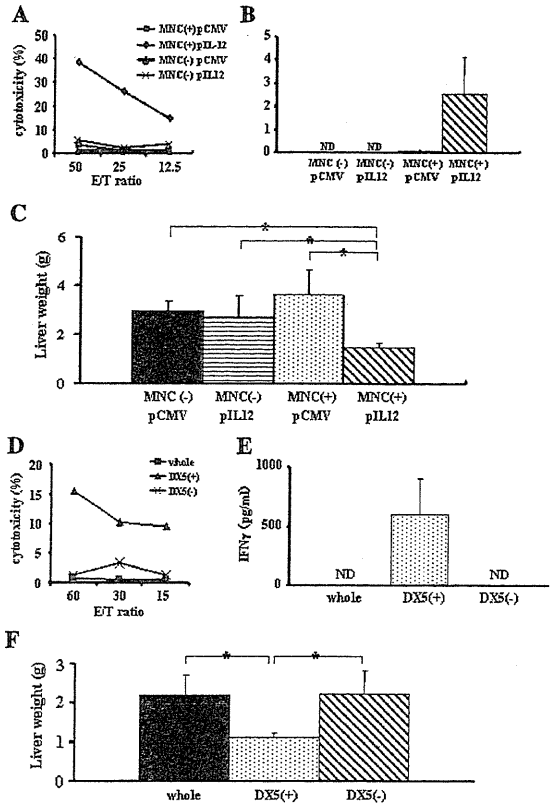

Fig. 5 Adoptive transfer of wild-type cells into GKO mice. Adoptive transfer of wild-type splenocytes restored anti-tumor effects of IL-12 in GKO mice. **a** GKO mice were intravenously injected with or without 2.0×10^8 splenocytes from wild-type mice and, 1 day later, hydrodynamically injected with either pCMV-IL-12 or pCMV. Mice were killed 4 days after plasmid injection. Yac1 lytic ability of hepatic mononuclear cells was expressed as the indicated effector and target ratios (E/T ratio). Experiments were done 3 times and representative data are shown. **b** and **c** GKO mice were intrasplenically injected with CT-26 cells and, 1 day later, intravenously injected with or without 2.0×10^8 splenocytes from wild-type mice. Two days after CT-26 injection, mice were hydrodynamically injected with either pCMV-IL-12 or pCMV. **b** The levels of serum IFNγ 4 days after plasmid injection are expressed as mean and SD (n = 6/group). **c** Fourteen days after plasmid injection, mice were killed to examine liver tumor development by measuring liver weight. The results are indicated as mean and SD (n = 6/group). *ND* not detectable. *$p < 0.01$. Adoptive transfer of wild-type NK cells, but not non-NK cells, restored anti-tumor effects of IL-12 in GKO mice. **d** Wild-type splenocytes were purified into $DX5^+$ cells and $DX5^-$ cells. GKO mice were intravenously injected with 4.0×10^6 whole mononuclear cells or $DX5^+$ cells or $DX5^-$ cells and, 1 day later, hydrodynamically injected with either pCMV-IL-12 or pCMV. Mice were killed 4 days after hydrodynamic injection. Yac1 lytic ability of hepatic mononuclear cells is expressed as the indicated effector and target ratios (E/T ratio). Experiments were done 3 times and representative data are shown. **e** and **f** GKO mice were intrasplenically injected with CT-26 cells and, 1 day later, intravenously injected with whole mononuclear cells, $DX5^+$ cells or $DX5^-$ cells (4.0×10^6/mouse). Two days after CT-26 injection, mice were hydrodynamically injected with either pCMV-IL-12 or pCMV. **e** The levels of serum IFNγ are expressed as mean and SD (n = 6/group). **f** Fourteen days after plasmid injection, mice were killed to examine liver tumor development by measuring liver weight. The results are expressed as mean and SD (n = 6/group). *ND* not detectable. *$p < 0.001$

serum levels of IP-10 and MIG, chemokines downstream of IFNγ, were measured after IL-12 therapy (Fig. 6e). pCMV-IL-12-injected mice showed significant increase in both levels compared with pCMV-injected mice. Significant increase after pCMV-IL-12 injection was also found in NK cell-depleted mice, but not in GKO mice. This result suggests that production of these chemokines was not completely suppressed in NK cell-depleted mice in our experimental condition. Immunohistochemical analysis revealed that tumoral accumulation of CD4-positive cells and CD8-positive cells was observed in pCMV-IL-12-injected mice but not in pCMV-injected mice. On the other hand, similar levels of CD31 expression were observed in tumors of pCMV-injected mice and pCMV-IL-12-injected mice (Fig. 6d). These results suggest that IL-12's anti-tumor effects might be mediated by T-cell accumulating in the tumor rather than anti-angiogenesis.

Discussion

IL-12 is recognized as a master regulator of adaptive type 1, cell-mediated immunity. One major action of IL-12 is its induction of other cytokines, particularly IFNγ. A large amount of evidence has indicated that IL-12 administration leads to IFNγ production from a variety of immune cells, such as T cells [16], B cells [17], NK cells [18] and NKT cells [22]. The relative impact of each immune cell as the source of IFNγ has been controversial. The present study highlighted NK cells as a most efficient producer of IFNγ that is critical for IL-12-induced anti-tumor effects.

Flow cytometric analysis revealed higher in vivo production of IFNγ of NK cells than that of other cell types. The levels of serum IFNγ were around fourfold higher in Rag2 KO mice which only possess NK cells than in wild-type mice. On the other hand, NK-cell depletion in wild-type mice led to twofold reduction of serum IFNγ levels. These data indicate substantial contribution of NK cells in IFNγ production in vivo. Previous research has demonstrated that the specific cellular effects of IL-12 are due mainly to activation of STAT4 [23, 24]. IL-12-induced STAT4 phosphorylation leads to the production of IFNγ [25]. In agreement with these reports, our in vitro analysis showed that, in contrast to STAT1, STAT4 was directly phosphorylated upon IL-12 stimulation, being independent of IFNγ. Of interest is the finding that NK cells express higher levels of STAT4 than non-NK cells, suggesting that NK cells possess an ideal expression profile of STATs for producing IFNγ upon IL-12 stimulation. Indeed, in vitro analysis revealed that NK cells, upon IL-12 exposure, displayed higher levels of IFNγ production as well as STAT4 phosphorylation than non-NK cells. These in vitro

