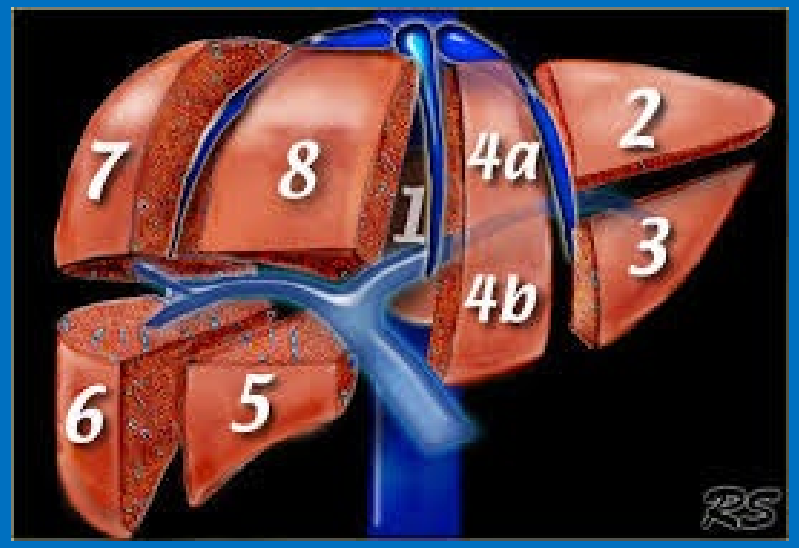
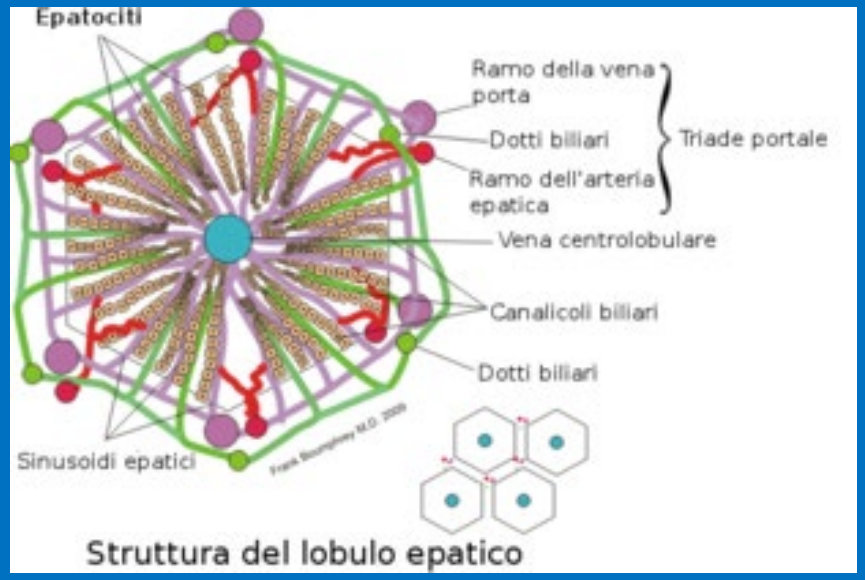
Fegato







Linee cellulari epatiche:

- Epatociti
- Colangiociti
- Cellule di Kuppfer
- fat-storing cell
- cellule stellate
- cellule di Ito

Lesione focale

Alterazione circoscritta di un tessuto o di un organo, a contorni più o meno definiti, che altera la sua normale struttura anatomica



CHE COSA FARE?

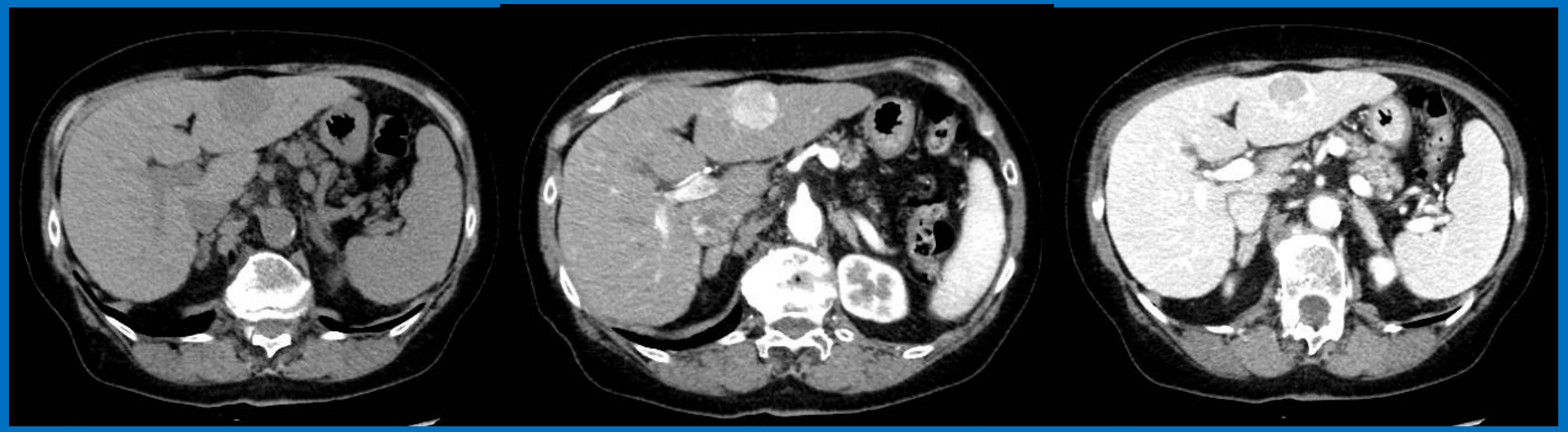
Epatocarcinoma (HCC)

Diagnosi

Ecografia: esame di primo livello, nodo ipoecogeno, difficilmente differenziabile dall'adenoma. Con l'integrazione mediante MDC è possibile evidenziare anche lesioni di piccole dimensioni.

