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LIVER

Open

CT With Hepatic Arterioportography as a Pretreatment Examination for Hepatocellular Carcinoma Patients: A Randomized Controlled Trial

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OBJECTIVES: **The combination of computed tomography with hepatic arteriography and arterial portography (CTHA/CTAP) can detect additional hepatocellular carcinoma (HCC) nodules undetected by conventional dynamic CT.**

METHODS: **In this single-center, randomized, open-label, controlled trial, we randomly assigned 280 patients who were diagnosed as having HCC by conventional dynamic CT, and eligible for radiofrequency ablation (RFA), to undergo CTHA/CTAP before treatment, or to the control group. Newly detected HCC nodules by CTHA/CTAP were intended to be ablated completely. The primary end point was recurrence-free survival and the key secondary end point was overall survival. The analysis was conducted on an intention-to-treat basis. Those with nonablated nodules were treated as for recurrence.**

RESULTS: **A total of 75 nodules were newly diagnosed as HCC by CTHA/CTAP in 45 patients. Three patients (one in the CTHA/CTAP group and two in the control group) who refused treatment were excluded from all analyses. The cumulative recurrence-free survival rates at 1, 2, and 3 years were 60.1, 29.0, and 18.9% in the CTHA/CTAP group and 52.2, 29.7, and 23.1% in the control group, respectively (*P*=0.66 by log-rank test; hazard ratio, 0.94 for CTHA/CTAP vs. control; 95% confidence interval (CI), 0.73–1.22). The cumulative overall survival rates at 3 and 5 years were 79.7 and 56.4% in the CTHA/CTAP group and 86.8 and 60.1% in the control group, respectively (*P*=0.50; hazard ratio, 1.15, 95% CI, 0.77–1.71).**

CONCLUSIONS: **CTHA/CTAP may detect recurrent lesions earlier. However, CTHA/CTAP before RFA did not improve cumulative recurrence-free survival or overall survival.**

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INTRODUCTION

Hepatocellular carcinoma (HCC) ranks as the fifth most common cancer worldwide (1). In Japan, ~35,000 patients die from HCC every year (2), and the main cause of HCC is hepatitis C virus infection. In chronic hepatitis patients, screening of HCC is usually performed by ultrasonography, and the diagnosis is confirmed by contrast-enhanced dynamic computed tomography (CT). Hyperattenuation in the arterial phase and hypoattenuation in the equilibrium phase are considered to be definitive signs of HCC (3–7). Hyperattenuation in the arterial phase is more emphasized when contrast material is injected from the hepatic artery through a catheter, because dilution of contrast material in the systemic circulation is avoided, thus keeping a high concentration of contrast material in the liver. This technique is called CT during hepatic arteriography (CTHA) (6,8–10). Similarly, hypoattenuation in the equilibrium phase is accentuated after injection of contrast material into the superior mesenteric artery, which is referred to as CT during arterial portography (CTAP) (11–14). The combination of CTHA and CTAP gives higher sensitivity and specificity for HCC detection than conventional dynamic enhanced CT (8).

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If new HCC nodules are detected with CTHA/CTAP, in addition to those detected with dynamic CT, the treatment of choice may be changed (15,16). For example, surgical resection and liver transplantation are usually contraindicated for multinodular HCC; that is, exceeding three nodules. Percutaneous tumor ablation methods, such as ethanol injection and microwave coagulation, have played an important role as nonsurgical treatments that can achieve high local cure rates without affecting background liver function (17–20). Radiofrequency ablation (RFA) is currently considered to be the most effective first-line percutaneous ablation protocol because of its greater efficacy in terms of local cure as compared with ethanol injection (21–24). However, even after complete ablation, patients frequently encounter intrahepatic tumor recurrence at a rate of 50% in 2 years, the majority of which occurs at locations distant from the primary ablated site (25). Considering the tumor doubling time, many nodules diagnosed as recurrent within 2 years were probably present at the time of first ablation. If nodules that are undetectable by conventional dynamic CT could be detected and ablated, the recurrence rate would be decreased.

Although CTHA/CTAP is one of the most sensitive techniques available for detection of small HCC, its disadvantages include invasiveness, high cost, and a high false-positive rate (26). The indication for CTHA/CTAP can be justified only when the expected benefits exceed the risk and cost of the procedure. We conducted a single-center, randomized, open-label, controlled trial to assess the utility of CTHA/CTAP before RFA in patients with early-stage HCC by comparing recurrence-free and overall survival.

METHODS

Patients

The study population consisted of patients with early-stage HCC with an indication for RFA. Those who met the following criteria were enrolled between September 2004 and February 2009: (i) diagnosis of typical HCC on dynamic CT performed within 2 weeks, i.e., hyperattenuation during the arterial phase and hypoattenuation during the equilibrium phase (5,6); (ii) tumor size ≤3.0 cm and no more than three tumor nodules; (iii) Child–Pugh class A liver function; and (iv) age >20 years. Exclusion criteria were: allergy to contrast media; portal or hepatic vein tumor thrombosis; extrahepatic metastasis; diffuse and infiltrative tumors; renal failure (serum creatinine >2.0 mg/dl, or serum urea nitrogen >30 mg/dl); impaired coagulation (e.g., platelet count $<50\times10^3/\mu l$, or prothrombin activity <50%); pregnancy; or past history of choledochojejunostomy. We included those with previous treatments as well as treatment-naive cases provided that there was no local recurrence at enrollment. These inclusion criteria and the study design did not change till the study completely ended. The study design conformed to the Declaration of Helsinki Principles and was approved by the ethics committee of our institution. The study was registered at the University Hospital Medical Information Network (UMIN) Clinical Trial Registry (UMIN-CTR000000070). Written informed consent was obtained from each patient. This study complied with the CONSORT guidelines for reporting of clinical trials (27).

Study design

Before receiving RFA, patients were randomly assigned to undergo CTHA/CTAP or not in equal numbers. Patient registration and randomization were performed by computer-generated allocation at a web-based data center (Internet Data and Information Center for Medical Research) administered by UMIN. At the time of randomization, patients were stratified either as treatment naive, for whom RFA was planned as an initial treatment for HCC, or recurrent, for whom RFA was planned for recurrent HCC. The randomization was based on the Efron's biased-coin design (28). In principal, the assignment was not blinded to the investigators and the participants. The interval between random assignment and implementation of treatment for HCC was <4 weeks. CTHA/CTAP was performed on the assigned patients on the second day of admission, and RFA was performed 2 or 3 days later, given that the total number of HCC nodules remained <4. When ≥4 HCC nodules were detected on CTHA/CTAP, patients first received transarterial chemoembolization (TACE) immediately after CTHA/CTAP, followed later by RFA to achieve complete ablation of the tumor nodules.

Radiographic procedures

For the diagnosis of HCC at study entry, intravenous contrast-enhanced dynamic CT was performed on an outpatient basis using an X-ray CT device with 4, 8, or 16 detector rows (Aquilion 4/16; Toshiba, Tokyo, Japan; LightSpeed Qx/I, LightSpeed Ultra; GE Healthcare, Milwaukee, WI). Images were obtained during the early arterial, late arterial, and equilibrium phases at 28, 40, and 120 s after starting the intravenous bolus injection of iopamidol (Iopamiron; Nihon Schering, Osaka, Japan) or iohexol (Omnipaque; Daiichi Sankyo, Tokyo, Japan) at a rate of 2.3–3.3 ml/s with a power injector. The total dose of iodine was 0.7 g/kg body weight, with an upper limit of 37 g iodine. The injection time for the contrast material was 30 s. Images were reconstructed with a section thickness of 2.5 mm and a reconstruction interval of 1.5 mm, and were reviewed by experienced radiologists.

CTHA/CTAP was performed on an inpatient basis. First, a 4-Fr modified Shepherd-hook catheter and a 4-Fr hepatic-curve catheter were placed in the celiac artery and superior mesenteric artery, respectively, through bilateral femoral arteries, according to Seldinger's method. Digital subtraction angiography was performed from the celiac artery to evaluate hepatic artery anatomy. A microcatheter was inserted through the 4-Fr catheter and placed in the proper or common hepatic artery for hepatic arteriography.

The CTAP catheter was placed in the superior mesenteric artery in all cases. In the case of a replaced or accessory right hepatic artery, the catheter was inserted well beyond the origin of the hepatic artery to prevent contrast medium overflow into the hepatic artery. Less than 30 ml of contrast agent, which was diluted to 100 mg I/ml, was used before the CTHA/CTAP study. First, CTAP was performed using 90 ml nonionic contrast medium diluted to 100 mg I/ml, and then CT scanning was performed 30 s after the start of the injection at a rate of 3.0 ml/s. Multidetector-row CT images were obtained during a single breath hold in a longitudinal direction with collimation of 1 mm, table speed of 30 mm/s, 120 kVp, and

300 mAs. CTHA was performed at least 5 min after CTAP, using the same parameters. CT scanning was performed at 10 and 45 s after the start of contrast medium injection into the microcatheter at a rate of 2.0–2.5 ml/s. A total of 30–50 ml contrast agent diluted to 100 mg I/ml was used. When the liver was perfused by two or more hepatic arteries such as a replaced right hepatic artery, accessory right hepatic artery, or left hepatic artery downstream of the left gastric artery, CTHA was performed from each of the respective arteries. A diagnosis of typical HCC on CTHA/CTAP was defined as a round hypervascular nodule on CTHA with a defect on CTAP, accompanied by corona enhancement during the second phase of CTHA or hypoattenuation during the equilibrium phase of prior dynamic CT (10,29).

TACE was additionally performed when ≥4 HCC nodules were detected on CTHA/CTAP, as evaluated at the time by the operating radiologist. The procedure used 3.0 ml contrast medium, 30 mg doxorubicin (Adriacin; Kyowahakko Kirin, Tokyo, Japan), and 3.0 ml iodized oil (Lipiodol Ultra-Fluid; Guerbet Japan, Tokyo, Japan). The amounts of contrast medium and iodized oil in this suspension were arbitrarily adjusted according to tumor size. This agent was injected into each feeder of the HCC, followed by infusion of 2-mm-diameter gelatin sponge particles (Gelpart; Nihonkayaku, Tokyo, Japan).

CTHA/CTAP images were scrutinized by two experienced radiologists, who made the final diagnosis. The radiologists were not blinded to information regarding the preceding conventional dynamic CT. Preceding intravenous contrast-enhanced dynamic CT was retrospectively reviewed for nodules newly diagnosed by CTHA/CTAP to determine whether the nodules could have been detected on dynamic CT.

