

Complete response with sorafenib and transcatheter arterial chemoembolization in unresectable hepatocellular carcinoma

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Abstract

Patients with advanced hepatocellular carcinoma (HCC) showing portal vein tumor thrombosis (PVTT) have an extremely poor prognosis. According to treatment guidelines, the only option for HCC patients with PVTT is sorafenib chemotherapy. However, in Asia, various treatments have been attempted and possible prolongation of overall survival has been repeatedly reported. We herein report the first case of a patient with an initially unresectable advanced HCC with PVTT who underwent curative hepatectomy after sorafenib and transcatheter arterial chemoembolization (TACE) showing complete histological response. Two months after induction with sorafenib, a significant decrease in serum alpha-fetoprotein level was observed and computed tomography imaging showed a significant decrease in tumor size. Because of remaining PVTT, TACE and curative resection were performed. The combination of sorafenib and TACE may be an effective treatment for HCC patients with PVTT.

Key words: Hepatocellular carcinoma; Sorafenib; Complete response; Portal vein tumor thrombosis; Transcatheter arterial chemoembolization

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Core tip: Patients with advanced hepatocellular carcinoma (HCC) showing portal vein tumor thrombosis (PVTT) have an extremely poor prognosis. The only proposed treatment option for HCC patients with PVTT is sorafenib chemotherapy. However, in Asia, various treatments have been attempted and possible prolongation of overall survival has been repeatedly reported. Here we report the first case of a patient with an initially unresectable advanced HCC and PVTT who underwent curative hepatectomy after sorafenib and transcatheter arterial chemoembolization (TACE) showing complete histological response. The combination of sorafenib and TACE may be an effective treatment for HCC patients with PVTT.

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INTRODUCTION

Patients with advanced hepatocellular carcinoma (HCC) showing portal vein tumor thrombosis (PVTT) have an extremely poor prognosis^[1,2]. The median survival of untreated HCC with PVTT has been reported to be 2.7-6 mo^[2,3]. According to the American Association for the Study of the Liver Disease/Barcelona Clinic for Liver Cancer Staging System and treatment guidelines, the only proposed treatment option for HCC patients with PVTT is sorafenib chemotherapy^[4]. In Asia, various treatments including hepatectomy and transcatheter arterial chemoembolization (TACE) have been attempted and possible prolongation of overall survival (OS) has been repeatedly reported^[5]. We herein report the first case of a patient with an initially unresectable advanced HCC with PVTT who underwent curative hepatectomy after sorafenib and TACE, showing complete histological response.

CASE REPORT

A 67-year-old man was diagnosed with HCC through abdominal ultrasound during examination for elevated liver enzymes by his family doctor and was referred to our hospital. The patient had no history of alcohol abuse, hepatitis B or C infection. Serum α -fetoprotein (AFP) level and protein induced by vitamin K absence or antagonist-II level were 1736 ng/mL (normal range: < 10 ng/mL) and 15388 mAU/mL (normal range: < 40 mAU/mL), respectively. Contrast-enhanced computed tomography (CT) scan revealed the presence of an 8.7 cm \times 6 cm tumor in the right paramedian sector,

showing early enhancement in the arterial phase and wash-out in the late phase together with PVTT limited to the first-order branch and invading the right portal vein (Figure 1). Right hepatectomy was considered to be necessary for curative resection. Although the patient's liver function was Child-Pugh A, the patient's indocyanine green retention rate at 15 min was 21% (normal range; < 10%) and right hepatectomy was considered to be intolerable according to our institutional criteria^[6]. Therefore, sorafenib was orally administered twice daily at a dose of 800 mg. During sorafenib treatment, the patient had no adverse event. Two months later, a significant decrease in serum AFP level was observed (195 ng/mL) (Figure 2). The CT scan showed a significant decrease in tumor size (3 cm); however, PVTT remained in the right portal vein (Figure 3). Four months later, serum AFP level decreased to within normal range (4.5 mg/mL), and 14 months later, CT scan revealed the residual PVTT in right portal vein (Figure 4). Portography revealed filling defect in S8 and digital subtraction arteriography showed irregular shaped tumor stain. Thus TACE was performed with 30 mg of miripulatin, 3 mL of lipiodol and gelatin sponge particle (Figure 5), followed by right paramedian sectionectomy. During the operation, neither the main tumor nor the PVTT was identified through intraoperative ultrasound. The operation time was 318 min and the estimated blood loss was 762 mL. The patient's postoperative course was uneventful, and he was discharged from hospital on postoperative day 11. Pathological examination revealed complete necrosis without viable tumor cells both in the scar of PVTT and the main tumor. To date, no recurrence has been observed after 12 mo of follow-up.