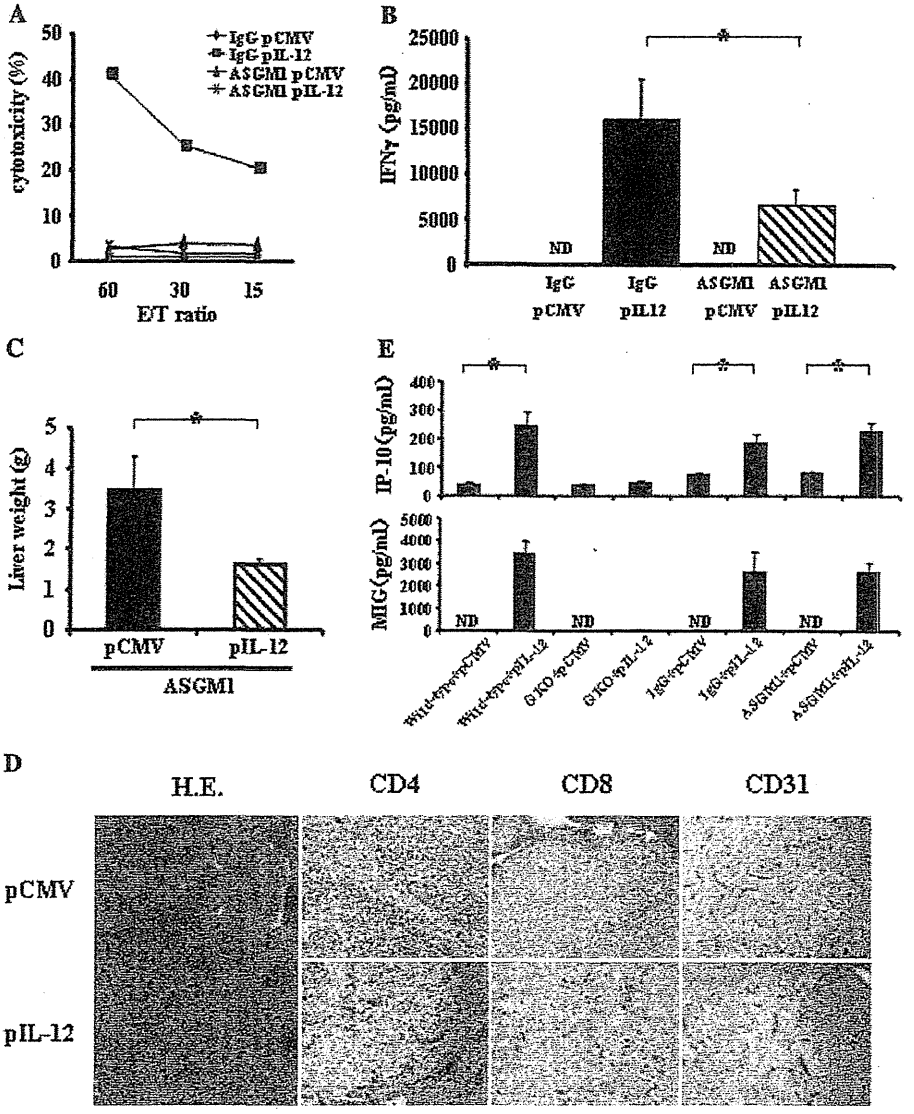

Fig. 6 Anti-tumor effects of IL-12 in NK-cell-depleted mice. Serum IFNγ levels and NK-cell activation. Wild-type mice were intraperitoneally injected with either anti-asialoGM1 antibody (ASGM1) or control IgG, and, 1 day later hydrodynamically injected with either pCMV-IL-12 or pCMV. Mice were killed 4 days after plasmid injection. **a** Yac1 lytic ability of hepatic mononuclear cells is expressed as the indicated effector and target ratios (E/T ratio). Experiments were done 2 times and representative data are shown. **b** The levels of serum IFNγ are expressed as mean and SD ($n = 6$/group). *ND* not detectable. *$p < 0.005$. Anti-metastatic effects. Wild-type mice were intrasplenically injected with CT-26 cells and, 1 day later and then every 5 days, intraperitoneally injected with either anti-asialoGM1 antibody (ASGM1) or control IgG, and hydrodynamically injected with either pCMV-IL-12 or pCMV 2 days after CT-26 injection. Fourteen days after plasmid injection, mice were killed to examine liver tumor development by measuring liver weight. **c** The results are indicated as mean and SD ($n = 6$/group). *$p < 0.001$. **d** Representative histology of liver sections analyzed by hematoxylin-eosin staining and immunohistochemistry of CD4, CD8 and CD31. **e** Serum levels of IP-10 and MIG. Wild-type or GKO mice were hydrodynamically injected with either pCMV-IL-12 or pCMV. Wild-type mice were intraperitoneally injected with either anti-asialoGM1 antibody (ASGM1) or control IgG, and 1 day later hydrodynamically injected with either pCMV-IL-12 or pCMV. Four days later, each mice were bled to measure the levels of serum IP-10 and MIG. Results are expressed as mean and SD ($n = 6$/group). *ND* not detectable. *$p < 0.001$

data are consistent with the in vivo observation that NK cells are efficient producers of IFNγ during IL-12 therapy.

Many studies have demonstrated that IFNγ production is required for the anti-tumor effects of IL-12 [14, 26, 27]. In fact, we have demonstrated that deletion of IFNγ abolished NK cytotoxicity and the anti-metastatic effect of IL-12 therapy in the liver. A large amount of evidence supports the concept that a major action of IL-12 is to promote the differentiation of naïve CD4 + T cells into Th1 cells, which produce IFNγ. Previous research reported that CD4

T-cell depletion caused inhibition of anti-tumor effects. More recent studies have supported a critical role of IFNγ as a third signal for CD8 T-cell differentiation. There have been many reports focusing on IFNγ production from T cells induced by IL-12 for the anti-tumor effect of IL-12 [28]. Segal et al. performed an elegant study showing a critical role of T-cell production of IFNγ in the anti-tumor effect by adoptively transferring T cells into GKO mice in a subcutaneous tumor model [29]. However, apart from this study, little is known about the contribution of each immune cell as a producer of IFNγ in terms of an anti-tumor effect. In our model, T-cell mediated adaptive responses were not required for the anti-metastatic effect of IL-12. More importantly, the anti-metastatic effects of IL-12 were restored in GKO mice by an adoptive transfer of wild-type NK cells. The same number of non-NK cells could not provoke IL-12-induced anti-tumor effects in GKO mice. The present study demonstrated for the first time a potent effect of NK cells on producing IFNγ that was critical for anti-metastatic effect during IL-12 therapy.

Our study showed that the main IFNγ producer of IL-12 was NK cells. So we focused on NK cells which were activated by IL-12 in an IFNγ-dependent manner to examine the cellular mechanism of protection against hepatic metastasis. Many studies have shown the importance of each subset (NK- [12], NKT- [10] and T [9, 30] cells) for anti-tumor effects of IL-12. In the present study, NK cells were sufficient while T cells, B cells, NKT cells were dispensable for IL-12-mediated NK-cell activation and anti-metastatic effects as IL-12 therapy showed Yac1 lytic ability and antimetastatic effects in Rag2 KO mice. On the other hand, NK-cell depletion by a repeated injection of anti-aialoGM1 antibody protected wild-type mice from macroscopic liver metastasis, but did not from microscopic liver metastasis. Thus, although NK cells were required for a full-blown IL-12 anti-tumor effect, other anti-tumor pathways are activated by IL-12 in the absence of NK cells. Serum levels of IP-10 and MIG suggest that production of these chemokines downstream of IFNγ was not suppressed in NK-cell-depleted mice in our experimental condition. When compared with the experiment on GKO mice, accumulation of CD4-positive cells and CD8-positive cells were more evident in NK-cell-depleted mice than in GKO mice (Supplementary Figure). On the other hand, there was no remarkable difference in the expression of CD31 between pCMV injection and pCMV-IL-12 injection. These results suggested that in NK-cell-depleted mice IL-12 may exert anti-tumor effect via T-cell accumulation rather than anti-angiogenesis.

Since the liver contains an abundance of immune cells (especially NK cells) [31], the cytokine-mediated activation of these cells may be a promising approach toward anti-tumor therapy in this organ [32]. IL-12 is a cytokine known to elicit a potent anti-tumor effect in mouse experimental models. However, clinical trials attempted to date were interrupted by fatal adverse effects. Systemic IL-12 therapy has been associated with dose-limiting toxicity [33]. IL-12 induces activation of the pro-inflammatory pathway which causes the complications of high dose cytokine, independent of the action of IFNγ [34]. On the other hand, the levels of immunosuppressive cytokine, for example, TGF-β1 or IL-10 were significantly higher in patients with hepatocellular cancer and colon cancer [35–38]. In particular, TGF-β1 in serum can limit NK-cell IFNγ production [39]. Thus, in patients with advanced disease, IL-12 may not be able to exert its potent anti-tumor immune-effects because IFNγ, which is an important mediator of the IL-12-induced immune response, is less effective in a tumor environment. In the present study, we demonstrated that NK-cell IFNγ production induced by IL-12 was sufficient for the anti-metastatic effect of IL-12 in the liver. Thus, a strategy of efficiently producing IFNγ from NK cells may be important for avoiding toxicity of IL-12 therapy.

IL-12 gene therapy has an advantage to allow local production of the cytokine at the tumor sites with low serum concentration. Studies demonstrated that intratumoral administration of adenovirus encoding IL-12 to animals with different types of carcinoma caused complete tumor eradication and increased long-term survival [40, 41]. Moreover, injection of IL-12-encoding adenovirus in one nodule of liver tumor resulted in regression of distant nodules in the liver [41]. However, in a clinical trial anti-tumor activity of IL-12-encoding adenovirus was only observed in the injected tumor sites, but not in distant tumors [42]. The present study shed light on hydrodynamic transfection of hepatocytes as a promising strategy to eradicate disseminated tumors from whole liver.

In summary, NK cells are not just an effector for innate immunity but a mediator producing IFNγ that is critical for the IL-12 anti-tumor effects. Extremely higher expression of STAT4 may be a basis for efficient production of IFNγ from NK cells.

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Factors affecting efficacy in patients with genotype 2 chronic hepatitis C treated by pegylated interferon alpha-2b and ribavirin: reducing drug doses has no impact on rapid and sustained virological responses

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SUMMARY. Reducing the dose of drug affects treatment efficacy in pegylated interferon (Peg-IFN) and ribavirin combination therapy for patients with hepatitis C virus (HCV) genotype 1. The aim of this study was to investigate the impact of drug exposure, as well as the baseline factors and the virological response on the treatment efficacy for genotype 2 patients. Two-hundred and fifty patients with genotype 2 HCV who were to undergo combination therapy for 24 weeks were included in the study, and 213 completed the treatment. Significantly more patients who achieved a rapid virological response (RVR), defined as HCV RNA negativity at week 4, achieved a sustained virological response (SVR) (92%, 122/133) compared with patients who failed to achieve RVR (48%, 38/80) ($P < 0.0001$). Multivariate logistic-regression analysis showed that only platelet counts [odds ratio (OR), 1.68; confidence interval (CI), 1.002–1.139] and RVR (OR, 11.251; CI, 5.184–24.419) were independently associated with SVR, with no correlation being found for the mean dose of Peg-IFN and ribavirin for RVR and SVR. Furthermore, in the stratification analysis of the timing of viral clearance, neither mean dose of Peg-IFN ($P = 0.795$) nor ribavirin ($P = 0.649$) affected SVR in each group. Among the patients with RVR, the lowest dose group of Peg-IFN (0.77 ± 0.10 μg/kg/week) and ribavirin (6.9 ± 0.90 mg/kg/day) showed 100% and 94% of SVR. Hence, RVR served as an important treatment predictor, and drug exposure had no impact on both SVR and RVR in combination therapy for genotype 2 patients.

Keywords: chronic hepatitis C, drug exposure, genotype 2, peginterferon and ribavirin combination therapy.

INTRODUCTION

The current standard of care for chronic hepatitis C (CHC) patients consists of combination therapy using pegylated interferon (Peg-IFN) and ribavirin [1–3]. Large, randomized clinical trials have demonstrated that 42–52% of hepatitis C virus (HCV) genotype 1 'difficult-to-treat' patients achieved sustained virological response (SVR), whereas 76–84% of HCV genotype 2 or 3 infected patients treated with Peg-IFN and ribavirin achieved SVR [4–6]. It also has been shown that in HCV genotype 2 and 3 infected patients, 24-week treatment regimens are just as effective as 48-week regimens [6,7]. Therefore, current guidelines recommend a 24-week treatment for these patients in contrast to 48 weeks for genotype 1 patients [1–3]. However, as side effects are common and treatment is expensive for this therapy, it would be ideal to be able to further reduce the total amount of drug medication

Abbreviations: ALT, alanine aminotransferase; BMI, body mass index; CHC, chronic hepatitis C; c-EVR, complete early virological response; ETR, end of treatment response; γ-GTP, γ-glutamyl transpeptidase; HCV, hepatitis C virus; IFN, interferon; NPV, negative predictive value; Peg-IFN, pegylated interferon; RVR, rapid virological response; SVR, sustained virological response.

