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LIST OF PUBLICATION

1. Whole genome sequence analysis of Hepatitis B virus (HBV) strains recovered from HBV/HIV-1 co-infected pregnant women. International Graduate Research Conference, 2015. Chiang Mai, Thailand. December 11, 2015. (*Proceedings*)



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Whole genome sequence analysis of hepatitis B virus (HBV) strains recovered from HBV/HIV-1 co-infected pregnant women

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ABSTRACT

Background & Aims: HBV genetic diversity has been reported to have an impact on diagnostic assays, failure to hepatitis B vaccination, response to antiviral therapy, liver disease progression and long-term clinical outcomes. HBV, as well as HIV, infections are major public health concerns in Southeast Asia. To date, data on HBV genetic diversity among HBV/HIV co-infected pregnant women is limited. This study aimed to analyze whole genome HBV sequences of HBV/HIV co-infected pregnant women.

Methods: Whole genome of HBV from HBV/HIV co-infected pregnant women was directly sequenced using BigDye Terminator cycle sequence. Genotyping and specific mutations were analyzed using a web-based analysis tools (HIV-grade: HBV-resistance interpretation tool). HBV genotype was also confirmed by phylogenetic analysis of the whole genome sequences together with HBV reference sequences using MEGA version 6.0.

Results: Two complete HBV genomes, 3,215 base pairs in length, were successfully amplified. Phylogenetic analysis showed that the two women were infected with HBV genotype C1. Analysis of *surface* gene showed the presence of a mutation K141N. Although this mutation has been described as an immune escape mutation, the woman infected with this virus did not transmit HBV to her baby. No mutation related to drug resistant within the *polymerase* gene was observed. The mutation in *precore/core* gene was not found in both samples even one sample showed HBeAg-negative phenotype.

Conclusion: Whole genome sequencing provides complete information that may be useful for clinical outcomes and epidemiological perspectives.

KEYWORDS

Hepatitis B virus (HBV), Genetic diversity, HBV/HIV co-infection, Whole genome (Full-genome) sequencing, pregnant woman

INTRODUCTION

Hepatitis B virus (HBV) belongs to the *Hepadnaviridae* family. It is a small DNA virus with approximately 3.2 kb partially double stranded circular DNA genome. This compact genome consists of four overlapping open reading frames (ORFs) (1) including *polymerase (P)*, *preS/S*, *precore/core (preC/C)* and *X* region. HBV replicates by reverse transcriptase, a viral enzyme which lacks proofreading activity; hence, incorrect bases incorporation are more occur than other DNA viruses. HBV has a high viral production, which is up to 10^{11} virions per day and high mutation rate with an

estimated of $1.4-3.2 \times 10^{-5}$ nucleotides substitutions per site per year (2). This unique life cycle leads to a heterogeneous viral population. HBV variants which can survive under endogenous pressure (host immune system) and exogenous pressure (anti-viral treatment and vaccination) are the predominant. Thus, HBV variants are related to immune response and response to treatment. HBV can be divided into 10 genotypes (3-8) based on a divergence of $\geq 8\%$ in the complete genomic sequence. HBV genotypes have a distinct geographical distribution worldwide. In Thailand, HBV genotype C and B are the 2

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predominant genotypes, accounting for 54-91% and 7-24%, respectively (9-12).

Impact of HBV genetic diversity, i.e. genotype, subtype and mutations, has been related to diagnostic assay detection problems (13, 14), failure to hepatitis B vaccination (15, 16), response to antiviral therapy (17), disease progression and long-term clinical outcomes (18-20). Several studies suggested the impact of specific mutations of the 4 ORFs related to clinical outcome. For example, in *core* region, substitution of thymine to cytosine at nucleotide 1753 (T1753C) and double mutation A1762T/G1764A have been associated with a decrease of HBeAg expression (21-23) and lead to a high risk of cirrhosis (24). In *surface* region, glycine at position 145 was substituted by arginine or lysine or alanine (sG145R/K/A) has been widely reported as vaccine escape mutant, which can infect vaccinated individuals (15, 16). Amino acid substitution in the reverse transcriptase region of the polymerase gene, rtM204I/V/S, is known to be associated with lamivudine resistance (25). Due to the overlapping between polymerase and surface genes, mutations in polymerase will effect to surface gene encoding. The mutation rtA181T in the polymerase gene results in a stop codon at amino acid position 172 in the overlapping *S* region (sW172*). This mutation was reportedly associated with an oncogenic role leading to hepatocellular carcinoma (HCC) (26).

