Table 1. Proportions of various virological responses of HCV-2a- and HCV-2b-infected patients treated with PEG-IFN/RBV.

Response	Proportion		
	HCV-2a	HCV-2b	All
RVR	46/61* (75%)	34/51 (67%)	80/112 (71%)
Non-RVR	15/61 (25%)	17/51 (33%)	32/112 (29%)
EVR	61/61 (100%)	51/51 (100%)	112/112 (100%)
ETR	61/61 (100%)	50/51 (98%)	111/112 (99%)
SVR	49/58 (84%)	34/47 (72%)	83/105 (79%)
Non-SVR	9/58 (16%)	13/47 (28%)	22/105 (21%)

*No. of patients/no. of total.
Abbreviations: RVR, rapid virological response; EVR, early virological response; ETR, end-of-treatment response; SVR, sustained virological response.
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HCV-J8 [19], respectively. The remaining C-terminal half (aa 2197 to 2442) of the consensus sequences were identical to those reported by Murakami et al. [8] except that His at position 2358 in the HCV-2b sequence was replaced with Cys, which was more conserved (59% of the isolates tested) than His (22%).

To investigate the impact of NS5A heterogeneity on the clinical outcome of PEG-IFN/RBV therapy, we first performed a sliding window analysis with a window size of 20 residues over the full-length NS5A sequences obtained from 23 RVR and 7 non-RVR patients infected with HCV-2a along with the consensus sequence, as described previously [8]. This analysis revealed that the number of aa mutations differed significantly between RVR and non-RVR isolates in two regions within the C-terminal half of NS5A (data not shown). The more C-terminally located one exactly matched the region that corresponded to IRRDR of HCV-1b, ranging from aa 2332 to 2387, thus being referred to as IRRDR[2a] (see Figure 1). The other region composed of a part of ISDR plus its carboxy-flanking region, ranging from aa 2232 to 2262, thus being referred to as ISDR/+C[2a] (see Figure 2). It was confirmed that the average numbers of aa mutations in IRRDR[2a] and ISDR/+C[2a] were each significantly larger in isolates from RVR than those from non-RVR patients (Table 3). More importantly, the average numbers of aa mutations in IRRDR[2a] and ISDR/+C[2a] were each significantly larger in SVR than in non-SVR. Sequences of IRRDR[2a] and ISDR/+C[2a] obtained from SVR and non-SVR patients and the number of mutations of each isolate are shown in Figures 1 and 2.

Likewise, a sliding window analysis on HCV-2b isolates (16 RVR and 6 non-RVR) identified an N-terminal part of IRRDR (aa 2332 to 2357), referred to as IRRDR/N[2b], that showed a significant difference in the number of aa mutations between RVR and non-RVR (data not shown). The average numbers of aa mutations in IRRDR/N[2b] were significantly larger in RVR than in non-RVR (Table 3). However, they did not differ significantly between SVR and non-SVR. Sequences of IRRDR[2b]/N obtained from RVR and non-RVR patients are shown in Figure 3.

Correlation between NS5A Sequence Heterogeneity and SVR or RVR in HCV-2a and HCV-2b infections

The receiver operating characteristic analysis identified the optimal thresholds of the numbers of aa mutations in IRRDR[2a] and ISDR/+C[2a] for the prediction of RVR and SVR in HCV-2a infection; four and one for IRRDR[2a] and ISDR/+C[2a], respectively (data not shown). Accordingly, we found that 86% (42/49) of SVR patients, and only 22% (2/9) of non-SVR, were infected with HCV-2a isolates having IRRDR with 4 or more mutations (IRRDR[2a]≥4) (Table 4). On the other hand, 14% (7/49) of SVR, and 78% (7/9) of non-SVR patients, were infected with isolates having IRRDR with 3 or less mutations (IRRDR[2a]≤3). These results suggested that IRRDR[2a]≥4 was significantly associated with SVR ($P=0.0003$). Similarly, 93% (42/46) of RVR patients, and only 33% (5/15) of non-RVR, were infected with HCV-2a isolates of IRRDR[2a]≥4 while 7% (4/46) of RVR patients, and 67% (10/15) of non-RVR, were infected with HCV-2a isolates of IRRDR[2a]≤3, with the results suggesting that IRRDR[2a]≥4 was significantly associated with RVR as well ($P<0.0001$).

As for ISDR/+C[2a] heterogeneity, 71% (35/49) of SVR, and 22% (2/9) of the non-SVR patients, were infected with HCV-2a isolates with ISDR/+C having one or more mutation (ISDR/+C[2a]≥1) (Table 4). On the other hand, 29% (14/49) of SVR patients, and 78% (7/9) of the non-SVR, were infected with isolates with ISDR/+C without mutation (ISDR/+C[2a] = 0). Thus, ISDR/+C[2a]≥1 was significantly associated with SVR ($P=0.008$).

Table 2. Demographic characteristics of HCV-2a- and HCV-2b-infected patients with SVR and non-SVR.

Factor	HCV-2a			HCV-2b		
	SVR	Non-SVR	*P* value	SVR	Non-SVR	*P* value
Age	49.78±13.67*	62.89±7.01	**0.007**	50.03±15.03	55.08±11.22	0.28
Sex (male/female)	22/27	3/6	0.72	17/17	8/5	0.53
Body weight (kg)	60.39±11.00	54.67±10.51	0.15	57.72±13.46	65.08±7.26	0.06
Platelets ($\times10^4$/mm^3)	18.54±5.71	19.43±10.78	0.72	17.57±5.65	15.20±7.281	0.27
Hemoglobin (g/dl)	14.38±6.07	14.0±1.56	0.88	14.19±1.59	13.78±1.5	0.49
γ-GTP (IU/L)	37.66±53.25	36.83±24.82	0.97	39.68±34.33	81.30±69.11	**0.02**
ALT (IU/L)	64.75±52.45	94.38±141.3	0.28	86.35±91.95	86.85±118.7	0.98
HCV-RNA (KIU/ml)	1350±1424	1598±1464	0.63	5543±7643	7905±14210	0.47
HCV core antigen (fmol/L)	6543±6927	6105±8290	0.91	9054±6743	9390±8723	0.92

*Mean ± S.D.
Abbreviations: SVR, sustained virological response; γ-GTP, gamma glutamyl transpeptidase; ALT, alanine aminotransferase.
doi:10.1371/journal.pone.0030513.t002

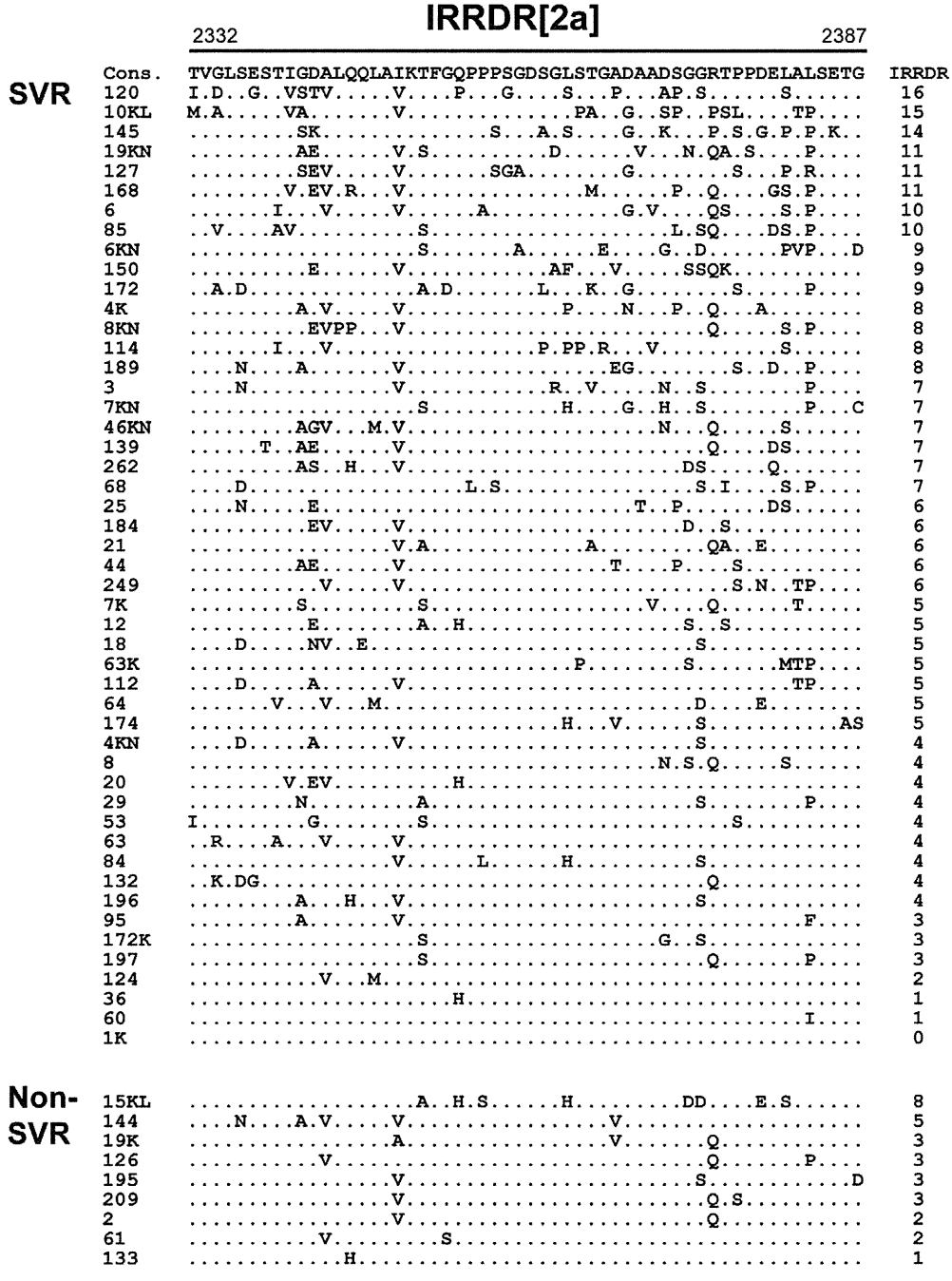

Figure 1. Sequence alignment of IRRDR[2a]. Sequences of IRRDR[2a] (interferon/ribavirin resistance-determining region of HCV-2a) obtained from SVR and non-SVR patients are aligned. The consensus sequence (Cons) is shown on the top. The numbers along the sequence indicate the aa positions. Dots indicate residues identical to those of the Cons sequence. The numbers of the mutations in IRRDR[2a] are shown on the right.
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As for HCV-2b infection, the receiver operating characteristic analysis identified "two" as the optimal threshold of the number of mutations in IRRDR/N[2b] by which to predict RVR (data not shown). Accordingly, we found that 65% (22/34) of RVR, and 18% (3/17) of non-RVR patients, were infected with HCV-2b isolates of IRRDR/N[2b]≥2 (Table 4). On the other hand, 35% (12/34) of RVR, and 82% (14/17) of the non-RVR patients, were infected with IRRDR/N[2b]≤1. These results suggested that IRRDR/N[2b]≥2 was significantly associated with RVR ($P = 0.0025$). However, no correlation, or even no tendency toward significant correlation, was observed between IRRDR/N[2b]≥2 and SVR in HCV-2b infection.

Correlation between NS5A Sequence Heterogeneity and Viremia Titers in the Serum of patients infected with HCV-2a and HCV-2b before PEG-IFN/RBV Therapy

Next, we examined the impact of IRRDR sequence heterogeneity on HCV titers in the serum before the initiation of the treatment. As shown in Figure 4A, patients infected with IRRDR[2a]≥4 had significantly lower pretreatment serum

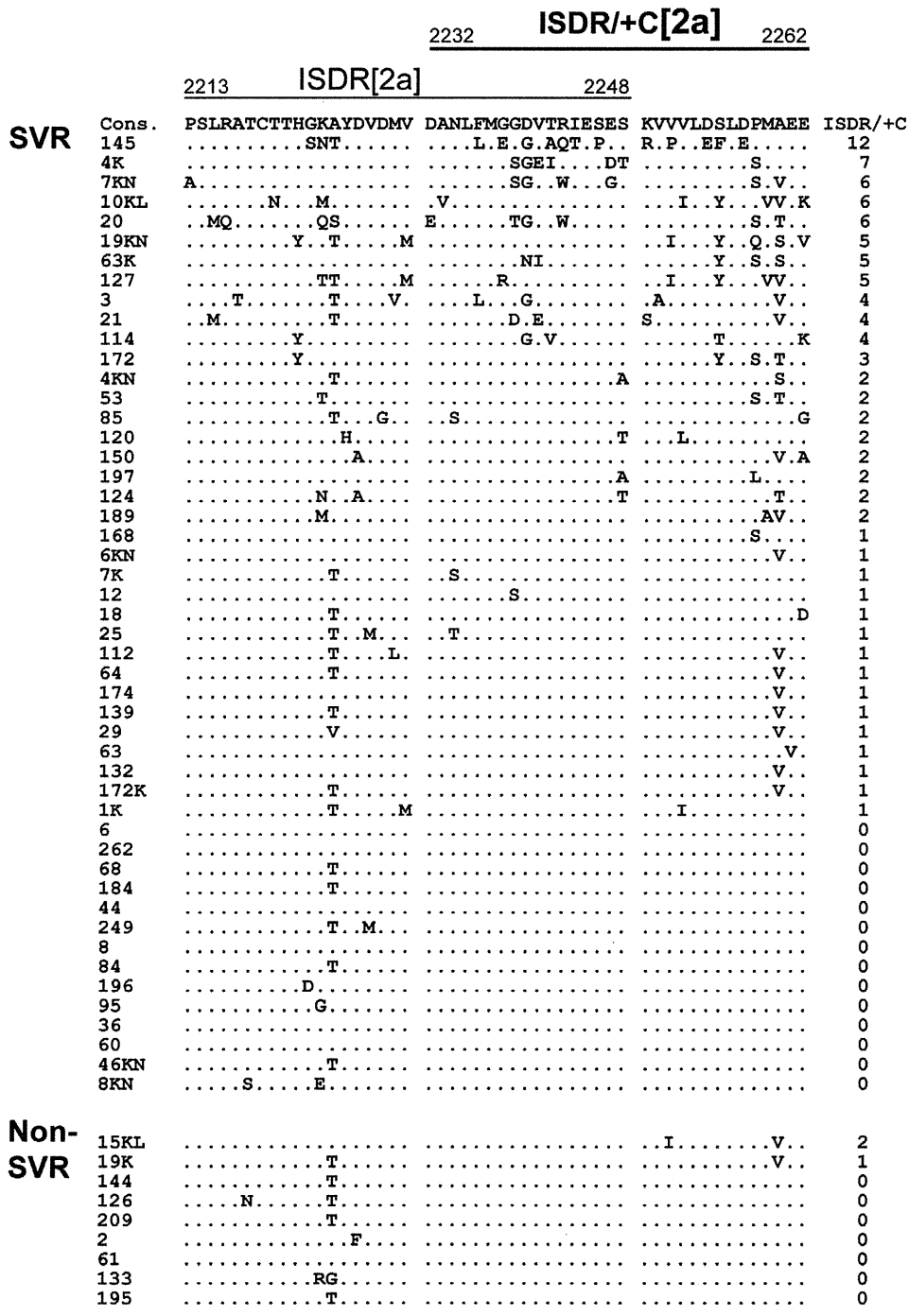

Figure 2. Sequence alignment of ISDR/+C[2a]. Sequences of ISDR/+C[2a] (part of interferon sensitivity determining-region plus its carboxy-flanking region of HCV-2a) obtained from SVR and non-SVR patients are aligned. The consensus sequence (Cons) is shown on the top. The numbers along the sequence indicate the aa positions. Dots indicate residues identical to those of the Cons sequence. The numbers of the mutations in ISDR/+C[2a] are shown on the right.
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HCV core antigen titers than those infected with IRRDR[2a]≤3. On the other hand, there was no significant difference in HCV viremia titers between ISDR/+C[2a]≥1 and ISDR/+C[2a] = 0 (Figure 4B). Also, in HCV-2b infection, there was no significant difference in pretreatment HCV viremia titers between IRRDR/N[2b]≥2 and IRRDR/N[2b]≤1 (Figure 4C).

