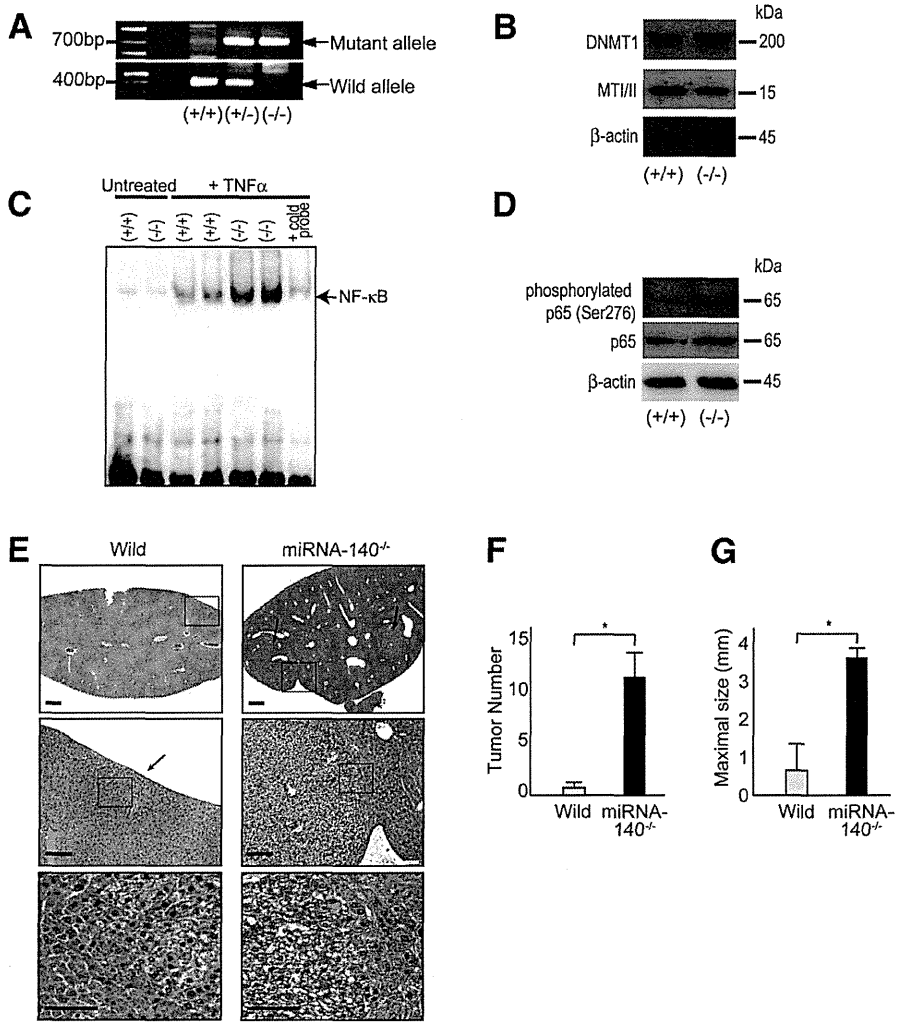

Fig. 4. miRNA-140$^{-/-}$ mice are prone to hepatocarcinogenesis. (A) Representative genotyping of mice with wild-type or mutant alleles. PCR genotyping was performed for miRNA-140 wild-type (419 bp; Wild) and knockout (734 bp; Mutant) alleles. (+/+), wild-type; (+/−), heterozygous; (−/−), knockout. (B) Increased Dnmt1 expression and decreased MTI/II expression in the liver tissues of miRNA-140$^{-/-}$ mice compared with wild-type mice. Western blotting was performed using antibodies against the indicated proteins. (+/+), wild-type; (−/−), miRNA-140$^{-/-}$. The image shown is representative of four independent experiments. (C) NF-κB-DNA binding was assessed via gel-shift assay using equal amounts of liver nuclear extracts from untreated and TNF-α-injected wild-type and miRNA-140$^{-/-}$ mice. (+/+), wild-type; (−/−), miRNA-140$^{-/-}$. Cold probe was added to TNF-α-injected knockout mouse nuclear extract to test assay specificity. A result representative of four independent experiments is shown. (D) Western blotting for phosphorylated p65 expression in the liver at 32 weeks after DEN treatment in miRNA-140$^{-/-}$ mice compared with wild-type mice. A result representative of four independent experiments is shown. (E) Representative histological images of mouse liver at 32 weeks after DEN treatment. Arrows indicate tumors. Higher-magnification images of the highlighted areas in the upper panels are shown in the lower panels. Scale bar, 500 μm. (F) The number (left panel) and size (right panel) of tumors (five random sections per mouse treated with DEN) are presented as the mean ± SD (wild-type mice, n = 8; miRNA-140$^{-/-}$ mice, n = 8). *$P < 0.05$.

components,[22] with subsequent impairment of miRNA function as molecular pathways and possible therapeutic targets for carcinogenesis and other diseases.

References

1. Parkin D, Bray F, Ferlay J, Pisani P. Global cancer statistics, 2002. CA Cancer J Clin 2005;55:74-108.
2. Block T, Mehta A, Fimmel C, Jordan R. Molecular viral oncology of hepatocellular carcinoma. Oncogene 2003;22:5093-5107.
3. Karin M. Nuclear factor-kappaB in cancer development and progression. Nature 2006;441:431-436.
4. Luedde T, Schwabe RF. NF-κB in the liver—linking injury, fibrosis and hepatocellular carcinoma. Nat Rev Gastroenterol Hepatol 2011;8:108-118.
5. Pikarsky E, Porat R, Stein I, Abramovitch R, Amit S, Kasem S, et al. NF-kappaB functions as a tumour promoter in inflammation-associated cancer. Nature 2004;431:461-466.
6. Liu P, Kimmoun E, Legrand A, Sauvanet A, Degott C, Lardeux B, et al. Activation of NF-kappa B, AP-1 and STAT transcription factors is a frequent and early event in human hepatocellular carcinomas. J Hepatol 2002;37:63-71.

7. Ji J, Shi J, Budhu A, Yu Z, Forgues M, Roessler S, et al. MicroRNA expression, survival, and response to interferon in liver cancer. N Engl J Med 2009;361:1437-1447.
8. Feng GS. Conflicting roles of molecules in hepatocarcinogenesis: paradigm or paradox. Cancer Cell 2012;21:150-154.
9. Bartel DP. MicroRNAs: target recognition and regulatory functions. Cell 2009;136:215-233.
10. Otsuka M, Jing Q, Georgel P, New L, Chen J, Mols J, et al. Hypersusceptibility to vesicular stomatitis virus infection in Dicer1-deficient mice is due to impaired miR24 and miR93 expression. Immunity 2007;27:123-134.
11. Otsuka M, Zheng M, Hayashi M, Lee JD, Yoshino O, Lin S, et al. Impaired microRNA processing causes corpus luteum insufficiency and infertility in mice. J Clin Invest 2008;118:1944-1954.
12. Kojima K, Takata A, Vadnais C, Otsuka M, Yoshikawa T, Akanuma M, et al. MicroRNA122 is a key regulator of α-fetoprotein expression and influences the aggressiveness of hepatocellular carcinoma. Nat Commun 2011;2:338.
13. Chang T-C, Yu D, Lee Y-S, Wentzel EA, Arking DE, West KM, et al. Widespread microRNA repression by Myc contributes to tumorigenesis. Nat Genet 2008;40:43-50.
14. Lu J, Getz G, Miska EA, Alvarez-Saavedra E, Lamb J, Peck D, et al. MicroRNA expression profiles classify human cancers. Nature 2005; 435:834-838.
15. Calin GA, Croce CM. MicroRNA signatures in human cancers. Nat Rev Cancer 2006;6:857-866.
16. Gaur A, Jewell DA, Liang Y, Ridzon D, Moore JH, Chen C, et al. Characterization of microRNA expression levels and their biological correlates in human cancer cell lines. Cancer Res 2007;67:2456-2468.
17. Kumar MS, Lu J, Mercer KL, Golub TR, Jacks T. Impaired microRNA processing enhances cellular transformation and tumorigenesis. Nat Genet 2007;39:673-677.
18. Lambertz I, Nittner D, Mestdagh P, Denecker G, Vandesompele J, Dyer MA, et al. Monoallelic but not biallelic loss of Dicer1 promotes tumorigenesis in vivo. Cell Death Differ 2010;17:633-641.
19. Otsuka M, Takata A, Yoshikawa T, Kojima K, Kishikawa T, Shibata C, et al. Receptor for activated protein kinase C: requirement for efficient microRNA function and reduced expression in hepatocellular carcinoma. PLoS One 2011;6:e24359.
20. Lujambio A, Esteller M. CpG island hypermethylation of tumor suppressor microRNAs in human cancer. Cell Cycle 2007;6:1455-1459.
21. Thomson J, Newman M, Parker J, Morin-Kensicki E, Wright T, Hammond S. Extensive post-transcriptional regulation of microRNAs and its implications for cancer. Genes Dev 2006;20:2202-2207.
22. Melo SA, Ropero S, Moutinho C, Aaltonen LA, Yamamoto H, Calin GA, et al. A TARBP2 mutation in human cancer impairs microRNA processing and DICER1 function. Nat Genet 2009;41:365-370.
23. Takata A, Otsuka M, Yoshikawa T, Kishikawa T, Kudo Y, Goto T, et al. A miRNA machinery component DDX20 controls NF-κB via microRNA-140 function. Biochem Biophys Res Commun 2012;13:564-569.
24. Miyaki S, Sato T, Inoue A, Otsuki S, Ito Y, Yokoyama S, et al. MicroRNA-140 plays dual roles in both cartilage development and homeostasis. Genes Dev 2010;24:1173-1185.
25. Garzon R, Heaphy CE, Havelange V, Fabbri M, Volinia S, Tsao T, et al. MicroRNA 29b functions in acute myeloid leukemia. Blood 2009;114:5331-5341.
26. Mourelatos Z, Dostie J, Paushkin S, Sharma A, Charroux B, Abel L, et al. miRNPs: a novel class of ribonucleoproteins containing numerous microRNAs. Genes Dev 2002;16:720-728.
27. Zender L, Xue W, Zuber J, Semighini C, Krasnitz A, Ma B, et al. An oncogenomics-based in vivo RNAi screen identifies tumor suppressors in liver cancer. Cell 2008;135:852-864.
28. Mouillet J, Yan X, Ou Q, Jin L, Muglia L, Crawford P, et al. DEAD-box protein-103 (DP103, Ddx20) is essential for early embryonic development and modulates ovarian morphology and function. Endocrinology 2008;149:2168-2175.
29. Voss M, Hille A, Barth S, Spurk A, Hennrich F, Holzer D, et al. Functional cooperation of Epstein-Barr virus nuclear antigen 2 and the survival motor neuron protein in transactivation of the viral LMP1 promoter. J Virol 2001;75:11781-11790.
30. Charroux B, Pellizzoni L, Perkinson R, Shevchenko A, Mann M, Dreyfuss G. Gemin3: a novel DEAD box protein that interacts with SMN, the spinal muscular atrophy gene product, and is a component of gems. J Cell Biol 1999;147:1181-1194.
31. Hutvágner G, Zamore P. A microRNA in a multiple-turnover RNAi enzyme complex. Science 2002;297:2056-2060.
32. Takata A, Otsuka M, Kojima K, Yoshikawa T, Kishikawa T, Yoshida H, et al. MicroRNA-22 and microRNA-140 suppress NF-κB activity by regulating the expression of NF-κB coactivators. Biochem Biophys Res Commun 2011;411:826-831.
33. Hu W, Johnson H, Shu H. Tumor necrosis factor-related apoptosis-inducing ligand receptors signal NF-kappaB and JNK activation and apoptosis through distinct pathways. J Biol Chem 1999;274: 30603-30610.
34. Cherian MG, Jayasurya A, Bay BH. Metallothioneins in human tumors and potential roles in carcinogenesis. Mutat Res 2003;533:201-209.
35. Huang GW, Yang LY. Metallothionein expression in hepatocellular carcinoma. World J Gastroenterol 2002;8:650-653.
36. Datta J, Majumder S, Kutay H, Motiwala T, Frankel W, Costa R, et al. Metallothionein expression is suppressed in primary human hepatocellular carcinomas and is mediated through inactivation of CCAAT/enhancer binding protein alpha by phosphatidylinositol 3-kinase signaling cascade. Cancer Res 2007;67:2736-2746.
37. Majumder S, Roy S, Kaffenberger T, Wang B, Costinean S, Frankel W, et al. Loss of metallothionein predisposes mice to diethylnitrosamine-induced hepatocarcinogenesis by activating NF-kappaB target genes. Cancer Res 2010;70:10265-10276.
38. Ghoshal K, Majumder S, Li Z, Dong X, Jacob ST. Suppression of metallothionein gene expression in a rat hepatoma because of promoter-specific DNA methylation. J Biol Chem 2000;275:539-547.
39. Harrington MA, Jones PA, Imagawa M, Karin M. Cytosine methylation does not affect binding of transcription factor Sp1. Proc Natl Acad Sci U S A 1988;85:2066-2070.
40. Li E, Beard C, Jaenisch R. Role for DNA methylation in genomic imprinting. Nature 1993;366:362-365.
41. Majumder S, Kutay H, Datta J, Summers D, Jacob ST, Ghoshal K. Epigenetic regulation of metallothionein-i gene expression: differential regulation of methylated and unmethylated promoters by DNA methyltransferases and methyl CpG binding proteins. J Cell Biochem 2006; 97:1300-1316.
42. Garzon R, Calin G, Croce C. MicroRNAs in cancer. Annu Rev Med 2009;60:167-179.
43. Merritt W, Lin Y, Han L, Kamat A, Spannuth W, Schmandt R, et al. Dicer, Drosha, and outcomes in patients with ovarian cancer. N Engl J Med 2008;359:2641-2650.
44. Horikawa Y, Wood CG, Yang H, Zhao H, Ye Y, Gu J, et al. Single nucleotide polymorphisms of microRNA machinery genes modify the risk of renal cell carcinoma. Clin Cancer Res 2008;14:7956-7962.
45. Yang H, Dinney CP, Ye Y, Zhu Y, Grossman HB, Wu X. Evaluation of genetic variants in microRNA-related genes and risk of bladder cancer. Cancer Res 2008;68:2530-2537.
46. Wu JM, Sheng H, Saxena R, Skill NJ, Bhat-Nakshatri P, Yu M, et al. NF-kappaB inhibition in human hepatocellular carcinoma and its potential as adjunct to sorafenib based therapy. Cancer Lett 2009;278: 145-155.
47. Gebhard C, Schwarzfischer L, Pham T, Andreesen R, Mackensen A, Rehli M. Rapid and sensitive detection of CpG-methylation using methyl-binding (MB)-PCR. Nucleic Acids Res 2006;34:e82.
48. Martello G, Rosato A, Ferrari F, Manfrin A, Cordenonsi M, Dupont S, et al. A microRNA targeting dicer for metastasis control. Cell 2010; 141:1195-1207.