TC: comportamento caratteristico, lesioni ipodense nello studio basale, con caratteristico ehnancement in fase arteriosa e "wash out" in fase portale.

RMN: Gold standard, soprattutto per tipizzazione di lesioni borderline (2cm). Lesioni ipointense in T1, iperintense in T2 con elevato contrast-ehnancement in fase arteriosa, "wash out" venoso e tardivo (ipointenso in fase tardiva con mdc epatospecifico a captazione epatocellulare, iperintenso in fase tardiva con mdc a captazione reticoloendoteliale)

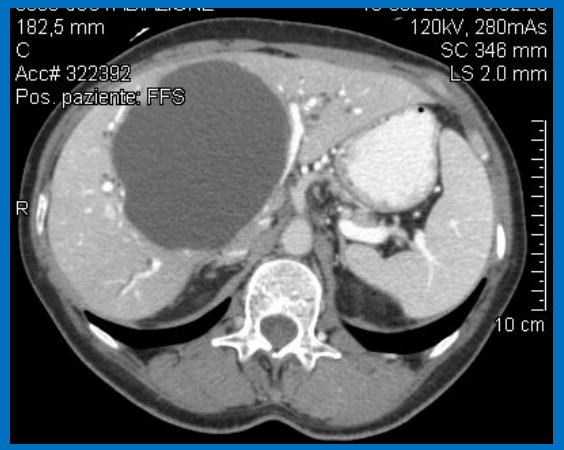


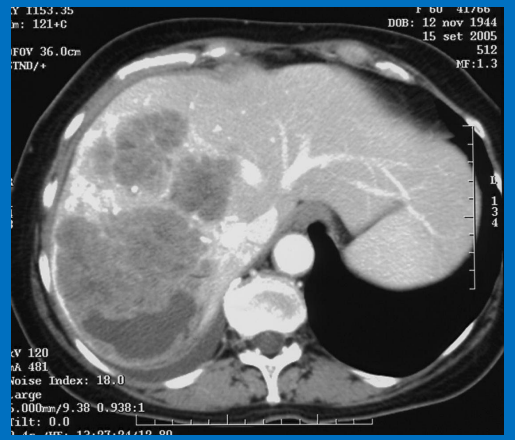
Lesione focale epatica

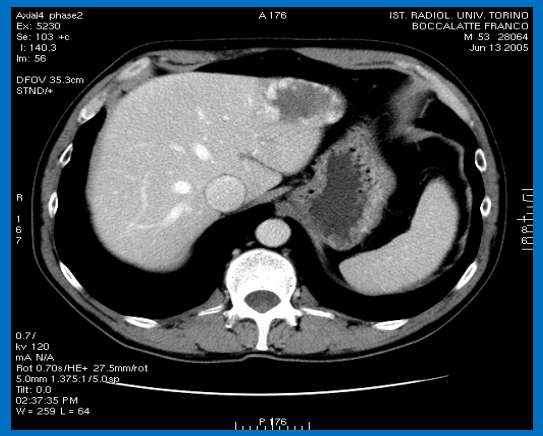
COSA?

- LESIONE PRIMITIVA
- LESIONE SECONDARIA

- LESIONE BENIGNA
- LESIONE MALIGNA





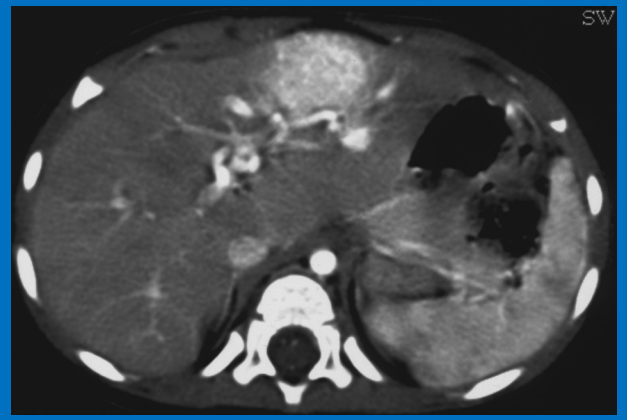


Lesione focale epatica



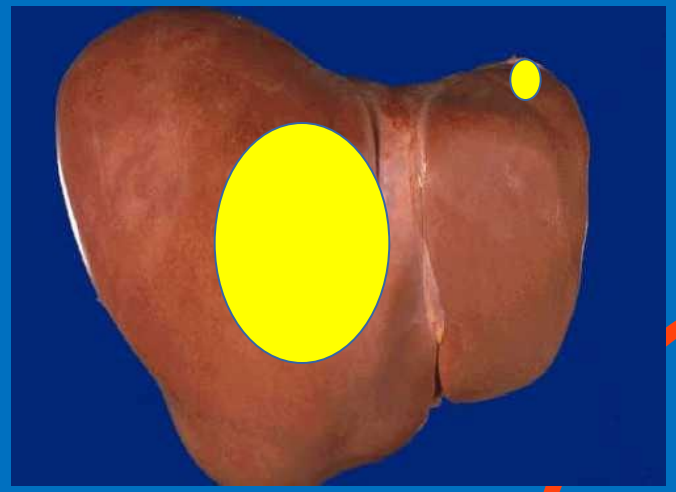
DOVE?

