

TABLE III. Sensitivity, Specificity, Positive Predictive Value (PPV), and Negative Predictive Value (NPV) for End-of-Treatment Response, According to Alpha-Fetoprotein and Type of Previous Response to Therapy

	% (Number)			
	Sensitivity	Specificity	PPV	NPV
(A) Alpha-fetoprotein (<10 µg/L)	100 (9/9)	66.7 (4/6)	81.8 (9/11)	100 (4/4)
(B) Type of previous response (partial response)	77.8 (7/9)	83.3 (5/6)	87.5 (7/8)	71.4 (5/7)
(A) and (B)	80.0 (8/10)	100 (5/5)	100 (8/8)	71.4 (5/7)

PPV, end-of-treatment response rates for patients with a combination of low levels of alpha-fetoprotein (<10 µg/L) and partial response (prediction of end-of-treatment response). NPV, non end-of-treatment response rates for patients with a combination of high levels of alpha-fetoprotein (≥10 µg/L) and null response (prediction of non end-of-treatment response).

The present study is the first to identify the pretreatment factors that can predict virological response to triple therapy in prior non-responders infected with HCV-1. The study identified substitution of aa70 (Arg70) and type of previous response (partial response) as predictors of sustained virological response in prior non-responders. The use of the combination of the above two predictors resulted in high sensitivity, specificity, PPV, and NPV for prediction of sustained virological response. Especially, all four patients (100%) who achieved sustained virological response had the combination of Arg70 and partial response. Hence, the T12PR24 regimen might achieve a higher-sustained virological response rate in prior non-responders with the combination of Arg70 and partial response.

A recent study (REALIZE Study) showed that 59% of prior partial responders infected with HCV-1 achieved sustained virological response following 48-week regimen of triple therapy [Zeuzem et al., 2011]. In this regard, predictors of end-of-treatment response might be useful in selecting prior non-responders who could achieve sustained virological response following extension of the combination therapy to 48 weeks (T12PR48). The present study identified alpha-fetoprotein level (<10 µg/L) and type of previous response (partial response) as predictors of end-of-treatment response in previous non-responders. The combination of the above two predictors had high sensitivity, specificity, PPV, and NPV for prediction of end-of-treatment response. Especially, seven of nine patients (77.8%), who achieved end-of-treatment response were patients with low levels of alpha-fetoprotein and showed partial response. Hence, the T12PR48 regimen might achieve high-sustained virological response rates in prior non-responders who have low levels of alpha-fetoprotein and experienced partial response to prior therapy. All four patients (100%) who had high levels of alpha-fetoprotein and null response could not achieve end-of-treatment response. Thus, triple therapy might not achieve sustained virological response in prior non-responders with high levels of alpha-fetoprotein and history of null response, and the development of more effective therapeutic regimens is desirable for these patients in the future. This result should be interpreted with

caution, since the present study was performed in Japanese patients infected with HCV-1b (with the exception of one patient infected with HCV-1a). Furthermore, the present study, based on a small number of patients, could not identify independent predictors by multivariate analysis. Any generalization of the results should await confirmation by a multicenter-randomized trial based on a larger number of prior non-responders, including patients of other races and those infected with HCV-1a.

The present study showed that high level of alpha-fetoprotein is a pretreatment predictor of poor virological response to triple therapy. Advanced liver fibrosis is usually associated with high levels of alpha-fetoprotein [Bayati et al., 1998; Chu et al., 2001; Hu et al., 2004]. Previous studies showed that high indocyanine green retention rates at 15 min (ICG R15) or lower serum albumin levels were also associated with advanced liver fibrosis, and that they were independent and significant predictors of poor virological response to PEG-IFN plus ribavirin combination therapy [Akuta et al., 2005, 2007a]. Further studies of large number of patients are required to explore the importance of various histopathological changes in the liver (including stage of fibrosis, platelet count, serum albumin, ICG R15, and alpha-fetoprotein), and to investigate the relationship between the severity of histopathological changes and the response to triple therapy.

The present study based on the direct sequencing identified the appearance of telaprevir-resistant variants during or after treatment in 82% of patients who did not show sustained virological response to triple therapy, but such variants were no longer detected at the end of the study except for one patient with baseline-resistant variant. The limitation of the present study was that the existence of minor clones of telaprevir-resistant variants could not be investigated. Further large-scale studies should be performed to investigate the effects of telaprevir-resistant variants on the response to treatment using the new drugs, including direct-acting antiviral therapy agents.

In conclusion, this study identified aa substitution of the core region, alpha-fetoprotein level, and type of previous response as predictors of virological response

to treatment with telaprevir/PEG-IFN/ribavirin in previous non-responders infected with HCV-1b. Further large-scale prospective studies are necessary to confirm these findings, and to help in the design of more effective therapeutic regimens.

REFERENCES

- Akuta N, Suzuki F, Sezaki H, Suzuki Y, Hosaka T, Someya T, Kobayashi M, Saitoh S, Watahiki S, Sato J, Matsuda M, Kobayashi M, Arase Y, Ikeda K, Kumada H. 2005. Association of amino acid substitution pattern in core protein of hepatitis C virus genotype 1b high viral load and non-virological response to interferon-ribavirin combination therapy. *Intervirology* 48: 372–380.
- Akuta N, Suzuki F, Kawamura Y, Yatsuji H, Sezaki H, Suzuki Y, Hosaka T, Kobayashi M, Kobayashi M, Arase Y, Ikeda K, Kumada H. 2007a. Predictive factors of early and sustained responses to peginterferon plus ribavirin combination therapy in Japanese patients infected with hepatitis C virus genotype 1b: Amino acid substitutions in the core region and low-density lipoprotein cholesterol levels. *J Hepatol* 46:403–410.
- Akuta N, Suzuki F, Kawamura Y, Yatsuji H, Sezaki H, Suzuki Y, Hosaka T, Kobayashi M, Kobayashi M, Arase Y, Ikeda K, Kumada H. 2007b. Amino acid substitutions in the hepatitis C virus core region are the important predictor of hepatocarcinogenesis. *Hepatology* 46:1357–1364.
- Akuta N, Suzuki F, Hirakawa M, Kawamura Y, Yatsuji H, Sezaki H, Suzuki Y, Hosaka T, Kobayashi M, Kobayashi M, Saitoh S, Arase Y, Ikeda K, Chayama K, Nakamura Y, Kumada H. 2010. Amino acid substitution in HCV core region and genetic variation near *IL28B* gene predict viral response to telaprevir with peginterferon and ribavirin. *Hepatology* 52:421–429.
- Akuta N, Suzuki F, Hirakawa M, Kawamura Y, Yatsuji H, Sezaki H, Suzuki Y, Hosaka T, Kobayashi M, Kobayashi M, Saitoh S, Arase Y, Ikeda K, Chayama K, Nakamura Y, Kumada H. 2011. Amino acid substitution in HCV core region and genetic variation near the *IL28B* gene affect viral dynamics during telaprevir, peginterferon and ribavirin treatment. *Intervirology* [Epub ahead of print].
- Bayati N, Silverman AL, Gordon SC. 1998. Serum alpha-fetoprotein levels and liver histology in patients with chronic hepatitis C. *Am J Gastroenterol* 93:2452–2456.
- Chayama K, Hayes CN, Abe H, Miki D, Ochi H, Karino Y, Toyota J, Nakamura Y, Kamatani N, Sezaki H, Kobayashi M, Akuta N, Suzuki F, Kumada H. 2011. *IL28B* but not *ITPA* polymorphism is predictive of response to pegylated interferon, ribavirin, and telaprevir triple therapy in patients with genotype 1 hepatitis C. *J Infect Dis* 204:84–93.
- Chu CW, Hwang SJ, Luo JC, Lai CR, Tsay SH, Li CP, Wu JC, Chang FY, Lee SD. 2001. Clinical, virological, and pathologic significance of elevated serum alpha-fetoprotein levels in patients with chronic hepatitis C. *J Clin Gastroenterol* 32:240–244.
- Donlin MJ, Cannon NA, Yao E, Li J, Wahed A, Taylor MW, Belle SH, Di Bisceglie AM, Aurora R, Tavis JE. 2007. Pretreatment sequence diversity differences in the full-length hepatitis C virus open reading frame correlate with early response to therapy. *J Virol* 81:8211–8224.
- El-Shamy A, Nagano-Fujii M, Sasase N, Imoto S, Kim SR, Hotta H. 2008. Sequence variation in hepatitis C virus nonstructural protein 5A predicts clinical outcome of pegylated interferon/ribavirin combination therapy. *Hepatology* 48:38–47.
- Enomoto N, Sakuma I, Asahina Y, Kurosaki M, Murakami T, Yamamoto C, Ogura Y, Izumi N, Marumo F, Sato C. 1996. Mutations in the nonstructural protein 5A gene and response to interferon in patients with chronic hepatitis C virus 1b infection. *N Engl J Med* 334:77–81.
- Fishman SL, Factor SH, Balestrieri C, Fan X, Dibisceglie AM, Desai SM, Benson G, Branch AD. 2009. Mutations in the hepatitis C virus core gene are associated with advanced liver disease and hepatocellular carcinoma. *Clin Cancer Res* 15:3205–3213.
- Fried MW, Shiffman ML, Reddy R, Smith C, Marinos G, Gonçales FL, Häussinger D, Diago M, Carosi G, Dhumeaux D, Craxi A, Lin A, Hoffman J, Yu J. 2002. Peginterferon alfa-2a plus ribavirin for chronic hepatitis C virus infection. *N Engl J Med* 347: 975–982.
- Ge D, Fellay J, Thompson AJ, Simon JS, Shianna KV, Urban TJ, Heinzen EL, Qiu P, Bertelsen AH, Muir AJ, Sulkowski M, McHutchison JG, Goldstein DB. 2009. Genetic variation in *IL28B* predicts hepatitis C treatment-induced viral clearance. *Nature* 461:399–401.
- Hézode C, Forestier N, Dusheiko G, Ferenci P, Pol S, Goeser T, Bronowicki JP, Bourlière M, Gharakhanian S, Bengtsson L, McNair L, George S, Kieffer T, Kwong A, Kauffman RS, Alam J, Pawlotsky JM, Zeuzem S, PROVE2 Study Team. 2009. Telaprevir and peginterferon with or without ribavirin for chronic HCV infection. *N Engl J Med* 360:1839–1850.
- Hu KQ, Kyulo NL, Lim N, Elhazin B, Hillebrand DJ, Bock T. 2004. Clinical significance of elevated alpha-fetoprotein (AFP) in patients with chronic hepatitis C, but not hepatocellular carcinoma. *Am J Gastroenterol* 99:860–865.
- Kato N, Hijikata M, Ootsuyama Y, Nakagawa M, Ohkoshi S, Sugimura T, Shimotohno K. 1990. Molecular cloning of the human hepatitis C virus genome from Japanese patients with non-A, non-B hepatitis. *Proc Natl Acad Sci USA* 87:9524–9528.
- Kieffer TL, Sarrazin C, Miller JS, Welker MW, Forestier N, Reesink HW, Kwong AD, Zeuzem S. 2007. Telaprevir and pegylated interferon-alpha-2a inhibit wild-type and resistant genotype 1 hepatitis C virus replication in patients. *Hepatology* 46:631–639.
- Lin C, Gates CA, Rao BG, Brennan DL, Fulghum JR, Luong YP, Frantz JD, Lin K, Ma S, Wei YY, Perni RB, Kwong AD. 2005. In vitro studies of cross-resistance mutations against two hepatitis C virus serine protease inhibitors, VX-950 and BILN 2061. *J Biol Chem* 280:36784–36791.
- Lin C, Kwong AD, Perni RB. 2006. Discovery and development of VX-950, a novel, covalent, and reversible inhibitor of hepatitis C virus NS3/4A serine protease. *Infect Disord Targets* 6:3–16.
- Manns MP, McHutchison JG, Gordon SC, Rustgi VK, Shiffman M, Reindollar R, Goodman ZD, Koury K, Ling MH, Albrecht JK. 2001. Peginterferon alfa-2b plus ribavirin compared with interferon alfa-2b plus ribavirin for initial treatment of chronic hepatitis C: A randomized trial. *Lancet* 358:958–965.
- McHutchison JG, Everson GT, Gordon SC, Jacobson IM, Sulkowski M, Kauffman R, McNair L, Alam J, Muir AJ, PROVE1 Study Team. 2009. Telaprevir with peginterferon and ribavirin for chronic HCV genotype 1 infection. *N Engl J Med* 360:1827–1838.
- McHutchison JG, Manns MP, Muir AJ, Terrault NA, Jacobson IM, Afdhal NH, Heathcote EJ, Zeuzem S, Reesink HW, Garg J, Bsharat M, George S, Kauffman RS, Adda N, Di Bisceglie AM, PROVE3 Study Team. 2010. Telaprevir for previously treated chronic HCV infection. *N Engl J Med* 362:1292–1303.
- Modi AA, Hoofnagle JH. 2007. New therapies for hepatitis C. *Hepatology* 46:615–617.
- Ohnishi Y, Tanaka T, Ozaki K, Yamada R, Suzuki H, Nakamura Y. 2001. A high-throughput SNP typing system for genome-wide association studies. *J Hum Genet* 46:471–477.
- Suppiah V, Moldovan M, Ahlenstiel G, Berg T, Weltman M, Abate ML, Bassendine M, Spengler U, Dore GJ, Powell E, Riordan S, Sheridan D, Smedile A, Fragomeli V, Müller T, Bahlo M, Stewart GJ, Booth DR, George J. 2009. *IL28B* is associated with response to chronic hepatitis C interferon-alpha and ribavirin therapy. *Nat Genet* 41:1100–1104.
- Suzuki A, Yamada R, Chang X, Tokunishi S, Sawada T, Suzuki M, Nagasaki M, Nakayama-Hamada M, Kawaida R, Ono M, Ohtsuki M, Furukawa H, Yoshino S, Yukioka M, Tohma S, Matsubara T, Wakitani S, Teshima E, Nishioka Y, Sekine A, Iida A, Takahashi A, Tsunoda T, Nakamura Y, Yamamoto K. 2003. Functional haplotypes of *PADI4*, encoding citrullinating enzyme peptidylarginine deaminase 4, are associated with rheumatoid arthritis. *Nat Genet* 34:395–402.
- Suzuki F, Suzuki Y, Akuta N, Sezaki H, Hirakawa M, Kawamura Y, Hosaka T, Kobayashi M, Saito S, Arase Y, Ikeda K, Kobayashi M, Chayama K, Kamatani N, Nakamura Y, Miyakawa Y, Kumada H. 2011. Influence of *ITPA* polymorphisms on decreases of hemoglobin during treatment with pegylated interferon, ribavirin, and telaprevir. *Hepatology* 53:415–421.
- Tanaka Y, Nishida N, Sugiyama M, Kurosaki M, Matsuura K, Sakamoto N, Nakagawa M, Korenaga M, Hino K, Hige S, Ito Y, Mita E, Tanaka E, Mochida S, Murawaki Y, Honda M, Sakai A, Hiasa Y, Nishiguchi S, Koike A, Sakaida I, Imamura M, Ito K, Yano K, Masaki N, Sugauchi F, Izumi N, Tokunaga K, Mizokami M. 2009. Genome-wide association of *IL28B* with response to