Hepatitis B virus and human immunodeficiency virus (HIV-1) infections are the major public health concerns, particularly in Southeast Asia (27). Co-infection of HBV and HIV has been common due to shared routes of transmission, e.g. perinatal transmission, contact with infectious fluid, and sexual exposure (28). HIV infection has a significant impact on HBV infection in terms of natural progression (29) and genetic diversity (30). In some particular condition, pregnancy may have an impact on HBV replication due to hormones produced and immune changes. However,

there has been some controversial information of pregnancy on HBV (31, 32). To date, data on HBV genetic diversity among HBV/HIV co-infected pregnant women is limited. This study aimed to demonstrate the possibility of performing a whole genome HBV sequences among HBV/HIV co-infected pregnant women. These preliminary data provide a better knowledge of HBV whole genome sequence that circulates in this population.

METHODOLOGY/EXPERIMENTAL DESIGN

Sample

Two plasma samples of HIV/HBV co-infected pregnant women from the perinatal HIV prevention trial (PHPT) were used (39). HBV DNA levels were previously quantified by the COBAS Amplicor HBV monitor test (Roche Diagnostics) or Abbott real-time HBV DNA™ assay (Abbott laboratories) (33).

HBV DNA amplification and sequencing

HBV DNA was extracted from 200 µL of plasma samples using Abbott Molecular's m2000sp sample extraction automation (Abbott Molecular Inc., IL, USA). Full-length HBV genome was amplified by PCR using primers P1-F and P2-R, as shown in Figure 1 and Table 1 (34). For each reaction, the total volume was 50 µL, containing 10 µL DNA template and Platinum Taq DNA polymerase high fidelity reaction mix (Invitrogen). Amplification conditions were as follows: 94°C for 2 min, followed by 40 cycles consists of denaturation at 94°C for 40 sec, annealing at 60°C for 90 sec and extension at 68°C for 3 min with an increment of 12 second per PCR cycle. All PCR products were purified using E.Z.N.A. Cycle Pure Kit (Omega Bio-Tek, Norcross, GA). Purified PCR products were applied to sequence with the set of HBV specific primers, as shown in Table 1 (34, 35) and BigDye Terminator Mix V. 3.1 reagents (Applied Biosystems, Foster

city, CA) using the ABI 3100 genetic analyzer (Applied Biosystems, Foster city, CA).

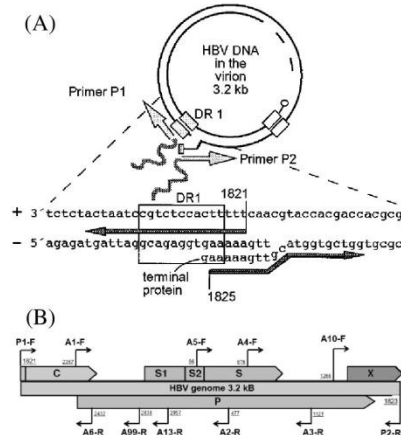


Figure 1 (A) Primers used for whole HBV genome amplification and sequencing, (B) primer binding sites of each specific primer used in HBV genome sequencing.

