

in the previous treatment, those who attained an SVR on re-treatment required a longer duration of re-treatment than the duration of the previous treatment (re-treatment, 63.8 ± 13.0 weeks vs. previous treatment, 53.9 ± 13.5 weeks, $p = 0.01$), while those without an SVR on re-treatment could be treated for almost the same period as that in the previous treatment (re-treatment, 58.8 ± 12.8 weeks vs. previous treatment, 54.2 ± 11.3 weeks, $p = 0.38$).

Comparison of the timing to the first undetectable HCV RNA level in the previous treatment and re-treatment could be carried out in 50 patients; most patients attained HCV RNA negativity on re-treatment earlier or with the same timing as in the previous treatment, and only one patient showed a later timing for re-treatment. The SVR rate on re-treatment was low, at 13% (3/24) among the patients with detectable HCV RNA at week 24 in the previous treatment. Among the 10 patients with HCV RNA negativity on re-treatment with the same timing as that in the previous treatment, an SVR was attained only by the patients who were re-treated for 72 weeks. Among the 23 patients with earlier HCV RNA negativity on re-treatment, an SVR of 61% was attained (14/23). The patients with an RVR on re-treatment attained a high SVR rate (88%, 7/8) regardless of the virologic response in the previous treatment (Fig. 2).

In genotype 2 patients, the HCV RNA negative rate on re-treatment was 56% (10/18) at week 4, 83% (15/18) at

week 12, and 89% (16/18) at week 24, and the SVR rate was 56% (10/18). The two patients without a c-EVR in the previous treatment did not attain an SVR on re-treatment. Among the patients with an RVR on re-treatment, the SVR rates were 60% (3/5) in those with 24-week treatment and 100% (5/5) in those with 48-week treatment.

Discussion

In the present study of the re-treatment of chronic hepatitis C patients who failed to show an SVR to Peg-IFN plus ribavirin therapy, the patients with relapse in the previous treatment showed a significant response on re-treatment compared with those with NR. This result showed similar findings to the evaluation of peg intron in control of hepatitis C cirrhosis (EPIC) study of relapse and NR [10]. In addition, in the present study, p-EVR in the previous treatment was a good indicator of negative prediction for SVR on re-treatment; no patient without p-EVR in the previous treatment attained SVR on re-treatment; that is, the negative predictive value for SVR on re-treatment was 100%. Recently, genetic polymorphism near the IL28B gene has been reported to be associated with the anti-viral effect of Peg-IFN plus ribavirin combination therapy [12–15]. Among Japanese genotype 1 patients, it has been reported that those with the major single-nucleotide polymorphism (SNP) allele of IL28B (rs8099917) show an SVR rate of 39%, while those with the minor allele show an SVR rate of only 11%. Hence, in re-treatment for patients who failed to show a SVR to Peg-IFN plus ribavirin therapy, pretreatment prediction should be done by taking IL28B SNPs and the previous treatment response into account. Patients with the minor SNP allele of IL28B who did not attain a p-EVR in the previous treatment should wait until new drugs become commercially available.

The next question is how the patients should be re-treated in order to attain an SVR on re-treatment. In the present study, the patients with a low serum HCV RNA level (less than $5 \log_{10}$ IU/ml) at the start of re-treatment showed a significant rate of cure on re-treatment, and this is almost the same result as that previously reported [9, 10]. In the present study, one patient with NR in the previous treatment started re-treatment with HCV RNA of 52 KIU/ml and attained an RVR and SVR. HCV RNA levels declined on re-treatment among 61% (34/56) of the patients compared to the start of the previous treatment, and it is important not to miss the timing of when the HCV RNA level is low.

With respect to treatment duration among patients with HCV RNA negativity during re-treatment, 72 weeks of treatment tended to increase the SVR rate compared to

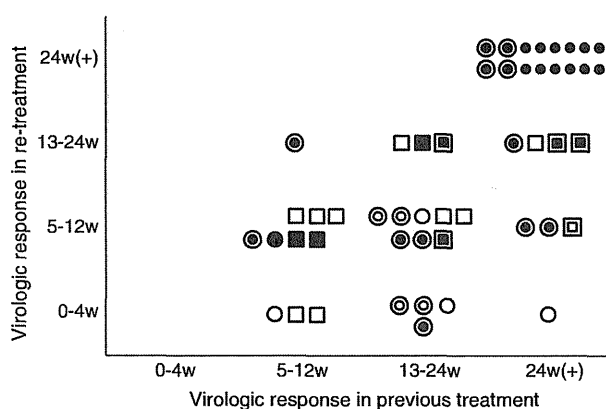


Fig. 2 Virologic response on re-treatment according to the timing of HCV RNA negativity in previous treatment and re-treatment. *Open double circles/open circles* sustained virologic response (SVR) with 48 weeks of re-treatment (*open double circles*, pegylated interferon [Peg-IFN] α -2a plus ribavirin; *open circles* Peg-IFN α -2b plus ribavirin). *Open double squares/open squares*, SVR with 72 weeks of re-treatment (*open double squares* Peg-IFN α -2a plus ribavirin; *open squares*, Peg-IFN α -2b plus ribavirin). *Closed double circles/closed circles*, non-SVR with 48 weeks of re-treatment or non-response (NR) with 24 weeks of re-treatment (*closed double circles*, Peg-IFN α -2a plus ribavirin; *closed circles* Peg-IFN α -2b plus ribavirin). *Closed double squares/closed squares*, non-SVR with 72 weeks of re-treatment (*closed double squares* Peg-IFN α -2a plus ribavirin; *closed squares*, Peg-IFN α -2b plus ribavirin)

48 weeks of treatment (72 weeks, 68%, 15/22, vs. 48 weeks, 44%, 7/16, $p = 0.13$). This result was almost the same as that of the re-treatment of patients with chronic hepatitis C who do not respond to peginterferon-alpha 2b. A randomized trial (REPEAT) study [9]. Furthermore, in the present study, among the patients with relapse in the previous treatment, those who attained an SVR on re-treatment required a longer re-treatment duration than the duration of the previous treatment. In fact, the longer treatment brought about an SVR in some patients whose timing of HCV RNA negativity on re-treatment was the same as that in the previous treatment, as shown in Fig. 2. Thus, especially to be noted is that the relapsers in the previous treatment should be re-treated for a longer period than that of the previous treatment.

It has been reported that splenectomy and partial splenic embolization (PSE) are considered to make it possible for patients with cirrhosis and thrombocytopenia to initiate and continue anti-viral therapy safely, by increasing the platelet counts [16–19]. If poor adherence and inappropriate duration have contributed to a poor response in previous treatment due to thrombocytopenia, there is a possibility that increasing the platelet counts by splenectomy or PSE contributes to improving the tolerability of and adherence to re-treatment, and to increasing the SVR rate in re-treatment. In the present study, one patient with cirrhosis and thrombocytopenia who showed NR in the previous treatment owing to poor adherence to the Peg-IFN α -2b (0.78 μ g/kg) regimen underwent splenectomy before re-treatment. As a result, the patient could continue with a sufficient dose of Peg-IFN (1.53 μ g/kg) in the re-treatment and attained HCV negativity at re-treatment week 24 and an SVR by extended treatment. Further study is needed on the issue of the effect of splenectomy or PSE in re-treatment on the efficacy of re-treatment with Peg-IFN plus ribavirin therapy.

In the present study, the SVR rate was relatively high (56%) in patients with genotype 2. The patients who could not attain SVR on re-treatment (2 patients) had not attained a c-EVR in the previous treatment. And, among the patients with an RVR on re-treatment, all patients treated for 48 weeks attained an SVR (5 patients), while 40% (2/5) of patients treated for 24 weeks could not attain an SVR. Thus, in patients with genotype 2, as well as in those with genotype 1, the previous treatment response and response-guided therapy can be useful in decisions on the indication for re-treatment or the treatment duration on re-treatment. However, in this study, detailed analysis was not possible because of the small number of genotype 2 patients. Further investigation is needed to clarify this.

The limitation of the present study was that two types of Peg-IFN were used. As for the type of Peg-IFN, some reports have suggested that Peg-IFN α -2a has a stronger

anti-viral effect than Peg-IFN α -2b [20, 21], and others have suggested that the two types of Peg-IFN have an almost equal anti-viral effect [22]. In this study, the HCV RNA negative rate at re-treatment week 12 was similar (α -2a, 59%, 13/22, vs. α -2b, 50%, 16/32, $p = 0.51$) between the patients with Peg-IFN α -2a and those with Peg-IFN α -2b. Furthermore, among 24 patients treated with Peg-IFN α -2a on re-treatment, an SVR rate of 38% was attained with 48-week treatment and an SVR rate of 60% was attained with 72-week treatment among patients with a p-EVR in the previous treatment, but no patient without a p-EVR in the previous treatment attained an SVR on re-treatment. Similarly, among 32 patients treated with Peg-IFN α -2b in re-treatment, an SVR rate of 56% was attained with 48-week treatment and an SVR rate of 79% was attained with 72-week treatment among patients with a p-EVR in the previous treatment, but no patient without a p-EVR in the previous treatment attained an SVR on re-treatment. As noted above, since the virologic responses to both Peg-IFNs among re-treated patients were similar, in this study we analyzed the effect of re-treatment without distinction of the type of Peg-IFN.

In conclusion, our results have demonstrated that the efficacy of re-treatment for genotype 1 patients who failed to show an SVR to previous treatment with Peg-IFN plus ribavirin could be predicted by the previous treatment response, especially in terms of p-EVR and a low HCV RNA level at the start of re-treatment. Re-treatment for 72 weeks led to clinical improvement for genotype 1 patients who attained HCV RNA negativity on re-treatment.

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Indications and limitations for aged patients with chronic hepatitis C in pegylated interferon alfa-2b plus ribavirin combination therapy

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Background & Aims: This study investigated the efficacy and adverse effects of pegylated interferon (Peg-IFN) plus ribavirin therapy in aged patients with chronic hepatitis C (CH-C).

Methods: A total of 1040 naïve patients with CH-C (genotype 1, $n = 759$; genotype 2, $n = 281$), of whom 240 (23%) over 65 years old (y.o.), were treated with Peg-IFN alfa-2b plus ribavirin and assessed after being classified into five categories, according to age.

Results: The discontinuance rate was higher for patients over 70 y.o. (36%), the most common reason being anemia. In the presence of genotype 1, the SVR rate was similar (42–46%) among patients under 65 y.o. and declined (26–29%) among patients over 65 y.o. For patients over 65 y.o., being male (Odds ratio, OR, 3.5, $p = 0.035$) and EVR (OR, 83.3, $p < 0.001$) were significant factors for SVR, in multivariate analysis. The Peg-IFN dose was related to EVR, and when EVR was attained, 76–86% of patients over 65 y.o. achieved SVR. SVR was not achieved (0/35, 0/38, respectively) if a 1-log decrease and a 2-log decrease were not attained at week 4 and week 8, respectively. In the presence of genotype 2, the SVR rate was similar (70–71%) among patients under 70 y.o. and declined among patients over 70 y.o. (43%).

