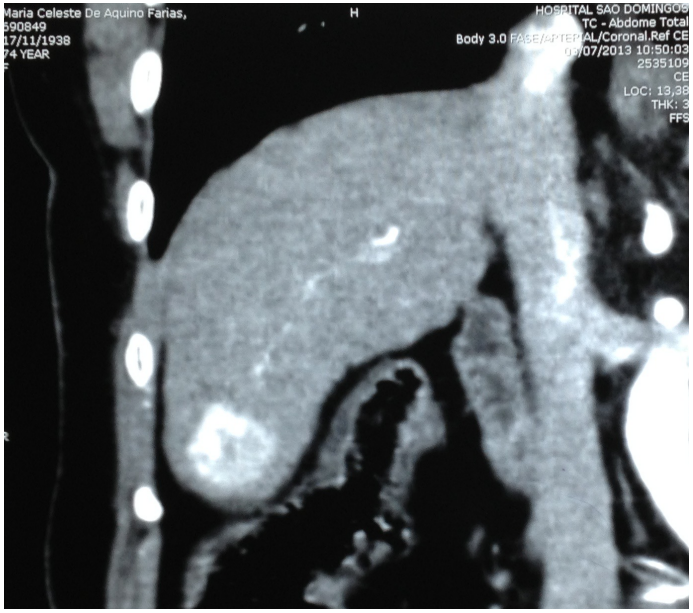
Cirurgia no Carcinoma hepatocelular
Qual a situação ideal?



Orlando Jorge M. Torres
Professor Titular e chefe do
Serviço de Cirurgia do Aparelho Digestivo
Unidade Hepatopancreatobiliar
Universidade Federal do Maranhão - Brasil

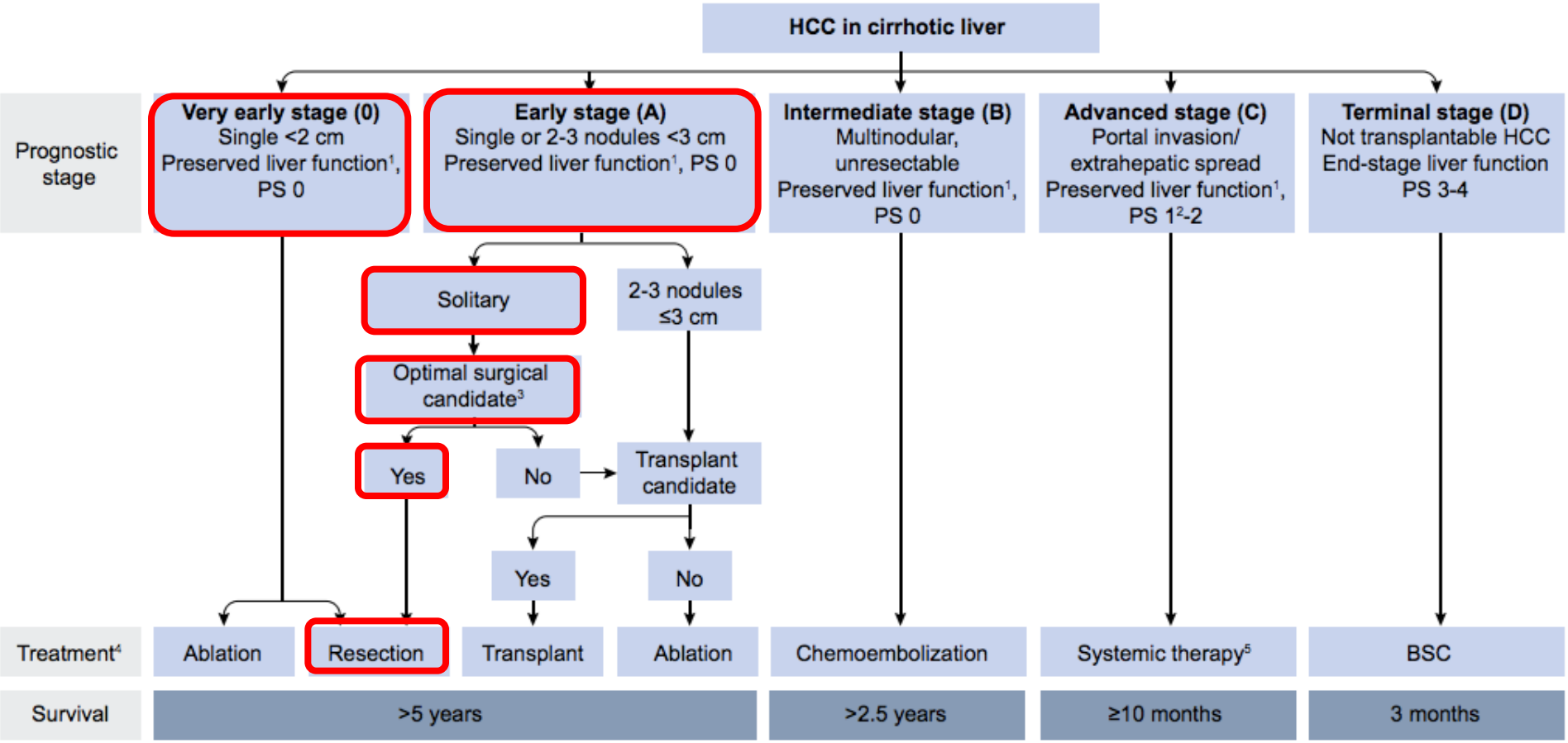
II Simpósio de Radiologia Intervencionista em Oncologia

Hotel Prodigy Santos Dumont - RJ
20 de Agosto 2022

II SRio
Simpósio de Radiologia Intervencionista em Oncologia

JOURNAL OF HEPATOLOGY

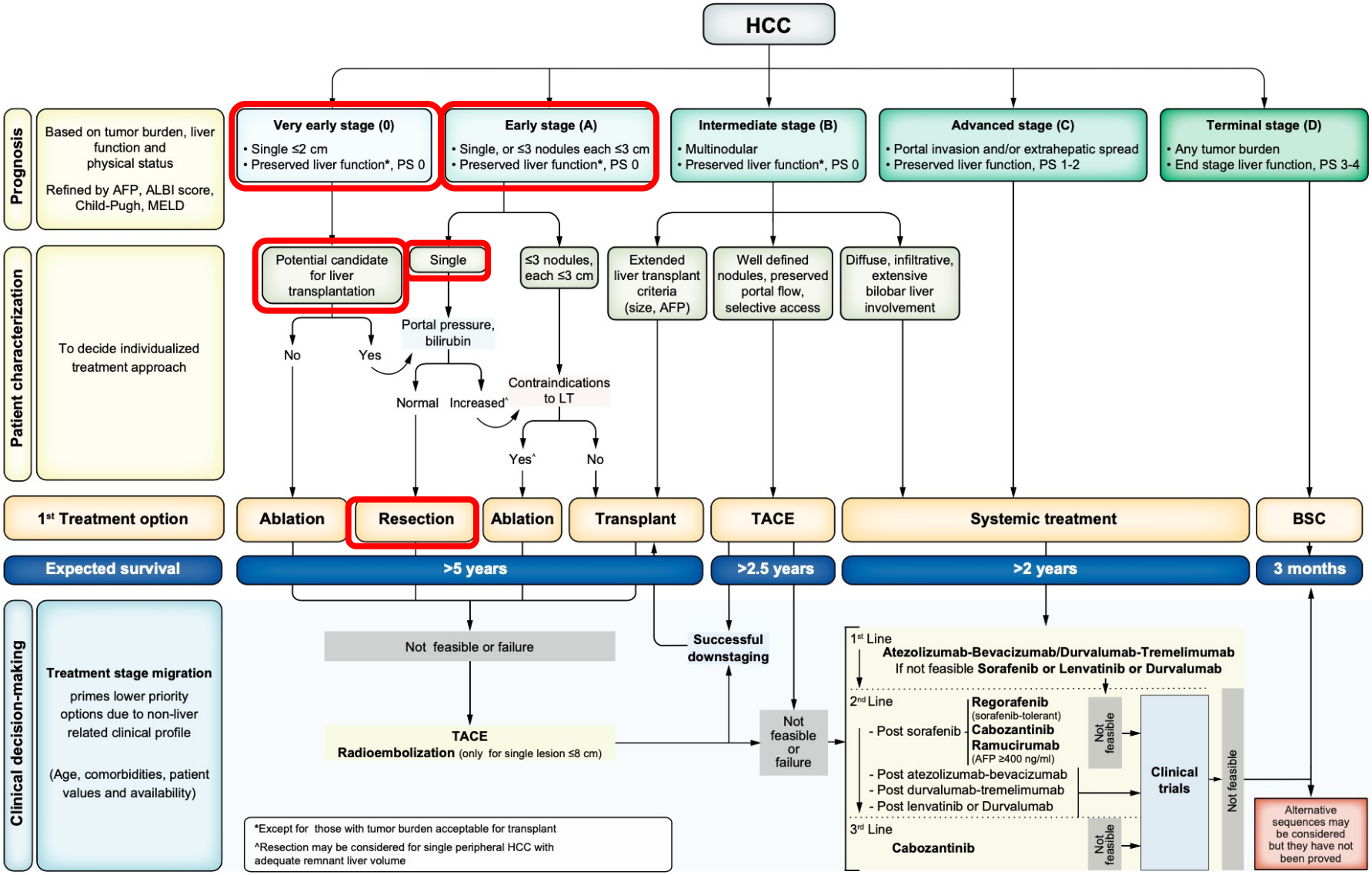
EASL Clinical Practice Guidelines: Management of hepatocellular carcinoma☆



Galle PR, et al. J Hepatol 2018;69:182-236

JOURNAL OF HEPATOLOGY

BCLC strategy for prognosis prediction and treatment recommendation: The 2022 update ☆



Reig M, et al. J Hepatol 2022;76:681-93

Evolução da cirurgia do fígado

- Manuseio peri-operatório
- Seleção de pacientes
- Refinamento da técnica
- Modulação do volume hepático
- Cirurgia minimamente invasive
  - Laparoscópica
  - Robótica
- Associação com outros procedimentos
- Redução da mortalidade (3-5%)

Fígado não cirrótico

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

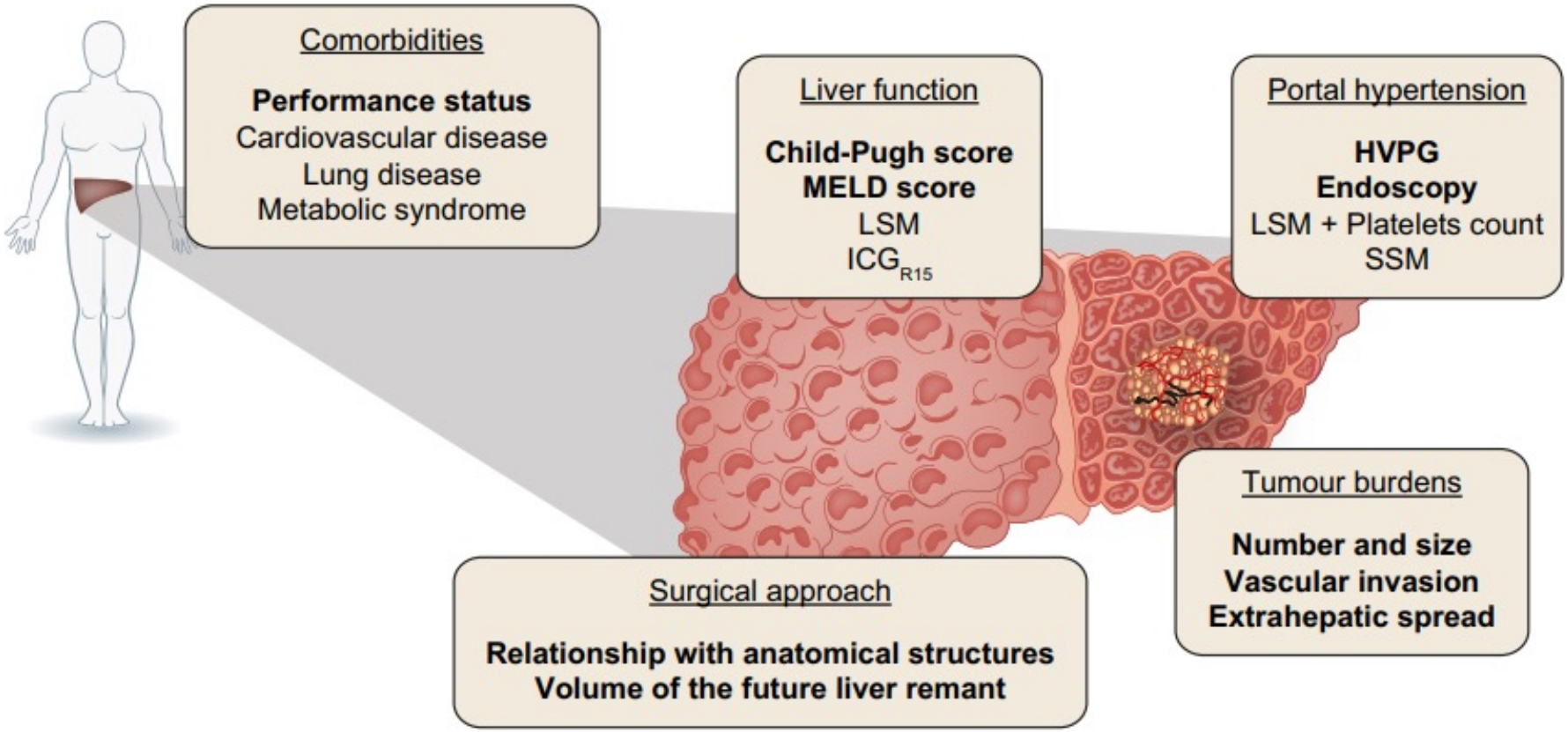
Galle PR, et al. J Hepatol 2018;69:182-236

RESSECÇÃO

	EASL guidelines	AASLD guidelines	APASL guidelines
Tumor burdens	No extrahepatic spread No macrovascular invasion Solitary nodule Regardless tumor size	No extrahepatic spread Solitary tumor <5 cm with/without vascular invasion Mulifocal tumor, none >5 cm	No extrahepatic spread Resectable tumor regardless vascular invasion, number and tumor size
Liver function	Child-Pugh A MELD <10	Child-Pugh A	Child-Pugh A and B
Volume of the future liver remnant	**Expected volume of the future liver remant** : >25-30% in the absence of severe fibrosis >40% in case of cirrhosis **If the future liver remnant is too small**, performing portal vein embolization + TACE should be performed		
Portal hypertension	CSPH is not an absolute contraindication for LR but must be evaluated with consistent technics and balanced with the extension of the LR and the liver function		
Performance status Comorbidities	Older age is not a contra-indication Adequate performance status and absence of major comorbidities		