Radiofrequency ablation

RFA was performed on an inpatient basis. The precise procedure of RFA is described elsewhere (30). All RFA procedures were performed percutaneously under ultrasonographic guidance. We used a 17-gauge cooled-tip electrode (Cool-Tip; RF Ablation System, Covidien, Boulder, Colombia, CO) for RFA. Radiofrequency energy was delivered for 6–12 min for each application. For large tumors, the electrode was repeatedly inserted into different sites, such that the entire tumor could be enveloped by assumed necrotic volumes. A CT scan with a 5-mm section thickness was performed 1–3 days after RFA to evaluate technical effectiveness. Complete ablation was defined as hypoattenuation of the entire tumor. We intended to ablate not only the tumor but also some of the liver parenchyma surrounding it. When we suspected that some portion of tumor remained nonablated, RFA was repeated. We did not predefine the procedure number in a treatment: treatment was generally continued until CT imaging demonstrated necrosis of the entire tumor.

Follow-up

The follow-up regimen after RFA consisted of blood tests and monitoring of tumor markers in an outpatient setting. Ultrasonography and dynamic CT were performed every 4 months. Tumor recurrence was defined as a newly developed lesion on a dynamic CT that showed hyperattenuation in the arterial phase with washout in the late phase. Recurrent site was categorized as intrahepatic recurrence distant from ablated nodules, local tumor progression defined as the appearance of viable cancer tissue touching the ablated nodules, and extrahepatic metastasis (31). The follow-up was censored in February 2011 when 2 years had passed after the enrollment of patient 280. No interim analysis was specified in the protocol.

End points

The primary end point was recurrence-free survival, where both recurrence and death were treated as an event. We intended to ablate all detected nodules in both groups. When additional nodules were detected by CTHA/CTAP, the newly detected nodules were also ablated. When > 3 nodules were diagnosed as HCC by CTHA/CTAP, we performed TACE and subsequently intended to ablate all of the nodules. When nonablated viable tumors were detected by CT for treatment evaluation, those cases were treated as an event 120 days after randomization. Even when newly detected nodules showed dense Lipiodol deposits after TACE, the nodules were considered as viable if the nodules were nonablated.

Secondary end points were the number of additional nodules detected by CTHA/CTAP, the proportion of patients with complete ablation, overall survival, and safety of CTHA/CTAP and RFA. Complications were defined according to the guidelines of the Society of Interventional Radiology (32). According to the guidelines, major complications were defined as those that required therapy or prolonged hospitalization, or left permanent adverse sequelae, or death.

Statistical analysis

This study was designed to detect a 15% increase in 2-year recurrence-free survival in the CTHA/CTAP group from an anticipated 35% in the control group. To detect this difference with a power of 80% and type I error of 5% (two-sided test), we needed 280 patients (140 for each arm). Differences between groups for each characteristic were tested for significance with Fisher's exact test for categorical variables and *t*-test for continuous variables. All data necessary for analysis was corrected in the main computer server system of University of Tokyo, Department of Gastroenterology.

Recurrence-free survival and overall survival were calculated using the Kaplan–Meier method and were compared by the log-rank test. Cox proportional hazard regression was used to calculate hazard ratios with 95% confidence interval (CI) between the groups in univariate and multivariate settings. The primary end point was evaluated in subgroups according to the following characteristics: age, sex, body mass index, treatment naivety, hepatitis B surface antigen (HBsAg) positivity, hepatitis C virus antibody positivity, tumor size, tumor number, platelet count, tumor marker positivity for α-fetoprotein (AFP), lens culinaris agglutinin-reactive fraction of AFP, and des-γ-carboxy prothrombin. An adjusted hazard ratio comparing the groups was calculated using multivariate Cox regression with factors that showed significance

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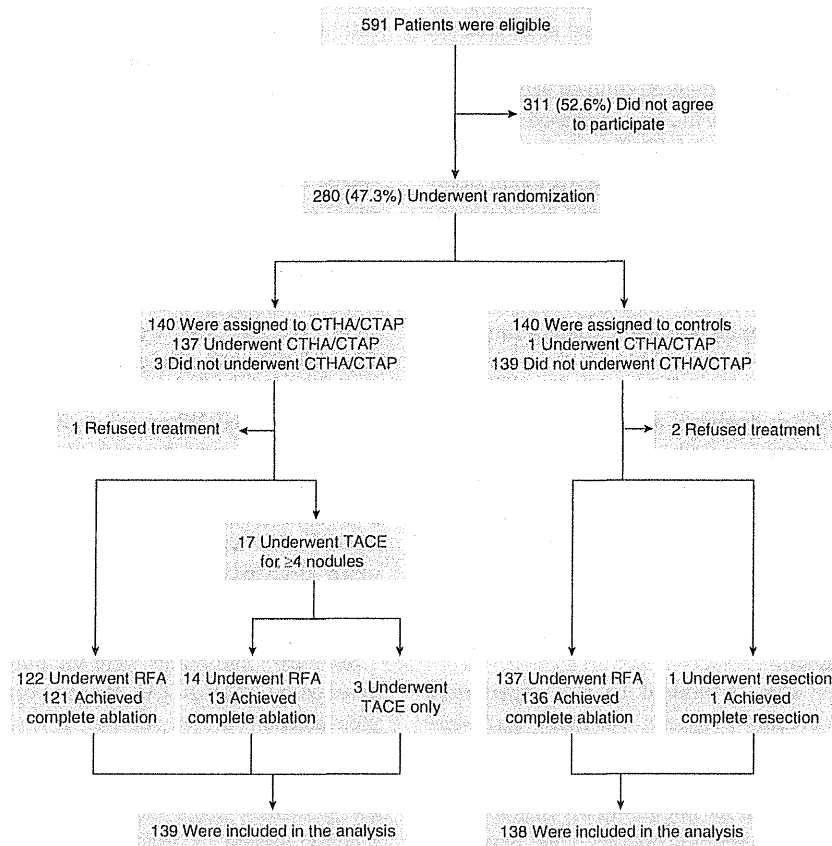

Figure 1. Patient enrollment and outcomes. CTAP, computed tomography during arterial portography; CTHA, computed tomography during hepatic arteriography; RFA, radiofrequency ablation; TACE, transarterial chemoembolization.

in univariate analysis. Data at entry were used for the analyses. A *post hoc* analysis comparing the recurrence-free survival of those with and without newly diagnosed HCC in the CTHA/CTAP group was performed.

All analyses were performed on an intention-to-treat basis. Differences with a two-sided P value of <0.05 were considered statistically significant. Data processing and analysis were performed with S-PLUS ver. 7 (TIBCO Software, Palo Alto, CA). Finally, all authors had access to the study data and had reviewed and approved the final manuscript.

RESULTS

Patient enrollment

According to the study protocol, the registration started from September 2004 for 5 years and the follow-up was censored in February 2011 when 2 years had passed after the enrollment of patient 280. During the study period, 280 of 591 (47.4%) eligible patients agreed to participate in the trial, and 140 of these were randomly assigned to undergo CTHA/CTAP before RFA. Three patients declined to undergo CTHA/CTAP after assignment. A total of 140 patients were randomly assigned to the control group. One patient assigned to the control group received CTHA/CTAP because of strong preference (**Figure 1**).

Treatment

In 45 (32.4%) patients, 75 nodules with a median diameter of 8 mm (range, 2–20) were additionally diagnosed by experienced radiologists as definite HCC on CTHA/CTAP. The detailed characteristics of newly diagnosed nodules have been reported previously (33). In 17 patients, the number of HCC nodules exceeded 3 after CTHA/CTAP, and TACE was performed subsequently. We intended to ablate all nodules by RFA including additionally detected nodules. In 122 patients, there were ≤3 HCC nodules, and complete ablation was obtained in 121 patients (99.2%). Among 17 patients treated with TACE, 14 (82.4%) subsequently underwent RFA and complete ablation was obtained in 13 (92.9%) patients. The remaining 3 patients (17.6%) did not undergo RFA because of tumor nodule multiplicity in 2 patients and simultaneously diagnosed malignant B-cell lymphoma in the third patient. Among 140 patients who were assigned to the control group, 137 (97.9%) were treated with RFA, and complete ablation was obtained in 136 (99.3%) patients. One patient withdrew consent and underwent hepatic resection. Two patients refused to receive

Table 1. **Baseline characteristics of the patients**[a]

Characteristics	CTHA/CTAP (*N*=139)	Control (*N*=138)	*P* value
Age, years	70 (63–74)	70 (64–75)	0.43
Male, *n* (%)	93 (67)	86 (62)	0.42
Alcohol >80g/day, *n* (%)	23 (17)	20 (15)	0.82
BMI (kg/m^2)	23.1 (21.4–25.1)	23.4 (21.2–25.3)	0.48
Viral markers			
HCVAb positive, *n* (%)	104 (75)	99 (72)	0.59
HBsAg positive, *n* (%)	21 (15)	20 (14)	1
Serum albumin (g/dl)	3.8 (3.6–4.1)	3.9 (3.6–4.1)	0.20
Total bilirubin (mg/dl)	0.8 (0.6–1.0)	0.8 (0.6–1.0)	0.31
AST (IU/l)	56 (34–69)	57 (33–70)	0.84
ALT (IU/l)	54 (29–63)	57 (27–73)	0.61
Platelet count (×10^3/μl)	128 (89–163)	130 (91–159)	0.88
Prothrombin activity (%)	80 (72–90)	81 (74–87)	0.39
Treatment-naive case, *n* (%)	77 (55)	74 (54)	0.81
Previously treated case, n *(%)*	62 (45)	64 (46)	
Resection, *n* (%)[b]	15 (24)	16 (25)	0.27
RFA, *n* (%)[b]	46 (74)	45 (70)	
Ethanol injection, *n* (%)[b]	10 (16)	3 (4.6)	
TACE, *n* (%)[b]	11 (18)	7 (11)	
Tumor size (cm)	1.6 (1.2–2.0)	1.7 (1.2–2.0)	0.91
Single nodule, *n* (%)	101 (73)	98 (71)	0.76
AFP >100ng/ml, *n* (%)	23 (17)	24 (17)	0.85
DCP >100mAU/ml, *n* (%)	16 (12)	22 (16)	0.28
AFP-L3 >15%, *n* (%)	16 (12)	15 (11)	0.86

AFP, α-fetoprotein; AFP-L3, lens culinaris agglutinin-reactive fraction of AFP; ALT, alanine aminotransferase; AST, aspartate aminotransferase; BMI, body mass index; CTHA/CTAP, computed tomography during hepatic arteriography and arterial portography; DCP, des-γ-carboxy prothrombin; HBsAg, hepatitis B surface antigen; HCVAb, hepatitis C virus antibody; RFA, radiofrequency ablation, TACE, transarterial chemoembolization.