Correlation between Core Protein Sequence Heterogeneity and RVR or SVR

A close correlation between core protein sequence patterns and treatment outcome has been proposed in HCV-1b infection [12,13]. To examine this hypothesis in HCV-2a and -2b infections, core regions of the virus genome were amplified from the pretreated sera, and the aa sequences deduced and aligned

Table 3. Average numbers of aa mutations within IRRDR[2a], ISDR/+C[2a] and IRRDR/N[2b] of HCV NS5A obtained form pre-treated sera of HCV-2a and -2b-infected patients with SVR, non-SVR, RVR and non-RVR.

NS5A region	No. of mutations			No. of mutations		
	SVR	Non-SVR	*P* value	RVR	Non-RVR	*P* value
IRRDR[2a] (aa 2332–2387)	6.4±3.4*	3.3±2.1	**0.01**	6.8±3.3	3.3±1.9	0.0003
ISDR/+C[2a] (aa 2232–2262)	2.0±2.4	0.3±0.7	**0.047**	2.1±2.5	0.6±0.7	0.025
IRRDR/N[2b] (aa 2332–2357)	1.8±1.5	1.4±1.3	0.45	2.0±1.4	1.0±1.2	0.01

*Mean ± S.D.

Abbreviations: SVR, sustained virological response; RVR, rapid virological response; IRRDR[2a], interferon/ribavirin resistance-determining region of HCV-2a; ISDR/+C[2a], part of interferon sensitivity determining-region plus its carboxy-flanking region of HCV-2a; IRRDR/N[2b], an N-terminal part of interferon/ribavirin resistance-determining region of HCV-2b.

doi:10.1371/journal.pone.0030513.t003

IRRDR[2b] 2387

2332 **IRRDR/N[2b]** 2357

	Cons.	AKVLTQDNVEGVLREMADKVLSPLQD	CNDSGHSTGVDTGGDSVQQPSDETAASEAG	IRRDR/N(2b)	Final response
RVR	73	.....S...I.K.....P..	S....R.....NI...P.....	4	SVR
	138	.....FK...G..F.....	H....R...A.....S.	4	SVR
	143	T.....D...R...S...	H.....AEA.....TA	4	SVR
	166	.R.....K.....SF..	Y.....A.....D..	4	Non-SVR
	183	.....T...I.K.....P..	S....R.....NI..L...A.V....	4	SVR
	231	.....FN.PR.	.....A.....S.D..	4	SVR
	2KL	.....KE.....P..	.....A.....T....	3	SVR
	7	.R.....I.....A.....	.....L...A.....D..	3	SVR
	21KN	.....I....VE.....	HT.....A.....	3	SVR
	116	.....GE..K.....	.....T.	3	SVR
	185	.....I.....I..E.	.....A.....D..	3	Non-SVR
	193	.....E...G.....F.....	.....A.....T.	3	SVR
	205	.....G....F.....F.....	Q.....A.....	3	Non-SVR
	233	.T.....R...K.....	.....T.	3	SVR
	4	V.....S.....	.Q.....T.	2	Non-SVR
	5KN	.R.....K.....	H.....A.....	2	SVR
	9KN	.....K.P..	N....L...AE.....D..	2	SVR
	94	.....F..P..	.....A.....T.	2	SVR
	106K	.....V.....G	.D...R.....	2	SVR
	212	.....E.....A.....	.....D..	2	SVR
	147	.R.....K.....	H.....A.....	2	Unknown
	229	.R.....I....	H.....E.....	2	Non-SVR
	11KL	.....I.....	.H.....M.....V..T.	1	SVR
	55KN	.R.....	H.....A.....A.....	1	SVR
	87	.....K.....	.....T....	1	SVR
	103	..I.....	.....AD.....	1	SVR
	165	.....F.....	H.....A.....S.	1	SVR
	1K	.....	.....A..A....T...T.	0	SVR
	10K	.....	.....I.L.....	0	SVR
	46	.....	.....	0	SVR
	99	.....	.....S..T.	0	SVR
	113	.....	.....T...T.	0	SVR
	179	.....	H.....A....N.A.....T...S.	0	SVR
	187	.....	Y.....T..T.	0	SVR
Non-RVR	18KN	.....G.....F.LP.E	.D.....T.	5	SVR
	13K	.....E...K.....	.D.....E....K.....	2	Non-SVR
	110	.....H...E.....	.H.....N.I..A.....T.	2	Unknown
	11K	.....N.....	.....C...A.....C.....G..T.	1	SVR
	23KN	.....E.....	.D.....M.....A.....S.	1	Non-SVR
	40KN	.....P..	HS...R.....D.E	1	SVR
	89	.....F.....	.....TE	1	Non-SVR
	157	.....N.....	YS.....P.....E	1	SVR
	164	.R.....	S.....I.....D.....T.	1	SVR
	170	.....E.....	SD.....N....I.....T.	1	Unknown
	265KL	.....I.....	.....E.	1	Non-SVR
	1	.....	YH.....A.....I...P.....	0	Non-SVR
	32KN	.....	.....G....	0	Non-SVR
	52	.....	H.....A.....T..T.	0	SVR
	105	.....	Y.....	0	Non-SVR
	107	.....	.....R.....	0	Non-SVR
	134	.....	.....G..T.	0	Unknown

Figure 3. Sequence alignment of NS5A of HCV-2b isolates. Sequences of IRRDR/N[2b] (an N-terminal part of interferon/ribavirin resistance-determining region of HCV-2b) obtained from RVR and non-RVR patients are aligned. The consensus sequence (Cons) is shown on the top. The numbers along the sequence indicate the aa positions. Dots indicate residues identical to those of the Cons sequence. The numbers of the mutations in IRRDR/N[2b] and the final treatment outcome of each patient are shown on the right.

doi:10.1371/journal.pone.0030513.g003

Table 4. Correlation between NS5A sequence heterogeneity and SVR or RVR in HCV-2a and HCV-2b infections.

Factor	SVR	Non-SVR	*P* value	RVR	Non-RVR	*P* value
IRRDR[2a]≥4	42/49* (86%)	2/9 (22%)	**0.0003**	42/46 (93%)	5/15 (33%)	<0.0001
IRRDR[2a]≤3	7/49 (14%)	7/9 (78%)		4/46 (7%)	10/15 (67%)	
ISDR/+C[2a]≥1	35/49 (71%)	2/9 (22%)	**0.008**	32/46 (70%)	7/15 (47%)	0.1
ISDR/+C[2a] = 0	14/49 (29%)	7/9 (78%)		14/46 (30%)	8/15 (53%)	
IRRDR/N[2b]≥2	17/34 (50%)	6/13 (46%)	1.0	22/34 (65%)	3/17 (18%)	0.0025
IRRDR/N[2b]≤1	17/34 (50%)	7/13 (54%)		12/34 (35%)	14/17 (82%)	

*No. of isolates with a given factor/total no. of SVR or RVR.
Abbreviations: SVR, sustained virological response; RVR, rapid virological response; IRRDR[2a], interferon/ribavirin resistance-determining region of HCV-2a; ISDR/+C[2a], part of interferon sensitivity determining-region plus its carboxy-flanking region of HCV-2a; IRRDR/N[2b], an N-terminal part of interferon/ribavirin resistance-determining region of HCV-2b.
doi:10.1371/journal.pone.0030513.t004

with the prototype sequences (HCV-J6 [18] and HCV-J8 [19]). The residues at positions 70 and 91, which were reported to be associated with the treatment outcome in HCV-1b infection [13], were both well conserved among HCV-2a and -2b isolates and, therefore, no correlation with treatment outcome was expected for these residues (Figures S1 and S2). In this connection, the residues at positions 48 and 110 of HCV-2a isolates showed certain degrees of variation. However, there was no significant correlation between the sequence patterns and the treatment outcome.

Identification of Independent Predictive Factors for SVR and RVR in HCV-2a and HCV-2b infections

In order to identify significant independent predictors of SVR in HCV-2a and HCV-2b infections, univariate and multivariate logistic regression analyses were carried out using all available data of baseline patients' parameters and viral genetic polymorphic factors. Univariate analysis identified 3 factors that were significantly associated with SVR in HCV-2a infection; the heterogeneity of IRRDR[2a] (≥4 vs. ≤3), ISDR/+C[2a] (≥1 vs. = 0) and patients' age (<55 years) (Table 5). Subsequently, these factors were entered in multivariate regression analysis. The result obtained revealed that the IRRDR[2a] heterogeneity was the only independent predictive factor for SVR in HCV-2a infection ($P = 0.001$). The IRRDR[2a] heterogeneity was also the independent predictive factor for RVR (Table S1).

As for HCV-2b infection, univariate analysis identified two host factors that were significantly, or almost significantly, associated with SVR; γ-GTP levels (<30 IU/L) and body weight (<65 kg) (Table 5). No viral factor was identified in this analysis. In subsequent multivariate analysis, γ-GTP levels was identified as an independent predictive factor for SVR in HCV-2b infection. In this connection, the heterogeneity of IRRDR/N[2b], a viral factor, was identified to be significantly associated with RVR in HCV-2b infection (Table S1).

Discussion

The clinical outcome of PEG-IFN/RBV therapy for HCV infection is influenced by a number of host and viral factors [20]. It has recently been reported that host genetic polymorphisms near or within the IL28B gene on the chromosome 19 show a critical impact on the treatment outcome of patients infected with HCV-1a and -1b [21–23]. Also, HCV genetic polymorphisms have been known to contribute to differences in the treatment outcome, as demonstrated by the observations that SVR rates for patients infected with HCV genotypes 2 and 3 are higher than those for patients infected with HCV genotype 1 [2,6]. Moreover,

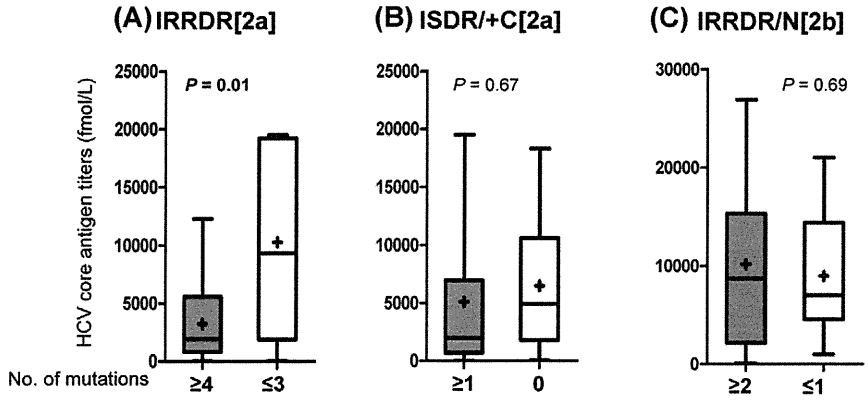

Figure 4. Correlation between NS5A sequence heterogeneity and pretreatment serum HCV core antigen titers in HCV-2a and HCV-2b infections. Pretreatment serum HCV core antigen titers of patients classified on the basis of the number of mutations in IRRDR[2a] (interferon/ribavirin resistance-determining region of HCV-2a) (≥4 vs. ≤3) (A), ISDR/+C[2a] (part of interferon sensitivity determining-region plus its carboxy-flanking region of HCV-2a) (≥1 vs. = 0) (B) and IRRDR/N[2b] (≥2 vs. ≤1) (an N-terminal part of interferon/ribavirin resistance-determining region of HCV-2b) (C) are depicted. Maximum and minimum values are indicated by the upper and lower bars, respectively. Distribution ranges are displayed as boxes. Mean and median values are also indicated inside the boxes as+and horizontal bars, respectively.
doi:10.1371/journal.pone.0030513.g004

Table 5. Univariate and multivariate analyses for identification of independent predictive factors for SVR in HCV-2a- and -2b-infected patients treated with PEG-IFN/RBV therapy.

Genotype	Variable	Univariate		Multivariate	
		Odds ratio (95% CI)	*P* value	Odds ratio (95% CI)	*P* value
HCV-2a	IRRDR[2a] mutations	21.0 (3.6–122.5)	0.0003	21.0 (3.6–122.5)	**0.001**
	ISDR/+C[2a] mutations	8.8 (1.6–47.4)	0.008		
	Age (<55 years)	9.8 (1.1–84.7)	0.026		
HCV-2b	γ-GTP (<30 IU/L)	26.0 (1.3–504.7)	0.004	6.2 (1.1–36.2)	0.04
	Body weight (<65 kg)	3.8 (1.0–13.9)	0.06		

Abbreviations: SVR, sustained virological response; IRRDR[2a], interferon/ribavirin resistance-determining region of HCV-2a; ISDR/+C[2a], part of interferon sensitivity determining-region plus its carboxy-flanking region of HCV-2a; γ-GTP, gamma glutamyl transpeptidase.
doi:10.1371/journal.pone.0030513.t005

polymorphisms of NS5A and core regions of a given HCV genotype, in particular HCV-1b, have been linked to the difference in SVR rates [7,8,11–13,17]. It should be noted that the significant link between polymorphisms of NS5A and core regions of HCV-1b and treatment outcome was inferred mostly from studies carried out on patients in Asian countries, in particular Japan, and that somewhat controversial results were obtained from studies carried out on patients infected with HCV-1a or -1b in non-Asian countries [24–31]. However, we would like to point out that most of these publications focused mainly on ISDR and core mutations, but not on IRRDR. In addition, the impact of viral genetic variation on treatment outcome in non-HCV-1 infection, either in Asian or non-Asian countries, is still unclear.

In our previous study, we identified IRRDR in NS5A of HCV-1b as a significant determinant for PEG-IFN/RBV treatment outcome; EVR and, more importantly, SVR [11,12]. Consistent with the previous observation, we have demonstrated in the present study that sequence heterogeneity within IRRDR is closely correlated with the treatment responses in HCV-2a and -2b infections. In HCV-2a infection, IRRDR[2a]≥4 was closely associated with RVR (Table S1) and SVR (Table 5). In HCV-2b infection, the sequence heterogeneity within an N-terminal part of IRRDR (IRRDR/N[2b]) was significantly associated with RVR (Table S1). Furthermore, both IRRDR[2a]≥4 and ISDR/+C[2a]≥1 showed remarkable positive predictive values (95%) for SVR prediction (Table S2), suggesting the clinical usefulness of these markers to encourage those patients to receive PEG-IFN/RBV treatment. On the other hand, their negative predictive values for non-SVR were rather low (50% and 33%). This suggests the possible involvement of another factor(s) that determines non-SVR and may limit the clinical usefulness of these markers to accurately predict non-SVR.

The present results were dependent upon the small number of non-SVR patients due to the high response rates of HCV-2a and -2b. In spite of this, the parallels between the RVR/non-RVR and the SVR/non-SVR analyses, especially in HCV-2a infection, support the possibility that the sequences presented in this study are truly representative of the viruses in general circulation.

The clinical correlation between IRRDR sequence heterogeneity and virological responses of IFN-based therapy in HCV infection can be linked to a recent experimental observation by Tsai et al. [32] that an HCV subgenomic RNA replicon containing NS5A of HCV-1b exerted more profound inhibitory effects on IFN activities than the original HCV-2a replicon, and that domain swapping between NS5A sequences of HCV-1b and -2a in the V3 and/or a C-terminal region including IRRDR resulted in a transfer of their anti-IFN activities. Also, it is worthy to note that IRRDR is among the most variable sequences across the different genotypes and subtypes of HCV [33] whereas its upstream and downstream sequences show a higher degree of sequence conservation (Figure 5). This may suggest that whereas the upstream and downstream sequences have a conserved function(s) across all the HCV genotypes, IRRDR sequences have a genotype-dependent or even a strain-dependent function(s). Indeed, the upstream sequences, especially a Pro-rich motif, play key roles in multiple stages of viral replication [34] while the downstream sequence in viral particle assembly and production [35]. Therefore, the sequence heterogeneity of IRRDR and its significant correlation with IFN-responsiveness imply the possibility that IRRDR is involved, at least partly, in the viral strategy to evade IFN-mediated antiviral host defense mechanisms. Its possible molecular mechanism, however, is yet to be elucidated. The IRRDR sequence heterogeneity also suggests genetic flexibility of this region and, indeed, the C-terminal portion of NS5A was shown to tolerate sequence insertions and deletions [36]. This flexibility might play an important role in modulating the interaction with various host systems, including IFN-induced antiviral machineries. It is also possible that the genetic flexibility of IRRDR is accompanied by compensatory changes elsewhere in the viral genome and that these compensatory changes affect overall viral fitness and responses to IFN-based therapy [37].

The relapse rate was higher in HCV-2b infection than in HCV-2a (Table 1). It should be noted that while the sequence heterogeneity within IRRDR[2a] was significantly correlated with both RVR and SVR in HCV-2a infection, IRRDR/N[2b] was correlated only with RVR in HCV-2b infection. These observations might be linked to an intrinsic difference in IFN- and/or RBV-sensitivity between HCV-2a and -2b isolates [8,38]. We assume that HCV-2b is considered between HCV-1b and HCV-2a in terms of resistance to PEG-IFN/RBV treatment and that an extended treatment for a total of 36~48 weeks would be needed to prevent relapse in HCV-2b infection, especially for patients who have risk factors that do not fit the SVR or RVR prediction criteria (Table 5 and Table S1).

A mutation at position 70 of the core protein of HCV-1b has been reported to be correlated with PEG-IFN/RBV treatment outcome [12,13]. In the present study, however, we found no significant correlation between core protein polymorphism and treatment outcome in HCV-2a or -2b infections. The residue at position 70 of the core protein of HCV-2a and -2b isolates was Arg, which is known to be associated with SVR in HCV-1b infection [12,13], and was well conserved in all the isolates tested in the present study (Figures S1 and S2). The observed sequence

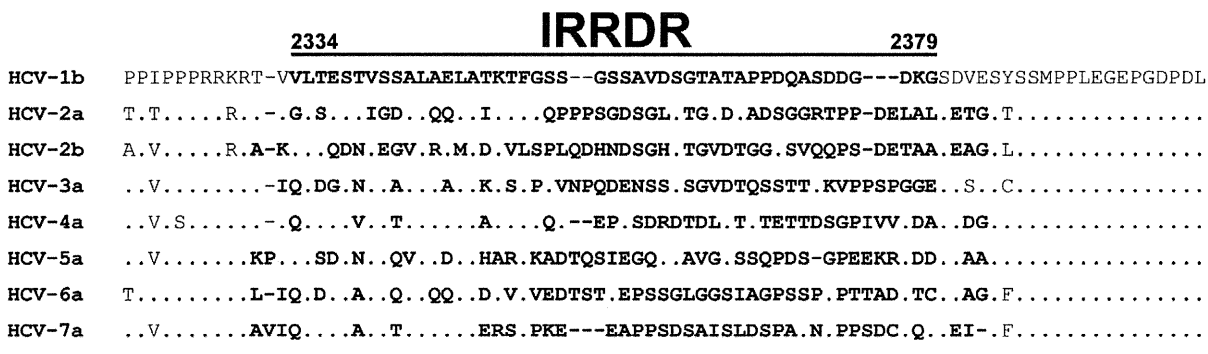

Figure 5. Sequence alignment of IRRDR (interferon/ribavirin resistance-determining region) and its upstream and downstream sequences of different HCV genotypes. The residues in the region that corresponds to IRRDR of HCV-1b [11] are written in boldface letters. Dots indicate residues identical to the HCV-1b sequence. References of aligned sequences are: HCV-1b, El-Shamy et al. [11]; HCV-2a and -2b, Murakami et al. [8]; HCV-3a, X76918; HCV-4a, Y11604; HCV-5a, AF064490; HCV-6a, D84262; HCV-7a, EF108306.
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conservation at position 70 might be the reason for the lack of significant correlation between core protein polymorphism and treatment outcome in HCV-2a or -2b infections. On the other hand, Thr at position 110 of the core protein of HCV-2a has recently been reported to be significantly associated with SVR [10]. In the present study, Thr at position 110 was found in 35% (14/40) and 14% (1/6) of SVR and non-SVR cases, respectively (Figure S1). Similarly, Thr at position 48 was found in 35% (14/40) of SVR cases, but not in non-SVR cases (0/6). The observed differences between SVR and non-SVR, however, were not statistically significant due possibly to the small number of samples tested. A larger-scale study would be needed to determine the possible importance of those residues.

We preliminarily analyzed a host genetic factor, the single nucleotide polymorphism (SNP) at rs8099917 near the IL28B gene [21–23], of a portion of the patients examined in the present study. The result showed that the minor genotypes (T/G and G/G) were found in 5.1% (2/39) and 15.4% (2/13) of RVR and non-RVR patients, respectively, and 2.8% (1/36) and 20.0% (2/10) of SVR and non-SVR patients, respectively (Kim et al., unpublished observation). Although the differences were not statistically significant due probably to the small number of the patients tested, the minor genotypes showed a trend toward being associated with non-SVR, and with non-RVR to a lesser extent, in HCV-2a and -2b infections, as has been reported for HCV-1a and -1b infections [21–23]. The impact of the IL28B SNP, however, appeared to be weaker in HCV-2a and -2b infections than that seen in HCV-1a and -1b infections, and also weaker than that of the most powerful viral factor, IRRDR[2a]≥4, in HCV-2a infection. In this context, we found that, of the four patients with the minor IL28B genotypes, two patients (nos. 2 and 105), who underwent unfavorable treatment response (non-RVR and non-SVR), were infected with HCV isolates of IRRDR[2a]≤3 or IRRDR/N[2b]≤1 while the other two patients (no. 63 and 106), who achieved favorable treatment response (SVR and/or RVR), were infected with HCV isolates of IRRDR[2a]≥4. This might imply the possibility that, in HCV-2 infection, the combination of the minor IL28B genotypes and a low degree of IRRDR sequence heterogeneity has a strong power to predict unfavorable treatment responses whereas a high degree of IRRDR sequence heterogeneity has a dominant predictive power for favorable treatment responses regardless the IL28B genotype. Analysis in a large-scale multicenter study is needed to clarify this issue.

In conclusion, our data suggest that the sequence heterogeneity of NS5A, i.e., IRRDR[2a]≥4, and ISDR/+C[2a]≥1 to a lesser extent, would be a useful predictive marker for SVR in HCV-2a infection. Also, IRRDR/N[2b]≥2 is significantly associated with RVR in HCV-2b infection. These results further emphasize the importance of NS5A, a viral factor, in determining the responsiveness to PEG-IFN/RBV therapy.

Supporting Information

Figure S1 Sequence alignment of the core protein of HCV-2a isolates. Core protein sequences (aa 1 to 120) of HCV-2a obtained from SVR and non-SVR patients are aligned. Prototype sequence of HCV-J6 [18] is shown on the top. The numbers along the sequence indicate the aa positions. Dots indicate residues identical to those of the prototype sequence.
(TIF)

Figure S2 Sequence alignment of the core protein of HCV-2b isolates. Core protein sequences (aa 1 to 120) of HCV-2b obtained from SVR and non-SVR patients are aligned. Prototype sequence of HCV-J8 [19] is shown on the top. The numbers along the sequence indicate the aa positions. Dots indicate residues identical to those of the prototype sequence.
(TIF)

Table S1 Univariate and multivariate analyses for identification of independent predictive factors for RVR in HCV-2a- and -2b-infected patients treated with PEG-IFN/RBV therapy.
(DOC)

Table S2 Positive and negative predictive values (PPV and NPV) of NS5A polymorphic factors for SVR prediction.
(DOC)

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Author Contributions

Conceived and designed the experiments: AE SRK HH. Performed the experiments: AE IS YI LD. Analyzed the data: AE IS YI LD SI SY TF ST YY YS TA HH. Contributed reagents/materials/analysis tools: SRK SI SY TF ST YY YS TA. Wrote the paper: AE SRK HH. Obtained permissions from the Ethics Committees: AE SRK HH.

References

1. Micallef JM, Kaldor JM, Dore GJ (2006) Spontaneous viral clearance following acute hepatitis C infection: a systematic review of longitudinal studies. J Viral Hepat 13: 34–41.
2. Fried MW, Shiffman ML, Reddy KR, Smith C, Marinos G, et al. (2002) Peginterferon alfa-2a plus ribavirin for chronic hepatitis C virus infection. N Engl J Med 347: 975–982.
3. Sherman KE, Flamm SL, Afdhal NH, Nelson DR, Sulkowski MS, et al. (2011) Response-guided telaprevir combination treatment for hepatitis C virus infection. N Engl J Med 365: 1014–1024.
4. Limaye AR, Draganov PV, Cabrera R (2011) Boceprevir for chronic HCV genotype 1 infection. N Engl J Med 365: 176; author reply 177–178.
5. Enomoto N, Takada A, Nakao T, Date T (1990) There are two major types of hepatitis C virus in Japan. Biochem Biophys Res Commun 170: 1021–1025.
6. Sarasin-Filipowicz M (2009) Interferon therapy of hepatitis C: molecular insights into success and failure. Swiss Med Wkly 140: 3–11.
7. Enomoto N, Sakuma I, Asahina Y, Kurosaki M, Murakami T, et al. (1996) Mutations in the nonstructural protein 5A gene and response to interferon in patients with chronic hepatitis C virus 1b infection. N Engl J Med 334: 77–81.
8. Murakami T, Enomoto N, Kurosaki M, Izumi N, Marumo F, et al. (1999) Mutations in nonstructural protein 5A gene and response to interferon in hepatitis C virus genotype 2 infection. Hepatology 30: 1045–1053.
9. Akuta N, Suzuki F, Tsubota A, Suzuki Y, Hosaka T, et al. (2003) Association of amino acid substitution pattern in nonstructural protein 5A of hepatitis C virus genotype2a low viral load and response to interferon monotherapy. J Med Virol 69: 376–383.
10. Kadokura M, Maekawa S, Sueki R, Miura M, Komase K, et al. (2011) Analysis of the complete open reading frame of hepatitis C virus in genotype 2a infection reveals critical sites influencing the response to peginterferon and ribavirin therapy. Hepatol Int 5: 789–799.
11. El-Shamy A, Nagano-Fujii M, Sasase N, Imoto S, Kim SR, et al. (2008) Sequence variation in hepatitis C virus nonstructural protein 5A predicts clinical outcome of pegylated interferon/ribavirin combination therapy. Hepatology 48: 38–47.
12. El-Shamy A, Kim SR, Ide YH, Sasase N, Imoto S, et al. (2012) Polymorphisms of hepatitis C virus non-structural protein 5A and core proteins and clinical outcome of pegylated-interferon/ribavirin combination therapy. Intervirology 55: 1–11.
13. Akuta N, Suzuki F, Kawamura Y, Yatsuji H, Sezaki H, et al. (2007) Predictive factors of early and sustained responses to peginterferon plus ribavirin combination therapy in Japanese patients infected with hepatitis C virus genotype 1b: Amino acid substitutions in the core region and low-density lipoprotein cholesterol levels. J Hepatol 46: 403–410.
14. Okamoto H, Sugiyama Y, Okada S, Kurai K, Akahane Y, et al. (1992) Typing hepatitis C virus by polymerase chain reaction with type-specific primers: application to clinical surveys and tracing infectious sources. J Gen Virol 73(Pt 3): 673–679.
15. El-Shamy A, Sasayama M, Nagano-Fujii M, Sasase N, Imoto S, et al. (2007) Prediction of efficient virological response to pegylated interferon/ribavirin combination therapy by NS5A sequences of hepatitis C virus and anti-NS5A antibodies in pre-treatment sera. Microbiol Immunol 51: 471–482.
16. Lusida MI, Nagano-Fujii M, Nidom CA, Soetjipto, Handajani R, et al. (2001) Correlation between mutations in the interferon sensitivity-determining region of NS5A protein and viral load of hepatitis C virus subtypes 1b, 1c, and 2a. J Clin Microbiol 39: 3858–3864.
17. Akuta N, Suzuki F, Hirakawa M, Kawamura Y, Yatsuji H, et al. (2009) Association of amino acid substitution pattern in core protein of hepatitis C virus genotype 2a high viral load and virological response to interferon-ribavirin combination therapy. Intervirology 52: 301–309.
18. Okamoto H, Okada S, Sugiyama Y, Kurai K, Iizuka H, et al. (1991) Nucleotide sequence of the genomic RNA of hepatitis C virus isolated from a human carrier: comparison with reported isolates for conserved and divergent regions. J Gen Virol 72(Pt 11): 2697–2704.
19. Okamoto H, Kurai K, Okada S, Yamamoto K, Lizuka H, et al. (1992) Full-length sequence of a hepatitis C virus genome having poor homology to reported isolates: comparative study of four distinct genotypes. Virology 188: 331–341.
20. Kau A, Vermehren J, Sarrazin C (2008) Treatment predictors of a sustained virologic response in hepatitis B and C. J Hepatol 49: 634–651.
21. Ge D, Fellay J, Thompson AJ, Simon JS, Shianna KV, et al. (2009) Genetic variation in IL28B predicts hepatitis C treatment-induced viral clearance. Nature 461: 399–401.
22. Tanaka Y, Nishida N, Sugiyama M, Kurosaki M, Matsuura K, et al. (2009) Genome-wide association of IL28B with response to pegylated interferon-alpha and ribavirin therapy for chronic hepatitis C. Nat Genet 41: 1105–1109.
23. Suppiah V, Moldovan M, Ahlenstiel G, Berg T, Weltman M, et al. (2009) IL28B is associated with response to chronic hepatitis C interferon-alpha and ribavirin therapy. Nat Genet 41: 1100–1104.
24. Duverlie G, Khorsi H, Castelain S, Jaillon O, Izopet J, et al. (1998) Sequence analysis of the NS5A protein of European hepatitis C virus 1b isolates and relation to interferon sensitivity. J Gen Virol 79: 1373–1381.
25. Squadrito G, Orlando ME, Cacciola I, Rumi MG, Artini M, et al. (1999) Long-term response to interferon alpha is unrelated to "interferon sensitivity determining region" variability in patients with chronic hepatitis C virus-1b infection. J Hepatol 30: 1023–1027.
26. Sarrazin C, Berg T, Lee JH, Ruster B, Kronenberger B, et al. (2000) Mutations in the protein kinase-binding domain of the NS5A protein in patients infected with hepatitis C virus type 1a are associated with treatment response. J Infect Dis 181: 432–441.
27. Chung RT, Monto A, Dienstag JL, Kaplan LM (1999) Mutations in the NS5A region do not predict interferon-responsiveness in American patients infected with genotype 1b hepatitis C virus. J Med Virol 58: 353–358.
28. Zeuzem S, Lee JH, Roth WK (1997) Mutations in the nonstructural 5A gene of European hepatitis C virus isolates and response to interferon alfa. Hepatology 25: 740–744.
29. Pascu M, Martus P, Hohne M, Wiedenmann B, Hopf U, et al. (2004) Sustained virological response in hepatitis C virus type 1b infected patients is predicted by the number of mutations within the NS5A-ISDR: a meta-analysis focused on geographical differences. Gut 53: 1345–1351.
30. Alestig E, Arnholm B, Eilard A, Lagging M, Nilsson S, et al. (2011) Core mutations, IL28B polymorphisms and response to peginterferon/ribavirin treatment in Swedish patients with hepatitis C virus genotype 1 infection. BMC Infect Dis 11: 124.
31. Donlin MJ, Cannon NA, Aurora R, Li J, Wahed AS, et al. (2010) Contribution of genome-wide HCV genetic differences to outcome of interferon-based therapy in Caucasian American and African American patients. PLoS One 5: e9032.
32. Tsai YH, Kuang WF, Lu TY, Kao JH, Lai MY, et al. (2008) The non-structural 5A protein of hepatitis C virus exhibits genotypic differences in interferon antagonism. J Hepatol 85: 2485–502.
33. Macdonald A, Harris M (2004) Hepatitis C virus NS5A: tales of a promiscuous protein. J Gen Virol 85: 2485–2502.
34. Hughes M, Gretton S, Shelton H, Brown DD, McCormick CJ, et al. (2009) A conserved proline between domains II and III of hepatitis C virus NS5A influences both RNA replication and virus assembly. J Virol 83: 10788–10796.
35. Tellinghuisen TL, Foss KL, Treadaway J (2008) Regulation of hepatitis C virion production via phosphorylation of the NS5A protein. PLoS Pathog 4: e1000032.
36. Moradpour D, Evans MJ, Gosert R, Yuan Z, Blum HE, et al. (2004) Insertion of green fluorescent protein into nonstructural protein 5A allows direct visualization of functional hepatitis C virus replication complexes. J Virol 78: 7400–7409.
37. Yuan HJ, Jain M, Snow KK, Gale Jr. M, Lee WM (2009) Evolution of hepatitis C virus NS5A region in breakthrough patients during pegylated interferon and ribavirin therapy. J Viral Hepat 17: 208–216.
38. Sakamoto N, Nakagawa M, Tanaka Y, Sekine-Osajima Y, Ueyama M, et al. (2011) Association of IL28B variants with response to pegylated-interferon alpha plus ribavirin combination therapy reveals intersubgenotypic differences between genotypes 2a and 2b. J Med Virol 83: 871–878.

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A Point Mutation at Asn-534 That Disrupts a Conserved *N*-Glycosylation Motif of the E2 Glycoprotein of Hepatitis C Virus Markedly Enhances the Sensitivity to Antibody Neutralization

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The molecular basis of antibody neutralization against hepatitis C virus (HCV) is poorly understood. The E2 glycoprotein of HCV is critically involved in viral infectivity through specific binding to the principal virus receptor component CD81, and is targeted by anti-HCV neutralizing antibodies. A previous study showed that a mutation at position 534 (N534H) within the sixth *N*-glycosylation motif of E2 of the J6/JFH1 strain of HCV genotype 2a (HCV-2a) was responsible for more efficient access of E2 to CD81 so that the mutant virus could infect the target cells more efficiently. The purpose of this study was to analyze the sensitivity of the parental J6/JFH1, its cell culture-adapted variant P-47 possessing 10 amino acid mutations and recombinant viruses with the adaptive mutations to neutralization by anti-HCV antibodies in sera of HCV-infected patients. The J6/JFH1 virus was neutralized by antibodies in sera of patients infected with HCV-2a and -1b, with mean 50% neutralization titers being 1:670 and 1:200, respectively ($P < 0.00001$). On the other hand, the P-47 variant showed 50- to 200-times higher sensitivity to antibody neutralization than the parental J6/JFH1 without genotype specificity. The N534H mutation, and another one at position 416 (T416A) near the first *N*-glycosylation motif to a lesser extent, were shown to be responsible for the enhanced sensitivity to antibody neutralization. The present results suggest that the residues 534, and 416 to a lesser extent, of the E2 glycoprotein are critically involved in the HCV infectivity and antibody neutralization. ***J. Med. Virol. 84:229–234, 2012.*** © 2011 Wiley Periodicals, Inc.

KEY WORDS: humoral immune mechanism; evasion; glycan

INTRODUCTION

Hepatitis C virus (HCV), a member of the family *Flaviviridae*, the genus *Hepacivirus*, is an enveloped, positive-stranded RNA virus that infects an estimated 170 million people worldwide. The virus evades the

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host immune system to establish chronic infection, which often leads to serious liver diseases, such as cirrhosis and hepatocellular carcinoma. Even with a current standard treatment with pegylated interferon *plus* ribavirin, sustained viral clearance is obtained for only approximately 50% of patients infected with HCV genotype 1b (HCV-1b). Neither antibody-based prophylaxis nor an effective vaccine is currently available.

A better understanding of the interplay between viral and host factors that determine HCV clearance or persistence is needed for the design of effective passive immunotherapy and effective vaccines. A growing body of evidence from studies in humans and chimpanzees suggests that HCV-specific T-cell immunity plays an important role in the viral clearance [Bowen and Walker, 2005]. Also, several studies have indicated a role for humoral immunity in HCV infection [Bartosch et al., 2003; Logvinoff et al., 2004; Lavillette et al., 2005; Netski et al., 2005; Pestka et al., 2007; Dowd et al., 2009]. However, this aspect remains poorly characterized.

The E2 glycoprotein of HCV plays an important role in viral attachment and, therefore, becomes a major target of anti-HCV neutralizing antibodies. Identification of protective epitopes in E2 conserved among different HCV strains is a major challenge in vaccine design [Tarr et al., 2006; Helle et al., 2007; Gal-Tanamy et al., 2008; Keck et al., 2008]. The development of infectious retroviral pseudoparticles (HCVpp) bearing HCV envelope glycoproteins helps us study interactions between E2 epitopes and the virus receptor CD81 or neutralizing antibodies [Bartosch et al., 2003; Logvinoff et al., 2004; Lavillette et al., 2005; Pestka et al., 2007; Dowd et al., 2009]. More significantly, authentic HCV particles produced by the HCV cell culture system (HCVcc) are currently available for this purpose [Lindenbach et al., 2005; Wakita et al., 2005; Zhong et al., 2005; Fournier et al., 2007].

Recently, it was demonstrated using HCVcc that a mutation at position 534 from Asn to His (N534H) in the E2 glycoprotein of the HCV J6/JFH1 strain confers an advantage to the mutant viruses at the entry level probably through more efficient access to CD81 [Bungyoku et al., 2009]. The Asn-534 is located in the sixth of 11 *N*-linked glycosylation sites and the N534H mutation is predicted to remove this glycosylation. The present study has shown that the N534H mutation in the E2 glycoprotein of HCV J6/JFH1 markedly enhances the sensitivity of the virus to neutralization by specific neutralizing antibodies in sera of patients infected with HCV.

MATERIALS AND METHODS

Cells and Viruses

Huh-7.5 cells [Blight et al., 2002] and pFL-J6/JFH1 [Lindenbach et al., 2005] were kindly provided by Dr. C. M. Rice (Rockefeller University, New York, NY, USA). Huh-7.5 cells were cultured in Dulbecco's modified Eagle's medium (DMEM; Wako, Osaka, Japan) supplemented with 10% fetal bovine serum (Biowest, Nuaille, France), 0.1 mM non-essential amino acids (Invitrogen, Carlsbad, CA), penicillin (100 IU/ml), and streptomycin (100 μg/ml) (Invitrogen) at 37°C in a CO_2 incubator. Propagation of HCV J6/JFH1, its cell culture-adapted mutant P-47 and recombinant viruses possessing each of the adaptive mutations was described previously [Deng et al., 2008; Bungyoku et al., 2009].

Human Sera and Anti-HCV Neutralization Test

Sera were collected from 89 patients infected chronically with HCV-1b or HCV-2a, who were treated with pegylated interferon α-2b and ribavirin, as described previously [El-Shamy et al., 2007, 2008]. Sera were also collected from 11 patients with acute HCV-1b infection, either severe acute hepatitis or mild self-resolving hepatitis. The study protocol was approved by the Ethic Committees in Kobe University and Yamagata University and informed written consent provided by patients and volunteers. Sera collected from healthy volunteers who were negative for anti-HCV antibodies served as a control. The sera were inactivated at 56°C for 30 min before being used for the virus neutralization test.

An HCV neutralization test was performed as described previously [Sasayama et al., 2010]. In brief, serially diluted serum samples were mixed with the same amount of HCV solution containing 1×10^4 cell-infecting units. After incubation at 37°C for 1 hr, the mixtures were inoculated to Huh-7.5 cells (2×10^5 cells per well in 24-well plates) and incubated in a 5% CO_2 incubator. After 3 hr, the inocula were removed and fresh complete DMEM were added to the cells. At 24 hr postinfection, cells were fixed with ice-cold methanol, blocked with 5% goat serum in phosphate-buffered saline and subjected to immunofluorescence analysis using mouse monoclonal antibody against HCV core antigen (2H9) [Wakita et al., 2005] and Alexa Fluor 488-conjugated goat anti-mouse IgG (H + L) (Molecular Probes, Eugene, OR). The immunostained cells were counterstained with Hoechst 33342 (Molecular Probes) at room temperature for 5 min and observed under a fluorescence microscope (BZ-9000; Keyence, Osaka, Japan). The number of HCV-infected cells in each well was counted by using a software BZ-H1C (Keyence). The serum dilutions that neutralized 50% of the virus infectivity was calculated by curvilinear regression analysis [Abe et al., 2003]. Titers were expressed as 50% neutralization titers (NT_{50}).

Statistical Analysis

Student's *t*-test was used to compare the data between different groups. A *P*-value of <0.05 was considered to be significant.

RESULTS

Anti-HCV Neutralizing Antibodies in Sera of Patients Infected With HCV

Sera were obtained from patients chronically infected with HCV-1b or -2a, and tested for anti-HCV neutralizing activities. Representative results of neutralization curves using the parental J6/JFH1 and the P-47 mutant as challenge viruses are shown in Figure 1. When measured against J6/JFH1, NT_{50} titers of sera of patients infected with HCV-1b ranged from 1:10 to 1:700, with the mean NT_{50} titer being 1:197, whereas those of patients infected with HCV-2a ranged from 1:100 to 1:1,500, with the mean value being 1:670 (Table I). The difference in NT_{50} between patients infected with HCV-1b and -2a was statistically significant ($P < 0.00001$). When measured against P-47, on the other hand, unexpectedly high NT_{50} titers were obtained ranging from 1:4,000 to 1:182,000, with the mean values being 1:40,500 and 1:32,900 for patients infected with HCV-1b and -2a, respectively. These results suggest the possibility that an adaptive mutation(s) of P-47, most probably present in the envelope glycoproteins, confers higher sensitivity to neutralization by anti-HCV antibodies.

Unlike the case with J6/JFH1, when P-47 was used as a challenge virus, no significant difference in NT_{50} titers was observed between patients infected with HCV-1b and -2a (Table I). This result suggests the possible presence of a genotype-dominant neutralization epitope(s) on the envelope glycoproteins of J6/JFH1 although anti-HCV neutralizing antibodies in patients' sera are reactive to both HCV-1b and -2a. The broad reactivity of the neutralizing antibodies in patients' sera across different HCV genotypes is consistent with previous observations by other researchers [Logvinoff et al., 2004; Meunier et al., 2005; Fournier et al., 2007; Pestka et al., 2007; Scheel et al., 2008].

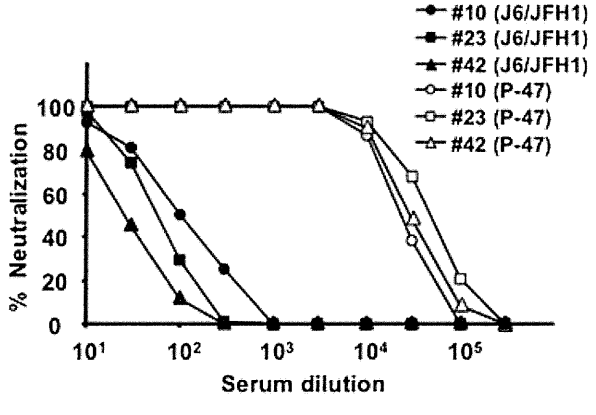

Fig. 1. Neutralization curves (NT_{50} assay) of sera obtained from HCV-infected patients against HCV J6/JFH1 and its adaptive mutant P-47. J6/JFH1 or P-47 was incubated with serial dilutions of HCV-infected patients (nos. 10, 23, and 42; all infected with HCV-1b) and tested for neutralization activities. The neutralization rates at each dilution were plotted. Filled and open symbols indicate data obtained with J6/JFH1 and P-47, respectively.

Sera obtained from patients with acute hepatitis C contained much lower titers of anti-HCV neutralizing antibodies compared to those in sera from chronic hepatitis patients, with the average NT_{50} titers against J6/JFH1 and the adaptive mutant P-47 being 1:15 and 1:126, respectively (Table I). Two patients with severe acute hepatitis C with elevated serum alanine aminotransferase levels of >1,000 IU/ml [Saito et al., 2004; unpublished], possessed relatively high NT_{50} titers against P-47 (1:150 and 1:1,100) compared to the remaining nine patients who experienced mild self-resolving hepatitis (<1:10 to 1:50).

A Single-Point Mutation (N534H or T416A) of the HCV E2 Glycoprotein Increases Sensitivity to Neutralization by Anti-HCV Antibodies

Neutralization of virus infectivity by antibodies usually involves their interaction with viral envelope glycoproteins. It has been reported that the cell culture-adapted mutant P-47 possesses 10 amino acid mutations, including four mutations in E2, compared to the parental J6/JFH1 [Bungyoku et al., 2009]. To examine which mutation(s) in E2 is responsible for the increased sensitivity of P-47 to neutralization by antibodies in patients' sera, recombinant viruses possessing each one of the four mutations in E2 were used (Fig. 2A). The result obtained revealed that a recombinant virus possessing a single-point mutation at position 534 from Asn to His (N534H) and another one possessing four mutations (E2) were as sensitive as P-47 to neutralization by sera of chronic hepatitis patients (Fig. 2B) and the two patients with acute hepatitis C (data not shown). The T416A and T396A mutants were also significantly more sensitive than J6/JFH1, but less sensitive than P-47, N534H, and E2 mutants, to neutralization by antibodies in patients' sera. In this connection, it was recently reported that a JFH1 virus-based T416A mutant showed increased sensitivity to antibody neutralization [Dhillon et al., 2010].

DISCUSSION

The present results revealed that sera of patients infected with HCV-1b possessed cross-genotypic neutralizing antibodies against the J6/JFH1 strain of HCV-2a, albeit with significantly lower titers (ca. one-third) compared to the homotypic neutralization titers observed for patients infected with HCV-2a (Table I). When measured against the adaptive mutant P-47 derived from J6/JFH1, neutralizing antibody titers of the patients sera increased markedly to the level 50- to 200-times higher than that measured against J6/JFH1. Also, the partial genotype-specificity observed with J6/JFH1 was no longer evident when measured against P-47. The marked increase in the sensitivity of P-47 to antibody neutralization was assigned to a mutation at position 534 (N534H), and another one at position 416 (T416A) to a lesser extent, of the E2 glycoprotein (Fig. 2).

TABLE I. NT_{50} Titers in Sera of HCV-Infected Patients With Chronic or Acute Hepatitis C

		NT_{50} titer[a] measured against	
CH/AH	Genotype	J6/JFH1	P-47
CH	HCV-1b (n = 69)	197 ± 164 (1)	40,500 ± 31,800 (206)
CH	HCV-2a (n = 20)	670 ± 652[b] (3.4)	32,900 ± 26,500[c] (167)
AH	HCV-1b (n = 11)	15 ± 28 (0.08) (<10–100)	126 ± 326 (0.6) (<10–1,100)

CH, chronic hepatitis; AH, acute hepatitis.
[a]Mean ± SD. The number in the parenthesis means the ratio when compared to the mean titer that was obtained with sera of HCV-1b-infected CH patients against J6/JFH1.
[b]$P < 0.00001$, compared to the mean titer obtained with sera of HCV-1b-infected patients against J6/JFH1 (Student's t-test).
[c]$P = 0.33$, compared to the mean titer obtained with sera of HCV-1b-infected patients against P-47 (Student's t-test).

The N534H and T416A mutations are located at the sixth, and in close proximity to the first, respectively, of the conserved 11 *N*-linked glycosylation sites of the HCV E2 glycoprotein [Helle et al., 2007; Bungyoku et al., 2009]. It was recently reported that the positions 416 and 534 are conformationally located in the former and the latter halves of the central domain 1 (DIa and DIb), respectively, of E2 and that the two parts of DI domain interact to form the CD81-binding region [Helle et al., 2010; Krey et al., 2010; Albecka et al., 2011]. This region is, therefore, considered as the possible target for neutralizing antibodies that inhibit E2-CD81 interactions [Helle and Dubuisson, 2008; Law et al., 2008; Owsianka et al., 2008; Perotti et al., 2008].

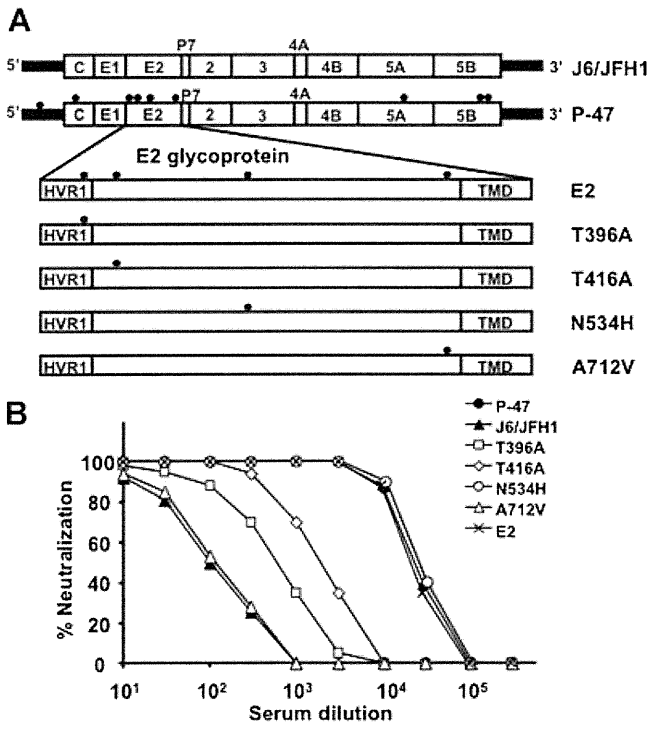

Fig. 2. Effects of amino acid mutations at positions 396, 416, 534, and 712 of the HCV E2 glycoprotein on neutralization by anti-HCV antibodies in patients' sera. **A**: A schematic diagram of the mutations seen in the adaptive mutant P-47 and recombinant viruses carrying each (T396A, T416A, N534H, and A712V) and all (E2) of the four mutations in E2. Filled circles indicate the positions of the mutations. **B**: A representative result of virus neutralization by anti-HCV antibodies in an HCV-infected patient (no. 10; HCV-1b).

The N534H mutation removes glycans at this position as it disrupts the consensus sequence for *N*-linked glycosylation. The removal of glycans at positions 417, 532, and 645 (the first, sixth, and eleventh glycosylation site, respectively) of the H77 isolate (HCV-1a) was shown to increase the sensitivity of HCVpp to neutralizing antibodies and to enhance the access of CD81 to its binding site on E2 [Falkowska et al., 2007; Helle et al., 2007]. It should be noted, however, that the HCVpp system relies on retroviral pseudoparticles bearing HCV envelope glycoproteins that assemble at the plasma membrane or in multivesicular bodies whereas HCV virions assemble on the endoplasmic reticulum membranes that are closely associated with lipid droplet [Miyanari et al., 2007; Helle and Dubuisson, 2008]. Therefore, the virus neutralization data obtained with HCVpp should be verified using the HCVcc system in which virion assembly and maturation take place through the authentic process.

By using the HCVcc system, it was shown that a variant virus possessing the N534K mutation spread faster than the parental JFH1 virus [Delgrange et al., 2007], with the result suggesting the possibility that removal of glycans on residue 534 resulted in more efficient access of E2 to CD81. It is also possible that removal of glycans on this residue might allow more efficient access of neutralizing antibodies to the CD81-binding region of E2, resulting in increased sensitivity to antibody neutralization. In fact, Helle et al. [2010] recently reported that removal of glycans at five (the first, second, fourth, sixth, and eleventh) *N*-linked glycosylation sites in E2 markedly increased the sensitivity of JFH1 virus to antibody neutralization, suggesting that the glycans interfere with the access of neutralizing antibodies to a determinant crucial for virus infectivity. It was also reported that mutations at positions 415 (N415D) and 416 (T416A) near the first glycosylation site of JFH1 virus increased the sensitivity to neutralizing antibodies in patients' sera [Dhillon et al., 2010]. Also, a mutation at position 451 (G451R), which is located in the domain 2 (DII) but still in close proximity to DI [Helle et al., 2010; Krey et al., 2010; Albecka et al., 2011],

increased the sensitivity of JFH1 virus to antibody neutralization [Grove et al., 2008].

In conclusion, the present study using J6/JFH1 virus, another HCVcc strain, has demonstrated that the N534H mutation within the sixth *N*-glycosylation site of the E2 glycoprotein, and the T416A mutation near the first *N*-glycosylation site to a lesser extent, markedly enhances sensitivity to neutralization by antibodies in sera of HCV-infected patients. These results suggest that glycans on Asn-534 of the HCV E2 glycoprotein plays an important role in protecting the virus from humoral immune mechanisms of the host.

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REFERENCES

Abe M, Kuzuhara S, Kino Y. 2003. Establishment of an analyzing method for a Japanese encephalitis virus neutralization test in vero cells. Vaccine 21:1989–1994.

Albecka A, Monserret R, Krey T, Tarr AW, Diesis E, Ball JK, Descamps V, Duverlie G, Rey F, Penin F, Dubuisson J. 2011. Identification of new functional regions in hepatitis C virus envelope glycoprotein E2. J Virol JVI accepts, 85:1777–1792.

Bartosch B, Bukh J, Meunier JC, Granier C, Engle RE, Blackwelder WC, Emerson SU, Cosset FL, Purcell RH. 2003. In vitro assay for neutralizing antibody to hepatitis C virus: Evidence for broadly conserved neutralization epitopes. Proc Natl Acad Sci USA 100:14199–14204.

Blight KJ, McKeating JA, Rice CM. 2002. Highly permissive cell lines for subgenomic and genomic hepatitis C virus RNA replication. J Virol 76:13001–13014.

Bowen DG, Walker CM. 2005. Adaptive immune responses in acute and chronic hepatitis C virus infection. Nature 436:946–952.

Bungyoku Y, Shoji I, Makine T, Adachi T, Hayashida K, Nagano-Fujii M, Ide YH, Deng L, Hotta H. 2009. Efficient production of infectious hepatitis C virus with adaptive mutations in cultured hepatoma cells. J Gen Virol 90:1681–1691.

Delgrange D, Pillez A, Castelain S, Cocquerel L, Rouillé Y, Dubuisson J, Wakita T, Duverlie G, Wychowski C. 2007. Robust production of infectious viral particles in Huh-7 cells by introducing mutations in hepatitis C virus structural proteins. J Gen Virol 88:2495–2503.

Deng L, Adachi T, Kitayama K, Bungyoku Y, Kitazawa S, Ishido S, Shoji I, Hotta H. 2008. Hepatitis C virus infection induces apoptosis through a Bax-triggered, mitochondrion-mediated, caspase 3-dependent pathway. J Virol 82:10375–10385.

Dhillon S, Witteveldt J, Gatherer D, Owsianka AM, Zeisel MB, Zahid MN, Rychłowska M, Foung SK, Baumert TF, Angus AG, Patel AH. 2010. Mutations within a conserved region of the hepatitis C virus glycprotein that influence virus-receptor interaction and sensitivity to neutralizing antibodies. J Virol 84: 5494–5507.

Dowd KA, Netski DM, Wang XH, Cox AL, Ray SC. 2009. Selection pressure from neutralizing antibodies drives sequence evolution during acute infection with hepatitis C virus. Gastroenterology 136:2377–2386.

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

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

Falkowska E, Kajumo F, Garcia E, Reinus J, Dragic T. 2007. Hepatitis C virus envelope glycoprotein E2 glycans modulate entry, CD81 binding, and neutralization. J Virol 81:8072–8079.

Fournier C, Duverlie G, François C, Schnuriger A, Dedeurwaerder S, Brochot E, Capron D, Wychowski C, Thibault V, Castelain S. 2007. A focus reduction neutralization assay for hepatitis C virus neutralizing antibodies. Virol J 4:35.

Gal-Tanamy M, Keck ZY, Yi M, McKeating JA, Patel AH, Foung SK, Lemon SM. 2008. In vitro selection of a neutralization-resistant hepatitis C virus escape mutant. Proc Natl Acad Sci USA 105:19450–19455.

Grove J, Nielsen S, Zhong J, Bassendine MF, Drummer HE, Balfe P, McKeating JA. 2008. Identification of a residue in hepatitis C virus E2 glycoprotein that determines scavenger receptor BI and CD81 receptor dependency and sensitivity to neutralizing antibodies. J Virol 82:12020–12029.

Helle F, Dubuisson J. 2008. Hepatitis C virus entry into host cells. Cell Mol Life Sci 65:100–112.

Helle F, Goffard A, Morel V, Duverlie G, McKeating J, Keck ZY, Foung S, Penin F, Dubuisson J, Voisset C. 2007. The neutralizing activity of anti-hepatitis C virus antibodies is modulated by specific glycans on the E2 envelope protein. J Virol 81:8101–8111.

Helle F, Vieyres G, Elkrief L, Popescu CI, Wychowski C, Descamps V, Castelain S, Roingeard P, Duverlie G, Dubuisson J. 2010. Role of N-linked glycans in the functions of hepatitis C virus envelope proteins incorporated into infectious virions. J Virol 84:11905–11915.

Keck ZY, Olson O, Gal-Tanamy M, Xia J, Patel AH, Dreux M, Cosset FL, Lemon SM, Foung SK. 2008. A point mutation leading to hepatitis C virus escape from neutralization by a monoclonal antibody to a conserved conformational epitope. J Virol 82:6067–6072.

Krey T, d'Alayer J, Kikuti CM, Saulnier A, Damier-Piolle L, Petitpas I, Johansson DX, Tawar RG, Baron B, Robert B, England P, Persson MA, Martin A, Rey FA. 2010. The disulfide bonds in glycoprotein E2 of hepatitis C virus reveal the tertiary organization of the molecule. PLoS Pathog 6:e1000762.

Lavillette D, Morice Y, Germanidis G, Donot P, Soulier A, Pagkalos E, Sakellariou G, Intrator L, Bartosch B, Pawlotsky JM, Cosset FL. 2005. Human serum facilitates hepatitis C virus infection, and neutralizing responses inversely correlate with viral replication kinetics at the acute phase of hepatitis C virus infection. J Virol 79:6023–6034.

Law M, Maruyama T, Lewis J, Giang E, Tarr AW, Stamataki Z, Gastaminza P, Chisari FV, Jones IM, Fox RI, Ball JK, McKeating JA, Kneteman NM, Burton DR. 2008. Broadly neutralizing antibodies protect against hepatitis C virus quasispecies challenge. Nat Med 14:25–27.

Lindenbach BD, Evans MJ, Syder AJ, Wölk B, Tellinghuisen TL, Liu CC, Maruyama T, Hynes RO, Burton DR, McKeating JA, Rice CM. 2005. Complete replication of hepatitis C virus in cell culture. Science 309:623–626.

Logvinoff C, Major ME, Oldach D, Heyward S, Talal A, Balfe P, Feinstone SM, Alter H, Rice CM, McKeating JA. 2004. Neutralizing antibody response during acute and chronic hepatitis C virus infection. Proc Natl Acad Sci USA 101:10149–10154.

Meunier JC, Engle RE, Faulk K, Zhao M, Bartosch B, Alter H, Emerson SU, Cosset FL, Purcell RH, Bukh J. 2005. Evidence for cross-genotype neutralization of hepatitis C virus pseudoparticles and enhancement of infectivity by apolipoprotein C1. Proc Natl Acad Sci USA 102:4560–4565.

Miyanari Y, Atsuzawa K, Usuda N, Watashi K, Hishiki T, Zayas M, Bartenschlager R, Wakita T, Hijikata M, Shimotohno K. 2007. The lipid droplet is an important organelle for hepatitis C virus production. Nat Cell Biol 9:1089–1097.

Netski DM, Mosbruger T, Depla E, Maertens G, Ray SC, Hamilton RG, Roundtree S, Thomas DL, McKeating J, Cox A. 2005. Humoral immune response in acute hepatitis C virus infection. Clin Infect Dis 41:667–675.

Owsianka AM, Tarr AW, Keck ZY, Li TK, Witteveldt J, Adair R, Foung SK, Ball JK, Patel AH. 2008. Broadly neutralizing human monoclonal antibodies to the hepatitis C virus E2 glycoprotein. J Gen Virol 89:653–659.

Perotti M, Mancini N, Diotti RA, Tarr AW, Ball JK, Owsianka A, Adair R, Patel AH, Clementi M, Burioni R. 2008. Identification of a broadly cross-reacting and neutralizing human monoclonal

antibody directed against the hepatitis C virus E2 protein. J Virol 82:1047–1052.

Pestka JM, Zeisel MB, Bläser E, Schürmann P, Bartosch B, Cosset FL, Patel AH, Meisel H, Baumert J, Viazov S, Rispeter K, Blum HE, Roggendorf M, Baumert TF. 2007. Rapid induction of virus-neutralizing antibodies and viral clearance in a single-source outbreak of hepatitis C. Proc Natl Acad Sci USA 104:6025–6030.

Saito T, Watanabe H, Shao L, Okumoto K, Hattori E, Sanjo M, Misawa K, Suzuki A, Takeda T, Sugahara K, Ito JI, Saito K, Togashi H, Kawata S. 2004. Transmission of hepatitis C virus quasispecies between human adults. Hepatol Res 30:57–62.

Sasayama M, Deng L, Kim SR, Ide Y, Shoji I, Hotta H. 2010. Analysis of neutralizing antibodies against hepatitis C virus in patients who were treated with pegylated-interferon plus ribavirin. Kobe J Med Sci 56:E60–E66.

Scheel TK, Gottwein JM, Jensen TB, Prentoe JC, Hoegh AM, Alter HJ, Eugen-Olsen J, Bukh J. 2008. Development of JFH1-based cell culture systems for hepatitis C virus genotype 4a and evidence for cross-genotype neutralization. Proc Natl Acad Sci USA 105:997–1002.

Tarr AW, Owsianka AM, Timms JM, McClure CP, Brown RJ, Hickling TP, Pietschmann T, Bartenschlager R, Patel AH, Ball JK. 2006. Characterization of the hepatitis C virus E2 epitope defined by the broadly neutralizing monoclonal antibody AP33. Hepatology 43:592–601.

Wakita T, Pietschmann T, Kato T, Date T, Miyamoto M, Zhao Z, Murthy K, Habermann A, Kräusslich HG, Mizokami M, Bartenschlager R, Liang TJ. 2005. Production of infectious hepatitis C virus in tissue culture from a cloned viral genome. Nat Med 11:791–796.

Zhong J, Gastaminza P, Cheng G, Kapadia S, Kato T, Burton DR, Wieland SF, Uprichard SL, Wakita T, Chisari FV. 2005. Robust hepatitis C virus infection in vitro. Proc Natl Acad Sci USA 102:9294–9299.

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Interferon-α suppresses hepatitis B virus enhancer II activity via the protein kinase C pathway

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ABSTRACT

HBV has two enhancer (En) regions each of which promotes its own transcription. En II regulates production of pregenomic RNA, a key product of HBV replication, more strongly than En I. Although IFN-α has been found to suppress En I activity, its effect on En II activity has not been examined. Here we used luciferase assay to demonstrate that IFN-α suppresses En II activity. Analysis with several deletion/mutation constructs identified two major segments, nt 1703–1727 and nt 1746–1770, within the En II sequence as being responsible for the suppressive effects of IFN-α. Pre-treatment with protein kinase C (PKC) inhibitors blocked this effect regardless of the expression levels of phospho-STAT1 and Mx upon IFN-α stimulation. These results indicate that IFN-α suppresses En II activity via the PKC pathway, which may be an alternative suppressive pathway for HBV replication. (136 words).

Introduction

Hepatitis B virus (HBV) causes acute and chronic hepatitis in humans, and chronic infection is closely associated with the development of liver cirrhosis and hepatocellular carcinoma (Lok and McMahon, 2009). HBV has a partially double-stranded 3.2-kb DNA genome (relaxed circular (RC) DNA) in its nucleocapsid. When HBV invades host cells, RC-DNA is converted into a plasmid-like covalently closed circular DNA (cccDNA) inside the nucleus. From the cccDNA, the 3.5-, 2.4-, 2.1-, and 0.8-kb mRNAs are transcribed by cellular RNA polymerase II (Beck and Nassal, 2007). Among these RNAs, 3.5-kb pregenomic RNA (pgRNA) serves as the template of reverse transcription for synthesis of negative-strand DNA. Thus, transcription of pgRNA from cccDNA is one of the key steps in HBV replication.

In the HBV genome, there are four promoters (CP, SPI, SPII, and XP) and two transcriptional enhancer regions. Both enhancers stimulate transcription from the promoters (Antonucci and Rutter, 1989; Moolla et al., 2002; Su and Yee, 1992; Vannice and Levinson, 1988; Yee, 1989). Enhancer I (En I), which is located upstream of the X gene, activates transcription in a relatively cell-independent manner (Vannice and Levinson, 1988). In contrast, enhancer II (En II) (Fig. 1), located just upstream of CP, specifically activates transcription in hepatocytes (Wang et al., 1990; Yee, 1989; Yuh and Ting, 1990). Hepatocytes selectively express transcription factors which activate En II activity, such as HNF1 (Wang et al., 1998), HNF3 (Johnson et al., 1995; Li et al., 1995), HNF4 (Guo et al., 1993; Raney et al., 1997), CCAAT/enhancer binding protein (C/EBP) (López-Cabrera et al., 1990, 1991; Yuh and Ting, 1991) and FTF (Ishida et al., 2000; Li et al., 1998). This characterizes En II as a hepatocyte-specific *cis*-acting element. A previous report showed that, upon transfection with HBV genome, human hepatic cells, but not non-hepatic cells, were able to express pgRNA (Sureau et al., 1986). For this reason, En II is considered to regulate the production of pgRNA more strongly than En I (Yee, 1989).

Interferon-α (IFN-α) has been used as an anti-viral agent against HBV. It suppresses HBV viral load and ameliorates hepatic inflammation (Jonas et al., 2010; Liaw, 2009). Type I IFN activates the Janus kinase (JAK) bound to the cytoplasmic domain of its receptor. JAK phosphorylates transcription factors such as signal transducers and activators of transcription (STAT) 1 and STAT2. Phosphorylated STAT1 and STAT2 bind to IFN regulatory factor 9 (IRF9). These transcription factors form a complex, IFN-stimulated gene factor 3 (ISGF3). This complex binds to IFN stimulation response element (ISRE) in the promoter region of various genes, and activates interferon-stimulated genes (ISGs) (Der et al., 1998). Some of the ISGs including RNA-activated protein kinase (PKR), 2′,5′-oligoadenylate synthetases (OAS), and Mx have been shown to possess antiviral activity. ISG induction by type I IFN is considered to be the main pathway to suppressing viral replication.

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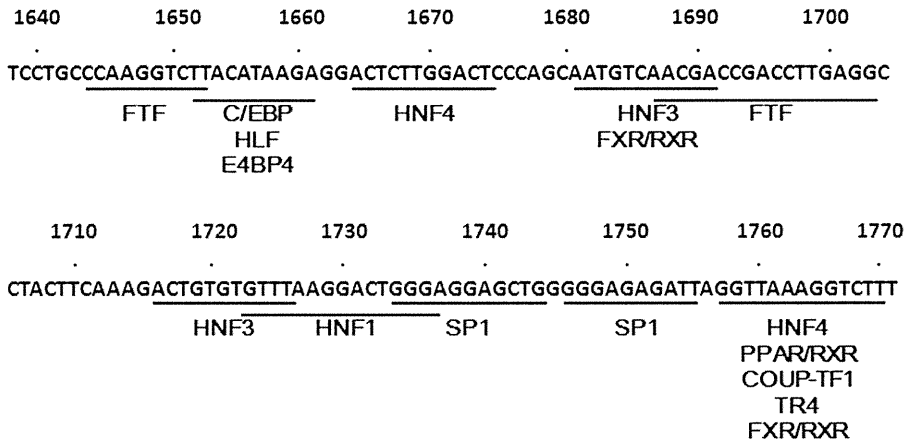

Fig. 1. Nucleotide sequences of the HBV En II region. The HBV sequence used in this study was of the *adw2* subtype (GenBank accession no. X02763). Numbering of the HBV sequence started at the unique *Eco*RI site. The underlined sequences represent the transcription factor binding sites mentioned in previous reports.

Type I IFN has been reported to inhibit HBV En I and core promoter activities (Nakao et al., 1999; Romero and Lavine, 1996; Schulte-Frohlinde et al., 2002; Tur-Kaspa et al., 1990). Nakao et al. demonstrated that IFN-α suppressed En I transcriptional activity by the binding of ISGF3 to the ISRE-like sequence in En I region (Nakao et al., 1999). However, there has been no study on the effect of IFN-α on HBV En II activity. In this study, we demonstrated that IFN-α suppressed En II activity via activation of PKC. Notably, STAT1 activation and ISG induction may be dispensable for IFN-α-mediated suppression of En II activity. This might shed light on understanding the inhibition of HBV replication by IFN-α.

Results

En II activity is down-regulated by IFN-α

We constructed a luciferase gene expression vector by inserting the En II sequence (nt 1640 to 1771) into pGL4LUC (pGL4LUC-En II). Huh-7 cells were transfected with pGL4LUC or pGL4LUC-En II, treated with or without IFN-α, and luciferase activities were evaluated. Insertion of En II increased the luciferase activity (about 228-fold) (Fig. 2A). IFN-α down-regulated the luciferase activity of pGL4LUC-En II, but did not affect that of pGL4LUC (Fig. 2B). This result suggested that IFN-α inhibited the activity of En II, and we examined the time course of IFN-α-induced suppression of En II activity. The suppressive effect of IFN-α on En II activity appeared at 3 h after administration of IFN-α, peaked at 6–12 h, and was gradually attenuated (Fig. 2C). Next, dose-response analysis showed that the En II activity was down-regulated by IFN-α in a dose-dependent manner, with the maximal suppressive effect at 300–1000 IU/m (Fig. 2D). We also examined the IFN-α-mediated suppression of En II activity in other hepatoma cell lines, PLC/PRF/5 and Hep3B. IFN-α significantly suppressed En II activities in both these cell lines (Fig. 2E). We next assessed whether or not IFN-α regulated HBV transcription in the HBV genome transfected cells by RT-PCR. HBV-RNA levels were significantly reduced by IFN-α (Fig. 2F). These results indicate that IFN-α suppresses HBV En II activity as well as its expression at a transcriptional level.

Both nt 1703–1727 and nt 1746–1770 within the En II region are required for suppression of En II activity by IFN-α

To determine the region responsible for the inhibitory effect of IFN-α on En II activity, we divided the En II sequence into six segments (Fig. 3A), and constructed plasmids containing En II sequences with deletion of each segment (pGL4LUC-En II-D1∼6). Huh-7 cells were transfected with these deleted constructs, treated with IFN-α, and then assayed for luciferase activity. None of the deletions could restore the suppressive activity by IFN-α (Fig. 3B), suggesting that there are several responsible regions for the IFN-α-induced suppression of En II activity. Next, we constructed plasmids containing four iterations of each segment within the En II sequence in tandem (pGL4LUC-En II-T1∼6) to examine the contribution of individual short fragments. IFN-α significantly suppressed the activities of pGL4LUC-En II-T2, T3, T4, T5 and -T6 in luciferase assay. Among them, the activities of pGL4LUC-En II-T4 and -T6 showed the largest suppression by IFN-α (Fig. 3C). On the basis of this result, we constructed a luciferase reporter vector with deletions of both segment 4 (nt 1703–1727) and segment 6 (nt 1746–1770) (pGL4LUC-En II-D4+6). The activity of this dual-deleted construct did not show a significant change due to IFN-α (Fig. 3D). These results suggest that both nt 1703–1727 and nt 1746–1770 within the En II region are required for the suppression of En II activity by IFN-α.

IFN-α-mediated suppression of En II activity is dependent on JAK activation

IFN-induced signal transduction occurs through the sequential activation of JAKs and STATs (Darnell et al., 1994). We examined the role of JAK in the inhibition of En II activity. JAK inhibitor alone did not affect En II activity. But the pre-treatment of the cells with JAK inhibitor completely blocked the suppressive effect of IFN-α on En II activity (Fig. 4A). The effect of JAK inhibitor was confirmed by the reducion of Mx induction in Western blot analysis (Fig. 4B). This result demonstrates that JAK activation is necessary for the IFN-α-induced suppression of En II activity.

The PKC pathway is involved in IFN-α-mediated suppression of En II activity

Previous reports demonstrated that type I IFN activated various kinases such as MAPK family members (MEK/ERK and p38 MAPK) (David et al., 1995; Goh et al., 1999), PI3K/Akt (Uddin et al., 1995), JNK (Caraglia et al., 1999) and protein kinase C (PKC) (Uddin et al., 2002). Here we examined the involvement of alternative pathways by pre-treatment with inhibitors for various kinases, including MEK, p38 MAPK, PI3K/Akt, JNK and PKC. The name of each inhibitors and its target kinase is commented in Table 1. As shown in Fig. 5A, only staurosporine, a PKC inhibitor, blocked the inhibitory effect of IFN-α, and other inhibitors did

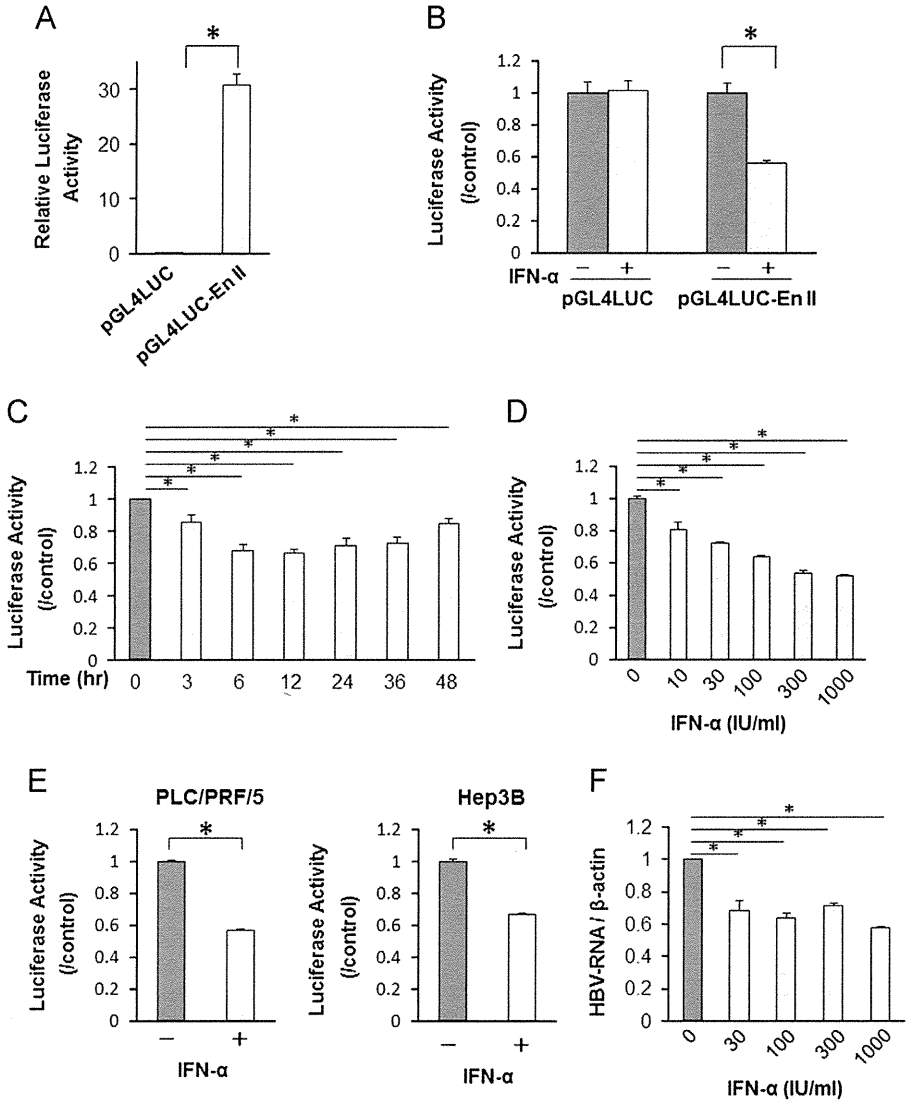

Fig. 2. Suppression of HBV En II transcriptional activity and reduction of HBV-RNA by IFN-α. A, B. Huh-7 cells were transfected with pGL4LUC or pGL4LUC-En II or incubated with or without IFN-α (100 IU/ml). After 24 h, the activity of firefly luciferase was evaluated. C. Huh-7 cells were transfected with pGL4LUC-En II, and incubated with IFN-α (100 IU/ml). Luciferase activities were evaluated at the indicated times. D. Huh-7 cells were transfected with various concentrations (0–1000 IU/ml) of IFN-α for 12 h and luciferase activities were evaluated. E. PLC/PRF/5 cells (left panel) and Hep3B (right panel) cells were transfected with pGL4LUC-En II, and incubated with or without IFN-α (300 IU/ml). Luciferase activities were evaluated. F. Huh-7 cells were transfected with pHBV1.5, and treated with IFN-α at various concentrations (0–1000 IU/ml). At 72 h after IFN-α treatment, cells were harvested, and the abundances of HBV-RNA were evaluated by quantitative RT-PCR. The HBV-RNA level of the IFN-α treated cells was normalized with that of non-treated cells. $*p < 0.05$. "/control" on the vertical axis means the ratio of luciferase activity of IFN-α treated cells normalized with that of non-treated cells.

not. Since staurosporine is a PKC inhibitor showing broad-spectrum activity (Marte et al., 1994), we also examined other inhibitors specific for PKC isoforms. Previous reports demonstrated that IFN-α activated PKC-α/β and PKC-δ (Pfeffer et al., 1990; Uddin et al., 2002). Indeed, activation of PKC-α/β and PKC-δ by IFN-α was confirmed by immunoblot analysis (Fig. 5B). Thus, we examined the PKC inhibitors rottlerin and Gö6976 (Gschwendt et al., 1994; Martiny-Baron et al., 1993). All PKC inhibitors blocked the suppression of En II activity by IFN-α (Fig. 5C). These results suggest that several isoforms of PKC are involved in the IFN-α-mediated suppression of En II activity. We also examined STAT1 activation and ISGs induction by IFN-α in cells pre-treated with these PKC inhibitors using immunoblot analysis (Fig. 5D). Expression levels of phospho-STAT1 and Mx differed among these PKC inhibitors. Staurosporine and Gö6976 slightly diminished the activation of STAT1, but rottlerin did not. This result suggests that PKC isoforms might not strongly regulate activation of STAT1. Rottlerin, a specific inhibitor for PKC-δ, inhibited the induction of Mx, which agreed with previous findings (Kaur et al., 2005). Staurosporine and Gö6976 did not suppress Mx expression. Taken together, all these PKC inhibitors blocked the suppression of En II activity by IFN-α regardless of the expression levels of phospho-STAT1 and Mx. These results suggest that STAT1 activation and ISG induction may be dispensable for the IFN-α-mediated suppression of En II activity. Next, we examined the effect of phorbol 12-myristate 13-acetate (PMA), a PKC activator (Castagna et al., 1982; Griner and Kazanietz, 2007). PMA suppressed En II activity (Fig. 5E), and PMA stimulation did not result in STAT1 phosphorylation and Mx induction (Fig. 5F), suggesting that suppression of En II by PMA is independent of STAT1 activation and ISG induction. On the basis of these findings, we conclude that IFN-α suppresses En II activity via the PKC pathway, which may not involve STAT1 activation and ISG induction.

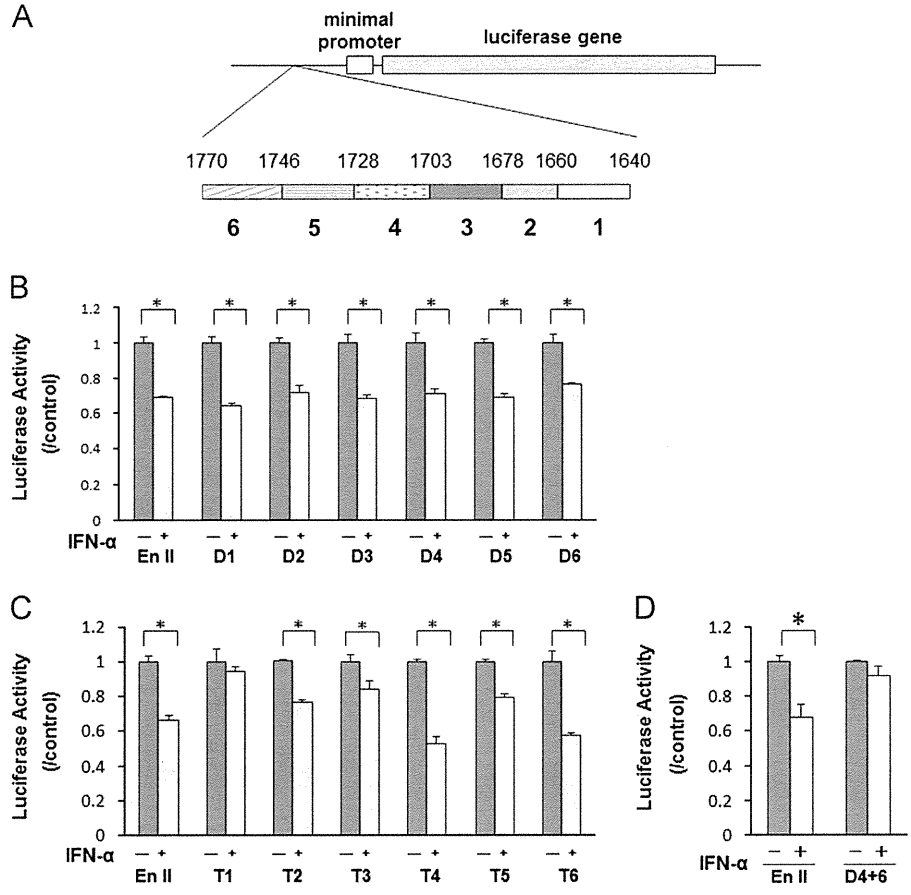

Fig. 3. Deletion/mutational analysis to identify the responsive sequence for the suppressive effect of IFN-α on En II. A. Scheme of pGL4LUC-En II and six segments defined within the En II sequence. The En II sequence was integrated just upstream of the minimal promoter of pGL4LUC. B. Huh-7 cells were transfected with the reporter vectors with deletion of each segment (pGL4LUC-En II-D1∼6), incubated with 300 IU/ml IFN-α for 12 h, and luciferase activities were evaluated. C. Plasmids containing four iterations of each segment within En II sequence in tandem (pGL4LUC-En II-T1∼6) were generated and luciferase activities were evaluated similarly. D. Plasmid with deletion of both nt 1703–1727 and nt 1746–1770 (pGL4LUC-En II-D4+6) was constructed and luciferase activities were evaluated similarly. *$p < 0.05$. "/control" on the vertical axis means the ratio of luciferase activity of IFN-α treated cells normalized with that of non-treated cells.

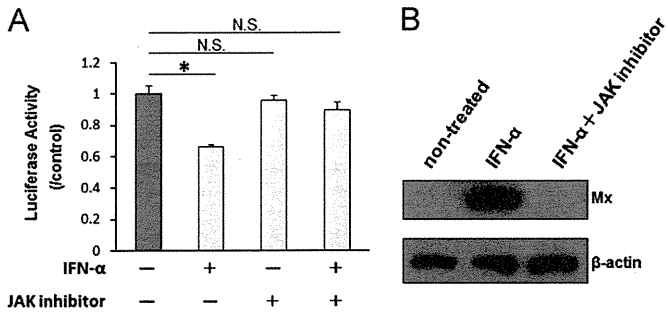

Fig. 4. Involvement of JAK activation in the IFN-α-induced suppression of En II activity. A. Huh-7 cells were transfected with pGL4LUC-En II and treated with JAK inhibitor (1 μM) for 1 h. The cells were then incubated with IFN-α(150 IU/ml) for 12 h, followed by luciferase assay. B. Huh-7 cells were pre-treated with JAK inhibitor for 1 h, and then incubated with IFN-α(150 IU/ml) for 12 h, followed by immunoblot analyses to detect Mx protein. *$p < 0.05$. "/control" on the vertical axis means the ratio of luciferase activity of IFN-α treated cells normalized by that of non-treated cells.

Knockdown of a single transcription factor does not influence IFN-α-induced suppression of En II activity

We anticipated that IFN-α suppressed En II activity by functional down-regulation of some transcription factor(s) phosphorylated in a PKC-dependent manner. Among transcription factors which bind the En II region, previous reports showed that Specificity Protein 1 (Sp1) (Mahoney et al., 1992; Pal et al., 1998; Rafty and Khachigian, 2001), Retinoid X Receptor α (RXRA) (Delmotte et al., 1999) and C/EBP (Mahoney et al., 1992) were inactivated by PKC. Thus, we examined the En II response to IFN-α after knockdown of these transcription factors. C/EBP, RXR and Sp1 expression was efficiently reduced by siRNA (Fig. 6A). We observed no significant change in the suppression of En II activity compared with control siRNA (Fig. 6B). This result suggests that several transcription factors (including unknown proteins) might be involved in the IFN-α-mediated suppression of En II activity.

Table 1
A comment of the inhibitors and its target kinase.

PD98059	MEK inhibitor
SB203580	P38MAPK inhibitor
LY294002	PI3K inhibitor
Akt-1-1/2	Akt inhibitor
SP600125	JNK inhibitor
Staurosporine	PKC inhibitor with broad spectrum
Rottlerin	Inhibitor specific for PKC-δ
Gö6976	Inhibitor specific for Ca^{2+}-dependent PKC isoforms

Discussion

In the present study, we demonstrated that IFN-α suppressed HBV En II activity. The inhibition by IFN-α of En II activity could be blocked by pre-treatment with PKC inhibitors, and this

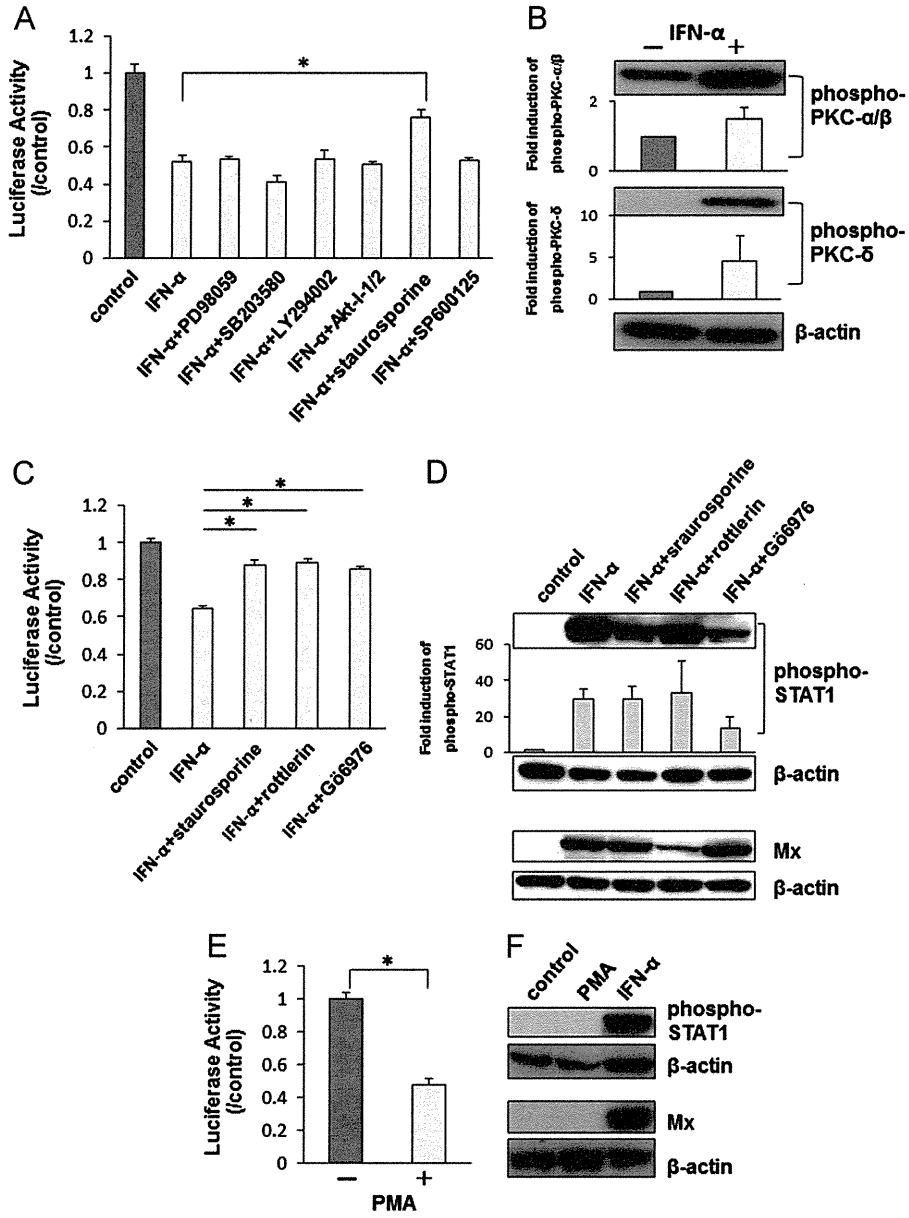

Fig. 5. PKC-dependent suppression of En II activity by IFN-α. A and C. Huh-7 cells were transfected with pGL4LUC-En II, treated separately with each kinase inhibitor for 1 h. The cells were then treated with IFN-α(1000 IU/ml) for 12 h, and luciferase activities were evaluated. B. Huh-7 cells were treated with IFN-α(1000 IU/m) for 12 h. Immunoblot analyses were performed to detect phosphorylated PKC-α/β and phosphorylated PKC-δ. Quantitative analysis of the expression level of phopho- PKC-α/β and -δ was performed by using ImageJ. Each level was normalized with that of IFN-α-non-treated cells. D. Huh-7 cells were harvested at 30 min to detect phosphorylated STAT1 and at 12 h to detect the expression of Mx after administration of IFN-α (1000 IU/m), and immunoblot analyses were performed. Quantitative analysis of the expression level of phopho-STAT1 was performed by using ImageJ. Each level was normalized with that of IFN-α-non-treated cells. E. Huh-7 cells were transfected with pGL4LUC-En II, treated with PMA (100 nM) for 12 h, and luciferase activities were evaluated. F. Huh-7 cells were treated with PMA (100 nM) or IFN-α(1000 IU/m). The cells were harvested at 30 min to detect phosphorylated STAT1 and at 12 h to detect the expression of Mx, and immunoblot analyses were performed. *$p < 0.05$. "/control" on the vertical axis means the ratio of luciferase activity of IFN-α/ PMA treated cells normalized with that of non-treated cells.

blocking effect may not involve STAT1 activation and ISG induction. The latter, ISG induction via the JAK-STAT pathway, has been considered to be the main mechanism suppressing viral replication. Our findings suggest a pathway for IFN-α repression of HBV transcription other than ISG induction.

PKCs are involved in a wide variety of cell functions and signal transduction pathways regulating cell migration and polarity, proliferation, differentiation and cell death (Nishizuka, 1988). In the PKC family, there are at least ten isoforms which can be divided into three sub-groups based on their structural characteristics and cofactor requirements. These include the classical PKC (cPKC: α, βI, βII, and γ), the novel PKC (nPKC: δ, ε, η and θ), and the atypical PKC (aPKC: ζ and ι/λ) (Azzi et al., 1992; Breitkreutz et al., 2007; Kikkawa et al., 1989). IFN-α can activate multiple PKC isoforms: not only PKC-δ, but also PKC-α/β (Pfeffer et al., 1990), PKC-ε (Pfeffer et al., 1991), and PKC-θ (Srivastava et al., 2004). Despite the variety of PKC isoforms, most phosphorylate similar sequences (Breitkreutz et al., 2007). Both the PKC-α/β inhibitor (Gö6976) and PKC-δ inhibitor (rottlerin) blocked the inhibitory effect of IFN-α on En II activity. Thus, it was speculated that each PKC isoform might be similarly involved in suppressing of En II activity.

Other studies have examined the role of the PKC pathway in HBV replication. Kang et al. (2008) reported that PKC-mediated phosphorylation increased capsid assembly and stability (von Hahn et al., 2011), and von Hahn et al. (2011) reported that the

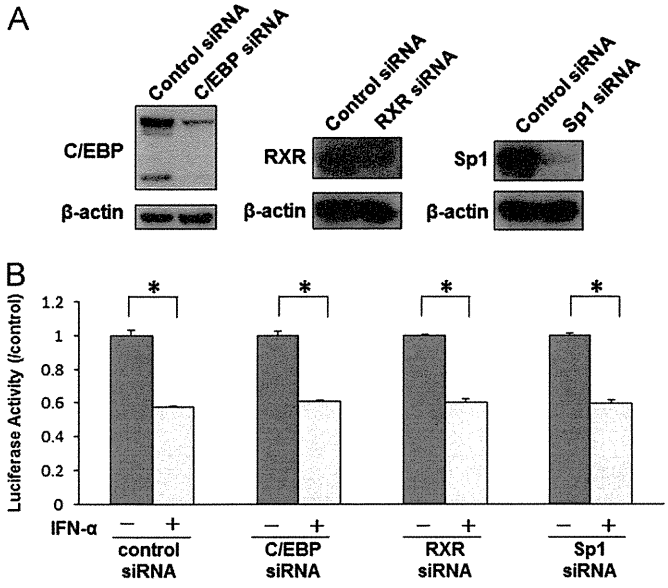

Fig. 6. IFN-α-mediated suppression on En II activity with knockdown of C/EBP, RXR and Sp1. A. Huh-7 cells were transfected with 10 nM siRNA (negative control or specific for C/EBP, RXR and Sp1). Immunoblot analyses for expressions of C/EBP, RXR, Sp1 and β-actin were performed at 48 h post siRNA transfection. B. Huh-7 cells were transfected with 10 nM siRNA (negative control or specific for C/EBP, RXR and Sp1). On the next day, si-RNA treated cells were transfected again with pGL4LUC-En II. On the following day, these transfected cells were incubated with IFN-α(1000 IU/ml) for 12 h, and luciferase activities were evaluated. "/control" on the vertical axis means the ratio of luciferase activity of IFN-α treated cells normalized with that of non-treated cells.

pan-PKC inhibitor sotrastaurin did not affect HBV replication. While the role of PKC in the HBV life cycle is still controversial, our findings suggest that PKC isoforms activated by IFN-α play inhibitory roles in HBV transcription by down-regulation of En II activity. As von Hahn et al. reported, sotrastaurin alone did not affect HBV replication. But, based on our present data about another pan-PKC inhibitor, staurosporine, we speculate that sotrastaurin may also block the inhibitory effect of IFN-α on En II activity.

We showed that knockdown of a single transcription factor did not influence the IFN-α-mediated suppression of En II activity, suggesting that several transcription factors might be involved in this suppression. We also showed that both segment 4 (nt 1703–1727) and segment 6 (nt 1746–1770) within the En II region are required for the IFN-α-induced suppression of En II activity. Although these two regions seem to be more important than the others, all the deleted version of reporter constructs showed almost completely similar suppression activities (Fig. 3B). We speculate that there may be some transcription factors which affect both the segment 4 and 6. Even if one of these regions is deleted, some factors may affect the other region, and result in the suppression of En II activity. Further study will be needed to clarify the mechanism.

Indeed, there are no identified transcription factors which could bind both segment 4 and 6. Only two transcription factors (HNF1 and 3) were reported to bind segment 4 (Johnson et al., 1995; Wang et al., 1998), and there have been no reports indicating that IFN-α or PKC inactivates HNF1 or 3. We also examined the expression levels of HNF1 and 3 of the IFN-α treated and the non-treated cells by RT-PCR. There was no significant difference in the expression of these transcription factors between the IFN-α treated and the non-treated cells (Nawa et al., unpublished data). Thus, we speculate that HNF1 or 3 might not be involved in the IFN-α mediated suppression of En II activity. There may be unknown transcription factors in the PKC pathway.

Previous reports showed that IFN-α suppressed En I activity (Nakao et al., 1999; Tur-Kaspa et al., 1990). Nakao et al. (1999) indicated that this occurred due to the binding of ISGF3 to an ISRE-like motif within the En I region. However, Rang et al. (2001) demonstrated that IFN-α reduced HBV-RNA levels derived from both HBV genome wild type and mutated ISRE-like motifs. This result contradicted the Nakao's result that the activity of the En I mutated ISRE-like motif was not suppressed by IFN-α. Schulte-Frohlinde et al. (2002) reported that IFN-α suppressed HBV core promoter regulated transcriptional activity, even when the ISRE-like motif of En I was deleted. The results of Rang et al. and Schulte-Frohlinde et al. suggest that IFN-α might suppress the activity of regions other than En I. In the present study, we demonstrated that IFN-α suppressed En II activity via the PKC pathway. En II might be one of the candidate regions down-regulated by IFN-α within the HBV genome.

Since En II activates viral transcription only in hepatocytes, it is responsible for the hepatocyte-specific gene expression of HBV. There had been no study on the effect of IFN-α on En II activity. Our study clarified that the PKC pathway is involved in the IFN-α-mediated suppression of En II activity, but may not involve ISG induction. Our result should aid in establishing better treatment with IFN-α against HBV infection. As we could not determine the molecule which inhibits En II activity by IFN-α, further study is needed to clarify this molecule and to control hepatitis B by IFN-α treatment.

Materials and methods

Plasmids

The HBV sequence used in this study was of the *adw2* subtype (GenBank accession no. X02763). Numbering of the HBV sequence started at the unique *Eco*RI site. The En II region in this study was defined as nt 1640–1771 of HBV sequence (Fig. 1) (Ishida et al., 2000). To construct pGL4LUC-En II, a plasmid containing the HBV En II region, the DNA fragment was amplified with PCR and inserted between *Hind* III and *Nhe* I site of pGL4 Luciferase Reporter Vector (pGL4LUC) (Promega, Madison, WI). The PCR primers were as follows: 5′-CCAAGCTTCTGCCCAAGGTC-3′ and 5′-CCCGCTAGCAAAGACCTTTAACCTAATCTCCTCC-3′. The constructs of the En II sequence with various deletions were generated by modifying pGL4LUC-En II using the QuikChange Site-Directed Mutagenesis Kit (Stratagene, La Jolla, CA). The constructs containing four tandem repeats of short fragment in En II sequence were generated by inserting duplexes of synthesized oligonucleotides into the multicloning site of pGL4LUC. All of the En II sequences were inserted in the antisense orientation to evaluate their enhancer activity.

Plasmid pHBV1.5 containing a 1.5-fold-overlength genome of HBV-DNA (GenBank accession no. AF305422) has been described previously (Bruss and Ganem, 1991).

Cell lines and reagents

The human hepatocellular carcinoma cell lines Huh-7, PLC/PRF/5, and Hep3B were cultured in Dulbecco's modified Eagle's medium (DMEM) supplemented with 10% heat-inactivated fetal bovine serum (Sigma-Aldrich, St. Louis, MO) in a humidified incubator at 5% CO_2 and 37 °C. Human natural IFN-α was kindly provided by Hayashibara Biochemical Laboratories, Inc. (Okayama, Japan).

The inhibitors/activators and the final concentrations used were: JAK inhibitor I (1 μM), PD98059 (10 μM), SB203580 (10 μM), LY294002 (10 μM), Akt-I-1/2 (5 μM), staurosporine (10 or 20 nM), rottlerin (5 μM), Gö6976 (1 μM), SP600125 (10 μM)