Conclusions: Aged patients up to 65 y.o. with genotype 1 and 70 y.o. with genotype 2 can be candidates for Peg-IFN plus ribavirin therapy. The response-guided therapy can be applied for aged patients with genotype 1.

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Introduction

Pegylated interferon (Peg-IFN) plus ribavirin combination therapy has led to a marked progress in the treatment of chronic hepatitis C (CH-C) [1–4]. However, in aged patients, problems remain with respect to its anti-viral effect and tolerability [5–9]. Recently, the addition of a protease inhibitor to Peg-IFN plus ribavirin combination therapy has been reported, on the one hand, to improve the anti-viral effect, and, on the other hand, to increase side effects, especially severe anemia [10–11].

Therefore, this new therapy does not solve the problems encountered when treating aged patients.

With aging, the progression of liver fibrosis and the occurrence of hepatocellular carcinoma (HCC) have been shown to be accelerated, especially in patients over 60 y.o. [12–14]. In general, the anti-viral therapy can lead to an improvement in liver fibrosis and thus diminish the risk of HCC and ameliorate the prognosis in patients with CH-C [15–21]. Among aged patients, those results are mainly achievable upon eradication of the hepatitis C virus (HCV) [18,21]. Accordingly, the first goal of treatment of aged patients with a high-risk of HCC should be HCV elimination.

Thus, a treatment strategy, aiming at the improvement of the anti-viral efficacy in aged patients, should be established based on detailed large-scale studies.

Some points need to be further elucidated when using the Peg-IFN plus ribavirin combination therapy for the treatment of aged patients with CH-C: (i) the characteristics before treatment

Keywords: Pegylated interferon plus ribavirin therapy; Chronic hepatitis C; Aged patients.

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Abbreviations: HCV, hepatitis C virus; CH-C, chronic hepatitis C; HCC, hepatocellular carcinoma; Peg-IFN, pegylated interferon; SVR, sustained virologic response; RVR, rapid virologic response; EVR, early virologic response; LVR, late virologic response; NR, non-response; WBC, white blood cell; RBC, red blood cell; Hb, hemoglobin; Plt, platelet; G-CSF, granulocyte-macrophage colony stimulating factor.



Assessment of drug exposure

The amounts of Peg-IFN alfa-2b and ribavirin, taken by each patient during the full treatment period, were evaluated by reviewing the medical records. The mean doses of Peg-IFN alfa-2b and ribavirin were calculated individually as averages, on the basis of the body weight at baseline: Peg-IFN alfa-2b expressed as $\mu\text{g}/\text{kg}/\text{week}$, ribavirin expressed as $\text{mg}/\text{kg}/\text{day}$.

Statistical analysis

Patients' baseline data are expressed as means \pm SD or median values. To analyze the difference between baseline data, ANOVA or Mantel-Haenszel Chi-square test were performed. Factors associated with the viral response were assessed by univariate analysis using the Mann-Whitney *U* test or Chi-square test and multivariate analysis using logistic regression analysis. A two-tailed *p* value <0.05 was considered significant. The analysis was conducted with SPSS version 15.0J (SPSS Inc., Chicago, IL).

Results

Patient's profile

Baseline characteristics of the patients categorized by age are shown in Table 1.

Genotype 1 patients ($n = 759$) were distributed into five categories: 266 patients were under 55 y.o. (group 1A), 159 were 55–59 y.o. (group 1B), 149 were 60–64 y.o. (group 1C), 134 were 65–69 y.o. (group 1D), and 51 were 70 y.o. or older (group 1E). With advancing age, the male-to-female ratio and peripheral blood cell count (WBC, neutrophil count, Red blood cell (RBC), Hb, Plt) decreased significantly. Patients with a progression of liver fibrosis (METAVIR fibrosis score 3 or 4) significantly increased with age (Table 1A).

Genotype 2 patients ($n = 281$) were also distributed into five categories: 145 patients were under 55 y.o. (group 2A), 43 were 55–59 y.o. (group 2B), 38 were 60–64 y.o. (group 2C), 41 were 65–69 y.o. (group 2D), and 14 were 70 y.o. or older (group 2E). As observed in genotype 1 patients, the peripheral blood cell count decreased and the ratio of advanced fibrosis (score 3–4) increased significantly with age (Table 1B). For both genotypes, the initial doses of Peg-IFN in patients over 70 y.o. were lower than in those under 70 y.o., this was not the case for the ribavirin doses.

Dose reduction and discontinuance for adverse event

The overall discontinuance rate of treatment was 15% (140/919); 18% (112/639) for genotype 1 and 10% (28/280) for genotype 2, respectively. Table 2 shows the reason for and the rate of treatment discontinuance according to age. The discontinuance rate increased with age, being 10% (36/363) for patients under 55 y.o., 15% (27/182) for patients with 55–59 y.o., 17% (28/169) for patients with 60–64 y.o., 19% (28/147) for patients with 65–70 y.o., and significantly higher, 36%, (21/58) for patients over 70 y.o. The discontinuance of treatment due to hemolytic anemia was significantly higher for patients over 70 y.o. as compared to those under 70 y.o. (<70 y.o., 1% (9/861) vs. ≥ 70 y.o., 16% (9/58), $p < 0.0001$).

The rate without dose reduction of both drugs decreased with age (<55 y.o., 41% (171/411); 55–59 y.o., 20% (40/202); 60–64 y.o., 26% (48/187); 65–69 y.o., 23% (41/175); ≥ 70 y.o., 18% (12/65)). In the presence of genotype 1, the mean dose of Peg-IFN

that would lead to the successful elimination of HCV, (ii) the prediction factors of treatment efficacy after the initiation of the therapy, and (iii) the utility of a response-guided therapy established in the treatment.

In the present study, using a large cohort, we aimed at clarify these points taking into account the patients' age.

Patients and methods

Patients

This study was a retrospective, multicenter trial conducted by the Osaka University Hospital and other institutions participating in the Osaka Liver Forum. A total of 1040 naïve patients with CH-C were enrolled between December 2004 and June 2007. All patients were Japanese, infected with a viral load of more than 10^5 IU/ml, and treated with a combination of Peg-IFN alfa-2b plus ribavirin. Patients were excluded from the study if they had decompensated cirrhosis or other forms of liver disease (alcohol liver disease, autoimmune hepatitis), coinfection with hepatitis B or anti-human immunodeficiency virus. This study was conducted according to the ethical guidelines of the 1975 Declaration of Helsinki and informed consent was obtained from each patient.

Treatment

All patients received Peg-IFN alfa-2b (PEGINTRON; Schering-Plough, Kenilworth, NJ, USA) plus ribavirin (REBETOL; Schering-Plough). Treatment duration was 48 weeks for patients with genotype 1 and 24 weeks for those with genotype 2. As a starting dose, Peg-IFN alfa-2b was given once weekly, at a dosage of 1.5 $\mu\text{g}/\text{kg}$, and ribavirin was given at a total dose of 600–1000 mg/day based on body weight (body weight <60 kg, 600 mg; 60–80 kg, 800 mg; >80 kg, 1000 mg), according to a standard treatment protocol for Japanese patients.

Dose reduction and discontinuance

Dose modification followed, as a rule, the manufacturer's drug information on the intensity of the hematologic adverse effects. The Peg-IFN alfa-2b dose was reduced to 50% of the assigned dose when the white blood cell (WBC) count was below $1500/\text{mm}^3$, the neutrophil count below $750/\text{mm}^3$ or the platelet (Plt) count below $8 \times 10^4/\text{mm}^3$, and was discontinued when the WBC count was below $1000/\text{mm}^3$, the neutrophil count below $500/\text{mm}^3$ or the Plt count below $5 \times 10^4/\text{mm}^3$. Ribavirin was also reduced from 1000 to 600 mg, 800 to 600 mg, or 600 to 400 mg when the hemoglobin (Hb) was below 10 g/dl, and was discontinued when the Hb was below 8.5 g/dl. Peg-IFN alfa-2b and ribavirin had to be both discontinued if there was a need to discontinue either of them. No ferric medicine or hematopoietic growth factors, such as epoetin alpha, or granulocyte-macrophage colony stimulating factor (G-CSF), were administered.

Virologic assessment and definition of virologic response

Serum HCV RNA level was quantified using the COBAS AMPLICOR HCV MONITOR test, version 2.0 (detection range 6–5000 KIU/ml; Roche Diagnostics, Branchburg, NJ) and qualitatively analyzed using the COBAS AMPLICOR HCV test, version 2.0 (lower limit of detection 50 IU/ml; Roche Diagnostics). The rapid virologic response (RVR) was defined as undetectable serum HCV RNA at week 4; the early virologic response (EVR) as undetectable serum HCV RNA at week 12; and the late virologic response (LVR) as detectable serum HCV RNA at week 12 and undetectable serum HCV RNA at week 24. Moreover, the sustained virologic response (SVR) was defined as undetectable serum HCV RNA, 24 weeks after treatment.

According to the protocol, genotype 1 patients, with less than a 2-log decrease in HCV RNA level at week 12 compared to the baseline, or with detectable serum HCV RNA at week 24, had to stop the treatment and were regarded as non-response (NR). Treatment discontinuance was evaluated except for those patients who had discontinued the treatment at up to 24 weeks, due to absence of response. Anti-viral efficacy was evaluated, for all study patients, using the intention-to-treat analysis (ITT analysis) and the per protocol analysis (PP analysis) for patients without treatment discontinuation due to side effects, and was assessed considering the definition of EVR or LVR for genotype 1, and RVR or non-RVR for genotype 2, as previously reported [1].

Research Article

Table 1. Baseline characteristics of patients.

