



2013 WCGCCC CONSENSUS STATEMENTS

Care of the HCC patient should be in a multidisciplinary team consisting of a hepatologist, hepatobiliary surgeon, medical oncologist, diagnostic and interventional radiologist, and radiation oncologist, pathologists, palliative care, nursing, pharmacy and other supportive oncology professionals.

Current and Future Systemic Strategies

(J. Knox)

- 1) What is the role of systemic therapy in the overall treatment for HCC?
 - Sorafenib is the recommended treatment for ECOG 0-2 patient with C-P A liver fxn who are not candidates for local therapy (as per BCLC algorithm)
 - Consideration should be given to enrollment on clinical trials if available.

Non-Surgical Management Options for Hepatocellular Cancers

(L. Dawson, R. Owen)

- 2) When is SBRT indicated, or an option, in the treatment of liver tumours?
 - In patients who are not eligible or have progressed through other local regional treatments – SBRT can be considered in patients with adequate liver reserve and minimal or no extrahepatic disease
 - Cases should be reviewed in multi-disciplinary conference which includes a Radiation Oncologist with SBRT expertise
 - Enrollment in clinical trials is strongly encouraged (e.g.: RTOG 1112)
- 3) When should interventional radiologic strategies be employed in HCC? What is/are the preferred techniques?
 - Various IR techniques are available and best decided on in a multidisciplinary setting.
 - When patients are not surgical candidates, RFA may be considered for lesions less than 5 cm.

- TACE should be available for patients who are not candidates for surgical resection/RFA based on Level I evidence. Criteria include lack of PVT, ECOG 0-1, CP B7 or less, bili <34, minimal extrahepatic disease, adequate organ function.
- TARE can be considered as downstaging therapy for liver transplant or resection in patients with locoregional disease ECOG 0/1 with \leq B7 liver function who have failed, or who are not candidates, for TACE. PVT is not a contraindication for TARE. Enrollment in clinical trials, where available, is strongly encouraged.

4) What type of access should be available provincially and nationally for these locoregional treatments?

- Given the sub-specialized skill set needed – access should be limited to those facilities that are able to provide experienced multi-disciplinary care.
- Embolization and ablation expertise should be available in every province, and is expected standard care in any tertiary facility caring for HCC patients.
- Access to TARE and SBRT should be available to patients, but they may need to travel to centres of excellence to receive them.

Bridging to Transplant

(K. Burak)

5) Who should be considered for transplant in HCC? How should they be managed while waiting for transplant?

- Patients with early stage HCC should be evaluated by a transplant team.
- Patients should be waitlisted for transplant as per local transplant guidelines.
- RFA, TACE and other local therapies are accepted bridging techniques and should be employed within a structured transplant program.

Debate: To Biopsy or Not to Biopsy?

(R. Peixoto, R. Semelka)

6) Is a biopsy needed to confirm the diagnosis of HCC?

- HCC can usually be diagnosed with a high degree of certainty by appropriate radiologic investigation, in patients with underlying cirrhosis or chronic hepatitis B. AFP may be a useful adjunct.
- Core biopsy is not routinely indicated for patients being considered for curative surgical resection or transplant. Biopsies should be carefully considered by a transplant team in patients eligible for transplant.
- Core biopsy can be considered for those patients with non-curative disease who are eligible for systemic therapies to confirm diagnosis and/or for research purposes.

- For nonsurgical patients with atypical radiologic findings, core biopsy may be useful.

The Role of Sorafenib in Early Child-Pugh B

(J. Davies)

7) Should Sorafenib be offered to patients with HCC and early Child-Pugh B?

- Outside of a clinical trial, Child Pugh B7 or greater patients should not be routinely treated with sorafenib, due to lack of evidence.