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VIRAL HEPATITIS

Low-dose intermittent interferon-alpha therapy for HCV-related liver cirrhosis after curative treatment of hepatocellular carcinoma

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Abstract

AIM: To assess the efficacy of low-dose intermittent interferon (IFN) therapy in patients with hepatitis C virus (HCV)-related compensated cirrhosis who had received curative treatment for primary hepatocellular carcinoma (HCC).

METHODS: We performed a prospective case controlled study. Sixteen patients received 3 MIU of natural IFN-alpha intramuscularly 3 times weekly for at least 48 wk (IFN group). They were compared with 16 matched historical controls (non-IFN group).

RESULTS: The cumulative rate of first recurrence of HCC was not significantly different between the IFN group and the non-IFN group (0% *vs* 6.7% and 68.6% *vs* 80% at 1- and 3-year, $P = 0.157$, respectively). The cumulative rate of second recurrence was not also significantly different between the IFN group and the non-IFN group (0% *vs* 6.7% and 35.9% *vs* 67% at 1- and 3-year, $P = 0.056$, respectively). Although the difference in the Child-Pugh classification score between the groups at initial treatment of HCC was not significant, the score was significantly worse at the time of data analysis in the non-IFN group than IFN group (7.19 ± 1.42 *vs* 5.81 ± 0.75, $P = 0.0008$). The cumulative rate of deviation from objects of any treatment for recurrent HCC was also higher in the non-IFN group than IFN group (6.7% and 27% *vs* 0 and 0% at 1- and 3-year, $P = 0.048$, respectively).

CONCLUSION: Low-dose intermittent IFN-alpha therapy for patients with HCV-related compensated cirrhosis after curative HCC treatment was effective by making patients tolerant to medical or surgical treatment for recurrent HCC in the later period of observation.

Key words: Hepatitis C virus; Hepatocellular carcinoma; Interferon therapy; Liver cirrhosis; Liver function; Recurrence; Survival

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INTRODUCTION

Hepatocellular carcinoma (HCC) is one of the most common malignant neoplasms worldwide. Approximately 80% of Japanese patients with HCC have a history of hepatitis C virus (HCV) infection, and most such patients have liver cirrhosis[1-3]. Although recent advances in imaging techniques and treatment of HCC have improved prognosis of patients with HCV-related HCC, the outcome is still unsatisfactory; the 5-year survival rate is only 50% to 70% even after curative treatment such as hepatic resection and local ablation[4]. The reasons for this unfavorable prognosis is considered to include high intrahepatic tumor recurrence rates and biochemical deterioration by sustained hepatic damage, both resulting from persistent HCV infection[5]. Even after curative hepatic resection for HCV-related HCC, the rate of intrahepatic tumor recurrence within 1 year is 20% to 40%, rising to about

80% by 5 years[4,6-8]. Intrahepatic recurrences of HCC may result from intrahepatic metastasis originating from the primary HCC or from ongoing multicentric carcinogenesis related to chronic HCV infection. In addition, sustained underlying HCV-related hepatic damage may compromise hepatic functional reserve, worsening clinical outcome. Thus, prevention of HCC recurrence and preservation of liver function are both highly important priorities in improving prognosis of patients with HCV-related HCC.

Interferon (IFN) therapy for patients with HCV infection is effective as evident by reduction of serum alanine transaminase (ALT) activity and eradication of HCV. Accordingly, IFN is valuable in minimizing hepatic necrosis, inflammation, and fibrosis, as well as reducing the likelihood of hepatocarcinogenesis[9-16]. The primary goal of treatment of patients with HCV infection is elimination of the virus. Several studies have reported recently that IFN therapy provided after curative treatment for HCV-related HCC prevents HCC recurrences and improves survival[17-23]. Such improvement of prognosis is more predominant when IFN therapy results in elimination of HCV RNA[24]. However, most patients with HCV-related HCC also have liver cirrhosis. Many centers do not advocate IFN therapy of patients with compensated cirrhosis, mainly because of the disappointing sustained virological response (SVR) rates in such patients[25]. Several studies indicated that the response of cirrhotic patients to antiviral therapy is low[26-28]. The reasons for the low SVR rate in such patients include inability to administer IFN at recommended doses due to adverse effects and dose-limiting cytopenia. On the other hand, several investigators suggested that the use of low-dose IFN therapy for viral elimination was as effective in the treatment of cirrhotic patients with HCV as it is in non-cirrhotic patients[29,30]. Furthermore, they indicated that the same therapy could improve the underlying liver histology. There is evidence to suggest that low-dose IFN therapy might be beneficial in HCV-related cirrhosis, not only because it prevents the progression of liver disease, but also because it reduces the risk of hepatocarcinogenesis[31,32]. In this regard, low-dose IFN therapy seems to be tolerable without significant life-threatening adverse effects than the standard dose of IFN.

However, it is not known whether low-dose IFN after curative treatment of primary HCC could slow disease progression or reduce the rate of clinical decompensation in cirrhotic patients, in addition to prevention of HCC recurrence. Several studies used the standard dose of IFN after HCC treatment[17,23,33], and studies using low-dose IFN therapy for HCV-related cirrhosis after HCC treatment also reported that such regimen may reduce late recurrence of HCC[34].

In this prospective case controlled trial, we assessed the efficacy of low-dose intermittent IFN therapy on HCV-related liver cirrhosis after curative treatment of primary HCC in terms of overall survival, HCC recurrence, and liver function.

