



LIVER ALLOCATION for HCC:

Where do WE go from here ?

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1. How much PRIORITY waiting OLT for HCC??

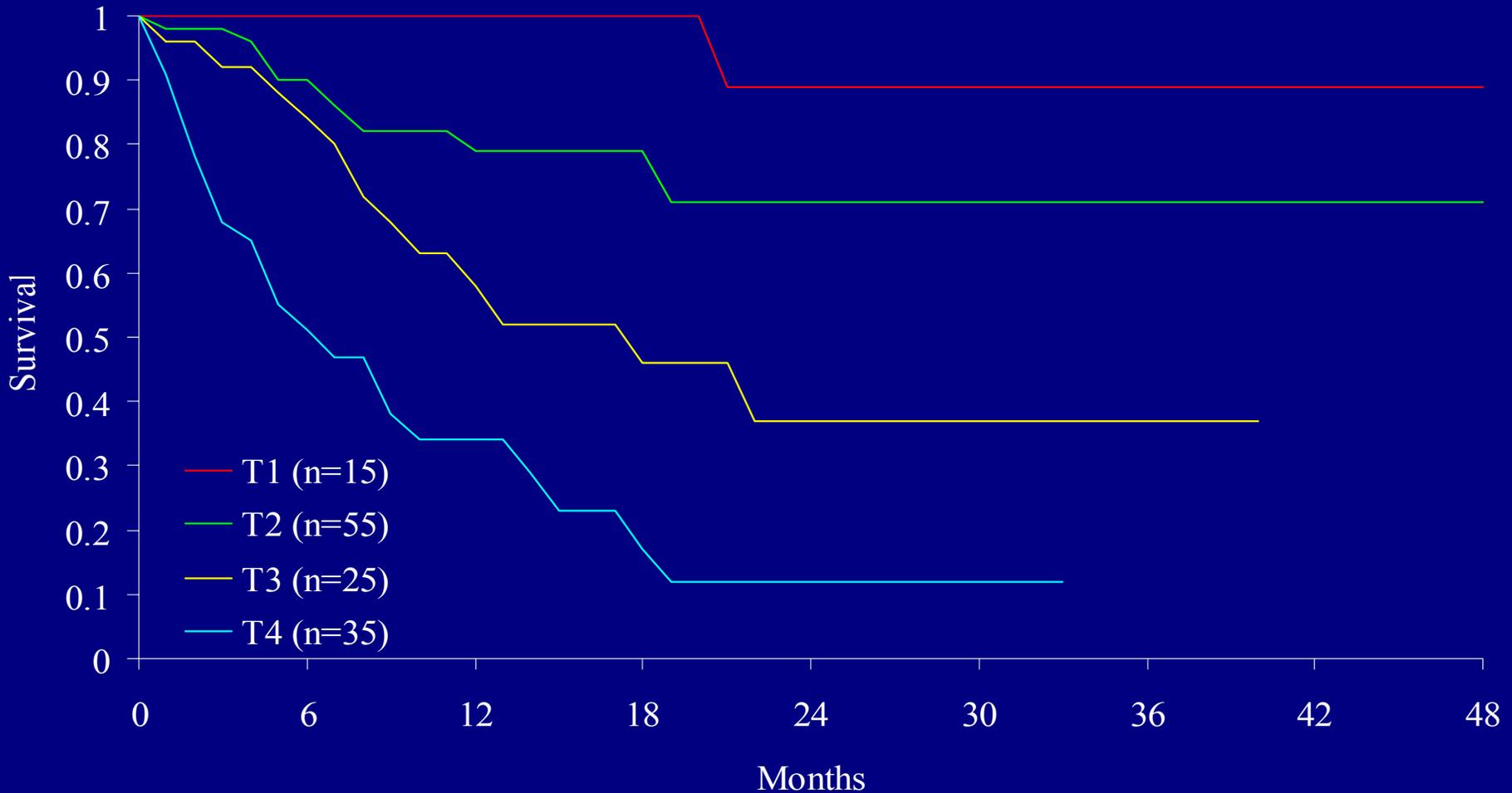
2. Should STAGING criteria change??

