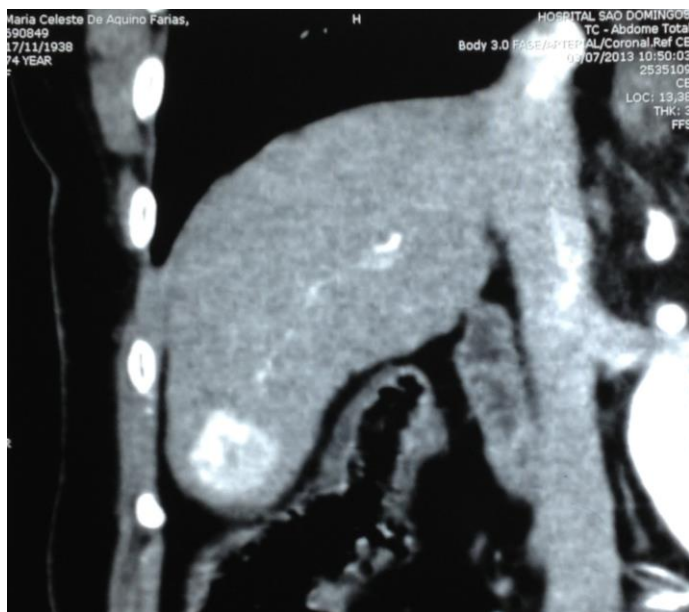




TRATAMENTO CIRÚRGICO DO CARCINOMA HEPATOCELULAR



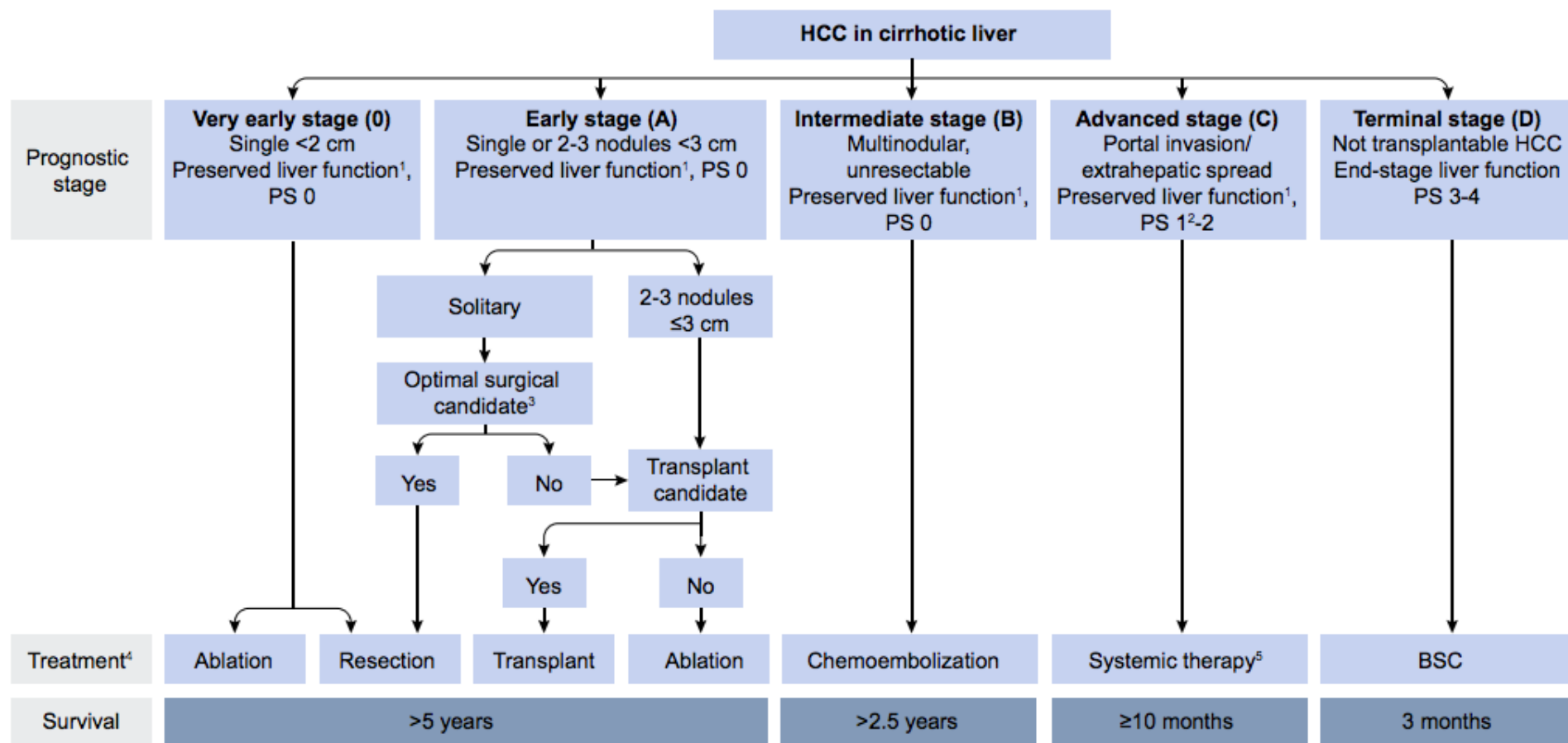
Orlando Jorge M. Torres MD, PhD
 Full Professor and Chairman
 Department of Gastrointestinal Surgery
 Hepatopancreatobiliary Unit
 Universidade Federal do Maranhão - Brazil



EASL Clinical Practice Guidelines: Management of hepatocellular carcinoma[☆]

European Association for the Study of the Liver^{*}

EASL Clinical Practice Guidelines: Management of hepatocellular carcinoma[☆]



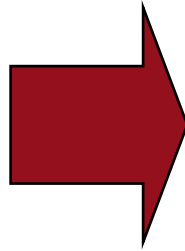
Tratamento do carcinoma hepatocelular

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	

***Sobrevida em 5 anos de 60-80%**

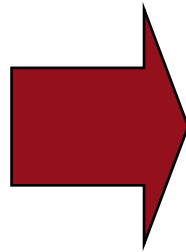
Ressecção do carcinoma hepatocelular

Fígado não cirrótico



☐ Primeira linha de tratamento

Fígado cirrótico *



- ☐ Função hepática preservada
- ☐ Sem sinais de hipertensão porta significativa
- ☐ Sem doença extra-hepática
- ☐ Sem invasão vascular

***Apenas 10-20% são candidatos**

Liver resection

Recommendations

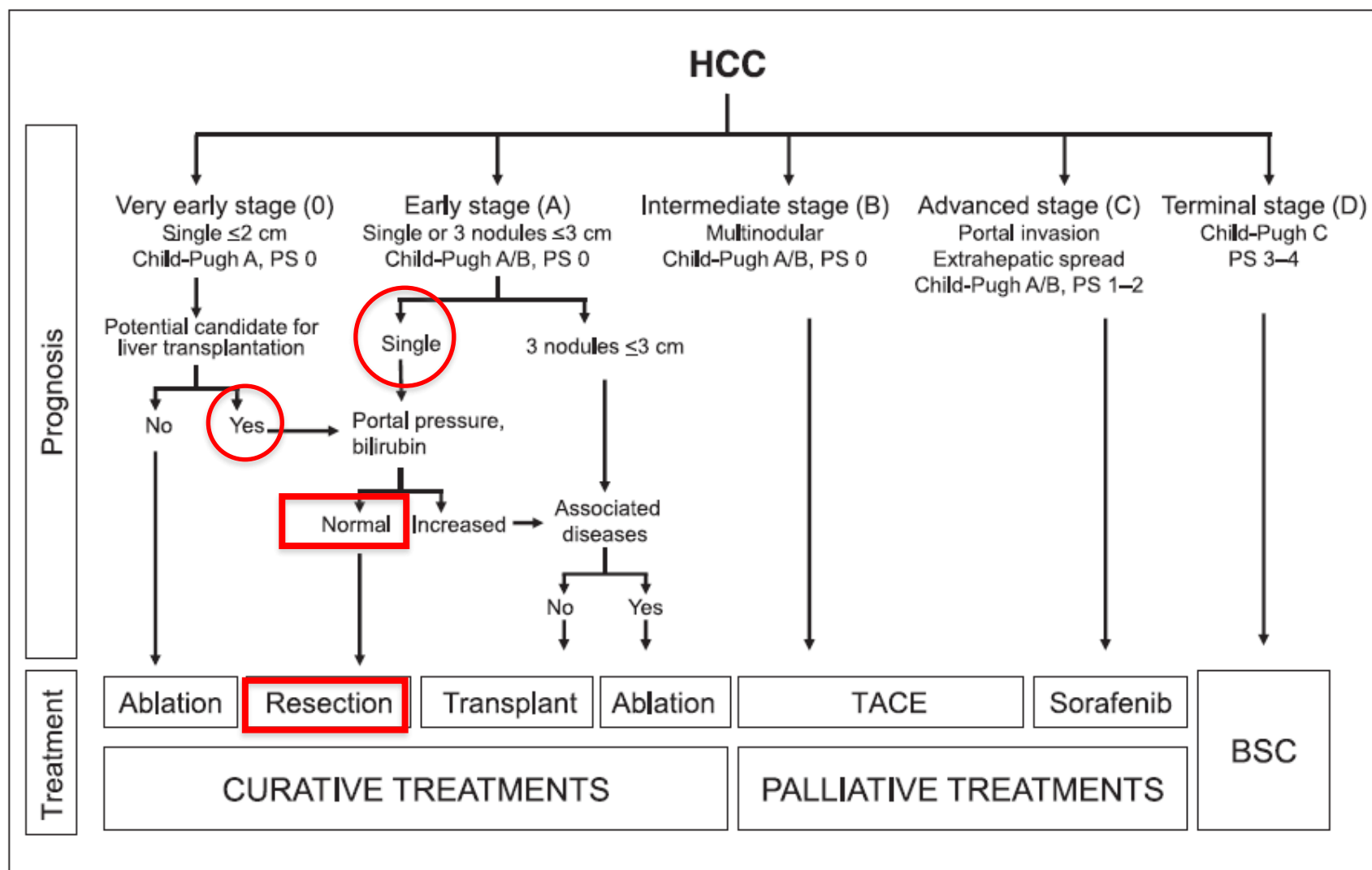
- Surgical resection is recommended as treatment of choice in patients with HCC arising on a non-cirrhotic liver (**evidence low; recommendation strong**).

Ressecção do carcinoma hepatocelular

☐ Recorrência

Até 75% dos pacientes em 5 anos pós ressecção

- ☐ Metástase do tumor primário original**
- ☐ Tumor de novo (predisposição pela cirrose)**



Ressecção

Evolução da cirurgia do fígado

- ☐ **Manuseio peri-operatório**
- ☐ **Seleção do paciente**
- ☐ **Refinamento da técnica**
- ☐ **Redução da mortalidade**
- ☐ **Laparoscopia**

***Mortalidade peri-operatória de 3-5% em centros de grande volume**

Ressecção hepática

- ☐ **MELD < 9**
- ☐ **Child-Pugh A**
- ☐ **Ausência de HP significativa**

- ☐ **Ressecabilidade do tumor**

Tamanho

Número

Localização

Envolvimento microvascular

- ☐ **Estado geral preservado**

Child-Pugh A

Clinical and biochemical parameters	Points		
	1	2	3
Albumin (g/dL)	>3.5	2.8–3.5	<2.8
Bilirubin (mg/dL)	<2	2–3	>3
Prothrombin time			
Seconds prolonged	<4	4–6	>6
%	>60	40–60	<60
INR	<1.7	1.7–2.3	>2.3
Encephalopathy	Absent	Moderate (Stage I–II)	Severe (Stage III–IV)
Ascites	Absent	Moderate	Refractory

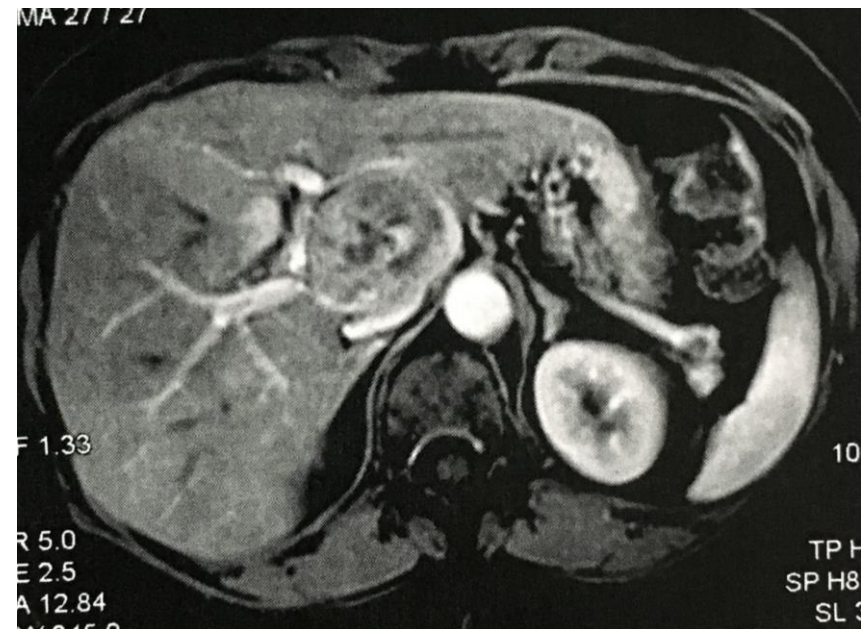
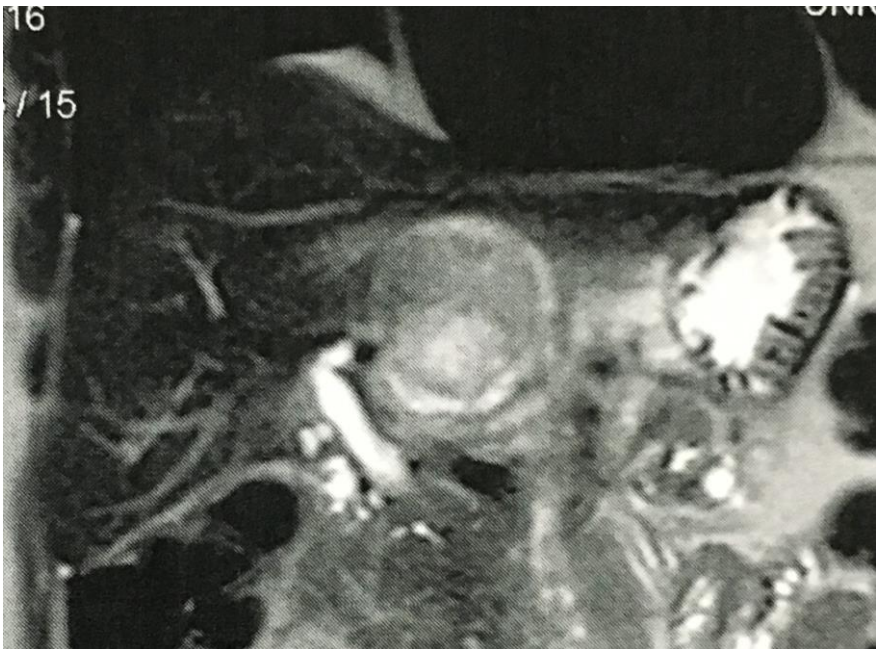
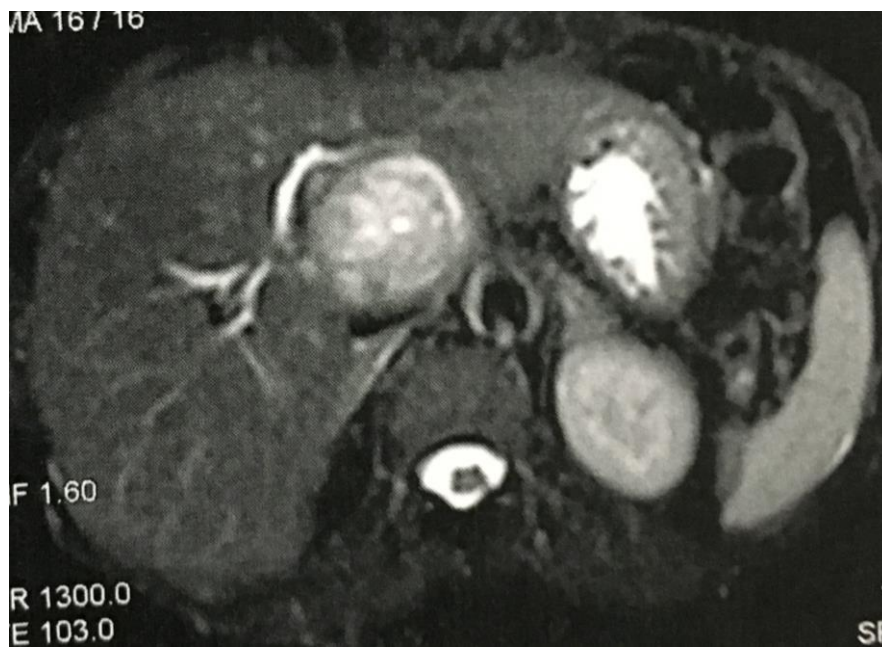
Total points: 5–6 points, Child–Pugh A; 7–9 points, Child–Pugh B; 10–15 points, Child–Pugh C

MELD < 9

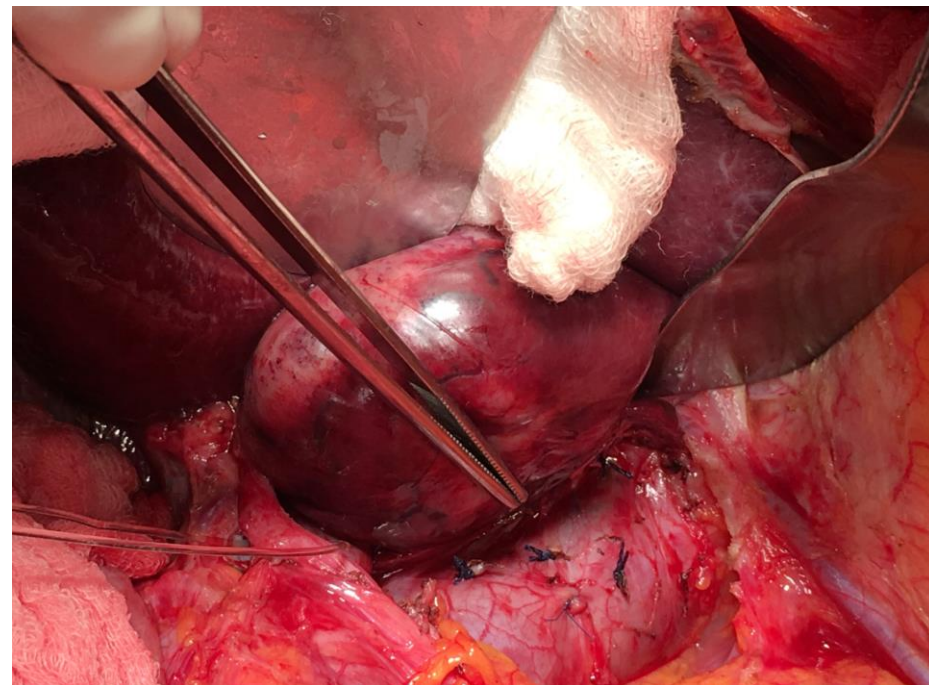
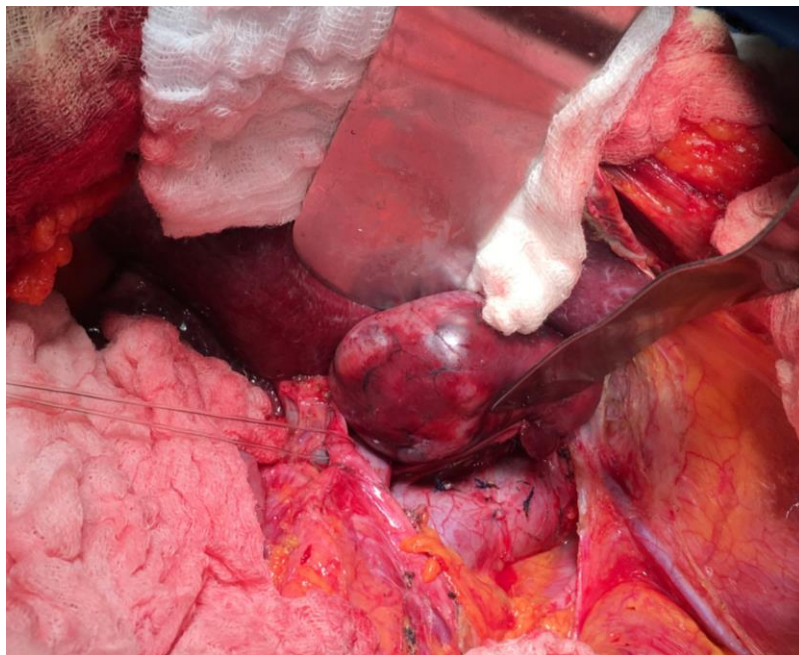
☐ **Bilirrubina**

