

Meanwhile, RFA technique and equipment have been developed for an effective and safe RFA, for example, the use of artificial ascites techniques, multiple overlapping ablations, the use of ultrasound contrast, fusion image guidance, the use of multiple electrodes and the combined treatment with transarterial chemoembolization (TACE). In addition, a few results of RFA combined with TACE for medium size HCC recently began to be reported. In those reports, the outcomes of RFA are comparable to those of surgery. Thus, combined treatment of TACE and RFA also could be performed for medium size HCC as first-line treatment. However, it is required to evaluate exactly the outcome of RFA compared with those of surgery through further studies.

2. Advanced HCC; How to approach HCC with portal vein invasion, with preserved liver function?

1) Evidence

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Hepatocellular carcinoma with portal vein invasion is one of the most challenging clinical scenarios to the professionals in this field. If the patient maintains preserved liver function at the time of diagnosis, it becomes more challenging to make decision on the best treatment option.

Natural disease course of patients in this group is usually very poor [1] and treatment outcomes have been disappointing regardless of treatment of modality [2-4]. Since most of the guidelines are generated as evidence-based, in this session, several significant guidelines and their suggested evidences are reviewed focusing on patients with HCC with portal vein invasion.

American association for the study of liver disease

(AASLD) [5] and European Association for the Study of the Liver (EASL) [6] guidelines are on the same stance. They specifically mention that resection, transplantation, and TACE are contraindicated. Sorafenib is the only recommendation based on 3 months survival benefit in median survival based on level I evidence [3].

National Cancer Center Network (NCCN) of U.S. guideline [7] states that hepatic resection is controversial but can be considered and arterially directed therapies are relatively contraindicated in this setting. It emphasizes that there is growing evidence for the usefulness of stereotactic body radiation therapy.

Asian Pacific Association for the Study of the Liver (APASL) guideline states that this group may be associated with worse prognosis but surgical resection is still considered the best treatment in terms of long-term survival [8]. At the same time, sorafenib is recommended for whom are not suitable for locoregional therapy in this group.

Evidence-based clinical practice guideline of Japan [9] states that liver resection may be selected. Consensus-based clinical practice guideline states [10] that sorafenib and hepatic arterial infusion chemotherapy are recommended for HCC patients with Vp3/Vp4 and resection and TACE is frequently performed when portal invasion is minimum such as Vp1/Vp2. But, in both guidelines, no specific reference was listed.

Finally, Korean Liver Cancer Study Group guideline permits resection, chemoembolization, radioembolization, and external beam radiation therapy based on various References [11], but it did not provide priority in terms of treatment modality. Interestingly, it recommended sorafenib only for patients with extrahepatic disease or locoregional treatment failure.

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2) Practice

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Panel 2.

Current Evidence and Practice in Pancreatic Surgery

1. Extent of resection in distal pancreatectomy for pancreatic body cancer: Special reference to LN dissection and retroperitoneal margin

1) Evidence

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Because the pancreatic body and tail cancers are often found in a large size than those of the head, unresectable cases are more common and the recurrence rate after resection is also higher. The goals of pancreatic cancer surgery are to obtain tumor free margins and perform a sufficient regional