

of positive HBV DNA was slightly higher than that of negative DNA ($P = 0.0078$, log-rank test).

Significance of serum HBV DNA in hepatocellular carcinogenesis

Cox proportional hazard model was performed for analysis of risk factors for liver carcinogenesis, using the 18 variables as mentioned above.

In the last step of stepwise regression analysis, the following five variables entered the model and could not be removed: sex ($P = 0.005$), serum HBV DNA ($P = 0.003$), past history of alcohol intake ($P = 0.003$), age ($P = 0.035$), and association of diabetes mellitus ($P = 0.022$) (Table 2). Accordingly, these five factors were significantly associated with hepatocellular carcinogenesis in the patients with non-B, non-C cirrhosis. Among them, gender was the strongest predictor of future HCC occurrence rate, indicating that male patients had 15.4 times as high carcinogenesis hazard as women patients. Similarly, positive HBV DNA (hazard ratio, 8.25) and little alcohol consumption of less than 500 kg (hazard ratio, 7.19) were the second and third strongest predictors for carcinogenesis, respectively. When the background factors of the cases were adjusted with the other significant factors, positive test for HBV DNA was significantly associated with the hepatocellular carcinogenesis rate.

Curves of carcinogenesis rates were generated from the multivariate analysis in an imaginary positive DNA group and an imaginary negative DNA group, with average sex ratio, average alcohol intake, average age and average association rate of diabetes (Fig. 2). The difference of the carcinogenesis curves indicated 'pure' impact of positive serum HBV DNA upon the carcinogenesis, which was

Table 2 Independent factors associated with liver carcinogenesis in the patients with non-B, non-C cirrhosis

Factors	Category	Hazard ratio (95% confidence interval)	P
Sex	Women	1	0.005
	Men	15.4 (2.24–111.1)	
Serum HBV DNA*	Negative	1	0.003
	Positive	8.25 (2.01–33.93)	
Total alcohol intake	≥500 kg	1	0.003
	<500 kg	7.19 (1.98–26.32)	
Age	<60 years	1	0.035
	≥60 years	3.98 (1.10–14.42)	
Diabetes mellitus	No	1	0.022
	Yes	3.89 (1.22–12.47)	

*Positive HBV DNA: positive for both HBc DNA and HBx DNA.

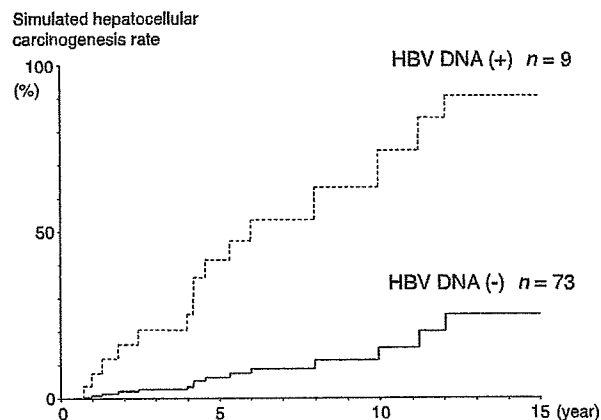


Fig. 2 'Adjusted' hepatocellular carcinogenesis rates in the positive HBV DNA group and the negative DNA group. Cox proportional hazard analysis showed that the carcinogenesis rate in the positive DNA group was significantly higher than that of the negative DNA group, when the other significant covariates were substituted with the same average parameters in the two groups.

adjusted with significant covariates assuming a standardized study group.

Mortality and causes of death

During the observation period, 36 (43.9%) of 82 patients died: 5 (55.6%) of 9 patients in the positive DNA group and 31 (42.5%) of 73 patients in the negative DNA group. Cumulative survival rates in patients with and without HBV DNA were 78.8% and 74.1% at the end of the fifth year, 54.4% and 44.4% at the tenth year, 38.4% and 29.6% at the 15th year, and 33.6% and 29.6% at the 20th year, respectively. Although the survival rate in the positive HBV DNA group was lower than in the negative group, statistical significance was not shown.

Causes of death included liver failure due to liver cirrhosis in 21 (4 in positive DNA group and 17 in negative DNA group), progression of HCC in 7 patients (all in negative DNA group), and other causes in 8 (one in positive DNA group and 7 in negative DNA group).

DISCUSSION

Epidemiological and molecular virological studies in the 1970s and early 1980s established a strong aetiological association between chronic HBV infection and the hepatocellular carcinogenesis [35]. We also estimated annual carcinogenesis rates as 0.5% in chronic hepatitis and 3% in cirrhosis, from cohorts of biopsy-proven HBV disease [5,7].

Integration of HBV DNA has been reported in the majority of HBsAg positive HCCs since 1980s, and the fact suggested HBV might be oncogenic. Up to now, there is no evidence

that HBV DNA is directly oncogenic and the mechanism by which chronic HBV infection leads to carcinogenesis remains unclear. Integration of HBV DNA may stimulate cellular pro-oncogenes or suppress growth-regulating genes [36]. Integration of HBV DNA, however, has been found in varied regions of the host chromosomes and no preferential and specific site has been identified until now. The other authors suggested that integration of HBV DNA could also induce carcinogenesis via transactivation of other oncogenes [37]. Both HBx protein and the truncated pre-S/S protein are potent transactivators and are commonly found in HCC tissue but their precise role in hepatocarcinogenesis remains unknown.

Occult HBV infection is generally defined as the detection of HBV DNA in the serum or liver tissue of patients who test negative for hepatitis B surface antigen [38–41]. Occult HBV infection was first reported in the early 1980s when hybridization techniques for the detection of HBV DNA became available. These studies showed that HBV DNA could be detected in HBsAg negative patients with HCC [42]. Recent studies using more sensitive techniques confirmed the close correlation between chronic occult HBV infection and carcinogenesis. Many authors demonstrated the relationship between occult HBV infection and hepatocellular carcinogenesis, mainly by a pilot study or a case-control study [17,19–27]. Shiota *et al.* [24] reported in their case studies without control group that serum of 18 out of 26 HCC patients without HBsAg and anti-HCV were positive for either S, C, or X region on PCR and southern blotting. Pollicino *et al.* [26] described that viral DNA was detected in 68 of 107 cases of HCC tissue (63.5%) and in 63 of 192 cases of chronic hepatitis tissue (32.8%), and concluded that occult HBV is a risk factor for development of HCC. The other authors also emphasized the high incidence of HBV DNA in either serum or HCC tissue compared with that of cases without HCC development. All the literatures, except one [43] from Taipei where HBV infection was endemic and prevalent, concluded that occult HBV infection was closely associated HCC development. However, precise risk or hazard ratio for carcinogenesis has not been reported.

Current study on this topic provided strong evidence of an association between occult HBV infection and HCC. In the patient cohort of non-B, non-C cirrhosis, occult HBV infection increased the future carcinogenesis rate with a hazard ratio of 8.25 (95% confidence interval, 2.01–33.93). It has been proposed that diagnosis of occult HBV infection be made only when HBV DNA can be detected using at least two sets of primers from different areas of the HBV genome in duplicate assay [38,39]. Appropriate negative controls must be included in each assay and specificity of the amplification reaction confirmed by sequencing of the amplicons. Using this strict criterion, occult HBV infection was found in 9 (11.0%) of 82 Japanese patients with non-B, non-C cirrhosis. Background features of the nine patients with serum HBV DNA showed a slightly younger age, a

lower ALT, a slightly lower bilirubin, and a slightly higher platelet count (Table 1). Although all these demographic and laboratory findings were considered to favour low carcinogenic risk, the patients with cryptic HBV DNA infection developed HCC more frequently. After adjustment of these background covariates in the multivariate analysis, positivity of serum HBV DNA proved to be an independent risk factor for hepatocarcinogenesis (Table 2).

As this retrospective cohort consisted of only cirrhosis as an advanced liver disease, and as it included both alcoholic and non-alcoholic cirrhosis, the hazard ratio of 8.25 could not be applied for varied stages and varied aetiologies of liver disease. In order to elucidate the impact of occult HBV infection on carcinogenesis, future studies should be performed also in the other cohort of chronic liver disease, such as HCV-related disease. Although anti-HBc and anti-HBs antibody were measured in a small numbers of the patients, an exact relationship between serum HBV DNA and serum positivity of anti-HBc antibody was not analysed in this study. When we tested anti-HBc antibody in a small part of subjects, 3 of 6 patients (50.0%) with positive HBV DNA had serum anti-HBc antibody and 7 of 19 patients (36.8%) without HBV DNA had anti-HBc (Fisher's exact test, $P = 0.69$). For the convenience of clinical circumstance and practical usefulness, significance of positive anti-HBc on carcinogenesis risk should be elucidated through a large-scale cohort study with an identical assay for anti-HBc antibody.

