RESULTS

Study population

A TOTAL OF 1865 subjects, consisting of 999 SVR patients (SVR rate 53.5%) and 866 non-SVR patients, were eligible for analysis. Of the non-SVR patients, 441 had transient response (TR) defined as viral negativity achieved during treatment (relapse: 408, virus breakthrough: 33), 400 patients had non-virological response (NVR) defined as viral negativity not being achieved, and the change in viral load during treatment was not known for 25 patients.

The duration of observation ranged from 3 months to 5 years and 8 months, with a median of 4 years and 3 months.

During the observation period, HCC developed in 59 patients (3.1%). Between patients who developed HCC and those who did not, significant differences in background factors were detected in age ($P < 0.0001$), hepatic fibrosis ($P = 0.0002$), virological efficacy ($P < 0.0001$), ALT levels ($P = 0.0089$), ALT level at 24 weeks after the end of treatment (≤40 vs. >40 IU/L) ($P < 0.0001$), platelet count ($P = 0.0001$), serum albumin ($P = 0.0062$), and alpha fetoprotein (AFP) ($P < 0.0001$) (Table 1).

Virological efficacy and incidence of HCC

The 5-year cumulative incidence of HCC by the Kaplan–Meier method was 1.1% in SVR patients and 7.1% in non-SVR patients, a difference that was significant ($P < 0.001$) (Fig. 1). No significant difference was observed in the incidence of HCC between TR and NVR patients among non-SVR patients, but the difference between TR and SVR patients was significant ($P < 0.0001$) (Fig. 2). This trend was also observed regardless of gender, with no significant difference in the incidence of HCC observed between TR and NVR in either male or female patients and a significant difference observed between TR and SVR in both male patients ($P = 0.0007$) and female ($P = 0.0065$) patients.

Factors contributing to HCC

The factors contributing to HCC selected in the multivariate analysis were therapeutic efficacy (SVR vs. NVR), sex, age (<60 vs. ≥60 years), ALT level at 24 weeks after the end of treatment (≤40 vs. >40 IU/L), and platelet count (<10 vs. ≥10 × 10 000/mm^3) (Table 2).

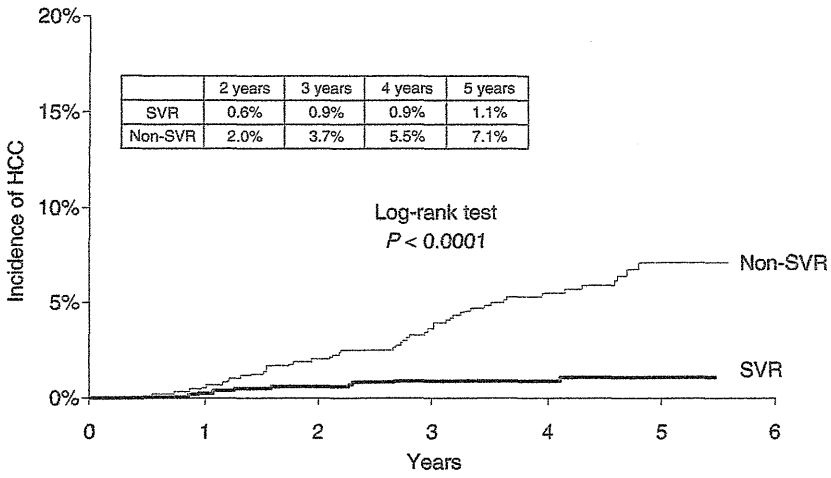
Biochemical response and incidence of HCC in non-SVR patients

Since ALT levels at 24 weeks after the end of treatment was selected as one factor contributing to HCC, the changes in ALT levels and onset of HCC were examined in 514 non-SVR patients with a pretreatment ALT level of more than 40 IU/L whose ALT level at 24 weeks after the end of treatment was obtained. Of these 514

Table 1 Patient background by onset of hepatocellular carcinoma (HCC) (1865 patients)

Factor	With onset of HCC ($n = 59$)	Without onset of HCC ($n = 1806$)	*P*-value
Gender (male/female)	40/19	1014/792	0.0832
Age	62 (44–74)	56 (17–77)	<0.0001
Diabetes (yes/no/unknown)	6/33/20	100/1040/666	0.1539
Hypertension (yes/no/unknown)	4/6/49	116/569/1121	0.0763
Alcohol abuse (yes/no/unknown)	11/16/32	195/493/1118	0.1930
Fibrosis (0/1/2/3/4/unknown)	0/12/13/15/4/15	57/573/355/205/56/560	0.0002
Genotype (1/2/3/unknown)	52/5/0/2	1421/365/2/18	0.0876
Effect of IFN (SVR/non-SVR)	10/49	989/817	<0.0001
Body mass index (kg/m^2)	22.6 (14.2–34.0)	22.9 (14.9–41.2)	0.8546
ALT (IU/L)	79 (24–343)	60 (8–984)	0.0089
ALT at 24 weeks after end of treatment (IU/L) (≤40/>40/unknown)	16/30/13	1105/352/349	<0.0001
Platelet count (×10 000/mm^3)	13.3 (4.3–22.2)	16.3 (3.6–213.3)	0.0001
Serum albumin (g/dL)	3.9 (2.9–4.7)	4.1 (2.8–5.9)	0.0062
AFP (ng/mL)	13 (2.2–327.9)	5 (0–875)	<0.0001

Median (minimum – maximum).
AFP, alpha fetoprotein; ALT, alanine aminotransferase; IFN, interferon; SVR, sustained virological response.



	2 years	3 years	4 years	5 years
SVR	0.6%	0.9%	0.9%	1.1%
Non-SVR	2.0%	3.7%	5.5%	7.1%

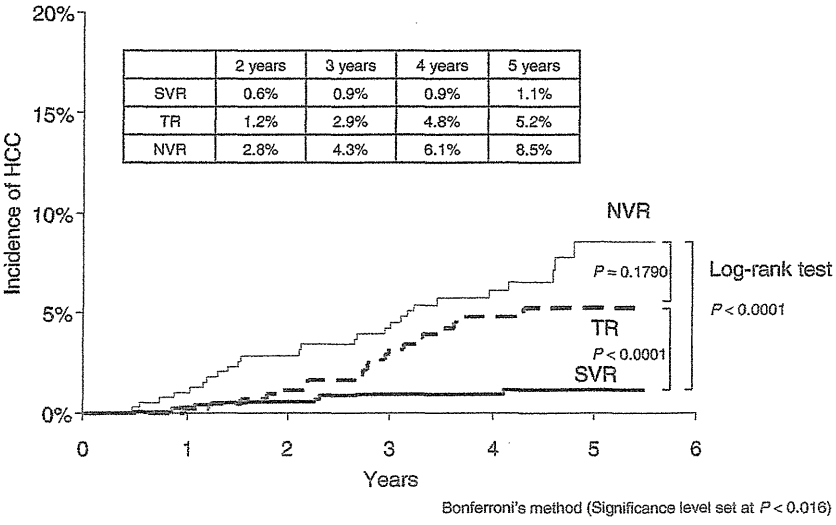
Figure 1 Onset of hepatocellular carcinoma (HCC) by therapeutic efficacy (1865 patients) (sustained virological response [SVR] vs. non-virological response [NVR]). The cumulative incidence of HCC was calculated by the Kaplan–Meier method. The difference between SVR and non-SVR was examined using the log-rank test.

patients, ALT level at 24 weeks after the end of treatment was reduced to less or equal to 40 IU/L (biochemical response: BR) in 234 patients, and the remaining 280 patients had values of more than 40 IU/L (non-BR). There were significant differences between BR and non-BR patients in the background factors of pretreatment ALT level, age, hepatic fibrosis, platelet count, AFP, and treatment duration. Selected as the factors contributing to BR in non-SVR patients in the multivariate analysis were TR, long treatment duration, and high platelet count before the start of treatment (Table 3).

The 5-year cumulative incidence of HCC was 3.4% in BR patients and 11.0% in non-BR patients, and the difference in incidence was significant ($P = 0.0012$) (Fig. 3). The 5-year cumulative incidence of HCC in male patients was 3.6% in BR patients and 13.9% in non-BR patients, and the difference was significant ($P = 0.0012$). In female patients, however, it was 3.5% in BR patients and 7.6% in non-BR patients, and although the incidence of HCC was lower in BR patients, the difference was not significant ($P = 0.0706$).

Incidence of HCC in patients with normal pretreatment ALT levels

When the incidence of HCC was compared between SVR (288) and non-SVR (214) patients among 502 patients with pretreatment ALT levels less or equal to 40 IU/L, the 5-year cumulative incidence of HCC was 0% in SVR patients and 4.8% in non-SVR patients, indicating a significant difference ($P = 0.0005$) between the groups



	2 years	3 years	4 years	5 years
SVR	0.6%	0.9%	0.9%	1.1%
TR	1.2%	2.9%	4.8%	5.2%
NVR	2.8%	4.3%	6.1%	8.5%

Figure 2 Onset of hepatocellular carcinoma (HCC) by therapeutic efficacy (sustained virological response [SVR] vs. transient response [TR] vs. non-virological response [NVR]). The cumulative incidence of HCC was calculated by the Kaplan–Meier method. The difference between each group was examined using the log-rank test (Bonferroni's Method, significance level set at $P < 0.016$).

Table 2 Factors contributing to hepatocellular carcinoma (all patients) Cox regression analysis (multivariate)

		Hazard ratio	95% confidence interval	*P*-value
Therapeutic efficacy	SVR	1		
	TR	2.055	0.709–5.955	0.1845
	NVR	2.985	1.036–8.601	0.0428
Sex	Male	1		
	Female	0.486	0.243–0.969	0.0405
Age	<60	1		
	≥60	2.005	1.035–3.883	0.0391
ALT at 24 weeks after end of treatment (IU/L)	≤40	1		
	>40	3.940	1.754–8.850	0.0009
Platelet count (×10 000/mm^3)	<10	1		
	≥10	0363	0.169–0.779	0.0093
Serum albumin (g/dL)	<4	1		
	≥4	0.594	0.310–1.140	0.1175

Factors examined: Of the 15 factors exhibiting $P < 0.2$ by log-rank test (therapeutic efficacy [1: SVR, 2: TR, 3: NVR], genotype [1: 1, 2: 2 or 3], sex [1: male, 2: female], age [1: <60, 2: ≥60], pre ALT [1: ≤40, 2: >40], +24 w ALT [1: ≤40, 2: >40], pre PLT [1: <10, 2: ≥10], pre ALB [1 <4, 2: ≥4], pre AFP [1: <20, 2: ≥20], grade [1: A0–1, 2: A2–3], stage [1: F0–1, 2: F2–4], hypertension [1: absent, 2: present], diabetes [1: absent, 2: present], heavy drinking [1: absent, 2: present], and treatment duration [1: ≤48 W, 2: >48 W]), nine factors were examined. Excluded were factors for which approximately 30% of values were missing (AFP, grade, stage, diabetes, hypertension, and heavy drinking).
AFP, alpha fetoprotein; ALB, albumin; ALT, alanine aminotransferase; NVR, non-virological response; PLT, platelet count; SVR, sustained virological response; TR, transient response.

(Fig. 4). This tendency is also observed with the 280 patients having pretreatment ALT levels of less or equal to 30 IU/L.

Onset of HCC in SVR patients

Hepatocellular carcinoma developed in 10 patients who achieved SVR. Multivariate analysis indicated that in SVR patients, the ALT level at 24 weeks after the end of treatment was the only significant factor contributing to HCC ($P = 0.0007$) (Table 4). In SVR patients with an ALT level of more than 40 IU/L at 24 weeks after the end of treatment, the 5-year cumulative incidence of HCC was 5.6% while the incidence in patients with an ALT level of less or equal to 40 IU/L was 0.7%, indicating a significant difference ($P = 0.0004$) between the groups (Fig. 5).

