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ESTADUAL DE LONDRINA

WESLEY LADEIRA CAPUTO

**GENES DIFERENCIALMENTE EXPRESSOS NO
CARCINOMA HEPATOCELULAR: ABORDAGEM IN SILICO
PARA O REPOSICIONAMENTO DE FÁRMACOS**

Londrina
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Dissertação apresentada ao Programa de Pós-Graduação em Patologia Experimental da Universidade Estadual de Londrina, como requisito parcial para obtenção do título de mestre em Patologia Experimental.

Orientador: Prof. Dr. Fábio Rodrigues Ferreira Seiva

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**“Go down in your own way
And every day is the right day
And as you rise above the fear lines in his
brow
You look down, hear the sound of the faces
in the crowd”
(LATIMER, Andrew).**

RESUMO

CAPUTO, Wesley Ladeira Caputo. **Genes diferencialmente expressos no carcinoma hepatocelular: abordagem *in silico* para o reposicionamento de fármacos.** 2023. 91f. Dissertação (Mestrado em Patologia Experimental) – Universidade Estadual de Londrina, Londrina, 2023.

O reposicionamento de medicamentos é uma estratégia que complementa a abordagem convencional no desenvolvimento de novos fármacos. O carcinoma hepatocelular (CHC) é uma doença prevalente e agressiva, necessitando de uma compreensão mais detalhada das alterações moleculares envolvidas para o tratamento adequado. Nesse estudo, buscamos em banco de dados experimentais de microarray e RNA-seq por genes diferencialmente expressos (DEGs) em células de CHC e saudáveis. Por meio de distintos processos de filtragem, identificamos e enriquecemos DEGs, bem como classes distintas de possíveis novos medicamentos capazes de atuar sobre esses genes. A análise de enriquecimento funcional revelou características biológicas distintas: Processos químicos associados a íons metálicos, incluindo zinco, cádmio e cobre, potencialmente implicando exposição crônica a íons metálicos na tumorigenese, foram eventos associados aos genes que estão regulados negativamente no CHC. Por outro lado, genes regulados positivamente foram associados com eventos mitóticos e atividades de quinase, alinhando-se com a relevância das quinases no CHC. Para investigar redes de interação entre os DEGs, empregamos métodos de análise topológica, identificando 25 genes centrais e seus fatores de transcrição. Na busca de potenciais opções terapêuticas, exploramos estratégias de reaproveitamento de medicamentos com base em abordagens computacionais, analisando seu potencial para reverter os padrões de expressão de genes-chave, incluindo AURKA, CCNB1, CDK1, RRM2 e TOP2A. Potenciais candidatos farmacológicos foram alvocidib, AT-7519, kenpaullone, PHA-34 793887, JNJ-7706621, danusertiba, doxorubicina e análogos, mitoxantrona, podofilox, teniposide e amonafide. Este estudo *in silico* ofereceu uma visão abrangente dos DEGs no CHC, lançando luz sobre potenciais alvos terapêuticos como os genes CDK1, RRM2 e TOP2A e oportunidades para experimentações futuras com o reposicionamento de medicamentos.

Palavras-chave: câncer de fígado; reaproveitamento de medicamentos; genes drogáveis; expressão reversa; bioinformática.

ABSTRACT

CAPUTO, Wesley Ladeira Caputo. **Comprehensive profiling and therapeutic insights into differentially expressed genes in hepatocellular carcinoma. 2023.** 53f. Dissertação (Mestrado em Patologia Experimental) – Universidade Estadual de Londrina, Londrina, 2023.

Drug repurposing is a strategy that complements the conventional approach of developing new drugs. Hepatocellular Carcinoma (HCC) is a highly prevalent and aggressive liver cancer, necessitating an in-depth understanding of the underlying molecular alterations for improved treatment. methods: we searched for a vast microarray experiment in addition to Rna-seq data. Through rigorous filtering processes, we have identified highly representative differentially expressed genes (DEGs) between tumor and non-tumor liver tissues and identify distinct class of possible new candidate drugs. Functional enrichment analysis revealed distinct biological processes associated with metal ions, including zinc, cadmium, and copper, potentially implicating chronic metal ion exposure in tumorigenesis. Conversely, up-regulated genes are associated with mitotic events and kinase activities, aligning with the relevance of kinases in HCC. To unravel the regulatory networks governing these DEGs, we employed topological analysis methods, identifying 25 hubs genes and their regulator transcription factors. In the pursuit of potential therapeutic options, we explored drug repurposing strategies based on computational approaches, analyzing their potential to reverse the expression patterns of key genes, including AURKA, CCNB1, CDK1, RRM2, and TOP2A. Potential therapeutic chemicals are alvocidib, AT-7519, kenpauillone, PHA-793887, JNJ-7706621, danusertibe, doxorubicin and analogues, mitoxantrone, podofilox, teniposide, and amonafide. This multi-omic study offers a comprehensive view of DEGS in HCC, shedding light on potential therapeutic targets and drug repurposing opportunities.

Keywords: liver cancer; drug repurposing; druggable genes; reverse expression; bioinformatic.

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LISTA DE ABREVIATURAS E SIGLAS

AAD	Terapia Antiviral de Ação Direta
AKT/mTOR	Proteína Quinase B/ Alvo de Rapamicina
AkT/mTOR	Proteína Quinase B/Alvo de Rapamicina
ANLN	Anilina, proteína de ligação à actina
ASPM	Fator de Montagem para Microtúbulos Fusiformes
AT-7519	Inibidor Seletivo de Proteína Quinase dependente de Ciclina
AURKA	Aurora Quinase A
BRAF	Proto-oncogene B-Raf, Serina/Treonina Quinase
BUB1B	Ponto de Verificação mitótico BUB1 Serina/Treonina Quinase B
CCNA2	Ciclina A2
CCNB1	Ciclina B1
CCNB1-Cdk1	Ciclina B1/ Ciclina dependente de Quinase 1
CCNB2	Ciclina B2
CDC	Centro de Controle e Prevenção de Doença
CDK1	Proteína Quinase Dependente de Ciclina 1
CDKN3	Inibidor de Quinase Dependente de Ciclina 3
CDKs	Quinases Dependentes de Ciclina
CEP55	Proteína Centrossomal 55
CHC	Carcinoma Hepatocelular
CMap	Mapa de Conectividade
c-Myc	Proto-oncogene Myc
CTNNB1	Proteína Beta Catenina 1
DAVID	Banco de dados para anotação, visualização e descoberta integrada

(Database for Annotation, Visualization and Integrated Discovery)

DHGNA	Doença Hepática Gordurosa Não Alcoólica
DNA	Ácido Desoxirribonucleico
DTL	Homólogo da Proteína Ligase da Ubiquitina E3
E2F1	Fator de Transcrição E2F 1
E2F3	Fator de Transcrição E2F 3
E2F4	Fator de Transcrição E2F 4
ECT2	Célula Epitelial Transformadora 2
ETV4-uPAR	Via de Sinalização ETV4-uPAR
FDA	Administração de Alimentos e Medicamentos
FGFR	Fator de Crescimento de Fibroblastos
GCN	Rede de Co-expressão Gênica
GCO	Observatório Global do Câncer
GDEs	Genes Diferencialmente Expressos
GEO	Expressão genética <i>Omnibus</i> (<i>Gene Expression Omnibus</i>)
GEO2R	Expressão genética <i>Omnibus 2 R</i> (<i>Gene Expression Omnibus 2 R</i>)
GSE	Banco de Dados de Eventos Espaciais Genômicos
GSEA	Análise de Enriquecimento de Conjunto Genético
GTEx	Expressão Genótipo-Tecido (<i>Genotype-Tissue Expression</i>)
GWAS	Integração de Dados de Estudos de Associação Genômica Ampla
HGFR	Fator de Crescimento de Hepatócitos
HMMR	Receptor de Motilidade Mediado por Hialuronano
JAK/STAT	Janus Quinase/Transdutor de Sinal e Ativador de Transcrição
JNJ-7706621 CDK1/CDK2	Inibidor Seletivo de Proteína Quinase dependente de Ciclina
KIF20A	Membro da Família Cinesina 20A

KIF4A	Membro da Família Cinesina 4A
LINCS	Biblioteca de Assinaturas Celulares Baseadas em Rede
MAPK	Proteína Quinase Ativada por Mitogênio
miR-144	Micro RNA 144
mRNA	RNA mensageiro
mTOR	Proteína de Mamíferos Alvo da Rapamicina
NCAPG	Subunidade G do Complexo de Condensina I
NEK2	Quinase 2 Relacionada ao NIMA
Notch 1	Receptor Notch 1
OCTAD <i>Discovery</i>	Descoberta Terapêutica do Câncer (<i>Open Cancer Therapeutic Discovery</i>)
OMS	Organização Mundial da Saúde
PBK	Quinase de Ligação PDZ
PDGFR	Receptor Beta do Fator de Crescimento Derivado de Plaquetas
PHA-34 793887	Inibidor Seletivo de Proteína Quinase dependente de Ciclina CDK2/CDK5/CDK7
PI3/AKT	Fosfatidilinositol 3-quinase putativo/ Proteína Quinase B
PI3K	Fosfatidilinositol 3-quinase putativo
PRC1	Regulador Proteico da Citocinese 1
RACGAP1	Proteína Ativadora Rac GTPase 1
RAS-MAPK	Proteína Quinase RAS Ativada por Mitogênio
RM	Ressonância Magnética
RRM2	Subunidade Reguladora do Ribonucleotídeo Redutase M2
SHARP	Protocolo Randomizado de Avaliação
TC	Tomografia Computadorizada
TCGA	O Atlas do Genoma do Câncer (<i>The Cancer Genome Atlas</i>)

TERT	Transcriptase Reversa da Telomerase
TFs	Fatores de Transcrição
TOP2A	DNA Topoisomerase II Alfa
TP53	Proteína Tumoral p53
VEGFR	Fator de Crescimento Endotelial Vascular
VHB	Vírus da Hepatite B
Wnt	Via de Sinalização Wnt
ZWINT	Proteína Cinetocoro Interagindo ZW10

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1 CAPÍTULO I: Revisão Bibliográfica

1.1 O CARCINOMA HEPATOCELULAR EM NÚMEROS

Dentre os tipos de cânceres com altas taxas de mortalidade, o câncer de fígado ocupa o quarto lugar em escala global (VILLANUEVA, 2019.; SUNG *et al.*, 2021), com 905.677 novos casos sendo diagnosticados no ano de 2020 (GCO, 2020; WHO, 2020). Dados da *National Center for Health Statistic* (NCHS) apontaram que a taxa de óbitos por câncer de fígado em 2020 foi de cerca de 830.180 pacientes (CDC, 2020; WHO, 2020). De acordo com a World Health Organization (WHO) em 2020, o continente Asiático possuiu a maior taxa de incidência de casos de câncer de fígado (49.3%), seguido do continente Europeu (22.8%) e continente Norte Americano (13.3%), enquanto as menores porcentagens foram observadas no continente Latino-americano (7.6%), África (5.7%) e Oceania (1.3%).

Os dados a respeito da incidência e mortalidade do câncer de fígado no Brasil são pouco homogêneos. Por exemplo, segundo a *Global Cancer Observatory* (GCO), a incidência de novos casos de câncer de fígado no nosso país, no ano de 2020, foi de 12.674 casos, ocupando a décima posição dentre os tipos de cânceres com maior incidência (GCO, 2020; WHO, 2020; CHOI *et al.*, 2023). Desse total, vieram a óbito cerca de 12.139 indivíduos (~96%), colocando o câncer de fígado na sétima posição de cânceres mais letais em 2020, no Brasil. Já de acordo com dados do Instituto Nacional do Câncer (INCA), a incidência de câncer de fígado, no biênio, 2020-2022, se mantém na 10ª posição (26.6%), porcentagem essa diluída com outros tipos de neoplasias (FERREIRA AND ANDRICOPULO 2020). Vale destacar que o câncer de fígado acomete cerca de 1.7 vezes mais o gênero masculino em comparação com o feminino (GCO, 2020; WHO, 2020). Nesse sentido, as estimativas do INCA para as taxas de mortalidade, para o biênio 2020-2022, colocaram o câncer de fígado na 6ª (5.3%) e 8ª (4.3%) posições, para homens e mulheres, respectivamente (Ferreira and Andricopulo 2020) (Figura 1). Dados sobre a tendência da mortalidade por câncer de fígado e vias biliares no Brasil, com estimativas até 2030 podem ser consultados em Cavalcante dos Santos, Gomes de Moraes Fernandes et al. (2020).

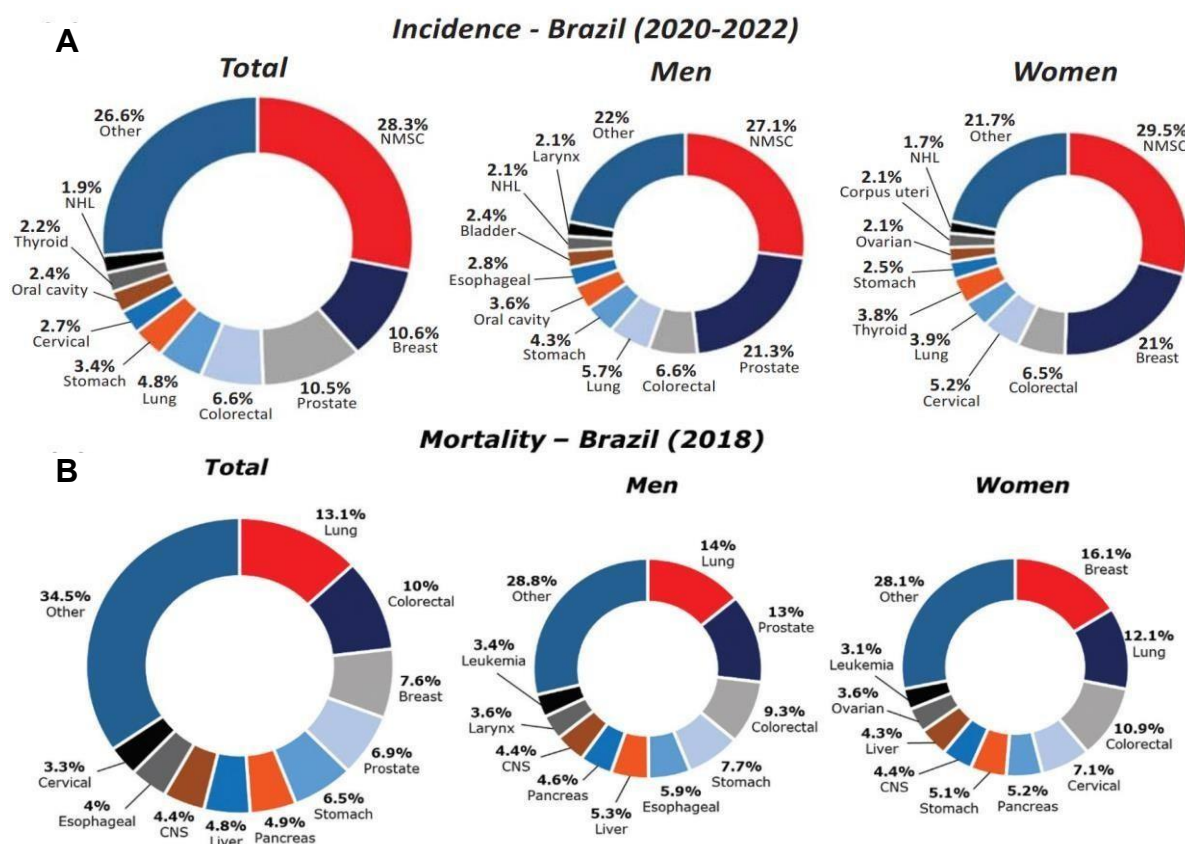


Figura 1 - Incidência e taxa de mortalidade dos 10 principais tipos de câncer no Brasil. **(A)** Incidência (%), para o biênio 2020-2022, separado por gênero; **(B)** Mortalidade (%) para o biênio 2020-2022, separado por gênero (Retirado e adaptado de FERREIRA e ANDRECOPULO, 2020).

1.2 ETIOLOGIA DO CARCINOMA HEPATOCELULAR

O Carcinoma Hepatocelular (CHC) é a forma mais comum de câncer de fígado, e tem como fatores etiológicos o uso excessivo de álcool, infecções pelo vírus da hepatite B ou C e a Doença Hepática Gordurosa Não Alcoólica (DHGNA) (ALBERTS *et al.*, 2022 SEIF *et al.*, 2022; PARK *et al.*, 2023). Aqui cabe destacar que o termo DHGNA vem sendo discutido e em 2020 foi proposto uma nova nomenclatura para a DHGNA, passando a ser reconhecida como doença hepática gordurosa metabólica (DHGM) ou “*Metabolic associated fatty liver disease (MAFLD)*” (Gofton, Upendran *et al.* 2023). O aumento da DHGM, acompanhada com síndrome metabólica e obesidade, são fatores amplificadores de risco para o CHC (CHUFFA *et al.*, 2022), a qual poderá se tornar a principal causa para o desenvolvimento do CHC em países ocidentais (YOUNOSSI *et al.*, 2019; CHON *et al.*, 2023). Ressalta-se também que diferenças de grupos étnicos e/ou raciais, apresentam um importante papel na probabilidade de sobrevivência após a identificação do tumor, sendo hispânicos e negros menos propensos do que brancos a suportar as ações tratativas, como

quimioterapias e radioterapias (RICH *et al.*, 2019).

A infecção pelo vírus da hepatite B é a principal causa do desenvolvimento de CHC (YUEN *et al.*, 2018). A vacinação contra o vírus da hepatite B reduz a incidência de CHC (CHANG *et al.*, 2009), entretanto, pessoas que não foram vacinadas, podem ser infectadas (257 milhões em 2015), estando, portanto, em risco de desenvolver CHC, principalmente, em regiões da Ásia e África (YUEN *et al.*, 2018). Em países ocidentais e no Japão, a causa principal de CHC é por infecção do vírus da hepatite C, após progressiva formação de fibrose hepática em estágio avançado (YOUNOSSI *et al.*, 2019).

O aumento da incidência do CHC, derivado da DHGM, é fator preocupante em países ocidentais, principalmente em pessoas com dieta baseada em altas taxas de carboidratos e gordura, como é o caso dos Estados Unidos (YOUNOSSI *et al.*, 2019). O comportamento alimentar inadequado, aliado ao sedentarismo, são fatores de risco para desenvolvimento e progressão da DHGM (ESTES *et al.*, 2018). Quando não diagnosticada, a disfunção dos hepatócitos pode progredir para cirrose hepática e assim, aumentar a probabilidade de desenvolver CHC (ESTES *et al.*, 2018; YOUNOSSI *et al.*, 2019). Acredita-se que a incidência de CHC nos Estados Unidos entre 2016 e 2030, aumentará em torno de 122% (ESTES *et al.*, 2018), de 5.510 para 12.240 casos. Vale destacar também, que o uso excessivo de álcool, tabaco e outros produtos tóxicos, podem contribuir para o desenvolvimento do câncer de fígado (VILLANEUVA, 2019) (Figura 2).

