Cirurgia para carcinoma hepatocelular além do BCLC: Como e quando?

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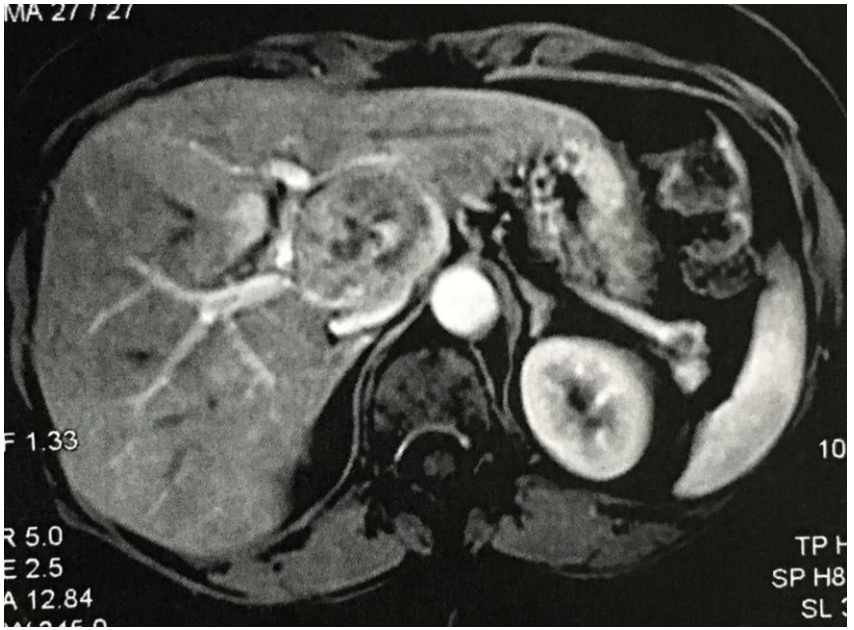
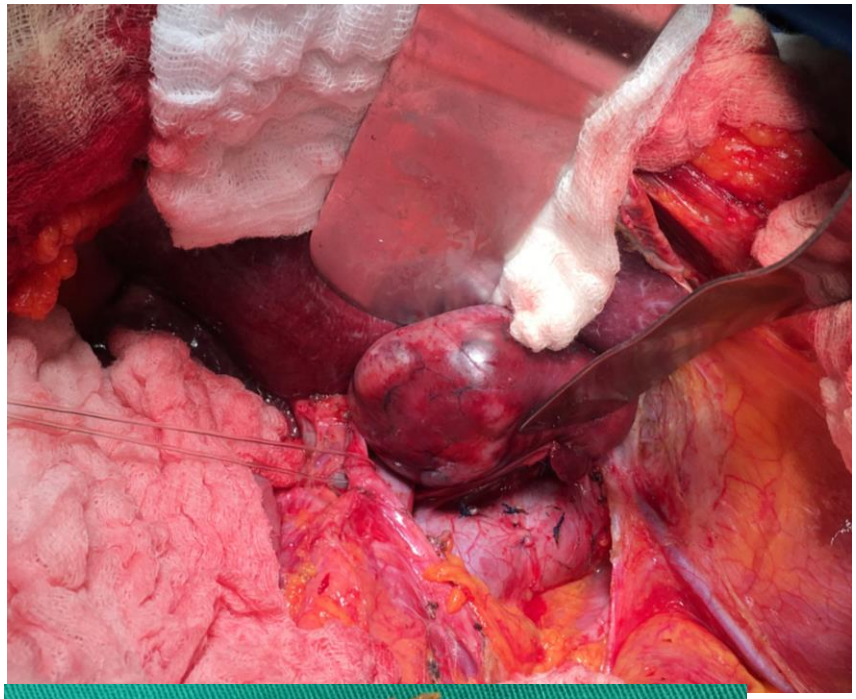
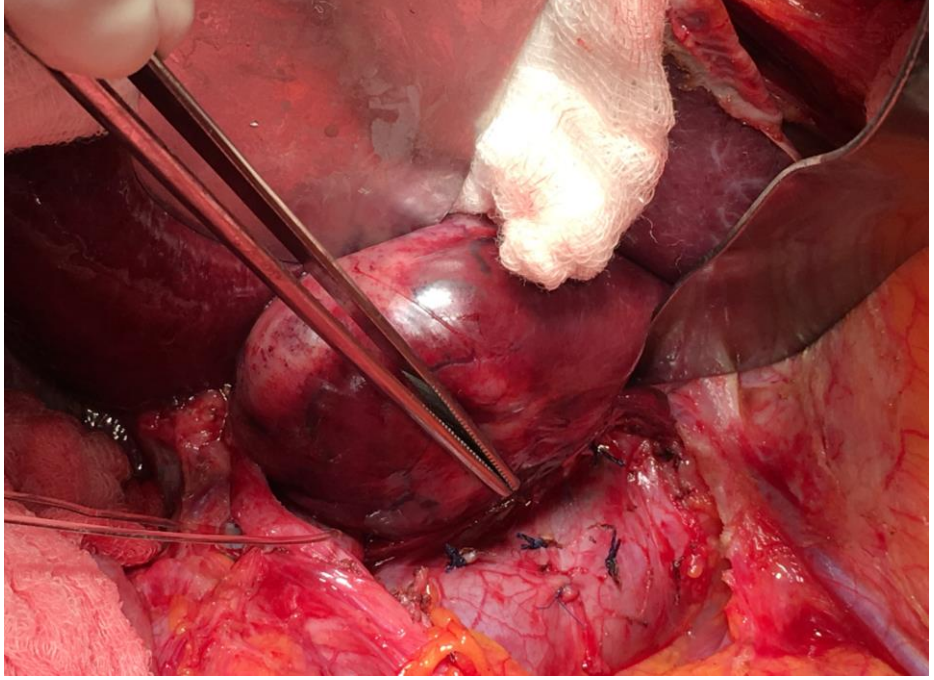
CONGRESSO BRASILEIRO DE CÂNCER DO APARELHO DIGESTIVO
25 A 27 DE AGOSTO
FECOMÉRCIO \ SP \ BR
2016



F, feminino, 70 a,
CHC em lobo caudado
Fígado normal
Child A5, MELD 8
Sem hipertensão porta



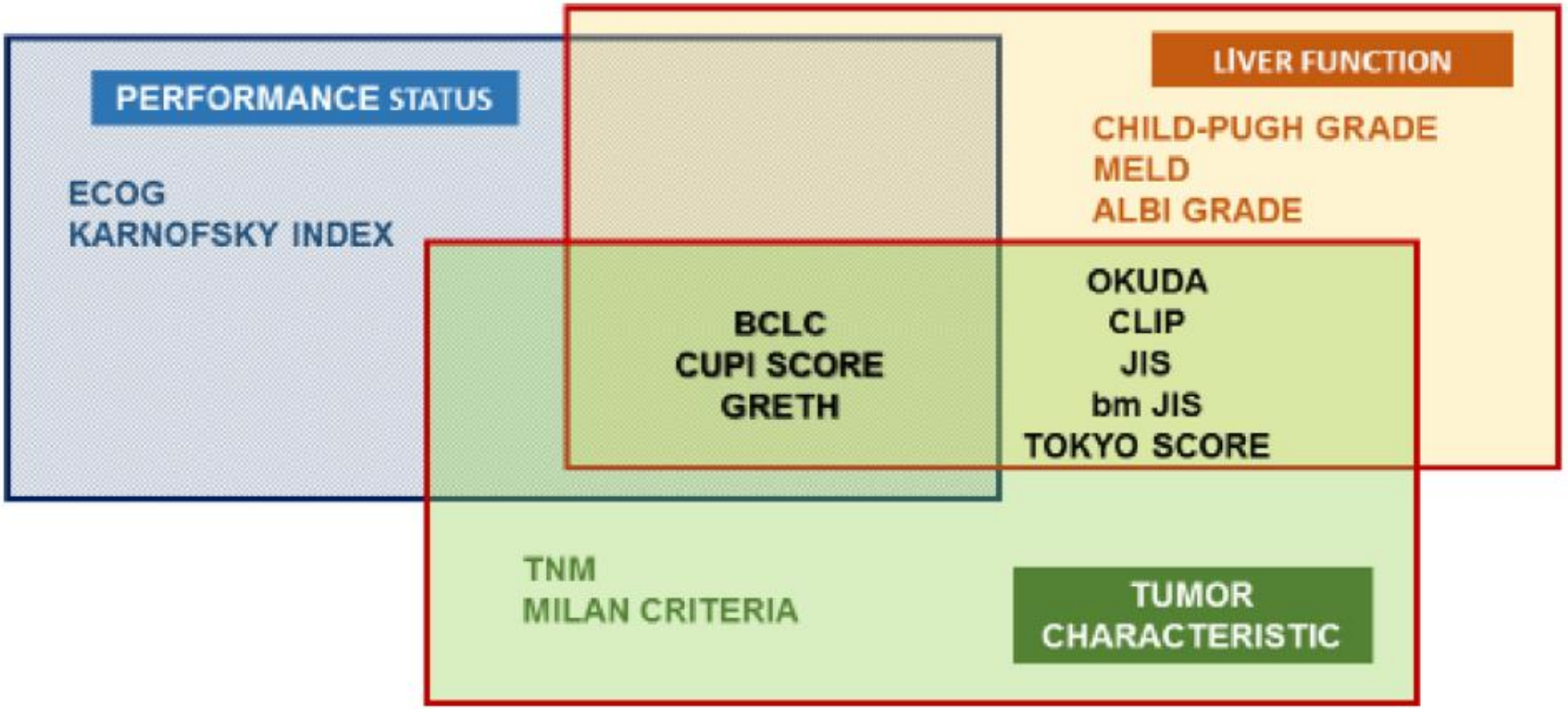


Cirurgia:
Ressecção de lobo caudado
Evolução satisfatória
Alta sem intercorrências

Tratamento do carcinoma hepatocelular

Cirurgia	Terapia ablativa local	Terapia loco-regional	Terapia sistêmica
Ressecção	Radiofrequência	Terapia transcateter	Quimioterapia
Transplante	Alcoolização	Quimio-lipiodolização	Hormonioterapia
	Ácido acético	TACE	Imunoterapia
	Microondas	TACE-DEB	Terapia alvo
	Crioablação	TAE	
	Eletroporação	Radioterapia	
	Terapia fotodinâmica	TARE	

Tratamento do carcinoma hepatocelular



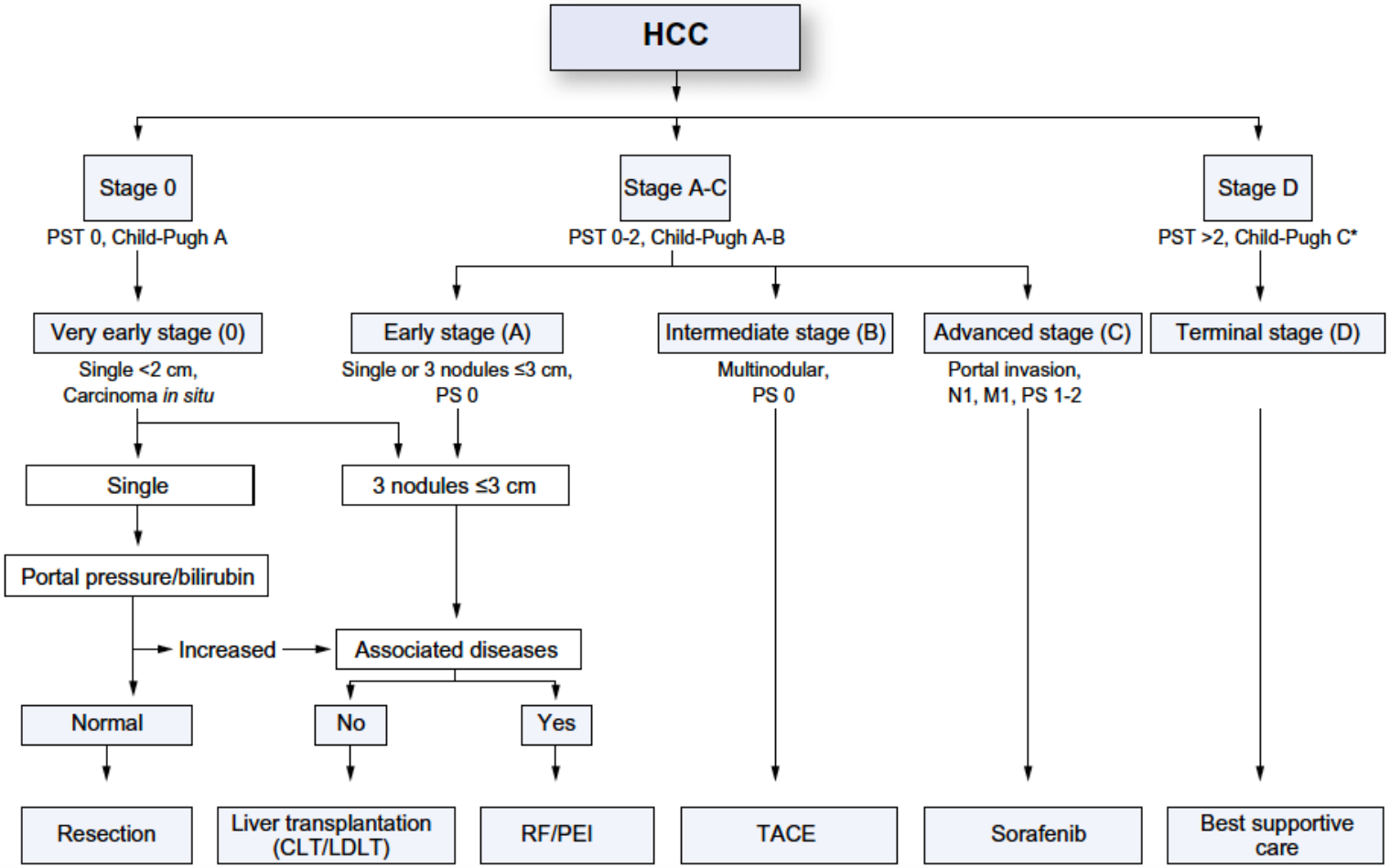
Sastre J, et al. Clin Transl Oncol 2015; 17: 988-95

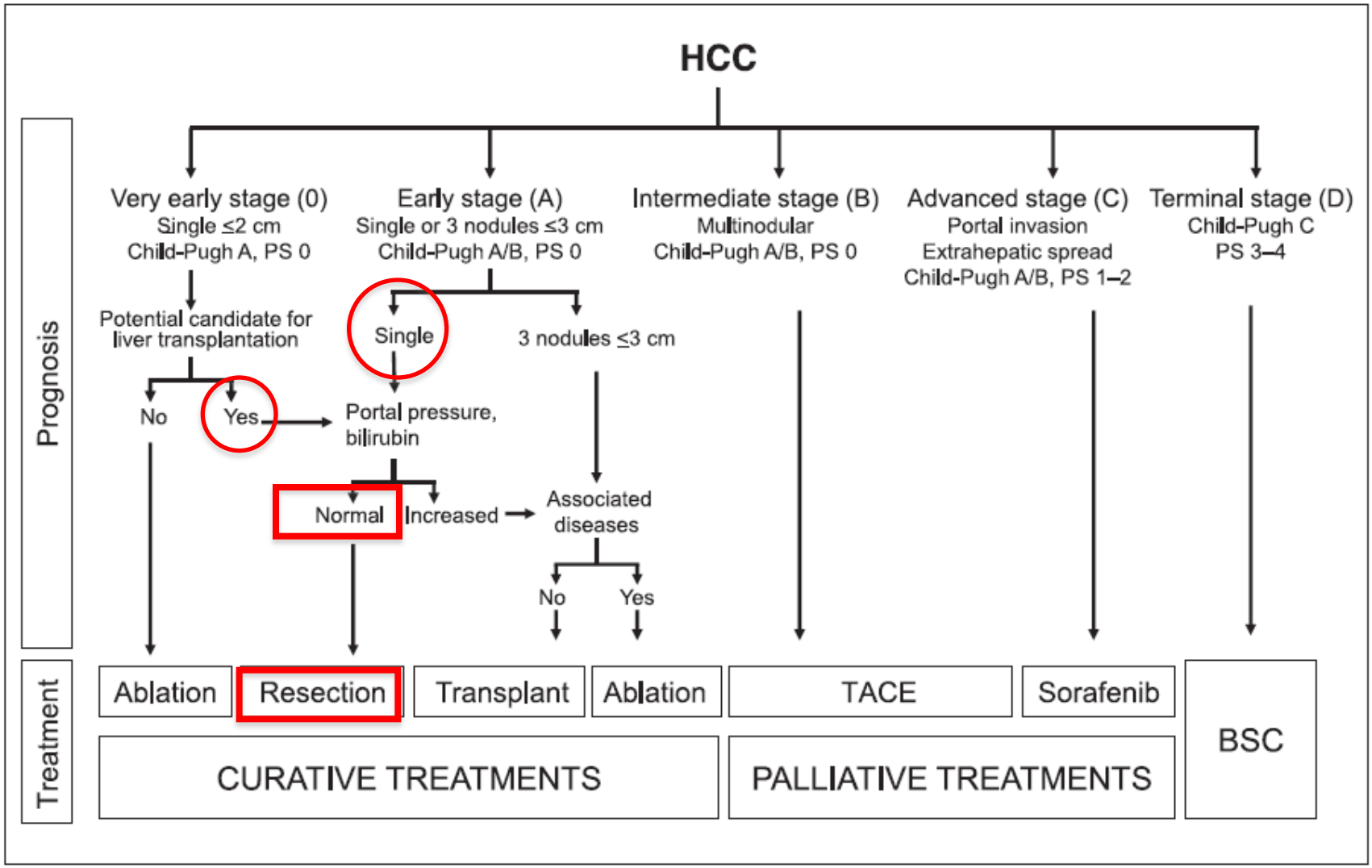
EASL EUROPEAN ASSOCIATION FOR THE STUDY OF THE LIVER | JOURNAL OF HEPATOLOGY

BCLC

EASL–EORTC Clinical Practice Guidelines: Management of hepatocellular carcinoma

European Association for the Study of the Liver*,
European Organisation for Research and Treatment of Cancer





Ressecção

Carrilho FL, et al. Arq Gastroenterol v 52, suppl 2015

Contraindicações para ressecção hepática BCLC

- Maior que 5 cm
- Múltiplos tumores
- Hipertensão porta
- Invasão vascular

BCLC

- Restritivo
- Ressecção oferecida 5-10%

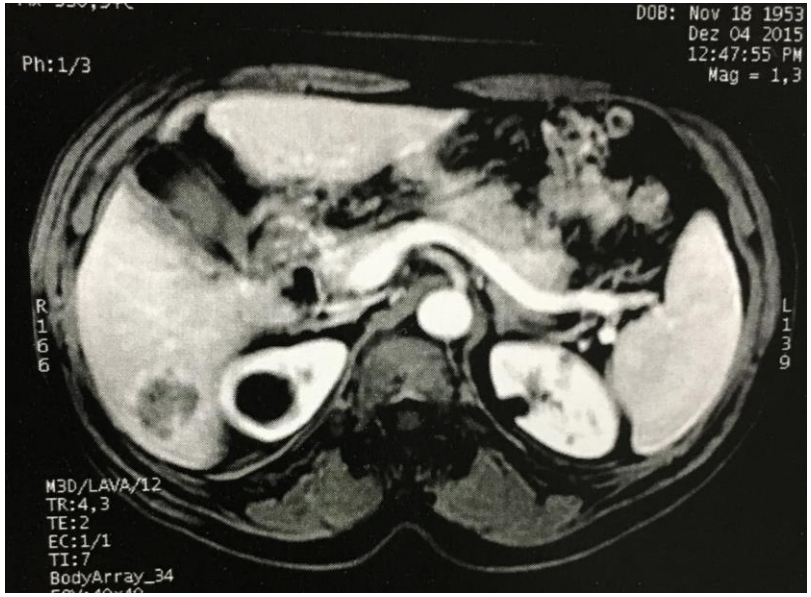
Evolução da cirurgia do fígado

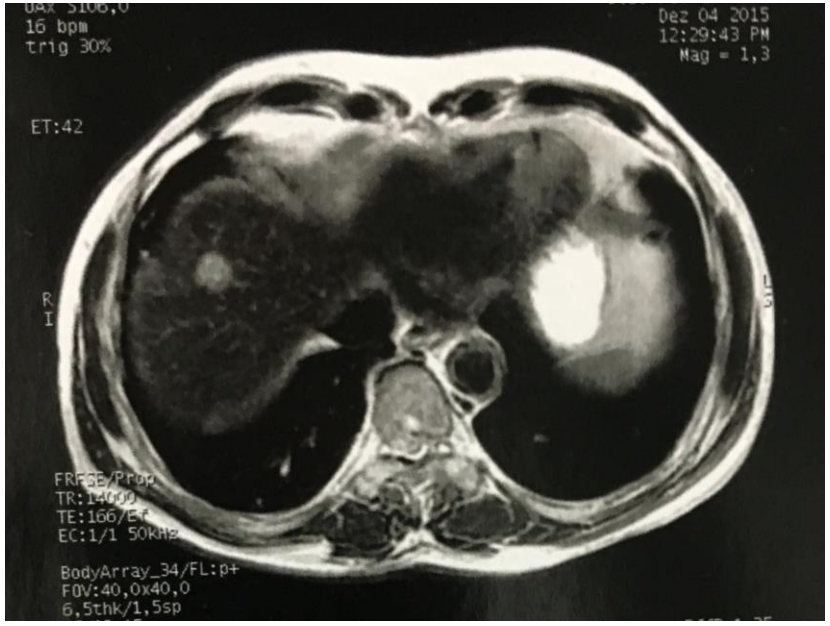
- Manuseio perioperatório
- Refinamento da técnica
- Redução da mortalidade
- Laparoscopia

É possível cirurgia (ressecção) para carcinoma hepatocelular além do BCLC?

