

*Multidisciplinary management of  
tumors of the liver and bile ducts*

Moderators:

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# Case 1

35 year old male followed for many years by PCP for ulcerative colitis

- Yearly colonoscopy shows quiescent disease
- Presents with
  - recent onset of itching,
  - fatigue and “yellow eyes”.
- No previous hx of liver disease
- Liver function tests are as follows:
  - Alkaline Phosphatase 500 u/l; T Bili 10 mg/dl, AST 276 u/l and ALT 400 u/l
  - INR 1.7, Cr 2.0 mg/dl and platelets 50,000
- Abdominal US:
  - dilated intrahepatic biliary tree
  - Normal sized CBD

AQ1. Appropriate next step in the management of this patients would be

1. MRCP
2. ERCP
3. Four phase CT abdomen
4. MRI with gadolinium contrast
5. PET scan

# Charles Rosen

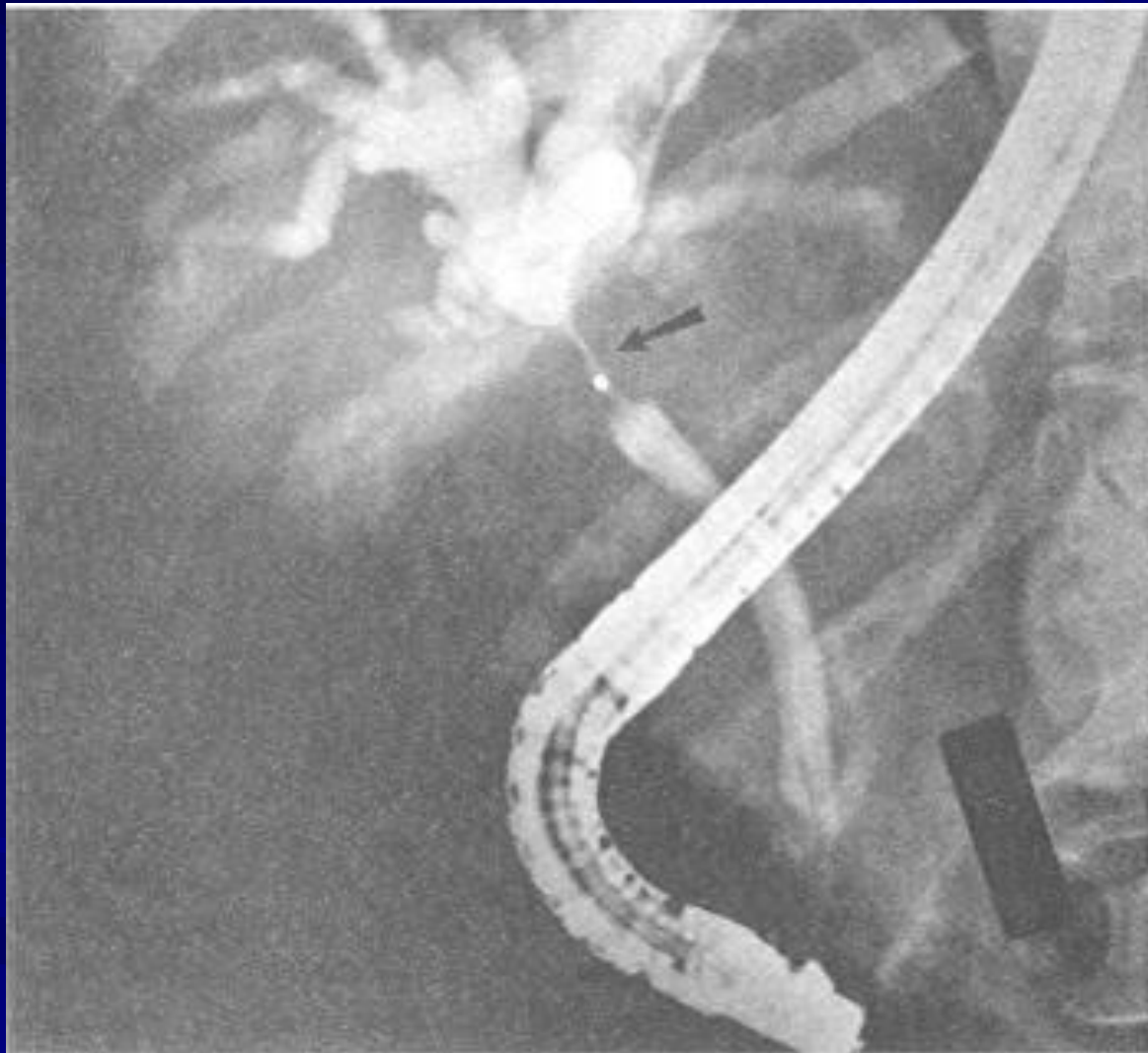
- What are the goals of further diagnostic evaluation in this patient
- Are there any common pitfalls in diagnostic workup that would make prevent liver transplantation
  - (if this patient is found to have intrahepatic cholangiocarcinoma )

