Neopterin as a Predictor of Response to Pegylated Interferon Therapy in Egyptian Patients with Chronic Hepatitis C Virus

Heba Gamal Abdelaziz1*, Tamer Mahmoud El-Tantawy2, Hanan Abd El-Mawgoud Attia1 and Mayada Mosa Hamed1

1Biochemistry and Molecular Biology Department, Faculty of Pharmacy, Al-Azhar University, Cairo, Egypt.
2Endemic Hepatogastroenterology, Faculty of Medicine, Cairo University, Cairo, Egypt.

Authors’ contributions

This work was carried out in collaboration among all authors. Author HGA designed the study. Authors HGA, TM ET and MMH performed the statistical analysis, wrote the protocol and wrote the first draft of the manuscript. Authors TMET, HAEMA and MMH managed the analyses of the study. All authors managed the literature searches and approved the final manuscript.

Article Information

DOI: 10.9734/AJRB/2020/v6i430127
Editor(s):
(1) Dr. Asmaa Fathi Moustafa Hamouda, Jazan University, Saudi Arabia.
Reviewers:
(1) Ndoe Guiaro Marcellin, Institute of Medical Research and Medicinal Plants Studies, Cameroon.
(2) M. Venkata Swamy, Acharya Nagarjuna University, India.
Complete Peer review History: http://www.sdiarticle4.com/review-history/58928

ABSTRACT

Background: Neopterin is a proinflammatory marker which participates in cell-mediated immunity, and its elevated concentrations declare the presence of interferon-γ in body fluids. In this study, neopterin concentrations were determined in patients with chronic hepatitis C virus (HCV) to assess whether its plasma level can be used to predict the response to antiviral therapy by pegIFN-γ combined with ribavirin before starting the treatment.

Materials and Methods: A total of 54 subjects (all males with an average age of 46.12 ± 9.89) were included in this study. Neopterin levels were evaluated by Enzyme-linked immunosorbent assay (ELIZA) in HCV patients treated with pegylated interferon combined with ribavirin. Liver function tests (Aspartate aminotransferase, Alanine aminotransferase), albumin and creatinine concentrations were also estimated.

Results: Mean and median pretreatment neopterin levels showed no statistically difference between patients with sustained virological response (cured) and non-responders (relapsed) where the

*Corresponding author: E-mail: dr.hebagamal@azhar.edu.eg, heba.g.a@gmail.com;
concentrations in both groups were $\geq 16$ nmol/L. On the other hand, a positive correlation was observed between neopterin level and creatinine at ($p \leq 0.05$).

**Conclusion:** Our study suggests that the pretreatment level of neopterin might not be used in routine clinical practice as a marker to predict the response to antiviral therapy in HCV patients.

**Keywords:** HCV; Neopterin; pegylated IFN-γ; ribavirin.

1. INTRODUCTION

Hepatitis C virus (HCV) is an enveloped, single-stranded ribonucleic acid (RNA) virus with positive polarity, belongs to hepaciviruses genus in the Flaviviridae family [1]. This virus is one of the most important human pathogens that can cause mild to severe liver diseases and is considered one of a major blood-borne infection worldwide, with a silent epidemiology, that it has reached pandemic proportions [2]. The chronic infection with HCV, remains a troublesome health problem worldwide, which approximately 3% of the population suffering from it. Its prevalence is higher in some countries of Asia and Africa and approximately 14.5% in Egypt [3]. In developing countries, the chronic hepatitis C is the most prominent cause of liver cirrhosis and hepatocellular carcinoma [4]. According to the World Health Organization there are about 185 - 200 million people chronically infected with HCV worldwide and it contributes a significant cause of morbidity and mortality [5]. In 2018, Egypt has one of the highest global burdens of HCV infection, with an estimated over 6 million people between 15-59 years, being chronically infected. Tragically, an estimated 150, 000 new people are being infected annually, and thousands die every year [6].