[a]Data are expressed as median (25th–75th percentiles) or number (percent).

[b]Including overlap.

any treatment and were lost to follow-up. Finally, 139 (99.3%) patients in the CTHA/CTAP group and 138 (98.6%) patients in the control group were included in the analysis.

Patient characteristics

There was no statistically significant difference in patient characteristics between the groups (**Table 1**). Median age at enrollment was 70 years, and approximately two-thirds of patients were male. Approximately 55% of patients were treatment-naive cases and the remaining patients had a history of previous treatment. Among those previously treated patients, the median interval between the initial treatment and the study enrollment was 42 (interquartile range, 22–65) months in the CTHA/CTAP group and 30 (20–61) months in the control group. There was no statistically significant difference between the two groups ($P=0.72$). The total number of HCC nodules detected in original contrast-enhanced dynamic CT was 197 (101 patients were uninodular and the rest were multinodular) in the CTHA/CTAP group and 196 (98 patients were uninodular and the rest were multinodular) in the control group.

Recurrence

By the end of the follow-up, tumor recurrence was identified in 109 patients (78.4%) in the CTHA/CTAP group and 112 patients (81.2%) in the control group. The distribution of recurrent site was intrahepatic distant recurrence ($N=98$), local tumor progression ($N=7$), both ($N=1$), and extrahepatic metastasis ($N=3$) in the CTHA/CTAP group and intrahepatic distant recurrence ($N=103$), local tumor progression ($N=4$), both ($N=2$), and extrahepatic metastasis ($N=3$) in the control group. Five patients (3.6%) in the CTHA/CTAP group and 1 patient (0.7%) in the control group in whom complete ablation could not be obtained by RFA were treated as recurrence on 120 days after randomization when the first follow-up CT would have been scheduled. In each group, four patients died without recurrence. The cumulative recurrence-free survival rates at 1, 2, and 3 years were 60.1, 29.0, and 18.9% in the CTHA/CTAP group and 52.2, 29.7, and 23.1% in the control group, respectively (**Figure 2a**). The difference between the two groups was not statistically significant ($P=0.66$ by log-rank test; hazard ratio, 0.94 for CTHA/CTAP vs. control; 95% CI, 0.73–1.22). The CTHA/CTAP group showed better recurrence-free survival with marginal statistical significance in the subgroups with higher AFP or AFP-L3 values (**Figure 3**).

Univariate Cox regression analysis identified older age ($P=0.01$), hepatitis C virus antibody positivity ($P=0.001$), lower albumin level ($P=0.04$), recurrent cases ($P<0.001$), multinodular HCC ($P<0.001$), and higher AFP level ($P=0.02$) as significant predictors for recurrence-free survival (**Table 2**). Adjusted hazard ratio of the CTHA/CTAP group vs. the control group by multivariate Cox regression analysis was 0.86 (95% CI, 0.67–1.12; $P=0.27$, **Table 3**).

Overall survival

By the end of the follow-up, 51 patients (36.7%) in the CTHA/CTAP group and 45 patients (32.6%) in the control group died. The cumulative overall survival rates at 3 and 5 years were 79.7 and 56.4% in the CTHA/CTAP group and 86.8 and 60.1% in the control group, respectively (**Figure 2b**). There was no statistically significant difference between the groups ($P=0.50$ by log-rank test; hazard ratio, 1.15, 95% CI, 0.77–1.71).

Safety

No procedural complications attributable to CTHA/CTAP or TACE were observed. Major complications related to RFA were observed in 2 patients (1.4%) in the CTHA/CTAP group (2 with neoplastic seeding) and in 3 patients (2.2%) in the control group (1 each with hepatic infarction, hemothorax, and neoplastic seeding). There was no procedure-related death.

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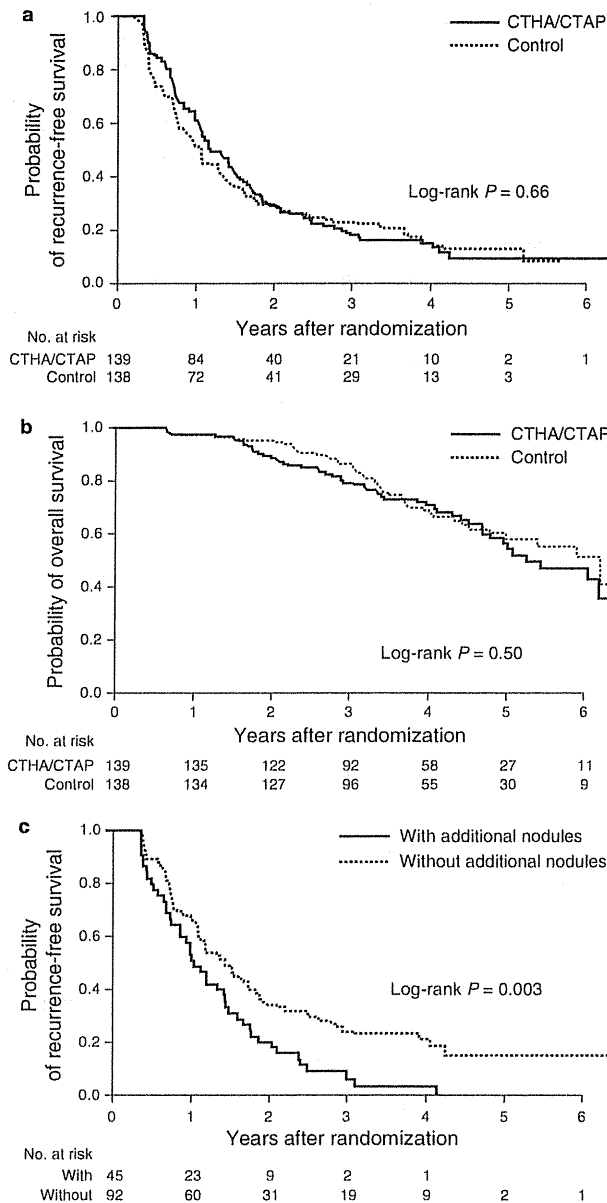

Figure 2. Kaplan–Meier estimate of the recurrence-free survival and overall survival. (**a**) The cumulative recurrence-free survival rates at 1, 2, and 3 years were 60.1, 29.0, and 18.9% in the CTHA/CTAP group and 52.2, 29.7, and 23.1% in the control group, respectively. (**b**) The cumulative overall survival rates at 3 and 5 years were 79.7 and 56.4% in CTHA/CTAP group and 86.8 and 60.1% in the control group, respectively. (**c**) Patients with an additional nodule detected by CTHA/CTAP showed significantly poorer recurrence-free survival than those without an additional nodule. CTAP, computed tomography during arterial portography; CTHA, computed tomography during hepatic arteriography.

Recurrence-free survival between those with and without additional nodules in CTHA/CTAP group

As a *post hoc* analysis, we compared the recurrence-free survival between those with (N=45) and without (N=92) additional HCC nodules diagnosed by CTHA/CTAP. As compared with those in whom additional HCC nodules were not detected by CTHA/CTAP, those with additional nodules included more HBsAg-negative patients (97.7 vs. 78.3%, P=0.002), previously treated patients (62.2 vs. 23.9%, P=0.006), and patients with multiple HCC nodules on dynamic CT (44.4 vs. 17.4%, P=0.002). Patients with additional nodule by CTHA/CTAP showed significantly poorer

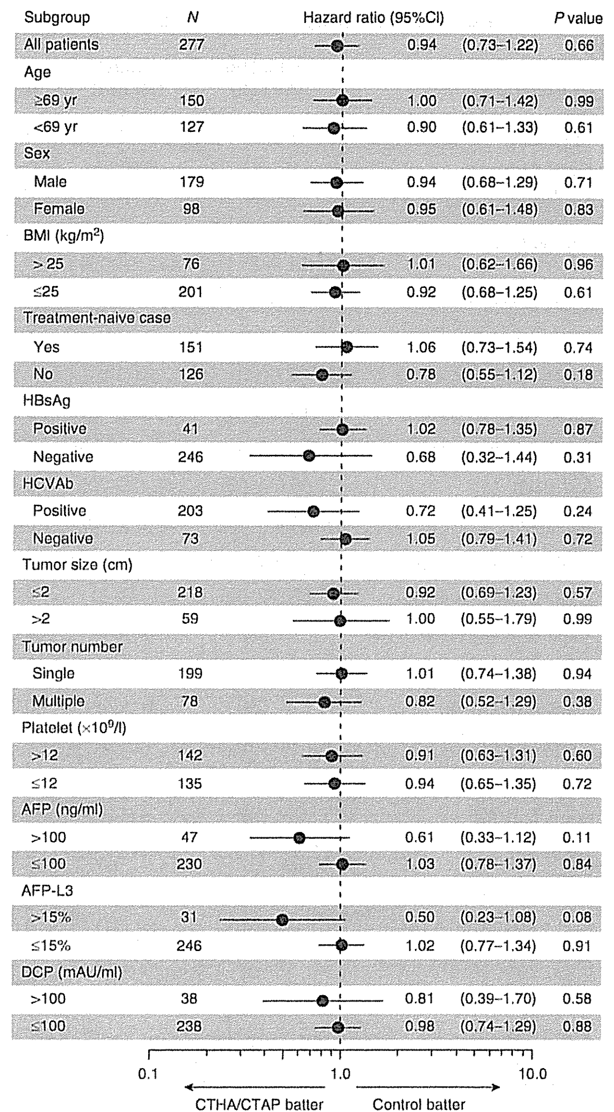

Figure 3. Recurrence-free survival of subgroups by Cox proportional hazard regression according to clinical characteristics at study entry. AFP, α-fetoprotein; BMI, body mass index; CI, confidence interval; CT, computed tomography; CTAP, computed tomography during arterial portography; CTHA, computed tomography during hepatic arteriography; DCP, des-γ-carboxy prothrombin; HBsAg, hepatitis B surface antigen; HCVAb, hepatitis C virus antibody; yr, year.