Allaire M, et al. JHEP Reports 2020

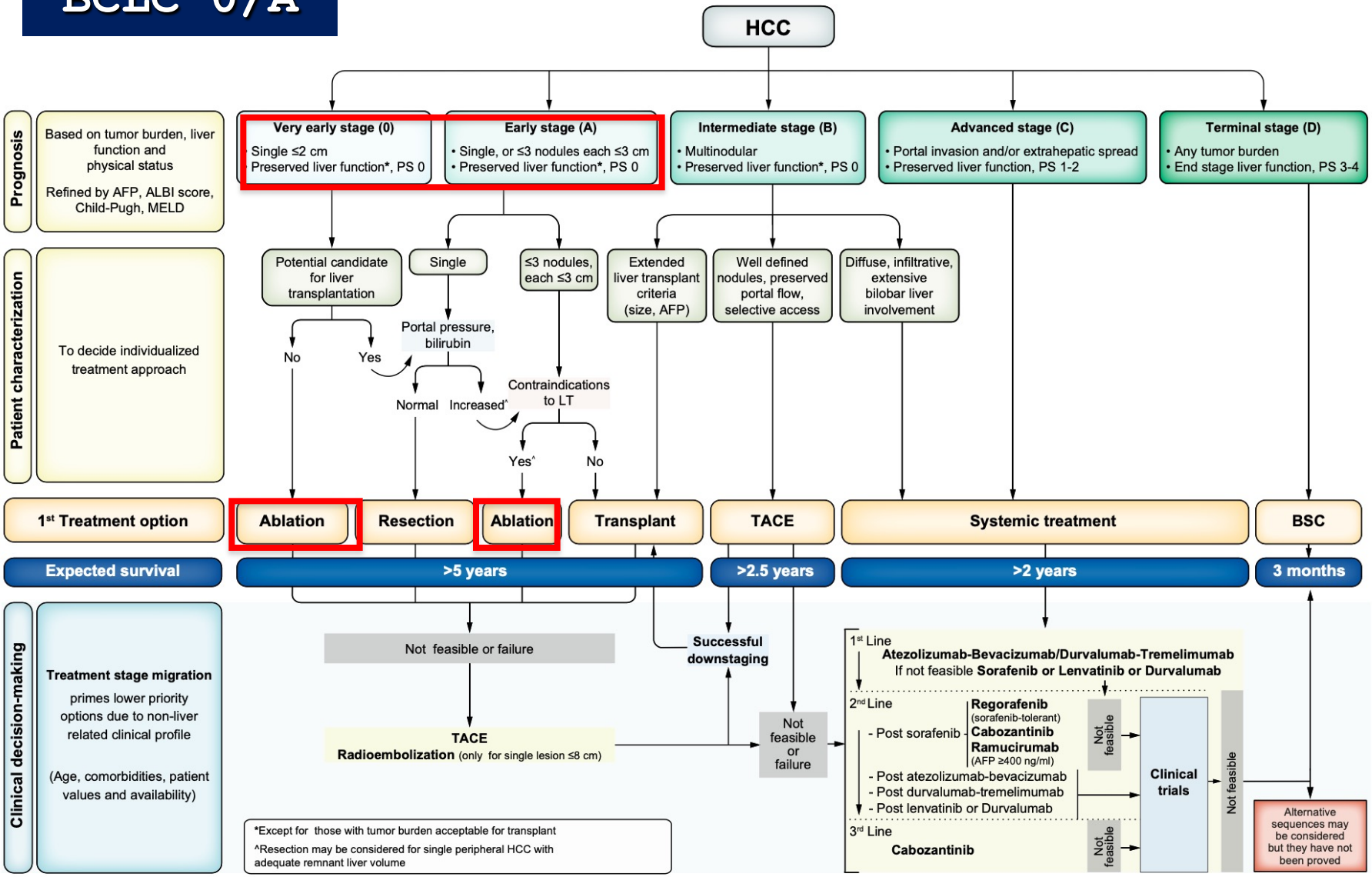
RESSECÇÃO



Allaire M, et al. JHEP Reports 2020

Ablação por radiofrequência

BCLC 0/A



Reig M, et al. J Hepatol 2022;76:681-93

Ablação por radiofrequência

Local ablation and external radiation

Recommendations

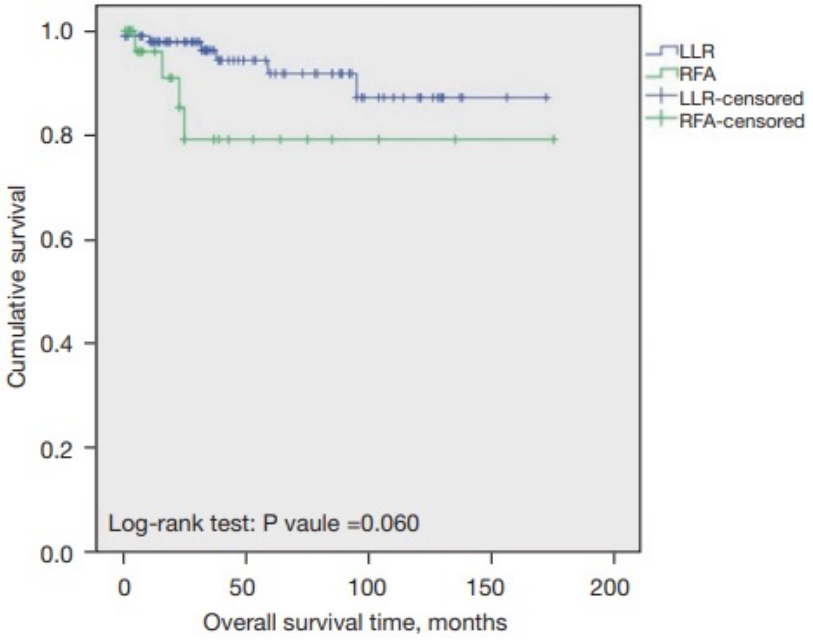
- Thermal ablation with radiofrequency is the standard of care for patients with BCLC 0 and A tumours not suitable for surgery (**evidence high; recommendation strong**). Thermal ablation in single tumours 2 to 3 cm in size is an alternative to surgical resection based on technical factors (location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

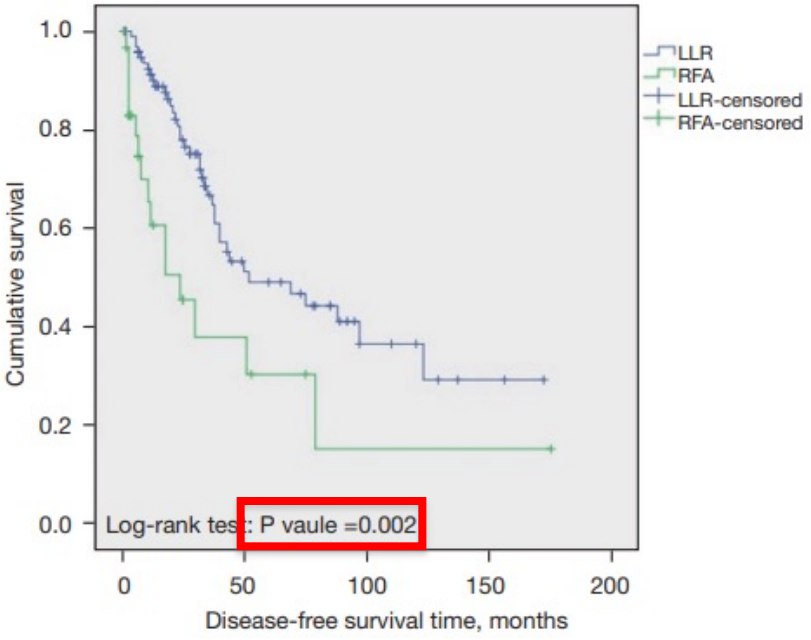
RESSECÇÃO

Galle PR, et al. J Hepatol 2018;69:182-236

Original Article

Pure laparoscopic liver resection versus percutaneous radiofrequency ablation for small hepatocellular carcinoma: a propensity score and multivariate analysis



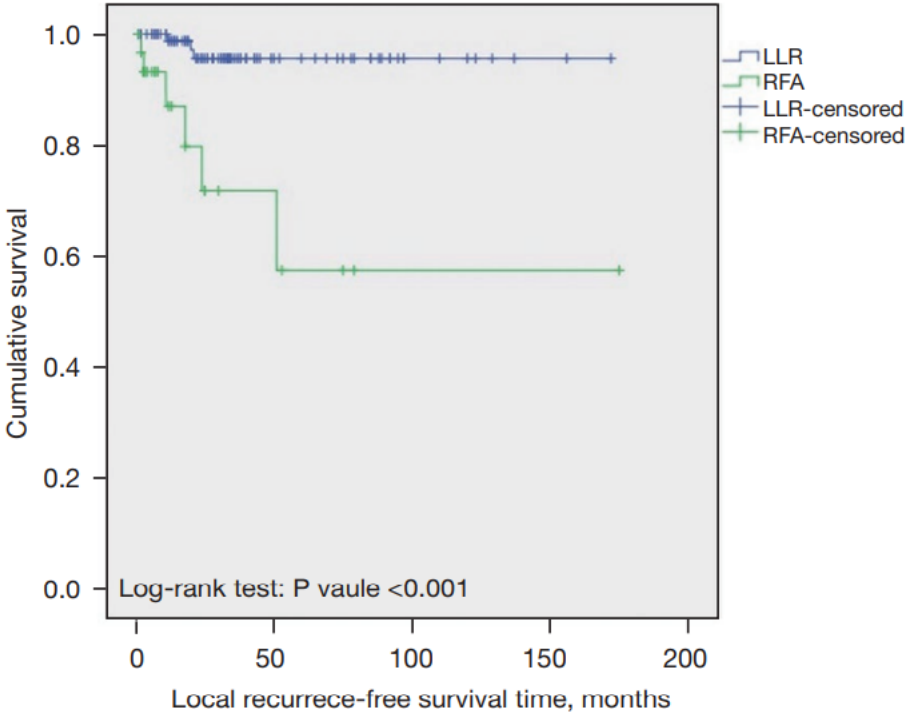


Cirurgia minimamente invasiva

Cheng KC, et al. Transl Cancer Res 2022;11:43-51

Original Article

Pure laparoscopic liver resection versus percutaneous radiofrequency ablation for small hepatocellular carcinoma: a propensity score and multivariate analysis



Conclusions: Both RFA and LLR are safe and feasible treatment options for patients with small HCC. LLR should be considered for patients with preserved liver function with a better disease-free survival; while RFA offered a comparable overall survival with less surgical trauma and shorter hospital stay.

Cheng KC, et al. Transl Cancer Res 2022;11:43-51

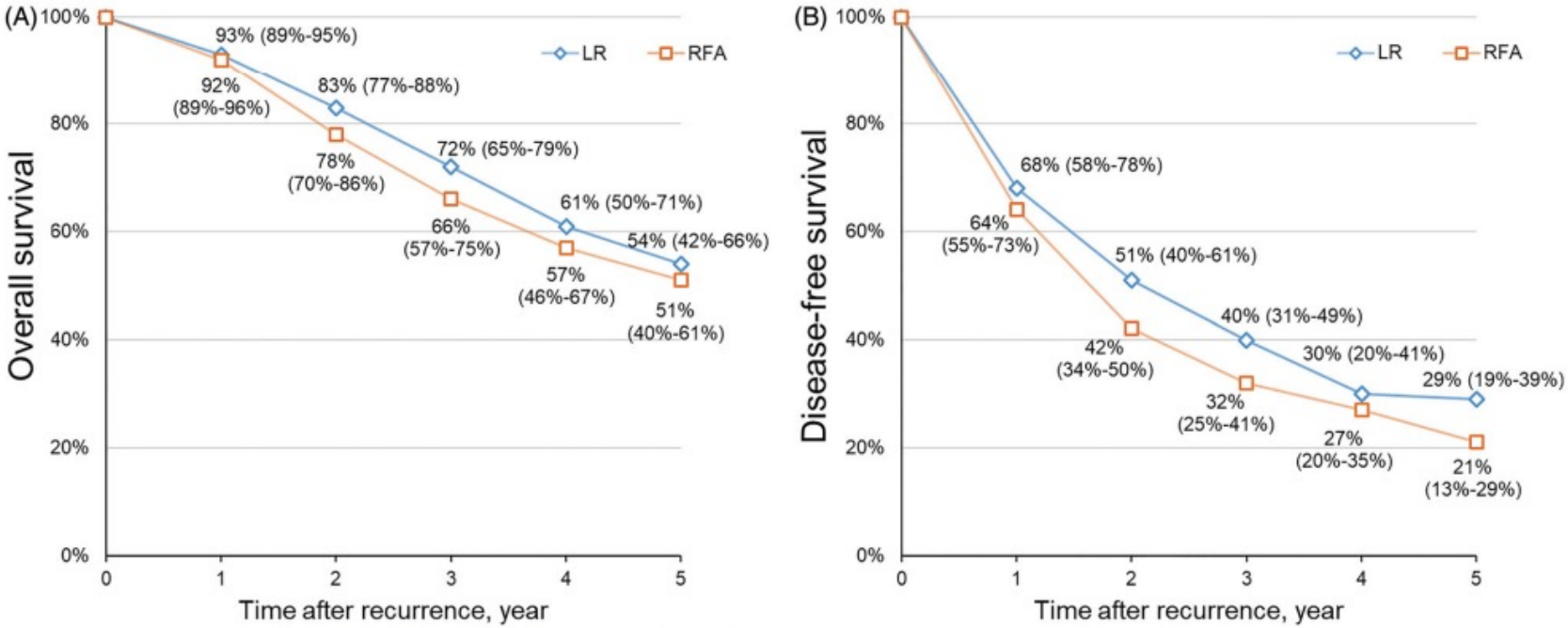
Cirurgia + trauma

INTERNATIONAL JOURNAL OF HYPERTHERMIA
2021, VOL. 38, NO. 1, 875–886
https://doi.org/10.1080/02656736.2021.1933218

Taylor & Francis
Taylor & Francis Group

OPEN ACCESS Check for updates

Liver resection versus radiofrequency ablation for recurrent hepatocellular carcinoma: a systematic review and meta-analysis



Ablação por radiofrequência

Yang Y, et al. Int J Hypert 2021;38:875-86

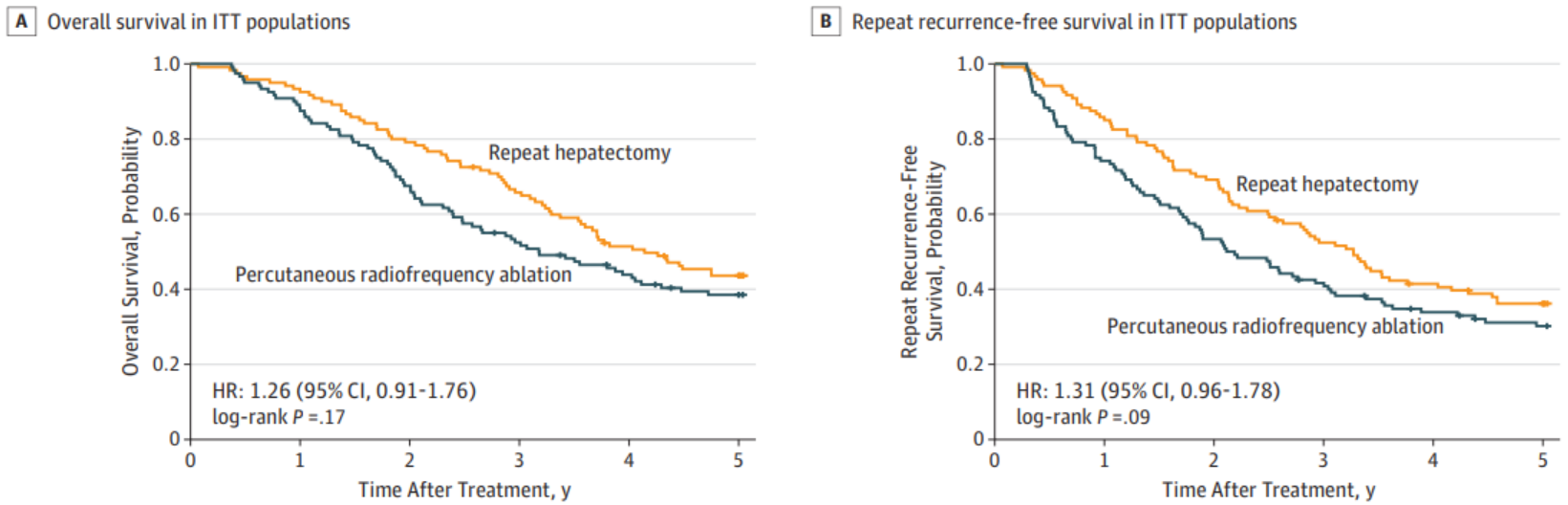
Research

Ablação por radiofrequência

JAMA Oncology | Original Investigation

Long-term Effects of Repeat Hepatectomy vs Percutaneous Radiofrequency Ablation Among Patients With Recurrent Hepatocellular Carcinoma

A Randomized Clinical Trial



- ❑ > 3 cm
- ❑ AFP > 200 ng/mL

Melhor controle local e sobrevida a longo prazo

Chia Y, et al. JAMA Oncol 2019

Ablação por radiofrequência

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

Ablação por radiofrequência

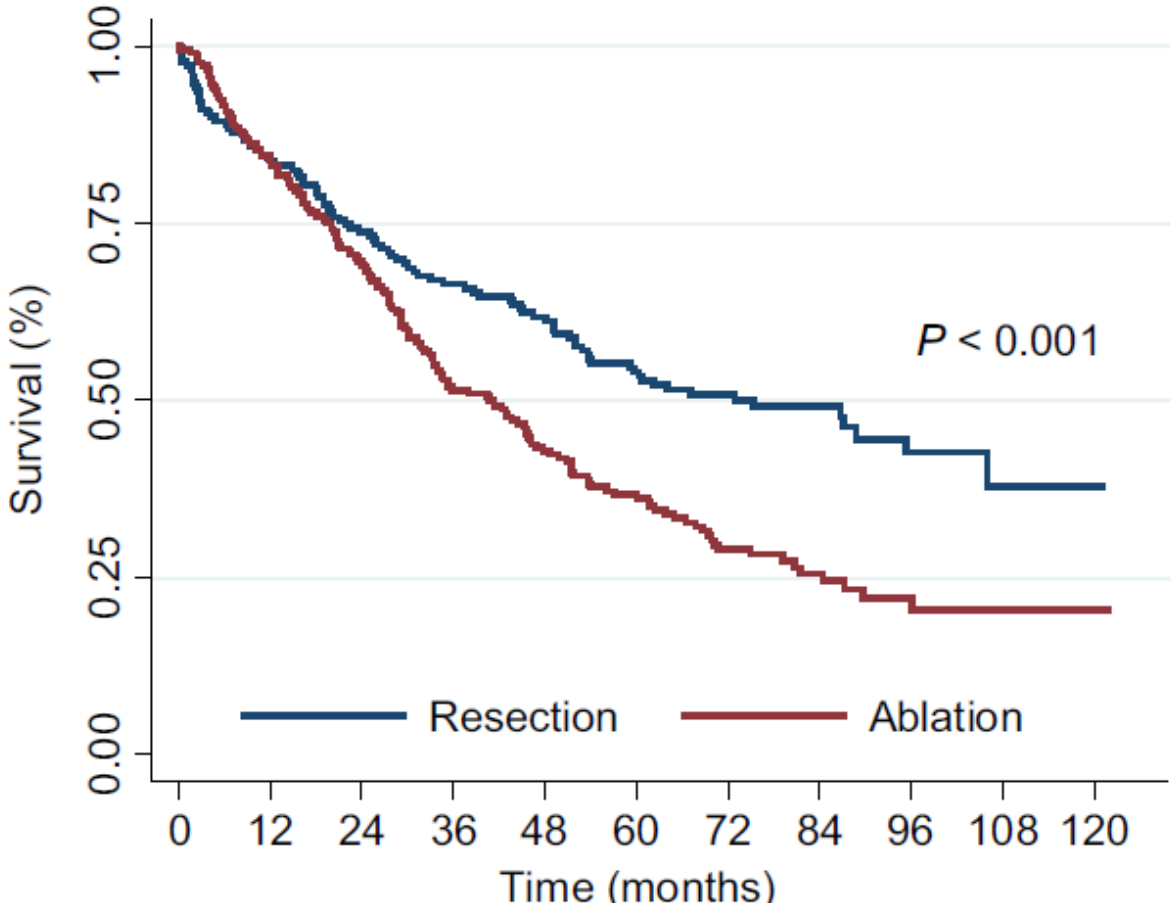
Conduta:
Ablação por RF:
Evolução satisfatória
Alta sem intercorrências

