Figure 2 Correlation between the undetectable time point and the decrease in viral load from day 7 to 14 (a,b) and correlation between the actual and predicted undetectable time points (c,d). (a,c) Results of analyses for the model preparation group; and (b,d) analyses for the model validation group. Black circles, actual cases; dotted line, (a,c) estimate obtained from the prediction formula; (b,d) equal values of actual and predicted undetectable time points.

undetectable time point are plotted in Figure 2(a), which shows a very strong and a significant correlation ($r^2 = 0.67$, $P < 0.0005$).

The validity of the prediction formula was investigated in the validation group. Analysis was possible in 32 patients, as the other patients were excluded from the analysis due to the following reasons: therapy was discontinued before viral clearance in eight patients, PEG-IFN dosage was reduced before viral clearance in nine patients and viral clearance was achieved before day 14 in two patients. There were six cases of NVR, and incomplete blood collections from 13 patients on day 7 and/or 14. A strong and a significant correlation was demonstrated between the undetectable time points that were predicted using this formula and the actual undetectable time points (Fig. 2c, $r = 0.53$, $P = 0.005$).

Although only one case was predicted to achieve a rapid virological response (undetectable viral load at week 4)[13] in the model validation group, the actual undetectable time point of this patient was week 8 (Fig. 2d). In contrast, all nine cases who were predicted to achieve a complete early virological response (undetected viral load until week 12),[13] the actual undetectable time points of these patients were within week 12. Because the prediction formula was derived by the least squares method, half of the patients, who were predicted not to achieve the complete early virological response, actually achieved it.

DISCUSSION

NUMEROUS STUDIES HAVE documented that the undetectable time point is related to therapeutic responses, and its usefulness in predicting therapeutic efficacy is clear.[9–13] In the present study, we were able to derive a formula for predicting the undetectable time point for patients with HCV genotype 1b and high serum viral loads during PEG-IFN-α-2b/ribavirin combination therapy. Though the various parameters for the HCV dynamics were investigated, the change in viral load from day 7 to 14 was the only parameter that was useful for predicting the undetectable time point.

The standard length of PEG-IFN/ribavirin combination therapy is 48 weeks for patients with HCV genotype 1b and high serum viral loads; however, a 72-week administration is recommended to improve therapeutic response.[3,13,18] Therefore, when undetectable time points are predicted as from weeks 13–24 by our formula, the SVR rates could be improved by continuing the IFN therapy for longer periods. By prediction of the undetectable time point early during the treatment using our formula, the physician can make early modification and optimization of currently ongoing therapy.

Another important issue of PEG-IFN/ribavirin treatment is adherence to treatment. Because dose reductions may delay the time until serum viral clearance, patients in whom the dosage of IFN and ribavirin was reduced during therapy were excluded in the present study. However, there are many patients in whom the dosage of drugs has to be reduced during therapy for a wide variety of clinical reasons. If reducing dosage before the predicted undetectable time point, administration of IFN for longer periods should be considered.

In conclusion, we created a formula for predicting the undetectable time point in patients treated with PEG-IFN-α-2b/ribavirin combination therapy. Viral eradication is the ultimate objective of IFN-based therapy, but many patients failed to achieve viral eradication for some reason. Because our prediction formula for the undetectable time point was made with a small population, it is necessary to correct it by further analysis with a larger population. However, an early viral response reflects efficacy of the therapy, and the estimation of an undetectable time point by our formula would be useful for determining the optimal duration of treatment in the early period of the therapy for each chronic hepatitis C patient.

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Review Article

Predictors of Virological Response to a Combination Therapy with Pegylated Interferon Plus Ribavirin Including Virus and Host Factors

Namiki Izumi, Yasuhiro Asahina, and Masayuki Kurosaki

*Department of Gastroenterology and Hepatology, Musashino Red-Cross Hospital, Kyonancho 1-26-1,
Musashinoshi, 180-8610 Tokyo, Japan*

Correspondence should be addressed to Namiki Izumi, nizumi@musashino.jrc.or.jp

A combination therapy with pegylated interferon (PEG-IFN) plus ribavirin (RBV) has made it possible to achieve a sustained virological response (SVR) of 50% in refractory cases with genotype 1b and high levels of plasma HCVRNA. Several factors including virus mutation and host factors such as age, gender, fibrosis of the liver, lipid metabolism, innate immunity, and single nucleotide polymorphism (SNPs) are reported to be correlated to therapeutic effects. However, it is difficult to determine which factor is the most important predictor for an individual patient. Data mining analysis is useful for combining all these together to predict the therapeutic effects. It is important to analyze blood tests and to predict therapeutic effects prior to initiating treatment. Since new anti-HCV agents are under development, it will be necessary in the future to select the patients who have a high possibility of achieving SVR if treatment is performed with standard regimen.

1. Progress in Virological Response in the Difficult-to-Treat Patients with Genotype 1 Hepatitis C Virus (HCV) Infection and Factors Correlated to the Efficacy

Recently, the average age of the patients with chronic hepatitis C has been increasing in Japan. Incidence of hepatocellular carcinoma (HCC) in the elderly patients with chronic hepatitis C (65 years or older) has demonstrated to be higher than younger ones when adjusted by the stage of hepatic fibrosis [1]. In Japan, refractory cases with genotype 1b and high HCVRNA levels are seen in as high as 70 percent of chronic hepatitis C patients. The outcome of conventional IFN monotherapy has been an SVR response of 3%–5% after 6 months of treatment in genotype 1b and high HCVRNA patients [2, 3], and virus mutation such as interferon sensitivity-determining region (ISDR) is shown to be correlated with the virological response [2]. The association of ISDR mutations and virological response to IFN monotherapy was denied in an Italian study [4]; however, it was confirmed by a Chinese study [5] and an international meta-analysis [6].

However, pegylated IFN (PEG-IFN) extends the duration of therapy and reduces adverse effects, and for this reason, PEG-IFN has become the cornerstone of therapy. Furthermore, by the combination therapy with PEG-IFN and ribavirin (RBV), the rate of SVR has dramatically improved. Even in the patients with genotype 1b and high HCVRNA level, SVR rate reaches as high as 40%–50%, thereby improving the therapeutic effects both in Western countries [7, 8] and in Japan [9, 10].

It is important to predict the rate of achieving SVR in the individual patient, before initiating treatment. Both virus- and host-related elements have been reported as factors correlated to therapeutic effects of combination therapy [11–13]. A particular focus has been placed on virus mutations, age, gender, fibrosis of the liver, lipid metabolism, and degree of fatty metamorphosis of the liver.

Among these factors related to PEG-IFN and RBV, innate immunity has been shown to be correlated in virological
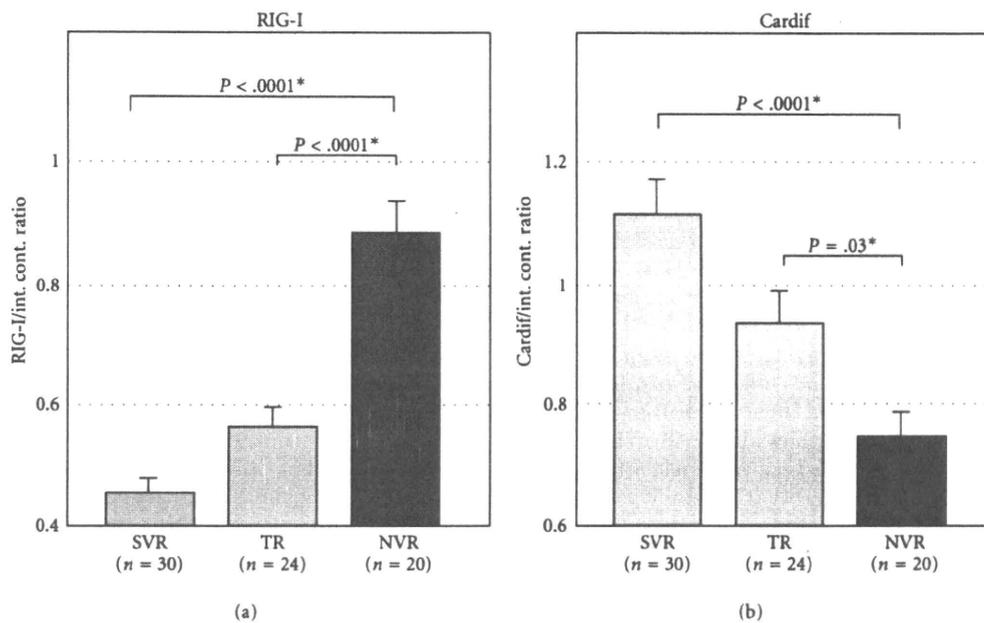
FIGURE 1: Expression of genes correlated to the intrahepatic innate immunity and virological response to PEG-IFN alpha-2b and RBV combination therapy. Open column indicates SVR ($n = 30$), gray column indicates TR ($n = 24$), and closed column indicates NVR ($n = 20$). Error bars indicate the standard error. The P values were analyzed by the Kruskal-Wallis test. Expression of Rig-I was significantly higher in NVR than in SVR patients, and Cardif expression was higher in SVR than in NVR. The figure was cited from [8].

response. Asahina et al. reported that liver biopsies were performed before the PEG-IFN and RBV combination therapy to examine the correlation between the gene expression involved in innate immunity and the therapeutic effects, and in the patients in whom RIG-I expression is high and the expression of Cardif, an adaptor gene, is low, it was found that there are many nonresponders (NVRs) in which HCVRNA does not become negative during the course of treatment [13]. It was therefore revealed that there are many NVRs among the patients in whom the ratio of RIG-I to Cardif in liver tissue is high and that this ratio is low in the SVR patients. Based on these findings, it has become clear that innate immunity is correlated to therapeutic effects (Figure 1).

