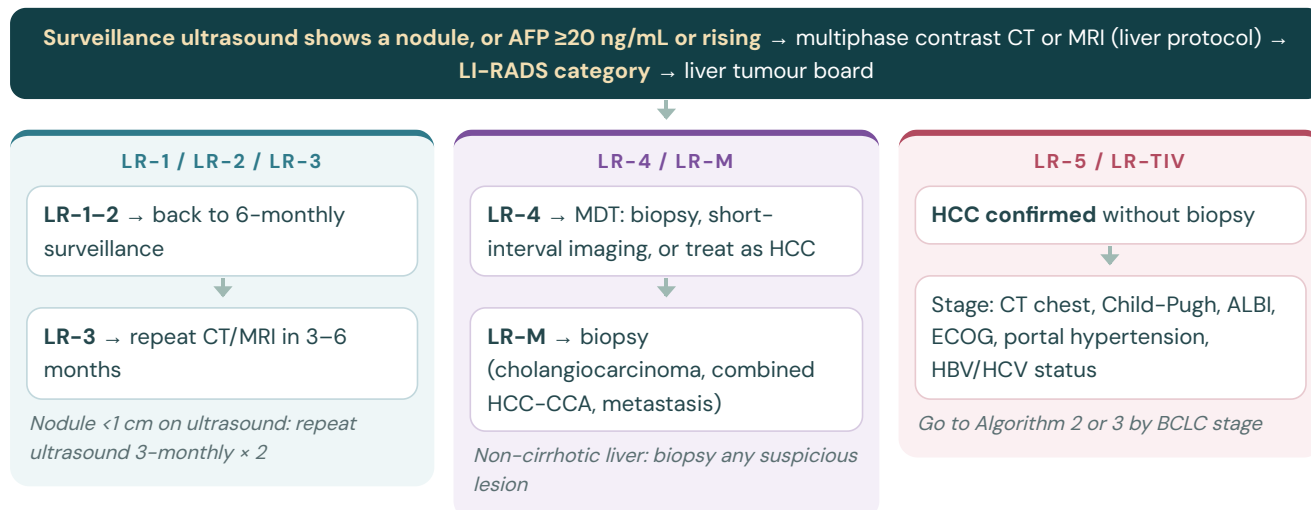


Hepatocellular Carcinoma: Liver nodule or raised AFP in an at-risk patient

Dr. Haritha Chiramana

MD, DM · Senior Medical
Oncologist & Hemato-Oncologist



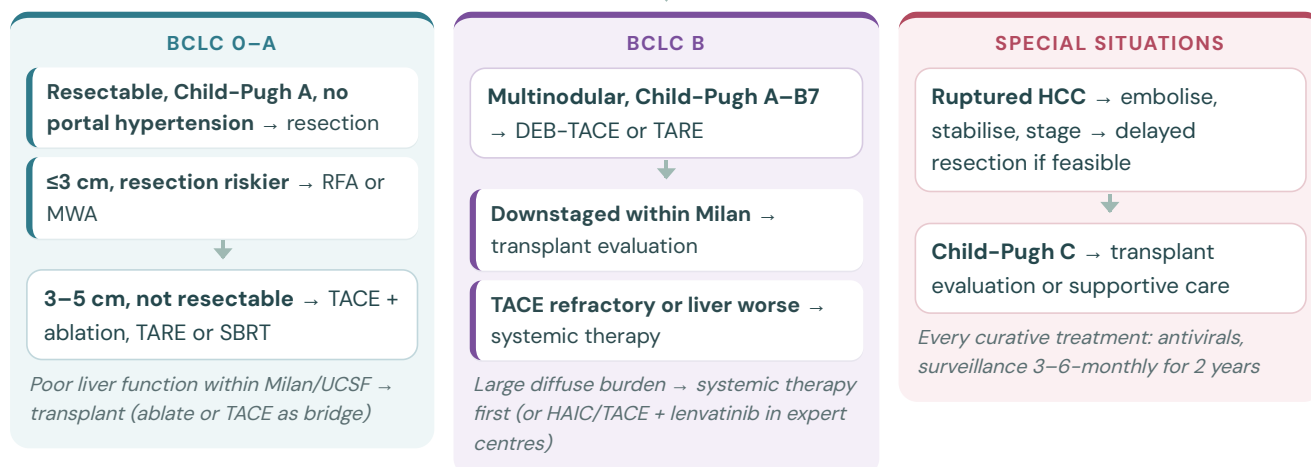
All patients: treat the hepatitis B or C · stop alcohol · varices screening if cirrhotic · surveillance continues for life, even after cure.