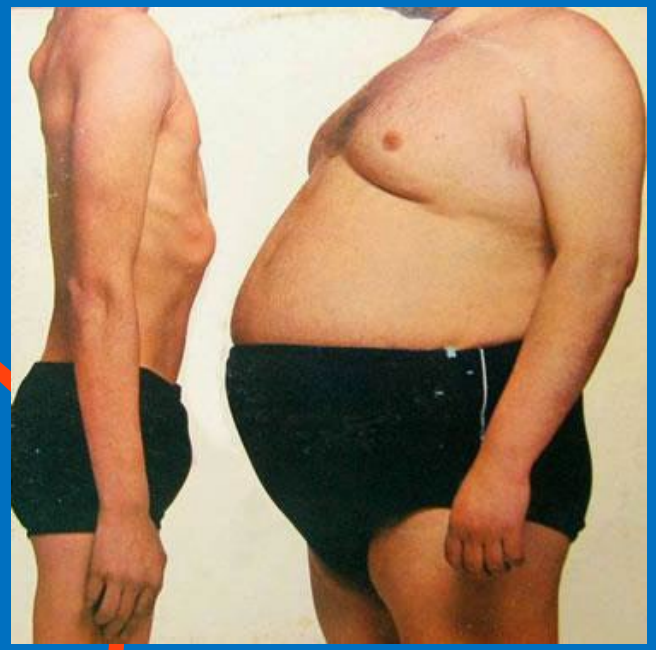




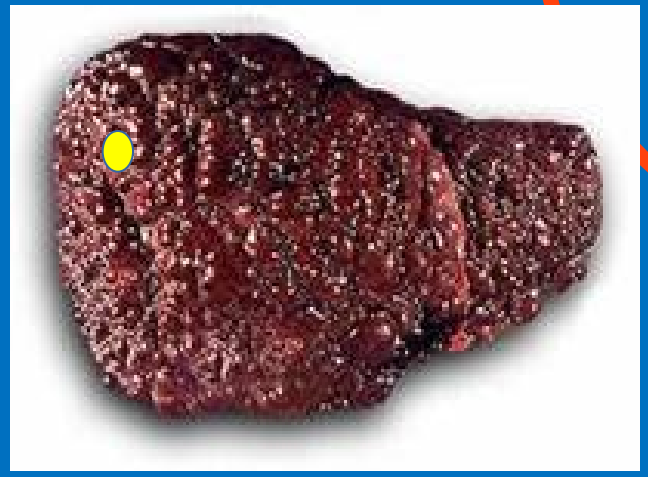


Lesione focale epatica





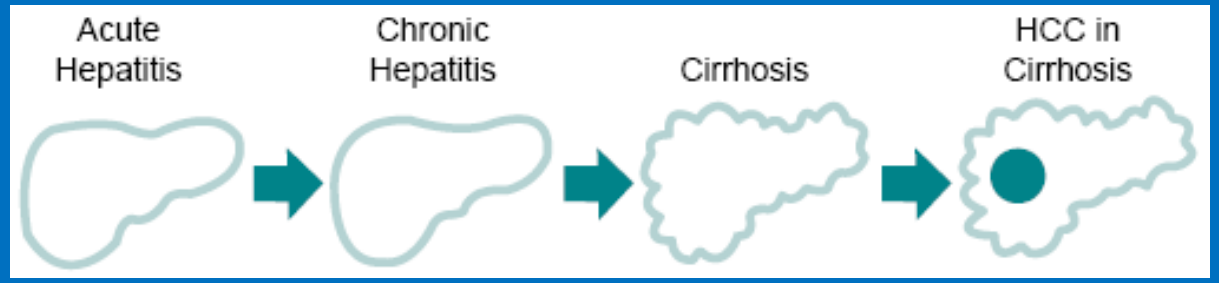
IN QUALE CONTESTO?