Although a lot of epidemiological and clinicopathological evidence of the relationship has been published, precise role of occult HBV in this setting has been still unclear. Patients with occult hepatitis B overlap with those who previously have been classified as having recovered [44]. In fact, the distinction between recovery and occult hepatitis B is likely to be somewhat arbitrary, as recovery does not necessarily imply eradication of infection in all cases [30], but includes the possibility of complete suppression in some cases by a broad and vigorous immune response [44]. One of the most important clinical questions is whether occult hepatitis B merely represents a marker of past infection, or whether HBV genome persistence contributes to liver disease. It is very likely that occult HBV is a cofactor in the development of HCC. Several studies found that patients co-infected with HBV and HCV have increased risks of HCC compared with those with mono-infection. Our cohort studies [45] also showed that a risk factor of a history of heavy drinking interacted with HBV or HCV subtypes in a characteristic manner from the viewpoint of carcinogenesis in cirrhosis. The other important problem is whether occult HBV infection alone causes HCC. To address this question, studies on occult HBV infection in patients with HCC might provide details on other causes of chronic liver disease including nonalcoholic fatty liver disease, which may masquerade as cryptogenic cirrhosis, hemochromatosis, alpha-1-antitrypsin deficiency, and autoimmune liver disease [46]. Recently,

Castillo *et al.* [47] reported a clinical state of occult HCV infection, which shows negative serum anti-HCV, negative serum HCV RNA, and positive HCV RNA in liver biopsy specimen. Although we did not test the possibility of occult HCV infection in this study, future studies should be also aimed at the influence of latent HCV infection on hepatocarcinogenesis.

In conclusion, occult HBV infection significantly increased the incidence of hepatocellular carcinogenesis in patients with non-B, non-C cirrhosis. Although non-B, non-C cirrhosis seemed to include varied aetiology of liver disease, cryptic HBV infection should be taken account in the prediction of future HCC development.

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Original Article

Efficacy of platinum analogue for advanced hepatocellular carcinoma unresponsive to transcatheter arterial chemoembolization with epirubicin

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Aim: Hepatocellular carcinoma (HCC) often shows resistance to transcatheter arterial chemoembolization (TACE). Such patients often have a poor prognosis and are unresponsive to other forms of therapy. The aim of this retrospective study was to determine the response to TACE using platinum analogues in patients deemed resistant to TACE using epirubicin.

Methods: We studied 152 consecutive patients with advanced HCC resistant to TACE using epirubicin. All cases were treated with platinum analogue using transcatheter arterial chemotherapy with or without embolization.

Results: Computed tomography at 3 months after therapy showed complete response (CR) in 6 patients (4.0%), partial response (PR) in 28 (18%), stable disease (SD) in 35 (23%), and progressive disease (PD) in 83 (55%). The cumulative survival

rates for PR/CR patients who received platinum analogue-transcatheter arterial chemotherapy with or without embolization (81.8% at first year, 53.9% at second year, and 33.1% at third year) were significantly higher than those of SD/PD patients (36.6%, 17.5% and 7.4%, respectively) ($P < 0.001$). The 50% survival period was extended almost 1.4 year in PR/CR patients who received platinum analogue-transcatheter arterial chemotherapy with or without embolization.

Conclusion: Our retrospective study is the first to report the efficacy of platinum analogues for advanced HCC unresponsive to TACE using epirubicin.

Key words: hepatocellular carcinoma, platinum analogue, transcatheter arterial chemoembolization, unresponsive

INTRODUCTION

HEPATOCELLULAR CARCINOMA (HCC) is one of the most common neoplasms in Africa and Asia including Japan. Since it is well known that more than 80% of the cases with HCC are associated with liver cirrhosis, a routine check-up for cirrhotic patients with ultrasound (US) could potentially lead to the detection of small HCC. However, because of the association of cirrhosis and tumor multiplicity, surgical resection is performed only in 20% of the cases or less.^{1,2} Transcatheter arterial chemoembolization (TACE) has been reported to be an effective palliative treatment for

patients with unresectable HCC, and many chemotherapeutic agents such as doxorubicin, epirubicin, mitomycin were used with lipiodol in Japan.^{3–10} Although repeated TACE is one of the most potent therapies for unresectable HCC, resistance to the therapy often ensues after therapy repetition, and long-term survival rates after 3 years are not sufficiently high at present.

Platinum analogues are effective against many malignant tumors, and in recent years, they have been used in the treatment of HCC. It has been reported that carboplatin-lipiodol treatment improved 1-year survival rate compared with doxorubicin-lipiodol treatment in patients with advanced HCC.¹¹ As for cisplatin, several studies reported its effectiveness for advanced HCC. Furthermore, the efficacy of cisplatin and lipiodol combination therapy has been reported by several investigators.^{12–19} To our knowledge, however, there is no information on the efficacy of platinum analogues in TACE-epirubicin resistant HCC patients.

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The purpose of this retrospective study was to examine the efficacy of platinum analogues (carboplatin and cisplatin) for advanced HCC unresponsive to TACE using epirubicin.

PATIENTS AND METHODS

Study population

FROM 1980 TO 2006, 1,250 patients were diagnosed with HCC at the Department of Hepatology, Toranomon Hospital, Tokyo, Japan. Of these, 565 patients underwent TACE treatment for HCC. Among the 565 patients, 184 patients were judged by two hepatologists as embolization-resistant HCC and they received a platinum analogue. All 184 patients had been considered to have unresectable HCC at the time of diagnosis of HCC, and had undergone TACE therapy at least twice until being considered TACE-resistant. Embolization-resistant HCC was defined as an HCC whose number and/or size had increased in the treated segment and/or extended other segments despite repetitive course of TACE using epirubicin, lipiodol and gelatin sponge. Thus, this retrospective cohort study was based on 184 consecutive patients with TACE-resistant HCC.

Before treatment with carboplatin or cisplatin, all the patients underwent a comprehensive evaluation consisting of medical history, physical examination, measurement of tumor size, performance status, chest radiograph, liver imaging studies [computerized tomography (CT), ultrasonography (US), digital subtraction angiography (DSA)], complete blood count, and blood chemistry. Diagnosis of HCC was established based on the findings of US, CT, and DSA.

Of the 184 patients, 32 were excluded because they did not meet the following inclusion criteria: (i) typical hypervascular HCC by all imaging modalities; (ii) no history of other malignancies; (iii) no evidence of extrahepatic metastasis of HCC; (iv) performance status of 0–1; (v) adequate liver function with bilirubin value of 5 mg/dL or less; (vi) sufficient hematopoietic function with a platelet count of more than 25,000/mm³ and leukocyte count of more than 2,000/mm³; and (vii) an expected survival time of at least 3 months. All patients gave informed consent to the treatment. Accordingly, 152 patients with TACE-resistant HCC were retrospectively evaluated for efficacy of platinum analogue for advanced HCC unresponsive to TACE-epirubicin. The observation starting point was the time of first therapy using platinum analogue at our hospital.

Serologic markers for HCV and HBV

The diagnosis of HCV infection was based on detection of serum HCV antibody with RNA positivity. Anti-HCV was detected using a second-generation enzyme-linked immunosorbent assay (ELISA II) (Abbott Laboratories, North Chicago, IL). HCV-RNA was determined by the Amplicor method (Cobas Amplicor HCV Monitor Test, v2.0, Roche Molecular Systems, Inc., NJ). Hepatitis B surface antigen (HBs-Ag) was tested by radioimmunoassay (Abbott Laboratories, Detroit, MI). Serum HBV-DNA level was determined independently, using the nested PCR, by an experienced technician (M.K), who was blinded to the clinical information. The used serum samples were stored –80°C at first consultation.

Treatment protocol

Patients were hydrated through a peripheral line. The femoral artery was catheterized under local anesthesia, and a catheter was inserted superselectively into the hepatic artery that supplied the target tumor, for injection of the platinum analogue with or without Lipiodol (Lipiodol Ultrafluide, Laboratoire Guerbet, Aulnay-sous-Bois, France) and small gelatin cubes (1 × 1 mm). The platinum analogue used was either carboplatin at 150 to 450 mg/body (63% of patients received 450 mg/body) or cisplatin at 40 to 100 mg/body (36% of patients received 100 mg/body). Both analogues were administered slowly under careful fluoroscopic guidance. When using Lipiodol, the platinum analogue and Lipiodol were divided into six to eight parts and mutually injected. In patients who received Lipiodol, the volume of injected Lipiodol ranged from 2.0 to 5.0 mL. The dose of Lipiodol was determined according to tumor size and the degree of liver dysfunction.