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ORIGINAL ARTICLE

Chronic hepatitis B in patients coinfected with human immunodeficiency virus in Japan: a retrospective multicenter analysis

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Abstract A nationwide survey in Japan revealed that about 6 % of human immunodeficiency virus (HIV)-positive patients are coinfected with hepatitis B virus (HBV). To further analyze the features of liver disease in HIV/HBV-coinfected patients, we analyzed 252 patients from six hospitals in the HIV/AIDS (acquired immunodeficiency syndrome) Network of Japan. The mean age was 39.5 years, and the proportion of male patients was very high (243 of 252; 96 %). The main transmission route was male homosexual contact (186 of 252; 74 %), followed by heterosexual contact. The HBV genotype was determined in 77 patients. Among them, genotype A HBV was the most frequent (58 of 77; 75 %) and was detected almost exclusively in homosexual patients. Acute hepatitis B was documented in 21 patients (8 %). Three of the 252 HIV/HBV-coinfected patients developed advanced liver disease with the complication of ascites, hepatic encephalopathy, or hepatocellular carcinoma. A comparison between patients not treated and those treated with antiretroviral drugs including anti-HBV drugs revealed that the baseline liver function was worse in treated patients. However, the serum albumin levels and platelet counts in both groups increased after treatment and were similar. Liver disease-associated death was not observed. Here, we characterize the clinical features of liver disease in HIV/HBV-coinfected patients in Japan for the first time. The findings suggest that antiretroviral therapy with anti-HBV drugs may retard the progression of a liver disease and prevent liver disease-associated death in such patients.

Keywords Acquired immunodeficiency syndrome · Chronic liver disease · HBV DNA · Genotype

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Introduction

The number of human immunodeficiency virus (HIV)-positive patients is growing in Japan [1]. Although combination therapy with antiretroviral agents has made HIV infection itself somewhat controllable in many cases since its introduction in 1996, and mortality from opportunistic infection has decreased, existing comorbidities are the focus of current patient care. In fact, more than 50 % of deaths in HIV-1-infected patients are not related to acquired immunodeficiency syndrome (AIDS); the mortality from liver disease is second only to AIDS-related mortality [2]. Risk factors related to significant liver

diseases among HIV-positive patients include a diagnosis of viral hepatitis [3], nonalcoholic fatty liver disease [4], and excessive alcohol consumption [5]. Among these factors, hepatitis B and hepatitis C are of particular importance because they can often lead to life-threatening diseases such as cirrhosis and hepatocellular carcinoma by themselves.

The estimated prevalence of chronic hepatitis B virus (HBV) infection in Japan is less than 1 %, or 0.9 million carriers [6]. However, about 6 % of HIV-positive patients are coinfected with HBV [7]; this coinfection rate is more than six times higher than that in the non-HIV population. In the United States, the HIV/HBV coinfection rate is reported to be in the range of 6–14 % [8–10].

Several issues make the management of HIV/HBV coinfection complicated. HBV infection tends to be persistent in HIV-positive patients [9, 11, 12]. Chronic HBV infection may lead to hepatitis, cirrhosis, or hepatocellular carcinoma. The progression of a liver disease associated with chronic HBV infection is more rapid in HIV/HBV-coinfected patients than in HBV-monoinfected patients [13].

Combination regimens of antiretroviral therapy (ART) for coinfected patients should be carefully determined. Initial combination regimens of ART for HIV/hepatitis C virus (HCV)-coinfected patients are basically the same as those for HIV patients without HCV infection. However, because some nucleoside reverse transcriptase inhibitors (NRTIs) used in HIV treatment have activity against HBV, and some NRTIs mainly used in HBV treatment have partial activity against HIV [14], careful choice of treatment agents is necessary in HIV/HBV coinfection. Abrupt discontinuation of NRTIs that are active against HBV may aggravate viral hepatitis. Administration of entecavir, which has a weak activity against HIV, to HIV/HBV-coinfected patients without simultaneous effective HIV treatment may cause the accumulation of drug-resistant HIV strains [15–17]. In such cases, drug resistance of HBV may occur as well [18].

Drug-induced liver injury following ART is another concern. HIV/HBV-coinfected patients show an increase in transaminase level at a higher rate [19, 20]. However, it is often unclear whether this increase is caused by drug hepatotoxicity because the treatment of HIV infection causes immune reconstruction in patients, which alone could contribute to the transaminase level increase in viral hepatitis.

The objective of this study is to clarify the clinical features of HIV/HBV coinfection in Japan and to clarify the impact of ART on liver function among HIV/HBV-coinfected patients. The estimated prevalence of chronic HBV infection among the general population in Japan is decreasing yearly, but it remains much higher than that in the United States [21], where universal hepatitis B vaccination is introduced. Thus, the detailed analysis of HIV/HBV coinfection in Japan is of particular importance.

Patients and methods

We have conducted a multicenter retrospective study based on the data from a nationwide survey in 2006 conducted by sending questionnaires to 372 member hospitals of the HIV/AIDS network of Japan as of January 2006, and part of the results was reported earlier [7]. Following the survey, 6 of the 207 hospitals that responded to the survey—Hokkaido University Hospital (Hokkaido, Japan), University of Tokyo Hospital (Tokyo, Japan), Nagoya University Hospital (Aichi, Japan), International Medical Center of Japan (currently, National Center for Global Health and Medicine, Tokyo, Japan), Osaka National Hospital (Osaka, Japan), and Hiroshima University Hospital (Hiroshima, Japan)—were chosen for further studies because more than two-thirds of the HIV/HBV-coinfected patients identified in the survey went to these hospitals, and because both HIV experts and hepatologists were following up those patients there.

The questionnaire sent to the hospitals included items regarding the number of patients who visited the hospitals at least once between January and December in 2006 as follows: (1) the number of HIV-positive patients; (2) the number of hepatitis B surface antigen (HBsAg)-positive patients among (1); (3) the number of patients among (2) who were determined at least once to have a serum alanine aminotransferase (ALT) level higher than 100 IU/l; (4) the number of HIV-positive patients who contracted HIV from blood products; (5) the number of HBsAg-positive patients among (4); (6) the number of patients among (5) who were determined at least once to have a serum ALT level higher than 100 IU/l; (7) the number of HIV-positive patients whose presumed transmission route is through homosexual contact; (8) the number of HBsAg-positive patients among (7); (9) the number of patients among (8) who were determined at least once to have a serum ALT level higher than 100 IU/l; (10) the number of HIV-positive patients who presumably contracted HIV through injection drug use; (11) the number of HBsAg-positive patients among (10); (12) the number of patients among (11) who were determined at least once to have a serum ALT level higher than 100 IU/l; (13) the number of HIV-positive patients whose transmission routes were classified as "others"; (14) the number of HBsAg-positive patients among (13); and (15) the number of patients among (15) who were determined at least once to have a serum ALT level higher than 100 IU/l.

We defined confirmed HIV infection with positivity for serum HBsAg as the criterion for HIV/HBV coinfection.

After identifying HIV/HBV-coinfected patients, medical records including laboratory data of these patients were reviewed between the date of the oldest available record for these patients and the final date of the record acquired by the end of the study. The laboratory data at the diagnosis or first recognition of HBV infection and the latest data in the study period were compared for analysis unless otherwise noted. HBV genotypes (A through D) were determined serologically by enzyme immunoassay (EIA) using commercial kits (HBV GENOTYPE EIA; Institute of Immunology, Tokyo, Japan) on the basis of the pattern of detection using monoclonal antibodies of a combination of epitopes on preS2-region products, each of which was specific for each genotype [22, 23].

Ethical issues

The respective ethics committees of the six hospitals approved the study. Informed consent was obtained from each study participant.

Statistical analyses

For the comparison of means of collected data, Student's *t* test (paired *t* test) was performed unless otherwise specified. The chi-square test was performed to determine the independence of clinical parameters.

Results

Two hundred and fifty-two patients were identified to have HIV/HBV coinfection. The mean age was 39.5 years, and the proportion of male patients was very high (243 of 252; 96.4 %). The main presumed transmission route of HIV was male homosexual contact (186 of 252; 73.8 %), followed by heterosexual contact. Among those HIV/HBV-coinfected patients, 21 of the 252 (8.3 %) acquired acute hepatitis during the study period (Table 1).

Table 1 Clinical background of HIV/HBV-coinfected patients

Number (male:female)	243:9
Age (year)	39.5 ± 9.6[a]
Presumed Transmission Route	
Transfusion	14
Homosexual contact	186
Heterosexual contact	24
Injection drug use	2
Others	4
Onset as acute hepatitis	21

[a] Mean ± standard deviation

The HBV genotype was determined in 77 patients. Among them, genotype A HBV was the most frequent (58 of 77; 75.3 %), followed far behind by genotype C (7 of 77; 9.1 %), which is the predominant genotype in the entire chronic hepatitis B population in Japan. Genotype B, which is also common in Japan, was found only in three patients (3.9 %). Genotype A was detected almost exclusively in homosexual patients (57 of 58; 98.3 %) (Fig. 1).

