RESEARCH ARTICLE

Daytime variation in hepatitis C virus replication kinetics following liver transplant [version 1; referees: 2 approved]

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Abstract

\textbf{Background:} There is a growing interest in the role of circadian regulated pathways in disease pathogenesis.

\textbf{Methods:} In a cohort of hepatitis C virus (HCV) infected patients undergoing liver transplantation, we observed differences in early viral infection kinetics of the allograft that associated with the time of liver transplant.

\textbf{Results:} A higher frequency of subjects transplanted in the morning showed a rebound in viral RNA levels (n=4/6) during the first week post-surgery. In contrast, no viral rebound was observed in seven subjects transplanted in the afternoon. None of the other parameters previously reported to influence viral replication in the post-transplant setting, such as donor age, cold-ischemia time and length of surgery associated with viral rebound.

\textbf{Conclusions:} These observation highlights a role for circadian processes to regulate HCV infection of the liver and warrants further investigation.

\textbf{Keywords}\nHCV, Circadian rhythm, liver transplant, allograft, viral rebound, time of day

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Author roles: Zhuang X: Formal Analysis, Investigation, Methodology, Writing – Original Draft Preparation, Writing – Review & Editing; Lai AG: Formal Analysis, Methodology, Resources, Software, Writing – Original Draft Preparation, Writing – Review & Editing; McKeating JA: Conceptualization, Formal Analysis, Funding Acquisition, Investigation, Methodology, Project Administration, Supervision, Validation, Visualization, Writing – Original Draft Preparation, Writing – Review & Editing; Rowe I: Conceptualization, Formal Analysis, Investigation, Project Administration, Resources, Validation, Writing – Original Draft Preparation; Balfe P: Conceptualization, Investigation, Methodology, Project Administration, Supervision, Writing – Original Draft Preparation, Writing – Review & Editing

Competing interests: No competing interests were disclosed.

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The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

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**Introduction**

The circadian clock is an evolutionarily conserved biological time-keeping system that synchronizes behavioural and physiological processes to a 24-hour cycle, including cell proliferation and metabolism. The circadian system is recognized to regulate host innate and adaptive immune responses to microbial pathogens to conserve energy utilization. The circadian system comprises a central clock in the suprachiasmatic nucleus of the hypothalamus and secondary clocks in the peripheral organs. The liver is a highly circadian regulated organ with up to 20% of genes under clock control. Research over the past two decades has demonstrated that disrupting clock function associates with the development of liver diseases, including fatty liver disease, cirrhosis and hepatocellular carcinoma (HCC), highlighting a key role for the circadian system in regulating hepatic function.

Viral infection of the liver is a global health problem with up to 150 million individuals infected with hepatitis C virus (HCV) that causes progressive liver disease and is one of the leading indications for liver transplantation. In almost every case HCV infects the newly transplanted organ or donor allograft, providing an unprecedented window to study the early stages of HCV infection. We had the opportunity to study the relationship between the time of liver transplantation and HCV replication dynamics in subjects enrolled in a clinical trial to assess the safety and efficacy of an entry inhibitor targeting scavenger receptor BI (SR-BI). We noted differences in viral infection of the allograft in control subjects that associated with the time of liver transplant, suggesting a role for circadian processes to regulate HCV entry into the liver.

**Results**

HCV infection of the newly transplanted graft is reported to show “rapid” or “slow” early phase replication kinetics, however, the host pathways defining these profiles are not well understood. To investigate whether HCV replication kinetics is influenced by the time of transplant, patients in the untreated arm of the trial were grouped according to their time of surgery between the hours 6am–1pm (AM) or 2pm–11pm (PM) (n=7). No patients were transplanted during the night (11pm–6am). Transplantation was required for liver failure (n=8) or HCC (n=5). Patients were infected with HCV genotype (Gt) 1 (7 patients) or Gt3 (4 patients), with single cases of Gt2 and Gt4. No significant differences in baseline median HCV RNA load were observed (5.4 log10 IU/ml) (Table 1). Additional clinical parameters previously reported to affect HCV replication or allograft survival, such as donor age (AM: median, 55 years; range 45–69 years; PM: median, 44 years; range, 29–64), cold-ischemia time, duration and time of operation were comparable in the AM or PM groups (Table 1). In four of six patients (#3, 7, 8 and 11) in the AM group, a viral rebound toward pre-transplant levels was observed during the time of study (Figure 2A). In contrast, none of the seven patients transplanted in the PM group showed a recovery of viral load to pre-transplant levels (Figure 2B).

