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# **NATIONAL OPTIMAL PATHWAY FOR HEPATOCELLULAR CARCINOMA: 2<sup>nd</sup> EDITION (2025)**

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## **Point of Suspicion to First Definitive Treatment in Adults (aged 16 and over)**

<b>Date of Issue: August 2025</b>
<b>Date of Review: August 2027</b>
<b>Owner: Upper Gastrointestinal Cancer Site Group</b>

# FOREWORD

The NHS Wales National Optimal Pathways (NOPs) have been developed as part of the Suspected Cancer Pathway (SCP) programme of work. They aim to establish consistent generic and site specific pathways that describe all routes of entry onto the pathway from the point of suspicion (PoS) of cancer. They describe good practice diagnostic and treatment pathways, the diagnostic pathway, including staging, should be performed within 28 days from PoS; and definitive treatment commenced within 21 days from date of Decision to Treat (DTT). The pathways also describe where patients should receive consistent information and support, tailored to meet their needs.

The NOPs aim to provide a platform to standardise care, reduce unwarranted variation and drive improvement whilst increasing quality across each of the cancer pathways in order to:

- meet the SCP cancer waiting time of 62 days for patients presenting with a suspicion of cancer,
- improve cancer patient experience, and,
- improve cancer patient outcomes throughout Wales to that comparable with the best outcomes in Europe.

The hepatocellular carcinoma (HCC) NOP is designed to help HCC cancer service providers and their commissioners see the basic structure of an effective and efficient HCC cancer pathway. In essence, this optimal pathway is about ensuring that each stage of the pathway happens quickly, that communications with patients are effective and that the entire team works in a coordinated but flexible way, focusing always on the patient's journey. It is recognised that the introduction of the National Optimal Pathway for HCC Cancer may present challenges for the Upper Gastrointestinal multidisciplinary teams. However, introducing a nationally agreed, clinically endorsed pathway will support service improvement. They will also provide clarity and consistency for primary care around the referral process into secondary care, including access to diagnostics, to ensure the patients move through the system in a timely manner.

## GROUP CONSULTATION

The Hepatobiliary (HPB) Cancer Site Group (CSG) is led by Mr. Nagappan Kumar, Consultant Surgeon. The pathways work has been led by Dr Tom Pembroke, Consultant Hepatologist. The group includes representation from the full range of professions involved in delivering cancer services. They were all able to contribute and comment on the development of the optimal pathway during a range of pathway workshops, CSG meetings and educational days, commenced in September 2019. An early draft was sent to the Upper Gastrointestinal Multidisciplinary Teams (MDTs), Health Boards and Velindre NHS Trust in October 2019. Separate workshops were also held with the Clinical Nurse Specialist (CNS) and Allied Health Professional (AHP) members to embed the Rehabilitation and Person Centred Care (PCC) into the pathway, ensuring all patient's needs are assessed and met in a timely manner. Wider consultation was sought in December 2019 from NHS Wales's stakeholders, including National Imaging and Pathology Networks and the Third sector; 10 responses were received, and these were all carefully considered during the revision process, prior to a final version being issued in January 2020.

This second edition (2025) of the NOP incorporates best practice guidance, including liver lesion surveillance and transplant referral criteria.

**Dr Tom Pembroke** (MDT Chair)

**Mr. Nagappan Kumar** (HPB Clinical Lead)

**Dr Jeff Turner** (SCP Clinical Lead)

**Professor Tom Crosby** (National Cancer Clinical Director WCN)

## National Optimal Cancer Pathway for suspected and confirmed Hepatocellular Carcinoma (HCC) from Point of Suspicion (PoS) to First Definitive Treatment (FDT) for patients 16 and over

