

Concurrent and subsequent radiofrequency ablation combined with hepatectomy for hepatocellular carcinomas

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Received: November 10, 2009 Revised: December 25, 2009

Accepted: January 2, 2010

Published online: April 27, 2010

Peer reviewers: Zenichi Morise, MD, PhD, Department of Surgery, Fujita Health University School of Medicine, 1-98 Dengakugakubo Kutsukakecho, Toyoake AICHI, 470-1192, Japan; Michael E de Vera, MD, Starzl Transplant Institute, UPMC, Montefiore 7, South 3459, 5th Ave, Pittsburgh, PA 15213, United States

Choi D, Lim HK, Rhim H. Concurrent and subsequent radiofrequency ablation combined with hepatectomy for hepatocellular carcinomas. *World J Gastrointest Surg* 2010; 2(4): 137-142 Available from: URL: <http://www.wjgnet.com/1948-9366/full/v2/i4/137.htm> DOI: <http://dx.doi.org/10.4240/wjgs.v2.i4.137>

Abstract

Partial hepatectomy has long been the standard treatment modality for patients with hepatocellular carcinoma (HCC), although the majority of patients with HCCs are not candidates for curative resection. Radiofrequency ablation (RFA) has been widely used as the preferred locoregional therapy. RFA and hepatectomy can be complementary to each other for the treatment of multifocal HCCs. Combining hepatectomy with RFA permits the removal of larger tumors while simultaneously ablating any smaller residual tumors. By using this combination treatment, more patients might become candidates for curative resection. For treating recurrent tumors involving the liver after hepatectomy, RFA has been performed recently instead of transcatheter arterial chemoembolization or ethanol ablation. Many retrospective studies on the combination of RFA and hepatectomy demonstrate favorable results of effectiveness and safety. However, further investigation of prospective design will be needed to confirm these encouraging results.

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Key words: Radiofrequency ablation; Hepatocellular carcinoma; Hepatectomy; Combination treatment

INTRODUCTION

Liver transplantation is the most effective treatment modality for patients with hepatocellular carcinoma (HCC), as it not only completely removes HCCs in the liver but also treats the underlying cirrhosis^[1]. However, transplantation has been performed restrictively owing to a shortage of donors and the long waiting time^[1]. Thus, partial hepatectomy has long been the standard treatment modality for patients with HCCs. However, the majority of patients with HCCs cannot undergo curative resection owing to inadequate functional hepatic reserve, multifocality, or both^[1-4].

Among many locoregional treatment modalities, transcatheter arterial chemoembolization (TACE), ethanol ablation and radiofrequency ablation (RFA) have been widely used. TACE is usually applied to patients with multiple tumors and relatively preserved function of the liver whilst ethanol ablation and RFA is usually performed on patients with a small number of tumors^[1-4]. RFA is increasingly used as the preferred therapy because it produces more consistent local tumor control and good survival results^[5-9]. Moreover, several recent studies reported that RFA might achieve long-term survival results similar to those for resection for small HCCs^[10-14]. A most recent report asserted that RFA can be considered the treatment of choice for patients with single 2 cm or smaller HCC, even when surgical resection is possible^[15].