Combining the replication kinetics from control subjects within AM or PM groups enabled us to apply lines of best fit and to conclude that the differences in replication kinetics were significant (Figure 3A) (F-test, p<0.001). A similar analysis of patients receiving the SR-BI antagonist ITX5061 failed to show any significant difference in replication kinetics between the AM (n=4) or PM (n=6) groups (Figure 3B), supporting a role for circadian regulation of HCV entry.

We and others have previously reported a rapid decrease in HCV RNA within the first 16 hours following surgery due to clearance of virus in the periphery by the reticular endothelial system of the new liver. To assess the influence of transplant time on viral clearance and allograft infection kinetics we calculated the area over the infection curve for control and treated subjects between 0–16 h and 24–168 h after transplantation (Figure 3C, D). Time of transplant had minimal effect on viral clearance in all subjects (Figure 3C, D). Control patients in the AM group showed higher rates of infection than those in the PM group, whereas this pattern was not apparent in the ITX5061-treated groups (AM, n=6; PM, n=4) and response to therapy was not time-dependent (Figure 3C, D). Structuring the data in this manner did not reach significance and this most likely reflects...
Table 1. Cohort data. Values shown for continuous variables are means (standard deviations).

<table>
<thead>
<tr>
<th>Variable</th>
<th>AM (n=6)</th>
<th>PM (n=7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, years</td>
<td>53 (11)</td>
<td>54 (7)</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Weight, kg</td>
<td>85 (11)</td>
<td>82 (16)</td>
</tr>
<tr>
<td>Indication for transplant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver failure</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>HCC</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>MELD score</td>
<td>13 (4.5)</td>
<td>15 (3.7)</td>
</tr>
<tr>
<td>Initial HCV RNA, log10 IU/ml</td>
<td>5.0 (1.5)</td>
<td>5.7 (0.6)</td>
</tr>
<tr>
<td>Genotype</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gt1</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Non-Gt1</td>
<td>4 (2 Gt3, 1 Gt2, 1 Gt4)</td>
<td>2 (2 Gt 3)</td>
</tr>
<tr>
<td>Donor data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age, years</td>
<td>56 (8)</td>
<td>45 (11)</td>
</tr>
<tr>
<td>Cold Ischaemic time, mins</td>
<td>534 (64)</td>
<td>583 (142)</td>
</tr>
<tr>
<td>Duration of operation, h</td>
<td>5.7 (2.0)</td>
<td>4.5 (0.8)</td>
</tr>
</tbody>
</table>

†Duration estimated between the start of anhepatic phase and arrival on intensive care unit. One patient's operation (AM) was 10 hours, all others were 4–6 hours. HCC, hepatocellular carcinoma; MELD, model for end-stage liver disease; HCV, hepatitis C virus.

In the context of liver transplantation, where recipients are immunosuppressed, the impact of recipient or allograft innate and adaptive immunity may be compromised, suggesting that differences in viral kinetics may reflect differences in hepatocellular permissivity to support HCV infection.

We recognize the limitations of this analysis, particularly with respect to the small number of patients studied. There are obvious ethical constraints in accessing donor liver tissue to assess its circadian status. However, to the best of our knowledge this is the first report highlighting a potential role for liver time-of-day regulated pathways to modulate HCV replication in vivo and this has clear translational potential for other hepatotropic infectious agents and the design of therapeutics.