☐ **Creatinina**

☐ **INR**



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

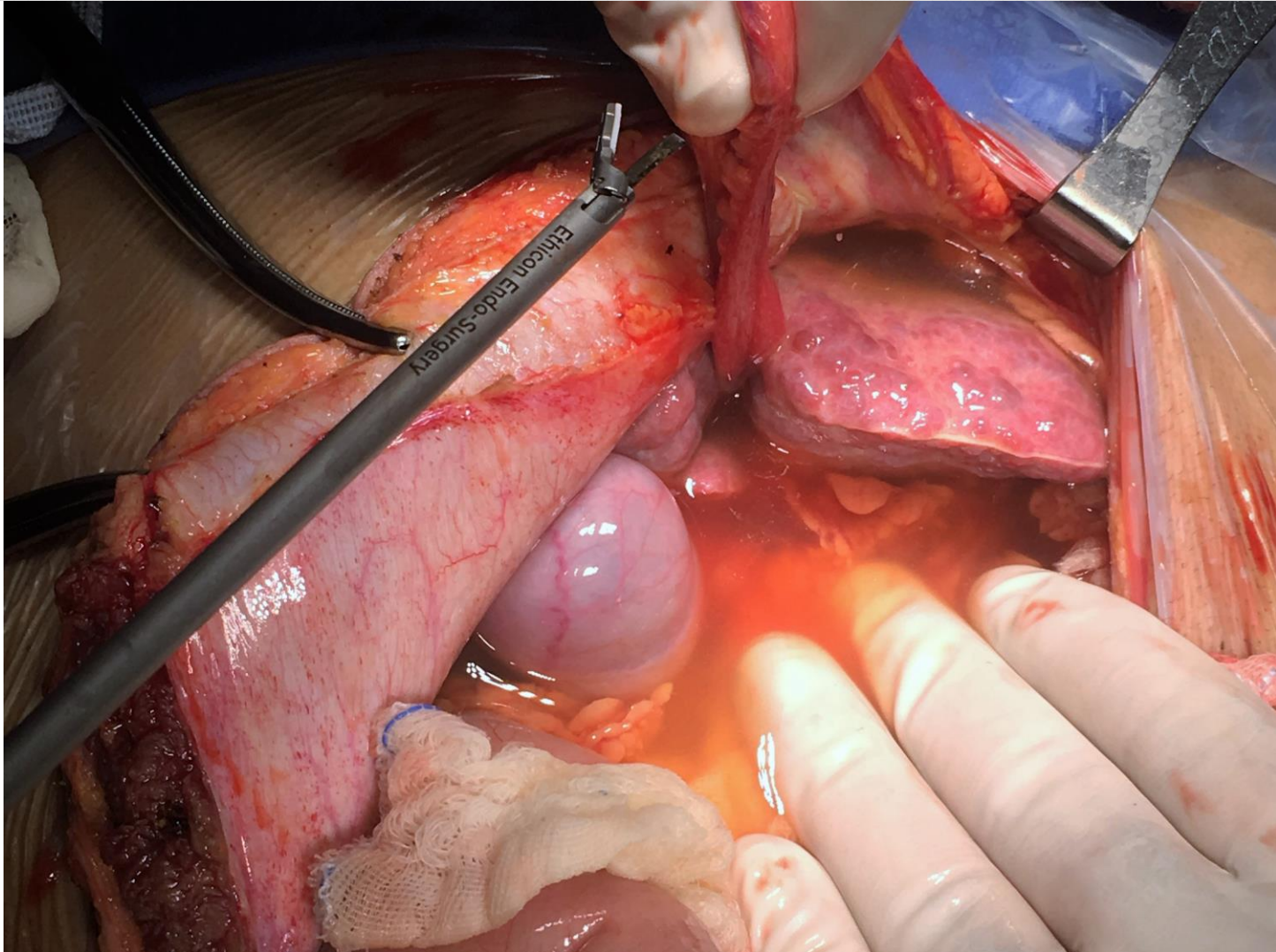


Cirurgia:
Ressecção de lobo caudado
Evolução satisfatória
Alta sem intercorrências

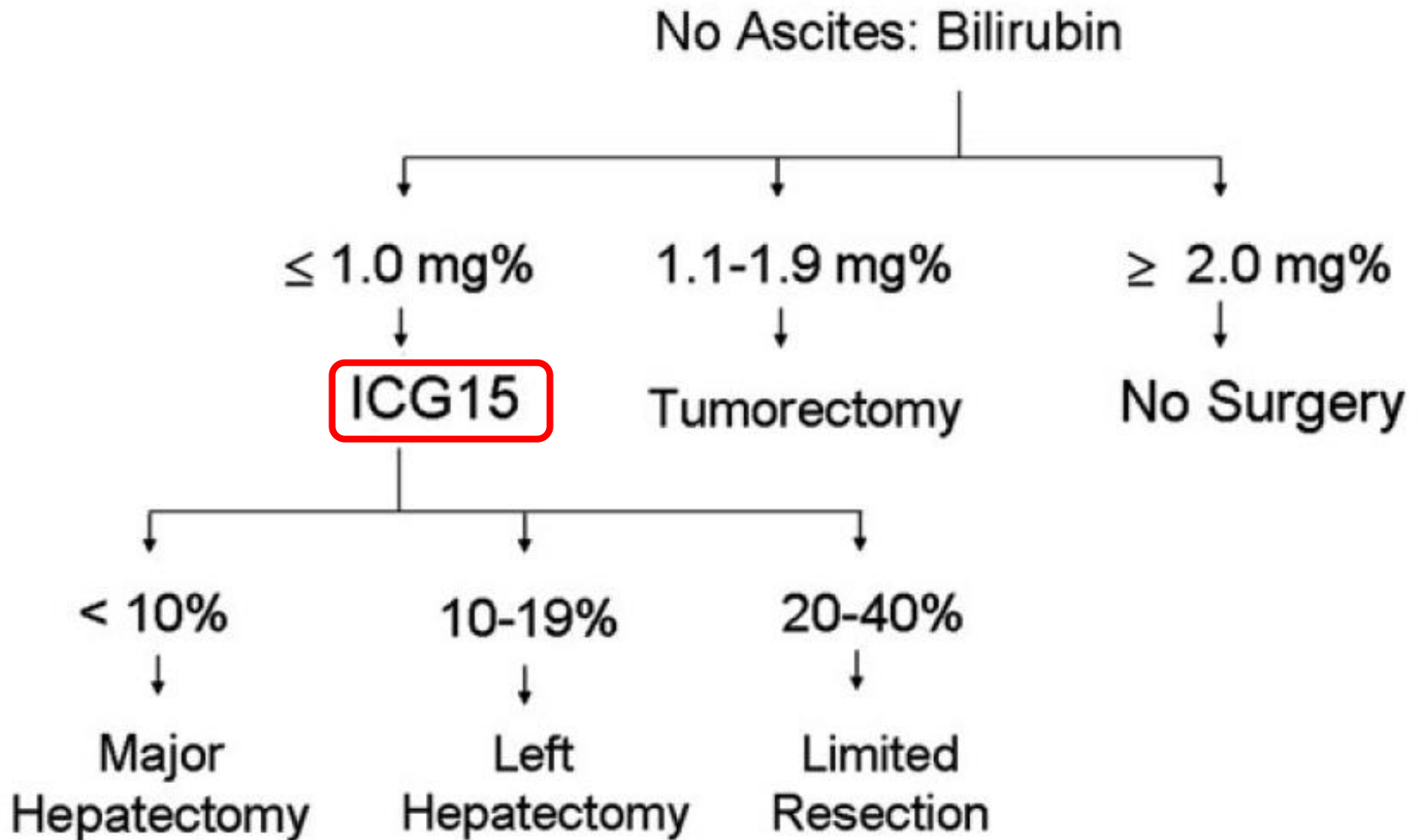
MD Anderson Cancer Center

Resection	Criteria
Minor	Child–Pugh A Bilirubin ≤ 2 mg/dL Absence of ascites Platelets $> 100,000/\text{mm}^3$
Major	Criteria for minor resection plus: Bilirubin ≤ 1 mg/dL Absence of portal hypertension Portal vein embolization for future liver remnant of $< 40\%$

Ausência de ascite

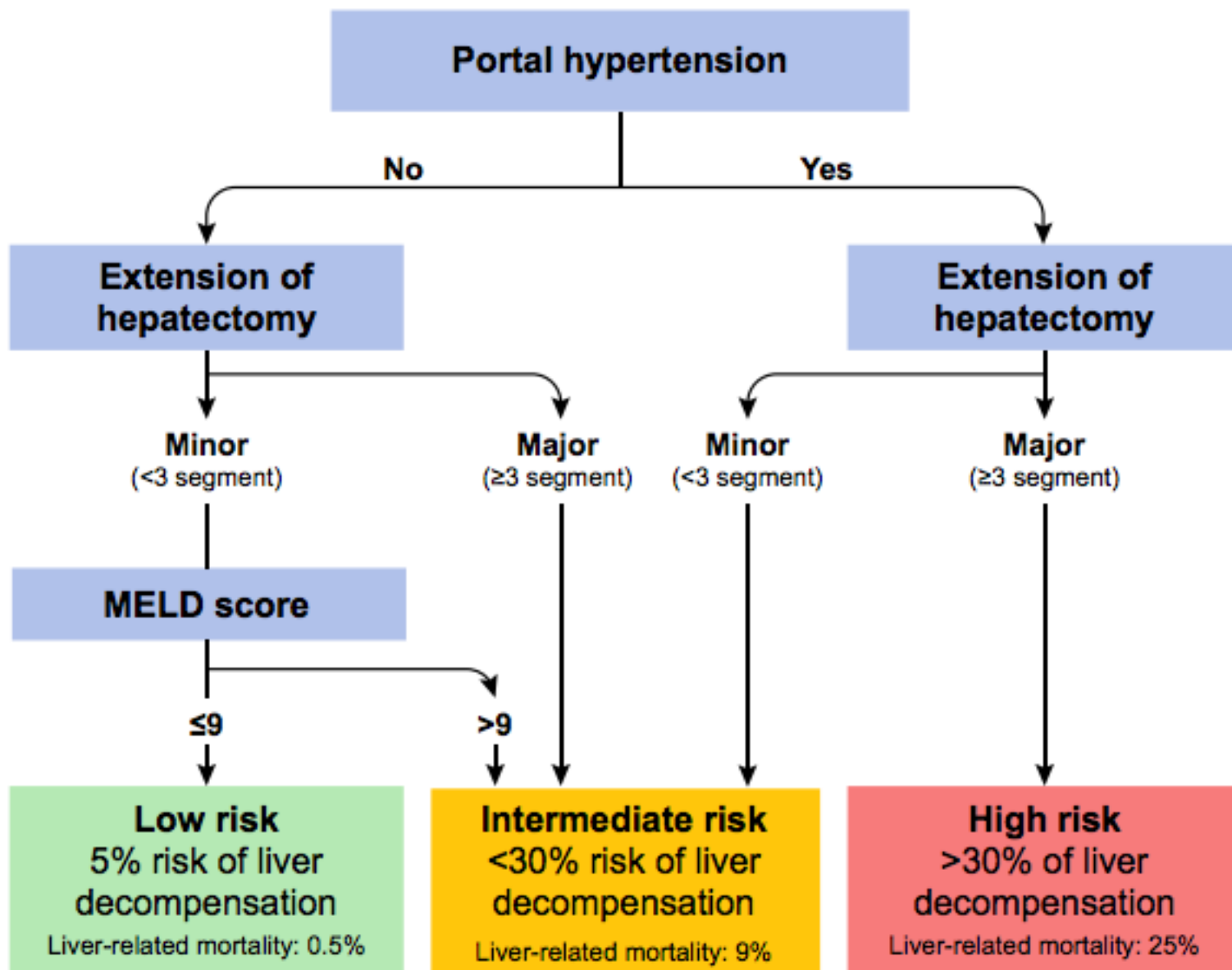


Verde de Indocianina



Hipertensão porta

- ☐ **Plaquetas < 100.000**
- ☐ **Esplenomegalia**
- ☐ **Varizes esofagogástricas (endoscopia)**
- ☐ **Gradiente da pressão venosa hepática < 10 mmHg**



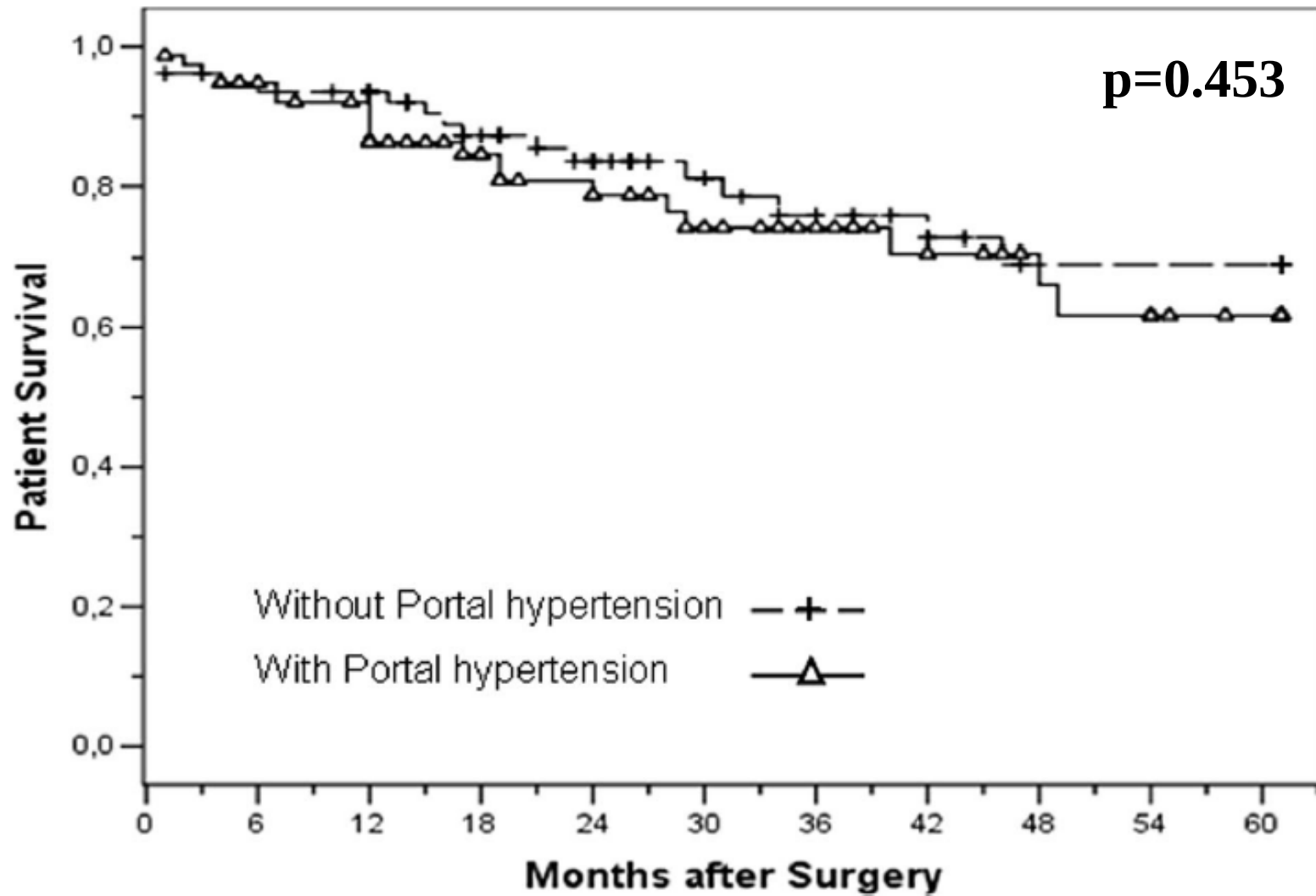
		Extension of hepatectomy	
		Major	Minor
Portal hypertension	Yes		
	No		MELD score >9 MELD score ≤9

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**

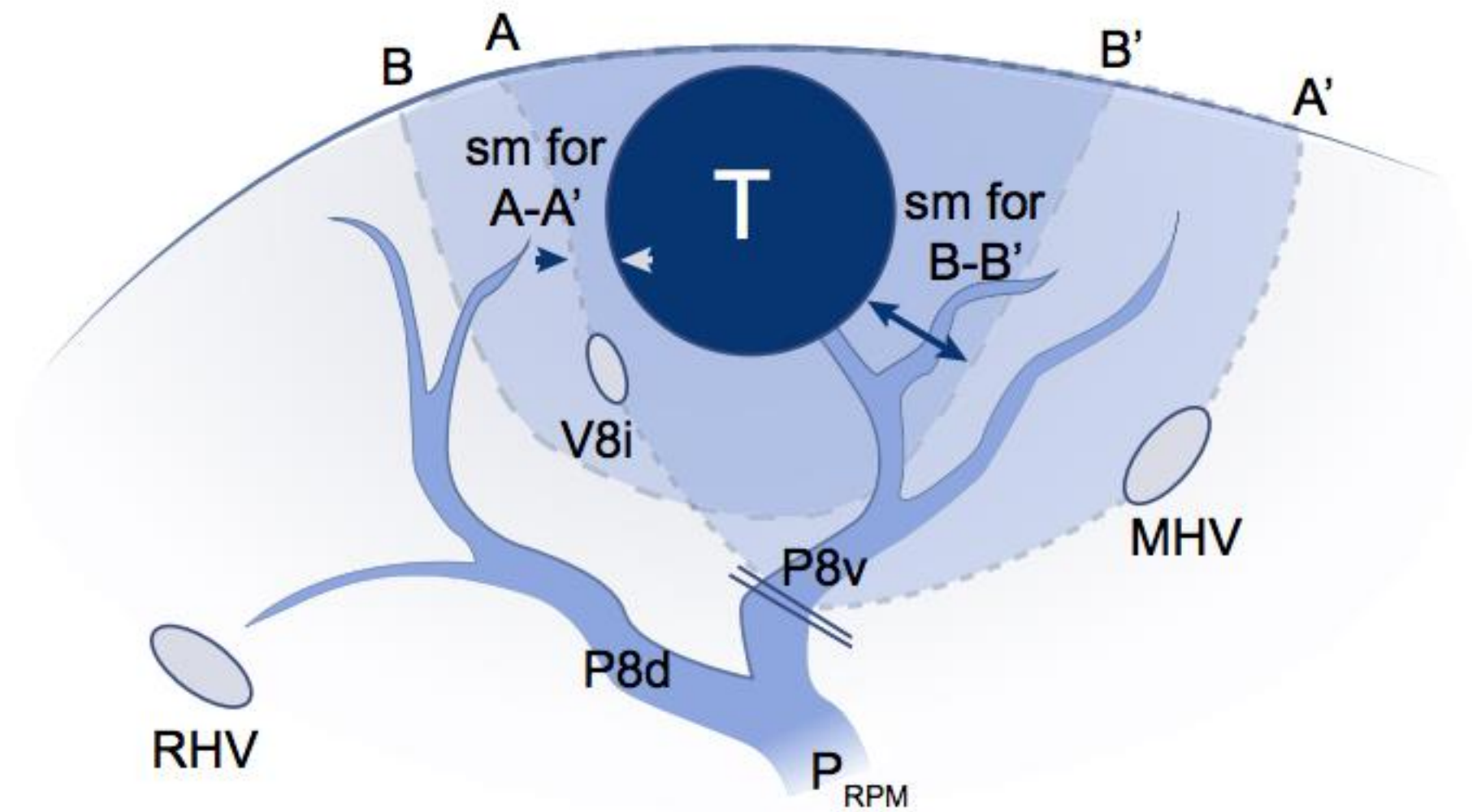
Background and Aims: The outcome of hepatic resection in cirrhotic patients has improved remarkably in recent years with improved surgical techniques and perioperative care; however, the role of portal hypertension is

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 resection, reserving these patients for other treatments. This review