Over the past decades, the combination of pegylated interferon (PEG-INF) and ribavirin (RBV) for 48 weeks was the standard treatment of HCV patient [7]. However, the efficacy of this combination to treat HCV patient was small where only 41% sustained virological response (SVR), defined as a viremia 24 weeks after completion of antiviral therapy [8]. As well as, between 2007 and 2014 the National program for control of HCV in Egypt has treated about 350, 000 patients with this combination [9] and the result showed SVR between 45% and 55% [10].

Interferon-stimulated genes (IFN-SGs) expression in the liver were suggested as a marker of response to anti-viral therapy as the guanosine triphosphate cyclohydrolase 1 (GTPCH), a rate-limiting enzyme of pteridines biosynthesis encoded by it. Neopterin, a stable byproduct of GTPCH-catalyzed reaction, is used as a marker of interferon-induced GTPCH activation [11]. Neopterin or 2-amino-4-hydroxy-6-(D-erythro-1', 2', 3'-trihydroxypropyl)-pteridine is produced from GTPCH-Iby activated monocytes, macrophages, dendritic cells, and endothelial cells and to a lesser extent in renal epithelial cells, fibroblasts, and vascular smooth muscle cells upon stimulation mainly by interferon gamma and to a lesser extent by interferon alpha and beta with its release being enhanced by tumor necrosis factor [12]. During acute viral infections increased neopterin levels have been observed, which correlate with the activity of disease [13] and subsequently neopterin elevations were noted in infections with hepatitis viruses, Epstein-Barr, measles, mumps, varicella zoster, rubella, and influenza viruses [14]. Elevated neopterin levels in body fluids were found at the end of the incubation period before the onset of clinical symptoms and just before specific antibodies against the virus become detectable, which is about two to four weeks after onset of increased neopterin production [15].

It was noted that in patients with acute viral hepatitis, most patients had elevated urinary neopterin levels with the highest levels found in patients with acute hepatitis A. While all patients with active hepatitis B had elevated neopterin serum levels and HbsAg carriers had normal urinary neopterin levels. A more recent investigation found that serum neopterin levels were significantly higher in patients with chronic hepatitis and cirrhosis than in control subjects as well as, cirrhotic patients had significantly higher serum neopterin levels than patients with chronic hepatitis [16]. We assessed neopterin concentrationsto define its availability as a marker to predict the response to antiviral therapy in chronic viral hepatitis C patients.

2. MATERIALS AND METHODS

The research protocol was reviewed and approved by the ethical committee of the ERMED (Railway Hospital) Hospital and faculty of pharmacy, Al-Azhar University, Cairo,
Initially 85 chronic hepatitis C patients admitted to ERMED (Railway Hospital) were randomly approached to participate in the study. Out of 85 patients who were deemed fit to participate in the study, the number of patients had been decreased as some of them stopped treatment due to health problems (as neutropenia, intractable cough, flaring psoriasis, high blood sugar), others showed non-response to treatment after 12 weeks while, others stopped treatment by themselves. Consequently, a total of 54 HCV patients all males were finally enrolled in the study. The inclusion criterion for enrolment in the present study was all positive serum HCV RNA by Quantitative PCR. Evidence of chronic hepatitis in liver biopsy.

2.1 Treatment Regimens

All patients with chronic hepatitis C were treated with a weekly subcutaneous injection of peg IFN-α-2b at a dose of 1.5 µg/kg per week in combination with a weight-adjusted dose of oral RBV (1000 mg/day for<75 kg, 1200 mg/day for>75 kg) for 48 weeks [17].

Every patient in this study was subjected to full history and clinical examination as well as laboratory investigations for complete blood counts (CBCs as Hemoglobin, White blood cells and platelet counts). HCV-RNA detection was done using qualitative PCR.