ECOG	Description
0	Fully active, able to carry on all pre-disease performance without restriction.
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work.
2	Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours.
3	Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours.
4	Completely disabled. Cannot carry on selfcare. Totally confined to bed or chair

Epatocarcinoma (HCC)

Agenti responsabili di epatopatia cronica-cirrose

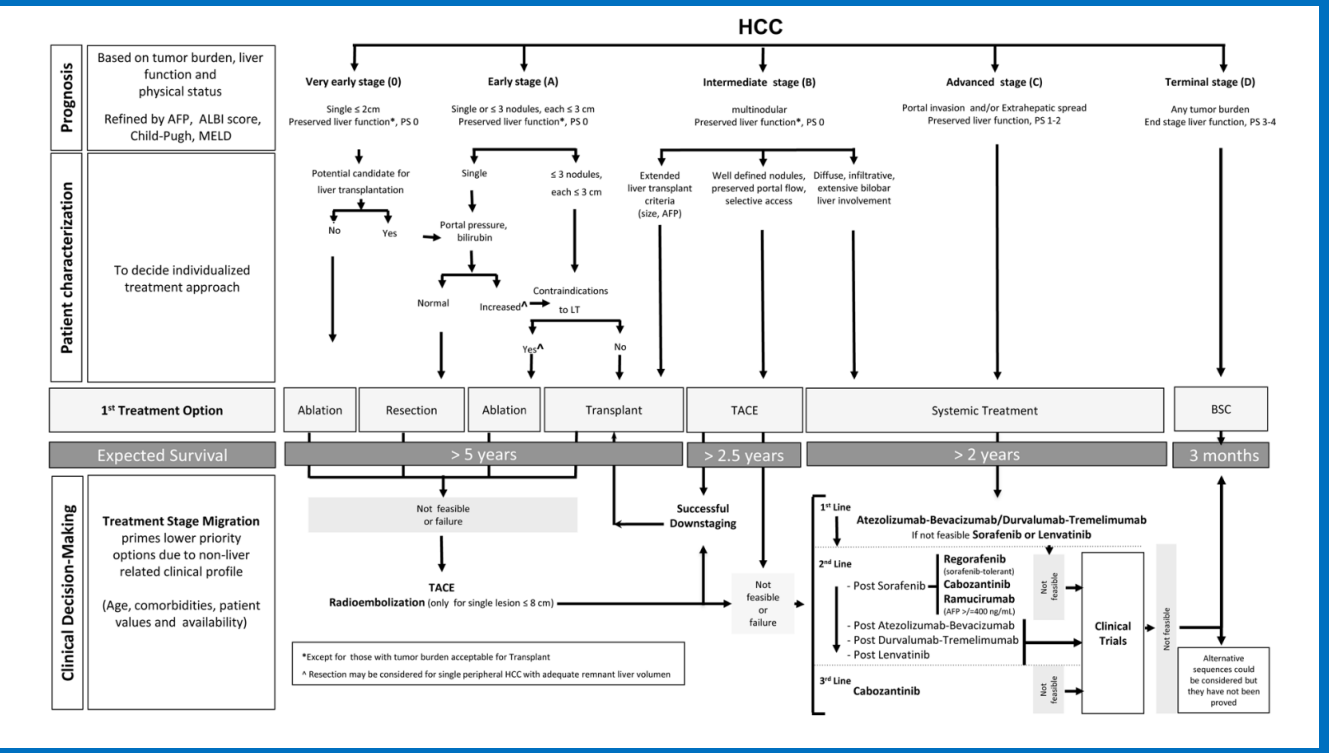


- **HBV:** integrazione del virus nel genoma degli epatociti con iper-espressione di oncogeni (*c-myc, c-fos, c-erbA*) e/o soppressione di geni oncosoppressori. Il DNA di HBV si ritrova nel genoma tumorale.
- **HCV:** carcinogenesi dovuta alla reazione necroinfiammatoria cronica provocata dal virus.
- **Alcool**
- **Emocromatosi o morbo di Wilson**
- **Aflatossina** (micotossina dell'*Aspergillus Flavus)*
- **Steroidi anabolizzanti**
- **Malattie metaboliche del fegato: NAFLD (Non-Alcholic Fatty Liver Disease)/ NASH (Non-Alcholic Steatohepatitis)**
- **Nuovi antivirali ad azione diretta (DAA) per il trattamento interferon-free della cirrosi HCV-relata.**

BCLC strategy for prognosis prediction and treatment recommendation: The 2022 update

Maria Reig, Jordi Bruix et al.

