STGE
Association Tunisienne de Gastro-Entérologie
الجمعية التونسية لأمراض الكبد و الجهاز الهضمي

Hepatocellular carcinoma EASL 2024

EASL
Recommendations

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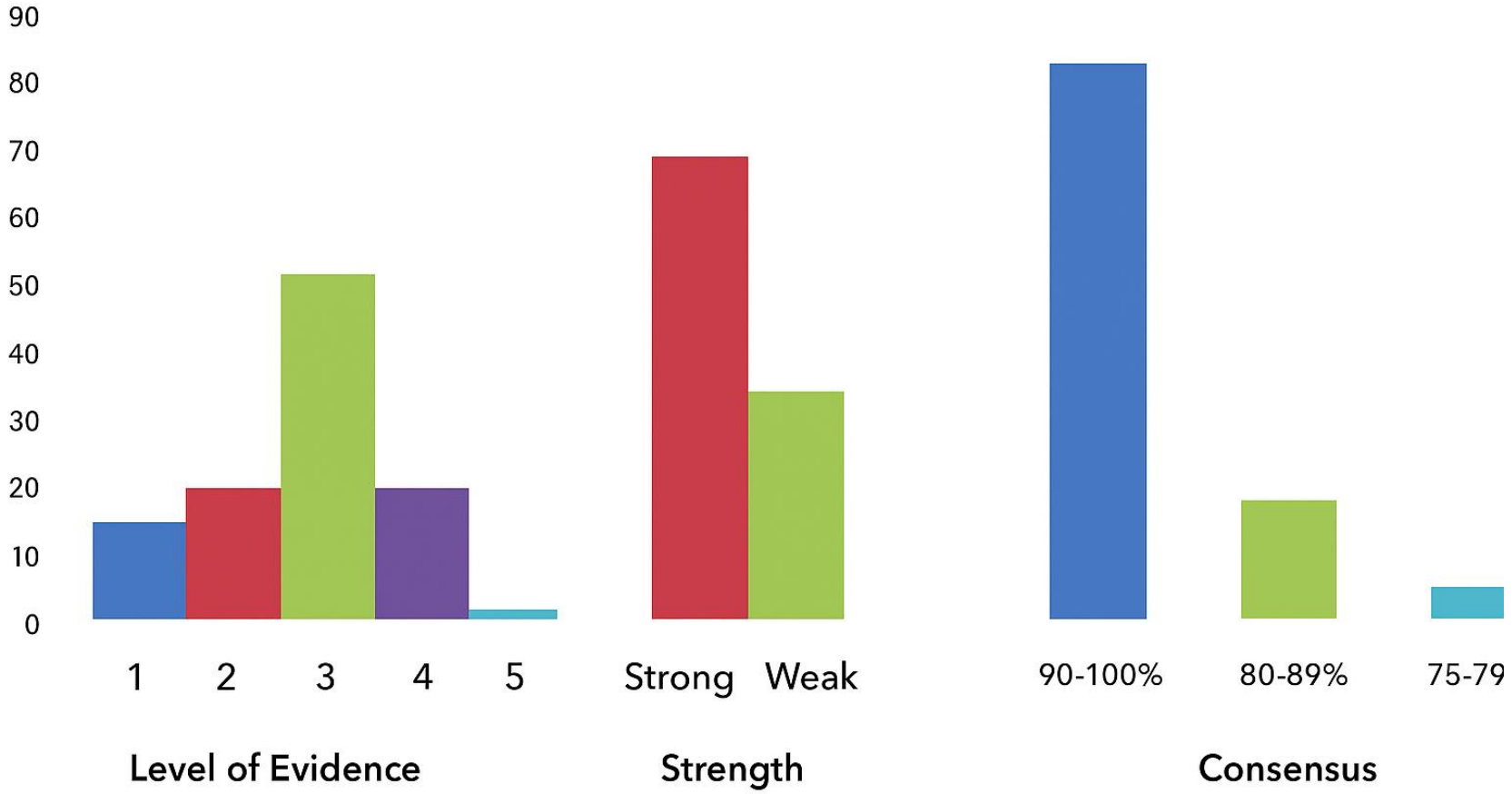
Introduction