MATERIALS AND METHODS

Patients

A total of 176 consecutive patients received their initial treatment for HCV-related primary HCC at Hiroshima University Hospital between August 2001 and December 2006. Of these, 67 patients with HCC underwent first medical or surgical therapeutic intervention with curative intent (defined as complete tumor eradication with no visible residual tumor in computed tomographic images, or resection of all evident tumor tissue). Medical treatments included percutaneous radiofrequency (RF) ablation and ethanol injection, while surgical procedures included hepatic resection and RF ablation under laparotomy. Among these 67 patients, 52 patients with liver cirrhosis (LC), which was diagnosed clinically and pathologically, were considered for this prospective study. Figure 1 shows our study flow. Among these 52 patients with HCV-related LC, we assessed 42 patients who met the following inclusion criteria: (1) the presence of up to three tumors with none exceeding 30 mm in diameter or a solitary tumor less than 50 mm in diameter; (2) tumor-node-metastasis (TNM) stage of Ⅰ, Ⅱ or Ⅲ; (3) detectable serum HCV RNA; (4) all seronegativity for hepatitis B marker including hepatitis B surface antigen, hepatitis B anti-core antibody and hepatitis B surface antibody ; (5) compensated cirrhosis with a Child-Pugh class A or B; (6) platelet count $\geqslant$ 40 000/μL; and (7) absence of local recurrence during the follow-up period and of any ectopic intrahepatic recurrence within 12 wk after treatment for primary HCC. We used the TNM classification system

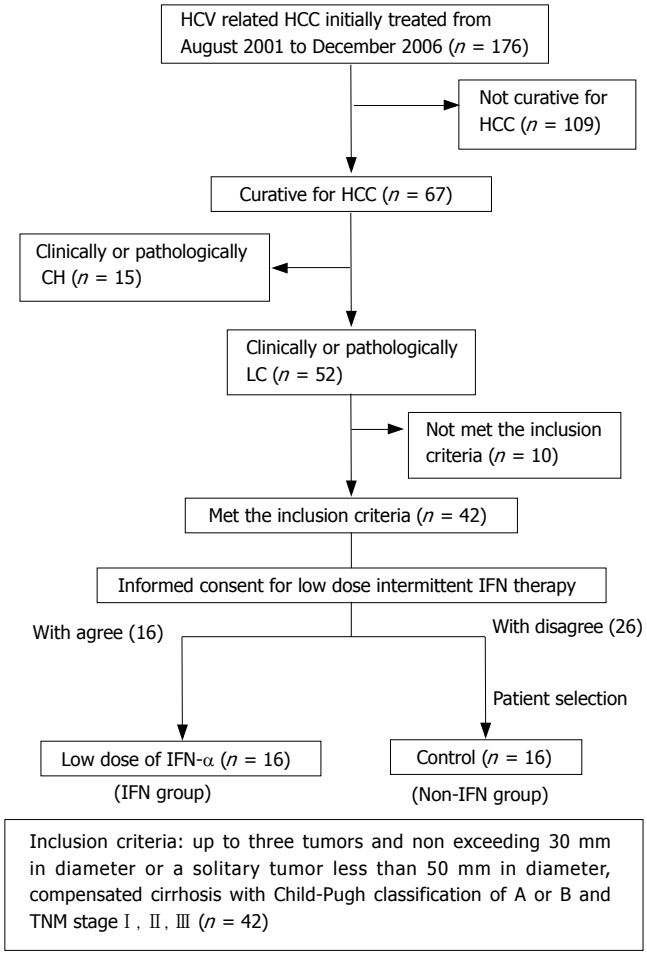

Figure 1 Schematic flow chart of enrolled patients.

Table 1 Characteristics of participating patients

	Interferon group	Non-interferon group	*P* value
No. of patients	16	16	
Age in years (range)	68.5[1] (53-73)	67.5[1] (58-75)	NS
Gender (Male/Female)	10/6	11/5	NS
Albumin (g/dL)	3.7[1] (3.0-4.8)	3.7[1] (3.0-4.5)	NS
Platelet count ($\times 10^4$/L)	8.0[1] (4.5-14.2)	8.4[1] (4.6-14.3)	NS
ICG R-15 (%)	17.3[1] (6.1-40.8)	18.2[1] (5-45)	NS
Alanine aminotransferase (IU/L)	59[1] (35-99)	58[1] (21-143)	NS
Alpha fetoprotein (ng/mL)	54[1] (5.3-293.6)	38[1] (5.0-1217)	NS
Child-Pugh score (A/B)	13/3	13/3	NS
Main tumor size (mm)	15[1] (10-50)	18[1] (10-40)	NS
No. of HCC tumors (single/multiple)	9/7	10/6	NS
Stage (Ⅰ/Ⅱ/Ⅲ)	8/3/5	7/5/4	NS
Treatment (medical/surgical)	8/8	9/7	NS
HCV genotype (1/2)	12/4	14/2	NS
Viral loads (low/high)	6/10	5/11	NS

ICG-R15: Indocyanine green retention at 15 min; Low viral loads: HCV RNA < 100 KIU/mL, high viral loads: HCV RNA ≥ 100 KIU/mL. [1]median.

of the Liver Cancer Study Group of Japan as a staging system for HCC[35]. The underlying liver condition leading to LC was identified by histopathological examination of resected tissue samples. When this was not available, laboratory tests were performed including serum albumin, platelet, prothrombin time and indocyanine green retention at 15 min (ICG-R15), and radiological examination such as ultrasonography and computed tomography.

Of the 42 patients with LC who met the above eligibility criteria, 16 patients received low-dose IFN therapy after signing a written informed consent (IFN group). Of the remaining 26 patients who rejected IFN therapy, we selected 16 patients as the control (non-IFN group). These 16 patients, who met the eligibility criteria mentioned above, were matched by age, gender, tumor size, number of tumors, TNM stage of HCC, serum albumin level, platelet counts, ICG-R15 and Child-Pugh class with patients of the IFN group. Thus, a total of 32 patients (16 in the IFN group and 16 in the non-IFN group) were enrolled in this study. All agreed to participate in the research protocol, which was approved by the hospital research ethics board. Table 1 shows the baseline characteristics of patients of the two groups. The data indicates no significant differences between the groups for age, gender, liver function, tumor characteristics, and therapeutic methods used against primary HCC.