Ordine Provinciale dei Medici Chirurghi e degli Odontoiatri Di Novara



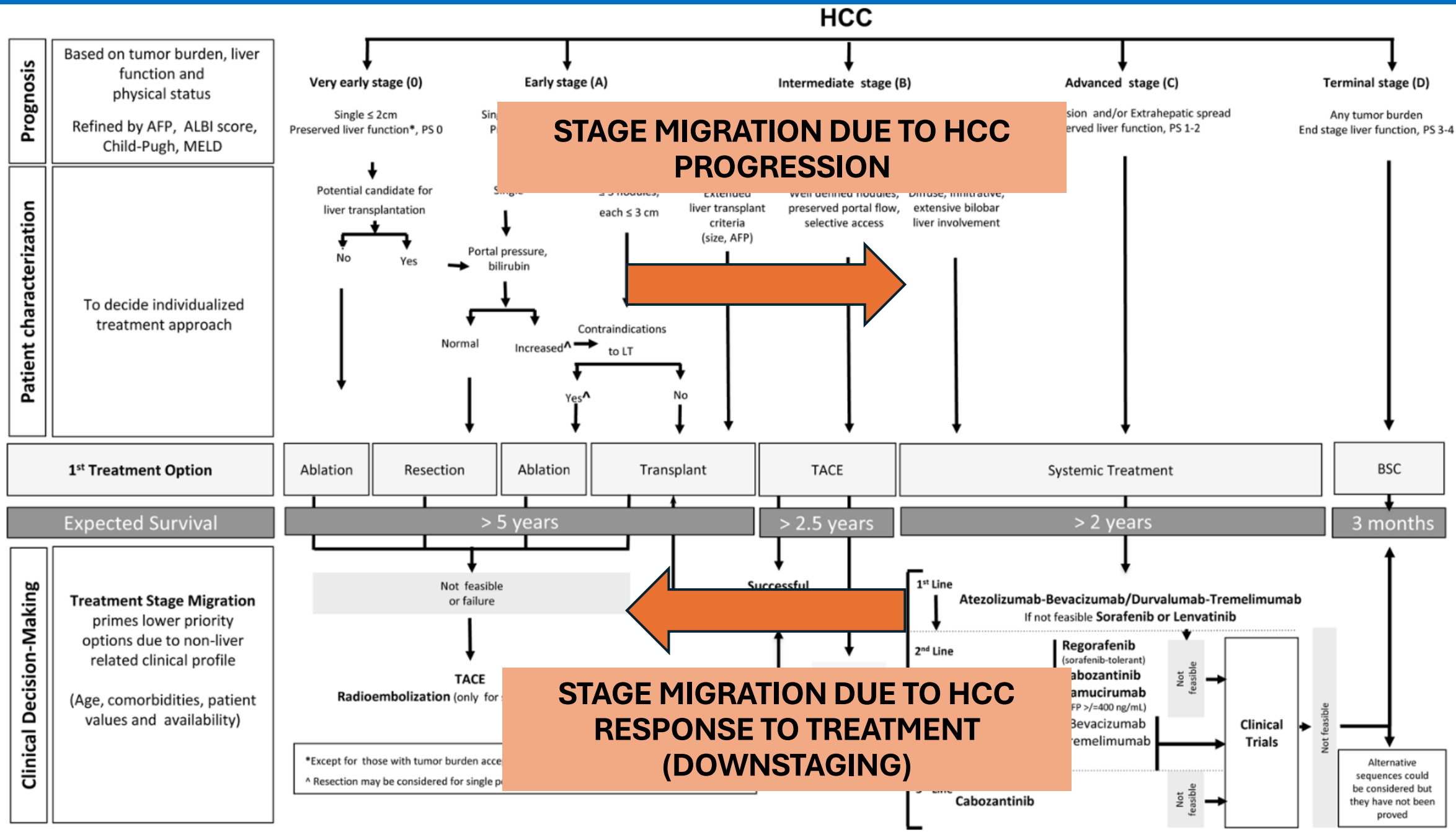
HHS Public Access
Author manuscript
J Hepatol. Author manuscript; available in PMC 2023 March 01.

Published in final edited form as:
J Hepatol. 2022 March ; 76(3): 681–693. doi:10.1016/j.jhep.2021.11.018.