DISCUSSION

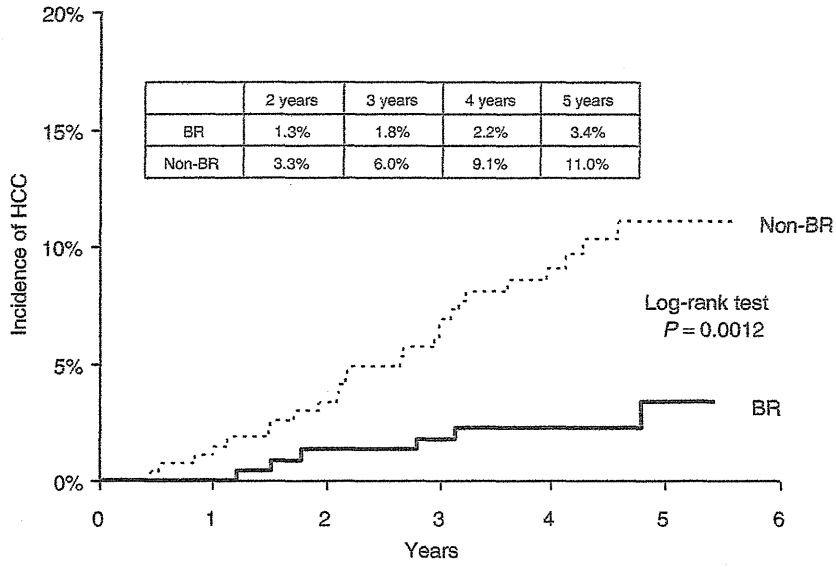
THIS STUDY INDICATED that the risk factors for HCC after PEG-IFN α-2b plus RBV combination therapy are NVR, male sex, older age, low platelet count, and an ALT level of more than 40 IU/L at 24 weeks after the end of treatment.

Kurokawa *et al.*[16] tracked 403 patients receiving PEG-IFN α-2b plus RBV combination therapy for a median

Table 3 Factors contributing to biochemical response in non-sustained virological response patients Logistic regression analysis (multivariate)

		Odds ratio	95% confidence interval	*P*-value
Virological response	NVR	1	1.480–3.203	0.0001
	TR	2.177		
Treatment duration	per week	1	1.000–1.022	0.0424
		1.011		
Platelet count	per 10 000/mm^3	1	1.018–1.099	0.0043
		1.058		

Factors examined were those exhibiting $P < 0.2$ by log-rank test: Genotype, virological response (TR/NVR), treatment duration, pre platelet count, diabetes, stage, and alanine aminotransferase (ALT).

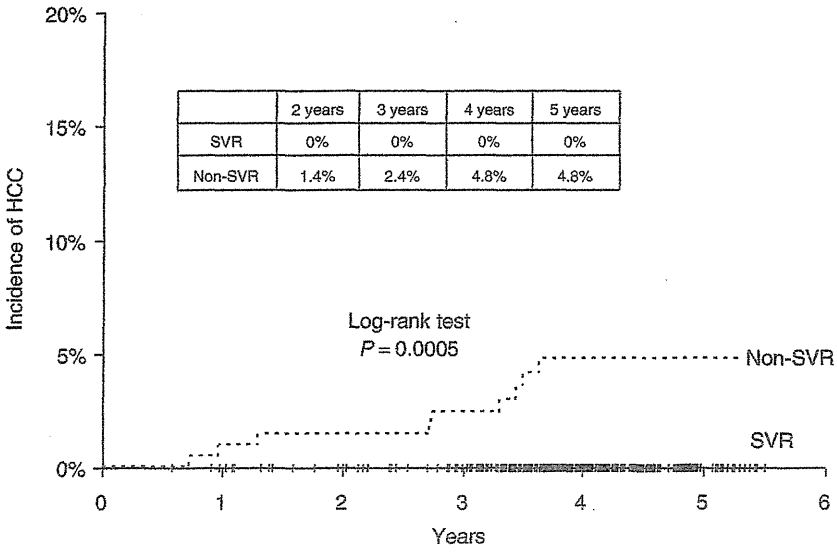


	2 years	3 years	4 years	5 years
BR	1.3%	1.8%	2.2%	3.4%
Non-BR	3.3%	6.0%	9.1%	11.0%

Figure 3 Alanine aminotransferase (ALT) normalization and hepatocellular carcinoma (HCC) in non-virological response [NVR] patients. The cumulative incidence of HCC was calculated by the Kaplan–Meier method. Log-rank test was used to study the difference between biochemical response (BR) and non-BR.

duration of 36.5 months and reported that in multivariate analysis, virological efficacy (SVR vs. non-SVR), age, and hepatic fibrosis were selected as the factors contributing to HCC. Arase *et al.*[15] tracked 500 patients 60 years of age and older receiving IFN alone or in combination with RBV for an average duration of 7.4 years and also reported that the factors contributing to HCC are virological efficacy (SVR vs. non-SVR), age, and hepatic fibrosis. In our study, hepatic fibrosis was not tested with multivariate analysis because more than 30% of values were missing, but it was selected as a significant factor in the univariate analysis. Platelet count was selected in multivariate analysis, and the results in our study are therefore considered to be generally consistent with these reports.

The results of the present study indicated no significant difference between TR and NVR in non-SVR in stratified cumulative incidence of HCC, and although there was a significant difference between SVR and both TR and NVR, TR was not significant against SVR in multivariate analysis, and NVR was the only significant factor. Kurokawa *et al.*[16] reported the same results by



	2 years	3 years	4 years	5 years
SVR	0%	0%	0%	0%
Non-SVR	1.4%	2.4%	4.8%	4.8%

Figure 4 Therapeutic efficacy and hepatocellular carcinoma (HCC) in patients with pretreatment alanine aminotransferase (ALT) of ≤40. The cumulative incidence of HCC was calculated by the Kaplan–Meier method. Log-rank test was used to study the difference between sustained virological response (SVR) and non-virological response (NVR).

Table 4 Factors contributing to hepatocellular carcinoma (sustained virological response [SVR] patients) Cox regression analysis (multivariate)

		Hazard ratio	95% confidence interval	*P*-value
ALT at 24 weeks after end of treatment (IU/L)	≤40	1		
	>40	16.054	3.235–79.681	$P = 0.0007$
Serum albumin (g/dL)	<4	1		
	≥4	0.196	0.036–1.073	$P = 0.0603$

Factors examined: Of the 10 factors exhibiting $P < 0.2$ by log-rank test (Genotype [1: 1, 2: 2 or 3], age [1: <60, 2: ≥60], pre ALT [1: ≤40, 2: >40], +24 w ALT [1: ≤40, 2: >40], pre PLT [1: <10, 2: ≥10], pre ALB [1: <4, 2: ≥4], pre AFP [1: <20, 2: ≥20], grade [1: A0–1, 2: A2–3], stage [1: F0–1, 2: F2–4], and diabetes [1: absent, 2: present]), 5 factors were examined. Excluded were pre ALT, with which HCC did not occur in the ≤40 group, and AFP, grade, stage, and diabetes, the factors for which approximately 30% of values were missing.
ALB, albumin; ALT, alanine aminotransferase; PLT, platelet count;

comparing cumulative incidences of HCC among SVR, TR and NVR (the results of multivariate analysis are not known). On the other hand, Morgan *et al.*,[19] in their follow-up study of the HALT-C Trial, reported that there was no difference between TR and NVR in the incidence of HCC or death related to hepatic disease/liver transplantation, but when all hepatic-related outcomes were examined, a significantly superior inhibition was observed with TR compared to NVR. Our results also demonstrate that although the difference is not significant, the cumulative incidence of HCC is lower in TR patients than in NVR patients, especially in male patients (5-year cumulative incidence of HCC: 6.0% vs. 10.7%). It is therefore necessary to continue to observe this for an extended number of years.

Our results study indicated that in non-SVR patients, whether or not ALT level is normalized after treatment is a greater contributing factor for the onset of HCC than virological response. Normalization of ALT has already been reported to contribute to the inhibition of the onset of HCC even under HCV-positive conditions,[13,20] and this was found to apply also to non-SVR patients receiving PEG-IFN α plus RBV combination therapy.

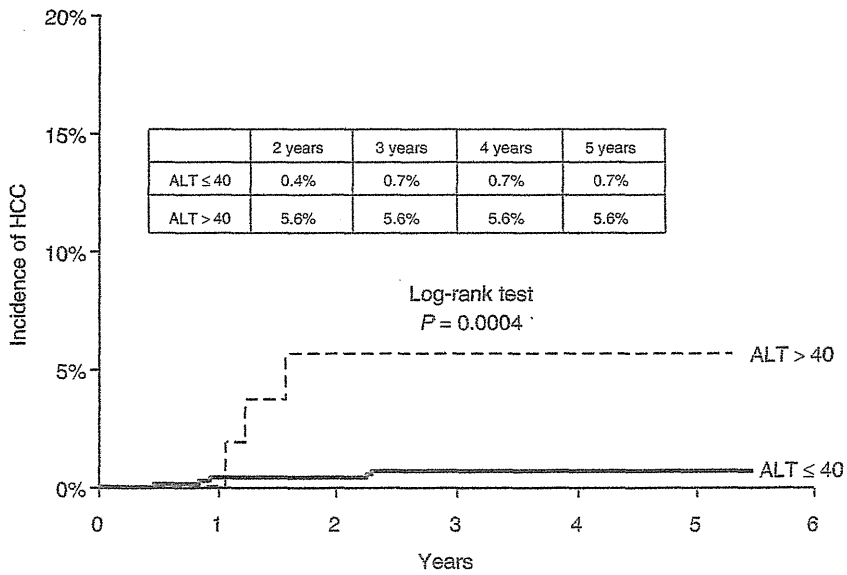


Figure 5 Alanine aminotransferase (ALT) levels at 24 weeks after end of treatment and hepatocellular carcinoma (HCC) in patients with sustained virological response (SVR). The cumulative incidence of HCC was calculated by the Kaplan–Meier method. Log-rank test was used to study the difference between SVR patients with an ALT level of more than 40 IU/L at 24 weeks after the end of treatment and those with an ALT level of less or equal to 40 IU/L.

Our investigation also indicated that abnormal ALT levels also contribute to the onset of HCC in SVR patients. In multivariate analysis, the only contributing factor to the development of HCC in SVR patients was ALT levels at 24 weeks after the end of treatment. However, the onset of HCC is also observed in patients who achieve ALT normalization after treatment, and it is therefore difficult to conclude that ALT is the only risk factor for the onset of HCC in SVR patients. The potential involvement of hepatic fibrosis as well as hepatic steatosis, which persists after viral clearance[21] and small amounts of virus remaining in the liver[22] have also been suggested as risk factors for the onset of HCC in SVR patients. Further detailed investigation is therefore necessary. Nevertheless, regardless of whether or not SVR is achieved, it is clear that abnormal ALT is a factor affecting the onset of HCC. Careful monitoring of changes in ALT and instituting measures to normalize ALT are therefore important regardless of whether or not SVR is achieved.

With the administration of PEG-IFN α plus RBV combination therapy tailored for individual patients and the addition of direct-acting antivirals to current combination therapy, the therapeutic outcomes for CHC will continue to further improve, and the number of patients who develop hepatic cirrhosis and HCC from hepatitis C can be expected to decrease in the future. HCC can occur even in patients achieving SVR, and even if SVR is not achieved, as long as the possibility to inhibit the onset of HCC remains, there will be a need for various treatment innovations to achieve the prevention of HCC, the ultimate goal of treatment of CHC.