**Suggested Maximum Times**  
 6 monthly screening

**Day 0 – Point of Suspicion (PoS)**

**DAY 7**

**DAY 14**

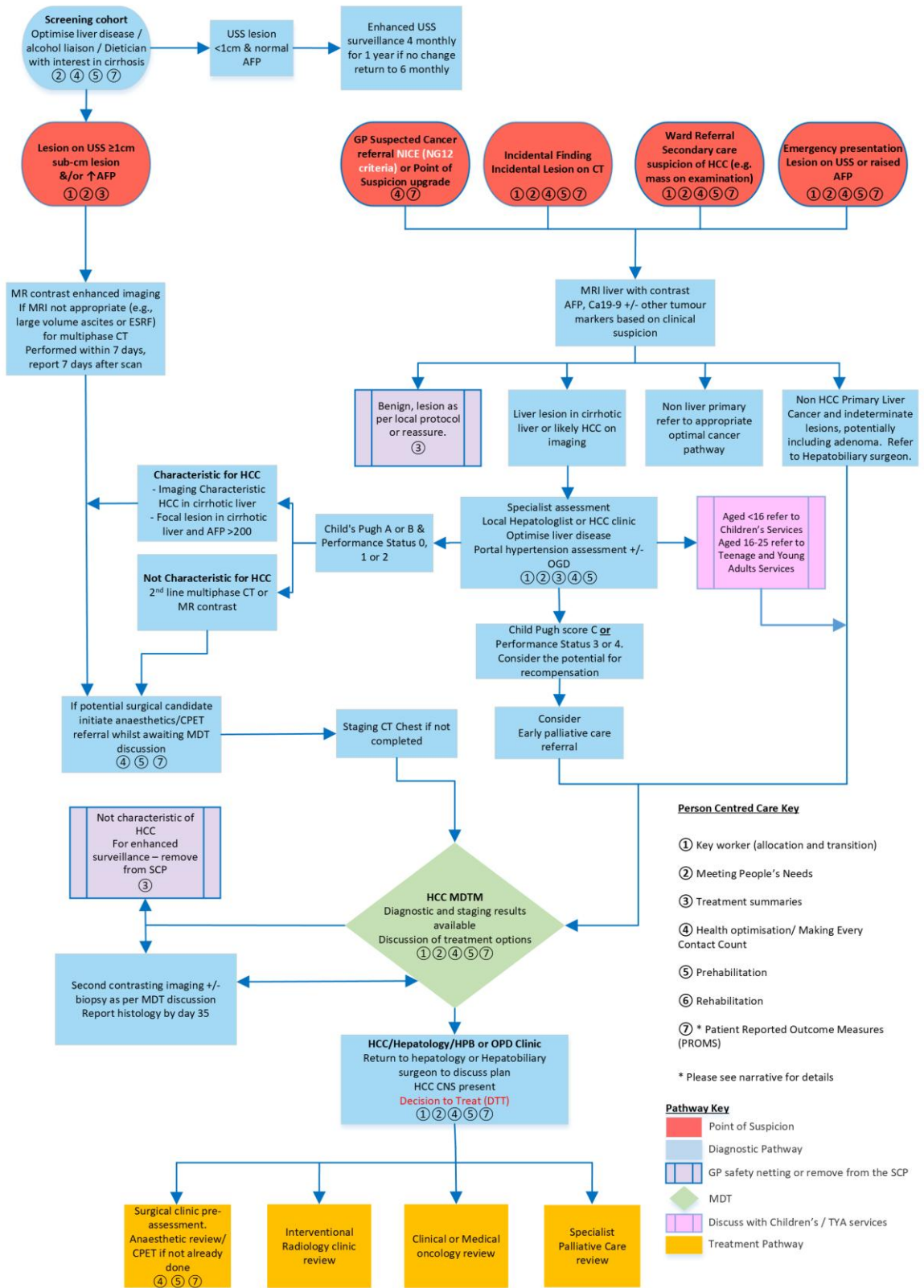
**DAY 21**

**Diagnostic Pathway <28 days from PoS**

**Treatment Pathway <21 days from DTT**

**First Definitive Treatment <62 days of PoS**

Consider Clinical Trials



**FIRST DEFINITIVE TREATMENT (FDT) 1 2 3 6 7**

- Transplant Centre Review
- Surgery
- Ablation
- TACE
- SIRT
- SBRT
- Systemic Anti Cancer Therapy (SACT)
- Specialist supportive/ palliative care

