

Perspective of laparoscopic liver resection for hepatocellular carcinoma

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Abstract

Liver resection (LR) for hepatocellular carcinoma (HCC) in patients with chronic liver disease (CLD) is associated with high risks of developing significant postoperative complications and multicentric metachronous lesions, which can result in the need for repeated treatments. Studies comparing laparoscopic procedures to open LR consistently report reduced blood loss and transfusions

requirements, lower postoperative morbidity, and shorter hospital stays, with no differences in oncologic outcomes. In addition, laparoscopic LR is associated with reduced postoperative ascites and a lower incidence of liver failure for HCC patients with CLD, due to the reduced surgery-induced parenchymal injury to the residual liver and limited destruction of the collateral blood/lymphatic flow around the liver. Finally, this procedure facilitates subsequent repeat LR due to minimal adhesion formation and improved vision/manipulation between adhesions. These characteristics of laparoscopic LR may lead to an expansion of the indications for LR. This editorial is based on the review and meta-analysis presented at the 2nd International Consensus Conference on Laparoscopic Liver Resection in Iwate, Japan, in October 2014 (Chairperson of the congress is Professor Go Wakabayashi from the Department of Surgery, Iwate Medical University School of Medicine), which is published in the *Journal of Hepato-Biliary-Pancreatic Sciences*.

Key words: Laparoscopic; Liver resection; Hepatocellular carcinoma; Chronic liver disease; Liver failure; Ascites; Indication; Repeat hepatectomy

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Core tip: Liver resection (LR) for hepatocellular carcinoma patients with chronic liver disease has high risks for developing significant postoperative complications and multicentric metachronous lesions with need of repeated treatments. Laparoscopic LR has advantages of reduced surgery-induced parenchymal injury and destruction of the collateral blood/lymphatic flow, which leads to reduced production of postoperative ascites, and facilitates repeat LR because of reduced adhesion formation and improved vision/manipulation between adhesions. These characteristics of laparoscopic LR may lead to expansion of the indications for LR.

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INTRODUCTION

Hepatocellular carcinoma (HCC) is among the most common primary cancers and causes of cancer-related deaths^[1,2]. The options for HCC treatment include transarterial chemoembolization and local ablation therapy^[3], but the best chance for cure is with liver resection (LR)^[4] or liver transplantation^[5]. Liver transplantation should be considered in patients with deteriorating liver function who are within the Milan criteria^[6], whereas LR should be considered for those with preserved liver function^[7,8]. However, most HCC patients are at high risk for developing significant postoperative complications and multicentric metachronous lesions with underlying chronic liver disease (CLD). For these patients, the oncologic therapeutic effects and degree of invasive surgical stress, especially to the impaired liver, should be considered during the treatments. The variety of symptoms in patients with CLD^[9] raises the risks associated with anesthesia and surgery^[10], which increase according to the preoperative Child-Pugh class^[11]. For severe CLD patients, refractory ascites often develop even with limited LR, which then leads to fatal liver failure^[12,13].

Currently, the treatment choice for an HCC patient with CLD depends on the combination of tumor and liver conditions^[14]. Nevertheless, there are still a considerable number of these patients who are unable to undergo one of the treatment modalities listed above. Such patients may benefit from less-invasive laparoscopic LR (LLR)^[15] compared to open LR (OLR)^[16]. Indeed, this procedure has recently been evaluated in a review and meta-analysis^[17], which was presented at the 2nd International Consensus Conference on Laparoscopic Liver Resection in Iwate, Japan, in October 2014 (the Chairperson of the Congress is Professor Go Wakabayashi from the Department of Surgery, Iwate Medical University School of Medicine).

OVERVIEW OF LLR

For the review and meta-analysis^[17], 2183 and 466 articles were identified under a PubMed search of "laparoscopic liver resection" and "laparoscopic liver resection + hepatocellular carcinoma," respectively. No randomized trials were available. All data were reported as case series, case-control studies, reviews, and meta-analyses. Of these, there was one Cochrane review and 81 comparative studies for LLR, as well as 12 meta-analyses for all types of indications^[18-22], colorectal metastases^[23,24], left lateral sectionectomy^[25], and HCC^[26].

In the absence of randomized studies, the Cochrane study could not draw any conclusions. The meta-analyses generally showed that LLR reduced blood loss, transfusion requirements and complication rates, shortened the hospital stay, and resulted in identical or better surgical margins than OLR. Several analyses examined long-term results and showed no differences in oncologic outcomes between LLR and OLR.

The indications for LLR are essentially the same as those for OLR. However, the centers reported in these studies identified technical feasibilities related to tumor conditions (such as size, and location) and extent of resection as the limiting factors. Typically, giant tumors (> 10-15 cm in diameter) are excluded from the indications for LLR due to the lack of appropriate view of operative field in the small abdominal cavity. Also, LR combined with major vessel resection and reconstruction and living-donor LR for transplantation are performed at only a few experienced centers. A previous international survey^[27] reported a relatively small percentage (approximately 40%) of LLR procedures with some groups of higher rates over 80%. Although the low rate and disparity of LLR application could lead to selection bias in the reported results, the studies showed that LLR generally produced better perioperative outcomes without compromising long-term oncologic outcome for the patients selected to undergo these procedures.

LLR FOR HCC WITH CLD

Patients who undergo LR are exposed to three different types of stresses that are of particular importance in patients with CLD: (1) general, whole-body surgical stress; (2) reduced liver function due to resected liver volume; and (3) surgery-induced injury to the area around the liver (caused by destruction of the collateral blood and lymphatic flow with laparotomy and mobilization of the liver) and residual liver parenchyma (caused by mesenchymal injury from the compression of the liver). With LLR, the reduced surgery-induced injury can lower the risk of refractory ascites, leading to less successive complications and a smooth recovery without liver failure.