IFN therapy

In the IFN group, patients received 3 MIU of natural IFN-alpha (human lymphoblastoid IFN; Sumiferon, Dainippon Sumitomo Pharmaceuticals, Osaka, Japan) intramuscularly three times weekly for at least 48 wk as long as possible. IFN therapy commenced within 12 wk after initial treatment for HCC. Patients received post-treatment IFN therapy up to the detection of HCC recurrence, and then patients who could have curative treatment for recurrent HCC restarted IFN therapy when possible. However, patients who had advanced liver dysfunction or untreatable progressive HCC did not receive IFN therapy. In the control group, none of the patients received IFN therapy after curative treatment of HCC; instead, they were on ursodeoxycholic acid (UDCA) and stronger neo minophagen C (SNMC).

Follow-up

After curative treatment for primary HCC, all patients underwent liver function tests, serum tumor marker assays such as alpha-fetoprotein (AFP) and protein induced by vitamin K absence or antagonist (PIVKA)-Ⅱ, every month, abdominal ultrasonography every 3 mo, and dynamic computed tomography (CT) every 6 mo. If recurrences of HCC were suspected, additional examinations including CT during arteriography or tumor biopsy were performed. Recurrence of HCC was defined as any new nodules appearing as hyperattenuation by CT during hepatic arteriography or as hypoattenuation in CT performed during arterioportography. Hypovascular HCC was confirmed histopathologically by fine-needle aspiration biopsy. Patients with recurrent HCC were treated medically or surgically, with curative intent if possible. Patients without curative treatment of recurrent HCC then received transcatheter chemoembolization. After repeated transcatheter chemoembolization, patients were finally unable to receive any treatment for recurrent HCC.

End points

We analyzed the outcome of this prospective study in December 2006. We compared the rate of HCC recurrence and the survival rate between IFN group and control group. We assessed whether low-dose of IFN therapy was effective in inhibiting recurrence of HCC, preserving liver function and prolonging survival. In addition, we also assessed the cumulative rate of deviation from objective of any treatment against recurrent HCC due to progression of HCC and/or underlying liver dysfunction.

Statistical analysis

The Chi-square and Fisher exact tests were used for categorical variables, while Student's *t*-test and the Mann-Whitney *U* test were used for continuous and ordinal variables, as appropriate. The Kaplan-Meier method used to assess cumulative survival and recurrence rates calculated from the date of diagnosis to the date of

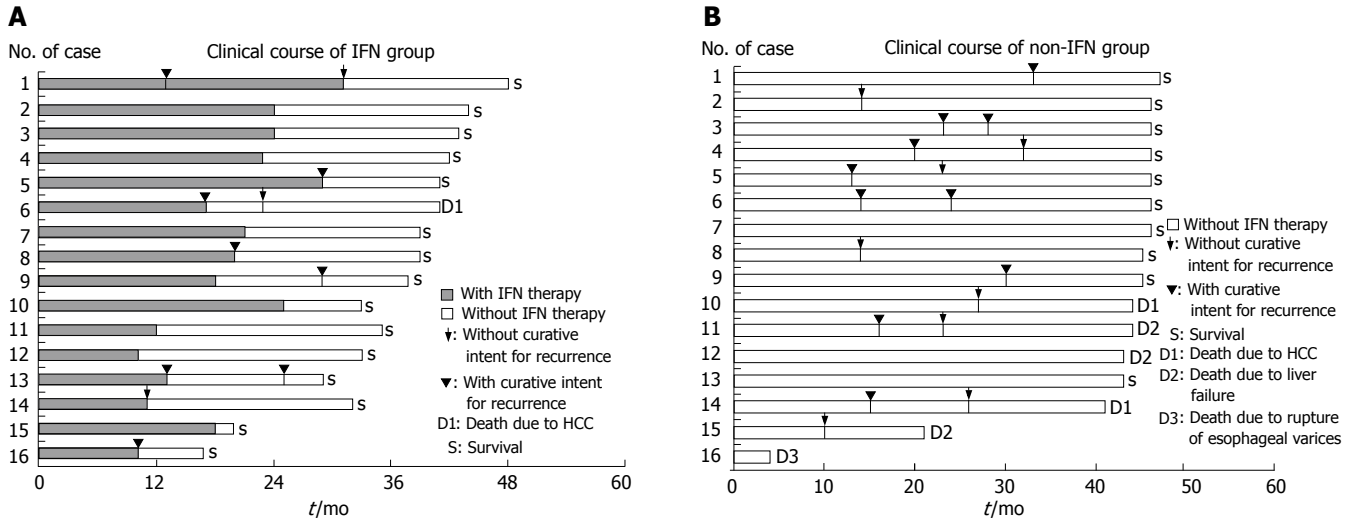

Figure 2 **A**: Clinical course of the interferon group. Patients who had a curative treatment for primary HCC received 3 MIU of natural interferon-alpha three times weekly for at least 48 wk as long as possible except Cases 12, 14 and 16. Recurrent HCCs were treated with or without curative treatment; **B**: Clinical course of the non-interferon group. Patients who had a curative treatment of primary HCC did not receive IFN therapy. Recurrent HCCs were also treated with or without curative treatment.

disease recurrence or death. Surviving patients and patients who died of causes unrelated to the liver were defined as censored cases, while patients who died of causes related to the liver were defined as noncensored cases. The log-rank test was used to compare survival and recurrence curves. *P* values below 0.05 were considered to indicate statistical significance. The JMP version 5.1 statistical software package (SAS Institute, Cary, NC) was used for analysis of data.

