Appendix B. Contacted Authors

Appendix Table B-1. Contacted authors, issue and response

|  |  |  |
| --- | --- | --- |
| Study | Issue | Response |
| T. Kato, T. Yamagami, T. Hirota, T. Matsumoto, R. Yoshimatsu and T. Nishimura. Transpulmonary radiofrequency ablation for hepatocellular carcinoma under real-time computed tomography-fluoroscopic guidance. Hepatogastroenterology 2008 55(85): 1450-3. PMID: . | Need info on extrahep mets, PV invasion, ECOG, Stage, Child Pugh | JK: emailed 3/6JK: sent followup 3/21JK: reemailed 3/30, need response by 4/13No response as of 4/17, excluded |
| P. Hildebrand, M. Kleemann, U. Roblick, L. Mirow, M. Birth and H. P. Bruch. Laparoscopic radiofrequency ablation of unresectable hepatic malignancies: indication, limitation and results. Hepatogastroenterology 2007 54(79): 2069-72. PMID: . | Individual patients listed in two tables. Table 1 has pt. charac. For 14 patients (needed since only 4 are HCC). Table 2 has outcomes for only 10 patients with no explanation on how they got rid of 4 patients or how those patients match to table 1. | JK: emailed 3/20Team: if no response, excludeJK: reemailed 3/30, need response by 4/13No response as of 4/17, excluded |
| K. C. Xu, L. Z. Niu, W. B. He, Z. Q. Guo, Y. Z. Hu and J. S. Zuo. Percutaneous cryoablation in combination with ethanol injection for unresectable hepatocellular carcinoma. World J Gastroenterol 2003 9(12): 2686-9. PMID | 65 patients rec’d cryoablation, but only 36 rec’d PEI following cryoablation. Results not reported separately. | JK: emailed 3/20Team: if no response, excludeJK: reemailed 3/30, need response by 4/13Email bounced back 3/30 due to recipient mailbox fullNo response as of 4/17, excluded |
| H. C. Jiang, L. X. Liu, D. X. Piao, J. Xu, M. Zheng, A. L. Zhu, S. Y. Qi, W. H. Zhang and L. F. Wu. Clinical short-term results of radiofrequency ablation in liver cancers. World J Gastroenterol 2002 8(4): 624-30. PMID: . | Need HCC-specific results | JK: emailed 3/20Emails bounced back, tried what I could find. So far, ‘liulianxin@medmail.com.cn’ hasn’t bounced back. I think ‘hongchaojiang@yahoo.com.cn’ is probably not the same author - I found that on PubMed.JK: re-emailed 3/30, need response by 4/13No response as of 4/17, exlude |
| A. Reso, C. G. Ball, F. R. Sutherland, O. Bathe and E. Dixon. Rupture and intra-peritoneal bleeding of a hepatocellular carcinoma after a transarterial chemoembolization procedure: a case report. Cases J 2009 2(1): 68. PMID: . | pt charac - PVT, extrahep mets, CP score, ECOG, BCLC or equivalent | JK: emailed 3/21JK: reemailed 3/30, need response by 4/13No response as of 4/17, include and note |
| N. Miyamoto, K. Tsuji, Y. Sakurai, H. Nishimori, J. H. Kang, S. Mitsui and H. Maguchi. Percutaneous radiofrequency ablation for unresectable large hepatic tumours during hepatic blood flow occlusion in four patients. Clin Radiol 2004 59(9): 812-8. PMID: . | In the paper, you stated that 1 patient was deemed inoperable because he/she refused hepatectomy. We would like to know which patient this is in the list of 4 patients in your paper. | YY: emailed 4/11No response as of 4/17, exclude |
| G. S. Liao, C. Y. Yu, M. L. Shih, D. C. Chan, Y. C. Liu, J. C. Yu, T. W. Chen and C. B. Hsieh. Radiofrequency ablation after transarterial embolization as therapy for patients with unresectable hepatocellular carcinoma. Eur J Surg Oncol 2008 34(1): 61-6. PMID: . | Survival time point | JK: emailed 3/20Emails bounced back. I tried without ‘.tw’ and that also bounced back. Found the third email through more detective work - so far hasn’t bounced back.JK: re-emailed 4/3 with 4/13 deadlineNo response as of 4/17 |