Furthermore, it was recently discovered that a single nucleotide polymorphism (SNP) of the host gene IL28B is significantly involved in the therapeutic response to the PEG-IFN and RBV combination therapy [14, 15]. The possibility of becoming an NVR is high in cases of the minor allele carriers of IL28B. However, it is not possible to routinely measure an SNP of IL28B in the clinical setting. In this paper, factors which can actually be used in real clinical practice are discussed for the prediction of the efficacy of PEG-IFN and RBV combination therapy.

2. Amount of HCVRNA

In the patients with chronic hepatitis C, it is not possible to directly measure the amount of virus, and the amount of HCVRNA is measured instead. Currently, a real-time PCR method which has an advantage of wide range and high sensitivity is utilized, and measurements can be taken from a single blood sample of a very small amount, that is, 1.2 log copies/ml, to a very large amount, that is, 8 log copies/ml. This method has a higher level of sensitivity than the conventional Amplicor monitor test and can therefore detect HCVRNA even if only a very small amount exists in the plasma. If the amount of HCVRNA in plasma is less than the range of sensitivity of the real-time PCR method, it is recorded as undetectable level. If the indication is "less than 1.2 log copies/ml of HCVRNA", it means that a very small amount of HCVRNA exists in the plasma. Since the indication of the real-time PCR method is based on log counts, a decrease of 1.0 in the numerical value means that the amount of HCVRNA has decreased to 1/10. With the application of this real-time PCR method, it has become possible to measure amounts of HCVRNA up to 8 log copies/ml, and it has also become possible to predict the efficacy before treatment and to monitor appropriately the reactivity during the course of treatment. However, in the patients in whom a PEG-IFN and RBV combination therapy is performed, SVR can be acquired even when the amount of virus prior to the treatment is quite large. It is therefore difficult to predict the virological response solely from the amount of HCVRNA before starting the treatment. Once treatment has commenced, at what week HCVRNA becomes negative is important for the prediction of therapeutic effects, and this serves as a parameter for deciding the duration of treatment [16].
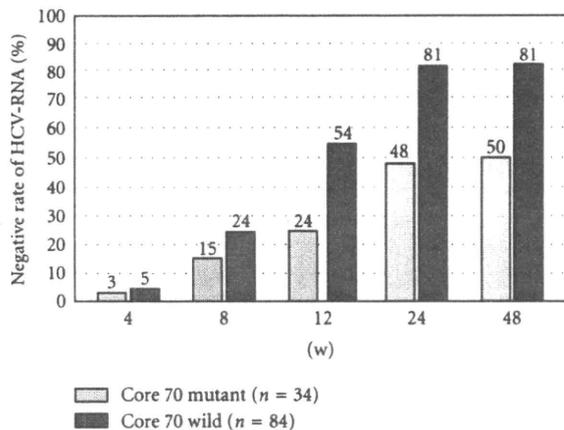
FIGURE 2: Comparison of aa70 mutations in the HCV core region and the rate of HCVRNA becoming negative during the course of treatment. Compared with the wild type, among the patients of aa70 mutations, there were fewer patients in whom HCVRNA had become negative during the course of treatment.
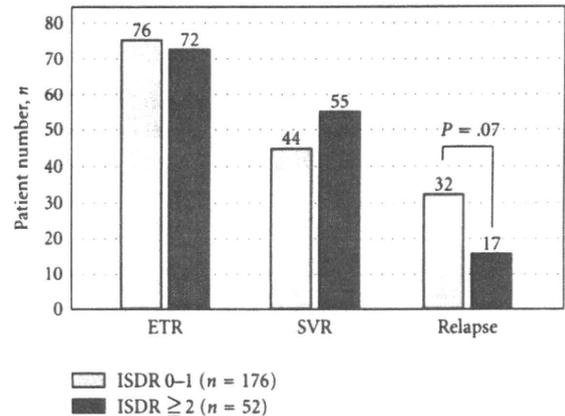

FIGURE 3: Number of ISDR substitutions and the comparison of virological response, SVR, and relapse at the end of the treatment. Compared with the patients with 2 or more sites of substitutions, the rate of SVR was lower and the rate of relapse was higher in the patients in whom there were fewer substitutions in ISDR, that is, 0 or 1 sites.

Measuring the rate of viral clearance from serum is helpful for predicting the likelihood of a response to PGEIFN and RBV and useful for determining the optimal duration of therapy if the patients start to receive the treatment [17]. In the AASLD practice guideline, response-guided therapy is highly recommended [18]. In two nationwide registration trials conducted in Japan [9, 10], the SVR rate was high, from 76% to 100%, in patients whose HCVRNA was cleared rapidly from serum by week 4 (rapid virological response; RVR), and 71% to 73% in patients who achieved undetectable HCVRNA from week 5 to week 12 (early virological response; EVR). In contrast, the SVR rate in patients with late clearance of HCVRNA from week 13 to week 24 was low at 29% to 36%. No patients without clearance of HCVRNA by week 24 achieved SVR.

The strategy of extending therapy in patients with delayed virological responses, defined as clearance of HCV-RNA between weeks 12 and 24, was evaluated in five studies [19–23]. These results cannot be compared directly with each other because of the heterogeneous study populations, differences in the baseline characteristics, and the different regimens utilized amongst them. Nevertheless, the results showed a trend toward a higher SVR rate by extending therapy from 48 to 72 weeks in patients with delayed virological response.

3. Viral Mutations in Core and NS5A Region

In the patients with genotype 1b HCV infection, the mutations in aa70 and aa91 in the core region have been shown to correlate with early virological response (EVR) during PEG-IFN and RBV combination treatment [11]. If aa70 in the core region is mutated to anything other than arginine and aa91 to anything other than leucine, it is difficult to achieve EVR, and it is thus highly possible that such cases

will become nonresponders. The examination results at our institution including 292 patients with genotype 1b infection demonstrated that, in the cases with mutations in aa70 in the core region, the rate of HCVRNA becoming negative during the course of combination treatment was low compared to the wild type of aa70 (Figure 2). However, core aa70 mutation is shown to have quasispecies detectable by cloning, and 70Q clone was positively selected during combination treatment with PEGIFN and RBV [24].

Furthermore, Enomoto et al. reported that the patients with 4 or more amino acid mutations were observed in interferon sensitivity-determining region (ISDR) within NS5A region [2]; SVR rate is higher than 90% by IFN monotherapy, and SVR is less than 10% in the patients with no mutation in ISDR. It has also been reported that, in PEG-IFN and RBV combination therapy, the number of ISDR mutations is involved in the SVR [12].

We analyzed the relationship between virological response and ISDR mutations in the patients with genotype 1b infection treated by PEG-IFN alpha-2b and BRV combination therapy. In the patients with 0 or 1 ISDR mutation, even if the rate of HCVRNA becoming negative at the end of treatment was the same, the rate of SVR would be lower compared with the patients having 2 or more mutations (Figure 3). This demonstrates that there is a higher incidence of relapse after the end of treatment in the patients with 0 or 1 ISDR mutation.

Enomoto and Maekawa reported that mutations both in NS5A-ISDR (interferon sensitivity-determining region) and core 70Q substitution are associated with no early viral response during PEGIFN and RBV combination therapy [25]. Association of core aa70 substitution and mutations in NS5A region is confirmed to be associated with viral response by PEGIFN and RBV combination therapy in a Japanese multicenter cooperative study [26]. The number of

mutations in the interferon sensitivity-determining region was shown to be associated with the viral response to PEGIFN and RBV combination treatment not only in Japan [27], but also in Tunisia [28].

Recently, a consensus has been established that mutations in aa70 in the core region are important for the prediction of HCVRNA becoming negative during the early course of treatment, and the number of ISDR mutations is important for the prediction of relapse after the end of treatment.