# BEST PRACTICE GUIDANCE

<p><b>Liver Lesion Surveillance</b></p>	<p>Adults with cirrhosis and selected individuals with HBV should be offered 6-monthly surveillance for HCC.</p> <p>Source: <a href="#">National Institute for Health and Care Excellence (NICE), (2017), Hepatitis B (chronic): Diagnosis and Management (CG165)</a></p> <p>Source: <a href="#">National Institute for Health and Care Excellence (NICE), (2017), Liver Disease (QS152)</a></p>
<p><b>Vetting &amp; Triage</b></p>	<p>It is recommended that the triage of referrals is undertaken using an electronic system (e.g. Welsh Patient Referral Service) to improve the timeliness, traceability and governance of pathways.</p> <p>Referrals for South Wales should be sent directly to the HCC Coordinator. Email: <a href="mailto:Hcc.MDT.cav@wales.nhs.uk">Hcc.MDT.cav@wales.nhs.uk</a></p> <p>Referrals for North Wales should be sent directly to the HCC Coordinator.</p> <p><a href="mailto:BCU.CancerMDTUpperGIWest@wales.nhs.uk">BCU.CancerMDTUpperGIWest@wales.nhs.uk</a> Ysbyty Gwynedd</p> <p><a href="mailto:BCU.CancerMDTUpperGICentral@wales.nhs.uk">BCU.CancerMDTUpperGICentral@wales.nhs.uk</a> Ysbyty Glan Clwyd</p> <p><a href="mailto:BCU.CancerMDTUpperGIEast@wales.nhs.uk">BCU.CancerMDTUpperGIEast@wales.nhs.uk</a> Wrexham Maelor</p> <p>Referrals received as suspected cancer (USC) should be prioritised within 1 day and urgent / routine referrals within 3 days due to the potential need for upgrade to suspected cancer (pathway entry date: date referral originally made by primary care).</p>
<p><b>Direct booking diagnostics</b></p>	<p>It is recommended that patients attending a face-to-face outpatient clinic appointment as their first point of contact can ‘direct book’ any onward diagnostic tests such as endoscopy and CT scans on the same day (i.e., leave the hospital with an appointment date and any preparation required for the test).</p>
<p><b>Key worker role</b></p>	<p>Local hepatology CNS team will coordinate initial work up with HCC CNS support as necessary. After MDT confirmation of diagnosis HCC CNS will provide holistic care and support.</p>
<p><b>Physiological optimisation</b></p>	<p>All individuals with cirrhosis and liver cancer are at high risk of decompensation. Management of risk factors including alcohol, diabetes and smoking can improve liver health and enable more aggressive therapies. All patients should be referred to dietetics to optimise liver disease and reduce the risk of sarcopenia and decompensation.</p> <p>It is recommended that if diagnostic investigations identify a suspected cancer, that teams give thought to patient fitness optimisation to run concurrently with pathological staging investigation. This could include consideration of the need for respiratory or cardiology (e.g., echocardiogram) investigation.</p>