| B. I. Carr. Hepatic arterial 90Yttrium glass microspheres (Therasphere) for unresectable hepatocellular carcinoma: interim safety and survival data on 65 patients. Liver Transpl 2004 10(2 Suppl 1): S107-10. PMID: . | Survival time point. Did PVT include PVTT? | JK: emailed 3/20JK: re-emailed 4/3 with 4/13 deadlineNo response as of 4/17 |
| R. C. Martin, 2nd, L. Rustein, D. P. Enguix, J. Palmero, V. Carvalheiro, J. Urbano, A. Valdata, I. Kralj, P. Bosnjakovic and C. Tatum. Hepatic arterial infusion of Doxorubicin-loaded microsphere for treatment of hepatocellular cancer: a multi-institutional registry. J Am Coll Surg 2011 213(4): 493-500. PMID: . | Survival time point | JK: emailed 3/20JK: re-emailed 4/3 with 4/13 deadlineNo response as of 4/17 |
| F. Gao, Y. K. Gu, W. J. Fan, L. Zhang and J. H. Huang. Evaluation of transarterial chemoembolization combined with percutaneous ethanol ablation for large hepatocellular carcinoma. World J Gastroenterol 2011 17(26): 3145-50. PMID: | Survival time point | JK: emailed 4/17Response: Dear Jenna Khan,  I have received your question about ‘Evaluation of transarterial chemoembolization combined with percutaneous ethanol ablation for large hepatocellular carcinoma’. The survival time was counted from the first TACE treatment.Thank you for your question!  Best wishes.  Jinhua Huang |
| D. Oh, H. Lim do, H. C. Park, S. W. Paik, K. C. Koh, J. H. Lee, M. S. Choi, B. C. Yoo, H. K. Lim, W. J. Lee, H. Rhim, S. W. Shin and K. B. Park. Early three-dimensional conformal radiotherapy for patients with unresectable hepatocellular carcinoma after incomplete transcatheter arterial chemoembolization: a prospective evaluation of efficacy and toxicity. Am J Clin Oncol 2010 33(4): 370-5. PMID: . | discrepency between text and table on recurrence status | JK: emailed 3/28JK: re-emailed 4/3 with 4/13 deadlineAuthor response: Sorry for late reply. I didn’t see your first e-mail.I review my data and the number of newly diagnosed HCC was 22 (55%).Thank you.Sincerely yours,Do Hoon Lim |
| K. Yamanaka, E. Hatano, M. Narita, K. Taura, K. Yasuchika, T. Nitta, S. Arizono, H. Isoda, T. Shibata, I. Ikai, T. Sato and S. Uemoto. Comparative study of cisplatin and epirubicin in transcatheter arterial chemoembolization for hepatocellular carcinoma. Hepatol Res 2011 41(4): 303-9. PMID: . | 21% in group 1 and 19% in group 2 were also getting RFA or PEIT with TACE, results not separated out. | JK: Emailed 3/21if no response, excludeJK: reemailed 3/30, need response by 4/13Response: However, we added a new result in accordance to your suggestion that RFA and PEIT were excluded in this study. RRs of patients with a single tumor were 75.0% (9/12) and 65.3% (21/32) for CDDP-TACE and EPI-TACE and RRs of patients with multiple tumors were 71.4% (10/14) and 37.0% (17/46) for CDDP-TACE and EPI-TACE. For the patients with multiple tumors, the relative risk and the odds ratio were 1.93 (95%CI 1.17-3.19) and 4.53 (95%CI 1.22-16.8).This was consistent with the result that included the patients receiving the simultaneous treatment of RFA and PEIT. We added the following sentences.(P. 10)Of these, we included RFA or PEIT combined with TACE in the eligibility criteria because either of the two treatment options can be exercised after TACE. However, since this factor would affect the RR, we also estimated the RR in patients without RFA or PEIT combined with TACE.(P. 14)When patients receiving RFA or PEIT combined with TACE were excluded, RRs of patients with a single tumor were 75.0% (9/12) and 65.3%(21/32) and those of patients with multiple tumors were 71.4% (10/14) and 37.0% (17/46) for CDDP-TACE and EPI-TACE, respectively. For patients with multiple tumors, the relative risk and the odds ratio were 1.93 (95% CI 1.17-3.19) and 4.53 (95% CI 1.22-16.8), respectively. CDDP-TACE also showed a higher RR than EPI-TACE in this analysis.Etsuro HatanoJK+YY: Exclude |