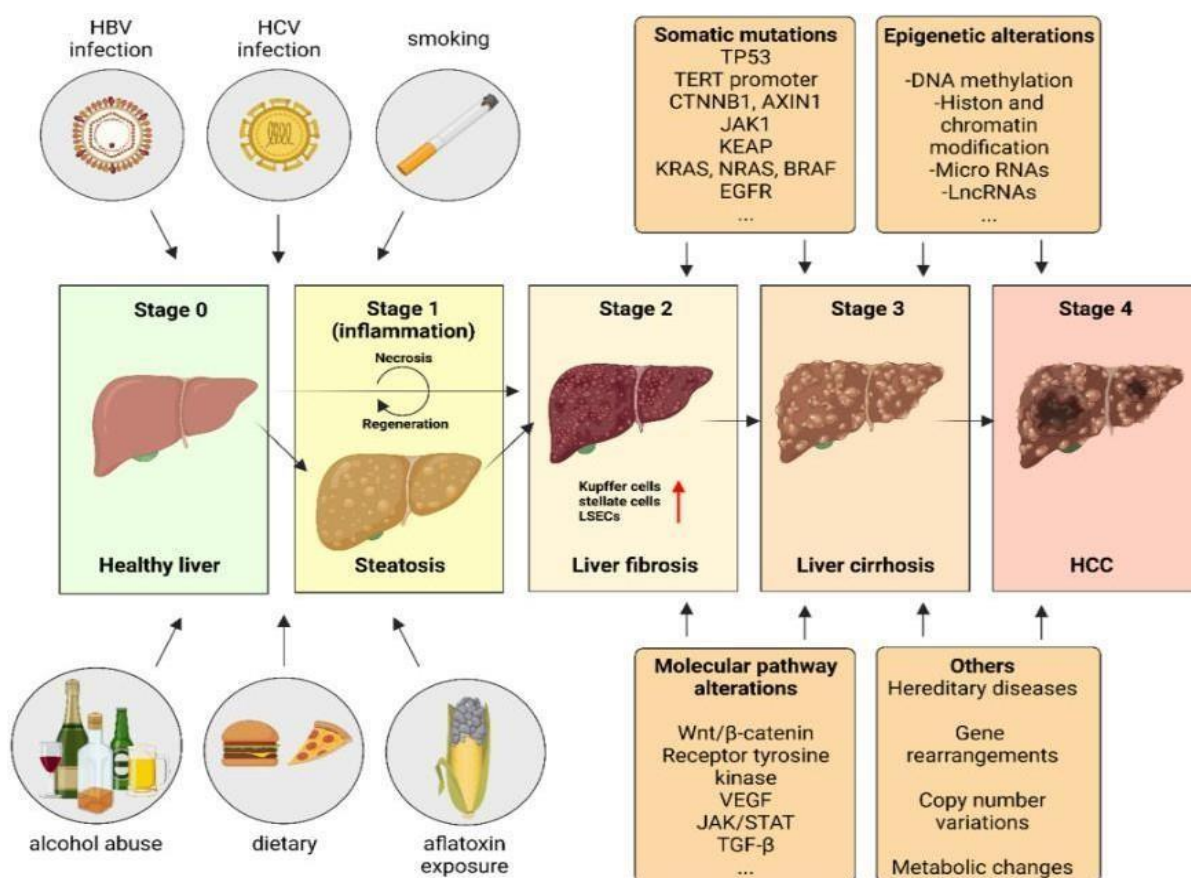


Figura 2 – Fatores de risco para a progressão e desenvolvimento do carcinoma hepatocelular (Retirado e adaptado de TUMEN *et al.*, 2020).

Indivíduos com doença hepática podem desenvolver inflamação hepática (hepatite), regeneração de hepatócitos anormais e fibrose hepática (YOUNOSSI *et al.*, 2019; PARK *et al.*, 2022), eventos que podem progredir para cirrose hepática. Associada à ocorrência de distintos eventos genéticos e epigenético, essa condição poderá induzir lesões pré-neoplásicas no tecido, como a formação de nódulos displásico (VILLANUEVA, 2019; ALBERTS *et al.*, 2022). Essas alterações promovem a migração, invasão, proliferação e vantagens na sobrevivência, culminado no processo de tumorigênese (CRAIG *et al.*, 2020; XU *et al.*, 2022).

Pacientes com CHC apresentam diferentes subtipos da doença, sendo classificados de acordo com alterações moleculares em subtipos proliferativo e não proliferativo (ZUCMAN *et al.*, 2015). A classe proliferativa é observada na infecção pelo vírus da hepatite B, a qual é identificada por altos níveis de alfa-fetoproteína, diferenciação celular alterada, mutações de TP53, instabilidade cromossômica e ativação de vias oncogênicas, como a RAS – MAPK (Rat Sarcoma - Proteína Quinase Ativada por Mitogênio), MAPK e mTOR (alvo de Rapamicina em Mamíferos)

(ZUCMAN, *et al.*, 2015; SIA, *et al.*, 2017). Os tumores da classe não-proliferativa, frequentemente apresentam mutações de CTNNB1 (beta catenina).

A via de sinalização Wnt / b-catenina regula o desenvolvimento embrionário, proliferação e diferenciação celular (VILCHEZ *et al.*, 2016), entretanto, também é um fator oncogênico presente no câncer de fígado. Em sequenciamento genômico de larga escala, mutações nos genes que codificam componentes dessa via, foram encontrados em cerca de 80% dos pacientes. Desta forma, o bloqueio e/ou prevenção da sinalização de Wnt / b-catenina pode diminuir o risco de câncer de fígado, bem como aumento da sobrevida do paciente (MOHAPATRA e CHANDRASEKARAN, 2022).

Cabe destacar por fim, que o microambiente tumoral também é fundamental para o desenvolvimento e progressão do câncer. O CHC é um complexo local que incorpora células não tumorais, como células do sistema imune e células circulantes (VILLANUEVA, 2011). Estima-se que 30% de casos de CHC identificados em estágios iniciais, possuem evidências de ativação do sistema imunológico (SIA, *et al.*, 2017; KOTSARI *et al.*, 2023).

1.3 A BIOINFORMÁTICA COMO FERRAMENTA NA ÁREA DA SAÚDE.

A bioinformática é uma área interdisciplinar que combina a biologia, informática e a estatística para lidar com grandes quantidades de dados biológicos. A análise desse tipo de dado é um dos principais desafios enfrentados em pesquisas das áreas da saúde e biológicas. A bioinformática fornece ferramentas e métodos computacionais para coletar, analisar e interpretar quantidades volumosas de dados, os chamados “big data” (PRUESS e APWEILER, 2003; KAUR *et al.*, 2020).

A análise de sequências de DNA e análise de expressão gênica são áreas importantes para bioinformática, pois podem ser usadas para identificar genes que estão envolvidos no desenvolvimento e progressão do câncer (WANG *et al.*, 2019). Além de identificar se estes genes estão diferencialmente expressos no câncer em comparação com amostras normais, os mesmos, podem ser utilizados para o desenvolvimento de terapias direcionadas e novos diagnósticos (AN NOORT *et al.*, 2014; YANG *et al.*, 2020; ZHANG *et al.*, 2020; PARRA *et al.*, 2023).

A busca, mineração e integralização dos conjuntos de dados de expressão gênica tumoral, fornecem meios para comparação de estudos semelhantes que já foram publicados. Dentre os objetivos desta metodologia, cita-se estabelecer uniformidade e verificar correlações, além de identificar os padrões e tendências de expressão gênica, conduzindo a descobertas e previsões mais precisas acerca de

candidatos a medicamentos para o tratamento do câncer (GUNDERSEN *et al.*, 2016). Atualmente, o avanço em pesquisas de proteômicas gera um alto influxo de informações a respeito das proteínas (LI *et al.*, 2020; SHARMA *et al.*, 2023), além disso as pesquisas de sequenciamento de nova geração são capazes de produzir um volume substancial de dados. Essas informações, por sua vez, necessitam ser armazenadas, curadas e organizadas, a fim de servir como base sólida para futuras pesquisas *in silico* (PRUESS e APWEILER, 2003; KAUR *et al.*, 2020; WANG *et al.*, 2021; PARRA *et al.*, 2023; SHARMA *et al.*, 2023).

A análise da expressão gênica com base na tecnologia de microarranjos é um método amplamente empregado, de alto rendimento e poderoso que permite a detecção simultânea de alterações na expressão de milhares de genes no nível do mRNA. Com base nesse perfil de expressão vários trabalhos identificaram diversos e distintos genes com expressão diferencial, os quais desempenham papel crítico na iniciação e progressão do CHC e podem ser considerados como potenciais alvos moleculares e marcadores de diagnóstico (ZHUANG *et al.*, 2018; YANG *et al.*, 2019; WANG *et al.*, 2022; FAN *et al.*, 2022; LEE *et al.*, 2023; LIU *et al.*, 2023).

Padrões de expressão gênica são valiosos recursos para o estudo e descoberta de potenciais alvos de drogas de cunho terapêutico em pacientes com câncer (CORSELLO *et al.*, 2020). Os perfis de expressão gênica em diferentes tipos de cânceres estão disponíveis para consulta e análise (WANG *et al.*, 2019), sendo possível reutiliza-los a partir de bancos de dados como *Gene Expression Omnibus* (GEO) e *The Cancer Genome Atlas* (TCGA) (WEISTEIN *et al.*, 2013; ZHU *et al.*, 2018). O perfil de expressão gênica em tecidos saudáveis também pode ser consultado no *Genotype-Tissue Expression* (GTEx) (<https://www.gtexportal.org/>) (CHEN *et al.*, 2022). Compreender a interação dos genes das amostras selecionadas é de suma importância quando se realiza análise comparativa de indivíduos com diferentes estados de saúde (CORSELLO *et al.*, 2020). Plataformas de enriquecimento de genes como Enrichr (KULESHOV *et al.*, 2016.; CARVALHO *et al.*, 2021.; JAWAID, 2023), e DAVID, são cruciais para análises *in silico* (CARVALHO *et al.*, 2021).

Por fim, é possível a integração de assinaturas gênicas com informações acerca dos efeitos de distintas drogas sobre a expressão gênica (CORSELLO *et al.*, 2017; ZENG *et al.*, 2021). Esse tipo de consulta e investigação pode ser feita em

plataformas como *Open Cancer Therapeutic Discovery* (OCTAD). A premissa nesse caso é que a atividade supressora ou inibidora de determinado composto em genes específicos (CORSELLO *et al.*, 2020), fornecerá uma base importante para identificar, computacionalmente, novos possíveis candidatos terapêuticos (SIRODA *et al.*, 2011.; ZENG *et al.*, 2022.; LIU *et al.*, 2023).

1.4 GENES E VIAS ALTERADAS DO CARCINOMA HEPATOCELULAR.

As vias de sinalização e de regulação do ciclo celular são fundamentais para o desenvolvimento do câncer. O ciclo celular de mamíferos é estritamente coordenado por reguladores na fase de transição G1 para S, incluindo, dentre outras, as proteínas p53, e distintas ciclinas (JOO *et al.*, 2001). A desregulação da via do p53 foi observada em praticamente todos os tipos de câncer, incluindo o CHC (LEVINE *et al.*, 2006; MENG *et al.*, 2014). Já as ciclinas fazem parte de uma família de proteínas necessárias para a entrada e progressão do ciclo celular, bem como regulam a programação de morte celular, com a ativação de quinases dependentes de ciclina (HYDBRING *et al.*, 2016). A regulação positiva de ciclinas, além de desencadear a desregulação do ciclo celular, também promove o crescimento celular descontrolado (ZHANG *et al.*, 2018), apontando que as ciclinas desempenham um papel vital na patogênese do câncer.

Os genes CCNB1, CCNA2 e CCNB2 estão entre os principais membros da família dos genes das ciclinas, os quais desempenham importante papel na regulação de proliferação, crescimento e apoptose. Além disso, alterações na expressão desses genes estão relacionadas à progressão e sobrevida de pacientes com câncer (KUHLLING *et al.*, 2003; ZHOU *et al.*, 2018; YANG *et al.*, 2019.). Já foi mostrado que os genes CCNB1 e CCNB2 estão superexpressos em amostras de tecidos de CHC comparado com tecidos hepáticos não cancerosos e/ou saudáveis (ANDRISANI *et al.*, 2010; LIU *et al.*, 2019).

Charlotte *et al.* (2017) mostraram através de análise proteogenômica integrada de dados de CHC que as principais vias relacionadas ao ciclo celular, transdução de sinal, metabolismo e controle transcricional e translacional estão desreguladas no CHC. Os autores descreveram que os genes relacionados com as vias Wnt- β -catenina, Akt/mTOR e Notch, com o ciclo celular e com a regulação de danos ao DNA estão frequentemente mutados no CHC. Além disso, os autores, por meio de agrupamentos proteogenômicos integrativos, revelaram que o CHC constitui alguns

subgrupos heterogêneos com função e regulação distintas de processos biológicos, reprogramação metabólica e ativação de quinases. (CHARLOTTE *et al.*, 2017)

Por meio de análise proteômica integrada, 15 genes centrais que foram significativamente enriquecidos nas vias de sinalização e ciclo celular, dentre eles: CCNB1, CDK1, RRM2, BUB1B, DTL, RACGAP1, ECT2, NEK2, PBK, TOP2A, ASPM, HMMR, CDKN3, PRC1 e ANLN; dentre esses genes, quatro potenciais alvos terapêuticos foram CCNB1, CDK1, RRM2 e BUB1B (Zhou *et al.*, 2019).

O gene CCNB1 está hiperexpresso no CHC e estritamente associado ao mau prognóstico de pacientes (CHAI *et al.*, 2018). Além disso, GU *et al.* (2019) identificaram que CCNB1 é rapidamente suprimido pelo miR-144 com medicamentos, terapia direcionada e terapias antitumorais (GU *et al.*, 2019).

CDK1 é uma serina/treonina quinase e possui papel importante na progressão do ciclo celular. Já foi mostrado que a inibição de CDK1 leva a supressão da proliferação celular (LV *et al.*, 2017). A expressão de CDK1 é significativamente maior em células de CHC, entretanto, o mecanismo subjacente correlacionado entre CDK1 e CHC carece de mais informações. Já o gene BUB1B está regulado positivamente em CHC, e participa do ponto chave de verificação do fuso mitótico, promovendo a proliferação tumoral e induzindo a radiorresistência em diversos tumores, incluindo o CHC (PASSAIA *et al.*, 2018).

Zhou *et al.* (2018) identificaram outros genes centrais, como por exemplo CDKN3, PBK, PRC1, e TOP2A, os quais apresentaram alto grau de interação em rede de interação proteína-proteína e estão intimamente relacionados ao CHC. O gene CDKN3 está constantemente superexpresso em amostras e linhagens celulares de CHC e sua expressão está relacionada com diferenciação tumoral, além de um estágio tumoral avançado, o que acaba contribuindo para promoção da proliferação celular (XING *et al.*, 2012). Já PRC1 está associado à recorrência precoce do CHC e a resultados desfavoráveis para os pacientes, atuando em conexão com a via de sinalização Wnt/ β -catenina (CHEN *et al.*, 2016). Além disso, a identificação de alterações na expressão de TOP2A desempenha papel crucial na detecção precoce e na terapia direcionada de diversos tipos de câncer, incluindo câncer de próstata (LABBÉ *et al.*, 2017), câncer uroteliais (AUMAYR *et al.*, 2018) e o CHC (PANVICHIAN *et al.*, 2015).

Yang *et al.* (2019), utilizando o banco de dados do GEO, analisaram a superexpressão dos genes CDK1, CCNB1, CDC20, BUB1, MAD2L1, MCM3, BUB1B,

MCM2, RFC4 em tecidos tumorais, indicando baixa sobrevivência em pacientes com CHC e grau avançado do tumor (Figura 3). Com esses resultados, CDK1, CCNB1, CDC20, BUB1, MAD2L1, MCM3, BUB1B, MCM2, RFC4, podem ser possíveis alvos terapêuticos para o desenvolvimento de novas terapias.

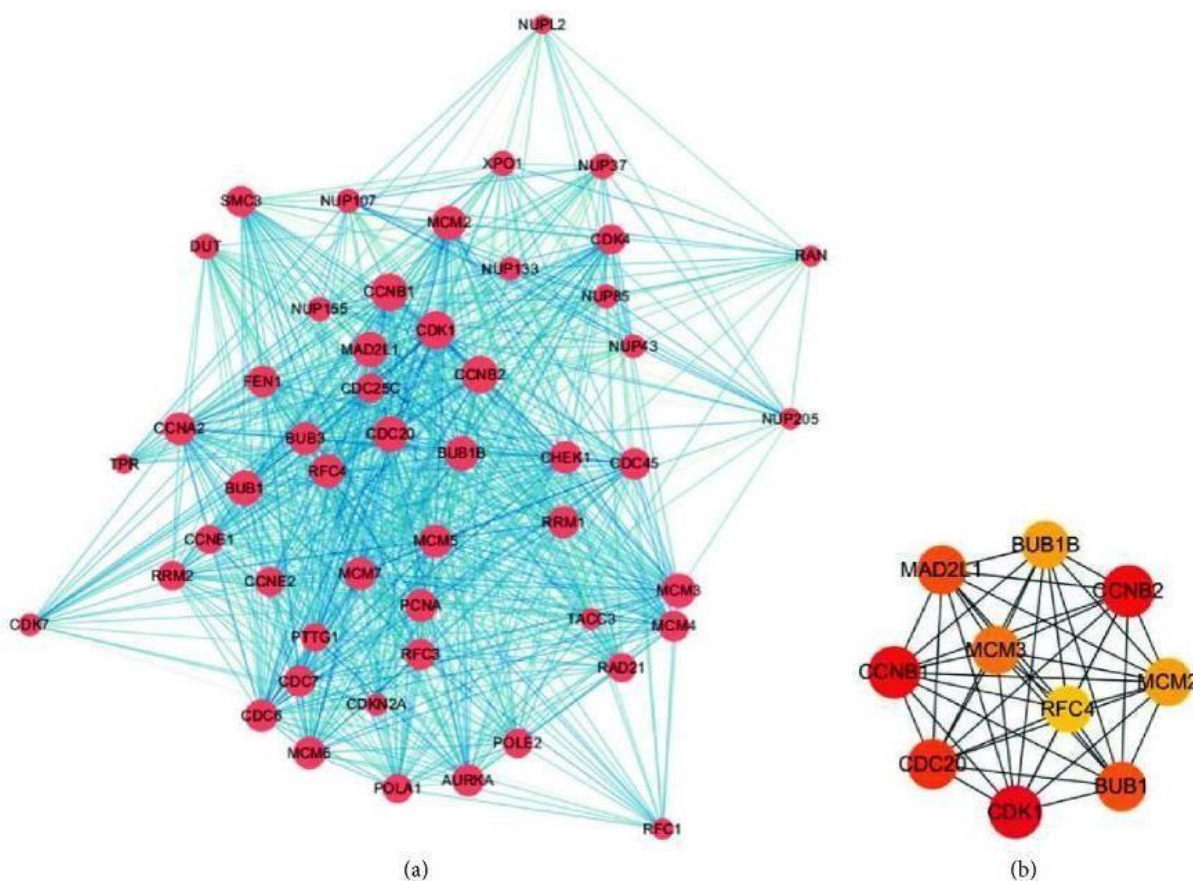


Figura 3 - Construção de rede Interação proteína-proteína (PPI) entre Genes Diferencialmente Expressos (DEGs) e os 10 principais genes no CHC. **(a)** Relações PPI entre DEGs. **(b)** Os 10 principais genes centrais. (Retirado e adaptado de YANG *et al.*, 2019).

A triagem de expressão gênica é uma ferramenta útil e que pode ser feita, em uma primeira etapa, por ferramentas de bioinformática. No trabalho de identificação e análise de biomarcadores, Li *et al.* (2018) identificaram 274 genes em que 189 eram regulados positivamente (*upregulated*) e 84 regulados negativamente (*downregulated*). Após análise de agrupamento hierárquico de genes centrais, os resultados demonstraram que esses genes centrais distinguiram claramente as amostras de CHC das amostras não cancerosas, sugerindo que eles podem ser considerados candidatos a biomarcadores. Em específico as alterações em *BUB1*, *CDC20*, *KIF20A*, *RACGAP1*, *CEP55*, *TOP2A* e *CDK1* foram associadas a uma menor

taxa de sobrevivência, sugerindo que esses genes desempenham papéis significativos na carcinogênese, progressão, invasão e/ou recorrência do CHC (LI *et al.*, 2018).

Usando análises de bioinformática, outros estudos identificaram 56 genes regulados positivamente e 33 regulados negativamente no CHC. Com base no grau de conectividade e por meio da rede de interação de proteínas, foram elencados 10 genes centrais, incluindo *CCNB1*, *CCNA2*, *CCNB2*, *NCAPG*, *PBK*, *MUSAP1*, *AURKA*, *ZWINT*, *PRC1* e *KIF4A* (Figura 4). Estes genes, por sua conectividade, desempenham papel crucial na progressão e manutenção do CHC (CHEN *et al.*, 2016; XIUDAO *et al.*, 2020). Vale destacar que os autores, após o processo de enriquecimento via KEGG, identificaram que o ciclo celular foi evidenciado como a via mais significativamente envolvida com estes genes.