Hepatocellular Carcinoma: Liver-confined HCC (BCLC 0–B)

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MD, DM · Senior Medical Oncologist & Hemato-Oncologist

HCC confined to the liver, no main or lobar portal vein thrombus → Child-Pugh, portal hypertension, future liver remnant, transplant eligibility → MDT



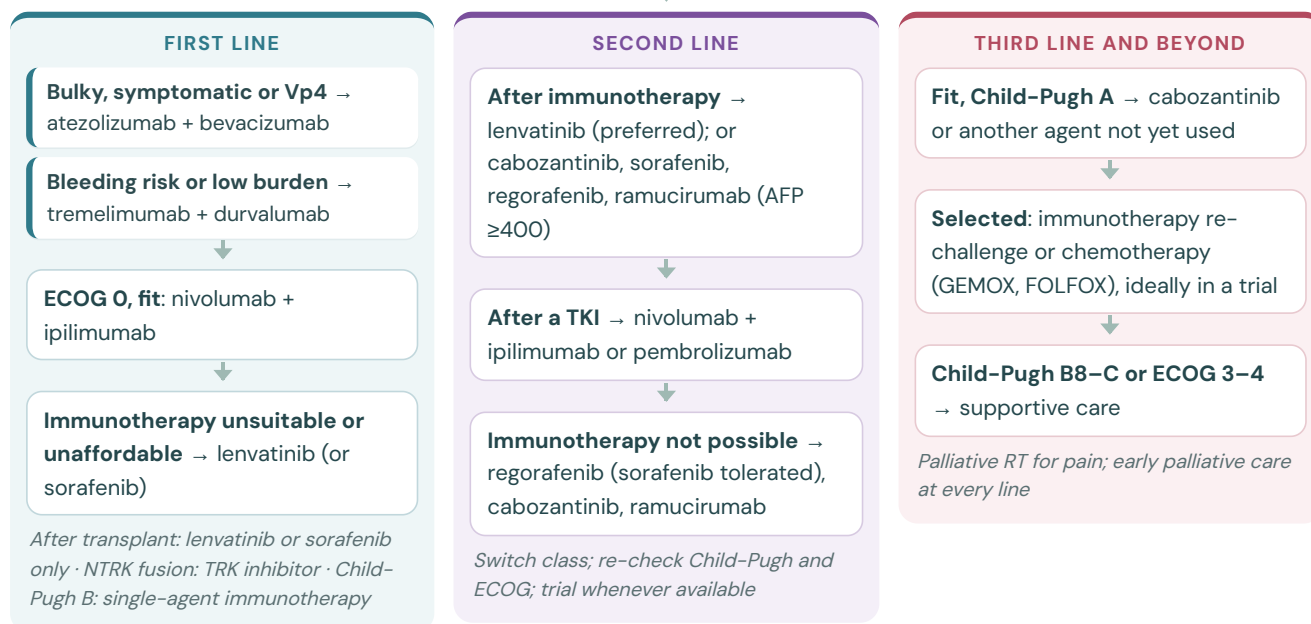
All patients: no adjuvant drug outside trials · hepatitis B antivirals for life · hepatitis C cure after HCC treatment · recurrence can often be treated again.

