. Sequence alignment of the core protein (aa 65–96) and IRRDR of NS5A obtained from pretreated sera in patients infected with HCV-1b. The consensus (Cons) sequence is shown at the top. Amino acids at positions 70 and 91 of the core protein, and position 2360 of NS5A are shown in boldface.

the other hand, of 35 patients infected with HCV isolates of non-wild-core, 11 (31%), 24 (69%), 12 (34%) and 12 (34%) patients were SVR, non-SVR, null-response and relapse (ETR-relapse *plus* breakthrough), respectively. Thus, there was no significant correlation between wild-core and SVR or non-SVR (p = 0.1). However, a single mutation at position 70 (Gln^{70} vs. non-Gln^{70}) was significantly correlated with treatment outcome (SVR vs. null-response; p = 0.04).

As for the on-treatment responses, wild-core (Arg^{70}/Leu^{91}) was significantly correlated with EVR and ETR, whereas Gln^{70} was correlated with non-EVR and non-ETR (table 4).

Table 4. Correlation between NS5A and core protein polymorphisms and on-treatment virological responses of patients treated with PEG-IFN/RBV

Protein	Factor	Total[a]	RVR[b]	Non-RVR	EVR	Non-EVR	ETR	Non-ETR	p value		
									RVR vs. non-RVR	EVR vs. non-EVR	ETR vs. non-ETR
NS5A	IRRDR≥6	24	5 (21)[c]	19 (79)	17 (71)	7 (29)	21 (87)	3 (13)	0.12	0.04	0.026
	IRRDR≤5	44	3 (7)	41 (93)	19 (43)	25 (57)	26 (59)	18 (41)			
	Ala^{2360}	18	4 (22)	14 (78)	13 (72)	5 (28)	16 (89)	2 (11)	0.19	0.1	0.04
	Non-Ala^{2360}	50	4 (8)	46 (92)	23 (46)	27 (54)	31 (62)	19 (38)			
	ISDR≥2	18	6 (33)	12 (67)	9 (50)	9 (50)	11 (61)	7 (39)	0.003	0.79	0.39
	ISDR≤1	50	2 (4)	48 (96)	27 (54)	23 (46)	36 (72)	14 (28)			
Core	Wild-core (Arg^{70}/Leu^{91})	33	5 (15)	28 (85)	23 (70)	10 (30)	28 (85)	5 (15)	0.47	0.009	0.009
	Non-wild-core	35	3 (9)	32 (91)	13 (37)	22 (63)	19 (54)	16 (46)			
	Gln^{70}	21	2 (10)	19 (90)	6 (29)	15 (71)	10 (48)	11 (52)	1.0	0.009	0.02
	Non-Gln^{70}	47	6 (13)	41 (87)	30 (64)	17 (36)	37 (79)	10 (21)			
	Met^{91}	19	2 (11)	17 (89)	8 (42)	11 (58)	11 (58)	8 (42)	1.0	0.29	0.25
	Non-Met^{91}	49	6 (12)	43 (88)	28 (57)	21 (43)	36 (73)	13 (27)			

RVR = Rapid virological response; EVR = early virological response; ETR = end-of-treatment response; IRRDR = interferon/ribavirin resistance-determining region; Ala^{2360} = alanine at position 2360; ISDR = interferon sensitivity-determining region; Arg^{70} = arginine at position 70; Leu^{91} = leucine at position 91; Gln^{70} = glutamine at position 70; Met^{91} = methionine at position 91.

[a] Total number of isolates with a given factor. [b] Number of RVR, non-RVR, EVR, non-EVR, ETR or non-ETR cases with a given factor. [c] Values in parentheses are percentages.

Table 5. Correlation between NS5A and core protein polymorphisms

Factor	% (number of subjects/number of subtotal)[a]		p value
	IRRDR≥6	IRRDR≤5	
Ala^{2360}	50 (12/24)	14 (6/44)	0.003
Non-Ala^{2360}	50 (12/24)	86 (38/44)	
ISDR≥2	42 (10/24)	18 (8/44)	0.047
ISDR≤1	58 (14/24)	82 (36/44)	
Wild-core (Arg^{70}/Leu^{91})	67 (16/24)	39 (17/44)	0.04
Non-wild-core	33 (8/24)	61 (27/44)	
Gln^{70}	21 (5/24)	36 (16/44)	0.27
Non-Gln^{70}	79 (19/24)	64 (28/44)	

IRRDR = Interferon/ribavirin resistance-determining region; Ala^{2360} = alanine at position 2360; ISDR = interferon sensitivity-determining region; Arg^{70} = arginine at position 70; Leu^{91} = leucine at position 91; Gln^{70} = glutamine at position 70.

[a] Number of isolates with a certain factor/total number of HCV isolates with IRRDR≥6 or IRRDR≤5.

Correlation between NS5A and Core Polymorphisms

We then examined the possible correlation among the polymorphic factors in NS5A and core proteins. A significant correlation was observed between IRRDR≤5 and non-Ala^{2360} as the majority (86%) of HCV isolates with IRRDR≤5 had non-Ala^{2360} ($p = 0.003$) (table 5). Also, a significant correlation was obtained between IRRDR≤5 and ISDR≤1 since 82% of IRRDR≤5 were ISDR≤1 ($p = 0.047$). When IRRDR and core polymorphisms were compared, IRRDR≥6 was significantly correlated with wild-core (Arg^{70}/Leu^{91}) ($p = 0.04$). On the other hand, there was no significant correlation between IRRDR≥6 and non-Gln^{70}, or IRRDR≤5 and Gln^{70}, although the majority (79%) of IRRDR≥6 were non-Gln^{70}.

Influence of NS5A and Core Polymorphisms on HCV Clearance Kinetics during PEG-IFN/RBV Combination Therapy

To investigate the influence of NS5A and core polymorphisms on HCV-RNA kinetics during the entire course of PEG-IFN/RBV combination therapy, Kaplan-Meier HCV survival curve analysis was carried out based on HCV-RNA positivity according to NS5A and core

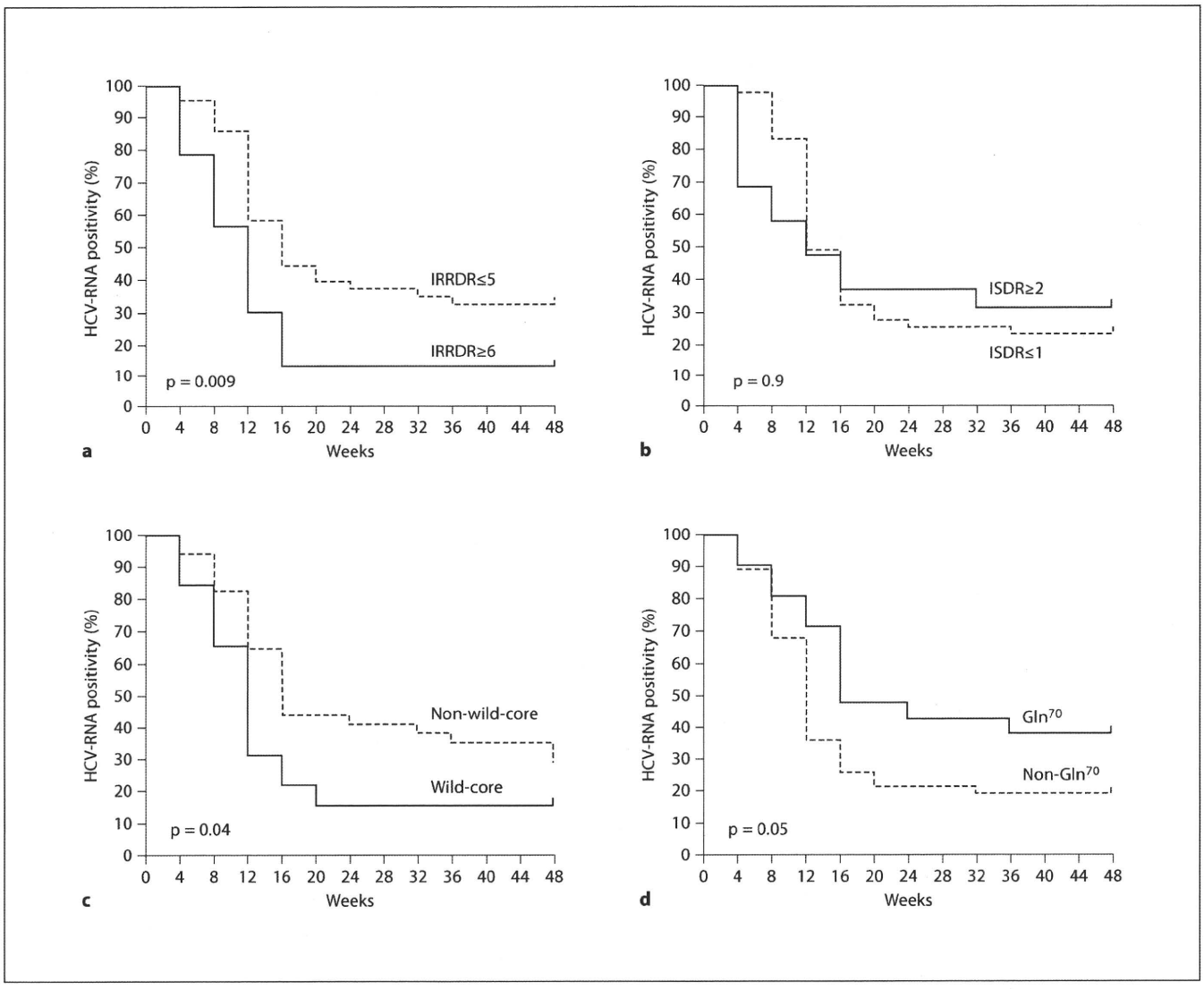

Fig. 2. Kaplan-Meier HCV survival curve analysis based on HCV-RNA positivity during the whole treatment course according to NS5A (**a**, **b**) and the core protein (**c**, **d**) polymorphisms. The difference between the analyzed groups was measured by the log-rank test.

polymorphisms. The result showed that HCV isolates of IRRDR≥6 were cleared from patients' sera more rapidly than those with IRRDR≤5 (fig. 2a). On the other hand, HCV-RNA clearance kinetics did not differ significantly between HCV isolates of ISDR≥2 and those of ISDR≤1 (fig. 2b). As for the core polymorphism, HCV isolates of non-wild-core or Gln^{70} persisted in patients' sera for longer periods of time than those of wild-core (Arg^{70}/Leu^{91}) or non-Gln^{70} (fig. 2c, d).