# Elliot Fishman

- What would be the most useful radiologic imaging test (s) to evaluate this patient and why?

# Martin Freeman

- Is there a need for biliary drainage in this patient if
  1. a potentially resectable cholangiocarcinoma is noted on imaging
  2. metastatic lesions are noted in the liver in addition to bile duct tumor
  3. no mass is identified
  
- What is the best way to drain the bile duct in this situation
  - PTC vs ERCP



Results of ERCP

# Pierre Clavien

- Are there different treatment algorithms for cholangiocarcinomas in patients with PSC and those who do not have PSC ?
- Is the current cholangiocarcinoma classification adequate ?

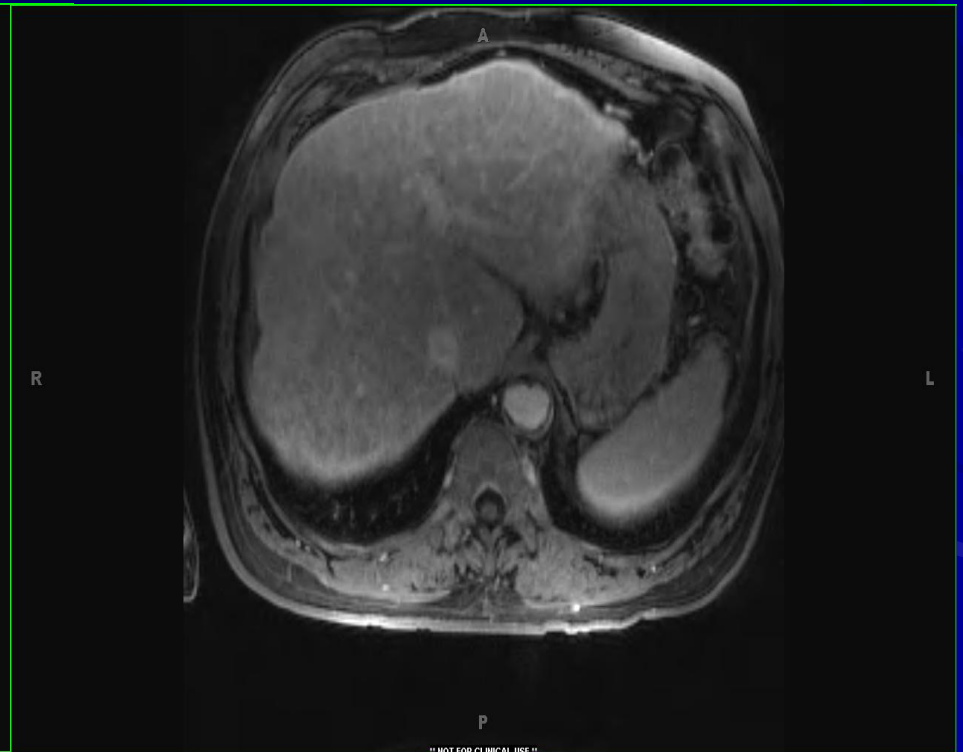
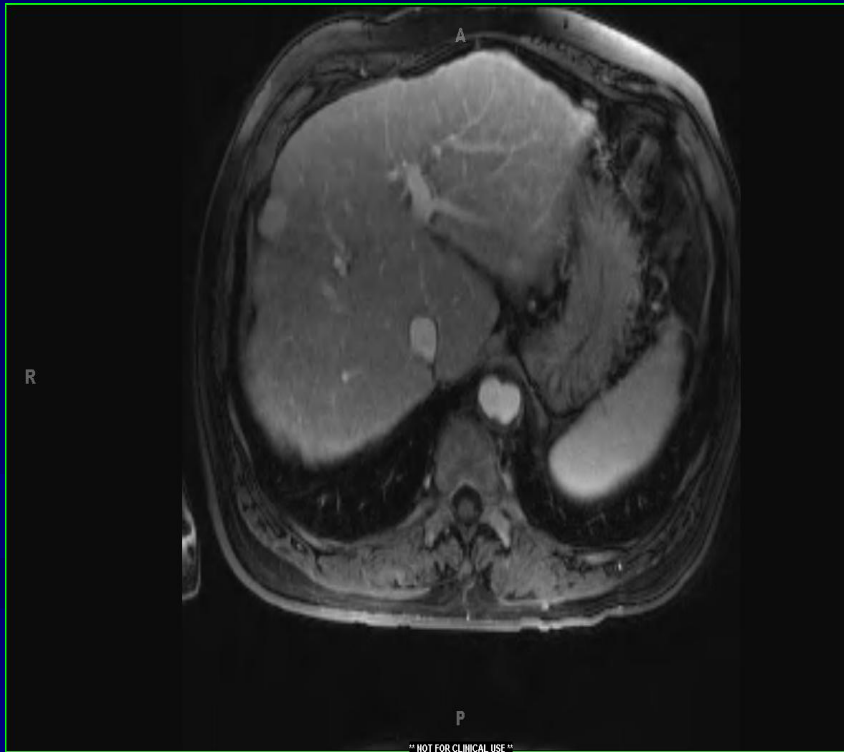


# Luis Balart

- What are the current recommendations for surveillance for cholangiocarcinoma in
  - PSC patients
  - Patients with ulcerative colitis but no documented PSC
  
- What can be done to reduce the risk of cholangiocarcinoma

# Case 2

- 66 year old male, h/o alcoholic cirrhosis (Childs-Pugh Class A) presented with congestive heart failure in 4/08
- Found to have critical Aortic stenosis
  - Rx Aortic valve replacement (porcine valve)
- CT show shows an incidental lesion