Selection criteria of type of therapy

Patients were treated by three type of therapy, depending on the extent of their tumors and liver function; (i)hepatic arterial injection (HAI) were performed for those patients with a tumor thrombus into main portal trunk or with severe liver function, (ii)chemolipiodolization (CL) were performed for those patients with tumor thrombus in distal portal branch complicated with severe liver function, (iii)TACE were performed for those patients without main portal vein thrombus and severe liver function.

Background and laboratory data

Table 1 summarizes the profiles and data of 152 patients who were treated with carboplatin or cisplatin. The

Table 1 Demographics and laboratory data of 152 patients with HCC who underwent transcatheter arterial chemotherapy using platinum analogue for advanced HCC unresponsive to TACE-epirubicin

Parameter	(n = 152)
Patient characteristics	
Sex (M : F)	122:30
Age (years)	67 (38–85)
Back grounds of liver disease	
Hepatitis B surface antigen positive	27
HCV antibody positive	123
Both negative	2
Status of liver function	
Child–Pugh classification (A/B/C)	98/51/3
Laboratory data	
Platelet count ($\times 10^4$ / μ L)*	11.0 (3.4–35.5)
Albumin (g/dL)*	3.0 (2.1–4.5)
Bilirubin (mg/dL)*	1.0 (0.3–4.3)
AST (IU/L)*	68 (21–488)
Prothrombin time (%)*	84 (45.5–114)
ICG R15 (%)*	38 (6.0–76)
AFP (μ g/L)*	236 (2.0–112,000)
DCP (AU/L)*	153 (10–131,000)

*Expressed as median (minimum, maximum).

AFP, alpha-fetoprotein; AST, aspartate aminotransferase; DCP, des-gamma carboxyprothrombin; HCC, hepatocellular carcinoma; ICG R15, indocyanine green retention rate at 15 minutes; TACE, transcatheter arterial chemoembolization.

patients consisted of 122 men and 30 women, and their age ranged from 38 to 85 years (median, 67 years). They included 27 (18%) HBs-Ag positive patients, 123 (81%) HCV antibody positive patients, and 2 (1%) negative for both. At the time of the first platinum analogue treatment, the median serum albumin concentration was 3.0 g/dL, total bilirubin 1.0 mg/dL, indocyanine green retention rate at 15 minutes (ICG R15) 38%, prothrombin activity 84%, alpha-fetoprotein (AFP) 236 μ g/L, and des-gamma-carboxyprothrombin (DCP) was 153 AU/L. As for Child-Pugh classification, 98 (64%) were class A, 51 (34%) were class B, and 3 (2%) were class C patients.

Characteristics of hepatocellular carcinoma

Table 2 summarizes the profiles of HCC that were treated with platinum analogue. The median tumor size was 40 mm. A solitary HCC was detected in 6 (4%) patients while multiple HCC were detected in 146 patients at the time of the first platinum analogue treatment. For the latter group, the tumors were localized to one segment in 10 (7%) patients, to one lobe in 32 (21%) patients, and in both lobes in 104 (68%)

Table 2 Profile of HCC in 152 patients who underwent transcatheter arterial chemotherapy using a platinum analogue for advanced HCC unresponsive to TACE-epirubicin

Profiles of liver cancer	
Tumor size (mm)*	40 (8–180)
Intrahepatic multiplicity	
Solitary	6
Multiple, localized to one segment	10
Multiple, localized to one lobe	32
Multiple, extended to both lobes	104
Portal vein invasion (no/yes)	106/46
Embolization iteration until unresponsiveness	4 (2–16)
The kind of used platinum analogue	
Carboplatin/Cisplatin	105/47
Treatment method	
HAI/CL/TACE	73/20/59

*Expressed as median (minimum, maximum).

CL, chemolipiodalization; HAI, hepatic arterial injection; HCC, hepatocellular carcinoma; TACE, transcatheter arterial chemoembolization.

patients. Portal vein invasion was noted in 46 (30%) patients. The number of courses of TACE-epirubicin until judgment of embolization-resistance ranged from 2 to 16 with a median of 4 courses. The median interval between diagnosis of HCC and judgment of embolization-resistance was 30.1 months.

The type of platinum analogue used for treatment was carboplatin for 105 (69%) patients, and cisplatin for 47 (31%) patients. With regard to the method used for delivery of platinum analogue, hepatic arterial injection (HAI) was used in 73 (48%) patients, chemolipiodalization (CL) was used in 20 (13%) patients and TACE in 59 (39%) patients.

Assessment of therapeutic effects and follow-up

The effects of chemotherapy were evaluated by CT every three months after treatment. The presence of non-enhanced tumor areas reflects tissue necrosis, and according to the findings of this imaging technique, the response to treatment was defined according to the World Health Organization criteria:²⁰ complete response: no evidence of neoplastic disease; partial response: reduction in total tumor load of $\geq 50\%$; no change: reduction of $< 50\%$ or increase of $< 25\%$; progressive disease: increase of $\geq 25\%$.

Patients were examined by physicians every 4 weeks including monitoring of AFP, DCP and other biochemical data after the diagnosis of embolization-resistance.

Table 3 Profile of 152 HCC patients who underwent transcatheter arterial chemotherapy using a platinum analogue for advanced HCC unresponsive to TACE-epirubicin, according to type of therapy

	HAI (n = 73)	CL (n = 20)	TACE (n = 59)
Profile of liver cancer and tumor marker			
Tumor size (mm)*	48 (8–180)	40 (8–100)	33 (12–180)
Intrahepatic multiplicity			
Solitary	4	1	1
Multiple, localized to one segment	3	2	5
Multiple, localized to one lobe	14	7	11
Multiple, extended to both lobes	52	10	42
Portal vein invasion (no/yes)	45/28	12/8	49/10
AFP (μg/L)*	257 (3–112000)	682 (17–65900)	145 (2–103000)
DCP (AU/L)*	400 (10–131000)	68 (10–53900)	40 (10–55420)
Status of liver function			
Child-Pugh classification (A/B/C)	43/28/2	13/6/1	42/17/0

*Expressed as median (minimum, maximum).

AFP, alpha-fetoprotein; CL, chemolipiodalization; DCP, des-gamma carboxyprothrombin; HAI, hepatic arterial injection; HCC, hepatocellular carcinoma; TACE, transcatheter arterial chemoembolization.

Imaging studies, as required for measurement of tumor size, were performed at around 3 months after therapy. Some patients took oral or intravenous medicinal herbs or other palliative therapies during the follow-up period.

Statistical analysis and ethical considerations

The factors that influenced the treatment outcome ((partial response (PR) or complete response (CR)) in this cohort were analyzed by the χ^2 test, and the cumulative survival rate was analyzed by Kaplan-Meier method. The risk factors involved in survival were evaluated by univariate analysis with the log-rank test. The independent factors associated with the curative effect (PR or CR) and survival rate were identified using the stepwise Cox regression analysis. Potential risk factors assessed for curative outcome (PR and CR) and survival rate included the following 17 variables: age, sex, HBs-Ag, HCV-antibody, aspartate transaminase (AST), albumin, bilirubin, AFP, DCP, prothrombin activity, ICG-R15, tumor size, multiplicity, portal vein invasion of HCC, treatment methods (HAI/CL/TACE), the type of platinum analogue (carboplatin/cisplatin) and the dose of platinum analogue used for treatment. Several variables were transformed into categorical data consisting of two-three simple ordinal numbers for univariate and multivariate analyses. All factors found to be at least marginally associated with the curative effect and survival ($P < 0.10$) in univariate analysis were entered into a multivariate logistic regres-

sion and Cox proportional hazard models. Significant variables were selected by stepwise method in the procedure. Proportional hazard analysis was also employed in the identification of contributing factors to the curative effect and survival rate. A P -value of less than 0.05 in two-tailed test was considered significant. Data analysis was performed using SPSS software version 11.0 (SPSS Inc, Chicago, Ill).

The study protocol was approved by the Human Ethics Review Committee of Toranomon Hospital. The physicians in charge explained the purpose and method of the clinical trial to each patient, who gave their informed consents for participation.

RESULTS

Efficacy of platinum analogue, according to type of therapy

TABLE 3 SUMMARIZES the profiles and data of 152 HCC patients who were treated with platinum analogue, according to type of therapy.

In these patients, 6 of 152 (4%) patients showed CR, 28 (18%) patients showed PR, 35 (23%) patients showed stable disease (SD), and 83 (55%) patients showed progressive disease (PD). Analysis according to type of therapy showed 73 of 152 (48%) patients received HAI, 20 (13%) received CL, and 59 (39%) received TACE. The efficacy of transcatheter arterial chemotherapy using platinum analogue according to the type of therapy was as follow; in HAI group: 1 of 73

Table 4 Efficacy of transcatheter arterial chemotherapy using platinum analogue for advanced HCC in 152 patients unresponsive to TACE-epirubicin, according to type of therapy

	CR (%)	PR (%)	SD (%)	PD (%)
Total (<i>n</i> = 152)	6 (4%)	28 (18%)	35 (23%)	83 (55%)
Type of therapy				
HAI (<i>n</i> = 73)	1 (1%)	9 (12%)	16 (22%)	47 (65%)
CL (<i>n</i> = 20)	1 (5%)	3 (15%)	7 (35%)	9 (45%)
TACE (<i>n</i> = 59)	4 (7%)	16 (27%)	12 (20%)	27 (46%)

CL, chemolipiodalization; CR, complete remission; HAI, hepatic arterial injection; HCC, hepatocellular carcinoma; PD, progressive disease; PR, partial response; SD, stable disease; TACE, transcatheter arterial chemoembolization.

