Barcelona Clinic Liver Cancer (BCLC)

Objetivo: Estadiar o carcinoma hepatocelular

Variáveis: score Chlild Pugh, nº de nódulos, tamanho dos nódulos, bilirrubina, pressão portal, comorbilidades, *performance status*.

Cálculo:

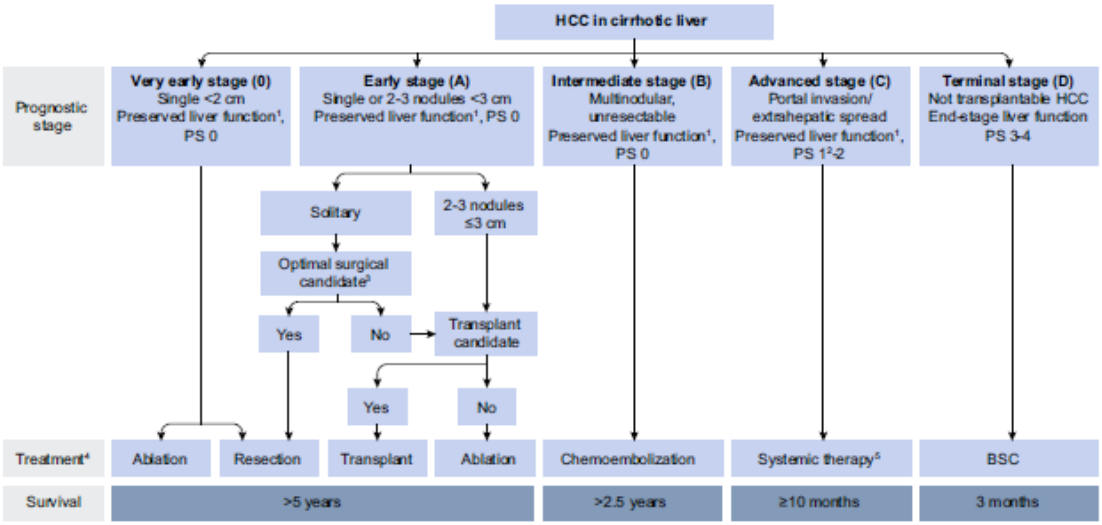

Fig. 3. Modified BCLC staging system and treatment strategy. [1]"**Preserved liver function**" refers to Child-Pugh A without any ascites, considered conditions to obtain optimal outcomes. This prerequisite applies to all treatment options apart from transplantation, that is instead addressed primarily to patients with decompensated or end-stage liver function. [2]**PS 1** refers to tumour induced (as per physician opinion) modification of performance capacity. [3]**Optimal surgical candidacy** is based on a multiparametric evaluation including compensated Child-Pugh class A liver function with MELD score <10, to be matched with grade of portal hypertension, acceptable amount of remaining parenchyma and possibility to adopt a laparoscopic/minimally invasive approach. The combination of the previous factors should lead to an expected perioperative mortality <3% and morbidity <20% including a postsurgical severe liver failure incidence <5%. [4]The **stage migration strategy** is a therapeutic choice by which a treatment theoretically recommended for a different stage is selected as best 1st line treatment option. Usually it is applied with a left to right direction in the scheme (*i.e.* offering the effective treatment option recommended for the subsequent more advanced tumour stage rather than that forecasted for that specific stage). This occurs when patients are not suitable for their first line therapy. However, in highly selected patients, with parameters close to the thresholds defining the previous stage, a right to left migration strategy (*i.e.* a therapy recommended for earlier stages) could be anyhow the best opportunity, pending multidisciplinary decision. [5]As of 2017 sorafenib has been shown to be effective in first line, while regorafenib is effective in second line in case of radiological progression under sorafenib. Lenvatinib has been shown to be non-inferior to sorafenib in first line, but no effective second line option after lenvatinib has been explored. Cabozantinib has been demonstrated to be superior to placebo in 2nd or 3rd line with an improvement of OS from eight months (placebo) to 10.2 months (ASCO GI 2018). Nivolumab has been approved in second line by FDA but not EMA based on uncontrolled phase II data. ASCO, American Society of Clinical Oncology; BCLC, Barcelona Clinic Liver Cancer; EMA, European Medicines Agency; FDA, Food and Drug Administration; MELD, model for end-stage liver disease; PS, performace status; OS, overall survival. Modified with permission from[57].

Fonte: EASL Clinical Practice Guidelines: Management of hepatocellular carcinoma, 2018