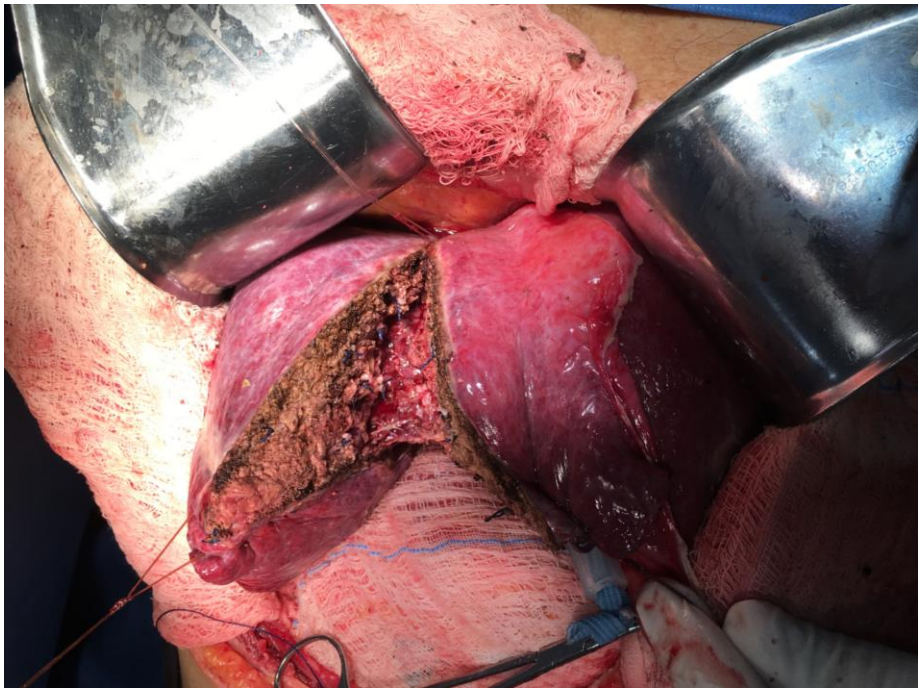
- Ablação
- Transplante
- TACE
- Sorafenib

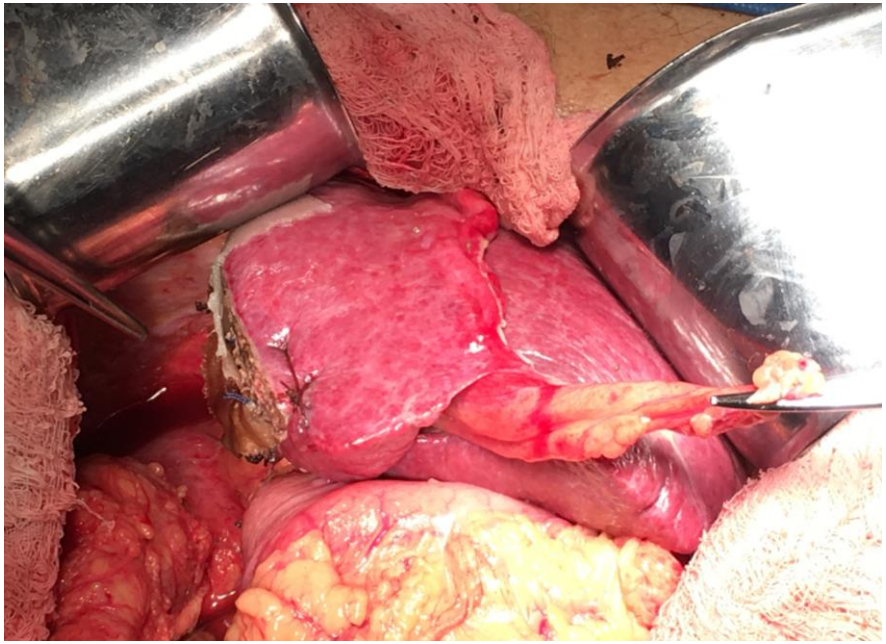
- **Ressecção**





L, masculino, 62 a,
Hepatopatia crônica
2 nódulos (CHC)
Child A6, MELD 9
110.000 plaquetas





Cirurgia:
Hepatectomia direita (5-8)
Evolução com ascite
Alta sem intercorrências

- **Maior que 5 cm**
- **Múltiplos tumores**
- **Hipertensão porta**
- **Invasão vascular**

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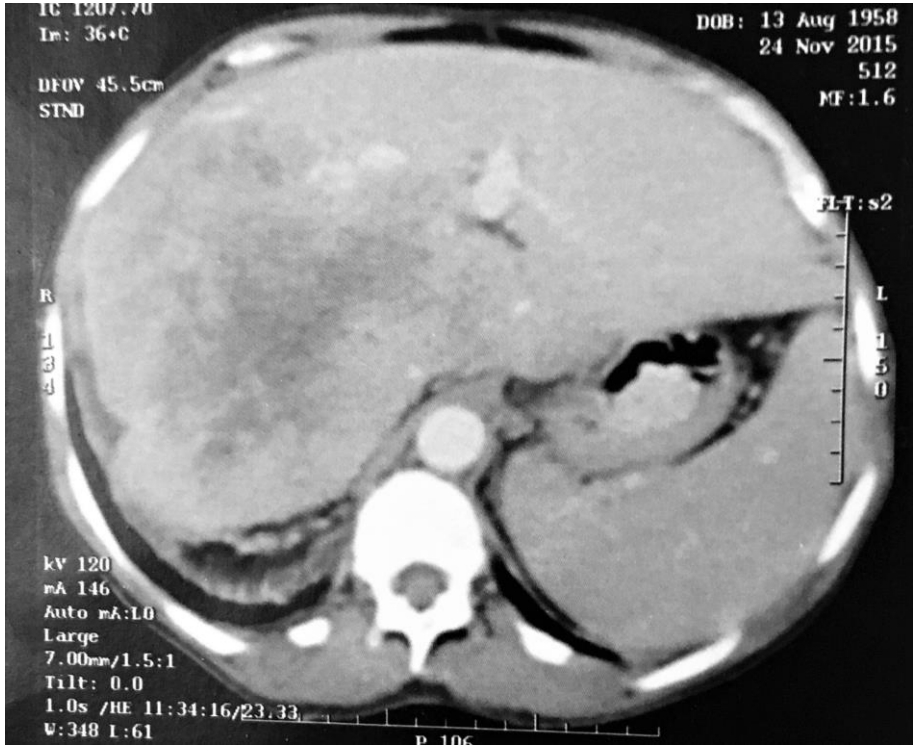
journal homepage: www.elsevier.com

Case Report

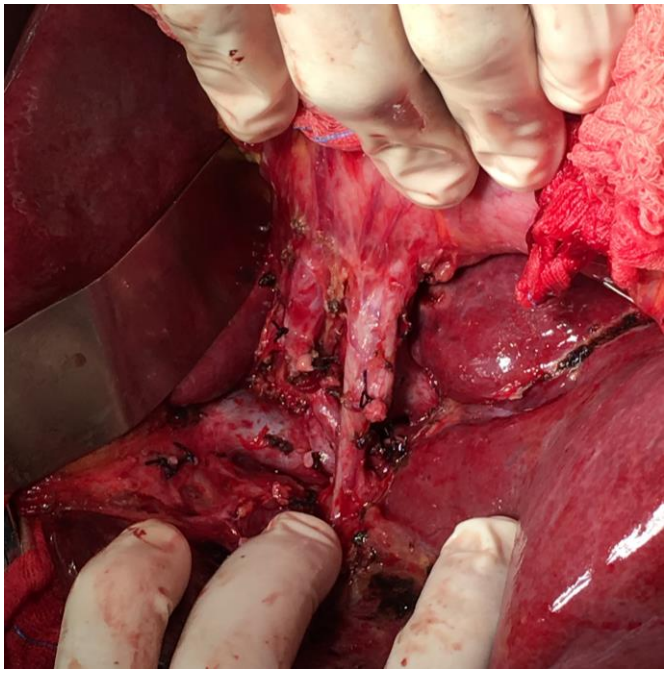
The ALPPS procedure for hepatocellular carcinoma larger than 10 centimeters

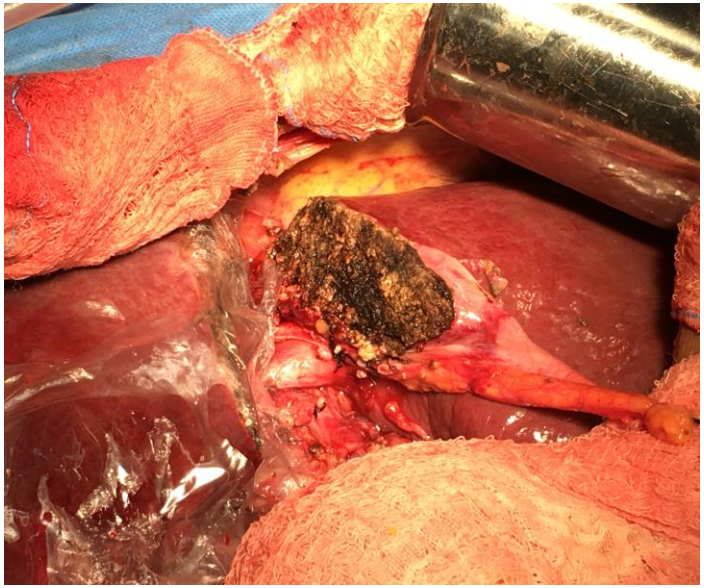
Orlando Jorge M. Torres *, Rodrigo Rodrigues Vasques, Thiago Henrique S. Silva, Miguel Eugenio L. Castelo-Branco, Camila Cristina S. Torres

Department of Digestive Surgery, Federal University of Maranhão, São Luiz, MA, Brazil

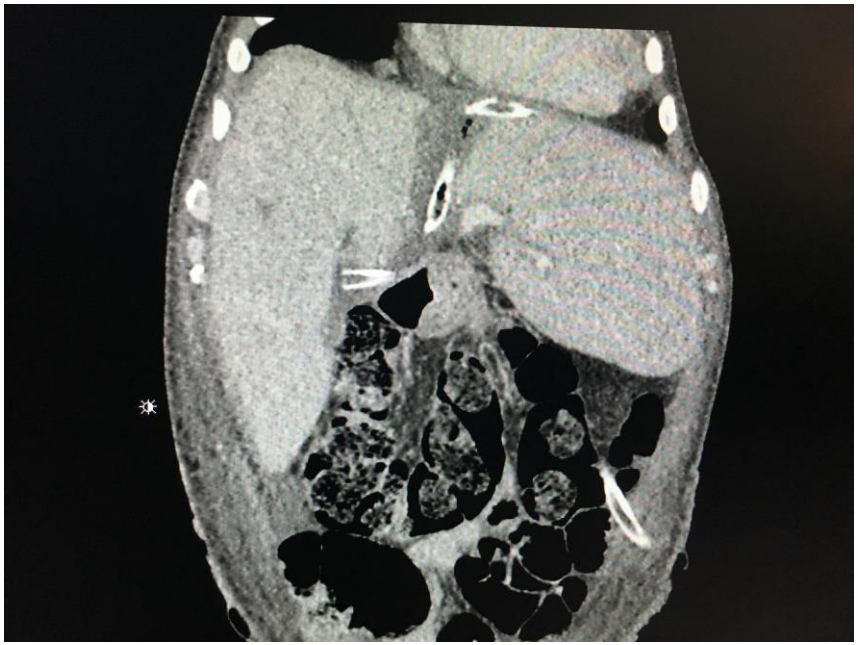


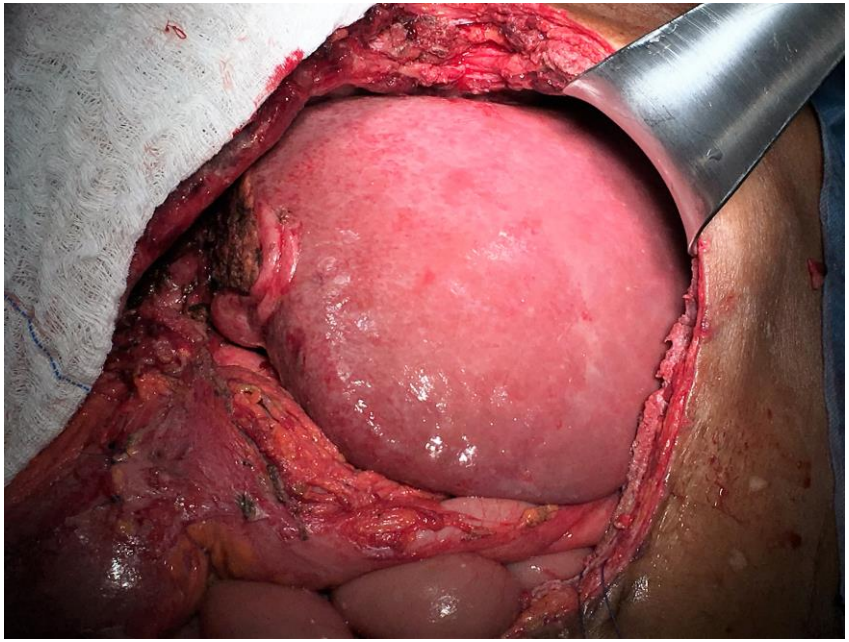
R, masculino, 57 a,
Hepatopatia crônica
Lesão única 19cm (CHC)
Child A5, MELD 9
AFP 508
123.000 plaquetas

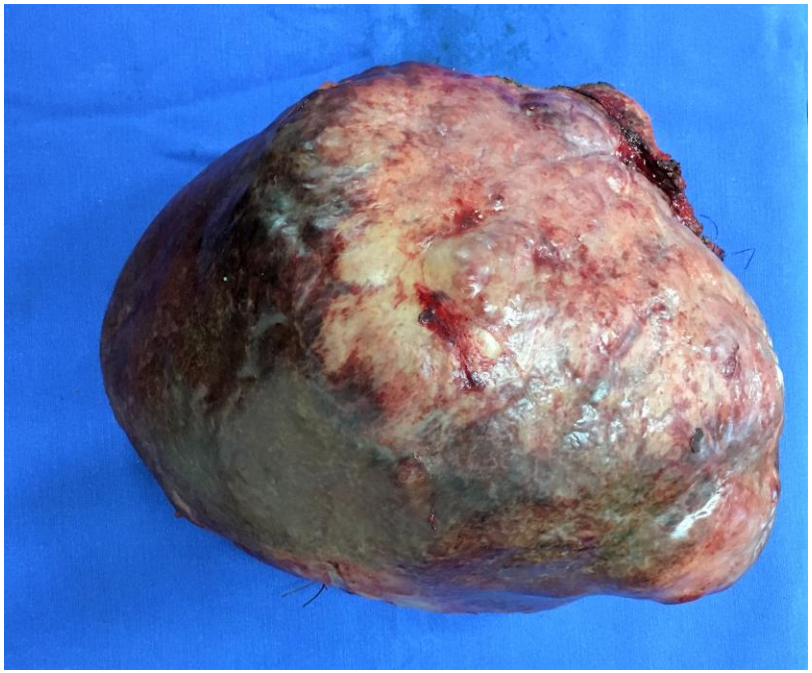




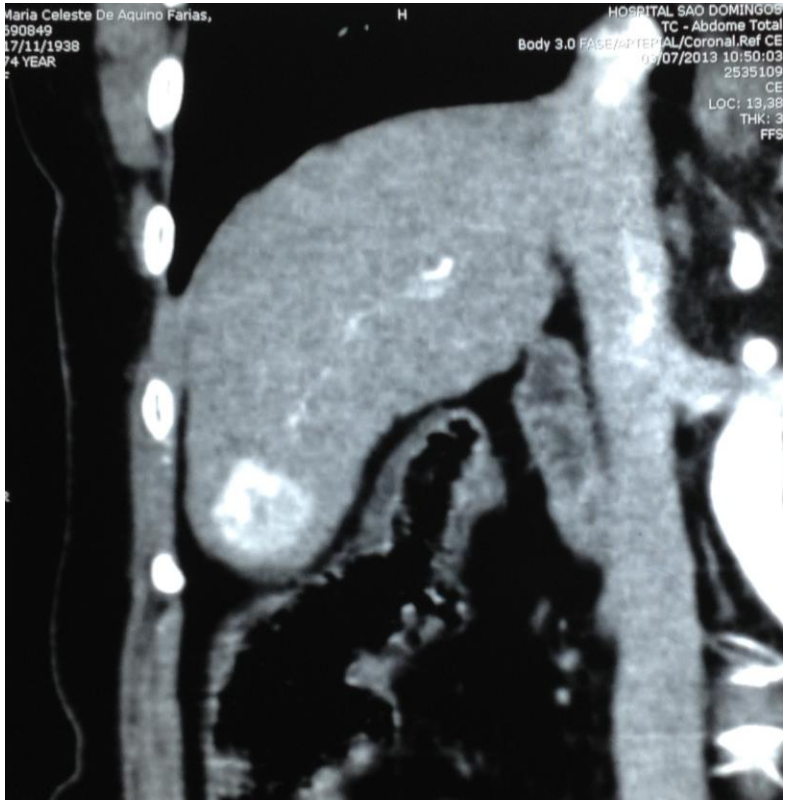
Conduta:
ALPPS



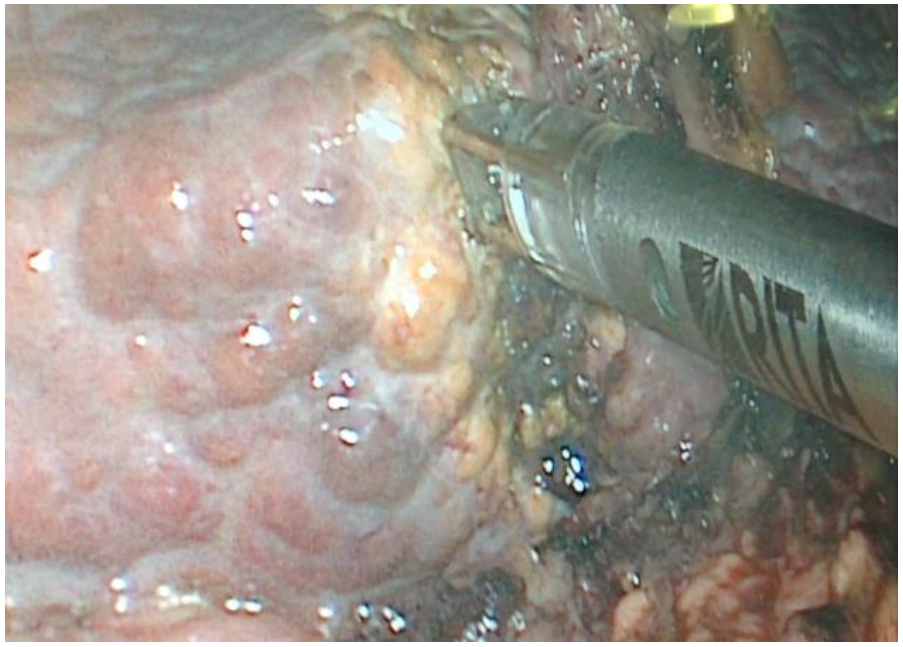


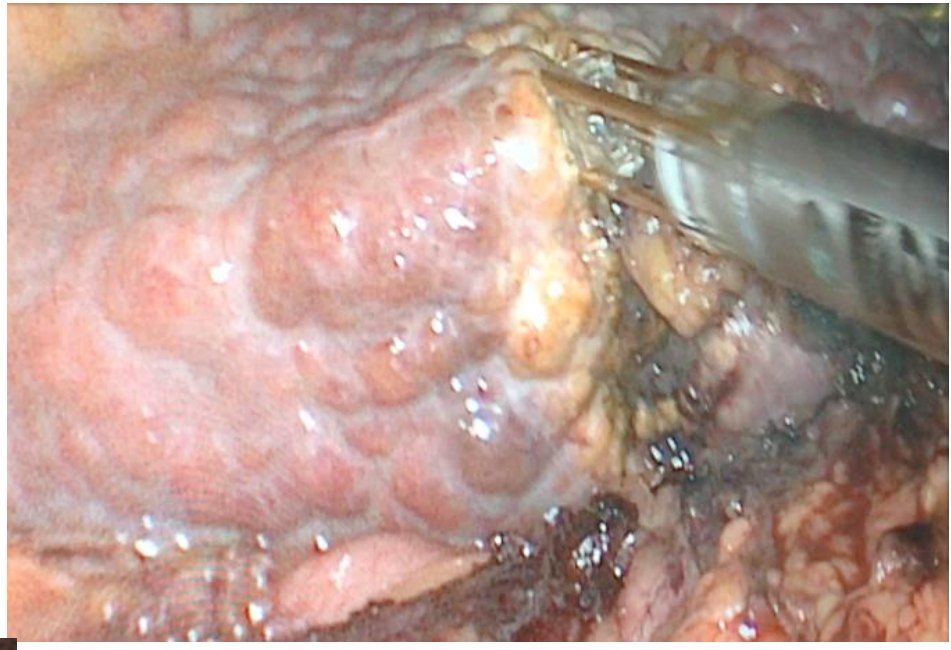


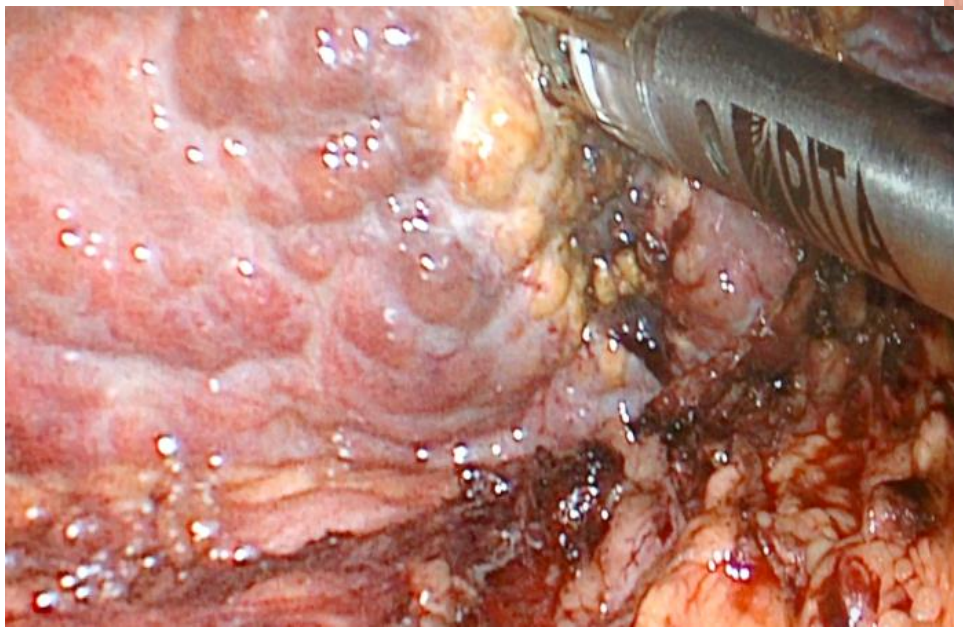
Pós-operatório:
Alta sem intercorrências



L, feminino, 72 a,
Hepatopatia crônica
Lesão única 6,5 cm Seg 6
Child A5, MELD 8
157.000 plaquetas







Hepatectomia laparoscópica
Com HABIB
Evolução favorável
Alta sem intercorrências

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ScienceDirect
EJSO 35 (2009) 11–15
EJSO the Journal of Cancer Surgery
www.ejso.com

For Debate

Liver resection for HCC with cirrhosis: Surgical perspectives out of EASL/AASLD guidelines

L. Capussotti [a,b,*], A. Ferrero [a,b], L. Viganò [a,b], R. Polastri [a,b], M. Tabone [c]

Table 1
Tumor characteristics in recent large published series

28-75% **24-39%** **3-14%**

Author	Year	Pts	Diameter (cm)		Multiple HCC	Major vascular invasion
			Median	>5 cm		
Fong[41]	1999	154	–	116 (75.3%)	42 (27.3%)	–
Poon[40]	2001	377	–	229 (60.7%)	–	–
Grazi[20]	2001	264	–	95 (36%)	0%	–
Belghiti[44]	2003	187	6	–	70 (39%)	16 (9%)
Vauthey/Nagorney[44]	2003	169	8	–	55 (33%)	24 (14%)
Ikai[44]	2003	230	3.5	–	72 (31%)	24 (10%)
Makuuchi[45]	2005	203		57 (28.1%)	57 (28.1%)	14 (6.9%)
Italian multicenter study[46]	2006	150	–	–	36 (24%)	5 (3.3%)

Capussotti L, et al. Eur J Surg Oncol 2009;35:11-15.

