NHS BLOOD AND TRANSPLANT

LIVER ADVISORY GROUP

MINUTES OF MEETING
FIXED TERM WORKING UNIT ON HCC
TELECONFERENCE

THURSDAY 24TH APRIL 2014 AT 11.30 A.M.

Present:

Murat Akyol (Chair)
James Powell (CGL)
Rebecca Jones
Krishna Menon
Mark Hudson
Paolo Muiesan
John Crookenden

1. Minimum Registration Criteria

At the previous meeting of the FTWU, three specific issues had been raised in relation to the management of patients with solitary HCC < 2cms in diameter.

- An investigation was performed by the Statistics and Clinical Studies Unit of NHSBT into the number of patients registered for liver transplantation with such tumours. From 1st January 2012 to 31st December 2013 64 patients were registered for transplantation with a solitary HCC < 2cms. However it was not entirely clear how many of these 64 patients had the solitary HCC as the only indication for transplantation. 40 of the 64 patients had other liver diseases registered as secondary or tertiary disease and there were only 7 patients who had only HCC as primary disease with no secondary or tertiary diagnosis.
- The concern about patients who present with early recurrence after resection of a small solitary HCC or those who are shown to have microvascular invasion on histology was discussed at length. It was decided that the presence of microvascular invasion on histology should not prevent consideration of liver transplantation for these patients should they re-present with recurrence or another indication for liver transplantation. For the purposes of eligibility for subsequent transplantation, the small solitary tumour excised would be counted only if recurrence occurred within 12 months. For late recurrences the standard eligibility criteria will apply.
- Patients with a single small tumour, which is not suitable for resection or ablation because of anatomical or other patient specific reasons should still be eligible for registration on the transplant list. The registration form should contain a free text box to explain why resection or ablation is not possible.

2. Policy on Downstaging

Detailed notes and the Minutes of the Consensus Conference (Birmingham, January 2014) had been received. Members acknowledged that the evidence supporting a policy of downstaging prior to transplantation was not strong. Nevertheless the working group support adoption of the criteria recommended at the consensus conference. Namely patients with a single tumour up to 8cms in diameter; 2 or 3 tumours each less than 5cms and total tumour diameter less than 8cms; or 4 or 5 lesions each less than 3cms and total tumour diameter less than 8cms should be considered eligible for downstaging. Any downstaging technique used by the local centres would be acceptable. Successful downstaging is defined as radiological disease and AFP values returning to the acceptable limit within the AFP/tumour size/number model (Duvoux). For those patients who have been successfully downstaged, transplant registration should not occur earlier than 6 months from the time of administration of the treatment or 3 months from the time of demonstration of success with downstaging.

The group also recommended that all patients successfully downstaged and those with small tumours treated with ablation should receive repeat imaging 6 weeks after treatment. Imaging should then be repeated 3 months later and thereafter with 6 monthly intervals.

Members also felt that data on successfully downstaged patients and on those who were subsequently registered for transplantation following alternative management for a small solitary tumour should be reviewed at LAG every 6 months. The database at NHSBT on these patients should also contain histology reports of resections/explanted livers.

3. Delivery of Timely Transplantation

The members felt that there was no further discussion or recommendation required on this item, over and above the one made at the previous meeting on 5th March 2014. The previous recommendation is reproduced here:

Whilst the FTWU has been charged to consider delivery of timely transplantation, it was felt that this was more an issue of allocation than selection. In the current centre based allocation system all clinicians have a similar approach (but not necessarily a written protocol or policy) of selecting patients with HCC close to "drop out" ahead of those with chronic liver disease and higher UKELD scores. It was not felt practical to formalise the degree of priority that should be given to HCC patients in the current centre based allocation system. The issue will of course gain much greater relevance and a formal protocol will be required if the decision is taken to move to a national allocation and national distribution system in the future. The clinical discretion exercised in the current centre based allocation system and/or the provisions of a future national allocation system should aim to achieve a degree of priority for the HCC patients that results in a "drop out" rate of those with HCC similar to the waiting list mortality for other non-HCC patients.