

Liver Cancer

[Disclaimer](#)

Liver cancer includes primary and secondary disease. This pathway deals primarily with Hepatocellular Carcinoma (HCC) and not cholangio-carcinoma or metastatic liver cancer, which are separate diseases and managed differently.

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Background – About Liver Cancer

Liver cancer presents as either primary cancer originating in the liver (hepatocellular carcinoma (HCC) or cholangiocarcinoma), or as secondary (metastatic) cancer. Most primary liver cancers arise in patients with underlying liver disease.

- HCC is now the seventh most common cause of cancer death in men in Australia. Primary liver cancer is the most rapidly rising cause of cancer death in Australia.
- Hepatitis B and C are responsible for about 50% of HCC cases.
- 90% of HCC cases arise in patients with cirrhosis. Patients with chronic hepatitis B or with non-alcoholic steatohepatitis may develop HCC in the absence of cirrhosis.
- The risk of HCC can be significantly reduced by diagnosing and treating the underlying liver diseases.
- Early diagnosis through routine surveillance of patients at risk improves survival.
- Aboriginal and Torres Strait Islanders have higher rates of HCC due to:
 - high rates of Hepatitis B and C infection
 - smoking and alcohol use
 - increasing obesity,

This group has half the five-year survival rate and 2.4 times the diagnosis rate as non-indigenous populations. This may be due in part to remoteness and lack of access to care.

Early hepatitis B immunisation, antiviral treatment for hepatitis C, lifestyle, and avoidance education, are critical in reducing the incidence in this group.

Assessment

Practice Point

The general practitioner has a significant role in considering the diagnosis of HCC in assessing [incidental liver lesions](#), screening high-risk groups, and excluding this condition in patients with deteriorating liver disease.

1. **Ask** and record if the patient identifies as being of Aboriginal or Torres Strait Islander origin. Consider the **specific cultural and spiritual needs** of each patient.

Ask if the patient identifies as being of Aboriginal or Torres Strait Islander origin

If a patient or their family want to know why you are asking this question, you may reply with:

- *We ask this question of everyone.*
- *It enables us to help you access extra services that are funded for Aboriginal and Torres Strait Islander peoples, such as support to buy medications and extra funded visits with some health care providers.*
- *This information helps our practice and the health care providers we refer you to, to provide culturally safe care.*

Cultural and spiritual considerations for Aboriginal and Torres Strait Islander People

- Consider **advice for communicating** with Aboriginal and Torres Strait Islander people.
 - **Advice for communicating with Aboriginal and Torres Strait Islander people**
 - *Encourage patients to book a longer consultation, to allow sufficient time for discussion and building trust.*

- Only use traditional terminology such as "Aunty" and "Uncle" if invited to do so.
- Consider the role of factors such as gender, kinship, family ties, language barriers and socio-economic issues.
- Offer the patient:
 - the option of seeing a health professional of the same gender or if this is not possible, referral to another [service](#).
 - the option to have support person present, such as a family member, a community member, or an Elder.
 - access to funding assistance to overcome any identified or potential financial barriers e.g., ITC Funding. See also [Integrated Team Care Program](#).
- Acknowledge and respect how cultural, spiritual and historical beliefs and experiences impact on **decision-making**.

Respecting Aboriginal and Torres Strait Islander people's decision-making processes

- Aboriginal and Torres Strait Islander knowledge, values, beliefs, cultural needs, and health history may strongly inform decision-making processes about treatment and ongoing care.
- If possible and if requested by the patient, support the inclusion of cultural practices e.g., involvement of a traditional healer, or performing ceremonies.
- Be aware the term "survivor" may have negative connotations for historical reasons.
- Proactively explore and monitor symptoms of **pain**.

Considerations for assessing and managing pain in Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander patients may not actively report pain or other needs.