REFERENCES

1 Chung H, Ueda T, Kudo M. Changing trends in hepatitis C infection over the past 50 years in Japan. *Intervirology* 2010; 53: 39–43.
2 Yoshizawa H. Hepatocellular carcinoma associated with hepatitis C virus infection in Japan: projection to other countries in the foreseeable future. *Oncology* 2002; 62 (Suppl 1): 8–17.
3 Umemura T, Ichijo T, Yoshizawa K, Tanaka E, Kiyosawa K. Epidemiology of hepatocellular carcinoma in Japan. *J Gastroenterol* 2009; 44 (Suppl XIX): 102–7.
4 Hamada H, Yatsuhashi H, Yano K *et al.* Impact of aging on the development of hepatocellular carcinoma in patients with posttransfusion chronic hepatitis C. *Cancer* 2002; 95: 331–9.
5 Fried MW, Shiffman ML, Reddy KR *et al.* Peginterferon alfa-2a plus ribavirin for chronic hepatitis C virus infection. *N Engl J Med* 2002; 347: 975–82.
6 Manns MP, McHutchison JG, Gordon SC *et al.* Peginterferon alfa-2b plus ribavirin compared with interferon alfa-2b plus ribavirin for initial treatment of chronic hepatitis C: a randomised trial. *Lancet* 2001; 358: 958–65.
7 Hadziyannis SJ, Sette H Jr, Morgan TR *et al.* Peginterferon alpha-2a and ribavirin combination therapy in chronic hepatitis C: a randomized study of treatment duration and ribavirin dose. *Ann Intern Med* 2004; 140: 346–55.
8 Iino S, Okita K, Omata M, Kumada H, Hayashi N, Tanikawa K. Clinical efficacy of PEG-interferon α-2b and ribavirin combination therapy for 48 weeks in chronic hepatitis C patients with genotype 1 and high viral load – retrospective comparison with interferon α-2b and ribavirin combination therapy for 24 weeks. *Kantansui* 2004; 49: 1099–121.
9 Nagase Y, Yotsuyanagi H, Okuse C *et al.* Effect of treatment with interferon α-2b and ribavirin in patients infected with genotype 2 hepatitis C virus. *Hepatol Res* 2008; 38: 252–8.
10 Watanabe S, Enomoto N, Koike K *et al.* Prolonged treatment with pegylated interferon α-2b plus ribavirin improves sustained virological response in chronic hepatitis C genotype 1 patients with late response in a clinical real-life setting in Japan. *Hepatol Res* 2010; 40: 135–44.
11 Farnik H, Lange CM, Sarrazin C, Kronenberger B, Zeuzem S, Herrmann E. Meta-analysis shows extended therapy improves response of patients with chronic hepatitis C virus genotype 1 infection. *Clin Gastroenterol Hepatol* 2010; 8: 884–90.
12 Sezaki H, Suzuki F, Akuta N *et al.* An open pilot study exploring the efficacy of fluvastatin, pegylated interferon and ribavirin in patients with hepatitis C virus genotype 1b in high viral loads. *Intervirology* 2009; 52: 43–8.
13 Moriyama M, Matsumura H, Aoki H *et al.* Decreased risk of hepatocellular carcinoma in patients with chronic hepatitis C whose serum alanine aminotransferase levels became less than twice the upper limit of normal following interferon therapy. *Liver Int* 2005; 25: 85–90.
14 Yu ML, Lin SM, Chuang WL *et al.* A sustained virological response to interferon or interferon/ribavirin reduces hepatocellular carcinoma and improves survival in chronic hepatitis C: a nationwide, multicentre study in Taiwan. *Antivir Ther* 2006; 11: 985–94.
15 Arase Y, Ikeda K, Suzuki F *et al.* Long-term outcome after interferon therapy in elderly patients with chronic hepatitis C. *Intervirology* 2007; 50: 16–23.
16 Kurokawa M, Hiramatsu N, Oze T *et al.* Effect of interferon alpha-2b plus ribavirin therapy on incidence of hepatocellular carcinoma in patients with chronic hepatitis. *Hepatol Res* 2009; 39: 432–8.
17 Butt AA, Wang X, Moore CG. Effect of hepatitis C virus and its treatment on survival. *Hepatology* 2009; 50: 387–92.
18 Cardoso AC, Moucari R, Figueiredo-Mendes C *et al.* Impact of peginterferon and ribavirin therapy on hepatocellular carcinoma: incidence and survival in hepatitis C patients with advanced fibrosis. *J Hepatol* 2010; 52: 652–7.

19 Morgan TR, Ghany MG, Kim HY *et al.* Outcome of sustained virological responders with histologically advanced chronic hepatitis C. *Hepatology* 2010; 52: 833–44.
20 Arase Y, Ikeda K, Suzuki F *et al.* Interferon-induced prolonged biochemical response reduces hepatocarcinogenesis in hepatitis C virus infection. *J Med Virol* 2007; 79: 1485–90.
21 Tanaka A, Uegaki S, Kurihara H *et al.* Hepatic steatosis as a possible risk factor for the development of hepatocellular carcinoma after eradication of hepatitis C virus with antiviral therapy in patients with chronic hepatitis C. *World J Gastroenterol* 2007; 13: 5180–7.
22 Radkowski M, Gallegos-Orozco JF, Jablonska J *et al.* Persistence of hepatitis C virus in patients successfully treated for chronic hepatitis C. *Hepatology* 2005; 41: 106–14.

APPENDIX I

IN ADDITION TO the study authors, the investigators in the PEG-IFN and Ribavirin, Find Evidence of Chronic Hepatitis C Therapy in Tokyo (PERFECT) Study Group included: Hiroyasu Adachi, Department of Internal Medicine, Tobu Chiki Hospital; Yoshio Aizawa Department of Internal Medicine, The Jikei University School of Medicine, Aoto Hospital; Masatoshi Akamatsu, Department of Gastroenterology, JR Tokyo General Hospital; Masahiro Arai, Department of Gastroenterology, Toshiba General Hospital; Yasuhiro Asahina, Department of Gastroenterology and Hepatology, Musashino Red Cross Hospital; Yoshimichi Chuuganji, Department of Gastroenterology, Tokyo Metropolitan Bokutoh Hospital; Yoshiyuki Fujita, Department of Gastroenterology, St. Luke's International Hospital; Yukiya Hakozaki, Department of Internal Medicine, Self-Defence Forces Central Hospital; Naoaki Hashimoto, Department of Gastroenterology, Tokyo Teishin Hospital; Katsuya Hattori, Department of Gastroenterology, Kohsei Chuo General Hospital; Seishu Hayashi, Division of Hepatology, Tokyo Metropolitan Komagome Hospital; Masanori Hirano, Department of Gastroenterology Tokyo Metropolitan Police Hospital; Keiichi Hirata, National Hospital Organization Disaster Medical Center; Department of Gastroenterology; Toshiya Horibe, International University of Health & Welfare Mita Hospital, Gastroenterology Center; Kazuhiko Hosoda, Department of Gastroenterology and Hepatology Yamanashi Hospital of Social Insurance; Hiroaki Igarashi, Department of Gastroenterology, Kawakita General Hospital; Yoshida Ikuma, Department of Internal Medicine, Kasai Cardiology & Neurosurgery Hospital; Tetsuya Irie, Department of Internal Medicine, Nakano General Hospital; Koji Ishii, Division of Gastroenterology and Hepatology, Department of Internal Medicine, Toho University School of Medicine; Takayoshi Ito, Department of Gastroenterology, Department of Medicine, Showa University School of Medicine; Naohiro Kawamura, The Third Department of Internal Medicine, Kyorin University School of Medicine; Tateo Kawase, Department of Gastroenterology, Kanto Central Hospital of the Mutual Aid Association of Public School Teachers; Hirokazu Komeichi, Department of Internal Medicine, Division of Cardiology, Hepatology, Geriatrics and Integrated Medicine, Nippon Medical School; Sadanori Kubo, Department of Internal Medicine, Showa University Toyosu Hospital; Naohiko Masaki, Division of Gastroenterology, International Medical Center of Japan, Toyama Hospital; Akihisa Miyazaki, Department of Gastroenterology, Juntendo University Nerima Hospital; Mitsuhiko Moriyama, Division of Gastroenterology and Hepatology, Department of Medicine, Nihon University of School of Medicine; Naoya Murashima, Department of Gastroenterology, Mishuku Hospital; Hikaru Nagahara, Department of Gastroenterology, Aoyama Hospital Tokyo Women's Medical University; Hisato Nakajima, Department of Gastroenterology and Hepatology, Jikei University School of Medicine Daisan Hospital; Ikuo Nakamura, Department of Gastroenterology, Tokyo Medical University; Ryo Nakata, Department of Gastroenterology, Japanese Red Cross Medical Center; Katsuhisa Nakatsuka, Division of Gastroenterology, Department of Internal Medicine Nippon Medical School; Yasuhiro Nishizaki, Department of Gastroenterology, Tokai University Tokyo Hospital; Osamu Noguchi, Division of Gastroenterology and Hepatology, Ome Municipal General Hospital; Toshihiko Nouchi, Department of Gastroenterology, Showa General Hospital; Yuki Ogura, Department of Medicine, Tokyo Metropolitan Fuchu Hospital; Masanaru Ozawa, Yoshikawa Hospital; Shigehiko Sainokami, Fussa Hospital; Naoya Sakamoto, Department of Gastroenterology and Hepatology, Tokyo Medical and Dental University; Minoru Sakamoto, Department of Internal Medicine, Faculty of Medicine, University of Yamanashi; Mina Sasaki, Department of Gastroenterology, Tokyo Metropolitan Geriatric Hospital; Yoshiyuki Sato, Department of Internal Medicine, Tokyo Kosei Nenkin Hospital; Koichi Shiraishi, Division of Gastroenterology and Hepatology, Tokai University Hachioji Hospital; Satoko Suzuki, Department of Gastroenterology, Juntendo University School of Medicine; Tomohiko Suzuki, Department of Internal Medicine, Tokyo Metropolitan Health and Medical Treatment Corporation Ohkubo Hospital;

Fumitaka Suzuki, Department of Hepatology, Toranomon Hospital; Kazumi Tagawa, Department of Gastroenterology, Mitsui Memorial Hospital; Ichiro Takagi, Division of Gastroenterology and Hepatology, Department of Internal Medicine, Jikei University School of Medicine; Seiichirou Takahashi, Department of Internal Medicine, Fujiyoshida Municipal Medical Center; Atsushi Tanaka, Department of Medicine, Teikyo University School of Medicine; Takuma Teratani, Department of Gastroenterology, Kanto Medical Center NTT EC; Katsutoshi Tokushige, Department of Medicine and Gastroenterology, Tokyo Women's Medical University; Masahiko Tomimatsu, Department of Medicine, Tokyo Women's Medical University Medical Center East; Shigeki Tsukada, Department of Gastroenterology, Juntendo Tokyo Koto Geriatric Medical Center; Hiroyuki Watanabe; Department of Gastroenterology, Yamanashi Red Cross Hospital; Michiyasu Yagura, Department of Gastroenterology, National Hospital Organization, Tokyo National Hospital; Haruki Yamada, Department of Internal Medicine, Social Insurance Central General Hospital; Toshio Yamada, Department of Gastroenterology, Tokyo Rinkai Hospital; Taro Yamanaka, Department of Gastroenterology, Itabashi Chuo Medical Center; Kiyomi Yasuda, Department of Hepatology, Kiyokawa Hospital; Yuji Yoshikawa, Department of Gastroenterology, Sanraku Hospital; Yoko Yoshioka, Department of Gastroenterology, Shiseikai-Daini Hospital; Hiroshi Yotsuyanagi, Department of Infectious Diseases, Internal Medicine, Graduate School of Medicine, University of Tokyo; Mikio Zeniya, Department of Gastroenterology, Jikei University Graduate School of Medicine.

