Optimal liver cancer surveillance in the community: do recall and reminder systems hold the answer?

Nicole Allard , Tracey Cabrie, Emily Wheeler, Jennifer MacLachlan, Ben Cowie.

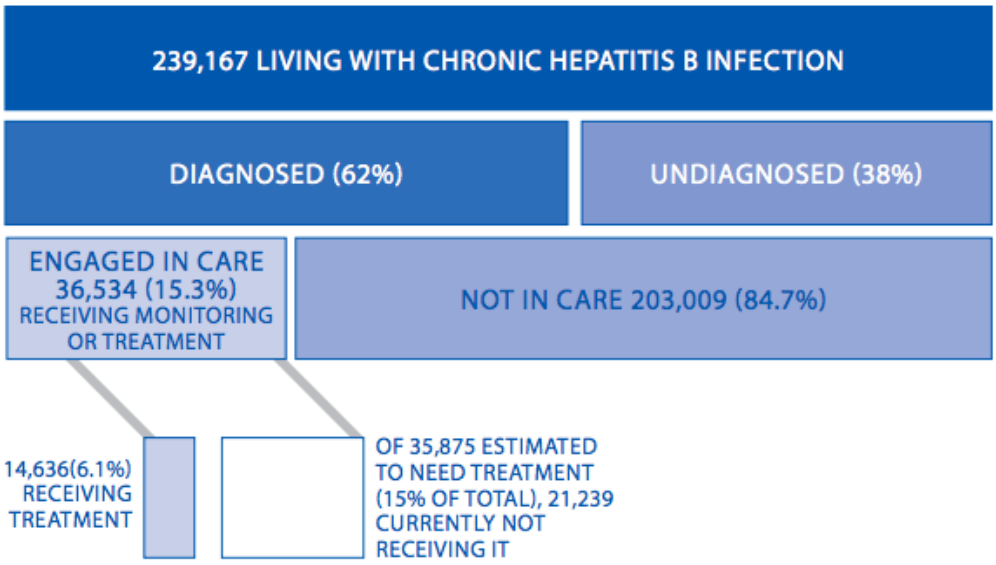
WHO Collaborating Centre for Viral Hepatitis, VIDRL
Peter Doherty Institute for Infection and Immunity
Joint venture of Royal Melbourne Hospital and The University of Melbourne

Disclosure

- None

- Acknowledgments
- cohealth, IHBS, VIDS

Figure: The cascade of care for CHB in Australia, 2015 – see Section 1 text



Background

Number eligible for or participating in HCC surveillance is unknown

Participation in bowel, breast and cervical screening is less in CALD

Health literacy, education and views about cancer

Optimal surveillance interval 6-8 months

Current Australian recommendations for HCC surveillance for people living with CHB

- **all people with cirrhosis**
- **those with a first-degree family history of HCC**
- **Asian men aged over 40 years, and Asian women aged over 50 years**
- **African people aged over 20 years**
- **Aboriginal or Torres Strait Islander people aged over 50 years**

Risk of HCC in CHB

Age, male sex and positive family history (1)

Viral load (2)

6 monthly US early detection improved survival- access to curative procedures (3)

genotypes African region 4.5 times more likely at a younger age

Ref: (1) Bruix J, Sherman M. Management of hepatocellular carcinoma. Hepatology. 2005 (2) Chen C et al. Long-term outcomes in hepatitis B: the REVEAL-HBV study. (3) Gane E. Screening for chronic hepatitis B infection in New Zealand: unfinished business.

Methods

Intervention

Audit at baseline people with CHB and eligible for HCC surveillance followed by IHBS, recalls regular review clinical guidance

Individuals became eligible or transferred care or new patients included

Retrospective analysis after 4.5 years

Demographic details, HCC surveillance frequency, monitoring

Ethics approval Melbourne Health and cohealth

Analysis STATA chi squared for difference of proportions

Definitions

No clear definition in the literature, recommended 6 monthly

Optimal surveillance 2 scans every 14 months

Sub optimal 1 scan every 14 months

Poor less than 1 scan/ 14 months

Participation: at least 2 scans and > 1 scan/ 2 years

Results- patient characteristics

67 patients received HCC surveillance or 213 person yrs of follow-up.

Baseline 43 (64 %) were born in sub Saharan African

5 (8%) cirrhosis.

Median age was 37.6 years (IQ 28.6- 50.2)

Participation 75%

Decrease in the proportion of patients being managed in hospital (from 25% to 15%) (p=0.055)

Recent US in 7 months 55.6% vs 9.5% Baseline (p< 0.001).

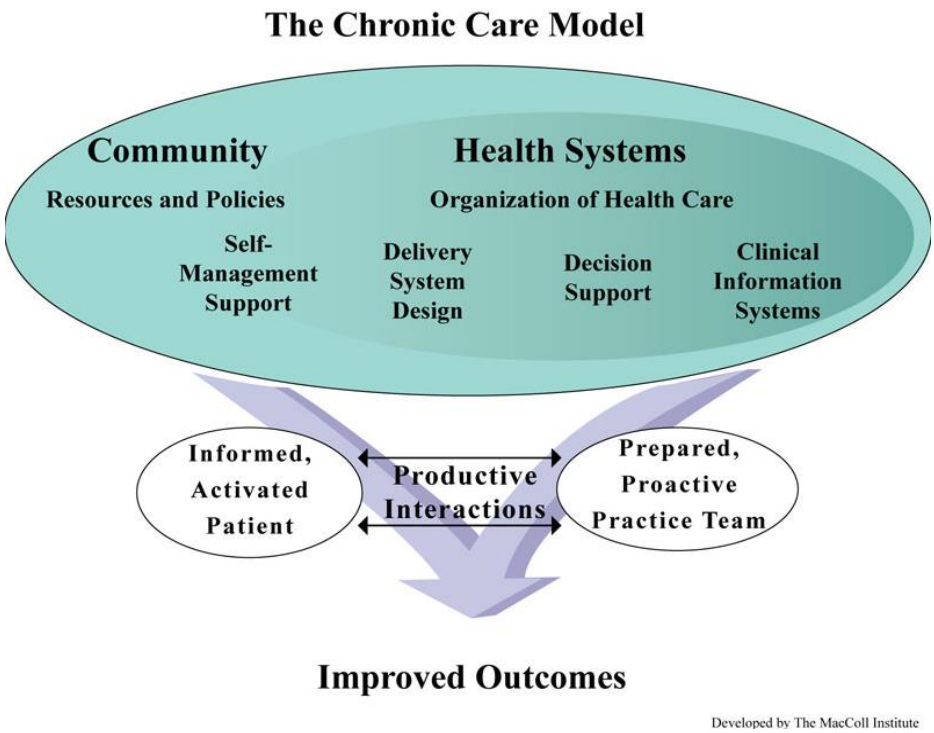
Strengths and limitations

Challenges in delivery a best practice/ supported setting

Not generalisable to other GP due to demographic/ practice

Proposed definitions for adherence / participation

Raises questions about understanding and risk from a patient perspective.



Conclusion

Challenges of HCC surveillance frequency

Recall and reminder systems assist but still barriers

There is little understanding about how individuals understand their risk of liver cancer or HCC surveillance

No tools to explain reason and frequency of HCC surveillance

Registries overseas Japan and Korea

Acknowledgements

- Co investigators
- Hepidemiology unit
- cohealth staff and patients
- IHBS
- Royal Melbourne Hospital