



Clinical Outcomes of Liver Metastases and Hepatocellular Carcinoma

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DESCRIPTION

Primary or secondary liver cancer is one of the most prevalent malignant tumors with a bad prognosis worldwide [1]. According to statistics, Hepatocellular Carcinoma (HCC), also known as primary liver cancer, is the third largest cause of cancer death and has the sixth highest incidence rate of malignant tumors worldwide [2]. HCC is the second most lethal malignant tumor in China [3]. Survival rates for hepatic metastases are also dramatically reduced [4]. Surgery, including hepatic resection or liver transplantation, is the main therapeutic option for HCC, with 5-year survival rates of 30-70% [5]. However, only a small number of patients are suitable for surgery. However, only a small number of patients are candidates for surgery. Most patients are in the middle or advanced stages when they are diagnosed, or the lesion is adjacent to vital blood vessels, resulting in a missed opportunity for surgery. Other treatments, such as Transcatheter Arterial Chemoembolization (TACE), Radiofrequency Ablation (RFA), and conventional radiation, should be used for unresectable patients. The therapeutic efficacy and prognosis for patients with liver cancer remain unsatisfactory. As a result, SBRT has emerged as a viable, non-invasive treatment option for malignant malignancies. The use of Transcatheter Arterial Chemoembolization is restricted. It can be utilized in patients with advanced unresectable liver cancer. However, the tumor grows again as a result of the establishment of collateral circulation following embolization. Interventional therapy has a two-year survival rate of 41%, but it is only 35% effective. RFA is only appropriate for early-stage lesions with a diameter of less than 3 cm. Chemotherapy has severe negative effects for liver cancers, whereas targeted therapy is a gentle approach. Recent study indicates that sorafenib can improve patient survival and prognosis, but it should be used in conjunction with other adjuvant therapy. Radiotherapy is a promising and hopeful treatment option for patients with primary or secondary liver cancer.

At the moment, the most often utilized radiotherapy procedures in clinical practice are 3-Dimensional Conformal Radiotherapy (3DCRT), Intensity-Modulated Radiation Therapy (IMRT), Stereotactic Body Radiation Treatment (SBRT), helical tomotherapy etc.

Many studies have proved radiotherapy's important function in treating liver cancer, and radiotherapy is appropriate for various stages of liver cancer. To avoid liver harm, conventional liver radiotherapy might cause radiation hepatitis, and the acceptable dose is limited. As a result, technological advances in radiation oncology have permitted the development of SBRT, which gives highly conformal dose distributions with rapid dose drop-off, allowing for dose escalation with ablative potential inside the tumor while sparing substantial sections of the liver. SBRT is now listed in the most recent version of the National Comprehensive Cancer Center Network guidelines for liver cancer as an indication for patients with unresectable disease or who are medically inoperable. The dose of SBRT varies between studies of therapies for liver cancer, and there is no unified standard.

The radiosensitivity of normal liver tissue is slightly lower than that of bone marrow, lymphatic tissue, and kidney. The radiotherapy dose for liver tumors is comparable to that for weakly differentiated squamous cell carcinoma, with a lethal dose of around 60 Gy/6 weeks. Normal liver, on the other hand, has a high regenerating capacity. As long as enough normal liver is retained, it can compensate for radiotherapy-induced partial liver function loss *via* hyperplasia. As a result, despite the current low research status, there is still a lot of space for future research into radiation for liver cancer.

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