- pegylated interferon-alpha and ribavirin therapy for chronic hepatitis C. *Nat Genet* 41:1105–1109.
- Thomas DL, Thio CL, Martin MP, Qi Y, Ge D, O'Huigin C, Kidd J, Kidd K, Khakoo SI, Alexander G, Goedert JJ, Kirk GD, Donfield SM, Rosen HR, Tobler LH, Busch MP, McHutchison JG, Goldstein DB, Carrington M. 2009. Genetic variation in IL28B and spontaneous clearance of hepatitis C virus. *Nature* 461:798–801.
- Zeuzem S. 2008. Telaprevir, peginterferon alfa-2a, and ribavirin for 28 days in chronic hepatitis C patients. *J Hepatol* 49:157–159.
- Zeuzem S, Andreone P, Pol S, Lawitz E, Diago M, Roberts S, Focaccia R, Younossi Z, Foster GR, Horban A, Ferenci P, Nevens F, Müllhaupt B, Pockros P, Terg R, Shouval D, van Hoek B, Weiland O, Van Heeswijk R, De Meyer S, Luo D, Boogaerts G, Polo R, Picchio G, Beumont M, REALIZE Study Team. 2011. Telaprevir for retreatment of HCV infection. *N Engl J Med* 364:2417–2428.

Original Article

Prevalence and predictive factors of diabetes in hepatitis virus positive liver cirrhosis with fasting plasma glucose level of <126 mg/dL

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Aim: The aim of this study was to evaluate the prevalence and predictive factors of diabetes in hepatitis virus positive liver cirrhotic patients with fasting plasma glucose (FPG) level of <126 mg/dL.

Methods: A total of 263 patients with hepatitis C virus (HCV) or hepatitis B virus (HBV) positive liver cirrhosis, FPG level of <126 mg/dL, and had diabetes status evaluated by the use of 75-g oral glucose tolerance test (OGTT), were enrolled in this study. Plasma glucose and insulin levels were analyzed periodically for 3 h after oral glucose loading. Diabetes was defined as a 2-h post-load glucose on the OGTT of ≥ 200 mg/dL. The prevalence of diabetes by use of OGTT and predictive factors for diabetes were evaluated by the use of the Mann-Whitney *U*-test, Fisher's exact probability test or multivariate analysis by logistic regression. Hypoalbuminemia was defined as serum albumin level of <3.9 g/dL. Elevated indocyanine

green retention rate at 15 min (ICG_{R15}) was regarded as $\geq 25\%$.

Results: Out of 263 patients, 44 (16.7%) were diagnosed as having diabetes. Multivariate analysis showed that diabetes occurred when patients had hypoalbuminemia of <3.9 g/dL (odds ratio [OR] 2.33; 95% confidential interval [CI] = 1.04–5.24; *P* = 0.040) and ICG_{R15} of <25% (OR 2.36; 95%CI = 1.01–5.58).

Conclusions: Hypoalbuminemia and elevated ICG_{R15} in hepatitis virus related cirrhotic patients with FPG level of <126 mg/day enhance diabetes pattern after OGTT with significant difference.

Key words: diabetes mellitus, hepatitis virus, liver cirrhosis, oral glucose tolerance test

INTRODUCTION

HEPATITIS C VIRUS (HCV) is one of the more common causes of chronic liver disease worldwide. Chronic hepatitis C is an insidiously progressive form of liver disease that relentlessly but silently progresses to cirrhosis and/or hepatocellular carcinoma over a period of 10–30 years.^{1–5} Lately, it have been

reported that chronic HCV infection is associated with type 2 diabetes mellitus (T2DM).^{9–11} Moreover, T2DM has been suggested to enhance with the development of HCC and poor prognosis of liver transplantation.^{12–15} Thus, early intervention to prevent or improve T2DM is necessary to get good prognosis in HCV patients.

However, the big problem in chronic liver disease is that fasting serum glucose (FPG) often shows normal level. Hence, examination of oral glucose tolerance test (OGTT) is necessary to evaluate diagnosis of precise diabetes in patients with chronic liver disease. With this background, we evaluated the prevalence of abnormal glucose state and predictive factors for diabetes in HCV positive liver cirrhosis patients with fasting plasma glucose level of <126 mg/dL. We investigated the

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prevalence of abnormal glucose state and predictive factors for diabetes in hepatitis B virus (HBV) positive patients with liver cirrhosis and compared with HCV.

METHODS

Patients

A TOTAL OF 263 Japanese patients who were diagnosed with liver cirrhosis by laparoscopic and/or histological findings from December 1998 to January 2005 in the Department of Hepatology, Toranomon Hospital, Tokyo, Japan were enrolled. Inclusion criteria were as follows: (i) evidence of liver cirrhosis by laparoscopy and/or histological findings; (ii) FPG level of <126 mg/dL; (iii) evidence of HCV or HBV by serum examination; (iv) negativity for antinuclear antibodies, or antimitochondrial antibodies in serum, as determined by indirect immunofluorescence assay; (v) no evidence of HCC nodules as shown by ultrasonography and/or computed tomography; (vi) no underlying systemic disease, such as systemic lupus erythematosus, rheumatic arthritis. Patients with any of the following criteria were excluded from the study: (i) advanced liver cirrhosis of encephalopathy, bleeding esophageal varices, or ascites, (ii) a history of diabetes, (iii) taking medicines that may influence on glucose tolerance such as branched chain amino acid (BCAA), thiazide diuretics, and angiotensin receptor antagonist.

A total of 263 patients with FPG of <126 mg/dL undertook a 75-g OGTT. Plasma glucose levels were analyzed periodically for 3 h after oral glucose loading. Impaired glucose tolerance (IGT) were defined as a 2-h post-load glucose on the OGTT of ≥ 140 mg/dL, but <200 mg/dL. Diabetes was defined as a 2-h post-load glucose on the OGTT of ≥ 200 mg/dL. T2DM was diagnosed by the use of the 2003 criteria of the American Diabetes Association.¹⁶

The index of insulin resistance was calculated on the fasting glucose and insulin by the homeostasis model for insulin resistance (HOMA-IR). Insulin secretion was calculated by the insulinogenic index (IGI); $IGI = (Ins_{30} - Ins_0) / (Glc_{30} - Glc_0)$, Ins_0 : fasting plasma insulin (mU/L); Ins_{30} : insulin 30 min after glucose intake (IU/mL); Glc_0 : fasting plasma glucose (mg/dL); and Glc_{30} : plasma glucose 30 min after glucose intake (mg/dL).

The physicians in charge explained the purpose and method of the OGTT to each patient. Informed consent was obtained from all patients included in the present study. All of the studies were performed retrospectively by collecting and analyzing data from the patient

records. This study had been approved by the Institutional Review Board of our hospital.

Clinical and laboratory analysis

Anthropometric analysis included height, weight and body mass index (BMI), and the latter was calculated as weight (kg) divided by the square of the height (m^2). Laboratory analysis was performed via standard laboratory methods. The biochemical parameters included aspartate aminotransferase (AST), alanine aminotransferase (ALT), γ -glutamyltransferase (GGT), total cholesterol, high density lipoprotein (HDL) cholesterol, triglyceride, albumin, platelet, fasting plasma glucose (FPG) and fasting insulin. Serum insulin levels were measured with a solid-phase radioimmunoassay (Diagnostic Products Corporation, Los Angeles, CA, USA). Hypoalbuminemia was defined as serum albumin level of <3.9 g/dL. Elevated indocyanine green retention rate at 15 min (ICG r_{15}) was regarded as $\geq 25\%$.