Table 2. **Univariate Cox's proportional hazard regression analysis of the risk for recurrence-free survival**

Variable	Hazard ratio (95% CI)	*P* value
CTHA/CTAP vs. control	0.94 (0.73–1.22)	0.66
Age (per year)	1.02 (1.00–1.04)	0.01
Female vs. male	1.02 (0.78–1.34)	0.88
Alcohol >80g/day	1.02 (0.88–1.17)	0.81
HCVAb positive	1.69 (1.23–2.31)	0.001
BMI (per 1.0kg/m^2)	1.02 (0.98–1.06)	0.35
Albumin (per 1.0g/dl)	0.72 (0.52–0.98)	0.04
Total bilirubin (per 1.0mg/dl)	1.02 (0.97–1.07)	0.51
AST >40IU/l	1.14 (0.99–1.31)	0.07
ALT >40IU/l	1.05 (0.92–1.20)	0.45
Platelet count >10×10^3/μl	0.89 (0.78–1.01)	0.08
Recurrent case	2.33 (1.79–3.02)	<0.001
Tumor size of maximal nodule >2.0cm	0.97 (0.85–1.10)	0.62
Multinodular	1.38 (1.20–1.59)	<0.001
AFP >100ng/ml	1.21 (1.03–1.43)	0.02
DCP >100mAU/ml	0.99 (0.82–1.20)	0.93
AFP-L3 >15%	1.20 (0.99–1.46)	0.07

AFP, α-fetoprotein; AFP-L3, lens culinaris agglutinin-reactive fraction of AFP; ALT, alanine aminotransferase; AST, aspartate aminotransferase; BMI, body mass index; CI, confidence interval; CTHA/CTAP, computed tomography during hepatic arteriography and arterial portography; DCP, des-γ-carboxy prothrombin; HCVAb, hepatitis C virus antibody.

Table 3. **Multivariate Cox's proportional hazard regression analysis of the risk for recurrence-free survival**

Variable	Hazard ratio (95% CI)	*P* value
CTHA/CTAP vs. control	0.86 (0.0.67–1.12)	0.27
Age (per year)	1.01 (0.99–1.02)	0.36
HCVAb positive	1.36 (0.98–1.89)	0.07
Albumin (per 1.0g/dl)	0.75 (0.53–1.07)	0.11
Recurrent case	2.21 (1.69–2.89)	<0.001
Multinodular	1.69 (1.27–2.25)	<0.001
AFP >100ng/ml	1.41 (0.996–1.98)	0.052

AFP, α-fetoprotein; CI, confidence interval; CTHA/CTAP, computed tomography during hepatic arteriography and arterial portography; HCVAb, hepatitis C virus antibody.

recurrence-free survival than those without additional nodules ($P=0.003$, **Figure 2c**).

DISCUSSION

An advance in diagnostic technology generally indicates improved sensitivity or specificity, which corresponds to the detection of smaller lesions with a clearer view in imaging modalities. In our previous study, we showed that 75 nodules with a mean diameter of 8.7mm (range, 2–20mm) in 45 (33%) of 139 patients who underwent CTHA/CTAP were additionally diagnosed as definite HCC, compared with dynamic CT examination (33). However, no significant difference was observed in terms of recurrence-free survival between those who did and did not undergo CTHA/CTAP before RFA.

One reason for this discrepancy may be that the impact of CTHA/CTAP on recurrence reduction was diluted by a long-term follow-up of >2 years. It is unlikely that CTHA/CTAP could detect small nodules that would be detected ≥2 years later by conventional dynamic CT. In fact, the number of recurrences identified within 1 year after enrollment was lower in the CTHA/CTAP group than the control group (54 vs. 65, data not shown).

Another reason could be that fewer patients achieved complete ablation of target nodules in the CTHA/CTAP group than in the control group. The additionally diagnosed HCC nodules were small, and detection of these nodules by ultrasonography was difficult. Recent technologies such as contrast ultrasonography or fusion imaging, which can improve the accuracy of ablation techniques (34–36), may increase the probability of detection of smaller nodules before RFA.

Precise evaluation of the stage of progression is important for deciding on treatment procedures in HCC management. Seventeen patients in the CTHA/CTAP group were diagnosed with ≥4 nodules by CTHA/CTAP, which is not considered suitable for RFA according to widely used criteria.

In our previous study, we showed that recurrence as opposed to initial occurrence, multinodularity on dynamic CT, and HBsAg negativity were significant predictors for finding additional HCC by CTHA/CTAP (33). In fact, the CTHA/CTAP group showed better outcomes in the subgroups with HBsAg-negative cases, previously treated patients, and multinodular HCC. However, *post hoc* analysis comparing recurrence-free survival of those with and without additional nodules detected by CTHA/CTAP showed that those with a higher probability of additional nodules were also at a higher risk of recurrence. The advantage of CTHA/CTAP in finding more HCC nodules might be counter balanced by the higher risk of recurrence.

This study has several limitations. First, the additional nodules detected by CTHA/CTAP were not confirmed histologically. Therefore, we cannot exclude the possibility of overdiagnosis. Second, 45% of the patients had a history of previous treatment including resection, RFA, and TACE. Those previous treatments might substantially alter the hemodynamic status in the liver and affect the accuracy of CTHA/CTAP. On the other hand, in the previously treated cases, the radiologists could refer to the past series of dynamic CT during performing CTHA/CTAP, which might improve the accuracy of CTHA/CTAP as compared with treatment-naive cases. Third, 17 patients in the CTHA/CTAP group underwent TACE as a salvage treatment because total number of HCC nodules exceeded 3 after CTHA/CTAP. This might affect the recurrence-free and overall survival in the CTHA/CTAP group.

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Our results may be extrapolated to other imaging modalities including gadoxetic acid-enhanced magnetic resonance imaging and second-generation contrast ultrasonography (37,38). These newly developed modalities also make possible the detection of small nodules that are invisible by dynamic CT. However, better diagnosis does not necessarily lead to better primary outcome.

In conclusion, CTHA/CTAP before RFA resulted in improved HCC diagnosis and detection of additional nodules in one-third of the study participants. However, it did not improve recurrence-free survival. The indications for CTHA/CTAP should be evaluated carefully.

Study protocol URL: https://upload.umin.ac.jp/cgi-open-bin/ctr/ctr.cgi?function=brows&action=brows&recptno=R000000117&type=summary&language=E.

CONFLICT OF INTEREST

Guarantor of the article: Ryosuke Tateishi, MD, PhD.

Specific author contributions: Conception and design: R.T., M.A., N.Y., T.G., S.S., H.Y., Y.M., and M.O.; analysis: R.T. and Y.M.; treatment and data collection: T.O., R.T., M.A., S.M., M.S., K.U., T.A., K.E., Y.K., T.G., and S.S.; drafting article: T.O.; critical revision: R.T., M.A., H.Y., K.O., and K.K.

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Potential competing interests: None.

Study Highlights

WHAT IS CURRENT KNOWLEDGE

- ✓ Computed tomography with hepatic arteriography and arterial portography (CTHA/CTAP) give higher hepatocellular carcinoma (HCC) detection sensitivity than conventional dynamic enhanced CT.
- ✓ CTHA/CTAP is an invasive procedure requiring the insertion of an intraarterial catheter through a femoral puncture.
- ✓ The indication for CTHA/CTAP can be justified only when the expected benefits exceed the risks and cost of the procedure.

WHAT IS NEW HERE

- ✓ Our study is the first randomized controlled trial (RCT) to evaluate the utility of CTHA/CTAP before radiofrequency ablation (RFA) in patients with HCC in the whole world.
- ✓ The best candidates for CTHA/CTAP were patients with multinodular HCC, and recurrent cases after previous treatment.
- ✓ However, CTHA/CTAP before RFA did not improve cumulative recurrence-free survival or overall survival.
- ✓ These observations are clinically important as the technique had limited utility and highlights the observation that patient outcomes are probably not related to the presence of small liver nodules.
- ✓ These findings reinforce the notion of genetic determinants of HCC recurrence.

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Induction of p53-Dependent p21 Limits Proliferative Activity of Rat Hepatocytes in the Presence of Hepatocyte Growth Factor

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Abstract

Background: Hepatocyte growth factor (HGF), a potent mitogen for hepatocytes, enhances hepatocyte function without stimulating proliferation, depending on the physiological conditions. p53, a transcription factor, suppresses the cell proliferation by expressing $p21^{WAF1/CIP1}$ in various tissues.

Aim: To investigate the mechanism through which the hepatocytes maintain mitotically quiescent even in the presence of HGF.

Methods: We studied the relationship between p53 and p21 expression and the effect of p53-p21 axis on hepatocyte proliferation in primary cultured rat hepatocytes stimulated by HGF. Hepatic p21 levels are determined serially after partial hepatectomy or sham operation in rats.

Results: DNA synthesis was markedly increased by HGF addition in rat hepatocytes cultured at low density but not at high density. Cellular p53 levels increased in the hepatocytes cultured at both the densities. p21 levels were increased and correlated with cellular p53 levels in hepatocytes cultured at high density but not at low density. When the activity of p53 was suppressed by a chemical inhibitor for p53, cellular p21 levels were reduced, and DNA synthesis was increased. Similarly, p21 antisense oligonucleotide increased the DNA synthesis. In rats after partial hepatectomy, transient elevation of hepatic p21 levels was observed. In contrast, in sham-operated rats, hepatic p21 levels were increased on sustained time scales.

Conclusion: p53-related induction of p21 may suppress hepatocyte proliferation in the presence of HGF in the setting that mitogenic activity of HGF is not elicitable.

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Introduction

Proliferation of hepatocytes occurs following the loss of parenchymal cells, while hepatocytes are usually mitotically quiescent. Hepatocyte growth factor (HGF), originally identified as a potent mitogen for hepatocytes in culture, has a pluripotent effect on various types of cells [1–6]. Previous reports indicate that circulating HGF levels in humans are increased with various degrees in physiological and pathological conditions such as acute hepatitis, fulminant hepatic failure, chronic hepatitis, liver cirrhosis, renal failure, post-partial hepatectomy and post-non-hepatectomized abdominal surgery [3,4,7–10]. In the liver of experimental animal models, mitogenic, anti-inflammatory, anti-apoptotic and anti-fibrogenetic activities of HGF have been observed [3,7]. In primary cultured hepatocytes, HGF addition has been shown to facilitate proliferation or function of the cells depending on the culture condition [2,11]. The mechanism is still under investigation if the specific activities of HGF are selectively expressed. Previously, we reported that HGF exerted mitogenic activity on hepatocytes through the induction of p53, a transcription factor, which increased production of transforming growth factor α (TGF-α), a complete mitogen for hepatocytes [12–14]. However, the mechanism is unknown through which hepatocytes maintain mitotically quiescent when HGF exerts other activities.

