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EDITORIAL

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Hilar cholangiocarcinoma

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Abstract

Hilar cholangiocarcinoma (HC) is a rare tumor. It accounts for 2/3 of the tumors of the biliary tract. Untreated, prognosis is very poor. Surgery is the only therapy that offers the possibility of cure but is technically very complex. With recent improvements in the therapeutic strategies applied by multidisciplinary teams, survival rates in the different series currently range from 25% to 45%. A group of experts devoted to HC (pathologists, gastroenterologists, radiologists, surgeons and oncologists) have reviewed and updated every open question in HC in a special issue.

Key words: Cholangiocarcinoma; Hilar; Perihilar; Klatskin; Surgery; Cancer; Review

Core tip: Most remarked avances are: imaging methods have improved diagnostic sensitivity and specificity, especially for determining biliary and vascular involvement; there have been several proposals to improve the classic Bismuth-Corlette classification; pre- and post-operative care; technical aspects trying to obtain a R0 resection: widespread use of liver resection, resection of segment I and venous and arterial resection, refinement of post-operative histology and adjuvant therapies.

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EDITORIAL

Hilar cholangiocarcinoma (HC) is a rare tumor (0.74-1.05 ×100000 inhabitants), representing 3% of gastrointestinal cancers[1,2]. It accounts for 2/3 of the tumors of the biliary tract[1]. Although HC is frequently discussed at surgical scientific meetings and arouses great interest, it has far fewer citations than other HPB cancers and several questions regarding the condition remain unanswered in the medical literature.

Untreated, the prognosis of HC is very poor. Surgery is the only therapy that offers the possibility of cure but is technically very complex[1,3]. A few years ago, the number of patients operated and resected was very low, and 5-year survival was mediocre. With recent improvements in the therapeutic strategies applied by multidisciplinary teams comprising radiologists, gastroenterologists, surgeons and oncologists, survival rates in the different series currently range from 25% to 45%[3,4].

A group of experts devoted to HC (pathologists, gastroenterologists, radiologists, surgeons and oncologists) have reviewed and updated every open question in HC in this special issue focusing in the following areas of the management and treatment of patients with HC:

Prof. Valls *et al*[5] has updated diagnostic methods in HC: Imaging methods have improved diagnostic sensitivity and specificity, especially for determining biliary and vascular involvement. These methods include multidetector computed tomography, Cholangio-magnetic resonance, percutaneous transhepatic cholangioscopy, positron emission tomography computed tomography and staging by laparoscopy reviewed by Prof. Rotellar *et al*[6].

Prof. Suarez-Munoz *et al*[7] have updated the classification/staging systems in HC: There have been several pro-

posals to improve the classic Bismuth-Corlette classification, among them the Memorial Sloan-Kettering Center system, the 7th edition of TNM, and the most complete system so far devised by de DeOliveira *et al*[2]. Correct preoperative staging is essential to identify the patients who should be operated.

Prof. Ramos[8] has devoted his paper to perioperative care and technical aspects: Several pre-operative measures have been used to minimize risks and improve results: uni- or bi-lobar pre-operative biliary drainage, the use of probiotics, autologous blood, replacement of drained bile, portal embolization, enteral nutrition, and so on[3]. The widespread use of liver resection (above 80% in the most recent series), resection of segment I, venous resection (performed in 6%-43% of patients), arterial resection, and the non-touch technique have improved survival for many reasons, but above all because they allow an increase in R0 resections.

Prof. Serrablo *et al*[9] have resumed surgical outcomes in HC: All these technical improvements have been achieved without significantly increasing morbidity and mortality[1-3]; mortality in HC surgery currently ranges between 0% and 11.9%[3,5].

Prof. Castellano-Megías *et al*[10] have reviewed the importance of an adequate and minucius pathologic study of surgical specimens in HC.

Dra. Ramírez-Merino *et al*[11] have updated the role of adjuvant treatment in HC: There have been advances in chemotherapy used, brachytherapy, photodynamic therapy, and so on.

All the authors hope that this special issue answered every question about HC that readers need to be answered.

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