Methods

Subjects

The data presented were obtained from subjects enrolled in an open-label phase 1b study to assess the effect of ITX5061 in patients undergoing liver transplantation at a single centre (Queen Elizabeth Hospital Birmingham, Birmingham, UK), described previously. All patients gave informed written consent and ethical approval was given by the UK National Research
Figure 2. Hepatitis C virus (HCV) replication kinetics in control subjects in the AM or PM transplant groups. HCV RNA levels were quantified in subjects undergoing liver transplant in the AM (A) or PM (B) groups, with data expressed relative to the mean value of three samples collected after admission to hospital and before surgery. Samples were collected at 0, 4, 8, 12, 16 and 24 h post-transplant and daily thereafter for 7 days (168 h).
The study was registered at clinicaltrials.gov (NCT01292824). The study enrolled men and women between the ages of 18 and 65 years who were suitable for liver transplantation. Patients with HCV-associated end-stage liver disease or HCC were enrolled regardless of their infecting Gt or previous anti-viral treatment. Patients co-infected with HBV or human immunodeficiency virus were excluded, as were patients receiving a liver from a HCV-positive donor.

Plasma collection and analysis
Plasma was collected at screening, before surgery, at the time of transplantation, and during a follow-up period of 90 days. HCV RNA levels were measured on admission to the hospital, immediately following the induction of anesthesia, at the time of portal vein clamping (the start of the anhepatic phase), immediately before perfusion of the allograft, and 1 hour later. Plasma samples were collected every 4 hours during the first post-transplant day, daily for the first week, weekly for the first month, and monthly thereafter up to 90 days. Plasma HCV RNA was measured using the COBAS TaqMan HCV test version 2.0 (Roche Diagnostics Ltd., Switzerland) in a laboratory accredited by the Health Protection Agency UK. Data were analysed using t-tests or F-tests in GraphPad Prism 7.0 software.

Data availability
Raw data for the study, including demographic information for untreated transplant patients and hepatitis C virus RNA levels in untreated and ITX5061-treated groups, are available on OSF: https://doi.org/DOI10.17605/osf.io/kjnh3. Data are available under the terms of the Creative Commons Zero “No rights reserved” data waiver (CC0 1.0 Public domain dedication).

Competing interests
No competing interests were disclosed.
References


Grant information

This work was supported by Wellcome Trust (through Institutional Strategic Support Funds awards and grant No. 200838 to J.A.M.), the PERCAT Research Development Fund at the University of Birmingham and by European Union’s Horizon 2020 research and innovation programme (grant agreement No. 667273).

The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.
Open Peer Review

Current Referee Status: ✓ ✓

Version 1

Referee Report 17 August 2018

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Salim I. Khakhoo
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The authors have performed a novel study investigating the role of the circadian clock in HCV infection. They have studied 13 patients with chronic HCV infection undergoing liver transplantation either for liver failure or for hepatocellular carcinoma. The study was performed on the back of a trial of an HCV entry inhibitor (ITX5061), which is designed to block re-infection of the liver allograft. They have performed serial HCV viral load measurements in the plasma post transplantation to determine the HCV kinetics during the week after transplantation. They stratify patients into those transplanted in the morning and those in the afternoon. They find that individuals transplanted in the morning were more likely to have had a rebound in viral load. This rebound begins 24-48 hours after the anhepatic phase in most of the individuals and in fig 3A appears to peak at around day 5. The sample size is small but in the untreated individuals is significant. This effect appears lost in the treated group. Overall the study is well conducted and interesting.

Comments

1. It is not clear why the authors have chosen the specific intervals. Is there a biological rationale, or was it for sample size convenience?
2. It is not clear to me which patients had received ITX5061 (this could be indicated in Figure 2).
3. The number of patients in each group should be indicated in Figure 3.
4. In figure 3 there are treated and untreated individuals. There are 13 patients in Figure 3C are 13 and an additional 9 patients in Figure 3D. These do not appear to be included in Table 1. They should be included.
5. How ITX5061 was used is not clear to me. Was it a single dose? Multiple doses? An Infusion? They need to clarify the statement “supporting a role for circadian regulation…” P2 para 1, as presumably it was given during the anhepatic phase for all patients.
6. How does the timing reflect doses of immunosuppression given? Could this also have an effect on the post-transplant kinetic?