4. Adherence

It has been confirmed that it is important to ensure 80% or more of the scheduled dose of both PEG-IFN and BBV in order to improve the rate of SVR, and together with the duration of treatment, the 80 · 80 · 80 has been established. However, Schiffman et al. recently reported that the dose of PEG-IFN in the initial stage of administration is important and that, if a sufficient dose of PEG-IFN is administered, then 60% or more of the RVB dose would be enough [29]. It is therefore of primary importance to ensure the dose of PEG-IFN.

In Japan, the average age of patients with chronic hepatitis C is increasing, and achieving good adherence is difficult in many patients. Consequently, the rate of SVR is low in elderly patients. How to improve the rate of SVR in elderly patients is an important issue. With regard to the dose of RBV, reducing the RBV dose based on the calculation of the total body clearance (CL/F) has been proposed to be useful for decreasing the discontinuation and improving the rate of SVR. Although there is no consensus on an appropriate dose of PEG-IFN in elderly patients, if the initial dose is set lower than the usual dose, discontinuation would be reduced. Thus, it is necessary to investigate whether such an initial dose would improve the rate of SVR.

Recently, the risk of hemolytic anemia was clearly demonstrated to correlate with ITAP gene SNP [30]. The predictive implication should be analyzed prospectively in clinical practice.

5. Host Factors

Zeuzem et al. described the factors related to the less response to interferon-based therapy, and he showed that several host factors such as older age, race, and obesity are responsible factors for the poor response to IFN [31]. Recently, insulin resistance which was examined by homeostasis model assessment index (HOMA-IR) was shown to be associated with a lower rate of SVR, and body mass index (BMI) was not identified as a significant factor for the poor response to PEGIFN and ribavirin combination therapy [32]. Insulin resistance was confirmed as a related factor to the nonresponse to interferon-based treatment [33]. However, Charlton et al. reported that obesity itself is an associated factor for decreased efficacy of interferon-based therapies, and they discussed the possible mechanism [34], and obesity was shown to be associated with the increased enhancement

of suppressor of cytokine signaling (SOCS) family in the hepatocytes [35].

6. Data Mining Analysis

Both virus- and host-related factors are correlated to therapeutic effects of PEG-IFN and RBV. One important question is which of these factors should be focused on in order to predict the therapeutic effects in an individual patient. In addition, in each individual patient, the host and virological factors are different. It is therefore difficult to predict the virological response in each case before treatment. Furthermore, although it is important to predict the relapse rate when HCVRNA becomes within an undetectable level in an individual patient, prediction of the rate of SVR including virological and host factors and adherence to the treatment has never been carried out in an individual patient.

A data mining analysis is the process of analyzing a large amount of data by a computer in order to develop an algorithm. Conventional statics have been used to examine certain hypothesis. Data mining is superior in that it can set an algorithm, using a computer, based on a large amount of data without a hypothesis.

We therefore conducted at our institute a data mining analysis of the patients with genotype 1b infection having high levels of HCVRNA to whom a PEG-IFN alpha-2b and RBV combination therapy was administered to investigate whether by the 12th week after the commencement of treatment HCVRNA became negative (EVR) (Figure 4) [36]. The most important factor for the prediction of EVR was the steatosis of the liver: when steatosis was observed in 30% or more of hepatocytes, EVR was found to be difficult to achieve. In the patients in whom steatosis was not severe, the second most important factor was the serum LDL cholesterol value. While the rate of EVR was 57% in the patients in whom this value was 100 mg/ml or above, the rate of EVR was 32% in the patients in whom the LDL cholesterol was less than 100 mg/dl.

The higher the LDL cholesterol value, the earlier the HCVRNA became negative. Among the patients with low LDL cholesterol values, while the rate of EVR was 15% in patients 60 years of age or older, the rate was high in the patients under the age of 60 years old, that is, 49%. Among patients under the age of 60, the rate of EVR was low, that is, 31%, in patients with a blood glucose level of 120 mg/dl or above whereas EVR was achieved in 71% of the patients with a blood glucose level of less than 120 mg/dl (Figure 4).

On the other hand, in the patients with high LDL cholesterol values, the next most important factor was age. While the rate of EVR was 50% in patients 50 years of age or older, EVR was achieved in 77% of the patients under the age of 50. Among patients of 50 years of age or older, the next most important factor was the gamma GTP value. While the rate of EVR was 35% in the patients in whom gamma GTP was 40 IU/L or above, EVR was achieved in 60% of the patients where the value was less than 40 IU/L.
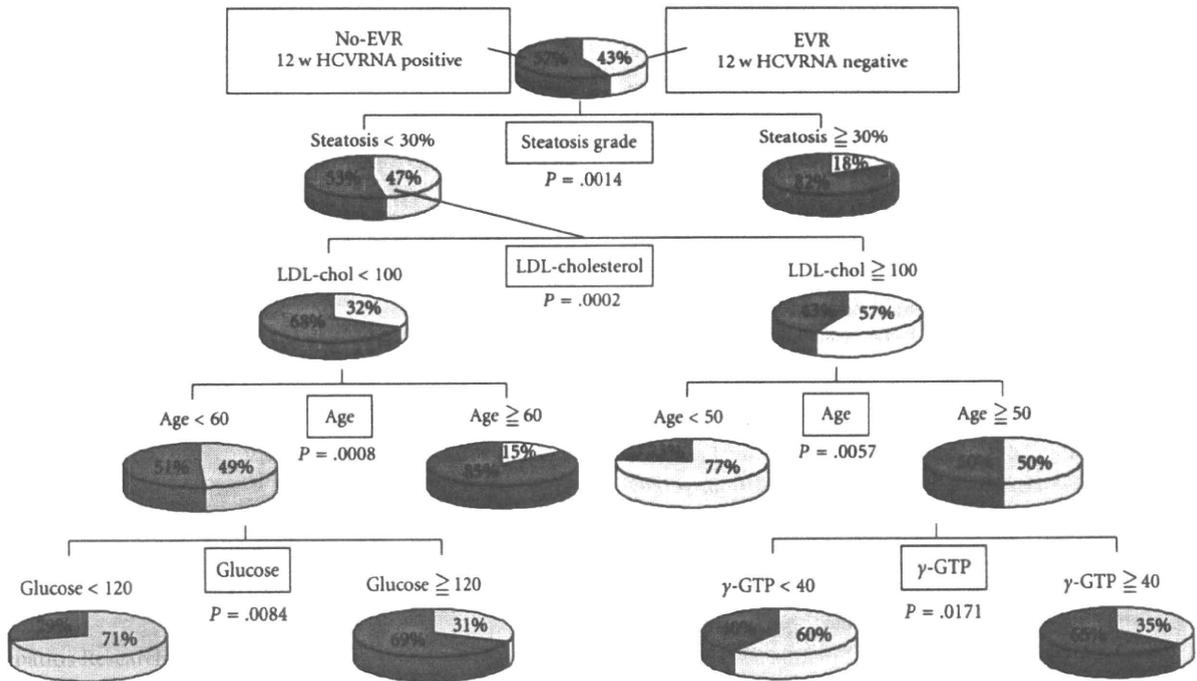
FIGURE 4: HCVRNA negative (EVR) algorithm at 12th week from data mining analysis of PEG-IFN alpha-2b plus RBV combination in the genotype 1b and high levels of HCVRNA. Both virological and host factors were evaluated by data mining analysis software from SPSS. This figure was cited from [36].

FIGURE 5: The rate of EVR in the patients with genotype 1b and high levels of HCVRNA, based on fatty deposition in the liver (a), and the LDL cholesterol value (b), respectively. EVR was highly achieved in the patients with less steatosis in the liver, and in those with high serum LDL-cholesterol levels. This is univariate analysis, and cited from [36].