Table 1 The set of HBV specific primers

Primer name	Nucleotide position	Nucleotide sequence	Ref.
P1-F	1821 - 1841	CCG GAA AGC TTG AGC TCT TCT TTT TCA CCT CTG CCT AAT CA	(34)
P1-R	1823 - 1806	CCG GAA AGC TTG AGC TCT TCA AAA AGT TGC ATG GTG CTG G	(34)
A1-F	2357 - 2380	GGC AGG TCC CCT AGA AGA AGA ACT	(34)
A2-R	477 - 455	GGA CAA ACG GGC AAC ATA CCT TG	(35)
A3-R	1121 - 1100	AGA AAG GCC TTG TAA GTT GGC G	(35)
A4-F	676 - 699	TTT ACT AGT GCC ATT TGT TCA GTG	(35)
A5-F	66 - 90	GCT CCA GTT CAG GAA CAG TAA ACC C	(35)
A6-R	2432 - 2408	ATT GAG ATC TTC TGC GAC GCG GCG A	(35)
A10-F	1266 - 1286	CCA TAC TGC GGA ACT CCT AGC	(34)
A13-R	2957 - 2935	TTG GGA TTG AAG TCC CAA TCT GG	(34)
A99-R*	2838 - 2814	CTT GTT CCC AAG AAT ATG GTG ACC C	-

*Unpublished primers were designed to sequence *pol* gene using primer design software

RESULTS AND DISCUSSION

Two HBV/HIV co-infected pregnant women were initially selected in this preliminary study. First woman (0496) was 22 years old and another (0675) was 27 years old at enrollment. CD4+ T-cell count were 500 and 250 cells/mm³ and HBV DNA levels were 5.68 log₁₀ and 7.84 log₁₀ IU/ml in woman 0496 and woman

Sequence Analysis

Complete reference genome sequences were collected from GenBank database (National Center for Biotechnology Information, Bethesda, MD) and HBVdb: Hepatitis B Virus Database (<https://hbvdb.ibcp.fr>) and aligned using the ClustalW method in BioEdit software version 7.2.5. The phylogenetic analysis was performed using whole genome sequences of the analyzed samples and HBV reference sequences. Phylogenetic tree was constructed using neighbor-joining tree method in Molecular Evolutionary Genetics Analysis (MEGA) software version 6.0 (The Biodesign Institute, Tempe, AZ). HBV genotyping and mutations in polymerase and surface regions were identified using a web-based analysis tools, HIV-grade: HBV-resistance interpretation tool (www.hiv-grade.de).

0675, respectively. The woman 0496 was negative for HBeAg while woman 0675 was positive. HIV viral load were 4.49 log₁₀ and 5.01 log₁₀ copies/mL in woman 0496 and woman 0675, respectively.

The two complete HBV genomes, 3,215 basepairs in length, were successfully amplified and analyzed (Fig.2). Using a web-based analysis tool,

the viruses from both women were identified as genotype C, which is a genotype predominantly found in Thailand. The previous study, in 1998 by Theamboonlers, A. *et. al.* reported that genotype C (54.4%) was dominated over B (23.5%) by nested PCR and sequencing of the “a” determinant in surface gene in wide-range HBV-infected population (12). In addition, the study among voluntary blood donors in 2006 found that genotype C was highly predominant (89.3%) and

genotype B was only 7.4% (9). Also, in the recent study of Louisirirotchakul, S. *et. al.* in 2012 found that 87.5% of genotype C and 10.5% of genotype B based on surface gene sequences (11). Our result was confirmed by phylogenetic analysis, the two genomes were clustered together with genotype C sequences collected from Thailand and Myanmar and HBV subgenotype C1 (Fig. 3), suggesting that these two women were infected with HBV genotype C1.

