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Significance of a reduction in HCV RNA levels at 4 and 12 weeks in patients infected with HCV genotype 1b for the prediction of the outcome of combination therapy with peginterferon and ribavirin

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Abstract

Background: The importance of the reduction in hepatitis C virus (HCV) RNA levels 4 and 12 weeks after starting peginterferon (PEG-IFN) and ribavirin combination therapy has been reported to predict a sustained virologic response (SVR) in patients infected with HCV genotype 1. We conducted a multicenter study to validate this importance along with baseline predictive factors in this patient subpopulation.

Methods: A total of 516 patients with HCV genotype 1 and pretreatment HCV RNA levels $\geq 5.0 \log_{10}$ IU/mL who completed response-guided therapy according to the AASLD guidelines were enrolled. The reduction in serum HCV RNA levels 4 and 12 weeks after starting therapy was measured using real-time PCR, and its value in predicting the likelihood of SVR was evaluated.

Results: The area under the receiver operating characteristics (ROC) curve was 0.852 for 4-week reduction and 0.826 for 12-week reduction of HCV RNA levels, respectively. When the cut-off is fixed at a $2.8\text{-}\log_{10}$ reduction at 4 weeks and a $4.9\text{-}\log_{10}$ reduction at 12 weeks on the basis of ROC analysis, the sensitivity and specificity for SVR were 80.9% and 77.9% at 4 weeks and were 89.0% and 67.2% at 12 weeks, respectively. These variables were independent factors associated with SVR in multivariate analysis. Among 99 patients who showed a delayed virologic response and completed 72-week extended regimen, the area under ROC curve was low: 0.516 for 4-week reduction and 0.482 for 12-week reduction of HCV RNA levels, respectively.

Conclusions: The reduction in HCV RNA levels 4 and 12 weeks after starting combination therapy is a strong independent predictor for SVR overall. These variables were not useful for predicting SVR in patients who showed a slow virologic response and experienced 72-week extended regimen.

Keywords: Chronic hepatitis C, Peginterferon, Ribavirin, Reduction in HCV RNA levels, Four and twelve weeks, Baseline factors, Response-guided therapy, Extended treatment

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Background

Many investigators have sought to identify factors that can predict the treatment outcome of peginterferon (PEG-IFN) and ribavirin combination therapy in patients infected with HCV genotype 1. Previous studies reported baseline host and viral factors that are associated with the treatment outcomes. The genetic polymorphisms near the *IL28B* gene (rs12979860 or rs8099917) reportedly constitute a host factor that is strongly associated with treatment outcome [1-5], and studies from Japan have reported that amino acid substitutions at residue 70 of the HCV core region and residues 2209–2248 of the NS5A region of HCV (i.e., interferon sensitivity-determining region, ISDR) are viral factors associated with treatment outcome in patients infected with HCV genotype 1 [6-10]. In addition to the baseline predictive factors, the response to HCV during therapy, i.e., the changes in serum HCV RNA levels after initiation of therapy, has also been shown to be an important predictor of treatment outcome [11-14]. Especially, the disappearance or the reduction in serum HCV RNA levels at 4 and 12 weeks after starting therapy have been reported to be important, therefore, rapid virologic response (RVR) or early virologic response (EVR) defined at 4 and 12 weeks after starting therapy, respectively, is a pivotal criteria in predicting treatment response [11-23].

There are adverse effects associated with PEG-IFN and ribavirin antiviral therapy, and the treatment course is costly. For these reasons, it is important to predict the likelihood that a patient will achieve SVR during early stages of therapy with high reliability, in order to prevent unnecessary treatment. This will become increasingly important with the emergence of new antiviral drugs against HCV [24-28]. In the present study, we conducted a multicenter cohort study to examine whether the reduction in HCV RNA levels 4 and 12 weeks after starting PEG-IFN and ribavirin combination therapy, along with baseline predictive factors, has any value in predicting SVR.

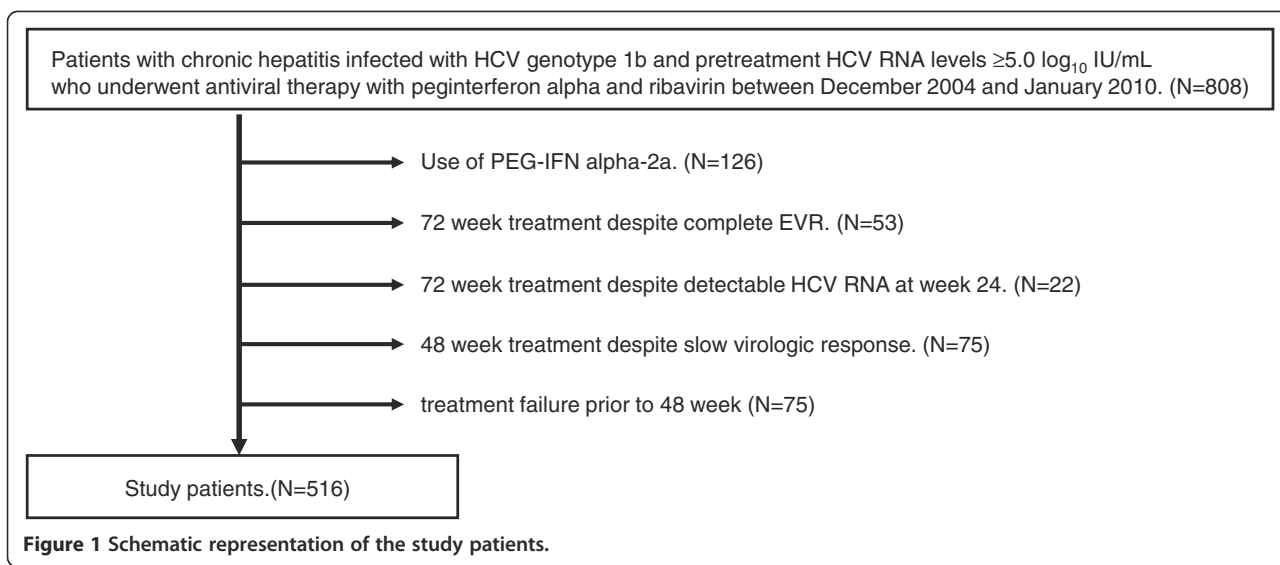
Methods

Patients, treatments, and evaluation of responses

The inclusion criteria for this multicentre study were (i) infection with HCV genotype 1 without co-infection with hepatitis B virus or human immunodeficiency virus; (ii) pretreatment HCV RNA levels $\geq 5.0 \log_{10}$ IU/mL, based on a quantitative real-time PCR-based method (COBAS AmpliPrep / COBAS TaqMan HCV Test; Roche Molecular Systems: Pleasanton, CA, US.; lower limit of quantification, $1.6 \log_{10}$ IU/ mL: lower limit of detection, $1.2 \log_{10}$ IU/ mL) [29,30]; (iii) standard PEG-IFN and ribavirin therapy according to the American Association for the Study of the Liver Diseases (AASLD) guidelines [31] started between December 2004 and