3. How should HCC ABLATED pts be staged??

MCV/VCU TRX HCC PROTOCOL

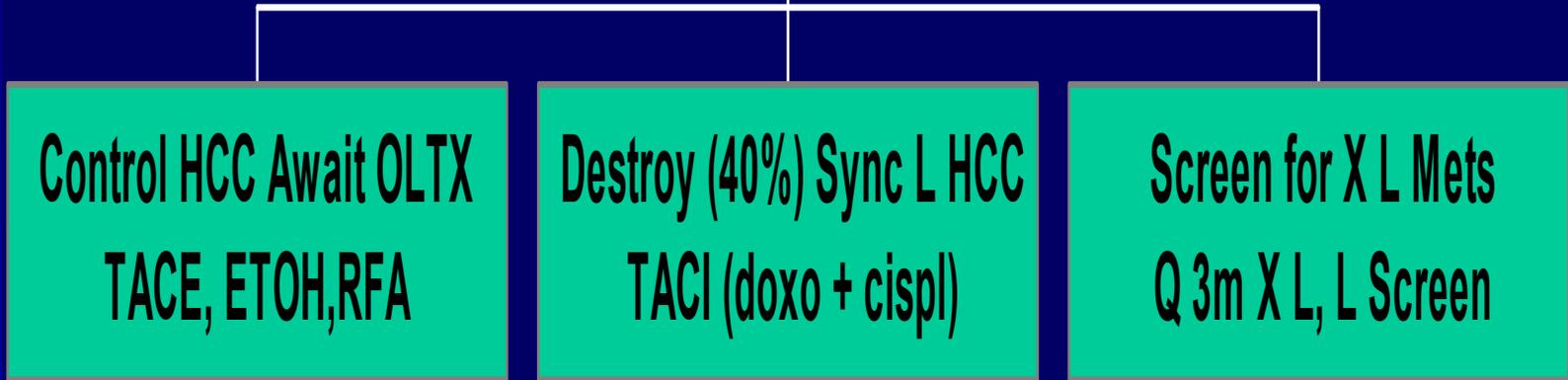
- 1/98-10/02: **Prospect**, Neoadjuv, HCC Study
- **135HCC/702** pts refer for Trx
- HCC, TNM staged; CX, CTP scored; Met w/up MRI, MRA, Ch-CT, Bone Sc-d₀, q3m.
- **TACE** (Cispl, Doxo, Ethiodol, EmboGoldumsphere)
- **TACI** (Cispl, Doxo)--2 wks after TACE, routine GCSF prn outpt.
- **RFA**, Cryo, Etoh, ± **reTACE** by MRI
- T_{1,2,3}N₀M₀ , Ch**B-C** CX → OLTx eval & List