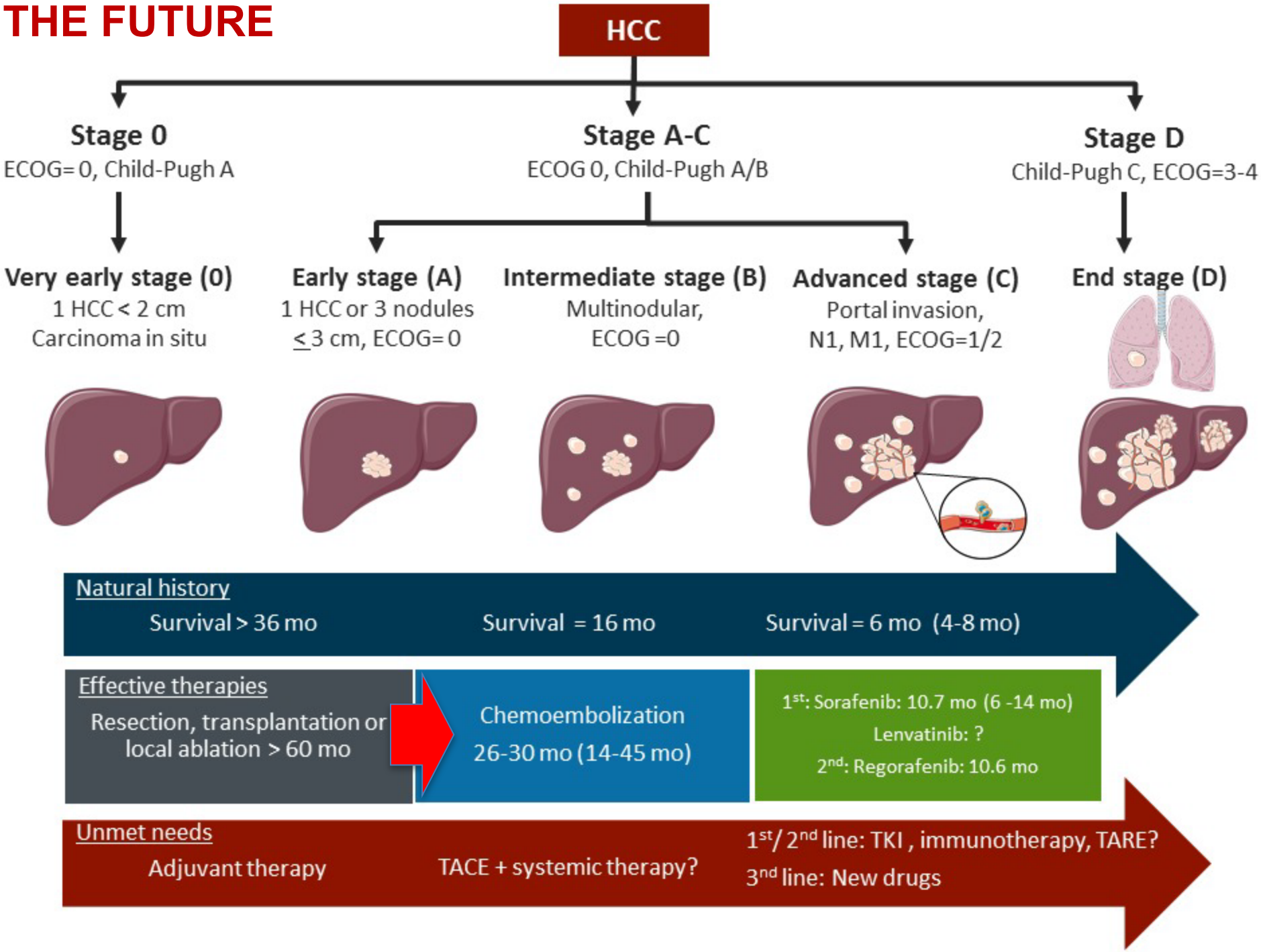


Fig. 1. BCLC staging and treatment strategy in 2022.

The BCLC system establishes a prognosis in accordance with the 5 stages that are linked to first-line treatment recommendation. The expected outcome is expressed as median survival of each tumour stage according to the available scientific evidence. Individualised clinical decision-making, according to the available data on September 15, 2021, is defined by teams responsible for integrating all available data with the individual patient's medical profile. Note that liver function should be evaluated beyond the conventional Child-Pugh staging.


HCC
Prognosis
Based on tumor burden, liver function and physical status
Refined by AFP, ALBI score, Child-Pugh, MELD
Patient characterization
To decide individualized treatment approach
Clinical Decision-Making
Treatment Stage Migration primes lower priority options due to non-liver related clinical profile
(Age, comorbidities, patient values and availability)
Very early stage (0)
Single ≤ 2cm
Preserved liver function*, PS 0
Early stage (A)
Intermediate stage (B)
each ≤ 3 cm
Extended liver transplant criteria (size, AFP)
Well defined nodules, preserved portal flow, selective access
Diffuse, infiltrative, extensive bilobar liver involvement
Advanced stage (C)
sion and/or Extrahepatic spread
erved liver function, PS 1-2
Terminal stage (D)
Any tumor burden
End stage liver function, PS 3-4
Potential candidate for liver transplantation
No
Yes
Portal pressure, bilirubin
Normal
Increased^
Contraindications to LT
Yes^
No
STAGE MIGRATION DUE TO HCC PROGRESSION
1st Treatment Option
Ablation
Resection
Ablation
Transplant
TACE
Systemic Treatment
BSC
Expected Survival
> 5 years
> 2.5 years
> 2 years
3 months
Not feasible or failure
Successful
1st Line
Atezolizumab-Bevacizumab/Durvalumab-Tremelimumab
If not feasible Sorafenib or Lenvatinib
2nd Line
Regorafenib
(sorafenib-tolerant)
abozantinib
amucirumab
FP >/=400 ng/mL)
Bevacizumab
remelimumab
Not feasible
Clinical Trials
Not feasible
Alternative sequences could be considered but they have not been proved
Cabozantinib
Not feasible
TACE
Radioembolization (only for
*Except for those with tumor burden acce
^ Resection may be considered for single p
STAGE MIGRATION DUE TO HCC RESPONSE TO TREATMENT (DOWNSTAGING)

THE FUTURE


HCC
Stage 0
ECOG= 0, Child-Pugh A
Stage A-C
ECOG 0, Child-Pugh A/B
Stage D
Child-Pugh C, ECOG=3-4
Very early stage (0)
1 HCC < 2 cm
Carcinoma in situ
Early stage (A)
1 HCC or 3 nodules
≤ 3 cm, ECOG= 0
Intermediate stage (B)
Multinodular,
ECOG =0
Advanced stage (C)
Portal invasion,
N1, M1, ECOG=1/2
End stage (D)
Natural history
Survival > 36 mo
Survival = 16 mo
Survival = 6 mo (4-8 mo)
Effective therapies
Resection, transplantation or
local ablation > 60 mo
Chemoembolization
26-30 mo (14-45 mo)
1st: Sorafenib: 10.7 mo (6 -14 mo)
Lenvatinib: ?
2nd: Regorafenib: 10.6 mo
Unmet needs
Adjuvant therapy
TACE + systemic therapy?
1st/ 2nd line: TKI , immunotherapy, TARE?
3nd line: New drugs