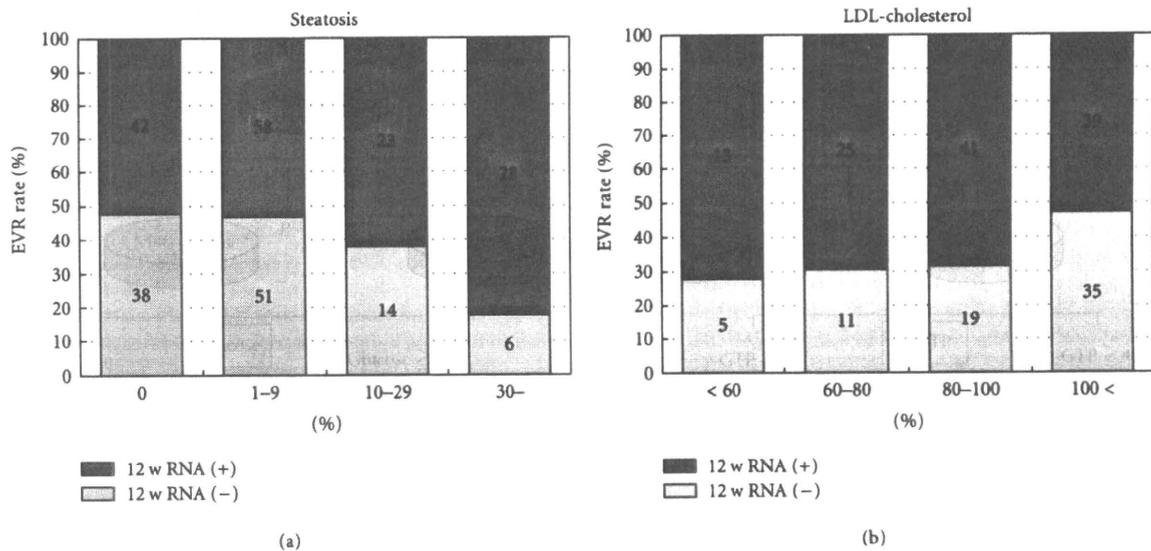We therefore compared these factors based on the original data. A univariate comparison of the fatty infiltration of the liver and the rate of EVR demonstrated that the rate of EVR was higher when the steatosis of the liver was less severe (Figure 5(a)). In addition, a comparison of the LDL cholesterol value and the rate of EVR demonstrated a significant correlation, confirming that the higher the LDL cholesterol value, the higher the rate of EVR (Figure 5(b)). Therefore, it was also proposed by the results of univariate analysis of each factor extracted from the data mining analysis that these factors were correlated to the rate of EVR.

From these observations, it is likely to improve the viral response to PEGIFN and ribavirin by reducing steatosis of the liver through daily walking or abstinating alcohol intake or by refraining from high-fat diet.

By utilizing data mining, it is therefore possible to assess virus- and host-related factors together and to predict the virological response in each patient, and thereby clinically useful information can be obtained. The algorithm should be validated including a large number of the patients.

Acknowledgment

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Special Report

Management of hepatitis C; Report of the Consensus Meeting at the 45th Annual Meeting of the Japan Society of Hepatology (2009)

Izumi Namiki,[1] Shuhei Nishiguchi,[2] Keisuke Hino,[3] Fumitaka Suzuki,[4] Hiromitsu Kumada,[4] Yoshihito Itoh,[5] Yusuhiro Asahina,[1] Akihiro Tamori,[6] Naoki Hiramatsu,[7] Norio Hayashi[7] and Masatoshi Kudo[8]

[1]Department of Gastroenterology and Hepatology, Musashino Red Cross Hospital, Musashinoshi, Tokyo, [2]Department of Hepatobiliary and Pancreas Disease, Hyogo Medical University, Nishinomiya, [3]Department of Hepatobiliary and Pancreas Disease, Kawasaki Medical University, Kurashiki, [4]Department of Hepatology, Toranomon Hospital, Tokyo, [5]Molecular Gstroenterology and Hepatology, Kyoto Prefectural University of Medicine, Kyoto, and [6]Department of Hepatology, Osaka City University Graduate School of Medicine, Report of Consensus Meeting in the 45th Annual Meeting of the Japan Society of Hepatology (2009), [7]Department of Gastroenterology, Osaka University and [8]Department of Gastroenterology, Kinki University, Osaka, Japan

The consensus meeting for the diagnosis, management and treatment for hepatitis C was held in 45th annual meeting for the Japan Society of Hepatology (JSH) in June 2009 where the recommendations and informative statements were discussed including organizers and presenters. The Several important informative statements and recommendations have been shown. This was the fourth JSH consensus meeting of hepatitis C, however, the recommendations have not been published in English previously. Thus, this is the first report of JSH consensus of hepatitis C. The rate of development of hepatocellular carcinoma (HCC) in HCV-infected patients in Japan is higher than in the USA, because the average age of the HCV-infected patients is greater and there are more patients with severe fibrosis of the liver than in the USA. In Japan, more than 60% of HCV-infected patients are genotype 1b infection, and they show lower response to perinterferon and ribavirin combination treatment. To improve the response rate is also an important issue in our country. To establish the original recommendations and informative statements to prevent the development of HCC is a very important issue in Japan.

Key words: chronic hepatitis C, peginterferon, ribavirin, fibrosis of the liver, hepatocellular carcinoma, HCV mutation

INTRODUCTION

HEPATITIS C VIRUS (HCV) infection is a major public health problem and a leading course of death from liver disease in Japan. Two million people are infected, and more than 30 000 patients die from hepatocellular carcinoma (HCC) and/or liver cirrhosis every year. HCC is the fourth leading cause of death from malignant neoplastic disease, and prevention of the development of HCC is an urgent issue in Japan. The purpose of this consensus is to provide clinicians with consensus-based approaches to diagnosis and treatment of HCV infection.

The consensus meeting for the diagnosis, management and treatment for hepatitis C was held during the 45th annual meeting of the Japan Society of Hepatology (JSH) in June 2009 (Congress President: M. Kudo), where the recommendations and informative statements were discussed and compared with AASLD practice guidelines which has been published in Hepatology.[1] This was the fourth JSH consensus meeting of hepatitis C, however, the recommendations have not been published in English previously. This is the first report of the JSH consensus of hepatitis C. Established information regarding the pathogenesis and contributing factors for disease

are recognized by the retinoic-inducible gene I (*RIG-I*) and specific Toll-like receptors when introduced into naïve cells.[9–11] Viral signaling through *RIG-I* and its adaptor protein, IFN promoter-stimulator 1 (IPS-1), activates IFN regulatory factor-3 (IRF-3) and the host IFN-α/β response that limits virus infection.[12,13] HCV NS3/4A protease cleaves IPS-1, releasing IPS-1 from the mitochondrial membrane.[14] Cleavage results in subcellular redistribution of IPS-1 and loss of interaction with *RIG-I*, thereby preventing downstream activation of IRF-3 and induction of IFNβ.[15]

Secreted IFNβ engages the local tissue through the autocrine and paracrine processes of binding the IFN-α/β receptors. This results in activation of the Jak-signal transducer and activator of transcription (STAT) pathway, in which the receptor-associated Jak and Tyk1 protein kinases catalyze the phosphorylation of STAT proteins. The resulting IFN-stimulated gene factor-3 (ISGF3) transcription factor complex localizes in the cell nucleus, where it binds to the IFN-stimulated response element (ISRE) within the promoter/enhancer region of IFN-stimulated genes (ISG). Jak-STAT signaling leads to a second wave of transcriptional activity stimulating ISG expression in the infected cells. Expression of the HCV core protein has been associated with increased expression levels of suppressor of cytokine signaling (SOCS)-3.[16] The SOCS proteins are known for their role as negative regulators and inhibitors of Jak-STAT signaling, where they mediate a classic negative feedback loop on IFN-α/β receptor signaling events.[17] The HCV NS5A protein has been shown to induce interleukin (IL)-8 production leading to partial inhibition of the IFN-induced antiviral response, probably through the alteration of ISG expression.[18] The HCV NS5A and E2 proteins also bind double-strand RNA-activated protein kinase (PKR) and inhibit its catalytic activity,[19,20] which allows HCV to evade in part the translational-suppressive actions of IFN. Thus, HCV evasion of the host response includes various strategies directed by viral proteins to control IFN signaling, ISG expression or function.

Informative statement: HCV evades intracellular host defenses through a complex combination of processes that include IFN signaling, modulation of its effectors and continual viral genetic variation. These mechanisms include cleavage of IPS-1 by the NS3/4A protease, inhibition of Jak-STAT signaling by HCV-induced SOCS3, inhibition of the IFN-induced antiviral response by NS5A-induced IL-8, and/or inhibition of catalytic activity of PKR by the NS5A and E2 proteins. (Grade A.)

Oxidative stress induced by HCV

Oxidative stress is well known to be present in CH-C to a greater degree than in other inflammatory liver diseases. Although the mechanisms underlying oxidative stress induced by HCV have not been elucidated fully, there are several lines of evidence suggesting that HCV directly generates reactive oxygen species (ROS) *in vitro* and *in vivo*. Hepatic ROS production is significantly higher in HCV core transgenic mice than in normal control mice in the absence of hepatic inflammation.[21] HCV core protein also produces ROS in human hepatoma Huh-7 cells and HeLa cells.[22] Analysis of the interaction of HCV core protein with mitochondria in transgenic mice and direct interaction of recombinant core protein and isolated mitochondria indicated oxidation of the mitochondrial glutathione pool and an increase in ROS production by the mitochondrial electron transport complex I, suggesting that direct interaction of core protein with mitochondria is an important cause of the oxidative stress seen in CH-C.[23]

Informative statement: Mitochondrial dysfunction induced by HCV leads to ROS generation that causes the oxidative stress seen in CH-C. (Grade A.)