| T. H. Kim, D. Y. Kim, J. W. Park, Y. I. Kim, S. H. Kim, H. S. Park, W. J. Lee, S. J. Park, E. K. Hong and C. M. Kim. Three-dimensional conformal radiotherapy of unresectable hepatocellular carcinoma patients for whom transcatheter arterial chemoembolization was ineffective or unsuitable. Am J Clin Oncol 2006 29(6): 568-75. PMID: . | 58.6% had PVT, might be using PVT to describe tumor and bland thrombus, 75.7% AJCC stage T3, which can include invasion, 5.7% T4 which is invasion | JK: emailed 3/20JK: reemailed 3/30, need response by 4/13Author Response:In my previous paper, 58.5% was percentage of HCC patients with portal vein tumor thrombosis. Unfortunately, I did not have statistics regarding to incidence of blend thrombosis because the blend thrombosis is not target of radiotherapy.Usually, portal vein tumor thrombosis is enhanced in dynamic CT, typically enhanced in arterial phase and wash out in portal or delayed phase, but blend thrombosis is not enhanced in dynamic CT. Blend thrombosis and tumor thrombosis is different in imaging study and thus, I only count the portal vein tumor thrombosis not blend thrombosis.Anyway, small percent of HCC patients with or without portal vein tumor thrombosis may has blend thrombosis. Best Wishes,Tae Hyun KimJK: Exclude on study pop |
| H. W. Chen, E. C. Lai, Z. J. Zhen, W. Z. Cui, S. Liao and W. Y. Lau. Ultrasound-guided percutaneous cryotherapy of hepatocellular carcinoma. Int J Surg 2011 9(2): 188-91. PMID: . | The two groups of patients include ‘unresectable HCC’ and ‘recurrent HCC’. Just to confirm, the ‘recurrent HCC’ group has unresectable recurrent HCC, correct? Also, table 1 lists statistics on ‘Liver function status at time of partial hepatectomy’ for both the unresectable HCC and Recurrent HCC groups. Did the unresectable HCC group also have previous partial hepatectomy? Or is that their liver function status at the time of enrollment whereas the recurrent HCC group has reported status at the time of partial hepatectomy?The two patient groups (unresectable and reccurrent unresectable) have outcomes reported separately. Do they have combined survival stats or even stats comparing the two groups? | JK: emailed 2/1Dr. Lau responded 2/8:For the 2 questions which you raised in your email to us, the replies are:(1) The two groups of patients included in our study are patients with unresectable HCC, and patients with recurrent HCC. The recurrent HCC group had patients with unresectable recurrent HCC;(2) For both groups of patients, the liver function status indicated was at the time of enrollment of the patients into the study.I hope I have answered what you asked. If there is any query, please do not hesitate to write to us again.With best wishes,W.Y. LauJK: emailed about combined stats 2/8JK: sent follow up email 3/21Author 3/23: Dear Jenna Khan,The survival curves of two different groups were shown in the paper. We have not compared the difference of both groups.Best regards,W.Y. LauTeam: Leave as is in two separate treatment group rows. |
| R. A. Lencioni, H. P. Allgaier, D. Cioni, M. Olschewski, P. Deibert, L. Crocetti, H. Frings, J. Laubenberger, I. Zuber, H. E. Blum and C. Bartolozzi. Small hepatocellular carcinoma in cirrhosis: randomized comparison of radio-frequency thermal ablation versus percutaneous ethanol injection. Radiology 2003 228(1): 235-40. PMID: . | Treatment dates | JK: emailed 2/28 |