DOI:10.1111/hpb.12446

Ablação por radiofrequência

ORIGINAL ARTICLE

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



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

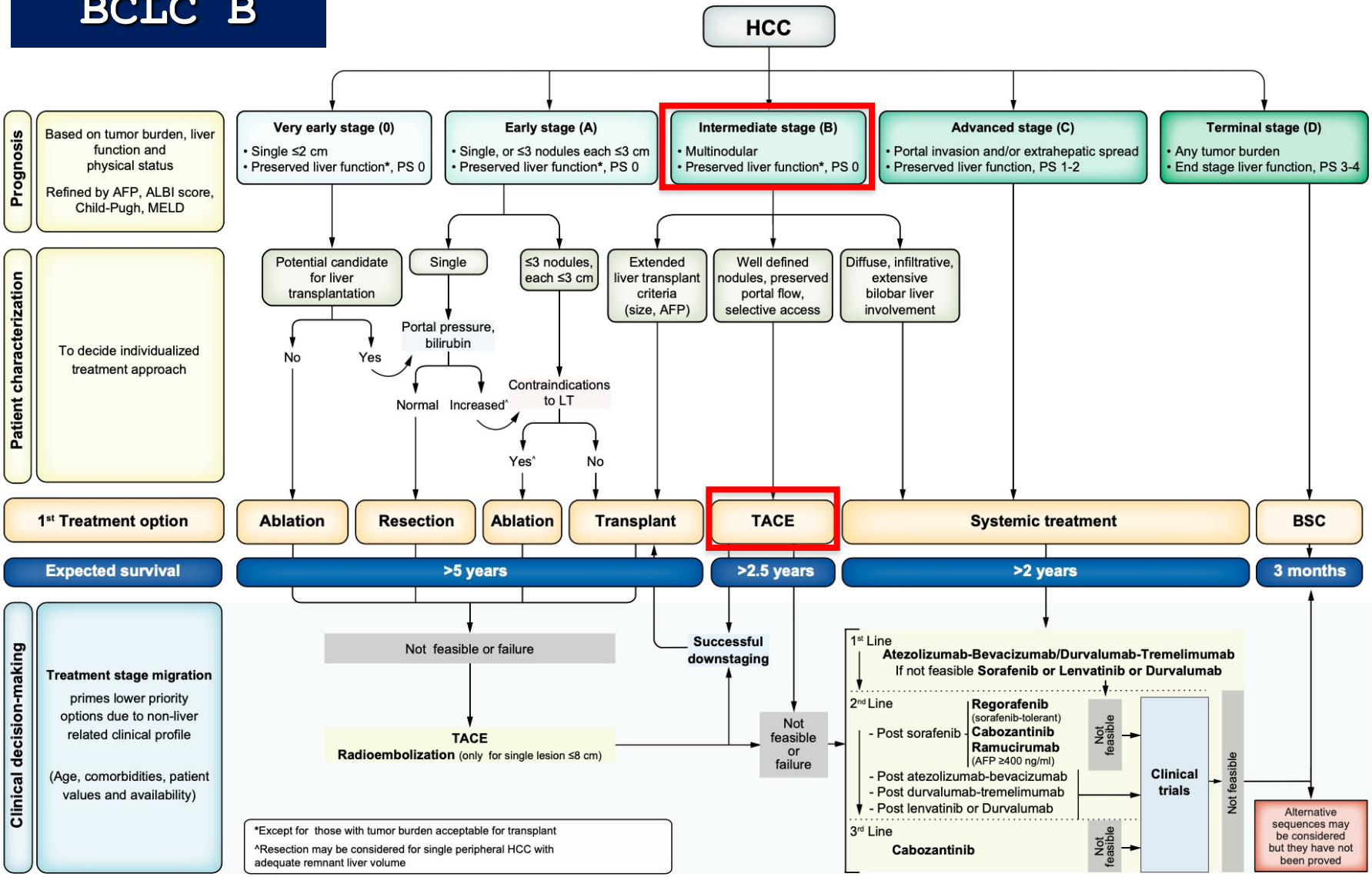
In conclusion, the present study provides further evidence supporting HR over ablation for patients with small, unifocal, HCC tumours. Numerous factors, both patient and tumour specific, continue to have a major influence on treatment allocation. Therefore, it would be short-sighted to suggest that ablation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

RESSECÇÃO

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

Quimioembolização

BCLC B



Reig M, et al. J Hepatol 2022;76:681-93

Lin *et al. BMC Gastroenterology* (2020) 20:99
https://doi.org/10.1186/s12876-020-01235-w

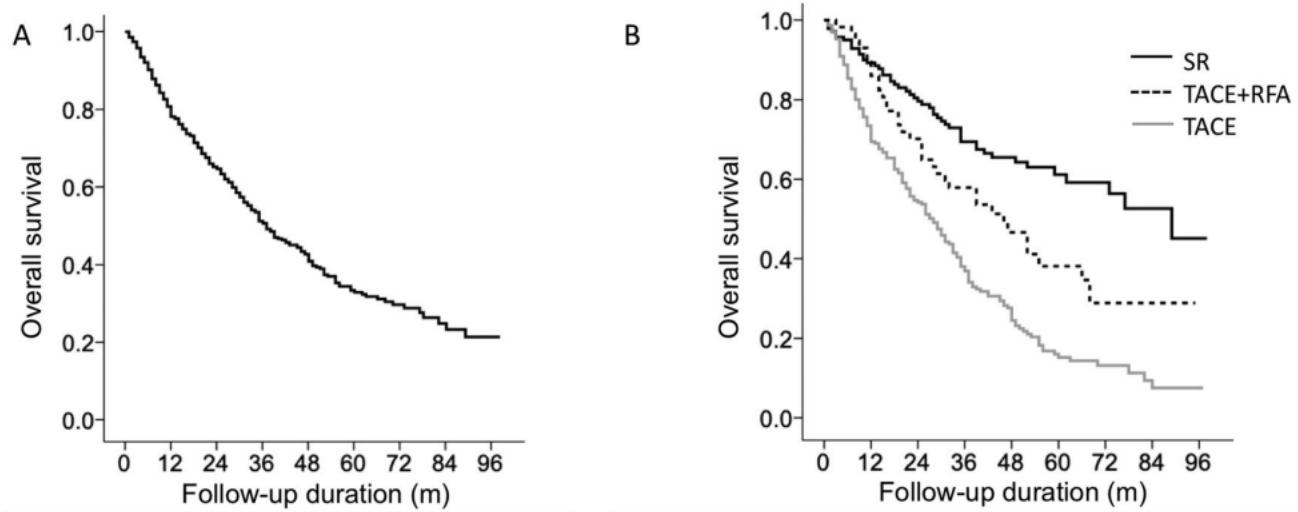
BMC Gastroenterology

RESEARCH ARTICLE Open Access

Comparison of overall survival on surgical resection versus transarterial chemoembolization with or without radiofrequency ablation in intermediate stage hepatocellular carcinoma: a propensity score matching analysis

Check for updates

Quimioembolização



Patient at risk	0m	12m	36m	60m	84m
All patients	428	324	170	63	15

Patient at risk	0m	12m	36m	60m	84m	P-value	HR (95% CI)
SR	140	121	76	32	9	Ref.	1
TACE	231	154	65	19	4	<0.0001	3.17 (2.31-4.36)
TACE+RFA	57	49	29	12	2	0.009	1.78 (1.15-2.75)

Fig. 2 Overall survival in Barcelona Clinic Liver Cancer stage B hepatocellular carcinoma (HCC) patients. Overall survival in all 428 HCC patients (**a**). Overall survival based on Cox regression analysis in HCC patients with different treatments before propensity score matching (**b**)

Lin CW, et al. BMC Gastroenterol 2020

Lin *et al. BMC Gastroenterology* (2020) 20:99
https://doi.org/10.1186/s12876-020-01235-w

BMC Gastroenterology

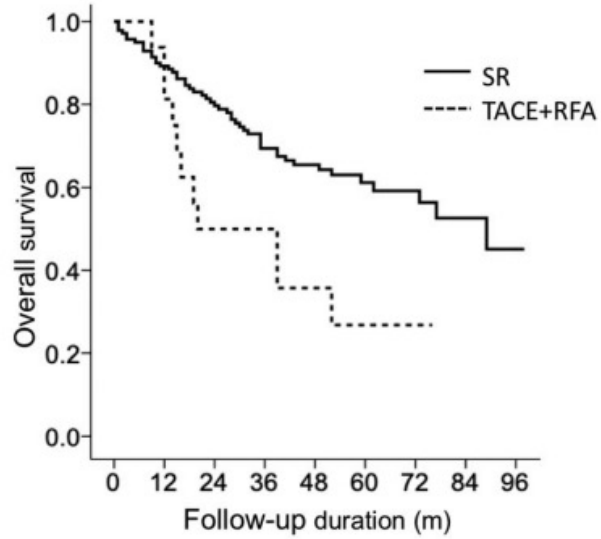
Quimioembolização

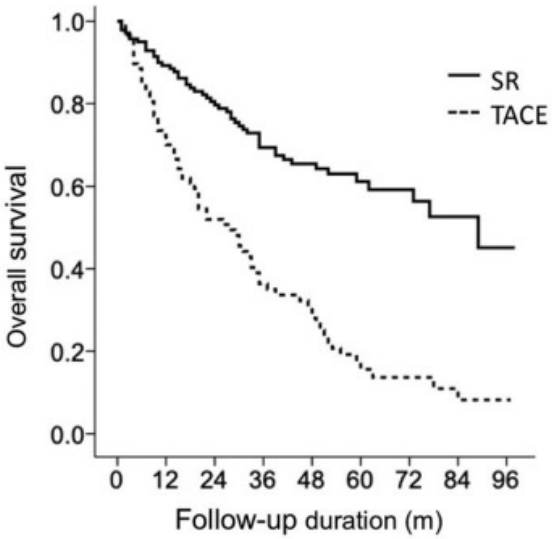
RESEARCH ARTICLE Open Access

Comparison of overall survival on surgical resection versus transarterial chemoembolization with or without radiofrequency ablation in intermediate stage hepatocellular carcinoma: a propensity score matching analysis

Check for updates

BCLC B





Patient at risk	0m	12m	36m	60m	84m	P-value	HR (95% CI)
SR	140	121	76	32	9	Ref	1
TACE+RFA	16	13	7	3	0	0.011	2.33 (1.21-4.49)

Patient at risk	0m	12m	36m	60m	84m	P-value	HR (95% CI)
SR	140	121	76	32	9	Ref	1
TACE	87	61	27	9	3	<0.0001	3.10 (2.15-4.46)

Lin CW, et al. BMC Gastroenterol 2020

Quimioembolização

Transarterial therapies

BCLC B

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**).

Galle PR, et al. J Hepatol 2018;69:182-236

Quimioembolização

Liver Cancer

Liver Cancer
DOI: 10.1159/000505093
Received: September 26, 2019
Accepted: November 22, 2019
Published online: January 28, 2020

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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]

BCLC B

Labgaa I, et al. Liver câncer 2020

TACE vs Ressecção

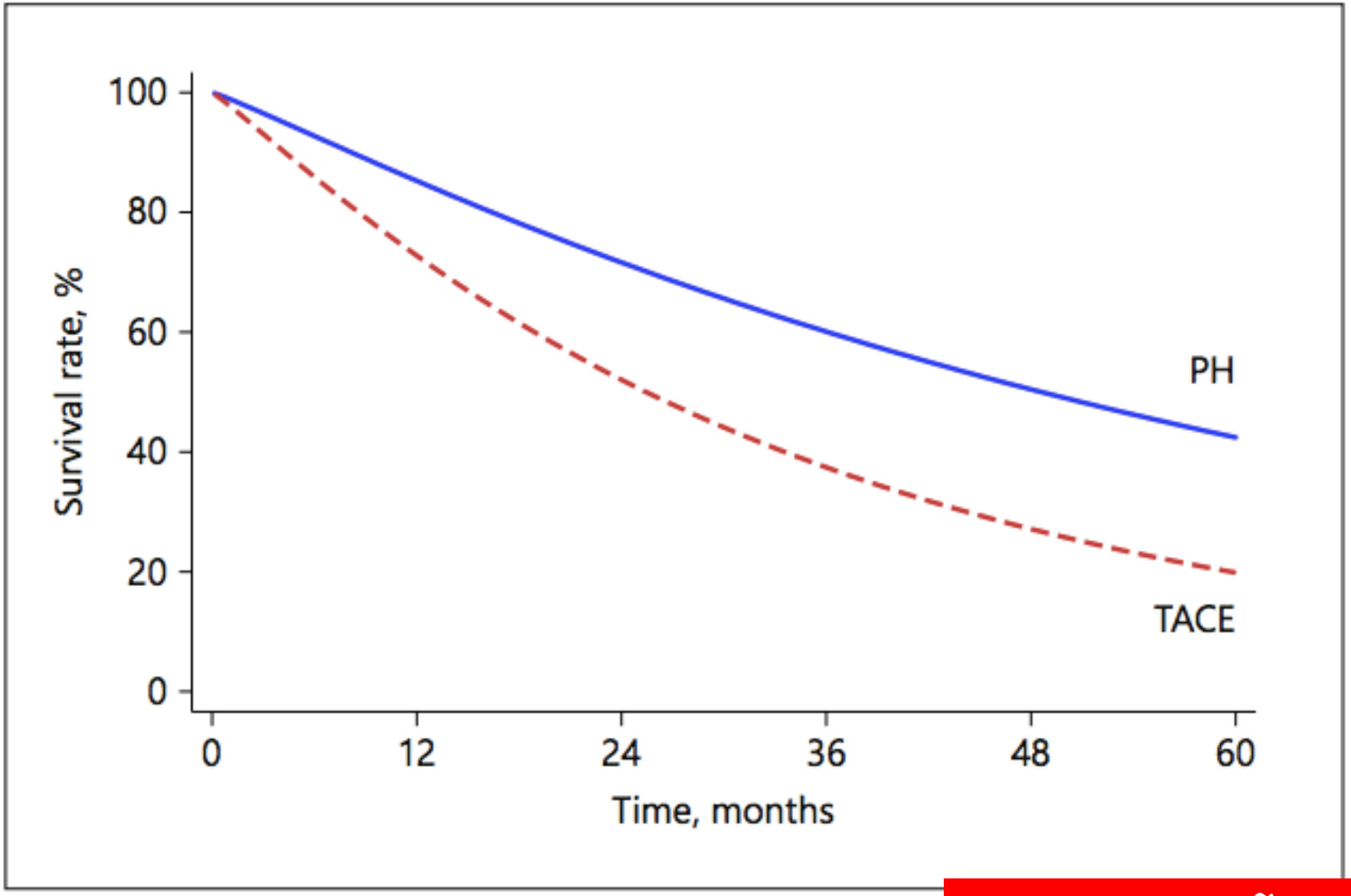
Quimioembolização

- **1.730 pacientes**

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

Labgaa I, et al. Liver câncer 2020

Quimioembolização



RESSECÇÃO

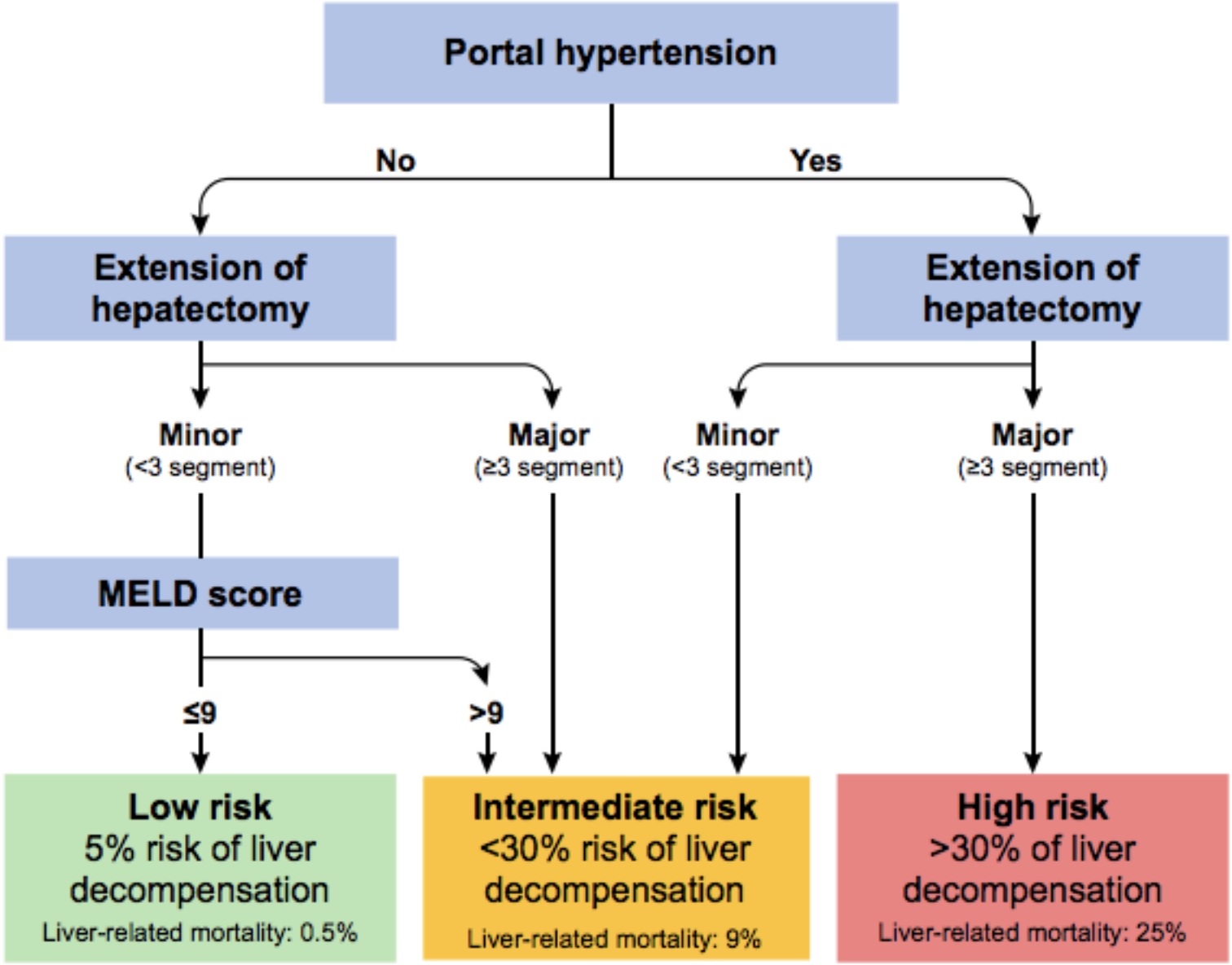
Labgaa I, et al. Liver câncer 2020

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.