EUROPEAN JOURNAL OF CANCER 47 (2011) 2117–2127

available at www.sciencedirect.com

ScienceDirect

journal homepage: www.ejconline.com

EJC

Phase III study of sorafenib after transarterial chemoembolisation in Japanese and Korean patients with unresectable hepatocellular carcinoma ☆

Masatoshi Kudo [a,*], *Kazuho Imanaka* [b], *Nobuyuki Chida* [c], *Kohei Nakachi* [d], *Won-Young Tak* [e], *Tadatoshi Takayama* [f], *Jung-Hwan Yoon* [g], *Takeshi Hori* [h], *Hiromitsu Kumada* [i], *Norio Hayashi* [j], *Shuichi Kaneko* [k], *Hirohito Tsubouchi* [l], *Dong Jin Suh* [m], *Junji Furuse* [n], *Takuji Okusaka* [o], *Katsuaki Tanaka* [p], *Osamu Matsui* [k], *Michihiko Wada* [q], *Iku Yamaguchi* [q], *Toshio Ohya* [q], *Gerold Meinhardt* [r], *Kiwamu Okita* [s]

[a] *Kinki University, Osaka-Sayama, Japan*
[b] *Osaka Medical Center for Cancer and Cardiovascular Disease, Osaka, Japan*
[c] *Sendai Medical Center, Sendai, Japan*
[d] *National Cancer Center Hospital East, Kashiwa, Japan*
[e] *Kyungpook National University Hospital, Daegu, South Korea*
[f] *Nihon University, Tokyo, Japan*
[g] *Seoul National University Hospital, Seoul, South Korea*
[h] *Miyazaki Medical Center Hospital, Miyakazi, Japan*
[i] *Toranomon Hospital, Tokyo, Japan*
[j] *Osaka University Hospital, Osaka, Japan*
[k] *Kanazawa University Hospital, Kanazawa, Japan*
[l] *Kagoshima University Hospital, Kagoshima, Japan*
[m] *Asan Medical Center, University of Ulsan, Seoul, South Korea*
[n] *Kyorin University, Mitaka, Japan*
[o] *National Cancer Center Hospital, Tokyo, Japan*
[p] *Yokohama City University Medical Center, Yokohama, Japan*
[q] *Bayer Yakuhin Ltd., Osaka, Japan*
[r] *Bayer HealthCare Pharmaceuticals, Montville, New Jersey, USA*
[s] *Shimonoseki Kohsei Hospital, Shimonoseki, Japan*

ARTICLE INFO

Article history:
Available online 12 June 2011

Keywords:
Hepatocellular carcinoma
Transarterial chemoembolisation
Sorafenib

ABSTRACT

Background: In Japan and South Korea, transarterial chemoembolisation (TACE) is an important locoregional treatment for patients with unresectable hepatocellular carcinoma (HCC). Sorafenib, a multikinase inhibitor, has been shown effective and safe in patients with advanced HCC. This phase III trial assessed the efficacy and safety of sorafenib in Japanese and Korean patients with unresectable HCC who responded to TACE.

Methods: Patients ($n = 458$) with unresectable HCC, Child-Pugh class A cirrhosis and ⩾25% tumour necrosis/shrinkage 1–3 months after 1 or 2 TACE sessions were randomised 1:1 to

☆ Results from this trial were presented at the American Society of Clinical Oncology Gastrointestinal Cancers Symposium, Orlando, Florida, USA, 22–24 January 2010.

* *Corresponding author: Address:* Department of Gastroenterology and Hepatology, Kinki University School of Medicine, 377-2 Ohnohigashi, Osaka-Sayama 589-8511, Japan. Tel.: +81 72 366 0221; fax: +81 72 367 2880.
E-mail address: m-kudo@med.kindai.ac.jp (M. Kudo).

0959-8049/$ - see front matter
doi:10.1016/j.ejca.2011.05.007

Randomised
Controlled trial

sorafenib 400 mg bid or placebo and treated until progression/recurrence or unacceptable toxicity. Primary end-point was time to progression/recurrence (TTP). Secondary end-point was overall survival (OS).

Findings: Baseline characteristics in the two groups were similar; >50% of patients started sorafenib >9 weeks after TACE. Median TTP in the sorafenib and placebo groups was 5.4 and 3.7 months, respectively (hazard ratio (HR), 0.87; 95% confidence interval (CI), 0.70–1.09; $P = 0.252$). HR (sorafenib/placebo) for OS was 1.06 (95% CI, 0.69–1.64; $P = 0.790$). Median daily dose of sorafenib was 386 mg, with 73% of patients having dose reductions and 91% having dose interruptions. Median administration of sorafenib and placebo was 17.1 and 20.1 weeks, respectively. No unexpected adverse events were observed.

Interpretation: This trial, conducted prior to the reporting of registrational phase III trials, found that sorafenib did not significantly prolong TTP in patients who responded to TACE. This may have been due to delays in starting sorafenib after TACE and/or low daily sorafenib doses.

1. Introduction

Hepatocellular carcinoma (HCC) is the fifth most common cancer worldwide, the third most common cause of cancer deaths in men and the sixth most common in women.[1] It has been estimated that 650,000 people per year die from HCC, about three-quarters in East Asian countries.[2,3] Aetiologic factors vary by geographic region; ~70% of HCC patients in the Asia-Pacific (AP) region have chronic hepatitis B virus (HBV) infection, except in Japan, where ~75% of HCC patients have chronic hepatitis C virus (HCV) infection.[2,3]

Many patients with HCC are not diagnosed until the disease is unresectable, such that only non-curative treatment options are available.[4,5] The most frequent locoregional treatment for unresectable HCC is transarterial chemoembolisation (TACE), which concentrates chemotherapeutic agents at the tumour site while blocking the primary artery feeding the tumour.[6,7] Compared with symptomatic treatment alone, TACE has been found to enhance survival in patients with unresectable HCC.[8,9] A meta-analysis of seven randomised trials of arterial embolisation in 545 patients showed that chemoembolisation with cisplatin or doxorubicin showed a significant 2-year survival benefit compared with control, whereas embolisation alone showed no benefit.[10] A subsequent meta-analysis of randomised trials showed that TACE improves patient survival compared with untreated patients, but not when compared with patients treated with arterial embolisation alone.[11] Furthermore, no chemotherapeutic agent was found superior to any other, and there was no evidence that lipiodol had any benefit.[11]

Although TACE effectively delays HCC progression or prevents recurrence within 6 months, it is less effective over longer periods,[12] with 2-year survival rates of 24–63%.[13] Recent trials in Asian patients have found that 2-year overall survival (OS) rates following TACE with a suspension of a fine powder formulation of cisplatin in lipiodol, an emulsion of doxorubicin in lipiodol, and epirubicin-loaded superabsorbent polymer microspheres were 76%, 46% and 59%, respectively.[14,15] Although multiple courses of TACE may improve local tumour control,[11] it may also worsen liver function, both because TACE itself damages the hepatic arterial system[16] and because many patients have poor underlying liver function due to cirrhosis.[17] New and effective treatment strategies for patients with unresectable HCC are therefore needed, including the optimisation of TACE and its combination with other treatment modalities.

The high rate of HCC recurrence after TACE may be due to its enhancement of angiogenesis and upregulation of vascular endothelial growth factor (VEGF) expression, resulting in the formation of rich vascular beds in residual tumours.[18–20] Post-TACE treatment with systemic multikinase inhibitors that are both antiproliferative and antiangiogenic may therefore lengthen time to recurrence, improve survival, and target lesions distal to the TACE site.

Sorafenib is a multikinase inhibitor with antiangiogenic and antiproliferative properties, targeting multiple pathways.[21–23] Two large randomised phase III studies, the Sorafenib Health Assessment Randomised Protocol (SHARP)[24] and Sorafenib Asia-Pacific (AP)[25] trials, demonstrated that sorafenib significantly improves OS in patients with advanced HCC, leading to its approval for the treatment of HCC in more than 90 countries. To date, sorafenib remains the only available systemic therapy proven to extend survival in these patients.

In patients with unresectable HCC, sorafenib after TACE may prolong time to recurrence/progression and/or minimise loss of liver function associated with repeated courses of TACE. This double-blind, placebo-controlled, phase III trial, designed before the results of the SHARP and Sorafenib AP trials were reported, assessed the efficacy and safety of sorafenib in patients in Japan and South Korea with unresectable HCC who responded to TACE.

2. Patients and methods

We screened patients ⩾18 years of age with unresectable HCC and Child-Pugh A cirrhosis who sustained a response 1–3 months after TACE, defined using the then-prevailing criteria in Japan as ⩾25% tumour necrosis and/or shrinkage.[26,27] Additional inclusion criteria were life expectancy ⩾12 weeks; maximum target lesion size of 70 mm; ⩽10 target lesions; Eastern Cooperative Oncology Group (ECOG) performance status (PS) 0 or 1; and adequate bone marrow (absolute

neutrophil count $\geqslant 1000/mm^3$; platelet count $\geqslant 50 \times 10^9/L$; prothrombin time [PT] – international normalised ratio $\leqslant 2.3$ or PT $\leqslant 6$ s above control), liver (total bilirubin $\leqslant 3$ mg/dL; alanine aminotransferase and aspartate aminotransferase $\leqslant 5 \times$ upper limit of normal [ULN]), and renal (serum creatinine $\leqslant 1.5 \times$ ULN; amylase and lipase $\leqslant 2 \times$ ULN) function.

Patients were excluded if they had macroscopic vascular invasion, renal failure, history of cardiac disease, active clinically serious infection, history of human immunodeficiency virus infection, symptomatic metastatic brain or meningeal tumour, extrahepatic metastasis, seizure disorder requiring medication, prior use of systemic agents for advanced HCC (although prior use of interferon, retinoid and/or vitamin K_2 as adjuvant treatment after curative local treatment was allowed), use of hematopoietic growth factors within 3 weeks before start of study drug, concomitant treatment with cytokines after the last course of TACE, history of organ allograft, documented history of substance abuse, or were pregnant or breast-feeding.

All patients provided written informed consent. The study was approved by the appropriate ethics committees and institutional review boards at each centre, and complied with Good Clinical Practice Guidelines, the Declaration of Helsinki, and local laws and regulations. Ongoing safety and efficacy were assessed independently by the Data Monitoring Committee. This study was registered at Clinicaltrials.gov as trial number NCT00494299.

2.1. *Procedures*

TACE was performed by injecting gelatin foam plus lipiodol in all cases. The chemotherapeutic agents used concurrently were epirubicin, cisplatin, doxorubicin and mitomycin. Eligible patients were stratified by response to TACE (complete response [CR], defined as 100% tumour necrosis or shrinkage versus non-complete response [non-CR], defined as $\geqslant 25\%$ but <100% tumour necrosis or shrinkage),[26] by ECOG PS (0 versus 1), and by number of courses of TACE (one versus two). Patients were blindly randomised 1:1 to 400 mg (two 200-mg tablets) sorafenib (Bayer Schering Pharma; Leverkusen, Germany) or matching placebo twice daily.

Treatment interruptions and dose reductions (first 400 mg qd, then 400 mg qod) were allowed for drug-related toxicity. Patients were monitored for adverse events (AEs) using the National Cancer Institute Common Terminology Criteria for Adverse Events (NCI-CTCAE) version 3.0, except that the hand-foot skin reaction (HFSR) was classified and managed by a protocol-defined scale. Treatment continued until radiologic progression or recurrence of HCC, unacceptable toxicity associated with study drug, or withdrawal of consent.

The trial was divided into 28-day cycles. Patients were evaluated for safety and compliance every 2 weeks during cycles 1–3, and every 4 weeks thereafter. Tumours were evaluated, centrally at an image registration centre, $\leqslant 28$ days before the first dose of study drug and every 8 weeks thereafter, or when evaluating recurrence or progression. Throughout treatment, lesions were evaluated by dynamic computed tomography (CT), preferably by the same investigator or radiologist as at screening.