Though recent several reports including ours indicate that p53 can stimulate cell proliferation by the specific induction of promoters for growth-associated factors such as TGF-α, p53 is generally recognized as a 'tumor suppressor gene', because, in some pathophysiological conditions, it up-regulates p21, which arrests cell cycle at G1 phase, and inhibits cell proliferation both in vitro and in vivo [14–17]. While p21 expression can be induced by growth-inhibitory stimuli such as DNA damage [18–22], recent

reports indicate the possibility that addition of some growth factors induces p21, and suppresses DNA synthesis especially in malignant cell lines[18,23–28]. However, relationship between p53 and p21 and its significance in non-malignant cells including hepatocytes in the presence of growth factors is still under investigation.

In this paper, we showed that p21 was up-regulated by HGF stimulation through the induction of p53, and suppressed hepatocyte proliferation in the setting that mitogenic activity was not elicitable.

Materials and Methods

Assay for p53 of cultured hepatocytes

Hepatocyte extracts were prepared according to the protocol from the manufacturer of the p53 enzyme-linked immunosorbent assay (ELISA) kit (Roche Molecular Biochemicals, Germany) [14].

Preparation of liver and cultured hepatocytes for p21 assay

Liver tissues and cultured hepatocytes were homogenized in the low salt resuspension buffer (pH 7.4, 50 mmol/L tris (hydroxymethyl) aminomethane, 5 mmol/L ethylenediaminetetraacetic acid, 0.2 mmol/L phenylmethylsulfonyl fluoride 1 μg/mL pepstatin and 0.5 μg/mL leupeptin). The suspensions were incubated with p21 antigen extraction agent (1.0 M potassium chloride, 6% zwittergent (Calbiochem, CA)), and centrifuged. The resultant supernatants were applied to ELISA described below.

Assay for p21 in liver extracts and cultured hepatocytes

The sandwich ELISA for p21 was developed using polyclonal anti p21 IgG (Santa Cruz, CA) and monoclonal p21 antibody (Santa Cruz, CA) as capture and detector antibodies, respectively. Horseradish peroxidase conjugated goat anti-mouse IgG (Zymed, CA) was used to detect the antibody-p21 complex.

The standard curve for p21 (1–164, full length amino acids, Santa Cruz Biotechnology, CA) of this assay made with the buffer showed the lower limit at 1.25 ng/mL. When the sample of rat liver prepared for p21 assay was diluted with the buffer, the dilution curve was similar to the standard curve. When p21 protein was diluted with sample of rat liver or hepatocytes prepared for p21 assay, the dilution curve was similar to the standard curve.

Determination of 5-bromo-2′-deoxy-uridine (BrdU) incorporation and total protein content of cultured hepatocytes

Incorporated BrdU was determined by ELISA, using BrdU labeling and the detection kit III (Roche Molecular Biochemicals, Germany). The total cellular protein was measured by Bradford's method [29].

Experiments with cultured hepatocytes

Hepatocytes were isolated from rat livers according to Seglen's method [30]. The isolated cells were cultured at densities of either 1.2×10^5 cells/cm^2 (high density culture) or 2.5×10^4 cells/cm^2 (low density culture) in the medium and incubated for 27 hours as we previously reported [14]. The medium was changed to Williams' medium E (WE) containing 10% fetal calf serum (FCS), various concentrations of HGF and 0.1 mmol/L BrdU. The cells were harvested serially for the determination of both the cellular p53 and p21 levels and, the BrdU incorporation into cellular DNA.

To study the effect of inhibition of p53 function on p21 levels and DNA synthesis in hepatocytes, the hepatocytes were cultured in WE containing 10% FCS, with or without 10 ng/mL HGF, 1 mmol/L BrdU and various concentrations of pifithrin-α (Alexis Biochemicals, CA) dissolved in dimethyl sulfoxide (DMSO) or the same concentrations of DMSO [31]. The cells were harvested 18 hours later to determine the cellular p21 levels and 24 hours later to determine the BrdU incorporation into cellular DNA.

To examine the effect of inhibition of p21 production on hepatocyte DNA synthesis, the hepatocytes were cultured in WE containing 10% FCS, 10 ng/mL HGF, 1 mmol/L BrdU and various concentrations of either p21 antisense oligonucleotide (5′-GACATCACCAGGATCGGACAT-3′), complementary to position 85–105 of rat p21 mRNA, or nonsense oligonucleotide (5′-GCAACGCTACTACGCAAGTAG-3′), containing the same numbers of G, C, A, and T as the p21 antisense oligonucleotide [32]. The cells were harvested as above, to determine the cellular p21 levels and the BrdU incorporation into cellular DNA.

Animal experiments

Five to six-weeks-old Male Sprague-Dawley rats (Japan SLC, Japan) were subjected to either of two-thirds partial hepatectomy (PH) or sham operation under diethyl ether anesthesia. In sham-operated rats, the abdomen was cut open under similar anesthesia, and the liver was briefly exposed outside the peritoneal cavity. The rats were serially anesthetized with diethyl ether. The liver was perfused through the portal vein with saline. After a near total exsanguination, the liver was excised and used for the p21 assays.

All animal study protocols conformed to and approved by the guideline of the Faculty of Medicine, University of Tokyo for humane care.

Statistical analyses

The differences between two unpaired samples were defined as significant when the p-values by both the Student's t-test and the Mann-Whitney U test were less than 0.05. The dose related effects were tested by one-way analysis of variance followed by Spearman's correlation test.

Results

Changes in DNA synthesis of cultured rat hepatocytes after HGF treatment

We determined the effect of cell density on DNA synthesis of cultured hepatocytes simulated by HGF. The addition of 10 ng/mL HGF to the medium caused only minor increase on DNA synthesis in hepatocytes cultured at high density. In hepatocytes cultured at low density, DNA synthesis increased after 12 hours of incubation, peaked at 24–30 hours and decreased thereafter by HGF addition (Figure 1). DNA synthesis was not induced significantly in high density cultured hepatocytes by HGF treatment.

Cellular p53 and p21 levels in cultured rat hepatocytes treated with HGF

To investigate the effect of HGF on p53 and p21 expressions and their relationship in proliferating and non-proliferating rat hepatocytes, we determined p53 and p21 protein levels in cultured hepatocytes at low and high density in the presence of various concentration of HGF.

As shown in Figure 2, when rat hepatocytes were cultured at high density with HGF, p53 levels increased at 10 ng/mL or 20 ng/mL of HGF addition ($F = 32.5$, $p<0.01$; $r = 0.84$, $p<0.01$).

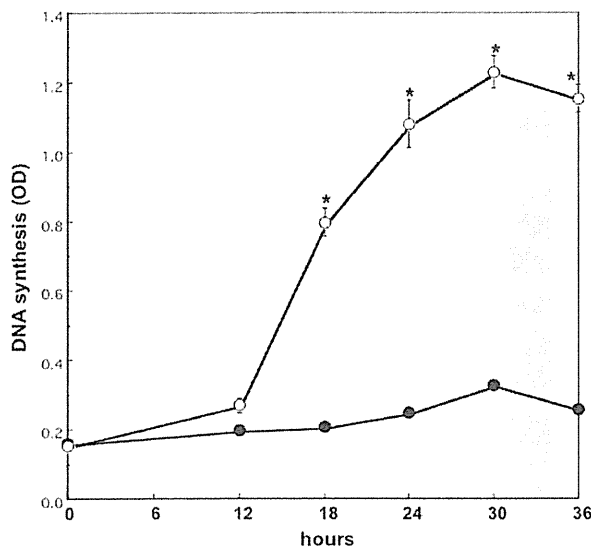

Figure 1. Changes in DNA synthesis of hepatocytes after HGF treatment. Rat hepatocytes were cultured in WE containing 10% FCS, 10 ng/mL HGF and 0.1 mmol/L BrdU, and were harvested serially. Closed circles denote hepatocytes cultured at high density. Open circles denote hepatocytes cultured at low density. Data are mean ± SEM of eight dishes. *p<0.01 compared with the values cultured for 0 hours.
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In hepatocytes cultured at low density, HGF addition also increased cellular p53 levels significantly in a dose-related manner up to 10 ng/mL of HGF ($F=23.4$, $p<0.01$; $r=0.90$, $p<0.01$) (Figure 2).

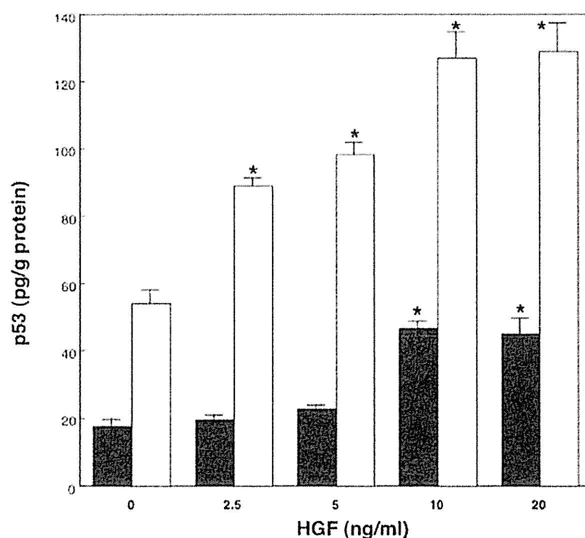

Figure 2. Cellular p53 levels in hepatocytes treated with HGF. Rat hepatocytes were cultured in WE containing 10% FCS and various concentration of HGF for 18 hours. Closed bars denote hepatocytes cultured at high density. Open bars denote hepatocytes cultured at low density. Data are mean ± SEM of four dishes. *p<0.01 compared with the values in the absence of HGF.
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The levels of p53 in high density cultured hepatocytes treated with 10 ng/mL HGF increased after 6 hours and reached a maximum at 24 hours (data not shown), while, in low density cultured hepatocytes treated with 10 ng/mL HGF, p53 levels significantly increased from 6 hours and peaked at 18 to 24 hours of incubation, similar to our previous report [14].

The levels of p21 protein in high density cultured hepatocytes treated with 10 ng/mL HGF increased in a time dependent manner (Figure 3). When hepatocytes cultured at high density were treated with HGF at increasing concentrations, p21 levels at 18 hours after HGF addition increased in a dose-related manner ($F=73.0$, $p<0.01$; $r=0.88$, $p<0.01$), and correlated with the cellular p53 levels ($r=0.69$; $p<0.01$) (Figure 4 and 5A). p21 levels in low density cultured hepatocytes were not increased by HGF addition, nor correlated with p53 levels (Figure 3, 4 and 5B).

p21 levels were increased in a dose related manner by HGF and correlated with p53 levels at high density cultured hepatocytes, while, at low density cultured hepatocytes, p53, but not p21, levels were increased by HGF and there was no correlation between p53 and p21 levels.