RESULTS

Clinical course of IFN group

Figure 2A shows the clinical course of 16 patients of the IFN group from the initial treatment of primary HCC to the date of data analysis. The duration of low-dose IFN therapy ranged from a minimum of 10 mo to a maximum of 25 mo (median 16 mo). Although 8 patients did not have HCC recurrence, HCC recurred in 8 patients after initial treatment of HCC during a median follow-up period of 37 mo. Of the recurred patients, 7 developed HCC recurrence during IFN therapy (Cases 1, 5, 6, 8, 13, 14 and 16) except 1 patient (Case 9) who had HCC recurrence after discontinuation of IFN therapy. Of the 8 patients with HCC recurrence, 4 were treated with surgical resection therapy (Cases 5, 9, 13 and 16), 3 patients with percutaneous RF ablation therapy (Cases 1, 6 and 8) and 1 patient transcatheter chemoembolization (Case 14). Of these patients, a patient with transcatheter chemoembolization (Case 14) could not have curative treatment and repeated transcatheter chemoembolization. He was excluded from the study concerning the next recurrence. Of the 7 patients with curative treatment for HCC recurrence, 2 restarted IFN therapy, one continued IFN therapy until next recurrence (Case 1), which was not curative, and the other continued until intolerant generalized fatigue (Case 8). The remaining 5 patients (Cases 5, 6, 13, 14 and 16) were followed without IFN therapy because of rejection of IFN therapy. Although one of these 5 patients was not curative for first recurrence (Case 14), he was tolerant to repeated transcatheter chemoembolization and was still alive at the date of data analysis. Two patients without curative treatment at the second recurrence (Cases 1 and 6) were also relatively tolerant to the repeated medical treatment such as transcatheter chemoembolization. Of these patients, one died of progression of HCC in spite of repeated transcatheter chemoembolization and hepatic arterial infusion (Case 6), another was alive at the date of data analysis (Case 1). Of 3 patients without curative treatment of HCC, two survivors' status of HCC were not progressive (stage Ⅱ and stage Ⅲ) and underlying liver function could be tolerant to the treatment such as transcatheter chemoembolization because of relatively preserved function (Cases 1 and 14).

The 16 patients who received IFN therapy included 2 patients with virological response (Cases 2 and 3) and 14 patients who did not get SVR [3 transient responders (Cases 8, 9 and 11), and 11 non-responders (Cases 1, 4, 5, 6, 7, 10, 12, 13, 14, 15 and 16)]. Among the 14 patients who did not show SVR, 8 were biochemical responders with normalized ALT (Cases 1, 4, 5, 7, 9, 10, 13 and 16), including 4 transient responders and 4 non-responders. Two sustained virological responders who received IFN therapy for 96 wk have viral characteristics of genotype 1 and low viral load. Among the patients who did not show SVR, 7 discontinued IFN treatment because of recurrence of HCC, while 2 patients restarted IFN therapy after the curative treatment of recurrent HCC. None of the patients who received IFN therapy developed life-threatening side effects.

Clinical course of non-IFN group

Among the non-IFN group, the first recurrence of HCC occurred in 13 patients during a median follow-up period of 45 mo (Figure 2B). HCC recurred in 6 of the 7 non-IFN patients who had a sustained normalized ALT. Of the 13 patients with recurrent HCC among the non-IFN group, 4 were treated with hepatic resection (Cases 1, 4, 9 and 11),

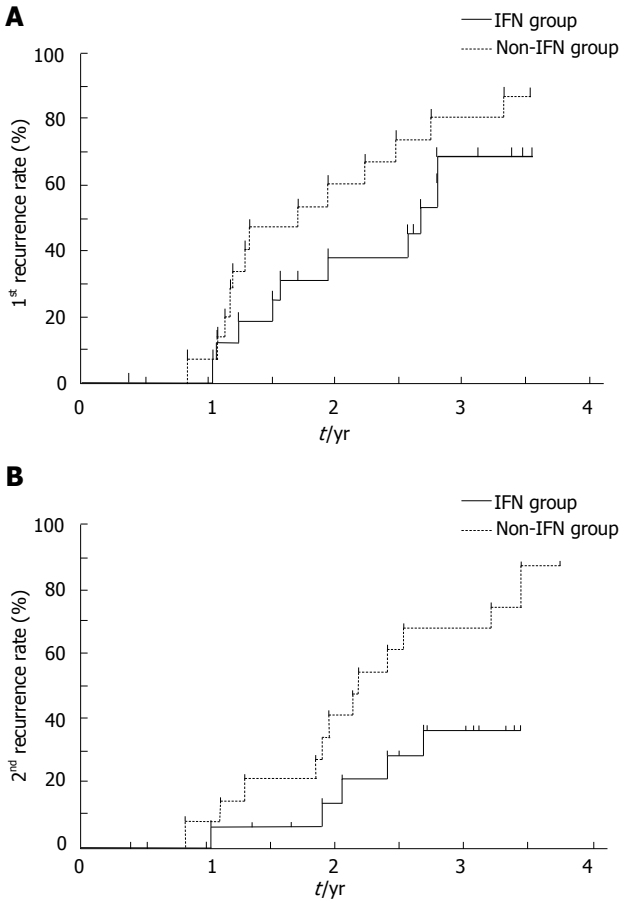

Figure 3 **A**: Cumulative rate of first recurrence. Rates of first recurrence for the IFN and non-IFN groups. The rate of first recurrence of HCC in the IFN group was not significantly different from that of the non-IFN group (P = 0.157); **B**: Cumulative rate of second recurrence. Rates of second recurrence for the IFN and non-IFN group. The rate of second recurrence of HCC in the IFN group was not significantly different from that of the non-IFN group (P = 0.056).

6 with local ablation including percutaneous RF ablation or ethanol injection (Cases 3, 5, 6, 7, 10 and 14) and 3 with transcatheter chemoembolization (Cases 2, 8 and 15). Of the 13 recurrent patients, 5 patients (2 received ethanol injection and 3 transcatheter chemoembolization) could not be treated curatively and was excluded from the study concerning the next recurrence. These 5 patients were treated repeatedly with transarterial chemoembolization after first recurrence. Among the remaining 8 patients who were treated curatively for first recurrence, 7 developed a second recurrence (Cases 3, 4, 5, 6, 9, 11 and 14). Among these 7 patients with second recurrence, 2 were treated curatively for HCC [1 with RF ablation (Case 3) and 1 with hepatic resection (Case 6)], while the remaining 5 patients were not (4 patients due to uncontrolled multiple HCC and one patient due to underlying liver dysfunction). The latter group of 5 patients received transarterial chemoembolization repeatedly after second recurrence.

