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PICTURES IN DIGESTIVE PATHOLOGY

Giant hepatocellular carcinoma

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CASE REPORT

A 59-year-old man was admitted to the hospital because of an abdominal mass. The patient drank more than 60 g ethanol/day. He had no history of cirrhosis or other medical disorders. Physical examination revealed a cachectic appearance and a large, hard, non-tender abdominal mass occupying the right upper quadrant and epigastric area with a rich collateral circulation (Fig. 1). Laboratory data revealed alkaline phosphatase 189 IU/L; AST 59 IU/L; ALT 16 IU/L; GGT 83 IU/L; total serum bilirubin 1.96 mg/dL, alpha fetoprotein 87.6 ng/mL. Hepatitis B and C virus serology were negative. A computed tomography (CT) scan (Fig. 2) demonstrated a mass that measured 20 x 17 cm in diameter in the left lobe of the liver. Numerous tortuous vessels, infiltration of the inferior cava vein, and superior mesenteric vein thrombosis were also recognized.

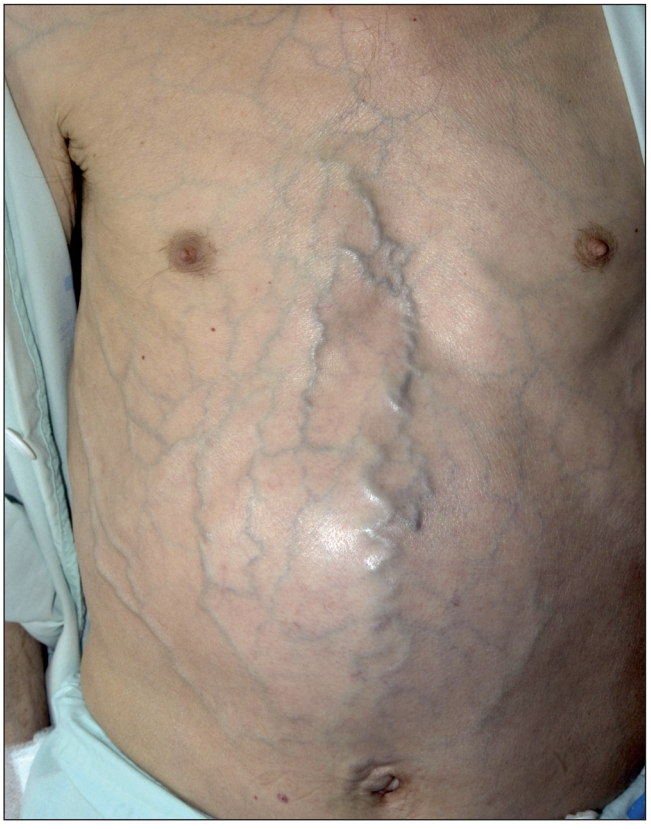

Fig. 1. Large abdominal mass with collateral circulation.

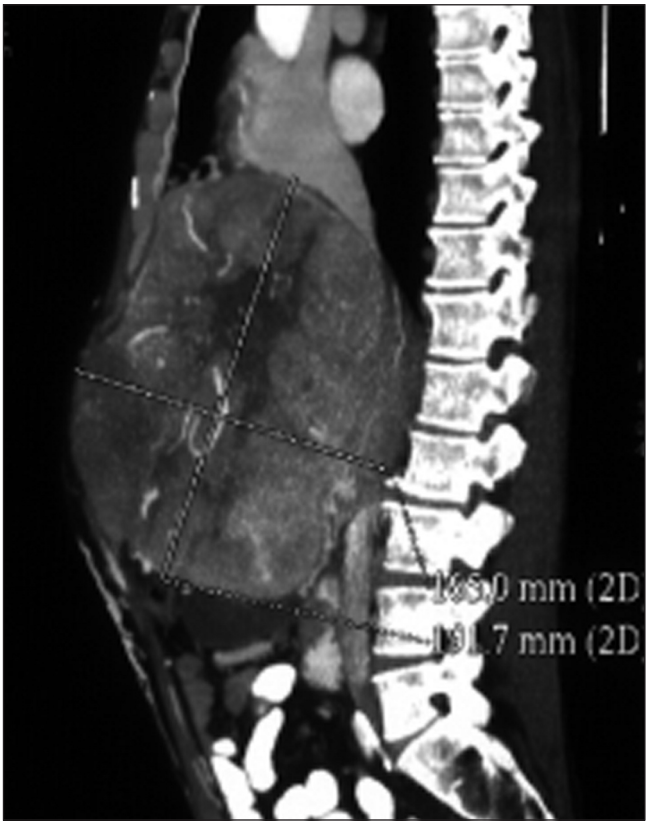

Fig. 2. Abdominal CT scan showing a tumor mass in the left lobe of the liver with infiltration of the inferior cava vein.

The splenic and portal veins were permeable. A final diagnosis of a moderately differentiated hepatocellular carcinoma (HCC) in a cirrhotic liver was established by fine needle aspiration cytology (Fig. 3). Due to end-stage of patient (ECOG performace status 3) best supportive care was the only treatment indicated. The patient died two months after diagnosis.

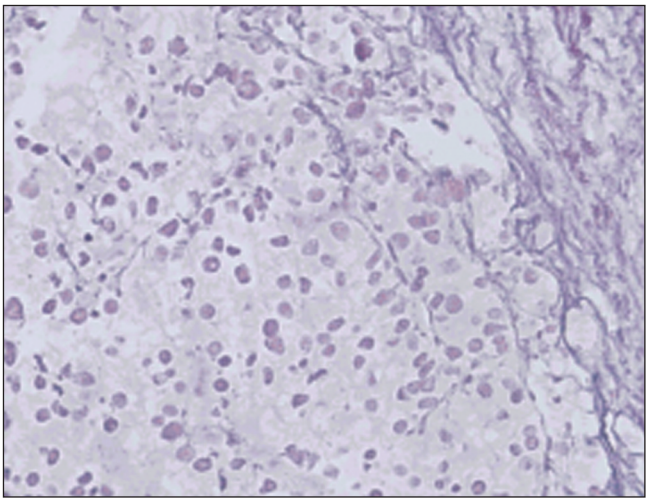

Fig. 3. Liver biopsy specimen with transition zone between fibrosis area and hepatocellular carcinoma (Wilder reticulin x 200).

DISCUSSION

A patient with cirrhosis and HCC detected at an end-stage (BCLC-D) is presented. More than 80% of HCC affect cirrhotic patients. Therefore, a strategy of 6-month surveillance with ultrasound would favor an early diagnosis in the asymptomatic phase of disease. A treatment with curative intention is possible during this clinical period, which would carry with it a 5-year survival higher than 80% (1,2).

Currently in Spain, more than 40% of HCC are detected casually or by symptoms associated with disease. This fact indicates the need to increase the identification of high-risk patients, who should be introduced into screening programs (3).

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