At the end of the study period, 113 patients (44.8 %) received some type of anti-HBV drug such as interferon, lamivudine, adefovir, or entecavir, not as part of anti-HIV treatment. Ninety-seven (38.5 %) patients were still taking anti-HBV drugs by the end of the study period. The median ALT level was 30.0 IU/l (5th percentile, 11.1; 95th percentile, 128.9), suggesting the existence of some liver injury. Liver function was normal in most HIV/HBV-coinfected patients. The mean serum albumin level was 4.1 ± 0.6 g/dl, and the median serum total bilirubin level was 0.8 mg/dl (5th percentile, 0.3; 95th percentile, 3.8). The mean platelet count was 21.0 ± 6.1 × 10^4/ml. The hepatitis B e antigen (HBeAg) was detected in 84 patients, and the HBV DNA level was high (higher than 100,000 IU/l) in 55 patients (Table 2). Three of the 252 (1.1 %) HIV/HBV-coinfected patients developed advanced chronic liver diseases, such as cirrhosis with the complication of ascites and/or hepatic encephalopathy, or hepatocellular carcinoma. Although we tried to retrieve information on alcohol consumption of the patients, it was available for only a limited number of patients (26 of 252); among the 26, only 2 patients had a habit of taking more than 60 g alcohol per day. The remaining 24 patients took alcohol only on social occasions. The antiretroviral agents used for these study patients are listed in detail in Table 3. Among those who had a known history of ART, 158 of 252 (62.7 %) received regimens that include anti-HBV drugs at least once previously, whereas 42 (16.7 %) did not, and no information is available for the remaining 52. The most common drug combination for HIV/HBV-coinfected patients was ATV/r + FTC/TDF (22 of 172; 12.8 %) (Table 4). FTC/TDF, composed of two drugs active against HBV, is recommended for HIV/HBV-coinfected patients

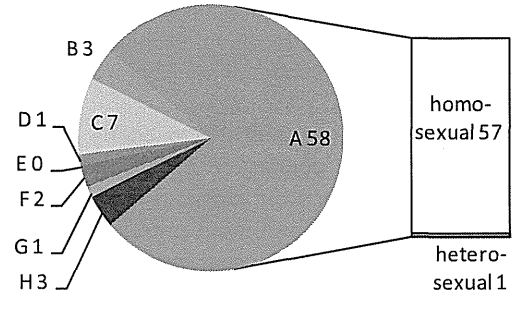

Fig. 1 Hepatitis B virus (HBV) genotype

Table 2 Liver function and related parameters of HIV/HBV-coinfected patients

Albumin (g/dl)	4.1 ± 0.6
Bilirubin[a] (mg/dl)	0.8 (5th percentile, 0.3; 95th percentile, 3.8)
ALT[a] (IU/l)	30.0 (5th percentile, 11.1; 95th percentile, 128.9)
WBC ($\times 10^3/\mu l$)	5.2 ± 1.6
Platelet ($\times 10^4/\mu l$)	21.0 ± 6.1
HBeAg (positive:negative)	84:68
HBV DNA (high:low)[b]	55:127

[a] Median and percentiles are provided instead of mean and standard deviation because of the nonnormality of the distribution

[b] HBV DNA level of 100,000 IU/l or higher is categorized as "high"

as one of the preferred NRTI backbones of the ART regimen [24].

We compared the clinical characteristics between patients who received the full ART and those who did not. Regarding the baseline statistical data, the observation period was longer for patients on ART, and there were more patients with AIDS in the ART group (10 of 64 vs. 52 of 162) (Table 5a). No significant difference was observed between the non-ART and ART groups in male/female ratio, age, transmission route, HBV markers, or advanced liver disease. Liver-related death was not observed, but hepatic failure with ascites and/or hepatic encephalopathy developed in 2 patients on ART and hepatocellular carcinoma developed in another patient.

Comparison between the ART group and the non-ART group revealed that the baseline liver function was worse in the ART group. At the beginning of the study period, the ART group showed a significantly lower CD4+ T-cell count than the non-ART group. The total white blood cell count and platelet count were also lower in the ART group. Although it is not statistically significant, the serum albumin level and prothrombin time (PT) index were lower in the ART group. However, at the end of the observation period, these parameters improved significantly in the ART group. The difference in CD4+ T-cell count between the ART and non-ART groups became marginal and became statistically insignificant (Table 5b).

Changes in the liver function of HIV/HBV-coinfected patients may not be fully explained by the changes in HBV activity because some parameters relevant to the estimation of liver function showed paradoxical changes. To clarify this observation, we compared the changes in liver function among HIV/HBV-coinfected patients on ART with respect to protease inhibitor (PI) use.

The mean serum total bilirubin level in patients on ART with PI use (PI group) at the beginning of the observation period was 1.1 mg/dl, whereas that in patients without PI use (non-PI group) was 0.8 mg/dl. The means at the end of the study period were 1.6 mg/dl in the PI group and 0.7 mg/dl in the non-PI group. Because the sample distribution of serum total bilirubin level did not follow the normal distribution by logarithmic transformation, we compared the means statistically. At the beginning, the difference in the mean between the PI group and the non-PI group was not significant ($p = 0.257$). At the end of the observation period, a statistically significant difference ($p = 0.001$) was observed. We then calculated the

Table 3 Antiretroviral treatment of HIV/HBV-coinfected patients

Antiretroviral drugs	Number of patients
NRTIs	
Zidovudine (AZT)	34
Didanosine (ddI)	9
Ddl / enteric coated	7
Zalcitabine (ddC)	1
Stavudine (d4T)	4
Lamivudine[a] (3TC)	84
Abacavir[3] (ABC)	38
Tenofovir[3] (TDF)	27
Emtricitabine (FTC) / TDF[a]	57
NNRTIs	
Nevirapine (NVP)	10
Efavirenz (EFV)	34
Delavirdine (DLV)	1
PIs	
Indinavir (IDV)	4
Ritonavir (RTV)	50
Nelfinavir (NFV)	8
Lopinavir (LPV)	3
Ritonavir-boosted LPV (LPV/r)	40
Atazanavir (ATV)	39
ATV/r	6
Fosamprenavir (FPV)	13

NRTI nucleoside reverse transcriptase inhibitor, *NNRTI* non-nucleoside reverse transcriptase inhibitor, *PI* protease inhibitor

[a] Agents with anti-HBV activity

Table 4 Antiretroviral regimens used for HIV/HBV-coinfected patients

Antiretroviral regimen	Number of patients
ATV/r + FTC/TDF	22
LPV/r + 3TC + TDF	8
LPV/r + FTC/TDF	7
EFV + FTC/TDF	6
ATV/r + 3TC + TDF	5

Table 5 Comparison of changes in clinical parameters of HIV/HBV-coinfected patients with or without antiretroviral therapy (ART)

a. Baseline statistical data	Natural course[a] (without ART)	With ART	*p* value (with vs. without ART)
Number (male:female)	84:6	159:3	0.105†
Age (year)	37.0 ± 10.3	39.0 ± 9.1	0.362
Observation period (month)	34.5 ± 55.5	50.9 ± 43.9	0.022*
Presumed transmission route	Blood products:homosexual contact:heterosexual contact:injection drug use:other		
	5:60:12:2:3	9:126:12:0:1	0.052†
Recognized acute hepatitis	10	11	0.243†
HBeAg (positive:negative)	42:18	100:40	0.394†
HBV DNA (high:low)	29:18	83:37	0.356†
HBV genotype	A:B:C:D:F:G:H		
	17:0:1:1:1:0:1	31:3:6:0:1:1:2	0.372†
Ascites	1/56	2/144	1.000†
Hepatocellular carcinoma	0/62	1/159	1.000†
Acquired immunodeficiency syndrome (AIDS)	10/64	52/162	0.012*,†

b. Comparison of clinical parameters between pre- and post-ART among patients with and without ART	Natural course (without ART)	With ART	*p* value (with vs. without ART)
CD4 count (per μl)			
Start[b]	402.9 ± 180.1	242.5 ± 187.6	0.000*
End[c]	406.4 ± 212.4	398.1 ± 195.9	0.883
p value (start vs. end)	0.893	0.000*	
Albumin (g/dl)			
Start	4.1 ± 0.4	3.8 ± 0.8	0.292
End	3.9 ± 0.8	4.2 ± 0.4	0.025*
p value	0.473	0.001*	
Bilirubin[d] (mg/dl)			
Start	0.7 (0.30, 4.26)	0.5 (0.30, 2.62)	0.138
End	0.5 (0.25, 1.30)	0.9 (0.36, 4.32)	0.000*
p value	0.046*	0.000*	
ALT[d] (IU/l)			
Start	46.0 (15.0, 1418.2)	34.0 (12.8, 1,068.8)	0.120
End	27.0 (9.9, 229.9)	31.5 (12.73, 89.3)	0.713
p value	0.003*	0.000*	
Prothrombin time index (%)			
Start	89.4 ± 13.1	78.8 ± 23.0	0.650
End	78.8 ± 27.3	84.2 ± 16.3	0.531
p value	0.377	0.218	
WBC ($\times 10^3/\mu l$)			
Start	6.1 ± 2.4	4.8 ± 2.1	0.000*
End	5.4 ± 1.4	5.1 ± 1.6	0.404
p value	0.044*	0.247	
Platelet ($\times 10^4$ /μl)			
Start	22.2 ± 6.5	19.3 ± 6.3	0.010*
End	21.2 ± 6.5	20.8 ± 6.1	0.649
p value	0.204	0.001*	

* $p < 0.05$

† Chi-square test was performed

[a] Two patients with habitual alcohol intake were included in this group

[b] Start of observation period

[c] End of observation period

[d] Means were compared by log transformation because of the nonnormality of the distribution; median and percentiles (5th percentile, 95th percentile) are provided

difference in serum total bilirubin level between the beginning and the end of the observation period [Dbilirubin level = (bilirubin level at the end) − (bilirubin level at the beginning)] in individual patients and compared it between the PI group and the non-PI group. The mean Dbilirubin level in the PI group was 0.5 ± 3.4 mg/dl and that in the non-PI group was −0.2 ± 1.6 mg/dl ($p = 0.250$). The Dbilirubin level in a patient in the PI group who was coinfected with HCV besides HIV/HBV as well was −27.4 mg/dl. Excluding this single outlier, the mean Dbilirubin level was significantly different between the PI and non-PI groups (mean Dbilirubin level 0.8 vs. −0.2; $p = 0.01$).

Discussion

We have summarized here the data from our comprehensive survey of HIV/HBV coinfection in Japan, focusing particularly on the clinical features of the patients and the effect of ART on liver function. As we reported earlier, HIV/HBV coinfection was observed in 6.3 % of Japanese HIV-positive patients [7]. Certain considerations for HBV coinfection are important in HIV patient care.

The major transmission route of HIV was male homosexual contact, which accounted for the infection in about 80 % of the patients; thus, male patients were the majority in the present cohort. The most frequently found genotype of HBV was genotype A, which is infrequent in HIV-negative patients in Japan. Genotype A is often found in the United States, Europe, India, and the west coast of Sub-Saharan Africa [25]. Although the data on HBV subgenotypes were not available in our study, some reports showed that most genotype A strains detected in HIV/HBV-coinfected individuals are of genotype Ae [26]. These findings suggest that HBV infection among Japanese HIV carriers is not caused by the spread of indigenous HBV, such as transmission in the perinatal period, but rather specific strains are circulating among the homosexual population in Japan. Genotypes B and C accounted for more than 96 % of the entire Japanese chronic HBV infection [27, 28]. These findings are compatible with the report that the presumed transmission route of HBV in HIV/HBV-coinfected patients is not from Japanese female partners but from male partners, as shown by Koibuchi et al. [29].

Seventy-five percent of HIV/HBV-coinfected patients received ART with two agents against HBV, and its efficacy against HBV as well as HIV is considered to be high. As recommended by the United States Department of Health and Human Services (DHHS) and the Japanese guidelines on HIV treatment, the initiation of ART with NRTIs with anti-HBV activity as the backbone is indicated for HIV/HBV-coinfected patients regardless of HIV viral load or CD4+ T lymphocyte count [30]. Nucleoside analogues can improve liver function in HBV-monoinfected patients [31]. Our study shows that ART decreased the levels of ALT and albumin in HIV/HBV-coinfected patients. It is noteworthy that the regimen used in ART includes multiple drugs with anti-HBV activity such as lamivudine plus abacavir, which is unusual for HBV-monoinfected patients.