The effect of pifithrin-α on p21 levels and BrdU incorporation in rat hepatocytes cultured at high and low density in the presence or absence of HGF

To elucidate the relationship between p53 expression and p21 expression as well as DNA synthesis in hepatocytes at non-proliferating condition even in the presence of HGF, we determined the effect of pifithrin-α, a chemical inhibitor of p53, on p21 levels and BrdU incorporation of hepatocytes cultured at high density in the presence of HGF.

The levels of p21 treated with 10 ng/mL HGF for 18 hours in hepatocytes at high density were reduced by the addition of

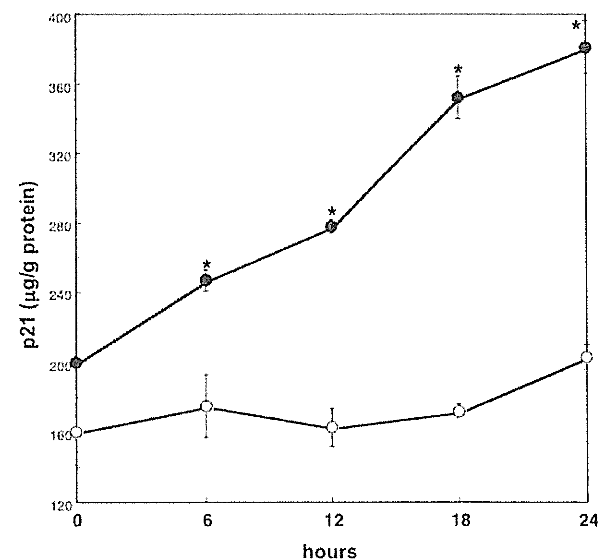

Figure 3. Serial changes in p21 protein levels of hepatocytes treated with HGF. Rat hepatocytes were cultured at high density in WE containing 10% FCS and 10 ng/mL HGF, and were harvested serially. Closed circles denote hepatocytes cultured at high density. Open circles denote hepatocytes cultured at low density. Data are mean ± SEM of four dishes. *p<0.01 compared with the values cultured for 0 hours.
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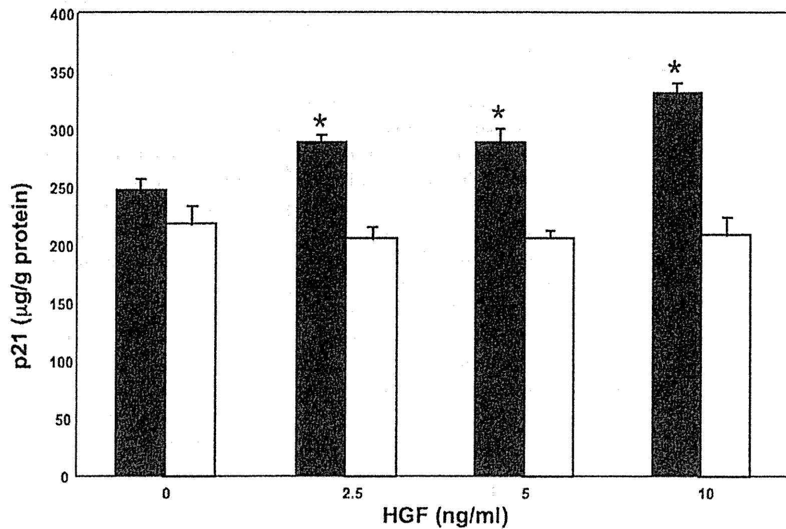

Figure 4. Cellular p21 levels in hepatocytes treated with HGF. Rat hepatocytes were cultured in WE containing 10% FCS and various concentration of HGF for 18 hours. Closed bars denote hepatocytes cultured at high density. Open bars denote hepatocytes cultured at low density. Data are mean + SEM of four dishes. *$p<0.05$ compared with the values in the absence of HGF.
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pifithrin-α, a chemical inhibitor of p53, when compared with the addition of vehicles ($p<0.01$) (Figure 6).

In contrast, the levels of p21 in hepatocytes at high density treated without HGF for 18 hours, the values of p21 protein were 211.5±24.9 μg/g protein (mean±standard error), and did not show any significant changes by the addition of pifithrin-α when compared with the addition of vehicles (202.2±57.4 μg/g protein). In addition, the levels of p21 in hepatocytes cultured at low density treated with 10 ng/mL HGF for 18 hours were not affected by pifithrin-α treatment (121.7±18.1 μg/g protein vs137.6±21.8 μg/g protein).

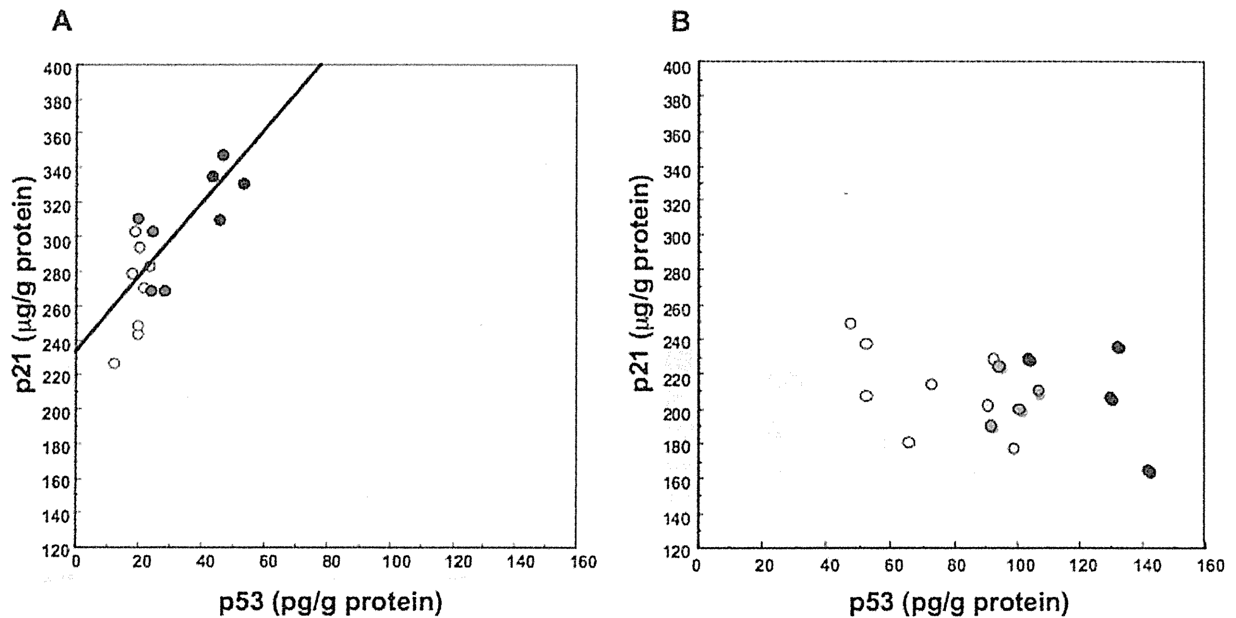

Figure 5. Cellular p53 and p21 levels in hepatocytes treated with HGF. Rat hepatocytes were cultured in WE containing 10% FCS and various concentrations of HGF for 18 hours. Open circles denote hepatocytes cultured in the absence of HGF. Dotted open circles denote hepatocytes cultured with 2.5 ng/mL HGF. Dotted closed circles denote hepatocytes cultured with 5 ng/mL HGF. Closed circles denote hepatocytes cultured with 10 ng/mL HGF. (A) Hepatocytes cultured at high density. (B) Hepatocytes cultured at low density.
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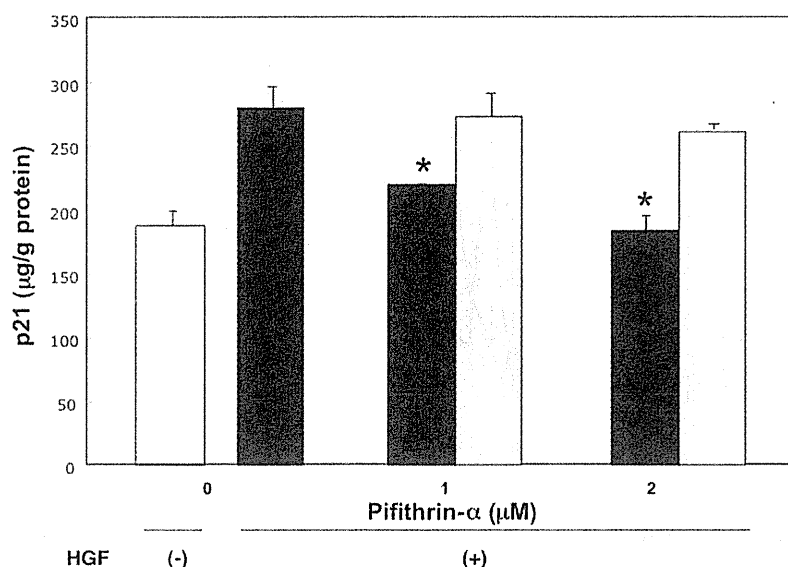

Figure 6. The effect of pifithrin-α on p21 levels of hepatocytes in the presence of HGF. Rat hepatocytes were cultured at high density in WE containing 10% FCS, 10 ng/mL HGF, along with various concentrations of pifithrin-α, the chemical inhibitor of p53, dissolved in DMSO, or DMSO of the same concentration for 18 hours. An open bar denotes hepatocytes cultured in the absence of HGF. Closed bars denote hepatocytes cultured with pifithrin-α in the presence of 10 ng/mL HGF. Dotted bars denote hepatocytes cultured with DMSO in the presence of 10 ng/mL HGF. Data are mean ± SEM of four dishes. *p<0.05 compared with the values treated only with HGF or values treated with HGF and DMSO.
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The levels of BrdU incorporation treated with 10 ng/mL of HGF for 24 hours were increased significantly by the addition of 2 μM of pifithrin-α, when compared with the addition of vehicles ($p<0.01$) (Figure 7). The total cellular protein levels were not affected by the addition of either pifithrin-α or vehicles (data not shown).

p21 levels were reduced and DNA synthesis was significantly increased by pifithrin-α a chemical inhibitor of p53, in the presence of HGF in high density cultured hepatocytes.

