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Letter to the Editor

# Impact of delayed time from diagnosis to treatment on the stage of hepatocellular carcinoma

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*To the Editor:*

We read with interest of the article by Dr. Lim et al. [1]. The authors concluded that a delay of ≥ 3 months from diagnosis to treatment in patients with Barcelona clinic liver cancer (BCLC) 0-A stage hepatocellular carcinoma (HCC) does not affect long-term outcomes after curative resection compared with those with a delay of < 3 months. Undoubtedly, this is a challenging viewpoint, which is contrary to traditional concept – the sooner the tumor removal, the better the oncologic prognosis. Herein, we would like to raise the following comments:

First, this study only selectively reported the operative outcomes in a group of lucky patients, whose tumors did not deteriorate quickly and still stay at BCLC 0-A stage even after 3 months of the median delayed time (range: 0.6–77 months). Surprisingly, the delayed time from diagnosis to surgery was more than 4 months in 32 of all 100 enrolled patients, and the longest delayed time even reached 77 months. However, in real-world clinical settings, even small and single HCC (BCLC 0-A stage) could deteriorate rapidly into multifocal or combining portal vein invasion (BCLC B-C stage) [2–4]. Thus, we wonder how many HCCs developed from BCLC 0-A to BCLC B-C stage in the same study period at their center, and how many initially resectable HCCs turned into unresectable ones just because of the delay from diagnosis to treatment. To our experiences, preoperative states of patients with BCLC 0-A HCC was usually well adjusted within one month, and operation was performed as early as possible to avoid the progression of tumor during the time from diagnosis to surgery. Generally, patients can achieve good prognosis.

Second, the delay from diagnosis to treatment mainly results from several objective factors, such as the difficulty of specialty referral, and limited medical resources, rather than patients' own willingness. When patients were informed of cancer, most of them must seek treatment the first time. So, "the reason of delay in work up of the patient", as the authors mentioned, rarely happens in real world. It's a minor defect that the authors did not give detail reasons for these 100 patients with the delay from diagnosis to treatment. Consequently, we suggested that adding these specific information might increase the meaning of the present study.

Third, according to the BCLC staging system, if patients with HCC suffered from cancer-related symptoms, such as abdominal pain, and distinct weight loss, their performance status should be identified as score 1–2, and their HCCs should be divided into BCLC C stage rather than BCLC 0-A stage. As shown in Table 1, 24 patients of all 100 patients were diagnosed with HCC detected by symptomatic presentation. Therefore, we doubt there may be confusion or wrong in the process of data entry in this study. Further confirmation and correction are suggested to increase the accuracy of this study.

In summary, clarification regarding the above-mentioned omission would greatly solidify the conclusions of their study.

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