Delphi Panel

Introduction

77 Recommendations

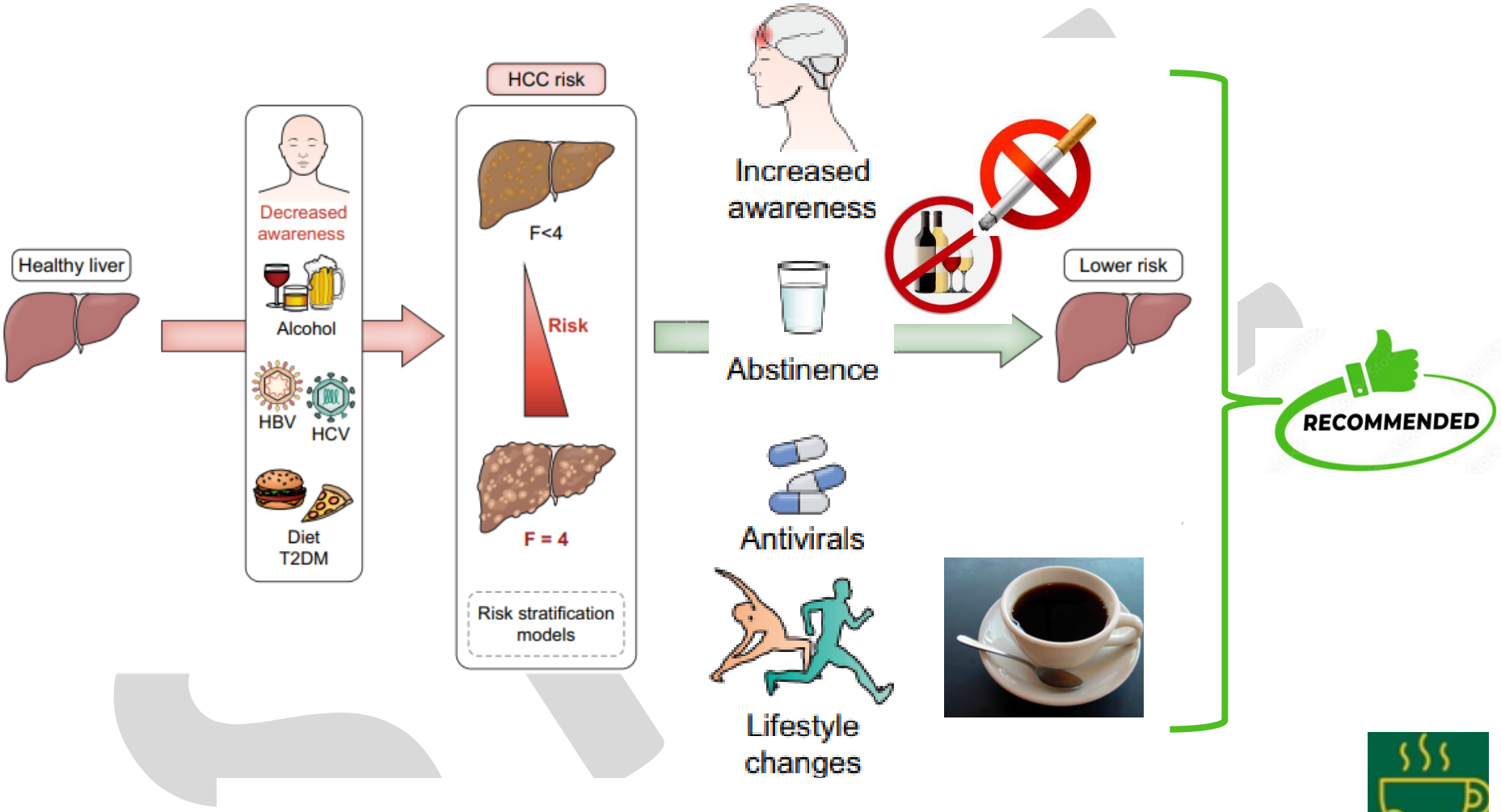


Section

- Prevention and screening
- Diagnosis and staging
- Surgery
- Locoregional therapies
- Systemic treatment