Comparison of the first and second recurrence rates of HCC

We compared the overall cumulative rates for first and second recurrence between IFN and non-IFN groups (Figure 3). The 1-, 2- and 3- year rates of first recurrence of HCC in the IFN and non-IFN group were not different (0% *vs* 6.7%, 38.1% *vs* 60% and 68.6% *vs* 80%, respectively, Figure 3A, P = 0.156). The 1-, 2- and 3-year rates of second recurrence in the IFN and non-IFN groups were 0% *vs* 6.7%, 13.5% *vs* 33.3% and 35.9% *vs* 67%, respectively (Figure 3B, P = 0.056).

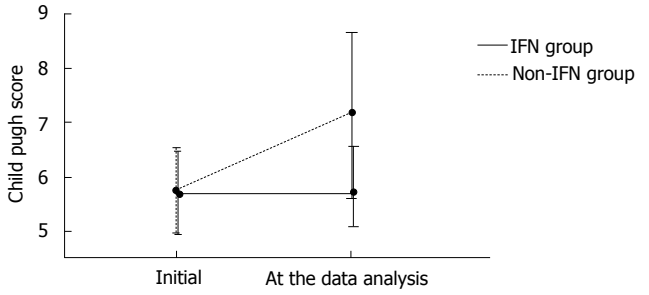

Figure 4 Effect of IFN therapy after curative treatment of HCC on Child-Pugh scores. IFN-treated patients were less likely to show deterioration of hepatic function. The average scores of Child-Pugh of the IFN group were significantly better preserved than the non-IFN group (P = 0.0008).

Liver function

Patients of the IFN group were less likely to develop worsening of hepatic dysfunction compared with the non-IFN group. We compared the average score determined for Child-Pugh classification at initial treatment of HCC with that at the time of data analysis (Figure 4). Although the difference in the Child-Pugh classification score between the two groups at initial treatment of HCC was not significant, the score was significantly worse at the time of data analysis in the non-IFN group than IFN group (P = 0.0008).

Deviation from objects of any treatments for recurrent HCC

At the date of data analysis, patients who developed recurrent HCC were treated repeatedly, as possible, for the purpose of curative treatment including surgical resection and ablative therapy such as RF ablation and ethanol injection. Patients who were difficult to treat with curative intent received transcatheter chemoembolization or hepatic arterial infusion. Although patients with recurrent HCC received repeated treatments, some patients finally could not be treated because of excessive progression of HCC or liver dysfunction. Figure 5 shows that the cumulative rate of deviation from objects of any treatment for recurrent HCC between the IFN group and non-IFN group. In the IFN group, one patient could not receive treatment due to progressively advanced HCC in later period. On the other hand, 8 patients in the non-IFN group could not receive treatment because of underlying liver dysfunction (n = 2) and progressively advanced HCC (n = 6). The 1-, 2- and 3- year rates of deviation from objects of any treatment for recurrent HCC in the IFN and non-IFN group were 0% *vs* 6.7%, 0% *vs* 20% and 0% *vs* 27%, respectively (P = 0.048). Thus, the IFN group tended to be treatable for recurrent HCC compared with the non-IFN group.

Survival of patients

At the date of data analysis, 1 patient among the IFN

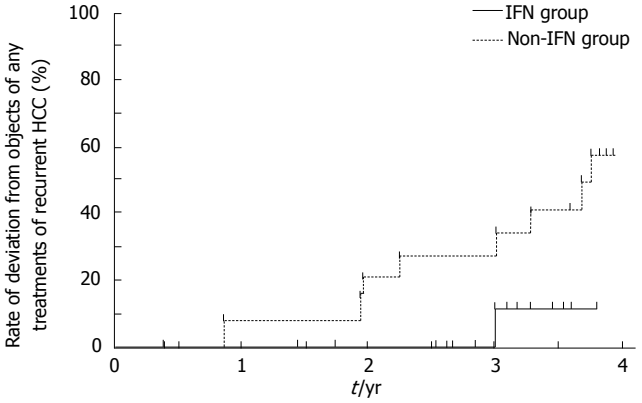

Figure 5 Cumulative rate of deviation from objects of any treatment of recurrent HCC. Recurrent HCC tended to be treatable later in the IFN group than non-IFN group ($P = 0.048$).

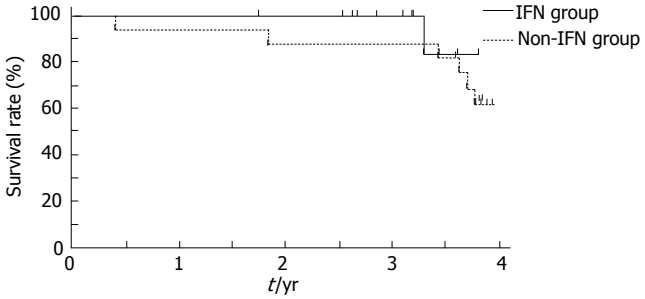

Figure 6 Cumulative survival rate. Comparison of the cumulative survival rates of the IFN and non-IFN groups. The cumulative survival rate was not significantly different between the two groups ($P = 0.45$).

group and 6 patients among the non-IFN group had died of liver disease. Of the 8 recurrence patients among the IFN group, 1 died of advanced multiple HCC and none died of liver failure. On the other hand, of the 13 recurrence patients among the non-IFN group, 2 died of advanced HCC and 2 died of liver failure in spite of the relatively early stage of HCC. Among the 3 patients without recurrent HCC of the non-IFN group, 1 died of liver dysfunction and 1 died of ruptured esophageal varices.