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the Journal of Cancer Surgery
ELSEVIER
EJSO 35 (2009) 11–15
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For Debate

Liver resection for HCC with cirrhosis: Surgical perspectives out of EASL/AASLD guidelines

L. Capussotti [a,b,*], A. Ferrero [a,b], L. Viganò [a,b], R. Polastri [a,b], M. Tabone [c]

[a] *Department of Surgery, Ospedale Mauriziano "Umberto I", Largo Turati 62, 10128 Torino, Italy*
[b] *Unit of Surgical Oncology, Institute for Cancer Research and Treatment, Candiolo, Italy*
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Accepted 20 June 2007
Available online 3 August 2007

Abstract

EASL/AASLD guidelines clearly define indications for liver surgery for HCC: patients with single HCC and completely preserved liver function without portal hypertension. These guidelines exclude from operation many patients that could benefit from radical resection and that are daily scheduled for hepatectomy in surgical centers. Patients with large tumors or with portal vein thrombosis cannot be transplanted or treated by interstitial treatments. In selected cases liver resection may obtain good long-term outcomes, significantly better than non-curative therapies. In cases of multinodular HCC, liver transplantation is the treatment of choice within Milan criteria; patients beyond these limits can benefit from liver resection, especially if only two nodules are diagnosed: even if they have a worse prognosis, survival results after liver surgery are better than those reported after TACE or conservative treatments. EASL/AASLD guidelines excluded from operating patients with portal hypertension but data about this topic are not conclusive and further studies are necessary. Selected patients with mild portal hypertension could probably be scheduled for liver resection and, considering the shortage of donors, listing for transplantation could be avoided.

In conclusion, guidelines for HCC treatment should consider good results of liver resection for advanced HCC, and indications for hepatectomy should be expanded in order not to exclude from radical therapy patients that could benefit from it.

Capussotti L, et al. Eur J Surg Oncol 2009;35:11-5

Primary Liver Resection Policy

In both institutions, resection was attempted as first-line treatment whenever possible in selected patients as previously described [16]. The main selection criteria for resection were the ability of the patient to handle a surgical intervention on a diseased liver (preserved general condition, preserved liver function, MELD score <9, Child-Pugh class A or B, absence of significant portal hypertension as defined by a portocaval gradient <10 mmHg) and the resectability of the tumor (size, number, and location of the lesions, macrovascular involvement) as assessed by imaging, which was discussed in a weekly multidisciplinary meeting for each case. The general condition of each patient was evaluated according to both American Society of Anesthesiologists Score and WHO classification. Postoperative mortality was defined as

Scatton O, et al. J Surg Oncol 2015; 111:1007-15

Ressecção hepática

- **MELD < 9**
- **Child-Pugh A ou B**
- **Ausência de HP significante**

  Gradiente porto-cava < 10 mmHg
- **Ressecabilidade do tumor**

  Tamanho

  Número

  Localização

  Envolvimento microvascular
- **Estado geral preservado**

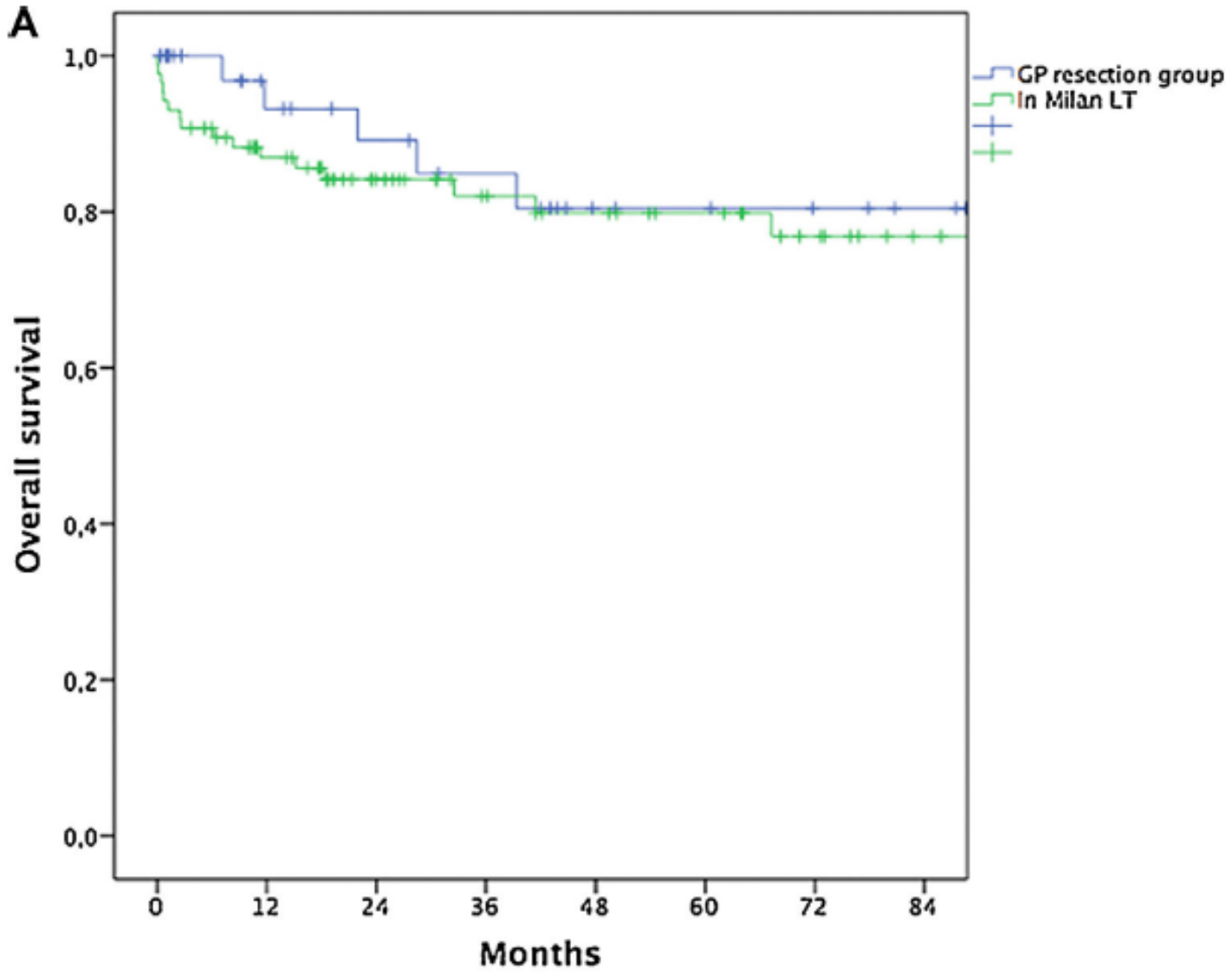
Scatton O, et al. J Surg Oncol 2015; 111:1007-15

TABLE II. Pathological Features of 221 Resected Patients

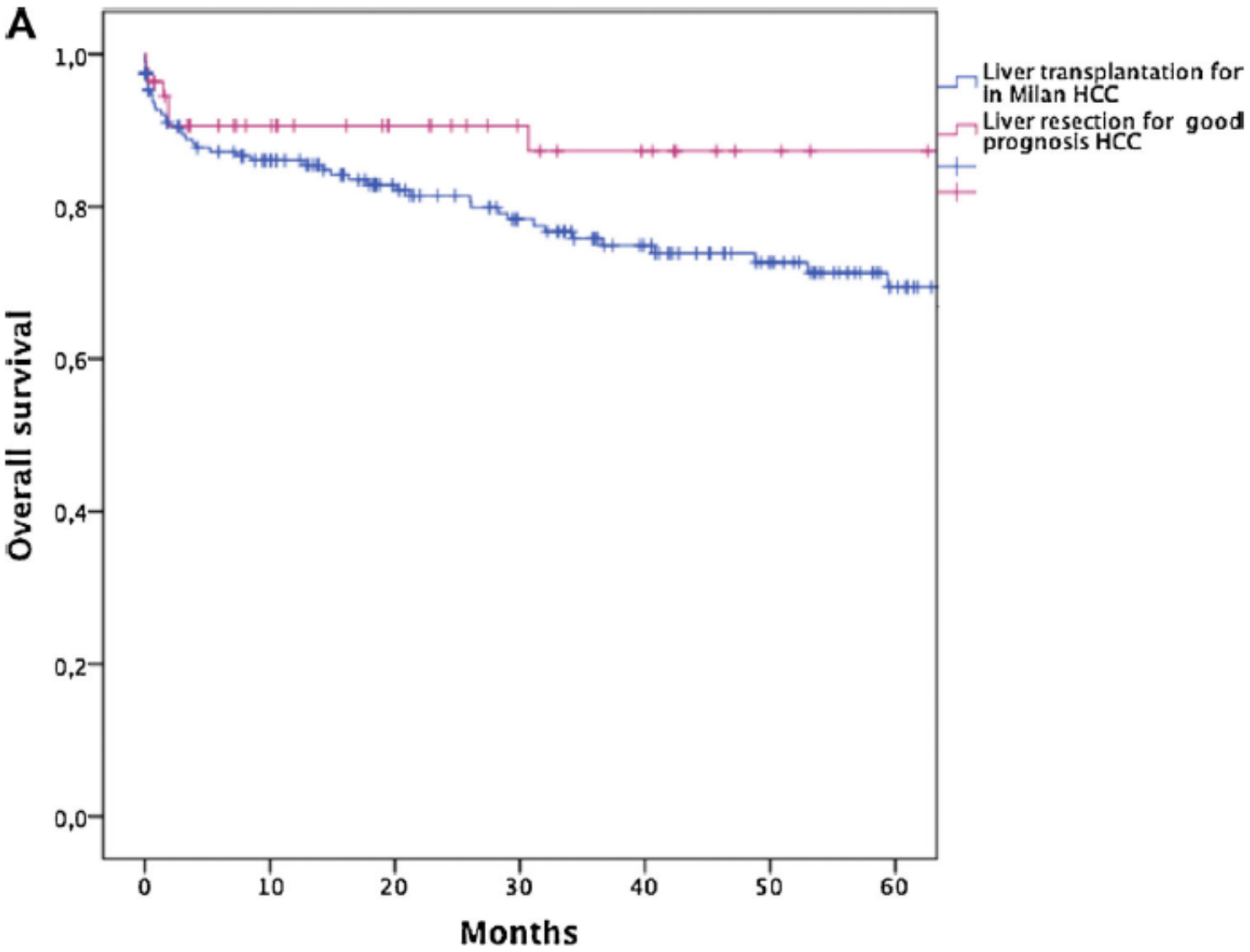
	Resected patients, n = 221
Single HCC (%)	138 (62.4)
Median maximum tumor size (mm)*	50 (8–250)
Differentiation grade (%)	
Well differentiated (%)	73 (33)
Moderately differentiated (%)	123 (55.7)
Poorly differentiated (%)	25 (11.3)
Encapsulated tumor (%)	107 (48.4)
Median margin (mm)*	8 (0–63)
R_0 resection (%)	176 (79.6)
Microvascular invasion (%)	87 (39.4)
Satellite nodules (%)	59 (26.7)
Underlying fibrosis	
F0 (%)	27 (12.2)
F1-2 (%)	43 (19.6)
F3 (%)	34 (15.4)
F4 (%)	117 (52.9)

*Expressed as median (range).

Scatton O, et al. J Surg Oncol 2015; 111:1007-15



Scatton O, et al. J Surg Oncol 2015; 111:1007-15



Scatton O, et al. J Surg Oncol 2015; 111:1007-15

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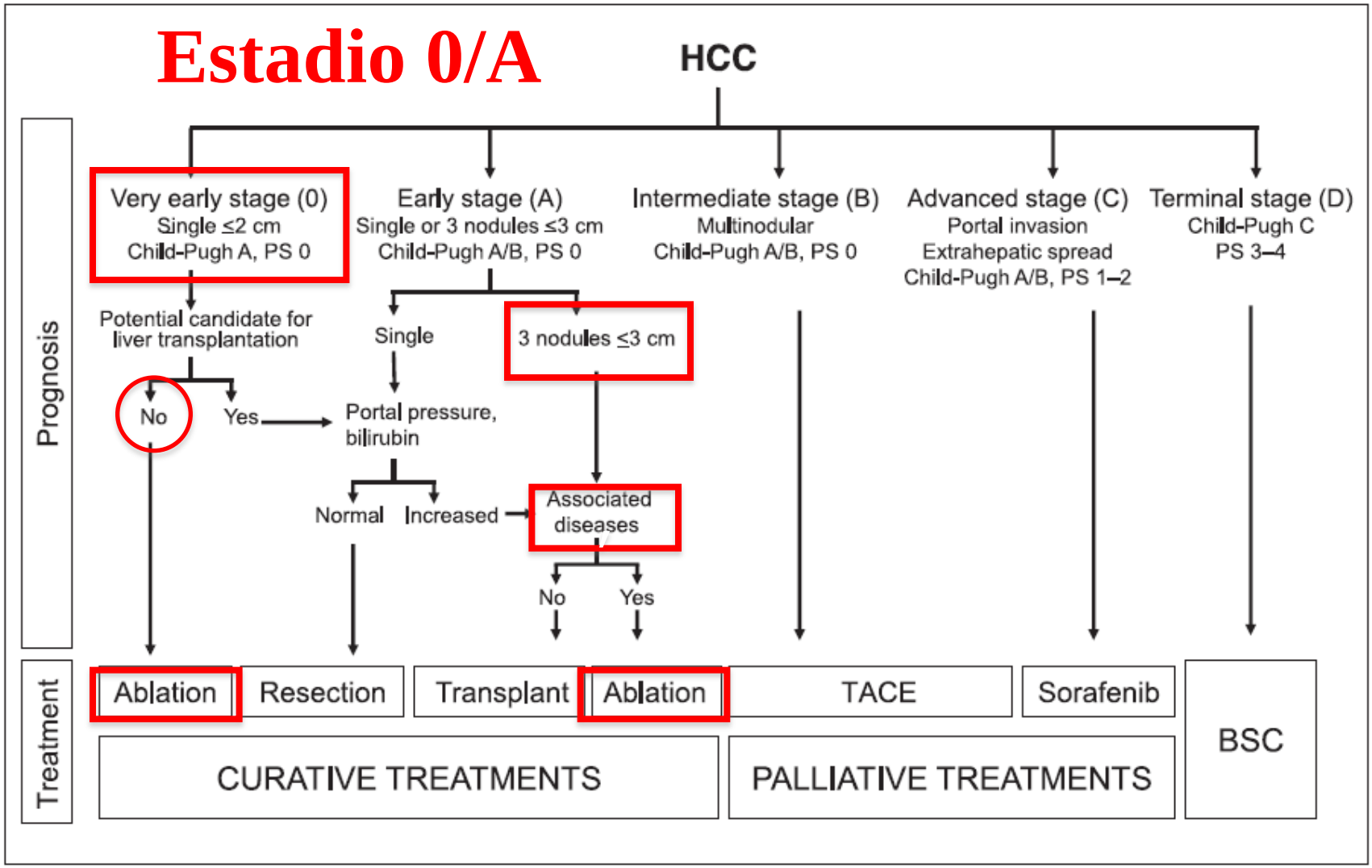


Ablação

Carrilho FL, et al. Arq Gastroenterol v 52, suppl 2015

ORIGINAL ARTICLE

Laparoscopic resection of hepatocellular carcinoma: a French survey in 351 patients

Olivier Soubrane[1], Claire Goumard[1], Alexis Laurent[2], Hadrien Tranchart[3], Stéphanie Truant[4], Brice Gayet[5], Chadi Salloum[6], Guillaume Luc[7], Safi Dokmak[8], Tullio Piardi[9], Daniel Cherqui[2], Ibrahim Dagher[3], Emmanuel Boleslawski[4], Eric Vibert[6], Antonio Sa Cunha[7], Jacques Belghiti[8], Patrick Pessaux[9], Pierre-Yves Boelle[1,10,11] & Olivier Scatton[1]

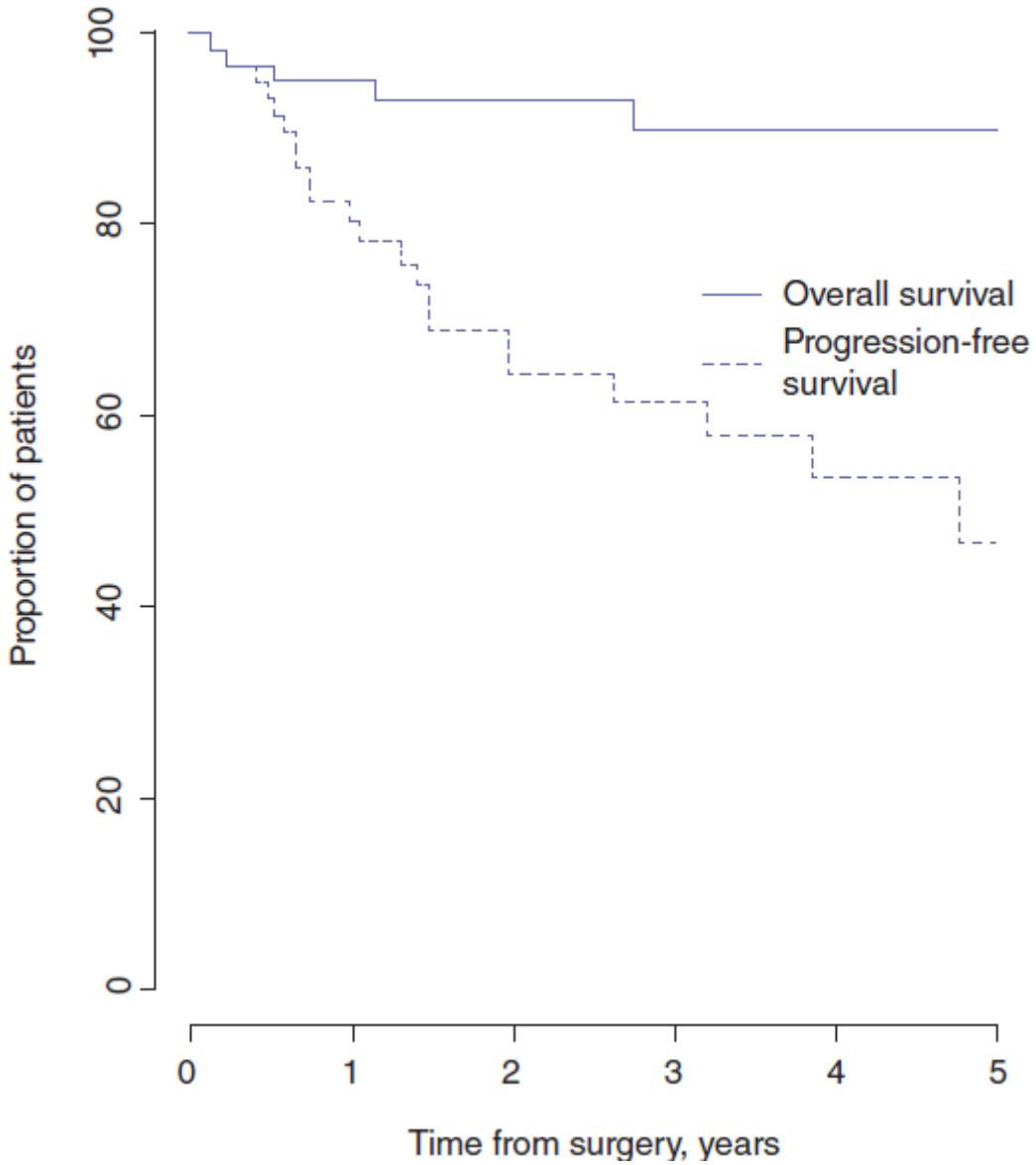
[1]Department of Hepatobiliary Surgery and Liver Transplant, St Antoine Hospital, Assistance Publique–Hôpitaux de Paris (AP-HP), University of Pierre and Marie Curie (UPMC), Paris, France, [2]Department of Digestive and Hepatobiliary Surgery, Henri Mondor Hospital, AP-HP, University of Paris East Créteil Val de Marne, Créteil, France, [3]Department of Digestive and Hepatobiliary Surgery, Antoine Béclère Hospital, AP-HP, University of Paris South, Clamart, France, [4]Department of Digestive and Hepatobiliary Surgery, Claude Huriez Hospital, University of Lille and North France, Lille, France, [5]Department of Digestive and Hepatobiliary Surgery, Institut Mutualiste Montsouris, Paris, France, [6]Department of Hepatobiliary Surgery and Liver Transplant, Paul Brousse Hospital, AP-HP, University of Paris South, Villejuif, France, [7]Department of Digestive and Hepatobiliary Surgery, Haut-Lévêque Hospital, University of Bordeaux, Bordeaux, France, [8]Department of Digestive and Hepatobiliary Surgery, Beaujon Hospital, University Denis Diderot Paris, Clichy, France, [9]Department of Digestive and Hepatobiliary Surgery, Hautepierre Hospital, University of Strasbourg, Strasbourg, France, [10]Department of Statistics, UPMC, UMR S 707, Paris, France and [11]National Institute of Health and Medical Research (INSERM), U707, Paris, France

Soubrane O, et al. HPB 2016;16:357-65

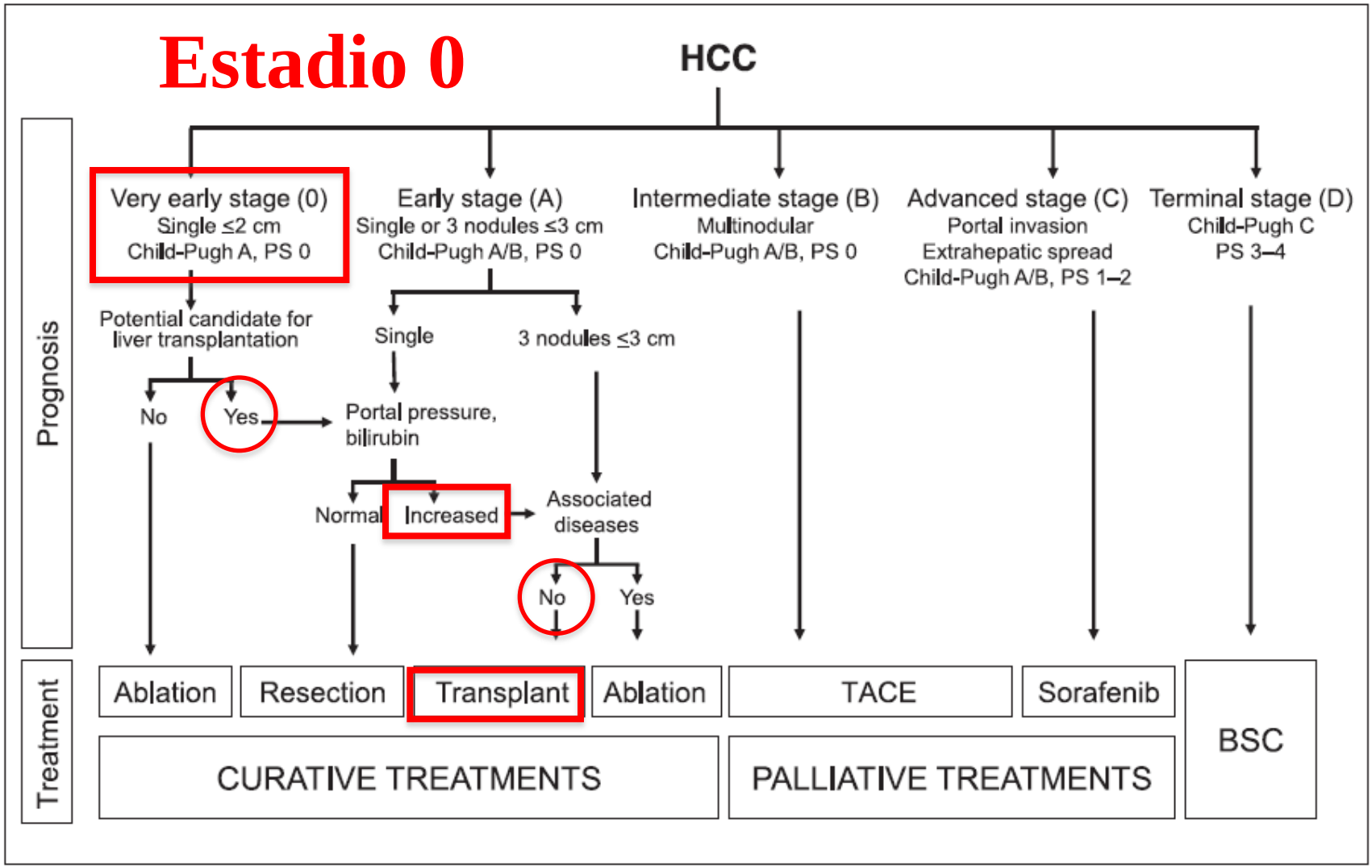
Table 4 Pathological features in 351 patients submitted to laparoscopic liver resection for hepatocellular carcinoma (HCC)