	<p>Patients should undergo an objective assessment of peri-operative risk to help inform peri-operative care requirements. They should also have access to peri-operative optimisation resources such as nutritional support, smoking cessation advice, exercise prehabilitation and intravenous iron.</p>
<b>Abnormal straight to test radiology results</b>	<p>MDT will not discuss abnormalities on radiology without an appropriate full clinical assessment.</p>
<b>Transplant Referral Criteria</b>	<p>Consider transplant referral, if appropriate. Concurrent referral to South Wales Multi-Disciplinary Team (MDT) advised for locoregional holding therapy during transplant assessment.</p> <p><a href="#">UK Liver transplant selection criteria 2023 (POL196/7) – Page 14</a></p> <ul style="list-style-type: none"> <li>• Radiological assessment should include both Multidetector computed tomography (MDCT) and Magnetic Resonance Imaging (MRI) with size being assessed by the widest dimensions on either scan.</li> <li>• A tumour (for the purposes of counting numbers) will require to be identified as an arterialised focal abnormality with portal phase washout on MDCT or Gd enhanced MR. Other tumours are considered indeterminate and do not count. Tumour rupture and an <math>\alpha</math>-fetoprotein (AFP) &gt;1,000 iu/ml are absolute contraindications to transplantation, as are extra hepatic spread and macroscopic vascular invasion.</li> </ul> <p>The following are criteria for transplantation listing:</p> <ul style="list-style-type: none"> <li>• A single tumour <math>\leq 5</math>cm diameter (Patients with very early stage HCC (solitary nodule &lt; 2cm, compensated cirrhosis; BCLC Stage 0) should be referred and reviewed to the national HCC appeals panel as detailed below before registration).</li> </ul> <p><b>Or</b></p> <ul style="list-style-type: none"> <li>• Up to 5 tumours all <math>\leq 3</math>cm or Single tumour &gt;5cm and <math>\leq 7</math>cm diameter where there has been no evidence of tumour progression, no extra-hepatic spread, and no new nodule formation over a 6-month period. Locoregional therapy +/- chemotherapy may be given during that time. Their transplant list place may be considered from the time of their first staging scan.</li> <li>• Locoregional therapy should be considered for all transplant list patients who have a hepatocellular carcinoma.</li> <li>• It is recognised that different imaging modalities may identify differences both in number and size of tumour, but to qualify as an HCC will require a congruent lesion to be seen on a minimum of two different radiological modalities. There must be no radiological evidence of vascular invasion and no distant metastasis.</li> <li>• See Appendix A for the details of a service development evaluation of orthotopic liver transplantation for HCC patients undergoing “down-staging”.</li> </ul> <p>Usual transplant unit referral - Cardiff and Vale UHB to The Royal Free Hospital, London.</p> <p>Aneurin Bevan UHB, Betsi Cadwaladr UHB, Cwm Taf Morgannwg UHB, Swansea Bay UHB, and Hywel Dda UHB to Queen Elizabeth’s Hospital Birmingham.</p>

# DEFINITIONS

<b>Decision to Treat</b>	<p>The DATE on which a <b>Decision to Treat</b> is made. For the cancer data sets, the <b>DECISION TO TREAT DATE</b> is the DATE that the consultation between the PATIENT and the clinician took place and a Planned Cancer Treatment was agreed.</p> <p>Source: <a href="https://datadictionary.nhs.uk">NHS Data Model and Dictionary (datadictionary.nhs.uk)</a></p>
<b>Direct to Test</b>	<p>GPs have direct access to diagnostic endoscopy, ultrasound, MRI, X-ray and CT for people suspected of cancer.</p> <p>Source: <a href="#">National Institute for Health and Care Excellence, Quality Standard 2016 (QS 124)</a></p>
<b>First Definitive Treatment</b>	<p><b>First Definitive Treatment</b> is the <b>first</b> CLINICAL INTERVENTION intended to manage a PATIENT's disease, condition or injury and avoid further CLINICAL INTERVENTIONS. What constitutes <b>First Definitive Treatment</b> is a matter of clinical judgement in consultation with others, where appropriate, including the PATIENT.</p> <p>Source: <a href="https://datadictionary.nhs.uk">NHS Data Model and Dictionary (datadictionary.nhs.uk)</a></p>
<b>Safety Netting</b>	<p>“Safety netting is a management strategy of patients, tests and referrals used in the context of diagnostic uncertainty in healthcare. It aims to ensure patients are monitored until signs and symptoms are explained or resolved.”</p> <p>Source: <a href="#">Royal College of General Practitioners (RCGP) - Home</a></p>
<b>Straight to Test</b>	<p>“Following clear referral criteria into secondary care (usually NICE guidance) the secondary care clinician (defined as per local protocol) will arrange a diagnostic procedure as the first episode of care in place of an outpatient episode. The clinician will retain clinical responsibility for the result including acting on the result.”</p> <p>Source: <a href="#">Delivering Cancer Waiting Times NHSE</a></p>
<b>Teenagers and Young Adults (TYA)</b>	<p>Young people (aged 16-24 years) with cancer have their diagnosis treatment and support agreed and delivered by a cancer-site specific multidisciplinary team and a teenage and young adult multidisciplinary team.</p> <p>Source: <a href="#">National Institute for Health and Care Excellence (NICE), 2014. Cancer services for children and young people (QS55)</a></p>