| R. A. Lencioni, H. P. Allgaier, D. Cioni, M. Olschewski, P. Deibert, L. Crocetti, H. Frings, J. Laubenberger, I. Zuber, H. E. Blum and C. Bartolozzi. Small hepatocellular carcinoma in cirrhosis: randomized comparison of radio-frequency thermal ablation versus percutaneous ethanol injection. Radiology 2003 228(1): 235-40. PMID: . | YY: The question is what is the date range (month/year – month/year) of the study in which you report the mean follow-up period of 22.9 months in the RF group and 22.4 months in the PEI group? I am particularly interested in whether or not the actual treatment (RF or PEI) was given after year 2000. | YY: emailed 2/27\*\*\*YY: If no response from author, we may be able to exclude on date. Paper was published in 2003 and follow-up was as long as 36 months, so some patients were likely treated before 2003EXCLUDED based on date it was received by the journal (6/2002) and followup time (mean 22months) |
| S. M. Lin, C. J. Lin, C. C. Lin, C. W. Hsu and Y. C. Chen. Radiofrequency ablation improves prognosis compared with ethanol injection for hepatocellular carcinoma < or =4 cm. Gastroenterology 2004 127(6): 1714-23. PMID: . | Unresectable? Same patient pop as ref 8? | JK: emailed 2/28 about resectable status and if the same patient population (2005 pub had a few more than 2004 pub)JK: email bounced back 3/4 |
| S. M. Lin, C. J. Lin, C. C. Lin, C. W. Hsu and Y. C. Chen. Randomised controlled trial comparing percutaneous radiofrequency thermal ablation, percutaneous ethanol injection, and percutaneous acetic acid injection to treat hepatocellular carcinoma of 3 cm or less. Gut 2005 54(8): 1151-6. PMID: . | Unresectable? | JK: emailed 2/28 about resectable status and if the same patient population (2005 pub had a few more than 2004 pub)Team: We will abstract both since they have a different set of comparators, slightly different # of patients and use different criteria (<3 cm and <=4cm lesions). A note will be made that these may have some of the same pt. population. |
| T. J. Vogl, N. E. Nour-Eldin, S. Emad-Eldin, N. N. Naguib, J. Trojan, H. Ackermann and O. Abdelaziz. Portal vein thrombosis and arterioportal shunts: effects on tumor response after chemoembolization of hepatocellular carcinoma. World J Gastroenterol 2011 17(10): 1267-75. PMID: . | YY: In the inclusion criteria, the authors stated “tumors of any size associated with PVT, either partial thrombosis of the main portal vein or segmental portal vein branch thrombosis.” The question is, does this imply that patients with portal vein tumor thrombus (PVTT), meaning PVT due to tumor invasion, were included in the study? If yes, what % of the entire sample consisted of patients with PVTT? | YY: emailed 2/17YY: emailed again 3/16. If no response, will send to Veena.Author response 3/20: Dear Dr Yoojung Yang Thanks for your inquiry and sorry for delay in your answer as the email was unintentionally reported as spam email.The sample of the study included all cases with PVT whether due to to tumor invasion or not. We did not subclassify the results into PVT and PVTT. My best regards Dr. med. Nour-Eldin A. Nour-Eldin MohammedYY+SB: Since 48.7% reported as having PVT and that does include PVTT, Exclude |
| B. Caspani, A. M. Ierardi, F. Motta, P. Cecconi, E. Fesce and L. Belli. Small nodular hepatocellular carcinoma treated by laser thermal ablation in high risk locations: preliminary results. Eur Radiol 2010 20(9): 2286-92. PMID: . | States in results that 7 of 32 successfully treated lesions had local recurrence, but in discussion section says 7 of 32 patients. There were 52 lesions among 49 total patients, so emailed to verify that it was 7 of 32 patients. | JK: emailed 3/28Response 3/28: 7 of the 32 patients.RegardsAMI |