Liver Biopsy was performed by experienced hepatologists under ultrasound guidance using 16G Menghini needles. Liver specimens were stained with haematoxilin/eosin standard procedures. Necroinflammatory activity and fibrosis were evaluated separately according to the Metavir score. Namely, fibrosis was divided into a five-point scale: F0 (no fibrosis), F1 (portal fibrosis without septa), F2 (portal fibrosis with few septa), F3 (numerous septa without cirrhosis) and F4 (cirrhosis). The necroinflammatory activity was graded in a four-point scale: A0 (none), A1 (mild), A2 (moderate) and A3 (severe) [18].

2.2 Methods

2.2.1 Sample collection

3ml of blood was drawn into a red capped evacuated glass collection tube; and allowed to clot for at least 30 minutes at room temperature. Following that, the serum was separated and stored in the dark at -20°C in a non-frost-free freezer before neopterin and liver biochemical parameters assay. Liver function tests (alanine aminotransferase (ALT), aspartate aminotransferase (AST), albumin, creatinine, International Normalized Ratio (INR) and prothrombin time (PT)) were measured using available commercial kits and the normal range provided in the kit used as a reference values in the study.

2.2.2 Measurement of plasmaneopterin

Neopterin concentration was evaluated using (DRG® Neopterin (EIA-1476, USA) (ELISA) commercial kit by Enzyme-linked immunosorbent assay according to the manufacturer instructions. The concentrations were reported as nanomoles per liter (nmole/L).

2.3 Statistical Methods

Descriptive statistics including Mean, Median, Standard deviation, and different percentiles (25 and 75) as well as frequency of different categories within each variable were obtained using IBM SPSS ver.23 software. A non-parametric Mann-Whitney Rank Sum Test was used to compare any factor with two groups instead of the parametric t test while Kruskal-Wallis One Way Analysis of Variance on Ranks was used for comparing three or more groups instead of the parametric one-way ANOVA. All pairwise multiple comparisons were performed using Dunn’s test. This test is used for comparisons that following a rank-based ANOVA and especially when group sizes are unequal (Systat Software, 2011). SigmaPlot® 12.5 and Microsoft™ Excel® 2013 were used for different comparison. Association between different variables was assessed using the non-parametric Spearman correlation. Degree of relationship and significance of association were considered only at p value < 0.05. Correlations were assessed using IBM SPSS ver. 23.

3. RESULTS

A total of 54 HCV patients with average age of 46.12± 9.89. Table (1) shows the demographic and biochemical data of participated patients; there were elevations in serum levels of ALT and AST with mean ± SD (93.46± 79.98 U/L and 76.52± 64.45U/L) respectively. As well as, there was high PCR value with mean ± SD (1253405.77± 2604964.55IU/ml) and an increase in WBC with mean ± SD (7.14± 3.42x1000/cm3). Moreover, there were increases in prothrombin
time and International Normalized Ratio (INR) with mean ± SD (12.28± 2.95 and 1.09± 0.27) respectively. However, serum levels of albumin, hemoglobin and creatinine were at normal values with mean ± SD (4.21± 0.90 g/dl, 14.29±2.97 g/dl and 0.92± 0.22 mg/dl) respectively. Liver histology showed different degree of fibrosis, where 16.6% of patients were F1 and F2, 5.55% were F4, while most patients were F3 with 61.11%. On the other hand, most of patients had mild necroinflammatory activity (A1) with 70.37%; whilst 27.77% had moderate activity (A2) and 1.85% had severe necroinflammatory activity (A3).

3.1 Spearman Correlation between Measured Variable and Plasma Neopterin Level

In order to investigate the possible correlation among different parameters, non-parametric Spearman correlation was detected among different variables as shown in Table (2). We revealed that, there was a highly positive significant association between ALT and AST at P value <0.001. Moreover, neopterin level showed a highly positive significant associations with serum creatinine and prothrombin (at P value <0.05).

3.2 Sustained Virological Response Assessment (SVR)

Follow up was done after six months of finishing treatment, (SVR assessment) and we revealed that the percent of patients with negative PCR was 81.48% (cured) and positive PCR was 18.52% (relapsed) as shown in Table (3).