The primary study end-point was time to progression (TTP) by central review, defined as time to recurrence in patients with CR and TTP in those with non-CR at study entry. Progression was defined as a $\geqslant 25\%$ increase in tumour size or development of a new lesion. The secondary end-point was OS, defined as time from randomisation to death from any cause. Exploratory analyses included TTP by investigator assessment and subgroup analyses of TTP by central review, based on aetiology (HBV versus HCV), response to TACE (CR versus non-CR), number of lesions ($\leqslant 3$ versus >3), number of prior courses of TACE (1 versus 2), age (<65 versus $\geqslant 65$ years), sex, treatment lag ($\leqslant 9$ versus >9 weeks), country of enrolment (Japan versus South Korea), and ECOG PS (0 versus 1).

2.2. *Statistical analysis*

Patient sample size was estimated based on TTP. If 30% and 70% of patients achieved CR and non-CR, respectively, in response to TACE, the median TTP for the placebo group in the mixed population would be 5.7 months. Clinically meaningful improvement was defined as median TTP 50% higher in the sorafenib than in the placebo group. Assuming one formal interim and one final analysis performed using an O'Brien-Fleming-type alpha spending function with a two-sided alpha of 0.05, 318 events would be required to achieve a statistical power of 95%. Accrual of 372 patients (186 in each group) within 18 months would be expected to result in 318 events after 30 months; if 10% of patients were lost to follow-up, 414 patients would have to be randomised to observe 318 events.

Efficacy was assessed in the intention-to-treat (ITT) population, defined as all randomised patients. The safety population included all patients who received at least one dose of study medication. TTP and OS in the two treatment arms were calculated by the Kaplan–Meier method and compared by the log-rank test, as were subgroups stratified by response to TACE (CR versus non-CR), ECOG PS (0 versus 1) and number of prior courses of TACE (1 versus 2). Hazard ratios (HRs) for sorafenib versus placebo and 95% confidence intervals (CI) were estimated by Cox proportional hazards models.

2.3. *Role of the funding source*

The study sponsors were involved in the design of the study; the collection, analysis and interpretation of data; the writing of the report; and the decision to submit the paper for publication.

3. Results

3.1. *Patients*

From 27th April 2006 to 10th July 2009, 552 patients were screened at 69 centres in Japan and seven centres in South Korea. Of these, 458 patients (387 at 67 centres in Japan and 71 at six centres in South Korea) met the eligibility criteria and were randomised, 229 each to the sorafenib and placebo groups. All were included in the ITT analysis (Fig. 1), whereas

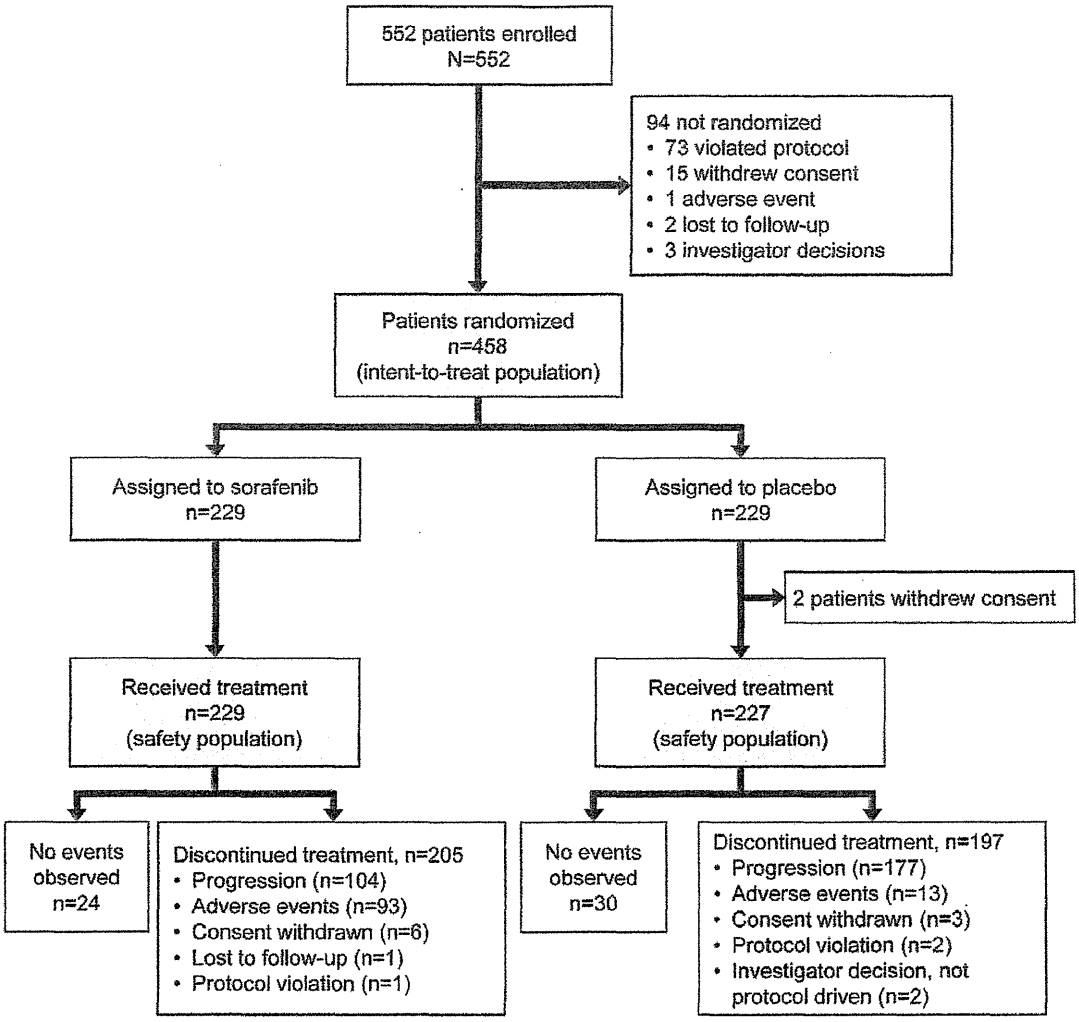


Fig. 1 – Enrolment and outcomes.

the 456 who received at least one dose of study drug were included in the safety analysis.

Demographic and baseline disease characteristics were similar in the sorafenib and placebo groups (Table 1). Of the 458 patients, 342 (74.7%) were male and 306 (66.8%) were ⩾65 years. Median age was 69 years (range, 29–86 years). At baseline, 403 patients (88.0%) had an ECOG PS of 0, 287 (62.7%) had HCV infection, and 336 (73.4%) had ⩽3 tumours. TACE consisted of gelatin foam plus lipiodol in all 458 patients, 60 for palliative intent and 398 for curative intent. Of these 458 patients, 355 received TACE monotherapy, including epirubicin ($n = 219$), cisplatin ($n = 89$), doxorubicin ($n = 49$) and mitomycin ($n = 1$); and 103 received combination treatments, including epirubicin + mitomycin ($n = 57$), cisplatin + epirubicin ($n = 16$), cisplatin + doxorubicin + mitomycin ($n = 13$), mitomycin + mitoxantrone ($n = 8$), doxorubicin + mitomycin ($n = 5$) and doxorubicin + iodixanol ($n = 4$). The median time from last TACE to randomisation was 9.3 weeks (range, 5.6–13.3 weeks), and the median time from initial diagnosis to study entry was 9.8 months (range, 1.6–144.3 months). Ten patients (2.2%) had received prior systemic anticancer therapy, consisting of prior adjuvant treatment with interferon, retinoid and/or vitamin K2 treatment after curative local treatment, and 219 (47.8%) had previously undergone some type of locoregional treatment, including radiofrequency ablation alone (10.7%), surgery alone (9.6%), percutaneous ethanol injection alone (5.9%), microwave coagulation therapy alone (0.2%) and other procedures (0.2%), with 21.2% having undergone multiple procedures (Table 1).

3.2. *Primary efficacy analysis*

By the cutoff date of 10th July 2009, 324 progression events (137 in the sorafenib and 187 in the placebo group) were confirmed by the Response Evaluation Committee. Median TTP by central review was 5.4 months (95% CI, 3.8–7.2 months) in the sorafenib group and 3.7 months (95% CI, 3.5–4.0 months) in the placebo group (HR [sorafenib/placebo], 0.87; 95% CI, 0.70–1.09; $P = 0.252$; Fig. 2). The 3-month progression-free rates in the sorafenib and placebo groups were 65.0% and 58.7%, respectively, and their 6-month progression-free rates were 45.7% and 33.5%, respectively.

Table 1 – Demographic and baseline characteristics of randomised patients (ITT population).

Variable	All patients			Japanese patients			Korean patients		
	Sorafenib + placebo ($n = 458$)	Sorafenib ($n = 229$)	Placebo ($n = 229$)	Sorafenib + placebo ($n = 387$)	Sorafenib ($n = 196$)	Placebo ($n = 191$)	Sorafenib + placebo ($n = 71$)	Sorafenib ($n = 33$)	Placebo ($n = 38$)
Median age (years)	69	69	70	71	70	71	60	61	59
Male (%)	74.7	76.0	73.4	72.9	74.0	71.7	84.5	87.9	81.6
ECOG PS[a] (%)									
0	88.0	87.8	88.2	91.5	91.3	91.6	69.0	66.7	71.1
1	12.0	12.2	11.8	8.5	8.7	8.4	31.0	33.3	28.9
Number of lesions (%)									
⩽3	73.4	72.9	73.8	70.8	69.9	71.7	87.3	90.9	84.2
>3	26.6	27.1	26.2	29.2	30.1	28.3	12.7	9.1	15.8
Aetiology (%)									
Alcohol	6.8	8.3	5.2	6.5	7.7	5.2	8.5	12.1	5.3
HBV	21.1	20.5	22.7	12.7	12.2	13.1	70.4	69.7	71.1
HCV	62.7	60.7	64.6	71.3	68.4	74.3	15.5	15.2	15.8
Other	5.9	7.0	4.8	7.0	8.2	5.8	0	0	0
Liver cirrhosis[b] (%)	68.3	69.4	67.2	66.7	67.3	66.0	77.5	81.8	73.7
Number of prior TACE[a] (%)									
1	64.4	64.2	64.6	66.7	66.3	67.0	52.1	51.5	52.6
2	35.6	35.8	35.4	33.3	33.7	33.0	47.9	48.5	47.4
Response to prior TACE[a,c] (%)									
CR	62.0	62.0	62.0	58.1	58.7	57.6	83.1	81.8	84.2
Non-CR	38.0	38.0	38.0	41.9	41.3	42.4	16.9	18.2	15.8
Prior local therapy (%)									
RFA	10.7	11.8	9.6	10.3	11.7	8.9	12.7	12.1	13.2
Surgery	9.6	7.0	12.2	10.3	8.2	12.6	5.6	0	10.5
PEI	5.9	4.8	7.0	6.5	5.1	7.9	2.8	3.0	2.6
MCT	0.2	0.4	0	0.3	0.5	0	0	0	0
Others	0.2	0.4	0	0	0	0	1.4	3.0	0
Multiple	21.2	20.5	21.8	24.0	23.0	25.1	5.6	6.1	5.3
Prior systemic therapy (%)	2.2	3.1	1.3	2.6	3.6	1.6	0	0	0

ITT = intention-to-treat; ECOG PS = Eastern Cooperative Oncology Group performance status; HBV = hepatitis B virus; HCV = hepatitis C virus; TACE = transarterial chemoembolisation; CR = complete response; non-CR = non-complete response; RFA = radiofrequency ablation; PEI = percutaneous ethanol injection; MCT = microwave coagulation therapy.

[a] Protocol-defined stratification factor.

[b] Clinically and/or histologically confirmed liver cirrhosis.

[c] Complete response was defined in the study protocol as 100% tumour shrinkage or necrosis.