STGE

Prevention



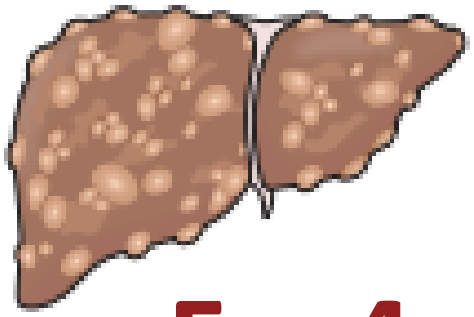
- Coffee consumption may be recommended to reduce the risk of HCC **(LoE 3, weak recommendation, consensus).**

Prevention

Statin, anti-inflammatory drugs or metformin

- Owing to a lack of evidence, the use of statins, aspirin and metformin cannot currently be recommended to reduce the risk of HCC development **(LoE 3, weak recommendation, strong consensus).**

Screening



F = 4

Combination use of US + AFP

↑ sensitivity

/ 6 months

MRI /Biomarker

Limited data

No screening if

- Patients with cirrhosis should be offered surveillance for HCC unless they have a relatively high risk of death from non-HCC causes, or they could not be offered a curative-intent treatment for HCC (*e.g.*, patients with Child-Pugh class C cirrhosis ineligible for liver transplantation) **(LoE 2, strong recommendation, strong consensus).**

Screening

F < 4

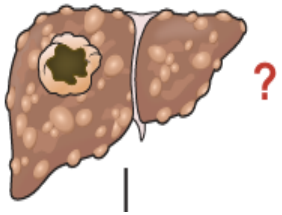
No current recommendation

- Patients with chronic liver disease and advanced fibrosis without cirrhosis have a higher risk of HCC than the general population, but HCC surveillance cannot currently be recommended in this group owing to insufficient evidence **(LoE 3, weak recommendation, strong consensus).**

Diagnosis

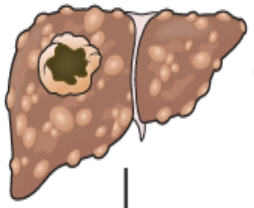
LI-RADS should be used to favour standardisation

New hepatic nodule



Diagnosis

LI-RADS should be used to favour standardisation



New hepatic nodule

?

Cirrhosis
Chronic HBV infection
History of HCC

Yes

High risk of HCC

CT/MRI

LI-RADS 1-4

Will immediate diagnosis change decision?

LR 3- 4

Yes

No

Imaging in 3 months

LR 1-2-3

LI-RADS M

LI-RADS 5

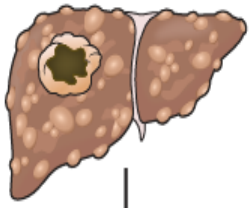
HCC

Biopsy

Non invasive criteria

Diagnosis

LI-RADS should be used to favour standardisation



New hepatic nodule

?

Cirrhosis
Chronic HBV infection
History of HCC

Yes

High risk of HCC

No

Low risk of HCC

CT/MRI

LI-RADS 1-4

Will immediate diagnosis change decision?

No

Imaging in 3 months

Yes

LI-RADS M

LI-RADS 5

HCC

Biopsy

Non invasive criteria

Diagnosis

- The non-invasive criteria should only be applied to patients with cirrhosis, chronic HBV infection or a history of HCC. In other patients, the diagnosis of HCC should be confirmed by biopsy **(LoE 1, strong recommendation, consensus).**

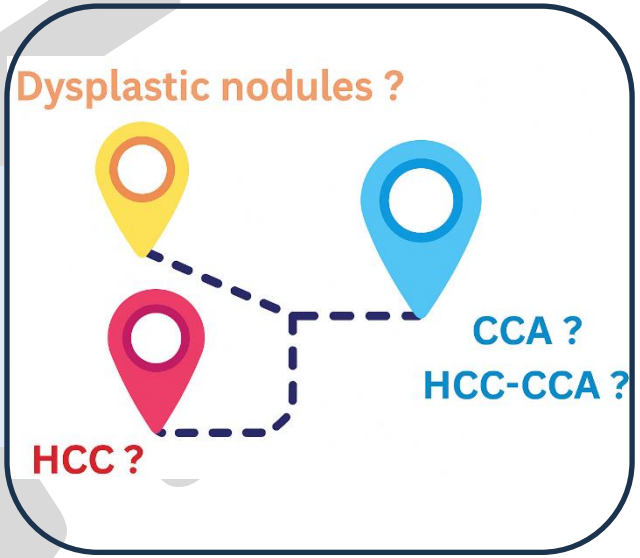
Non-invasive criteria non applicable if

- Age < 18 years
- Cirrhosis due to congenital fibrosis
- Vascular disorders budd-chiari syndrome, portal vein thrombosis
- Diffuse NRH