3.3 Initial PCR and Response to Treatment

To investigate the possible relationship between PCR and first response to the treatment, the 54 patients had been divided into three groups (response at four, 12 and 24 weeks). The differences statistically not significant between different groups. Median of PCR at different categories is shown in Table (4).

Table 1. Biochemical characteristics of HCV patients

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean ± SD</th>
<th>Percentile 25</th>
<th>Median</th>
<th>Percentile 75</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (yrs)</td>
<td>46.12± 9.89</td>
<td>42.0</td>
<td>49.5</td>
<td>54.25</td>
</tr>
<tr>
<td>Hemoglobin (g/dl)</td>
<td>14.29±2.97</td>
<td>13.50</td>
<td>14.40</td>
<td>15.62</td>
</tr>
<tr>
<td>Platelets (10^9/L)</td>
<td>190.02±60.17</td>
<td>159.75</td>
<td>188.50</td>
<td>224.75</td>
</tr>
<tr>
<td>WBCs (/cm^3)</td>
<td>7.14± 3.42</td>
<td>5.27</td>
<td>7.25</td>
<td>8.47</td>
</tr>
<tr>
<td>Prothrombin (sec)</td>
<td>12.28± 2.95</td>
<td>12.50</td>
<td>13.0</td>
<td>13.7</td>
</tr>
<tr>
<td>INR</td>
<td>1.09± 0.27</td>
<td>1.00</td>
<td>1.10</td>
<td>1.21</td>
</tr>
<tr>
<td>ALT (IU/L)</td>
<td>93.46± 79.98</td>
<td>44.0</td>
<td>54.50</td>
<td>76.5</td>
</tr>
<tr>
<td>AST (IU/L)</td>
<td>76.52± 64.45</td>
<td>40.0</td>
<td>55.0</td>
<td>74.25</td>
</tr>
<tr>
<td>Albumin (g/dl)</td>
<td>4.21± 0.90</td>
<td>4.00</td>
<td>4.30</td>
<td>4.60</td>
</tr>
<tr>
<td>Creatinine (mg/dl)</td>
<td>0.92± 0.22</td>
<td>0.80</td>
<td>0.90</td>
<td>1.00</td>
</tr>
<tr>
<td>PCR (HCV RNA) (IU/ml)</td>
<td>1253405.77± 2604964.55</td>
<td>55046.25</td>
<td>130988</td>
<td>419888.75</td>
</tr>
</tbody>
</table>

Fibrosis

<table>
<thead>
<tr>
<th>Activity (degree of inflammation)</th>
<th>F0</th>
<th>F1</th>
<th>F2</th>
<th>F3</th>
<th>F4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>9</td>
<td>9</td>
<td>33</td>
<td>3</td>
</tr>
</tbody>
</table>