Metabolic disorders caused by HCV

Epidemiological studies have suggested a link between type 2 diabetes and chronic HCV infection, which implies HCV-induced insulin resistance. A high level of tumor necrosis factor (TNF)-α and disturbance of tyrosine phosphorylation of the insulin receptor substrate (IRS)1 by TNF-α has been demonstrated in HCV core transgenic mice.[24] Another possible mechanism is that HCV core-induced SOCS3 promotes proteosomal degradation of IRS1 and IRS2 through ubiquitination.[25] Hepatic steatosis is one of the histopathological features in CH-C. HCV core protein inhibits microsomal triglyceride transfer protein activity and secretion of very low density lipoprotein.[26] HCV core protein also upregulates the sterol regulatory element binding protein (SREBP)1c promoter activity through the enhanced binding of the LXRα/RXRα to LXR-response element,[27] which leads to an increase in transcription of genes involved in hepatic fatty acid synthesis. Hepatic iron accumulation is also a histopathological feature of CH-C, even though its levels are not extremely high. HCV-induced ROS downregulates the transcriptional activity of hepcidin, a negative regulator in iron homeostasis, in transgenic mice expressing the HCV polyprotein[28] and in HCV replicon cells[29] (Fig. 1).

Table 2 Definitions of virological responses to interferon therapy

RVR (rapid virological response)	Undetectable HCV RNA at week 4
cEVR (complete early virological response)	Undetectable HCV RNA at week 12
pEVR (partial early virological response)	Two log drop of HCV RNA without undetectable level at week 12
LVR (late virological response)	Undetectable HCV RNA between week 13 and 24 week
NVR (null virological response)	Positive HCV RNA during treatment
Relapse	Undetectable HCV RNA at end of treatment followed by detectable level after treatment
SVR (sustained virological response)	Undetectable HCV RNA at 24 weeks after treatment

improved the ability to define the extent of fibrosis without a liver biopsy, particularly when combined with other non-invasive markers,[37] but it is not yet ready to replace liver biopsy. Among the pathological features, steatosis and excess hepatocellular iron that affect disease progression and possibly impede treatment response are difficult to diagnose without liver biopsy. Thus, a liver biopsy should be considered if it is desirable to determine the stage of fibrosis or presence of steatosis or excess hepatocellular iron for prognostic purposes or making a decision regarding treatment.

Recommendation 2: A liver biopsy should be considered if it is desirable to determine the stage of fibrosis or presence of steatosis or excess hepatocellular iron for prognostic purposes or making a decision regarding treatment. (Level 1, Grade C.)

VIRAL LOAD, GENOTYPE, VIRAL MUTATIONS

DEFINITIONS OF VIROLOGICAL responses to IFN therapy are summarized in Table 2.

HCV RNA assay and genotype

In clinical practice, the usual approach is to test initially for antibodies to HCV (anti-HCV), then to use HCV RNA to document viremia. The quantity of HCV RNA is useful to know before providing and monitor-

ing HCV treatment. For HCV RNA determination, quantitative tests based on target amplification (reverse transcriptase polymerase chain reaction [RT–PCR]) and signal amplification (branched DNA [bDNA]) techniques with differing sensitivity and linear measuring ranges are commercially available. The COBAS Amplicor HCV Monitor Test v2.0 (Roche Molecular Systems, Branchburg, NJ, USA), however, requires sample dilutions for accurate quantification of high-titer specimens. In addition, the assay displays relatively low sensitivities of approximately 600 IU/mL. Recently, the COBAS AmpliPrep/COBAS TaqMan HCV test (Roche Molecular Systems) and AccuGene m-HCV (Abbott Molecular, Des Plaines, IL, USA) have become available. These meet the requirements for highly sensitive detection and reliable quantification of HCV in clinical samples.

There are six major HCV genotypes. Genotype specificity predicts the likelihood of treatment response and determines the duration of treatment. Therefore, HCV genotype should be determined in all HCV-infected persons prior to treatment in order to determine the duration of therapy and likelihood of response.[38]

Many reports showed that sustained virological response (SVR) rates in IFN monotherapy and IFN plus ribavirin (RBV) combination therapy were higher in patients who had lower pretreatment RNA levels and genotype 2 infections.[39–41]

Recommendation 3: HCV RNA level and genotype should be determined in all HCV-infected persons prior to treatment in order to predict the efficacy of response of therapy. SVR rate in IFN therapy are higher in patients who had lower pretreatment RNA levels and genotype 2 HCV infections in IFN therapy. (Level 1, Grade A.)

HCV mutation

IFN sensitivity determining region (ISDR)

Enomoto *et al.* were able to demonstrate a strong correlation between the number of mutations within the carboxy terminal region of the NS5A gene, the ISDR spanning codons 2209–2248, and response to IFN therapy.[42] Thus, no patient infected with HCV with a wild-type ISDR sequence (identical to the prototype Japanese HCV strain [HCV-J]) responded to IFN therapy whereas all patients infected with the "mutant type", defined by four or more amino acid substitutions in this region, showed an SVR.[43] These initial findings have been confirmed by other Japanese studies but controversial data were reported from other parts of the world, particularly from Europe and the

USA. This may indicate that geographical factors account for different sensitivities of HCV genotype 1b infection to antiviral therapy. Pascu *et al.* reported that the distribution of wild-, intermediate- and mutant-type ISDR sequences differed significantly between Japanese ($n = 655$) (44.1%, 37.6% and 18.3%, respectively) and European patients ($n = 525$) (24.8%, 63.4% and 11.8%, respectively; $P = 0.001$). However, there was a significant positive correlation between the number of ISDR mutations and SVR rate, irrespective of geographical region.[44]

Moreover, Shirakawa *et al.* reported that a logistic regression model that includes the sequence of ISDR of HCV, and other factors (T-helper cell [Th]1/Th2 ratio, bodyweight and neutrophil count) can be useful for accurately predicting accurately the SVR rate before pegylated (PEG)-IFN and RBV combination therapy.[45]

Recommendation 4: The ISDR should be evaluated before IFN treatment in order to predict the response to treatment. (Level 2b, Grade B.)

IFN/RBV resistance-determining region (IRRDR)

El-Shamy *et al.* have reported recently that a high degree of sequence variation in the V3 and the pre-V3 regions (amino acid [aa]2334–2355) of NS5A, which they refer to collectively as the IRRDR (aa2334–2379), was closely correlated with virological response in HCV-1b-infected patients treated with PEG-IFN and RBV.[46] A high degree (>6 aa substitutions) of sequence variation in the IRRDR

should be a useful marker for predicting SVR, whereas a less diverse (<5) IRRDR sequence predicts non-SVR.

Amino acid substitutions in the HCV core region

Akuta *et al.* identified pretreatment substitutions of aa70 and aa91 in the core region as independent and significant pretreatment factors associated with virological non-response, based on 48-week combination therapy of IFN plus RBV.[47] Moreover, they identified aa70 and aa91 substitutions in the core region as predictors of response to PEG-IFN-RBV therapy in Japanese patients infected with HCV genotype 1b[48] (Table 3). Donlin *et al.* reported sequencing the complete pretreatment genotype 1 HCV open reading frame using samples from 94 participants in the Virahep-C study to assess the effects of viral diversity on response to therapy.[49] Genotype 1b sequences from patients with more than 3.5 log declines in viral RNA levels by day 28 (marked responders) were more variable than those from patients with declines of less than 1.4 log (poor responders) in core and NS3. Moreover, arginine (R) at aa70 in the core region was related to a marked response.

Recently evaluations were made of the impact of aa substitutions in HCV core region on hepatocarcinogenesis. Akuta *et al.* reported that cumulative hepatocarcinogenesis rates in double wild-type (arginine at aa70/leucine at aa91) of the HCV core region were significantly lower than those in the non-double wild type in CH-C patients.[50] Moreover, another report showed that a logistic regression model developed

Table 3 Factors associated with sustained virological response to 48-week pegylated interferon plus ribavirin combination therapy in patients infected with hepatitis C virus genotype 1b, identified by multivariate analysis ($n = 114$) 52)

Factor	Category	Risk ratio (95% confidence interval)	P
Amino acid substitution in core region	1: double wild	1	
	2: non-double wild	0.102 (0.022–0.474)	0.004
Low-density lipoprotein cholesterol (mg/dL)	1: <86	1	
	2: ≥86	12.87 (2.177–76.09)	0.005
Sex	1: male	1	
	2: female	0.091 (0.017–0.486)	0.005
ICG R15 (%)	1: <10	1	
	2: ≥10	0.107 (0.017–0.678)	0.018
γ-Glutamyltransferase	1: <109	1	
	2: ≥109	0.096 (0.0011–0.819)	0.032
Ribavirin dose (mg/kg)	1: <11.0	1	
	2: ≥11.0	5.173 (1.152–23.22)	0.032

through analysis of full-length core gene sequences identified seven polymorphisms significantly associated with increased HCC risk (36G/C [aaK12N], 209A [aaR70Q], 271U/C [aaL91M], 309A/C, 435A/C, 481A and 546A/C).[51] HCV core gene sequence data might provide useful information about HCC risk.

