HCV-specific cellular immune responses in subjects exposed to but uninfected by HCV

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Haplotype Analysis Finds Linkage Disequilibrium in the IL-12 Gene in Patients With HCV

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HCV is a major cause of liver disease worldwide. IL-12 plays an essential role in the balance of T helper 1 (Th1) differentiation versus a T helper 2 (Th2) driven response from its naïve precursor. Linkage disequilibrium measures the degree to which alleles at two loci are associated and the non-random associations between alleles at two loci. Haplotypes of the three IL-12B loci studied were determined in the patient cases and the normal healthy control subjects. The frequency of the 12 possible IL-12B haplotypes on the 3 loci was determined in subjects heterozygous at only one of the loci within the studied haplotype. Haplotype frequencies were compared between the patient groups and controls (n = 49) to determine if any preferential combination of markers occurred using chi-squared and applying the Bonferroni correction. 45 HCV RNA negative patients; 88 HCV RNA positive patients; and 15 uninfected cases at high risk of HCV infection (EU) were studied. The haplotype “C” SNP of the 3’ UTR with the “E” 4 bp deletion of the intron 4 region was in linkage disequilibrium ($\chi^2 = 45.15, P < 0.001, 95\% \text{ CL}$). The haplotype analysis of the insertion allele of the promoter with the deletion allele of the intron 4(“E”) IL-12B polymorphism showed linkage disequilibrium ($\chi^2 = 5.64, P = 0.02$). Linkage disequilibrium of polymorphisms is reported in the IL-12 gene in patients with HCV infection and contributes to the understanding of patient genotype and expected production of IL-12, responding to infection. J. Med. Virol. 87:1207–1217, 2015.

KEY WORDS: IL-12B gene; Proinflammatory cytokine; gene polymorphism; hepatitis C; virus clearance

INTRODUCTION

Hepatitis C virus (HCV) is one of several viruses that results in hepatitis and is a major cause of liver disease worldwide [Gravitz, 2011]. Infection with the virus causes chronic hepatitis in 80% of those infected and it is unclear why some individuals are able to initiate and maintain effective antiviral responses to the virus and others do not. HCV infection continues to be one of the leading blood-borne infections in some regions, despite the efforts taken to eradicate the transmission of the virus by blood products [Cornberg et al., 2011]. Evidence suggests that HCV-specific T helper cell (Th) responses of Th1 helper cell type are involved in resolution of HCV infection and long-term control of viremia. Cytokines are known to drive Th1 helper cell responses in response to viral infection and, in acute infection, HCV-specific Th1 helper cell responses occur more frequently and are stronger in individuals who clear viremia [Diepolder et al., 1995] and the loss of HCV-specific Th1 helper cell reactivity following apparent resolution of acute HCV infection has been linked to the reappearance of HCV RNA [Gerlach et al., 1999]. Furthermore, Th1 helper cell-type responses against many viral antigens (multi-specific), rare in patients with a chronic infection, are found in the majority of HCV antibody positive cases without viremia many years after exposure to infection [Cramp et al., 1999; Cramp et al., 2000], suggesting a role in the long-term control of viremia. In treatment-related resolution of viremia, induction of T helper cell responses has been shown to be important and the enhanced sustained treatment response

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rates seen with ribavirin in combination with alpha interferon may be related to its ability to promote a T1 helper cell response by suppression of interleukin-10 (IL-10) production [D’Andrea et al., 1993; Cramp et al., 2000]. A cohort of intravenous drug users have been identified who, despite a long history of intravenous drug use and sharing of injecting equipment, remain seronegative and aviremic for hepatitis C virus (HCV) and it is suggested that an innate immune activation may be the key to prevention of infection in this cohort. These individuals have cytokine profiles that infer innate immune responses when exposed to the virus [Warshow et al., 2012]. They also appear to have different T-cell responses [Thurairajah et al., 2008].

The functional IL-12 heterodimer is known as IL-12p75 (but sometimes referred to as p70) and is a proinflammatory cytokine with immunoregulatory function [Gubler et al., 1991]. The dimers are p40 and p35 and the physiological role of p40 is not well characterized and its role may be underestimated. It is thought to form dimers that possibly influence the regulation of early immune responses [Gillessen et al., 1995].

IL-12 is a key signal of the innate immune system, acts as a bridge between innate and acquired immunity and thus plays a crucial role in the development of antiviral immune responses [Trinchieri, 1995, 1998, 2003]. Its production is important in the generation of cell-mediated immunity against many intracellular pathogens, including bacteria, fungi, protozoans, and viruses [Johnson and Sayles, 1997; Trinchieri, 1998, 2003]. The cytokine can, however, enhance or inhibit humoral immunity depending on the Ig isotype and the stimulus to antibody formation. IgG2a,b and IgG3 responses are associated with T1 helper cell responses [Germain, 1995] and T2 helper cell responses are associated with IgG1 antibodies which are suppressed by IL-12 [Buchanan et al., 1995].