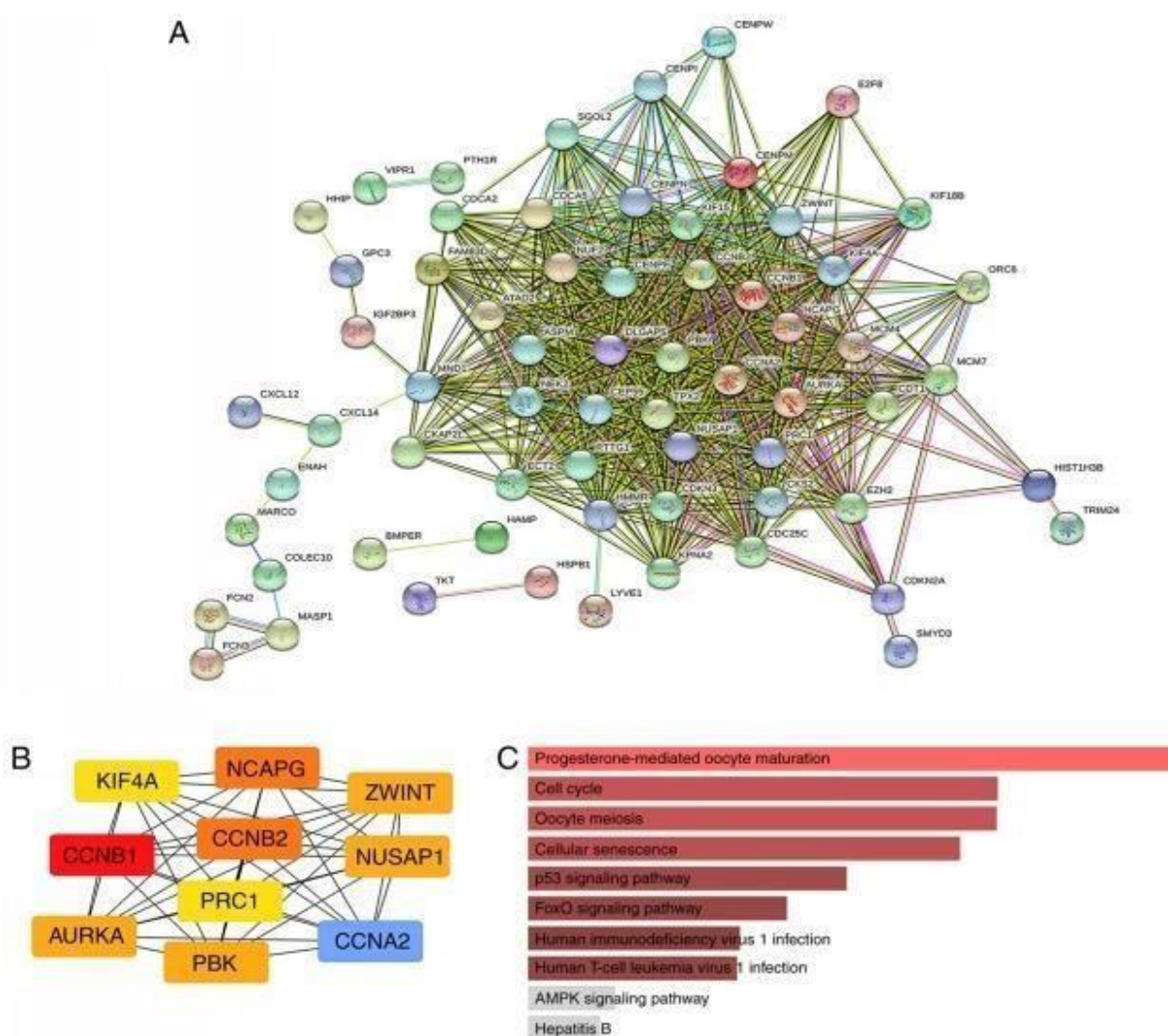


Figura 4 - Identificação da rede de interação proteína-proteína e *hub genes*. **(A)** A rede de interação proteína-proteína foi construída a partir de todos os 89 DEGs usando o banco de dados STRING. **(B)** Os 10 principais *hub genes* na PPIN foram selecionados pelo plugin cytoHubba do Cytoscape (v3.6.1) com base em seu grau de conectividade. Os 10 genes *hub* identificados, como *CCNB1*, *CCNA2*, *CCNB2*, *NCAPG*, *PBK*, *NUSAP1*, *AURKA*, *ZWINT*, *PRC1* e *KIF4A*, enciclopédia de genes e genomas de Kyoto. **(C)** Principais processos biológicos envolvendo *hub genes* (Retirado e adaptado de XIUDAO *et al.*, 2020).

O gene NCAPG é uma subunidade que regula o complexo de condensina, e está relacionado com a via do ciclo celular e condensação cromossômica mitótica, a qual desempenha papel importante na conversão da cromatina interfásica em cromossomos já condensados durante o processo de mitose e meiose (COHEN *et al.*, 2014). De acordo com Zhang *et al.* (2018) o *knockdown* de NCAPG suprime o crescimento, proliferação e manutenção de células de CHC, além disso, inibe o crescimento de xenoinxertos em células de linhagens tumorais de fígado HuH7 e HCCLM3. Os autores identificaram que a elevada expressão de CCNB1, possui uma correlação positiva significativa com a superexpressão de NCAPG em pacientes com CHC.

AURKA é uma serina/treonina quinase relacionada à divisão celular, regulação da mitose e progressão do ciclo celular (VADER e LENTE., 2008). AURKA tem sido amplamente estudada no CHC. A elevada expressão de AURKA está intrinsecamente associada com características agressivas do câncer (JENG *et al.*, 2004), incluindo promoção de metástase, modulando a transição epitelial-mesenquimal (CHEN *et al.*, 2017), e favorece a quimiorresistência via sinalização NF-kappaB/microRNA-21/PTEN (ZHANG *et al.*, 2014). Além disso, foi observado um elevado polimorfismo para AURKA, indicando que AURKA pode ser identificado como um biomarcador preditivo para o prognóstico de fases iniciais do CHC (WANG *et al.*, 2018). A elevada expressão de AURKA está inversamente relacionada à sobrevida global, e sobrevida livre da doença em pacientes CHC (ZHOU *et al.*, 2018).

As disparidades observadas nas assinaturas genéticas propostas para o CHC estão associadas a eventos carcinogênicos diferentes e diversos. Estes eventos englobam vários processos biológicos, tais como eventos mitóticos e respostas de stress a íons metálicos específicos. Além disso, estas assinaturas apontam para vias cruciais, incluindo MAPK, FoxO, sinalização VEGF e desintoxicação de compostos inorgânicos. Consequentemente, torna-se evidente que o debate sobre a seleção de genes relevantes para eventos ligados ao CHC continua a ser um tema de discussão aberto e intrincado. Em parte, as discrepâncias encontradas em diferentes estudos podem ser explicadas pelo fato de as células de tecidos saudáveis (não tumorais) e as células recolhidas de tecidos adjacentes ao tumor (frequentemente referidas como tecido normal adjacente) diferem nos seus perfis genéticos e de expressão. Além disso, a maioria dos estudos baseia-se em poucos conjuntos de dados de microarray, limitando assim os seus resultados de investigação.

1.5 DIAGNÓSTICO E TRIAGEM

A maioria dos casos de CHC é precedida por casos de hepatite B crônica e/ou cirrose (SINGAL *et al.*, 2019). Entretanto, devido a um baixo rastreamento de pacientes com casos que não apresentam características marcantes, outros meios de identificação são utilizados, como utilização de imagens transversais, as quais podem demonstrar anormalidade da massa hepática e/ou agravamento da disfunção hepática.

Os pacientes com anormalidade no teste de vigilância, ou seja, aqueles pacientes em que foram identificados nódulos hepáticos na imagem de ultrassonografia abdominal, ou níveis elevados de α -fetoproteína (>20ng/ml), são pertencentes a populações de risco, e necessitam de avaliação diagnóstica. A grande maioria das lesões de até <1 cm de diâmetro, não são consideradas lesões de CHC, entretanto, lesões >1 cm de diâmetro são necessárias análises de imagens, através de ressonância magnética (MARREO *et al.*, 2018). Vale ressaltar que embora a ressonância magnética, imagens transversais e computadorizadas sejam importantes na identificação do CHC em casos de pacientes de risco, as diretrizes práticas incentivam e recomendam cada vez mais realizar a análise de biópsias para identificar e caracterizar molecularmente o CHC (MARREO *et al.*, 2018).

Embora a maioria dos casos de CHC demonstre características detalhadas em técnicas de imagens, cerca de 10% dos tumores apresentam característica fenotípica atípica, ou seja, sem as principais características de imagem de CHC. O Grupo de Consenso Internacional para Neoplasia Hepatocelular elencou as principais características histopatológicas do CHC, incluindo invasão estromal, tratos portais intratumorais, padrão pseudoglandular, aumento da densidade celular, artérias não pareadas e alterações da estrutura lipídica (VILLANUEVA *et al.*, 2011). Em havendo suspeita clínica de paciente com CHC, no entanto, é recomendado que se realize biópsia tecidual (MARRERO *et al.*, 2018).

O prognóstico de CHC é determinado pelo estágio em que o tumor se encontra, existindo opções terapêuticas com capacidade curativa e capazes de aumentar a sobrevida em até 5 anos, em cerca de 70% dos casos de CHC em estágio iniciais. Para pacientes em estágios avançados e sintomáticos, a média de sobrevida é de aproximadamente 1 -1,5 anos, recebendo tratamento com terapia sistêmica (LLOVET *et al.*, 2016; VILLANUEVA, 2019). Desta forma é recomendado pelas sociedades profissionais, que ocorra a vigilância e o acompanhamento de pacientes com CHC de

alto risco, incluindo aqueles que apresentam cirrose ou infecção pelo vírus da hepatite B (ZHANG *et al.*, 2004).

Os biomarcadores sanguíneos surgem como objeto de interesse por pesquisadores. Apenas o biomarcador sanguíneo validado para vigilância de CHC é a α -fetoproteína (SINGAL *et al.*, 2014). Uma meta-análise avaliou diferentes modalidades de vigilância e revelou que a sensibilidade da ultrassonografia para a detecção precoce do CHC aumentou de forma significativa, passando de 45% quando utilizada isoladamente, para 63% quando combinada com a medição de α -fetoproteína. É importante notar que essa combinação resultou em uma ligeira diminuição na especificidade devido a um aumento nos resultados falso-positivos relacionados à α -fetoproteína (TZARTZEVA *et al.*, 2018). Embora a vigilância por meio de tomografia computadorizada (TC) ou ressonância magnética (RM) provavelmente tenha aprimorado a sensibilidade na detecção precoce do CHC (TZARTZEVA *et al.*, 2018), há preocupações relacionadas à exposição à radiação, utilização de contraste, capacidade de recursos radiológicos e custos que limitam a sua adoção generalizada.

Atualmente, não existem intervenções comprovadas disponíveis para prevenir o desenvolvimento de CHC em pacientes de alto risco, além do tratamento da causa primária, como a hepatite viral. A eficaz supressão da replicação do vírus da hepatite B (VHB) com antivirais e a implementação de programas de vacinação universal contra o VHB têm contribuído para uma redução na incidência de CHC (CHANG, 2009; PAPTODORIDIS *et al.*, 2015). Semelhante, a alta taxa de cura da infecção pelo vírus da hepatite C (VHC) com a nova terapia antiviral de ação direta (AAD) tem contribuído para a redução da incidência de CHC em pacientes com infecção crônica pelo VHC (KANWAL *et al.*, 2017). Entretanto, ainda não existem evidências sólidas sobre os efeitos da interrupção do consumo de álcool ou da reversão da DHGNA no risco de desenvolvimento de CHC, sendo, portanto, essa uma área em aberto e que merece mais detalhada investigação científica.

1.6 TERAPIAS PARA O CARCINOMA HEPATOCELULAR

1.6.1 Terapia de Alvo Molecular

A patofisiologia do CHC é conhecida por ser um processo complexo com múltiplas etapas, associadas a eventos moleculares errôneos e diversas vias de sinalização (LLOVET *et al.*, 2021). Atualmente vias de sinalização envolvendo proteínas kinases são as mais estudadas, pois estão relacionadas a sobrevivência

celular, diferenciação, migração, proliferação e angiogênese (GOTINK *et al.*, 2010). Dependendo de onde são encontradas, as quinases podem ser divididas em quinases receptoras e quinases não receptoras (GOTINK *et al.*, 2010). As quinases receptoras traduzem sinais extracelulares para dentro da célula, enquanto quinases não receptoras, traduzem os sinais intracelulares (GOTINK *et al.*, 2010; JIAO *et al.*, 2018). Além disso, vários receptores do grupo de receptores de tirosina como receptor do fator de crescimento endotelial vascular (VEGFR), receptor do fator de crescimento de fibroblastos (FGFR) e receptor do fator de crescimento de hepatócitos (HGFR) se comunicam via fosforilação (REGAD, 2015; GHOURI *et al.*, 2018). Com os receptores fosforilados, recruta-se diversas moléculas que atuam em vias de sinalização celular como a via Ras/Raf/MEK/ERK, PI3K (Figura 5) e AKT/mTOR, desencadeando carcinogênese, invasão e metástase (JIAO *et al.*, 2018). Dessa forma, os fatores relacionados a angiogênese e seus receptores e as moléculas de sinalização intracelulares representam um importante alvo molecular para tratamento.

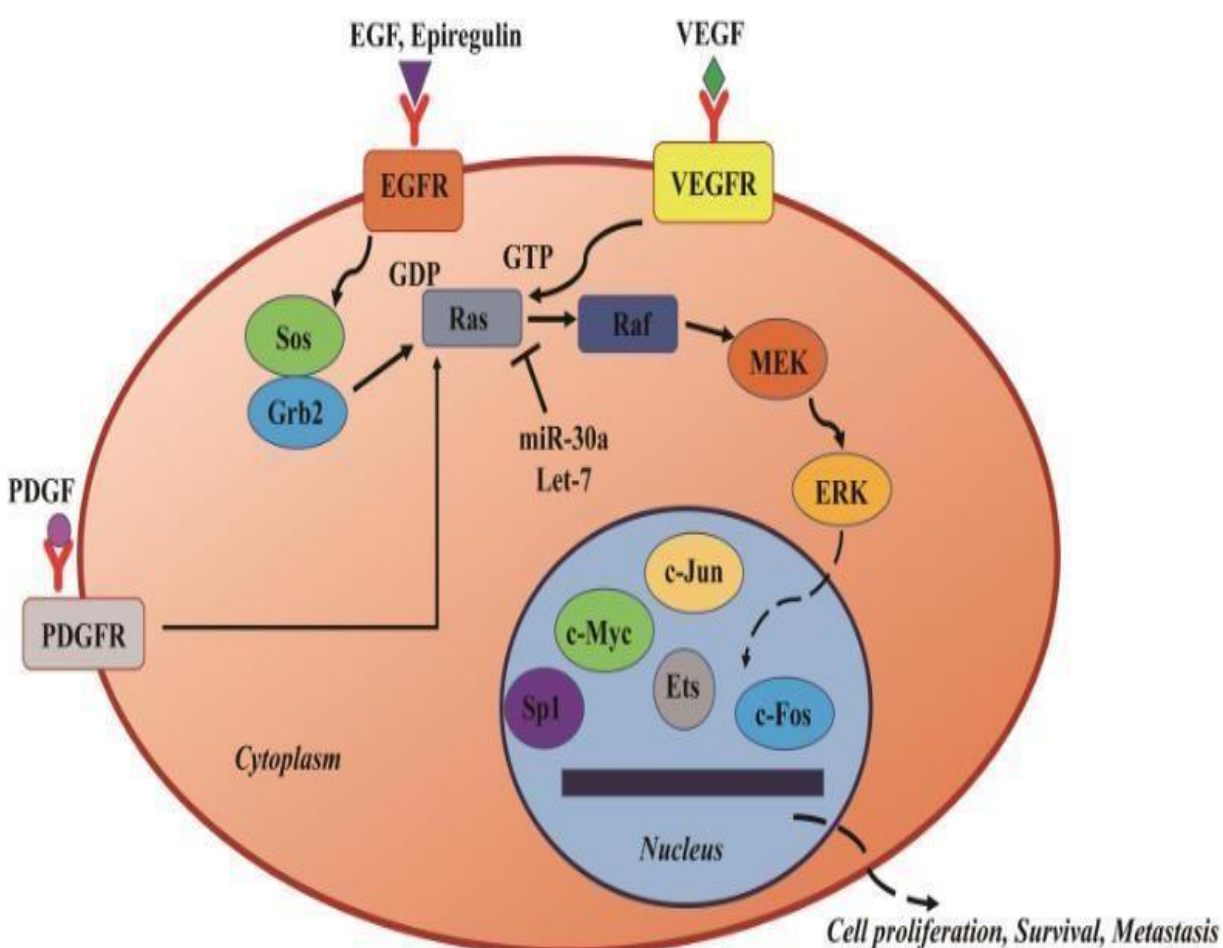


Figura 5 - Ativação da cascata de sinalização Ras/Raf/MEK/ERK no CHC através de fatores de crescimento e hormônios. (Retirado e adaptado de SHIRAGANNAVAR *et al.*, 2023).

1.6.2 Terapia de Primeira Linha

O sorafenibe é um inibidor múltiplo de tirosina-quinases, possuindo efeitos antiangiogênicos e antiproliferativo, atuando no bloqueio de vias como Raf/MEK/ERK e vias JAK/STAT, além de inibir receptores do fator de crescimento endotelial vascular (VEGF) (QIN *et al.*, 2019). O protocolo randomizado de avaliação do sorafenibe (SHARP) em 2007, contando com a participação de 602 pacientes com CHC, os quais foram alocados randomicamente para receber placebo ou sorafenib, mostrou que houve melhora na sobrevida de pacientes com CHC avançado (10.7 meses vs 7.9 meses) (LLOVET *et al.*, 2008), tornando-se o primeiro tratamento de primeira linha pra CHC, após aprovado pela *Food and Drug Administration* (FDA). Alguns dos parâmetros e resultados obtidos no SHARP são resumidos na Tabela 1. Achados semelhantes foram encontrados em estudo com 226 pacientes da Ásia, no qual ficou evidenciado aumento da sobrevida global (6.5 meses vs 4.2 meses) (CHENG *et al.*, 2009; CHENG *et al.*, 2013).

Tabela 1 – Resultados de eficiência entre o grupo Sorafenibe e Placebo (Retirado e adaptado de LLOVET *et al.*, 2008).

RESULTADOS	SORAFENIBE (N= 299	PLACEBO (N= 303	TAXA DE RISCO	pVALOR
Sobrevivência Global (mo)			0.69 (0.55-0.87)	<0.001
Média	10.7	7.9		
IC 95%	9.4-13.3	6.8-9.1		
Taxa de Sobrevivência de 1 ano	44	33		0.009
Tempo para Progressão Sintomática			1.8 (0.88-1.31)	0.77
Média	4.1	4.9		
IC 95%	3.5-4.8	4.2-6.3		
Tempo para Progressão Radiológica (mo)			0.58 (0.45-0.74)	<0.001
Média	5.5	2.8		
IC 95%	4.1-6.9	2.7-3.9		
Nível de Resposta (%)				
Completa	0	0		NA
Parcial	2	1		0.05
Estabilidade da Doença	71	67		0.17
Taxa de Controle da Doença (%)	43	32		0.002

No entanto, vale destacar que alguns pacientes foram submetidos a doses mais baixas durante o ensaio clínico, pois nestes pacientes alguns efeitos adversos com o

tratamento de sorafenib foram identificados, como: náuseas, vômito, dor abdominal e diarreia (LLOVET *et al.*, 2008; CHENG *et al.*, 2013; BRUIX *et al.*, 2017.; KUDO, 2018). Recentemente os critérios de elegibilidade de pacientes para o tratamento com sorafenibe, requerem uma reserva considerável de função hepática (KUDO, 2018). Dessa forma é fundamental obter maneiras de mitigar os efeitos adversos para uma melhor eficácia do tratamento com sorafenibe.