Among the studies in the review, HCC cases were included in four meta-analyses^[26,28-30] (with 494 to 1238 patients) and 23 comparative studies^[31-53], 13 of which^[31-36,41,43,44,49-51,53] examined the rates of postoperative ascites and liver failure. We conducted a meta-analysis for postoperative ascites and liver failure in nine and six of these studies that were of a high quality^[17]. The analysis showed reduced incidences of postoperative ascites (odds ratio 0.26, 95%CI: 0.14-0.49; $P < 0.001$) and liver failure (odds ratio 0.24, 95%CI: 0.10-0.56; $P = 0.001$), which are associated with LLR.

The impact of LLR on ascites production and liver failure depends on the severity of the background CLD, extent of the resection, and the operative technique (extent of dissection of the peritoneal attachments

Table 1 Possible conditions for the expansion of liver resection indication with laparoscopic liver resection

| Patient group | Indications |
|---|---|
| Patients with severe liver dysfunction (Child-Pugh B/C) | LLR for subcapsular HCCs, particularly for the tumors on suspended ruptures LLR as the bridging therapy to liver transplantation, with the advantage of examination and evaluation of tumor pathology before transplantation LLR for HCCs in the patients with hepatitis B virus-related severe liver dysfunction without previous antiviral treatments who could acquire the recovery of liver function after antiviral treatments ^[62] |
| Patients with repeat lesions | Repeat LLR for the patients with deteriorated liver function and multicentric metachronous HCCs who have undergone multiple treatments and are usually treated with local ablation therapy, transarterial chemoembolization, or sorafenib |

HCC: Hepatocellular carcinoma; LLR: Laparoscopic liver resection.

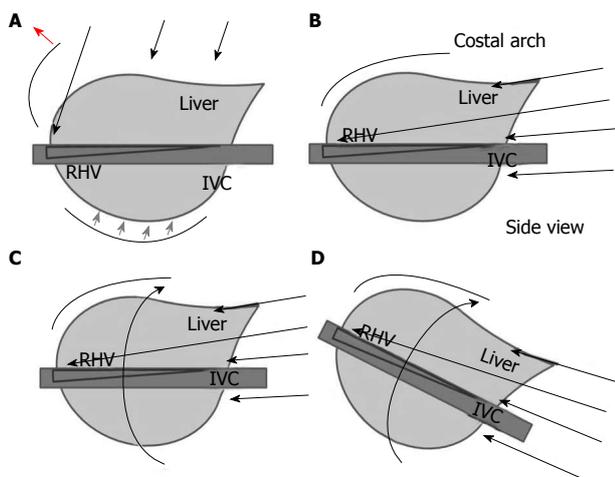


Figure 1 Specific view and approach/manipulation of laparoscopic liver surgery. A: The long arrow shows the direction of view and approach for open liver surgery. The subphrenic space is opened with a large subcostal incision plus lifting of the costal arch (red arrow) and the liver is picked up with the dissection of retroperitoneal attachments (gray arrows); B: Arrows show the direction of approach of the laparoscope and forceps; C,D: In laparoscopic liver resection, adjustments of laparoscopic view allow for fine operative fields and handling of large-volume liver/tumors by postural changes/rotation, which reduce compression of the liver parenchyma. IVC: Inferior vena cava; RHV: Right hepatic vein.

and adhesions). There are six comparative studies from five institutions in which all patients with HCC had liver cirrhosis^[31,33,36,42,45,53]. Among them, all three studies^[31,33,53] that examined postoperative ascites production showed a significant reduction with LLR. Another study compared the perioperative results after LLR between patients with severe cirrhosis (Child-Pugh B/C and ICG R15 \geq 40%) and with mild-moderate cirrhosis^[54]. Although it was a retrospective small-sized non-matched study, it showed comparable short-term outcomes, including postoperative ascites production, in these patients. The positive results from these well-designed studies examining the outcome of LLR for severe cirrhotic patients could lead to expansion of the indications for LLR.

Additional benefits of LLR in other aspects were found in other studies. The development of fewer adhesions with laparoscopic surgery was found to facilitate subsequent surgeries^[55]. With the initial LR

performed in laparoscopic approach, the subsequent salvage transplantation requires a shorter operative time, with reduced blood loss and fewer transfusions^[56]. Furthermore, recurrence with potential multicentric metachronous lesions is an important issue for HCC patients with CLD. Repeat LR increases the difficulty of LR as a result of modifications to the anatomy and the formation of adhesions. Two studies^[57,58] compared laparoscopic and open procedures with regard to repeat LR. The operating time of repeat LLR was significantly shorter with previous LLR compared to OLR. In addition, repeat LLR was associated with reduced blood loss and postoperative morbidity, and a shorter hospital stay compared with repeat OLR regardless of the approach used in the previous LR. The benefit of LLR for repeat procedures may be due to a reduced need for adhesiolysis because of the specific view and approach/manipulation of LLR (Figure 1)^[59-61]. This may also cause the reduction of surgery-induced injury on the liver and the area surrounding it.

CONCLUSION

The advantages of LLR for HCC patients with CLD include reductions of surgery-induced parenchymal injury and destruction of the collateral blood/lymphatic flow around the liver. LLR also minimizes the production of postoperative ascites and results in fewer subsequent fatal complications. The formation of fewer adhesions and improved vision and manipulation between adhesions facilitates subsequent repeat LR procedures. These characteristics of LLR may lead to expansion of the indications for LR for these patients (Table 1). However, further investigations are required to document the benefits of LLR in specific conditions.

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