Although IL-12 plays a key role in intracellular microorganism defense, excessive production has been associated with some organ-specific autoimmune diseases, including type1 diabetes mellitus, multiple sclerosis, rheumatoid arthritis, and Crohn’s disease [Ronningen et al., 2004]. The cytokine interleukin-12 (IL-12) mediates a variety of these responses from resting lymphocytes, cytolytic T-cell maturation and cell stimulation [Trinchieri, 1995; Sene et al., 2010].

The precise role of IL-12 in HCV infection is poorly understood but its involvement in enhancing the cytotoxic response and the fact that Th1 driven responses are important for HCV clearance suggest that IL-12 is an important factor in the disease. Further to this, IL-12 and IFN-γ levels are lower in patients with viremic, chronic HCV than in patients who spontaneously cleared the virus [Sarib et al., 2000]. IL-12 enhanced the immune response of these patients when cell cultures were treated with the cytokine [Fan et al., 2000; Bes et al., 2004]. However, patients that are infected chronically with HCV, higher serum IL-12 levels were associated with greater proinflammatory activity and lower serum levels of IL-12 showed fewer signs of piecemeal necrosis [Quiroga et al., 1998]. The differentiation of uncommitted T cells, during the induction of a cytotoxic antiviral host response, is characterised by the secretion of lymphokines associated with cell-mediated immunity rather than those secreted during a humoral response. [Gately et al., 1991; Diepolder et al., 1995]. A strong Th1 CD4+ response is also thought to be essential for spontaneous viral clearance and this is facilitated by the expression of IL-12 from macrophages and dendritic cells (Fig. 2). IL-12 mediates some physiological activities by acting as a potent inducer of IFN-γ secretion by Th1 and natural killer cells and is extremely important in the clearance of viremia [Ma et al., 1996]. Although the production of IL-12 is vital for HCV viral clearance initiating Th1 responding cells, unregulated and ongoing IL-12 production can result in infection-induced immunopathology and liver damage. Existing intrahepatic memory CD8+ T cells targeting dominant epitopes of HCV, in spontaneously resolved infection, failed to prevent persistence after reinfection. This indicates a need for a broader T cell epitope response to reduce the risk of a second persistent infection and the recently successful of IFN-free direct-acting antiviral therapy appears to restore the CD8+ antiviral response (Fig. 1). [Callendret et al., 2014; Martin et al., 2014].

Although APCs produce most of the cytokine, T cells also produce IL-12 [Trinchieri, 2003], they also have IL-12 receptors that respond the cytokine in an immune response [Grohmann et al., 2001]. An important property of IL-12 is to induce the production of large amounts of IFN-γ from resting and activated T and NK cells [Dorman and Holland, 2000]. The most distinctive role of IL-12 is to regulate the balance between Th1 and Th2 cells (Fig. 2). Allogeneic CTL responses are promoted by IL-12 in Th1-differentiated peripheral cells; IL-12 induced the synthesis of IFN-γ; IL-2 and TNFα expression [Chan et al., 1991; Bertagnolli et al., 1992]. However, IL-10 has been

![Fig. 1. shows the RFLP digest products of the Taq-1 enzyme](image-url)
shown to inhibit lymphocyte production of IFN-γ by suppressing IL-12 synthesis in accessory cells [D’Andrea et al., 1993]. It has also been reported that individuals with a defective production of IL-12 only respond to staphylococcus aureus when supplemented with IFN-γ but not with staphylococcus aureus alone [Frucht and Holland, 1996].

Several polymorphisms have been described on the IL-12B gene both in the translated and untranslated regions [Huang et al., 2000]. Some differences in expression in IL-12B associated with polymorphic differences have been reported and mutations in the IL-12 p40 gene or its receptor have been shown to lead to reduced IL-12 signalling [Seegers et al., 2002]. Polymorphisms have been described showing associations with several other diseases such as asthma, Crohn’s disease, multiple sclerosis and diabetes [Morahan, 2001; Morahan et al., 2002; Seegers et al., 2002; Muller-Berghaus et al., 2004; Randolph et al., 2004].

Strong linkage disequilibrium with the T1DM susceptibility locus in Australian and British diabetes families [Morahan, 2001]. However in a group of Danish, European and American patients, evidence for the presence of T1DM linkage disequilibrium of the (C1159A) SNP was not found in patients with T1DM. Typing of three microsatellites in the region of this SNP and construction of haplotypes did not reveal a susceptibility locus in Australian and British diabetes families [Morahan, 2001; Morahan et al., 2002; Seegers et al., 2002; Muller-Berghaus et al., 2004; Randolph et al., 2004].

