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Enhancing HCC Outcomes Through Multidisciplinary Care

Dr. Turck:

You're listening to *Project Oncology* on ReachMD. I'm Dr. Charles Turck. And joining me to discuss the role of the multidisciplinary team in hepatocellular carcinoma care is Dr. Hannah Lee. She's an Associate Professor of Internal Medicine and a transplant hepatologist at Virginia Commonwealth University in Richmond. Dr. Lee, welcome to the program.

Dr. Lee:

Thank you for having me.

Dr. Turck:

To start us off, Dr. Lee, would you tell us about how the treatment landscape for hepatocellular carcinoma has evolved over the past few years?

Dr. Lee:

Oh my gosh, there's been a lot of progress—something as supposedly straightforward as a liver transplant or resection as a curative route all the way to advanced disease needing systemic therapy with immunotherapy and whatnot. So we've made a lot of progress in terms of treatment of advanced hepatocellular carcinoma with new FDA-approved systemic therapy that we are working in collaboration with our medical oncology team.

Dr. Turck:

Well, given those changes in the treatment landscape, what's the role of the multidisciplinary team in all of this?

Dr. Lee:

Yeah. I think when people think of cancer, they immediately want to send them to the oncologist. I think with liver disease, chronic liver disease, cirrhosis, liver cancer, all of these, the key words here is that you don't send them straight to an oncologist necessarily because it involves the liver and it involves cirrhosis, so it does require the input of a transplant hepatology team to decide with the interventional radiologist, the liver surgeons, the medical oncologists—all who have experience in dealing with liver cancer—we come together, we review the images, and we decide what stage these patients are in because we always want to make sure first if they're a curative candidate through liver transplantation or resection because if we've caught it early enough, we can do those things to shoot for cure. And it requires all of us to come together to review the case together.

And if they're not curative, then we have to discuss, okay, what are the treatment options? Because it does involve taking into consideration the state of the liver, is there cirrhosis or not? And if there is, what is the liver function like? Is it well compensated or decompensated cirrhosis? Where is the location of the cancer within the liver? Because location within the liver also plays an important role in how we treat it. Also, is there extra hepatic involvement? Has it left the liver? That would be more advanced for sure. And then the functional status of the patient. All of these variables we need to review together to decide.

Dr. Turck:

I was wondering if you would touch again upon who should be part of this team, so the different members and the value each of those members has.

Dr. Lee:

Absolutely. So obviously me being a transplant hepatologist, I think we're important. The transplant hepatology team and our radiology team—radiologists who are trained to be able to interpret liver cancer findings because not all radiologists have that extensive training. So that's important. Those who are trained and experienced to read it, interpret it, and know the criteria we need to interpret liver cancer. Our liver surgeons are usually transplant surgeons because they can help us decide: is this something simply resectable or do we need to go straight to transplant? And then we have our interventional radiologists. They are the ones that help us if we need to do local regional treatment if it has not advanced outside the liver. And actually, if we can do some treatment to get it under control—whether it be more of a curative route or to bridge the transplant to keep the cancer under control—our interventional radiologists play a big role in this because they can offer radioembolization or transarterial chemoembolization. These are treatments that are targeted specifically in the area of the cancer within the liver. And then we have our radiation oncologists who also play a big role in this in that sometimes we have to do stereotactic beam radiation therapy, which is a very localized, external beam treatment to the localized cancer. And then we have our medical oncologists who help us decide "All right, are we at the point where we need to do systemic therapy?" And when I say "systemic," we don't do chemotherapy for liver cancer patients. Chemotherapy does not work. That's old-school treatment. We're now at immunotherapy. We're now at monoclonal anti-VEGF type of therapy, and they will help us decide whether it's time for that, and they would do the treatments in those situations. We also have our very important nurse navigator and coordinator team that helps us and our patients navigate this really complex system because it can get very complicated when there are so many providers and specialists involved. And then—this is a relatively new concept—is having our palliative care team be involved in the care of our patients with liver disease. Palliative care is well-known in the cancer realm but not really in the liver cancer and liver care realm, so we're starting to incorporate them into this care as well. It's very important.