Biopsy

Diagnosis

Bx = tumoral + non tumoral parenchyma



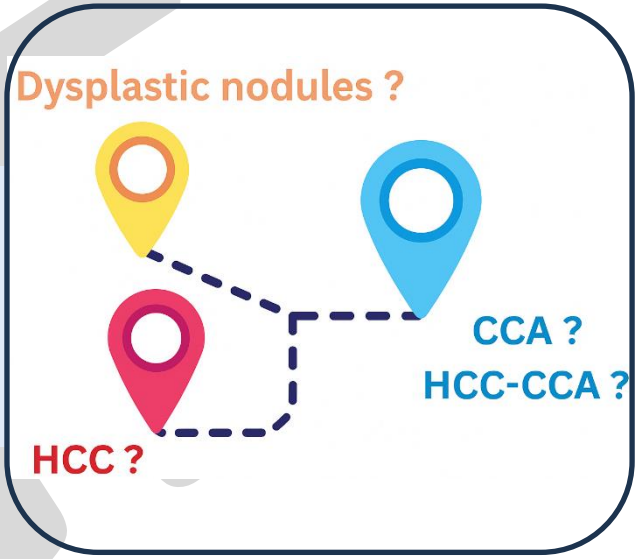
- In patients undergoing tumour biopsy for the diagnosis of HCC, it is suggested to simultaneously obtain a sample of the non-tumoural liver parenchyma to facilitate the diagnosis **(LoE 3, weak recommendation, consensus).**

Histological prognostic features

- Differentiation grade
- Vascular, neural oy lymphatic infiltration
- Macrotrabecular-massive

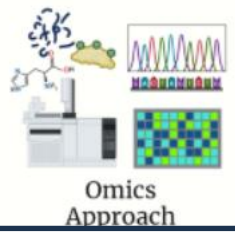
Diagnosis

- In patients undergoing tumour biopsy for the diagnosis of HCC, it is suggested to simultaneously obtain a sample of the non-tumoural liver parenchyma to facilitate the diagnosis **(LoE 3, weak recommendation, consensus).**



- Until therapeutic decisions can be reliably informed by molecular analysis of tumours, routine molecular analysis is not recommended **(LoE 3, strong recommendation, strong consensus).**

No evidence yet supports systematic molecular analysis



Work up and staging

Main determinants for clinical decisions making

Tumour stage	Very early BCLC 0	Early BCLC A	Intermediate BCLC B	Advanced BCLC C
Other determinants	Liver function - Portal hypertension - Performance status - Comorbidities - Patient preferences			
Main initial treatment aim	Tumour ablation			Disease control