DISCUSSION

Sorafenib has been reported to prolong survival in patients with unresectable or advanced HCC; however, complete response (CR) was not achieved in these reports^[4,7,8]. In Asian countries, including Japan, liver resection and TACE have been reported to improve the prognosis of patients with HCC with PVTT. In the presence of PVTT, TACE is theoretically contraindicated in Western countries because of the potential risk of hepatic insufficiency that results from ischemia following TACE. However, recent studies demonstrate that TACE can be safely performed in the presence of adequate collateral circulation around the occluded portal vein^[9,10]. A median OS period after treatment with TACE was reported to be 5.6-16.5 mo in patients with HCC accompanied by PVTT^[11-13]. A median OS period after treatment with surgery was reported to be 6-19.9 mo^[14-16]. Furthermore, Minagawa *et al.*^[16] reported a high survival rate in these patients with the combination of TACE followed by hepatic resection. In the very recent paper, liver resection is associated with prolongation of overall survival of HCC with PVTT^[13].

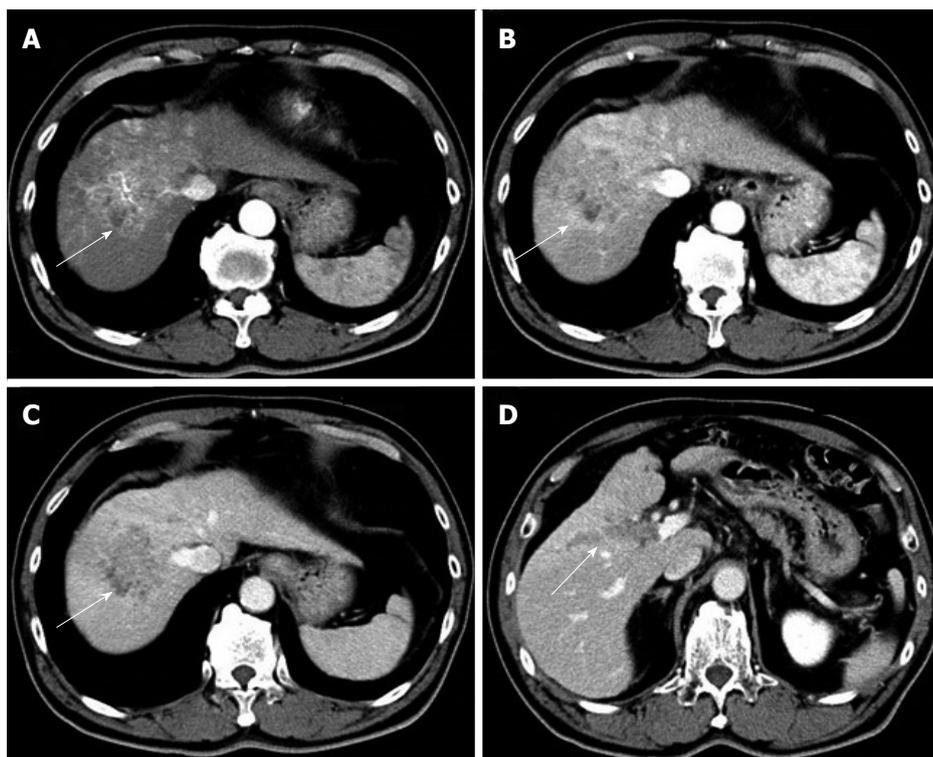


Figure 1 Contrast-enhanced computed tomography before sorafenib introduction. Heterogeneous hypervascularized tumor (A-C, arrow) in the right paramedian sector, showing early enhancement in the arterial phase and wash-out in the late phase together with portal vein tumor thrombosis (D, arrow) limited to the first-order branch and invading the right portal vein.

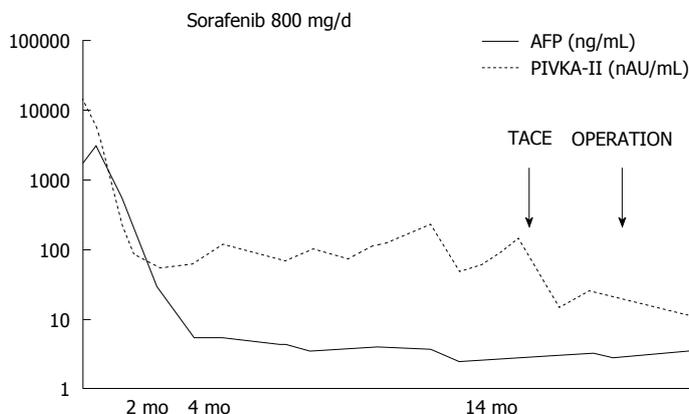


Figure 2 Clinical course as assessed by tumor markers and therapeutic events. AFP: α -fetoprotein; PIVKA-II: Vitamin K absence or antagonist-II; TACE: Transcatheter arterial chemoembolization.

