How to plan surgical extent based on clinical factors?

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Liver resection has been a challenging operation. The mortality is in range of 1-8% and morbidity is around 15-30% according to different literatures. One of the main reasons for mortality is due to post hepatectomy liver failure. Various clinical parameters were used to predict liver failure before the operations. The child Pugh score, the ICG evaluation and the liver volumetry are the fundamentals for preoperative evaluation. Different countries used different criteria to streamline their treatment modalities. In Asia, we tend to adopt a more aggressive approach because the number of HBV related HCC is very high. We are all under the pressure to operate on marginal patients in terms of poor biology of tumour, small future liver remnant and poor liver parenchymal reserves. A cautious but bold approach to surgery including combined RFA and resection, portal vein embolization and ALPPS can potentially increase the number of patients amendable to surgical resections.