

Erratum

Efficacy of hepatic resection for huge (≥ 10 cm) hepatocellular carcinoma: good prognosis associated with the uninodular subtype: Int J Clin Exp Med 2015; 8(11): 20581-20588

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Abstract: Background: The value of hepatic resection (HR) for huge hepatocellular carcinomas (HCC) (≥ 10 cm in diameter) remains controversial. The aim of this study is to evaluate the efficacy of hepatic resection (HR) for patients with huge HCC. Methods: A total of 739 patients with huge HCC (≥ 10 cm in diameter) (huge HCC group, n = 244) or small HCC (< 10 cm in diameter) (small HCC group, n = 495) who received initial HR were retrospectively analyzed. Overall survival (OS) and disease-free survival (DFS) were obtained using the Kaplan-Meier method and compared by Log-Rank test. Prognostic factors of huge HCC were identified based on Cox regression analyses. Results: The hospital mortality of these two groups were similar (P = 0.252). The 5-year OS of huge HCC group and small HCC group were 30.3% and 51.9%, respectively (P < 0.001). Uninodular huge HCC had a significant higher 5-year OS (50.6%) than multinodular huge HCC (26.9%) (P = 0.016). Multivariate analysis revealed that uninodular huge HCC and absence of PVTT independently predicted better OS for huge HCC patients. Conclusion: HR is a safe and effective approach for the treatment of huge HCC, especially for the uninodular subtype.

Keywords: Hepatic resection, hepatocellular carcinoma, huge, uninodular, mortality, overall survival, disease-free survival

I have read with interest the original article "Efficacy of hepatic resection for huge (≥ 10 cm) Hepatocellular carcinoma: good prognosis associated with the uninodular subtype" by Zhu et al. [1].

The authors have shared their experience of hepatic resection for huge (≥ 10 cm) hepatocellular carcinoma.

I want to congratulate Zhu et al. For their excellent outcome but I have one correction and some comments on the article.

Correction is: in the session of Prognostic factors for huge HCC (page 20583), it is written as "In the univariate analysis, HbsAg (-), AFP level < 400 ng/ml, uninodular huge HCC and absence of PVTT predicted better OS for huge HCC. The above predictive factors in univariate analysis were contained in them multivariate analysis. Uninodular huge HCC (HR = 1.834, 95% CI:

1.108-3.037, P = 0.018) and PVTT (HR = 1.656, 95% CI: 1.159-2.366, P = 0.006) still independently predicted better OS for huge HCC in multivariate analysis (Table 3)".

When we read the paragraph we understood that absence of PVTT predicted better OS for huge HCC. However it is written "Uninodular huge HCC (HR = 1.834, 95% CI: 1.108-3.037, P = 0.018) and PVTT (HR = 1.656, 95% CI: 1.159-2.366, P = 0.006) still independently predicted better OS for huge HCC in multivariate analysis (Table 3)". (Last sentence of prognostic factors for huge HCC on page 20583).

It has to be corrected as Uninodular huge HCC (HR = 1.834, 95% CI: 1.108-3.037, P = 0.018) and absence of PVTT (HR = 1.656, 95% CI: 1.159-2.366, P = 0.006) still independently predicted better OS for huge HCC in multivariate analysis (Table 3).

Efficacy of HR for huge HCC

Zhu et al. Reported that overall survival was significantly different between uninodular huge HCC group than multinodular huge HCC group ($P = 0.016$) but disease-free survival of patients between uninodular huge HCC and multinodular huge HCC was not significantly different according to the article ($P = 0.07$).

In the huge HCC group, 42 of them are uninodular HCC and 202 are multinodular HCC. 67 patients had cirrhosis in the huge HCC group. Four of the uninodular HCC patients (9.5%) have cirrhosis which means 63 patients (31.1%) in them multinodular huge HCC group have cirrhosis.

My comments are:

Did the type of liver resection affect the overall survival between uninodular and multinodular huge HCC?

How do you explain similar disease free survival between uninodular and multinodular huge HCC groups since one out of three patient in the multinodular HCC group has cirrhosis? Cirrhotic liver remnant is also a very well known risk factor for recurrence after liver resection [1, 2].

In Table 2, it is shown that recurrence was seen in 97 of the (39.8%) huge HCC patients. 88 patients had intrahepatic recurrence and 9 had extra hepatic recurrence.

My comment is:

In Figure 3B, most of the recurrence seems to be happened within the first year after surgery. What was the reason for early recurrence? How many patients in the uninodular HCC group had either intrahepatic or extrahepatic recurrence? How did this different recurrence rate in the huge HCC group affected the survival outcome between uninodular and multinodular HCC groups?

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