| F. Laspas, E. Sotiropoulou, S. Mylona, A. Manataki, P. Tsagouli, I. Tsangaridou and L. Thanos. Computed tomography-guided radiofrequency ablation of hepatocellular carcinoma: treatment efficacy and complications. J Gastrointestin Liver Dis 2009 18(3): 323-8. PMID: . | patient pop - CP scores, ECOG, BCLC or equiv?? | JK: emailed 2/28JK: sent follow up email 3/21Team: if no answer then excludeResponse: Dear Jenna Khan, I apologize for the delay in my response to you, but I am too busy this period.Unfortunately, I could not find the requested information about the study population. Regards,F. Laspas, MD, MScExclude |
| L. Zhou, Y. P. Yang, Y. Y. Feng, Y. Y. Lu, C. P. Wang, X. Z. Wang, L. J. An, X. Zhang and F. S. Wang. Efficacy of argon-helium cryosurgical ablation on primary hepatocellular carcinoma: a pilot clinical study. Ai Zheng 2009 28(1): 45-8. PMID: . | YY: I am writing with a clarifying question on your 2009 publication entitled, “Efficacy of argon-helium cryosurgical ablation on primary hepatocellular carcinoma: a pilot clinical study.” Your study staged HCC patients based on BCLC as “early,” “middle,” and “advanced.” Do these correspond to A, B, and C? Please kindly confirm. | YY: emailed 2/17Author: I am so happy to receive your letter. Thanks a lots. You are very interest on our work. In my manuscript entitled “ Efficacy of argon-helium cryosurgical ablation on primary hepatocellular carcinoma: a pilot clinical study”, our patients with HCC staged based on Barcelona Clinic Liver Cancer staging, “early” is correspond to stage A, “middle” as stage B and “ advanced” as stage C. In the near future, my some work was publiction. Please download from attachments. I hope you give me some directions. Best wishes and good Luck. Regards, Yongping Yang |
| L. M. Kulik, B. I. Carr, M. F. Mulcahy, R. J. Lewandowski, B. Atassi, R. K. Ryu, K. T. Sato, A. Benson, 3rd, A. A. Nemcek, Jr., V. L. Gates, M. Abecassis, R. A. Omary and R. Salem. Safety and efficacy of 90Y radiotherapy for hepatocellular carcinoma with and without portal vein thrombosis. Hepatology 2008 47(1): 71-81. PMID: . | Treatment dates | JK: emailed 2/8JK: emailed 2/28 againResponse from Author 2/29: 2002 to 2004 |
| R. Miraglia, G. Pietrosi, L. Maruzzelli, I. Petridis, S. Caruso, G. Marrone, G. Mamone, G. Vizzini, A. Luca and B. Gridelli. Predictive factors of tumor response to trans-catheter treatment in cirrhotic patients with hepatocellular carcinoma: a multivariate analysis of pre-treatment findings. World J Gastroenterol 2007 13(45): 6022-6. PMID: . | Treatment dates and survival time pointTreatments were TOCE, TACE or TAE. Pt. characteristics and survival reported combined. We need separate stats for the 3 different treatments. | JK: emailed 2/8Response on 2/8: will be able to address my questions after 2/15, JK will email when back on 2/21Author response 2/10:Ciao JennaOne of mine co-authors sent me the data you asked me.- the study period is from 1/2000 to 12/2003- survival was calculated considering the data of the first treatmet.Let me know if you need some other data.Ciao da palermo!Roberto JK: emailed 3/20 to see if we could get TACE, TOCE and TAE results reported separatelyResponse 3/23: Dear Jennaunfortunately it is impossible to give you separate patient survival statistics for TOCE, TACE and TAE. this because in the protocol we use to treat HCC patients the type of treatment is tailored in the basis of the clinical condition of the patient the day of the procedure. so the same patient can be treated with TOCE and the next time only with TAE if bilirubin worsened a little bit for example. The protocol used should be explained in the paper. so it is impossible to give you separate survival according to different treatments, we can just considered the cumulative survival for the protocol used. sorryRobertoTeam: Exclude |
