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Full Length Research Paper

Evaluation of liver fibrosis index calculated by strain elastography for assessment of liver fibrosis in chronic viral hepatitis

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The accurate measurement of the liver fibrosis is important for the decision in the treatment of chronic viral hepatitis. The various types of ultrasound elastography are relatively well studied. Transient elastography (TE) and shear wave elastography (SWE) are proven methods of assessment of liver stiffness and possess the properties of a prognostic indicator. In contrast to this method, the significance of strain elastography used to assess the degree of liver stiffness remains insufficiently established. In this study, RT elastography was conducted in 144 patients. 34 of them were with chronic viral Hepatitis C, 80 with chronic viral Hepatitis B and 30 healthy individuals as control group. The biomarkers APRI, Fibroindex, Forn's index, FIB-4, and Fibrotest were examined. In all patients outside of the control group, a liver biopsy was performed for histological evaluation of fibrosis. The RT-generated elastographic imaging was subjected to qualitative analysis by a specially developed program and the derived liver fibrosis index (LFI) was compared to histological and laboratory data. The value of LFI increases as fibrosis progresses. LFI is significantly different in the cases of moderate fibrosis (F0-2) and advanced fibrosis (F3, 4). LFI shows a good correlation in determining advanced fibrosis and good reproducibility of the results. LFI was found to be an independent prognostic factor in patients with chronic liver disease. Strain elastography can be used to determine advanced liver fibrosis without influence of hepatic inflammation, unlike other serology markers of liver fibrosis. RTE is probably a prognostic factor in chronic liver diseases.

Key words: Real-time liver elastography, strain liver elastography, liver stiffness.

INTRODUCTION

The assessment of liver stiffness is essential for the treatment of patients with chronic liver diseases. This is due to the fact that the stiffness caused by the progression of hepatic fibrosis is closely related to the prognosis of chronic liver diseases (National Institutes of Health Consensus Development Conference Statement, 2002). Liver biopsy is the gold standard in the assessment of liver fibrosis (Bravo et al., 2001). However, this is an invasive method that shows that there are possible shortcomings, such as errors in the procedures and variability in the results of different researchers (Maharaj et al., 1986; Regev et al., 2002). Therefore, considerable effort is being made to develop non-invasive markers that reflect liver stiffness. Different blood markers and serum models based on an algorithm, such as FIB4 or AST to Platelet Ratio Index (APRI) are used to assess the degree of hepatic fibrosis. Good outcomes of liver fibrosis prediction are then reported (Martínez et al., 2011). However, similar blood markers may be affected by a variety of factors, regardless of whether or not there is relation to the liver (Ferraioli et al., 2015).

On the other hand, elastography can be developed as a procedure that is able to assess the stiffness of the liver in a non-invasive way. Most of the methods are costly and special equipment is required for their application. In contrast, RTE can be performed by using a conventional ultrasonic probe during a routine ultrasound scan and RTE has proven effectiveness even in patients with ascites (Hirooka et al., 2011). Several studies also show the effectiveness of RTE in the assessment of hepatic fibrosis in patients with chronic liver diseases (Koizumi et al., 2011; Ochi et al., 2012; Shiraishi et al., 2014; Yada et al., 2013). RTE is considered to be a relatively efficient and easy to apply method, but further studies are still needed to provide more evidence and to introduce a standardized method of study(Ferraioli et al., 2015; Kan et al., 2015).

In this study, we assessed the effectiveness of RTE in a contingent of patients with varying degrees of hepatic fibrosis.

METHODOLOGY

Patients

144 patients were examined for the period from 2013 to 2016 that attended the Gastroenterology Clinic at University Hospital Kaspela. 34 were with chronic viral Hepatitis C, 80 with chronic viral Hepatitis B and 30 healthy individuals as control group. For all patients, serological tests for non-invasive biomarkers and RT elastography were performed. This was followed by a liver biopsy. These procedures were conducted within 2 days. A liver biopsy was not performed within healthy individuals. The chronic viral hepatitis was proved by the presence of viral markers HBsAg, Anti-HBcore TOTAL or Anti-HCV in patients that entered the Clinic at least 6 months after the first positive findings.

The control group consisted of healthy individuals with normal levels of liver enzymes, negative viral markers, no medical history of cardiac, pulmonary and neoplastic diseases, and no excessive alcohol intake (up to 15 g of pure alcohol/day on average monthly). This retrospective study has been approved by the institutional ethics committee. Written informed consent was obtained by all patients that participated in this study.

Measuring the stiffness of the liver

An Aloka Alpha 7 ultrasound system, Hitachi-Aloka, Japan, with an additional elastography module installed, was used for the assessment of liver stiffness by RTE. The transducer model was UST-5412, 5-13 MHz. The reception of RT elastogram was in accordance with the manufacturer's protocol and the guidelines published by the World Federation for Ultrasound in Medicine and Biology (WFUMB; Ferraioli et al., 2015). The transducer was placed in the right intercostal space around the 5-8 rib between the front and the middle axillary line. The patients were examined in a lying position, with the right hand raised above the head. The depth of the study was between 20 and 50 mm, with an area of 350 to 500 mm^2. The results are assumed to be exact at a pressure value of 3-4 in green color at a scale of 0 to 6. Liver Fibrosis Index /LFI/ presented by Fujimoto et al. (2013) was used for the comparison of the RTE images.