Laboratory investigation

Hepatitis B surface antigen (HBsAg) was assayed using commercially available radioimmunoassay kits. Antibody against HCV was detected with a third-generation enzyme-linked immunoassay. HCV-RNA was determined by the Amplicor method (Cobas Amplicor HCV Monitor Test, v2.0, Roche, Tokyo, Japan). HbA1c was measured using a high performance liquid chromatography (HPLC) method. Height and weight were recorded at baseline and the body mass index (BMI) was calculated as weight (in kg)/height (in m^2).

Statistical analysis

The results are presented as means \pm standard deviation (SD) or as numbers. Statistical differences in quantitative data were determined using the Mann-Whitney U-test, Fisher's exact probability test or multivariate analysis by logistic regression.

Multivariate analysis for diabetes was carried out by logistic regression. The Statistical Program for Social Sciences software package (SPSS 11.5 for Windows, SPSS, Chicago, IL, USA) was used to perform statistical analysis. A *P*-value < 0.05 was considered to be statistically significant.

RESULTS

Patients' characteristics

TABLE 1 SHOWS the characteristics at the day of evaluating OGTT in the 263 enrolled patients. The

Table 1 Clinical characteristics of cirrhotic patients with hepatitis C virus (HCV)†

Characteristic	
<i>n</i>	263
Sex (male/female)	178/85
Age (years)	51.6 ± 11.2
Body mass index	21.8 ± 3.0
HBV/HCV	96/167
Fasting plasma glucose (mg/dL)	84 ± 13
Albumin (g/dL)	4.1 ± 0.5
Total cholesterol (g/dL)	163 ± 37
HDL cholesterol (g/dL)	47 ± 13
Triglyceride (mg/dL)	98 ± 35
Uric acid (mg/dL)	5.2 ± 1.2
AST (IU/L)	78 ± 70
ALT (IU/L)	72 ± 68
GGT (IU/L)	74 ± 50
Platelet (×10 ⁴ /mm ³)	11.3 ± 4.1
ICG _{R15} (%)	25.4 ± 14.0

†Data are number of patients or mean ± standard deviation. ALT, alanine aminotransferase; AST, aspartate aminotransferase; GGT, γ -glutamyltransferase; HBV, hepatitis B virus; HDL, high density lipoprotein; ICG_{R15}; indocyanine green retention rate at 15 min.

mean age was 51.6 years and mean FPG level was 84 mg/dL. The serum albumin level was 4.1 ± 0.5 g/dL and ICG_{R15} was 26.5 ± 14.0%. On the diagnosis of liver cirrhosis, 160 of 263 patients were diagnosed by laparoscopy and liver biopsy; 69 patients were diagnosed

by laparoscopy only; 34 patients were diagnosed by biopsy only.

Prevalence of IGT and diabetes in hepatitis virus positive liver cirrhosis with FPG of <126 mg/dL

Out of 263 patients who had hepatitis virus-related liver cirrhosis with FPG of <126 mg/dL, 44 (16.7%) patients were diagnosed as having DM and 73 (27.8%) patients were diagnosed as having IGT. Table 2 shows the predictive factors for DM pattern by the use of OGTT in hepatitis virus related cirrhotic patients. Multivariate analysis showed that diabetes occurred when patients had hypoalbuminemia of <3.9 g/dL (odds ratio [OR] 2.33; 95% confidential interval [CI] = 1.04–5.24; *P* = 0.040) and ICG_{R15} of <25% (OR 2.36; 95%CI = 1.01–5.58). Table 3 shows the incidence of diabetes based on serum albumin and ICG_{R15}. The incidence of diabetes in patients with hepatitis virus related liver cirrhosis was 5.8% (7/120) in group A with serum albumin level of ≥3.9 g/dL and ICG_{R15} of <25%. On the other hand, that was 35.6% (21/59) in group B with hypoalbuminemia of <3.9 g/dL and ICG_{R15} of ≥25%.

Changes of glucose state based on difference of serum albumin level

Table 4 shows the glucose and insulin dynamics after OGTT in cirrhotic patients that belonged to group A with serum albumin level of ≥3.9 g/dL and ICG_{R15} of

Table 2 Predictive factors for diabetes in cirrhotic patients with hepatitis C virus (HCV)

Variables	Univariate analysis		Multivariate analysis	
	OR (95% CI)	<i>P</i> -value	OR (95% CI)	<i>P</i> -value
Age (per 10 years)	1.50 (1.04–2.16)	0.031		
Gender (M/F)	1.08 (0.52–2.23)	0.842		
Body mass index (per 5)	1.18 (0.59–2.36)	0.631		
HCV/HBV	2.38 (1.05–5.43)	0.039		
AST (IU/L, ≥37/<37)	1.01 (0.45–2.25)	0.996		
ALT (IU/L, ≥42/<42)	0.81 (0.40–1.65)	0.563		
GGT (IU/L, ≥109/<109)	1.89 (0.66–5.45)	0.238		
Platelet (×10 ⁴ /mm ³ , <10/≥10)	2.59 (1.26–5.32)	0.009		
Albumin (g/dL, <3.9/≥3.9)	3.40 (1.66–6.94)	0.001	2.33 (1.04–5.24)	0.040
Triglyceride (mg/dL, ≥150/<150)	2.26 (0.74–6.90)	0.152		
Total cholesterol (mg/dL, ≥180/<180)	0.69 (0.30–1.60)	0.387		
HDL cholesterol (mg/dL, <40/≥40)	1.09 (0.43–2.73)	0.857		
ICGR15 (% , ≥25/<25)	3.64 (1.67–7.95)	0.001	2.36 (1.01–5.58)	0.049

ALT, alanine aminotransferase; AST, aspartate aminotransferase; GGT, γ -glutamyltransferase; HBV, hepatitis B virus; HDL, high density lipoprotein; ICG_{R15}, indocyanine green retention rate at 15 min; OR, odds ratio.

Table 3 Diabetic rate based on serum albumin and ICG_{R15}

	Albumin; ≥ 3.9 g/dL	Albumin; < 3.9 g/dL	Total
ICG _{R15} < 25 (%)	5.8% (7/120)	15.0% (3/20)	7.1% (10/140)
ICG _{R15} ≥ 25 (%)	20.3% (13/64)	35.6% (21/59)	27.6% (34/123)
Total	10.9% (20/184)	30.4% (24/79)	16.7% (44/263)

ICG_{R15}, indocyanine green retention rate at 15 min.

$< 25\%$ or group B with serum albumin level of < 3.9 g/dL and ICG_{R15} of $\geq 25\%$. The serum glucose levels at 0, 60, 90, 120, and 180 min after the initiation of OGTT in patients with serum albumin level of < 3.9 g/dL and ICG_{R15} of $\geq 25\%$ were statistically higher than those in patients with serum albumin level of ≥ 3.9 g/dL and ICG_{R15} of $< 25\%$. HOMA-IR in patients with serum albumin level of < 3.9 g/dL and ICG_{R15} of $\geq 25\%$ was higher than that in patients with serum albumin level of ≥ 3.9 g/dL and ICG_{R15} of $< 25\%$. IGI in patients with serum albumin level of < 3.9 g/dL and ICG_{R15} of $\geq 25\%$ was lower than that in patients with serum albumin level of ≥ 3.9 g/dL and ICG_{R15} of $< 25\%$.

DISCUSSION

WE HAVE DESCRIBED the prevalence of abnormal glucose state and predictive factors for diabetes in HCV or HBV positive liver cirrhosis patients with fasting plasma glucose level of < 126 mg/dL in the present study. Enrolled patients had liver cirrhosis diagnosed with laparoscopy and/or histological examination.

There are sometimes discrepancies between laparoscopic finding and histological findings in patients with HCV.¹⁷ Thus, in the present study, cirrhotic patients diagnosed by either laparoscopy and/or histological examination were enrolled.

The present study shows several findings with regard to the prevalence of abnormal glucose state in hepatitis virus related cirrhotic patients with FPG level of < 126 mg/dL. First, approximately 17% of the cirrhotic patients with FPG level of < 126 mg/dL had diabetic pattern by the OGTT. If OGTT was not performed in patients who were diagnosed as having diabetes after OGTT, diabetes would be missed.

Second, multivariate analysis suggested that lower serum albumin level and elevated ICG_{R15} were independent risk factors of diabetes mellitus. Our result shows that patients with hypoalbuminemia and elevated ICG_{R15} should pay attention to complication of T2DM even if FPG is in the normal range. In the present study, hypoalbuminemia was defined as serum albumin level of < 3.9 g/dL and elevated ICG_{R15} was regarded as $\geq 25\%$. As the serum albumin level (mean \pm standard deviation)

Table 4 Glucose and Insulin dynamics after oral glucose tolerance test (OGTT) in cirrhotic patients

	Group A (albumin; < 3.9 g/dL) (ICG _{R15} ; $\geq 25\%$)	Group B (albumin; ≥ 3.9 g/dL) (ICG _{R15} ; $< 25\%$)	P-value
Number	59	120	
HOMA-IR	3.22 \pm 2.24	2.14 \pm 1.12	0.003
IGI	0.70 \pm 0.53	0.96 \pm 0.83	0.042
Glucose (mg/dL)			
At 0 min	89.3 \pm 12.0	82.8 \pm 10.3	0.034
At 30 min	170.3 \pm 42.1	159.4 \pm 31.4	0.058
At 60 min	200.6 \pm 70.7	168.0 \pm 49.9	0.020
At 90 min	206.3 \pm 64.8	168.0 \pm 62.0	0.002
At 120 min	179.7 \pm 68.5	136.3 \pm 49.0	< 0.001
At 180 min	153.4 \pm 64.2	117.7 \pm 59.3	< 0.001
Insulin (ml/L)			
At 0 min	14.1 \pm 9.4	10.4 \pm 5.1	0.011
At 30 min	72.1 \pm 36.3	75.1 \pm 31.9	0.758
At 120 min	138.4 \pm 76.5	102.1 \pm 62.8	0.004

HOMA-IR, homeostasis model for insulin resistance; IGI, insulinogenic index.

of the approximately 70 000 subjects without liver damage and kidney damage in our hospital was 4.5 ± 0.3 g/dL, lower limit of normal albumin level was defined as 3.9 g/dL (=mean-2 × standard deviation). On ICG_{R15}, we divided the patients into two groups based on mean level of 25%. The hypoalbuminemia and elevated ICG_{R15} indicates the severity of liver cirrhosis. Thus, our results suggest that severity of liver cirrhosis was the most important factor for predicting T2DM. The reported predictive factors of diabetes mellitus in liver cirrhosis were age, male, BMI, and Child–Pugh score.^{9,10,18–21} Quintana *et al.* have reported hypoalbuminemia as risk factor of diabetes mellitus in cirrhotic patients.²² On the other hand, EL-Serag *et al.* have reported that hepatogeneous diabetes is less frequently associated with risk factors such as age, BMI, and family history of diabetes.²³

Third, patients with serum albumin level of <3.9 g/dL and ICG_{R15} of ≥25% revealed high insulin resistance and low insulin secretion compared to patients with serum albumin level of ≥3.9 g/dL and ICG_{R15} of <25%. This result suggests that insulin resistance and insulin secretion are associated with the onset of diabetes in advanced liver cirrhosis.

The precise mechanism of hepatogeneous diabetes is not precisely known. The possible mechanism is the following: (i) insulin resistance of muscle and adipose tissue; and (ii) impairment of the insulin secretion activity of the beta-cells of the pancreas.^{24,25} Our results show the elevated insulin resistance and decrease of insulinogenic index. Thus, our results agreed with the possible mechanism of hepatogeneous diabetes.