# CLINICAL EVIDENCE

<b>Point of Suspicion/ Referral</b>	<p>The point of suspicion is when a clinician refers a patient or requests a test concerned that a patient may have cancer. Pathway start dates are defined in Appendix 1: Suspected Cancer Pathway Definitions – pathway start date (pages 23 – 29) in the following guidance:</p> <p><a href="#">Suspected cancer pathway: guidelines (WHC/2024/07)   GOV.WALES</a></p>
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	<p>Additional information:</p> <p><a href="#">Cancer Risk Assessment Tool (RAT)</a></p> <p><a href="#">Q Cancer Risk Assessment Tool</a></p>
<b>Diagnosis and Management</b>	<p><a href="#">European Association for the Study of the Liver HCC guidelines 2018</a></p> <p><a href="#">EASL Clinical Practice Guidelines: Management of hepatocellular carcinoma 2018</a></p> <p><a href="#">American Association of the Study of Liver Disease HCC guidelines 2018</a></p> <p><a href="#">BCLC strategy for prognosis prediction and treatment recommendation: The 2022 update - Journal of Hepatology (journal-of-hepatology.eu)</a></p> <p><a href="#">Merits and boundaries of the BCLC staging and treatment algorithm: Learning from the past to improve the future with a novel proposal - Journal of Hepatology (journal-of-hepatology.eu)</a><a href="#">American Association of the Study of Liver Disease HCC guidelines 2018</a></p> <p><a href="#">HAP scoring reference</a> <a href="#">Kadalayil et al Ann Oncol 2013;24(10):2565-70</a></p> <p><a href="#">British Society of Gastroenterology guidelines for the management of hepatocellular carcinoma in adults (2024)</a></p> <p><a href="#">National Institute for Health and Care Excellence (NICE), (2017), Hepatitis B (chronic): Diagnosis and Management (CG165)</a></p> <p><a href="#">National Institute for Health and Care Excellence (NICE), (2017), Liver Disease (QS152)</a></p> <p><a href="#">NICE guideline Radiofrequency ablation of hepatocellular carcinoma 2003</a></p> <p><a href="#">UK Liver transplant selection criteria 2023 (POL196/7) – Page 14</a></p> <p><a href="#">Policies and guidance - ODT Clinical - NHS Blood and Transplant</a></p>

## PERSON CENTRED CARE

Person-centred cancer care is culturally embedded and supported by a common approach to assessing and managing people’s needs and care should be co-produced to ensure people affected by cancer to achieve the outcomes that matter to them’ (Cancer Quality Statement, 2021).

<b>Key Worker</b>	<p>QS 14: Patients are made aware of who to contact, how to contact them and when to make contact about their ongoing healthcare needs. <a href="#">National Institute for Health &amp; Care Excellence (NICE, 2012) CG138 Clinical Guideline: Patient Experience in adult NHS services</a></p> <p>A cancer key worker is “a person who, with the patient’s consent and agreement, takes a key role in coordinating the patient’s care and promoting continuity, ensuring the patient knows who to access for information and advice”.</p>
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	<ol style="list-style-type: none"> <li>1. All cancer patients must have an allocated key worker.</li> <li>2. Allocation / Review of key worker to take place at key time points including: <ol style="list-style-type: none"> <li>a. Around the time of diagnosis <i>*please note: allocation of key worker <b>may</b> occur earlier than time of diagnosis, if there is a very high level of suspicion of cancer e.g. evidence obtained via pathology, radiology, endoscopy.</i></li> <li>b. Commencement of treatment</li> </ol> </li> </ol> <p><a href="#">Key workers for cancer patients (Welsh Health Circular /2014/001) GOV.WALES</a></p> <p><a href="#">Cancer Improvement Plan for Wales</a></p>
<p><b>Meeting People's Needs</b></p>	<p>QS 4: Patients have opportunities to discuss their health beliefs, concerns, and preferences to inform their individualised care.</p> <p>QS 10: Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene, and anxiety. <a href="#">National Institute for Health &amp; Care Excellence (NICE, 2012) CG138 Clinical Guideline: Patient Experience in adult NHS services</a></p> <p>Assessment and discussion of patients' needs for physical, psychological, social, spiritual, and financial support should be undertaken at key points including:</p> <ul style="list-style-type: none"> <li>• Around diagnosis <i>*please note: undertaking a Holistic Needs Assessment <b>may</b> occur earlier than time of diagnosis, if there is a very high level of suspicion of cancer e.g. evidence obtained via pathology, radiology, endoscopy; and it is supported by professional judgement.</i></li> <li>• At commencement, during, and at the end of treatment.</li> </ul> <p><a href="#">National Institute for Clinical Excellence (NICE, 2004) CSG4 Improving Supportive &amp; Palliative care for adults with cancer</a></p> <p>Ideally Holistic Needs Assessments should be undertaken electronically. <a href="#">Cancer Improvement Plan for Wales</a> The Macmillan eHNA is <i>one</i> tool which is both valid and reliable. <a href="#">Snowden A &amp; Fleming M (2015) Validation of the electronic HNA.</a></p> <p>Where appropriate, the impact of the cancer and its treatment on future fertility should be discussed with the cancer team at the earliest opportunity. The eligibility criteria for treatment are set out in the WHSSC Specialist Fertility Commissioning Policy, CP38 (link below). Opportunity should be provided to explore any individual concerns and address any unmet needs and early speciality referral should also be offered.</p> <p><a href="http://whssc.nhs.wales/commissioning/whssc-policies/fertility/specialist-fertility-services-commissioning-policy-cp38-feb-2020/">whssc.nhs.wales/commissioning/whssc-policies/fertility/specialist-fertility-services-commissioning-policy-cp38-feb-2020/</a></p>
<p><b>Health Optimisation / MECC</b></p>	<p>QS 9: Patients experience care that is tailored to their needs and personal preferences, taking into account their circumstances, their ability to access services and their coexisting conditions.</p> <p><a href="#">National Institute for Health &amp; Care Excellence (NICE, 2012) CG138 Clinical Guideline: Patient Experience in adult NHS services</a></p>