| R. Miraglia, G. Pietrosi, L. Maruzzelli, I. Petridis, S. Caruso, G. Marrone, G. Mamone, G. Vizzini, A. Luca and B. Gridelli. Predictive factors of tumor response to trans-catheter treatment in cirrhotic patients with hepatocellular carcinoma: a multivariate analysis of pre-treatment findings. World J Gastroenterol 2007 13(45): 6022-6. PMID: . | YY: 1. In Table 1, you report the BCLC stages as follows: BCLC stage (1/2/3/4) 61/115/14/0. Do stages 1, 2, 3, and 4 correspond to BCLC stages A (early), B (intermediate), C (advanced), and D (terminal)? Also, since these numbers do not add up to the entire sample of 200 patients (61+115+14+0=190), I am wondering if this was simply a type error or if the remaining 10 patients were staged BCLC 0 (very early stage). 2. You stated that patients were evaluated for pre-treatment portal vein invasion (lobar, segmental, or subsegmental) per CT imaging. How many patients (n, %) in the sample actually had portal vein invasion?  | YY: emailed 2/23Author: Thanks for your interest in our paper.- BCLC stages 1,2,3,4 correspond to A,B,C,D. - BCLC A are 71 patients and not 61, sorry this was type error.- 15 patients had partial non-tumoral portal vein thrombosis (no enhancement in the thrombus in arterial phase). No patient had macroscopic neoplastic portal vein invasion at the time of diagnosis. Thanks again and let me know if you need more information.Kind regardsRoberto MiragliaAuthor: 1/2000 - 12/2003 is the period considered. Before (we started in 6/1999) we used a different protocol so for this reason we excluded those patients from the analisis. CiaoRoberto |
| F. S. Chan, K. K. Ng, R. T. Poon, J. Yuen, W. K. Tso and S. T. Fan. Duodenopleural fistula formation after percutaneous radiofrequency ablation for recurrent hepatocellular carcinoma. Asian J Surg 2007 30(4): 278-82. PMID: . | Treatment dateOther patient characterisitics: ECOG, stage, Child Pugh | JK: emailed 3/7 - bounced back, tried twice, could not find an alternate emailTeam: Exclude |
| W. Lu, Y. H. Li, Z. J. Yu, X. F. He, Y. Chen, J. B. Zhao and Z. Y. Zhu. A comparative study of damage to liver function after TACE with use of low-dose versus conventional-dose of anticancer drugs in hepatocellular carcinoma. Hepatogastroenterology 2007 54(77): 1499-502. PMID: . | YY: In the paper, you stated there were total 112 patients who were randomized to low-dose group (n=52) and conventional dose (n=60). However, in Table 1, the group sizes are reported as 40 and 42, respectively. Is this an error? Also, does “PV involvement” refer to portal vein invasion? Please kindly explain the statistics reported here: 48/4 for low dose and 55/5 for conventional dose.  | YY: emailed 2/23Author: Dear Dr.Yang: I am very sorry for the misprinting mistakes in my manuscipt. The total number in our groups is 112 cases. There are 52 cases in group A and 60 in group B. “PV involvement” refer to portal vein trunk or main branch invasion, not including small PV branch invasion. 48/4 refer to no PV invasion in 48 cases and PV invasion in 4 cases.  Thank you for you kindly attention to my manuscriptYY: 3/5 Per the author’s response, there were <10% of pts in each arm with portal vein trunk or main branch invasion, not including small PV branch invasion. Our protocol does not define portal vein invasion in such detail (i.e., location of the pv) – so the question is do we exclude this paper given that there may be >10% of pts with any type of portal vein invasion --- OR do we keep it since we do not have the #s for small PV branch invasion? I’ve emailed the author again with the question about #s of small pv branch invasion. Hopefully he has those numbers, but if not, we may have to exclude the paper given the uncertainties.Team: if no response, send email to VeenaYY: follow-up email 3/20Author response 3/20: Dr. Yang： Thank you very much for your interesting on my paper.  