January 2010; (iv) completed treatment regimen of 48- or 72-week duration with virologic outcomes available for evaluation; and (v) 100% medication adherence for both PEG-IFN and ribavirin during the initial 4 weeks of therapy and 80% or more throughout the treatment period. With regard to inclusion criterion (i), this study did not include any patients infected with HCV genotype 1a because this genotype is usually not found in the Japanese general population. With regard to criterion (ii), we focused on patients with pretreatment HCV RNA level $\geq 5.0 \log_{10}$ IU/mL because the use of ribavirin along with PEG-IFN is not allowed by Japanese National Medical Insurance System for patients with pretreatment HCV RNA levels $< 5.0 \log_{10}$ IU/mL. With regard to criterion (iv), the treatment duration was determined based on the response-guided therapy according to AASLD guidelines. Patients in whom serum HCV RNA disappeared until 12 weeks after starting therapy (complete EVR) underwent 48-week treatment regimen. Patients in whom serum HCV RNA disappeared after 12 weeks but until 24 weeks after starting therapy (delayed virologic response) underwent 72-week extended treatment regimen. Patients whose treatment was discontinued due to the presence of serum HCV RNA at 24 weeks of therapy (partial responders or null responders as per the AASLD guidelines), or due to viral breakthrough were also included in the study.

A total of 808 patients underwent the combination therapy with PEG-IFN and ribavirin between December 2004 and January 2010 in one of the following five Liver Centers: Musashino Red Cross Hospital, Kurume University Hospital, Ogaki Municipal Hospital, Shinmatsudo Central General Hospital, and Kagawa Prefectural Central Hospital. For 126 patients, the treatment regimen consisted of weekly PEG-IFN alpha-2a (Pegasys, Chugai Pharmaceutical, Tokyo, Japan) and daily ribavirin (Copegus, Chugai Pharmaceutical). The other 682 patients were treated with weekly PEG-IFN alpha-2b (Pegintron, MSD Co., Tokyo, Japan) and daily ribavirin (Rebetol, MSD Co.). We excluded patients who had been treated with PEG-IFN alpha-2a and ribavirin in order to avoid the influence of PEG-IFN subtype on the association between viral dynamics and treatment outcome. In 682 patients who received PEG-IFN alpha-2b, 516 patients fulfilled the eligibility criteria and were included for analysis (Figure 1). The doses of PEG-IFN alpha-2b and ribavirin were adjusted based on the patient's body weight. Patients ≤ 45 kg were given 60 μ g of PEG-IFN alpha-2b weekly, those > 45 kg and ≤ 60 kg were given 80 μ g, those > 60 kg and ≤ 75 kg were given 100 μ g, those > 75 kg and ≤ 90 kg were given 120 μ g, and those > 90 kg were given 150 μ g. Patients ≤ 60 kg were given 600 mg of ribavirin daily, those > 60 kg and ≤ 80 kg were given 800 mg, and those > 80 kg were given 1000 mg per



day. Dose modifications of PEG-IFN or ribavirin were based on the manufacturer's recommendations.

SVR was defined as undetectable serum HCV RNA 24 weeks after the end of therapy. A patient was considered to have relapsed when serum HCV RNA levels became detectable between the end of treatment and 24 weeks after completion of therapy, although serum HCV RNA levels were undetectable at the end of therapy. A non-response was defined as detectable serum HCV RNA at 24 weeks after initiation of therapy (i.e., null response or partial non-response according to the AASLD guidelines). RVR was defined as undetectable serum HCV RNA 4 weeks after starting therapy. EVR was defined as the disappearance or a decrease in serum HCV RNA levels by at least $2 \log_{10}$ at 12 weeks after starting therapy. Patients were considered to have a complete EVR if the serum HCV RNA levels were undetectable 12 weeks after starting therapy and a partial EVR if the serum HCV RNA levels were detectable but had decreased by at least $2 \log_{10}$ at 12 weeks of therapy. A non-EVR was defined as a lack of a decrease of HCV RNA by more than $2 \log_{10}$ at 12 weeks when compared to pretreatment levels. Patients were considered to have a delayed virologic response if serum HCV RNA levels became undetectable after 12 weeks but until 24 weeks on treatment.

The study protocol was in compliance with the Helsinki Declaration and was approved by the ethics committee of each participating institution, i.e., the ethics committee of Musashino Red Cross Hospital, the ethics committee of Kurume University Hospital, the ethics committee of Ogaki Municipal Hospital, the ethics committee of Shimatsudo Central General Hospital, and the ethics committee of Kagawa Prefectural Central Hospital. Prior to initiating the study, written informed consent was

obtained from each patient to use their clinical and laboratory data and to analyze stored serum samples.

Measurements of serum HCV RNA levels, amino acid substitution at residue 70 in the HCV core, amino acid sequence of HCV NS5A-ISDR, and genetic polymorphisms near the IL28B gene

After a patient gave informed consent, serum samples were obtained during the patient's regular hospital visits, just prior to beginning treatment, and every 4 weeks during the treatment period and the 24-week follow-up period after treatment. Serum samples were stored at -80°C until they were analyzed. HCV RNA levels were measured using a quantitative real-time PCR-based method (COBAS AmpliPrep/ COBAS TaqMan HCV Test) [29,30]. The reduction in HCV RNA 4 and 12 weeks after initiation of therapy was calculated. When calculating the decrease in serum HCV RNA, HCV RNA level was defined as 0 when HCV RNA was undetectable.