When we compared the characteristics of patients on ART with those not on ART, there were some notable differences in their immune status and liver function. At the beginning of the observation period, patients on ART showed a lower CD4+ T-cell count and poorer liver function. Our study is a retrospective observation, and patients were not grouped randomly. These observations are rather understandable because those who had a low CD4+ T cell count were more likely candidates for ART. Additionally, patients on ART had a longer observation period and were more likely to develop AIDS. These findings are also understandable because the longer the duration of HIV infection, the more likely is the immune system of the patient to deteriorate. Moreover, once ART is started, patients need to visit clinics or hospitals regularly for a long period; in reality, for the rest of their life. Following current recommendations for the initiation of ART for HIV infection, patients with worse immune status are more likely to receive the treatment. These findings can explain our observation.

Our data show that the serum albumin level and platelet count improved in the patients who were on ART. As the regimen of ART usually contains two drugs against HBV, ART suppresses HBV replication, which may lead to an improved liver function, as observed in HBV-monoinfected patients treated with nucleoside analogues [31]. Long-term treatment with lamivudine was shown to regress the fibrosis of the liver [32, 33] and decrease the proportion of patients with hepatocellular carcinoma complication [34]. In view of these findings, ART for HIV/HBV-coinfected patients may markedly improve the prognosis of patients. In our study, only a small number of patients with advanced liver diseases associated with HBV infection such as cirrhosis or hepatocellular carcinoma were observed, which could be attributable in part to the short observation period and the short duration of HBV infection. If we had a longer observational period, we would be able to clarify the difference in clinical course between the ART and non-ART groups, and the actual significance of ART for HIV/HBV-coinfected patients should become clearer.

We found that some parameters related to liver function changed paradoxically, particularly in the ART group. Although the mean serum albumin level, ALT level, and platelet count improved, the mean serum bilirubin level worsened, from 0.5 to 0.9 mg/dl. On the other hand, the serum bilirubin level in the non-ART group decreased. Both changes are statistically significant, which suggests

that the observed hyperbilirubinemia was not associated with HBV activity. The increase in serum bilirubin level is presumably caused by PIs. Hyperbilirubinemia following PI administration was previously reported [35]. Although it is unclear whether hyperbilirubinemia itself may lead to liver injury, PIs should be used carefully particularly for patients with advanced liver diseases.

Our present study has one major limitation; that is, the effect of alcohol on liver function was not analyzed because the history of alcohol consumption could not be obtained in the majority of the studied patients. Excessive alcohol consumption has been found to be an important risk factor for the development of severe hepatic injury in HIV-infected patients with [3] or without HCV coinfection [5]. Our present study showed that among the 26 patients whose history of alcohol consumption was available, only 2 patients were habitual drinkers. The results suggested that the effect of alcohol on liver function is small in HIV/HBV-coinfected patients in Japan.

In conclusion, ART with anti-HBV drugs may retard the progression of liver diseases and prevent liver-related death in HIV/HBV-coinfected patients. Multiple agents with anti-HBV activity seem essential for the efficacy. PIs should be carefully used particularly for patients with advanced liver diseases.

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References

1. Ministry of Health, Labour and Welfare of Japan (ed). Annual Health, Labour and Welfare Report 2010–2011, Tokyo, Japan, 2011
2. Weber R, Sabin CA, Friis-Moller N, Reiss P, El-Sadr WM, Kirk O, et al. Liver-related deaths in persons infected with the human immunodeficiency virus: the D:A:D study. Arch Intern Med. 2006;166:1632–41.
3. Sulkowski MS. Drug-induced liver injury associated with antiretroviral therapy that includes HIV-1 protease inhibitors. Clin Infect Dis. 2004;38(Suppl 2):S90–7.
4. Lemoine M, Serfaty L, Capeau J. From nonalcoholic fatty liver to nonalcoholic steatohepatitis and cirrhosis in HIV-infected patients: diagnosis and management. Curr Opin Infect Dis. 2012;25:10–6.
5. Chaudhry AA, Sulkowski MS, Chander G, Moore RD. Hazardous drinking is associated with an elevated aspartate aminotransferase to platelet ratio index in an urban HIV-infected clinical cohort. HIV Med. 2009;10:133–42.
6. Tanaka J, Koyama T, Mizui M, Uchida S, Katayama K, Matsuo J, et al. Total numbers of undiagnosed carriers of hepatitis C and B viruses in Japan estimated by age- and area-specific prevalence on the national scale. Intervirology. 2011;54:185–95.
7. Koike K, Kikuchi Y, Kato M, Takamatsu J, Shintani Y, Tsutsumi T, et al. Prevalence of hepatitis B virus infection in Japanese patients with HIV. Hepatol Res. 2008;38:310–4.
8. Spradling PR, Richardson JT, Buchacz K, Moorman AC, Brooks JT. Prevalence of chronic hepatitis B virus infection among patients in the HIV Outpatient Study, 1996–2007. J Viral Hepat. 2010;17:879–86.
9. Alter MJ. Epidemiology of viral hepatitis and HIV co-infection. J Hepatol. 2006;44:S6–9.
10. Sherman KE, Peters M, Koziel MJ. HIV and liver disease forum: conference proceedings. Hepatology. 2007;45:1566–77.
11. Weinbaum CM, Sabin KM, Santibanez SS. Hepatitis B, hepatitis C, and HIV in correctional populations: a review of epidemiology and prevention. AIDS 2005;19(suppl 3):S41–S416.
12. Salmon-Ceron D, Lewden C, Morlat P, Bevilacqua S, Jougla E, Bonnet F, et al. Liver disease as a major cause of death among HIV infected patients: role of hepatitis C and B viruses and alcohol. J Hepatol. 2005;42:799–805.
13. Thio CL, Seaberg EC, Skolasky R Jr, Phair J, Visscher B, Munoz A, et al. HIV-1, hepatitis B virus, and risk of liver-related mortality in the Multicenter Cohort Study (MACS). Lancet. 2002;360:1921–6.
14. Mendes-Correa M, Nunez M. Management of HIV and hepatitis virus coinfection. Expert Opin Pharmacother. 2010;11:2497–516.
15. Bessesen M, Ives D, Condreay L, Lawrence S, Sherman KE. Chronic active hepatitis B exacerbations in human immunodeficiency virus-infected patients following development of resistance to or withdrawal of lamivudine. Clin Infect Dis. 1999;28:1032–5.
16. Lok AS, McMahon BJ. Chronic hepatitis B: update 2009. Hepatology. 2009;50:661–2.
17. Jain MK, Comanor L, White C, Kipnis P, Elkin C, Leung K, et al. Treatment of hepatitis B with lamivudine and tenofovir in HIV/HBV-coinfected patients: factors associated with response. J Viral Hepat. 2007;14:176–82.
18. Quarleri J, Moretti F, Bouzas MB, Laufer N, Carrillo MG, Giuliano SF, et al. Hepatitis B virus genotype distribution and its lamivudine-resistant mutants in HIV-coinfected patients with chronic and occult hepatitis B. AIDS Res Hum Retroviruses. 2007;23:525–31.
19. Sulkowski MS, Thomas DL, Chaisson RE, Moore RD. Hepatotoxicity associated with antiretroviral therapy in adults infected with human immunodeficiency virus and the role of hepatitis C or B virus infection. JAMA. 2000;283:74–80.
20. den Brinker M, Wit FW, Wertheim-van Dillen PM, Jurriaans S, Weel J, van Leeuwen R, et al. Hepatitis B and C virus co-infection and the risk for hepatotoxicity of highly active antiretroviral therapy in HIV-1 infection. AIDS 2000;14:2895–2902.
21. Alter MJ, Hadler SC, Margolis HS, Alexander WJ, Hu PY, Judson FN, et al. The changing epidemiology of hepatitis B in the United States. Need for alternative vaccination strategies. JAMA. 1990;263:1218–22.
22. Usuda S, Okamoto H, Iwanari H, Baba K, Tsuda F, Miyakawa Y, et al. Serological detection of hepatitis B virus genotypes by ELISA with monoclonal antibodies to type-specific epitopes in the preS2-region product. J Virol Methods. 1999;80:97–112.
23. Usuda S, Okamoto H, Tanaka T, Kidd-Ljunggren K, Holland PV, Miyakawa Y, et al. Differentiation of hepatitis B virus genotypes D and E by ELISA using monoclonal antibodies to epitopes on the preS2-region product. J Virol Methods. 2000;87:81–9.
24. Soriano V, Vispo E, Barreiro P. New 2011 updated DHHS antiretroviral treatment guidelines and chronic hepatitis B. AIDS. 2011;25:1013–4.
25. Miyakawa Y, Mizokami M. Classifying hepatitis B virus genotypes. Intervirology. 2003;46:329–38.
26. Shibayama T, Masuda G, Ajisawa A, Hiruma K, Tsuda F, Nishizawa T, et al. Characterization of seven genotypes (A to E, G and H) of hepatitis B virus recovered from Japanese patients infected with human immunodeficiency virus type 1. J Med Virol. 2005;76:24–32.

27. Orito E, Ichida T, Sakugawa H, Sata M, Horiike N, Hino K, et al. Geographic distribution of hepatitis B virus (HBV) genotype in patients with chronic HBV infection in Japan. Hepatology. 2001;34:590–4.
28. Matsuura K, Tanaka Y, Hige S, Yamada G, Murawaki Y, Komatsu M, et al. Distribution of hepatitis B virus genotypes among patients with chronic infection in Japan shifting toward an increase of genotype A. J Clin Microbiol. 2009;47:1476–83.
29. Koibuchi T, Hitani A, Nakamura T, Nojiri N, Nakajima K, Jyuji T, et al. Predominance of genotype A HBV in an HBV-HIV-1 dually positive population compared with an HIV-1-negative counterpart in Japan. J Med Virol. 2001;64:435–40.
30. Ratcliffe L, Beadsworth MB, Pennell A, Phillips M, Vilar FJ. Managing hepatitis B/HIV co-infected: adding entecavir to truvada (tenofovir disoproxil/emtricitabine) experienced patients. AIDS. 2011;25:1051–6.
31. Hyun JJ, Seo YS, Yoon E, Kim TH, Kim DJ, Kang HS, et al. Comparison of the efficacies of lamivudine versus entecavir in patients with hepatitis B virus-related decompensated cirrhosis. Liver Int. 2012;32:656–64.
32. Dienstag JL, Goldin RD, Heathcote EJ, Hann HW, Woessner M, Stephenson SL, et al. Histological outcome during long-term lamivudine therapy. Gastroenterology. 2003;124:105–17.
33. Suzuki Y, Arase Y, Ikeda K, Saitoh S, Tsubota A, Suzuki F, et al. Histological improvements after a three-year lamivudine therapy in patients with chronic hepatitis B in whom YMDD mutants did not or did develop. Intervirology. 2003;46:164–70.
34. Hiraoka A, Michitaka K, Kumagi T, Kurose K, Uehara T, Hirooka M, et al. Efficacy of lamivudine therapy for decompensated liver cirrhosis due to hepatitis B virus with or without hepatocellular carcinoma. Oncol Rep. 2005;13:1159–63.
35. Zucker SD, Qin X, Rouster SD, Yu F, Green RM, Keshavan P, et al. Mechanism of indinavir-induced hyperbilirubinemia. Proc Natl Acad Sci USA. 2001;98:12671–6.

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ORIGINAL ARTICLE—LIVER, PANCREAS, AND BILIARY TRACT

Systemic combination therapy of intravenous continuous 5-fluorouracil and subcutaneous pegylated interferon alfa-2a for advanced hepatocellular carcinoma

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Abstract
Background In Japan, sorafenib is now the first-line therapy for individuals with advanced hepatocellular carcinoma (HCC), but no other treatment is available for such patients. The aim of this study was to assess the efficacy and safety of combination therapy with systemic continuous intravenous infusion of 5-fluorouracil (5-FU) and subcutaneous peginterferon alfa-2a, which was used before sorafenib was introduced to Japan.
Methods Two hundred and twenty-three HCC patients, who were not amenable to curative surgery, percutaneous ablation, or transarterial chemoembolization (TACE), and for whom intraarterial chemotherapy was not indicated because of the presence of extrahepatic metastasis or stenosis of the common hepatic artery, received peginterferon alfa-2a (90 μg subcutaneously on days 1, 8, 15, and 22) and 5-FU (500 mg/day intravenously given continuously on days 1–5 and 8–12). We assessed their response to treatment and survival, and treatment safety.
Results The response rate was 9.4 % (including six patients with complete response) and the disease-control rate was 32.7 %. The median time to progression was 2.0 months. The overall median survival time was 6.5 months (Child–Pugh class A: 9.2 months vs. Child–Pugh class B: 2.8 months). In a multivariate analysis, Eastern Cooperative Oncology Group (ECOG) performance status >0, Child–Pugh class B, and the presence of macroscopic vascular invasion were independent predictors of poor prognosis. The major grade 3–4 adverse events were leucopenia (13.9 %) and thrombocytopenia (5.8 %). No treatment-related deaths occurred.
Conclusions This combination therapy was well tolerated and showed promising efficacy. Further studies are needed to establish the usefulness of this treatment.