	<p>Health Optimisation refers to a proactive approach to supporting people who present to NHS services with concurrent comorbid health conditions (e.g., anaemia, diabetes), or health risk behaviours (e.g. smoking, physical inactivity).</p> <p><a href="#">Welsh Government (2018) A Healthier Wales.</a>  <a href="#">Welsh Government (2015) Wellbeing of Future Generations Act.</a></p> <p>Making Every Contact Count (MECC) is a behaviour change approach that helps health and social care professionals to help people to improve their health and wellbeing through prevention and early intervention. <a href="#">MECC // Public Health Network :: Home</a></p> <p><b>Lifestyle advice / resources are available</b> from <a href="#">Making Every Contact Count (MECC)</a></p> <p><i>*Please note: Whilst addressing concurrent comorbidities and health risk behaviours is the responsibility of <b>all</b> health and social care professionals, at <b>every</b> contact throughout the pathway; earliest possible intervention <b>may</b> impact on cancer treatment choices / outcomes (especially in respect to tobacco smoking). <a href="#">National Institute for Clinical Excellence (NICE, 2018) NG92 NICE Guideline Stop Smoking Interventions and services.</a></i></p>
<b>Prehabilitation</b>	<p>All patients should be given multimodal prehabilitation advice and support covering physical activity, emotional wellbeing, eating well, stopping smoking, and reducing alcohol intake prior to undergoing treatment in order to enhance patient outcomes. Patient needs and goals should be evaluated on an individual basis and appropriate levels of support, from universal self-management advice to specialist support which includes timely access to allied health professional should be provided.</p> <p>Patients should have the opportunity to take part in evidence-based education and rehabilitative activities, including self-management programmes, <i>where available</i>, that promote their ability to manage their own health if appropriate.</p> <p><a href="#">National Institute for Health &amp; Care Excellence (NICE, 2012) CG138 Clinical Guideline: Patient Experience in adult NHS services</a>  <a href="#">Welsh Government (2018) A Healthier Wales.</a>  <a href="#">Welsh Government (2015) Wellbeing of Future Generations Act.</a>  <a href="#">The Quality Statement for Cancer.</a></p>
<b>Rehabilitation</b>	<p>All patients will have their needs for rehabilitation services assessed, with referral to an appropriate level of rehabilitative support, throughout the patient pathway including timely access to AHPs to meet individual holistic patient needs and goals.</p> <p><i>*Please note: not <b>all</b> patients will require specialist cancer rehabilitation services. Referral into non-cancer rehabilitation, self-management, and fitness services <b>may</b> be suitable to meet some patients' needs.</i></p> <p><a href="#">National Institute for Health and Care Excellence (NICE) CSG4 (2004) resources for improving supportive and palliative care for adults with cancer.</a></p>
<b>Patient Reported Outcome Measures (PROMs) / Patient Reported</b>	<p>Patient Reported Outcome Measures (PROMs) are questionnaires that patients are asked to complete <b>before</b> and <b>after</b> treatment to assess the impact on health and wellbeing.</p> <p><b>Some</b> of the Cancer Site Groups (CSGs) have been working with the International Collaboration for Health Outcome Measurement (ICHOM), Value Based Healthcare Team, <a href="#">National PROMS, PREMS, &amp; Effectiveness Programme (NPP&amp;EP)</a> and other partners, to pilot</p>