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without loss of treatment efficacy for genotype 2 and 3 patients.

In HCV genotype 1 patients, reducing drug doses affects treatment efficacy. In our investigation of HCV genotype 1 patients, the rate of complete early virological response (c-EVR), defined as HCV RNA negativity at week 12, was affected by the mean dose of Peg-IFN during the first 12 weeks dose-dependently ($P < 0.0001$) [8]. Furthermore, we showed that only 4% relapse was found in patients given ≥12 mg/kg/day of ribavirin among those with c-EVR, and the relapse rate showed a decline in relation to the increase in the dose of ribavirin ($P = 0.0002$) [9]. On the contrary, it remains to be determined whether treatment efficacy can be preserved by further reducing both drug doses in genotype 2 and 3 patients. Because lower doses are expected to cause fewer adverse effects, it is important to find whether reduced drug doses can be used while retaining efficacy.

In the present study, we retrospectively evaluated the efficacy of Peg-IFN alpha-2b and ribavirin combination therapy for 24 weeks in patients infected with HCV genotype 2 and analysed the factors that affected the treatment efficacy, with particular interests in the drug impact of Peg-IFN and ribavirin.

PATIENTS AND METHODS

Patient selection and study design

Patients considered to be eligible for this study were those infected with HCV genotype 2 who underwent Peg-IFN alpha-2b (Schering-Plough K.K., Tokyo, Japan) and ribavirin (Schering-Plough K.K.) combination therapy from December 2005 to July 2007 at 29 medical institutions taking part in the Osaka Liver Forum and had completed the 24-week observation after a clinical course of 24 weeks. Patients with the following criteria were excluded: hepatitis B virus or human immunodeficiency virus coinfection, decompensated liver disease, severe cardiac, renal, haematological or chronic pulmonary disease, poorly controlled psychiatric disease, poorly controlled diabetes and immunologically mediated disease. Liver biopsy had been performed within 24 months prior to the treatment, and histological results were classified according to the METAVIR scoring system [10].

Written informed consent was obtained from each patient, and the study protocol was reviewed and approved according to the ethical guidelines of the 1975 Declaration of Helsinki by institutional review boards at the respective sites.

Patients were treated with Peg-IFN alpha-2b plus ribavirin for the duration of the study of 24 weeks. Peg-IFN alpha-2b and ribavirin dosages were based on body weight according to the manufacturer's instructions: Peg-IFN alpha-2b was given subcutaneously weekly (45 kg or less, 60 μg/dose; 46–60 kg, 80 μg/dose; 61–75 kg, 100 μg/dose; 76–90 kg, 120 μg/dose; 91 kg or more, 150 μg/dose), and ribavirin was given orally daily (60 kg or less, 600 mg/day; 61–80 kg, 800 mg/day; 81 kg or more, 1000 mg/day). The drug doses were also modified based on the manufacturer's instructions according to the intensity of the haematologic adverse effects.

Virological tests

Serum HCV RNA level was quantified by PCR assay (COBAS Amplicor HCV Test v2.0, Chugai-Roche Diagnostics, Tokyo, Japan), with a sensitivity limit of 5000 IU/mL and a dynamic range from 5000 to 5 000 000 IU/mL [11].

Serum HCV RNA was assessed by qualitative PCR assay (COBAS Amplicor HCV Monitor Test v2.0, Chugai-Roche Diagnostics), with a detection limit of 50 IU/mL [12].

Assessment of efficacy

Serum HCV RNA (qualitatively or quantitatively) was measured at weeks 4, 8, 12 and 24 during treatment and after 24 weeks of follow-up without treatment. Patients were classified as having a rapid virological response (RVR) if serum HCV RNA was undetectable (<50 IU/mL) at week 4 and at the end of treatment response (ETR) at week 24 of treatment. SVR was defined as undetectable HCV RNA at week 24 after treatment. Patients with an ETR who seroreverted to HCV RNA during follow-up were classified as relapsers.

Drug exposure

The amounts of Peg-IFN alpha-2b and ribavirin actually taken by each patient during the treatment period were evaluated by reviewing the medical records. The mean doses of both drugs were calculated individually as averages on the basis of body weight at baseline; Peg-IFN alpha-2b expressed as μg/kg/week and ribavirin as mg/kg/day.

Data collection

The medical records were retrospectively reviewed and the factors necessary for this examination were extracted: age, sex, body weight, body mass index (BMI), basic laboratory assessments, liver histology, quantitative and qualitative HCV RNA, dose of Peg-IFN alpha-2b and ribavirin received at each administration, and the response to treatment.

Statistical analysis

This study was a retrospective study and, for treatment results and the analysis of related factors, analysis was carried out only for cases in which the treatment had been completed (per-protocol analysis). Continuous variables are reported as the mean with standard deviation (SD) or

median level, while categorical variables are shown as the count and proportion. In univariate analysis, the Mann–Whitney *U*-test was used to analyse continuous variables, while chi-squared and Fisher's exact tests were used for analysis of categorical data. Variables with $P < 0.05$ at univariate analysis were retained for the multivariate logistic-regression analysis. Stepwise and multivariate logistic-regression models were used to explore the independent factors that could be used to predict a virological response. The significance of trends in values was determined with the Mantel–Haenszel chi-square test. For all tests, two-sided *P*-values were calculated and the results were considered statistically significant if $P < 0.05$. Statistical analysis was performed using the SPSS program for Windows, version 15.0J (SPSS, Chicago, IL, USA).

RESULTS

The baseline characteristics for the total cohort are shown in Table 1. Most of the patients were female (56%) with a mean age of 54 years. Seventy per cent of the patients were treatment naïve. Of the 250 patients, liver biopsies were performed for 174 patients, and 18 of them had advanced fibrosis (F 3–4).

Of the total of 250 patients, 37 (15%) were withdrawn from treatment because of adverse events: decreased haemoglobin ($n = 10$), psychiatric problems including depression ($n = 9$), fatigue ($n = 3$), thrombocytopenia, neutropenia, pyrexia, rash, cerebral haemorrhage, bleeding of ocular fundus, dyspnea, dizziness, jaundice, transaminase rise, gastrointestinal symptoms ($n = 1$) and other adverse events ($n = 4$). Eight of these patients who discontinued treatment prematurely had SVR (8/37; 22%).

Drug adherence

Seventy-nine of the 213 patients (37%) required dose reduction of Peg-IFN alpha-2b, 99 (46%) of ribavirin because of adverse events (not including patients who later discontinued treatment because of adverse event). Neutropenia (24/79; 30%) and thrombocytopenia (24/79; 30%) were the most common adverse events for dose reduction of Peg-IFN alpha-2b, and decreased haemoglobin (82/99; 83%) for that of ribavirin.

Virological response

Of the 213 patients who completed 24 weeks of treatment and 24 weeks of follow-up, 160 (75%) patients were clear of HCV RNA at week 4, 191 (90%) at week 8, 196 (92%) at week 12. ETR was observed for 195 (92%), and SVR for 160 (75%). The relapse rate was 18% (35/195).

Virological response according to the timing of viral clearance

Positive and negative prediction of sustained virological response according to the timing of viral clearance

We examined SVR rates according to the timing of viral clearance for the case in which HCV RNA was cleared during the treatment (Fig. 1a). The SVR rate was 92% (122/133) for patients clear of HCV RNA until week 4, 64% (37/58) from week 5 until week 8, 20% (1/5) from week 9 until

Table 1 Baseline demographic and viral characteristics of patients

Number of cases	250	
Age (years)*	54.0 ± 12.4	(22–76)
Sex (male/female)	110/140	
Body weight (kg)*	60.3 ± 11.7	(39–99)
Body mass index (kg/m^2)*	23.1 ± 3.2	(16–35)
Past IFN therapy (naïve/experienced)†	175/70	
HCV RNA (KIU/mL)‡	1700	(4–5000 <)
Fibrosis (0/1/2/3/4)§	18/98/40/14/4	
Activity (0/1/2/3)§	15/81/70/8	
White blood cells ($/mm^3$)*	5210 ± 1,750	(2100–13 870)
Neutrophils ($/mm^3$)*	2700 ± 1,250	(590–9020)
Red blood cells ($\times 10^4/mm^3$)*	436 ± 48	(307–554)
Haemoglobin (g/dL)*	13.9 ± 1.4	(10–18)
Platelets ($\times 10^4/mm^3$)*	18.3 ± 6.4	(4–41)
ALT (IU/L)*	79 ± 77	(13–581)
γ-GTP (U/L)*	56 ± 65	(7–479)
Creatinine(mg/dL)*	0.7 ± 0.1	(0.4–1.1)

IFN, interferon; HCV, hepatitis C virus; ALT, alanine aminotransferase; γ-GTP, γ-glutamyl transpeptidase. *Values expressed as mean ± SD (range), †interferon treatment history was not known for five patients. ‡values expressed as median (range), §data for 76 patients are missing.