WBCs: white blood cells (normal range: 4,000-11,000/cm3), INR: international normalized ratio (normal range: 0.8-1), prothrombin time (PT) (normal range: 10-14 sec), ALT: alanine amino-transferase (normal range: 5-35 IU/L), AST: aspartate transaminase (normal range: 5-45 IU/L), albumin (normal range: 3.2-4.5 g/dl), creatinine (normal range: 0.6-1.2 mg/dl) and PCR: polymerase chain reaction
Table 2. Spearman correlations among different recorded variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Age</th>
<th>Prothrombin</th>
<th>INR</th>
<th>ALT</th>
<th>AST</th>
<th>Albumin</th>
<th>Creatinine</th>
<th>PCR (HCV RNA)</th>
<th>Neopterin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>1.000</td>
<td>-0.012</td>
<td>0.035</td>
<td>0.038</td>
<td>0.076</td>
<td>-0.315</td>
<td>-0.077</td>
<td>-0.197</td>
<td>0.191</td>
</tr>
<tr>
<td>P value</td>
<td>0.930</td>
<td>0.798</td>
<td>0.781</td>
<td>0.584</td>
<td>0.019*</td>
<td>0.575</td>
<td>0.152</td>
<td>0.165</td>
<td></td>
</tr>
<tr>
<td>Prothrombin</td>
<td>-0.012</td>
<td>1.000</td>
<td>0.294</td>
<td>0.054</td>
<td>-0.075</td>
<td>-0.190</td>
<td>0.081</td>
<td>0.005</td>
<td>0.300</td>
</tr>
<tr>
<td>P value</td>
<td>0.930</td>
<td>0.030*</td>
<td>0.695</td>
<td>0.586</td>
<td>0.167</td>
<td>0.558</td>
<td>0.970</td>
<td>0.027*</td>
<td></td>
</tr>
<tr>
<td>INR</td>
<td>0.035</td>
<td>0.294</td>
<td>1.000</td>
<td>-0.173</td>
<td>-0.148</td>
<td>-0.135</td>
<td>0.1622</td>
<td>0.012</td>
<td>0.222</td>
</tr>
<tr>
<td>P value</td>
<td>0.798</td>
<td>0.030*</td>
<td>0.210</td>
<td>0.285</td>
<td>0.329</td>
<td>0.241</td>
<td>0.927</td>
<td>0.106</td>
<td></td>
</tr>
<tr>
<td>ALT</td>
<td>0.038</td>
<td>0.054</td>
<td>-0.173</td>
<td>1.000</td>
<td>0.788</td>
<td>-0.079</td>
<td>-0.149</td>
<td>-0.062</td>
<td>-0.021</td>
</tr>
<tr>
<td>P value</td>
<td>0.781</td>
<td>0.695</td>
<td>0.210</td>
<td>-0.000**</td>
<td>0.566</td>
<td>0.279</td>
<td>0.655</td>
<td>0.876</td>
<td></td>
</tr>
<tr>
<td>AST</td>
<td>0.076</td>
<td>-0.075</td>
<td>-0.148</td>
<td>0.788</td>
<td>1.000</td>
<td>-0.096</td>
<td>-0.183</td>
<td>-0.157</td>
<td>-0.033</td>
</tr>
<tr>
<td>P value</td>
<td>0.584</td>
<td>0.586</td>
<td>0.285</td>
<td>0.000**</td>
<td>0.489</td>
<td>0.185</td>
<td>0.254</td>
<td>0.810</td>
<td></td>
</tr>
<tr>
<td>Albumin</td>
<td>-0.315</td>
<td>-0.190</td>
<td>-0.135</td>
<td>-0.079</td>
<td>-0.096</td>
<td>1.000</td>
<td>0.145</td>
<td>0.148</td>
<td>-0.119</td>
</tr>
<tr>
<td>P value</td>
<td>0.019*</td>
<td>0.167</td>
<td>0.329</td>
<td>0.566</td>
<td>0.489</td>
<td>0.292</td>
<td>0.283</td>
<td>0.389</td>
<td></td>
</tr>
<tr>
<td>Creatinine</td>
<td>-0.077</td>
<td>0.081</td>
<td>0.1622</td>
<td>-0.149</td>
<td>-0.183</td>
<td>0.145</td>
<td>1.000</td>
<td>0.204</td>
<td>0.336</td>
</tr>
<tr>
<td>P value</td>
<td>0.575</td>
<td>0.558</td>
<td>0.241</td>
<td>0.279</td>
<td>0.185</td>
<td>0.292</td>
<td>0.138</td>
<td>0.012**</td>
<td></td>
</tr>
<tr>
<td>PCR</td>
<td>-0.197</td>
<td>0.005</td>
<td>0.012</td>
<td>-0.062</td>
<td>-0.157</td>
<td>0.148</td>
<td>0.204</td>
<td>1.000</td>
<td>0.140</td>
</tr>
<tr>
<td>P value</td>
<td>0.152</td>
<td>0.970</td>
<td>0.927</td>
<td>0.655</td>
<td>0.254</td>
<td>0.283</td>
<td>0.138</td>
<td>0.310</td>
<td></td>
</tr>
<tr>
<td>Neopterin</td>
<td>0.191</td>
<td>0.300</td>
<td>0.222</td>
<td>-0.021</td>
<td>-0.033</td>
<td>-0.119</td>
<td>0.336</td>
<td>0.140</td>
<td>1.000</td>
</tr>
<tr>
<td>P value</td>
<td>0.165</td>
<td>0.027*</td>
<td>0.106</td>
<td>0.876</td>
<td>0.810</td>
<td>0.389</td>
<td>0.012**</td>
<td>0.310</td>
<td></td>
</tr>
</tbody>
</table>