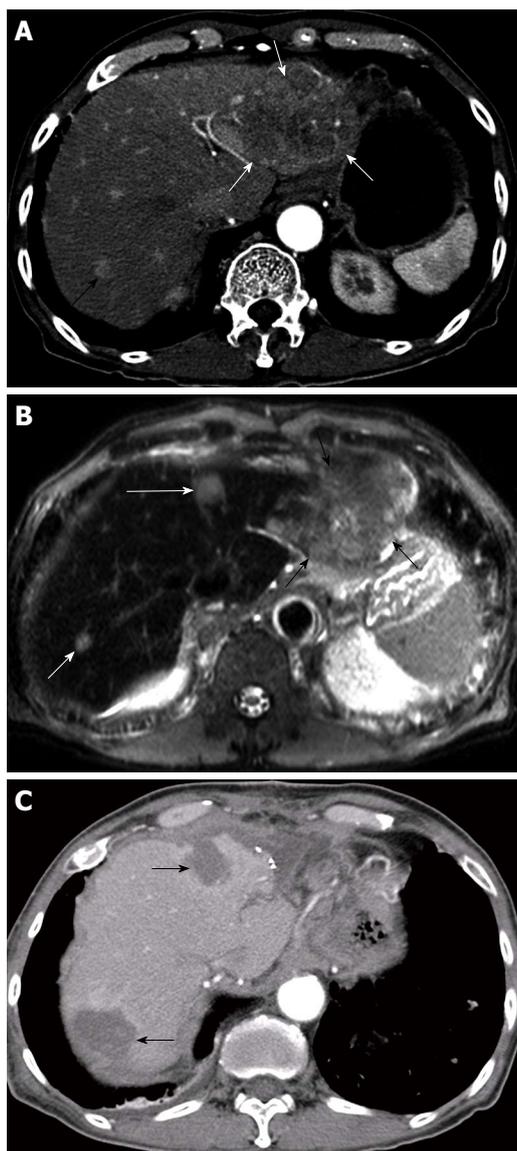


Figure 1 Successful radiofrequency ablation (RFA) combined with hepatic resection for multifocal hepatocellular carcinomas (HCCs) in a 74-year-old man. A: Contrast-enhanced transverse helical CT scan obtained during the arterial phase before treatment shows two HCCs in the both hepatic lobes. There are 11.0-cm-diameter HCC (white arrows) in left lateral segment and 1.1-cm-diameter HCC (black arrow) in liver segment 7; B: Ferucarbotran-enhanced T2-weighted fast spin echo MR image shows another 1.5-cm-diameter HCC (long white arrow) in liver segment 4. He underwent resection for a large tumor and concurrent RFA for two small tumors; C: Contrast-enhanced transverse helical CT scan obtained 1 mo after combined hepatectomy and RFA shows two round ablation zones (arrows) of low attenuation that suggests technical success of ablation. At 4 mo after treatment, multiple metastatic tumors were found in the both lungs (not shown).

PRINCIPLE OF CONCURRENT RFA AND HEPATECTOMY

RFA is competitive with hepatectomy in the treatment of small HCCs, although RFA and hepatectomy can be complementary to each other for the treatment of multifocal HCCs^[16]. In order to permit complete treatment of unresectable multifocal hepatic tumors including metastases from colorectal cancer, RFA or other locoregional

therapies combined with hepatic resection have been introduced^[17-20]. A prior report proposed that reduction surgery allowed a survival benefit for patients with multiple HCCs when combined with intraoperative adjuvant therapy for remaining satellite tumors^[20]. This study found that the cumulative survival results of these patients with reductive hepatic resection were better than those of patients treated non surgically with TACE or ethanol ablation. Figure 1 shown a RFA combined with hepatic resection for multifocal HCCs in a 74-year-old man.

When compared to colorectal liver metastasis, combining hepatectomy with RFA may play a more important role in treating HCC because of the high frequency of multifocal tumors and associated liver cirrhosis^[16]. In a previous study of patients with bilobar HCCs, combined resection of HCC in one lobe and wedge resection or ethanol ablation of lesions in the contralateral lobe showed better long-term survival than nonsurgical treatments^[21]. However, wedge resection for contralateral lobe lesions can be performed only for superficial tumors, and ethanol ablation is reported to be inferior to RFA in terms of local tumor control. RFA is a better modality for treatment of contralateral lesions and can be performed for deep tumors^[16].

In patients with multifocal HCCs that are untreatable with hepatectomy alone, the dominant tumors are resected first, and the remaining small tumors can be treated simultaneously with RFA. This makes more patients potential candidates for curative resection. All sonographically-detectable small tumors can be completely eradicated with preserving hepatic reserve^[22,23]. Intraoperative RFA can be performed for some tumors ineligible for percutaneous RFA. Tumors near the hepatic hilum, stomach, colon, or diaphragm can easily be treated with intraoperative RFA.

CLINICAL RESULTS OF CONCURRENT RFA AND HEPATECTOMY

Recently, Choi *et al*^[22] reported good perioperative results and long-term survival in a series of 53 patients who had undergone combined hepatectomy and RFA for multifocal HCCs. During a single operation, as well as hepatectomy the intraoperative RFA procedures were performed for one or more (up to three) of 59 small (4 cm or smaller in maximum diameter) unresectable HCCs^[22]. This study also found that resected tumor size was a significant prognostic predictor of long-term survival. They confirmed an important role for RFA in enhancing the chance of curative treatments for patients with multifocal tumors that might traditionally be considered unresectable.