Thus, TACE and surgery are the common choices of the treatment for HCC in Japan. Anticoagulants (e.g., low molecular weight heparin, warfarin and oral anticoagulant) has been reported to be effective for portal vein thrombosis^[17]. However, evidence is limited concerning the effect of anticoagulants other than anti-cancer treatment for PVTT. After treatment of HCC with PVTT with sorafenib, an OS period of 6.2-12.3 mo has been reported^[13,18]. Although CR after sorafenib treatment is rare, to the best of our knowledge, 10 cases of HCC patients with PVTT who achieved CR after treatments including sorafenib have been reported

(Table 1)^[19-27]. Four of the 10 cases underwent hepatectomy and had confirmed histological CR. Five of the 10 cases only underwent sorafenib treatment, and the other cases had other combined treatment modalities. The median time to normalized level of serum AFP was 4.5 mo (range, 2.75-6.5 mo). The median time to CR is 8 mo (range, 6-16.5 mo). All cases including ours, showed disappearance of the main tumor and PVTT. We herein report the first case of histologically confirmed CR of HCC with PVTT after sorafenib and TACE. Combination of sorafenib and TACE may be an effective treatment for HCC patients with PVTT.



Figure 3 Two months after sorafenib induction. Computed tomography showed the significantly decrease in size (3 cm) and hypervascularization (A and B, arrow), and portal vein tumor thrombosis remained in the second-order branch of portal vein (C, arrow).

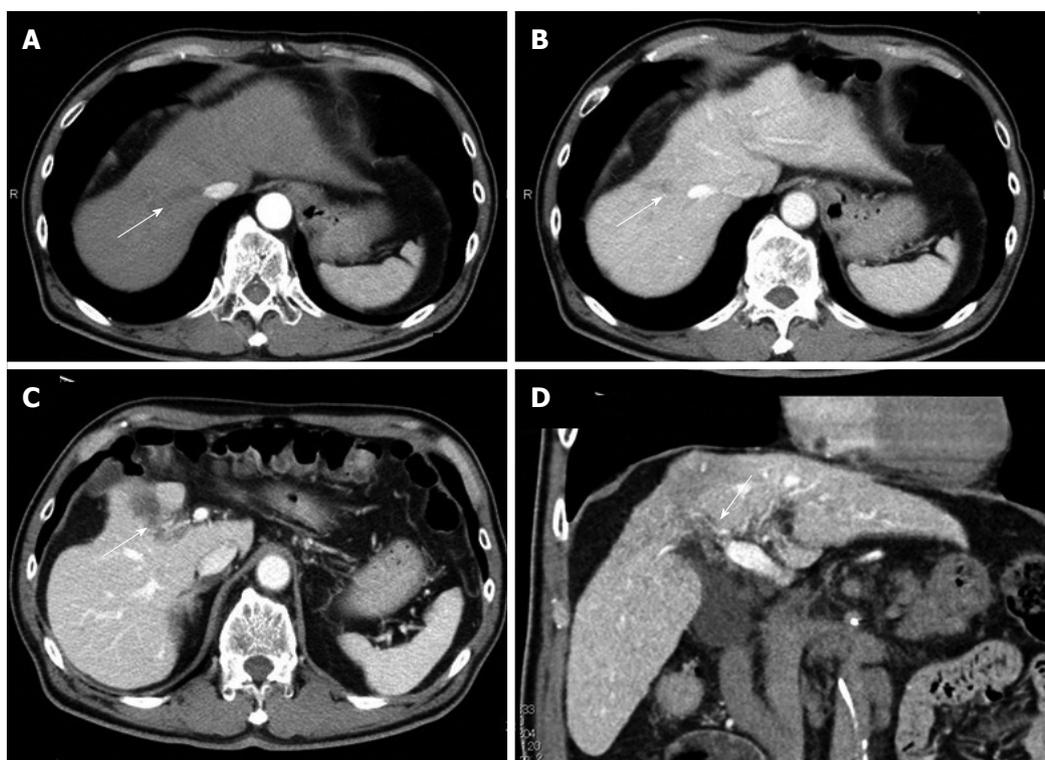


Figure 4 Fourteen months after sorafenib induction. Computed tomography revealed the tumor disappearance (A and B, arrow) and the residual portal vein tumor thrombosis (C and D, arrow) in the right anterior portal vein.