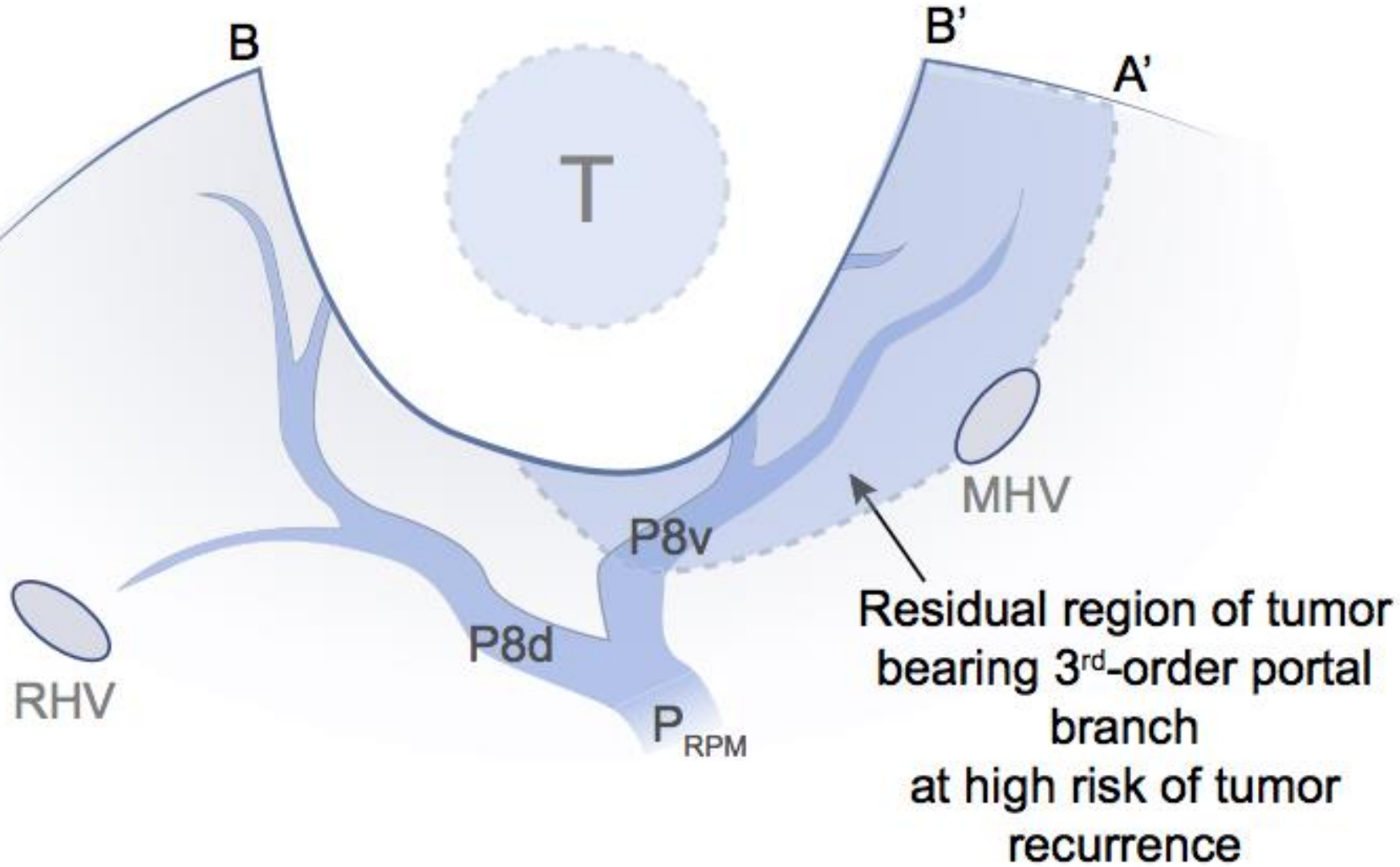


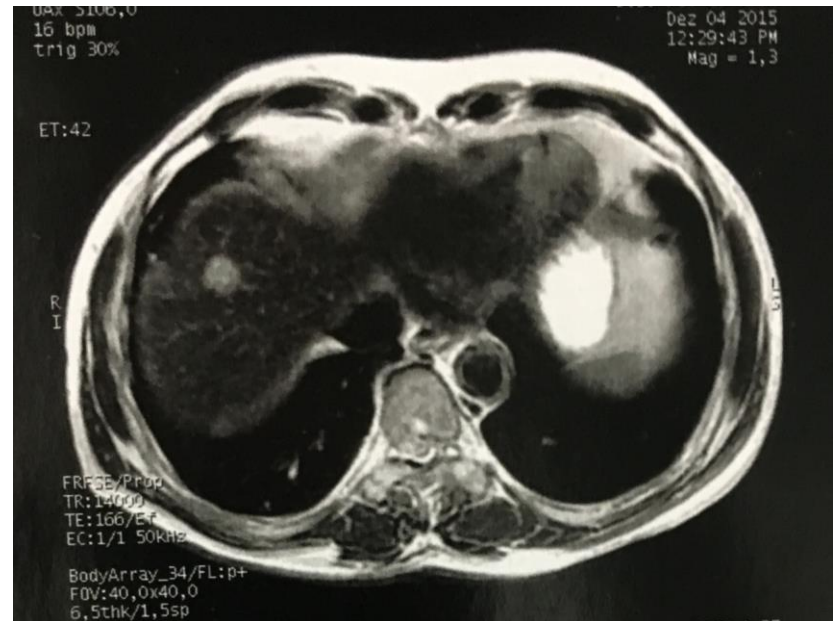
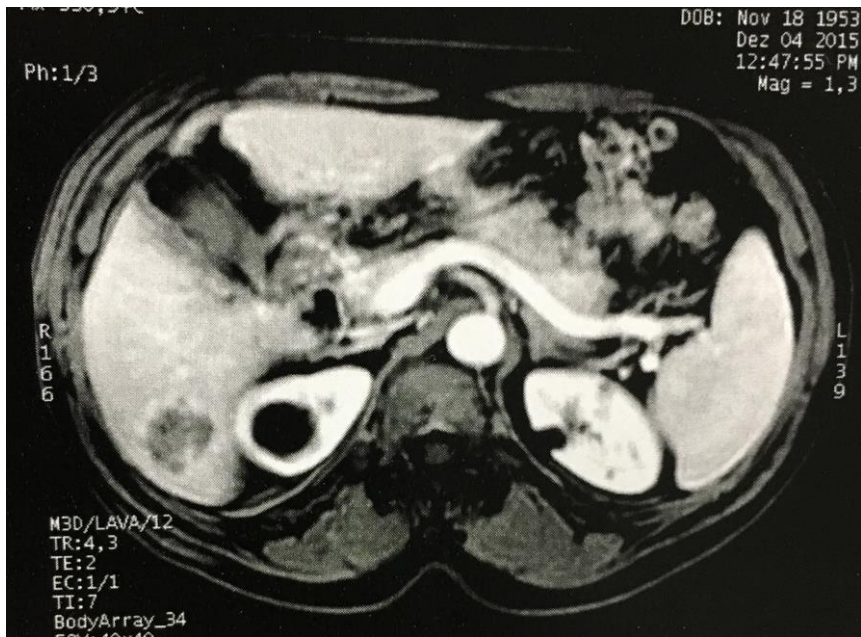
In conclusion, the EASL/AASLD guidelines clearly define indications for hepatic resection for HCC: patients with single HCC and completely preserved liver function without portal hypertension. These guidelines exclude from surgery many patients who could potentially benefit from curative resection. However,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

RESSECÇÃO ANATÔMICA



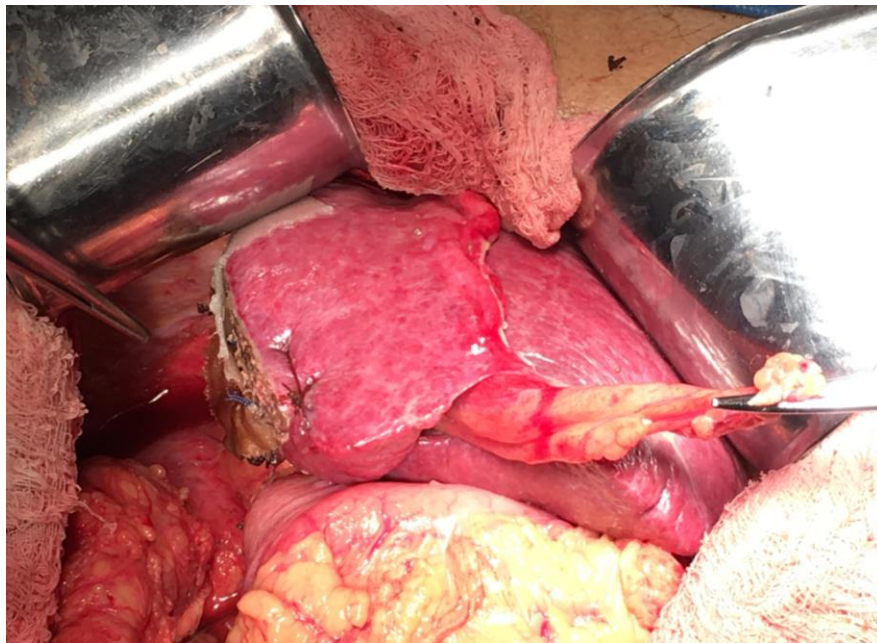
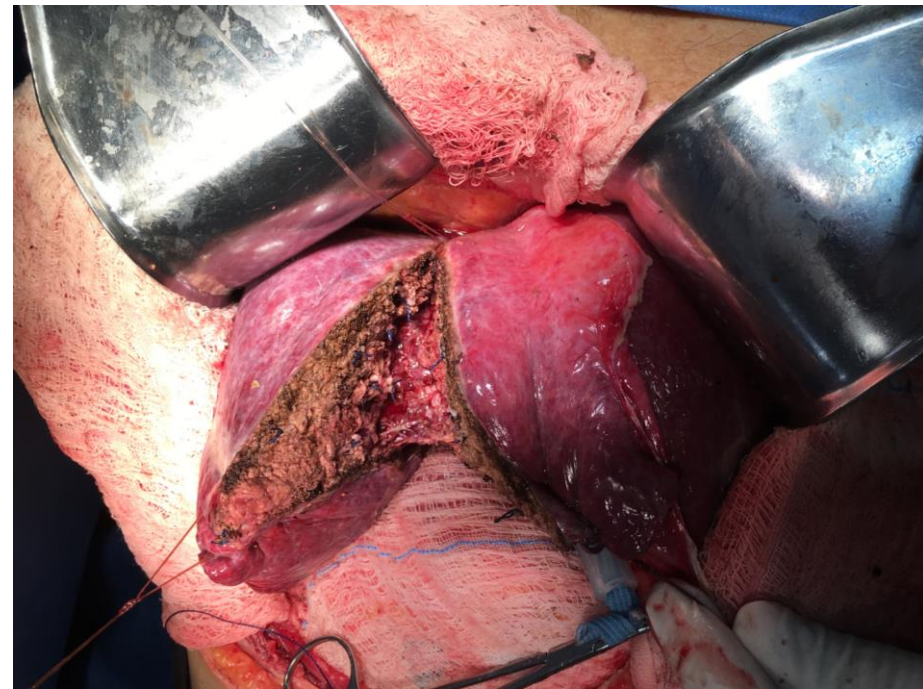
RESSECÇÃO NÃO ANATÔMICA





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

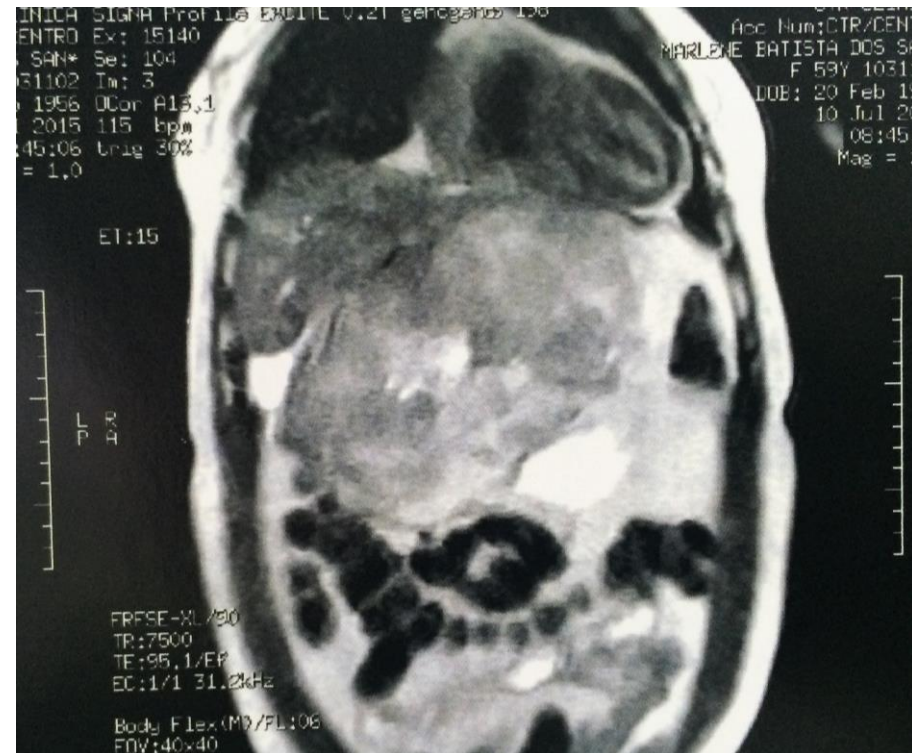
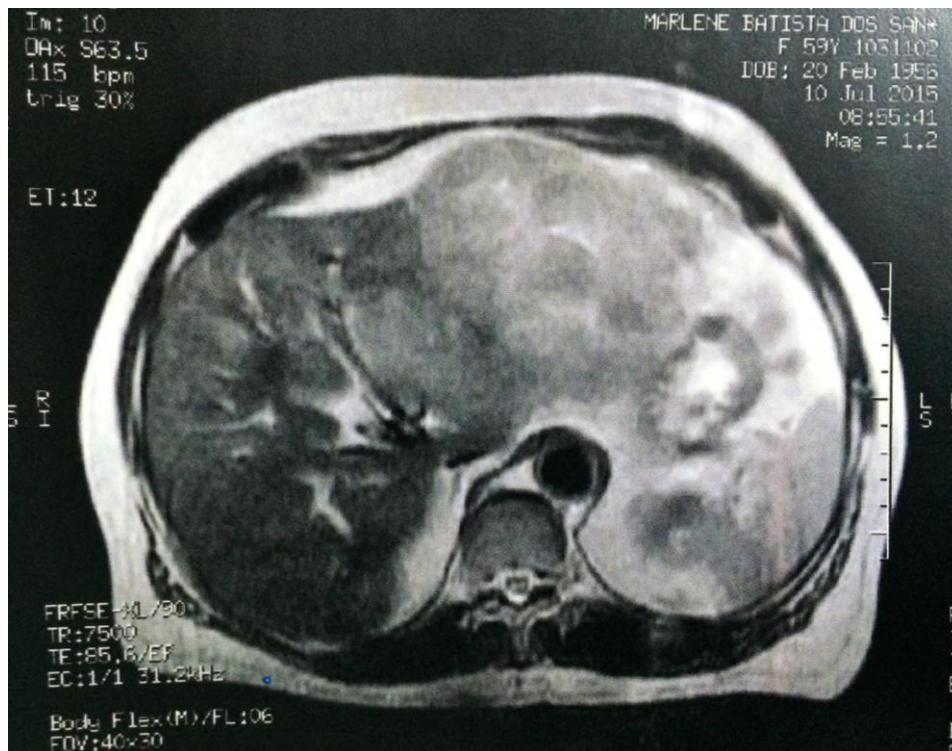
❑ Doença multifocal



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

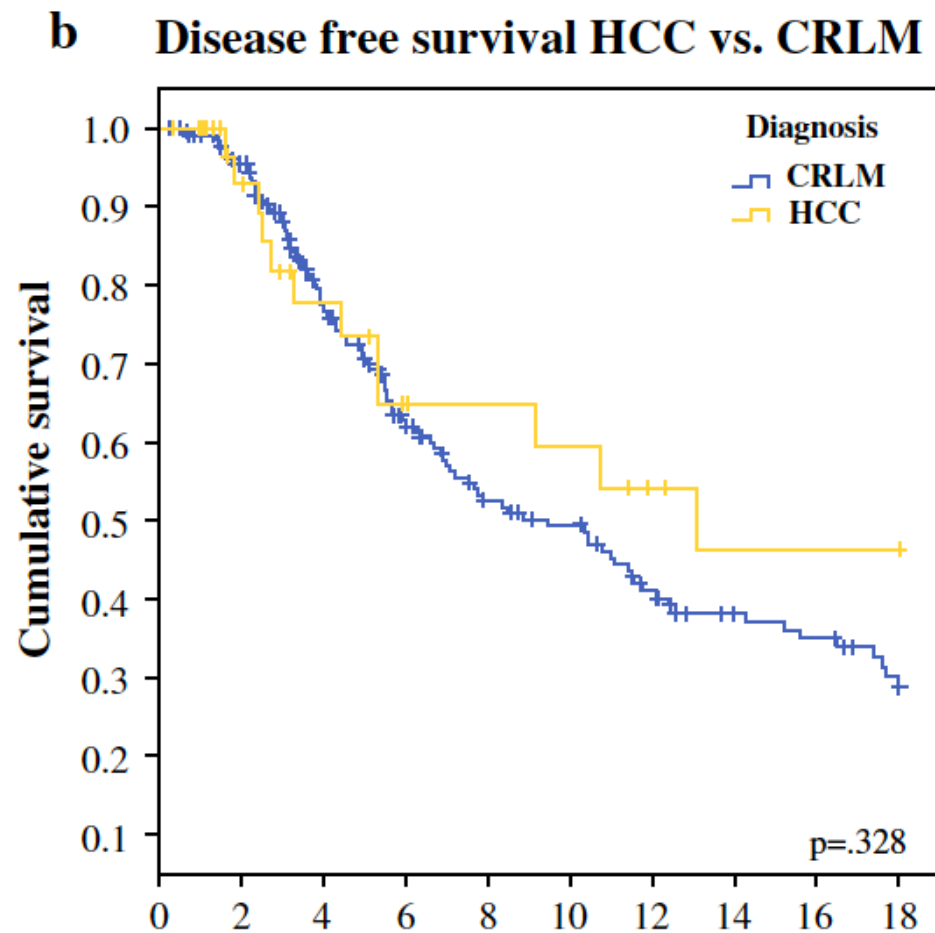
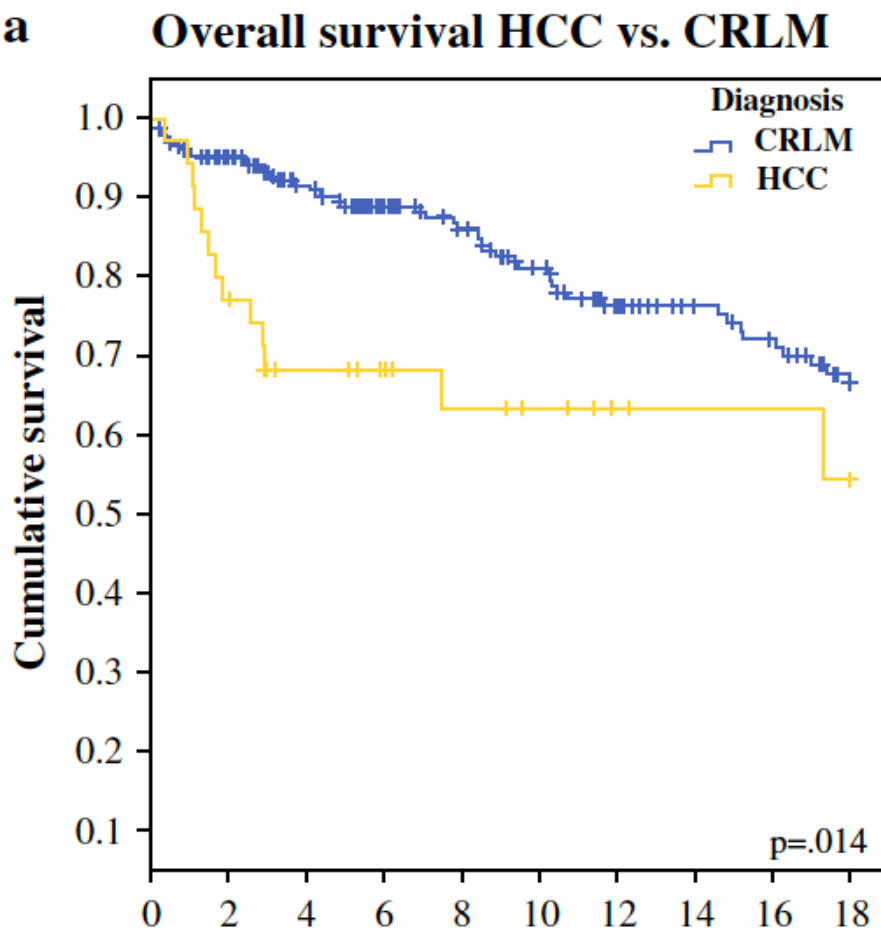
Extensão tumoral intra-hepática

Tamanho

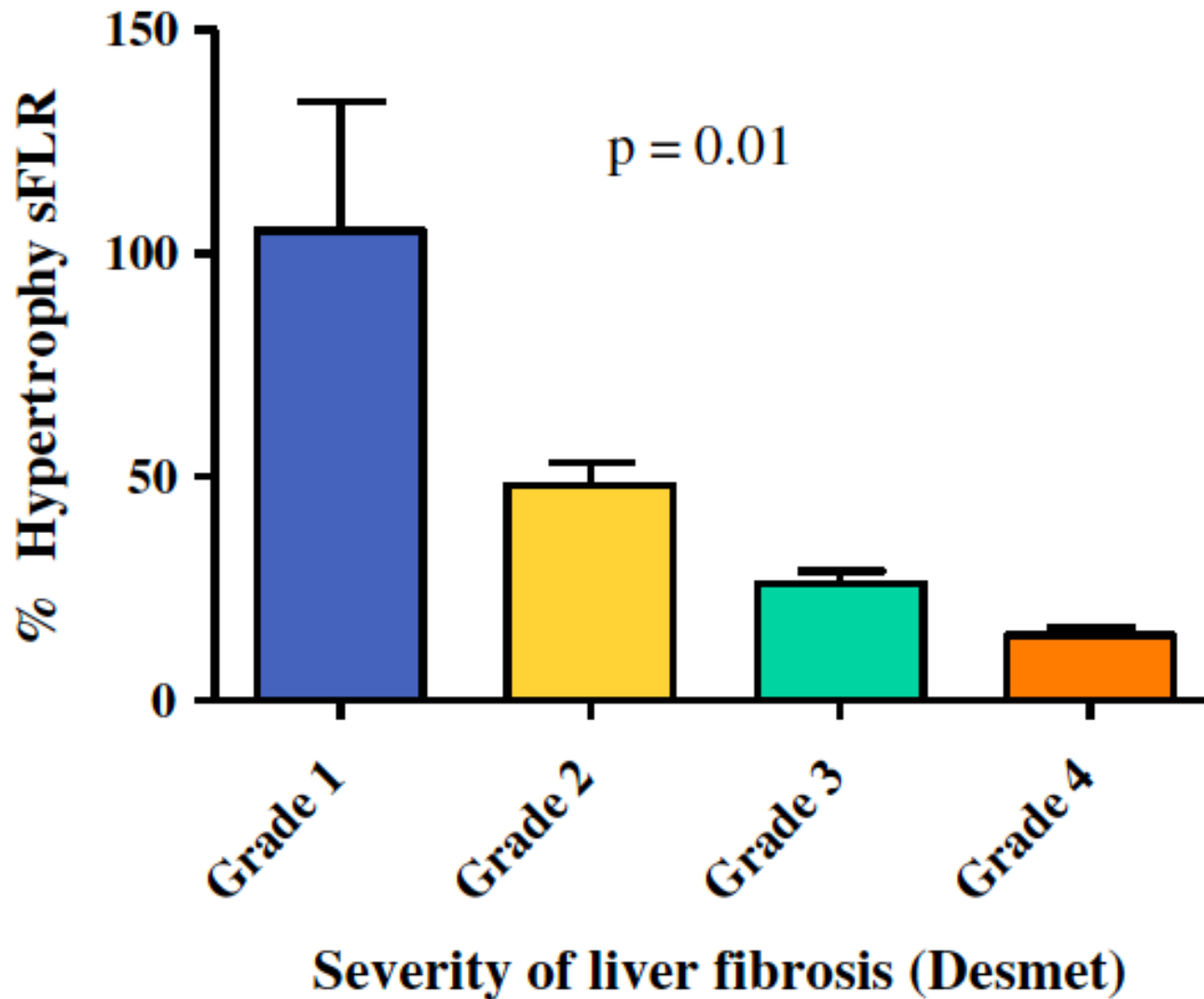


Should ALPPS be Used for Liver Resection in Intermediate-Stage HCC?