(1%) patients showed CR, 9 of 73 (12%) patients showed PR, 16 of 73 (22%) patients showed SD, and 47 of 73 (65%) patients showed PD; in CL group: 1 of 20 (5%) patients showed CR, 3 of 20 (15%) patients showed PR, 7 of 20 (35%) patients showed SD, and 9 of 20 (45%) patients showed PD; in TACE group: 4 of 59 (7%) patients showed CR, 16 of 59 (27%) patients showed PR, 12 of 59 (20%) patients showed SD, and 27 of 59 (46%) patients showed PD (Table 4).

Factor influencing curative effect (PR or CR)

We then investigated the factors associated with curative effect (PR or CR) after treatment using platinum analogue. Univariate analysis identified the following 11 factors that influenced the rate of curative effect (PR or CR): serum DCP (< 100 IU/L/≥ 100 IU/L, *P* = 0.001), serum AFP (< 200 μg/L/≥ 200 μg/L, *P* = 0.005), ICG-R15 (< 30%/≥ 30%, *P* = 0.005), tumor size (< 20 mm/

≥ 20 mm, *P* = 0.011), portal vein invasion (yes/no, *P* = 0.014), total bilirubin (< 1.5 mg/dL/≥ 1.5 mg/dL, *P* = 0.018), treatment method (HAI/CL/TACE, *P* = 0.021), type of platinum analogue (carboplatin/cisplatin, *P* = 0.021), intrahepatic multiplicity that extended to both lobes (yes/no, *P* = 0.028), age (< 60/≥ 60, *P* = 0.057), and serum AST (< 50 IU/L/dL/≥ 50 IU/L, *P* = 0.057). These parameters were entered into multivariate logistic regression analysis. The curative effect (PR or CR) was significantly higher for elderly patients (aged ≥ 60, risk ratio: 7.75; 95% CI: 1.80–33.40), small size HCC (< 20 mm, risk ratio: 4.88; 95% CI: 1.62–14.71), TACE-platinum analogue treatment (yes, risk ratio: 3.91; 95% CI: 1.34–11.38), lower serum total bilirubin level (< 1.5 mg/dL, risk ratio: 3.44; 95% CI: 1.22–9.71), and Tumor multiplicity, extended to both lobes (no, risk ratio: 2.30 (1.03–7.09) (Table 5).

Table 5 Factors associated with curative effects in patients who underwent transcatheter arterial platinum analogue therapy for advanced HCC unresponsive to TACE-epirubicin

Factors	Category	Risk Ratio (95% confidence interval)	<i>P</i>
Age (year)	1: < 60	1	0.006
	2: ≥ 60	7.75 (1.80–33.40)	
Tumor size (mm)	1: ≥ 20	1	0.005
	2: < 20	4.88 (1.62–14.71)	
Tumor therapy	1: HAI	1	0.256
	2: CL	2.47 (0.52–11.69)	
	3: TACE	3.91 (1.34–11.38)	
Bilirubin (mg/dL)	1: ≥ 1.5	1	0.020
	2: < 1.5	3.44 (1.22–9.71)	
Multiple HCC, extended to both lobes (yes/no)	1: yes	1	0.044
	2: no	2.30 (1.03–7.09)	

CL, chemolipiodalization; CR, complete remission; HAI, hepatic arterial injection; HCC, hepatocellular carcinoma; PR, partial response; TACE, transcatheter arterial chemoembolization.

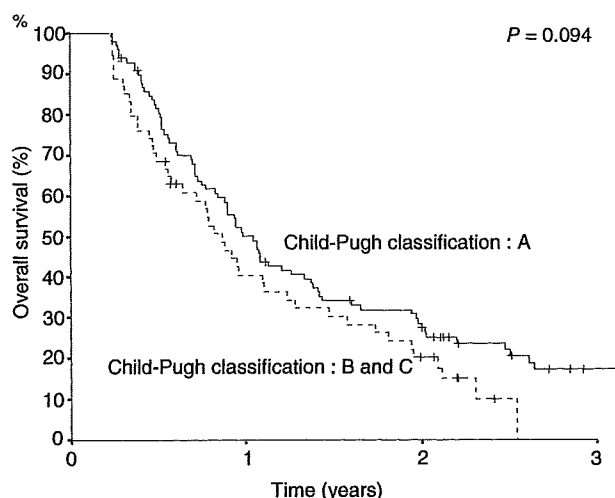


Figure 1 Cumulative survival rates after the first use of platinum-analogue for advanced HCC unresponsive to TACE-epirubicin, according to Child-Pugh classification.

Cumulative survival rate according to Child-Pugh classification

During the observation period, 125 of 152 (82.2%) patients died. The cumulative survival rates after the first use of platinum analogue therapy for advanced HCC unresponsive to TACE-epirubicin according to Child-Pugh classification were 50.1% at the end of the first year, 28.7% at the second year, and 17.2% at the third year for patients with Child-Pugh class A, and 40.5% at the first year, 20.3% at the second year, 0% at the third year for patients with Child-Pugh class B and C. The cumulative survival rates were slightly higher in patients with Child-Pugh class A than in those with Child-Pugh class B and C ($P = 0.094$), but no statistical significance was not there (Fig. 1).

Cumulative survival rate according to type of therapy

The cumulative survival rates after the first use of platinum analogue therapy for advanced HCC unresponsive to TACE-epirubicin according to type of therapy were 33.6% at the end of the first year, 15.4% at the second year, and 5.6% at the third year for patients with HAI group, 55.0% at the first year, 24.0% at the second year, 18.0% at the third year for patients with CL group, and 60.8% at the first year, 40.0% at the second year, 21.7% at the third year for patients with TACE group.

The cumulative survival rate was significantly different in these three type of therapy ($P = 0.002$) (Fig. 2).

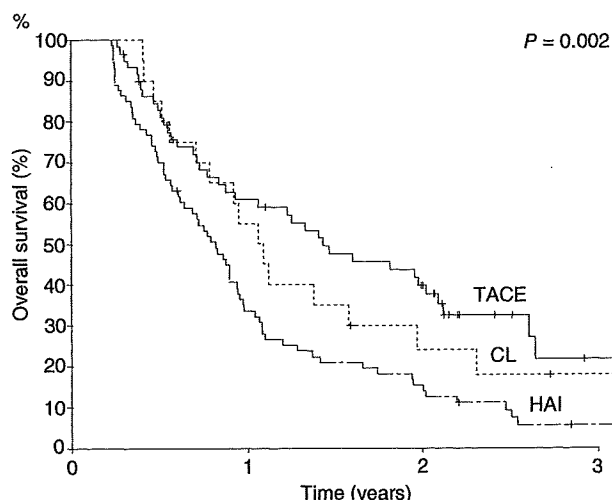


Figure 2 Cumulative survival rates after the first use of platinum-analogue for advanced HCC unresponsive to TACE-epirubicin, according to type of therapy.

Cumulative survival rate according to treatment effect

The cumulative survival rates after the first use of platinum analogue therapy for advanced HCC unresponsive to TACE-epirubicin were 81.8% at the end of the first year, 53.9% at the second year, and 33.1% at the third year for patients with PR or CR, and 36.6% at the first year, 17.5% at the second year, 7.4% at the third year for patients with PD or SD. The cumulative survival rates were significantly higher in patients with PR or CR than in those with SD or PD by transcatheter arterial chemotherapy using platinum analogue ($P < 0.001$) (Fig. 3). The 50% survival period was extended almost 1.4 year in patients with PR or CR by transcatheter arterial chemotherapy using platinum analogue.