Patients with genotype 1							
Factor	<55 y.o.	55 - 59 y.o.	60 - 64 y.o.	65 - 69 y.o.	≥70 y.o.	p value	
Number	266	159	149	134	51		
Age (y.o.)	44.4 ± 8.1	56.9 ± 1.4	62.0 ± 1.4	66.8 ± 1.4	71.4 ± 1.7	<0.001	
Sex: male / female	160 / 106	64 / 95	57 / 92	54 / 80	23 / 28	<0.001	
Body weight (kg)	64.6 ± 11.7	58.3 ± 9.4	58.1 ± 9.6	56.3 ± 9.3	56.3 ± 9.2	<0.001	
White blood cells (/mm ³)	5608 ± 1668	4901 ± 1664	4888 ± 1488	5113 ± 1426	4883 ± 1511	<0.001	
Neutrophils (/mm ³)	2923 ± 1214	2425 ± 1031	2559 ± 1155	2535 ± 1017	2599 ± 1149	<0.001	
Red blood cells (×10 ⁴ /mm ³)	454 ± 47	432 ± 38	427 ± 40	424 ± 37	424 ± 46	<0.001	
Hemoglobin (g/dl)	14.4 ± 1.5	13.8 ± 1.2	13.7 ± 1.3	13.6 ± 1.2	13.7 ± 1.4	<0.001	
Platelets (×10 ⁴ /mm ³)	18.6 ± 6.2	16.3 ± 5.7	15.4 ± 5.3	15.1 ± 5.0	14.4 ± 4.2	<0.001	
AST (IU/L)	62 ± 50	62 ± 45	64 ± 46	72 ± 45	64 ± 40	0.295	
ALT (IU/L)	79 ± 68	76 ± 64	73 ± 63	77 ± 58	65 ± 41	0.657	
Serum HCV RNA (KIU/ml)*	1800	1600	1700	1700	1700	0.691	
Histology (METAVIR)†	Fibrosis, 0 - 2 / 3 - 4	177 / 19	99 / 20	90 / 19	76 / 28	21 / 9	0.001
	Activity, 0 - 1 / 2 - 3	117 / 79	63 / 56	59 / 50	47 / 57	13 / 16	0.146
Peg-IFN dose (µg/kg/week) [‡]	1.47 ± 0.14	1.47 ± 0.16	1.46 ± 0.18	1.44 ± 0.18	1.36 ± 0.24	<0.001	
Ribavirin dose (mg/kg/day) [§]	11.5 ± 1.1	11.5 ± 1.4	11.5 ± 1.4	11.5 ± 1.7	11.2 ± 2.2	0.65	

Patients with genotype 2							
Factor	<55 y.o.	55 - 59 y.o.	60 - 64 y.o.	65 - 69 y.o.	≥70 y.o.	p value	
Number	145	43	38	41	14		
Age (y.o.)	40.9 ± 8.9	56.7 ± 1.3	62.3 ± 1.4	66.7 ± 1.5	71.8 ± 1.8	<0.001	
Sex: male / female	78 / 67	17 / 26	17 / 21	18 / 23	6 / 8	0.441	
Body weight (kg)	63.4 ± 12.0	59.5 ± 11.5	58.6 ± 11.7	58.5 ± 9.8	55.9 ± 6.8	0.783	
White blood cells (/mm ³)	6011 ± 1965	4874 ± 1346	4982 ± 1210	5079 ± 1877	4414 ± 871	<0.001	
Neutrophils (/mm ³)	3214 ± 1511	2468 ± 971	2576 ± 950	2492 ± 1119	2521 ± 683	0.001	
Red blood cells (×10 ⁴ /mm ³)	454 ± 48	430 ± 42	432 ± 50	430 ± 43	408 ± 48	<0.001	
Hemoglobin (g/dl)	14.3 ± 1.6	13.5 ± 1.3	13.9 ± 1.4	13.9 ± 1.3	13.3 ± 1.2	0.001	
Platelets (×10 ⁴ /mm ³)	21.3 ± 5.4	18.3 ± 6.1	17.0 ± 5.2	15.8 ± 5.4	13.9 ± 4.7	<0.001	
AST (IU/L)	53 ± 59	57 ± 45	55 ± 38	83 ± 48	68 ± 29	0.029	
ALT (IU/L)	65 ± 59	73 ± 70	68 ± 62	105 ± 62	78 ± 43	0.008	
Serum HCV RNA (KIU/ml)*	1700	1100	900	1100	500	0.008	
Histology (METAVIR)‡	Fibrosis, 0 - 2 / 3 - 4	102 / 0	25 / 3	29 / 2	21 / 9	7 / 1	<0.001
	Activity, 0 - 1 / 2 - 3	68 / 34	18 / 10	18 / 13	9 / 21	5 / 3	0.01
Peg-IFN dose (µg/kg/week) [‡]	1.48 ± 0.16	1.48 ± 0.14	1.45 ± 0.18	1.46 ± 0.15	1.28 ± 0.26	0.001	
Ribavirin dose (mg/kg/day) [§]	11.5 ± 1.1	11.4 ± 1.2	11.5 ± 1.4	11.3 ± 1.6	11.0 ± 1.4	0.55	

*, Data shown are median values.

†, 201 Missing.

‡, 82 Missing.

§, Initial doses.

during the whole treatment period was lower (1.1 ± 0.3 µg/kg/week) for patients over 70 y.o. than for those under 70 y.o. (1.3 ± 0.3 µg/kg/week) and that of ribavirin decreased with age (<55 y.o., 10.3 ± 1.9 mg/kg/day; 55–59 y.o., 9.8 ± 1.9 mg/kg/day; 60–64 y.o., 9.3 ± 2.3 mg/kg/day; 65–69 y.o., 9.2 ± 2.3 mg/kg/day; ≥70 y.o., 8.5 ± 2.5 mg/kg/day). The same tendency was observed with genotype 2.

Sustained virologic response

In genotype 1 patients, the overall SVR rate was 40% (305/759), being 46% (123/266) for group 1A, 44% (70/159) for group 1B, 42% (62/149) for group 1C, 26% (35/134) for group 1D, and 29% (15/51) for group 1E, following ITT analysis. The same tendency was observed using the PP analysis (n = 647). The SVR rates for patients over 65 y.o. were significantly lower than those for patients under 65 y.o. (ITT analysis: ≥65 y.o., 27% vs. <65 y.o.,

44%, p < 0.0001; PP analysis: ≥65 y.o., 31% vs. <65 y.o., 50%, p < 0.0001) (Fig. 1A). Among genotype 1 patients over 65 y.o., the SVR rate was significantly lower for female patients than for male patients (ITT analysis: male, 40% (31/77) vs. female, 18% (19/108), p < 0.001; PP analysis: male, 49% (27/55) vs. female, 20% (18/90), p < 0.001).

Moreover, for genotype 2 patients, the overall SVR rate was 78% (220/281), being 88% (128/145) for group 2A, 70% (30/43) for group 2B, 71% (27/38) for group 2C, 71% (29/41) for group 2D, and 43% (6/14) for group 2E, following ITT analysis. The same tendency was observed with the PP analysis (n = 253). The SVR rates for patients over 70 y.o. were significantly lower than those for patients under 70 y.o. (ITT analysis: ≥70 y.o., 43% vs. <70 y.o., 80%, p < 0.0001; PP analysis: ≥70 y.o., 56% vs. <70 y.o., 85%, p < 0.05) (Fig. 1B). Among patients over 70 y.o. with genotype 2, the difference according to gender was not clear because of the small sample.

Table 2. Reasons for treatment discontinuation.

Factor	<55 y.o. (n = 363)	55 - 59 y.o. (n = 182)	60 - 64 y.o. (n = 169)	65 - 69 y.o. (n = 147)	≥70 y.o. (n = 58)	Total (n = 919)
Neutropenia	2	3	0	0	0	5
Thrombopenia	1	0	1	1	0	3
Anemia	0	4	3	2	9	18
Fatigue	1	1	3	3	1	9
Gastrointestinal disorder	2	1	0	0	1	4
Cough, Dyspnea	1	0	3	0	0	4
Vertigo	1	0	0	0	3	4
Psychosis (depression)	7 (3)	7 (3)	4 (4)	3 (3)	2 (2)	23
Rash	5	2	5	7	1	20
Thyroid dysfunction	2	0	2	0	0	4
Fundal hemorrhage	0	2	0	2	0	4
Drug-induced hepatitis	3	1	0	0	0	4
Interstitial pneumonia	0	1	0	1	1	3
Cerebral hemorrhage, infarction	2	0	0	1	0	3
Others	9	5	7	8	3	32
Total	36 (10%)	27 (15%)	28 (17%)	28 (19%)	21 (36%)	140 (15%)

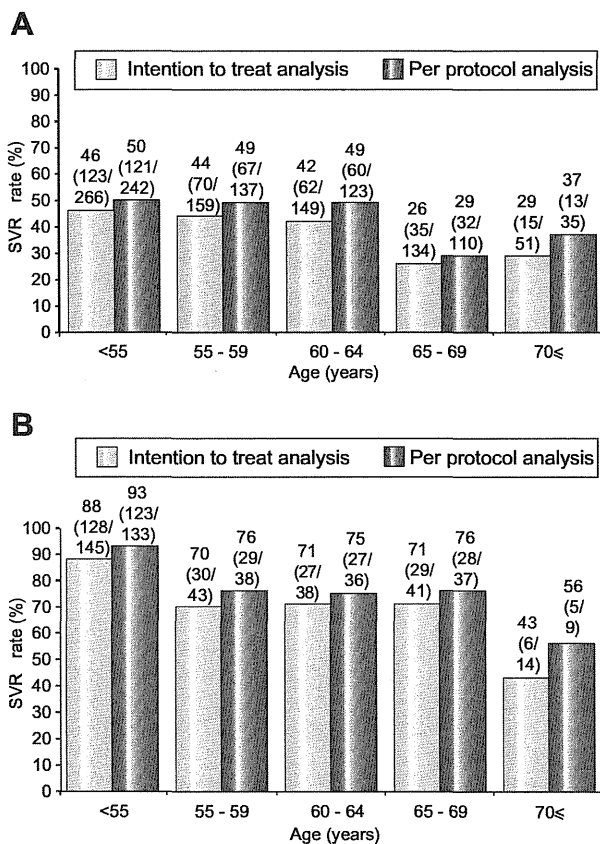


Fig. 1. SVR rate according to age. (A) Genotype 1. (B) Genotype 2.

Timing of HCV RNA negatvation for genotype 1, according to age

Treatment responses distributing EVR, LVR, and NR according to age are shown in Fig. 2. The rates of NR were similar in patient groups under 65 y.o. (30–36%), but increased in almost half of

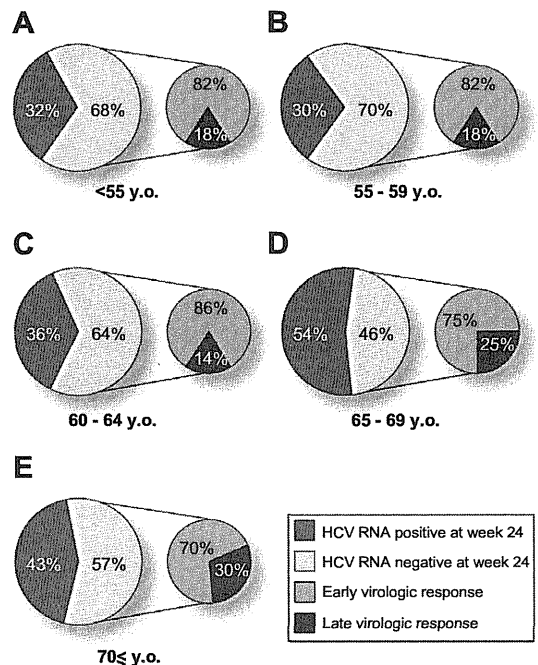


Fig. 2. Antiviral effect during treatment according to age. (A) <55 y.o. (B) 55–59 y.o. (C) 60–64 y.o. (D) 65–69 y.o. (E) ≥70 y.o.

the patients over 65 y.o. ($p < 0.0001$). Moreover, among the virologic responders, the proportion of LVR tended to increase in patients over 65 y.o. (25–30%) compared to patients under 65 y.o. (14–18%) ($p = 0.06$).