Next, HCV clearance kinetics during the very early stages of the treatment course, e.g., 24 h, 1, 2 and 4 weeks after initiation of PEG-IFN/RBV therapy was examined. For this purpose, a possible correlation between the degree of IRRDR, ISDR and core polymorphisms and the proportion of patients who achieved significant reduction (1 log after 24 h, 1 log after 1 week, 1.5 log after 2 weeks, and 2 log after 4 weeks) of core antigen titers was analyzed. Interestingly, IRRDR≥6 was significantly associated with reduction and/or disappearance of serum HCV core antigen titers at 24 h, 1, 2 and 4 weeks after initiation of the treatment (table 6). Again, there was no significant correlation between ISDR sequence variation

Table 6. Correlation between the proportions of patients with rapid reduction of HCV core antigen titers and degree of NS5A and core protein polymorphisms

Protein	Criteria	Number of patients with significant reduction of HCV core antigen titers/number of total							
		24 h[a] (≥1 log)[b]	p value	1 week (≥1 log)	p value	2 weeks (≥1.5 log)	p value	4 weeks (≥2 log)	p value
NS5A	IRRDR≥6	20/23	0.0006	18/23	0.004	17/23	0.018	19/23	0.008
	IRRDR≤5	17/40		16/40		16/40		19/40	
	ISDR≥2	10/19	1.0	11/19	0.59	10/19	1.0	11/19	1.0
	ISDR≤1	24/44		21/44		22/44		27/44	
Core	Wild core (Arg^{70}/Leu^{91})	23/31	0.01	22/31	0.02	20/31	0.13	24/31	0.005
	Non-wild-core	13/32		13/32		14/32		13/32	
	Gln^{70}	6/19	0.03	5/19	0.01	6/19	0.06	6/19	0.004
	Non-Gln^{70}	28/44		27/44		26/44		32/44	

Note: Patients Nos. 108, 111, 129, 135 and 152 were excluded from this analysis because their core antigen titers at certain time points were missing.

IRRDR = Interferon/ribavirin resistance-determining region; ISDR = interferon sensitivity-determining region; Arg^{70} = arginine at position 70; Leu^{91} = leucine at position 91; Gln^{70} = glutamine at position 70.

[a] Period after initiation of IFN/RBV therapy.

[b] Criteria of significant reduction of HCV core antigen titers.

(ISDR≥2 and ISDR≤1) and reduction of HCV core antigen titers during the very early stages of PEG-IFN/RBV therapy. On the other hand, non-wild-core or Gln^{70} were significantly associated with slow reduction and/or persistence of HCV core antigen in the patients' sera (table 6).

Identification of Independent Predictive Factors for SVR by Uni- and Multivariate Logistic Regression Analyses

Finally, in order to identify significant independent predictive factors of PEG-IFN/RBV treatment outcome, first, all available data of baseline patients' parameters, on-treatment responses and NS5A and core polymorphisms were entered in a univariate logistic analysis. This analysis yielded 11 factors that were correlated or nearly correlated with the treatment outcome; IRRDR mutations categorized as IRRDR≥6 and IRRDR≤5, Ala^{2360} and non-Ala^{2360}, core protein polymorphism categorized as wild-core (Arg^{70}/Leu^{91}) and non-wild-core, Gln^{70} and non-Gln^{70}, RVR and non-RVR, EVR and non-EVR, ETR and non-ETR, HCV core antigen titers, age, platelets count and hemoglobin levels (table 7). Subsequently, these 11 factors were entered in multivariate logistic regression analysis. This analysis yielded IRRDR mutations ($p = 0.005$), EVR ($p = 0.0001$) and age ($p = 0.02$) as independent predictive factors of PEG-IFN/RBV treatment outcome (table 7).

Discussion

Both host and viral genetic polymorphisms influence the outcome of PEG-IFN/RBV therapy for HCV-infected patients [15]. It has recently been reported that host genetic polymorphisms near or within the IL28B gene on chromosome 19 show a significant impact on the treatment outcome for patients infected with HCV genotype 1 (HCV-1a and -1b) [16–18]. Also, HCV genetic polymorphisms have been known to contribute to differences in the treatment outcome, as demonstrated by the observations that SVR rates for patients infected with HCV genotypes 2 and 3 are higher than those for patients infected with HCV genotype 1 [15]. Moreover, viral genetic polymorphisms, especially in the NS5A (ISDR and IRRDR) and the core regions, among HCV isolates of a given genotype have been linked to the difference in SVR rates [6–9, 19, 20]. In the present study, we compared the impact of IRRDR, ISDR and core polymorphisms of HCV-1b isolates on the clinical outcome of PEG-IFN/RBV therapy. Our results suggest that the degree of IRRDR mutations is more dominant than that of ISDR mutations and core polymorphism for predicting the anti-HCV treatment outcome.

IRRDR corresponds to a region near the C-terminus of NS5A. The obtained result that the IRRDR polymorphism influences the clinical outcome of IFN-based anti-HCV therapy can be linked to a recent experimental observation by Tsai et al. [21]. They reported that an HCV

Table 7. Uni- and multivariate logistic regression analyses to identify independent predictive factors for success of PEG-IFN/RBV combination therapy

Univariate		Multivariate	
variable	p value	odds ratio (95% CI)	p value
IRRDR mutations (IRRDR≥6 vs. IRRDR≤5)	<0.0001	14.33 (2.24–91.65)	0.005
Ala^{2360}	0.01	1.75 (0.19–15.36)	0.62
Core polymorphism (wild-core vs. non-wild-core)	0.06	0.41 (0.05–3.28)	0.34
Gln^{70}	0.04		
RVR	<0.0001		
EVR	<0.0001	41.83 (6.12–285.68)	0.0001
ETR	<0.0001		
HCV core antigen, fmol/l	0.05		
Age	0.01	0.91 (0.84–0.99)	0.02
Platelets, $\times 10^4/mm^3$	0.07		
Hemoglobin, g/dl	0.006		

IRRDR = Interferon/ribavirin resistance-determining region; Ala^{2360} = alanine at position 2360; Gln^{70} = glutamine at position 70; RVR = rapid virological response; EVR = early virological response; ETR = end-of-treatment response.

subgenomic RNA replicon containing NS5A of HCV-1b exerted more profound inhibitory effects on IFN activity than the original HCV-2a replicon, and that domain swapping between NS5A sequences of HCV-1b and -2a in the V3 and/or a C-terminus region including IRRDR resulted in a transfer of their anti-IFN activity. Since the C-terminal region of NS5A is among the most variable sequences across the different genotypes and subtypes of HCV [22], the difference in IFN responsiveness among different strains of a given HCV subtype could also be attributable, at least partly, to the genetic polymorphism within this region. The molecular mechanism underling the possible involvement of IRRDR in IFN responsiveness of the virus is still unknown. The significant difference in IRRDR sequence pattern may suggest genetic flexibility of this region and, indeed, the C-terminal portion of NS5A was shown to tolerate sequence insertions and deletions [23, 24]. This means that the C-terminal portion of NS5A is not essential for virus replication in cultured cells. It does not exclude the possibility, however, that the same region plays an important role in modulating the interaction with various host systems, including IFN responsiveness. It is also possible that the genetic flexibility of this region, especially IRRDR, is accompanied by compensatory changes elsewhere in the viral genome and that these compensatory changes affect overall viral fitness and responses to IFN therapy [25].

While we observed significant correlation between the overall number of mutations in IRRDR and PEG-IFN/RBV responsiveness, we also found a particular aa mutation, Ala^{2360}, that was significantly associated with SVR (tables 3, 7; fig. 1). It is possible that Ala or Val at this position confers a certain advantage for interaction between NS5A and the other viral or host proteins, which might affect IFN-induced antiviral responses. This issue needs to be elucidated in further studies.

The ISDR polymorphism was the only virological factor examined that showed a significant correlation with RVR (table 4), with the result being consistent with a recent report by other investigators [26]. This significant correlation, however, disappeared as the treatment went on. In contrast, the IRRDR polymorphism did not correlate significantly with RVR, however, it was the dominant viral genetic factor that was correlated with SVR (tables 3, 7). Interestingly, the combination of IRRDR and ISDR polymorphisms (IRRDR≥6 *plus* ISDR≥2) was significantly correlated with RVR and SVR (p = 0.0001 and 0.01, respectively; data not shown). This suggests a possible integrated influence of IRRDR and ISDR polymorphisms, or NS5A as a whole, on the treatment outcome. Further study is needed to clarify the issue.

The core protein polymorphisms (wild-core vs. non-wild-core, and Gln^{70} and non-Gln^{70}) were significantly correlated with the on-treatment HCV clearance kinetics

(fig. 2c, d; tables 4, 6). However, this significant correlation became blurred thereafter and eventually no significant correlation was observed between wild-core (Arg^{70}/Leu^{91}) and the final treatment outcomes (table 3). On the other hand, Gln^{70} was significantly associated with null-response, and almost significantly with non-SVR. This result is consistent, at least partly, with previous reports, including a recent multicenter study in Japan, that identified Gln^{70} as a predictive factor for poor responses to PEG-IFN/RBV treatment [8, 9, 14].

Recently, it was reported that the C-terminal region of NS5A plays a critical role in regulating the early phase of HCV particle formation [27, 28]. Moreover, sequence alteration within this region affected the degree of interaction between NS5A and core protein, which in turn affected the efficiency of progeny virus production [29]. In the present study, we observed a significant correlation between the degree of IRRDR mutations (IRRDR≥6) and the core polymorphism (table 5). Therefore, it would be interesting to investigate the degree of interaction between NS5A with IRRDR of high or low degrees of sequence variation and the wild-type (Arg^{70}/Leu^{91}) or non-wild-type of core protein, and also the impact of these interactions on progeny virus production and IFN sensitivity of the virus.

The present study identified the IRRDR polymorphism as the only viral genetic factor that independently predicted PEG-IFN/RBV treatment outcome (table 7). On the other hand, HCV is likely to utilize an alternative mechanism(s) by which to escape IFN actions through its various structural and non-structural proteins [30]. Also, a different lineage(s) of HCV-1b strains that relies more on the alternative mechanism than on IRRDR may prevail in other regions of the world. It is possible, therefore, that the impact of the IRRDR polymorphism differs with different cohorts. Analysis in a large-scale multicenter study is needed to clarify this issue.

In conclusion, NS5A (IRRDR and ISDR) and core protein polymorphisms are useful viral markers for predicting the outcome of PEG-IFN/RBV therapy for chronic hepatitis C. In particular, IRRDR≥6 is a useful marker for prediction of SVR.