Factor affecting survival rate

We then investigated the factors associated with survival rate after the first transcatheter arterial chemotherapy using platinum analogue for advanced HCC unresponsive to TACE-epirubicin. Univariate analysis identified the following 13 factors that influenced the survival rate: portal vein invasion (yes/no, $P < 0.001$), type of platinum analogue (carboplatin/cisplatin, $P = 0.001$), tumor size ($< 20 \text{ mm} / \geq 20 \text{ mm}$, $P = 0.001$), serum DCP ($< 100 \text{ IU/L} / \geq 100 \text{ IU/L}$, $P = 0.001$), age ($< 60 / \geq 60$, $P = 0.001$), serum AFP ($< 200 \mu\text{g/L} / \geq 200 \mu\text{g/L}$, $P = 0.006$), treatment method (HAI/CL/TACE, $P = 0.008$), intrahepatic multiplicity that extended to both lobes

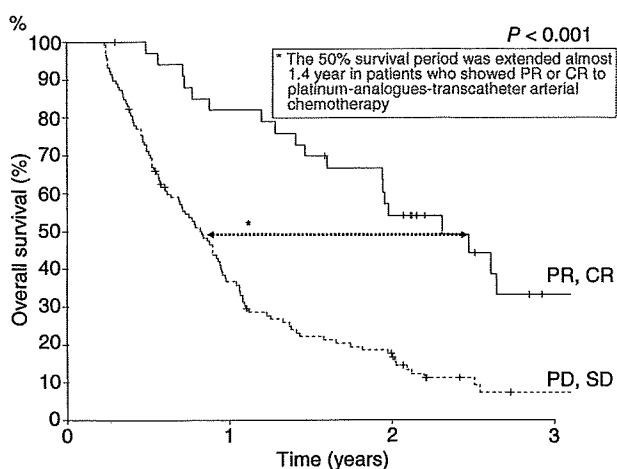


Figure 3 Overall survival rates after the first use of platinum-analogue for advanced HCC unresponsive to TACE-epirubicin, according to treatment effect.

(yes/no, $P = 0.012$), serum AST (< 50 IU/L/ ≥ 50 IU/L, $P = 0.014$), prothrombin activity ($< 80\%$ / $\geq 80\%$, $P = 0.020$), HBs-Ag (positive/negative, $P = 0.048$), anti HCV antibody (positive/negative, $P = 0.063$), and total bilirubin (< 1.5 mg/dL/ ≥ 1.5 mg/dL, $P = 0.068$). These parameters were entered into multivariate Cox proportional hazard analysis. The curative survival rate was significantly higher for small size HCC (< 20 mm, hazard ratio: 2.60; 95% CI: 1.30–5.19), no evidence of portal vein invasion (hazard ratio: 2.08; 95% CI: 1.37–3.16), TACE treatment (yes, hazard ratio:

1.93; 95% CI: 1.23–3.02), HBs antigen negative (yes, hazard ratio: 1.82; 95% CI: 1.13–2.93), and low AST level (< 50 IU/L, hazard ratio: 1.67; 95% CI: 1.06–2.61) (Table 6).

Toxic effects

The most common side effects observed after treatment with a platinum analogue were fever and vomiting. Low-grade fever of 37–38°C lasting for a few days occurred in 78 (51.3%) patients, and fever of $\geq 38^\circ\text{C}$ occurred in the other 51 (33.6%) patients. Nausea was reported in 125 (82.2%) patients, vomiting was noted at the time of treatment in 49 (32.2%) patients, dull pain in the upper abdomen was reported at the time of infusion by 31 patients (20.4%), a rise in serum aminotransferases was seen in 80 (52.6%) patients: 36 showed a rise up to twice the values before treatment, and 44 showed a rise of 1.5 to 1.9 times the baseline values. Within one week of treatment, 42 (27.6%) patients showed a transient rise in total bilirubin level to twice the pretreatment value. No adverse effects due to embolization in critical organs such as the lung, the heart, or brain were noted.

Causes of death

During the observation period, 125 (82.2%) patients died. The cause of death was HCC in 106 (84.8%) patients, liver failure in 14 (11.2%) patients and other causes in 5 (4.0%) patients.

Table 6 Factors associated with overall survival rate in patients with underwent transcatheter arterial platinum analogue therapy for advanced HCC unresponsive to TACE-epirubicin (Multivariate Cox proportional hazard analysis)

Factors	Category	Hazard Ratio (95% confidence interval)	P
Tumor size (mm)	1: ≥ 20	1	0.007
	2: < 20	2.60 (1.30–5.19)	
Portal vein invasion (yes/no)	1: yes	1	0.001
	2: no	2.08 (1.37–3.16)	
Tumor therapy	1: HAI	1	0.050
	2: CL	1.80 (1.00–3.24)	
	3: TACE	1.93 (1.23–3.02)	
HBs antigen	1: positive	1	0.013
	2: negative	1.82 (1.13–2.93)	
AST (IU/L)	1: ≥ 50	1	0.026
	2: < 50	1.67 (1.06–2.61)	

CL, chemolipiodalization; HAI, hepatic arterial injection; HCC, hepatocellular carcinoma; TACE, transcatheter arterial chemoembolization.

DISCUSSION

ALTHOUGH TACE IS one of the most potent methods of treatment for unresectable HCC, various types of resistances to therapy can occur during the repetition of embolization. However, to our knowledge, there is no report that assessed the efficacy of platinum analogue for TACE-resistant HCC patients. Since various chemotherapeutic agents have occasionally produced objective tumor regression in palliative management of advanced liver cancer, we used platinum analogues for embolization-resistant HCC.

In our study, the 50% survival period was extended almost 1.4 year in patients who showed PR or CR in response to transcatheter arterial chemotherapy using platinum analogue for TACE-resistant HCC. We consider this outcome encouraging in TACE-resistant HCC, because these types of tumors are usually unexpected respond to any treatment. Multivariate analysis indicated that it is important to deliver the platinum analogue via TACE in order to achieve a satisfactory curative effect. A previous study reported the efficacy of cisplatin when injected with Lipiodol for preoperative TACE therapy (termed "sandwich therapy") in patients with HCC who received TACE as the first treatment.¹⁴

In univariate analysis, the cumulative survival rates were slightly higher in patients with Child-Pugh class A than in those with Child-Pugh class B and C, but in multivariate analysis, the factor of liver function was not significantly related to survival rate. In the result of multivariate analysis, tumor related factors more affected on the cumulative survival rates than liver function in this study.

The type of therapy, in univariate analysis, the cumulative survival rates were significantly different among the therapies. Multivariate analysis disclosed that the type of therapy significantly affected on cumulative survival rate after the first use of platinum analogue therapy for advanced HCC unresponsive to TACE-epirubicin.

These results indicated that it is important to deliver the platinum analogue via TACE in order to obtain a more long term survival, as well as curative effect.

Our results showed that the survival rate of HBV-positive HCC patients was significantly lower than that of HCV-positive patients with advanced HCC. HBV-related HCC or non-viral hepatitis-related HCC are often diagnosed at a more advanced stage than HCV-related HCC, and patients with such advanced-stage HCC related to HBV or non-viral etiology showed poor prognosis compared to those with HCV-related HCC.²¹

This may explain the lower survival rate in our patients with HBV-related HCC.

In this study, we used two types of platinum analogues (cisplatin and carboplatin), and the results of univariate analysis, the curative effect (PR and CR) and overall survival rate were significantly better for cisplatin than carboplatin use. It is reported that cisplatin is more effective as an anti-tumor agent compared with carboplatin,^{22,23} although there are no studies that compared the efficacy of the two agents in HCC. Our study was limited because it was retrospective in nature, but our results indicate that the chemotherapeutic effects of platinum analogues against HCC are more favorable for cisplatin than carboplatin, similar to other solid tumors. Further studies are required to investigate the underlying mechanism for the difference in efficacy of cisplatin than carboplatin.

A number of molecular-based chemotherapeutic agents are expected to become available in the future, such as Sorafenib,²⁴ and the primary therapy of advanced stage HCC may change with the introduction of these drugs. However, the results of our study suggested the advantage of using cisplatin in patients with TACE-resistant HCC. Although further studies are required to confirm our findings, the combination of various types of molecular targeting drugs and TACE may improve the treatment outcome in advanced-stage HCC.

In conclusion, the present study reports the efficacy of platinum analogues in patients with advanced HCC unresponsive to TACE-epirubicin. Most such patients have poor prognosis mainly because of lack of effective therapy. However, our results show that the 50% survival period of patients who respond to platinum analogues-transcatheter arterial chemotherapy was extended to almost 1.4 years. Accordingly, we recommend this form of chemotherapy for patients with advanced HCC unresponsive to TACE-epirubicin.

