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NEWS AND NOTES

SUPPLEMENT

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CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Large hepatocellular cancers: hepatic resection or liver transplantation?

SIR,—We congratulate Dr O Søreide and colleagues (28 September, p 853) on their excellent results with resection of large hepatocellular tumours and for more clearly defining the resectability of these lesions in non-cirrhotic livers. Although we agree that results after resection appear to be better than those after liver transplantation, they state that 23 out of 36 patients were not considered for resection because of multicentric disease. These are precisely the patients whose livers are usually replaced, so comparing the two groups may not be appropriate. Despite a generally high recurrence rate in patients transplanted for unresectable primary liver tumours, the Pittsburgh group have shown good results in the treatment of seven fibrolamellar hepatocellular carcinomas, with no deaths before 12 months although four patients had recurrent disease, two dying at 15 and 33 months and two still alive at 17 and 36 months (Iwatsuki S *et al*, personal communication). Interestingly, in a separate group of cirrhotic patients whose tumours, although otherwise resectable, were in livers replaced for end stage hepatic disease there were no recurrences during follow up of four months to 15 years.

Dr Søreide and colleagues rightly state that solitary primary liver tumours should be considered firstly for resection and only secondarily for liver transplantation. If exploration is undertaken in an institution without a liver replacement programme and resection is found to be impossible at this stage then the patient needs to be allowed to recover and transferred to a transplant centre. If, on the other hand, resectability remains in doubt, after extensive investigation the patient should be explored with a replacement liver available in case it proves impossible to remove the tumour. This is the policy we have adopted. We have performed major hepatic resection for large liver tumours and proceeded to transplantation only when both lobes of the liver were extensively affected.

Since 1982 we have treated 11 patients with large primary liver tumours (excluding Klatskin tumours): two were treated by resection, and nine patients were transplanted because multicentric disease or cirrhosis made resection impossible. Three of the transplanted patients died after operation, two with tumours in cirrhotic livers. The third patient was a tertiary referral, having had two previous laparotomies, the second undertaken with a specific view to extensive resection. Four patients were well at 40, 24, 10, and 4 months with minimal immunosuppression; two died at 4 and 10 months but achieved excellent palliation. Their mean hospital stay was 21·6 days. These patients were mainly those Dr Søreide and others excluded as unsuitable for surgical treatment.

Among tumours diagnosed radiologically and laparoscopically as unresectable we have yet to find one that proved amenable to local resection at laparotomy. If this occurred we would not proceed automatically to transplantation but offer the liver to other centres. This has happened with the discovery of previously undiagnosed abdominal metastatic spread. A policy of having a replacement liver available for immediate implantation, if this proves necessary, avoids the greatly increased risk of repeated re-exploration.

R M KIRBY, D ADAMS, D CLEMENTS, L ANGRISANI, W A JUREWICZ, E ELIAS, P MCMASTER

Queen Elizabeth Medical Centre, Birmingham B15 2TH

SIR,—Dr O Søreide and colleagues suggest that there is a choice in the management of liver cancers and advise an attempt at tumour resection before considering liver transplantation (28 September, p 853). All of us concerned in liver transplantation would agree that resection is the ideal treatment and practise this. Among others considered for transplantation at the Royal Free Hospital, five patients had large malignant liver tumours. In two cases successful resection has been possible and in three others the tumour had already spread beyond the liver, which contraindicated both resection and transplantation. None of the patients had cirrhosis, and, although cirrhosis is known to be associated with a high postoperative mortality,[1] we do not regard it as a contraindication to resection provided liver function is good.[2] In the past 10 years we have resected hepatomas from five patients with cirrhosis. Two patients died after operation but the three other patients are well and tumour free.

It is important to note that only 13 of the authors' 36 patients (36%) were suitable for surgical resection. It would also be interesting to know how many of the remaining patients were suitable for transplantation and whether they had such a procedure since it must not be forgotten that some of the patients surviving longest after a liver graft had the operation for primary malignancy.[3] Previous upper abdominal surgery increases the difficulty of transplantation and may prejudice postoperative survival so a laparotomy which fails to proceed to resection is not in the patient's best interest unless he can be offered a transplant as soon as an organ becomes available and before adhesions can form.

We do not believe that there is a choice between