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References

1 Bialek SR, Terrault NA: The changing epidemiology and natural history of hepatitis C virus infection. Clin Liver Dis 2006;10:697–715.
2 Williams R: Global challenges in liver disease. Hepatology 2006;44:521–526.
3 Fried MW, Shiffman ML, Reddy KR, Smith C, Marinos G, Goncales FL Jr, Haussinger D, Diago M, Carosi G, Dhumeaux D, Craxi A, Lin A, Hoffman J, Yu J: Peginterferon alfa-2a plus ribavirin for chronic hepatitis C virus infection. N Engl J Med 2002;347:975–982.
4 Backus LI, Boothroyd DB, Phillips BR, Mole LA: Predictors of response of US veterans to treatment for the hepatitis C virus. Hepatology 2007;46:37–47.
5 Welker MW, Hofmann WP, Welsch C, von Wagner M, Herrmann E, Lengauer T, Zeuzem S, Sarrazin C: Correlation of amino acid variations within nonstructural 4B protein with initial viral kinetics during interferon-α-based therapy in HCV-1b-infected patients. J Viral Hepat 2007;14:338–349.
6 Enomoto N, Sakuma I, Asahina Y, Kurosaki M, Murakami T, Yamamoto C, Ogura Y, Izumi N, Marumo F, Sato C: Mutations in the nonstructural protein 5A gene and response to interferon in patients with chronic hepatitis C virus 1b infection. N Engl J Med 1996;334:77–81.
7 El-Shamy A, Nagano-Fujii M, Sasase N, Imoto S, Kim SR, Hotta H: Sequence variation in hepatitis C virus nonstructural protein 5A predicts clinical outcome of pegylated interferon/ribavirin combination therapy. Hepatology 2008;48:38–47.
8 Akuta N, Suzuki F, Kawamura Y, Yatsuji H, Sezaki H, Suzuki Y, Hosaka T, Kobayashi M, Kobayashi M, Arase Y, Ikeda K, Kumada H: Predictive factors of early and sustained responses to peginterferon plus ribavirin combination therapy in Japanese patients infected with hepatitis C virus genotype 1b: amino acid substitutions in the core region and low-density lipoprotein cholesterol levels. J Hepatol 2007;46:403–410.
9 Akuta N, Suzuki F, Sezaki H, Suzuki Y, Hosaka T, Someya T, Kobayashi M, Saitoh S, Watahiki S, Sato J, Matsuda M, Kobayashi M, Arase Y, Ikeda K, Kumada H: Association of amino acid substitution pattern in core protein of hepatitis C virus genotype 1b high viral load and non-virological response to interferon-ribavirin combination therapy. Intervirology 2005;48:372–380.
10 Okamoto H, Sugiyama Y, Okada S, Kurai K, Akahane Y, Sugai Y, Tanaka T, Sato K, Tsuda F, Miyakawa Y, et al: Typing hepatitis C virus by polymerase chain reaction with type-specific primers: application to clinical surveys and tracing infectious sources. J Gen Virol 1992;73:673–679.
11 El-Shamy A, Sasayama M, Nagano-Fujii M, Sasase N, Imoto S, Kim SR, Hotta H: Prediction of efficient virological response to pegylated interferon/ribavirin combination therapy by NS5A sequences of hepatitis C virus and anti-NS5A antibodies in pretreatment sera. Microbiol Immunol 2007;51:471–482.

12 Ogata S, Nagano-Fujii M, Ku Y, Yoon S, Hotta H: Comparative sequence analysis of the core protein and its frameshift product, the F protein, of hepatitis C virus subtype 1b strains obtained from patients with and without hepatocellular carcinoma. J Clin Microbiol 2002;40:3625–3630.
13 Shirakawa H, Matsumoto A, Joshita S, Komatsu M, Tanaka N, Umemura T, Ichijo T, Yoshizawa K, Kiyosawa K, Tanaka E: Pretreatment prediction of virological response to peginterferon plus ribavirin therapy in chronic hepatitis C patients using viral and host factors. Hepatology 2008;48:1753–1760.
14 Okanoue T, Itoh Y, Hashimoto H, Yasui K, Minami M, Takehara T, Tanaka E, Onji M, Toyota J, Chayama K, Yoshioka K, Izumi N, Akuta N, Kumada H: Predictive values of amino acid sequences of the core and NS5A regions in antiviral therapy for hepatitis C: a Japanese multi-center study. J Gastroenterol 2009;44:952–963.
15 Kau A, Vermehren J, Sarrazin C: Treatment predictors of a sustained virologic response in hepatitis B and C. J Hepatol 2008;49:634–651.
16 Ge D, Fellay J, Thompson AJ, Simon JS, Shianna KV, Urban TJ, Heinzen EL, Qiu P, Bertelsen AH, Muir AJ, Sulkowski M, McHutchison JG, Goldstein DB: Genetic variation in IL28B predicts hepatitis C treatment-induced viral clearance. Nature 2009;461:399–401.
17 Suppiah V, Moldovan M, Ahlenstiel G, Berg T, Weltman M, Abate ML, Bassendine M, Spengler U, Dore GJ, Powell E, Riordan S, Sheridan D, Smedile A, Fragomeli V, Muller T, Bahlo M, Stewart GJ, Booth DR, George J: IL28B is associated with response to chronic hepatitis C interferon-α and ribavirin therapy. Nat Genet 2009;41:1100–1104.
18 Tanaka Y, Nishida N, Sugiyama M, Kurosaki M, Matsuura K, Sakamoto N, Nakagawa M, Korenaga M, Hino K, Hige S, Ito Y, Mita E, Tanaka E, Mochida S, Murawaki Y, Honda M, Sakai A, Hiasa Y, Nishiguchi S, Koike A, Sakaida I, Imamura M, Ito K, Yano K, Masaki N, Sugauchi F, Izumi N, Tokunaga K, Mizokami M: Genome-wide association of IL28B with response to pegylated interferon-α and ribavirin therapy for chronic hepatitis C. Nat Genet 2009;41:1105–1109.
19 Murakami T, Enomoto N, Kurosaki M, Izumi N, Marumo F, Sato C: Mutations in nonstructural protein 5A gene and response to interferon in hepatitis C virus genotype 2 infection. Hepatology 1999;30:1045–1053.
20 Akuta N, Suzuki F, Hirakawa M, Kawamura Y, Yatsuji H, Sezaki H, Suzuki Y, Hosaka T, Kobayashi M, Kobayashi M, Saitoh S, Arase Y, Ikeda K, Kumada H: Association of amino acid substitution pattern in core protein of hepatitis C virus genotype 2a high viral load and virological response to interferon-ribavirin combination therapy. Intervirology 2009;52:301–309.
21 Tsai YH, Kuang WF, Lu TY, Kao JH, Lai MY, Liu CJ, Chen PJ, Hwang LH: The non-structural 5A protein of hepatitis C virus exhibits genotypic differences in interferon antagonism. J Hepatol 2008;49:899–907.
22 Macdonald A, Harris M: Hepatitis C virus NS5A: tales of a promiscuous protein. J Gen Virol 2004;85:2485–2502.
23 Moradpour D, Evans MJ, Gosert R, Yuan Z, Blum HE, Goff SP, Lindenbach BD, Rice CM: Insertion of green fluorescent protein into nonstructural protein 5A allows direct visualization of functional hepatitis C virus replication complexes. J Virol 2004;78:7400–7409.
24 Appel N, Pietschmann T, Bartenschlager R: Mutational analysis of hepatitis C virus nonstructural protein 5A: potential role of differential phosphorylation in RNA replication and identification of a genetically flexible domain. J Virol 2005;79:3187–3194.
25 Yuan HJ, Jain M, Snow KK, Gale Jr M, Lee WM: Evolution of hepatitis C virus NS5A region in breakthrough patients during pegylated interferon and ribavirin therapy. J Viral Hepat 2009;17:208–216.
26 Enomoto N, Maekawa S: HCV genetic elements determining the early response to peginterferon and ribavirin therapy. Intervirology 2010;53:66–69.
27 Hughes M, Griffin S, Harris M: Domain III of NS5A contributes to both RNA replication and assembly of hepatitis C virus particles. J Gen Virol 2009;90:1329–1334.
28 Appel N, Zayas M, Miller S, Krijnse-Locker J, Schaller T, Friebe P, Kallis S, Engel U, Bartenschlager R: Essential role of domain III of nonstructural protein 5A for hepatitis C virus infectious particle assembly. PLoS Pathog 2008;4:e1000035.
29 Masaki T, Suzuki R, Murakami K, Aizaki H, Ishii K, Murayama A, Date T, Matsuura Y, Miyamura T, Wakita T, Suzuki T: Interaction of hepatitis C virus nonstructural protein 5A with core protein is critical for the production of infectious virus particles. J Virol 2008;82:7964–7976.
30 Gale M Jr, Foy EM: Evasion of intracellular host defence by hepatitis C virus. Nature 2005;436:939–945.

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Secondary Structure of the Amino-Terminal Region of HCV NS3 and Virological Response to Pegylated Interferon Plus Ribavirin Therapy for Chronic Hepatitis C

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The aim of the study was to identify a predictive marker for the virological response in hepatitis C virus 1b (HCV-1b)-infected patients treated with pegylated interferon plus ribavirin therapy. A total of 139 patients with chronic hepatitis C who received therapy for 48 weeks were enrolled. The secondary structure of the 120 residues of the amino-terminal HCV-1b non-structural region 3 (NS3) deduced from the amino acid sequence was classified into two major groups: A and B. The association between HCV NS3 protein polymorphism and virological response was analyzed in patients infected with group A ($n = 28$) and B ($n = 40$) isolates who had good adherence to both pegylated interferon and ribavirin administration (>95% of the scheduled dosage) for 48 weeks. A sustained virological response (SVR) representing successful HCV eradication occurred in 33 (49%) in the 68 patients. Of the 28 patients infected with the group A isolate, 18 (64%) were SVR, whereas of the 40 patients infected with the group B isolate only 15 (38%) were SVR. The proportion of virological responses differed significantly between the two groups ($P < 0.05$). These results suggest that polymorphism in the secondary structure of the HCV-1b NS3 amino-terminal region influences the virological response to pegylated interferon plus ribavirin therapy, and that virus grouping based on this polymorphism can contribute to prediction of the outcome of this therapy. ***J. Med. Virol. 82:1364–1370, 2010.*** © 2010 Wiley-Liss, Inc.

KEY WORDS: hepatitis C; interferon; ribavirin; interaction; polymorphism

INTRODUCTION

Hepatitis C virus (HCV) is the major pathogen that causes chronic liver diseases with a risk of progression to cirrhosis and hepatocellular carcinoma. Currently, the standard treatment for chronic hepatitis C is antiviral therapy using pegylated interferon (Peg-IFN) plus ribavirin (RBV), and this approach is most effective for eradication of HCV viremia. However, even with the widely used treatment regimen of 48 weeks, the rate of sustained virological response (SVR), which indicates eradication of viremia, is still approximately 50% for patients infected with the therapy-resistant HCV genotype 1b (HCV-1b) with a high viral load [Manns et al., 2001; Bruno et al., 2004; Hadziyannis et al., 2004]. It would be useful to predict the virological response to this therapy and to identify patients who would obtain beneficial therapeutic effects before treatment, in order to avoid any serious side effect and to eliminate those who would not be helped by the treatment. In the future it will be important to establish a protocol of tailor-made medicine for chronic hepatitis C.

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Both the HCV genotype and pre-treatment viral load are major viral factors that influence the response to IFN-based antiviral therapy, but IFN resistance is also partly due to variation of the amino acid sequence encoded by HCV itself. Enomoto et al. [1996] proposed that variation of 40 amino acids within the NS5A region (aa 2,209–2,248), which is referred to as the IFN sensitivity-determining region (ISDR), is well correlated with IFN responsiveness. ISDR and its adjacent sequence bind and inhibit the enzymatic activity of a double-stranded RNA-activated protein kinase (PKR), which can have an antiviral effect, and therefore the combined region is referred to as the PKR-binding domain (PKR-BD) [Gale et al., 1997, 1998]. A correlation between sequence variation in the PKR-BD and IFN responsiveness has been reported [Nousbaum et al., 2000], and some reports show a correlation between IFN responsiveness and the sequence diversity of variable region 3 (V3) (aa 2,356–2,379) or surrounding regions near the carboxy terminus of NS5A [Murphy et al., 2002; Sarrazin et al., 2002; Puig-Basagoiti et al., 2005]. A high degree of amino acid substitution in the V3 and pre-V3 regions (aa 2,334–2,355) of NS5A, which is referred to as the IFN/RBV resistance-determining region (IRRDR) (aa 2,334–2,379), has been associated with SVR in Peg-IFN/RBV combination therapy for patients infected with HCV-1b [El-Shamy et al., 2007, 2008]. In addition to these findings in non-structural proteins of the virus, amino acid substitution in a structural region of HCV has been reported to be a predictive viral marker for the virological response to PegIFN/RBV therapy. Amino acid polymorphisms in the HCV core region (Arg70 vs. Gln70 and Leu91 vs. Met91) correlate with virological outcome and on-treatment viral kinetics in Peg-IFN/RBV therapy [Akuta et al., 2006, 2007], and a double wild-type HCV core (Arg70 and Leu91) may be a significant predictor of SVR in Peg-IFN/RBV therapy [Akuta et al., 2007].