J. G. D'Haese, MD¹, J. Neumann, MD², M. Weniger, MD¹, S. Pratschke, MD¹, B. Björnsson, MD³, V. Ardiles, MD⁴, W. Chapman, MD, FACS⁵, R. Hernandez-Alejandro, MD⁶, O. Soubrane, MD⁷, R. Robles-Campos, MD⁸, M. Stojanovic, MD, PhD⁹, R. Dalla Valle, MD¹⁰, A. C. Y. Chan, MD, MBBS, FRCS, FCSHK, FHKAM (Surgery)¹¹, M. Coenen, PhD, MPH¹², M. Guba, MD¹, J. Werner, MD, MBA¹, E. Schadde, MD, FACS¹³, and M. K. Angele, MD, FACS^{1,14}



e Hypertrophy in fibrosis

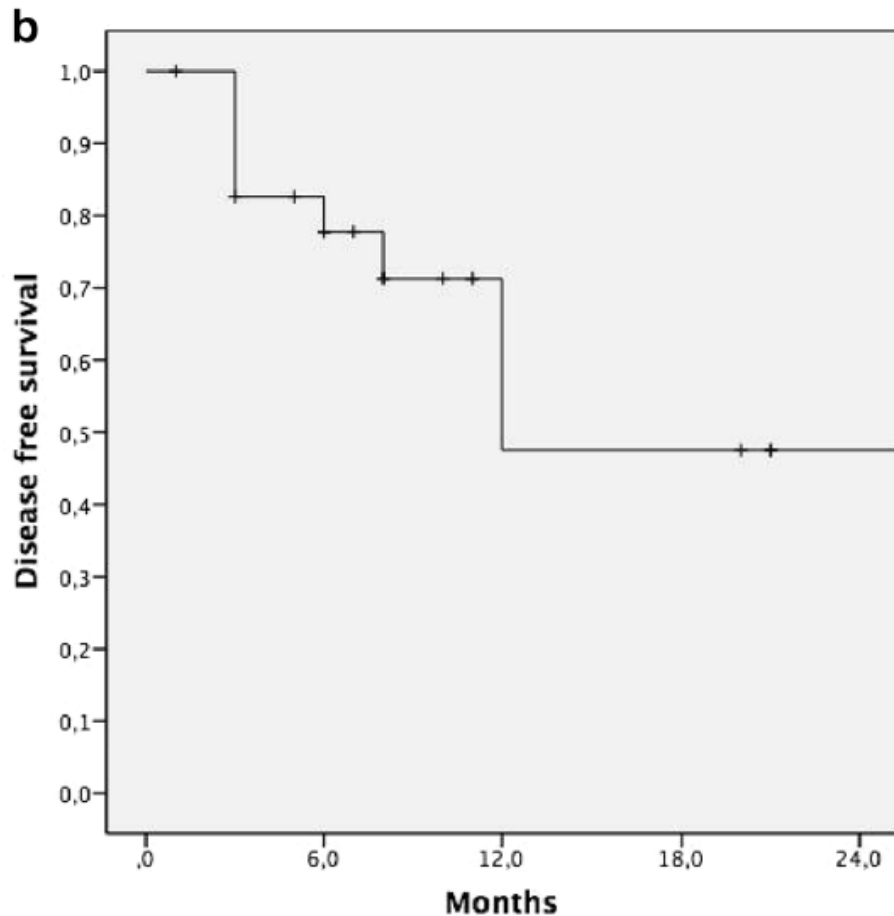




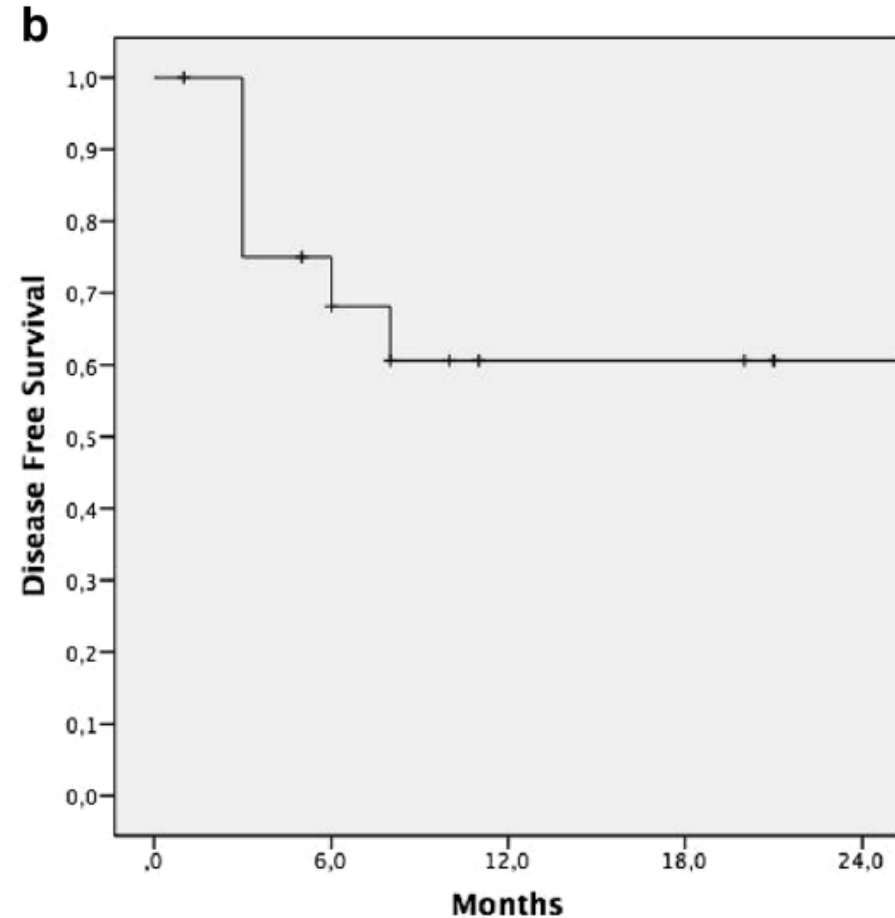
The ALPPS procedure: hepatocellular carcinoma as a main indication. An Italian single-center experience

Giovanni Vennarecci¹ · Daniele Ferraro¹ · Antonella Tudisco¹ · Giovanni Battista Levi Sandri¹ · Nicola Guglielmo¹ ·
Giammauro Berardi¹ · Isabella Sperduti² · Giuseppe Maria Ettore¹

ALPPS – SOBREVIDA LIVRE DE DOENÇA



TODA SÉRIE



HCC



Contents lists available at ScienceDirect

International Journal of Surgery Case Reports

journal homepage: www.elsevier.com

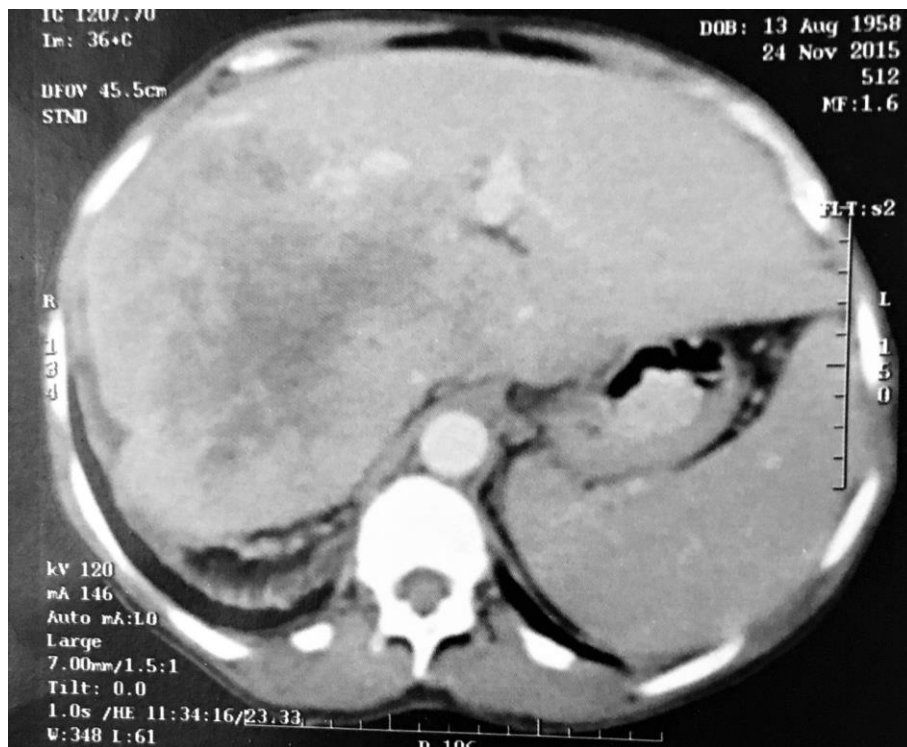


Case Report

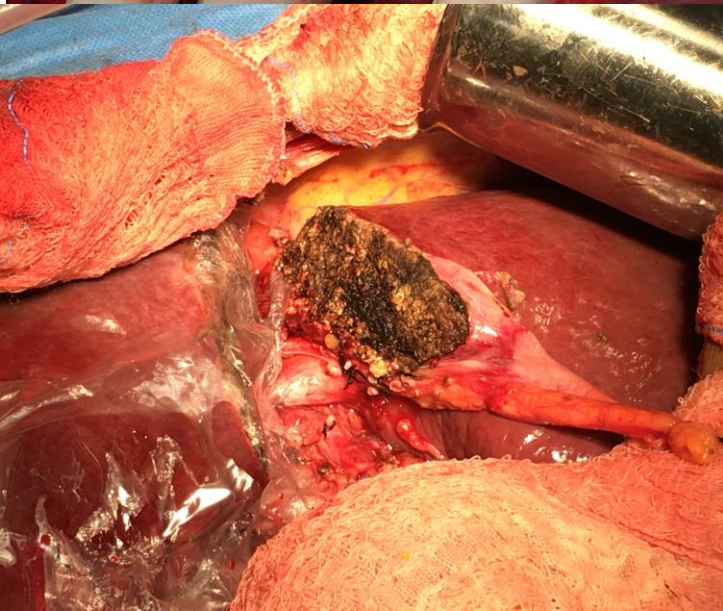
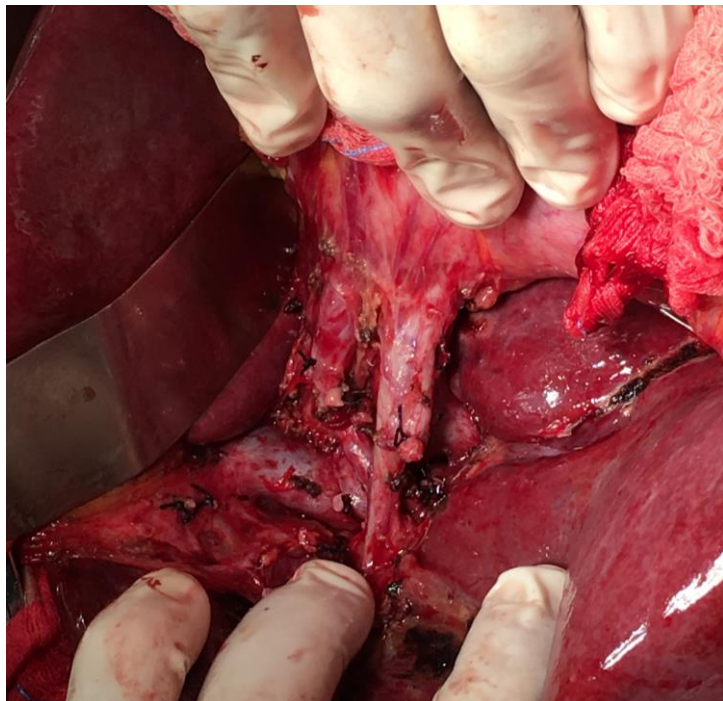
The ALPPS procedure for hepatocellular carcinoma larger than 10 centimeters

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

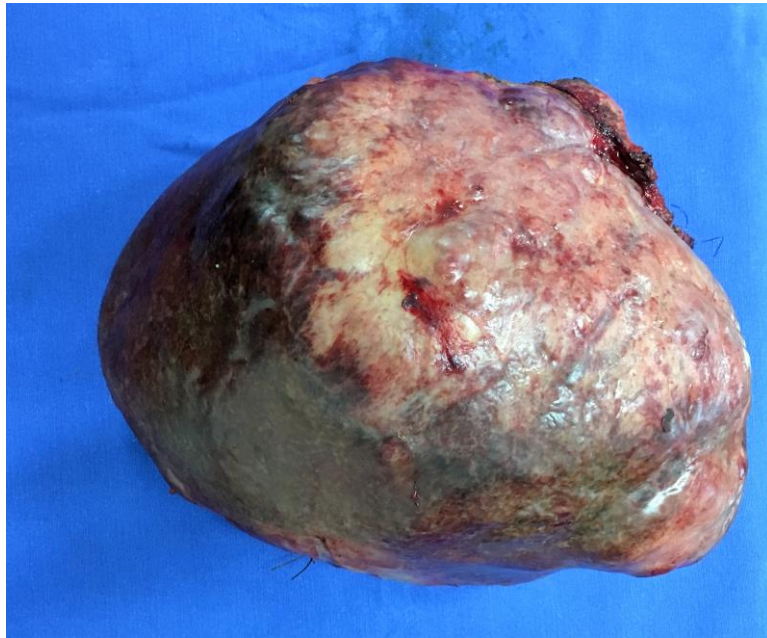
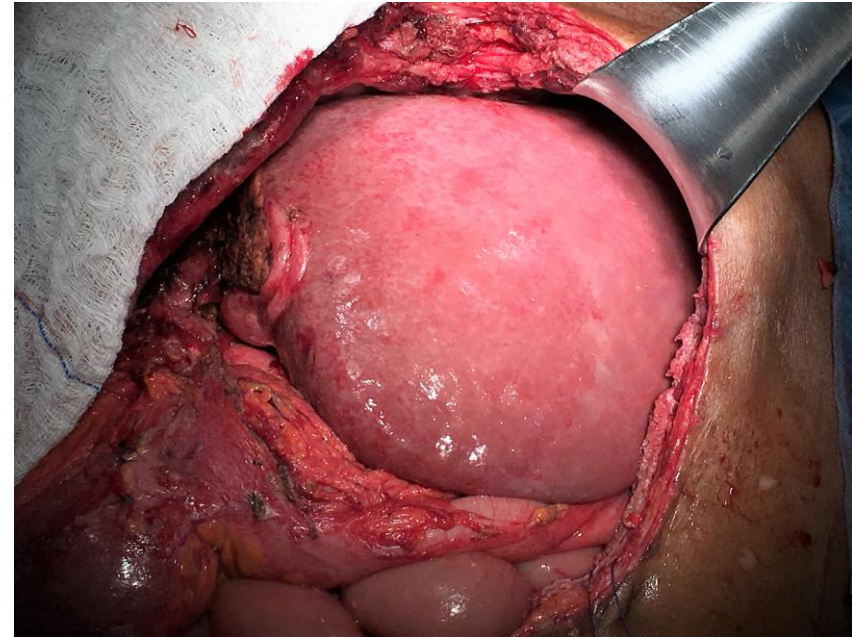
Department of Digestive Surgery, Federal University of Maranhão, São Luiz, MA, Brazil



**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**

Meta-Analysis of Laparoscopic Versus Open Resection for Hepatocellular Carcinoma

Yan-Ming Zhou · Wen-Yu Shao · Yan-Fang Zhao ·
Dong-Hui Xu · Bin Li

ORIGINAL ARTICLE

Laparoscopic Liver Resection for Hepatocellular Carcinoma

Ten-Year Experience in a Single Center

Eric C. H. Lai, MB ChB, MRCSEd, FRACS; Chung Ngai Tang, MB BS, FRCS;
Joe P. Y. Ha, MB BS, FRCS; Michael K. W. Li, MB BS, FRCS



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DOI: 10.3748/wjg.v20.i25.8274

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ISSN 1007-9327 (print) ISSN 2219-2840 (online)
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META-ANALYSIS

Laparoscopic vs open approach to resection of hepatocellular carcinoma in patients with known cirrhosis: Systematic review and meta-analysis

Ahmed Twaij, Philip H Pucher, Mikael H Sodergren, Tamara Gall, Ara Darzi, Long R Jiao

Surgical Endoscopy
<https://doi.org/10.1007/s00464-018-6426-3>



Laparoscopic liver resection of hepatocellular carcinoma located in unfavorable segments: a propensity score-matched analysis from the I Go MILS (Italian Group of Minimally Invasive Liver Surgery) Registry

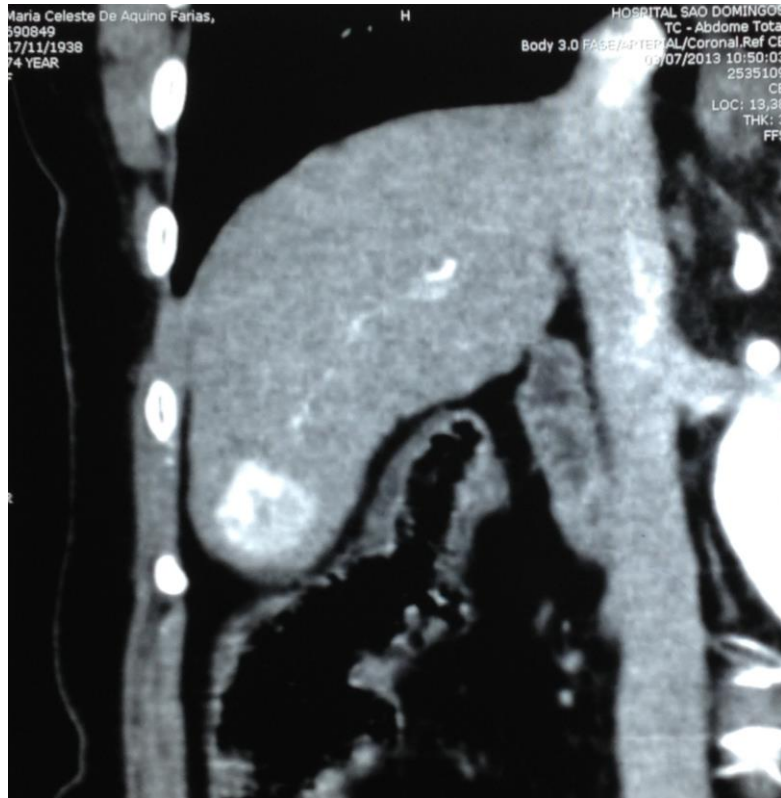
Giovanni Battista Levi Sandri¹ · Giuseppe Maria Ettorre¹ · Luca Aldrighetti² · Umberto Cillo³ · Raffaele Dalla Valle⁴ ·
Alfredo Guglielmi⁵ · Vincenzo Mazzaferro⁶ · Alessandro Ferrero⁷ · Fabrizio Di Benedetto⁸ · Salvatore Gruttadauria⁹ ·
Luciano De Carlis¹⁰ · Giovanni Vennarecci¹ on behalf of I Go MILS Group on HCC

Zhou YM, et al. Dig Dis Sci 2011;56:1937-43

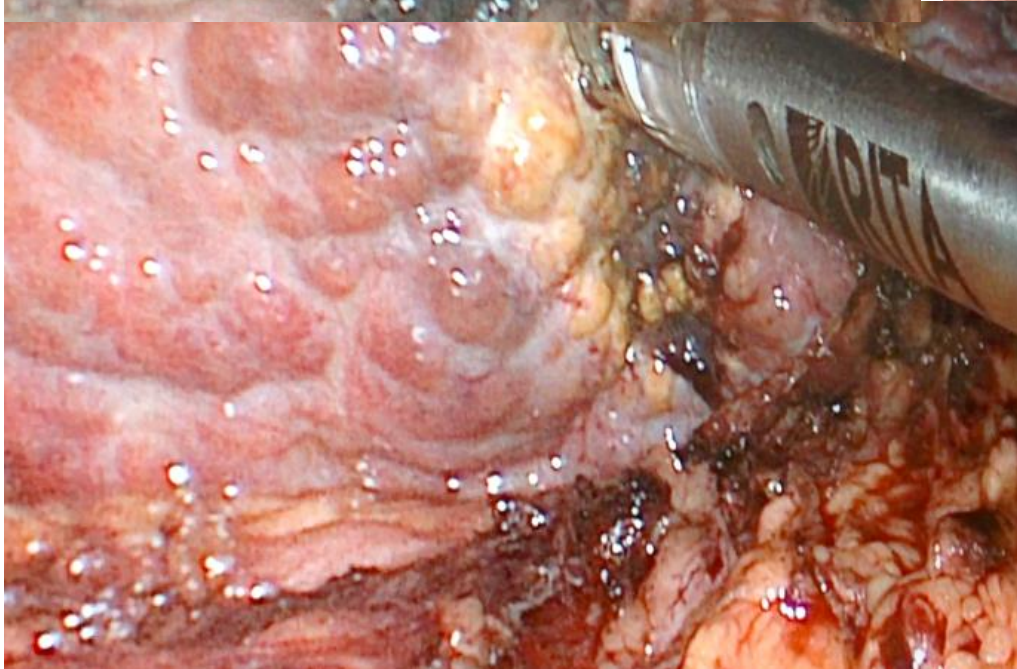
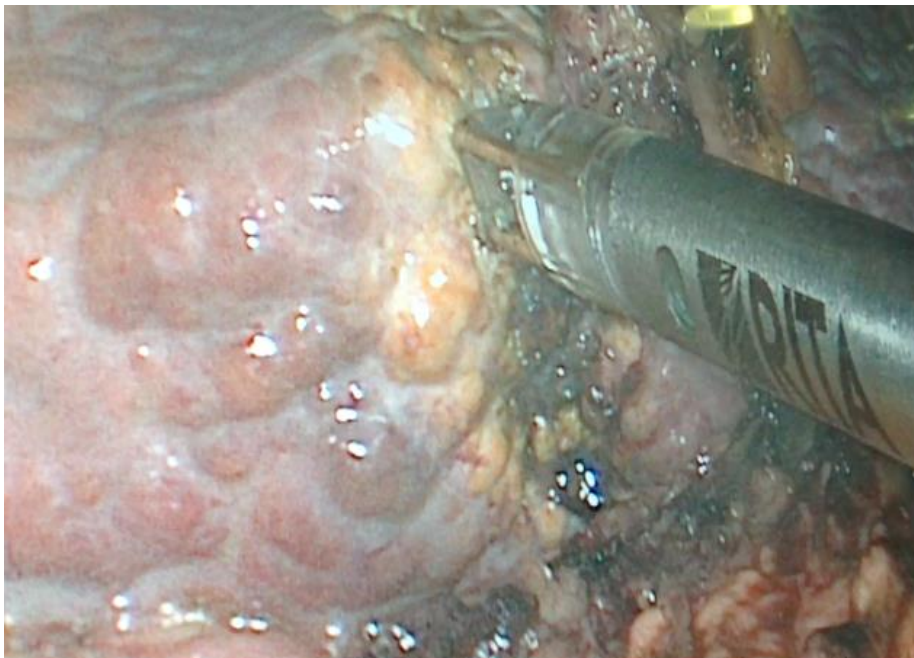
Twaij A, et al. World J Gastroenterol 2014