Hepatocellular Carcinoma: Systemic therapy by line (first, second, third)

Dr. Haritha Chiramana

MD, DM · Senior Medical Oncologist
& Hemato-Oncologist

Not suitable for local therapy → Child-Pugh A (or B7) and ECOG 0–1? → prior liver transplant? → HBV prophylaxis, HCV test, endoscopy if anti-VEGF planned



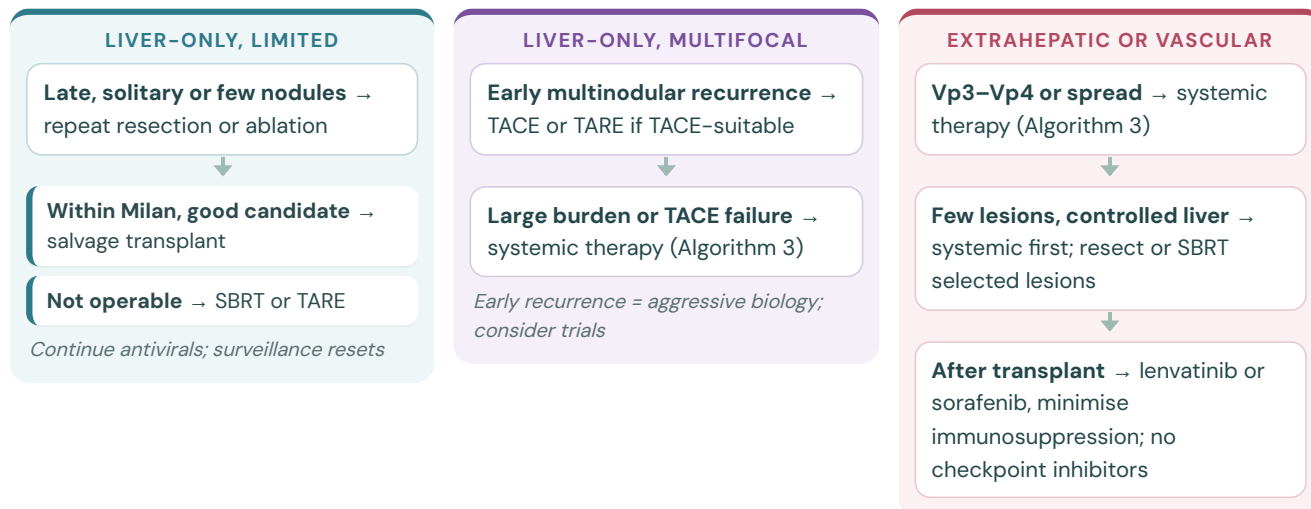
All patients: CT/MRI at 6–8 weeks then every 2–3 months · AFP · liver tests, thyroid, cortisol · nutrition · cost plan · goals of care discussed at each progression.