Amino acid 70 of the HCV core region and the amino acid sequence of ISDR region (residues 2209–2248 of the NS5A region) were analyzed by direct nucleotide sequencing of each region as previously reported [6,7]. The following PCR primer pairs were used for direct sequencing of the HCV core region:

5'-GCCATAGTGGTCTGCGGAAC-3' (outer, sense primer),
5'-GGAGCAGTCCTTCGTGACATG-3' (outer, antisense primer),
5'-GCTAGCCGAGTAGTGTT-3' (inner, sense primer),
and
5'-GGAGCAGTCCTTCGTGACATG-3' (inner, antisense primer).

The following PCR primers were used for direct sequencing of ISDR:

5'-TTCCACTACGTGACGGGCAT-3' (outer, sense primer),
 5'-CCCCTCCATGTGTAGGACAT-3' (outer, antisense primer),
 5'-GGGTCACAGCTCCCTGTGAGCC-3' (inner, sense primer), and
 5'-GAGGGTTGTAATCCGGGCGTGC-3' (inner, antisense primer).

When evaluating ISDR, HCV was defined as wild-type when there were 0 or 1 amino acid substitutions in residues 2209–2248 as compared with the HCV-J strain [32], and as non-wild-type when there was more than 1 substitution.

Genotyping of rs 8099917 polymorphisms near the *IL28B* gene was performed using the TaqMan SNP assay (Applied Biosystems, Carlsbad, CA) according to the manufacturer's guidelines. A pre-designed and functionally tested probe was used for rs8099917 (C_11710096_10, Applied Biosystems). Genetic polymorphism of rs8099917 reportedly corresponds to rs12979860 in more than 99% of individuals of Japanese ethnicity [33]. The TT genotype of rs8099917 corresponds to the CC genotype of rs12979860, the GG genotype of rs8099917 corresponds to the TT genotype of rs12979860, and the TG heterozygous genotype of rs8099917 corresponds to the CT of rs12979860.

Statistical analyses

Quantitative values are reported as medians and ranges. Differences in percentages between groups were analyzed with the chi-square test. Differences in mean quantitative values were analyzed by the Mann–Whitney U test. The receiver-operating characteristics (ROC) analyses were performed to determine the cut-offs of the reduction in HCV RNA levels at 4 and 12 weeks after starting therapy to evaluate the sensitivity, specificity, positive predictive value (PPV), negative predictive value (NPV), and accuracy for predicting SVR. Univariate and multivariate analyses using a logistic regression model were performed to identify factors that predict SVR. The factors that are potentially associated with SVR were included in the analyses, i.e., age, sex, body mass index (BMI), serum alanine aminotransferase activity, serum gamma-glutamyl transpeptidase level, total-cholesterol levels, neutrophil count, hemoglobin, platelet count, grade of activity and fibrosis of the liver, pretreatment HCV RNA levels, reduction in HCV RNA levels 4 and 12 weeks after starting therapy, amino acid substitution at residue 70 in the HCV core (arginine vs. glutamine or histidine), amino acid mutations in ISDR (non-wild-type

vs. wild-type), and genetic polymorphisms near the *IL28B* gene (rs8099917, genotype TT vs. genotype TG or GG). Data analyses were performed using StatFlex statistical software, version 6 (Artech Co., Ltd., Osaka, Japan). All *p* values were two-tailed, and *p* < 0.05 was considered statistically significant.

Results

Patient characteristics and treatment outcome

The characteristics of the patients are shown in Table 1. Genotyping of rs8099917 near the *IL28B* gene was performed in 396 patients. Amino acid substitutions at residue 70 in the HCV core region were measured in 361 patients. Amino acid sequences in the ISDR were evaluated in 416 patients. Among 516 patients who were included in the analysis, treatment was completed at 48 weeks in 268 patients who underwent the standard regimen because they showed complete EVR. Treatment was extended from 48 weeks to 72 weeks in 99 patients who yielded delayed virologic response. Treatment was discontinued until 48 weeks in 149 patients because

Table 1 Characteristics of study patients

Age (years), median (range)	60.0 (20.0–80.0)
Sex (male/female) (%)	245 (47.5)/ 271 (52.5)
Body weight (kg), median (range)	58.0 (36.35–107.6)
BMI, median (range)	22.7 (15.8–37.0)
Prior treatment for HCV (no/yes) (%)	359 (69.6)/ 157 (30.4)
Initial dose of PEG-IFN (μg), median (range)	80.0 (40.0–150.0)
Initial dose of ribavirin (mg), median (range)	600 (400–1000)
Pretreatment HCV RNA levels (log ¹⁰ IU/mL), median (range)	6.1 (5.0–7.7)
Platelet count (×10 ³ /μL)	161 (43–352)
Hemoglobin (g/dL)	13.9 (9.7–17.9)
Neutrophil count (/μL)	2489 (578–7480)
Alanine aminotransferase (IU/L)	47 (10–485)
LDL-cholesterol (mg/dL)	99 (25–226)
Total-cholesterol (mg/dL)	171 (29–325)
γ-glutamyl transpeptidase (IU/L)	34.5 (7.0–579)
Alfa fetoprotein (ng/mL)	5.0 (0.8–584)
Fibrosis score (F1/F2/F3/F4) (%)	208(45.9)/139(30.7)/69(15.2)/37(8.2)
Activity score (A1/A2/A3/A4) (%)	258(56.1)/178(38.7)/24(5.2)/0(0)
Genetic polymorphisms of rs8099917 (TT/GG or TG) (%)	288 (72.7)/ 108(27.3)
Amino acid at residue 70 of HCV core (arginine/glutamine or histidine) (%)	242 (67.0)/ 119 (33.0)
Amino acid sequence of ISDR (non-wild-type/wild-type) (%)	110 (26.4)/ 306 (73.6)

BMI, body mass index; *HCV*, hepatitis C virus; *PEG-IFN*, peginterferon; *ISDR*, interferon sensitivity-determining region. (N = 516).

serum HCV RNA remained positive 24 weeks after starting therapy (partial response or null response), or because patients experienced viral breakthrough during therapy.

