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RESPONSE TO LETTER

Effect of Different Liver Resection Modalities on the Prognosis of Patients with Hepatocellular Carcinoma on the Left Lateral Lobe [Response to Letter]

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Dear editor

We have read the letter to the editor for our article "Effect of Different Liver Resection Modalities on the Prognosis of Patients with Hepatocellular Carcinoma on the Left Lateral Lobe" written by Chen et al. This is a very good letter and also covered many questions that we are interested in. Here we provide a point-by-point response to the comments.

1. In the LLH group, was there a predominant pattern of recurrence localized primarily around the surgical margins?

Response: In our article, we found that narrow resection margin (Hazard Ratio (HR):1.457, 95% Confidential Interval (CI): 1.038–2.047; HR:1.415, 95% CI: 1.061–1.887), tumor diameter > 5 cm (1.645, 1.161–2.330; 1.488, 1.123–1.971), multiple tumors (2.021, 1.330–3.073; 1.987, 1.380–2.861), and microvascular invasion (MVI) (1.753, 1.253–2.452; 1.438, 1.087–1.902) are independent risk factors for overall survival (OS) and tumor recurrence (TR), while liver resection modality is not. After propensity score matching, liver resection modality is not an independent risk factor for OS and TR. Further analysis revealed that wide resection margins were achieved in all patients in the LH group but only 59.0% patients in the LLL group. The OS and TR rates were not significantly different between patients with wide resection margins in LLL group and LH group (P=0.766 and 0.919, respectively), but significantly different between patients with narrow resection margins in LLL group and LH group (P=0.012 and 0.017, respectively). Therefore, we propose that liver resection modality is not an independent risk factor for the prognosis of patients with HCC on the left lateral lobe as long as wide margins are obtained. Besides, as you said, there were similar risk of metastasis of tumors in the left lobe of the liver to the liver segments in the left inner lobe and the left outer lobe. We are also very interested in the difference of the site and mode of tumor recurrence between LLL group and LH group. However, we only conducted preliminary statistics on the number of patients of recurrence in the early stage, without further analysis of the site or mode of recurrence. We are further collecting relevant data to analysis of the site or mode of recurrence.

2. In this study, was there an evaluation of the potential greater benefit of LH in a specific patient subset? Furthermore, was the feasibility of screening this subset through predictive modeling considered?

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Response: Thank you very much for your suggestion. There were 315 patients included in this study. The insufficient number of patients has limited our ability to conduct further subgroup analysis such as based on MVI. However, we are currently continuing to collect patients and expand the sample size to conduct further subgroup analysis. Next, we hope to evaluate of the potential greater benefit of LH in a specific patient subset and screen this subset through predictive modeling.

3. There is a discrepancy in the text regarding Table 1, where the number of patients in the LH group should be corrected from (n = 66) to (n = 61).

Response: Thank you very much for your question. We have confirmed the main text and Table 1, and the number of LH group (n=66) is correct.

Disclosure

The authors report no conflicts of interest in this communication.

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