Hepatocellular Carcinoma: Recurrence after curative treatment

Dr. Haritha Chiramana

MD, DM · Senior Medical Oncologist & Hemato-Oncologist

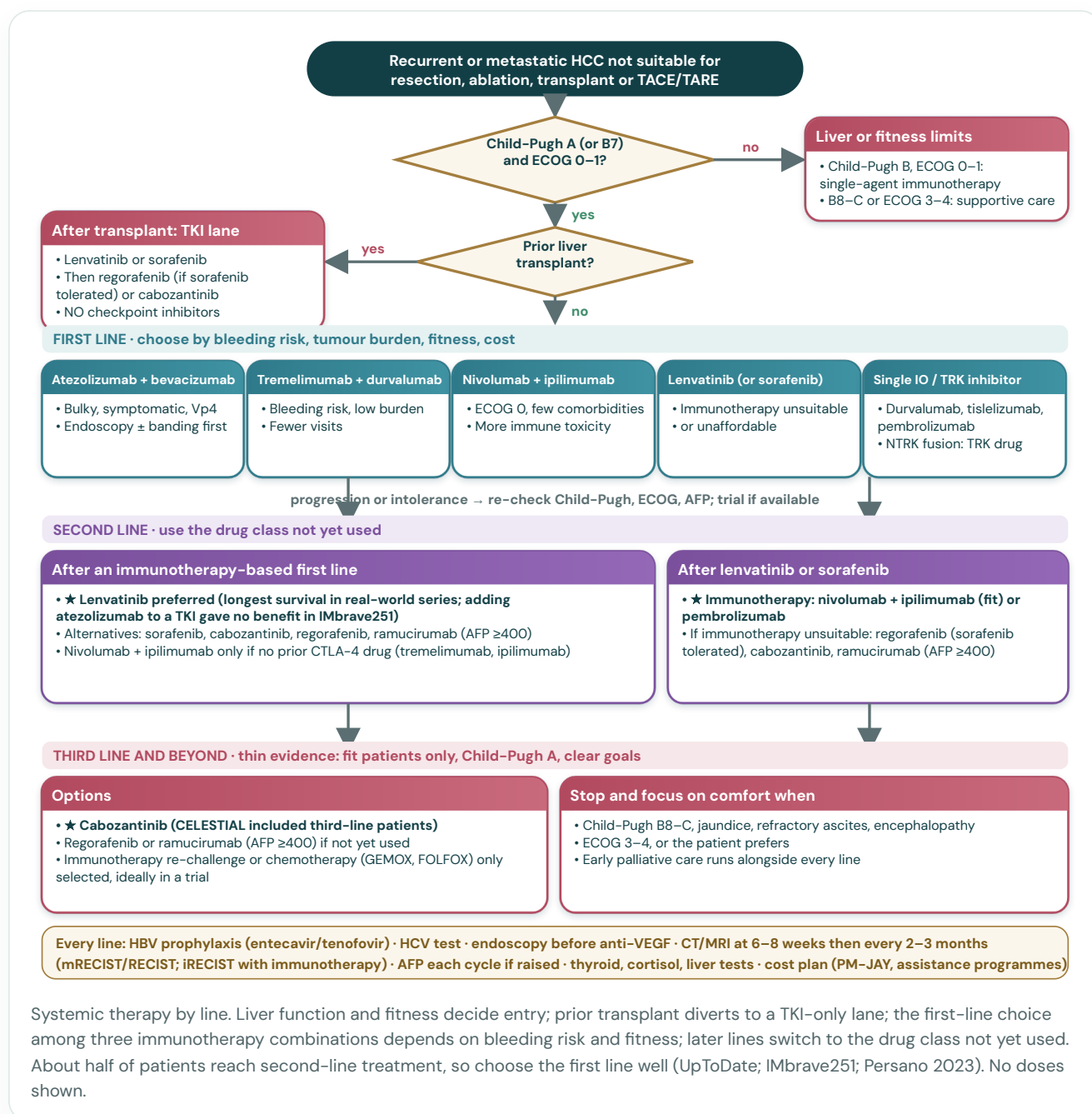
Recurrence on surveillance → multiphase CT/MRI + CT chest + AFP → is it liver-only? → liver function and fitness → MDT



All patients: hepatitis B suppression and hepatitis C cure · alcohol abstinence · re-stage liver function before every decision.