The limitation of present study is that our cohort contains Japanese patients only. Thus, the result needs to be confirmed in other ethnic groups. Moreover, in patients with chronic liver disease, HbA1c levels have been seen to be apparently lower than real values due to a shortened half-life of erythrocytes originating from hypersplenism.²⁶ Thus, we could not evaluate the HbA1c in the present study.

In conclusion, our data suggest that physicians in charge of hepatitis virus related cirrhotic patients with hypoalbuminemia and elevated ICG_{R15} should pay attention to complication of diabetes.

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REFERENCES

- 1 Kiyosawa K, Furuta S. Review of hepatitis C in Japan. *J Gastroenterol Hepatol* 1991; 6: 383–91.
- 2 Alter MJ, Margolis HS, Krawczynski K *et al.* The natural history of community acquired hepatitis C in the United States. *N Engl J Med* 1992; 327: 1899–905.
- 3 van Rossum TG, Vulto AG, de Man RA *et al.* Review article: glycyrrhizin as a potential treatment for chronic hepatitis C. *Aliment Pharmacol Ther* 1998; 12: 199–205.
- 4 Colombo M, Kuo G, Choo QL *et al.* Prevalence of antibodies to hepatitis C virus in Italian patients with hepatocellular carcinoma. *Lancet* 1989; 2: 1006–8.
- 5 Hasan F, Jeffers LJ, De Medina M *et al.* Hepatitis C-associated hepatocellular carcinoma. *Hepatology* 1990; 12: 589–91.
- 6 Kew MC, Houghton M, Choo QL, Kuo G. Hepatitis C virus antibodies in southern African blacks with hepatocellular carcinoma. *Lancet* 1990; 335: 873–4.
- 7 Tsukuma H, Hiyama T, Tanaka S *et al.* Risk factors for hepatocellular carcinoma among patients with chronic liver disease. *N Engl J Med* 1993; 328: 1797–801.
- 8 Ikeda K, Saitoh S, Koida I *et al.* A multivariate analysis of risk factors for hepatocellular carcinogenesis: a prospective observation of 795 patients with viral and alcoholic cirrhosis. *Hepatology* 1993; 18: 47–53.
- 9 Imazeki F, Yokosuka O, Fukai K *et al.* Prevalence of diabetes mellitus and insulin resistance in patients with chronic hepatitis C: comparison with hepatitis B virus-infected and hepatitis C virus-cleared patients. *Liver Int* 2008; 28: 355–62.
- 10 Arao M, Murase K, Kusakabe A *et al.* Prevalence of diabetes mellitus in Japanese patients infected chronically with hepatitis C virus. *J Gastroenterol* 2003; 38: 355–60.
- 11 Arase Y, Suzuki F, Suzuki Y *et al.* Sustained virological response reduces incidence of onset of type 2 diabetes in chronic hepatitis C. *Hepatology* 2009; 49: 739–44.
- 12 Rouabhia S, Malek R, Bounecer H *et al.* Prevalence of type 2 diabetes in Algerian patients with hepatitis C virus infection. *World J Gastroenterol* 2010; 16: 3427–31.
- 13 Kawamura Y, Arase Y, Ikeda K *et al.* Diabetes enhances hepatocarcinogenesis in noncirrhotic, interferon-treated hepatitis C patients. *Am J Med* 2010; 123: 951–6.e1.
- 14 Veldt BJ, Chen W, Heathcote EJ *et al.* Increased risk of hepatocellular carcinoma among patients with hepatitis C cirrhosis and diabetes mellitus. *Hepatology* 2008; 47: 1856–62.
- 15 Imai K, Takai K, Nishigaki Y *et al.* Insulin resistance raises the risk for recurrence of stage 1 hepatocellular carcinoma after curative radiofrequency ablation in hepatitis C virus-positive patients. *Hepatol Res* 2010; 40: 376–82.
- 16 Genuth S, Alberti KG, Bennett P *et al.* Expert Committee on the Diagnosis and Classification of Diabetes Mellitus. Follow-up report on the diagnosis of diabetes mellitus. *Diabetes Care* 2003; 26: 3160–7.

- 17 Arase Y, Suzuki F, Suzuki Y *et al.* Potential of laparoscopy in chronic liver disease with hepatitis B and C viruses. *Hepatol Res* 2008; 38: 877-85.
- 18 Caronia S, Taylor K, Pagliaro L *et al.* Further evidence for an association between non-insulin-dependent diabetes mellitus and chronic hepatitis C virus infection. *Hepatology* 1999; 30: 1059-63.
- 19 Mason AL, Lau JY, Hoang N *et al.* Association of diabetes mellitus and chronic hepatitis C virus infection. *Hepatology* 1999; 29: 328-33.
- 20 Mangia A, Schiavone G, Lezzi G *et al.* HCV and diabetes mellitus: evidence for a negative association. *Am J Gastroenterol* 1998; 93: 2363-7.
- 21 Custro N, Carroccio A, Ganci A *et al.* Glycemic homeostasis in chronic viral hepatitis and liver cirrhosis. *Diabetes Metab* 2001; 27: 476-81.
- 22 Quintana JO, García-Compeán D, González JA *et al.* The impact of diabetes mellitus in mortality of patients with compensated liver cirrhosis-a prospective study. *Ann Hepatol* 2011; 10: 56-62.
- 23 El-Serag HB, Hran T, Everhart JE. Diabetes increases the risk of chronic liver disease and hepatocellular carcinoma. *Gastroenterology* 2004; 126: 460-8.
- 24 Nishida T, Tsuji S, Tsuji M *et al.* Oral glucose tolerance test predicts prognosis of patients with liver cirrhosis. *Am J Gastroenterol* 2006; 101: 70-5.
- 25 Garcia-Compean D, Jaquez-Quintana JO, Gonzalez-Gonzalez JA, Maldonado-Garza H. Liver cirrhosis and diabetes: risk factors, pathophysiology, clinical implications and management. *World J Gastroenterol* 2009; 15: 280-8.
- 26 Koga M, Kasayama S, Kanehara H, Bando Y. CLD (chronic liver diseases)-HbA1C as a suitable indicator for estimation of mean plasma glucose in patients with chronic liver diseases. *Diabetes Res Clin Pract* 2008; 81: 258-62.

Transcatheter Arterial Chemotherapy Using Miriplatin–Lipiodol Suspension with or without Embolization for Unresectable Hepatocellular Carcinoma

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Objective: The purpose of this retrospective study was to compare the anti-tumor and adverse effects of transcatheter arterial chemoembolization and transcatheter arterial infusion chemotherapy using miriplatin–lipiodol suspension in patients with unresectable hepatocellular carcinoma.

Methods: From 2007 to 2010, 162 consecutive patients with unresectable hepatocellular carcinoma were treated using miriplatin. Of these, 122 patients were treated by transcatheter arterial chemoembolization and 40 were treated by transcatheter arterial infusion chemotherapy. There were no significant differences in baseline characteristics between the two groups, except for prothrombin activity. Assessments were performed 1–3 months after treatment.

Results: Objective responses were achieved in 13 patients undergoing transcatheter arterial infusion chemotherapy and 70 patients undergoing transcatheter arterial chemoembolization (33 versus 57%, $P = 0.003$). By multivariate logistic regression analysis, objective response was significantly associated with (i) a *Lens culinaris* agglutinin-reactive fraction of α -fetoprotein $\leq 10\%$ ($P = 0.004$; risk ratio = 3.09; 95% confidence interval = 1.42–6.70), (ii) no previous transcatheter arterial chemoembolization ($P = 0.007$; risk ratio = 4.41; 95% confidence interval = 1.49–13.07) and (iii) transcatheter arterial chemoembolization using gelatin sponge 1 mm particles ($P = 0.021$; risk ratio = 2.97; 95% confidence interval = 1.17–7.49). Fever, anorexia and elevated serum transaminase levels were observed in most patients after miriplatin administration; there were no significant differences in the number of adverse effects between the two groups.

Conclusions: These results suggest that the addition of embolizing agents to a treatment regimen using miriplatin–lipiodol suspension can be safely used for patients with unresectable hepatocellular carcinoma. Objective response was achieved in a significantly higher number of transcatheter arterial chemoembolization patients than transcatheter arterial infusion chemotherapy patients.

Key words: miriplatin – hepatocellular carcinoma – transcatheter arterial chemoembolization

INTRODUCTION

Hepatocellular carcinoma (HCC) is one of the most common malignant diseases worldwide (1). Since it is well known that more than 80% of HCC cases are associated with liver

cirrhosis, routine clinical evaluations of cirrhotic patients that include ultrasound could potentially lead to the detection of small HCCs (2–4). Curative therapies, including resection, liver transplantation and percutaneous ablation

(percutaneous ethanol injection and radiofrequency ablation), are applicable to only 30–40% of HCC patients. For patients with advanced HCC, transcatheter arterial chemoembolization (TACE) has been recognized as an effective palliative treatment option (5–12).

Although many chemotherapeutic agents, including doxorubicin, epirubicin, mitomycin C and cisplatin, are used with lipiodol, a lipid lymphographic agent consisting of ethyl esters of iodized fatty acids from poppy seed oil (Lipiodol Ultra-Fluide; Laboratoire Guerbet, Aulnay-Sous-Bois, France), the best choices for first- and second-line drugs for TACE remain uncertain (13–15). Miriplatin (*cis*-[[(1*R*,2*R*)-1,2-cyclohexanediamine-*N,N'*bis(myristato)]-platinum(II)monohydrate; Dainippon Sumitomo Pharma Co., Ltd, Osaka, Japan) is a novel lipophilic cisplatin derivative that can be suspended in lipiodol (16–19). When lipiodol is injected into an artery supplying HCC nodules, it selectively accumulates in the tumor. A miriplatin–lipiodol suspension deposited within HCC nodules will gradually release active platinum compounds into tumor tissues. Clinical trials have demonstrated that miriplatin is effective in the treatment of HCC, but the addition of embolizing agents to miriplatin–lipiodol suspension has not been evaluated (20,21). We hypothesized that the addition of embolizing agents to miriplatin–lipiodol suspension would increase the anti-tumor effects in patients with HCC. The purpose of this retrospective study was to compare the anti-tumor effects and adverse effects of TACE and transcatheter arterial infusion chemotherapy (TAI) using miriplatin–lipiodol suspension in patients with unresectable HCC.

PATIENTS AND METHODS

STUDY POPULATION

From December 2007 to December 2010, 162 consecutive patients with unresectable HCC were treated using transcatheter arterial chemotherapy with a miriplatin–lipiodol suspension at our institution. Of these, 122 patients were treated using TACE and 40 were treated using TAI. The patients were divided into two groups primarily based on when they were treated. After the approval of miriplatin in Japan, miriplatin was initially administered by TAI. After our experience using TAI plus miriplatin, TACE was used with miriplatin. Patients in the TAI group were mainly treated from January 2010 to May 2010, and patients in the TACE group were mainly treated from June 2010 to December 2010. The study protocol was approved by the ethics committee of our hospital, and written informed consent was obtained from all participating patients.

CHARACTERIZATION OF HEPATOCELLULAR CARCINOMAS

Before treatment with miriplatin, all patients underwent comprehensive evaluations consisting of medical history, physical examination, measurement of tumor size,

assessment of performance status, chest radiography, liver imaging studies [dynamic computerized tomography (dynamic CT), ultrasonography (US), digital subtraction angiography (DSA)], complete blood count and blood chemistries.