In patients with HCC in a cirrhotic liver, preoperative evaluation including Child-Pugh classification, indocyanine green retention test, and volumetric analysis is essential^[2,3,24-29]. Although survival after resection for properly selected candidates can reach 70% at 5 years^[2], large series of resections for HCCs reported moderate or good, 3-year and 5-year survival rates between 51%-73% and 34%-59%, respectively^[29-32]. Choi *et al*^[22] demonstrated that resection plus RFA provided long-term survival comparable to that with hepatectomy alone. This study

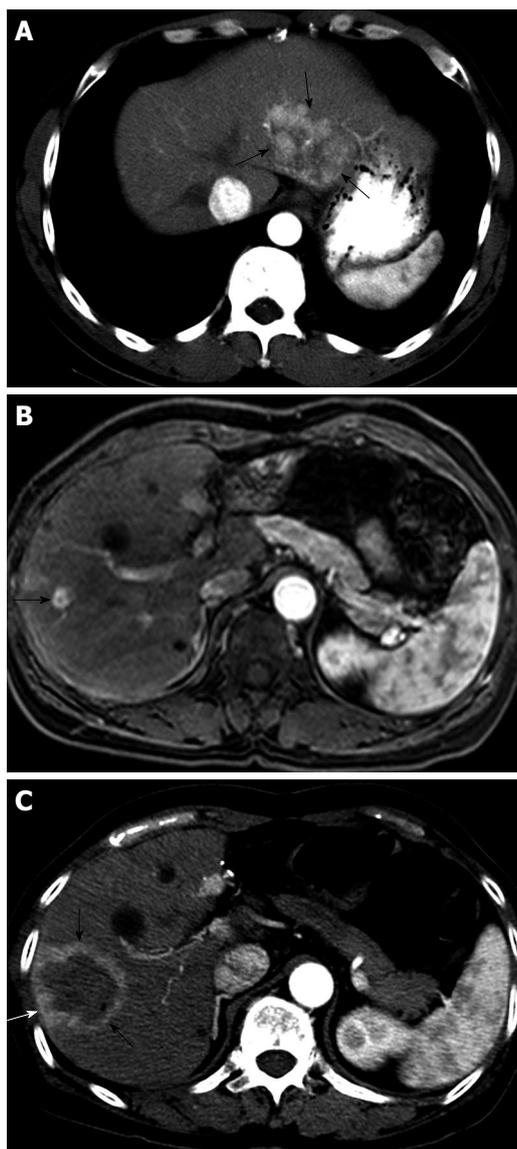


Figure 2 Successful RFA of intrahepatic recurrent HCC in a 49-year-old man. A: Contrast-enhanced transverse helical CT scan obtained during the arterial phase before hepatectomy shows a 5.7-cm-diameter HCC (arrows) in left lateral segment; B: At 5 years after left lateral segmentectomy, Gd-EOB-DTPA-enhanced T1-weighted MR image obtained during the arterial phase before RFA shows a 1.0-cm-diameter recurrent HCC (arrow) in liver segment 8; C: Contrast-enhanced transverse helical CT scan obtained 1 h after RFA shows a round ablation zone (arrows) of low attenuation with peripheral rim hyperemia. The patient has been alive without recurrence for 14 mo.

reported that the cumulative survival rates at 1, 3 and 5 years were 87% 80% and 55%, respectively. However, in spite there being only one case with incomplete ablation and two others with local tumor progression after ablating 66 tumors, the 5-year cancer-free survival was 0%. Either tumor recurrence at the other parts of the liver or extrahepatic metastasis is very common where multifocal HCCs are treated. Although small recurrent tumors in the liver could possibly be ablated, novel adjuvant therapies such as sorafenib may be needed^[33-35].

Despite the theoretical appeal of combining hepatectomy with RFA, safety can be a concern because both resection and intraoperative RFA are procedures that may

potentially cause morbidity^[22,23]. Choi *et al.*^[22] reported no operative mortality and an 8% of major complication rate in a study of combined hepatectomy and RFA for multifocal HCCs. Their selection criterion for lobectomy of 10% or less indocyanine green retention at 15 min is conservative. The strategy of hepatectomy and RFA may reduce the surgical risk when compared with an extended resection, although this is still a high-risk procedure in patients with limited hepatic reserve.