I remember that about 8% of the patient had small PV branch invasion in each arm.  Thanks .Wei luYY: Refid 536 author response below. If we add the 8% of small pv branch invasion to the % portal vein trunk or main branch invasion (reported in the paper), the overall PV invasion exceeds 10% in each arm, which would exclude this paper. |
| A. Kumar, D. N. Srivastava, T. T. Chau, H. D. Long, C. Bal, P. Chandra, T. Chien le, N. V. Hoa, S. Thulkar, S. Sharma, H. Tam le, T. Q. Xuan, N. X. Canh, G. S. Pant and G. P. Bandopadhyaya. Inoperable hepatocellular carcinoma: transarterial 188Re HDD-labeled iodized oil for treatment--prospective multicenter clinical trial. Radiology 2007 243(2): 509-19. PMID: . | Survival time point | JK: emailed 3/7 Excluded - 38% had PVTTEmail bounced back 3/7 |
| I. R. Kamel, D. K. Reyes, E. Liapi, D. A. Bluemke and J. F. Geschwind. Functional MR imaging assessment of tumor response after 90Y microsphere treatment in patients with unresectable hepatocellular carcinoma. J Vasc Interv Radiol 2007 18(1 Pt 1): 49-56. PMID: . | Paper states they allowed extrahepatic mets, PVT and portal invasion, but they only report PVT for pt. dem. In the results. Emailed author about extrahep mets and portal invasion. | JK: emailed 3/9Author response: I do not recall but portal vein thrombosis is indicative of vascular invasion, and considered by some as proof of extrahepatic disease. Hope this helps. JK: excluded based on study population |
| K. S. Chok, K. K. Ng, R. T. Poon, C. M. Lam, J. Yuen, W. K. Tso and S. T. Fan. Comparable survival in patients with unresectable hepatocellular carcinoma treated by radiofrequency ablation or transarterial chemoembolization. Arch Surg 2006 141(12): 1231-6. PMID: . | Survival time point | JK: emailed 3/20Response 3/21: Hi Mr Khan,Thank you for your question.Survival time measurement from the time of treatment.Thank you!Dr Chok |
| C. S. Georgiades, K. Hong, M. D’Angelo and J. F. Geschwind. Safety and efficacy of transarterial chemoembolization in patients with unresectable hepatocellular carcinoma and portal vein thrombosis. J Vasc Interv Radiol 2005 16(12): 1653-9. PMID: . | Need % with PVTT since it seems they are using PVT to include PVTT and bland thrombus | JK: emailed 3/20Response 3/20: Sorry but this is so long ago I can’t remember but yes it was probably more than 10%.J.F. Geschwind, MDExclude on patient population |
| J. L. Raoul, E. Boucher, D. Olivie, A. Guillygomarc’h, K. Boudjema and E. Garin. Association of cisplatin and intra-arterial injection of 131I-lipiodol in treatment of hepatocellular carcinoma: results of phase II trial. Int J Radiat Oncol Biol Phys 2006 64(3): 745-50. PMID: . | Treatment period? Survival time point? | JK: emailed 3/20 - first email bounced back, found alternateResponse 3/20: Sorry, I do not remember exactly the period but it was around 2001 -02Survival time: tà = day of signature of informed consent meaning 2 – 4 weeks before the first injection Best regards Jean-Luc Raoul |