The clinical diagnosis of HCC was based on the findings of dynamic CT, US or DSA and increased serum levels of α -fetoprotein (AFP) and/or des- γ -carboxyprothrombin (DCP). Imaging studies included triphasic contrast-enhanced CT with bolus contrast injection and CT during arterial portography combined with CT during hepatic arteriography at the time of TACE. Lesions that appeared hypervascular during the arterial phase and that had relatively low density on the portal venous phase were diagnosed as HCC. Patients who had extrahepatic metastases of HCC or other malignancies were excluded.

Tumor staging was performed according to the criteria of the Liver Cancer Study Group of Japan (22) and was based on the following three criteria: (i) solitary tumor, (ii) <2 cm in diameter and (iii) no vessel invasion. Stage I (T1) was defined as fulfilling all three criteria; Stage II (T2) as fulfilling two criteria; Stage III (T3) as one of three criteria; and Stage IVA (T4) as none of the three criteria with no distant metastasis, or any T factor with lymph node metastasis; and Stage IVB as any T factor with distant metastasis.

There were 129 patients (80%) who had undergone previous TACE. Among these patients, the median number of TACE procedures was 4 (range, 1–13), and the median interval between the last previous TACE procedure and miriplatin administration was 4 months (range, 1–41).

TREATMENTS

Patients were hydrated through a peripheral line. The femoral artery was catheterized after administering local anesthesia, and the catheter was inserted super-selectively into the hepatic artery that supplied the target tumor. The dosage of miriplatin was limited to 120 mg. The miriplatin–lipiodol suspension was slowly administered under fluoroscopic guidance. In the TAI patients, the miriplatin–lipiodol suspension was administered through tumor-supplying vessels until stasis and reflux were achieved. In the TACE patients, 1 mm gelatin sponge particles (Gelpart; Nippon Kayaku, Tokyo, Japan) were injected after the administration of the miriplatin–lipiodol suspension until stasis and reflux were achieved. TACE was performed for patients without thrombus of the main portal vein and severe liver dysfunction. Each dose of miriplatin–lipiodol was determined according to the size of the tumor and the degree of liver dysfunction.

ASSESSMENT OF THERAPEUTIC EFFECT

The effect of chemotherapy was evaluated by dynamic CT 1–3 months after TACE or TAI and was based on changes in the maximum diameters of the viable target lesions, that

is, lesions showing enhancement in the arterial phase. The categories of responses were based on the modified Response Evaluation Criteria in Solid Tumors (mRECIST) as follows: complete response (CR) = disappearance of any intratumoral arterial enhancement in all target lesions; partial response (PR) = at least a 30% decrease in the sum of diameters of viable (enhancement in the arterial phase) target lesions; stable disease (SD) = any patient not qualifying for either PR or progressive disease (PD); and PD = an increase of at least 20% in the sum of the diameters of viable target lesions (23).

TOXICITY EVALUATIONS

Treatment-related toxicity was assessed using the National Cancer Institute Common Terminology Criteria version 4.0. Within 2 weeks before TACE or TAI with miriplatin, and at 3–7 days and 1 month after the procedures, the following toxicity evaluations were made: hematological assessments (leukocyte and thrombocyte counts) and clinical chemistry assessments [serum aspartate aminotransferase (AST), serum alanine aminotransferase (ALT), albumin, total bilirubin and prothrombin activity (PT)]. The indocyanine green retention rate at 15 min (ICG-R15) was assessed before and at 1 week after miriplatin administration.

STATISTICAL ANALYSIS

Distributions of patient characteristics were assessed by the χ^2 test, the Mann–Whitney *U*-test, the Friedman test, the Wilcoxon signed-rank test and Bonferroni adjustments as appropriate. Multivariate logistic regression analysis was used to determine significant predictors for objective response (CR or PR). All variables were expressed as medians (minimum–maximum). All tests were two-sided, and *P* values <0.05 were considered statistically significant. Statistical analyses were performed using SPSS, version 13.0 (SPSS Inc., IBM; Somers, New York, USA).

RESULTS

PATIENT CHARACTERISTICS

The clinical characteristics of the treatment groups are summarized in Table 1. At the time of miriplatin administration, there were 117 (72%) Child–Pugh class A patients and 45 (28%) class B patients. There were no significant differences between the two groups for any baseline characteristics except for PT.

There were 27 patients diagnosed with a solitary tumor, and 135 patients diagnosed with multiple tumors. The median maximum tumor size was 20 mm (range, 7–100 mm). There were 15 patients with Stage I, 75 patients with Stage II, 64 patients with Stage III and 8 patients with Stage IVA tumors.

One hundred and twenty-nine of 162 patients (80%) had a history of TACE, 108 (67%) patients previously received

Table 1. Characteristics of 162 hepatocellular patients who underwent transcatheter arterial chemotherapy using miriplatin

Variables ^a	Without embolization	With embolization	<i>P</i> value
Number of cases	40	122	
Age (years)	74 (45–91)	72 (45–87)	0.490 ^b
Gender (male)	75%	65%	0.230 ^c
Albumin (g/dl)	3.3 (2.5–4.2)	3.3 (2–4.2)	0.494 ^b
Total bilirubin (mg/dl)	1.1 (0.4–4.7)	1.1 (0.4–4.9)	0.864 ^b
Prothrombin (%)	78 (48–100)	83 (45–123)	0.034 ^b
Platelet ($\times 10^3/\mu\text{l}$)	83 (36–261)	93 (29–282)	0.485 ^b
Child–Pugh score	6 (5–9)	6 (5–9)	0.197 ^b
α -Fetoprotein (ng/ml)	67 (3–331 900)	31 (1.8–152 800)	0.517 ^b
Des- γ -carboxyprothrombin (AU/l)	39 (9–4626)	53 (6–65 290)	0.758 ^b
Dosage of miriplatin (mg)	75 (20–120)	80 (20–120)	0.981 ^b
Dosage of lipiodol (ml)	3 (1–6)	3 (1–6)	0.085 ^b
Tumor size (mm)	20 (7–82)	20 (10–100)	0.639 ^b
Number of tumors	4 (1–50)	4 (1–100)	0.725 ^b
Previous transcatheter arterial chemoembolization	80%	80%	0.946 ^c
Injection from segmental branch of the hepatic artery	10%	18%	0.229 ^c
Evaluation time point (months)	2.1 (1–3)	2.2 (1–3)	0.758 ^b

There were no significant differences between the two groups for any baseline characteristics except for PT.

^aVariables are expressed as median (minimum–maximum).

^bMann–Whitney *U*-test.

^c χ^2 test.

TACE with epirubicin and 50 (31%) previously received TACE with cisplatin. Among these patients, the median number of TACE procedures was 4 (range, 1–13), and the median interval between the last previous TACE procedure and miriplatin administration was 4 months (range, 1–41).

The median dosages of miriplatin were 75 mg (range, 20–120 mg) in the TAI group and 80 mg (range, 20–120 mg) in the TACE group (*P* = 0.981). In the TAI group, four patients (10%) were injected with the miriplatin–lipiodol suspension via the peripheral to segmental branch of the hepatic artery. Eleven patients (28%) were injected with the miriplatin–lipiodol suspension via the anterior or posterior segmental branch of the right hepatic artery. Twenty patients (50%) were injected with the miriplatin–lipiodol suspension via the right or left branch of the hepatic artery, and five patients (13%) were injected with the miriplatin–lipiodol suspension via the proper hepatic artery. In the TACE group, 22 patients (18%) were injected with the miriplatin–lipiodol suspension via the peripheral to segmental branch of the hepatic artery. Thirty patients (25%) were injected with the miriplatin–lipiodol suspension via the anterior or posterior segmental

branch of the right hepatic artery. Sixty-six patients (54%) were injected with the miriplatin–lipiodol suspension via the right or left branch of the hepatic artery, and four patients (3%) were injected with the miriplatin–lipiodol suspension via the proper hepatic artery.

TREATMENT EFFECTS

The times of the evaluations after treatment was not statistically significant between the two groups of patients ($P = 0.758$). Forty-one of 162 (25%) patients achieved CR, 42 (25%) achieved PR, 51 (31%) maintained SD and 28 (17%)

Table 2. Tumor response^a 1–3 months after miriplatin administration

	CR	PR	SD	PD	Total
Number of TAI patients (%)	6 (15%)	7 (18%)	18 (45%)	9 (22%)	40
Number of TACE patients (%)	35 (29%)	35 (29%)	33 (27%)	19 (15%)	122
<i>P</i> value	CR rate, $P = 0.084^b$ Objective response rate, $P = 0.003^b$				

TAI, transcatheter arterial infusion chemotherapy; TACE, transcatheter arterial chemoembolization; CR, complete response; PR, partial response; SD, stable disease; PD, progressive disease.
^aResponses assessed by mRECIST criteria.
^b*P* values were analyzed by the χ^2 test.

developed PD. In the TAI group, 6 of 40 (15%) patients achieved CR and 7 of 40 (18%) achieved PR, for an objective response rate of 33%. In the TACE group, 35 of 122 (29%) patients achieved CR and 35 of 122 (29%) patients achieved PR, for an objective response rate of 57%. Although there was no significant difference in the CR rate ($P = 0.084$), the objective response rate was significantly higher in the TACE group than in the TAI group ($P = 0.003$; Table 2).

Among the treatment-naïve patients with HCC, 10 of 32 (31%) patients achieved CR, 12 (38%) achieved PR, 8 (25%) maintained SD and 2 (6%) developed PD. In the TAI group, one of eight (13%) patients achieved CR and two of eight (25%) achieved PR, for an objective response rate of 38%. In the TACE group, 9 of 24 (38%) patients achieved CR and 10 of 24 (42%) patients achieved PR, for an objective response rate of 79%. There was no significant difference in the objective response rates of treatment-naïve patients undergoing TAI versus those undergoing TACE ($P = 0.072$).

RESULTS OF LABORATORY TESTING

Table 3 shows the results of blood samples tested before, 1 week after and 1 month after miriplatin administration. In the TAI group, the only significant difference seen after miriplatin administration was for AFP concentrations. PT, AFP and DCP values were significantly decreased in the TACE group. For multiple comparisons using Bonferroni adjustments, tumor markers were significantly decreased between

Table 3. Blood samples tested before, 1 week after and 1 month after miriplatin administration

	Pre-treatment	1 week	1 month	<i>P</i> value
TAI group ($n = 40$)				
Total bilirubin (mg/dl)	1.1 (0.4–4.7)	1.1 (0.5–4.6)	1.1 (0.4–5.4)	0.710 ^a
Albumin (g/dl)	3.3 (2.5–4.2)	–	3.2 (2.6–4.1)	0.640 ^b
Prothrombin activity (%)	68.9 (53–99)	73.2 (53–91)	69.1 (55–87)	0.337 ^a
Platelet ($\times 10^3/\mu\text{l}$)	8.3 (3.6–26.1)	8.4 (2.9–18.5)	9.0 (3.7–22.1)	0.064 ^a
AFP ($\mu\text{g/l}$)	60.0 (4.3–282 200)	44.5 (4.5–237 200)	63.5 (4.0–331 900)	0.035 ^a
DCP (AU/l)	39.0 (9–4626)	58.0 (7–4024)	64.0 (10–3540)	0.970 ^a
TACE group ($n = 122$)				
Total bilirubin (mg/dl)	1.1 (0.4–4.9)	1.0 (0.2–3.5)	1.0 (0.3–4.0)	0.338 ^a
Albumin (g/dl)	3.3 (2.0–4.2)	–	3.3 (2.1–4.4)	0.386 ^b
Prothrombin activity (%)	78.5 (53–123)	73.5 (46–100)	76.1 (51–95)	0.002 ^a
Platelet ($\times 10^3/\mu\text{l}$)	10.0 (2.9–28.2)	8.8 (3.2–27.4)	9.6 (2.9–31.7)	0.501 ^a
AFP ($\mu\text{g/l}$)	34.0 (2.6–36800)	25.8 (1.9–14440)	24.0 (3.0–30890)	<0.0001 ^a
DCP (AU/l)	55.0 (9–39050)	37.0 (10–14490)	26.0 (6–15518)	<0.0001 ^a

Values are expressed as median (minimum–maximum). In the TAI group, the only significant difference seen after miriplatin administration was for AFP concentrations. PT, AFP and DCP values were significantly decreased in the TACE group. AFP, α -fetoprotein; DCP, des- γ -carboxyprothrombin.