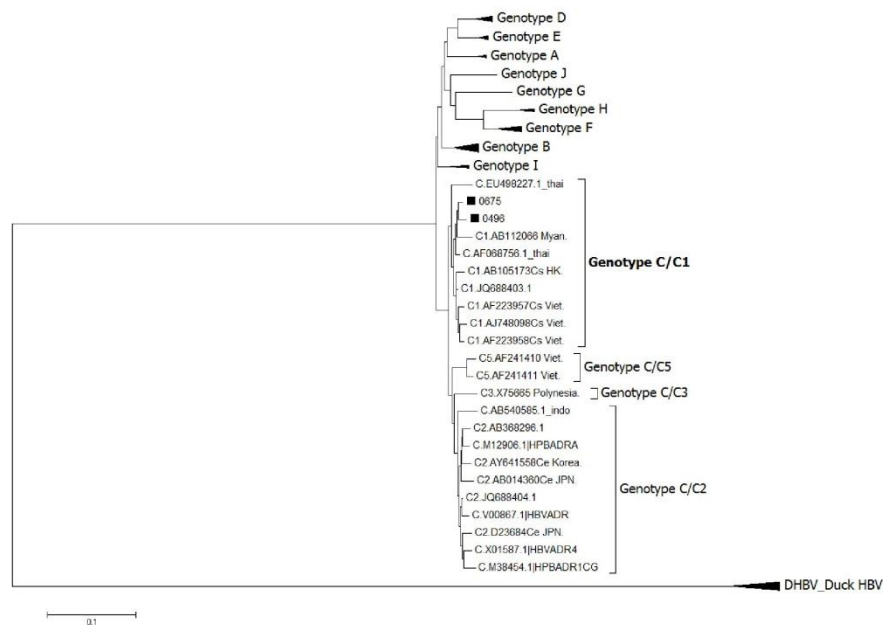


Figure 3 Phylogenetic analysis of the HBV strains isolated compared with 46 reference sequences on the basis of full genome sequence

Hepatitis B surface antigen (HBsAg) contains the major epitopes that localized in the region known as the “a” determinant, which is the target for neutralizing antibody produced during natural infection or following vaccination. Mutations of HBsAg have been associated to clinical aspects of HBV infection. We observed that the woman 0496 had only one substitution

within the “a” determinant, from lysine to asparagine at the position 141 (sK141N), as shown in Figure 4. In the previous study, this mutant was also found in HBV infected children despite vaccinated with hepatitis B vaccine suggesting that this mutation may play an important role in immune escape (36). However, in this study, these two women did not transmit