Postoperative data	Value
Histological cirrhosis, *n* (%)	247 (70%)
Histological fibrosis F2, F3, *n* (%)	55 (16%)
Maximum tumour size, mm, median (range)	35 (5–170)
Single HCC, *n* (%)	302 (86%)
Multiple HCC, *n* (%)	49 (14%)
Bilobar HCC, *n* (%)	24 (7%)
Encapsulated HCC, *n* (%)	162 (46%)
Satellite nodules, *n* (%)	81 (23%)
Well or moderately differentiated HCC, *n* (%)	319 (91%)
Poorly differentiated HCC, *n* (%)	32 (9%)
Vascular invasion, *n* (%)	119 (34%)
Tumour-free margin, *n* (%)	323 (92%)
Margin, mm, median (range)	10 (0–78)

Soubrane O, et al. HPB 2016;16:357-65



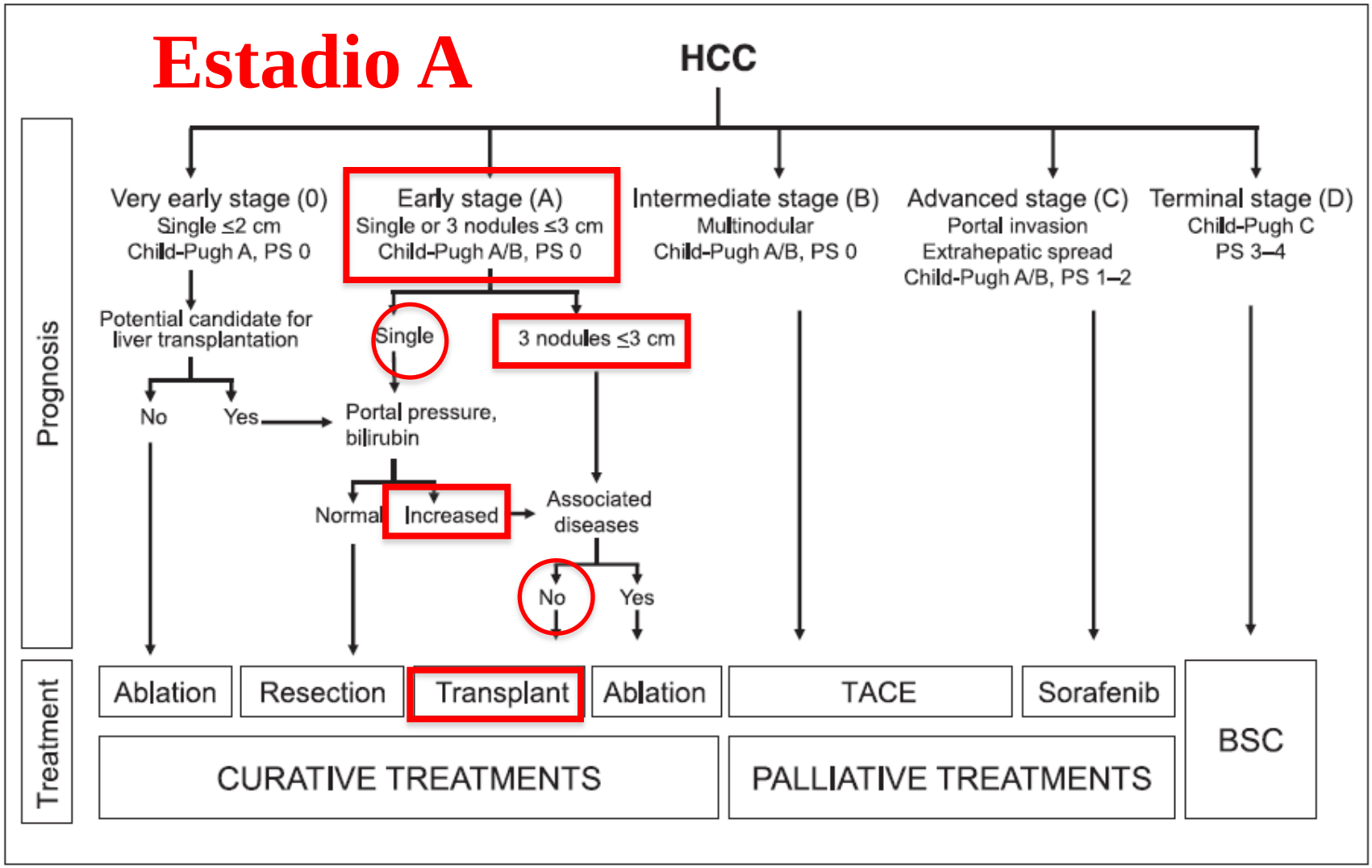
Soubrane O, et al. HPB 2016;16:357-65



Transplante

Carrilho FL, et al. Arq Gastroenterol v 52, suppl 2015

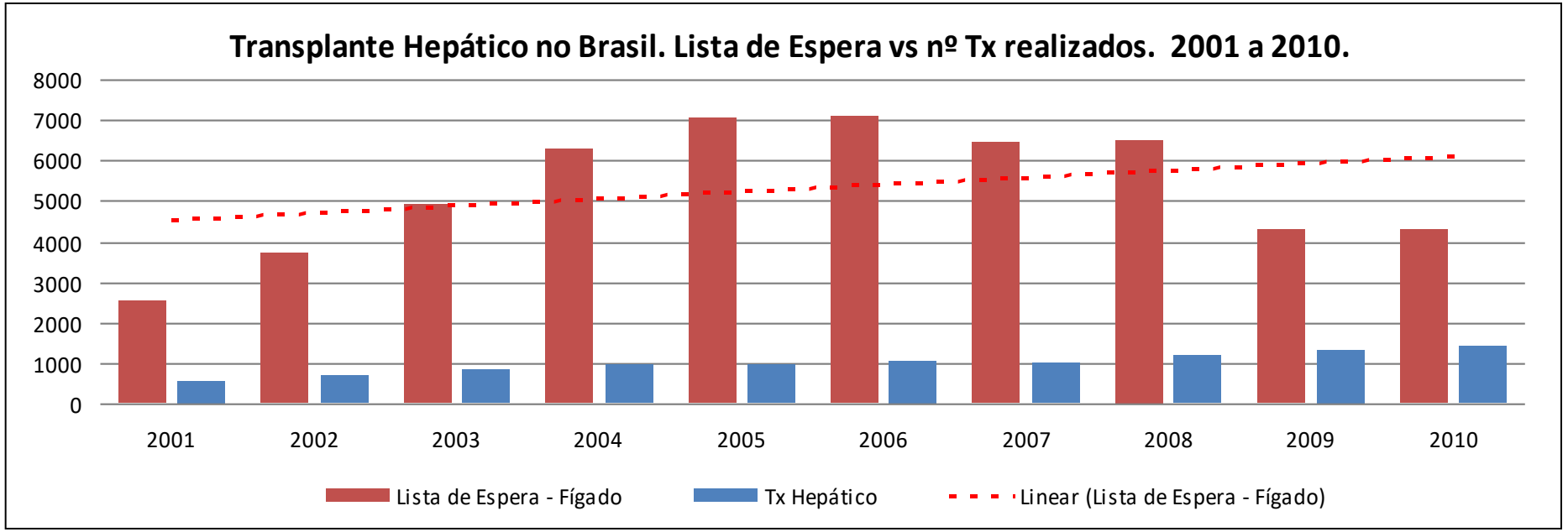
Estadio A



Transplante

Carrilho FL, et al. Arq Gastroenterol v 52, suppl 2015

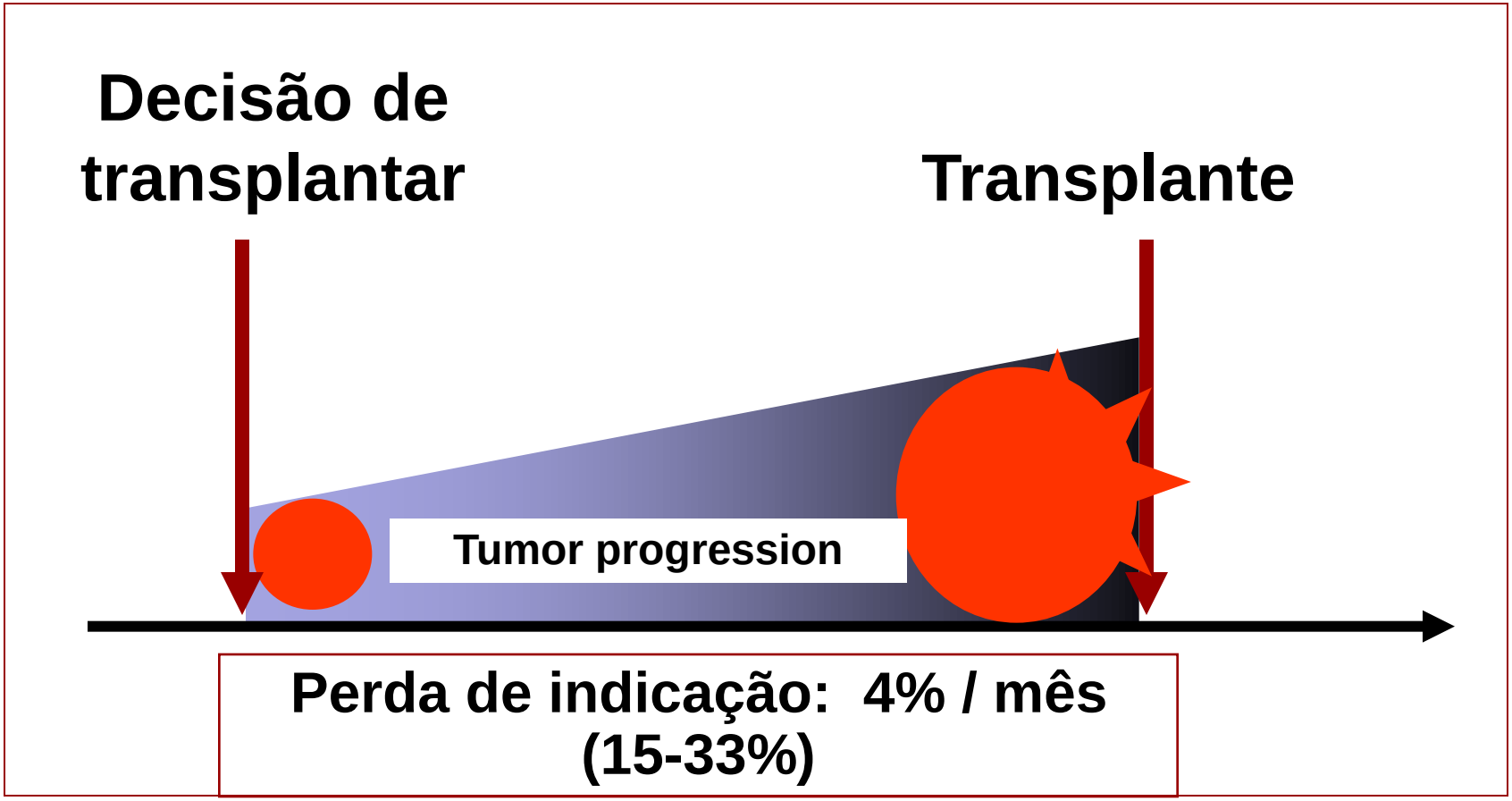
Necessidade de Transplante de Fígado - Brasil



Tx Fígado - Brasil		
Nº Tx em 2010:	**1413**	
Lista de Espera - 2010:	**4304**	
% Tx 2010/Lista de Espera:		**33%**

FALTA DE ÓRGÃOS!!!

Transplante para CHC



Yao FY, et al. Liver Transpl. 2002
Roayaie S et al. Clin Liver Dis 2005

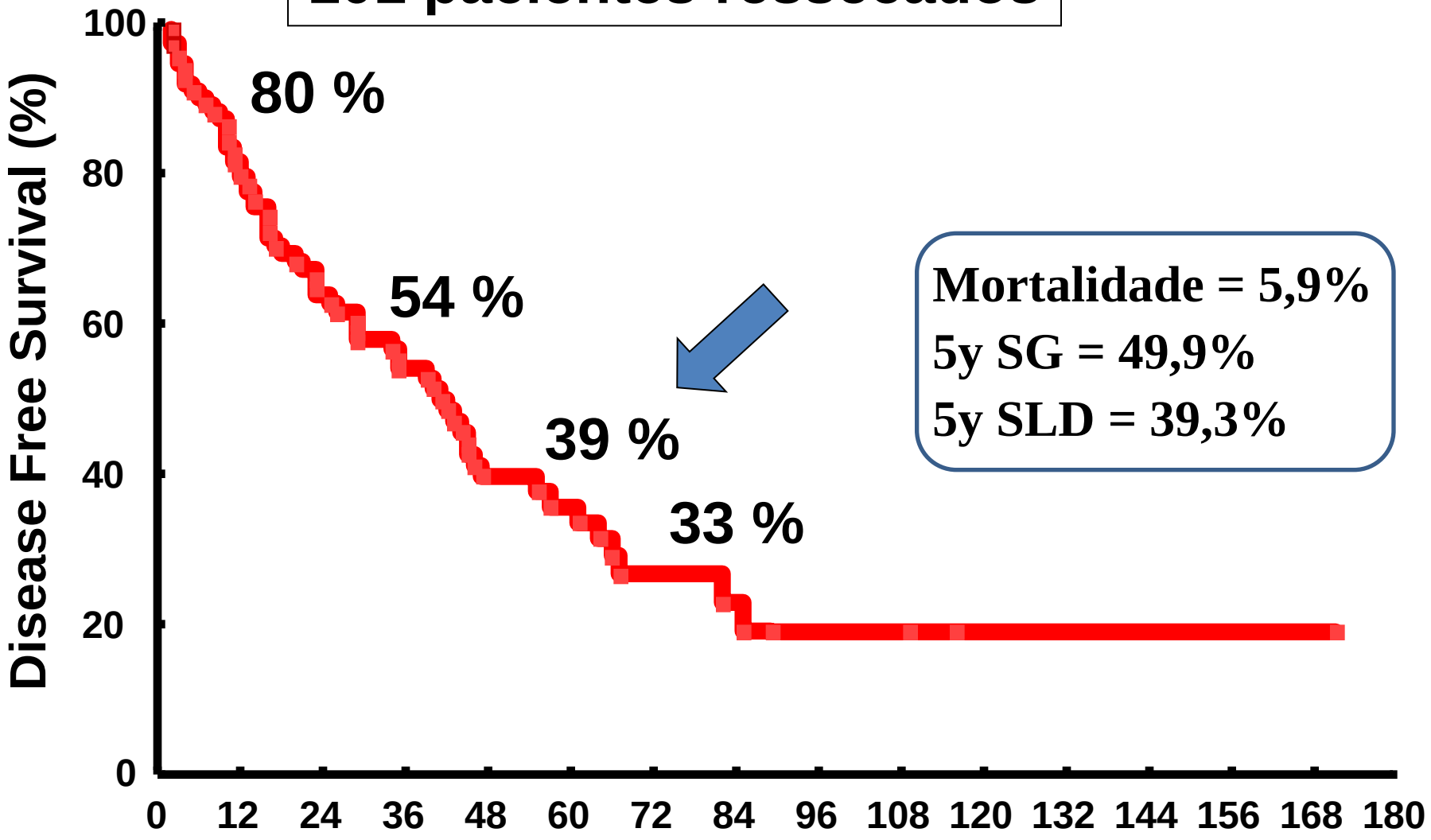
Mortalidade na Lista de Espera - CHC

Mortalidade na lista de espera (MLE)	Jan 2013 - dez 2013
Mortalidade global	34,1%
Mortalidade pediátrica	29,15%
Mortalidade Adulto	34,4%
Mortalidade CHC (Milan + Downstaging)	28,25%

Source: Secretaria de Estado da Saúde do Estado de SP – Sistema Estadual de Transplantes

Sobrevida
101 pacientes ressecados

MEDICINA
USP

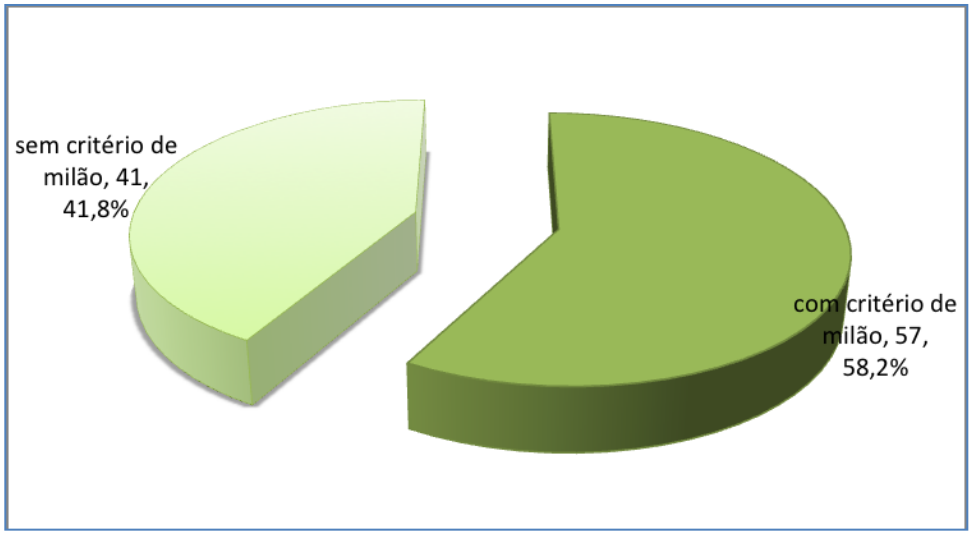


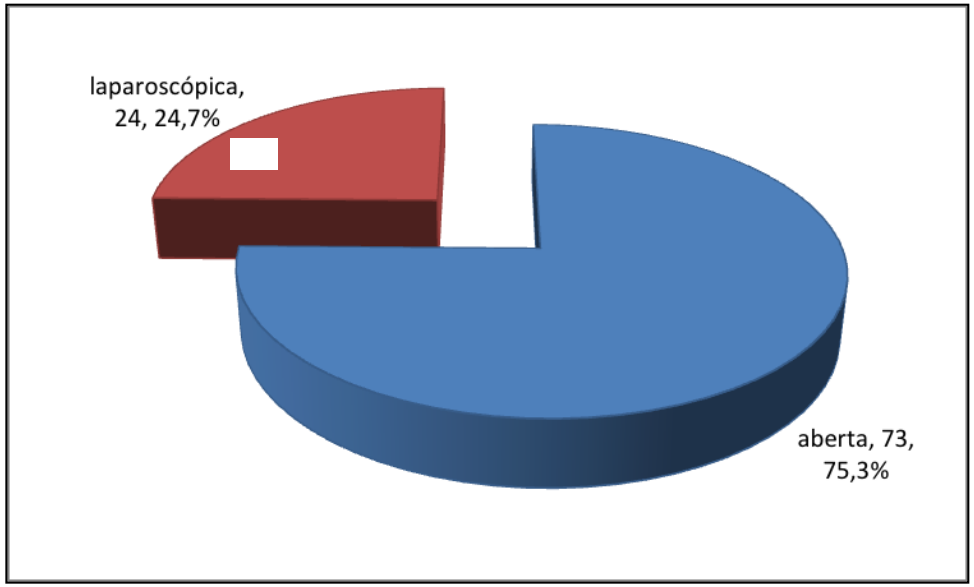
Mortalidade = 5,9%
5y SG = 49,9%
5y SLD = 39,3%

