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Letter to the Editor

Should we invariably follow the current guidelines to treat our HCC patients?

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To the Editor:

We read with great interest the article by Dr. Vitale et al. [1], which developed an ITA.LI.CA scoring system to improve the prognostic utility for patients with re-staging hepatocellular carcinoma (HCC) before additional therapies. We appreciate the authors' work and believe that the study has important value in guiding reasonable treatments for HCC. Herein, we would like to raise the following comments.

The managements of HCC are different from those of the other tumors because of heterogeneity and complexity of the cancer, as liver undertakes several important metabolic functions. Nowadays, there have been more than 10 staging guidelines for HCC, including Barcelona Clinic Liver Cancer (BCLC) classification, Cancer of the Liver Italian Program (CLIP), and the Hong Kong Liver Cancer (HKLC) [2–4]. Although the BCLC classification has been endorsed by American and European guidelines for HCC treatment, the best tool for staging with treatment recommendations for HCC remains controversial [5–7]. As more and more people become aware of the concept of precise medicine and multi-disciplinary team (MDT), it is necessary for clinicians to realize the importance of these promising methods [8]. A previous study has shown that multi-disciplinary methods of care delivery reduce mortality and improve outcome for HCC patients [9]. Therefore, in the real world, it is highly recommended that all HCC patients be offered a multidisciplinary collaborative consultation and treatment according to their present condition, instead of being treated simply according to any current staging guideline [10]. Of note, it should not be ignored that the change in patients' HCC stage could occur after a period of treatment. When these re-staging events happened, their treatment regimen should be modified accordingly.

There are many re-staging HCC examples over time in our clinical practice. In many cases, it would be better if clinicians could sequentially adopt a variety of different treatments rather than only one single treatment for the patients according to a certain guideline. As we know, one important life-threatening complication of HCC is the spontaneous rupture of the tumor [11]. According to the BCLC classification, the ruptured HCC patient with hemorrhagic shock (performance status 3–4) should be classified as having a terminal stage HCC (BCLC stage D) and should only be given supportive care. However, one possible solution is to use transarterial embolization (TACE) in order to stop bleeding. This treatment may decrease the HCC stage and the re-stage may reach to BCLC stage A-C [12]. We therefore point out that it is inappropriate to follow the guidelines without careful evaluation of the patients' condition. Furthermore, a previous study showed that patients with ruptured HCC may even benefit from emergency liver resection, which is effective for hemostasis and cancer treatment [13].

Also, performance status plays an important role in the BCLC staging system, and patients with 1–2 performance status scores are classified as having the advanced stage HCC, thus losing the chance of curative resection. However, performance status is actually not the contraindication of hepatic resection, and many patients can still benefit from curative resection in the clinical practice. In a word, there are many potential avenues for HCC re-staging. In order to provide the re-staging patients with the best management, right time, right conditions, and right treatment are indispensable.

Thus, in the pursuit of giving the optimal treatments for our HCC patients, we should not obey the current staging guidelines rigidly.

References

[1] Vitale A, Farinati F, Noaro G, Burra P, Pawlik TM, Bucci L, et al. Restaging patients with hepatocellular carcinoma before additional treatment decisions: a multicenter cohort study. Hepatology 2018;68:1232–1244.
[2] Forner A, Reig M, Bruix J. Hepatocellular carcinoma. Lancet 2018;391:1301–1314.
[3] European Association For The Study Of The Liver European organisation for research and treatment of cancer. EASL-EORTC clinical practice guidelines: management of hepatocellular carcinoma. J Hepatol 2012;56:908–943.
[4] Liu PH, Hsu CY, Hsia CY, Lee YH, Su CW, Huang YH, et al. Prognosis of hepatocellular carcinoma: assessment of eleven staging systems. J Hepatol 2016;64:601–608.
[5] Yang T, Lau WY, Zhang H, Huang B, Lu JH, Wu MC. Grey zone in the Barcelona clinic liver cancer classification for hepatocellular carcinoma: surgeons' perspective. World J Gastroenterol 2015;21:8256–8261.
[6] Yau T, Tang VY, Yao TJ, Fan ST, Lo CM, Poon RT. Development of Hong Kong liver cancer staging system with treatment stratification for patients with hepatocellular carcinoma. Gastroenterology 2014;146:1691–1700.
[7] Adhoute X, Penaranda G, Bronowicki JP, Raoul JL. Usefulness of the HKLC vs. the BCLC staging system in a European HCC cohort. J Hepatol 2015;62:492–493.

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[8] Aronson SJ, Rehm HL. Building the foundation for genomics in precision medicine. Nature 2015;526:336–342.
[9] Serper M, Taddei TH, Mehta R, D'Addeo K, Dai F, Aytaman A, et al. Association of provider specialty and multidisciplinary care with hepatocellular carcinoma treatment and mortality. Gastroenterology 2017;152:1954–1964.
[10] Giannini EG, Bucci L, Garuti F, Brunacci M, Lenzi B, Valente M, et al. Patients with advanced hepatocellular carcinoma need a personalized management: a lesson from clinical practice. Hepatology 2018;67:1784–1796.
[11] Tanaka S, Kaibori M, Ueno M, Wada H, Hirokawa F, Nakai T, et al. Surgical outcomes for the ruptured hepatocellular carcinoma: multicenter analysis with a case-controlled study. J Gastrointest Surg 2016;20:2021–2034.
[12] Moris D, Chakedis J, Sun SH, Spolverato G, Tsilimigras DI, Ntanasis-Stathopoulos I, et al. Management, outcomes, and prognostic factors of ruptured hepatocellular carcinoma: a systematic review. J Surg Oncol 2018;117:341–353.
[13] Yang T, Lin C, Zhai J, Shi S, Zhu M, Zhu N, et al. Surgical resection for advanced hepatocellular carcinoma according to Barcelona Clinic Liver Cancer (BCLC) staging. J Cancer Res Clin Oncol 2012;138:1121–1129.

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