- Offer patients the option to discuss their needs with a health professional of the same gender.
- If available, use a pain tool that is culturally appropriate for the local community.
- Allow sufficient time to discuss and explain the options, usage, and side-effects of pain relief in full.
- Be aware of:
 - significant cultural practices regarding which family members can assist with providing pain relief, and how pain medication is administered.
 - fears that pain relief medicines may accelerate the passing of the patient.
- Understand how the concept of **family** is different for Aboriginal and Torres Strait Islander people.

Considerations when discussing family with Aboriginal and Torres Strait Islander people

For Aboriginal and Torres Strait Islander people:

- the concept of family is broader than being genetically related.
- be sensitive when taking a family history, as discussing members of the stolen generation may be distressing
- Be sensitive when referring to people who have died – check and ask permission. There may be cultural taboos in discussing Sorry Business (referring to people who have died).

- Be supportive and understanding if **appointments** are missed, and facilitate follow-up or rebooking.

Appointments for Aboriginal and Torres Strait Islander people

- Patients who identify as Aboriginal and Torres Strait Islander people may have complex factors e.g., family and community responsibilities, or previous experiences with mainstream medical services, that make it difficult for them to attend appointments.
- The following supports may facilitate this process:
 - Recall and reminders
 - ITC funding
 - Referral to an Aboriginal Liaison officer, support, or health worker.
- Aboriginal and Torres Strait Islander people are more likely to have multiple co-morbidities that can impact treatment outcomes.
- Ensure contact details are up to date.
- If available, use **assessment tools and resources** designed specifically for Aboriginal and Torres Strait Islander people.

Aboriginal and Torres Strait Islander assessment tools and resources

See SCNAT-IP – online tool that assesses the supportive care needs of Aboriginal and Torres Strait Islander cancer patients and their families.

For more information, see [principles for care provision for Aboriginal and Torres Strait Islander Peoples](#).

2. Liver cancer may present as an [incidental liver lesion](#) on ultrasound.
3. In patients not previously known to have liver disease who present with **symptoms** suggestive of exacerbations of liver disease:

Symptoms of liver disease

- Upper abdominal discomfort
 - Abdominal swelling or very firm palpable liver edge
 - Right shoulder pain
 - Back pain
 - Weight loss
 - Fever
 - Jaundice
 - Signs of obstructive jaundice, dark urine, pale stools, pruritus
 - Bruising suggesting coagulopathy
 - Unusual tiredness
 - Reduced appetite or nausea
- Consider **risk factors**.
 - Family history of hepatic malignancy
 - Cirrhosis of any cause
 - Chronic hepatitis – chronic HBV and chronic HCV
 - Alcoholic liver disease
 - Fatty liver disease (NAFLD)
 - Iron storage disease
 - History of IV drug use, needle sharing
 - History of blood transfusion prior to 1990
 - Patients with chronic hepatitis B:

- *males aged > 40 years*
- *females aged > 50 years*
- *Patients with [fatty liver](#) and a [non-alcoholic fibrotic liver disease \(NAFLD\) fibrosis score](#) ≥ -1.455*
- *The combination of obesity and type 2 diabetes is a strong risk factor for non-alcoholic steatohepatitis related (NASH) cirrhosis. Assess these patients using the NAFLD Fibrosis score every 3 years.*
- *Migrants from **high prevalence countries or environments** for viral hepatitis should be screened at least once for HBV and HCV. Testing for viral hepatitis and enrolment in routine HCC surveillance reduces death from liver cancer.*

High prevalence countries or environments

Hepatitis B (HBV):

- *Asia*
- *Middle East*
- *Pacific*
- *Sub Saharan Africa*
- *Eastern Europe*
- *ATSI*

Hepatitis C (HCV):