*, denote significant correlations at P value < 0.05 while **, denote highly significant correlations at P value < 0.001, empty cells are representing non-significant correlation
Table 3. Frequency of positive and negative PCR patients after six months of finishing
treatment

<table>
<thead>
<tr>
<th>PCR after 6 months of finishing treatment</th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>+Ve</td>
<td>10</td>
<td>18.52</td>
</tr>
<tr>
<td>-Ve</td>
<td>44</td>
<td>81.48</td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 4. Kruskal-wallis one way analysis of variance on ranks for the PCR titer at the different
first response time of treatment (four, 12 and 24 weeks)

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Median</th>
<th>25%</th>
<th>75%</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 weeks</td>
<td>29</td>
<td>88166</td>
<td>44058</td>
<td>805973</td>
<td>0.242</td>
</tr>
<tr>
<td>12 weeks</td>
<td>22</td>
<td>485370.5</td>
<td>136690.3</td>
<td>970595.8</td>
<td></td>
</tr>
<tr>
<td>24 weeks</td>
<td>3</td>
<td>1966826</td>
<td>686</td>
<td>3451142</td>
<td></td>
</tr>
</tbody>
</table>

To examine the possible relationship between PCR and liver fibrosis, patient’s liver biopsies before
starting the treatment had been classified into four groups according to their degree of fibrosis (F1-F4).
No significant differences were detected for PCR at different liver biopsy categories. Median of PCR at
different liver biopsy categories is shown in Table (5).

Also, none significant differences were detected for PCR at different response groups. Median of
PCR titer at different response categories is shown in Table (6).

3.4 Neopterin Level and Response to Treatment

Table 5. Kruskal-wallis one way analysis of variance on ranks for the PCR titer between
different liver biopsy groups

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Median</th>
<th>25%</th>
<th>75%</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>F1</td>
<td>9</td>
<td>190726</td>
<td>13910</td>
<td>935138</td>
<td>0.943</td>
</tr>
<tr>
<td>F2</td>
<td>9</td>
<td>287632</td>
<td>81042</td>
<td>1343633</td>
<td></td>
</tr>
<tr>
<td>F3</td>
<td>33</td>
<td>165199</td>
<td>45441</td>
<td>763303</td>
<td></td>
</tr>
<tr>
<td>F4</td>
<td>3</td>
<td>627500</td>
<td>499735</td>
<td>4439985</td>
<td></td>
</tr>
</tbody>
</table>

Secondly, after the follow up the participants divided into two groups according the PCR
results to cured, and relapsed. We noticed that, there were none significant differences detected
for neopterin level between the two groups with means ±SD (21.54± 40.40, 42.06± 65.34
respectively). Median of Neopterin level at different response categories is shown in Table (8).

4. DISCUSSION

Hepatitis C virus is an enveloped RNA virus which contains a single positive stranded RNA
molecule. The virus is a causative agent of acute and chronic hepatitis as well as liver cirrhosis
and hepatocellular carcinoma in humans [19].