Patient Survival by Cancer Stage



MCV/VCU TRX HCC PROTOCOL

Stage HCC
Stage Liver Reserve
(Mets, +LN, >5cm+vasc inv)
non oper



Control HCC Await OLTX
TACE, ETOH, RFA

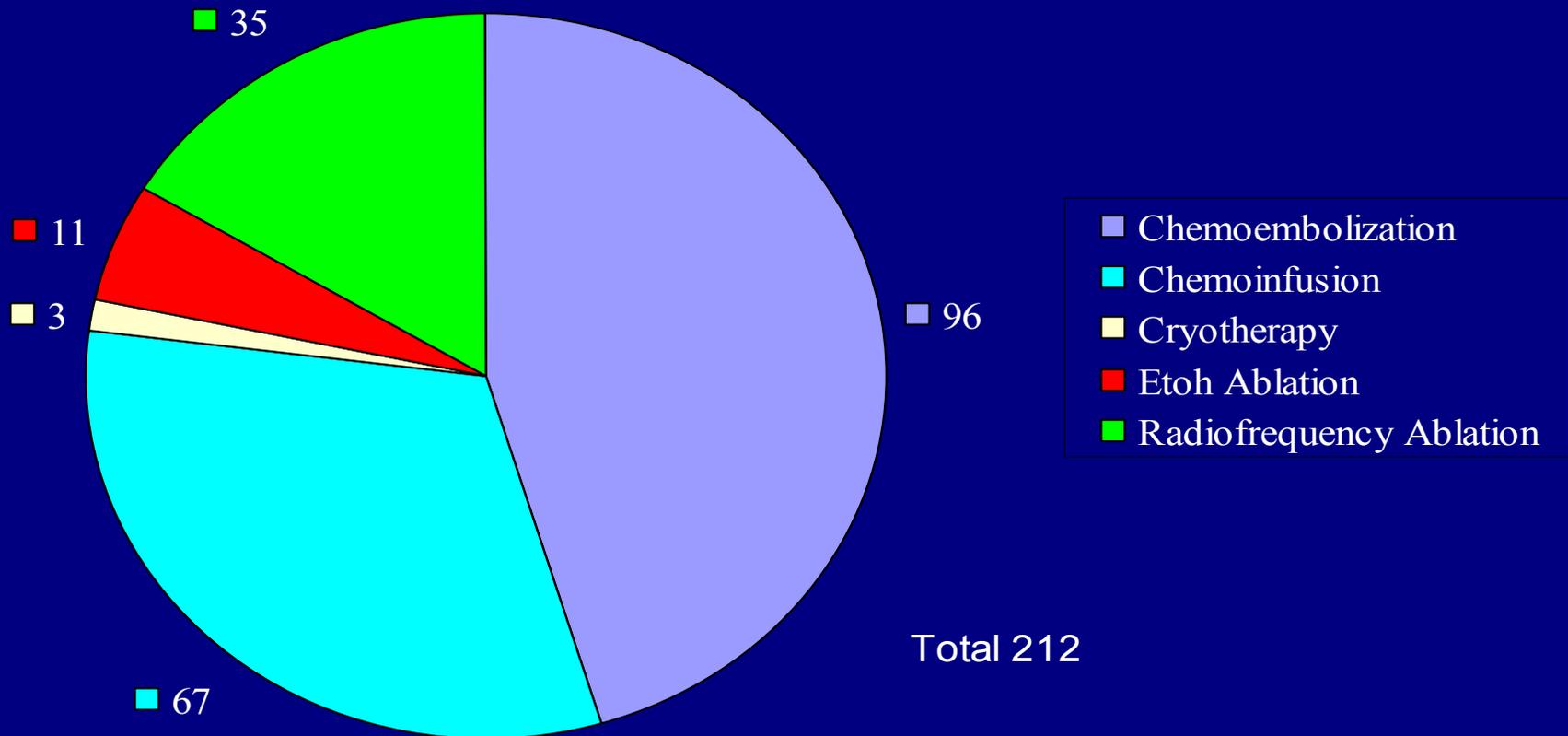
Destroy (40%) Sync L HCC
TACI (doxo + cispl)