Lai EC, et al. Arch Surg 2009

Sandri GB, et al. Surg Endosc 2018



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**

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

Olivier Soubrane¹, Claire Goumard¹, Alexis Laurent², Hadrien Tranchart³, Stéphanie Truant⁴, Brice Gayet⁵, Chadi Salloum⁶, Guillaume Luc⁷, Safi Dokmak⁸, Tullio Piardi⁹, Daniel Cherqui², Ibrahim Dagher³, Emmanuel Boleslawski⁴, Eric Vibert⁶, Antonio Sa Cunha⁷, Jacques Belghiti⁸, Patrick Pessaux⁹, Pierre-Yves Boelle^{1,10,11} & Olivier Scatton¹

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

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

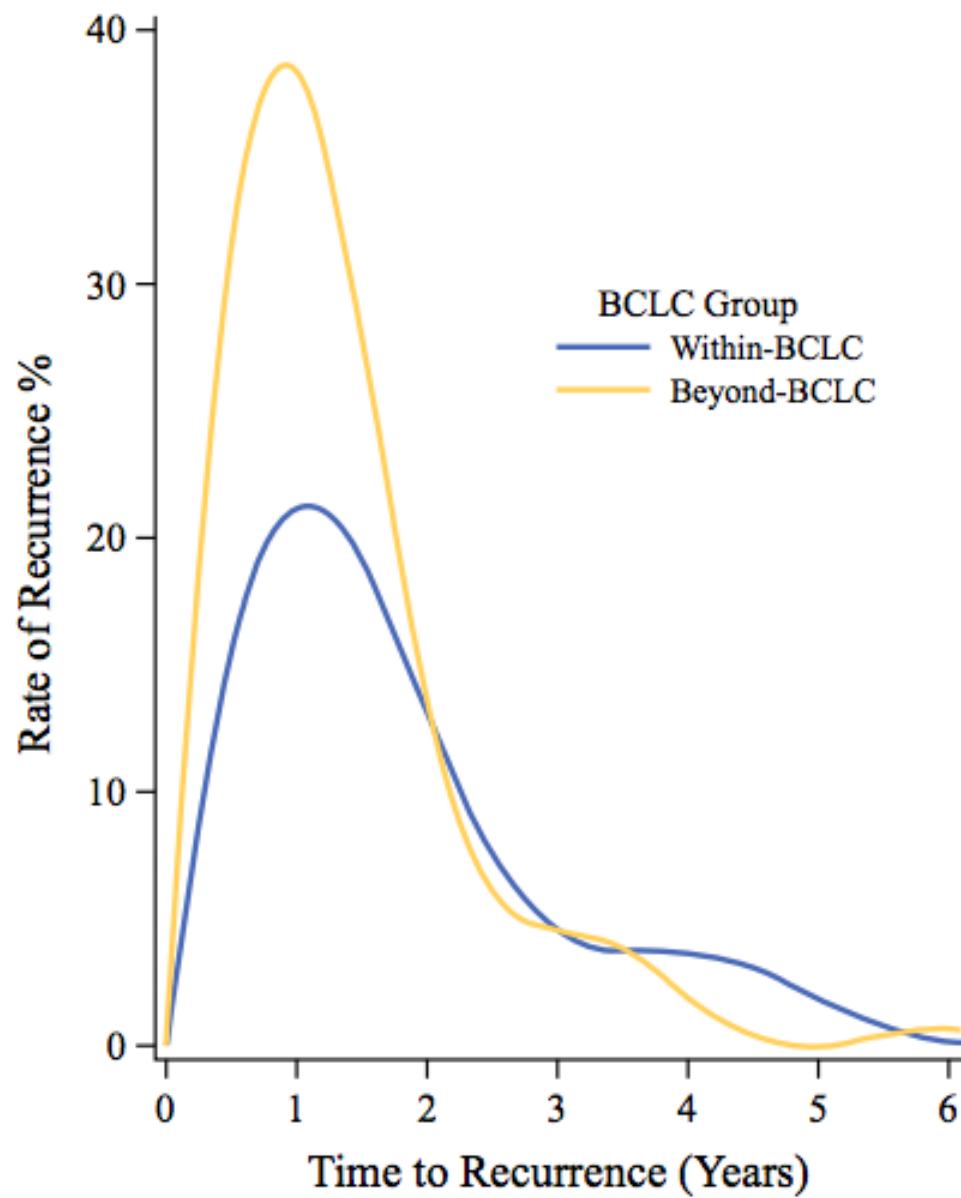
Postoperative data	Value
Histological cirrhosis, <i>n</i> (%)	247 (70%)
Histological fibrosis F2, F3, <i>n</i> (%)	55 (16%)
Maximum tumour size, mm, median (range)	35 (5–170)
Single HCC, <i>n</i> (%)	302 (86%)
Multiple HCC, <i>n</i> (%)	49 (14%)
Bilobar HCC, <i>n</i> (%)	24 (7%)
Encapsulated HCC, <i>n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



ORIGINAL ARTICLE – HEPATOBILIARY TUMORS

Recurrence Patterns and Outcomes after Resection of Hepatocellular Carcinoma within and beyond the Barcelona Clinic Liver Cancer Criteria

Diamantis I. Tsilimigras, MD¹, Fabio Bagante, MD^{1,2}, Dimitrios Moris, MD, PhD¹, J. Madison Hyer, MS¹, Kota Sahara, MD¹, Anghela Z. Paredes, MD, MS¹, Rittal Mehta, MPH¹, Francesca Ratti, MD³, Hugo P. Marques, MD⁴, Olivier Soubrane, MD⁵, Vincent Lam, MD⁶, George A. Poultsides, MD⁷, Irinel Popescu, MD⁸, Sorin Alexandrescu, MD⁸, Guillaume Martel, MD⁹, Aklile Workneh, MD⁹, Alfredo Guglielmi, MD², Tom Hugh, MD¹⁰, Luca Aldrighetti, MD³, Itaru Endo, MD, PhD¹¹, and Timothy M. Pawlik, MD, MPH, PhD, FACS¹

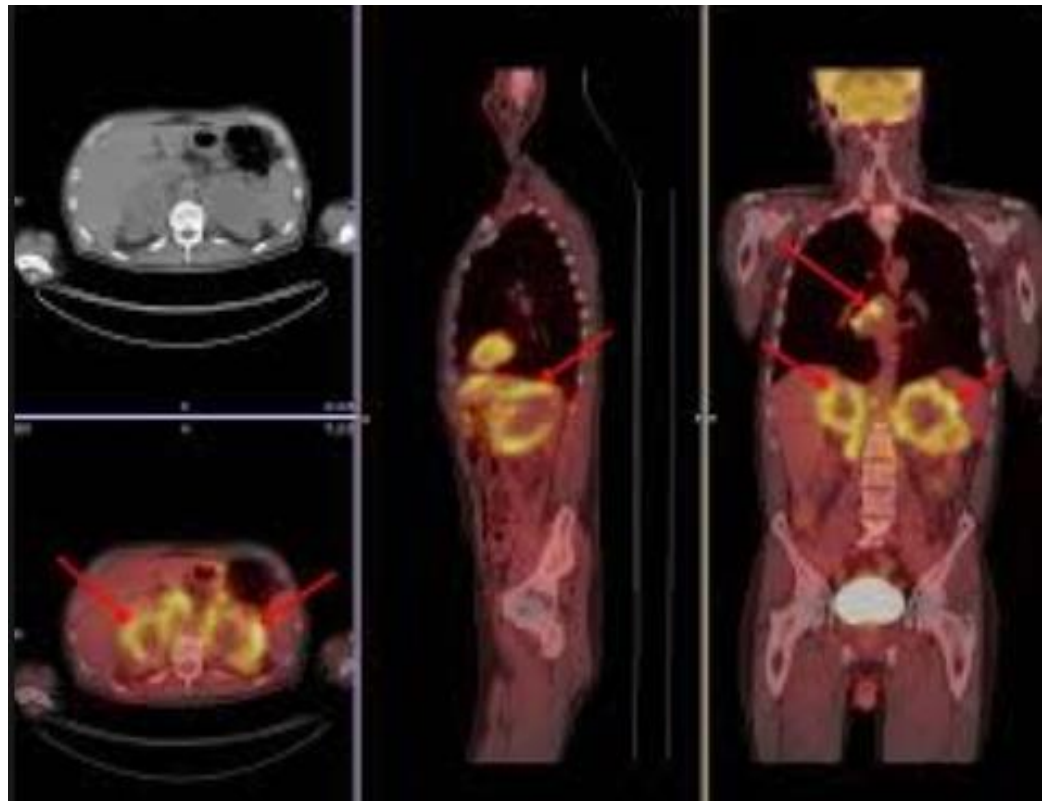


Risco operatório

- ☐ **Geral – Idade > 70**
- ☐ **ASA escore >3**
- ☐ **Insuficiência renal crônica**
- ☐ **Desnutrição**

Avaliar doença extra-hepática

- ☐ Metástase pulmonar (TC de tórax)
- ☐ Metástase óssea/cerebral (PET-CT)

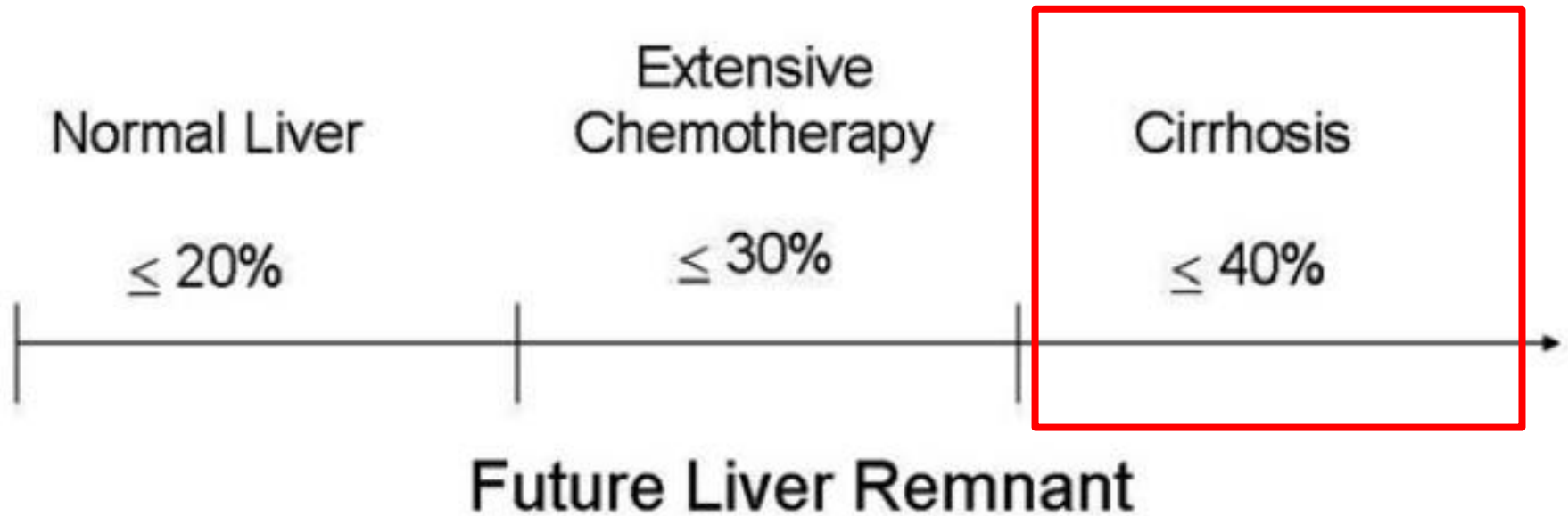


Remanescence hepática futuro > 40%



$$\text{sFLR} = \frac{\text{Measured FLR volume}}{\text{TLV} = -794 + 1267 \times \text{BSA}} = \% \text{ of TLV}$$

Embolização da veia porta



***Fígado cirrótico tem a capacidade de hipertrofia reduzida**

Outras opções

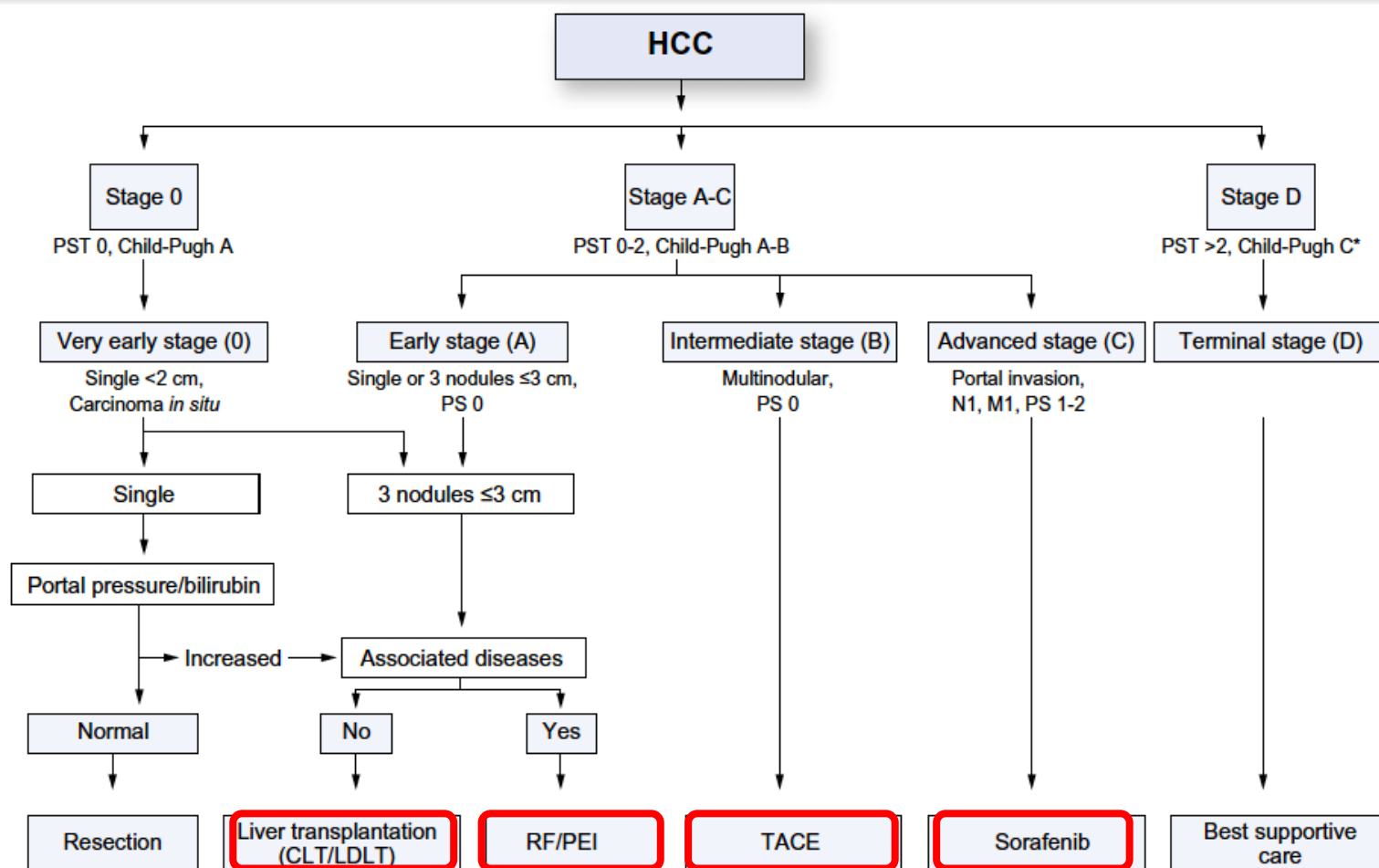
- ☐ **TACE-EVP sequencial**
- ☐ **Embolização da veia hepática**
- ☐ **Radioembolização em alta dose (Y90)**

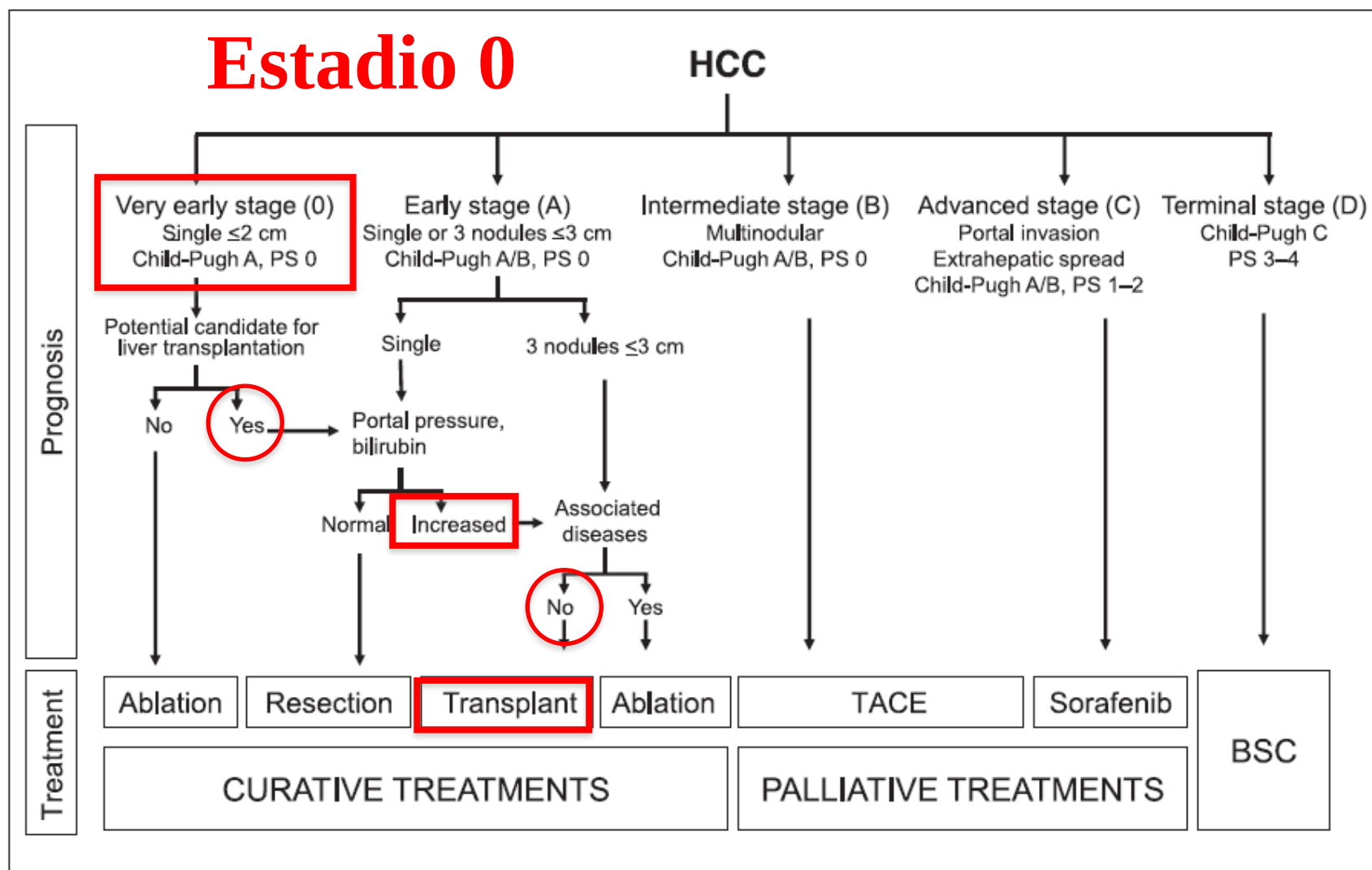
***Fígado cirrótico tem a capacidade de hipertrofia reduzida**

