Cancer Becoming Primary Basis for Liver Transplantation

For the first time, in well-established liver disease programs, liver cancer has become one of the most common reasons for transplantation. This continuing shift in the cause of liver failure, and increase in primary liver cancer, is due to exposure of a generation of patients to hepatitis C.

Our Lady of Lourdes is one of the very few transplant centers in the region, and the only one in South Jersey, with a specially organized liver tumor program. Its service follows many patients long term who have cirrhosis from causes that include hepatitis—providing treatment and, for some, eventual listing for transplant status.

“These patients need to find an end-to-end liver disease and liver cancer program that works integrally with a liver transplant program,” said Hisham ElGenaidi, MD, who directs hepatology for the Liver Tumor Center at Our Lady of Lourdes Medical Center in Camden.

Other Surgical Options Rarely Workable

Symptomatic hepatitis C liver disease is on the rise in the U.S. and around the world because of the number of patients exposed, but untreated, for decades due to lack of visible symptoms. (See page 2.) And transmission rates have the potential to resurge due to a new generation of I.V. drug users and other risks. Meanwhile, fatty liver disease—also seen increasingly in young patients—is the fastest rising cause of cirrhosis and risk for primary liver cancer.

Patients with this cancer are candidates for surgery if the cancer has not spread to other organs. Depending on the size and location of the tumors, excision is an option for patients if they are free of portal hypertension. However, recurrence after such care is common. Also, major liver resection is possible for only a few patients, because most have evidence of portal hypertension at presentation.

“A diseased liver will usually produce more tumors. As a result, transplanting the organ is the only curative surgical treatment for most patients,” said Lourdes hepatologist Ashraf Malek, MD.

Other Steps Help Get Patients to Transplantation

Five-year survival for primary liver cancer is negligible without treatment, but achievable for most patients with treatment. Criteria for transplantation emphasize patients with small, early liver tumors. But, many patients must suffer a high-risk wait for a donor organ, the availability of which has not kept pace with demand.

All patients with advanced liver disease or primary liver cancer should be evaluated at a center focused on both liver tumors and liver transplantation.

Lourdes’ multidisciplinary Liver Tumor Center performs a number of interventions to achieve local control, often as a bridge to transplant or to shrink tumors to meet criteria for the transplant list, including tumor ablation or transarterial chemoembolization. (For metastatic liver cancer, the team may ablate or resect tumors to prolong survival but only if the primary cancer is under control.)

Until just recently, surgical teams have deemed most patients on the transplant wait list to be too sick to undergo drug treatment for hepatitis C infection. While these patients can still be transplanted, a new drug (sofosbuvir, see page 2) now permits them to receive the antiviral therapy while awaiting transplant.

“The latest drugs and treatment regimens are not only game changers, but bring a whole different perspective to how we manage patients with hepatitis C and what the expectations are,” said Dr. ElGenaidi. “The bottom line is hepatitis C is an infection that must be screened for as aggressively as it is treated, and transplant is a primary option when the cirrhotic liver develops tumors.”

For more information, visit www.lourdesnet.org or call 1-888-LOURDES (1-888-568-7337).
New Awareness Needed About Hepatitis C and Its Cure

Just in time for an upsurge in the number of individuals experiencing symptoms of hepatitis C, new treatments continue to arrive. Antiviral medications used over the last several years have helped to cure 70 percent of patients treated. And now, new agents make for regimens that are even more effective and faster acting—in some cases without the need for accompanying interferon injections and the serious side effects that go with them.

“These are exciting times for the treatment of hepatitis C,” said Lourdes hepatologist Hisham ElGenaidi, MD, who receives a large volume of referrals for this therapy and has one of the country’s largest treatment practices for this condition. “A once fatal disease is now a curable infection with medications.”

Baby boomers infected in the 1970s and 1980s have begun to show signs of the disease. “Patients may only experience vague symptoms such as fatigue until they are very sick due to years in which the virus has slowly compromised their liver function,” said Lourdes hepatologist Ashraf Malek, MD.

In late 2013, the FDA approved Sovaldi (sofosbuvir) as the first hepatitis C drug not requiring co-administration of interferon. The drug blocks a protein needed by the virus to replicate. Treatment may take 12 to 24 weeks—compared with 48 weeks needed with some previous therapies. The agency also approved Olysio (simeprevir). Used with interferon and ribavirin, this drug has shown an 80 percent cure rate in 24 weeks. Which drug combination used may depend on the genotype of the virus, but interferon-free regimens are in the pipeline for even more patients. The drugs are expensive lifesavers but offer a less costly option than treating the complications of hepatitis C. Patients also take far fewer pills per day.

Only a tiny fraction of the millions of Americans with hepatitis C have been treated. But more drugs are on the way as part of a race to address this estimated multi-billion dollar market.

“Identifying the right combination therapy is complex and getting more complex. But faster-acting, all-oral regimens are a real breakthrough that will make treatment easier with cure rates well into the 90s,” said Dr. ElGenaidi.

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