Interactions between viral and host proteins in infected cells may influence therapeutic effects and the natural history of infection, since the HCV NS3 region has a significant effect on immunity. The amino-terminal part of this region encodes a serine protease, for which the minimum activity has been mapped to a region between aa 1,059 and 1,204 [Yamada et al., 1998]. The serine protease inactivates Cardif, a caspase recruitment domain (CARD)-containing adaptor protein that interacts with the RNA helicase retinoic acid inducible gene 1 (RIG-1)-dependent antiviral pathway in infected cells [Foy et al., 2003; Meylan et al., 2005; Evans and Seeger, 2006]. This action inhibits phosphorylation and subsequent heterodimerization of interferon regulatory factor-3 (IRF-3), which is essential for activation of IFN signaling through translocation of IRF-3 heterodimers into the nucleus, and eventually blocks IFN-beta production. In addition, inactivation of IRF-3 is postulated to influence the therapeutic effect of IFN-based antiviral therapy, because the IRF-3 heterodimer translocates into the nucleus to bind to the IFN-stimulated response element that produces many antiviral proteins, including 2′,5′-oligoadenylate synthetase and PKR [Nakaya et al., 2001; Grandvaux et al., 2002]. Collectively, these findings suggest that polymorphisms in HCV NS3 structure deduced from sequence variation may influence IFN-related signaling and the antiviral effect of IFN-based anti-HCV therapy.

We have focused on polymorphisms in the secondary structure of the viral polyprotein that interacts with host proteins involved in immunity, with the aim of identification of predictive viral markers for the response to Peg-IFN/RBV therapy. In this study, we examined the potential correlation between polymorphisms in the secondary structure of the HCV NS3 amino-terminal region and virological responses to Peg-IFN/RBV therapy in patients infected with HCV-1b with a high viral load.

PATIENTS AND METHODS

Patients and Treatment Regimen With Peg-IFN Plus Ribavirin

A total of 139 consecutive patients diagnosed with chronic hepatitis C were enrolled in the study from December 2004 to March 2007. These patients included 81 men and 58 women, and were aged from 31 to 75 years old (mean ± SD, 56.8 ± 8.7 years old). All patients were infected with HCV-1b with a high viral load of over 100 KIU/ml, and all received Peg-IFN/RBV therapy. Patients with alcoholic liver injury, autoimmune liver disease, and those who had symptoms of decompensated cirrhosis including ascites were excluded. Briefly, all patients were treated with a combination of Peg-IFN-alpha 2b (Pegintron®; Schering-Plough, Kenilworth, NJ) and RBV (Rebetol®; Schering-Plough) for 48 weeks. Peg-IFN was administered subcutaneously once a week and RBV was given orally twice a day for the total dose. The dosages were determined on the basis of body weight according to the Japanese standard prescription information supplied by the Japanese Ministry of Health, Labour and Welfare, and there was a limit for calculating the optimized dose: patients with body weights of 35–45, 46–60, 61–75, and 76–90 kg were given Peg-IFN at doses of 60, 80, 100, and 120 μg, respectively, and those with body weights of <60, 60–80, and >80 kg were given RBV at doses of 600, 800, and 1,000 mg, respectively. The dose of Peg-IFN or RBV was reduced according to the Japanese standard criteria based on the white blood cell count, neutrophil count, hemoglobin concentration and platelet count [Hiramatsu et al., 2008].

Virological Tests and Response to Peg-IFN Plus Ribavirin

Virological responses were evaluated at 12 weeks after the start of treatment with an early depletion of viremia referred to as an early virological response (EVR), at the end of treatment with depletion of viremia referred to as an end of treatment virological response (ETR), and at 24 weeks after completion of treatment,

with a clinical outcome of a sustained virological response (SVR) representing successful HCV eradication. All patients were negative for hepatitis B surface antigen. Quantification of serum HCV RNA was performed using an RT-PCR-based commercial kit (Amplicor HCV monitor test, ver. 2.0, Roche Diagnostics, Tokyo, Japan). This Amplicor HCV RNA assay has a lower limit of detection of 50 IU/ml. SVR was determined by monitering negativity for HCV RNA monthly for 6 months. The real-time PCR assay kit (COBAS TaqMan HCV Auto, Roche Diagnostics) for more precise quantitation of HCV viremia has recently become available and pre-treatment viral titers were re-evaluated using preserved serum samples. This real-time PCR assay has a lower limit of detection of 15 IU/ml. The study protocol was approved by the Ethics Committee of Yamagata University Hospital. Informed consent was obtained from all patients.

PCR Amplification of the Amino-Terminal Region of NS3

RNA was extracted from 50 μl of serum using an RNeasy Mini kit (Qiagen, Tokyo, Japan). To amplify the region of the HCV genome encoding the amino-terminal region of NS3 (1,027–1,206), a one-step PCR was performed in a tube using the Superscript One-Step RT-PCR kit with Platinum Taq (Gibco-BRL, Tokyo, Japan) and an outer set of primers: NS3-F1 (sense primer; 5′-ACA CCG CGG CGT GTG GGG ACA T-3′; nucleotides 3,295–3,316) and NS3-AS2 (antisense primer; 5′-GCT CTT GCC GCT GCC AGT GGG A-3′; nucleotides 4,040–4,019), as reported previously [Ogata et al., 2002a, 2003]. PCR was initially performed at 45°C for 30 min at RT and then at 94°C for 2 min, followed by the first-round PCR for forty 3-min cycles at 94°, 55°, and 72°C for 1 min each. The second-round PCR was performed with *Pfu* DNA polymerase (Promega, Tokyo, Japan) and an inner set of primers: NS3-F3 (sense primer; 5′-CAG GGG TGG CGG CTC CTT-3′; nucleotides 3,390–3,407) and NS3-AS1 (antisense primer; 5′-GCC ACT TGG AAT GTT TGC GGT A-3′; nucleotides 4,006–3,985). The second-round PCR was performed for 35 cycles, with each cycle consisting of 1 min at 94°C, 1.5 min at 55°C, and 3 min at 72°C. This method allowed amplification of the corresponding portion of the HCV genome from HCV-1b RNA-positive samples. The amplified fragments were purified with a QIAquick PCR purification kit (Qiagen) and directly sequenced (without being subcloned) in both directions using a dRhodamine Terminator Cycle Sequencing Ready Reaction kit and an ABI 377 sequencer (Applied Biosystems, Tokyo, Japan).

Classification of the Secondary Structure of the HCV-1b NS3 Amino-Terminal Region

The secondary structure of the amino-terminal region of HCV NS3 was predicted by computer-assisted Robson analysis [Garnier et al., 1978] with Genetyx-Mac software (ver.10.1; Software Development Co., Tokyo, Japan). Previously, the full-length secondary structure of the HCV-1b NS3 region was analyzed, and this showed that the secondary structure deduced from the carboxy-terminal 60 residues was well conserved in terms of linear structure, without any turn structure [Ogata et al., 2002a]. We have shown that the secondary structure of the 120 residues in the amino-terminal region of HCV-1b NS3 can be classified into two major groups: A and B (Fig. 1) [Ogata et al., 2002a, 2003]. Briefly, the criteria for this classification are as follows: in group A isolates, the carboxy-terminal 20 residues (aa 1,125–1,146) are oriented leftward relative to a domain composed of the remaining amino-terminal region; whereas in group B isolates, the same 20 residues are oriented rightward relative to the rest of the amino-terminal domain.

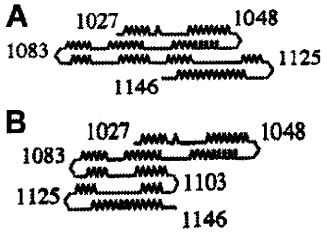

Fig. 1. Secondary structure of the 120 amino-terminal residues of HCV-1b nonstructural 3 (NS3) region classified into two major groups: A and B. The looped, zigzag, straight, and bent lines represent α-helix, β-sheet, coil, and turn structures, respectively. The numbers indicate amino acid positions. **A**: Group A, (**B**) Group B.

Analysis of Amino Acid Substitutions in the Core Region

To amplify a region of the HCV genome encoding the core region including positions 70 and 91, reverse transcription and the first-round PCR were performed in a tube by the Superscript One-Step RT-PCR kit with Platinum *Taq* (Gibco-BRL) and an outer set of primers, followed by second-round PCR with an inner set of primers in accordance with procedures reported previously [Ogata et al., 2002b]. The sequences of the amplified fragments were determined by direct sequencing.

Statistical Analysis

Data were analyzed by a χ^2 test for independence with a two-by-two contingency table and a Student *t*-test. A P-value <0.05 was considered significant.

RESULTS

Virological Response *and Adherence* to the Peg-IFN Plus Ribavirin Regimen

Rates of virological responses in patients treated with PegIFN/RBV combination therapy for 48 weeks are shown in Figure 2. Of the 139 patients enrolled in the study, SVR, non-SVR and cessation of therapy occurred in 58 (42%), 62 (45%), and 19 (14%), respectively. Serious

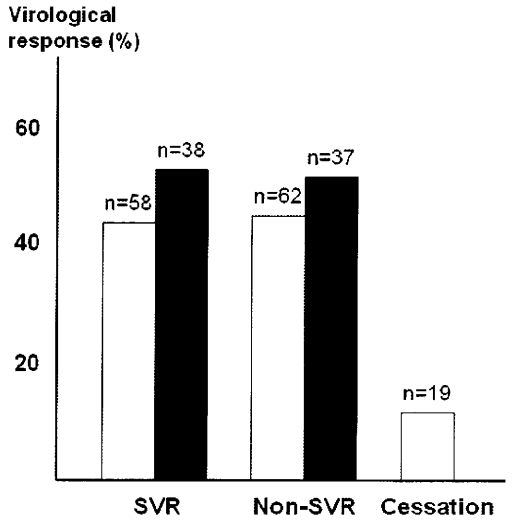

Fig. 2. Virological response in patients treated with peginterferon plus ribavirin for 48 weeks. The results are shown for all 139 subjects (open bars) and for 75 cases with good adherence of >80% of the scheduled dosages (closed bars). SVR, sustained virological response.

adverse events that necessitated discontinuation of this therapy were depression in one patient, thyroid function disorder in 2, general itching in 2, infection in 2, anorexia in 2, occurrence of hepatocellular carcinoma in 2, and a decreased neutrophil count in 2. Six patients also terminated this therapy at their own request. Of the 139 patients, 75 (54%) received >80% of the scheduled dosage of Peg-IFN and RBV designated before treatment, and of these 75 cases SVR and non-SVR occurred in 38 (51%) and 37 (49%), respectively.