1.6.3 Terapia de Segunda Linha

Em 2017, regorafenibe foi aprovado pela FDA para pacientes com progressão de CHC durante o tratamento com sorafenibe (BRUIX *et al.*, 2017). Como um análogo fluorado do sorafenibe, o regorafenibe compartilha uma gama de receptores alvo, como VEGFR, PDGFR, FGFR e BRAF, e apresenta efeitos antiproliferativos e anti-angiogênicos com maior robustez do que o sorafenibe. Um estudo randomizou 573 pacientes com CHC refratária ao tratamento com sorafenibe em 2 grupos, sendo, grupo regorafenib (n=379) e grupo placebo (194). O tratamento mostrou aumento na sobrevida dos pacientes do grupo tratados com regorafenibe em comparação com o grupo placebo (10.6 meses vs 7.8 meses) (WILHELM *et al.*, 2011; KUDO *et al.*, 2018).

1.6.4 Terapia Adjuvante e Neoadjuvante

As terapias moleculares (LLOVET *et al.*, 2018) e antivirais (KANWAL *et al.*, 2017), são eficientes na tentativa de diminuir a incidência de casos de CHC, no entanto, não erradica o risco de infecção. Foi observado que tratamentos à base de interferons, reduz, de 6.2 para 1.5%, o risco de desenvolver CHC (MORGAN *et al.*, 2013). O uso de antivirais de ação direta em pacientes infectados com o vírus da hepatite C e com fibrose hepática avançada reduziu o risco de desenvolver CHC (KANWAL *et al.*, 2017).

A ressecção e ablação cirúrgica é utilizada quando o diagnóstico para CHC está em estágio inicial, ou quando o tumor é solitário, localizado e sem risco de metástase (CHENG *et al.*, 2021), sendo que para estes pacientes a taxa de sobrevida chega a mais de 60% e com baixa mortalidade (ISHIZAWA *et al.*, 2008). Pacientes com diagnóstico de CHC em estágio intermediário, devem ser triados para a Terapia Transarterial, sendo a Quimioembolização Transarterial a mais utilizada (LLOVET e BRUIX, 2003). Com as limitações no tratamento do CHC, novos esforços acerca de tratamentos com potencial curativo, devem ser implementadas. Neste cenário,

pesquisas que visam o reposicionamento de drogas tem se mostrado uma alternativa emergente para o desenvolvimento terapêutico contra o câncer (LI *et al.*, 2016; PUSHPAKOM *et al.*, 2019).

1.7 REPOSICIONAMENTO DE DROGAS

A definição acerca do reposicionamento de drogas (“*drug reprofiling*”, “*drug repurposing*” ou “*drug repositioning*”) tem sido matéria de estudo desde a publicação de Ashburn e Thor em 2004. De acordo com os autores, o reposicionamento de medicamentos se trata do processo de identificar e desenvolver novos usos para medicamentos aprovados pela “*Food and Drug Administration*” (FDA), ou que estejam sob investigação em ensaios clínicos (ASHBURN *et al.*, 2004).

As abordagens computacionais para escolha de possíveis candidatos terapêuticos, são classificadas de acordo com os dados que são utilizados para investigação. As abordagens podem ser baseadas em informações sobre os medicamentos ou sobre a doença. Nesta classificação, por exemplo, as estratégias que são baseadas em medicamentos, geralmente, a busca e descoberta vem pela perspectiva das propriedades químicas e moleculares do produto, enquanto as estratégias baseadas na doença, a descoberta vem a partir das análises das características clínicas e patológica da doença (DUDLEY *et al.*, 2011; PARK *et al.*, 2022; SEIF *et al.*, 2023).

As vantagens em reaproveitar medicamentos já aprovados ou que estejam em ensaios clínicos, são a utilização de compostos sem risco, com custo potencialmente menor, bem como redução no tempo de desenvolvimento (PUSHPAKOM *et al.*, 2019; SHARMA *et al.*, 2023). Pesquisas que visam reposicionar drogas aprovadas por agências reguladoras ou em ensaios clínicos se tornam alternativas de grande valor, pois podem auxiliar no desenvolvimento de novas terapias contra o câncer, as quais podem ser transpostas para área clínica, beneficiando pacientes com novas estratégias terapêutica ou otimizando a eficiência de terapias personalizadas (PUSHPAKOM *et al.*, 2019; ZHANG *et al.*, 2020.; MOTTINI *et al.*, 2021; SHARMA *et al.*, 2023).

Diversos estudos realizaram a combinação de diferentes perfis de expressão de genes induzidos por drogas, a fim de selecionar compostos com alta afinidade para inibir e/ou reverter a expressão de genes associados ao câncer (VAN NOORT *et al.*, 2014; CHEN *et al.*, 2017; PESSETTO *et al.*, 2017). A relação existente entre droga-

doença pode ser identificada através de robustas assinaturas gênicas associadas à determinado tipo de câncer, e podem ser obtidas por meio de análises sistemáticas de conjunto de dados de transcriptomas (HANASH, 2004).

Nos últimos anos, é crescente o interesse em estudos que visam o reposicionamento de medicamentos (DUDLEY *et al.*, 2011; CHENG *et al.* 2013; BRUM *et al.*, 2015; ZHANG *et al.*, 2016; FERRERO *et al.*, 2018; WU *et al.*, 2021; WANG *et al.*, 2022; ZHAO *et al.*, 2023; YU *et al.*, 2023). Alguns estudos iniciais (Campillos *et al.*, 2008; Keizer *et al.*, 2009) objetivaram considerar, predominantemente, as semelhanças químicas entre os medicamentos, enquanto estudos mais recentes (Xu *et al.*, 2016; Zhang *et al.*, 2016; WU *et al.*, 2021; WANG *et al.*, 2022; ZHAO *et al.*, 2023; YU *et al.*, 2023) se dedicaram a integração de dados heterogêneos de diversos bancos de dados.

O reaproveitamento de medicamentos candidatos ao reposicionamento, tem maior expectativa de sucesso, bem como um desenvolvimento mais rápido, pois essas drogas candidatas já foram aprovadas pelos diversos estágios de desenvolvimentos, e os perfis de segurança, farmacocinéticos e toxicológico são conhecidos o que resulta em menor risco para o reposicionamento desses medicamentos (MULLARD, 2016).

O menor custo e risco para o reposicionamento de medicamentos também se estende as doenças raras e negligenciadas (HODOS *et al.*, 2016), tendo em vista que, muitas dessas patologias afetam cerca de 10% da população mundial, mas apenas algumas, possuem tratamentos que são conhecidos (DAVIES *et al.*, 2017). Vale ressaltar que os métodos terapêuticos para doenças raras, exceto terapias contra o câncer, têm demonstrado efetiva taxa de sucesso global, com média superior a 25% em ensaios clínicos (MULLARD, 2016).

Com as novas ferramentas e disponibilidade de computação de dados de alto rendimento, métodos de triagem e extensas quantidades de dados ômicos auxiliaram para que as estratégias para o reposicionamento de medicamentos se tornassem mais robustos e sistematizados (SLEIGH *et al.*, 2012). Importante apontar que o aumento das informações genômicas em larga escala e disponíveis publicamente em bancos de dados, torna essa abordagem mais atraente, pois oferece uma alternativa de baixo custo em relação aos dispendiosos trabalhos de laboratório (SLEIGH *et al.*, 2012). Além disso, a combinação de dados genômicos, fenotípicos e outros dados clínicos, com abordagens computacionais, podem fornecer uma visão mais ampla do

mecanismo de ação do medicamento, bem como um melhor entendimento acerca do mecanismo da doença.

Os avanços no campo da genômica aumentaram significativamente a quantidade e disponibilidade de dados genéticos e transcriptômicos. Em particular, os dados de expressão gênica podem ser explorados e utilizados amplamente para os métodos de reposicionamento de medicamentos. Bases de dados, como o Mapa de Conectividade (CMap) (Lamb *et al.*, 2006), em associação com a Biblioteca de Assinaturas Celulares Baseadas em Rede Integrada (LINCS) (SUBRAMANIAN *et al.*, 2017), fornecem ricas fontes de recursos de perfis de expressão gênica, sendo possível comparar amostras de tecido e/ou linhagens celulares de câncer, com tecidos predominantemente adjacentes ao tumor e/ou tecidos saudáveis.

Por exemplo, Lamb *et al.* (2006), construíram um mapa com detalhes, projetado para entender as conexões entre doença, genes e perturbações que drogas causam nesses genes. Os medicamentos candidatos a reposicionamento, foram priorizados de acordo com sua conectividade negativa com a assinatura genica da doença. De maneira objetiva, o conceito formulado pelos pesquisadores é de que a assinatura ou a expressão genica alterada em determinada doença, é contrabalanceada pela assinatura oposta da droga, revertendo a célula em seu estado normal (LAMB *et al.*, 2006).

Hu e Agarwal (2009), construíram uma rede de conexão entre droga e doença, usando o sistema de assinaturas de medicamentos CMap como parte da metodologia e adicionaram dados de drogas e doenças do Gene Expression Omnibus (GEO). Eles construíram assinaturas gênicas de drogas e doenças, utilizando duas abordagens metodológicas distintas para construção das redes. Para primeira abordagem, a correlação estatística foi utilizada, enquanto para segunda abordagem, fez-se uso da Análise de Enriquecimento de Conjunto Genético (GSEA).

Um aspecto importante para que o reposicionamento de drogas seja impulsionado, é o fato de que as drogas, geralmente, apresentam mais de um alvo no sistema biológico (DIMITRAKOPOULOS e BEERENWINKEL, 2016). Esse efeito é explorado dentro do campo do reposicionamento de medicamentos por similaridade química. A bioinformática e a quimio-informática exploram e preveem novos alvos para drogas existentes, bem como drogas similares com alvos conhecidos, através de análise das propriedades químicas e estruturais do alvo e do medicamento em questão (SWAMIDASS, 2011).

Atualmente, existem métodos que podem integrar diferentes conjuntos de dados de fontes distintas e prever drogas que podem desempenhar a sua função no mesmo alvo (CHIANG e BUTTE, 2009; KEISER *et al.*, 2009., LI *et al.*, 2016; DIMITRAKOPOULOS e BEERENWINKEL, 2016). Os dados de alto rendimento, como dados bioquímicos de propriedades estruturais e químicas de composto, são extraídos da literatura e de banco de dados, como PubChem (BOLTON *et al.*, 2018) e ChEMBL (GAULTON *et al.*, 2017), enquanto que dados que envolvam perfil de expressão gênica, podem ser obtidos no Pubmed GEO2R.

Yuan *et al.* (2022) propuseram uma abordagem de reposicionamento de medicamentos baseado no perfil de expressão de mRNA, com o objetivo de identificar e redirecionar medicamentos existentes para o CHC (Figura 6). Através de rede de co-expressão gênica (GCN), foi possível identificar genes que desempenham funções fundamentais na rede de co-expressão.

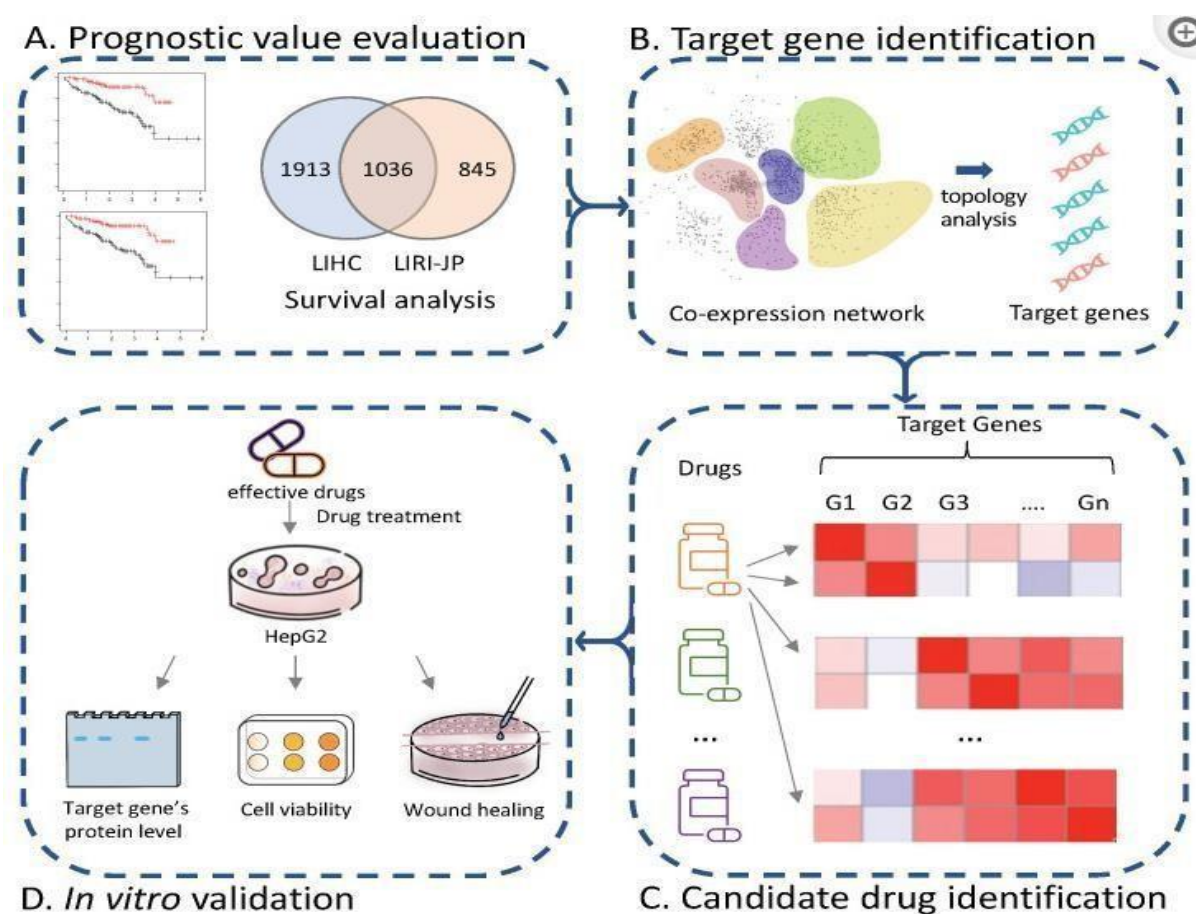


Figura 6 - Fluxograma de abordagem sistemática de reposicionamento de medicamentos para carcinoma hepatocelular (Retirado e adaptado de YUAN *et al.*, 2022).

A partir da avaliação da influência e/ou perturbação dos medicamentos nestes genes, os autores conseguiram priorizar os principais medicamentos para o CHC, os quais evidentemente necessitarão de validação experimental (YUAN *et al.*, 2022). Além disso, estudos têm investigado diferentes abordagens terapêuticas, como a administração de vitamina A, vitamina K e análogos de retinol, para a quimioprevenção do CHC (KANWAL *et al.*, 2017). Atualmente, estudos não controlados, retrospectivos e baseados na população têm sugerido que medicamentos como a metformina, estatinas, café e aspirina podem desempenhar um papel na prevenção do CHC (KENNEDY *et al.*, 2017; SIMON *et al.*, 2020). Por exemplo, um estudo retrospectivo feito na Suécia, mostrou que o uso de aspirina reduziu a incidência estimada de CHC de 8% para 4% em pacientes diagnosticados com hepatites B e C (SIMON *et al.*, 2020). A aspirina parece desempenhar um papel no combate ao CHC, principalmente através da modulação de diversas vias oncogênicas fundamentais. Isso inclui a regulação das vias de sinalização AMPK, Wnt/ β -catenina, NF- κ B e PI3K-Akt-MTOR (Figura 7). As mudanças nessas vias oncogênicas estão intimamente relacionadas à expressão e atividade da enzima COX-2. De maneira semelhante, o celecoxib, um inibidor da COX-2, também demonstra capacidade de inibir a proliferação e invasão de células de carcinoma hepatocelular (TAI *et al.*, 2019).

Para finalizar são necessários alguns apontamentos em relação ao reposicionamento de drogas e análises *in silico*. Em primeiro lugar, as análises de bioinformática são geralmente executadas utilizando-se bases de dados de acesso público e irrestrito. Esses dados são alimentados por pesquisadores e centros de estudo, ficando a curadoria desses dados sob a responsabilidade dos gestores dos bancos de dados. Em segundo lugar, a verificação empírica, ou seja, a validação experimental é essencial para confirmar os genes preditos identificados, bem como as interações fármaco-gene. Por fim, e não menos óbvio, os compostos candidatos à reposicionamento deverão também ser objeto de etapas clínicas. Contudo, e tendo em conta estas limitações, investigações utilizando o enorme volume de dados já disponíveis na literatura especializada não só alargam o espectro de potenciais abordagens terapêuticas, como também abrem caminho para futuros estudos experimentais e tem o potencial de reduzir o tempo necessário para uma terapia mais eficiente.

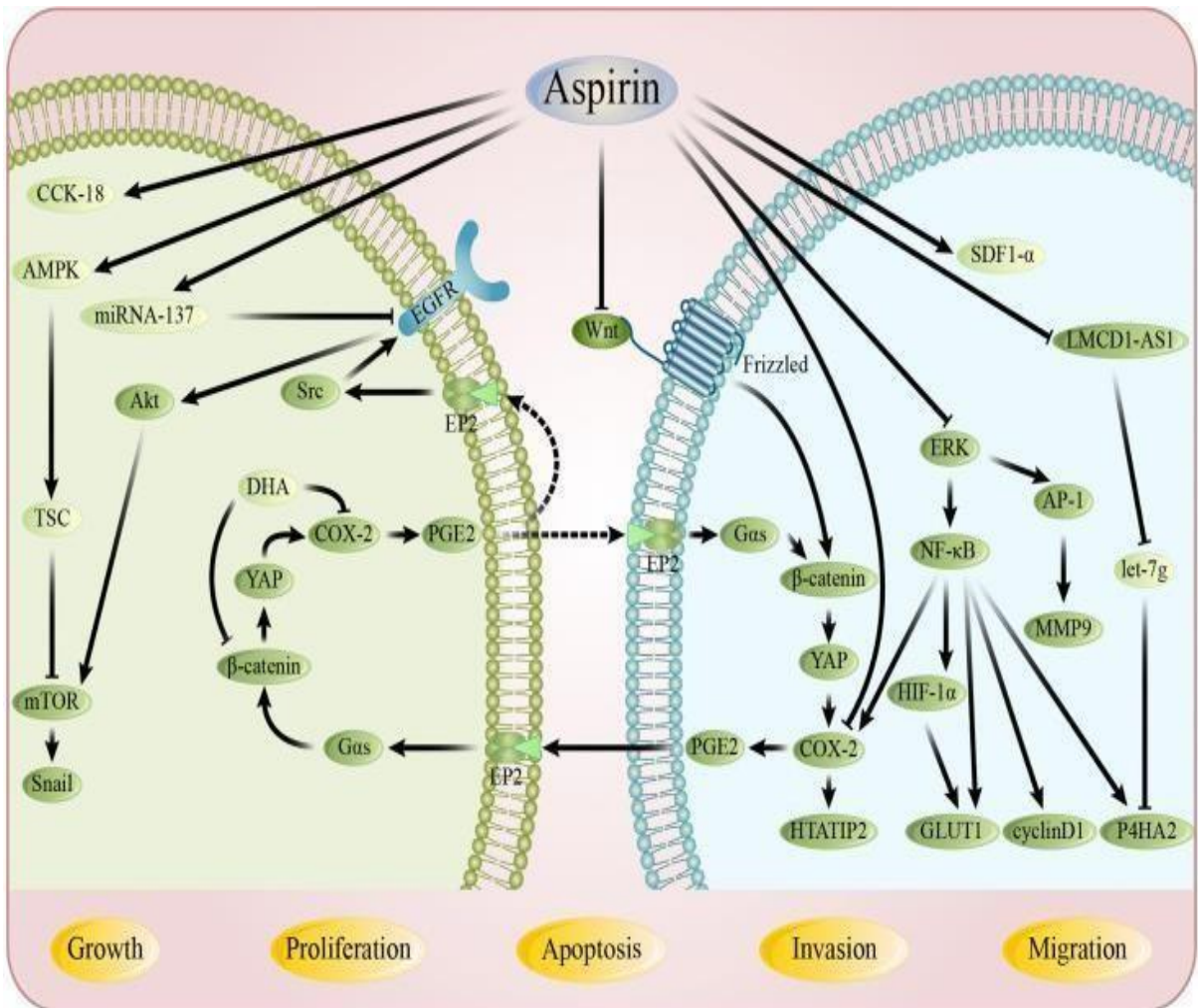


Figura 7 - Mecanismos moleculares pelos quais a aspirina poderia atuar no CHC. Ao regular vários intermediários downstream (por exemplo, β -catenina, NF- κ B) que são críticos na progressão do CHC, a aspirina exerce um efeito anticancerígeno de amplo espectro nas principais funções das células tumorais, incluindo proliferação, apoptose e invasão (Retirado e adaptado de QIU *et al.*, 2022).