<p><b>Experience Measures (PREMs)</b></p>	<p>tools and data capture methods, which will inform a consistent approach to PROMS &amp; PREMS for cancer. <a href="#">The Quality Statement for Cancer</a></p> <p><i>*Please note: there are outstanding questions relating to tool selection, data capture intervals, data capture methods and data analysis / reporting which <b>may</b> prevent the implementation of PROMS &amp; PREMS across all pathways at this time. PROMS &amp; PREMS have been included in the pathways, in recognition of this work, and will be updated pending further advice from the CSGs.</i></p> <p>Patient Reported Experience Measures (PREMs) are questionnaires that patients are asked to complete at <b>any time</b> during their pathway to help professionals to understand their experience of NHS services. This information is crucial to understanding the value of healthcare as perceived by patients. <a href="#">Welsh Government (2018/19). Chief Medical Officer Annual Report</a></p> <p><i>*Please Note: Whilst it is good practice to collect PREMS throughout the pathway, there is no current standard for cancer PREMS in Wales; further advice regarding this will be sought via the CSGs in due course.</i></p>
<p><b>Communication</b></p>	<p>Clinicians must ensure patients are kept up to date about their care pathway and are supported to make individualised choices about their treatment.</p> <p>Clinicians should consider the value of interventions and discuss with the patient the likely outcome of treatment options.</p> <p>Clinicians in secondary and tertiary care must ensure that all decisions relating to a patient’s care or treatment are communicated to the patient and their primary care clinician in a timely manner and within 24 hours of diagnosis.</p> <p>Clinicians must ensure that the clinical intention of any intervention such as tests or treatment is clear to patients, and whether it is just a stage of the agreed pathway or considered start of first definitive treatment and as such ends the pathway.</p> <p>Clinicians must make contemporaneous records of discussions and decisions and include reasons for deviations from recommended clinical practice in the patient’s clinical record. Decisions should be made in a timely manner, and any onward referrals be completed promptly, according to local/national guidelines and optimal pathways and include adequate information to allow the receiving clinician to initiate appropriate interventions with the minimum of delay. Referrers must ensure that the patient is aware and agrees for a suspected cancer referral to be made.</p> <p><a href="#">Suspected cancer pathway: guidelines (WHC/2023/025)   GOV.WALES</a></p> <p><b>Treatment Summary</b></p> <p>A treatment summary is a tool completed by secondary care professionals after a significant phase of a patient's cancer treatment. A treatment summary describes the patient’s cancer diagnosis, prognosis, and aim, types and side effects of any treatment that they have had. It also highlights any signs and symptoms of recurrence that the patient needs to be aware of. It is designed to be shared with the person living with cancer and their GP either electronically or as a paper document, and should use easy to understand, clear and concise language. Additionally, it can be used by the person affected by cancer to help inform other health and social care professionals, employers/occupational health, or financial institutions e.g., benefits services or banks, about their cancer care and treatment.</p>

<b>Research</b>	<p>Patients should have the opportunity to take part in research and clinical trials where available.</p> <p><a href="http://healthandcareresearchwales.org">People in research   Health Care Research Wales (healthandcareresearchwales.org)</a> <a href="http://ecmcnetwork.org.uk">EC Trial Finder   ECMC (ecmcnetwork.org.uk)</a></p>