- *Africa*
- *Egypt*
- *Mediterranean*
- *Pakistan*
- *Southern Asia*
- *ATSI*

- Examine the patient for **signs of liver disease**.
 - *Jaundice*
 - *Abdominal pain or distension*
 - *Fever*
 - *Spider naevi*
 - *Hepatomegaly*
 - *Liver tenderness*
 - *Masses or irregularity*
 - *Palmar erythema*
 - *Flapping tremor*
 - *Bleeding or bruising*
 - Arrange blood tests including LFT, electrolytes and urea, FBE, alpha-fetoprotein, viral markers, iron studies (iron overload).
 - Arrange liver ultrasound, and if indicated, abdominal CT.
4. In patients known to have liver disease presenting with these **symptoms**, consider deterioration of the underlying disease or complications, including development of HCC.
 5. Assess the patient and carer or family's coping mechanisms and supports.
 6. Look for symptoms of depression or anxiety.

1. If patient identifies as Aboriginal or Torres Strait Islander, understand their **specific cultural and spiritual needs** when discussing and delivering treatment options.

Cultural and spiritual considerations for Aboriginal and Torres Strait Islander People

- Offer referral to culturally appropriate social and emotional wellbeing [services](#).
 - Consider including an [expert](#) in the multidisciplinary team, to provide culturally appropriate care to Aboriginal and Torres Strait Islander people.
 - Provide culturally appropriate information or resources about the signs and symptoms of recurrent disease, secondary prevention, and healthy living.
2. If patient has known [risk factors](#) for HCC, or new or suspicious lesion on ultrasound, arrange **routine surveillance**: This may be managed by the Liver Clinic.
 - Arrange six-monthly liver ultrasound and serum alpha-fetoprotein, watching particularly for changes in alpha-fetoprotein.
 - If ultrasound detects a new or suspicious liver lesion, confirm diagnosis with a four-phase contrast CT scan or contrast MRI scan of the abdomen (the latter is not eligible for Medicare rebate). A standard post-contrast CT scan is inadequate for HCC diagnosis. CT and MRI may be no better than US for surveillance.
 - Biopsy is rarely required for diagnosis of HCC.
 - Severity of liver failure, number of lesions, and degree of vascular invasion, determines staging and prognosis. Disease staging may also involve positron emission tomography (PET) in select cases.
 3. If patient has **chronic liver disease**, manage to reduce the chance of developing HCC. This includes appropriate **lifestyle interventions**.

Chronic liver disease

- [Cirrhosis](#)
- [Fatty Liver](#)
- [Chronic Hepatitis B](#)
- [Chronic Hepatitis C](#)
- [Abnormal LFT](#)
- [Haemochromatosis](#)
- Contamination of food with aflatoxin

Lifestyle interventions

- Abstinence from alcohol for patients with cirrhosis. Any alcohol will lead to more liver damage.
- Ensure updated vaccination against hepatitis A and B viruses, and check eligibility for pneumococcus as early as possible, as antigenic response becomes weaker as cirrhosis progresses. Ensure annual influenza vaccination.
- Manage obesity. Encourage healthy living, including physical activity, in patients with metabolic syndrome.
- Maintain adequate nutrition to avoid loss of muscle mass and reduce risk of encephalopathy. Most patients require a high protein and high energy diet.
- [Cease smoking](#) (tobacco and nicotine).
- Monitor drug interactions and the possible need for dose reductions when prescribing for patients with cirrhosis.
- The use of metformin in patients with type 2 diabetes may reduce the risk of HCC.

- *Anabolic steroids increase the risk of hepatocellular cancer.*

4. Refer patients with HCC to a specialist unit for ongoing management.

- Some treatments are curative, and others can significantly prolong life expectancy.
- All investigations and initial referral for patients with HCC should be completed within two weeks of presentation and treatment commenced within four weeks of presentation.
- Consider factors which impact on **treatment decisions**.