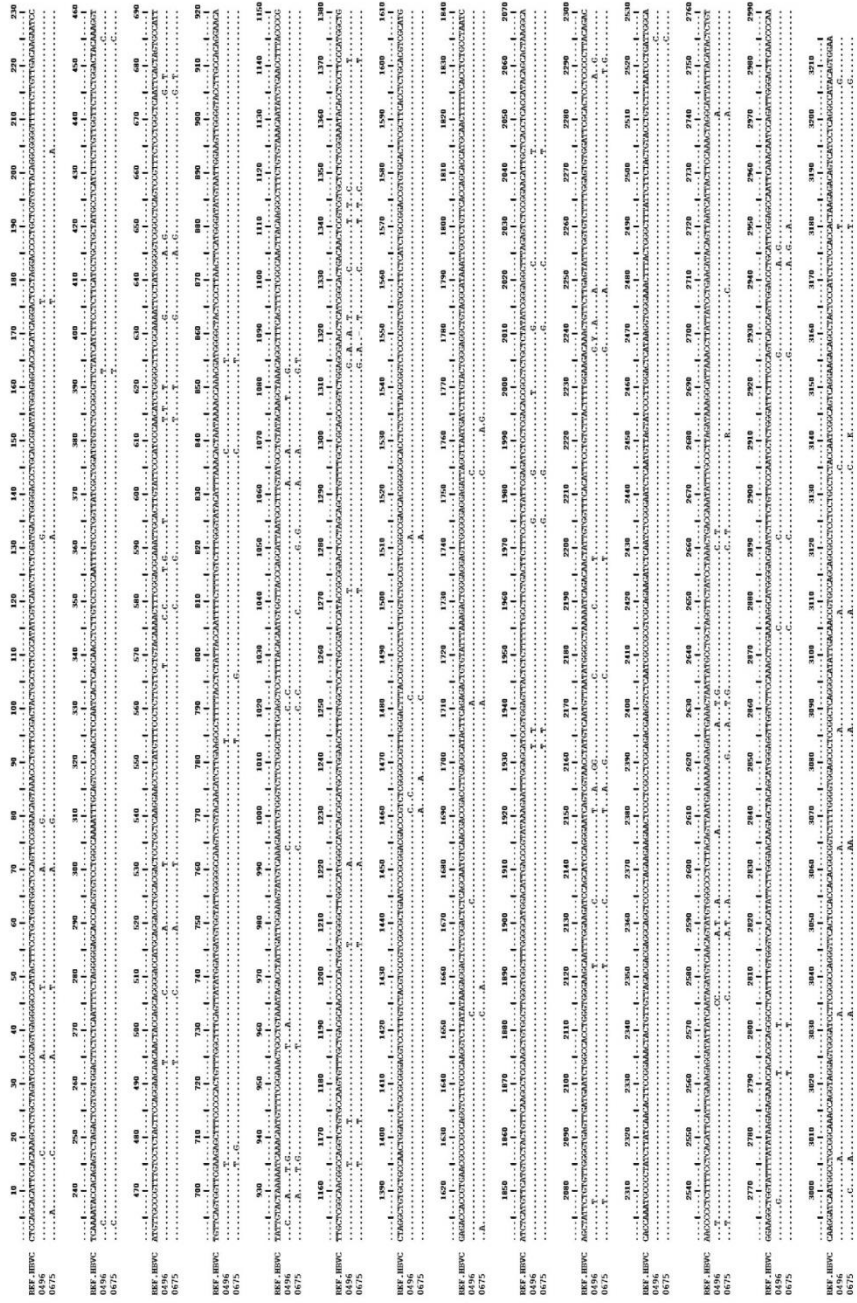


Figure 2 Whole genome HBV sequences (3,215 base pairs in length)

either HBV or HIV to their baby although one woman was infected with sK141N HBV mutant.

	120	130	140	150
Reference
0496	PGTSTTSTGPKCTCTIPAGQTSMEFSPCCCTKPSDGNCTCIPSPS			
0675

Figure 4 Amino acid sequence of the “a” determinant region of HBsAg

Selection of antiviral therapy is critical issue in management of HIV/HBV co-infection. Several available anti-HIV drugs are also active against HBV and can lead to drug-resistant HBV. Lamivudine (3TC) widely uses as an oral therapy for chronic HBV infection. Drug resistance mutations are usual with prolonged 3TC therapy (37). Recent study showed that the prevalence of 3TC mutants were 5.5% in naïve HBV/HIV individuals who has never experienced to any antiviral drugs (38). This present data, amino acid substitution in the polymerase gene which related to antiviral resistance was not detected, indicating that these two women were not infected with drug-resistant HBV.

Furthermore, this study investigated the presence of mutation associated with HBeAg serological status. The A1762T and G1764A mutations in the basal core promoter (BCP) region and the G1896A mutation in the precore (PC) region are found commonly in HBeAg-negative patients (21-23). The mutation in BCP/PC region was not found in both two samples even the 0496 sample showed HBeAg negative phenotype.

The limitation of this study was a small number of samples analyzed. Further study with a larger sample sizes is needed to confirm the finding.

CONCLUSION

Current molecular methods allow us to better understand the genetic diversity of HBV that are associated with clinical outcomes and epidemiological perspectives. Identification of HBV genotype and specific mutations are useful in guiding treatment of chronic infection. In this study, whole genome HBV sequences of two HBV/HIV co-infected pregnant women were successfully sequenced in our setting. Therefore, further investigations are possible and necessary

to find out the patterns of HBV mutation in our country and Southeast Asia, particularly in HBV/HIV co-infected pregnant population.

ACKNOWLEDGEMENT

This study was supported by the National Research University Project under Thailand’s Office of the Higher Education Commission; National Institutes of Health, USA (grant numbers: 5 R01 HD 33326); Faculty of Associated Medical Sciences (AMS), CMU; the Institut de Recherche pour le Développement (IRD) UMI 174/ Programs for HIV Prevention and Treatment (PHPT), Chiang Mai, Thailand.

We thank the women who participated in this study; all members of Division of Clinical Microbiology, AMS, CMU; and UMI174/PHPT staffs for their help and contribution.

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