Keywords Hepatocellular carcinoma · Systemic chemotherapy · Survival analysis · Time to progression

Abbreviations

AIC	Akaike information criterion
ALT	Alanine aminotransferase
AST	Aspartate aminotransferase
CR	Complete response
CT	Computed tomography
DCP	Des-gamma-carboxy prothrombin
ECOG	Eastern Cooperative Oncology Group
HBV	Hepatitis B virus
HCC	Hepatocellular carcinoma
HCV	Hepatitis C virus
MRI	Magnetic resonance imaging
MST	Median survival time
NA	Not assessable
PD	Progressive disease
PR	Partial response

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RECIST	Response to treatment in solid tumors
SD	Stable disease
TACE	Transcatheter arterial chemoembolization
TTP	Time to progression
5-FU	5-Fluorouracil

Introduction

Hepatocellular carcinoma (HCC) is a leading cause of cancer-related death, with a particularly high incidence in Asian countries, including Japan [1, 2]. HCC usually develops in a liver already suffering from chronic disease, most notably due to hepatitis B virus (HBV) or hepatitis C virus (HCV) infection [3]. In the past, HCC was diagnosed often only at a very advanced stage, which was associated with a very poor prognosis [4]. Close surveillance of designated high-risk patients, using advanced diagnostic modalities, has now facilitated HCC detection at a much earlier stage. Together with the considerable advances in HCC treatment, such as surgical resection, percutaneous ablation, transcatheter arterial chemoembolization (TACE), and liver transplantation, the survival time of HCC patients has been much prolonged in recent years [5–10].

However, the potentially curative treatment modalities described above are not indicated for patients with advanced HCC with extrahepatic metastasis or macroscopic vascular invasion , and their prognosis remains poor. In two recent large randomized controlled trials, sorafenib, a multi-kinase inhibitor, significantly prolonged survival in patients with advanced HCC, even when the primary lesion was associated with vascular invasion or extrahepatic metastases, and this agent is now widely regarded as the standard treatment for such patients [11, 12]. However, even with sorafenib, the median survival time (MST) of such patients is rather short, ranging from 6.5 to 10.7 months. Thus, the development of new drugs or new regimens that include cytotoxic and molecular-targeted agents still remains necessary.

Previously, we reported the efficacy of therapy using a combination of intrahepatic arterial 5-fluorouracil (5-FU) and subcutaneous interferon alfa for patients with advanced HCC with portal venous invasion [13]. Because most intraarterially administered 5-FU is taken up by the liver during the first pass, this combination chemotherapy would not be effective against extrahepatic metastasis. Nevertheless, the mechanism underlying the chemotherapy with intraarterial 5-FU would function if 5-FU could reach extrahepatic lesions via systemic administration. Therefore, we expected that a combination of systemic intravenous 5-FU and subcutaneous interferon would be effective against extrahepatic metastasis of HCC. We report the efficacy and safety of this treatment for advanced HCC, which we performed before sorafenib was introduced to Japan.

Patients, materials, and methods

Patients

The present study was conducted as a retrospective cohort study. We analyzed 223 consecutive patients who received combination therapy comprised of continuous intravenous infusion of 5-FU and subcutaneous pegylated interferon-alfa for advanced HCC at Kyoundo Hospital from January 1, 2004, to May 31, 2009, when sorafenib was licensed in Japan. The study population consisted of patients with advanced HCC who were not amenable to curative surgery, percutaneous ablation, or TACE, and for whom intraarterial chemotherapy was not indicated because of the presence of extrahepatic metastasis or stenosis of the common hepatic artery. Patients with a previous history of treatment, including systemic chemotherapy, were included. The eligibility criteria also included an Eastern Cooperative Oncology Group (ECOG) performance status score of 2 or less [14], Child–Pugh liver function class A or B, adequate hematologic function (white blood cell count, $\geq$3000/μL; hemoglobin, $\geq$8.5 g/dL; platelet count >30000/μL; and prothrombin time international normalized ratio, $\leq$2.3), adequate hepatic function (albumin, $\geq$2.8 g/dL; total bilirubin, $\leq$3 mg/dL; and alanine aminotransferase [ALT] and aspartate aminotransferase [AST], $\leq$5 times the upper limit of the normal range), and adequate renal function (serum creatinine, $\leq$1.5 times the upper limit of the normal range). Patients were required to have at least one measurable target lesion according to the response to treatment in solid tumors (RECIST) guidelines ver. 1.0 [15]. All patients provided written informed consent before treatment. The treatment protocol was approved by the ethics committee of the institution.

Diagnosis of HCC

Intrahepatic lesions, vascular invasion, and extrahepatic metastasis of HCC were diagnosed with contrast-enhanced computed tomography (CT) or magnetic resonance imaging (MRI), considering hyperattenuation in the arterial phase with washout in the late phase as the definitive sign of HCC [16, 17]. Ultrasound-guided tumor biopsy was also performed when radiological findings were atypical. Bone scintigraphy was added when bone metastasis was suspected because of symptoms but was not confirmed on CT or MRI.

Treatment

One cycle of this treatment consisted of 4 weeks (days 1–28). Peginterferon alfa-2a (90 μg) was administered subcutaneously on days 1, 8, 15, and 22, and 5-FU (500 mg/day) was systemically administered via continuous intravenous infusion, using a portable infusion pump, on days 1–5 and 8–12. Treatment was continued until disease progression, unacceptable toxicity, or patient refusal occurred. This protocol had no treatment interval, and the next cycle started on the day after day 28 of the previous cycle. The first one or two treatment cycles were provided during hospitalization and 5-FU was administered through a peripheral intravenous catheter. Patients who could be expected to survive for a relatively long period underwent implantation of an indwelling central intravenous catheter and were treated on an outpatient basis thereafter. Indwelling central intravenous catheters were inserted by ultrasound-guided subclavian vein puncture and the catheter tip was placed into the superior vena cava using a guidewire under fluoroscopic guidance. When adverse events caused by 5-FU became clinically important, the dose of 5-FU was reduced by 50 %. As prevention and treatment for stomatitis, sodium gualenate hydrate and sodium bicarbonate were used as a gargle. Dexamethasone ointment was also used for stomatitis. Antidiarrheal agents such as loperamide hydrochloride were used for diarrhea.

Response and toxicity assessment

To assess the response to treatment, contrast-enhanced CT or MRI was performed at the end of the first and second cycles and every two cycles thereafter. In principle, treatment responses were evaluated according to the RECIST guidelines ver.1.0 [15]. The best overall response was adopted in the analysis. Complete response (CR) was defined as the disappearance of both intrahepatic lesions and extrahepatic metastasis. CR was confirmed by repeat assessments performed 4 weeks or more after the criteria for response were first met. Patients who had not completed the first cycle were regarded as having progressive disease (PD) if radiological disease progression was confirmed at the time, and as "not assessable (NA)" if imaging was not performed at the time. Toxicity was evaluated using the National Cancer Institute Common Toxicity Criteria version 3.0. During hospitalization, patients were interviewed about their symptoms and underwent a daily physical examination. Blood tests were performed every week. When treated as outpatients, they were required to visit the outpatient department at least once every 2 weeks.

Statistical analysis

We included in the analysis those patients who could not complete the first cycle. The categorical variables were compared by χ^2tests, whereas continuous variables were compared with an unpaired Student's *t*-test (parametric) or Mann–Whitney *U*-test (nonparametric). A P value of <0.05 was considered statistically significant. Overall survival and time to progression (TTP) were calculated using the Kaplan–Meier method. Patients were censored at the time of the last visit, when lost to follow up, or at the end of the study period. Follow up ended on June 30, 2010. The clinical data at baseline were assessed as predictors of survival using univariate and multivariate Cox proportional hazard regression analysis. The following variables were included in this analysis: age, sex, ECOG performance status, hepatitis B surface antigen (HBsAg), hepatitis C virus antibody (HCVAb), Child–Pugh classification, platelet count, Barcelona-Clinic Liver Cancer (BCLC) staging classification [18], presence of viable intrahepatic lesions, macroscopic vascular invasion, extrahepatic metastasis, and a history of previous treatment. Stepwise variable selection with the Akaike information criterion (AIC) was used to find the best model in multivariate analysis. All analytical procedures were performed with S-plus Ver. 7.0 (Insightful, Seattle, WA, USA).

Results

Patients

A total of 223 patients, 176 male and 47 female, with an average age of 64.3 years, received this treatment. Patient characteristics are listed in Table 1. Child–Pugh classification was A in 166 patients (74.4 %) and B in 57 (25.6 %). Macroscopic vascular invasion was present in 103 patients (46.2 %). Extrahepatic metastasis was present in 166 (74.4 %) patients. Those patients without extrahepatic metastasis who were treated with this regimen had contraindications to intraarterial chemotherapy because of stenosis of the common hepatic artery, mainly due to repeated TACE. Two hundred and ten (94.2 %) patients had previously received some other treatment. The median number of cycles of the combination treatment was two (range 1–13). Four patients did not complete the first cycle because of deterioration of performance status, unacceptable toxicity, or patient refusal.

Response to treatment

Six patients had CR (2.7 %), 15 (6.7 %) had a partial response (PR), 52 (23.3 %) had stable disease (SD), and

Table 1 Demographic and baseline characteristics of patients ($n = 223$)

Variable, n (%)	
Age (years)[a]	64.3 ± 10.6
Male sex	176 (78.9)
ECOG performance status	
0	159 (71.3)
1	57 (25.6)
2	7 (3.1)
Viral infection	
HBsAg, positive	58 (26.0)
Anti HCVAb, positive	125 (56.1)
Both positive	4 (1.8)
Both negative	36 (16.1)
Child–Pugh classification	
Class A	166 (74.4)
Class B	57 (25.6)
Platelet count ($10^3/\mu l$)[b]	127 (34–840)
BCLC stage	
B	22 (9.9)
C	201 (90.1)
Viable intrahepatic lesion, present	213 (95.5)
Macroscopic vascular invasion, present[c]	103 (46.2)
Portal vein	73
Hepatic vein or vena cava	51
Maximum tumor size (cm)[b]	5.2 (1.0–20.0)
AFP >100 ng/mL	143 (64.1)
AFP-L3 >15.0 %[d]	147 (66.2)
DCP >100 mAU/mL[e]	152 (68.8)
Extrahepatic metastasis, present[c]	166 (74.4)
Lung	91
Lymph node	52
Bone	33
Adrenal gland	11
Dissemination	20
Others	5
Previous therapy[c]	
None	13 (5.8)
Surgical resection	78 (35.0)
Percutaneous ablation	95 (42.6)
Transarterial chemoembolization	150 (67.3)
Radiotherapy	32 (14.3)
Transarterial chemotherapy	65 (29.1)
Systemic chemotherapy	46 (20.6)
Cycles of systemic 5-FU + IFN therapy[b]	2 (1–13)

ECOG Eastern Cooperative Oncology Group, *HBsAg* hepatitis B surface antigen, *HCVAb* hepatitis C virus antibody , *BCLC* Barcelona-Clinic Liver Cancer, *AFP* alpha fetoprotein, *DCP* des-gamma-carboxy prothrombin, *5-FU* 5-fluorouracil, *IFN* interferon

[a] Mean ± SD

[b] Median (range)

[c] Including overlap

[d] Missing in one case

[e] Missing in two cases

Table 2 Summary of efficacy measures ($n = 223$)

Level of response, n (%)	
Complete response	6 (2.7)
Partial response	15 (6.7)
Stable disease	52 (23.3)
Progressive disease	132 (59.2)
Not assessable	18 (8.1)
Response rate (%)	9.4
Disease-control rate (%)	32.7
Time to progression (months)	
Median	2.0
95 % confidence interval (CI)	2.0–3.1
Overall survival (months)	
Median	6.5
95 % CI	5.13–9.13
1-year survival rate (%)	31.2
2-year survival rate (%)	12.7
3-year survival rate (%)	7.1

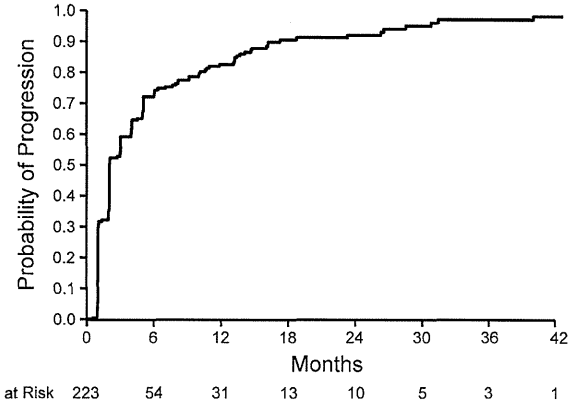

Fig. 1 Kaplan–Meier analysis of time to progression

132 (59.2 %) had PD. Treatment response was not assessable in the remaining 18 (8.1 %) patients due to symptomatic PD or their being lost to follow up before evaluation. The response rate was 9.4 % and the disease-control rate was 32.7 % (Table 2). The median TTP was 2.0 months (Fig. 1). There was no statistically significant difference in TTP between Child–Pugh class A and class B patients (median 3.0 vs. 2.0 months, $P = 0.19$).