Treatment decisions

Factors which affect treatment decisions:

- *Age of the patient*
- *Severity of the underlying liver disease*
- *Size, number and location of HCC lesions*
- *Presence of co-morbidities*
- *Functional capacity, muscle mass, and nutritional status*

To assist with treatment decisions, use the Barcelona Clinic Liver Cancer Staging System which incorporates anatomical staging, liver function, and patient performance capacity. See [chart](#) for algorithm.

Treatment options for HCC

- *Local ablative therapies are common treatments for HCC:*
 - *Radiofrequency ablation (RFA)*
 - *Transarterial chemoembolization (TACE)*
 - *Stereotactic radiotherapy*
- *Surgery is most suitable for early stage disease and compensated liver function.*
- *Targeted therapy with sorafenib*
- *Liver transplant may also be a treatment option.*

5. Consider:

- **Psychosocial management and support.**
 - *Ask the patient how they are feeling emotionally at every visit.*
 - *Listen to fears and concerns about treatment and prognosis.*
 - *Consider referral to:*
 - *Hospital clinical psychologist.*
 - *Psychologist via patient's mental health plan.*

Support of patient and family

Ask the patient and carers:

- *About their support network and the level of support provided.*
- *How their family and partner are dealing with their cancer.*
- *If they need further assistance with practical issues e.g., transport, work, childcare.*

Provide the patient and their family and carers with information about [support services and peer support programs](#) and how these can be accessed.

- **Lifestyle and stress reduction** approaches.

Patients may wish to consider:

- *Acupuncture*
- *Mindfulness*
- *Yoga*
- *Healthy eating*
- *Exercise*

- *Massage*

See [Exercise and Lifestyle Modification Programs](#).

- [travel and accommodation subsidies](#) if the patient is travelling more than 100 km each way to receive care.
 - discussing cancer-related [fitness to drive](#) and referring for an [OT driving assessment](#).
2. Where prognosis is uncertain or poor, consider discussing [advance care planning](#).
 3. For end-stage management, see [New Palliative Care Patient](#).

Referral

- If patient has HCC, arrange [immediate gastroenterology referral or admission](#) or, if available a [specialist hepatobiliary cancer unit](#) Management will include liaison with the oncology and hepatobiliary surgical units. Interventions may include:
 - surgical resection.
 - liver transplantation.
 - interventional radiology procedures for patients not suitable for the above – percutaneous ablation or transarterial chemoembolization
 - new treatments, which are constantly emerging
 - palliative care.
- If patient has primary HCC, and requires psychological interventions and/or supportive counselling, consider referral utilising a Mental Health Care Plan and EPC referral to a [private psychologist](#).
- Patients who have alcohol and or drug dependency may benefit from referral to an [alcohol and drug withdrawal service](#) and [social worker support](#), in addition to specialist assessment and management.
- If Aboriginal or Torres Strait Islander patient, offer referral to **specific Indigenous services**. For all referrals, to both mainstream and Indigenous services, ensure Indigenous status is clearly marked on the referral.

Referral Options for Aboriginal and Torres Strait Islander people

- *For hospital referrals, consider engaging support from the [Aboriginal Hospital Liaison Officers](#).*
- *For community referrals, consider referral to an Aboriginal Community Controlled Health [service](#).*
- *For care coordination, support and advocacy throughout treatment, consider referral to [Integrated Team Care Program](#).*

Information

For health professionals

Further information

- Cancer Australia – [Liver Cancer](#)
- National Cancer Institute – [General Information About Adult Primary Liver Cancer](#)

For patients

- Cancer Australia – [Liver Cancer](#)
- Cancer Council NSW – [Liver Cancer](#)

References

1. Strasser S. [Hepatocellular carcinoma: the most rapidly rising cause of cancer death in Australia](#). Medicine Today. 2016.
2. Sherman M, Burak K, Maroun J, Metrakos P, Knox JJ, Myers RP, et al. [Multidisciplinary Canadian consensus recommendations for the management and treatment of hepatocellular carcinoma](#). Curr Oncol. 2011 Oct;18(5):228-40.

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