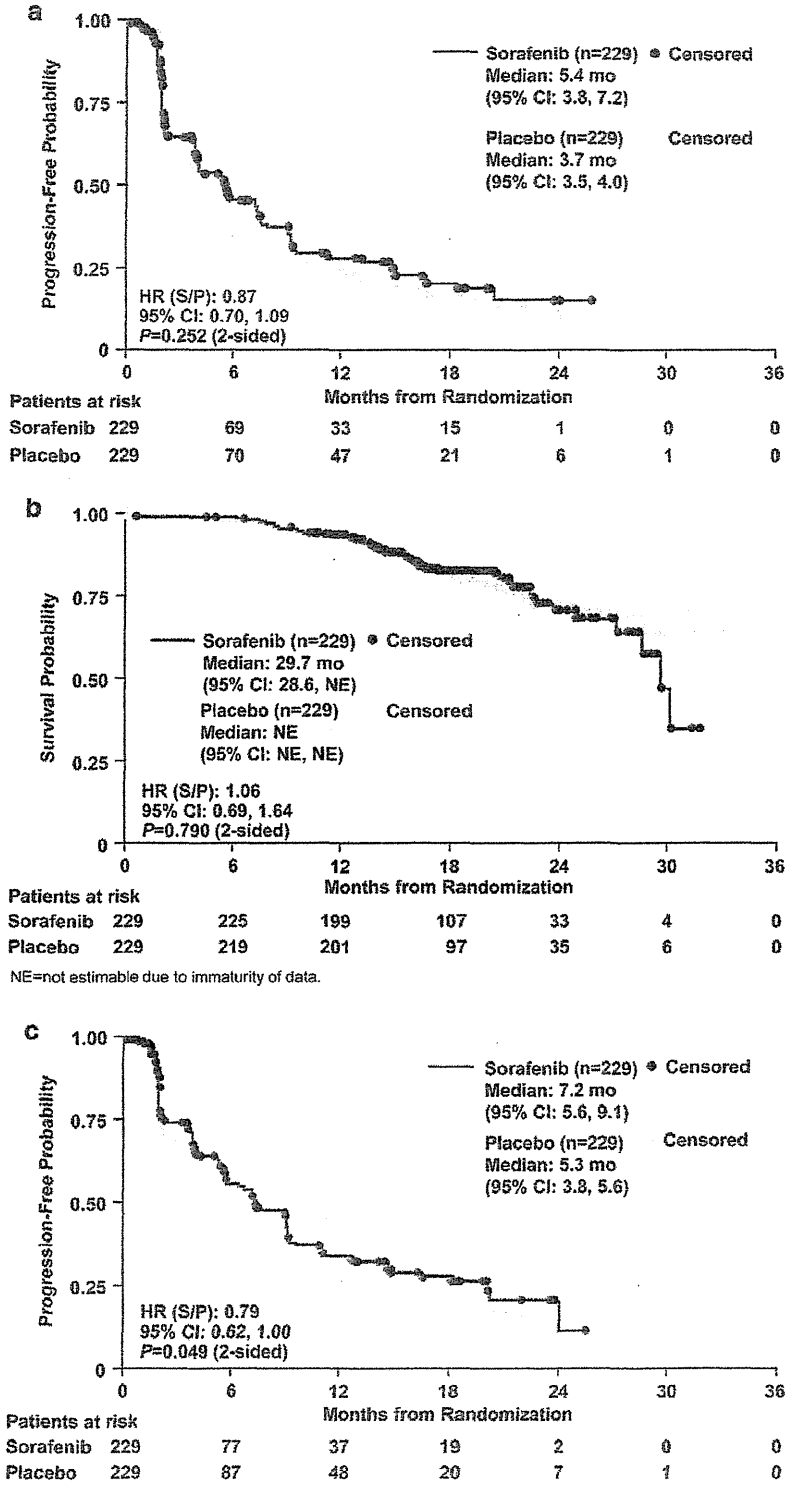


Fig. 2 – Kaplan–Meier analysis of time to progression (TTP) and overall survival (OS). (a) TTP by central review (primary intention-to-treat (ITT) analysis); (b) OS (secondary ITT analysis) and (c) TTP by investigator assessment (exploratory ITT analysis).

3.3. *Secondary efficacy analysis*

At the same cutoff date, there were 84 deaths, 43 in the sorafenib and 41 in the placebo group; the remaining patients were censored on that date. Median OS was 29.7 months in the sorafenib group (95% CI, 28.6 months – not yet reached) but had not yet been reached in the placebo group (HR [sorafenib/placebo], 1.06; 95% CI, 0.69–1.64; $P = 0.790$). The

Table 2 – Exploratory subgroup analyses of TTP by central review based on demographic, baseline and prognostic characteristics (ITT population; subgroups that included at least 10% of patients).

Variable	Subgroup	*n*	Number of events	Number of patients censored	Median TTP (95% confidence interval [CI]) (months)		Hazard ratio [HR] (95% CI) for Sorafenib/placebo
					Sorafenib	Placebo	
Aetiology	HBV	99	56	43	9.1 (5.6–20.3)	5.6 (3.7–10.9)	0.84 (0.49–1.44)
	HCV	287	217	70	5.3 (3.7–7.1)	3.6 (2.0–3.7)	0.81 (0.62–1.07)
Response to TACE	CR	284	179	105	7.4 (5.6–9.2)	5.3 (3.7–7.4)	0.84 (0.63–1.14)
	Non-CR	174	145	29	2.1 (1.8–3.9)	1.9 (1.8–3.6)	0.85 (0.61–1.18)
Number of lesions	⩽3	336	219	117	7.1 (5.3–7.8)	3.8 (3.7–5.5)	0.83 (0.64–1.09)
	>3	122	105	17	3.7 (2.0–5.3)	2.0 (1.9–3.7)	0.87 (0.59–1.29)
Number of prior TACE	1	295	212	83	5.4 (3.8–7.4)	3.7 (3.5–5.5)	0.91 (0.70–1.20)
	2	163	112	51	5.3 (3.7–7.8)	3.7 (2.1–3.8)	0.76 (0.52–1.11)
Age group	<65 years	152	90	62	9.1 (5.6–18.2)	3.7 (3.5–7.2)	0.68 (0.44–1.03)
	⩾65 years	306	234	72	3.8 (3.5–5.4)	3.7 (2.1–3.9)	0.99 (0.76–1.28)
Sex	Male	342	241	101	5.4 (3.8–7.4)	3.7 (3.5–5.3)	0.78 (0.60–1.00)
	Female	116	83	33	5.3 (3.6–7.4)	3.7 (2.1–5.3)	1.16 (0.75–1.79)
Treatment lag[a]	⩽9 weeks	205	150	55	5.5 (3.9–9.1)	3.7 (3.5–5.3)	0.74 (0.53–1.03)
	>9 weeks	253	174	79	5.1 (3.7–7.2)	3.7 (2.0–5.3)	0.95 (0.71–1.29)
Country of enrolment	Japan	387	289	98	3.9 (3.7–5.5)	3.7 (2.1–3.8)	0.94 (0.75–1.19)
	South Korea	71	35	36	NE[b] (9.0–NE)	5.5 (3.7–11.0)	0.38 (0.18–0.81)
ECOG PS	0	403	286	117	5.4 (3.8–7.2)	3.7 (3.6–5.3)	0.88 (0.69–1.11)
	1	55	38	17	5.4 (1.8–16.6)	3.5 (1.8–5.5)	0.78 (0.40–1.51)

[a] Treatment lag was defined as time from the most recent TACE to randomisation.
[b] NE = not estimable due to censored data.

1-year survival rates in the sorafenib and placebo groups were 94.6% and 94.1%, respectively, and their 2-year survival rates were 72.1% and 73.8%, respectively.

3.4. *Exploratory analyses*

At the cutoff date, investigators had reported 304 progression events, 120 in the sorafenib and 184 in the placebo group. Median TTP by investigator assessment in the sorafenib and placebo groups were 7.2 months (95% CI, 5.6–9.1 months) and 5.3 months (95% CI, 3.8–5.6 months), respectively (HR [sorafenib/placebo], 0.79; 95% CI, 0.62–1.00; $P = 0.049$). Their 3-month progression-free rates were 74.1% and 67.9%, respectively, and their 6-month progression-free rates were 54.9% and 41.4%, respectively.

Exploratory analyses of TTP by central review were performed in subgroups containing ⩾10% of patients, including by aetiology (HBV versus HCV), response to TACE (CR versus non-CR), number of lesions (⩽3 versus >3), number of prior courses of TACE (1 versus 2), age (<65 versus ⩾65 years), sex, treatment lag (⩽9 versus >9 weeks), ECOG PS (0 versus 1) and country of enrolment. These analyses were performed to provide descriptive information only; the study was not powered to compare subgroup response to treatment, and no adjustments were made for multiple comparisons. Median TTP and the HR for TTP (sorafenib/placebo) in each subgroup are shown in Table 2, and Forest plots of HRs for TTP are shown in Fig. 3. Most HRs favored sorafenib. Differences were observed, however, between Japanese and Korean patients. The HR for TTP was 0.94 (95% CI, 0.75–1.19) for Japanese patients and 0.38 (95% CI, 0.18–0.81) for Korean patients (Fig. 4). Median TTP in sorafenib-treated patients in the

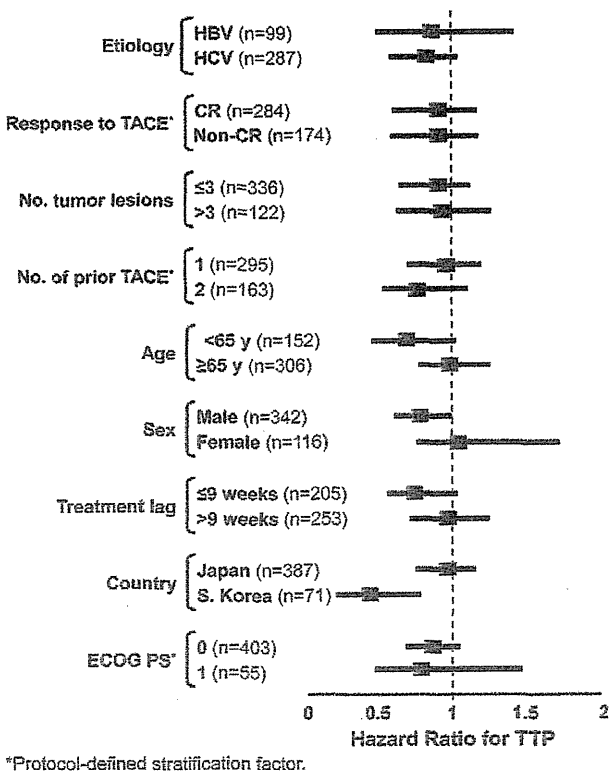


Fig. 3 – Subgroup analyses of TTP by central review (exploratory ITT analyses in subgroups that include at least 10% of patients): forest plot depicting hazard ratio (HR) for TTP (sorafenib over placebo) for each subgroup.

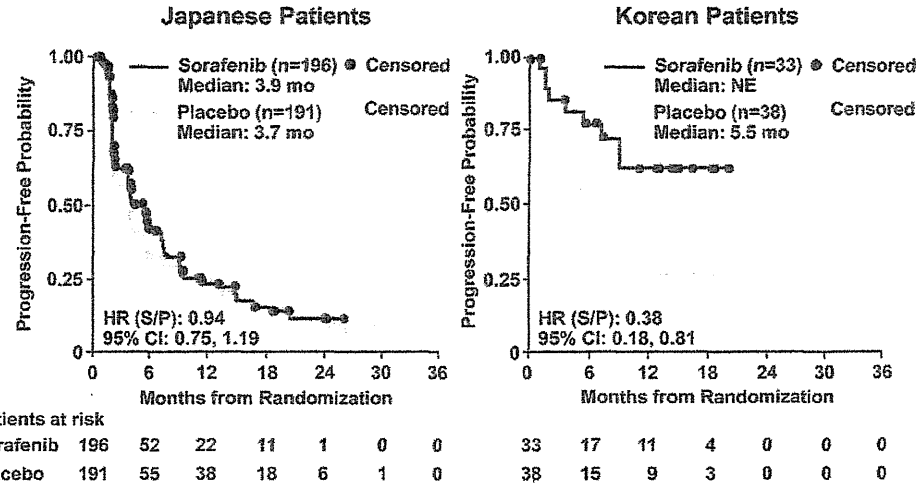


Fig. 4 – Kaplan–Meier analysis of TTP by central review, by country of enrolment (exploratory ITT analysis).