RESSECÇÃO

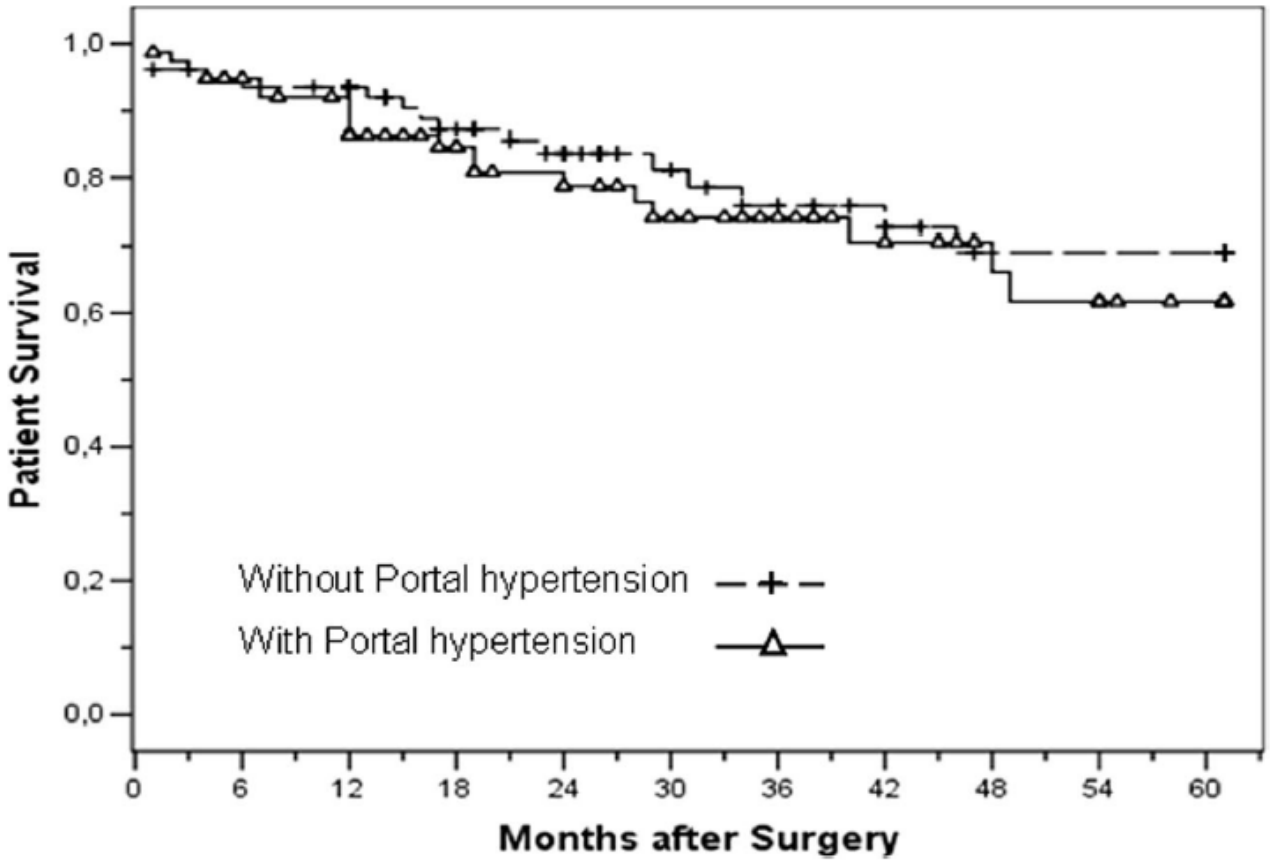
Labgaa I, et al. Liver câncer 2020



Galle PR, et al. J Hepatol 2018;69:182-236

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**



p=0.453

Hipertensão porta

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

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**

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.

RESSECÇÃO

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

Journal of Clinical and Translational Research 2022; 8(3): 209-217

Journal of Clinical and Translational Research

Journal homepage: http://www.jctres.com/en/home

- ❑ Transplante
- ❑ Ablação

ORIGINAL ARTICLE

Outcomes of surgical resection of super-giant (≥15 cm) hepatocellular carcinoma: Volume does matter, if not the size

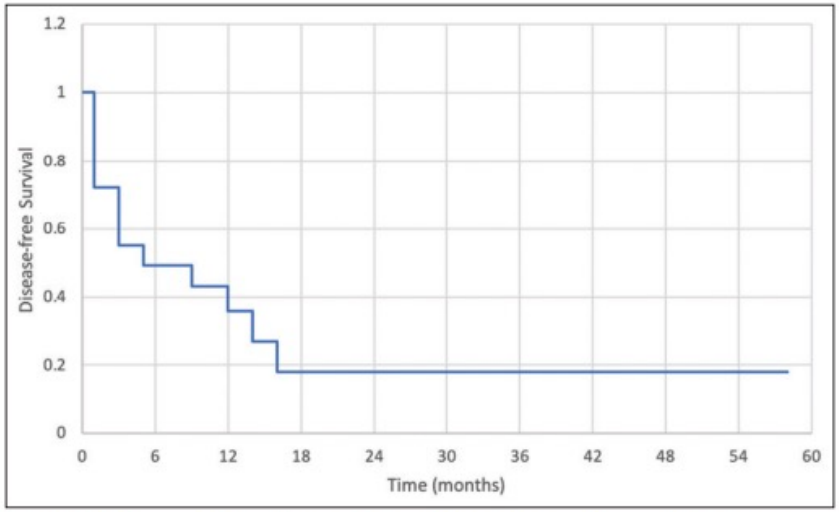


Figure 1. Disease-free survival in patients who underwent hepatic resection of super-giant hepatocellular carcinoma.

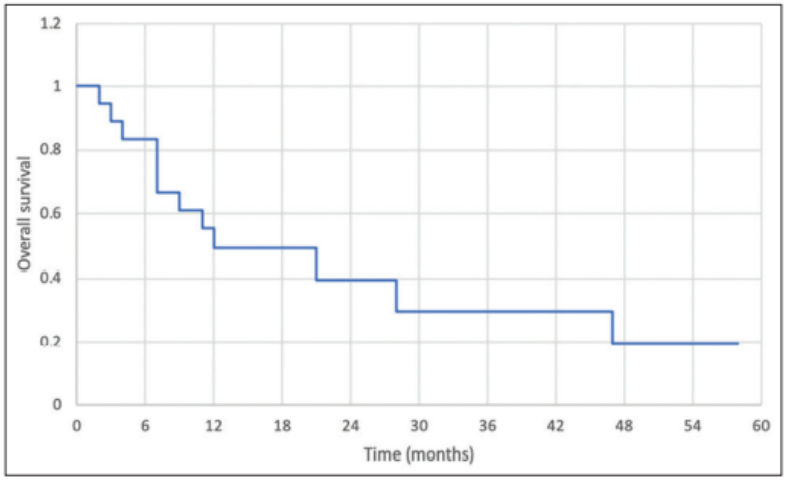


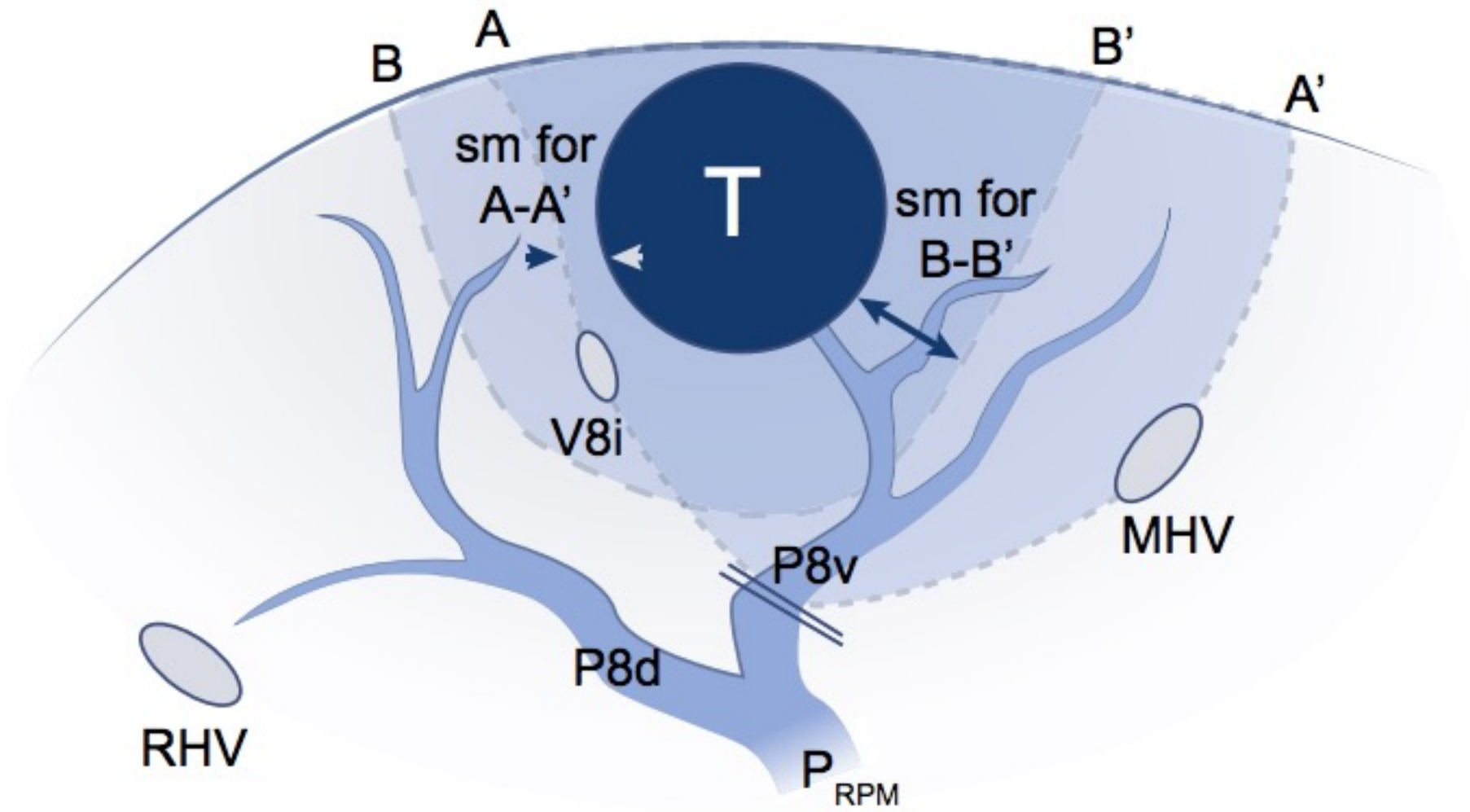
Figure 2. Overall survival in patients who underwent hepatic resection of super-giant hepatocellular carcinoma.

Tamanho da lesão

Wee JJ, et al. J Clin Trasl Res 2022

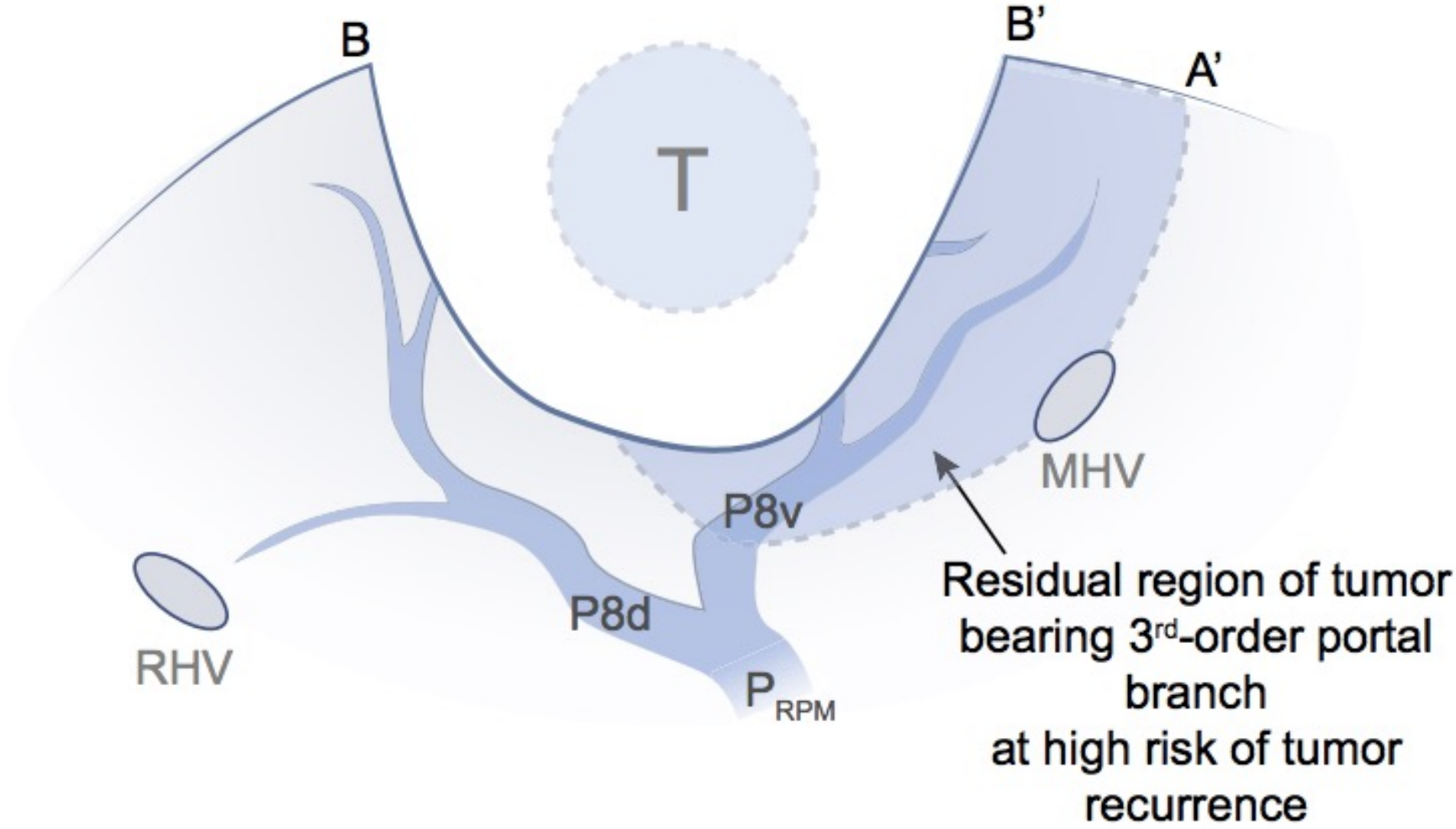
RESSECÇÃO

RESSECÇÃO ANATÔMICA



Galle PR, et al. J Hepatol 2018;69:182-236

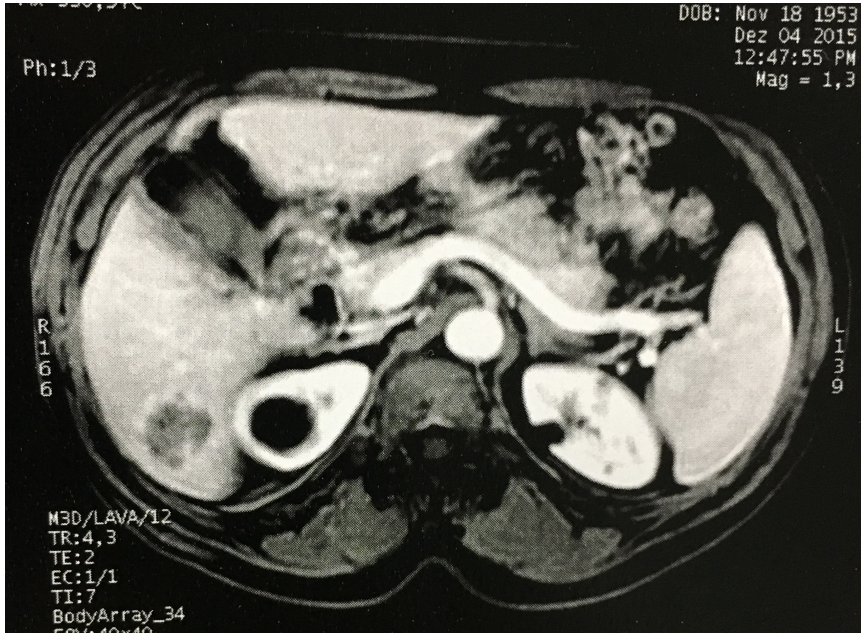
RESSECÇÃO NÃO ANATÔMICA

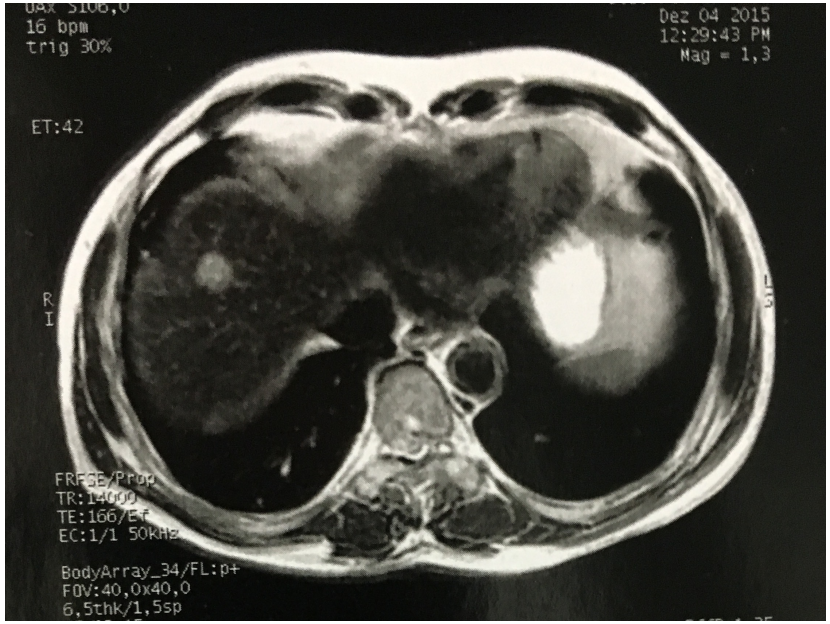


Galle PR, et al. J Hepatol 2018;69:182-236

BCLC B

Partial hepatectomy vs. transcatheter arterial chemoembolization for multiple hepatocellular carcinomas of BCLC-B stage: A meta-analysis of high-quality studies