Patients with HCV infection investigated for linkage disequilibrium in other genes involved in the immune response to viral infection such as DQB1’0301 and the haplotype HLA-DRB1’1101-HLA-DQB1’0301 is also found more frequently in cases who spontaneously clear HCV [Alric et al., 1997; Cramp et al., 1998]. DRB1’04 and DQA1’03 alleles are protective in strong linkage disequilibrium with DQB1’0301 [Cramp et al., 1998]. Although MHC molecules that differ by one amino acid can have modified peptide binding ability for HCV epitopes [Peano et al., 1994], MHC class II associations with disease outcome may not be directly related to antigen presentation but through linkage disequilibrium with other genes or haplotypes as has been observed with the TNF-α promoter polymorphism and MHC genotypes [Wilson et al., 1993].

Understanding genetic factors do influence, to a degree, the outcome of HCV infection. The viral immune response is not a simple mechanism but has multiple factors influencing its direction and there are unquestionably many more genetic factors to pursue. It is clear that environmental factors also have determining influences on the success of viral resolution [Gorham et al., 1996, 1997].

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Studying patients and the clinical consequences resulting from defects in the IL-12 dependent IFN-γ pathway has shed much light on the Th1/Th2 paradigm during immune responses, which has largely been based on animal models [Lamm et al., 2000].
Identification of mutations of the IL-12 p40, IL-12 receptorβ1 and the IFN-γ receptor gives insight into the mechanisms involved in the human host defense against intracellular pathogens [Dorman and Holland, 2000].

Linkage disequilibrium was identified in the IL-12B gene in asthma patients [Muller-Berghaus et al., 2000; Randolph et al., 2004].

MATERIALS AND METHODS

Patients

133 European Caucasoid patients who are HCV antibody positive were included in this study, recruited from The Institute of Liver Studies at King’s College Hospital. Three groups of patients were studied; HCV antibody positive but HCV RNA negative (n = 45) cases with spontaneous viral clearance, HCV antibody and HCV RNA positive patients with chronic infection (n = 88). The third group consisted of individuals who had proved exposure to the virus but were not found to be HCV antibody positive (n = 15). There was also a group of healthy controls that had not been exposed to HCV (n = 49). All patients in the study were recruited over some time and the study was a retrospective study.

Patient Testing for HCV

Serological testing for anti-HCV. In all cases, the presence or absence of HCV antibodies was determined by second or third generation assay (Abbott IMx, Abbott Diagnostics, Maidenhead, UK).

Some patients infected with HCV resolved the virus spontaneously and had undetectable HCV RNA. Anti-HCV specificity was confirmed using a third generation line immunoassay (INNO-LIA HCV AbIII, Innogenetics) as an antibody confirmatory test. ME Cramp et al. at King’s College Hospital, London, performed the tests. No false positive HCV antibody results were identified.

Detection of HCV RNA. Less than 100 copies/ml of HCV RNA could be detected using a commercially available assay (Amplicor, Roche, Basel, Switzerland) [Gerken et al., 1996]. Results were confirmed by using nested PCR (Innogenetics, Gent, Belgium).

Extraction of high molecular weight DNA. The DNA isolation process consists of first eliminating the erythrocytes with red cell lysis buffer. Secondly, the membranes of the white cells are lysed along with the nuclei. The DNA from the nuclei is treated with Proteinase K, which is a recombinant enzyme identical to the protease originally isolated from Tritrachium Album, a mould that is one of the most active endopeptidases known. The activity of Proteinase K can be enhanced by the addition of SDS.

Finally DNA is precipitated out of solution by adding cations from 5M NaCl and ice-cold ethanol. Then washed with 70% ethanol to remove any salt contamination.

Reagents.

Red Cell Lysis Buffer (RCLB): 0.144 M Cl (38.5 g/5 L), 0.001 M NaHCO3, 0.001 M NaCl, 0.47 M NaCl, 0.002 M EDTA (0.744 g/L) (The solution was adjusted to pH 8 using concentrated HCL or NaOH).

SDS

Proteinase K (A stock solution was made up using 2 mg/ml in sterile water and stored at −20°C).

6 M NaCl (350.64 g/L).

Absolute ethanol (100% Stored at −20°C).

70% ethanol.

SDS (10% solution 10 g made up to 100 μl of sterile water). 5–20 ml of frozen venous blood was defrosted at room temperature, allowing 1 hr per 10 ml of blood. The blood was then transferred into 50 ml Falcon tubes and 25 ml of red cell lysis buffer was added. The solution was mixed by inversion and then left at room temperature for 5 min.

The Falcon tubes were centrifuged at room temperature for 10 min at 600 g. The supernatant of the red cell lysis mixture was then discarded and the same process of adding RCLB and centrifugation was repeated. The pellet was resuspended in 6 ml of RCLB and centrifuged again for 10 min at 600 g.

The haemolycate was discarded and the pellet was resuspended in 3 ml of NLB, 200 μl of 10% SDS and 600 μl of Proteinase K. The mixture was incubated at 40°C in a water bath for 24 hr.