| D. A. Bush, D. J. Hillebrand, J. M. Slater and J. D. Slater. High-dose proton beam radiotherapy of hepatocellular carcinoma: preliminary results of a phase II trial. Gastroenterology 2004 127(5 Suppl 1): S189-93. PMID: . | PV invasion? | YY: emailed 2/17Author: Patients in our study did not have portal vein invasion. I’ve attached our most recent publication. I included two references from Japan describing good results with proton beam in patients with vascular invasion.D BushYY: His 2011 paper (update on refid 718 published in 2004) is not in Distiller --- probably didn’t get picked up during initial search. BUT we’d exclude it based on the treatment dates between April 1998 and October 2006. The 2004 paper doesn’t specify the treatment dates --- do we exclude it assuming the same tx dates given that the earlier report was preliminary results of the same phase II study? Interestingly, the 2004 report has n=34 and 2011 has n=76.The two other attachments (both Japanese studies) do not meet our inclusion criteria as pts exhibited PVTT (also pre-2000 tx dates).YY: Excluded |
| J. Hansler, M. Frieser, S. Schaber, C. Kutschall, T. Bernatik, W. Muller, D. Becker, E. G. Hahn and D. Strobel. Radiofrequency ablation of hepatocellular carcinoma with a saline solution perfusion device: a pilot study. J Vasc Interv Radiol 2003 14(5): 575-80. PMID: . | Treatment dates | JK: emailed 2/8 - bounced back, tried several times, can’t find alternate emailJK: followup ranges to 2.9 years and paper received by journal in 2002. Exclude on date. |
| R. Sacco, I. Bargellini, M. Bertini, E. Bozzi, A. Romano, P. Petruzzi, E. Tumino, B. Ginanni, G. Federici, R. Cioni, S. Metrangolo, M. Bertoni, G. Bresci, G. Parisi, E. Altomare, A. Capria and C. Bartolozzi. Conventional versus Doxorubicin-eluting Bead Transarterial Chemoembolization for Hepatocellular Carcinoma. J Vasc Interv Radiol 2011 (): . PMID: . | Survival time point | JK: emailed 3/20Response 3/20: time point for survival was the time of treatment (C or DEB TACE)Best regardsRodolfo Sacco, MD, Ph.D. |
| I. Bargellini, R. Sacco, E. Bozzi, M. Bertini, B. Ginanni, A. Romano, A. Cicorelli, E. Tumino, G. Federici, R. Cioni, S. Metrangolo, M. Bertoni, G. Bresci, G. Parisi, E. Altomare, A. Capria and C. Bartolozzi. Transarterial chemoembolization in very early and early-stage hepatocellular carcinoma patients excluded from curative treatment: A prospective cohort study. Eur J Radiol 2011 (): PMID: . | YY: Your study included HCC patients in BCLC stage 0 and A “who could not be offered surgical or ablative treatments and underwent TACE.” Was the distinction between stage 0 and A purely the tumor size and number – i.e., stage 0 defined as single nodule <2cm and stage A defined as single nodule <5cm or up to 3 nodules ≤3cm? JK: Survival time point | YY: emailed 2/17Author: Dear dr yang, the distinction between Bclc 0 and A was based on lesion size.thank you for your interest in our paperBest regardsIrene BargelliniJK: emailed about survival definition 3/21Author 3/23: in the paper survival was calculated from study treatment. Feel free to contact me for any need.Best regards,Irene Bargellini |
| R. G. Gish, S. C. Gordon, D. Nelson, V. Rustgi and I. Rios. A randomized controlled trial of thymalfasin plus transarterial chemoembolization for unresectable hepatocellular carcinoma. Hepatol Int 2009 (): . PMID: . | treatment period  | JK: emailed 3/21, Re-emailed 3/27 GishR@sutterhealth.org, bounced back so I emailed all authors since their emails were availableResponse 3/26: The study period was 2004-2006.Thanks.Israel Rios, MD |
| F. Sundram, T. C. M. Chau, P. Onkhuudai, P. Bernal and A. K. Padhy. Preliminary results of transarterial rhenium-188 HDD lipiodol in the treatment of inoperable primary hepatocellular carcinoma. European Journal of Nuclear Medicine and Molecular Imaging 2004 31(2): 250-257. PMID: | Treatment dates, PVT? | JK: emailed 2/28, bounced back and can’t find alternate email addressJK: Excluded - same as 737, so 737 was kept |