Wang P, et al. Eur J Surg Oncol 2022

Número de lesões

ALPPS

Ann Surg Oncol
DOI 10.1245/s10434-015-5007-0

Annals of
SURGICAL ONCOLOGY
OFFICIAL JOURNAL OF THE SOCIETY OF SURGICAL ONCOLOGY

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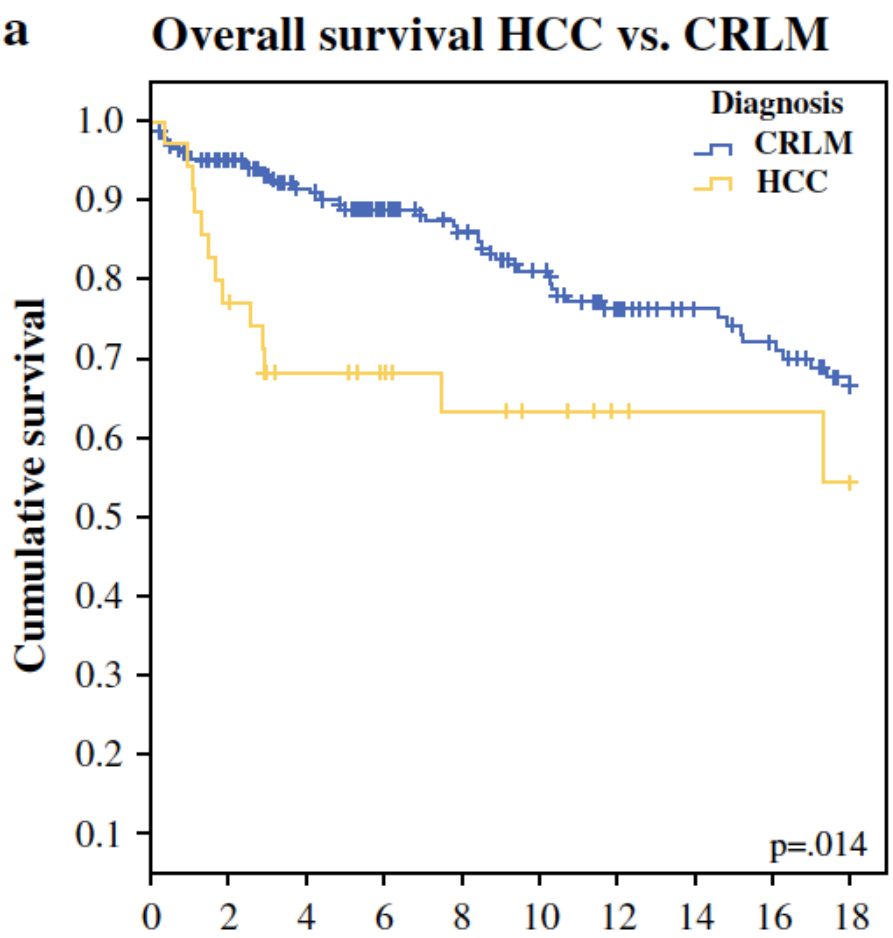
ORIGINAL ARTICLE – HEPATOBILIARY TUMORS

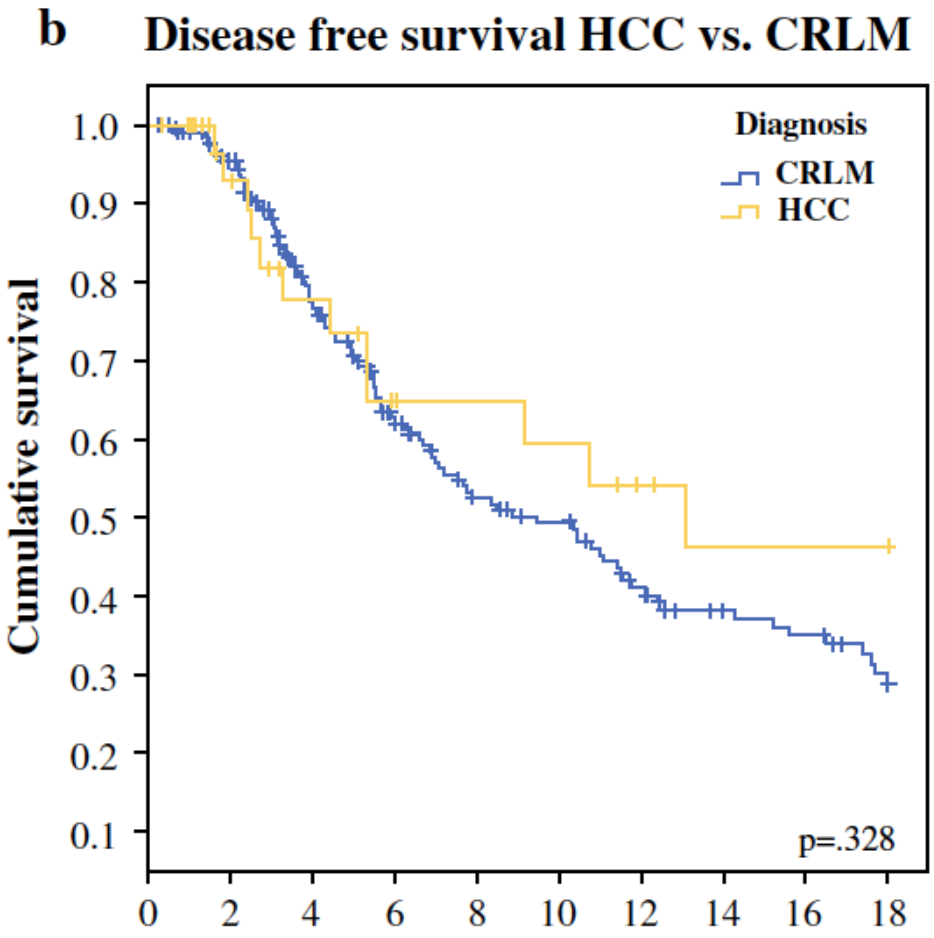
Should ALPPS be Used for Liver Resection in Intermediate-Stage HCC?

J. G. D'Haese, MD[1], J. Neumann, MD[2], M. Weniger, MD[1], S. Pratschke, MD[1], B. Björnsson, MD[3], V. Ardiles, MD[4], W. Chapman, MD, FACS[5], R. Hernandez-Alejandro, MD[6], O. Soubrane, MD[7], R. Robles-Campos, MD[8], M. Stojanovic, MD, PhD[9], R. Dalla Valle, MD[10], A. C. Y. Chan, MD, MBBS, FRCS, FCSHK, FHKAM (Surgery)[11], M. Coenen, PhD, MPH[12], M. Guba, MD[1], J. Werner, MD, MBA[1], E. Schadde, MD, FACS[13], and M. K. Angele, MD, FACS[1,14]

D'Haese JG, et al. Ann Surg Oncol 2015

ALPPS





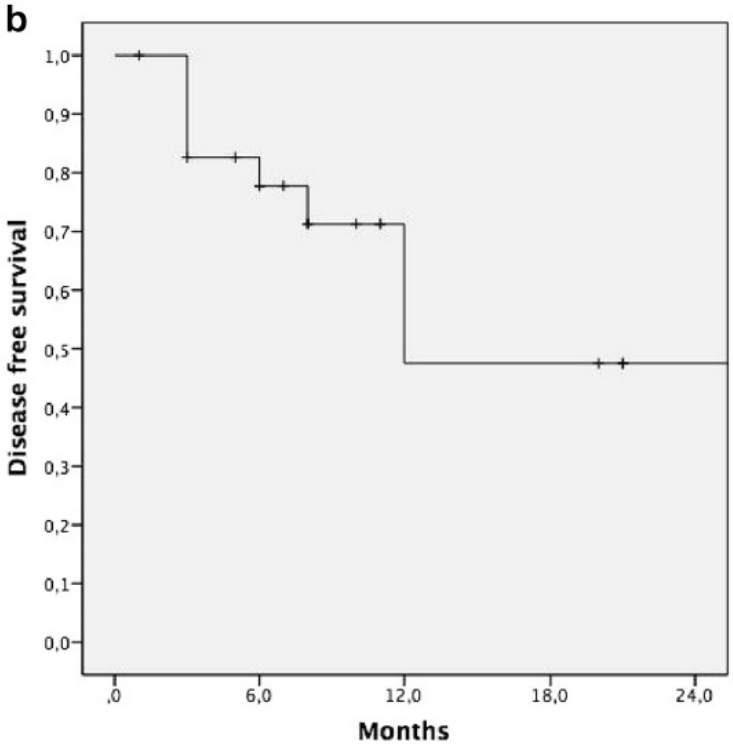
D'Haese JG, et al. Ann Surg Oncol 2015

Updates in Surgery
https://doi.org/10.1007/s13304-018-0596-3

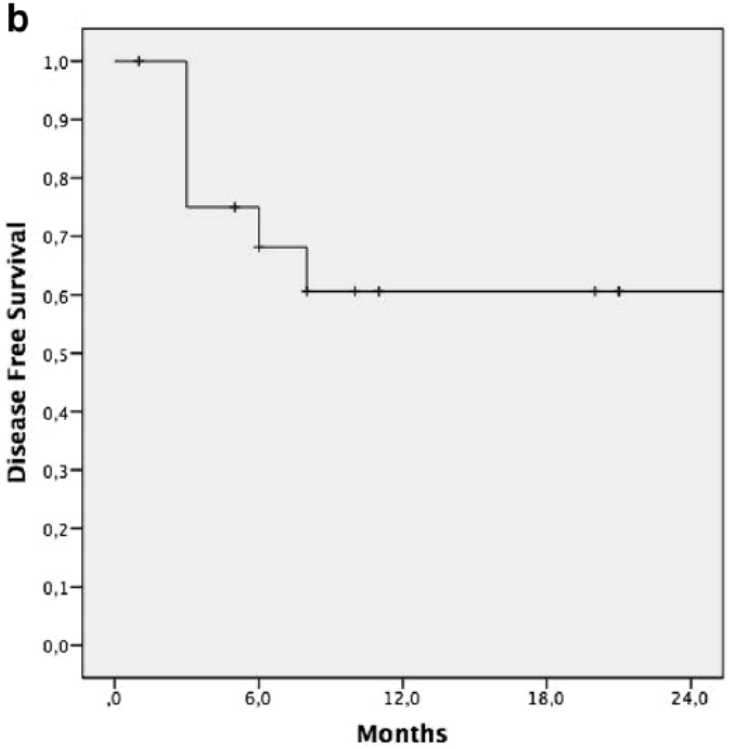
ALPPS

ORIGINAL ARTICLE

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



TODA SÉRIE



HCC

Vennarecci G, et al. Updates Surg 2018

International Journal of Surgery Case Reports xxx (2016) xxx-xxx

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International Journal of Surgery Case Reports

journal homepage: www.elsevier.com

Case Report

The ALPPS procedure for hepatocellular carcinoma larger than 10 centimeters

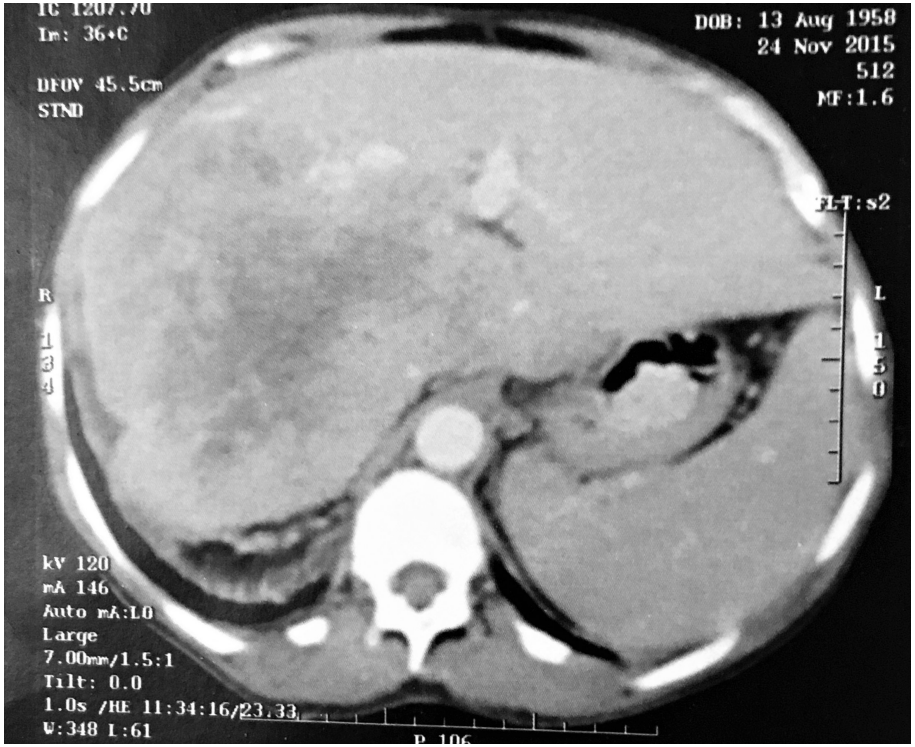
Orlando Jorge M. Torres *, Rodrigo Rodrigues Vasques, Thiago Henrique S. Silva, Miguel Eugenio L. Castelo-Branco, Camila Cristina S. Torres

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

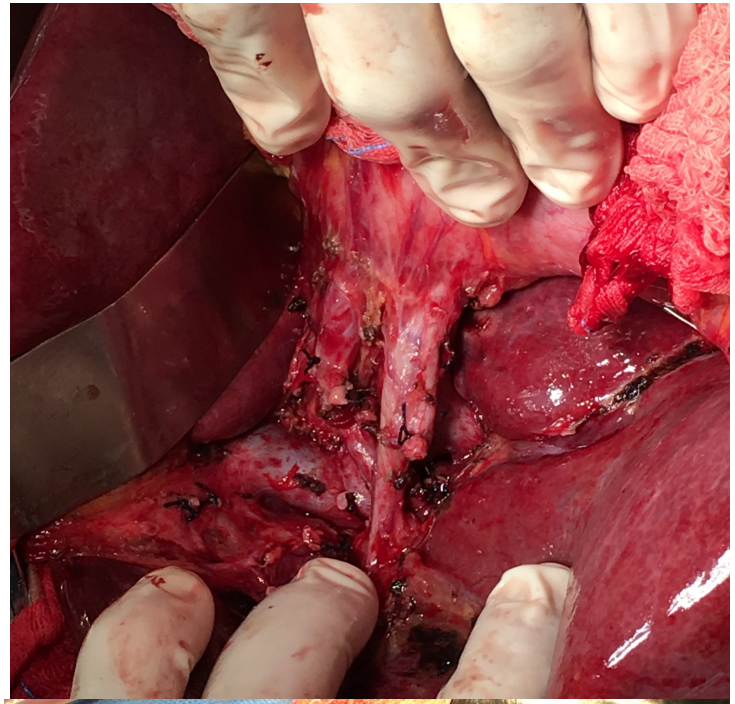
ALPPS

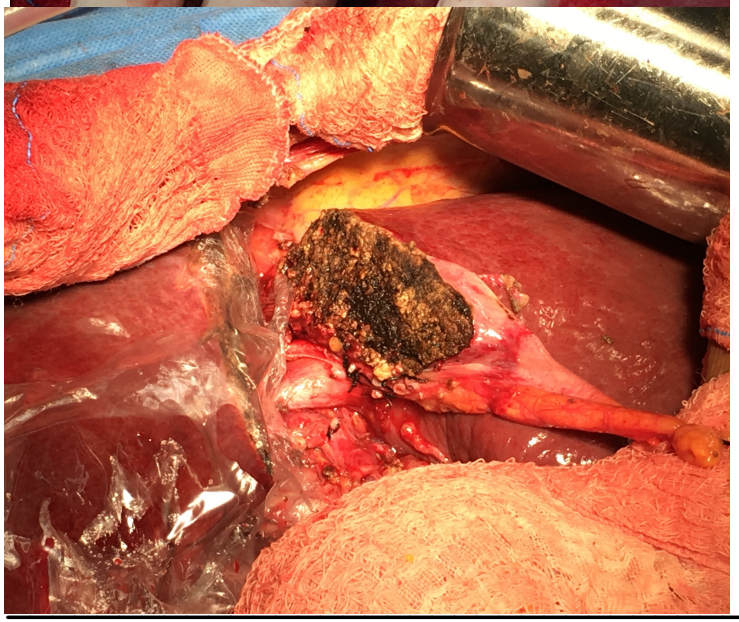
Torres OJM, et al. Int J Surg Case Rep 2016.