Survival

The overall MST was 6.5 months (Fig. 2a). The survival rates at 1, 2, and 3 years were 31.2, 12.7, and 7.1 %, respectively (Table 2). MST was significantly longer in Child–Pugh class A as compared with class B patients (9.2 vs. 2.8 months, $P < 0.001$) (Fig. 2b). The MSTs of patients

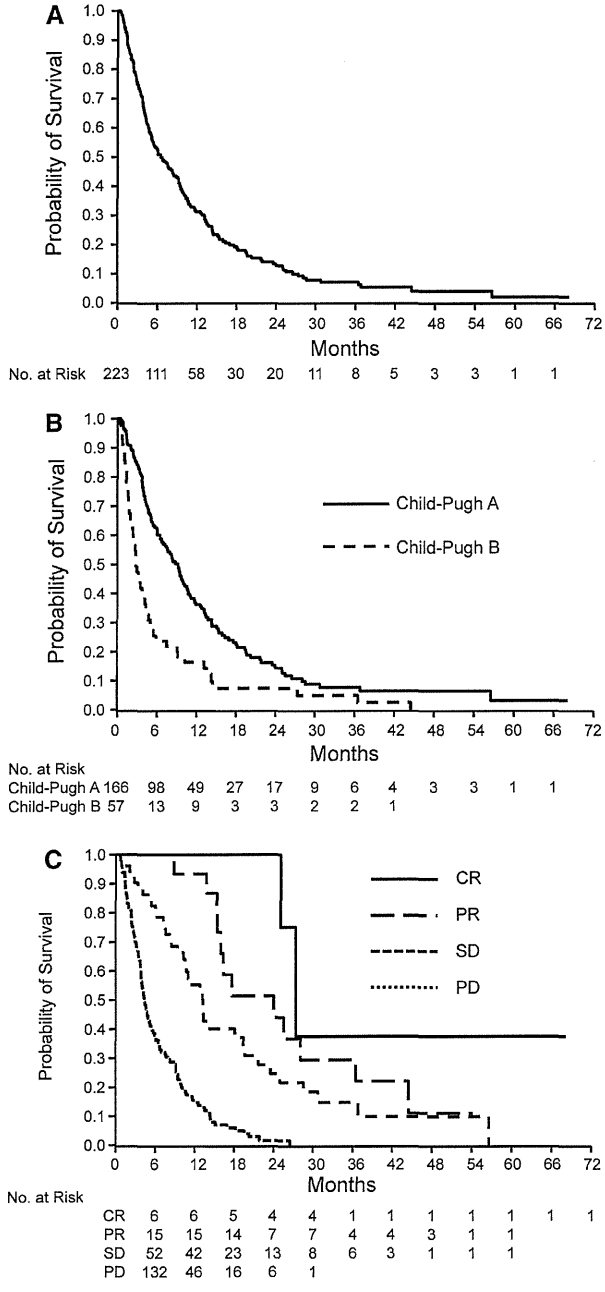

Fig. 2 Kaplan–Meier analysis of overall survival (**a**); stratified based on Child–Pugh classification (**b**) and response to treatment (**c**). *CR* complete response, *PR* partial response, *SD* stable disease, *PD* progressive disease

with CR, PR, SD, and PD were 27.4, 24.0, 13.2, and 4.4 months, respectively (Fig. 2c, $P < 0.001$). Based on a univariate analysis, the following factors were significantly associated with shorter survival time: ECOG performance status >0, Child–Pugh class B, and presence of macroscopic vascular invasion (Table 3). A multivariate analysis showed that all of these factors were also independent prognostic factors (Table 4).

Table 3 Predictors of overall survival: univariate analysis ($n = 223$)

Variable	Hazard ratio (95 % CI)	*P*
Age (years) >65	1.01 (0.76–1.35)	0.94
Male sex	1.03 (0.73–1.45)	0.87
ECOG performance status >0	1.73 (1.25–2.39)	<0.001
HBsAg, positive	0.87 (0.63–1.20)	0.38
Anti HCVAb, positive	1.06 (0.80–1.42)	0.68
Child–Pugh class B versus A	2.12 (1.54–2.92)	<0.001
Platelet count >127,000/μL	1.25 (0.94–1.67)	0.13
BCLC stage C	1.46 (0.89–2.41)	0.14
Viable intrahepatic lesion, present	1.85 (0.76–4.49)	0.17
Macroscopic vascular invasion, present	1.37 (1.03–1.83)	0.03
Extrahepatic metastasis, present	1.35 (0.97–1.87)	0.08
Previous chemotherapy, present	1.16 (0.86–1.55)	0.34

Table 4 Predictors of overall survival: multivariate analysis ($n = 223$)

Variable	Hazard ratio (95 % CI)	*P*
ECOG performance status >0	1.46 (1.04–2.05)	0.03
Child–Pugh class B	1.83 (1.31–2.55)	<0.001
Macroscopic vascular invasion, present	1.39 (1.03–1.88)	0.03
Extrahepatic metastasis, present	1.35 (0.96–1.92)	0.09

Table 5 Safety profile

	Grade 1–2, *n* (%)	Grade 3–4, *n* (%)
Leukopenia	25 (11.2)	31 (13.9)
Anemia	0 (0)	1 (0.4)
Thrombocytopenia	20 (9.0)	13 (5.8)
Stomatitis	11 (4.9)	3 (1.3)
Anorexia	2 (0.9)	1 (0.4)
Diarrhea	2 (0.9)	0 (0)
Skin rash	2 (0.9)	1 (0.4)

Safety

Adverse events graded as 3 or 4 were observed in 28 (12.6 %) patients. The incidence of major adverse events is presented in Table 5. The major grade 3–4 adverse events were leucopenia (13.9 %) and thrombocytopenia (5.8 %). A common non-hematological toxicity was stomatitis (6.2 %, any grade). Fever, which was mostly low-grade, occurred in about 90 % of the patients, usually after the first administration of peginterferon, and was gradually

attenuated during subsequent administrations. Elevations in bilirubin, AST, and ALT levels from baseline occurred in 7.6 % of patients, although most cases of such elevation occurred due to progression of the intrahepatic lesion, and not due to the treatment itself. There were no catheter-related problems, including infection or occlusion. No treatment-related deaths occurred.

Discussion

Wadler et al. first reported combination therapy with intravenous 5-FU and subcutaneous interferon for a malignant neoplasm. They treated 30 patients with advanced colorectal cancer using this protocol [19]. However, the following phase III trial failed to establish the efficacy of the treatment [20]. Subsequently, Patt et al. [21] reported systemic combination therapy for HCC patients, reporting that the treatment induced a decrease of more than 50 % in the size of each measurable lesion in 18 % of the treated patients. Since then, several studies have demonstrated the efficacy of combination therapy of intraarterial 5-FU and subcutaneous interferon for patients with advanced HCC with portal venous invasion, reporting response rates of 44–63 % [13, 22, 23]. Furthermore, other studies have revealed the mechanism underlying the antitumor effects of this combination therapy [24–31]. However, only a case series of a small number of patients has reported on this systemic combination therapy in HCC patients [32]. The present study is the first report of this therapy in a large number of patients ($n = 223$).

In the past, systemic chemotherapy for advanced HCC using various cytotoxic agents, such as doxorubicin, 5-FU, cisplatin, and etoposide, has been investigated. However, few agents showed response rates above 20 %, and the number of patients included in those studies was small. Furthermore, no regimens demonstrated convincing survival benefits in phase III trials [33, 34]. Single-agent 5-FU [35–37] and related drugs such as eniluracil/5-FU [38, 39] and uracil/tegafur [40, 41] showed low response rates. An impressive result came from phase II and phase III studies of PIAF (combination of cisplatin, interferon alfa, doxorubicin, and 5-FU). The response rates of these studies were 26 and 20.9 %, respectively [42, 43], which were actually better than that of the present study, although the number of patients was small and the characteristics of the patients differed from those in our study.

At present, sorafenib is the standard treatment for advanced HCC with extrahepatic metastasis or vascular invasion. Before the availability of sorafenib, we treated such patients with a combination of systemic intravenous 5-FU and subcutaneous interferon. The MSTs in the SHARP study and the Asian-Pacific study of sorafenib (both randomized controlled trials) were 10.7 and 6.5 months, respectively, whereas the MST in the present study was 6.5 months. However, both these trials of sorafenib consisted only of Child–Pugh class A patients, and the MSTs in these two studies were comparable to the MST of the Child–Pugh class A patients in our study (9.2 months). The disease-control rate in our study was 32.7 %, which was comparable to that of sorafenib (43 % in the SHARP study; 35.3 % in the Asian-Pacific study). Moreover, there were no complete responders in either of these randomized controlled trials, and the response rates were also low (2 % in the SHARP study; 3.3 % in the Asian-Pacific study). On the other hand, in the present study, six (2.7 %) patients achieved a complete response, and the response rate of 9.4 % was higher than that in these two studies. Thus, the combination of intravenous 5-FU and subcutaneous interferon is worth consideration as a choice of treatment for advanced HCC.

The response rate of 52.6 % that we observed in our previous study where we treated HCC patients with portal venous invasion with a combination of intraarterial 5-FU and subcutaneous interferon [13] was much better than that observed here. This may be partly because the local concentration of 5-FU in the liver is higher after intraarterial infusion than after systemic administration. However, systemic rather than intraarterial administration is appropriate for patients with extrahepatic metastases because intraarterially administered 5-FU is substantially removed by the liver in the first pass [44, 45].

In our previous study [13], we combined interferon alfa, not pegylated, with the intraarterial administration of 5-FU. Here, we combined pegylated interferon alfa with the systemic administration of 5-FU mainly because of the convenience in an outpatient setting. Whereas non-pegylated interferon needs to be administered three times a week, pegylated interferon requires only once-a-week administration.

Cirrhotic patients have lower clearance rates of 5-FU than non-cirrhotic patients [46]. Thus, such patients with poor liver function may have more severe adverse events. However, there were few serious adverse events in the present study, although as many as 25.6 % of the patients were Child–Pugh class B. Although grade 3 or 4 leucopenia and thrombocytopenia were observed, the baseline white blood cell and platelet counts in the patients with these events were almost always low because of background cirrhosis, and they were able to continue to receive treatment. In addition, we did not observe any serious adverse events in relation to infection.

According to our data, ECOG performance status, Child–Pugh classification, and the presence of vascular invasion were independent prognostic factors. This is consistent with our previous study findings on the prognosis of patients with

extrahepatic metastasis of HCC [47]. In the present study, we also analyzed prognosis as stratified by treatment response, and better treatment response resulted in better prognosis. This point is to be confirmed in future prospective studies.