SVR rate according to the timing of HCV RNA negatvation

SVR rates according to EVR or LVR in genotype 1, and RVR or non-RVR in genotype 2 are summarized in Table 3. Genotype 1 patients with EVR achieved high SVR rates regardless of age; in particular, if EVR had been attained, 76% of patients with 65–69

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Table 3. SVR rate according to genotype and viral response in patients responding to PEG-IFN plus ribavirin combination therapy.

Factor	<55 y.o.	55 - 59 y.o.	60 - 64 y.o.	65 - 69 y.o.	≥70 y.o.
Genotype 1					
with EVR, % (n)	85 (114/134)	79 (62/79)	81 (55/68)	76 (29/38)	86 (12/14)
with LVR, % (n)	23 (7/30)	29 (5/17)	46 (5/11)	23 (3/13)	17 (1/6)
Genotype 2					
with RVR, % (n)	93 (57/61)	82 (14/17)	85 (17/20)	92 (11/12)	100 (4/4)
without RVR*, % (n)	96 (22/23)	60 (6/10)	57 (4/7)	50 (4/8)	0 (0/3)

RVR, rapid virologic response.

EVR, early virologic response.

LVR, late virologic response.

*, Serum HCV RNA was detectable at week 4, but undetectable at week 24.

Table 4. Multivariate analysis for the factors associated with SVR among all patients.

Factor	Category	Odds ratio	95% CI	<i>p</i>
Age (y.o.)	<65 / ≥65	0.485	0.295 - 0.799	0.005
Sex	male / female	0.524	0.353 - 0.777	0.001
Platelets ($\times 10^4/\text{mm}^3$)	<12 / ≥12	1.780	1.039 - 3.049	0.040
Serum HCV RNA (KIU/ml)	<2000 / ≥2000	0.599	0.401 - 0.896	0.010
Histology (METAVIR): Fibrosis	0 - 2 / 3 - 4	0.599	0.333 - 1.076	0.090

y.o. and 86% of patients over 70 y.o. achieved SVR, and these SVR rates compared favorably with those of younger patients. On the other hand, the SVR rates for patients with LVR ranged from 17% to 46%, which were lower than those for EVR patients in each age group, and no significant differences of SVR rates were found among LVR patients by age.

With genotype 2, patients with RVR achieved high SVR rates ranging from 82% to 100% regardless of age. Even for patients without RVR, 96% of those under 55 y.o. attained SVR, a rate that was significantly higher than that for patients over 55 y.o. (50%, 14/28) ($p < 0.001$).

Factors associated with SVR for genotype 1

The factors associated with SVR were assessed for the variables shown in Table 1. The factors selected as significant by the univariate analysis: age, gender, WBC, neutrophils, RBC, Hb, Plt, aspartate aminotransferase, serum HCV RNA level, the degree of liver fibrosis, and the initial dose of Peg-IFN, were evaluated by multivariate logistic regression analysis. The factor of age over 65 y.o. was the independent factor for SVR ($p = 0.005$), apart from the gender ($p = 0.001$), Plt value ($p < 0.05$), and serum HCV RNA level ($p = 0.01$) (Table 4).

Factors associated with EVR and SVR for patients over 65 y.o. with genotype 1

The results of univariate analysis for EVR among patients over 65 y.o. are shown in Table 5A. Gender, Plt value, and mean dose of Peg-IFN during the first 12 weeks were factors significantly associated with EVR. In multivariate analysis, the mean dose of Peg-IFN during the first 12 weeks was the independent factor for EVR ($p = 0.03$), apart from gender ($p = 0.002$) (Table 5B). The EVR rates were 41% (41/101) in patients who received ≥ 1.2 $\mu\text{g}/\text{kg}/\text{week}$ on average during the first 12 weeks, and declined to 36% (8/22) in patients given 0.9–1.2 $\mu\text{g}/\text{kg}/\text{week}$ of Peg-IFN, and

to 14% (3/22) in patients administered with < 0.9 $\mu\text{g}/\text{kg}/\text{week}$ of Peg-IFN.

The baseline and on-treatment factors, which are correlated with the SVR among the patients over 65 y.o., were assessed by univariate and multivariate analyses. Univariate analysis showed that factors significantly associated with SVR were gender and virologic response (Table 6A), and they were also selected as significant independent factors in multivariate analysis ($p = 0.035$, $p < 0.001$) (Table 6B).

Negative prediction of SVR for patients over 65 y.o. with genotype 1

We tried positive and negative predictions of SVR for aged patients, focusing on the decrease of HCV RNA at treatment week 4 and 8. The SVR rate was 47% (29/62) for patients with more than a 1-log decrease in HCV RNA level at week 4, while no patients with less than a 1-log decrease at week 4 attained SVR (0/35) ($p < 0.0001$). Similarly, 55% (35/64) of patients with more than a 2-log decrease at week 8 attained SVR, whereas no patients with less than a 2-log decrease at week 8 attained SVR (0/38) ($p < 0.0001$).

Discussion

Peg-IFN plus ribavirin combination therapy can improve anti-viral efficacy and is presently recommended as first-line therapy [1–4]. However, with respect to aged patients with CH-C, there have been only a few small-scale cohort studies which reported poor anti-viral effect and poor tolerability in comparison with non-aged patients [5–9]. The problem in the treatment of aged patients with CH-C is most serious in Japan, because HCV carriers in Japan are 10–20 years older than those in the United States and European countries [22]. Therefore, in the present study, we examined the efficacy and prevalence of side effects with a focus on patient's age using a large-scale cohort.

Table 5. Factors associated with EVR among patients over 65 y.o.

Univariate analysis				
Factor		EVR	Non-EVR	p value
Number		52	93	
Age (y.o.)		67.9 ± 2.3	67.8 ± 2.5	0.66
Sex: male / female		28 / 24	27 / 66	0.003
White blood cells (/mm ³)		5063 ± 1474	5001 ± 1422	0.76
Neutrophils (/mm ³)		2566 ± 1110	2551 ± 1071	0.87
Red blood cells (×10 ⁴ /mm ³)		426 ± 36	421 ± 38	0.64
Hemoglobin (g/dl)		13.7 ± 1.2	13.5 ± 1.2	0.21
Platelets (×10 ⁴ /mm ³)		16.5 ± 5.5	14.0 ± 4.6	0.009
AST (IU/L)		70 ± 51	70 ± 40	0.49
ALT (IU/L)		76 ± 58	70 ± 41	0.80
Serum HCV RNA (KIU/ml)*		1700	1900	0.62
Histology (METAVIR)†	Fibrosis, 0 - 2 / 3 - 4	25 / 10	47 / 20	0.54
	Activity, 0 - 1 / 2 - 3	16 / 19	29 / 37	0.52
Peg-IFN dose (µg/kg/week)‡		1.35 ± 0.24	1.25 ± 0.31	0.03
Ribavirin dose (mg/kg/day)‡		10.0 ± 2.2	9.6 ± 2.3	0.40

Multivariate analysis				
Factor	Category	Odds ratio	95% CI	p value
Sex	male / female	0.309	0.149 - 0.644	0.002
Platelets (×10 ⁴ /mm ³)	<12 / ≥12	-	-	N.S
Peg-IFN dose (µg/kg/week)‡	<1.2 / ≥1.2	2.481	1.079 - 5.705	0.03

*, Data shown are median values.
 †, 43 Missing.
 ‡, Mean doses during 0 to 12 weeks.
 N.S., not statistically significant.

Table 6. Factors associated with SVR among patients over 65 y.o.

Univariate analysis				
Factor		SVR	Non-SVR	p value
Number		45	100	
Age (y.o.)		68.0 ± 2.4	67.7 ± 2.5	0.45
Sex: male / female		27 / 18	28 / 72	<0.001
White blood cells (/mm ³)		5006 ± 1516	5030 ± 1409	0.81
Neutrophils (/mm ³)		2575 ± 1130	2548 ± 1063	0.96
Red blood cells (×10 ⁴ /mm ³)		427 ± 40	421 ± 36	0.53
Hemoglobin (g/dl)		13.8 ± 1.3	13.5 ± 1.2	0.14
Platelets (×10 ⁴ /mm ³)		16.1 ± 5.6	14.3 ± 4.7	0.09
AST (IU/L)		71 ± 54	69 ± 40	0.47
ALT (IU/L)		76 ± 56	70 ± 43	0.77
Serum HCV RNA (KIU/ml)*		1700	2000	0.51
Histology (METAVIR)†	Fibrosis, 0 - 2 / 3 - 4	21 / 8	51 / 22	1.00
	Activity, 0 - 1 / 2 - 3	14 / 15	31 / 41	0.66
Peg-IFN dose (µg/kg/week)‡		1.27 ± 0.28	1.23 ± 0.33	0.31
Ribavirin dose (mg/kg/day)‡		8.8 ± 2.1	9.1 ± 2.5	0.38
Virologic response: EVR / non-EVR		41 / 4	11 / 89	<0.001

Multivariate analysis				
Factor	Category	Odds ratio	95% CI	p value
Sex	male / female	0.283	0.088 - 0.914	0.035
Virologic response	EVR / non-EVR	0.012	0.004 - 0.043	<0.001

*, Data shown are median values.
 †, 43 Missing.
 ‡, Mean doses during treatment.

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With respect to the side effects and discontinuance rate of treatment in aged patients with CH-C, treated with Peg-IFN plus ribavirin combination therapy, Reddy et al. reported that there was no difference related to the incidence and reason for side effects between non-aged and aged patients [6]. Another paper reported that the incidence of side effects was more frequent in aged patients [5]. In our study, not only the continuance rate without reduction of both drug decreased with age, but also the discontinuance rate of treatment increased with age, with a third of the patients over 70 y.o. discontinuing the treatment. The discrepancy, existing between our results and those reported in the former study cited above, is due to the difference in the number of aged patients enrolled; Reddy's study analyzed a small cohort including only a few cases of patients over 65 y.o. and classified all those over 50 y.o. as aged patients.