As a final outcome, 272 patients (52.7%) achieved SVR, 90 patients (17.5%) relapsed, and 128 patients (24.8%) had a non-response (48 patients with partial response and 80 patients with null-response). Viral breakthrough was observed in 26 patients (5.0%). The rate of SVR was 79.9% (214 of 268 patients) among patients with complete EVR in whom treatment was completed at 48 weeks and 58.6% (58 of 99 patients) among patients with delayed virologic response who underwent the extended 72-week regimen.

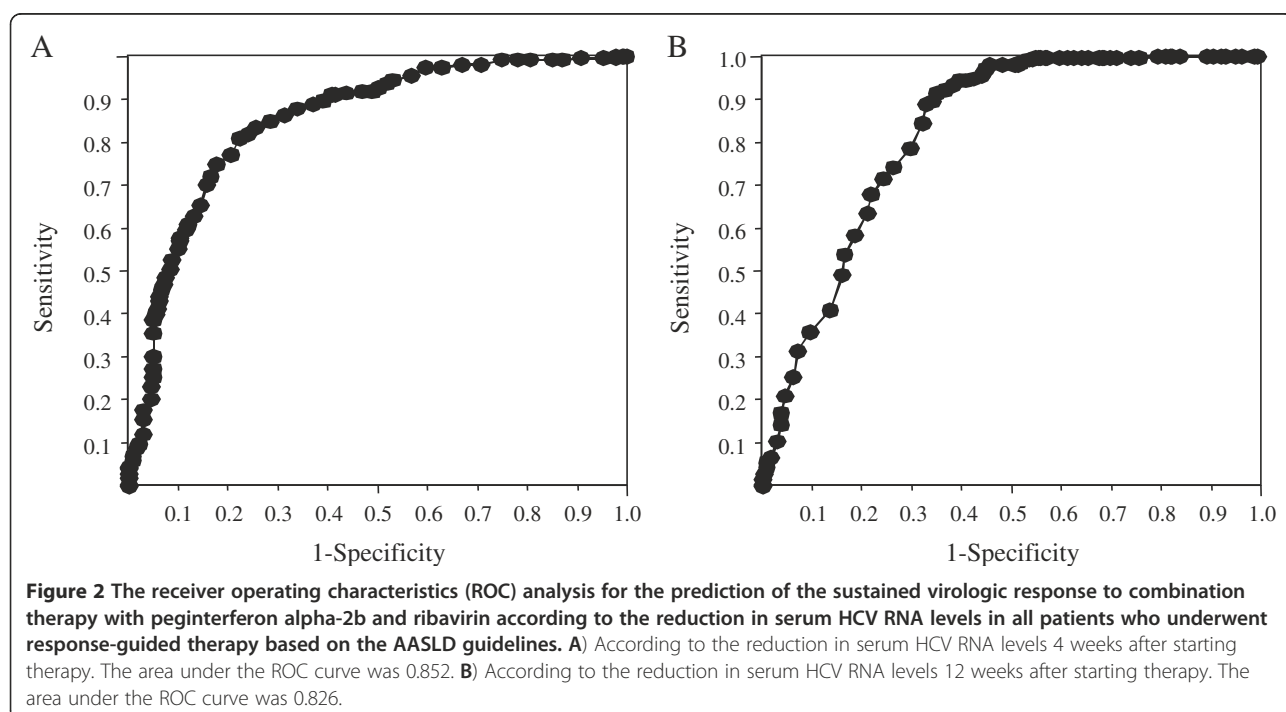
Baseline factors affecting SVR in all patients who underwent response-guided therapy according to AASLD guidelines

In all patients who underwent treatment according to the AASLD guidelines, the rate of SVR was significantly higher in patients with the TT genotype of rs8099917 near the *IL28B* gene (179 of 288 patients [62.3%] with TT genotype vs. 15 of 108 patients [13.9%] with TG/GG genotype, $p < 0.0001$). In addition, SVR rate was significantly higher in patients with HCV with arginine at residue 70 in the HCV core region (145 of 242 patients [59.9%] with arginine vs. 34 of 119 patients [28.6%] with glutamine or histidine, $p < 0.0001$). SVR was significantly higher in patients with HCV with non-wild type ISDR (75 of 110 patients [68.2%] with non-wild-type ISDR

vs. 139 of 306 patients [45.4%] with wild-type ISDR, $p < 0.0001$). SVR was significantly higher in patients with pretreatment HCV RNA levels $< 6.0 \log_{10}$ IU/mL (127 of 199 patients [63.8%] with pretreatment HCV levels $< 6.0 \log_{10}$ IU/mL vs. 145 of 317 patients [45.7%] with pretreatment HCV RNA levels $\geq 6.0 \log_{10}$ IU/mL, $p < 0.0001$).

Association between reduction of serum HCV RNA levels 4 and 12 weeks after starting therapy and SVR in all patients who underwent response-guided therapy according to the AASLD guidelines

The ROC analysis was performed in 516 patients who underwent the response-guided therapy according to the AASLD guidelines in order to evaluate the association between the reduction in serum HCV RNA levels 4 and 12 weeks after starting therapy and SVR (Figure 2). The area under the ROC curve was 0.852 and the best cut-off was calculated as $2.8 \log_{10}$ IU/mL, when evaluated with the reduction of serum HCV RNA levels 4 weeks after starting therapy. The rate of SVR was significantly higher in patients with greater than $2.8\text{-}\log_{10}$ reduction at 4 weeks (220 of 274 patients [80.3%] with $> 2.8\text{-}\log_{10}$ reduction vs. 52 of 242 patients [21.5%] with $\leq 2.8\text{-}\log_{10}$ reduction, $p < 0.0001$). The sensitivity, specificity, PPV, NPV, and accuracy were 80.9%, 77.9%, 80.3%, 78.5%, and 79.5%, respectively, at this cut-off level. When evaluated with the reduction of serum HCV RNA levels 12 weeks after starting therapy, the area under the ROC curve was



0.826 and the best cut-off was calculated as 4.9 log₁₀ IU/mL. The rate of SVR was significantly higher in patients with greater than 4.9-log₁₀ reduction at 12 weeks (242 of 321 patients [75.4%] with > 4.9-log₁₀ reduction vs. 30 of 194 patients [15.5%] with ≤ 4.9-log₁₀ reduction, *p* < 0.0001). The sensitivity, specificity, PPV, NPV, and accuracy were 89.0%, 67.2%, 75.4%, 84.5%, and 78.7%, respectively, at this cut-off level.