ALPPS



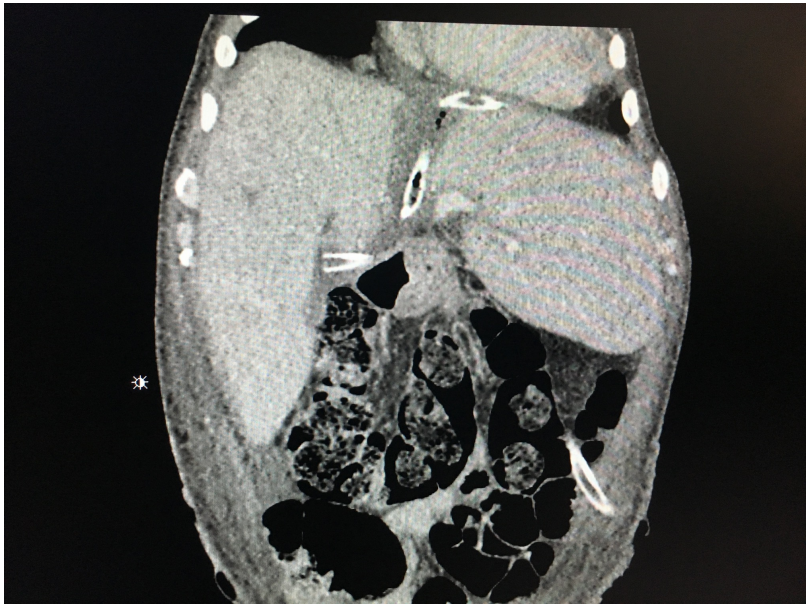
R, masculino, 57 a,
Hepatopatia crônica
Lesão única 19cm (CHC)
Child A5, MELD 9
AFP 508
123.000 plaquetas

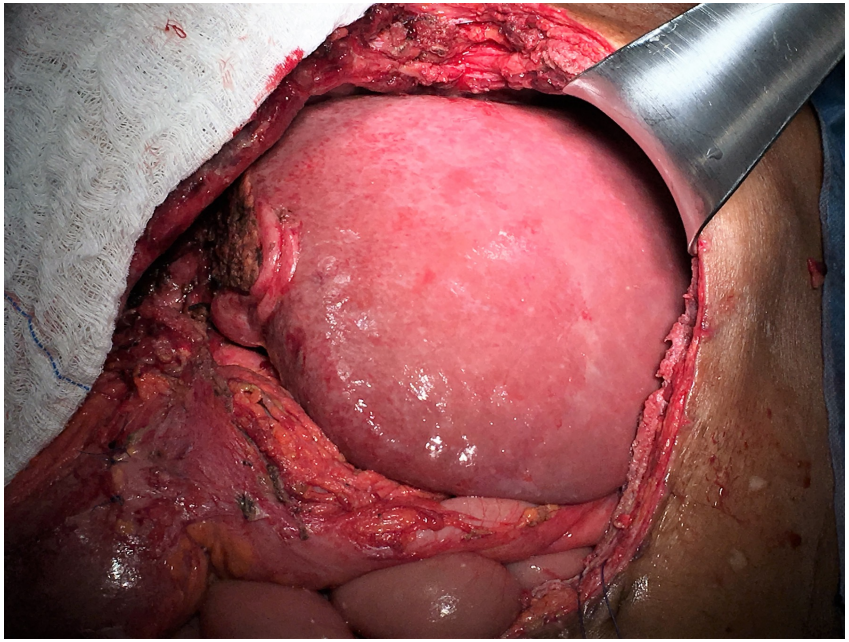


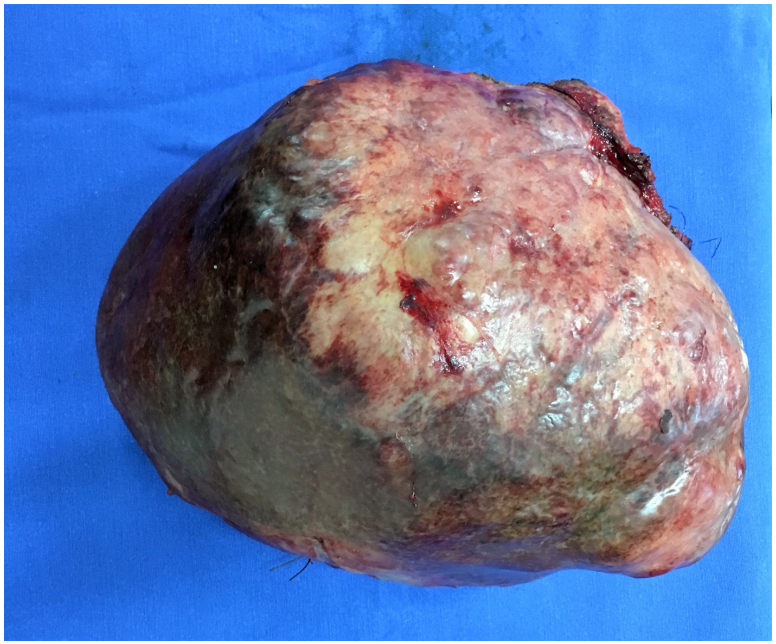


Conduta:

ALPPS



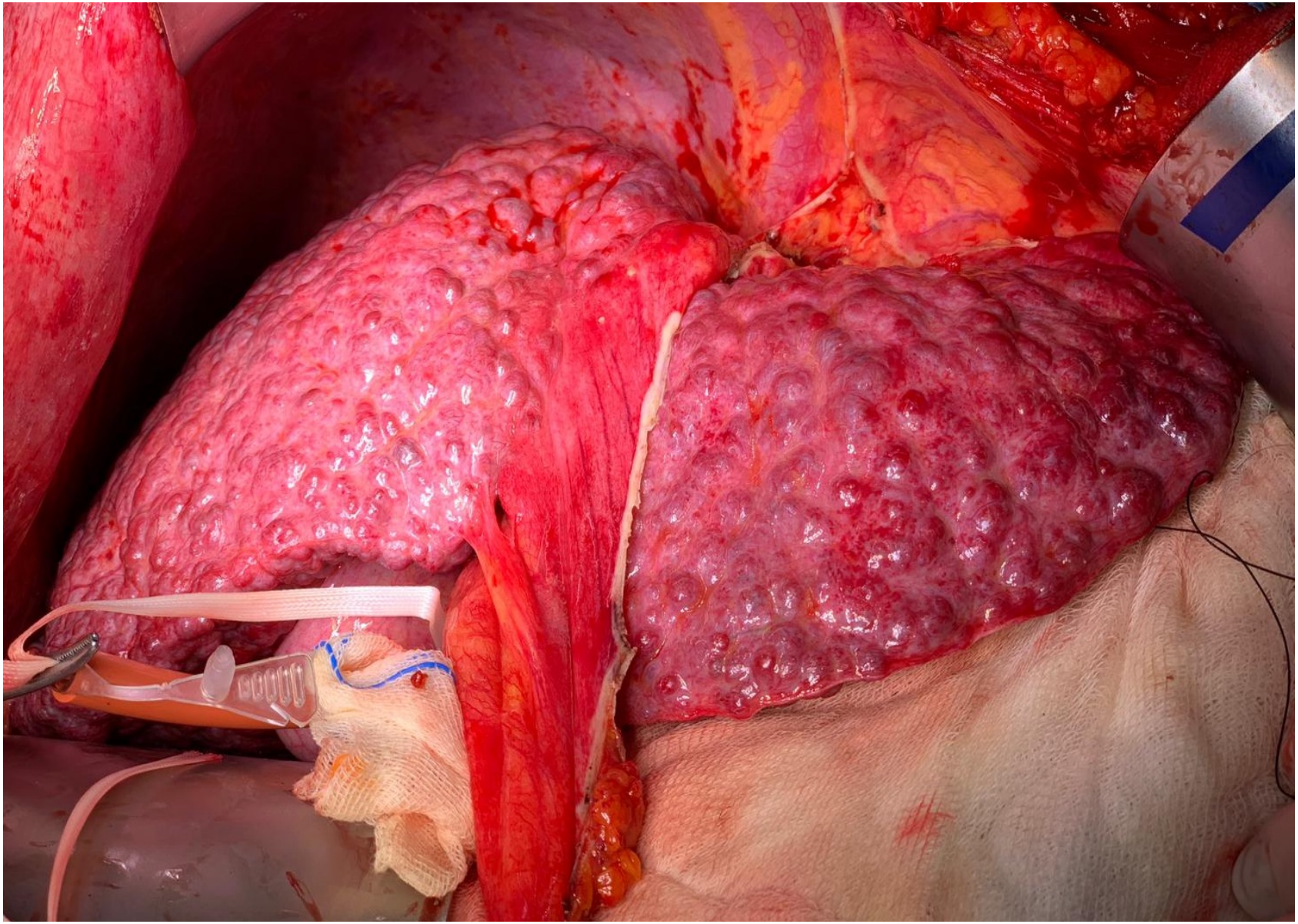




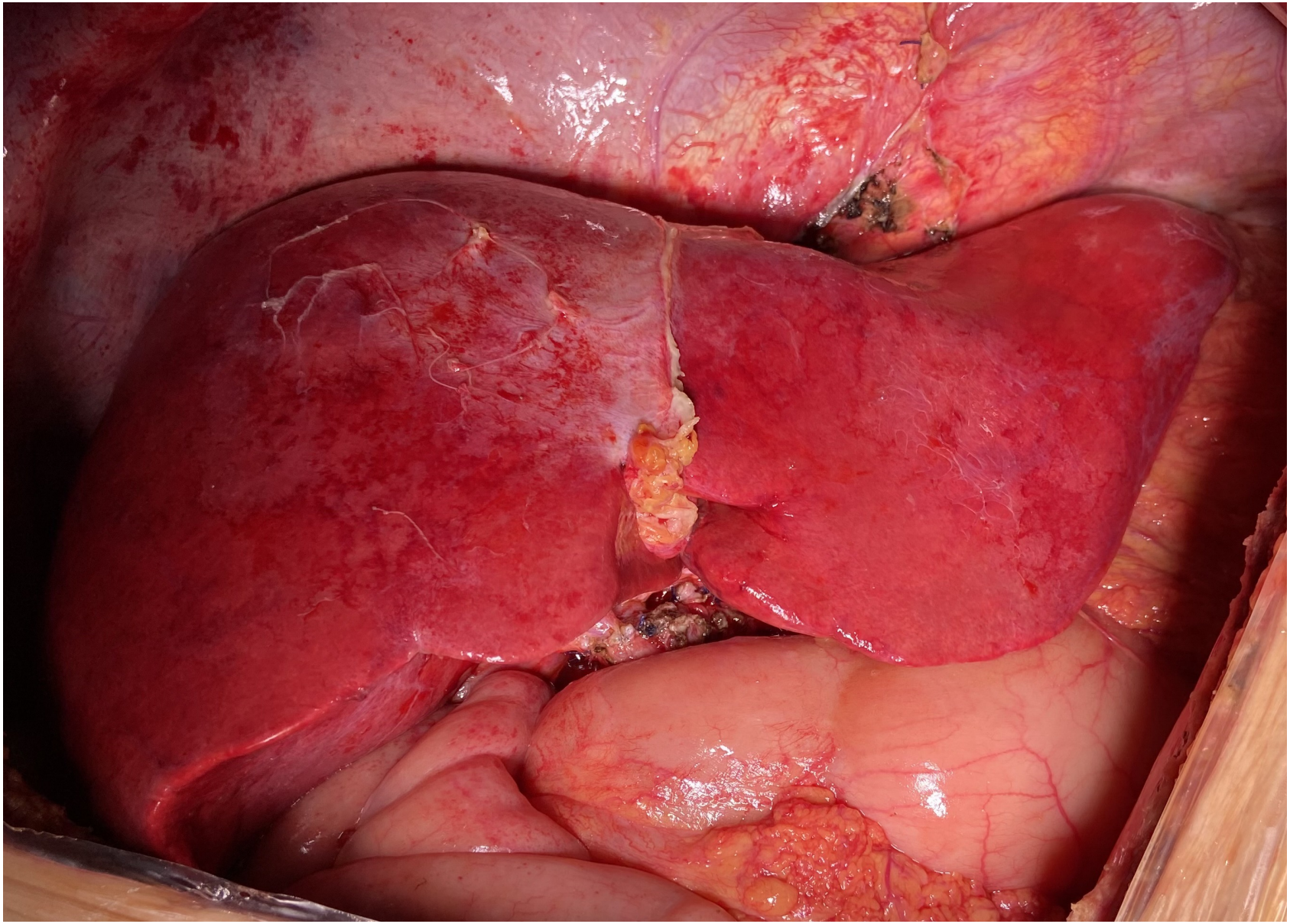
Pós-operatório:
Alta sem intercorrências

ALPPS

Transplante hepático



Transplante hepático



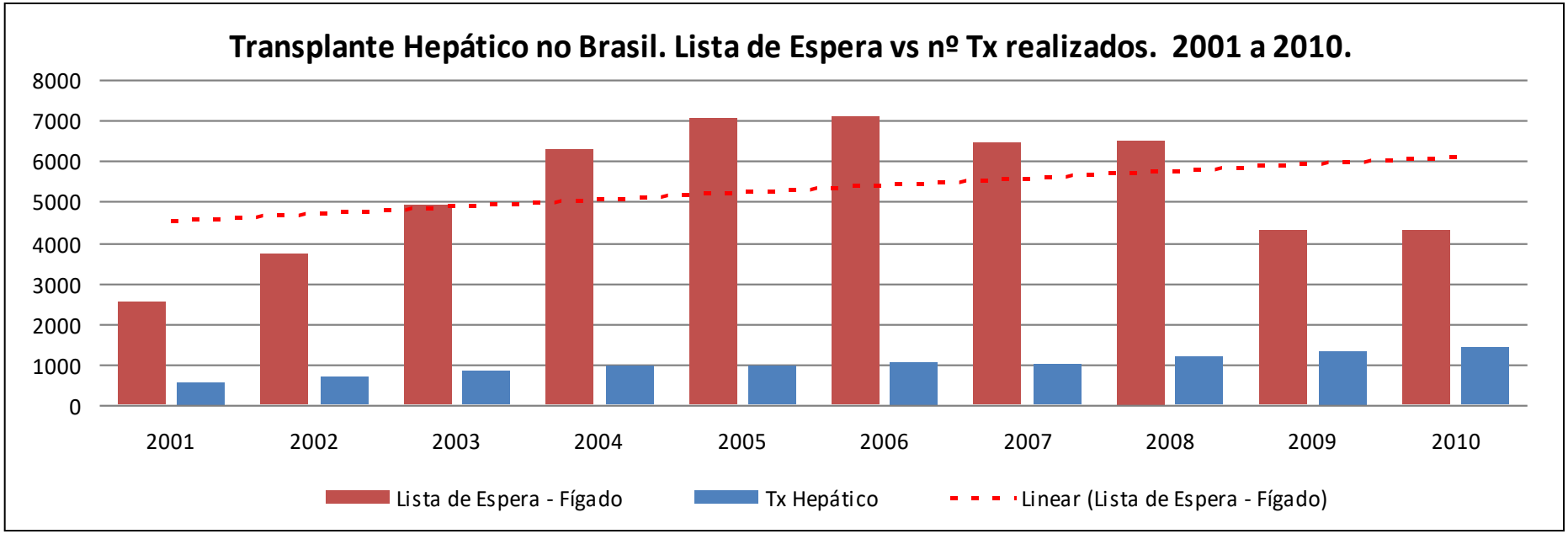
Liver transplantation

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.