Discontinuance of treatment due to progression of anemia was significantly higher in patients over 70 y.o., accounting for 43% (9/21) of the discontinuance in this group. Although the ratio of advanced fibrosis (score 3–4) increased with age, the high discontinuance rate due to anemia among patients over 70 y.o. was similar regardless of the progression of fibrosis (F0–2: <70 y.o., 1% (6/559) vs. ≥ 70 y.o., 21% (6/28), $p < 0.0001$; F3–4: <70 y.o., 0% (0/83) vs. ≥ 70 y.o., 22% (2/9), $p < 0.0001$). It is possible that poor hematopoietic function and renal function led to the progression of anemia in aged patients. For patients who develop severe anemia, using epoetin alpha or taribavirin, which are ribavirin pro-drugs, has been shown to result in a lower incidence of anemia, although no significant increase of SVR has been reported so far, even with the addition of taribavirin to Peg-IFN [23–24].

With genotype 1 patients, the SVR rates were almost equal up to 65 y.o. (49–50%), but decreased to 31% (45/145) among the patients that were over 65 y.o., and even for those who completed the entire treatment schedule in this study. Since the degree of liver fibrosis and drug exposure have been shown to be associated with anti-viral efficacy, the progression of liver fibrosis or decrease of drug exposure with age could account for the reduction of SVR rate among the aged patients. However, the stratified analysis, according to the progression of liver fibrosis and drug exposure, revealed that older patients still yielded low a SVR rate (F0–2, Peg-IFN during the first 12 weeks ≥ 1.2 $\mu\text{g}/\text{kg}/\text{week}$: <65 y.o., 55% (143/261) vs. ≥ 65 y.o., 33% (15/46), $p < 0.0001$; F0–2, Peg-IFN during the first 12 weeks <1.2 $\mu\text{g}/\text{kg}/\text{week}$: <65 y.o., 43% (26/60) vs. ≥ 65 y.o., 23% (6/26), $p = 0.07$), which means that older patients would be difficult to treat. From our results showing a low SVR rate and a high discontinuance rate for patients over 65 y.o., the genotype 1 patients under 65 y.o. were those who benefited the most from Peg-IFN plus ribavirin combination therapy. The high prevalence of treatment failure (non-SVR) among the aged patients seems to be due to the high populations of NR and LVR (Fig. 2). A high population of LVR is considered to lead to a higher transient response rate among aged patients, since those over 65 y.o. with LVR showed a much higher relapse rate (79%, 15/19) than those with EVR (21%, 11/52) ($p < 0.0001$), as can be seen from Table 3.

In this study, multivariate analysis for SVR, in patients over 65 y.o., showed that the factors associated with SVR were EVR and gender. This indicates that better SVR can be expected even with older patients if EVR is attained and response-guided therapy guidelines can be useful for aged patients. A low SVR rate among aged female patients was as previously reported [7], although the

mechanism remains unclear. This finding suggests that female patients should be treated before 65 y.o.

The next question is how aged patients should be treated in order to attain EVR. We have examined the impact of drug exposure on treatment efficacy [25–26] and reported that Peg-IFN is dose-dependently correlated with EVR [25]. In this study, the dose-dependent efficacy of Peg-IFN for EVR was also revealed in aged patients over 65 y.o., with less than 0.9 $\mu\text{g}/\text{kg}/\text{week}$ of Peg-IFN leading to a low EVR rate for aged patients. If patients are difficult to treat with more than 1.2 $\mu\text{g}/\text{kg}/\text{week}$ of Peg-IFN, using as much Peg-IFN as possible is desirable, in order to attain higher EVR rates. Accordingly, a reduction of Peg-IFN to 80% may need to be considered, although the manufacturer's drug information recommends reducing the dose of Peg-IFN to 50% of the assigned one. Since reduction of Peg-IFN has been reported to not affect the SVR rate after HCV RNA disappearance [26], using G-CSF for aged patients who develop severe neutropenia can be beneficial, especially in the first 12 weeks.

We also examined the negative prediction of SVR, i.e. an HCV RNA decrease at an earlier point of treatment than the usual prediction at treatment week 12 of a 2-log decrease, among aged patients with CH-C treated by Peg-IFN plus ribavirin combination therapy. We found that none of the patients without a 1-log decrease at week 4 or a 2-log decrease at week 8 could attain SVR, even if the complete treatment duration was given, the negative predictive value (NPV) for SVR equaled 100%. This earlier prediction is applied just as well to aged patients as to non-aged patients in order to avoid additional adverse effects. Recently, a genetic polymorphism near the *IL28B* gene has been reported to be associated with non-response to Peg-IFN plus ribavirin combination therapy [27–29], which is beneficial to patients. Nevertheless, even in the presence of this genetic polymorphism, NPV for SVR remains at 57–87%; 100% accuracy is not guaranteed. Thus, in addition to the pretreatment prediction, an earlier negative prediction for SVR during treatment is also considered to be useful.

We have shown in this study that, in the presence of genotype 2, HCV was easily eliminated even among aged patients; the SVR rates were over 75% for patients who had completed the treatment, and these rates were similar up to 70 y.o. The SVR rate of genotype 2 patients over 70 y.o. was 43%, however, the age limitation of the treatment among patients over 70 y.o. remains unclear, because of the small number of patients enrolled in this study. We have reported that the reduction of treatment drugs had little effect on anti-viral efficacy for patients with genotype 2, meaning that SVR can be attained even with aged patients who are usually given lower drug doses than non-aged patients [30]. Patients under 70 y.o. with genotype 2 should, at least, benefit from this therapy. The SVR rate was maintained among genotype 2 patients being 65–69 y.o., compared to genotype 1 patients. The higher efficacy with shorter treatment duration in genotype 2 aged patients can account for it.

In conclusion, the strategy of a response-guided therapy and an earlier negative prediction for SVR may be beneficial for aged patients, especially those with genotype 1. At present, aged patients up to 65–70 y.o. with CH-C can be candidates for Peg-IFN plus ribavirin combination therapy, if its efficacy and adverse effects are fully taken into account. At the same time, there is an urgent need to establish new treatment procedures, such as combination therapy with protease inhibitor plus polymerase inhibitor without Peg-IFN or ribavirin, for non-responders or patients

with poor tolerability for Peg-IFN plus ribavirin combination therapy among aged patients.

Conflict of interest

The authors who have taken part in this study declared that they do not have anything to disclose regarding funding or conflict of interest with respect to this paper.

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Amino Acid Substitution in the Core Protein has no Impact on Relapse in Hepatitis C Genotype 1 Patients Treated With Peginterferon and Ribavirin

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Previous reports demonstrated that amino acid (aa) substitutions in the hepatitis C virus (HCV) core protein are predictors of non-virological responses to pegylated interferon (Peg-IFN) and ribavirin combination therapy. The aim of this study was to investigate the impact of core aa substitutions on viral kinetics during the treatment and relapse after the treatment. The 187 patients with HCV genotype 1 enrolled in this study were categorized into four groups according to core aa substitution patterns: double-wild group (n=92), Arg70/Leu91; 70-mutant group (n=42), Gln70/Leu91; 91-mutant group (n=31), Arg70/Met91; and double-mutant group (n=22), Gln70/Met91. The relationship between the core aa substitutions and the virological response was examined. Multivariate logistic regression analyses showed that substitution at aa 70 was significantly associated with a poor virological response during the first 12 weeks (decline of <1 log from baseline at week 4, <2 log at week 12), and substitution at aa 91 was significantly associated with detectable HCV RNA at week 24. With respect to relapse, only the ribavirin exposure (odds ratio (OR), 0.77; 95% confidence interval (CI), 0.60–0.98) and HCV RNA disappearance between weeks 13 and 24 (OR, 23.69; 95% CI, 5.44–103.08) were associated independently with relapse, with no correlation being found with the core aa substitutions and relapse. In conclusion, the results showed that core aa substitutions can be strong predictive factors at pretreatment of the non-response, but not for relapse, for virological responders with HCV RNA disappearance during treatment. **J.**

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KEY WORDS: amino acid substitution; core protein; hepatitis C virus; peginterferon and ribavirin combination therapy; relapse

INTRODUCTION

The current standard of care for chronic hepatitis C patients is combination therapy using pegylated interferon (Peg-IFN) and ribavirin [Anonymous, 2002; Strader et al., 2004; Dienstag and McHutchison, 2006]. However, the treatment outcome in response to this combination therapy among patients infected with hepatitis C virus (HCV) genotype 1 is still unsatisfactory and the chance of sustained virological response ranges from 42% to 52% [Manns et al., 2001; Fried et al., 2002; Hadziyannis et al., 2004]. Therefore, tailoring treatment regimens for individual patients has become an important issue.

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Outcome of therapy is influenced by various factors. Some host factors, such as age, sex, body weight, insulin resistance, and liver fibrosis have been reported as pretreatment factors affecting virological response to this combination therapy [Manns et al., 2001; Fried et al., 2002; Hadziyannis et al., 2004; Romero-Gomez et al., 2005]. Recently, several genome-wide association studies identified single nucleotide polymorphisms (SNPs) near the interleukin (IL)-28B gene, which encodes interferon (IFN) lambda-3, as associated with response to Peg-IFN plus ribavirin treatment among patients infected with HCV of European [Suppiah et al., 2009], African [Ge et al., 2009], and Asian ancestry [Tanaka et al., 2009]. These studies suggest that host genetic variants may be associated strongly with response to IFN-alpha-based therapy. However, the ethical problem to perform host genetic search for all patients remains, and the sustained virological response rate is only 48–69% in patients having favorable IL-28B genotype to this combination therapy [Thompson et al., 2010].

Response-guided therapy is a dynamic approach to management of chronic hepatitis C patients based on the virological response at weeks 4 and 12 of treatment. At present, it is regarded as an excellent strategy for optimizing the treatment duration for individual patients. Earlier HCV RNA disappearance has been shown to lead to a higher sustained virological response rate [Ferenci et al., 2005; Berg et al., 2006; McHutchison et al., 2009], while patients without an early virological response, defined as showing an at least 2 log decrease from the baseline of HCV RNA levels at week 12 is recommended for discontinuing the treatment under the current guidelines [Anonymous, 2002; Strader et al., 2004; Dienstag and McHutchison, 2006].