Figure 5 Angiography 14 mo after sorafenib induction. A: Portography revealed filling defect in S8 (arrow); B: Digital subtraction arteriography showed irregular shaped tumor stain (arrow); C: Transcatheter arterial chemoembolization was performed with 30 mg of mirpolutin, 3 mL of lipiodol and gelatin sponge particle.

Table 1 Cases of hepatocellular carcinoma patients with portal vein tumor thrombosis who achieved complete response in the literature

Age	Sex	Etiology	Extrahepatic metastasis	Pre-AFP	Post-AFP	Sorafenib dose	Duration (mo)	Time to CR (mo)	Resection	Other therapy	Follow-up period (mo)
54	Male	Hepatitis C	Lung	52347	30.2	800-400	5	5	+	EBRT	14
83	Male	None	Lung	41948	W.N.L.	800-400-200-100	34	8	-	TACE RFA	34
59	Male	Hemochromatosis	Little omentum LN	866	W.N.L.	800	6	6	+	HAI None	16
57	Male	Hepatitis B	None	17000	W.N.L.	800-400	12	12	+	None	12
74	Male	Hepatitis C	ND	3300	W.N.L.	400	8	8	-	None	24
84	ND	Hepatitis C	None	353	W.N.L.	800	12	6	-	None	12
69	Male	Hepatitis C	None	n.d.	ND	800-400-200	62	23	-	None	62
74	Male	None	ND	33058	2	800-400-200	19	19	-	None	19
68	Male	Hepatitis C	Dissemination	4773	45.7	800-400	28	24	+	None	40
48	Male	Hepatitis C	None	135835	W.N.L.	800	9	4	-	None	31
67	Male	None	None	3385	W.N.L.	800	14	14	+	TACE	26

AFP: α -fetoprotein; CR: Complete response; LN: Lymph node; W.N.L.: Within normal limit; EBRT: External beam radiotherapy; TACE: Transcatheter arterial chemoembolization; RFA: Radiofrequency ablation; HAI: Hepatic arterial infusion chemotherapy; ND: Not described.

COMMENTS

Case characteristics

A 67-year-old man had no symptom.

Clinical diagnosis

On physical examination, he had a palpable mass in right upper quadrant of the abdomen.

Differential diagnosis

Hepatocellular carcinoma, metastatic liver tumor, intrahepatic cholangiocarcinoma, malignant lymphoma and liver hemangioma.

Laboratory diagnosis

The patient have elevated hematological value for alkaline phosphatase (316 IU/L), Glutamic-oxaloacetic transaminase (80 IU/L), glutamic pyruvic transaminase (89 IU/L), γ -glutamyltranspeptidase (338 IU/L), α -fetoprotein (1736.3 ng/mL), protein induced by vitamin K absence or antagonist-II (15388 mAU/mL).

Imaging diagnosis

Contrast-enhanced computed tomography scan revealed the presence of an 8.7 cm \times 6 cm tumor in the right paramedian sector, showing early enhancement in the arterial phase and wash-out in the late phase together with portal vein tumor thrombosis limited to the first-order branch and invading the right portal vein.

Pathological diagnosis

Histological examination after sorafenib chemotherapy and transcatheter arterial chemoembolization showed complete necrosis without viable tumor cells both in the scar of portal vein tumor thrombosis and the main tumor.

Treatment

The patient received a sorafenib chemotherapy and transcatheter arterial chemoembolization.

Related reports

Sorafenib chemotherapy is associated with prolongation of overall survival of advanced hepatocellular carcinoma (HCC), compared with best supportive care. However, complete response after sorafenib treatment with or without other treatments is very rare.

Term explanation

Portal vein tumor thrombosis is a form of venous thrombosis affecting the hepatic portal vein, caused by tumor invasion.

Experiences and lessons

This case report presents a new choice of treatment for advanced hepatocellular carcinoma accompanying with portal vein tumor thrombosis. Combination of sorafenib and transcatheter arterial chemoembolization may be an effective treatment for HCC patients with portal vein tumor thrombosis.

Peer-review

The authors have described a case of advanced hepatocellular carcinoma with portal vein thrombosis that showed complete response after sorafenib and transcatheter arterial chemoembolization. The article provides another choice of treatment for advanced hepatocellular carcinoma.

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