Elevation of Serum Apolipoprotein B after Successful Eradication of Hepatitis C Virus in Patients with Chronic Hepatitis C Treated by IFN-Based Therapy

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Abstract

Background: Hepatitis C Virus (HCV) infection is closely tied to the lipid metabolism of liver cells. We recently reported that serum levels of LDL- and VLDL-cholesterol (Cho) increased in patients with Chronic Hepatitis C (CHC) showing Sustained Virologic Response (SVR) after treatment with interferon (IFN)-based therapy. LDL- and VLDL-Cho contained apolipoprotein (apo)-B synthesized in the liver as a major protein component. The goal of the present study was to clarify how serum lipid marker changes in CHC patients showing SVR after treatment with IFN-based therapy.

Patients and methods: The study included 121 consecutive patients with CHC infected with HCV genotype 1 (n=66, male/female: 40/26) or HCV genotype 2 (n=55, male/female: 38/17). Ninety-five patients received PEG-IFN alpha and Ribavirin (RBV). Twenty-six patients received PEG-IFN alpha-2a alone. SVR was defined as being negative for serum HCV-RNA on RT-PCR at 24 weeks after the End of Therapy (EOT). Fasting serum triglyceride (T-G), total-Cho, and apo-B were evaluated before starting therapy and at 24 weeks after EOT.

Results: SVR rates were 74% (90/121). Serum levels of total-Cho and apo-B increased significantly (p<0.05 by Wilcoxon test) in patients infected with HCV genotypes 1 and 2 who achieved SVR at 24 weeks after EOT, as compared to before the start of therapy, but no increases were seen in non-SVR patients.

Conclusions: Infection with HCV genotypes 1 and 2 equally lowered serum levels of apo-B and total-Cho, which increased after HCV was successfully eradicated.

Keywords: Chronic hepatitis C; Cholesterol; Apolipoprotein-B; PEG-IFN; Ribavirin

Introduction

As hepatic biosynthesis of lipids has been suggested to play a role in the processes of infection and replication of Hepatitis C Virus (HCV) [1,2], HCV infection and serum lipid markers are thought to be related. Serum cholesterol (Cho) levels have been reported to be a predictor of Sustained Virologic Response (SVR) in patients with Chronic Hepatitis C (CHC) receiving antiviral therapy [3-6], but the precise mechanism for this phenomenon has not yet been confirmed.

We also reported recently that serum levels of total Cho (T-Cho) and its fraction increased in CHC patients showing SVR after treatment with interferon (IFN)-based therapy [7,8], and Corey et al. [9] reported similar observations.

The proteins associated with lipoproteins, known as apolipoproteins (apos), are required for the assembly, structure, and function of lipoproteins, and apos activate enzymes important in lipoprotein metabolism. It is known that apo-B is the major structural protein in chylomicron, Very Low Density Lipoprotein (VLDL)-Cho, Intermediate Density Lipoprotein (IDL)-Cho and Low Density Lipoprotein (LDL)-Cho, which are synthesized in the liver.

The goal of the present study was to clarify how serum levels of lipid markers change in CHC patients showing SVR after treatment with IFN-based therapy.

Patients and Methods

Patients

The study included 121 consecutive patients with CHC who were infected with genotype 1 (n=66; male/female: 40/26; age: 28 to 72 years) having baseline HCV-RNA ranging from 3.9 to 7.4 log copies/ml, as quantified by real time (RT)-PCR (lower detection limit: 1.2 log copies/ml, upper limit: 9.1 log copies/ml; TaqMan; Chugai Pharmaceutical Co., Ltd., Tokyo, Japan), or with genotype 2 (n=55; male/female: 38/17; age: 31 to 76 years) having baseline HCV-RNA ranging from 3.2 to 7.1 log copies/ml, as quantified by RT-PCR. All patients were positive for anti-HCV antibody on testing with third-generation enzyme-linked immunosorbent assay and were positive for serum HCV-RNA on RT-PCR, but were negative for hepatitis B surface antigen. Patients were excluded if they were known to be homosexual or were intravenous drug users, if they were positive for antinuclear antibodies, or if they had metabolic liver dysfunction, history of familial hyperlipidemia, HIV co-infection or renal dysfunction. Furthermore, patients were excluded if they were taking lipid-lowering drugs, if they were taking hypoglycemic agents, or if they had a history of habitual alcohol abuse (daily alcohol consumption > 20 g/day in men and >10 g/day in women).

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Of the 121 patients, 82 had undergone percutaneous liver biopsy before therapy under ultrasonographic control, and tissue specimens thus obtained were scored according to the Histology Activity Index (HAI) of Knodell et al. [10], and were divided into three grades (Grade 1 for HAI scores of 1-3; Grade 2 for HAI scores of 4-8; and Grade 3 for HAI scores of 9 or more). Specimens were also divided into four groups from stage 1 to stage 4 based on the fibrosis score of Desmet [11].

