Letter regarding “Treatment options for solitary hepatocellular carcinoma ≤5 cm: Surgery vs. Ablation: A multicenter retrospective study”

Running title: LR vs. Ablation for solitary HCC

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Dear Editor:

I read with interest the research performed by Kariyama et al. on the therapeutic efficacy of ablation and surgery in solitary hepatocellular carcinoma (HCC) measuring ≤5 cm.¹ The study's division of patients into different size categories and the comparison of treatment effects within these groups offer valuable insights. Notably, the lack of significant differences in recurrence-free survival (RFS) and overall survival (OS) between the two treatment modalities for HCC ≤3 cm and the preference for surgical liver resection in the 3–5 cm range provide valuable insights for clinicians managing patients with HCC. The median RFS of 3.6 years following surgical resection compared to 2.0 years for the ablation group after surgical resection suggests a potential advantage of surgery in terms of delayed recurrence. Notably, however, there was no significant difference in OS between the two treatment modalities. Their findings were based on a cohort database of 2,067 individuals. It is crucial to acknowledge the limitations of observational studies, such as the potential confounding factors and biases that may affect treatment outcomes.

Several Asian guidelines recommend local ablation for very early- or early-stage HCCs ≤3 cm,² and Chinese guidelines extending this recommendation to solitary HCC ≤5 cm,³ reflect the regional variations and evolving perspectives on the optimal treatment strategies for different stages of HCC. Previous randomized controlled trials (RCTs) that did not find surgery to be superior to radiofrequency ablation (RFA) in terms of OS aligned with existing literature.⁴-⁶ However, the observation that RFS was significantly longer or tended to be longer in patients undergoing surgery than in those undergoing RFA is an interesting point.⁵,⁷ This discrepancy between RFS and OS outcomes suggests that while surgery may delay recurrence, it may not necessarily translate into a significant improvement in OS. The study by Shin et al., which included a substantial number of RCTs and matched non-randomized trials, suggested that liver resection may be superior to RFA in terms of oncological outcomes.⁸ However, it is important to consider the specific patient populations, study designs, and methodologies of the included trials when interpreting these results.
This study could have implications for clinical decision-making and may contribute to the ongoing discussion regarding the optimal treatment approach for solitary HCC ≤5 cm. When determining the most appropriate treatment strategy for individual cases, it is imperative to consider factors such as patient comorbidities, overall health status, and tumor characteristics including tumor size, number, and location. The heterogeneity of HCC, even within defined criteria, such as the Milan criteria, underscores the need for tailored treatment strategies. A well-designed RCT focusing on solitary HCC of various sizes could help address some existing gaps in the literature and contribute to a more nuanced understanding of the optimal treatment approach for this specific patient population. In addition, clinical research that considers not only clinical outcomes, but also patient-reported outcomes and quality-of-life measures could further enhance our understanding of the holistic impact of different treatment modalities.

Conflicts of interest

The author has no conflicts of interest to disclose.

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Conceptualization, Investigation, Project administration, Visualization, Writing – original draft, Writing – review & editing: JMK
References