2 JUSTIFICATIVA

O carcinoma Hepatocelular é uma doença complexa e multifatorial, que ainda apresenta elevadas taxas de mortalidade. Apesar dos avanços recentes para a terapia do CHC, os efeitos colaterais, as altas taxas de recidiva e a descontinuação do tratamento, impõe a necessidade de contínua investigação na busca de novas terapias, isoladas ou em associação. O reposicionamento de drogas é uma realidade e que se beneficia de ferramentas de bioinformática capazes de extrair, estruturar, e integrar *big data*. Assim, esse estudo se justificou, pois, buscou identificar genes diferencialmente expressos em amostras de CHC, enriqueceu redes de interação proteica e propôs genes-centrais que podem estar relacionados ao CHC. Por meio de análises *in silico*, também se identificou possíveis drogas que já se encontram no mercado, as quais poderão ser testadas experimentalmente em futuros projetos.

3 OBJETIVOS

Nosso estudo buscou identificar o perfil de expressão gênica e compreender, por meio de uma abordagem *in silico*, alterações moleculares comuns no CHC. Após a identificação, foram investigados possíveis genes-alvo para serem candidatos em potencial para o reposicionamento de fármacos.

3.1 Objetivos Específicos

- I. Identificar, Genes Diferencialmente Expressos em tecido tumoral, tecido saudável e de tecido adjacente ao tumor;
- II. Enriquecer os Genes Diferencialmente Expressos e identificar genes-centrais em redes de interação proteína-proteína;
- III. Buscar fatores de transcrição responsáveis pela regulação da expressão dos genes-centrais;
- IV. Explorar potenciais drogas ou moléculas capazes de reverter a expressão dos genes encontrados;
- V. Oferecer opções terapêuticas para serem experimentadas e validadas em ensaios futuros.

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CAPÍTULO II

Comprehensive profiling and therapeutic insights into differentially expressed genes in hepatocellular carcinoma.

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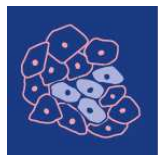
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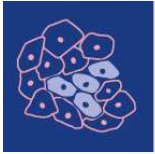
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Comprehensive Profiling and Therapeutic Insights into Differentially Expressed Genes in Hepatocellular Carcinoma

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Article

Comprehensive Profiling and Therapeutic Insights into Differentially Expressed Genes in Hepatocellular Carcinoma

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Simple Summary: Hepatocellular carcinoma remains crucial due to its high prevalence and the need for improved understanding and treatment options. This study utilizes extensive microarray and RNA-seq data to identify key differentially expressed genes in hepatocellular carcinoma (HCC) and FDA-approved novel druggable genes. We uncovered potential associations between metal ion exposure and tumorigenesis, as well as the relevance of kinases in HCC. Topological analysis reveals 25 hub genes and their regulatory transcription factors, while computational drug repurposing suggests several novel therapeutic candidates targeting key genes, highlighting potential avenues for future experimental assays and clinical cohorts with HCC patients.

Abstract: Background: Drug repurposing is a strategy that complements the conventional approach of developing new drugs. Hepatocellular carcinoma (HCC) is a highly prevalent type of liver cancer, necessitating an in-depth understanding of the underlying molecular alterations for improved treatment. **Methods:** We searched for a vast array of microarray experiments in addition to RNA-seq data. Through rigorous filtering processes, we have identified highly representative differentially expressed genes (DEGs) between tumor and non-tumor liver tissues and identified a distinct class of possible new candidate drugs. **Results:** Functional enrichment analysis revealed distinct biological processes associated with metal ions, including zinc, cadmium, and copper, potentially implicating chronic metal ion exposure in tumorigenesis. Conversely, up-regulated genes are associated with mitotic events and kinase activities, aligning with the relevance of kinases in HCC. To unravel the regulatory networks governing these DEGs, we employed topological analysis methods, identifying 25 hub genes and their regulatory transcription factors. In the pursuit of potential therapeutic options, we explored drug repurposing strategies based on computational approaches, analyzing their potential to reverse the expression patterns of key genes, including AURKA, CCNB1, CDK1, RRM2, and TOP2A. Potential therapeutic chemicals are alvocidib, AT-7519, kenpaullone, PHA-793887, JNJ-7706621, danusertibe, doxorubicin and analogues, mitoxantrone, podofilox, teniposide, and amonafide. **Conclusion:** This multi-omic study offers a comprehensive view of DEGs in HCC, shedding light on potential therapeutic targets and drug repurposing opportunities.

Keywords: liver cancer; drug repurposing; druggable genes; reverse expression; bioinformatics



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1. Introduction

Precision medicine is a patient-centric approach that leverages individualized genomic information to inform drug treatment decisions, aiming to enhance clinical outcomes. In recent years, various methods have emerged to decipher and interpret multi-omics data, leading to the development of strategies for precise drug selection. These methods enable the identification of specific genetic characteristics associated with drug sensitivity or

resistance while also integrating genetic markers with gene ontologies and biological networks to predict drug response on an individual level. Furthermore, by integrating multiple data sources, these approaches hold promise for optimizing drug therapies for personalized medicine [1].

Drug repositioning, or drug repurposing, involves the identification of novel uses for approved or investigational drugs beyond their original intended targets. This drug reprofiling approach offers a cost-effective and time-efficient process for drug development compared to traditional de novo drug discovery, which often involves long and expensive processes [2]. Among the numerous biological and medical applications that can benefit from drug repositioning, the field of basic and clinical oncology stands out; a quick and simple search in the Pubmed repository using the combination of “Cancer and Drug Repositioning” yields over 1100 articles in the period of 2020–2023 (accessed on 28 June 2023).

In this scenario, bioinformatics has emerged as a powerful discipline, allowing for the analysis and interpretation of large-scale biological data. With the advancement of high-throughput methodologies, such as next-generation sequencing and omics technologies, computational tools and algorithms have become crucial in the exploration of complex biological processes, disease mechanisms, and the discovery of potential therapeutic targets [1,3]. In addition, bioinformatics approaches to the study of tumor events and processes are providing insights into the underlying molecular mechanisms of the disease, which can guide the selection of potential drugs for repositioning. Just to provide further context, the combination of the terms “bioinformatics AND cancer” returned nearly 49,000 articles in PubMed between 2020 and 2023 (accessed on 28 June 2023).

Among distinct types of cancers, hepatocellular carcinoma (HCC) is the most common primary liver cancer and a leading cause of cancer-related mortality worldwide. It predominantly arises in the setting of chronic liver diseases, including hepatitis B and C virus infections, alcoholic liver disease, non-alcoholic fatty liver disease, and cirrhosis. HCC is characterized by aggressive tumor growth, high recurrence rates, and limited treatment options, necessitating a comprehensive understanding of its molecular pathogenesis and the development of effective therapeutic strategies. In this context, it is undeniable that significant progress has been made in the treatment of HCC with multiple drugs and combinations. Available drugs such as sorafenib, levatinib, regorafenib, cabozantinib, ramucirumab, nivolumab, and pembrolizumab, either alone or in combination, have proven to be effective in phase I/II studies and prolong survival in phase III randomized controlled trials. However, the limitations of these chemotherapeutics involve common side effects, including hypertension, weight loss, hand-foot skin reactions, fatigue, liver injury, and bleeding [4]. These side effects highlight the need for ongoing research and innovation in the field of oncology to address these limitations and improve the overall therapeutic experience for HCC patients.

The integration of genomic, transcriptomic, and epigenomic data has led to the identification of molecular signatures and biomarkers associated with HCC diagnosis, progression, and prognosis [5,6]. Molecular markers not only aid in early detection but also provide valuable insights into the underlying molecular mechanisms and heterogeneity of HCC, paving the way for personalized treatment approaches. To evaluate HCC through the use of bioinformatic approaches, distinct studies have proposed gene signatures for HCC [7–12]. Notably, Zhang et al. [13] identified intrinsic associations between HCC and specific genes, including *CCNA2*, *CCNB1*, *CDC20*, *CDK1*, *PTTG1*, and *TTK*, elucidating their relevance to HCC-related events. Conversely, Wang et al. [14] pointed out that the signature composed by *MARCO*, *CLEC4M*, *FCGR2B*, *LYVE1*, *TIMD4*, *STAB2*, *CFP*, *CLEC4G*, *CLEC1B*, *FCN2*, *FCN3*, and *FOXO1* reflects altered genes that may contribute to the pathogenesis of HCC, deserving a deep exploration. The disparities observed in these gene signatures are associated with different and diverse carcinogenic events. These events encompass various biological processes, such as mitotic events and stress responses to specific metal ions. Additionally, they pertain to molecular functions involving immune system responses,

carbohydrate and peptide binding capacities, heme interactions, and microtubule-related activities. Moreover, these signatures implicate crucial pathways, including MAPK, FoxO, VEGF signaling, and detoxification of inorganic compounds. Consequently, it becomes evident that the ongoing debate regarding the selection of pertinent genes remains an open and intricate subject of discussion.

In part, the discrepancies found in different studies can be explained by the fact that cells from healthy (non-tumor) tissues and cells collected from tissues adjacent to the tumor (frequently referred to as adjacent-normal tissue) differ in their genetic and expression profiles [15]. Furthermore, most of the studies rely on a few microarray datasets, thus limiting their investigative outcomes.

The efficacy of a drug to reverse cancer-associated gene expression has already been proven efficient and able to be tested in subsequent experimental procedures [16]. The success of drug repositioning for the development of anti-tumoral strategies heavily relies on the availability and utilization of bioinformatic tools and resources. These tools facilitate the analysis of diverse tumoral biological data types, such as genomic, transcriptomic, proteomic, and metabolomic data, enabling the identification of potential drug-disease associations. Herein, we used distinct bioinformatics approaches to identify hub genes and TFs that are linked to HCC and discuss possible drugs that can be repurposed in order to achieve the most effective therapeutic option for patients with liver cancer.

2. Materials and Methods

2.1. Data Mining and Processing

In the initial phase, we conducted an active and manual search in the public repository GEO (Gene Expression Omnibus, available at <https://www.ncbi.nlm.nih.gov/geo/> (accessed on 10 May 2023)) to locate microarray gene expression datasets containing samples of HCC that could be compared with non-tumor tissue samples. For data processing, we utilized the R language through the R Studio platform [17]. Data processing, statistical analyses, and graphical representations were performed using R, unless explicitly stated. We followed the R script presented at https://sbc.shef.ac.uk/geo_tutorial/tutorial.nb.html# (accessed on 20 May 2023) with few adaptations to scrutinize the GEO Series (GSE) datasets; in cases where genes required normalization and resulted in a significant number of missing values (NAs or NaNs), they were excluded from the study.

Our workflow was conducted based on the following inclusion criteria: (I) GSE datasets with a minimum of 10 tumor and non-tumor samples that include gene symbols or minimum information to find gene symbols; (II) the species *Homo sapiens*; and (III) access to raw data were permitted. Each dataset was individually analyzed using a univariate statistical approach with the `lmFit` and `eBayes` functions of the R package `limma` [18], resulting in lists of differentially expressed genes (DEGs) with \log_2 fold change (\log_2FC) and adjusted p -values. The threshold values $\log_2FC > 2.0$ and p -value < 0.05 indicated up-regulated DEGs, while $\log_2FC < -2.0$ and p -value < 0.05 indicated down-regulated DEGs. We filtered out genes without concurrent Ensembl, Entrez, and HCNB identifiers, which were gathered using `hgnc` [19], `biomart` [20], and `org.Hs.eg.db` [21] packages. In the cases where genes had multiple probes, we chose the probe with the highest absolute \log_2FC value. The gene distribution was visualized using Volcano plots created with the `EnhancedVolcano` package [22].

Our primary objective was to illustrate the differences between DEGs in tumor versus adjacent-tumor tissue samples and those in normal (healthy) patients versus HCC samples. For the sake of simplicity, from now on, we will refer to the “adjacent group”, the DEGs comparing adjacent tumor and tumor tissue, and to those genes that differ between healthy and tumor tissue as the “normal group”. We aimed to identify DEGs shared between these two conditions using Venn diagrams [23]. We also searched for DEGs obtained from RNA-seq analysis by comparing the TCGA database (<https://www.cancer.gov/ccg/research/genome-sequencing/tcga> (accessed on 1 June 2023)) and the GTEx project (<https://gtexportal.org/home/> (accessed on 1 June 2023)); those genes comprise

the “TCGA group”. To obtain TCGA/GTEX DEGs, we used the R script described in [24], which involved the UCSCXenaTools [25] and edgeR [26] packages. The parameters used were TCGA TARGET GTEX and TCGA Liver Cancer. For TCGA samples, we selected forPrimarySiteTCGA = “Liver,” forHistologicaltype = “Hepatocellular Carcinoma,” and forSampleType = “Primary Tumor.” For healthy tissue samples in GTEX, the parameters parastudy = “GTEX”, forPrimarysiteGTEX = “Liver,” and forPrimaryTissueGTEX = “Liver”, were chosen. The same thresholds were applied to the TCGA group: an adjusted p -value of 0.05 and a fold change of 2.0.

2.2. Functional Enrichment and Pathway Analysis

To propose a robust profile of HCC-associated DEGs, we applied a final filtering step. We selected only DEGs that appeared in at least 5 GSEs in the adjacent group and in at least 2 GSEs in the normal group. The final profile comprised the genes that were also present in the TCGA group.

For gene enrichment analysis, we used Gene Ontology (GO) to define DEGs and their RNA or protein products and to determine the unique biological properties of transcriptomic and genomic data. The Kyoto Encyclopedia of Genes and Genomes (KEGG), Reactome pathway and Wiki pathways, which represent a collection of databases that deal with genomes, drugs, diseases, chemical materials, and biological pathways, were also consulted [13]. Enrichment analysis was carried out using enrichR [27], and the results were visualized using the ggplot2 library [28].

2.3. Identification of Hub Genes and Transcription Factors and Protein–Protein Interaction Network Elaboration

To propose a HCC signature, we elaborated a PPI Network and identified hub genes by analyzing the centrality of nodes (genes) using the CytoNCA plugin version 2.1.6 [29]. Four centrality measures, namely eigenvector centrality (EGC), degree centrality (DC), betweenness centrality (BC), and maximal clique centrality (MCC), were employed to identify crucial genes. The highest-ranked genes based on each centrality value were considered hub genes. Given that gene expression is regulated by specific transcription factors (TFs), which in a cancer scenario are often affected in expression, we searched for TFs associated with the hub genes in the TRRUST v.2 [30] and X2Kweb [31] databases. The relationship between TF and genes was illustrated using a Sankey diagram created with SankeyMATIC (<https://sankeymatic.com/> (accessed on 1 July 2023)).

To assess functional protein association networks and evaluate protein–protein interaction (PPI) networks, we utilized the STRING online tool (<http://string-db.org>, accessed on 10 July 2023). We employed the following arguments: full STRING network; active interaction sources: text mining, experiments, databases, co-expression, neighborhood, gene fusion, co-occurrence; minimum required interaction score: 0.9 (highest confidence). The resulting PPI network was visualized using Cytoscape software version 3.9.1 [32].

2.4. Drug Screening and the Association of Genes with Cancer Cell Events

Individual hub gene and TF expression were corroborated through the GSCA (Gene Set Cancer Analysis) database [33]. The GSCA web tool allows for the determination of the association of a set of genes with cellular events that are hallmarks of tumor cells. Next, we submitted our signature and consulted the Open Cancer Therapeutic Discovery web portal (OCTAD; <http://octad.org> (accessed on 10 August 2023)) [34] to search for candidate drugs that may be useful against HCC. As of September 2023, the OCTAD database comprised 19,128 samples derived from both normal and tumor tissues, sourced from a variety of reputable datasets, including GTEX, TCGA, St. Jude Hospital, MET 500, and TARGET. OCTAD performs deep-learning-based analysis, providing a drug reversal potency score that suggests complementary compounds that may be efficacious against more than 50 cancer types. The lower the score, the higher the potential the candidate drug possesses [16]. To further validate our findings, we searched for interactions between genes

and chemicals by consulting the Drug–Gene Interaction Database (DGIdb; <https://www.dgidb.org/> (accessed on 15 August 2023)), using the R package rDGIdb [35]. Finally, we assessed the web tool shinyDepMap (<https://labsyspharm.shinyapps.io/depmap> (accessed on 24 August 2023)) to check out the essentiality of genes for cancer cell survival, i.e., the growth reduction caused by knockdown/knockout (efficacy) and the selectivity of our set of genes across 423 distinct cancer cell lines [36].

3. Results

3.1. Data Mining, Filtering, and HCC—Associated Gene Identification

In our initial search, we individually analyzed 17 GSEs for paired cancerous and non-cancerous adjacent tissue (adjacent group), 4 datasets for paired cancerous and non-cancerous healthy tissue (normal group), and the TCGA-LIHC/GTEX database (TCGA group), ultimately totaling 2292 HCC samples and 1361 non-tumor samples; in Table 1, the platforms, the type, and number of samples are described, and the distribution of genes per GSE is shown in Figure S1. In the adjacent group, out of a total of 22,508 genes, we filtered 191 DEGs, and for the healthy tissue samples, 263 DEGs were filtered from a universe of 20,038 genes (Figure 1A,B). An initial relevant finding was that while 146 DEGs are shared between the adjacent and normal groups, 117 and 45 genes are differentially expressed in an exclusive manner in healthy and adjacent tissues, respectively (Figure 1C). As a “quality control” of our data, we checked the mean expression of four random genes in the Liver Cancer Expression Resource database [37] to confirm there are differences between normal tissue and non-tumor adjacent tissue (Figure S2A). We also compared the fold change profile in each of the GSEs and could observe, through heat-maps, a few differences between the individual GSEs (Figure S2B). To achieve a greater degree of assertiveness in relation to DEGs, we searched for DEGs that were also described in the TCGA group; the 110 genes that constitute the intersection of the three groups were separated into 73 down-regulated and 37 up-regulated genes in HCC (Figure S3A). By heat-mapping, we made sure that \log_2FC was similar between the three conditions (Figure S3B).

Table 1. Datasets manually curated to identify DEGs commonly found in HCC.

