Preface

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The World Cancer report published in 2014 by the International Agency for Research on Cancer (IARC), WHO, has documented that the hepatocellular cancers (HCC) are the second most frequent cause of cancer related deaths in the world. As per this report, collated by 250 leading scientists in 40 countries, the most common causes of cancer death in 2012 were, cancers of the lung (1.6 million, 19.4% of the total), liver (0.8 million, 9.1%), and stomach (0.7 million, 8.8%). During last three decades, information on various aspects in HCC has exploded leading to improved prevention, diagnosis, staging, therapy and control of the problem. Liver transplant in HCC today is feasible and successful, with a 5 year survival reaching up to 70%. Despite these advancements, the incidence of HCC globally has doubled and HCC related deaths has increased during the last two decades, possibly due to inadequate control strategies to ameliorate the HBV and HCV infection, the leading causes of HCC globally and addition of lifestyle related liver diseases like fatty liver disease and alcoholic liver diseases which are other important causes of HCC.

During 1999 to 2009, at least 32 well evaluated guidelines on prevention, diagnosis, staging, therapy of HCC, have been published which includes recommendation and supporting evidence with clarity of presentation. Most of these consensus recommendation has emanated from the developed world. Such recommendations, even though evidenced based are often inadequate in resource constrained countries like India where the infrastructure for holistic approach to control and treat HCC are still inadequate and may be considered sub-optimal. Further, due to substantial hepatic reserve, often liver diseases do

not have specific phenotypic clinical manifestation. Usual clinical experience in India would suggest that HCC most often presents clinically in very advanced stage when specific curative or even effective palliation is not offered to these sick patients. It is ironical to have such a dichotomy between rapid and substantial advancement in this area and transferring these benefit to those with HCC in India due to inadequate awareness and infrastructure. Further, the published information on various aspects on HCC from India is limited. Therefore, the Indian National Association for Study of the Liver (INASL) set up a Task-Force on HCC in 2011, with a mandate to develop consensus guidelines for diagnosis and management of HCC, relevant to disease patterns and clinical practices in India. The Task-Force first identified various contentious issues on various aspects of HCC and these issues were allotted to individual members of the Task-Force who reviewed them in detail. The Task-Force used the Oxford Center for Evidence Based Medicine—Levels of Evidence of 2009 for developing an evidence-based approach. A 2-day round table discussion was held on 9th and 10th February, 2013 at Puri, Odisha, to discuss, debate, and finalize the consensus statements. The members of the Task-Force reviewed and discussed the existing literature at this meeting and formulated the INASL consensus statements for each of the issues. These issues, including the consensus guideline on the prevention, diagnosis, and management on HCC in India (The Puri Consensus), have been published in the present issue of the INASL official journal 'The JCEH'. The consensus guideline have carefully evaluated the evidences available from India and other countries, and modified them to suit the Indian conditions. The guideline has also provided

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the weakness and strength of each suggestion or recommendation in objective manner with an option to modify them with change in understanding the dynamics of the disease. The various issues on HCC such as the epidemiology, the risk factors, surveillance strategy, and the risk group for surveillance, the diagnostic approach, staging, therapeutic allocation, role of each form of therapy, the process of evaluation for treatment response and the role of supportive care in very advanced disease have been dealt clearly and has been published in this issue of the journal as separate article by an expert. Each of these articles has tried to collate available information on each issue from India and other parts of the globe and has provided the gap in knowledge on HCC which needed to be investigated particularly in India.

The chapter on the epidemiology provides the present status of HCC prevalence and incidence in India based on the ICMR cancer registry and has depicted the inadequacy and improvement necessary in the registry. India harbors about 10% of the global population with chronic HBV and HCV infection and yet the prevalence of HCC in India is considered to be lowest in the world. Obviously the reporting of the HCC patients needs a relook and needs to be appropriately reflected to assess the actual burden of this disease in our country. The risk factors of HCC in India have been discussed in the next chapter in which besides HBV, HCV and aflatoxin; type 2 diabetes and metabolic syndrome have been depicted to be risk factor in future. This assumes importance, because, India besides harboring substantial proportion of chronically infected HBV and HCV population, is likely to have highest prevalence of type 2 diabetes in the world and they are more prone to develop other features of metabolic syndrome. The surveillance of these high risk individuals to detect HCC in an early stage has been recommended. Detection of early stage HCC is considered to be curable. But the intricacies of surveillance and its cost effectiveness is an important variable in implementing the surveillance policy in resource constraint countries like India. These aspects and the need to develop an appropriate surveillance strategy for India in particular have been discussed well. The modalities and frequency of surveillance tests, cost effectiveness and also the logistics of its delivery in the Indian context has been depicted in the next chapter. Often HCC is detected by ultrasonography during evaluation of non-specific symptoms and such detection due to wide access to ultrasonography throughout the country is a common clinical experience in India. Approach to such a nodule seems important in the clinical context of appropriate approach in HCC management. The subsequent chapter provides a brief state of the art over view on the informations on approach to such a nodule. Progress on various imaging modalities in detection of HCC has revo-

lutionized the diagnostic approach and therapeutic response evaluation in HCC. Aptly, the next chapter discusses the typical and atypical imaging characteristics of HCC and is needed to develop the suitable diagnostic and screening strategy for HCC. As indicated in this chapter that most of the HCC today can be diagnosed only based on the imaging studies, histopathological diagnosis in HCC needs a special discussion to understand its role clearly in the present scenario which has been discussed in the subsequent chapter. Various immunohistochemical and other advanced histopathological technique also have been addressed to provide complete information. The cross-sectional clinical presentation of HCC would indicate that this disease presents to clinicians at various stages of progression. The appropriate staging and the treatment allocation as per the staging and their influence on the outcome have been discussed in the specific chapter addressed to this particular issue. The subsequent chapters provide the various therapeutic strategies aimed to treat HCC. These include the loco-regional ablative techniques practiced widely, surgical resection, liver transplant, transarterial chemo-embolization, which are therapy with an aim to either cure or to provide substantive palliation in HCC. Treatment of advanced HCC not amenable to the previously mentioned treatment by external beam radiotherapy and supportive management has also been outlined in quite detail. The therapeutic aspect as mentioned above has been dealt separately for each form of treatment and their suitability in Indian situation have been addressed.

Needless to say that without adequate study from India, developing a consensus to approach HCC in India was difficult. Various chapters in the present issue in the journal have discussed about these lacunae and have provided suggestion for future improvement. We will consider this effort as a substantial leap in the strategy to address the control and management of HCC in India. This beginning may look innocuous, because many will argue that consensus recommendation on HCC are numerous. But the present recommendation and various other issues discussed in each chapter included in this special issue of the JCEH, is distinct for the Indian situation. Particularly the effort of the consensus team to identify our constraints to provide adequate management in absence of ideal infrastructure to do so is the unique approach which intentionally aims to plug the lacunae in future. It is natural that with passing time and as the country acquires further expertise and infrastructure, the recommendation will be modified to suit the need of the nation. We hope that this consensus on various aspect of HCC will be the initiation for establishing a multicentric platform under the aegis of INASL to investigate and generate information on specific areas with an aim to develop control and cure HCC in India.