1 ml of 6 M NaCl was added and shaken vigorously for at least 15 sec. The remaining content of the falcon tubes was then centrifuged for 15 min at 2000 g. The resulting supernatant was transferred into a 15 ml falcon tube with 8 ml of absolute ethanol at a temperature of −20°C and mixed by gentle inversion until DNA could be seen to precipitate from the solution.

The DNA was transferred to an Eppendorf tube containing 500 μl of sterile water using an inoculating loop.

When DNA is extracted from cell lysates, it is unusual to remove all the proteins by digestion with proteolytic enzymes such as Proteinase K, even though these enzymes are usually active against a broad spectrum of native proteins. DNA samples often require further purification.

Summary of Genetic Studies

Interleukin-12B gene. The three described polymorphisms of IL-12B studied in the populations infected with HCV were IL-12B (1188A/C) 3'UTR polymorphism, IL-12B 4 bp insertion/deletion promoter polymorphism and the IL-12B 4 bp insertion/deletion intron 4 polymorphism (Table I).

Stock solutions for PCR.

TBE Buffer (10%): 107.8 g Triz base, 55 g Boric acid, 7.44 g EDTA, 1 L distilled water.
(All ingredients were mixed using an automatic stirrer in a conical flask).

<table>
<thead>
<tr>
<th>Region</th>
<th>Taq-1 3' UTR</th>
<th>Promoter</th>
<th>Intron 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>(1188A/C) chromosome 5q 31–33</td>
<td>3 kb upstream of the transcriptional start site 5q 31–33</td>
<td>Chromosome 5q 31–33</td>
</tr>
<tr>
<td>Polymorphism/method</td>
<td>Single nucleotide polymorphism (SNP) “A”/“C” substitution</td>
<td>4 bp insertion PAGE*</td>
<td>4 bp deletion PAGE*</td>
</tr>
<tr>
<td>Clinical significance</td>
<td>“C” allele associated with increased IL-12 expression; different IL-12 levels associated with autoimmune diseases</td>
<td>Heterozygote associated with IL-12 expression and more severe form of asthma</td>
<td>In linkage with Taq-1 polymorphism</td>
</tr>
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<td>Reason for investigation</td>
<td>Increased IL-12B expression may confer improved resolution of viremia</td>
<td>May preferentially drive a Th2 response thus associated with RNA positive patients</td>
<td>Shows similar distribution to the Taq-1 polymorphism</td>
</tr>
<tr>
<td>Results</td>
<td>HCV RNA negatives significantly lower “A” allele than HCV RNA positives; allele expresses lower levels of IL-12B</td>
<td>No significant differences between groups</td>
<td>Linkage disequilibrium seen with Taq-1 polymorphism</td>
</tr>
</tbody>
</table>

TABLE 1. Interleukin-12B Polymorphisms Investigated

<table>
<thead>
<tr>
<th>Region</th>
<th>Taq-1 3' UTR</th>
<th>Promoter</th>
<th>Intron 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>(1188A/C) chromosome 5q 31–33</td>
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</tr>
</tbody>
</table>

65°C for 90 min of the 1188A/C polymorphism of IL-12B gene produces two fragments of 156 and 71 bp when the “C” allele is present. When the “A” allele is present the Taq-1 enzyme cut site is abolished and produces a single product of 227 bp long.

Recognition sequence for Taq-1

5’T^CG A-3’
3’A GC^T-5’

Digestion products were separated and visualized under UV light using 2% agarose gel electrophoresis and staining with ethidium bromide (Table II).

**IL-12B 4 bp insertion/deletion promoter polymorphism.** The IL-12B insertion/deletion promoter gene has a 4 bp microinsertion polymorphism arising at the 5′ promoter end of the gene 3 kb upstream of the transcriptional start site. Two primers were used to amplify the DNA products the reverse primer was radiolabelled with 32pATP. This resulted in a 281 bp fragment and 285 bp fragment with the insertion.

Molecular genotyping was performed using the PAGE method to separate the 4 bp larger insertion allele (designated allele “2”) from the smaller allele (designated allele “1”) as described above. A 6% gel concentration was used (Table II).

**IL-12B 4 bp insertion/deletion inton-4 polymorphism.** The IL-12B gene insertion/deletion, inton 4 has a 4 bp microinsertion polymorphism. Two primers were used to amplify the DNA products the reverse primer was radiolabelled with 32pATP. This resulted in a 254 bp fragment and 258 bp fragment with the insertion.

Molecular genotyping was performed using the PAGE method described previously and a 6% gel concentration (Table II).

Primers Designed for This Study

Areas in italic highlight the forward primer, bold areas highlight the reverse primer and green areas highlight the polymorphism.