# Contd.

## ■ LFTs:

- INR 1.4, Plts 178K, AlkPhos 134, AST 36, ALT 23

## ■ 6/08

- Undergoes laparoscopic resection of liver lesion

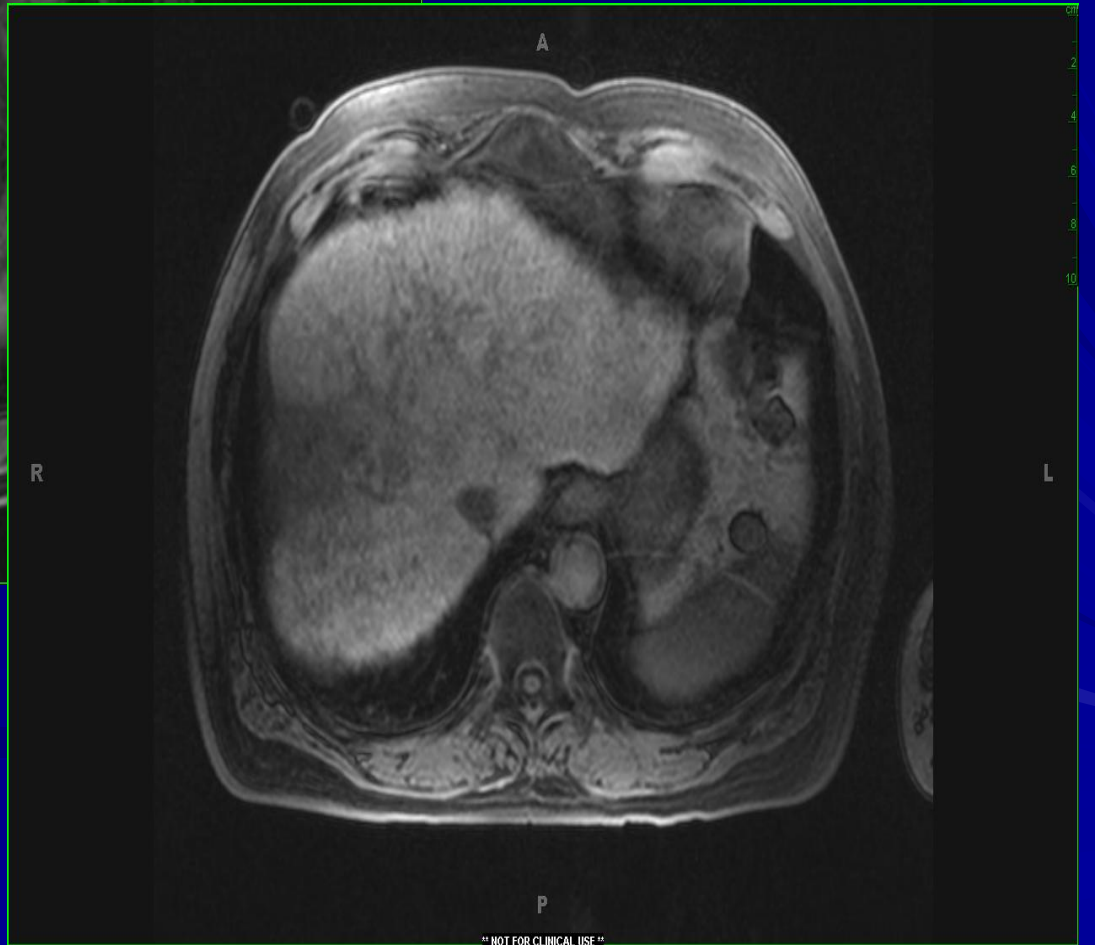
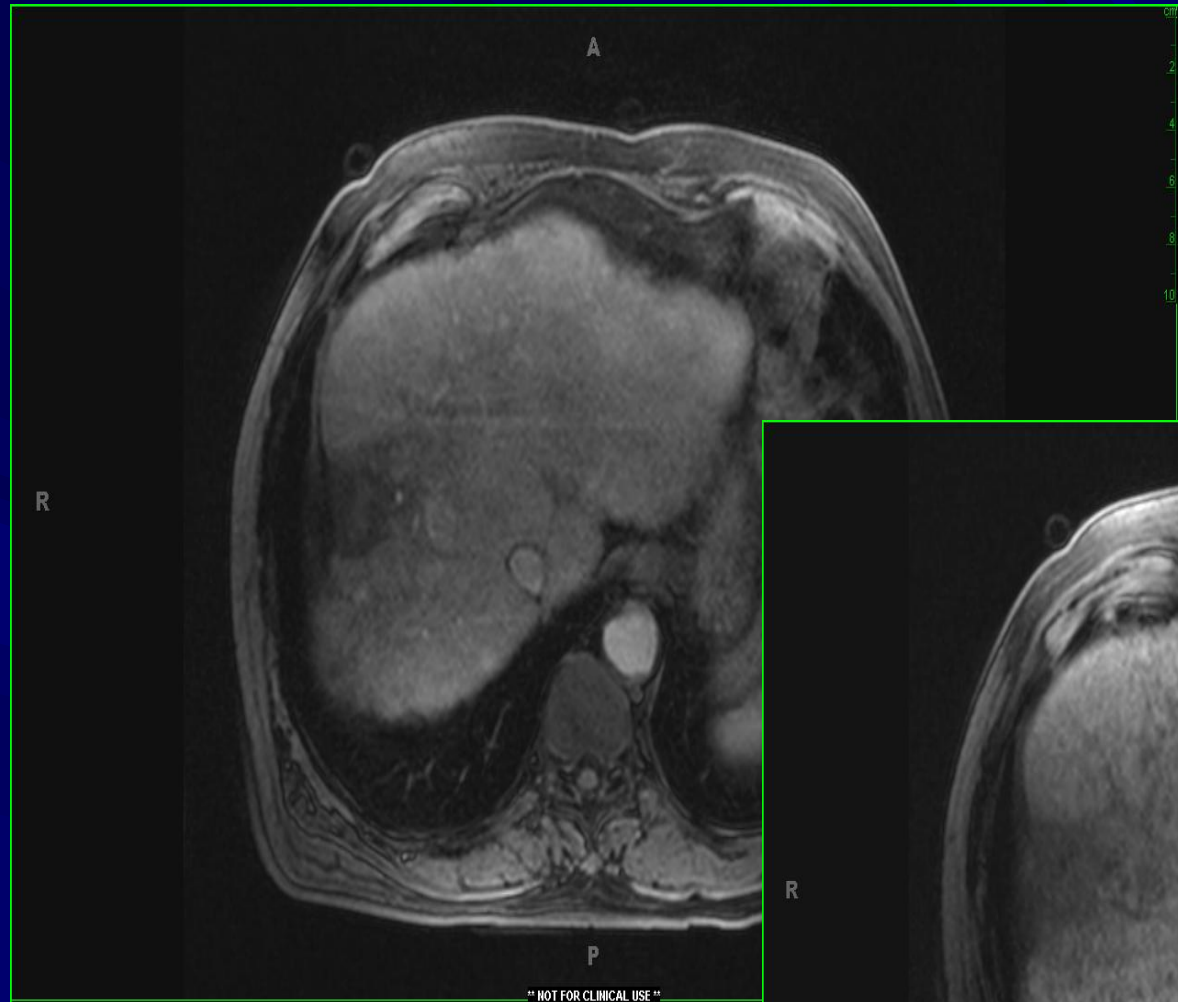
## ■ Pathology