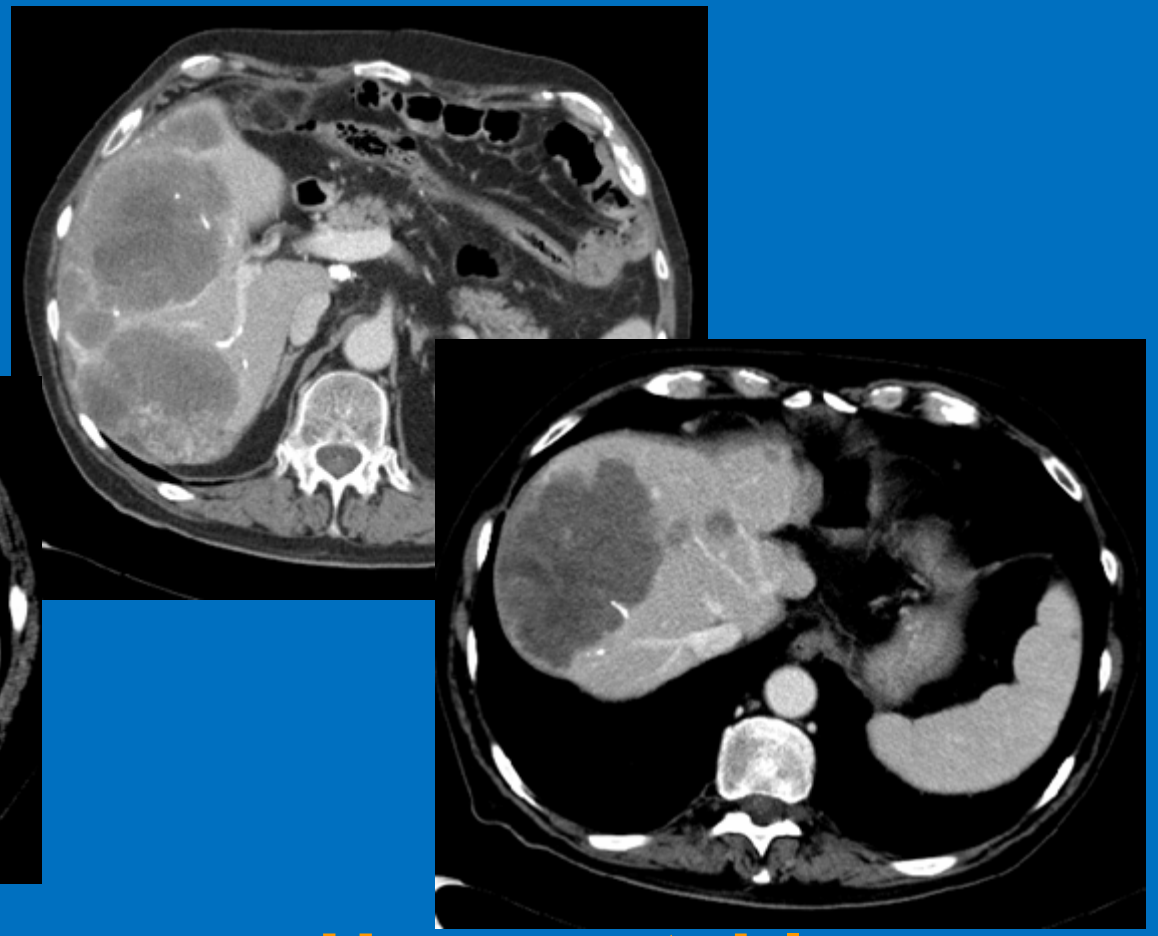
Liver metastases from colorectal cancer : a multidisciplinary approach

Azienda Ospedaliero Universitaria Maggiore della Carità
Corso Mazzini, 18
Novara
Regione Piemonte

The most important clinical decision to be determined either at first diagnosis or during follow-up