Prevalence of Types of Secondary Structure of the Amino-Terminal Region of HCV NS3

The prevalence of the types of secondary structure of HCV NS3 in the 139 subjects is shown in Table I. Among these subjects, 43 (31%), 70 (50%), and 26 (19%) were classified into groups A, B, and others, including 3 of mixed type (A plus B) and 23 of non-A, non-B type. Of the 75 cases with good adherence to administration of >80% of the scheduled dosage, 28 (37%), 40 (53%) and 7 (9%) were classified into groups A, B, and others. The amino acid data of group A and B in the cases with good adherence to administration are available in the DDBJ/EMBL/GenBank databases with the accession numbers AB548070–AB548137. Our analysis revealed no specific correlations between amino acid sequences and the secondary structure deduced by the Robson method, as we have reported previously [Ogata et al., 2003].

TABLE I. Prevalence of the HCV NS3 Secondary Structure Type

	Group A (%)	Group B (%)	Others (%)
Enrolled cases (n = 139)	43 (31)	70 (50)	26 (19)
Adherent cases (n = 75)	28 (37)	40 (53)	7 (9)

Characteristics of Adherent Patients Based on Different HCV NS3 Structure Types

The virological responses to Peg-IFN/RBV combination therapy for patients infected with group A and B isolates were assessed in the 68 subjects with good adherence to the scheduled dosage of Peg-IFN and RBV. The characteristics of patients infected with group A and B isolates are shown in Table II. Age, gender, pre-treatment level of serum HCV RNA and ALT, and frequency of fibrosis stage did not differ significantly between the two groups. Peg-IFN/RBV combination therapy was completed in all the patients, and the total administered dosages of Peg-IFN and RBV was >95% of the scheduled dosage in both groups.

Relationship Between Virological Responses and Polymorphisms in the HCV NS3 Amino-Terminal Region

In the 68 patients who received >95% of the scheduled doses of Peg-IFN and RBV for 48 weeks, SVR and non-SVR occurred in 33 (49%) and 35 (51%), respectively. The EVR, ETR, and SVR rates in patients infected with group A and B isolates are shown in Table III. There was a significant difference in the rates of EVR between subjects infected with group A and B isolates: EVR was achieved in 19 of 28 (68%) patients with group A infection, compared to 17 of 40 (43%) with group B infection ($P < 0.05$). The final outcome also differed significantly between subjects infected with group A and B isolates: SVR was achieved in 18 of 28 (64%) patients with group A infection, compared to 15 of 40 (38%) with group B infection ($P < 0.05$).

Polymorphisms in Core Amino Acids 70/91 and in the HCV NS3 Secondary Structure

The wild-type core sequence (Arg70, Leu91) has been associated with SVR in Peg-IFN/RBV combination therapy, while the non-double wild-type containing one or two substitutions at positions 70 and/or 91 was associated with non-SVR [Akuta et al., 2007]. Therefore, we examined substitutions at positions 70 and 91 in the HCV core region in pre-treatment serum samples of 44 cases that were available for testing. The double wild-type 70/91 sequence was found in 22 of the 44 cases (50%), of which 12 were SVR and 10 were non-SVR. Combination analysis of polymorphisms of the HCV core 70/91 positions and the NS3 amino-terminal region showed that 10 (83%) of the 12 SVR cases and only 3 (30%) of the 10 non-SVR cases with the double wild-type core had a group A polymorphism in HCV NS3 (Table IV). Thus, combination analysis of the core and NS3 regions may improve prediction of the outcome of Peg-IFN/RBV therapy.

TABLE II. Characteristics of Adherent Patients Infected With HCV Group A and B Isolates

	Group A (n = 28)	Group B (n = 40)	P
Age (years)	55.5 ± 9.5	55.5 ± 8.9	NS[a]
Sex (men/women)	18/10	21/19	NS[b]
Pre-treatment HCV RNA (KIU/ml)	1,635 ± 930	2,087 ± 1,422	NS[a]
Alanine aminotransferase level (U/L)	80 ± 62	71 ± 47	NS[a]
Stage of liver fibrosis			
F1 or F2/F3 or F4	19/9	28/12	NS[b]
Drug adherence dosage (%)			
Pegylated interferon	97.7 ± 5.2	95.2 ± 7.3	NS[a]
Ribavirin	96.8 ± 6.4	95.3 ± 7.7	NS[a]

NS, not significant.
[a]t-test.
[b]χ^2 test.

Re-Evaluation of Pre-Treatment HCV Viremia Status Using Real-Time PCR

Since the viral titer before treatment is a major predictive marker of the outcome of Peg-IFN/RBV therapy, we re-evaluated the pre-treatment viral titers more precisely using preserved serum samples taken within 1 month before treatment, using a real-time PCR assay. The pre-treatment viral titers did not differ significantly between sera with group A and B isolates (5.98 ± 0.94 vs. 6.25 ± 0.62 logIU/ml) (Table V). The secondary structure polymorphisms of HCV NS3 were independent of the pre-treatment viral titers.

DISCUSSION

Antiviral therapy with Peg-IFN/RBV for 48 weeks fails to eradicate HCV in about half of patients infected with a high titer of HCV genotype 1b, and the severe adverse events and high costs associated with this therapy require outcome prediction to allow targeted treatment for chronic hepatitis C. The pre-treatment viral titer, viral factors that influence the virological response to IFN-based anti-HCV therapy have been widely investigated. Viral kinetics showing prompt seronegativity after the start of treatment is a critical factor for achieving SVR, and thus the possible correlation between an early virological response and genetic sequence variation of the HCV has been studied. In particular, amino acid substitutions in the HCV core region at positions 70 and 91 or multiple mutations detected in the IRRDR of the HCV NS5A region are useful markers for predicting EVR and subsequent SVR.

TABLE III. Virological Responses in Subjects With Different Polymorphisms in the Secondary Structure of HCV NS3

	EVR*	ETR**	SVR*
Group A (n = 28)	19 (68%)	23 (82%)	18 (64%)
Group B (n = 40)	17 (43%)	25 (63%)	15 (38%)

EVR: early virological response at 12 weeks after the start of treatment.
ETR: virological response at the end of treatment.
SVR: sustained virological response 24 weeks after completion of treatment.
*$P < 0.05$.
**$P = 0.08$; χ^2 test.

To date, the influence of several single amino acid substitutions and accumulation of these changes in the viral genome on the effect of IFN-based anti-HCV therapy has been examined. Since interactions between host and viral proteins in infected cells may influence the therapeutic effect of an antiviral agent, we focused on the association of structural polymorphism of a viral protein with the effect of Peg-IFN/RBV combination therapy in this study. Our results suggest that polymorphism analysis of secondary structure deduced from sequence variations in the HCV NS3 amino-terminal region can be used to predict viral responses to this therapy.

Amino acid sequences of the HCV NS3 amino-terminal region, which encodes a serine protease, vary greatly among HCV isolates. Interactions between HCV NS3 and host proteins may influence both oncogenesis and immunity, and thus elucidation of the biological significance of these interactions could result in a new prognostic marker for HCC or a predictive marker for anti-HCV therapy. First, HCV NS3 interacts with the p53 tumor suppressor to suppress p53-dependent apoptosis or p21 transcriptional activity [Ishido and Hotta, 1998; Kwun et al., 2001; Deng et al., 2006]. Transfection of a plasmid expressing the amino-terminal portion of HCV NS3 induces cell transformation in vitro, and transplanted cells proliferate with sarcoma-like features in vivo [Sakamuro et al., 1995]. These findings suggest that NS3 may be involved in the oncogenic pathway in HCV infection. We have shown that the secondary structure of the 120-residue amino-terminal region of NS3 (1,027–1,146) is classifiable into two major groups: A and B. This region encodes a serine protease and also includes p53-binding sites. Our

TABLE IV. Treatment Outcome of Cases With a Double Wild-Type Core Region and Different HCV NS3 Structural Polymorphism

	Group A (%)	Group B (%)	P
SVR (n = 12)	10 (83)	2 (17)	0.02[a]
Non-SVR (n = 10)	3 (30)	7 (70)	

SVR, sustained virological response.
[a]χ^2 test.

TABLE V. Pre-Treatment HCV RNA Levels Measured by Real-Time PCR for Subjects With Different HCV NS3 Structural Polymorphism

	Group A	Group B	*P*
SVR (n = 33)	5.78 ± 1.05	6.13 ± 0.71	NS[a]
Non-SVR (n = 35)	6.33 ± 0.59	6.32 ± 0.55	NS[a]
Total (n = 68)	5.98 ± 0.94	6.25 ± 0.62	NS[a]

SVR, sustained virological response. NS, not significant.
[a]*t* test.

previous cross-sectional studies revealed that the prevalence of group B infection is significantly higher in HCC cases than in non-HCC cases [Ogata et al., 2003], and that the group B infection is an independent risk factor for development of HCC in patients with chronic HCV infection [Nishise et al., 2007]. Second, NS3 interacts with host proteins associated with IFN signaling and thus influences cellular immunity. Since the serine protease encoded by the amino-terminal region of NS3 inhibits the IFN-signaling pathway, polymorphism of this region is likely to influence the effect of Peg-IFN/RBV combination therapy.

Several factors associated with the virological response to this therapy are well known, with adherence to both IFN and RBV strongly influencing outcome [Pearlman, 2004; Arase et al., 2005; Yamada et al., 2008]. In this study, we analyzed 75 cases in which >80% of the scheduled dosage of both drugs was administered. Of these cases, 28 (37%) and 40 (53%) were infected with group A and B isolates, respectively, which were similar rates to those for the 139 cases in the overall study. Age, gender, viral load before treatment, ALT level, proportion of fibrosis stage and adherence to Peg-IFN and RBV did not differ between the group A and B cases. However, the frequencies of SVR and EVR were significantly higher in group A, and those for non-EVR and non-SVR were significantly higher in group B. The results suggest that infection with the group B isolate, which correlates with a higher rate of HCC, is resistant to Peg-IFN/RBV therapy. The pre-treatment viremia status in the 68 cases with group A or B isolates showed no significant differences between the two groups of patients. Therefore, these results suggest that the secondary structure of the HCV NS3 amino-terminal region may be useful for prediction of the outcome of Peg-IFN/RBV combination therapy. In this initial study setting, the relationship of these polymorphisms to the frequency of rapid viral response at 4 weeks after the start of treatment was not evaluated. It will be important to assess this relationship in a future study.

The polymorphism in HCV core region (Arg70/Leu91) is a useful predictive marker for virological responses in Peg-IFN/RBV therapy [Akuta et al., 2007]. Interestingly, a combined analysis of polymorphisms of the core region (which encodes a structural protein) and HCV NS3 (a nonstructural protein) improved the prediction rate. Therefore, analysis of NS3 polymorphism in combination with the core structural polymorphism appears to improve prediction of the outcome of Peg-IFN/RBV therapy. A larger, multi-center prospective study would be necessary to validate the present results. In conclusion, the results of this study suggest that secondary structure polymorphism in the amino-terminal region of HCV NS3 is a useful predictive marker of the effect of Peg-IFN/RBV combination therapy for chronic hepatitis C. Although the present findings are clinically important, and will be helpful for predicting the outcome of Peg-IFN/RBV therapy, further in vitro studies will be needed to elucidate the molecular mechanism underlying the association of HCV NS3polymorphisms with clinical outcome.

REFERENCES

Akuta N, Suzuki F, Sezaki H, Suzuki Y, Hosaka T, Someya T, Kobayashi M, Saitoh S, Watahiki S, Sato J, Kobayashi M, Arase Y, Ikeda K, Kumada H. 2006. Predictive factors of virological non-response to interferon-ribavirin combination therapy for patients infected with hepatitis C virus of genotype 1b and high viral load. J Med Virol 78:83–90.