### IFN regimens

After providing informed consent, 58 patients received PEG-IFN alpha-2b (PegIntron®; MSD K.K., Tokyo, Japan) at weekly doses adjusted for body weight according to the manufacturer’s instructions (45 kg or less=60 μg/dose; 46 to 60 kg=80 μg/dose; 61 to 75 kg=100 μg/dose; 76 to 90 kg=120 μg/dose; and ≥91 kg=150 μg/dose) in combination with oral ribavirin (Rebetol®; MSD, K.K.) at daily doses adjusted for body weight according to the manufacturer’s instructions (60 kg or less=600 mg/day; 61 to 80 kg=800 mg/day; and ≥81 kg or more=1,000 mg/day) for 48 weeks for HCV genotype 1 and high viral load.

Thirty-seven patients received PEG-IFN alpha-2a (Pegasys®; Chugai Pharmaceutical Co., Ltd.) at 180 μg per week in combination with ribavirin (Copegus®, Chugai Pharmaceutical Co., Ltd.) given orally at daily doses adjusted for body weight according to the manufacturer’s instructions (60 kg or less=600 mg/day; 61 to 80 kg=800 mg/day; and ≥81 kg or more=1,000 mg/day) for 48 weeks for HCV genotype 1 and high viral load, and for 24 weeks for HCV genotype 2 and high viral load.

The remaining 26 patients received PEG-IFN alpha-2a (Pegasys®) alone at 180 μg per week for 24 to 48 weeks for HCV genotype 1 or genotype 2 and low viral load (serum HCV-RNA < 4.9 log copies/ml).

Some patients needed slight adjustment of the PEG-IFN and RBV doses, because of decreases in leukocyte count, platelet count or hemoglobin during therapy.

Serum HCV-RNA was measured using RT-PCR before the start of therapy and every 4 weeks thereafter until the End of Therapy (EOT), as well as at 24 weeks after EOT. SVR was defined as being negative for serum HCV-RNA by RT-PCR at 24 weeks after EOT.

### Statistical analysis

Results shown in the table 1 are presented as medians and 10th to 90th percentiles.

Comparisons between two groups were performed by nonparametric Mann-Whitney test or Wilcoxon’s signed rank test. Multiple comparisons were performed by parametric Tukey’s test. In all analyses, a probability value of less than 0.05 was considered to indicate statistical significance.

### Table 1: Clinical background of patients with chronic hepatitis C.

|                       | Genotype 1 | Genotype 2 | Genotype 3 |
|-----------------------|------------|------------|------------|
| No. of patients       | 66         | 55         | 51         |
| Age                   | Median     | 55 (41-66) | 54 (40-67) |
| Sex                   | NS#        | 40/26      | 38/17      |
| Laboratory data       |            |            |            |
| Serum HCV level (IU/mL) | 6.3 (4.8-6.9) | 5.5 (3.8-6.6) | p < 0.01* |
| AST (IU/l)            | Median     | 49 (24-86) | 54 (26-86) |
| ALT (IU/l)            | Median     | 54 (25-117) | 58 (25-151) |
| CHe (IU/l)            | Median     | 252 (111-380) | 295 (205-397) |
| Albumin (g/dl)        | Median     | 4.2 (3.6-4.8) | 4.2 (3.4-4.6) |
| T-Chol (mg/dl)        | Median     | 162 (131-212) | 166 (137-219) |
| T-G (mg/dl)           | Median     | 87 (63-181) | 96 (54-246) |
| Peripheral Blood      |            |            |            |
| WBC (10^3/μl)         | Median     | 4.8 (3.4-7.7) | 5.2 (3.5-6.9) |
| RBC (10^6/μl)         | Median     | 4.5 (3.6-5.0) | 4.6 (3.9-5.2) |
| PLT (10^9/μl)         | Median     | 15.1 (8.2-25.6) | 17.1 (10.2-25.6) |
| PT (%)                | Median     | 94 (79-112) | 98 (73-114) |
| Pathological findings |            |            |            |
| Activity (1/2/3/none) | (22 / 23 / 0 / 21) | (16 / 21 / 0 / 18) | NS* |
| Staging (1/2/3/4/none) | (18/13 /1/13/21) | (21 /7/3/6 /18) | NS* |
| IFN regimen           |            |            |            |
| Ribavirin + Peg-IFN-alpha 2b (n=) | 29       | 29         |            |
| Ribavirin + Peg-IFN-alpha 2a (n=) | 48 (48-72) | 24 (24-48) | p < 0.01 |
| PEG-IFN-alpha alone (n=) | 29         | 22         |            |
| Efficacy of therapy   |            |            |            |
| SVR/Relapser/NVR      | (40 / 13 / 13) | (51 / 3 / 1) | p < 0.01 |

In parentheses, range represents 10th and 90th percentiles.
Results

Response of CHC to treatment

Of the 66 CHC patients (61%) infected with HCV genotype 1, 40 achieved SVR, while 50 of 55 CHC patients (91%) infected with genotype 2 achieved SVR.