With regard to the cumulative survival rates of the IFN and non-IFN groups (Figure 6), the respective rates of survival were 100% *vs* 93.7% at 1 year, 100% *vs* 87.5% at 2 years, 100% *vs* 87.5% at 3 years and 83.3% *vs* 61.4% at 4 years. Thus, the cumulative survival rate was not significantly different between the two groups for first 4 years after curative treatment of HCC ($P = 0.45$). The median survival time following the first treatment of HCC was 37 mo (range, 17 to 45) for the IFN group and 45 mo (range, 4 to 47) for the non-IFN group.

DISCUSSION

HCC recurrence is still a risk even if HCV-related HCC is treated with curative intent. Most of such patients with HCC have underlying liver cirrhosis, and deterioration of underlying hepatic function may be a hindrance to treatment of recurrent HCC and be associated with prognosis. The present prospective case controlled study of cirrhotic patients shows that low-dose intermittent IFN therapy after curative treatment of HCC could preserve liver function and increase the chance of treatment for recurrent tumor.

Previous studies indicated that IFN therapy after curative treatment of HCC was effective in inhibiting or delaying the development of recurrent HCC[17-23,34,36]. Although several recent studies have reported the efficacy of chemoprevention with IFN therapy after treatment of HCV-related HCC, the basis of the benefit was not clear. Shiratori *et al*[23,33] and Ikeda *et al*[17] reported that IFN therapy in cirrhotic patients reduced recurrence of HCC and improved prognosis. Although they used standard IFN dosage per time, there are no other reports on the effect of low-dose IFN therapy after curative treatment of primary HCC in cirrhotic patients. Sakaguchi *et al*[21] reported that low-dose, long-term, intermittent IFN therapy in patients who had curative HCV-related HCC suppressed recurrence of HCC and improved survival, though it was not clear whether their patients had underlying liver cirrhosis or not. On the other hand, Mazzaferro *et al*[34] indicated that low-dose intermittent IFN therapy seemed to reduce late recurrence in patients with HCV-related cirrhosis after resection of HCC. Considered together, these results suggest that low-dose IFN therapy is potentially useful for cirrhotic patients when used as long as possible. However, our results of low-dose intermittent IFN therapy showed no significant difference in recurrence between those who received IFN therapy and those who did not. Unfortunately, since the difference in treatment outcome between the above three studies might be due to the use of different IFN regimens (e.g., dosage and frequency), and background characteristics of cirrhotic patients (e.g., performance status), the results varied and no standard IFN regimen to pursue after curative treatment of HCV-related HCC could be advocated.

The design of the present study was not randomized controlled type, and differed in details of the IFN protocol and characters of patients from the other studies. Although there was no significant difference in the recurrence rate between the IFN and non-IFN groups, the recurrence rate in the later period of observation including second recurrence appeared to be lower in patients with IFN therapy. Furthermore, the recurrent HCC in patients on IFN therapy did not seem to be aggressive compared with that in patients without IFN therapy, probably because they could be treated with curative intent during the observation period. Thus, low-dose intermittent IFN therapy seemed to have delayed or reduced the chance of development of recurrent HCC in the later period of observation, although IFN did not completely inhibit HCC recurrence in our cirrhotic patients.

Most cirrhotic patients cannot receive a standard full-dose IFN regimen due to underlying liver dysfunction and unfavorable complication such as cytopenia. Hence, it could be difficult to achieve SVR in most cirrhotic patients on low-dose intermittent IFN therapy. Valla *et al*[37] performed a randomized, controlled trial of IFN-alpha 2b but the results showed a lack of any benefits in terms of sustained biochemical response, liver function test

results, histology, occurrence of decompensation or HCC, or prolongation of survival. On the other hand, Everson and coworkers[29,30] suggested that the use of low-dose IFN therapy for viral elimination was as effective in the treatment of cirrhotic patients with HCV as it is in non-cirrhotic patients. Several recent studies have reported that IFN therapy following HCC treatment improved liver function of patients with HCV-related HCC, although it is not clear which specific IFN action is important for these benefits. We also demonstrated that preservation of liver function was significantly better in the IFN group than in the non-IFN group even when HCV was not completely eradicated. Thus, hepatic functional preservation increases the chance of treatment for recurrent. Therefore, the cumulative rate of deviation from objects of any treatment for recurrent HCC might be lower in patients with IFN therapy than in patients without IFN therapy as we showed that low-dose IFN resulted in less advanced recurrence and hepatic functional preservation. Although the survival rates were not significantly different between the two groups in our observation period, we need a longer observation to determine differences in survival rates. Although we also assessed the correlation between the observed beneficial effects of the low-dose intermittent IFN therapy and HCV genotype, we could not reach the clear conclusion due to small sample size. In the future, the study with large sample size may be needed to conclude.

In our study, only about 12.5% (2/16) of patients who received IFN therapy had sustained viral elimination. And there were no significant difference in population of patients with normalized ALT between the IFN and non-IFN group (n = 10, n = 7, respectively). In spite of these results, patients treated with low-dose intermittent IFN therapy have a hepatic functional preservation greater than IFN untreated patients who received continuous medication with UDCA or SNMC after curative treatment of HCC. Although the mechanism of this reason is not well known, we suggested that the anti-inflammatory activity by low-dose intermittent IFN therapy may be stronger than medication with UDCA or SNMC and induce regression or retardation of underlying hepatic fibrosis, and finally, inhibits the progression of hepatic dysfunction.

Adverse effects such as reduction in blood counts by low-dose of IFN-alpha were not observed in our study, although neutropenia and/or thrombocytopenia were identified before IFN therapy. Furthermore, none of the patients required dose reduction in our study. Although 4 patients discontinued IFN therapy because of generalized fatigue, 2 of these patients restarted IFN therapy after that. Therefore, low-dose intermittent IFN-alpha therapy can be used relatively safely for cirrhotic patients with thrombocytopenia. However, patients who can not receive even low-doses of IFN also exist due to severe cytopenia or advanced liver cirrhosis. Medication with UDCA or SNMC or phlebotomy may be useful in decreasing ALT level for those patients.