Dr. Turck:

For those just tuning in, you're listening to *Project Oncology* on ReachMD. I'm Dr. Charles Turck, and today I'm speaking with Dr. Hannah Lee about multidisciplinary care for patients with hepatocellular carcinoma.

So, Dr. Lee, now that we know who the core members of the healthcare team are in the treatment of this disease, what are some best practices for communicating and collaborating with one another?

Dr. Lee:

Great question. Best practices: I think that any patient out in the community—and obviously where I work, we're a tertiary care center and we're an academic center, and so we get a lot of referrals out from the community and those within our health system. I think what's important is that out in the community, patients with chronic liver disease and patients with cirrhosis need to be screened for liver cancer, and this is a standard of practice. The GI doctors generally know about this. Primary care doctors may or may not. They have a lot on their plate already. So can we get these patients—anyone with liver disease, liver conditions, and liver spots—can they be sent to us, a liver center sooner than later so that we can review these cases as they come and try to clarify what these spots are? Is it liver cancer or not? Is it precancerous? And kind of start that early and get them plugged in with us so that we can monitor the patients. And then if there is something concerning with early liver cancer, we can get on it.

Dr. Turck:

Absolutely. And I was wondering too if you would spend a bit more time describing the role of non-hospice palliative care and how we can incorporate it into the multidisciplinary model.

Dr. Lee:

Yes. I'm very passionate about this specific topic, and you are rightfully excellent in saying non-hospice palliative care because when people think about palliative care, they think about hospice; they think about end of life; they think about "Hey, this means I'm ready to give up and, and be at home with my family until I pass." But actually, we're also trying to educate the community and change the mindset of the practice that palliative care covers the spectrum of chronic illness, even early on. Any patient with symptoms from their chronic illness and any patient with symptoms from side effects of their cancer treatment, that is grounds for palliative care right there to support them in managing their symptoms and to support them in improving their quality of life as they battle their chronic illness.

Not only that, but we need to remember mental health. And especially in my line of work—liver disease—there's a lot of struggle with addiction and mental health, depression, anxiety, alcohol use disorder, and things like that, and we forget that this piece is also very critical in the care of our patients. And my philosophy as a hepatologist is I'm not just focused on the liver. My philosophy is patient-centered care. And I follow the Picker Institute, their eight principles that not only involves the care of their liver disease, but their preferences, physical comfort, emotional support, and family support. All of these are so important. Coordination of care. And I think that

the palliative care piece also includes mental health supports and spiritual supports if they have a faith-based background. All of it is important, and all of this has nothing to do with end-of-life hospice care.

Dr. Turck:

And, Dr. Lee, what kind of impact can a multidisciplinary approach, as a whole, have on our patients with hepatocellular carcinoma in terms of outcomes and also the whole healthcare experience from the patient's perspective?

Dr. Lee:

Yeah, high impact, positive impact. There is data out there showing that when patients are cared for in a multidisciplinary approach, there's better patient satisfaction. Obviously, that's very important. More importantly, outcomes are improved because for the decision-making about what to do for the patient, everyone's coming together to make a decision together. It's not going from one clinic to one specialist and then another clinic and they're all kind of scattered about. This is all one-stop shopping; you make a decision right then and there. And then we have a multidisciplinary clinic as well at VCU so that everyone's there to see the patient together if needed, but we have our plan already.

Dr. Turck:

Well, given those impacts, I want to thank my guest, Dr. Hannah Lee, for joining me to discuss how we can take a multidisciplinary approach to hepatocellular carcinoma care. Dr. Lee, it was great having you on the program.

Dr. Lee:

Thank you so much for having me.

Dr. Turck:

For ReachMD, I'm Dr. Charles Turck. To access this and other episodes in our series, visit *Project Oncology* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening.