HEPATOLOGY
Official Journal of the American Association for the Study of Liver Diseases

Human Blood Dendritic Cell Antigen 3 (BDCA3)$^+$ Dendritic Cells Are a Potent Producer of Interferon-λ in Response to Hepatitis C Virus

Sachiyo Yoshio,[1] Tatsuya Kanto,[1] Shoko Kuroda,[1] Tokuhiro Matsubara,[1] Koyo Higashitani,[1] Naruyasu Kakita,[1] Hisashi Ishida,[1] Naoki Hiramatsu,[1] Hiroaki Nagano,[2] Masaya Sugiyama,[3] Kazumoto Murata,[3] Takasuke Fukuhara,[4] Yoshiharu Matsuura,[4] Norio Hayashi,[5] Masashi Mizokami,[3] and Tetsuo Takehara[1]

The polymorphisms in the interleukin (*IL*)-*28B* (interferon-lambda [IFN]-λ3) gene are strongly associated with the efficacy of hepatitis C virus (HCV) clearance. Dendritic cells (DCs) sense HCV and produce IFNs, thereby playing some cooperative roles with HCV-infected hepatocytes in the induction of interferon-stimulated genes (ISGs). Blood dendritic cell antigen 3 (BDCA3)$^+$ DCs were discovered as a producer of IFN-λ upon Toll-like receptor 3 (TLR3) stimulation. We thus aimed to clarify the roles of BDCA3$^+$ DCs in anti-HCV innate immunity. Seventy healthy subjects and 20 patients with liver tumors were enrolled. BDCA3$^+$ DCs, in comparison with plasmacytoid DCs and myeloid DCs, were stimulated with TLR agonists, cell-cultured HCV (HCVcc), or Huh7.5.1 cells transfected with HCV/JFH-1. BDCA3$^+$ DCs were treated with anti-CD81 antibody, inhibitors of endosome acidification, TIR-domain-containing adapter-inducing interferon-β (TRIF)-specific inhibitor, or ultraviolet-irradiated HCVcc. The amounts of IL-29/IFN-λ1, IL-28A/IFN-λ2, and IL-28B were quantified by subtype-specific enzyme-linked immunosorbent assay (ELISA). The frequency of BDCA3$^+$ DCs in peripheral blood mononuclear cell (PBMC) was extremely low but higher in the liver. BDCA3$^+$ DCs recovered from PBMC or the liver released large amounts of IFN-λs, when stimulated with HCVcc or HCV-transfected Huh7.5.1. BDCA3$^+$ DCs were able to induce ISGs in the coexisting JFH-1-positive Huh7.5.1 cells. The treatments of BDCA3$^+$ DCs with anti-CD81 antibody, cloroquine, or bafilomycin A1 reduced HCVcc-induced IL-28B release, whereas BDCA3$^+$ DCs comparably produced IL-28B upon replication-defective HCVcc. The TRIF-specific inhibitor reduced IL-28B release from HCVcc-stimulated BDCA3$^+$ DCs. In response to HCVcc or JFH-1-Huh7.5.1, BDCA3$^+$ DCs in healthy subjects with IL-28B major (rs8099917, TT) released more IL-28B than those with IL-28B minor genotype (TG). *Conclusion*: Human BDCA3$^+$ DCs, having a tendency to accumulate in the liver, recognize HCV in a CD81-, endosome-, and TRIF-dependent manner and produce substantial amounts of IL-28B/IFN-λ3, the ability of which is superior in subjects with IL-28B major genotype. (HEPATOLOGY 2013;57:1705-1715)

Hepatitis C virus (HCV) infection is one of the most serious health problems in the world. More than 170 million people are chronically infected with HCV and are at high risk of developing liver cirrhosis and hepatocellular carcinoma. Genome-wide association studies have successfully identified the genetic polymorphisms (single nucleotide polymorphisms, SNPs) upstream of the promoter region of the

Abbreviations: Ab, antibody; HCV, hepatitis C virus; HCVcc, cell-cultured hepatitis C virus; HSV, herpes simplex virus; IHL, intrahepatic lymphocyte; INF-λ, interferon-lambda; IRF, interferon regulatory factor; ISGs, interferon-stimulated genes; JEV, Japanese encephalitis virus; Lin, lineage; mDC, myeloid DC; MOI, multiplicity of infection; PBMC, peripheral blood mononuclear cell; pDC, plasmacytoid DC; Poly IC, polyinosine-polycytidylic acid; RIG-I, retinoic acid-inducible gene-I; SNPs, single nucleotide polymorphisms; TLR, Toll-like receptor; TRIF, TIR-domain-containing adapter-inducing interferon-β.

From the [1]Department of Gastroenterology and Hepatology, Osaka University Graduate School of Medicine, Osaka, Japan; [2]Department of Surgery, Osaka University Graduate School of Medicine, Osaka, Japan; [3]Research Center for Hepatitis and Immunology, National Center for Global Health and Medicine, Ichikawa, Japan; [4]Department of Molecular Virology, Research Institute for Microbial Diseases, Osaka University, Osaka, Japan; [5]Kansai Rosai Hospital, Hyogo, Japan.

Received July 2, 2012; accepted November 13, 2012.

Supported in part by a Grant-In-Aid for Scientific Research from the Ministry of Education, Culture, Sports, Science, and Technology, Japan and a Grant-In-Aid from the Ministry of Health, Labor, and Welfare of Japan.

interleukin (IL)-28B / interferon-lambda 3 (IFN-λ3) gene, which are strongly associated with the efficacy of pegylated interferon-α (PEG-IFN-α) and ribavirin therapy or spontaneous HCV clearance.[1-4]

IFN-λs, or type III IFNs, comprise a family of highly homologous molecules consisting of IFN-λ1 (IL-29), IFN-λ2 (IL-28A), and IFN-λ3 (IL-28B). In clear contrast to type I IFNs, they are released from relatively restricted types of cells, such as hepatocytes, intestinal epithelial cells, or dendritic cells (DCs). Also, the cells that express heterodimeric IFN-λ receptors (IFN-λR1 and IL-10R2) are restricted to cells of epithelial origin, hepatocytes, or DCs.[5] Such limited profiles of cells expressing IFN-λs and their receptors define the biological uniqueness of IFN-λs. It has been shown that IFN-λs convey anti-HCV activity by inducing various interferon-stimulated genes (ISGs),[5] the profiles of which were overlapped but others were distinct from those induced by IFN-α/β. Some investigators showed that the expression of IL-28 in PBMC was higher in subjects with IL-28B major than those with minor; however, the levels of IL-28 transcripts in liver tissue were comparable regardless of IL-28B genotype.[2,6]

At the primary exposure to hosts, HCV maintains high replicative levels in the infected liver, resulting in the induction of IFNs and ISGs. In a case of successful HCV eradication, it is postulated that IFN-α/β and IFN-λ cooperatively induce antiviral ISGs in HCV-infected hepatocytes. It is of particular interest that, in primary human hepatocytes or chimpanzee liver, IFN-λs, but not type I IFNs, are primarily induced after HCV inoculation, the degree of which is closely correlated with the levels of ISGs.[7] These results suggest that hepatic IFN-λ could be a principal driver of ISG induction in response to HCV infection. Nevertheless, the possibility remains that DCs, as a prominent IFN producer in the liver, play significant roles in inducing hepatic ISGs and thereby suppressing HCV replication.

DCs, as immune sentinels, sense specific genomic and/or structural components of pathogens with various pattern recognition receptors and eventually release IFNs and inflammatory cytokines.[8] In general, DCs migrate to the organ where inflammation or cellular apoptosis occurs and alter their function in order to alleviate or exacerbate the disease conditions. Therefore, the phenotypes and/or capacity of liver DCs are deemed to be influenced in the inflamed liver. In humans, the existence of phenotypically and functionally distinct DC subsets has been reported: myeloid DC (mDC) and plasmacytoid DC (pDC).[9] Myeloid DCs predominantly produce IL-12 or tumor necrosis factor alpha (TNF-α) following proinflammatory stimuli, while pDCs release considerable amounts of type I IFNs upon virus infection.[9] The other type of mDCs, mDC2 or BDCA3$^+$(CD141) DCs, have been drawing much attention recently, since human BDCA3$^+$ DCs are reported to be a counterpart of murine CD8a$^+$ DCs.[10] Of particular interest is the report that BDCA3$^+$ DCs have a potent capacity of releasing IFN-λ in response to Toll-like receptor 3 (TLR3) agonist.[11] However, it is still largely unknown whether human BDCA3$^+$ DCs are able to respond to HCV.

Taking these reports into consideration, we hypothesized that human BDCA3$^+$ DCs, as a producer of IFN-λs, have crucial roles in anti-HCV innate immunity. We thus tried to clarify the potential of BDCA3$^+$ DCs in producing type III IFNs by using cell-cultured HCV (HCVcc) or hepatoma cells harboring HCV as stimuli. Our findings show that BDCA3$^+$ DCs are quite a unique DC subset, characterized by a potent and specialized ability to secrete IFN-λs in response to HCV. The ability of BDCA3$^+$ DCs to release IL-28B upon HCV is superior in subjects with IL-28B major (rs8099917, TT) to those with minor (TG or GG) genotype, suggesting that BDCA3$^+$ DCs are one of the key players in IFN-λ-mediated innate immunity.

Patients and Methods

Subjects. This study enrolled 70 healthy volunteers (male/female: 61/9) (age: mean ± standard deviation [SD], 37.3 ± 7.8 years) and 20 patients who underwent surgical resection of liver tumors at Osaka University Hospital (Supporting Table 1). The study was approved by the Ethical Committee of Osaka University Graduate School of Medicine. Written informed consent was obtained from all of them. All healthy volunteers were negative for HCV, hepatitis B virus (HBV), and human immunodeficiency virus (HIV) and had no apparent history of liver, autoimmune, or malignant diseases.

Address reprint requests to: Tatsuya Kanto, M.D., Ph.D., Department of Gastroenterology and Hepatology, Osaka University Graduate School of Medicine, 2-2 Yamadaoka, Suita, 565-0871 Japan. E-mail: kantot@gh.med.osaka-u.ac.jp; fax: +81-6-6879-3629.

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DOI 10.1002/hep.26182

Potential conflict of interest: Nothing to report.

Additional Supporting Information may be found in the online version of this article.

Reagents. The specifications of all antibodies used for FACS or cell sorting TLR-specific synthetic agonists, pharmacological reagents, and inhibitory peptides are listed in the Supporting Materials.

Separation of DCs from PBMC or Intrahepatic Lymphocytes. We collected 400 mL of blood from each healthy volunteer and processed them for PBMCs. Noncancerous liver tissues were obtained from patients who underwent resection of liver tumors (Supporting Table 1). For the collection of intrahepatic lymphocytes (IHLs), liver tissues were washed thoroughly with phosphate-buffered saline to remove the peripheral blood adhering to the tissue and ground gently. After Lin-negative ($CD3^-$, $CD14^-$, $CD19^-$, and $CD56^-$) cells were obtained by the MACS system, each DC subset with the defined phenotype was sorted separately under FACS Aria (BD). The purity was more than 98%, as assessed by FACS Canto II (BD). Sorted DCs were cultured at 2.5×10^4/well on 96-well culture plates.

Immunofluorescence Staining of Human Liver Tissue. Tissue specimens were obtained from surgical resections of noncancerous liver from the patients as described above. Briefly, the 5-mm sections were incubated with the following antibodies: mouse biotinylated antihuman BDCA3 antibody (Miltenyi-Biotec), and mouse antihuman CLEC9A antibody (Biolegend) and subsequently with secondary goat antirabbit Alexa Fluor488 or goat antimouse Alexa Fluor594 (Invitrogen, Molecular Probes) antibodies. Cell nuclei were counterstained with Dapi-Fluoromount-GTM (Southern Biotech, Birmingham, AL). The stained tissues were analyzed by fluorescence microscopy (Model BZ-9000; Keyence, Osaka, Japan).

Cells and Viruses. The *in vitro* transcribed RNA of the JFH-1 strain of HCV was introduced into FT3-7 cells[12] or Huh7.5.1 cells. The stocks of HCVcc were generated by concentration of the medium from JFH-1-infected FT3-7 cells. The virus titers were determined by focus forming assay.[13] The control medium was generated by concentration of the medium from HCV-uninfected FT3-7 cells. Infectious JEVs were generated from the expression plasmid (pMWJEATG1) as reported.[14] HSV (KOS) was a generous gift from Dr. K. Ueda (Osaka University). Huh7.5.1 cells transduced with HCV JFH-1 strain was used for the coculture with DCs. The transcripts of ISGs in Huh7.5.1 were examined by reverse-transcription polymerase chain reaction (RT-PCR) methods using gene-specific primers and probes (Applied Biosystems, Foster City, CA).

Secretion Assays. IL-28B/IFN-λ3 was quantified by a newly developed chemiluminescence enzyme immunoassay (CLEIA) system.[15] IL-29/IFN-λ1, IL-28A/IFN-λ2, and IFN-β were assayed by commercially available enzyme-linked immunosorbent assay (ELISA) kits (eBioscience, R&D, and PBL, respectively). IFN-α was measured by cytometric beads array kits (BD) according to the manufacturer's instructions.

Statistical Analysis. The differences between two groups were assessed by the Mann-Whitney nonparametric *U* test. Multiple comparisons between more than two groups were analyzed by the Kruskal-Wallis nonparametric test. Paired *t* tests were used to compare differences in paired samples. All the analyses were performed using GraphPad Prism software (San Diego, CA).

Results

Human BDCA3$^+$ DCs Are Phenotypically Distinct from pDCs and mDCs. We defined $BDCA3^+$ DCs as $Lin^-HLA\text{-}DR^+BDCA3^{high+}$ cells (Fig. 1A, left, middle), and pDCs and mDCs by the patterns of CD11c and CD123 expressions (Fig. 1A, right). The level of CD86 on pDCs or mDCs is comparatively higher than those on $BDCA3^+$ DCs (Fig. 1B). The expression of CD81 is higher on $BDCA3^+$ DCs than on pDCs and mDCs (Fig. 1B, Supporting Fig. S1). CLEC9A, a member of C-type lectin, is expressed specifically on $BDCA3^+$ DCs as reported elsewhere,[16] but not on pDCs and mDCs (Fig. 1B).

Liver BDCA3$^+$ DCs Are More Mature than the Counterparts in the Periphery. $BDCA3^+$ DCs in infiltrated hepatic lymphocytes (IHLs) are all positive for CLEC9A, but liver pDCs or mDCs are not (data not shown). The levels of CD40, CD80, CD83, and CD86 on liver $BDCA3^+$ DCs are higher than those on the peripheral counterparts, suggesting that $BDCA3^+$ DCs are more mature in the liver compared to those in the periphery (Fig. 1C).

In order to confirm that $BDCA3^+$ DCs are localized in the liver, we stained the cells with immunofluorescence antibodies (Abs) in noncancerous liver tissues. Liver $BDCA3^+$ DCs were defined as $BDCA3^+$ $CLEC9A^+$ cells (Fig. 1D). Most of the cells were found near the vascular compartment or in sinusoid or the space of Disse of the liver tissue.

BDCA3$^+$ DCs Are Scarce in PBMCs but More Abundant in the Liver. The percentages of $BDCA3^+$ DCs in PBMCs were much lower than those of the other DC subsets ($BDCA3^+$ DCs, pDCs and mDCs, mean $\pm$ SD [%], 0.054 ± 0.044, 0.27 ± 0.21 and 1.30 ± 0.65) (Fig. 2A). The percentages of $BDCA3^+$ DCs in IHLs were lower than those of the others ($BDCA3^+$ DCs, pDCs, and mDCs, mean $\pm$ SD [%],

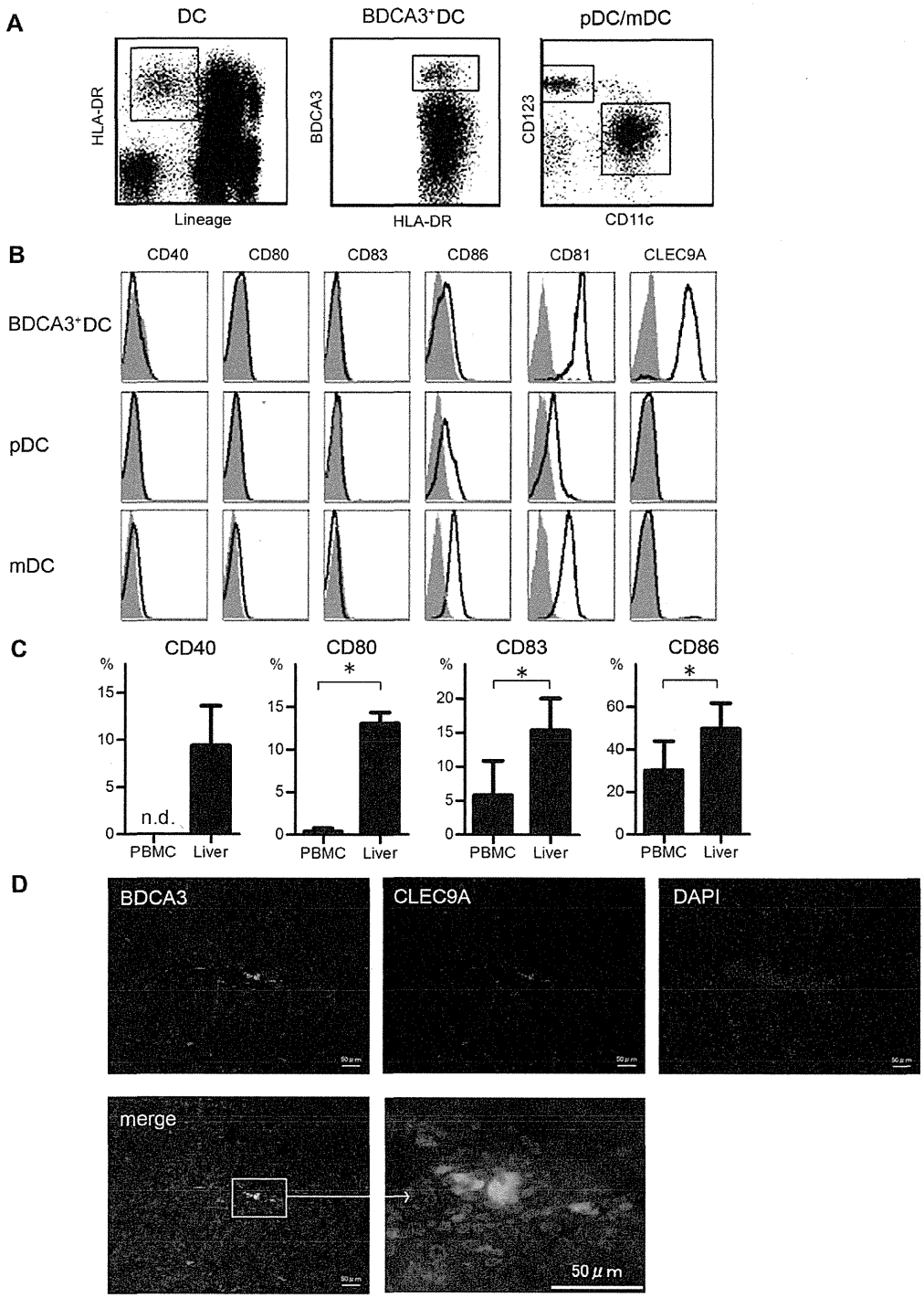

Fig. 1. Identification and phenotypic analyses of peripheral blood and intrahepatic BDCA3$^+$ DCs. (A) We defined BDCA3$^+$ DCs as Lineage$^-$HLA-DR$^+$BDCA3^{high+} cells (middle), pDCs as Lineage$^-$HLA-DR$^+$CD11c$^-$CD123^{high+} cells, and mDCs as Lineage$^-$HLA-DR$^+$CD11c$^+$CD123^{low+} cells (right). (B) The expressions of CD40, CD80, CD83, CD86, CD81, and CLEC9A on each DC subset in peripheral blood are shown. Representative results of five donors are shown in the histograms. Filled gray histograms depict data with isotype Abs, and open black ones are those with specific Abs. (C) The expressions of costimulatory molecules on BDCA3$^+$ DCs were compared between in PBMCs and in the liver. The results are shown as the percentage of positive cells. Results are the mean ± SEM from four independent experiments. *$P < 0.05$ by paired t test. (D) The staining for BDCA3 (green), CLEC9A (red) identifies BDCA3$^+$ DCs (merge, BDCA3$^+$CLEC9A$^+$) in human liver tissues. Representative results of the noncancerous liver samples are shown. BDCA, blood dendritic cell antigen; pDC, plasmacytoid DC; mDC, myeloid DC; CLEC9A, C-type lectin 9A.

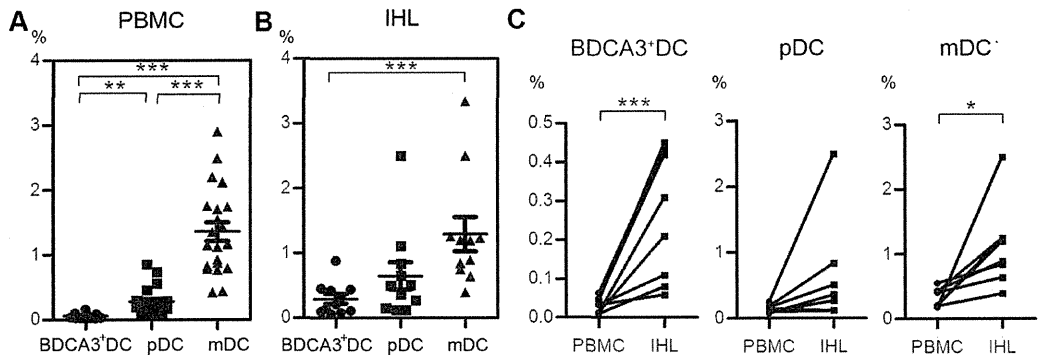

Fig. 2. Analysis of frequency of DC subsets in the peripheral blood and in the liver. Frequencies of BDCA3$^+$ DCs, pDCs, and mDCs in PBMCs (21 healthy subjects) (A) or in the intrahepatic lymphocytes (IHLs) (11 patients who had undergone surgical resection of tumors) (B) are shown. Horizontal bars depict the mean ± SD. $^{**}P < 0.005$; $^{***}P < 0.0005$ by Kruskal-Wallis test. (C) The paired comparisons of the frequencies of DC subsets between in PBMCs and in IHLs. the results of eight patients whose PBMCs and IHLs were obtained simultaneously are shown. $^{*}P < 0.05$; $^{***}P < 0.0005$ by paired t test. IHLs, intrahepatic lymphocytes; pDC and mDC, see Fig. 1.

0.29 ± 0.25, 0.65 ± 0.69 and 1.2 ± 0.94) (Fig. 2B). The percentages of BDCA3$^+$ DCs in the IHLs were significantly higher than those in PBMCs from relevant donors (Fig. 2C). Such relative abundance of BDCA3$^+$ DCs in the liver over that in the periphery was observed regardless of the etiology of the liver disease (Supporting Table 1).

BDCA3$^+$ DCs Produce a Large Amount of IFN-λs upon Poly IC Stimulation. We compared DC subsets for their abilities to produce IL-29/IFN-λ1, IL-28A/IFN-λ2, IL-28B/IFN-λ3, IFN-β, and IFN-α in response to TLR agonists. Approximately 4.0×10^4 of BDCA3$^+$ DCs were recoverable from 400 mL of donated blood from healthy volunteers. We fixed the number of DCs at 2.5×10^4 cells/100 mL for comparison in the following experiments.

BDCA3$^+$ DCs have been reported to express mRNA for TLR1, 2, 3, 6, 8, and 10.[17] First, we quantified IL-28B/IFN-λ3 as a representative for IFN-λs after stimulation of BDCA3$^+$ DCs with relevant TLR agonists. We confirmed that BDCA3$^+$ DCs released IL-28B robustly in response to TLR3 agonist/poly IC but not to other TLR agonists (Fig. S2). In contrast, pDCs produced IL-28B in response to TLR9 agonist/CpG but much lesser to other agonists (Fig. S2). Next, we compared the capabilities of DCs inducing IFN-λs and IFN-β genes in response to relevant TLR agonists. BDCA3$^+$ DCs expressed extremely high levels of IL-29, IL-28A, and IL-28B transcripts compared to other DCs, whereas pDCs induced a higher level of IFN-β than other DCs (Fig. S3A).

Similar results were obtained with the protein levels of IFN-λs, IFN-β, and IFN-α released from DC subsets stimulated with TLR agonists. BDCA3$^+$ DCs produce significantly higher levels of IL-29, IL-28B, and IL-28A than the other DC subsets. In clear contrast, pDCs release a significantly larger amount of IFN-β and IFN-α than BDCA3$^+$ DCs or mDCs (Fig. 3A, Fig. S3B). As for the relationship among the quantity of IFN-λ subtypes from poly IC-stimulated BDCA3$^+$ DCs, the levels of IL-29/IFN-λ1 and IL-28B/IFN-λ3 were positively correlated ($R^2 = 0.76$, $P < 0.05$), and those of IL-28A/IFN-λ2 and IL-28B/IFN-λ3 were positively correlated as well ($R^2 = 0.84$, $P < 0.0005$), respectively (Fig. S3C). These results show that the transcription and translation machineries of IFN-λs may be overlapped among IFN-λ subtypes in BDCA3$^+$ DCs upon poly IC stimulation.

Liver BDCA3$^+$ DCs sorted from IHLs possess the ability to produce IL-28B in response to poly IC (Fig. 3B), showing that they are comparably functional. In response to poly IC, BDCA3$^+$ DCs were capable of producing inflammatory cytokines as well, such as TNF-α, IL-6, and IL-12p70 (Fig. S4A). By using Huh7 cells harboring HCV subgenomic replicons (HCV-N, genotype 1b), we confirmed that the supernatants from poly IC-stimulated BDCA3$^+$ DCs suppressed HCV replication in an IL-28B concentration-dependent manner (Fig. S4B). Therefore, poly IC-stimulated BDCA3$^+$ DCs are capable of producing biologically active substances suppressing HCV replication, some part of which may be mediated by IFN-λs.

BDCA3$^+$ DCs Produce IL-28B upon HCVcc or HCV/JFH-1-Transfected Huh7.5.1 Cells. We stimulated freshly isolated BDCA3$^+$ DCs, pDCs and mDCs with infectious viruses, such as HCVcc, Japanese encephalitis virus (JEV), and herpes simplex virus (HSV). In preliminary experiments, we confirmed that HCVcc stimulated BDCA3$^+$ DCs to release IL-28B in a dose-dependent manner (Fig. S5). BDCA3$^+$ DCs

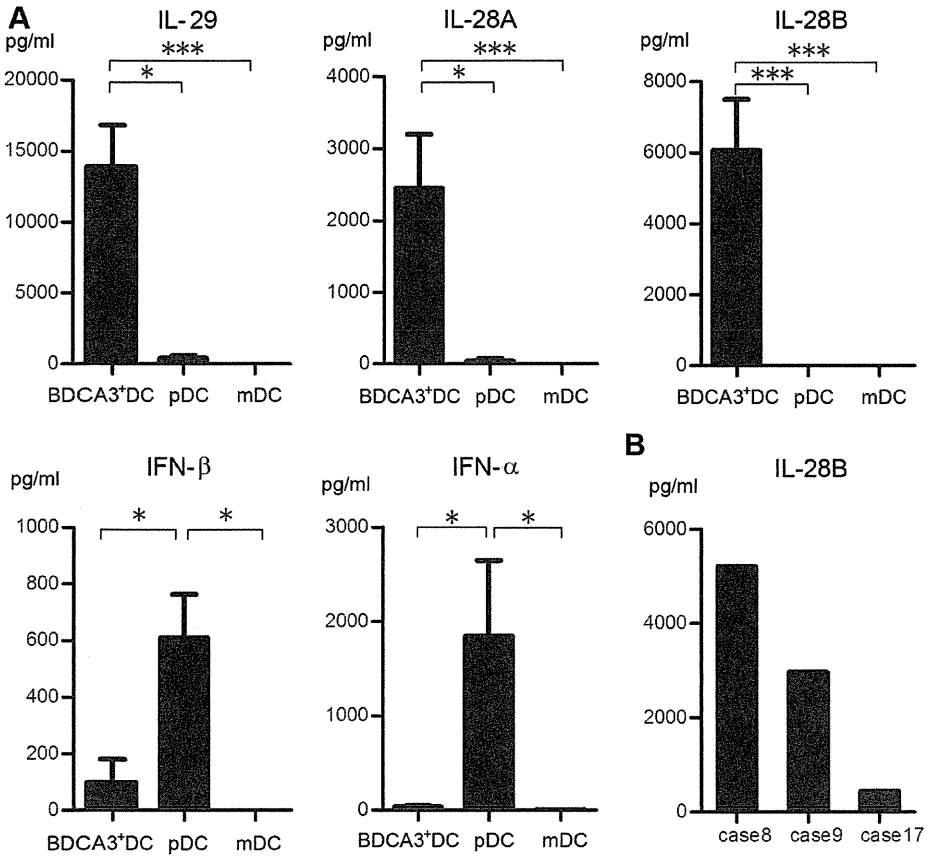

Fig. 3. BDCA3$^+$ DCs recovered from peripheral blood or intrahepatic lymphocytes produce large amounts of IL-29/IFN-λ1, IL-28A/IFN-λ2, and IL-28B/IFN-λ3 in response to poly IC. (A) BDCA3$^+$ DCs and mDCs were cultured at 2.5×10^4 cells with 25 mg/mL poly IC, and pDCs were with 5 mM CPG for 24 hours. The supernatants were examined for IL-29, IL-28A, IL-28B, IFN-β and IFN-α. Results are shown as mean $\pm$ SEM from 15 experiments. $^*P < 0.05$; $^{***}P < 0.0005$ by Kruskal-Wallis test. (B) For the IL-28B production, BDCA3$^+$ DCs in intrahepatic lymphocytes were cultured at 2.5×10^4 cells with 25 mg/mL poly IC for 24 hours. The samples of cases 8 and 9 were obtained from patients with non-B, non-C liver disease and that of case 17 was from an HCV-infected patient (Supporting Table 1).

produced a large amount of IL-28B upon exposure to HCVcc and released a lower amount of IFN-α upon HCVcc or HSV (Fig. 4A). In contrast, pDCs produced a large amount of IFN-α in response to HCVcc and HSV and a much lower level of IL-28B upon HCVcc (Fig. S6). In mDCs, IL-28B and IFN-α were not detectable with any of these viruses (data not shown).

BDCA3$^+$ DCs produced significantly higher levels of IL-28B than the other DCs upon HCVcc stimulation (Fig. 4B). By contrast, HCVcc-stimulated pDCs released significantly larger amounts of IFN-β and IFN-α than the other subsets (Fig. 4B). Liver BDCA3$^+$ DCs were capable of producing IL-28B in response to HCVcc (Fig. 4C). These results show that, upon HCVcc stimulation, BDCA3$^+$ DCs produce more IFN-λs and pDCs release more IFN-β and IFN-α than the other DC subsets, respectively. Taking a clinical impact of IL-28B genotypes on HCV eradication into consideration, we focused on IL-28B/IFN-λ3 as a representative for IFN-λs in the following experiments.

In a coculture with JFH-1-infected Huh7.5.1 cells, BDCA3$^+$ DCs profoundly released IL-29, IL-28A, and IL-28B (Fig. 4D, the results of IL-29 and IL-28A, not shown), whereas BDCA3$^+$ DCs failed to respond to Huh7.5.1 cells lacking HCV/JFH-1, showing that IL-28B production from BDCA3$^+$ DCs is dependent on HCV genome (Fig. 4D). In the absence of BDCA3$^+$ DCs, IL-28B is undetectable in the supernatant from JFH-1-infected Huh7.5.1 cells, demonstrating that BDCA3$^+$ DCs, not HCV-replicating Huh7.5.1 cells, produce detectable amount of IL-28B (Fig. 4D). In the coculture, BDCA3$^+$ DCs comparably released IL-28B either in the presence or the absence of transwells, suggesting that cell-to-cell contact between DCs and Huh7.5.1 cells is dispensable for IL-28B response (Fig. 4E). In parallel with the quantity of IL-28B in the coculture, ISG15 was significantly induced only in JFH-1-infected Huh7.5.1 cells cocultured with BDCA3$^+$ DCs (Fig. 4F). A strong induction was observed with other ISGs in JFH-1-infected Huh7.5.1 in the presence of BDCA3$^+$ DCs, such as IFIT1, MxA, RSD2, IP-10, and USP18 (Fig. S7). The results clearly show that BDCA3$^+$ DCs are capable of producing large amounts of IFN-λs in response to cellular or cell-free HCV, thereby inducing various ISGs in bystander liver cells.

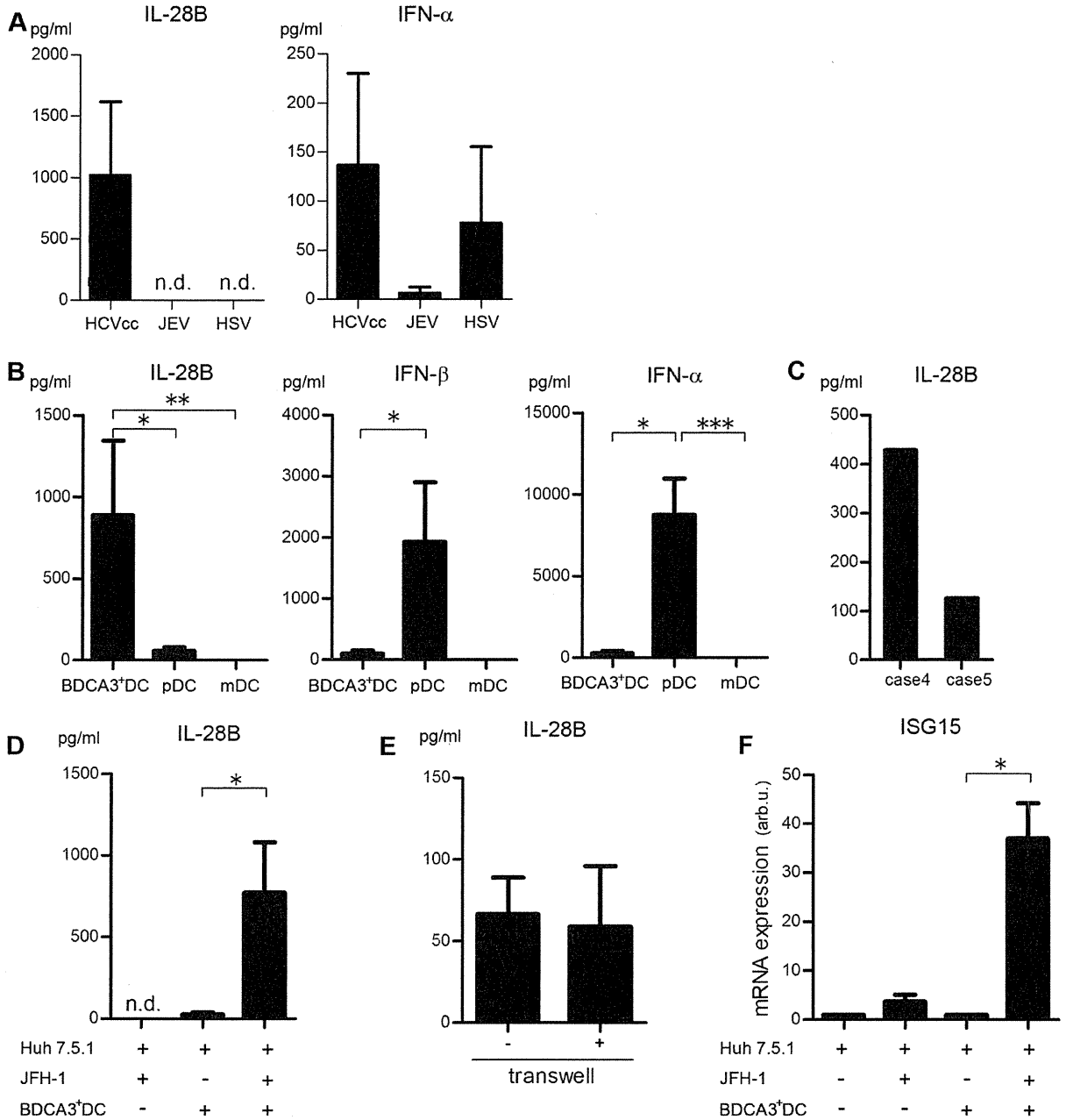

Fig. 4. BDCA3$^+$ DCs produce IL-29, IL-28A, and IL-28B upon cell-cultured HCV or HCV/JFH-1-transfected Huh7.5.1 cells, thereby inducing ISG. (A) BDCA3$^+$ DCs were cultured at 2.5 $\times$ 10^4 cells for 24 hours with HCVcc, JEV, or HSV at a multiplicity of infection (MOI) of 10. Results are shown as mean $\pm$ SEM from six experiments. n.d.; not detected. (B) BDCA3$^+$ DCs, pDCs, and mDCs were cultured at 2.5 $\times$ 10^4 cells for 24 hours with HCVcc at an MOI of 10. The results are shown as mean $\pm$ SEM from 11 experiments. *$P < 0.05$; **$P < 0.0005$; ***$P < 0.0005$ by Kruskal-Wallis test. (C) BDCA3$^+$ DCs recovered from intrahepatic lymphocytes were cultured at 2.5 $\times$ 10^4 cells for 24 hours with HCVcc at an MOI of 10. Both of the samples (cases 4 and 5) were obtained from patients with non-B, non-C liver disease. (D,E) BDCA3$^+$ DCs were cocultured at 2.5 $\times$ 10^4 cells with JFH-1-transfected (MOI = 2) or -untransfected Huh7.5.1 cells for 24 hours. The supernatants of JFH-1-transfected Huh7.5.1.cells without BDCA3$^+$ DCs were also examined. In some experiments of the coculture with JFH-1-transfected Huh7.5.1 cells and BDCA3$^+$ DCs, transwells were inserted into the wells (E). Results are shown as mean $\pm$ SEM from five experiments. *$P < 0.05$ by paired t test. (F) BDCA3$^+$ DCs were cocultured at 2.5 $\times$ 10^4 cells with JFH-1-transfected Huh7.5.1 cells (MOI = 2) or -untransfected Huh7.5.1 cells for 24 hours. The Huh7.5.1.cells were harvested and subjected to real-time RT-PCR analyses for ISG15 expression. The results are shown as mean $\pm$ SEM from five experiments. *$P < 0.05$ by paired t test. HCVcc, cell-cultured HCV; JEV, Japanese encephalitis virus; HSV, herpes simplex virus.

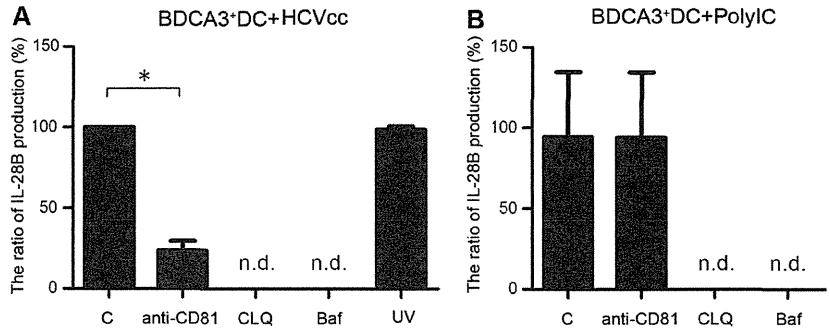

Fig. 5. The CD81 and endosome acidification is involved in the production of IL-28B from HCV-stimulated BDCA3$^+$ DCs, but HCV replication is not necessary. (A,B) BDCA3$^+$ DCs were cultured at 2.5 $\times$ 10^4 cells with HCVcc at an MOI of 10 (A) or poly IC (25 μg/mL) (B). In some experiments, UV-irradiated HCVcc was used at the same MOI, and BDCA3$^+$ DCs were treated with anti-CD81Ab (5 mg/mL), chloroquine (10 mM), or bafilomycin A1 (25 nM). The results are expressed as ratios of IL-28B quantity with or without the treatments. They are shown as mean $\pm$ SEM from five experiments. *$P < 0.05$ by paired t test. C, control; CLQ, treatment with chloroquine; Baf, treatment with bafilomycin A1; UV, ultraviolet-irradiated HCVcc; n.d., not detected.

CD81 and Endosome Acidification Are Involved in IL-28B Production from HCV-Stimulated BDCA3$^+$ DCs, but HCV Replication Is Not Involved. It is not known whether HCV entry and subsequent replication in DCs is involved or not in IFN response.[18,19] To test this, BDCA3$^+$ DCs were inoculated with UV-irradiated, replication-defective HCVcc. We confirmed that UV exposure under the current conditions is sufficient to negate HCVcc replication in Huh7.5.1 cells, as demonstrated by the lack of expression of NS5A after inoculation (data not shown). BDCA3$^+$ DCs produced comparable levels of IL-28B with UV-treated HCVcc, indicating that active HCV replication is not necessary for IL-28B production (Fig. 5A).

We next examined whether or not the association of HCVcc with BDCA3$^+$ DCs by CD81 is required for IL-28B production. It has been reported that the E2 region of HCV structural protein is associated with CD81 on cells when HCV enters susceptible cells.[13,20] We confirmed that all DC subsets express CD81, the degree of which was most significant on BDCA3$^+$ DCs (Fig. 1B, Fig. S1). Masking of CD81 with Ab significantly impaired IL-28B production from HCVcc-stimulated BDCA3$^+$ DCs in a dose-dependent manner (Fig. 5A, Fig. S8), suggesting that HCV-E2 and CD81 interaction is involved in the induction. The treatment of poly IC-stimulated BDCA3$^+$ DCs with anti-CD81 Ab failed to suppress IL-28B production (Fig. 5B).

HCV enters the target cells, which is followed by fusion steps within acidic endosome compartments. Chloroquine and bafilomycin A1 are well-known and broadly used inhibitors of endosome TLRs, which are reported to be capable of blocking TLR3 response in human monocyte-derived DC.[21,22] In our study, the treatment of BDCA3$^+$ DCs with chloroquine, bafilomycin A1, or NH4Cl significantly suppressed their IL-28B production either in response to HCVcc or poly IC (Fig. 5A,B, NH4Cl, data not shown). These results suggest that the endosome acidification is involved in HCVcc- or poly IC-stimulated BDCA3$^+$ DCs to produce IL-28B. The similar results were obtained with HCVcc-stimulated pDCs for the production of IL-28B (Fig. S9). We validated that such concentration of chloroquine (10 mM) and bafilomycin A1 (25 nM) did not reduce the viability of BDCA3$^+$ DCs (Fig. S10).

BDCA3$^+$ DCs Produce IL-28B in Response to HCVcc by a TIR-Domain-Containing Adapter-Inducing Interferon-β (TRIF)-Dependent Mechanism. TRIF/TICAM-1, a TIR domain-containing adaptor, is known to be essential for the TLR3-mediated pathway.[23] In order to elucidate whether TLR3-dependent pathway is involved or not in IL-28B response of BDCA3$^+$ DCs, we added the cell-permeable TRIF-specific inhibitory peptide (Invivogen) or the control peptide to poly IC- or HCVcc-stimulated BDCA3$^+$ DCs. Of particular interest, the TRIF-specific inhibitor peptide, but not the control one, significantly suppressed IL-28B production from poly IC- or HCVcc-stimulated BDCA3$^+$ DCs (Fig. 6A,B). In clear contrast, the TRIF-specific inhibitor failed to suppress IL-28B from HCVcc-stimulated pDCs (Fig. 6C), suggesting that pDCs recognize HCVcc in an endosome-dependent but TRIF-independent pathway. These results show that BDCA3$^+$ DCs may recognize HCVcc by way of the TRIF-dependent pathway to produce IL-28B.

BDCA3$^+$ DCs in Subjects with IL-28B Major Genotype Produce More IL-28B in Response to HCV than Those with IL-28B Minor Type. In order to compare the ability of BDCA3$^+$ DCs to release IL-28B in healthy subjects between IL28B major (rs8099917, TT)

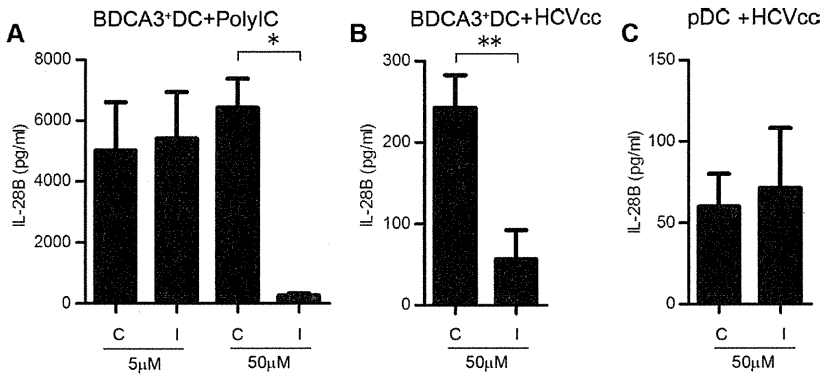

Fig. 6. BDCA3$^+$ DCs produce IL-28B upon HCVcc stimulation in a TRIF-dependent mechanism. BDCA3$^+$ DCs or pDCs had been treated with 5 or 50 mM TRIF inhibitory peptide or control peptide for 2 hours. Subsequently, BDCA3$^+$ DCs were stimulated with Poly IC (25 μg/mL) or HCVcc (MOI = 10), and pDCs were stimulated with HCVcc (MOI = 10), respectively. IL-28B was quantified by ELISA. They are shown as mean ± SEM from five experiments. *$P < 0.05$ by paired t test. C, TRIF control peptide; I, TRIF inhibitory peptide.

and minor hetero (TG) genotypes, we stimulated BDCA3$^+$ DCs of the identical subjects with poly IC (25 mg/mL, 2.5 mg/mL, 0.25 mg/mL), HCVcc or JFH-1-infected Huh 7.5.1, and subjected them to ELISA. The levels of IL-28B production by poly IC-stimulated BDCA3$^+$ DCs were comparable between subjects with IL-28B major and minor type (Fig. 7A). Similar results were obtained with the lesser concentrations of poly IC (Fig. S11). Of particular interest, in response to HCVcc or JFH-1 Huh7.5.1 cells, the levels of IL-28B from BDCA3$^+$ DCs were significantly higher in subjects with IL-28B major than those with minor type (Fig. 7B,C, S12).

Discussion

In this study we demonstrated that human BDCA3$^+$ DCs (1) are present at an extremely low frequency in PBMC but are accumulated in the liver; (2) are capable of producing IL-29/IFN-λ1, IL-28A/IFN-λ2, and IL-28B/IFN-λ3 robustly in response to HCV; (3) recognize HCV by a CD81-, endosome acidification and TRIF-dependent mechanism; and (4) produce larger amounts of IFN-λs upon HCV stimulation in subjects with IL-28B major genotype (rs8099917, TT). These characteristics of BDCA3$^+$ DCs are quite unique in comparison with other DC repertoires in the settings of HCV infection.

At the steady state, the frequency of DCs in the periphery is relatively lower than that of the other immune cells. However, under disease conditions or physiological stress, activated DCs dynamically migrate to the site where they are required to be functional. However, it remains obscure whether functional BDCA3$^+$ DCs exist or not in the liver. We identified BDCA3$^+$CLEC9A$^+$ cells in the liver tissue (Fig. 1D). In a paired frequency analysis of BDCA3$^+$ DCs between in PBMCs and in IHLs, the cells are more abundant in the liver. The phenotypes of liver BDCA3$^+$ DCs were more mature than the PBMC counterparts. In support of our observations, a recent publication showed that CD141$^+$ (BDCA3$^+$) DCs are accumulated and more mature in the liver, the trend of which is more in HCV-infected liver.[24] We confirmed that liver BDCA3$^+$ DCs are functional, capable of releasing IFN-λs in response to poly IC or HCVcc.

BDCA3$^+$ DCs were able to produce large amounts of IFN-λs but much less IFN-β or IFN-α upon TLR3 stimulation. In contrast, in response to TLR9 agonist,

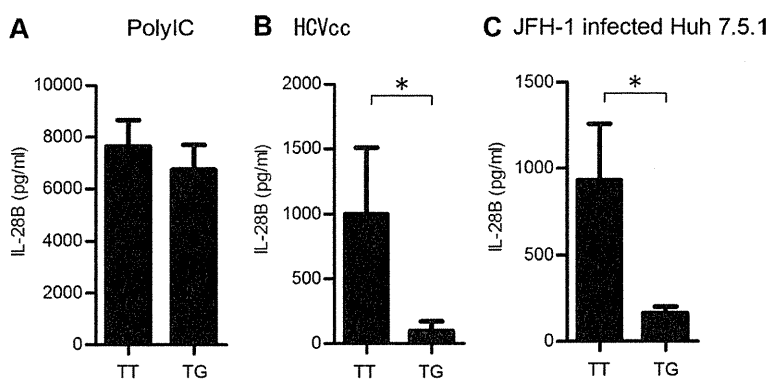

Fig. 7. In response to HCVcc, BDCA3$^+$ DCs of healthy donors with IL-28B major genotype (rs8099917, TT) produced more IL-28B than those with minor type (TG). BDCA3$^+$ DCs of healthy donors with IL-28B TT (rs8099917) or TG genotype were cultured at 2.5 × 10^4 cells with 25 mg/mL poly IC (A), with HCVcc at an MOI of 10 (B), or with JFH-1-infected Huh 7.5.1 cells (C) for 24 hours. The supernatants were subjected to IL-28B ELISA. The same healthy donors were examined for distinct stimuli. The results are the mean ± SEM from 15 donors with TT and 8 with TG, respectively. *$P < 0.05$ by Mann-Whitney U test.

pDCs released large amounts of IFN-β and IFN-α but much less IFN-λs. Such distinctive patterns of IFN response between BDCA3$^+$ DCs and pDCs are of particular interest. It has been reported that interferon regulatory factor (IRF)-3, IRF-7, or nuclear factor kappa B (NF-κB) are involved in IFN-β and IFN-λ1, while IRF-7 and NF-κB are involved in IFN-α and IFN-λ2/λ3.[5] Presumably, the stimuli with TLR3/retinoic acid-inducible gene-I (RIG-I) (poly IC) or TLR9 agonist (CpG-DNA) in DCs are destined to activate these transcription factors, resulting in the induction of both types of IFN at comparable levels. However, the results of the present study did not agree with such overlapping transcription factors for IFN-λs, IFN-β, and IFN-α. Two possible explanations exist for different levels of IFN-λs and IFN-α production by BDCA3$^+$ DCs and pDCs. First, the transcription factors required for full activation of IFN genes may differ according to the difference of DC subsets. The second possibility is that since type III IFN genes have multiple exons, they are potentially regulated by post-transcriptional mechanisms. Thus, it is possible that such genetic and/or posttranscriptional regulation is distinctively executed between BDCA3$^+$ DCs and pDCs. Comprehensive analysis of gene profiles downstream of TLRs or RIG-I in BDCA3$^+$ DCs should offer some information on this important issue.

BDCA3$^+$ DCs were found to be more sensitive to HCVcc than JEV or HSV in IL-28B/IFN-λ3 production. Such different strengths of IL-28B in BDCA3$^+$ DCs depending on the virus suggest that different receptors are involved in virus recognition. Again, the question arises of why BDCA3$^+$ DCs produce large amounts of IFN-λs compared to the amounts produced by pDCs in response to HCVcc. Considering that IRF-7 and NF-κB are involved in the transcription of the IL-28B gene, it is possible that BDCA3$^+$ DCs successfully activate both transcription factors upon HCVcc for maximizing IL-28B, whereas pDCs fail to do so. In support for this possibility, in pDCs it is reported that NF-κB is not properly activated upon HCVcc or hepatoma cell-derived HCV stimulations.[25]

In the present study we demonstrated that HCV entry into BDCA3$^+$ DCs through CD81 and subsequent endosome acidification are critically involved in IL-28B responses. Involvement of TRIF-dependent pathways in IL-28B production was shown by the significant inhibition of IL-28B with TRIF inhibitor. Nevertheless, active HCV replication in the cells is not required. Based on our data, we considered that BDCA3$^+$ DCs recognize HCV genome mainly by an endosome and TRIF-dependent mechanism. Although the results with UV-irradiated HCVcc, anti-CD81 blocking Ab, and chloroquine were quite similar, the TRIF-specific inhibitor failed to suppress IL-28B from pDCs (Fig. 6, Fig. S9).

In the coculture with JFH-transfected Huh7.5.1 cells, BDCA3$^+$ DCs presumably receive some signals for IL-28B production by way of cell-to-cell dependent and independent mechanisms. In the present study, most of the stimuli to BDCA3$^+$ DCs for IL-28B production may be the released HCVcc from Huh7.5.1 cells, judging from the inability of suppression with transwells. However, a contribution of contact-dependent mechanisms cannot be excluded in the coculture experiments. HCV genome is transmissible from infected hepatocytes to uninfected ones through tight junction molecules, such as claudin-1 and occuludin. Further investigation is needed to clarify whether such cell-to-cell transmission of viral genome is operated or not in BDCA3$^+$ DCs.

The relationship between IL-28B expression and the induction of ISGs has been drawing much research attention. In primary human hepatocytes, it is reported that HCV primarily induces IFN-λ, instead of type-I IFNs, subsequently enhancing ISG expression.[7] Of particular interest is that the level of hepatic IFN-λs is closely correlated with the strength of ISG response.[26] These reports strongly suggest that hepatic IFN-λs are a crucial driver of ISG induction and subsequent HCV eradication. Besides, it is likely that BDCA3$^+$ DCs, as a bystander IFN-λ producer in the liver, have a significant impact on hepatic ISG induction. In support of this possibility, we demonstrated in this study that BDCA3$^+$ DCs are capable of producing large amounts of IFN-λs in response to HCV, thereby inducing ISGs in the coexisting liver cells.

Controversial results have been reported regarding the relationship between IL28B genotypes and the levels of IL-28 expression. Nevertheless, in chronic hepatitis C patients with IL-28B major genotype, the IL-28 transcripts in PBMCs are reported to be higher than those with minor genotype.[2] In this study, by focusing on a prominent IFN-λ producer (BDCA3$^+$ DCs) and using the assay specific for IL-28B, we showed that the subjects with IL-28B major genotype could respond to HCV by releasing more IL-28B. Of interest, such a superior capacity of BDCA3$^+$ DCs was observed only in response to HCV but not to poly IC. Since the pathways downstream of TLR3-TRIF leading to IL-28B in BDCA3$^+$ DCs should be the same, either HCV or poly IC stimulation, two plausible explanations exist for such a distinct IL-28B response. First, it is possible that distinct epigenetic regulation may be

involved in IL-28B gene according to the IL-28B genotypes. Recently, in influenza virus infection, it is reported that micro-RNA29 and DNA methyltransferase are involved in the cyclooxygenase-2-mediated enhancement of IL-29/IFN-λ1 production.[27] This report supports the possibility that similar epigenetic machineries could be operated as well in HCV-induced IFN-λs production. Second, it is plausible that the efficiency of the stimulation of TLR3-TRIF may be different between the IL-28B genotypes. Since HCV reaches endosome in BDCA3$^+$ DCs by way of the CD81-mediated entry and subsequent endocytosis pathways, the efficiencies of HCV handling and enzyme reactions in endosome may be influential in the subsequent TLR3-TRIF-dependent responses. Certain unknown factors regulating such process may be linked to the IL-28B genotypes. For a comprehensive understanding of the biological importance of IL-28B in HCV infection, such confounding factors, if they exist, need to be explored.

In conclusion, human BDCA3$^+$ DCs, having a tendency to accumulate in the liver, recognize HCV and produce large amounts of IFN-λs. An enhanced IL-28B/IFN-λ3 response of BDCA3$^+$ DCs to HCV in subjects with IL-28B major genotype suggests that BDCA3$^+$ DCs are one of the key players in anti-HCV innate immunity. An exploration of the molecular mechanisms of potent and specialized capacity of BDCA3$^+$ DCs as IFN-λ producer could provide useful information on the development of a natural adjuvant against HCV infection.

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Review Article

Genome-Wide Association Study Reveals Host Genetic Factors for Liver Diseases

Nao Nishida[1,2], Katsushi Tokunaga[2] and Masashi Mizokami[1]

[1]*The Research Center for Hepatitis & Immunology, National Center for Global Health and Medicine, Ichikawa, Chiba, Japan;*
[2]*Department of Human Genetics, The University of Tokyo, Bunkyo-ku, Tokyo, Japan*

Abstract

A number of disease-associated genetic markers for common liver diseases have been identified using genome-wide association studies (GWASs). The GWAS strategy is based on genome-wide single-nucleotide polymorphism typing technologies, which are now commercially available, accompanied by statistical methods to identify host genetic factors that are associated with target diseases or complex genetic traits. One of the most striking features of the GWAS strategy is the ability to identify unexpected disease-associated genetic markers across the entire human genome. Here, we describe the technological aspects of the GWAS strategy with examples from actual GWAS reports related to hepatitis research, including drug response for patients with chronic hepatitis C, susceptibility to primary biliary cirrhosis, and hepatitis-B-related hepatocellular carcinoma.
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Introduction

Numerous single-nucleotide polymorphisms (SNPs) have been discovered and deposited in public databases (e.g. the National Center for Biotechnology Information [http://www.ncbi.nlm.nih.gov], Ensembl [http://asia.ensembl.org/index.html], and the MEXT Integrated Database Project [http://dbcls.rois.ac.jp]) through international SNP discovery projects such as the Human Genome Project,[1] the International HapMap project (http://hapmap.ncbi.nlm.nih.gov/index.html.en), and the 1000 Genomes project (www.1000genomes.org). Together with the development of technologies for large-scale SNP genotyping, genome-wide association studies (GWASs) using hundreds of thousands of SNPs allow the identification of candidate genetic loci for multifactorial diseases. Disease-associated SNPs have also been deposited in public databases, such as the database of Genotypes and Phenotypes (www.ncbi.nlm.nih.gov/gap). Moreover, a number of SNPs have been reported to be associated with complex genetic traits, such as body mass index,[2] height,[3] and hair thickness.[4] In the National Human Genome Research Institute (NHGRI) GWAS catalog (www.genome.gov), more than 8,800 trait- or disease-associated SNPs with genome-wide significance ($p<5\times10^{-8}$) have been archived from a total of 1,551 published GWAS (through March, 2013).[5]

Here, we describe a GWAS strategy to identify disease-associated SNPs, including SNP genotyping technologies for both the GWAS stage and the following replication stage. Based on this GWAS strategy, we have identified associations of genetic variations with diseases related to hepatitis B and C viruses (HBV and HCV), including drug response in patients with chronic HCV infection,[6] susceptibility to primary biliary cirrhosis (PBC),[7] and HBV-related hepatocellular carcinoma (HCC).[8]

Technologies for GWAS and replication analysis

A number of SNP typing methods have been used to analyze a single SNP, or SNPs at multiple sites of a template or templates simultaneously. Most of the methods employ single or multiple site-specific amplifications and a genotyping step based on various types of chemical reactions, including Sanger direct sequencing, 5′ exonuclease fluorescence-based assay (TaqMan),[9] pyrosequencing,[10] DigiTag2 assay,[11] single-base extension,[12] and matrix-assisted laser desorption/ionization time-of-flight mass spectrometry (MALDI-TOF).[13]

Together with technology developments in large-scale SNP genotyping, the most recent versions of commercially available genotyping platforms allow the simultaneous analysis of more than one million SNPs across the whole genome in a single experiment. Two platforms are commercially available and widely used for genome-wide SNP typing: Affymetrix SNP GeneChip arrays[14] and Illumina BeadArray genotyping technology.[15] The number of SNPs embedded in both platforms has been gradually increasing since 2003, when the first commercial genome-wide SNP genotyping platform was released by Affymetrix.[16] The first platform of the Affymetrix GeneChip Mapping 10K Array included 14,548 SNPs, which enabled the performance of whole-genome linkage analyses and was indeed used to identify a disease-associated missense mutation in the *HOXD10* gene with Charcot–Marie-Tooth disease through a family-based linkage study.[17] The current versions of the commercial platforms from Affymetrix and Illumina include more than 900,000 SNPs (Genome-Wide Human SNP Array 6.0) and 4.3 million SNPs (HumanOmni5-Quad BeadChip), respectively. A newly released genome-wide SNP typing platform, named the

Keywords: GWAS; Hepatitis B infection; Hepatitis C infection; Primary biliary cirrhosis; HLA-DP; Hepatocellular carcinoma; Host genetic factors.
Abbreviations: GWAS, genome-wide association study; SNP, single nucleotide polymorphism; HBV, hepatitis B virus; HCV, hepatitis C virus; PBC, primary biliary cirrhosis; HCC, hepatocellular carcinoma; PCR, polymerase chain reaction; HLA, human leukocyte antigen; CHB, chronic hepatitis B.
Received: 2 April 2013; Revised: 13 May 2013; Accepted: 22 May 2013
DOI of original article: http://dx.doi.org/10.14218/JCTH.2013.010XX.
Correspondence to: Masashi Mizokami, The Research Center for Hepatitis & Immunology, National Center for Global Health and Medicine, 1-7-1 Kohnodai, Ichikawa, Chiba 272-8516, Japan. Tel: +81-47-372-3501 Ext. 1250, Fax: +81-47-375-4766, E-mail: mmizokami@hospk.ncgm.go.jp

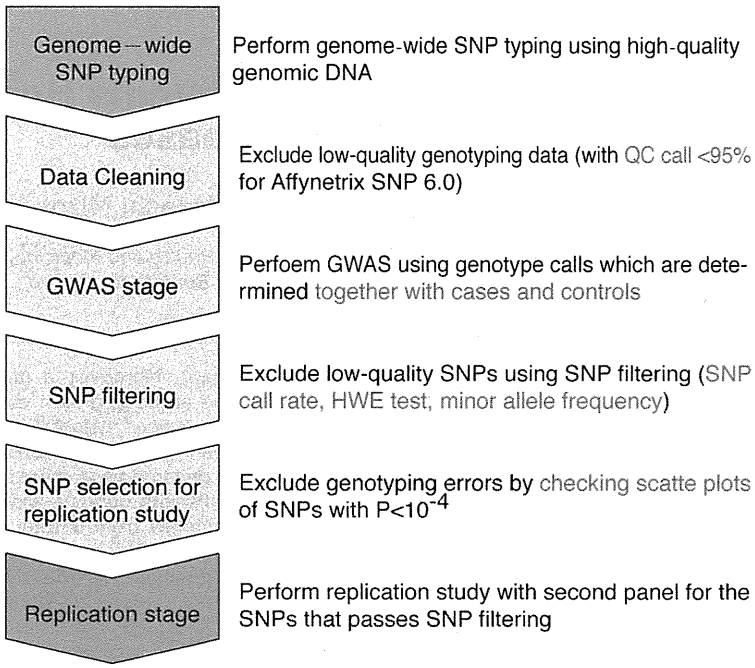

Fig. 1. GWAS strategy from genome-wide SNP typing to replication analysis.

Affymetrix Axiom Genome-Wide ASI 1 Array, has a probe set for SNPs (including rare and common variants) that are optimized for Asian populations. These platforms open a new approach for researchers to perform GWASs with hundreds of thousands of SNPs, allowing the identification of candidate genetic loci for multifactorial diseases.

In 2002, the first GWAS using 92,788 gene-based SNPs was reported by a Japanese group (RIKEN), which identified the lymphotoxin-α gene as being associated with susceptibility to myocardial infarction.[18] The RIKEN group developed its own platform to perform a GWAS based on the Invader assay[19] with multiplex polymerase chain reaction (PCR).[20] Since 2002, the number of published genome-wide associations with genome-wide significance ($p<5\times10^{-8}$) has increased annually, reaching 1,551 publications in the NHGRI GWA catalog (through March, 2013).[5]

For a replication study following a GWAS stage, several candidate genetic regions that have been detected in the initial GWAS need to be analyzed. Suitable platforms for replication analyses have the ability to perform multiplex detections in a single reaction, such as the mini-sequencing (SNaPshot) technique,[21] chip-based genotyping by mass spectrometry (Sequenom),[22] and the DigiTag2 assay.[11] The DigiTag2 assay is our own technology for multiplex SNP typing, and represents a simple and cost-effective approach by combining multiplex PCR to enrich genetic regions including the target SNPs with an oligonucleotide ligation assay to determine the genotype of the target locus. For a single locus analysis the TaqMan assay would be more commonly used to determine the genotype of the target locus, as opposed to conventional Sanger sequencing, which is more commonly used when a large number of samples need to be analyzed.

Hepatitis research based on GWAS

In a GWAS, two groups of participants are compared to detect the "association(s)" of certain variants with a particular trait by examining differences in allele and/or genotype frequency of all SNPs, which exist across the entire genome. GWAS enables the effective detection of associated variations in strong linkage disequilibrium with the causal variants and genes, and the following replication analysis and high-density mapping identify the causal variants and genes using an independent set of participants with a larger number of samples. However, the association of SNPs with low minor allele frequency (below 1–5%; known as rare variants) would be difficult to detect in a SNP-based GWAS because of insufficient statistical power due to the limitation of sample number.[23] Fig. 1 outlines the GWAS strategy from whole-genome SNP typing to replication analysis.

The emerging strategy of GWAS has revealed disease-causing alleles, or variants that lead to susceptibility to complex polygenic diseases with small additive or multiplicative effects on the disease phenotype. For example, a recent GWAS and subsequent meta-analyses in populations of European descent identified human leukocyte antigen (HLA) and 21 non-HLA susceptibility loci, most of which are involved in interleukin (IL)-12/IL-12 receptor (IL-12R) signaling, tumor necrosis factor (TNF)/toll-like receptor (TLR)–nuclear factor (NF)-κB signaling, and B-cell differentiation in the development of PBC.[24–27] PBC is a chronic cholestatic liver disease characterized by chronic non-suppurative destructive cholangitis of the intrahepatic small bile ducts. A high concordance rate in monozygotic twins and familial clustering of patients with PBC indicates the involvement of strong genetic factors in the development of PBC.[28] To

Table 1. Replication analysis of Japanese samples for SNPs associated with PBC in previous studies, and two newly identified loci (*TNFSF15* and *POU2AF1*).

Gene name	SNP	OR	95% CI	P-value
Significant associations with PBC				
TNFSF15	rs4979462	1.57	1.76–1.40	1.85×10^{-14}
POU2AF1	rs4938534	1.38	1.55–1.23	3.27×10^{-8}
IKZF3	rs9303277	1.44	1.63–1.28	3.66×10^{-9}
CD80	rs2293370	1.48	1.68–1.29	3.04×10^{-9}
IL7R	rs6890853	1.47	1.69–1.28	3.66×10^{-8}
Suggestive associations with PBC				
NFKB1	rs7665090	1.35	1.52–1.21	1.42×10^{-7}
STAT4	rs7574865	1.35	1.52–1.19	1.11×10^{-6}
Marginal associations with PBC				
CXCR5	rs6421571	1.42	1.75–1.16	0.0004
TNFAIP2	rs8017161	1.22	1.38–1.08	0.0006
MAP3K7IP1(TAB1)	rs968451	1.29	1.52–1.10	0.0009
rs6974491	rs2717948	1.33	1.66–1.07	0.005
DENND1B	rs12134279	1.14	1.33–0.98	0.0405
No apparent associations with PBC				
rs11117432	rs8062669	1.21	1.52–0.96	0.0521
IL12RB2/SCHIP1	rs3790567	1.12	1.28–0.98	0.0540
RPS6KA4	rs538147	1.12	1.28–0.98	0.0554
TNFRSF1A	rs1800693	1.12	1.30–0.97	0.0607
CLEC16A	rs12924729	1.10	1.28–0.94	0.1197
MMEL1	rs3748816	1.07	1.20–0.95	0.1256
PLCL2	rs1372072	1.07	1.20–0.95	0.1396
SPIB	rs3745516	1.08	1.27–0.92	0.1803
IRF5/TNPO3	rs4728142	1.08	1.30–0.90	0.2027
RAD51L1	rs911263	1.07	1.30–0.89	0.2353
IL12A	rs6441286	1.02	1.15–0.91	0.3422

identify susceptibility loci for PBC in the Japanese population, we conducted a GWAS and subsequent replication study using a total of 1,327 PBC patients and 1,120 healthy controls.[7] In addition to the most significant susceptibility region at *HLA*, two significant susceptibility loci (*TNFSF15* and *POU2AF1*) with *p*-values $<5\times10^{-8}$ were identified (Table 1). Moreover, of the 21 non-HLA susceptibility loci that were identified in populations of European descent, three loci (*IKZF3*, *CD80*, and *IL7R*) showed significant associations and two loci (*NFKB1* and *STAT4*) showed suggestive associations with PBC in the Japanese population. Five other loci (*CXCR5*, *TNFAIP2*, *MAP3K7IP1*, rs6974491, and *DENND1B*) also showed marginal associations ($p<0.05$) with PBC in the Japanese population (Table 1). These results indicate that additional important disease pathways (via *TNFSF15* and *POU2AF1*) – differentiation to T-helper 1 (Th1) cells (via *TNFSF15*, *CD80*, *IL12*, *IL12R*, and *STAT4*; Fig. 2), B-cell differentiation (via *POU2AF1*, *CXCR5*, *SPIB*, *IL7R*, and *IKZF3*), and NF-κB signaling – in addition to the previously reported disease pathways have a role in the development of PBC in Japanese populations.

In another study that aimed to identify host genetic factors related to drug response to pegylated interferon-α plus ribavirin treatment for HCV infected patients, comparatively small number of samples were analyzed in a GWAS, including samples from 154 Japanese HCV patients undergoing pegylated interferon-α/ribavirin treatment, 78 null virologic responders, and 64 virologic responders.[6] Despite the small number of samples in the GWAS in comparison with other studies in European descendants (European American,[29] Australian,[30] and Swiss[31]), the same disease-causing locus of *IL28B* was identified with the strongest association in the Japanese population. In general, the number of samples affects the statistical power of detection in a GWAS. Moreover, false-positive associations can increase when low-quality genotype data are incorporated in the analysis, presumably caused by accidental errors in genotyping steps or low-quality genomic DNA. The Japanese GWAS was able to successfully identify the risk factors in a small number of samples because: (1) *IL28B* is a strong host risk factor for drug response in Asian and white populations; and (2) quality controls were used in sample collection in terms of clinical characteristics, and the genotype data were checked for quality.[14]

As for HBV-related HCC, a GWAS using chronic HBV carriers with and without HCC in five independent Chinese samples found that one SNP (rs17401966) in *KIF1B* was associated with susceptibility to HBV-related HCC.[32] Moreover, in the most recent report on this topic, genetic variants in the *STAT4* and *HLA-DQ* genes were identified as

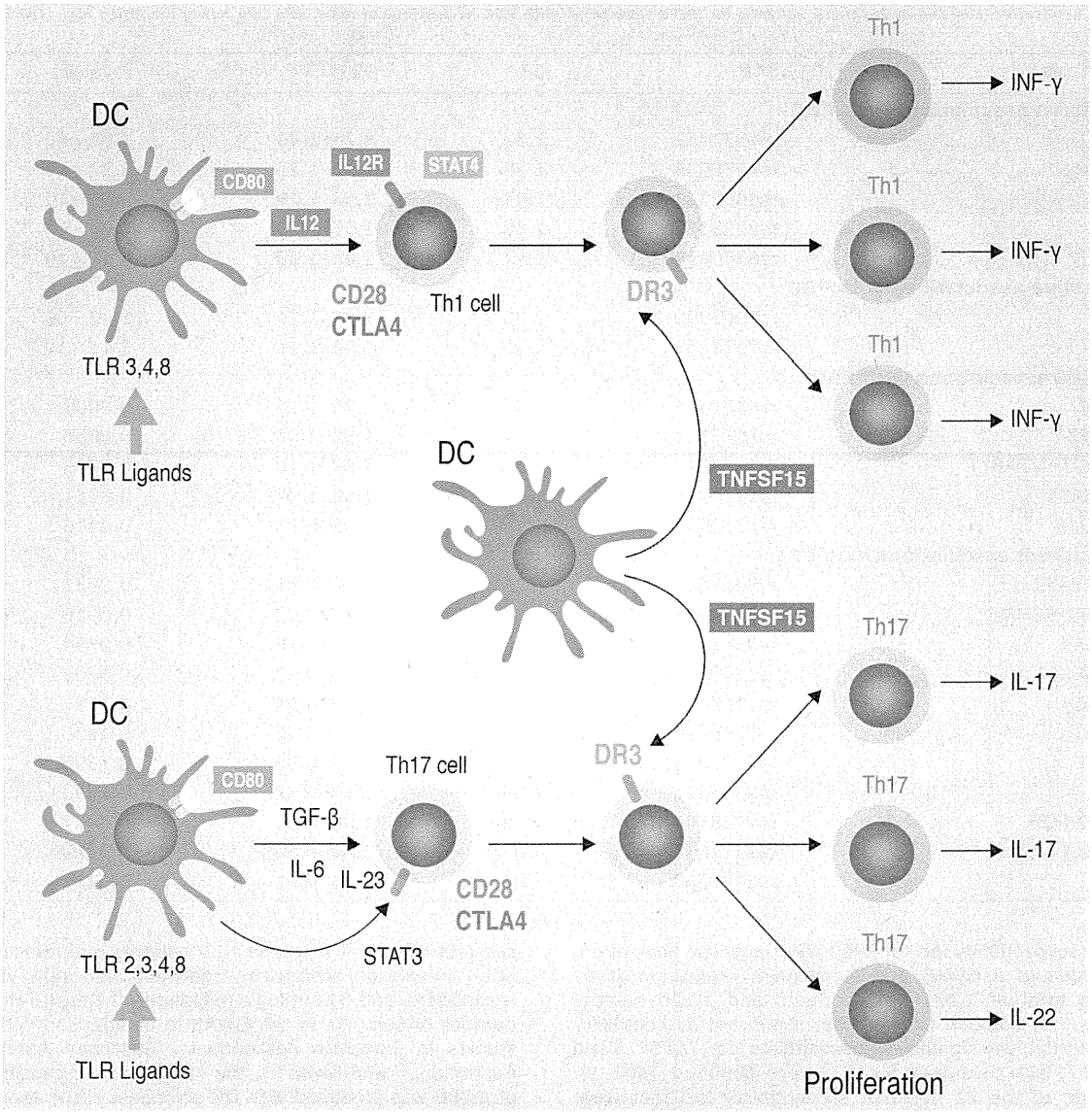

Fig. 2. T-cell proliferation via *TNFSF15* and other related genes. A proportion of susceptibility genes associated with PBC (*CD80*, *IL12A*, *IL12RB2*, *STAT4*, and *TNFSF15*) are related to T-cell proliferation via both Th1 and Th17 cells.

genetic susceptibility loci for HBV-related HCC in the Chinese population.[33] We performed SNP genotyping of rs17401966 on the *KIF1B* gene in Japanese, Korean, and Hong Kong populations for the purpose of replication analysis of a previous GWAS report.[8] We first examined two independent Japanese HBV-related HCC populations and healthy controls, including 179 patients and 769 controls from Biobank Japan, and142 patients and 251 controls from various hospitals. We did not detect any associations between rs17401966 and HCC in the Japanese population. We also detected no association of the SNP with HBV-related HCC in Korean and Hong Kong populations using 164 patients and 144 controls, and 94 patients and 187 controls, respectively. In a recent report from another group, no significant association of the *KIF1B* gene was observed in HBV-related HCC patients of Saudi Arabian ethnicity.[34] These results may be explained by genetic diversity among the Chinese, Japanese, Korean, Hong Kong, and Saudi Arabian populations. The complexity of multivariate interactions in the pathogenesis of HCC may lead to difficulties in identifying the gene(s) associated with HBV-related HCC.