EASL–EORTC Clinical Practice Guidelines: Management of hepatocellular carcinoma

BCLC

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

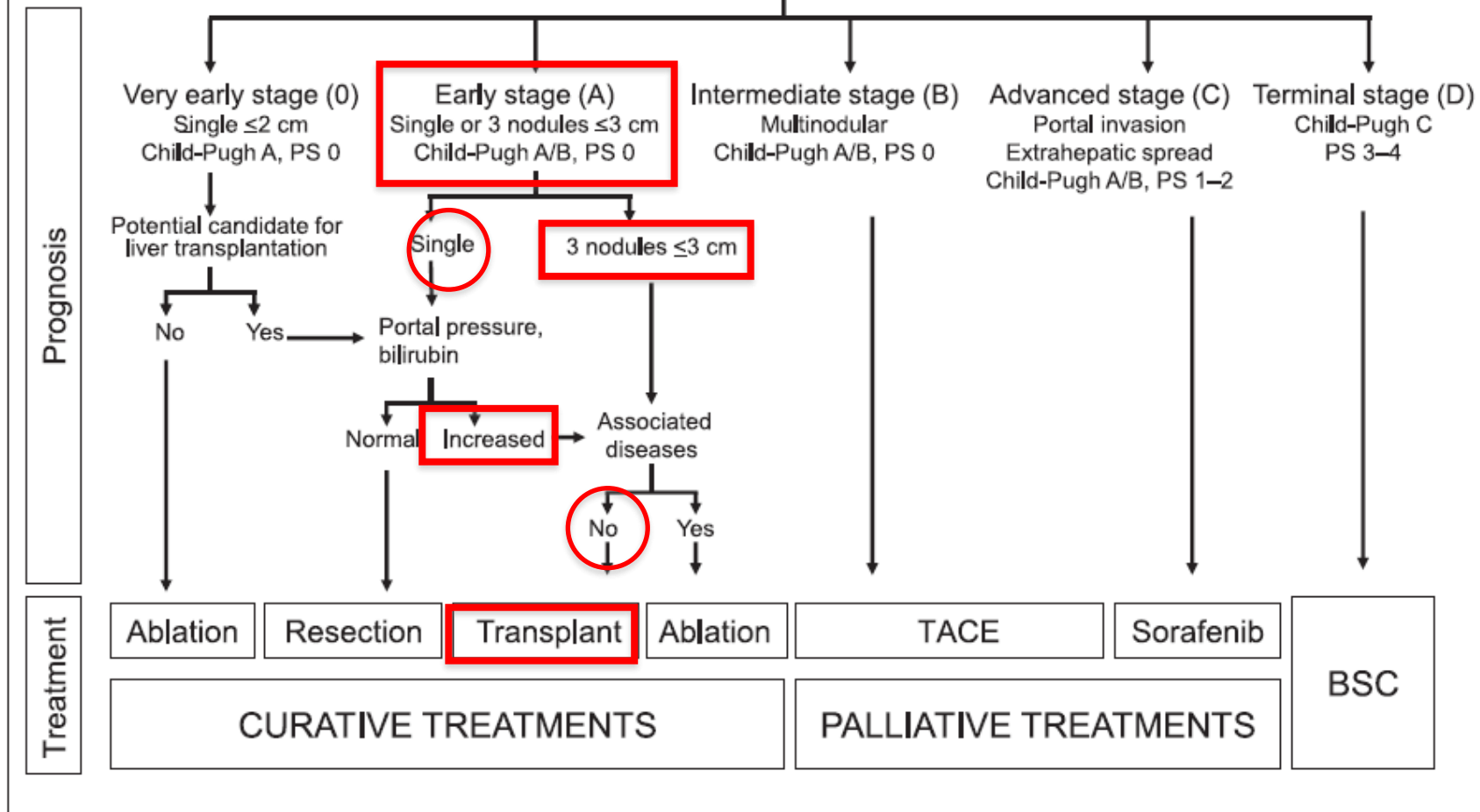




Transplante

Estadio A

HCC

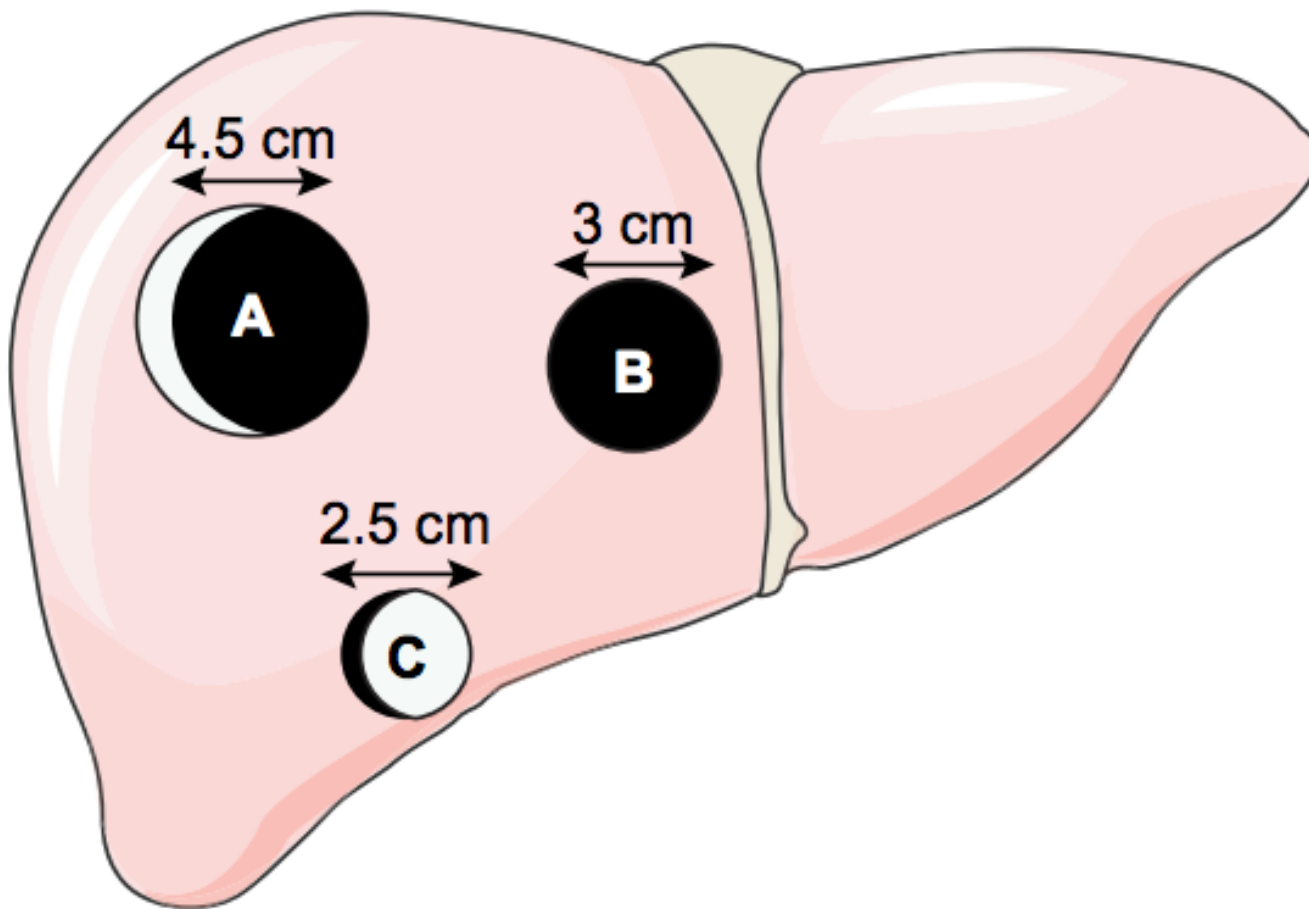


Transplante

Liver transplantation

Recommendations

- LT is recommended as the first-line option for HCC within Milan criteria but unsuitable for resection (**evidence high; recommendation strong**). Milan criteria are the benchmark for selection of patients with HCC for LT and the basis for comparison with other suggested criteria.

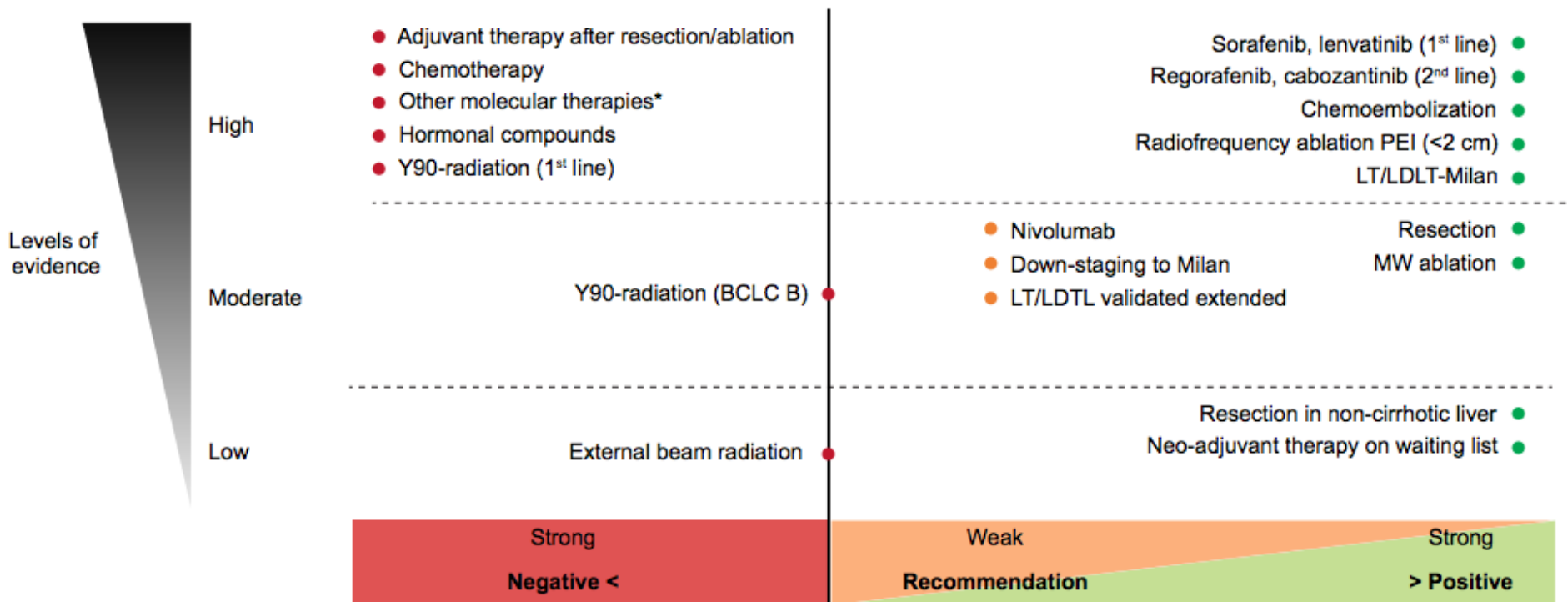


AFP serum level

150 ng/ml

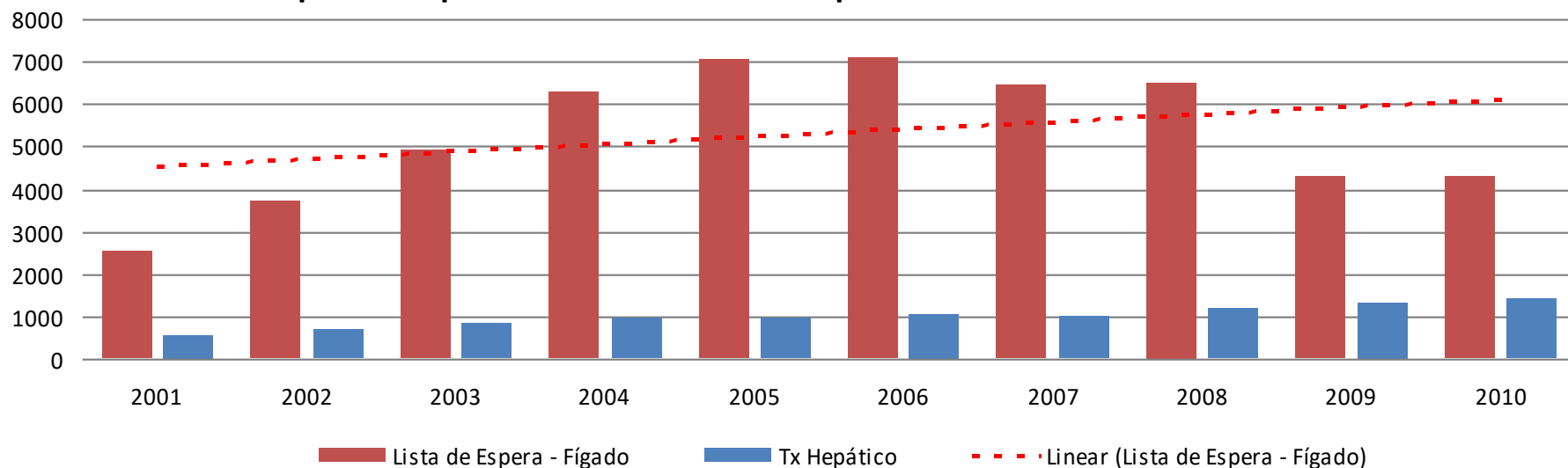


45 ng/ml



Necessidade de Transplante de Fígado - Brasil

Transplante Hepático no Brasil. Lista de Espera vs nº Tx realizados. 2001 a 2010.

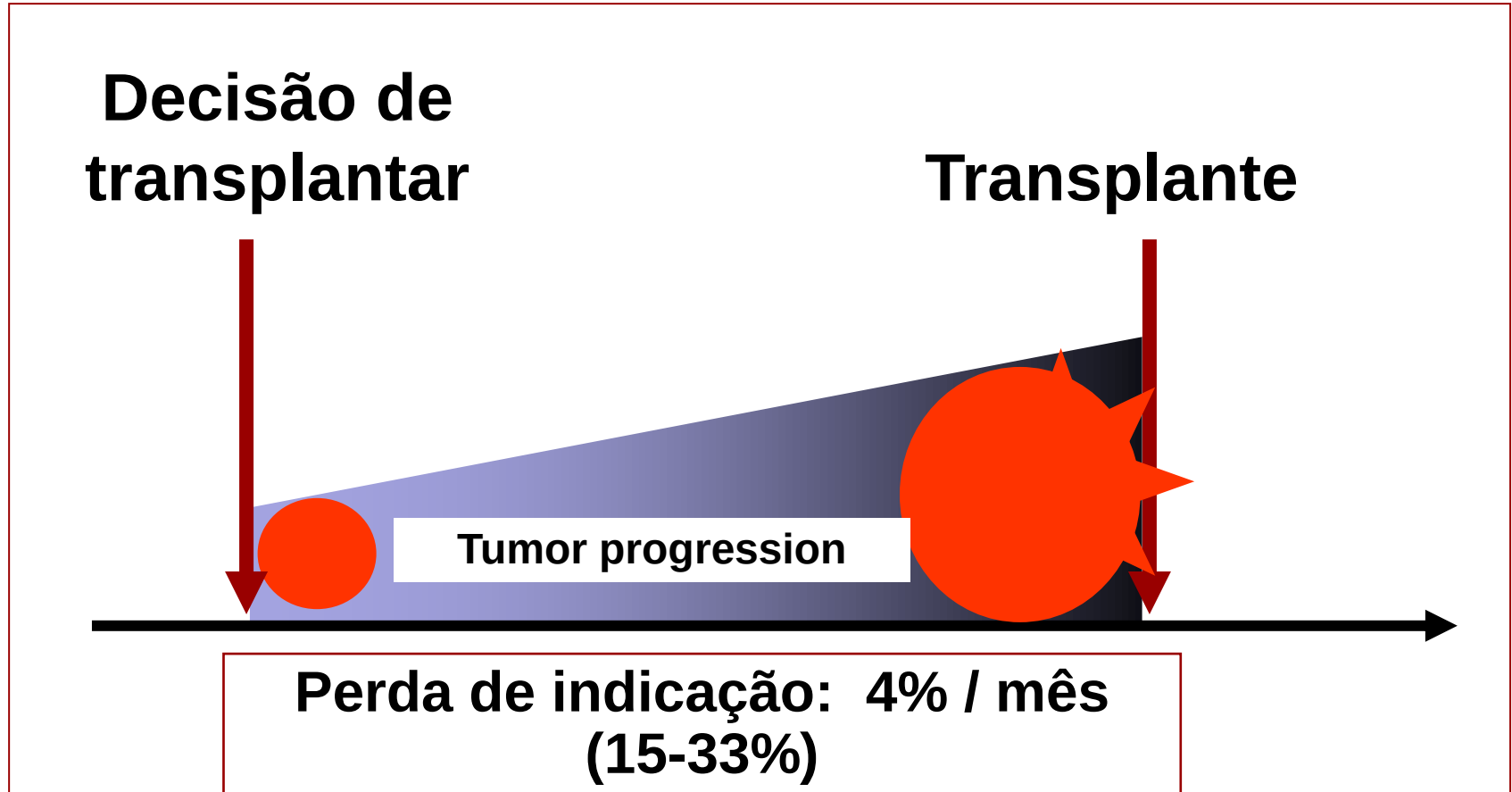


Tx Fígado - Brasil

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

FALTA DE ÓRGÃOS!!!

Transplante para CHC



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

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

14

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Table 1
Tumor characteristics in recent large published series

Author	Year	Pts	Diameter (cm) Median	28-75%	24-39%	3-14%
				>5 cm	Multiple HCC	Major vascular invasion
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%)

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.

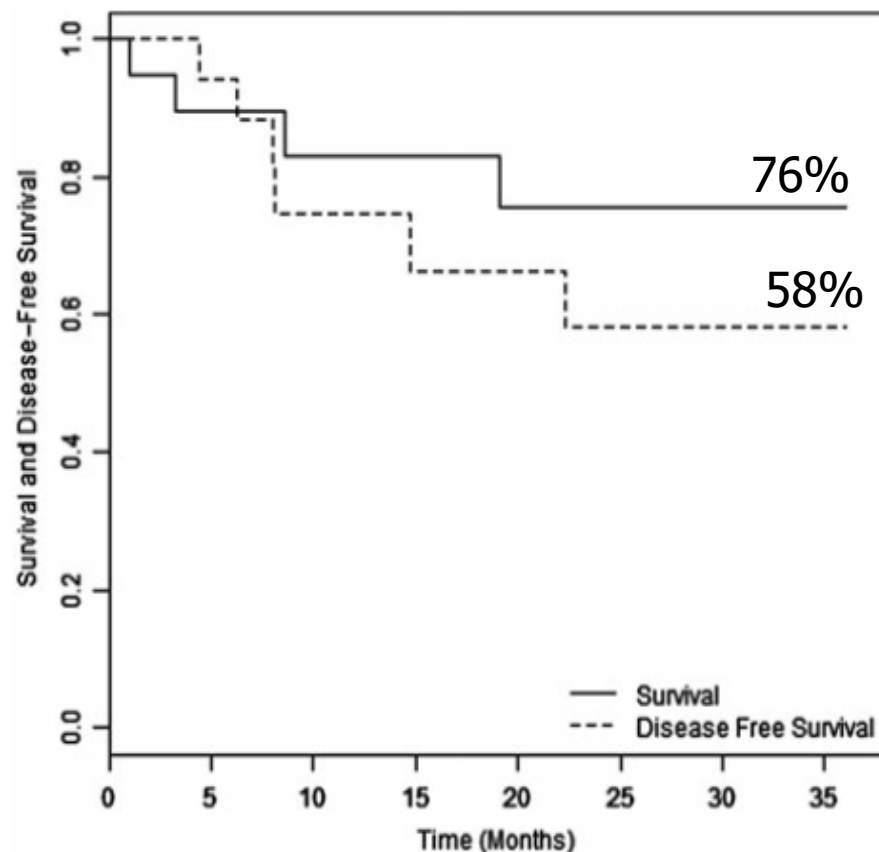
In conclusion, guidelines for HCC treatment should consider good results of liver resection for advanced HCC, and indications for hepatectomy should be expanded in order not to exclude from radical therapy patients that could benefit from it.

