Factors of Response to Pegylated Interferon/Ribavirin Combination Therapy and Mechanism of Viral Clearance

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showed that IRRDR ≥6 and ISDR ≥2 were significant pretreatment predictors of RVR, and multivariate analysis identified IRRDR ≥6 and hemoglobin as significant predictors of SVR. Pretreatment IFN-λ1 was significantly higher in the SVR group than in the non-SVR group and also in the IRRDR ≥6 group than in the IRRDR ≤5 group. Conclusions: IRRDR ≥6 was the only significant predictor of SVR and was correlated with IFN-λ1. High serum levels of IFN-λ1 may be conducive to effective PEG-IFN/RBV combination therapy because of the immunomodulatory system.

Introduction

Although the triple therapy of combined pegylated interferon (PEG-IFN), ribavirin (RBV) and protease inhibitors has already been initiated, PEG-IFN and RBV combination therapy for chronic hepatitis C virus (HCV) infection with a high viral load of genotype 1b, the standard
treatment in Japan since 2004, provides sustained virological response (SVR) in only approximately 50% of such patients [1]. Single-nucleotide polymorphisms in proximity to the interleukin 28B (IL-28B) gene (rs8099917, rs12979860) on chromosome 19 is reported in proximity to the interleukin 28B (IL-28B) gene determining region (IRRDR). In recent years, viral factors such as the core protein, non-structural protein 5A (NS5A), the IFN sensitivity-determining region (ISDR) and the IFN/RBV resistance-determining region (IRRDR) [4–8] have been associated with virological response. Nonetheless, the mechanism of how these host and viral factors affect viral clearance has not been precisely elucidated to date.

IFN-λ1 is considered to be associated with the inhibition of the replication of HCV by an immunological mechanism [9, 10]. Few studies, however, have demonstrated the correlation among IFN-λ1 serum levels, the clinical outcome of PEG-IFN and RBV combination therapy, and viral and host factors. We investigated the viral and host factors associated with response to PEG-IFN and RBV combination therapy and the correlation of viral and host factors with IFN-λ1.

Patients and Methods

Patients
A total of 58 patients (32 men, 26 women; age 57.3 ± 10.4 years) seen at Kobe Asahi Hospital and diagnosed with chronic HCV and high viral loads of genotype 1b were enrolled in the study. Patients demonstrating hemoglobin levels ≥11 g/dl (women) or ≥12 g/dl (men), platelet count ≥9 × 10⁴/mm³, HCV RNA ≥5.0 log IU/ml, neutrophil count ≥1.500/mm³ and thyroid-stimulating hormone levels within normal limits were included in the study; those demonstrating human immunodeficiency virus or hepatitis B coinfected, psychiatric conditions, or a history of severe psychiatric disorder were excluded.

Treatment comprised PEG-IFN-α2b (1.5 μg per kilogram body weight, once a week) plus RBV (600–1,000 mg daily, based on body weight) for a total of 48 weeks, according to the standard treatment protocol for Japanese patients. Informed written consent was obtained from each patient and the study protocol conformed to the ethical guidelines approved by the Ethics Committee of Kobe Asahi Hospital.

Laboratory Tests
HCV RNA was extracted from 140 μl of serum with the use of a commercially available kit (QIAamp viral RNA kit; Qiagen, Tokyo, Japan). Amplification of full-length NS5A and the core regions of the HCV genome was carried out as described [5]. The sequences of the amplified fragments of NS5A and the core regions were determined by direct sequencing without subcloning. The amino acid (aa) sequences were deduced and aligned with the use of GENETYX Win software version 7.0 (GENETYX Corp., Tokyo, Japan). Genetic polymorphism rs8099917 around the IL-28B gene was determined by real-time PCR using the TaqMan assay. We defined the IL-28B major allele as homozygous (TT) for the major sequence and the minor allele as homozygous (GG) or heterozygous (TG) for the minor sequence. IFN-λ1 was assayed before initiation of therapy and at 4, 12 and 48 weeks after therapy by ELISA Ready-SET-Go (unit, pg/ml; NatuTec, Frankfurt, Germany).

Statistical Analysis
Rapid virological response (RVR) and SVR were defined as undetectable HCV RNA at weeks 4 and 24, respectively, after treatment. The potential pretreatment factors associated with virological response were assessed by univariate analysis of arginine (Arg70), or glutamine (Gln70), and at aa 91 of leucine/methionine, or a history of severe psychiatric disorder were excluded.