- 2 cm well-differentiated HCC
- surgical margins negative
- no angiolymphatic invasion
- adjacent liver cirrhotic with moderate bridging fibrosis.

## ■ Patient is followed with bi-annual MRI surveillance

## ■ 8/10

- MRI : shows new lesion medial to previous lesion
  - (? New tumor vs. Local recurrence)



## AQ2. What is true about the management of this patient?

- The patient should have had liver transplantation for treatment of the initial lesion
- RFA of the initial lesion would have been sufficient treatment
- Chemoembolization is the appropriate treatment for the recurrent lesion
- Recurrent lesion should best be managed by liver transplantation

# Dr. Fishman

- What is the best imaging modality for surveillance for recurrent tumors in patients treated with resection of HCC?
- Are the imaging characteristics of recurrent hepatoma sufficiently specific to obviate the need for biopsy?
  - When is biopsy needed for a definitive diagnosis?

# Dr. Balart

- How often should we perform surveillance imaging in a patient like this
  - When is biopsy needed for diagnosis in patients with suspected recurrent hepatom
- Is there a difference in management based on etiology of underlying liver disease
  - viral hepatitis **vs** alcoholic liver disease



# Charles Rosen

- How should we manage this patient
- Is transplant an option?
- How about bridging therapies?



# Pierre Clavien

- Was the initial management of this patient incorrect? (as patient was managed at Wash U and not at SLU 😊 )
  - Should up-front transplant have been considered?
- Would the management be different in Europe vs. US?