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Laparoscopic Resection of Hepatocellular Carcinoma: When, Why, and How? A Single-Center Experience

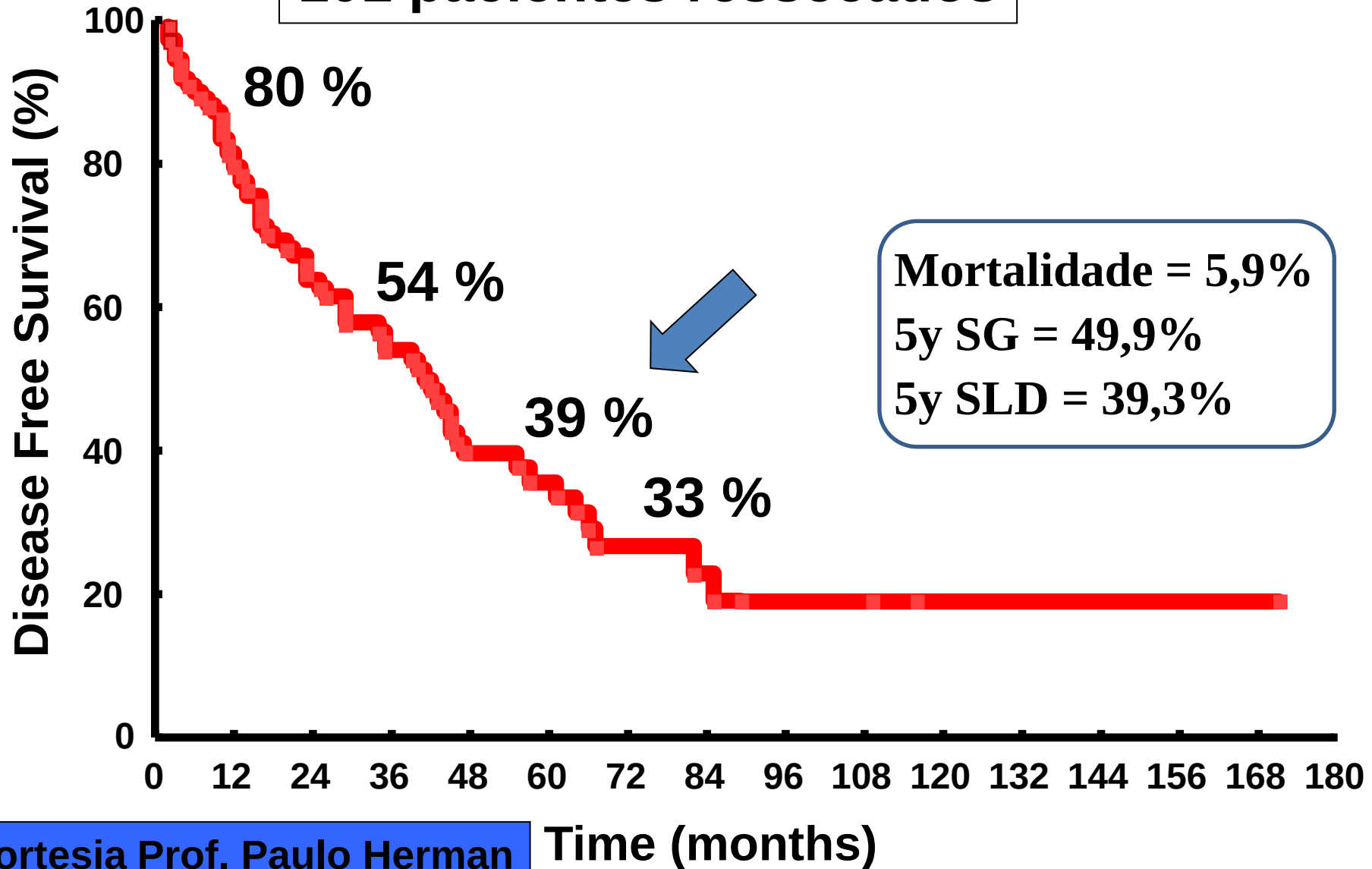
Paulo Herman, MD, Marcos Vinicius Perini, MD, Fabricio Ferreira Coelho, MD,
Jaime Arthur Pirolla Kruger, MD, Renato Micelli Lupinacci, MD, Gilton Marques Fonseca, MD,
Felipe de Lucena Moreira Lopes, MD, and Ivan Cecconello, MD

- CHC: n=30 (35,2%) – 2007/2013
- 21 homens, média idade= 54,7 a
- Procedimentos:
 - 10 não-anatômicas
 - 14 bissegmentectomia 2/3
 - 4 bissegmentectomia 6/7
 - 1 hepatectomia D
 - 1 hepatectomia E
- Margens livres = 100%
- Conversão= 13,3%
- Mortalidade= 3,3%



Sobrevida

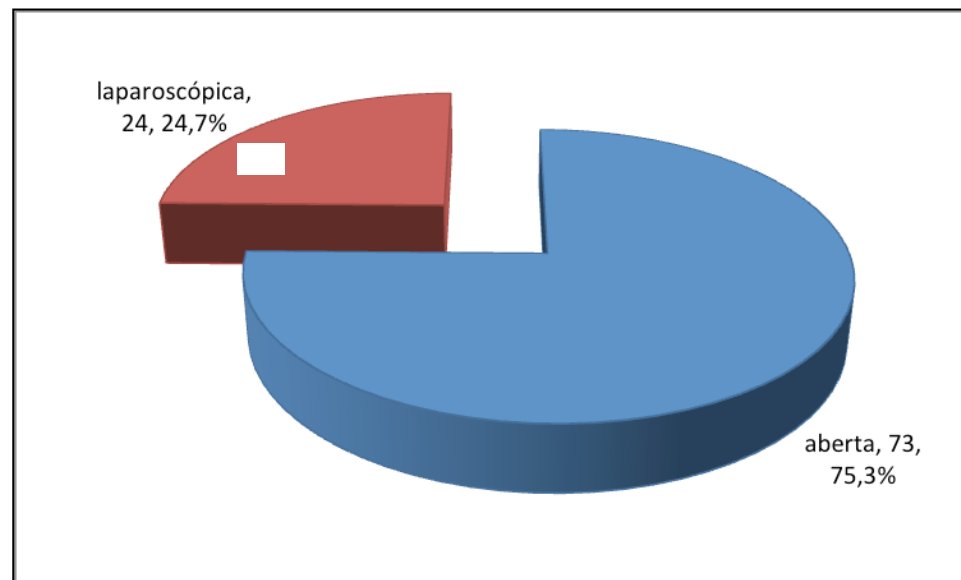
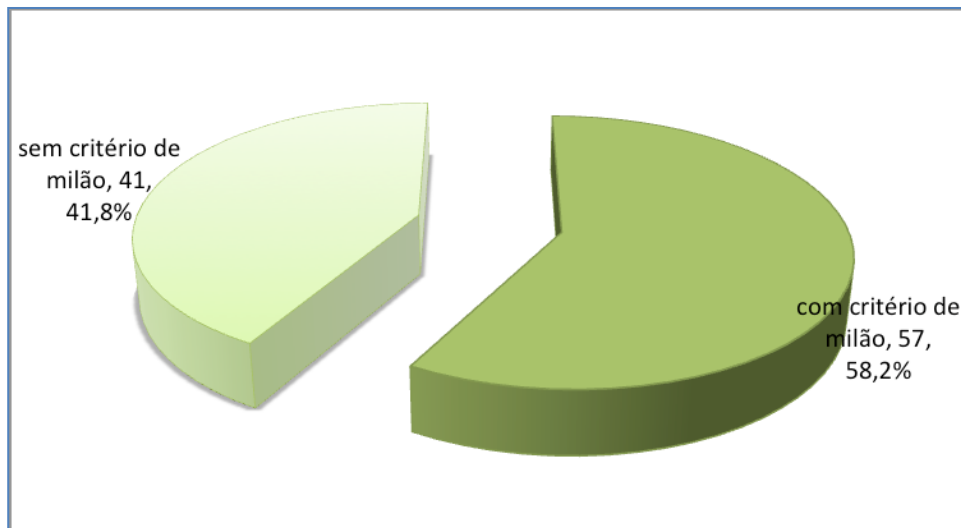
101 pacientes ressecados



Cortesia Prof. Paulo Herman
Cirurgia do Fígado - USP

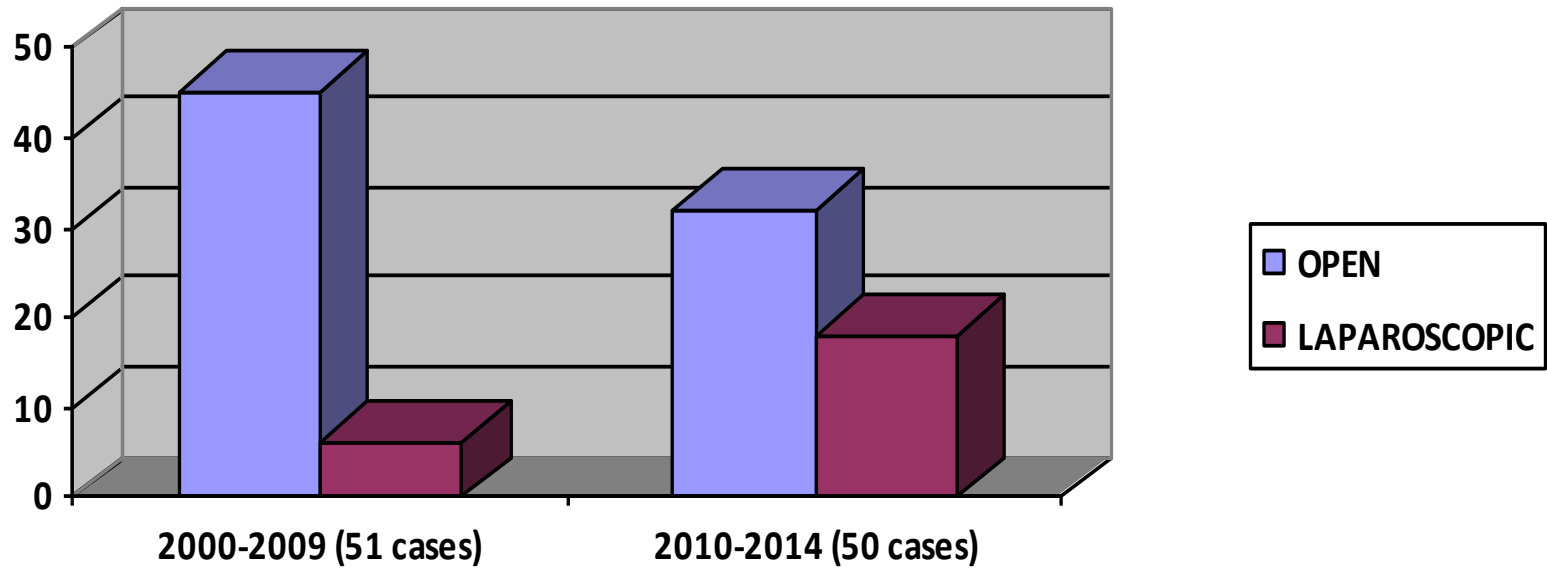
HCFMUSP

101 pacientes ressecados



HC FMUSP

101 pacientes ressecados

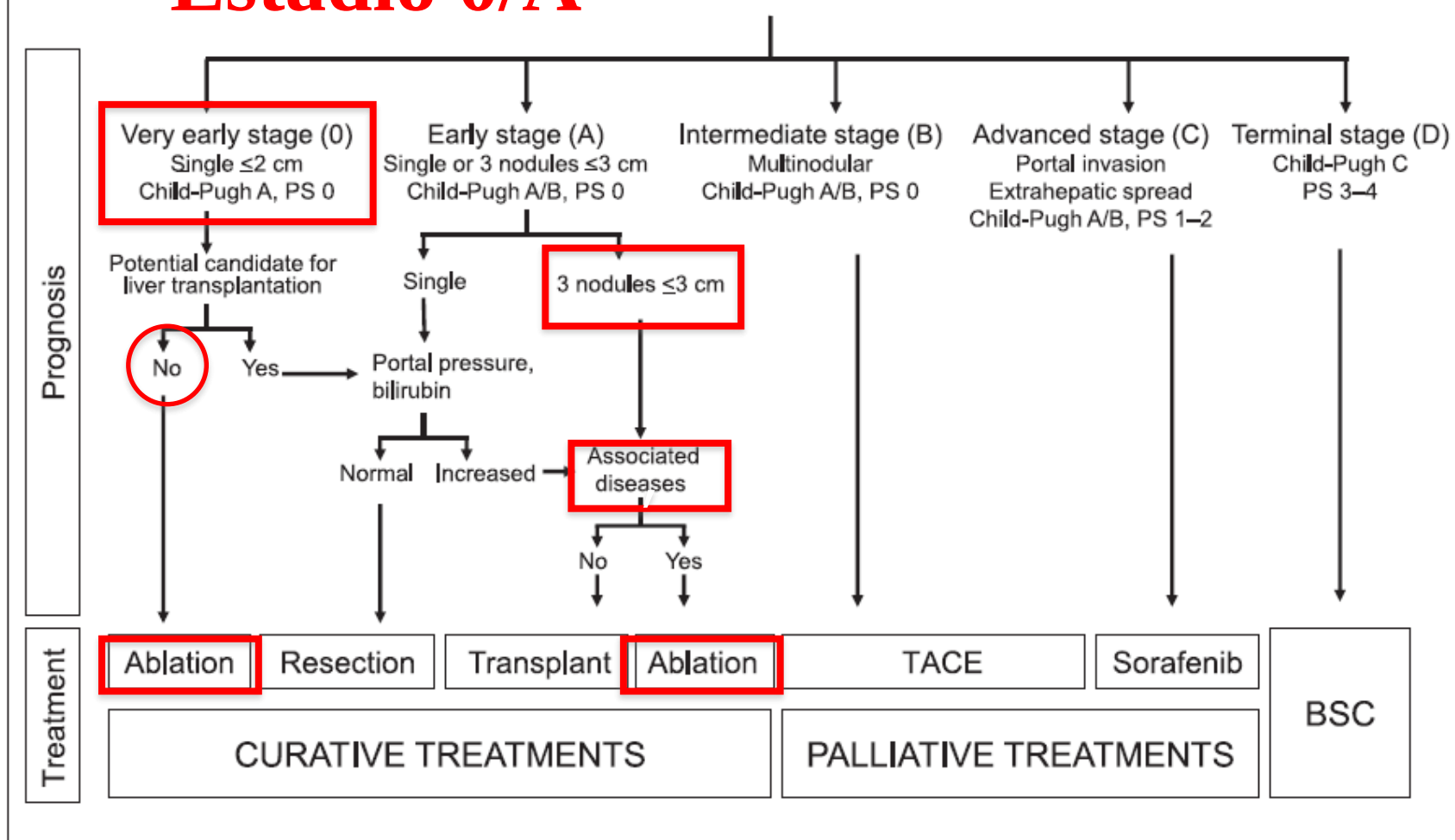


Ressecção CHC - Laparoscopia
68% - 2014/2015

Cortesia Prof. Paulo Herman
Cirurgia do Fígado - USP

Estadio 0/A

HCC



Ablação

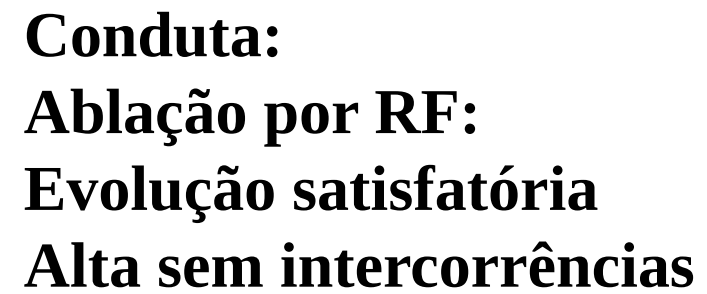
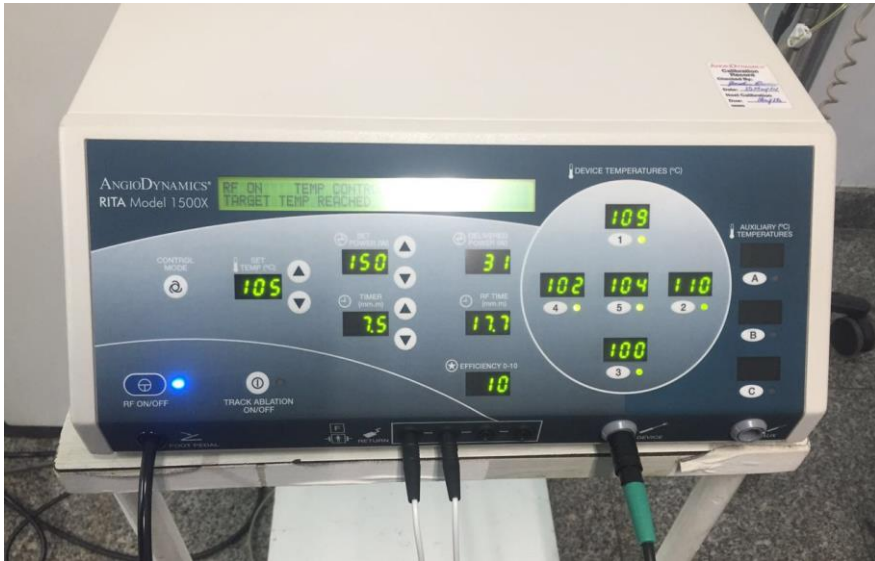
Local ablation and external radiation

Recommendations

- Thermal ablation with radiofrequency is the standard of care for patients with BCLC 0 and A tumours not suitable for surgery (**evidence high; recommendation strong**). Thermal ablation in single tumours 2 to 3 cm in size is an alternative to surgical resection based on technical factors (location of the tumour), hepatic and extrahepatic patient conditions.



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

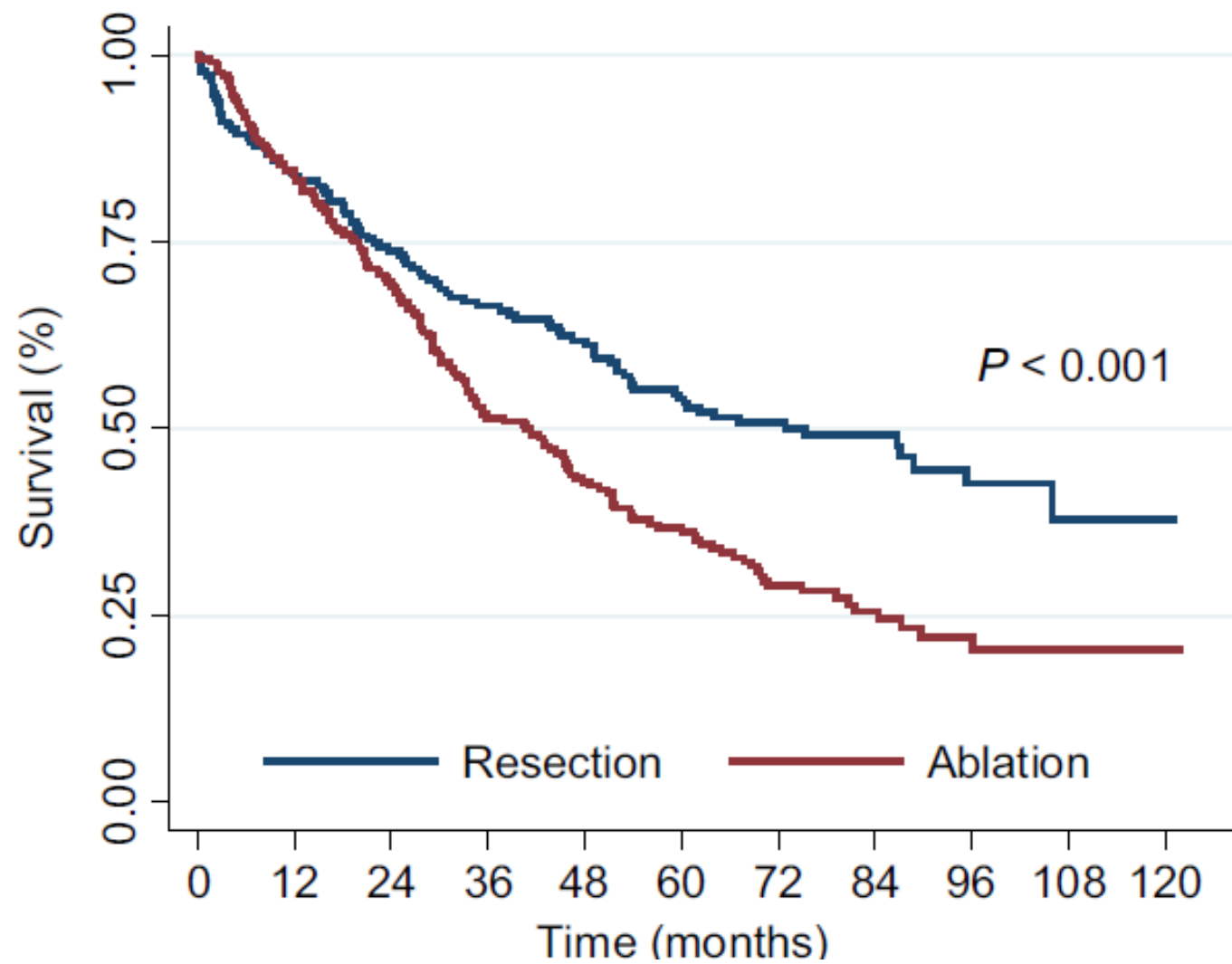


ORIGINAL ARTICLE

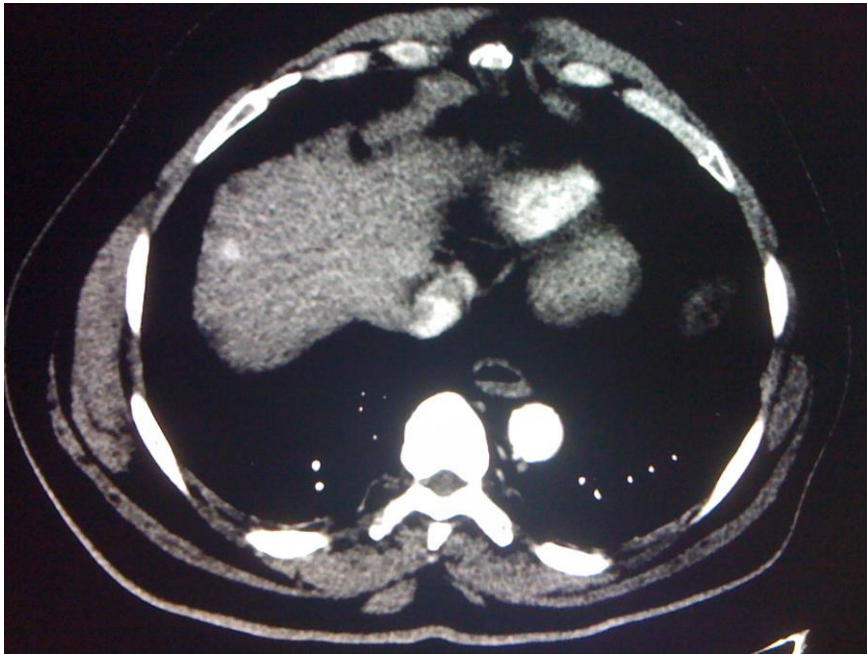
Surgical resection versus ablation for hepatocellular carcinoma ≤ 3 cm: a population-based analysis

John T. Miura¹, Fabian M. Johnston¹, Susan Tsai¹, Dan Eastwood², Anjishnu Banerjee², Kathleen K. Christians¹, Kiran K. Turaga¹ & T. Clark Gamblin¹