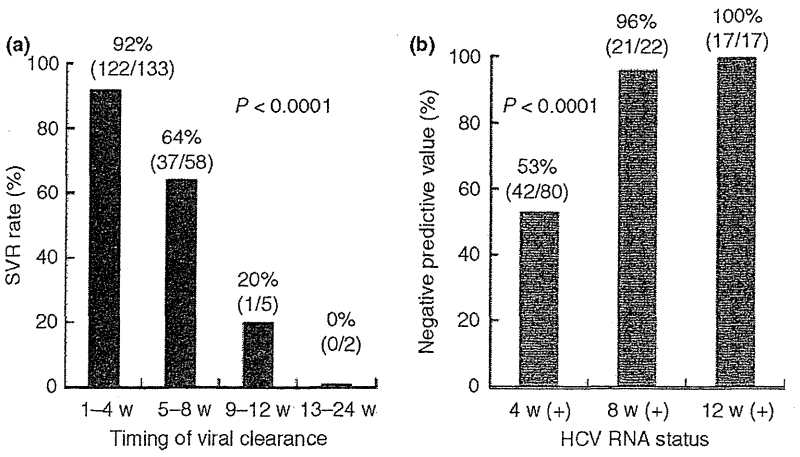

Fig. 1 (a) SVR rates according to timing of viral clearance. The number above each bar shows the percentage, and the numbers inside parentheses show the number of patients showing responses over the total number in the subgroup. The timing of viral clearance was time-dependently correlated with SVR ($P < 0.0001$). (b) Negative predictive values according to time of HCV RNA positivity. The number above each bar shows the percentage, and the numbers inside parentheses show the number of patients showing responses over the total number in the subgroup. The time of HCV RNA positivity was time-dependently correlated with NPV ($P < 0.0001$).

week 12 and 0% (0/2) from week 13 until week 24. The Mantel–Haenszel chi-square test showed that SVR rates were diminished with a delay in the timing of viral clearance becoming late ($P < 0.0001$). Significantly, more patients who attained RVR achieved final SVR (92%, 122/133) than patients who failed to attain RVR (48%, 38/80; $P < 0.0001$).

Next, we examined the negative predictive value (NPV) for the proportion of patients with treatment failure among those with HCV RNA persistence at week 4, 8 and 12 (Fig. 1b). NPV was 53% at week 4, 96% at week 8 and 100% at week 12. Only one of the 22 patients with positive HCV RNA at week 8 reached SVR.

Predictors of sustained virological response

Both pretreatment and treatment factors that could be associated with the response to Peg-IFN and ribavirin combination therapy were compared between patients with and without SVR in Table 2. This univariate analysis showed that age ($P = 0.029$), baseline HCV RNA level ($P = 0.033$), past IFN treatment history ($P = 0.028$), platelets counts ($P = 0.020$) and having RVR ($P < 0.0001$) contributed to achievement of SVR. Factors that were significantly associated with SVR by univariate analysis were then analysed by multivariate logistic regression analysis. SVR was attained independent of high platelet counts [odds ratio (OR) 1.070, 95% confidence interval (CI) 1.003–1.140, $P = 0.040$] and having RVR (OR 11.526, 95% CI 5.317–24.984, $P < 0.0001$; Table 3). As for drug doses, the mean dose of Peg-IFN alpha-2b was 1.32 ± 0.27 μg/kg/week in patients with SVR and 1.27 ± 0.29 μg/kg/week in those without SVR ($P = 0.130$), while that of ribavirin was 10.2 ± 1.9 and 10.2 ± 2.0 mg/kg/day ($P = 0.949$), respectively. Thus, neither Peg-IFN nor ribavirin drug exposure during the full treatment period affected attainment of SVR.

Predictors of rapid virological response

To delineate features that might help identify patients most likely to reach RVR, we also analysed these factors because having RVR turned out to be one of the most powerful predictors of SVR attainment. By univariate and multivariate logistic-regression analyses. RVR was attained independent of younger age (OR 0.648, 95% CI 0.494–0.850, $P = 0.002$) and lower baseline HCV RNA level (OR 0.964, 95% CI 0.944–0.984, $P < 0.0001$; Tables 4 & 5). The mean dose of Peg-IFN alpha-2b during the first 4 weeks was 1.31 ± 0.27 μg/kg/week in patients with RVR and 1.31 ± 0.29 μg/kg/week in those without RVR ($P = 0.259$), that of ribavirin was 10.1 ± 1.8 mg/kg/day and 10.3 ± 2.1 mg/kg/day ($P = 0.637$), respectively. Thus, neither Peg-IFN nor ribavirin drug exposure during the first 4 weeks had an impact on attainment of RVR.

Virological response according to drug exposure and the timing of viral clearance

Impact of drug exposure on sustained virological response

To more closely evaluate the impact of drug exposure on virological response, we classified the average doses of both drugs into four categories (Peg-IFN alpha-2b: up to 0.9 μg/kg/week, from 0.9 to >1.2 μg/kg/week, from 1.2 to >1.5 μg/kg/week, from 1.5 μg/kg/week; ribavirin: up to

Table 2 Factors associated with SVR among patients who completed the treatment – univariate analysis

Factor	SVR (n = 160)	Non-SVR (n = 53)	P-value
Age (years)*	52.4 ± 12.6	56.9 ± 10.2	0.029
Sex (male/female)	66 / 94	26 / 27	0.202
Body weight (kg)*	59.5 ± 11.5	59.9 ± 12.5	0.896
Body mass index (kg/m^2)*	22.8 ± 3.1	22.8 ± 3.5	0.817
HCV RNA (KIU/mL)†	1170	1600	0.033
Past IFN therapy (naive/experienced)‡	116/41	31/22	0.028
Fibrosis (F 0–2/3–4)§	106/10	30/5	0.247
Activity (A 0–1/2–3)§	62/54	20/15	0.847
White blood cells (/mm^3)*	5260 ± 1680	4720 ± 1500	0.078
Neutrophils (/mm^3)*	2740 ± 1270	2420 ± 1020	0.186
Red blood cells (×10^4/mm^3)*	435 ± 44	437 ± 55	0.820
Haemoglobin (g/dL)*	13.9 ± 1.3	14.0 ± 1.5	0.441
Platelets (×10^4/mm^3)*	19.0 ± 6.0	16.5 ± 6.2	0.020
ALT (IU/L)*	86 ± 89	64 ± 45	0.514
γ-GTP (U/L)*	54 ± 67	58 ± 59	0.512
Creatinine (mg/dL)*	0.7 ± 0.1	0.7 ± 0.1	0.457
Mean Peg-IFN dose (μg/kg/week)*	1.32 ± 0.27	1.27 ± 0.29	0.130
Mean ribavirin dose (mg/kg/day)*	10.2 ± 1.9	10.2 ± 2.0	0.949
RVR (yes/no)	122/11	38/42	<0.0001

IFN, interferon; HCV, hepatitis C virus; ALT, alanine aminotransferase; γ-GTP, γ-glutamyl transpeptidase; CI, confidence interval. *Values expressed as mean ± sd. †values expressed as median. ‡interferon treatment history was not known for three patients. §data for 62 patients are missing.

Table 3 Factors associated with SVR among patients who completed the treatment – multivariate analysis

Factor	Category	Odds ratio	95% CI	P-value
Age (years)	By 10	–	–	NS
HCV RNA (KIU/mL)	By 100 KIU/mL	–	–	NS
Platelets (×10^4/mm^3)	By 1 × 10^4/mm^3	1.068	1.002–1.139	0.045
Past IFN therapy	Naïve/experienced	–	–	NS
RVR	Yes/no	11.251	5.184–24.419	<0.0001

IFN, interferon; HCV, hepatitis C virus; CI, confidence interval.

8 mg/kg/day, from 8 to >10 mg/kg/day, from 10 to >12 mg/kg/day, from 12 mg/kg/day). SVR rates relative to the mean drug doses during the full treatment period and the timing of HCV RNA clearance are shown in Table 6. As also shown in Fig. 1a, the respective rates for SVR according to the timing of viral clearance were 92% in patients clear of HCV RNA until week 4, 64% from week 5 until week 8 and 14% from week 9 until week 24. On the contrary, according to mean drug doses, the respective rates for SVR were 89% (24/27), 73% (11/15), 79% (85/107) and 82% (40/49) in patients who received Peg-IFN up to 0.9 μg/kg/week, from 0.9 to >1.2 μg/kg/week, from 1.2 to >1.5 μg/kg/week and from 1.5 μg/kg/week, respectively, and 80% (24/30), 80% (40/50), 82% (68/83) and 79% (27/34) in patients who received ribavirin up to 8 mg/kg/day, from 8 to >10 mg/kg/day, from 10 to >12 mg/kg/day and from 12 mg/kg/day, respectively. If the category of the timing of viral clearance was the same, the respective rates for SVR attainment according to the mean doses of both Peg-IFN and ribavirin were similar. Furthermore, multivariate analysis by the Mantel–Haenszel chi-square test showed that neither the mean dose of Peg-IFN (P = 0.795) nor ribavirin (P = 0.649) affected SVR rates after stratification of the timing of viral clearance. Among the patients with RVR, SVR rates were as high as 88–100% regardless of Peg-IFN alpha-2b medication, and the least medicated group (<0.9 μg/kg/week, the mean dose with SD was 0.77 ± 0.10 μg/kg/week, 0.50–0.89) showed 100% of SVR rate (19/19). Similarly, SVR rates were as high as 91–94% regardless of ribavirin medication among the patients with RVR, and 17 of 18 patients (94%) in the least medicated group (<8 mg/kg/day, the mean dose with SD was 6.9 ± 0.90 mg/kg/day, 5.0–7.9)

Table 4 Factors associated with RVR among patients who completed the treatment – univariate analysis