IL-12 Promoter Region Insertion/Deletion Polymorphism

<table>
<thead>
<tr>
<th>Fragment size</th>
<th>IL-12B promoter</th>
<th>IL-12B Intron 4</th>
<th>IL12B 3’UTR</th>
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<tbody>
<tr>
<td>281 bp</td>
<td>256–258 bp</td>
<td>227 bp</td>
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</table>

Optimised MgCl₂

<table>
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<th>Optimised MgCl₂</th>
<th>IL-12B promoter</th>
<th>IL-12B Intron 4</th>
<th>IL12B 3’UTR</th>
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</thead>
<tbody>
<tr>
<td>12 µl</td>
<td>12 µl</td>
<td>3 µl</td>
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Annealing Temperature

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<th>Annealing Temperature</th>
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<th>IL12B 3’UTR</th>
</tr>
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<tbody>
<tr>
<td>55°C</td>
<td>53°C</td>
<td>55°C</td>
<td></td>
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</table>

Cycle

<table>
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<tr>
<th>Cycle</th>
<th>IL-12B promoter</th>
<th>IL-12B Intron 4</th>
<th>IL12B 3’UTR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>95°C for 3 min</td>
<td>95°C for 5 min</td>
<td>95°C for 3 min</td>
</tr>
<tr>
<td>2</td>
<td>95°C for 20 sec</td>
<td>95°C for 1 min</td>
<td>95°C for 20 sec</td>
</tr>
<tr>
<td>3</td>
<td>95°C for 20 sec</td>
<td>55°C for 1 min</td>
<td>55°C for 20 sec</td>
</tr>
<tr>
<td>4</td>
<td>72°C for 30 sec</td>
<td>72°C for 2 min</td>
<td>72°C for 30 sec</td>
</tr>
<tr>
<td>5</td>
<td>Cycles 2–4 × 35</td>
<td>Cycles 2–4 × 35</td>
<td>Cycles 2–4 × 35</td>
</tr>
<tr>
<td>6</td>
<td>72°C for 2 min</td>
<td>72°C for 10 min</td>
<td>72°C for 2 min</td>
</tr>
<tr>
<td>7</td>
<td>4°C for ever</td>
<td>4°C for ever</td>
<td>4°C for ever</td>
</tr>
</tbody>
</table>

References


Polymerase chain reaction specific conditions for genotyping of the IL-12 polymorphisms studied in patients with HCV.

**Statistical Analysis**

The frequency of the alleles and genotypes in both patient subgroups and controls were compared for significance with one sided testing, using contingency tables and chi-squared test with Yates correction where appropriate. *P* values of <0.05 were considered to be significant. We also included odds ratios with 95% confidence limits where appropriate. The results are described using percentage frequency, *P* values, chi-squared and odds ratio values. A Yates correction was applied to all *P* values.

A power calculation found that groups of size approximately 80 gives a power of 0.8 for detecting a difference in proportions of 0.16 based on a chi-square test with a 0.05 significance level. It was agreed that the sample size was adequate to give sufficient power to find significant statistical difference in this cohort.

In order to ensure that differences between the patient groups were not found by chance, a Bonferroni calculation was applied to the data [Benjamini and Hochberg, 1995].

**Hardy–Weinberg Distribution**

In a non-selected population, the relative frequencies of different alleles tend to be constant and are described by a single equation. Several factors may distort the gene frequencies in a population. The patients infected with HCV were recruited from the South East of England whereas the healthy control subjects. A high frequency may indicate the possibility that evolutionary forces are in operation and applying selective pressure in favor of heterozygotes or homozygotes for mutant genes that cause the more common inherited disorders. We tested for Hardy Weinberg distribution in the population of the genotypes that were studied using the calculation (p² + 2pq + q² = 1). The frequency of C = p and the frequency of T = q. This tested for genetic variation of a population in equilibrium [Emigh, 1980].

**IL-12B Intron 4 Insertion/Deletion Polymorphism**

**IL-12B 3’ UTR Polymorphism**

**TABLE II. PCR Conditions for the IL-12 Polymorphisms Studied**

Testing for Linkage Disequilibrium With Haplotypes

The non-random association of haplotype frequencies of two genotypes, encoded at different loci was assessed for linkage disequilibrium. When a pair of alleles occurs together more frequently than predicted from the individual allelic frequencies, they are described as being in linkage disequilibrium. The genotype data collected was tested for linkage disequilibrium.

Percentage Frequency of Haplotypes

Haplotypes of the three IL-12B loci studied were determined in the patient cases and the normal healthy control subjects. The frequency of the 12 possible IL-12B haplotypes on the 3 loci was determined in subjects heterozygous at only one of the loci within the studied haplotype. Haplotype frequencies were compared between the patient groups and controls to determine if any preferential combination of markers occurred using chi-squared and applying the Bonferroni correction, in order to ensure that differences between the patient groups were not found by chance [Benjamini and Hochberg, 1995].

RESULTS

IL-12B Promoter Polymorphism

One hundred fifty nine patients and 90 controls for the IL-12B 4 bp insertion/deletion promoter polymorphism were compared for genotype frequency using contingency tables and Yates correction. The HCV RNA positive (n = 84) and HCV RNA negative patient (n = 58) groups were comparable in terms of age, sex, route and duration of infection. The EU cases were taken from the Kings and South West cohorts (n = 17).