Screen for X L Mets
Q 3m X L, L Screen

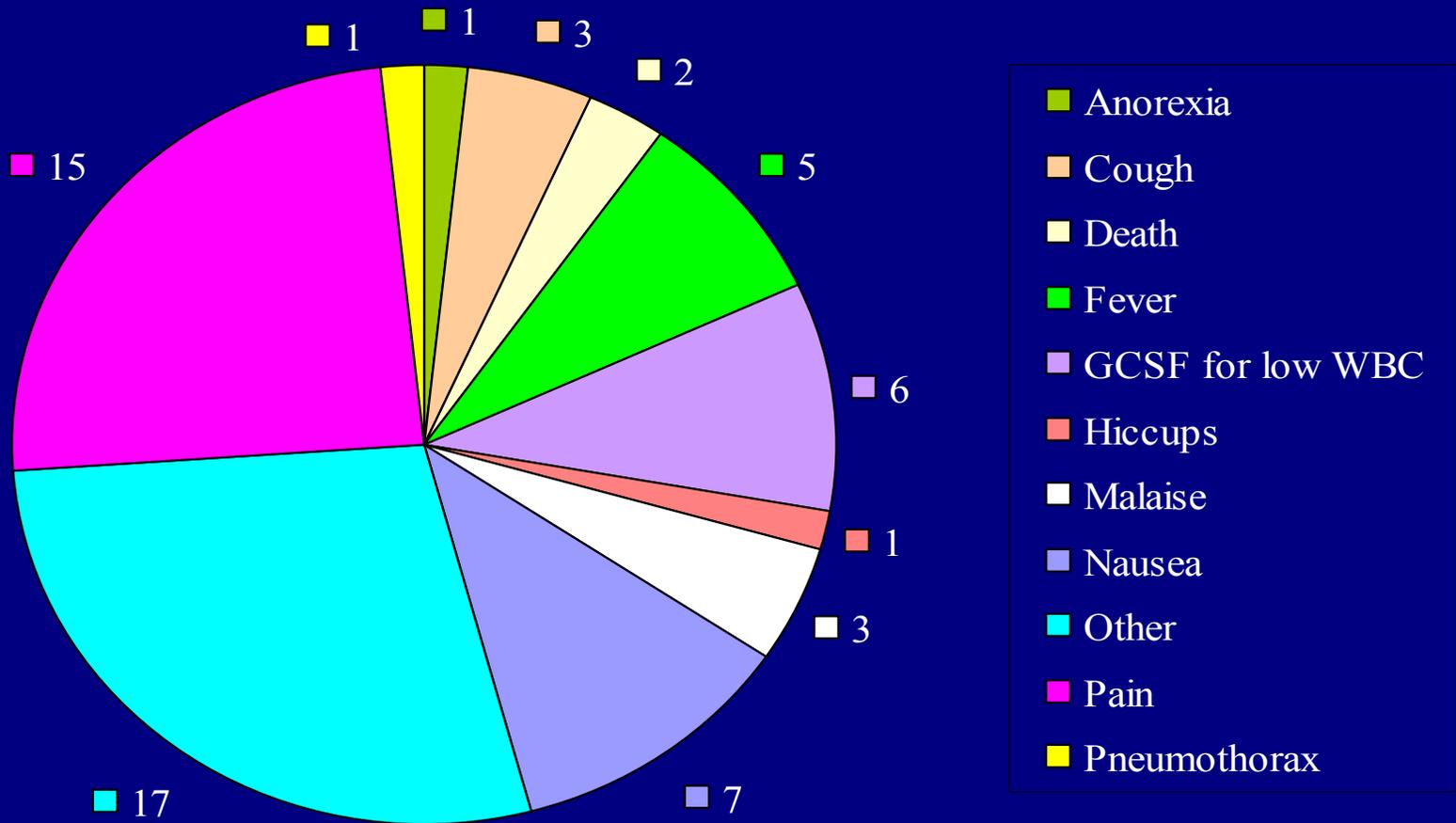
MCV/VCU TRX HCC PROTOCOL

- **I** : HCC → TACE → Resect → TACI → F-up(6)
- **II**: HCC → TACE + Ablate → TACI → F-up(3)
- **III**: HCC(Cx) → TACE + Ablate → TACI →
List (30) → OLTX (25) → F-up
- **IV**: HCC(Cx) → TACE + Ablate → TACI →
F-up(63)
- **V**: HCC (advan dz, xL mets, med morb.) →
hospice(16)
- **I**: Incidental HCC Post Trx. On Explant (12)