Factor	RVR (n = 133)	Non-RVR (n = 80)	P-value
Age (years)*	51.9 ± 12.3	56.3 ± 11.3	0.010
Sex (male/female)	60/73	32/48	0.279
Body weight (kg)*	60.2 ± 11.6	58.6 ± 11.9	0.276
Body mass index (kg/m^2)*	22.9 ± 3.2	22.6 ± 3.1	0.369
HCV RNA (KIU/mL)†	1050	1800	0.001
Past IFN therapy (naive/experienced)‡	97/34	50/29	0.068
Fibrosis (F 0–2/3–4)§	86/8	50/7	0.315
Activity (A 0–1/2–3)§	51/43	31/26	1.000
White blood cells (per mm^3)*	5300 ± 1760	4850 ± 1400	0.205
Neutrophils (per mm^3)*	2740 ± 1290	2530 ± 1090	0.340
Red blood cells (×10^4/mm^3)*	440 ± 45	432 ± 49	0.628
Haemoglobin (g/dL)*	13.9 ± 1.4	13.9 ± 1.4	0.975
Platelets (×10^4/mm^3)*	18.9 ± 6.1	17.5 ± 6.1	0.170
ALT (IU/L)*	87 ± 93	69 ± 52	0.630
γ-GTP (U/L)*	57 ± 71	53 ± 53	0.658
Creatinine (mg/dL)*	0.7 ± 0.1	0.7 ± 0.1	0.203
Mean Peg-IFN dose (μg/kg/week)*	1.31 ± 0.27	1.31 ± 0.29	0.259
Mean ribavirin dose (mg/kg/day)*	10.1 ± 1.8	10.3 ± 2.1	0.637

IFN, interferon; HCV, hepatitis C virus; ALT, alanine aminotransferase; γ-GTP, γ-glutamyl transpeptidase; CI, confidence interval. *Values expressed as mean ± SD, †values expressed as median, ‡interferon treatment history was not known for three patients, §data for 62 patients are missing.

Table 5 Factors associated with RVR among patients who completed the treatment – multivariate analysis

Factor	Category	Odds ratio	95% CI	P-value
Age (years)	By 10	0.648	0.494–0.850	0.002
HCV RNA (KIU/mL)	By 100 KIU/mL	0.964	0.944–0.984	<0.0001

HCV, hepatitis C virus; CI, confidence interval.

achieved SVR. In addition, we examined the drug impact on SVR in the patients with the least medication of both drugs (<0.9 μg/kg/week of Peg-IFN and <8 mg/kg/day of ribavirin). Nine patients were categorized into this group and six of these patients achieved SVR (67%); patients with RVR had a significantly higher SVR rate (100%, 5/5) than patients without RVR (25%, 1/4; P = 0.048). Thus, SVR attainment was dependent on time, not on drug dose.

DISCUSSION

In the present study, we found that having RVR and high platelet counts were statistically associated with reaching SVR according to multivariate analysis. The timing of viral clearance was closely related to the treatment effect in patients with genotype 2, similar to the case for those with genotype 1. Ninety-two per cent of SVR was observed for patients with RVR and, conversely, 96% of the patients with HCV RNA positivity at week 8 showed non-SVR. The predictability of SVR based on EVR, defined as a decline of at least 2-log from the baseline of the HCV RNA level at week 12, has been assessed, and genotype 1 patients who have failed to reach EVR are recommended to discontinue the treatment after 12 weeks, because the likelihood of SVR is 0–3% in the absence of EVR [5,13]. On the basis of our examination of patients with genotype 2, not EVR, but 8-week monitoring of the HCV RNA level can be used.

As a significant factor for SVR, not liver fibrosis, but the platelet count was selected. Everson *et al.* [14] reported that patients with low platelet counts (≤12.5 × 10^4/mm^3) achieved lower SVR rates than patients with normal platelet counts (>12.5 × 10^4/mm^3) even in the case of patients with the same category of liver fibrosis treated by Peg-IFN plus ribavirin combination therapy. Thus, independent of liver fibrosis, thrombocytopenia itself seems to participate in treatment failure, although the mechanism remains unknown.

Our study also demonstrated that younger age (OR 0.648, 95% CI 0.494–0.850, P = 0.002) and lower HCV RNA level (OR 0.964, 95% CI 0.944–0.984, P < 0.0001) were statistically associated with reaching an RVR. Zeuzem *et al.* [7] previously reported that pretreatment viral load was not

Table 6 SVR rates according to Peg-IFN alpha-2b and ribavirin exposure and the timing of viral clearance among patients with virological response during the treatment

Timing of viral clearance (week)	Peg-IFN dose (μg/kg/week)				Ribavirin dose (mg/kg/day)				Total
	<0.9	0.9–1.2	1.2–1.5	1.5≤	<8	8–10	10–12	12≤	
1–4	100% (19/19)	91% (10/11)	92% (65/71)	88% (28/32)	94% (17/18)	92% (33/36)	91% (51/56)	91% (20/22)	92% (122/133)
5–8	63% (5/8)	33% (1/3)	64% (19/30)	71% (12/17)	58% (7/12)	54% (7/13)	74% (17/23)	60% (6/10)	64% (37/58)
9–24	–	0% (0/1)	17% (1/6)	–	–	0% (0/1)	0% (0/4)	50% (1/2)	14% (1/7)
Total	89% (24/27)	73% (11/15)	79% (85/107)	82% (40/49)	80% (24/30)	80% (40/50)	82% (68/83)	79% (27/34)	81% (160/198)

*$P = 0.795$ for comparison of the four Peg-IFN groups after stratification of the timing of viral clearance. **$P = 0.649$ for comparison of the four ribavirin groups after stratification of the timing of viral clearance.

associated with reaching RVR in genotype 2 patients. In contrast, Dalgard *et al.* [15] reported that independent predictors of RVR in genotype 2 or 3 patients were male gender, younger age (≤40 years) and low viral load (≤400/KIU/mL). The influence of viral load on reaching RVR remains controversial in the Peg-IFN and ribavirin combination therapy in genotype 2 patients, but patients with lower viral load seem favoured to reach HCV RNA levels below the detection limit, that is, to attain RVR, if the virological response is the same.

Recently, because of substantial adverse effects and costs associated with this therapy, studies have been carried out to determine the possibility of further reducing the total amount of drug medication without compromising antiviral efficacy in HCV genotype 2 and 3 patients. There seem to be two ways to achieve. One is by shortening the treatment duration, and the other is by decreasing the doses of the treatment drugs. With respect to the former, several studies on genotype 2 patients have been reported. At first, some studies of small numbers of subjects demonstrated that cumulatively analysed genotype 2 and 3 patients had high SVR rates up to 12 to 16 weeks of therapy (82–94%), similar to patients subjected to 24-week therapy (76–95%) [16–19]. However, further prospective investigation of large numbers of subjects revealed that shortening the treatment duration was associated with an increase in the rate of relapse and that significantly higher relapse rates led to lower SVR rates (71–81.1%), even among those with RVR [15,20,21]. The latest study by Mangia *et al.* [22] showed that shortened therapy after RVR was acceptable only for patients who had no signs of advanced liver fibrosis and low BMI. Considering the results of these trials, shortened therapy is regarded as optional treatment for selected patients displaying favourable baseline characteristics. Therefore, shortening treatment duration from 24 weeks should not be generally recommended for patients who are infected genotype 2 or 3 and can tolerate 24-week Peg-IFN and ribavirin combination therapy.

Another attempt to improve the treatment tolerability for genotype 2 or 3 patients has focused on dose reduction of treatment drugs. Weiland *et al.* [23] examined low-dose Peg-IFN alpha-2a (135 μg weekly) with a weight-based standard-dose of ribavirin (11 mg/kg daily) for genotype 2 and 3 patients. They demonstrated that SVR rates of 86% were achieved, which is equal to those in previous representative randomized controlled studies of standard dose Peg-IFN therapy (76–84%) [4–6]. In contrast, Ferenci *et al.* [24] examined the efficacy of standard-dose Peg-IFN alpha-2a (180 μg weekly) with low-dose ribavirin (400 mg daily) in comparison with standard-dose Peg-IFN alpha-2a (180 μg weekly) and ribavirin (800 mg daily) for genotype 2 and 3 patients, and demonstrated that there was no difference between the two treatment groups with respect to SVR rates (64% with 400 mg/day compared with 69% with 800 mg/day) and relapse rates (20% with 400 mg/day compared

with 17% with 800 mg/day). These studies showed that either drug dose can be reduced for genotype 2 and 3 patients without compromising antiviral efficacy. In the present study, neither Peg-IFN nor ribavirin drug exposure participated in reaching RVR and SVR. In particular, more than 90% of patients having RVR achieved SVR regardless of the drug exposure level, as long as the mean Peg-IFN dose was over 0.5 μg/kg/week and ribavirin was over 5.0 mg/kg/day. The results of our study suggested that genotype 2 patients may receive reduced levels of both drug doses on the condition that they can complete the full 24-week course of combination therapy. Randomized, prospective trials that reduced both Peg-IFN and ribavirin should be conducted for CHC patients to clarify this.

In the present study, while the treatment outcome was independent of the individual ribavirin exposure in patients who had completed the 24-week treatment, the most common reason to withdraw the treatment was decreased haemoglobin because of ribavirin medication. Based on the results of randomized controlled trials [6], using a ribavirin dose of 800 mg/day is recommended for genotype 2/3 patients [1–3]. However, several studies have shown that some patients cannot tolerate even this suboptimal ribavirin dose. This is a serious problem for patients with the risk of anaemia, especially elderly patients. The ageing of patients is progressing around the world, requiring improvement in treatment tolerability. Recently, Andriulli *et al.* [25] examined the effect of ribavirin in a 12-week course of therapy on CHC genotype 2 patients with RVR in two groups, one continuing with ribavirin and the other receiving Peg-IFN alpha-2a alone after week 6. The relapse rates were higher (46% *vs* 17%; $P < 0.001$) and overall SVR rates were lower (54 *vs* 82%; $P < 0.001$) in patients who stopped receiving ribavirin at week 6. Thus, ribavirin medication throughout the treatment period is necessary to raise the SVR rate even in genotype 2 or 3 patients with RVR. In the present study, the ribavirin dose could be reduced without loss of efficacy for genotype 2 patients, as long as the patients were treated for 24 weeks. Therefore, in the patients with the risk of anaemia, it would be better to reduce the dose of ribavirin before anaemia arises rather than being forced to discontinue the combination therapy because of anaemia caused by ribavirin medication. We previously reported that in CHC patients treated by IFN or Peg-IFN in ribavirin combination therapy, a decline of haemoglobin concentration by 2 g/dL at the end of 2 weeks from the start of the treatment can be used to identify patients likely to develop severe anaemia [26,27]. This kind of predictive factor for the progression to severe anaemia can be of much help in reducing ribavirin with appropriate timing.