No significant differences were found in the distribution of the IL-12B insertion/deletion promoter polymorphisms between the HCV RNA positive and HCV RNA negative cases.

Patient Data for the IL-12B Intron 4 Polymorphism

Two hundred fourteen patients and 94 ethnically matched healthy controls were genotyped for the IL-12B 4 bp insertion/deletion intron 4 polymorphism.

No significant differences were found in the distribution of the IL-12B insertion/deletion intron 4 polymorphisms between the HCV RNA positive (n = 120) and HCV RNA negative (n = 66) cases or any of the EU cases (n = 28).

Patient Data for the IL-12B 3’UTR Polymorphism

Two hundred forty nine patients and 105 controls were typed for the IL-12B 3’UTR (1188A/C) polymorphism.

The HCV exposed uninfected (n = 54), HCV RNA positive (n = 123) and HCV RNA negative patient (n = 72) groups were comparable in terms of age, sex, route and duration of infection.

RNA positive cases had increased frequency of the AA genotype compared to the HCV RNA negative cases (66% vs 50%, \( \chi^2 = 4.12, P = 0.04, \text{OR} = 1.93 (1.02 < \text{OR} < 3.65) \)). The healthy control cases (n = 105) also had an increased frequency of “AA” genotype than the RNA negative cases (68% vs 50%, \( \chi^2 = 4.93, \text{OR} = 2.09 (1.08 < \text{OR} < 4.06) \)). There was a significantly higher frequency of “A” alleles in the healthy control group (83.3%) when compared to the RNA negative group (72.9%) (\( \text{OR} = 0.5 (0.31 < \text{OR} < 0.93) \)) [Houldsworth et al., 2005].

No other comparisons were significantly different.

Linkage Disequilibrium

Analyzing all cases together (i.e., all HCV cases and controls) we found that the 3’UTR “C” and intron 4 “E” alleles are in strong linkage disequilibrium (\( \chi^2 = 45.15, P < 0.0001 \)). There are 4 kb between the IL-12B 3’UTR A/C Taq1 polymorphism and IL-12B intron 4 insertion/deletion polymorphism (Table III). As the distance in kb increases between polymorphisms towards the 5’ end of the gene linkage disequilibrium diminishes [Fig. 3].

There were no significant differences observed either between the 3’UTR or promoter or between the promoter and the intron 4 haplotype groups. However there was a non-significant trend before Bonferroni correction for 12 different groups (\( x \times 11 \)) between the 3’UTR and the intron 4 haplotype and the healthy control group, = 0.034, \( \chi^2 = 4.46 \).

TABLE III. Percentage Frequency of Haplotypes of IL-12B (1188A/C) 3’ UTR Polymorphism (AC), IL-12B 4 bp Insertion/Deletion Intron 4 Polymorphism (EF) and IL-12B 4 bp Insertion/Deletion Promoter Polymorphism (1/2)

<table>
<thead>
<tr>
<th>Haplotype</th>
<th>RNA positive</th>
<th>RNA negative</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>“A”-“1”</td>
<td>66.7% (45)</td>
<td>50.0% (22)</td>
<td>44.8% (30)</td>
</tr>
<tr>
<td>“A”-“2”</td>
<td>33.3% (29)</td>
<td>32.2% (19)</td>
<td>49.2% (33)</td>
</tr>
<tr>
<td>“C”-“1”</td>
<td>0.0% (0)</td>
<td>6.7% (6)</td>
<td>3.0% (2)</td>
</tr>
<tr>
<td>“C”-“2”</td>
<td>0.0% (0)</td>
<td>11.1% (8)</td>
<td>3.0% (2)</td>
</tr>
<tr>
<td>“A”-“F”</td>
<td>77.5% (138)</td>
<td>73.3% (66)</td>
<td>85.7% (84)</td>
</tr>
<tr>
<td>“A”-“E”</td>
<td>10.1% (18)</td>
<td>12.2% (11)</td>
<td>4.4% (4)</td>
</tr>
<tr>
<td>“C”-“F”</td>
<td>5.6% (10)</td>
<td>6.7% (6)</td>
<td>5.5% (5)</td>
</tr>
<tr>
<td>“C”-“E”</td>
<td>6.8% (12)</td>
<td>7.8% (7)</td>
<td>5.5% (5)</td>
</tr>
<tr>
<td>“1”-“F”</td>
<td>47.5% (38)</td>
<td>37.7% (20)</td>
<td>40.2% (37)</td>
</tr>
<tr>
<td>“1”-“E”</td>
<td>10% (8)</td>
<td>11.3% (6)</td>
<td>3.3% (3)</td>
</tr>
<tr>
<td>“2”-“F”</td>
<td>28.8% (23)</td>
<td>34.0% (18)</td>
<td>47.8% (44)</td>
</tr>
<tr>
<td>“2”-“E”</td>
<td>13.7% (11)</td>
<td>17.0% (9)</td>
<td>8.7% (8)</td>
</tr>
</tbody>
</table>

The number of subjects is given in parentheses. “A” = A allele in IL-12B gene (1188A/C) polymorphic site, “C” = C allele in IL-12B gene (1188A/C) polymorphic site, 1 = 4 bp deletion on IL-12B promoter region, 2 = 4 bp insertion on IL-12B promoter region, F = 4 bp insertion on IL-12B intron 4 region, E = 4 bp deletion on IL-12B intron 4 region.