Korean subgroup could not be estimated since it was not attained by the study cutoff date.

3.5. *Safety*

The safety analysis included 229 sorafenib-treated and 227 placebo-treated patients; their incidence of drug-related AEs (DRAEs) were 100% and 61%, respectively. Most DRAEs were mild to moderate (Table 3), with the most frequent in the sorafenib and placebo groups being HFSR (82% versus 7%), elevated lipase (44% versus 8%), alopecia (41% versus 3%) and rash/desquamation (40% versus 11%). In the sorafenib group, 24% and 4% of patients experienced grades 3 and 4 elevated lipase, respectively, compared with 3% and <1%, respectively, in the placebo group. There was no radiographic or clinical evidence of pancreatitis in either group. The overall incidences of grade 3 HFSR (protocol-defined scale) in the sorafenib and placebo groups were 35% and 0%, respectively, and the overall incidence of serious DRAEs was 18% and 9%, respectively. There were no drug-related deaths.

The median durations of treatment in the sorafenib and placebo groups were 17.1 weeks (range, 1.0–112.1 weeks) and 20.1 weeks (range, 2.1–144.1 weeks), respectively (Table 4), and the median daily doses of sorafenib and placebo were 386.0 mg (range, 112.0–794.5 mg) and 785.8 mg (range, 276.1–810.3 mg), respectively. In the sorafenib group, 40 patients (17.5%) received >80% of the planned dose, compared with 206 (90.7%) in the placebo group. The most common reasons for discontinuing treatment in the sorafenib and placebo groups were disease progression (104/229 [45%] versus 177/229 [77%]) and adverse events (93/229 [41%] versus13/229 [6%]).

Doses were reduced in 166 of the 229 sorafenib-treated (72.5%) and in 33 of the 227 placebo-treated (14.5%) patients,

Table 3 – Treatment-emergent, drug-related adverse events occurring in ≥20% of patients in either group.[a]

Adverse event	Sorafenib (n = 229) Grade (%)			Placebo (n = 227) Grade (%)		
	Any	3	4	Any	3	4
HFSR	82	35	–	7	0	–
Elevated lipase[b]	44	24	4	8	3	<1
Alopecia	41	–	–	3	–	–
Rash/desquamation	40	4	0	11	0	0
Other metabolic abnormality	32	8	1	4	2	<1
Diarrhoea	31	6	0	5	1	0
Hypertension	31	15	0	7	1	0
Hypophosphatemia	28	16	0	6	3	0
Thrombocytopenia	25	11	1	2	<1	0
Elevated AST	25	12	<1	5	3	0
Elevated ALT	21	8	<1	5	2	0
Elevated amylase	21	6	1	8	2	<1

HFSR = hand–foot skin reaction; AST = aspartate aminotransferase; ALT = alanine aminotransferase; NCI-CTCAE = National Cancer Institute Common Terminology Criteria for Adverse Events.

[a] Patients were monitored for adverse events using NCI-CTCAE v3.0, except for HFSR, which was classified according to a 3-grade, protocol-defined scale (grade 1, HFSR does not disrupt normal activities; grade 2, HFSR affects the activities of the patient; and grade 3, patient is unable to work or perform activities of daily living because of HFSR).

[b] There was no radiographic or clinical evidence of pancreatitis in either arm.

Table 4 – Summary of study drug administration.

Assessment	All patients		Japan		South Korea	
	Sorafenib ($n = 229$)	Placebo ($n = 227$)	Sorafenib ($n = 196$)	Placebo ($n = 190$)	Sorafenib ($n = 33$)	Placebo ($n = 37$)
Median duration of treatment (weeks)	17	20	16	20	31	33
Median daily dose (mg)	386	786	382	786	403	766
Patients with dose reduction (%)	73	14	71	11	82	32
Patients with dose interruption (%)	91	18	92	17	85	24
Patients with discontinuation (%)	90	87	93	88	70	78
Due to progression (%)	51	90	52	90	39	90
Due to adverse events (%)	45	7	44	7	57	3
HFSR	11	0	10	0	18	0
Thrombocytopenia	4	0	5	0	3	0
Hypophosphatemia	4	<1	4	1	3	0
Hypertension	4	0	5	0	0	0
Neutropenia	4	<1	4	1	0	0
Elevated AST	2	<1	2	1	3	0
Rash/desquamation	2	0	2	0	3	0
Elevated ALT	2	1	1	1	6	0
Diarrhoea	1	0	1	0	3	0
Other	11	4	19	3	18	3

HFSR = hand–foot skin reaction; AST = aspartate aminotransferase; and ALT = alanine aminotransferase.

due primarily to AEs (163 versus 27). Forest doses were interrupted temporarily in 208 of the 229 sorafenib-treated (90.8%) and 41 of the 227 placebo-treated (18.1%) patients, again due primarily to AEs (206 versus 38).

A total of 107 patients – 94 of the 229 (41.0%) in the sorafenib group and 13 of the 227 (5.7%) in the placebo group – permanently discontinued study drug due to AEs. The most common AEs leading to discontinuation of sorafenib were HFSR (11.4%), thrombocytopenia (4.4%), hypertension (3.9%), hypophosphatemia (3.9%) and neutropenia (3.5%); the most common AE leading to discontinuation of placebo was increased ALT (0.9%).

Death within 30 days of receiving study drug occurred in one patient (0.4%) in each group; neither was deemed drug-related.

4. Discussion

This phase III randomised, controlled trial, assessing the efficacy and safety of sorafenib after response to TACE in Japanese and Korean patients with unresectable HCC, employed a protocol consistent with the practice of TACE in these countries at that time.[28,29] Moreover, the protocol was designed before the combination or sequential use of TACE and sorafenib or their optimal timing had been adequately studied, and before the effect of TACE on susceptibility to sorafenib had been characterised. In this setting, sorafenib did not significantly prolong TTP or OS by central review in patients with unresectable HCC who responded to TACE. Exploratory secondary and subgroup analyses suggested, however, that post-TACE sorafenib had a positive impact on these patients. Median TTP by investigator review was approximately 2 months longer in the sorafenib than in the placebo group, and exploratory subgroup analyses suggested that TTP may have been affected by several factors, including age, number of prior TACE courses, treatment lag, treatment duration, total exposed dose and nationality.

Several factors may have contributed to these results. For example, unusually high percentages of sorafenib-treated patients required dose reductions (73%) and/or interruptions (91%), resulting in a much lower than planned median daily dose of sorafenib (386 mg). In comparison, 26% and 44% of sorafenib-treated patients in the SHARP trial, and 31% and 43% of those in the Sorafenib AP trial, required dose reductions and interruptions, respectively, due to AEs,[24,25] and median daily doses of sorafenib were higher in the SHARP (797 mg) and Sorafenib AP (795 mg) trials.

The better outcomes observed in Korean patients may have been due to their substantially longer median treatment duration (31 versus 16 weeks), resulting in a favourable HR in Koreans (0.38; 95% CI, 0.18–0.81). Moreover, the Korean and Japanese subgroups differed in baseline characteristics. Japanese patients were older and a higher percentage had $\geqslant 3$ lesions on enrolment. Moreover, Japanese patients were less likely to have received >1 TACE to achieve CR prior to sorafenib. Finally, these subgroups differed in principal aetiology of HCC, in that ~70% of Japanese patients had HCV and ~70% of Korean patients had HBV.

We found that the incidence of treatment-emergent adverse events in the sorafenib-treated patients in this trial was generally higher than that observed in previous trials of sorafenib in patients with HCC. We found that the rates of all grade HFSR, Grade 3 HFSR and discontinuation due to HFSR were higher in this trial than in the SHARP[24] and Sorafenib AP[25] trials. We also found that the rates of all grade alopecia; rash/desquamation; hypertension, including grade 3 hypertension; thrombocytopenia and elevated liver function enzymes were higher in this trial than in the two previous phase III trials of sorafenib in patients with HCC. These results were unexpected and may have been due to the combination of TACE with sorafenib treatment in this trial. These findings suggest that adjustments in sorafenib dose (e.g. starting at a lower dose after TACE) or the timing of sorafenib treatment with respect to TACE may be required for these two

modalities to be tolerated in combination and also have synergistic effects.

The timing of post-TACE sorafenib may also have contributed to the absence of a positive effect of sorafenib observed in this study. Local hypoxia resulting from TACE can induce angiogenesis[18] and enhance serum concentrations of VEGF,[19,20] suggesting that sorafenib may exert its greatest antiangiogenic effects when administered immediately after or even before TACE. Serum VEGF concentrations have also been found to correlate with impaired liver function, tumour size, tumour number, macroscopic vascular invasion,[30] and poor OS.[31] Of our sorafenib-treatment patients, 60% had a treatment lag >9 weeks prior to randomisation, due primarily to the need for central review of CT scans, and shorter lag time has been found associated with better outcomes.

Several ongoing phase II/III trials in patients with unresectable HCC may provide insight into the optimal combination treatment and the optimal timing of sorafenib relative to TACE. These include trials testing TACE with doxorubicin-eluting beads and sorafenib or placebo and alterations in timing of conventional TACE relative to sorafenib or placebo.[32–35]

5. Conclusion

Sorafenib did not significantly improve median TTP by central review in Japanese and Korean patients with unresectable HCC who responded to TACE, although exploratory analyses suggested that sorafenib may have clinical benefits in certain patient subsets, including males, patients <65 years of age, and those with a shorter treatment lag between TACE and sorafenib; and that longer treatment duration and greater total daily dose may be associated with clinical improvements. No new or unexpected AEs were observed. The results of these and other clinical investigations may help refine the use of sorafenib and TACE, and define their optimal combination, in patients with unresectable HCC.

Author contributions

Drs. Masatoshi Kudo and Kiwamu Okita were involved with the study concept and design; acquisition of data; analysis and interpretation of data; drafting of the manuscript; critical revision of the manuscript for important intellectual content; statistical analysis; and study supervision.

Drs. Kazuho Imanaka, Nobuyuki Chida, Kohei Nakachi, Won-Young Tak, Tadatoshi Takayama, Jung-Hwan Yoon, Takeshi Hori, Hiromitsu Kumada, Norio Hayashi, Shuichi Kaneko, Hirohito Tsubouchi, Dong Jin Suh, Junji Furuse, Takuji Okusaka, Katsuaki Tanaka and Osamu Matsui were involved with the acquisition of data; analysis and interpretation of data; drafting of the manuscript; critical revision of the manuscript for important intellectual content; statistical analysis; and study supervision.

Drs. Michihiko Wada, Iku Yamaguchi, Toshio Ohya and Gerold Meinhardt were involved with the study concept and design; analysis and interpretation of data; drafting of the manuscript; critical revision of the manuscript for important intellectual content; statistical analysis; administrative and technical support; and study supervision.

Clinical trials

Clinicaltrials.gov Identifier NCT00494299.

Conflict of interest statement

Masatoshi Kudo received advisory and speaker fees and research and travel grants from Bayer. Won-Young Tak received advisory and speaker fees from Bayer, Junji Furuse received advisory fees from Bayer, Takuji Okusaka received advisory and speaker fees, research and travel grants from Bayer. Osamu Matsui received consulting and advisory fees and research grants from Bayer. Michihiko Wada, Iku Yamaguchi, Toshio Ohya and Gerold Meinhardt are employees of Bayer. Kiwamu Okita received consulting fees from Bayer. All other authors declared no conflicts of interest.