> *Recommendation 5: Amino acid substitutions in the HCV core region (aa70 and aa91) should be determined before IFN treatment in order to predict the response to treatment. (Level 2b, Grade B.)*

NS3 protein secondary structure

Recently, Ogata *et al.* reported that HCV-1b strains can be classified into different groups based on the secondary structure of an amino-terminal portion of the NS3 protein and that specific strains are more prevalent among patients with HCC.[52] Moreover, the cumulative incidence of HCC was highest among patients infected with specific group HCV-1b, in whom the risk of HCC significantly increased compared with that among patients infected with another group (hazard ratio = 4.95 [95% confidence interval = 1.43–17.11]) after adjustment for age and histological stage.[53]

> *Informative statement: NS3 protein secondary structure may be related to hepatocarcinogenesis. (Grade B.)*

NATURAL HISTORY OF CH-C

Progression to cirrhosis and HCC

PREVIOUS PUBLICATIONS REPORTED that approximately 60–80% of patients with acute hepatitis C develop chronic infection in the natural course.[54–57] Because it is difficult to ascertain precisely when the HCV infection occurred except for patients who had blood transfusions, and because chronic infection progresses slowly and asymptomatically, the natural entity of the disease has not been elucidated fully. Seeff *et al.* compared the long-term prognosis of HCV antibody-positive and -negative young men and reported that liver disease-related death was very rare in HCV antibody-positive patients.[58,59] Kenny-Walsh studied the liver histology of 363 young women 17 years after HCV infection and showed that 83% had no or mild hepatic fibrosis whilst 2% had liver cirrhosis.[60] These results demonstrate that progression to serious liver disease is a rare event two decades after infection of young people with HCV.

On the other hand, in blood transfusion-associated CH-C patients the mean interval to liver cirrhosis is estimated to be approximately 20–30 years and that to HCC approximately 30–40 years.[61,62] Because HCC is the most serious complication of HCV-infected people, it is desirable to predict the overall incidence of HCC in each patient. Up to now, many investigators have reported a close relationship between the stage of hepatic fibrosis and incidence of HCC. According to reports from Japan, the annual incidence of new HCC in liver cirrhosis is estimated to be approximately 5–8%.[63–65]

> *Informative statement: The natural history of CH-C is highly variable. HCV infection does not have much impact on the overall mortality of all the infected people, whereas progression to liver cirrhosis is observed 20–30 years and to HCC 30–40 years after infection. In Japan, the annual incidence of HCC in liver cirrhosis is estimated to be 5–8%. (Level 2b, Grade B.)*
> *Recommendation 6: Treatment of HCV-infected people should be determined in consideration of the higher annual incidence of HCC in patients with liver cirrhosis in Japan as compared to Western countries. (Level 2b/3, Grade B.)*

Progression of fibrosis

The rate of progression of fibrosis varies among patients with CH-C. Poynard *et al.*[66] calculated the average progression rate of hepatic fibrosis in CH-C to be 0.133 fibrosis units/year. In Japan, Shiratori *et al.*[67] reported this to be 0.10 fibrosis units/year. In HCV carriers with persistently normal aminotransferase levels (PNALT), progression of hepatic fibrosis is slower. Persico *et al.*[68] reported that median histological scores did not differ after 5 years of follow up in PNALT and Okanoue *et al.*[69] calculated the average progression rate of hepatic fibrosis in PNALT to be 0.05 fibrosis units/year.

> *Informative statement: On average, progression of hepatic fibrosis in CH-C is 0.10–0.13 fibrosis score units/year. The hepatic stage/grade score of HCV carriers with PNALT are generally low and the progression of hepatic fibrosis is slow. Excessive alcohol intake, insulin resistance and hepatic steatosis are the major factors which induce the progression of hepatic fibrosis. (Level 2b, Grade B.)*

Alanine aminotransferase (ALT) levels

Alanine aminotransferase is an easy tool to evaluate hepatocellular damage in liver diseases. In the past, a higher incidence of HCC was reported in liver cirrhotic patients with elevated ALT levels.[70] The normal range of serum ALT level varies according to the institutions or hospitals, but it is likely to be located between 30 IU/L

and 40 IU/L. Recently, Kumada *et al.*[71,72] demonstrated that the cumulative incidence of hepatocarcinogenesis increased in parallel with the increase in ALT average integration value in CH-C even in patients with normal ALT levels. In a community-based study, an elevated ALT level (>35 IU/l) was shown to be a significant risk factor of HCC development.[73]

Recommendation 7: To prevent the occurrence of HCC, levels of serum ALT should be controlled at below 30 IU/l. (Level 3, Grade A.)

IFN administration

More than two decades have passed since IFN began to be used to treat CH-C patients. Nowadays, more than 70% of HCV-infected people can be cured by the combination therapy of PEG-IFN plus RBV. However, even in patients who were cured of HCV infection and attained an SVR, the occurrence of HCC may be reported long after completion of IFN therapy. The risk factor of HCC occurrence after IFN therapy is a combination of advanced hepatic fibrosis score before therapy, older age and male sex.[74-76] Bruno *et al.*[75] reported that annual incidence of HCC occurrence in liver cirrhosis after attaining SVR was 0.66%, which was one-third of the incidence of HCC in liver cirrhosis without a virological response (non-SVR).

Recommendation 8: Surveillance is required for the occurrence of HCC in patients with CH-C and liver cirrhosis. Even if IFN-based therapy is successful in attaining SVR, screening for the detection of HCC by computed tomography (CT), magnetic resonance imaging or ultrasonography and measurement of the serum tumor markers should be carried out routinely, especially for patients with advanced hepatic fibrosis, older age and male sex, because they are at high risk for the occurrence of HCC. (Level 2b, Grade A.)

Indication of IFN therapy for CH-C

Interferon-based therapy is used to treat chronic HCV-infected patients worldwide and PEG-IFN plus RBV is the first choice indication for CH-C patients. Because IFN and RBV have a variety of adverse effects including depression and thyroid dysfunction, "who and how" to treat should be determined with caution. The AALSD practice guideline advocates that treatment decision should be individualized based on the severity of liver disease, the potential for serious side-effects, the likelihood of treatment response, the presence of comorbid condition and the patient's readiness for treatment.[1]

Recommendation 9: Treatment decision of IFN therapy for CH-C should be individualized based on the body/

mental condition, probability of successful therapy and prolonged survival, and likelihood of provoking serious adverse effects. Scores of hepatic stage/grade should be considered as well. For aged patients, in whom HCV infection is regarded as the major determinant of survival, IFN-based therapy should be considered with caution. (Level 3, Grade A.)

PEG-IFN AND RBV COMBINATION THERAPY

Factors associated with virological response to PEG-IFN and RBV combination therapy

TREATMENT WITH PEG-IFN-α-2A or -2b together with RBV has been evaluated in two nationwide phase III registration trials in Japan.[77,78] In one trial, which determined efficacy of PEG-IFNα-2b and RBV,[79] the SVR rate to 48-week combination therapy was 48% (121/254) in patients with HCV genotype 1b and a high viral load (≥100 KIU/mL). Another trial using PEG-IFN-α-2a and RBV demonstrated an SVR rate to 48-week combination therapy of 59% (57/96) in patients with HCV genotype 1b and a high viral load (≥100 KIU/mL).[80] Based on these results, the currently recommended standard therapy for the patients with CH-C in Japan is the combination of a PEG-IFN together with RBV, except for the treatment naïve patients with a low viral load for whom a PEG-IFN monotherapy is recommended.

These clinical trials identified the following factors that are associated with non-SVR in patients with HCV genotype 1b and a high viral load: (i) older patients; (ii) non-responders to previous IFN therapy; (iii) advanced fibrosis; (iv) female sex; and (v) poor adherence below 80%. In marked contrast to the data from Europe and the USA, the SVR rate in Japanese female patients is lower than that in the male patients. Several community-based retrospective studies in Japan also demonstrated that female patients, especially older female patients, are more difficult to treat compared with other patients.[81,82] Other factors associated with virological response reported from Japan include the low-density lipoprotein cholesterol level,[83] α-fetoprotein (AFP) level,[83] whole-body insulin sensitivity index,[84] single nucleotide polymorphisms of MAP-KAPK3,[85] RIG-I/IPS-1 ratio,[86] Th1/Th2 ratio[45] and PKR response.[87] Association between viral mutations and treatment response is discussed in depth above.