After Bonferroni correction for 12 degrees of freedom (n = 1−11) there were no significant differences between any of the haplotypes.

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There was a non-significant trend before Bonferroni correction between the promoter and the intron 4 haplotype for patients versus the healthy control group for \(2/F\), \(\chi^2 = 6.69, P = 0.01, \text{OR} = 1.55\). \(P_c\) was not significant between any of the groups.

When the expected frequency of alleles of all subjects studied was compared to those observed we found that the haplotype combining “C” SNP of the \(3'\) UTR with the “E” 4bp deletion of the intron 4 region was in linkage disequilibrium with the rest of the gene giving a \(\chi^2\) of 45.15 for the CE haplotype giving a \(P \leq 0.05\) at the 95% confidence limit (Table III).

**Haplotype Analysis of IL-12B Promoter and Intron 4 Polymorphisms**

The haplotype analysis of the insertion allele of the promoter (“2”) with the deletion allele of the intron 4 (“E”) IL-12B polymorphism occurred significantly more frequently than expected \(\chi^2 = 5.64, P = 0.02\) showing linkage disequilibrium between these two polymorphisms (Table III).

**DISCUSSION**

In general, pathogenic mechanisms for diseases of immune disregulation often exhibit cytokine patterns dominated by either a Th1 or Th2 differentiation. Different genotypes of immune compounds such as KIR/HLA can affect the kinetics of human antiviral innate immunity [Ahlenstiel et al., 2004, 2008].

IL28B rs.1297860-CC polymorphism is also associated with a population of individuals that remain uninfected with HCV and are antibody negative, despite proved exposure to the virus and are a distinctly different population from patients that spontaneously resolve infection after testing HCV antibody positive [Knapp et al., 2011].

Although there is no effective vaccine for HCV in humans, antiviral treatment has recently greatly improved for patients infected with HCV. Recent advances, using a chimpanzee based HCV vaccine strategy, with durable, broad, sustained, and balanced T cell responses, characteristic of those associated with viral control has just been published offering an optimistic future for individuals exposed to HCV [Swadling et al., 2014]. The elucidation of innate immune responses to HCV infection holds great potential for the development of new therapies against the virus. Effective cellular immune responses are critical in the resolution of viral infections including HCV, and the possible role of immunogenetic factors such as cytokine gene polymorphisms in determining disease outcome via their influence on immune reactivity is of much interest [Hill, 1998]. IL-12 is a key cytokine and plays a central role in the promotion and maintenance of anti-viral immune responses, [Morahan, 2001; Piazzolla et al., 2001; Morahan et al., 2002; Tsunemi et al., 2002]. The IL-12 gene is a prime candidate gene for infectious as well as Th1 mediated autoimmune diseases and many chronic infections including HIV [Wolday et al., 2000] and HCV are associated with impaired IL-12 production [Schlaak et al., 1998; Piazzolla et al., 2001]. Whether this lower IL-12 secretion is a cause or consequence of chronic infection remains unclear, but an individual’s genetically influenced ability to produce IL-12 in response to antigen exposure is likely to be important in influencing the outcome of infection. Part of this study was specifically designed to address the influence of IL-12B polymorphisms on the resolution of HCV infection by comparing the findings in a large group of patients without persistent viremia following HCV infection, with a group individuals that have a chronic infection.

Spontaneous resolution of hepatitis C viremia showed a non-significant trend of association with the presence of one or more “C” alleles at the IL-12B \(3'\) UTR (1188A/C) polymorphism. The lower producing “A” allele was significantly associated with chronic HCV infection and lower IL-12 production indicating a role for the IL-12B polymorphism in IL-12 secretion and the outcome of HCV infection. No other IL-12B individual polymorphism studied had any association with the outcome of disease in the patients studied [Houldsworth et al., 2003, 2005].

The “A” allele of IL-12B, in our investigation, was of particular interest where an unfavourable clinical outcome has been shown to be associated with lower IL-12 production. It is worthy of mention that whilst not significant when corrected for multiple comparisons, overall just 34% of RNA positive cases carried one or more copy of the “C” allele that has been shown to enhance IL-12 production [Seegers et al., 2002] compared to 50% of patients that are HCV...
RNA negative. In the study by Seegers et al. [Seegers et al., 2002], in vitro secretion of the biologically active IL-12 p70 heterodimer from stimulated monocytes was found to be significantly greater in heterozygous cases (A/C) than in those with the homozygous “AA” genotype, and higher still for those homozygous “CC”. A plausible biological explanation for the improved clinical outcomes we have shown is that an enhanced ability to produce IL-12 following antigenic stimulation promotes and maintains the Th1 response needed to control and clear HCV infection [Diepolder et al., 1995; Takaki et al., 2000]. This explanation is in keeping with a previously reported in vitro T cell studies from King’s College Hospital (involving some of the patients in this study) demonstrating more vigorous Th1 cell responses and greater IFN-gamma production in response to HCV antigens in those patients who resolved viremia [Cramp et al., 1999].