Cortesia Prof. Paulo Herman
Cirurgia do Fígado - USP

HCFMUSP

HCFMUSP
101 pacientes ressecados





Cortesia Prof. Paulo Herman
Cirurgia do Fígado - USP

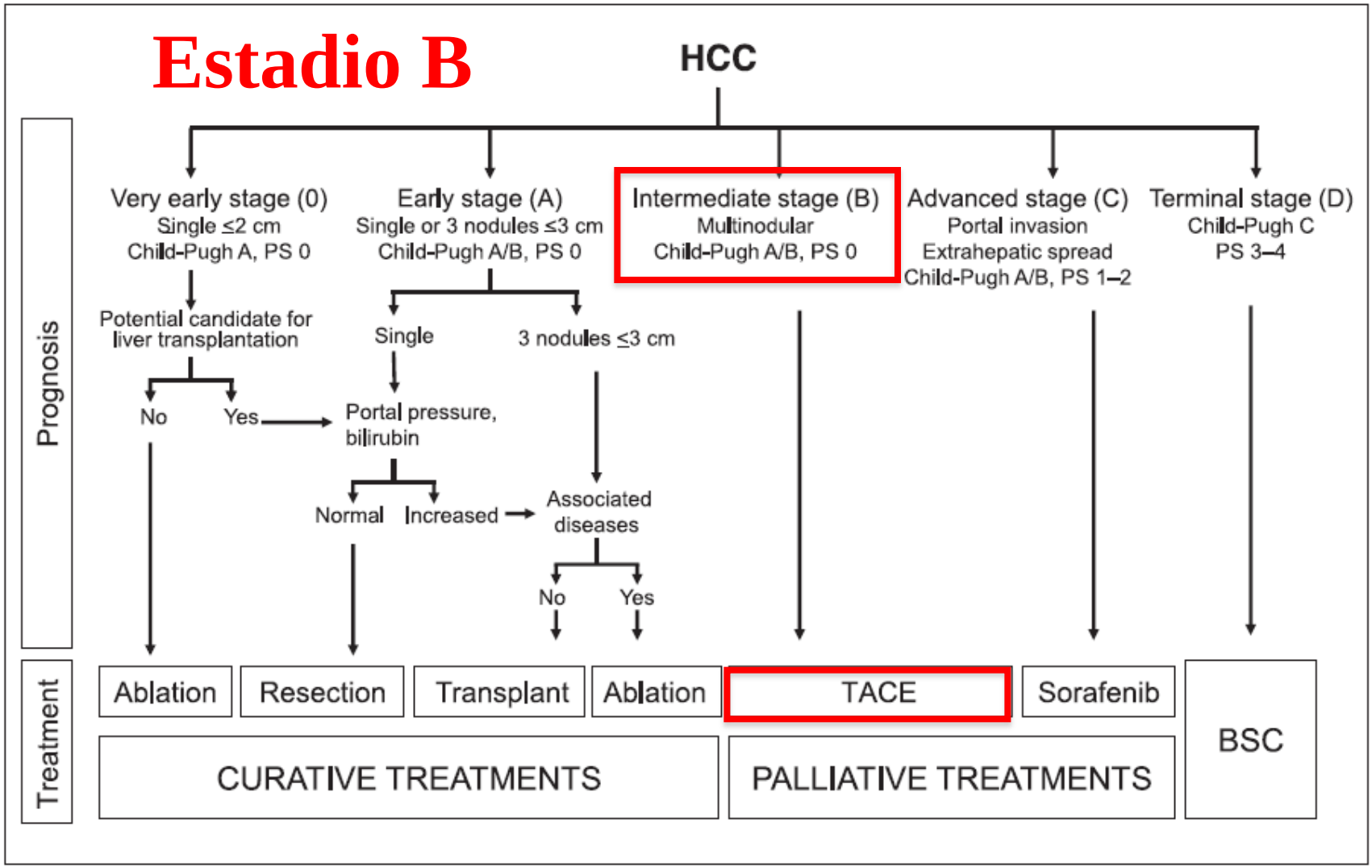
MEDICINA USP

HCFMUSP
101 pacientes ressecados

Ressecção CHC - Laparoscopia
68% - 2014/2015

Cortesia Prof. Paulo Herman
Cirurgia do Fígado - USP

Estadio B



TACE

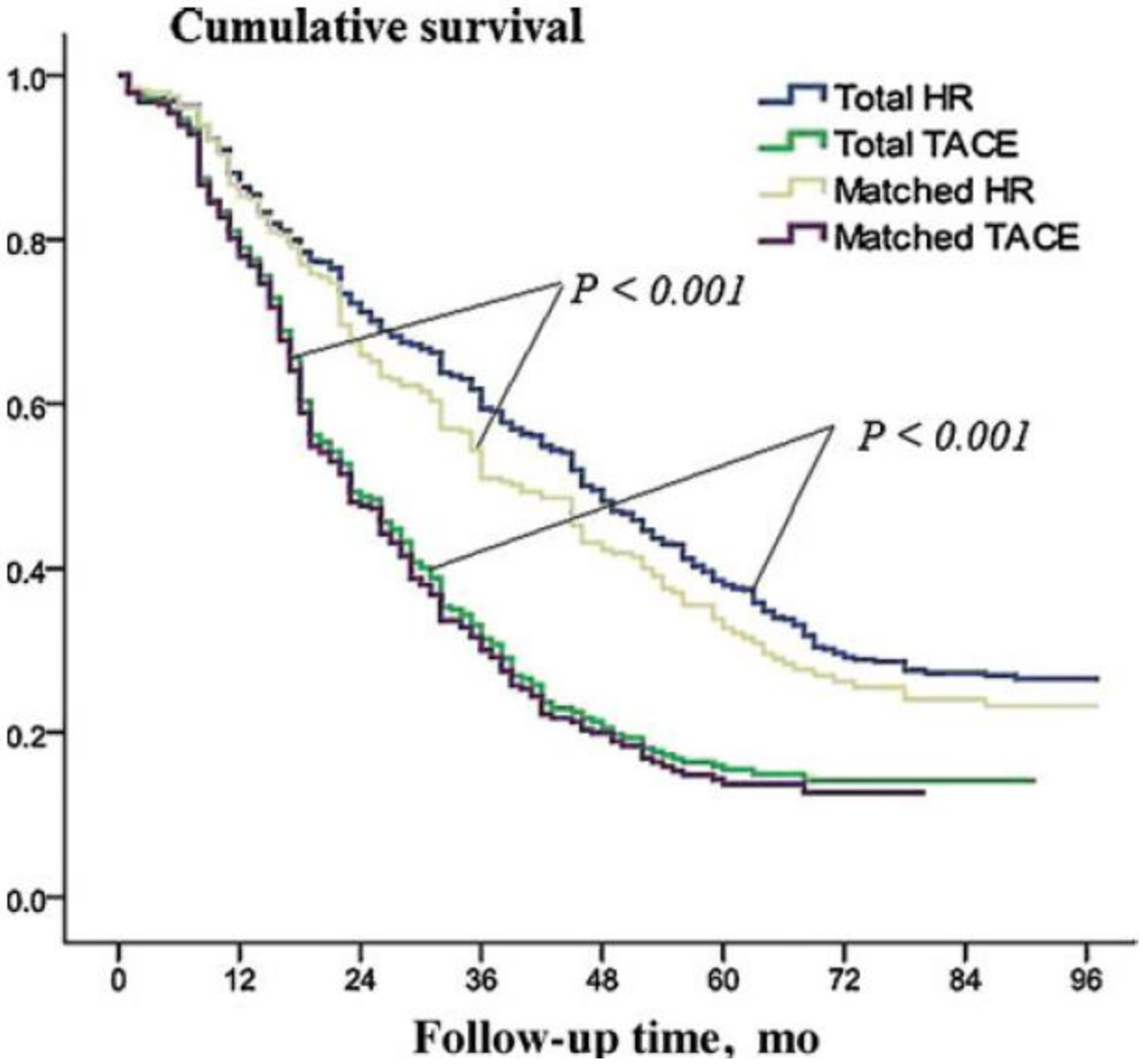
Carrilho FL, et al. Arq Gastroenterol v 52, suppl 2015

ORIGINAL ARTICLE

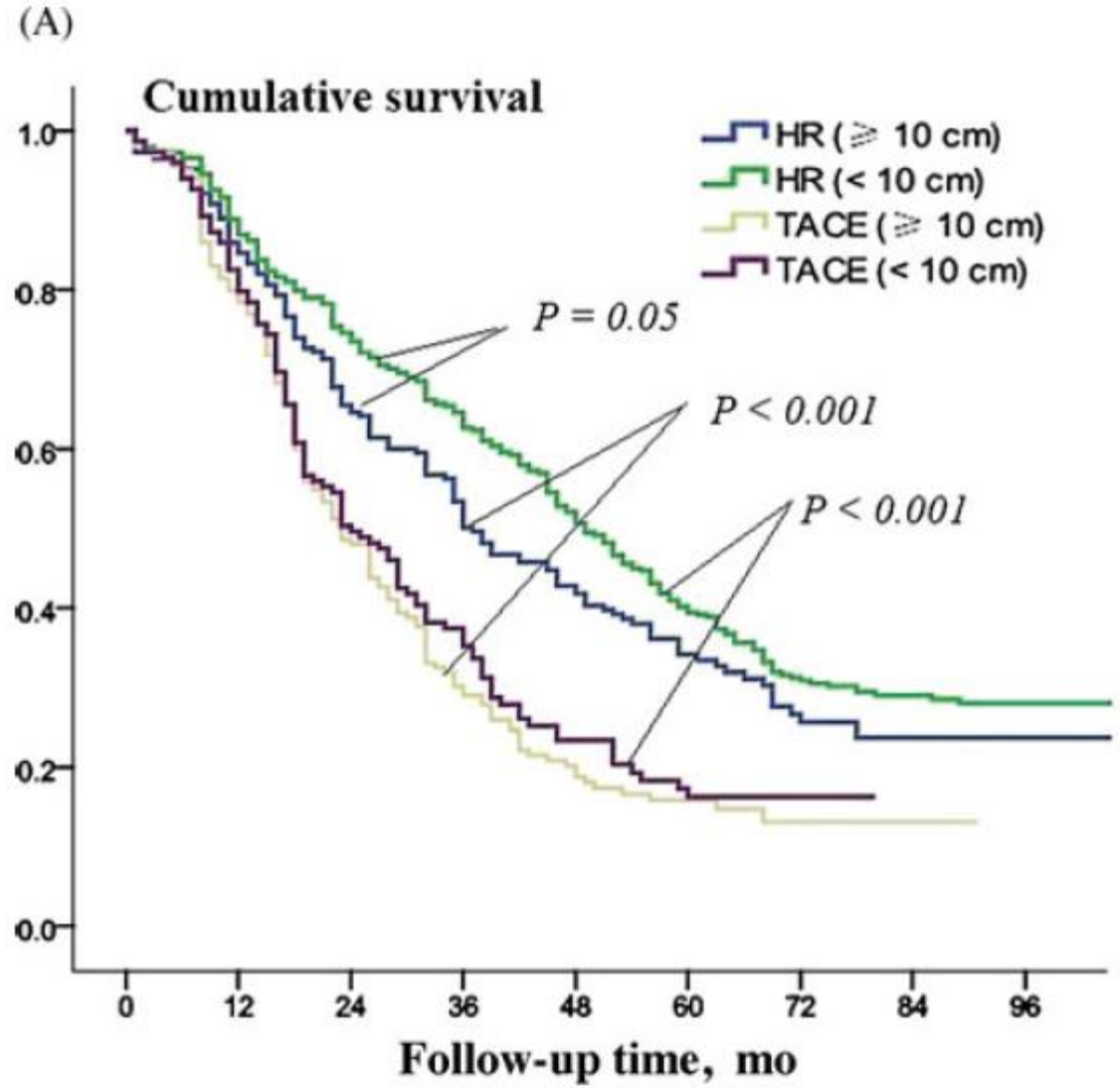
Hepatic Resection Associated With Good Survival for Selected Patients With Intermediate and Advanced-Stage Hepatocellular Carcinoma

Jian-hong Zhong, MD, Yang Ke, MD,* Wen-feng Gong, MD,* Bang-de Xiang, MD, PhD,* Liang Ma, MD,* Xin-ping Ye, MD, PhD,† Tao Peng, MD, PhD,† Gui-sheng Xie, MD,‡ and Le-qun Li, MD, PhD**

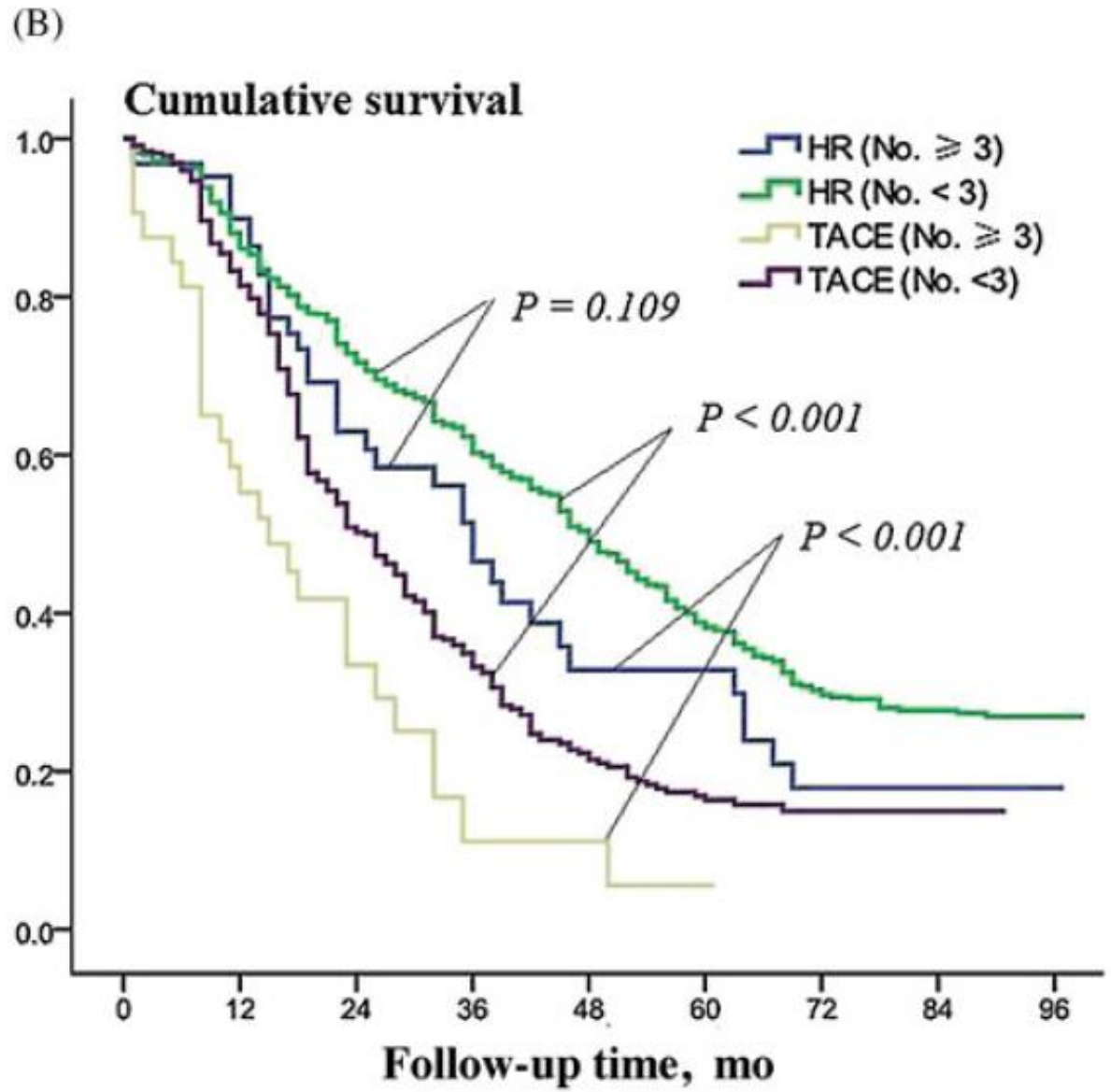
Zhong JH, et al. Ann Surg 2014;260:329-40



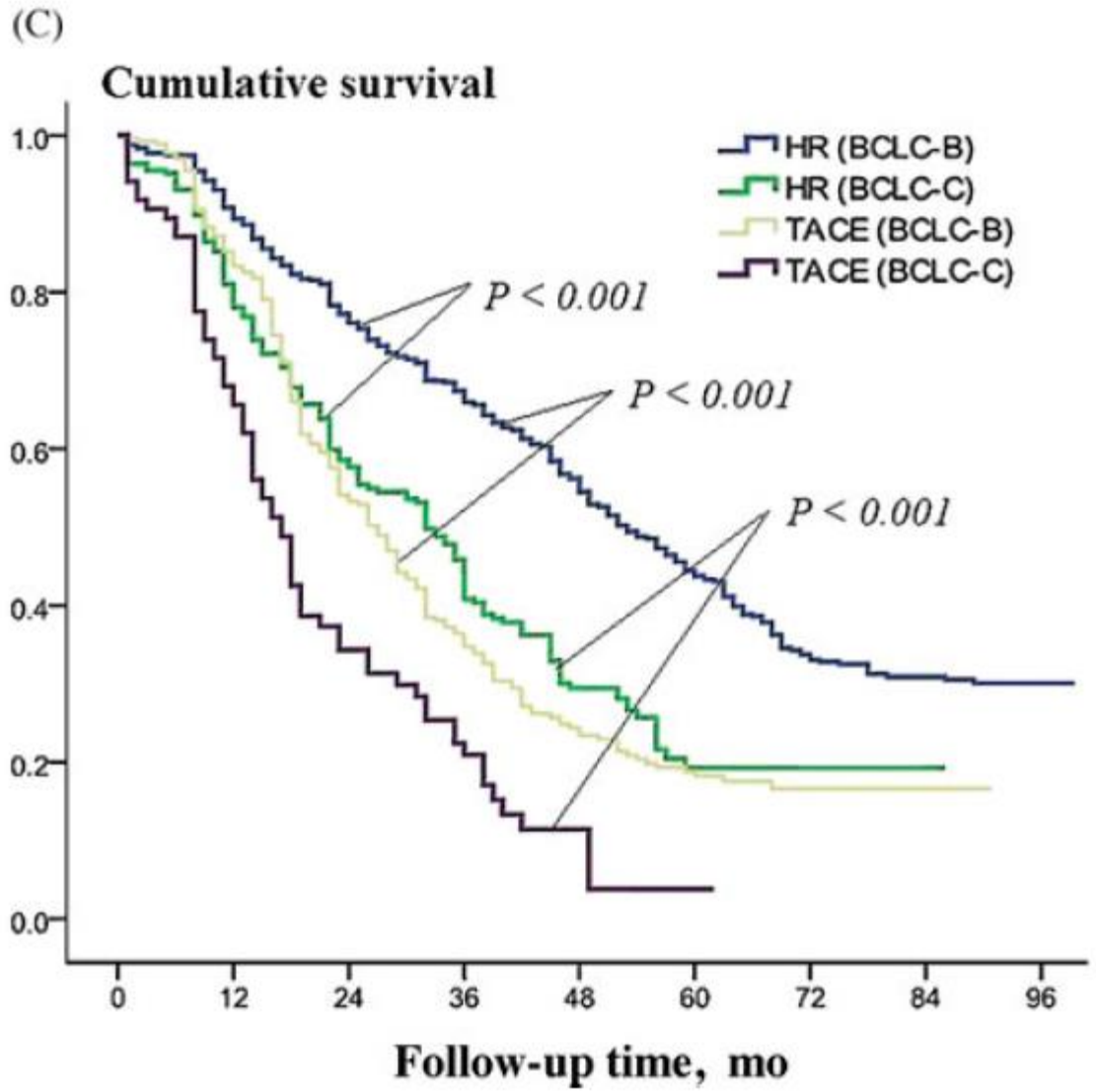
Zhong JH, et al. Ann Surg 2014;260:329-40



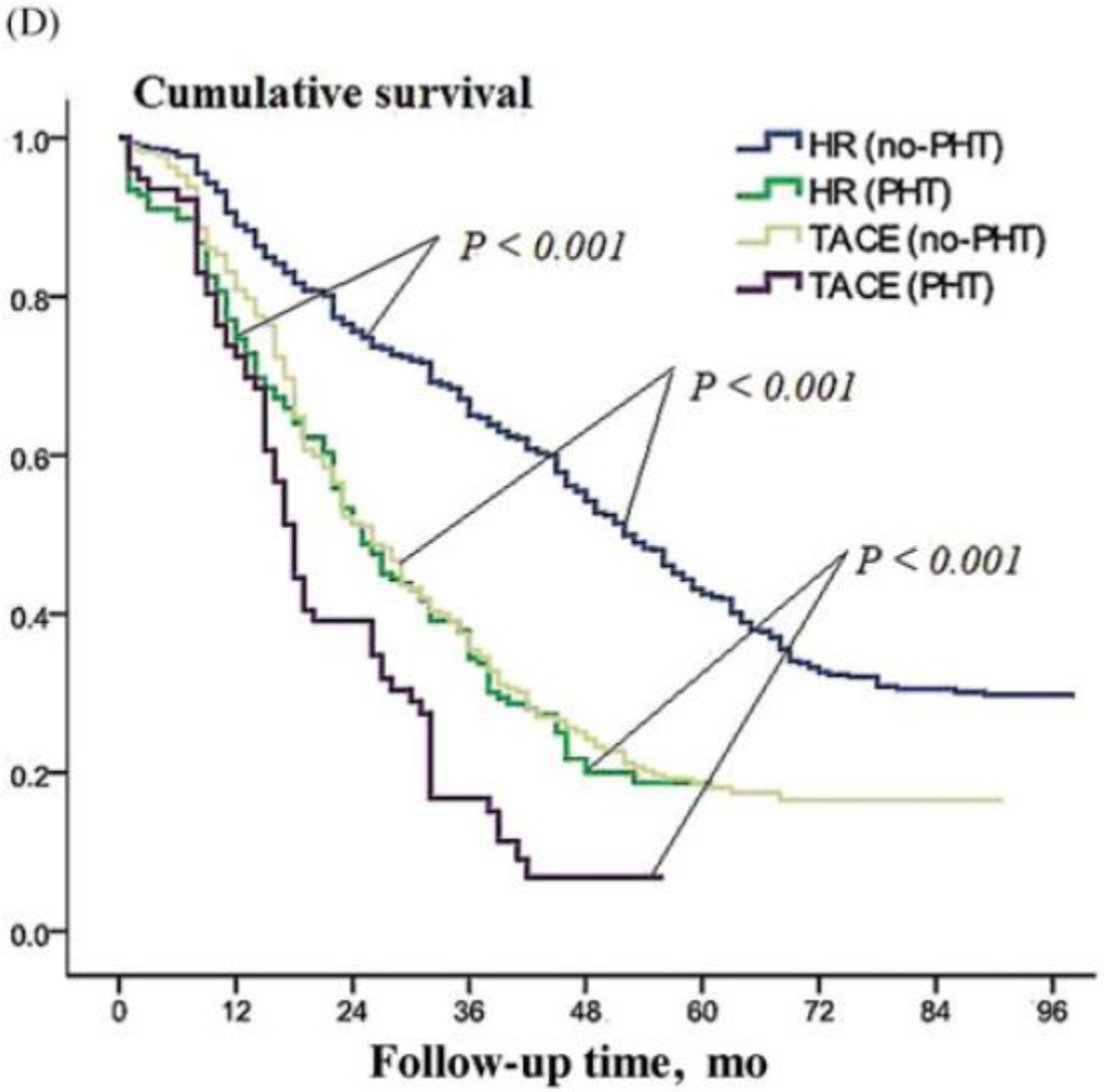
Zhong JH, et al. Ann Surg 2014;260:329-40



Zhong JH, et al. Ann Surg 2014;260:329-40



Zhong JH, et al. Ann Surg 2014;260:329-40



Zhong JH, et al. Ann Surg 2014;260:329-40

Hepatic Resection Associated With Good Survival for Selected Patients With Intermediate and Advanced-Stage Hepatocellular Carcinoma

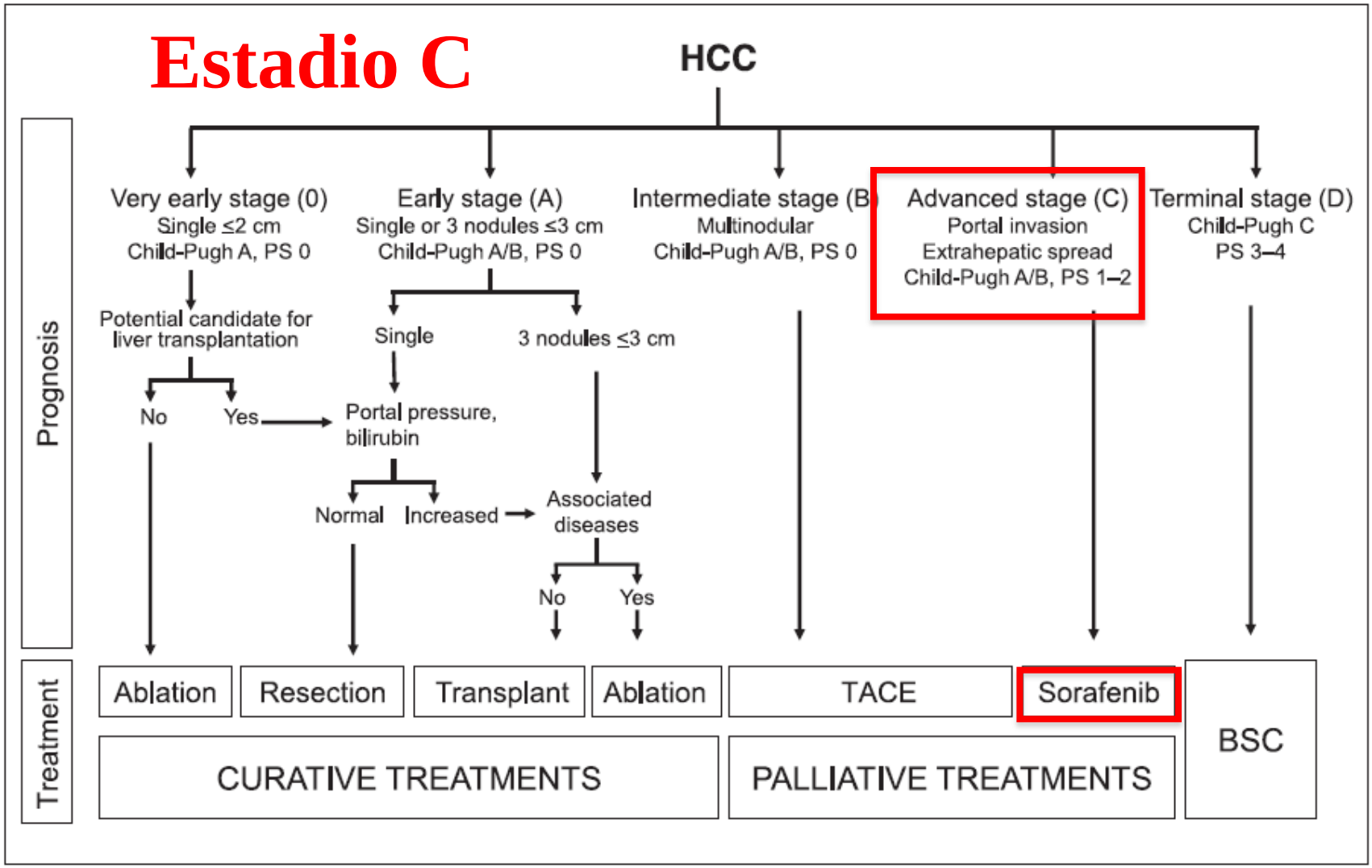
Jian-hong Zhong, MD, Yang Ke, MD,* Wen-feng Gong, MD,* Bang-de Xiang, MD, PhD,* Liang Ma, MD,* Xin-ping Ye, MD, PhD,† Tao Peng, MD, PhD,† Gui-sheng Xie, MD,‡ and Le-qun Li, MD, PhD**

CONCLUSIONS

In this way, our clinical and literature studies suggest that HR should be considered a fundamental part of total curative treatment of HCC. Compared to TACE, HR can provide significant survival benefit for patients with HCC involving large solitary tumors, multinodular tumors, macrovascular invasion, and PHT. It is important that such patients have at least Child-Pugh class A liver function.