A multivariate analysis showed that the reductions in serum HCV RNA levels at 4 and 12 weeks after starting therapy were independent factors associated with SVR, along with pretreatment HCV RNA levels, platelet counts, polymorphisms of rs8099917 near the *IL28B* gene, and amino acid mutations in the HCV NS5A-ISDR (Table 2).

Association between reduction of serum HCV RNA levels 4 and 12 weeks after starting therapy and SVR in patients with delayed virologic response who underwent an extended 72-week regimen according to response-guided therapy

The ROC analysis was performed in 99 patients with delayed virologic response who underwent an extended 72-week treatment regimen according to the response-guided therapy of the AASLD guidelines to evaluate the association between reduction in serum HCV RNA

levels 4 and 12 weeks after starting therapy and SVR (Figure 3). The area under the ROC curve was 0.516 and the best cut-off was calculated as 2.3 log₁₀ IU/mL, when evaluated with the reduction of serum HCV RNA levels 4 weeks after starting therapy. There was no significant difference in the rate of SVR according to the reduction at 4 weeks (21 of 33 patients [63.6%] with > 2.3-log₁₀ reduction vs. 37 of 66 patients [56.1%] with ≤ 2.3-log₁₀ reduction, *p* = 0.6120). The area under the ROC curve was 0.482 and the best cut-off was calculated as 5.1 log₁₀ IU/mL, when evaluated with the reduction of serum HCV RNA levels 12 weeks after starting therapy. There was no significant difference in the rate of SVR according to the reduction at 12 weeks (24 of 42 patients [57.1%] with > 5.1-log₁₀ reduction vs. 34 of 57 patients [59.6%] with ≤ 5.1-log₁₀ reduction, *p* = 0.9634).

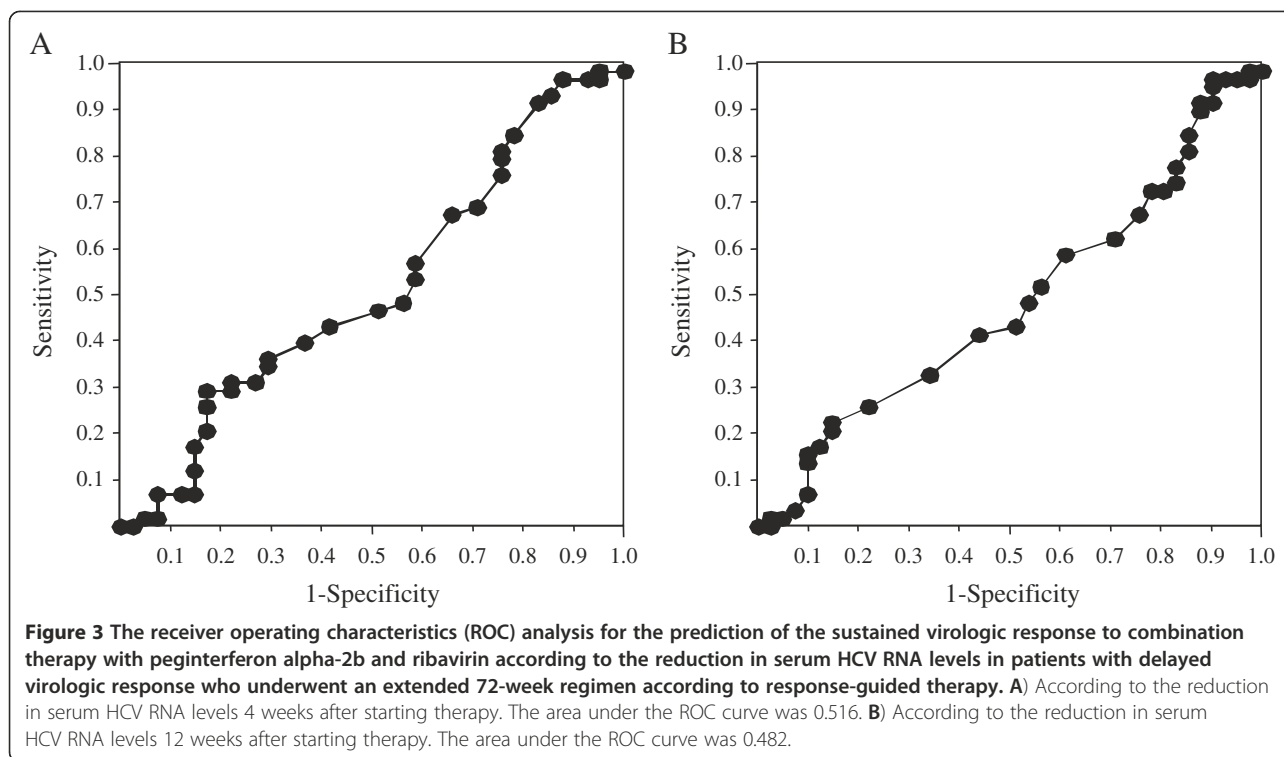
Discussion

Several previous studies have reported that patients who achieved RVR, in whom serum HCV RNA levels become undetectable 4 weeks after starting the therapy, had a high likelihood of achieving SVR [15-18]. However, there are relatively few patients infected with treatment-resistant HCV genotype 1 who achieve RVR. A considerable percentage of patients achieve SVR even without RVR. Therefore, RVR has high specificity but low

Table 2 Univariate and multivariate analyses for sustained virologic response to the combination therapy with peginterferon and ribavirin in patients who underwent response guided therapy according to the AASLD guidelines