In addition to viral kinetics during treatment, other viral factors have also been reported to be associated with this combination therapy outcome [Manns et al., 2001; Fried et al., 2002; Hadziyannis et al., 2004; Shirakawa et al., 2008]. Previous studies indicated that amino acid (aa) 70 and/or 91 substitutions in the HCV core protein were independent pretreatment predictors of null or weak response to this combination therapy in genotype 1 patients [Akuta et al., 2007b,c]. The HCV core protein has been reported to inhibit signal transducer and activator of transcription (STAT)-1 phosphorylation, and disrupt the normal IFN-stimulated transcriptional response to viral infection [Lin et al., 2006]. It is supposed that the HCV core region might be associated with resistance to IFN therapy involving the Janus activated kinase (Jak)-STAT signaling cascade [Blindenbacher et al., 2003; Bode et al., 2003; Melen et al., 2004; de Lucas et al., 2005]. Recently, Okanoue et al. [2009] have demonstrated that wild type of core aa 70 and 91 are important for positive prediction of the virological response. However, the impact of core aa substitutions on the extent of HCV RNA decline during the treatment or virological relapse after completion of treatment has not yet been investigated in detail. Approximately 30% of genotype 1 patients who become

HCV RNA negative at the end of the treatment will experience relapse [Hadziyannis et al., 2004]. Being able to distinguish between end-of-treatment responders with a high probability of relapse and those with a low probability of relapse will be useful in reducing relapse rates and improving treatment outcome.

The aim of this study was to evaluate the impact of aa substitutions in the HCV core protein on viral kinetics and virological relapse in patients with HCV genotype 1 treated by Peg-IFN alpha-2b and ribavirin combination therapy.

PATIENTS AND METHODS

Patient Selection and Study Design

Patients considered to be eligible for this study were those who were infected with HCV genotype 1, had a viral load more than 10^5 IU/ml, had started Peg-IFN alpha-2b (Schering-Plough K.K. Tokyo, Japan) and ribavirin (Schering-Plough K.K.) combination therapy from December 2005 to June 2008 at Osaka University Hospital and three other medical institutions taking part in the Osaka Liver Forum, and had been examined with respect to the aa sequences at positions 70 and 91 in the HCV core protein with pretreatment serum samples. Patients with the following criteria were excluded: hepatitis B virus or human immunodeficiency virus co-infection; decompensated liver disease; severe cardiac, renal, hematological, or chronic pulmonary disease; poorly controlled psychiatric disease; poorly controlled diabetes; and immunologically mediated disease. As a result of screening at the institutions concerned, 187 patients with HCV genotype 1 were enrolled in this study. Liver biopsy had been performed within 12 months prior to the treatment, and histological results were classified according to the METAVIR scoring system [Bedossa and Poynard, 1996].

Written informed consent was obtained from each patient, and the study protocol was reviewed and approved according to the ethical guidelines of the 1975 Declaration of Helsinki by Institutional Review Boards at the respective sites.

Peg-IFN alpha-2b and ribavirin dosages were based on body weight according to the manufacturer's instructions: Peg-IFN alpha-2b was given subcutaneously weekly (45 kg or less, 60 µg/dose; 46–60 kg, 80 µg/dose; 61–75 kg, 100 µg/dose; 76–90 kg, 120 µg/dose; and 91 kg or more, 150 µg/dose), and ribavirin was given orally daily (60 kg or less, 600 mg/day; 61–80 kg, 800 mg/day; and 81 kg or more, 1,000 mg/day). The drug doses were also modified based on the manufacturer's instructions according to the severity of the adverse hematologic effects.

Detection of Amino Acid Substitutions in Core Region

The nucleotide sequence encoding aa 1–191 (the core protein of HCV) was analyzed by direct sequencing as described by Akuta et al. [2005, 2007b]. In brief, HCV

RNA was extracted from the serum samples and converted to cDNA and two nested rounds of polymerase chain reaction (PCR) were performed. Primers used in the PCR were as follows: the first PCR was performed using cc11 (sense, 5'-GCC ATA GTG GTC TGC GGA AC-3') and e14 (antisense, 5'-GGA GCA GTC CTT CGT GAC ATG-3') primers. The second PCR was performed using cc9 (sense, 5'-GCT AGC CGA GTA GTG TT-3') and e14 (antisense) primers. All samples were denatured initially at 95°C for 15 min. The 35 cycles of amplification were set as follows: denaturation for 1 min at 94°C, annealing of primers for 2 min at 55°C, and extension for 3 min at 72°C with an additional 7 min for extension. Then 1 µl of the first PCR product was transferred to the second PCR reaction. The conditions for the second PCR were the same as the first PCR, except that the second PCR primers were used instead of the first PCR primers. The amplified PCR products were purified by the QIA quick PCR Purification Kit (Qiagen, Tokyo, Japan) after agarose gel electrophoresis and then used for direct sequencing. Dideoxynucleotide termination sequencing was performed with the Big Dye Deoxy Terminator Cycle Sequencing Kit (Perkin-Elmer, Tokyo, Japan). The obtained nucleotide and amino acid sequences were compared with the prototype sequence of genotype 1b HCV-J (GenBank Accession No. D90208) [Kato et al., 1990]. Wild types virus encoded arginine (Arg) and leucine (Leu) at aa 70 and 91, respectively, and the aa substitutions were glutamine (Gln) or histidine (His) at aa 70 and methionine (Met) at aa 91. If the intensities of the band were similar, the case was regarded as competitive. Two patterns of mutant and competitive were labeled as mutant. In this study, patients were categorized into four groups according to aa substitution patterns: double-wild group, Arg70/Leu91; 70-mutant group, Gln or His70/Leu91; 91-mutant group, Arg70/Met91; and double-mutant group, Gln or His70/Met91.

Virological Tests

Serum HCV RNA level was quantified by PCR assay (COBAS Amplicor HCV Monitor Test v2.0, Chugai-Roche Diagnostics, Tokyo, Japan), with a sensitivity limit of 5,000 IU/ml and a dynamic range from 5,000 to 5,000,000 IU/ml.

Serum HCV RNA was assessed by qualitative PCR assay (COBAS Amplicor HCV Test v2.0, Chugai-Roche Diagnostics), with a detection limit of 50 IU/ml.

Efficacy Assessments

Patients who achieved negative HCV RNA at week 12 were defined as having a complete early virological response. Patients who became HCV RNA negative between weeks 13 and 24 were defined as having a late virological response. According to the established guidelines, the treatment was considered to have failed if the patients showed an insufficient virological response at week 12 (a detectable HCV RNA and a decrease of <2 log from the baseline level) or at week 24 (a detectable

HCV RNA), and therapy was discontinued. The end-of-treatment response was defined as undetectable HCV RNA at week 48. Patients with end-of-treatment response and undetectable HCV RNA 24 weeks after completion of therapy were defined as having sustained virological response. Relapse was defined as a case in which HCV RNA had been undetectable at the end-of-treatment, but detectable during the 24-week follow-up after the treatment.

Drug Exposure

The amounts of Peg-IFN alpha-2b and ribavirin actually taken by each patient during the treatment period were evaluated by reviewing the medical records. The mean doses of both drugs were calculated individually as averages on the basis of body weight at baseline; Peg-IFN alpha-2b expressed as µg/kg/week and ribavirin as mg/kg/day.

Data Collection

The medical records were retrospectively reviewed and the factors necessary for this examination were extracted: age, sex, body weight, body mass index (BMI), basic laboratory assessments, liver histology, quantitative and qualitative HCV RNA, dose of Peg-IFN alpha-2b and ribavirin received at each administration, and the response to treatment.

Statistical Analysis

Continuous variables are reported as the mean with standard deviation (SD) or median level, while categorical variables are shown as the count and proportion. In univariate analysis, the Mann-Whitney *U*-test (between two groups) or Kruskal-Wallis test (among more than three groups) was used to analyze continuous variables, while chi-squared and Fisher's exact tests were used for analysis of categorical data. For all tests, two-sided *P* values were calculated, and the results were considered statistically significant if *P* < 0.05. Variables that achieved statistical significance (*P* < 0.05) or marginal significance (*P* < 0.10) on univariate analysis were subjected to multivariate logistic regression analysis. Stepwise and multivariate logistic regression models were used to explore the independent factors that could be used to predict a virological response. Statistical analysis was performed using the SPSS program for Windows, version 15.0J (SPSS, Chicago, IL).

RESULTS

Baseline Characteristics of Study Groups

The total study population was predominately male (55.6%), with a mean age of 56.2 years. The baseline characteristics of all patients and the four study groups according to core aa substitution patterns are shown in Table I. Mean age of patients in the double-mutant group was higher than the other three groups (*P* = 0.003). More patients in the double-wild group had

TABLE I. Baseline Demographic and Viral Characteristics of Patients

Characteristic	Total (n = 187)	Double-wild (n = 92)	70-Mutant (n = 42)	91-Mutant (n = 31)	Double-mutant (n = 22)	P value ^a
Age (years)	56.2 ± 9.3	55.7 ± 9.2	57.0 ± 9.8	52.4 ± 9.9	61.8 ± 4.7	0.003
Sex (male/female)	104/83	51/41	26/16	18/13	9/13	0.444
Body weight (kg)	60.9 ± 11.6	60.9 ± 11.7	62.2 ± 11.7	62.5 ± 13.2	56.0 ± 7.5	0.193
Body mass index (kg/m ²)	22.8 ± 3.1	22.8 ± 3.0	22.8 ± 3.1	23.1 ± 3.6	22.1 ± 2.4	0.627
Past IFN therapy (naïve/experienced)	118/69	45/47	34/8	20/11	19/3	<0.001
HCV RNA (×10 ³ IU/ml) ^b	1,700	2,100	1,400	1,500	1,230	0.122
Fibrosis (0–2/3–4) ^c	105/29	56/11	22/6	14/7	13/5	0.366
Activity (0–1/2–3) ^d	83/50	42/24	18/10	11/10	12/6	0.771
White blood cell (×10 ⁶ /l)	4,980 ± 1,520	4,990 ± 1,420	5,180 ± 1,760	4,890 ± 1,430	4,660 ± 1,560	0.795
Red blood cell (×10 ¹² /l)	4.34 ± 0.46	4.33 ± 0.46	4.41 ± 0.52	4.39 ± 0.42	4.18 ± 0.32	0.145
Hemoglobin (g/dl)	13.9 ± 1.4	13.9 ± 1.4	14.0 ± 1.7	14.2 ± 1.4	13.5 ± 1.1	0.253
Platelet (×10 ⁹ /l)	161 ± 54	167 ± 49	165 ± 65	154 ± 60	138 ± 30	0.067
ALT (IU/l)	74 ± 61	73 ± 67	79 ± 56	81 ± 64	57 ± 37	0.263
γ-GTP (IU/l)	62 ± 74	47 ± 54	81 ± 89	70 ± 93	78 ± 78	0.032

IFN, interferon; HCV, hepatitis C virus; ALT, alanine aminotransferase; γ-GTP, gamma-glutamyl transpeptidase.

^aP value for comparison among double-wild, 70-mutant, 91-mutant, and double-mutant.

^bValues expressed as median.

^cData for 53 patients are missing.