Histological assessment of liver stiffness

Disposable biopsy guns with tru-cut needle 16 Ga, 22 mm biopsy length, were used for histological assessment of hepatic fibrosis. The right lobe in the intercostal space was biopsied under ultrasound control after evaluation for the safest and best access. The biopsy was evaluated to be successful in histological data for the presence of at least 5 portal spaces. The histological staging of the degree of fibrosis was calculated using the Metavir scoring system (Bedossa et al., 2003).

Other markers for assessment of liver stiffness

We used the biomarkers APRI, Fibroindex, Fibroscore, Forn's index, FIB-4 and Fibrotest, for the calculation of which Alfa 2 Macroglobuline, Haptoglobin, Apolipoprotein A1, GGT, ASAT, ALAT, total bilirubin, platelets, cholesterol and fasting glucose were examined. Data was collected for age, gender and BMI of the patients. The blood samples were taken on the same day of the RTE.

Statistical analysis

Statistical analysis data obtained from the patients was collected in a Microsoft Excel file. For a statistical study of quantitative variables, the mean and standard deviations were calculated. The diagnostic performances of liver stiffness measurements and of the serologic tests were assessed by using the area under the receiver operating curve (AUROC). ROC curves were thus built for the detection of significant fibrosis (F ≥ 2 Metavir) and cirrhosis (F4). Optimal cut-off values were chosen to maximize the sum of sensitivity (Se) and specificity (Sp). Positive predictive values (PPV), negative predictive values (NPV), and positive likelihood ratios (+LR) were also assessed. We calculated 95% confidence intervals (CI) of the AUROC curves to compare their predictive values. We also evaluated the correlation between the non-invasive tests and the histological severity of fibrosis. Statistical analysis was performed using Microsoft Excel and SPSS software, version 19.0 (SPSS).

Table 1. Correlation between laboratory parameters and RTE.

Parameter	RT Elastography	Fibrotest	APRI	Fibroindex	Forns index	FIB-4 score
Correlation Coefficient	1.000	0.552	0.273	0.420	0.434	0.385
Sig. (2-tailed)	.	0	0.014	0	0	0

Table 2. Correlation between histology results and RTE.

Stage	Area	Std. Error	Sig.	95% Confidence Interval	
				Lower Bound	Upper Bound
F1	0.310	0.058	0.005	0.197	0.423
F2	0.593	0.062	0.276	0.471	0.715
F ≥3	0.962	0.020	0.000	0.922	1.001

Table 3. Comparison between work and control groups

Parameter	Group	N	Mean	Std. Deviation	Std. Error Mean	u	P
Elastography	Work	80	20.34	9.06	1.01	3.25	<0.01
	Control	30	16.36	3.78	0.68		
APRI	Work	80	0.25	0.23	0.02	5.73	<0.001
	Control	30	0.09	0.03	0.01		
Fibroindex	Work	80	1.09	0.62	0.07	3.28	<0.01
	Control	30	0.74	0.42	0.08		
Forns' index	Work	80	5.17	2.00	0.22	1.60	>0.05
	Control	30	4.66	1.23	0.23		
Fib-4	Work	80	1.75	1.48	0.16	1.75	>0.005
	Control	30	1.40	0.62	0.11		
Fibrotest	Work	80	1.22	1.11	0.12	4.06	<0.001
	Control	30	0.57	0.57	0.10		

RESULTS

Correlation between the LFI value with histological assessment and biomarkers by diseases

Chronic viral Hepatitis B

Elastography/biomarkers: In the study of the relationship between the laboratory parameters and the Elastography, significant correlation dependence was found only in Fibrotest – 0.0552 (Table 1).

Elastography/biopsy: From the table presented we cannot interpret the results for F1 and F2. This is because, at the F1 stage the area under the curve is less than 0.50 and in the F2 stage there is no significance of the obtained result P = 0.276. In stage F ≥3, AUROC is 0.962 and the diagnostic value shows a threshold level of 24.96, a sensitivity of 100%, a specificity of 89%, a positive prognostic value of 70.8% and a negative prognostic value of 100% (Table 2).

The data presented shows that the study has high sensitivity and specificity values, which means that the test methodology has very good demarcation capabilities and can serve to identify the group of individuals with advanced fibrosis. The same applies to the positive and negative prognostic values. We divided the group into two according to the established threshold and we found that 70.8% of all those with values above 24.96 falls into stage F ≥3 and the others are in stages from F0 to F3. 100% of all at this stage were adequately recognized, which corresponds to the abovementioned sensitivity P<0.001 (χ^2 = 51.32; Table 3).

We established a difference between the two groups on all biomarkers tested, except for Forns index (Table 3). We searched for the relationship between the groups and the established thresholds for Elastography and the Fibrotest score. The entire control group had a value of less than 2 for the Fibrotest score P <0.05 (x^2 = 4.41) and over 24.96 for Elastography P <0.01 (x^2 = 7.90).