Surgery : LR or LT

Thermal ablation

Intra-arterial TTT

EBRT external Rxt / SIRT : internal Rxt

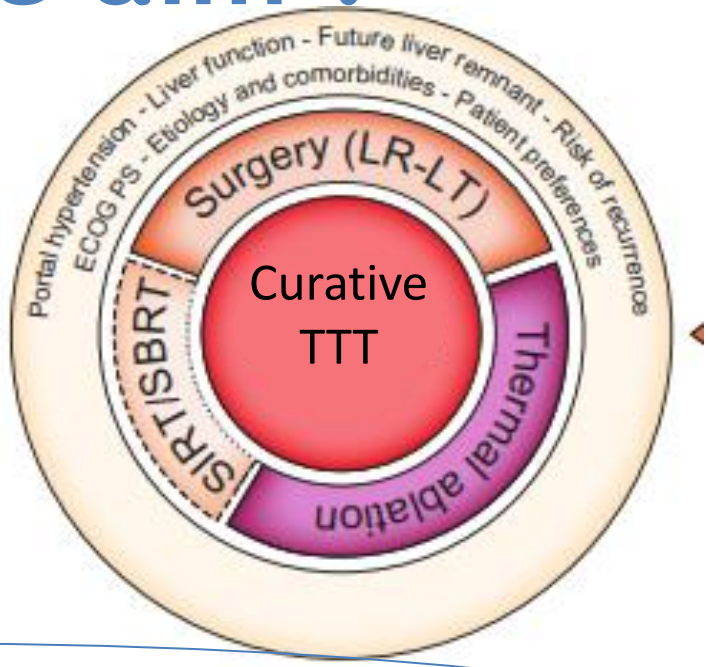
Systemic TTT

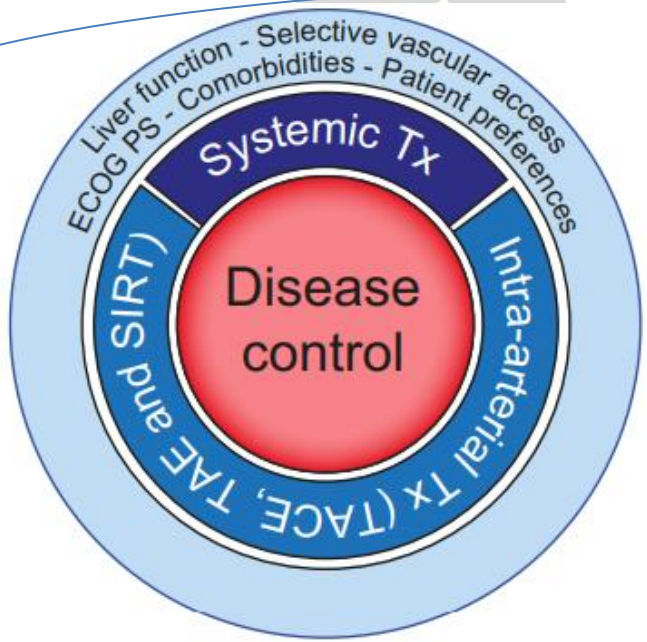
Multidisciplinary assessment and clinical decision making

What is the aim ?

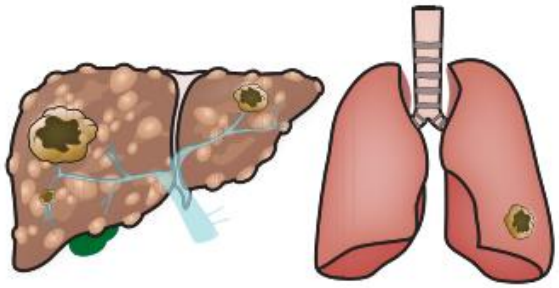
Small burden of disease

BCLC Stage 0-A-B





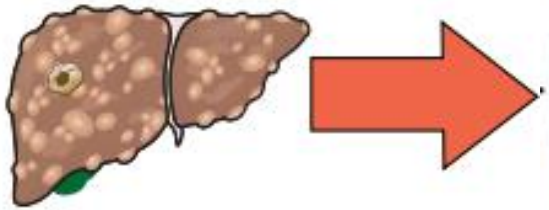
Vascular invasion or
extrahepatic disease