Recommendation 10: Predictors associated with a non-SVR to PEG-IFN and RBV include: (i) age older than 60 years, particularly older women; (ii) advanced fibro-
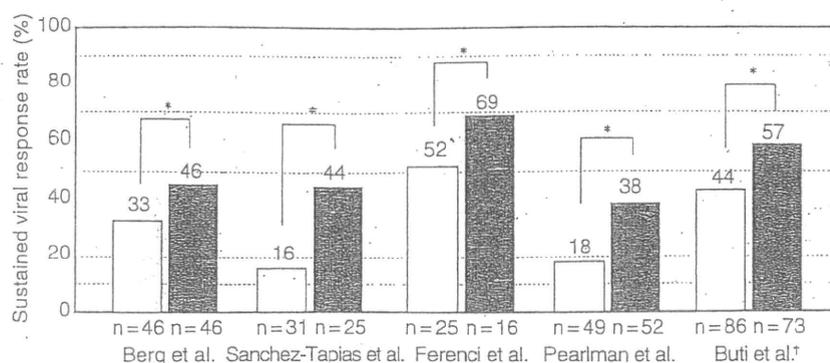
Figure 2 Comparison of sustained virological response rate between 48-week (open column) and 72-week (closed column) treatment with pegylated interferon and ribavirin in patients with partial early virological responder, which is defined as ≥2 log reduction in hepatitis C virus (HCV) RNA level compared to baseline HCV RNA level but detectable HCV RNA at treatment week 12. *Statistical significance between two treatment groups. †Comparison in patients with ≥80% adherence is shown.

sis; (iii) non-responder to previous IFN therapy; and (iv) poor adherence below 80%. (Level 2a, Grade B.)

Response-guided therapy for patients with HCV genotype 1

Measuring the rate of viral clearance from serum is helpful in predicting the likelihood of a response to PEG-IFN and RBV, and useful for determining the optimal duration of therapy. In two nationwide registration trials conducted in Japan,[77,78] the SVR rate was high, from 76–100% in patients whose HCV RNA was cleared rapidly from serum by week 4, and 71–73% in patients who achieved undetectable HCV RNA from week 5 to week 12. In contrast, the SVR rate in patients with late clearance of HCV RNA from week 13 to week 24 was low at 29–36%. No patients without clearance of HCV RNA by week 24 achieved SVR. It should be noted that time point of HCV clearance was determined by measurement of serum HCV RNA utilizing the Ampricor HCV method in these trials.

Recommendation 11: Measuring the time of viral clearance from serum is helpful in predicting the likelihood of a response to PEG-IFN and RBV. Measurement of HCV RNA is recommended at weeks 4, 12 and 24. (Level 1, Grade A.)

As mentioned above, patients whose HCV RNA measured by Amplicor HCV had not cleared by week 24 were unable to achieve SVR with 48-week standard PEG-IFN and RBV therapy. However, in a retrospective study conducted in 52 patients without HCV RNA clearance from serum by week 24, the rate of ALT normalization 6 months after the completion of therapy (so-called biochemical response) was 56% (5/9) and 62% (8/13) of

patients achieved ALT normalization up to 2 years after the completion of therapy (sustained biochemical response).[88] Therefore, the proposal that recommends a continuation of PEG-IFN and RBV therapy for 48 weeks in biochemical responders at week 24 even without HCV clearance has been accepted widely in Japan. This proposal is in marked contrast to the AASLD practice guideline,[1] in which treatment discontinuation is strongly recommended in patients whose HCV RNA remains positive at week 24.

Recommendation 12: It is impossible to achieve SVR in patients without HCV RNA clearance by week 24 measured by Amplicor HCV. (Level 1, Grade A.) However, it is recommended to continue the therapy for 48 weeks even in patients without HCV RNA clearance by week 24 if ALT normalizes at week 24, because a sustained biochemical response can be obtained in these patients. (Level 4, Grade C.)

The strategy of extending therapy in patients with delayed virological responses, defined as clearance of HCV RNA between weeks 12 and 24, was evaluated in five studies.[89-93] These results cannot be compared directly with each other because of the heterogeneous study populations, differences in the baseline characteristics and the different regimens utilized amongst them. Nevertheless, the results showed a trend toward a higher SVR rate by extending therapy from 48 to 72 weeks in patients with delayed virological response (Fig. 2).[89-93]

In Japan, a randomized controlled trial was conducted in 113 patients with HCV genotype 1b and a high viral load, comparing a 48-week treatment group and extended treatment group where patients were treated for an additional 44 weeks after clearance of

HCV RNA from serum. In this trial, the SVR rate was 36% in the 48-week treatment group and 53% in the extended treatment group, and the SVR rate was significantly higher in patients in the extended treatment group who became HCV RNA-negative during the period week 16–24 (9% vs 78%, $P = 0.005$).[94] In addition, in a case–control study matched for age, sex and the timing of HCV RNA clearance from serum, the SVR rate was high at 62% in the 72-week treatment group ($n = 65$) compared to 33% in the 48-week treatment group ($n = 130$), and the extended treatment was particularly effective in patients with HCV core mutations at aa70 and aa91 as well as patients a with wild type of ISDR sequence.[79] Accordingly, 72-week extended treatment is recommended for patients who are slow to clear of HCV RNA between weeks 12 and 24.

Currently, HCV RNA clearance from serum is determined by real-time PCR detection, although most of former studies utilized the Amplicor HCV method for this purpose. Because real-time PCR is highly sensitive, it should be reevaluated in terms of who gains benefit from extended therapy. Currently, there is no sufficient evidence to determine this. Nevertheless, substantial number of community-based Japanese study using real-time PCR detection suggested that SVR could be obtained by 72-week treatment if HCV RNA became undetectable by week 36. Accordingly, when determining the timing of HCV RNA clearance using real-time PCR detection, 72-week treatment could be recommended for patients who achieve HCV RNA clearance between weeks 12 and 36.

> *Recommendation 13: 72-week extended therapy should be considered for patients with HCV genotype 1 who have delayed HCV RNA clearance from serum between weeks 12 and 24. (Level 2a, Grade B.)*
>
> *Recommendation 14: When using a real-time detection PCR method for measurement of HCV RNA, SVR can be obtained by 72-week extended treatment in patients who have achieved HCV RNA clearance by week 36. (Level 2b, Grade C.)*

Response-guided therapy for patients with HCV genotype 2

Six trials have evaluated a shortening of the duration of therapy from 24 weeks to 12–16 weeks for patients with chronic HCV genotype 2 and 3.[80,95–99] Although the data from some of these trials suggest that patients with genotype 2 and 3 infection who achieve viral clearance from serum by week 4 can shorten their treatment duration to 12–16 week,[80,95,99] the benefit of a shortening the duration of therapy remains controversial.[96] In a recent

study by Mangia *et al.*, the factors associated with relapse after shorter duration of therapy are identified as age over 45 years, pre-treatment platelet count of less than 140×10^9/L, and body mass index over 30 kg/m²,[100] suggesting shortening the duration of therapy can be considered only in particular patients without predictors associated with relapse. Because most Japanese patients have risk factors for relapse such as older age and advanced fibrosis, shortening the duration of the therapy is not generally recommended for Japanese patients with genotype 2, even if they achieve viral clearance by week 4.

PEG-IFN and RBV combination therapy in patients with compensated cirrhosis

In the early Western registration trials, patients with HCV-related compensated cirrhosis did achieve SVR but at lower rates than did those without cirrhosis.[101–103] Subsequently, there was one treatment study that focused exclusively on patients with compensated cirrhosis.[104] In this study, 124 patients with compensated cirrhosis were assigned randomly to an RBV 1000/1200-mg (standard dose) group and 600/800-mg (low dose) group to determine the efficacy of PEG-IFN and RBV combination therapy. The SVR was achieved in 52% of patients who received the standard RBV dose and in 38% of those treated with the low dose. Serious adverse events developed in 14% and 18% of recipients of the standard and low RBV doses, respectively, while dose reduction was necessary in 78% and 57% of the two groups, respectively. HCV genotype 2/3 and platelet count over 150×10^9/L were identified as factors contributing to SVR. Thus, patients with HCV-related compensated cirrhosis can be treated successfully with PEG-IFN and RBV but careful observation is needed because of an anticipated higher rate of adverse effects. Although PEG-IFN and RBV for patients with compensated cirrhosis has not been approved yet in Japan, the following recommendation is reasonable.

> *Recommendation 15: Patients with HCV-related compensated cirrhosis can be treated successfully with PEG-IFN and RBV but careful observation is needed because of an anticipated higher rate of adverse effects. (Level 3, Grade B.)*

Retreatment with PEG-IFN and RBV combination therapy for patients who failed to respond to previous IFN treatment

Seven randomized controlled trials have been reported so far that examine the efficacy of PEG-IFN and RBV

combination therapy in patients who failed to respond to previous standard IFN therapy with or without RBV.[105-111] The SVR rate varies among these trials ranging 6–45%, and was lower among non-responders to previous IFN therapy compared with relapsers. In a study using PEG-IFNα-2b and RBV at two different doses (1.5 μg/kg per week of PEG-IFNα-2b together with 800 mg/day of RBV or 1.0 μg/kg per week of PEG-IFN together with 1000–1200 mg/day of RBV), the SVR rate was low at 10% and 6% in non-responders to previous treatment, but was high at 50% and 32% in relapsers, respectively.[109] In a phase III clinical trial in Japan, the SVR rate was also low in non-responders but sufficiently high in relapsers.[77] Accordingly, PEG-IFN and RBV combination therapy is well indicated for patients who relapse after standard IFN therapy with or without RBV.