During acute viral infections increased neopterin levels have been observed, and subsequently
neopterin elevations were noted in infections with hepatitis viruses [14] and considered as a useful
predictor of response to treatment of chronic HCV infection with pegylated interferon
combined with ribavirin [20].
Table 7. Kruskal-wallis one way analysis of variance on ranks for the neopterin level at the different first response groups

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Median</th>
<th>25%</th>
<th>75%</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 weeks</td>
<td>29</td>
<td>9.486</td>
<td>5.534</td>
<td>15.217</td>
<td>0.849</td>
</tr>
<tr>
<td>12 weeks</td>
<td>22</td>
<td>9.091</td>
<td>8.202</td>
<td>10.277</td>
<td></td>
</tr>
<tr>
<td>24 weeks</td>
<td>3</td>
<td>8.3</td>
<td>4.743</td>
<td>13.439</td>
<td></td>
</tr>
</tbody>
</table>

Table 8. Mann-whitney rank sum test for the neopterin level between the two groups of responses

<table>
<thead>
<tr>
<th>Group</th>
<th>N</th>
<th>Median</th>
<th>25%</th>
<th>75%</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relapse</td>
<td>10</td>
<td>9.684</td>
<td>8.202</td>
<td>50.198</td>
<td>0.321</td>
</tr>
<tr>
<td>Cured</td>
<td>44</td>
<td>9.289</td>
<td>5.534</td>
<td>10.672</td>
<td></td>
</tr>
</tbody>
</table>

In chronic hepatitis, the IFN-gamma secreted from T lymphocytes activates macrophages and NP is released [21]. Grüngreif et al. [22] reported that, the serum NP levels of the patients with CHB and CHC were significantly higher than the serum NP levels of the control group. The high NP level in patients with chronic hepatitis C was linked to the stimulation of cellular immune system, where NP levels seem to increase in patients undergoing an immune-stimulator treatment. This may be caused by induction of the immune-regulatory cascade that stimulates IFN-γ secretion [23].

In this study we estimated the serum level of neopterin in HCV patients before treatment with pegylated interferon combined with ribavirin for 48 weeks for its evaluation as a marker of response to pegylated interferon therapy combined with ribavirin.

We revealed that, there were no statistically significance differences detected for neopterin level between cured and relapsed groups, as its concentration was higher in both groups ≥ 16 mmol/L. This result was in consistent with Ozcimen et al. [24] who measured serum level of neopterin (NP) before and after treatment in CHC and reported that the NP values at the end of 1-year pegylated interferon alpha and/or ribavirin therapy were found higher than the initial NP values without differentiating between the responders and non-responders (the number of responders were more). This highness was attributed to the immune-modulator effect of interferon as in most of infections, when a comparison is made before and after an infection treatment, a decrease is seen in NP levels because of the decline in immune system activation at the end of the treatment. However, when the disease is treated with an IFN therapy, which is a treatment that stimulates the immune system, the NP level remains high at the end of the treatment in connection with the IFN therapy.

On the other hand, neopterin level showed no statistical significance difference between chronic hepatitis C patients at different first response to treatment (Table 6). This result was in contract to Gregory et al. [25] who showed that pretreatment neopterin concentrations were lower in patients with sustained virological response than in relapsed. Also contradictory to Oxenkrug et al. [20] who reported that serum neopterin levels were found to be a useful predictor of response to treatment of chronic HCV infection with pegylated interferon combined with ribavirin, where mean and median pretreatment neopterin concentrations were lower in patients with sustained virological response than in non-responders. The rate of response was two-fold higher among patients with pretreatment neopterin levels <16 nmol/L than in patients with neopterin levels ≥16 nmol/L. Thus, they concluded that the neopterin levels measured before an antiviral treatment could be used for response to treatment estimates.