In a previous report that studied 179 Japanese individuals with chronic HBV infection (CHB) and 934 control participants, a GWAS identified significant associations of CHB with a region including *HLA-DPA1* and *HLA-DPB1*.[35] The same group was also conducted a second GWAS with a total of 2,667 Japanese patients with persistent HBV and 6,496 controls, which confirmed significant associations between

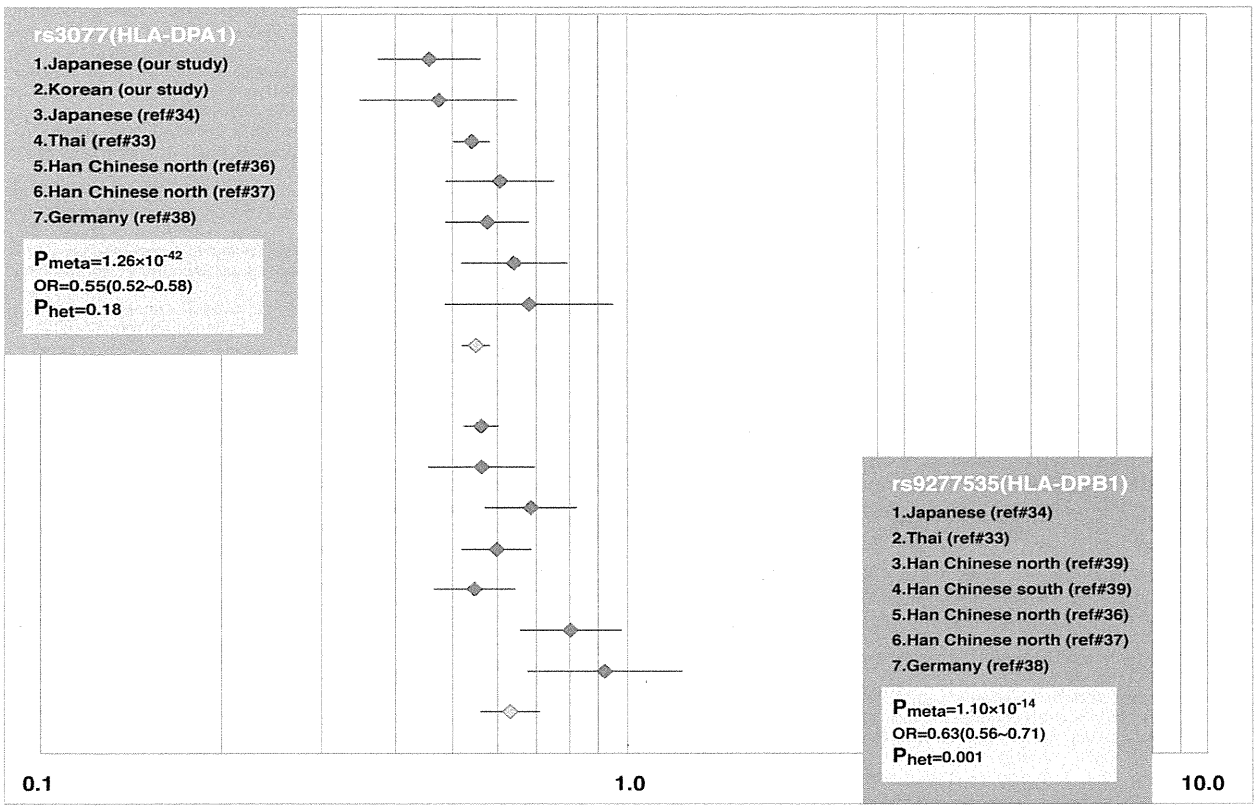

Fig. 3. Associations of *HLA-DP* with CHB and HBV clearance in Asian populations. Meta-analysis using the random-effects model across seven independent studies, including six additional published data sets, showed $Pmeta = 1.26 \times 10^{-42}$, odds ratio (OR) 0.55 for rs3077, and $Pmeta = 1.10 \times 10^{-14}$, OR 0.63 for rs9277535. Heterogeneity was tested using a general variance-based method.

the *HLA-DP* locus and CHB, in addition to associations with another two SNPs located in a genetic region including the *HLA-DQ* gene.[36] We performed a GWAS using samples from Japanese HBV carriers, healthy controls, and individuals who spontaneously resolved HBV infections (hepatitis B surface antigen [HBsAg] negative and hepatitis B core antibody [anti-HBc] positive), in order to confirm or identify the host genetic factors related to CHB and viral clearance.[37] In the subsequent replication analysis, we validated the associated SNPs in the GWAS using two independent sets of Japanese and Korean individuals. In our study, healthy controls with no clinical evidence of HBV exposure were randomly selected; therefore, HBV-resolved individuals were prepared to clearly identify the host genetic factors related to CHB or HBV clearance. An association analysis conducted with the Japanese and Korean data identified the *HLA-DPA1* and *HLA-DPB1* genes with $Pmeta = 1.89 \times 10^{-12}$ for rs3077 and $Pmeta = 9.69 \times 10^{-10}$ for rs9277542. We also found that the *HLA-DPA1* and *HLA-DPB1* genes were significantly associated with protective effects against CHB in Asian populations including Japanese, Korean, Chinese, and Thai individuals ($Pmeta = 1.26 \times 10^{-42}$ for rs3077 and $Pmeta = 1.10 \times 10^{-14}$ for rs9277535) (Fig. 3).[35–41] The SNP rs9277535 was located about 4 kb upstream from rs9277542 and showed strong linkage disequilibrium of r^2 0.955 in the HapMap JPT (Japanese in Tokyo, Japan) population. These results suggest that the associations between the *HLA-DP* locus and the protective effects against persistent HBV infection and with clearance of HBV are widely replicated in East Asian populations; however, there are few reports of GWASs in Caucasian or African populations. Further studies are necessary to clarify the pathogenesis of CHB and the mechanisms of HBV clearance, including functional analyses of the *HLA-DP* molecule.

The GWASs described above have successfully identified disease-associated genes or SNPs using different types of genome-wide SNP tying platforms. The embedded SNPs are varied among platforms by selecting the tagging SNPs and the suitable SNPs for their own genotyping strategy; however, the genome coverage among platforms revealed no differences over 60% between the HapMap CEU samples and the HapMap JPT+CHB samples.[42] Moreover, the genome coverage of the current version of the Affymetrix Genome-Wide Human SNP Array 6.0 platform has been estimated to reach 75% in the Japanese population.[14]

Conclusions

Together with technology developments, GWASs are a promising strategy with which to identify host genetic factors for multactorial diseases, including common liver diseases, and various host genetic traits. The GWAS strategy may allow researchers to identify unexpected significant associations. Recently, new strategies and emerging technologies for

massive parallel sequencing (also termed next-generation sequencing) have allowed whole-genome analysis to identify single-nucleotide variations and structural variations (including insertion, deletion, duplication, translocation, and transposition events). The costs of using these emerging technologies are currently high; therefore, common SNP-based GWASs using the genome-wide SNP analysis technologies introduced in this paper still have an important potential role in the fields of clinical and basic research.

Conflict of interest

None

Author contributions

Genotyping and statistical analyses for hepatitis studies (NN), acquisition of genotyping data on hepatitis researches (KT), manuscript writing (NN, KT), critical review (MM).

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Soluble MICA and a *MICA* Variation as Possible Prognostic Biomarkers for HBV-Induced Hepatocellular Carcinoma

Vinod Kumar[1,2]*, Paulisally Hau Yi Lo[1], Hiromi Sawai[3], Naoya Kato[4], Atsushi Takahashi[2], Zhenzhong Deng[1], Yuji Urabe[1], Hamdi Mbarek[1], Katsushi Tokunaga[3], Yasuhito Tanaka[5], Masaya Sugiyama[6], Masashi Mizokami[6], Ryosuke Muroyama[4], Ryosuke Tateishi[7], Masao Omata[7], Kazuhiko Koike[7], Chizu Tanikawa[1], Naoyuki Kamatani[2], Michiaki Kubo[2], Yusuke Nakamura[1], Koichi Matsuda[1]

1 Laboratory of Molecular Medicine, Human Genome Center, Institute of Medical Science, The University of Tokyo, Tokyo, Japan, **2** Center for Genomic Medicine, The Institute of Physical and Chemical Research (RIKEN), Kanagawa, Japan, **3** Department of Human Genetics, Graduate School of Medicine, The University of Tokyo, Tokyo, Japan, **4** Unit of Disease Control Genome Medicine, The Institute of Medical Science, The University of Tokyo, Tokyo, Japan, **5** Department of Clinical Molecular Informative Medicine, Nagoya City University Graduate School of Medical Sciences, Aichi, Japan, **6** The Research Center for Hepatitis and Immunology, National Center for Global Health and Medicine, Chiba, Japan, **7** Department of Gastroenterology, Graduate School of Medicine, The University of Tokyo, Tokyo, Japan

Abstract

MHC class I polypeptide-related chain A (MICA) molecule is induced in response to viral infection and various types of stress. We recently reported that a single nucleotide polymorphism (SNP) rs2596542 located in the *MICA* promoter region was significantly associated with the risk for hepatitis C virus (HCV)-induced hepatocellular carcinoma (HCC) and also with serum levels of soluble MICA (sMICA). In this study, we focused on the possible involvement of MICA in liver carcinogenesis related to hepatitis B virus (HBV) infection and examined correlation between the *MICA* polymorphism and the serum sMICA levels in HBV-induced HCC patients. The genetic association analysis revealed a nominal association with an SNP rs2596542; a G allele was considered to increase the risk of HBV-induced HCC ($P = 0.029$ with odds ratio of 1.19). We also found a significant elevation of sMICA in HBV-induced HCC cases. Moreover, a G allele of SNP rs2596542 was significantly associated with increased sMICA levels ($P = 0.009$). Interestingly, HCC patients with the high serum level of sMICA (>5 pg/ml) exhibited poorer prognosis than those with the low serum level of sMICA (≤5 pg/ml) ($P = 0.008$). Thus, our results highlight the importance of *MICA* genetic variations and the significance of sMICA as a predictive biomarker for HBV-induced HCC.

Citation: Kumar V, Yi Lo PH, Sawai H, Kato N, Takahashi A, et al. (2012) Soluble MICA and a *MICA* Variation as Possible Prognostic Biomarkers for HBV-Induced Hepatocellular Carcinoma. PLoS ONE 7(9): e44743. doi:10.1371/journal.pone.0044743

Editor: Erica Villa, University of Modena & Reggio Emilia, Italy

Received May 3, 2012; **Accepted** August 7, 2012; **Published** September 14, 2012

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Funding: This work was conducted as a part of the BioBank Japan Project that was supported by the Ministry of Education, Culture, Sports, Science and Technology of the Japanese government. The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

Competing Interests: The authors have declared that no competing interests exist.

