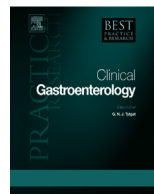
Best Practice & Research Clinical Gastroenterology 28 (2014) 921–935

Contents lists available at ScienceDirect

Best Practice & Research Clinical Gastroenterology



13

Systemic treatment

Maria Reig, MD [a, b, 1], Alessia Gazzola, MD [a, 1], Roberto Di Donato, MD [a, 1], Jordi Bruix, MD [a, b, *]

[a] Barcelona Clinic Liver Cancer (BCLC) Group, Liver Unit, Hospital Clínic Barcelona, IDIBAPS, University of Barcelona, Spain
[b] Centro de Investigación Biomédica en Red de Enfermedades Hepáticas y Digestivas (CIBERehd), Spain

Keywords:
Hepatocellular carcinoma
Systemic treatment
Patients selection
Management
Tumour response
RECIST

A B S T R A C T

In the last years the management of patients with liver cancer has been improved. The BCLC staging/treatment strategy identifies the optimal candidates for each treatment option and sorafenib is the only effective systemic treatment. Others (sunitinib, brivanib, linifanib, everolimus, ramucirumab) have failed in terms of safety/survival benefit. Some patients at intermediate/early stage, may be considered for systemic therapy when options of higher priority may have failed or not be feasible. The 800 mg/day is the recommended starting dose. Close follow-up and easy access for the patients so that they can report any adverse event and implement dose adjustments is the key point in the management of them. Development of early dermatologic adverse events has been correlated with better outcome and the pattern of radiologic progression characterizes better the prognosis/outcome of these patients. Treatment beyond progression may be considered if there is no option for a second line research trial.

© 2014 Elsevier Ltd. All rights reserved.

Introduction

Treatment of hepatocellular carcinoma (HCC) should aim to improve the survival of the patients with a proper balance between risks and benefits. The BCLC staging and treatment strategy [1,2](Fig. 1) serves this aim as it incorporates the effective options that are now fully accepted according to proper

* Corresponding author. BCLC group, Liver Unit, Hospital Clínic, C/Villarroel 170, Floor 4 Stair 11, 08036 Barcelona, Spain. Tel.: +34 93 227 9803; fax: +34 93 227 5792.

E-mail addresses: mreig1@clinic.ub.es (M. Reig), gazzola@clinic.ub.es (A. Gazzola), rdonato@clinic.ub.es (R. Di Donato), jbruix@clinic.ub.es (J. Bruix).

[1] Tel.: +34 93 227 9803; fax: +34 93 227 5792.

http://dx.doi.org/10.1016/j.bpg.2014.08.003
1521-6918/© 2014 Elsevier Ltd. All rights reserved.

data and identifies the optimal candidates for each options. The survival benefit offered by a given option should have been demonstrated through robust investigations. The optimal method is through phase 3 randomised trials that compare any proposed intervention versus the standard of care if this exists, or versus no treatment if such established approach is not available [3]. Interestingly, such high quality evidence is not available for options that aim to provide complete removal of the malignant disease (surgical resection, ablation and liver transplantation) and the evidence is based on cohort analysis with major validation by independent groups [4]. For intermediate BCLC B stage there is adequate evidence through randomized trials and metanalysis to have transarterial chemo-embolization as first option [5–7]. Until the development of sorafenib no systemic approach had shown to improve survival, and now this agent constitutes the first line intervention for patients with advanced BCLC C stage HCC and for patients with earlier stages that cannot receive the treatment that would correspond to such stage.

The BCLC staging and treatments strategy [1,2] links initial staging for prognosis estimation with the first line option to be considered. It has been reviewed in extense elsewhere [1,2,8] and in this chapter we will review the current approach for systemic treatment and the still unmet needs in this field.

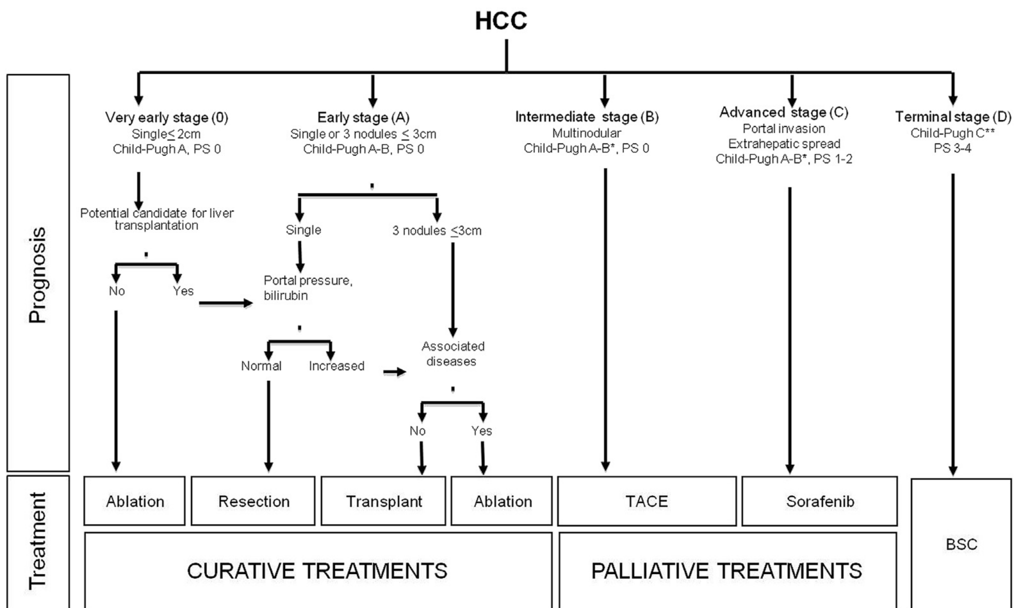


Fig. 1. BCLC staging and treatment strategy [modified from Forner et al (Lancet 2012; 379:1245–55)]. The figure represents the first approach to the evaluation of the patients with expected prognosis and initial treatment option to be considered. As shown, the upper part of the scheme defines prognosis according to the relevant clinical and tumour related parameters. Bottom part depicts the decision process to select a treatment option for first consideration. As in all recommendations, final treatment indication should take into account a detailed evaluation of additional characteristics (age, comorbidties) of the patients that imply a personalized decision making. * Note that Child-Pugh classification is not sensitive to accurately identify those patients with advanced liver failure that would deserve liver transplant consideration. Some patients fitting in Child-Pugh B, and even A, may present a poor prognosis because of clinical events not captured by such system, ie: spontaneous bacterial peritonitis, recurrent variceal bleeding, refractory ascites with or without hepatorenal syndrome, recurrent encephalopathy, severe malnutrition. ** Patients with end stage cirrhosis due to heavily impaired liver function (Child-Pugh C or earlier stages with predictors of poor prognosis, high MELD score) should be considered for liver transplantation. Among them, HCC may become a contraindication if exceeding the enlistment criteria.

Download English Version:

https://daneshyari.com/en/article/3254114

Download Persian Version:

https://daneshyari.com/article/3254114

Daneshyari.com