Galle PR, et al. J Hepatol 2018;69:182-236

Necessidade de Transplante de Fígado - Brasil

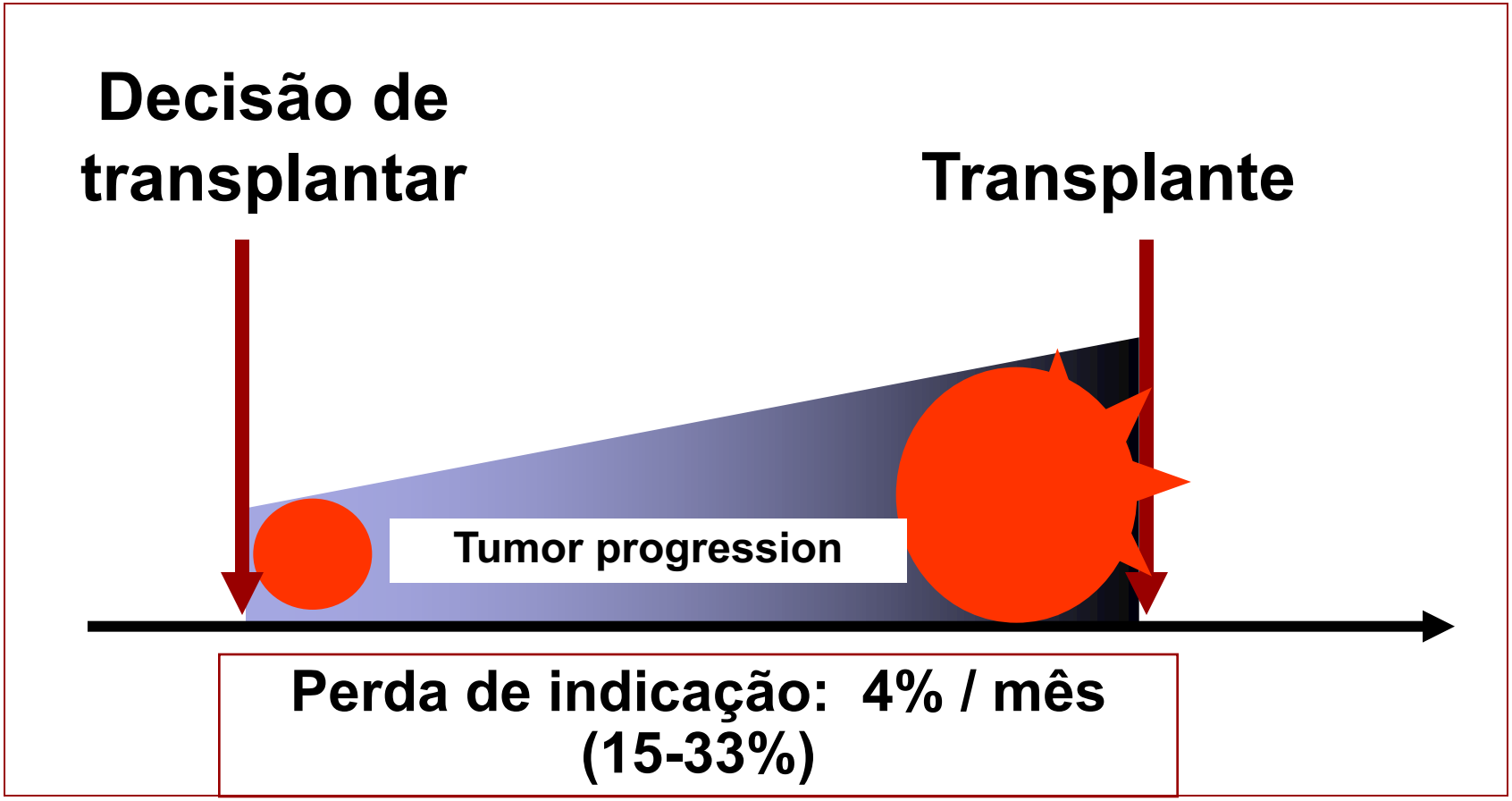


Tx Fígado - Brasil		
Nº Tx em 2010:	**1413**	
Lista de Espera - 2010:	**4304**	
% Tx 2010/Lista de Espera:		**33%**

FALTA DE ÓRGÃOS

Transplante hepático

Mortalidade em lista



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

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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]

NÚMERO E TAMANHO

Table 1
Tumor characteristics in recent large published series

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%)

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

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

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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*
[c] *Department of Gastroenterology, Ospedale Mauriziano "Umberto I", Largo Turati 62, 10128 Torino, Italy*

Accepted 20 June 2007
Available online 3 August 2007

NÚMERO E TAMANHO

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

Cirurgia minimamente invasiva

Dig Dis Sci (2011) 56:1937–1943
DOI 10.1007/s10620-011-1572-7

REVIEW

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

World Journal of Gastroenterology

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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

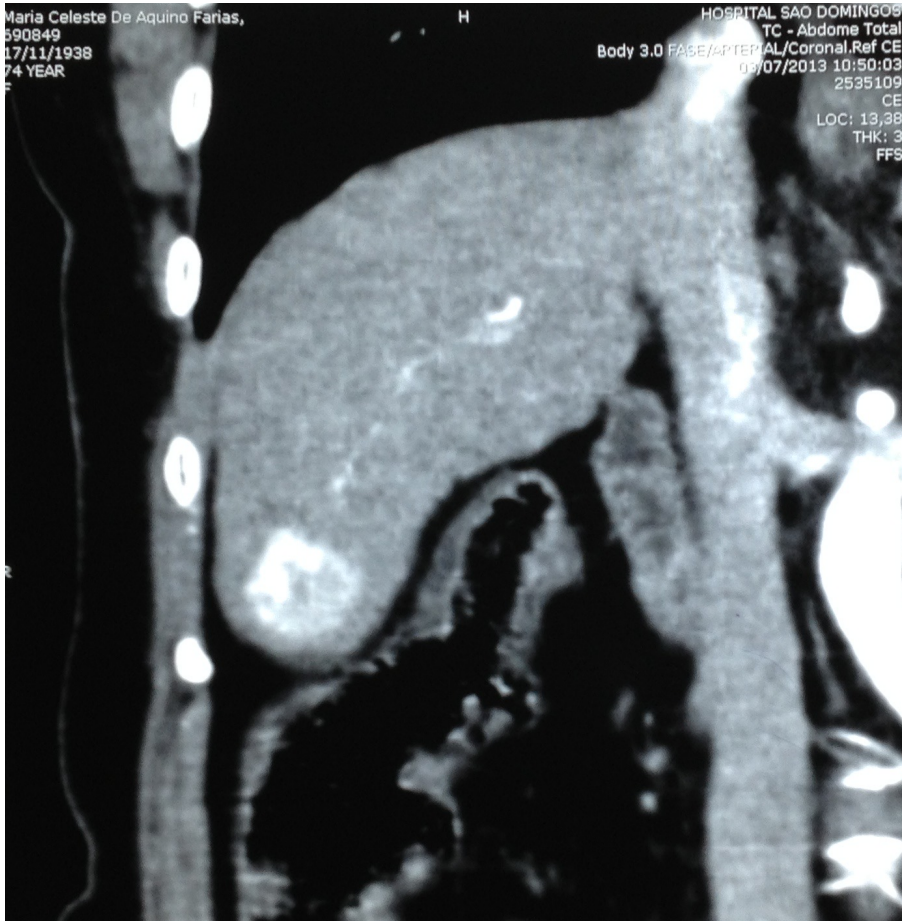
CrossMark

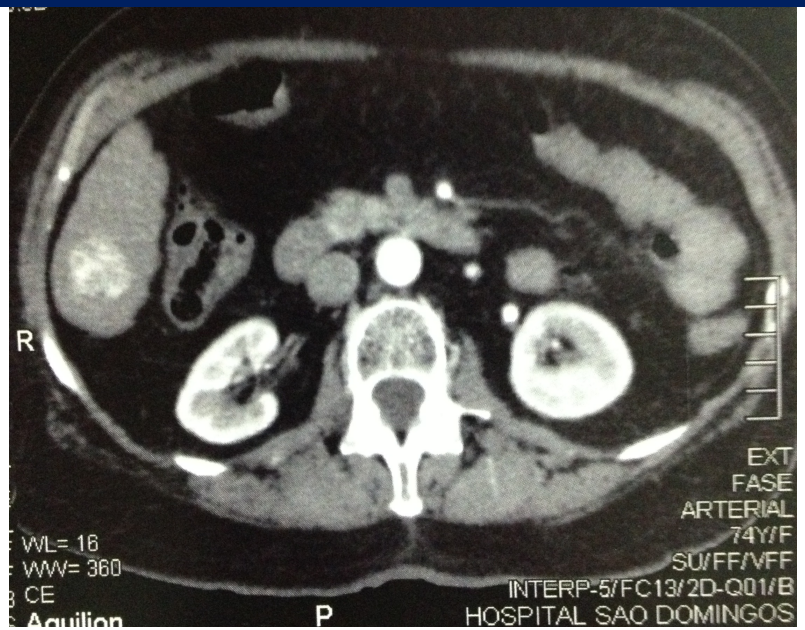
Laparoscopic liver resection of hepatocellular carcinoma located in unfavorable segments: a propensity score-matched analysis from the I Go MILS (Italian Group of Minimally Invasive Liver Surgery) Registry

Giovanni Battista Levi Sandri[1] · Giuseppe Maria Ettorre[1] · Luca Aldrighetti[2] · Umberto Cillo[3] · Raffaele Dalla Valle[4] · Alfredo Guglielmi[5] · Vincenzo Mazzaferro[6] · Alessandro Ferrero[7] · Fabrizio Di Benedetto[8] · Salvatore Gruttadauria[9] · Luciano De Carlis[10] · Giovanni Vennarecci[1] on behalf of I Go MILS Group on HCC

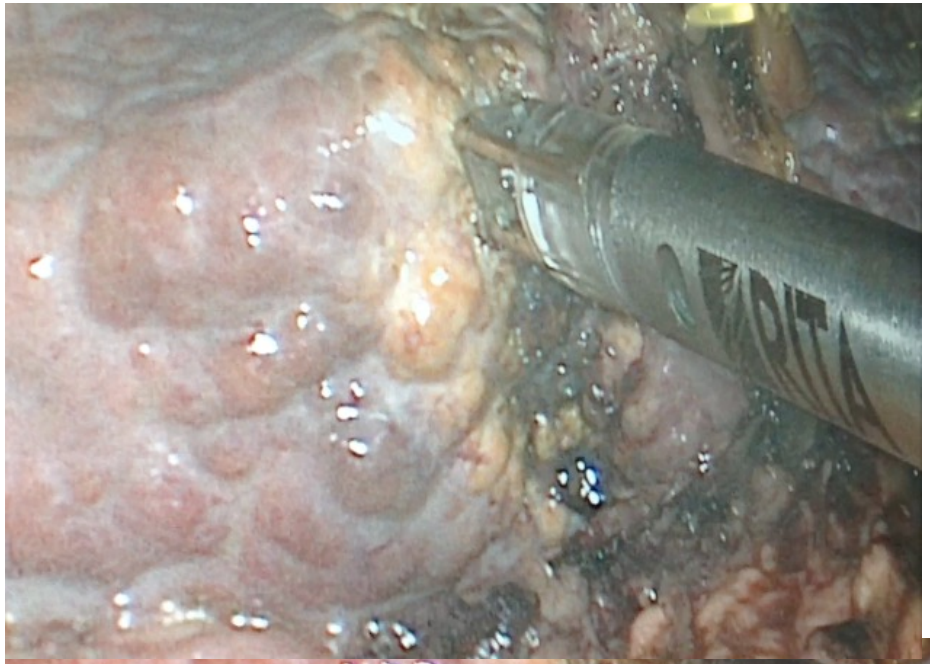
Zhou YM, et al. Dig Dis Sci 2011;56:1937-43
Twaij A, et al. World J Gastroenterol 2014
Lai EC, et al. Arch Surg 2009
Sandri GB, et al. Surg Endosc 2018

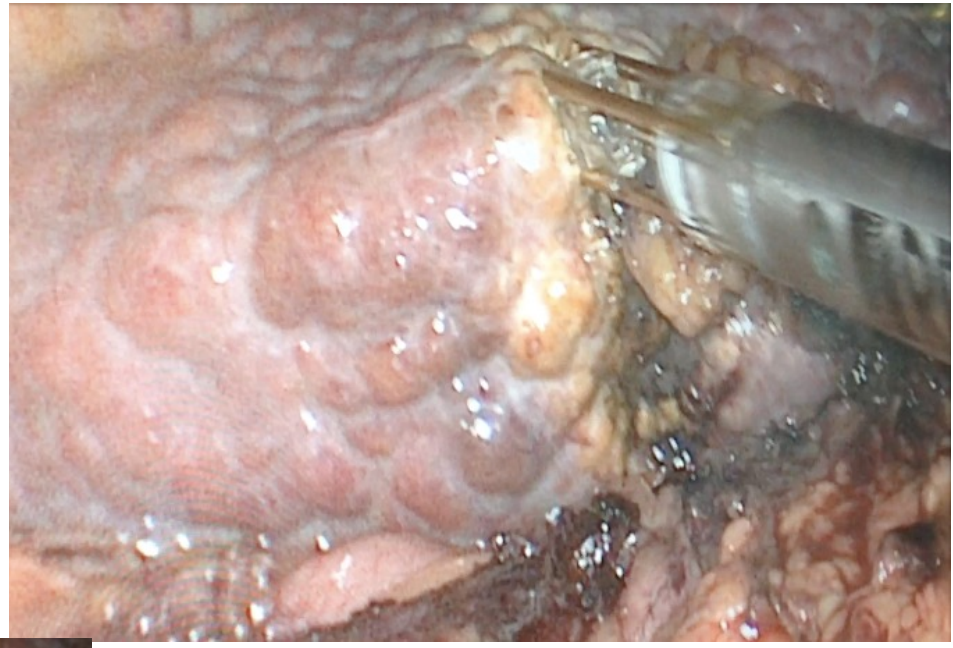
Cirurgia minimamente invasiva

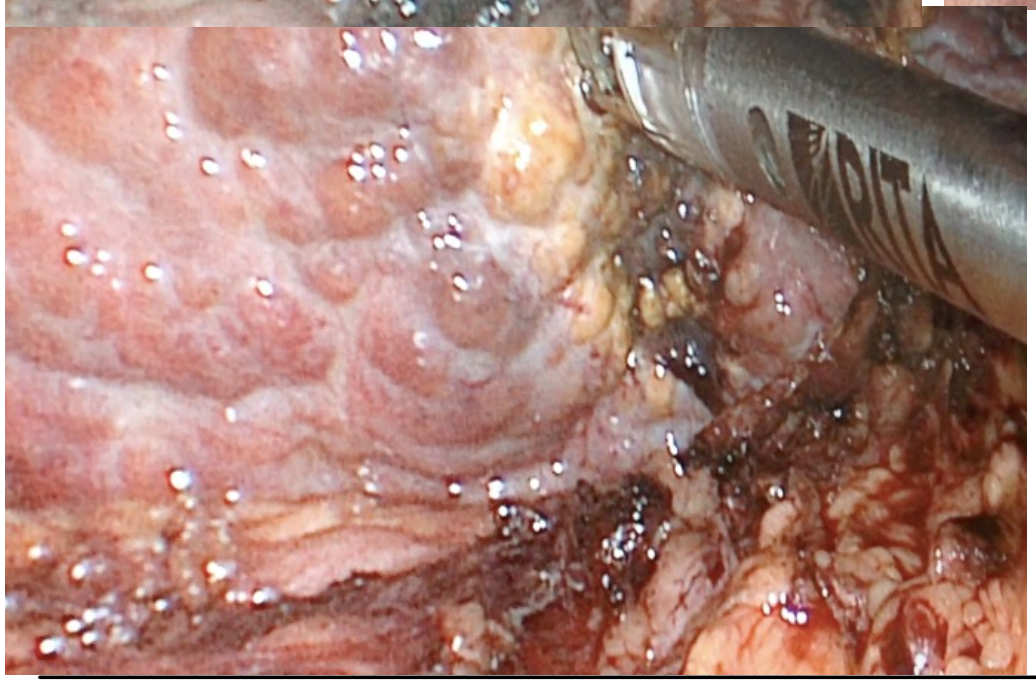




L, feminino, 72 a,
Hepatopatia crônica
Lesão única 6,5 cm Seg 6
Child A5, MELD 8
157.000 plaquetas







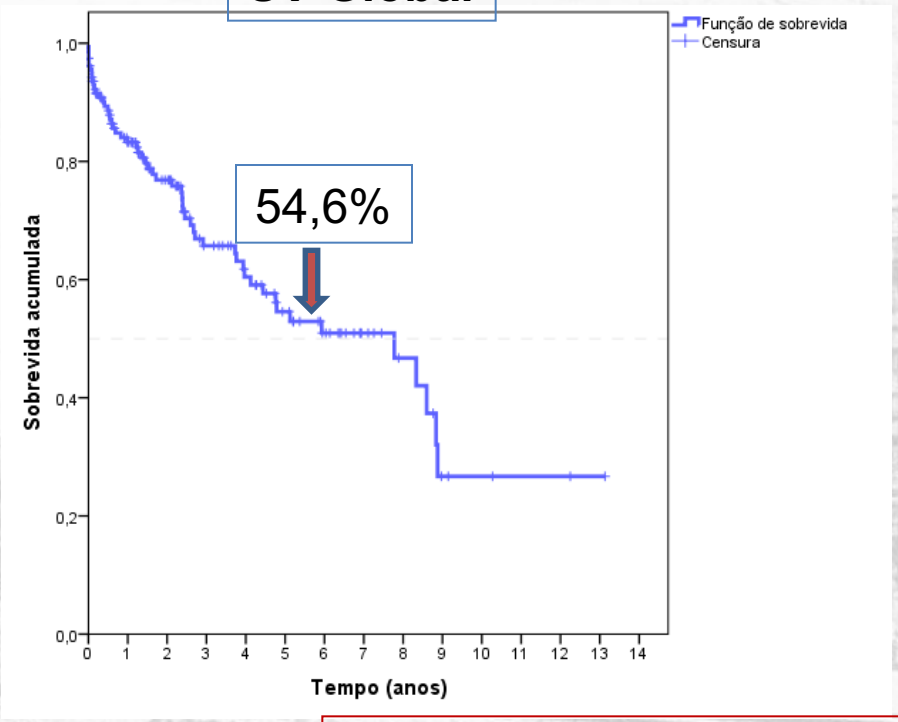
Hepatectomia laparoscópica
Com HABIB
Evolução favorável
Alta sem intercorrências