Zhong JH, et al. Ann Surg 2014;260:329-40

Estadio C



Sorafenib

Carrilho FL, et al. Arq Gastroenterol v 52, suppl 2015

A Snapshot of the Effective Indications and Results of Surgery for Hepatocellular Carcinoma in Tertiary Referral Centers: Is It Adherent to the EASL/AASLD Recommendations?

An Observational Study of the HCC East-West Study Group

Guido Torzilli, MD, PhD, Jacques Belghiti, MD,† Norihiro Kokudo, MD, PhD,‡ Tadatoshi Takayama, MD, PhD,§ Lorenzo Capussotti, MD,¶ Gennaro Nuzzo, MD,|| Jean-Nicolas Vauthey, MD,** Michael A. Choti, MD,†† Eduardo De Santibanes, MD,‡‡ Matteo Donadon, MD,* Emanuela Morenghi,§§ and Masatoshi Makuuchi, MD, PhD¶¶*

Torzilli G, et al. Ann Surg 2013;257: 929-37

TABLE 2. Pattern of Presentation According to the BCLC Classification

BCLC Class	n (%)
BCLC 0-A [n = 931]*	
Single ≤2 cm	204 (22)
Single ≤5 cm	604 (65)
Up to 3 tumors, none >3 cm	123 (13)
BCLC B [n = 666]	
Single >5 cm	456 (68.5)
Multiple	210 (31.5)
BCLC C [n = 222]	
PV invasion	60 (27)
First-order PV	20 (9)
Second-order PV	16 (7)
Third-order PV	24 (11)
HV invasion	77 (35)
IVC invasion	15 (7)
PV + HV invasion	63 (28)
PV + IVC invasion	—
HV + IVC invasion	7 (3)

*The number of patients for whom the data were available.
HV indicates hepatic vein; IVC, inferior vena cava; PV, portal vein.

Torzilli G, et al. Ann Surg 2013;257: 929-37

TABLE 3. Surgical Procedures Stratified According to the BCLC Classification

	BCLC 0-A	BCLC B	BCLC C	*P**
Type of resection [n = 1674]†				
Minor	684 (88)	365 (58)	102 (38)	**0.000**
Major	93 (12)	268 (42)	162 (62)	
No. removed segments [n = 1674]				
≤1	565 (73)	231 (37)	53 (20)	**0.000**
2	119 (15)	134 (21)	49 (18)	
3	14 (2)	53 (8)	41 (16)	
>3	79 (10)	215 (34)	121 (46)	

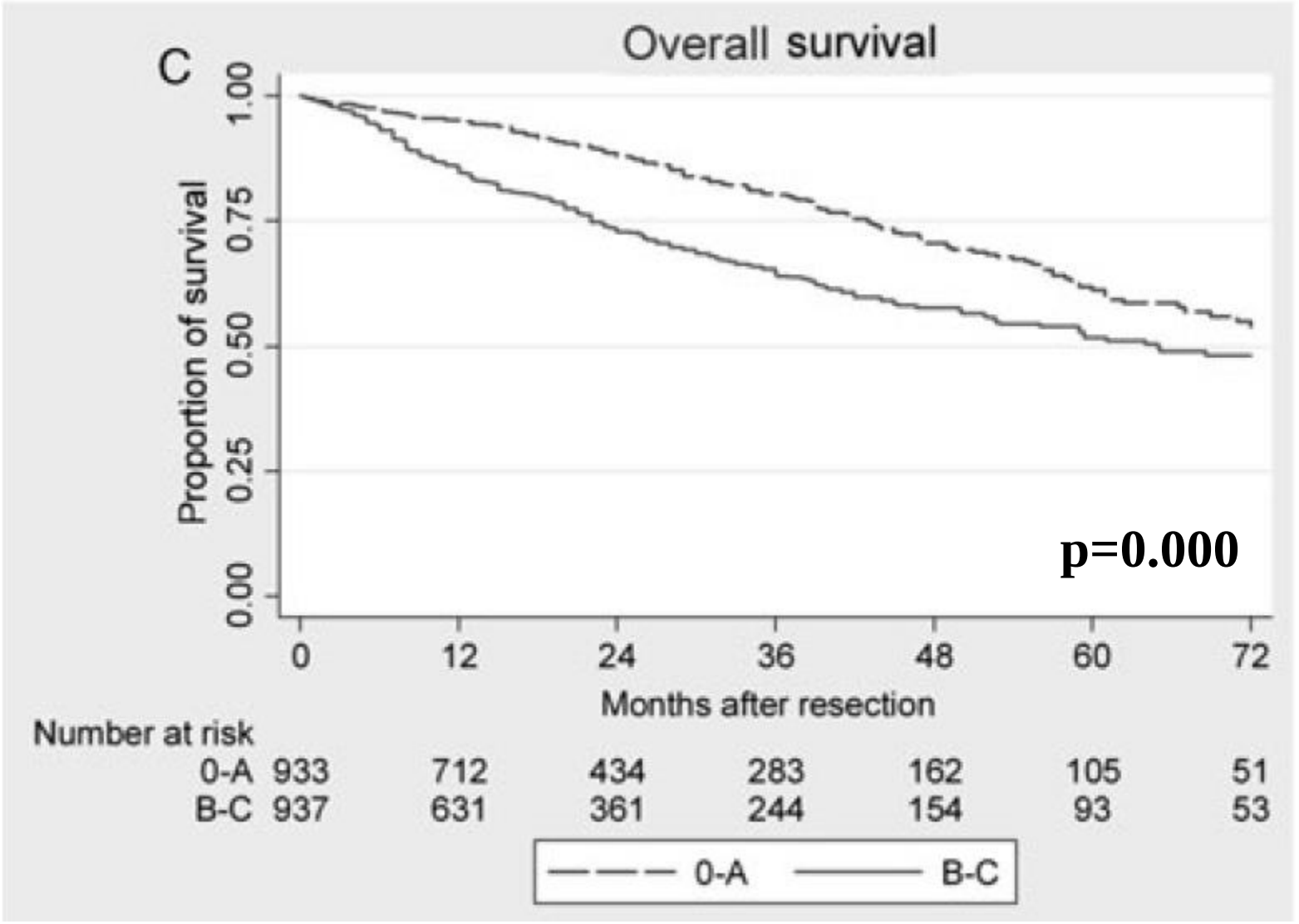
Bold values indicate statistically significant.
Values given are number (percentage).
*χ^2 test.
†The number of patients for whom the data were available.

Torzilli G, et al. Ann Surg 2013;257: 929-37

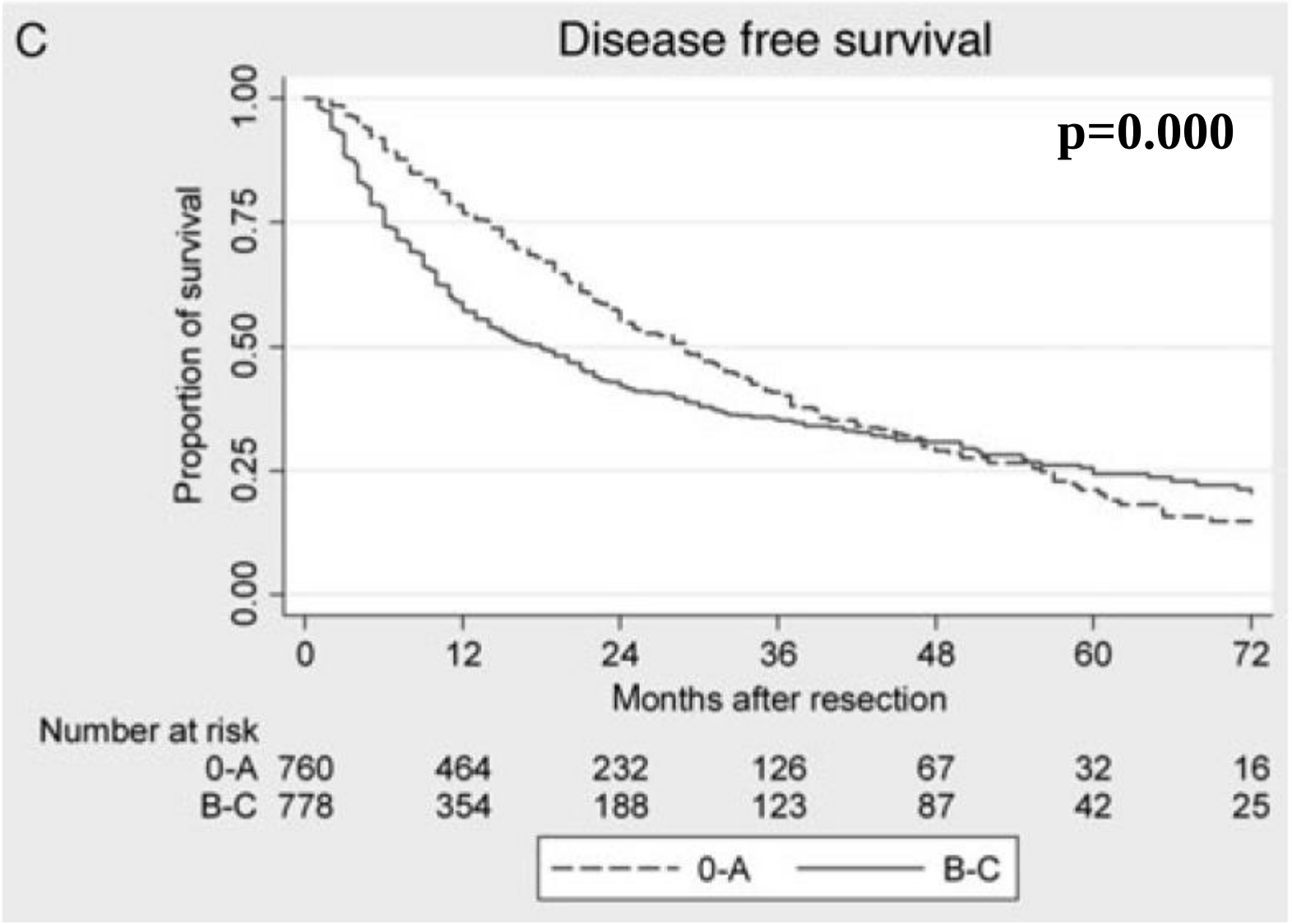
Mortalidade pós-operatória – 2,7%

	30 Dias (%)	90 Dias (%)
BCLC 0-A	1,6	2,0
BCLC B	3	3
BCLC C	2,5	3

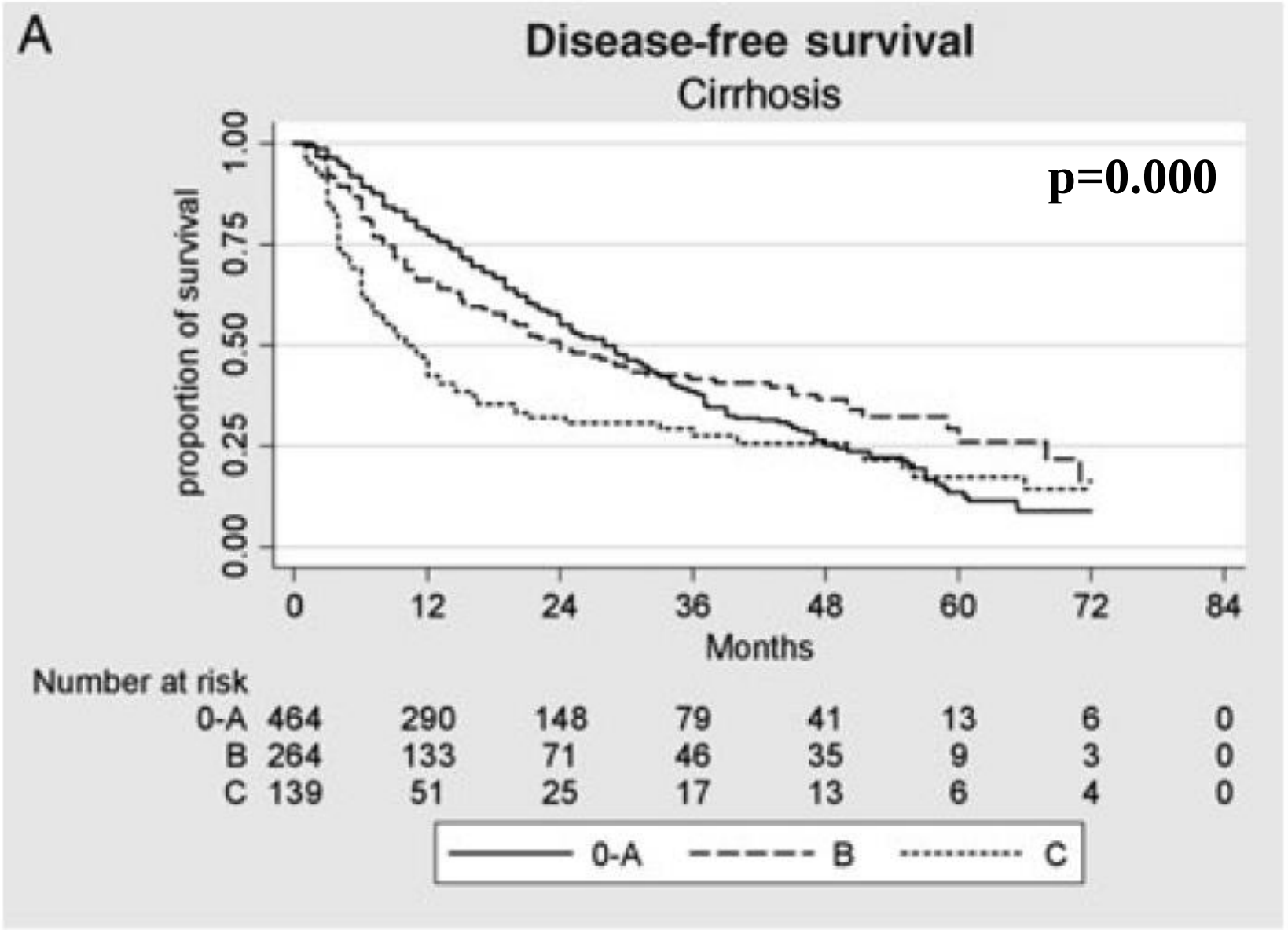
Torzilli G, et al. Ann Surg 2013;257: 929-37



Torzilli G, et al. Ann Surg 2013;257: 929-37



Torzilli G, et al. Ann Surg 2013;257: 929-37



Torzilli G, et al. Ann Surg 2013;257: 929-37

TABLE 6. Main Published Studies of Surgical Resection for BCLC B, C, and B-C HCC in the Last Decade

Author	Year	BCLC Class	No. Patients	3-yr OS, %	5-yr OS, %	3-yr DFS, %	5-yr DFS, %	Operative Mortality, %
Minagawa et al[14]	2001	C	18	42	42	—	—	5
Ng et al[15]	2005	B	380	50	39	38	26	2.4
Chirica et al[17]	2008	B-C	20	56	45	20	17	5
Ishizawa et al[19]	2008	C	98	71	56	37	25	0.2
Wang et al[12]	2008	B	243	64	50	—	—	—
		C	14	29	29	—	—	—
Torzilli et al[18]	2008	B	24	80	—	44	—	0
		C	28	74	—	17	—	3.6
Present series	2011	B	737	71	57	38	27	3.1
		C	297	49	38	28	18	2.5

DFS indicates disease-free survival; OS, overall survival.

29-57%

Torzilli G, et al. Ann Surg 2013;257: 929-37

Conclusões

The herein analyzed numbers are large enough to request an update of the EASL/AASLD therapeutic guidelines related to BCLC B and C patients: for the latter, if within Child class A and performance status 0-1, evaluation by a surgical team specifically expert in liver surgery should be mandatory. It is hoped that this study will also stimulate prospective studies able to better disclose the proportion of patients harboring intermediate or advanced HCC who could benefit from a surgical approach.

Torzilli G, et al. Ann Surg 2013;257: 929-37

- **Maior que 5 cm**
- **Múltiplos tumores**
- **Hipertensão porta**
- **Invasão vascular**

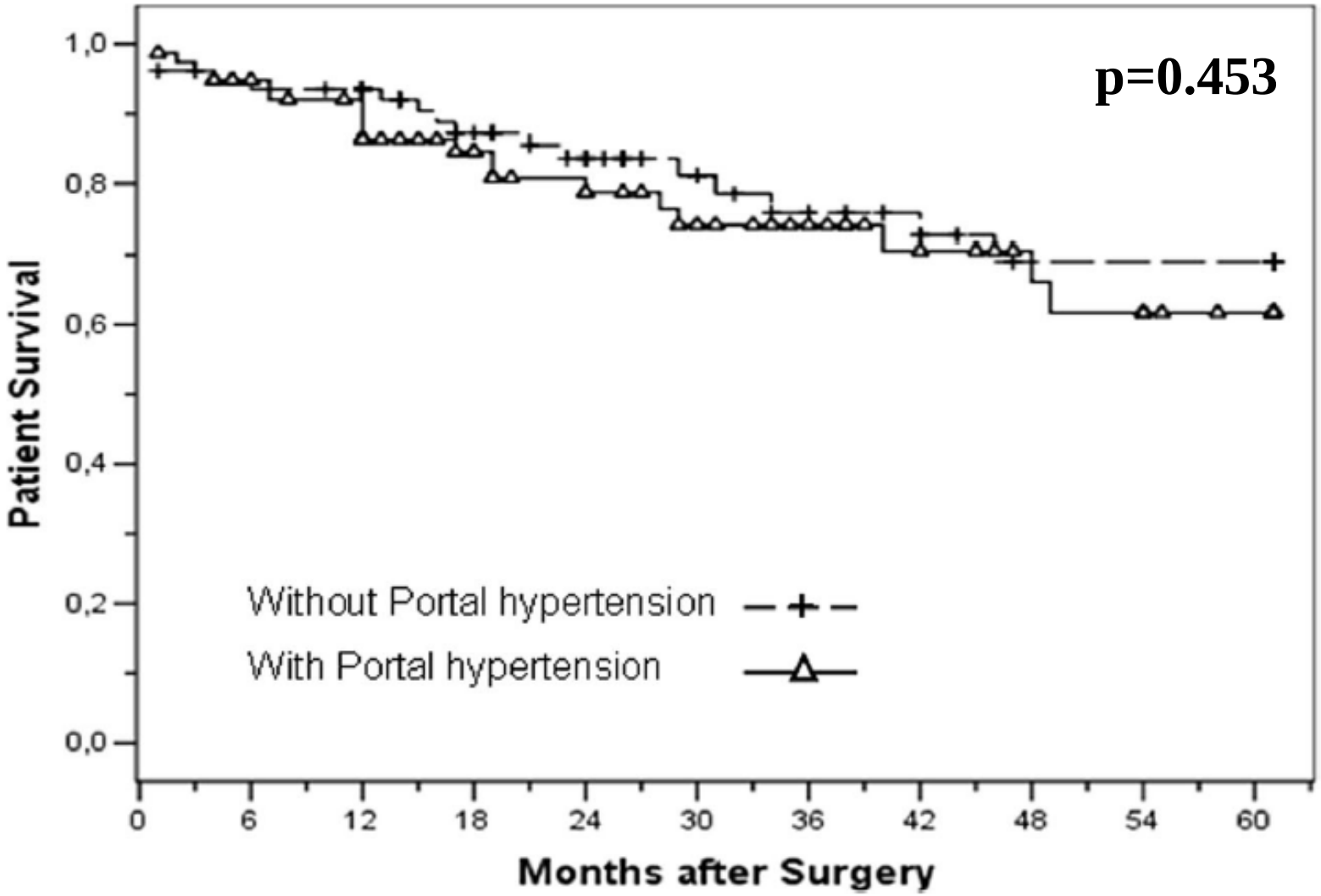
Is Portal Hypertension a Contraindication to Hepatic Resection?