The effect of p21 antisense oligonucleotides on BrdU incorporation in rat hepatocytes cultured at high density in the presence of HGF

We investigated the effect of suppression of p21 expression on DNA synthesis in non-proliferationg hepatocytes in the presence of HGF. BrdU incorporation in hepatocytes cultured at high density in the presence of 10 ng/mL of HGF was significantly increased after a 24-hour exposure to p21 antisense oligonucleotide, when compared with that of hepatocytes treated with the nonsense oligonucleotide ($p<0.01$) (Figure 8). The total cellular protein levels were not affected by the addition of either oligonucleotide (data not shown). Suppression of p21 expression increased the DNA synthesis in the presence of HGF in high density cultured hepatocytes.

p21 levels in the liver after two-thirds PH or sham operation in rats

To study p21 expression profile in regenerating and quiescent rat liver, we determined hepatic p21 levels in rats after PH and sham operation. Hepatic p21 levels were increased to the maximal levels at 4 hours, and decreased to the basal levels at 8 hours after PH with minor increase at 48 hours. In contrast, hepatic p21 levels of sham-operated rats were increased up to 2.5-fold higher than preoperative levels at 12 to 48 hours and decreased to the

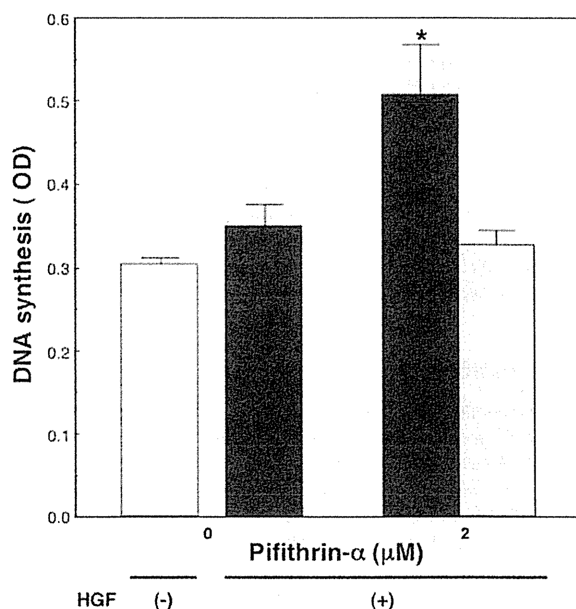

Figure 7. The effect of pifithrin-α on DNA synthesis of hepatocytes in the presence of HGF. Rat hepatocytes were cultured at high density in the same medium as described in the legend of Figure 6, except that the medium contained 1 mmol/L BrdU, for 24 hours. An open bar denotes hepatocytes cultured in the absence of HGF. Closed bars denote hepatocytes cultured with pifithrin-α in the presence of 10 ng/mL HGF. A dotted bar denotes hepatocytes cultured with DMSO in the presence of 10 ng/mL HGF. Data are mean ± SEM of eight dishes. *p<0.01 compared with the values treated only with HGF or values treated with HGF and DMSO.
doi:10.1371/journal.pone.0078346.g007

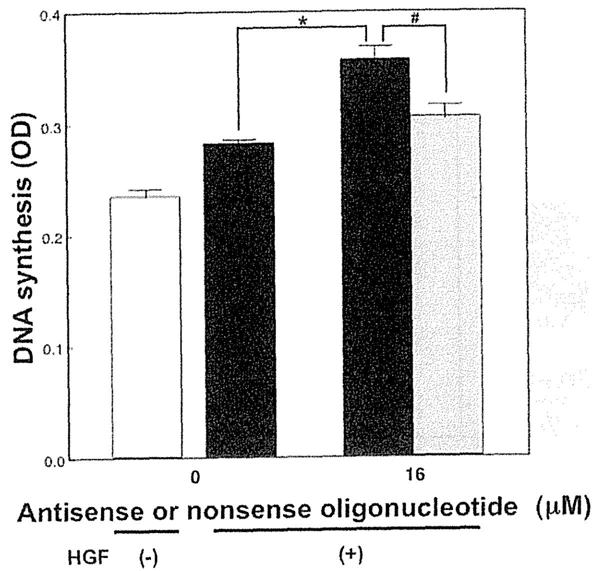

Figure 8. The effect of p21 antisense on DNA synthesis of hepatocytes in the presence of HGF. Rat hepatocytes were cultured at high density in WE containing 10% FCS, 10 ng/mL HGF, 1 mmol/L BrdU, along with various concentrations of either p21 antisense or nonsense oligonucleotide for 24 hours. An open bar denotes hepatocytes cultured in the absence of HGF. Closed bars denote hepatocytes cultured with p21 antisense oligonucleotide in the presence of 10 ng/mL HGF. A dotted bar denotes hepatocytes cultured with nonsense oligonucleotide in the presence of 10 ng/mL HGF. Data are mean ± SEM of eight dishes. *$p<0.05$ compared with the values treated only with HGF, and #$p<0.01$ compared with the values treated with HGF and nonsense oligonucleotide.
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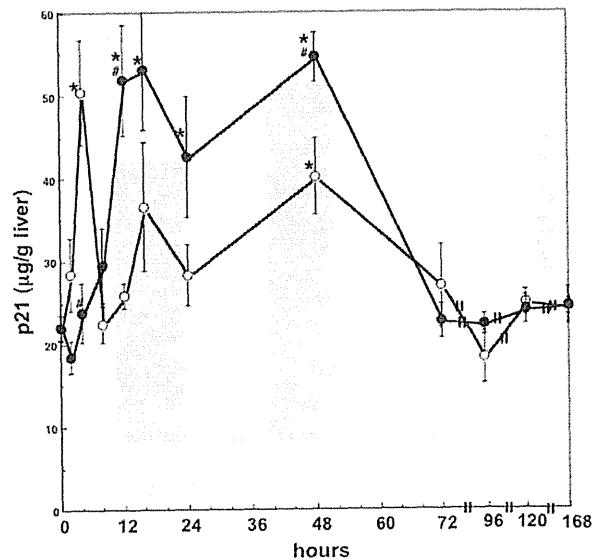

Figure 9. Changes in hepatic p21 levels after two thirds partial hepatectomy in rats. Data are mean ± SEM of four rats. Open and closed circles indicate the hepatic p21 levels in partially hepatectomized rats and in sham-operated rats, respectively. *$p<0.05$ compared with the values at 0 hour, and #$p<0.05$ compared with the values of partially hepatectomized rats.
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preoperative level at 72 hours. Hepatic p21 levels were significantly higher in sham-operated rats than in rats after PH except within 4 hours after surgery (Figure 9). In sham-operated rats, hepatic p21 levels were increased on sustained time scales while only transient elevation was observed in partial hepatectomized rats.

Discussion

We confirmed that DNA synthesis was not induced significantly in hepatocytes cultured at high density even in the presence of HGF, as we previously reported [2]. HGF seems to increase p53 and p21, and maintain mitotically quiescent in the hepatocytes.

We determined p21 protein levels *in vitro* and *in vivo* using newly developed ELISA system. Although p21 expression has been extensively studied in proliferating and non-proliferating hepatocytes and in the liver with or without regenerative stimuli [33–36], the results are inconsistent. In most of these reports, p21 mRNA levels were studied, or p21 protein levels were determined by Western blotting. When p21 synthesis is induced, p21 mRNA levels are generally up-regulated. Furthermore, p21 synthesis is further increased at the post-transcriptional level in hepatocytes [37]. Thus, in this study, we determined p21 protein expressions which may function as transcription factor. In addition, to avoid the unstable results, we determined p21 protein levels utilizing a quantitative method which was sensitive enough to detect p21 during observation periods *in vitro* and *in vivo*.

We suppressed p53 activity and p21 expression using pifithrin-α and a p21 antisense oligonucleotide, respectively. Pifithrin-α disturbs the nuclear transport of p53 leading to the inhibition of the function of p53 *in vitro* and *in vivo* [31,38]. We used pifithrin-α at the same concentration as previously reported in hepatocytes [14,38]. The efficacy of the p21 antisense oligonucleotide was also previously reported in other cell culture systems [32].

Previously, we reported that the addition of HGF to the medium increased p53 contents in hepatocytes cultured at low density followed by the increase of DNA synthesis by hepatocytes [14]. In this present paper, we showed that the p53 levels were also increased by HGF treatment in hepatocytes cultured at high density which did not show apparent burst of DNA synthesis. The mechanisms responsible for the increase of p53 in hepatocytes by HGF are still undefined. However, it has been reported that activation of mitogen activated protein (MAP) kinase influences transcription factors including p53 [39]. Considering that MAP kinase is thought to mediate the intracellular effects of HGF [40], HGF might increase p53 through the interaction of MAP kinase and p53. Recently, the relationship between growth factors and p53 has been shown in a couple of reports. HGF was shown to increase p53 expression in a rat epithelial cell line, and insulin-like growth factor I was reported to induce p53 expression in cardiac muscle cells [41,42]. In primary cultured rat hepatocytes, epidermal growth factor (EGF) was shown to induce p53 expression in a phosphatidylinositol-3 kinase-dependent way [36]. In addition, p53 null hepatocytes were reported to be refractory to the stimulation of EGF [43].

p21 is known to be induced by p53-dependent and -independent mechanisms according to the cell types and situations [18]. Following DNA damage, p53 appears to be necessary for p21 induction in various kinds of cell types [18]. Many experiments showed that p21 was the major effector of p53 in inducing growth arrest in malignant cells [17,18]. Furthermore,

p21 was reported to be induced by p53 and negatively regulate cell proliferation in normal fibroblasts without DNA damage [44]. In addition, expression of the p53-induced p21 was greatly diminished by targeting p53 with anti-p53 antibody, and the cells reentered S-phase in fibroblasts [45]. We showed that cellular levels of p21 correlated with those of p53 and suppression of p53 activity by pifithrin-α resulted in the decrease of p21 levels followed by an increase of DNA synthesis in hepatocytes cultured at high density. p21 seems to be induced by p53 dependent mechanism in the present culture system of hepatocytes leading to suppression of proliferation.