	Univariate analysis	Multivariate analysis*	Odds ratio (95% confidence interval)
Age (years)	< 0.001	N.S.	
Sex (male/female)	0.005	N.S.	
BMI, median (range)	N.S.		
Prior treatment for HCV (no/yes)	N.S.		
Pretreatment HCV RNA levels (log ₁₀ IU/mL), (≤6.0 vs. 6.0<)	0.015	0.013	2.235 (1.189-4.203)
Platelet count (×10 ³ /μL)	< 0.001	0.011	1.007 (1.002-1.013)
Hemoglobin (g/dL)	0.002	N.S.	
Neutrophil count (μL)	0.003	N.S.	
Alanine aminotransferase (IU/L)	N.S.		
Total-cholesterol (mg/dL)	0.001	N.S.	
γ-glutamyl transpeptidase (IU/L)	0.014	N.S.	
Fibrosis score (F1 or F2/F3 or F4)	< 0.001	N.S.	
Activity score (A1 or A2/A3 or A4)	0.002	N.S.	
Genetic polymorphisms of rs8099917 (TT/GG or TG)	< 0.001	< 0.001	5.782 (2.298-14.552)
Amino acid at residue 70 of HCV core (arginine/glutamine or histidine)	< 0.001	N.S.	
Amino acid sequence of ISDR (non-wild-type/wild-type)	< 0.001	0.038	2.077 (1.041-4.147)
Reduction of HCV RNA [Pre - 4 week] (log ₁₀ IU/mL), (≤2.8 vs. 2.8<)	< 0.001	< 0.001	3.911 (1.935-7.908)
Reduction of HCV RNA [Pre - 12 week] (log ₁₀ IU/mL), (≤4.9 vs. 4.9<)	< 0.001	0.013	2.578 (1.220-5.448)

*Multivariate analysis was performed on 314 patients in whom all variables were available. (N = 516).



sensitivity for predicting SVR. Previous studies from Asia evaluated the predictive value of the degree of reduction in serum HCV RNA levels 4 weeks after starting therapy, in addition to RVR [19-21]. However, the number of patients in these studies was small and the analyses were not sufficient to form reliable conclusions.

In the present study, we evaluated the ability of a decrease in serum HCV RNA levels 4 weeks after starting therapy to predict the likelihood of SVR as a final outcome in Japanese patients infected with HCV genotype 1b, based on the data from a large, multi-institution study. The ROC analyses showed that a reduction in serum HCV RNA levels 4 weeks after starting therapy was strongly associated with SVR, and its predictive value was higher than that of a reduction in serum HCV RNA levels 12 weeks after starting therapy, with higher area under the ROC curve and accuracy. Multivariate analyses including baseline factors that were associated with SVR revealed that the reductions of HCV RNA level at both 4 and 12 weeks after starting therapy were independent factors associated with SVR, and the reduction at 4 weeks had a second strongest impact for SVR, following genetic polymorphisms of rs8099917 near *IL28B* gene.

The important novelty from this study is that the reductions of HCV RNA level 4 and 12 weeks after starting therapy had no predictive value for SVR when focusing on patients who showed delayed virologic response and underwent the extended 72-week treatment

regimen according to the response-guided therapy. This was in contrast to the prediction for SVR in all patients who underwent response-guided therapy. The impact of the reduction of HCV RNA level on the prediction of SVR would decline by the selection of patients based on the delayed virologic response. There were also no baseline factors that were associated with SVR in patients who underwent the extended 72-week treatment (data not shown). Prolonged treatment duration may relieve delayed virologic responders from unfavorable conditions. Further studies will be, therefore, needed to identify predictive factors for SVR in patients with delayed virologic response who underwent the 72-week treatment regimen.

There are several limitations to this study. The data were based on Japanese patients infected with HCV genotype 1b. Therefore, these results should be confirmed in patients of other ethnicities and patients infected with HCV genotype 1a. In addition, the value of the reduction in HCV RNA levels 4 and 12 weeks after starting therapy as predictors of SVR should be evaluated in patients who underwent therapy with PEG-IFN alpha 2a and ribavirin to determine the best cut-off levels with that regimen. Statistically, there were many missing data. We performed complete case analysis without the imputation of missing data for multivariate analysis. Although comparison between cases with and without missing data did not show statistically significant differences for cases characteristics, we cannot rule

out that the condition of data missing completely at random does not hold. Furthermore, this resulted in the decrease in the number of patients analyzed in multivariate analysis and might have substantially caused the reduction of statistical power, altering the value of non-significant results. In addition, the study did not perform internal validation. The use of hold-out method or split-group validation was difficult because of the number of study patients. Therefore, the validation in another larger study patients will be required in the future for confirming the results of this study.

Conclusions

A reduction in HCV RNA levels 4 and 12 weeks after starting therapy indicated likelihoods that patients will achieve SVR as a final outcome of combination therapy for HCV infection when patients underwent the response-guided therapy according to the AASLD guidelines. These reductions in serum HCV RNA levels were not predictive for SVR when focusing on patients who showed delayed virologic response and underwent the extended 72-week regimen.

Abbreviations

HCV: Hepatitis C virus; PEG-IFN: Peginterferon; SVR: Sustained virologic response; ROC: Receiver operating characteristics; ISDR: Interferon sensitivity-determining region; RVR: Rapid virologic response; EVR: Early virologic response; AASLD: American Association for the Study of the Liver Diseases; BMI: Body mass index; PPV: Positive predictive value; NPV: Negative predictive value.

Competing interests

The authors declare the following matters.

The authors have not received reimbursements, fees, funding, or salary from an organization that may in any way gain or lose financially from the publication of this manuscript, neither now nor in the future.

The authors have no stocks or shares in an organization that may in any way gain or lose financially from the publication of this manuscript, neither now nor in the future.

The authors are currently applying no patents relating to the content of the manuscript. We have not received reimbursements, fees, funding, or salary from an organization that holds or has applied for patents relating to the content of the manuscript.

The authors do not have any other financial competing interests.

There are no non-financial competing interests to declare in relation to this manuscript.

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Authors' contributions

Study design: HT, TK, NS, KT, TI, MS, HG, KM, and NI. Treatment of patients and data acquisition: HT, TK, NS, KT, TI, MS, and NI. Data analyses: HG and KM. Manuscript preparation: HT. Read and approval of the final manuscript: HT, TK, NS, KT, TI, MS, HG, KM, and NI. All authors read and approved the final manuscript.