Acknowledgements

This study was supported by Bayer HealthCare Pharmaceuticals and Onyx Pharmaceuticals. Editorial and writing support was provided by John D. Zoidis, MD, Bayer HealthCare Pharmaceuticals, Montville, New Jersey, USA.

REFERENCES

1. Kudo M. The 2008 Okuda lecture management of hepatocellular carcinoma: from surveillance to molecular targeted therapy. *J Gastroenterol Hepatol* 2010;**25**:439–52.
2. Yuen MF, Hou JL, Chutaputti A. Hepatocellular carcinoma in the Asia-Pacific region. *J Gastroenterol Hepatol* 2009;**24**:346–53.
3. Asia-Pacific working party on prevention of hepatocellular carcinoma. Prevention of hepatocellular carcinoma in the Asia-Pacific region: consensus statements. *J Gastroenterol Hepatol* 2010;**25**:657–63.
4. Llovet JM, Burroughs A, Bruix J. Hepatocellular carcinoma. *Lancet* 2003;**362**:1907–17.
5. Makuuchi M, Kokudo N. Clinical practice guidelines for hepatocellular carcinoma: the first evidence based guidelines from Japan. *World J Gastroenterol* 2006;**12**:828–9.
6. Bruix J, Sherman M. Management of hepatocellular carcinoma: an update. *Hepatology* 2011;**53**:1020–2.
7. Trevisani F, De Notariis S, Rossi C, Bernardi M. Randomized control trials on chemoembolization for hepatocellular carcinoma: is there room for new studies? *J Clin Gastroenterol* 2001;**32**:383–9.
8. Lo CM, Ngan H, Tso WK, et al. Randomized control trial of transarterial lipiodol chemoembolization for unresectable hepatocellular carcinoma. *Hepatology* 2002;**35**:1164–71.
9. Llovet JM, Real MI, Montaña X, et al. Arterial embolisation or chemoembolisation versus symptomatic treatment in patients with unresectable hepatocellular carcinoma: a randomised controlled trial. *Lancet* 2002;**359**:1734–9.
10. Llovet JM, Bruix J. Systematic review of randomized trials for unresectable hepatocellular carcinoma: chemoembolization improves survival. *Hepatology* 2003;**37**:429–42.
11. Marelli L, Stigliano R, Triantos C, et al. Transarterial therapy for hepatocellular carcinoma: which technique is more effective? A systematic review of cohort and randomized studies. *Cardiovasc Intervent Radiol* 2007;**30**:6–25.

12. Cheng H-Y, Wang X, Chen D, Xu A-M, Jia Y-C. The value and limitation of transcatheter arterial chemoembolization in preventing recurrence of resected hepatocellular carcinoma. *World J Gastroenterol* 2005;**11**:3644–6.
13. Llovet JM. Updated treatment approach to hepatocellular carcinoma. *J Gastroenterol* 2005;**40**:225–35.
14. Kasai K, Ushio A, Sawara K, et al. Transcatheter arterial embolizaiton with a fine-powder formulation of cisplatin for hepatocellular carcinoma. *World J Gastroenterol* 2010;**16**:3437–44.
15. Seki A, Hori S, Kobayashi K, Narumiya S. Transcatheter arterial embolization with epirubicin-loaded superabsorbent polymer microspheres for 135 hepatocellular carcinoma patients: single-center experience. *Cardiovasc Intervent* 2011;**34**:557–65.
16. Takayasu K, Arii S, Ikai I, et al. Prospective cohort study of transarterial chemoembolization for unresectable hepatocellular carcinoma in 8510 patients. *Gastroenterology* 2006;**131**:461–9.
17. Groupe d'Etude et de Traitement du Carcinome Hépatocellulaire. A comparison of lipiodol chemoembolization and conservative treatment for unresectable hepatocellular carcinoma. *N Engl J Med* 1995;**332**:1256–61.
18. Fernández M, Semela D, Bruix J, et al. Angiogenesis in liver disease. *J Hepatol* 2009;**50**:604–20.
19. Wang B, Xu H, Gao ZQ, et al. Increased expression of vascular endothelial growth factor in hepatocellular carcinoma after transcatheter arterial chemoembolization. *Acta Radiol* 2008;**49**:523–9.
20. Li X, Feng G-S, Zheng C-S, Zhuo C-K, Liu X. Expression of plasma vascular endothelial growth factor in patients with hepatocellular carcinoma and effect of transcatheter arterial chemoembolization therapy on plasma vascular endothelial growth factor level. *World J Gastroenterol* 2004;**10**:2878–82.
21. Wilhelm S, Chien DS. BAY 43-9006: preclinical data. *Curr Pharm Des* 2002;**8**:2255–7.
22. Wilhelm SM, Carter C, Tang L, et al. BAY 43-9006 exhibits broad spectrum oral antitumor activity and targets the RAF/MEK/ERK pathway and receptor tyrosine kinases involved in tumor progression and angiogenesis. *Cancer Res* 2004;**64**:7099–109.
23. Carlomagno F, Anaganti S, Guida T, et al. BAY 43-9006 inhibition of oncogenic RET mutants. *J Natl Cancer Inst* 2006;**98**:326–34.
24. Llovet JM, Ricci S, Mazzaferro V, et al. Sorafenib in advanced hepatocellular carcinoma. *N Engl J Med* 2008;**359**:378–90.
25. Cheng A-L, Kang Y-K, Chen Z, et al. Efficacy and safety of sorafenib in patients in the Asia-Pacific region with advanced hepatocellular carcinoma: a phase III randomised, double-blind, placebo-controlled trial. *Lancet Oncol* 2009;**10**:25–34.
26. Liver Cancer Study Group of Japan. Criteria for the evaluation of direct efficacy in treatment of liver cancer. *Kanzo* 2004;**45**:380–5.
27. Takayasu K, Arii S, Matsuo N, et al. Comparison of CT findings with resected specimens after chemoembolization with iodized oil for hepatocellular carcinoma. *AJR Am J Roentgenol* 2000;**175**:699–704.
28. Yamada R, Nakatsuka H, Nakamura K, et al. Hepatic artery embolization in 32 patients with unresectable hepatoma. *Osaka City Med J* 1980;**26**:81–96.
29. Yamada R, Sato M, Kawabata M, et al. Hepatic artery embolization in 120 patients with unresectable hepatoma. *Radiology* 1983;**148**:397–401.
30. Shim JH, Park J-W, Kim JH, et al. Association between increment of serum VEGF level and prognosis after transcatheter arterial chemoembolization in hepatocellular carcinoma patients. *Cancer Sci* 2008;**99**:2037–44.
31. Schoenleber SJ, Kurtz DM, Talwalkar JA, Roberts LR, Gores GJ. Prognostic role of vascular endothelial growth factor in hepatocellular carcinoma: systematic review and meta-analysis. *Br J Cancer* 2009;**100**:1385–92.
32. Lencioni R, Zou J, Leberre M, et al. Sorafenib (SOR) or placebo (PL) in combination with transarterial chemoembolization (TACE) for intermediate-stage hepatocellular carcinoma (SPACE). *J Clin Oncol* 2010;**28**(15 Suppl.) [Abstract TPS178].
33. Thomas MB, Jaffe D, Choti MM, et al. Hepatocellular carcinoma: consensus recommendations of the National Cancer Institute Clinical Trials Planning Meeting. *J Clin Oncol* 2010;**28**:3994–4005.
34. Park J-W, Kim HY, Shim JH, et al. Interim analysis of a phase II study of the combination of TACE and sorafenib for unresectable hepatocellular carcinoma in National Cancer Center Korea (COTSUN Korea Trial). In: Proceedings of the fourth annual conference of the International Liver Cancer Association (ILCA), Montreal, Quebéc, Canada; 10–12 September 2010. p. 26 [Abstract O-027].
35. US national institutes of health. Transcatheter arterial chemoembolization therapy in combination with sorafenib (TACTICS), NCT01217034. Available from: http://www.clinicaltrials.gov/ct2/show/NCT01217034?term=sorafenib±AND±tactics&rank=1 [accessed 07.12.10].

INTERNAL MEDICINE

ORIGINAL ARTICLE

The Development of Chronic Kidney Disease in Japanese Patients with Non-alcoholic Fatty Liver Disease

Yasuji Arase[1,2,4], Fumitaka Suzuki[1], Mariko Kobayashi[1], Yoshiyuki Suzuki[1], Yusuke Kawamura[1], Naoki Matsumoto[1], Norio Akuta[1], Masahiro Kobayashi[1], Hitomi Sezaki[1], Satoshi Saito[1], Tetsuya Hosaka[1], Kenji Ikeda[1], Hiromitsu Kumada[1], Yuki Ohmoto[2], Kazuhisa Amakawa[2], Hiroshi Tsuji[2], Shiun Dong Hsieh[2], Kazuhisa Kato[2], Maho Tanabe[2], Kyoko Ogawa[2], Shigeko Hara[3] and Tetsuro Kobayashi[4]

Abstract

Objective Chronic kidney disease (CKD) is present in patients with nonalcoholic fatty liver disease (NAFLD). The aim of this retrospective study was to assess the cumulative development incidence and predictive factors for new onset of CKD in Japanese patients with NAFLD.

Methods A total of 5,561 NAFLD patients without CKD were enrolled. CKD was defined as either an estimated glomerular filtration rate of <60 mL/min/1.73 m^2 or dipstick proteinuria ($\geq +1$). A blood sample and a urine sample were taken for routine analyses during follow-up. The mean observation period was 5.5 years. The primary goal is the new development of CKD. Independent factors associated with new development of CKD were analyzed by using the Kaplan-Meyer method and the Cox proportional hazards model.

Results Of 5.561 NAFLD patients, 263 patients developed CKD. The cumulative development rate of CKD was 3.1% at the 5th year and 12.2% at the 10th year. Multivariate Cox proportional hazards analysis showed that CKD development in patients with NAFLD occurred when patient had low level of GFR of 60-75 mL/min/1.73 m^2 [hazard ratio:2.75; 95% confidence interval (CI) =1.93-3.94; p<0.001], age of ≥50 years (hazard ratio: 2.67; 95% CI=2.06-3.46; p<0.001), diabetes (hazard ratio: 1.92; 95% CI=1.45-2.54; p<0.001), hypertension (hazard ratio: 1.69; 95% CI=1.25-2.29; p<0.001), and elevated serum gamma-glutamyltransferase of ≥109 IU/L(hazard ratio: 1.35; 95% CI=1.02-1.78; p=0.038).

Conclusion Our retrospective study indicates that the annual incidence of CKD in Japanese patients with NAFLD is about 1.2%. Five factors of low eGFR level, aging, type 2 diabetes, hypertension, and elevated gamma-glutamyltransferase, increases the risk of the development of CKD.

Key words: nonalcoholic fatty liver disease, chronic kidney disease, gamma-glutamyltransferase

(Intern Med 50: 1081-1087, 2011)
(DOI: 10.2169/internalmedicine.50.5043)

Introduction

Nonalcoholic fatty liver disease (NAFLD) is one of the more common causes of chronic liver disease in Western world (1-4) and in many Asian nations (5, 6). NAFLD is considered to be the liver component of metabolic syndrome (7-9). It is associated with obesity, dyslipidemia, pituitary dysfunction, hypertension, sleep apnea, and type 2 diabetes mellitus (T2DM) (10-16). Moreover, NAFLD often causes cardiovascular disease and stroke (17, 18). Thus, NAFLD is emerging as a new significant health problem in many countries.

On the other hand, there has been a recent dramatic in-

[1]Department of Hepatology and Okinaka Memorial Institute for Medical Research, Toranomon Hospital, Japan, [2]Department of Health Management Center, Toranomon Hospital, Japan, [3]Department of Nephrology, Toranomon Hospital, Japan and [4]Department of Third Internal Medicine (Metabolism), University of Yamanashi, Japan
Received for publication December 21, 2010; Accepted for publication February 1, 2011
Correspondence to Dr. Yasuji Arase, es9y-ars@asahi-net.or.jp