^a*P* values were analyzed by the Friedman test.

^b*P* values were analyzed by the Wilcoxon signed rank test.

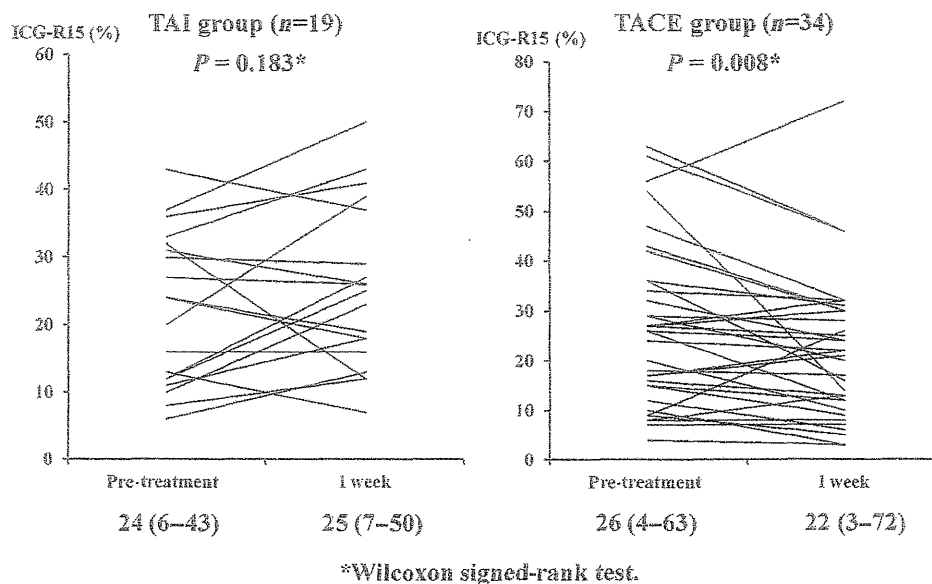


Figure 1. Comparison of indocyanine green retention rate at 15 min (ICG-R15) before and 1 week after miriplatin administration. Although there were no significant changes in ICG-R15 before and after miriplatin administration in the TAI group, ICG-R15 values were significantly lower 1 week after miriplatin administration in the TACE group.

values determined before and 1 week after miriplatin administration [AFP ($P = 0.004$) in the TAI group; AFP ($P < 0.0001$) and DCP ($P = 0.001$) in the TACE group (α level was $P = 0.016$)]. ICG-R15 was assessed before and 1 week after miriplatin administration in 53 patients from the two groups. Although there were no significant differences seen in the TAI group, ICG-R15 values were significantly decreased 1 week after miriplatin administration in the TACE group (Fig. 1).

MULTIVARIATE ANALYSIS FOR FACTORS ASSOCIATED WITH OBJECTIVE RESPONSE

We evaluated variables for association with objective response (complete or partial) after treatment using miriplatin. Univariate analysis identified the following 10 factors that were associated with objective response: a *Leus culinaris* agglutinin-reactive fraction of AFP (AFP-L3) $\leq 10\%$ ($P = 0.0005$), first-time transcatheter arterial chemotherapy ($P = 0.005$), the use of gelatin particles (TACE, $P = 0.007$), solitary tumor ($P = 0.004$), injection artery (peripheral to segmental hepatic artery, $P = 0.049$), AFP $\leq 30 \mu\text{g/l}$ ($P = 0.053$), DCP $\leq 40 \text{ AU/l}$ ($P = 0.03$), total bilirubin $\leq 1.0 \text{ mg/dl}$ ($P = 0.011$), lactate dehydrogenase $\leq 210 \text{ IU/l}$ ($P = 0.057$) and hemoglobin $> 11.0 \text{ g/dl}$ ($P = 0.051$; Table 4).

These parameters were subjected to multivariate logistic regression analysis. Objective response was significantly associated with AFP-L3 $\leq 10\%$ [$P = 0.004$; risk ratio = 3.09; 95% confidence interval (CI) = 1.42–6.70], first-time transcatheter arterial chemotherapy ($P = 0.007$; risk ratio = 4.41; 95% CI = 1.49–13.07) and patients undergoing TACE ($P = 0.021$; risk ratio = 2.97; 95% CI = 1.17–7.49; Table 4).

ADVERSE EFFECTS

The adverse effects occurring after miriplatin administration are summarized in Table 5.

Fever, anorexia and elevation of serum transaminase levels were observed in most patients after miriplatin administration. Grade 4 neutrocytopenia was seen in one patient (1%) in the TACE group; Grade 4 aspartate aminotransferase elevations were seen in one patient (3%) in the TAI group and four patients (3%) in the TACE group; and Grade 4 alanine aminotransferase elevation was seen in one patient (1%) in the TACE group. Increases in serum alanine aminotransferase levels and anorexia tended to occur more frequently in the TACE group. Hepatic abscess was observed in one patient (3%) in the TAI group and one patient (1%) in the TACE group ($P = 0.403$). Resolution of all abscesses was achieved using continuous administration of antibiotic drugs without drainage.

All patients with adverse effects recovered within 2 weeks. No vascular complications involving the hepatic artery were observed among the 68 patients who again underwent angiography 3–6 months after miriplatin administration. No other serious complications or treatment-related deaths were observed. There were no other significant differences in adverse effects between the two groups.

DISCUSSION

TACE is widely performed for patients with HCC who are not eligible for curative therapy. The survival benefit of TACE has been confirmed by randomized control trials and meta-analysis (8–10,12,13). Various anticancer drugs, such as doxorubicin hydrochloride, epirubicin hydrochloride,

Table 4. Univariate and multivariate analyses for predictors of objective response (logistic regression analysis)

	Category	Univariate		Multivariate	
		Odds ratio (95% CI)	P value	Odds ratio (95% CI)	P value
<i>Lens culinaris</i> agglutinin-reactive fraction of AFP	1: ≤10; 0: >10	3.53 (1.73–7.20)	0.0005	3.09 (1.42–6.70)	0.004
First-time transcatheter arterial chemotherapy	1: yes; 0: no	3.32 (1.42–7.74)	0.005	4.41 (1.49–13.07)	0.007
Use of gelatin particles	1: yes; 0: no	2.79 (1.31–5.93)	0.007	2.97 (1.17–7.49)	0.021
Tumor multiplicity	1: solitary; 0: multiple	4.12 (1.56–10.85)	0.004		
Tumor size	1: ≤19 mm; 0: >19 mm	–	0.725		
Injection artery	1: peripheral to segmental hepatic artery; 0: others	2.45 (1.00–6.03)	0.049		
AFP (μg/l)	1: ≤30; 0: >30	1.88 (0.99–3.56)	0.053		
DCP (AU/l)	1: ≤40; 0: >40	2.04 (1.07–3.88)	0.030		
Total bilirubin (mg/dl)	1: ≤1.0; 0: >1.0	2.25 (1.19–4.25)	0.011		
Lactate dehydrogenase (IU/l)	1: ≤210; 0: >210	1.84 (0.98–3.45)	0.057		
Hemoglobin (g/dl)	1: ≤11.0; 0: >11.0	0.514 (0.26–1.00)	0.051		

CI, confidence interval.

Table 5. Adverse effects after miriplatin administration

Grade	Number of TAI patients (n = 40)				Number of TACE patients (n = 122)				P value ^a
	1	2	3	4	1	2	3	4	
White blood cell decreased	2 (5%)	12 (30%)	1 (3%)	0	1 (1%)	27 (22%)	7 (6%)	0	0.204
Neutrophil count decreased	1 (3%)	8 (20%)	0	0	2 (2%)	21 (17%)	5 (4%)	1 (1%)	0.694
Anemia	10 (25%)	8 (20%)	3 (8%)	0	40 (33%)	21 (17%)	3 (2%)	0	0.425
Platelet count decreased	18 (45%)	12 (30%)	2 (5%)	0	72 (59%)	21 (17%)	11 (9%)	0	0.203
Aspartate aminotransferase increased	16 (40%)	8 (20%)	9 (22%)	1 (3%)	55 (45%)	23 (19%)	30 (25%)	4 (3%)	0.983
Alanine aminotransferase increased	15 (37%)	8 (20%)	2 (5%)	0	54 (44%)	12 (10%)	19 (16%)	1 (1%)	0.080
Fever	17 (42%)	2 (5%)	0	0	67 (55%)	14 (11%)	0	0	0.082
Anorexia	10 (25%)	0	0	0	56 (46%)	1 (1%)	0	0	0.050
Nausea	6 (15%)	0	0	0	23 (19%)	0	0	0	0.581
Abdominal pain	3 (8%)	3 (8%)	0	0	22 (18%)	4 (3%)	0	0	0.168
Hepatic infection	0	0	1 (3%)	0	0	0	1 (1%)	0	0.403

^aP values were analyzed by the χ^2 test.

mitomycin C, cisplatin and neocarzinostatin, have been used as TACE agents for the treatment of HCC. However, the most effective and least toxic TACE protocol for HCC has yet to be identified (13–15).

Although TACE can be repeated in most patients, therapeutic efficacy cannot be maintained by repeating TACE using the same anticancer drug if the tumor is thought to be resistant to it. Various types of resistance to therapy can occur during repeated TACE. Platinum derivatives are frequently administered to patients with advanced HCC that

has become unresponsive to anthracycline and antibiotic drugs (24,25).

Miriplatin was developed as a lipophilic platinum complex in an effort to produce a superior anti-tumor effect in HCC with lower toxicity compared with cisplatin (16–19). Miriplatin–lipiodol suspension is a stable colloidal emulsion that is deposited within HCC tumors, where active derivatives of miriplatin are gradually released. According to pharmacokinetic studies, the plasma concentration of total platinum in patients treated with miriplatin–lipiodol

suspension is much lower than the concentration in patients who are administered intra-arterial cisplatin; the C_{\max} is ~300-fold lower and the T_{\max} roughly 500-fold longer than the corresponding values for intra-arterial cisplatin. Miriplatin–lipiodol releases 1,2-diaminocyclohexane platinum (II) dichloride (DPC), which is the active platinum compound that binds to nuclear DNA and mediates miriplatin–lipiodol cytotoxicity. Also, in a cisplatin-resistant rat hepatoma cell line model, DPC did not show cross-resistance with cisplatin (26).