Our results revealed that there was a significant positive relationship detected between neopterin level and creatinine at P value <0.05. This result was in agreement with Pihlstrøm et al. [26] who reported that there was a high degree of correlation between neopterin and creatinine as neopterin is chemically inert and its elimination is solely through the kidneys, compromised renal function leads to a rise in serum neopterin that is not caused by increased inflammatory activity [27]. Subsequent studies had confirmed that elevation of serum or urinary neopterin precedes the rise in creatinine by up to several days in patients with acute early complications [28].
For liver function tests, our study revealed that there was a significant increase in the serum levels of liver function enzymes ALT and AST. On the other hand, highly significant positive relationship was detected between ALT and AST at P value <0.001. This result was in agreement with Rukiye and Fikriye [29] who reported that higher levels of AST and ALT in HCV patients than healthy patients.

Our study showed that serum levels of Albumin was at normal value with mean± SD (4.2 ± 0.90), this result was in agreement with Ge et al. [30] who worked on patients with early nonalcoholic fatty liver disease, viral hepatitis, and cirrhosis and reported that no differences were observed in albumin levels among the healthy control and nonalcoholic fatty liver disease and hepatitis patients (p = 0.36). However, the albumin levels of cirrhotic patients were significantly lower than those of the non-cirrhotic patients (p<0.001). Furthermore, the albumin levels continued to decrease as the liver lost more function.

As well as our study showed that there was an increase in prothrombin time and International Normalized Ratio (INR) (Table 1). Also, there was a significant positive relationship between them at P value <0.05, and our results agreed with Sajjadieh et al. [31] who reported that PTs and INR parameters were significantly different between patients and control group. Patients with elevated biochemical fibrosis markers had high PT values that differed significantly from those of control participants.

Also our study showed that there was a significant increase in PCR with mean± SD 1253405.77± 2604964.55; this result was in agreement with Kato et al. [32] who observed significantly higher HCV RNA titers in patients with chronic active hepatitis and cirrhosis compared to those with milder histological abnormalities such as persistent chronic hepatitis.

To investigate the relationship between PCR and response to treatment, the patients had been divided into two groups according to response to treatment into cured, and relapsed. There was no statistical significance difference within different response groups (p>0.05). This result agreed with Shiffmanet al. [33] who worked on patients with chronic HCV who completed a 6-month course of interferon therapy and reported that the mean serum HCV RNA titer before the start of interferon therapy was not significantly different for biochemical responders or non-responders.

To explore possible relationship between PCR and degree of fibrosis (F1-F4), patients had been divided into four groups according to their degree of fibrosis (F1-F4). Our study revealed that a non-significant correlation were detected between PCR and degree of fibrosis (F1-F4) p=0.94 and this result was in agreement with Noreldin et al. [34] who reported that there were no statistically significant difference between PCR with activity and fibrosis (p=0.37, p=0.22 respectively). This could be attributed to the fact that serum HCV RNA load is not a stable parameter because it fluctuates. In addition, a high amount of circulating HCV does not always imply a more active state of viral replication in the liver nor does it indicate a more severe degree of liver disease. HCV is known to replicate both within the liver as well as in extra-hepatic sites [35].

5. CONCLUSION

The evaluation of pretreatment concentrations of neopterin might not be a predictor for response to antiviral therapy (pegIFN and ribavirin) in chronic hepatitis C patients. Some limitation was found, firstly, the study should be applied on large scale of patients to confirm our results. Secondly, evaluation of serum neopterin level in HCV patients before and after treatment in addition to healthy individuals as control group to assess the association between neopterin level and response to treatment.

DISCLAIMER

The products used for this research are commonly and predominantly use products in our area of research and country. There is absolutely no conflict of interest between the authors and producers of the products because we do not intend to use these products as an avenue for any litigation but for the advancement of knowledge. Also, the research was not funded by the producing company rather it was funded by personal efforts of the authors.

CONSENT

Patients were informed about the study and informed consents were obtained.

ETHICAL APPROVAL

The research protocol was reviewed and approved by the ethical committee of the
ERMED (Railway Hospital) Hospital and faculty of pharmacy, Al-Azhar University, Cairo, Egypt.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

REFERENCES


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Peer-review history:
The peer review history for this paper can be accessed here:
http://www.sdiarticle4.com/review-history/58928