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High Serum Des-gamma-carboxy Prothrombin Level Predicts Poor Prognosis After Radiofrequency Ablation of Hepatocellular Carcinoma

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BACKGROUND: Currently, surgical resection is considered the first-line treatment for early stage hepatocellular carcinoma (HCC). Radiofrequency ablation (RFA) has been an alternative choice for unresectable HCC. However, RFA is expected to have similar therapeutic efficacy for early stage HCC with fewer invasions. **METHODS:** The authors retrospectively analyzed 199 patients who underwent surgery and 209 patients who underwent RFA for HCC with a maximum diameter of ≤ 3 cm and tumors numbering ≤ 3 . All patients were complicated with Child-Pugh A cirrhosis. **RESULTS:** The 3- and 5-year survival rates of the resection (90.3%, 79.0%, respectively) and RFA groups were similar (87.4%, 74.8). The 1- and 3-year tumor recurrence-free survival rates of the resection group (83.1%, 51.0%, respectively) were higher than in the RFA group (82.7%, 41.8%; $P = .011$). Multivariate analysis identified prothrombin time $\geq 80\%$ (hazard ratio [HR], 2.72; 95% confidence interval [CI], 1.56-4.74; $P < .001$) as an independent prognostic factor for survival in the resection group. Des-gamma-carboxy prothrombin (DCP) < 100 arbitrary units (AU)/L (HR, 5.49; CI, 2.23-13.5; $P < .001$) and platelet count $\geq 1.0 \times 10^5$ (HR, 2.70; CI, 1.24-5.88; $P = .012$) were significant markers in the RFA group. Among patients with DCP ≥ 100 AU/L, treatment procedure (HR, 1.26; CI, 1.04-1.53; $P = .020$) was a significant prognostic factor for survival. **CONCLUSIONS:** High DCP levels reflect the biologic aggressiveness and progression of HCC tumors. In the aforementioned cases, we recommend surgical resection rather than RFA for such patients. *Cancer* 2009;115:571-80. © 2008 American Cancer Society.

KEY WORDS: hepatocellular carcinoma, DCP, radiofrequency, prognostic factor.

Hepatocellular carcinoma (HCC) is the sixth most common malignancy and third most deadly carcinoma in the world.¹ In Japan, HCC is ranked third among males and fifth among females as the leading causes of cancer death.² Most patients with HCC are infected with either hepatitis B virus (HBV) or hepatitis C virus (HCV), and have complications stemming from underlying chronic liver disease. The importance of liver condition in the treatment of HCC should be clearly discerned.³

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A maximum tumor diameter of ≤ 3 cm and tumors numbering ≤ 3 are good candidates for liver transplantation in patients with Child-Pugh class B and C.^{4,5} However, patients with Child-Pugh class A conditions should be treated curatively.^{5,6} Hepatectomy is currently recommended for patients with single asymptomatic HCC and extremely well-preserved liver function, who have neither clinically substantial portal hypertension nor abnormal bilirubin levels.⁶ However, resection is suitable for only 20% to 35% of patients with HCC because of poor hepatic reserve.^{7,8} Radiofrequency ablation (RFA) was introduced as a minimally invasive therapy for such cirrhotic patients.⁹⁻¹³ RFA was the initial choice for unresectable HCC; however, 2 recent randomized controlled trials concluded that there were no substantial statistical survival differences between resection and RFA.^{9,10} Although the results of these studies have not yet reached a worldwide consensus, some authors recommend RFA as a first-line therapy for such early stage HCC.¹¹⁻¹³

Tumor staging and the decision between possible treatment options are conducted predominantly based on tumor size, number, vascular invasion, and extrahepatic metastasis evaluated by imaging analysis such as ultrasonography or dynamic computed tomography (CT). However, the malignant nature of the tumor as well as other characteristics are not generally considered.^{14,15} Alpha-fetoprotein (AFP) and des-gamma-carboxy prothrombin (DCP) are HCC-specific tumor markers. High levels of serum tumor markers often indicate HCC development in the liver. On the basis of histopathological analysis, serum AFP and DCP levels are also correlated with tumor differentiation, microscopic portal invasion, or intrahepatic metastasis.^{16,17}

This present study is an attempt to evoke discussion on treatment strategies for small HCC measuring ≤ 3 cm by comparing the long-term outcome of patients treated with either hepatectomy or RFA as the first-line treatment for HCC. AFP and DCP were also accounted as indicators in the decision-making and treatment procedure.

MATERIALS AND METHODS

Patients

A total of 1057 patients were admitted to the Department of Hepatology, Toranomon Hospital between 1995 and 2006 for the treatment of initially developed HCC. The major background liver disease was HCV (767 patients,

72.6%), followed by HBV (196 patients, 18.5%), HCV + HBV (8 patients, 0.8%), alcoholic liver diseases (habitual drinking of ethanol at >80 g/day, 48 patients, 4.5%), primary biliary cirrhosis (4 patients, 0.4%), autoimmune hepatitis (2 patients, 0.2%), and cryptogenic liver disease (42 patients, 4.0%). Treatment of HCC included surgical resection in 281 patients, local ablation therapy in 398 patients (RFA, 267 patients; microwave coagulation, 47 patients; ethanol injection, 84 patients), and transarterial chemoembolization in 378 patients. Among these patients, we included patients with Child-Pugh A cirrhosis and HCC measuring ≤ 3 cm in diameter and numbering ≤ 3 tumors who were treated radically by either surgical resection or RFA. Table 1 summarizes the profile of the 199 patients who received resection and 209 patients who received RFA. HBV-related liver diseases were more common among patients who underwent resection, who were younger (62 vs 67 years; $P < .001$) than patients with RFA. The maximum tumor diameter was larger in the resection group than in the RFA group (20 vs 18 mm; $P < .001$). With regard to laboratory tests, serum albumin level, platelet count, and prothrombin time (%) were higher among patients in the resection group, whereas serum aspartate aminotransferase (AST) levels were higher among patients in the RFA group. None of the patients in either group had tumor invasion of the major portal branch or extrahepatic metastasis. Our institution does not require informed consent for retrospective analysis.

Diagnosis of HCC

Diagnosis of HCC was predominantly based on image analysis. If a hepatic nodular lesion was found on screening ultrasonography, the patient underwent dynamic CT and/or dynamic magnetic resonance imaging (MRI). Furthermore, when a liver nodule showed hyperattenuation in the arterial phase of dynamic study and washout in portal or delayed phase, or showed typical hypervascular staining on digital subtraction angiography, the nodule was diagnosed as HCC. According to the American Association for the Study of Liver Disease guidelines, we obtained at least 2 dynamic imaging images before treatment.⁵ When the nodule did not appear in the abovementioned typical imaging features, a fine needle aspiration biopsy was carried out followed by histological examination and diagnosis.

Table 1. Clinical Background of 199 Patients Who Underwent Hepatic Resection and 209 Patients Who Underwent Radiofrequency Ablation of Liver Tumor

Factors	Resection Group (n = 199)	RFA Group (n = 209)	P
Age, y*	62 (29-80)	67 (38-87)	<.001
Sex, men:women	146:53	137:72	NS
HBV:HCV:HBV + HCV:others	60:121:3:15	22:176:1:10	<.001
Habitual alcohol intake, yes:no	29:170	9:200	
Diameter of HCC, mm*	20 (9-30)	18 (8-30)	<.001
No. of HCC, 1:2:3	168:22:9	169:29:11	
Tumor vascularity, present:absent	185:14	156:53	
Albumin, g/dL*	3.7 (2.8-4.7)	3.6 (2.6-4.4)	<.001
Bilirubin, mg/dL*	1.0 (0.3-2.4)	1.0 (0.2-2.4)	NS
AST, IU/L*	43 (13-386)	55 (17-208)	<.001
Platelets, $\times 10^4/\text{mm}^3$ *	13.1 (4.0-27.2)	10.5 (2.7-25.3)	<.001
Prothrombin time, %*	92 (62-115)	88 (57-125)	.006
AFP, ng/mL*	22 (1-7960)	18 (2-1490)	NS
DCP, AU/L*	20 (<10-1650)	17 (<10-1370)	NS

RFA indicates radiofrequency ablation; NS, not significant; HBV, hepatitis B virus; HCV, hepatitis C virus; HCC, hepatocellular carcinoma; AST, aspartate aminotransferase; IU, international units; AFP, alpha-fetoprotein (AFP); DCP, des-gamma-carboxy prothrombin; AU, arbitrary units.

*Data are expressed as median (range).

Method of Treatment

Physicians and surgeons usually discuss together the preferred choice of therapy in individual patients. Hepatic resection was performed under intraoperative ultrasonographic monitoring and guidance. For small and superficial HCCs, arterial and portal vein clamping at hepatic hilum was not usually performed to maintain liver perfusion.

RFA was performed using 3 different devices: the radiofrequency interstitial tumor ablation system (RITA, RITA Medical Systems Inc., Mountain View, Calif), the cool-tip system (Tyco Healthcare Group LP, Burlington, Vt), and the radiofrequency tumor coagulation system (RTC system, Boston-Scientific Japan Co., Tokyo, Japan). In the first 2 systems, treatment procedures were performed according to the protocol advised by the manufacturer. However, treatment using the RTC system was performed by adopting the "stepwise hook extension technique."¹⁸ The needle was inserted into the tumor percutaneously under ultrasonographic guidance. Because the HCC nodule could not be observed by ultrasonography in 6 cases, the needle was inserted under CT assistance. In the case of RFA, dynamic CT was performed 1 to 3 days after therapy, and the ablated area was evaluated. The goal of treatment was to obtain a necrotic area larger than the

original tumor size, with a surrounding treatment margin of ≥ 5 mm in all directions. When this was not achieved or a residual tumor was found, additional ablation was considered. Of 206 total patients, total ablation session was required once in 149 (71.3%) patients, twice in 47 (22.5%) patients, and 3 times or more in 13 patients (6.2%).