Clinical trials have shown that miriplatin is effective for the treatment of HCC, but the efficacy and safety of adding embolizing agents has not been evaluated. Some clinical studies have demonstrated the efficacy and safety of TACE with miriplatin (27–29). To the best of our knowledge, there have not been any clinical studies comparing TACE with TAI. There is an ongoing Phase III trial comparing miriplatin and epirubicin used as TACE agents (JapicCTI-080632[ja]). Although the endpoint of this trial is overall survival, results on the survival benefits of each therapy will be reported within the next several years.

In the present study using miriplatin–lipiodol suspension, the addition of an embolizing agent led to a more favorable result compared with TAI alone, as assessed 1–3 months after TACE and TAI treatments. Additionally, no serious adverse events and no vascular complications were observed with the addition of embolizing agents. In comparisons of ICG-R15 values before and 1 week after administration of miriplatin–lipiodol suspension, the ICG-R15 was only significantly decreased in the TACE group. Improvement of hepatic arterial flow caused by tumor artery embolization may be a reason that the ICG-R15 values decreased in the TACE group.

By multivariate analysis, AFP-L3 values, no previous transcatheter arterial chemotherapy, and the use of gelatin particles (TACE) were highly correlated with objective response after miriplatin–lipiodol suspension administration. Among these factors, AFP-L3 and no previous transcatheter arterial chemotherapy might be considered as surrogate markers for tumor sensitivity to chemotherapy and grade of malignancy.

Previous studies have reported that complete tumor necrosis after TACE provided favorable long-term survival in HCC patients (7,30). In this study, tumor response occurred after TACE using miriplatin–lipiodol suspension. Our results together with the results of previous studies suggest that transcatheter arterial chemotherapy using miriplatin–lipiodol suspension and embolizing agents may provide a more favorable prognosis than arterial infusion alone for patients with HCC.

Recently, a drug-eluting bead has been developed to enhance drug delivery to tumors and reduce systemic exposure. Conventional TACE and TACE with drug-eluting beads are increasingly being performed in Western countries. A prospective, controlled, randomized study comparing TACE using doxorubicin-loaded microspheres with TACE

using conventional doxorubicin showed that there were no significant differences in the rates of CR, objective response, and control of disease (31). Patients with the Child–Pugh class B disease, ECOG score of 1, bilobar disease or recurrence after curative treatment benefited more from TACE using doxorubicin-loaded microspheres than from conventional TACE. Both conventional TACE and TACE using drug-eluting beads are potent palliative options for the treatment of HCC. Additional clinical studies are needed to assess patient selection and verify the survival benefits of conventional TACE using miriplatin and TACE using miriplatin-eluting beads.

Since this was a retrospective study, the patients were not randomized with respect to TACE or TAI treatments. A prospective study is needed to assess the safety and efficacy of TACE using miriplatin–lipiodol suspension. In addition, there should be more study to determine the most effective, least toxic anticancer agent among the various available anti-tumor agents used for TACE.

In conclusion, the combination of embolizing agents with miriplatin–lipiodol suspension can be used safely for patients with unresectable HCC. Assessments performed shortly after treatments showed that the rate of objective response was significantly higher in the TACE patient group than in the TAI group after transcatheter arterial chemotherapy using miriplatin–lipiodol suspension.

Authors' contribution

N.I.: study concept and design, database management and statistical analysis, and writing the paper; K.I.: study concept and design and study supervision; Y.K.: data collection; H.S.: data collection; T.H.: data collection; N.A.: data collection; M.K.: data collection; S.S.: data collection; F.S.: data collection; Y.S.: data collection; Y.A.: study supervision; and H.K.: study supervision.

Conflict of interest statement

The following authors have received honoraria (lecture fees) from Dainippon Sumitomo Pharma Co., Ltd, Osaka, Japan: Hiromitsu Kumada, Kenji Ikeda, Yasuji Arase, Yoshiyuki Suzuki, Fumitaka Suzuki and Norio Akuta.

References

1. Parkin DM, Bray F, Ferlay J, Pisani P. Global cancer statistics, 2002. *CA Cancer J Clin* 2005;55:74–108.
2. Bosch X, Ribes J, Borrás J. Epidemiology of primary liver cancer. *Semin Liver Dis* 1999;19:271–85.
3. Okuda K, Fujimoto I, Hanai A, Urano Y. Changing incidence of hepatocellular carcinoma in Japan. *Cancer Res* 1987;47:4967–72.
4. Kudo M. Early detection and curative treatment of early-stage hepatocellular carcinoma. *Clin Gastroenterol Hepatol* 2005;3:S144–8.
5. Yamada R, Sato M, Kawabata M, Nakatsuka H, Nakamura K, Takashima S. Hepatic artery embolization in 120 patients with unresectable hepatoma. *Radiology* 1983;148:397–401.

6. Lin DY, Liaw YF, Lee TY, Lai CM. Hepatic arterial embolization in patients with unresectable hepatocellular carcinoma: a randomized controlled trial. *Gastroenterology* 1988;94:453–6.
7. Ikeda K, Kumada H, Saitoh S, Arase Y, Chayama K. Effect of repeated transcatheter arterial embolization on the survival time in patients with hepatocellular carcinoma. *Cancer* 1991;68:2150–4.
8. Llovet JM, Real MI, Montaña X, Planas R, Coll S, Aponte J, et al. Barcelona Liver Cancer Group. Arterial embolisation or chemoembolisation versus symptomatic treatment in patients with unresectable hepatocellular carcinoma: a randomised controlled trial. *Lancet* 2002;359:1734–9.
9. Lo CM, Ngan H, Tso WK, Liu CL, Lam CM, Poon RT, et al. Randomized controlled trial of transarterial lipiodol chemoembolization for unresectable hepatocellular carcinoma. *Hepatology* 2002;35:1164–71.
10. Cammà C, Schepis F, Orlando A, Albanese M, Shahied L, Trevisani F, et al. Transarterial chemoembolization for unresectable hepatocellular carcinoma: meta-analysis of randomized controlled trials. *Radiology* 2002;224:47–54.
11. Ikeda M, Maeda S, Shibata J, Muta R, Ashihara H, Tanaka M, et al. Transcatheter arterial chemotherapy with and without embolization in patients with hepatocellular carcinoma. *Oncology* 2004;66:24–31.
12. Takayasu K, Arii S, Ikai I, Omata M, Okita K, Ichida T, et al. Prospective cohort study of transarterial chemoembolization for unresectable hepatocellular carcinoma in 8510 patients. *Gastroenterology* 2006;131:461–9.
13. Marelli L, Stigliano R, Triantos C, Senzolo M, Cholongitas E, Davies N, et al. Transarterial therapy for hepatocellular carcinoma: which technique is more effective? A systematic review of cohort and randomized studies. *Cardiovasc Intervent Radiol* 2007;30:6–25.
14. Kamada K, Nakanishi T, Kitamoto M, Aikata H, Kawakami Y, Ito K, et al. Long-term prognosis of patients undergoing transcatheter arterial chemoembolization for unresectable hepatocellular carcinoma: comparison of cisplatin lipiodol suspension and doxorubicin hydrochloride emulsion. *J Vasc Interv Radiol* 2001;12:847–54.
15. Ikeda M, Maeda S, Ashihara H, Nagahama H, Tanaka M, Sasaki Y. Transcatheter arterial infusion chemotherapy with cisplatin–lipiodol suspension in patients with hepatocellular carcinoma. *J Gastroenterol* 2010;45:60–7.
16. Maeda M, Uchida NA, Sasaki T. Liposoluble platinum (II) complexes with antitumor activity. *Jpn J Cancer Res* 1986;77:523–5.
17. Kishimoto S, Ohtani A, Fukuda H, Fukushima S, Takeuchi Y. Relation between intracellular accumulation and cytotoxic activity of *cis*[[[(1*R*,2*R*)-1,2-cyclohexanediamine-*N,N'*bis(myristato)]]platinum(II)] suspended in lipiodol. *Biol Pharm Bull* 2003;26:683–6.
18. Hanada M, Baba A, Tsutsumishita Y, Noguchi T, Yamaoka T. Intra-hepatic arterial administration with miriplatin suspended in an oily lymphographic agent inhibits the growth of human hepatoma cells orthotopically implanted in nude rats. *Cancer Sci* 2009;100:189–94.
19. Hanada M, Baba A, Tsutsumishita Y, Noguchi T, Yamaoka T, Chiba N, et al. Intra-hepatic arterial administration with miriplatin suspended in an oily lymphographic agent inhibits the growth of tumors implanted in rat livers by inducing platinum–DNA adducts to form and massive apoptosis. *Cancer Chemother Pharmacol* 2009;64:473–83.
20. Fujiyama S, Shibata J, Maeda S, Tanaka M, Noumaru S, Sato K, et al. Phase I clinical study of a novel lipophilic platinum complex (SM-11355) in patients with hepatocellular carcinoma refractory to cisplatin/lipiodol. *Br J Cancer* 2003;89:1614–9.
21. Okusaka T, Okada S, Nakanishi T, Fujiyama S, Kubo Y. Phase II trial of intra-arterial chemotherapy using a novel lipophilic platinum derivative (SM-11355) in patients with hepatocellular carcinoma. *Invest New Drugs* 2004;22:169–76.
22. Kudo M, Chung H, Osaki Y. Prognostic staging system for hepatocellular carcinoma (CLIP score): its value and limitations, and a proposal for a new staging system, the Japan Integrated Staging Score (JIS score). *J Gastroenterol* 2003;38:207–15.
23. Lencioni R, Llovet JM. Modified RECIST (mRECIST) assessment for hepatocellular carcinoma. *Semin Liver Dis* 2010;30:52–60.
24. Kawamura Y, Ikeda K, Hirakawa M, Hosaka T, Kobayashi M, Saitoh S, et al. Efficacy of platinum analogue for advanced hepatocellular carcinoma unresponsive to transcatheter arterial chemoembolization with epirubicin. *Hepatol Res* 2009;39:346–54.
25. Maeda N, Osuga K, Higashihara H, Tomoda K, Mikami K, Nakazawa T, et al. Transarterial chemoembolization with cisplatin as second-line treatment for hepatocellular carcinoma unresponsive to chemoembolization with epirubicin–lipiodol emulsion. *Cardiovasc Intervent Radiol* 2011 (4 January Epub ahead of print).
26. Kishimoto S, Miyazawa K, Terakawa Y, Ashikari H, Ohtani A, Fukushima S, et al. Cytotoxicity of *cis*-[[[(1*R*,2*R*)-1,2-cyclohexanediamine-*N,N'*bis(myristato)]]platinum (II)] suspended in lipiodol in a newly established cisplatin-resistant rat hepatoma cell line. *Jpn J Cancer Res* 2000;91:1326–32.
27. Ikeda K, Okusaka T, Ikeda M, Morimoto M. Transcatheter arterial chemoembolization with a lipophilic platinum complex SM-11355(miriplatin hydrate)—safety and efficacy in combination with embolizing agents. *Gan To Kagaku Ryoho* 2010;37:271–5 (in Japanese).
28. Imai N, Ikeda K, Seko Y, Kawamura Y, Sezaki H, Hosaka T, et al. Previous chemoembolization response after transcatheter arterial chemoembolization (TACE) can predict the anti-tumor effect of subsequent TACE with miriplatin in patients with recurrent hepatocellular carcinoma. *Oncology* 2011;80:188–94.
29. Imai Y, Chikayama T, Nakazawa M, Watanabe K, Ando S, Mizuno Y, et al. Usefulness of miriplatin as an anticancer agent for transcatheter arterial chemoembolization in patients with unresectable hepatocellular carcinoma. *J Gastroenterol* 2011 (6 October Epub ahead of print).
30. Shim JH, Kim KM, Lee YJ, Ko GY, Yoon HK, Sung KB, et al. Complete necrosis after transarterial chemoembolization could predict prolonged survival in patients with recurrent intrahepatic hepatocellular carcinoma after curative resection. *Ann Surg Oncol* 2010;17:869–77.
31. Lammer J, Malagari K, Vogl T, Pilleul F, Denys A, Watkinson A, et al. Prospective randomized study of doxorubicin-eluting-bead embolization in the treatment of hepatocellular carcinoma: results of the PRECISION V study. *Cardiovasc Intervent Radiol* 2010;33:41–52.