Hepatocellular Carcinoma: Systemic therapy by line: flowchart

Dr. Haritha Chiramana
MD, DM · Senior Medical Oncologist &
Hemato-Oncologist

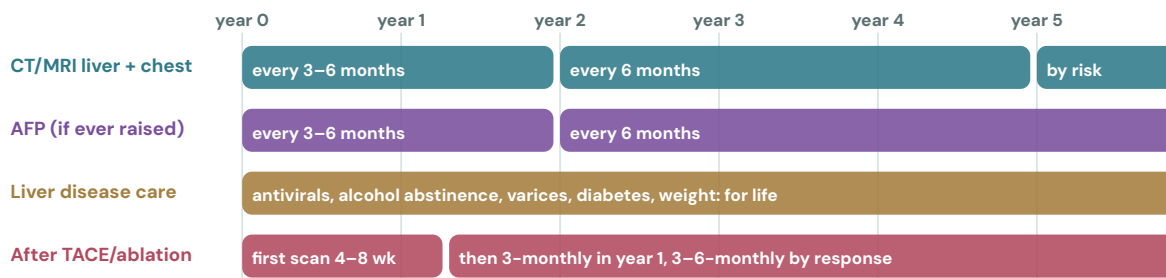


Hepatocellular Carcinoma: Follow-up and survivorship plan

Dr. Haritha Chiramana

MD, DM · Senior Medical Oncologist & Hemato-Oncologist

Years after curative treatment (resection, ablation) or after liver-directed therapy



Response after locoregional therapy is read with LI-RADS treatment response (viable enhancement), after systemic therapy with mRECIST or RECIST 1.1 (iRECIST with immunotherapy). After TARE or SBRT wait about 3 months for the first scan.

A simple follow-up rhythm (NCCN, AASLD, UpToDate). Continue for at least 5 years and then keep lifelong HCC surveillance, because the cirrhotic liver that produced the first cancer can produce a second one.

Treat the liver too

- Hepatitis B: entecavir or tenofovir for life
- Hepatitis C: cure with direct-acting antivirals
- No alcohol at all; control diabetes and weight
- Band varices; carvedilol if portal hypertension
- Vaccinate against hepatitis A and B; test the family

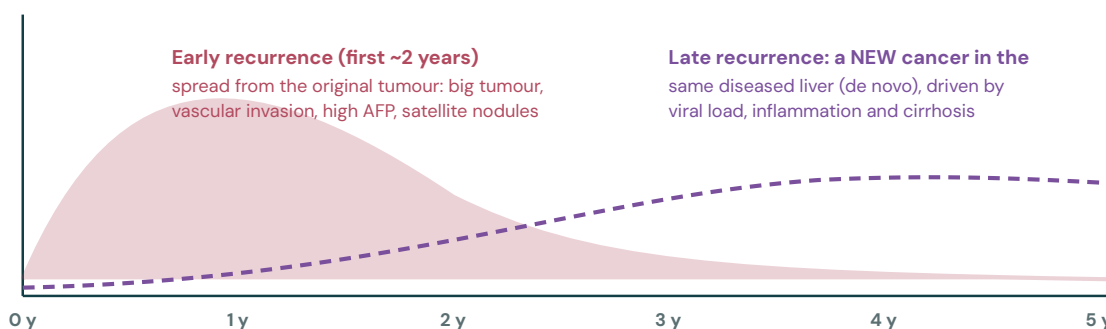
Red flags to report

- Jaundice, new or worse ascites, confusion
- Vomiting blood or black stools
- Sudden severe abdominal pain (rupture)
- Fever with right upper abdominal pain after TACE
- Diarrhoea, rash or jaundice on immunotherapy

Do not forget

- CT/MRI + AFP 3–6-monthly for 2 years, then 6-monthly
- HBV prophylaxis before TACE or immunotherapy
- Endoscopy within 6 months before bevacizumab
- No checkpoint inhibitors after liver transplant
- Lifelong surveillance even after cure

Recurrence after resection or ablation (illustrative shape, not to scale)



Reduce it: suppress hepatitis B (nucleos(t)ide analogue), cure hepatitis C, stop alcohol, control diabetes and weight. No adjuvant drug has proven benefit (STORM, IMbrave050, KEYNOTE-937); repeat resection, ablation or transplant can still cure.

When relapses happen. Early recurrences reflect the first tumour; late ones are new tumours in a liver that still carries the original risk. That is why antiviral therapy and liver care matter as much as the scan schedule.