Measurement of Serum AFP and DCP

Serum AFP level was measured by chemiluminescent enzyme immunoassay (CLEIA) using a commercial assay kit (Lumipulse Prestoll AFP, Fujirebio Inc., Tokyo, Japan). DCP level was measured by CLEIA (Lumipulse PIVKA II Eisai, Eisai, Tokyo, Japan).

Follow-up Protocol

Physicians examined the patients every 4 weeks after treatment, and liver function tests and tumor markers were also measured once every month. After completion of HCC eradication, recurrence was surveyed with contrast enhancement 3-phase CT every 3 months. Local tumor progression was defined as tumor recurrence adjacent to the resected or ablated area.

Statistical Analysis

Differences in background features and laboratory data between resection and RFA groups were analyzed by the chi-square test and Mann-Whitney *U* test. Survival and recurrence-free survival were analyzed using the Kaplan-Meier technique, and differences in curves were tested using the log-rank test. Independent risk factors associated with survival and recurrence-free survival were studied using stepwise Cox regression analysis.¹⁹ Potential risk factors for survival and recurrence-free survival included the following 14 variables: age, sex, etiology of background liver disease, amount of alcohol intake, serum albumin, bilirubin, AST, platelet count, prothrombin time, AFP, DCP, diameter of the HCC, tumor multiplicity, and tumor vascularity evaluated by dynamic CT or dynamic MRI. A probability of less than .05 was considered significant. Data analysis was performed using SPSS statistical software version 10 (SPSS Inc., Chicago, Ill).

RESULTS

Survival and Recurrence-free Survival Rates

During the median follow-up of 3.3 years (range, 0.1-12.2 years), 112 (56.3%) of 199 patients in the resection group and 120 (57.4%) of 209 patients in the RFA group developed HCC recurrence. HCC recurrences mainly occurred in other sites in the liver. However, in the RFA group, local tumor progression, defined as HCC recurrence adjacent to the treated site, was seen in 18 (8.6%) of 209 patients, but noted in only 1 patient of the resected group. The cumulative local tumor progression rate in the RFA group was 2.7%, 11.3%, and 12.5% at 1, 3, and 5 years, respectively. The tumors were treated with surgical resection in 2 patients, additional tumor ablation in 8 patients, and transcatheter chemoembolization in the remaining 8 patients.

Exactly 64 patients of the resection group and 31 patients of the RFA group died during the follow-up. The cause of death among patients in the resection group was tumor progression in 51, hepatic failure in 10, gastrointestinal bleeding in 1, and other causes in 2. Uniformly, the cause of death in the RFA group was tumor progression in 16, hepatic failure in 13, gastrointestinal bleeding in 1, and other causes in 1. The cumulative survival rates for the resection group at 1, 3, 5, and 7 years were 96.9%,

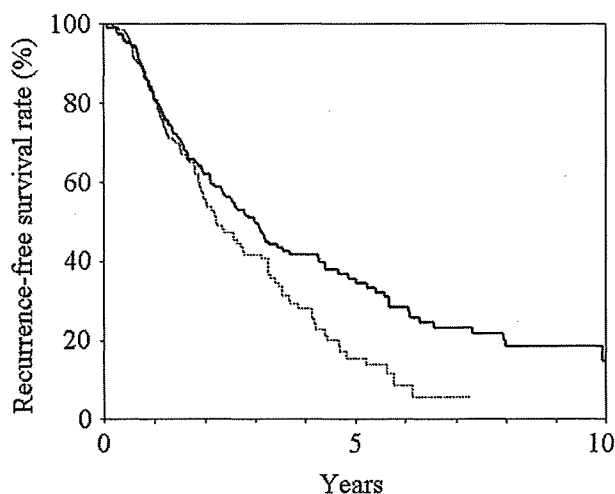


FIGURE 1. Cumulative recurrence free survival rates of the patients who underwent surgical resection (solid line) and radiofrequency ablation (RFA) (dotted line) are shown. The recurrence-free survival rate of the resection group was higher than of the RFA group ($P=.011$).

90.3%, 79.0%, and 61.5%, whereas those for the RFA group were 99.0%, 87.4%, 74.8%, and 65.4%, respectively. The overall survival rates were not significantly different between the 2 groups.

The tumor recurrence-free survival rates for the resection group at 1, 3, 5, and 7 years were 83.1%, 51.0%, 36.8%, and 23.3%, and for the RFA group were 82.7%, 41.8%, 17.0%, and 5.8%, respectively (Fig. 1). The recurrence-free survival rate was higher in the resection group than in the RFA group ($P=.011$).

Factors Associated With Survival in Patients in the Resection Group

Among 199 patients treated with surgical resection, factors associated with survival were evaluated by both univariate and multivariate analysis (Table 2). Single tumor, serum albumin >3.8 g/dL, and prothrombin time $>80\%$ were significant by Kaplan-Meier analysis, whereas factors such as age, sex, etiology of background liver disease, amount of alcohol intake, bilirubin, AST, platelet count, AFP, DCP, diameter of the HCC, and tumor vascularity were not significantly related to patients' survival. In a multivariate analysis using the Cox proportional hazard model, prothrombin time $>80\%$ (hazard ratio [HR], 2.72; 95% confidence interval [CI], 1.56-4.74; $P < .001$) was the independent prognostic factor for survival.

Table 2. Results of Univariate and Multivariate Analyses of Factors Associated With Survival of Patients Treated by Surgical Resection

Variable	No.	% 5-Year Survival Rate	Hazard Ratio (95% CI)	P
Univariate analysis				
No. of tumors				.012
Single	167	82.4	—	
Multiple	32	59.8	—	
Albumin, g/dL				.020
≥ 3.8	134	91.1	—	
< 3.8	64	73.1	—	
Prothrombin time (%)				.003
≥ 80	168	83.0	—	
< 80	29	60.1	—	
Multivariate analysis				
Prothrombin time, %, ≥ 80 / < 80			2.72 (1.56-4.74)	$< .001$

CI indicates confidence interval.

Table 3. Results of Univariate and Multivariate Analyses of Factors Associated With Survival in Patients Treated With Radiofrequency Ablation

Variable	No.	% 5-Year Survival Rate	Hazard Ratio (95% CI)	P
Univariate analysis				
Platelets, $\times 10^4/\text{mm}^3$.006
≥ 10	111	84.1	—	
< 10	98	65.5	—	
DCP, AU/mL				$< .001$
< 100	187	77.3	—	
≥ 100	13	33.6	—	
Multivariate analysis				
DCP, AU/L, < 100 / ≥ 100			5.49 (2.23-13.5)	$< .001$
Platelets, $\times 10^4/\text{mm}^3$, ≥ 10 / < 10			2.70 (1.24-5.88)	.012

CI indicates confidence interval; DCP, des-gamma-carboxy prothrombin; AU, arbitrary units.

Factors Associated With Survival in Patients in the RFA Group

We also evaluated the factors associated with the survival of 209 patients treated with RFA (Table 3). Platelet count $\geq 1.0 \times 10^5$ and DCP < 100 arbitrary units (AU)/L were significant in univariate analysis, whereas 12 other variables were not associated with survival. Multivariate analysis identified DCP < 100 AU/L (HR, 5.49; 95% CI, 2.23-13.5; $P < .001$) and platelet count $\geq 1.0 \times 10^5$ (HR, 2.70; 95% CI, 1.24-5.88; $P = .012$) as significant and independent determinants of survival.

Factors Associated With Recurrence-free Survival in Patients in the Resection Group

Next, we evaluated the factors associated with recurrence-free survival in patients treated with surgical resection (Table 4). Presence of a single tumor, serum albumin ≥ 3.8 g/dL, platelet count $\geq 1.0 \times 10^5$, and prothrombin time $\geq 80\%$ were significant in the univariate analysis, whereas 10 other variables were not significant factors for recurrence-free survival. In multivariate analysis, single tumor (HR, 2.39; 95% CI, 1.51-3.80; $P < .001$), serum albumin ≥ 3.8 g/dL (HR, 1.54; 95% CI, 1.02-2.32;

Table 4. Results of Univariate and Multivariate Analyses of Factors Associated With Recurrence-free Survival Among Patients Treated With Resection

Variable	No.	% 3-Year Survival Rate	Hazard Ratio (95% CI)	P
Univariate analysis				
No. of tumors				<.001
Single	166	55.4	—	
Multiple	32	24.5	—	
Albumin, g/dL				.009
≥3.8	63	71.7	—	
<3.8	134	42.1	—	
Platelets, ×10 ⁴ /mm ³				.025
≥10	137	60.3	—	
<10	60	33.0	—	
Prothrombin time, %				.009
≥80	167	55.7	—	
<80	29	29.0	—	
Multivariate analysis				
No. of tumors, single/multiple			2.39 (1.51-3.80)	<.001
Albumin, g/dL, ≥3.8/<3.8			1.54 (1.02-2.32)	.040
Platelets, ×10 ⁴ /mm ³ , ≥10/<10			1.47 (1.03-2.12)	.036

CI indicates confidence interval.