No polymorphisms in the coding region of the IL-12B gene have been identified, indicating a high level of conservation of genes in humans. However several intronic polymorphisms have been discovered and some are associated with disease. Although the polymorphisms studied are not in the coding region, a single alteration in a gene, including polymorphisms in intronic, non-coding sequences, may affect the protein transcription, function or activity. Gene polymorphisms can alter the tertiary structure or the binding ability of a protein either to enable intracellular transport, binding to substrates or co-ordination with cofactors. This may explain why the variant “C” allele in the 3’UTR (1188A/C) of the IL-12B gene produces more IL-12. As the 3’UTR region is known to be able to influence quantity of protein translation by effects on mRNA stability [Grzybowska et al., 2001], and transcriptional activity [Le Cam and Legaverend, 1995].

One research group carried out the 3’UTR polymorphism investigation in treated HCV cases but did not report the same association as we with self-limiting cases but did find that the SNP was associated with a reduced relapse rate in patients undergoing antiviral combination therapy [Mueller et al., 2004]. In contrast to our study, Mueller et al. studied mainly women in the patient group that had spontaneously resolved infection and they had treated all of the cases with antiviral therapy whereas the RNA negative group in this study resolved the viremia spontaneously without treatment. These differences in population may have influenced the genetic frequency of the Mueller group cases.

Modified peptide binding ability for HCV epitopes happens with at least one amino acid change [Peano et al., 1994] but this is not the only reason for MHC class II associations with disease outcome and may not be directly related to antigen presentation. Some HLA associations with disease are found in one population but not in another, possibly because of linkage disequilibrium with other genes or haplotypes. This phenomenon has been observed with the TNF-α promoter polymorphism and MHC genotypes [Wilson et al., 1993].

Linkage disequilibrium can be influenced by several factors, including selection, the rate of recombination, the rate of mutation, genetic drift, non-random mating, and population structure as well as genetic linkage [Ardlie et al., 2002]. Haplotypes can be informative provided associations within haplotypes are significant as in the Saami and African populations described earlier [Pritchard and Przeworski, 2001].

Linkage disequilibrium was found in the IL-12B gene at the 3’UTR end with intron 4 and exon 8. The two polymorphisms, “C” SNP of the 3’UTR (exon 8) and the 4 bp deletion of intron 4, both appeared together with a much higher frequency than expected. Although we did not find any haplotype associations associated with resolution of viremia in the IL-12B genes, other haplotype combinations may be interesting to investigate. The data was generated from a cohort from the London area, which has a high degree of ethnicity but we selected a European Caucasoid population from this area, however it is difficult to assess the purity of this gene pool in a community with such a broad ethnic mix.

There was a trend in the control group compared to the patient groups with an increased frequency of IL-12B promoter insertion/intron 4 insertion haplotype compared to the patient groups. However, no significant difference was observed in haplotype associations, after the p value was corrected using a Bonferroni correction (×11). There was also a trend of increased frequency of the 3’UTR “A”/intron 4 insertion in the control group. This could have been due to ethnic differences between the control population from the South West and the patient group from the South East. It may be necessary to take this into consideration with any further study by a further correction or by ensuring that the controls come from the same area as the patient cohort.

It would be interesting to investigate the IL-12B haplotypes in different ethnic groups to see if the same haplotype association occurs. These findings support the concept that an individual’s genetically determined ability to produce IL-12 is another factor that may influence the outcome of HCV infection. Associations of genes with immune responses to infection may also provide clues to the development of end-stage complications such as cirrhosis or hepatocellular carcinoma. Further analysis of the human genome may eventually allow us to determine the natural outcome of HCV infection and enable us to design appropriate antiviral therapy as well as predict an individual’s response to therapy. Direct antiviral therapies have led to the most dramatic breakthroughs in treatment and understanding immune responses depending on patient genotype may help to improve treatments [Zuckerman, 2012].

More study is needed to investigate further haplo-type combinations associated with immune responses to HCV in order to fully understand protective mechanisms against viremia. Understanding how haplotypes interact in the cytokine response to HCV infection may lead to enhanced understanding of immune responses in patients. Interleukin-12, as a genetic adjuvant, was found to enhance hepatitis C virus NS3 DNA vaccine immunogenicity [Naderi et al., 2013].

REFERENCES


Haplotype Analysis Finds Linkage Disequilibrium