Our study has some limitations. First, it is a retrospective study, and we could not obtain complete information for all patients. However, this is the first study of Peg-IFN and ribavirin combination therapy in which the drug dose of Peg-IFN and ribavirin taken by each patient was assessed independently for HCV genotype 2 patients. Our results can be taken as an evidence offering suggestions for the treatment of CHC genotype 2 patients. Second, this cohort included patients with different histories of past IFN treatment. Patients who had failed to recover with previous IFN-based treatment were likely to experience treatment failure again [28]. Therefore, we examined the predictors of treatment response separately according to treatment history, and confirmed that in both naïve and treatment-experienced patients, the mean dose of Peg-IFN and ribavirin showed no correlation with SVR or RVR in both groups.

In conclusion, our study demonstrates that RVR is an important treatment predictor and more than 90% of patients having RVR achieve SVR with combination therapy of Peg-IFN and ribavirin for genotype 2 infected CHC patients regardless of the drug exposure. Further prospective, randomized studies are necessary to assess whether the standard or a reduced dose of each drug can produce equivalent outcomes.

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Reduced risk of hepatocellular carcinoma after interferon therapy in aged patients with chronic hepatitis C is limited to sustained virological responders

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SUMMARY. This study was undertaken to investigate the effect of interferon (IFN) monotherapy on the risk of hepatocellular carcinoma (HCC) in aged-patients with chronic hepatitis C. Seven hundred and twenty-five patients with histologically proven chronic hepatitis C were enrolled in this retrospective cohort study; 531 received IFN monotherapy for 6 months between 1992 and 1995, and 157 were collected as a historical control. The effect of IFN therapy on the development of HCC was compared between the patients with chronic hepatitis C under 60 years old (non-aged group, $n = 531$) and those 60 and over (aged group, $n = 194$). A stepwise Cox proportional-hazards regression analysis in the non-aged group revealed that IFN therapy (risk ratio 0.52, 95% CI 0.33–0.81, $P = 0.004$), older age ($P = 0.001$), and higher histological stage ($P < 0.001$) were independent factors associated with the development of HCC. In the aged-group, only higher histological stage ($P = 0.002$) and male gender ($P = 0.011$), but not IFN therapy (risk ratio 0.77, 95% CI 0.42–1.40, $P = 0.386$), were identified as independent risk factors for HCC, although HCC was significantly reduced when sustained virological response (SVR) was obtained (risk ratio 0.23, 95% CI 0.08–0.64, $P = 0.005$). In conclusion, inhibitory effect of IFN on development of HCC in the patients with chronic hepatitis C aged 60 and over was limited to the patients achieving SVR when treated with 6 months-IFN monotherapy.

Keywords: aged patients, chronic hepatitis C, hepatocellular carcinoma, interferon, sustained virological response.

INTRODUCTION

In Japan, based on the epidemiological surveillance as well as the study on molecular tracing of hepatitis C virus (HCV), HCV infection is considered to spread from the 1920s and to expand more after World War II [1–5], The data of first-time blood donor candidates in Osaka demonstrated that the prevalence of anti-HCV antibodies among the candidates born in 1925–1935 was 7–10%, which was much higher than the prevalence of anti-HCV antibodies among the younger population [6]. Accordingly, chronic hepatitis C patients have become aged in Japan and HCV-related hepatocellular carcinoma (HCC) patients have also been shown to be old with a peak around age 70 and tended to decrease [1,3,5]. More importantly, the main cause of death in the patients with chronic hepatitis C has been reported to be HCC [7–10].

In the 1990s, interferon (IFN) therapy was used for the treatment of the patients with chronic hepatitis C worldwide and it has been shown by many studies including our reports that IFN therapy reduced the risk of HCC in patients with chronic hepatitis C [7,11–17]. This inhibitory effect of IFN therapy on hepatocarcinogenesis is notable when sustained virological response (SVR) was obtained, although SVR rate of IFN monotherapy was not very high. It has been also

Abbreviations: IFN, interferon; HCC, hepatocellular carcinoma; SVR, sustained virological response; HCV, hepatitis C virus; non-SVR, nonsustained virological response.

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reported that HCC development was significantly reduced in the patient achieving SVR as compared with those without SVR in chronic hepatitis C patients treated with IFN and ribavirin [18].

For the treatment of the patients with chronic hepatitis C, a combination of peginterferon and ribavirin has become a standard therapy, which has a high SVR rate [19–21]. However, the combination treatment has several adverse effects such as haemolytic anaemia which may not be tolerable for aged patients with chronic hepatitis C. On the other hand, aging is a significant risk factor for HCC in chronic hepatitis C patients. Accordingly, it is an important issue whether IFN monotherapy could reduce incidence of HCC in aged patients with chronic hepatitis C. Recently, Arase *et al.* [22] reported that long-term IFN monotherapy using low-dose of natural IFN-α was effective in preventing hepatocarcinogenesis in aged patients with chronic hepatitis C. In contrast, the hepatitis C antiviral long-term treatment against cirrhosis (HALT-C) Trial has shown that maintenance peginterferon therapy for 3.5 years did not reduce the incidence of HCC and the rate of disease progression in chronic hepatitis C patients with bridging fibrosis or cirrhosis who failed to respond to the combination therapy of peginterfeon-α2a and ribavirin [23,24].

We conducted a long-term multicenter retrospective cohort study to clarify the effect of 6-month IFN monotherapy on the incidence of HCC in aged patients with chronic hepatitis C.

MATERIAL AND METHODS

Patients

This study was conducted at Osaka University Hospital and six university-affiliated hospitals. IFN-treated patients consisted of 568 consecutive patients with chronic hepatitis C who had undergone liver biopsy 1 week to 2 months before IFN therapy and received either human lymphoblastoid IFN, recombinant IFN-α2a or recombinant IFN-α2b for 6 months between 1992 and 1995. The control group consisted of 158 consecutive patients with chronic hepatitis or cirrhosis who had undergone liver biopsy between January 1986 and December 1989, when IFN therapy had not been available in Japan. All the patients were positive for anti-HCV. The inclusion criteria in this study were as follows: (1) histological diagnosis of chronic hepatitis or cirrhosis; (2) no history of clinical signs at entry into the study of complications of cirrhosis, i.e. ascites, jaundice, encephalopathy, or variceal bleeding; (3) no previous IFN therapy; (4) no evidence of HCC at entry into the study as assessed by ultrasonography and/or computed tomography; (5) absence of serum hepatitis B surface antigen; (6) absence of co-existing liver diseases such as autoimmune hepatitis or primary biliary cirrhosis and (7) absence of excessive alcohol consumption (>80 g/day).

Sustained virological response was defined as persistent HCV RNA negativity during IFN therapy and follow-up. Patients showing positive HCV RNA after IFN therapy were classified as nonsustained virological response (non-SVR). In the patients with non-SVR, patients whose ALT levels decreased to the normal range and remained normal during IFN therapy were classified as transient biochemical response and patients without a decrease of ALT levels of the normal range during the therapy were classified as zbiochemical nonresponse.

Hepatitis C virus antibody was measured by first-, second-, or third-generation enzyme-linked immunosorbent assays (Ortho Diagnostics, Tokyo, Japan). Serum HCV RNA was measured by reverse transcription polymerase chain reaction or complementary DNA assay [25].

Follow-up

The starting date of follow-up of the patients was defined as the date of liver biopsy. Abdominal ultrasonography or computed tomography and biochemical examinations including α-fetoprotein were performed every 3–6 months during follow-up equally in the IFN-treated and control patients. The diagnosis of HCC was confirmed by needle biopsy, by surgically resected tumour specimens, or by typical radiological findings on hepatic angiography or dynamic computed tomography. In the patients residing in Osaka whose follow-up data were not obtained, the Osaka Cancer Registry was used to determine whether HCC had occurred and the data were available until the end of 2002 in this study [13,26]. Accordingly, we decided to use the date of the development of HCC or the end of 2002 as the end of follow-up. As the longest observation period of the patients in the IFN group was 11 years, only the follow-up data for the first 11 years were considered in the control group. The study protocol was in accordance with the Helsinki Declaration of 1975 (revised in 1983) and approved by the Ethical Committee of the Ikeda Municipal Hospital.

Histological evaluation

The sections were stained with haematoxylin–eosin and Azan-Mallory and histology of liver biopsy specimens was scored by two authors in a blinded manner using two scoring methods as described before [13]. Briefly, fibrosis score of Desmet *et al.* was used for the assessment of histological staging and a total score of histological activity (components 1–3) using the Knodell histological activity index was used for the assessment of histological grading [13,27,28].

Statistical analysis

Patients who did not complete the treatment protocol were included for the analysis on an intention-to-treat basis. The chi-square test and Student's *t*-test were used to compare the

baseline characteristics. The Kaplan–Meier method was used to calculate the cumulative incidence of HCC, and the log-rank test was used to compare the cumulative incidence of HCC between the groups. To estimate independent risk factors for the development of HCC, a stepwise Cox proportional-hazards regression analysis was used. For the analysis, IFN therapy, age, gender, and histological staging and activity scores were used as variables. A P value <0.05 was considered statistically significant. Data are presented as the mean ± SD and were analysed using SPSS version 11.0 (SPSS Inc., Chicago, IL, USA).