Potential pretreatment factors associated with virological response were assessed by univariate analysis using Student’s t test, Fisher’s exact test or χ² test, and by multivariate analysis using logistic regression analysis. The factors in multivariate logistic regression analysis were included in descending order according to correlation. The most appropriate model was chosen by AIC (Akaike Information Criterion). We compared pretreatment IFN-λ1 in the IRRDR ≥6 and IRRDR ≤5 groups, in the ISDR (ISDR ≥2 and ISDR ≤1) and IRRDR (IRRDR ≥6 and IRRDR ≤5) – and mutated core protein amino acid substitutions at aa 70 of arginine (Arg70), or glutamine (Gln70), and at aa 91 of leucine (Leu91), or methionine (Met91), were examined. Factors associated with virological response were assessed by univariate analysis using Student’s t test, Fisher’s exact test or χ² test, and by multivariate analysis using logistic regression analysis. The factors in multivariate logistic regression analysis were included in descending order according to correlation. The most appropriate model was chosen by AIC (Akaike Information Criterion). We compared pretreatment IFN-λ1 in the IRRDR ≥6 and IRRDR ≤5 groups, in the ISDR ≥2 and ISDR ≤1 groups, in the IL-28B TT genotype for the major sequence and in the IL-28B GG genotype and TG genotype for the minor sequence, and in the core protein (aa 70 and aa 91) wild and mutant. Variables with a p value <0.05 were considered statistically significant. All statistical analyses were carried out with the use of Excel Statistics 2011 by SSRI.
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R e s u l t s

Patient baseline characteristics are listed in table 1. RVR was observed in 8.6% (5/58) and SVR in 44.8% (26/58) of the patients. ISDR ≥2 and IRRDR ≥6 were significantly associated with RVR as assessed by univariate analysis (p = 0.012, p = 0.004; table 2). IRRDR ≥6 was most significantly correlated with RVR, which was from biased data of distribution (table 2). As a result, we were not able to conduct multivariate analysis for RVR. By univariate analysis, the significant factors associated with SVR were age, sex, hemoglobin, IL-28B major, IRRDR ≥6 (p = 0.015, p = 0.016, p < 0.001, p = 0.006, p < 0.001, p = 0.037; table 3). The pretreatment IFN-λ1 serum level in SVR was significantly higher than in non-SVR (38.8 vs. 24.7 pg/ml, p = 0.037; table 3). By multivariate analysis, hemoglobin and IRRDR ≥6 were significantly associated with SVR (p = 0.02, p = 0.005; table 4). Pretreatment IFN-λ1 was significantly higher in the IRRDR ≥6 group than in the IRRDR ≤5 group (40.5 vs. 25.2 pg/ml, p = 0.041; fig. 1), but demonstrated no significant difference between the ISDR ≥2 group and the ISDR ≤1 group (37.2 vs. 29.1 pg/ml, p = 0.45; fig. 1), among the IL-28B TT genotype group, the TG genotype group and the GG genotype group (TT vs. TG, 33.4 vs. 24.6 pg/ml, p = 0.26; TT vs. GG, 33.4 vs. 20.8 pg/ml, p = 0.48; TG vs. GG, 24.6 vs.

Discussion

Pretreatment factors significantly and independently predictive of the outcome of treatment of patients infected with high viral loads of HCV-1b are IL-28B major genotype (TT) as a host factor [11], and substitutions of aa 70 and aa 91.
The level of IFN-λ1 has been reported to be significantly higher in carriers of the IL-28B major genotype (TT) and in the IL-28B minor homozygous (GG) as well as in the heterozygous (TG) allele. Nonetheless, for unclear reasons, no significant association was observed between a high level of serum IFN-λ1 and IL-28B major (major 33.4 pg/ml, minor 24.1 pg/ml; p = 0.20; data not shown). Further study is needed to clarify the relation between IL-28B and IFN-λ1.

It is well known that the antiviral mechanism of IFN comprises two phases [15, 16]. The first is direct inhibition of viral replication mediated by a number of proteins induced through the activation of the JAK-STAT pathway, including double-stranded RNA-activated protein kinase, myxovirus resistance gene A and 2′,5′-oligoadenylate synthetase, which block translation, block replication and degrade viral RNA, respectively [17–21]. The second is an indirect antiviral mechanism mediated by the stimulation of the host cell-mediated immune function including the cytotoxic T cell. The fact that IFN-λ1 significantly downregulates the secretion of IL-13 but elevates IFN-γ suggests that IFN-λ1 is related to an elevation of the Th1 response accompanied with a decrease of the Th2 response [10]. High levels of IFN-λ1 predispose to spontaneous resolution of HCV infection because of an elevation of the Th1 response [9]. Also, IFN-λ1 upregulates the chemokines MIG (Monokine induced by IFN-γ), IP-10 (IFN-γ-inducible protein 10) and I-TAC (IFN-inducible T cell α-chemoattractants), which are antimicrobial chemoattractants in peripheral blood mononuclear cells [22]. Taken together, these data suggest that IFN-λ1 stimulates the immunomodulatory effect [23].

The epitope located at position 2416, at a distance of 37 aa from IRRDR has been identified as an HLA-A26 CD8+ T cell epitope [24], which was targeted in all patients examined with acute resolving HCV infection. Therefore, IRRDR is regarded as the area (NS5A) related to immune function [5]. Our data demonstrated that IRRDR was significantly associated with IFN-λ1. From the above results, we infer that the achievement of SVR in patients with high IFN-λ1 levels is associated with the immunomodulatory system. Because of the small number of patients in our study, analysis in a large-scale multicenter study is needed.

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Disclosure Statement

The authors have no conflicts of interest to declare.
References