Is the work clearly and accurately presented and does it cite the current literature?
Yes

Is the study design appropriate and is the work technically sound?
Yes
Are sufficient details of methods and analysis provided to allow replication by others?
Yes

If applicable, is the statistical analysis and its interpretation appropriate?
Yes

Are all the source data underlying the results available to ensure full reproducibility?
Yes

Are the conclusions drawn adequately supported by the results?
Yes

**Competing Interests:** No competing interests were disclosed.

**Referee Expertise:** Hepatology, immunology viral hepatitis

I have read this submission. I believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Referee Report 14 August 2018
doi:10.21956/wellcomeopenres.16003.r33654

William L. Irving  
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This paper describes HCV viral replication kinetics in patients in the 7 day period following liver transplantation. To do this, the authors had access to a highly unique set of samples from patients undergoing transplantation in the control arm of a clinical trial of a potential HCV entry inhibitor. The key observation was made that in 4 of 6 patients whose transplant operation occurred between the hours of 6am to 1pm (the AM group), viral load rebounded to pre-transplant levels within the week of follow-up, compared to 0 of 7 patients whose operation took place between the hours of 2pm and 11pm (the PM group). The difference in viral replication kinetics of the 2 groups was statistically significant. For trial patients who received the trial entry inhibitor, there was no difference in replication kinetics. The time of transplant had minimal effect on the initial decline in viral load (clearance of virus from the periphery by the new allograft) in the first 16 hours post-transplantation, but rebound of viral replication, assessed as "the area over the infection curve") was greater in the AM group, although this did not achieve statistical significance, most likely due to the small numbers of patients in each group. In summary, the data are strongly suggestive of an association between HCV allograft infection rate and the time of day of transplantation, and the authors interpret these data to suggest a role for circadian processes to regulate HCV entry into the liver.

The authors acknowledge 2 major limitations to this work – firstly, the small numbers of patients studied, and secondly, the absence of more direct data relating to the circadian status of the donor liver, for which there are obvious ethical constraints. Nevertheless, the observations made using this unusual set of samples are of interest in themselves, and raise further questions. If I have interpreted the data correctly, the implication is that whilst all of the implants appear to take up virus equally well, at least in the first 16 hours, it is only livers implanted in the AM period where the expression of factors underpinning either viral entry or those necessary for rapid viral replication (or both) just happen to be at an optimal level such that
viral rebound becomes apparent soon after that initial 16 hour “mopping-up” period. I would be interested to hear the authors’ views on two issues related to this:

1. How important might be the time of day of removal of the donor liver? Is it a fair assumption that the circadian status of this liver will become fixed (almost literally frozen) as it is removed from neuronal and hormonal influences at the time of removal? Presumably data on time of removal will be available, although this is not mentioned in the manuscript. Was there also a correlation between viral replication kinetics in the recipient and time of day of removal of the donor organ?

2. A related question, to which the answer most probably will be pure speculation, is how long would it take for the donor liver to become synchronised to the circadian pattern of the recipient? The liver would be exposed to circulating humoral factors immediately, but there would be an absence of neuronal connections.

A couple of minor points for clarification:

1. The mean duration of the transplant operation was around 5 hours. So would it be true to say, for instance, that there were no operations that began at 11 am and continued until 4 pm ie straddling the time definitions for AM and PM? Or if that is not true, then into which category would such an operation be classified – AM according to the start time or PM according to the finish time?

2. The authors dismiss any possible confounding by the age of the donor liver – but the median age of the PM livers, at 44 years, was less than the entire range of the AM livers (45-69 years, 1st para of the results). Liver age is a critical factor in both patients with chronic HCV infection (the older age at infection, the more likely disease progression) and the long-term prognosis of liver transplant recipients. Is it not conceivable that this might also be a factor in the PM group being better able to suppress HCV replication, at least in the early post-transplantation phase? Was the donor age in the 4 AM patients who rebounded any different from the donor age of the remaining patients?

Is the work clearly and accurately presented and does it cite the current literature?

Yes

Is the study design appropriate and is the work technically sound?

Yes

Are sufficient details of methods and analysis provided to allow replication by others?

Yes

If applicable, is the statistical analysis and its interpretation appropriate?

Yes

Are all the source data underlying the results available to ensure full reproducibility?

Yes

Are the conclusions drawn adequately supported by the results?

Yes

**Competing Interests:** No competing interests were disclosed.

I have read this submission. I believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.