MEDICINA USP

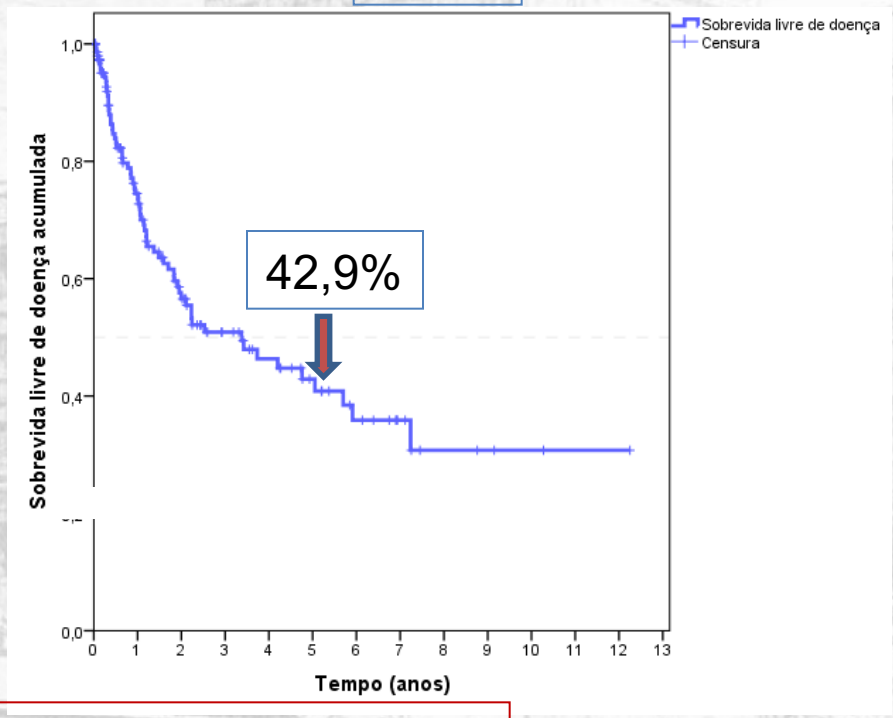
HCFMUSP 2010-2017
213 pacientes ressecados

Cirurgia minimamente invasiva

SV Global



SVLD



CHC < 5cm

SG (5a) = 56,3%; SLD (5a) = 51,2%

Cortesia: Prof. Paulo Herman (USP)

SERVIÇO DE CIRURGIA DO FÍGADO
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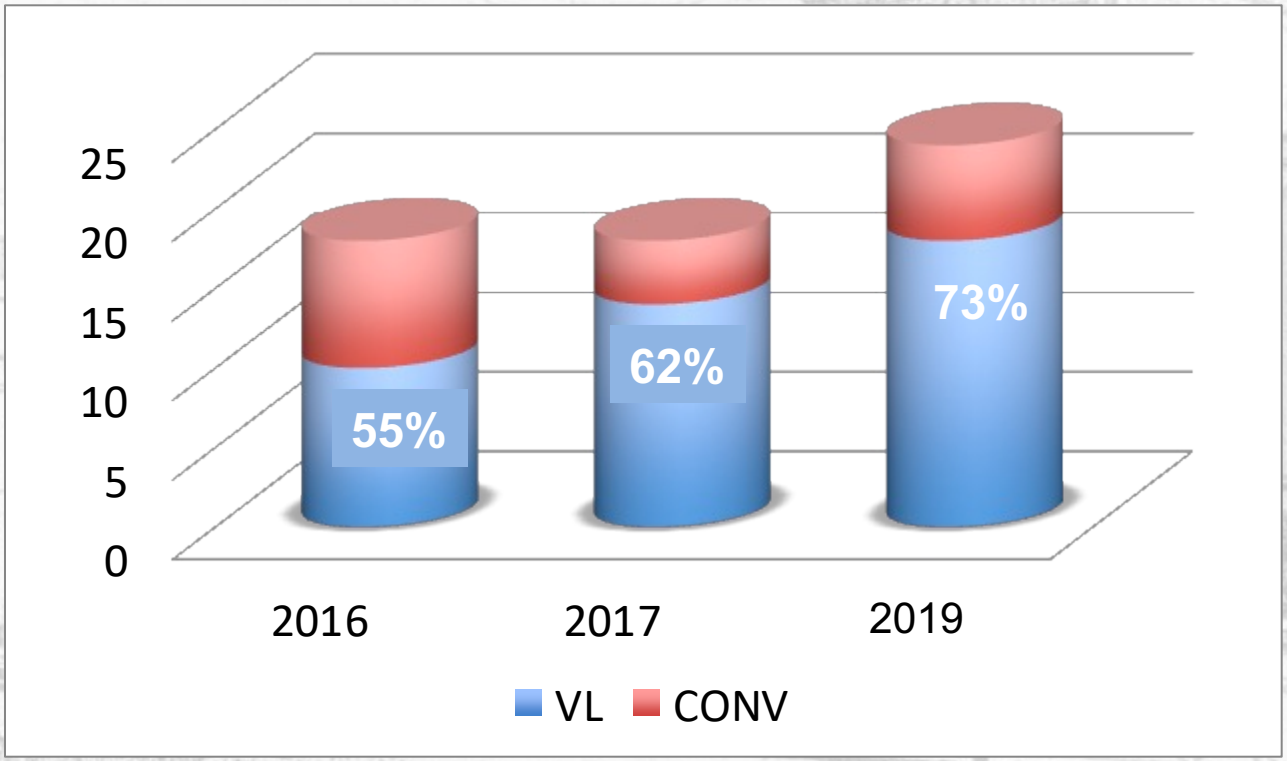
MEDICINA USP

HCFMUSP
213 pacientes com CHC ressecados
Aberta X Laparoscópica

Cirurgia minimamente invasiva



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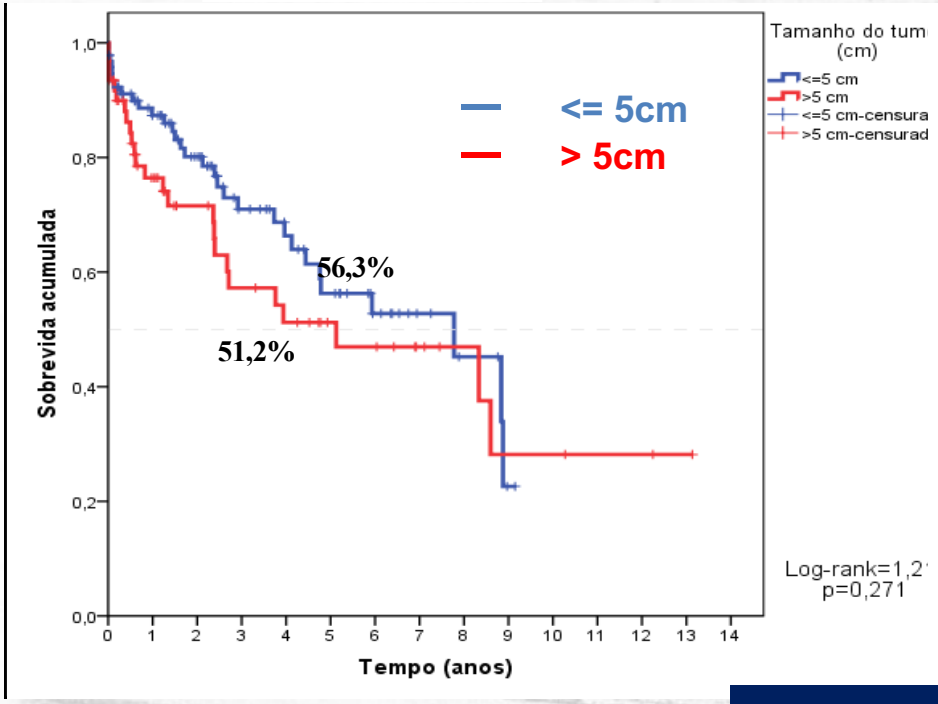
n=213 → 2010-2017

Sobrevida Global



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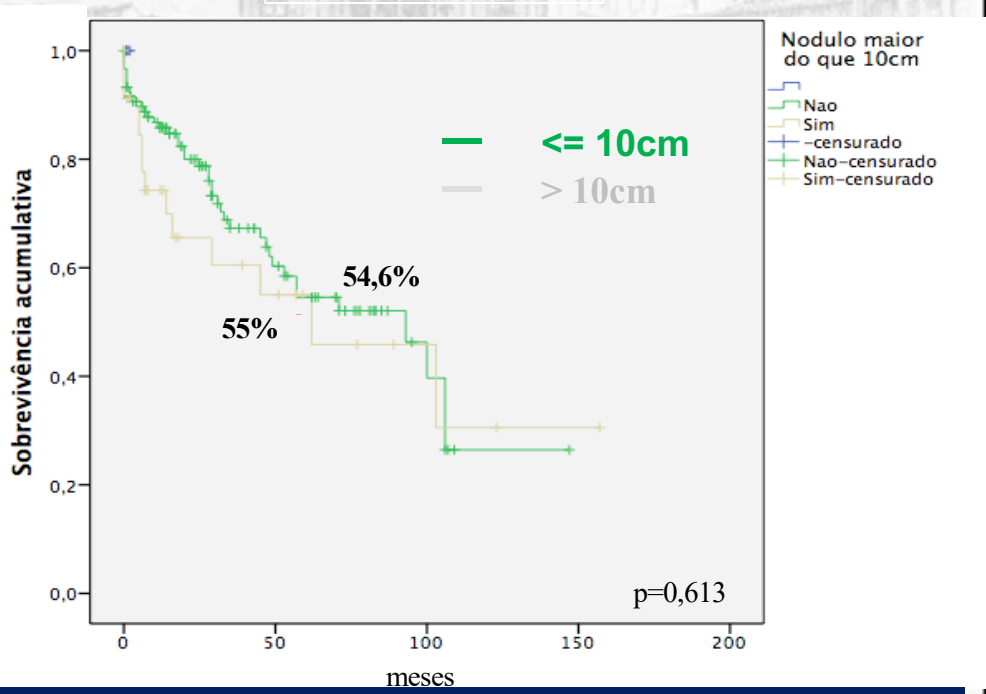
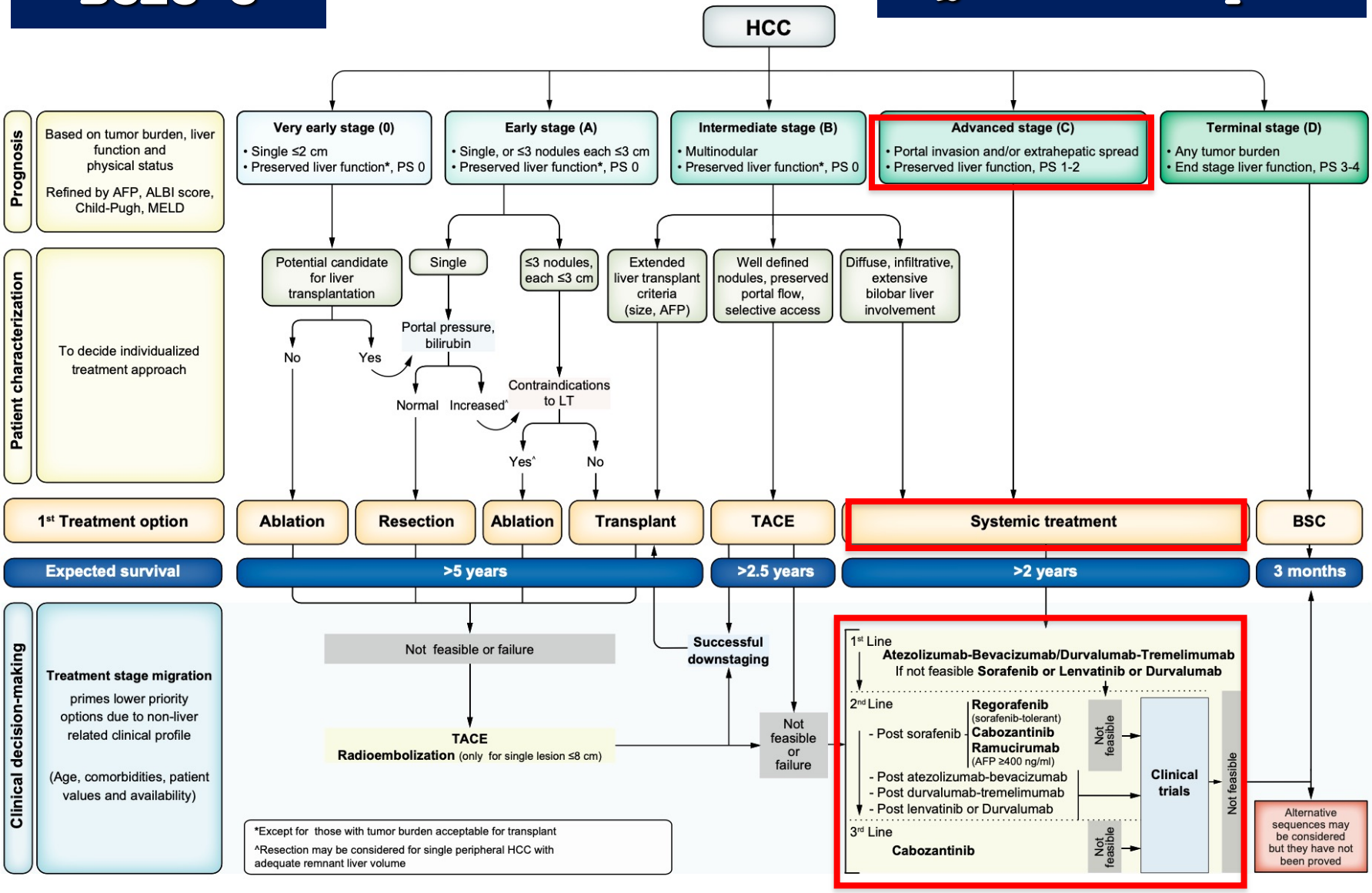


Cirurgia minimamente invasiva

Cortesia: Prof. Paulo Herman (USP)

BCLC C

Quimioterapia



Reig M, et al. J Hepatol 2022;76:681-93

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?

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.

RESSECÇÃO

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

BCLC C

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%

RESSECÇÃO

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

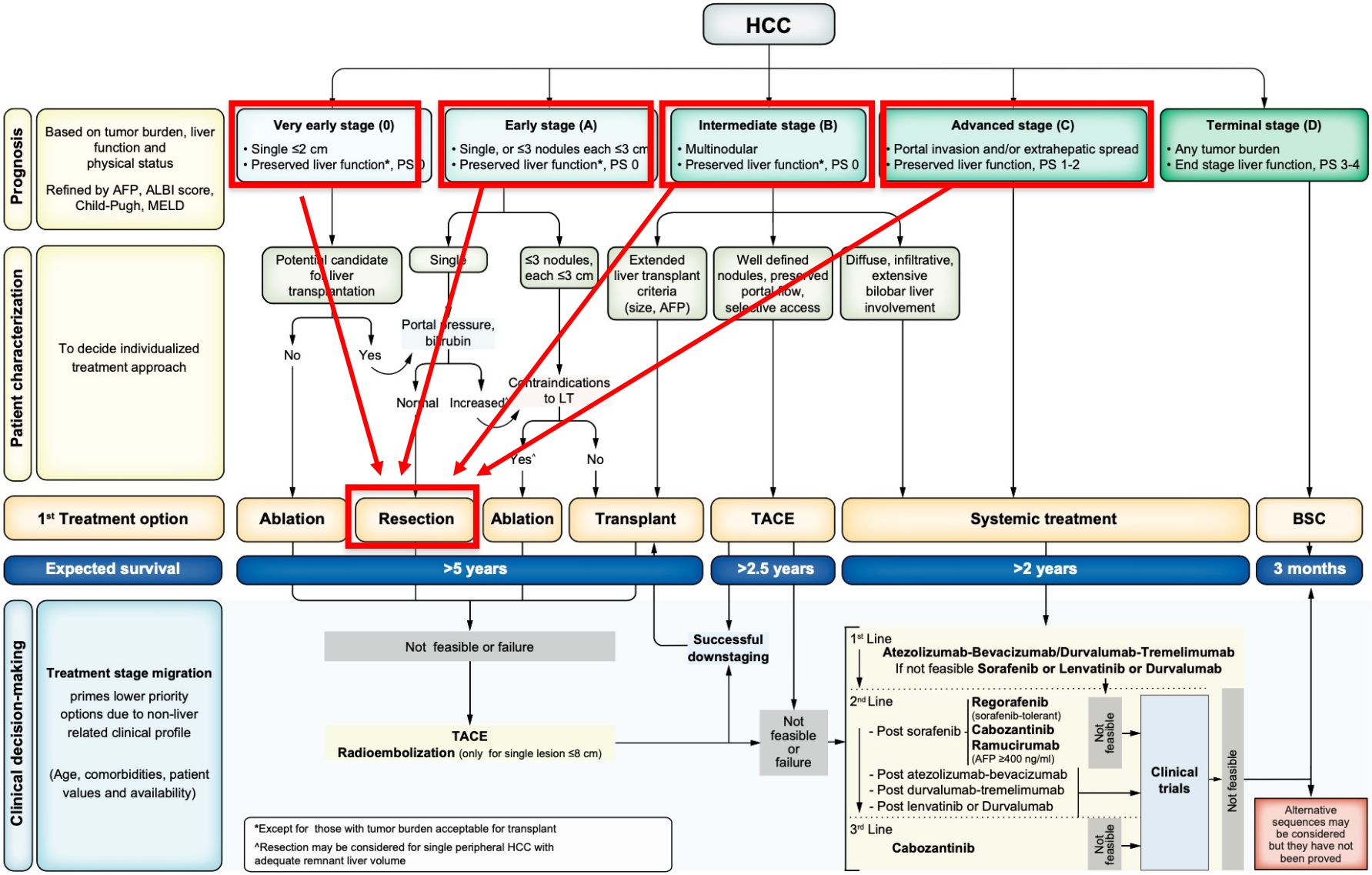
Quimioterapia

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.

RESSECÇÃO

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

Cirurgia no Carcinoma hepatocelular
Qual a situação ideal?



Reig M, et al. J Hepatol 2022;76:681-93

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