$P = .040$), and platelet count $\geq 1.0 \times 10^5$ (HR, 1.47; 95% CI, 1.03-2.12; $P = .036$) were independent prognostic factors for recurrence-free survival.

Factors Associated With Recurrence-free Survival in Patients in the RFA Group

Factors associated with recurrence-free survival were evaluated in patients treated by RFA. The 3-year recurrence-free survival rate was 44.7% in 185 patients with DCP <100 AU/L, whereas it was 0.0% in 13 patients with DCP ≥ 100 AU/L. Univariate and multivariate analysis identified only DCP <100 AU/L (HR, 6.82; 95% CI, 3.49-13.3; $P < .001$) as a significant determinant of recurrence-free survival.

Survival and Recurrence-free Survival in Patients With DCP >100 AU/L

Figure 2 shows the cumulative survival rate, and Figure 3 shows the recurrence-free survival rate based on DCP levels. The survival rate and recurrence-free survival rate were associated with DCP in the RFA group, but they were not associated with DCP in the resection group. AFP >400 AU/L was associated with neither survival rate nor recur-

rence-free survival rate in either the resection or the RFA group. Therefore, 27 selected patients from the resection group and 13 from the RFA group whose DCP was ≥ 100 AU/L were examined to determine whether the overall survival rate was different between the resection and RFA groups. The backgrounds of the 2 groups based on treatment procedure are shown in Table 5. Treatment procedure (resection), age <65 years and serum albumin >3.8 g/dL were significant in the univariate analysis. Multivariate analysis revealed that treatment procedure (HR, 1.26; 95% CI, 1.04-1.53; $P = .020$) was a significant and independent determinant in the overall survival rate (Table 6).

DISCUSSION

Patients with HCC usually have a history of chronic liver disease, especially cirrhosis. Unfortunately, even when curative therapy is performed, tumor recurrence is frequent. For this reason, less invasive treatment procedures are needed to preserve liver function.

The Barcelona Clinic Liver Cancer (BCLC) guideline for the treatment of HCC recommends resection for patients with a single HCC and Child-Pugh A who have no other complications.⁵ The suggested option for RFA includes patients with multiple tumors and associated

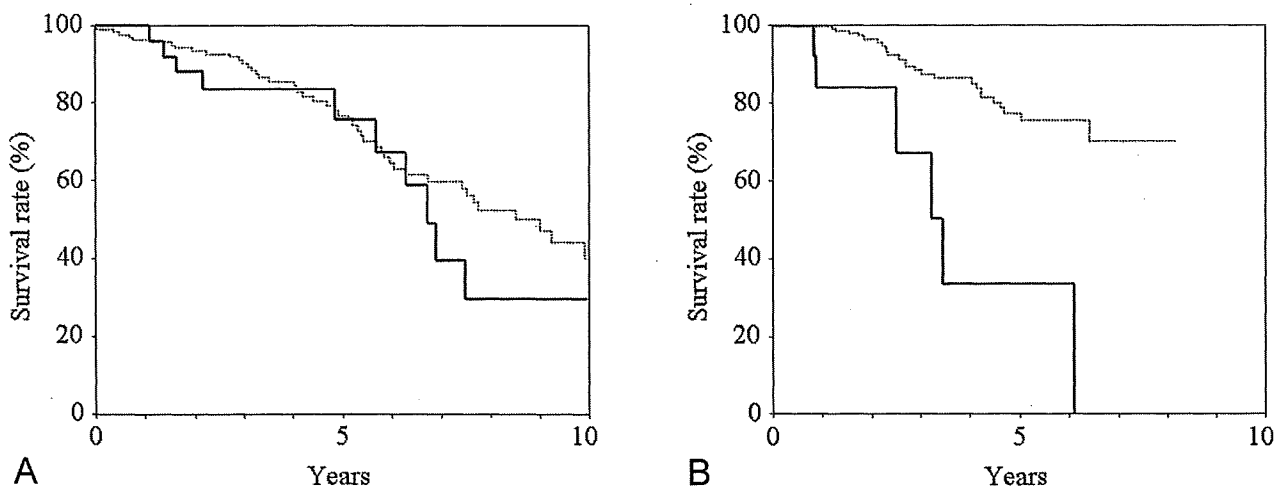


FIGURE 2. Cumulative overall survival rate of the patients who underwent surgical resection and radiofrequency ablation based on des-gamma-carboxy prothrombin (DCP) level is shown. Solid line indicates DCP level ≥ 100 AU/L; dotted line, DCP level < 100 AU/L. (A) Cumulative survival rate of patients who underwent resection based on DCP level is shown. (B) Cumulative survival rate of patients who underwent radiofrequency ablation (RFA) based on DCP level is shown. Prognosis of patients who underwent RFA varied according to DCP level, whereas prognosis of patients who underwent resection was independent of DCP level.

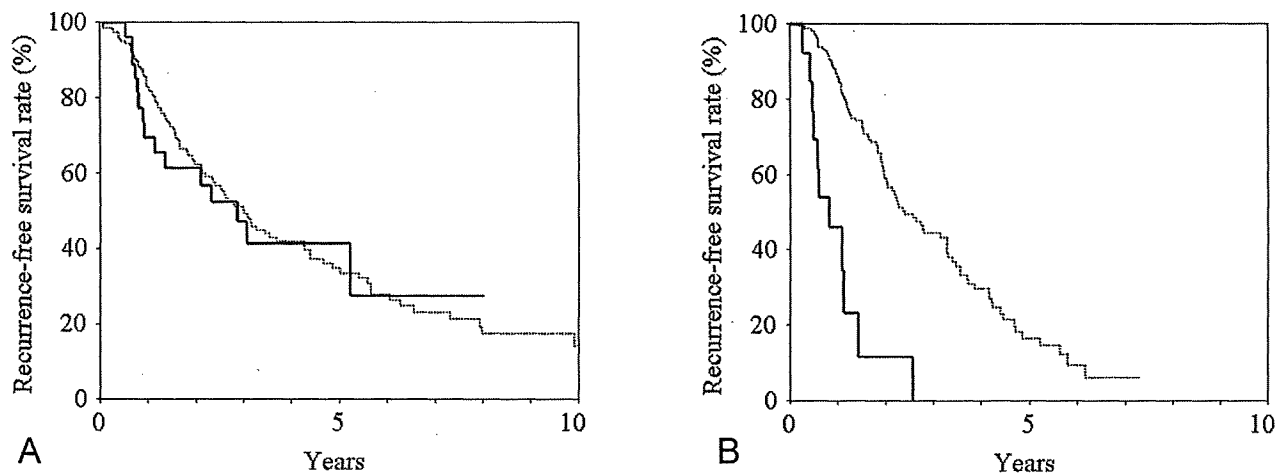


FIGURE 3. Cumulative recurrence-free survival (RFS) rate of the patients who underwent surgical resection and radiofrequency ablation based on des-gamma-carboxy prothrombin (DCP) level is shown. Solid line indicates DCP level ≥ 100 AU/L; dotted line, DCP level < 100 AU/L. (A) Cumulative RFS rate of patients who underwent resection based on DCP level is shown. (B) Cumulative RFS rate of patients who underwent RFA based on DCP level is shown. Prognosis of patients who underwent RFA varied according to DCP level.

disease. However, in clinical practice, RFA is widely applied as a curative treatment for variable stages of HCC. Advances in imaging diagnosis have allowed identification of small HCC measuring < 2 cm during the course of chronic liver disease.³ The use of RFA seems to be an excellent option for the aforementioned tumors.

In the present study, we focused on the malignant potential of HCC and examined 2 representative tumor

markers of HCC. AFP has been used as a tumor marker for HCC worldwide, and is considered by some as a predictor of survival or recurrence after RFA.¹² DCP is also useful as a prognostic factor in patients with HCC.²⁰⁻²²

In the present study, serum albumin levels and prothrombin time, which reflect liver function, were significantly associated with survival in patients who undergo resection similar to tumor multiplicity. Likewise, serum