^dData for 54 patients are missing.

been treated previously for HCV infection ($P < 0.001$). Patients in the double-wild group had significantly lower gamma-glutamyl transpeptidase (γ-GTP) levels ($P = 0.032$).

Progress of Patients

The progress of patients in this study is shown in Figure 1. Of the 187 patients, 183 completed 4 weeks of treatment. Among them, 133 were assessed based on HCV RNA dynamics between baseline and week 4.

Those completing 12 weeks of treatment totaled 181, of which 154 were assessed for HCV RNA dynamics between baseline and week 12. Those completing 24 weeks of treatment totaled 153, and all were assessed for HCV RNA quantitatively or qualitatively at week 24. Those completing 48 weeks of treatment totaled 114. These 114 patients and the 55 patients who had discontinued treatment because of treatment failure entered a follow-up period. Among these 169 patients, 164 completed 24 weeks follow-up and the sustained virological response (SVR) rate

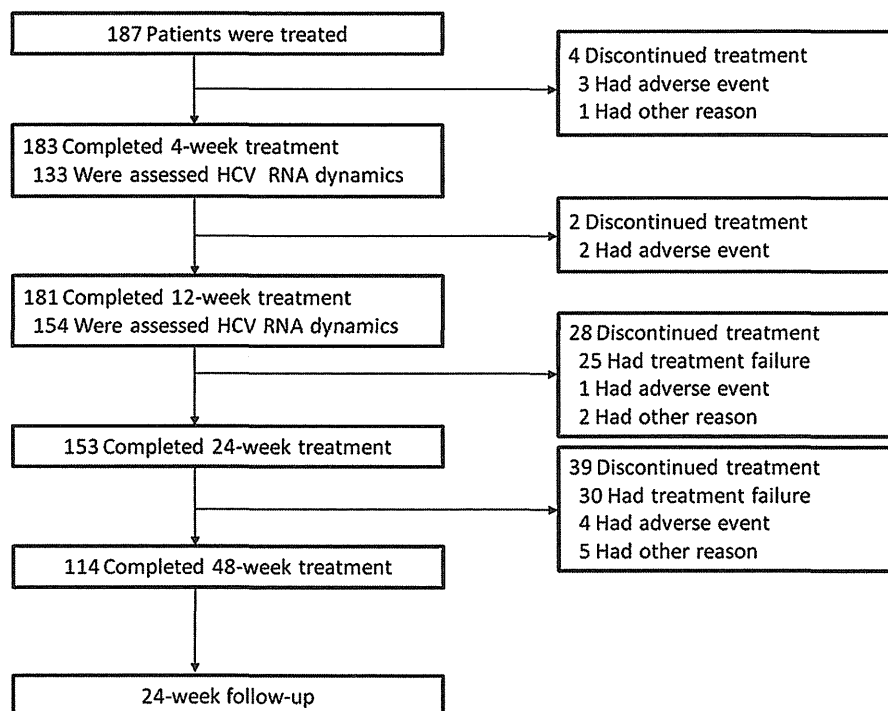


Fig. 1. Treatment and follow-up of the study patients. Treatment was discontinued for patients with <2 log decrease from the baseline HCV RNA level at week 12 or detectable HCV RNA at week 24.

TABLE II. Multivariate Analysis for Factors Associated With <1 log Decrease in HCV RNA Level at Week 4, <2 log Decrease at Week 12, Detectable HCV RNA at Week 24, and Relapse After Treatment

Factor	Category	Odds Ratio	95% CI	P value
HCV RNA <1 log decrease at week 4				
White blood cells ($\times 10^6/l$)	<5,000/5,000 \leq	—	—	NS
γ -GTP (IU/l)	<40/40 \leq	—	—	NS
Peg-IFN dose (μ g/kg/week)	By 0.1 μ g/kg/week	0.80	0.67–0.97	0.020
Core aa 70	Wild/mutant	1/2.80	1.16–6.75	0.022
HCV RNA <2 log decrease at week 12				
γ -GTP (IU/l)	<40/40 \leq	—	—	NS
Peg-IFN dose (μ g/kg/week)	By 0.1 μ g/kg/week	—	—	NS
Core aa 70	Wild/mutant	1/2.72	1.09–6.78	0.032
Detectable HCV RNA at week 24				
Platelet ($\times 10^9/l$)	<150/150 \leq	—	—	NS
γ -GTP (IU/l)	<40/40 \leq	1/2.46	1.02–5.95	0.045
Core aa 91	Wild/mutant	1/4.11	1.73–9.78	0.001
Relapse after treatment				
Ribavirin dose (mg/kg/day)	By 1 mg/kg/day	0.77	0.60–0.98	0.036
Virological response	Complete early virological response/late virological response	1/23.69	5.44–103.08	<0.001

CI, confidence interval; NS, not significant difference; γ -GTP, gamma-glutamyl transpeptidase; Peg-IFN, pegylated interferon; aa, amino acid.

was 48.2% (79/164), based on per-protocol set. Among the 106 patients who had an end-of-treatment response and completed follow-up, 27 showed relapse during the follow-up period; the relapse rate was 25.5% (27/106).

IMPACT OF CORE-RELAPSE AFTER TREATMENT (TABLE II)

Impact of core aa substitutions on <1 log viral decrease rate at week 4, <2 log at week 12, detectable HCV RNA at week 24, and virological relapse after treatment (Table II).

The impact of core aa substitutions on <1 log viral decrease rate at week 4, <2 log at week 12, detectable HCV RNA at week 24, and virological relapse after treatment (Table II).

The impact of the core aa substitutions on <1 log viral decrease at week 4, which is a predictor of non-sustained virological response; fewer than 5% of patients without 1 log decrease at week 4 had an sustained virological response [McHutchison et al., 2009] was examined. Among the 133 patients who completed 4 weeks of treatment, 31 failed to show a ≥ 1 log decrease of HCV RNA level at week 4. Univariate analysis for factors associated with <1 log decrease of HCV RNA level at week 4 was performed on the following variables: age, sex, body weight, BMI, history of past IFN therapy, baseline HCV RNA level, histological fibrosis and activity, white blood cell count, red blood cell count, hemoglobin level, platelet count, alanine aminotransferase (ALT) level, γ -GTP level, dose exposure of Peg-IFN and ribavirin, and aa substitutions in the HCV core protein. The results indicated that pretreatment white blood cell count, γ -GTP level, the mean dose of Peg-IFN during the first 4 weeks of treatment and single-spot substitution in the HCV RNA core position at aa 70 contributed to a <1 log decrease of HCV RNA level at week 4. Analysis of

these factors by multivariate logistic regression analysis showed that substitution of aa 70 (odds ratio (OR) 2.80, 95% confidence interval (CI) 1.16–6.75, $P = 0.022$) as well as the mean dose of Peg-IFN (OR 0.80, 95% CI 0.67–0.97, $P = 0.020$) was independently associated with viral decline (<1 log) at week 4.

Next, the impact of the core aa substitutions on <2 log viral decrease rate at week 12, which is presently considered to be the most reliable predictor of non-sustained virological response [Fried et al., 2002; Davis et al., 2003] was examined. Among the 154 patients who completed 12 weeks of treatment, 25 failed to show a ≥ 2 log decrease of HCV RNA level at week 12. Univariate analysis was performed on the same factors in the preceding examination. As a result, pretreatment γ -GTP level, the mean dose of Peg-IFN during the first 12 weeks of treatment and single-spot substitution in the HCV RNA core position at aa 70 contributed to a <2 log decrease of the HCV RNA level. These factors were then analyzed by multivariate logistic regression analysis; only substitution of aa 70 (OR 2.72, 95% CI 1.09–6.78, $P = 0.032$) was found to be independently associated with an insufficient virological response (<2 log HCV RNA decrease from baseline level) at week 12.

The impact of the core aa substitutions on detectable HCV RNA at week 24, which is another non-sustained virological response predictor [Davis et al., 2003] was also examined. Among 153 patients who completed 24 weeks of treatment, 30 still had detectable HCV RNA at week 24. Univariate analysis revealed that pretreatment platelet count, γ -GTP level, and single-spot substitution in the HCV RNA core position at aa 91 contributed to the HCV RNA remaining positive. Multivariate logistic regression analysis, using these factors, indicated that substitution of aa 91 (OR 4.11, 95% CI 1.73–9.78, $P = 0.001$) as well as γ -GTP level (>40 IU/l) (OR 2.46, 95% CI 1.02–5.95, $P = 0.045$) was

independently associated with detectable HCV RNA at week 24.

Next, the factors associated with virological relapse after the treatment was examined. Univariate analysis was performed on the virological response (complete early virological response or late virological response) in addition to the factors in the preceding examination, revealing the mean dose of ribavirin during the full treatment period and a late virological response, but not aa substitutions (single-spot substitution in the HCV RNA core position at aa 70, $P = 0.467$; aa 91, $P = 0.776$).

These factors were analyzed by multivariate logistic regression analysis. This analysis revealed that the mean ribavirin dose (OR 0.77, 95% CI 0.60–0.98, $P = 0.036$) and a late virological response (OR 23.69, 95% CI 5.44–103.08, $P < 0.001$) were independently associated with relapse.

Relapse Rates According to the Timing of HCV RNA Disappearance, Ribavirin Dose, and Core aa Substitution Patterns

The relapse rates were indicated according to the time to the first non-detection of HCV RNA, mean ribavirin dose and core aa substitution patterns (Fig. 2). The relapse rate was 0% (0/10) in patients with undetectable HCV RNA during 1–4 weeks, and increased 13.3% (6/45) during 5–8 weeks, 25.9% (7/27) during 9–12 weeks, 40% (2/5) during 13–16 weeks, 100% (6/6) during 17–20 weeks, and 100% (3/3) during 21–24 weeks (Fig. 2A). Similarly, the relapse rates increased as the mean ribavirin dose decreased; 13.3% (2/15) in patients receiving ≥ 12 mg/kg/day of ribavirin, 21.1% (8/38) at 10–12 mg/kg/day, 28.6% (8/28) at 8–12 mg/kg/day, and 36% (9/25) at < 8 mg/kg/day (Fig. 2B). On the other hand, the relapse rates were similar among the four core aa substitution patterns; 23.0% (14/61) in patients in the double-wild group, 36% (9/25) in 70-mutant group, 23.1% (3/13) in 91-mutant group, and 14.3% (1/7) in double-mutant group (Fig. 2C). In the subgroup of patients receiving < 10 mg/kg/day of ribavirin, no significant difference of the relapse rates was observed between double-wild group and 70-mutant and/or 91-mutant group (31.3% (10/32) in double-wild group vs. 33.3% (7/21) in 70-mutant and/or 91-mutant group), and also in the patients receiving ≥ 10 mg/kg/day of ribavirin (13.8% (4/29) in double-wild group vs. 25% (6/24) in 70-mutant and/or 91-mutant group) (Fig. 3). Among patients with complete early virological response, the relapse rates were also similar between double-wild group and 70-mutant and/or 91-mutant group (13.7% (7/51) in double-wild vs. 18.4% (7/38) in 70-mutant and/or 91-mutant group). The impact of core aa substitutions on relapse rates in patients with late virological response could not be assessed because of the small number of patients.