Alessandro Cucchetti, MD, Giorgio Ercolani, MD,* Marco Vivarelli, MD,* Matteo Cescon, MD,* Matteo Ravaioli, MD,* Giovanni Ramacciato, MD,† Gian Luca Grazi, MD,* and Antonio Daniele Pinna, MD**

Background and Aims: The outcome of hepatic resection in cirrhotic patients has improved remarkably in recent years with improved surgical techniques and perioperative care; however, the role of portal hypertension is

trying to define the role of each therapeutic option. They reported well-defined indications for hepatectomy for HCC; in particular, portal hypertension was considered as a contraindication for liver

Cucchetti A, et al. Ann Surg 2009;250: 922-8



Cucchetti A, et al. Ann Surg 2009;250: 922-8

In conclusion, the EASL/AASLD guidelines clearly define indications for hepatic resection for HCC: patients with single HCC and completely preserved liver function without portal hypertension. These guidelines exclude from surgery many patients who could potentially benefit from curative resection. However, faced with the same MELD score and hepatectomy extent planning, the presence of esophageal varices, splenomegaly, and platelet count $<100{,}000/mm^3$ should not be considered as a contraindication for hepatic resection.

Cucchetti A, et al. Ann Surg 2009;250: 922-8

DOI:10.1111/j.1477-2574.2012.00594.x HPB

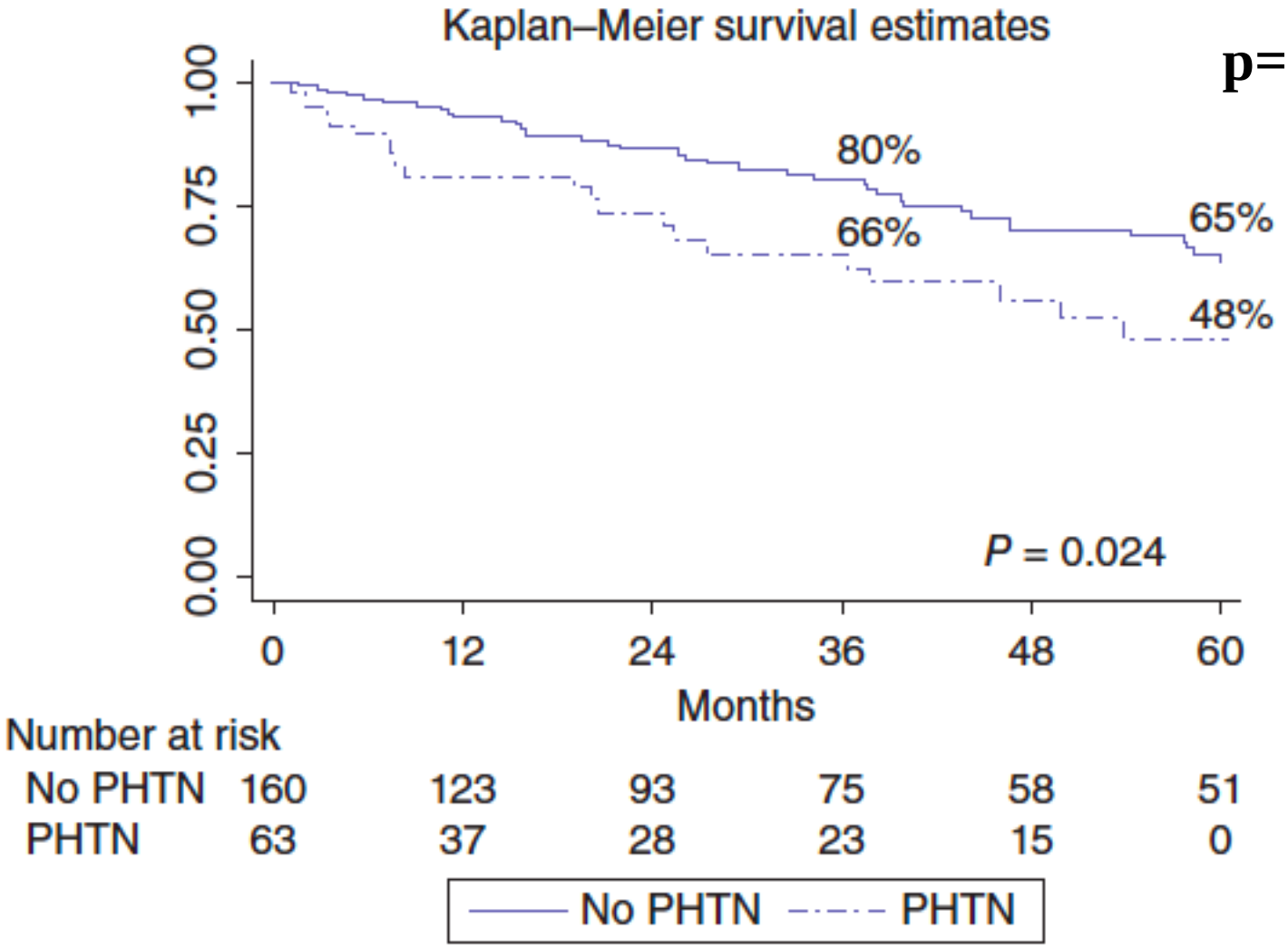
ORIGINAL ARTICLE

Hepatic resection for hepatocellular carcinoma in patients with Child–Pugh's A cirrhosis: is clinical evidence of portal hypertension a contraindication?

Roberto Santambrogio[1], Michael D. Kluger[2,3], Mara Costa[1], Andrea Belli[2], Matteo Barabino[1], Alexis Laurent[2], Enrico Opocher[1], Daniel Azoulay[2] & Daniel Cherqui[2,3]

[1]Chirurgia 2, Epato-bilio-pancreatica e Digestiva, Ospedale San Paolo, Università di Milano, Italy, [2]Department of Digestive and Hepatobiliary Surgery and Liver Transplantation, Hôpital Henri Mondor, Créteil, France, and [3]Section of Hepatobiliary Surgery and Liver Transplantation, Department of Surgery, New York Presbyterian Hospital – Weill-Cornell Medical Center, New York, USA

Santambrogio R, et al. HPB 2013;15::78-84



Santambrogio R, et al. HPB 2013;15::78-84

Table 2 Intra-operative findings

	160 no-PHTN	*P*	63 PHTN
HR > 2 segments	50 (31%)	0.038	11 (17%)
Laparoscopic approach	56 (35%)	NS	26 (41%)
Operation time (min)	196 ± 64	NS	189 ± 69
Pringle manoeuver	88 (55%)	NS	31 (49%)
Pringle timing (min)	30.5 ± 26	NS	30.2 ± 21
Intra-operative bleeding (ml)	292 ± 262	NS	340 ± 340

HR, hepatic resection; PHTN, portal hypertension, NS, not significant.

Santambrogio R, et al. HPB 2013;15::78-84

Conclusions: PHTN should not be considered an absolute contraindication to a hepatectomy in cirrhotic patients. Patients with PHTN have short- and long-term results similar to patients with normal portal pressure. A limited hepatic resection for early-stage tumours is an option for Child–Pugh class A5 patients with PHTN.

Santambrogio R, et al. HPB 2013;15::78-84

- **Maior que 5 cm**
- **Múltiplos tumores**
- **Hipertensão porta**
- **Invasão vascular**

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CMH

http://dx.doi.org/10.3350/cmh.2016.22.1.160
Clinical and Molecular Hepatology 2016;22:160-167

Original Article

Survival outcomes of hepatic resection compared with transarterial chemoembolization or sorafenib for hepatocellular carcinoma with portal vein tumor thrombosis

Jung Min Lee[1], Byoung Kuk Jang[1], Yoo Jin Lee[1], Wang Yong Choi[1], Sei Myong Choi[1], Woo Jin Chung[1], Jae Seok Hwang[1], Koo Jeong Kang[2], Young Hwan Kim[3], Anil Kumar Chauhan[4], Soo Young Park[5], Won Young Tak[5], Young Oh Kweon[5], Byung Seok Kim[6], and Chang Hyeong Lee[6]

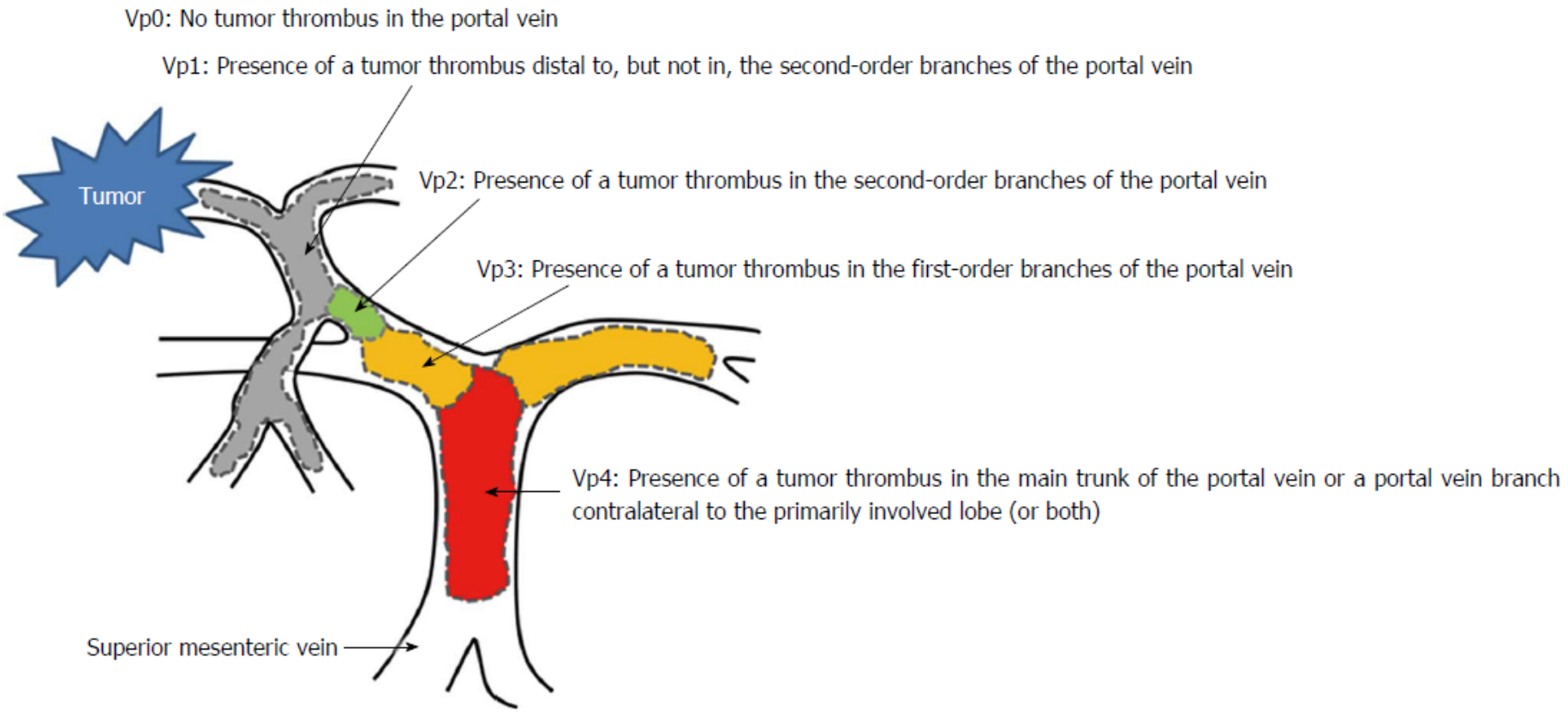
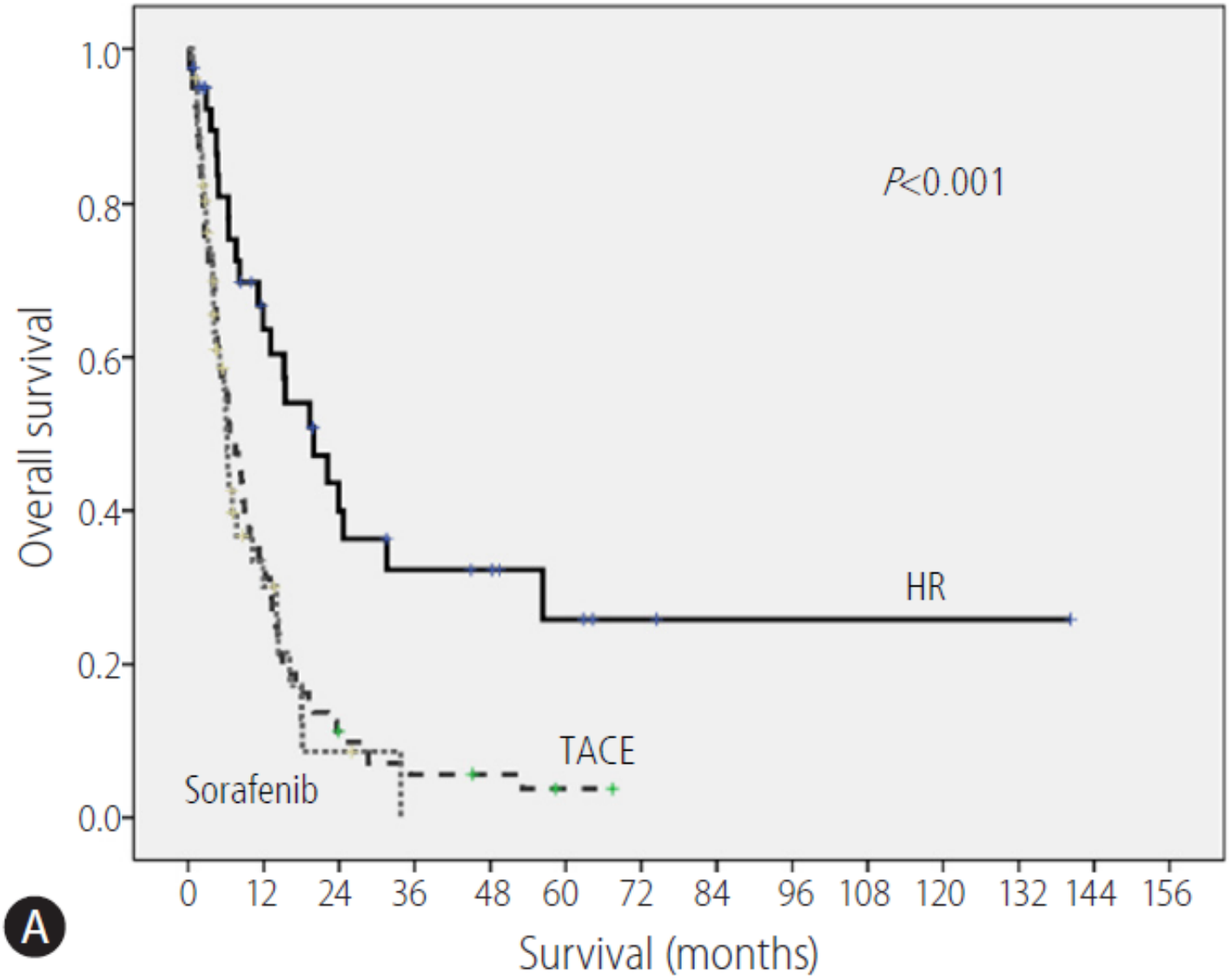
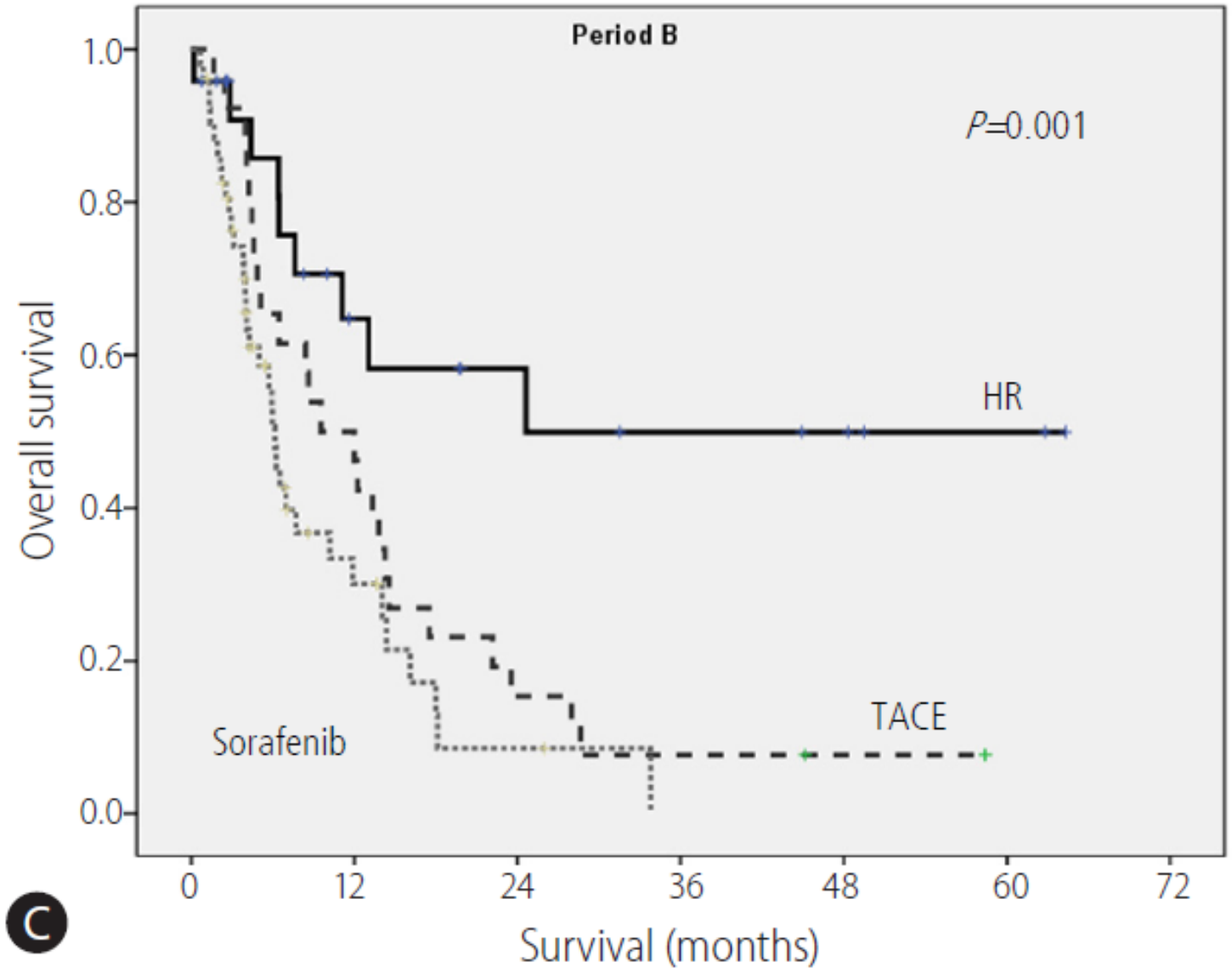


Figure 1 Classification for hepatocellular carcinoma with portal vein tumor thrombosis.

Lee JM, et al. Clin Mol Hepatol 2016; 22: 160-7



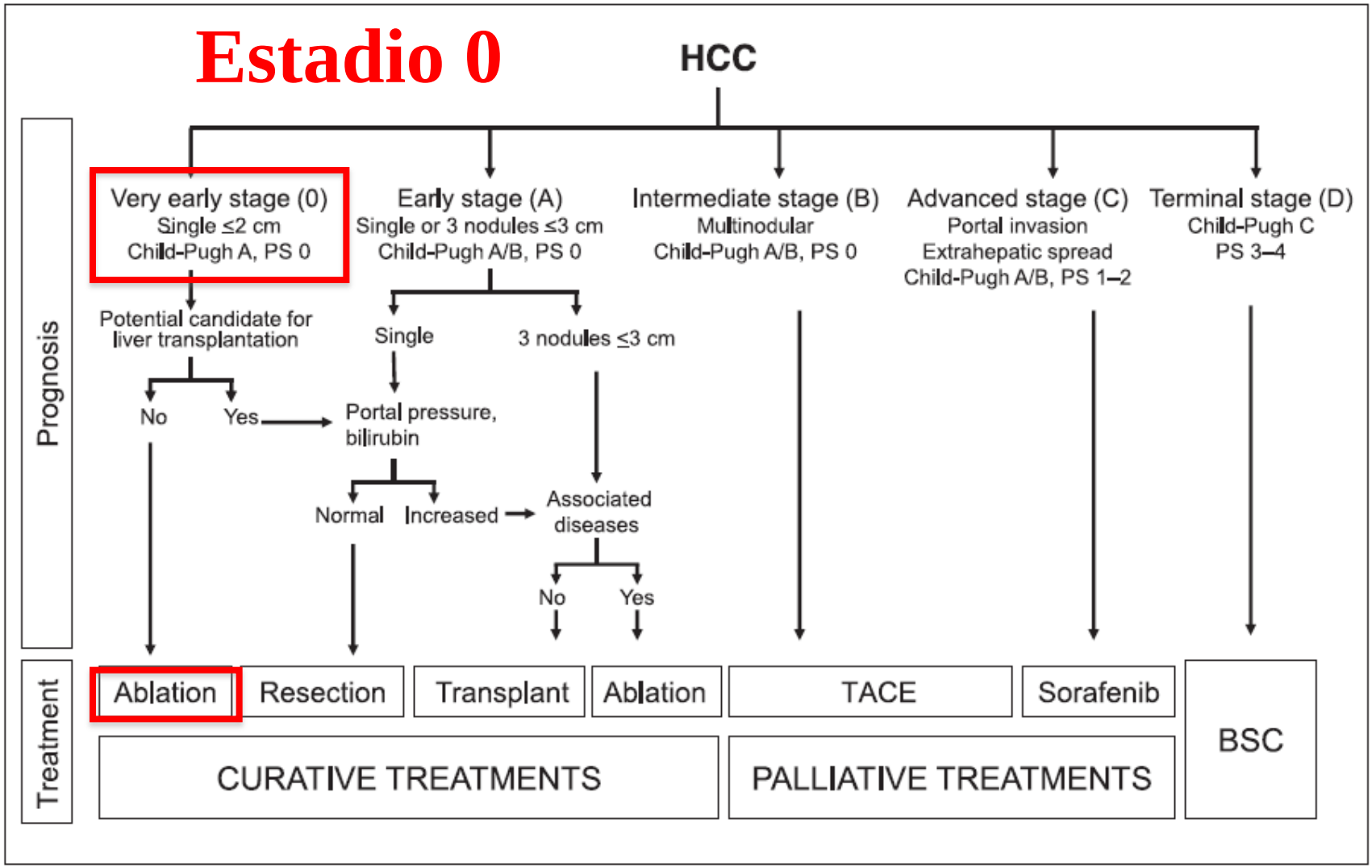
Lee JM, et al. Clin Mol Hepatol 2016; 22: 160-7



Lee JM, et al. Clin Mol Hepatol 2016; 22: 160-7

A ressecção hepática como primeira opção, pode proporcionar melhor sobrevida a longa prazo que TACE ou Sorafenib, para pacientes com carcinoma hepatocelular ressecável, trombo tumoral de veia porta tipo I e boa função hepática