Previous several reports have shown that growth factors can induce p21 production and suppress cell proliferation. Transient induction of p21 mRNA following stimulation of growth factors such as EGF, platelet-derived growth factor and fibroblast growth factor is reported in several cell lines, leading to cell cycle arrest [18,26–28,46]. p21 was up-regulated by HGF addition, and mediated growth inhibition in a hepatoma cell-line [23–25]. In primary cultured rat and mouse hepatocytes, p21 is reported to be induced by EGF and to have a role in the blockage of hepatocyte replication of the second round but not of the first round [33]. In addition, Wierod et.al reported that EGF induced p21 through the activation of p53 in primary cultured rat hepatocytes [36]. However, they noted that EGF-induced p21 might positively regulate DNA synthesis, since stimulatory effect of EGF on DNA synthesis was abrogated when p53 was inhibited, and rescued by ectopical p21 addition [36]. It was reported that the role of p21 might differ by its concentrations [47]. To examine the role of intrinsic p21 in regulating DNA synthesis of hepatocytes, the effect of p21 inhibition in the presence of EGF should be studied. In our culture system using primary cultured rat hepatocytes and HGF, we showed that suppression of HGF-induced increase of p21 production positively regulated DNA synthesis by hepatocytes cultured at high density, suggesting that up-regulation of p21 maintained mitotically quiescent in hepatocytes in the presence of HGF. No apparent change of p21 expression was caused by pifithrin-α in hepatocytes cultured without HGF treatment, suggesting the effect of p53 inhibition on baseline p21 seemed to be minimal. In the high density cultured hepatocytes, protein production such as albumin is increased by HGF addition [2,11]. In contrast, in hepatocytes cultured at low density, we previously reported that HGF induced TGF-α production through the induction of p53, and hepatocyte proliferation occurred [14]. It is possible to speculate that induction of diverse effector genes of p53 plays a role in the expression of different activities of HGF. Further investigations would be required to clarify the mechanism(s) of the selective expression of p53 related genes in hepatocytes in different conditions stimulated by HGF.

Previous experiments in rats showed that hepatic levels of p21 protein after PH determined by Western blot analysis were increased at two time points, first immediately after resection and second after the peak of DNA synthesis. In sham operated rats, the p21 levels were almost undetectable throughout the 7-day time course [34]. Controversially, some reports demonstrated that hepatic p21 protein levels determined by Western blot analysis were decreased in partially hepatectomized rats and increased in sham-operated rats. The maximum decrease was observed immediately before the peak DNA synthesis, with increased p53 levels after PH, while the levels began to increase immediately after sham operation, and continued up to 48 hours of observation [48]. In mice after PH, p21 expression was reported to be increased before DNA synthesis of hepatocytes and reached maximum after the peak of hepatocyte DNA synthesis on Western blot analysis [49]. In the present study, hepatic p21 protein levels were increased immediately after PH, but returned to preoperative levels within 8 hours, while a sustained increase of p21 levels was observed after sham operation up to 48 hours. The reason for the discrepancy of the data is unclear. The difference of the assay system might influence the observations. Previously, we reported that hepatic p53 levels as well as hepatic and circulating HGF levels were increased after sham operation without the increase of hepatocyte proliferation [12,14], while, in rats after PH, hepatic p53 levels were increased and reached maximal levels, when hepatic HGF levels have been shown to reach maximum prior to an increase in hepatocyte proliferation [13,14]. These observations raise the possibility that the increase of p21 is related to keep quiescent when hepatocyte proliferation is not physiologically required even though HGF levels are increased. Previous studies described that c-Jun controlled hepatocyte proliferation by a p53/p21-dependent mechanism in mice [50]. p21 knock out mice demonstrated markedly accelerated hepatocyte proliferation compared to cogenic wild-type mice after PH [49]. These reports support our hypothesis. Significance of the transient increase of hepatic p21 levels after PH is still to be elucidated. The role of p21 may change depending on its concentration; p21 promotes cyclin/cdk complex assembly at low concentration, whereas, at higher concentrations, p21 is inhibitory to cdk in human normal fibroblast and human osteosarcoma cell [47]. The levels and the timing of the increase might influence the activity of p21.

Author Contributions

Conceived and designed the experiments: YI TT. Performed the experiments: YI TT TN YT. Analyzed the data: YI TT NO. Contributed reagents/materials/analysis tools: TT KK. Wrote the paper: YI TT HI.

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Original Article

Perihepatic lymph node enlargement is a negative predictor for sustained responses to pegylated interferon-α and ribavirin therapy for Japanese patients infected with hepatitis C virus genotype 1

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Aim: Although perihepatic lymph node enlargement (PLNE) is reportedly associated with the negative outcome of interferon therapy for chronic hepatitis C, there were limitations in that the results were obtained in patients with various genotypes, viral loads and treatment regimens. We aimed to precisely clarify the significance of PLNE in interferon therapy for chronic hepatitis C.

Methods: Between December 2004 and June 2005, 112 patients with hepatitis C virus (HCV) genotype 1 and HCV RNA of more than 100 KIU/mL were enrolled, who underwent pegylated interferon-α plus ribavirin therapy thereafter. PLNE was defined as a perihepatic lymph node of more than 1 cm in the longest axis by ultrasonography.

Results: The sustained virological response (SVR) rate was lower in patients with PLNE (4/22, 18.2%) than in those without (37/90, 41.1%; $P = 0.045$) and viral load decline was smaller in patients with PLNE than in those without ($P = 0.028$). The proportion of PLNE positive patients was the smallest in the SVR group ($P = 0.033$) among the patient groups divided by the treatment outcome. PLNE was retained as a negative predictor for SVR by multivariate logistic regression analysis ($P = 0.012$). Furthermore, PLNE was not significantly associated with the mutations at HCV core protein and at interferon sensitivity-determining region, or interleukin-28B polymorphism in 45 patients with HCV genotype 1, enrolled between December 2011 and March 2012.

Conclusion: PLNE is a negative predictor for SVR in patients with HCV genotype 1 and HCV RNA of more than 100 KIU/mL treated with pegylated interferon-α plus ribavirin, independent of other known predictors for SVR.

Key words: chronic hepatitis C, hepatitis C virus core protein, interferon sensitivity-determining region, interleukin-28B

INTRODUCTION

PERIHEPATIC LYMPH NODE enlargement (PLNE) is frequently observed in patients with chronic liver disease,[1] especially in those with hepatitis C.[2,3] Although it has been shown that PLNE is associated with inflammatory activity, stage of liver fibrosis or hepatitis C viral load,[3-8] the reported findings were inconsistent,[2,9] suggesting that the clinical significance of PLNE has not been fully established yet. We have recently reported that PLNE is a negative predictor for hepatocellular carcinoma (HCC) development in chronic hepatitis C patients.[10]

Regarding PLNE and efficacy of interferon (IFN) therapy for chronic hepatitis C, PLNE was reportedly more frequently found in non-responders.[11,12] Dietrich *et al.* reported that perihepatic lymph node volume before IFN treatment was significantly larger in non-responders than in sustained virological responders,

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based on a study in which the patients had various genotypes and viral loads and were treated with IFN-α with or without ribavirin (RBV).[11] Soresi *et al.* reported that PLNE was more frequent in non-responders to IFN-α with RBV, although this association did not reach statistical significance by logistic regression analysis, in which the patients also had various genotypes.[12] We also reported that the sustained virological response (SVR) rate in patients who received IFN therapy was significantly lower in patients with PLNE than in those without, although our patients also had various genotypes and viral loads, and treatment regimens were various including IFN-α or pegylated IFN-α (PEG IFN) with or without RBV.[10] It is well known that patients with hepatitis C virus (HCV) genotype 1 and high baseline viral load are most difficult to treat with IFN[13] and that PEG IFN plus RBV has been the most effective standard of care for chronic hepatitis C until telaprevir emerged.[14] Thus, the previous results regarding PLNE and efficacy of IFN therapy for chronic hepatitis C had limitations, because they were analyzed with various genotypes, viral loads and treatment regimens.

In this study, in order to precisely clarify the potential association between PLNE and efficacy of IFN therapy for chronic hepatitis C, we analyzed the patients with HCV genotype 1 and HCV RNA of more than 100 KIU/mL at the start of therapy by PEG IFN with RBV in the well-characterized chronic hepatitis C cohort, in which liver stiffness values were found to be a risk for HCC development.[15]

METHODS

Subjects

THE PREVIOUS COHORT in which we originally analyzed the risk of liver stiffness for HCC development was employed; 866 chronic hepatitis C patients were enrolled between December 2004 and June 2005 at the Department of Gastroenterology, The University of Tokyo Hospital.[15] Among these patients, 112 patients, who had HCV genotype 1 and HCV RNA >100 KIU/mL, underwent PEG IFN plus RBV therapy after the enrollment. The potential association between PLNE and efficacy of PEG IFN plus RBV therapy was examined with these patients. When each subject was screened for HCC with ultrasonography at or immediately after the enrollment, the presence of PLNE was evaluated. The criteria to identify PLNE were previously described, and PLNE was defined as a lymph node at perihepatic area which was at least 1 cm in the longest axis.[10]

Moreover, between December 2011 and March 2012, 45 chronic hepatitis C patients with genotype 1 were enrolled at the Department of Gastroenterology, The University of Tokyo Hospital, to assess the potential association between PLNE and the known factors to predict the response to IFN therapy, namely, the mutations at position 70 of HCV core protein, those at IFN sensitivity-determining region (ISDR) of NS5A protein or interleukin (IL)-28B polymorphism.

The present study was carried out in accordance with the ethical guidelines of the Declaration of Helsinki and was approved by the Institutional Research Ethics Committee of the authors' institution. Informed consent was obtained for the use of the samples in this study.

Laboratory tests

Sequences of ISDR and the core region of HCV were determined by direct sequencing after amplification by reverse transcription and polymerase chain reaction as reported previously.[16,17] Genetic polymorphism in one tagging single nucleotide polymorphism located near the *IL-28B* gene (rs8099917) was determined by direct sequencing.[18] Homozygosity (GG) or heterozygosity (TG) of the minor sequence was defined as having the IL-28B minor allele, whereas homozygosity for the major sequence (TT) was defined as having the IL-28B major allele. Null virological response (NVR) was defined as detectable HCV RNA by qualitative polymerase chain reaction with a lower detection limit of 50 IU/mL (Amplicor; Roche Diagnostic Systems, Pleasanton, CA, USA) during the therapy. SVR was defined as undetectable HCV RNA 24 weeks after the completion of therapy. Relapse was defined as reappearance of HCV RNA after the completion of therapy. HCV RNA was quantitated using Amplicore HCV ver. 2.0 (Roche, Tokyo, Japan) or Cobas Ampliprep/Cobas TaqMan assay system (Roche, Tokyo, Japan). HCV genotype was determined based on the serotyping assay (SRL, Tokyo, Japan) or direct sequence analysis.[19]

Statistical analysis

Data were expressed as the mean ± standard deviation (SD) unless otherwise indicated. The categorical variables were compared by χ^2-test or Fischer's exact test, whereas continuous variables were compared by unpaired Student's *t*-test (parametric), Mann–Whitney *U*-test (non-parametric), Kruskal–Wallis rank sum test (non-parametric) or Wilcoxon rank sum test (non-parametric). For comparing group means, we used ANOVA. In the analysis of predicting factors for the responses to PEG IFN plus RBV therapy, the following

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