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

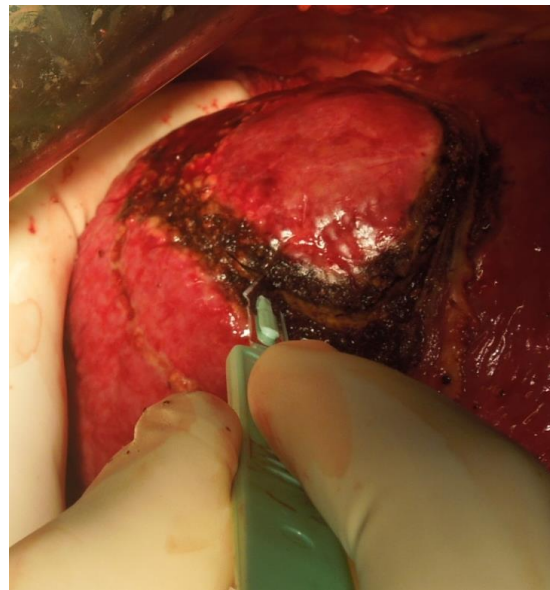
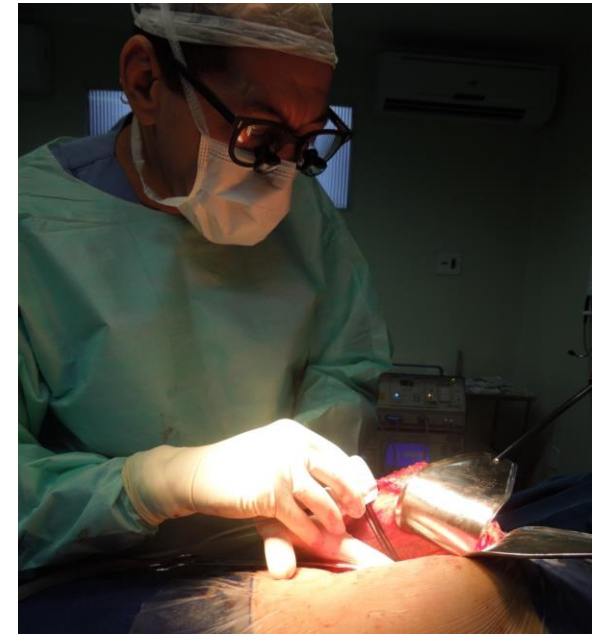
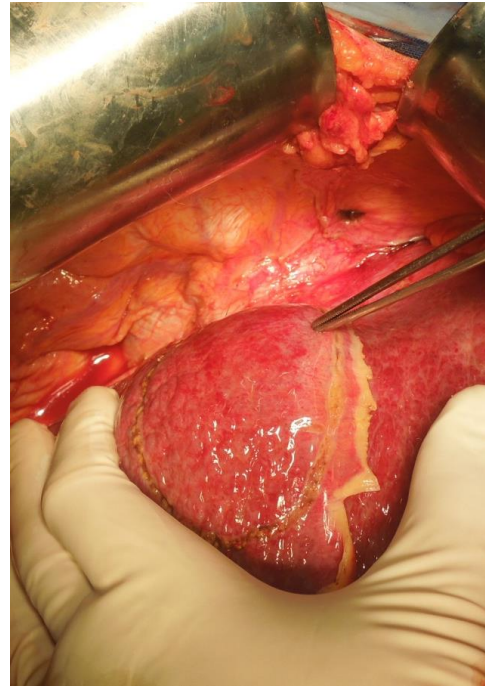
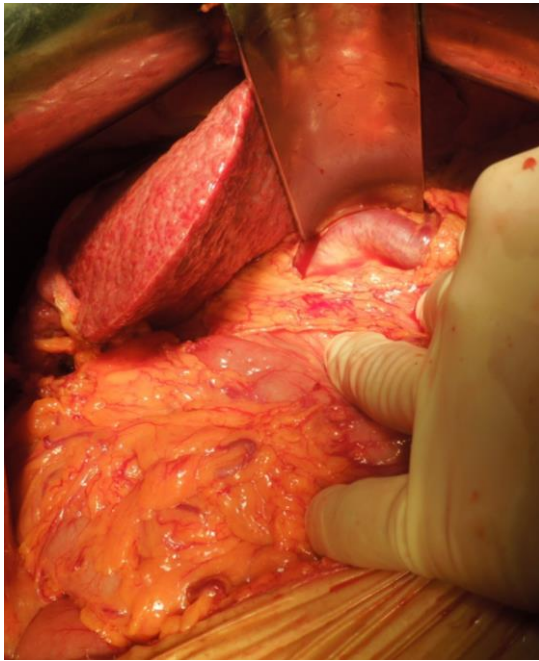


In conclusion, the present study provides further evidence supporting HR over ablation for patients with small, unifocal, HCC tumours. Numerous factors, both patient and tumour specific, continue to have a major influence on treatment allocation. Therefore, it would be short-sighted to suggest that ablation 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.



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

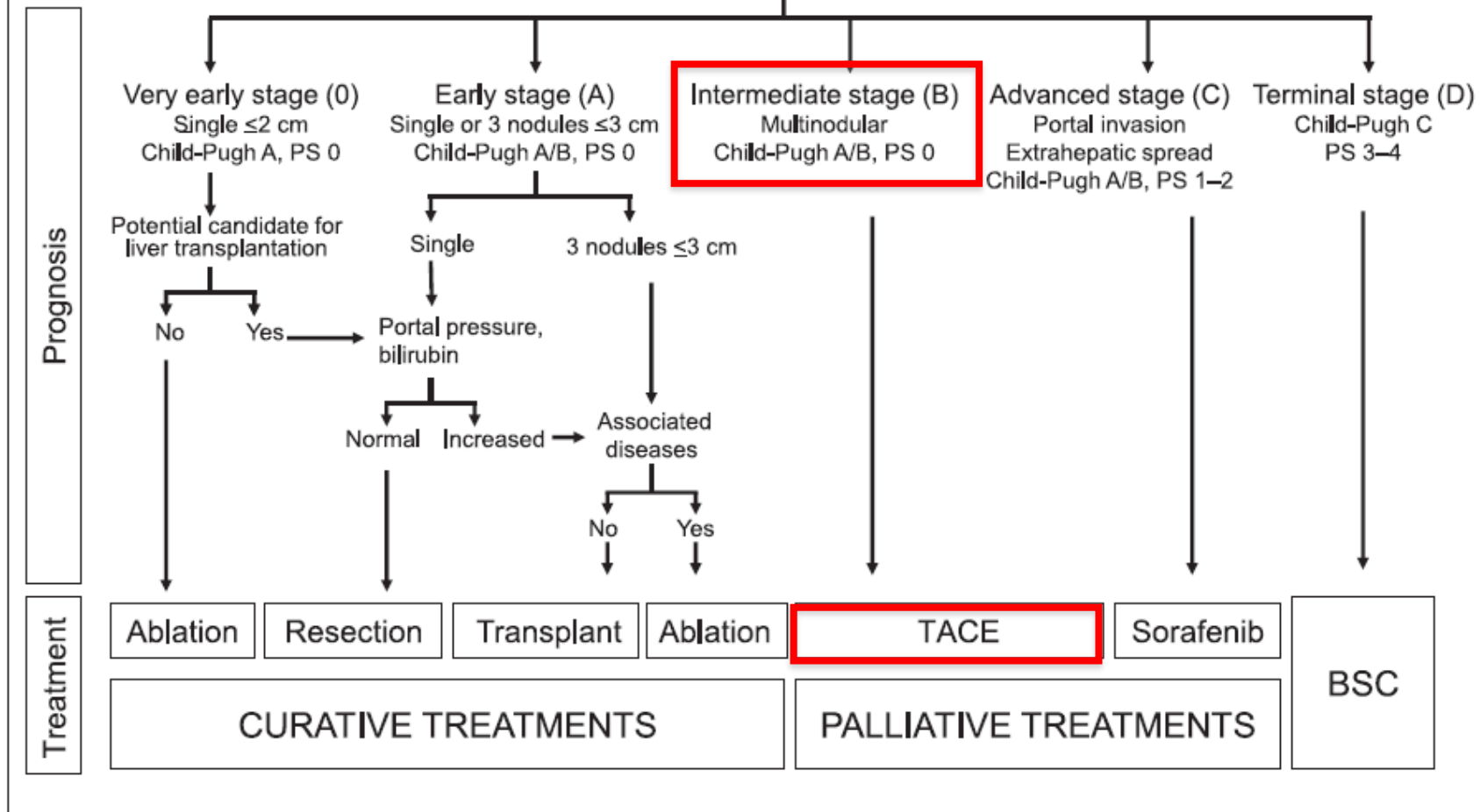




Hepatectomia com Habib
Evolução favorável
Alta sem intercorrências

Estadio B

HCC



TACE

Transarterial therapies

Recommendations

- TACE is recommended for patients with BCLC stage B and should be carried out in a selective manner (**evidence high; recommendation strong**). The use of drug-eluting beads has shown similar benefit to conventional TACE (cTACE; gelfoam-Lipiodol[®] particles) and either of the two can be utilised (**evidence high; recommendation strong**). TACE should not be used in patients with decompensated liver disease, advanced liver and/or kidney dysfunction, macroscopic vascular invasion or extrahepatic spread (**evidence high; recommendation strong**). There is insufficient evidence to recommend bland embolisation, selective intra-arterial chemotherapy and lipiodolisation (**evidence moderate**).

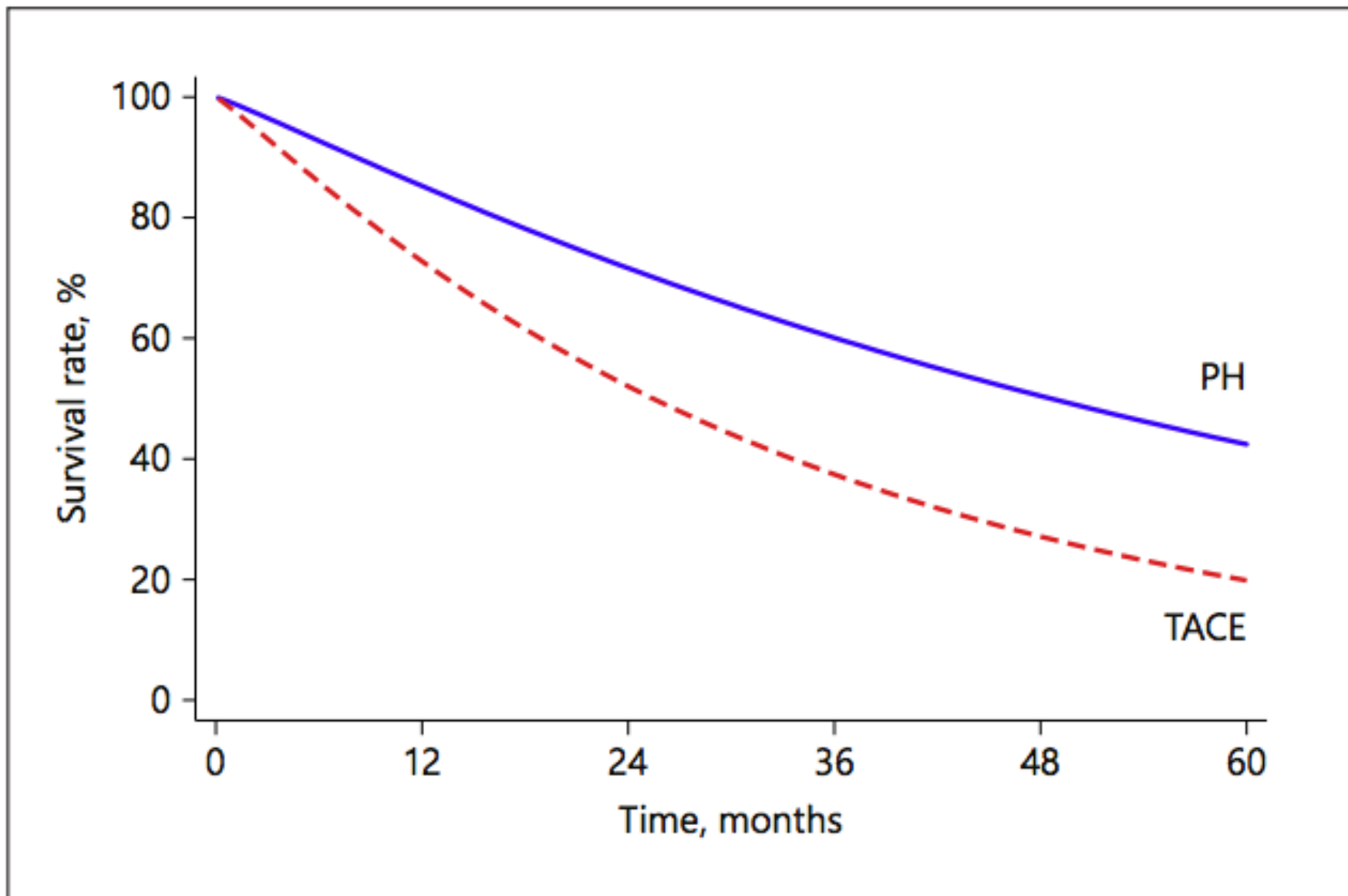
Meta-Analysis

Comparison of Partial Hepatectomy and Transarterial Chemoembolization in Intermediate-Stage Hepatocellular Carcinoma: A Systematic Review and Meta-Analysis

Ismail Labgaa^a Patrick Taffé^b David Martin^a Daniel Clerc^a
Myron Schwartz^c Norihiro Kokudo^d Alban Denys^e Nermin Halkic^a
Nicolas Demartines^a Emmanuel Melloul^a

TACE vs Ressecção

- ☐ **1.730 pacientes**
 - Hepatectomia 750**
 - TACE 980**
- ☐ **BCLC B**
- ☐ **Metanálise**
- ☐ **Sobrevida global**
- ☐ **Mortalidade em 90 dias pós-procedimento**

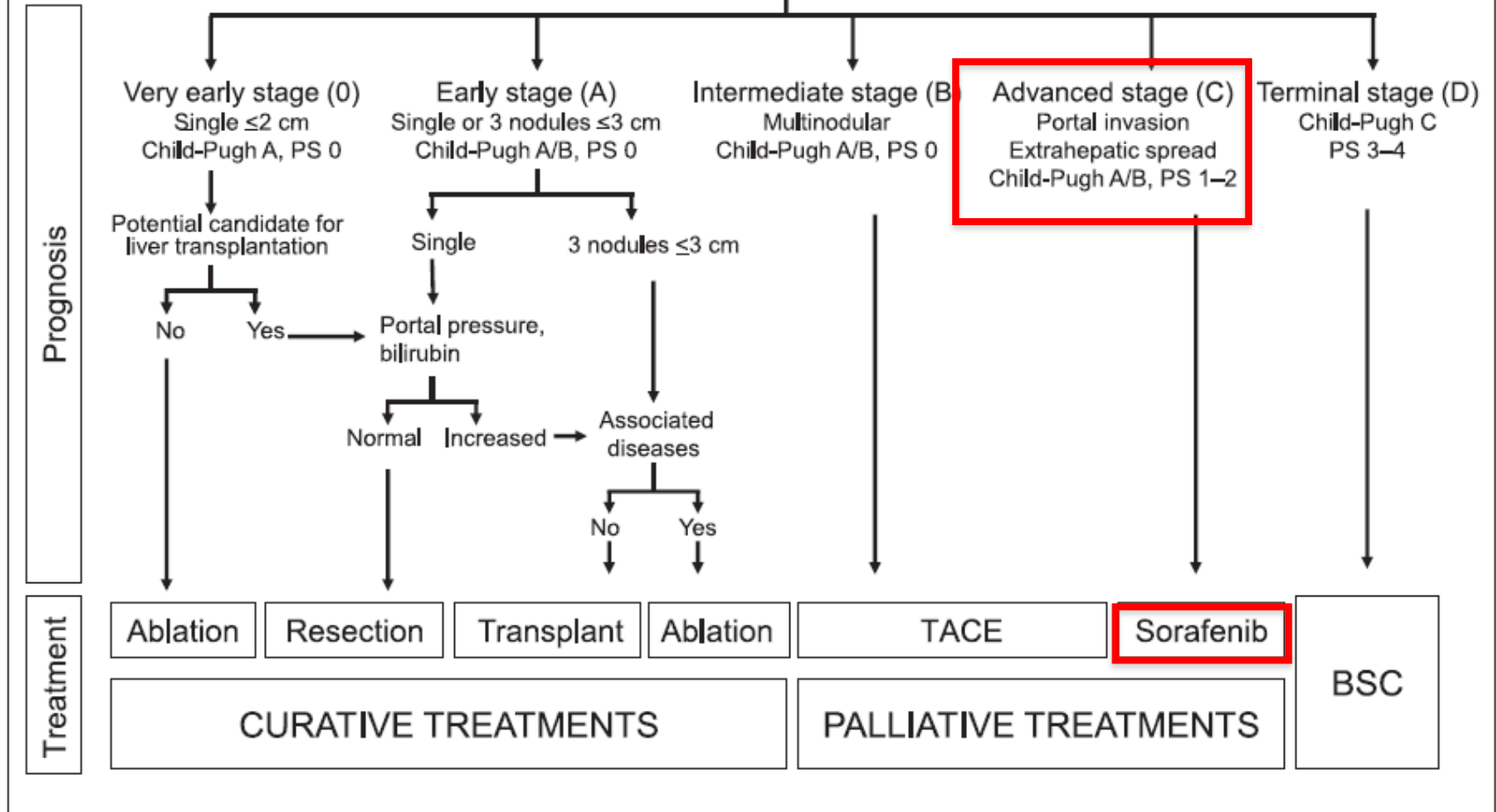


TACE

Conclusions: In patients with intermediate HCC, PH was associated with increased long-term survival compared to TACE, with comparable postprocedural mortality. These results suggest considering PH as treatment option in intermediate HCC and highlight the urgent need to refine the selection of patients with BCLC-B stage who may benefit from PH.

Estadio C

HCC



Sorafenib

Systemic therapies

Recommendations

- Sorafenib is the standard first-line systemic therapy for HCC. It is indicated for patients with well-preserved liver function (Child-Pugh A) and with advanced tumours (BCLC-C) or earlier stage tumours progressing upon or unsuitable for loco-regional therapies (**evidence high; recommendation strong**).

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 Morengi, §§ and Masatoshi Makuuchi, MD, PhD¶¶*

TABLE 2. Pattern of Presentation According to the BCLC Classification

BCLC Class	n (%)
<i>BCLC 0-A</i> [n = 931]*	
Single ≤ 2 cm	204 (22)
Single ≤ 5 cm	604 (65)
Up to 3 tumors, none > 3 cm	123 (13)
<i>BCLC B</i> [n = 666]	
Single > 5 cm	456 (68.5)
Multiple	210 (31.5)
<i>BCLC C</i> [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.

TABLE 3. Surgical Procedures Stratified According to the BCLC Classification

	BCLC 0-A	BCLC B	BCLC C	<i>P</i> *
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.

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

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

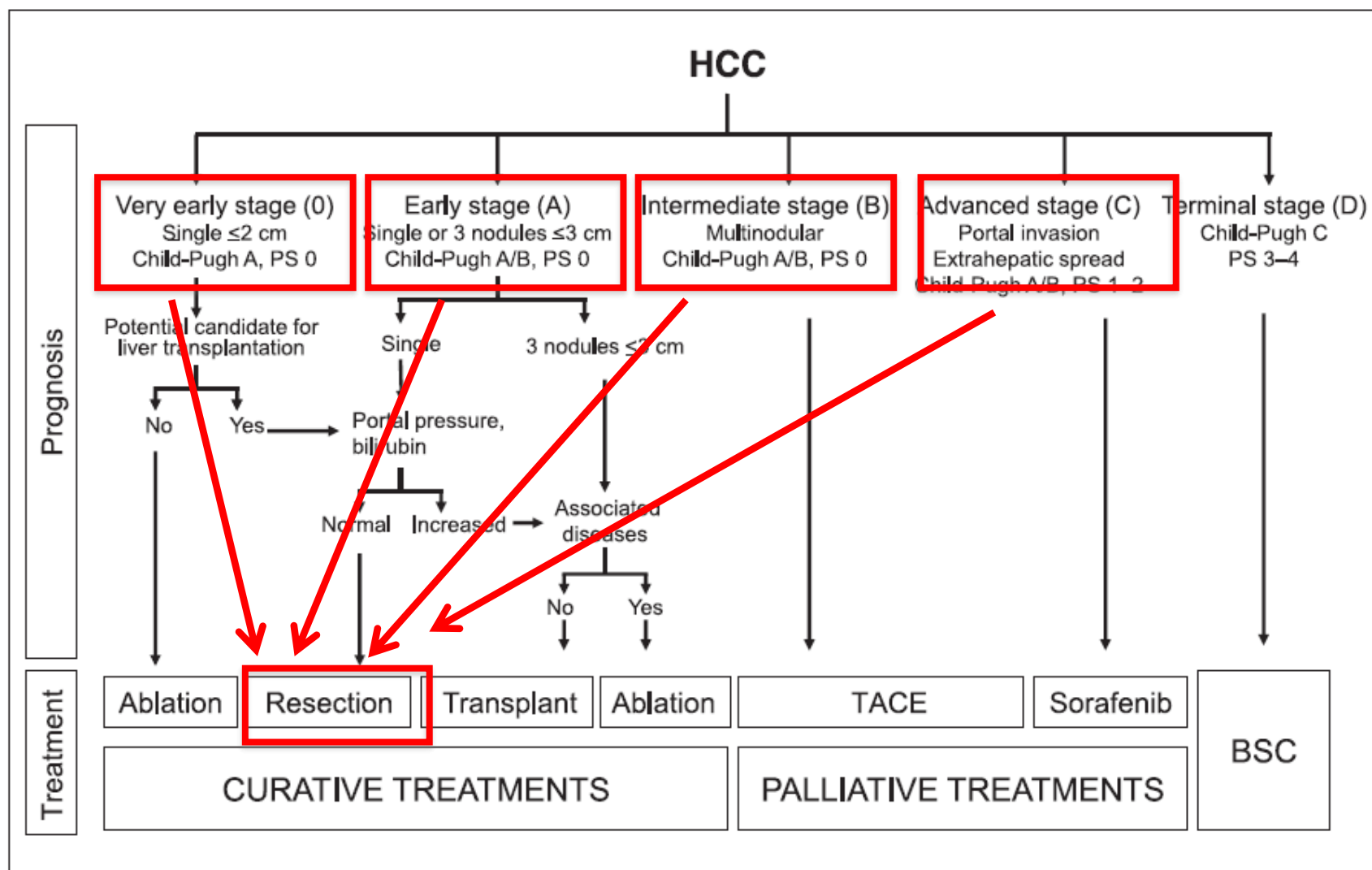
Author	Year	BCLC Class	No. Patients	3-yr OS, %	5-yr OS, %	3-yr DFS, %	5-yr DFS, %	Operative Mortality, %
Minagawa et al ¹⁴	2001	C	18	42	42	—	—	5
Ng et al ¹⁵	2005	B	380	50	39	38	26	2.4
Chirica et al ¹⁷	2008	B-C	20	56	45	20	17	5
Ishizawa et al ¹⁹	2008	C	98	71	56	37	25	0.2
Wang et al ¹²	2008	B	243	64	50	—	—	—
		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%

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.





Obrigado!

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