Lee JM, et al. Clin Mol Hepatol 2016; 22: 160-7



Ablação

Carrilho FL, et al. Arq Gastroenterol v 52, suppl 2015

DOI:10.1111/hpb.12446 HPB

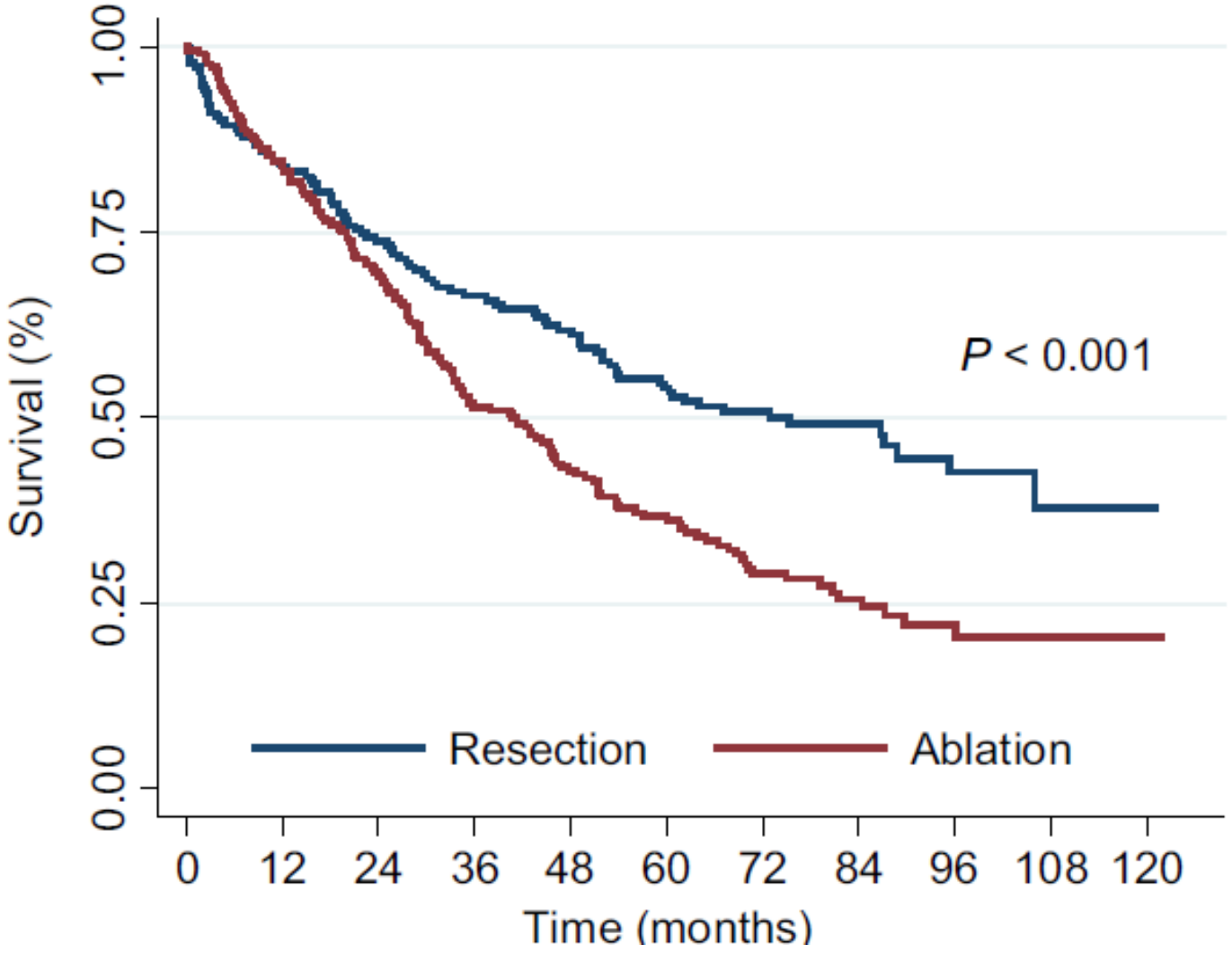
ORIGINAL ARTICLE

Surgical resection versus ablation for hepatocellular carcinoma ≤ 3 cm: a population-based analysis

John T. Miura[1], Fabian M. Johnston[1], Susan Tsai[1], Dan Eastwood[2], Anjishnu Banerjee[2], Kathleen K. Christians[1], Kiran K. Turaga[1] & T. Clark Gamblin[1]

[1]Division of Surgical Oncology, and [2]Department of Biostatistics, Medical College of Wisconsin, Milwaukee, WI, USA

Miura JT, et al. HPB 2015;17:896-901

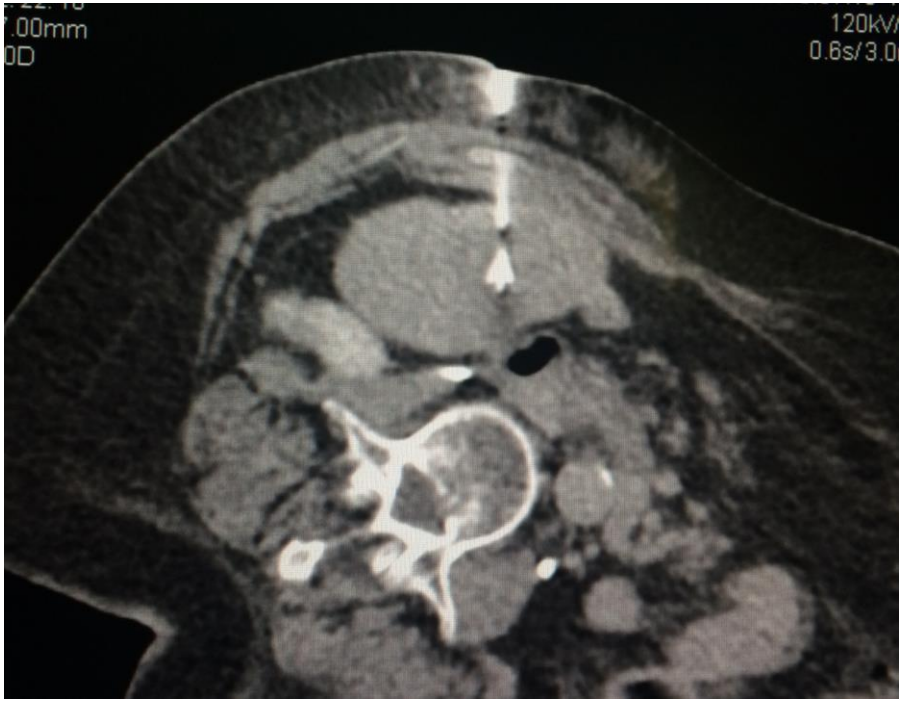


Miura JT, et al. HPB 2015;17:896-901

In conclusion, the present study provides further evidence supporting HR over ablation for patients with small, unifocal, HCC tumours. Numerous factors, both patient and tumour specific, continue to have a major influence on treatment allocation. Therefore, it would be short-sighted to suggest that ablation has no role for this subset of HCC tumours. Instead, in the setting of a good surgical candidate, treatment strategies should continue to emphasize a HR first approach for single, <3 cm HCC tumours, with ablation being reserved for patients less suited for the operating room.

Miura JT, et al. HPB 2015;17:896-901

C, feminino, 80 a,
CHC em lobo segmento 6
Fígado cirrótico
Child A5, MELD 9
Sem hipertensão porta
Comorbidades



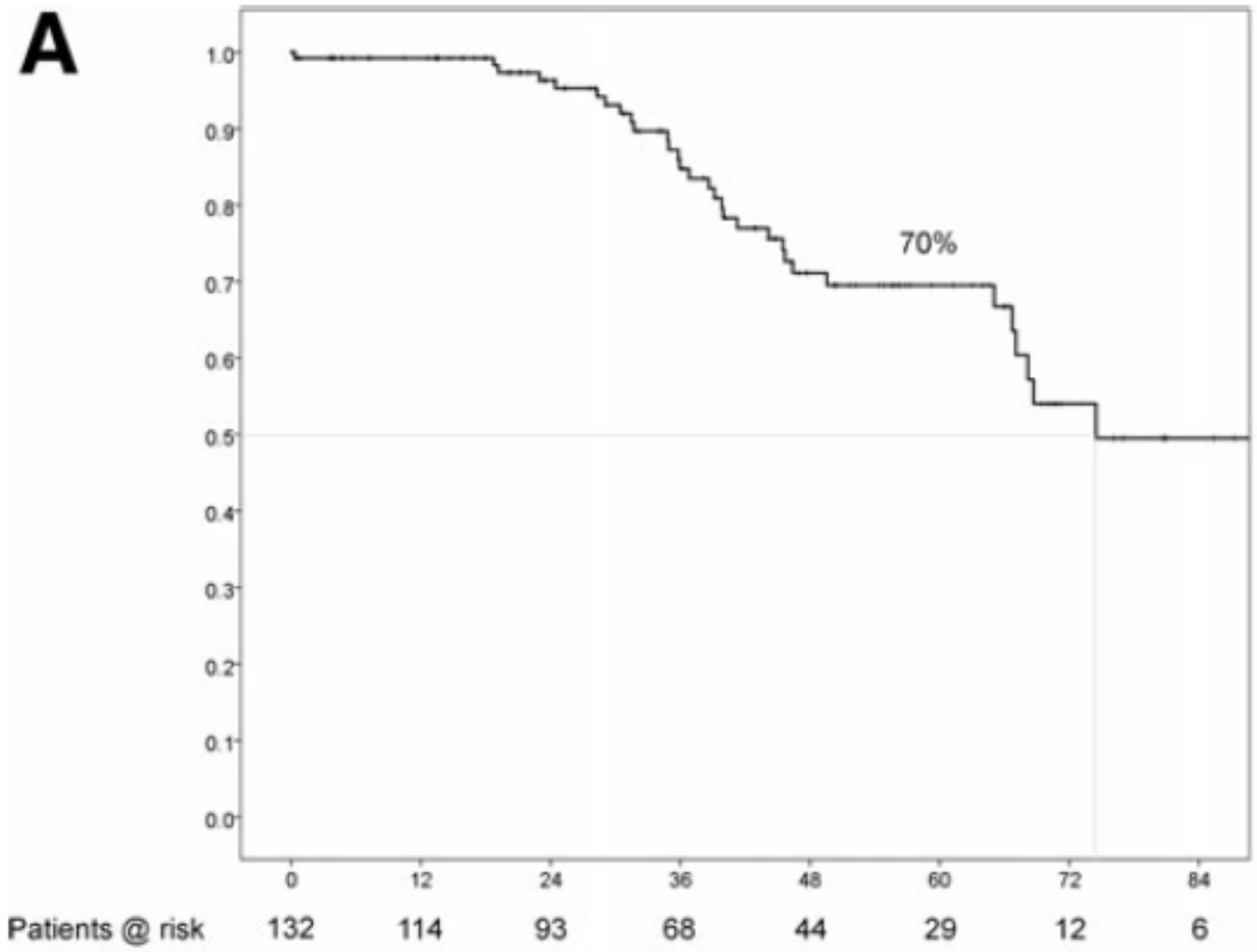
Conduta:
Ablação por RF:
Evolução satisfatória
Alta sem intercorrências

HEPATOLOGY
Official Journal of the American Association for the Study of Liver Diseases

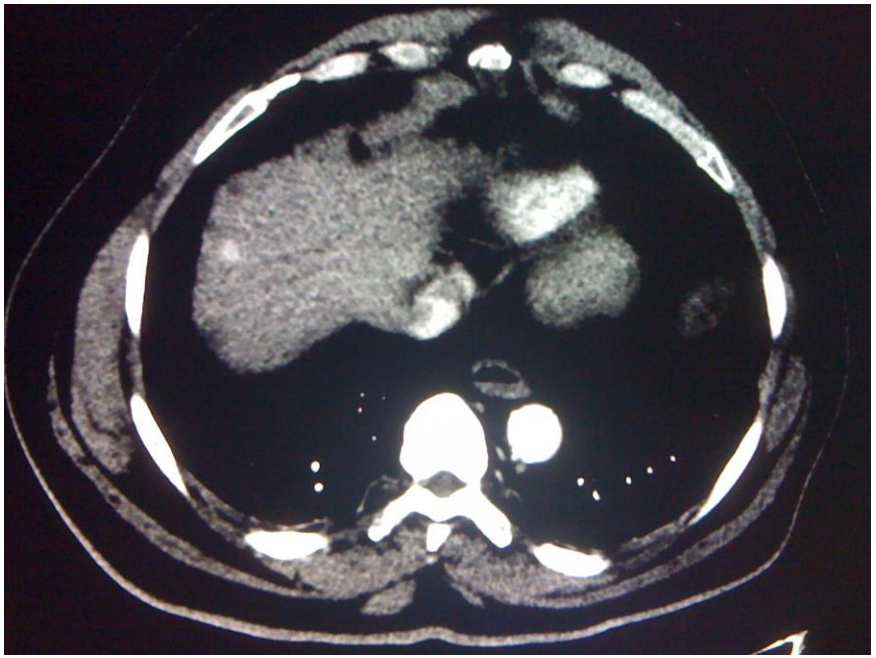
Resection of Hepatocellular Cancer ≤2 cm: Results From Two Western Centers

Sasan Roayaie,[1] Khaled Obeidat,[1] Carlo Sposito,[2] Luigi Mariani,[2] Sherrie Bhoori,[2] Alessandro Pellegrinelli,[2] Daniel Labow,[1] Josep M. Llovet,[1,3,4] Myron Schwartz,[1] and Vincenzo Mazzaferro[2]

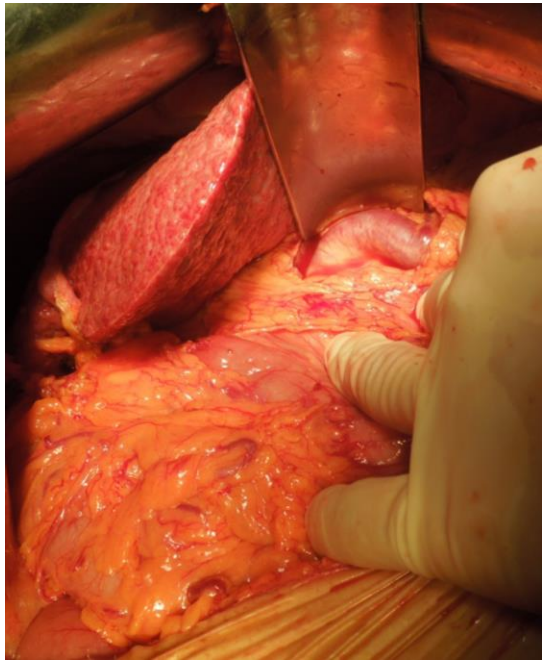
Roayaie S, et al. Hepatology 2013;57:1423-35

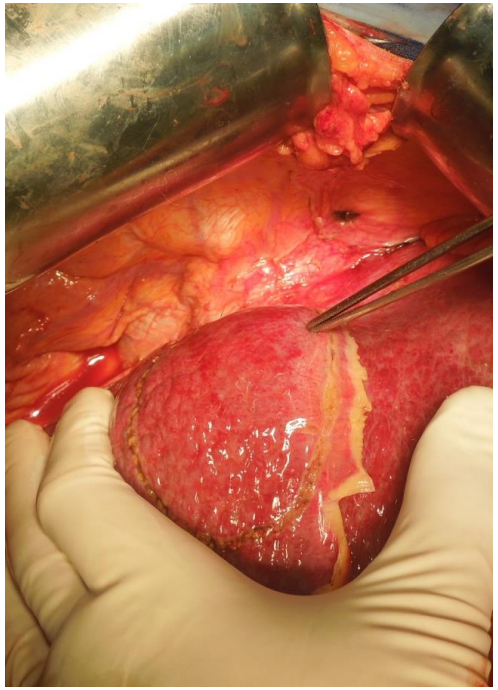


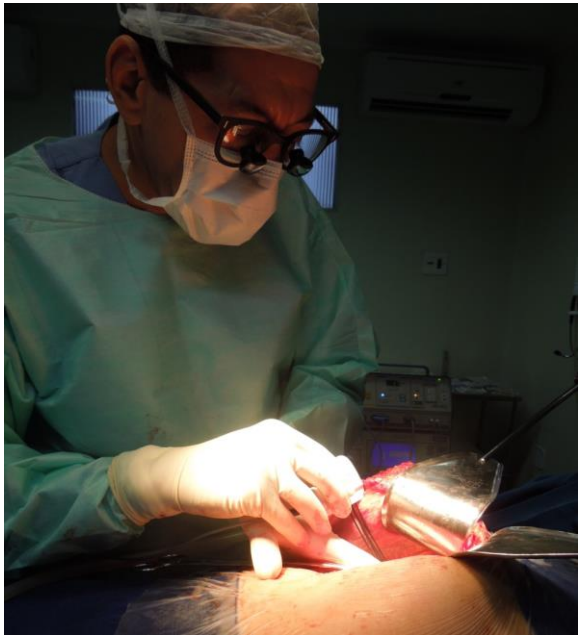
Roayaie S, et al. Hepatology 2013;57:1423-35



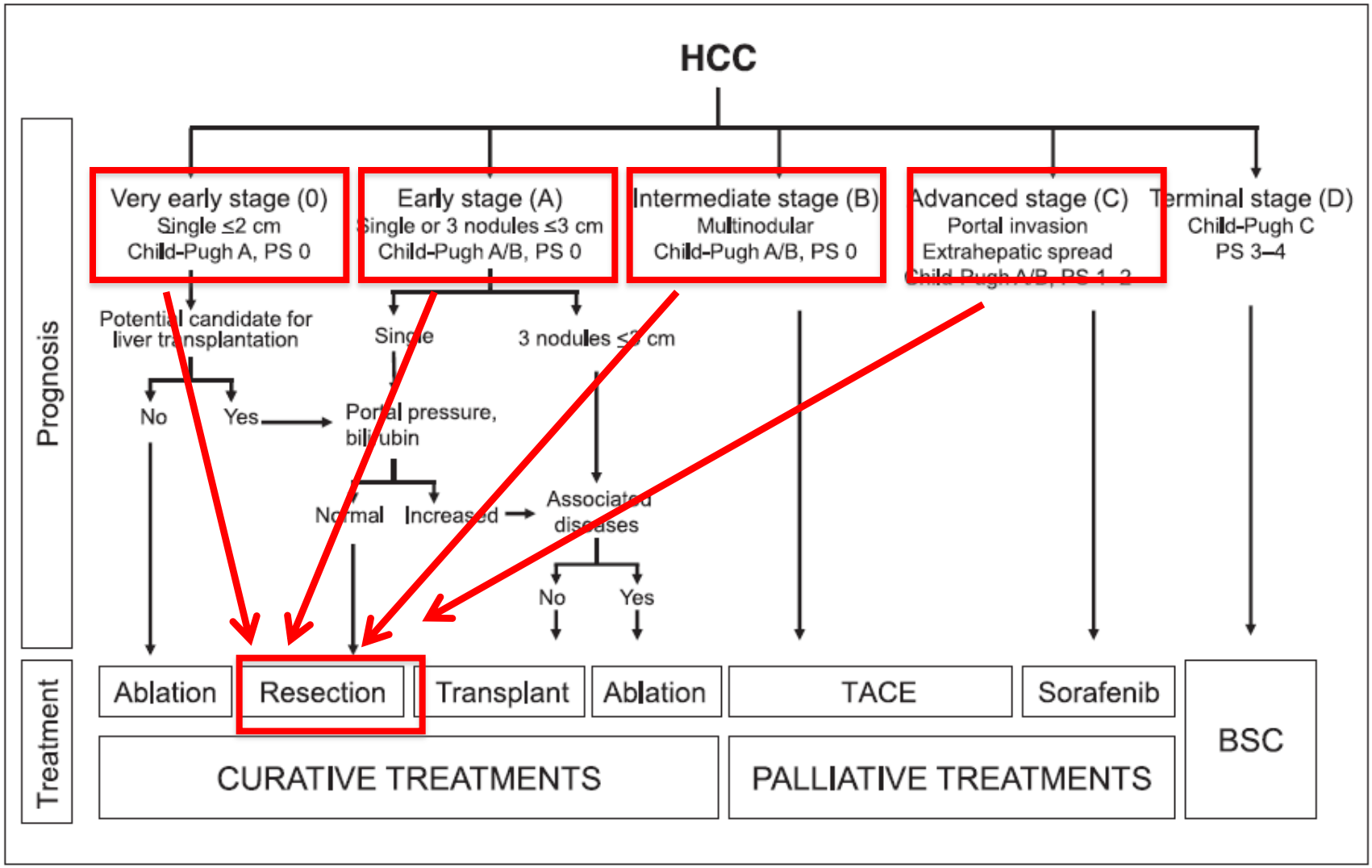
F, masculino, 66 anos
Cirrose, vírus C.
CHC (2 cm) em segmento 8
Child A6 MELD 9
Hipertensão porta
Sem comorbidades







Hepatectomia com Habib
Evolução favorável
Alta sem intercorrências



Carrilho FL, et al. Arq Gastroenterol v 52, suppl 2015

Capussotti L, et al. Eur J Surg Oncol 2009;35:11-5

Soubrane O, et al. HPB 2016;16:357-65

Torzilli G, et al. Ann Surg 2013;257: 929-37

Santambrogio R, et al. HPB 2013;15::78-84

Miura JT, et al. HPB 2015;17:896-901

Wei Q, et al. Asian J Surg 2016.

Scatton O, et al. J Surg Oncol 2015; 111:1007-15

Zhong JH, et al. Ann Surg 2014;260:329-40

Cucchetti A, et al. Ann Surg 2009;250: 922-8

Lee JM, et al. Clin Mol Hepatol 2016; 22: 160-7

Sakoda M, et al. Journal of Cancer 2016:7:1029-36.

Liu PH, et al. PLoS 2016.

BCLC precisa ser revisado/atualizado

DOI: 10.1590/S0004-28032015000500001

BRAZILIAN SOCIETY OF HEPATOLOGY RECOMMENDATIONS FOR THE DIAGNOSIS AND TREATMENT OF HEPATOCELLULAR CARCINOMA

Flair J **CARRILHO**[1], Angelo Alves de **MATTOS**[2], Alex F **VIANEY**[3], Denise Cerqueira P **VEZOZZO**[1], Fábio **MARINHO**[4], Francisco J **SOUTO**[5], Helma P **COTRIM**[6], Henrique Sergio M **COELHO**[7], Ivonete **SILVA**[8], José Huygens P **GARCIA**[9], Luciana **KIKUCHI**[1], Patricia **LOFEGO**[10], Wellington **ANDRAUS**[4], Edna **STRAUSS**[1], Giovanni **SILVA**[11], Isaac **ALTIKES**[12], Jose Eymard **MEDEIROS**[13], Paulo L **BITTENCOURT**[14] and Edison R **PARISE**[8]

Recommendation

To adopt the Barcelona Clinic Liver Cancer (BCLC) classification as the HCC staging system of choice for use in Brazil (1B).

Carrilho FL, et al. Arq Gastroenterol v 52, suppl 2015

CONGRESSO BRASILEIRO DO CB-IHPBA
PORTO ALEGRE
10 a 12 de agosto de 2017

COLOQUEM EM SUAS AGENDAS

Lençóis Maranhenses