The combination therapy described in the present study was performed before the advent of sorafenib. It will now be important to evaluate the efficacy of this combination therapy in cases of sorafenib failure. It is also necessary to assess the efficacy and safety of this treatment, as well as that of sorafenib, for patients with poor liver function [48, 49].

In conclusion, the combination of continuous intravenous infusion of 5-FU and subcutaneous peginterferon alfa-2a was well tolerated and showed promising efficacy in a subset of patients with advanced HCC. Further studies; for example validating the efficacy of this treatment in patients with sorafenib failure and conducting a randomized controlled trial comparing this treatment with sorafenib, are needed to definitively establish the usefulness of this treatment.

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References

1. Parkin DM, Bray F, Ferlay J, Pisani P. Global cancer statistics, 2002. CA Cancer J Clin. 2005;55(2):74–108.
2. Matsuda T, Marugame T, Kamo K, Katanoda K, Ajiki W, Sobue T. Cancer incidence and incidence rates in Japan in 2003: based on data from 13 population-based cancer registries in the Monitoring of Cancer Incidence in Japan (MCIJ) Project. Jpn J Clin Oncol. 2009;39(12):850–8.
3. Shiratori Y, Shiina S, Imamura M, Kato N, Kanai F, Okudaira T, et al. Characteristic difference of hepatocellular carcinoma between hepatitis B- and C-viral infection in Japan. Hepatology. 1995;22(4 Pt 1):1027–33.
4. Okuda K, Ohtsuki T, Obata H, Tomimatsu M, Okazaki N, Hasegawa H, et al. Natural history of hepatocellular carcinoma and prognosis in relation to treatment. Study of 850 patients. Cancer. 1985;56(4):918–28.
5. Arii S, Yamaoka Y, Futagawa S, Inoue K, Kobayashi K, Kojiro M, et al. Results of surgical and nonsurgical treatment for small-sized hepatocellular carcinomas: a retrospective and nationwide survey in Japan. The Liver Cancer Study Group of Japan. Hepatology. 2000;32(6):1224–9.
6. Shiina S, Tagawa K, Niwa Y, Unuma T, Komatsu Y, Yoshiura K, et al. Percutaneous ethanol injection therapy for hepatocellular carcinoma: results in 146 patients. AJR Am J Roentgenol. 1993; 160(5):1023–8.
7. Llovet JM, Real MI, Montana X, Planas R, Coll S, Aponte J, et al. Arterial embolisation or chemoembolisation versus symptomatic treatment in patients with unresectable hepatocellular carcinoma: a randomised controlled trial. Lancet. 2002;359(9319):1734–9.
8. Shiina S, Teratani T, Obi S, Sato S, Tateishi R, Fujishima T, et al. A randomized controlled trial of radiofrequency ablation with ethanol injection for small hepatocellular carcinoma. Gastroenterology. 2005;129(1):122–30.
9. Mazzaferro V, Regalia E, Doci R, Andreola S, Pulvirenti A, Bozzetti F, et al. Liver transplantation for the treatment of small hepatocellular carcinomas in patients with cirrhosis. N Engl J Med. 1996;334(11):693–9.
10. Shiina S, Tateishi R, Arano T, Uchino K, Enooku K, Nakagawa H, et al. Radiofrequency ablation for hepatocellular carcinoma: 10-year outcome and prognostic factors. Am J Gastroenterol 2011 [Epub ahead of print].
11. Llovet JM, Ricci S, Mazzaferro V, Hilgard P, Gane E, Blanc JF, et al. Sorafenib in advanced hepatocellular carcinoma. N Engl J Med. 2008;359(4):378–90.
12. Cheng AL, Kang YK, Chen Z, Tsao CJ, Qin S, Kim JS, 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(1):25–34.
13. Obi S, Yoshida H, Toune R, Unuma T, Kanda M, Sato S, et al. Combination therapy of intraarterial 5-fluorouracil and systemic interferon-alpha for advanced hepatocellular carcinoma with portal venous invasion. Cancer. 2006;106(9):1990–7.
14. Oken MM, Creech RH, Tormey DC, Horton J, Davis TE, McFadden ET, et al. Toxicity and response criteria of the Eastern Cooperative Oncology Group. Am J Clin Oncol. 1982;5(6):649–55.
15. Therasse P, Arbuck SG, Eisenhauer EA, Wanders J, Kaplan RS, Rubinstein L, et al. New guidelines to evaluate the response to treatment in solid tumors. European Organization for Research and Treatment of Cancer, National Cancer Institute of the United States, National Cancer Institute of Canada. J Natl Cancer Inst. 2000;92(3):205–16.
16. Torzilli G, Minagawa M, Takayama T, Inoue K, Hui AM, Kubota K, et al. Accurate preoperative evaluation of liver mass lesions without fine-needle biopsy. Hepatology. 1999;30(4):889–93.
17. Bruix J, Sherman M. Management of hepatocellular carcinoma. Hepatology. 2005;42(5):1208–36.
18. Llovet JM, Burroughs A, Bruix J. Hepatocellular carcinoma. Lancet. 2003;362(9399):1907–17.
19. Wadler S, Schwartz EL, Goldman M, Lyver A, Rader M, Zimmerman M, et al. Fluorouracil and recombinant alfa-2a-interferon: an active regimen against advanced colorectal carcinoma. J Clin Oncol. 1989;7(12):1769–75.
20. Greco FA, Figlin R, York M, Einhorn L, Schilsky R, Marshall EM, et al. Phase III randomized study to compare interferon alfa-2a in combination with fluorouracil versus fluorouracil alone in patients with advanced colorectal cancer. J Clin Oncol. 1996; 14(10):2674–81.
21. Patt YZ, Yoffe B, Charnsangavej C, Pazdur R, Fischer H, Cleary K, et al. Low serum alpha-fetoprotein level in patients with hepatocellular carcinoma as a predictor of response to 5-FU and interferon-alpha-2b. Cancer. 1993;72(9):2574–82.
22. Sakon M, Nagano H, Dono K, Nakamori S, Umeshita K, Yamada A, et al. Combined intraarterial 5-fluorouracil and subcutaneous interferon-alpha therapy for advanced hepatocellular carcinoma with tumor thrombi in the major portal branches. Cancer. 2002;94(2):435–42.
23. Ota H, Nagano H, Sakon M, Eguchi H, Kondo M, Yamamoto T, et al. Treatment of hepatocellular carcinoma with major portal vein thrombosis by combined therapy with subcutaneous interferon-alpha and intra-arterial 5-fluorouracil; role of type 1 interferon receptor expression. Br J Cancer. 2005;93(5):557–64.
24. Damdinsuren B, Nagano H, Sakon M, Kondo M, Yamamoto T, Umeshita K, et al. Interferon-beta is more potent than interferon-alpha in inhibition of human hepatocellular carcinoma cell

growth when used alone and in combination with anticancer drugs. Ann Surg Oncol. 2003;10(10):1184–90.
25. Eguchi H, Nagano H, Yamamoto H, Miyamoto A, Kondo M, Dono K, et al. Augmentation of antitumor activity of 5-fluorouracil by interferon alpha is associated with up-regulation of p27Kip1 in human hepatocellular carcinoma cells. Clin Cancer Res. 2000;6(7):2881–90.
26. Moriyama M, Hoshida Y, Kato N, Otsuka M, Yoshida H, Kawabe T, et al. Genes associated with human hepatocellular carcinoma cell chemosensitivity to 5-fluorouracil plus interferon-alpha combination chemotherapy. Int J Oncol. 2004;25(5):1279–87.
27. Kondo M, Nagano H, Wada H, Damdinsuren B, Yamamoto H, Hiraoka N, et al. Combination of IFN-alpha and 5-fluorouracil induces apoptosis through IFN-alpha/beta receptor in human hepatocellular carcinoma cells. Clin Cancer Res. 2005;11(3):1277–86.
28. Takaoka A, Hayakawa S, Yanai H, Stoiber D, Negishi H, Kikuchi H, et al. Integration of interferon-alpha/beta signalling to p53 responses in tumour suppression and antiviral defence. Nature. 2003;424(6948):516–23.
29. Nagano H, Miyamoto A, Wada H, Ota H, Marubashi S, Takeda Y, et al. Interferon-alpha and 5-fluorouracil combination therapy after palliative hepatic resection in patients with advanced hepatocellular carcinoma, portal venous tumor thrombus in the major trunk, and multiple nodules. Cancer. 2007;110(11):2493–501.
30. Yamamoto T, Nagano H, Sakon M, Wada H, Eguchi H, Kondo M, et al. Partial contribution of tumor necrosis factor-related apoptosis-inducing ligand (TRAIL)/TRAIL receptor pathway to antitumor effects of interferon-alpha/5-fluorouracil against hepatocellular carcinoma. Clin Cancer Res. 2004;10(23):7884–95.
31. Nakamura M, Nagano H, Sakon M, Yamamoto T, Ota H, Wada H, et al. Role of the Fas/FasL pathway in combination therapy with interferon-alpha and fluorouracil against hepatocellular carcinoma in vitro. J Hepatol. 2007;46(1):77–88.
32. Patt YZ, Hassan MM, Lozano RD, Brown TD, Vauthey JN, Curley SA, et al. Phase II trial of systemic continuous fluorouracil and subcutaneous recombinant interferon alfa-2b for treatment of hepatocellular carcinoma. J Clin Oncol. 2003;21(3):421–7.
33. Burroughs A, Hochhauser D, Meyer T. Systemic treatment and liver transplantation for hepatocellular carcinoma: two ends of the therapeutic spectrum. Lancet Oncol. 2004;5(7):409–18.
34. Nowak AK, Chow PK, Findlay M. Systemic therapy for advanced hepatocellular carcinoma: a review. Eur J Cancer. 2004;40(10):1474–84.
35. Link JS, Bateman JR, Paroly WS, Durkin WJ, Peters RL. 5-Flourouracil in hepatocellular carcinoma: report of twenty-one cases. Cancer. 1977;39(5):1936–9.
36. Zaniboni A, Simoncini E, Marpicati P, Marini G. Phase II study of 5-fluorouracil (5-FU) and high dose folinic acid (HDFA) in hepatocellular carcinoma. Br J Cancer. 1988;57(3):319.
37. Tetef M, Doroshow J, Akman S, Coluzzi P, Leong L, Margolin K, et al. 5-Fluorouracil and high-dose calcium leucovorin for hepatocellular carcinoma: a phase II trial. Cancer Invest. 1995;13(5):460–3.
38. Llovet JM, Ruff P, Tassopoulos N, Castells L, Bruix J, El-Hariry I, et al. A phase II trial of oral eniluracil/5-fluorouracil in patients with inoperable hepatocellular carcinoma. Eur J Cancer. 2001;37(11):1352–8.
39. Benson AB 3rd, Mitchell E, Abramson N, Klencke B, Ritch P, Burnhan JP, et al. Oral eniluracil/5-fluorouracil in patients with inoperable hepatocellular carcinoma. Ann Oncol. 2002;13(4):576–81.
40. Mani S, Schiano T, Garcia JC, Ansari RH, Samuels B, Sciortino DF, et al. Phase II trial of uracil/tegafur (UFT) plus leucovorin in patients with advanced hepatocellular carcinoma. Invest New Drugs. 1998;16(3):279–83.
41. Ishikawa T, Ichida T, Sugitani S, Tsuboi Y, Genda T, Sugahara S, et al. Improved survival with oral administration of enteric-coated tegafur/uracil for advanced stage IV-A hepatocellular carcinoma. J Gastroenterol Hepatol. 2001;16(4):452–9.
42. Leung TW, Patt YZ, Lau WY, Ho SK, Yu SC, Chan AT, et al. Complete pathological remission is possible with systemic combination chemotherapy for inoperable hepatocellular carcinoma. Clin Cancer Res. 1999;5(7):1676–81.
43. Yeo W, Mok TS, Zee B, Leung TW, Lai PB, Lau WY, et al. A randomized phase III study of doxorubicin versus cisplatin/interferon alpha-2b/doxorubicin/fluorouracil (PIAF) combination chemotherapy for unresectable hepatocellular carcinoma. J Natl Cancer Inst. 2005;97(20):1532–8.
44. Ensminger WD, Rosowsky A, Raso V, Levin DC, Glode M, Come S, et al. A clinical-pharmacological evaluation of hepatic arterial infusions of 5-fluoro-2′-deoxyuridine and 5-fluorouracil. Cancer Res. 1978;38(11 Pt 1):3784–92.
45. Goldberg JA, Kerr DJ, Watson DG, Willmott N, Bates CD, McKillop JH, et al. The pharmacokinetics of 5-fluorouracil administered by arterial infusion in advanced colorectal hepatic metastases. Br J Cancer. 1990;61(6):913–5.
46. Ueno H, Okada S, Okusaka T, Ikeda M, Kuriyama H. Phase I and pharmacokinetic study of 5-fluorouracil administered by 5-day continuous infusion in patients with hepatocellular carcinoma. Cancer Chemother Pharmacol. 2002;49(2):155–60.
47. Uchino K, Tateishi R, Shiina S, Kanda M, Masuzaki R, Kondo Y, et al. Hepatocellular carcinoma with extrahepatic metastasis: clinical features and prognostic factors. Cancer. 2011;117(19):4475–83.
48. Worns MA, Weinmann A, Pfingst K, Schulte-Sasse C, Messow CM, Schulze-Bergkamen H, et al. Safety and efficacy of sorafenib in patients with advanced hepatocellular carcinoma in consideration of concomitant stage of liver cirrhosis. J Clin Gastroenterol. 2009;43(5):489–95.
49. Pinter M, Sieghart W, Graziadei I, Vogel W, Maieron A, Konigsberg R, et al. Sorafenib in unresectable hepatocellular carcinoma from mild to advanced stage liver cirrhosis. Oncologist. 2009;14(1):70–6.