Resectable



Unresectable

QUALI STRUMENTI NELLA BORSA DEL MEDICO

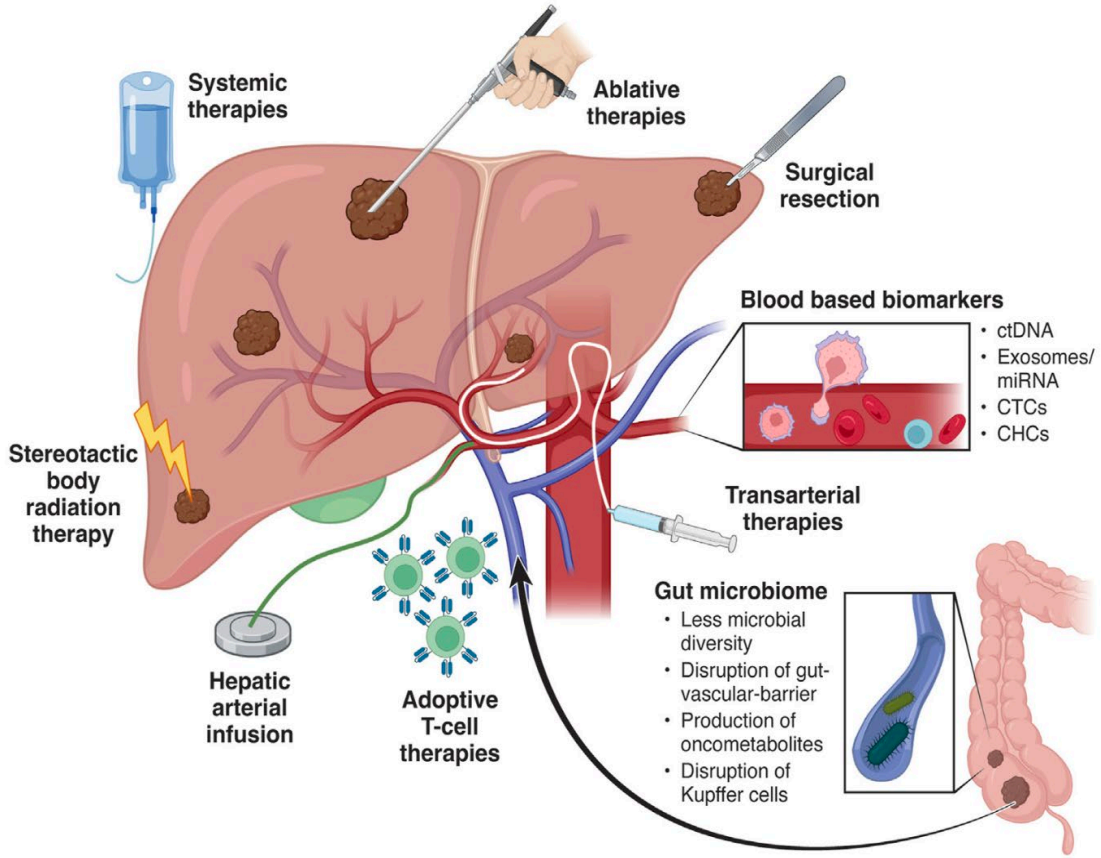


Figure 1. Modern scientific and clinical paradigms in management and treatment options for patients with colorectal cancer liver metastases (CRLM).

- Scheele J. Et al.: Br.J.Surg.-1990
  5yrs O.S. =>24-30%
- Calderon N.F. et al.: Cancers-2023:15
  5yrs O.S. => 50-60%

Patel et al. (2023)- Cellular and Molecular Gastroenterology and Hepatology Vol. 16, Iss. 6

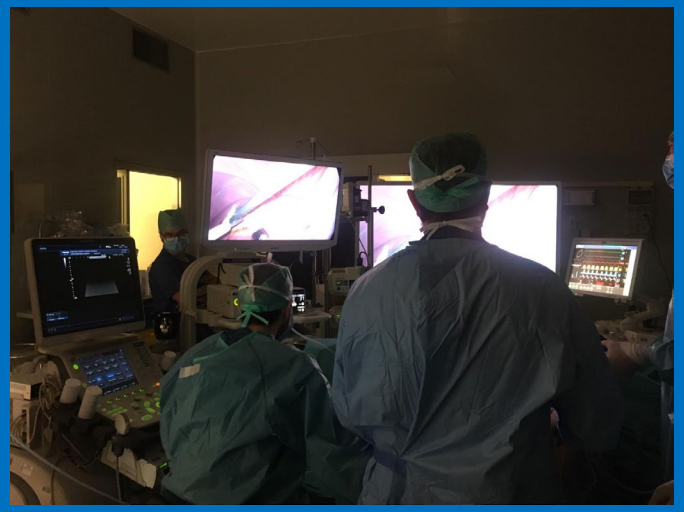
LA REALTA' DELL'AOU MAGGIORE DELLA CARITA'

Azienda Ospedaliero Universitaria Maggiore della Carità di Novara













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QUALI PROPOSTE PER IL NOSTRO TERRITORIO?

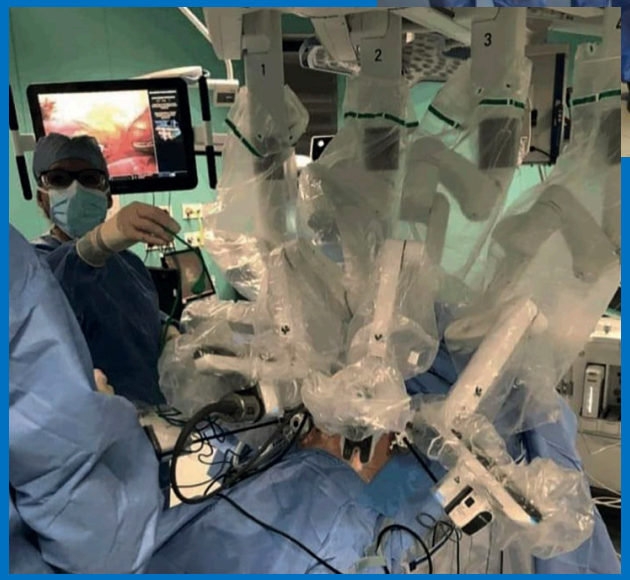
- **Investire in cultura e ricerca**
- **Investire nella formazione dei giovani medici**
- **Investire in qualità**
- **Prendersi carico del paziente a 360°**

Chirurgia Generale 2
Grazie!

Azienda Ospedaliero Universitaria Maggiore della Carità di Novara











Chirurgia Generale 2

A.O.U. Ospedale Maggiore della Carità Novara

Volume di Attivita' : fegato 1/12/2016- 1/1/24



- 410 resezioni epatiche:

- 250 resezioni open
- 160 resezioni MILS: 35 Robot;125 VLS

- 160 resezioni pancreatiche:

- 43 distali
- 117 DCP (19 DCPT)