Table 4. Correlation between laboratory parameters and RTE.

Parameter	RT Elastography	Fibrotest	APRI	Fibroindex	Forns index	FIB-4 score
Correlation Coefficient	1.000	0.480	0.209	0.320	0.427	0.224
Sig. (2-tailed)	.	0.005	0.243	0.070	0.013	0.210

Table 5. Correlation between histology results and RTE.

		Elastography			95% Confidence Interval for Mean	
METAVIR	N	Mean	Std. deviation	Std. error	Lower Bound	Upper Bound
F0	13	13.44	4.13	1.14	10.95	15.94
F1	8	17.83	6.92	2.45	12.04	23.61
F2	6	21.16	7.64	3.12	13.14	29.17
F3	7	29.67	4.01	1.64	25.45	33.88
Total	34	18.86	7.97	1.39	16.03	21.69

Table 6. Comparison between work and control groups.

Group		Elastography		
		Upto 25.64	Over 25.65	Total
Work	count	26	7	33
	% within group	78.8%	21.2%	100%
Control	count	19	0	19
	% within group	100%	0%	100%
Total	count	45	7	52
	% within group	86.5%	13.5%	100%

Chronic viral Hepatitis C

Elastography/biomarkers: We established a moderate correlation between Elastography and the Fibrotest score P <0.01 (r = 0.480) and between Elastography and the Forns index P <0.01 (r = 0.427; Table 4).

Elastography/biopsy: It can be seen from the Table 5 that the increase in the degree of fibrosis also increases the Elastography values P<0.001 (F = 11.89). The difference is the most distinct between F0 and F3 stages (Table 5).

According to the fibrosis thresholds, the AUROC range from 0.50 (95% CI: 0.29 – 0.71) at ≥ F1, at F2 stage – 0.66 (95% CI: 0.46 – 0.86) and at F3 stage – 0.93 (95% CI: 0.83 – 1.02). However, a statistically significant result is only AUROC at F3 P<0.001, as the statistical error is relatively small – 0.047, which is an indicator of high reliability of the given test methodology. The results speak of good differentiation capabilities of the Real-Time Elastography in the advanced stage of fibrosis. Diagnostic accuracy of the Elastography at F3 stage showed a threshold level of 25.65, sensitivity of 83.3%, specificity of 93%, positive prognostic value of 71.4% and negative prognostic value of 96.2%. The data presented in F3 indicates that the study has high sensitivity and specificity values. This supports the test methodology in having very good differentiation capabilities and can serve to identify the group of individuals with advanced fibrosis.

Comparison between work and control groups (Table 6): There is a significant difference between the two groups P<0.05 (χ^2 = 4.66). All control groups fall into the group below the Elastography threshold of 25.64 (Table 6). This means that Elastography cannot be used and has no diagnostic value in relation to healthy individuals.

DISCUSSION

Within the present study, RTE has proved to be an effective tool in the determination of advanced liver fibrosis. Our results showed higher efficiency of RTE, compared to some blood biomarkers for fibrosis. In

previous studies for determination of liver stiffness with RTE, similar results occurred, indicating a good diagnostic benefit if an adequate procedure was performed. ROI with an area of 2.5 x 2.5 cm should be placed deeply in the liver capsule, by avoiding large vessels, in order to produce homogeneous images (Fujimoto et al., 2013; Hiroyasu et al., 2011; Tatsumi et al., 2010; Yada et al., 2013). Our study was also conducted with the purpose to include a sufficient volume of the hepatic parenchyma according to the RTE guidelines. Our results were comparable to other studies due to the fact that the LFI used as an indicator in this study displayed good correlations with histologically proven fibrosis and other markers for fibrosis. The results suggest that LFI is unable to fully differentiate between mild, moderate and advanced stage of liver fibrosis. The RTE method is capable of assessing liver fibrosis without being affected by inflammatory processes of the liver and jaundice (Ferraioli et al., 2015). RTE can be used in patients with ascites (Hirooka et al., 2011) and can be a suitable method for determining advanced liver fibrosis.

This study contains several limitations. First of all, the LFI indicator used in this study for determination of liver stiffness is a relative assessment. Until now, there is no unified opinion on the use of a particular algorithm. In the European guidelines for the application of Elastography, there is a proposal for the implementation of further studies on RTE (Cosgrove et al., 2013; Sporea et al., 2014). It is necessary for a standardized analytical method for RTE in future large scale multicenter studies to be defined, bur for sure LFI is able to determine advanced fibrosis in HCV and HBV patients. The successful RTE depends on the clarity of the B-mode images (Yada et al., 2013). In the case of patients with HBV infection, a high degree of irregularity of the hepatic parenchyma is detected in B-mode (Daiki et al., 2003), which may have some impact on LFI upon HBV. Further studies are needed in the case of HBV.

In conclusion, our study has demonstrated that the RTE method with the application of LFI can accurately and reliably determine an advanced stage of liver fibrosis.

Statement

The authors declare no conflict of interests.

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