GSE	Platform	Type	Tumor Sample	Non-Tumor Sample
102079	GPL 570	Adjacent-tissue	152	91
121248	GPL 570	Adjacent-tissue	70	37
12941	GPL 5175	Adjacent-tissue	10	10
136247	GPL 17586	Adjacent-tissue	39	30
14520	GPL 571	Adjacent-tissue	225	220
22405	GPL 10553	Adjacent-tissue	24	24
25097	GPL 10687	Adjacent-tissue	268	243
36376	GPL 10558	Adjacent-tissue	240	193
39791	GPL 10558	Adjacent-tissue	72	72
41804	GPL 570	Adjacent-tissue	20	20
45267	GPL 570	Adjacent-tissue	46	41
57957	GPL 10558	Adjacent-tissue	39	39
60502	GPL 96	Adjacent-tissue	18	18
64041	GPL 6244	Adjacent-tissue	60	60
76427	GPL 10558	Adjacent-tissue	115	52
84005	GPL 5175	Adjacent-tissue	38	38
84402	GPL 570	Adjacent-tissue	14	14
102079	GPL 570	Healthy liver	152	14
112790	GPL 570	Healthy liver	183	15
62232	GPL 570	Healthy liver	81	10
50579	GPL 14550	Healthy-liver	67	10
TCGA x GTEX	RNA-Seq	-	359	110

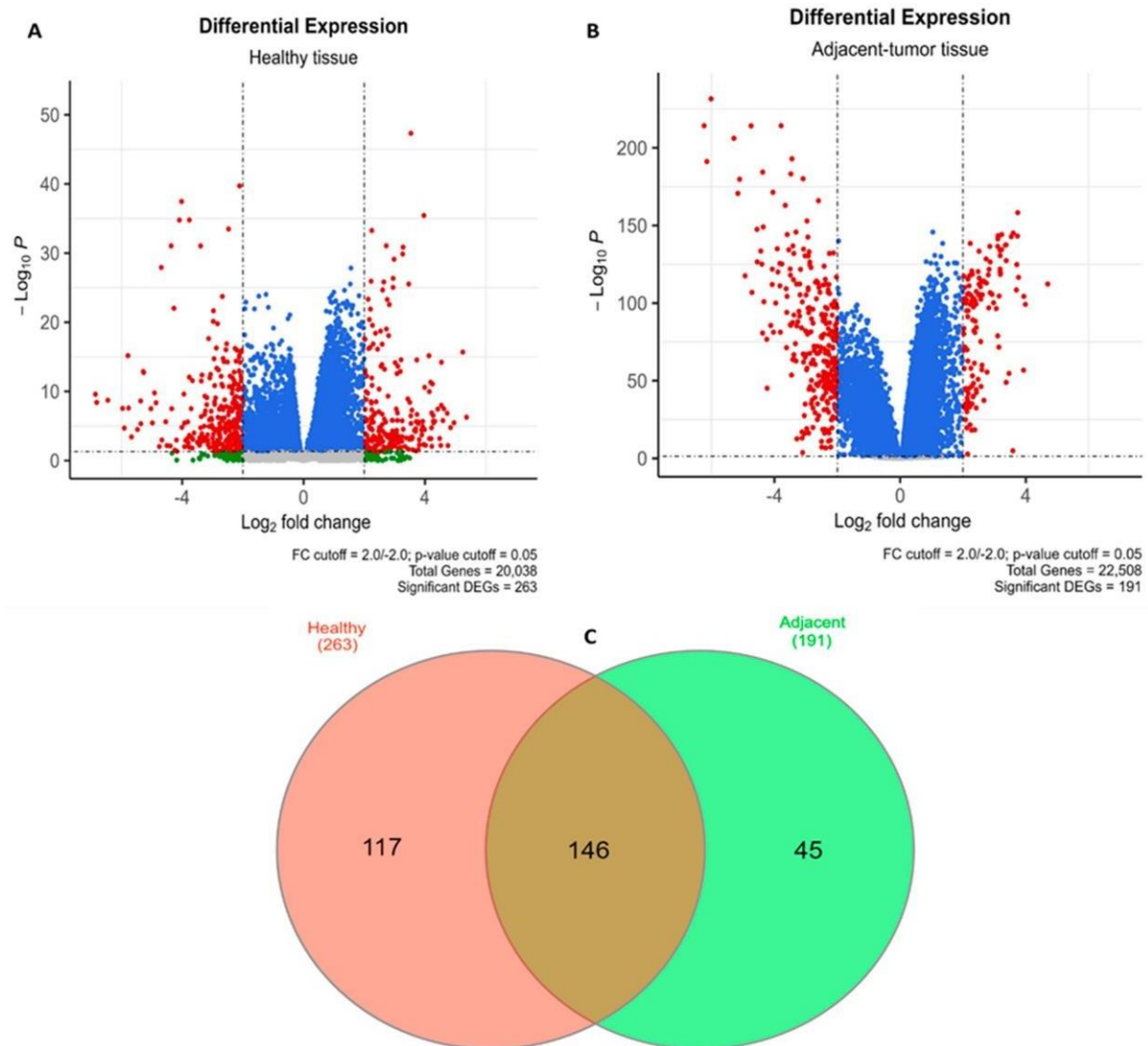


Figure 1. Distribution of DEGs. Volcano plots showing the distribution of DEGs found in (A) healthy and (B) adjacent tissue versus tumor tissues. Gray dots: Genes that do not fit in the FC cutoff and have p -value > 0.05 ; Blue dots: Genes that do not fit in the FC cutoff and have p -value < 0.05 . Green dots: Genes that fit in the FC cutoff and have p -value > 0.05 ; Red dots: Genes that fit in the FC cutoff and have p -value < 0.05 . (C) Venn diagram evidencing the number of shared DEGs between the two conditions.

The genes *APOF*, *GPC3*, *C9*, *CLEC1B*, *CYP1A2*, *FCN3*, *HAMP*, and the gene *MT1M* were the most frequent genes found in the datasets we examined.

To make sure that our DEGs are related to HCC, we entered the 110 genes into the DISGenet database using the R package *disgenet2r* [38]. As expected, the first term that returned was hepatocellular carcinoma with an extremely significant false discovery rate (FDR = 4.63×10^{-21}), and other diseases related to the liver were also found (Table 2).

Table 2. DISGENet results showing strong association between DEGs and liver events.

Term	Ratio	FDR
Liver carcinoma	68/3593	4.63×10^{-21}
Carcinogenesis	55/4065	3.02×10^{-9}
Liver diseases	19/606	1.50×10^{-7}
Chronic liver disease	10/129	3.18×10^{-7}
Hepatocarcinogenesis	17/527	4.73×10^{-7}
Liver neoplasms	26/1321	8.22×10^{-7}
Malignant neoplasm of liver	20/805	1.26×10^{-6}
Liver and Intrahepatic Biliary Tract Carcinoma	15/607	6.31×10^{-5}

3.2. Gene Ontology and Pathway Enrichment Analysis of the HCC-Associated Genes

GO enrichment analysis, provided by the R Studio Enricher package, showed that down-regulated DEGs were significantly enriched in 64 biological processes (BP), 18 molecule functions (MF), and 6 cellular components (CC). The top five BP included “steroid metabolic process” (GO:0008202), “cellular response to zinc ion” (GO:0071294), “cellular response to copper ion” (GO:0071280), “exogenous drug catabolic process” (GO:0042738), and “cellular response to cadmium ion” (GO:0071276). The top five MF included “steroid hydroxylase activity” (GO:0008395), “oxidoreductase activity” (GO:0016712), “arachidonic acid epoxygenase activity” (GO:0008392), “estrogen 2-hydroxylase activity” (GO:0101021), and “arachidonic acid monooxygenase activity” (GO:0008391). The top five CC included “Endoplasmic Reticulum Membrane” (GO:0005789), “Membrane Attack Complex” (GO:0005579), “Collagen-Containing Extracellular Matrix” (GO:0062023), “Serine-Type Endopeptidase Complex” (GO:1905370), and “Endopeptidase Complex” (GO:1905369) (Figure 2A). Up-regulated DEGs were significantly enriched in 78 BP, 5 MF, and 13 CC. The top five terms were “mitotic spindle organization” (GO:0007052), “microtubule cytoskeleton organization involved in mitosis” (GO:1902850), “regulation of mitotic cell cycle phase transition” (GO:1901990), “anaphase-promoting complex-dependent catabolic process” (GO:0031145), and “regulation of G2/M transition of mitotic cell cycle” (GO:0010389) for BP. The top five MF were “protein serine/threonine kinase activity” (GO:0004674), “histone kinase activity” (GO:0035173), “protein kinase binding” (GO:0019901), “cyclin-dependent protein serine/threonine kinase regulator activity” (GO:0016538), and “microtubule motor activity” (GO:0003777). For GO CC, the top five terms included “Spindle” (GO:0005819), “Microtubule Cytoskeleton” (GO:0015630), “Intracellular Non-Membrane-Bounded Organelle” (GO:0043232), “Nucleus” (GO:0005634), and “Cyclin-Dependent Protein Kinase Holoenzyme Complex” (GO:0000307) (Figure 2B).

We performed functional annotation for DEGs using three distinct pathway analyses: the Kyoto Encyclopedia of Genes and Genomes (KEGG), Reactome, and WikiPathways. Down-regulated DEGs were significantly enriched in 15 KEGG, 38 Reactome, and 29 Wiki pathways. KEGG analysis showed that down-regulated DEGs were mainly enriched in Caffeine, Retinol, Drug metabolism, “Mineral absorption”, and “Metabolism of xenobiotics by cytochrome P450”. The top five Reactome pathways were “Metallothioneins Bind Metals”, “Cytochrome P450—Arranged by Substrate Type”, “Response to Metal Ions”, “Phase I—Functionalization Of Compounds”, and “Xenobiotics”. In the Wikipathways the main terms were “Oxidation by Cytochrome P450”, “Metapathway biotransformation Phase I and II”, “Nuclear Receptors in Lipid Metabolism and Toxicity”, “Zinc homeostasis” and “Fatty Acid Omega Oxidation”. The number of significantly enriched pathways for the up-regulated DEGs was 7 (KEGG), 81 (Reactome), and 11 (WikiPathways). The top five KEGG pathways were “Cell cycle”, “Oocyte meiosis”, “p53 signaling pathway”, “Human T-cell leukemia virus 1 infection” and “Cellular senescence”. Reactome pathways were “Cell Cycle, Mitotic”, “Mitotic Prometaphase”, “M Phase”, “APC/C-mediated Degradation Of Cell Cycle Proteins” and “Resolution Of Sister Chromatid Cohesion”. The top five Wiki pathways were “Retinoblastoma gene in cancer”, “Cell cycle”, “Regulation of sister

chromatid separation at the metaphase-anaphase transition”, “Gastric Cancer Network 1” and “DNA damage response”. Pathways enrichment are depicted in Figure 3A,B.

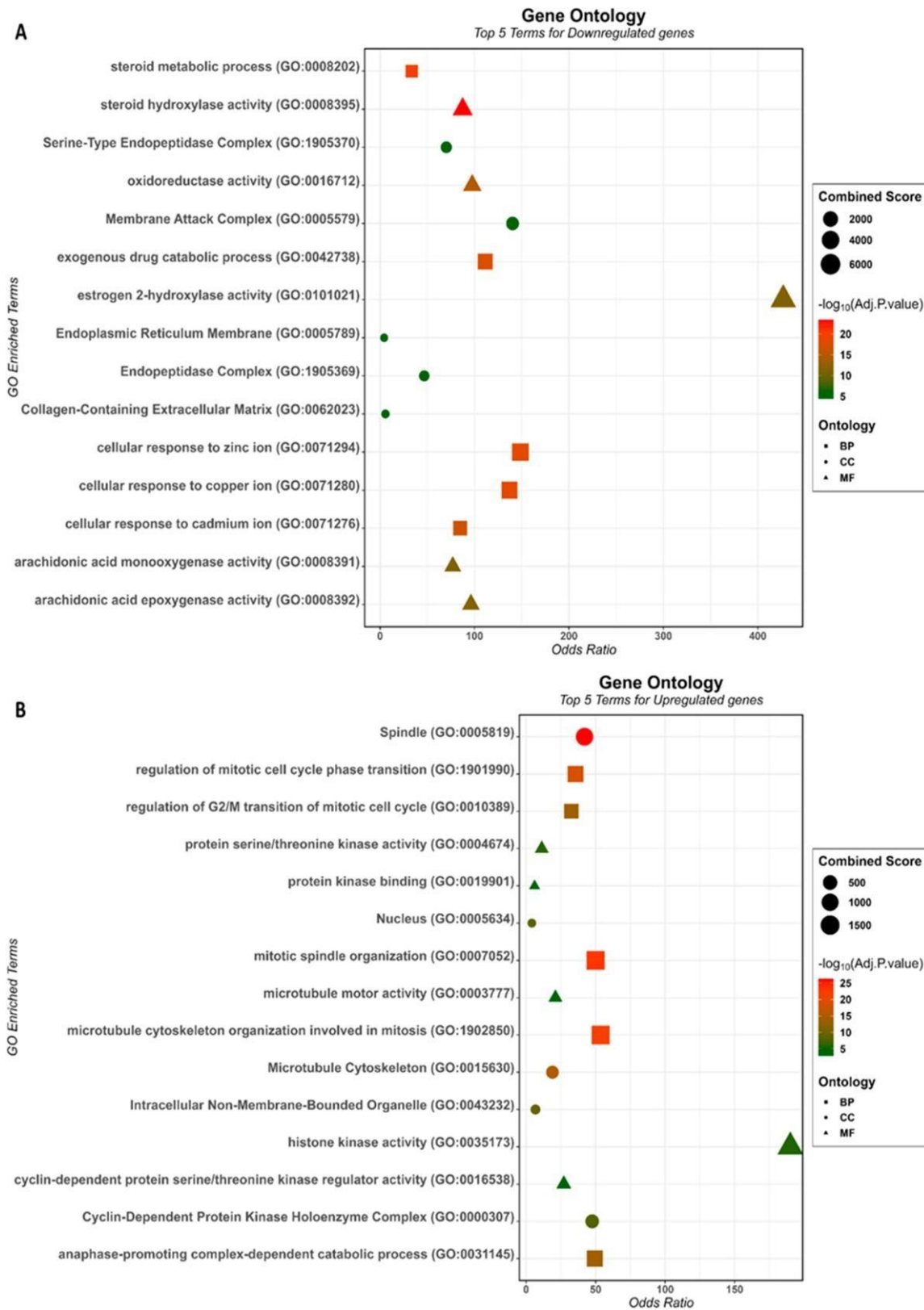


Figure 2. The top 5 GO terms enriched for DEGs that are (A) down-regulated and (B) up-regulated in HCC.

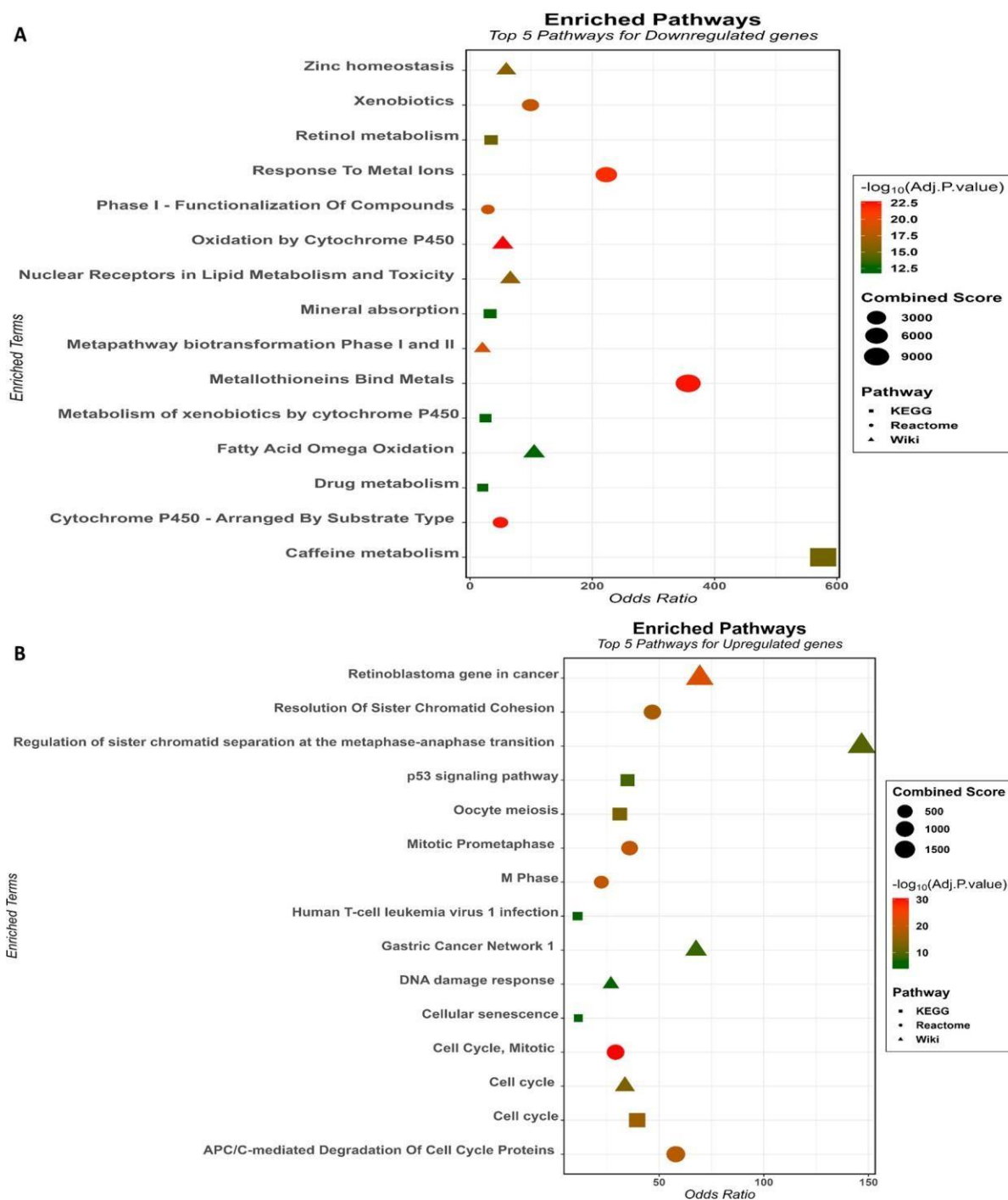


Figure 3. The top 5 pathways enriched for DEGs that are (A) down-regulated and (B) up-regulated in HCC.

3.3. Hub Genes, Transcription Factors, and the PPI Network

We used CytoNCA V2.1.6, a CytoScape plugin, for centrality analysis of the PPI network to identify crucial nodes (hub genes). The hub genes were selected based on degree centrality (DC), eigenvector centrality (EGC), betweenness centrality (BC), and maximal clique centrality (MCC) [7]. According to the centrality values, we ranked the top genes as the crucial ones; we found 25 hub genes that are described in Table S1.

Transcription factors (TFs) are pivotal gene expression regulators, orchestrating the intricate process by which genetic information is converted into functional molecules in

living organisms. In the context of cancer, TFs play a dual role, acting as both drivers and suppressors of tumorigenesis. We searched for TFs that regulate the expression of the 25 hub genes and found 28 TFs that have been described to repress or activate a specific target gene (TRRUST database) or have a hypergeometric *p*-value lower than 0.05 (X2KWeb database). The TFs that regulate a higher number of hub genes are *E2F4* and *NFYB* (both regulating 15 genes), followed by *NFYA* (14), *SIN3A* (13), and *FOXM1* (10). The hub genes that are targets of distinct TFs were *CCNB1* (12), *CDK1* (11), *AURKA* (9), and *TOP2A* (7). Interestingly, *PTTG1* acts as both a *FOXM1*-regulated gene and a modulator of *CCNB1* and *CDK1* expression (Figure 4A). We also elaborated an expression kinase network displaying the inferred regulatory network predicted to regulate the hub genes. Note the protein kinases *ATM*, *CDC2*, *CDK4*, *MAPK14*, and *JNK1* that act downstream in response to TF modulation and have already been associated with HCC (Figure 4B).

