Sir,

I would like to thank Drs Hung and Shih for commenting on our article.1 As they mentioned in their letter, surgical resection has been the standard local therapy for hepatocellular carcinoma until other less invasive modalities of treatment emerged, such as percutaneous ethanol injection (PEI) and radiofrequency thermal ablation (RFA), especially for smaller tumors. That is why we wanted to investigate whether there is any role for surgical treatment of this high-risk disease in terms of multiple lesions in the liver. If the results of surgical and nonsurgical therapy are not different, then patients need not undergo the more invasive surgical treatment.

First, in their letter, the authors mentioned that “both the treated and non-treated patients did not add up to the number of recurrence of 93”. This is because as the indications for the modalities of treatment might be different in the follow-up discovery of recurrences, each patient might receive more than one kind of treatment during their postoperative lifetime.

Second, with regard to our control group, we selected those with serum albumin level ≥3.5 g/dL, total bilirubin level <2 mg/dL, tumor number ≤3 and tumor size ≤5 cm from our database of 874 patients (actually 178 patients with tissue proof as stated in our article) who underwent nonsurgical treatment. Certainly, there might be selection bias and we admitted it. However, this is the only way to make both the surgical and nonsurgical groups match, and the comparison is important for we had to know if there was any benefit for surgery. In addition, only those with small tumors could undergo PEI or RFA, which was advocated by the authors.

Third, and the most important statements the authors made, “…the overall cumulative survival … leveled off at 5 years (26.2% vs. 22.6%). Surgical resection is not any better than nonsurgical treatment in the long term.” In fact, we had already clearly shown in the first part of the study that one-block resection was the only independent factor to be associated with better prognosis for those who underwent hepatectomy. In the second part of our study comparing the surgical and nonsurgical groups, we showed in Figures 3 and 4 that the difference in overall survival was contributed to by those who received one-block resection. In other words, patients might benefit from surgical resection only when one-block resection can be conducted if they have acceptable liver function reserve.

References