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**To treat or not to treat “immunotolerant phase” of hepatitis B infection: A tunnel of controversy**

Mekky MA.Managing immunotolerant phase of HBV infection

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**Abstract**

Hepatitis B virus (HBV) infection is a global public health problem with an estimated 350 million people worldwide that are chronically infected and approximately 500000 patients die annually from HBV-related liver diseases. Management of chronic HBV is challenging and waves of guidelines are emerging every year. One of the hottest topic and a matter of debate is the management of patients in their early immunotolerant phase of infection. With the lack of evidence, the dealing with this particular subset of patients carries a great conflict with opposing views. In this review, the author tried to highlight the pros and cons of these views and to propose a reasonable solution to unearth this dilemma.

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**Key words:** Liver biopsy; Hepatitis B Virus; immunotolerant phase; Polymerase chain reaction; Nucleotide analogue

**Core tip:** In this mini-review, the author tried to discuss the management dilemma of this peculiar subset of patients suffering from chronic hepatitis B in their immunotolerant phase. As already known, the immunotolerant phase of hepatitis B virus may last for a long period and hence there may be a potential for subtle liver damage. A thorough review was done for the updated published reports and a merge of the various management options with a special point of view of the author is stated.

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**Introduction**

Hepatitis B virus (HBV) infection is a global public health problem with an estimated about 350 million people are chronically infected worldwide. Fifteen to forty percent of these individuals will develop serious sequelae during their lifetime and have greater evolution to cirrhosis or hepatocellular carcinoma (HCC). The estimated 5-year rate of progression from chronic hepatitis B (CHB) to cirrhosis was estimated to be 12%-20% and the 5-year cumulative risk of developing HCC was also estimated to be between 10%-17% in patients with cirrhosis. These figures varied from country to another according to the disease endimicity and prevalence[1-3]. The natural history of CHB is complex and was described to run through different immunologic phases, that may overlap. In its early phases, HBV infection is characterized by a minimal liver damage on liver biopsy, a high level of HBV replication and a positivity for HBe-antigen (HBeAg). These patients are asymptomatic, and have normal levels of serum alanine aminotransferase (ALT). This phase was described as “immunotolerant phase”[3,4].

The dealing with these patients carries a great conflict with two opposing views. One view is optimistic, conservative and relying upon the long-term course of benignity of the disease. They are adopting the view of “let the patient on close follow up”. On the other hand, the other view is pessimistic view and is relying upon the great risk of cancer development, even without cirrhosis. This latter view is adopting the view of “to treat the patient and why to wait”. Between these two views, really there are no evidently based guidelines.

In this review, an extensive online research for English reviews and articles that tackle this subject by using key words “immunotolerant”, “HBV”, and “management” was done. The author tried to highlight the pros and cons of all views regarding the management of strategies of this subject and tried to make a reasonable proposed solution for this dilemma.

**Immunotolerant phase: Characteristics and immunologic insight**

The natural history of HBV infection is perplexing and its net result is an interplay between the viral replication and the host immune response. After primary infection, an immunotolerant phase characterized by a very high rate of viral replication but without liver injury takes place. The mechanism of this tolerance is not yet fully understood[5]. Those patients infected early in life through vertical or early horizontal infection. Such infection most often occurs in areas with high rates of endemic infection, low rates of maternal screening, and lack of widely available neonatal prophylaxis with HBV vaccine and hepatitis B immunoglobulin[6,7].

It is believed that before birth, HBeAg acts as a “tolerogen viral protein” in the fetus, and thus virus specific T-cells undergo deletion. This phase lasts from weeks to years depending on the age at acquisition. After years/decades, this tolerance is somehow ruptured and immune attack against infected hepatocytes, to clear them, begins and this causes liver damage. During this “immune clearance phase”, ALT levels increase and HBV-DNA levels begin to decrease. Immune attacks to infected hepatocytes resulted in HBeAg seroconversion and this seroconversion is usually associated with sustained remission of liver disease. Selection pressures for the virus come from either competition between viral variants, which are different in their replicative efficiency, and the host immune activity[8-10].

It was found that the majority of young children presented in immunotolerant phase have either minimal chronic hepatitis or, more commonly, non-speciﬁc reactive hepatitis, in spite of persistently normal ALT activity[11-13].

Wang *et al*[14], studied seven patients (age range between 7-25 years) by follow up them for at least 17 years with serial sampling for ALT activity and viral load. They concluded that the interplay between viral replication and host immunity explains the pattern of HBV dynamics within the host during the early stages of infection. That is, without immune selection, competition between peers increases the viral load and decreases the nucleotide diversity; in contrast, host immunity accelerates viral evolution and decreases copy numbers but increases diversity.

The fully infected liver can yield between 109 to1010 viruses per ml of serum, a level of production that would be expected to persist if infection were benign and the host were truly immunotolerant. Virus titers in adolescent and young adult carriers in the immunotolerant phase of infection tend to be lower, ranging from 107 to 109 copies per ml[15,16]. Some studies explaining the declining of virus titres during the time in the immunotolerant phase by a low but persistent immune destruction of infected cells by the cytotoxic T-cell, that leads, overtime, to an adaptive immune response[14].