RFA FOR RECURRENT HCCS AFTER HEPATECTOMY

Another combination treatment is subsequent RFA for recurrent HCCs after hepatectomy. In spite of curative hepatectomy, recurrent tumors are found in more than 70% of patients within 5 years after hepatectomy, and repeat hepatectomy is recommended for intrahepatic recurrence^[36-42].

However, this is not feasible in the majority of patients because of significant hepatic dysfunction or multiplicity of recurrent HCCs^[41,43-45].

In the past, such patients underwent TACE or ethanol ablation^[45-48]. Recently, RFA has increasingly been performed for treating recurrent tumors in the remnant liver after hepatectomy^[49-54]. In addition to some initial reports introducing the possibility of RFA to treat recurrent HCCs after hepatectomy^[49-51], a study with 45 patients documented that the 3-year survival rate after percutaneous RFA for recurrent HCCs after hepatectomy was 54%^[52]. Lu *et al.*^[54] also reported on the long-term survival results of 72 patients who underwent percutaneous microwave ablation ($n = 33$) and RFA ($n = 39$). The overall survival rates at 3 years and 5 years after thermal ablation were 43% and 18%, respectively. In another study, the 3-year survival rate after percutaneous RFA for recurrent HCCs after hepatectomy was 44%^[55].

Repeat hepatectomy may promise complete resection of intrahepatic recurrences, and any extrahepatic lesions in the abdominal cavity can also be explored. However, this operation is more difficult to perform than an initial hepatectomy, and it results in increased risks of postoperative morbidity and mortality^[38,41]. In prior reports on repeat hepatectomy for recurrent HCCs, the 3-year and 5-year survival rates were 56% to 83% and 40% to 52%, respectively^[38,39,41,56,57]. A recent study of RFA for recurrent HCCs after hepatectomy in 102 patients demonstrated comparable long-term survival results (65.7% and 51.6% at 3 and 5 year, respectively)^[53]. This study also showed that the primary effectiveness rate was 93.3% (111 of 119) and the cumulative rate of local tumor progression at 5 years was 11.9%. In this study, liver abscess is the only complication, which can be related with bilioenteric anastomoses following surgical procedures^[58]. When percutaneous RFA is performed for recurrent HCCs abutting the gastrointestinal tract, bowel perforation frequently occurred due to postoperative adhesion^[59,60]. Figure 2 shown a successful RFA of intrahepatic recurrent HCC in a 49-year-old man.

In three studies with large populations, long-term survival of patients with HCCs treated with percutaneous RFA as a first-line treatment depended upon the Child-Pugh class, serum α -fetoprotein (AFP) level, age, tumor size, and multiplicity of tumors^[61-63]. In addition, several prior reports suggested various prognostic factors after surgical resection for HCCs^[24,29,64-66]. Among them, histopathologic grading of resected HCCs, tumor size, Child-Pugh class, fibrosis staging of the liver, serum AFP level, and microvascular invasion were generally considered to be prognostic predictors. However, in a recent study of RFA for recurrent HCCs after hepatectomy by Choi *et al.*^[53] serum AFP level before RFA and resected tumor size were independent significant predictive factors of long-term survival. Lu *et al.*^[54] reported that the pre-ablation serum AFP level was the only prognostic predictor.

CONCLUSION

For the treatment of multifocal HCCs and recurrent HCC, RFA can be complementary to hepatectomy. In fact, most patients with HCCs received multimodal approaches to treatment that included hepatectomy, TACE, RFA, ethanol ablation, microwave ablation, radiation therapy, or systemic chemotherapy, either in sequence or combination^[35,67]. Aggressive combination treatment by concurrent RFA and hepatic resection may enhance the chance of curative treatments for patients with multifocal tumors that are traditionally considered unresectable. However, further investigation should compare the outcome of hepatectomy plus RFA with that of hepatectomy alone to see whether the survival results are truly comparable^[6]. For recurrent HCCs in patients who were not eligible for repeat hepatectomy, RFA should be considered. However, it remains unclear whether percutaneous RFA can replace repeat hepatectomy as the standard treatment for small, resectable, recurrent HCCs. For this issue, randomized controlled trials that compare RFA and repeat hepatectomy would be needed.

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