Original Article

Difference in malignancies of chronic liver disease due to non-alcoholic fatty liver disease or hepatitis C in Japanese elderly patients

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Aim: Malignancies that include hepatocellular carcinoma often occurred in patients with chronic liver disease. The aim of this retrospective match control study was to assess the cumulative development incidence and predictive factors for total malignancies in elderly Japanese patients with non-alcoholic hepatic diseases (NAFLD) or hepatitis C virus (HCV).

Methods: A total of 1600 NAFLD patients with age of ≥ 60 years were enrolled, and 1600 HCV patients with age of ≥ 60 years were selected as control by matching 1:1 with NAFLD group for age, sex, and follow-up period. The primary goal is the first development of malignancies. Evaluation was performed by the use of the Wilcoxon rank sum test, the Kaplan–Meier method, and Cox proportional hazard model. The mean observation period is 8.2 years in both NAFLD and HCV group, respectively.

Results: The number of patients with the development of malignancies was 167 in the NAFLD group and 395 in the

HCV group. The 10th development rate of malignancies was 13.9% in the NAFLD group and 28.2% in the HCV group (risk ratio 2.27; $P < 0.001$). The incident rates of hepatocellular carcinoma in all the malignancies were 6.0% (10/167) in the NAFLD group and 67.6% (267/395) in the HCV group ($P < 0.001$). The malignancies in the NAFLD group were observed in the following order: gastric cancer 34 cases (20.4%) > colon cancer 31 cases (18.6%) > prostate cancer 21 cases (12.6%).

Conclusions: The incident rates of hepatocellular carcinoma in all the malignancies were approximately 6% in the NAFLD group and two-thirds in the HCV group.

Key words: carcinogenesis, hepatitis C virus, non-alcoholic fatty liver disease

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INTRODUCTION

NON-ALCOHOLIC FATTY LIVER disease (NAFLD) is one of the more common causes of chronic liver disease worldwide.^{1–6} NAFLD is considered to be the liver component of metabolic syndrome.^{7,8} It is associated with obesity, dyslipidemia, pituitary dysfunction, hypertension, sleep apnea, and diabetes mellitus type 2

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(T2DM).^{9–13} In addition, NAFLD sometimes progressed to non-alcoholic steatohepatitis (NASH). In patients with cirrhotic NASH, liver-related events such as hepatocellular carcinoma (HCC) and liver failure are one of the main causes of morbidity and mortality.¹⁴ However, studies on prolonged prognosis of NAFLD are few in Japan. Thus, the true prevalence and natural history of NAFLD in Japanese patients are still unclear.

On the other hand, hepatitis C virus (HCV) often causes liver cirrhosis and HCC.^{15–16} The majority of HCC is ascribed to hepatitis viruses, of which 70–80% corresponding to approximately 35 000 per year is attributed to the persistent infection with HCV in Japan. However, studies on malignancies other than HCC are few in the HCV patients.

With this background in mind, the present study was initiated to investigate the cumulative incidence and risk factors of malignancies that includes HCC after prolonged follow-up in elderly Japanese patients with NAFLD or HCV. The strengths of the current study are the large numbers of patients included and the long-term follow-up of patients.

METHODS

Patients

THE NUMBER OF patients who were diagnosed with fatty liver by the ultrasonography (US) between January 1994 and December 2007 in the Health Management Center and/or Department of Hepatology, Toranomon Hospital, Tokyo, Japan was 10 810. Of these, 1600 Japanese patients satisfied the following enrolled criteria; (i) age of ≥ 60 years; (ii) daily alcohol intake of < 20 g/day; (iii) negativity for hepatitis B surface antigens (HBsAg), hepatitis C virus antibodies, antinuclear antibodies, or antimitochondrial antibodies in serum, as determined by radioimmunoassay, enzyme-linked immunosorbent assay or indirect immunofluorescence assay; (iv) the absence of malignancies by gastrofiberscope, abdominal US, chest X-ray, and/or chest computed tomography (CT); (v) annual examination for health screening; and (vi) no underlying systemic disease, such as systemic lupus erythematosus, rheumatic arthritis. Patients with either of the following criteria were excluded from the study: (i) they had illnesses that could seriously reduce their life expectancy; and (ii) they had history of carcinogenesis. In the same period, 7189 HCV patients without fatty liver determined by US were followed in the same hospital. Seven inclusion criteria and two exclusion criteria described in

NAFLD group were applied to 2575 of these 7189 HCV patients without fatty liver. Thus, a total of 1600 NAFLD patients with age of ≥ 60 years were enrolled, and 1600 HCV patients with age of ≥ 60 years were selected as controls by matching 1:1 with the NAFLD group for age, sex, and follow-up period.

Patients were classified into three groups according to fasting plasma glucose (FPG): (i) those with FPG level of < 109 mg/dL (normal glucose group); (ii) those with FPG level of 109–125 mg/dL (pre-diabetes group); and (iii) those with FPG level of ≥ 126 mg/dL (diabetes group).¹⁹ Patients were regarded as hypertensive by the confirmation of blood pressure ≥ 140 mmHg systolic and/or ≥ 90 mmHg diastolic on at least three visits. We considered persons smokers if they had smoked a cigarette at the initiation of follow-up.

The primary goal is the development of malignancies. The diagnosis of malignancies was made due to tumor marker, imaging (US, CT or magnetic resonance imaging [MRI]), and/or histological examination.^{20–27} All of the studies were performed retrospectively by collecting and analyzing data from the patient records. This study had been approved by the Institutional Review Board of our hospital.

Medical evaluation

Diagnosis of fatty liver was based on the presence of an ultrasonographic pattern consistent with bright liver with stronger echoes in the hepatic parenchyma than in the renal parenchyma.²⁸ US test was performed with a high-resolution, real-time scanner (model SSD-2000; Aloka Co., Ltd, Tokyo Japan. Mode Logic-700 MR; GE-Yokokawa Medical Systems, Tokyo, Japan). Body weight was measured in light clothing and without shoes to the nearest 0.1 Kg. Height was measured to the nearest 0.1 cm. Height and weight were recorded at baseline and the body mass index (BMI) was calculated as weight (in kg)/height (in m²). All the patients were interviewed by physicians or nurse staff in the Toranomon Hospital using a questionnaire that gathered information on demographic characteristics, medical history, and health-related habits including questions on alcohol intake and smoking history.

Laboratory investigation

Anti-HCV was detected using a second-generation enzyme-linked immunosorbent assay (ELISA II) (Abbott Laboratories, North Chicago, IL, USA). HCV-RNA was determined by the Amplicor method (Cobas Amplicor HCV Monitor Test, v2.0, Roche, Tokyo,

Japan). HBsAg was tested by radioimmunoassay (Abbott Laboratories, Detroit, MI, USA). The used serum samples were stored at -80°C at the first consultation. Diagnosis of HCV infection was based on detection of serum HCV antibody and positive RNA.

Follow-up

We used 60 years of age as the starting point for observations in 1417 patients (NAFLD, 694 patients; HCV, 723 patients) who came to our hospital before the age of 60. In 1783 patients (NAFLD, 906 patients; HCV, 877 patients) who came after the age of 60, the day of first visit was used as the start of observations. All patients were followed up at least twice a year by monitoring hematological and biochemical data. Imaging examinations were done approximately once a year for each patient, using abdominal-US and Chest X-ray. Moreover, the patients were checked for tumor marker (carcinoembryonic antigen [CEA], α -fetoprotein [AFP], and prostate-specific antigen [PSA]), gastrofiberscope (or gastrography), and occult blood test of feces at least one year. Two hundred and eighty-two patients were lost to follow-up. Because the appearance of malignancy was not identified in these 282 patients, they were considered as censored data in statistical analysis.²⁹ Patients treated with antiviral agents were regarded as withdrawals at the time of having the negativity of HCV RNA level by the Amplicor method.

Statistical analysis

Clinical differences between the NAFLD group and HCV group were evaluated by Wilcoxon rank sum test or Fisher's exact test. The cumulative development rates of malignancies were calculated by using the Kaplan–Meier technique, and differences in the curves were tested using the log-rank test.³⁰ Independent risk factors associated with malignancies were studied using the stepwise Cox regression analysis.³¹ The following 15 variables were analyzed for potential covariates for incidence of primary goals in NAFLD group and HCV group: age, gender, body mass index, hypertension, current smoking, albumin, triglyceride, total cholesterol, aspartate aminotransferase (AST), alanine aminotransferase (ALT), gamma-glutamyltransferase (GGT), fasting plasma glucose, platelet, and AFP at the initiation time of follow-up. A *P*-value of less than 0.05 was considered significant. Data analysis was performed using the computer program SPSS package (SPSS 11.5 for Windows, SPSS, Chicago, IL, USA).

RESULTS

Characteristics of the patients enrolled

TABLE 1 SHOWS the baseline characteristics of the 1600 patients in NAFLD group and the 1600 patients in the HCV group at the initiation of follow-up. There are significant differences in several baseline characteristics such as body mass index, AST, ALT, triglyceride, total cholesterol, fasting plasma glucose, platelet, AFP between the HCV group and NAFLD group as shown in Table 1.

Development of malignancy

A total of 562 subjects (167 in NAFLD group and 395 in HCV group) developed malignancy during follow-up. The cumulative development rate of carcinogenesis at the 10th year was determined to be 13.9% in the NAFLD group and 28.2% in the HCV group by the use of the Kaplan–Meier method (Fig. 1). The development rate of each malignancy in both groups is shown in Table 2. The malignancies in the NAFLD group were observed in the following order: gastric cancer 34 cases (20.4%) > colon cancer 31 cases (18.6%) > prostate cancer 21 cases (12.6%). On the other hand, HCC in the HCV group accounted for two-thirds of malignancy. The development rates per 1000 person years in HCC and malignant lymphoma in the HCV group was statistically higher than those in the NAFLD group. However, there were no significant differences in gastric cancer, colon cancer, prostate cancer, and lung cancer between both groups. The incidence rates of HCC in all of the malignancies were 6.0% (10/167) in the NAFLD group and 67.6% (267/395) in the HCV group ($P < 0.001$). Seven of 10 NAFLD patients with development of HCC were evaluated as having histological liver condition at the time of development of HCC. One patient had simple steatosis, and another six patients had non-alcoholic steatohepatitis (NASH). The grade of liver fibrosis in six NASH patients with development of HCC was as follows: grade 1, one patient; grade 2, two patients; grade 3, two patients; grade 4, one patient.

The development rates of each malignancy between the NAFLD group and the HCV group based on the difference of gender are shown in Table 3. The development rates of HCC expressed by 1000 person years in the HCV group were two orders of magnitude higher than those in the NAFLD group in both males and females. There were no significant differences in other malignancies except for HCC between the