RESULTS

Table 1 shows the baseline characteristics of the aged (60 years old and over) and non-aged (under 60 years old) groups. Both the histological stage and activity were significantly higher in the aged group than in the non-aged group. The proportion of male patients of the non-aged group was significantly higher than that of the aged group. In Table 2, baseline characteristics of controls and IFN-treated patients in the aged and non-age groups were compared. In the non-aged group, age at entry, proportion of male gender, histological activity score, serum ALT level and platelet count did not differ between the control and IFN-treated patients. However, histological stage of IFN-treated patients was less advanced as compared with that of the control patients. In the age-group, age at entry, proportion of male gender, histological stage and activity, serum ALT level and platelet count did not differ between the control and IFN-treated patients.

During the follow-up period, HCC was found in 35 controls and 44 IFN-treated patients among the non-aged group and in 14 controls and 48 IFN-treated patients among the aged group. The median tumour sizes of HCC in controls and IFN-treated patients at the time of discovery on ultrasonography or computed tomography were 22 mm (range, 10–55 mm) and 19 mm (range, 8–52 mm) respectively ($P \geq 0.2$). In the non-aged group, the cumulative incidence of HCC estimated by the Kaplan–Meier Method of IFN-treated patients was significantly lower than that of control patients (log-rank test, $P < 0.001$, Fig. 1a), whereas there was no difference in the cumulative incidence of HCC between controls and IFN-treated patients in the aged group (log-rank test, $P = 0.498$, Fig. 1b). The cumulative incidence of HCC of SVR and non-SVR patients and controls of the aged and non-aged groups are shown in Fig. 2. The 10-year incidences of HCC for controls, non-SVR and SVR patients in the non-aged group were 30.1%, 15.8%, 4.5% respectively (log-rank test, $P < 0.001$, Fig. 2a). Also, the 10-year incidences of HCC for controls, non-SVR and SVR patients in the aged group were 39.1%, 38.9%, 12.7% respectively (log-rank test, $P = 0.015$, Fig. 2b).

In Table 3, risk ratios for the development of HCC calculated by a stepwise Cox regression analysis in the aged and non-aged patients with chronic hepatitis C according to virological and biochemical responses to IFN are summarized. In the 410 IFN-treated patients of non-aged group, 134 patients (32.7%) achieved SVR and the remaining 276 showed non-SVR (Table 3). Of this 276 patients showing non-SVR, 163 showed transient biochemical response and 113 showed biochemical nonresponse during the IFN treatment. On the other hand, 41 (25.9%) of 158 IFN-treated patients of the aged group obtained SVR and the other 117 did not obtain SVR (Table 3). Of the 117 non-SVR patients, 57 showed transient biochemical response and 60

Table 1 Baseline characteristics of aged and non-aged patients with chronic hepatitis C

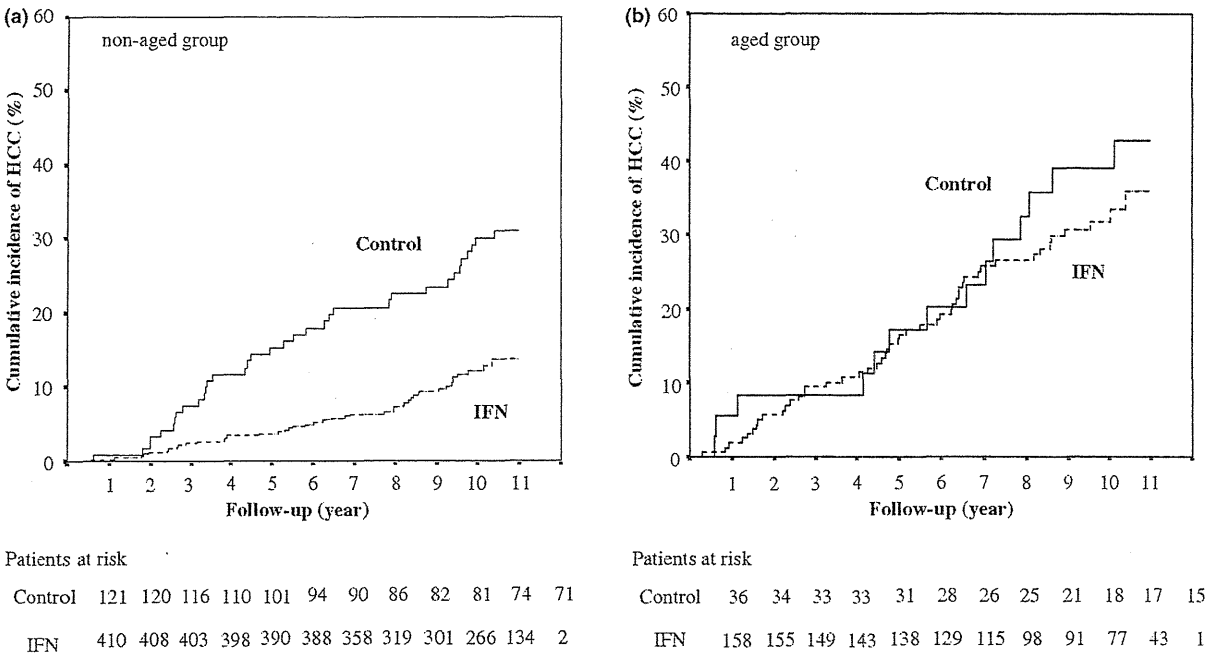
	Non-aged group (n = 531)	Aged group (n = 194)	P value
Control group (n)/IFN group (n)	121/410	36/158	0.262
Age	48.1 ± 9.7	63.7 ± 3.3	<0.001
Gender			
Male	353	108	0.009
Female	178	86	
Histological stage*			
F0, 1	186	37	0.001
F2	157	69	
F3	141	69	
F4	47	19	
Histological activity†			
<10	329	104	0.049
≧ 10	202	90	
ALT (IU/L)	117 ± 86	104 ± 60	0.053
Platelete count ($10^4/\mu L$)	15.4 ± 5.6	14.4 ± 5.6	0.040

*According to Desmet *et al.*[27] †Based on components 1–3 of the Knodell histological activity.

Table 2 Baseline characteristics of controls and IFN-treated patients in aged and non-aged groups

	Non-aged group			Aged group		
	Controls	IFN-treated	*P* value	Controls	IFN-treated	*P* value
n	121	410		36	158	
Age	48.4 ± 10.5	48.0 ± 9.4	0.736	64.6 ± 3.6	63.5 ± 3.2	0.059
Gender						
Male	75	278	0.273	22	86	0.579
Female	46	86		14	72	
Histologic stage*						
F0,1	27	159	<0.001	8	29	0.933
F2	28	129		12	57	
F3	47	94		12	57	
F4	19	28		4	15	
Histologic activity†						
<10	72	257	0.525	20	84	0.854
≧ 10	49	153		16	74	
ALT (IU/L)	127 ± 80	114 ± 88	0.132	110 ± 85	103 ± 53	0.523
Platelete count ($10^4/\mu L$)	15.2 ± 6.1	15.4 ± 5.4	0.766	15.0 ± 5.4	14.3 ± 5.7	0.486
HCV RNA load						
High	ND‡	166		ND‡	54	
Low	ND‡	116		ND‡	30	
HCV RNA serotype						
1	ND‡	231		ND‡	90	
2	ND‡	102		ND‡	32	

*According to Desmet *et al.* [27] †Based on components 1–3 of the Knodell histologic activity. ‡Not done.



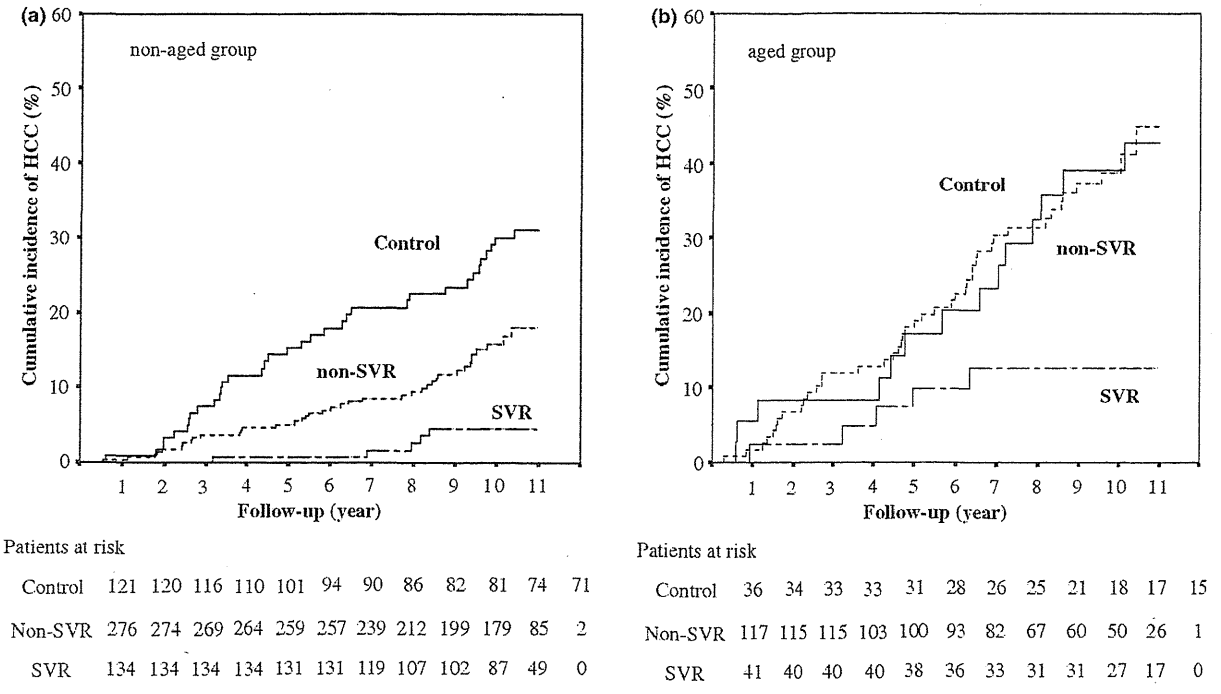
Patients at risk

Control	121	120	116	110	101	94	90	86	82	81	74	71
IFN	410	408	403	398	390	388	358	319	301	266	134	2

Patients at risk

Control	36	34	33	33	31	28	26	25	21	18	17	15
IFN	158	155	149	143	138	129	115	98	91	77	43	1

Fig. 1 Cumulative incidence of hepatocellular carcinoma in IFN-treated (dotted line) and control (solid line) patients of the non-aged group (a) and the aged group (b). A log-rank test of the two curves showed a significant difference in the non-aged group ($P < 0.001$), whereas no significant difference was observed in the aged group ($P = 0.498$).