Akuta N, Suzuki F, Kawamura Y, Yatsuji H, Sezaki H, Suzuki Y, Hosaka T, Kobayashi M, Kobayashi M, Arase Y, Ikeda K, Kumada H. 2007. Predictive factors of early and sustained responses to peginterferon plus ribavirin combination therapy in Japanese patients infected with hepatitis C virus genotype 1b: Amino acid substitutions in the core region and low-density lipoprotein cholesterol levels. J Hepatol 46:403–410.

Arase Y, Ikeda K, Tsubota A, Suzuki F, Suzuki Y, Saitoh S, Kobayashi M, Akuta N, Someya T, Hosaka T, Sezaki H, Kobayashi M, Kumada H. 2005. Significance of serum ribavirin concentration in combination therapy of interferon and ribavirin for chronic hepatitis C. Intervirology 48:138–144.

Bruno S, Cammà C, Di Marco V, Rumi M, Vinci M, Camozzi M, Rebucci C, Di Bona D, Colombo M, Craxì A, Mondelli MU, Pinzello G. 2004. Peginterferon alfa-2b plus ribavirin for naïve patients with genotype 1 chronic hepatitis C: A randomized controlled trial. J Hepatol 41:474–481.

Deng L, Nagano-Fujii M, Tanaka M, Nomura-Takigawa Y, Ikeda M, Kato N, Sada K, Hotta H. 2006. NS3 protein of hepatitis C virus associated with the tumor suppressor p53 and inhibits its function in an NS3 sequence-dependent manner. J Gen Virol 87:1703–1713.

El-Shamy A, Sasayama M, Nagano-Fujii M, Sasase N, Imoto S, Kim SR, Hotta H. 2007. Prediction of efficient virological response to pegylated interferon/ribavirin combination therapy by NS5A sequences of hepatitis C virus and anti-NS5A antibodies in pre-treatment sera. Microbiol Immunol 51:471–482.

El-Shamy A, Nagano-Fujii M, Sasase N, Imoto S, Kim SR, Hotta H. 2008. Sequence variation in hepatitis C virus nonstructural protein 5A predicts clinical outcome of pegylated interferon/ribavirin combination therapy. Hepatology 48:38–47.

Enomoto N, Sakuma I, Asahina Y, Kurosaki M, Murakami T, Yamamoto C, Ogura Y, Izumi N, Marumo F, Sato C. 1996. Mutations in the nonstructural protein 5A gene and response to interferon in patients with chronic hepatitis C virus 1b infection. N Engl J Med 334:77–81.

Evans JD, Seeger C. 2006. Cardif: A protein central to innate immunity is inactivated by the HCV NS3 serine protease. Hepatology 43:615–617.

Foy E, Li K, Wang C, Sumpter R, Jr., Ikeda M, Lemon SM, Gale M, Jr. 2003. Regulation of interferon regulatory factor-3 by the hepatitis C virus serine protease. Science 300:1145–1148.

Gale MJ, Jr., Korth MJ, Tang NM, Tan SL, Hopkins DA, Dever TE, Polyak SJ, Gretch DR, Katze MG. 1997. Evidence that hepatitis C virus resistance to interferon is mediated through repression of the PKR protein kinase by the nonstructural 5A protein. Virology 230:217–227.

Gale MJ, Jr., Korth MJ, Katze MG. 1998. Repression of the PKR protein kinase by the hepatitis C virus NS5A protein: A potential mechanism of interferon resistance. Clin Diagn Virol 10:157–162.

Garnier J, Osguthorfe DJ, Robson B. 1978. Analysis of the accuracy and implications of simple methods for predicting the secondary structure of globular proteins. J Mol Biol 120:97–120.

Grandvaux N, Servant MJ, tenOever B, Sen GC, Balachandran S, Barber GN, Lin R, Hiscott J. 2002. Transcriptional profiling of interferon regulatory factor 3 target genes: Direct involvement in the regulation of interferon-stimulated genes. J Virol 76:5532–5539.

Hadziyannis SJ, Sette H, Jr., Morgan TR, Balan V, Diago M, Marcellin P, Ramadori G, Bodenheimer H, Jr., Bernstein D, Rizzetto M, Zeuzem S, Pockros PJ, Lin A, Ackrill AM. 2004. Peginterferon-alpha2a and ribavirin combination therapy in chronic hepatitis C: A randomized study of treatment duration and ribavirin dose. Ann Intern Med 140:346–355.

Hiramatsu N, Kurashige N, Oze T, Takehara T, Tamura S, Kasahara A, Oshita M, Katayama K, Yoshihara H, Imai Y, Kato M, Kawata S, Tsubouchi H, Kumada H, Okanoue T, Kakumu S, Hayashi N. 2008. Early decline of hemoglobin can predict progression of hemolytic anemia during pegylated interferon and ribavirin combination therapy in patients with chronic hepatitis C. Hepatol Res 38:52–59.

Ishido S, Hotta H. 1998. Complex formation of the nonstructural protein 3 of hepatitis C virus with the p53 tumor suppressor. FEBS Lett 438:258–262.

Kwun HJ, Jung EY, Ahn JY, Lee MN, Jang KL. 2001. p53-dependent transcriptional repression of p21(waf1) by hepatitis C virus NS3. J Gen Virol 82:2235–2241.

Manns MP, McHutchison JG, Gordon SC, Rustgi VK, Shiffman M, Reindollar R, Goodman ZD, Koury K, Ling M, Albrecht JK. 2001. Peginterferon alfa-2b plus ribavirin compared with interferon alfa-2b plus ribavirin for initial treatment of chronic hepatitis C: A randomized trial. Lancet 358:958–965.

Meylan E, Curran J, Hofmann K, Moradpour D, Binder M, Bartenschlager R, Tschopp J. 2005. Cardif is an adaptor protein in the RIG-I antiviral pathway and is targeted by hepatitis C virus. Nature 437:1167–1172.

Murphy MD, Rosen HR, Marousek GI, Chou S. 2002. Analysis of sequence configurations of the ISDR, PKR-binding domain, and V3 region as predictors of response to induction interferon-alpha and ribavirin therapy in chronic hepatitis C infection. Dig Dis Sci 47:1195–1205.

Nakaya T, Sato M, Hata N, Asagiri M, Suemori H, Noguchi S, Tanaka N, Taniguchi T. 2001. Gene induction pathways mediated by distinct IRFs during viral infection. Biochem Biophys Res Commun 283:1150–1156.

Nishise Y, Saito T, Sugahara K, Ito JI, Saito K, Togashi H, Nagano-Fujii M, Hotta H, Kawata S. 2007. Risk of hepatocellular carcinoma and secondary structure of hepatitis C virus (HCV) NS3 protein amino-terminus, in patients infected with HCV subtype 1b. J Infect Dis 196:1006–1009.

Nousbaum J, Polyak SJ, Ray SC, Sullivan DG, Larson AM, Carithers RL, Jr., Gretch DR. 2000. Prospective characterization of full-length hepatitis C virus NS5A quasispecies during induction and combination antiviral therapy. J Virol 74:9028–9038.

Ogata S, Ku Y, Yoon S, Makino S, Nagano-Fujii M, Hotta H. 2002a. Correlation between secondary structure of an amino-terminal portion of the nonstructural protein 3 (NS3) of hepatitis C virus and development of hepatocellular carcinoma. Microbiol Immunol 46:549–554.

Ogata S, Nagano-Fujii M, Ku Y, Yoon S, Hotta H. 2002b. Comparative sequence analysis of the core protein and its frameshift product, the F protein, of hepatitis C virus subtype 1b strains obtained from patients with and without hepatocellular carcinoma. J Clin Microbiol 40:3625–3630.

Ogata S, Florese RH, Nagano-Fujii M, Hidajat R, Deng L, Ku Y, Yoon S, Saito T, Kawata S, Hotta H. 2003. Identification of hepatitis C virus (HCV) subtype 1b strains that are highly, or only weakly, associated with hepatocellular carcinoma on the basis of the secondary structure of an amino-terminal portion of the HCV NS3 protein. J Clin Microbiol 41:2835–2841.

Pearlman BL. 2004. Hepatitis C treatment update. Am J Med 117:344–352.

Puig-Basagoiti F, Forns X, Furcić I, Ampurdanés S, Giménez-Barcons M, Franco S, Sánchez-Tapias JM, Saiz JC. 2005. Dynamics of hepatitis C virus NS5A quasispecies during interferon and ribavirin therapy in responder and non-responder patients with genotype 1b chronic hepatitis C. J Gen Virol 86:1067–1075.

Sakamuro D, Furukawa T, Takegami T. 1995. Hepatitis C virus nonstructural protein NS3 transforms NIH 3T3 cells. J Virol 69: 3893–3896.

Sarrazin C, Herrmann E, Bruch K, Zeuzem S. 2002. Hepatitis C virus nonstructural 5A protein and interferon resistance: A new model for testing the reliability of mutational analyses. J Virol 76:11079–11090.

Yamada K, Mori A, Seki M, Kimura J, Yuasa S, Matsuura Y, Miyamura T. 1998. Critical point mutations for hepatitis C virus NS3 proteinase. Virology 246:104–112.

Yamada G, Iino S, Okuno T, Omata M, Kiyosawa K, Kumada H, Hayashi N, Sakai T. 2008. Virological response in patients with hepatitis C virus genotype 1b and a high viral load: Impact of peginterferon-alpha-2a plus ribavirin dose reductions and host-related factors. Clin Drug Investig 28:9–16.

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ORIGINAL ARTICLE

17β-estradiol inhibits the production of infectious particles of hepatitis C virus

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ABSTRACT

Persistent infection with hepatitis C virus causes serious liver diseases, such as chronic hepatitis, hepatic cirrhosis and hepatocellular carcinoma. The male gender is one of the critical factors in progression of hepatic fibrosis due to chronic HCV infection; thus female hormones may play a role in delaying the progression of hepatic fibrosis. It has also been reported that women are more likely than men to clear HCV in the acute phase of infection. These observations lead the present authors to the question: do female hormones inhibit HCV infection? In this study using HCV J6/JFH1 and Huh-7.5 cells, the possible inhibitory effect(s) of female hormones such as 17β-estradiol (the most potent physiological estrogen) and progesterone on HCV RNA replication, HCV protein synthesis and production of HCV infectious particles (virions) were analyzed. It was found that E_2, but not P_4, significantly inhibited production of the HCV virion without inhibiting HCV RNA replication or HCV protein synthesis. E_2–mediated inhibition of HCV virion production was abolished by a nuclear estrogen receptor (ER) antagonist ICI182780. Moreover, treatment with the ERα-selective agonist 4, 4′, 4″- (4-propyl-[1H]-pyrazole-1, 3, 5-triyl)trisphenol (PPT), but not with the ERβ-selective agonist 2, 3-bis (4-hydroxyphenyl)-propionitrile (DPN) or the G protein-coupled receptor 30 (GPR30)-selective agonist 1-(4-[6-bromobenzo 1, 3 dioxol-5-yl]-3a, 4, 5, 9b-tetrahydro-3H-cyclopenta [c] quinolin-8-yl)-ethanone (G-1), significantly inhibited HCV virion production. Taken together, the present results suggest that the most potent physiological estrogen, E_2, inhibits the production of HCV infectious particles in an ERα–dependent manner.

