Perspective
Volume 8:6, 2024

Journal of Hepatology and Pancreatic Science

ISSN: 2573-4563 Open Access

Effectiveness of Including Locoregional Therapy in Patients with Stable HCC Treated with ATZ/BEV

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Introduction

Hepatocellular Carcinoma (HCC) represents one of the most common and aggressive forms of liver cancer globally, with a high mortality rate and a significant public health burden. HCC typically arises in the setting of chronic liver diseases, most commonly cirrhosis, which can result from viral hepatitis, alcohol use, or non-alcoholic fatty liver disease (NAFLD). Although there have been significant advancements in the treatment of HCC, the prognosis for patients with advanced stages of the disease remains poor. Over the past few years, immunotherapy, particularly the combination of Atezolizumab (ATZ) and Bevacizumab (BEV), has emerged as a promising treatment option for patients with advanced or unresectable HCC. This combination has shown efficacy in improving survival compared to previous standard treatments. However, the inclusion of Locoregional Therapies (LRTs), such as Transarterial Chemoembolization (TACE), Radiofrequency Ablation (RFA), or other locoregional interventions, in the treatment regimen for patients with stable HCC receiving ATZ/BEV has become an area of intense investigation [1,2].

Description

The combination of ATZ and BEV has been a groundbreaking advancement in HCC treatment. Atezolizumab, an anti-PD-L1 antibody, works by blocking the interaction between the programmed cell death protein 1 (PD-1) on T cells and PD-L1 on tumor cells, thereby enhancing the immune response against cancer cells. Bevacizumab, on the other hand, is a monoclonal antibody targeting Vascular Endothelial Growth Factor (VEGF), which plays a critical role in tumor angiogenesis. By inhibiting VEGF, BEV disrupts the blood supply to tumors, thereby inhibiting their growth. The combination of these two agents has demonstrated positive clinical outcomes, including improved Overall Survival (OS) and progression-free survival (PFS), in patients with advanced HCC. This combination has been shown to be effective for patients who have failed previous therapies or who are not candidates for surgery or liver transplantation.

TACE, one of the most commonly used locoregional therapies for HCC, involves the selective catheterization of the hepatic artery and the infusion of chemotherapy agents, often followed by embolization to block the blood supply to the tumor. This results in both direct tumor cell killing due to the chemotherapy agents and ischemic necrosis of the tumor due to the loss of blood supply. TACE is commonly used in patients with intermediate-stage HCC and has been associated with improved survival and a reduction in tumor size. The role of TACE in combination with immunotherapy, such as ATZ/BEV, has been an area of considerable interest. It is hypothesized that locoregional therapies such as TACE may enhance the immune response by increasing tumor antigen release, thereby priming the immune system for more effective systemic treatment. Furthermore, the local tumor control achieved by TACE may reduce the overall tumor burden, potentially improving the efficacy of subsequent immunotherapy.

Conclusion

The addition of locoregional therapies such as TACE and RFA to ATZ/BEV therapy for patients with stable HCC holds significant promise for improving treatment outcomes. Locoregional therapies may enhance the immune response, provide better tumor control, and potentially overcome the limitations of systemic therapies alone. While there are challenges related to the safety and optimal sequencing of these treatments, ongoing research will shed light on the best strategies for combining locoregional therapies with immunotherapy. Ultimately, a tailored, multidisciplinary approach that incorporates both systemic and local therapies could provide the most effective treatment for patients with HCC and improve their survival and quality of life.

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Received: 02 November, 2024, Manuscript No. hps-25-160273; **Editor Assigned:** 04 November, 2024, PreQC No. P-160273; **Reviewed:** 18 November, 2024, QC No. Q-160273; **Revised:** 23 November, 2024, Manuscript No. R-160273; **Published:** 30 November, 2024, DOI: 10.37421/2573-4563.2024.8.311

How to cite this article: Finn, Facciorusso. "Effectiveness of Including Locoregional Therapy in Patients with Stable HCC Treated with ATZ/BEV." *J Hepato Pancreat Sci* 8 (2024): 311.