Most cirrhotic patients who had received curative treatment for primary HCC have a limited hepatic reserve or thrombocytopenia. Therefore, low-dose intermittent IFN therapy might be effective for better prognosis. However, further studies of larger samples followed-up for longer periods should be conducted to establish a definite conclusion about the effect of low-dose IFN therapy for the prevention of progressive liver disease and effect of treatment for recurrent HCC.

REFERENCES

1 **Tsukuma H**, Hiyama T, Tanaka S, Nakao M, Yabuuchi T, Kitamura T, Nakanishi K, Fujimoto I, Inoue A, Yamazaki H. Risk factors for hepatocellular carcinoma among patients with chronic liver disease. *N Engl J Med* 1993; **328**: 1797-1801

2 **Takano S**, Yokosuka O, Imazeki F, Tagawa M, Omata M. Incidence of hepatocellular carcinoma in chronic hepatitis B and C: a prospective study of 251 patients. *Hepatology* 1995; **21**: 650-655

3 **Shiratori Y**, Shiina S, Imamura M, Kato N, Kanai F, Okudaira T, Teratani T, Tohgo G, Toda N, Ohashi M. Characteristic difference of hepatocellular carcinoma between hepatitis B- and C- viral infection in Japan. *Hepatology* 1995; **22**: 1027-1033

4 **Ikeda K**, Saitoh S, Tsubota A, Arase Y, Chayama K, Kumada H, Watanabe G, Tsurumaru M. Risk factors for tumor recurrence and prognosis after curative resection of hepatocellular carcinoma. *Cancer* 1993; **71**: 19-25

5 **Kubo S**, Nishiguchi S, Shuto T, Tanaka H, Tsukamoto T, Hirohashi K, Ikebe T, Wakasa K, Kuroki T, Kinoshita H. Effects of continuous hepatitis with persistent hepatitis C viremia on outcome after resection of hepatocellular carcinoma. *Jpn J Cancer Res* 1999; **90**: 162-170

6 **Kumada T**, Nakano S, Takeda I, Sugiyama K, Osada T, Kiriyama S, Sone Y, Toyoda H, Shimada S, Takahashi M, Sassa T. Patterns of recurrence after initial treatment in patients with small hepatocellular carcinoma. *Hepatology* 1997; **25**: 87-92

7 **Shimada M**, Takenaka K, Gion T, Fujiwara Y, Kajiyama K, Maeda T, Shirabe K, Nishizaki T, Yanaga K, Sugimachi K. Prognosis of recurrent hepatocellular carcinoma: a 10-year surgical experience in Japan. *Gastroenterology* 1996; **111**: 720-726

8 **Nagasue N**, Uchida M, Makino Y, Takemoto Y, Yamanoi A, Hayashi T, Chang YC, Kohno H, Nakamura T, Yukaya H. Incidence and factors associated with intrahepatic recurrence following resection of hepatocellular carcinoma. *Gastroenterology* 1993; **105**: 488-494

9 **Chayama K**, Saitoh S, Arase Y, Ikeda K, Matsumoto T, Sakai Y, Kobayashi M, Unakami M, Morinaga T, Kumada H. Effect of interferon administration on serum hepatitis C virus RNA in patients with chronic hepatitis C. *Hepatology* 1991; **13**: 1040-1043

10 **Hagiwara H**, Hayashi N, Mita E, Ueda K, Takehara T, Kasahara A, Fusamoto H, Kamada T. Detection of hepatitis C virus RNA in serum of patients with chronic hepatitis C treated with interferon-alpha. *Hepatology* 1992; **15**: 37-41

11 **Shindo M**, Di Bisceglie AM, Hoofnagle JH. Long-term follow-up of patients with chronic hepatitis C treated with alpha-interferon. *Hepatology* 1992; **15**: 1013-1016

12 **McHutchison J**, Blatt L, Sedghi-Vaziri A, Russell J, Schmid P, Conrad A. Is there an optimal time to measure quantitative HCV RNA to predict non-response following interferon treatment for chronic HCV infection? *J Hepatol* 1998; **29**: 362-368

13 **Castilla A**, Prieto J, Fausto N. Transforming growth factors beta 1 and alpha in chronic liver disease. Effects of interferon alfa therapy. *N Engl J Med* 1991; **324**: 933-940

14 **Manabe N**, Chevallier M, Chossegros P, Causse X, Guerret S, Trépo C, Grimaud JA. Interferon-alpha 2b therapy reduces liver fibrosis in chronic non-A, non-B hepatitis: a quantitative histological evaluation. *Hepatology* 1993; **18**: 1344-1349

15 **Jimenez SA**, Freundlich B, Rosenbloom J. Selective inhibition of human diploid fibroblast collagen synthesis by interferons. *J Clin Invest* 1984; **74**: 1112-1116

16 **Baron S**, Tyring SK, Fleischmann WR, Coppenhaver DH, Niesel DW, Klimpel GR, Stanton GJ, Hughes TK. The interferons. Mechanisms of action and clinical applications.