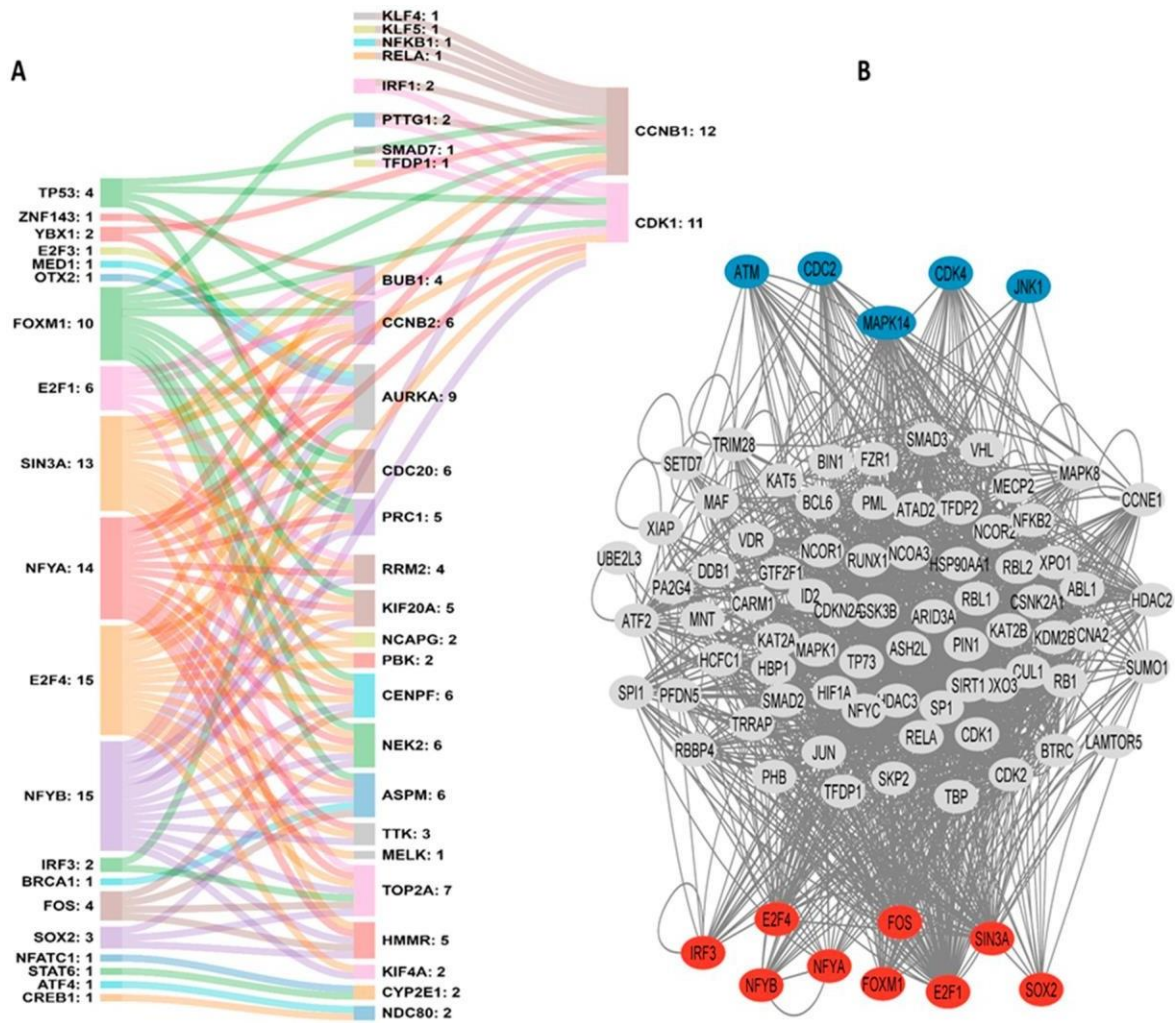


Figure 4. Transcription factors and Hub genes. (A) Sankey diagram providing insights into the relationships between TFs and genes that compose the HCC signature. (B) Expression kinases network, retrieved and adapted from <https://maayanlab.cloud/X2K/> (accessed on 15 June 2023). Red nodes represent the top transcription factors predicted to regulate the expression of the Hub genes; gray nodes represent intermediate proteins that physically interact with the enriched TFs and connect them. Blue nodes represent the top predicted protein kinases known to phosphorylate downstream proteins.

We explored the interconnectedness of the 53 genes that comprise our HCC signature, treating them as a cluster, and established a protein–protein interaction network

employing the STRING tool. This tool serves as an invaluable resource, capable of systematically and autonomously identifying associations between proteins, including their corresponding genes, across diverse knowledge repositories, such as PUBMED, KEGG Pathways, GO terms, and Reactome, among others [39]. The PPI network was built with 52 nodes interacting via 223 edges, an average node degree of 8.58, and an enrichment p -value $< 10^{-16}$ (Figure S4).

Next, we confirmed the differential expression of hub genes (Figure S5A) and explored the expression pattern of the TFs. Except for *YBX1*, *TP53*, *TFDP1*, *STAT6*, *SIN3A*, *RELA*, *NFATC1*, *MED1*, *KLF5*, *CREB1*, and *ATF4*, the other proteins show statistically significant differences in tumor versus non-tumor hepatic tissue; specifically, the TFs *E2F1*, *FOXM1*, *PTTG1*, *BRCA1*, *E2F3*, *NFYA*, *IRF3*, *ZNF143*, *E2F4*, and *NFYB* have high expression, and conversely, the genes *NFKB1*, *SMAD7*, *IRF1*, *KLF4*, and *FOS* are down-regulated in liver cancer tissues (Figure S5B).

3.4. Novel Candidate Drugs and Their Gene Expression Reversal Potential

To search for candidate-druggable genes, we submitted the 53 genes to the publicly accessible OCTAD platform (<http://octad.org> (accessed on 10 August 2023)) for the purpose of identifying compounds with potential utility in the treatment of HCC. Leveraging advanced deep-learning methodologies, OCTAD generates a succinct metric known as the summarized reversal gene expression score (sRGES). This metric serves as an indicator of a candidate drug's ability to modulate gene expression profiles, specifically by either inhibiting the overexpression of particular genes or promoting the activation of genes exhibiting lower expression levels. In accordance with the recommendations provided by the platform, we considered candidate drugs with sRGES values less than -0.25 for further investigation.

By selecting the drugs that have been tested in HCC cells only, such as Huh7.5 and HepG2, we retrieved 190 candidate compounds, which are categorized into the following experimental stages: 70 “launched”, 9 “phase 1”, 1 “phase 1/2”, 13 “phase 2”, 1 “phase 2/3”, 11 “phase 3”, 81 “preclinical stage”, and 4 drugs were withdrawn. The top 50 drugs ranked by sRGES are depicted in Figure 5A. Among the candidate compounds, we could verify a big diversity of mechanisms of action (moa), but inhibitors of HDAC, topoisomerase, CDK, EGFR, and dopamine receptor antagonists were the moa shared by at least five different chemicals (Figure 5B). From the 347 target genes retrieved from the OCTAD database, *ADRA1A*, *CDK1*, *CDK2*, *EGFR*, *GSK3B*, *HDAC1*, *HTR2A*, *HTR2C*, and *TOP2A* are target genes of at least 8 different drugs (Figure S6A). Nine of our genes are shared with the OCTAD database: *AURKA*, *CCNB1*, *CDK1*, *FOXM1*, *IRF3*, *RELA*, *RRM2*, *TOP2A*, and *TP53* (Figure S6B). These genes are targets of the following drugs: danusertib and JNJ-7706621 (*AURKA*); kenpaullone (*CCNB1*); alvocidib, aminopurvalanol-a, AT-7519, CDK1-5-inhibitor, indirubin, JNJ-7706621; kenpaullone, PHA-793887 (*CDK1*); thiostrepton (*FOXM1*); piceatanol (*IRF3*); bortezomib, caffeic-acid-phenethyl-ester, pyrrolidine-dithiocarbamate, triptolide (*RELA*); cladribine, gemcitabine (*RRM2*); amonafide, amsacrine, daunorubicin, doxorubicin, idarubicin, mitoxantrone, pirarubicin, podofilox, teniposide (*TOP2A*); pifithrin-mu (*TP53*). Details about each drug are described in Table S2.

To double-check our findings, we consulted the repository DGIdb [35]. The nine candidate-druggable genes returned 568 distinct drugs gathered from different sources (Figure 6A). The drugs are distributed as follows: 47 distinct compounds that act over *AURKA*, 3 over *CCNB1*, 48 over *CDK1*, 51 over *RELA*, 12 over *RRM2*, 80 *TOP2A*, and 377 drugs that have already been described to interact with the *TP53* gene. We then opted to check out candidate drugs that are common in the two databases; 37 drugs are shared in OCTAD and DGIdb (Figure 6B). *TP53* and *RELA* expressions did not differ in hepatic tumor tissue, so we did not consider the drugs that interact with those genes. Alvocidib, amonafide, amsacrine, AT-7519, cladribine, danusertibe, daunorubicin, doxorubicin, gemcitabine, idarubicin, JNJ-7706621, kenpaullone, mitoxantrone, PHA-793887, podofilox, and teniposide are candidate chemicals able to reverse gene expression patterns in HCC tissues;

drug-gene interactions are represented in Figure 6C. The search for candidate drugs to combat HCC stands as a pivotal endeavor, fueled by the unique importance and intricate challenges posed by this type of cancer. The drug screening strategy we have put forward is a strategic pursuit designed to tackle the specific genetic or molecular traits that underlie these tumors. The drug screening we proposed can help identify and target the specific molecular intricacies of HCC and may stimulate continuous innovation within the oncology field, which can extend to the broader landscape of cancer research and therapeutics. It also offers the potential to reduce healthcare costs, streamline resource allocation, and optimize patient care. Finally, it unearths drugs that recognize and combat tumor heterogeneity, thereby taking a significant step towards tailoring treatments to the specific needs of each patient.

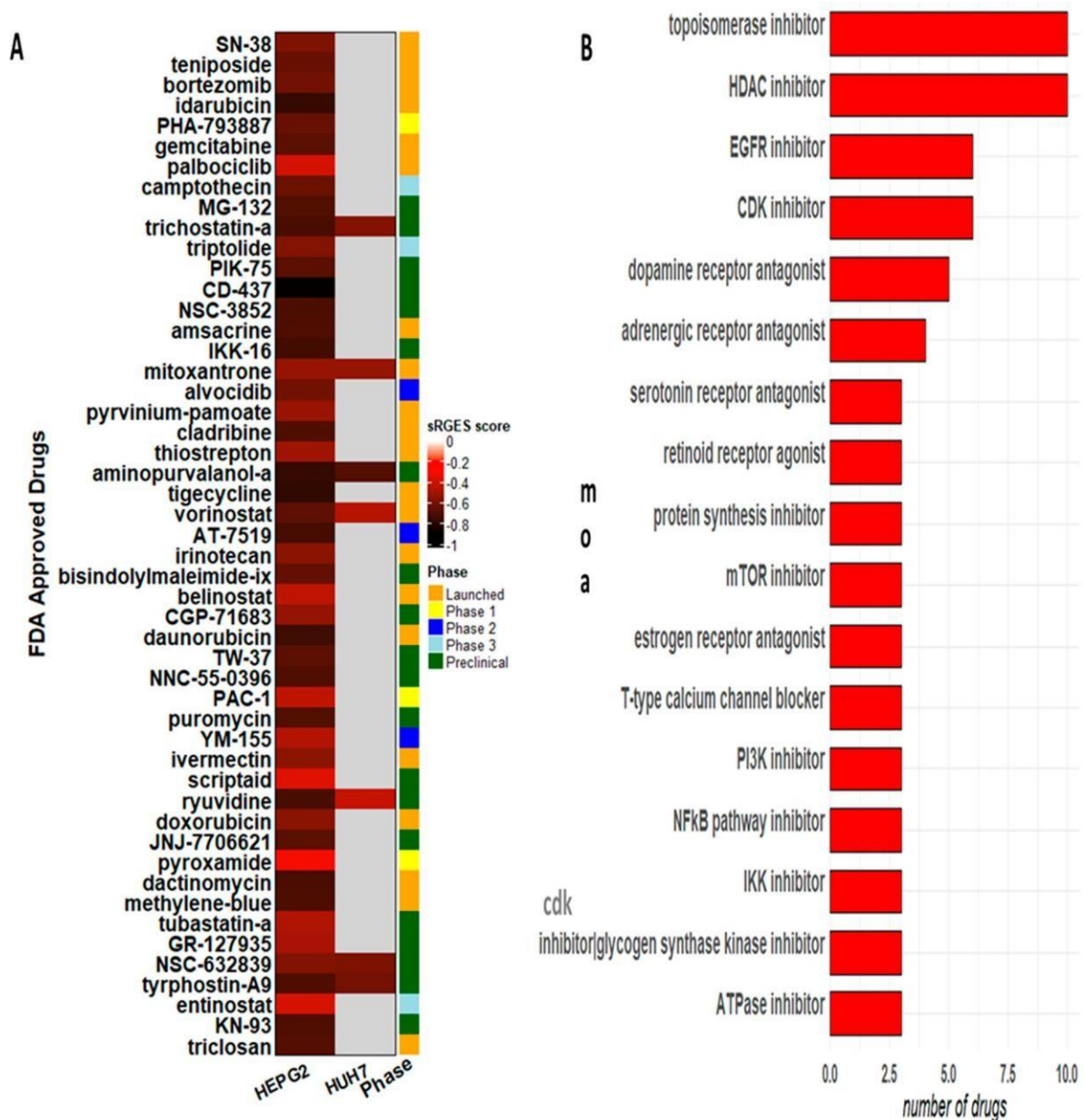


Figure 5. OCTAD results, showing the (A) top 50 ranked drugs experimented against HCC cell lines and (B) the main mechanism of action (moa) described by candidate drugs.

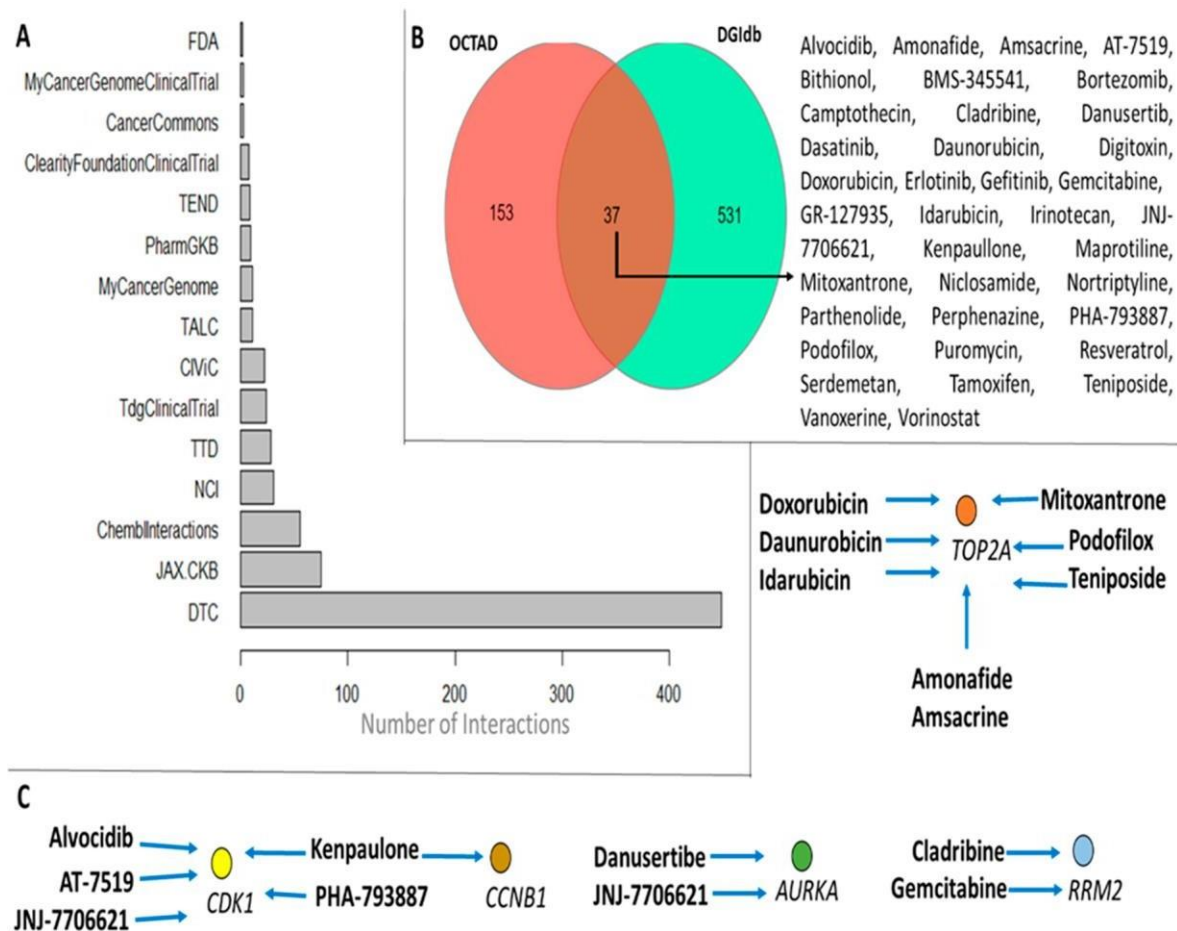


Figure 6. Drug and target-gene interactions: (A) different sources where the interactions were retrieved; (B) drugs shared in two distinct databases; and (C) druggable genes and their respective compounds. FDA: Food and Drug Administration; TEND: Trends in the exploitation of novel drug targets; TALC: Targeted Agents in Lung Cancer; CIViC: Clinical Interpretation of Variants in Cancer; NCI: NCI Cancer Gene Index; JAX-CKB: The Jackson Laboratory Clinical Knowledgebase; DTC: Drug Target Commons. Blue arrows mean that the expression pattern may be reversed after treatment.

Lastly, we verified whether the selected druggable genes are critical entities for events involved with the tumorigenesis process. Through gene set variance analysis (GSVA) and the pathway activity module, we verified some cancer-related pathways and their relationship with our genes. Apoptosis, cell cycle, and epithelial mesenchymal transition (EMT) showed a positive and significant correlation; on the other hand, the hormone AR, hormone ER, RASMAPK, and RTK pathways correlate inversely with our genes (Figure 7A). The essentiality of our genes for cell survival was evaluated by the shinyDepMap tool (<https://labsyspharm.shinyapps.io/depmap> (accessed on 24 August 2023)), which presents the efficacy and selectivity of specific genes regarding cell growth. Though the five genes had lower selectivity, all of them presented relative high efficacy, especially *TOP2A*, *RRM2*, and *CDK1* genes (Figure 7B).