DISCUSSION

Kobayashi et al. [2010] investigated the clinical and virological factors influencing these core aa substitutions in patients infected with HCV genotype 1 who had not received antiviral therapy, and found that HCV variants with wild type of core aa 70 and 91 significantly decreased with age, while those with the mutant type of core aa 70 and/or 91 significantly increased with age. Furthermore, they demonstrated that the proportion of patients with the mutant type of core aa 70 HCV variant significantly increased with an elevated γ -GTP level and a decrease in platelet counts. In this study, the significant differences of baseline demographics between patient groups according to core aa substitution pat-

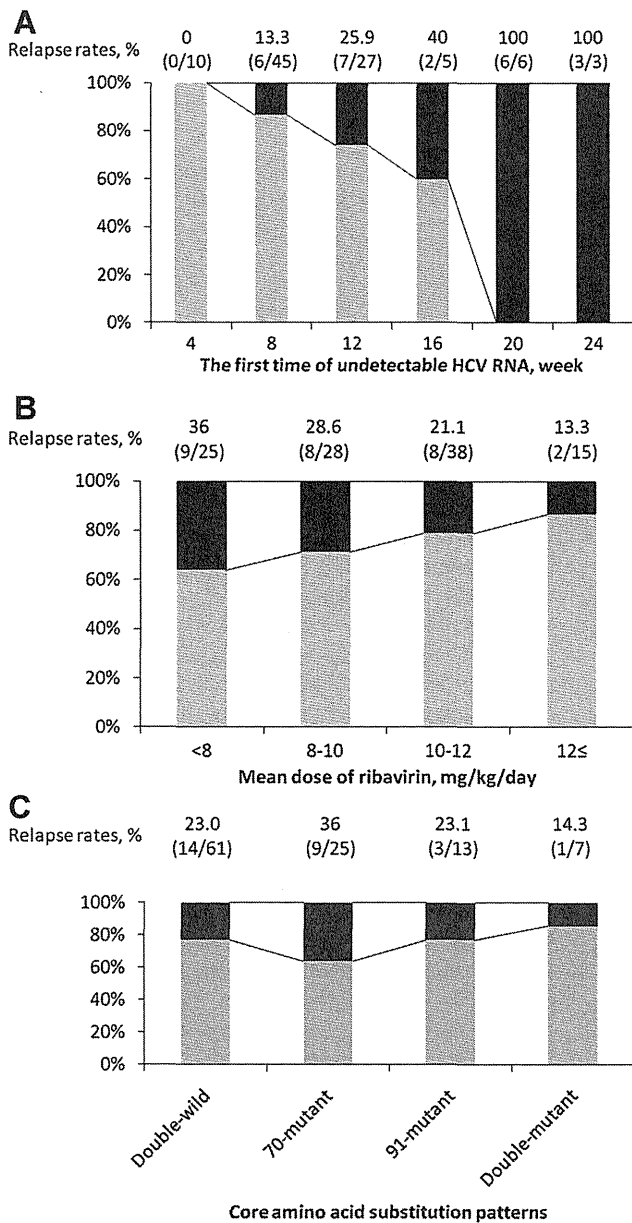


Fig. 2. Relapse rates according to the timing of HCV RNA disappearance (A), mean ribavirin dose (B), and core amino acid substitution patterns (C) in patients who had end-of-treatment response and completed 24-week follow-up. Relapse rates are shown as percentages and the number of patients with relapse in relation to the total number of patients examined is shown at the top of each column. Gray bar, sustained virological response; black bar, relapse.

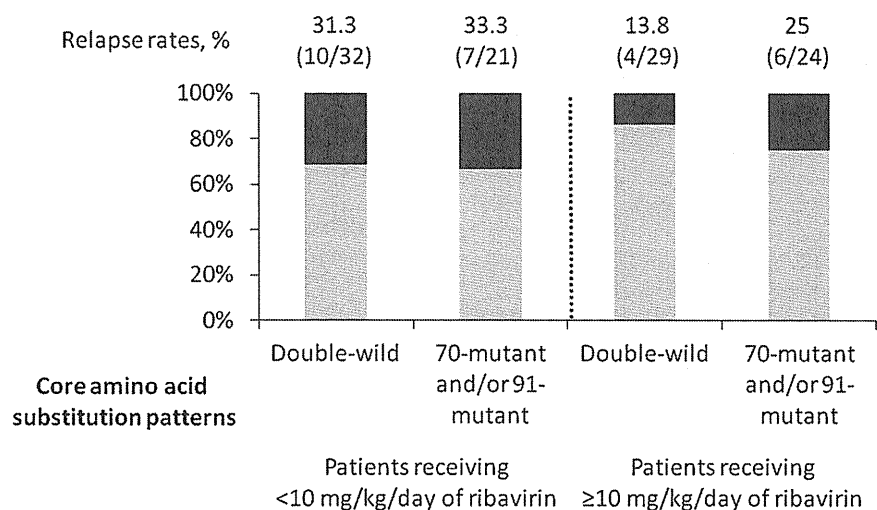


Fig. 3. Relapse rates according to core amino acid substitution patterns in patients receiving <10 mg/kg/day and receiving ≥ 10 mg/kg/day of ribavirin. Relapse rates are shown as percentages and the number of patients with relapse in relation to the total number of patients examined is shown at the top of each column. Gray bar, sustained virological response; black bar, relapse.

terns were similarly found in age, platelet count, and γ -GTP level. Accordingly, this study cohort had no specific bias and seems to reflect the natural background of the patients according to the HCV variance. In this study, the impact of HCV core aa substitutions on the virological response were evaluated by multivariate analysis, in order to resolve the bias of patient background factors among the groups classified according to the core aa substitution patterns. Recently, Abe et al. [2010] reported that the human genotype of the rs8099917 SNP at the IL28B locus was associated with lower γ -GTP level and viral wild type of core aa 70 and 91. Possibly these differences of IL28B genotype may influence the difference of patient background factors. Further studies are needed to clarify the relationship between human genetic variation and HCV core amino acid substitutions.

The HCV core protein has been reported to have an effect on a variety of cellular functions [Lai and Ware, 2000; Joo et al., 2005; Ariumi et al., 2007; Waris et al., 2007; Osna et al., 2008]. Currently, aa substitutions in the HCV core region has been thought to be related with outcome of antiviral therapy [Akuta et al., 2005; Donlin et al., 2007] and also the development of hepatocellular carcinoma [Akuta et al., 2007a; Hu et al., 2009]. Importance of core aa substitutions, especially at aa 70 and 91, comes to be recognized, and the new method to detect these substitutions easily has been proposed [Nakamoto et al., 2009]. As for the mechanism of antiviral activity on core aa substitutions, Ikeda et al. [2010] showed that core aa substitutions were not associated with intracellular antiviral response to IFN-alpha by in vitro analysis. The mechanism of antiviral activity and hepatocarcinogenesis on core aa substitutions has not been elucidated enough, so far. Further in vitro studies will be needed to clarify this.

Previous studies showed that patients with substitution of core aa 70 often had slow or no decrease in HCV RNA levels during the early phase of IFN-alpha treatment [Akuta et al., 2005, 2007b,c; Donlin et al., 2007]. Consistent with these reports, multivariate analysis in this study revealed that substitution of core aa 70 could be independently associated with insufficient viral decline during the first 12 weeks after the treatment (decline of <1 log from baseline at week 4, <2 log at week 12). This suggests that patients with substitution of core aa 70 are likely to fail to have a sustained virological response. On the other hand, dose exposure of Peg-IFN during the first 4 weeks of treatment was also independently linked to a minimal decline in HCV RNA (<1 log) at week 4 in this study. This suggests that maintaining the dose of Peg-IFN as high as possible until the disappearance of HCV RNA can help avoid treatment failure [McHutchison et al., 2002; Oze et al., 2009], especially in patients with substitution of core aa 70. On the other hand, substitution of core aa 91 was independently associated with detectable HCV RNA at week 24. This suggests that patients with substitution of core aa 91 are likely to achieve non-sustained virological response even if they had a ≥ 2 log decline in the HCV RNA level at week 12. The reason for the difference of the impact on virological response is not yet clear.

Multivariate logistic regression analysis also showed that the dose exposure of ribavirin during the full treatment period and having late virological response were independently associated with relapse. As for ribavirin exposure, it has been previously demonstrated that the relapse rate among patients responding to the treatment showed a decline in relation to the increase in the dose of ribavirin [Hiramatsu et al., 2009]. In this study, relapse rates were also decreased from 36% to 13.3% with increasing dose exposure of ribavirin among patients with end-of-treatment response. These results

confirm that maintaining a sufficient dose of ribavirin during the full treatment period could reduce the possibility of relapse, and that an extended duration of therapy for patients with late virological response could increase the chance of achieving sustained virological response, regardless of core aa substitution patterns [Berg et al., 2006; Pearlman et al., 2007; Ferenci et al., 2010].

In this study, the COBAS Amplicor HCV Test v2.0, with a lower limit of detection of 50 IU/ml, was used to assess the serum HCV RNA. Recently, real-time PCR-based HCV RNA assays with a higher sensitivity, COBAS TaqMan HCV assay (Chugai-Roche Diagnostics), with a lower limit of detection of 15 IU/ml, have been introduced. Sarrazin et al. [2010] compared virological response rates that were originally tested by COBAS Amplicor assay with those retested by COBAS TaqMan assay, using the same cohort. Among genotype 1 patients, complete early virological response and sustained virological response rates were similar when virological responses were defined as <50 IU/ml by Amplicor assay (77% and 87%) and <15 IU/ml by TaqMan assay (76% and 88%). Therefore, measuring HCV RNA by the Amplicor assay in this study would have little effects on the results.

In conclusion, the results have demonstrated that substitution of core aa 70 could be independently associated with an insufficient decline in HCV RNA level during first 12 weeks, and substitution of core aa 91 was independently associated with detectable HCV RNA at week 24, all of which were considered to be important negative predictors of attaining sustained virological response in patients with HCV genotype 1 treated with Peg-IFN plus ribavirin. On the other hand, only dose exposure of ribavirin and no complete early virological response was independent predictors of virological relapse among patients with end-of-treatment response, not substitution of core aa 70 or 91. The aa substitution patterns of the HCV core protein can be an important pretreatment predictor for non-response in patients with HCV genotype 1 treated with Peg-IFN plus ribavirin, but not for relapse after the completion of therapy.

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