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## Hepatocellular carcinoma in cirrhotic liver CT an MRI findings

**GERMÁN CASTRILLÓN<sup>1</sup>**

For all practical purposes, you should consider cirrhosis to be a pre-malignant condition. This means that a patient with cirrhosis is at risk for developing hepatocellular carcinoma (HCC). The greater or lesser risk depends on the etiology of the cirrhosis. There are a lot of complications of cirrhosis, but the most dreaded one is hepatocellular carcinoma. I am going to do a brief review of cirrhosis and then I will talk about the HCC that is the focus of this review.

Imaging the cirrhotic liver is one of the more difficult tasks in radiology. Imaging plays a huge role, regardless of the cause of the cirrhosis and the hepatocellular carcinoma. The first thing that I look for are morphologic changes. Look for nodularity of the liver, signal intensity heterogeneity, and central atrophy. Central atrophy refers to the fact that in many cases of cirrhosis, the anterior segment of the right lobe and the medial segment of the left lobe shrink. This may be accompanied by hypertrophy of the

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caudate lobe and/or the lateral segment of the left lobe. This is reflected in measurements of the caudate right lobe. This measurement will increase, in patients with cirrhosis. Although it is a diffuse process and usually you do get central atrophy, about 25% of patients with end stage liver disease are going to have livers that look normal by size and contour. There may be signal intensity changes that you might note. About one-third of these patients with cirrhosis have diffusely atrophied liver (1,2).

The nomenclature of cirrhotic nodules has been one of the problems over the years fortunately now it is quite simple; there are regenerative nodules (siderotic or no siderotic), dysplastic nodules (high or low grade) and hepatocellular carcinoma if it is small, under 2 cm, it is called small HCC and if it is larger it is called overt HCC. (3) One of the pathologic factors of this spectrum that affects imaging appearances is the vascular supply to the nodule. Through this progression, one sees loss of visualization of portal tracts within the nodules and development of new arterial vessels, termed nontriadal arteries, since typical distal hepatic arterial flow through the portal triad is not typically seen past the lobular level. These nontriadal arteries become the dominant blood supply in large dysplastic nodules and small HCC; this is the main factor for the diagnostic by imaging of HCC (4)

Can imaging be used to differentiate between benign and malignant nodules in the cirrhotic liver? It is the clue.

I am going to talk about magnetic resonance imaging and computed tomography and its possibilities to answer the question.

Despite being present pathologically in all cirrhotic livers, regenerative cirrhotic nodules are seen in a minority of patients at CT and in approximately half of patients at MR imaging, with predominantly siderotic nodules being visualized with both techniques (5). Micronodular changes are rarely seen at CT or MR imaging, macronodular changes, especially large ones (8-10 mm), are readily identifiable because they distort the liver margin and, if they are siderotic, appear at unenhanced CT as predominantly high-attenuation nodules throughout the liver. These nod-

ules typically do not enhance at arterial-phase contrast-enhanced, and during portal-venous-phase, they enhance homogeneously and to the same degree that surrounding fibrotic tissue does; thus, they are indistinguishable. MR imaging, with its increased susceptibility to the effects of iron within regenerative nodules, is better able to show siderotic nodules. These nodules are best identified at T2-weighted and gradient-echo imaging (6,7).

Dysplastic nodules contain cellular atypia without frank malignant changes. MR imaging of large dysplastic nodules may show a distinct pattern of homogeneous high signal intensity on T1-weighted images and very low signal intensity on T2-weighted images (8). Dysplastic nodules may show, along with cellular atypia, pathologically new nontriadal arterial flow to nodules, which characterizes them as distinct from regenerative nodules (3). This increased arterial supply is also present in hepatocellular carcinoma and, as we shall see, is a critical aid to the detection of this carcinoma in patients with cirrhosis. Dysplastic nodules typically do not show vivid arterial-phase enhancement, but occasionally, lesions can become enhanced and simulate hepatocellular carcinoma (9).

Frank hepatocellular carcinoma has a variable appearance at CT and MR imaging. Most small hepatocellular carcinoma nodules are vascular, become enhanced at CT and MR imaging, are optimized with arterial-phase imaging (10), and show a washout of tumoral contrast material during the portal-venous phase. A minority are hypovascular and best seen at portal-venous-phase or equilibrium-phase imaging. The signal intensity of hepatocellular carcinoma varies on both T1- and T2-weighted images among hypo-, iso- and hyperintensity in comparison with liver parenchyma (11).

How does MRI compare to CT? The recommendation of whether to use CT or MR, all depends on personal preference. It depends on what you are most comfortable with and what you do best. I think that the best way to detect HCC is the MRI, because we can see both things, that are important to differentiate the HCC of the others nodules, and are the vascularity and the tisular characterization.

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## Pathology of liver tumors

GERMAN OSORIO SANDOVAL<sup>1</sup>

Liver tumors can be clasifficated according to the origin cell in epithelial and no epithelial. The epithelial tumors source of the duct or the hepatic cell. It is malignant an benign. The principal epithelial tumor malignant are hepatocelullar carcinoma, hepatoblastoma and cholangiocarcinoma. The hepatoblastoma is the most common malignant epithelial tumor of the liver, in the first two years of life. Malignant Primary tumors of the liver are relatively rare especially in patients without underlying liver disease.

The most frequent benign epithelial tumors are focal nodular hyperplasia, liver cell adenoma and bile duct adenoma. The adenoma is much most important benign tumor of the liver; and its association with synthetic oral contraceptive and anabolic steroids is well established. Focal nodular hyperplasia occurs in all ages and sexes. It usually solitary, around 5 cms in size and forms a well-circumscribed fibrous globular mass. A central stellate scar is frequently seen in the imaginologic studies.

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