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Screening for Hepatocellular Carcinoma: Where Is the Inconsistency?

Singal et al[1] investigated various determinants of the "inconsistent" surveillance for hepatocellular carcinoma in patients with cirrhosis (13% receiving annual surveillance and <2% receiving biannual surveillance). Indeed, hepatologists' professional societies in the United States and Europe repeatedly promote hepatocellular carcinoma screening, with a grade I recommendation, but the uptake of screening for hepatocellular carcinoma still remains low, even in high-quality organization.[2] However, the inconsistency may lie elsewhere and may apply to the recommendation itself.

First, it is enduringly flying in the face of evidence. Raw data analyses of observational studies have shown repeatedly that nonscreened patients die at an older age than screened patients (lead time and length time bias),[3,4] and among the 3 randomized controlled trials available, only 1, from China, is positive but has several major flaws.[4] Kansagara et al[5] provide us a systematic review of the benefit/harm ratio of hepatocellular carcinoma screening in patients with liver disease that concluded to the lack of evidence for benefit.

Second, screening is not a test; a quality insurance program is a prerequisite for efficacy. Diagnosis of small tumors (<2 cm) in cirrhotic liver with fibrous septa and regenerative nodules is a complex issue that is far more demanding than prescribing an ultrasound scan. However, even in highly specialized units, the test interval is inconsistent with the recommendation for 40% of those screened.[6]

It is time for these professional societies to stop eating dessert first and to rapidly change their recommendation; to support the design of randomized controlled trials as the recent request to the Veterans Health Administration Cooperative Studies Program; and to engage investigations because lack of multidisciplinary expertise and potential conflict of interests may explain such an erring way.[7]

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