* E-mail: koichima@ims.u-tokyo.ac.jp

Introduction

Hepatocellular carcinoma (HCC) reveals a very high mortality rate that is ranked the third among all cancers in the world [1]. HCC is known to develop in a multistep process which has been related to various risk factors such as genetic factors, environment toxins, alcohol and drug abuse, autoimmune disorders, elevated hepatic iron levels, obesity, and hepatotropic viral infections [2]. Among them, chronic infection with hepatitis B virus (HBV) is one of the major etiological factors for developing HCC with considerable regional variations ranging from 20% of HCC cases in Japan to 65% in China [3].

Interestingly, clinical outcome after the exposure to HBV considerably varies between individuals. The great majority of individuals infected with HBV spontaneously eliminate the viruses, but a subset of patients show the persistent chronic hepatitis B infection (CHB), and then progresses to liver cirrhosis and HCC through a complex interplay between multiple genetic and environmental factors [4]. In this regard, genome wide association studies (GWAS) using single nucleotide polymorphisms (SNPs) have highlighted the importance of genetic factors in the pathogenesis of various diseases including CHB as well as HBV-induced HCC [5,6,7,8,9,10,11,12,13]. Recently, we identified a genetic variant located at 4.7 kb upstream of the *MHC class I polypeptide-related chain A* (*MICA*) gene to be strongly associated with hepatitis C virus (HCV) -induced HCC development [14].

MICA is highly expressed on viral-infected cells or cancer cells, and acts as ligand for NKG2D to activate antitumor effects of Natural killer (NK) cells and $CD8^+$ T cells [15,16]. Our previous results indicated that a G allele of SNP rs2596542 was significantly associated with the lower cancer risk and the higher level of soluble MICA (sMICA) in the serum of HCV-induced HCC patients, demonstrating the possible role of MICA as a tumor suppressor. However, elevation of serum sMICA was shown to be associated with poor prognosis in various cancer patients [17,18,19,20].

Matrix metalloproteinases (MMPs) can cleave MICA at a transmembrane domain [21] and release sMICA proteins from cells. Since sMICA was shown to inhibit the antitumor effects of NK cells and $CD8^+$ T cells by reduction of their affinity to binding to target cells [22,23], the effect of MICA in cancer cells would be modulated by the expression of MMPs. To elucidate the role of MICA in HBV-induced hepatocellular carcinogenesis, we here report analysis of the *MICA* polymorphism and serum sMICA level in HBV-induced HCC cases.

Materials and Methods

Study participants

The demographic details of study participants are summarized in Table 1. A total of 181 HCC cases, 597 CHB patients, and 4,549 non-HBV controls were obtained from BioBank Japan that was initiated in 2003 with the funding from the Ministry of Education, Culture, Sports, Science and Technology, Japan [24]. In the Biobank Japan Project, DNA and serum of patients with 47 diseases were collected through collaborating network of 66 hospitals throughout Japan. List of participating hospitals is shown in the following website (http://biobankjp.org/plan/member_hospital.html). A total of 226 HCC cases, 102 CHB patients, and 174 healthy controls were additionally obtained from the University of Tokyo. The diagnosis of chronic hepatitis B was conducted on the basis of HBsAg-seropositivity and elevated serum aminotransferase levels for more than six months according to the guideline for diagnosis and treatment of chronic hepatitis (The Japan Society of Hepatology, http://www.jsh.or.jp/medical/gudelines/index.html). Control Japanese DNA samples (n = 934) were obtained from Osaka-Midosuji Rotary Club, Osaka, Japan. All HCC patients were histopathologically diagnosed. Overall survival was defined as the time from blood sampling for sMICA test to the date of death due to HCC. Patients who were alive on the date of last follow-up were censored on that date. All participants provided written informed consent. This research project was approved by the ethics committee of the University of Tokyo and the ethics committee of RIKEN. All clinical assessments and specimen collections were conducted according to Declaration of Helsinki principles.

SNP genotyping

Genotyping platforms used in this study were shown in Table 1. We genotyped 181 HCC cases and 5,483 non-HBV control samples using either Illumina Human Hap610-Quad or Human Hap550v3. The other samples were genotyped at SNP rs2596542 by the Invader assay system (Third Wave Technologies, Madison, WI).

MICA variable number tandem repeat (VNTR) locus genotyping

Genotyping of the *MICA* VNTR locus in 176 HBV-induced HCC samples was performed using the primers reported previously by the method recommended by Applied Biosystems (Foster City, CA) [14]. Briefly, the 5′ end of forward primer was labeled with 6-FAM, and reverse primer was modified with GTGTCTT non-random sequence at the 5′ end to promote Plus A addition. The PCR products were mixed with Hi-Di Formamide and GeneScan-600 LIZ size standard, and separated by GeneScan system on a 3730×l DNA analyzer (Applied Biosystems, Foster City, CA). GeneMapper software (Applied Biosystems, Foster City, CA) was employed to assign the repeat fragment size (Figure S1).

Quantification of soluble MICA

We obtained serum samples of 111 HBV-positive HCC samples, 129 HCV-positive HCC samples, and 60 non-HBV controls from Biobank Japan. Soluble MICA levels were measured by sandwich enzyme-linked immunosorbent assay, as described in the manufacturer's instructions (R&D Systems, Minneapolis, MN).

Statistical analysis

The association between an SNP rs2596542 and HBV-induced HCC was tested by Cochran-Armitage trend test. The Odds ratios were calculated by considering a major allele as a reference. Statistical comparisons between genotypes and sMICA levels were performed by Kruskal-Wallis test (if more than two classes for comparison) or Wilcoxon rank test using R. Overall survival rate of the patients was analyzed by Kaplan-Meier method in combination with log-rank test with SPSS 20 software. The period for the survival analysis was calculated from the date of blood sampling to the recorded date of death or the last follow-up date. Differences with a P value of <0.05 were considered statistically significant.

Results

Association of SNP rs2596542 with HBV-induced HCC

In order to examine the effect of rs2596542 genotypes on the susceptibility to HBV-induced HCC, a total of 407 HCC cases and 5,657 healthy controls were genotyped. The Cochran Armitage trend test of the data revealed a nominal association

Table 1. Demographic details of subjects analyzed.

Subjects	Source	Genotyping platform	Number of Sample	Female (%)	Age (mean+/−sd)
Liver Cancer	BioBank Japan	Illumina Human Hap610-Quad	181	17.9	62.94±9.42
	University of Tokyo	Invader assay	226		
Control	BioBank Japan	Illumina Human Hap550v3	4549	47.95	55.19±12.5
	Osaka**	Illumina Human Hap550v3	934		
	University of Tokyo	Invader assay	174		
Chronic hepatitis B*	BioBank Japan	Invader assay	597	45.66	61.31±12.6
	University of Tokyo	Invader assay	102		

*Chronic hepatitis B patients without liver cirrhosis and liver cancer during enrollment.
**Healthy volunteers from Osaka Midosuji Rotary Club, Osaka, Japan.
doi:10.1371/journal.pone.0044743.t001

between HBV-induced HCC and rs2596542 in which a risk allele G was more frequent among HBV-induced HCC cases than an A allele (P = 0.029, OR = 1.19, 95% CI: 1.02–1.4; Table 2). To further investigate the effect of rs2596542 on the progression from CHB to HBV-induced HCC, we genotyped a total of 699 CHB cases without HCC. Although the progression risk from CHB to HBV-induced HCC was not statistically significant with rs2596542 (P = 0.197 by the Cochran Armitage trend test with an allelic OR = 1.3 (0.94–1.36); Table 2), we found a similar trend of association in which the frequency of a risk-allele G was higher among HBV-induced HCC patients than that of CHB subjects. Since we previously revealed that an A allele was associated with a higher risk of HCV-induced HCC with OR of 1.36 [14], the s2596542 alleles that increased the risk of HCC were opposite in HBV-induced HCC and HCV-induced HCC.

Soluble MICA levels are associated with SNP rs2596542

We subsequently performed measurement of soluble MICA (sMICA) in serum samples using the ELISA method in 176 HBV-positive HCC cases and 60 non-HBV controls. Nearly 30% of the HBV-induced HCC cases revealed the serum sMICA level of >5 pg/ml (defined as high) while the all control individuals except one showed that of ≤5 pg/ml (defined as low) ($P = 4.5 \times 10^{-6}$; Figure 1A). Then, we examined correlation between SNP rs2596542 genotypes and serum sMICA levels in HBV-positive HCC cases. Interestingly, rs2596542 genotypes were significantly associated with serum sMICA levels (P = 0.009; Figure 1B); 39% of individuals with the GG genotype and 20% of those with the AG genotype were classified as high for serum sMICA, but only 11% of those with the AA genotype were classified as high (AA+AG vs GG; P = 0.003) (Figure 1B). These findings were similar with our previous reports in which a G allele was associated with higher serum sMICA levels in HCV-induced HCC patients [14].

Negative association of variable number of tandem repeat (VNTR) with sMICA level

The *MICA* gene harbors a VNTR locus in exon 5 that consists of 4, 5, 6, or 9 repeats of GCT as well as a G nucleotide insertion into a five-repeat allele (referred as A4, A5, A6, A9, and A5.1, respectively). The insertion of G (A5.1) causes a premature translation termination and results in loss of a transmembrane domain, which may produce the shorter form of the MICA protein that is likely be secreted into serum [25]. However, the association of this VNTR locus with serum sMICA level was controversial among studies [14,26,27,28]. Therefore, we examined the association between the VNTR locus and sMICA level in HBV-induced HCC patients, and found no significant association (Figure S1 and S2), concordant with our previous report for HCV-induced HCC patients [14].

Soluble MICA levels are associated with survival of HCC patients

In order to evaluate the prognostic significance of serum sMICA levels in HCC patients, we performed survival analysis of HCC patients. A total of 111 HBV-infected HCC patients and 129 HCV-infected HCC patients were included in this analysis. The mean survival period for HBV- and HCV-infected patients with less than 5 pg/ml of serum sMICA were 67.1 months (95% CI: 61.1–73.1, n = 83), and 58.2 months (95% CI: 51.4–65.0, n = 85), respectively. On the other hand, for patients with more than 5 pg/ml of serum sMICA, the mean survival periods were 47.8 months (95% CI: 34.8–30.9, n = 28) for HBV-induced HCC patients and 59.5 months (95% CI: 51.9–67.1, n = 44) for HCV-induced HCC patients. The Kaplan-Maier analysis and log-rank test indicated that among HBV-induced HCC subjects, the patients in the high serum sMICA group showed a significantly shorter survival than those in the low serum sMICA (P = 0.008; Figure 2). In addition, we performed multi-variate analysis to test whether sMICA is an independent prognostic factor by including age and gender as covariates. The results revealed significant association of sMICA levels with overall survival (P = 0.017) but not with age and gender (Table S1).However, we found no association between the serum sMICA level and the overall survival in the HCV-induced HCC subjects (P = 0.414; Figure S3). Taken together, our findings imply the distinct roles of the *MICA* variation and sMICA between HBV- and HCV-induced hepatocellular carcinogenesis.

Vascular invasion in HBV-related HCC patients is associated with soluble MICA levels

Since sMICA levels were associated with the overall survival of HBV-related HCC patients, we tested whether sMICA levels affect survival through modulating invasive properties of tumors or size of the tumors. We tested the association between sMICA levels and vascular invasion in 35 HBV-related HCC cases, among whom 7 cases were positive and 21 cases were negative for vascular invasion. We found significant association between sMICA levels and vascular invasion (Figure 3; P = 0.014) in which 7 cases with positive vascular invasion showed high levels of sMICA (mean = 54 pg/ml) than 21 cases without vascular invasion (mean = 7.51 pg/ml). However, we found no association between tumor size and sMICA levels (P = 0.56; data not shown). These results suggest that sMICA may reduce the survival of HBV-related HCC patients by affecting the invasive properties of tumors.

Discussion

Several mechanisms such as HBV-genome integration into host chromosomal DNA [29] and effects of viral proteins including HBx [30] are shown to contribute to development and progression of HCC, while the immune cells such as NK and T cells function as key antiviral and antitumor effectors. MICA protein has been

Table 2. Association between HCC and rs2596542.

SNP	Comparison	Chr	Locus	Case MAF	Control MAF	P*	OR*	95% CI
rs2596542	HCC vs. Healthy control	6	*MICA*	0.294	0.332	0.029	1.19	1.02–1.4
rs2596542	HCC vs. CHB	6	*MICA*	0.294	0.320	0.197	1.13	0.94–1.36

Note: 407 HCC cases, 699 CHB subjects and 5,657 non-HBV controls were used in the analysis.
Chr.,chromosome; MAF, minor allele frequency; OR, odds ratio for minor allele; CI, confidence interval.
*Obtained by Armitage trend test.
doi:10.1371/journal.pone.0044743.t002