Research Article

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Comparison of resection and ablation for hepatocellular carcinoma: A cohort study based on a Japanese nationwide survey

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Background & Aims: The treatment of choice for early or moderately advanced hepatocellular carcinoma (HCC) with good liver function remains controversial. We evaluated the therapeutic impacts of surgical resection (SR), percutaneous ethanol injection (PEI), and radiofrequency ablation (RFA) on long-term outcomes in patients with HCC.

Methods: A database constructed on the basis of a Japanese nationwide survey of 28,510 patients with HCC treated by SR, PEI, or RFA between 2000 and 2005 was used to identify 12,968 patients who had no more than 3 tumors (⩽3 cm) and liver damage of class A or B. The patients were divided into SR (n = 5361), RFA (n = 5548), and PEI groups (n = 2059). Overall survival and time to recurrence were compared among them.

Results: Median follow-up was 2.16 years. Overall survival at 3 and 5 years was respectively 85.3%/71.1% in the SR group, 81.0%/61.1% in the RFA, and 78.9%/56.3% in the PEI. Time to recurrence at 3 and 5 years was 43.3%/63.8%, 57.2%/71.7%, and 64.3%/76.9%, respectively. On multivariate analysis, the hazard ratio for death was significantly lower in the SR group than in the RFA (SR *vs.* RFA:0.84, 95% confidence interval, 0.74–0.95; $p = 0.006$) and PEI groups (SR *vs.* PEI:0.75, 0.64–0.86; $p = 0.0001$). The hazard ratios for recurrence were also lower in the SR group than in the RFA (SR *vs.* RFA:0.74, 0.68–0.79; $p = 0.0001$) and PEI groups (SR *vs.* PEI:0.59, 0.54–0.65; $p = 0.0001$).

Conclusions: Our findings suggest that surgical resection results in longer overall survival and shorter time to recurrence than either RFA or PEI in patients with HCC.

Keywords: Hepatectomy; Surgical resection; Radiofrequency ablation; Percutaneous ethanol injection.

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Abbreviations: HCC, hepatocellular carcinoma; SR, surgical resection; RFA, radiofrequency ablation; PEI, percutaneous ethanol injection; TACE, transcatheter hepatic arterial chemoembolization.

Introduction

Hepatocellular carcinoma (HCC) is the fifth most common cancer in men and the seventh in women, worldwide [1]. Outcomes remain disappointing, despite recent progress in the techniques of diagnosis and therapy. Japanese [2], European [3] and American [4] clinical practice guidelines strongly recommend surgical resection (SR) and percutaneous ablation, including radiofrequency ablation (RFA) and percutaneous ethanol injection (PEI), for the management of early or moderately advanced HCC (i.e., up to 3 tumors 3 cm or less in diameter) in patients with adequately maintained liver function. Although comparative studies of these treatments have been conducted previously [5–7], the most suitable treatment strategy still remains controversial.

By nationwide surveys initiated in 1965, the Liver Cancer Study Group of Japan has prospectively collected data on patients with HCC in Japan. The Group conducted two retrospective analyses to define the treatment with the best outcomes [8,9]. However, each of the analyses was flawed, and had several problems: data on RFA were not included in the first report [8], and the follow-up period was short in the second one [9]. Although the second analysis demonstrated that surgical resection was superior to RFA and PEI for preventing recurrence [9], no apparent difference in the overall survival could be discerned between surgery and percutaneous ablation therapies (RFA and PEI). Thus, the treatment of choice for less advanced HCC still remains under debate.

Before starting this study, the results of 2 randomized controlled trials (RCT) were available [10,11]. As we pointed out in a previous report [12], however, the study designs of these 2

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trials were critically flawed by factors such as insufficient sample size, excessively optimistic hypotheses, and high conversion ratios. Because of these problems, the results of the two RCTs do not allow firm conclusions to be drawn concerning the important clinical question: is surgery or percutaneous ablation the treatment of choice for early or moderately advanced HCC? To answer this question, we conducted this cohort study based on the latest data available from a Japanese nationwide survey.

Patients and methods

Patients and settings

The Liver Cancer Study Group of Japan has performed nationwide surveys of patients with primary liver cancer since 1965. Patients are registered and followed up, as reported previously [9]. Although this study protocol was not submitted to the Institutional Review Board of each institution participating in the nationwide survey, the collection and registration of data of patients with HCC were performed with the approval of each institution. Because RFA has been available for clinical use since 1999 in Japan, we set the study period from 2000 to 2005, to exclude preliminary experiences with RFA. During this period, a total of 28,510 patients with HCC were registered and received surgical resection, RFA or PEI as the primary treatment with curative intent for HCC. We identified 12,968 patients who met the following criteria: (1) liver function classified as liver damage A or B defined by the Liver cancer Study Group of Japan [13]; (2) number of tumors 3 or less; (3) maximum tumor diameter $\leqslant$3 cm. The 12,968 patients were divided into 3 groups according to the treatment received: SR group (n = 5361, 41.3%), RFA group (n = 5548, 42.8%), and PEI group (n = 2059, 15.9%). The diagnostic criteria and details of follow-up were described previously [8]. Because it has been unusual for biopsies to be performed in cases treated by percutaneous ablation in Japan, histological findings such as microscopic vascular invasion, tumor grading, and microscopic intrahepatic metastasis were not evaluated in this study. Relevant clinical data were collected and analyzed.

Statistical analyses

The baseline characteristics of the three groups (Table 1) were compared by analysis of variance for continuous variables and by Chi-square or Mantel-trend tests for categorical variables. Consistent with our preliminary report [9], the SR group had a higher proportion of younger patients and male patients than the RFA and PEI groups. Hepatitis C virus infection was less prevalent in the SR group than in the RFA and PEI groups. Based on the liver damage class, serum albumin and total bilirubin levels, platelet counts, and the indocyanine green retention rate at 15 min, liver function was better in the SR group than in the RFA and PEI groups, consistent with our previous report [9]. As for tumor-related factors, the number of tumors was smaller, and the maximum tumor diameter was larger in the SR group than in the RFA or PEI group. The SR group had the lowest proportion of patients with abnormally elevated alpha-fetoprotein levels ($\geqslant$15 ng/ml) and the highest proportion of patients with abnormally elevated des-γ-carboxy prothrombin levels ($\geqslant$40 AU/ml).

Overall survival and time to recurrence curves were plotted using the Kaplan–Meier method and compared with the use of the log-rank test. Recurrence was diagnosed on the basis of imaging studies, clinical data, and/or histopathological studies at each institution [9].

The therapeutic impacts of surgical resection, RFA and PEI were estimated using a Cox proportional hazards model including the following 10 covariates: age, gender, liver damage class, hepatitis C virus antibody, hepatitis B surface antigen, platelet count, number of tumors, tumor size, and serum alpha-fetoprotein and des-γ-carboxy prothrombin levels. The results of multivariate analysis were expressed as hazard ratios with 95% confidence intervals. p values of <0.05 were considered to indicate statistical significance.

For the subgroup analyses, the study populations were classified into 8 subgroups according to the tumor size (< or $\geqslant$2 cm), tumor number (single or multiple), and liver damage class (A or B). Macroscopic vascular invasion was excluded from the subgroup analyses because its presence is a contraindication to percutaneous ablation therapies. The therapeutic impacts of the three treatments were evaluated in each of these subgroups, and hazard ratios with 95% confidence intervals and p values were calculated according to the above three factors (tumor size, number of tumors, and liver damage class).

Results

The median follow-up after treatment was 2.16 years, and the 5th and 95th percentiles were 0.14 and 5.19 years, respectively. The overall survival rates at 3/5 years were 85.3%/71.1% in the SR group, 81.0%/61.1% in the RFA group, and 78.9%/56.3% in the PEI group (Fig. 1). The median survival times were 8.4, 5.9, and 5.6 years in the three groups, respectively. The time to recurrence rates at 3/5 years in the 3 groups were 43.3%/63.8%, 57.2%/71.7%, and 64.3%/76.9%, respectively (Fig. 2).

According to the results of the multivariate analysis, the hazard ratio for death in the SR group was 0.84 (0.74–0.95, $p = 0.006$) relative to that in the RFA group, and 0.75 (0.64–0.86, $p = 0.0001$) relative to that in the PEI group (Table 2A). The hazard ratios for recurrence in the SR group were 0.74 (0.68–0.79, $p = 0.0001$) and 0.59 (0.54–0.65, $p = 0.0001$) relative to those in the RFA and PEI groups, respectively (Table 2B). These results indicated that the overall survival and time to recurrence rates were both significantly better in the SR group than in the RFA and PEI groups.

The overall survival rates following surgical resection, RFA and PEI in the 4 subgroups with a single tumor are shown in Fig. 3A–D. The results of the subgroup analyses (summarized in Fig. 4A) showed that the overall survival was significantly longer in the SR group than in the RFA group in 2 subgroups of patients, namely, those who had a single tumor smaller than 2 cm in diameter with liver damage class A, and those who had a single tumor 2 cm or larger in diameter with liver damage class B.

As shown in Fig. 4B, the time to recurrence was shorter in the SR group than that in the RFA group in the 4 following subgroups: patients with a single tumor with liver damage class A (regardless of the tumor size), those with multiple tumors 2 cm or larger in diameter with liver damage class A, and those with a single tumor 2 cm or larger in diameter with liver damage class B.

Discussion

Our study showed that surgical resection was associated with significantly lower risk of both death and recurrence as compared to RFA and PEI in patients with early or moderately advanced HCC. Our previous preliminary report [9] suggested that surgery reduces the risk of recurrence, but failed to demonstrate any difference in the overall survival between surgery and percutaneous ablation therapies in patients with early or moderately advanced HCC. The present study reconfirms that surgery is associated with a reduced recurrence rate and newly shows that surgery yields a longer overall survival than percutaneous ablation therapies.

Differences in the results between the present study and previous investigations are most likely related to the sample size and length of follow-up. The total number of subjects increased markedly from 7185 in our previous study to 12,968 in this study, and the median follow-up period increased from 10.4 months to 2.16 years (25.9 months). These factors are considered not only to have enhanced the reliability of our findings, but also to have strengthened our conclusions. We believe that our results, which are, of course, subject to the inherent drawbacks of the study design, are meaningful, given the current lack of credible data derived from well-designed RCTs.

The large sample size and prolonged follow-up period also allowed us to perform several subgroup analyses, which were not feasible in our previous study [9]. We classified the patients

Cancer

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