2nd Jaipur Surgical Festival (JSF)
HPB Oncology
2-4 December 2022
Mahatma Gandhi Medical College & Hospital (MGMCH)
Jaipur Rajasthan India

Panel Discussion - Surgical Resection for HCC

Moderator: Dr Shaleen Agarwal, Max, New Delhi
Panelists: Govind Nandakumar, Bengaluru ONLINE; Hitesh Chavda, Ahmedabad; Jayanth Reddy, Bengaluru ONLINE; Swati Purohit Joshi (Radiology), Jaipur; VG Shelat, Singapore

Liver resection (LR) is one of the curative options for early HCC in non-cirrhotic and in selected cases of cirrhotic patients.

USG abdomen can be used as a screening tool for diagnosis of HCC however smaller lesions (<2cm) can be missed out. CECT is a diagnostic of HCC especially when a lesion has characteristic enhancement pattern. MRI has higher sensitivity to detect smaller lesions and helps in cirrhotic livers. Biopsy is recommended only in indeterminate lesions or for tumour biology study purpose.

Factors to be considered prior to LR include assessment of patient comorbidities, liver parameters in terms of LFT & portal hypertension and tumour burden to decide extent of hepatectomy. Adequacy of future liver remnant must be assessed preoperatively.

Noncirrhotic liver with solitary lesion with adequate FLR would be an ideal patient for LR. Whereas in cirrhotics with CTP A or early B status, patients with MELD < 9 & ICGR <15% are considered safer candidates for LR. Preoperative fibroscan may predict PRLF. Patients having ALBI score > Grade 2 are high risk candidates. HVPG >10 mm Hg is defined as clinically significant portal hypertension (CSPH); however platelet count < 1 L/dl, spleen size > 12 cm, presence of oesophageal varices are indirect indicators of CSPH.

There are variations in guidelines as far as tumour burden is considered. EASL recommend LR in cases of a resectable solitary nodule without macrovascular invasion and extrahepatic spread regardless of its size. AASLD guidelines advocate LR in patients with CTP A and resectable T1 or T2 HCC (solitary tumour < 5 cm with or without vascular invasion or multifocal tumour < 5 cm). Meanwhile, according to APASL, all tumours without extrahepatic metastases are potentially resectable regardless of vascular invasion status, number and size of lesion.

Although there is an extension of tumour burden-related indications for LR, a complete R0 resection with an adequate FLR is advised. FLR augmentation is attempted for expected smaller remnants.

LR in cirrhotic livers is surgically challenging. Anatomical resections minimize blood loss and exhibit lesser recurrence rates but parenchyma preserving non anatomical resections are also done in selected cases. Intraoperative use of energy devices and USG guidance facilitate the surgery. Laparoscopic LR is feasible and has similar oncological results. Salvage liver transplantation for recurrence after LR can also be proposed.

Appropriate patient selection, preoperative evaluation & planning and meticulous surgery result in better outcomes.

Summary prepared by
Rapporteur
Sharvari Pujari
KEMH, Mumbai