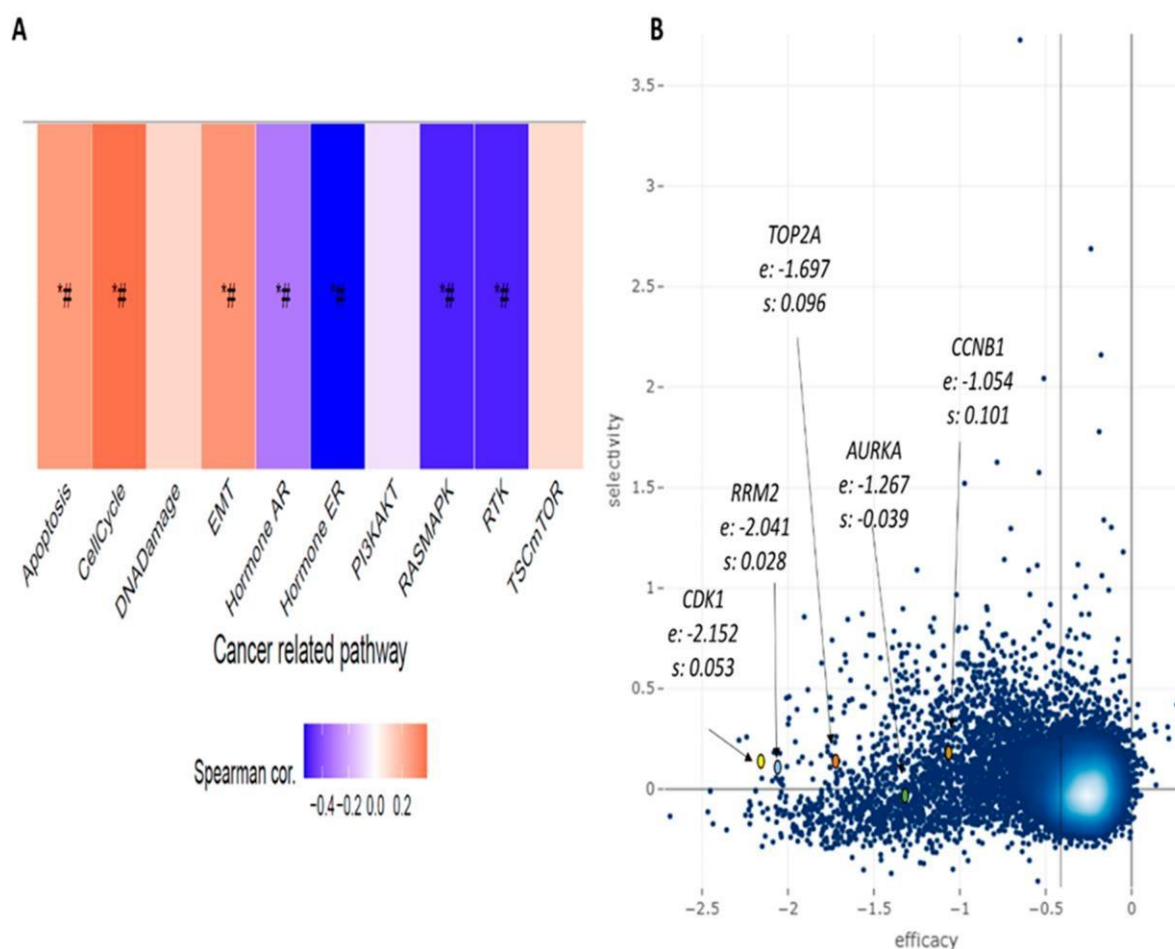


Figure 7. Essentiality of the five druggable genes for liver tumor cell survival: (A) association between GSVA score and activity of cancer-related pathways in HCC; $* p < 0.05$; # FDR < 0.05 . (B) Efficacy (e) and selectivity (s) of genes across all cancer cell lines available at the Cancer Dependency Map (DepMap); the blue dots represent 15,847 genes evaluated. Efficacy refers to the cellular growth reduction caused by the loss of function of a specific gene.

4. Discussion

Besides being the most common primary liver malignancy, HCC also accounts for an elevated rate of morbidity and mortality. HCC is strongly associated with previous conditions and environmental risk factors, such as liver cirrhosis, HBV and HCV infections, alcohol abuse, and non-alcoholic steatohepatitis. This last one deserves special attention as it is intrinsically correlated with obesity, the 21st century epidemic [40]. Genetic alterations also contribute to HCC; thus, understanding the role played by deregulated related genes and identifying new drugs and chemicals that interact with those genes may help treat liver cancer more effectively.

One difference between this study and other studies that have proposed gene signatures for HCC [7,9,13,14,41,42] is that we searched for and worked on a large number of microarray experiments, in addition to the well-established RNA-seq experiments gathered from TCGA and GTEx databases. After robust filtering processes, we selected only DEGs that are in common with what we called healthy, adjacent, and TCGA groups, thus resulting in a selection of highly representative genes that are differentially expressed in tumor versus non-tumor tissue. The choice of more than one filtering process may be more effective in finding DEGs in distinct types of tumors [39]. Our approach seems relevant, especially as it highlights the differences between healthy liver tissue and tissue that has already been affected to some extent by tumor cells and their microenvironment.

Some of the most frequently deregulated genes we found have been previously confirmed to be altered in HCC [10,43]. The down-regulated suppressor tumor gene *APOF* codes for Apolipoprotein F, which inhibits cholesteryl ester transfer among plasma circulating lipoproteins. In vitro and in vivo experiments showed that the reversion of *APOF* expression was effective against tumor growth, proliferation, and migration [44]. The proteoglycan *GPC3* (Glypican 3) is not normally expressed in healthy liver tissues, but the gene is up-regulated in HCC. *GPC3* is involved with Wnt signaling and Hippo pathways, both associated with liver tumor cell differentiation, survival, proliferation, migration, and invasion [45]. *CLEC1B*, encoding the CLEC-2 protein, a C-type lectin-like receptor 2, is down-regulated in HCC samples. *CLEC1B* regulates distinct signaling pathways related to immune and inflammatory responses and is inversely correlated with the proliferation and migration of HCC cells [46]. The predominantly liver-expressed cytochrome P450 1A2 (*CYP1A2*) is down-regulated in HCC. *CYP1A2* was identified as an antagonist of the hepatocyte growth factor/*c*-mesenchymal–epithelial transition factor (HGF/MET) signaling pathway, which is associated with tumor progression, survival, and metastasis [47]. Ficolin-3 (encoded by *FCN3*) is a protein member of the ficolin family that is down-regulated in HCC. Through pathways associated with mannose-binding lectin-associated serine proteases, ficolin-3 activates the complement system. In distinct HCC cell lines, the overexpression of *FCN3* inhibited cell proliferation and led cells to apoptosis [48]. Hepcidin (encoded by the *HAMP* gene) is a protein hormone mainly produced and secreted from the liver that, associated with ferroportin, contributes to iron homeostasis. The downregulation of *HAMP*, as we demonstrated in HCC, was also related to liver fibrosis and cirrhosis, both important risk factors for liver cancer [49]. The cysteine-rich protein Metallothionein 1M (encoded by the *MT1M* gene) participates in metal detoxification, and its overexpression was found to avoid HCC progression in vitro and in a xenograft nude mice model [50].

Of the 110 DEGs, most are down-regulated in HCC, while 37 are up-regulated genes. The 110 genes are closely related to liver cancer as well as other events associated with liver disease. Through GO enrichment analysis, we demonstrated that down-regulated genes are involved in distinct biological processes associated with zinc, cadmium, and copper ions. This may not be unexpected, as chronic exposure to some metal ions has a strong association with the tumorigenesis process. Low concentrations of cadmium trigger fibrogenic and oncogenic signaling pathways in distinct HCC cell lines [51]. In vivo models also corroborate metal ion metabolism as an important event that may be involved with HCC [52]. Conversely, up-regulated gene enrichment returned distinct biological processes associated with mitotic events and molecular functions linked to kinase activities. Kinases are enzymes responsible for the ATP-dependent phosphorylation of several downstream target proteins, which in turn respond in specific patterns. Distinct kinases are known to have their expression profiles and/or activities deregulated in cancer. Excessive lactate production, a hallmark of tumor cells, induces the proliferation and metastasis of HCC cells by inhibiting adenylate kinase 2 function [53]. Furthermore, some of the actual available drugs to treat HCC are multikinase inhibitors [54]. Pathway enrichment of down-regulated genes reaffirmed the relevance of metal ions and pointed out detoxification events as relevant for HCC biology. For the genes that are up-regulated in HCC, the p53 signaling pathway and distinct events associated with cell division were enriched. Our results corroborate previous studies that evaluated distinct GSEs [10,55,56].

As can be seen in this and other studies, the number of genes with altered expression in HCC is enormous, running into hundreds. We suggest that the higher number of deregulated genes is more likely to be the consequence rather than the cause of the carcinogenic process; thus, trying to generalize about all dysregulated genes seems uninformative. One strategy is to use tools that predict degrees of centrality based on gene co-expression networks. As a mathematical model, node centrality analyses have limitations, but in biological terms, it is assumed that co-expressed genes must be co-regulated, and the degree of connectivity between genes may reflect their physiological and pathological roles [57]. We adopted 4 distinct topological analysis methods to select 25 deregulated

hub genes (*ASPM*, *AURKA*, *BUB1B*, *CCNB1*, *CCNB2*, *CDC20*, *CDK1*, *CENPF*, *CYP1A2*, *CYP26A1*, *CYP2E1*, *DLGAP5*, *HMMR*, *KIF20A*, *KIF4A*, *MELK*, *NCAPG*, *NDC80*, *NEK2*, *PBK*, *PRC1*, *PTTG1*, *RRM2*, *TOP2A*, *TTK*). Transcription factors (TFs) play a pivotal role in gene regulation, orchestrating the intricate process by which genetic information is converted into functional molecules in living organisms. We found 28 TFs that regulate our hub genes and showed *E2F4*, *NFYB*, *NFYA*, *SIN3A*, and *FOXM1* to control at least 10 different genes. The overexpression of those five TFs has already been described to participate in different stages and events related to liver cancer and to have prognostic values for patients with HCC [58–60]. The significance of TFs in gene regulation extends across diverse biological contexts, driving advancements in our understanding of complex genetic networks, disease etiology, and potential therapeutic interventions.

Chemotherapy remains the cornerstone of treatment for solid tumors like HCC, with various drugs and regimens under constant investigation. Notably, the drug 5-fluorouracil (5-FU), a breakthrough that emerged from research on rat hepatoma, has played a pivotal role in this field. First synthesized in 1950 by Charles Heidelberger and collaborators and approved for human trials in 1962, 5-FU undergoes metabolic transformations involving enzymes like dihydropyrimidine dehydrogenase, orotate phosphoribosyltransferase, uridine phosphorylase, and uridine kinase. Through a series of phosphorylation steps, 5-FU is converted into active metabolites, including FdUTP and FdUMP, which disrupt DNA synthesis by irreversibly inhibiting thymidylate synthase. Thymidylate synthase is essential for DNA synthesis as it converts deoxyuridine monophosphate (dUMP) into deoxythymidine monophosphate (dTMP), a basic component of pyrimidines [61,62]. Thus, thymidylate synthase inhibition exhibits a potent anti-cancer mechanism. However, 5-FU, like many chemotherapy drugs, is associated with significant systemic toxicity [63], underscoring the need for novel adjuvants to mitigate adverse effects and enhance the overall efficacy of anti-cancer treatments.

A promising strategy in therapeutic treatment involves the systematic re-utilization of drugs with well-established safety and pharmacokinetic profiles, considering that numerous drugs possess multiple targets and targets can be influenced by multiple drugs. The exploration of drug repositioning extends beyond approved drugs and encompasses a growing pool of late-stage failures that have been halted due to insufficient efficacy or safety concerns [64]. One strategy for drug repurposing is based on computational approaches, which revolve around the analysis of pre-existing data sources, including chemical structures, gene expression data, proteomic information, and electronic health records [36]. Drug repurposing offers distinct advantages such as diminished initial drug development prerequisites, financial and temporal savings, and a heightened likelihood of receiving regulatory approvals compared to the conventional de novo drug discovery route. After consulting two distinct drug-gene interaction databases, we found 18 chemicals that have been tested in HCC cells and have the potential to reverse the gene expression pattern of the protein-coding genes *AURKA*, *CCNB1*, *CDK1*, *RRM2*, and *TOP2A*. We also showed that the loss-of-function of *CDK1*, *RRM2*, and *TOP2A* has the highest efficacy in reducing cellular proliferation.

CDK1 (Cyclin-Dependent Kinase 1) is a critical regulator of the cell cycle, and its dysregulation has been implicated in various cancers. We found *CDK1* to be upregulated, which has been associated with tumor development and HCC progression. Five drugs may interact with *CDK1*: (i) **Alvociclib**, the cyclin-dependent kinase inhibitor, is being considered to treat acute myeloid leukemia [65]; (ii) **AT-7519**, the second-generation small molecule multi-CDK inhibitor, was experimented against glioblastoma, lung cancer, myeloma, and leukemic cells [66–69]; more recently, AT-7519 has demonstrated anti-tumoral effects against HCC [70]; (iii) **Kenpaullone**, a multiple kinase inhibitor known for its inhibitory potential of GSK3 activity, has been experimented to be effective in some neurological disorders, cystic fibrosis, ototoxicity, and preventing oxidative stress damage in cardiomyocytes [71–74]. Kenpaullone may also act upon *CCNB1*, the gene that encodes Cyclin B1. The *CCNB1* gene is significantly up-regulated in HCC, and there is a positive

correlation with *CCNB1* overexpression and vascular invasion in HCC samples [75]. We did not find experimental studies regarding kenpaullone and HCC. **(iv) PHA-793887**: Few experimental studies have been conducted to certify its activity, but it was demonstrated in vitro that PHA-793887 was able to interfere with the viability of osteosarcoma cells [76]. **(v) JNJ-7706621**: a potent inhibitor of CDKs and Aurora kinase (AURKA) demonstrated effectiveness in dealing with the herpes simplex virus 1 [77].

AURKA, coding for Aurora A kinase, is up-regulated in HCC. *AURKA* is a mitotic regulator that is subject to several regulatory interactions and post-translational modifications, including covalent CoA modification induced by oxidative stress [78]. Besides JNJ-7706621, **danusertibe** is able to reverse the *AURKA* expression. Danusertibe exhibits inhibitory activity against all known Aurora kinases and was identified to inhibit DNA helicases [79]. Danusertibe suppressed liver tumor cell proliferation in vitro and in vivo [80].

Ribonucleotide reductase regulatory subunit M2 (*RRM2*) overexpression found in HCC samples increased the proliferative and migratory capabilities of Hep3B and Huh7 cells [81]. *RRM2* is the target of **cladribine** and **gemcitabine**. Some of the applications for cladribine are for treating acute myeloid leukemia, the rare Rosai-Dorfman disease, and multiple sclerosis [82–84]. The heterocyclic drug gemcitabine, a nucleoside analogue of deoxycytidine, acts in synergism with sorafenib to improve the chemoresistance of Huh7 cells [85].

TOP2A is the druggable gene that we found to be the target of eight distinct drugs. Among them, we showed that the anthracycline antibiotics and classic cancer chemotherapeutics **(i) doxorubicin, (ii) daunorubicin, and (iii) idarubicin** are predicted to be able to reverse *TOP2A* upregulation. Their chemical properties and differences can be consulted elsewhere [86]. Inhibition of *TOP2A* by doxorubicin contributes to suppressing the growth of sorafenib-resistant HCC tumors in vitro and in vivo [87]. At this point, it is imperative to address a key facet of HCC treatment with doxorubicin. Despite its widespread use as a cytotoxic agent, it is crucial to acknowledge the ongoing debate regarding doxorubicin's clinical activity, with some asserting that it either lacks significant demonstrable benefits or offers minimal efficacy against HCC when used systemically [88,89]. As a potential alternative, a single-center clinical trial highlighted that transarterial chemoembolization using idarubicin exhibits a favorable safety profile, achieves high tumor response rates, and extends time to progression significantly [90,91].

Similar to doxorubicin and idarubicin, **(iv) Mitoxantrone** also has the ability to reduce the growth of chronic myeloid leukemia K562 cells by a mechanism involving proteasomal activity [92]. **(v) Podophyllotoxin (Podofilox)**, an aryltetralin cyclolignan extracted from the roots and rhizomes of *Podophyllum* species, and its derivative **(vi) teniposide** have already shown anti-tumoral properties for distinct types of neoplasia, including HCC [93–95]. **(vii) Amonafide**, a naphthalimide, was initially tested to treat acute myeloid leukemia and breast cancer. By intercalating DNA and blocking the binding of topoisomerases, amonafide promotes apoptotic cell death [96] and was effective against HepG2 and Huh7 cells [97]. The synthetic aminoacridine derivative **(viii) amsacrine** has a mechanism of action similar to amonafide and showed potential effects in treating malignant lymphoma and acute myeloid leukemia [98]. We found no recent study dealing with amsacrine and HCC.

5. Perspectives and Limitations

The concomitant administration of drugs with distinct mechanisms of action holds promise as a viable strategy for addressing neoplastic conditions. The synergy resulting from the combination of two or more drugs can yield superior therapeutic outcomes in the context of HCC, as demonstrated by prior research [99]. To cite a few examples, the co-inhibition of AURKA and HSF1 has exhibited remarkable anti-tumor efficacy against HCC cells, both in vitro and in vivo [100], while the concurrent use of danusertibe and sorafenib has been shown to produce additive effects [80]. Furthermore, pharmacologically active compounds with new chemical structures analogous to and derived from natural compounds, such as congeners of podophyllotoxin and amonafide, are possible

and promising options that deserve further evaluation [94,97]. Despite the limitations commented below, our study underscores the undeniable importance of repurposing novel chemical candidates for addressing HCC. This includes the promising avenue of combining predicted drugs with established compounds in conventional chemotherapeutic regimens, thereby shedding light on innovative drug replacement strategies.

This study encountered two relevant constraints. Firstly, bioinformatics analyses were executed without undergoing experimental validation. Secondly, empirical verification is essential for confirming the identified hub genes and drug-gene interactions. With these limitations in mind, investigations akin to ours not only broaden the spectrum of potential therapeutic approaches but also pave the way for forthcoming experimental studies.

6. Conclusions

Through a comprehensive evaluation and comparison of multiple datasets highlighting DEGs in HCC, we have meticulously curated a robust list of genes. This compilation comprises 25 DEGs along with their associated transcription factors. Notably, *CDK1*, *TOP2A*, and *RRM2* emerge as promising candidates for potential drug testing, either in isolation or in combination. Upon successful experimental validation of these novel therapeutic approaches, they hold the potential for clinical testing within a specific cohort of HCC patients.

Supplementary Materials: The following supporting information can be downloaded at: <https://www.mdpi.com/article/10.3390/cancers15235653/s1>, Data S1: All genes found in GSEs of Healthy Samples. Data S2: All genes found in GSEs of Adjacent Samples. Data S3: Shared genes in details. Data S4: Transcription Factors. Figure S1: Circos-plot showing the number and distribution of genes by GSE. Figure adopted from the web tool MetaScape. Figure S2: (A) Difference in the mean expression between Normal and Adjacent non-tumor tissue (data extracted from the cancerliver database, available at <https://webs.iitd.edu.in/raghava/cancerliver/index.html>); HCC: Hepatocellular carcinoma; CCA: Cholangiocarcinoma; HA: Hepatic Adenoma. (B) Heat-maps with log₂FC from Normal versus tumor tissue and Adjacent-non tumor versus tumor tissue. Figure S3: DEGs and their differential expression profile: (A) Venn diagram showing DEGs shared between Healthy, Adjacent, and TCGA groups; (B) Heat-maps of the 110 DEGs with log₂FC. Figure S4: PPI network for HCC signature with minimum required interaction score of 0.9 (highest confidence). Nodes with no connections are not shown. Data obtained and adapted from the STRING database. Figure S5: Differential Expression of (A) Hub genes and (B) Transcription factors. The data are based on normalized and batch-corrected RSEM mRNA expression. Retrieved and adapted from Liu, C. J., Hu, F. F., Xia, M. X., Han, L., Zhang, Q., and Guo, A. Y. (2018), GSCALite: a web server for gene set cancer analysis, *Bioinformatics* 34, 3771–3772. Figure S6: Target genes found in (A) the OCTAD database and (B) shared with our DEGs. Table S1: Top genes ranked by distinct node centralities of the PPI network. Table S2: Details about drugs that can potentially reverse the expression pattern of DEGs found in HCC. Data retrieved from Pubchem (<https://pubchem.ncbi.nlm.nih.gov/>, accessed in September, 2023). CAS: Chemical Abstracts Service; moa: mechanism of action. * The synonyms provided here are not the only ones available in the database. Reference [101] are cited in the supplementary materials.

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Institutional Review Board Statement: This study was a retrospective analysis of existing publicly available datasets, and therefore, ethics approval is not required.

Informed Consent Statement: Patient consent was waived because this retrospective study was based on existing publicly available datasets.

Data Availability Statement: The datasets reanalyzed during the current study are available in the GEO (<https://www.ncbi.nlm.nih.gov/geo/> (accessed on 10 May 2023)), TCGA (<https://portal.gdc.cancer.gov/> (accessed on 1 June 2023)), and DepMap (<https://depmap.org/> (accessed on 24 August 2023)) repositories. The data generated during this study are included in this published article and its Supplementary Information Files.

Conflicts of Interest: The authors declare no conflict of interest.

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