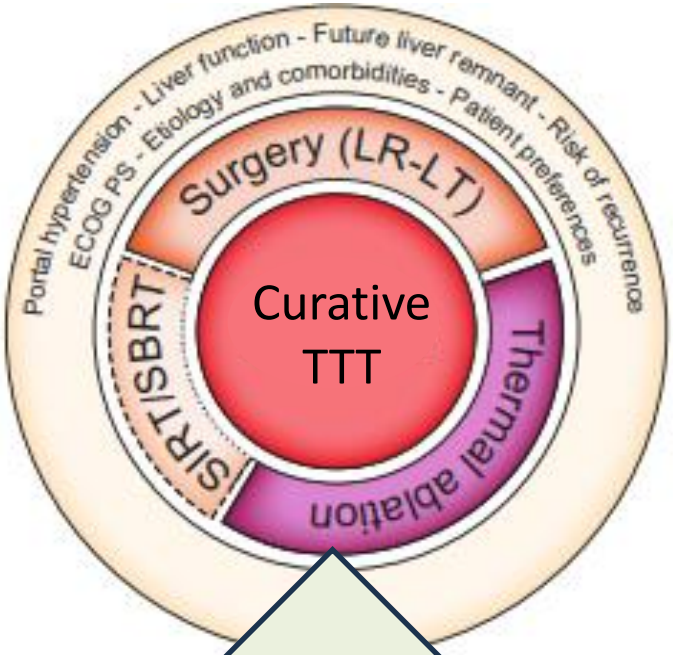
BCLC Stage B-C

The aim may change !

Small burden of disease



BCLC Stage 0-A-B

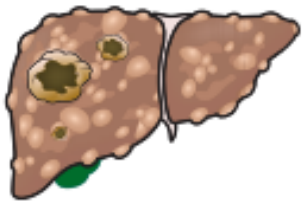


Systemic treatment

?

Downstaging

Loco-regional therapies



BCLC Stage B-C

Liver transplantation

Ideal" theoretical treatment

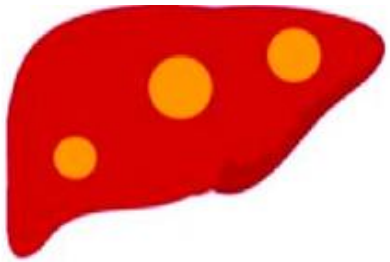
5-year survival > 70% and > 60% at 10 years

Selection:

- No vascular invasion, no metastasis
- Transplant criteria adopted by each center

Within Milan criteria → Consider bridge TTT → Transplant

Single tumor nodule < 5 cm



3 tumor nodules < 3 cm

Liver transplantation

Ideal" theoretical treatment

5-year survival > 70% and > 60% at 10 years

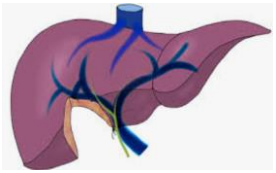
Selection:

- No vascular invasion, no metastases
- Transplant criteria adopted by each center

Within Milan criteria	Consider bridge TTT	Transplant
Beyond Milan within extended criteria	Downstaging	
Histological High-risk recurrence after LR	Observation > 6 mois	

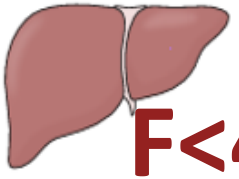
AFP level > 1000 ng/ml =

Absolute contraindication to LT



Liver resection

Preoperative assessment for LR ++



F<4

Reference option in **non-cirrhotic**
If single HCC even large

F=4

Preferred option in cirrhosis in:

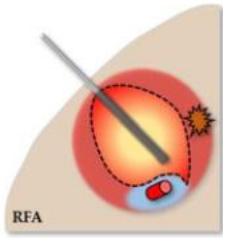
- ✓ **Unique HCC > 2 cm < 5 cm**
- ✓ **< 3 nodules 3 <cm same segment**
- ✓ **Child A - no CSPH- sufficient LV**

Child B- CSPH possible if minor resection

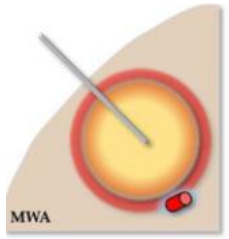
CSPH / CHILD B:
contraindicated if **major LR**

Advanced age **not an absolute contraindication**

HCC < 2cm: Resection or thermal ablation



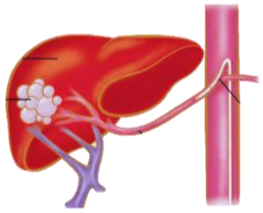
Thermal ablation



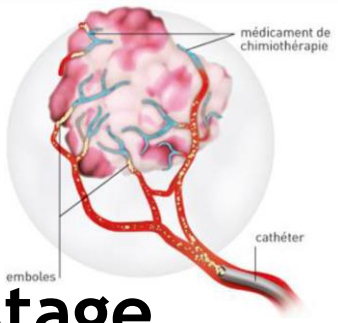
Selection:

- ✓ Tumor size < 3 to 5 cm
- ✓ Accessible via US or CT scan
- ✓ Away from vascular (heat sink) or bilary structures
- ✓ Preserved liver function

- No one thermal ablation technique (radiofrequency or microwave) is recommended over the others



Intra-arterial therapy



-> First line palliative TTT of intermediate stage

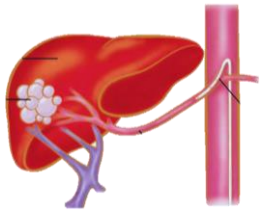
Selection:

- ✓ Multinodular
- ✓ Large size
- ✓ Preserved liver function
- ✓ Preserved portal flow
- ✓ No metastasis

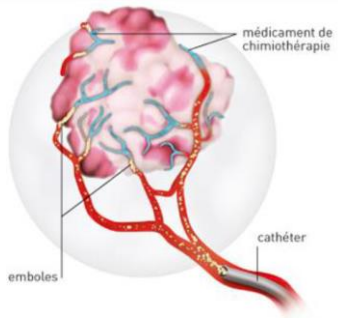
Conventional TACE (cTACE)

Drug-eluting beads TACE (DEB-TACE)

Trans-arterial embolisation (TAE)



Intra-arterial therapy



cTACE or DEB TACE ??

cTACE, DEB-TACE should be considered equivalent

TACE or Trans arterial embolization (TAE) ?

TAE ⇨ acceptable alternative to TACE

When to stop TACE ?

No response after up **to 2 consecutive TACE**
According to mRecist criteria

Intra-arterial therapy:SIRT

Y90

Y90

Selection:

- ✓ Single within MC or larger HCC
- ✓ Preserved liver function
- ✓ Thrombosis (VP1-3)

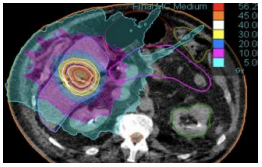
⛔ Contredicated if troncular portal thrombosis (VP4)

Alternative to ablation ✓

Alternative to TACE ✓

Single tumours unsuitable for LR or LT or TACE significant risk of recurrence

Bridge to LT or LR ✓



EBRT

External beam radiation therapy

Selection:

- ✓ Single ou pauci-nodular HCC 3 to 5 cm
- ✓ Preserved liver function
- ✓ Unsuitable for resection or ablation
- ✓ Good alternative for TACE
  - High risk complications from TACE
- ✓ Recurrence after ablation

Not an alternative to systemic TT

Systemic treatment

Diffuse HCC – PVT- Extra hepatic spread- PS 0-1
Preserved liver function CHILD A

1st Line	**Atezo-Beva** Or Durva -Treme If no feasible: Sorafenib / Lenvatinib (TKI)
2nd Line	Tyrosine kinase inhibitors (TKI)
3rd Line	?

The choice **should not be influenced by aetiology**

Systemic treatment ICI-based combinations

Should patients with mildly decompensated cirrhosis be offered systemic therapy?

- Patients with decompensated cirrhosis **should not be routinely treated with systemic therapy outside a prospective clinical trial.**

Careful selection in Child-Pugh 7-8 patients

Systemic treatment
ICI-based combinations

How to assess ?

RECIST v1.1

Response	Target lesions	Non-target	New lesions
CR	Disappearance of all target lesions	Disappearance of all non-target lesions	No
	Lymph node axis < 10 mm	Normalization of tumor marker levels	Partial Response
PR	30% ≥ decrease in SLD from baseline (≥ 4 weeks)	No progression	No
PD	≥ 20% increase in SLD from Nadir with an absolute SoD increase ≥ 5 mm	Unequivocally progression in lesion size	Yes, appearance of new unequivocally metastatic lesions
SD	Neither PR nor PD with the Nadir as reference point	Persistence of one or more non-target lesions and/or tumor markers > normal	No

Systemic treatment
ICI-based combinations

Until when ?

Complete / partial response

Stable disease

Progressive disease

Switch to 2nd Line

If ongoing clinical benefit

Conclusion

➡ Multidisciplinary team

Factors considering for treatment selection

- Safety
- Rationality
- Response
- Real-World data
- HRQoL