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References

1. Ge D, Fellay J, Thompson AJ, Simon JS, Shianna KV, Urban TJ, Heinzen EL, Qiu P, Bertelsen AH, Muir AJ, Sulikowski M, McHutchison JG, Goldstein DB: **Genetic variation in IL28B predicts hepatitis C treatment-induced viral clearance.** *Nature* 2009, **461**:399–401.
2. Suppiah V, Moldovan M, Ahlenstiel G, Berg T, Weltman M, Abate ML, Bassendine M, Spengler U, Dore GJ, Powell E, Riordan S, Sheridan D, Smedile A, Fragomeli V, Müller T, Bahlo M, Stewart GJ, Booth DR, George J: **IL28B is associated with response to chronic hepatitis C interferon-alpha and ribavirin therapy.** *Nat Genet* 2009, **41**:1100–1104.
3. Tanaka Y, Nishida N, Sugiyama M, Kurosaki M, Matsuura K, Sakamoto N, Nakagawa M, Korenaga M, Hino K, Hige S, Ito Y, Mita E, Tanaka E, Mochida S, Murawaki Y, Honda M, Sakai A, Hiasa Y, Nishiguchi S, Koike A, Sakaida I, Imamura M, Ito K, Yano K, Masaki N, Sugauchi F, Izumi N, Tokunaga K, Mizokami M: **Genome-wide association of IL28B with response to pegylated interferon-alpha and ribavirin therapy for chronic hepatitis C.** *Nat Genet* 2009, **41**:1105–1109.
4. McCarthy JJ, Li JH, Thompson A, Suchindran S, Lao XQ, Patel K, Tillmann HL, Muir AJ, McHutchison JG: **Replicated association between an IL28B gene variant and a sustained response to pegylated interferon and ribavirin.** *Gastroenterology* 2010, **138**:2307–2314.
5. Rauch A, Kutalik Z, Descombes P, Cai T, Di Iulio J, Mueller T, Bochud M, Battegay M, Bernasconi E, Borovicka J, Colombo S, Cerny A, Dufour JF, Furrer H, Günthard HF, Heim M, Hirschel B, Malinverni R, Moradpour D, Müllhaupt B, Witteck A, Beckmann JS, Berg T, Bergmann S, Negro F, Telenti A, Bochud PY, Swiss Hepatitis C Cohort Study; Swiss HIV Cohort Study: **Genetic variation in IL28B is associated with chronic hepatitis C and treatment failure: a genome-wide association study.** *Gastroenterology* 2010, **138**:1338–1345.
6. Enomoto N, Sakuma I, Asahina Y, Kurosaki M, Murakami T, Yamamoto C, Ogura Y, Izumi N, Marumo F, Sato C: **Mutations in the nonstructural protein 5A gene and response to interferon in patients with chronic hepatitis C virus 1b infection.** *N Engl J Med* 1996, **334**:77–81.
7. Akuta N, Suzuki F, Sezaki H, Suzuki Y, Hosaka T, Someya T, Kobayashi M, Saitoh S, Watahiki S, Sato J, Matsuda M, Kobayashi M, Arase Y, Ikeda K, Kumada H: **Association of amino acid substitution pattern in core protein of hepatitis C virus genotype 1b high viral load and non-virological response to interferon-ribavirin combination therapy.** *Intervirology* 2005, **48**:372–380.
8. Donlin MJ, Cannon NA, Yao E, Li J, Wahed A, Taylor MW, Belle SH, Di Bisceglie AM, Aurora R, Tavis JE: **Pretreatment sequence diversity differences in the full-length hepatitis C virus open reading frame correlate with early response to therapy.** *J Virol* 2007, **81**:8211–8224.
9. Maekawa S, Enomoto N: **Viral factors influencing the response to the combination therapy of peginterferon plus ribavirin in chronic hepatitis C.** *J Gastroenterol* 2009, **44**:1009–1015.
10. Hayes NC, Kobayashi M, Akuta N, Suzuki F, Kumada H, Abe H, Miki D, Imamura M, Ochi H, Kamatani N, Nakamura Y, Chayama K: **HCV substitutions and IL28B polymorphisms on outcome of peg-interferon plus ribavirin combination therapy.** *Gut* 2011, **60**:261–267.
11. Zeuzem S, Herrmann E, Lee JH, Fricke J, Neumann AU, Modi M, Colucci G, Roth WK: **Viral kinetics in patients with chronic hepatitis C treated with standard or peginterferon alpha2a.** *Gastroenterology* 2001, **120**:1438–1447.
12. Buti M, Sanchez-Avila F, Lurie Y, Stalgis C, Valdes A, Martell M, Esteban R: **Viral kinetics in genotype 1 chronic hepatitis C patients during therapy with 2 different doses of peginterferon alpha-2b plus ribavirin.** *Hepatology* 2002, **35**:930–936.
13. Berg T, Sarrazin C, Herrmann E, Hinrichsen H, Gerlach T, Zachoval R, Wiedenmann B, Hopf U, Zeuzem S: **Prediction of treatment outcome in patients with chronic hepatitis C: significance of baseline parameters and viral dynamics during therapy.** *Hepatology* 2003, **37**:600–609.
14. Lee SS, Ferenci P: **Optimizing outcomes in patients with hepatitis C virus genotype 1 or 4.** *Antiviral Res* 2008, **13**:S9–S16.
15. Martinez-Bauer E, Crespo J, Romero-Gomez M, Moreno-Otero R, Sola R, Tesei N, Pons F, Forn X, Sanchez-Tapias JM: **Development and validation**