Patients at risk

Control	121	120	116	110	101	94	90	86	82	81	74	71
Non-SVR	276	274	269	264	259	257	239	212	199	179	85	2
SVR	134	134	134	134	131	131	119	107	102	87	49	0

Patients at risk

Control	36	34	33	33	31	28	26	25	21	18	17	15
Non-SVR	117	115	115	103	100	93	82	67	60	50	26	1
SVR	41	40	40	40	38	36	33	31	31	27	17	0

Fig. 2 (a) Cumulative incidence of hepatocellular carcinoma categorized by sustained virological response (dashed line), nonsustained virological response (dotted line), and controls (solid line) of the non-aged group (a) and the aged group (b). A log-rank test of the three curves showed a significant difference between these groups (non-aged group, $P < 0.001$; aged group, $P = 0.015$).

showed biochemical nonresponse. In the non-aged group, stepwise Cox regression analysis identified IFN therapy (risk ratio 0.52, 95% CI 0.33–0.81, $P = 0.004$), older age (risk ratio 1.07, 95% CI 1.03–1.10, $P = 0.001$), and higher histological stage (score 3 or 4) (risk ratio 4.03, 95% CI 2.41–6.76, $P < 0.001$) as independent risk factors associated with the development of HCC. In the non-aged group, the development of HCC was strongly suppressed when SVR was achieved (risk ratio 0.20, 95% CI 0.08–0.50, $P < 0.001$) (Table 3). In the patients with transient biochemical response of the non-SVR group among the non-aged group, HCC development was also significantly reduced (risk ratio 0.47, 95% CI 0.26–0.86, $P = 0.015$). In the aged group, stepwise Cox regression analysis revealed that only higher histological stage (score 3 or 4) (risk ratio 2.27, 95% CI 1.36–3.78, $P = 0.002$) and male gender (risk ratio 2.00, 95% CI 1.17–3.41, $P = 0.011$) were independent factors responsible for the development of HCC (Table 3). Although IFN therapy was not identified as an independent variable for HCC, the risk of HCC was significantly decreased in the patients with SVR in the aged group as shown in the Table 3 (risk ratio 0.23, 95% CI 0.08–0.64, $P = 0.005$). In the

Table 3 Risk ratios for hepatocellular carcinoma in aged and non-aged patients with chronic hepatitis C according to virological and biochemical responses to interferon*

	Non-aged group (n = 531)				Aged group (n = 194)			
	n	Risk ratio	95% CI	P value	n	Risk ratio	95% CI	P value
Control group	121	1.00			36	1.00		
IFN group	410	0.52	0.33–0.81	0.004	158	0.77	0.42–1.40	0.388
Sustained virological response	134	0.20	0.08–0.50	0.001	41	0.23	0.08–0.64	0.005
Nonsustained virological response	276	0.65	0.41–1.03	0.068	117	1.07	0.58–1.97	0.821
Transient biochemical response†	163	0.47	0.26–0.86	0.015	57	0.67	0.32–1.43	0.303
Biochemical nonresponse†	113	0.86	0.51–1.47	0.584	60	1.46	0.77–2.78	0.245

*A stepwise Cox regression analysis was carried out by using interferon therapy, age, gender, and histologic stage and histologic activity scores as variables. †Nonsustained virological response was classified into transient biochemical response and biochemical nonresponse according to the ALT response during the interferon treatment.

patients with transient biochemical response of the non-SVR group of aged patients, HCC development was not reduced (risk ratio 0.67, 95% CI 0.32–1.43, $P = 0.303$, Table 3) in contrast to the patients showing transient biochemical response in the non-aged group.

As the cumulative incidence of HCC calculated by the Kaplan–Meier Method of the patients with SVR in the aged group was much higher than that in the non-aged group, we also carried out Cox proportional-hazards regression analysis to estimate risk factors responsible for HCC development in the 175 patients achieving SVR. As a result, older age (risk ratio 1.09, 95% CI 1.01–1.18, $P = 0.025$) and higher histological activity before IFN therapy started (10 or more of the total score of components 1–3 in Knodell's histological activity index) (risk ratio 4.16, 95% CI 1.07–16.25, $P = 0.040$) were identified as risk factors associated with HCC among the patients with SVR.

DISCUSSION

In this long-term retrospective cohort study, an inhibitory effect of 6 months-IFN monotherapy in early 1990s on the cumulative incidence of HCC were compared between the patients with histologically proven chronic hepatitis C under 60 years old (non-aged group) and those 60 years old and over (aged group). Because of retrospective analysis, there were some differences in baseline characteristics between the two groups. In the aged group, the histological stage and activity as well as the proportion of male patients were significantly higher than in the non-aged group. Also, SVR rate in the aged group was lower than that in the non-aged group. To avoid the influence of these biases, we performed Cox proportional-hazards regression analysis to see whether IFN monotherapy reduced the risk of HCC in the aged and non-aged groups. Then, we found that IFN therapy for 6 months significantly reduced the risk of HCC (risk ratio 0.52) in the non-aged group, whereas this inhibitory effect of IFN monotherapy on HCC development was recognized only in the patients achieving SVR among the aged-patients.

It is difficult to explain why IFN had no inhibitory effect on HCC development in the aged patients, whereas IFN had significant inhibitory effect in the non-aged patients of this study. Many clinical studies have demonstrated that aging was an independent risk factor associated with HCV-related HCC other than advanced histological staging and male gender [7,11–17,29]. However, molecular mechanism of the impact of aging on haepetocarcinogenesis has not been elucidated. Moriya *et al.* reported that lipid hydroperoxide products accumulated in the liver without inflammation and may play a role in the development of HCC in HCV core gene transgenic mice [30,31]. A long-term infection of HCV may lead to HCC through some molecular alterations.

Recently, there have been two controversial reports from the United States and Japan as to the long-term effect of low-dose IFN therapy on the incidence of HCC in chronic hepatitis C [22,24]. The report from Japan was a non-randomized retrospective study and observed beneficial effect of long-term natural IFN-α therapy on hepatocarcinogenesis in aged chronic hepatitis C patients [22]. The HALT-C Trial from the United States, a large prospective randomized study, reported that treatment with peginterfeon-α2a at a dose of 90 μg weekly for 3.5 years did not prevent HCC development in the patients with bridging fibrosis or cirrhosis who did not obtain SVR by combination therapy of peginterferon and ribavirin [24]. The result was consistent with our data in the aged patients. However, the annual incidence of HCC of the HALT-C Trial, about 1%, was much lower than that in the aged group in this study, about 4%. Accordingly, a randomized prospective study to determine the effect of long-term IFN or peginterferon therapy on the incidence of HCC in chronic hepatitis C, especially in the aged patients, may be needed in Japan.

This study has a limitation, because we used historical controls as control patients. A lead-time bias may have occurred. Detection of HCC by the screening program could be less effective in controls than IFN-treated patients. In that case, we might underestimate the effect of IFN on the cumulative incidence of HCC. However, such underestimation may be unlikely as the tumour sizes at the time of detection were not different between the control and IFN-treated patients.

The 10-year incidence of HCC for SVR patients of the aged group (12.7%) was much higher than that of non-aged group (4.5%) in our study. Makiyama *et al.* [32] studied the risk factors for developing HCC after obtaining sustained biochemical response to IFN therapy in chronic hepatitis C and reported that older age, male gender and advanced fibrosis were associated with HCC. Consistent with their results, we found that older age was an independent risk factor for HCC in the patients with SVR, suggesting a high potential of developing HCC even after eradication of HCV RNA in the aged patients. Another possibility is that malignant foci, which could not be detected by imaging modalities, had already existed before IFN therapy. Our finding indicates that even in the patients showing SVR, a follow-up examination to investigate HCC should be carried out for at least 10 years, particularly in the aged patients.

In conclusion, IFN monotherapy reduced the risk of HCC in the patients with chronic hepatitis C under 60 years old. In contrast, this inhibitory effect of IFN on hepatocacinogenesis was limited to patients showing SVR in the aged-patients when treated with 6 months-IFN monotherapy. These results suggest that combination therapy of peginterferon and ribavirin is recommended even in the aged patients with chronic hepatitis C to obtain better preventive effect of IFN on HCC development. For reasons of relatively high cumulative incidence of HCC in the aged chronic hepatitis C patients with SVR to IFN therapy, they should be followed carefully even after eradication of HCV by IFN therapy.