**Immunotolerant phase: Management options and debates**

Of a particular concern, the fact that until now there is no drug therapy that actually being effective in achieving a sustained response against HBV in the immunotolerant phase[17].

The currently approved treatment options of chronic HBV infection are interferon and nucleoside analogues (NA). Interferon acts primarily as an immunomodulatory agent, while NAs have essentially antiviral effects. According to current consensuses and guidelines statements, treatment candidates are patients with active liver disease which is characterized by persistently elevated ALT levels and by detectable HBV-DNA (10**5** copy/mL) by most commercial assays, irrespective of their HBeAg/Ab status. These statements also concluded that HBeAg-negative inactive carriers do not need any treatment because of the absence of viral replication and liver injury. Also, patients in immunotolerant phase should be followed up without treatment[18,19].

However, and in the light of the Risk Evaluation of Viraemia Elevation and Associated Liver Disease-study, a baseline high HBV-DNA level was associated with a significant risk of hepatocellular carcinomas[20]. These results led to the debate on whether a HBV infected person with normal liver enzymes, unremarkable liver histology, but with a detectable level of HBV DNA (high or low regardless the cutoff) should be treated with antiviral drugs or not[20,21].

As a role, most of the current guidelines recommend that patients with moderate/severe inflammation or bridging fibrosis/cirrhosis must be treated. Also, they recommend liver biopsy for the grey zone of patients who do not meet the typical criteria; have a detectable level of HBV-DNA and/or fluctuating or persistently elevated ALT. The presence of significant inflammation or bridging fibrosis/cirrhosis is an indication for treatment[22,23].

Hence, and in the light of the previous statements, we can assume that there are two options regarding the management of the immunotolerant phase; the “why to wait” view and the “close follow up” view.

The “why to wait” view is adopting the option to treat all patients that have a persistently high level of viral replication regardless the phase of infection and relying only on the presence of detectable DNA levels only. They relying on the high risk of cancer/cirrhosis development, and considering the infection is not totally benign[24]. Therefore, earlier treatment intervention may be beneﬁcial in preventing disease progression. A recently published study aimed to break this tolerance in children by treating a group of HBV-infected children presented in the immunotolerant phase with lamivudine and interferon and comparing them to untreated group. They reported a cure rate in more than one-fifth of the studied cohort, a figure that is still primitive and not high[25].

On the opposing wall, another strong option is existed and adopting the view of “to wait and to observe”. This view is relying on some evidence. The first is the evidence of the benign long term course of immunotolerant phase[26]. The second is the pooled results of poor response to the antiviral therapy in this unique phase which hardly reaches to 19%[27]. The third is the proved emerging resistance on the long term therapy[28]. The last is the heavy cost burden of the treatment.

[Wong](http://www.ncbi.nlm.nih.gov/pubmed?term=Wong%20GL%5BAuthor%5D&cauthor=true&cauthor_uid=23808759) *et al*[29]studied the risk of liver fibrosis progression in HBeAg-positive patients at different phases by recruiting two hundred forty-seven HBeAg-positive patients without advanced fibrosis at baseline. They found liver fibrosis progression is uncommon in HBeAg-positive patients and hence, their results enforce the follow-up strategy.

As known, the degree of fibrosis or inflammation upon liver biopsy cannot be predicted by the level of HBV-DNA and also, ALT was considered as an imperfect surrogate marker for liver disease[30]. Therefore, without an evidence of normal liver histology, the definition of immunotolerant disease depends mainly on the persistence of normal ALT level as a major determinant. Nevertheless, and unfortunately, the definition of a “normal” ALT level has been redefined several times and was subjected to a strong debate. In the study of Prati *et al*[31] they modified the normal upper limit for ALT to be 30 IU/mL for men and 19 IU/mL for women. Re-introducing these relatively low figures will endorse much more patients under the umbrella of raised ALT levels.

The most appropriate way to clear-cut this miss is to perform a liver biopsy. However, there are still some unanswered questions; *e.g.,,* what is the optimal timing of liver biopsy during the natural history of this phase, how many times to do it and at what intervals, which drug is the best to start with,…. *etc.*.

Another light that may help in breaking the tolerance is the trial of using therapeutic vaccines. In spite of its preliminary application, the published results of the study of [Buchmann](http://www.ncbi.nlm.nih.gov/pubmed?term=Buchmann%20P%5BAuthor%5D&cauthor=true&cauthor_uid=23306359) *et al*[32] carry a great hope for a wide future applicability. They evaluated the potential use of a novel vaccine formulation comprising particulate hepatitis B surface and core antigen, and the saponin-based adjuvant for its ability to stimulate T and B cell responses in C57BL/6 mice. Their results were promising and a future intense research in this subject is deemed to be mandatory.

**Conclusion**

Immunotolerant phase of chronic HBV is a challenging problem, with an increasing awareness of its occurrence especially in endemic areas. More intense studies are required for a better delineation of the pathogenesis and which is better is to break the tolerance or to wait the natural clearance. Till this, the most suitable solution is to perform liver biopsy to stand on a solid base in choosing the best option, is to wait or to interfere.

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