Ablative Procedures



Complications of Ablative Procedures

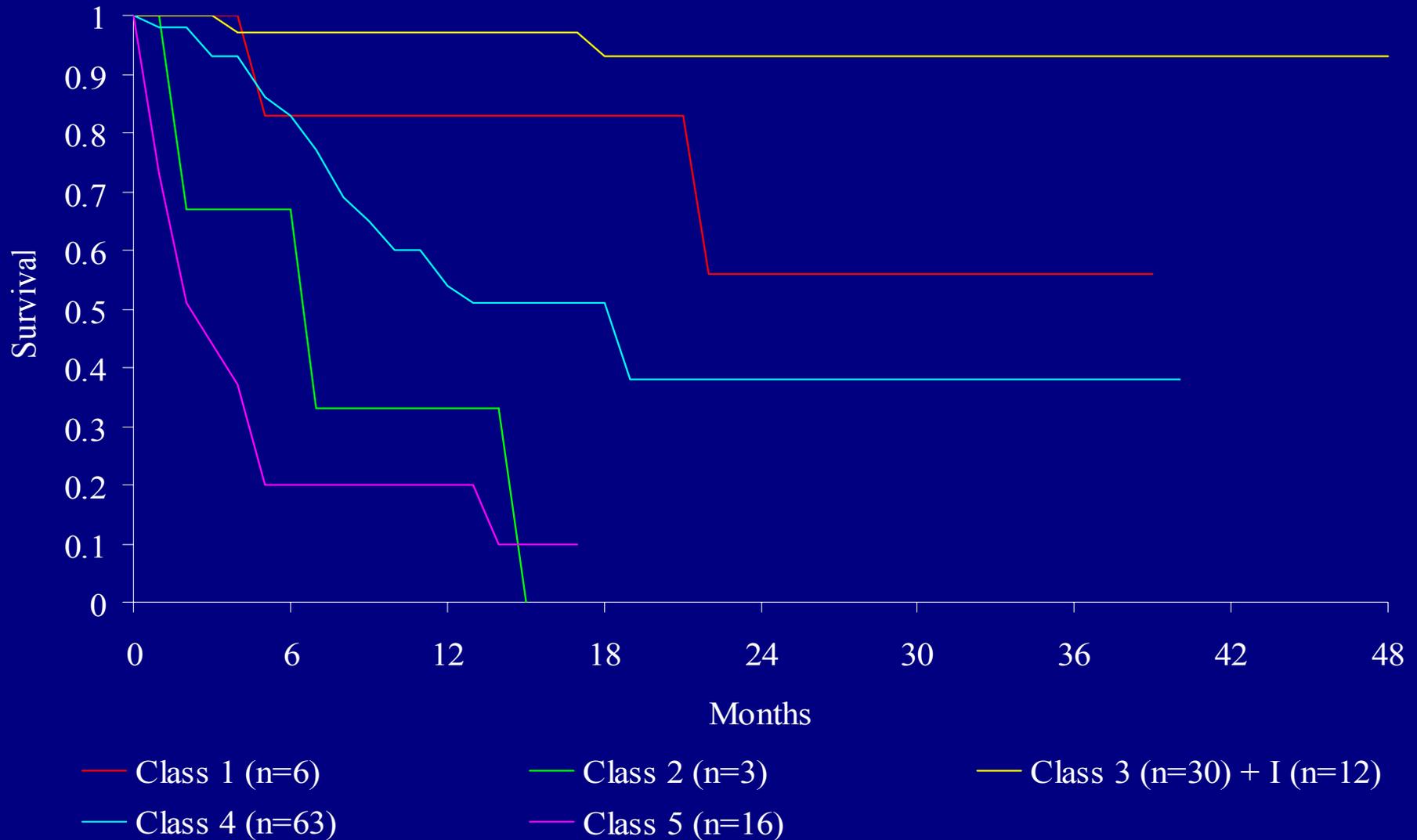


MCV/VCU TRX HCC PROTOCOL

- **Intent to treat: 1/98-10/02:** 35 pts ablated & listed.
25 pts transplanted: 34m mean f/up, **all** alive,
1 recur(30m), **7**m mean waite t., 2.6abl proced/pt.
5 pts (**14%**), delisted(m)—**5,5,5,8,14**(**3**dead: 2,HCC;
1,2^oablation).
- **Ablated HCC, OLTX(clin 3), explant path:**
Stage: T1(**6**), T2(**14**), T3(**2**), T4a(**3**). 16%<staged preop.

Histo: 22% complete HCC necr., 32HCC's/**25**explants,
56% microVasc invasion, 92%G2-3,
87.5%<10mitoses/HPF
- **Incidental HCC, OLTX(clin 3), explant path: 1/98-10/02:**
12/255t(4.7%) pts transplanted: 32m mean f/up, **all** alive,
0 recur, **13**m mean waite t., mean CTP 10pts.
Stage: T1(**4**), T2(**7**), T4a(**1**).

Patient Survival by Clinical Class



Time to XL Mets from Dx: Ablated HCC/CX, No OLTX

- T1 (5): No XL mets
- T2 (42): 5 pts, 19-637d (mean 278d (9m)), med 7m.
- T3 (20): 7 pts, 42-1091d (mean 308d (10m)), med 4m.

- Kamada K et al. Am J Surg 2002; 184 : "TACE vs TACE+PEI for T1, T2 HCC & Ch A,B CX.
32 pts, TACE+PEI:
Survival: 1yr(90%); 3yr(65%); 5yr(50%)
Recur: 1yr(42%); 3yr(69%); 5yr(84%)
Death: 8% hep fail, 92% HCC related

CONCLUSIONS: (with curative intent)

- T2 HCC (CX) should get MELD(24) priority to be transplanted within 6m.
- T1 HCC + Ch B-C CX should get MELD(20) priority to be transplanted within 6-12m.
- T3, T4a HCC (CX), ABLATED, + NO nodes & NO macrovasc invasion on RARE MRI should get MELD(24) priority to be transplanted within 6m.