Data on retreatment of patients who failed to respond to previous PEG-IFN plus RBV therapy have been evaluated in two trials.[112,113] In a randomized controlled trial that used two different doses of PEG-IFN-α-2a (360 or 180 μg/week) with two different durations of therapy (72- or 48-week),[112] an SVR was achieved in 7–14% of patients. It should be noted, however, that the SVR was favorable at 52% in patients who achieved HCV RNA clearance from serum by week 12 in the 72-week treatment arm.[112] In the other trial that used PEG-IFN-α-2b and RBV in 2333 patients who failed to respond to previous PEG or standard IFN together with RBV, an SVR was achieved in 56% of patients whose HCV RNA was cleared from serum by week 12 and in 48% of those with genotype 1.[113] Accordingly, it is reasonable to propose that SVR could be obtained by retreatment with PEG-IFN and RBV in patients who achieve HCV RNA clearance by week 12 of retreatment, even if they failed to respond to previous PEG-IFN and RBV combination therapy.[112,113] In contrast, in the AASLD practice guideline, retreatment with PEG-IFN and RBV is not recommended for patients who did not achieve an SVR after a prior full course of PEG-IFN and RBV. Because it is still unclear who is more likely to respond to retreatment with PEG-IFN and RBV, and new drugs such as protease inhibitors may be indicated in the near future for patients who failed to respond to previous PEG-IFN and RBV therapy, data with retreatment of PEG-IFN and RBV should be accumulated to enable a conclusive recommendation.

Recommendation 16: Retreatment with PEG-IFN and RBV can be considered for non-responders and relapsers who were treated previously with IFN-based therapy with or without RBV. An SVR could be obtained in these patients whose HCV RNA is cleared from serum by week 12 of retreatment with PEG-IFN and RBV. (Level 2b, Grade B.)

MONOTHERAPY WITH IFN OR PEG-IFN

IN JAPAN, IFN monotherapy has been used to treat HCV infection since 1992. Today, IFN monotherapy is used only in patients with specific characteristics because combination therapy with PEG-IFN and RBV has achieved a high rate of SVR. Recently, a large randomized control trial (RCT) of maintenance therapy with a low dose of PEG-IFN was reported.[114] There were no differences in progression of liver disease between a PEG-IFN group and a control group. However, Japanese studies of elderly patients or patients who received maintenance therapy for longer periods showed that IFN can improve outcomes in advanced hepatic fibrosis.

Naïve patients with low viral loads

Previous studies showed that 3 MIU of IFN monotherapy achieved SVR rates of 15–45% in patients with fewer than 2×10^6 copies of HCV.[115-118] Monotherapy with 180 μg/week of PEG-IFN-α-2a or 1.5 μg/kg per week of PEG-IFN-α-2b produced SVR rates of 16–46% in patients with fewer than 2×10^6 copies.[119-121] In Japanese patients with fewer than 1×10^5 copies of HCV, 6 MIU of IFN treatment for 24 weeks achieved an SVR rate of 86% (127/148).[122] PEG-IFN monotherapy for 48 weeks similarly achieved an SVR rate of 86% (106/123). A recent RCT showed that PEG-IFN monotherapy for 24 weeks produced the same SVR rate as similar treatment for 48 weeks in patients with fewer than 1×10^5 copies of HCV. On the basis of these results, monotherapy with IFN or PEG-IFN is considered to be an effective treatment for naïve patients with fewer than 5.0 log copies/mL of HCV.[123]

Recommendation 17: Monotherapy with IFN or PEG-IFN can be considered for naïve patients with low viral loads (<5.0 log copies/mL). (Level 2a, Grade B.)

Patients with chronic kidney disease

Patients with chronic kidney disease (CKD) who undergo hemodialysis have a high prevalence of HCV infection. In Japan, one study reported that HCV RNA was detected in 117 (22%) of 543 patients who underwent maintenance hemodialysis.[124] Hemodialysis patients infected with HCV have a higher mortality rate than uninfected hemodialysis patients.[125] This higher

mortality is attributed to the frequent progression to cirrhosis and/or HCC in HCV-infected patients who receive hemodialysis.

Because RBV is excreted renally, it is currently contraindicated in patients with CKD who have a creatinine clearance of less than 50 mL/min. In addition, pharmacokinetic studies have shown that the clearance of IFN is lower in patients who undergo hemodialysis than in patients who have normal renal function.[126]

Studies of antiviral therapy in patients who undergo hemodialysis suggest that IFN monotherapy is generally well tolerated and that SVR rates are higher than those in patients with normal renal function.[127] The overall SVR rate was reported to be 33–37% in hemodialysis patients.[128] However, the number of subjects in these trials was too low to support confident conclusions. Adverse events are common in this population, and many patients discontinue therapy prematurely because of such events. A recent RCT showed in EASL 2008 that 135 μg/week of PEG-IFN-α-2a for 48 weeks achieved an SVR rate of 39% (23/38), whereas a dose of 90 μg/week produced an SVR rate of 35% (16/43). In 74% of the patients, treatment was completed as scheduled.

Another important point is when to initiate antiviral therapy in hemodialysis patients. IFN might induce allograft rejection and renal failure.[129] Therefore, IFN therapy should be considered before renal transplantation. The next issue to be resolved is the efficacy and safety of low-dose RBV combination therapy in hemodialysis patients.

In 2008, KDIGO proposed guidelines for the treatment of patients with CKD.[130] In Japan, a committee including hepatologists and specialists for CKD is planning a clinical trial for HCV-infected patients with CKD.

Recommendation 18: 3 MIU of IFN thrice weekly or 90 or 135 μg of PEG-IFN-α-2a weekly is recommended for patients with CKD. (Level 2a, Grade B.)

Patients with acute HCV infection

Acute HCV infection progresses to chronic infection in approximately 70% of patients.[131] Antiviral treatment should therefore be considered for this group of patients. On the other hand, it is difficult to identify patients with self-limited disease not requiring therapy. The results of previous studies indicate that anti-HCV treatment should be initiated if HCV RNA is detected continuously for more than 12–16 weeks. If treatment is initiated within this period, monotherapy with IFN or PEG-IFN achieves an SVR rate of more than 80% in patients with acute HCV infection.[132] Reliable evidence

showing that additional treatment with RBV improves the SVR rate in such patients is not available.

Recommendation 19: Patients with acute HCV infection should be considered as candidates for antiviral therapy. If HCV RNA is detected continuously for 12 or 16 weeks from the onset, treatment with 6 MIU of IFN or 180 μg of PEG-IFN monotherapy should be initiated. (Level 2a, Grade B.)

Patients who receive curative treatment for HCC

Hepatocellular carcinoma frequently recurs in HCV-infected patients, even after curative therapy for HCC. Prevention of the recurrence of HCC is essential in such patients. Several RCT showed that the incidence of HCC was low in an IFN-treated group, compared to a control group (Table 4).[133,134] For example, Kubo *et al.* reported that 3 MIU IFN monotherapy thrice weekly for 96 weeks inhibited the recurrence of HCC in patients who had undergone a curative resection.[134] Furthermore, Shiratori *et al.* performed an RCT in 74 patients who had received curative percutaneous ethanol injection therapy for HCC. They reported that second and third recurrences of HCC were less frequent in patients who received IFN.[135] In an Italian study of 150 patients who had undergone curative resection, the recurrence rate of HCC 2 years after operation was significantly lower among patients who received IFN.[136]

Japanese studies showed that the survival rate was also improved by IFN treatment owing to the suppression of HCC and/or the progression of hepatic failure.[137,138]

Recommendation 20: IFN therapy should be considered for patients after curative treatment for HCC. (Level 1, Grade A.)

Maintenance therapy for patients with advanced hepatic fibrosis

Previous studies of patients with advanced hepatic fibrosis, defined as a fibrosis score 3 or 4, showed that IFN monotherapy inhibited the occurrence of HCC, compared to patients who did not receive IFN.[64,139,140] In Japanese studies, IFN was effective not only in SVR patients, but also in non-SVR patients.[139,141] On the other hand, an Italian study showed that the incidence of HCC decreased only in cirrhotic patients in whom HCV was eradicated by IFN therapy.[75]

Case–control studies in patients older than 60 years showed that a low dose of IFN reduced ALT and AFP levels and decreased the incidence of HCC, compared to a control group.[142,143] RCT for IFN monotherapy non-