JAMA 1991; **266**: 1375-1383
17 **Ikeda K**, Arase Y, Saitoh S, Kobayashi M, Suzuki Y, Suzuki F, Tsubota A, Chayama K, Murashima N, Kumada H. Interferon beta prevents recurrence of hepatocellular carcinoma after complete resection or ablation of the primary tumor-A prospective randomized study of hepatitis C virus-related liver cancer. *Hepatology* 2000; **32**: 228-232
18 **Kubo S**, Nishiguchi S, Hirohashi K, Tanaka H, Shuto T, Yamazaki O, Shiomi S, Tamori A, Oka H, Igawa S, Kuroki T, Kinoshita H. Effects of long-term postoperative interferon-alpha therapy on intrahepatic recurrence after resection of hepatitis C virus-related hepatocellular carcinoma. A randomized, controlled trial. *Ann Intern Med* 2001; **134**: 963-967
19 **Kubo S**, Nishiguchi S, Hirohashi K, Tanaka H, Shuto T, Kinoshita H. Randomized clinical trial of long-term outcome after resection of hepatitis C virus-related hepatocellular carcinoma by postoperative interferon therapy. *Br J Surg* 2002; **89**: 418-422
20 **Nishiguchi S**, Tamori A, Kubo S. Effect of long-term postoperative interferon therapy on intrahepatic recurrence and survival rate after resection of hepatitis C virus-related hepatocellular carcinoma. *Intervirology* 2005; **48**: 71-75
21 **Sakaguchi Y**, Kudo M, Fukunaga T, Minami Y, Chung H, Kawasaki T. Low-dose, long-term, intermittent interferon-alpha-2b therapy after radical treatment by radiofrequency ablation delays clinical recurrence in patients with hepatitis C virus-related hepatocellular carcinoma. *Intervirology* 2005; **48**: 64-70
22 **Suou T**, Mitsuda A, Koda M, Matsuda H, Maruyama S, Tanaka H, Kishimoto Y, Kohno M, Hirooka Y, Kawasaki H. Interferon alpha inhibits intrahepatic recurrence in hepatocellular carcinoma with chronic hepatitis C: a pilot study. *Hepatol Res* 2001; **20**: 301-311
23 **Shiratori Y**, Shiina S, Teratani T, Imamura M, Obi S, Sato S, Koike Y, Yoshida H, Omata M. Interferon therapy after tumor ablation improves prognosis in patients with hepatocellular carcinoma associated with hepatitis C virus. *Ann Intern Med* 2003; **138**: 299-306
24 **Akamatsu M**, Yoshida H, Shiina S, Teratani T, Obi S, Tateishi R, Mine N, Kondo Y, Kawabe T, Omata M. Sustained viral response prolonged survival of patients with C-viral hepatocellular carcinoma. *Liver Int* 2006; **26**: 536-542
25 **Schalm SW**, Fattovich G, Brouwer JT. Therapy of hepatitis C: patients with cirrhosis. *Hepatology* 1997; **26**: 128S-132S
26 **Hadziyannis SJ**, Sette H, Morgan TR, Balan V, Diago M, Marcellin P, Ramadori G, Bodenheimer H, Bernstein D, Rizzetto M, Zeuzem S, Pockros PJ, Lin A, Ackrill AM. Peginterferon-alpha2a and ribavirin combination therapy in chronic hepatitis C: a randomized study of treatment duration and ribavirin dose. *Ann Intern Med* 2004; **140**: 346-355
27 **Zeuzem S**, Feinman SV, Rasenack J, Heathcote EJ, Lai MY, Gane E, O'Grady J, Reichen J, Diago M, Lin A, Hoffman J, Brunda MJ. Peginterferon alfa-2a in patients with chronic hepatitis C. *N Engl J Med* 2000; **343**: 1666-1672
28 **Poynard T**, Marcellin P, Lee SS, Niederau C, Minuk GS, Ideo G, Bain V, Heathcote J, Zeuzem S, Trepo C, Albrecht J. Randomised trial of interferon alpha2b plus ribavirin for 48 weeks or for 24 weeks versus interferon alpha2b plus placebo for 48 weeks for treatment of chronic infection with hepatitis C virus. International Hepatitis Interventional Therapy Group (IHIT). *Lancet* 1998; **352**: 1426-1432
29 **Everson GT**, Jensen DM, Craig JR, van Leeuwen DJ, Bain VG, Ehrinpreis MN, Albert D, Joh T, Witt K. Efficacy of interferon treatment for patients with chronic hepatitis C: comparison of response in cirrhotics, fibrotics, or nonfibrotics. *Hepatology* 1999; **30**: 271-276
30 **Everson GT**. Management of cirrhosis due to chronic hepatitis C. *J Hepatol* 2005; **42** Suppl: S65-S74
31 **Mazzella G**, Accogli E, Sottili S, Festi D, Orsini M, Salzetta A, Novelli V, Cipolla A, Fabbri C, Pezzoli A, Roda E. Alpha interferon treatment may prevent hepatocellular carcinoma in HCV-related liver cirrhosis. *J Hepatol* 1996; **24**: 141-147
32 **Serfaty L**, Aumaître H, Chazouillères O, Bonnand AM, Rosmorduc O, Poupon RE, Poupon R. Determinants of outcome of compensated hepatitis C virus-related cirrhosis. *Hepatology* 1998; **27**: 1435-1440
33 **Shiratori Y**, Imazeki F, Moriyama M, Yano M, Arakawa Y, Yokosuka O, Kuroki T, Nishiguchi S, Sata M, Yamada G, Fujiyama S, Yoshida H, Omata M. Histologic improvement of fibrosis in patients with hepatitis C who have sustained response to interferon therapy. *Ann Intern Med* 2000; **132**: 517-524
34 **Mazzaferro V**, Romito R, Schiavo M, Mariani L, Camerini T, Bhoori S, Capussotti L, Calise F, Pellicci R, Belli G, Tagger A, Colombo M, Bonino F, Majno P, Llovet JM. Prevention of hepatocellular carcinoma recurrence with alpha-interferon after liver resection in HCV cirrhosis. *Hepatology* 2006; **44**: 1543-1554
35 **The general rules for the clinical and pathological study of primary liver cancer**. Liver Cancer Study Group of Japan. *Jpn J Surg* 1989; **19**: 98-129
36 **Lin SM**, Lin CJ, Hsu CW, Tai DI, Sheen IS, Lin DY, Liaw YF. Prospective randomized controlled study of interferon-alpha in preventing hepatocellular carcinoma recurrence after medical ablation therapy for primary tumors. *Cancer* 2004; **100**: 376-382
37 **Valla DC**, Chevallier M, Marcellin P, Payen JL, Trepo C, Fonck M, Bourliere M, Boucher E, Miguet JP, Parlier D, Lemonnier C, Opolon P. Treatment of hepatitis C virus-related cirrhosis: a randomized, controlled trial of interferon alfa-2b versus no treatment. *Hepatology* 1999; **29**: 1870-1875

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