- of two models for early prediction of response to therapy in genotype 1 chronic hepatitis C. *Hepatology* 2006, **43**:72–80.
16. Poordad F, Reddy KR, Martin P: **Rapid virologic response: a new milestone in the management of chronic hepatitis C.** *Clin Infect Dis* 2008, **46**:78–84.
 17. Martinot-Peignoux M, Maylin S, Moucari R, Ripault M-P, Boyer N, Cardoso A-C, Giuily M, Castelnaud C, Pouteau M, Stern C, Aupepin A, Bedossa P, Asselah T, Marcellin P: **Virological response at 4 weeks to predict outcome of hepatitis C treatment with pegylated interferon and ribavirin.** *Antivir Ther* 2009, **14**:501–511.
 18. de Segadas-Soares JA, Villela-Nogueira CA, Perez RM, Nabuco LC, Brandao-Mello CE, Coelho HSM: **Is the rapid virologic response a positive predictive factor of sustained virologic response in all pretreatment status genotype 1 hepatitis C patients treated with peginterferon- α 2b and ribavirin?** *J Clin Gastroenterol* 2009, **43**:362–366.
 19. Yu JW, Wang GQ, Sun LJ, Li XG, Li SC: **Predictive value of rapid virological response and early virological response on sustained virological response in HCV patients treated with pegylated interferon α -2a and ribavirin.** *J Gastroenterol Hepatol* 2007, **22**:832–836.
 20. Huang C-F, Yang J-F, Huang J-F, Dai C-Y, Chiu C-F, Hou N-J, Hsieh M-Y, Lin Z-Y, Chen S-C, Hsieh M-Y, Wang L-Y, Chang W-Y, Chuang W-L, Yu M-L: **Early identification of achieving a sustained virological response in chronic hepatitis C patients without a rapid virological response.** *J Gastroenterol Hepatol* 2010, **25**:758–765.
 21. Toyoda H, Kumada T, Kiriyaama S, Tanikawa M, Hisanaga Y, Kanamori A, Tada T, Arakawa T, Fujimori M, Niinomi T, Ando N, Yasuda S, Sakai K, Kimura J: **High ability to predict the treatment outcome of peginterferon and ribavirin combination therapy based on the reduction in HCV RNA levels at 4 weeks after starting therapy and amino acid substitutions in hepatitis C virus in patients infected with HCV genotype 1b.** *J Gastroenterol* 2011, **46**:501–509.
 22. Marcellin P, Reau N, Ferenci P, Hadziyannis S, Messinger D, Tatsch F, Jensen D: **Refined prediction of week 12 response and SVR based on week 4 response in HCV genotype 1 patients treated with peginterferon alfa-2a (40KD) and ribavirin.** *J Hepatol* 2012, **56**:1276–1282.
 23. Toyoda H, Kumada T, Kiriyaama S, Tanikawa M, Hisanaga Y, Kanamori A, Tada T, Hosokawa T, Arakawa T, Fujimori M: **Outcome in partial early virologic responders to combination therapy with peginterferon and ribavirin in patients infected with hepatitis C virus genotype 1b.** *J Med Virol* 2011, **83**:101–107.
 24. Jacobson IM, McHutchison JG, Dusheiko G, Di Bisceglie AM, Reddy KR, Bzowej NH, Marcellin P, Muir AJ, Ferenci P, Flisiak R, George J, Rizzero M, Shouval D, Sola R, Terg RA, Yoshida EM, Adda N, Bengtsson L, Sankoh AJ, Kieffer TL, George S, Kauffman RS, Zeuzem S, ADVANCE Study Team: **Telaprevir for previously untreated chronic hepatitis C virus infection.** *N Engl J Med* 2011, **364**:2405–2416.
 25. Zeuzem S, Andreone P, Pol S, Lawitz E, Diago M, Roberts S, Focaccia R, Younossi Z, Foster GR, Horban A, Ferenci P, Nevens F, Mullhaupt B, Pockros P, Terg R, Shouval D, van Hoek B, Weiland O, Van Heeswijk R, De Meyer S, Luo D, Boogaerts G, Polo R, Picchio G, Beumont M, REALIZE Study Team: **Telaprevir for retreatment of HCV infection.** *N Engl J Med* 2011, **364**:2417–2428.
 26. Poordad F, McCone J Jr, Bacon BR, Bruno S, Manns MP, Sulkowski MS, Jacobson IM, Reddy KR, Goodman ZD, Boparai N, DiNubile MJ, Sniukiene V, Brass CA, Albrecht JK, Bronowicki JP: **SPRINT-2 Investigators. Boceprevir for untreated chronic HCV genotype 1 infection.** *N Engl J Med* 2011, **364**:1195–1206.
 27. Bacon BR, Gordon SC, Lawitz E, Marcellin P, Vierling JM, Zeuzem S, Poordad F, Goodman ZD, Sings HL, Boparai N, Burroughs M, Brass CA, Albrecht JK, Esteban R: **HCV RESPOND-2 Investigators. Boceprevir for previously treated chronic HCV genotype 1 infection.** *N Engl J Med* 2011, **364**:1207–1217.
 28. Lok AS, Gardiner DF, Lawitz E, Martorell C, Everson GT, Ghalib R, Reindollar R, Rustgi V, McPhee F, Wind-Rotolo M, Persson A, Zhu K, Dimitrova DI, Eley T, Guo T, Grasel DM, Pasquinelli C: **Preliminary study of two antiviral agents for hepatitis C genotype 1.** *N Engl J Med* 2012, **366**:216–224.
 29. Colucci G, Ferguson J, Harkleroad C, Lee S, Romo D, Sovieiro S, Thompson J, Velez M, Wang A, Miyahara Y, Young S, Sarrazin C: **Improved COBAS TaqMan hepatitis C virus test (version 2.0) for use with the High Pure system: enhanced genotype inclusivity and performance characteristics in a multisite study.** *J Clin Microbiol* 2007, **45**:3595–3600.
 30. Pittaluga F, Alice T, Abate ML, Ciancio A, Cerutti F, Varetto S, Colucci G, Smedile A, Ghisetti V: **Clinical evaluation of the COBAS Ampliprep/COBAS TaqMan for HCV RNA quantitation in comparison with the branched-DNA assay.** *J Med Virol* 2008, **80**:254–260.
 31. Ghany MG, Strader DB, Thomas DL, Seeff LB: **Diagnosis, management, and treatment of hepatitis C: an update.** *Hepatology* 2009, **49**:1335–1374.
 32. Kato N, Hijikata M, Ootsuyama Y, Nakagawa M, Ohkoshi S, Sugimura T, Shimotohno K: **Molecular cloning of the human hepatitis C virus genome from Japanese patients with non-A, non-B hepatitis.** *Proc Natl Acad Sci USA* 1990, **87**:9524–9528.
 33. Tanaka Y, Nishida N, Sugiyama M, Tokunaga K, Mizokami M: **λ -interferons and the single nucleotide polymorphisms: a milestone to tailor-made therapy for chronic hepatitis C.** *Hepatol Res* 2010, **40**:449–460.

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