Changes in serum lipids in CHC patients

There were no significant differences in baseline serum levels of T-Chol, T-G, apo-A1, apo-A2 and apo-B between CHC patients infected with HCV genotypes 1 and 2. However, the serum levels of T-Chol and apo-B had increased significantly (p < 0.05, Wilcoxon's test) at 24 weeks after EOT, as compared to before the start of therapy, in CHC patients with both HCV genotypes 1 and 2 (Figure 1a and Figure 1e). Serum levels of apo-A2 had decreased significantly (p < 0.05 by Wilcoxon's tests) at 24 weeks after EOT, as compared to before the start of therapy, in CHC patients with only HCV genotype 1, while there were no differences between pre-therapy values and those at 24 weeks after EOT in CHC patients infected with genotype 2 (Figure 1d).

There were no significant differences in serum levels of T-G or apo-A1 before the start of therapy and at 24 weeks after EOT in CHC patients infected with either HCV genotype 1 or 2 (Figure 1b and Figure 1c).

Changes in other serum liver marker in CHC patients

Serum levels of albumin showed a median value of 4.2 g/dl (10th-90th range: 3.7 - 4.6 g/dl) before the start of therapy, and a median 4.4 g/dl (10th-90th range: 3.9 - 4.7 g/dl) at 24 weeks after EOT in SVR patients, while albumin levels were a median 4.0 g/dl (10th-90th range: 3.2 - 4.5 g/dl) before the start of therapy and a median 4.0 g/dl (10th - 90th range: 3.2 - 4.3 g/dl) at 24 weeks after EOT in non-SVR patients.

Peripheral blood PT was a median 96% (10th-90th range: 75% - 114%) before the start of therapy and a median 97% (10th - 90th range: 82% - 111%) at 24 weeks after EOT in SVR patients, while PT was a median 93% (10th - 90th range: 79% - 111%) before the start of therapy and a median 90% (10th-90th range: 79% - 117%) at 24 weeks after EOT in non-SVR patients. There were no significant differences in serum levels of albumin or peripheral blood PT between pre-treatment values and those at 24 weeks after EOT in either group.

Discussion

The present study demonstrated that serum levels of T-Chol and apo-B increased significantly in patients infected with genotypes 1 and 2 who achieved SVR at 24 weeks after EOT, as compared to pre-therapy levels, but such increases were not seen in non-SVR patients. In addition, serum levels of apo-A2 decreased significantly in patients infected with only genotype 1 who achieved SVR at 24 weeks after EOT, as compared to pre-therapy levels. These changes suggest that infection with HCV genotypes 1 and 2 equally lowered host serum levels of T-Cho and apo-B, which increased after HCV was successfully eradicated. It was also suggested that HCV genotype 1 infection increased serum levels of apo-A2, which decreased after HCV was successfully eradicated. It was also suggested that HCV genotype 1 infection increased serum levels of apo-A2, which decreased after HCV was successfully eradicated. It was also suggested that HCV genotype 1 infection increased serum levels of apo-A2, which decreased after HCV was successfully eradicated.
It is known that apo-B is present as a lipoprotein in LDL-Cho and VLDL-Chol. VLDL-Chol is secreted into the bloodstream after assembly with apo-B. HCV is reported to cause acquired Hypo B Lipoproteinemia (HBL), in which fat accumulates in hepatocytes, steatosis develops and serum levels of apo-B decrease in those infected with HCV genotype 3 [13,14] or HCV genotype 1 [12]. Serum levels of these lipid markers increased when SVR is obtained among treated CHC patients infected with genotype 2. It is reported to be in inverse relationship between LDL cholesterol and HDL cholesterol [21]. Therefore, serum HDL-C which is including Apo-A2 might be compensatory increased with decreased serum LDL cholesterol which is including apo-B before the start of treatment, and serum Apo-A2 included in HDL-C decreased with increased Apo-B included in LDL-C after successful elimination of HCV. However, it must be left to the future study of whether this phenomenon occurs only in CHC patients infected with HCV genotype 1.

When cholesterol levels are discussed, the relationship with liver function becomes a problem, as serum cholesterol levels tend to decrease in patients who show histological progression of chronic liver disease [22]. In the present study, serum albumin and peripheral blood PT were measured in order to assess hepatic synthetic function, but there were no significant differences in these parameters between baseline and assessment. Therefore, the changes in serum lipid markers do not necessarily depend on amelioration of liver function brought by eradication of HCV.

In conclusion, our results suggest that HCV genotypes 1 and 2 equally reduce serum levels of T-Chol and apo-B, which increase after HCV is successfully eradicated.

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