Key words 17β-estradiol, estrogen receptor, hepatitis C virus, sex difference.

HCV, an enveloped RNA virus which belongs to the genus *Hepacivirus* within the family *Flaviviridae*, prevails in most parts of the world with an estimated number of about 170 million carriers; hence HCV infection is a major global health-care problem (1). Persistent infection with HCV causes serious liver diseases, such as chronic hepatitis, hepatic cirrhosis and hepatocellular carcinoma (2, 3). In the USA, the prevalence of anti-HCV antibodies is twice as high in men as in women (4). The male gender is thought to be one of the critical factors in progression of hepatic fibrosis in chronic HCV infection (5, 6). It has also been reported that progression of hepatic fibrosis is faster in postmenopausal than in premenopausal women, and that hormone replacement therapy with estrogen and

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List of Abbreviations: DMEM, Dulbecco's modified Eagle's medium; DMSO, dimethyl sulfoxide; DPN, 2, 3-bis (4-hydroxyphenyl)-propionitrile; E_2, 17β-estradiol; ER, estrogen receptor; G-1, 1-(4-[6-bromobenzo 1, 3 dioxol-5-yl]-3a, 4, 5, 9b-tetrahydro-3H-cyclopenta [c] quinolin-8-yl)-ethanone; GPR30, G protein-coupled receptor 30; HCV, hepatitis C virus; P_4, progesterone; PPT, 4, 4′, 4″- (4-propyl-[1H]-pyrazole-1, 3, 5-triyl)trisphenol; SEM, standard error of the mean.

progesterone significantly delays progression of hepatic fibrosis in postmenopausal women (6, 7). This potential innate resistance of premenopausal women to hepatic fibrosis may be attributed to female hormones, such as estrogens and progesterone. In fact, E_2, the most potent physiological estrogen, has been reported to suppress the progression of liver fibrosis and hepatocarcinogenesis (8, 9). Moreover, women are more likely than men to clear HCV in the acute phase of infection, even within a few months after infection (10). These observations imply the possibility that female hormones inhibit HCV infection, either at the level(s) of virus attachment/entry, virus RNA replication, virus protein synthesis or production of infectious virus particles (virions).

Estrogens utilize three kinds of ER; ERα, ERβ and GPR30 (11–15). Specific agonists and antagonists of ER are available and widely used to examine the roles of estrogens. In the present study, we examined the possible effects of female hormones, especially E_2 and P_4, on HCV RNA replication, protein synthesis and virion production in cultured cells.

MATERIALS AND METHODS

Cell culture and virus infection

A human hepatoma-derived cell line, Huh-7.5, which is highly permissive to HCV RNA replication (16), was kindly provided by Dr. C. M. Rice (The Rockefeller University, New York, NY, USA). The cells were maintained in phenol red-free DMEM (Sigma–Aldrich, St Louis, MO, USA) supplemented with 10% heat-inactivated and charcoal-stripped FBS (Israel Beit Haemek, Haemek, Israel), 0.1 mM non-essential amino acids (Invitrogen, Carlsbad, CA, USA), 100 IU/mL penicillin and 100 μg/mL streptomycin (Invitrogen).

The pFL-J6/JFH1 plasmid that encodes the entire viral genome of a chimeric strain of HCV-2a, J6/JFH1 (17) was kindly provided by Dr. C. M. Rice. A cell culture-adapted mutant derived from J6/JFH1 (P-47 strain) (18, 19) was used for infection experiments. The virus was inoculated into Huh-7.5 cells at a multiplicity of infection of 1.0 and incubated for 2 hr. After the residual virus had been removed by washing, the cells were cultured in the presence or absence of female hormones, and agonists and an antagonist of estrogen receptors (see below). Culture supernatants were collected at 0, 1, 2 and 3 days postinfection and virus titers were determined, as described below.

Virus titration

Culture supernatants containing HCV were serially diluted 10-fold in DMEM and inoculated into Huh-7.5 cells (2×10^5 cells per well in a 24-well plate). After incubation at 37°C for 6 hr, the cells were fed with fresh DMEM. At 24 hr postinfection, the cells were fixed with ice-cold methanol, blocked with 5% goat serum in PBS and subjected to immunofluorescence analysis using mouse monoclonal antibody against the HCV core protein (2H9) and Alexa Fluor 488-conjugated goat anti-mouse IgG (H+L, Molecular Probes, Eugene, OR, USA). Hoechst 33342 (Molecular Probes) was used for counterstaining of the nuclei. HCV-positive foci were counted under a fluorescent microscope (BX51; Olympus, Tokyo, Japan) and virus titers were expressed as focus-forming units per ml, as reported previously (18, 19).

Chemicals

E_2 and P_4 were purchased from Sigma–Aldrich (St Louis, MO, USA). ICI182780 (an antagonist of ERα and ERβ), PPT (an ERα-selective agonist) (20) and DPN (an ERβ-selective agonist) (21) were purchased from Tocris Bioscience (Bristol, UK). G-1 (a GPR30-selective agonist) (22) was purchased from Calbiochem (Darmstadt, Germany). DMSO, which was used as a solvent, was obtained from Wako Pure Chemical Industries (Osaka, Japan). The concentrations of E_2 and P_4 used in this study were 0.4 μM and 3 μM, respectively, which correspond to the estimated highest concentrations in the sera of pregnant women. ICI182780 was used at a concentration of 1 μM, PPT and DPN at 0.1, 1 and 10 μM, and G-1 at 0.1 and 1 μM. As G-1 has been reported to lose its GPR30-binding specificity at concentrations over 1 μM, a concentration of 10 μM for G-1 was not tested. The final concentration of DMSO as a control never exceeded 0.01%.

Cell viability assay

Cells plated on 96-well microtiter plates (2.0×10^4 cells/well) were inoculated with HCV and treated with E_2, P_4 or DMSO. The cell viability in each well was determined by WST-1 assay (Roche Diagnostics, Mannheim, Germany) until 3 days postinfection.

Real-time quantitative RT-PCR

Total cellular RNA was isolated using the RNAiso reagent (Takara Bio, Kyoto, Japan) and cDNA was generated using the QuantiTect Reverse Transcription system (Qiagen, Valencia, CA, USA). Real-time quantitative PCR was performed on a SYBR *Premix Ex Taq* (Takara Bio) using SYBR green chemistry in ABI PRISM 7000 (Applied Biosystems, Foster, CA, USA). Primer sets used in this study are shown below: HCV NS5B, 5′-ACCAAGCTCAAACTCACTCCA-3′ and 5′-AGCGGGGTCGGGCAC GAGACA-3′ (23);

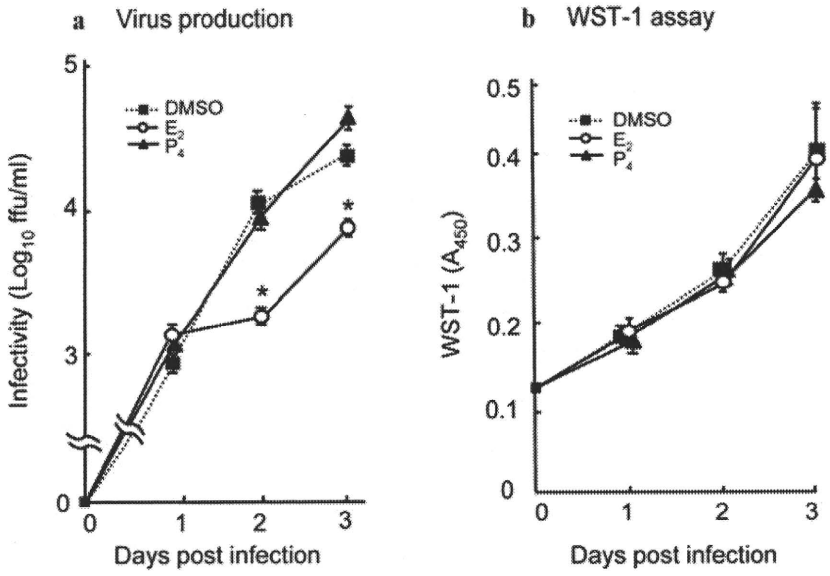

Fig. 1. Effects of E_2 and P_4 on HCV virion production and cell growth. (a) HCV virion production. Huh-7.5 cells were inoculated with HCV at a multiplicity of infection of 1.0, incubated for 2 hr, and cultured for 0, 1, 2 and 3 days after virus infection. The HCV-infected cells were treated with E_2 (0.4 μM), P_4 (3 μM) or DMSO (control) from 2 hr postinfection to sampling time (days 1, 2 and 3). The culture supernatants of HCV-infected cells were assayed for virus infectivity. Data are shown as mean ± SEM. (b) Cell growth. HCV-infected cells were treated with E_2, P_4 or DMSO (control) from 2 hr to 3 days postinfection. Cell growth in each culture was determined by WST-1 assay. Data are shown as mean ± SEM.

β-actin, 5′-GCGGGAAATCGTGCGTGACATT-3′ and 5′-GATGGAGTTGAAGGTAGTTTCGTG-3′.

Immunoblotting

Cells were solubilized in lysis buffer as reported previously (18, 19). The cell lysates were subjected to 8% sodium dodecyl sulfate-polyacrylamide gel electrophoresis and transferred to polyvinylidene difluoride membrane (Millipore, Billerica, MA, USA). The membranes were incubated with mouse monoclonal antibodies against HCV NS3 (Chemicon International, Temecula, CA, USA), followed by incubation with peroxidase-conjugated goat anti-mouse IgG (Medical & Biological Laboratories Co. Ltd., Nagoya, Japan). The positive bands were visualized by using ECL detection system (GE Healthcare UK, Buckinghamshire, UK).

Statistical analysis

Results were expressed as mean ± SEM. Statistical significance was evaluated by one-way analyses of variances.

RESULTS

E_2 inhibits HCV virion production, but not HCV RNA replication or HCV protein synthesis

We first examined the effect of E_2 or P_4 treatment on HCV virion production. At 2 hr after virus inoculation, the HCV-infected Huh-7.5 cells were treated with E_2 (0.4 μM) or P_4 (3 μM) for 3 days. Culture supernatants were collected every day and titrated for viral infectivity. As shown in Figure 1a, E_2 treatment significantly suppressed HCV virion production at 2 and 3 days postinfection, whereas treatment with P_4 did not. The same treatment (E_2 or P_4) did not exert significant cytotoxicity (Fig. 1b). Next, we examined the effect of E_2 on HCV RNA replication and HCV protein synthesis under the same experimental conditions. We found that HCV RNA replication and HCV protein synthesis in both HCV-infected cells and HCV RNA replicon-harboring cells (23) were all unaffected by treatment with E_2 or P_4 (Fig. 2a–c). Moreover, treatment of the cells with E2 either prior to, or during, virus inoculation did not significantly inhibit HCV virion production (Fig. 3a). These results collectively suggest that E_2 inhibits HCV virion production, but not at the level of virus entry, RNA replication or protein synthesis. We also observed that E_2 –mediated inhibition of HCV virion production occurs in a dose-dependent manner (Fig. 3b).

