The NCCN Clinical Practice Guidelines on Liver Cancer: Guidelines for All Settings?

Liver cancer occurs relatively infrequently in the United States. As Arciero and Sigurdson (in this issue) point out, only 18,000 cases are expected this year. The important fact to remember, though, is that, worldwide, hepatocellular cancer ranks as one of the most devastating tumors. In China, for instance, with its estimated 130 million cases of chronic hepatitis B infection, more than 300,000 deaths occur a year from liver cancer. The reasons for this high prevalence worldwide are multiple, including hepatitis B and C virus infection, aflatoxins, and chemical exposures, so improvement in preventative rather than therapeutic measures may ultimately be the step that eradicates the morbidity and mortality from the disease. This month's article by Kulik explores the possible role of interferon-based therapy in halting the progression of hepatitis C disease to its malignant phase.

Meanwhile, the asymmetric international distribution of liver cancers raises an interesting problem for guideline users—are the NCCN guidelines usable as they are promulgated or can they be modified to accommodate local practices and cultural preferences? This question was brought home vividly at an NCCN conference in India. The attendees pointed out that the NCCN cervix screening guideline recommendations based on PAP test findings are irrelevant in many local sites, because annual PAP testing would far exceed the economic resources of many villages. In addition, the cervix treatment guidelines were believed to be unnecessarily nuanced for early stage disease, which was not relevant there, because only stage 3 and 4 disease was seen in these settings. One proposal was to create 2 guidelines, one for the more economically advanced segments of society, in which the goal should be the NCCN level of care, and a leaner set of recommendations for the segments of society in which this level of care is not feasible.

In a recent article, Fervers et al.1 addressed the issue of “transcontextual adaptation” and discussed a framework for adapting guidelines to meet local organizational or cultural needs. The first steps are a broad search for existing guidelines and a careful analysis of their quality. The next step is a detailed analysis of the coherence between the evidence and the recommendations, thereby setting limits on the amount of modification that can legitimately be made. After these analyses, guidelines can be modified to bring them in line with local needs, with the assurance that the modifications do not contradict high-level evidence. In some instances, de novo recommendations may be inserted, but these should be based on evidence drawn separately from the guidelines. Reasons that guidelines might have to be modified include availability of medical resources and equipment, cultural preferences, patient preferences, and differences in patient populations or prevalence of disease.

One caveat for organizational modifiers: adaptation is not valid for resource reasons if referral to another facility is an alternative. As outlined in the article by Botha and Langnas (in this issue), liver transplantation, which is obviously a specialized procedure, is a potentially beneficial and curative approach to liver tumors. An institution cannot “adapt” the guidelines by deleting this option because it does not have the capacity to perform this complex procedure. If the guideline is formally revised, it should specifically state that referral for liver transplantation is the acceptable mode of treatment.

Reference