A nuclear estrogen receptor antagonist, ICI182780, abolishes E_2-mediated inhibition of HCV virion production

We hypothesized that E_2 signaling through nuclear ER (ERα and ERβ) was involved in the E_2–mediated inhibition of HCV virion production. To test this possibility, we used ICI182780 (1 μM), an antagonist of ERα and ERβ. The results clearly demonstrated that treatment of cells with ICI182780 abolished E_2–mediated inhibition of HCV virion production (Fig. 4).

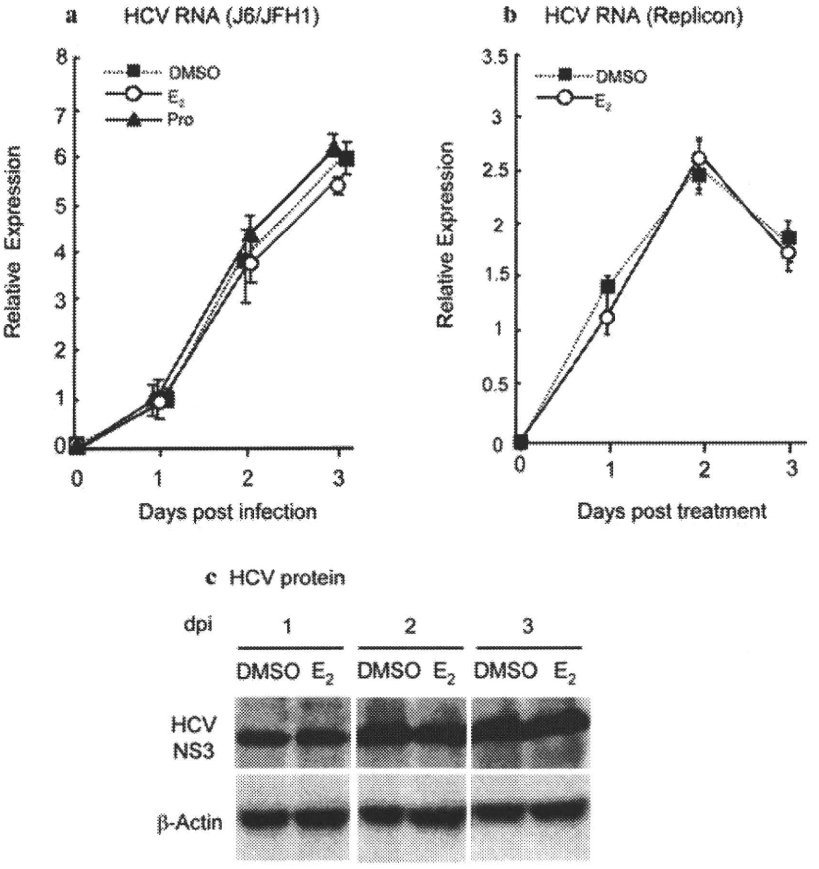

Fig. 2. Effects of E_2 and P_4 on HCV RNA replication and HCV protein synthesis. (a) HCV RNA replication. Huh-7.5 cells were inoculated with HCV at a multiplicity of infection of 1.0, incubated for 2 hr, and cultured for 0, 1, 2 and 3 days after virus infection. The HCV-infected cells were treated with E_2 (0.4 μM) or DMSO (control) from 2 hr to sampling time (days 1, 2 and 3). HCV RNA replication levels were determined by real-time quantitative RT-PCR and normalized with β-actin mRNA levels. Data are shown as mean ± SEM. (b) Huh-7.5 cells harboring a full-genomic HCV RNA replicon (23) were treated with E_2 (0.4 μM) or DMSO, and HCV RNA replication levels determined as in (a). (c) HCV protein synthesis. HCV-infected cells were treated with E2 or DMSO as in (a) and the amount of HCV protein synthesis determined by immunoblot analysis using anti-NS3 antibody. The degree of β-actin expression as determined by anti-β-actin antibody served as a control. dpi, days postinfection.

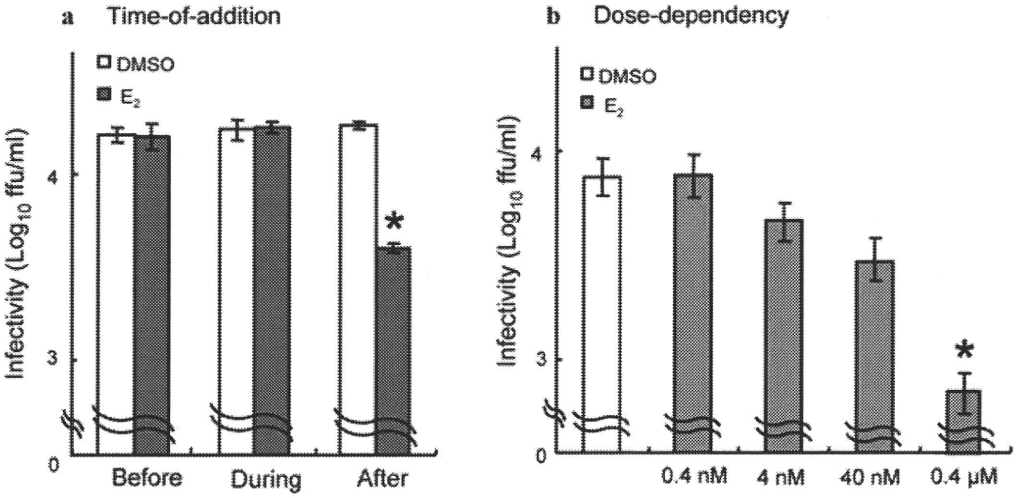

Fig. 3. Kinetic analysis of E_2–mediated inhibition of HCV virion production. (a) Time-of-addition experiment. Huh-7.5 cells were inoculated with HCV at a multiplicity of infection of 1.0, incubated for 2 hr, and cultured up to 2 days after virus infection. Treatment of the cells with E_2 (0.4 μM) was performed before or during virus inoculation for 2 hr, or after virus inoculation until sampling time (day 2). The culture supernatants of HCV-infected cells were assayed for viral infectivity. Data are shown as mean ± SEM. *$P < 0.05$, compared with DMSO control. (b) Dose–dependency experiment. Huh-7.5 cells were inoculated with HCV as in (a). The HCV-infected cells were treated with various concentrations of E_2 (0.4 nM to 0.4 μM]) from 2 hr postinfection to sampling time (day 2). The culture supernatants of HCV-infected cells were assayed for viral infectivity. Data are shown as mean ± SEM. *$P < 0.05$, compared with DMSO control.

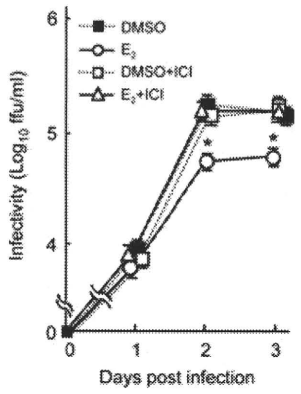

Fig. 4. Effects of ER antagonist, ICI182780, on HCV virion production. Huh-7.5 cells were inoculated with HCV at a multiplicity of infection of 1.0, incubated for 2 hr, and cultured for 0, 1, 2 and 3 days after virus infection. The HCV-infected cells were treated with E_2 (0.4 μM) and/or ICI182780 (1 μM) or DMSO (control) from 2 hr postinfection to sampling time (days 1, 2 and 3). The culture supernatants of HCV-infected cells were assayed for virus infectivity. Data are shown as mean ± SEM. *$P < 0.05$, compared with DMSO control.

Estrogen receptor-α-selective agonist 4, 4′, 4″- (4-propyl-[1H]-pyrazole-1, 3, 5-triyl) trisphenol inhibits HCV virion production

To determine which estrogen receptor(s) is/are involved in the E_2–mediated down-regulation of HCV virion production, we used receptor-specific agonists, such as PPT (an ERα-selective agonist) (20), DPN (an ERβ-selective agonist) (21) and G-1 (a GPR30-selective agonist) (22). Treatment of cells with PPT (10 μM), but not with DPN (10 μM) or G-1 (1 μM), significantly inhibited HCV virion production (Fig. 5). PPT treatment at a concentration of 1 μM also brought about a weak, but significant, inhibition of HCV virion production at 2 days postinfection. On the other hand, PPT did not mediate significant cytotoxicity at the concentrations tested (data not shown).

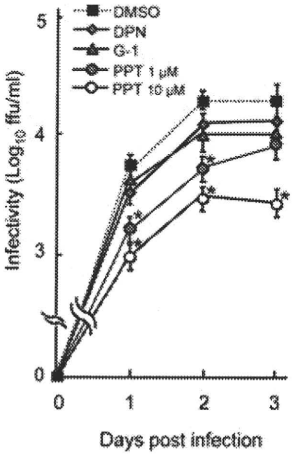

Fig. 5. Effects of ER-specific agonists on HCV virion production. Huh-7.5 cells were inoculated with HCV at a multiplicity of infection of 1.0, incubated for 2 hr, and cultured for 0, 1, 2 and 3 days after virus infection. The HCV-infected cells were treated with PPT (ERα-selective agonist; 1 and 10 μM), DPN (ERβ-selective agonist; 10 μM) or G-1 (GPR30-selective agonist; 1 μM) from 2 hr postinfection to sampling time (days 1, 2 and 3). The culture supernatants of HCV-infected cells were assayed for viral infectivity. Data are shown as mean ± SEM. *$P < 0.05$, compared with DMSO control.

DISCUSSION

We have demonstrated in the present study that treatment of Huh-7.5 cells with E_2 inhibits HCV virion production, but not HCV RNA replication or HCV protein synthesis (Figs 1 and 2). Treatment of the cells with E_2 either prior to, or during, virus inoculation did not significantly suppress HCV virion production (Fig. 3a). These results collectively suggest that E_2 inhibits HCV infection at the virion assembly/secretion level, but not at the level of virus attachment/entry, virus RNA replication or virus protein synthesis. E_2 has been reported to possess antioxidant and anti-apoptotic activities in fibrotic liver and cultured hepatocytes (24, 25). It should be noted, however, that E_2 did not exert anti-apoptotic or cytotoxic (pro-apoptotic) effect under our experimental conditions (Fig. 1b). In contrast to E_2, another female hormone, P_4, did not significantly affect HCV virion production (Fig. 1a).

E_2-mediated inhibition of HCV virion production was abolished by a nuclear ER (ERα and ERβ) antagonist, ICI182780 (Fig. 4), this result suggesting that suppression of HCV virion production may be induced by ER signal transduction. Three types of ER have been reported so far; ERα, ERβ and GPR30 (11–15). To determine which ER is involved in the suppression of HCV virion production, we used ER-specific agonists, PPT (for ERα) (20), DPN (for ERβ) (21) and G-1 (for GPR30) (22). We found that PPT, but not DPN or G-1, inhibits the production of HCV infectious particles (Fig. 5), suggesting that ERα plays an important role in the inhibition of HCV virion production. It has been reported that, in hepatocytes, ERα constitutes a minor proportion of the total ER, and that an estrogen-mediated anti-apoptotic effect is mediated principally through ERβ (26). However, the importance of ERα–mediated signal transduction should not be ignored. The rationale for this assertion is that ERα is known to be involved in lipid metabolism (27), that certain lipid metabolism disorder(s) possibly result(s) in abnormal accumulation of lipid droplets, and that such an accumulation is required for HCV virion maturation in virus-infected cells (27), that certain lipid metabolism disorder(s) possibly result(s) in abnormal accumulation of